Somerset

Adult Drug Treatment Plan - community and prisons 2011/12

Planning Framework

Glossary

JCM	Joint Commissioning Manager
DC	DAAT Coordinator
DA	DAAT Administrator
SMCPC	Substance Misuse Coordinator in Primary Care (Shared Care Coordinator)
PIU	Partnership Intelligence Unit
TP	Turning Point
CAP	Community Access Programme
TP AM	Turning Point Area Manager
TP SM	Turning Point Service Manager
CAP TL	Community Access Programme Team Leader
HMP SM	HMP Shepton Mallet
HCM	Health Care Manager
ATCG	Adult Treatment Commissioning Group
SCMG	Shared Care Monitoring Group
DSG	HMP Shepton Mallet Drugs Strategy Group
PHPB	HMP Shepton Mallet Prison Health Partnership Board
IOM	Integrated Offender Management
DIP	Drugs Intervention Programme

Planning Section 1: Commissioning for positive outcomes

Please see checklist at Appendix 1 of the 2011/12 treatment plan guidance for possible areas to include within this planning grid

Identification of key priorities following needs assessment relating to commissioning system:

Somerset benefits from a strong DAAT Partnership. Locally, there remains a commitment to drug and alcohol treatment, and a recognition of its benefits, even in the difficult and transitional local financial and organisational environment. This will be monitored closely to ensure partners commitment and funding is maintained for the years ahead, supported by the use of newly developed tools (Such as the NTA value for money calculator).

The commissioning structures in Somerset are in a good position, with well established engagement of key stakeholders and the developing Service User consultation group in progress. Some actions from the 2010-11 Adult Drugs Treatment Plan will be carried forward, notably better formal engagement with Job Centre Plus, a functioning providers forum and a mechanism for Carers and concerned others involvement in commissioning.

These structures have been supported over the past year by the DAAT's improved data management and evaluation function, delivered through the Partnership intelligence Unit. This function requires further development in enabling the DAAT to have a consistent awareness of service performance information. As identified in the needs assessment, for this to be meaningful, the quality and consistency in the data being collected must be improved. This is particularly important in relation to Hidden Harm (information relating to substance misusing parents), TOP completion rates, information recorded through Job Centre Plus and that relating to inpatient detoxification.

Further challenges have emerged over the past year in relation to information sharing, which require quick resolution. In particular there have been obstacles around the process in relation to substance misusing parents and DIP / IOM. Changes in the way DIP data is processed provide some opportunity, but will have to be carefully managed to avoid errors.

Action planning around the way DIP is operating, as identified in the needs assessment, is underway. Somerset is making progress by clarifying the specific resources used within DIP, but further work is needed from all partners with the emergence of IOM. In terms of commissioning, there is a continued need to ensure that DIP is utilised effectively and is fully engaged with other aspects of IOM work.

IDTS commissioning systems are supported by the Prison Drugs Strategy Group and the Prison Health Partnership Board. To ensure that best outcomes are delivered and value for money achieved, these structures will need to be reviewed over the course of the year. Links have been established to the Adult Treatment Commissioning Group and the DAAT Board to do this.

Somerset continues to deliver a significant programme of training, particularly for the wider workforce around alcohol brief interventions. The DAAT will continue to commission targeted drugs training: for children and family services to understand adult drug use, for mental health services to progress Dual Diagnosis joint working and other priority groups as they emerge. On top of this the DAAT continues to give its support to Turning Point for the roll out of training to underpin the new recovery focused model of treatment which will "be live" during 2011-12. The delivery of effective workforce improvement will continue to be monitored through service audit in 2011-12.

This training need outlines the most significant outcome for Somerset in 2011-12 i.e. an increase in the number of successful completions. The DAAT needs to adapt its commissioning structures to ensure that an agreed numerical target (proposed to be 156) of successful completions is met and that resources are attached to delivering this.

Expected outcomes 2011-12:

1. DAAT partners have confirmed their funding commitments for 2011/12 and indicated as far as their financial planning allows commitments to 2013/14
2. Formal engagement mechanism is agreed with Job Centre Plus (such as attendance at Adult Treatment Commissioning Group) and with Carer and concerned other support services.
3. Effective provider's forum, with representation from service users and carers, which "owns" delivery of this treatment plan and specifically includes Hidden Harm on its agenda.
4. Partnership Intelligence Unit delivers "real time" performance information to DAAT commissioning team, including analysis of data quality which enables improvement planning with providers.
5. Accurate activity and performance information is produced by Job Centre Plus, Somerset Partnership (for inpatient detox use) and Turning Point (particularly information relating to parents and TOPs completion).
6. An effective Information Sharing Protocol is agreed between Turning Point, the DAAT team and Children & Family services to enable sharing of information relating to parental substance misuse.
7. An effective Information Sharing Protocol is agreed between Turning Point, Avon and Somerset Police, Avon and Somerset Probation Trust and the DAAT team to support the delivery of DIP as part of IOM.
8. Clear resources are used specifically for DIP and activity levels (which are accurately and easily monitored) reflect these resources
9. IOM systems and expectations are transparent and DIP is delivered as part of this system, including the involvement of DIP workers in caseload identification.
10. Best use is made of IDTS resources, as communicated through performance information, the Drugs Strategy Group and the Prison Health Partnership Board and approved by the DAAT
11. Turning Point deliver training for their staff on the recovery focused treatment model, and this is evidenced through the DAAT's service review
12. DAAT commissioned training around adult drug use is delivered for Children and Family services staff, mental health service staff and other staff from the wider workforce to support the wider understanding of the needs of drug users and the adult drugs treatment system

