

Locally Enhanced Service for Substance Misuse

Reference: LES18

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1. Financial Details

This agreement is to cover 2009/10 commencing 1 April 2010. Participating practices will be able to sign up to two levels of service:

Level 1

This is the core level of service for practices to participate in the scheme, whereby practices prescribe for their own registered patients. Practices will be paid £244.20 per patient per annum. This will be paid quarterly, one month in arrears.

Payments will be generated via submission on the standard PCT quarterly monitoring returns to the Primary Care Manager.

The Shared Care Co-ordinator will contact each surgery following submission and request client data to verify claims made. A prescribing audit will also be carried out by the Medicines Management team on a bi-annual basis and for comparison against activity under the LES. Further information and action may then result.

Practices must participate in two local training updates throughout the year,. Where they have a GP that has completed the RCGP Substance Misuse Qualification, Part One., a minimum of one local training update is required.

Practices may also be asked to participate in accommodating outreach clinics by DRIVE designed to provide more accessible venues for service users. This will be by negotiation and of benefit to practices that have a larger number of patients in shared care.

2. Service Aims

Drug misuse and its complications pervade every part of society and social classes and are a problem found across the whole country.

The number of drug users in the general population is estimated to be in the regions of 150,000 – 200,000, though since the demise of the Home Office Addicts Index, exact prevalence rates are difficult to estimate accurately. Based on current estimates however, it would be expected that almost every general practitioner would have patients with drug misuse registered with them, though prevalence rates in inner cities and urban areas will be significantly higher than in rural areas.

The following elements of the service would need to be in place already for the purpose of this LES:

- (i) an accurate register of patients**
- (ii) a sequential review as appropriate**
- (iii) safe and secure practices, appropriate for the provision of such services**
- (iv) a good knowledge of, and effective liaison with, local drug services and other agencies, including non-statutory services**
- (v) links between local pharmacies, primary care drug support workers, social services (including the Child Protection Service) and local mental and clinical health teams.**

This specification incorporates details included in the Shared Care Handbook 2008 developed by the Shared Care Monitoring Group, and this document should be read in conjunction with this specification.

Defining Shared Care

The Department of Health has defined shared care as follows:

“The joint participation of specialists and GPs (and other agencies as appropriate) in the planned delivery of care for patients with a drug misuse problem informed by an enhanced information exchange beyond routine discharge and referral letters. It may involve the day to day management by the GP of the patient’s medical needs in relation to his or her drug misuse. Such arrangements would make explicit which clinician was responsible for different aspects of the patient’s treatment and care. This may include prescribing substitute drugs in appropriate circumstances”. (*Department of Health, 1995*).

Shared Care: Working in partnership

GPs have been actively involved in treating drug users for many years, particularly in areas where there has been a scarcity of specialist drug services and where non-prescribing services have needed the assistance of GPs to enable them to offer stabilisation and detoxification to clients.

UK national policy seeks to encourage GPs and primary care services to be more actively involved in treating drug users because it is thought to encourage users to access treatment earlier in areas where accessibility to specialist services is limited. National pressure to develop shared care schemes has been strongly influenced by the Government’s national strategy (National Drugs Strategy – Drugs protecting families and communities (2008-2018)) setting a target of increasing the participation of problem drug users in drug treatment programmes with a positive impact on health and crime.

Shared care emphasises the importance of **partnership** working - ie GPs **should not prescribe in isolation** - but agree a care plan with colleagues from the designated specialist agency (**DRIVE**) - and jointly deliver treatment enabling clients to stabilise on substitute medication and eventually become drug free. Shared Care is therefore a rational model to improve service delivery, utilising different skills in an effective manner. **It is not limited to prescribing** and covers a range of treatment options for clients including psychosocial interventions. Appendix 1 describes the responsibilities of GPs and specialist drug workers participating in shared care please also refer to Shared Care Handbook for outline of responsibilities for all agencies involved in treatment of substance misusers.

