Executive summary:

Remit: the three ADPs are seeking to develop a stepped care approach to the provision of ORT across the Third Sector, Social Work, SMD community clinical services within the Hubs, Harm Reduction Team and primary care. The intention is to ensure that people's ORT needs are met safely efficiently in a way that enhances access to other recovery oriented provision.

Key deliverables

1. Develop a clear stepped care model for delivering ORT
2. A plan for developing non medical prescribing

Methodology:
Small steering group. Brief literature search, interviews with agreed individuals, data on activity from NHS Lothian and from Triage assessments during the month of April

Key findings:
(SMD) Caseloads at point of analysis (July 2016): total for drugs= 651. There were significantly more SMD referrals than discharges between April 2015 and April 2016.

In the month of April 2016 95 individuals completed triage assessment and were requesting help with either opiates / benzodiazepines as main drug. (45 from TPS, 50 from Lifeline) As of July 20th 18 of these individuals had been referred to the substance misuse directorate (SMD) , 25 patients remain open to Lifeline or TPS,50 patients are no longer in contact with any substance misuse service in Edinburgh. Some patients who remain engaged are still waiting for key worker allocation. 1 patient had died. Rates of planned vs. unplanned discharge were not available for all areas, but where figures were available the vast majority of discharges were unplanned.

A number of concerns about the current system of care and pathway were described.

7 recommendations were made.
Recommendation 1: Change to a Single system- reconfigure services around panels of caregivers aligned with new GP clusters.

Recommendation 2: Referral for ORT is expedited at triage assessment

Recommendation 3: Move towards Integrated training and strategic development for a single system of care

Recommendation 4: Prescribing carried out at a prescriber/patient appointment (includes options around non medical prescribing)

Recommendation 5: Implementing a stepped model embedding phasing and layering of interventions.

Recommendation 6: Clarify social work staff contribution to the ORT pathway

Recommendation 7: Refocus the current LTMP service towards intensive treatment for high tariff patients as part of the integrated pathway.

> Addiction is characterized by inability to consistently abstain, impairment in behavioural control, craving, diminished recognition of significant problems with one's behaviors and interpersonal relationships, and a dysfunctional emotional response. Like other chronic diseases, addiction often involves cycles of relapse and remission. Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death (Statement, A.P.P., *The Definition of Addiction*, 2011, American Society of Addiction Medicine).

Contents:

Introduction

This report was commissioned by Edinburgh Drug and Alcohol Partnership with authority from the Integrated Joint Board in Lothian. From the scoping paper (Appendix1).

"Background and context:
The three ADPs share a priority to develop a recovery oriented system of care for adults with drug/alcohol problems and their families. The planning and delivery of this priority happens at a local level in partnership through ADP structures. This includes the provision of ORT within a number of settings.

The Scottish Government has indicated that there will be a 20% reduction in the earmarked funding for drug/alcohol services available to ADPs at a national level. In Edinburgh this reduction equates to an approximate cut of £1.38 million and £460k in Midlothian & East Lothian and West Lothian respectively. It is very likely that the funding available for alcohol and drug treatment will continue to reduce for the foreseeable future and this presents significant challenges to the current model of care. It is anticipated that there needs to be a £90k (+ Mid & East and West Lothian) saving against this pathway.

As a result the three ADPs are seeking to develop a stepped care approach to the provision of ORT across the Third Sector, Social Work, SMD community clinical services within the Hubs, Harm Reduction Team and primary care. The intention is to ensure that people's ORT needs are met safely efficiently in a way that enhances access to other recovery oriented provision."

2 key deliverables were specified

1. Develop a clear stepped care model for delivering ORT

The model should set out clearly how people's ORT needs can be safely and practically met at the lowest step in the model. This should include service descriptions of each step as well as clinical and social criteria. New thinking is needed about the roles of existing professional groups including the role of the third sector, nurse and pharmacist as well as the role of GPs with a special interest in drug treatment within specialist services.

2. A plan for developing non medical prescribing

There are opportunities to develop non medical prescribing within the Nursing and Pharmacy professions. The role of Nurse and Pharmacy prescribing will need to be included within the stepped care model; however a plan is needed for how nurse and pharmacy prescribing can be developed within localities in each of the ADP areas."

The aim of this report is review current practice, briefly referring to current evidence where relevant in order to address these key deliverables in the context of substance misuse services in Edinburgh City.

The benefits of effective replacement treatment pathway are reduced risk of BBV infection, reduced risk of overdose, improved retention in drug treatment and reintegration into communities.

Opiate replacement therapy needs to be part of a more dynamic treatment system which focuses on individuals holistic needs including housing and employment to maximise benefits of treatment.

Evidence reviewed by the NTA research team (models of care for the treatment of adult drug misusers: update 2005 – consultation report) commented that drug treatment use is often episodic with service users dipping in and out of treatment over time. They suggested that an average time in treatment for someone with a heroin dependence problem is 5 to 7 years with some heroin users

requiring indefinite maintenance on substitute opioid. The biggest improvement and client outcomes are likely to be in the first six years of treatment and retaining clients in treatment for a minimum of three months is required in order to produce any effective change. The "client and provider" approach requires a partnership between the treatment provider and the service user; both working towards common explicit goals around all their needs, not just their drug treatment needs.

The National Drug Evidence Centre research (National Drug Evidence Centre, University of Manchester 2004 treatment and effectiveness: demonstration analysis of treatment surveillance data about treatment completion and retention. London: NTA) showed that the best predictor of retention intimacy treatment was related to service factors rather than client characteristics.

Therefore is crucial that services are able to engage with and retain clients in the first three months of the treatment in order to have the best chance of producing positive outcomes. If patients disengage from treatment during this time there should be mechanisms in place to facilitate re-engagement. Treatment services need to provide swift assessment and access to opiate replacement therapy (ORT) in order to retain patients. There is no evidence that insisting on structured psychosocial intervention prior to initiating prescribing has any benefit in terms of outcomes.

Methodology

A steering group to review the scope of the review and time frame (6 weeks) was formed involving representatives of the substance misuse senior management team senior and EADP representatives. The project was to be confined to the provision of ORT within the city of Edinburgh and focused on health and third service provision. Alcohol dependence treatments were excluded. Residential services, DTTO and the primary care facilitation team were excluded and initial proposal to gather information via a series of focus groups was set aside in favour of a series of interviews with identified individuals. Interviews with key NHS substance misuse service staff, representatives from primary care, public health and BBV services were agreed. All interviews were conducted privately with an assurance that where possible statements would not be identifiable. The rationale for this was to allow an open discussion which would try to identify significant cultural factors and inter-team relationships.

A basic review of key documents and literature was carried out (appendix 2) but this did not constitute a formal literature review.

Data was gathered from the Primary care facilitation team, NHS Lothian TRAK system, Turning Point and Lifeline managers. The initial plan was to look at data from the year April 2015 to April 2016 but after talking to staff this was revised. Given the change in the Third sector provision since April 1st 2016 it was agreed to focus on the progress of patients attending triage assessment at the drop-ins, who were seeking treatment for drug problems (excluding cannabis, novel psychoactive substances and stimulants) received in April 2016. Patients requesting treatment of benzodiazepine as their first drug were included as this is normally in context of opiate dependence. It was felt that this would be an easily reproducible audit to monitor the effectiveness of changes made to the system.

Section 1: Current Services and Pathways:

Services for people with opiate dependence are currently delivered by services in 4 geographical areas across the city, supported by General Practice Enhanced Services (GPES). The majority of secondary care services are accessed through drop in clinics at recovery hubs (see figure 1 below). Opiate replacement therapy is provided by and supported by five main service providers: the GP Enhanced services, NHS Lothian, Lifeline, Turning point, Social work. There have been four significant pressures on the services in the last year:

1. *Implementation of a new contract for third sector provision, which was awarded to Lifeline and Turning point from April 1st 2016*
2. *Integration of health and social work services*
3. *Changes in the boundaries within Edinburgh City sectors (this report refers to the old boundaries throughout)*
4. *HEAT A11 standards*

The case for need to change: staff expressed concern that the current systems are only beginning to "bed in" and that now is not the best time to look at significant changes, suggesting that the current systems are given at least 6 to 12 months to settle. It was highlighted that previous services had left a backlog of cases and that equals figures will not be representative of normal activity. So is there any need to act more urgently?

NHS Substance misuse service data:

Data on NHS activity, sourced from TRAK, from April 2015 to April 2016 representing activity on nursing, medical and some group work. OT and psychology activity in the SMD were not reported. Senior staff felt that these figures are fairly accurate although they comment that there may be a lack of consistency between allocating patients to be planned versus unplanned discharged categories.

Table 1: Summary of TRAK data for SMD referrals and discharges

Team	Referrals	Discharges	Planned Discharges	Unplanned Discharges
HRT	74	26	6	23
North Total	409	330	84	246
NE	*171*	*145*	33	112
NW	*238*	*185*	51	134
South Total	338	303	152	151
SE	*160*	*114*	57	57
SW	*178*	*189*	95	94
Total NHS Activity	821	662	242	420

Table 2 TRAK data on SMD Caseloads (includes waiting list) on 1st July 2016

Team	LTMP	North Total	*NE*	*NW*	South Total	*SE*	*SW*

Caseload (Total 651)	63	249	*145*	*104*	339	*156*	*183*

552 of the above cases are currently held on nursing caseloads. Key worker caseloads have a target maximum of 35 within NHS Lothian.

Analysis of Lifeline and TPS Triage Data for April 2016:

Turning point reported referrals of over 150 new cases in the first quarter of 2016, but similar date was not available from Lifeline due to the implementation of the new contract. Key worker caseloads have a target maximum 40 for turning Point and Lifeline

Methodology: Data for patients attending triage assessment in April was matched to the SMD prescribing system to ascertain whether the SMD had started a prescription and to the TRAK system to ascertain date of referral. TRAK was also used to double check if the titration clinic had been used for starting a prescription. Due to the low numbers detected the data was sent back to the TRAK team to check that no referrals had been missed.

