Portsmouth CITY COUNCIL

NOTICE OF MEETING

CABINET MEMBER FOR HEALTH, WELLBEING & SOCIAL CARE

THURSDAY, 6 FEBRUARY 2020 AT 2.00 PM

THE EXECUTIVE MEETING ROOM - THIRD FLOOR, THE GUILDHALL

Telephone enquiries to Anna Martyn 023 9283 4870
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If any member of the public wishing to attend the meeting has access requirements, please notify the contact named above.

Membership

Cabinet Member for Heatlh, Wellbeing & Social Care
Councillor Matthew Winnington (Cabinet Member)

Group Spokespersons
Councillor Graham Heaney
Councillor Luke Stubbs

(NB This agenda should be retained for future reference with the minutes of this meeting).

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Deputations by members of the public may be made on any item where a decision is going to be taken. The request should be made in writing to the contact officer (above) by 12 noon of the working day before the meeting, and must include the purpose of the deputation (for example, for or against the recommendations). Email requests are accepted.

A G E N D A

1 **Apologies for absence**

2 **Declaration of interests**

3 **Funding for Residential Rehabilitation (Social Impact Bond)** (Pages 3 -

10)

Purpose
To seek approval from the Cabinet member for Health, Wellbeing and Social Care to commit funding towards a pilot social impact bond (SIB) which will deliver drug and alcohol residential rehabilitation.

RECOMMENDED that the Cabinet Member approves

1) **a funding contribution towards the social impact bond of no more than £100,000.**

2) **that the funding source proposed for this pilot would be the Public Health reserve. At the end of this pilot a longer term funding source would need to be identified if the service is to be maintained.**

4 Adult Social Care Older Persons Care Strategy (Pages 11 - 20)

Purpose
The report is for information only and the purpose is to update the Cabinet Member for Health, Wellbeing and Social Care as to progress against the Adult Social Care Strategy.

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Portsmouth CITY COUNCIL

Title of meeting:	Cabinet Member for Health, Wellbeing and Social Care
Date of meeting:	6th February 2020
Subject:	Funding for residential rehabilitation (social impact bond)
Report by:	Director of Public Health
Wards affected:	All
Key decision:	No
Full Council decision:	No

1. Purpose of report

1.1 To seek approval from the Cabinet member for Health, Wellbeing and Social Care to commit funding towards a pilot social impact bond (SIB) which will deliver drug and alcohol residential rehabilitation.

2. Recommendations

2.1 It is recommended that the Cabinet Member:

a. Approve a funding contribution towards the social impact bond of no more than £100,000.

b. Approve that the funding source proposed for this pilot would be the Public Health reserve. At the end of this pilot a longer term funding source would need to be identified if the service is to be maintained.

3. Background

3.1 The rationale for investing in residential rehabilitation services

The misuse of alcohol is widely recognised as a driver for anti-social behaviour and crime. Alcohol misuse is also linked to a number of poor outcomes for adults and young people, in particular, poor health and social problems such as unemployment, homelessness and poverty.

There are an estimated 3,075 adults in Portsmouth who are dependent on alcohol, this is a rate of 1.86 per 100, the second highest rate in the South East and higher than the England average 1.39 per 100. There are however only around 292 people in alcohol treatment at any one time in the city, a significant amount of unmet need.

The cost of drug misuse is far reaching, including not only financial costs, but also the costs of drug related crime, health issues and impact on families and communities. The Government defines drug related harms as:

> "far reaching and affect our lives at every level. It includes crime committed to fuel drug dependence; organised criminality, violence and exploitation which goes hand in hand with production and supply; and the irreparable damage and loss to the families and individuals whose lives it destroys"[1].

There are an estimated 1,541 adults dependent on illicit opiates and / or crack cocaine in the city. Although this headline number is relatively low, the impact of harm is high to the individual and the wider community. Portsmouth has one of the highest rates of drug related deaths in England, a rate of 8.8 per 100,000 population, compared to an England average of 4.3 per 100,000. There are currently 759 opiate users in treatment, around half of the prevalence in the city.

