SPECIFICATION FOR THE PROVISION OF A

LOCAL COMMISSIONED SERVICE

SERVICE:	**Opiate Drug Misuse Locally Commissioned Service**
PERIOD:	1 April 2021 – 31 March 2022
UPDATED:	**December 2020**

1. Background

1.1. Islington's vision for substance misuse treatment is support more people to successfully leave the drug treatment system free from dependence. The aim is to assist the substance misuse treatment system to continue to develop a recovery based model of treatment which will enable more people to successfully and sustainably complete treatment. This includes:

- Supporting the treatment system to better promote recovery in the opiate using population.
- Supporting patients with different patterns of drug and alcohol use (i.e. increasing use of novel psychoactive substances ['legal highs'] and alcohol).
- Increasing uptake of treatment for people, including young people who misuse drugs and alcohol.
- Developing more flexible and personalised services, with a greater emphasis on community based programmes.

1.2. This Locally Commissioned Service (LCS) supports GPs and substance misuse teams to work with patients to support their recovery from opiate drug misuse. The service is delivered in partnership on a shared care basis by the GP and the Primary Care Drug Treatment service(s) commissioned by Islington Council to support the patient's treatment and recovery goals.

1.3. It is envisaged that this service will develop and compliment developments in integrated care as it becomes embedded within the Council and the Clinical Commissioning Group.

1.4. Managing the care of patients will require a multidisciplinary response; wherever possible, this should be provided in collaboration with others such as other primary care practitioners, practice nurses, dispensing pharmacists, drug treatment practitioners and addiction specialists.

1.5. The service will contribute to the following borough wide outcomes

- Increased numbers of patients in Islington becoming abstinent from opiate drugs

- Patients for whom complete abstinence is not achievable at present will be supported to reduce their illicit drug use and work towards recovery
- A reduction in the number of drug related deaths in Islington.
- A reduction in harm to people who use opiates, their families, their carers and the wider community.
- A reduction of street drug use and associated anti-social behaviour.

2. Aims and Objectives

2.1. The effectiveness of well delivered, evidence based treatment for drug misuse is well established. This LCS supports a range of interventions for opioid drug dependence within primary care settings by supporting GPs to provide non-specialist care and treatment in partnership with a primary care drug misuse team. The service will meet the following objectives:

- Improve access to primary care based treatment for patients who meet the locally agreed criteria
- Normalise the drug treatment process
- Encourage a holistic approach by addressing the patient's wider physical, mental and social health and wellbeing
- Promote continuity of care
- Promote access to additional specialist clinical treatment or input where required
- Promote recovery from drug misuse

2.2. Practices will be offered practical and clinical support to deliver this service by the locally commissioned primary care drug treatment provider(s). The level of support delivered from the primary care drug treatment service(s) will be determined by the number of shared care patients receiving drug treatment, the level of practitioner competence and in agreement between the lead GP and primary care drug misuse team (s). The primary care drug treatment team will support GPs with data collection and reporting to meet the requirements of the Substance Misuse Commissioning Team and Public Health England (PHE).

3. Duration

3.1. This LCS will be for 1 April 2021 – 31 March 2022.
3.2. The LCS specification will be reviewed annually.

4. Patient Group

4.1. The target population for the LCS will be:

- Adult patients (18 years old or over) registered with an Islington CCG contracted general practitioner for general medical services (GMS)
- Objectively opioid dependent i.e. 1) clinically assessed/observation of opioid withdrawal symptoms 2) opioid positive urinalysis (or other near patient testing methods such as oral fluid and/or breath testing, where available with confirmatory urinalysis)
- Patients who have had an initial period of titration and stabilisation with local community drug treatment services so that they can develop peer support networks and attend service based recovery groups which can then be sustained once accessing primary care treatment. It is expected that this period will be a minimum of 3 months. (NB: it is recognised that there may need to be exceptions to this but these cases will be subject to discussion and agreement between the patient, drug treatment service and the practice).

4.2. Patients will usually be assessed by a specialist drug treatment service and referred to the GP/primary care team prior to receiving treatment under this LCS.