Key findings From April Triage Data

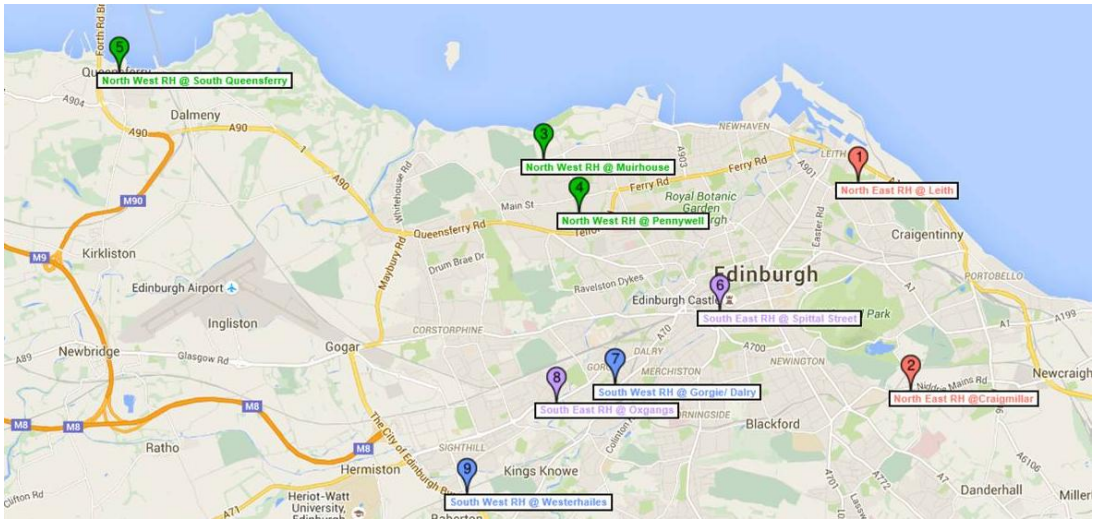
95 individuals completed triage assessment and were requesting help with either opiates / benzodiazepines as main drug. 45 from TPS, 50 from Lifeline

- 1 patient is now deceased
- 5 were already on a prescription for ORT and 1 was a DTTO client.
- By 20th July 2016 18 individuals had been referred to the substance misuse services (8 from TPS, 10 from lifeline):
    - 5 went to titration clinic
    - 12 had prescriptions started out with titration clinic
    - 1 patient with SMD not scripted
- 25 patients remain open to Lifeline or TPS
- As of 20th July 50 of these patients are not in contact with any substance misuse service in Edinburgh.
- Some patients who remain engaged are still waiting for key worker allocation.
- Rates of planned vs. unplanned discharge were not available for all areas, but where figures were available the vast majority of discharges were unplanned.

Section 2: Current Pathway for ORT Provision

The majority of patients accessing ORT within Edinburgh city do so through self referral to the Recovery Hubs. These are outlined below:

Figure 1: Drop in access for recovery hub services in Edinburgh (Correct July 2016)

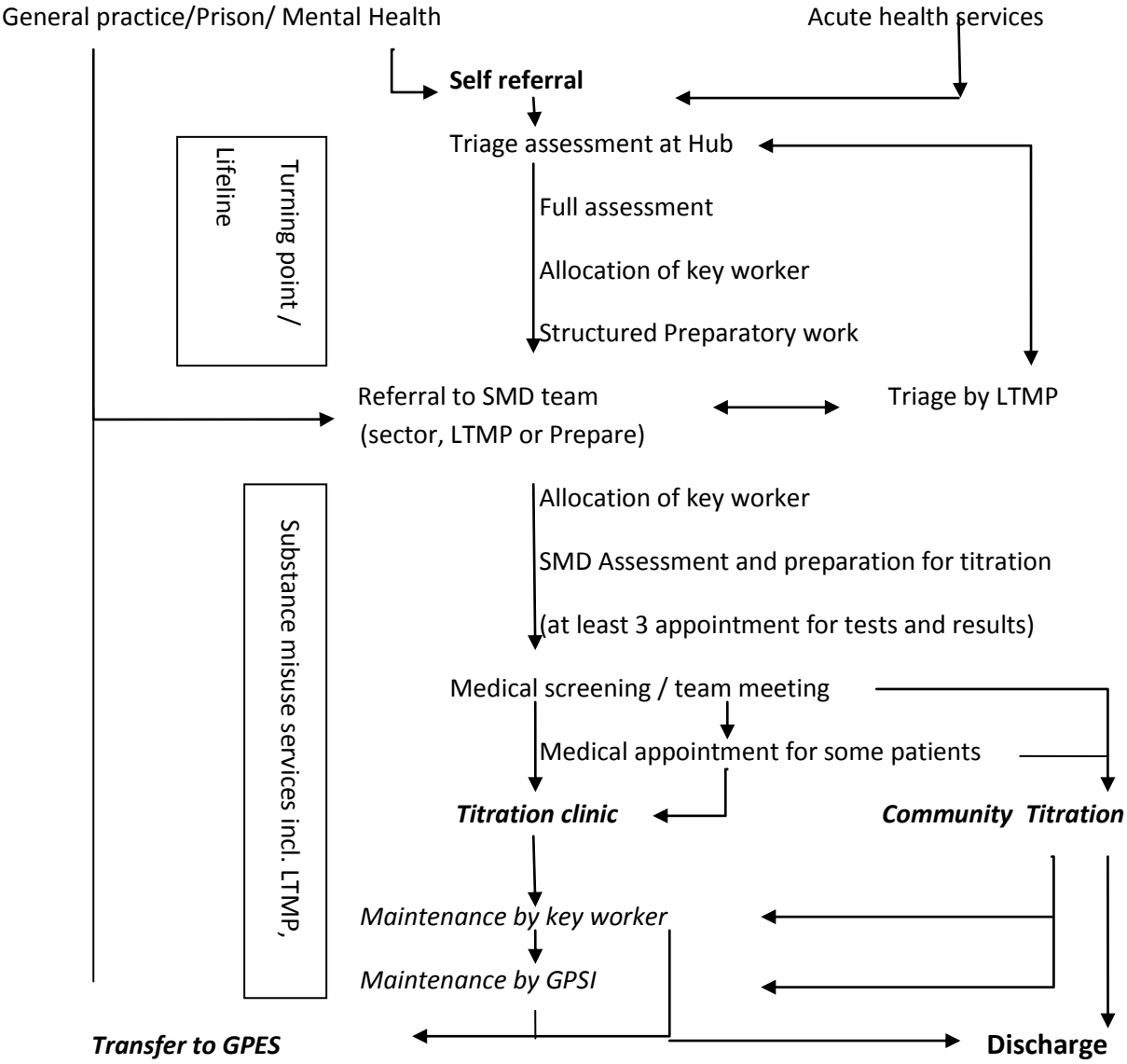


The SMD finalised its patient pathway in April 2016 (see appendix 3) due to the planned changes in the third sector contracts this pathway does not incorporate the full pathway. For the purposes of this review I wanted to try to gather consensus on the pathway specific to ORT as perceived by staff across the services. While there were some individual team difference there was in general agreement about the overall pathway and I have condensed this into the figure 2.

There were several recurrent themes of reported inefficiencies and delays in the existing pathway

- Multiple reassessments and Repeated outcome measures by services within a few days
- Increasing use of Sci Gateway referral direct to health team.
- Lack of clarity in who Hub accepts with inappropriate attendances at triage (e.g. for bus pass request).
- Lack of capacity for key working or following the patient through his journey.
- Delay in initiating testing.
- Discharge if fail to attend first assessment appointment with SMD (strategy felt to be due to pressure of HEAT standards)
- Multiple / unnecessary triage attendance (Patients already on the prescription needing to go through HUB triage assessment prior to receiving health assessment, initial triage indicating more suitable for LTMP but attendance at LTMP triage resulting in redirection back to local hub)

Figure 2: Combined referral pathway for ORT only within Edinburgh city (based on interviews):



(The Ritson in in-patient unit was not included in this pathway as it primarily provides transfers from methadone to buprenorphine and was covered by the residential review).

At interview there were various opinions on how well this process is working. At the front-end there was concern about the safety and effectiveness of third sector screening and assessing complex patients at triage. There was concern that the current single pathway placed patients with high risk of physical or mental health problems at increased risk due to the delays in accessing treatment. There was concern that these patients are more likely to drop out if they did not have their needs met quickly. Several people reflected that in other medical triage contexts more senior people are allocated to triage.

Some individuals felt that it was taking up to 4 months for patients to get through to starting a prescription but others did not feel that it was taking so long. No one believed that there was a concerning amount of dropout in the pathway. Some individuals felt that the requirement for

patients to undergo a period of structured preparatory work was beneficial to the patient and that if patients dropped out during this preparatory work they would come back “more ready and more motivated” in the next episode of treatment.

The perception among SMD staff was that the majority of patients progressed to titration clinic without delay and few community titrations occur due to pressure on nurses’ time. Recently there has been a drop in patients being referred to SMD which was felt to be due to a “backlog” within Turning Point and Lifeline.

The majority of staff felt that the new system had already produced improvements in relationships between NHS and third sector. There was a perception of improved governance within the third sector and increased levels of trust. There was a feeling that there was already movement in developing a shared culture around treatment and team building. This is particularly strong where physical co-location was in place.

There was some frustration about the predominance of the medical prescribing model. There was a feeling that there was aligning of the HEAT A11 (drug/alcohol treatment) and A12 (psychological therapy) targets. It was felt, especially among the nursing staff, that the majority of time was spent” policing the prescription” rather than carrying out good-quality psychological therapies.

There was recognition that there were cultural differences between nurses / services and that some nurses do not feel confident to undertake community titration and will “always insist” that patients are titrated through the titration clinic. There was acceptance about lack of consistency of the culture across the city with some individuals being very recovery focused and others becoming more “punitive” in their approach as a response to the pressures on caseloads. There were particular differences in the approach to the “cohort of people who just want a script” with some individuals being more ready to accept this and others insisting on a level of recovery work if prescribing is to be either initiated or continued. There were descriptions of some pressure on patients to reduce prescriptions (as a marker of recovery) which was perceived cause harm to the patient by either being maintained on an inadequate dose or resulting in disengagement from the service. There was concern about a small number of “revolving door patients” whose needs did not seem to be met by the current model.

There is recognition that a significant number of patients are not able to be discharged from the system due to lack of prescribers out with the key working system. There is also inconsistency around closing cases when patients were involved with social work, LEAP or long-term psychotherapy.

There was a large amount of dissatisfaction with the current clinical meeting set up with a feeling that the meetings tended to focus on prescription issues and crises rather than supporting structured case management and detailed case discussion. There was general agreement that there is a lack of integrated care planning and case management, which resulted in a large degree of duplication across services and lack of clarity about “who is doing what and when” and lack of co-ordination of appointments.

The role of social work within the pathway

Currently the perception is that addiction social workers provide time limited input from patients with "complex needs in three domains". There was a mixed understanding of the criteria social work involvement when compared to the thresholds for project workers in the third sector. There was a perception that there is further work to do to integrate social workers into the hub model including joint triage, case allocation and co-location.

It was felt strongly by most interviewees that social work addiction workers should form a vital part of the team and that they provide skills and information which could be invaluable. All staff interview who expressed an opinion stated that they would like to have the role of social work addiction workers clarified and see them embedded within the teams.

