SHEFFIELD CITY COUNCIL
Cabinet Report

Report of: Richard Webb – Executive Director of Communities

Date: 15th January 2014

Subject: Drug & Alcohol Community Treatment Commissioning & Procurement Plan

Author of Report: Jo Daykin-Goodall, 0114 273 6851

Summary: This report sets out the work undertaken by the Sheffield Drug & Alcohol Co-ordination Team to develop a commissioning & procurement plan for publicly funded community drug and alcohol treatment in Sheffield.

This report includes the proposed services which DACT believes will meet local need in Sheffield and will improve performance against national indicators which generate investment into the city (Public Health Grant and Health Premium). The proposal is to commission three 'end to end' services for: Opiates, Non Opiates and Alcohol, in order to offer integrated treatment journeys from initial identification of substance misuse to recovery support on completion of treatment. Services will be commissioned in line with local need, clinical guidelines, national strategic guidelines and performance indicators. Commissioning will streamline provision, achieving cost savings and will offer value for public money.

This report proposes that the planned re-tender commences in February 2014.

Reasons for Recommendations:
The proposals in this report are based on a robust commissioning process. There is an annual process of detailed analysis of local need and trends carried out to inform local commissioning. There is proactive quarterly performance monitoring on currently commissioned services which has been used to identify good practice and shortcomings within the current model and provision. There is reference to national strategy, performance indicators, funding models and national clinical and good practice guidelines moderated against local need and demand. These processes have informed the development of the commissioning and procurement plan and the associated service specifications.

There has been further reference to the investment that successful drug treatment completions bring to the city in the form of the Public Health Grant and the expected Health Premium. There is a need to commission effectively and resource sufficiently in order to secure the outcomes required to maximise the investment and potential gains through the Health Premium. This is balanced against

the financial pressures experienced by Sheffield City Council and the need to spread any investment across a range of public health outcomes.

The commissioning & procurement plan recommends cost savings of £1.2m across 3 years as achievable without negative impact on service users, communities and performance. This approach achieves the majority of savings through integration of services. Further savings are achieved through the expected 10% per annum successful exits from opiates services which will reduce overall demand on treatment as these cohorts are not being replaced by new initiates. There may be a future need to redirect volumes of care to non-opiates services and this will be carefully monitored and adjusted during the contract terms.

This report follows 6 months internal consultation within Sheffield City Council on the outline commissioning and procurement plan which set out the proposed type and volume of treatment to be commissioned and the associated costs and savings from the commissioning model. A further 8 week Public and Stakeholder consultation was launched on 4th November 2013 and the outcomes of this will be included as an appendix when this report goes to Cabinet on 15th January 2014.

Commissioning and Finance within Communities Portfolio, Commercial Services, and the Director of Public Health have been key stakeholders in the development of this plan.

Recommendations:

Members are asked to:

- Note and approve the Sheffield Drug & Alcohol Community Treatment Commissioning & Procurement Plan, including the model of 'end to end' services and the associated cost savings as outlined in this report.

- Agree delegated approval to the Director of Commissioning, in consultation with the Cabinet Members for Health, Care and Independent Living and Homes and Neighbourhoods and Director of Commercial Services to approve the Procurement Strategy for the tenders for each service.

- Delegate approval to the Director of Commissioning and Director of Commercial Services in consultation with the Director of Legal and Governance to agree contract terms and approve a contract award following the tender process.

- Delegate to the Director of Commissioning (Communities) in consultation with the Cabinet members for Health, Care and Independent Living and Homes and Neighbourhoods the ability to take such steps as he thinks appropriate to achieve the outcomes outlined in this report.

