



London Borough of Hammersmith & Fulham

CABINET

2 MARCH 2015

CORE DRUG AND ALCOHOL ADULT SERVICES RE-PROCUREMENT

Report of the Cabinet Member for Health and Adult Social Care : Councillor Vivienne Lukey

Open Report

Classification - For Decision

Key Decision: Yes

Wards Affected: All

Accountable Executive Director: Liz Bruce, Executive Director Adult Social Care and Health

Report Author: Gaynor Driscoll, Head of Commissioning, Public Health Department

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1. EXECUTIVE SUMMARY

- 1.1. This report seeks approval to re-procure core drug and alcohol services across Hammersmith and Fulham (H&F), Royal Borough Kensington and Chelsea (RBKC) and Westminster City Council (WCC) during 2015, streamlining systems and making efficiencies to bring added value to each borough, and ensure improved outcomes for service users. Appendix A provides the business case for approval to proceed to procurement. It contains the information to inform the cabinet members decision making process.
- 1.2. This report sets out the preferred option, the rational to re-procure, some background information on why we invest in substance misuse services and what is excluded from the procurement strategy.

2. RECOMMENDATIONS

- 2.1 That approval be given to procure core drug and core alcohol services during 2015 in accordance with Option 3b as set out in this report, providing for a revised service model across the three boroughs that retains sovereignty.
- 2.2 That the appointment of the successful provider be delegated to the Cabinet Member for Health and Adult Social Care.

3. REASONS FOR DECISION

- 3.1. Investing in substance misuse as referenced in Appendix A evidences the need to maintain support for treatment services. Current contracts are due for renewal 31 March 2016. This allows for a three month consultation period and full year procurement period from April 2015.
- 3.2. The current treatment system is not sustainable in its current form. Redesign must take place in order to meet the changing needs of drug and alcohol users. Drug using trends are changing and our current service model has failed to engage with these groups of users.
- 3.3. There are identified unmet needs for alcohol users who range from street homeless to residents who work and are drinking at increasing and high risk levels.
- 3.4. Hammersmith and Fulham has the second highest rate for alcohol related hospital admission in the country. There are higher than average increasing and high risk alcohol users in the borough leading to significant health problems and costs to the community. In relation to drug use the estimated prevalence of opiate and crack cocaine use is 10.1 per 1000 head of population. This is not fully reflective of the wider range of drug use amongst residents, including cannabis, new psychoactive substances (legal highs) and khat.

4. INTRODUCTION AND BACKGROUND

- 4.1. H&F has been commissioning drug and alcohol services on behalf of health and local authority since the 1990's. These services are well embedded in a wider network of service provision with longstanding collaborative and integrated relationships across the three local authorities.
- 4.2. Public Health England has researched the impact of investing in Drugs and Alcohol and the following identifies the averages across England:
 - Every 5,000 patients screened in primary care may prevent 67 A&E admissions and 61 hospital admissions - Costs = £25,000, Saves = £90,000.
 - One alcohol liaison nurse can prevent 97 A&E visits and 57 hospital admissions – Costs = £60,000, Saves £90,000.
 - Every 100 dependent people in treatment can prevent 18 A&E visits and 22 hospital admissions - Costs = £40,000, saves £60,000.
 - Every £1 spent on drug and alcohol treatment saves £2.50 costs to society.

4.3. The main aims of the re-procurement are to reduce the harms caused by drug and alcohol use and support the successful completion of treatment by being more responsive to changing drug trends. The new service will:

- manage a wide range of substances
- increase satellite and outreach working
- increase home treatment
- engage more service users earlier
- increase numbers accessing alcohol treatment
- increase the focus on employability
- reduce hospital admissions.

4.3 Current contracts are due for renewal 31 March 2016 and the opportunity exists to redesign, make efficiencies and improve accessibility based on the evidence shown below.

	Users of Opiates and Crack		Users of Other Drugs		Alcohol Misusers	
	Prevalence Estimate	2013-14 Treatment Population	Prevalence Estimate	2013-14 Treatment Population	Prevalence Estimate	2013-14 Treatment Population
H&F	1548	692 (45%)	2805	150 (5%)	7667	432 (6%)

4.4 There are a number of services that will not be included in the procurement exercise as they have been recently commissioned or sit outside core provision:

- in-patient detox
- care management (purchased care packages, safeguarding)
- group work programme across the three boroughs
- primary care support service across the three boroughs
- reducing reoffending service
- pharmacy and GP contracts
- young people and transitions.

4.5 The attached business case (Appendix A) was presented to the Public Health Transformation and Integration Board on the 10 December 2014 and the Shared Services Board on the 26 November 2014 and the 07 January 2015 with revisions. The report is also following the required processes in Westminster City Council and the Royal Borough of Kensington and Chelsea. Lead members for public health have also been consulted.

5. PROPOSAL AND ISSUES

5.1. The new service will work in partnership to transform public services in order to benefit local residents. A key feature of the new service will be the requirement to work across networks in order to improve joint working and integrate pathways. It is

¹ National Drug Treatment Monitoring System 2013-14 Treatment Activity. Projecting Adult Needs and Service Information System 2014. Health Profiles Public Health England 2014.

intended that services will be more accessible to support people in their own homes and local areas through the remodelling of treatment services.

- 5.2. Drug services - core interventions will continue. These include, prescribing, psychosocial interventions, education, training and employment support, hepatitis screening and support into blood borne virus (BBV) treatment, peer mentoring.
- 5.3. Alcohol services - the service will include hospital liaison, older people and alcohol services, community detoxification, and a range of alcohol treatment interventions.
- 5.4. The proposed service model will respond flexibly to the needs of residents of the borough through earlier intervention and diversion from entrenched addiction issues. In addition we will shift emphasis away from costly medically led services to focus on the holistic needs of our residents.

6. OPTIONS AND ANALYSIS OF OPTIONS

Option 1 – do nothing.

This is not recommended as we will not be able to sustain the level of core provision required by our residents.

Option 2a – procure three integrated core drug and core alcohol services – single borough.

Pros – providers would focus on one borough, in line with localism.

Cons – this is the current model and does not meet identified need, the procurement process will be more complex, limited efficiency savings to be gained, more resource intensive for commissioners and contract management, does not recognise the mobility of service users nor service user choice, does not take account of sustainability.

Option 2b – procure one integrated core drug and core alcohol service across H&F; RBKC; WCC.

Pros – one contract to manage, communication may be easier as only dealing with one provider.

Cons – option would not meet identified need for alcohol users or new drug trends, large complex contract to manage, does not take account of sustainability, does not recognise the mobility or service users nor service user choice.

Option 3a – procure six separate core drug and core alcohol services – single borough.

Pros – smaller contracts to manage, easier to promote locally, could be more responsive to neighbourhoods.

Cons – limited efficiencies to be made as there will be increased management costs, six contracts to manage and therefore increased costs to authorities in terms of legal, commissioning and contracting, risk of duplication of services, does not take account of sustainability.

Option 3b – procure separate core drug and core alcohol services across H&F; RBKC; WCC within a framework agreement.

Pros – efficiencies to be made as two contracts to manage, meets the identified need for alcohol service, new drug trends addressed, performance management more efficient, takes service user and wider partnership feedback into consideration, creates more equitable and sustainable service for our populations, increases choice, clarifies pathways.

Cons – limited alcohol provider market, one size doesn't fit all therefore the new model must recognise the differences across the three authorities as part of the procurement process.

Option 4 – procure services with additional neighbouring authorities to the three boroughs.

6.1 Option 4 cannot be achieved in respect of the boroughs included in the West London Alliance as the majority are currently in the middle of their own procurement of drug and alcohol services. Other central London boroughs are also either out to procurement or recently have recently commissioned specialist services.

6.2 It is recommended that we have approval to proceed to procure core drug and core alcohol services during 2015 and that the cabinet supports Option 3b to procure a revised service model across the three boroughs that retains sovereignty.

7. CONSULTATION

7.1. Consultation will take place with service users and council departments where there are links and joint working if approval to proceed is granted.

8. EQUALITY IMPLICATIONS

8.1 An equality impact assessment will be conducted if approval to proceed is granted.

9. LEGAL IMPLICATIONS

9.1. Core drug and alcohol services are Part B services for the purposes of the Public Contract Regulations 2006 (as amended) (Regulations). The proposed contracts should be procured in accordance with the Regulations and the Contract Standing Orders.

9.2. Legal Services will be available to advise throughout the procurement process.

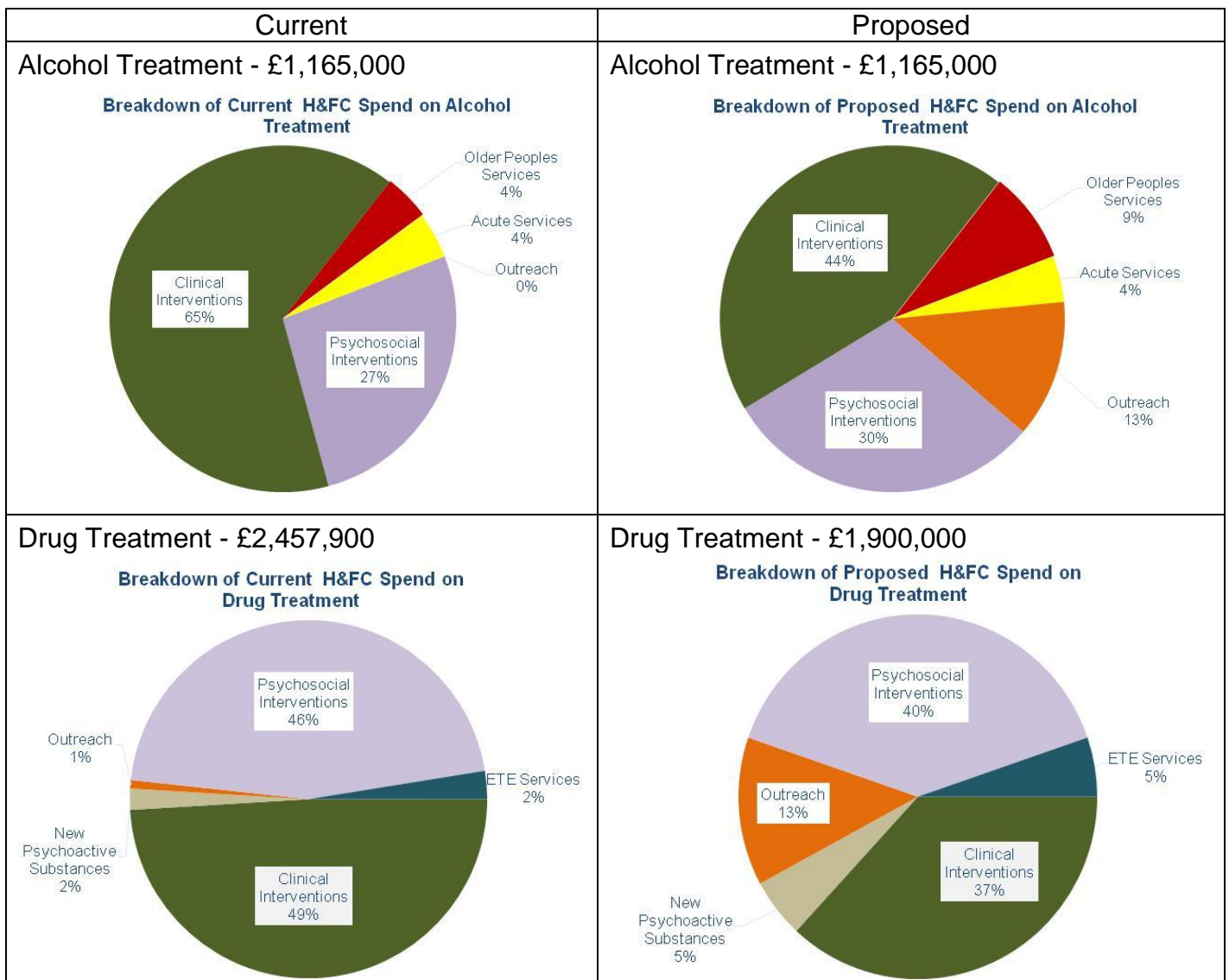
9.3. Implications completed by: Kar-Yee Chan, Solicitor (Contracts), Bi-borough Legal Services, 020 8753 2772.