Addiction Social Workers clearly have the potential to work with those with the most complex social care needs, providing case management and key working. It is difficult to set clear criteria for the addiction social work team as their role should be focussed on working with people with the highest social complexity. Clearly the decision about case allocation to this team should sit within the hub multi-disciplinary team, so that they are effectively working with those with the highest social complexity on the caseload of the Hub.

Role of the Low Threshold Medication Programme (LTMP).

This service provides care for patients who are hard to contain at the Hubs. It primarily accepts patients who are “risky injectors” (groin and neck injectors who inject frequently and are at high risk of overdose) and patients who have behavioural problems which mean that they are at risk of losing their scripts due to poor engagement.

The service offers daily dispensing for 30 patients and weekly prescriptions for up to 40 patients. Patients on the daily programme benefit from a range of peer support and group work in addition to key working. There are dental and wound care facilities available (which are also open to patients elsewhere in the city). Patients on “weekly” have all progressed through the daily programme and are retained in order to engage in high intensity recovery work with the aim of discharge to GP prescribing in the majority of cases.

80% of LTMP referrals come from the LTMP drop in triage assessment and 20% from referrals from SMD city teams.

Patients are titrated through the Spittal St Titration clinic. A band 5 nurse supports this titration clinic and provides methadone education, naloxone training and BBV testing. There is currently no routine medical assessment prior to titration for the majority of patients.

There is a well developed peer development programme run through the LTMP

Currently patients have some difficulty moving on from the LTMP. This is felt to be due to a combination of resource and capacity issues. Some patient factors also play a role including ambivalence about progress and fear of loss of the support given at the LTMP.

Staff outside the LTMP expressed some lack of understanding of the role of the LTMP. In particular there was poor understanding of the referral criteria and process and the perception that patients were rarely accepted onto the programme from the Hubs. Most staff did not seem aware that direct referral was possible and thought that all referrals had to go through the LTMP triage system. There was a feeling that there were no significant differences between patients managed at the hubs and by LTMP.

There was a perception of need for some of the LTMP services to be available locally - notably wound care and dental services. However in general it was felt that a centralised service offering more intensive care to high risk patients was needed and was best placed centrally. It was not felt that transport issues were significant for city patients especially as patients attending LTMP are provided with bus tokens currently.

Primary care provision of ORT

The GP Enhanced service for opiate dependence (referred to as the NES) currently provides the bulk of prescribing for opiate replacement therapy within the city. There are many practices that are not part of the scheme and their patients on maintenance and replacement therapy are currently held within the SMD. There is no expected change for the NES in 2017 but the NES contract is currently being renegotiated nationally. It is expected that some form of NES will continue but there is a possibility the NES will be abandoned completely.

There are expected pressures on capacity within the NES within NHS Lothian. These come from several factors in addition to possible changes to the agreed national enhanced service.

- Several practices in special administration within NHS Lothian, the majority of whom are currently doing the enhanced contract work.
- Many practices are under severe strain due to current workload. One interviewee stated “most practices are drowning”.
- There are increasing problems with GP in recruitment in Scotland and even within NHS Lothian there are increasing numbers of vacancies to GP posts.

Consequently there is a feeling that any reduction in funding for the enhanced contract would be seen as “the final straw "and would be highly likely to result in practices withdrawing from providing the enhanced service. There is already substantial disquiet about the recent changes to the enhanced contract for testing for blood-borne viruses, which has resulted in substantial loss of revenue to practices which currently provide enhanced services for opiate misuse. Practices are open to continuing to provide services for drug misusers but feel that the current contract is unhelpful in finding realistic solutions such as use of health care assistants and non-medical prescribers within the practice.

Currently about 10% of patients managed within the NES are perceived as “very difficult, resource consuming and changing very little”. It is felt that these patients would be better managed within the substance misuse service but that there is a reluctance to refer these patients due to perceived lack of capacity.

GP practices in Edinburgh are currently being aligned into geographic clusters. These clusters are roughly 20 to 30,000 patients per cluster. These clusters avoided been agreed but will not be operational until 2017.

There is currently some variation in the amount of input into the enhanced practices from the SMD. In some areas sessions of nursing care are dedicated to supporting patients managed primarily by the GP. It is felt that this provision has increased capacity within primary care and improve the quality of care for these patients.

From the interviews are carried out the overall feeling was that GPs do want to continue this work and see the change in the national contract is being committed to look at new models for making this practical.

Under existing arrangements several areas of inefficiency or sub optimal care are described.

1. Patients who destabilise in general practice currently have to go back through the hubs to access the NHS substance misuse service. It was felt that this was inefficient and also resulted in some patients disengaging from treatment.

2. Patients requiring titration were perceived to have a very long wait. This has resulted in GPs retitrating patients themselves, which was felt to be outside the majority of GPs area of competence.

3. Patients with significant mental health problems relating to their substance misuse face unreasonable delay in having a health assessment in some areas. There were significant geographical difference in delivery of mental health assessment with some areas accepting direct referral to consultant and others requiring transit through the hub assessment. Some GPs expressed lack of confidence in the triage assessment available at hubs in detecting high levels of risk around mental health issues. It was felt that for this group of patients increased capacity for joint working would negate the necessity for the prescribing to be handed back to the substance misuse services.

4. Capping of numbers for new patients or strict criteria for accepting patients (e.g. one practice where a maximum dose of methadone was required)

The Homeless Practice sits under the south-east CHCP. This provides a time limited service to the most chaotic individuals, the majority of whom have substance misuse problems. There are opportunities for increased partnership working, especially with the low threshold medication clinic.

Section 3: Other relevant issues that could have impact on the ORT Stepped care model and pathway

Non-medical prescriber options for NHS Lothian

Senior staff estimated that between 20 and 40% of patients currently on ORT within the SMD currently do not require key working and could be managed by non-medical prescribers. Some of these patients may be able to return to the GP enhanced service but a significant proportion is retained as their GP does not prescribe ORT.

a) Nursing non-medical prescribing.

NHS Lothian has a clear non-medical prescribing nursing structure with a pan NHS Lothian clinical governance framework. The SMD has trained several nursing non-medical prescribers but these have only recently started delivering services. Several pilots have been completed around nursing non-medical prescribing within the SMD. There is no nursing non-medical prescriber active within Edinburgh city. In Midlothian nursing non-medical prescribers are providing titration and maintenance prescribing. Several nurses are currently undergoing training as non-medical prescribers.

There seem to be several barriers for successfully utilising nursing non-medical prescribers. These are primarily cultural and organisational and it has until now been difficult until now to see how useful the non-medical nursing prescriber could contribute to increasing capacity within the service. The original vision was for nurses to primarily prescribe for their own caseload with the aim of freeing up medical time, this does not provide any increase in capacity but would free up time for medical case reviews.

Four potential benefits for nursing non-medical prescribing where suggested during interviews.

1. The use of nursing non-medical prescribers to provide maintenance clinics for patients who are stable. This would require ring fenced time in nurses job plans to ensure clear delineation from any other activities such as keep working for group work. At interview it was felt that it may be possible for nursing non-medical prescribers to provide this role within the nursing team, but not (without further negotiation) for third sector agencies.

2. To increase capacity at titration clinics. This is currently happening in some SMD areas for patients who are felt suitable for non-medical titration.

3. Provision of more standardised detoxification with wider choice of medication.

4. Provision of BBV treatment, wound care and treatment of wound infections in the hubs.

The possibility of developing the nurse practitioner role or suggested. However, it was felt that non-medical nursing prescribing need not be confined to the nurse practitioner role.

b) Pharmacy non-medical prescribing

There is currently one pharmacy non-medical prescriber within the SMD. This individual currently prescribes at the titration clinic at Spittal Street centre. There are seven other pharmacy prescribers

employed by NHS Lothian working in respiratory diabetes and polypharmacy roles. These are employed on a sessional basis (£125 per session) by NHS Lothian. Their substantive post is within the community pharmacy. Money for this service is currently allocated this year.

There are also a small number of pharmacy prescribing sessions based in GP surgeries, within GP clusters. This is a different funding scheme. They are all employed these sessions by NHS Lothian at band 7 or 8A-level.

NHS Lanarkshire is using pharmacy prescribers to support prescribing within their substance misuse services. NHS Lanarkshire does not have a GP enhanced service for substance misuse. These pharmacists are in general embedded in the substance misuse service teams. In addition, they have several pharmacy prescribers to operate maintenance clinics in their local pharmacies. (The non-medical prescribing policy makes it clear that prompted prescribers are not allowed to prescribe the patients for whom they dispense ORT). In Lanarkshire pharmacists take on approximately 16 to 20 patients per session (equivalent to a caseload of 160 - 200 whole time).

It is felt that there is a workforce in non-medical pharmacy prescribing which would be available for this type of work in NHS Lothian.

Blood born virus care.

Glasgow has seen a resurgence in new cases of HIV since the start of 2015 – with 57 new cases reported in intravenous drug using patients in that calendar year. This has not yet been replicated in NHS Lothian. New technology now reveals if Hepatitis C has been contracted recently: there have been an unexpected number of new cases this year in NHS Lothian. It is unclear if this is linked to a recent spike in intravenous Novel Psychoactive Substances.

The Blood Borne Virus Managed Care Network (BBV MCN) lead reports that there has been good progress in achieving first tests in patients, but progress on retesting has been slow. Practitioners report that the good intentions seem have been “scuppered by workload, staff turnover and the HEAT standards”. Overall testing and immunisations is very patchy with no easy way of auditing immunisations. Immunisation is currently centred on motivated individuals rather than systems. There is no central database of who has been tested or immunised and key workers mainly rely on patients reports. TRAK needs to be configured to make this more easily visible. Currently immunisations are not recorded on TRAK. Testing now is recorded in the investigations section of TRAK but as tests are not requested through TRAK there is no alert to the tester or record of actions.

The BBV MCN recommends that the professional key working the patient carries out testing and immunisation.

Treatment of Hepatitis C has dramatically changed. The majority of patients seeking treatment who are ready have been treated. There is now a waiting list of unstable opiate dependent patients where the only barrier to treatment is their lack of stability. Injecting is no longer a barrier to treatment and patients just need to be stable enough to comply with treatment and not be sharing injecting equipment.

Increasing numbers of Drug related deaths (DRDs)

The last ISD report, in 2015 concluded that:

- "Collectively, seven in ten individuals (71%) who died a drug-related death in 2013 had been in contact with a service (drug treatment, hospital, police or prison) which may have identified them as being at risk of drug-related death.

- The drug most frequently found to be implicated in death in 2013 was heroin/morphine (44%), followed by methadone (42%), diazepam (19%) and alcohol (18%). Opioids (methadone, heroin, morphine or buprenorphine) were implicated in 76% of cases.

- The mean age of individuals suffering a drug-related death increased from 34.4 in 2009 to 39.1 in 2013. The percentage of deaths among individuals aged 35 and over has increased from half of deaths (50%) in 2009 to two-thirds (66%) of deaths in 2013.