Expected outcomes 2012-13 and 2013-14:

Delivery Plan for 2011/12:

Key milestones	**By when**	**By whom**
1.DAAT partners have confirmed their funding commitments for 2011/12 and indicated as far as their financial planning allows commitments to 2013/14		
a) Discuss partners commitments for 12/13	February 12	DAAT Chair
b) Ensure representatives of GP Commissioning Consortia are included in the DAAT when they are established in shadow form	March 12	DAAT Chair
2. Formal engagement mechanism is agreed with Job Centre Plus (such as attendance at Adult Treatment Commissioning Group) and with Carer and concerned other support services.		
a) Establish a twice yearly carer / significant other group, and agree through this, representation at the ATCG	June 11	JCM
b) Establish regular liaison meetings between the DAAT and Job Centre Plus in light of JC+ staff restructuring	June 11	JCM
c) Agree a representative of Job Centre Plus to attend ATCG	June 11	ATCG Chair
3. Effective provider's forum, with representation from service users and carers, which "owns" delivery of this treatment plan and specifically includes Hidden Harm on its agenda.		
a) Complete first 6 monthly intake of Somerset DAAT Service User Consultation Group	June 11	JCM
b) Establish involvement roles with Service Users from first intake, establish regular wider consultation group (3 monthly or 6 monthly), and recruit to second six monthly intake	July 11	JCM
c) Deliver providers forum with this treatment plan as a core part of the agenda	April 11	JCM

d) Establish Hidden Harm as part of the provider's forum agenda, with representation from services working with children & families and safeguarding issues to progress the actions set out Somerset's Hidden Harm strategy.	April 11	JCM
4. Partnership Intelligence Unit delivers "real time" performance information to DAAT commissioning team, including analysis of data quality which enables improvement planning with providers.		
a) Agree protocol for Turning Point to supply PIU with NDTMS extracts prior to upload	April 11	JCM / Turning Point Area Manager / PIU
b) Agree format for interrogation and reporting of this data to inform performance monitoring, in particular noting blank fields and TOP completion	April 11	JCM / DAAT Co-ordinator / PIU
c) Agree data set to be collected from other agencies (Police, Probation, County Council and health services) and implement system of collection by the PIU and reporting to the DAAT team	June 11	JCM / DAAT Co-ordinator / PIU
5. Accurate activity and performance information is produced by Job Centre Plus, Somerset Partnership (for inpatient detox use) and Turning Point (particularly information relating to parents and TOPs completion)		
a) Review data collected by JC+ advisers (substance misuse flags and use of TPR 1 and TPR 2) and support the delivery of joint training to advisers if required for correct identification.	September 11	JCM / JC+ Lead
b) Somerset Partnership to report on the use of their inpatient detox beds to NDTMS	July 11	ATCG Chair / JCM / Som Par Lead Manager
c) Use the analysis of Turning Point data extract to produce exception report relating to blank parental fields and use this information in the contract review process	July 11	PIU / JCM / DAAT Co-ordinator
d) Use the analysis of Turning Point data extract to produce an immediate TOPs completion rate report, so that non-compliance can be picked up and addressed with Turning Point. Review TOP outcomes to inform ATCG reporting.	July 11	PIU / JCM / Turning Point Service Manager
6.An effective Joint Working and Information Sharing Protocol is agreed between Turning Point, the DAAT team and Children's Social Care to enable sharing of information relating to parental substance		

misuse		
a) DAAT to develop agreed set of information to share between Turning Point and CSC	May 11	DAAT Co-ordinator
b) Ensure that a joint working and information sharing protocol is agreed specifically between Turning Point and Children's Social Care as an addition to the agreed Somerset multi-agency protocol on working with substance misusing parents	July 11	Turning Point Service Manager / CSC lead / JCM
7. An effective Information Sharing Protocol is agreed between Turning Point, Avon and Somerset Police, Avon and Somerset Probation Trust and the DAAT team to support the delivery of DIP as part of IOM		
a) DIP Action Plan Group Chair to ensure that all partners agree to ISP	May 11	DIP Action Plan Group Chair
b) Review the use of ISP in providing effective targeting and support to those identified through IOM	September 11	DIP Action Plan Group Chair
8. Clear resources are used specifically for DIP and activity levels (which are accurately and easily monitored) reflect these resources		
a) Ensure that the investment schedule produced for DIP reflects an actual amount of allocated worker time, including time spent engaging with service users through the Courts and on – release from prison. Utilise service audit to review this.	June 11	JCM / Turning Point Service Manager
b) Commission the capacity for data entry of DIR forms within the DAAT / PIU team and use this process to provide regular monthly updates on activity levels	April 11	JCM
c) Review need for, and implement training as required, on "identification" for Police (and Probation) staff	August 11	JCM
d) Agree activity level ambitions with Turning Point, monitor performance to these levels and report to ATCG and in contract monitoring meetings, with revisions to actions agreed at DIP Action Plan Group if performance ambitions not met.	May 11	JCM Turning Point Service Manager ATCG Chair DIP Action Plan

