West Dunbartonshire Community Health & Care Partnership Commissioning Strategy For Alcohol and Drug Services

2011 – 2021

September 2011

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ACKNOWLEDGEMENTS

The CHCP gratefully acknowledges the comments and contributions from all those local stakeholders involved throughout the process of developing this commissioning strategy, particularly those staff planning and delivering our local services. This commissioning strategy has also benefited from considered feedback from colleagues at Social Care Social Work Improvement Scotland (SCSWIS), the Joint Improvement Team (JIT), and the Scottish Government.

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An electronic version of this Commissioning Strategy can be downloaded from the WD CHCP website: www.wdchcp.org.uk

1. OUR AMBITION

1.1 Vision

West *Dunbartonshire Community Health and Care Partnership's (CHCP) vision for the provision of Alcohol and Drug Services across the West Dunbartonshire Council area is to reduce the harmful effects of alcohol and drugs and promote recovery.*

1.2 Scope

The Institute of Public Care (IPC) has defined a commissioning strategy as "a formal statement of plans, for specifying, securing and monitoring services to meet people's needs at a strategic level. This applies to all services, whether they are provided by the NHS, the Local Authority, other public agencies or by the voluntary and private sectors".

The focus of this commissioning strategy reflects the requirements of Scottish Government as they relate to the provision of alcohol and drug services which address *prevention*, and support *recovery* from problems associated with alcohol and drug addiction. It forms part of a suite of commissioning strategies covering the breadth of operational responsibilities of West Dunbartonshire Community Health and Care Partnership (developed jointly on behalf of NHS Greater Glasgow and Clyde and West Dunbartonshire Council).

The aim of this Commissioning Strategy is to project how the local provision of community-based alcohol and drug services will need to be developed over the course of the next ten years (i.e. 2011 to 2021) so as to reflect changes in demand, development of policy, emergent best practice and available resources.

1.3 Values

There are four core values that underpin the CHCP's approach to strategic commissioning, namely:

- Quality
- Fairness
- Sustainability
- Openness

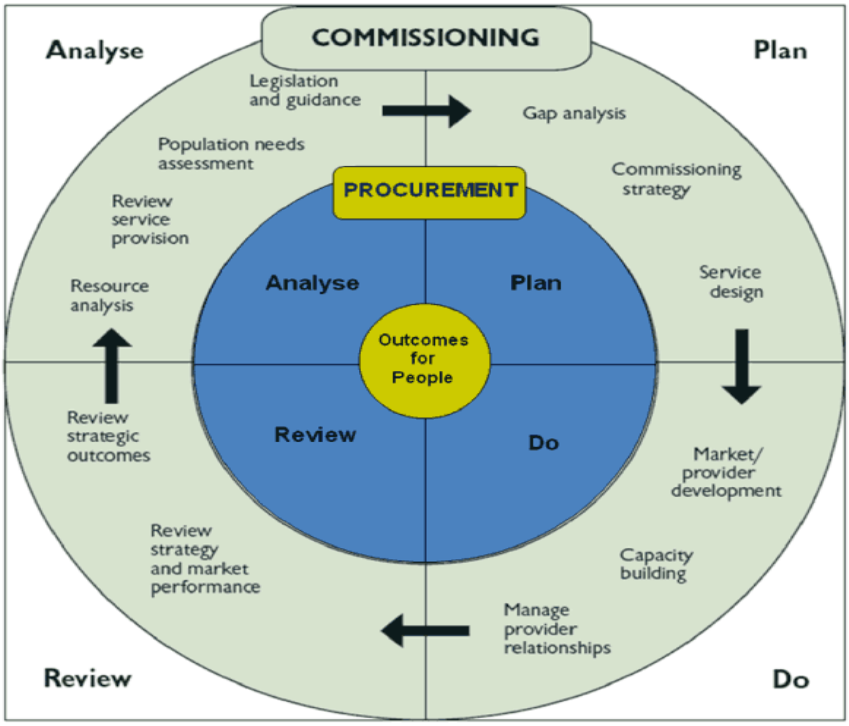
These values are manifested through a systematic concern for the following principles:

- Optimal outcomes for individual service users.
- A client-centred approach appropriate to individual needs through an emphasis on informed self-care, co-production and personalisation of services.
- Effective and safe services that draw upon the best available evidence and local feedback from service users.
- Equalities-sensitive practice.
- Acceptability of service provision informed through constructive engagement with local stakeholders – including staff, community groups and elected representatives.
- Affordable and efficient services that continue to be reflective of the relative demands across the West Dunbartonshire population as a whole.

1.4 Delivering Strategic and Outcome-based Commissioning

This commissioning strategy is a key element of an on-going process of commissioning as advocated by the IPC and illustrated below (Diagram 1) and further detailed in Appendix I.

Diagram 1: Strategic Commissioning Cycle



The Audit Commission (2003) has emphasised three particular strengths of this model:

- The cyclical nature of the activities involved, from understanding needs and analysing capacity to monitoring services.
- The importance of meeting needs at a strategic level for whole groups of service users.
- The importance of commissioning services to meet the needs of service users, no matter who provides them.

Audit Scotland has emphasised the challenging financial climate in which the public sector will be expected to deliver services over the coming years. Alongside the realities of a reduction in public sector budgets, CHCP services also have to manage the increasing complexity of demands for and capacity of services whilst being responsive to demographic changes within the population. Robust commissioning of community-based alcohol and drug services is essential to ensure that high quality and sustainable services are available to those who need them. This commissioning strategy will drive the substance of relevant operational service plans on an annual basis, within the wider context of the Community Planning Partnership's multi-agency Alcohol and Drug Strategy 2011-2012 (that the CHCP has lead responsibility for) and the CHCP's wider set of development priorities as set within its annual CHCP Strategic Plan.

The CHCP will account for the delivery of the above approach primarily through its core governance arrangements to NHS Greater Glasgow and Clyde and West Dunbartonshire Council (as articulated within its Scheme of Establishment); and to its wider set of local partners through the auspices of the West Dunbartonshire Community Planning Partnership's Alcohol & Drug Partnership (ADP).

2. LEGISLATIVE AND POLICY CONTEXT

2.1 The Scottish Government has set a clear purpose for its policy and spending programmes, i.e. "to focus Government and public services on creating a more successful country with opportunities for all of Scotland to flourish, through increasing sustainable economic growth".

Within this overall purpose, the Scottish Government has established strategic objectives of making Scotland *wealthier and fairer, healthier, safer and stronger, smarter and greener*. At a local authority-level, the above are reflected within agreed Single Outcome Agreements (SOA) that bring together national outcomes with local priorities; and the delivery of which are overseen by Community Planning Partnerships (CPP). All health and social care services are expected to deliver outcomes in relation to:

- User satisfaction.
- Faster access to services.
- Support for carers.
- Quality of assessment and care planning.
- Identifying those most at risk.

Both the corporate priorities of NHS Greater Glasgow & Clyde and West Dunbartonshire Council in relation to alcohol and drug services reflect the above in general terms as well as the following specific policy directives:

2.1.1 <u>Changing Scotland's Relationship with Alcohol: A Framework for Action</u>

In March 2009, the Scottish Government published Changing Scotland's Relationship with Alcohol: A Framework for Action. This national Framework set out the strategy for tackling alcohol misuse in Scotland; adopted a population approach with specific interventions targeting particular groups; and identified the need for sustained action across four areas:

a) Reduced Alcohol Consumption
- Discount ban in off sales.
- Ensure smaller measures of wine are available in on-sales.
- Minimum retail price per unit of alcohol.

b) Supporting Families and Communities
- Increase age limit to 21 for off-sales (this may be left to the discretion of the local licensing boards to implement).
- Social Responsibility Fee (a fee that may be applied to licensed premises).
- Improve identification and assessment of children affected by parental alcohol misuse.
- Call for a reduction in the UK drink driving limit for blood alcohol concentration from 80mg to 50mg per ml of blood.

c) Positive Attitudes, Positive Choices
- Improve public awareness, e.g. information and education campaigns.
- Limit promotional material in shops, pubs and off-licenses.
- Promotion of workplace alcohol policies.

d) Improve support and treatment
- HEAT target for alcohol brief interventions.
- NHS Health Scotland Workforce Development Strategy.
- Integrated care pathways for offenders.

2.1.2 <u>The Road to Recovery: A New Approach to Tackling Scotland's Drug Problems</u>

In March 2008, Scotland's national drug strategy, The Road to Recovery, was published. This national strategy signalled the imperative to embrace a cultural shift focusing on the concept of recovery. The Strategy defined recovery as "a process through which an individual is enabled to move on from their problem drug use towards a drug free life as an active and contributing member

of society". It incorporated the principle that recovery is most effective when service user needs and aspirations are placed at the centre of their care and treatment. In short, an aspirational and person centred process. The strength of the recovery principle is that it can bring about a shift in thinking – a change in attitude both by service providers and by the individual with the drug problem.

The Strategy recognised that the historical polarised debate between the harm reduction and abstinence philosophies was false - they are on a 'continuum of care'; and emphasised the need to reform the manner in which drug services are planned, commissioned and delivered so as to place a stronger emphasis on outcomes and recovery. It recommended a range of appropriate treatment and rehabilitation services ought to be available at a local level. Treatment services must integrate effectively with generic services to fully address the needs of individuals with problem drug use not just their addiction. Alongside the wider effort to promote recovery from problem drug use, specific action to prevent drug related deaths was to be developed further.

