Report to:	**Health Overview & Scrutiny Panel**
Date:	**22nd March 2012**
Report by:	**Barry Dickinson, Senior Programme Manager, Integrated Commissioning Unit**
Subject:	**Re-modelling of community substance misuse services for Portsmouth, including de-commissioning existing services and re-commissioning in line with the new model**

1. Purpose of the Report:

This report has two purposes:

- To inform the Health Overview & Scrutiny Panel of community based services as requested by the panel in November when reviewing the plans for re-modelling of in-patient detoxification;
- To present plans to re-model community based services in order to develop a more Recovery Oriented Integrated System of drug and alcohol treatment for the panel's consideration.

2. Background Context:

The 2011/12 Substance Misuse Treatment Plan and NHS Portsmouth Programme Plan for Substance Misuse included an aim of reviewing the existing treatment system and pathways, with a view to creating a system that is more clearly and effectively recovery oriented. Work on that review has been taking place since October 2010 through consultation within the commissioning team and with stakeholders. This paper details the progress of that review and presents a proposed new model for delivering substance misuse treatment within a recovery system. The plan has received approval from the Safer Portsmouth Partnership and will be presented for Integrated Commissioning Board approval on 13th March.

3. National and Local Drivers for Change::

The National Drug Strategy from 1998 presented a clear aim of increasing the number of drug users entering and remaining in treatment, primarily driven by recognition of the link between drug use and acquisitive offending and a desire to reduce crime. Funding for drug treatment was increased, via the "pooled treatment budget", to support this aim and Portsmouth, in line with most other areas responded positively, achieving quite significant increases in the numbers accessing treatment. The current National Drug Strategy issued in late 2010 seeks a more ambitious approach to delivering treatment, through an increased emphasis on attaining positive outcomes from treatment rather than retaining people in treatment. This shift accords with the growing recovery community, both locally and nationally. The strategy refers to "visible contagious recovery" promoted by recovery champions in the community, in treatment/therapeutic roles and strategically.

In Portsmouth we have a well established network of people in recovery (recovery community), which has grown up primarily from the peer-led fellowship movement. The 12-step fellowship groups have a good evidence base of supporting people to achieve and sustain recovery from addiction locally, nationally and internationally. Over the past few years we have sought to develop greater integration

between the peer-support fellowship groups and treatment services. A significant aspect of this integration has been the growth of the PUSH service user forum over the past six years; a partnership funded peer-led service user representation group with a clear ethos of promoting recovery. This group delivers peer-advocacy support for people accessing the treatment services, contributing feedback on an individual, service and system level. This feedback and the views of the growing number of people in recovery engaged with the peer support network accords with the national strategy aim of promoting more recovery focused treatment.

We are therefore in a position of having national (top down) and local (bottom up) drivers for developing a more recovery focused treatment system. A third driver has been around improving performance and efficiency. This relates to the allocation of national drug treatment funding, which is calculated on a formula that takes account of local "complexity" (primarily demographics and deprivation), numbers of individuals accessing treatment and the proportion that are successfully completing treatment and then remaining out of treatment. Whilst there are financial as well as social gains to society from engaging problematic substance users in treatment, through their reduced illicit substance use and associated offending; these gains are even greater if people are enabled to progress through treatment and into sustainable recovery. This involves a more holistic approach that engages the individuals concerned with a whole range of mainstream services, peer support and hopefully training and employment.

4. Consultation to date:

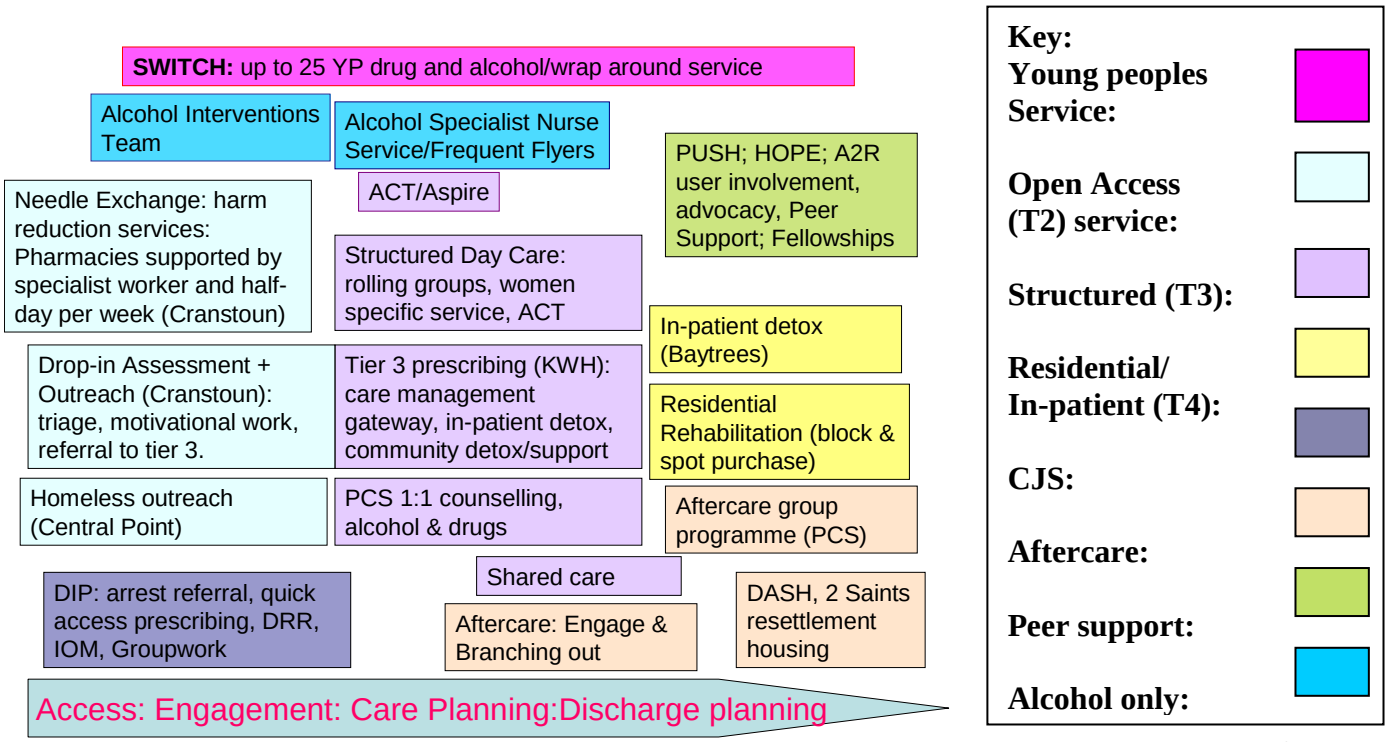
In response to the national and local drivers mentioned as well as the scheduled end-date of three of our substance misuse provider contracts, the action to review the pathway was agreed in the 2011/12 treatment plan.

Specific consultation on the proposed model has included two externally facilitated consultation events with current service provider managers, commissioners and service user representatives (in November 2011 and January 2012). The resulting draft plan and issues highlighted have been taken to the Recovery Action Alliance (quarterly drug and alcohol stakeholder open forum) in early February 2012.

Whilst these consultation meetings acknowledged that we have seen improvements in the current system in relation to services becoming more outcome and recovery focused, and particularly in the extent to which peer-support services are more linked up with specialist treatment services, the overall feedback presented a picture of rather inconsistent levels of engagement with recovery.

5. Current system:

The diagram below (figure 1) shows the current treatment services, with the nominal pathway through treatment moving from left to right:



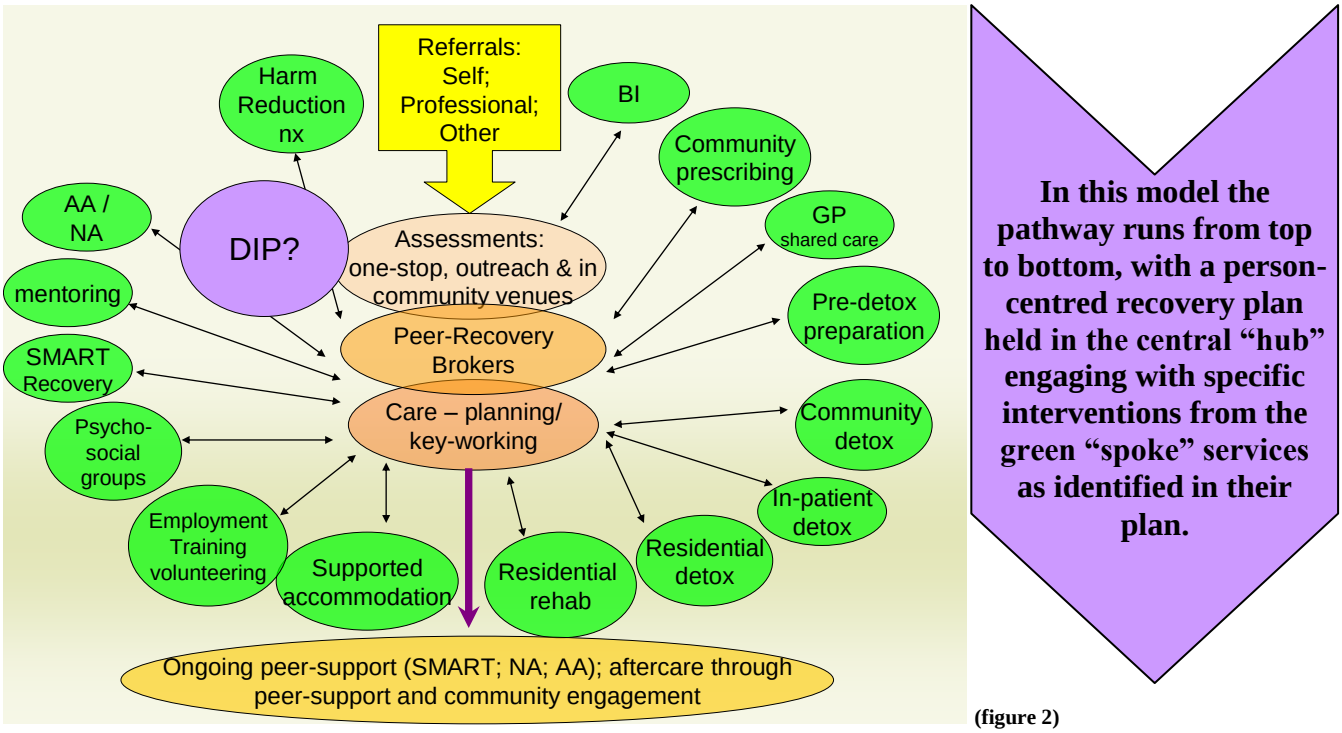
(figure 1)

Whilst the system does have a principle point of access via the Cranstoun delivered Open Access Assessment, people can also directly access the Alcohol, Counselling and Peer Support services, or engage with DIP via criminal justice referral. The main issues identified from consultation with the system were: a sense of "pot-luck" regarding which worker/service you engaged with and a lack of consistent clear direction through the system into recovery.

For individuals undertaking detoxification, preparatory groups are currently available from the community teams at Kingsway House and Cranstoun Drug Services. Post-detox support is available from Cranstoun, through the peer support network, or through onward referral to residential treatment in some cases.

6. Proposed ROIS model:

The proposed new model is represented diagrammatically below (figure 2):



(figure 2)

The model depicted in figure 2 aims to deliver a Recovery Oriented Integrated System (ROIS). The principle advantage being a consistent, person centred and recovery focused plan of care/treatment developed between the individual and their worker in the recovery hub. The hub would need to be independent of the specific interventions delivered but have very clear and open information and communication links with them. It is envisaged that the hub may operate from multiple access points, to maximise accessibility, despite being a single independent team.

One of the developments over the past year to try to embed a recovery focus more concretely in the existing services has been the training of volunteer "recovery brokers". The brokers are individuals with lived experience of recovery who have taken part in an extensive training programme to broaden their understanding of different concepts of and pathways through recovery and equip them with necessary professional skills around working with vulnerable people who are now starting to operate in treatment services, enabling people to engage earlier with the recovery community. The new model incorporates the peer brokers within the "hub" to provide people entering treatment with early engagement with people in recovery and to ensure solid links between the system and the recovery/peer-support community.

The model is compatible with the planned changes to the detoxification pathway presented to the Health Overview and Scrutiny Panel in November. That model includes a brokerage role assessing complexity and level of need which would fit into the hub assessment model of this system. The client centred care/recovery planning function integral to this model aims to ensure that any intervention including detoxification takes place within an agreed and service-user needs led recovery pathway; this will ensure that people are engaged with ongoing support matched to their needs before and after detoxification, to increase the chance of a long-term successful outcome.

The detailed interventions included in the "spokes" surrounding the hub on the diagramme are not intended to be an exhaustive list. It is envisaged that they will include commissioned specialist services addressing the prescribing, detoxification, harm reduction and psychosocial intervention needs of

substance users in line with national good practice and equivalent to services currently provided in the City. However, the precise services commissioned will be determined by further detailed consultation and development with specialist focus groups. Additionally the "spoke" services incorporate non-specialist interventions available in the City to ensure that individuals' diverse recovery plans are accommodated and integration with mainstream community activities is encouraged.

7. Issues to be resolved through ongoing consultation and development:

Further work is required to develop the conceptual model shown into a working system. The project plan proposes to establish a number of specific focused working groups, involving commissioners and other stakeholders with relevant expertise and interest, to develop detailed plans for the following areas, which have been identified as key through the consultation to date:

- **Recovery Hub:** Mapping existing staff resources and client flows; identifying skills, structures, governance, ongoing training requirements, operating models including early intervention, re-engagement of people who drop-out, accessibility etc to set up the assessment and care management hub;
- **Communications:** Evaluate the IT system requirements to support this model of case management; information sharing and governance requirements between different elements of the system and more broadly and develop plans to support these developments;
- **Criminal Justice (DIP):** Appraise options for engagement, assessment and ongoing management of criminal justice referrals to determine whether this remains distinct as now or is integrated within the Hub model;
- **Outcome monitoring:** the increased prominence of peer-led interventions and increased diversity of pathway options presents potential challenges in evidencing successful outcomes across the system;
- **Quality Standards:** consistency and quality of assessment and care management are essential to this models success, developing quality standards and training plans to embed these will be integral to achieving consistency and quality;
- **Service specifications:** reviewing best-practice models elsewhere to identify which specialist interventions are needed, what type of programmes and develop specifications and effective procurement plans to contract these;
- **Needle Exchange and Low-threshold interventions:** where do these best fit within this model?;
- **Funding and Contracting:** brokerage and contractual structures to support moving from current block funded arrangements to more personalised, performance rewarding arrangements that support patient choice without prejudicing smaller providers.

8. Financial Implications:

The proposed re-modelling is planned within existing resources. The detailed resource and capacity mapping for each element of the new model has yet to be completed, although some savings from current contractual values will be necessary to ensure the future services are within the funding allocation available, most of which will be routed via Public Health funding post April 2013. These savings should be achievable from more effective contracting and potentially reduced management costs in the new model.

9. Equality and Diversity

An equality impact assessment has been undertaken as this proposal would involve a significant service change. The review and re-modelling work, particularly regarding accessibility to the assessment and

care planning hub, has the potential to positively improve the accessibility of services for under-represented groups. Further assessments will be carried out in relation to individual service specifications within the overall programme to ensure that specific changes identified do not negatively impact on any particular groups.

10. Risks

- The following risks have been identified, with mitigating actions/plans (scale 1(low) – 5(severe)):

Identified Risk	Likelihood	Severity of Impact	Mitigating actions
Service User, public or other stakeholder objections	Possible (2)	Significant (3)	Ongoing engagement; to date consultation with service user forum and stakeholders has been supportive of plans. The further development work will engage these stakeholders in detailed planning to resolve outstanding issues.
Contractual difficulties in establishing newly configured services, e.g. TUPE of staff	Possible (2)	Significant (3)	The complexity of re-configuring, particularly if this involves developing an in-house "hub" will require input from contractual and legal experts to ensure the process works – the timescale of 12 months and involvement of appropriate experts in the working groups will be needed to ensure this risk does not delay the project.
Financial constraints requiring increased cost savings	Possible (2)	Major (4)	Success of the model is reliant on sufficient continued investment in community recovery services; however, the re-modelling will allow re-tendered contracts to be made in line with future budget allocation. The model is also better suited to a personal health budget funding framework, which offers greater flexibility to deal with funding fluctuations. Ongoing engagement with funding decision makers, including new Police & Crime Commissioner when elected will be necessary to secure continued funding.

11. Action Plan:

The attached project timetable shows the timescale for developing and implementing this model over the next year. The key milestones and actions are summarised below:

March: seek approval from the relevant partnership governance bodies – Safer Portsmouth Partnership, Integrated Commissioning Board, Health Overview & Scrutiny Committee; Serve notice on current statutory service (12 months); obtain extensions on PCC contracts to align current end dates for 31st March 2013;
March – May: Working groups to develop detailed plans as outlined above;
May – July: Draft service specifications;
Aug – Dec: Procurement processes to tender new services and develop in-house "hub";
1st April 2013: New system start-up date.

Barry Dickinson, Senior Programme Manager