Sheffield Safer Communities Partnership (DAAT)/logo

Adult drug treatment plan 2009/10

Part 1: Strategic summary, needs assessment and key priorities

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<table>
<tr><td colspan="2">The strategic summary incorporating the findings of the needs assessment, together with local partnership ambition for effective engagement of drug users in treatment, the funding and expenditure profile, harm reduction and primary care self audits have been approved by the Partnership and represent our collective action plan.</td></tr>
<tr><td>Signature</td><td>Signature</td></tr>
<tr><td>Chair, Sheffield Safer Communities Partnership</td><td>Chair, Sheffield Adult Joint Commissioning Group</td></tr>
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Overall direction and purpose of the partnership strategy for drug treatment

Governance
Sheffield Safer Communities Partnership is the local strategic partnership responsible for drug & alcohol treatment. Activity is devolved to its strategic team the Sheffield Drug & Alcohol Action Team (DAAT) led by the Director of Substance Misuse Strategy. The DAAT staff is formally employed within the Public Health directorate of Sheffield Primary Care Trust (PCT) with the PCT also holding budgets, contracts and undertaking any procurement activity on behalf of the Safer Communities Partnership. The Joint Commissioning Group (JCG) is formally chaired by the Director of Public Health, a joint post between Sheffield PCT and the Local Authority. Treatment performance is monitored through the JCG with DIP performance receiving scrutiny at the DIP Strategic Board; with combined performance activity being reported to the Safer Communities Partnership Performance Board of which the Director of Substance Misuse Strategy is a member.

Target 20 of the Local Area Agreement is to increase the proportion of drug users who are recorded as receiving effective treatment by 5% in 2008/09 to 10% by 2010/11. Milestone target for 2009/10 is 8%. This reflects the PSA 25, the National Treatment Agency and Vital Signs national targets for local delivery.

Treatment System
Sheffield has a complex drug treatment system with a multi-provider model which historically "evolved" rather than having been "designed". In 2007-8 the partnership refreshed all provider agreements with detailed capacity planning; targets and robust performance monitoring frameworks which were then consolidated in 2008/09. These provider agreements all terminate on 31 March 2010 providing a procurement opportunity for the partnership to streamline the treatment system. Developing a procurement plan to create a logically planned treatment system which reduces currently high unit costs and provides value for money will be the key treatment priority in 2009/10. The contractual framework and governance of finance under the pooled budget system will be reviewed within the procurement project plan.

The National Drug Strategy declares that the goal of drug treatment is to become drug free. A treatment priority in 2009/10 is to create an "abstinence pathway" ensuring abstinence is a real choice which can be made at different points of the treatment journey. Promoting abstinence based treatment requires an intensive focus on commissioning arrangements; consideration of models of commissioning in line with Tier 4 guidance, including regional commissioning will form part of the project plan for this work. Abstinence should be fully integrated within the mainstream treatment system.

Sheffield has a drug treatment system where the "front end" is well resourced and well utilised with 4600 one to one advice and information sessions taken up at Tier 2 in 08/09. A changing trend of drug use towards younger users (19-25) being ACCErs (alcohol, cannabis, powder cocaine and ecstasy) has been identified as a challenge for capacity at Tier 2 and work will continue to keep open access "fit for purpose". Improving the "end stage" of the client journey remains a priority with a focus on planned discharge (Sheffield is currently in the bottom quartile); improving education, training and employment guidance and aftercare for drug free completions. The partnership has ambitions to improve access & engagement to treatment of crack users and treatment exits for all clients. A number of initiatives will support these ambitions including reinvigoration of key working; a reconfigured pathway to OSI/PSI and a non medical prescribing pharmacy based treatment to increase client clinical contact in the first 12 weeks.

Improving outcomes is a key national priority. Partnership work will be undertaken with JobCentrePlus around referrals into treatment, benefits and 'ETE' (Education, Training and Employment) in line with the Welfare Reform Bill. Partnership work will continue with the Local Authority and Supporting People to develop an agreed accommodation strategy for substance misuse. Recording treatment outcomes and tracking progress through the Treatment Outcomes Profile (TOP) is a key tool to evidence that treatment promotes social (re)integration; Sheffield aims to continue to achieve 80% compliance for initial TOP and improve performance on review & discharge TOP.

