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Cheshire and Merseyside Inpatient Detoxification Consortium and Pathway

# Impact Report

2024-2025

# Contents



## Acknowledgement and Further Information


The MIAA Solutions Team would like to thank Cheshire and Merseyside Consortium members for their co-operation and support in completing this report.


Should you require any further information, please contact IPDSupport@miaa.nhs.uk

# Foreword

As Wirral's Director of Public Health, I am pleased to introduce this Cheshire and Merseyside Inpatient Detoxification (IPD) Consortium Impact Report. This report reflects both the progress the Consortium has made, and the challenges that continue, in addressing substance misuse across Wirral and the wider Cheshire and Merseyside region.

The impact on individuals and communities arising from harmful drug and alcohol use continues to be a pressing Public Health challenge. It drives health inequalities, damages families and communities, and places significant pressure on health, social care and criminal justice systems. Yet, it is also recognised that recovery is very possible and achievable when people are provided with the right support at the right time. This Impact Report demonstrates how critical the IPD pathway is in delivering that possibility.

The results achieved this year are very encouraging, showing a steady improvement in the performance of the consortium. Over the reporting period, 82% of service users successfully completed their detox treatment, compared with a national average of 47%. The positive outcomes being achieved are a testimony to the expertise and hard work of both the community teams across Cheshire and Merseyside, and the teams providing the treatment and care in the IPD units. A further factor contributing to this positive and encouraging story is the strength of the partnership approach across the nine local authorities.

The real benefits arising from this effective partnership include more people gaining access to IPD treatment, and gaining this access quicker, with average waiting times lower than the national benchmark.

This is leading to a growing confidence in the quality and effectiveness of the pathway, reflected by some of our nine areas choosing to supplement the Consortium grant with some of their local funding, to increase their capacity for placements along this pathway. Increasing numbers also point to the scale of demand and this in turn underlines the importance of protecting and sustaining the resources that make this possible.

Detoxification is often a crucial step in a person's recovery journey, and for some people their living circumstances make this a difficult step to take, unless they can be given time in the protected and supported treatment environments that the IPD units provide. By providing safe, medically managed environments, the pathway offers for some the foundation on which longer-term recovery and rehabilitation can build. The benefits are not just experienced by the individual building their recovery, but also by healthier families, stronger and safer communities, and reduced demand on NHS services.

The report also highlights the reality that the patterns of substance use change, evidenced by the marked rise in ketamine use being seen locally and across the country. The new and complex challenges that ketamine is presenting, and the significantly younger age group it is affecting, is underlining how clinical pathways and the treatment offer, need to be able to adapt to meet new and changing needs. The collective nature of the consortium working together has supported the services in achieving just that.

The challenge to the Consortium now, therefore, is to consolidate the progress that has been achieved and to continue to evolve to meet emerging needs.

This report acknowledges the commitment of all those working to deliver this pathway and produce this report. It highlights what can be achieved through working together in an informed and responsive way. The task ahead is to sustain and scale up this progress, to respond to newly emerging challenges, such as ketamine, and to ensure that the consortium continues to provide timely access to effective detoxification for those in need, providing them with and the treatment and ongoing support to enable them to move forward on their recovery journeys.

**Dave Bradburn**
Director of Public Health, Wirral Council

# What is the Cheshire and Merseyside Inpatient Detoxification Consortium?

Since 2020/21, the Department of Health and Social Care (DHSC) has allocated additional ring-fenced funding to Local Authorities in England to enhance inpatient detoxification (IPD) drug and alcohol treatment and recovery provision.

Today, the Cheshire and Merseyside IPD Consortium Pathway supports an end-to-end service that serves as an important step in the recovery process, tracking and monitoring service user activity from referral through to residential treatment completion.

## Consortium Membership

- 2024–2025: Five IPD provider units (six facilities) and representatives from all nine local authority drug and alcohol commissioners and their community services (Figure 1).
- 2025–2026: A new IPD provider will join, alongside “Experts” with lived experience.

## Roles and Responsibilities

- **Director of Public Health (DPH):** The strategic lead, advocate, and accountable officer for local public health, ensuring that substance misuse is addressed through evidence-based prevention, harm reduction, treatment, and recovery programmes, in partnership with statutory and community stakeholders.
- **Commissioners:** Delivery of the local plan signed-off by their DPH. This role includes being accountable for activity and expenditure that meet local requirements.
- **Community Referring Teams:** Decide on placement activity and expenditure, monitor service user needs and allocation, notify IPD providers of funding sources, and liaise regarding any use of grant or core funding.
- **Service Providers:** Deliver appropriate, safe, and effective treatments and provide timely reporting, including admission changes, barriers, and constraints in bed availability or waiting times.


*Figure 1: Map of the Cheshire and Merseyside Footprint*

## Aims of the Consortium

The Consortium operates through a person-centred, demand-led model that is efficient, flexible, and supports both referring community teams and IPD providers.

**Service user benefits include:**

- Wider choice of inpatient detoxification providers
- More appropriate matching of provider treatment offers to clinical need and distance from home area
- Reduced waiting times

*“It was always MIAA Solutions’ vision to develop a Consortium model that embraced and supported a creative space for all our independent partners.*

*With MIAA and Wirral Council providing invaluable and cost-saving centralised support, the approach has allowed our membership to focus on collaborative service delivery and improvement initiatives.”*

**Jane Pine, Senior Programme Delivery Manager MIAA Solutions**

**Impact Statement: The Consortium model demonstrates collaborative governance, efficient resource allocation, and improved service user experience, setting a benchmark for regional commissioning of inpatient detoxification services.**

# Thoughts from our Lead Commissioner

Gary Rickwood, Wirral Public Health Team

Drug and alcohol dependency can affect anyone but is more common and harmful in more deprived communities. This is generally due to poorer access to protective factors like healthcare, stable housing, and social support.

Cheshire and Merseyside has some excellent drug and alcohol treatment and recovery services, offering quick access to a range of high quality harm reduction, treatment and recovery support interventions.

Experience has shown us that these services can offer an effective pathway to a much more stable and safer lifestyle, including, but not limited to, sustained abstinence.

## Anybody can choose a successful path to recovery, but not everyone will.

For some people, the only realistic option for them is to step away from the environment that they are living in, with all the familiar connections, temptations, and often chaos that will be part of this, and to temporarily locate themselves to the safe haven of a residential detoxification facility.

## The benefits of the Consortium approach are wide reaching for service users and their supporting community teams

The shift to a multi-provider, demand-led inpatient detoxification model has been transformative; it supports approved alignment of placements with clinical needs, reduces bottlenecks for accessing timely treatment and ensures accountable funding use despite increasing service user complexity.

