Public Document Pack

Democratic Services Section
Legal and Civic Services Department
Belfast City Council
City Hall
Belfast
BT1 5GS

7th January, 2021

MEETING OF PEOPLE AND COMMUNITIES COMMITTEE

Dear Alderman/Councillor,

The above-named Committee will meet remotely via Microsoft Teams on Tuesday, 12th January, 2021 at 5.15 pm, for the transaction of the business noted below.

You are requested to attend.

Yours faithfully,

SUZANNE WYLIE

Chief Executive

AGENDA:

1. **Routine Matters**

   (a) Apologies

   (b) Minutes

   (c) Declarations of Interest

2. **Restricted**

   (a) Finance Update (Pages 1 - 4)

   (b) Partnerships in Parks and Open Spaces. - Belfast MELA 2021 (Pages 5 - 12)

3. **Matters referred back from the Council/Motions**

   (a) Motion - Creating Better Access into the Hills (Pages 13 - 14)

   (b) Motion - 30 by 30 Biodiversity Campaign (Pages 15 - 16)

4. **Committee/Strategic Issues**

   (a) Multi-Agency Support Hubs - Belfast Pilot (Pages 17 - 22)

   (b) Committee Update on Local Air Quality Management Matters (Pages 23 - 28)

   (c) 'Amazing Spaces Smart Places' Small Business Research Initiative (Pages 29 - 32)

   (d) Response to the Food Standards Agency consultation on the review of the Food Law Code of Practice, Food Law Practice Guidance and implementation of the competency framework (Pages 33 - 82)

   (e) Belfast City Council response to the new substance use strategy for Northern Ireland - "Making Life Better - Preventing Harm and Empowering Recovery: A Strategic Framework to Tackle the Harm from Substance Use" (Pages 83 - 214)

   (f) Belfast City Airport Request - Rookery at Victoria Park: Implications to Air Safety (Pages 215 - 222)

5. **Operational Issues**

   (a) Proposal for naming a new street (Pages 223 - 224)

6. **Issues Raised in Advance by Members**

   (a) CCTV equipment CS Lewis Square and to consider the CCTV needs for the remainder of the Greenway - Councillor Newton

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Belfast City Council

PEOPLE AND COMMUNITIES COMMITTEE

Subject:	Motion – Creating Better Access into the Hills
Date:	12th January, 2021
Reporting Officer:	Sara Steele, Democratic Services Officer
Contact Officer:	Sara Steele, Democratic Services Officer

Restricted Reports				
Is this report restricted?	**Yes**		**No**	X
If Yes, when will the report become unrestricted?				
After Committee Decision				
After Council Decision				
Some time in the future				
Never				

Call-in				
Is the decision eligible for Call-in?	**Yes**	X	**No**	

1.0	**Purpose of Report/Summary of Main Issues**
1.1	To bring to the Committee's attention the Motion in respect of Creating Better Access into the Hills which was referred to the Committee by the Council on 7th January.
2.0	**Recommendation**
2.1	The Committee is requested to • Consider the motion and if the proposal is agreed a report on how this would be facilitated, resourced and managed will be brought back
3.0	**Main Report**
	<u>Key Issues</u> The Council, at its meeting on 7th January, considered the following motion which had been moved by Councillor Donnelly and seconded by Councillor Garrett.

	"As a City, one of Belfast's best natural attributes is its surrounding hills and landscape. The Cavehill and Divis mountains offer spectacular views of the city that visitors and Belfast residents flock to all year around to enjoy. *More so now than ever before, locations like Divis mountain offers space for outdoor recreation and essential health and well-being. As a city council we must work with partners to develop a plan which is respectful of the natural environment and surrounding area but also supports the increased demand for parking and user facilities at Divis Mountain.* *Therefore, we call on this Council, working alongside partners in the Department of Infrastructure, The National Trust and the Belfast Hills Partnership, to develop and implement a resourced plan for enhanced user facilities, including parking at the Divis Mountain walk site on Divis Road, Hannahstown, as well as cyclist parking and to explore the creation of further access points into the hills from different locations across the city which in itself will take pressure of the car park and allow residents to access the hills on foot from their neighbouring communities."* In accordance with Standing Order 13(f), the Motion was referred without discussion to the People and Communities Committee. **Financial and Resource Implications** None. **Equality or Good Relations Implications** None.
4.0	**Appendices - Documents Attached**
	None

Belfast City Council

PEOPLE AND COMMUNITIES COMMITTEE

Subject:	Motion – 30 by 30 Biodiversity Campaign
Date:	12th January, 2021
Reporting Officer:	Sara Steele, Democratic Services Officer
Contact Officer:	Sara Steele, Democratic Services Officer

Restricted Reports				
Is this report restricted?	**Yes**		**No**	X
If Yes, when will the report become unrestricted?				
After Committee Decision				
After Council Decision				
Some time in the future				
Never				

Call-in				
Is the decision eligible for Call-in?	**Yes**	X	**No**	

1.0	**Purpose of Report/Summary of Main Issues**
1.1	To bring to the Committee's attention the Motion in respect of the 30 by 30 Biodiversity Campaign which was referred to the Committee by the Council on 7th January.
2.0	**Recommendation**
2.1	The Committee is requested to • Consider the motion and if the proposal is agreed a report on how this would be facilitated, resourced and managed will be brought back.
3.0	**Main Report**
3.1	**<u>Key Issues</u>** The Council, at its meeting on 7th January, considered the following motion which had been moved by Councillor Smyth and seconded by Councillor Michelle Kelly.

3.2	*"This Council recognises the positive steps made during this term to improve its environmental commitments. It is also aware of the 30 by 30 pledge made by 64 Nations at the UN Biodiversity Summit in September 2020, to return 30% of land and sea to nature by 2030, and signals an ambition to reverse biodiversity loss within the next 10 years. This Council also notes the increasing awareness of the citizens of this city to the climate crisis and their willingness to play their part, no matter how small and, in this context, welcomes progress on the Council working with others to assist residents in transforming their alleyways and open spaces"* *Building on this, the Council will develop and put together a 30 by 30 biodiversity campaign in collaboration with its partners that will educate, inform and support our citizens and communities to maximise the green spaces they have around their homes to support urban biodiversity throughout the city.* *We believe that a 30 by 30 Biodiversity campaign can deliver positive benefits and can help meet this Council's legal obligations under 'The Wildlife and Natural Environment Act (Northern Ireland) 2011' to further and strengthen biodiversity in this city for the decades to come."*
3.3	In accordance with Standing Order 13(f), the Motion was referred without discussion to the People and Communities Committee.
3.4	**Financial and Resource Implications** None.
3.5	**Equality or Good Relations Implications** None.
4.0	**Appendices - Documents Attached**
	None

Belfast City Council

PEOPLE AND COMMUNITIES COMMITTEE

Subject:	Multi-Agency Support Hubs – Belfast Pilot
Date:	12 January 2021
Reporting Officer:	Ryan Black, Director of Neighbourhood Services
Contact Officer:	Alison Allen, Neighbourhood Services Manager

Restricted Reports				
Is this report restricted?	**Yes**		**No**	X
If Yes, when will the report become unrestricted?				
After Committee Decision				
After Council Decision				
Some time in the future				
Never				

Call-in				
Is the decision eligible for Call-in?	**Yes**	X	**No**	

1.0	**Purpose of Report or Summary of main Issues**
1.1	The purpose of this report is to provide Members with details of the Multi-Agency Support Hub concept and to seek a decision on Council's participation.
2.0	**Recommendations**
2.1	The Committee is asked to • Agree to Council's participation as outlined in the report below and to support Botanic DEA as the pilot area.
3.0	**Main report**
3.1	<u>Background</u> The Multi Agency Support Hub concept brings key professionals together to facilitate early, better quality information sharing and decision making to work together to improve a vulnerable person's situation. Support hubs are designed to help vulnerable people get

	access to the right support, at the right time, from the right organisation in their local area in keeping with the following principles:
3.2	• Accurately assessing and meeting need. **(Information sharing)** • Enabling agencies to cooperate in order to prevent "persons of concern" from suffering significant harm. **(Coordinated intervention)** • Promoting sound decision making. **(Collaborative decision making)** • Ensuring the provision of appropriate services – and the integration of these into a coherent plan. • Avoiding duplication of assessments and service provision. • Ensuring compliance with statutory duties. • Preventing "persons of concern" from having to repeat their 'stories'. • Reducing the impact of harm and promoting good outcomes for "persons of concern". • Preventing or managing risk with respect to "persons of concern",
3.3	All partners are equal within the Multi-Agency Support Hub with a chairing organisation/individual identified from within the group. Administrative support is normally provided by the Community Safety Team within each local authority but this has yet to be discussed for Belfast (with a small amount of additional financial support available from Department of Justice to cover costs).
3.4	The Support Hubs can help people who may be experiencing a range of problems. This can include being a victim of ongoing antisocial behaviour or crime. Other people may need support in order to avoid being drawn into behaviour which may lead to offending. Others may find themselves in difficult situations which can affect their personal safety, physical or mental health. The person seeking help will be asked for their consent to be supported by the hub as the individual's opinions and welfare are at the centre of any decision and action taken. Support Hubs firmly focus on reducing the vulnerability for individuals.
3.5	With specific focus on early intervention, the work of those in the support hub also includes identifying concerns about individuals who as yet may not have been referred to the hub. In these cases, agencies will work together to provide early intervention with individuals in order to reduce vulnerability and improve wellbeing.
3.6	To date, Belfast is the only local authority area in Northern Ireland without an operating Multi-Agency Support Hub.

Belfast Support Hub Proposal

3.7 The proposal for the Belfast Support Hub was discussed with partner agencies (detailed below) at a collective meeting on 17/01/2020.

3.8 **Proposed Partners:**

- PSNI
- Health and Social Care Trust
- Local Council
- Northern Ireland Housing Executive
- Youth Justice Agency
- Probation Board for NI
- Education Authority
- Northern Ireland Ambulance Service
- Northern Ireland Fire and Rescue Service

3.9 Representatives from these agencies participating in other Support Hubs were present and were all very positive in relation to the benefits it brings, specifically acknowledging the following:

- Having health partners around the table ensures that where there may be an underlying mental health issue contributing to the wider vulnerability, it can be properly identified and the person appropriately supported.
- It creates streamlined information sharing arrangements. There is no need for ISA or GDPR considerations as this is all done with the persons consent.
- Opportunity to refresh existing collaborative structures and focus service on the most vulnerable
- Co-ordinated support and cutting down on duplication of work by different services
- Improving the life of vulnerable people in society whilst at the same time easing the pressure on front line services.
- Focuses on the underlying causes of problems, facilitates information exchange and contributes to early intervention.

3.10 It was acknowledged however, that in Belfast there are a range of existing multi-agency working arrangements e.g. Family Support Hubs, Anti-Social Behaviour Forums. Whilst this is the case, there remain a significant number of individuals who are not meeting the threshold for the more specialist services in these multi-agency groups but may still require

	additional help and support from more than one agency. These individuals often do not know who to turn to for help and will contact multiple organisations or engage in the wrong services because their needs are not being looked at holistically.
3.11	It is for this reason partners agreed that because Belfast was a much larger area than other local authority areas and also had higher degrees of vulnerability, it would be extremely complex to establish Support Hub arrangements across the city and that a pilot area should be taken forward to test the concept in Belfast. A Support Hub pilot area will allow for appropriate evaluation and 'ironing out' of any implementation challenges in a Belfast context before consideration is given to whether a wider roll out is appropriate and it should not automatically be assumed it will work effectively in Belfast, just because it works in other local authorities in Northern Ireland.
3.12	Following discussion on possible pilot areas, Botanic DEA was suggested as a suitable area for a pilot within Belfast. The reasons for this were that it is a diverse community with a range of complex needs, there are high levels of crime and ASB and there is a mixture of settled and transient communities co-existing within the area.
3.13	Partners present at the meeting agreed that Botanic DEA should be the pilot area within Belfast, however, Council Officers present reminded those at the meeting that a formal Council position could only be taken on this after Committee decision and ratification at Full Council.
3.14	The Support Hub concept aligns well to the Belfast Agenda, Belfast: Our Recovery and our Inclusive Growth agenda ensuring all partners in the city work to make life better for residents, support vulnerable people more effectively by addressing any barriers they face, supporting early intervention/prevention and ensuring Belfast's success can reach every citizen.
3.15	For Members information, the proposal for a Multi-Agency Support Hub Pilot to be established in the Botanic DEA has been endorsed by Belfast PCSP and the Living Here Board of the Belfast Community Planning Partnership.
3.16	Members are asked to consider if they will endorse this and Council's participation in the pilot.

	Next Steps:
3.17	If Council endorses the recommendation that there should be a Support Hub Pilot established in Botanic DEA, a small project team of Officers from each partner agency will be pulled together to plan implementation.
	Financial & Resource Implications
3.18	There are not expected to be any financial implications beyond staff time. In other local authorities, administrative support is usually provided by the Community Safety Team within the Council. This is yet to be agreed for Belfast and will need to be considered carefully considering the high demands on Council Officers at present. Department of Justice will provide a small grant to cover administrative costs for up to 3 years.
	Equality or Good Relations Implications/Rural Needs Assessment
3.19	None at present, but will be kept under continuous review.
4.0	**Appendices – Documents Attached**
	None

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PEOPLE AND COMMUNITIES COMMITTEE

Belfast City Council

Subject:	Committee Update on Local Air Quality Management Matters
Date:	12th January 2021
Reporting Officer:	Siobhan Toland, Director of City Services, City and Neighbourhood Services Department
Contact Officer:	Vivienne Donnelly, City Protection Manger.

Restricted Reports				
Is this report restricted?	**Yes**		**No**	X
If Yes, when will the report become unrestricted?				
After Committee Decision				
After Council Decision				
Some time in the future				
Never				

Call-in				
Is the decision eligible for Call-in?	**Yes**	X	**No**	

1.0	**Purpose of Report or Summary of main Issues.**
1.1	The Committee will be aware that a number of ambient air quality initiatives and projects have been progressed by officers within the City and Neighbourhood Services Department during 2020. Including the development of new Air Quality Action Plan for the city, procurement of consultancy services to deliver a detailed assessment for nitrogen dioxide (NO_2) and fine particulate matter ($PM_{2.5}$) and the provision of local site operator and technical project support to the Department of Agriculture, Environment and Rural Affairs (DAERA) to enable research into the chemical composition of particulate matter within the city, to include the role of ammonia (NH_3) in formation of local particulate matter. An update report on these initiatives and projects was provided to the Committee at its meeting of 8th September 2020.

1.2	This report serves to provide a further 'year-end' update to Committee and to provide an overview of the how these projects are to be progressed during 2021.
2.0	**Recommendations.**
2.1	The Committee is asked to • Note contents of this report.
3.0	**Main report.**
	Key Issues.
3.1	**Air Quality Action Plan.** Committee Members will be aware that the current Belfast City Air Quality Action Plan is scheduled to conclude at the end of 2020. Accordingly, officers have already engaged with a range of government Departments, the Public Health Agency, local public transport providers, the Port of Belfast and sustainable environment and transport organisations in order to develop a new Air Quality Action Plan for the city. In accordance with government policy guidance, a Steering Group, comprising representatives from the above-mentioned organisations, has been convened in order to oversee development, implementation and delivery of the new Air Quality Action Plan.
3.2	Organisations represented on the Steering Group have recently provided the transport and related actions that each organisation proposes to implement throughout the anticipated 5-year duration of the Air Quality Action Plan in order to address any remaining nitrogen dioxide (NO_2) hot spots and to improve ambient air quality generally across the city. In addition, it is anticipated that the new Action Plan will also reflect actions to address fine particulate matter ($PM_{2.5}$) once the detailed assessment for nitrogen dioxide and fine particulate matter has been concluded and reported by December 2022.
3.3	The Department for Environment, Food and Rural Affairs (Defra) has provided a standardised Action Plan template for local authorities and Steering Group partners to populate with their actions, under the headings of public health, planning and policy context, source apportionment, the required reduction in emissions, key priorities and action plan measures. It is for council officers, working alongside their Steering Group counterparts to now populate this Defra template in order to create a draft Air Quality Action Plan for the city. It is anticipated that the key components of the draft Action Plan will be presented to the People and Communities Committee for consideration at its meeting of 9th February 2021.
3.4	In addition, and by way of a limited internal consultation, ahead of any formal engagement process that might be required in March and April 2021, it is proposed that the draft Action

	Plan will also be presented to the council's 'Living Here' Board in February 2021 in order to ensure consistency with the Belfast Agenda Community Plan. An overview of the draft Plan will similarly be presented to the Climate Plan Programme Board in order to ensure consistency with the council's Resilience Strategy and its associated actions on climate change. Subject to any comments received through both internal and other engagement processes being addressed within the Plan, it is anticipated that the Air Quality Action Plan will be presented to the 11th May 2021 meeting of the People and Communities Committee and to the June 2021 Council meeting for formal consideration and adoption.
3.5	The Air Quality Action Plan must then be uploaded to the Defra Local Air Quality Management Report Submission Website so that an appraisal of the technical aspects of the Plan can be completed. The outcome of this appraisal process is normally known within 4 to 6 weeks of the submission date. Where necessary, technical aspects of the Air Quality Action Plan will be amended to take account of the appraisers' comments and it is anticipated that the Action Plan can then be implemented from August or September 2021.
3.6	**Detailed assessment for nitrogen dioxide (NO_2) and fine particulate matter ($PM_{2.5}$).** Members were previously advised that officers had completed development of a detailed technical specification for the appointment of a suitably qualified and experienced environmental consultancy to deliver a detailed assessment for nitrogen dioxide (NO_2) and fine particulate matter ($PM_{2.5}$) for the city. This specification has since been issued by way of local and European tenders, with the council's Air Quality and Procurement staff currently engaged in the evaluation process, with a view to appointing a contractor from early 2021.
3.7	The detailed assessment project will comprise additional ambient monitoring for nitrogen dioxide (NO_2) and fine particulate matter ($PM_{2.5}$) across the city through the deployment of a number of small sensor air quality monitoring equipment; the development of an up to date local emissions inventory for the city for nitrogen dioxide (NO_2) and fine particulate matter ($PM_{2.5}$) sources; and atmospheric dispersion modelling employing the local emissions inventory data in order to generate spatial and temporal predictions for nitrogen dioxide (NO_2) and fine particulate matter ($PM_{2.5}$) concentrations across the city. The dispersion modelling will also identify the locations and extents of any exceedences of national, European or WHO air quality standards for nitrogen dioxide (NO_2) and fine particulate matter ($PM_{2.5}$).
3.8	The detailed assessment for nitrogen dioxide (NO_2) and fine particulate matter ($PM_{2.5}$) project is being supported via the Department of Agriculture, Environment and Rural Affairs

	(DAERA) local air quality management grant process and the project is scheduled to be concluded and reported by December 2022.
3.9	**Installation of an Ion Chromatogram analyser at the Belfast Centre Lombard Street monitoring site.** In the previous update report of 8th September 2020, Members were advised that as an addendum to the detailed assessment for nitrogen dioxide (NO_2) and fine particulate matter ($PM_{2.5}$), council officers were liaising with their DAERA counterparts and the UK Centre for Ecology and Hydrology regarding a project to identify and quantify the water-soluble gases and aerosols in air containing different sizes of particulate matter. The aim of this project was to aid in the better understanding of some of the chemical mechanisms involved in the formation of particulate matter in Belfast and across Northern Ireland. It was therefore proposed that council officers would undertake a local site operator role for the Monitor for AeRosols and Gases (MARGA) ion chromatogram equipment that was to be installed at the Belfast Centre Lombard Street monitoring site. Council air quality staff already provide local site operator functions for some of the analysers located at this Environment Agency operated monitoring station.
3.10	However, as a consequence of detailed discussions with DAERA and the UK Centre for Ecology and Hydrology staff regarding the technical and operational requirements of the Marga equipment, it was concluded that the project could not be reasonably and safely undertaken at the Lombard Street site at the current time due to various national, regional, travel and workplace Covid 19 restrictions. Accordingly, it has been proposed that delivery of this project will be revisited whenever Covid 19 restrictions and working practices safely permit.
3.11	<u>Financial & Resource Implications.</u> Permission for the public advertisement of Tender T2044 for ambient air quality assessment within the Council boundary for $PM_{2.5}$ and NO_2 ambient pollutants was obtained at the Strategic Policy and Resources Committee meeting of Friday 24th January 2020. Funding of up to £125,000 to support delivery of the detailed assessment project has been secured from the DAERA Local Air Quality Management grant scheme for the 2020-2021 grant year.
3.12	<u>Equality or Good Relations Implications / Rural Needs Assessments</u> None.
4.0	**Appendices – Documents Attached**

	None.

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PEOPLE AND COMMUNITIES COMMITTEE

Belfast City Council

Subject:	'Amazing Spaces Smart Places' Small Business Research Initiative
Date:	12 January 2021
Reporting Officer:	Ryan Black, Director of Neighbourhood Services
Contact Officer:	Alison Allen, Neighbourhood Services Manager

Restricted Reports				
Is this report restricted?	**Yes**		**No**	X
If Yes, when will the report become unrestricted?				
After Committee Decision				
After Council Decision				
Some time in the future				
Never				

Call-in				
Is the decision eligible for Call-in?	**Yes**	X	**No**	

1.0	**Purpose of Report or Summary of main Issues**
1.1	The purpose of this report is to provide an update on the progress of the 'Amazing Spaces Smart Places', Small Business Research Initiative (SBRI) challenge.
2.0	**Recommendations**
2.1	The Committee is asked to; • Note the ongoing progress of this work.
3.0	**Main report**
3.1	Key Issues Members will recall previous updates on funding secured from Department of Economy (via Department of Justice) to facilitate fully funded innovation contracts with a small number of SME's to support the following objectives:

	- Open spaces are more welcoming environments enjoyed by everyone - Increased positive usage and animation of open spaces - Empowered and involved communities - Crime and anti-social behaviour is reduced in open spaces in the city - Maintenance and security costs are reduced
3.2	The SBRI process is a 'pre-procurement' exercise, designed to enable SME's with funding for research/design and prototyping to stimulate innovative solutions, services and products to meet public sector needs.
3.3	It is used widely across both the UK and Ireland and Belfast City Council has already had previous experience leading on a successful SBIR project - the Rates Maximisation challenge in conjunction with Land & Property Services (LPS). The Rates Maximisation challenge led to a full procurement exercise for technology that will increased Council's rates income based on the SBRI research/design and prototyping work.
3.4	Council has been successful in securing funding at both Phase 1 (£120K) and Phase 2 (£225K) to support this work and there is no cost to the Council and this Committee has identified implementation of Phase 2 as a priority action in the 20/21 Committee Plan.
3.5	The number of organisations in receipt of funding has reduced as the feasibility (technical and operational) and commercial viability (condition of the DfE funding) of proposed solutions has been worked through at each stage and Council is now working with two SME's as part of Phase 2.
3.6	Two technological solutions remaining as potentially feasible and commercially viable and details are provided below. Both solutions have been fully developed and tested in a lab/office environment and on site testing is required for the prototypes in Q4 20/21 to determine effectiveness against the programme objectives at point 3.2 and the technical robustness of the solutions.
3.7	**<u>SparroWatch</u>** • SparroWatch is developing a range of technology to be used in Belfast's Parks and open spaces. They are developing a combination of hardware and software that will be used to improve safety and park management. SparroWatch are designing

	battery-powered cameras that provide a simple and low cost installation option to monitor parks. The Cameras will be located at Ormeau, Falls Park/City Cemetery and Dunville Park. It is hope that the this prototype will help address the ongoing issues of vandalism and ASB in these sites • SparroWatch will also send a weekly statistical report to BCC (this will not contain any information identifying individuals) analysing park usage in Belfast through insights generated by Google Maps.
3.8	**Civic Dollar** • This prototype platform is a unique product using a mixture of technology, psychology and gamification to encourage greater use of the parks and open spaces. If properly utilized, it will have the desired effect of encouraging people to visit parks, open spaces and attractions as well as affecting behavioural change and driving footfall to local businesses. • Encourage users to visit tourist areas across Belfast and Northern Ireland by creating geo-fences and earning CivicDollars while they visit, and trade them with local hotels, restaurants and businesses • Expand the functionality of the platform to allow more business to drive footfall back by trading CivicDollars for a greater range of goods and services. • Allow businesses to trade CivicDollars with the government (central/local and with businesses) to encourage the use of the system (the viability of this is being tested as part of Phase 2) • On site testing is initially planned for the parks/open spaces along the Connswater Community Greenway before role out to a small number of other parks/open spaces across North, South, East and West Belfast.
3.9	As companies have been working with data throughout, real and perceived concerns about any privacy/data protection impacts from the project were identified at the initiation stage and a full privacy/data protection screening exercise was completed.
3.10	Council's Information Governance Unit (within Legal Services) are actively engaged in providing support to Officers and the successful SME's in ensuring ongoing and full compliance with legislation and Information Commissioner Officer Guidance. Additionally, based on political and community feedback, proactive community engagement has been undertaken both by Officers and by the SME's themselves to provide reassurance that no data that would identify an individual is being used.

	Financial & Resource Implications
3.11	Phase 1 (18/19) - £120,000 Phase 2 (19/20 and 20/21) - £225,000
	Equality or Good Relations Implications/Rural Needs Assessment
3.12	As mentioned in the main report, equality and privacy implications have been proactively managed & mitigated on an ongoing basis. This includes avoiding bias or stereotyping in the project. The equality and privacy impact screening process remains under constant review.
4.0	**Appendices – Documents Attached**
	None

Belfast City Council

PEOPLE AND COMMUNITIES COMMITTEE

Subject:	Response to the Food Standards Agency consultation on the review of the Food Law Code of Practice, Food Law Practice Guidance and implementation of the competency framework
Date:	12th January 2021
Reporting Officer:	Siobhan Toland, Director, City Services
Contact Officer:	Damian Connolly, City Protection Manager, City and Neighbourhood Services Department Elizabeth Gilchrist, Senior Environmental Health Officer, City and Neighbourhood Services Department

Restricted Reports				
Is this report restricted?	**Yes**		**No**	X
If Yes, when will the report become unrestricted?				
After Committee Decision				
After Council Decision				
Some time in the future				
Never				

Call-in				
Is the decision eligible for Call-in?	**Yes**	X	**No**	

1.0	**Purpose of Report or Summary of main Issues**
1.1	The Food Standards Agency (FSA) as the central competent authority for food and feed regulation in the UK, is responsible in overseeing the official (food law) controls undertaken by district councils. As part of this role the FSA provide a Food Law Code of Practice (FLCOP) and Practice Guidance (FLPG) for all district councils. The Food Law Code of Practice is statutory and gives instructions that district councils must consider when enforcing food law. Local authorities need to follow and implement the relevant sections of the Code that apply. The Practice Guidance is non-statutory and is offered as a complement to the statutory Code of Practice. The Practice Guidance gives general advice on the approach to enforcement of the law.

1.2	The most significant change to the FLCOP is the removal of the baseline qualifications previously required by Environmental Health Officers (EHO's) to work in the Food Safety and Port Health functions of a district council. This will instead be replaced with a Competency Framework to be assessed by the Lead Food Officers within the food safety and port health units of each district council.
2.0	**Recommendations**
2.1	The Committee is asked to; • Note the consultation and the draft consultation response. (Appendix 1 & 2) • Note the draft response was submitted in line with December deadline, subject to final response being submitted following committee consideration.
3.0	**Main report**
	Key Issues
3.1	Under the current Food Law Code of Practice (Northern Ireland), officers authorised to carry out Food Safety official controls and other interventions to verify compliance with food law are required to have a baseline qualification issued by the Environmental Health Registration Board (EHRB) / Chartered Institute of Environmental Health (CIEH). This baseline qualification requires a period of practical training to have been completed prior to the officers' certification, and authorities are not permitted to authorise officers to carry out food safety official controls without that EHRB certification.
3.2	The proposed changes to the Food Law Code of Practice remove the necessity for the full certification from EHRB/CIEH. This change has been introduced as a result of the CIEH ceasing the provision of the baseline qualification assessment and the need to urgently recruit EHO's and Technical Officers (TO's) to the port health function ahead of EU exit.
3.3	Belfast City Council have already had to avail of this proposed change in the qualifications in order to recruit staff to the Port Health section, in preparation for EU exit. A derogation from the FSA was given to Belfast City Council in advance of the FLCOP consultation. In the consultation response the Lead Food Officer in Port Health has asked that the FSA give consideration to the implementation of the NI Protocol and the need for significant sanitary and phytosanitary (SPS) checks on GB-NI trade. A review of the qualifications and competencies required to complete the checks on the documents that must accompany imported foods has been suggested. BCC suggest only EHRB qualified officers should be authorised to refuse entry to a food import if it fails by virtue of unsuitable accompanying documents, reject a consignment or take enforcement action.
3.4	The proposed Competency Framework will apply to all EHO's and TO's working in the Food Safety and Port Health functions, including those who already have the appropriate baseline qualifications issued by the CIEH and undergone the current FLCOP competency assessment.

	These EHO's and TO's are currently deemed authorised and competent to carry out official food safety controls appropriate to their role/unit. This proposal will cause a time burden on district councils, both on EHO's and TO's completing the Competency Framework and on the Lead Food Officers assessing. The consultation response recognises the need for a replacement to the baseline qualification for new officers, however it presents the case for reducing the prescriptiveness and complexity of the proposed Competency Framework and that is should not be required for those who have the appropriate qualifications and competency. **Finance and Resource Implications** **Financial**
3.5	The FSA are not offering any financial assistance to compensate for the officer time that will be required to complete the proposed Competency Framework, which is currently estimated at 10 working days per officer and 4 days per officer for the Lead Food Officer to assess. The impact on the ability of the Food Safety team to absorb this will be kept under review. **Human Resources**
3.6	There are no human resource implications. **Equality or Good Relations Implications/ Rural Needs Assessment**
3.7	There are no equality or good relations implications associated with this report. A rural needs assessment is not required.
4.0	**Appendices - Documents Attached**
	Appendix 1 – Consultation Appendix 2 – Consultation response

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Review of the Food Law Code of Practice, Food Law Practice Guidance, and implementation of the Competency Framework

Launch date: 13 November 2020
Respond by: 10 December 2020

This consultation will be of most interest to

Competent Authorities (district councils (DCs)) in Northern Ireland. Food Standards Agency (FSA) approved assurance schemes, private sector assurance bodies, professional awarding bodies, FSA delivery partners, Trade Unions and Expert Groups may also have an interest.

Consultation subject/purpose

To seek stakeholder views on the FSA proposals to update and simplify the Food Law Code of Practice (Northern Ireland) (the Code) and the Food Law Practice Guidance (Northern Ireland) (the Practice Guidance). Key proposals include:

- Modernisation of the baseline knowledge, skills, and experience requirements to enable a wider cohort of District Council (DC) professionals to undertake official food controls and other official activities, which the current Code restricts;
- Replacing existing competency requirements with the FSA Knowledge and skills for the effective delivery of official food and feed controls and other activities (Competency Framework), that defines competency by activity rather than by role;
- Introducing a provision to enable the FSA to be more responsive in issuing instructions, whereby DCs may legitimately depart from the Code, in limited circumstances; and
- Updating the Code to reflect the Official Control Regulation (EU) 2017/625 (the OCR), and EU exit implications, where the negotiated position is known.

How to respond

Email: CodeReviewResponses@food.gov.uk
Name: Julie Telford
Division/Branch: Local Authority and Policy Delivery Team

Details of consultation

Introduction

1. In Northern Ireland, DCs are the Competent Authorities responsible for the verification of compliance with food law in food business establishments, and at points of entry. The Food Standards Agency (FSA) is responsible for setting out direction and guidance on the approach that DCs should take in the Code. This is complemented by the Practice Guidance.

2. The Code sets out instructions and criteria to which DCs must have regard when discharging their duties in relation to the delivery of official food controls and other official activities[1]. The FSA, as the Central Competent Authority, is responsible for ensuring food safety and food hygiene in England, Wales, and Northern Ireland.

3. The FSA is required to consult on amendments to the Code prior to implementation[2]. The Code requires regular review and revision to ensure that it reflects current priorities, policy, and legislative requirements so that DC delivery of food control activities remain effective, consistent, and proportionate.

4. The purpose of this consultation is to provide stakeholders with an opportunity to comment on the main proposals outlined at paragraph 13. The consultation has been prepared in coordination with England. The changes to the England Code and their Practice Guidance is subject to a separate but similar consultation.

Background

5. The National Audit Office (NAO) carried out a review of the food safety and standards regulatory system in 2019, which examined Local Authority (LA) resources for delivering food control activities in England. The report, Ensuring Food Safety and Standards, concluded that LA budgets for food regulation have reduced substantially since their last report on food regulation in 2013. Between 2012-13 and 2017-18, LA expenditure data shows that their spending on food hygiene controls fell by an estimated 19% from £125 million to £101 million[3].

6. Following Local Government Reform in NI, which commenced on 1 April 2015, NI has seen a decline in the number of food control staff within DCs. A comparison of the Local Authority Enforcement Monitoring System (LEAMS) data, from 2013/2014 and 2018/19, shows a decline from 5.8 to 3.9 full time equivalent DC food officers in post per 1000 establishments. This is a decrease of 32.76%.

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[1] Official controls and other official activities have the meanings as defined in Article 2(1) and Article 2(2) of Regulation (EU) 2017/625

[2] Food Standards Act 1999, Schedule 3 and Article 39(1) of The Food Safety (Northern Ireland) Order 1991

[3] Source: National Audit Office analysis of local authority revenue expenditure and financing England outturn data, 2012-13 to 2017-18

7. To ensure that DCs use resources efficiently and to maximise the effectiveness of consumer protection provided by their controls, the Code requires DCs to take a risk-based approach to delivering food control activities, targeting their resources at the food businesses that represent the highest risk to consumers. To do this, DCs are obliged to ensure they have, or have access to, a sufficient number of suitably qualified and experienced staff so that food control activities can be performed efficiently and effectively[4].

8. In January 2020, the FSA Board considered the status of the Regulating Our Future (ROF) programme and proposed next steps for the refreshed second phase of work the Achieving Business Compliance Programme (the ABC Programme)[5].

9. In line with the FSA ambition 'to be an excellent, accountable modern regulator' the Board agreed on a refreshed programme of work that focuses around four key priorities. One of these relates to Skills for the job: Altering expectations around professional skill levels so that DCs can deploy skills and resources effectively in undertaking controls on food businesses and offer appropriate assurance.

10. Our objective through this work is to develop a Competency Framework for all individuals engaged in delivering front-line food and feed law-related activities, whether carried out by the DCs, FSA or FSA delivery partners[6]. The Competency Framework when fully implemented will also apply to those working in the private sector who undertake assurance activities that are formally recognised to inform targeting/frequency of DC and FSA official controls, such as FSA approved assurance schemes[7]. The framework will describe the competencies required for specific activities rather than take a role-based or profession-based approach.

11. Due to the difficulties that DCs are having in recruiting staff and the nearing of the end of the UK's transition period, we have brought forward the timescales for consulting and implementing the Competency Framework for DC food control activities through this revision of the Code and the Practice Guidance.

12. This work when fully implemented will deliver:

- an activity-based model which will enable DCs to use resources efficiently and to maximise the effectiveness of consumer protection;
- a clearly defined set of competencies required to deliver front-line official food and feed controls, other official activities and other activities related to these; and
- a Competency Framework that will improve quality and consistency by setting a standard applicable to all individuals working in the private sector in Northern Ireland, Wales, and England who undertake assurance activities that are formally recognised.

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[4] Article 5(e) of Regulation (EU) 2017/625
[5] Modernising Regulation – Progress Update and Forward Plan. (FSA 20-01-07),
[6] Includes those contracted by the FSA for delivery of official Controls in approved meat and dairy establishments in England and Wales and the Department of Agriculture, Environment and Rural Affairs (DAERA)
[7] Earned Recognition – Approved assurance schemes

Main proposals

13. The main proposals are:

1) Modernisation of the baseline knowledge, skills, and experience requirements to enable DCs to fully recognise the potential of a wider cohort of professionals to undertake, food control activities, which the Code restricts;
2) Replacing the existing competency requirements with a Competency Framework that defines competency by activity rather than by role, which will be initially implemented for DC food controls;
3) Introducing a provision to enable the FSA to be more responsive in issuing instructions, whereby DCs may legitimately depart from the Code, in limited circumstances;
4) Updating the Code to reflect the OCR, and EU exit implications, where the negotiated position is known;
5) Simplification, clarification and alignment of the Code and the Practice Guidance with those of England to promote consistency in the interpretation and implementation of food control activities. This includes the removal and relocation of sections of the Code to the Practice Guidance; and
6) Inclusion of other minor amendments to keep pace with current practices.

Policy objectives

14. The proposed policy changes are intended to enable:

- DCs to efficiently target training resource at clearly defined competence requirements that reflect the activities being undertaken, and drive an improvement in the quality and consistency of the delivery of food control activities;
- DCs to deploy current resources efficiently and to maximise the effectiveness of consumer protection by enabling a wider cohort of professionals to undertake certain activities, which the current Code restricts; and
- the FSA to be more responsive in issuing instructions whereby DCs may legitimately depart from the Interventions Programme that is based on the intervention ratings schemes in the Code (including the type and frequency of intervention), in the following limited circumstances:
  - in response to a public health emergency;
  - in response to a state of emergency; or
  - to accommodate the work of FSA approved feasibility studies, pilots, or pathfinder projects.

Detailed Proposals

Proposal 1: A modernised approach to knowledge, skills, and experience

15. We have taken a considered approach to modernise requirements and better recognise the validity of available knowledge, skills and experience without undermining food safety and standards, or consumer protection. The proposed changes to the Code include amending the baseline qualification requirements, broadening the list of 'suitable' qualifications to enable a wider cohort of professionals to undertake certain official food controls, which the Code restricts, providing they can demonstrate they are competent.

16. The modernisation of the knowledge, skills and experience requirements in the Code includes:

- broadening the list of suitable qualifications for the delivery of official food control activities;
- removing unnecessary restrictions for Category A and B Food Hygiene and Category A Food Standards interventions;
- enabling DCs to extend the authorisations of officers holding qualifications with current restrictions. For example, an officer with the Ordinary Certificate in Food Premises Inspection could be authorised to seize and detain food providing they can demonstrate the relevant competencies; and
- inclusion of the role of an appropriately trained assistant for an Authorised Officer at a Border Control Post, which is a role specified in the Trade in Animals and Related Products Regulations (Northern Ireland) 2011. The Authorised Officer being referred to as an Official Fish Inspector (OFI) in the previous Code and who carries out the regulatory functions in relation to fish, fishery products, aquatic invertebrates, live bivalve molluscs, live echinoderms, live tunicates and live marine gastropods. The appropriately trained assistant in the proposed Code will have their authorisation restricted to align with that of the Regulatory Support Officer (RSO).

Authorisation requirements for officers holding a suitable qualification

17. The following case studies describe the practical implications of the proposed changes to an officer's authorisation, for newly appointed and existing staff, and those officers whose qualifications have restrictions.

Case Study 1: – Baseline Qualification

This case study applies to an authorised officer who has a baseline qualification, for example, the Higher Certificate in Food Control, Certificate of Registration issued by the Environmental Health Registration Board (EHRB) or Diploma in Consumer Affairs and Trading Standards (DCATS) with Food Standards service delivery module.

1. Can they be authorised under the current **Code**? **Yes**, if competent.
2. Are there any restrictions? **No**.

3. Can they be authorised under the **proposed Code**? **Yes**, if competent.
4. Are there any restrictions? **No**.

Under the requirements of the proposed Code, this officer would be able to undertake all official food controls, with no restrictions, if they were competent.