10. FINANCIAL AND RESOURCES IMPLICATIONS

10.1 As part of the agreed three year substance misuse business plan 2014-2017 it is the ambition to make efficiencies in the region of £2 million across the whole system, of which approximately £560,000 relates to Hammersmith and Fulham, which will be generated through this procurement. Additional efficiencies will be considered in response to further needs assessment work.

10.2 The pie charts below show the current core drug and core alcohol annual investment profile and proposed future investment profile.

HAMMERSMITH & FULHAM COUNCIL



There are no efficiencies being drawn down from the investment in Alcohol services within H&F due to the high levels of need within the borough and 2nd highest admission to hospital rates for directly attributable alcohol related disease.

10.3 The figures above are contained within the overall budget envelope for substance misuse services.

10.4 Implications verified/completed by: Timothy Carr (Finance Business Partner) 020 7641 1772

11 RISK MANAGEMENT

11.1 Management of this risk is noted on the Council's strategic risk register, risk number 4 market testing and risk number 5 Public Health risks. As referenced in Appendix A the impact of not sustaining core services for our drug and alcohol using populations will create a range of problems across our communities which will lead to a higher expenditure. Unless we re-procure, essential core services may not be sustainable.

11.2 Re-procuring services could result in a sites used for service provision. There is a mix of provider owned/leased and council managed properties across the substance misuse system. This risk will need to be managed through the procurement process. Procurement and mobilisation risks remain the responsibility of the Adult Social Care department and are therefore managed within the existing departments risk management process.

11.3 Implications verified/ by: Michael Sloniowski Tri-borough Risk Manager telephone 020 8753 2587.

12 PROCUREMENT AND IT STRATEGY IMPLICATIONS

12.1 This report proposes the move to two separate three year contracts One for core alcohol treatment and one for core drug treatment. Contracts will include break clauses and opportunities to vary the level of investment each year.

12.2 The Hammersmith and Fulham contribution to the to the contracts are £1,165,000 for the alcohol service and £1,900,000 for the drug service per annum.

12.3 The Hammersmith and Fulham Contract Standing Orders state that for tenders over the EU Threshold for Supplies and Services (currently £172,514), Officers are required to use a competitive process via an Invitation to Tender and a minimum of 5 tenders should be sought.

12.4 A restricted tender process will be used and the opportunity will be advertised through the capitalEsourcing portal in line with the mandatory requirements

12.5 Implications completed by: Sherifah Scott, Head of Procurement and Contracts ASC, 020 7641 8954

LOCAL GOVERNMENT ACT 2000
LIST OF BACKGROUND PAPERS USED IN PREPARING THIS REPORT

No.	Description of Background Papers	Name/Ext of holder of file/copy	Department/ Location
1.	None		

LIST OF APPENDICES:

Appendix A: Business Case version 22

APPENDIX A: BUSINESS CASE VERSION 22

BUSINESS CASE – Approval to Proceed to Procurement

Proposal Name: Core Drug and Alcohol Adult Services Procurement

Proposal Sponsor: Liz Bruce, Executive Director Adult Social Care and Health

Submitted By: Gaynor Driscoll

Job Title: Head of Substance Misuse, Sexual Health and Offender Health

Department / Team: Public Health – Substance Misuse, Sexual Health and Offender Health Commissioning Team

2. EXECUTIVE SUMMARY

- 2.1. This report seeks approval to re-procure core drug and alcohol services across Hammersmith and Fulham (H&F), Royal Borough Kensington and Chelsea (RBKC) and Westminster City Council (WCC) during 2015, streamlining systems and making efficiencies to bring added value to each borough, and ensure improved outcomes for service users. To set the context, Appendix 1 provides background information on the current system and who it is provided for, performance, gaps and opportunities.
- 2.2. The conditions attached to the ring fenced Public Health grant are broadly the same as in previous years. However Public Health England have added a new condition for 2015/16 stating that Local Authorities should “have regard to the need to improve the take up of, and outcomes from, their drug and alcohol misuse treatment services”. This supports both the ongoing priority given to drug and alcohol treatment services by PHE and the option recommended in this report.
- 2.3. H&F, RBKC and WCC have been commissioning externally, drug and alcohol services on behalf of health and local authorities since the 1990’s. These services are well embedded in a wider network of service provision with longstanding collaborative and integrated relationships across the three local authorities, including Community Safety, Housing, Family and Children’s services, Adult Social Care, Environmental Health, and externally with primary care, acute care, job centres, the independent sector, NHS Commissioning Board, Mayor’s Office, Home Office, Dept. Of Health. The current system has been commissioned taking account of the Government Drug Strategy (2008). The revised 10 year drugs strategy in 2010 has resulted in making some modifications to our system however we need a more thorough system transformation to ensure we meet the changing needs of our local populations.
- 2.4. Investing in drug treatment optimises an individual’s social capital. There is a significant and growing body of evidence showing that investing in the prevention and treatment of drug and alcohol misuse improves social, physical, human and recovery capital. As individuals recover from their addiction or problem use they increase their ability to access education, training and employment, sustain appropriate housing, commit fewer crimes

and improve relationships often reconnecting with their families and gain positive social networks. The impact of not investing in this will result in a negative impact on individuals, families and the community increasing costs to health and social care systems, criminal justice systems and increases demands on the welfare benefits system. (Appendix 2).

2.5. The main aims of the re-procurement are to reduce the harms caused by drug and alcohol use and support the successful completion of treatment by being more responsive to changing drug trends. The new service will:

- manage a wide range of substances
- increase satellite and outreach working
- increase home treatment
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2.6. Current contracts are due for renewal 31 March 2016 and the opportunity exists to redesign, make efficiencies and improve accessibility based on the evidence shown below.

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H&F	1548	692 (45%)	2805	150 (5%)	7667	432 (6%)
RBKC	1563	531 (34%)	2032	240 (12%)	6332	454 (7%)
WCC	2255	1178 (52%)	3371	380 (11%)	9966	696 (7%)

We invest significant amounts of the public health grant into both alcohol and drug services. Recent efficiencies to the substance misuse system have resulted in no allocation from the local authorities general funds being given. The whole system is now totally funded through health. The greatest proportion of the current budget is spent on high cost clinical services. The proposed revised model will move the whole system towards a more psychosocial model increasing opportunities for earlier identification, early intervention and more effectively supporting individuals to sustain their recovery. Through this shift in emphasis we are able to achieve significant efficiencies for each borough, approx. 20% of the total allocated to core substance misuse services. In so doing we also expect to achieve better outcomes.

2.7. There are a number of services that will not be included in the procurement exercise as they have been recently commissioned or sit outside core provision:

- in-patient detox
- care management (purchased care packages, safeguarding)
- group work programme across the three boroughs

² National Drug Treatment Monitoring System 2013-14 Treatment Activity. Projecting Adult Needs and Service Information System 2014. Health Profiles Public Health England 2014.

- primary care support service across the three boroughs
- reducing reoffending service
- pharmacy and GP contracts
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3. OPTIONS

2.1 Option 1 – do nothing

This is not recommended as services will not be able to sustain the level of core provision required by our residents

Option 2a – procure three integrated core drug and core alcohol services – single borough

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Cons – limited alcohol provider market, one size doesn't fit all therefore the new model must recognise the differences across the three authorities as part of the procurement process.

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Option 4 cannot be achieved in respect of the boroughs included in the West London Alliance as the majority are currently in the middle of their own

procurement of drug and alcohol services. Other central London boroughs are also either out to procurement or have recently commissioned specialist services.

- 2.2. It is recommended that we have approval to proceed to procure core drug and core alcohol services during 2015 and that the board supports Option 3b to procure a revised service model across the three boroughs. This contracted model will retain sovereignty for each borough although the aim will be to procure two providers to deliver the services across the three boroughs to gain the most efficiency savings. This shared borough model has been successfully implemented for primary care specialist services and the specialist groupwork programme both of which achieved significant efficiencies for each borough and have demonstrated improved quality.