Service users have responded very positively to having greater choice in their treatment. Feedback suggests that there is an increasing word-of-mouth promotion of this option among the service user group. This, in turn, has had a positive impact on re-energising community workforce morale.

The placements funded by the grant has meant that the service provider units are operating close to full capacity and have greater financial security, which has increased their buy-in and support to the partnership approach.

Due to the positive outcomes, some local authorities have taken the step to top up their national grants with local ‘core’ funds to maximise the benefits of this pathway.

## A genuine spirit of collaboration

I believe that the Consortium has worked so well because it balances structure with flexibility, and because there is a genuine spirit of collaboration between commissioners, providers, and MIAA as programme leads.

I am hugely grateful to all Consortium members for their passion and the nine Directors of Public Health for the way that they have embraced and supported the development of the Consortium approach. I am particularly grateful for the leadership shown by MIAA, and for the internal hosting and support from the Wirral Council back office teams.

Gary

**Impact Statement: This report provides evidence that the Cheshire and Merseyside Inpatient Detoxification Consortium demonstrates significant achievements in:**

- **Collaborative governance and decision-making**
- **Demand-led, service user-centred care**
- **Enhanced access, equity, and choice for service users**
- **Rapid responses to emerging substance misuse trends, including ketamine**
- **Data-driven planning and system-wide learning**

**We would like to offer this model as a national exemplar for system-led commissioning of inpatient detoxification services.**

# National Context

The Government's 10-year drug strategy, "From Harm to Hope", sets out a national ambition to reduce drug use, drug-related deaths, and harm, while improving treatment engagement and recovery outcomes. Recent national data underscores both the urgency and complexity of the challenge.

## Key National Concerns (OHID, 2024)

- **Record High Death Rates**: Drug poisoning deaths have nearly doubled since 2012, with opioids and synthetic opioids contributing significantly.
- **Health Inequalities**: Individuals in treatment continue to face disproportionately high mortality rates, compounded by smoking and drinking.
- **Pandemic Impact**: Deaths during treatment rose during COVID-19 restrictions.
- **Ageing Cohort**: Older heroin users present with accumulated physical and mental health conditions, often exacerbated by significant social needs.
- **Polydrug & Alcohol Use**: Increased prevalence of complex cases heightens overdose risk.
- **Alcohol-Specific Deaths (ASDs)**:
  - National upward trend: **8,274 deaths in 2023** (+4.6% compared with 2022).
  - Alcohol dependent service users face an eightfold higher risk of cirrhosis.
  - Cheshire & Merseyside recorded **436 deaths** in 2023 (–1.1% compared with previous year).
- **Ketamine Misuse**: Adults entering treatment for ketamine issues rose eightfold in less than a decade, from **426 (2014–15)** to **3,609 (2023–24**), and are continuing to rise. This issue is complicated by the appeal of this drug among under 18's, and adult IPD services not being registered to accommodate younger users.

## Drug and Alcohol Misuse Deaths

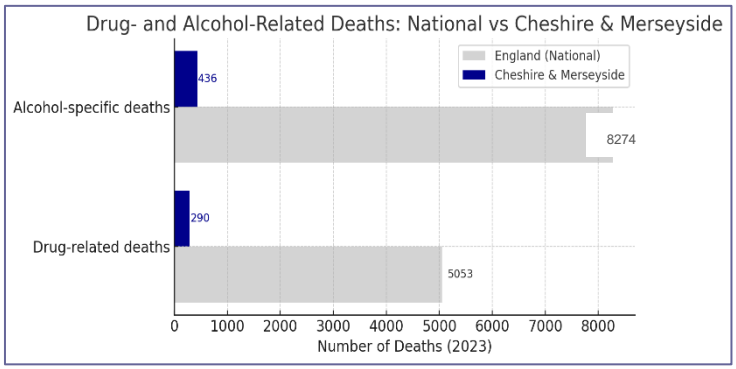



*Figure 2: National vs. CM Drug and Alcohol related deaths*

**England, 2023:**

- 5,053 drug-specific deaths, increased by 481 (+15%) compared with 2022.
- Greatest increases seen in cocaine, opioids, and Gamma-Aminobutyric Acid (GABA) drugs.
- Deaths occurring during treatment have risen since 2020 (from 3726 to 4022), however could be due to increases in treatment population.
- Digital-only treatment associated with double the death rate compared to face-to-face care.

**Cheshire and Merseyside:**

- Drug-related deaths: 290, representing 5.74% of the national total, have remained stable in recent years, compared with an 10.5% increase nationally.
- Alcohol-specific deaths: 436, representing 5.27% of the national total, slightly down from the previous year.

**Impact Statement: National data shows rising deaths and increasing treatment complexity, particularly linked to opioids, polydrug use, and alcohol harm.**

**In contrast, Cheshire and Merseyside's stablising mortality outcomes are possibly pointing towards the positive impact of the collective substance misuse initiatives across Cheshire and Merseyside, including the collaborative, demand-led commissioning, positioning the Consortium as a regional system able to respond effectively to national challenges.**

# National Context Continued

## Alcohol

- In 2023 the number of alcohol-specific deaths in England was 8,276. This was a 4.6% increase since 2022 and equates to a rate of 15.0 per 100,000 population in 2023.
- Cheshire and Merseyside figures total 5.27% of the national total (436), down by 5 on previous year (441)[1].

## Potential years of life lost (PYLL)

- Potential years of life lost (PYLL) is a measure of premature mortality. It estimates the length of time a person potentially may have lived had they not died prematurely.
- As with alcohol-specific and alcohol related mortality rates, the PYLL rate for both males and females has increased since 2019.[2]
  - In 2023 in England, the potential years of life lost (PYLL) due to alcohol-related conditions stood at 1,246 per 100,000 population for males, and 533 per 100,000 for females - meaning men lost more than twice as many potential years as women (a disparity that has persisted since 2016)
  - Additionally, these PYLL rates for both sexes have shown an upward trend since 2019, indicating a growing burden of premature mortality associated with alcohol consumption

## Year on year percentage change in drug and alcohol deaths

- Cheshire and Merseyside's year on year change in proportion of drug deaths shows promise with 0% change from previous year against England's 10.5% increase.
- The number of alcohol-specific deaths in England was 8,274 with Cheshire and Merseyside figure totalling 5.27% of the national total (436), down by 5 on previous year (441). For Cheshire and Merseyside, the % change from previous year was -1.13% against the overall England continuing trend of +4.60 increase.