With the launch of the revised UK Clinical Guidelines "Orange Book" in 2007 there has been a welcome shift of emphasis from "quantity" of treatment places to "quality" and clinical governance of treatment. In Sheffield, the priority improvement area has been psychosocial aspects of treatment particularly for those in prescribing modalities and DAAT will continue to take the lead in ensuring all treatment has a psychosocial component. This is viewed as the key to behaviour change and better outcomes for those in treatment. A reconfigured PSI pathway has been consulted on in 2008/09 and will be implemented in 2009/10. Three clinical audits will take place during the year.

Sheffield has a well developed Service User Involvement Programme. The DAAT will strategically develop this workstream in 2009/10 devolving more autonomy and responsibility to provider services whilst providing a steady stream of well trained, vetted and drug free former service users available for placements.

The National Drug Strategy has a welcome focus on families and communities. The partnership will continue to work closely with the Safeguarding Children's Board to improve life chances and outcomes for children of substance misusing parents. The DAAT are represented on strategic Safeguarding boards and involved in any case review concerning substance misuse. The "Hidden Harm" service funded through the pooled treatment budget provides training & consultancy to the drug treatment workforce and providers to ensure best practice in safeguarding children is followed.

The DAAT employs a Carers & Communities officer through the pooled treatment budget to work at a neighbourhood management level with six of the Safer Neighbourhood Areas where drugs & alcohol are a priority ensuring a strategic and appropriate response which addresses community safety and treatment needs.

The DAAT commissions a carers support services and this will be reviewed in 2009/10 to ensure a greater focus on supporting carers of those in treatment. The city Carers Strategy is being revised in 2008/09 and efforts are being made by the DAAT to ensure drug/alcohol carers are not overlooked.

Alignment of the treatment system with the Criminal Justice system continues to be a strategic goal. The DAAT employs a Criminal Justice Lead for strategic oversight of all areas where criminal justice and substance misuse interface. The Drug Interventions Programme was tendered in 2007/08 and is approaching the end of Year 1 of new provider agreements with a significantly improved dashboard. Local analysis of numbers into treatment through DIP has indicated a changing trend towards powder cocaine use which will be monitored in 2009/10. Initiatives to increase client engagement in treatment through the CJIT will be piloted in 2009/10 including an expansion of peer escort to treatment including Tier 4 treatment. Through these initiatives a reduction in re-offending and improved treatment outcomes are sought.

Likely demand for open access, harm reduction and structured drug treatment interventions. This section should identify and consider the differential impact on diverse groups and ensure that the overall plan contains actions to address negative impact.

Sheffield has around 42% of the estimated problematic drug users in the city within the treatment system. A further 4% of the PDU are known to DIP, however DIP into treatment conversions remain lower than desired.

There were 4600 Tier 2 advice & information sessions held in 2008/09. Sheffield has invested to ensure the high levels of activity at Tier 2/b result in improved access to structured treatment. Tier 2 continues to grow and demand particularly within hostels annually outstrips capacity.

A key issue for the partnership is maximising the effectiveness of Tier 2/b as a vehicle to engage substance misusing individuals into treatment.

Prescribing (GP & Specialist) - The Single Point of referral for prescribing has improved client access to the most appropriate prescribing treatment service based on their need, using an agreed zoning system. Shared Care continues to expand. Substitute prescribing demand matches commissioned capacity.

PSI – there are low referrals to PSI from prescribing modalities which remains an area of focus. PSI/OSI pathways will be reconfigured in 08/09 and implemented in 09/10.

Structured Daycare – there was increased demand for Structured Daycare in 08/09 with a mixture of referrals from prescribers and from Tier 2 for stimulants clients. Demand will be closely monitored in 09/10.

Inpatient detoxification & residential rehabilitation - Tier 4 scored 'good' in the 2007/8 Improvement review, however work continues to improve the number of referrals into tier 4 treatment, to address the attrition between prison and rehab and to create an abstinence pathway in 2009/10. Commissioning issues such as "cost per case" and approved providers lists for Tier 4 will continue to be explored.