- Nine out of ten (88%) of individuals were known to be using drugs prior to death and, of these, almost two-thirds (64%) also had a history of intravenous (IV) drug use. In 2013, almost one third (31%) were prescribed an Opioid Replacement Therapy (ORT) drug at the time of death (an increase since 2009 (21%)), while over half (51%) had been prescribed an ORT at some point since 2009. Over one third of the 2013 cohort (37%) had been prescribed an anti-depressant in the 30 days before death (the most commonly prescribed substance being mirtazapine). Diazepam was recently prescribed to one-fifth (21%) and gabapentin to one-tenth (10%) of the cohort. Anti-depressant and gabapentin prescriptions have both increased since the National Drug Related Death Database (NDRDD) started in 2009. Almost three quarters (72%) had a medical condition recorded in the six months prior to death, while almost two thirds (63%) had a psychiatric condition recorded (higher than in any previous cohort)." (http://www.isdscotland.org/Health-Topics/Drugs-and-Alcohol-Misuse/Publications/2015-04-28/2015-04-28-NDRDD-Report.pdf)

In Lothian the picture is similar: From the 2014 figures (http://www.drdlothian.org.uk/Data/Pages/default.aspx):

- The Edinburgh and Lothians Drug-related Death Case Review Group reviewed 99 cases of drug-related death (DRD) which occurred in 2014. This is a 20% increase on the previous year's total (79). It is the highest Lothian annual total on record.
- Over two thirds of all drug-related deaths in Lothian occurred in the city of Edinburgh. Most were white, single Scottish men who had a known history of substance misuse (to services and/ or the Police). The majority of deaths (75) occurred among those with a long term history of substance misuse (greater than 5 years). 61% were known to be intravenous drug users (60 cases). The median age at death was 41 years.
- In just over half of cases (57), the deceased had been in contact with a drug treatment service at the time of death. Most of those were in treatment with their GP under the National Enhanced Service (NES) (34). In 25 cases (one quarter of the case total) the now deceased had contact with NHS Lothian's SMD at some point in the year prior to death. 14 were in current active treatment with SMD at time of death.
- Two thirds of the cohort had diagnosed mental health problems, depression being the most commonly reported condition.
- In 71 cases the deceased had physical health problems prior to death, respiratory conditions being the most common.

Figure 3 Patient Factors that Increase Risk of Methadone Toxicity/ Opioid Overdose

Recent benzodiazepine use	Use of other sedating drugs
Alcohol-dependent patients	Over 35 years old
Respiratory Illnesses	Taking drugs that inhibit methadone metabolism
Lower opioid tolerance	Liver disease
Recent discharge from inpatient rehabilitation facility or recent incarceration	

It is clear that in the opiate dependent population there are an increasing number of people with opiate dependence who have intractable mental health or physical health problems. Some represent a complex medical problem requiring multidisciplinary coordination of care. This makes the implementation of a step model more difficult as more and more patients are moving into the higher level intervention brackets.

Delivering for Mental Health: implications for ORT

> 'All *substance misuse and mental health agencies should have assessment processes which identify co-morbidity systematically to match care appropriate to level of need.*'
>
> *Delivering for Mental Health* (Scottish Executive, 2006)

The *Delivering for Mental Health* draft report (Scottish Executive, 2006) highlights the prevalence of mental health problems in those treated for substance misuse. It states that, between April 2001 and March 2002, more than 40% of those seeking treatment for their drug-related problem in Scotland, for the first time or following a period of 6 months absence, did so as a result of mental health problems. It makes three key recommendations, drawn from *Mind the Gaps - Meeting the needs of people with co-occurring substance misuse and mental health problems* (Scottish Executive, 2003) and *A Fuller Life - Report of the Expert Group on Alcohol Related Brain Damage* (Scottish Executive, 2004).

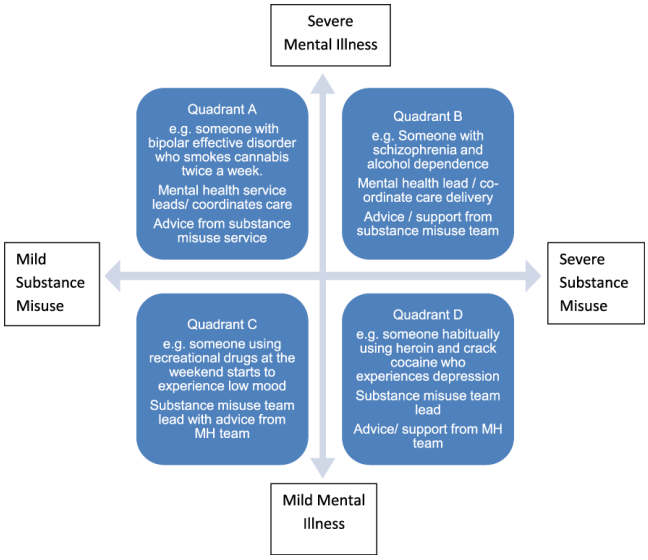
1. The needs of people who misuse substances and require interventions should be met through a consultative and co-working arrangement between substance misuse and mental health services with agreement reached on the allocation of responsibilities between services which addresses all stages and transitions.

2. A shared protocol on the arrangements, including monitoring and review of performance and outcomes, should be agreed and published.

3. NHS boards and partner agencies should ensure an effective and accountable commissioning process for this client group.

It recommends the matrix taken from the Department of Health Mental Health Policy Implementation Guide - Dual Diagnosis Good Practice Guide (2002) which helps identify the problem severity of co-existent psychiatric and substance misuse disorders in order to determine lead agency responsibility. The horizontal axis represents severity of mental illness and the vertical axis the severity of substance misuse.

Quadrant model of dual diagnosis



Harm reduction and Recovery – getting the balance right.

> **Patient focused care: ORT needs to be delivered in a dynamic way which does not allow people to drift into long-term maintenance prescribing without effort being made to promote their recovery**
> J Strang NTA 2012

In the 1980s harm reduction developed in the UK as a distinct strategy to address the HIV epidemic. 1988 the UK government's official drug policy advisers echoed the McClelland committee, asserting that "The spread of HIV is a greater danger to individual public health than drug misuse."

In 2008 the Scottish Government, closely followed by the 2012 the UK governments, move to a recovery-oriented treatment system was launched claiming that the best protection against blood borne viruses is full recovery". This roadmap challenged the existing culture of remaining in methadone and other maintenance programs,continuing drug use and the acceptance of the need for long-term harm reduction services such as needle exchanges. The current place of harm reduction strategies has been under threat as the two recovery documents have been interpreted increasingly as requiring patients on substitute programs to demonstrate movement along the recovery Road in order to stay in treatment.

The fundamental question is whether harm reduction is a primary goal, a second-best outcome when recovery is for the moment unattainable or valid only as an engagement strategy and platform for recovery.

It is vital to have a shared understanding and culture which balances the two approaches at any point in client's journey. It must be remembered that recovery is:

• An individual process or journey rather than a predetermined destination

• built on hope, not coercion, in order to sustain motivation and support expectations of an individually fulfilled life

• About enabling people to gain a sense of control over their own problems, the services they receive, and their lives

• helping people to find opportunities to participate in wider society

• Culturally appropriate

Entering and staying in treatment, coming off opioid replacement therapy (ORT) and exiting structured treatment are all important indicators of an individual's recovery progress, but they do not in themselves constitute recovery. Coming off OST or exiting treatment prematurely can harm individuals, especially if it leads to relapse, which is also harmful to society. Recovery is a broader and more complex journey that incorporates overcoming dependence, reducing risk-taking behaviour and offending, improving health, functioning as a productive member of society and becoming personally fulfilled. Protective benefits have too often become an end in themselves rather than providing a safe platform from which users might progress towards further recovery.
In a recovery oriented system of care it is not acceptable to leave people on ORT without actively supporting their recovery and regularly reviewing the benefits of their treatment. Treatment must be supportive, aspirational, realistic and protective. It must be recognised that for a small number of people. There is clear benefit to maintenance on ORT. Despite ongoing drug use. Patients should not be forced to come off their ORT unless it is clear that the risks of being on a prescription outweigh the risks of continue prescribing. This will ultimately be the decision of the prescriber in consultation with others involved in the clients care.

Lessons from the NUKA model (*Nuka system of care*, Alaska, King's Fund, 2015)

In an innovative development Native Alaskans were enabled to create, manage and own their whole healthcare system. They achieved this by:

- being actively involved in the management and governance structure
- participating in advisory groups in their local areas
- Taking part in surveys, focus groups and telephone hotlines used by managers to ensure that people can give feedback that is acted on.

Since it was established, the Nuka model of care has significantly improved access to primary care services. Customer satisfaction has increased and there have been large reductions in emergency care and hospital admissions. The success can be partially attributed to several factors: they were given control of a single budget and authority to break down barriers between primary care, community services and mental health services. Success clearly hinged on its leaders' commitment and the strong links they forged with their community. Service users actively engaged shared responsibility for their health and engaged in governance of the system. The organisation made significant changes to its supporting functions (e.g. IT), systems and processes and invested highly in strategic planning, training and infrastructure to deliver significant improvements in outcomes. A key trigger was the level of disillusionment with the old system and the eagerness of the Alaska Native people to take greater control.

While a move to a full NUKA like system is not feasible within the current structures there are several themes and principals that would be worth considering in moving forward in developing the ORT pathway.

a) Creation of a vision based organisation: building culture around core ideologies (vision, mission, goals and principals). Senior leaders invested deeply in developing the organisation's guiding principles then embedding them through communication, training and systems.

b) Promotion of pride and self confidence

c) Relationship based model of care: Care provision designed to eliminate barriers between those

giving and receiving services.

d) The concept of panels of people giving services to a specified population. Small teams are fully responsible and I held fully accountable for care of people on the panels.

e) Panels support patients in taking ownership of their care – "I work with my team and have determined what I need when, where and how I want it. I know the team and the team knows and cares about me. Care is coordinated"

The redesign allowed it to move from four-week waits to same-day appointments while reducing the proportion of doctors and nurses per head of population, it achieved these improvements under the same funding arrangement. The King's fund commented that these results would have been impossible if each of the groups involved remained within their separate organisations, micromanagement structures, service specifications and employment contracts.

It must be remembered that the NUKA approach is a whole system structure of care. If we were to consider moving towards incorporating any of the values above we would need to make a huge cultural shift away from staff determining intervention types and frequency. There would be essential huge benefits to patients from this move. Our patients are typically disempowered and passive participants in the treatment journey.

Section 4: Models of care.

There are three main approaches described for modelling services for substance misusers: Tiers of care, stepped care and phasing/layering. These approaches are not mutually exclusive and are summarised below.