The proposed Code includes these qualifications in the list of ‘suitable’ qualifications, so there is no change.

Case Study 2 – Qualification with known restriction

This case study applies to an authorised officer who has a qualification with a known restriction, for example, the Higher Certificate in Food Premises Inspection, the Ordinary Certificate in Food Premises Inspection or Certificate of Competence in Food Standards service delivery module.

1. Can they be authorised under the current **Code**? **Yes**, if competent.
2. Are there any restrictions? **Yes,** restricted by the current Practice Guidance.
3. Can they be authorised under the **proposed Code**? **Yes**, if competent.
4. Are there any restrictions? **No**.

Under the requirements of the proposed Code, this officer could be authorised to deliver official food control activities, if competent. Regardless of their level of experience or demonstration of competency, their authorisation of duties would be restricted though based on the qualification they hold. For example, they may not be able to seize or detain food or undertake inspections of high-risk businesses.

The amended Code proposes to include these qualifications in the list of ‘suitable’ qualifications, meaning as long as the officer can demonstrate they are competent, they can be authorised to undertake all official food control activities, relevant to their role.

Case Study 3 – Environmental Health Degree

This case study applies to a recent Environmental Health degree graduate, who has not obtained a Certificate of Registration or completed the Competency Development Portfolio (CDP).

1. Can they be authorised under the current **Code**? **No**.
2. Are there any restrictions? **N/A**.
3. Can they be authorised under the **proposed Code**? **Yes**, if competent.
4. Are there any restrictions? **No**.

Under the requirements of the current Code, this officer would not have a baseline qualification or equivalent, nor a qualification with known restrictions, so they could not be authorised to undertake any official food controls. However, they could be authorised as an RSO.

The proposed Code will expand the list of qualifications deemed ‘suitable’ to include the Environmental Health degree (without EHRB), meaning as long as the officer can

demonstrate they are competent, they can be authorised to undertake official food control activities, with no restrictions.

Proposal 2: Implementation of the Competency Framework

18. The development of the Competency Framework is part of the ABC Programme and our overall aim is to develop a single framework for individuals undertaking official food and feed controls and other assurance activities.

19. The Competency Framework has been developed in collaboration with a Competency Reference Group. The Group comprises representatives from DCs in Northern Ireland, local authorities (LAs) and Port Health Authorities (PHAs) in England and Wales, as well as professional qualification awarding bodies (the Chartered Institute for Environmental Health (CIEH), the Chartered Trading Standards Institute and the Institute for Food and Technology), private sector assurance bodies, FSA delivery partners, FSA Operations, and educational providers.

20. The Competency Framework when fully implemented will:

- set out the competencies (knowledge and skills) required for individuals engaged in delivering food and feed law related activities in Northern Ireland, by DCs, the FSA, FSA delivery partners and private sector assurance bodies;
- improve consistency by setting a standard applicable to all individuals undertaking food law related activities;
- facilitate the transfer and movement of individuals across the public and private sectors and from other countries to Northern Ireland, by allowing the competencies for specific activities to be demonstrated through a wider range of methods; and
- increase transparency by establishing a clear and accessible framework to demonstrate the competency required for individuals carrying out these activities.

21. The Competency Framework defines competency by activity rather than taking a role-based or profession-based approach, each activity stands alone, which means an individual can be authorised to undertake one or multiple activities within the framework depending on their role. The activities in the Competency Framework provide more detail for the same competencies that are included in the current Code. In addition, there are new competencies for the activities of E4: Assessing industry assurance of compliance and E5: Supporting and contributing to external audits.

22. The Competency Framework will initially only apply to DCs who undertake official food controls and other activities and will be implemented through the amended Code and Practice Guidance.

23. We will further develop and implement the Competency Framework in due course in respect of official controls and other activities undertaken by the FSA, FSA delivery partners, and by DCs, LAs and PHAs in England and Wales for feed controls. Please note that whilst feed control activities have been included in the Competency Framework for consultation purposes, they will be implemented separately to the DC food official control activities.

24. We will also further develop the framework to cover formally recognised private sector assurance activities, for example FSA approved assurance schemes, which inform the targeting and frequency of DC or FSA food control activities. For this reason, we welcome views on the Competency Framework at this stage, although it will be implemented separately to the food control activities for formally recognised private sector assurance activities.

25. We are also working with the professional bodies, as we recognise that alignment of the requirements for professional status with the requirements of the Competency Framework, would be beneficial for current and future members of the professional bodies. In addition, CIEH has advised that they will be aligning the syllabus of their Advanced Professional Certificate in Food Hygiene and Standards Control qualification to the Competency Framework.

26. The existing methods of competency assessment set out in the Code, and the Practice Guidance remain unchanged. Lead Food Officers (LFOs) will be responsible for assessing the competency of officers against the Competency Framework.

27. We recognise that the full and effective implementation of the Competency Framework is dependent on having a consistent approach to the assessment of competency. We are researching how other regulators (both nationally and internationally) and other organisations assess and authorise competency. This will help to identify potential options for assessing competency and help inform decisions on the approach that we will take in the future.

28. We anticipate consulting on the options for assessment of competency in spring 2021.

Assessment requirements for authorised officers holding a suitable qualification

29. The following case studies describe the practical implications of the proposed changes on officer assessment, for newly appointed and existing staff, and those officers whose qualifications have current restrictions.

Case Study 4 – Baseline Qualification

This case study applies to a newly appointed officer or an existing authorised officer who has a baseline qualification.

1. When the revised competency requirements are implemented, will a **newly appointed officer** require an initial assessment against the Competency Framework by the LFO? **Yes**, as currently – only required for specific activities undertaken.
2. When the revised competency requirements are implemented, will an **existing authorised officer** require an initial assessment against the Competency Framework by the LFO? **No**, unless undertaking new activities not covered by their current authorisation.
3. Will ongoing assessment against the revised competency requirements be the same process as it is now? **Yes**, to be assessed by the LFO in accordance with

the Practice Guidance. This is an interim measure as we have initiated work to consider the process for assessing competency under the framework.

As currently, for new officers joining a DC, their competency will need to be assessed for the specific activities and sub-activities within the Competency Framework they are required to undertake. Their authorisations are required to be restricted if they are unable to demonstrate all required competencies for an activity.

For existing authorised officers, an initial assessment against the Competency Framework is not required, which means if they were competent to undertake specific activities previously, they will continue to be competent to do so.

If there are any new activities within the Competency Framework which the authorised officer has not undertaken before, they would need to demonstrate their competency before being authorised to undertake that activity. For example, if they were to start supporting and contributing to external audits, they would need to demonstrate the competencies for activity E5: Supporting and contributing to external audits.

As currently, if competencies cannot be demonstrated then the officer can gain these through the methods outlined in the Practice Guidance, which include attending training, e-learning, receiving coaching from other competent officers or shadowing other competent individuals.

With regards to ongoing assessment, the authorised officer's competency would be assessed against the Competency Framework on an ongoing basis in accordance with the Practice Guidance, for example as part of a yearly appraisal.

Case Study 5 – Qualification with known restriction

This case study applies to a newly appointed officer or an existing authorised officer who has a qualification with a known restriction.

1. When the revised competency requirements are implemented, will a **newly appointed officer** require an initial assessment against the Competency Framework by the LFO? **Yes**, as currently – only required for specific activities undertaken.
2. When the revised competency requirements are implemented, will an **existing authorised officer** require an initial assessment against the Competency Framework by the LFO? **No**, unless undertaking new activities that were previously restricted.
3. Will ongoing assessment against the revised competency requirements be the same process as it is now? **Yes**, assessed by the LFO in accordance with the Practice Guidance. This is an interim measure as we have initiated work to consider the process for assessing competency under the framework.

As currently, for new officers joining a DC, their competency will need to be assessed for the specific activities and sub-activities within the Competency Framework they are required to undertake. Their authorisations are required to be restricted if they are unable to demonstrate all required competencies for an activity.

For existing authorised officers, an initial assessment against the Competency Framework is not required, which means if they were competent to undertake specific activities previously, then they will continue to be competent to do so.

If the DC determines the officer should undertake additional activities and sub-activities listed in the Competency Framework, the LFO would assess whether the officer can demonstrate the relevant competencies.

Based on their previous experience, the officer may not be able to demonstrate the competencies for the activities they were previously restricted from undertaking, for example seizing or detaining food.

If this is the case, as currently, the officer can gain the competencies through the methods outlined in the Practice Guidance which include attending training, e-learning, receiving coaching from other competent officers or shadowing other competent individuals.

When the officer has demonstrated all the competencies to the LFO for the relevant additional activities, they can be authorised to undertake them.

With regards to ongoing assessment, the officer's competency would be assessed against the Competency Framework on an ongoing basis in accordance with the Practice Guidance, for example, as part of a yearly appraisal.

Case Study 6 – Environmental Health Degree

This case study applies to a newly appointed officer or an existing officer who is an Environmental Health degree graduate but has not obtained a Certificate of Registration or completed the Competency Development Portfolio (CDP).

1. When the revised competency requirements are implemented, will a **newly appointed officer** require an initial assessment against the Competency Framework by the LFO? **Yes**, only required for specific activities undertaken.
2. When the revised competency requirements are implemented, will an **existing authorised officer** require an initial assessment against the Competency Framework by the LFO? **Yes**, as not previously able to be authorised for official controls.
3. Will ongoing assessment against the revised competency requirements be the same process as it is now? **Yes**, assessed by the LFO in accordance with the Practice Guidance. This is an interim measure as we have initiated work to consider the process for assessing competency under the framework.

Officers with an Environmental Health degree may not currently be authorised to undertake official controls, so an assessment against the Competency Framework is required for newly appointed officers. It would also be required for existing officers with this qualification who could have been authorised as RSOs.

The DC would need to determine which specific activities and sub-activities listed in the Competency Framework the officer would be required to undertake and then the LFO would assess whether they can demonstrate the relevant competencies.

Based on their background, it is likely that the officer will meet most of the relevant knowledge competencies but may not be able to demonstrate all the applicable competencies.

If this is the case, the officer can gain the competencies through the methods outlined in the Practice Guidance which include attending training, e-learning, receiving coaching from other competent officers or shadowing other competent individuals.

When the officer has demonstrated all the competencies to the LFO for the relevant activities, they can be authorised to undertake them.

As the officer gains more experience, they may then be able to demonstrate competencies for additional activities, at which point they could be authorised for these.

With regards to ongoing assessment, the officer's competency would be assessed against the Competency Framework on an ongoing basis in accordance with the Practice Guidance, for example, as part of a yearly appraisal.

As currently, for new officers joining a DC, their competency will need to be assessed for the specific activities within the Competency Framework they are required to undertake. Their authorisations are required to be restricted if they are unable to demonstrate all required competencies for an activity.

Proposal 3: Departure from the Code

30. The FSA is proposing to introduce a provision[8] to enable the FSA to be more responsive in issuing instructions allowing DCs to legitimately depart from the Competent Authorities Interventions Programme that is based on the intervention ratings schemes in the Code (including the type and frequency of intervention) upon instruction from the FSA, in the following limited circumstances:

    - in response to a public health emergency, for example a pandemic;
    - in response to a state of emergency, for example regional flooding; or
    - to accommodate the work of FSA approved feasibility studies, pilots, or pathfinder projects.

31. This will enable the FSA to respond in an agile way, without necessitating agreement from the Minister, especially in a crisis.

Proposal 4: Implementation of the OCR & EU Exit implications

32. The update to the Code will also include the necessary changes brought about by the OCR, which were subject to a 6-week formal consultation in August 2019[9].

    The 'basic act' of the OCR, made changes across several policy areas. However, these changes created relatively few impacts on DCs. The editorial changes are highlighted in yellow in the proposed Code and Practice Guidance. For the purposes

[8] See sections 2.3 of the proposed Code and the Practice Guidance (Northern Ireland)
[9] Consultation on the implementation of the official controls regulations (August 2019)

of meeting accessibility requirements, we have produced accessible versions of the Code and the Practice Guidance for use with a screen reader. Changes in respect the Official Control Regulation (EU) 2017/625, are readable as <OCR change start>, and <OCR change end>.

33. The UK left the European Union (EU) on 31 January 2020 and the Withdrawal Agreement, including the Northern Ireland protocol (NIP), entered into force. As part of the Withdrawal Agreement, from 31 January to 31 December 2020 (the Transition Period), EU law continued to apply to, and in, the UK. Under the NIP, most food hygiene and safety laws will continue to apply in Northern Ireland in much the same way, after the Transition Period. EU bodies such as the European Commission or European Food Safety Authority (EFSA) will retain certain functions in relation to Northern Ireland and Competent Authorities in NI will retain certain obligations to the EU.

34. Any necessary changes to reflect the UK's withdrawal from the EU are highlighted in green throughout the proposed Code and the Practice Guidance. For the purposes of meeting accessibility requirements, we have produced accessible versions of the Code and the Practice Guidance for use with a screen reader. Changes in respect of EU Exit, are readable as <EU Exit change start>, and <EU Exit change end>.

Proposal 5: Revised Code and Practice Guidance

35. The Code and Practice Guidance has a revised structure and format to present clear, concise information to improve readability and promote consistency in the implementation of food control activities, including:

- clarification of text where necessary to facilitate consistent interpretation and approach by authorised officers and RSOs;
- a dedicated chapter for food incidents, alerts, and food crime; and
- clearer links to the OCR, and the Framework Agreement on Official Feed and Food Controls by Local Authorities.

Proposal 6: Other minor amendments to keep pace with current practices

36. There have been some minor changes to the Code not brought about by the changes listed above. These are 'minor' contextual amendments to reflect current practices in certain areas. For example:

- the 'serious localised food hazard' definition has been expanded to include 'undeclared allergens, a serious anaphylaxis reaction requiring medical intervention as a result of exposure to allergens in food, or hospitalisation or death as a result of exposure to allergens in food'; and
- we have moved the model forms from the Code and provided links within the Practice Guidance where these are available on the FSA Smarter Communications Platform, to facilitate easier use by DCs, and updating by the FSA.

37. Annex B and C to this consultation document provide an overview of the changes including where requirements have been moved from the Code to the Practice Guidance and vice versa. All new requirements and amendments, other than EU Exit or OCR changes, are highlighted in turquoise in the proposed Code and the Practice Guidance. For the purposes of meeting accessibility requirements, we have produced accessible versions of the Code and the Practice Guidance for use with a screen reader. Amendments other than EU Exit or OCR changes, are readable as <Amendment start>, and <Amendment end>.

Impacts

Costs

Costs to District Councils

Revisions to the Code, and the Practice Guidance and implementation of the Competency Framework

38. The current landscape and the general performance of official controls and other official activities under the OCR remains substantially the same[10].

39. DCs, as Competent Authorities, which deliver official regulatory controls across food will have to familiarise themselves with the Competency Framework and the changes to the Code and Practice Guidance.

40. In line with BEIS guidance on the appraisal of new guidance[11], we have estimated the one-off familiarisation time by multiplying the average number of words a person can read per minute with the documents wordcount.

41. We assume across the 11 DCs, in Northern Ireland[12], that one Environmental Health Officer (EHO) from each DC, will spend three hours to read and familiarise themselves with the revisions to the Code, the Practice Guidance and the Competency Framework, and two hours to prepare and disseminate this information to staff via the appropriate channels.

Competency Framework

42. While the proposed changes to the amended Code and Practice Guidance provide DCs with greater scope to maximise the effectiveness of the resources, DCs remain responsible for assessing the competency of their authorised officers and authorising them accordingly. As officers' competencies currently need to be re-assessed on an on-going basis, no significant additional burden is introduced. However, the ongoing assessment of competencies under the proposed changes

[10] Consultation on the implementation of the official controls regulations (August 2019)

[11] Business impact target – Appraisal of guidance

[12] Annual report on local authority food law enforcement for England, Northern Ireland and Wales 1 April 2018 to 31 March 2019

might take longer than currently, due to the additional details of how competency is demonstrated in the Competency Framework. There might also be additional one-off costs to DCs to implement the Competency Framework into their existing systems. We would welcome views and evidence from stakeholders on the likely associated costs.

43. We are currently developing additional materials to assist LFOs in assessing and recording the competency of their officers (new and existing), including a Summary of Officers Competency Table, and also a Competency Assessment Record, which LFOs and officers can use to assess competency. We are aiming to have these available for the implementation of the Competency Framework for DCs food control activities in February 2021. Drafts of the materials developed so far are included with consultation package.

Costs to FSA approved assurance schemes, and FSA delivery partners and private sector assurance bodies

44. The Competency Framework when fully implemented will also apply to those working in the private sector who undertake assurance activities that are formally recognised, and those official control activities undertaken by FSA delivery partners. The Code only applies to DC activities. Private sector bodies, recognised by the FSA to provide industry assurance, are therefore not required to have regard to the Code. As such, we do not foresee any impacts on these stakeholders as a result of the proposed changes to the Code within this consultation. Timescales for fully implementing the Competency Framework will be confirmed in due course.

45. We anticipate consulting on options for the assessment of competency in spring 2021 and that this may have an impact on these stakeholders as it will relate to the implementation of the Competency Framework. We will assess the impact of these proposed changes as part of the consultation process for implementation and seek stakeholders' views accordingly. In the meantime, we would welcome any initial views on the associated impacts.

Benefits

Benefits to consumers

46. The modernisation of the baseline knowledge, skills and experience requirements and introduction of the Competency Framework will improve the quality and consistency of food control activities meaning consumers will benefit from enhanced consumer protection through more efficient allocation of resources, maximising the effectiveness of consumer protection provided by these controls.

Benefits to district councils

47. The amendments to the Code will enable DCs to recruit from a wider range of officers and use their resources more efficiently to maximise the effectiveness of consumer protection provided by their controls. This will be particularly useful where a specific type of officer operates predominantly, such as at points of entry for imported food.

48. The modernisation of the current qualification requirements in the Code and the implementation of an activity-based Competency Framework provides the flexibility for officers with a wider range of qualifications and experience to be authorised for the activities they are required to undertake, providing they can demonstrate their competency.

49. A full regulatory impact assessment has not been produced for the updated Code. The FSA has certified the impact as being below the de minimis threshold of +/- £5m equivalent annual net direct cost to business.

Engagement and Consultation Process

50. The FSA is conscious of the time and resource burdens currently imposed on stakeholders.

51. Informal stakeholder engagement began on 7 September 2020 for eight weeks when we presented information on our proposals at virtual meetings and events.

52. We have sought views from a wide range of stakeholders, through informal engagement events about the main proposals prior to this public consultation, including:

- DCs, LAs and PHAs;
- The Competency Reference Group (see paragraph 19 for membership);
- Trade Unions;
- Association of Chief Trading Standards Officers (ACTSO);
- Food Standards and Labelling Focus Group;
- The National Food Hygiene Focus Group;
- The National Agriculture Panel (NAP); and
- The National Animal Feed Ports Panel.

53. The Competency Framework has been developed in collaboration with the Competency Reference Group and engagement with this group began in January 2019. We will continue to engage with the Competency Reference Group as we research how other regulators (both nationally and internationally) and other organisations assess and authorise competency.

54. We are undertaking a formal four-week written consultation as we endeavour to have the proposed amendments incorporated into the Code and ready for publication as soon as possible post EU transition.

55. Information gathered from this consultation will be considered when preparing a finalised version of the Code for submission to the Minister for approval. Information supplied by consultees will also inform any assessment of the impact these revisions will have.

56. At the end of the consultation period, the FSA will analyse the responses, make any relevant amendments to the Code, the Practice Guidance and Competency Framework and within three months of the consultation ending we aim to publish a summary of responses received and provide a link to it on our website.

Questions asked in this consultation

57. So that we fully understand your responses, and adequately take account of them, please explain, and where possible evidence, any answers that contradict the assumptions we have made in this consultation.

Consultation Questions:

1. Does the layout/presentation and clarified text of the proposed Code and the Practice Guidance make the documents easier to use, improve readability, and facilitate consistent interpretation? If not, how could they be improved?

2. Do you agree that the proposed suitable qualification requirements provide DCs with the ability to deploy current resources more efficiently by, allowing a wider cohort of professionals to undertake food control activities, which the Code restricts? If not, why not? (Please specify any additional flexibility you would wish to see, and why).

3. Does the Competency Framework include:

    a. all the relevant activities for the delivery of front-line official food and feed controls, other official activities and other activities related to these, whether carried out by DCs and FSA delivery partners?
    b. all the relevant activities for those working in the private sector who undertake assurance activities that are formally recognised to inform targeting/frequency of official controls?
    c. the relevant competencies (knowledge and skills) for each activity and sub-activity?

    If not, what changes would you wish to see, and why?

4. Do you agree that by defining competency by activity rather than taking a role or profession-based approach this provides DCs and FSA delivery partners with greater flexibility in the utilisation of resources? If not, why not?

5. Do you agree that by setting a standard that will apply to all individuals undertaking food and feed control activities, including assurance activities that are formally recognised, will improve the quality and consistency of delivery across the public and private sector? If not, why not?

6. Do you foresee any problems with the provision to allow the FSA to be more responsive in issuing instructions, whereby DCs may legitimately depart from the Code, in limited circumstances? If yes, what, if any safeguards or conflicts should we consider?

7. Do you agree that the key aspects of the OCR that have applied since the 14th December 2019 have been reflected, within the proposed Code and the Practice Guidance?

Consultation Questions Continued:

8. Do you agree with our assessment of the impacts on DCs, FSA approved assurance schemes, private sector assurance bodies, FSA delivery partners, and consumers, resulting from the proposed changes to the Code, the Practice Guidance, and implementation of the Competency Framework? Do you have any additional evidence to better understand the identified impacts? In particular, please indicate:

    a. if you agree with our assumptions on familiarisation and dissemination time?

    b. how long it currently takes to assess the competency of a newly appointed member of staff and the ongoing assessment of a member of staff already in post?

    c. whether you foresee any changes in the assessment time, from the implementation of the Competency Framework?

    d. how many new members of staff do you appoint every year?

    e. whether you foresee changes to the number of new staff that need to be appointed every year?

9. Do you foresee any other impacts from the implementation of the main proposals detailed in paragraph 13, beyond what we have identified? Where possible, please explain your views and provide quantifiable evidence (for example, costs associated with updating existing templates, the benefits of greater flexibility to allocate staff to activities)

Relevant documents

1) Draft Food Law Code of Practice (Northern Ireland)
2) Draft Food Law Code of Practice (Northern Ireland) – Accessible screen reader version
3) Draft Food Law Practice Guidance (Northern Ireland)
4) Food Law Practice Guidance (Northern Ireland) – Accessible screen reader version
5) Draft FSA Knowledge and skills for the effective delivery of official food and feed controls and other activities (Competency Framework)
6) Draft Competency Assessment Record
7) Draft Summary of Officers Competency Table
8) Regulation (EU) 2017/625 on official controls and other official activities
9) Consultation on the implementation of the OCR

Responses

58. Responses are required by **midnight on 10 December 2020**. Please state, in your response, whether you are responding as a private individual or on behalf of an organisation/company (including details of any stakeholders your organisation represents). All comments and views should be sent to: CodeReviewResponses@food.gov.uk.

59. Thank you on behalf of the Food Standards Agency for participating in this public consultation.

Yours,

Julie Telford

Local Authority and Policy Delivery Team

Annex A: Standard Consultation Information

Disclosure of the information you provide

Information provided in response to this consultation may be subject to publication or release to other parties or to disclosure in accordance with the access to information regimes (these are primarily the Freedom of Information Act 2000 (FOIA), the Data Protection Act 2018 (DPA) and the Environmental Information Regulations 2004).

If you want information you provide to be treated as confidential, please be aware that, under the FOIA, there is a statutory Code of Practice with which public authorities must comply and which deals, amongst other things, with obligations of confidence.

In view of this, it would be helpful if you could explain to us why you regard the information you have provided as confidential. If we receive a request for disclosure of the information, we will take full account of your explanation, but we cannot give an assurance that confidentiality can be maintained in all circumstances.

Any automatic confidentiality disclaimer generated by your IT system will not, of itself, be regarded as binding.

The Food Standards Agency will be what is known as the ‘Controller’ of the personal data provided to us.

Why we are collecting your personal data

Your personal data is being collected as an essential part of the consultation process, so that we can contact you regarding your response and for statistical purposes. We may also use it to contact you about related matters.

The Data Protection Act 2018 states that, as a government department, the Food Standards Agency may process personal data as necessary for the effective performance of a task carried out in the public interest. i.e. a consultation.

What we do with it

All the personal data we process is located on servers within the European Union. Our cloud-based services have been procured through the government framework agreements and these services have been assessed against the national cyber security centre cloud security principles.

No third parties have access to your personal data unless the law allows them to do so. The Food Standards Agency will sometimes share data with other government

departments, public bodies, and organisations which perform public functions to assist them in the performance of their statutory duties or when it is in the public interest.

What are your rights?

You have a right to see the information we hold on you by making a request in writing to the email address below. If at any point you believe the information, we process on you is incorrect you can request to have it corrected. If you wish to raise a complaint on how we have handled your personal data, you can contact our Data Protection Officer who will investigate the matter.

If you are not satisfied with our response or believe we are processing your personal data not in accordance with the law you can complain to the Information Commissioner's Office (ICO) online or telephone 0303 123 1113.

Our Data Protection Officer in the FSA is the Information Management and Security Team Leader who can be contacted at the following email address: informationmanagement@food.gov.uk.

Further information

If you require a more accessible format of this document, please send details to the named contact for responses to this consultation and your request will be considered.

This consultation has been prepared in accordance with HM Government consultation principles.

Annex B: Summary of Changes to the Food Law Code of Practice and Practice Guidance

Reference	Record of changes to the Code	Revised Code	Current Code
COP1	Chapter 1 Introduction updated with information regarding the status of the Code in relation to EU exit	Chapter 1	Chapter 1
COP2	Chapter 2 amended to include administration, liaison, and co-ordination, which includes some parts of Chapter 2 and 3 of the current code. New general section added at section 2.2	Chapter 2 Section 2.2	Chapters 2 and 3
COP3	New section on departure from the Code	Chapter 2 Section 2.3	N/A
COP4	Requirements relating to documented control procedures, policies, plans, and programmes added to Chapter 2, which bring together all requirements for these documents. These documents were required under the Code and Framework agreement, but they were provided for throughout the Code. This amendment brings them altogether	Chapter 2 Section 2.4	Throughout the Code
COP5	New designation of Competent Authorities section	Chapter 2 Section 2.5	N/A
COP6	New section on liaison between FSA and District Councils in FSA approved establishments	Chapter 2 Section 2.6.2	N/A
COP7	New section on provision of discretionary services which includes some requirements from the conflict of interest section of the current Code	Chapter 2 Section 2.8	Chapter 3 Section 3.1.1.1

Reference	Record of changes to the Code	Revised Code	Current Code
COP8	New section on Appointment of a Public Analyst	Chapter 2 Section 2.9	N/A
COP9	New section on Facilities and Equipment	Chapter 2 Section 2.10	N/A
COP10	Section on enforcement email addresses updated	Chapter 2 Section 2.11	Chapter 2 Sections 2.3.2.3 and 2.4.1.8
COP11	Section on Retention of Records expand and clarified	Chapter 2 Section 2.14	Chapter 3 Section 3.5.2
COP12	Completely revised Chapter 4 of the current Code on qualifications and competency now Chapter 3 which also includes authorisation of officers (see main proposals in the consultation package for changes).	Chapter 3	Chapter 4
COP13	New chapter 5 created to consolidate all advice on Incidents, alerts, and food fraud	Chapter 5	Multiple Sections of Chapter 2
COP14	Updated definition of non-hazardous incidents	Chapter 5 Section 5.2.1	Chapter 2 Section 2.3.1.1
COP15	Updated criteria for serious localised food hazard	Section 5.2.2	Chapter 2 Section 2.3.1.3

Reference	Record of changes to the Code	Revised Code	Current Code
COP16	New section on Competent Authority response to pre-incident contact by the FSA	Section 5.3.1	N/A
COP17	Updated advice on food hazards assessment to appropriately categorise food hazards and seek advice of the FSA if in doubt about food hazards and now includes 'the likely effectiveness of any consumer recall' in the assessment	Chapter 5 Section 5.3.3.1	Chapter 2 Section 2.3.1.7
COP18	Action on receiving food alerts to include documenting the Competent Authority response to the outcome of each food alert updated	Chapter 5 Section 5.4.3	Chapter 2 Section 2.3.2.4
COP19	Addressing Food Criminality moved to new Chapter 5 covering Incidents and Alerts, Tackling Food Criminality and email address updated	Chapter 5 Section 5.5.1	Chapter 2 Section 2.3.1.5
COP20	Section on Out of Hours Service moved to Chapter 5 covering incidents and alerts	Chapter 5 Section 5.7	Chapter 2 Section 2.4.1.7
COP21	Live Bivalve Mollusc sample result communication to FBO and FSA	Chapter 7 Section 7.3.5 Code	N/A
COP22	Removal of model food business registration form	N/A	Annex 5

Reference	Record of changes in the Practice Guidance	Revised Practice Guidance	Current Practice Guidance
PG1	Chapter 1 Introduction updated with information regarding the status of the Code in relation to EU exit	Chapter 1	N/A
PG2	Chapter 2 changes from 'Communications' to 'Administration, Liaison and Co-ordination' which merges parts of Chapter 2 and 3 of current Practice Guidance and reflected in introduction	Chapter 2	Chapter 2
PG3	New section added on relevant dataset lists	Section 2.2	N/A
PG4	New section on Departure from the Code added to provide further guidance on the new section to the Code	Chapter 2 Section 2.3	N/A
PG5	New sections added covering requirements relating to documented control procedures, policies, plans and programmes, to add further details to the new sections added to Chapter 2 of the Code. These sections consolidate the requirements included across the Code and Practice Guidance. Section 2.6.1 includes the requirements for a service plan from the Framework Agreement	Chapter 2 Sections 2.4 to 2.5 and 2.6.1.1, and 2.6.2, 2.7.1 to 2.7.3	Throughout the Practice Guidance
PG6	New section on Primary Authorities added	Chapter 2 Section 2.9	N/A
PG7	New section on Facilities and Equipment added	Chapter 2 Section 2.10	N/A

Reference	Record of changes in the Practice Guidance	Revised Practice Guidance	Current Practice Guidance
PG8	New section on enforcement email addresses added to include the details of how these details should be provided to the FSA	Chapter 2 Section 2.11	N/A
PG9	New section on escalating technical queries to the FSA or other Government Agency added	Chapter 2 Section 2.15	N/A
PG10	Authorisations, competence, and qualifications - Introduction section maintained and updated	Chapter 3 Section 3.1	Chapter 4 Section 4.1
PG11	Known qualifications with restrictions amended to enable holders of the specified qualifications to be authorised to undertake restricted activities provided they can demonstrate their competence	Chapter 3 Section 3.3.1.1	Chapter 4 Section 4.5
PG12	Section on equivalency of qualifications retained but now includes details that were previously within the Code	Chapter 3 Section 3.3.2	Chapter 4 Section 4.6
PG13	Section on Competency framework now called, "Competency Requirements", the detail has been retained but with some updated content. The guidance has been moved and updated in the Competency Framework Document	Chapter 3 Section 3.4	Chapter 4 Section 4.7
PG14	Section on training updated and formatting amended	Chapter 3 Section 3.5	Chapter 4 Sections 4.8.4 and 4.8.8

Reference	Record of changes in the Practice Guidance	Revised Practice Guidance	Current Practice Guidance
PG15	Section on CPD requirements retained but formatting amended and includes the "Core" CPD requirements	Chapter 3 Section 3.6	Chapter 4 Sections 4.8.1, 4.8.2, 4.8.3
PG16	New Education and advisory work wording added	Chapter 4 Section 4.2.7	N/A
PG17	Updated to direct DCs to ensure their management information systems (databases) are updated as soon as practicable	Chapter 4 Section 4.3.4	N/A
PG18	Removed intervention types for hygiene and standards	Removed	Chapter 5 Sections 5.2.1.1 and 5.2.1.2
PG19	Various terms updated for imports under new regulations: Border Inspection Posts now referred to as Border Control Posts. CED, and CVEDs now CHED	Chapter 4 Section 4.5	N/A
PG20	Updated charges section title to Fees and updated wording in line with the OCR	Chapter 4 Section 4.5.11	Chapter 5 Section 5.5.16
PG21	Sampling: New paragraph on Sampling of goods attained via distance communication added in line with the OCR	Chapter 4 Section 4.6.22	N/A
PG22	Sampling: Right to second opinion paragraph added in line with the OCR, links added to guidance.	Chapter 4 Section 4.6.23	N/A
PG23	Inspection of ships and aircraft	Chapter 4 Section 4.7	Chapter 5 Section 5.4

Reference	Record of changes in the Practice Guidance	Revised Practice Guidance	Current Practice Guidance
PG24	New section on action by the Competent Authority - responses to pre-incident contact by FSA	Chapter 5 Section 5.2.2	N/A
PG25	Additional guidance on responding to the FSA in relation to food incident notifications to the FSA.	Chapter 5 Section 5.2.3	N/A
PG26	New advice added on Food Business Operator Root Cause Analysis when food is recalled or withdrawn	Chapter 5 Section 5.2.5	N/A
PG27	Liaison with other countries has been updated and to note that this area is under review and will be updated as necessary	Chapter 5 Section 5.4	Chapter 2 Section 2.3
PG28	Introduction has been amended so that it reflects the content of the chapter	Chapter 6 Section 6.1	Chapter 6 Section 6.1.1
PG29	FSA’s Food Law Prosecution Outcomes Database section has been amended to include links to the correct spreadsheets and updated email address to be used	Chapter 6 Section 6.4.3	Chapter 6 Section 6.1.5
PG30	Section on Powers of Entry moved, as more closely related to enforcement. Section now entitled "Investigating Offences” and includes a new section on "Powers in Relation to Vehicles"	Chapter 6 Section 6.5	Chapter 3 Section 3.1.2
PG31	Food hygiene and food standards notices sections have been restructured and largely amalgamated to	Chapter 6 Section 6.6	Chapter 6 Section 6.2.1 and 6.2.2

Reference	Record of changes in the Practice Guidance	Revised Practice Guidance	Current Practice Guidance
	remove duplicated text. Some specific elements have been retained where appropriate. A new appeals summary table has been added at section 6.6.10		
PG32	A new Remedial Action Notice section which includes relevant details previously in the Code and also further information provided	Chapter 6 Section 6.7	Some references throughout Chapter 6
PG33	Prohibition Procedures section has been amended to include relevant details from the Code	Chapter 6 Section 6.8 to 6.12	Chapter 6 Section 6.2.3 Practice Guidance
PG34	Seizure and Detention section has been amended to include relevant details from the Code	Chapter 6 Section 6.13	Chapter 6 2.4 Practice Guidance
PG35	Table on marine biotoxin methods updated	Chapter 7 Section 7.1.11	Chapter 7 Section 7.1.11
PG36	Advice updated in relation to Live Bivalve Molluscs and other shellfish which fail to satisfy requirements	Chapter 7 Section 7.1.14	Chapter 7 Section 7.1.14
PG37	Matters relating to meat section includes updated links	Chapter 7 Section 7.3	Chapter 7 Section 7.3
PG38	Matters relating to egg products and liquid egg - further clarification on identification marking in relation to liquid egg	Chapter 7 Section 7.6.6	Chapter 7 Section 7.5.6
PG39	Food for specific groups - some sections updated and under review and will be updated as necessary	Chapter 7 Section 7.7	Chapter 7 Section 7.6

Reference	Record of changes in the Practice Guidance	Revised Practice Guidance	Current Practice Guidance
PG40	Bottled water - advice, legislative references, and links to guidance updated	Chapter 7 Section 7.9	Chapter 7 Section 7.8
PG41	New section added on Animal feed – former foodstuffs and co-products, animal by-product controls, and catering waste	Chapter 7 Section 7.10.4 to 7.10.6	N/A

Annex C: Summary of record of movement from the Food Law Code of Practice and Practice Guidance

Reference	Record of movement of text from the Code and Practice Guidance	Where relocated	Where located previously
MOV1	Details on the requirements on the content of documented procedures	Chapter 2 Practice Guidance	Throughout the Code
MOV2	Authorisations section split, with authorisation procedure requirements moved to Chapter 2 of the Code, appointment of authorised officers moved to Chapter 3 of the Code, and other details included in the Practice Guidance	Chapter 2 Section 2.4.1 and Chapter 3 Section 3 3.3 Code and 3.2 Practice Guidance	Chapter 4 Section 4.2 Code
MOV3	Monitoring of interventions procedure (control verification procedure)	Chapter 2 Section 2.4.1 Code	Chapter 3 Section 3.5.6.1 Code
MOV4	Requirement for a written enforcement policy	Chapter 2 Section 2.4.2 Code	Chapter 6 Section 6.1.2 Code
MOV5	Sampling policy and sampling programme	Chapter 2 Section 2.4.2 Code	Chapter 8 Section 8.1.1 Code
MOV6	Requirement for a written service plan	Chapter 2 Section 2.4.3 Code	Chapter 5 Section 5.11 Code
MOV7	Alternative Enforcement Strategy	Chapter 2 Section 2.4.3 Code	Chapter 5 Section 5.3.1.3 Code

Reference	Record of movement of text from the Code and Practice Guidance	Where relocated	Where located previously
MOV8	Monitoring system requirements (control verification system requirements)	Chapter 2 Section 2.4.4.4 Practice Guidance	Chapter 5 Section 3.5.6.2 Code
MOV9	Competent Authority's Management Information Systems	Chapter 2 Section 2.4.4.4 Practice Guidance	Chapter 3 Section 3.6.1 Code
MOV10	Details of how enforcement email addresses details should be provided to the FSA	Chapter 2 Section 2.11 Practice Guidance	Chapter 2 Section 2.3 and 2.4.1.8 Code
MOV11	Registration of Food Business Establishments - details about registration of establishments moved, leaving only direction for Competent Authorities	Chapter 2 Section 2.12 Practice Guidance	Chapter 3 Section 3.2 Code Chapter 3 Section 3.2 Practice Guidance
MOV12	Approval of Food Establishments - details about approval of establishments moved to the Practice Guidance, leaving only directions to Competent Authorities in the Code	Chapter 2 Section 2.13 Practice Guidance	Section 3.3 Code and 3.3 Practice Guidance
MOV13	Retention of Establishment Record Files	Chapter 2 Section 2.14 Code	Section 3.4 Practice Guidance
MOV14	Information in establishment record files	Chapter 2 Section 2.14.3 Practice Guidance	Chapter 3 Section 3.5.1 Code
MOV15	Information supplied to the FSA in relation to supply of approved establishment details	Chapter 2 Section 2.13.9 Practice Guidance	Chapter 2 Section 2.3.1 Practice Guidance
MOV16	Non-compliance with legislation in Member States has been moved	Chapter 5 Section 5.4.3 of Practice Guidance	Chapter 2 Section 2.3.2.8 Practice Guidance