2.1.3 HEAT Targets

For the period 2011/12 there are two alcohol and drug specific NHS HEAT (Health, Efficiency, Access & Treatment) targets (both of which are incorporated within the CHCP's current Key Performance Indicators):

- H4: Achieve agreed number of screenings using the setting-appropriate screening tool and appropriate alcohol brief intervention, in line with SIGN 74 guidelines for 2011/12.
- A11: By March 2013, 90% of clients will wait no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery.

2.1.4 Health Improvement and Health Inequalities

Health improvement *is "pursued both through wide ranging health promotion effort, aimed at promoting good health and preventing ill-health, and through maximising the population benefits of treatment of ill health"* (Scottish Executive, 2005).

While the overall health of communities in Scotland is improving, it is clear that the most rapid improvements are within more affluent communities resulting in marked differences in health status, life expectancy, and premature mortality. The widening gap in health status between the most affluent communities and most deprived communities demonstrates that socio-economic factors impact on health and are determined by life circumstances and where people live. The Scottish Government has acknowledged that inequalities in health such as these are no longer acceptable, and have introduced three key social policy documents which together aim to address the ongoing cycle of poverty and inequalities which persist in deprived communities:

- Equally Well.
- The Early Years Framework.
- Achieving Our Potential.

The role of the CHCP in improving health and reducing health inequalities is set out in the WD CHCP Scheme of Establishment in terms of its corporate responsibility for health improvement; and reinforced by the 2009 CEL 26 Health Improvement and Community Health Partnerships Advice Note, i.e.:

- To take action to reduce health inequalities.
- To prioritise health improvement.
- To plan for health improvement.
- To strengthen partnership working.
- To build capacity and resources for health improvement.
- To integrate improving health activity across all functions/services.

Current policy stipulates that the delivery for improving health and health inequalities should be tackled across all Community Planning Partners with the CHCP having a key leadership role in co-ordinating the health improvement activity specifying that this should be 'outcome focused'.

2.1.5 The National Quality Standards for Substance Misuse Services

The delivery of Alcohol and Drug Services is inspected and reported using the framework of the National Quality Standards for Substance Misuse Services. A key contribution to local service standards has been the series of best practice publications issued by the Effective Interventions Unit.

2.2 The above, alongside other national guidance, have provided the core tenets for how the CHCP will increasingly discharge its responsibilities for Alcohol and Drug Services in West Dunbartonshire over the next ten years, i.e.:

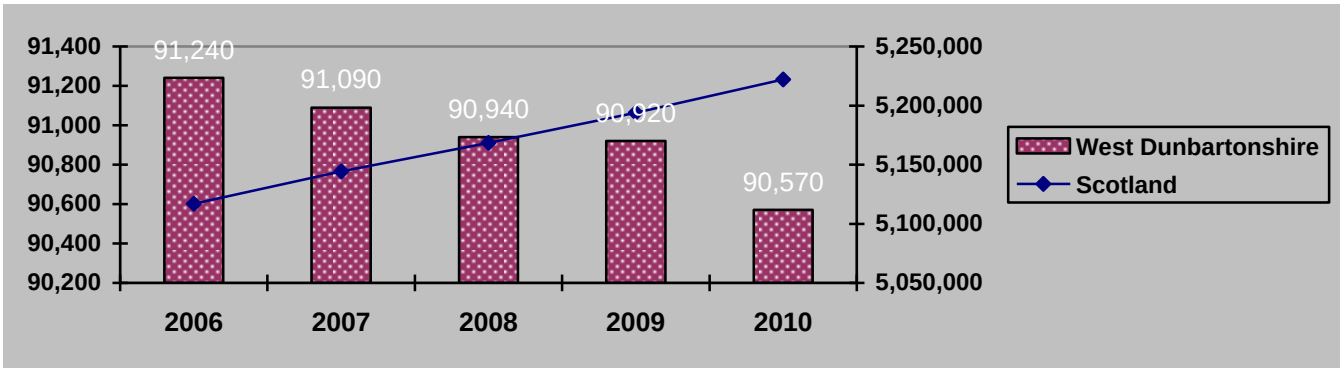
- A person-centred and outcome-based model of delivery that emphasises early intervention and recovery.
- Integrated care pathways and planning for each individual service user reinforced by co-ordinated assessment systems.
- Community alternatives to hospital admission and residential care.
- An effective contribution to a whole population prevention agenda through the local Community Planning Alcohol and Drug Partnership.

3. DEMOGRAPHIC PROFILE AND NEED

3.1 Population Size

The population of West Dunbartonshire reported in the 2001 census was 93,388. By mid-2008 the population had reduced to 90,940, and in 2009 that figure dropped to 90,920 with a further reduction by mid-2010 to 90,570 (Chart 1 - General Registrar for Scotland).

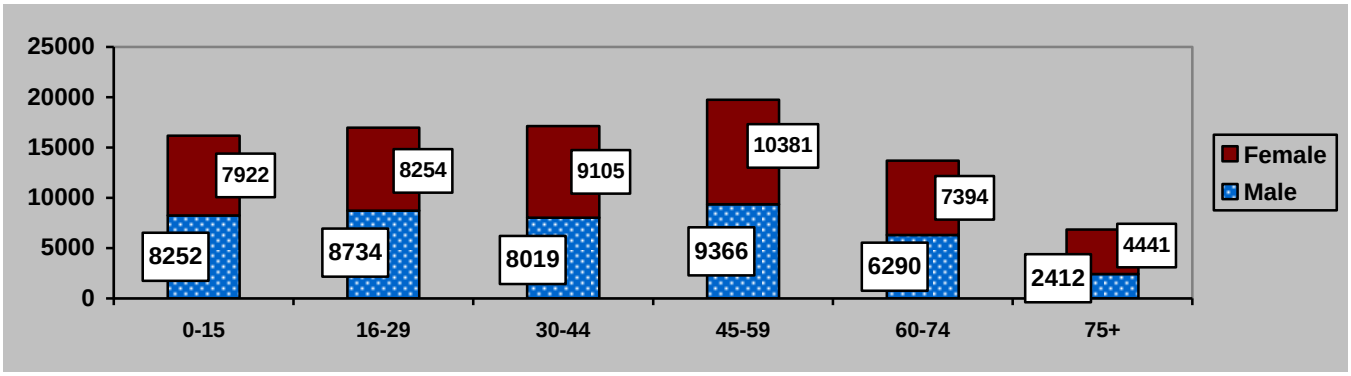
Chart 1: Population number 2006-2010



3.2 Age and Gender Profile

The population of West Dunbartonshire continues to age, and in 2011 the proportion of people over pension age (65) exceeds those of school age (under 16 years). There are more men than women in the population. Of those over 65 14% are men and 25% are women. Sixty seven percent of men and 59% of women are of working age (Chart 2).

Chart 2: West Dunbartonshire population (number) by age and gender (mid 2010)



3.3 Population Living with a Drug or Alcohol Problem

As of mid-2010, 63% of West Dunbartonshire's population was aged 15-64 years. Of these 60,554 people, 7.1% (4,668) were identified as dependent on alcohol, drugs or both; with the majority of those individuals being alcohol dependent (3,633).

In 2008/09 there were 2,686 referrals to alcohol and drug services. The level of referrals fell in 2009/10 to 2,259. It is estimated that in 2009/10, 2409 people with drug or alcohol dependencies did not seek support from alcohol or drug services.

3.4 Illicit Drug Related Deaths

The report GROS: Drug Related Deaths 2009 noted that there had been 545 drug-related deaths registered in Scotland in 2009 reflective of a continuing upward trend in drug deaths since 1999. The demographic profile of the 545 drug users who died in 2009 were as follows:

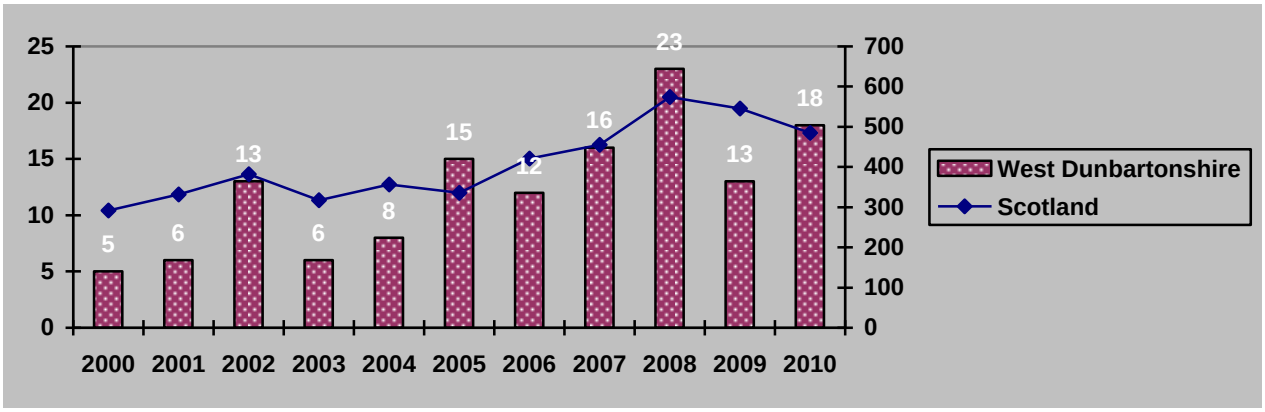
- 404 (76%) males.
- 131 (24%) females.
- 189 (35%) aged 35-44 years.
- 178 (33%) aged 25-34 years.
- 71 (13%) aged under 25 years.
- 78 (14%) aged 45-54 years.
- 29 (5%) aged 55 years and over.

For the same period there were 13 drug related deaths in West Dunbartonshire. Whilst they spiked in 2008 to 23, it is important to note that the 5 year average for the period 2005-2009 was 16.

Local data indicates that the split between male and female drug related deaths mirrors that reported at a national level with the majority of drug related deaths in males aged 35 – 44 years.

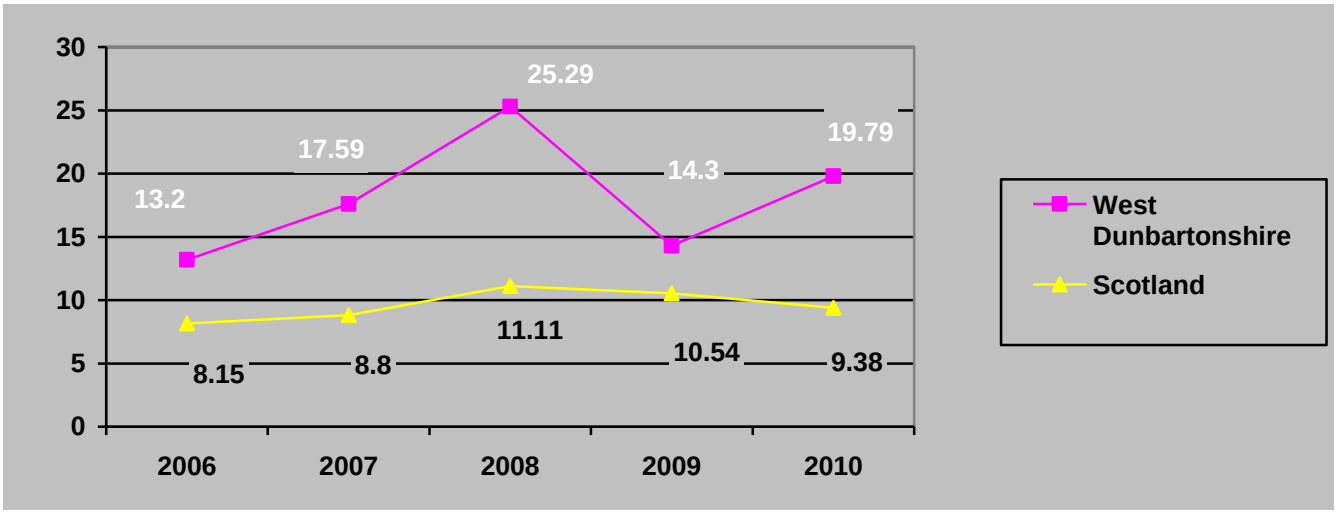
Recently published data has indicated an increase in the total number of drug related deaths to 18 in 2010 (Chart 3).

Chart 3: Number of drug related deaths



West Dunbartonshire is recorded as having the 2nd highest drug related death rates in Scotland. In 2005 the number of drug related deaths within West Dunbartonshire was recorded as 15, there has been no steady upward or downward trend over that same 5 year period, with figures falling to 12 in 2006, rising again in 2008 to 23 and dropping once again in 2009 to 13. A further rise to 18 drug related deaths was recorded in 2010 (Chart 4).

Chart 4: Drug related death rate – 5 year averages per 100,000 population



As Chart 4 demonstrates, when the figures are shown as a rate per 100,000 per head of population, West Dunbartonshire has a higher rate of drug related deaths than Scotland.

3.5 Alcohol-Related Deaths

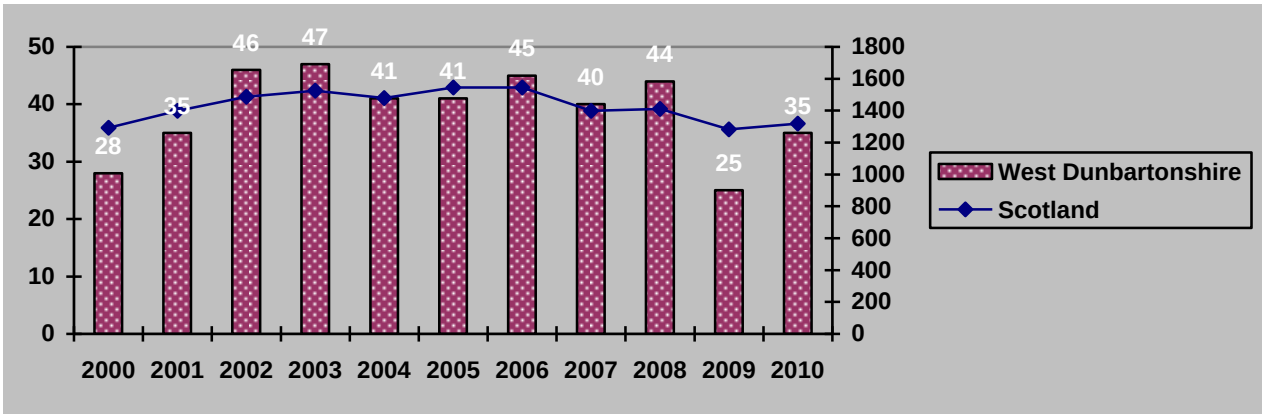
In 2009, there were 1,282 alcohol related deaths registered in Scotland. This reflects a fall from the 2008 figure of 1,411. More men than women died of alcohol-related conditions in 2009, with men accounting for 837 (65%) and women accounting for 445 (35%) of deaths where alcohol was the 'underlying cause'. Over two-thirds of deaths where alcohol was the 'underlying cause' where amongst individuals aged 50 years old or over. This was true for both men and women.

Trends over a 5 year period (2005-2009) have fluctuated. Overall, there was a 15% fall in deaths where alcohol was an 'underlying cause' from 1,513 in 2005 to 1,282 in 2009. However, the data shows that this is not a consistent trend, with deaths increasing to 1,546 in 2006 before falling to 1,399 in 2007 and then rising again to 1,411 in 2008. There was an 18% fall in alcohol-related deaths for men from 1,021 in 2005 to 837 in 2009 compared to a 10% fall for women from 492 in 2005 to 445 in 2009.

The difference in rates of alcohol-related deaths between the most and least deprived has varied over the 5 years, with rates in the most deprived areas being 6.6 times greater than those in the least in 2005, rising to 7.8 times greater in 2008, before dropping to 6.3 times greater in 2009.

In West Dunbartonshire a similar picture arises over the same 5 year period, as local figures have fluctuated from 32 in 2005 to 28 in 2006. There was a slight increase in 2007 to 29 and a further rise in 2008 to 32. A reduction of almost 50% in 2009 to 17 alcohol related deaths and a doubling of that total to 37 alcohol related deaths recorded in West Dunbartonshire during 2010 indicated against there being a clear year-on-year local pattern (Chart 5). It is fair to say though that the male/female split in terms of alcohol related deaths confirms that the majority of those deaths are of older males.

Chart 5: Number of alcohol related deaths



West Dunbartonshire has the 3rd highest recorded level of alcohol related deaths in Scotland (based upon 5 year average). Taken as an average the number of alcohol related deaths in West Dunbartonshire showed a downward trend from an average of 42.8 for the period the 2003 – 2007 to an average of 39 for the period 2005 – 2009.

Chart 6: Alcohol related death rate – 5 year averages per 100,000 population

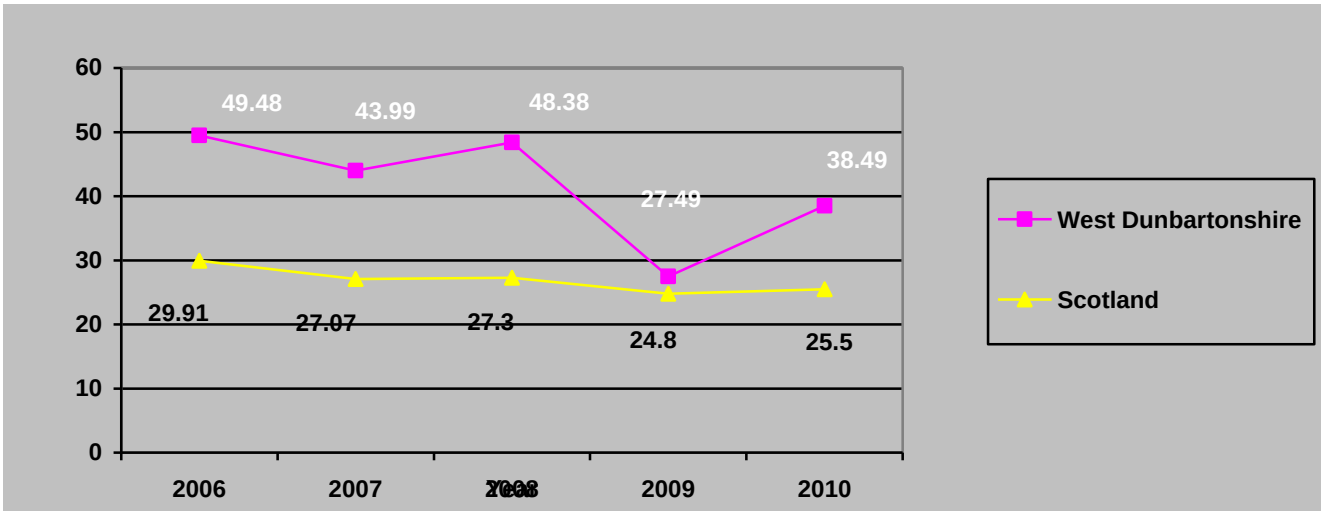


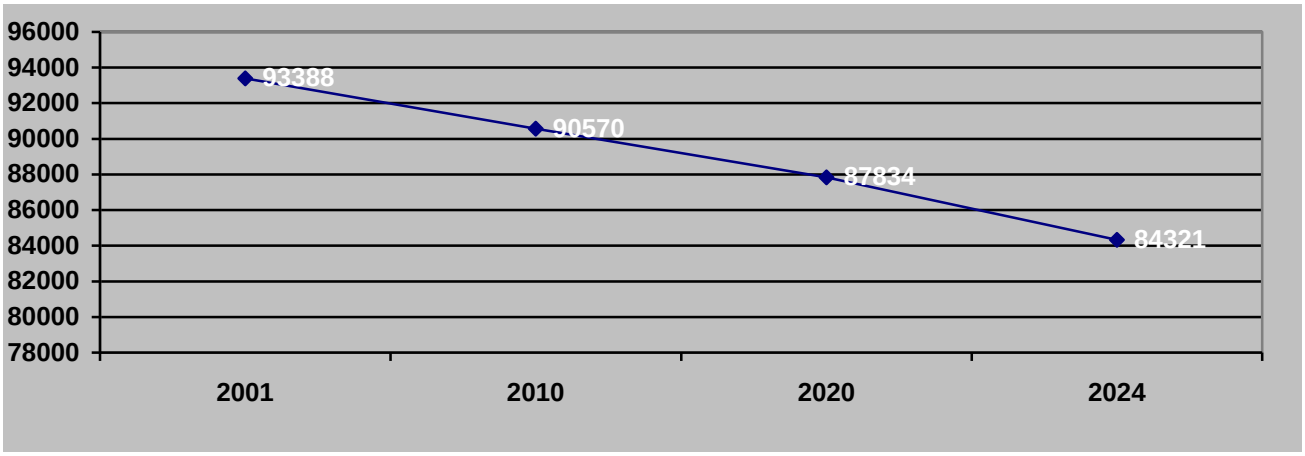
Chart 6 above indicates the rate of alcohol related deaths per 100,000 head of population. As with Chart 5, the rate for West Dunbartonshire is far greater than that recorded for Scotland as a whole. Again, similar to the rate for drug related deaths, the rate per 100,000 population has been greater in West Dunbartonshire than the rate for Scotland over the same 5 year period. Although there has been a reduction in numbers of alcohol and drug related deaths in general terms, there are approximately 1.7 alcohol related deaths to every drug related death. This is a decrease from the 2009 figures, which indicated that there were 3 alcohol related deaths to every drug related death. It is worth noting that the West Dunbartonshire Drug Related Death Group reviewed the medical records of individuals certified as drug related deaths. Whilst the majority of these had a history of chronic alcohol misuse this was not recorded as either the primary or secondary cause of death.

4. PROJECTED PROFILE OF FUTURE NEED

4.1 Population Size and Profile

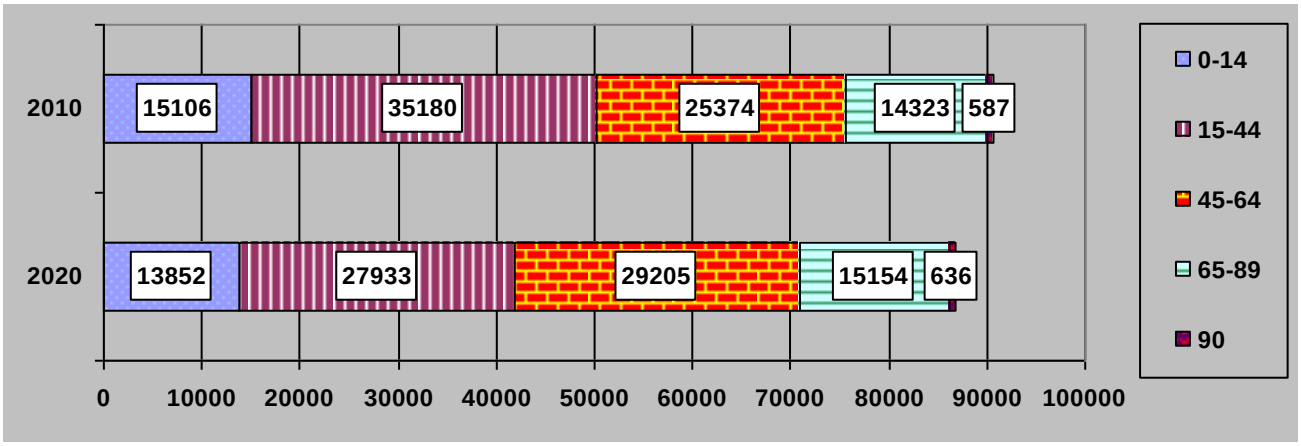
Analysis of the data taken from the General Registrar Office for Scotland and projecting likely trends in the population of West Dunbartonshire indicates a continued reduction in population size of approximately 3.2% over the next 10 years. Assuming this trend continues the population will continue to decrease at a rate of 3.2% over 10 years with a projected population of 87,834 in 2020 (Chart 7).

Chart 7: West Dunbartonshire – actual and projected population number



National and local evidence indicates that the population of West Dunbartonshire is ageing (Chart 8) due to a combination of factors: that the number of births within the area are dropping; the number of people migrating to other council areas within the 15 – 44 age group is increasing; and the number of deaths registered annually is falling. This mirrors the situation for Scotland as a whole.

Chart 8: West Dunbartonshire - population (number) by age group at 2010 and projected for 2020



Whilst the population projections indicate a down ward trend in the total population, and that the trend is of an older rather than young population, additional information using 5 yearly projections from the General Registrars Office for Scotland demonstrate that there will be more females than males. Specifically the number of males in the 0 – 15 age range is higher than the number of females. However, as we progress through each of the age ranges that is reversed with the number of females being greater than males in each of the remaining 5 age ranged identified within Charts 9 and 10.

Chart 9: West Dunbartonshire - projected population by gender and age (2018)

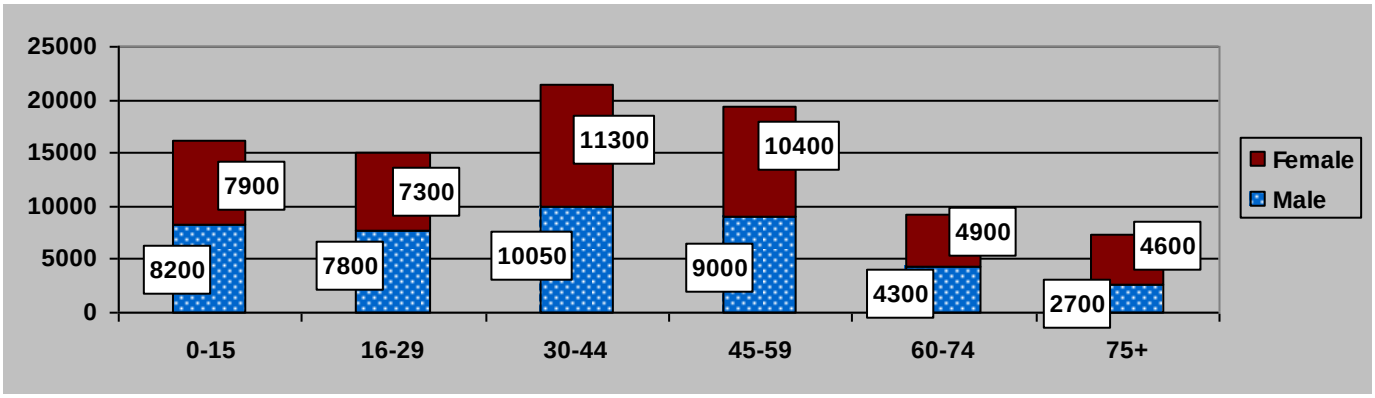
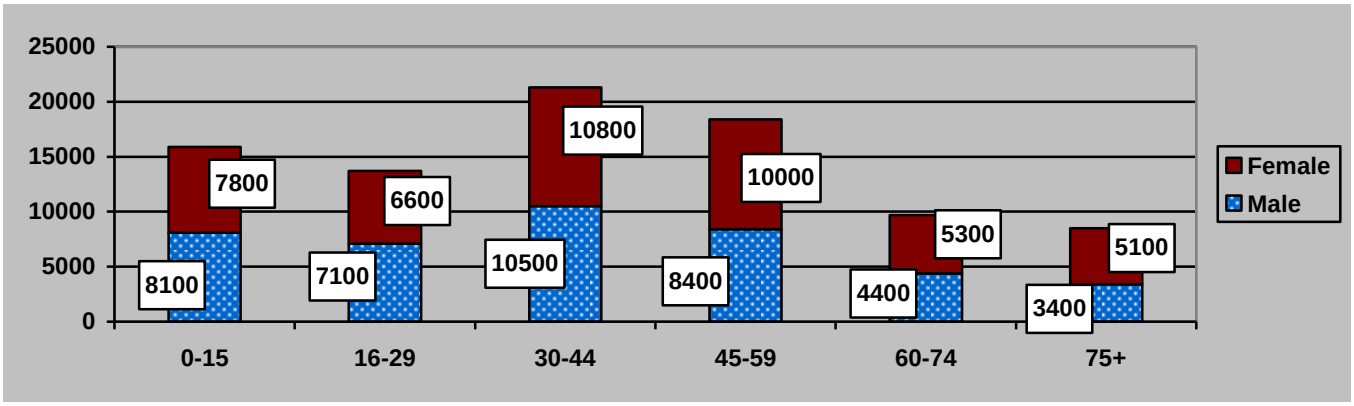


Chart 10: West Dunbartonshire - projected population (number) by gender and age (2023)



5. PROVISION AND DEMAND

5.1 Alcohol and Drug Service provision within West Dunbartonshire has been historically and predominantly shaped around harm reduction.

CHCP Alcohol and Drug Services provide integrated health and social care services for individuals living with problems linked to drug/and or alcohol misuse. In delivering those services, staff consider the physical, medical and social needs of individuals. This, along with the use of Integrated Care Planning of services, reflects the aim of ensuring that our local services and indeed the care plans of individuals are focussed on their specific needs. Within the Community Health and Care Partnership (CHCP) there are two Community Addiction Teams (CATs): the Clydebank CAT and the Leven CAT. Both of these well-regarded teams are composed of health and social care staff working together.

Alcohol and drug services are also provided by other parts of the NHS system locally (e.g. general practice and community pharmacy); supported by other CHCP services (e.g. CHCP Health Improvement Team); and through funding arrangements/service level agreements with local voluntary sector providers.

There is a demonstrably strong track record for delivery within local alcohol and drug services (e.g. in relation to waiting times and delivery of alcohol brief interventions), positive user engagement and established partnership working (most evidently within the local Alcohol and Drug Partnership).

5.2 Service demand has grown by approximately 11% since 2006, in part as a consequence of additional resources and increased capacity in service provision. That increase in demand for services is starting to slow down, with local interrogation of data suggesting that a plateau has been reached. However local analysis also indicates that that there is a large cohort - probably more than 2,500 - who does not seek help (i.e. who have needs but do not express demands) alongside a significant fall-out from service interventions.

5.3 It has been problematic to precisely quantify the number of referrals who take up services across public and voluntary sectors. Whilst work is on-going to improve the accuracy of data collection systems, the local estimate of 2,409 people not seeking services is most probably a conservative one (taking into account that a significant percentage of referrals will not follow through). Given the changing context, challenges and financial realities previously highlighted, the only way such unmet need can be addressed will be through the re-modelling of services (both those directly managed and those delivered via a service level agreement/contract by other organisations) as set out within this commissioning strategy and re-apportioning of available resources accordingly.

5.4 Work is also on-going to review the provision of residential rehabilitation. This is because:

- It is, on the whole, a costly service, which is only available to a minority of individuals recovering from drug or alcohol addiction.
- Changes in resource allocation across NHS Greater Glasgow and Clyde has meant that current access to residential rehabilitation is being reduced.
- More effective use of local resources and the provision of a more needs led service will be achieved by delivery of local community rehabilitation services.

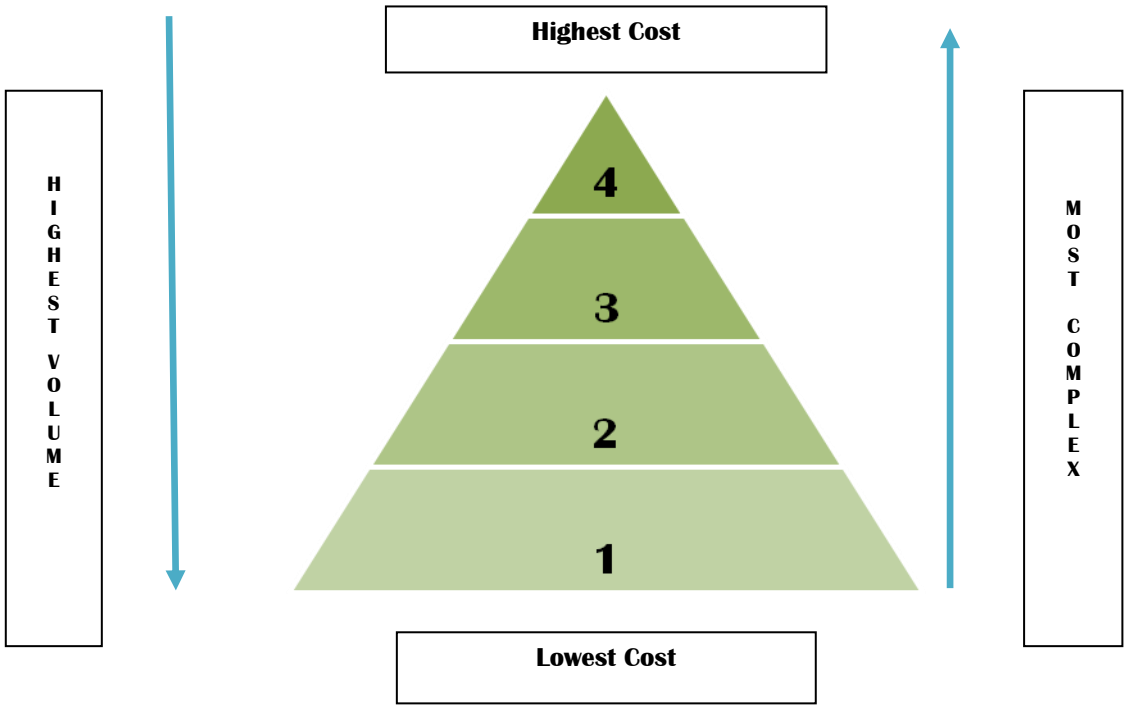
5.4 Based on prevalence data, service usage and service fallout, it is likely that the current level of demand for services is likely to continue over the next 3 – 5 years. What is anticipated to change is the nature of the needs within the population, the types of demands that are expressed, the expectations concerning how best to meet them and the reduced finances available to resource them. Fortunately all of the above provide a strong foundation for the developments necessary going forward to ensure that the CHCP continues to lead and operate a service model that is fit-for-purpose and contributes positively to the wider agenda of the Community Planning ADP.

6. MODEL OF SERVICE PROVISION – NOW & NEXT

6.1 Service-Oriented Model of Provision – 2010

The operating systems in West Dunbartonshire are based on the pathway for the individual, who may directly access any one of the first three tiers. This service-oriented tiered model of provision is illustrated in Diagram 2 below.

Diagram 2: Service-Oriented Tiered Model of Provision



6.1.1 Tier 1 services are:

- General information provision about drugs, drug use, associated harms, treatment options and related matters.
- Identification and referrals to other services.
- Prevention and education activities.
- Alcohol Brief Interventions

6.1.2 Tier 2 services are:

- Group work and recovery.
- Relapse management.
- Therapeutic interventions (non-clinical).
- Harm reduction.

6.1.3 Tier 3 services are:

- Advice/Information about alcohol and drug use, associated harm, Blood Borne Viruses (BBV), treatment options and other clinical treatment related matters.
- Post residential rehab/detox support.
- Drug/alcohol testing.
- Maintenance/Stabilisation/Substitute Prescribing and Titration.

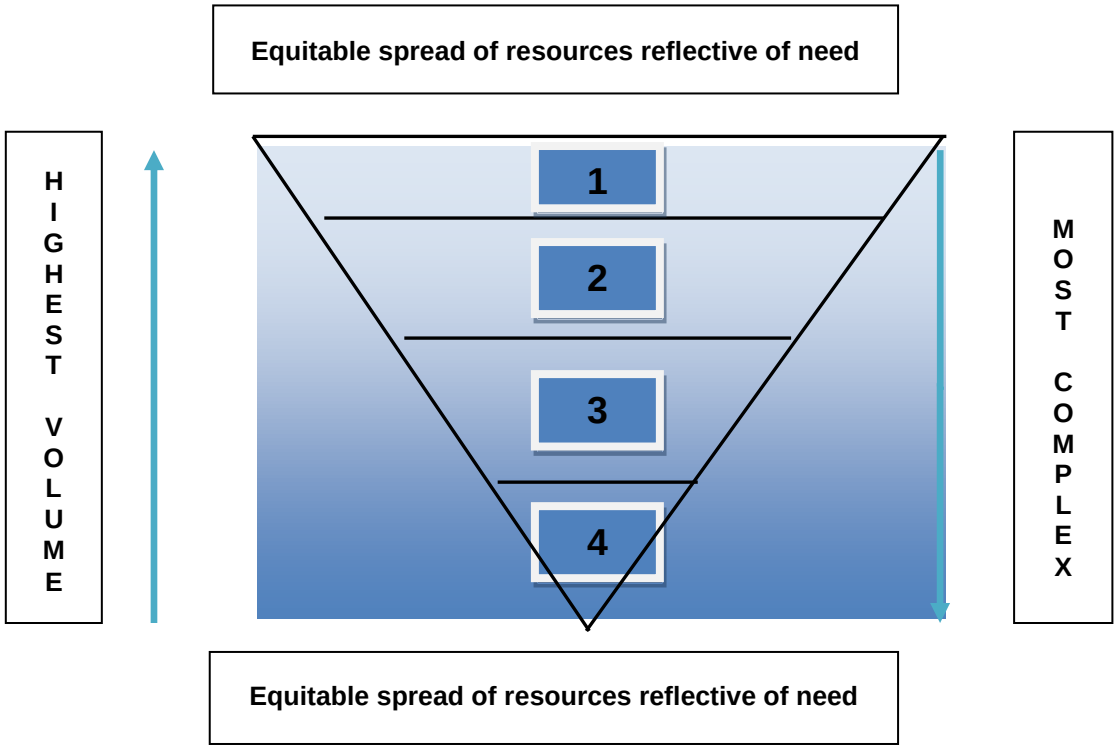
6.1.4 Tier 4 services are:

- Inpatient/residential specialist alcohol and drug detoxification and stabilisation.
- Residential Rehabilitation.

6.2 Person Centred Model of Provision – The Future

Increasingly, alcohol and drug services are driven to develop and provide interventions which ensure that the individual is explicitly central to the development, implementation and management of their own care package. This will be manifested in the implementation of a recognised tiered person-centred approach to service provision and which represents a paradigm shift in the way local services will increasingly be delivered (Diagram 3).

Diagram 3: Tiered Person-Centred Model of Provision



6.2.1 Tier 1 is available for the whole community.

6.2.2 Tier 2 is for people with alcohol or drug problems.

6.2.3 Tier 3 is for people with more complex needs.

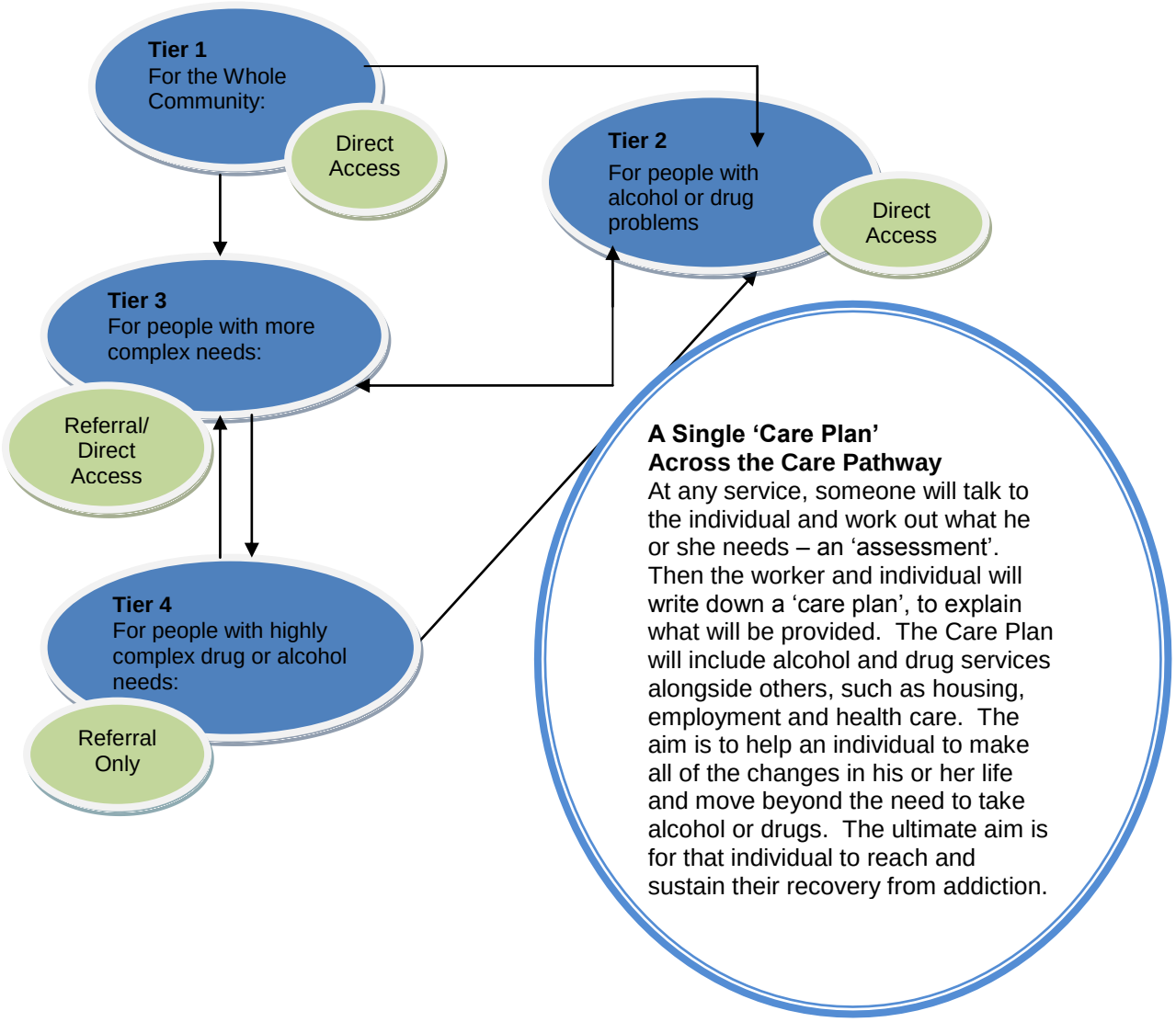
6.2.4 Tier 4 is for people with highly complex drug or alcohol needs.

6.3 Part of this approach to offering appropriate and increasingly personalised support to enable people to recover from problem drug and alcohol use is to develop an individual care plan based on a holistic assessment of their needs with agreed outcomes (goals) detailed within a recovery plan. This will be routinely carried out through the Single Shared Assessment (SSA) process and be subject to regular review to allow the support needed to be adjusted to reflect progress made towards recovery. It will cover both treatment and rehabilitation services, as well as addressing associated issues such as training or employment needs. The relevant actions in the recovery plan can then be shared with the appropriate service providers involved in that individual's care, to ensure an integrated approach to delivering the plan, as well as forming the basis for a more proactive engagement of the individual in their own recovery.

7. CARE PATHWAY

7.1 Audit Commission reports suggest that the drive to expand community services requires a well-planned "journey of care" with a package of support. This has been and is the ethos of alcohol and drug services in West Dunbartonshire. That commitment remains, albeit in an up-dated version that explicitly reflects the new model above and the principles set out earlier within this commissioning strategy (Diagram 4 below).

Diagram 4: The Person-Centred and Outcome-Focused Care Pathway



7.2 A key element of this person-centred and outcome-focused model is the provision of specialist and rehabilitation services that are locally based within a community setting. While it is acknowledged there will continue to be a need for residential care, the evidence suggests that better outcomes are achieved when individuals can access a range of care in their own communities. This will mean facilitating a change in emphasis from residential and hospital provision to community based rehabilitation, accompanied by the necessary reallocation of resources to support this shift in the balance of care to community settings.

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8. FINANCIAL FRAMEWORK

8.1 The financial framework for West Dunbartonshire CHP has been prepared on the basis of an aligned budget process that complies with and respects the integrity of the distinct financial governance and accountability arrangements of its parent organisations, i.e. West Dunbartonshire Council and NHS Greater Glasgow & Clyde. The corresponding financial framework for each and all CHCP service areas are rigorously reviewed on an annual basis, with an increasing emphasis on ensuring a clear relationship with and understanding of the service priorities that need to be met, both in-year and going forward.

8.2 The total financial framework for alcohol & drug services in the 2011 – 2012 financial year is £4,445,000.00.

8.3 All public sector services face budgetary restrictions. The rising gap between provision and potential need will be further challenged as local services manage further limitations on budgets. Increasing emphasis on efficiencies and effectiveness will become the norm, as will an increasing need to review the wider partnership demands to collaborate to reduce the impact on the individual and the community.

8.4 Local government and health boards have faced demanding budget reductions and the expectation is this will be the challenge over the next few years. Importantly any substantial dependence on such non-recurrent and time-limited funding streams poses risk in terms of sustainable service delivery, especially in the challenging financial climate that is anticipated to continue for some years ahead.

8.5 Addiction is recognised as an issue of concern across Scotland, and West Dunbartonshire services have notable successes in attracting new funding streams from the Scottish Government, including new uplifts arising for 2008-2011 (and recurring). The development of new services and/or improved access will result in higher expectations; expectations from individuals for enhanced access and broader service choice as well as expectations from central government regards performance. Operational service planning needs to recognise these expectations, particularly where these expectations are linked to performance contracts with the Government. Failure to link performance to investment in the short-term will lead to a withdrawal of funding streams.

8.6 In addition to its directly managed services, the CHCP has also funded activity and service provision from third sector sector organisations in relation to alcohol and drugs. It is both appropriate and fair that the CHCP's external funding arrangements are robustedly and routinely tested to ensure best value against the resources available and the model of provision identified. In doing this, it is important to appreciate that local voluntary sector partners have often faced challenges of managing a range of short-term funding streams and appropriate weight should be attached to continuity of defined service provision for individuals. It is also important to understand that while matched funding arrangements between third sector organisations with the local authority and/or NHS has to-date enabled successful levering in of further external resources, the changed financial climate will likely diminish the scope for such arrangements and the capacity it supported going forward (not least because of the increased pressures on and reduced availability of such external funding).

8.7 Reviews of all service provision, in house and externally purchased in line with best value competitiveness principles is required corporately and departmentally. This may result in a shift in both service provision and the associated financial framework. This new service design or reconfiguration will be carried out in accordance with the Procurement Guiding Principles set out in Appendix II and will be detailed as part of the procurement planning within the service's Operational Plan.

8.8 The Scottish Government has initiated some scoping on the Integrated Resource Framework (IRF): this is specifically to improve the quality of financial frameworks across Local Authorities and NHS organisations, including Primary Care and Acute Services. This work will require to be undertaken by the CHCP as part of the improving and developing financial framework for the service.

9. DELIVERING OUR AMBITION – NEXT STEPS

9.1 Addiction remains a significant and growing issue within West Dunbartonshire, posing difficulties for individuals with a drink or drug problem, for family members affected by someone's problem and for the wider community. Alcohol and drug problems are themselves mirrors of social deprivation, and collaboration across the Community Planning ADP is pivotal to future well-being within the area.

9.2 Robust commissioning of community-based alcohol and drug services is essential to ensure that high quality and sustainable services are available to those who need them. This commissioning strategy will drive the substance of relevant operational service plans on an annual basis, within the wider context of the Community Planning Partnership's multi-agency Alcohol and Drug Strategy 2011-2012 (that the CHCP has lead responsibility for) and the CHCP's wider set of development priorities as set within its annual CHCP Strategic Plan.

9.3 The following provides a synopsis of the key issues for continued prioritisation in the short-term as per the vision and values set out at the start of this commissioning strategy.

9.3.1 Quality Service Provision

National Quality Standards call for all areas across Scotland to offer a range of service routes, and for the quality of services to reflect a minimum standard. Service inspections and supported self-assessments for and by SCSWIS aim to ensure that quality standards and personalised services achieving good service user outcomes are maintained.

Local deliberations within the Alcohol and Drug Strategy process continue to identify ways of improving both choice and service quality. Using the Public Service Improvement Framework (PSIF) there will be an expectation on services, internal and externally purchased to set fresh, aspirational goals which continually drive further improvements. Regular, internal audits of the Single Shared Assessment (SSA) process and documentation will continue to provide an overview of service delivery and support a shared approach to Care Planning and Review.

Whilst CHCP services have a good track record in achieving national targets, there is no room for complacency. There is wide ownership of targets and a commitment to sustain achievements. A new national framework for collating waiting times data, and a new target (HEAT A11: 90% accessing treatment within 21 days of referral) will continue to test the CHCP.

9.3.2 Personalisation

The CHCP works with people using our services to offer more flexibility, choice and control over their support so that they can live at home more independently. It is important that our local services create arrangements which will facilitate more choice and control over service provision and promote the opportunities for co-production with service users. This will include ensuring built in flexibility by the introduction of framework agreements that enable individuals to access these services via Self-Directed Support (SDS) options.

In line with the National Standard Eligibility Criteria and Waiting Times for the Personal and Nursing Care for Older People framework, West Dunbartonshire is amending relevant policies, procedures and assessment documentation. The existing criterion used in West Dunbartonshire CHCP is compatible with the current Scottish Government Guidance of Critical, Substantial, Moderate, Low or No risk. Work is progressing to update current recording systems to be able to report in line with the Guidance. The updated Guidance from the Scottish Government suggests that eligibility for services is recorded at the end of the assessment. The recording of Eligibility Criteria is a mandatory field on all Single Shared Assessments (SSA) and Specialist Assessment templates across client groups and service areas. West Dunbartonshire will be applying the criteria to all Community Care Client groups and services and will be able to report on this in the near future following the updated Scottish Government Guidance.

Work on the development of local qualitative service user outcomes is progressing. Adopting such a framework will assist in the assessment of the impact of services on the people who use them. This will enable monitoring and reporting of outcomes which our services are supporting individuals to achieve

and will be consistent with the client centred personalised approach within our new service model. A clearer and improved focus for service delivery and the resulting improved outcomes for individuals will be evident. Developing the service user satisfaction survey (undertaken annually since 2006/07) will be an important element of this.

9.3.3 Recovery

While it is acknowledged there will continue to be a need for residential rehabilitation, the CHCP is committed to developing and enabling greater access to rehabilitation within community settings. As already described, this will mean facilitating a change in emphasis from residential and hospital provision to community based rehabilitation, accompanied by the necessary reallocation of resources to support this shift in the balance of care to community settings.

Recovery Capital refers to the capacity of communities both directly and indirectly to support recovery. Monitoring and analysis of how the wider community, and groups within the whole population, lead the recovery agenda will be important in guiding specialist services. Involvement of service users in planning and developing addiction services is part of the Scottish Government's national plans for alcohol and drug services. The drive is reflected in its published *National Quality Standards for Substance Misuse Services* (2006). The capacity to undertake regular consultations and surveys has been limited to an annual audit of single shared assessments and the annual service user satisfaction surveys. The need to gather and monitor local data, linked to need, has been highlighted as a proposed action within the Community Planning Alcohol and Drug Strategy. The West Dunbartonshire Community Planning ADP is committed to ensuring that the services provided locally are needs led; and that the people who are accessing those services are actively encouraged to participate in the planning and delivery of those services. Through a combination of CHCP and broader Community Planning engagement and consultation activities a strategic approach to the development of recovery capital will be established. This provides a sound platform for developing this important agenda, particularly across equality groups and in a manner that is appropriately representative of the wider community (and not just special interest groups).

9.3.4 Early Intervention and Prevention

The Scottish Government encourages local areas to develop a whole population approach to the prevention of alcohol or drug misuse problems. Prevention related activity and outcomes are more difficult to quantify than the delivery of services (outputs) and demonstrating the benefits of our activity will be a challenge. Traditionally focussed on the younger population, prevention now needs to develop a targeted approach to all population groups. With the apparent gap in numbers of individuals living with alcohol or drug misuse problems and those actually seeking support and services, the projected reduction in population size and the increase in the population aged 64+, it is essential that the development of a whole population approach to prevention related activity needs to be supported.

Work is on-going to review the current prevention and education delivery, resources, and range of work undertaken in West Dunbartonshire. This work aims to provide a financial figure for the current spend in prevention and education and identify areas where realignment of investment in prevention and education may pay dividends to the wider public purse. Current examples of prevention related activity include delivery of Alcohol Brief Interventions and a move from awareness raising activity to the provision of diversionary related activities aimed at changing behaviours. In recognising that the current gap between need and access to support should be reduced there is a strong argument that the current level of resource allocation linked to the delivery of Alcohol Brief Interventions (ABI) in particular is at least maintained (e.g. within general practice); and that the potential for extending ABI training and thus provision to other key staff groups is explored. West Dunbartonshire has to-date a good track-record in exceeding its contribution to the national target: thus the intention is that the number of ABIs delivered locally should be increased in order that the gap between the numbers living with alcohol problems and those accessing supports may be reduced.

9.3.5 Best Value

The financial challenges facing the public sector are well documented the scale of the reduction in finances brings immediate challenges for the CHCP to manage expenditure more efficiently and

effectively but also to ensure long term sustainable services. Whilst there is scope to make further efficiency savings the funding gap currently faced is unlikely to be bridged by efficiency savings alone. The need to reduce costs provides the CHCP with an opportunity to reconfigure and streamline service delivery. However, in doing so we must focus on two things, long-term financial sustainability for services and the achievement of good outcomes for service users. This requires a clear understanding of service costs including how different activity levels affect costs, and a clear methodology for setting service specifications and budgets based on priorities and the outcomes to be achieved for the people who use those services. In keeping with the IPC's cyclical commissioning process, this necessary work stream (including the application of the Procurement Principles appended here) will be taken forward as an explicit element of annual operational service plans for the CHCP's Addiction Services.

9.3.6 Population Needs

The Equality Act 2010 imposes a general equality duty designed to integrate consideration of the advancement of equality into the day-to-day business of public authorities. Therefore the CHCP, in the exercise of its functions (e.g. as an employer, service planner and provider) must have due regard to the need to:

1. Eliminate unlawful discrimination, harassment and victimisation and other conduct that is prohibited by the Act.
2. Advance equality of opportunity between people who share a characteristic and those who don't.
3. Foster good relations between people who share a characteristic and those who don't.

All CHCP strategies, plans, performance reports and procurement activity are scrutinised to ensure that the requirements and duties laid out within Equalities legislation are being met.

Access to alcohol and drug services by certain groups remains low. Historically, women are less likely than men to access addiction services, particularly women with parenting roles. Through local reviews, however, it has become evident that there are increasing numbers of women accessing some local services i.e. the Out of Hours Telephone Support Service which, through its confidential nature, allows a degree of anonymity. Similarly the delivery of equitable access to services has enabled an increase in the number of women accessing treatment services. This increase requires the provision of more holistic support to families to reduce the likelihood of referrals to social work and to promote early intervention to assessment of need. Steps have been taken to increase the level of care planning activity for vulnerable groups; in particular women with co-morbid profiles, yet access levels have not shifted significantly.

A review of service access by older people (50 +) also suggests an area of service need which has not had specific attention previously. *"Alcohol and Ageing: Is Alcohol a Major Threat to the Baby Boomers*", a Health Scotland commissioned report states that if the baby boomers (born between 1945 – 1965) carry their current drinking patterns into old age they are likely to experience higher than anticipated levels of morbidity. Analysis of drug and alcohol related deaths, and the changing population demographics suggest that focussed interventions for older people are required. Within that cohort it is suggested, that particular attention should be paid to the alcohol and drug related support needs of older men, in particular. Targeting delivery of ABI on this particular population group may therefore be a way of ensuring that older males are able to access appropriate supports and services at a point before their alcohol misuse becomes problematic or chronic.

With constraints on budgets it is apparent that different approaches to service delivery are required to reflect the needs of different types of people and ensure equitable access to supports and services to other population groups i.e. women and older people.

9.3.7 Information Management

The commissioning task starts with improvements to data collection and analysis. Current performance management systems are provided across a number of service areas and due to the complexity of information recording and gathering it is difficult to ascertain the definitive number of people using the services compared to the number of referrals currently recorded. The ability to adequately utilise the data contained within both the Commissioning and Alcohol and Drug Strategies, and convert it to viable options to achieve an effective challenge to the rise in substance

misuse and associated problems will require staff commitment and time, an additional resource burden which will need to be addressed. Whilst some national data will be used appropriately there are many data fields that are collected at levels far greater than that covered by the West Dunbartonshire CHCP and will not provide local data. Going forward there is a pressing need to refine data collection systems that provide clear, unambiguous, local data that informs commissioning the cyclical commissioning process that this document is a key part of.

Realising the potential of outcome based commissioning as described requires improving information recording and sharing between and within the NHS and the local authority and across CHCP services (including the systematic application of Single Shared Assessment and recording of the Care First information system).

9.3.8 Strengthening Links with Other Service Areas

- Out of Hours Support Services

Established as a direct result of an identified need; the HEAR Out of Hours Telephone Support Service has, through the use of internal audit, grown and developed in a way that is led by the needs of those who access local services. Whilst continued funding and extension of operating hours remains a local priority, use of the service will be reviewed and modifications implemented as required. Opportunities to link with other local authority areas to maximise efficiency need consideration. The longer term view is that this and other out of hours supports will grow to the point where support is available on a 24/7 basis.

- Blood Borne Viruses (BBV) and Sexual Health

The transmission of BBV, particularly between injecting drug users, continues to present a number of challenges to services, including reaching those at risk but not engaging with services and providing treatment, support and advice to those already living with a BBV. Services such as the needle exchange service, attempt to address issues of reaching those furthest from services, as does the new Hepatitis C treatment service available within Dumbarton Joint Hospital. Further developing the range of services and embedding new practice across West Dunbartonshire will require partnership support and resources. The promotion of good health remains a core component of services which focus on individuals holistically. This includes the promotion of positive sexual health and the need for individuals to take responsibility for their own health.

- Child Protection

The welfare of children affected by parental substance misuse is a paramount concern. Local protocols and training have supported developments, but the volume of work is concerning, with a working estimate of over 2,000 young people directly affected by parental drug misuse and a further 3,000 affected by parental alcohol misuse (as reflected by national estimates within Audit Scotland Report, March 2009 - *Drug and Alcohol Services in Scotland*). On-going training, as well as discussion with and guidance from the Child Protection Committee (CPC) will continue to be important.

- Domestic Violence

Following the introduction of the Domestic Abuse Pathfinder Project in Clydebank, there has been an increase in the number of women being referred to the Police with complex needs, including alcohol and drug addiction issues. Future services need to develop to respond to the needs of these women and their families, supporting them on their journey to recovery, and supporting the continued identification and pathway support in the absence of the Pathfinder Project. Services will need to continue to monitor access by women and note patterns of need. Cross referencing of information and actions contained within the Integrated Children's Services Plan and its associated Commissioning Strategy will ensure an accurate picture of those patterns of need is obtained and used to shape future service provision.

- Adult Support & Protection

The CHCP and its partners are committed to the support and protection of adults at risk of harm, who by virtue of disability or illness, are more vulnerable to being harmed. The West Dunbartonshire Adult Protection Committee brings together Council, Health, Police and Third Sector members to provide cooperation, guidance and oversight of policies and services that support and protect adults at risk. There is an extensive programme of knowledge and skills based training that equips staff in the public and independent sectors to intervene, support and protect adults at risk and this priority will continue.

- Mental Health

A high level of mental ill health is experienced by addiction clients. Whilst a local protocol is in place joint training and maintenance of care pathways remain key tools to improve services for individuals with the most complex needs.

The CHCP is committed to the prevention of suicide and self harm. The Choose Life initiative in West Dunbartonshire is lead by the CHCP Health Improvement Team. Cornerstones of prevention activity include, co-ordination of work across organisations, project development (for example, the Seasons for Growth Programme in schools), public awareness campaigns, and suicide prevention and self harm awareness training to public sector and third sector staff and community interest groups.

- Homelessness

A high percentage of people with alcohol and drug problems experience homelessness. Local protocols between alcohol and drug services and homelessness are in place. The CHCP recognises that there were many barriers experienced by clients leaving prison and moving into homeless accommodation. Whilst in prison, and with support from the Prison Through-care Service and a local voluntary sector drug service, the clients drug intake is reduced. However, once they moved from prison to homeless accommodation those same clients became significantly at risk of overdose.

Discussions between West Dunbartonshire Council Homeless Services and the CHCP's Addiction Service have led to a proposal for the future provision of supported accommodation for up to 40 individuals (in a year) who are considered as statutory homeless and who wish to attain abstinent recovery from drug addiction. In addition it is the proposed to establish four homeless satellite flats, with some housing support, which will allow individuals to move from fully supported accommodation to a more independent means of living. This core and cluster development will be supported by and independent sector provider following an appropriate procurement exercise

- Criminal Justice

A local steering group has been established to look at issues of Prison Through-care, Drug Treatment and Testing Orders, Turnaround Services, Arrest Referral and all other criminal justice links with addictions. With changes in sentencing policies, in particular the roll out of Community Payback Orders (CPO), a shared pathway is essential to support the needs of this particular client group. The financial impact addiction has on the public purse, through crime, disorder and the public response to crime and disorder indicates a need to prioritise this area for continued collaboration.

- Welfare Rights and Money Advice (WRMA)

Partnership discussions with WRMA are being pursued with changes to the UK benefits system, good collaboration will be vital. Income maximisation remains central to ensuring better "recovery capital" for those experiencing drug or alcohol problems.

Appendix I

COMMISSIONING: DEFINING THE STAGES OF THE PROCESS

Analyse

- Identify the impact that you wish to have in relation to your strategic objective. This will take account of the mission and key policy drivers within your organisation and will mean focussing resources on the achievement of results for people w ho use our services. This "Outcome based' commissioning" is a strategic process of specifying, securing and monitoring outcomes to meet peoples' needs at a strategic level.

- Develop an understanding of the needs of service users and link this back to the outcomes desired for service delivery. This will involve consultation with service users and organisations that advocate on their behalf. You will be seeking to understand 'how' you will know that the outcomes and impact you are looking for have been achieved.

Plan

- Resources or a budget for the service should be agreed based on the outcomes sought and the assessed need. Initial targets will become clearer once the budget is agreed. The process is reiterative and may require that you take a step back if it is clear that your budget will not allow you to achieve the desired outcomes.

- The best service available within resources should be designed based on the outcomes sought and the assessed need. Effective outcome based commissioning minimises the attention on inputs and the micromanagement of services and focuses on the achievements made by service users at the end of any programme.

Do

- Options appraisal helps decide how the service should be delivered. Purchasing the service through a competitive process – procurement – is often the best option in terms of securing Best Value. At this point you will engage more fully with procurement professionals to follow established processes that will take account of Best Value, EU legislation and the strategic aims of the procurement strategy.

Review

- Once your service delivery organisation is in place you will have to monitor and evaluate the service delivery, involving key stakeholders (particularly service users) as appropriate. Monitoring and evaluation should be proportionate to the contract value and contract length to ensure value for money. Information gathered from the monitoring/evaluation process should help you redesign the service and make decisions regarding any future contracting processes.

PROCUREMENT GUIDING PRINCIPLES

The following guiding principles for the procurement of care and support services reflect the complexity of procuring care and support services and the complexity and the challenges associated with upholding values, delivering high standards and responding to individuals needs whilst complying with procurement rules and securing best value. Taken together, the principles govern all procurement activity and will be used as a framework for evaluating local practice.

1. **Outcomes** – achieve positive outcomes for service users and carers through the delivery of good quality, flexible and responsive services which meet individuals' needs and respect their rights.
2. **Strategic commissioning** – place the procurement of services within the wider context of strategic commissioning, reflecting strategic and service reviews.
3. **Personalisation** – secure personalised services which provide independence, choice and control for service users.
4. **Involvement** – involve service users and carers as active partners in defining their needs and the outcomes they require and in the design of their services.
5. **National Care Standards** – ensure services meet the National Care Standards and adhere to the principles underpinning the Standards (dignity, privacy, choice, safety, realising potential and equality and diversity).
6. **Codes of Practice (Scottish Social Services Council)** – ensure staff involved in procuring services promote the interests and independence of service users and carers, protect their rights and safety and gain their trust and confidence; ensure employers provide training and development opportunities which enable staff involved in procuring services to strengthen and develop their skills and knowledge.
7. **Best value**– secure best value by balancing quality and cost and having regard to efficiency, effectiveness, economy, equal opportunities and sustainable developments.
8. **Benefit and risk** – base strategic decisions concerning the procurement of services on benefit and risk analysis of the potential effects on: the safety and well-being of service users and carers; the quality and cost of services; and partnership working with service providers and workforce issues.
9. **Procurement rule** – ensure procurement exercises comply with the principles deriving from the Treaty on the Functioning of the European Union (equal treatments, non-discrimination and transparency), the requirements of the Public Contracts (Scotland) Regulations 2006, statutory guidance issued under section 52 of the Local Government in Scotland Act 2003 and Scottish public procurement policy.
10. **Leadership** – ensure senior managers give a high priority to the procurement of care and support services, setting clear strategic goals managing.
11. **Workforce** –ensure the procurement of services takes account of the importance of skilled and competent workforce in delivering positive outcomes for service users.
12. **Partnership** – promote collaboration between public bodies and partnership working across the public, private and voluntary sectors to make the best use of the mixed economy of care and bring about cultural change in all sectors.