1. Vision
To develop a holistic treatment system which supports people in need of substance misuse services on their journey to recovery. The treatment pathway will encourage self care and management and be tailored to the individuals’ needs.

The historical commissioning of services has been piecemeal (reflecting the way drug and alcohol services have been funded)—leading to disjointed and competing services, which is often confusing to the individual trying to seek help. Our vision is to bring all provider services together within a consortium model, whereby one of the existing care providers acts as ‘lead provider’ – similar to the model created for the Drug System Change Pilot (SCP). The new consortium model will ensure that clients in need of a service will have access to treatment at the right time and place and by the right people to encourage successful engagement and ongoing treatment, which is appropriate to the individuals’ needs.

It is proposed by commissioners that the South London & Maudsley NHS Foundation Trust (SLaM) will act as lead provider and head the consortium.

We will create a single pathway to treatment, which will increase the numbers of people accessing services and lead to increased positive outcomes for the individual, whether that be abstinence, maintenance or a level of stability not previously attainable.

The Lambeth Treatment Model aims to:

• Improve the service user experience

• Develop a Consortium of current providers; the providers will work as one organisation with a single assessment, shared protocols and clear lines of management and supervision.

• Increase accessibility for those groups currently under-represented within Lambeth, by increasing access points and times for assessment and reducing the gaps and stages along the treatment pathway.
• Develop a single care plan which will begin at assessment and stay with the service user until they exit treatment

• Support the service user by ensuring quick access to treatment (or re-access) acknowledging that addiction can be a relapsing condition, and not making relapse a bar to good safe treatment interventions.

• Deliver on key social, clinical and organisational/partnership outcomes including TOPS, local safeguarding procedures and worklessness

• Ensuring best value and effectiveness of treatment

The Consortium approach will demonstrate that in response to increased demands and reduced funds, committed dedicated providers can work together to deliver a comprehensive safe, effective and innovative treatment system which will not be hampered by organisational boundaries.

2. Rationale

In response to the need to reduce unnecessary costs and increase the throughput and quality of Lambeth Addiction Services; whilst ensuring there are financially viable and effective services for service users, NHS Lambeth with Local Authority partners, will lead a remodelled and re-commissioned treatment service which will deliver the full range of interventions needed within a treatment pathway through to recovery.

This revised model has been informed by the stakeholder’s event on the 14th of January, meetings with the Service User Council, GPs and Provider organisations. The model is only the first informed draft, based on the information and consultation so far. This may change depending upon the outcome of the costing exercise and the level of efficiencies required; and the continuing consultation.

The following service model will be developed via Commissioner-led service remodelling (including a re-costing exercise) which would negate the need for whole scale re-commissioning of services, thereby ensuring a smoother transition without the destabilising effect of re-tendering of services.

All service provision needs to flow with clear seamless pathways to each area of delivery. The new service model needs to ensure that individual organisations do not hold onto service users unnecessarily or restrict their opportunity to access services provided elsewhere.

The new model will ensure those moving through the treatment system are not passed between or held up in different organisations: there will be a natural progression through the service; it will appear as one provider.
3. **Interim process**
All organisations will receive notification by the end of March 2010 on the anticipated 2010/11 funding for their part of the consortium.

Unless otherwise notified, organisations will be funded at the current level (without inflation uplift) until the end of June 2010. This is to attempt to support organisations through transition and enable the remodelled service to have a planned implementation. However, it may be a more stepped approach with some organisations where they are able to make savings and changes, prior to the end of June.

4. **How will efficiencies be met?**
The development phase of the new model will include estimating the costs of the service interventions including staff costs. The model will be planned in consultation with providers.

Who, how and where the services are delivered will be part of the remodel and therefore may face funding reductions.

The new service model will be developed and implemented by October 2010, with ongoing developments to enhance and establish the service.

5. **The Consortium**
It is proposed by Commissioners that the Consortium will be led by SLaM. The Consortium will work in an inclusive transparent way, where pathways and processes are clear to the service users, providers and commissioners, with all partners working to the same goals.

The service remodel will be implemented with the close scrutiny of the Joint Commissioning Group; which will ensure the organisations are fully unified in their delivery and operationally.

The consortium will need to be able to demonstrate their ability to manage the whole system and the sub-contractual arrangements with other provider partners.

The SMT within the Local Authority will be a partner organisation, continuing there statutory responsibilities under the NHS and Community Care Act.

Additional service providers that do not fall into the single pathway model, such as Trust will be initially managed via the commissioner and partnered to the consortium for the first 12-18 months of the new treatment service.

**Why SLaM to lead?**
SLaM is the largest treatment provider in Lambeth; with the experience of multi level service provision (e.g. contingency management; DRR; shared care, psychosocial interventions, specialist prescribing; therapeutic treatment and inpatients) and clinical responsibility and governance to lead a consortium.
This is also in response to recommendations contained in Andy Burnham’s (Health Secretary) statement in September 2009.