		Group Chair
9. IOM systems and expectations are transparent and DIP is delivered as part of this system, including the involvement of DIP workers in caseload identification.		
a) Ensure Somerset DIP is linked strategically and operationally with Somerset IOM to ensure that delivery is co-ordinated	April 11	JCM / DIP Action Plan Group Chair / IOM lead
b) Support the Somerset Community Safety Partnership in its oversight of the Somerset Reducing Reoffending Strategy incorporating IOM including DIP	July 11	Somerset Reducing Reoffending Lead
c) DIP Action Plan Group to ensure that DIP staff are involved in the IOM tasking meeting	June 11	DIP Action Plan Group Chair
d) DIP Action Plan Group to continue to monitor the interface between DIP and IOM	Quarterly to March 12	DIP Action Plan Group Chair
10. Best use is made of IDTS resources, as communicated through performance information, the Drugs Strategy Group and the Prison Health Partnership Board and approved by the DAAT		
a) Review the use of these groups to drive IDTS performance and maintain governance	September 11	JCM
b) Continue to exception report on IDTS performance to ATCG	Quarterly to March 12	JCM
11. Turning Point deliver training for their recovery focused treatment model, and this is evidenced through the DAAT's service review		
a) Turning Point to complete training on MoPSI and commence delivery	April 11	Turning Point Service Manager
b) DAAT JCM to undertake service audit	November 11	JCM
12. DAAT commissioned training around adult drug use is delivered for staff working with children & families, mental health service staff and other staff from the wider workforce to support the wider		

understanding of the needs of drug users and the adult drugs treatment system		
a) Establish a delivery programme with both children's social care and mental health staff for 2011/12	June 11	JCM / DC
b) Use the providers forum to assess other relevant sectors to target with training	Ongoing	Provider Forum Chair

Other Comments/Updates:

Planning Section 2: Maintaining and improving access to treatment

Please see checklist at Appendix 1 of the 2011/12 plan guidance for possible areas to include within this planning grid

Identification of key priorities following needs assessment relating to access to the drug treatment system:

Needs assessment has identified that waiting times for first interventions are almost always under 3 weeks for community treatment with the majority of those accessing inpatient and residential treatment having already been through the community services for a period of time. The exception to this may be non-PDU drug users (users of other drugs than heroin or crack cocaine). Those non-PDU's approaching the service that do not have additional risks may be waiting for such a length of time to have not featured in the needs assessment data set.

Whilst it is not clear how far this reflects the drug using population, rather than the general population in Somerset, there may be an issue with access to treatment for women and those from a BME background. Establishing links with key equalities focussed services locally will enable a greater understanding of use of substances by these population groups.

There were 30% more referrals into treatment in 2009/10 than 2008/9. With low numbers leaving, this creates some concern about the capacity of the system and potential increase in waiting times. The configuration of the service is generally perceived to promote access. The majority (58%) of referrals are self referrals, which is considerably greater than the regional (18%) and national (40%) averages. This is likely to be a reflection of Turning Point's direct access service. Feedback from the needs assessment consultation group indicated that although organisations may still be referring people to the same extent, due to Turning Point's 'walk in' policy, people arriving at the service are not always easily distinguished by their source of referral.

It is possible that this issue has also affected the accurate recording of DIP treatment entries. The level of recorded DIP activity has been significantly lower than expected, and is contradictory between different sources. It is clear that a number known to DIP through prison have not gone on to access treatment in the community. This will be considered in revising the DIP system in light of IOM and to ensure consistent delivery of the DIP operational handbook. Work to link prescribing treatment to IDTS treated prisoners on release will be built on. Advocacy and mutual aid services for drug users in HMP Shepton Mallet may require some development.

It is clear that the development of separate premises for the delivery of the CAP service for those that are abstinent will promote the uptake and access to aftercare. Whilst inpatient detox and residential rehab are available through Turning Point, and have seen a significant increase in use over the last year, clear information about availability and access routes must be available to people at all points in the treatment system.

Expected outcomes 2011-12:

1. Maintain waiting times with 96% or more first treatment entries accessing under 3 weeks
2. Develop effective service for low risk non-PDU drug users, outside the capacity of the treatment service for PDU's
3. Clarify true patterns of referral to Turning Point through accurate data recording
4. DIP delivers 20 new treatment entries per month as evidenced through DIRWeb and matched to NDTMS data
5. Information on, and active support of access to, advocacy and mutual aid services is available at all drugs treatment locations, including those in HMP Shepton Mallet
6. Enhance the DAATs understanding of the patterns of drug and alcohol use in Somerset's BME and female population, including those women in HMP Eastwood Park
7. Numbers entering inpatient detox and residential rehab remain at least at 10-11 levels, and information about access is available at all points in the treatment system
8. At least 200 people access the CAP service over the year to develop independent recovery skills and access support for education training or employment.