Reference	Record of movement of text from the Code and Practice Guidance	Where relocated	Where located previously
MOV17	Data Protection and Freedom of Information	Chapter 2 Section 2.14.2 Practice Guidance	Chapter 3 Section 3.4.1 Practice Guidance
MOV18	Section on Information Requirement has been retained under the title of "retention of HACCP plans"	Chapter 2 Section 2.14.3.1 Practice Guidance	Chapter 3 Section 3.5.1.1 Practice Guidance
MOV19	Guidance issued to Competent Authorities section moved to sit with other details about enforcement policies	Chapter 2 Section 2.5.2 Practice Guidance	6.1.4 Practice Guidance
MOV20	Primary Authority Role section has been moved to avoid duplication of information, as there was already a section on Primary Authority included	Chapter 2 Section 2.9 Practice Guidance	Chapter 6 Section 6.1.6 Practice Guidance
MOV21	Delegation of official controls moved to Chapter 3 as relates to authorisation	Chapter 3 Section 3.2 Code	Chapter 2 Section 2.4.1.9 Code
MOV22	Delivery of Interventions	Chapter 4 Practice Guidance	Chapter 5 Practice Guidance
MOV23	Section on BTSF removed	N/A	4.8.4.2 Practice Guidance
MOV24	Planning and Notification of Interventions	Chapter 4 Section 4.2.1 Code	Chapter 5 Section 5.2.3 Code
MOV25	Description of intervention types	Chapter 4 Section 4.2.1 Practice Guidance	Chapter 5 Section 5.2 Code

Reference	Record of movement of text from the Code and Practice Guidance	Where relocated	Where located previously
MOV26	Official controls and non-official controls	Chapter 4 Section 4.2.1 Practice Guidance	Chapter 5 Section 5.2.1 Code
MOV27	Inspections and Audits	Chapter 4 Section 4.2.2 Practice Guidance	Chapter 5 Section 5.2.2.1 Code
MOV28	Food Hygiene Inspections	Chapter 4 Section 4.3.3.1 Practice Guidance	Chapter 5 Section 5.2.2.2 code
MOV29	Food Standards Inspections	Chapter 4 Section 4.3.3.3 Practice Guidance	Chapter 5 Section 5.2.2.3 Code
MOV30	Reports following Official Controls	Chapter 4 Section 4.3.4 Practice Guidance	Chapter 3 Section 3.5 Code
MOV31	Nominated officer for imported food	Chapter 4 Section 4.5.1 Code	Chapter 2 Section 2.4.1.6 Code
MOV32	Retention of import documentation	Chapter 4 Section 4.5.12 Practice Guidance	Chapter 3 Section 3.5.3 Code
MOV33	Sampling	Chapter 4 Section 4.6 Practice Guidance	Chapter 7 Code
MOV34	Managing Incidents and Alerts	Chapter 5 Section 5.2 Practice Guidance	Chapter 2 Section 2.1 Practice Guidance

Reference	Record of movement of text from the Code and Practice Guidance	Where relocated	Where located previously
MOV35	Information Supplied to the FSA covering incidents and alerts, as it relates to food hazards	Chapter 5 Section 5.2.4 Practice Guidance	Chapter 2 Section 2.4.1 Code
MOV36	Enforcement action and revisits – food hygiene and food standards	Chapter 6 Practice Guidance	Chapter 5 Section 5.2.4 Practice Guidance
MOV37	Prosecutions section has been removed, but some of the details from this section have been included in Chapter 6 of the Code	Chapter 6 Section 6.2 Code	Chapter 6 Practice Guidance
MOV38	Voluntary Procedures section created which includes details moved from the Code covering voluntary prohibitions and voluntary surrender as well as a general requirements section being added	Chapter 6 Section 6.14 Practice Guidance	Chapter 6 Sections 6.2.4.11 Practice Guidance Chapter 6 Sections 6.2.5, 6.2.8 and 6.2.10.7 Code
MOV39	Remedial Action Notices	Chapter 6 Section 6.7 Practice Guidance	Chapter 6 Section 6.2.3 Practice Guidance Chapter 6 Section 6.2.12 Code
MOV40	Enforcement of Imported Food section moved from Code to be consistent with approach taken to other enforcement powers	Chapter 6 Section 6.16 Practice Guidance	Chapter 6 Section 6.2.11 Code
MOV41	Enforcement in approved establishments moved as relates to practical enforcement	Chapter 6 Section 6.15 Practice Guidance	Chapter 3 Sections 3.3.18, 3.3.19, 3.3.20, 3.3.21 and 3.3.22 Code

Reference	Record of movement of text from the Code and Practice Guidance	Where relocated	Where located previously
MOV42	Crown Establishments	Chapter 6 Section 6.17 Practice Guidance	Chapter 3 Section 3.1.3 Practice Guidance Chapter 3 Section 3.1.2.8 Code
MOV43	Powers to carry out official controls section moved from the Code as more closely related to enforcement	Chapter 6 Section 6.2 Practice Guidance	Chapter 3 Section 3.1.1.2 Code
MOV44	Section on Food Complaints moved, as more closely related to enforcement action	Chapter 6 Section 6.3 Practice Guidance	Chapter 2 Section 2.1.2 Practice Guidance
MOV45	The enforcement approach section	Chapter 6 Section 6.4.1 Practice Guidance	Chapter 6 Section 6.1.2 Practice Guidance
MOV 46	Enforcement Information section	Chapter 6 Section 6.4.2 Practice Guidance	Chapter 6 Section 6.1.3 Practice Guidance
MOV47	Powers of entry as it relates to practical enforcement	Chapter 6 Section 6.5.1 Practice Guidance	Chapter 3 Section 3.1.2 Code and Practice Guidance
MOV48	Hygiene Improvement Notices and Improvement Notices section now merged with section on Food Information Regulation Improvement Notices, and includes details that have been moved from the Code	Chapter 6 Section 6.6 Practice Guidance	Chapter 6 Sections 6.2.1 to 6.2.2 Code and Practice Guidance
MOV49	Managing Incidents and Alerts moved to new Chapter 5 covering Incidents and Alerts	Chapter 5 Code	Chapter 2 Sections 2.3 and 2.4.1.4 Code

Reference	Record of movement of text from the Code and Practice Guidance	Where relocated	Where located previously
MOV50	Previous content on incidents moved to a new Chapter 5 Food Incidents, Alerts and Food Crime which consolidates all incident related content	Chapter 5 Practice Guidance	Chapter 2 Section 2.1 and 2.2 Practice Guidance
MOV51	Access to Information	Chapter 5 Section 5.3.7 Code	Chapter 3 Section 3.4 Code
MOV52	Section on Enforcement within Competent Authority-run establishments moved as related to enforcement policy	Chapter 2 Section 2.5.2 Practice Guidance	Chapter 3 Section 3.1.1.2
MOV53	Food establishment intervention rating schemes	Annex 1 Code	Chapter 5 Section 5.6 Code
MOV54	Revisits	Chapter 6 Section 6.5 Code	Chapter 5 Section 5.2.4 Code
MOV55	Inspections of ships and aircraft	Chapter 4 Section 4.7 Practice Guidance	Chapter 5 Section 5.5 Code
MOV56	Section on operating in another Competent Authorities area moved to Chapter 6 on enforcement as it relates to enforcement rather than administration	Chapter 6 Section 6.6 Code	Chapter 3 Section 3.1.2.5 Code
MOV57	Practical aspects of enforcement for example service of notices, destruction and disposal of food, seizure and detention and voluntary procedures	Chapter 6 Practice Guidance	Chapter 6 Code
MOV58	Matters relating to Live Bivalve Molluscs (LBMs)	Chapter 7 Section 7.1 Practice Guidance	Chapter 7 Section 7.1 Practice Guidance

Reference	Record of movement of text from the Code and Practice Guidance	Where relocated	Where located previously
MOV59	Requirement for DCs to notify the FSA for LBM purification centre details i.e. the bullet ‘where a live bivalve mollusc purification centre or modification to an existing centre is proposed	Chapter 7 Section 7.3.4 Code	Chapter 2 Section 2.4.1.2 Code
MOV60	Model registration form, temporary closure notice and Q&A on LBMs replaced with links to the forms on Smarter Comms	Smarter Comms with reference at Chapter 7 Section 7.1.19 Practice Guidance	Section 7.1.19.1, 7.1.19.2, Annex 1 Practice Guidance
MOV61	Fishing vessel check lists and Q&A on fishery products replaced with links to Smarter Comms	Smarter Comms with reference at Chapter 7 Section 7.2.7 Practice Guidance	Section 7.2.7.1 to 7.2.7.3 Practice Guidance
MOV62	Halal food requirements transferred to Smarter Comms	Smarter Comms with reference at Chapter 7 Section 7.3.9 Practice Guidance	Annex 2 Practice Guidance
MOV63	Documentation section covering the template notices and forms which can be used by authorised officers	Smarter Comms with reference at relevant locations in Chapter 6	Chapter 6 Section 6.3 Practice Guidance
MOV64	Food business establishment/food premises intervention report	Chapter 4 Section 4.3.4 Practice Guidance	Annex 2 Code

Annex C: List of interested parties

Chartered Institute of Environmental Health (NI)
Consumer Council
Department of Agriculture, Environment and Rural Affairs (Food and Feed)
Dairy UK
Department of Health
Federation of Small Businesses
Food NI
GMB (TUF)
Health and Safety Executive for Northern Ireland
Hospitality Ulster
IFST (NI) Branch
Institute of Hospitality (NI) Branch
Livestock & Meat Commission for Northern Ireland
National Association of Agricultural Contractors (NI)
NI District Council Heads of Service
NI District Council Lead Food Officers
NI Schools Catering Association
NIPSA (TUF)
Northern Ireland Food Advisory Committee (NIFAC)
Northern Ireland Food and Drink Association
Northern Ireland Food Chain Certification (NIFCC)
Northern Ireland Food Chain Certification (Red Tractor)
Northern Ireland Food Managers Group (NIFMG)
Northern Ireland Grain Trade Association (NIGTA)
Northern Ireland Hotels Federation
Northern Ireland Local Government Association (NILGA)
Northern Ireland Meat Exporters Association (NIMEA)
Northern Ireland Retail Consortium
Northern Ireland Trading Standards
Northern Ireland Pork and Bacon Forum
Northern Ireland Chamber of Commerce
Poultry Association for Northern Ireland
Retail NI
Siptu (TUF)
Ulster Farmers Union
Unison (TUF)
Unite the Union (TUF)
University of Ulster (Jordanstown)

Food Standards Agency Consultation

Review of the Food Law Code of Practice, Food Law Practice Guidance, and implementation of the Competency Framework

Belfast City Council Response

Consultation subject/purpose

To seek stakeholder views on the FSA proposals to update and simplify the Food Law Code of Practice (Northern Ireland) (the Code) and the Food Law Practice Guidance (Northern Ireland) (the Practice Guidance)

Belfast City Council welcomes the opportunity to comment on the review of the Food Law Code of Practice, Food Law Practice Guidance, and implementation of the Competency Framework. Belfast City Council do recognise that the proposed changes to the code in terms of proposed suitable qualification of Environmental health and technical officers have assisted in the recruitment of staff in the port health unit. However the very short 4 week formal consultation period allotted to consider the proposed competency framework is of concern. This consultation has been released at a time when Belfast City Council are operating in unprecedented times with significant pressure on resources. This is in addition to the preparatory work that is ongoing in relation to EU Exit. The proposed competency framework is complex and resource intensive.

Following correspondence received by EHNI on 25th November 2020 from Maria Jennings, FSA NI, regarding an extension on the date of the final submission of Council responses to 31st January 2021, this is a draft submission which will be submitted by the requested date of 10th Dec 2020. It will be followed up by a formal Council response by 31st January 2021

Consultation Questions:

1. **Does the layout/presentation and clarified text of the proposed Code and the Practice Guidance make the documents easier to use, improve readability, and facilitate consistent interpretation? If not, how could they be improved?**

   Belfast City Council agree that the layout/ presentation and clarified text make the document easier to use.

Belfast City Council have concerns that the current level of detail provided in the proposed Competency Framework which will pose a burden on already stretched food safety resources and Lead Food Officers. It may also not facilitate consistency without significant training and further supporting guidance.

Belfast City Council would seek clarification on the legal basis of Section 5.2.5-Practice Guidance and boundaries of application. Currently there are difficulties getting businesses to return a risk cause analysis.

2. **Do you agree that the proposed suitable qualification requirements provide DCs with the ability to deploy current resources more efficiently by, allowing a wider cohort of professionals to undertake food control activities, which the Code restricts? If not, why not? (Please specify any additional flexibility you would wish to see, and why).**

While it is agreed that the proposed suitable qualification requirements allow for a wider cohort of professionals to undertake food control activities, the NI Protocol and the need for significant SPS checks on GB-NI trade requires consideration be given to reviewing the qualifications and competencies required to complete documentary checks. Suitably trained and competent non-qualified officers should perhaps be able to complete simple documentary checks and record results. Only qualified officers should be authorized to fail a documentary check, reject a consignment or take enforcement action.

The current delivery model for SPS checks considers utilising non-qualified but trained and competent contractors to carrying out and record simple ID seal checks in GB Ports. The qualifications and competencies of the COP should be reviewed to allow this approach. Only qualified officers should be authorised to fail a documentary check, reject a consignment or take enforcement action.

Belfast City Council do not agree with the need to introduce the proposed complex competency framework for officers who hold the EHRB qualification and who are fully competent under the current Code. These officers should be exempt from the need to migrate to the proposed competency framework. There needs to be recognition of the qualifications obtained by these officers and the competency assessment that they have already undertaken.

Officers who hold the EHRB qualification but who are not fully competent in Food Control should be capable of a fast track method to achieve competency without the need to complete the full proposed Competency Framework. Recognition of these officer's existing competencies must be reflected in any proposed Competency Framework.

Belfast City Council also recognises the benefits of using the competency framework for staff who may carry out limited food safety duties and are not required to complete all of the assessment sections. However it limits the

usefulness of these staff. Belfast City Council require EHO's that have a wider range of skills and competencies available. This allows for the development and movement of staff with an EH qualification between functions in the wider Environmental Health Service.

It also enables a more holistic EH approach across a number of key areas to maximise the outcomes from any inspection, investigation or contact with business.

The proposed complex and resource intensive Competency Framework will be prohibitive to building resilience into the Environmental Health Service by hindering or restricting the movement of officers into the Food Control function from other core functions when the need to redeploy resources arises.

3. Does the Competency Framework include:

a. all the relevant activities for the delivery of front-line official food and feed controls, other official activities and other activities related to these, whether carried out by DCs and FSA delivery partners?

b. all the relevant activities for those working in the private sector who undertake assurance activities that are formally recognised to inform targeting/frequency of official controls?

c. the relevant competencies (knowledge and skills) for each activity and sub-activity?

If not, what changes would you wish to see, and why?

a. The competency framework is too detailed and prescriptive. This level of detail lends itself to the requirement for regular updating as new and emerging activities and processes emerge. Belfast City Council are concerned that the prescriptive detail of the Specialist and High Risk Activities could leave the competency status of food officers open to legal challenge. A more generic non-exhaustive listing of activities would reduce the burden of completion and recognise the wider skills of EHO's. This would also mitigate against legal challenge of an officer's competency. Belfast City Council would expect that the FSA will provide no cost training in all the currently prescribed Specialist and High risk activities if these are to be retained within the Competency Framework.

b. Belfast City Council are unable to comment on the relevant activities for those working in the private sector. It is recognised though that those in the private sector in these roles should meet the same competency standards as an EHO.

c. Refer to comments in a.
The FSA must recognise that NI Councils enforce both Food Hygiene and Food Standards legislation. It is therefore duplicitous to require officers to complete

certain sections common to both Food Hygiene and Food Standards when the applicable skills are transferable.

4. **Do you agree that by defining competency by activity rather than taking a role or profession-based approach this provides DCs and FSA delivery partners with greater flexibility in the utilisation of resources? If not, why not?**

   Competency by individual sub activity fails to recognise the skills of an EHO. There are aspects of a competency assessment that could facilitate the use of resources from other functions within the Environmental Health Service, however officer activities may have to be restricted due to qualifications and would limit their usefulness to a particular activity. To address Belfast City Council's concerns, the FSA should carry out a competency mapping exercise for officers who meet the baseline qualification in order to expedite the completion of the proposed Competency Framework.

5. **Do you agree that by setting a standard that will apply to all individuals undertaking food and feed control activities, including assurance activities that are formally recognised, will improve the quality and consistency of delivery across the public and private sector? If not, why not?**

   It is difficult to answer whether this will improve quality and consistency of delivery across the public sector. While the EHRB provided a consistent qualification that all candidates had to complete, under the new proposals each individual will be submitting different evidence for assessment and assessed by differing Lead Food Officers. The EHRB was a useful qualification for both the profession and employers in that it provided a recognised independent level of consistency and removed the burden from the employer to carry out assessments.

   It is difficult to comment whether setting such a standard will achieve the desired outcome as the assessment methodology has not been fully developed at the time of issue of this consultation.

   To ensure that the proposals achieve the aim of improving quality and consistency of delivery, comprehensive training, guidance and support must be provided by the FSA.

6. **Do you foresee any problems with the provision to allow the FSA to be more responsive in issuing instructions, whereby DCs may legitimately depart from the Code, in limited circumstances? If yes, what, if any safeguards or conflicts should we consider?**

   Belfast City Council do not foresee any problems with the provision.

7. **Do you agree that the key aspects of the OCR that have applied since the 14th December 2019 have been reflected, within the proposed Code and the Practice Guidance?**

Belfast City Council agree with this statement.

8. Do you agree with our assessment of the impacts on DCs, FSA approved assurance schemes, private sector assurance bodies, FSA delivery partners, and consumers, resulting from the proposed changes to the Code, the Practice Guidance, and implementation of the Competency Framework? Do you have any additional evidence to better understand the identified impacts? In particular, please indicate:

a. if you agree with our assumptions on familiarisation and dissemination time?

b. how long it currently takes to assess the competency of a newly appointed member of staff and the ongoing assessment of a member of staff already in post?

c. whether you foresee any changes in the assessment time, from the implementation of the Competency Framework?

d. how many new members of staff do you appoint every year?

e. whether you foresee changes to the number of new staff that need to be appointed every year?

a. The timeframe for familiarisation and dissemination time has been grossly under-estimated.

To date the Lead Food Officer in Belfast City Council involved in the response to the consultation has spent significantly more time than the allotted time of '3 hours to read and 2 hours to prepare and disseminate' suggested in the consultation. The Lead food officer has had to familiarise themselves with the competency framework spreadsheets and guidance that accompanies the framework. This officer would suggest that more than 25 hours has been spent on research, analysis, meetings, webinars and drafting the consultation response to date.

To prepare and disseminate this information requires significantly more time than the proposed time of 2 hours stated in the consultation. It would require more than 2 hours for officers to familiarise themselves with the spreadsheets alone. From previous experience in disseminating the 2016 Competency Framework it took in excess of a full working day to disseminate the information to officers.

This does not take into account the time that would be required for the Lead Food Officer to provide ongoing guidance, advice and assistance to both new and fully authorised staff to complete their individual assessments.

b. Belfast City Council would question the FSA's assumption that there would be 'no significant additional burden' to local authorities to introduce the new competency framework. Belfast City Council believes that significant time will need to be taken to complete the proposed Competency Framework. This assumption is based on the experience of the implementation of the current Competency Framework and would conclude that the new Competency Framework is a more complex and time consuming process. Lead Officer experience would indicate that it took at least 5 days for officers to complete the existing Competency Framework document as prescribed in the current Code.

Significant time is required by the Lead Food Officer to assess the proposed Competency Framework and complete the necessary administrative duties. Belfast City Council would predict that it will take 10 days per officer and 4 days per assessment for the lead officer to complete the proposed competency framework.

To mitigate against this significant time spend Belfast City Council propose that current fully authorised officers retain their current Competency Framework now and into the future and are not required to transition to the proposed Competency Framework.

The impact on the proposed competency assessment on the Lead Food Officer in port is still to be assessed. There are currently 23 newly recruited officers, with a further 6 posts to be filled, in the port health unit and they are being assessed under the current competency framework. The majority of these staff may have to migrate to the proposed competency framework if the FSA introduce as planned. This will be a duplication of time spent for both the individual officers and the Lead Food Officer. Currently we have a senior EHO assisting the Lead Officer in port health with the completion of the current competency frameworks due to the volume of new staff that are undergoing training. Currently it is estimated that these staff are taking the time as indicated above to complete the current assessment. The senior EHO has spent to date 5 days collating authorisation and competency information to assist the lead food officer with the competency assessment.

c. Experience would suggest that ongoing competency review, which in Belfast City Council takes place annually, under the current competency assessment takes at least 2 days for each officer and a day per assessment review for the Lead Food Officer.

d. Staff recruitment and retention can be unpredictable.

Inland recruitment			
	EHO's	TO's	Retained
2020	2 temporary	1 permanent	0
2019	6 temporary		2 EHO

	2 permanent		
2018	3 temporary		0
Port recruitment			
2020	15	8	
2019	0	0	
2018	0	0	

Although this question is limited to new staff, the FSA must consider the redeployment of existing staff into the food function, temporary cover requirements such as maternity or carer leave and the need to employ agency staff.

d. Belfast City Council cannot fully predict the number of staff required as the Council will have to address the out-workings of food related work at the end of the Transition Period and the implementation of the NI Protocol. In the current working environment there has been an extensive recruitment campaign for the port health function, however inland the fall out of working under covid procedures has resulted in difficulties recruiting and retaining staff inland.

Additional resources will be required to address the current Council backlog of inspections due to the Covid pandemic. The FSA proposal on how to address the businesses which were inspected outside the Mandatory FHRS is welcomed as to inspect these premises again would have put another significant burden on the food safety team. Dealing with these priority issues will necessitate additional resources to address the Competency Framework and officers authorisations.

Costs to FSA approved assurance

9. Do you foresee any other impacts from the implementation of the main proposals detailed in paragraph 13, beyond what we have identified? Where possible, please explain your views and provide quantifiable evidence
(for example, costs associated with updating existing templates, the benefits of greater flexibility to allocate staff to activities)

Councils are currently in the midst of covid operating procedures as well as preparing for EU exit under the NI protocol. Belfast in particular is one of the main port authorities impacted by the implementation of the NI protocol.

There is a backlog of inspections in Belfast City Council and across all District Councils due to the Covid19 pandemic which the FSA are aware of. Belfast City Council will require direction from the FSA on how best to utilise current

resources, as the completion of the new Competency Framework for existing authorised officers would impact on our ability to complete the FSA priorities on Official Controls as directed by FSA communication dated 30th September 2020.

Lead Food Officers presently have significant monitoring duties to complete in order to fulfil the requirements of the food service delivery plan and required procedures. The proposed competency framework would pose a further burden onto the current competency assessment monitoring. The employment of temporary and agency staff would further increase the burden on lead food officers. A further complication for short term contract staff would be the need to have an agreed system for the sharing of competency assessments between local authorities.

The completion of the competency assessment is an onerous task at present and is seen by officers as a deterrent to entering the food safety role. The proposed competency framework is significantly more onerous and can only increase the pressure on food units to recruit and retain staff.

Additional resources will also have be deployed to review and amend certain internal policies and procedures to comply with the changes in the COP and Practice Guidance.

Belfast City Council

PEOPLE AND COMMUNITIES COMMITTEE

Subject:	Belfast City Council response to the new substance use strategy for Northern Ireland – "Making Life Better – Preventing Harm and Empowering Recovery: A Strategic Framework to Tackle the Harm from Substance Use"
Date:	12th January 2021
Reporting Officer:	Ryan Black, Director of Neighbourhood Services
Contact Officer:	Kelly Gilliland, Neighbourhood Services Manager, North

Restricted Reports				
Is this report restricted?	**Yes**		**No**	X
If Yes, when will the report become unrestricted?				
After Committee Decision				
After Council Decision				
Some time in the future				
Never				

Call-in				
Is the decision eligible for Call-in?	**Yes**	X	**No**	

1.0	**Purpose of Report or Summary of Main Issues**
1.1	Members will be aware that this Committee previously approved the Council's response to the pre-consultation exercise for the development of this strategy back in September 2019, which was then ratified by Council at its October meeting (this is included in Appendix 2).
1.2	The Department of Health has now developed its draft substance use strategy for Northern Ireland, based on feedback received as part of the pre-consultation exercise, and is now consulting on this. The consultation opened on **30th October 2020 and closes on Friday 5th February 2021 at 5.00pm.**

1.3	Addressing substance misuse and mental health remain two key priorities within the Belfast Agenda and indeed for members. Therefore as with the pre-consultation response, Council is making the case as part of their response that the new strategy, and the structures associated with it, need to integrate and align with community planning structures to ensure both regional and local impact can be maximised.
2.0	**Recommendations**
2.1	The Committee is asked to • Approve the draft consultation response at Appendix 1 and for this to be submitted to the Department of Health by the deadline of 5th Feb.
3.0	**Main Report**
	Key Issues
3.1	The draft consultation response is attached at Appendix 1 for Members consideration.
3.2	The Council's response at the pre-consultation stage is included at Appendix 2 – we intend to resubmit this along with our response.
	Financial & Resource Implications
3.3	There are no financial and resource implications for Council at present.
	Equality or Good Relations Implications/Rural Needs Assessment
3.4	The consultation document confirms that the Department of Health has completed equality, good relations and rural needs screening (links to these provided within the document).
4.0	**Appendices – Documents Attached**
	Appendix 1 – Draft Council Response Appendix 2 – Council's Response to the Pre-Consultation on the development of the Strategy Appendix 3 – "Making Life Better – Preventing Harm and Empowering Recovery: A Strategic Framework to Tackle the Harm from Substance Use" (DoH)

Consultation to seek views on the new Substance Use Strategy for Northern Ireland – "Making Life Better – Preventing Harm and Empowering Recovery: A Strategic Framework to Tackle the Harm from Substance Use"

Consultation opened on Friday 30 October 2020.

Consultation closes on Friday 05 February 2021 at 17:00.

Summary

The Department of Health is responsible for leading and co-ordinating action on Northern Ireland's new substance use strategy on a regional and local basis.

Consultation Description

The new Substance Use Strategy for Northern Ireland – **"Making Life Better – Preventing Harm and Empowering Recovery: A Strategic Framework to Tackle the Harm from Substance Use"** – was issued for public consultation on 30 October 2020:

https://www.health-ni.gov.uk/SUS-consultation

The current strategy – the New Strategic Direction for Alcohol & Drugs Phase 2 (NSD Phase 2) – was published and endorsed by the former NI Executive in 2012.

The NSD Phase 2 was recently reviewed, and a report has been published which looked at its outcomes, outputs, and stakeholder views on how successful this has been.

Taking on board the outcomes from the review a pre-consultation exercise took place in 2019 on what should be contained within a new substance use strategy. This was followed by the development of the new strategy on a co-production basis with involvement from key stakeholders including; the community and voluntary sector; service users; health professionals; academics; and key government departments and agencies.

We are now seeking views from partners and the general public on the new strategy. We want your views on the vision, indicators, outcomes and targets set out in the new strategy. And we want your views on what should be prioritised, in the event that not all actions can be taken forward in the final published strategy.

Next Steps

Following this consultation, we will collate and analyse all views and inputs, and begin the process of developing the final strategy. This will need to be agreed by the Minister of Health and the NI Executive before being published. It is important to note that the NSD Phase 2 – and all the structures that support action and collaboration – will remain in place until any new strategy is put in place.

The Closing Date for responses is Friday 05 February 2021

Ways to respond: Respond Online

It may be easier for you to respond online, and you can do this by clicking on the Green Button "Respond Online" above – this will take you straight to the online questionnaire on the Citizen Space.

Alternatively, you can access the relevant documentation on the DoH website at:

https://www.health-ni.gov.uk/SUS-consultation

or contact us using the details below:

Email: HDPB@health-ni.gov.uk

Write to: Health Development Policy Branch
Room C4.22
Castle Buildings
Stormont Estate
BELFAST
BT4 3SQ

INTRODUCTION	
	What is your name?
	Name: Kelly Gilliland
	What is your e-mail address? *If you enter your email address then you will automatically receive an acknowledgement email when you submit your response.*
	E-mail: gillilandk@belfastcity.gov.uk
	Is your response being submitted on behalf of an organisation or as an individual? (*please tick below as appropriate*)
	X **Organisation** *Please use text box below to state the name of your organisation etc?* ☐ **Individual**
	[*text box*] Belfast City Council

Equality/Good Relations and Rural Screening (Chapter 1)

Question 1a	**Have you any comments on either the Equality/Good Relations or Rural screening documents?** No comments.
Question 1b	**Have you anything you believe we should be considering in future Equality/Good Relations or Rural screenings?** No comments.

Vision, Outcomes, Values, Priorities and Target Groups (Chapter 5)

Question 2a	**Do you agree with the Vision?** X Yes ☐ No If No, please provide further information. Suggest adding in 'assisted to' to emphasise that there will now be a focus on developing and providing recovery-focussed services. People in Northern Ireland are supported in the prevention and reduction of harm related to the use and misuse of alcohol and other drugs, and will be empowered, and assisted to, maintain recovery.
Question 2b	**Do you agree with the Outcomes?** X Yes ☐ No If No, please provide further information. Whilst we welcome the focus on harm reduction we also feel there needs to be another outcome or two alluding to prevention and early intervention aspects. E.g. • People will be made aware of the risks and harms of using substances. • Services will aim to intervene early to prevent harm/further harm occurring.
Question 2c	**Do you agree with the Values?** X Yes ☐ No

	If No, please provide further information. Value – 'Community based with local flexibility to address needs': It might also be beneficial to have an outcome that clearly focuses on community provision working in partnership with others. Much positive work has been taken forward locally by both BDACT and BDACT Connections however there is still much more that could and should be done in relation to awareness-raising. Also, as well as local flexibility there needs to be local accountability therefore it would also be good within this value to reference the role of Trusts/LGDs and community planning. Value – 'Long Term focus': … 'the need to focus on prevention and early intervention as much as treatment and support' – lends weight to our response to question 2b for the need for an outcome which is clearly focussed on prevention & early intervention.
Question 2d	**Do you agree with the Priorities?** X Yes ☐ No If No, please provide further information. Priority – 'Workforce Development': Suggest rewording to: It is vital that we have capacity to deliver on the strategy, and that all those who work in the substance use field, and those who come into contact with people at risk, are able to: raise awareness of harms and risks; provide timely and accurate information; signpost to relevant services; provide effective high quality early intervention and treatment interventions; and, provide ongoing support to those in recovery. Priority – 'Supporting People throughout their Recovery Journey': The community sector has a vital part to play in the recovery process, we need to ensure that any recovery support services that are developed are linked closely with the wide ranging support that is already available within the community – taking a holistic approach where possible. Priority – 'Supporting People with Co-Occurring Substance Use and Mental Health': Need to be more specific here in what action is going to be taken outside of aligning strategies – by aiming for integration wherever possible e.g. in messaging, in prevention initiatives (holistic approach), in service integration, etc.
Question 2e	**Do you agree with the Target Groups?** X Yes ☐ No If No, please provide further information. We believe the wording in 5.8 should be stronger – where is currently states 'Service providers should always keep in mind these groups may need additional support …' we are suggesting that this should state 'Service providers

	should be aware of the varying needs of specific groups, and have measures in place to enable them to actively respond to those needs.' Whilst 5.7 and 5.8 are focussed on ensuring equity of 'access to services' we feel that it would be beneficial here to also draw out the requirement to actively target these groups for prevention and early intervention purposes also and the importance of tailored messaging.
Question 2f	**Have you any further comments?** Belfast City Council is pleased to see that some of its feedback has been taken on board from the pre-consultation phase, however there are other elements which Council would still like to be considered – therefore we are once again submitting our pre-consultation response as a supplementary submission along with our response.

Outcome A – Fewer People are at risk of harm from the use of Alcohol and Other Drugs (Chapter 6)

Question 3a	**Do you agree these indicators help to demonstrate progress against this outcome of having fewer people at risk of harm?** X Yes ☐ No If No, please provide further information.
Question 3b	**Are you aware of any other indicators that would demonstrate such progress?** X Yes ☐ No If Yes, please provide further information. It would be helpful to include some of the more holistic indicators mentioned within 6.5 e.g. 'Preventing harm before it occurs, and intervening at an early stage for those most at risk, will have positive impacts across many sectors and on issues such as: exclusion from school, academic performance, community safety, reducing offending and reoffending, homelessness, community cohesion, emotional health and wellbeing, etc.' 6.9 – suggest including tobacco use indicators also given potential as 'gateway' drug. Do surveys currently ask about nitrous oxide use – if not – suggest future inclusion given levels of current usage within Belfast. 6.10 – Information on what doesn't work and why should be shared with key sectors/groups such as EA/schools and youth service, C&V sector, etc. Reference could also be made here to the work being done in terms of developing the Emotional Health & Wellbeing Framework (noted in A1) and what it aims to cover/achieve. The framework is mentioned on p34 but not much detail given.
Question 4a	**Will these actions achieve this outcome of having fewer people at risk of harm?** X Yes ☐ No If No, please provide further information. All of the actions listed need timescales assigned to them within the final document. A1 – as noted in response to 3b more information should be given on the 'work emerging' from the Emotional Health & Wellbeing Framework, its aims and

	objectives and the timeframe for its implementation. The framework is mentioned on p34 but not much detail given. Council would also like to draw attention to the Belfast Youth Forum's 'Elephant in the Room' report, particularly the recommendations, and request that these are considered as part of both the framework development and in the implementation of both this strategy and the forthcoming mental health strategy. https://www.belfastcity.gov.uk/Documents/youth-forum/Elephant-in-the-room A2 – does this relate to NI potentially piloting the Icelandic Prevention/Planet Youth approach? Belfast City Council, along with a number of other Councils, had previously expressed an interest in this approach and had attended a seminar re. same back in 2017 and would therefore be keen for more detail on how the 'Northern Ireland Prevention Approach' will be developed. A3 – Suggest also adding at the end 'And further develop, and build on, their social media engagement through the associated FB and Twitter pages.' A4 – this need to be clearer – in terms of the 'community support mechanisms' is this referring to the locality-based DACT Connections Services and whilst the review should be led by PHA it would also need to include input from relevant stakeholders – again what is the timeframe for this? A5 – Older people need targeted for prevention and early intervention too, also in light of Covid-19 so do a range of others - people with lost jobs, lost income, those suffering as a result of social isolation who may have turned to substance use as a coping mechanism - anecdotal evidence of this with some stats re increase alcohol use/purchasing [Dec 20 Belfast Telegraph article quoting 70% jump in shop sales of lager and beer] etc. A6 – Will there be scope for this brief intervention training to be substance misuse focussed given the rise in polydrug use and will it include an element of educating about local service provision at Tier 2 (C&V) and Tier 3 (Stat) – given the findings of the NIAO report that GPs mostly auto refer (inappropriately) to statutory Tier 3? A8 – Will there also be local plans/actions developed and will there be additional resources for assigned for hidden harm? Will the Youth Substance Misuse Services once again be able to take referrals for or from children concerned about, or impacted by, parental substance misuse?
Question 4b	**Will these actions make positive impacts on the indicators?** X Yes ☐ No If No, please provide further information. As noted previously all of the actions need timescales/targets attached.
Question 4c	**Which actions would you prioritise if they cannot all be taken forward, or are there other actions likely to have a bigger impact?** No comment.

Outcome B: Legislation and the Justice System support Preventing and Reducing the Harm related to Substance Use (Chapter 7)

Question 5a	**Do you agree these indicators help to demonstrate progress against this outcome of legislation and the justice system preventing and reducing harm?** X Yes ☐ No If No, please provide further information.
Question 5b	**Are you aware of any other indicators that would demonstrate such progress?** X Yes ☐ No If Yes, please provide further information. General: % of people receiving support in the justice system for substance misuse related issues % of people successfully completing prevention and/or treatment programmes within the justice system. Relevant YJA stats? There may also be information available via Trust or LGD level Anti-Social Behaviour Forums (NIHE), Youth Diversion Forums (YJA) and Concern Hubs (PSNI) where in place – this goes back to enhancing relevance for communities if localised data is also used where/when it is available. Drugs: No. or percentage of drug seizures by PSNI No. or percentage of customs seizures in relation to prescription meds etc.
Question 6a	**Will these actions achieve this outcome of legislation and the justice system preventing and reducing harm?** X Yes ☐ No If No, please provide further information.

	All of the actions listed need timescales assigned to them within the final document. B1 – Suggest as well as scaling up across NI they will also need to be scaled up within the pilot sites such as Belfast as well as demand far outweighed capacity to respond during the pilot phase. B2 – What is the timescale for the development of the Transitions Service? Will data from this service be able to inform indicators suggested above and also to form part of wider picture – this goes back to the NIAO report in terms of better recording and reporting of outcomes focussed data? B4 – Could this timescale be clearer i.e. within a year of publication of the strategy? Given the renewed focus within this strategy on harm reduction and that there are currently only two actions noted under drugs within this section would it be possible to include two further actions, namely; B9: The Department of Health will work with the NI Executive and the UK Government to explore whether further harm reduction models and service types could be introduced in NI (even on a pilot basis) for example safe/medical supervised injecting facilities. Reference could also be made to how this type of action is being progressed in RoI. Furthermore, the Futuresearch on Drugs and Alcohol back in 2013 made reference to exploring the benefits of decriminalisation (e.g. Portugal - decriminalisation of personal possession) - could there be an action in terms of further exploring this as no action has been taken to date.
Question 6b	**Will they make positive impacts on the indicators?** X Yes ☐ No If No, please provide further information.
Question 6c	**Which actions would you prioritise if they cannot all be taken forward, or are there other actions likely to have a bigger impact?** No comment.

Outcome C – Reduction in the Harm caused by Substance Use (Chapter 8)

Question 7a	**Do you agree these indicators help to demonstrate progress against this outcome of reducing harm?** X Yes ☐ No

	If No, please provide further information.
Question 7b	**Are you aware of any other indicators that would demonstrate such progress?** X Yes ☐ No If Yes, please provide further information. General: Nos. of people accessing treatment services (NI Sub Mis Database & annual Census) Nos. of people successfully completing/having positive outcomes via treatment services (NIAO report recommendation) Given links with MH – Nos./Rates of suicides where substances are also noted as being present Alcohol: No./% of young people drinking/drinking excessively Drugs: General drug usage stats (not just focussed on injecting drugs)/Polydrug use stats
Question 8a	**Will these actions achieve this outcome of reducing harm?** X Yes ☐ No If No, please provide further information. 8.17 – the report referenced (The effectiveness of interventions related to the use … Review of reviews, Health Research Board, Ireland) makes specific reference to a combination of low and moderate quality evidence indicating that drug consumption rooms appear likely to be acceptable to people who inject drugs and that they may be associated with reduced sharing and reuse of syringes etc. and not associated with increases in injecting drug use. This lends weight to earlier request for the strategy to make a commitment to exploring other evidence based HR models/interventions (response noted under 6A). All of the actions listed need timescales assigned to them within the final document. C2 – 'joined up and intensive outreach service' – this is most welcome however such a service needs to be localised and led equally by all partners. In Belfast, in response to issued raised by the Belfast Drugs and Alcohol Coordination Team within community planning we are proposing exploring and potentially adaption the Complex Lives approach developed by Doncaster Council and would be keen that this informs the development of such as service particularly in Belfast.

	C3 – Given that 'Supporting People with Co-Occurring Substance Use and Mental Health' is a priority within the strategy it is somewhat concerning that this is the only mental health related action noted thus far. We would argue that the action needs to go beyond training and also that the training should not just be focussed on suicide prevention but all tiers of mental health. Suggested additional actions: Review of, leading to improved, pathways between Mental Health & Substance Misuse services – at both Tier 2 (between C&V sector services) and Tier 3 (between statutory services). Key substance misuse services should have Mental Health practitioner posts embedded within them such as Daisy/Start 360 were able to do within the PHA-funded youth substance misuse service for a time bound period thanks to Lottery funding. And/or key services (adult and youth) should have access to consultation time with statutory MH professionals re clients of concern. C6 – Suggest this should also have a local element or local linkages - seems remiss when have a localised approach for suicide deaths and yet no. of alcohol and drug related deaths are much higher and only a regional approach is being proposed. C8 – Would add in ensuring equity of provision and access based on nos. attending. NB Belfast has recently lost two of its largest and longest standing community pharmacy NSES providers and yet has the largest nos. across the region availing of this service. There also needs to be a focus on, and perhaps targets included, in terms of increasing return rates - is there a similar WHO or UK target for return rates that we should be aiming for?
Question 8b	**Will they make positive impacts on the indicators?** X Yes ☐ No If No, please provide further information.
Question 8c	**Which actions would you prioritise if they cannot all be taken forward, or are there other actions likely to have a bigger impact?** No comment.