4. WHY RE-PROCURE

- 4.1. The current contracts are due for renewal 31 March 2016. This allows for a three month consultation period and full year procurement period from April 2015.
- 4.2. The current treatment system is not sustainable in its current form. Redesign must take place in order to meet the needs of *all* drug and alcohol users. Drug using trends are changing and this group has been a population that our current service model has failed to engage.
- 4.3. There are identified unmet needs for alcohol users who range from street homeless to residents who work and are drinking at increasing and high risk levels. These individuals typically do not access drug services. Anecdotal feedback supports the perception that there is stigma attached to accessing drug services.
- 4.4. There is an increase in drug and alcohol related deaths. A split of drug and alcohol services will enable more of a focus on early identification and treatment of those most at risk and do not engage in treatment services. Current drug and alcohol services have an ageing population and to meet the needs services must be flexible and target broader cohorts.
- 4.5. Alcohol use increases incidences of heart disease, stroke, depression and anxiety, breast cancer in women, pancreatitis, liver cirrhosis, high blood pressure and harm to unborn babies. Drug use increases incidences of infection from blood borne viruses for injectors, depression, anxiety, personality disorder, liver damage from drug overdose, poor vein health and arthritis, lung damage due to tobacco use, bladder problems from ketamine use, increased risk of sexually transmitted diseases.
- 4.6. Drug and alcohol use does not only effect the individual. Families and the children of drug and alcohol users are also affected. Partners and children of drug and alcohol users may go on to suffer from physical, psychological problems. Parental substance misuse is a factor in 29% of all serious case reviews. Nationally alcohol is a factor in half of violent assaults and 13% of road fatalities. Investing in treatment prevents 4.9 million crimes per year. The Department of Works and Pensions estimates that, 80 per cent of individuals

receiving treatment for drug dependency are on benefits.³ It is also estimated also that approximately 160,000 dependent drinkers in England are in receipt of one or more of the main benefits.⁴ DWP estimate that 1 in 15 of their benefit claimants has a drug or substance misuse problem

- 4.7. Drug and alcohol use causes significant social and economic problems. Effective prevention, treatment and recovery can substantially reduce the economic and social costs of substance misuse related harm. Therefore drug and alcohol treatment must be effective in supporting individuals through treatment and to sustained recovery. Services must impact on health and mortality rates, improve relationships and communities, reduce drug related crime, and reduce costs on the health and welfare system. Public Health estimates that alcohol related harm costs society 21 billion per year and drug addiction costs society 15.4 billion per year. Investing in drug treatment saves 960 million the public, businesses, criminal justice service and NHS(PHE publications gateway number: 2013-190)

5. KEY FEATURES OF THE NEW SERVICE

- 5.1. The new service will work in partnership to transform public services in order to benefit local residents. See Appendix 4 for proposed key performance indicators. A key feature of the new service will be the requirement to work across networks in order to improve joint working and integrate pathways. For example, working with health trainers and community champions to identify drug and alcohol users. Our services will be more accessible and go out into the community to support people in their own homes and local areas.
- 5.2. Drug services - the core interventions will continue: prescribing; psychosocial interventions; education, training and employment support; hepatitis screening and support into blood borne virus (BBV) treatment; peer mentoring. The new service will be responsive to changing trends and have a skilled workforce that will work collaboratively with key stakeholders on a wider range of cross cutting themes.
- 5.3. Alcohol services - the service will continue to provide alcohol services such as hospital liaison nurses, older people and alcohol services, community detoxification, and core alcohol interventions. The service will generate efficiencies in wider health services including through diverting alcohol users from A&E and hospital admission and reducing ambulance call outs.
- 5.4. The proposed service model will respond to the needs of families through early identification and prevention work prior to reaching crisis. Specialists will work alongside family services and lead or contribute to joint needs assessments. The service will maintain a focus on hidden harm and prevention work with provision of bespoke training.
- 5.5. Work with violent perpetrators will be a key priority area within the new service model and will support the three boroughs violence against women and girls

²<http://www.dtors.org.uk/reports/BaselineMain.pdf>

⁴ Population estimates of alcohol misusers who access DWP benefits by Gordon Hay and Linda Bauld Department for Work and Pensions

priorities. The new model will also work with local criminal justice agencies by sharing intelligence and supporting the case management of offenders on integrated offender management programmes.

6. BENEFITS

- 6.1. Separate core drug and core alcohol services will ensure the needs of specific groups are prioritised. For example, the Community Alcohol Support Service (CASS) in H&F has shown a recent increase in numbers for high risk cohort of individuals who would not present to integrated models. Feedback from service users has shown that they prefer separate services set up to deal specifically with their needs.
- 6.2. Separate services gives staff the opportunity to increase knowledge and expertise enabling provider organisations to develop a higher calibre of staff.
- 6.3. A more responsive service operating flexibly will enable more clients to engage in treatment and recovery. Staff will be mobile through satellite, outreach and home visiting which supports joint working and will reduce the demand on sites.
- 6.4. A responsive drug or alcohol service will be more accessible to partners and the public with clear pathways to treatment. The service will work jointly across local authority and health departments to support cross cutting themes.
- 6.5. Separate core drug and core alcohol contracts across the three boroughs will streamline the system and support efficient monitoring and performance management. This will result in reducing the number of contracts from eight to two. These contract will be rigorously managed through a set of clearly defined outcome measures and key performance indicators as proposed in Appendix 3.

7. RISKS

- 7.1. Unless we re-procure, essential core services may not be sustainable due to funding restrictions and changing trends resulting in services not being fit for purpose.
- 7.2. Re-procuring services could result in a loss of buildings. There is a mix of provider owned/leased and council managed properties across the substance misuse system. This risk will need to be managed through the procurement process.

8. PROCUREMENT PROCESS

- 8.1. It is proposed that WCC lead on the procurement process on behalf of the other two boroughs in line with current shared services arrangements. WCC as the Lead Borough will enter into a framework with the successful provider

and the two other boroughs. Each of the three boroughs will be able to call the contracts off via an access agreement.

8.2. The procurement strategy for this process will be presented at Adults Commissioning, Shared Services Board, Public Health Transformation Board and Contracting Board and Contracts Approval Board. An initial procurement timetable is attached in Appendix 4.

8.3. Consortia of health and substance misuse independent sector providers will be welcomed as well as tenders from sole providers. If approved the tender will be restricted as there is a limited pool of specialised substance misuse/health providers.

9. FINANCE

9.1 Public Health England has researched the impact of investing in Drugs and Alcohol and the following identifies the averages across England:

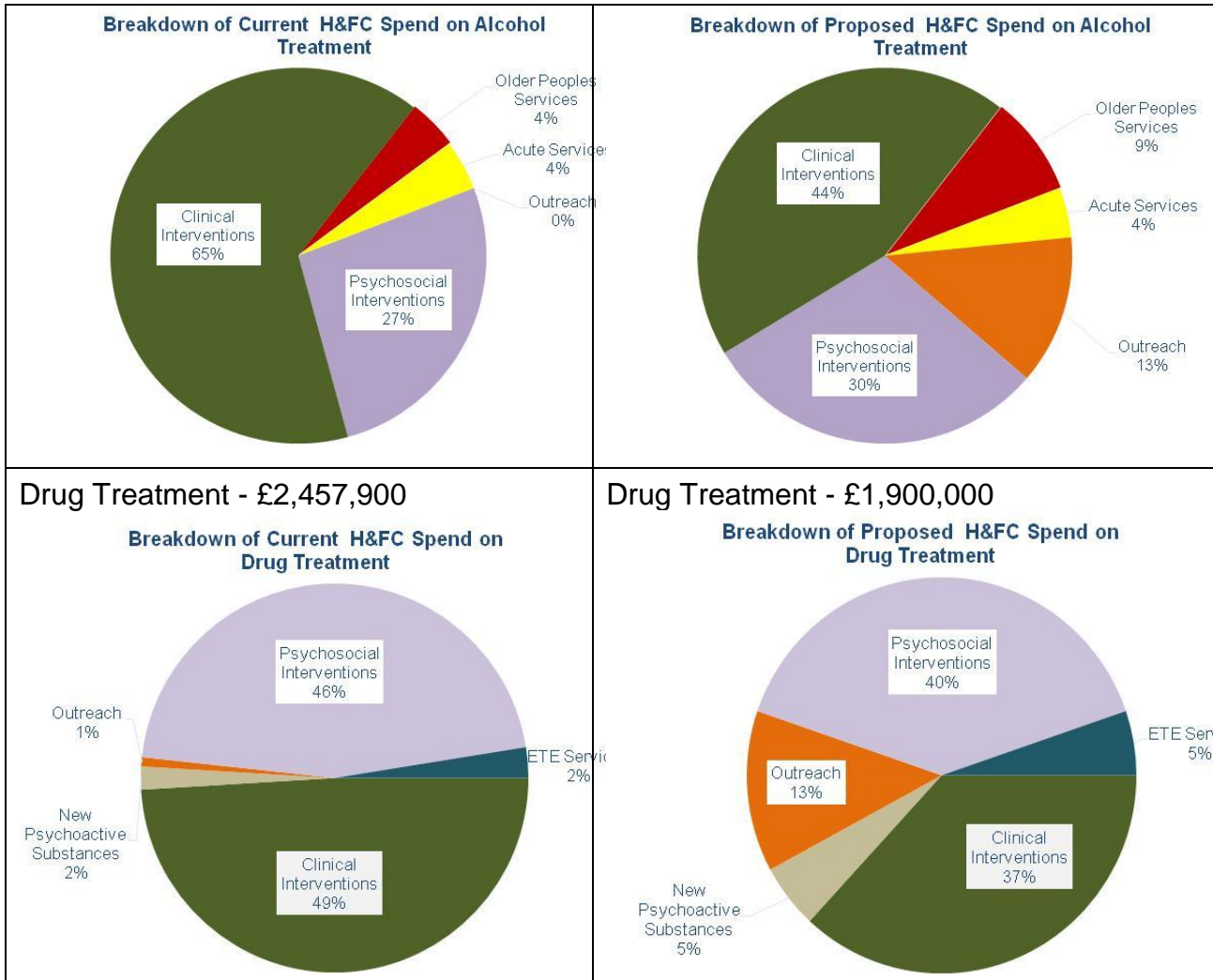
- Every 5,000 patients screened in primary care may prevent 67 A&E admissions and 61 hospital admissions - Costs = £25,000, Saves = £90,000.
- One alcohol liaison nurse can prevent 97 A&E visits and 57 hospital admissions – Costs = £60,000, Saves £90,000.
- Every 100 dependent people in treatment can prevent 18 A&E visits and 22 hospital admissions - Costs = £40,000, saves £60,000.
- Every £1 spent on drug and alcohol treatment saves £2.50 costs to society. The majority of savings made reduce the costs to health care systems. All expenditure on this area of work is funded by health. We intend to negotiate with the NHS to secure a percentage of the savings made to the whole system to be allocated to the three authorities.

9.2 As part of the agreed three year substance misuse business plan 2014-2017 it is our ambition to make efficiencies in the region of £2 million by March 2016 across the whole system, most of which will be generated through this procurement. Additional efficiencies will be considered in response to further needs assessment work.

9.3 The pie charts below show the current core drug and core alcohol annual investment profile and proposed future investment profile.