Expected outcomes 2012-13 and 2013-14:

Delivery Plan 2011-12:

Actions and milestones	By when	By whom
1. Maintain waiting times with 96% or more first treatment entries accessing under 3 weeks		
a) Monitor waiting times as part of contract review process with Turning Point	Quarterly	JCM
b) Complete review of all in treatment for over 104 weeks, in order to promote successful completions and create capacity for new entries	August 11	JCM/ SMCPC / TP SM
2. Develop effective service for low risk non-PDU drug users, outside the capacity of the treatment service for PDU's		
a) Further scope the need for treatment support to non-PDU drug users	May 11	JCM / PIU
b) Develop additional service brief in light of above, within existing resources and utilising mutual aid support as well as considering commissioned services	June 11	JCM / ATCG
c) Publicise available services to non-PDU's in light of above	July 11	JCM / Treatment providers
3. Establish true patterns of referral to Turning Point through accurate data recording		
a) Scope the need for training around referral sources, and investigate the integration of this into the MoPSI model of treatment and training	April 11	TP SM
b) In light of above and the re-configuration of the DIP service, deliver training as needed for DIP workers and treatment staff to ensure that the process of DIP referral is understood and DIP referrals are recorded accurately on both DIRWeb and NDTMS systems	June 11	JCM / TP SM
c) Monitor referral information through contract review	Quarterly	JCM

4. DIP delivers 20 new treatment entries per month as evidenced through DIRWeb and matched to NDTMS data		
a) Commission DIP training on “Identification” as defined in the DIP Operational Handbook to Police and Courts staff (and CARATS staff at HMP Shepton Mallet if reviewed as necessary)	April 11	JCM / ASC DIP Lead
b) Ensure that DIP is delivered through clearly identified, ring-fenced provision in Turning Point, which includes specific capacity to meet and intervene with drug users coming through the Courts and leaving prison, in line with the DIP operational handbook	June 11	JCM / DIP Action Plan Group Chair / TP SM
c) Deliver “green” ratings on all actions on the DIP Action plan	September 11	DIP Action Plan Group Chair
d) Monitor DIR forms being input through PIU in real time for monthly performance updates, feeding into quarterly contract reviews	Monthly from April 11	PIU / JCM
e) Review and develop actions as required based on performance information	Quarterly from April 11	JCM
5. Information on, and active support of access to, advocacy and mutual aid services is available at all drugs treatment locations, including those in HMP Shepton Mallet		
a) Review available information at all sites	May 11	TP SM / SM HCM
b) Contact AA, NA, CA and MA in order to understand if the DAAT can support increasing the available number of self help meetings in the county	April 11	JCM
c) Gather new resources and display	May 11	TP SM / SM HCM
d) Use the proposed Recovery Day to promote mutual aid services and gather any new material available	September 11	JCM
6. Enhance the DAATs understanding of the patterns of drug and alcohol use in Somerset’s BME and female population, including those women in HMP Eastwood Park		
a) Develop links with Somerset’s BME groups (MECA, SREC, BDA) to identify a process to:	Ongoing (as in	PIU / JCM / DC

• Understand needs of adults in relation to substance misuse • Assess the drugs/alcohol training needs of staff including volunteers working in these organisations • Establish data collection system between these organisations, PIU, & DAAT • Establish pathways between these services and specialist drug and alcohol treatment services	Young People's treatment plan)	
b) Develop a fuller understanding of the needs of female drug users in Somerset through a review of the available data including the data available from HMP Eastwood Park	August 11	JCM / PIU
7. Numbers entering inpatient detox and residential rehab remain at least at 10-11 levels, and information about access is available at all points in the treatment system		
a) Monitor the numbers entering detox and rehab and report on this at least bi-annually to the ATCG	September 11	JCM
b) Ensure that information about access to detox and rehab is given out at all points in the treatment journey, and review this at service audit	To be reviewed in November 11	TP SM / JCM
8. At least 200 people access the CAP service over the year.		
a) Ensure that CAP is promoted within the treatment system, in line with the MoPSI treatment model	May 11	TP SM / CAP TL
b) Monitor the numbers and demographics of those accessing CAP through contract reviews	Quarterly to March 12	JCM

Other Comments/Updates:

Planning Section 3: Delivering recovery and progress within treatment

Please see checklist at Appendix 1 of the 2011/12 plan guidance for possible areas to include within this planning grid

Identification of key priorities following needs assessment relating to recovery and effectiveness of the drug treatment system:

The primary challenge for the treatment system identified in the 2011 Adult Drugs Needs Assessment is the large number of people in treatment for more than 2 years and the low rate of successful completion that the system currently delivers.

In particular, a specific piece of work should be undertaken to review those individuals in treatment for over 4 years. Tailored interventions require development to support them to move through and out of the treatment system, as they are largely both self reporting, and evaluated as, receiving little benefit from their current treatment.

A further programme of work should be developed for those individuals in treatment for 2-4 years to ensure that they are offered sufficient support (especially those in shared care) and receive sufficient opportunities, particularly for psychosocial input to make progress in reducing their "on-top" illegal drug use.

To respond to the above priorities, further development will be made in the use of outcomes in the commissioning system. This will particularly useful in assisting the progress of those in GP shared care.

The "Hidden harm" strategy should continue to develop the work in improving the pathways of support given to parents. In particular correct identification and recording of parental status by Turning Point is needed to support this.

A specific approach to working with 16-24 year olds should be considered. These individuals are more likely to have complex needs, more likely to be arrested and more likely to have acute housing problems, yet are decreasingly likely to enter treatment with Turning Point.

A review of the use of general psychiatric beds for inpatient detox should be undertaken given the improved outcomes for those undergoing detox in "non-medical" environments.