Outcome D – People access High Quality Treatment and Support Services to Reduce Harm and Empower Recovery (Chapter 9)

Question 9a	**Do you agree these indicators help to demonstrate progress against this outcome of accessing treatment?** X Yes ☐ No If No, please provide further information.
Question 9b	**Are you aware of any other indicators that would demonstrate such progress?** X Yes ☐ No If Yes, please provide further information. General: Nos. re-entering treatment services within a given period NB 'measures to be developed for statutory services' – this is critical (NIAO report) – what is the timeframe for this – who/how will it be taken forward? NB 'service user feedback on treatment (to be developed)' – again what is the timeframe for this – who/how will it be taken forward?
Question 10a	**Will these actions achieve this outcome of accessing treatment?** ☐ Yes ☐ No If No, please provide further information. 9.5 Would also include combined mental health and substance misuse issues. 9.6 Worth also noting the stigma in terms of public acceptability and greater tolerance of certain substances and/or certain types of services over others and the challenges that this presents in terms of equity of provision and access (Belfast NSES closures - case in point). 9.7 As well as childcare issues would also include fear of social services involvement. 9.8 We would argue the need for integrated services across the board it is not just young people who live/lead complex lives – e.g. previous reference to Doncaster Council's complex lives approach for adults which we are keen to explore in Belfast. 9.10 As noted in response to C3 this is really important however each strategy needs to include clear and specific actions to address this issue. 9.11 As noted in 9.8 this point again makes the case for integrated service provision for those with complex lives.

	9.14 It is also important to ensure that services have appropriate levels of/nos. of skilled staff in post – this has particularly been a recurring issue in the past within statutory services. There is also a need for more workers skilled in both Mental Health and Subtance Misuse interventions e.g. CBT specialists, Dual Diagnosis workers - have we enough? All of the actions listed need timescales assigned to them within the final document. D1 – The COVID-19 Addiction Services Rebuilding Plan – this is the first time that this has been referenced within the document – who is leading on this and what is the timeframe for its development/implementation? D3 – needs to include reference to provision of mental health training (and as noted previously wider scope than just suicide prevention training). D4 – If the revised PHA/HSCB Alcohol and Drug Commissioning Framework is to be 'in line with the strategy' surely it has to come after the strategy has been consulted on and finalised and yet PHA has already commenced consulting on this framework and proposed changes? D5 – Given the need for closer linkages and the fact that a Tier 3 review was already completed a number of years ago - would it not be better to complete a joint review of Tier 2 and 3 services - has the need for this been covered somewhat under the NIAO report? What is the anticipated timeframe for this? D6 – Suggest this action should also state that the DAMHS/CAMHS service should also have a formalised relationship and pathway with the PHA/HSCB commissioned youth substance misuse service. D7 – Again would argue that this needs to be carried out urgently (timeframe?) and would also express concern that quite a number of reviews have been noted as actions within the strategy as a whole and particularly within this section. D10 – Consideration should also be given to support outside of treatment services e.g. peer support models – particularly given the low nos. having engaged through formalised treatment services to date. D12 – the three week waiting time is welcome but seem ambitious given the experience in Belfast to-date – what is the anticipated timeframe for this target to be a reality?
Question 10b	**Will they make positive impacts on the indicators?** X Yes ☐ No If No, please provide further information.
Question 10c	**Which actions would you prioritise if they cannot all be taken forward, or are there other actions likely to have a bigger impact?** No comment.

Outcome E – People are Empowered and Supported on their Recovery Journey (Chapter 10)

Question 11a	**Do you agree these indicators help to demonstrate progress against this outcome of empowering people?** X Yes ☐ No If No, please provide further information.
Question 11b	**Are you aware of any other indicators that would demonstrate such progress?** X Yes ☐ No If Yes, please provide further information. General: Percentage increase in no. of services who offer dedicated and sustained recovery support/programmes during the life of the strategy (baseline needed).
Question 12a	**Will these actions achieve this outcome of empowering people?** X Yes ☐ No If No, please provide further information. All of the actions listed need timescales assigned to them within the final document. E1 – This action needs to be clearer - what will the outcome be - a plan, a framework, a charter? E4 – Again clarity needed – does this mean integrated with Suicide Bereavement services or delivered by partners such as CRUSE etc.? E6 – Could this action be more specific - e.g. could reference be made to the Interdepartmental Homeless Action Plan which is currently a rolling plan in place until 2022 - next iteration of this building on learning to date? The plan is referenced on p34 but not much detail given.
Question 12b	**Will they make positive impacts on the indicators?** X Yes ☐ No

	If No, please provide further information.
Question 12c	**Which actions would you prioritise if they cannot all be taken forward, or are there other actions likely to have a bigger impact?** No comment.

Outcome F – Information, Evaluation and Research better supports Strategy Development, Implementation and Quality Improvement (Chapter 11)

Question 13a	**Will these actions achieve this outcome of better information, evaluation and research?** X Yes ☐ No If No, please provide further information. All of the actions listed need timescales assigned to them within the final document. F1 – How often will the update reports be published and will there be a local (Trust/LGD) element as well as a regional overview given in terms of progress presented and outcomes achieved? F3 – As noted previously – what is/will be the timeframe for the development of the T3/T4 outcomes framework? F4 – Will there be linkages between this Research Oversight Group and DACTs/Community Planning structures to ensure that local needs in relation to research are also considered?
Question 13b	**Which actions would you prioritise if they cannot all be taken forward, or are there other actions likely to have a bigger impact?** No comment.

Making it Happen – Governance and Structures (Chapter 12)

Question 14	**Do you agree with the proposal to review the role, function and membership of DACTs, and consider linkages with other local delivery structures?** X Yes

	☐ No If No, please provide further information. 12.6 Use of language – DACTs and DACT Connections services are still/remain the current delivery structures – 'previously these had been delivered by.' It is also unclear as to why PCSPs have been specifically mentioned as these are not new and were in fact operational during the previous strategy's timeframe and have a specific focus and remit flowing from Dept of Justice (arguably DACTs should remain, and remain under DoH to maintain the health prevention and harm reduction focus). We would agree on the need to build linkages via community planning (CP) and arguably have already commenced this within Belfast context (as noted previously we are working closely with BDACT on looking at drug and alcohol issues and how they are impacting locally as well as potential solutions) however neither the PCSP nor the CP structures in Belfast could absorb the breadth of work currently associated with/taken forward by BDACT. All structures should be periodically reviewed in terms of role, function, membership, etc. However, the issue appears more related to authority and accountability for the DACTs (as for many partnerships operating in Belfast and beyond). There is no point in having DACTs if the issues they raise, and actions they identify, aren't accepted and acted upon at a higher level within the organisations represented or structures that they are linked to. Furthermore, those responsible for commissioning and service planning need to work more collaboratively to avoid duplication and to maximise impact particularly when addressing the more complex 'wicked' issues such as substance misuse and mental health.
Question 15	**Do you agree with the proposed governance structures?** X Yes ☐ No If No, please provide further information. As noted in question 14 we feel it would be useful to more clearly outline how the regional structure – and particularly DACTs as the local delivery mechanism – relate locally at HSCT/LGD/Community Planning level structurally.
Question 16	**Do you agree with the Timeframe proposed?** X Yes ☐ No If No, please provide further information.

	As noted previously, perhaps more important than an overall timeframe for the strategy itself is that all of the actions identified within it are assigned (even notional) timeframes. Five years with the option to review and either extend or develop a new approach seems reasonable.

FINAL COMMENTS	
Question 17	**Have you any other comments you wish to make at this stage?** Belfast City Council welcomes the opportunity to consider the draft strategy 'Making Life Better – Preventing Harm & Empowering Recovery: A Strategic Framework to Tackle the Harm from Substance Use.' Councillors continue to raise concerns about the impact of alcohol and drugs on individuals, families and communities in Belfast on an ongoing basis. It remains our position that there is a need for more effective coordination and collaboration at both service planning and service delivery levels and therefore that both the new strategy, and structures associated with it, need to integrate and align with community planning structures to ensure both regional and local impact can be maximised. Clear governance at both a regional and local level will facilitate flexible inter-agency action across organisations and also ensure collective accountability. Given the prominence of related outcomes in the Belfast Agenda, Belfast City Council would like to emphasise that it wants to be an active participant and co-producer of any strategies and action plans seeking to address these issues in Belfast for the benefit of its citizens.

THIS IS THE END OF THE QUESTIONNAIRE

Thank you for taking the time to complete this questionnaire.

Please submit your completed response via e-mail to:

HDPB@health-ni.gov.uk

APPENDIX 2 - BELFAST CITY COUNCIL DRAFT RESPONSE

PRE CONSULTATION TO SEEK VIEWS ON THE SUCCESSOR STRATEGY TO THE NEW STRATEGIC DIRECTION FOR ALCOHOL & DRUGS PHASE 2

Introduction

Belfast City Council welcomes the opportunity to consider and input into the pre consultation exercise to seek views on a successor strategy to the 'New strategic direction for alcohol and drugs phase 2' issued by the Department of Health on 17 May 2019**.** People & Communities Committee on 06 August agreed the consultation response enclosed. This response remains subject to ratification by Council on 2 September 2019 following which we can update our response with any changes and notify you of this.

Councillors continue to raise concerns about the impact of alcohol and drugs on individuals, families and communities in Belfast on an ongoing basis.

As a result, a strategic round table workshop took place on this issue in 2017, facilitated by the Belfast Strategic Partnership and including Elected Members, following two notices of motion on alcohol & drugs and suicide & drug related death.

The key messages coming from that workshop were the need for strategic leadership, joint commissioning, focused outcomes, systemic change from silo working and services to integrate early and preventive interventions centred on the person's immediate and ongoing needs. A further Officer workshop on 9 July 2019 agreed these issues remain current and provide an accurate reflection of the continuing challenges experienced when operating in this area.

It remains our position that there is a need for effective leadership and that any new strategy needs to integrate and align with community planning structures regionally to ensure both regional and local impact.

We also believe any strategy must recognise the inextricable link between alcohol/drugs and mental health/wellbeing. For that reason outcomes should align with Belfast Agenda where the city seeks to ensure no one is left behind, everyone reaches their potential and experiences good health and wellbeing.

The strategy needs to be able to facilitate flexible inter-agency action across organisations but ensure collective accountability. This should include preventative universal services as well as targeted services for those individuals in need of specific help.

Additionally, the strategy should recognise the potential for non-health related services to play a positive role in addressing these issues and draw those services in to the accountability arrangements e.g. PSNI and Education. It should also seek to explore the relationship between enforcement, prevention and intervention in maximising successful outcomes.

Finally, given the prominence of related outcomes in the Belfast Agenda, Council would like to emphasise that it wants to be an active participant and co-producer of strategies to address these issues in Belfast for the benefit of its citizens.

Consultation Response

1. What is your name: Belfast City Council

2. What is your email address: allena@belfastcity.gov.uk

3. Is your response on behalf of an organization: Yes

4. From your experience and from the findings of the Review/other sources of evidence, does NI still need a substance misuse strategy? Yes

5. Should it cover both Alcohol & drug misuse

Yes, however the strategy should integrate more effectively with other relevant strategies i.e. mental health and wellbeing (including suicide).

If you wish please explain your choice

Council seeks a straightforward approach to the next strategy and this begins with the vision to ensure we leave no one behind. The strategy therefore should be clear on how it is supporting individuals, families and communities.

6. Should they have equal priority Yes.

7. What should the overall vision be for any future substance misuse strategy?

As outlined in the Belfast Agenda we need to provide the opportunity for all our residents to lead healthy, engaged and fulfilling lives as part of vibrant, growing, welcoming and sustainable communities and neighbourhoods. Any future strategy needs to capture how early prevention from accessing substances that cause harm is delivered; regulating or enforcing where needed to ensure opportunity to harm is reduced and where that is not possible create treatment and support for individuals, families and communities to enable the recovery throughout their lives.

8. Should a future substance misuse strategy have a set of values and principles?

A future strategy underpinned by values and principles is welcomed, however the Council believes further work is required to agree values and principles that can operate across enforcement, prevention and intervention approaches.

9. What overall outcome should we seek to achieve?

The overall outcome should align with Belfast Agenda where the city seeks to ensure no one is left behind, everyone reaches their potential and experiences good health and wellbeing. Additionally, given the cross cutting nature of this issue, the overall outcome should seek to demonstrate how an integrated strategy adds value above and beyond the work of the relevant individual organisations.

10. What indicators should we be measuring to demonstrate that we are working to the overall outcomes?

Further work is required on this, however it is essential that the impact measurement tool is agreed and available for use by all partners particularly as part of delivering collaboratively via community planning. If not, it is essential a single approach is agreed for data management and evidence gathering/building services and commissioning or we continue to work in a disparate silo way and make it more difficult operationally to respond effectively. The indicators should focus more on the difference the strategy makes at an individual, family and community level and less on how much was done.

11. What do you believe the key focus of the strategy should be?

Council agrees with the key areas of focus detailed below, but would highlight the strategy should explore further how these areas interact with each other for added value and maximum effect.

- Regulation, legislation & enforcement

- Supply reduction

- Prevention/early intervention

- Harm reduction

- Treatment and support

- Recovery

Council believes that further detailed consideration is required to understand how decriminalisation, changes to the legal classification of different types of drug and safe injecting facilities ('drug consumption rooms') could positively help achieve the stated policy objectives above.

Council also believes that any future strategy should appropriately address the ongoing challenges with insufficient investment to meet demand for addiction services at both the prevention and early intervention stages but also at the more chronic stages where inpatient care is needed. Council believes there is an urgent need for more dedicated facilities to address addiction.

Finally, Council believes that the strategy should consider how these issues affect not just the individual and family, but also the communities and neighbourhoods they live in, for example in the form of increased drug paraphernalia and crime.

12. Are you aware of any other sources of evidence, research or studies that would support action to address substance misuse and your proposed outcomes and indicators?

A discussion note from a strategic workshop held by Belfast Strategic Partnership in 2017 is enclosed with the response and covers the main Belfast issues that remain relevant. Council also believes lessons should be learned from the positive outcomes achieved in other jurisdictions experiencing similar challenges, particularly the Portuguese model. Additionally, Council would also wish to highlight the recommendations in the West Belfast Drugs Panel Report (June 2018).

13. Who needs to be involved if we are to effectively address substance misuse & address the outcomes and indicators you proposed?

Council believes as the convener of community planning in Belfast, it should be an active participant in addressing substance misuse as part of delivering the outcome where everyone fulfils their potential and experiences good health and wellbeing to ensure no one is left behind. Additionally, service users, families, GP's, commissioners of services and delivery agents should be included.

14. Were there any gaps in the previous strategy that need to be addressed?

Council believes any strategy aimed at addressing the serious harm caused by drugs and alcohol should have seriously considered the potential for positive outcomes to be achieved from decriminalisation, changes to the legal classification of different types of drugs and safe injecting facilities. This was not present in the previous strategy and Council believes it should be included in any future strategy.

Council also believes the previous strategy lacked specific detail on how the necessary resources (financial and staff) and infrastructure (facilities) would be put in place to support the policy aims and objectives and that this should be addressed in any future strategy.

Finally, as above, Council believes any future strategy should fully explore the impact of drugs and alcohol on communities and neighbourhoods, for example in the form of increased drug paraphernalia and crime.

15. Are you aware of evidence-based actions that would meet these gaps?

A large body of evidence is available both nationally and internationally fully exploring the matters referred to above.

16. Are you aware of any innovative approaches or low cost/ no cost actions that would make a difference?

These have been referenced above at point 12.

17. Have you any views on where existing or additional resources should be prioritized?

This is difficult to respond to as the previous strategy is not explicit regarding all costs. However, Council does believe there is sufficient local, national and international evidence demonstrating how prevention delivers better outcomes and value for money in the long term.

18. Substance misuse does not have an equal impact on society. Do you believe the strategy should prioritise any of the at risk population groups?

As outlined previously, Councils' approach to inclusive growth does recognise the need for universal services as well as services that may be targeted towards at risk population groups (including at risk geographies). However, Council believes that further detail is needed in any future strategy on who are 'at risk' population groups and the evidence supporting this.

MAKING LIFE BETTER

Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

Making Life Better –

Preventing Harm & Empowering Recovery:

A Strategic Framework to

Tackle the Harm from Substance Use

A CONSULTATION DOCUMENT

Foreword from Robin Swann MLA

Minister of Health

I am all too aware of the impact that alcohol and drug use has on individuals, our health service, our society, our communities and our families. We all know people whose lives have been scarred and altered forever through the harm caused by alcohol and drugs. It is up to all of us to play our part in tackling this issue and to effectively reduce the harm caused by substance use.

This is a consultation on a potential new strategy to replace the previous substance misuse strategy "New Strategy Direction for Alcohol on Drugs, Phase 2" (NSD Phase 2) which has been in place since 2012. We published a full review of NSD Phase 2 and launched a pre-consultation for this new strategy in 2019. Following this, stakeholders from the Voluntary and Community sector, Academia, health professionals and Government colleagues, along with service users, joined with us to help in the co-production of this new consultation document.

The review and pre-consultation highlighted many issues. They showed that while much progress had been made under the previous strategy, and there were positive signs around the level of substance use particularly among our young people, new challenges have emerged. Polydrug use is increasing the potential for serious harm and putting people at risk of tragic outcomes, the misuse of prescription medicines remains a key issue, and alcohol continues to be our society's drug of choice – causing more harm to individuals and families than any other substance. We also need to ensure that legislation, such as alcohol pricing or the classifications of drugs, and the justice system works to support our overall vision – that people in Northern Ireland are supported in the prevention and reduction of harm related to the use and misuse of alcohol and other drugs, and will be empowered to maintain recovery.

Our engagement so far has pointed to many things we can do better, including the need to better join up services for those suffering multiple needs, such as mental health and substance use. Another issue that came across strongly in the co-production process was the need for a

more holistic treatment system, providing patient centred care around the needs of the service users. The need to ensure we invest in treatment and harm reduction also featured highly, along with the need to ensure that we get better at preventing harm developing in the first place, and making sure that support is in place for individuals throughout their recovery journey.

We must choose the most effective tools to tackle this threat, which may require some changes in how we think about this problem. It has been shown that the stigma felt by those suffering harm leads to a fear of coming forward for treatment and support. This we must urgently address.

There is evidence that many people have been experiencing increased stress and isolation this year as a result of COVID-19, and some have increased their alcohol and drug use in response. This past few months has been an extremely difficult period for the Health and Social Care sector and this has put a strain on existing services, which we are working hard to address. Many services had to switch to being provided online and to quickly find new ways to operate. I want to pay tribute to the hard work and dedication of staff and volunteers working right across the sector at this very challenging time. It is now important that we learn from this experience and fine tune innovative ways of working.

I wish to thank all those who took part in the review, those who responded to the pre-consultation and especially those who helped in the co-production of this document. I hope they can see their contribution reflected in this consultation, as I believe they have all made it stronger and better, and I am extremely grateful for their efforts, especially at this most trying of times.

However, we do not wish to be complacent – we want to hear a wide range of views and ideas to make our new strategy even better. Please send us your thoughts and comments, or please take part in one of the consultation events we will be organising. Help us to make the final strategy as good as it can be, so that we can more effectively reduce the harm caused by substance use across Northern Ireland.

CONTENTS

1. THIS CONSULTATION & HOW TO RESPOND

Topic of this consultation:

1.1 **This consultation seeks views on the development of a new strategy to reduce the harm related to substance use in Northern Ireland.**

Scope of this consultation:

1.2 We are keen to hear the views of all those with an interest in addressing the harm related to substance use including:

- members of the public;
- community and voluntary sector organisations;
- service users and those who use alcohol and/or drugs;
- health bodies;
- health professionals;
- justice agencies;
- local councils;
- business and industry bodies;
- academics; and
- other Government Departments and agencies.

Geographical Scope:

1.3 The strategy falls within the scope of the devolved administration. However as some of the powers are not devolved to the Northern Ireland Assembly, we will continue to work closely with UK Government, the other devolved administrations, and the Government in the Republic of Ireland on these proposals.

Body/Bodies Responsible for the Consultation:

1.4 This consultation is being undertaken by the Health Development Policy Branch in the Department of Health.

Duration:

1.5 Since the consultation period will cover the Christmas holidays, the consultation period has been extended by 2 weeks and so will be open for 14 weeks from **Friday 30 October 2020 to Friday 05 February 2021**.

Enquiries:

1.6 For any enquiries about the consultation, please email the Department at: HDPB@health-ni.gov.uk or write to:

Making Life Better – Preventing Harm Empowering Recovery: A Consultation
Health Development Policy Branch
Department of Health
Room C4.22, Castle Buildings
BELFAST BT4 3SQ
Tel: (028) 9052 0540

How to Respond:

1.7 Online: You can respond online by accessing the consultation documents on the 'Citizen Space' web service and completing the online survey there. The online version can be accessed at the following link:

https://www.health-ni.gov.uk/SUS-consultation

1.8 Alternatively you can respond via the email or office address above, however we would much prefer responses by Citizen Space.

1.9 When you reply, it would be very useful if you could confirm whether you are replying as an individual or submitting an official response on behalf of an organisation. If you are replying on behalf of an organisation, please include:

- your name;
- your position (if applicable);
- the name of your organisation;
- an address (including postcode); and
- an e-mail address.

Consultation Response:

1.10 We will consider the responses received and publish an outcome report on the Department's website.

Accessibility:

1.11 Alternative formats of this consultation document and the questionnaire (such as other languages, large type, Braille, easy read and audio cassette) may be made available on request. Please contact the Department to discuss your requirements.

Consultation Principles:

1.12 This consultation is being conducted in line with the Fresh Start Agreement – (Appendix F6 – Eight Steps to Good Practice in Public Consultation-Engagement).[1] These eight steps give clear guidance to Northern Ireland departments on conducting consultations.

Feedback on the Consultation Process:

1.13 We value your feedback on how well we consult. If you have any comments about the consultation process (as opposed to comments about the issues which are the subject of the consultation), including if you feel that the consultation does not adhere to the values expressed in the Eight Steps to Good Practice in Public Consultation Engagement or that the process could be improved, please address them to:

Health Development Policy Branch
Department of Health
Room C4.22, Castle Buildings
Stormont Estate
BELFAST BT4 3SQ
E-mail: HDPB@health-ni.gov.uk

[1] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/479116/A_Fresh_Start_-_The_Stormont_Agreement_and_Implementation_Plan_-_Final_Version_20_Nov_2015_for_PDF.pdf

Equality and Rural Screening:

1.14 As per the Department of Health's Equality Scheme[2] and in order to comply with the Rural Needs Act (Northern Ireland) 2016[3], this policy has been screened for both Equality/Good Relations[4] and Rural Needs[5] impacts. These screening documents are both available at: https://www.health-ni.gov.uk/SUS-consultation.

1.15 These screenings have indicated that there is no significant negative impact from this strategy in terms of Equality of Opportunity, Good Relations or Rural Needs and thus no need for further Equality or Rural Impact Assessments. As part of this consultation, we welcome comments on these screening documents or inputs on areas where those responding may feel we should take further information into consideration in any future screening.

Consultation Question 1 – Have you any comments on either the Equality/Good Relations or Rural screening documents? Have you anything you believe we should be considering in future Equality/Good Relations or Rural screenings?

Privacy, Confidentiality and Access to Consultation Responses:

1.16 For this consultation, we may publish all responses except for those where the respondent indicates that they are an individual acting in a private capacity (e.g. a member of the public). All responses from organisations and individuals responding in a professional capacity may be published. When doing so, we will remove email addresses and telephone numbers from these responses; but apart from this, we may publish them in full. For more information about what we do with personal data please see the link to our consultation privacy notice at paragraph 1.17.

1.17 Your response, and all other responses to this consultation, may also be disclosed on request in accordance with the Freedom of Information Act 2000 (FOIA) and the Environmental Information Regulations 2004 (EIR); however all

[2] https://www.health-ni.gov.uk/doh-equality#toc-0
[3] https://www.legislation.gov.uk/nia/2016/19/contents
[4] https://www.health-ni.gov.uk/sites/default/files/consultations/health/doh-sus-esa.pdf
[5] https://www.health-ni.gov.uk/sites/default/files/consultations/health/doh-sus-rias.pdf

disclosures will be in line with the requirements of the Data Protection Act 2018 (DPA) and the General Data Protection Regulation (GDPR) (EU) 2016/679.

1.18 If you want the information that you provide to be treated as confidential it would be helpful if you could explain to us why, so that this may be considered if the Department should receive a request for the information under the FOIA or EIR.

1.19 DoH is the data controller in respect of any personal data that you provide, and DoH's Privacy Notice, which gives details of your rights in respect of the handling of your personal data, can be found at: https://www.health-ni.gov.uk/articles/health-development-policy-branch-and-health-improvement-policy-branch-steering-groups-privacy-notice.

2. BACKGROUND

Introduction

2.1 **This chapter outlines the history of approaches to address the harm related to substance use in Northern Ireland, as well as summarising the review of the previous strategy and the process to develop this consultation document.**

Context

2.2 While the financial cost can never bring home the full impact that substance use related harm has on individuals, families and communities across Northern Ireland, the harms related to the use of alcohol and other drugs costs Northern Ireland hundreds of millions of pounds every year. The cost of alcohol misuse alone was estimated at up to £900 million in 2008/09[6], and if we were to add in the costs of the harm related to other drugs this would almost certainly take this figure to over £1 billion[7].

2.3 Most worrying has been the increase in alcohol and drug related deaths and the legacy these leave for families and communities.

2.4 Each and every one of these deaths is potentially preventable and therefore addressing this issue must be a key priority for the Department of Health and the Executive, but also for wider civic society and for the general public.

2.5 Addressing the harm related to alcohol and other drugs is therefore a key public health priority, and must continue to be so over the coming years.

History

2.6 Since 1986, there have been a number of Government initiatives to develop and implement a strategic response to alcohol and drug use. Initially there were separate strategies for Drug (1999) and Alcohol (2000) use, however in 2001 the Model for the Joint Implementation of the Drug and Alcohol Strategies (JIM) was launched.

[6] https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/alcohol-and-drug-social-costs-of-misuse-ni-2008-09.pdf

[7] The overall cost of drug misuse was estimated at £15.4bn in England in 2014, Northern Ireland proportion of this would be £0.426 bn. https://researchbriefings.files.parliament.uk/documents/CDP-2017-0230/CDP-2017-0230.pdf

2.7 In 2004 following a review of the two strategies and of the JIM, there was agreement that a *New Strategic Direction for Alcohol and Drugs*[8] (NSD) needed to be developed to tackle the harm related to these issues in Northern Ireland. Its implementation began in October 2006.

2.8 In 2011, following a review of the initial NSD, it was agreed that it would be updated, revised, and extended. This process also allowed the NSD Phase 2[9] to reflect new trends and re-direct effort to where it was most needed or to where new issues/concerns were emerging. The strategy's implementation was subsequently extended to allow alignment with the Regional Commissioning Framework for Alcohol and Drug Services.

Review of NSD Phase 2

2.9 During 2018, the Department of Health undertook a full review[10] of NSD Phase 2. The review evaluated the impact of NSD Phase 2 on its aims of preventing and addressing harm related to substance use in Northern Ireland. The review considered three specific aspects of the implementation of the NSD Phase 2 strategy:

a) ***Outputs*** – i.e. the actions taken by Government Departments and their agencies, through the NSD structures, and the progress made;

b) ***Outcomes*** – i.e. the impact that NSD Phase 2 had on the range of indicators and outcomes it set out to achieve and the differences made for the public, service users and carers; and

c) ***Stakeholder views and structures*** – i.e. a review of the views of key stakeholders on the delivery of the NSD and the associated structures, in the context of recent and emerging Government policy.

2.10 The final review was published in January 2019[11]. In summary, the review reported some encouraging signs in relation to reductions in substance use at the population level – for example, there had been significant reductions in the levels of binge drinking and the percentage of young people who drink and get

[8] https://www.health-ni.gov.uk/articles/alcohol-and-drugs-misuse#toc-0
[9] https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/alcohol-and-drug-new-strategic-direction-phase-2-2011-16.pdf
[10] Terms of Reference at Annex I
[11] https://www.health-ni.gov.uk/sites/default/files/publications/health/NSD%20PHASE%202%20Final%20Review%20-%20October%202018_0.pdf

drunk. Among adults, prevalence of illegal drug use had largely plateaued and significant numbers of individuals and families continue to access treatment and support services for alcohol and drug use. In addition, drug use among young people had fallen significantly.

2.11 However, this was offset by increases in a range of indicators related to harm. For example, hospital admissions and deaths as a direct result of harm related to substance use, are high and rising, and there are ongoing concerns about polydrug use, the misuse of prescription drugs and Novel Psychoactive Substances. There appears to be a significant cohort of people engaging in increasingly risky behaviours, causing an acute increase in related harms. This has also impacted justice related issues, including organised crime, exploitation, trafficking, etc.

2.12 In terms of progress against the outputs within the NSD Phase 2, 24 (17%) of the outcomes within the strategy had been completed, 98 (70%) of the actions were classed as being on track for achievement as they were long term or ongoing in nature, and in 17 (12%) of the actions progress was being made but with some delay. 2 (1%) of the actions were not on target for achievement, mostly as other areas had been prioritised instead.

2.13 Stakeholders felt that NSD Phase 2 acted as a driver for increasingly effective collaboration and partnership working at both strategic and operational level, and successfully raised the profile of alcohol and drug-related harm in Northern Ireland. In particular, the consistency, diversity of representation and commitment of the NSD Steering Group was recognised. The Regional Commissioning Framework for Alcohol & Drugs was credited with bringing about service improvements in terms of better availability, accessibility, equity, co-ordination and consistency. Investment in workforce development was also highlighted, as was the progress made on embedding transition to an evidence-informed harm reduction approach.

2.14 However, stakeholders also felt there should have been greater alignment between strategic and operational elements of NSD Phase 2, along with better/more effective integration across the strategic agendas of other Government Departments. Also by placing focus on issues related to acute

service provision, more structured opportunities may have been missed for evidence-informed future planning. Stakeholders also felt there could have been a better response to unintended outcomes and change management issues caused by the implementation of the Regional Commissioning Framework, and benefits could also have accrued from more data sharing and critical evaluation on existing programmes and services.

Pre-Consultation Process

2.15 Following the publication of the final review, the Department took forward a pre-consultation exercise as the first step of potentially developing a new substance use strategy for Northern Ireland. A small task and finish group was set up to take forward this process[12]. The aim of the pre-consultation exercise was to seek collective agreement on the need for a new strategy, and on the outcomes, indicators and priority areas it should target, in order to agree a collective vision before moving on to develop the more detailed actions and priorities contained in this document.

2.16 The pre-consultation exercise, which closed in September 2019, involved the following 3 elements:

- an online survey using Citizen Space;
- a series of engagement events / focus groups / workshops; and
- bi-lateral meetings.

2.17 57 responses were received in total – both through the online survey and via other written submissions. A number of engagement events and meetings were also held, to capture feedback from attendees. A summary of responses[13] was considered by the Pre-Consultation Task & Finish Group, and subsequently by the NSD Steering Group, and this has informed the development of this consultation document.

[12] TOR for this group is available at Annex II
[13] Attached at Annex III

NI Audit Office (NIAO) Report on Addiction Services in NI

2.18 The NIAO published a 'value for money' review of *Addiction Services in Northern Ireland*[14] on 30 June 2020, which contained 10 recommendations and focused on 3 main messages:

- the level of harm and complexities associated with alcohol and drug use is rising;
- there are inconsistencies in the referral pathways for, and provision of, Tier 4 rehabilitation beds across the five Trusts; and
- data collection should focus more on outcomes.

2.19 Overall, the NIAO report broadly reflected the issues raised in the review of the NSD Phase 2 and mirrored many of the views from the Pre-Consultation Exercise on the development of this new strategy. The findings and recommendations from the report are incorporated throughout this strategy.

Writing Group

2.20 Finally, a task and finish group[15] was established to support the development of this consultation document through a co-production approach. The Department would like to thank the members of this group who gave freely of their time and experience to help us make this consultation better, more informative and more inclusive.

[14] https://www.niauditoffice.gov.uk/publications/addiction-services-northern-ireland

[15] Terms of Reference for this Substance Use Strategy Writing Group are set out at Annex IV.

3. KEY STATISTICS

Introduction

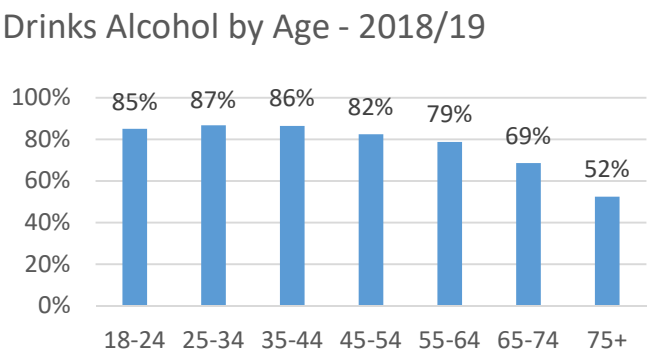
3.1 **This chapter will set out current trends in a range of key statistics in relation to alcohol and other drugs.**

Statistics

3.2 Alcohol and drug use, and the related harms, are ongoing challenges in Northern Ireland. The position is not static, the nature of substance use changes over time, and while there have been positive moves in some key indicators over the last number of years, others are moving in the opposite direction.

Alcohol Prevalence

3.3 The use of alcohol is common in Northern Ireland. The most recent survey findings indicate that 79% of respondents drink alcohol; this proportion has remained relatively consistent since 2010/11[16].



The proportion of adults who drink alcohol **declines in older age**

In 2018/19, around **four-fifths** of those aged **64 & under** drank alcohol compared with **two-thirds** (69%) of those aged **65-74** and around **half** (52%) of those aged **75 & over**

3.4 In 2017/18, a fifth (20%) of respondents reported drinking above recommended weekly limits[17], with males (31%) around three times more likely to do so than females (9%).

[16] A breakdown of survey responses is given at Annex VIII.

[17] The Chief Medical Officers' guideline for both men and women is that to keep health risks from alcohol to a low level, it is safest not to drink more than 14 units a week on a regular basis. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/545937/UK_CMOs_report.pdf

In 2017/18, a **fifth (20%)** of adults **drank in excess** of the **weekly limit**

(14 units for both males and females)

3.5 The proportion drinking above guidelines has fallen from 26% in 2010/11 to 20% in 2017/18. The proportion of males drinking above guidelines has fallen from 37% in 2010/11 to 31% in 2017/18 and the proportion of females has fallen from 15% to 9%.

	2010/11	2011/12	2013/14	2015/16	2017/18	Trend	Change 10/11-17/18
Drinking alcohol above weekly limits (aged 18+)	24%	22%	20%	20%	18%		
MALES Drinking alcohol above weekly limits (aged 18+)	37%	36%	32%	32%	31%		
FEMALES Drinking alcohol above weekly limits (aged 18+)	15%	13%	12%	11%	9%		

Male and female drinking patterns differ significantly

In 2018/19, over four-fifths of males (**83%**) were drinkers, with a tenth of males (**9%**) reporting that they thought they drank **quite a lot or heavily**

In 2018/19, almost a fifth of male drinkers (**16%**) drank on **3 or more** days per week

In 2017/18, around a third of males (**31%**) drank **in excess of the guidelines.**

In 2018/19, three-quarters of females (**76%**) were drinkers, with **2%** reporting that they thought they drank **quite a lot or heavily**.

In 2018/19, a tenth of female drinkers (**10%**) drank on **3 or more** days per week

In 2017/18, around a tenth of females (**9%**) drank **in excess of the guidelines.**

3.6 Considering deprivation, in 2017/18 there was no significant difference in the proportion who drank above the guidelines between those living in the most deprived (21%) and those living in the least deprived (22%) areas. However, those in urban areas (22%) were more likely to drink in excess of the guidelines than those in rural areas (17%).

Binge Drinking 2005-2013

3.7 Patterns of consumption are also important, with those who drink large volumes of alcohol in one sitting putting themselves at a higher risk. The most recent figures (2013) show that around 31% of adults binge drink[18] but this has fallen from 38% in 2005.

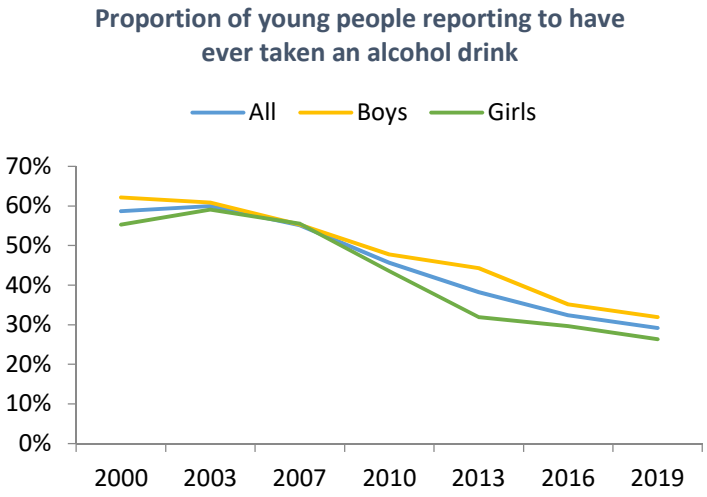
3.8 Over a third of males (35%) and more than a quarter of females (27%) had engaged in at least one binge drinking session in the week prior to the survey. Younger adults (18-29 year olds) were more likely to binge drink than older adults (60-75 year olds).

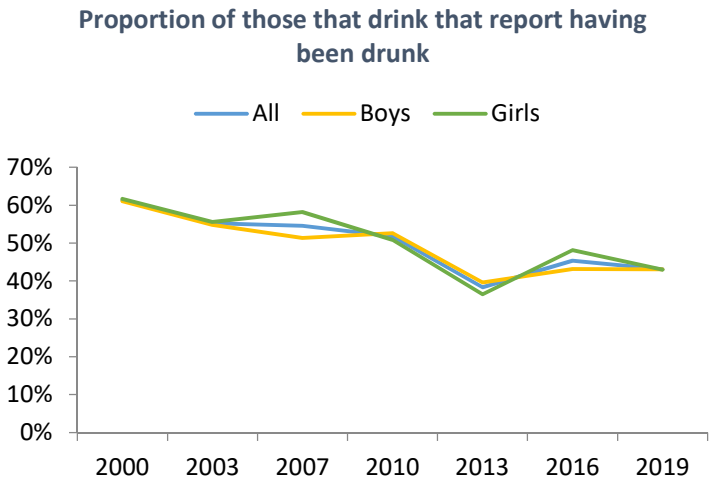
Prevalence – Children and Young People

3.9 Consumption of alcohol among our young people is also an issue of concern, with this having the potential to impact on a young person's immediate wellbeing, academic achievement, and longer term health and wellbeing as an adult.

3.10 Young Persons Behaviour and Attitudes Survey in 2019[19] shows that since 2000, there has been a decline in both the proportion of young people ever having drank alcohol and the proportion of those who drink that report having been drunk. The proportion of young people aged 11-16, reporting to have ever taken an alcoholic drink has fallen from 59% in 2000 to 29% in 2019.