*Figure 3:England vs.CM alcohol specific deaths*

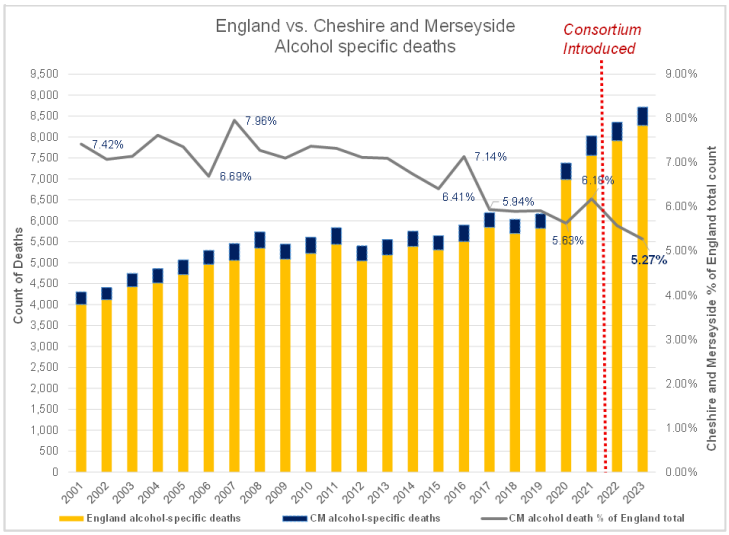



*Figure 4:PYLL National Male vs. Female PYLL*

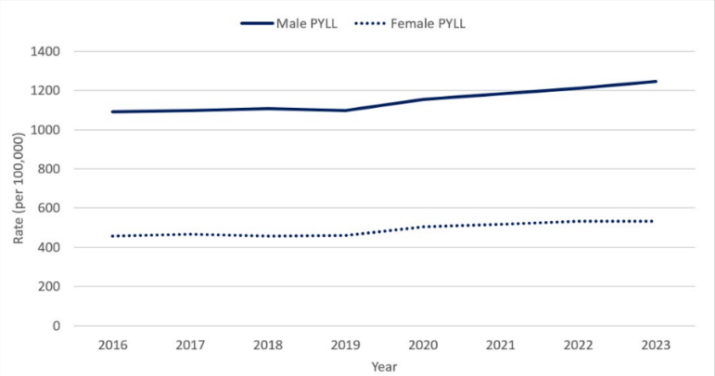



*Figure 5: % change in number of alcohol deaths (England vs.CM)*

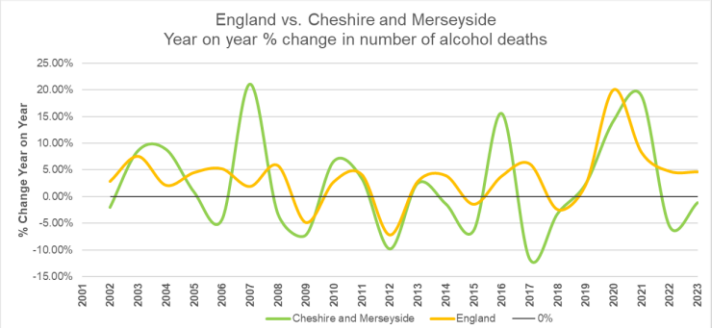
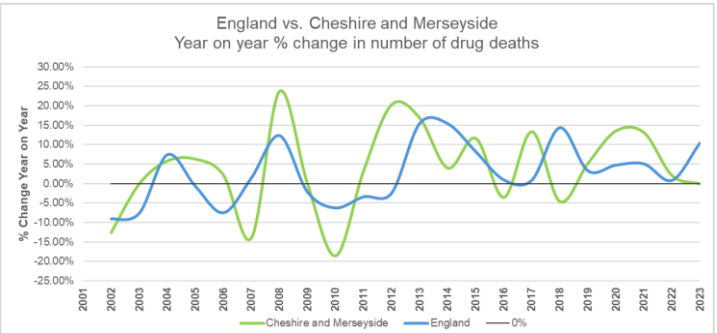



*Figure 6: % change in number of drug deaths (England vs.CM)*




[1] Dataset Sources: ONS Drug Misuse Deaths and ONS Alcohol-specific Deaths

[2] Source: https://www.gov.uk/government/statistics/alcohol-profile-february-2025-update/alcohol-profile-short-statistical-commentary-february-2025

# The Consortium Pathway

Across England, the commissioning of Consortia inpatient detoxification services and how these are embedded into a service user pathway varies across sub-regions.

## Why choose a demand-led commissioning model?

In Cheshire and Merseyside the commissioners chose to operate a ‘demand-led’ commissioning model, rather than a block contract arrangement.

This preference was determined by the fact that the Consortium had a wide-ranging selection of providers to choose from within the geographic footprint, or close by, with capacity able to meet demand.

A demand-led model ensures flexibility in that service user needs can be met without the requirement to predetermine the quantity or type of need across Cheshire and Merseyside’s service provider units. The result is that service provider unit payments are efficiently and transparently linked to actual services delivered. It also maintains some degree of “Friendly” competition.

## A North West Universal Referral Form

One of the innovative improvements delivered by MIAA during 2024-2025 was the North West Universal Referral Form on behalf of all North West Consortia (Lancashire and South and Cumbria, Greater Manchester, and Cheshire and Merseyside).

The Universal Referral Form has streamlined referrals across the North West, reducing delays, standardising data, and supporting service user choice.

*"The North West Universal Referral Form is a strong example of a collaborative initiative that has resulted in streamlining access for service users, service providers and referring teams.*

*Agreeing a common data set and documentation realised these benefits and allowed flexibility to adapt to IPD estate availability, service user choice, and waiting times.”*

**Rachel Dyer, MIAA Solutions**

## A bespoke tracking and monitoring app that provides real time pathway insights from start to finish

In the early stages of implementation of the Consortium pathway, the MIAA Team designed, developed and delivered an effective and valuable monitoring system that supports national and local system reporting requirements.

The system tracks bed availability, treatment episodes, budgets and spend, and drug-of-concern analysis, enabling data-driven decision making.

This has meant that at any given time, Consortium members have visibility of pipeline and treatment activities, costs / spend, treatment placements and drug of concern analysis and budgets remaining for their area(s).

*“Such an excellent report. Brilliant information, giving us easy, valuable and fascinating analysis. I commend it to my colleagues.”*

**Gary Rickwood, Wirral Public Health Team**

**Impact Statement: The pathway ensures timely, equitable access, efficient resource use, and enhanced, real-time visibility analysis of service delivery and outcomes.**

**Covering Colwyn Bay to Manchester and Prestwich, our broad reach delivers choice and equitable access.**

**Independence from a single provider ensures tailored placements, better outcomes, and optimised system capacity.**

# Stakeholders, Partners and Governance

The achievements arising from this Consortium's approach would not be possible without the participation of the many teams involved.

The Consortium collaborates through bi-monthly forums, a communication microsite and task and finish groups.

This allows the Consortium to make decisions collectively, with the MIAA Solutions team preparing papers and driving the agendas and task and finish groups that facilitate decision-making, shared learning and continual improvement.