Traditionally services for opiate dependent patients have been commissioned and delivered in four tiers. The use of tiers provided a framework for structuring drug treatment and development of integrated care pathways (ICPs). ICPs are specific for each treatment intervention. Well-structured ICPs help to design and provide clarity of the suitable client, expectations of the client, the roles responsibilities of the service and its place within the overall treatment journey. Many key documents emphasise the importance of care planning in the patient journey "*Changing Habits: The Commissioning and Management of Community Drug Treatment Services for Adults* (Audit Commission, 2002) highlighted the imperative need for good care planning in order to ensure that clients receive an integrated package of care that provides a holistic response to their problems.

Table 3: Summary of standard tiered care model:

Tier 1	Drug-related information and advice screening assessment and signposting or referral to specialist drug services. (Provided in the context of general health e.g. liver units antenatal wards accident and emergency social care education etc)
Interventions	Drug treatment screening and assessment, Referral/ signposting to specialist drug treatment services, Drug advice and information, Partnership or shared care working with specialist drug treatment services for interventions within the context of their generic services.
Tier 2	Screening, assessment referral to structured drug treatment, brief psychosocial interventions harm reduction interventions including metal exchange and after-care. (Maybe provided separately from Tier 3, but will often be delivered in the same setting, and by the same staff as Tier 3 interventions. Other settings to increase access throughout reach e.g. Street work, domiciliary visits in primary care settings. Pharmacy settings and criminal justice settings are also important. Due to their unique roles in access).
Interventions	Screening assessment and referral to structured drug treatment. Interventions which attract motivate drug misusers in local treatment systems including engagement with party group such as pregnant when offenders still in users etc Interventions to reduce harm and risk due to blood-borne viruses and other infections, including dedicated networks changes. Minimise the risk of overdose. Dispensing and distribution of naloxone. Brief psychosocial interventions for drug and alcohol misuse, including interventions for stimulant and cannabis where it does not require structured treatment. After-care support. Liaison and support for generic providers of Tier 1 interventions
Tier 3	Community-based specialist drug assessment and coordinated care plans treatment (*Provided in specialist drug treatment services in their own premises in the community or in general practice or hospital sites, domiciliary visits if required. Provision for offenders delivered in prison settings or specialist community services.)*

Interventions	Comprehensive drug misuse assessment. Planning and review offered with regular key working sessions a standard practice. Community care assessment and case management drug misusers. Care coordination for those with complex needs. Harm reduction activities as integral to care plan treatment. Range of prescribing interventions in the context of a package of care in line with "Clinical Guidelines". Range of structured evidence-based psychosocial interventions assisting individuals to make changes in drug and alcohol using behaviours and to address coexisting conditions such as depression and anxiety. Structured day programmes and care plans. Liaison services for acute medical and psychiatric health services (e.g. pregnancy mentor health hepatitis services). Range of drug treatment interventions for drug misusing offenders.
Tier 4	Residential specialists drug treatment which is Planned and coordinated to ensure continuity of care and after-care (*Specialist bespoke inpatient residential substance misuse units or wards)*
Interventions	Inpatient specialist drug and alcohol detoxification and stabilisation services. A range of drug and our call residential rehabilitation units to suit the needs of different service users. Range of drug "halfway houses" or supported accommodation.

These tiers already exist within Edinburgh substance misuse services.

Stepped care Models

Stepped care embodies two key principles:

1. Treatment should always have the best chance of delivering positive outcomes while burdening the patient as little as possible.

2. Scheduled reviews, to detect and act on non-improvement, must be in place to enable stepping up to more intensive treatments, stepping down where a less intensive treatment becomes appropriate and stepping out when an alternative treatment or no treatment become appropriate.

Current provision of stepped care in Lothian Substance misuse service:

Turning point and Lifeline have elements of stepped care built into their service specification. At a basic level and degree of stepped care already exists in NHS Lothian substance misuse treatment services: with general practice in theory, providing the lowest tier of ORT, SMD providing the next level and residential treatment being provided by LEAP and the Ritson clinic. However, the current system lacks sophistication and anomalies in provision mean that the level of provision currently is not consistently matched to clinical need.

Stepped care should standardise systems and procedures with the explicit aim of improving efficiency. In stepped care the least intensive intervention that is appropriate for a person is typically provided first, and people can step up or down the pathway according to changing needs and in response to treatment and recovery. Rather than regarding withdrawal from therapy as a reflection of a lack of motivation for treatment on the part of the patient, stepped care models see monitoring

of progress and outcome as a fundamental responsibility of therapists and the system of care within which they work.

Stepped care models need to recognise that adverse consequences may result from patients entering on too low a step and if judgements about 'treatment failure' at lower levels may adversely affect outcomes if this results in discharge rather than reviewing the current care needs. In Opiate dependence both these risks can be mitigated against by structured case review and attention to cultural factors within the team.

Efficiency assumption: integral to the stepped care model is the assumption that minimal interventions are more efficient because they use minimal resources. I could find no evidence that tested this theory in opiate dependence. However studies in alcohol treatment have quoted data relating to 'therapist hours per abstinent patient'. It may be useful to carry out a more comprehensive analysis of costs and outcomes, such as direct treatment costs in other sectors (e.g. primary and secondary care visits and medication, use of social services and third sector providers) and whole system treatment costs.

Acceptability assumption: stepped care assumes that clients will accept the limitations on access imposed by the step structure. I could find no direct research on acceptability in the opiate dependent population. A second important issue is the acceptability of stepped care to professionals. It cannot be assumed that all professionals will feel comfortable with the philosophical assumptions that underpin stepped care models or the changes to working methods that may be required.

In England the National Institute of Clinical Excellence (NICE) has already recommended step care models treatment of mental health disorders such as depression and there are examples of stepped care models in the UK for psychological therapies.

Figure 4 Stepped care model for psychological therapies:

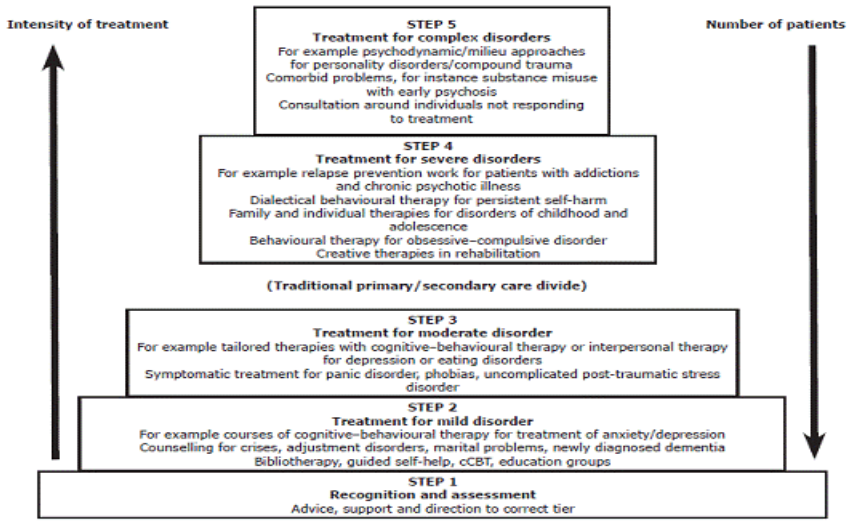
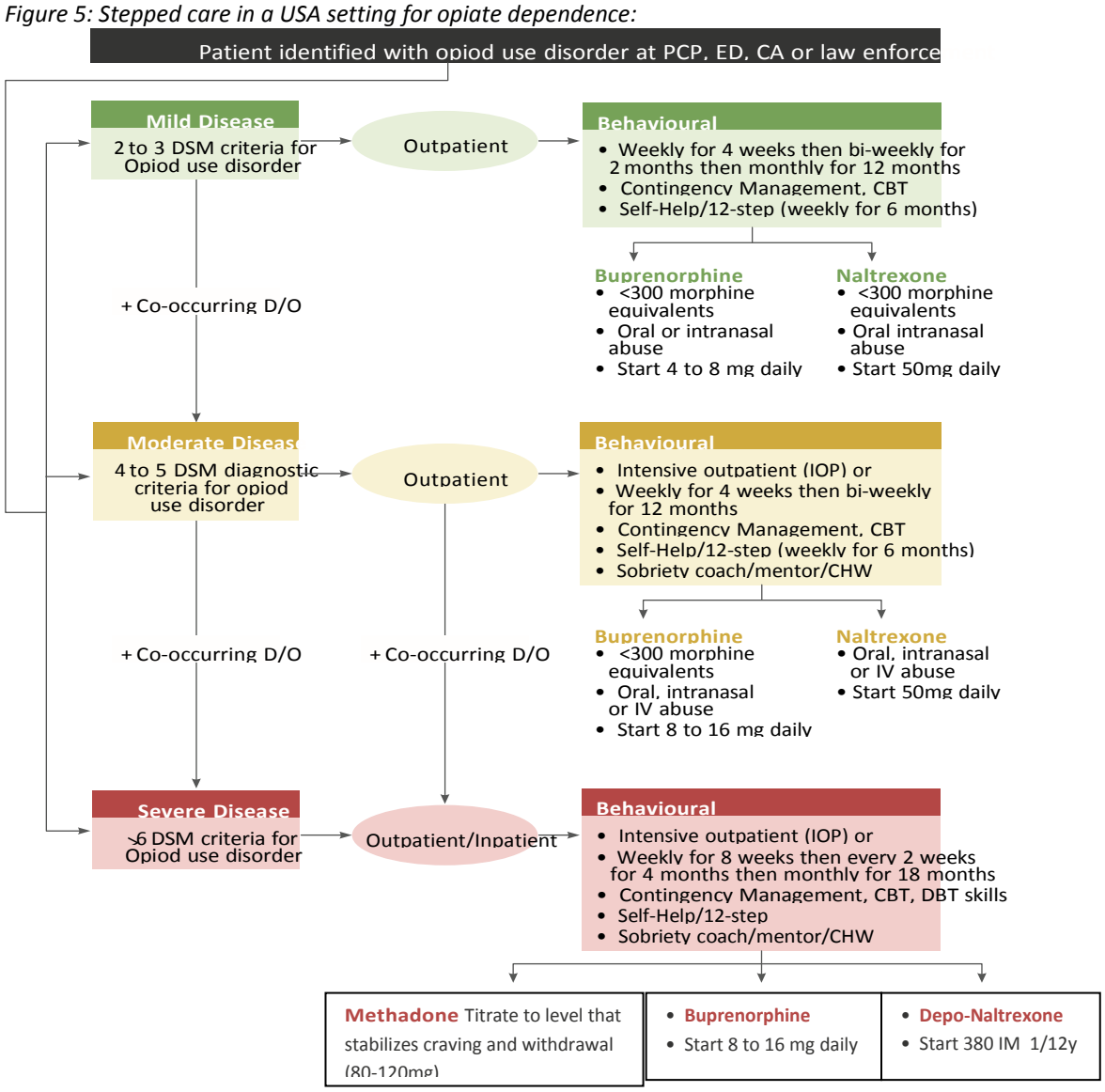


Figure 5: Stepped care in a USA setting for opiate dependence:



Layering and Phasing:

This approach involves developing a dynamic pathway where phasing of treatment and layering of interventions is more fluid and time limited. Outlining phases of treatment provides a framework which can be useful to both the patient and those involved in delivering treatment. It can be used to outline expectations from both the patient and the workers which facilitate optimal benefit. Although phases appear to be linear it must be recognised that substance misuse is a non linear relapsing condition and patients may move quickly between phases.