Appropriate use of the resources for IDTS in HMP Shepton Mallet should be made to ensure that those with long term dependence on opiate based painkilling medication and with histories of alcohol dependence receive the service they require.

Annual service audit will be undertaken t ensure that care planning is of good quality and consistent in its application, is sufficiently challenging in terms of goal setting and that service users have ownership of it. In particular review will focus on the continuity of care from prison into treatment (where needs assessment has indicated that significant drop out occurs).

Recovery in treatment will be supported by a range of healthcare input. Treatment services will continue to provide general healthcare assessments, access to Hepatitis B and C testing and Hep B vaccination and provide support for those in treatment to access most commonly related specialist healthcare (Hepatitis C treatment and smoking cessation in particular).

The support needs of carers of those with substance misuse problems will continue to be met through the commissioned provision within Turning Point and that delivered by the In-Touch project. The DAAT will review the delivery of carer's assessments and groups by Turning Point at contract review meetings, and bring together a bi-annual meeting of those agencies working with carers.

Work with Job Centre Plus and other partners in delivering education training and employment opportunities for drug users will continue, with the effective joint working opportunities offered by the national partnership agreement made "live" in Somerset. A written strategic plan, with partners sign up, will be delivered covering this.

The DAAT will also need to take account of the wider changes in public sector funding in relation to supported housing provision. It has worked closely over the last few years with supported housing and work is already in hand to be a part of the remodelling of service provision for socially excluded groups (which covers drugs/alcohol/offenders/mental health) and despite this being about managing budget reductions it does create opportunities for increased joint commissioning with Somerset County Council for supported housing services.

More work needs to be done to deliver an effective service to those with a dual diagnosis. Both the level of specialist input and the criteria operated by mental health services and substance misuse services will need to be revised in light of the new Dual Diagnosis working protocol. Sufficient monitoring of the implementation of this will need to be made to ensure that drug users have access to both secondary mental health services and IAPT.

Expected outcomes 2011-12:

1. Implementation of MoPSI within Turning Point, delivering an evidenced and effective recovery orientated treatment system
2. Reduction in the percentage of the treatment population in treatment for more than 4 years to under 15%
3. Reduction in the percentage of the treatment population in treatment for more than 2 years to under 35%
4. Benefits of treatment are evidenced through consistent TOPs completion
5. Hidden Harm strategy is delivered effectively by all agencies working together with drug using parents, and Turning Point records are able to provide information which support this view
6. A specific approach to working with 16-24 year olds is evaluated and implemented as appropriate
7. Review of the use of general psychiatric beds for inpatient detox is undertaken and the most effective provision of inpatient detox is commissioned
8. GP Shared Care is developed in a strategic way which meets the needs of the treatment system, including geographical location, and is linked to the delivery of MoPSI

9. Pharmacy services are delivered in a way which provides the most effective level of service
10. An appropriate strategy is in place for those in HMP Shepton Mallet with long term dependency on painkilling medication, taking into account the potential implications of methadone treatment for parole
11. Psycho-social alcohol treatment is co-ordinated and delivered with both prison, healthcare and CARATs staff in HMP Shepton Mallet
12. Care planning is evaluated as effective and consistent, and continuity of care from prison to community is clear
13. Improve the uptake of Hepatitis B and C testing and Hep B vaccination to 90% for all those entering treatment, and support access to a range of relevant healthcare including Hepatitis C treatment and smoking cessation
14. Continue to plan and co-ordinate to meet the support needs of carers of those with substance misuse issues
15. Deliver a written strategic plan to increase access to education, training and employment for drug users
16. Increased direct involvement in the commissioning of supported housing provision locally.
17. Effective dual diagnosis services are delivered, including an appropriate level of specialist input and clear access for drug users to both IAPT and secondary mental health services.

Expected outcomes 2012-13 and 2013-14:

Delivery Plan:

Actions and milestones	**By when**	**By whom**
1. Implementation of MoPSI within Turning Point, delivering an evidenced and effective recovery orientated treatment system		
a) Fully roll out the MoPSI Programme, including all groups and materials	June 11	TP AM / TP SM
b) Monitor the delivery of MoPSI through both data reporting and performance information at	Quarterly to	JCM

quarterly review meetings	March 12	
c) Review effectiveness of MoPSI through clinical audit, service users feedback and TOPs information	January 12	JCM
2. Reduction in the percentage of the population in treatment for more than 4 years to under 15%		
a) Undertake review with Turning Point staff of all those in treatment for more than four years on a case by case basis, identifying any patterns or unmet need	October 11	TP SM / JCM
b) Review the Shared Care agreement with GPs, and Turning Point to establish a pathway for care of those in prescribing treatment for over 4 years requiring no other drugs treatment input by their GP, including a fast track access back into the specialist service if required	August 11	JCM / SMCPC
c) Ensure MoPSI process of treatment delivery by Turning Point identifies the needs of those in treatment for 4 years plus in the segmentation process, by reviewing the segmentation information	October 11	JCM / TP SM
d) Review the proportion of people in treatment 4 years plus, including their location and service modality, at contract review meetings from NDTMS data	Quarterly from April 11	JCM
3. Reduction in the percentage of population in treatment for more than 2 years to under 35% by March 12		
a) Review the proportion in treatment for 2-4 years in tandem with the segmentation process and roll out of MoPSI programme	September 11	TP SM / JCM
b) Ensure treatment delivery by Turning Point identifies the needs of those in treatment for 2-4 years in the segmentation process, and this is evidenced through a decrease in this cohort remaining in treatment and increase in successful completions, demonstrating gains from treatment.	September 11	JCM / TP SM
c) Review the proportion of people in treatment 2-4 years, including their location and service modality, at contract review meetings from NDTMS data	Quarterly from April 11	JCM