Background Papers: Needs Assessment (Drugs), Government Alcohol Strategy (2012), Government Drug Strategy (2010)

Category of Report: OPEN (Appendix 1 **closed** under Paragraph 3 of schedule 12A – information relating to the financial and business affairs of any particular person and pp47-51 of Appendix 6 **closed** with reference to Paragraph 1 of Schedule 12A – Information relating to any individual)

Statutory and Council Policy Checklist

Financial Implications
YES Cleared by: Liz Orme
Legal Implications
YES Cleared by: David Hollis
Equality of Opportunity Implications
YES Cleared by: Phillip Reid
Tackling Health Inequalities Implications
YES
Human rights Implications
YES
Environmental and Sustainability implications
NO
Economic impact
NO
Community safety implications
YES
Human resources implications
NO (provider –provider TUPE)
Property implications
NO
Area(s) affected
Health & Wellbeing, Community Safety, Public Health
Relevant Cabinet Portfolio Leader
Councillor Mary Lea, Cabinet Member for Health, Care and Independent Living Councillor Harry Harpham, Cabinet Member for Homes and Neighbourhoods
Relevant Scrutiny Committee if decision called in
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Is the item a matter which is reserved for approval by the City Council?
YES
Press release
NO

REPORT TITLE

1.0 SUMMARY

1.1 This report sets out the work undertaken by the Sheffield Drug & Alcohol Co-ordination Team to develop a commissioning & procurement plan for publicly funded community drug and alcohol treatment in Sheffield.

This report includes the proposed services which DACT recommends are commissioned and procured to meet local need in Sheffield and improve performance against key national indicators which drive investment in the city (Public Health Grant/Health Premium).

The proposal is to commission three 'end to end' services for: Opiates, Non Opiates and Alcohol, in order to offer integrated treatment journeys from initial identification of substance misuse to recovery support on completion of treatment. Services will be commissioned in line with local need, clinical guidelines, national strategic guidelines and performance indicators. Commissioning will streamline provision, achieving cost savings and will offer value for public money.

1.2 This report proposes that the planned re-tender commences in February 2014.

2.0 WHAT DOES THIS MEAN FOR SHEFFIELD PEOPLE

2.1 The commissioning model creates three "end to end" services for: Opiates, Non Opiates and Alcohol. This will mean that Sheffield residents with substance misuse problems have all their needs met within a single service specific to their substance of misuse with no need to transfer when they require higher or lower intensity interventions. It is intended that that this will create better ease of access, avoid disengagement and enable individuals to progress through to recovery.

2.2 The commissioning model has been based on data, intelligence and service user feedback (for example many alcohol users state that they do not wish to be treated alongside drug users). This commissioning model is therefore responsive to how local people wish to use substance misuse services as well as local need and demand for services.

The Opiates Service will be the largest service reflecting current need and demand; opiate users are the dominant group requiring and requesting drug treatment. Heroin users generally require long term treatment as this form of addiction is considered particularly damaging to social capital. Professor Strang writes that, "heroin users are the largest single group in treatment and use an especially tenacious, habit forming drug in the most dangerous ways[1]"; this is as true in Sheffield as it is nationally. The median treatment journey for heroin from first time in treatment to one or more years of abstinence is 9 years over three or four treatment episodes (*Medications in Recovery*, 2012, p27). Heroin users therefore require a service offer which can support continuous engagement and recovery progress over time. Opiate users who began using heroin in the "epidemic" of the 1990s are now ageing (the average age of opiate users in treatment is 40) and are not being replaced by new users; this is good news. However, the task of providing services to meet the recovery need of this cohort will continue for the medium term.

[1] National Treatment Agency, 2012, Medications in Recovery, NHS

Non opiates are a growth area nationally for drug misuse but non opiate users are under-represented in Sheffield service currently; therefore a discrete service has been designed for these predominantly younger users tailored to their specific need. These individuals may not consider that they have a substance misuse problem and may consider their use to be "recreational", even when it is causing anti-social behaviour, health harms, problems with social functioning including education and worklessness or causing offending behaviour. This group therefore require a particular offer, including assertive interventions to identify illicit use and motivational interventions to encourage them to address this use. These predominantly younger individuals do not identify as individuals with substance misuse problems and therefore are particularly unlikely to want to be treated alongside those with long term, entrenched use. This non opiates offer rebalances drug treatment so that the needs of older opiate users who require longer treatment journeys are met, as are the need of younger non-opiate users. Those core cities that are performing best against national indicators (Public Health Outcomes Framework) tend to have a focused tailored offer for non-opiate users. Treating non-opiate use provides "quick wins" with shorter and less costly treatment journeys in high volumes.