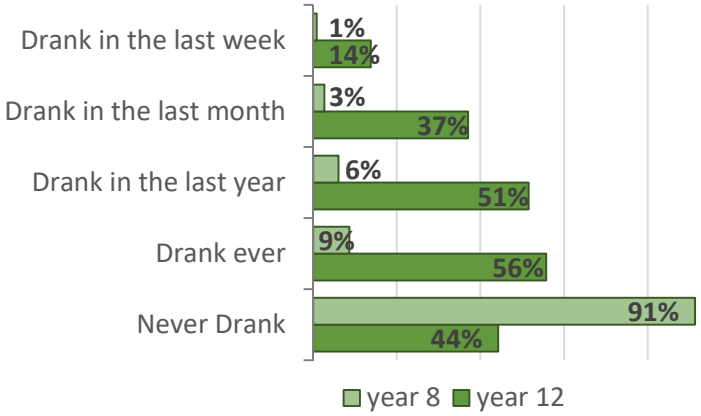
[18] https://www.health-ni.gov.uk/publications/adult-drinking-patterns-northern-ireland-survey-2013
[19] https://www.health-ni.gov.uk/articles/young-persons-behavioural-attitudes-survey

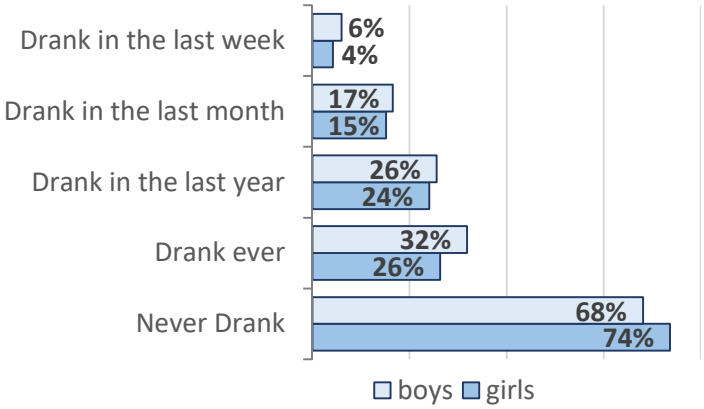




3.11 In 2019, boys (32%) were more likely to have taken a drink than girls (26%); and those in Year 12 (56%) were more likely to have done so than those in Year 8 (9%).

Have you ever taken an alcoholic drink (not just a taste or a sip)?



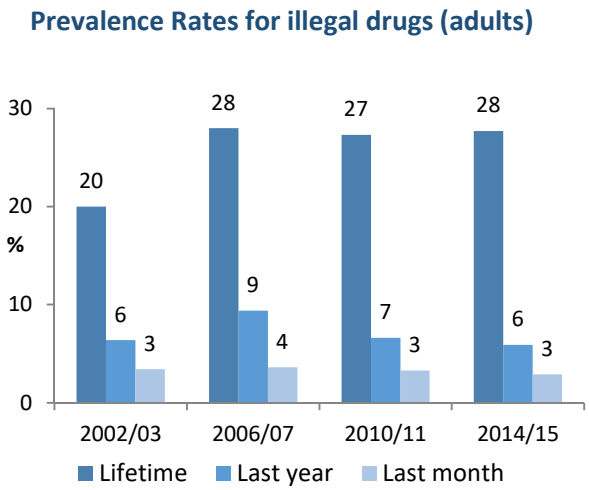


Illegal Drug Use

3.12 In terms of prevalence of other drug use among adults, the most recent Drug Prevalence Survey in 2014/15 found that more than a quarter (28%) of people surveyed reported having used an illegal drug during their lifetime, with 6% having done so during the previous year and 3% during the last month[20].

[20] https://www.health-ni.gov.uk/articles/drug-prevalence-survey

3.13 Comparing the most recent years of the survey, there has been very little change in the proportion of respondents reporting lifetime, last year or last month use of illegal drugs.



3.14 Cannabis was the most commonly reported illegal drug with a quarter of respondents (25%) reporting having ever used the drug, 5% reporting recent use in the last year and 3% reporting use in the last month. After cannabis, the most commonly reported drugs ever used were ecstasy (10%), poppers (7%) and cocaine powder (7%).

3.15 Almost a quarter of respondents (24%) reported ever taking anti-depressants, while over a fifth reported taking other opiates (22%) and sedatives or tranquillisers (21%).

3.16 In 2017/18, a pilot drugs module was included in the Health Survey Northern Ireland[21]. Whilst direct comparisons are difficult due to the different survey source and methodology, the findings from the pilot indicated similar levels of last year prevalence of illegal drugs compared with the 2014/15 Drug Prevalence Survey[22].

3.17 It should be noted that there are limitations in using a general population survey to estimate drug use. In their survey handbook, the European Monitoring Centre for Drugs and Drug Addiction[23] draw attention in particular to the fact that such surveys exclude those who are homeless and those living in institutions. Additionally, more chaotic drug users may be under-represented in household surveys. Whilst the limitations should be acknowledged, surveys do help gauge the extent of problematic drug use and are useful in capturing trend data.

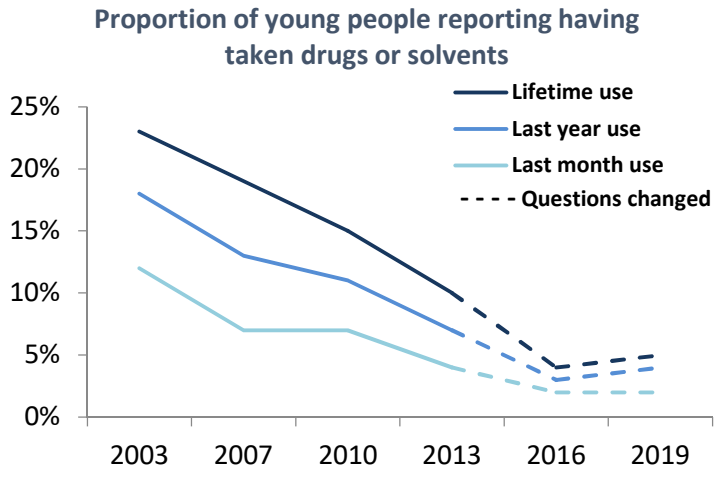
[21] https://www.health-ni.gov.uk/sites/default/files/publications/health/pilot-drugs-hsni.pdf

[22] https://www.health-ni.gov.uk/publications/all-ireland-drug-prevalence-survey-201415

[23] https://www.emcdda.europa.eu/html.cfm/index58052EN.html_en

Drug Use among Children and Young People

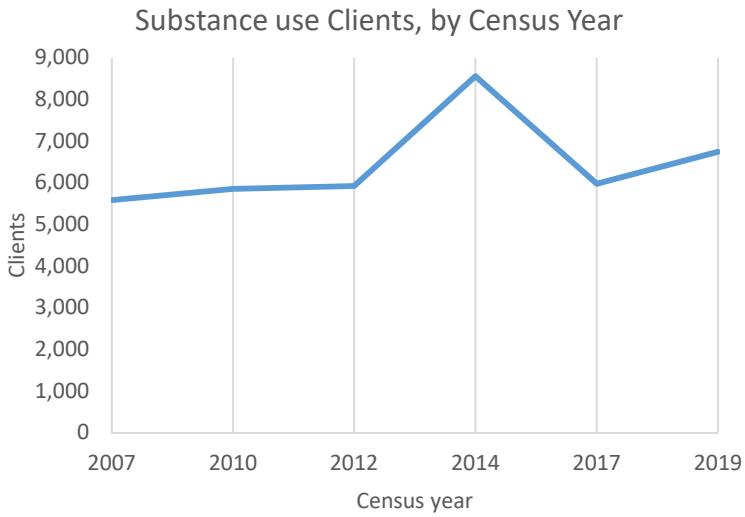
3.18 Encouragingly, among young people we have seen very significant reductions in self-reported use of other drugs and solvents.



The proportion of young people reporting ever having taken drugs has fallen from 23% in 2003 to 5% in 2019

It should be noted that the questions on young people taking drugs changed in 2016 and thus may not be directly comparable with previous years.

3.19 The most recent findings from the Young Persons Behaviour and Attitudes Survey in 2019 indicate lifetime use at 5%, last year use at 4%, and last month use at 2%.



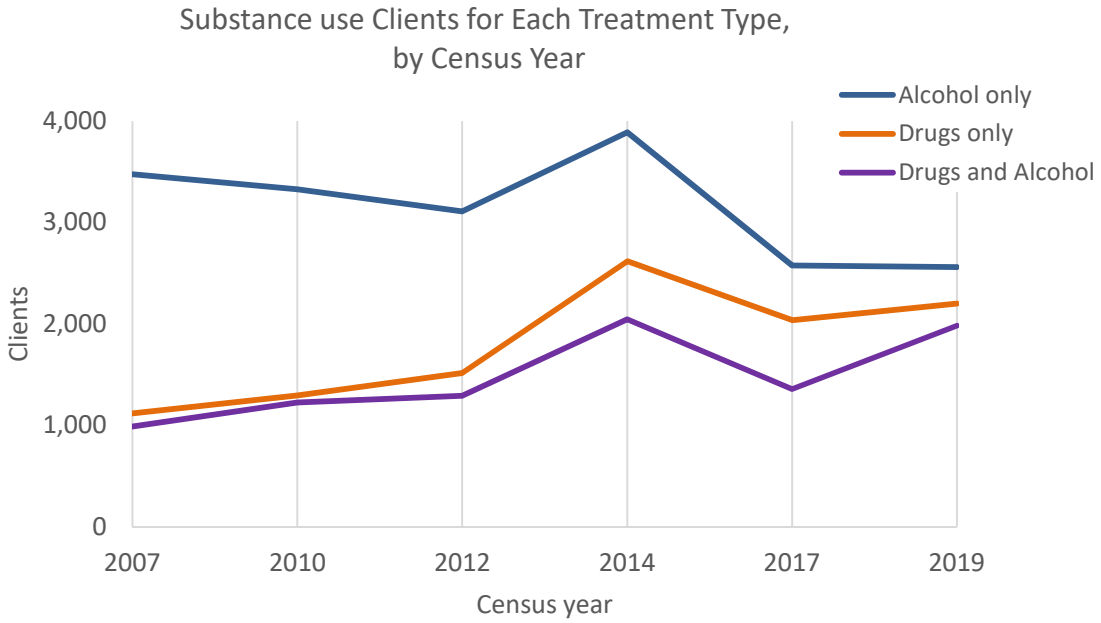
3.20 As mentioned previously, these prevalence figures are based on survey information, so there is the potential that this under-reports actual usage, but the trends should remain consistent over time.

Treatment

3.21 On 30 April 2019, a total of 6,743 persons were reported to be in treatment for use of alcohol and/or drugs[24] in Northern Ireland. The chart below shows the trend over the last 12 years. In 2019 there was an increase in the number of clients in treatment.

3.22 Previous to 2019, the number in treatment had remained relatively stable with the exception of 2014. It should be noted that additional lottery-funded alcohol projects were running during 2014 which would have contributed to the increased number of clients in that year.

3.23 Treatment types have changed over the years with increases in the proportion of clients in treatment for drugs, or drugs and alcohol, and a decrease in those for alcohol only.



In 2007, 62% of clients presented for alcohol only, by 2019 this had fallen to 38%

Clients presenting for Drugs only increased from 20% in 2007 to 33% in 2019

Drugs and alcohol increased from 18% to 29% for same period

[24] https://www.health-ni.gov.uk/sites/default/files/publications/health/drug-alcohol-census-2019.html

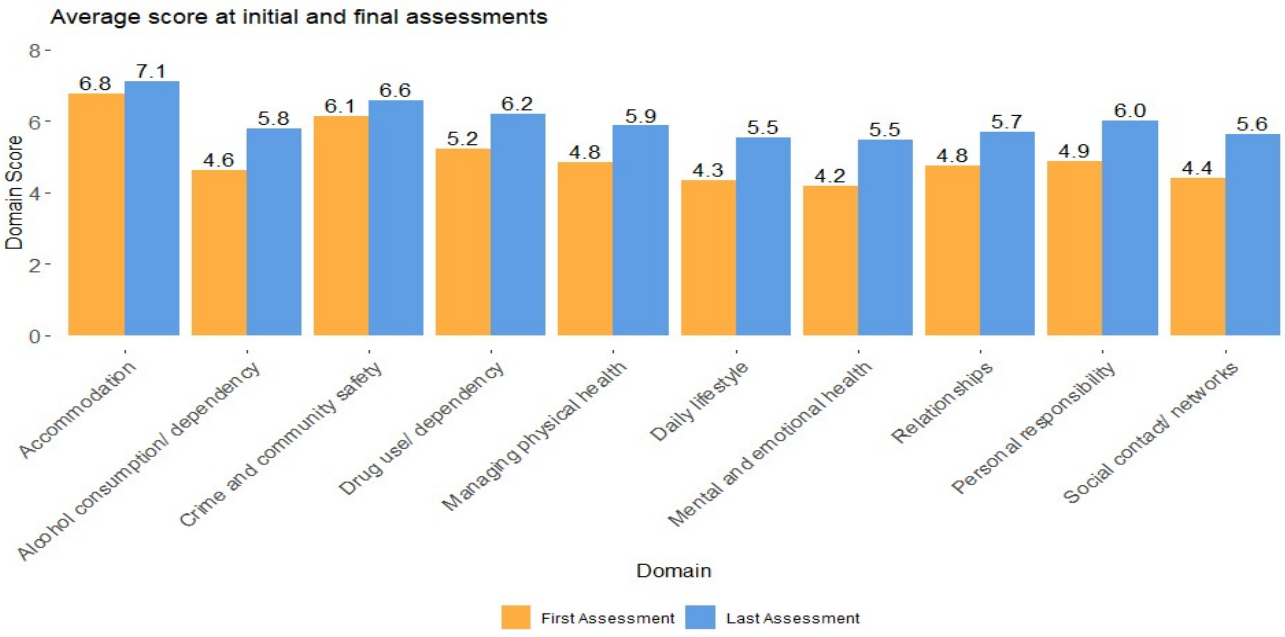
Measuring Impact

3.24 The Impact Measurement Tool (IMT) is a data collection system used to assess the effectiveness of tier one and tier two drug & alcohol services commissioned by the Public Health Agency and is split into the following typologies:

- Adult Treatment (Step 2)[25];
- Young Persons Treatment;
- Low Threshold Services;
- Parental Substance use;
- Workforce Development; and
- Targeted Prevention.

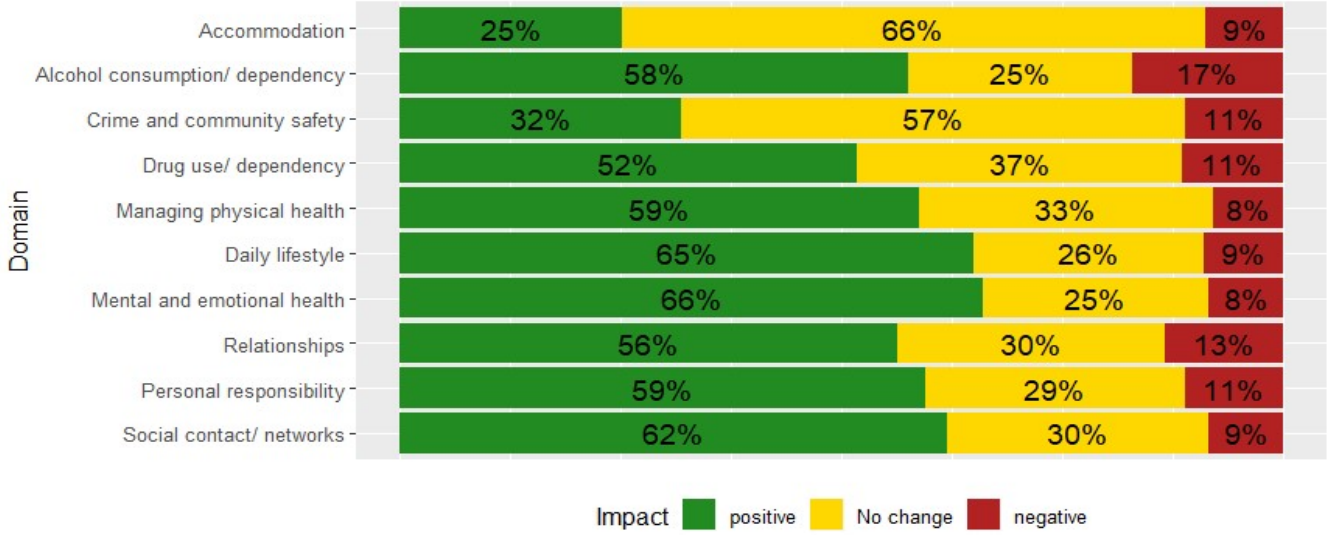
Findings relating to a number of typologies are presented below and further information is available online[26].

3.25 The **Adult Treatment** typology collects data relating to individuals aged 18 and over, who are receiving Step 2 treatment or aftercare for alcohol and / or drug use. During 2018/19 impact data was collected for 775 clients.

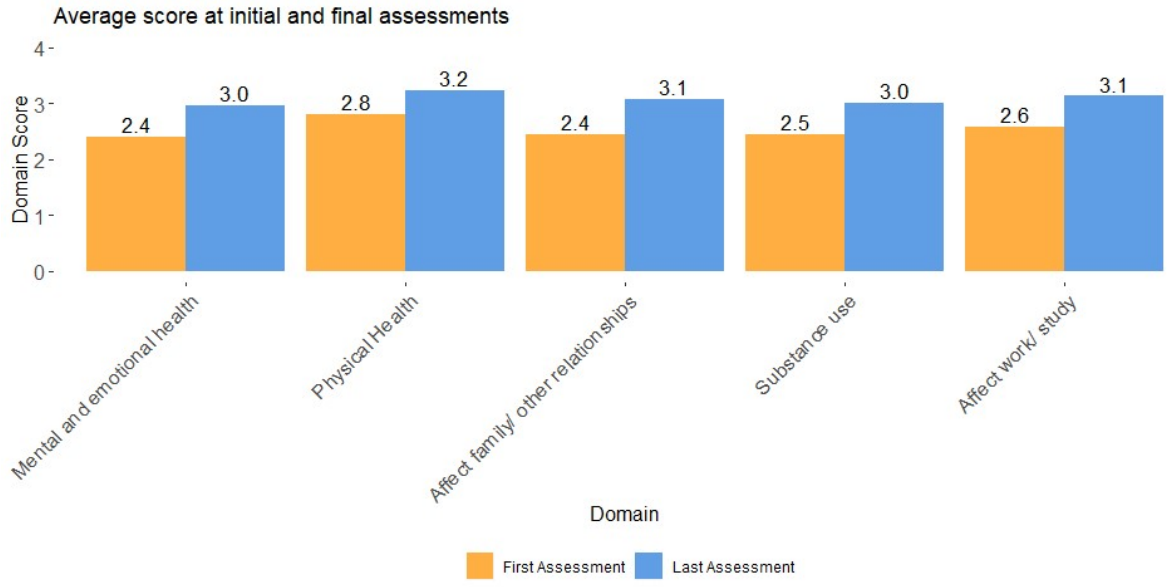


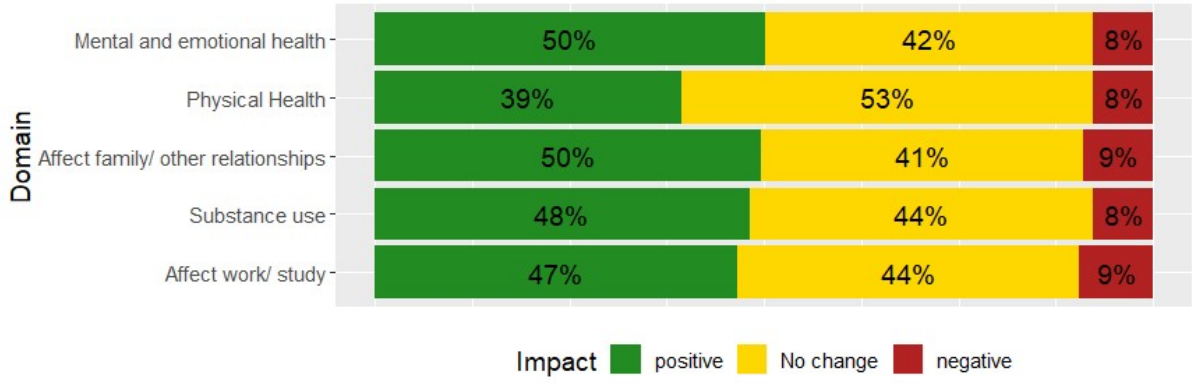
Note- The high proportion of clients seeing no change in both the Crime and Accommodation domains can be attributed in part to their first assessment being at the top of the scale (i.e. no criminal activity or satisfactory accommodation), thus no improvement could be made.

[25] https://services.drugsandalcoholni.info/node/13
[26] https://www.health-ni.gov.uk/sites/default/files/publications/health/imt-18-19.pdf



3.26 The **Youth Treatment** typology covers the provision of community based early intervention services for young people aged 11–25 who are identified as having substance use difficulties. During 2018/19, impact data was collected for 908 young people and was measured across 5 key Domains at the beginning of, during, and/or following treatment.

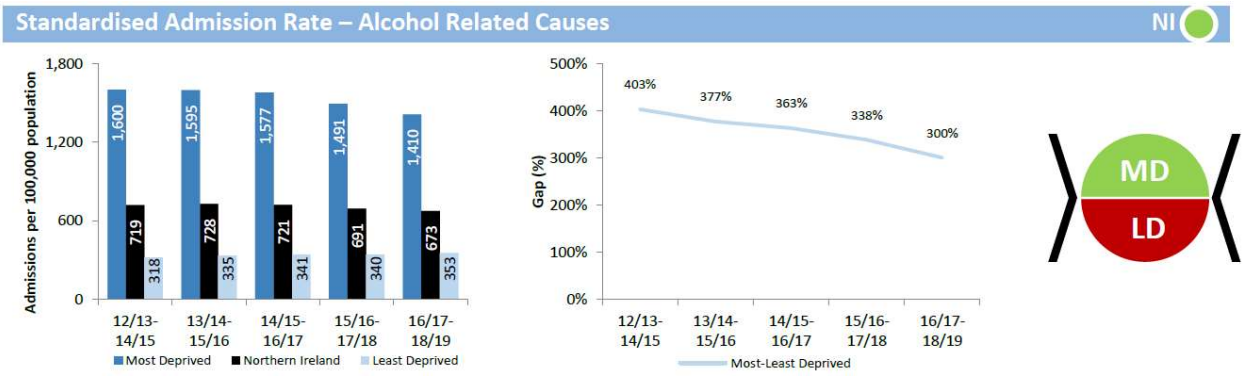




Admissions to Hospital

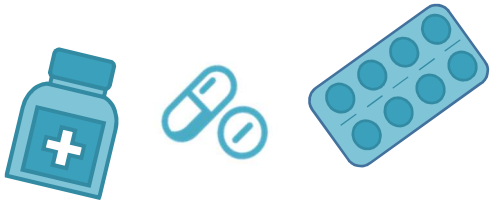
3.27 Admissions to hospital for alcohol (only) related diagnosis have remained at around 12,000 per year for the last 5 years, though interestingly admissions for alcohol and drug related diagnosis have fallen from 1,883 a decade ago to 1,263 in 2018/19. Admissions to hospital for drug (only) related diagnosis have also fallen from 3,346 a decade ago to 2,543 in 2018/19. However, it should be noted these figures are only for those who get admitted, not all those who attend Emergency Departments, and that both remain high.

3.28 Age standardised admission rates, which allow for direct comparison over time and between different population groups, show a fall in alcohol related admissions in NI (from 719 to 673 admissions per 100,000 population) and its most deprived areas (from 1,600 to 1,410 admissions per 100,000 population) over the last five years. With a slight increase in the least deprived areas (from 318 to 353 admissions per 100,000 population), the inequality gap in admissions between the most and least deprived areas has narrowed slightly however the rate in the most deprived areas is four times the rate in the least deprived areas.

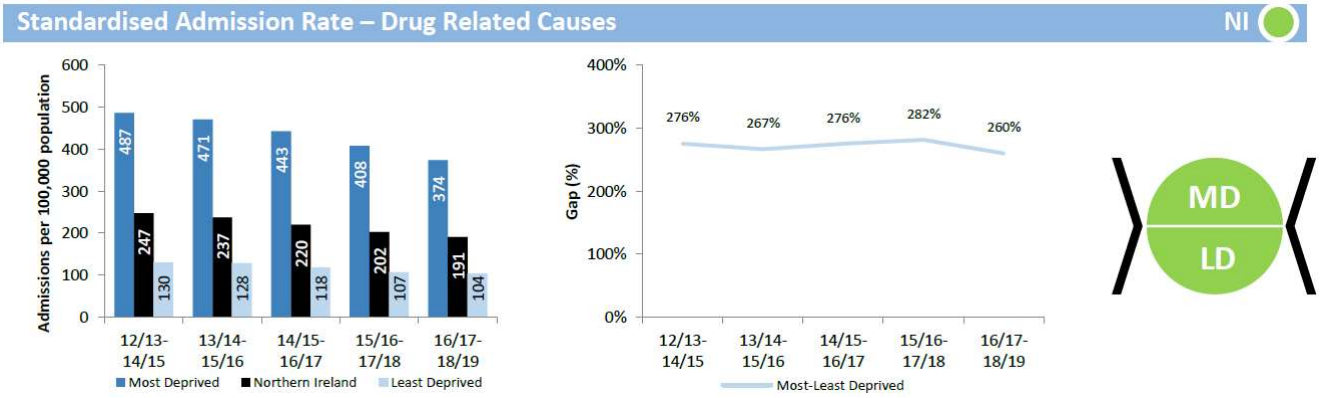


3.29 Age standardised admission rates for drug related causes also decreased over the last five years in NI (from 247 to 191 admissions per 100,000 population) and its most (from 487 to 374 admissions per 100,000 population) & least deprived (from 130 to 104 admissions per 100,000

The drug related admission rate in the most deprived areas was **more than three and a half times** the rate in the least deprived areas.



population) areas. With admissions decreasing at a greater rate in the most deprived areas than in the least deprived areas, the inequality gap narrowed slightly. The standardised drug related admission rate in the most deprived areas is more than three and a half times the rate in the least deprived areas.



Deaths

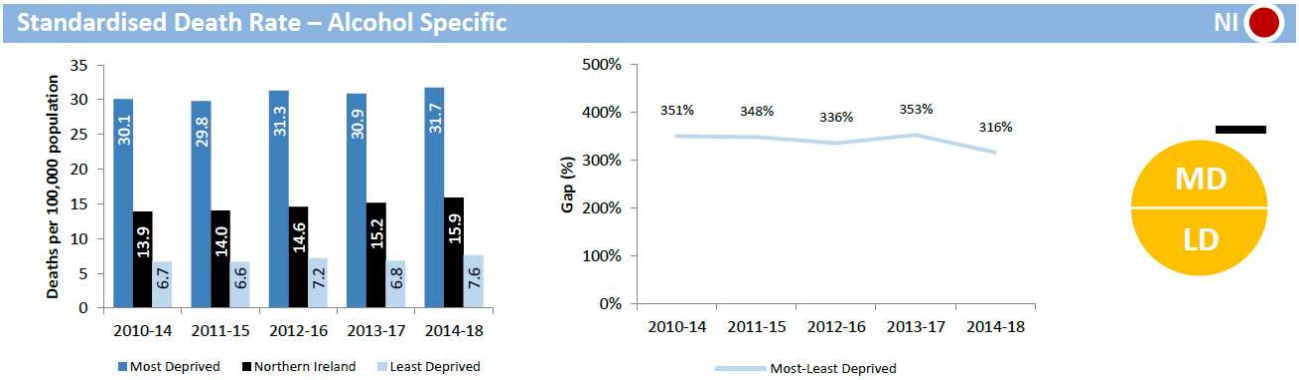
3.30 284 people[27] in Northern Ireland lost their lives related to an alcohol-specific cause and 189 from a drug-related death in 2018[28]. This is the highest number of drug-related deaths on record and, whilst not the highest number of alcohol specific deaths on record, they are approximately 17% higher than there were in 2008.

3.31 In recent years, the proportion of those who died from alcohol-specific causes aged 55-64 has increased; in 2018 this age group accounted for over a third of such deaths (36.6%), while those aged 45-54 accounted for 29.6% of the total. We therefore have to think about how alcohol impacts on people as they get older. Of the 189 drug-related deaths in 2018, 72 (38.1%) were in the 25-34 age group with a further 50 (26.5%) in the 35-44 age group – therefore we seem to have a growing cohort of young people experiencing drug related harm.

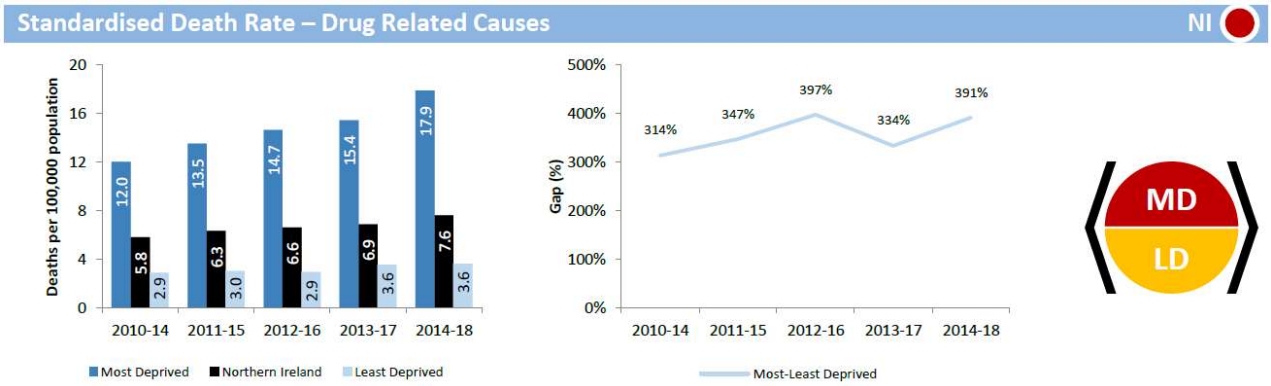
[27] https://www.nisra.gov.uk/statistics/cause-death/alcohol-deaths#toc-0
[28] https://www.nisra.gov.uk/statistics/cause-death/drug-related-deaths

3.32 The statistics (based on the period 2014 to 2018) also indicate that there are notably higher numbers of alcohol-specific deaths in areas of deprivation across Northern Ireland, with the age standardised death rate in the most deprived areas (31.7 deaths per 100,000 population) being more than four times the rate in in the least deprived areas (7.6 deaths per 100,000 population).

Alcohol specific mortality in the most deprived areas was **over four times** that in least deprived.



3.33 The statistics also indicate that there are notably higher numbers of drug-related deaths in areas of deprivation across Northern Ireland. People living in the most deprived areas are five times more likely to die from a drug-related death than those in the least deprived areas.



Costs

3.34 A report in 2008 estimated the cost of alcohol misuse alone at up to £900 million[29] made up as follows:

ANNUAL COST ESTIMATE	
Cost Element	Upper £m
Health Care	158.0
Social Work	82.0
Fire and Police	279.3
Courts and Prisons	103.6
Wider costs (including workplace)	258.2
TOTAL	**881.1**

3.35 The Dame Carol Black Review of Drugs[30] put the social cost of drug misuse in the UK at £20bn, assuming the costs to Northern Ireland match our population share then this would be around £0.6bn locally. Taking the total cost of the harm related to substance use in Northern Ireland up to £1.5bn.

3.36 However, these financial costs do not reveal the true impact that substance use related harm has on individual people, their families and on local communities across Northern Ireland.

Justice System

3.37 People with alcohol and drug issues often interact with the Justice System – for example, alcohol is a factor in 20% of all crimes, and this has been stable over time[31]. The numbers detected and convicted for drink/drug driving have fallen over the years, but there were still almost 2,000 convictions in 2017/18. Drug and alcohol driving collision figures also present a mixed picture. Overall the number of collisions of all categories involving substances are down, but the proportion of collisions that are substance use related have remained roughly static or have increased slightly. Drug seizures and drug arrests have also been increasing.

[29] https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/alcohol-and-drug-social-costs-of-misuse-ni-2008-09.pdf
[30] https://www.gov.uk/government/publications/review-of-drugs-phase-one-report
[31] https://www.psni.police.uk/globalassets/inside-the-psni/our-statistics/police-recorded-crime-statistics/2019/march/crime-bulletin-mar-_19.pdf

4. WIDER CONTEXT

Introduction

4.1 **This chapter provides some of the wider context in relation to substance use. This includes other key drivers and supporting strategies, which will support addressing this key issue.**

Context and Strategic Drivers

4.2 Substance use, and the related harm, is not just an issue of personal responsibility and people's behaviours. It is very much interlinked with wider health outcomes, including health inequalities, and more widely with the economic, social and environmental circumstances in which people are born, grow, live, work and age.

4.3 We know there are overlaps and interactions between substance use and poverty/deprivation, mental health and wellbeing, community relations, community safety and justice, employment, economic development, trauma, and the impact of our past. To truly address this issue, we need to work collectively as Government and society to tackle these wider determinants.

Rights

4.4 Everything we do must be underpinned by the rights of the individual service user to be treated as a human being, with dignity and respect. Individuals have the right to access a quality service that will support them on their pathway to recovery. They should be properly consulted and involved in all aspects of their treatment.

Trauma and ACEs

4.5 Many people who come to harm from substance use have a history of trauma, as well as being particularly vulnerable to experiencing further trauma. Studies have consistently shown a high prevalence of co-occurring mental disorders in people who have problems with alcohol and drugs and clear connections with homelessness and interactions with the justice system.

4.6 Many of those who suffer most from alcohol and drug related harm have experienced domestic violence (in their family of origin and/or in intimate partner relationships) and services should be equipped to respond appropriately to this issue.

4.7 In addition, Adverse Childhood Experiences (ACEs) are stressful or traumatic events, including abuse and neglect. They may also include household dysfunction, such as witnessing domestic violence or growing up with family members who have substance use disorders.

4.8 There is a need for awareness of the impact of ACES, later traumas/stressors such as domestic violence (physical, emotional, financial and sexual), sexual exploitation, bereavements, community violence, poverty etc. on people's ability to engage with services, treatment and recovery and what additional supports they may require. While research indicates women are more likely to be victims of domestic violence and sexual exploitation – men can also be victims of these traumas.

4.9 Northern Ireland is known to suffer from higher rates of trauma (and mental illness) than other parts of the UK[32], with researchers having linked to the long-term impacts of our past[33]. In addition the recently published Youth Wellbeing Survey[34], found that anxiety and depression is 25% more common in children and young people in Northern Ireland compared to other parts of the UK.

4.10 All those affected need support from a wide range of services and integrated approaches are needed to address homelessness, mental health problems, unemployment and general healthcare needs.

Stigma

4.11 There is a stigma that surrounds those who experience issues with alcohol and drug use. Negative attitudes and stigma – from the public, from professionals, and from self-stigmatisation – can be a real barriers to accessing treatment and

[32] https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(18)30392-4/fulltext

[33] http://www.niassembly.gov.uk/globalassets/documents/raise/publications/2016-2021/2017/health/0817.pdf

[34] http://www.hscboard.hscni.net/our-work/social-care-and-children/youth-wellbeing-prevalence-survey-2020/

other services. We need to challenge this stigma and ensure that it is not a barrier to help-seeking behaviour.

Peer Support

4.12 There is the potential to build upon and better use the expertise and experience of peers to better support individuals throughout their recovery journey. As well as providing additional support to service users, it will give improved access to an alternate voice, so that service users are more able to feel ownership and a level of control of their recovery pathway. It can also assist those who are ready for the opportunity to support others, to gain experience, to potentially give a role or purpose, and to help their peers.

4.13 The Department will liaise with Scottish counterparts on the evaluation of their peer navigator model being run jointly between Justice and Health.

North/South and East/West

4.14 The Department of Health will continue to liaise with counterparts in Ireland through regular meetings of the North South Alcohol Policy Advisory Group (NSAPAG). This forum gives both administrations the opportunity to discuss the latest developments on alcohol related policy and legislation, and to take forward joint action where appropriate.

4.15 There is also a “Misuse of Substances” sectoral group established under the British-Irish Council (BIC). Ireland provides the administration and chairs the meetings of this sectoral group which has representation from the UK Government, Scotland, Northern Ireland, Wales, Jersey, Guernsey and the Isle of Man. This particular BIC Sectoral Group provides officials from all member jurisdictions a forum to share regular updates on alcohol and drug related policy from their respective administrations.

Impact of COVID-19

4.16 The emergence of COVID-19 has heightened the risks involved with the management of substance use services, in what is already a high-risk clinical scenario. Guidance was published aimed at helping all alcohol and drug services to address the challenges posed by the need to ensure that premises

are safe for both patients and staff in terms of social distancing measures, and that these also comply with the necessary infection control protocols[35].

4.17 The sudden challenging environment due to social distancing restrictions imposed during the COVID-19 crisis meant that measures needed to be put in place to support people with alcohol and drug issues adversely impacted by social isolation. Robust procedures ensured continuity of service provision for all service users and, although some residential services had to temporarily close, by and large, substance use services remained operational. This was achieved by using a mixture of face to face/telephone support and interventions primarily continuing on a telephone/video-link basis, and managed as appropriate within risk management, social distancing and infection control guidelines. In particular, measures were adopted to support those with more acute dependency issues, and to ensure associated services remained fully operational and accessible across all Health & Social Care Trust areas.

4.18 In response to the particular challenges posed in maintaining a viable service for this population group during this unprecedented public health situation, a COVID-19 Addictions Subgroup maintained communication flows between the Department, the HSCB, the PHA and the local Trusts. The subgroup helped to provide clarity on regional actions required in relation to the COVID-19 outbreak and how these should be applied by all addiction service providers across Northern Ireland, including addressing the broader requirements for people with dependency issues. The impact of COVID-19 on all of our treatment and support services continued to be managed within existing financial and workforce resources, and re-configured as the need arose.

4.19 At the same time, the PHA continued to highlight the health risks associated with using alcohol and drugs, with specific messaging related to the difficulties some faced during this period of social isolation, including information on where local help and support can be accessed. Further information on substance use was also developed for the general public and for people with dependency issues.

[35] https://www.health-ni.gov.uk/sites/default/files/publications/health/guidance-for-alcohol-drug-services-during-the-covid-19-pandemic-june-2020.pdf

4.20 It is vital that we use the learning from the impact of COVID-19 and the response of services to ensure we rebuild our service provision in the most effective way possible. *Mental Health Impact of the COVID-19 Pandemic in Northern Ireland – A Rapid Review*[36] outlines some evidence of the potential psychological impact of the COVID-19 outbreak among the population in NI, in terms in vulnerability to alcohol dependency and mental health problems associated with contributing social factors such as isolation, loneliness, stigma, domestic violence, economic recession, and heightened risk of unemployment. The appendix of *International Policy Guidance and Responses to COVID-19 Mental Health Recovery Rapid Review*[37] outlines risks which could be reframed as learning and what is required of services to mitigate these risks.

4.21 One of the early key learnings from the pandemic was the success for many service users of the switch to on-line/digital access to services. This resulted in a very low number of missed appointments and thus an improvement in the productivity of some services. However, while it is apparent that such a switch to digital services did suit some services users, it would not suit everyone. Face-to-face meetings will still be required for some services and for some users, and we need to ensure that we do not negatively impact on those who cannot access or have limited access to technology or on-line services. Ultimately, it is important that the services have flexibility built in so that they can be tailored to the needs of the individual service users.