5. Service outline

5.1. Each practice will see a maximum number of 30 patients. This number can be increased through agreement with commissioners and will be dependent on level of FTE posts supporting drug treatment in the primary care team, the level of practitioner training, competence/experience and links with support/drug treatment services. Where a practice acts as a hub practice for the locality, the number can be increased through agreement with commissioners.

5.2. Practices may provide care for patients outside their own registered list within the agreed locality (though agreement with practices in the locality). Patients, the GP and the drug treatment service must have an effective means of communication with the registered doctor including information and data sharing agreements.

5.3. Practices will ensure that all GP's involved in the Opiate Substitute Prescribing Shared Care arrangement have attended and passed the RCGP certificate in Substance Misuse Management level 1.

Applicable national standards e.g. NICE, Royal College of GPs (RCGP)

5.4. The Practice will have systems in place that ensure the Service is delivered in accordance with current and emerging practice guidance.

5.5. The Practice will nominate a lead GP to attend the appropriate RCGP Certificate course, as a minimum this is the RCGP Certificate in the management of drug use in Primary Care Part 1

5.6. This lead practitioner should demonstrate ongoing continued professional development (CPD) in the area of substance misuse and associated health (minimum of 3 hours per annum). This information should be made available to commissioners on request.

5.7. The nominated lead practitioner will disseminate relevant substance misuse and associated health information to the team

5.8. Attend at least one substance misuse educational/training seminar component per year (to fulfil CPD requirements as above).

5.9. The nominated lead practitioner will ensure the safety and training of clinical and non-clinical staff is maintained.

Clinical staff at the practice will:

5.10. Treat dependent drug users, with support from primary care drug treatment workers, GP with Special Interests (GPSIs) (where commissioned) and appropriate consultant(s).

5.11. Utilise pharmacological interventions which are based on NICE guidelines and within the prescribing protocols agreed with local drug treatment service(s).

5.12. Ensure that 6 monthly care plan reviews with patients are conducted in conjunction with the primary care treatment team. This will include completion of patient Treatment Outcome Profile (TOP), where the primary care drug treatment service has an agreed support role (section 2.2). Practice staff and primary care drug treatment team will employ best endeavours to encourage the patient to attend reviews.

5.13. TOP will be reviewed with individual patients every six months following the initial assessment, and when patient is exiting treatment. TOP cycle should coincide with the patients' overall care plan cycle. Primary care drug treatment practitioners will submit TOP data for patients seen at the practice.

5.14. In partnership with the primary care drug treatment team support and encourage all patients to work towards personal recovery goals. This includes:

- reducing the use of illicit drugs in addition to their opiate substitute medication prescription,
- limiting alcohol consumption,
- addressing smoking status, if appropriate
- reducing risk of Blood Borne Virus,
- good management of any health issues,
- improved mental health and
- through the primary care drug treatment team improving social reintegration including housing, family life, gaining employment engagement with volunteering, training and other recovery activities.

5.15. Support and encourage all patients to access NICE recommended psychosocial and community recovery support interventions to promote recovery from opioid drug misuse, via substance misuse services or other available intervention such as IAPT.

5.16. Identify and treat the common complications of drug misuse and refer on to appropriate specialist treatment or healthcare.

5.17. Undertake a physical review of each patient every 12 months. This should include:

- Current substance use and injecting status
- Recording alcohol intake and providing brief advice/intervention
- Lung health – including recording smoking status, smoking cessation advice given or referral to specialist smoking cessation service if required
- Heart health – including ECG, blood pressure checks, blood tests (if required). Appropriate cardiovascular examination in intravenous drug users at risk of sub-acute bacterial endocarditis and venous thrombosis.
- Liver health – LFTs, blood tests (if required)
- Kidney health – blood tests (if required)
- Sexual health – STI testing, BBV testing
- Healthy weight – BMI, blood tests, advice on diet/exercise if required
- Cancer Screening – prostate health for men over 50, cervical smear tests, breast screening, bowel screening
- Wound care – for injecting drug users

- Screening for blood borne infections and onward referral for treatment as appropriate

5.18. The outcomes of the physical health review should be reviewed by the practice, patient and primary care drug treatment worker every quarter. Where it is necessary, referrals should be made and recorded, by the practice, for ongoing care for any identified issues.