Around 45% of acquisitive crimes (theft, burglaries etc.) are committed by heroin and crack users. Nationally 40% of prisoners report having used heroin. A typical heroin user spends £1,400 per month on heroin and on average any heroin or crack user not in treatment commits crime costing £26,074 per year.

Public Health England (PHE) estimate that the economic and social benefit of drug treatment in 2016/17 in Portsmouth was £6,066,519 in terms of improvements in crime, health and social care. They estimate 16,033 crimes were prevented due to participation in drug treatment.

Further PHE research[2] suggests the following benefits to the public sector from investment in treatment (including health, criminal justice and social care costs):

- Alcohol treatment reflects a return on investment of £3 for every £1 invested, which increases to £26 over 10 years.
- Drug treatment reflects a return on investment of £4 for every £1 invested, which increases to £21 over 10 years

3.2 **Residential Rehabilitation**

Residential rehabilitation is a 24-hour setting providing intensive, structured psychosocial interventions for people who have an abstinence goal in the main. Residential programmes in England vary in duration and intensity of care, but common elements include communal living with other people in recovery; addressing cognitive and emotional symptoms of dependence; improved skills for activities of daily living, and referral for continuing/aftercare support.

[1] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/628148/Drug_strategy_2017.PDF

[2] https://www.gov.uk/government/publications/alcohol-and-drug-prevention-treatment-and-recovery-why-invest/alcohol-and-drug-prevention-treatment-and-recovery-why-invest

Two systematic reviews[3, 4] have examined the effects of therapeutic community (TC) residential programmes following a NICE review. Treatment comparisons suggest that longer TC programmes may have better rates of completion than shorter TC programmes. However, the evidence quality for the effectiveness of residential rehabilitation is low due to the lack of comparison groups in the evaluation designs. Nevertheless, NICE endorses residential treatment for people seeking abstinence who have significant comorbid physical, mental health or social problems, and particularly emphasises this setting of treatment for people who have not benefited from previous community-based interventions.

The treatment provided usually starts with detoxification for a period of 1 - 4 weeks depending on the substance and level of addiction. This involves medical provision overseeing a physical withdrawal from the substance. Following on from this, a period up to 6 months is typically spent addressing the psychological aspects of addiction and preparing the person to return to their home, or resettling them into unsupported accommodation. There are a range of different models and timescales offered by different providers. Providers of residential rehabilitation are usually in the private or voluntary sector.

Employment support within a residential rehabilitation setting shows benefit according to PHE. The addition of employment related support to a residential drug rehabilitation facility has been shown to increase the likelihood of employment post-treatment.

3.3 **The potential client cohort that would be suitable/benefit from such services**

There are currently over 1000 service users within our treatment system. Many would benefit from residential rehabilitation, however the reality is access has been restricted to manage costs. In 2013/14 before significant funding reductions in treatment spend, the annual spend on residential rehabilitation was £371,000 (this did not include detoxification which was another £710,000). In 2019/20 the combined budget for residential rehabilitation and detoxification is £135,000. In 2018, 20 people benefited from residential rehabilitation; however stays have been much shorter than previously, typically only 8 weeks are funded.

The substance misuse service has stated they would have no difficulty identifying at least 2 suitable service users per month. Therefore the 12 placements would be made within 6 months. The clients who would be referred would be those that have the greatest need and also are particularly high cost to the public sector. This will be in line with the NICE recommendation that this type of treatment should be available to people with significant comorbid physical, mental health or social problems and for who have not benefitted from community based treatment. We would also be particularly considering people who have a history of homelessness and offending behaviour.

[3] Malivert M, Fatséas M, Denis C, Langlois E, Auriacombe M. Effectiveness of therapeutic communities: a systematic review. Eur Addict Res. 2012;18(1):1–11.
[4] Vanderplasschen W, Colpaert K, Autrique M, Rapp RC, Pearce S, Broekaert E, et al. Therapeutic communities for addictions: a review of their effectiveness from a recovery-oriented perspective. ScientificWorldJournal. 2013;2013:427817.

3.4 Details of expected drop-out rates/successful completions - based on national/local data

Although now 20 years old the large National Treatment Outcome Research Study (NTORS)[5] was one of the largest studies of the effectiveness of residential rehabilitation in England. It was a prospective cohort study of 408 drug users attending 23 different residential units. It found that rate of abstinence from all drugs during the 3 months prior to follow-up had increased from 2.5 to 37%. Just over half of the sample was abstinent from illicit opiates at 1 year follow-up. The high rates of crime committed by service users prior to treatment, also dropped by half.

There were 20 rehab placements in 2018 funded in Portsmouth, 9 are thought to still be abstinent[6]. This is not a direct comparison with the model proposed in the SIB as in many cases the service has only placed service users for around 8 weeks of rehab, rather than the longer stay in the SIB. The assumptions made in the SIB business case that 1 in 6 service users will progress through the whole treatment programme and in to work, based on Yeldall Manor data, seem reasonable to the Public Health directorate. Based on the evidence and local data, we could expect 6 of the 12 placements to stay in treatment up to one year.

4. Social Impact Bond

4.1 A cost comparison based on the above data of commissioning the service directly v's SIB

Using data from the rehab providers we currently commission, considering best value for money, the costs of a similar programme on offer through the SIB would cost £26,780 per person, detailed below:
Stage 1: 14 days detox: £1250 + 11 weeks rehab: £6875 = £8,125
Stage 2: £625 p.w. x 13 weeks = £8,125
Stage 3: £405 p.w. x 26 weeks = £10,530
Total: £26,780

In 2018 there were 20 clients who received residential rehabilitation, the following was observed:

9 (45%) completed residential treatment and remain abstinent
8 (40%) completed residential treatment (average 8 weeks), but relapsed after leaving
3 (15%) left treatment early (average after 2 weeks)

Modelling these costs into what we might expect in terms of length of stay and cost for 12 placements (to compare to that available with the SIB), the details are in the table below:

[5] Gossop M et al Treatment retention and 1 year outcomes for residential programmes in England, Drug and Alcohol Dependence 57 (1999) 89–98
[6] this is not an exact figure as the service is no longer in contact with some of the service users

Length of stay in residential treatment	Number of service users (total= 12)	Estimated Cost
Complete detox, but then drop out	2	£2,500
Complete at least 8 weeks, but relapse after treatment	4	£20,000[7]
Complete full treatment and remain abstinent	6[8]	£160,680
Total		£183,180

Therefore based on this model the equivalent cost of providing the level of treatment available in the SIB, through our current commissioning arrangements for 12 service users, would be: £183,180.

4.2 Rationale for using the Social Impact Bond, as opposed to PCC investing directly itself.

The SIB has pulled in funding from the Department for Culture, Media and Sport's (DCMS) Life Chances Fund, to off-set some of our outcome payment, which would be £50,000 per outcome for Portsmouth City Council. For every £1 Portsmouth City Council pays the DCMS will contribute and additional 35p towards the bond.

We have negotiated with the SIB provider that we will have 12 people go through treatment, but will pay for only 2 outcomes (people in employment), even if the provider has a higher number of outcomes. Therefore our total liability will be £100,000 if these 2 outcomes are achieved. If the provider fails to achieve an outcome, then Portsmouth City Council would pay nothing, the liability sits with the social investor who will pay the costs up front.

Public Health believes that the risk borne between the parties is clear, reasonable and appropriate. Using local and national data it is estimated that the SIB should provide £183,180 worth of treatment. The maximum cost of this to Portsmouth City Council would be £100,000. If the provider fails to achieve any employment outcomes, then the liability would be zero for the Council.

[7] This cost is likely to be higher compared to the SIB model as this group of people completed the treatment that was paid for (average 8 weeks). If they were provided with longer they would likely stay longer and may have been less likely to relapse. Each additional person that stays engaged for 1 year, would cost an additional £21,780.

[8] It is reasonable to expect that 6 would achieve this with an enhanced stay in residential rehabilitation, as the current average if 45% of clients abstinent after a shorter period of treatment. 50% would be in line with the findings of the UKATT trail detailed above.

4.3 **The outcomes against which any payment would be made are clearly defined and measurable.**

Outcomes would only be paid if someone was in a sustainable job (not zero hours contract or short term contract) for more than 3 months after a full year of treatment. The job must be with an employer independent of the SIB. This must be validated by the commissioner speaking to the employee and proof supplied (i.e. contract of employment and wage slips). It is in the interest of the SIB provider to maximise outcomes as they are looking to use the Portsmouth clients as evidence that their model of treatment, with an extended treatment stay, is effective in getting service users into sustainable employment. They will use this evidence to market the SIB to other areas for investment.

4.4 **The plans at the end of the SIB period**

It is anticipated that the initial time period of the SIB will be 15-24 months as service users go through treatment, become job ready, seek employment and spend 3 months in a job. During this period each client will be tracked to record their progress. The end of this initial period will coincide with the retender of our main substance misuse contract, due for completion by November 2021. The success or otherwise of the SIB will allow us to consider the balance of residential rehabilitation funding within this contract, especially if it is successful with the challenging cohort we are looking to consider as part of the SIB.

In addition, if the SIB is effective and outcomes good, then the funding approach is something that the City Council, along with NHS and police colleagues may want to consider investment in. As stated earlier in this paper, the clients that would be eligible for this scheme would be those that have significant comorbid physical, and mental health problems. We would also be particularly considering people who have a history of homelessness and offending behaviour. These are high-cost individuals across the public sector and could warrant additional investment from partners and a co-ordinated funding approach.

4.5 **Funding**

Should the outcomes be achieved, then the funding source proposed for this pilot would be the Public Health reserve. At the end of this pilot a longer term funding source would need to be identified if the service is to be maintained. A review and retender of the main substance misuse contract is due to be completed by November 2021.

5. Conclusion

The social impact bond provides an opportunity to provide long term residential rehabilitation to individuals impacted by addiction who have a history of homelessness and offending. It provides good value for money compared to current funding models and the risk is borne by the SIB investor. Portsmouth City Council will only be liable to pay if any of the service users achieve sustainable employment.

6. Integrated impact assessment

The integrated impact assessment was completed. The service will enhance access to support for people coming from vulnerable disadvantaged groups. The service does not have any other negative or positive impact.

7. Legal implications

The terms, conditions and specification for the proposed contract between the Council and the SIB provider will need to be reviewed and agreed to ensure that they are suitable to deliver the desired outcomes as described in this report, including the particular allocation of financial risks and liabilities as between the Council and the provider which forms the basis of the SIB.

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8. Finance comments

As set out above, this is a pilot opportunity to trial residential rehabilitation services for cohort of 12 people for a maximum 15-24 month treatment period. This pilot opportunity will be provided through a Social Impact Bond (SIB) arrangement, which will operate on a payment by results arrangement, rather than tradition commissioning arrangement. The payments made by the City Council under the SIB arrangement, would be triggered after evidence of successful completion of the full treatment and 3 months post-treatment employment is provided; as explained in sections 5 and 6 above.

The contractual agreement between the City Council and SIB provider have yet to be agreed. Based on the initial financial modelling, the estimated costs via traditional commissioning model could be in range of £23-27k per person; for each person who completed the treatment programme. Based on estimated completion rates for each treatment stages, the total cost under traditional commissioning model would be in the region of £160k-£180k, and would be dependent on the number of individuals completing the various stages of the programme.

As explained within section 5 above, the City Council's maximum liability for this trial period would be limited to £100,000; and will be dependent on the outcomes being achieved. If the outcomes are not achieved, then the City Council would not be required to make a payment. Under the SIB arrangement, the SIB provider will fund the costs of providing these services during the pilot period. Should the outcomes be achieved, then the funding source proposed for this pilot would be the Public Health reserve. At the end of this pilot a longer term funding source would need to be identified if the service is to be maintained. A review of the main substance misuse contract is due in the future as referenced in section 4.4.

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Signed by:

Background list of documents: Section 100D of the Local Government Act 1972

The following documents disclose facts or matters, which have been relied upon to a material extent by the author in preparing this report:

Title of document	Location

The recommendation(s) set out above were approved/ approved as amended/ deferred/ rejected by …… on ……

……
Signed by:

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(Please note that "Information Only" reports do not require Equality Impact Assessments, Legal or Finance Comments as no decision is being taken)

Portsmouth CITY COUNCIL

Title of meeting:	Cabinet Member for Health, Wellbeing & Social Care
Subject:	Adult Social Care Older Persons Strategy Update
Date of meeting:	6th February 2020
Report by:	Chief Health & Care Portsmouth
Wards affected:	All

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1. Purpose of report

1.1. The purpose of this report is to update the Cabinet Member as to progress against the Adult Social Care Strategy.

2. Context

In order to provide a social care service that meets the needs of Portsmouth residents, meets the Council's statutory duties and manages the demands of increasing needs and costs, Adult Social Care (ASC) has been working to a service wide strategy. Implementing the ASC Strategy will achieve outcomes for residents and work toward financial balance. By 2022, our aim is that ASC in Portsmouth will be:

- Delivering services that have technology at the heart of the care and support offer;
- Working in a way that recognises the strengths that people have, and have access to in their networks and communities - and draws on these to meet their needs;
- Working efficiently and responsively, using a reablement approach centred around the needs of the customers;
- Delivered through a market based on individual services to people that meet their needs and help them achieve the outcomes they want to achieve and keep them safe;
- Delivered, (where appropriate) through PCC residential services in one service area to enable quality and maximum effectiveness.

This strategy will enable ASC to be financially stable and sustainable.

These outcomes align to the priorities in the 'Blueprint for health & care in Portsmouth' published in 2015:

- Improve the range of services people can access to maintain their independence
- Give people more control, choice and flexibility over the support they receive

- Do away with multiple assessments and bring services together in the community
- Bring together services for children, adults and older people where there is a commonality of provision, including a family centred approach
- Create better resources and opportunities for people with care and support needs and their carers.

2. Recommendations

2.1. It is recommended that the Cabinet Member notes the progress against the Strategy.

Key:
ASC - Adult Social Care
MTFS - Medium Term Financial Strategy
CIS - Community Independence Service
PRRT - Portsmouth Rehabilitation & Reablement Team
MCP - Multispecialty Community Provider
AT - Assistive Technology
CCG - Clinical Commissioning Group

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Key Strategic aim/shift	Project objectives	Lead	Update	MTFS link
Delivering services that have technology at the heart of the care and support offer	Developing a set of principles and ways of working to guide staff in having the right conversation with people. Agree the measures across all rehab services. Understand the role and capability of Assistive Technology, (AT) in supporting reablement approach. Ensure there is a clear offer for acute admissions avoidance and supporting timely discharges. Introduce electronic care-planning into PCC managed care homes, meeting the standards of Good Governance, (Regulation 17[1]).	Project manager / Head of Service Senior Project Manager / Head of Service	Intervention underway studying current use of AT, learning wider demand and new technology that can support the care planning process. PRRT/CIS carrying AT to use as standard when assessing need. Hospital Discharge project has offered recommendations to increase take up and decrease response times for AT in Portsmouth. Funding identified from 'winter pressures'. Project Group established	Group Accountant - CIS - reduce length of stay in Domiciliary Care. Reduce package growth in dom care.
	Redesign domiciliary care delivery in the city	Contracts Team manager / Interventionist.	The technology model is in draft ready for discussion with existing providers as part of soft market testing. The application enables real	Senior accountant - Reduce package

[1] The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. http://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents

			time updates on health and wellbeing, to help timely, informed decision-making.	growth in Dom care.
	Assistive Technology (AT) Board - bringing together partners in Health & Care in Portsmouth from statutory, independent and voluntary to increase implementation of AT in care.	Project manager / Head of Service	Board established with statutory attendance. Independent sector have working group ready and representation to be agreed on AT Board. AT Development plan approved and Joint AT development plan being explored with NHS partners via the MCP.	To be established.