Related Strategies and Policies

4.22 This strategy cannot address all the wider causes of substance use related harm and will therefore focus on where there are specific substance use related actions that can have a positive impact. However, we will work with others, and play our part in addressing these issues through the wider strategies set out below. This is not an exhaustive list but these are the main strategic drivers.

New Decade, New Approach[38] was published as part of the return of the Executive and Assembly in Northern Ireland, contains a range of commitments that will support the delivery of this strategy, in particular the commitments to:

[36] https://www.health-ni.gov.uk/sites/default/files/publications/health/mh-impact-covid-pandemic.pdf
[37] https://www.health-ni.gov.uk/sites/default/files/publications/health/international-policy-covid19.pdf
[38] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/856998/2020-01-08_a_new_decade__a_new_approach.pdf

- publish a Mental Health Action Plan[39] and a Mental Health Strategy;
- establish an expert group to examine and propose an action plan to address links between persistent educational underachievement and socio-economic background;
- develop and implement an Anti-Poverty Strategy;
- tackle paramilitarism; and
- extend existing welfare mitigation measures beyond March 2020.

The **Draft Programme for Government's**[40] (PfG) overarching objective is "Improving wellbeing for all – by tackling disadvantage and driving economic growth". The achievement of the PfG, and in particular Outcomes: 3 (We have a more equal society); 4 (We enjoy long, healthy, active lives); 7 (We have a safe community where we respect the law and each other); 10 (We have created a place where people want to live and work, to visit and invest); and 12 (We give our children and young people the best start in life), will have a real impact on addressing substance use, and this strategy will also have a direct impact on meeting those outcomes.

Making Life Better[41] is the Northern Ireland Executive's strategic framework for public health. It is designed to provide direction for policies and actions to improve the health and wellbeing of people and to reduce health inequalities. Through *Making Life Better*, the Executive is committed to creating the conditions for individuals, families and communities to take greater control over their lives and be enabled and supported to lead healthy lives.

Published in 2019, the aim of the **Children and Young People's Strategy**[42] is to work together to improve the well-being of all children and young people in Northern Ireland – delivering positive long-lasting outcomes.

The Strategy has been developed in the context of the Children's Services Co-operation Act (NI) 2015, (CSCA) which places a duty on the Executive to adopt

[39] https://www.health-ni.gov.uk/publications/mental-health-action-plan
[40] https://www.northernireland.gov.uk/sites/default/files/consultations/newnigov/draft-pfg-framework-2016-21.pdf
[41] https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/making-life-better-strategic-framework-2013-2023_0.pdf
[42] https://www.education-ni.gov.uk/sites/default/files/publications/education/2019-2029%20CYP%20Strategy.pdf

a strategy to improve the well-being of children and young people, and requires that for the purpose of determining children's well-being, regard is to be had to the relevant provision of the United Nations Convention on the Rights of the Child.

The **Mental Health Action Plan**[43], published by DoH on 19 May 2020, aims to initiate the reform of mental health services and provides the foundations for longer term strategic change. The Action Plan contains 38 actions designed to bring about service improvements to mental health in the short to medium term, creating a focused basis for decision making and immediate service improvements. It will link into existing strategies with the primary aim to deliver high quality services where they are needed and ensure that all people in Northern Ireland are supported in their mental health.

One of the key actions set out in the Mental Health Action Plan is to develop a new, ten-year Mental Health Strategy. This was a commitment set out in *New Decade, New Approach*, and will be the key strategic vehicle for change to mental health services over the next decade. The Strategy will be person-centred, taking a whole life approach and a whole system focus and the aim is to ensure long-term improved outcomes for people's mental health. The Strategy will be co-produced with individuals with lived experience and other stakeholders, and it is expected that a final Strategy will be published in July 2021.

Homelessness Strategy[44] **and the Interdepartmental Homelessness Action Plan**[45] the Housing Executive's homelessness strategy, Ending Homelessness Together, published in April 2017, provides strategic direction for addressing homelessness in Northern Ireland through to March 2022. The strategy recognises the important role of other agencies in providing advice, assistance and support to prevent households reaching crisis point. Partnership working is at the core of this homelessness strategy, and is reflected in its vision of 'ending homelessness together'.

[43] https://www.health-ni.gov.uk/publications/mental-health-action-plan
[44] https://www.nihe.gov.uk/Documents/Homelessness/homelessness-strategy-northern-ireland-2017-2022.aspx?ext=.
[45] https://www.communities-ni.gov.uk/sites/default/files/publications/communities/dfc-inter-departmental-homelessness-action-plan.pdf

The Department for Communities has also led on the development of the Inter-Departmental Homelessness Action Plan to complement the Northern Ireland Housing Executive's new Homelessness Strategy. It focuses on addressing gaps in those non-accommodation services that have the most impact, or have the potential to more positively impact, on the lives and life chances of people who are homeless and those who are most at risk of homelessness.

Health and Wellbeing 2026: Delivering Together[46] sets out a ten-year approach for change in Health & Social Care, which places emphasis on health promotion, the prevention of ill-health, early intervention, and supporting independence and wellbeing. "*Delivering Together*" highlights the importance of supporting communities to create the social and environmental conditions that lead to improved health and wellbeing, and commits to supporting primary care to take a more proactive multidisciplinary approach to physical, mental and social wellbeing with a greater emphasis on prevention and early intervention.

An Emotional Health and Wellbeing Framework for Children and Young People is being jointly developed by DE, DoH and PHA. The Framework will aim to ensure that children and young people are empowered to take better care of their wellbeing and receive the right support, at the right time, according to their needs.

The Education Authority Youth Service is well positioned to provide youth specific education and support to young people on health and wellbeing, including information and support on substance use. The **Youth Service Regional Assessment of Need 2020-2023**[47] specifically mentions the impact of substance abuse amongst young people.

Protect Life 2[48] was published in September 2019. It focuses on suicide prevention as a societal issue and seeks to ensure collaborative cross-departmental engagement to address risk factors for suicide and self-harm, as well as engagement across wider society.

[46] https://www.health-ni.gov.uk/sites/default/files/publications/health/health-and-wellbeing-2026-delivering-together.pdf
[47] https://www.eani.org.uk/sites/default/files/2020-02/Youth%20Service%20Regional%20Assessment%20of%20Need%202020-23.pdf
[48] https://www.health-ni.gov.uk/sites/default/files/publications/health/pl-strategy.PDF

The Road Safety Strategy to 2020 – The Department for Infrastructure's Road Safety Strategy includes a large number of action measures to improve road safety and to reduce deaths and serious injuries on our roads. It continues to focus on problem areas, including drink and drug driving.

Problem Solving Justice – The Justice System frequently comes into contact with people suffering from alcohol and drug related harm, often in challenging circumstances.

Problem Solving Justice is an international model being developed in Northern Ireland aimed at tackling the root causes of offending behaviour and reducing harmful behaviour within families and the community. More detail on Problem Solving Justice can be found in Chapter 7.

5. VISION, OUTCOMES, VALUES, PRIORITIES AND TARGET GROUPS

Introduction

5.1 **Based on the pre-consultation process, this chapter sets out the proposed overall vision for this new strategy, along with a number of related outcomes, and outlines a number of values that should be at the heart of developing and implementation any new strategy. A range of key priorities and target groups have also been identified.**

Vision

5.2 In support of the overall objective of the draft Programme for Government of "Improving wellbeing for all – by tackling disadvantage and driving economic growth", it is proposed that the Vision for the new substance use strategy should be:

People in Northern Ireland are supported in the prevention and reduction of harm related to the use and misuse of alcohol and other drugs, and will be empowered to maintain recovery.

Outcomes

5.3 It has been agreed that, in line with the overall approach set out in the draft Programme for Government, the new strategy would be taken forward using an Outcomes Based Accountability type approach. Rather than develop one overarching outcome, it was felt that a range of population-level outcomes would better reflect the holistic approach needed to address these multi-faceted issues. We are therefore proposing six outcomes that will help achieve the overall vision above. These are:

A. Fewer People are at Risk of Harm from the Use of Alcohol and Other Drugs.
B. Legislation and the Justice System Support Preventing and Reducing the Harm related to Substance Use.
C. Reduction in the Harm Caused by Substance Use.
D. People Access High Quality Treatment and Support Services to Reduce Harm and Support Recovery.
E. People Are Empowered and Supported on their Recovery Journey.
F. Information, Evaluation and Research Better Supports Strategy Development, Implementation and Quality Improvement.

5.4 The following chapters provide more detail on each of these outcomes along with actions to achieve them and the indicators that demonstrate progress.

Values

5.5 The development of the strategy, and its subsequent implementation, should be guided by and fully informed by the following Values:

- Person-Centred Approach: Everyone has the right to access treatment and support to help them overcome the harm caused by their substance use. Individuals and families should be at the centre of our approach to address this issue and we need to design and deliver policies and services with the support of those who use them.
- Shared Responsibility, Co-Production and Collaboration – Health-led: All partners need to be involved in addressing this issue, and while it is essential that we take a public health approach to addressing it, health alone cannot solve it. We need the support of all partners, including service users and the wider public.
- Evaluation, Evidence and Good Practice-Based: It is essential that we use high quality and up-to-date evidence to inform policy and implementation, including the use of best practice developed locally, nationally or internationally. In order to determine if this strategy and its actions are being effective, they must be subjected to appropriate evaluation and ongoing monitoring.
- Universal, but with an increased focus on those most at risk: The harm from substance use can affect people from all walks of life, age groups and backgrounds. It is therefore vital that universal services are available for all those who need them, and that prevention initiatives are widely available. However, we also know the impact of substance use is not felt equally across society, if we are to address the inequalities that exist we must get better at targeting more intensive interventions at those most at risk. Given their legal status and developmental stage, the main focus for children should be on early intervention, prevention and treatment, whilst avoiding a formal Justice response where possible. Other specific groups, such as those who suffer from homelessness, are even more effected by alcohol and drug related inequalities. We have to get much better at identifying and reaching out to those most at risk.

- Community based with local flexibility to address needs: One of the key issues that came through the review of the previous strategy was the lack of connection between the framework and what was happening at the community level. Therefore, while we will take forward regional approaches and services where possible, we should ensure that people are supported within local communities and there is an ability to deliver local solutions to local issues where needed.
- Long-term Focus: While it will be vital that we take forward short and medium term actions, and address any acute issues we are facing now, short-termism should not detract from the longer-term vision and that we focus on prevention and early intervention as much as treatment and support.

Priorities

5.6 The co-production process identified a number of priorities that must be addressed within our overall approach. These are as follows:

- Polydrug Use: One of the biggest changes that occurred over the course of the previous strategy was the increase in people using more than one substance at the same time. This includes using illegal drugs, alcohol, prescription medicines, novel psychoactive substances, counterfeit medicines, and image and performance enhancing drugs. This change has meant that providing support to individuals is increasingly complex, both in terms of treatment and harm reduction messages, and that the risk of death increases substantially. In 2018, the majority (80%) of Drug Related Deaths involved the consumption of 2 or more substances while the proportion of Drug Related Deaths with 3 or more drugs present in the body at the time of death increased from 25% in 2008 to 50% in 2016 & 2018. It is vital that we address this growing practice and ensure that we provide information and services that take account of this trend.
- Alcohol and Drug Related Deaths: The level of alcohol and drug related deaths is of increasing concern. Alcohol specific and drug related deaths are preventable and addressing this issue must be a key priority in everything we do, and will require new and innovative approaches.
- Supporting Families – including Hidden Harm: The harm caused by substance use doesn't happen in isolation and the harm is felt beyond the individual, with family members also impacted. The impact of parental or

carer substance use on their children and young people (what is often called hidden harm) is a particular concern – especially as we learn more about the impact of Adverse Childhood Experiences. We must ensure that supports are in place for family members, that family based treatment options are available were appropriate, and that we redouble our efforts to protect those children affected by Hidden Harm.

- Improving Service Access and Quality: The evidence is clear – treatment works. However, we need to ensure that there is quick access to clear service pathways and that all services are delivered in line with *Drug Misuse and Dependence: UK Guidelines on Clinical Management*[49] and the forthcoming UK Guidelines on the Treatment of Alcohol Dependence.
- Workforce Development: It is vital that we have capacity to deliver on the strategy, and that all those who work in the substance use field, and those who come into contact with people at risk, have the skills and experience to help and support people through their recovery journey.
- Supporting People throughout their Recovery Journey: Recovery is a personal journey. For some a successful outcome may be improving their quality of life and overcoming their dependence on the substance – alcohol, illegal drug, or prescription medicine – that is causing them the most harm. For others, their ultimate goal might be abstinence. The key focus for the system should be to help individuals and families to achieve their goals. Recovery can be self-led, peer-led, through mutual engagement, and can encompass all sectors. Journeys can start by simply engaging with outreach or harm reduction services, and people need to be supported to maintain recovery after treatment has ended.
- Supporting People with Co-occurring Mental Health and Substance Use: Substance use should not be a barrier to accessing services. Evidence from treatment providers suggests that presentations for substance use are becoming increasingly complex, not only with co-occurring mental health issues, but also polydrug use, homelessness, justice involvement, and other vulnerabilities and needs. Alcohol and drug use and mental health can be inter-related – mental health issues can cause people to "self-medicate" and high levels of alcohol and drug use can impact significantly on mental health. This was raised as an emerging issue in all stages of the

[49] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/673978/clinical_guidelines_2017.pdf

process to date in the development of this consultation. We will therefore need to ensure we align our response to this issue across this strategy and the forthcoming Mental Health Strategy.

Target Groups:

5.7 During the development of this strategy, consideration was given to flagging up specific target groups who would be most affected by each of the actions being proposed to achieve the outcomes of the strategy. However, this was felt to have the potential to limit the scope of the strategy and could have led to some service users being excluded. Therefore this strategy was made universal, open to all those who use alcohol and/or drugs or are affected by the use of alcohol and/or drugs by others. No one should be excluded from accessing the services they need.

5.8 At the same time, there are some groups who are particularly at risk of being negatively impacted by the use of alcohol and/or drugs. Service providers should always keep in mind that these groups may need additional support to access existing services or even require alternative services to address their specific needs:

- children and young people, particularly looked after children;
- those transitioning from child to adult services;
- vulnerable women and individuals in the pre and post-natal period;
- those not in Education, Employment or Training (NEET);
- families / family Members impacted by others' substance use, and particularly those affected by Hidden Harm;
- people in areas of deprivation;
- those in contact with the Justice System;
- those experiencing homelessness;
- access for those in rural areas;
- those who drink at harmful levels;
- people who inject drugs;
- vulnerable members of the LGBT community;
- those experiencing significant levels of psychological trauma;
- those with mental health issues; and
- older people.

Consultation Question 2 – Do you agree with the Vision, Outcomes, Values, Priorities and Target Groups as set out in this chapter? Have you any further comments?

6. OUTCOME A – FEWER PEOPLE ARE AT RISK OF HARM FROM THE USE OF ALCOHOL AND OTHER DRUGS

Introduction

6.1 **The focus of this chapter is on preventing the harm related to the use of alcohol and other drugs, and to ensure that early interventions are in place for those most at risk.**

Indicators

General

- % of children in care, or at the edge of care, due to substance use.

Alcohol

- % of adults drinking above the UK CMO Guidelines;
- % of adults who engage in heavy episodic drinking;
- % of young people who get drunk; and
- Mean age of first drink.

Drugs

- % of adults who have used drugs in the past year/month;
- % of young people who have used drugs;
- Mean age of first drug use;
- % of young people/children partaking in polydrug use; and
- % of adults partaking in polydrug use.

Consultation Question 3 – Do you agree these indicators help to demonstrate progress against this outcome of having fewer people at risk of harm? Are you aware of any other indicators that would demonstrate such progress?

Context

6.2 The most effective way to reduce the long-term harm associated with substance use is to improve our approaches to prevention and early intervention. While risk and protective factors for alcohol and other drugs overlap, they exist in different regulatory frameworks, therefore some measures will focus specifically on alcohol and others on drugs.

6.3 In general there have been some positive trends at the population level in Northern Ireland. As set out in Chapter 4, during the course of the previous strategy, there had been some evidence of significant reductions in the levels of heavy episodic drinking ("binge drinking") and the percentage of young people who drink and get drunk.

6.4 Among adults, prevalence of illegal drug use has largely plateaued at the population level and significant numbers of individuals and families continue to access treatment and support services for alcohol and drug use. In addition, drug use among young people has fallen significantly. However, clearly we need to do more to ensure that prevalence of substance use – and its related harms – continue to fall.

6.5 It is also important to note that alcohol and drug related harm has consequences beyond the individuals themselves and beyond the health system. Preventing harm before it occurs, and intervening at an early stage for those most at risk, will have positive impacts across many sectors and on issues such as: exclusion from school, academic performance, community safety, reducing offending and reoffending, homelessness, community cohesion, emotional health and wellbeing, etc. It is therefore vital that we take a holistic and cross-sectoral/Departmental approach to prevention and early intervention, and that partners beyond health and social care play their full role.

Approach

6.6 Our approach to prevention is based on the 3 key elements of the European Monitoring Centre for Drug Dependence and Addiction (EMCDDA) definition:

- Universal Prevention (i.e. improving education and awareness in the general public);
- Targeted Prevention (i.e. interventions with individuals, groups, families or communities who are at most risk); and
- Environmental Prevention (i.e. addressing the wider cultural, social, and economic environments that influence substance use).

6.7 There have been a number of recent reviews across the UK and Ireland that have set out evidence in relation to prevention and early intervention:

- In 2015, Public Health England published "The international evidence on the prevention of drug and alcohol use"[50];
- In 2016, the Scottish Government published "What Works in Drug Education and Prevention?"[51];
- In 2017, the Health Research Board in Ireland published "The effectiveness of interventions related to the use of illicit drugs: prevention, harm reduction, treatment and recovery. A review of reviews"[52]; and
- In addition, there are a number of related National Institute of Clinical Excellence (NICE) guidelines[53].

6.8 In general, the evidence shows that consistent and co-ordinated prevention activities delivered through a range of programmes and in a variety of settings (e.g., at home; in school; among peers; in the workplace; throughout the local community; and in the media) are most likely to lead to positive outcomes. Evidence also suggests that modifying the environment where risky behaviour takes place can reduce harmful outcomes. It is likely that accurate and consistent information about the health and social impacts of alcohol and drug use is only effective when delivered alongside interventions that develop the skills and personal resources people need to avoid early initiation.

6.9 We must also be aware of the potential gateway to substance use provided by substances such as alcohol, tobacco and nitrous oxide, etc.

6.10 It is also important to note that there is clear evidence on prevention and early intervention approaches that are ***not*** likely to work, or can in fact have negative consequences. These include:

- standalone school-based or other prevention programmes designed only to increase knowledge about drugs;
- having ex-users deliver testimonials or using police officers to deliver standalone programmes;

[50] https://www.gov.uk/government/publications/preventing-drug-and-alcohol-misuse-effective-interventions
[51] https://www.gov.scot/publications/works-drug-education-prevention/
[52] https://www.drugsandalcohol.ie/27253/1/fHB2656_Review%20of%20reviews_web.pdf
[53] https://www.nice.org.uk/guidance/ng135; https://www.nice.org.uk/guidance/ph24; and https://www.nice.org.uk/guidance/ng64

- theatre/drama based education/awareness raising to prevent illegal drug use;
- befriending/buddying-type mentoring programmes that have no short- or long-term preventative effects on illegal drug use; and
- universal public information media programmes targeting drug use.

Alcohol Units

6.11 Analysis of the knowledge of the recommended drinking limits indicates that these are poorly known among both men and women, so steps need to be taken to raise awareness of the current *UK CMOs' Low Risk Drinking Guidelines*[54] *and* better communicate this vital information to the public in a clear manner.

Actions

6.12 The following actions are proposed to support progress against the outcome and indicators, based on the wider context and the evidence of what works in terms of prevention and early intervention.

General	
A1	The Department of Health will work with the Department of Education to ensure that Substance Use and Hidden Harm are included as appropriate in the work emerging from the Emotional Health & Wellbeing Framework for Children and Young People being led by the Department of Education.
A2	A Northern Ireland Prevention Approach, based on up-to-date evidence and an analysis of the risk and protective factors impacting our young people, will be developed by the PHA and delivered in Northern Ireland and reviewed after 5 years – while this will be a universal programme, it should also be targeted at those at most risk and those in disadvantaged communities.
A3	The PHA will update the drugandalcoholni.info website with up-to-date information in terms of substance use, support materials and the services available in Northern Ireland.

54 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/545937/UK_CMOs__report.pdf

A4	The current community support mechanisms will be reviewed by the PHA to ensure they can support the local implementation of this Strategy in the community, promote prevention, collaboration and access to services.
A5	Targeted prevention and early interventions will continue to target those young people most at risk of substance use, including looked after children, etc. Establishing effective operational relationships, including with local Youth Services, will assist in the success of this action.
A6	The *Making Every Contact Count* programme in primary care will include brief interventions and advice in respect of alcohol and drug use.
A7	The HSCB and the PHA will ensure that the Substance Use Liaison role will be included as part of the new Mental Health Service model operating across general hospitals / Emergency Departments.
A8	The Hidden Harm Action Plan will be updated by the PHA and the HSCB to ensure that supports are in place, in a stepped care approach, to mitigate the risk for those children and young people who live with substance misusing parents or carers, in particular the Joint Working Protocol on Hidden Harm will be promoted and used across all services.
Alcohol	
A9	The PHA will promote and raise awareness of the UK Chief Medical Officer low-risk drinking guidelines and understanding of alcohol units across the region.
A10	The Department for Infrastructure will seek to improve access to its Course for Drink Drive Offenders scheme – a rehabilitation scheme that aims, through education, to make drink drive offenders take more responsibility for their actions and reduce the risk of re-offending.
Other Drugs	
A11	The PHA will promote raising awareness of the harm associated with the illicit use of prescribed medicines and also the harm associated with polydrug use. This will include working with HSCB to promote awareness across primary and secondary care healthcare providers.

Consultation Question 4 – Will these actions achieve this outcome of having fewer people at risk of harm and make positive impacts on the indicators? Which actions would you prioritise if they cannot all be taken forward or are there other actions likely to have a bigger impact?

7. OUTCOME B: LEGISLATION AND THE JUSTICE SYSTEM SUPPORT PREVENTING AND REDUCING THE HARM RELATED TO SUBSTANCE USE

Introduction

7.1 **The focus of this chapter is on the wider legislative environment, how we reduce the availability of substances causing harm, and how the Justice System helps to prevent and reduce harm.**

Indicators

General

- % of people in the justice system who have substance use related issues;
- % of crimes that are alcohol and/or drug related; and
- Number of people detected for drink/drug driving offences.

Alcohol

- % of people who drink at harmful levels.

Drugs

- Number of Organised Crime Gangs disrupted;
- Number of people on Enhanced Combination Orders and/or Community Resolution Notices for substance use related offences; and
- % of population inappropriately using prescription only medications.

Consultation Question 5 – Do you agree these indicators help to demonstrate progress against this outcome of legislation and the justice system preventing and reducing harm? Are you aware of any other indicators that would demonstrate such progress?

Context

7.2 The legislative environment has an impact on the availability, accessibility, and the behavioural norms that exist in relation to the use of both alcohol and other drugs. However, it is important to note that the regulatory environment for alcohol, illegal drugs and prescription only medicines are very different.

7.3 It is also important to note that people who suffer from alcohol and drug related harm are more likely than average to come into contact with the justice system, and may have more complex issues such as higher rates of poor mental health, may have other long-term conditions, and may have a history of trauma.

Alcohol

7.4 Restrictions on the sale of alcoholic drinks in Ireland were first introduced in 1634. Further restrictions were not added for centuries until the new Northern Ireland Parliament, created in 1920, enacted the Intoxicating Liquor Act (Northern Ireland) 1923. The following decades saw many more amendments to this legislation with the current licensing laws, the Licensing (Northern Ireland) Order 1996, coming into force in February 1997.

7.5 The aim of licensing law is to try and strike a balance between the controls which are necessary for the protection of public health and the preservation of public order, the demand for individual freedom of choice and the opportunity for local businesses to continue to provide a high level of service to their customers. Following a public consultation in 2019, the Minister for Communities recently announced that a Bill will be brought forward aimed at further updating NI's liquor licensing legislation.[55]

7.6 From a public health perspective, the SAFER Initiative by the WHO[56] and Public Health England evidence review published in 2016 "*The Public Health Burden of Alcohol and the Effectiveness and Cost-Effectiveness of Alcohol Control Policies*"[57] both highlight the strong evidence on policies and legislation that regulate the price and availability of alcohol, and seek to reduce drink driving, are effective in reducing alcohol-related harm.

Minimum Unit Pricing

7.7 Minimum Unit Pricing for Alcohol (MUP) is a population health measure that would set a minimum price that could be charged per unit (8 mg or 10ml) of

[55] https://www.communities-ni.gov.uk/articles/proposed-changes-liquor-licensing-laws-northern-ireland
[56] https://www.who.int/substance_abuse/safer/en/
[57] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/733108/alcohol_public_health_burden_evidence_review_update_2018.pdf

alcohol. Any alcoholic beverage has a set number of units; MUP therefore ensures that a drink cannot then be sold for a price lower that the number of units multiplied by the MUP.

7.8 MUP of 50p per unit of alcohol was introduced in Scotland in 2018, following years of legal appeals by the Scotch Whisky Association. A Supreme Court case was heard in late 2017, which found in favour of the Scottish Government position of introducing the measure and also found that MUP was not a breach of the EU Trade laws.

7.9 In June 2020, Public Health Scotland published a study undertaken in collaboration with the University of Glasgow which shows a decline in population alcohol consumption following the introduction of MUP. This study shows a net reduction, when compared to England & Wales, in per adult sales of alcohol from supermarkets and off-licences of between 4-5 per cent in the 12 months following the implementation of MUP. This study is very promising and indicates that Minimum Unit Pricing may be an effective measure, but it is too early to be definitive.

7.10 The National Assembly for Wales also agreed a minimum unit price of 50p per unit of alcohol and this was introduced on 02 March 2020. The Government in the Republic of Ireland has already indicated a willingness to introduce Minimum Unit Pricing and wish to liaise with Northern Ireland in order to take account of any cross-border issues regarding trade.

Alcohol Advertising

7.11 Restricting alcohol advertising is also a key element of the WHO Safer initiative to reduce alcohol consumption and related harms across the whole population. In particular, there is the potential that restrictions on alcohol marketing ensure that vulnerable groups, such as children and young people, and those recovering from alcohol dependence, are specifically protected. There is evidence to show that alcohol advertising seen by children and young people

is associated with both the initiation of drinking and with heavy drinking[58]. Powers over broadcast advertising are reserved to the UK Parliament.

Drugs

7.12 The legislative regulatory framework in relation to other drugs, including the illicit use of Prescription Medicines and New Psychoactive Substances, will also impact on the availability of these substances, and the harm they can cause, in our communities. There are links between the illicit supply of drugs and serious and organised crime, as well as impacts on communities through criminal activity, the impact of anti-social behaviour, drug-related litter, sex work, and drug-related deaths.

7.13 The legal framework relating to the misuse of drugs, including the Misuse of Drugs Act 1971 and the Psychoactive Substances Act 2016, is reserved to the UK Government. The Advisory Council on the Misuse of Drugs[59] is an advisory non-departmental public body which makes recommendations to government on the control of dangerous or otherwise harmful drugs, including classification and scheduling under the Misuse of Drugs Act and its regulations. Further detail on related legislation is available on the Department of Health's website[60].

Problem Solving Justice

7.14 The Justice System frequently comes into contact with people suffering from alcohol and drug related harm, often in challenging circumstances. These contacts therefore can provide useful opportunities to intervene early with some of the most at risk and vulnerable members of our community, support them into treatment and recovery, and help to reduce harm. This can include crisis interventions on the street, signposting to interagency support, diversion at the point of potential arrest, support within police custody, opportunities at the point of sentencing, and the delivery of healthcare in prisons.

7.15 Problem Solving Justice is an international model being developed in Northern Ireland aimed at tackling the root causes of offending behaviour and reducing

[58] Finan et al., (2020). Alcohol Marketing and Adolescent and Young Adult Alcohol Use Behaviours: A Systematic Review of Cross-Sectional Studies. https://www.jsad.com/doi/full/10.15288/jsads.2020.s19.42
[59] https://www.gov.uk/government/organisations/advisory-council-on-the-misuse-of-drugs
[60] https://www.health-ni.gov.uk/articles/misuse-drugs-legislations

harmful behaviour within families and the community. There are opportunities through this approach to consider how we manage those arrested from substance-related crimes, but also those arrested for other criminal behaviours who may have alcohol and/or drug related issues.

7.16 Problem Solving Justice is not just relevant to the Criminal Justice System but also to Civil and Family justice. A pilot of a Family Drug & Alcohol Court, designed to help families involved in care proceedings when there is parental substance use, is currently being evaluated. A Substance use Court has also been piloted. Enhanced Combination Orders allow for alternatives to a prison sentence to be considered, for sentences of 12 months or less, and this includes where an offence involves drugs.

7.17 A draft Problem Solving Justice 5-Year strategic plan is also currently being developed for wider consideration. This is based on evidence from independent evaluations of current initiatives, which includes consideration of options for the rollout of those initiatives shown to produce the right outcomes for individuals, families and communities.

Improving Health within the Justice Setting

7.18 Research tells us that many of the people in contact with the Justice System are likely to have unmet health needs, including those relating to substance use. In June 2019 the Departments of Health and Justice published the 'Improving Health within Criminal Justice' Strategy. The strategy and associated action plan, which was developed jointly between the Departments, outlines a substantial work programme to ensure that children, young people and adults in contact with the justice system have the highest attainable standard of health and well-being.

7.19 One of the action measures was to develop a Joint Health & Criminal Justice Substance Use Action Plan to further support those people in contact with the Justice System. In 2017 a Joint Strategy for the Management of Substance Use in Custody was finalised. Once the Substance Use Strategy for Northern Ireland is published, the Northern Ireland Prison Service and South Eastern Health &

Social Care Trust will take forward work to review its joint strategy, which will include a range of further actions to improve outcomes in this area.

Transition from Prison

7.20 The arrangements for service users moving from the Justice System, particularly prisons, and making the transition back into community-based services has been repeatedly identified as an area that needs attention. Providing service users with a clear pathway into support services will aid their transition and it is believed reduce the incidents of disengaging with services.

7.21 We can learn from the care after custody service established in England (RECONNECT) to see if a similar service needs to be provided that links not only Justice and Health services but also other critical services such as housing and benefits.

Actions

7.22 The following actions are proposed to support progress against the outcome and indicators, based on the wider context and the evidence of what works in terms of legislation, supply reduction, and how the Justice System helps to prevent and reduce harm.

General	
B1	Following evaluation of the Problem Solving Justice initiatives, further consideration will be given to their effectiveness and the need to further scale up these approaches across Northern Ireland, together with the wider roll-out of Enhanced Combination Orders/Community Resolution Notices for drug possession and drug-related offences.
B2	Appropriate services, and treatment where applicable, should be provided to those who come into contact with the justice system. As part of this, a new transition service will be developed and tested by the SEHSCT Prisons Healthcare team. This will aim to better coordinate the continuity of care for those being released from prison into the community, including connections towards ongoing appointments and treatments. Service users

	will be navigated towards the community/voluntary sector and peer support as an integral part of these arrangements.
Alcohol	
B3	Work on a new Liquor Licensing Bill being taken forward by the Department for Communities[61] provides an opportunity to strengthen alcohol licensing laws in Northern Ireland and ensure it takes account of public health issues.
B4	The Department of Health will bring forward a consultation on the introduction of Minimum Unit Pricing for Alcohol in Northern Ireland within a year.
B5	The Department of Health will work with the UK Government to tighten restrictions on the advertising of alcohol, including giving consideration to the introduction of a 9pm "watershed".
B6	The Department for Infrastructure will introduce the lower drink driving limits agreed by the NI Assembly in 2016. It will continue to monitor the effects of legislation in Great Britain and Ireland that introduced certain drug driving limits, before developing proposals for any change to drug driving laws here.
Other Drugs	
B7	The NI Executive will work with the UK Government, and the Advisory Council on the Misuse of Drugs, to ensure the Misuse of Drugs Act 1971 reflects the needs of Northern Ireland and supports the delivery of the outcomes and indicators in this strategy.
B8	The PSNI and the Organised Crime Task Force will continue to co-ordinate enforcement activity and ensure that those involved in the illicit supply and distribution of drugs are targeted appropriately.

Consultation Question 6 – Will these actions achieve this outcome of legislation and the justice system preventing and reducing harm? Will they make positive impacts on the indicators? Which actions would you prioritise if they cannot all be taken forward or are there other actions likely to have a bigger impact?

[61] https://www.communities-ni.gov.uk/articles/proposed-changes-liquor-licensing-laws-northern-ireland

8. OUTCOME C – REDUCTION IN THE HARM CAUSED BY SUBSTANCE USE

Introduction

8.1 **The focus of this chapter is on harm reduction and support for those at the start of their recovery journey and into the treatment system as required.**

Indicators

General

- Rate of alcohol and/or drug related deaths;
- The inequality gap in the rate of alcohol and/or drug related deaths;
- Rate of alcohol and/or drug related hospital admissions; and
- The inequality gap in the rate of alcohol and/or drug related hospital admissions.

Alcohol

- % of adults drinking above the UK CMO Guidelines.

Drugs

- Prevalence of blood borne viruses among those who use drugs;
- Number of needle and syringe exchanges;
- Number of naloxone kits distributed; and
- Rate/number of naloxone kits reported to have been used.

Consultation Question 7 – Do you agree these indicators help to demonstrate progress against this outcome of reducing harm? Are you aware of any other indicators that would demonstrate such progress?

Context

8.2 Not every person who comes to harm because of their substance use is able, or willing, to stop. For those individuals, it is vital that a range of accessible non-judgemental services are in place to provide them with support and to help them take measures that reduce the harm they may suffer.

8.3 284 people in Northern Ireland lost their lives related to an alcohol-specific cause. In 2018, 196 (69.0%) alcohol-specific deaths were males and 88 (31.0%) were females[62]. It is important to note that these are only alcohol-specific deaths – alcohol is also a contributory factor in many other deaths, with links to several forms of cancer. Alcohol remains by volume the most harmful of all the substances in use across Northern Ireland.

8.4 One of the long-term harms that can be caused by excessive drinking is Alcohol-Related Brain Damage (ARBD). This is a brain disorder caused by drinking too much alcohol on a regular basis over a long period of time. It is possible to reverse many of the effects of this disorder if the symptoms (which can resemble dementia) are caught early enough.

8.5 In respect of the 189 drug-related deaths:

- Opioids were the most common group of substances reported in drug-related deaths (115), with heroin/Morphine being mentioned on 40 death certificates – a significant increase from 24 in 2017, tramadol on 27, and fentanyl on 10;
- Benzodiazepines (prescription medicines that can also be used illicitly) were the second most reported group of substances (97);
- Pregabalin (another prescription medicine) also increased significantly and was reported on 54 death certificates; and
- Alcohol was also mentioned in 23% of all drug-related deaths[63].

8.6 The greatest increases in drug-related deaths over the past ten years have been seen in men, aged 25-44. The other key trend is increasing polydrug use – including the misuse of prescription medicines and alcohol – in our most recent figures over 70% of our drug related deaths involved two or more substances.

[62] https://www.nisra.gov.uk/publications/alcohol-specific-deaths-2008-2018
[63] https://www.nisra.gov.uk/statistics/cause-death/drug-related-deaths

8.7 Recent research[64] has also shown that in Northern Ireland the most at-risk groups for drug-related deaths are younger age groups, males, those living on their own, those with low educational attainment, and there is a strong link between drug use and mental health issues and long-term illnesses.

8.8 There is also a real health inequality in both alcohol and drug related deaths. While substance use is observed across all socio-economic groups, the harm is mostly felt by those in our most deprived communities – with the most-to-least deprived gap in alcohol-specific deaths being 353%, 334% for drug-related deaths, 338% for alcohol-related admissions to hospital, and 282% for drug-related admissions.

8.9 Blood Borne Viruses (BBVs) are viruses that some people carry in their blood and can be spread from one person to another. Those who inject themselves with drugs and share needles are more susceptible to these blood borne viruses.

8.10 The misuse of prescription medication has been shown to be associated with a wide range of substance use related harms. As well as people illicitly seeking out prescription medicines, there can also be issues with involuntary addiction to prescription medications if they are not taken or prescribed in line with guidelines, this can particularly occur in relation to sedatives/tranquilisers and opioids in relation to managing chronic pain.

8.11 In 2017, Public Health England (PHE) undertook a review[65] to identify the scale, distribution and causes of prescription drug dependence, and what might be done to address it. It showed that in the year 2017 to 2018, 1-in-4 adults in England were prescribed benzodiazepines, z-drugs, gabapentinoids, opioids for chronic non-cancer pain, or antidepressants.

8.12 There are also cases where individuals try to access medication on-line if prescriptions they feel they require are not increased or stopped too quickly.

[64] https://www.nisra.gov.uk/sites/nisra.gov.uk/files/publications/Drug-related%20Deaths%20in%20Northern%20Ireland%20-%20Findings.pdf
[65] https://www.gov.uk/government/publications/prescribed-medicines-review-report.

This increases their chances of getting lower quality medication and incorrect dosage quantities which can lead to an accelerated risk of harm.

Harm Reduction

8.13 Harm reduction services have been proven over time to reduce alcohol and drug related harm, to provide vital and lifesaving services for those most in need, and to support people to begin their recovery journey. They also provide an important signal to those suffering from substance use related harm that their lives are meaningful and are worth saving.

8.14 It should be acknowledged that being abstinent from alcohol is not the outcome that all people will want to achieve, and harm reduction approaches will also be taken to reduce consumption at both hazardous and harmful levels. Recent research has shown that the use of controlled drinking as a harm reduction outcome is less than clear. [66]

Evidence

8.15 The recently published Northern Ireland Audit Office[67] report on substance use services states that "There is clear evidence that harm reduction projects are a cost effective way of tackling the harms related to alcohol and drug use. The Department should ensure the further development of cost effective harm reduction initiatives as part of the new alcohol and drugs strategy".

8.16 Harm reduction services include measures to reduce the spread of blood borne viruses, reverse overdoses through the supply of naloxone, provide alternatives to stabilise lives, provide advice on safer injecting and substance use, and provide guidance on how to reduce harm, the risk of overdose and death.

8.17 Much of the evidence for the effectiveness of specific harm reduction approaches is set out in "*The effectiveness of interventions related to the use of illicit drugs: prevention, harm reduction, treatment and recovery. A review of*

66 https://www.researchgate.net/publication/232068307_Controlled_drinking_harm_reduction_and_their_roles_in_the_response_to_alcohol-related_problems

67 https://www.niauditoffice.gov.uk/publications

reviews"[68] published by the Health Research Board in Ireland. In addition, there are a range of National Institute for Clinical Excellence[69] (NICE) guidelines for the delivery of specific interventions. Public Health England have also published advice responding to drug related deaths[70] and the Advisory Council on the Misuse of Drugs (ACMD) produced a report specifically on reducing opioid related deaths in 2016[71].

Actions

8.18 The following actions are proposed to support progress against the outcome and indicators, based on the wider context and the evidence of what works in terms of harm reduction.