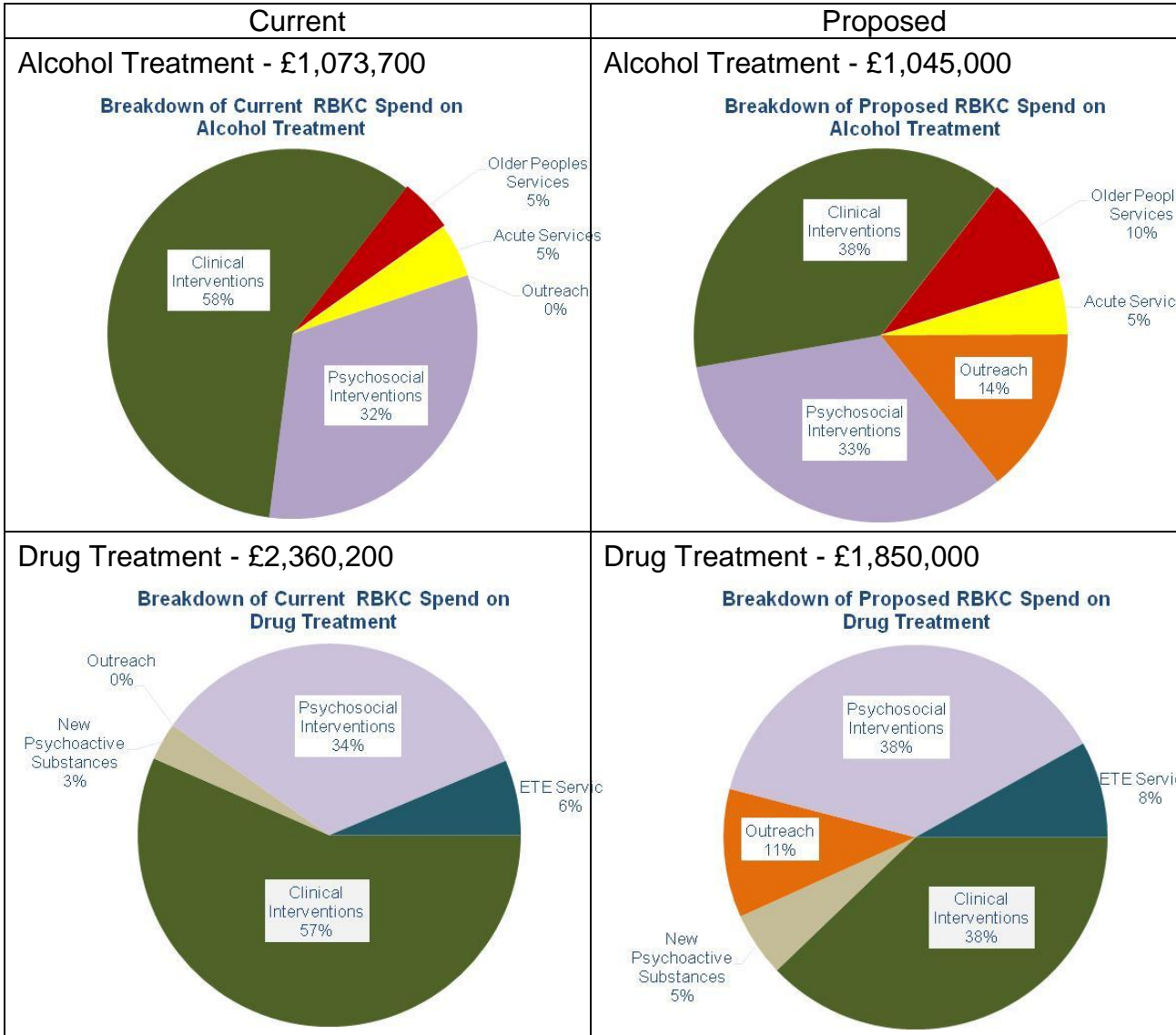
HAMMERSMITH & FULHAM COUNCIL

Current	Proposed
Alcohol Treatment - £1,165,000	Alcohol Treatment - £1,165,000

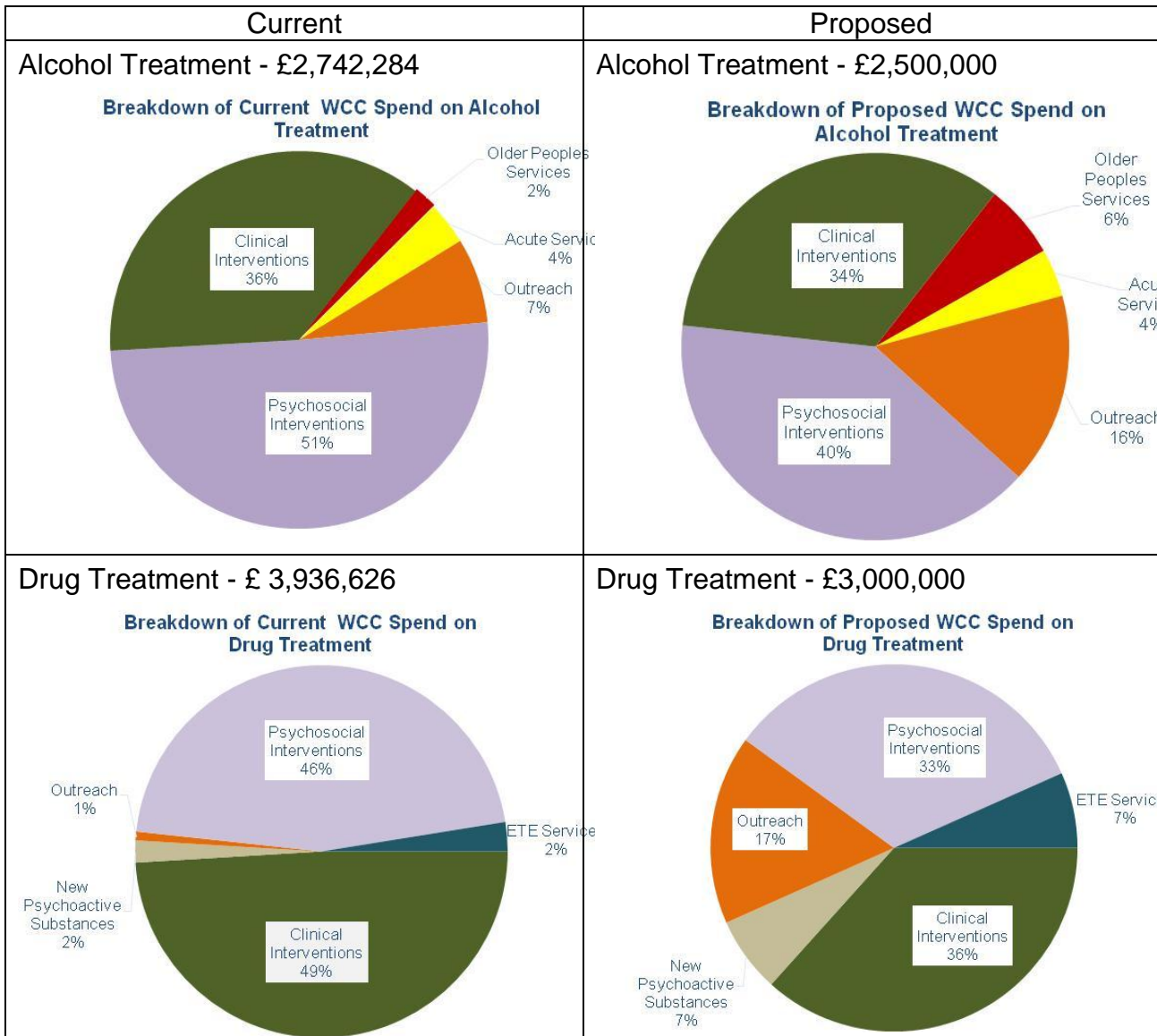


There are no efficiencies being drawn down from the investment in Alcohol services within H&F due to the high levels of need within the borough and 2nd highest admission to hospital rates for directly attributable alcohol related disease.

ROYAL BOROUGH OF KENSINGTON AND CHELSEA



CITY OF WESTMINSTER



(APPENDIX 1)

DRUGS AND ALCOHOL COMMISSIONING 2013 - 2015 BACKGROUND INFORMATION

Vision:

'To improve the health and wellbeing of drug and alcohol misusers including offenders, their families through ensuring those people in need of services have access to the full range of treatment and recovery opportunities and are protected from the harms caused as a result of alcohol and drug misuse and/or criminality. All of this will be done whilst reducing costs and improving service effectiveness.'

To achieve our vision, we will:

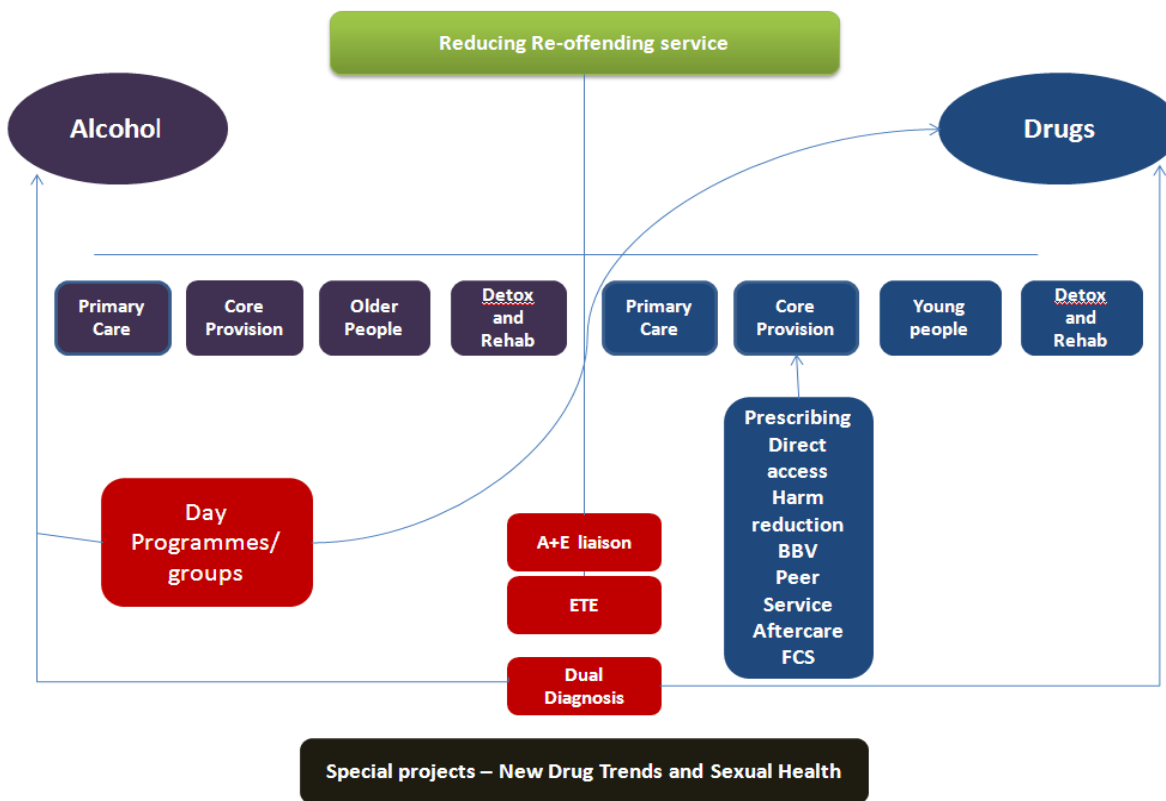
- Continue to commission services to protect our high-quality front line provision, improve effectiveness and reduce costs.
- Jointly commission services and share resources.
- Innovate, and share learning and ideas in relation to best practice.
- Ensure individuals we work with develop and retain a strong sense of personal responsibility for their behaviour.
- Collaborate more effectively with key partners across the statutory and voluntary sector to ensure we are successful.