4. Benefits of treatment are evidenced through consistent TOPs completion		
a) TOPs completion remains at over 85%, and is monitored on a monthly basis through DAAT / PIU information management structures (through analysis of extracts provided by treatment agencies)	Quarterly from April 11	PIU / JCM
b) TOPs outcome reports are used at contract review and delivered to ATCG to evaluate the outcomes of the service, in conjunction with successful completions measure	Quarterly from April 11	JCM / ATCG Chair
5. Hidden Harm strategy is delivered effectively by all agencies working together with drug using parents, and Turning Point records are able to provide information which support this view		
a) Ensure agreement to the Hidden Harm strategy from all partners	June 11	DC
b) Deliver the action plan associated with the strategy – monitor delivery of the strategy and report progress via DAAT and LSCB	As action plan	DC
c) Ensure ISP in place with Turning Point to promote joint working as agreed in the strategy	June 11	PIU / TP AM
d) Use information provided by Turning Point to PIU to monitor recording around parental information at contract review meetings	Quarterly from April 11	JCM
6. A specific approach to working with 16-24 year olds is evaluated and implemented as appropriate		
a) Complete further review of the treatment needs of 16-24 year olds in Somerset, including reviewing the effectiveness of the new configuration of the Young People's substance misuse service, needs identified through Supporting people commissioned services and information from Turning Point	December 11	PIU / DC / JCM
b) Analyse information base of effective services for working with 16-24 year old drug users, and in light of above, produce commissioning intentions to address the needs of this group	February 12	DC / JCM
7. Review of the use of general psychiatric beds for inpatient detox is undertaken and the most		

effective provision of inpatient detox is commissioned		
a) Establish process for reporting information on the use of the detox beds on Rowan and Rydon wards by Somerset Partnership to the DAAT and through NDTMS	June 11	JCM
b) Review contract for use of beds with Somerset Partnership	September 11	JCM / ATCG Chair
c) Based on above information, along with information in the needs assessment, develop a commissioning strategy for 12-13 and onwards to commission the most effective inpatient detox facility	December 11	JCM
8. GP Shared Care is developed in a strategic way which meets the needs of the treatment system, including geographical location, and is linked to the delivery of MoPSI		
a) Produce an action plan to implement the actions identified in the Uni of Bath evaluation of Shared Care in Somerset and report the progress of these actions to ATCG	Quarterly at ATCG meetings	SMCPC
b) Agree a future commissioning strategy for Shared Care which delivers resources to progress drug users through treatment and encourages strategic surgeries to join the scheme without resources being used where not needed – as stated in the Shared Care Action Plan	June 11	SMCPC / SCMG Chair
c) Establish a pathway for access to psychosocial interventions for those in Shared Care as part of the MoPSI roll-out, and circulate this to all partners in the Shared Care scheme	May 11	SMCPC / TP SM
d) Renegotiate LES with LMC in light of the above	October 11	JCM / SMCPC
9. Pharmacy services are delivered in a way which provides the most effective level of service		
a) Undertake a review of the need and scope of pharmacy needle exchange services in light of information about patterns of use moving from pharmacy to Turning Point	August 11	SMCPC / DA
b) Based on review, commission revised contract with needle exchange suppliers	September 11	JCM / SMCPC
c) Also based on review, renegotiate SLA with LPC for pharmacy needle exchange, to move away from “any willing provider” model to DAAT distinguishing strategic locations for services	September 11	SMCPC / JCM
d) Produce reports on the levels of supervised consumption being claimed by pharmacies and	August 11	DA / SMCPC / TP SM

contrast with the information provided by Turning Point (particularly in light of changes via MoPSI)		
e) Undertake a quality review of pharmacy services	March 12	SMCPC
10. An appropriate strategy is in place for those in HMP Shepton Mallet with long term dependency on painkilling medication		
a) Undertake clinical review of the cohort identified, assessing individual circumstances, with the findings reported back to the DAAT JCM	July 11	HMP SM HCM
b) Establish implications of transition to methadone treatment	July 11	HMP SM DSG Chair
c) Provide appropriate clinical interventions in light of above and review at DSG and ATCG	Quarterly to March 12	HMP SM HC / JCM
11. Psycho-social alcohol treatment is co-ordinated and delivered with both prison, healthcare and CARATs staff in HMP Shepton Mallet		
a) Ensure all healthcare staff at HMP SM have had training appropriate training around interventions for alcohol use	December 11	JCM / HCM
b) Review programme of psycho-social delivery in HMP SM	June 11	JCM / HCM / CARATs worker
c) In light of review and best practice information, establish programme of alcohol intervention	September 11	JCM / HCM / CARATs worker
d) Co-ordinate programme of activity with security actions relating to use of alcohol in the establishment as directed through DSG and reported to ATCG and PHPB	Quarterly to March 12	PHPB Chair / ATCG Chair / DSG Chair / JCM
12. Care planning is evaluated as effective and consistent, and continuity of care from prison to community is clear		
a) Monitor the recording of care plan completion at contract review (through NDTMS reported information)	Quarterly to March 12	JCM