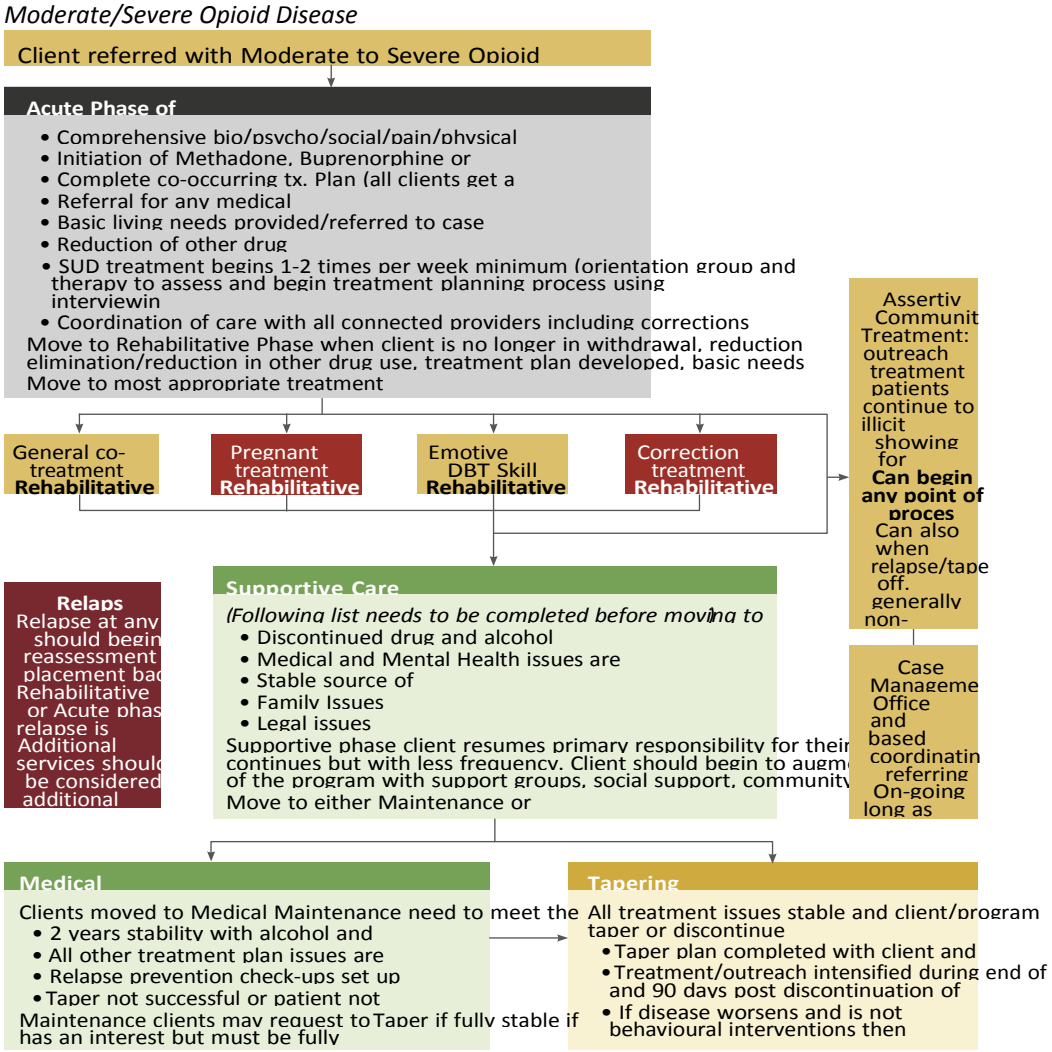
Layering interventions within each phase recognises that individuals have different needs and varying severity of need. Defining the layers of intervention will make sure that the appropriate level of care is provided by the appropriate person and for the appropriate timescale. Interventions will be offered on a case-by-case basis through independent clinical and/or managerial decisions. It is the intensity of intervention and the seniority of staff delivering intervention that are stepped in this model. For instance choosing any suitable intervention for a patient with anxiety problems who is in the maintenance phase will be determined by a combination of level of dependence and severity of mental health problem. Thus the patients who is severely dependent with severe and enduring mental health problem would receive input from a senior psychologist compared to a patient with a

low level of physical dependence, who has no underlying severe mental health problems who would receive anxiety management through one of the anxiety groups delivered by the statutory services.

Another example would be in choosing the prescriber for initiating opiate replacement therapy: it patient with a low-level physical dependence who had no significant mental or physical health problems would enter the non-medical prescriber titration route whereas a patient with a high level of physical dependence with co morbid substance use and complex physical health issues would enter a medical prescribing titration route. (See recommendations for further details.)

Regular recovery care plan reviews and the recovery-orientated culture, enhanced visibility and facilitated access to mutual aid, and a more overt collaborative approach to care planning should ensure nobody stays on ORT for any longer than appropriate. However, it is equally vital that resources are used efficiently and are not wasted in providing interventions that are not likely to be successful.

Figure 6: An example of a phased model: Opiate Treatment Path Behavioural Health Paths For Moderate/Severe Opioid Disease



Section 5: Conclusions and Recommendations

It is clear that the current systems and structures are not providing best use of current resources nor delivering timely treatment with which it is easy to engage. Even recognising the stressors from the recent new contract implementation it is disappointing that so few patients are remaining engaged with the service or obtaining a prescription within two months.

If the current key working approach to treatment is to be continued there would need to be substantial increases in the numbers of staff available to deliver the pathway.

There are many interesting lessons to be learned from the NUKA model. In particular the concepts of a panel of care providers links to a defined population of service users offers a new way of working. Historically, the key working model has developed without any clear evidence base and the NUKA concepts of reducing the number of service determined appointments and moving to patients led interventions centres around agreed areas of need would fit well with the recovery model that is now accepted in Scotland.

Recommendation 1: Change to a Single system- reconfigure services around panels of caregivers aligned with new GP clusters.

This recommendation involves moving to a single system of care which would negate the need for referrals between agencies, multiple reassessments and duplicate outcome measures.

How this would work: each panel would have a maximum of about 10 members drawn from NHS nonstatutory services and social work. The aim would be to retain patients within this panel until they are ready for discharge back to the GP. Each patient would have a nominated case manager who would work through the episode of care. The Case worker not necessarily be responsible for key working, rather their role would be assessing and monitoring the service user's needs on an ongoing basis, co-ordinating the provision of care from different agencies, organising care review meetings and inviting relevant parties, ensuring compliance with local protocols and ensuring that the service user and their family are given the opportunity to play an active role in the planning and review of care. The decision about which individual worker or agency should act as should be taken on the basis of the person most likely to be able to deliver on the interventions required. Factors relevant to this decision may include:

- Service user's preference
- Level and nature of assessed risk to the service user and to others
- Relative level and frequency of involvement with service user
- Legal or statutory requirements e.g. Care Programme Approach, Childcare issues

Other care givers would be responsible for conducting specialist assessment when required, providing specialist care, monitoring that aspect of care, attending or providing written evidence at care review meetings and providing ongoing feedback to the case manager.

This system would rely on effective integrated care across services and would be greatly facilitated by location of the core members of the team. Team meetings with the attendance by core panel

members and would have responsibility for reviewing new assessments, regular reviews and discharges (both planned and unplanned). Team meetings would also be an option, chief discussing duty calls and complex cases.

In order for this to work most effectively a single record and unifying administration systems would be required.

Membership of each panel:

Panel members working primarily within each panel	Care givers working across panels
Admin Support workers Case managers: third sector staff, Addiction CPNs, Addiction social workers Non medical prescriber	Psychologist GPSI/ Speciality doctor Consultant psychiatrist

Advantages of integrating care across services.

> *The **overarching aim** of integrated care is to support drug or alcohol users to overcome their drug or alcohol problem and their associated health and social difficulties by providing effective, co-ordinated and timely treatment and care.*

The layering and facing approach requires case managers to combine and co-ordinate all the services required to meet the assessed needs of the individual patient. This ensures that

- treatment, care and support to be person-centred, inclusive and holistic to address the wide ranging needs of drug and alcohol users;
- the service response to be needs-led and not limited by organisational or administrative practices;
- collaborative working between agencies and service providers at each stage in the progress of the individual in treatment, from initial assessment onwards
- access to all interventions involved in the phased pathway

In order to develop good integrated care it is important to recognise that there are a number of different treatment philosophies and approaches in the substance misuse field. These reflect the different beliefs, needs and priorities of both service users and providers. The NTA guidance identified three common barriers to partnership working:

- Culture clashes, ideological differences and rivalry between organisations
- Difficulty maintaining continuity of care when there are multiple agencies involved
- Difficulties in establishing accountability arrangements when multiple organisations are involved
- The Care manager not necessarily be responsible for key working, rather their role would be assessing and monitoring the service user's needs on an ongoing basis, co-ordinating the provision of care from different agencies, organising care review meetings and inviting

relevant parties, ensuring compliance with local protocols and ensuring that the service user and their family are given the opportunity to play an active role in the planning and review of care. Records kept by the Care Co-ordinator should provide evidence of the fulfilment of these functions.

Recommendation 2: Referral for ORT is expedited at triage assessment

The current pathway involves a complicated series of hurdles for chaotic patients to negotiate with consequent high levels of disengagement and delay. It is possible to move to a system where prescribing is initiated while comprehensive assessment is completed.

Options for improving the pathway:

1. Prescribing assessment: Define a smaller assessment with only key components required for suitability and urgency for commencement of ORT to be highlighted. This could be completed at triage assessment resulting in the next appointment being with the prescribing care givers.
2. Drug testing started at triage assessment for patients highlighted as suitable for ORT.
3. Moving to use of the Time Line Follow Back (TLFB) method of assessing substance use in lieu of drug diaries. This method of gathering substance use information has been successfully used in the treatment of alcohol disorders and can be used to gather valid data for up to the preceding 90 days.
4. Implementation of the recently approved titration guidance so that places in the titration clinic is released. Many patients seeking restart of treatment can be titrated in the community. This is not currently happening due to a combination of cultural and organisational factors. This could be facilitated by using non medical prescribers for community titration.

Recommendation 3: Move towards Integrated training and strategic development for a single system of care

For the single system approach to work it is important that treatment systems and services having a clear and coherent vision and framework for recovery that are visible to people in treatment, owned by all staff and maintained by strong leadership who will ensure that purposeful treatment interventions are properly assessed, planned, measured, reviewed and adapted. It is important that 'phased and layered' interventions are regularly reviewed by the staff group to ensure that they reflect the different needs of people at different times. Integrated training will ensure that the whole system remains focused on agreed goals and priorities.

Additionally there is a need for an overarching clinical lead that will have the responsibility for monitoring the effectiveness of the system, reviewing the strategy and providing feedback to the EADP Treatment and Recovery Commissioning Collaborative.

Recommendation 4: Prescribing carried out at a prescriber/patient appointment

Currently the majority of prescriptions are produced within the SMD through a batch prescribing process where key workers generate prescriptions, have them described and either post them, hand them to patients or delivered to community pharmacies. Prescribers only see patients when triggered by the key worker. One unintended consequence of this system is that patients on prescriptions must remain in key working.

Removing prescription management from the key worker would have two principal advantages. Firstly, a clinical advantage in that the prescriber is assessing the patient at the time that scripts are given, and ensuring that the prescription is appropriate. Secondly, key working can be focused on specific patients of work outside of prescription management. This would be expected to increase capacity for targeted key working.

There are several options for prescribing:

1. Increasing capacity in primary care

i) Formation of "super practices" where practices take on patients outside their own practice for Enhanced services

Pros: Access to medical prescribing, creation of centres of high expertise

Cons: May not be attractive to GP practices, May not represent "good value for money" as general medical services not integrated.

ii) Increasing capacity at existing practices

- Enabling a non-medical prescriber (nurse or pharmacist) within practices without reduction in payments through the enhanced contract, allowing GPs to focus on recovery work or co-morbidity and increasing capacity. Prescribing pharmacists could be provided where there is no enhanced prescribing by the GP. The use of non-medical prescribers within the SMD for enhanced practices was less welcome:-The GP view was that where non-medical prescribers were to be used they should probably work in Vision or EMIS, so that there was no loss of enhanced service funding. The significant loss of income for practices seeing many drug users was highlighted.
- Enabling specialist admin support workers who could arrange appointments and prescriptions as required, thereby removing this work from GPs. This would involve access to the Illy system which has much inbuilt system allowing streamlining of scheduling and prescribing generally. However it was difficult to see how these could be spread across a large number of practices and again, for stable patients, actually generating prescriptions is relatively straightforward and it is not always easy to anticipate when a next appointment is needed without seeing the patient first. Practice IT is already complex and a further web-based system with separate log-ins, when systems are already quite slow, might not be welcomed. However it might be useful for a small number of practices with a large number of drug misuse patients, or those which run clinics, where the titration reduction scripts and diary function might be of value.
- SMD nurses based in GP surgeries providing two-way help, i.e., able to refer patients to the GP for health issues and seeing patients where there are substance misuse difficulties. This currently happens in other areas in NHS Lothian, both for enhanced and non-enhanced

practices. IT and record keeping issues were felt to be unresolved with GP practices preference being for records to be kept on Vision or EMIS.

- Moving to a NUKA like system where all substance misuse services sit within primary care “panels” which cover the whole of NHS Lothian. This would involve the development of some "super practices" which would commit to taking on patients which are registered with non-enhanced practices.

1. Use of non-medical prescribers

Pharmacy prescribing options:

Pros:

- *Could be recruited and deployed relatively quickly.*
- *High level of competency in polypharmacy issues*
- *Skilled at managing a high volume of work efficiently: expected whole time of 160 – 200 cases.*

Cons:

- *Would need to develop skills specific to substance misuse prescribing*
- *Less able to manage co morbid physical or mental health*
- *Management issues need to be clarified*

There are several options for employing these individuals and these would need to be discussed at senior management level. There are pros and cons to embedding pharmacy prescribers within the substance misuse services, General Practice enhanced service or within the community. The main advantage of basing pharmacy prescribers outside the team is that it provides an avenue for discharge from the service. The main advantages of embedding pharmacists within the general practice enhanced service would be to increase capacity in that service and facilitate potential formation of "super practices" in real take on patients from non-prescribing practices. The main advantages of embedding in the substance misuse service are control of clinical governance, development of a shared culture, improved communication and retention of the patient within the whole system facilitating movement between prescribers. Pharmacists embedded within the team would be able to provide prescribing support as part as a holistic care plan at all phases of treatment. The third option would be to use independently contracted pharmacists for maintenance clinics with the prescribing component of their care being discharged from the substance misuse service.

Nursing non medical prescribing options:

Pros:

- *competencies in management of co-morbid mental or physical health (depending on training)*
- *Likely to be experienced in managing substance misuse*

Cons:

- *Unclear pool of recruits*
- *Few existing nurses in SMD have appropriate training*
- *Poor uptake of training in past*
- *Risk of loss of skills either through promotion to management role or movement to another post.*
- *May be more restrictive about which patients feel competent to prescribe for.*

Both types of non medical prescriber could provide the following.

- Provision of maintenance clinics for patients who are stable. This would require ring fenced time in nurses job plans to ensure clear delineation from any other activities such as keep working for group work. At interview it was felt that it may be possible for nursing non-medical prescribers to provide this role within the nursing team, but not (without further negotiation) for third sector agencies.
- To increase capacity at titration clinics. This is currently happening in some SMD areas for patients who are felt suitable for non-medical titration.
- Provision of more standardised detoxification with wider choice of medication.
- Provision of BBV treatment, wound care and treatment of wound infections in the hubs.

Recommendation 5: Implementing a stepped model embedding phasing and layering of interventions.

Defining phases of treatment:

MAT: Medication assisted treatment (see appendix 3) is a structured, evidence based, policy guided framework for the standardised delivery of methadone, buprenorphine or other maintenance treatment for opioid dependent users.

The programme is specifically called medication *assisted* treatment in order to prioritise the non-pharmacological, therapeutic components of comprehensive maintenance treatment while at the same time recognising the crucial but adjunctive role played by the prescription itself. The focus of treatment is to promote recovery and enable patient responsibility for this.

NHS Lothian SMD recognises that best outcomes are achieved while the client progresses through a structured treatment programme. This is why a client needs to most effectively utilise his or her time in treatment in order to prepare for eventual, mutually agreed, discharge from treatment. Clear boundaries and expectations for both patient and key worker are essential for consistent movement through the recovery process.

How could this work?

The programme defines 4 main phases of treatment: Engagement/assessment, Stabilisation, Maintenance and Detoxification..

It is important to define the minimum number of layers if intensity which delivers optimal levels of care according to need. Addiction patients are particularly complex in the spectrum of their needs and use of a point system across axes can help define the intensity of intervention and the relevant level of skill needed to deliver that intervention. For safe delivery of opiate replacement therapy it is important to define both the prescriber and the case manager who will be responsible for monitoring the patient and feeding back changes in the clinical state which could have an immediate effect on the prescription. I have suggested minimum required input for each of these in the table below.

Table: Layered care grid for ORT

1= case manager *2= Prescriber*		**Severity of Dependence** (*Score based on table A)*		
		Low *(0-2)*	Medium *(2-5)*	High *(6+)*
Level of Health Complexity *(Score based on table B)*	Low 0-2	1. Third sector / Social Worker 2. NMP / GP	1. Third sector / Social Worker 2. NMP / GP	1. Nurse 2. NMP
	Medium 2-5	1. Third sector / Social Worker 2. NMP / GP	1. Nurse 2. NMP/GP	1. Nurse 2. GPSI
	High 6+	1. Nurse 2. Nursing NMP/ GPSI	1. Nurse 2. GPSI	1. Nurse 2. Consultant

(the role of social work to be clarified)

Table A: Determining level of Dependence: Suggested scoring system (will need to be refined once in use)

Points scored in each category. Max =10		Factor indicating severity of dependence relevant to ORT				
		Length of opiate dependence	Accidental Drug Overdose history	Injecting status	Benzodiazepine use (diazepam equivalent) and alcohol use (weekly units/ dependence)	Other Sedating drug use
Points	0	< 5 years	None	None	< 30mg/day <21 units/week	none
	1	6-10 years	1 episode in last 3 months	Peripheral sites only	30-50mg daily and 50mg max in single dose. 22- 50 units but not dependent	1-2 other substances being used
	2	11+ years	>1 episode in last 3 months,	Groin / neck injector	50mg daily and /or using > 50 mg in single dose Alcohol dependence	3 or more other substances being used or risky gabapentanoid use

Table B: Determining Level of Health complexity: Suggested scoring system (will need to be refined once in use)

Points scored for each box. Max =10		Health Factor relevant to ORT				
		Physical health			Mental health	
Points	0	< 35 years old	Minor pain issues	Well controlled asthma / chest condition	Well controlled mental health issues	No admissions in last 12 months
	1	35 – 50 years old	Prescribed minor opiates for pain	Poorly controlled chest condition under GP care	Symptomatic : ADHD Depression Anxiety Personality disorder	Admitted for mental health in last 12 months
	2	Over 50 years old	Complex pharmacology relating to pain and mental health	Admitted for physical health in last 3 months	Severe enduring mental health issue with active symptoms	Admitted under mental health act for mental health in last 3 months

Recommendation 6: Clarify social work staff contribution to the ORT pathway

Social work addiction staff have a unique set of skills that can provide valuable input to the ORT pathway. There is not universal understanding within the hubs of their role in relation to working with social complexity particularly in relation to third sector project workers. This may be difficult to achieve within a written protocol or separate stepped care model. Instead teams should further integrate into the Hubs model so that all referrals (including those which are direct to Social Work) go through the triage and the most complex are allocated to Social Work to act as the key worker. Opportunities for co-location will no doubt aid this process.

Recommendation 7: Refocus the current LTMP service towards intensive treatment for high tariff patients as part of the integrated pathway.

The LTMP service was perceived as a valuable resource which it would not be practicable to reproduce in the hubs. There would be benefits to improving integration into the wider ORT pathway, communication with the local teams and simplifying transfer across services.

The service could be better explicitly targeted at those who are hard to engage at the hubs and who have the most complex needs, rather than the current perception of being for groin injectors only.