At the top of our governance structure are the nine Cheshire and Merseyside Directors of Public Health (DsPH) who are accessed through the Cheshire and Merseyside DsPH collaborative 'Champs.'

Wirral Council host the Consortium, providing key corporate functions in areas such as public health, finance, procurement and legal services. They enable access to governance systems for ratification of Consortium plans and major change initiatives.

*"This is the most joined-up approach I've experienced in 30 years – and it is highly effective."*

***Steven Kelly, Team Manager, Wirral Ways Community Team (CGL)***

**Impact Statement: Collaborative governance ensures consistent oversight, inclusive decision-making, and continuous improvement across the Consortium.**

# How is Funding Used?

The Consortium has consistently received £652k each year since 2022, and splits the total grant allocation across the following expenditure buckets:

- Service user treatments 82%
- Cheshire and Merseyside-wide support 15%
- Contingency pot 2.7%
- Service user travel expenses 0.3%

The Contingency pot is a sum of money that is held back from the main service user treatments fund and is used to make up local authority balances of their final treatment episodes. Towards the end of the financial year, this helps to make up complete placement costs for maximum use of the total grant allocation.

## How is the grant allocated to local authorities?

OHID provide the proportional split of the grant based on local authority population need.

For Cheshire and Merseyside, the split is as follows:

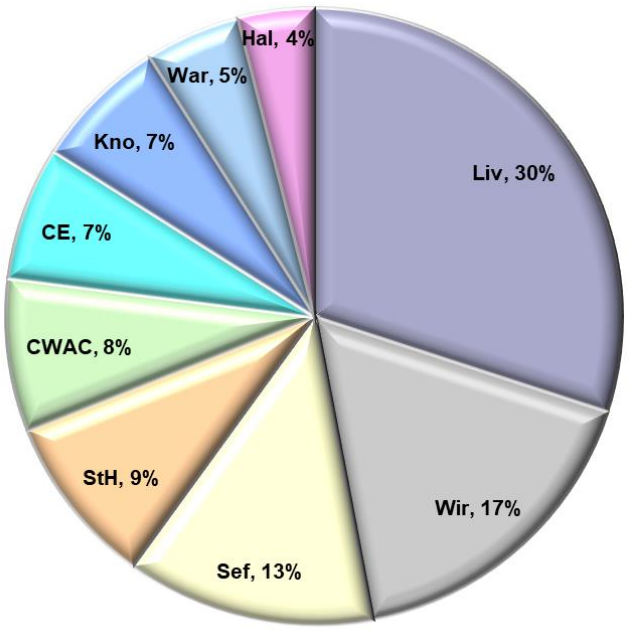



*Figure 7: Percentage funding split across CM authorities*

## The Knowsley Project

In 2024, a pilot project assessed the impact of Knowsley Council's use of core funds to top-up their grant allocation. The aims were to widen the scope (and benefits) of the Consortium's grant funded pathway to include core-funded service users.

After successfully piloting the core funding 'top-up,' the nine Directors of Public Health across Cheshire and Merseyside (Champs) approved the expansion of the pilot to offer all local authorities who were interested in the option, to top-up their grant funding with core monies.

*"We recognised that there were so many more options for service users and, as a result, the wait times were shorter. Once someone decides that they want to go into treatment it is important to act quickly, and through the Consortium approach we are able to do this more effectively."*

**Emma Costello, Commissioning and Contracts Officer, Knowsley Council**

## Expanding flexibility around funding

2025-2026 will see a third of authorities make the move to utilise some of their core monies to top up their grant funding allocations. One of the authorities will be St. Helens Council.

## What learnings are there for the wider system?

*"Avoid putting all your eggs in one basket. A consortium approach supports better risk-management, flexibility, and user-centred care. Regional collaboration also drives more equitable access and supports quality improvement through peer learning."*

**Barry Akehurst, St. Helens Council**

**Impact Statement: Flexible funding models maximise treatment capacity, reduce bottlenecks, and support fair access.**


# Pathway Impacts and Benefits

We asked Consortium members to express what they thought were the key impacts and benefits of the consortium approach.

Here are their thoughts.

## True collaboration

*"It is good to have everyone on the same page.*

*With nine local authority commissioning teams and community drug and alcohol services and six Inpatient Detoxification provider facilities, all working together and openly sharing good practice and learnings, we have been able to continuously improve the pathway and move towards a higher-quality and more standardised approach – e.g. Universal Referral Form."*

## More efficient pathway

*"The pathway is much smoother.*
*It is a vital clinical option for some people who need to remove themselves from their living situations that prevent them from moving out of dependence and on to recovery. A smoother pathway eases the burden on our frontline workforce and service provider units."*

## Doing things once (and not nine times)

*"MIAA's central co-ordinator role means that instead of governance / process and procurement activities being replicated across all 9 local authorities, they are performed once on behalf of the consortium by MIAA."*

## Shared learnings

*"Sharing operational and clinical approaches to aid problem solving – for example ketamine treatment approaches and Children and Young people pathways."*

## Increased service user choice and impartial access

*"The regional offer has a wide range of facilities, increases service user choice and supports equitable access; i.e. regardless of postcode, service users have access to the same quality and range of providers."*

## Sustained abstinence

*"More individuals are sustaining abstinence and also had fewer people leaving a placement prematurely. Sustained abstinence brings positive motivation for long term change and feeling like they can become more involved in their community."*

## Reduced waiting times

*"Getting service users into detoxification when they are really ready can help to increase their detoxification success rate.*

*There is also a secondary benefit whereby reliance on community teams for ongoing support is also reduced."*

## Fantastic reporting

*"Visibility of bed availability and latest status of expenditure compared with budget at local authority level is a fantastic asset and helps commissioners and community teams manage budgets in real time."*

# Consortium Pathway Flow

The data set out on the following pages, using data collected from across the Consortium pathway, tells the story and shares insights on the natural flow of the Consortium service user journey.

Information from the Inpatient Detoxification reporting portal (IPDAPP) and feedback collected from a survey of consortium members has been used to produce the storyboard.

## 1. Making a referral

Referring teams primarily consider the following top three factors when choosing a treatment facility.

### Choosing the right facility for the service user

Community referring teams need to ensure that the provider can meet the individual's specific health and treatment needs, including access to other clinical support if required. For example, mental health, physiotherapy, etc.

Referring teams have access to provider unit collateral that sets-out their service offer, however Dan Bennett, Adferiad's Head of Commercial Relationships has been leading a project to produce a digitalised North West 'detoxification directory' that will set out details of the detoxification facilities across the North West.

The outcome is "an at-a-glance gallery of information that will support referrers and service users to make an informed decision on the most appropriate and timely treatment."