5.19. Where patients meet the eligibility criteria they can be referred for an NHS Health Check.

5.20. Practices will offer the test for blood borne viruses including HIV, hepatitis C if the patient is deemed at risk, as clinically indicated. If patients would prefer for tests to be carried out by a BBV nurse within substance misuse treatment services, practices will inform the drug treatment service of this request. Practices will actively participate in any locally agreed substance misuse Hepatitis C pathway for referral to specialist heptology treatment in the community.

5.21. Offer as routine immunisation for hepatitis B to at-risk individuals their partners, families and carers.

5.22. Practices will provide information to users, carers, partners and families about the effects, harms and treatment options for various common illicit drugs. Harm reduction advice will be provided to drug users and their families.

Prescribing

5.23. Prescribing interventions are only one part of opioid drug treatment and should be provided by the practice in collaboration with the patient and with the drug treatment service providing recovery oriented care planning and psychosocial interventions to support the patients' treatment goals.

5.24. Prescribing should be in line with the following guidance (or updated versions thereof*): (please see links below)*

- Drug misuse and dependence UK guidelines on clinical management, DoH 2017[1]
- NICE Drug Misuse Guidance Opioid Detoxification, 2008
- NICE Drug Misuse Technology Appraisal Methadone and Buprenorphine 2007
- Safer Management of Controlled Drugs'
- Medications in Recovery:re-orientiating drug dependence treatment, 2012
- Medications in Recovery: best practice in reviewing treatment, 2013

5.25. Practices will prescribe, using best practice, substitute (opiate and non-opiate) drugs or antagonists as outlined in the guidance above. Practices will provide

- Maintenance prescribing
- Detoxification prescribing
- Reduction dose prescribing

[1]Drug Misuse and dependence UK guidelines on Clinical management , Department of Health 2017
http://www.nta.nhs.uk/publications.aspx?category=Drug+treatment+guidance
Nice Drug Misuse Guidance Opioid Detoxification

5.26. The prescribing interventions may be categorised and defined as:

- **Maintenance substitute prescribing**.
  - Practices will be expected to adhere to good practice and pro-actively manage patients in line with clinical guidelines.

- **Reduction dose prescribing**
  - The treatment option for each patient is to be decided on a case to case basis and clarified in the care plan upon referral to shared care. Treatment objectives should be reviewed in conjunction with the shared care drug treatment service.

- **Detoxification prescribing**.
  - Detoxification, in dependent opiate users is "a clearly defined process supporting safe and effective discontinuation of opiates while minimising withdrawals. The duration of opioid detoxification should normally be up to… 12 weeks in a community setting[2]". Additional consultations can be agreed/provided by the drug treatment service on a case by case basis.

5.27. Prescribing will take place within a context of wider care planning objectives, individual patient recovery outcomes and milestones in which the co-existing physical, emotional, social and legal problems are addressed.

5.28. Procedures must be in place to ensure continuity of prescribing in the event of absence of the lead GP doctor with training in drug misuse.

5.29. Prescriptions will be issued following face-to-face consultations with the GP/Primary Care team/drug treatment practitioner on an agreed frequency as appropriate and dependent on identified risk factors.

6. Successful completion of drug treatment

6.1. The successful completion of drug treatment is the key Public Health indicator for the drug treatment system

6.2. The drug treatment indicator is based on the number leaving treatment free of their drug dependency who do not then re-present to treatment again within six months, expressed as a proportion of the total number on treatment

7. Policies and procedures

7.1. An accurate and up to date register of patients receiving treatment for opioid drug treatment, excluding alcohol, will be maintained by the practice. Practices must be able to produce this register on request.

7.2. The practice will identify those patients receiving treatment under this LCS in this practice register and through the agreed SNOMED codes.