Appendixes

Appendix 1: Scoping paper for this project **From:** Watson, Fiona E **Sent:** 31 May 2016 15:48 **To:** Cockayne, Lucy; Kehoe, Michael; Lawrence, Rebecca; Petrie, Rachel; Stewart, Duncan; Brown, Christopher J; Craven, Judith; Miles, David; Ewart, David; Scott, Ian; Marshall, Jane; McCartney, David; Murray-Park, Rowena; Simmonte, Muriel; Tay, Joe; Thomas, Digby; Williams, Nigel **Cc:** Mckigen, Tracey; Eccles, Debbie **Subject:** FW: Stepped care model for ORT delivery

Dear all
I received the attached from Nick Smith and have suggested to him that I circulate to the SMD consultants and GPs for note of interest. This means that the whole system is now being considered (i.e. residential and community) which is good, albeit by slightly different processes. You will see that although Nick would like a Lothianwide solution, East, Mid and West Lothian have not yet replied to him, so the focus may remain Edinburgh services.He is suggesting one session per week for 6 weeks but there is probably room for negotiation on that. I would endeavour to source any backfill that was required for whoever does the work.
Please review Nick's paper and let me know if you are interested. Time is of the essence, so comments by close of play on 8 June please.
Regards
Fiona

Developing a stepped care approach to opiate replacement therapy in Lothian

Introduction
This paper sets out the requirements of the three ADPs in Lothian in developing a stepped care approach to the provision of opiate replacement therapy (ORT). It summarises current arrangements and sets out the deliverables and timeframes for the review.

Background and context
The three ADPs share a priority to develop a recovery oriented system of care for adults with drug/alcohol problems and their families. The planning and delivery of this priority happens at a local level in partnership through ADP structures. This includes the provision of ORT within a number of settings.

The Scottish Government has indicated that there will be a 20% reduction in the earmarked funding for drug/alcohol services available to ADPs at a national level. In Edinburgh this reduction equates to an approximate cut of £1.38 million and £460k in Midlothian & East Lothian and West Lothian respectively. It is very likely that the funding available for alcohol and drug treatment will continue to reduce for the foreseeable future and this presents significant challenges to the current model of care. It is anticipated that there needs to be a £90k (+ Mid & East and West Lothian) saving against this pathway.

As a result the three ADPs are seeking to develop a stepped care approach to the provision of ORT across the Third Sector, Social Work, SMD community clinical services within the Hubs, Harm Reduction Team and primary care. The intention is to ensure that people's ORT needs are met safely efficiently in a way that enhances access to other recovery oriented provision.

ORT delivery
Edinburgh and Lothians are unique in the levels of GP involvement in the delivery of ORT. This approach has been developed in response to the needs of local communities and is a significant asset within the system of care. This operates under a national enhanced service agreement (NES) between NHS Lothian and GPs as contractors.

Alongside GPs there are a number of professionals who are currently involved in the provision of ORT within the community. These are:

- Consultant psychiatrists
- Nurses
- GPs with a specialist interest in substance misuse who work within specialist drug/alcohol services
- Third sector practitioners and Social Workers (by providing triage, comprehensive assessment and key working to those receive ORT)
- Pharmacists
- GPs in primary care

Given the current financial and capacity challenges the three ADPs require a stepped care model which safely reduces demand on the most expensive professionals and services. The model needs to consider Nurse and Pharmacist prescribing, as well as the role of the Third Sector and Social Workers particularly in their capacity as key workers.

Edinburgh

In Edinburgh there are currently about 3,400[1] people in clinical treatment with primary drugs issues, of whom 2,800 are in primary care and 550 in SMD clinical teams within the Hubs. The vast majority of these will be receiving ORT. There is a slight trend of a reducing number of opiate users (particularly younger users) presenting over time, but the total number of people in care is not likely to significantly decline in the near future. Given the demand for treatment in the hubs and risks to primary care's ability to deliver at current levels (due to shrinking GP numbers) the current model of delivery is probably unsustainable even without reductions in funding: there is too much demand for the capacity available.

In Edinburgh in particular the waiting time for ORT can be long and the inability to offer easy access to ORT has implications for drug related death risks and impacts on every aspect of drug users' lives. Edinburgh has not achieved the HEAT waiting times target since December 2014 and the longest reported current wait is over 26 weeks. As a result many patients who are ready to access ORT are unable to access it quickly and, presumably, a further group are deterred from seeking help by the length of the wait. There is clearly a high level of demand on the clinical teams within the Hubs whilst they continue to operate under the current model of care.

Estimates by SMD teams within the Hubs suggest that 10-15% of all patients on the caseloads of the nurses are opiate users who are ready for GP only care but cannot be transferred to their GP for capacity reasons or because they are not part of the NES scheme. This is a significant problem as these patients cannot continue their treatment with their local GP and they taking capacity in the most specialist service.

Recent development work has sought to shift non-clinical tasks from Nurses to the Third Sector to increase capacity. This includes triage, comprehensive assessment, key working, and responsibility for developing peer working. However the financial challenge requires a review of the model of care across services in order to future-proof provision for 2016/17 and beyond.

Midlothian and East Lothian

We will need to populate this with Mid and East data.

In Midlothian and East Lothian, the HEAT A11 standard is being met but for a number of months NHSL services have not met the 90% target. NHSL services are working towards ensuring that the standard is consistently met.

[1] NES data and Waiting times data

West Lothian

Key deliverables

1. **Develop a clear stepped care model for delivering ORT**

   The model should set out clearly how people's ORT needs can be safely and practically met at the lowest step in the model. This should include service descriptions of each step as well as clinical and social criteria. New thinking is needed about the roles of existing professional groups including the role of the third sector, nurse and pharmacist as well as the role of GPs with a special interest in drug treatment within specialist services.

2. **A plan for developing non medical prescribing**

   There are opportunities to develop non medical prescribing within the Nursing and Pharmacy professions. The role of Nurse and Pharmacy prescribing will need to be included within the stepped care model, however a plan is needed for how nurse and pharmacy prescribing can be developed within localities in each of the ADP areas.

Timescales

30 July Develop stepped care model

Each Locality would responsible for implementing the model alongside key partners.

Appendix 2 Evidence around ORT provision and key policies applicable to service provision:

It was not in the remit of this report to carry out a formal literature review around evidence for ORT. However A summary of the key evidence based recommendations will help inform service provision:

Long term USA studies suggest that, over 30 years, half of dependent users will die, one fifth will recover and the remainder will continue to use opiates, albeit some at a lower level xx3. Well-delivered ORT provides a platform of stability and safety that protects people and creates the time and space for them to move forward in their personal recovery journeys. ORT has an important and legitimate place within recovery orientated systems of care.

Methadone treatment has been used for more than 30 years to effectively and safely treat opioid addiction. Properly prescribed, methadone is not intoxicating or sedating, and its effects do not interfere with ordinary activities such as driving a car. The medication is taken orally and it suppresses opioid withdrawal for 24 to 36 hours. Patients are able to perceive pain and have emotional reactions. Most important, methadone relieves the craving, a major reason for relapse, associated with Opioid Use Disorders. It is also been shown that the quality of life in patients on methadone maintenance treatment is significantly improved. Among methadone patients, it has been found that normal street doses of heroin are ineffective at producing euphoria, thus making the use of heroin more easily extinguishable.[4]

Buprenorphine is a particularly attractive treatment for Opioid Use Disorders because, compared with other medications, such as methadone, it causes weaker opiate effects and is less likely to cause overdose problems. it is a partial agonist at the mu opioid receptor which allows for a decreased overall increase in dopamine release thus creating a ceiling effect of the addictive potential of the medication. Buprenorphine also produces a lower level of physical dependence, so patients who discontinue the medication generally have fewer withdrawal symptoms than do those who stop taking methadone. Because of these advantages, buprenorphine is appropriate for use in a wider variety of treatment settings than other currently available

medications. Several other medications with potential for treating heroin overdose or addiction are currently under investigation by NIDA.

Naloxone and naltrexone are medications that also block the effects of morphine, heroin, and other opioids. As antagonists, they are especially useful as antidotes. Naltrexone has long-lasting effects, ranging from 1 to 3 days, depending on the dose. The injectable version of Naltrexone (Vivitrol*) lasts for 30 days. Naltrexone blocks the pleasurable effects of heroin and is useful in treating some highly motivated individuals. Naltrexone has also been found to be successful in preventing relapse by former opioid addicts released from prison on probation.

Although behavioural and pharmacologic treatments can be extremely useful when employed alone, science has taught us that integrating both types of treatments will ultimately be the most effective approach. The majority of research finds that the type of psychological intervention is less important than the therapist factors. The 2012 guidance from the British Association for pharmacology summarised the research findings around supervised consumption and specific psychological therapies: “The optimal mode of delivery of methadone is unknown. The majority of research studies are based on supervised consumption, so the advantages of supervision over unsupervised dosing are therefore not established… An updated Cochrane review (Amato et al., 2011a) examined the effectiveness of agonist maintenance treatment combined with a specific psychosocial treatment versus the effectiveness of agonist maintenance treatment alone (with standard counselling)... An earlier version of this review showed a reduction in heroin use with addiction of a psychosocial treatment, but the updated version with added studies found no evidence of reduction in heroin use or number of patients abstinent at the end of follow-up. There is no clear evidence of enhancement of agonist maintenance treatments by specific psychosocial treatments”

Appendix 3: Outline of revised NHSL MAT Framework (original under development by the Practice Development Group, subgroup of the SMD Quality improvement team)

Phase of MAT & timeframe	Goals	Prescribing	Role of Key worker	Other Interventions
Phase 1 Engagement and Assessment (target: 21 days from most, 5 days for high risk patients)	Assessment for appropriate treatment (not necessarily medication). Naloxone training/ provision	None, unless transfer from other prescriber (any transferred script to be daily supervised)	Comprehensive assessment using • SMD Assessment • Care Bundle • Recovery Plan	Liaise with Other agencies • General Adult • GP • Partnership agencies
Phase 2 Stabilisation (target: 12 appointments)	Medical assessment where needed Cease i.v. use and dependence on illicit opiates. Minimised substance use Harm reduction	Titration onto opiate substitution Alcohol detoxification Dose adjustment until client neither in withdrawal nor craving and not dependent on illicit opiates use / ceased. (evidenced by opiate and MAM negative samples)	Regular review of adequacy of medication dose Address other drug and alcohol use Engage with recovery plan Harm reduction advice + information	BBV evaluation, testing and primary immunisations Referral to BBV service if required Child protection assessment Liaise with GP and other Services Engagement with recovery activities
Phase 3 Maintenance ORT	Work towards and maintain total abstinence from illicit opiates Address other drug and alcohol use	Methadone or Buprenorphine for most clients Diazepam detoxification in some circumstances Relapse prevention	Case management Prescribing reviews Engagement with recovery plan.	Vaccination boosters Referral to other agencies as required
Phase 4 Opiate Detoxification	To detoxify and maintain abstinence after detoxification	Detoxification and induction onto Naltrexone for relapse prevention if appropriate	Supervise detoxification	Joint care plan with aftercare agencies