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Portsmouth CITY COUNCIL

Key Strategic aim/shift	Project objectives	Lead	Update	MTFS link
Working in way that recognises the strengths that people have, and have access to in their networks and communities - and draws on these to meet their needs.	Identify where low-level, preventative services and support are required. Establish access to these services along with measures. Develop a co-ordinated approach to provision of information and tools that help people to access support and maintain independence. Structure assessment and processes to consider non-statutory service solutions. Enhance care and support in PCC managed care homes.	Project manager / Head of Service Head of Service	Funding has been identified for a community catalyst role[2]. This post has been created to achieve 3 broad aims: • provide personal, flexible and responsive support and care • give local people more choice and control over the support they get • offer an alternative to more traditional services Ongoing discussion with CCG colleagues around the links with social prescribing. Information and advice resource in development with the HIVE via BCF funding. Redesign of ASC Duty service in process. To include an active link with community connector service.	Finance Manager ASC - Reduce package growth in dom care / cost avoidance. Spend to Save project identified.

[2] https://www.somerset.gov.uk/social-care-and-health/somerset-micro-enterprise-project/

			Strength Based learning and development offer to be reviewed. Case Audit tool introduced. 'Be There for Care' project, enabling volunteers to work with residents in care homes[3].	

Key Strategic aim/shift	Project objectives	Lead	Update	MTFS link
Working effectively to target investment in reablement.	Identify effectiveness of the reablement offer required through demand; outcome; impact on future costs. Upskill and support social workers and other professionals to think beyond traditional service solutions and identify clear rehab goals as part of the assessment process. Use strength based, outcome focussed approach to assessment.	Project manager / snr project manager / Head of Service /	Gathering data through PRRT and CIS to understand reablement demand across services. Established links with CCG/Solent colleagues to plan reablement investment priorities in Portsmouth. Duty redesign work linking with CIS to expand reablement capacity. Dom care redesign work linking with reablement approach	Group Accountant-CIS - reduce length of stay in Domiciliary Care Senior accountant - PRRT - target and focus reablement offer in the city.
Delivered through a market based on individual services to people that meet need, achieve key outcomes and keep them safe.	Develop tools and processes to ensure co-production with service users and the market	Project manager / Head of Service	Corporate Communications plan for working with Portsmouth citizens drafted.	To be established.

[3] https://volunteer.hiveportsmouth.com/we-support/bethere/

	Develop approaches for market including outcome-based commissioning		Publishing market position statement for ASC in February/March 2020. Initial provider day took place in December 2019. Significant interest and working groups agreed to move forward with introducing pilot model in Portsmouth. Extra care specification drafted for re-tender, including community connector model.	

Key Strategic aim/shift	**Project objectives**	**Lead**	**Update**	**MTFS link**
Providing quality and effective in-house services	Repurpose outdated estate to provide for gaps in services in Portsmouth.	Project manager / Head of Service	Hilsea Lodge has now closed and staff have transferred to work with people in other units. This was partly facilitated through secondment agreements with Hampshire County Council. Uses for the site to fill gaps in provision currently in discussion with Housing, Neighbourhood & Building services. Whilst there is an intention to design and build supported living for people with a physical disability using a site in the city, work will focus on repurposing the Edinburgh House site. Edinburgh House has been demolished in order for the site to be repurposed to provide extra care for people living with dementia.	Finance Manager ASC Senior accountant - estates management / managing in-house spend.

			Commenced exploration of demands for use within in-house residential /nursing / rehab units. This is in conjunction with CCG and Solent NHS Trust partners. Harry Sotnick House project group established and working towards 1/4/20 for HSH to come back into PCC management.	

Key Challenges:

- Project and Programme management capacity is the most significant challenge in implementing the strategy.
- The change to the existing domiciliary model to work in the way that we have learned is most effective is significant.
- Keeping informed of and assessing the wide range of technology in the market.
- Upskilling staff in technology and strength based practice.
- Demand exceeds capacity for community connectors.
- ASC continues to be challenged by the budget position.
- ASC continues to be challenged by the pressures to discharge people from hospital which can result in inappropriate and costly placements.
- To develop clear commissioning intentions across all cohorts of service users, understanding demand and supporting flexible, creative responses within limited budgets.
- Transforming an existing market that has gaps in provision and creating a diverse range of provision.
- Co-producing services and supporting service users using Direct Payments.

Signed by (Director)

Appendices:

Background list of documents: Section 100D of the Local Government Act 1972

The following documents disclose facts or matters, which have been relied upon to a material extent by the author in preparing this report:

Title of document	Location

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