Strategic objectives:

- Commissioning for results - we will regularly review the treatment system and remodel services and interventions to achieve the best possible outcomes for individuals, families and the wider community.
- Improving Access - we will ensure services are widely marketed and responsive and flexible to the assessed needs of service users and are delivered through site based, satellite and outreach provision
- Delivering Recovery - we will fully embed a recovery oriented approach throughout the treatment system from first point of access through to successful completion.
- Reducing Reoffending - we will work jointly with community safety partners to deliver a reducing reoffending model that addresses the needs of short term offenders to reduce the impact of crime and substance misuse on the community and on the offender.
- Responding to New Drug Trends - we will continue to innovate to respond to the changing patterns of substance misuse services.
- YP and Transition- we will improve the interventions available to young people at risk of developing entrenched substance misuse problems and ensure we develop effective prevention, diversion and treatment services to meet their needs jointly with Family and Children's services.
- Resources - ensure resources are deployed effectively and efficiently to achieve value for money, and to reduce costs whilst delivering improved outcomes.

Services Map

While the configuration of services vary across the three boroughs, the treatment interventions available to our residents is comparable and represented in the following diagram.



There are a number of services that are commissioned to deliver the above system. Specific areas of work include:

- Advice, awareness raising, training programmes, sign posting and brief advice
- Specialist direct access services and prescribing services
- Substance misuse detoxification services
- Residential rehabilitation packages of care
- Community based day programmes and structured groupwork
- Specialist prevention diversion and treatment services for young people and those in transition
- Drug and alcohol intervention services across the criminal justice settings
- Primary Care support services, prescribing services and pharmacy schemes
- Dual diagnosis provision
- Needle exchange and blood borne virus treatment and screening.
- Peer led services and mutual aid initiatives
- New psychoactive drugs services (Club Drugs/legal highs)
- Targeted services to the homeless population
- A&E liaison and hospital liaison
- Older persons alcohol services

Who are they for?

Treatment services are available to residents whose lives are affected by substance misuse with the intensity of support varying in accordance with need. Interventions range from low threshold direct access to more intensive, formal or structured interventions.

The investment is targeted at those young people (14 years +) and adults with no upper age limit who have a need for drug or alcohol related specialist interventions. We work with resident populations of the three boroughs and those homeless registered on the National CHAIN data base as the responsibility of the area.

Across the three borough substance misuse in our adult resident population is estimated as:

Estimate	Hammersmith & Fulham	Kensington & Chelsea	Westminster
Dependent Drug Users	4,353	3,595	5,626
Dependent drinkers	7,667	6,332	9,966

Source: Projecting Adult Needs and Service Information System October 2014

The number of adult residents accessing specialist structured treatment interventions in 2013-14 was as followed:

Substance Using Cohort	Hammersmith & Fulham	Kensington & Chelsea	Westminster
Opiate and or crack cocaine	692	531	1,178
Other drug	150	240	380
Primary alcohol	432	454	696

Who is the contracted provider or providers?

The commissioning intentions are moving towards a three borough service model with an increasing number of shared services.

Borough based specialist treatment services:

- H&F specialist services are provided through CNWL; Blenheim CDP; Foundation 66 with some additional investments being made to housing support and peer led organisations (the Firm; Outside Edge and Groundswell).
- RBKC specialist services are provided through CNWL; Blenheim CDP , Foundation 66 and adult social care with additional investment in the peer led charity "Build on Belief"
- WCC specialist services are provided through Turning Point (SWDAS) and a consortium between Westminster Drug Project, CNWL and F66 (NWDAS)

Three Borough Shared Services are :

- Blenheim CDP Primary Care Support Services
- Turning Point Structured Group Work / Day Programmes
- Turning Point/Catch 22 Reducing Reoffending

- F66 Older People and Alcohol

Detoxification Framework Providers are:

- CNWL – Max Glatt Unit (high needs/risk drugs and alcohol)- may close following CNWL consultation and notice period.
- Cranstoun -City Roads (up to medium needs/risk drugs)
- F66 - Long Yard (up to medium needs/risk alcohol)

Out Of London Detoxification Block Contract

- Action on Addiction - Clouds House (Fellowship based programme)

Residential Treatment Packages:

- Purchased through individual spot purchasing agreements

Primary Care Services:

- Shared Care Scheme - contracts with individual GPs
- Pharmacy Scheme - contracts with individual Pharmacies

Targets and outcomes

Substance Misuse and Offender Health services play a pivotal role in the delivery of the vision and outcomes set out in the Public Health Outcomes Framework.

In addition to the more pertinent indicators, 2.15, 2.16, 2.18, the substance misuse treatment system also contributes to the achievement of a number of additional outcomes in relation to criminal justice, blood borne viruses and preventable illness and falls. (please see table below)

Objective 1:
Improvements against wider factors which affect health and wellbeing and health inequalities

- 1.7 People in prison who have a mental illness or a significant mental illness
- 1.9 Sickness absence rate
- 1.10 Killed and seriously injured casualties on England’s roads
- 1.11 Domestic abuse
- 1.12 Violent crime (including sexual violence)
- 1.13 Re-offending

Objective 2:
People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities

- 2.14 Smoking prevalence – adults (over 18s)
- 2.15 Successful completion of drug treatment
- 2.16 People entering prison with substance dependence issues who are previously not known to community treatment
- 2.18 Alcohol-related admissions

Objective 3: The population’s health is protected from major incidents and other threats, whilst reducing health inequalities

- 3.4 People presenting with HIV at a late stage of infection
- 3.5 Treatment completion for TB

Objective 4:
Reduced numbers of people living with preventable ill health and people dying prematurely, whilst reducing the gap between communities

- 4.6 Under 75 mortality rate from liver disease
- 4.13 Health-related quality of life for older people

levels
1.15 Statutory
 homelessness

to hospital
2.24 Injuries due
 to falls in people
 aged 65 and over

The local performance management framework, which supports the commissioning of services, is aligned with public health outcomes framework.

Estimates of Opiate and Crack Cocaine Use:

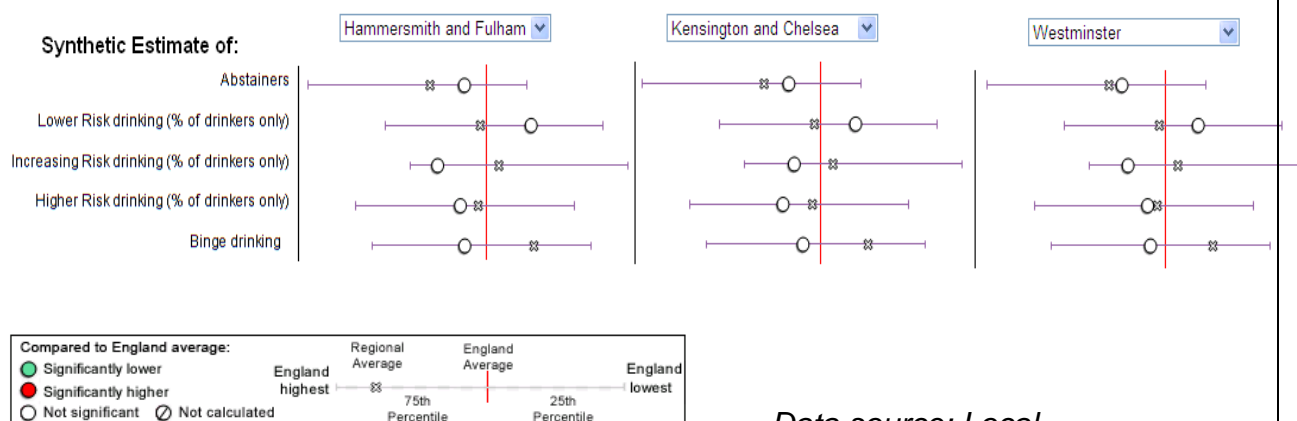
2011-12 Estimate		Number of users			
		Opiate &/ or Crack User	Opiate users	Crack users	Injecting
Hammersmith and Fulham	Number	1,390	1,141	997	325
	Rate per 1,000 population	10.09	8.29	7.24	2.36
Kensington and Chelsea	Number	1,065	809	881	205
	Rate per 1,000 population	9.21	6.99	7.61	1.77
Westminster	Number	2,550	2,026	2,007	833
	Rate per 1,000 population	15.57	12.37	12.25	5.09
London	Rate per 1,000 population	9.55	7.63	6.96	1.97
England	Rate per 1,000 population	8.40	7.32	4.76	2.49

Source: Estimates of the Prevalence of Opiate Use and/or Crack Cocaine Use, **2011/12**. Liverpool John Moores University.

Patterns of Alcohol Consumption (residents 16 years+):

- Lower Risk drinking - consumption of fewer than 22 units of alcohol per week for males, and fewer than 15 units of alcohol per week for females.
- Increasing Risk drinking - consumption of between 22 and 50 units of alcohol per week for males, and between 15 and 35 units of alcohol per week for females.
- Higher Risk drinking - consuming more than 50 units of alcohol per week for males, and more than 35 units of alcohol per week for females.
- Binge drinking - adults who consume at least twice the daily recommended amount of alcohol in a single drinking session (that is, eight or more units for men and six or more units for women).