Alcohol use is an important aspect of the night-time economy for Sheffield but for some people is a significant issue for health and community safety. Sheffield fortunately performs well on the harms caused by alcohol use compared to other cities according to Local Alcohol Profiles for England (LAPE)[2] however Public Health England estimate that alcohol costs the Sheffield economy £205m pa and costs the NHS in Sheffield £38m. Alcohol use in Sheffield is on a spectrum, with many residents choosing total abstinence or drinking within sensible guidelines. Other individuals are drinking in a way which risks their health or safety, including binge drinking above safer guidelines set by the Department of Health. These individuals can be given a screening assessment and brief interventions and advice to bring their alcohol use back into safer levels (often termed 'IBA' or 'identification and brief advice'. Some individuals are not physically dependent on alcohol but require intensive interventions to change their drinking behaviour. Some individuals in Sheffield are drinking dependently and require medical interventions in order to safely reduce or stop drinking. Through this commissioning and procurement plan, services will be commissioned for Sheffield people who are drinking above safer guidelines. Sheffield residents will be offered stepped interventions at the lowest intensity to meet their needs.

Over the counter (OTC) and prescription drug users are a group who require particular support to both identify that their use is problematic, and then to address their use. These individuals are often unintentionally addicted to substances and may be embarrassed to seek help. The needs of these individuals will be addressed within the Opiates service because these individuals require a medical intervention and the predominant substances are opiate (usually codeine) based medications. However, bespoke clinics including satellite support into GP practice will be used to avoid stigma for these individuals in seeking and benefitting from the service commissioned.

All commissioned services will promote independence, support individuals to improve their health and well-being and reduce dependence on services by supporting social recovery capital. This will include the use of self-help, self-care and recovery coaching to encourage use of the city's free recovery assets in their broadest sense including libraries, parks, woodland and countryside, museums and galleries and public spaces. Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) core texts have already been provided to the city's libraries to borrow or for reference and quiet reflection within the library setting. Peer mentoring and recovery support from volunteers will be encouraged within these offers.

This means that Sheffield people will get the help and support they need and feel is right for them, in line with the Sheffield Health & Wellbeing Strategy.

[2] due to be updated in February 2014

3.0 OUTCOME AND SUSTAINABILITY

3.1 This report recommends £4.6m investment in drug and alcohol treatment services, reducing to £3.9m by Year 3. There is an additional £800,000 in variable costs which underpin these services including medical waste collection, urine tests, needle exchange paraphernalia, hepatitis vaccinations and blood tests; these services will be procured separately to maximise cost savings.

This expenditure is significant, but it should be remembered that drug treatment attracted £10m in funding to Sheffield in 2013/14 through the Public Health Grant. The Health Premium, the variable element of the Public Health Grant paid against a range of Public Health Outcome Framework indicators, is also expected to be based partially on drug treatment outcomes and will attract further investment in the city.

3.2 Public Health England, in their "Why Invest?" presentation, estimates that a typical heroin user spends £1,400 *per month* on drugs. This is predominantly resourced through criminal activity. By way of contrast, it is proposed that Sheffield invests circa £2,000 *per year*, per individual in effective treatment.

The purpose of investment in drug and alcohol treatment is to enable individuals to achieve sustained recovery. Around 250 individuals in Sheffield leave treatment drug free each year out of a treatment population of around 2,500. It is estimated after leaving treatment drug free 20-80% of heroin users are likely to be in remission[3] after 3-5years. It is further estimated that, among survivors, 40% of heroin users eventually attain stable remission (over one to two decades)[4].

Those who do not successfully leave treatment continue to be assessed monthly, as a minimum, for benefit and for progress against recovery goals for example ceasing injecting, making reliable improvements in their use of heroin, improvements in physical and psychological health and reduced offending. This is measured on the Treatment Outcome Profile (TOP) which is reported nationally.

This information is about heroin use because this has dominated national strategy as being most costly to the health economy and criminal justice system. There is not similar reliable information and data on non-opiate/"recreational drug use".

The annual cost of alcohol related harm to the heath economy in England is estimated at £3.5bn and £11bn to crime in England (PHE, 2013, Why Invest?)

4.0 MAIN BODY OF THE REPORT

4.1 Proposed Service Re-design

This report sets out the planned commissioned and procurement of community drug and alcohol treatment from 2014.

The proposed plan makes a number of proposed changes to the current service design and

[3] NTA (2012) Medications in Recovery, NHS, 6.5.11
[4] Ibid.

pathways. The key change is the creation of three end-to-end pathways for non-opiate, opiate and alcohol users. This means that a service user will start and finish their treatment journey within a single service receiving all necessary interventions within that service. “End to end” services for different cohorts of drug users will avoid barriers and “hand offs” in the process of seeking help and treatment.

Detailed specifications have been drafted for all the proposed services and these will be consulted upon with relevant stakeholders. A summary of the proposed services is included as an appendix (**Appendix 2**).

Specialist needle exchange and harm reduction (wound care and blood borne virus) services sit as discrete services within the Non Opiates and Opiates contract respectively. The nurse based harm reduction service will offer in-reach clinics into the Specialist Needle Exchange. The Specialist Needle Exchange will be operated within both services for appointment based offers within recovery services with a more visible open access mobile offer. This will complement the pharmacy needle exchange offer within the city.

The Alcohol Service will not be co-located with any drugs service.

Streamlining and integration directs funds away from infrastructure costs (e.g. premises and overheads) towards front line service delivery. This will provide better value for public money.

All proposed services are commissioned based on estimated need using national prevalence estimates, balanced against local data showing patterns of demand. All proposed services to be commissioned comply with the National commissioning and clinical guidance. All proposed services to be commissioned comply with national key performance indicators and data capture requirements and aim to maximise performance against these indicators. A combination of national unit costs and regional benchmarking will be used to set a ‘fair price’ for contracts. National unit costs were developed in 2006 and have not been updated since so are not routinely applied.

Flat rates are paid for premises, overheads and non-clinical pay costs benchmarked to current Sheffield city centre prices. There is additional small investment in alcohol treatment in the city which has been resourced by a commensurate reduction in drug contracts. The cost saving from the opiates contract is derived from the merger of two large prescribing services with separate premises, overheads and senior management structure. The cost saving from the non-opiates contract is derived from the merger of a number of small and medium sized services and realistic assessment of numbers through based on 2013/14 data.

A per capita payment system allows additional activity to be funded at a fair payment if demand increases. This equally enables reduction in capacity to be made in response to changing need and demand during the 3-5 year contract. This will be operationalized through annual adjustment of activity targets and funding, in Q3 of each contract year to take effect in Q1 of the following year. This annual planning arrangement shares risk between purchaser and provider and maximises the retention of the skilled workforce and minimises the impact on the therapeutic relationships between staff and service users.

This procurement plan has been configured in line with Sheffield City Council’s cost savings targets, although these are subject to change. This plan creates a £1.2m cost saving over 3 years. Sheffield DACT through redesign of the treatment system will be able to deliver savings

in Year 1 through service redesign without impacting on service quality. Savings in Year 2 have been achieved through a reduction in system capacity and the impact of this will be carefully monitored to ensure this does not result in increased waiting times.

Table 1: Proposed contracts

Current Contracts	Current provider(s)	Change in volumes of care commissioned Yr 1	Expected volumes (new contract)	Proposed contracts to be offered	Procurement Round
Tier 2	CRI (Arundel St Project)	Reduction in needle exchange capacity reflecting 2013/14 usage	400 registered needle exchange 400 Open Access/ Assertive outreach 400 PSI	**Contract 1** – Non Opiates Service (Drugs) including Specialist Needle Exchange (Drugs)	**Round 1** (Procurement to commence Q4 January 2013/14, contract award and mobilisation Q2 - including TUPE where relevant- contracts begin delivery Q3 2014/15)
Psychosocial Interventions 'PSI' (Drugs) Structured Daycare and Aftercare Carer Support	Turning Point RDASH	Increase in formal PSI Increase in recovery support.			
GP Deputising, Specialist Pregnancy Clinic & Shared Care Support - Drugs 14 GP Shared Care Contracts Specialist Prescribing Drugs Harm Reduction Service Drugs	PCASS (Guernsey House) SHSC (Fitzwilliam Centre)	No change in assessments Small reduction of 150 primary care prescribing places reflecting 2013/14 usage Increase in PSI provision	800 SPAR assessments 2,450 prescribing including 950 secondary care & 1,500 primary care 900 PSI	Contract 2 – Opiates Services (Drugs)	**Round 1** (Procurement to commence Q4 January 2013/14, contract award and mobilisation Q2- including TUPE where relevant - contracts begin delivery Q3 2014/15)
SEAP & Tier 2 – Alcohol Medical Prescribing – Alcohol PSI (Alcohol)	SHSC (Fitzwilliam Centre) Turning Point	Increase of 250 medical places	3,000 SEAP 1,000 prescribing 500 PSI	**Contract 3** – ALCOHOL Services	**Round 2** (Procurement to commence Q2 2014/15, contract award and mobilisation Q4 2014/15 -including TUPE where relevan -contracts begin delivery Q1 2015/16)

4.2 **Legal**

Under s2B of the National Health Service Act 2006 each local authority must take such steps as it considers appropriate for improving the health of the people in its area. This can be achieved by:

(a) Proving information and advice;
(b) Providing services or facilities designed to promote healthy living (whether by helping individuals to address behaviour that it detrimental to health or in any other way);
(c) Providing services or facilities for the prevention, diagnosis or treatment of illness;
(d) Providing financial incentives to encourage individuals to adopt healthier lifestyles;
(e) Providing assistance (including financial assistance) to help individuals to minimise any risks to health arising from their accommodation or environment;
(f) Providing or participating in the provision of training for persons working or seeking to work in their field of health improvement;
(g) Making available the services of any person or any facilities

As Part B Services above the relevant threshold the contract procurement will be under the Public Contracts Regulations 2006 and covered by EU Treaty obligations of transparency. This will require an open and fair procedure to be adopted. Compliance with the Council's Contracts Standing Orders should achieve the required legal obligations.

This report has further legal implications in that these are contractual arrangements. The commissioning and procurement plan requires contracts to be extended in order that there is seamless transition between current and proposed contracts e.g. GP Shared Care contracts end on 31st March 2014 but will be extended until 30th September 2014 and then included in the new Opiates contract from 1st October 2014.

The current form of contract does not require notice to be given, but good practice of providing notice at the start of a planned procurement is observed wherever possible to ensure preparedness for transfer of patients and patient information. If notice were served on 1st April 2014 this would provide 6 months' notice to drug contractors and 9 months' notice to alcohol contractors.

A new form of contract will be developed for these contracts, based on the Sheffield City Council contract and on the non-mandatory public health contract. This has already been prepared by Legal Services for domestic abuse and requires minor amendment of schedules to be fit for purpose for drug and alcohol services.

Three new contracts would be entered into and 22 contracts terminated under this arrangement as described in **Table 1** (above).

It is proposed that contracts are entered into for 3-5 years with a break clause at year 3. This allows sufficient time for contracts to "bed in" and begin performing. This length of contract term also allows sufficient time for a planned retender following the 3 year term. The 2 year extension to be granted only subject to satisfactory performance.

4.3 **Financial**

The current contracts are predominantly funded through the Public Health Grant which is a variable government grant to the Local Authority. There are some additional funds from Sheffield City Council and Probation within the current contracts. It is anticipated that in future contracts will be entirely funded through the Public Health Grant as external funding reduces.

The proposed Commissioning and Procurement Plan aims to secure £1.2m savings over 3 years 2014/15-2016/17 on current contract values as set out in **Appendix 1**.

There are further possible savings to be secured through re-specification and procurement of supplies contracts such as medical waste, urine testing and needle exchange paraphernalia. This will further be explored in 2014/15 with Commercial Services.

The proposed contracts are costed on a per capita basis wherever possible as this allows flexibility to increase, reduce or move volumes of care according to need and demand. For example, opiate use is declining and as individuals leave treatment successfully without re-presentation they are not being replaced by new entrants. This is a success story for drug treatment and means as purchaser Sheffield City Council will be able to release the value in these contracts over the 3-5 year period. However, some of this released value (at a lesser cost) may need to be moved into the Non Opiates contract as this area is likely to see increased demand. The volume adjustment will be a joint planned process with the provider based on forecasting at the mid-year and Q3 review and will be implemented in Q1 of the following year. This allows a degree of "risk sharing" with providers and planning to maximise the retention of skilled staff and minimise the impact on service users.

Commercial

A Procurement Strategy is being prepared by Commercial Services to support the proposed Commissioning & Procurement Plan.

The procurement route for all contracts will be open competitive tender.

Contracts in excess of £500,000 must be under the Council's seal (Sheffield City Council Contract Standing Orders) and this applies to all three contracts to be let through this commissioning and procurement plan.

The end dates of current contracts create two clear 'Rounds' staggered across the financial years 2013/14 and 2014/15. It is proposed to tender drugs services in Round 1 and the alcohol service in Round 2.

5.0 ALTERNATIVE OPTIONS CONSIDERED

5.1 The "Do nothing" option of re-tendering all current services using the same model and specifications was considered as part of this process. This option was rejected because the current system was only ever an interim position in the total reconfiguration of the treatment system which commenced in 2009. Option 1 does not address the current problems in the system of non-value adding steps, hand offs and unnecessary transfers for clients to receive support. It does not address current performance issues of a plateau in treatment exits. It does not rebalance the treatment system towards non opiates. It does not achieve the required cost savings.

5.2 Combine drug and alcohol services together into single services. This option was rejected because it does not meet the current expressed preferences of alcohol service users to be treated separate from drug users. It does not ensure a differentiated offer or distinct culture of service for non-opiate users as a minority group within drug and alcohol treatment services. This will be retained as an option in future procurements as the treatment population changes and is less dominated by opiate use (assuming the current trend continues and 10% of the opiate using population leave treatment successfully and do not return).

6.0 REASONS FOR RECOMMENDATIONS

6.1 The proposals in this report are based on a robust commissioning process. There is an annual process of detailed analysis of local need and trends carried out to inform local commissioning. There is proactive quarterly performance monitoring on currently commissioned services which has been used to identify good practice and shortcomings within the current model and provision. There is reference to national strategy, performance indicators, funding models and national clinical and good practice guidelines moderated against local need and demand. These processes have informed the development of the commissioning and procurement plan and the associated service specifications.

There has been further reference to the investment that successful drug treatment completions bring to the city in the form of the Public Health Grant and the expected Health Premium. There is a need to commission effectively and resource sufficiently in order to secure the outcomes required to maximise the investment and potential gains through the Health Premium. This is balanced against the financial pressures experienced by Sheffield City Council and the need to spread any investment across a range of public health outcomes. The commissioning & procurement plan recommends cost savings of £1.2m across 3 years as achievable without negative impact on service users, communities and performance.

6.2 This report follows 6 months internal consultation within Sheffield City Council on the outline commissioning and procurement plan which set out the proposed type and volume of treatment to be commissioned and the associated costs and savings from the commissioning model. A further 8 week Public and Stakeholder consultation was launched on 4th November 2013 and the outcomes of this will be included as an **Appendix**.

6.3 Commissioning and Finance within Communities Portfolio, Commercial Services, and the Director of Public Health have been key stakeholders in the development of this plan.

7.0 REASONS FOR EXEMPTION

7.1 Not applicable

8.0 RECOMMENDATIONS

8.1 Members are asked to:

- Note and approve the Sheffield Drug & Alcohol Community Treatment Commissioning & Procurement Plan, including the model of 'end to end' services and the associated cost savings as outlined in this report.
- Agree delegated approval to the Director of Commissioning, in consultation with the Cabinet Members for Health, Care and Independent Living and Homes and Neighbourhoods and Director of Commercial Services to approve the Procurement Strategy for the tenders for each service.
- Delegate approval to the Director of Commissioning and Director of Commercial Services in consultation with the Director of Legal and Governance to agree contract terms and approve a contract award following the tender process.
- Delegate to the Director of Commissioning (Communities) in consultation with the Cabinet members for Health, Care and Independent Living and Homes and Neighbourhoods the ability to take such steps as he thinks appropriate to achieve the outcomes outlined in this report.

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