Benefits of shared care

Shared care can benefit those living in areas where there may be limited access to specialist services. Shared care is thought to be increasingly preferred by some drug users wishing to access treatment in a primary care setting in the community (Drug Misuse and Dependence Guidelines on Clinical Management 2007 Department of Health). It is also thought to:

- Normalise the process of obtaining treatment for drug users and be less stigmatising
- Increase opportunities for younger people and adults to seek help at an earlier stage in their drug using career - particularly those well known to their GP, who may be able to assess their drug use in the wider context of knowledge of the family (recognising that some may prefer not to consult their own GP because of family connection and concerns about confidentiality)
- Improve the overall quality of physical health as drug misusers appear to learn to make more appropriate use of primary care benefitting themselves and their families.
- Enable general practitioners to provide a more holistic form of health care
- Enable the specialist drug services to concentrate resources on clients with more complex needs and those requiring formal psychological treatment.

Patients suitable for shared care scheme

Please refer to Shared Care Handbook for criteria and care pathways for Shared Care clients

Aims of treatment within a harm minimisation philosophy

Introduction: The primary goal of any drug treatment strategy should be one of minimising the physical, social and psychological harm to individuals and to society. While a long-term goal of helping clients to achieve total abstinence is desirable this is rarely achieved by pressurising individuals to change their behaviour and stop drug use when they are insufficiently motivated or able to do so.

Harm minimisation strategies help to reduce the major health risks associated with injecting and other risk taking behaviour associated with drug misuse and enable people to start taking responsibility for managing their drug use themselves by reducing the risk of harm to others and society. Prescribing the appropriate dose of substitute medication on a stabilising basis helps to alleviate symptoms of withdrawal enabling people to engage with the treatment process and eventually cease illicit drug use - although many will experience

difficulty initially in both ceasing to take heroin and stopping injecting. A maintenance programme can add structure and stability to the life of a former illicit drug user

Overall aim of treatment:

- To enable individuals to engage in a process of change whereby their drug taking and risky behaviour ceases to have an impact on their lifestyle.
- To enable people to assume their human rights and responsibilities and an opportunity to develop a drug free life and integrate into society.

Objectives:

1. Stopping or reducing the use of illicit or non-prescribed drugs by the individual
2. Reducing the risk of prescribed drugs being diverted onto the illicit market
3. Assisting the client to remain healthy, until with appropriate care and support, he/she can achieve a street-drug-free life
4. Reducing the dangers associated with drug misuse, particularly the risk of HIV, Hepatitis B and C, and other blood borne infections especially from injecting, sharing injecting equipment and sexual transmission.
5. Enabling the client to engage with the treatment process and achieve sufficient stability so that he/she may address emotional, social and family problems - and re-engage with the wider community by accessing new interests, training and job opportunities to assist in maintaining change and achieving a drug free lifestyle
6. Reducing the need for criminal activity to finance drug misuse.
7. Reducing the duration of episodes of drug misuse and the chance of future relapse.
8. Reducing deaths from both prescribed and illicit drug use (including alcohol use)

3. Criteria

The Locally Enhanced Service Specification utilises the following criteria, as set out in the Nationally Enhanced Service Specification. Modifications to these criteria reflect local circumstances as of 1st April 2007. The criteria are:

1. Direct Service Delivery
2. Data Collection
3. Facilities
4. Staffing
5. Liaison/Shared Care
6. Review/Audit

On aspiring to the level 2 service, practices should submit evidence of completion of the RCGP Part Two qualification. They may also be asked to complete brief business plans that satisfy these criteria.

Criteria One : Direct Service Delivery

- **develop and co-ordinate the care of drug users and develop practice guidelines.** Practices must have knowledge of local detoxification procedures
- **treat dependent drug users with support.** This will be with specialist support from, for

example, the shared care Community Drug and Alcohol Team service and specialist providers. GpWsl and nurses with specialist interest may be also be developed. It includes the prescribing of substitute (opiate and non-opiate) drugs or antagonists using best practice as outlined in the Drug Misuse and Dependence Guidelines on Clinical Management 2007 and NICE guidelines published 2007

- **ensure that prescribing takes place within a context in which the co-existing physical, emotional, social and legal problems are addressed as far as possible.**
- **provide care for patients outside their own registered list (if the practice has agreed to look after such patients).** These patients must have an effective means of communication with the registered doctor.
- a sequential review as appropriate
- A practitioner providing enhanced services in drugs and substance misuse should have the skills to:
 - (i) identify and treat the common complications of drug misuse
 - (ii) carry out an assessment of a patient's drug use
 - (iii) provide harm reduction advice to a current drug user or his or her family
 - (iv) test (or refer for testing) for other viruses, including HIV, and immunisation for hepatitis B to at-risk individuals
 - (v) provide drug information to carers and users as to the effects, harms and treatment options for various common drugs of use
 - (vi) assess and refer appropriately, patients for drug misuse substitution treatment
 - (vii) utilise the range of commonly used treatment options available for treatment including pharmacological interventions
 - (viii) be aware of local policy
 - (ix) work in an appropriate multidisciplinary manner.