The Consortium panel will consist of senior personnel from each partner organisation and service user representatives, the panel will have the ability to make all key decisions. It will meet monthly, with ad hoc meetings when necessary.

Organisations represented on the Consortium Panel on a regular Basis:
SLaM (Consortium Lead)
Blenheim/CDP
London Borough of Lambeth
Foundation 66
Mainliners
SUC Members
Commissioning lead
Ad hoc membership
JCM
DAT Manager
DAT Performance & data Manager
Criminal Justice Lead

6. Monitoring and Governance

Initially the delivery of the new model will be closely monitored with regular monthly meeting which will be commissioner led.

After the first 6 months of the new model being operational there will be Quarterly performance monitoring meetings where the consortium lead will be responsible for ensuring that appropriate representation is provided at agreed partnership working groups.

A Governance structure for the revised system will be developed in conjunction with all parties to ensure the effective development of the system and corresponding interfaces with other service areas.

7. Workforce

It is expected that all staff appointed have a satisfactory Criminal Records Bureau (CRB) assessment, are appropriately inducted into employment and trained, as a minimum, in all matters relating to Health & Safety, governance and skills training to standards agreed with the commissioner (for example NVQ 3/4). All staff requiring a clinical qualification and membership of a professional body is checked for the validity of that qualification and membership.

Training
The Consortium model presents an opportunity to develop cross-borough training opportunities through pooling resources and expertise previously located within individual service providers. A key priority for training is a focus on psychosocial skills to implement the recovery agenda. Training should be linked to practice-based supervision to consolidate the skills learnt.
8. The Service Delivery Model
The following model is not an exhaustive list of all interventions; the detail of all interventions will be agreed and highlighted once the overall model is accepted.

The service will be a single pathway for all drug and alcohol, enabling equity of provision with increased accessibility for all alcohol and drug service users.

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Recovery
Supporting and developing the service user in their recovery will be continuous and begin at the initial contact with the treatment system, wherever that may be. All workers will have a responsibility to consider reintegration and longer term recovery management and to start this process. This will be driven through high-quality care planning and the use of mapping tools developed from ITEP, BTEI and NTA-led recovery initiatives. In addition, there will be a recovery management team that will develop expertise and have responsibility for co-ordinating all related recovery functions, including: Aftercare, Day programmes, support groups, Psychology, rehabilitation and personalisation.

The management team will have a role in ensuring a high standard of recovery orientated interventions across all provider organisations: provide specialist support and evidence-based NICE recommended interventions; non prescribing interventions in line with the recovery agenda; with the aim of ensuring clients engage with mainstream services as well as developing cost-effective long-term recovery support structures. The figure below illustrates how the recovery element works into and across all the areas whilst also
Draft for comment

maintaining a separate identity; necessary to preserve the integrity of this important element of the new service model.

Recovery related activities defined in care pathways for each part of the service
Specialist recovery support accessed through stepped care from these parts of the service
Day programmes and groups
The current provision includes:

Latch House: Tier 4 supported housing for Primary crack using men from prison, with a day programme and activities for the residents. The average stay is 6 months?

Rise: Shared Lambeth and Southwark service which has 9 spaces available for Lambeth for men and women. It is not an abstinence service.

Lambeth Harbour: Relapse Prevention, Art Therapy, Life Skills; Physical health group; CBT Group; Prison post release group

Lorraine Hewitt House: Relapse Prevention; Parenting classes; Art therapy

Choices: Motivation, Creative expression, relapse prevention and health education

Aftercare: Ad hoc creative groups – e.g. creative writing, Film and art.

SMT: pre-detox groups & rehabilitation - The SMT will work in partnership with the consortium under the specialist recovery umbrella, the review of the capacity to support the personalisation agenda will be a key deliverable within the first year of the consortium forming.

The services all run independently and there is currently no overall management to ensure standardisation and quality

Once under the umbrella of recovery, this should ensure equity and potentially increased capacity
Assessment and Treatment:

Assessment
There will be a common assessment tool with a minimum data set for drug and alcohol which will be completed at the first entry into treatment and will be accepted by all parties to service provision. The assessment will include the highest level of information required including an initial discussion on steps to recovery.

The care plan will begin at the first assessment.

Training will be run to ensure all workers are delivering to the same (high) standard.

The Assessment and treatment will be delivered at:
- GP practices by shared care staff; this will be mainly through booked appointment, with a smaller number being held as open assessment clinics.
- Lorraine Hewitt House - will run an open Assessment service 5 mornings a week
- Lambeth Harbour - will run an open Assessment service 3 afternoons/evenings a week

Treatment
“Treatment” is not limited to medical interventions, we will be refocusing service delivery to ensure service users get the psychosocial interventions they need.

