AI 9

BRIEFING FOR HEALTH OVERVIEW & SCRUTINY PANEL ON RE-MODELLING OF SUBSTANCE MISUSE SERVICES 2012/13

BACKGROUND: Two papers have been presented to the HOSP in November 2011 and March 2012 relating to different aspects of the ongoing re-modelling of Substance misuse treatment services. This paper aims to clarify the two projects.

CONTEXT: The national drug strategy introduced in October 2010 shifts the emphasis in drug treatment from trying to hold as many people as possible in treatment in order to reduce the level of associated crime, to trying to support as many people as possible to progress through treatment into sustainable recovery. The system re-design work is aimed at creating a Recovery Oriented Integrated System, in order to achieve this aim. This is split into two separate but linked projects:

1. Re-design and re-modelling of the Detoxification Pathway;
2. Re-design and re-modelling of the whole recovery treatment system (community pathway).

Project 1 Detoxification:
Current Position: at present the service for medically supported detoxification for people in Portsmouth is commissioned from Solent NHS trust and delivered from Baytrees in-patient unit. Access to this service is via the community drug and alcohol team, also provided by Solent NHS. Although in theory Baytrees and Solent's community team can offer out-patient and home detoxification services, this rarely, if ever, occurs. People needing medically assisted detoxification are therefore admitted to Baytrees for between 8 days and four weeks. The service is purchased on a block contract, whereby Portsmouth nominally purchase 11 beds, as do Hampshire, with one further bed available on a spot-purchase basis for other areas. Actual bed usage is more like a 65:35 split in Hampshire's favour. Approximately 250 Portsmouth people are admitted for detoxification each year, with approximately 60 – 70% completing this part of their treatment (although the figure is much lower for drug detox than for alcohol). Notice was served on this contract in December 2011 to allow for the re-modelling.

In addition we currently commission an Alcohol Specialist Nurse Service (ASNS) from Portsmouth Hospitals Trust which provides alcohol detoxification for people who are admitted to QA for other conditions and are identified as needing detoxification from alcohol. This service continues the detoxification on a day patient basis if necessary post-discharge. As this service relates to a different pathway into treatment (i.e. not those seeking detox from the general community) it is not included in the re-modelling plan.

Issues/Concerns: The current position represents poor value for money as it provides a 24-hour medically staffed detoxification for everyone, irrespective of their presenting complexity of need. Comparison with other areas and analysis of a recent sample of 51 admissions shows that the majority of those admitted to Baytrees from Portsmouth could have safely been offered less intensive detoxification options.

Patient Choice is limited by having only one option for detoxification. Accessibility is restricted to those who can make themselves available for an in-patient stay. The culture of admitting people for in-patient detoxification in all cases contributes to a pattern of repeated admissions and limited wrap around support planning.

PLANNED CHANGE: The proposed new model for detoxification is based on a Personal Health Budget (PHB) approach that is being delivered successfully for alcohol detoxification in Southampton. The model involves a community based nurse acting as an assessor/detox broker. The nurse assesses all people who require a medically assisted detoxification to determine what level of support and intensity of intervention they need. Factors considered include medical history and current situation (physical and mental health), social and family support, accommodation, caring responsibilities, complexity of substance use and anything else likely to impact on the safety and effectiveness of the detoxification.

People are assigned to a band (reflecting the complexity of their needs and risks), which has a nominal financial allocation attached to it. They are then able to select from the range of options available within the band. Options range from Home Detoxification (lowest banding/most straightforward cases); Daily Detoxification (attending daily, but remaining living at home); Detox in a residential rehabilitation or other supported facility (several available); Detox in an in-patient medical hospital.

Evidence from the Southampton pilot is that most people fit within the middle bands and choose either the daily detoxification or residential rehabilitation facility. Both of these options offer considerable cost savings over the in-patient facility (Baytrees or equivalent). Long-term outcomes are no-worse than for an in-patient detoxification. Research evidence suggests that the non-medical interventions and programme of wrap around support are a far greater determinant of long-term recovery than the type of detox undertaken. A major advantage of detoxification in a residential rehabilitation centre is that it takes place within an environment and culture of people engaging in long-term recovery focused, abstinence based treatment – hence detox patients are engaged with this culture and more likely to continue with this once the detox element is completed. Similarly with daily or home detox these allow people to be linked in to community based group and individual recovery programmes more seamlessly than is the case when they attend in-patient units.

By shifting to a multiple option, needs assessed model of detoxification as planned, we will release significant resources from the current block contract with Solent. This will enable a greater number of people to access detoxification, going some way to meeting the estimated unmet demand highlighted in the Alcohol needs assessment. Within the model there is also capacity to increase the funding available for longer-term residential treatment, where demand has grown over recent years and has been a cost-pressure within the treatment system.

The principle risk of the change is de-stabilisation of the provider model operated by Solent at Baytrees. Solent are exploring ways in which they can adapt their business model to continue delivering an in-patient unit without the Portsmouth block-contract, but there is a risk that this may not be possible. If so, the impact on the model would be minimal as such facilities are available elsewhere when needed on a spot-purchase basis.

On balance the advantages for patient choice, efficiency and potential increased capacity support the proposed change and consultation with service user groups and the full range of providers in the City has shown clear support for this change.

Project 2; Community Re-modelling:

Current Position: In Portsmouth we currently have a multi-provider system of drug and alcohol treatment with three main providers and two smaller providers delivering specific elements of adult treatment. Cranstoun Drug Services provide Drop-in assessment, outreach assessment and community based group-work. Solent NHS trust provide community prescribing and care management, as well as some group provision. Surrey & Borders NHS provide our Criminal Justice (Drug Intervention Programme (DIP)). Portsmouth Counselling Service provide 1:1 counselling and South Hampshire CBT provide a specific group/1:1 programme called ACT. Additionally the City Council host an Alcohol Intervention Team that provide alcohol brief advice and some group sessions, primarily linked to GPs and the Specialist Nurse Service at QA.

This model incorporates key working within all of the agencies and feedback from the consultation suggests that the level of service received is patchy. As all agencies have an element of key working, the degree of partnership working is variable with significant numbers of people remaining "stuck" in single services and not making use of the range of facilities available.

A further feature of the substance misuse sector in Portsmouth is a very active peer-led recovery community, incorporating long-standing fellowship (AA/NA) groups, the service user forum (PUSH), Act2Recovery and SMART groups (peer led alternative to AA/NA). Whilst this community has grown in recent years, again feedback has been that exposure to the recovery community is variable depending on which service and/or which key worker an individual engages with when entering treatment.

PROPOSED RE-MODEL: The plan for re-modelling is aimed at more consistently engaging people with recovery, promoting a greater throughput of people into sustained recovery, reducing the likelihood of people becoming "stuck" in services and increasing consistency of engagement with a wide range of community resources to support recovery.

The proposed method for achieving this is to create:

- a specific assessment and recovery planning service (Hub); staffed by professional workers and trained volunteer peer-recovery brokers.
- a range of "spokes" – interventions delivered by specialist providers independently from the "hub", but coordinated by workers in the hub,
- providers delivering "spoke" interventions are able to concentrate solely on delivering their services;
- the recovery hub is able to concentrate on high quality person-centred assessments and ongoing recovery planning/care management, to support and enable people to access the interventions then need and progress through the system.

The independence (of the hub) from delivering interventions is essential to ensure that the full range of options are considered and included as appropriate to an individual's personal recovery plan.

Specific roles within the "hub" are still being consulted on, as are the specific "spoke" interventions to be commissioned and the contractual arrangements needed to facilitate this. We are positively considering setting up the hub as an in-house unit, to ensure the independence and impartiality from specific interventions and providers. Whilst peer recovery brokers are integral to the "hub", they will not replace professional workers and their functions will be commensurate with their training and skills, thus ensuring safe and effective practices.

Notice has been served on all community providers to enable the development of the model in time for a 1st April 2013 start date. This timescale is driven to some degree by existing contractual timeframes for several of the providers.

The two papers already presented to HOSP give more complete evidenced detail of the proposals and are available if required; this paper is intended to give a simplified summary. I have also attached a diagram showing a potential simple pathway of what an individual's treatment/recovery journey may look like within the new model.

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Sample pathway