General	
C1	The PHA will continue to develop and expand highly accessible Low Threshold Outreach Services to meet the growing needs of those who use alcohol and other drugs.
C2	The PHA and HSCB will lead a process to develop a joined-up and integrated intensive outreach service to specifically identify and support those most at risk of alcohol and drug related deaths. It is vital that this links with existing statutory services, community and voluntary sector services, homeless services, and suicide prevention services.
C3	Increased screening and testing for blood borne viruses for those in treatment, with support to access follow-up treatment and support, including peer-led services.
C4	Suicide prevention training will be provided to all staff working in substance use related services.
C5	The Department of Health, the Department of Justice, and the PHA will continue to grow and expand the Drug & Alcohol Monitoring & Information System to ensure that up-to-date information on current trends is available to relevant key services and those at risk.

[68] https://www.hrb.ie/fileadmin/publications_files/Review_of_reviews_draft_03_FINAL_28_June_2017.pdf
[69] https://www.nice.org.uk/guidance/ph52; https://www.nice.org.uk/guidance/ng64; and https://www.nice.org.uk/guidance/cg51
[70] https://www.gov.uk/government/publications/health-matters-preventing-drug-misuse-deaths/health-matters-preventing-drug-misuse-deaths
[71] https://www.gov.uk/government/publications/reducing-opioid-related-deaths-in-the-uk

C6	A process of strategically reviewing alcohol and drug related deaths at a regional level will be established under the Organised Crime Task Force to share trends and inform policy and practice.
C7	The PHA and the HSCB will work with experts to develop an Overdose & Relapse Prevention Framework to target those at most risk.
Other Drugs	
C8	The PHA will continue to develop and expand the Needle and Syringe Exchange Scheme, both within community pharmacies and within the community, to ensure adequacy of exchange services. This will include establishing measurement of packs distributed per person, with the aim of ensuring that we meet the WHO target of 200-300 sterile needle and syringe sets distributed per person per year.
C9	The PHA will expand the capacity of naloxone provision to people who use drugs, their peers, family members, and those likely to come into contact with those at risk of overdose. This will include establishing the need for nasal naloxone for carers and services on the periphery of substance use (such as police officers).
C10	Building on the current processes, the HSCB will put in place additional support to monitor prescribing levels and support for prescribers to better understand who may be at risk of harm through use/misuse of prescription medicines and to support associated harm reduction measures.
C11	The HSCB will produce an updated Prescription Drug Misuse Action Plan.

Consultation Question 8 – Will these actions achieve this outcome of reducing harm and will they make positive impacts on the indicators? Which actions would you prioritise if they cannot all be taken forward or are there other actions likely to have a bigger impact?

9. OUTCOME D – PEOPLE ACCESS HIGH QUALITY TREATMENT AND SUPPORT SERVICES TO REDUCE HARM AND EMPOWER RECOVERY

Introduction

9.1 **The focus of this chapter is on providing accessible, high quality, substance use related treatment and support to those who need additional help. Treatment should not be seen as the end point, and support must be provided for people to continue and maintain their recovery.**

Indicators

General

- Numbers in treatment for substance use;
- Waiting times for treatment for substance use;
- Number waiting for treatment;
- Waiting time for Opioid Substitution Therapy (OST);
- Number on OST;
- Outcomes for those in treatment (Impact Measurement Tool and measures to be developed for statutory services);
- Rate of alcohol and/or drug related hospital admissions; and
- Service user feedback on treatment (to be developed).

Consultation Question 9 – Do you agree these indicators help to demonstrate progress against this outcome of accessing treatment? Are you aware of any other indicators that would demonstrate such progress?

Context

9.2 Many people who use substances may be able to reduce harm and take their recovery journey forward without specifically needing to access services. Therefore, self-care support and advice is critical to supporting people on their journey. However, some people will need further help and support on their recovery journey. Their needs are likely to differ over time, with more or less intensive services being required to meet those needs.

9.3 Treatment and support services in Northern Ireland are broadly structured in a 4-Tier model, as set out in the "Alcohol and Drug Commissioning Framework for Northern Ireland".

- Tier 1 interventions include provision of alcohol and/or drug-related information and advice, screening and referral to specialised drug treatment interventions, provided in the context of general healthcare settings, or social care, education or justice settings where the main focus is not drug treatment.
- Tier 2 interventions include provision of alcohol and/or drug-related information and advice, triage assessment, referral to structured alcohol and/or drug treatment, brief psychosocial interventions, harm reduction interventions (including needle exchange) and aftercare. Tier 2 interventions may be delivered separately from Tier 3 but will often also be delivered in the same setting and by the same staff as Tier 3 interventions. Other typical settings to increase access are through outreach (general detached or street work, peripatetic work in generic services or domiciliary (home) visits), and in primary care settings.
- Tier 3 interventions include provision of community-based specialised alcohol and/or drug assessment and co-ordinated care planned treatment and alcohol and/or drug specialist liaison. Tier 3 interventions are normally delivered in specialised alcohol and/or drug treatment services with their own premises in the community or on hospital sites. Other delivery may be by outreach (peripatetic work in generic services or other agencies or domiciliary or home visits). Tier 3 interventions may be delivered alongside Tier 2 interventions.
- Tier 4 interventions include provision of inpatient and residential specialised drug treatment, which is care-planned and care-coordinated to ensure continuity of care and aftercare. Ideal settings to provide inpatient alcohol and/or drug detoxification and stabilisation are specialised dedicated inpatient or residential substance use units or wards.

9.4 Ensuring a clear pathway to a holistic treatment and support system and improving the quality of available treatment options is integral to achieving better outcomes. We must ensure that any silos or blockages in the system that detract from service users being able to access clear pathways to recovery are

eliminated. For example, the transition from moving from children/young person focused addiction services to adult based services has been highlighted as a challenging time for service users and one which can be fraught with difficulties due to the lack of specific connections between services.

9.5 Recent evidence, and experiences from elsewhere, provide some indication of likely future trends and the types of challenges in the years ahead. The proliferation of Novel Psychoactive Substances, misuse of prescription medicines, polydrug use, and the changing geographic and demographic profile of substance use are among the issues that will contribute to the demand for services under this strategy.

Improving Access & Removing Barriers

9.6 As outlined in the "Wider Context" section (Chapter 4), we must take into account and be fully aware of the effect that trauma and stigma have on the ability of people to access treatment and support and start themselves on the road to recovery. Individuals who have experienced significant trauma in either childhood or adulthood can develop addiction problems as a result of the psychological impact of these experiences. However stigma, either from the trauma and/or related to the addiction, can hamper any attempt at seeking support.

9.7 Women can experience barriers to engaging and sustaining involvement with treatment and rehabilitation services. Issues with childcare can also be a barrier for women attending treatment and after-care services.

9.8 We also need to consider the treatment and support services available to young people, both standalone alcohol and drug services, and the need for integrated services that respond to the complexity of young people's lives.

9.9 A recurring theme in the process to co-produce this consultation document was a concern about access to services for people who have a co-occurring mental health and substance use problem, often called "dual diagnosis". For some individuals, their alcohol and drug use and mental health is inter-related. Both general mental health difficulties and symptoms associated with psychological

trauma can lead people to "self-medicate" with alcohol and other substances to manage these aversive feelings. However, this heightened level of alcohol and drug use can, in turn, result in an exacerbation of these mental health issues. Guidelines (such as the *UK Guidelines on the Clinical Management of Drug Dependency*[72]) are clear – no matter where the individual with co-occurring issues is first referred to, whether mental health or substance use services, they should work collectively together to address the issues and clients should not be referred back and forward between services unnecessarily.

9.10 However, service users often report difficulties in accessing services and unclear lines of referral. We will therefore need to address this issue both through this strategy and the forthcoming Mental Health Strategy.

9.11 Those who are homeless are also at a higher risk of harm related to substance use, with those who are rough sleepers or those using emergency accommodation particularly at risk. While substance use can lead to homelessness, homelessness can also contribute to the development of substance use problems.

Evidence

9.12 Treatment and support works. The evidence shows that investment in substance use treatment can substantially reduce the economic and social costs of substance use related harm. The *Drug Treatment Outcomes Study* (DTORS)[73] suggested that there are net benefits from treatment, with an overall benefit-cost ratio of approximately 2.5:1. This suggests that every £1 invested in treatment results in a £2.50 benefit to society. It also estimated that the cost of healthcare alone for adult substance users coming to harm but not in structured treatment was £5,380 per annum, and that healthcare costs fall by 31% when users are in treatment. There will also be additional savings to justice and other settings from ensuring the provision of accessible and quality treatment and support.

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72 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/673978/clinical_guidelines_2017.pdf

73 Referenced in this Public Health England report: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/586111/PHE_Evidence_review_of_drug_treatment_outcomes.pdf

9.13 There is a range of guidelines and evidence in respect of the effectiveness of treatment and support services. The main document is the "*UK Guidelines on the Clinical Management of Drug Dependency*"[74], page 42 of which outlines the principles for trauma informed care. A similar document is currently being produced for the treatment of alcohol dependence. In addition, in 2017, the Health Research Board in Ireland published "*The Effectiveness of Interventions related to the Use of illicit drugs: Prevention, Harm Reduction, Treatment and Recovery. A review of reviews*"[75], and there are a number of related National Institute of Clinical Excellence (NICE) guidelines[76].

Workforce Development

9.14 We must ensure that we have the capacity to deliver on this strategy. As part of this it is important to ensure that all those who work across the substance use field, and those who come into contact with people at risk, have the necessary skills and experience to help and support people through their recovery journey.

Actions

9.15 The following actions are proposed to support progress against the outcome and indicators, based on the wider context and the evidence of what works in terms of harm reduction.

General	
D1	The COVID-19 Addiction Services Rebuilding Plan will be implemented to ensure that substance use services are in place and that learning from how services operated during the pandemic is built into future delivery and planning for any future waves.
D2	The PHA and the HSCB will ensure that self-care advice and support is available through a range of sources, including online, via apps, etc.

[74] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/673978/clinical_guidelines_2017.pdf
[75] https://www.drugsandalcohol.ie/27253/1/fHB2656_Review%20of%20reviews_web.pdf
[76] https://www.nice.org.uk/guidance/ng135; https://www.nice.org.uk/guidance/ph24; and https://www.nice.org.uk/guidance/ng64;

D3	The PHA will continue to deliver a programme of workforce development in relation to substance use, in line with national standards such as DANOS[77] etc. This would include the need for a trauma-informed approach and appropriate training on stigma associated with substance use.
D4	The PHA and the HSCB will revise the Alcohol and Drug Commissioning Framework for Northern Ireland to produce a new strategic plan that is outcomes focused and in line with the strategy, evidence and best practice guidelines. This new plan should: • ensure that the population of NI have access to a continuum of service with clear pathways and step up/step down provision; • ensure that all services are delivered in line with the UK-wide "Drug Misuse and Dependence: Guidelines on Clinical Management"[78]; • provide support to address the wider physical, mental health, and wellbeing needs of those in treatment, including housing, education, employment, personal finance, healthcare e.g. they should be supported to stop smoking and address other physical health conditions; • recognise the importance of co-production and strengthen joint working between the community and voluntary sector, service users and peers, and the Health and Social Care Sector; and • develop a clear governance structure to provide oversight and support consistent implementation of the priorities identified within the strategy across the region.
D5	A review of Tier 3 services (to include pathways and linkages to Tier 2 services) will be completed, with the development of an implementation plan to increase access to services to those most at risk and to reduce waiting times.
D6	The PHA and the HSCB will review services available for children and young people, particularly looking at the transition of young people from children to adult services. This will include standalone services commissioned by the PHA, and the expansion of the DAMHS service within CAMHS.

[77] https://www.skillsforhealth.org.uk/resources/service-area/19-alcohol-drugs
[78] https://www.gov.uk/government/publications/drug-misuse-and-dependence-uk-guidelines-on-clinical-management

D7	The HSCB will review the support provided for those with co-occurring mental health and substance use issues urgently, to ensure that services are delivered in line with the relevant guidelines and ensure collaboration across all key services.
D8	Building on the ongoing project in the Western Health & Social Care Trust area to design and develop an integrated model between all Tiers of Addiction Services and the Regional Trauma Network, the proposed model will be considered and rolled out across the region.
D9	The PHA, the HSCB and the HSCTs will work to strengthen the link between maternity (including neo natal) and substance use services, and that treatment services work to reduce barriers for women and those with childcare responsibilities.
D10	Family support services will be reviewed by the PHA to ensure that evidence-based supports are available for all those who wish to avail of them, whether or not their family member is in treatment. Service models will also be updated to ensure the involvement of family members in treatment as appropriate.
Alcohol	
D11	Alcohol treatment and support services will be taken forward in line with the new UK-wide Clinical Guidelines on Alcohol, once these have been finalised.
Other Drugs	
D12	The HSCB will take forward the recommendations from the review of Opioid Substitution Therapy with a specific focus on reducing waiting times with the target that no-one waits more than 3 weeks, at most, from referral to assessment and treatment.

Consultation Question 10 – Will these actions achieve this outcome of accessing treatment and will they make positive impacts on the indicators? Which actions would you prioritise if they cannot all be taken forward or are there other actions likely to have a bigger impact?

10. OUTCOME E – PEOPLE ARE EMPOWERED AND SUPPORTED ON THEIR RECOVERY JOURNEY

Introduction

10.1 **The focus of this chapter is on empowering recovery for those who experience harm related to their substance use. This goes beyond reducing demand to putting in place supports to help people throughout their recovery journey.**

Indicators

General

- Measure of Stigma (to be developed);
- Proportion of people in treatment who receive support to access services that promote recovery;
- Number of people involved in recovery communities or mutual aid supports; and
- Outcomes for those in recovery communities or mutual aid supports.

Consultation Question 11 – Do you agree these indicators help to demonstrate progress against this outcome of empowering people? Are you aware of any other indicators that would demonstrate such progress?

Context

10.2 People who use substances have the same right to health as anyone else, and have the same rights as non-users to access other health services – their substance use should not be a barrier to accessing wider support. For some, this will mean access to prevention and early intervention, harm reduction, treatment and support. However, some will require further help and support, not only in relation to their substance use but also the circumstance in which they are born, develop, grow, live, work and age that enable them to live longer, more active, healthier lives.

10.3 People with alcohol and drug problems are also some of the most vulnerable and excluded people within our communities and society. They can experience

stigma, and discrimination, from others in their communities, from the media and from all of society. In particular they are at risk of violence from some paramilitary and vigilante groups, which can further stigmatise them and make them less likely to come forward for treatment and support. This is unacceptable and has to change.

Recovery

10.4 Recovery is a journey – it involves people setting their own goals and aspirations, and being respected and supported to achieve this. It must also be recognised that part of the recovery journey can often involve relapse. For some people, reducing harm and stabilising their lives will be the goal, some may wish to reduce harm from and intake of their primary substance of use, and for some it might mean a move to abstinence. It is important that we value all these goals and empower people to support them. These goals may also be dynamic over time and this is why person-centred approaches are vital.

10.5 We also need to give hope to individuals and show them that their lives matter. By making recovery more visible to them, we have the opportunity to signal that individual lives matter, that positive change can be achieved and that support can be provided to people throughout their recovery journey.

10.6 Social isolation can be a real issue for those using substances and their families, including during their recovery journey. There is the potential to use recovery communities to provide safe spaces for people to connect with others on their journey and to support each other.

10.7 We also need to ensure that all our approaches, projects and services are informed by service users, their families, and other experts by experience. They have much they can add from their perspective that can improve the effectiveness and quality of our services. By listening to people who have experienced these issues, by involving them in co-designing and co-producing our services and responses, by being prepared to be challenged by their views and sharing power to make changes, we can develop new and innovative solutions to meet the challenges we are facing.

Evidence

10.8 The Health Research Board in Ireland published "*The effectiveness of interventions related to the use of illicit drugs: prevention, harm reduction, treatment and recovery. A review of reviews*"[79] which includes evidence in relation to recovery and re-integration that has informed this chapter. In addition, the UK Advisory Council on the Misuse of Drugs established a specialist Recovery Committee that has been providing advice and guidelines in respect of the recovery agenda[80]. There are also relevant NICE Guidelines[81].

Actions

10.9 The following actions are proposed to support progress against the outcome and indicators, based on the wider context and the evidence of what works in terms of recovery.

General	
E1	The Department of Health, the PHA and the HSCB will work with experts and key stakeholders, including those with lived experience, to address stigma as a way of reducing barriers to seeking treatment, to improve prevention and to reduce harm.
E2	We will build on the regional structure in place to support the involvement of experts by experience, service users and their families at all implementation levels of this strategy, from policy development to local service design and delivery.
E3	The PHA, the HSCB and Health & Social Care Trusts will work with service users and their families to support the development and commissioning of recovery communities, mutual aid and peer-led support including research throughout Northern Ireland.
E4	Learning from support provided in relation to deaths by suicide, the PHA will develop material and services for those bereaved by substance use. Acknowledging the complexity of these issues and the potential stigma,

[79] https://www.drugsandalcohol.ie/27253/1/fHB2656_Review%20of%20reviews_web.pdf
[80] https://www.gov.uk/government/organisations/advisory-council-on-the-misuse-of-drugs
[81] https://www.nice.org.uk/guidance/qs23/chapter/Quality-statement-7-Recovery-and-reintegration

	these should be built into existing bereavement supports and not a stand-alone service.
E5	The Department of Health will liaise with the Department for the Economy on how to ensure that there are no barriers for service users in accessing employability training and support.
E6	The Department of Health will liaise with the Northern Ireland Housing Executive and the Department for Communities on how to reduce homelessness among, and improve access to housing for, service users.

Consultation Question 12 – Will these actions achieve this outcome of empowering people and will they make positive impacts on the indicators? Which actions would you prioritise if they cannot all be taken forward or are there other actions likely to have a bigger impact?

11. OUTCOME F – INFORMATION, EVALUATION AND RESEARCH BETTER SUPPORTS STRATEGY DEVELOPMENT, IMPLEMENTATION AND QUALITY IMPROVEMENT

Introduction

11.1 **The focus of this chapter is on how we can improve our knowledge of what works and the impact we are having to ensure this strategy is delivering its aims and objects. It also focuses on ensuring that research and evidence feeds strategy and policy development, implementation and good practice.**

Indicators

11.2 These are enabling measures so we do not propose having specific indicators for this outcome chapter.

Monitoring

11.3 We have a range of information from surveys, hospital data, justice data, service data, etc., and it is vital that this information is collated, analysed and made available to all key stakeholders in a transparent and usable format. In addition, we need to review the monitoring information we are collecting to ensure it is fit for purpose and is required – data should not be collected unless it serves a purpose for strategic/policy development or performance management so as to focus on the information that provides the greatest insight.

11.4 We also need to ensure we take opportunities to benefit from new data sources as they come on-stream. We must also be aware of the importance of gathering the same data over a significant amount of time to ensure trends are captured and properly understood.

11.5 The sharing of information between services is a key challenge and one that we must look to address to reduce the burden on service users and to fully manage risk across all key stakeholders. All information sharing will be in line

with the requirements of the Data Protection Act 2018 (DPA) and the General Data Protection Regulation (GDPR) (EU) 2016/679.

Outcomes Based Evaluation

11.6 There are a range of new actions that will be developed by partners in the delivery and implementation of this strategy. In line with the Evaluation, Evidence and Good Practice-Based value and principle for this strategy, as well as the approach taken by the Programme for Government, these should be monitored and/or evaluated on the basis of the outcomes they achieve in terms of making people's lives better and not just on process information and data. This is particularly important for new actions or innovative approaches, where the evidence may not yet point in a clear direction.

11.7 We commit that the findings from these outcome-based evaluations will be used to directly inform decision-making in both the long and short term.

11.8 As at present, no funding will be provided to projects, services or organisations which do not provide outcome or evaluation data.

Research

11.9 We also need to recognise that while we broadly know "what works", there are still many areas were evidence is lacking and outcomes are unclear. Many organisations collect and use data in various formats, so there must be a method to allow for data linkages to made, in line with GDPR requirements. In addition, substance use is dynamic so trends can change quickly and we need to ensure we have access to quickly available evidence and research that is specific to the needs of the people in Northern Ireland, as well as evidence from a national or international perspective. A planned and comprehensive research programme will therefore be essential to ensuring this strategy remains up-to-date and evidence informed as its implementation moves forward.

Actions

11.10 The following actions are proposed to achieve the outcome in relation to information, evaluation and research.

General	
F1	The Department of Health will publish regular update reports on the implementation of this strategy, outlining progress against its outcomes, indicators and actions.
F2	Consideration will be given to developing or amending current monitoring mechanisms to ensure these are robust and fit-for-purpose.
F3	The HSCB will develop an outcomes framework for all Tier 3 and Tier 4 services to monitor the impact and effectiveness of these services. Tier 1 and 2 services commissioned by the PHA will continue to be required to complete the Impact Measurement Tool.
F4	A funded two-year research programme will be developed to meet the needs of the development and implementation of this strategy. A new cross-sectoral sub-group will be established to support the development and oversight of this programme. This sub-group will also consider linkages between research in this sector as well as legacy of research.

Consultation Question 13 – Will these actions achieve this outcome of better information, evaluation and research? Which actions would you prioritise if they cannot all be taken forward, or are there other actions likely to have a bigger impact?

12. MAKING IT HAPPEN – GOVERNANCE and STRUCTURES

Introduction

12.1 **It is essential that robust governance structures are put in place to ensure that the final strategy is overseen and delivered in line with the final agreed vision, and that outcomes are achieved – measured via positive progress on indicators – through the delivery of the agreed actions. This chapter will outline the proposed delivery structure for the new strategy, seeking to achieve alignment from the strategic to the local level.**

Structures

Strategic Level

12.2 As set out earlier in this document, it is vital that we see substance use within our wider approach to improving health and addressing health inequalities. It is therefore proposed that the Cross-Departmental Ministerial Committee on Public Health, which oversees the delivery of *Making Life Better* at the Executive level, provides the overall Ministerial governance for this Strategic Framework.

12.3 In order to support and advise the Ministerial Committee on Public Health, a new cross-sectoral/cross-departmental Programme Board will be established to drive forward and oversee the implementation of *Preventing Harm, Empowering Recovery*. The membership of the Programme Board will cover heath, justice, academics, community/voluntary sector, local government and vitally service users, their families, and other experts by experience. The Programme Board will establish policy advisory sub-committees on specific elements of the strategy as required.

Regional Delivery

12.4 The Public Health Agency and the Health & Social Care Board will establish a new Regional Implementation Board to oversee the delivery of the strategy within the Health & Social Care Sector, and to align with key partners in other sectors. To avoid duplication and to ensure alignment of the strategic direction across both this strategy and the forthcoming Mental Health Strategy, this

implementation board will also serve as part of the governance and delivery structures for the Mental Health Strategy.

12.5 The Organised Crime Task Force Drugs Group will continue to co-ordinate enforcement activity and intelligence sharing at the regional level. The Drug & Alcohol Monitoring & Information System (DAMIS) and Drug Deaths intelligence sharing will remain key agendas for this group. There will also be closer cooperation with relevant agencies in Ireland so that there can be early warnings of trends on a cross-border basis.

Local Delivery

12.6 *Preventing Harm, Empowering Recovery* clearly recognises that local assessment of need, and the development and delivery of services, programmes and initiatives to meet these needs, is paramount to address these issues effectively. It is therefore vital that local structures are in place that support these functions. Previously these had been delivered through the local Drug and Alcohol Co-ordination teams (DACTs), supported by the PHA and the DACTs Connections Service.

12.7 However, the local delivery landscape has changed dramatically in recent years. Policing and Community Safety Partnerships (PCSPs) are now well established and Community Planning structures at local government level also now exist. We believe there is still a need for local partnerships focused specifically on the harm related to the use of alcohol and other drugs, however, it would now be appropriate for the PHA to review the role, function and membership of Drug & Alcohol Co-ordination Teams, supported by DoH and other partners, to ensure they are effective and strategically placed to inform, support and monitor the delivery of *Preventing Harm, Empowering Recovery*. This review should include an assessment of the linkages and overlaps with other local delivery structures. DACTs will remain in place until this review is completed.

Consultation Question 14 – Do you agree with the proposal to review the role, function and membership of DACTs, and consider linkages with other local delivery structures?

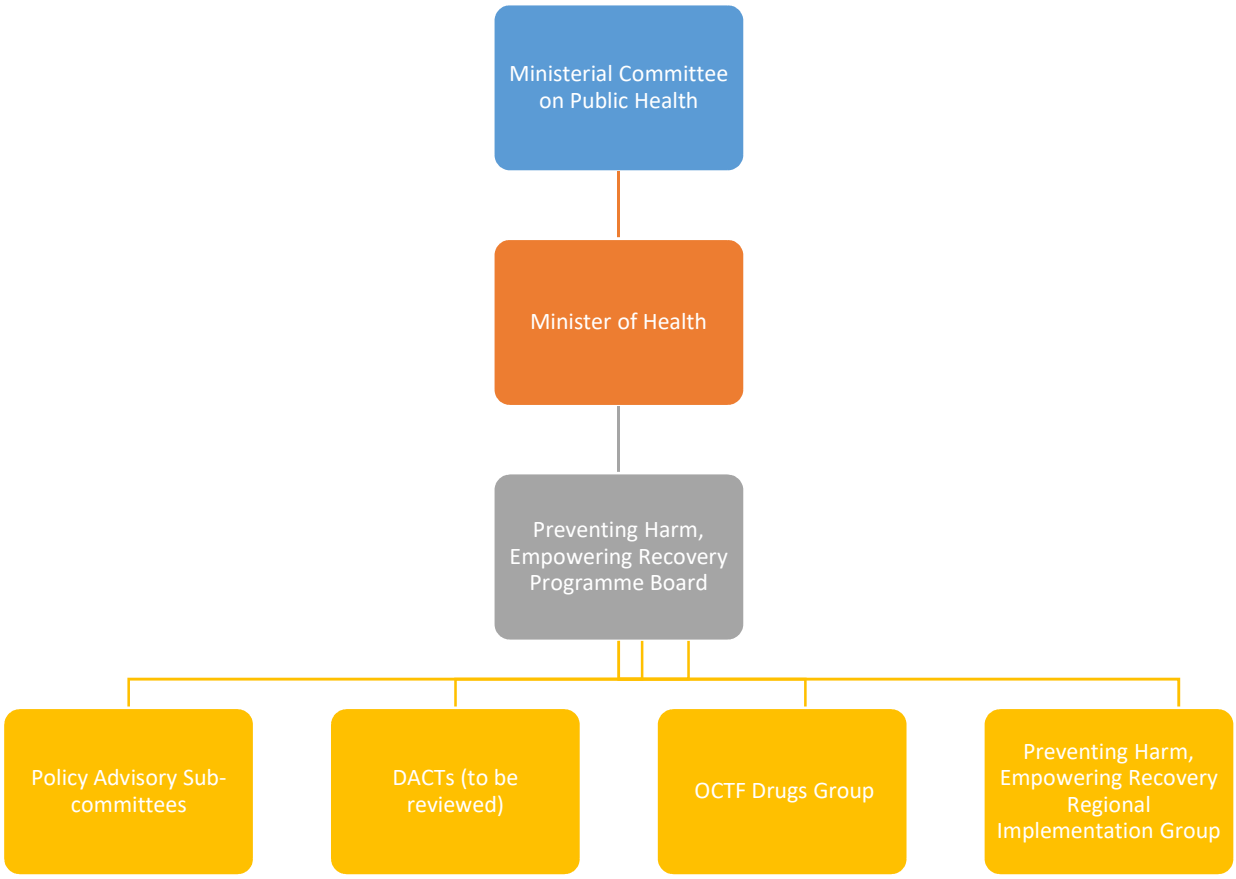
Involvement of Service Users and the Community and Voluntary Sector

12.8 Given that "Shared Responsibility, Co-Production & Collaboration" is proposed as a key value in the development and implementation of *Preventing Harm, Empowering Recovery,* service users must be represented at every level of the strategy's governance structures – from the Programme Board, to the sub-committees, to DACTs (to be reviewed), down to being involved in the design and implementation of local services. The experience and expertise of service users should be central to everything we take forward.

12.9 Similarly the community and voluntary sector play a key role in identifying issues, proposing solutions, holding the public sector to account, and advocating for their local communities and clients. It is essential that their voices are heard throughout the governance structures for *Preventing Harm, Empowering Recovery* – with membership at the programme board, the sub-committees, and DACTs (to be reviewed).

Overall Structure

12.10 We are therefore proposing the governance structure would look like the below:



Consultation Question 15 – Do you agree with the proposed governance structures? Have you any further comments?

Funding

12.11 Currently DoH invests approximately £16 million per year in delivery of the previous strategy. However, it is difficult to estimate the total funding that supported the implementation of the NSD Phase 2 as additional resources, both financial and people, were invested in its supporting actions. For example, a proportion of the Police Service of Northern Ireland budget will be spent on reducing supply, and a proportion of the Education budget will be spent on resilience and knowledge raising but it is impossible to disaggregate these out from overall budgets and universal approaches.

12.12 Following this consultation process, and the finalisation of actions, we will need to determine what funding is required to deliver on the new strategy.

Timeframe

12.13 While this is a long term strategy, it should operate initially for a five-year period before being revised and updated in light of circumstances at that time. It may be that the strategy is fully reviewed and a new one developed, or that a new action plan developed, within the overall policy framework, to be delivered in the following 3 to 5 years.

Consultation Question 16 – Do you agree with the Timeframe proposed? Have you any further comments?

ANNEX I

REVIEW OF THE NEW STRATEGIC DIRECTION FOR ALCOHOL AND DRUGS TERMS OF REFERENCE JULY 2017

INTRODUCTION

The New Strategic Direction for Alcohol and Drugs (NSD) Phase 2 is the Executive's cross-departmental strategy for preventing and addressing the harm related to substance use in Northern Ireland. It followed on from the original New Strategic Direction for Alcohol and Drugs which was reviewed and updated in 2011/12. The NSD has been a living document with additional action and priorities added during its life.

Detail

The original NSD had a five-year life span (covering the period 2006 to 2011). During 2009 and 2010, discussions were undertaken by the NSD Steering Group, the Advisory Groups, the Health and Social Care sector, and other key stakeholders on how these issues could be taken forward once the NSD ended.

It was initially agreed that an update document be developed to see how effective the NSD was in terms of delivering on its aims and objectives. This document looked particularly at the progress against the NSD's key priorities, completion of the NSD outcomes, and progress against its indicators.

Overall, the update was very positive, and it highlighted much progress in key areas. It also raised a number of areas where not as much progress had been made as originally anticipated and which would require further work. It also highlighted that a number of the strategic drivers had changed during the period 2006-2011, and that a number of new issues had emerged that were not originally a high priority within the NSD.

The NSD Steering Group acknowledged that significant progress had been made, but it also recognised that the timespan for the original NSD allowed a limited amount of time for a public health strategy to be embedded and, particularly, to change culture and behaviours.

Accordingly it was agreed that, rather than undertaking a full new strategic development process, the existing NSD (in light of the update document) would be reviewed, revised, and extended until 2016. This decision was taken to ensure a consistent approach on the issue over a ten-year period, and to ensure that resources continue to be directed at front-line services, programmes, and interventions.

This process would also allow the NSD Phase 2 to reflect new trends, and re-direct effort to where it is most needed or to where new issues/concerns are emerging.

Emerging Issues

As highlighted above, since the publication of the original NSD a number of issues had emerged – and these issues now have a greater prominence in NSD Phase 2. These emerging issues were identified, noted and considered by the NSD Steering Group and the relevant Advisory Groups. This process was also informed by the Independent

Sector Forums, the Advisory Council on the Misuse of Drugs, the British-Irish Council Drug Misuse Sectoral Group, and recent research. These issues were also acknowledged in the NSD Update Report. These emerging issues include:

- Prescription or Over-The-Counter Drugs
- Emerging Drugs of Concern / "Legal Highs"
- Families and Hidden Harm
- Recovery
- Mental Health, Suicide, and Drugs and Alcohol Misuse, Sexual Violence and Abuse, and Domestic Violence
- Alcohol; and
- Local funding

Consultation

NSD Phase 2 was issued for public consultation on 04 March 2011, and the process ran until 31 May 2011. In order to aid the analysis of the responses to the consultation, the Department provided a consultation 'Response Questionnaire'. The questionnaire focused responses on the main proposals in NSD Phase 2. In addition to this, respondents were encouraged to provide any general comments.

NSD Phase 2 Extension

NSD Phase 2 was originally anticipated to be a 5-year strategy document running from 2011 to 2016. However, there was a delay in publishing and implementing the final document while awaiting Executive approval. In addition, one of the key outcomes in the Strategy was the development and implementation of a Commissioning Framework for Alcohol and Drug Services. The process to develop this framework, and to commission services within its parameters, took longer than anticipated – meaning these services only came on-stream in financial year 2015/16.

The former Minister therefore agreed to extend the implementation of NSD Phase 2 by at least a year to give the strategy its full five years of implementation, allow the newly commissioned services time to bed in and to impact on the indicators and outcomes, and allow for a better fit in with the timescale for the Commissioning Framework.

AIM OF REVIEW

The aim of this review is to evaluate the impact of NSD Phase 2 on its aims of preventing and addressing harm related to substance use in Northern Ireland. This will be a comprehensive, inter-departmental evaluation, facilitated and led by DoH, which will consider fully the outputs of the strategy, i.e. what has been done and the outcomes, what difference this has made to people's lives, etc. It will also consider the effectiveness of the current NSD structures and make recommendations on the way forward.

SCOPE OF THE REVIEW

The review will consider three specific aspects of the implementation of the NSD Phase 2 strategy:

a. ***Outputs*** – i.e. the action which has been taken by Government Departments and their agencies, through the NSD structures, and the progress made.

b. ***Outcomes*** – i.e. – the impact that NSD Phase 2 has had on the range of indicators and outcomes it set out to achieve and the differences made for the public, service users and carers.

c. ***Stakeholder views and structures*** – a review of the views of key stakeholders on the delivery of the NSD and the associated structures, in the context of recent and emerging Government policy.

It will also consider the necessary actions and structures to take forward to prevent and address substance use following the end of the current Strategy.

Given the nature of the funding, and the interconnectedness of the actions and outcomes with other government strategies and actions, it will not explicitly deal with value for money at the strategic level – but the organisations delivering on individual actions should be continuously monitoring the value for money of these at that level.

TIMING OF ASSIGNMENT

The target date for completion of the NSD Review is 31 March 2018.

NSD Phase 2 will remain extant until the review is completed and, if deemed appropriate, a new strategy is put in place.

METHODOLOGY

Each Department/Agency with responsibility for actions within NSD Phase 2 will take ownership of the evaluation of their own actions. DoH will lead on the completion of the evaluation and collate input from other Departments/Agencies.

The methodology for carrying out this evaluation is as follows:

	Action	**Detail**
1	**Evaluation of Outputs**	The evaluation of outputs can be evaluated primarily using quantitative analysis. This will involve each Department/agency with responsibility for actions in the NSD Phase 2 gathering information on what action has been taken to implement their actions. DoH gathers monitoring information on the progress of the actions on an annual basis. This will be used as a basis for evaluating the outputs, however Departments will add to this with statistical information etc. where this is available.
2	**Evaluation of Outcomes**	The evaluation of outcomes requires gathering of quantitative analysis across a range of indicators and outcomes. As part of this exercise, Departments should cross-reference any reviews or evaluations completed by their Department or by Arms Lengths Bodies, community &

		voluntary sector, highlighting any relevant information or findings therein. DoH will collate the outcome analysis.
3	**Analysis of the Effectiveness of the NSD Phase 2 and its Structures**	On behalf of DoH, the Institute of Public Health in Ireland will lead a qualitative piece of work with key stakeholders on how effective they believe the NSD strategy has been to date, what learning there has been, what could come next, and the effectiveness of the structures and learning in this area.

ROLES AND RESPONSIBILITIES

The evaluation will be led by DoH with input from the other Departments and Agencies with responsibility for actions. IPH will lead the qualitative work with stakeholders – giving a greater independence to this work.

The NSD Steering Group act as the steering group for the review. Updates on progress will be given at each meeting.

The Health Minister will agree the review and seek comments and agreement from the Executive.

OUTPUTS AND TIMETABLE

Target date for completion of the evaluation is March 2018. An indicative timetable for the various phases of the evaluation is set out below.

OUTPUT	**TARGET DATE**
1. Agree Terms of Reference	Next NSD SG Meeting
2. Evaluation of Outputs and Outcomes of NSD Phase 2 Actions	End December 2017
3. Analysis of the effectiveness of NSD Phase 2 and its Structures	End February 2018
4. Develop Options for Way Forward	March 2018
5. Finalise Report and Sign off	End March 2018

ANNEX II

PRE-CONSULTATION EXERCISE TO SEEK VIEWS ON A SUCCESSOR STRATEGY TO THE NEW STRATEGIC DIRECTION FOR ALCOHOL AND DRUGS PHASE 2
TERMS OF REFERENCE
FEBRUARY 2019

Background
The Health Development Policy Branch (HDPB) within the Department of Health (DoH) is responsible for leading and co-ordinating action on Northern Ireland's substance use strategy across government departments, the Voluntary & Community Sector and other relevant agencies on a regional and local basis. The current strategy launched in 2012 – the ***New Strategic Direction for Alcohol & Drugs Phase 2*** (NSD Phase 2) – is taken forward under the structures and mechanisms set up under NSD Phase 2 endorsed by the former NI Executive in 2012.

DoH recently reviewed and evaluated the implementation of this strategy in order to evaluate its effectiveness and is now moving forward to the next phase of the process which is to seek views on what should be included in a possible successor strategy. As part of this process, it is intended to carry out a pre-consultation exercise to help inform the development process. Separate pieces of work will look at both the evidence base and developing a successor strategy. Subject to approval, further formal public consultation would take place on any new proposed substance use strategy whenever Ministers are in place to make decisions.

The NSD Phase 2 Review Report is available online at: https://www.health-ni.gov.uk/publications/alcohol-and-drug-misuse-strategy-and-reports

Tasks
As part of the exercise, it will be necessary to seek out the views of a wide range of individuals, organisations, agencies, and groups. The following tasks will be carried out:

- conduct a pre-consultation exercise to help inform the development of strategic recommendations for addressing alcohol and drug-related harm in Northern Ireland to follow on from NSD Phase 2;
- collect data and evidence from the general public, interested groups, organisations involved in substance use, individual projects, healthcare professionals from the statutory, community and voluntary sector and others;
- collate said data and evidence to be set within pre-defined themes; and
- produce summary reports of data and evidence within above themes for consideration by the Advisory Group and the NSD Steering Group.

It is envisaged the data collection will primarily involve the following three elements:

- an Online Survey (using Citizen Space)
- a series of Focus Group events / workshops (aligned with the process led by the PHA and the HSCB in relation to the revision of the Regional Commissioning Framework for Alcohol and Drug Services); and
- Bi-Lateral Meetings.

It is anticipated that, as per the recommendations in the review, the pre-consultation process will be taken forward in line with an outcomes based accountability approach.

Project Requirements
In order to facilitate the development of the Pre-Consultation Exercise, a small Advisory Group will be established and tasked with looking at specific issues and developing strategic recommendations to be included in a successor strategy to NSD Phase 2. This Group will ensure adherence to the NICS document A Practical Guide to Policy Making in Northern Ireland. The group will report to the NSD Steering Group – which will retain strategic oversight of the process.

Membership will consist of officials & representatives as appropriate from: DoH, DoJ/PSNI, PHA/HSCB, the Chairs of DACTs, NIADA and RSUN/SU reps.

Roles & Responsibility

HDPB will:
- develop a framework, in consultation with the Advisory Group, for undertaking the pre-consultation process as described, including a detailed work plan which outlines proposed methodology;
- make all necessary arrangements for the focus group events i.e. venue, dates, timetables, materials and equipment. DoH will identify potential participants and provide a list of points of contact;
- provide regular progress reports to the Advisory Group;
- provide data/evidence and summary reports to the NSD Steering Group; and
- provide any additional analysis felt appropriate for the Pre-Consultation Exercise.

The Advisory Group will:
- provide expert advice and guidance;
- inform the development of the consultation framework;
- support the identification of stakeholders and engagement opportunities; and
- support the development of final report.

Timescales & Deliverables
DoH intends to commence this process during February 2019, to be undertaken in line with the Review of the Alcohol & Drugs Commissioning Framework led by the PHA. All work associated with this pre-consultation exercise should be completed by 31 December 2019.

DoH reserves the right to extend the project's timescale to enable the Pre-Consultation Exercise to be fully completed in accordance with this Terms of Reference. There should be a contingency for a further 3 months under the Project Requirements of these TOR.

OUTPUTS AND TIMETABLE
Target date for completion of the Pre-Consultation Exercise is 31 December 2019. An indicative timetable for the various phases of this exercise is set out overleaf.

OUTPUT	TARGET DATE
4. Agree Terms of Reference	08 March 2019
5. Devise Online Survey Questionnaire for Completion	19 April 2019
6. Hold Focus Groups / Pre-Consultation Events	May/June/July 2019
7. Hold a series of Bi-Lateral Discussions	May/June 2019
8. Complete Analysis of the responses for consideration by Advisory Group	30 September 2019
6. Draft Summary Report, including Options/Recommendations for Way Forward	30 September 2019
7. Present Report to NSDSG and sign off	NSD Meeting following completion of 6.

It is important to note that the outputs listed above relate solely to this pre-consultation exercise. Work will be undertaken separately by HDPB to examine the evidence base and also to begin development of a possible successor strategy for public consultation.

GDPR / Retention of Data / Intellectual Property

The General Data Protection Regulation (GDPR), which came into force on 25 May 2018, requires all of us to process personal data in accordance with the data protection principles: https://www.health-ni.gov.uk/articles/health-development-policy-branch-and-health-improvement-policy-branch-steering-groups-privacy-notice

Any data collected by HDPB shall remain the intellectual property of the Department of Health. Once commissioned, all documents/results of the study will become the property of DoH who are the accounting department for HDPB. This will include all questionnaires/survey documents used to inform the summary report.

Any online questionnaires / survey documents completed & returned to the HDPB will become the property of DoH. The results of this pre-consultation exercise will also become the property of the Department.

References

Relevant documents are available on the DoH website at:
https://www.health-ni.gov.uk/publications/alcohol-and-drug-misuse-strategy-and-reports

https://www.health-ni.gov.uk/articles/alcohol-statistics

ANNEX III

PRE-CONSULTATION EXERCISE: SUMMARY of RESPONSES

NOVEMBER 2019

Background

Endorsed by the former NI Executive and launched in 2012, Northern Ireland's current cross-sectoral substance use strategy – the ***New Strategic Direction for Alcohol & Drugs Phase 2*** (NSD Phase 2) – was recently reviewed and evaluated in order to evaluate the effectiveness of its implementation. The NSD Phase 2 Review Report is available online at: https://www.health-ni.gov.uk/publications/alcohol-and-drug-misuse-strategy-and-reports.

In line with an Outcomes Based Accountability approach (as per the recommendations in the Final Review Report), the review process moved forward to the next phase by carrying out a pre-consultation exercise in order to seek views on what should be included in a possible successor strategy, and to help to inform the future strategy development process. The pre-consultation process is an attempt to seek collective agreement on the need for a new strategy, and on the Outcomes, Indicators and Priority Areas it should target.

The overall aim is to agree a collective vision before moving on to the more detailed action that will subsequently be taken to develop proposals for any new substance use strategy going forward. Subject to the political situation and having obtained the necessary approval to proceed, the intention is to have a further formal public consultation on these proposals in early 2020.

Pre-Consultation Exercise – Process / Approach

The Online Survey was launched on **17 May 2019** with an original closing date of 09 August 2019, which was later extended to **06 September 2019**.

Adopting a blank page approach, the pre-consultation sought the views of a wide range of individuals, organisations, agencies and groups by:

- conducting a pre-consultation exercise to help inform the development of strategic recommendations for addressing alcohol and drug-related harm in Northern Ireland to follow on from NSD Phase 2;
- collecting data and evidence from the general public, interested groups, organisations involved in substance use, individual projects, healthcare professionals from the statutory, community and voluntary sector and others;
- collating data and evidence within pre-defined themes;
- producing a summary report of data and evidence for consideration by the Pre-Consultation Advisory Group and the over-arching NSD Steering Group.

The data collection primarily involved the following 3 elements:

- an Online Survey using Citizen Space;
- a series of engagement events / Focus Groups / workshops
- Bi-Lateral Meetings.

Data Analysis

57 responses were received in total, with 15 responses received from individuals and 42 responses received from organisations. (Online Survey via Citizen Space = 30; Word / pdf versions received from organisations = 27).

The survey was mainly designed to capture views on the need for a new strategy and seek agreement on the Outcomes, Indicators and Priority Areas it should target.

Most of the survey questions contained open text fields to allow submission of views and supporting evidence. A few questions allowed a quantitative analysis in order to provide a high-level overview of what approach respondees felt should be adopted and what should be included for consideration when developing proposals for a new strategy. It should be noted however some respondents did not complete the actual survey template and merely provided submissions to the Department, meaning that all the questions were not answered and accordingly the figures below are skewed somewhat – the views represented in these submissions were captured where appropriate.

In addition to the Online Survey, a number of engagement events and meetings were held, where attendees were encouraged to respond to the survey and where views and comments were recorded – these are broadly reflected and represented in the analysis below. In order to provide more localised flavour, each DACT also arranged events specific to their respective areas and collective responses were submitted. Similar meetings were held with service users, local community fora and DACTs/PCSPs.

Overview:

4. Does NI still need a substance use strategy?

Yes = 81%; No = <2%

5. Should any new strategy continue to cover both Alcohol & Drugs?

Yes = 81%; No = <2%

6. If still a combined strategy, should Alcohol & Drugs have equal priority?

Yes = 72%; No = 7%

8. Should a future strategy have a set of Values & Principles?

Yes = 72%; No = 0%

Outcomes & Indicators:

11. What do you believe the Key Focus of any new strategy should be?

- Early Intervention 79%
- Harm Reduction 75%
- Recovery 72%
- Treatment & Support 72%
- Prevention 72%
- Supply Reduction 44%
- Regulation, Legislation & Enforcement 40%
- Other 33%

Actions & Gaps:

17. Have you any views on where existing or additional resources should be prioritised?

- Early Intervention 68%
- Prevention 65%
- At-Risk Population Groups 58%
- Treatment & Support 58%
- Harm Reduction 53%
- Recovery 47%
- Regulation, Legislation & Enforcement 25%
- Supply Reduction 23%
- Other 12%

18. Do you believe the strategy should prioritise any of the At-Risk Population groups below?

- Young People 60%
- Homeless People 60%
- People Living in Areas of Multiple Deprivation 56%
- Pregnant Women 40%
- People Living in Rural Areas 39%
- Older People 32%
- Single Parents 28%
- Other 28%

ANNEX IV

Substance Use Strategy Writing Group
January 2020

Draft Terms of Reference

Background

The Health Development Policy Branch (HDPB) within the Department of Health (DoH) is responsible for leading and co-ordinating action on Northern Ireland's substance use strategy across government departments, the Voluntary & Community Sector and other relevant agencies on a regional and local basis. The current strategy launched in 2012 – the ***New Strategic Direction for Alcohol & Drugs Phase 2*** (NSD Phase 2) – is taken forward under the structures and mechanisms set up under NSD Phase 2 endorsed by the former NI Executive in 2012.

DoH recently reviewed and evaluated the implementation of this strategy in order to evaluate its effectiveness and is now moving forward to the next phase of the process which is to seek views on what should be included in a possible successor strategy. The NSD Phase 2 Review Report is available online at: https://www.health-ni.gov.uk/publications/alcohol-and-drug-misuse-strategy-and-reports

Subsequently the Department undertook a pre-consultation process to begin the development of the new substance use strategy. The outcomes of this process are included at Annex A.

Following a commitment within "New Decade, New Approach", the Department is now leading a co-production process to develop a new substance use Strategy.

Status

The cross-sectoral Substance Use Strategy Writing Group has been established by the Department of Health, on a task and finish basis, to co-produce a formal consultation on a new substance use strategy.

Constitution

The Writing Group shall be a Task & Finish Group set up to initially meet for a limited period (up to 6 months) to develop a draft Substance Use Strategy consultation document, with further meetings held as required to finalise the Strategy following public consultation as required. The process for the work shall be agreed at the first meeting.

Membership

Membership of the Writing Group shall comprise of representatives as detailed on the attached membership list with others being co-opted as required to provide additional expertise. Taking account of timeframe & diary availabilities etc., members should ensure deputies can attend when required to maintain consistent organisational

representation. If all members are unable to attend a particular meeting, a quorum of the Writing Group will agree actions for taking forward whenever the situation merits, with further comments invited electronically.

Objective

To provide strategic advice in respect of substance use and draft a strategy for substance use. Specific information gathering, analysis and drafting duties may be assigned to members of the Group.

Timeframe

Draft Substance Use Strategy to be published for public consultation by no later than July 2020. An interim report on progress will be available within 3 months.

The formal Public Consultation will then last for 12 weeks.

Secretariat

The group will be overseen and chaired by Health Development Policy Branch, DoH who will also provide the Secretariat.

ANNEX V

GLOSSARY OF TERMS

ACEs	Adverse Childhood Experiences
ACMD	Advisory Council on the Misuse of Drugs
ARBD	Alcohol-Related Brain Damage
BBV	Blood Borne Viruses
CAMHS	Child and Adolescent Mental Health Services
CMO	Chief Medical Officer
COVID	Coronavirus Disease
CSCA	Children's Services Co-operation Act
DACTs	Drug and Alcohol Coordination Teams
DAMHS	Drug and Alcohol Mental Health Service
DAMIS	Drug and Alcohol Monitoring and Information System
DANOS	Drug and Alcohol National Occupational Standards
DE	Department of Education
DfC	Department for Communities
DfE	Department for the Economy
DfI	Department for Infrastructure
DoH	Department of Health
DoJ	Department of Justice
DTORS	Drug Treatment Outcomes Study
EIR	Environmental Information Regulations
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
EU	European Union
FOIA	Freedom of Information Act
GDPR	General Data Protection Regulation
HDPB	Health Development Policy Branch in the Department of Health
HSC	Health and Social Care
HSCB	Health and Social Care Board
HSCTs	Health and Social Care Trusts
IMT	Impact Measurement Tool
IPH	Institute of Public Health in Ireland
JIM	Joint Implementation Model of the Drug and Alcohol Strategies
LGBT	Lesbian, Gay, Bisexual, and Transgender
MUP	Minimum Unit Pricing
NEET	Those not in Education, Employment or Training
NI	Northern Ireland
NIADA	Northern Ireland Alcohol and Drugs Alliance
NIAO	Northern Ireland Audit Office
NICE	National Institute of Clinical Excellence
NIHE	Northern Ireland Housing Executive
NSAPAG	North South Alcohol Policy Advisory Group
NSD	New Strategic Direction for Alcohol and Drugs
NSES	Needle and Syringe Exchange Scheme
OCTF	Organised Crime Task Force
OST	Opioid Substitution Therapy

PCSPs	Policing and Community Safety Partnerships
PfG	Programme for Government
PHA	Public Health Agency
PHE	Public Health England
Polydrug	The use of several, typically illegal, drugs together.
PSNI	Police Service of Northern Ireland
RSUN/SU	Regional Service User Network/Service User
SEHSCT	South Eastern Health and Social Care Trust
SG	Steering Group
Trusts	Health and Social Care Trusts
UK	United Kingdom
WHO	World Health Organisation
WHSCT	Western Health and Social Care Trust

ANNEX VI

FULL LIST OF CONSULTATION QUESTIONS

No.	Question	Page No.
1	Have you any comments on either the Equality/Good Relations or Rural screening documents? Have you anything you believe we should be considering in future Equality/Good Relations or Rural screenings?	8
2	Do you agree with the Vision, Outcomes, Values, Priorities and Target Groups as set out in this chapter? Have you any further comments?	42
3	Do you agree these indicators help to demonstrate progress against this outcome of having fewer people at risk of harm? Are you aware of any other indicators that would demonstrate such progress?	43
4	Will these actions achieve this outcome of having fewer people at risk of harm and make positive impacts on the indicators? Which actions would you prioritise if they cannot all be taken forward or are there other actions likely to have a bigger impact?	48
5	Do you agree these indicators help to demonstrate progress against this outcome of legislation and the justice system preventing and reducing harm? Are you aware of any other indicators that would demonstrate such progress?	49
6	Will these actions achieve this outcome of legislation and the justice system preventing and reducing harm? Will they make positive impacts on the indicators? Which actions would you prioritise if they cannot all be taken forward or are there other actions likely to have a bigger impact?	55
7	Do you agree these indicators help to demonstrate progress against this outcome of reducing harm? Are you aware of any other indicators that would demonstrate such progress?	56
8	Will these actions achieve this outcome of reducing harm and will they make positive impacts on the indicators? Which actions would you prioritise if they cannot all be taken forward or are there other actions likely to have a bigger impact?	61
9	Do you agree these indicators help to demonstrate progress against this outcome of accessing treatment? Are you aware of any other indicators that would demonstrate such progress?	62

10	Will these actions achieve this outcome of accessing treatment and will they make positive impacts on the indicators? Which actions would you prioritise if they cannot all be taken forward or are there other actions likely to have a bigger impact?	68
11	Do you agree these indicators help to demonstrate progress against this outcome of empowering people? Are you aware of any other indicators that would demonstrate such progress?	69
12	Will these actions achieve this outcome of empowering people and will they make positive impacts on the indicators? Which actions would you prioritise if they cannot all be taken forward or are there other actions likely to have a bigger impact?	72
13	Will these actions achieve this outcome of better information, evaluation and research? Which actions would you prioritise if they cannot all be taken forward or are there other actions likely to have a bigger impact?	75
14	Do you agree with the proposal to review the role, function and membership of DACTs, and consider linkages with other local delivery structures?	77
15	Do you agree with the proposed governance structures? Have you any further comments?	79
16	Do you agree with the Timeframe proposed? Have you any further comments?	79

ANNEX VII

SUMMARY OF OUTCOMES & ASSOCIATED ACTIONS

OUTCOME A

Fewer People are at Risk of Harm from the Use of Alcohol and Other Drugs.

ACTIONS:

No.	Action	Lead(s)
A1	The Department of Health will work with the Department of Education to ensure that Substance Use and Hidden Harm are included as appropriate in the work emerging from the Emotional Health & Wellbeing Framework for Children and Young People being led by the Department of Education.	DE DOH
A2	A Northern Ireland Prevention Approach, based on up-to-date evidence and an analysis of the risk and protective factors impacting our young people, will be developed by the PHA and delivered in Northern Ireland and reviewed after 5 years – while this will be a universal programme, it should also be targeted at those at most risk and those in disadvantaged communities.	PHA DE Local Gov DoJ Other Gov Depts
A3	The PHA will update the drugandalcoholni.info website with up-to-date information in terms of substance use, support materials and the services available in Northern Ireland.	PHA
A4	The current community support mechanisms will be reviewed by the PHA to ensure they can support the local implementation of this strategy in the community, promote prevention, collaboration and access to services.	PHA
A5	Targeted prevention and early interventions will continue to target those young people most at risk of substance use, including looked after children, etc. Establishing effective operational relationships, including with local Youth Services, will assist in the success of this action.	PHA DE
A6	The Making Every Contact Count programme in primary care will include brief interventions and advice in respect of alcohol and drug use.	HSCB
A7	The HSCB and the PHA will ensure that the Substance Use Liaison role will be included as part of the new Mental Health Service model operating across general hospitals / Emergency Departments.	HSCB PHA
A8	The Hidden Harm Action Plan will be updated by the PHA and the HSCB to ensure that supports are in place, in a stepped care approach, to mitigate the risk for those children and young people who live with substance misusing parents or carers, in particular the Joint Working Protocol on Hidden Harm will be promoted and used across all services.	PHA HSCB DE
A9	The PHA will promote and raise awareness of the UK Chief Medical Officer low-risk drinking guidelines and understanding of alcohol units across the region.	PHA DOH
A10	The Department for Infrastructure will seek to improve access to its Course for Drink Drive Offenders scheme – a rehabilitation scheme that aims, through education, to make drink drive offenders take more responsibility for their actions and reduce the risk of re-offending.	DfI
A11	The PHA will promote raising awareness of the harm associated with the illicit use of prescribed medicines and also the harm associated with polydrug use. This will include working with HSCB to promote awareness across primary and secondary care healthcare providers.	PHA HSCB

OUTCOME B

Legislation and the Justice System Support Preventing and Reducing the Harm related to Substance Use.

ACTIONS

No.	Action	Lead(s)
B1	Following evaluation of the Problem Solving Justice initiatives, further consideration will be given to their effectiveness and the need to further scale up these approaches across Northern Ireland, together with the wider roll-out of Enhanced Combination Orders/Community Resolution Notices for drug possession and drug-related offences.	DoJ
B2	Appropriate services, and treatment where applicable, should be provided to those who come into contact with the justice system. As part of this, a new transition service will be developed and tested by the SEHSCT Prisons Healthcare team. This will aim to better coordinate the continuity of care for those being released from prison into the community, including connections towards ongoing appointments and treatments. Service users will be navigated towards the community/voluntary sector and peer support as an integral part of these arrangements.	SEHSCT DoJ PHA HSCB
B3	Work on a new Liquor Licensing Bill being taken forward by the Department for Communities provides an opportunity to strengthen alcohol licensing laws in Northern Ireland and ensure it takes account of public health issues.	DfC DoH
B4	The Department of Health will bring forward a consultation on the introduction of Minimum Unit Pricing for Alcohol in Northern Ireland within a year.	DoH
B5	The Department of Health will work with the UK Government to tighten restrictions on the advertising of alcohol, including giving consideration to the introduction of a 9pm “watershed”.	DoH
B6	The Department for Infrastructure will introduce the lower drink driving limits agreed by the NI Assembly in 2016. It will continue to monitor the effects of legislation in Great Britain and Ireland that introduced certain drug driving limits, before developing proposals for any change to drug driving laws here.	DfI
B7	The NI Executive will work with the UK Government, and the Advisory Council on the Misuse of Drugs, to ensure the Misuse of Drugs Act 1971 reflects the needs of Northern Ireland and supports the delivery of the outcomes and indicators in this strategy.	DoH
B8	The PSNI and the Organised Crime Task Force will continue to co-ordinate enforcement activity and ensure that those involved in the illicit supply and distribution of drugs are targeted appropriately.	PSNI OCTF DoJ

OUTCOME C

Reduction in the Harm Caused by Substance Use.

ACTIONS

No.	Action	Lead(s)
C1	The PHA will continue to develop and expand highly accessible Low Threshold Services to meet the growing needs of those who use alcohol and other drugs.	PHA
C2	The PHA and HSCB will lead a process to develop a joined-up and integrated intensive outreach service to specifically identify and support those most at risk of alcohol and drug related deaths. It is vital that this links with existing statutory services, community and voluntary sector services, homeless services, and suicide prevention services.	PHA HSCB
C3	Increased screening and testing for blood borne viruses for those in treatment, with support to access follow-up treatment and support, including peer-led services.	PHA HSBC HSCTs
C4	Suicide prevention training will be provided to all staff working in substance use related services.	PHA HSCB
C5	The Department of Health, the Department of Justice and the PHA will continue to grow and expand the Drug & Alcohol Monitoring & Information System to ensure that up-to-date information on current trends is available to those at risk and shared with relevant key services.	DoH DoJ PHA
C6	A process of strategically reviewing alcohol and drug related deaths at a regional level will be established under the Organised Crime Task Force to share trends and inform policy and practice.	OCTF
C7	The PHA and the HSCB will work with experts to develop an Overdose & Relapse Prevention Framework to target those at most risk.	PHA HSCB
C8	The PHA will continue to develop and expand the Needle & Syringe Exchange Scheme, both within community pharmacies and within the community, to ensure adequacy of exchange services. This will include establishing measurement of packs distributed per person, with the aim of ensuring that we meet the WHO target of 200-300 sterile needle and syringe sets distributed per person per year.	PHA
C9	The PHA will expand the capacity of naloxone provision to people who use drugs, their peers, family members, and those likely to come into contact with those at risk of overdose. This will include establishing the need for nasal naloxone for carers and services on the periphery of substance use (such as police officers).	PHA
C10	Building on the current processes, the HSCB will put in place additional support to monitor prescribing levels and support for prescribers to better understand who may be at risk of harm through use/misuse of prescription medicines and to support associated harm reduction measures.	HSCB
C11	The HSCB will produce an updated Prescription Drug Misuse Action Plan.	HSCB

OUTCOME D

People Access High Quality Treatment and Support Services to Reduce Harm and Empower Recovery.

ACTIONS

No.	Action	Lead(s)
D1	The COVID-19 Addiction Services Rebuilding Plan will be implemented to ensure that substance use services are in place and that learning from how services operated during the pandemic is built into future delivery and planning for any future waves.	HSCB HSCTs
D2	The PHA and the HSCB will ensure that self-care advice and support is available through a range of sources, including online, via apps, etc.	PHA HSCB
D3	The PHA will continue to deliver a programme of workforce development in relation to substance use, in line with national standards such as DANOS etc. This would include the need for a trauma-informed approach and appropriate training on stigma associated with substance use.	PHA
D4	The PHA and the HSCB will revise the Alcohol and Drug Commissioning Framework for Northern Ireland to produce a new strategic plan that is outcomes focused and in line with the strategy, evidence and best practice guidelines. This new plan should: • ensure that the population of NI have access to a continuum of service with clear pathways and step up/step down provision; • ensure that all services are delivered in line with the UK-wide "Drug Misuse and Dependence: Guidelines on Clinical Management"; • provide support to address the wider physical, mental health, and wellbeing needs of those in treatment, including housing, education, employment, personal finance, healthcare e.g. they should be supported to stop smoking and address other physical health conditions; • recognise the importance of co-production and strengthen joint working between the community and voluntary sector, service users and peers, and the Health and Social Care Sector; and • develop a clear governance structure to provide oversight and support consistent implementation of the priorities identified within the strategy across the region.	PHA HSCB
D5	A review of Tier 3 services (to include pathways and linkages to Tier 2 services) will be completed, with the development of an implementation plan to increase access to services to those most at risk and to reduce waiting times.	HSCB HSCTs
D6	The PHA and the HSCB will review services available for children and young people, particularly looking at the transition of young people from children to adult services. This will include standalone services commissioned by the PHA, and the expansion of the DAMHS service within CAMHS.	PHA HSCB
D7	The HSCB will review the support provided for those with co-occurring mental health and substance use issues urgently, to ensure that services are delivered in line with the relevant guidelines and ensure collaboration across all key services.	HSCB PHA

D8	Building on the ongoing project in the Western Health & Social Care Trust area to design and develop an integrated model between all Tiers of Addiction Services and the Regional Trauma Network, the proposed model will be considered and rolled out across the region.	HSCB HSCTs
D9	The PHA, the HSCB and the HSCTs will work to strengthen the link between maternity (including neo-natal) and substance use services, and that treatment services work to reduce barriers for women and those with childcare responsibilities.	PHA HSCB HSCTs
D10	Family support services will be reviewed by the PHA to ensure that evidence-based supports are available for all those who wish to avail of them, whether or not their family member is in treatment. Service models will also be updated to ensure the involvement of family members in treatment as appropriate.	PHA
D11	Alcohol treatment and support services will be taken forward in line with the new UK-wide Clinical Guidelines on Alcohol, once these have been finalised.	PHA HSCB
D12	The HSCB will take forward the recommendations from the review of Opioid Substitution Therapy with a specific focus on reducing waiting times with the target that no-one waits more than 3 weeks, at most, from referral to assessment and treatment.	HSCB

OUTCOME E

People Are Empowered & Supported on their Recovery Journey.

ACTIONS

No.	Action	Lead(s)
E1	The Department of Health, the PHA and the HSCB will work with experts and key stakeholders, including those with lived experience, to address stigma as a way of reducing barriers to seeking treatment, to improve prevention and to reduce harm.	DoH PHA HSCB
E2	We will build on the regional structure in place to support the involvement of experts by experience, service users and their families at all level of the implementation of this strategy, from policy development to local service design and delivery.	DoH
E3	The PHA, the HSCB and HSCTs will work with service users and their families to support the development and commissioning of recovery communities, mutual aid and peer-led support including research throughout Northern Ireland.	PHA HSCB HSCTs
E4	Learning from support provided in relation to deaths by suicide, the PHA will develop material and services for those bereaved by substance use. Acknowledging the complexity of these issues and the potential stigma, these should be built into existing bereavement supports and not a stand-alone service.	PHA
E5	The Department of Health will liaise with the Department for the Economy on how to ensure that there are no barriers for service users in accessing employability training and support.	DfE DoH
E6	The Department of Health will liaise with the Northern Ireland Housing Executive and the Department for Communities on how to reduce homelessness among, and improve access to housing for, service users.	DfC NIHE DoH

OUTCOME F

Information, Evaluation and Research Better Supports Strategy Development, Implementation and Quality Improvement.

ACTIONS

No.	Action	Lead(s)
F1	The Department of Health will publish regular update reports on the implementation of this strategy, outlining progress against its outcomes, indicators and actions.	DoH
F2	Consideration will be given to developing or amending current monitoring mechanisms to ensure these are robust and fit-for-purpose.	DoH PHA HSCB
F3	The HSCB will develop an outcomes framework for all Tier 3 and Tier 4 services to monitor the impact and effectiveness of these services. Tier 1 and 2 services commissioned by the PHA will continue to be required to complete the Impact Measurement Tool.	HSCB PHA
F4	A funded two-year research programme will be developed to meet the needs of the development and implementation of this strategy. A new cross-sectoral sub-group will be established to support the development and oversight of this programme. This sub-group will also consider linkages between research in this sector as well as legacy of research.	DoH

Alcohol Survey – Breakdown of respondents.

	Base (N)	Proportion
Overall		
All respondents	935	31%
Base (N)	935	
Gender		
Male	491	35%
Female	444	27%
Base (N)	935	
Age group		
18-29	185	50%
30-44	287	36%
45-59	276	28%
60-75	187	11%
Base (N)	935	

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PEOPLE AND COMMUNITIES COMMITTEE

Belfast City Council

Subject:	Belfast City Airport Request – Rookery at Victoria Park: Implications to Air Safety
Date:	12th January 2021
Reporting Officer:	Ryan Black, Director of Neighbourhood Services
Contact Officer:	Cate Taggart, Neighbourhood Services Manager (East)

Restricted Reports				
Is this report restricted?	**Yes**		**No**	X
If Yes, when will the report become unrestricted?				
After Committee Decision				
After Council Decision				
Some time in the future				
Never				

Call-in				
Is the decision eligible for Call-in?	**Yes**		**No**	X

1.0	**Purpose of Report or Summary of main Issues**
1.1	The purpose of the report is for Members to consider a request from Belfast City Airport (BCA) to gain access to Victoria Park to carry out works to mitigate against perceived risk of bird strike from rooks. The request is as a result of the BCA reporting an increased frequency of rook occurrence around the airport and their plan to manage any associated risk, in line with their Wildlife Hazzard Assessment and the Civil Aviation Authority licensing requirements. The requests seeks permission from the Council, via an agreement, to carry out works such as; 1. The removal of old rook nests by Mid-January 2021;

	2. Thinning of sheltering pines, structural pruning of preferred nesting trees, and reducing shelter from high level ivy; 3. Potential removal of nest foundations in late February / March, should nest building resume.
2.0	**Recommendations**
2.1	Members views are sought on the request from Belfast City Airport to grant them access under licence to Victoria Park to facilitate; 1. The removal of old rook nests by Mid-January 2021; 2. Any necessary thinning of sheltering pines, structural pruning of preferred nesting trees, and reducing shelter from high level ivy; 3. Potential removal of rook nest foundations in late February / March 2021, should nest building resume. Members are advised that any agreement would be developed by the Councils Legal Services Department and will include a requirement to ensure that any works are permissible, the required licences are in place, an effective communication plan is agreed and the needs of the park users are taken into consideration. Any licence would be progressed under the Directors delegated authority, taking into consideration Members views.
3.0	**Main report**
	<u>Key Issues</u>
3.1	In line with Belfast City Airport's national aerodrome license requirements and associated guidance material presented in CAP772: Wildlife Hazard Management at Aerodromes, the airport have a concern regarding the recent establishment of a rookery at Victoria Park.
3.2	In spring 2020, rooks formed a small colony containing 20 nests in the northern corner of the park - 300 metres from the airport's southern approach. As the habitat currently selected for nesting is prevalent throughout the park, the airport is concerned of the potential for this rookery to expand unless some level of intervention can be explored.
3.3	In response to officer request for more detailed supporting information, BCA submitted the attached report. The report outlines George Best City Airport's Wildlife Hazard Assessment. The assessment identifies the source of the risk, assesses the relative severity of the risk, and outlines the recommended action in order to reduce and maintain

	the risk to an acceptable level in compliance with the Civil Aviation Authority licensing requirements.
3.4	In the interest of public safety and to meet their obligations to act with due diligence, the airport have identified the potential threat presented by the small rookery (circa. 20 nests) which became established at the northern corner of Victoria Park in spring 2020, 300 metres from the Airport's southern landing approach.
3.5	BCA are seeking to carry out initial remedial actions in the first instance which would involve the removal of old nests – outside of the breeding season - to prevent them advertising the suitability of the site to new prospecting pairs. in order to mitigate against the associated risk, the old rook nests should be removed from trees by mid-January in advance of the 2021 nesting season in an attempt to reduce the area's attractiveness to prospecting rooks
3.6	As site fidelity after only one year might still be strong, any signs of rebuilding would need to be discouraged until the habitat can be modified to the extent that rooks no longer find it attractive. Such management prescriptions would include thinning of sheltering pines, strategic structural pruning of preferred nesting trees, and reducing shelter from high level ivy.
3.7	The concern is that rooks will start to rebuild nests this coming Spring. The intention is that the requested access to Victoria Park to support an early removal of nest foundations will decrease the probability of nesting at this site. The report suggests that, given there is similar habitat contiguous to the present rookery, it would be prudent to assume that after any breeding success the colony will likely expand further into the park.
3.8	The BCA report notes that if the proposed measures have limited success and nest building resumes, the issue of active discouragement by regular removal of nest foundations in late February / March becomes a more delicate necessity. They recognise this will require an active stakeholder communications plan in order to manage any negative feedback. They note that habitat modification should be explored as a longer-term solution going forwards from Autumn 2021.

3.9	Belfast City Airport have confirm that any necessary activity to mitigate against any risk would be exercised under a general wildlife licence. They note that habitat modification should be explored as a longer-term solution going forwards from Autumn 2021.
3.10	If members are minded to support the request, BCA will appoint a suitable contractor with previous experience to undertake the work.
3.11	If members are content, officers will review the submitted risk assessment and insurance certificates in line with procedure and work with Legal Services to issue the requested licence. The licence will include relevant conditions to ensure that Belfast City Airport confirm that all works is permissible and any required licences are in place to allow work to take place within the required timescales. The licence will also place an onus on Belfast City Airport to ensure that health and safety measures are implemented, essential signage is assembled, one-way systems are established where necessary, and any COVID specific mitigations are in place.
	<u>Financial & Resource Implications</u>
3.12	BCA will be responsible for any costs associated with the request.
	<u>Equality or Good Relations Implications/Rural Needs Assessment</u>
3.13	None
4.0	**Appendices – Documents Attached**
	Appendix 1: Belfast City Airport Report – Rookery at Victoria Park: Implications to Air Safety

Objective

This short report is a rationale and review of options presented by the development of a small rookery (circa 20 nests) which became established in the northern corner of Victoria Park in spring 2020, 300 metres from the airport's southern landing approach.

Risk

The aim of George Best City Airport 's Wildlife Hazard Assessment (WHA) is to identify sources of risk and to assess the relative severity of those risks and reduce and maintain risk to an acceptable level in compliance to Civil Aviation Authority licensing requirements . Risk assessment is difficult with low frequency events and, for bird strike risk, factors such as size and flocking behaviour may be more significant than simple frequency of occurrence.

Rooks, by individual mass (c.310g), have a low severity rating for engine damage and as no bird strikes pertaining to this species have occurred at George Best City Airport during the most recent 5 year review, the risk matrix for this species is scored as low.

Daily bird observation records kept by the airport to monitor local trends have recorded an increasing frequency of rook occurrence around the airport, doubling over the last three years, with the average number of rooks per observation also up by 50% (from 6 to 9) to a level whereby the probability of an air strike might be expected to rise (Fig 1). Manipulating inter runway habitat and regular scaring to dissuade birds from landing around the airport is the mainstay of risk reduction. However, even if these growing risks are being adequately managed, these methods may not influence the establishment of regular flight lines that traverse the airport's landing approach between the adjacent rookery and possible foraging destinations, potentially elevating collision risk for this species further. It is therefore in the interest of public safety that the airport must act with due diligence and flag any perceived potential threat while at a manageable scale. As there is similar habitat contiguous to the present rookery it would be prudent to assume that after any breeding success the colony will likely expand further into the park.

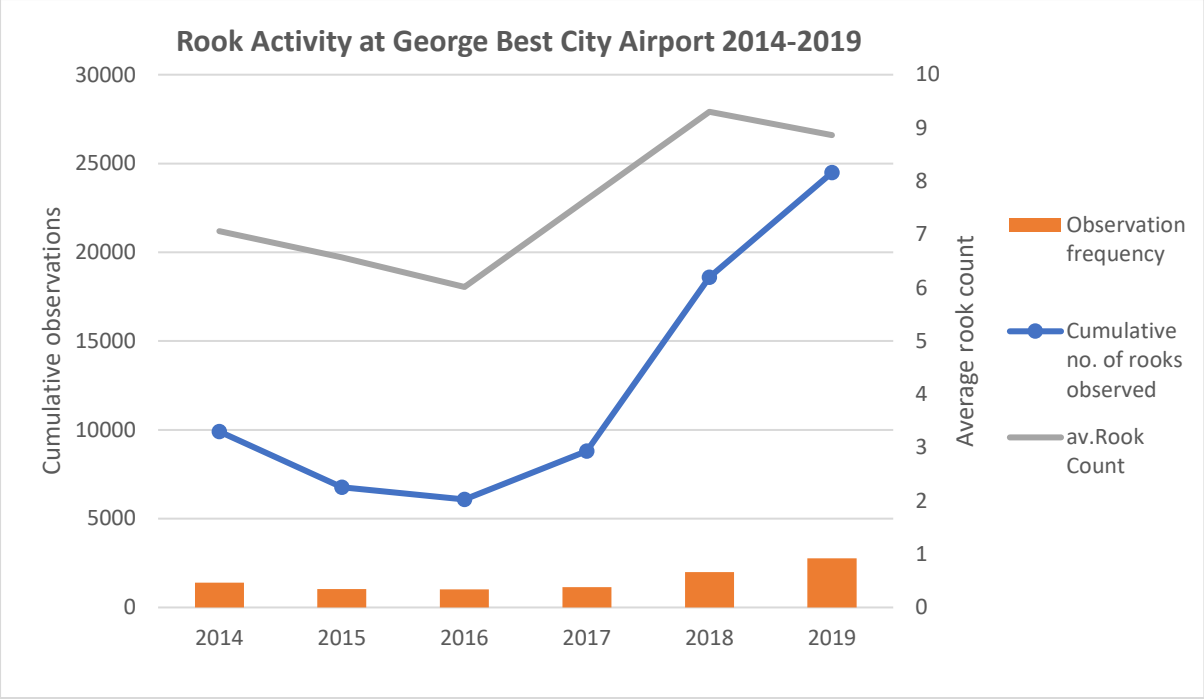

Fig 1.

Proposed Remedial Action

Remedial action in the first instance would involve the removal of old nests – outside of the breeding season - to prevent them advertising the suitability of the site to new prospecting pairs. As site fidelity after only one year might still be strong, any signs of rebuilding would need to be discouraged until the habitat can be modified to the extent that rooks no longer find it attractive. Such management prescriptions would include thinning of sheltering pines, strategic structural pruning of preferred nesting trees, and reducing shelter from high level ivy.

To ensure optimal results, these prescriptions would normally be enacted simultaneously, however, with time scale limitations and managing sensitivities of park users, an element of phasing may be the only option available, with nest removal as the first priority. A proposed target deadline of mid-January is specified to buffer against the chance of a resurgence of rook activity - in advance of an early spring. If nest building resumes the issue of active discouragement by regular removal of nest foundations in late February/March becomes a more delicate necessity and well informed PR management an integral part, regardless of the legitimacy of the action and/or the legality to operate under license in the interests of public safety. Monitoring and reviewing efficacy of management actions, managing negative feedback and any management refinement would be communicated efficiently among the relevant stakeholders to ensure a successful outcome.

Wildlife is not always predictable, and all scenarios must therefore be envisaged to enable the most appropriate response as the situation evolves. Response to management prescriptions similarly need to be monitored to guide effort required and for any potential refinement.

Nest removal

As the rook nests are between 10 and 15m high, it is envisaged that most can be dislodged from the ground or the higher ones from ladders, using extended poles. Recording trees used and photographing nests before and after removal will inform and facilitate any structural pruning that might be feasible as a management tool. In the event of nest rebuilding the same information would be recorded prior to removal.

Any thinning or structural pruning would have to be carried out using a suitable contractor prior to the nesting season.

Extent of 2020 rookery at Victoria Park

Rookery showing habitat type (ivy clad oak/birch with pines behind)

Belfast City Council

PEOPLE AND COMMUNITIES COMMITTEE

Subject:	Proposal for naming a new street
Date:	12th January 2021
Reporting Officer:	Ian Harper, Building Control Manager
Contact Officer:	Roisin Adams, Business Coordinator

Restricted Reports				
Is this report restricted?	**Yes**		**No**	X
If Yes, when will the report become unrestricted?				
After Committee Decision				
After Council Decision				
Some time in the future				
Never				

Call-in				
Is the decision eligible for Call-in?	**Yes**	X	**No**	

1.0	**Purpose of Report or Summary of main Issues**
1.1	To consider applications for the naming of a new street in the City.
2.0	**Recommendations**
2.1	Based on the information presented, the Committee is required to make a recommendation in respect of an application for naming a new street in the City. The Committee may either: • Grant the application, or • Refuse the application and request that the applicants submit other names for consideration.
3.0	**Main report**
3.1	**Key Issues** The power for the Council to name streets is contained in Article 11 of the Local Government (Miscellaneous Provisions) (NI) Order 1995.

3.2	Members are asked to consider the following application for naming a new street in the City. The application particulars are in order and the Royal Mail has no objections to the proposed names. The proposed new names are not contained in the Council's Streets Register and do not duplicate existing approved street names in the City.

Proposed Name	Location	Applicant
Gardenmore Green	Off Summerhill Road, BT17	Radius Homes

3.3	Radius Homes have proposed Gardenmore Green, as their first choice as the new street is located at the junction of Gardenmore Road and Summerhill Road and the new street is surrounded by green space. Radius housing association has proposed, Gardenmore Grove as the second choice and Summerhill Green as the third choice, as the development is surrounded by green space and the site was previously planted with trees.
	Financial & Resource Implications
3.4	There are no Financial, Human Resources, Assets and other implications in this report.
	Equality or Good Relations Implications/Rural Needs Assessment
3.5	There are no direct Equality implications.
4.0	**Appendices – Documents Attached**
	None