b) Carry out annual audit of care plans at both community providers and within HMP Shepton Mallet	December 11	JCM
c) Develop transfer protocols for IDTS treatment from all prisons receiving Somerset residents on short term sentences, in line with the work already underway	December 11	TP SM
d) Using information available through DIRWeb, report at quarterly contract monitoring to ensure the effectiveness of care plan transfers from DIP in prisons to the community	Quarterly to March 12	JCM / PIU
13. Improve the uptake of Hepatitis B and C testing and Hep B vaccination to 90% for all those entering treatment, and support access to a range of relevant healthcare including Hepatitis C treatment and smoking cessation		
a) Ensure that all new treatment entries receive testing for Hep B and C and vaccination for Hep B, and that information is correctly and accurately recorded, so that these measures are reported at least 90%	Quarterly to March 12	JCM
b) Continue to participate in the Blood Borne Virus steering group and support the development of Hep B and C testing and Hep B vaccination in pharmacies if practical	Quarterly to March 12	SMCPC
c) Evaluate the need for BBV testing and vaccination in the Shared Care LES in light of requests for Turning Point to take on the work, and the pathway through treatment to shared care, and present this evaluation to the SCMG	October 11	SMCPC / SCMG Chair
d) Review the performance information reported to PHPQI on testing and vaccination in HMP Shepton Mallet, and discuss any exceptions at ATCG and PHPB	Quarterly to March 12	JCM / HMP SM HCM
e) Use regional fora to progress the transfer of information (vaccination records) from prison healthcare to community treatment agencies	March 12	JCM
f) Provide smoking cessation information and resources, especially information on where to access smoking cessation in each locality, to all staff and service users of community drugs treatment	January 12	JCM
g) Continue to liaise with the Hepatitis C treatment services at both Musgrove Park and Yeovil District Hospitals to provide supportive access for treatment of drug users	Ongoing to March 12	JCM / TP Clinical Lead

14. Continue to plan and co-ordinate to meet the support needs of carers of those with substance misuse issues		
a) Review the numbers of carers assessments made and the number of support groups and attendees as commissioned through Turning Point, at contract review meetings	Quarterly to March 12	JCM
b) Organise a bi-annual meeting for carers agencies / carers to facilitate joint working and co-ordinate support	August 11	JCM
c) Review outcomes delivered by In-Touch at ATCG, with a view to demonstrating its effectiveness, including the effectiveness of "one-off" commissioned interventions (such as PACT Group work programme)	September 11	JCM
d) Use bi-annual forum to draw on carers and carer organisations insight for the annual needs assessment	February 12	JCM
15. Deliver a written strategic plan to increase access to education, training and employment for drug users		
a) Establish a short terms working group around ETE opportunities for drug users including JC+, ETE providers and TP CAP to develop the strategy	June 11	JCM
b) Link this to SCC worklessness programme	June 11	DC
c) Deliver the strategy to ATCG	September 11	JCM
16. Housing strategy		
a) Participate in both the socially excluded and young people's thematic groups to agree supported housing pathways for drug and alcohol misusers and the remodelling of future provision 2012/13 onwards	September 11	JCM / DC
b) Link to work with options appraisal for specific service for 16-24 year olds	December 11	JCM / DC
c) Link to segmentation work (4 years+ more likely to be recorded as acute housing need)	September 11	JCM

d) Evaluate the needle exchange provision established in TAH and extend to include provision of BBV testing & vaccination as part of the Turning Point service offered in the homeless hostel.	August 11	SMCPC
e) Extend needle exchange/BBV to Yeovil homeless hostel (subject to evaluation outcomes)	October 11	SMCPC
17. Effective dual diagnosis services are delivered, including an appropriate level of specialist input and clear access for drug users to both IAPT and secondary mental health services.		
a) Establish the new Dual Diagnosis protocol	August 11	JCM / MH Commissioning Manager
b) Review the remit and function of the Dual Diagnosis Psychiatrist	August 11	JCM / Dual Diagnosis Psychiatrist / Som Par / TP Clinical Lead
c) Review effectiveness of protocol in promoting access for Dual Diagnosis clients to appropriate care	February 12	JCM / MH Commissioning Manager

Other Comments/Updates:

Planning Section 4: Achieving outcomes and successful completions

Please see checklist at Appendix 1 of the 2011/12 plan guidance for possible areas to include within this planning grid

Identification of key priorities following needs assessment relating to outcomes, discharge and exit from the drug treatment system:

There is a focus on the Somerset treatment system to improve the number, rate and percentage of successful completions in both the short and ling term. This is most apparent in the community services delivered by Turning Point which have shown a low number of successful completions for all drug users (PDU's and Non-PDU's), and a low rate of exit from the system overall (a low percentage of those in treatment actually leaving).

The needs assessment shows that 30% of treatment exits in Somerset were planned; this is below the regional and national average. The percentage of planned exits has also fallen by 7% between 2008/9 and 2009/10.

Turning Point's MoPSI model of delivery is designed to address this issue in the long term, as are the revisions in commissioning approaches to Shared Care and to wider interventions (inpatient detox, residential rehab and services for non-PDU drug users).