Borough	Abstainers	Lower risk drinking (% of drinkers only)	Increasing risk (% of drinkers only)	High risk drinking (% of drinkers only)
H&F Council	18.75%	71.77%	21.07%	7.16%
RBKC	19.76%	72.08%	20.57%	7.35%
Westminster	21%	72.16%	20.82%	7.02%



Performance against National Outcome Measures

(See prevalence information above for regional and national comparisons)

- Performance against 1.13 Reducing Reoffending

There will be verified information available at the end of March 2015

- Performance against 2.15 Successful Completion of Drug Treatment

% of drug users that left drug treatment successfully who do not re-present to treatment within 6 months

Opiate	2012-13	2013-14
H&F	7.21% (47/652)	7.78% (50/643)
RBKC	9.89% (52/526)	9.39% (45/479)
WCC	7.44% (85/1142)	7.89% (88/1115)
Non Opiate	2012-13	2013-14

H&F	29.54% (83/281)	36.07% (101/280)
RBKC	23.9% (103/431)	36.34% (161/443)
WCC	30.34% (169/557)	30.13% (166/551)

Performance against 2.15 Successful Completion of Drug Treatment is a priority for Public Health England with this outcome being attached to a “health premium” in coming years.

- **Performance against 2.16 People Entering Prison with Substance Misuse Issues Who were Not Previously Known to Community Services.**

(the proportion of adults starting structured substance misuse treatment in prison who had not received it in the community prior to custody)

The below table is recently released baseline activity for 2013-14 not previously collated.

Borough	Number Previous treated in community	Number Not previously treated in community
H&F	129	135
RBKC	52	67
WCC	122	156

- **Performance against 2.18 Alcohol Related Hospital Admissions**

The number of admissions involving an alcohol-related primary diagnosis or an alcohol-related external cause per 100,000 population

Borough	2011-12	2012-13	2013-14
H&F	615.51	627.98	651.58
RBKC	515.27	427.40	425.11
WCC	581.59	550.87	515.58

Issues, gaps and opportunities

The following priorities were identified from the annual joint needs assessment:

- Ensure the current treatment and recovery system is accessible, responsive and effective and includes action plans based on feedback/ involvement from service users
- Improve the ability of the treatment system to respond to the needs of those who misuse a broader range of substances.
- Revised BBV strategy to be progressed with a best practice model for the identification & treatment of Blood Borne Viruses and other health conditions.
- Maximise recovery opportunities through education, training, employment opportunities and increased peer led initiatives
- Increase opportunities to reduce reoffending and divert substance misusing offenders into treatment through the newly procured joint projects with Community Safety - Starting Over and Minerva Projects.
- Strengthen drug & alcohol treatment pathways from GP surgeries and hospital into

treatment services.

- Provide a multi-agency and the three borough responses to young people's and transition groups substance misuse needs.

Additional cross cutting priorities include:

- the need to divert more alcohol misusing residents into treatment particularly from primary care and the local hospital settings.
- Safeguarding is a focus across both Adults and Children due to the high incidents of violence, neglect and exploitation linked to substance misuse.

What it costs and what do we get for the money?

The budget for all substance misuse commissioning was originally allocated to Primary Care Trusts through a ring-fenced grant referred to as the pooled treatment budget (PTB). Locally this budget was transferred to the three local authorities to commission drug treatment services on behalf of health and social care. Following the creation of CCGs and the shift of public health responsibilities to local authorities this PTB and any additional alcohol funding streams formed part of the Public health ring-fenced grant allocation and identified as a ring-fence budget line within the overall Public Health Budget to ensure local authorities continued to invest in drug and alcohol prevention, treatment and recovery services. Locally we managed to negotiate up our substance misuse allocation from Public Health England and made efficiencies to ensure that we no longer needed to draw on any general fund allocations previously awarded. This ring-fence will go in 2016/17.

Cost of Providing Services

The total annual spend by the Substance Misuse and Offender Health Commissioning Team across the three borough is £20.66 million;

- H&F - £5,626,793
- RBKC - £5,725,545
- WCC - £9,325,287

Return on Investment

The provision of substance misuse treatment is cost effective and delivers a range of benefits for the individual and wider society. This has been demonstrated by several national studies. Depending on the source, the return on investment of drug treatment ranges from £2.50 to £13 for every £1 invested. Less detailed analysis is available on the cost benefits of alcohol treatment although most estimates give a £5 return for every £1 spent. A new tool to measure alcohol treatment cost effectiveness is under development.

By using the former National Treatment Agency's value for money tool, the local return from investment on drug treatment is as follows

H&F £1 investment = £6.07 return

RBKC £1 investment = £4.78 return

WCC £1 investment = £3.57 return

The above outcome is based on 2012 figures prior to a full data cleanse in H&F which inflated the return on investment. WCC are the lowest due to a combination of high

levels of complex cases remaining in the system for significantly longer than average and having poorer outcomes due to the large street homeless cohort. All three boroughs exceed the national average for return significantly.

Prevention

We have less than 4% allocated to targeted prevention in the budget overall although in our young people provision there is a greater emphasis on prevention and diversion with little on structured treatment.

We invest in awareness raising and prevention campaigns and are in the process of reconfiguring resources to address the need for earlier intervention particularly in relation to families impacted by substance misuse.

Joint Working

We commission jointly services with ASC, FCS, Housing, Community Safety, Youth offending service and health in addition to the specialist drug and alcohol services. The majority of expenditure is targeted at diversion, treatment and sustaining recovery.

The investment also buys excellent internal and external collaborative partnership arrangements, commissioning expertise and specialist knowledge, informed needs assessment, a whole system approach, performance and outcome monitoring.

Service User Recovery Journey

C. Is a woman in her thirties with a pattern of drug and alcohol problem use since her teens

C's addiction to alcohol and cocaine was ruining her life and nearly led to early death. Unable to cope C took an overdose and was hospitalised. She survived but the experience had a profound impact. C knew it was time to make a change and sought help from Drug and Alcohol treatment Services after meeting with the specialist hospital liaison nurse. The nurse explained the help she could receive from treatment services and identified with C. what she needed through an initial assessment. A referral was made to the local service.

C accessed the core treatment services and undertook a community programme from detoxification through to abstinence. During her first year of being drug and alcohol free C was able to concentrate on making healthier choices leading to her building the confidence to sustain the changes she had made. C was encouraged to apply to become a peer mentor and she felt that it could offer her an opportunity to continue her personal development and help rebuild her life: "I knew I wanted to go into a helping role. I have lots of experience in the matter and thought why not?" C was accepted onto the programme and over the six week course: "I learnt about boundaries, that everyone's recovery is different, that it's OK not to be OK, It's OK to ask questions, and it's OK not to know. You're dealing with peoples' lives – if I don't know something I'm going to find out".

C now had developed a personal and professional skill set to support others in their recovery journey. C successfully completed the programme and achieved an OCN Level 2 Award in Peer mentoring.

Since completing the peer mentor programme, C has undertaken a Level 2 Counselling Skills course and is due to start a Level 3 Health and Social Care course. Her life is now unrecognisable from what it was before becoming engaged with treatment services. C

has now gained paid employment through the traineeship 'Giving Something Back' peer advocacy scheme. C has gone from strength to strength and is positive about what the future now holds for her.

(APPENDIX 2)

WHY INVEST IN DRUG AND ALCOHOL TREATMENT



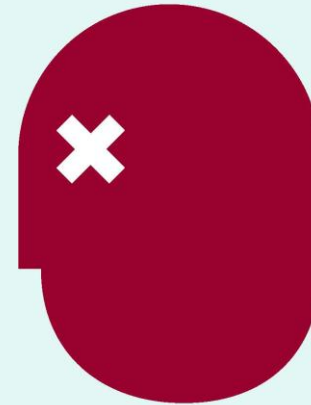
Public Health
England

Alcohol and drugs
prevention, treatment
and recovery:
why invest?



Public Health
England

Alcohol problems are widespread



9 million adults drink at levels that increase the risk of harm to their health

1.6 million adults show some signs of alcohol dependence

Alcohol is the third biggest risk factor for illness and death

Drug use is widespread but addiction is concentrated



2.7 million adults used an illegal drug in the past year

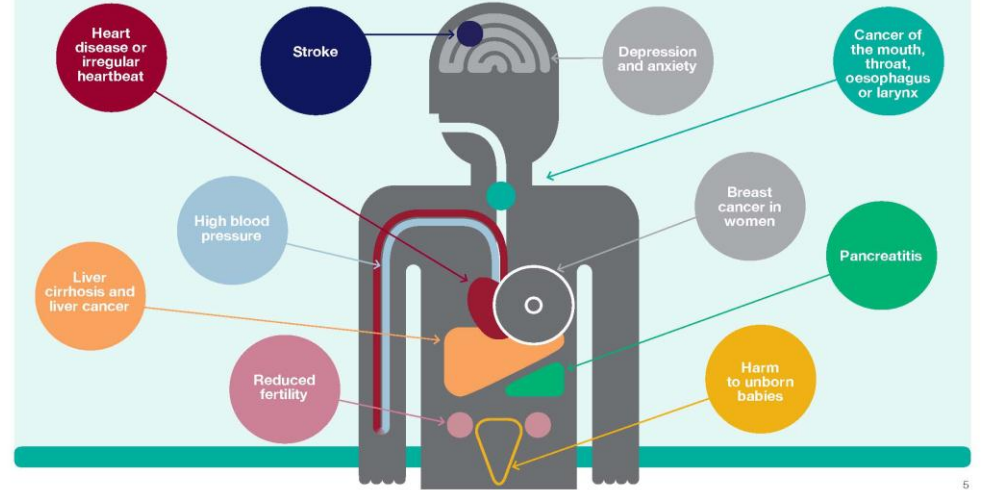
294,000 heroin and crack users in England

40% of prisoners have used heroin

1,200,000 affected by drug addiction in their families – mostly in poor communities