The Partnership is making no significant changes to commissioned treatment capacity in 09/10 but uses proactive quarterly monitoring of capacity within the treatment system swiftly identifies probable bottlenecks and in year investment and "cost & volume" contracting is used to ensure there is sufficient capacity and no impact on waiting times for treatment. The steady growth of Tier 2 presents a strategic challenge to the Partnership as a greater proportion of treatment funding is directed to those not in formal treatment.

Equality: The Partnership has implemented much of the learning on diversity arising from the HCC/NTA Improvement Review; a key area for improvement is in conducting Equalities Impact Assessments (EIA). EIAs will be undertaken in relation to commissioned services and workstreams during 2009/10.
Gender: Access to treatment by women remains around 25% and there is no apparent problem for women accessing treatment. Separate clinics can be accessed by women; for pregnant women there is a pregnancy clinic and a referral pathway has been established for women who sell sex to finance drug misuse.
Race: Access to treatment by BME communities remains very close to the population estimate figure for BME communities of 11%. Sheffield has well developed treatment for stimulants and there appears to be some correlation between primary stimulant use and ethnicity. The partnership remains alert to the changing drug treatment needs of new communities in Sheffield. Data collection has improved but there is still further work to ensure ethnicity data is captured. BME service users are often under-

represented at Tier 4 treatment and this should be considered as part of development of an abstinence pathway.
Disability: Data is not collected on disability and this was an area for improvement identified by the NTA/HCC review. Disability Discrimination Act audits were undertaken by all services.
Sexual Orientation: Data is not collected and this is an area for consideration by the partnership in order to accurately identify need, rather than make assumptions arising from stereotypes which may or may not be accurate.
Age: The needs assessment identifies a missing cohort of younger people who would be expected to present for treatment. Local analysis suggests the nature of drug use is changing among younger people who are more likely to be ACCErs (alcohol, cannabis, powder cocaine and ecstasy) and more likely to receive brief interventions at Tier 2/2b than enter structured treatment. A trend towards powder cocaine use is beginning to be noted within DIP.
Religion/Belief: Data is not collected on religion/belief. Sheffield has diverse communities who share an Islamic faith including the majority Pakistani community and smaller Yemeni, Somali, and Kurdish communities. Breakthrough Multi-Ethnic Drugs Service are a commissioned provider for Tier 2 outreach and PSI as well as consultancy and training for other drug treatment providers and communities, including faith communities.

Key findings of current needs assessment. This should be a brief summary of prevalence and penetration levels, treatment system mapping, the characteristics of met and unmet need, attrition rates and treatment outcomes. The full needs assessment report should be submitted with the adult drug treatment plan.

Needs Assessment Summary

Engagement in treatment – Tier 2 activity continues to increase with over 4600 one to one advice sessions held. 50% of the opiate and/or crack PDU engaged in tiers 3 and 4 treatment during 2007/8. An estimated 44% were treatment naïve compared with 49% of the Crack PDU. The effectiveness of drug treatment requires further work, since Sheffield is in the lowest quartile for planned discharges (21%) despite an 89% retention rate (Q2 2008/9). Sheffield has a "revolving door" of clients dropping out and then re-engaging in treatment but this remains to be quantified.

The Sheffield Treatment Pathway – The Single Point of referral for prescribing has improved client access to the most appropriate prescribing treatment service based on their need, using an agreed zoning system. Shared Care continues to expand and the work undertaken by SPAR provides a key opportunity to identify practices to focus on. It is recognised Sheffield has a large number of providers of drug treatment and for a client to receive more than one modality will result in being treated by a number of workers. Key working in all modalities needs to be improved and effective identification and referral of clients into PSI are to be addressed as part of the PSI project.

Tier 4 scored 'Good' in the 2007/8 Improvement Review, however work continues to improve the number of referrals into Tier 4 treatment, to address the number of prison clients who fail to start Rehab and to create an abstinence pathway in 2009/10.

Drug – Poly-drug use is now the norm in Sheffield, with most service users using crack and opiates and 21% using at least three drugs. Treatment options for crack use in Sheffield scored 'high' on the improvement review, however more options need to be explored to further encourage crack users to engage with treatment. Prescribing services see a large number of clients with heroin and crack use, but the PSI and structured Daycare services still don't see the same level of activity that the Orange book indicates is required by clients who receive prescribing treatment.

Powder cocaine use has increased during 2007/8, with 18% of all DIP contacts using cocaine. Treatment appears to be appropriate at Tier 2b; however some Tier 3 services have noticed an increase in the number of non PDU drug clients entering treatment.

Alcohol use has increased; it is often part of a client's poly drug use and is frequently becoming the dependant substance once a client is maintained for their drug use, with clients separated into two groups, less complex and complex alcohol users. Opportunities to provide the most appropriate treatment need exploring.

Diversity – Scored 16 out of 23 on the latest Improvement review and actions are being implemented. 27% of clients in structured treatment are female compared with 23% of the total PDU. The BME in treatment population is reflective of the Sheffield BME population, treatment information is becoming available in a number of languages and services are all commissioned to provide a culturally aware service. Breakthrough continually works towards meeting the needs of BME communities providing drug treatment and training within a number of communities.

Area – The most frequent postcodes of residence for clients in structured treatment and entering DIP are S2 (20%), S5 (19%), S8 (9%) and S6 (8%). The DAAT's strategy continues to provide centralised services alongside a growing citywide shared care and pharmacy network located in key areas of need.

Harm reduction – A Harm Reduction strategy and Blood Borne Virus strategy have been written in 2008/9. New targets for achieving Hepatitis B vaccination and Hepatitis C have been agreed in line with NTA targets with the city also adopting a completion target for Hep B vaccination. More individuals are being vaccinated and tested year on year. The Hepatitis clinic is continually seeing increased referrals due to more tests being undertaken, and the nurse led clinics at Tier 1 and Tier 2 services continue to have a high activity. Both services under go continual process review to ensure they are meeting client's health needs, including the introduction of a specific DVT service from December 2008.

2,013 (41%) of the crack and opiate PDU are injectors; 30% of people in structured treatment currently inject on entry and 30% previously injected, compared with 50% of DIP clients previously and 60% who injected in the past month. 1286 used the pharmacy needle exchange in 2008/9 and over 1,000 used Turning Point or their Sharp Action van. Over 50% of clients using the Wicker pharmacy needle exchange are in structured treatment. New harm reduction initiatives are being implemented or are in pilot stage.

Housing – A citywide drug use and housing strategy is to be written by the DAAT in 2009. In 2006/07 12% of people using the Supporting People service presented with drugs as either their primary or secondary need. Housing staff were trained on drugs awareness in 2008/9. 19% had a housing need and 12% were NFA when starting drug treatment in 2007/8 and housing issues are consuming more worker time at Tiers 2 and 3. Drug work held with clients residing in hostels has increased significantly during 2007/8, with crack groups starting in some hostels in 2008/9.

Crime – In 2007/8 there were 14,719 reported serious acquisitive crimes in Sheffield, a reduction of 19% on the previous year, however theft and handling offences increased 34%. There were 4,858 arrests for trigger offences, 58% were theft and 15% burglary. 41% of drug test results were positive, 54% for opiates and cocaine, 32% cocaine (increase of 9%) and 14% for opiates. Drug purities have remained within the normal range and class A drugs account for 57% of the street value seized in April to September 2008. Performance on DIP compact targets has increased

since tendering the service in April 2008 and the police and probation service now have SLAs with the DAAT.

Families and Carers – An estimated 9994 family and carers are affected by opiate and crack users in Sheffield. In 2007/8 RODA provided a service to at least 500 individuals with numbers increasing. Eighty-six babies were born in Sheffield to mothers who were referred to the Multi-Agency Pregnancy Liaison and Assessment Group due to drug or alcohol misuse during pregnancy, of which 68 babies went home with their mothers. The family and carers pathway has been updated and the Carer's Strategy is being updated. Opportunities to involve the family with the substance misuser in structured drug treatment are actively being explored in some treatment services.

Communities –Six Safer Neighbourhood Areas have Drugs and Alcohol as a priority: Hillsborough, Ecclesfield, Burngreave, Woodhouse/Mosborough, Manor/Arbourthorne and Broomhall. SNA areas include the Communities and Development worker on all planned events where drug and alcohol are to be addressed, drug treatment is promoted and referrals into drug treatment are monitored. Consistency in reporting drug activity in each SNA areas is to be addressed in 2009.

Overdose Near Misses and Drugs Related Deaths – Naloxone Hydrochloride was administered on 101 occasions to patients aged 18 years to 64 years by the Yorkshire Ambulance Service based in Sheffield (May 2006 - May 2007). Between April 2007 and March 2008 there were 14 recorded drugs related deaths, five were female. Class A drugs were recorded in 11 of 14 cases, with heroin and cocaine mentioned in four and heroin in six cases. All drug related deaths are investigated and overdose prevention courses are ongoing throughout the year.

Attrition & treatment outcomes –Sheffield is in the lowest quartile for planned discharges (21%) despite an 89% retention rate (Q2 2008/9). Anecdotal provider reports suggest that Sheffield has a "revolving door" of clients dropping out and then reengaging in treatment but this has not been quantified and requires further analysis. Sheffield has a large number of providers of drug treatment and for a client to receive more than one modality will result in being treated by a number of workers, across agencies. This is a design flaw of the current system which requires clear integrated care pathways and effective care co-ordination across multi-disciplinary teams and organisational boundaries to avoid client disengagement through multiple transfers. Improved outcomes will be sought in 09/10 through more robust keyworking; increased clinical contact through a pharmacy based non medical prescribing pilot and expanded peer support and escort to treatment with criminal justice clients. The element of the problem which is due to data capture will receive intensive scrutiny by DAAT data analysts. Procurement planning will resolve design flaws in the current system. Positive outcomes have not been quantified and this will receive more partnership attention in 09/10 particularly in terms of employment, training and housing.

Improvements to be made in relation to the impact of treatment in terms of its outcomes. This should cover improvements in individual drug user's health and social functioning, lower public health risks from blood borne viruses and overdose, and improvements in community safety.

Health

A recording issue at the largest provider in Sheffield led to poor recorded performance on general healthcare assessments. This was investigated and the partnership is reassured that healthcare assessments for all those entering drug treatment is standard. This will continue to be monitored for quality and coverage in 2009/10.

Social Functioning

Psychosocial interventions are viewed as the key treatment activity which will change behaviour and improve social functioning. The partnership will continue to prioritise improving key working and formal PSI. Workforce development approaches will standardise the "baseline" skills for keyworking and PSI and work will continue on improving pathways.

Blood Borne Viruses (BBV)

The partnership has made a significant investment in provision of screening and immunisation at Tiers 1,2 & 3. A local target of completion of Hepatitis B immunisations has been set. A BBV strategy and task group are in place to improve joined up working between agencies and providers to achieve targets. A shared database of BBV information will improve clinical governance. Demand within the Tier 3 prescribed services would be expected to decline as Hep A/B immunity is achieved and Hep C status is known. However, the need to re-test within Tier 2 where service users may continue to be exposed to Hepatitis C, will require a continued assessment of demand. Opportunistic testing offered through needle exchange and Tier 1 hostels and daycare settings to immunise and test the treatment resistant and naïve remains a priority.

Overdose

The partnership prioritises learning from drug related deaths through confidential review; annual research and resourcing of bi-monthly overdose prevention training events. Improvements in 2009/10 will be to provide overdose training on a monthly basis due to increasing demand; and to participate in South Yorkshire DAAT

research into post custody deaths. The rise of female deaths as a proportion of deaths is of concern against an overall decline in drug related deaths from the Sheffield "trend" of 18 (+ or - 3).

Community Safety
Anecdotal provider evidence from the annual needs assessment suggested a revolving door for some clients with a particular focus on younger clients (19-25) entering treatment through DIP. This requires further detailed analysis in 2009/10 in order to improve outcomes for this group, reduce re-offending and improve community safety. This activity pattern is linked to poor planned discharge figures for the partnership but at present this remains anecdotal. The Partnership works closely with Safer Neighbourhoods Areas to provide a conduit for community concerns of anti-social behaviour, criminal damage, needle waste and drug dealing and linkage into treatment and support systems where appropriate. Training in drugs awareness is provided to all Safer Neighbourhoods Areas where substance misuse has been identified as a priority and this will be expanded in 2009/10 so that "expert practitioners" within communities can access accredited advanced training.

Key priorities for 2009/10. This section should cover the key priorities for developing open access, harm reduction and structured drug treatment interventions to meet local needs during 2009/10 and beyond. This should include any key priorities linked to the government's Drug Strategy and any actions outstanding from the Healthcare Commission/NTA improvement reviews.

Procurement
- The partnership will develop a procurement plan to ensure all contracts ending on 31st March 2010 are tendered whilst maintaining a stable and effective treatment system.
- Unit costs for Sheffield are high and reducing unit costs will be a key priority within procurement planning.
- Contractual frameworks and financial governance of the pooled budget will be reviewed as part of the procurement planning process.

Open Access (Tier 2)
- Additional capacity for assertive outreach to vulnerable people (homeless, street sex workers, street drinkers who are often "methadone maintained")
- Ensuring open access is configured to respond to changing trends in drug use including powder cocaine/ACCEr
- Additional Team Leader capacity for Tier 2 Open Access to improve the effectiveness of Tier 2 as a gateway to treatment.

Tier 2b/Tier 2/ Tier 3 interface
- improving outcomes for "revolving door" clients. The number needs to be quantified and cases sampled to identify common features: demographic, substance, offending, modality as well as individual features which may influence better outcomes.

Harm Reduction
- improve "offer" of needle exchange items in busiest pharmacies
- foil and crack packs to continue to be offered through specialist needle exchange
- continue to offer blood borne virus screening & immunisation both planned and opportunistic

Structured Drug Treatment (Tier 3)
- fully integrate quality key working and formal Psychosocial Interventions into prescribing services as per UK Clinical Guidelines "Orange Book".
- Continue to expand GP Shared Care to extend geographical "reach" of treatment
- Continue to monitor the implementation of the Single Point of Assessment & Referral for substitute prescribing ensuring appropriate share of treatment between GP and specialist prescribing.

- "Audit" alcohol interventions as part of treatment for poly drug use
- Develop an abstinence pathway ensuring the choice to lead a "drug free" life is available at every point in the client journey

Structured Drug Treatment (Tier 4)
- Develop commissioning practice in line with HCC/NTA Improvement Review
- Address prison-rehabilitation attrition through "ICE" (Increasing Client Engagement) pilot of increased peer escort and support.
- develop an abstinence pathway, ensuring the choice of abstinence is available and commissioned treatment is appropriate at every stage of a treatment journey. The Abstinence pathway will be fully integrated with the treatment system.

Equality & Diversity
- Equality Impact Assessments to be conducted in relation to all commissioned services and workstreams.
- Data collection issues in relation to disability and religion to be considered

Workforce Development - provision of accredited and non accredited training for drug treatment and Tier 1 workforce.

Hidden Harm - identification of children in substance misusing households; application of safeguarding protocols; training; advice and consultancy from commissioned "Hidden Harm" service for all providers

Clinical Governance – continue to support implementation of UK Clinical Guidelines. Conduct three clinical audits.

Planned discharge
-improve the quality and take up of keyworking
-improve data capture
-increase clinical contact in the first 12 weeks of treatment through non medical prescribing action research pilot
- design out flaws in the treatment system through procurement planning

Improved Employment Outcomes
- upskill all keyworkers to offer improved advice and guidance on education, training and employment
- improve aftercare offer for stable or drug free clients

Criminal Justice/Treatment Alignment
- Improve "DIP into treatment" performance through "ICE" pilot
- Implement more effective care pathways for OSI/PSI to improve offer for non-PDU users