### Geographical accessibility

Referrals are often influenced by the location of the service, i.e. whether it is within reasonable reach of the service user local area or family support, or if the facility provides transportation.

### Bed availability and waiting time

Timely access to detoxification can be critical, especially where there is an escalating risk.

The national target for access to IPD treatments is 30 days from initial referral.

In 2024-2025, the Consortium pathway average waiting time across all drugs of concern was 28.49 days.

Referral teams aim to reduce delays by factoring in current capacity and waitlists across providers.

Wait times can be affected by service user complexities, such as polydrug use that requires a bespoke clinical approach, aligning rehabilitation placements or post-treatment housing arrangements – or quite simply that the service user delayed their planned treatment.

The graph below illustrates the varying length of time for onboarding for the four drug groups and across service providers. Clearly 'alcohol only' and 'non-opiate' onboarding has a quicker turnaround time than the other drug groups.

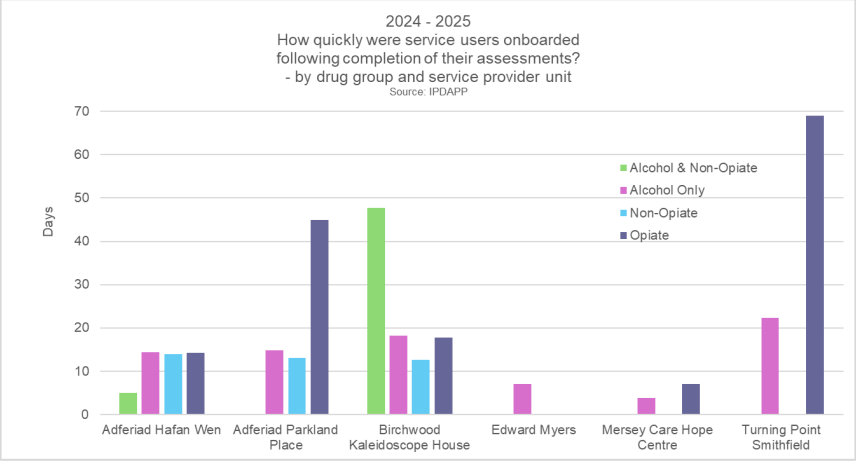



*Figure 8: Average onboarding time following completion of assessments – by drug of concern and provider facility*

*"The impact of the Consortium Pathway has been great - it offers choice to service users and places a great deal of autonomy regarding their care in their own hands.*

*The pathway into treatment has been streamlined through the single referral form, making it speedier for service users to access their provider of choice…and as a result more service users are staying in treatment and completing their treatment episodes."*

**Trevor Smith, PH Practitioner (Addictions), Liverpool**

## 2. Choosing a provider

The Consortium ethos has always been that referring teams should consider service user choice and spread their referrals across the full provider selection.

During 2024 – 2025, there were **an additional 174 referrals made across the Consortium pathway** equating to a 20%[3] increase from the previous year, with all nine community teams making at least four referrals to the **Birchwood** unit on the Wirral. **Wirral Council**'s referring team favoured Birchwood's treatment facility, partly because of its close geographical location for their service users.

**Adferiad's Parkland Place and Hafan Wen** units increased their referral share in 2024 – 2025, partly due to **Knowsley** placing 29 referrals across the two sites[4].

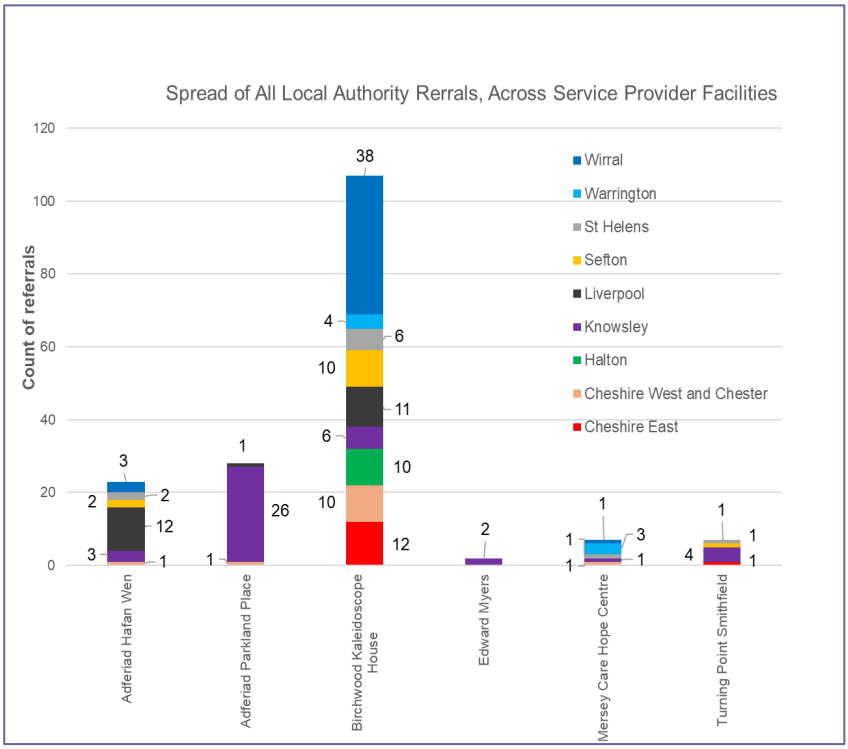



*Figure 9: Spread of LA referrals across all facilities*

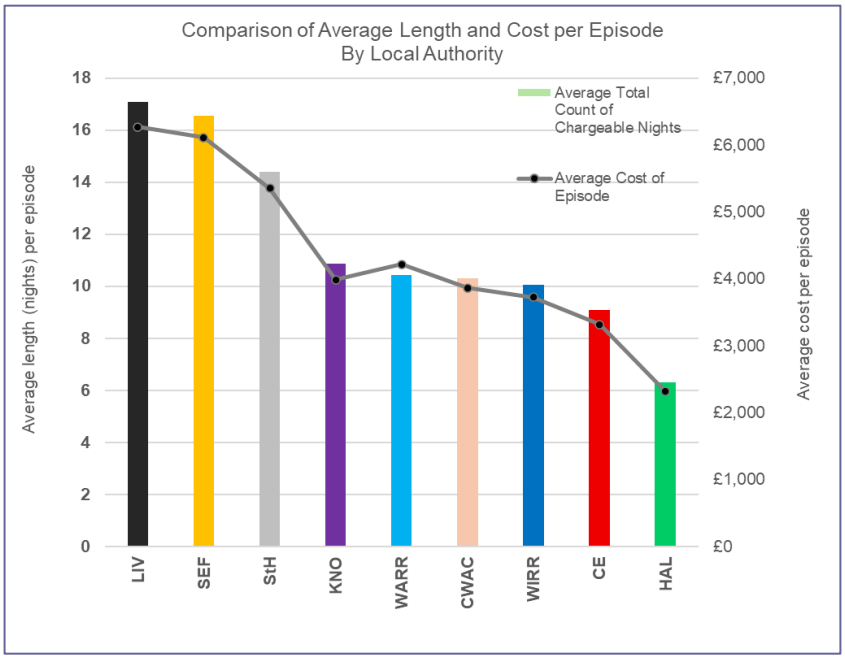



*Figure 10: comparison of average length and cost per episode by LA*

### Average length of stay and cost of episode

**Liverpool and Sefton** have the largest grant allocations, and both have existing, robust, block contract arrangements in place with Merseycare's Hope Centre to support their core funding IPD activities.