The percentage of clients exiting 'unplanned dropped out' is greater than the regional and national average and 'unplanned prison' is greater than the regional average. Whilst unplanned exits are a concern, some caution should be applied to the percentages as the total number of exits for any reason is comparatively low (292 in 09/10). The lowest rate of successful completion in 09/10 in comparison to the numbers accessing the modality was GP Shared Care, with the Turning Point Mendip service the lowest geographical locality.

As suggested from the above, the retention in treatment for 12 weeks or more that the Somerset system shows is extremely high (at 91% PDUs and 89% all adults for 09/10). The service redesign to promote successful completions will have to be delivered in an effective way which maintains this.

The restructured aftercare service should be developed to ensure that it supports those achieving abstinence to maintain this. This includes developing strong links to mutual aid groups, including improving the links established to the McGarvey fellowship.

To maintain the benefits of the treatment system, an "orange card" scheme should be developed to enable those exiting treatment that are evaluated as high risk to re-enter quickly in case of relapse.

Expected outcomes 2011-12:

1. Increase in the actual number of people successfully completing treatment free of the drug (or drugs) of their dependence. Consideration of the levels of successful completion in comparative populations suggests that this should be 156 people in 2011-12.

2. The percentage of exits which are successful completions reaches 40% by the end of the year for all adults 3. The percentage of successful completions as proportion of the treatment population reaches 12.5% by the end of the year for PDU's 4. Retention in treatment for 12 weeks rates for all adults and PDU's remain above 85% 5. The CAP Aftercare service is evaluated following restructuring as delivering effective support for long term independent recovery 6. All those leaving treatment have information about mutual aid services 7. An "orange card" scheme for those deemed to be at high risk is implemented to enable swift return to treatment following relapse 8. McGarvey Fellowship is supported to continue to provide a community recovery fellowship, and this is linked to the development of the CAP service and is publicised throughout the treatment system
Expected outcomes 2012-13 and 2013-14:

Delivery Plan:

Actions and milestones	By when	By whom
1. Increase in the actual number of people successfully completing treatment free of the drug (or drugs) of their dependence. Consideration of the levels of successful completion in comparative populations suggests that this should be 156 people in 2011-12.		
a) Deliver the actions identified in the Improving Successful Completions Action Plan between turning Point and the DAAT	September 11	TP AM / TP SM/ JCM / SMCPC
2. The percentage of exits which are successful completions reaches 40% by the end of the year for all adults 3.		
a) Re-establish monthly meetings to review Turning Point's discharges	April 11	JCM / TP SM
b) Support a review of Turning Point's faltering engagement policy in line with MoPSI to ensure	September 11	JCM / TP AM

that “manners matter” principles are accommodated in dealing with those at risk of dropping out of treatment		
c) Deliver the findings of the 2010 service audit, including recommendations for implementation of findings related to unplanned exits	April 11	JCM
4. The percentage of successful completions as proportion of the treatment population reaches 12.5% by the end of the year for PDU’s		
a) Deliver segmentation work and process of reviewing 2 years + and 4 years + cohorts, as outlined in section 3 above	September 11	JCM
b) Monitor successful completions as proportion of the treatment population at contract review meetings	Quarterly to March 12	JCM
5. Retention in treatment for 12 weeks rates for all adults and PDU’s remain above 85%		
a) Monitor retention in treatment at contract review meetings and require action form provider as necessary	Quarterly to March 12	JCM
6. The CAP Aftercare service is evaluated following restructuring as delivering effective support for long term independent recovery		
a) Establish a clear reporting form for CAP (which does not report aftercare as treatment), so that the benefits of the CAP service can be clearly measured, including capacity of the service, the length of time people are supported by the service, the numbers of people successfully exiting drug free and an outcome measurement of the benefits of the service (possibly TOPs, to be agreed)	May 11	JCM / TP AM / CAP TL
b) Undertake service audit for CAP service	December 11	JCM
c) Create a tool for tracking those exiting CAP for re-entry to the treatment system	June 11	JCM / PIU / CAP data

		lead
7. All those leaving treatment are able to access mutual aid services if they require		
a) Ensure up-to date information is available through CAP on mutual aid services	April 11	CAP TL
b) Support mutual aid services to deliver across the geographical spread of Somerset (including within HMP Shepton Mallet), including a plan to support for resourcing of this if necessary	June 11	JCM
8. An “orange card” scheme for those deemed to be at high risk is implemented to enable swift return to treatment following relapse		
a) Turning Point to present protocol for “orange card” scheme to DAAT partners for agreement through SCMG / ATCG	June 11	TP AM / TP SM
b) The scheme is publicised with partners, along with information regarding MoPSI so that all partners (especially in health services) are aware of the criteria and pathways to support people to re-enter the service if necessary	September 11	TP AM / TP SM/ JCM / SMCPC
9. McGarvey Fellowship is supported to continue to provide a community recovery fellowship, and this is linked to the development of the CAP service and is publicised throughout the treatment system		
a) Revise specification and outcomes commissioned from McGarvey Fellowship to ensure that the service is safely governed and delivers effective support for drug users	July 11	JCM
b) Ensure information about McGarvey Fellowship is up to date (including website) and is available at Turning Point offices	May 11	McGarvey Fellowship
c) Review the role and deployment of McGarvey volunteers in the Turning point service	August 11	JCM / McGarvey Fellowship / TP SM

Other Comments/Updates: