For feedback, please contact Sandie.Harwood@leicester.gov.uk Last updated 4-Apr-16 Review date 30-Apr-17

Drugs

Introduction

Drug misuse is associated with a range of psychological, physical and social issues and addressing these remain a key national and local priority.

Under the Misuse of Drugs Act 1971, illegal drugs are placed into one of 3 classes - A, B or C. This is broadly based on the harms they cause either to the user or to society when they are misused.

- Class A drugs include: heroin (diamorphine), cocaine (including crack), methadone, ecstasy (MDMA), LSD and magic mushrooms
- Class B drugs include: amphetamines, barbiturates, codeine, cannabis, cathinones (including mephadrome) and synthetic cannabinoids
- Class C drugs include: benzodiazepines, GHB/GBL, Ketamine, anabolic steroids and BZP.

Not all drugs are illegal, however their being legal does not mean that they are not harmful. The use of novel psychoactive substances (NPS) represents an emerging risk and the extent of the impact of these substances is not yet fully understood.

Who's at risk and why?

A number of factors have been identified as increasing the risk of drug misuse including[1]:

- Growing up in a household in which neglect, drug misuse, emotional or physical abuse has taken place
- Mental health problems including depression, anxiety and attention deficit disorder
- Unemployment, low educational attainment, vocational problems
- Socialising with other people who use/misuse drugs
- Previous drug use

On a number of these factors feature in the Leicester population. For example:

- the city has higher reported rates of domestic abuse than the England average (22 per 1,000 population compared to 19.4 per 1,000) in 2013/14;
- the proportion of the adult population long term unemployed is 0.91%, higher than the England average of 0.61%;
- the proportion of adults in Leicester with low educational attainment is 41.5%, again higher than the England average of 35.8%[2].

Drug misuse comprises the use of illegal drugs such as Class A drugs, volatile substances such as gas, over the counter (OTC) and prescribed drugs, such as opiate based pain killers and tranquillizers, along with emerging substances such as NPS, which are sometimes referred to as 'legal highs'.

Overall, drug use within the adult population is relatively low and illicit drug use has reduced significantly over the last 10 years. Despite this downward trend in drug use in the long term, a significant increase in 2013/14, compared to the previous year, indicates that illicit drug use continues to be a considerable national challenge.

According to the Crime Survey for England and Wales (CSEW) 2013/14[3], 8.8% of adults nationally (aged 16-59) had taken an illicit drug in the previous year, with just 3.1% having taken a Class A drug. Cannabis is the most prevalent and popular illicit drug used, having been taken by 6.6% of 16-59 year olds, followed by powder cocaine (2.4%) and ecstasy (1.6%). Compared to data from the 1996 Crime Survey, there is some evidence that fewer young adults (aged 16-24 years) report drug use and the proportion of users aged over 45 years has increased.

Drug use and drug dependence are known causes of premature mortality, with drug poisoning accounting for 1 in 7 (14.6%) deaths among people in their 20s and 30s in 2014[4].

Problems are wide ranging and include physical and psychological dependency, acute medical problems such as overdose and drug-induced psychosis; chronic illness such as blood borne viruses through the use of shared injecting equipment (it is estimated that 50% of those who inject drugs are infected with Hepatitis C virus[5]), and social consequences such as drug related acquisitive crime and the risk of criminal proceedings through illegal use.

Rates for overall and frequent drug use have remained fairly static over the last 3 years. The overall rate of frequent drug use (more than once per month) is 3.1%.

Gender
Men are three times more likely to be frequent drug users than women.

Age
Young adults (16-24 years) are nearly three times more likely to be frequent users, compared to older adults (25- 59 years).

Ethnicity
The Crime Survey for England and Wales suggests that rates of overall drug use vary across different ethnic groups. Those from Mixed race backgrounds were found to have the highest rates of reported drug use, followed by those from All White backgrounds. All South Asian backgrounds had the lowest rates of drug use.

Sexuality
Sexual orientation also appears to be an important factor. Rates of overall drug use were reported to be significantly higher for gay/bisexual adults than heterosexuals (28.4% compared to 8.1%). This was the case for both sexes, although more so for gay/bisexual men.

Socioeconomic status
Frequent drug users were five times more likely to be unemployed rather than in employment. Frequent drug users were also twice as likely to live in the 20% most deprived output areas, than the 20% least deprived output areas.

The overall drug market, for those who regularly use drugs, in particular those opiates such as heroin, appears to be developing in its complexity and level of risk. A national street drug survey by Drugscope entitled 'Down a Stony Road[6], undertaken at the end of 2014, highlights concerns around the increased levels of purity in heroin (potentially increasing the risk of overdose), the increased use of prescribed drugs such as Pregabalin (an anti-convulsant) alongside heroin and NPS, in particular, synthetic cannabinoids.

The September 2015 ONS report into drug-related deaths in 2014[7] also identified the increased purity of heroin, alongside greater use of prescribed opioid painkillers, as likely factors in the increase in drug-related deaths 2012-14.

The level of need in the population

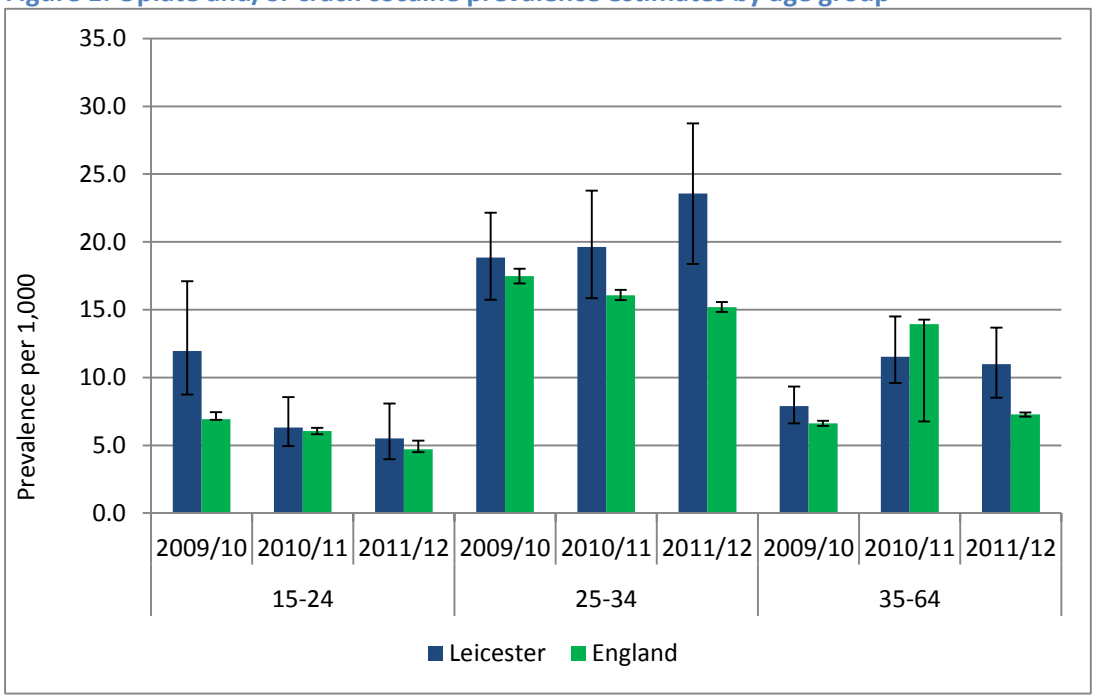
Prevalence of drug taking in Leicester

The drug prevalence rates from the 2013/14 Crime Survey of England and Wales applied to the Leicester, suggest that around 18,396 of 16-59 year olds in Leicester took an illegal drug in the last year; it is likely that around two-thirds of these were male. Most of this drug use would be related to cannabis. 16-24 year olds are more likely to have a higher rate of drug use and are twice as likely to be frequent users. About 3,757 local 16-24 year olds are likely to be 'regular users', which means they are using drugs at least once per month.

Areas with relatively high rates of deprivation are more likely to have higher rates of drug use amongst the population. In Leicester, those areas with the highest presenting need to local drug services (per 1,000 head of the adult population), are also areas with high levels of deprivation including New Parks, Abbey and Eyres Monsell. However, Spinney Hills and Belgrave areas have high deprivation and low rates of presentation to drug services. These areas have large South Asian communities, which national surveys suggest have a lower prevalence of drug misuse.

Based on the Glasgow prevalence model from John Moores University (2011/12), Figure 1 shows that Leicester has a relatively high rate of opiate and crack/cocaine users (OCUs) - estimated to be 12.6 per 1,000, compared to a national rate of 8.4 per 1,000. This is equivalent to approximately 2,859 (with a 95% confidence interval (CI) of between 2,424 and 3,281) OCUs in Leicester, 617 of whom are injecting the drugs they use. In contrast to the national trend, the prevalence estimation model indicates an increasing number of OCUs in Leicester, though the rate does fluctuate. Approximately 45% of the estimated OCUs are aged 25-34 years old. However, there have been no updates on the Glasgow model since 2011/12.

Figure 1: Opiate and/or crack cocaine prevalence estimates by age group



Data: *Glasgow Prevalence model, John Moore's University*

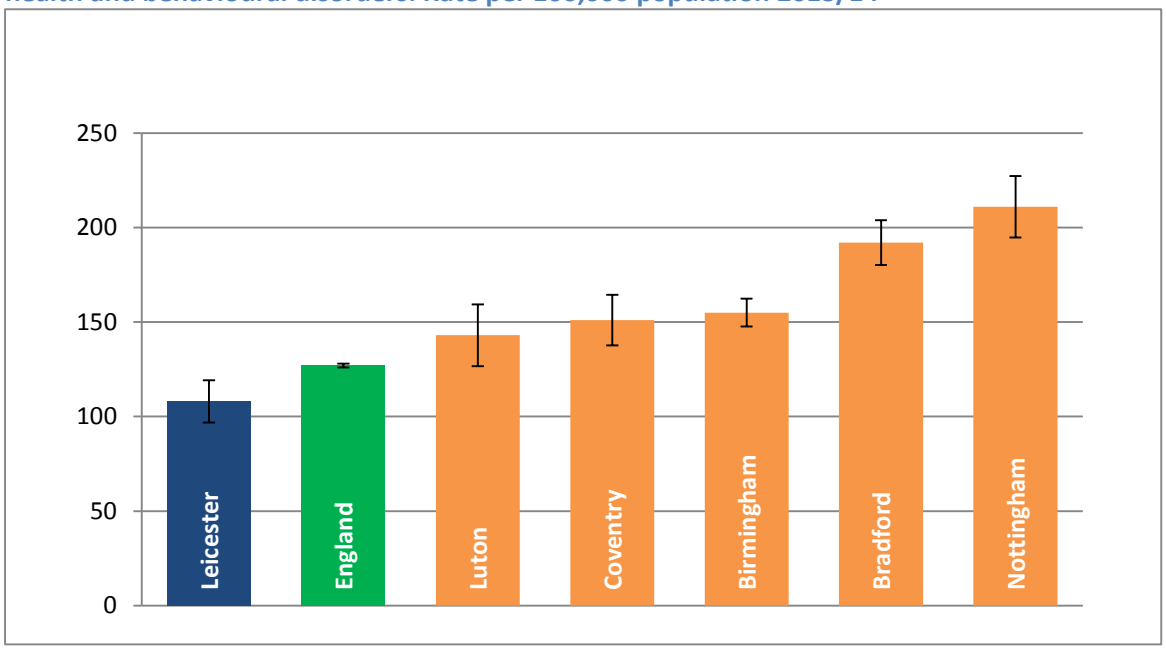
Hospital Admissions

Hospital admission in drug users may be for the primary effects of drug use such as poisoning or as a consequence of co-morbidities such as mental health issues.

Drug related mental health hospital admissions

Figure 2 shows that hospital admission rates in Leicester, with a primary or secondary diagnosis of drug-related mental health problems in 2013/14, were lower than the England average and peer comparator local authorities.

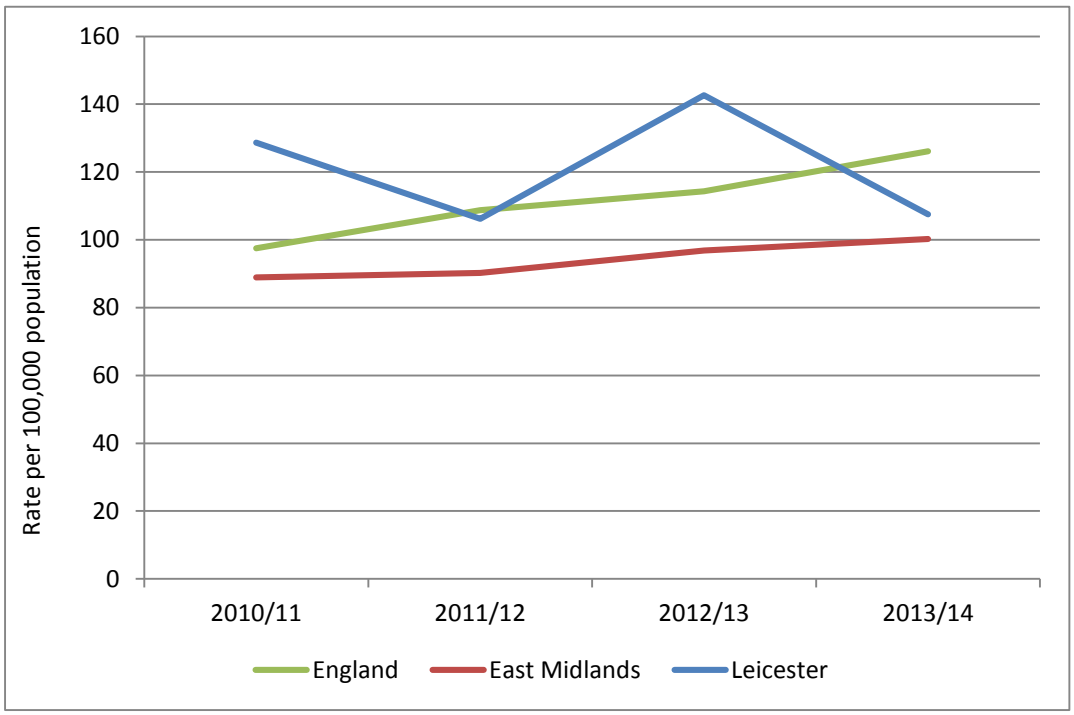
Figure 2: Hospital admission rates with a primary or secondary diagnosis of drug-related mental health and behavioural disorders. Rate per 100,000 population 2013/14



Data: *Health and Social Care Information Centre, Drug Misuse in England data 2014*

Figure 3 shows that there has been an increase in the national rate of hospital admissions for drug-related mental health and behavioural disorders over time, whilst Leicester's rate has fluctuated. Although the local trend appears now to be falling, admission rates remain above the East Midlands regional average.

Figure 3: Trend in hospital admission rates with a primary or secondary diagnosis of drug-related mental health and behavioural disorders

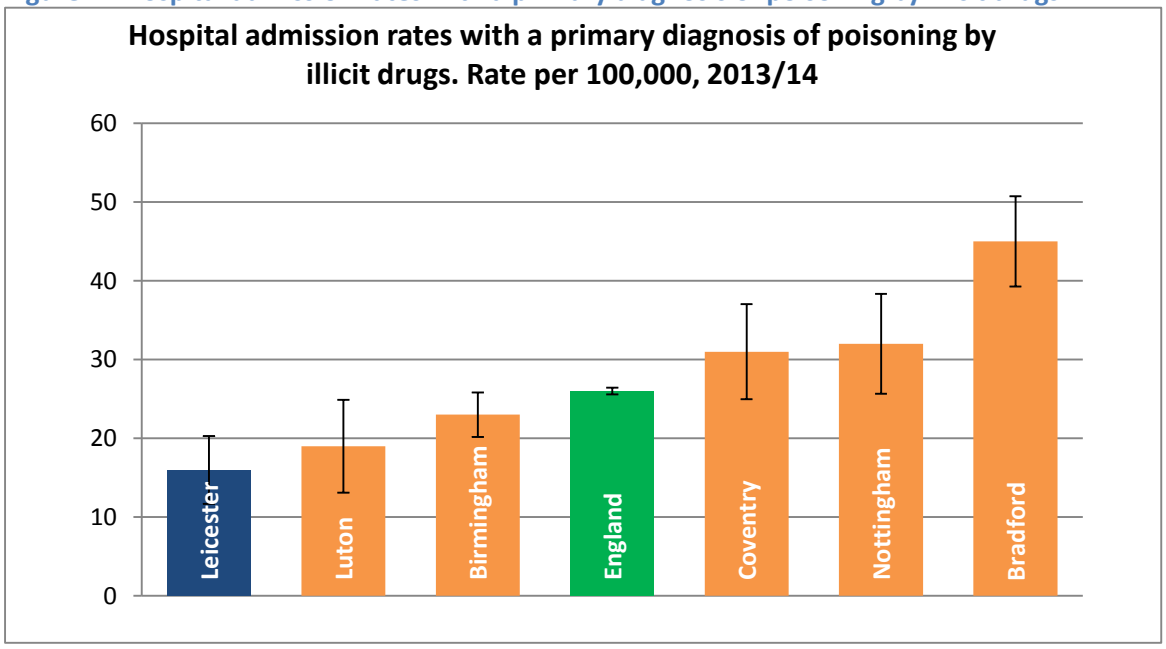


Data: *Health and Social Care Information Centre, Hospital Episode Statistics*

Drug Poisoning Hospital Admissions

Figure 4 illustrates the hospital admission rates in 2013/14 for a primary diagnosis of poisoning by illicit drugs. Leicester has the lowest rate in our comparator group and the rate of admission is lower than the national average.

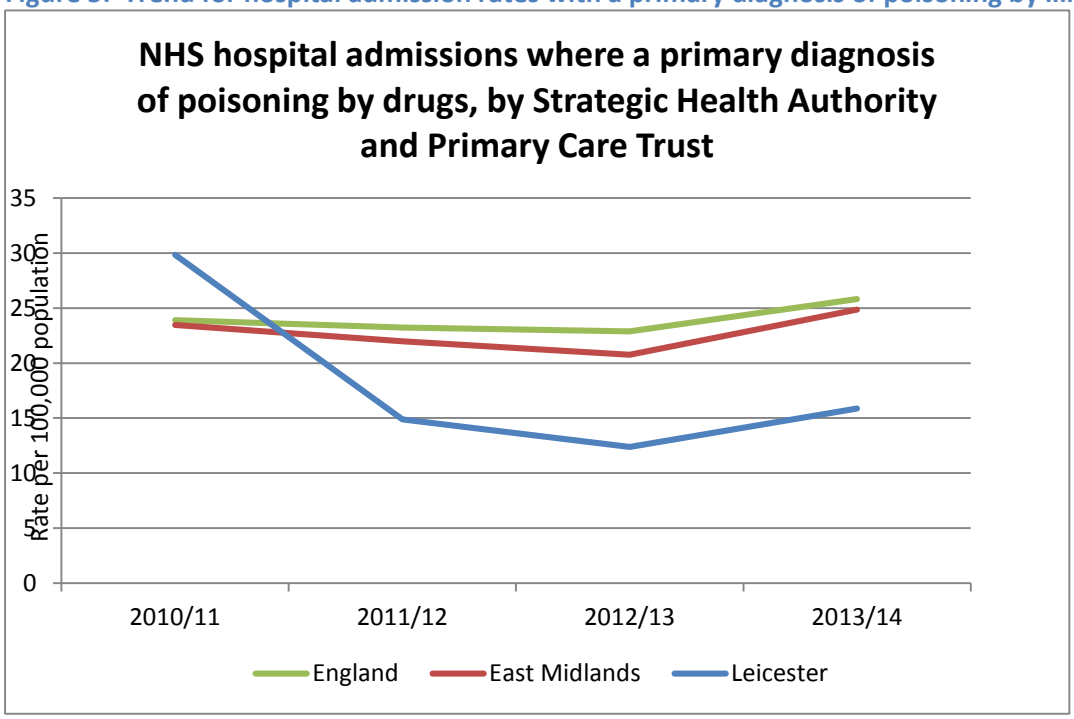
Figure 4: Hospital admission rates with a primary diagnosis of poisoning by illicit drugs



Data: *Health and Social Care Information Centre, Drug Misuse in England data 2014*

Figure 5 shows that for drug poisoning, hospital admission rates in Leicester have reduced over the past 3 years, although there was an increase in 2013/14. Rates are lower than the regional and national averages.

Figure 5: Trend for hospital admission rates with a primary diagnosis of poisoning by illicit drugs



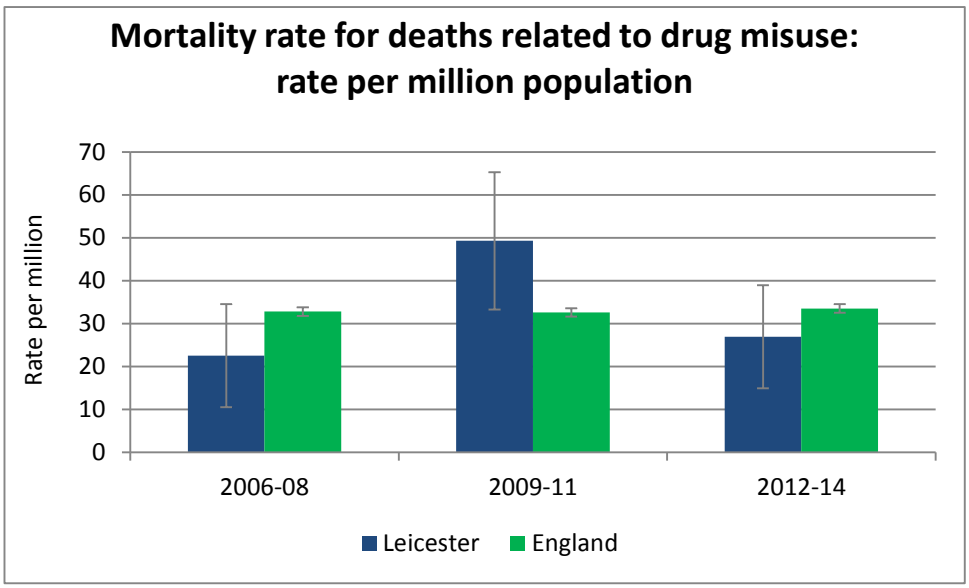
Mortality

Nationally, drug-related poisonings, as a proportion of drug-related deaths (which also include suicide, dependence and other factors) significantly increased over 2014[8]:

- There were 3,346 drug poisoning deaths registered in England and Wales in 2014, the highest since comparable records began in 1993, of which two-thirds involved illegal drugs.
- The mortality rate from drug misuse was the highest ever recorded at 39.9 deaths per million.
- Males were over 2.5 times more likely to die from drug misuse than females (58.0 and 21.9 deaths per million for males and females respectively), in particular those in the 30-49 age group.
- Deaths involving heroin and/or morphine increased by almost two-thirds over the years 2012 through 2014, and deaths involving cocaine increased by 46% from 2013.
- People aged 40 to 49 had the highest mortality rate from drug misuse (88.4 deaths per million); followed by people aged 30 to 39 (87.9 deaths per million).

Figure 6 shows that in Leicester, numbers of drug-related deaths are relatively small and fluctuate annually. Between 2006 and 2014 there were 96 drug related deaths in Leicester (roughly 10 per year).

Figure 6: Mortality rate for deaths related to drug misuse



Data: *ONS drug-related deaths: http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-406863*

Drug use and other vulnerabilities

It is known from local figures that there is a close association between housing and substance related need, and other vulnerabilities. For example, of the 879 users presenting to Action Homeless services from April 2014 to November 2015, 56% had a primary substance misuse issue. Furthermore, 27% of those adults identified by the Leicester City Council in 2014/15 with a housing support-related need, had an identified issue with alcohol, drugs or both; and of this group over a quarter had either a mental health problem and/or are offending.

Hard Edges: Mapping severe and multiple disadvantage identified Leicester as having the 11th highest prevalence of severe and multiple disadvantage among upper tier (social services) local authorities in England (looking at combined homelessness, substance misuse and offending data).[9]

Presenting Need

Table 1 shows that of the 1,400-1,500 people in Leicester drug treatment services, over 90% are opiate and/or crack users (OCUs). The numbers of opiate users in treatment have remained consistent over the last 3 years – 1,298 (2014/15), 1,304 (2013/14) and 1,281 (2012/13) - and roughly one-third of these also use crack.

Table 1: Numbers recorded in drug treatment services in Leicester

Leicester	2010/11	2011/12	2012/13	2013/14
Total	1546	1412	1432	1467
OCU	90%	92%	94.5%	93%
Cannabis	6%	5%	4%	5%
Amphetamine	2%	1%	1%	1%
Other	2%	2%	0.5%	1%

Data: National Drug Treatment Monitoring System

Roughly a quarter of people in treatment are undergoing their first episode of treatment, although it should be noted that for some individuals, this treatment has lasted 6 or more years. Whilst this illustrates good engagement, it does also suggest that some people are not moving through the system into recovery. Of those having repeat treatment episodes, there has been an increase in the proportion having three or more treatment episodes, from 37% to 42% between 2012 and 2015.

Based on the 'Glasgow estimates' of expected numbers of OCUs, Public Health England estimate that only 46.6% of Leicester's OCUs appear in treatment services, with this being slightly lower than the England average of 53.8%. There is still some work to be done locally, to fully understand why some individuals who might benefit from treatment services, are not engaging with those services.

Cannabis is the next most common drug for which clients receive treatment. During 2013–2015, in the region of 280 people were treated for cannabis use per year.

Over the same time period, the numbers in treatment for cocaine and amphetamine have been increasing from 92 to 113 and from 65 to 85 respectively.

Alcohol is also an issue for some drug users. There has been an increase in the number of users in the combined drug and alcohol treatment system. These rose from 319 to 354 and 39% of these were drinking more than 400 units of alcohol per month.

The demographic profile of the local treatment population has remained relatively unchanged between 2010/11 and 2014/15. The male: female ratio has stayed around 76:24. There have been some slight changes in the ethnic make up of those in treatment, although the proportion of White British users has remained consistently high at around 76-79%. The next largest ethnic groups are Indian at 6%, White Other at 3-4%, White/Black Caribbean at 2.5-3%, and Other Asian at 2-3%. Other black and minority ethnic (BME) groups constituted very low proportions of service take up, typically 1-2% or less.

The proportion of White British drug users within the Criminal Justice (CJ) drug service is higher than the White British rate across all local drug services, at around 84%.

The national crime survey on drugs (CSEW 2013/14) found that adults from a Mixed ethnic group background were most likely to have taken an illicit drug in the last year, compared to any other ethnic group (17.1%); adults from an Asian or Asian British background generally had the lowest levels of drug use (3.4%); and around 9% of White British adults reported use of drugs in the last year. 5.8% of those from a Black or Black British background reported use of drugs. However, the most commonly used drug was cannabis, and those using this exclusively, feature minimally within the local treatment population.

There seems to be a gradual ageing of the drug treatment population, echoing the national trend. The 25-44 year old cohort has consistently represented around 74% of users, however the 20-29 age group has reduced from 30% to 20% over the last 4 years, while the 35-49 age group has risen from 38% to 48%.

Leicester has a large proportion of drug referrals coming from the Criminal Justice system: 43.5% in 2014/15 compared to around 32% nationally. 37% of drug users refer themselves. Both men and women are more likely to be referred via the Criminal Justice system than any other route, although women are more likely to self-refer than men.

Levels of complexity in the local treatment population (38%) are higher than England (30%) and have risen since 2011/12. Complexity scores are given for frequency and type of drug use, for instance, high scores are given both to opiate use and daily opiate use.

The proportion of users with "dual diagnosis" (12%) and a "housing problem" (25%) are relatively small, but reflect areas of complexity. These levels have remained relatively constant for the last 3-4 years.

In looking at housing need for those who successfully complete treatment, nationally 81% no longer report a housing need, compared to 63% locally, suggesting that this remains an issue for a significant number of users in recovery.

Around a quarter of adults in specialist drug services have children living with them for at least part of the time. Five areas - New Parks, Braunstone, Abbey, Beaumont Leys and Stoneygate - have above average rates of presenting need and numbers of children in the general population, suggesting the potential impact from parental substance misuse may be greater here than in other areas.

Over the counter (OTC)/Prescription drugs are a reported concern for a relatively small proportion of those in treatment. For those who also use illegal drugs (6% of the overall treatment population), it appears benzodiazepines are the most common concern; with opiate based medication the main concern for those who were not also using illegal drugs (3%).

The numbers presenting to treatment services for use of 'club' drugs (including ecstasy, ketamine, mephedrone (known as 'MCAT') and other NPS), is relatively low - just 55 people or 2.5% of all those using drug and alcohol treatment services; although the numbers have increased since 2013/14(37). Mephedrone (or 'MCAT') has been the most frequently reported club drug for those in treatment, accounting for around two-thirds of those using club drugs in 2014/15.

Current services in relation to need

The 2010 drug strategy *Reducing Demand: Restricting Supply; Building Recovery*[10] aimed to support people to achieve a drug free life. Previous strategies were mainly concerned with the harms caused by drug misuse. Although a harm reduction approach is still relevant, the strategy looked at taking this further, by supporting individuals to choose recovery as a way out of dependence, on all drugs, including prescription and over the counter substances, as well as alcohol dependence.

Specialist substance misuse services have a key role to play, in both providing evidenced treatments that have proven clinical effectiveness, such as opioid substitution therapy (recommended by NICE[11]) and in preventing drug-related deaths through overdose prevention and the like.[12]

It is a requirement of the public health grant (that provides most funding for drug treatment services) for 2015/16 that local authorities, in discharging their functions around public health: "have regard to the need to improve the take up of, and outcomes from, its drug and alcohol misuse treatment services."

Adult drug services are currently delivered by two services – LIFT, which is for those in the Criminal Justice system including those in H.M.P. Leicester; and Leicester Recovery Partnership, which is for those not in the Criminal Justice system. Successful completion (which mainly equates to abstinence) of treatment and non-representation (within 6 months) are key outcomes. A newly contracted service will begin on 1st July 2016, which will combine all adult and young person drug and alcohol services for Leicester and Leicestershire.

In addition, there are 15 beds allocated at the Woodlands centre in Nottinghamshire for clients requiring specialist inpatient detoxification from substances across Leicester, Leicestershire (and Rutland); and a project called 'The Avenue' provides supported accommodation for up to 10 adults across two properties in Leicester City, alongside floating support. Referrals come from the specialist substance misuse services. This project is currently being retendered and a newly contracted service will start in July 2016.

A small number of users (around 15 per year) go to specialist residential rehabilitation centres around the country. This pathway is managed by the Community Care Assessment Team, with staff from Leicester City Council and is currently located within Leicestershire Recovery Partnership. The team receives referrals from treatment services in Leicester, Leicestershire (and Rutland) and undertakes multi-disciplinary assessments and follow up reviews, following placement.

The high level Public Health Outcomes Framework (PHOF) indicator for substance misuse, measures levels of successful completions and non-representations (PHOF indicator 2.15), aiming at increasingly high levels of individuals that successfully complete treatment and do not represent within 6 months. 2014/15 saw improvements in the proportion of individuals successfully completing drug treatment in Leicester.

There is an increasing focus on recovery from substance misuse, which goes beyond both abstinence and successful completion of drug or alcohol treatment. It includes abstinence, alongside improved physical and mental health and opportunities to develop activities and networks away from substances. It has a focus on making and sustaining progress on "jobs, homes, friends".

Peer support and mutual aid is an important ingredient of recovery, as it provides opportunities for support and the development of a user's own capacity to provide support to others. Access to mutual aid has a low access threshold and is available whether or not people are in treatment. It is an important ingredient of support for those who have successfully left treatment drug free, but face an ongoing challenge to maintain their abstinence.

Treatment providers have an important role to play in supporting users into recovery. Beyond the provision of clinical care and psycho-social interventions, they can work to link users to activities and networks that help to grow recovery capital; they can also provide a link to mutual aid and offer opportunities for users to become volunteers and peer mentors. There is a developing recovery community in Leicester, in particular through the work of 'Dear Albert', which develops mutual aid facilitation through its 'you do the MAFs' (Mutual Aid Facilitation) courses[1]. This community is independent of, but works collaboratively with, treatment services.

Projected services use and outcomes in 3-5 years and 5-10 years

It is difficult to project service use demand, as there is a connection to market availability, price and legality of substances, as well as accessibility and promotion of service pathways. For instance, increased availability and purity of heroin, may increase opiate treatment demand; the impact of classifying khat in June 2014 has not yet had an impact on presenting need, but may do so in due course; and forthcoming legislation on NPS may have an impact on problem use. Furthermore, services have traditionally focussed on Class A drug use, in particular opiates, and if pathways for non-opiates such as cannabis are developed more fully in future, demand may be greater than current trends suggest.

[1] More information about this can be found at: http://www.dearalbert.co.uk/

On the basis of trends of service activity between 2010/11 and 2014/15, by 2017/18 we expect the minimum levels of treatment demand to be around:

- Opiates - around 1,200-1,300 individuals per annum (this fits within the levels of demand within the last two to three years, which have been relatively static).
- Non-opiates - around 170-190 individuals per annum, with this prediction allowing for a small increase in those seeking help with non-opiates only. This does not include those who use non-opiates alongside opiates.

However, as indicated above, the demand for non-opiates could be higher than this, if different pathways are developed and promoted effectively.

In addition to treatment, services are required for information and advice around substances and these are needed not only for those in treatment, but also for those who may not have a treatment need; advice for carers and parents and needle exchange services, including for those who use steroids. Just over half of those accessing the centre-based scheme, report being steroid users. Based on current levels of demand, we expect between 500-600 people to use the centre-based needle exchange scheme per year. Currently around 500-600 people use the specialist centre-based needle exchange service per year, with an average of about 11 contacts per day. Where known, about 56% of these are using performance and image enhancing drugs (PIEDS). There was a 106% rise in those citing PIED use in contact with the local centre-based needle exchange from 2009/10 to 2012/13. This does not include those who also access pharmacy-based schemes, where we anticipate that, on average, 6 people use those services per day.

Unmet needs and service gaps

According to Glasgow University estimates, only around half of opiate and crack cocaine users may be in treatment locally.

Cannabis use is more widespread than other drugs nationally and locally, yet there are a relatively small number of users presenting to services.

A relatively small number of primary OTC/prescription drug users are in contact with services.

Young adults are under-represented within services, despite their being the most regular users of illegal drugs.

There are relatively few individuals from BME communities within drug services. Where members of these communities do present, they are at a significantly lower rate than the local population as a whole. There may be a number of explanations for this, for example, prevalence of drug use, the types of drugs used and the presenting needs in these populations are different from the main cohort (mainly opiate use), which may make treatment services appear irrelevant/unsuitable /culturally inappropriate to BME communities. It may be that the stigma associated with drug misuse dissuades individuals from seeking help, that families try to support individuals with drug problems within the family unit, or that some communities are not aware of the local treatment services and the help and support they can offer.

The British Crime survey has indicated that overall drug use amongst South Asian communities is significantly lower than for mixed race and White British populations. However, if we compare presenting need over the 2011/12 to 2014/15 period within the largest BME group in Leicester, the Asian Indian population, with other comparable areas, Leicester appears to have a relatively low

proportion of Asian Indian clients presenting to drug services. This comparison looks at five other areas with Asian Indian populations ranging from 15.6% to 26.4%, compared to an estimated rate in Leicester of around 28%. Over each of these three years, the proportion of Asian Indian clients receiving treatment within Leicester drug services was 6%. For the other five areas, only one area had a proportion of Asian Indian clients lower than 6% and that was only in 2012/13. All, but one of these areas, had a higher proportion of Asian Indian individuals in treatment than Leicester over 2012/13, 2013/14 and 2014/15 and the range was 6% to 15% in 2014/15. Although none of these areas had a proportion of Asian Indian clients that matched the estimated Leicester Asian Indian population, they were all nearer these treatment levels.

This comparison, albeit just for one BME cohort, suggests that there may be unmet need around presenting need for drug users from BME communities.

Recommendations for consideration by commissioners

Commissioners are recommended to:

- Require that services target and become more responsive to users facing multiple issues such as housing and mental illness.
- Require that services promote services for, and engage more effectively with individuals using non-opiate substances, including Novel Psychoactive Substances.
- Have services and commissioners jointly develop further a recovery focused approach and support the growth of recovery communities and opportunities.
- Continue to retain as an integral aim of services, the reduction of harm through, for example, safe and effective substitute prescribing and needle exchange services.
- Develop a strategy to increase engagement of BME communities and consider engagement with other groups that may be under represented, such as those from lesbian, gay, bisexual and transgender (LGBT) communities.

Key contacts

Mark Aspey, Commissioning Manager, Adult Social Care, Leicester City Council; mark.aspey@leicester.gov.uk

Julie O'Boyle: Consultant in Public Health, Leicester City Council; Julie.oboyle@leicester.gov.uk

References

[1] National Institute on Drug Abuse, 2004

[2] http://fingertips.phe.org.uk/profile-group/mental-health/profile/common-mental-disorders/data#page/1/gid/8000041/pat/6/par/E12000004/ati/102/are/E06000016

[3] https://www.gov.uk/government/publications/drug-misuse-findings-from-the-2013-to-2014-csew/drug-misuse-findings-from-the-201314-crime-survey-for-england-and-wales

[4] http://www.ons.gov.uk/ons/dcp171778_414574.pdf

[5] PHE 2015 Hepatitis in the UK:

http://www.hcvaction.org.uk/sites/default/files/resources/Hepatitis%20C%20in%20the%20UK%202015%20report.pdf

[6] http://www.senedd.assembly.wales/documents/s36321/ASMAI%2030%20DrugScope.pdf

[7] Deaths Related to Drug Poisoning in England and Wales: 2014 registrations
http://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsrelatedtodrugpoisoninginenglandandwales/2015-09-03
[8] http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-406863

[9] *Hard Edges: Mapping severe and multiple disadvantage.* The LankellyChase Foundation, 2015
http://lankellychase.org.uk/wp-content/uploads/2015/07/Hard-Edges-Mapping-SMD-2015.pdf

[10] *Reducing Demand: Restricting Supply; Building Recovery, December 2010*
https://www.gov.uk/government/publications/drug-strategy-2010
[11] https://www.nice.org.uk/guidance/ta114

[12] http://www.nta.nhs.uk/uploads/teip-drd-2014.pdf