In 2024 – 2025, both Liverpool and Sefton chose to utilise their grant funding and the Consortium pathway to support treatments for their most complex cases. This is evident when comparing average length of stay and subsequent bed night costs across all local authorities. **St Helens** also had a block contract arrangement in place with the Chapman Barker Unit in 2024 – 2025, and like Liverpool and Sefton, had chosen to adopt this approach to support treatment for their most complex cases.

2025-2026 will see Greater Manchester Mental Health Trust's **Chapman Barker Unit** join the Consortium, increasing the choice of providers to six (seven units).

**Impact Statement: The demand-led, service user-centred model increases autonomy, streamlines access, and ensures equitable treatment distribution.**

[3] Figure relates specifically to the IPD Consortium Pathway only

[4] Note that in 2024 – 2025, Knowsley used core funding to top up their grant allocation

# 3. Treatment analysis

## Drug group: alcohol

Alcohol remains the most common primary substance for inpatient detoxification placements.

Regionally, 'alcohol only' accounted for the majority of Consortium treatment episodes (118) and is linked to the highest volume of early exits (14) and full completions (104).

Key statistics for alcohol only detoxification:

- 4 hospitalisations
- Average length of stay 9.5 days.
- Average cost of treatment £3,490
- 47 female (40%)
- 65 male (55%)
- 6 gender unknown (5%)
- 14 incomplete episodes (12% of total)
    - 11 against medical advice
    - 2 Breached rules
    - 1 hospitalised and did not return to treatment.

## Drug group: alcohol & non-opiate

There were seven Consortium treatment episodes classified as 'alcohol and non-opiate.'

Crack cocaine was noted to continue to be prevalent among service users requiring inpatient detoxification, often in conjunction with other drug use (e.g. heroin or alcohol), contributing to complex poly-substance profiles and high relapse risk.

- The average length of stay for this drug group was 13.3 nights
- Average treatment cost of £4,964
- 1 episode that ended early against medical advice.

## Drug group: opiate

There were 29 Consortium treatment episodes that were classified as 'opiate only'

- Twice as many males (19) in treatment than females (9) and one unknown gender

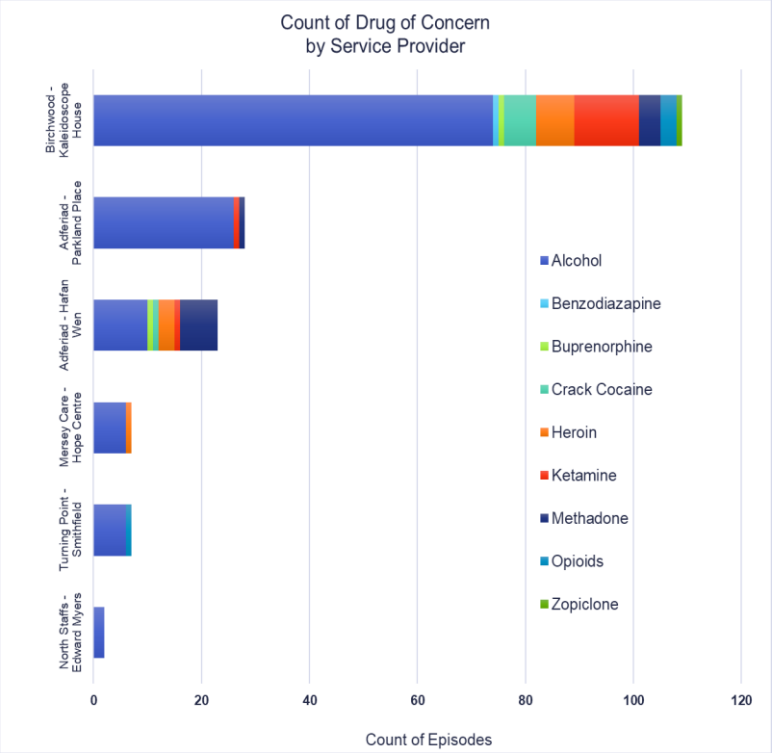



*Figure 11: Count of drug of concern across service provider facility*

- Heroin, illicit opioids (such as codeine), synthetic opioids, and nitazines were all mentioned in the top three drugs of concern by Consortium members when surveyed
- 9 service users (31%) in this group left treatment early (7 male and 2 female).
- The average length of stay for the Opiate group was 19.5 nights, producing an average treatment cost of £7,202. There was 1 episode that ended early against medical advice.

## Drug group: non-opiate

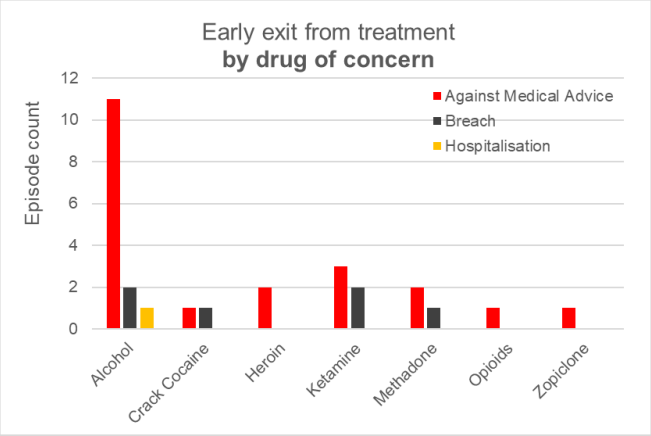
Ketamine (14 episodes) was a strong theme noted in the regional survey and is a growing concern for the Consortium, particularly among younger users. This is due to its significant impact on physical health (e.g. bladder / kidney issues, cardiac problems and extreme weight loss).

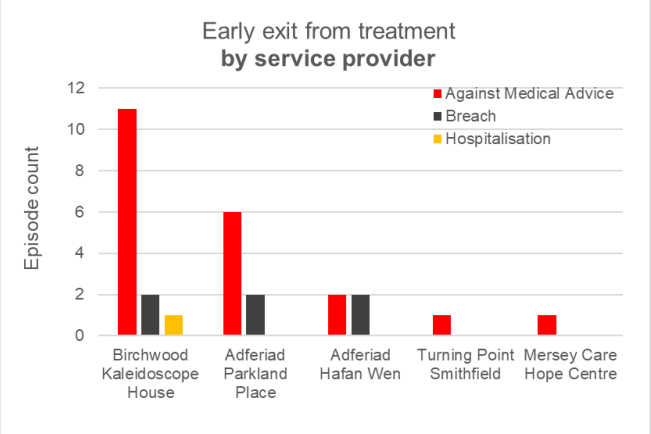
- The need for inpatient detoxification in these cases is increasing, often with additional medical support needed pre and post admission.
- Other drugs in this category included benzodiazepine, crack cocaine and zopiclone (22 non-opiate episodes in total).
- 8 treatment episodes ended early, with 3 breach of rules and 5 against medical advice.

# 4. Treatment exits

According to an OHID report published in November 2024[5], nationally, and across all treatment settings, 47% completed their treatment successfully in 2023-2024, and over a third (37%) dropped out or left treatment without completing it.

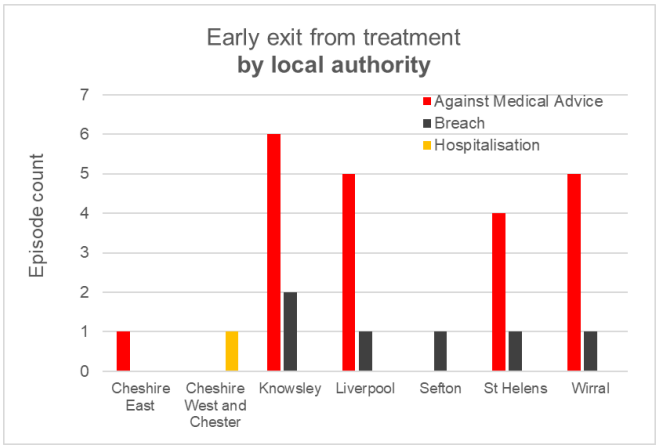
In Cheshire and Merseyside during 2024-2025, 32 service users, equating to 18.39%, exited the Consortium treatment pathway early: 1 was hospitalised, 6 breached rules, and 25 left against medical advice[6].




In interpreting the bar charts on this page it should be noted that:

- There were significantly more placements for Alcohol detox than any other substance.
- Knowsley and Wirral made significantly more placements than the other Local Authorities
- Birchwood had by far the most placement commencements, followed by Parkland Place.




Barry Akehurst, Public Health Practitioner, St. Helens Council, provides his thoughts on why he feels that some service users exit the service before completing treatment.

*"A mix of complex needs, including mental health, housing instability, and lack of readiness to change. It is something we continue to address through integrated pathways and assertive engagement.*

*Service users' expectations of the detoxification process can significantly influence their experience. For those undergoing detoxification for the first time, the process may feel overwhelming, even with extensive pre-detoxification planning provided by the community treatment team. The sense of overwhelm can lead to a deterioration in mental health, prompting some individuals to leave to return to their familiar support networks.*

*In some cases, service users may choose to exit detoxification early if they feel they have achieved their immediate goals in the first week of being admitted and no longer require further medically assisted intervention. External factors, such as relationship pressures or a desire to reunite with loved ones, can also contribute to early departures.*

*Additionally, cravings or urges to use substances may become intense and difficult to manage, which can result in the service user discontinuing treatment prematurely."*

**Impact Statement: Exit data highlights the importance of tailored pre-treatment support and integrated pathways to reduce dropouts and improve outcomes.**

[5] Source: OHID Adult substance misuse treatment statistics 2023 to 2024

[6] Source: C&M IPDAPP (reporting portal)

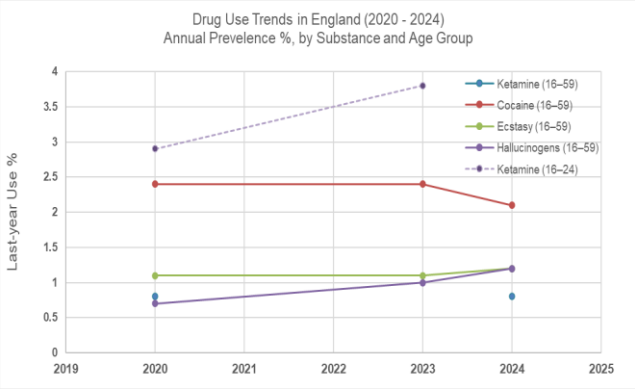
# Ketamine Case Study
# *'The new kid on the block'*

In Cheshire and Merseyside the community team in St Helens started to recognise a significant and concerning rise in Ketamine use among younger people from late 2021 to early 2022. This increase had spread across Merseyside by 2024.

At this time there was a general lack of awareness of the serious physical harm that regular ketamine use could cause, and because of this, many users only sought help after 3 - 4 years' use due to a lack of awareness and stigma.

An attraction of Ketamine to this user group was that it was, and remains cheap, widely available, and sold for as little as £5 per gram.

## National context




The Office of National Statistics published a report which provided a comparison of ketamine misuse trends with other drug misuse trends in England and Wales[7].

- Ketamine misuse has seen a significant rise, particularly among young people, with a 231% increase in use among 16-24-year-olds since 2013 (approximately 269,000 young people) – although this will be a major under reporting of the number of young people using this drug.
- This highlights a growing concern specific to ketamine, and it is assumed that users may underestimate the drug's addictiveness and the risk of irreversible physical damage, such as bladder damage, amongst other health risks.

## Jack's Story

Josephine Moore RGN, registered manager at Birchwood IPD facility, shares Jack's story[8].

Jack was 24, weighed 6st 10lbs (BMI 13.4)when he first came to Birchwood. He had been taking Ketamine since the age of 16.

Jo's team worked with Jack's GP and also local acute healthcare teams to get Jack stabilised and within six days, Jack joined the programme at Birchwood (Jan 25).

Jack's treatment involved 28 days detoxification on a low dose Lorazepam reducing regime after which he moved into Birchwood's rehabilitation programme. Jack was very engaged with this programme and progressed really well.

Birchwood have supported dietitian engagement that began in April 25. Jack has also required treatment and care from healthcare teams to treat his physical health. This includes orthopaedics (for broken arm left untreated), nasal reconstruction and continued close monitoring from Hepatology and Urology teams.

In just under 11 weeks, Jack gained weight; from 6 to 11 stone, with a new BMI of 22.7.

## Jo's personal reflection

*"I knew from the moment I saw Jack that without treatment his life was at serious risk. Thankfully, once he came into Birchwood, the community drug service reacted very quickly and arranged funding for Jack.*

*The reflection needs to be around how we can have a Multi-Disciplinary Team (MDT) process in place for these types of cases. If left much longer Jack's case could have been another death review.*

*We must learn from complex cases like this and prevent these harms and injuries form worsening or even starting. In these cases involving Ketamine, we still have a lot of work to do."*

**Impact Statement: The case highlights the effectiveness of rapid, coordinated responses for high-risk, complex cases, including emerging drug trends.**

[7] Source: ONS Drug Misuse in England and Wales

[8] Jack's name has been changed to protect his privacy

# Challenges Ahead

Consortium members have provided their thoughts on emerging / future challenges that we may need to address collectively.

## Low volume / high complexity need from children and young people (CYP)

In November 2024, OHID published the “Children and young people's substance misuse treatment statistics 2023 to 2024”. The report covered alcohol and drug treatment data for individuals aged 17 and under across England and stated that 14,352 young people (under 18) received specialist substance misuse (mostly community based) treatment in 2023-2024 (an increase of 16% on previous year), with 85% of young people who left treatment successfully completing this episode.

In the North West region, there is the availability of a small, tailored CYP inpatient detoxification service from the Chapman Barker unit (GMMH), however treatment places are limited and not always suitable for all CYP cases.

Offering inpatient detoxification services for under-18s in the UK faces several barriers:

1. **Limited facilities:** there are few residential units equipped to handle the specific needs of U-18s, particularly those with high physical health or dual diagnosis needs.
2. **Funding and resources:** limited funding and resources can limit the availability and quality of services.
3. **Workforce challenges:** high staff turnover and the need for specialised training to handle adolescent cases can impact service availability.
4. **Parental consent:** parental consent is required for treatment, which can delay or complicate access.
5. **Stigma:** societal stigma around substance use disorders can prevent adolescents from seeking or receiving care.
6. **Engagement:** the multiagency approach (CAMHS, Social worker, GP etc is slow and MDT discussions may be frequently cancelled and/or delayed). In addition, adolescents may have lower personal insight and motivation and face challenges in engaging with treatment.

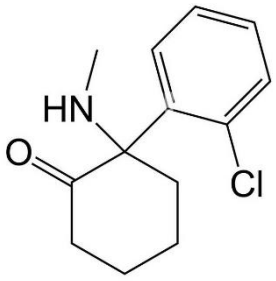
## Increasing complexities

There are increasing challenges associated with substance misuse, especially with younger people, and with more complex cases. The numbers and intensity are rising. This in turn demands more time from community teams and IPD service providers, alongside specialist input, and a coordinated multi discipline approach across systems. These increasing complexities include:

- **polysubstance use** (ketamine, alcohol, crack cocaine, opioids)
- **physical health issues** (bladder damage, malnutrition, chronic pain)
- **mental health challenges requiring dual support** (anxiety, depression, trauma)
- **high-risk patterns among younger users with limited service engagement**
- **unstable housing / homelessness adding barriers to recovery.**

## Increasing prevalence of Ketamine

As previously discussed, there is increasing occurrence of Ketamine use across Cheshire and Merseyside.




The associated and severe physical health problems, including bladder damage, kidney failure, liver damage, incontinence, and impotence often require intensive medical treatment and can have long-term negative physical and mental health consequences.

In Cheshire and Merseyside, even with the extensive stable of treatment facilities there remains limited capacity, and it is being recognised that we must look at how we can work together, across multiple disciplines, to support individuals who require inpatient detoxification treatments.

**Impact Statement: Proactive planning and multiagency collaboration are required to manage high-complexity cases and emerging substance misuse trends.**

# Impact: Changing Lives Through Collaboration

"This pathway is more than a service; it is a lifeline. It offers hope, choice, and a chance for recovery to those who need it most."

## At a Glance: This Year's Achievements

| | |
|---|---|
| **Lives Transformed** | **174** service users accessed life-changing inpatient detoxification through the Consortium pathway – a **20% increase** year-on-year. |
| **Treatment Success** | **82% of Consortium pathway service users completed treatment fully**, outperforming the 47% national rate across all treatment settings. |
| **Access & Speed** | **28.49 days** average wait vs. 30-day national indicative target. |
| **Reducing Costs** | **Average bed cost of £353**, lower than national averages |
| **Safety & Outcomes** | **Drug-related deaths: no change** locally vs. 10.5% national rise.<br>**Alcohol-specific deaths down 1.1%** locally vs. +4.6% nationally. |
| **Equity & Choice** | **5** providers, **6** sites; **access is equal regardless of postcode**. |
| **System Efficiency** | A **Universal Referral Form** replacing 6, streamlining access for all. |
| **Emerging Threat** | Responsive **call to action** on rising ketamine misuse. |

## A Collaborative Model That Works

The Consortium unites nine local authorities, six inpatient facilities, community teams, and commissioning leaders in a single, demand-led pathway. This approach:

- Created a practice among IPD providers of communication, collaboration and co-operation, rather than being in unspoken competition. This has had positive benefits for staff morale as well as improving the treatment offer to service users.
- Minimised waiting times for placement commencement for service users, as this practice of collaboration has mean that referrals can be shared around if the first-choice provider has a longer wait time.
- This process is made more efficient and effective by the adoption of a shared referral form by consortium members (and wider).

## Behind every statistic there is a personal story of recovery and courage

- Individuals finding safety after years of instability and turmoil
- Families finding recovery through stability and hope.
- Community teams empowered to be able to respond faster and offer life changing opportunities

## Looking Ahead

The Consortium stands ready to:

- Respond to the Ketamine challenge with rapid and co-ordinated actions from the teams.
- Expand equitable access across the region.
- Embed lived experience voices in planning and decision making.
- Offer this model, and its benefits as an example of effective, system led commissioning.

# 2025 – 2026 Timetable for Improvement

| Month | Planned Activity | Lead / Owner |
|---|---|---|
| September 2025 | *Impact Report* publication | Jane Pine, MIAA Solutions & Gary Rickwood |
| October 2025 | Further enhancement of the IPD reporting platform | Jane Pine & Emma Monk, MIAA Solutions |
| October 2025 | Embed Experts by Experience | Emma Monk, MIAA Solutions |
| November 2025 | Explore / establish Detox Directory & Vacancy Portal funding | Dan Bennett & MIAA Solutions |
| November 2025 | NHS PSR new service provider framework mobilised | Jane Pine, MIAA Solutions |
| December 2025 | Determine the future approach to future Consortium administrative support | Gary Rickwood & Commissioners |
| January 2026 | Assess children's pathway, focus on Ketamine crisis | Consortium & MIAA Solutions |

**Impact Statement:** **The timetable demonstrates the Consortium's accountability, continuous improvement, and forward planning while embedding service user voice and innovative tools into the pathway.**