Within the first 3 weeks the service user will be: vaccinated and tested; have a full health and psychological screen. Within this initial treatment phase the service user will start the appropriate treatment which may include:

- Psycho social interventions
- Titration
- Community detox (drug and alcohol)
- Referred to inpatient (via the Borough Consultant)
- Continuing care team (complex needs)
- Offered appropriate recovery and support packages (see Specialist recovery section)

Within 12 weeks all service users that have entered treatment should be either within primary care or the Continuing care team.

Shared Care
Shared care will operate with 3 levels of support for service users; all service users within shared care will be given information on and supported to attend groups and specialist support on offer in the borough from the beginning of their treatment.

Shared care will be for all drugs including alcohol. We will look to trial community alcohol detox with the support of trained pharmacists
breathalysing and dispensing detox medication: this would be a developmental piece of work which would need a lead-in time of 6 months to support Pharmacists.

We will also look to trial evening sessions for functioning users who are in need of early stage support, e.g. occasional crack /cocaine users and/or problem drinkers. This may also attract young adults who would attend the GP but would not be appropriate for the specialist services.

Crack cocaine users attending the GP practice can be treated through shared care if assessed as appropriate and not in need of the complex care. Interventions would include health screens and review to ensure they are linked into the appropriate service if they lapse, or are in need of more intensive support.

**Intensive:** For those new into treatment or recently stabilised and entering shared care; weekly support and treatment with the GP and Nurse/Drugs worker.

**Intermediate:** For those who are not seen as high risk and have an established treatment regime which they are adhering to recently transferred from a specialist service: monthly review and support with the Nurse/drugs worker; 2 weekly observations with the practice nurse or GP.

**Review:** For those established in treatment and want to engage in less intensive interventions and have achieved some sort of stability, they will receive 3 monthly review by a nurse/drugs worker and monthly observations by a practice nurse or GP. They can however contact services to opt back into more regular key working by contacting one of the Consortium services.

**Development:** All nurses will be required to take bloods and vaccinate: this will be a stepped development to enable staff to receive appropriate training.

**Complex needs**
There will be two centres where specialist interventions are delivered - Lorraine Hewitt House and Lambeth Harbour.

Service users who will be treated through this part of the service include:

Complex cases - dependent on level of severity, e.g. dual diagnosis, poly drug use, mental health issues; Family issues, such as child protection.

There will be the ability for any part of the service to divert service users to this part of the service if a more complex need becomes evident after treatment in another domain has began.
**Harm Reductions**
Lambeth have a mobile harm reduction bus, which will be used by the partnership organisation within the consortium, the times and location of this service will be reviewed and developed after consultation.

Harm reduction initiatives are still integral to this model and will be included within the recovery priorities.

When a review of the buildings with costs and use is completed it may be necessary for some groups to evolve and be delivered from different venues this will be negotiated and discussed with service users and providers.

**Developments**: Volunteer and service user led services, with the service user council look into the viability of service user and volunteer run groups; It is hoped that by mid march this research would have been completed and we will have a firm proposal for the development of a service user led element to our treatment delivery.

We will have a menu of provision and interventions available for service users including psycho social interventions and group programmes.

We will aim to develop increased day provision for crack users

We will be supporting service users in accessing mainstream services, to support there ongoing recovery.

**Inpatient**
We will work on the implementation and enhance the inpatient protocols. Whilst one of the most costly elements of treatment, it is still an essential requirement. We will work towards earlier interventions and increased community detoxification and stabilisation. However, the need for good clinically safe inpatient treatment is an essential element to any drug and alcohol treatment service.

As part of this remodel we will look to develop in partnership with providers, care packages which will be focused specifically on the treatment and potentially reduce the length of stay and thereby cost of each inpatient stay. This would need to be managed in partnership; as in some cases it may mean a more intensive community support is required on exit from detox.

**Risks**: This has to be in collaboration with other boroughs as it would not be feasible for providers to change there working for one borough.

**Timescale**: The changes may take 6 months from the agreement of the packages of care – taking us to January 2011.
**Actions**: develop packages of care and discuss at ‘7 Boroughs Meeting’.

**Role of service user groups**
The service user council in Lambeth is an essential tool for monitoring and developing treatment. The Council may over the time of the pilot change to reflect the different elements of treatment rather than be service based – in line with the new model and consortium approach.

There will be service user representation on the consortium board.

In line with the recovery agenda Lambeth need to review its capacity to offer work experience with a view to future employment

**Additional services:**
- Tendering of Peer support service for the borough.
- Volunteer led services

**9. Conclusion**
There is broad agreement from stakeholders and providers on the remodelling of the services in a single integrated pathway.

We are embarking on a new and exciting way of developing service provision, which will require the commitment and support of all stakeholders. Statutory and non statutory services will be working under one umbrella with health and social inclusion agenda united.

The new integrated pathway will give service users a clearer outline of their progression, with support to enter mainstream generic provision.