Criteria Two: Data Collection

- Develop and maintain an accurate register of all patients receiving treatment under this specification

Criteria Three: Facilities

- Practice in safe and secure premises, appropriate for the provision of such services

Criteria Four : Staffing

- ensure that all staff providing the service to patients will have the necessary skill and training to do so. This includes continuing training and professional development
- **demonstrate additional training and continuing professional development.** This should be commensurate with the level of service provision expected of a clinician in line with any national or local guidance to meet the requirements of revalidation
- **maintain the safety and training of clinical and non-clinical staff**
- It is expected that the level of training required for a GP providing an enhanced service is identified in the GP's personal development plan and, where additional training is required, local mechanisms are found to address this.

Criteria Five : Liaison/Shared Care

- Exhibit a good knowledge of, and effective liaison with, local drug services and other agencies, including non-statutory services

- links between local pharmacies (particularly those providing supervised consumption), primary care drug support workers, social services (including the Child Protection Service) and local mental and clinical health teams.
- Practices must have knowledge of local detoxification procedures
- Act as a resource to practice colleagues in the care of drug users.

Criteria Six : Review/Audit

All practices undertaking this service will be subject to an annual review, coordinated by the PCT Shared Care Coordinator, including an:

- audit of prescribing of substitute medication if appropriate and adherence to the minimum standards laid out by the PCT / shared care monitoring group
- audit of hepatitis B screening and immunisation data relevant to this patient population.

Additionally practices will be subject to an annual review including the following:

- attendance rates
- non-attendance rates
- review against outcomes
- financial review.

4. Accreditation

Those doctors who have previously provided services similar to this enhanced service and who satisfy at appraisal and revalidation that they have such continuing medical experience, training and competence as is necessary to enable them to contract for the enhanced service shall be deemed professionally qualified to do so.

For 2010/11, this will include participating in local training events as a minimum, completing the Part One RCGP qualification is another option.

A practitioner providing enhanced services in drugs and substance misuse should have the skills to:

- (i) identify and treat the common complications of drug misuse
- (ii) carry out an assessment of a patient's drug use
- (iii) provide harm reduction advice to a current drug user or his or her family
- (iv) test (or refer for testing) for other viruses, including HIV, and immunisation for hepatitis B to at-risk individuals
- (v) provide drug information to carers and users as to the effects, harms and treatment options for various common drugs of use
- (vi) assess and refer appropriately, patients for drug misuse substitution treatment
- (vii) utilise the range of commonly used treatment options available for treatment including pharmacological interventions
- (viii) be aware of local policy
- (ix) work in an appropriate multidisciplinary manner.

Appraisal criteria

The appraisal criteria will include both the generalist and special interest aspects of the work.

GP role and responsibilities:

- With appropriate specialist training (RCGP part one and/or part two on substitute prescribing and treatment of drug users in primary care) - to take clinical responsibility for substitute prescribing with support from the specialist drug worker.
- To participate in regular bi-monthly / quarterly review meetings with specialist drug key worker
- To participate in regular peer support/supervision/training sessions.

CPD requirements

It is expected that the level of training required for a GP providing an enhanced service is identified in the GP's personal development plan and, where additional training is required, local mechanisms are found to address this.

5. Ongoing Measurement & Evaluation

The ongoing measurement will be the annual review including the following:

- attendance rates
- non-attendance rates
- review against outcomes
- financial review

This will also assist the practice and the PCT in assessing the baseline for contracting under an upgraded specification after the period that this specification covers.

In addition the practice is required to agree with the PCT an outline plan at the start of the year and to submit a completed document at the end of the contractual period for evaluation purposes.

7. Signature Sheet

This document constitutes the agreement between the practice and the PCT in regards to this locally enhanced service.

Practice Stamp

By signing this agreement, the above practice agrees to provide this service in accordance with the service specifications.

Please detail all General Practitioners who will be offering this service:

GP Name	Date of RCGP*

*Please attach copies of certificates

Signature on behalf of the Practice:

Signature	Name	Date

Signature on behalf of the PCT:

Signature	Name	Date