Communities Committee

Item No……

Report title:	**Adult drug and alcohol services**
Date of meeting:	**8 March 2017**
Responsible Chief Officer:	**Dr Louise Smith, Director of Public Health**

Strategic impact

A re-design of the drug and alcohol service contract will meet the commitment detailed in the Council's Public Health Strategy, agreed by committee on 16th November 2016: to 'redesign drug and alcohol services to focus on recovery, with the aim of supporting people back into education and employment.'

This in turn supports the Council's priorities to 'protect and support vulnerable people' and to 'help Norfolk to be economically prosperous by helping people back into employment'.

Executive summary

Protecting people with drug and alcohol addictions from harm and helping them to recover, supports some of the most vulnerable groups in our society and addresses some of the greatest health inequalities. In addition to helping the individual, substance misuse services can reduce crime, protect children and reduce use of other health and social services.

The current service is performing well on some indicators but it is not delivering the numbers of clients successfully completing treatment that are seen elsewhere. Current provision caters for certain groups within the substance misusing population, while there are also populations that are underserved. In addition to improving service user outcomes there is a need to reduce costs in line with shrinking budgets, and to respond to changing needs.

Three options are suggested for future commissioning strategy:

1. Proceed now to re-design the service through re-procurement starting in March 2017, with successor service starting in April 2018.

2. Extend the current contract for two years and negotiate service re-design with the current provider, followed by a re-procurement exercise from July 2018, with successor service starting in October 2019.

3. Extend the current contract under its current model for two years with no proposal for a formal re-design or re-procurement.

Recommendations:
To agree the option for the commissioning of drug and alcohol services and delegate its implementation to the Director of Public Health.

1. Background

Drug and alcohol dependency is associated with a range of harms to individuals, their families and the wider community, including poor physical and mental health, unemployment, homelessness, family breakdown and criminal activity. Clients can have a range of significant social and economic needs for support, for example with housing, income, reducing crime and safeguarding their children. Drug and alcohol treatment services – through provision of harm reduction and structured clinical and psychosocial interventions – can reduce this harm and help individuals to recover.

Last year over 4,150 adults in Norfolk received specialist drug and alcohol treatment. Of these:

- 61% were parents
- 21% lived with a child
- 11% were regularly employed
- 21% had housing problems
- 22% were diagnosed with mental health problems

Just over half of clients have an opiate dependency, one third misuse alcohol, and the rest use more than one substance.

National evidence shows that a harm reduction approach, including prescribing and providing clean needles, can reduce crime, improve health and reduce harms such as overdoses, HIV and hepatitis C infection, and avoidable deaths.

Furthermore, evidence shows that where clients are also supported with a broader programme of planned social and psychological support they can manage or overcome their dependency and recover. The goal of psychosocial interventions is to help people build and sustain motivation for behaviour change and recovery, to recognise and cope with drug-conditioned urges and emotions, and to engage with or develop family and community recovery supports. Given the additional evidence on the outcomes that can be achieved with a carefully implemented integrated recovery model, this approach now forms a central tenet of national strategies and the commissioning of local services.

Recovery is both clinical and can be personally defined. A personal recovery could include having positive relationships, engaging in meaningful activities, living in safe housing, entering employment and improving mental health.

The potential estimated cost savings and natural benefits in real terms for Norfolk of treating opiate users alone over a five year period are:

- £70.4m for crime services
- £70.9m for health services

It is estimated that for every £1 spent on treatment £4.54 can gained in total benefits. On average, a heroin or crack user not in treatment commits crime costing around £26,074 a year.

National data shows that for every 100 alcohol dependent people treated, treatment can prevent 18 A&E visits and 22 hospital admissions, saving £60,000. One alcohol liaison nurse can prevent 97 A&E visits and 57 hospital admissions, saving £90,000.

2. Local Context

Commissioning the service is a public health responsibility and funded as part of the public health grant. Under Norfolk County Council's constitution, decisions on drug and alcohol service commissioning are the responsibility of the Communities Committee.

Norfolk substance misuse services are commissioned from Norfolk Recovery Partnership (NRP). This provider partnership is led by the NHS mental health trust (Norfolk and Suffolk NHS Foundation Trust), working with Rapt (Rehabilitation for Addicted Prisoners Trust) and The Matthew Project.

Some service outcomes are good. Out of 11 Key Performance Indicators (KPIs) NRP are meeting 5 - those relating to waiting times, retention of new clients in effective treatment and compliance with reporting data. However, NRP are not meeting targets that relate to the provision of a recovery focused treatment system, such as the proportion successfully completing treatment and not re-presenting, and the proportion in treatment for more than six years.

The 'successful completion of drug and alcohol treatment' is the main drug and alcohol treatment indicator in the Public Health Outcomes Framework and the basis on which funding is provided to the County Council to commission services, as part of the Public Health grant. In 2015-16 Norfolk's 'successful completions' performance was two-thirds the national average (10.9% successfully completed drug treatment locally compared to 15.2% nationally). This places Norfolk among the lowest performing 20% of Local Authorities nationally.

A recent needs assessment highlighted that the clinical nature of the service may be prohibitive to some people's engagement, and that, while the service specification describes an integrated recovery service, this does not seem to be being met.

Commissioners are working with the provider to seek improvements in outcomes within the current service specification, service and staffing model, and current budget. An action plan has been in place since May 2016.

Additionally, over summer and autumn 2016, PH commissioners worked with the provider to identify re-design options that could be made within the current contract to reduce costs. A new service model was proposed by NRP, but external expert advice to NCC was that the proposals would not deliver the outcomes we are seeking. We were advised that given the historic poor performance and a continuing inability to deliver on the current service specification (with respect to successful completion of treatment outcomes) the proposals did not go far enough in providing a robust evidence-based plan to address the current performance issues and to re-orient the service to a greater recovery focus.

In addition, NHS England, who fund the prison service through NCC commissioning, wish to commission it directly using a national specification and contract. This means they are seeking to agree a date to exit current arrangements and end their funding for the prison element within the NRP contract.

Furthermore reductions in the public health budget mean that there is a need to reduce the annual contract costs by 13.8% by 2018/19. For the period October 2017 to September 2019, there is a £1.36m gap between the current costs of £13.22m and the budget of £11.86m.

The current contract ends in September 2017 but can be extended subject to mutual agreement for up to 2 years. From October 2019, the current legal and procurement advice is that this service should be re-procured through a competitive re-procurement exercise on the market.

Re-procuring the service would allow for fundamental changes to be made, including:

1. Improving performance in relation to successful completions of treatment and other under achieving KPIs
2. Separating out the commissioning and provision of the prison service
3. Reducing costs in line with the budget for drug and alcohol services agreed by Committee
4. Aligning services with NCC strategic priorities i.e. impact on adult social care, dementia, criminal justice services, children's services and Learning Disabilities.
5. Rebalancing of the investment for NCC, ensuring it maximises the impact on other health and social care services.
6. Working towards community based recovery, utilising all available resources in the local community
7. Ensuring the right support is available for people with complex care needs i.e. older adults and those with long term conditions, poor mental health, experiencing domestic abuse or engaged in sex work
8. Offering greater integration across the local authority and wider partners
9. Responding proactively to emerging issues, for example supply, exploitation, safeguarding.

3. Proposal (or options)

There are three main options available to NCC as the commissioners of this service:

1. **Proceed to re-design the service through re-procurement**

This option supports the opportunity to improve services to support quality of life, particularly for some of Norfolk's most vulnerable people.

This would require NCC to extend the current contract for 6 months, with a new service starting April 2018; 12 months is a tight and ambitious timescale to redesign and re-procure a new service.

The current providers have indicated they are willing to work with this proposal and timescale. This option carries the opportunities of a redesign by competition on the market, with the risks of an unsuccessful tender process, or a drop in performance associated with a change in management provider.

2. **Seek to redesign the service under the current contract**

We can extend the current contract, by mutual agreement, for two years (October 2017 – September 2019) and work with the current provider to redesign and improve the service, and reduce costs in that time.

This option has the advantage of being in line with the spirit of the Sustainability and Transformation Plan (STP) collaboration with the NHS

This option is not favoured by the provider who runs the risk of redesigning the current service and then undergoing the exercise again within 18 months as part of a market based re-procurement.

3. **Extend the current contract as is**

Extend the current contract with its current model and costs for two years and delay the redesign work and the progression of joint work with the NHS under the STP programme.

Commissioners would work with the provider to seek to improve some aspects of performance however they have had concerns about the current service provision since April 2013 when it started in its current form.

This option would deliver continuity and stability for now but the need for changes in service outcomes remain, current costs are above budget and the current legal potions is that any contract beyond September 2019 would require a re-procurement exercise.

4. Financial Implications

The re-procurement would seek to reduce costs.

Option 1 – A formal re-procurement process would look to deliver an improved service within the cost envelope for drug and alcohol services agreed by Committee in November 2016.

Option 2 – Costs are unknown as they would be subject to negotiation with the existing provider. Some additional investment would be required.

Option 3 – Costs would be £1.36m in excess of the current planned budget and fully exhaust Public Health reserves leaving no contingency or funding for the transformation required.

5. Issues, risks and innovation

A detailed risk assessment and risk register for the project will take place once a decision has been made which option to pursue.

Risk	**Mitigation**
Timescale – Potential risk for slippage	Option 1 - Advice from procurement colleagues is that 12 months is a tight and ambitious timescale to redesign and re-procure a new service. The current providers have indicated they are willing to work with this proposal and timescale. Options 2 & 3 – Redesign within agreed contractual and/or extension period, relies on provider and commissioner jointly developing and agreeing redesign and actions to take, both difficult to predict and measure
Scope – Potential risk of services being commissioned that are not relevant or appropriate	Option 1 - Commissioners have the greatest flexibility for collaboration with partners, align with STP, and engage with service users to inform the development of the service. Leading to improved services provided; outcomes for service users; and impact on NCC and partner priorities; impact on the Norfolk population. Options 2&3 - Commissioners would work with the provider to seek to improve some aspects of performance and service user outcomes
Market - Lack of competition and innovation in supply	Option 1 – Engagement of the market, including market engagement events to inform commissioning process and service development, will mitigate risks of an unsuccessful tender process. We do have evidence of an effective market in this field with a number of potential providers. Options 2&3 - Commissioners would work with the provider to seek to improve aspects of performance and service user outcomes

Risk	Mitigation
Cost – Uncertainty in meeting agreed target costs budgeted for drug & Alcohol Services. Risk dependent upon the option pursued.	Option 1 - The cost envelope is in line with the budget for drug and alcohol services agreed by Committee Options 2 – Negotiation would be required with the existing provider Option 3 – Costs would be greater than budget
Future Changes - Potential drop in performance or quality of services associated with a change in management, staff retention and culture during transition mobilisation phase of a new service.	Option 1 – it is not anticipated that there will be an interruption of services provided, however other changes are difficult to predict and measure Options 2 & 3 – Redesign within agreed contractual and/or extension period, relies on provider and commissioner jointly developing and agreeing redesign and actions to take, both difficult to predict and measure

Officer Contact

If you have any questions about matters contained or want to see copies of any assessments, e.g. equality impact assessment, please get in touch with:

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