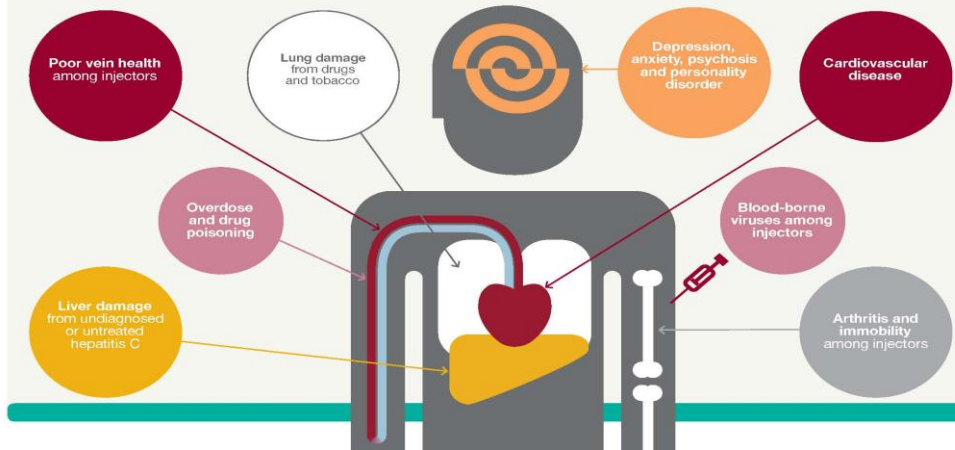
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Alcohol misuse damages health



5

Drug misuse damages health



6

Alcohol and drug deaths

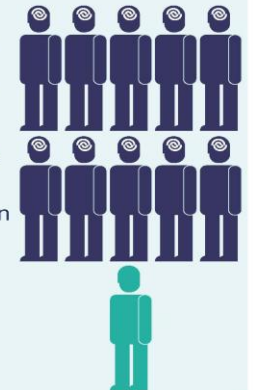
Alcohol misuse leads to many deaths

21,485 people died from alcohol-related causes in 2012



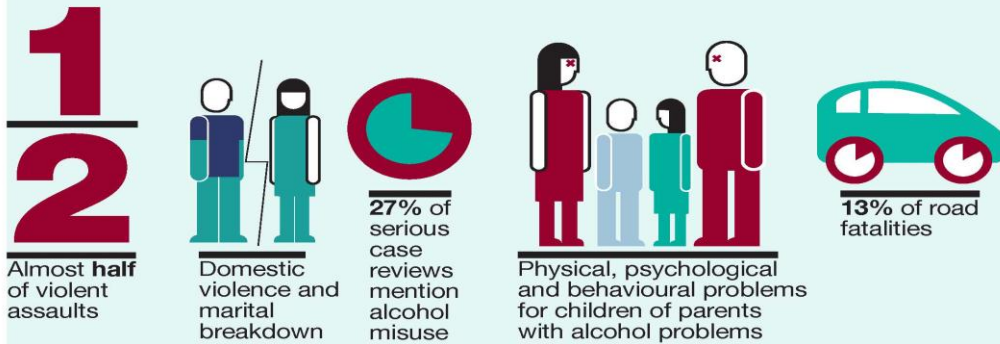
Deaths among heroin users are **10 times** the death rate in the general population

Deaths involving new drugs and some prescription medicines are rising



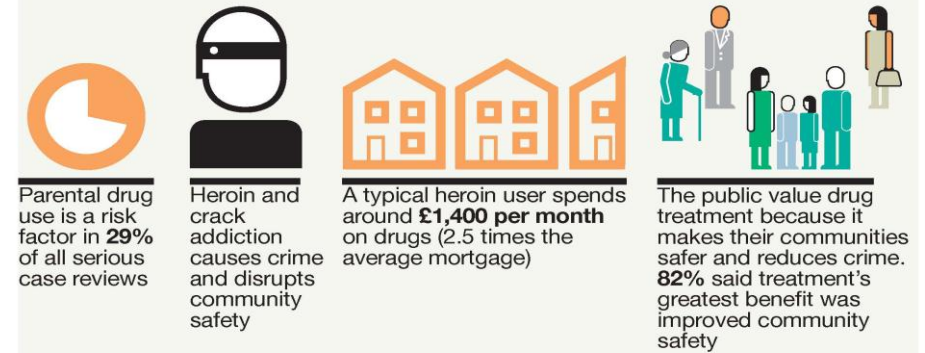
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Alcohol misuse harms families and communities



9

Drug misuse harms families and communities



10

The annual cost of alcohol-related harm

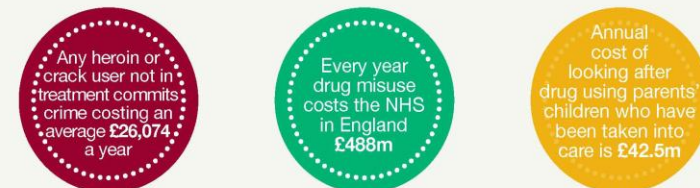


12

The annual cost of drug addiction

Every year it costs society

£15.4bn



13

Alcohol – what needs to be done

1 2 3 4

1 Improve awareness of alcohol harm among young people and delay the age of first use

2 For people who drink, make lower risk drinking the norm and an easy choice to make

3 Target those who are most at risk

4 Respond to and reduce the harm experienced by those who have already developed problems

15

Drugs – what needs to be done

1 2 3 4

1 Prevention measures to build resilience among young people and to promote drug-free environments

2 Develop effective responses to the harm of new drugs, and help people who are addicted to medicines

3 Respond to the growing number of older drug users, many of whom have serious addiction and health problems

4 A package of support (treatment, housing, employment, positive social networks) to help people recover and rebuild families and communities

16

Population-wide prevention



18

Targeted prevention – alcohol

Hospital alcohol liaison services to reduce the unnecessary burden on the NHS

Brief interventions in primary care and other settings to reduce the impact of alcohol on health

Evidence-based screening in the NHS Health Check to reduce harmful drinking

Prevention programmes to reduce young people's alcohol consumption

19



Targeted prevention and harm reduction – drugs

Advice, testing, vaccination and treatment for blood-borne viruses

Needle and syringe programmes to prevent infection and spread of blood-borne viruses

Prevent avoidable overdose deaths

Work with local health partners to prevent and treat addiction to medicines

Prevention programmes aimed at young people to reduce drug harms

20



Specialist treatment (alcohol and drugs)



Specialist treatment should be accessible, matched to local need and NICE-compliant

All patients should have a mutually agreed and regularly reviewed care plan, setting out their treatment goals

All treatment should include support for behaviour change

It may also include appropriate prescribed medicines

Residential and community rehabilitation should be available for those who need it



21



Support for sustained recovery

Everyone should have access to support that promotes and sustains their recovery

Help people access mutual aid groups (e.g. AA, NA, SMART Recovery) and other positive social networks

People in recovery need access to stable accommodation

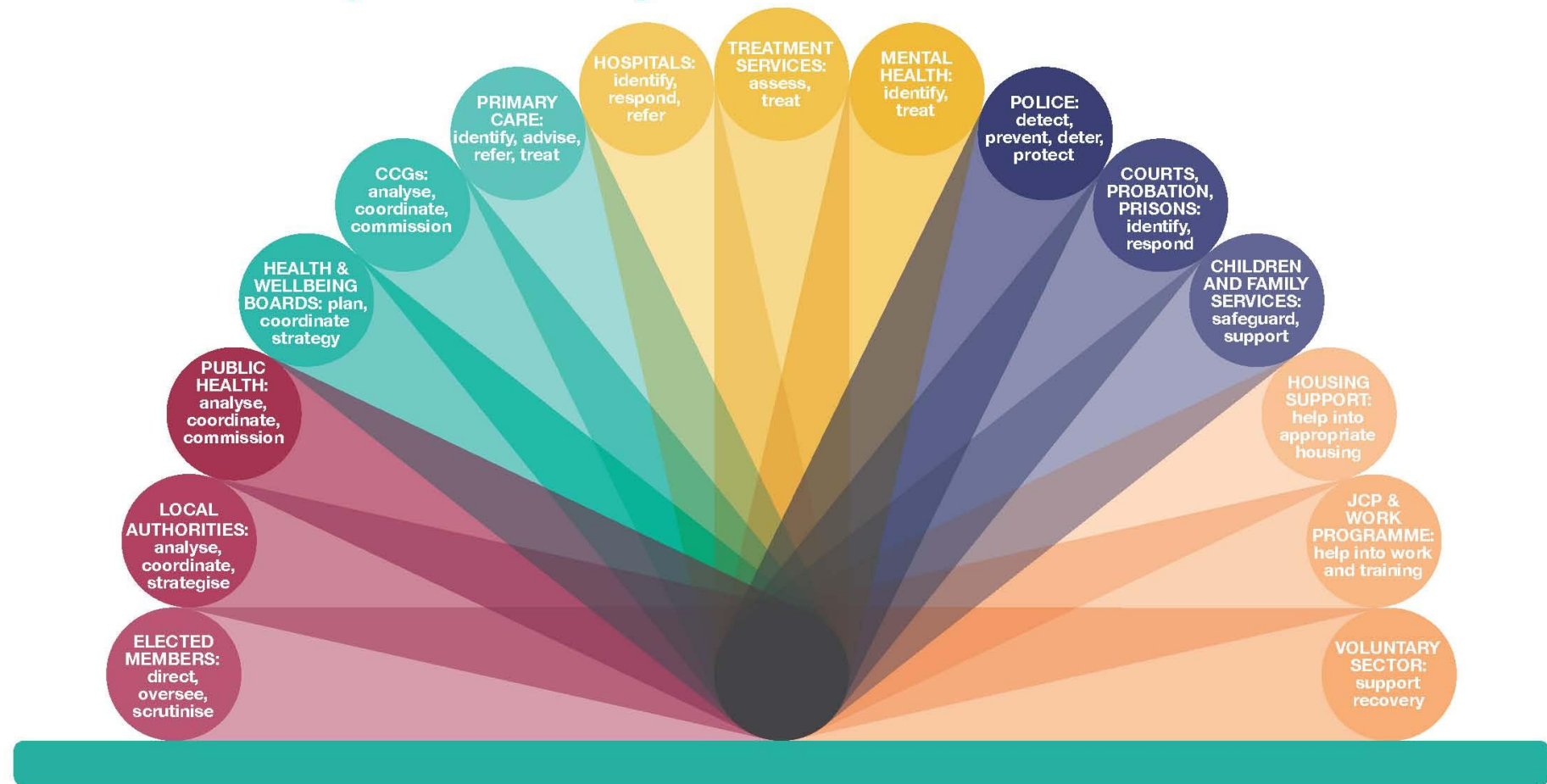
They should be supported into education, training or employment

Doing all of this will enable individuals to reach their full potential, will lead to better outcomes and save money

22



Partnership: the key to success



Intervening early works and saves money



25

Investing in alcohol interventions saves money

Every 5,000 patients screened in primary care may prevent 67 A&E visits and 61 hospital admissions	One alcohol liaison nurse can prevent 97 A&E visits and 57 hospital admissions	Every 100 alcohol-dependent people treated can prevent 18 A&E visits and 22 hospital admissions
Costs £25,000 Saves £90,000	Costs £60,000 Saves £90,000	Costs £40,000 Saves £60,000



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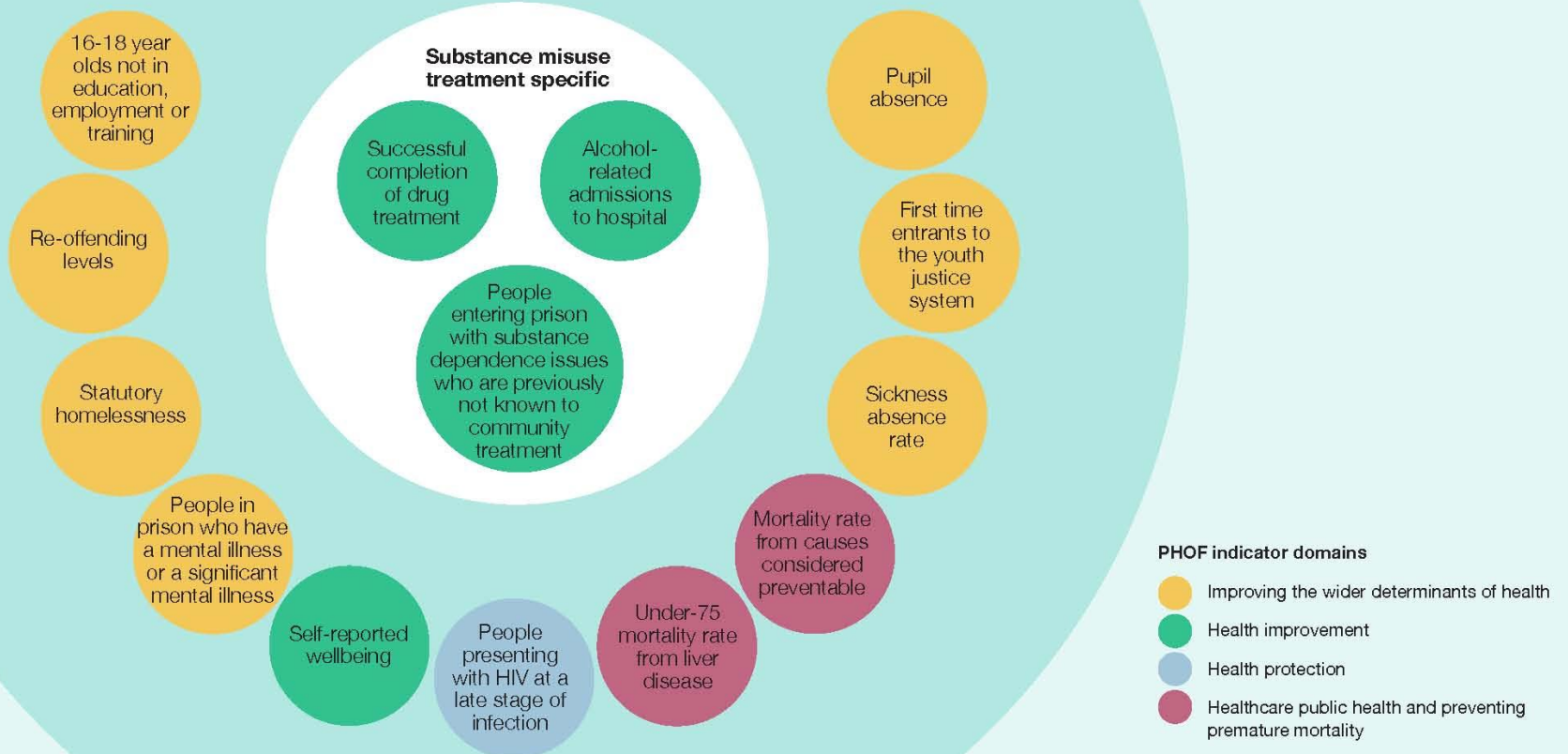
Investing in drug treatment cuts crime and saves money



27



Drug and alcohol interventions lead to better public health outcomes



(APPENDIX 3)

TREATMENT SYSTEM OUTCOMES

The table below contains the first draft of the expected outcomes of the recommissioned treatment system. The targets are for all three boroughs, unless otherwise indicated. These are partnership outcomes and a number of other local performance indicators will underpin the agency's performance management framework. This will include minimum standards around waiting times, compliance with audit criteria, reduction in use among those actively engaged in treatment and post treatment outcomes. A flexible case management system, which allows locally tailored reporting, will be a core component to the service requirements.

Outcomes delivered by the New Treatment System	2013-14 Baseline	Y1	Y2	Y3	Source	Rationale
Percentage of the estimated number of problematic drinkers accessing specialist treatment interventions.	5.6% H&F 7.1% RBKC 7% WCC	8%	11%	14%	NDTMS	NICE recommends capacity for at least one in seven of the estimated dependent drinking population to access treatment ⁵ .
Maintain the proportion of the estimated number of opiate and crack cocaine misusers engaged in treatment	49.8% H&F 49.9% RBKC 46.2% WCC	50%	50%	50%	NDTMS	The opiate and crack cocaine misusing treatment proportion is comparatively high across the three boroughs.
Increase the proportion of non-opiate misusers accessing treatment.	150 H&F 240 RBKC 380 WCC	5% on 2013-14 baseline	10% on 2013-14 baseline	15% on 2013-14 baseline	NDTMS	The treatment system needs to be more accessible to users of all drugs. In particularly psychoactive substances.
Percentage of the opiate misusing treatment population successfully completing and not re-presenting within 6 months (PHO 2.15i)	7.8% H&F 9.4% RBKC 7.9% WCC	9.5% (WCC 9%)	10% (WCC 9.5%)	11% (WCC 10%)	NDTMS	2013-14 Top quartile range for Local Authorities. WCC has a more complex opiate treatment population so targets need to be different for this local authority.
Percentage of the non-opiate drug misusing treatment population successfully completing treatment and not re-presenting within 6 months (PHO 2.15ii)	36.1% H&F 36.3% RBKC 30.1% WCC	37%	38.5%	40%	NDTMS	2013-14 Top quartile range for Local Authorities.
Percentage of the alcohol misusing treatment population successfully completing treatment	42% H&F 34.9% RBKC 31.7% WCC	45% (WCC 35%)	48% (WCC 40%)	50% (WCC 45%)	NDTMS	Top quartile performance is 39.53% in Quarter 2 of 2014-15.

⁵ Alcohol dependence and harmful alcohol use quality standard. August 2011. NICE quality standard 11

Outcomes delivered by the New Treatment System		2013-14 Baseline	Y1	Y2	Y3	Source	Rationale
Reduction, on 2013-14 baseline, in the number of alcohol related hospital admissions (PHO 2.18)		(Provisional) 927.30 H&F 595.54 RBKC 980.13 WC	H&F 0% RBKC 0% WCC 1%	H&F 3% RBKC 0% WCC 2%	H&F 5% RBKC 0% WCC 3%	North West Public Health Observatory	Between 2012-13 and 2013-14 admissions increased by 4.77% in H&F. Therefore a 0% increase would represent a challenging target. RBKC has the 4th lowest rate of admissions in 2013-14 so keeping these low will be challenging.
Proportion of the treatment population, deemed eligible, who have been tested for Hepatitis C.		69% H&F 89% RBKC 76% WCC	100%	100%	100%	NDTMS	
Reduction in the proportion of the drug using treatment population, involved in criminal activity, at the 6 month treatment review.		Baseline to be established in 2014-15	50%	50%	50%	TOPs	
Improvement in the number of current and former service users, engaging in paid employment		Baseline to be established in 2014-15	To be confirmed	To be confirmed	To be confirmed	Local data	
Percentage of the surveyed treatment population who agree that:	Their drug/ alcohol use has decreased	80% H&F 85% RBKC 83% WCC	85%	85%	85%	Annual Survey (local data)	
	The service meets their needs	91% H&F 92% RBKC 81% WCC	95%	95%	95%		
	They are satisfied with the service they receive	90% H&F 97% RBKC 88% WCC	95%	95%	95%		

Source:

NDTMS - National Drug Treatment Monitoring System - Reporting system for all drug and alcohol structured treatment activity.

TOPs - Treatment Outcomes Profiles - Part of the NDTMS which looks at self-reported outcomes throughout the clients treatment journey.

(APPENDIX 4 - PROCUREMENT TIMETABLE)

Meeting Title	Date of Meeting	Report	Report Submission Date	Final Report to be submitted to	Notes
Coco	03-Nov-14	Approval to proceed	29-Nov-14		Agreed move to next stage
Cabinet Members	N/A	Approval to proceed	November/ December		Report to individual cabinet member briefings agreed to proceed
Shared Services Management Board	26-Nov-14	Approval to proceed	10-Nov-14		Wanted further information for next board
PH Transformation Board	10-Dec 14	Approval to proceed	8-Dec 14		Further comments provided
Shared Services Management Board	07-01-15	Approval to proceed	30-Dec-14		Revised report required additional information on why invest
Legal and finance		Approval to proceed	January	Rhian Davies WCC + Kay RBKC H&F Rachel Wigley Finance	
H&F Officer Briefing Board	12-Feb-15	Approval to proceed	02-Feb-15		
WCC Cabinet	23-Feb-15	Approval to proceed	12-Feb-15		
RBKC Cabinet digest	13-Feb-15	Approval to proceed	11 –Feb -15		
H&F Cabinet	02-Mar-15	Approval to proceed	02-Feb-15		
Coco		Procurement Strategy			
Legal and finance		Procurement Strategy			
PH Transformation Board		Procurement Strategy			
Shared Services Management Board		Procurement Strategy			
Procurement Contracts Approval Board (CAB)		Procurement Strategy			

Meeting Title	Date of Meeting	Report	Report Submission Date	Final Report to be submitted to	Notes
PH Cabinet Members Steering Group		Procurement Strategy			
CoCo		Award report			
Legal and finance		Award report			
Procurement Contracts Approval Board (CAB)		Award Report			
PH Transformation Board		Award Report			
Shared Services Management Board		Award Report			
H&F Officer Briefing Board		Award Report			
PH Cabinet Members Steering group or individual Members briefings		Award Report			
WCC Cabinet		Award report			
RBKC Cabinet and Leaders Group		Award report			
H&F Cabinet		Award report			