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[2] http://www.nice.org.uk/guidance/CG52/chapter/1-Guidance section 1.3.2.2
NICE drug Misuse technology Appraisal 114 Methadone and Buprenorphine for the management of opioid dependence 2007
Medications in Recovery
http://www.nta.nhs.uk/uploads/medications-in-recovery-main-report3.pdf

7.3. Numbers collated in Quarter 1 of the year will provide baseline aspiration numbers. An end of year reconciliation will be completed following Quarter 4 patient registration and quality indicator extraction through EMIS WEB.

7.4. The practice will work with agreed guidelines for the care of drug users in primary care in conjunction with drug treatment services (s) prescribing policies. .

8. Days/hours of operation

8.1. The Service shall be available for in line with the usual operational times of the respective practice.

Response times and prioritisation

8.2. The response given to patients contacting the practice for a Service will be consistent with the response given to any other patient of the practice. Advance appointment booking for regular clinic attendees will be available.

9. <u>Relationships with other service providers</u>

9.1. Practices will maintain links with local pharmacies, drug treatment services, social services (including Safeguarding) and local mental health and clinical health teams, as appropriate

9.2. The practice will be offered practical and clinical support to deliver this LCS as outlined in sections 2.2 as appropriate.

9.3. If practice staff have concerns about destabilisation of patients, a pathway enabling rapid transfer back into drug treatment services will be in place for all GPs/primary care teams participating in this LCS delivery.

10. Provider Eligibility

10.1. Practices will be eligible to provide this service if they fulfil the following criteria (detailed under Appendix 2):

- Development and maintenance of a practice 'register'
- Lead GP competency and professional development

11. Evidenced Activity data collection & Quality monitoring

11.1. <u>Data collection</u>

11.2. Local collection mechanisms and quality monitoring requirements will apply (see Appendix 1)

11.3. Performance data will be collated quarterly using the provided Drug Misuse LCS template. Data extracted via MIQUEST/EMISWEB during 2020-21 will provide both LBI and primary care teams with baseline data for future activity monitoring and measuring of quality indicators.

11.4. National Drug Treatment Monitoring submission (NDTMS) will be undertaken by the primary care drug treatment service for patients seen for psychosocial interventions under this LCS.

11.5. Practices will be advised on progress at the end of each quarter through an individual feedback report. Practices will be expected to take appropriate action

for the following quarterly monitoring and show improvement, where appropriate.

11.6. Practices may be asked to provide audits as requested by the commissioner.

12. Pricing

12.1. Patients seen for a prescribing intervention for opiate drug misuse treatment will award the primary care team a per patient per annum payment of £465.00

12.2. Providers will be paid an upfront aspiration payment of 80% of £465.00 (£372 per patient) of the annual payment for patients identified in the practice register as receiving opiate prescribing from their GP. This aspiration payment (not target linked) will be based on the patient register numbers at end quarter 1 within year.

12.3. Practices will be paid the remaining 20% payment (maximum £93 per patient), which is target linked at the end of the year (following quarter 4 patient register extraction) subject to satisfactory completion of the performance monitoring targets. The payment will be calculated from the number of patients receiving drug misuse treatment for which the target has been achieved (excluding those which have been exception reported). Payment will be calculated against each of the relevant prescribing intervention targets, each relevant target will be equally weighted

12.4. For payments at £465 per patient per year. This will be broken down as follows:

- 80% of the £465 will be a fixed payment per patient
- 10% paid for a health care review per patient
- 10% paid for each completed BBV intervention (this would mean that a service user has either: 1. been offered and refused BBV interventions, 2. been assessed as not appropriate to offer an intervention, 3. has acquired immunity, 4. Has started a course of Hep B immunisations and been tested for Hep C)

12.5. Up to a maximum payment of £465

Appendix 1- Evidenced Activity & Quality Monitoring

Quality Indicator	How it is measured by MIQUEST / EMISWEB	Read code (included for reference)	SNOMED code	Target (% of patients)	Frequency of monitoring	Exception Report
Healthcare review of all opioid drug using patients treatment using template provided *All patients including detoxification patients should have a healthcare review completed by the end of the treatment period or within year whichever is earlier*	Urine drug Test: % of patients with Urine Drug Levels in the last year	46Q1 No drug found in urine 46QB0 - Urine methadone negative 46QB1 - Urine methadone positive 46Qr1 - Urine buprenorphine negative 46Qr0 - Urine buprenorphine positive 46QL0 - Urine opiate negative 46QL1 - Urine opiate positive 46QJ - Urine codeine level 46QK - Urine dihydrocodeine level 46Qm - Urine morphine metabolite level 46Q50 - Urine amphetamine positive 46Q51 - Urine amphetamine negative 46Q80 - Urine benzodiazepine negative 46Q81 - Urine benzodiazepine positive 46QA0 - Urine cocaine negative 46QA1 - Urine cocaine positive 46QM1 - Urine cannabinoid negative 46QM0 - Urine cannabinoid positive 46Qa - Urine methylamphetamine level 46Q9 - Urine barbiturate 46Qu - Urine ketamine level	167481003 202051000000109 201381000000109 371411000000109 371401000000107 202191000000102 201401000000109 1019991000000103 1020001000000107 996901000000109 201351000000103 202011000000105 202021000000104 201361000000100 202041000000106 201371000000107 202031000000102 201411000000106 1023851000000109 1010171000000107 1022051000000107	100%	Annual	Yes (where patient commenced prescribing treatment within the last quarter of reporting period)
	Injecting/non-injecting drug users: % of patients designated as “injecting”/”previously injecting”/”never injecting” drug users in their record in the past year	13c0 Injecting 13c2 Never injecting 13cJ Previously injecting	226034001 413096007 416479009			

Care plan review using the NDTMS Treatment Outcome Profile (TOP) tool on a six monthly basis (where patient has given consent)	% of all patients with "substance misuse care plan agreed/reviewed" in their record in the last year *All patients including detoxification patients should have a TOP completed at the end of treatment*	9HC2 Substance misuse clinical management plan agreed 9HC3 Substance misuse clinical management plan reviewed	415659002 198861000000103	80%	Q2 & Q4	Yes (where the patient commenced treatment within the last two months of the reporting period)
Health and Wellbeing outcomes and milestones achieved	% of patients with 1.goals discussed AND 2 goals achieved in their record in the last year	67L2 identifying personal goals AND either one or both of the following 8CMX – Review of patients goals 67LO Goal achieved	713578002 775501000000108 390802008	100%	Q2 & Q4	No

Appendix 2: Provider Eligibility - Required evidence

1.1 Development and maintenance of a practice 'register'

- The practice will develop a register or other system for identifying patients with an opioid drug misuse problem using the agreed codes
- The practice will identify those patients receiving treatment under this LCS in this practice register and through the agreed SNOMED codes.
- Numbers collated in Quarter 1 of the year will provide baseline aspiration numbers. An end of year reconciliation will be completed following Quarter 4 patient registration and quality indicator extraction through EMIS WEB.

1.2 Competency and professional development

- The practice should nominate a lead GP/primary care team member to attend the appropriate RCGP Certificate course, as a minimum this is the RCGP Certificate in the Management of drug use in Primary Care Part 1.
- This lead practitioner should demonstrate ongoing continued professional development (CPD) in the area of substance misuse and associated health (minimum of 3 hours per annum)
- The nominated lead practitioner will disseminate relevant substance misuse and associated health information to the team
- Joint meetings (as a minimum every three months or equivalent) with the drug treatment system support workers for the purpose of discussing patients
- At least one substance misuse educational/training seminar component per year (to fulfil CPD requirements as above).
- The nominated lead practitioner will ensure the safety and training of clinical and non-clinical staff is maintained.

Appendix 3 - INDICATIVE ACTIVITY PLAN

Performance Indicator	Indicator	Threshold	Method of Measurement
Number of Patients	Number of individual patients who are in receipt of the Service each quarter.	Reviewed each quarter	Quarterly reports from key workers and EMIS Web reports.
Contacts with Patients	Frequency at which the Provider holds consultations with patients	All Patients to have, at least, a quarterly consultation with the GP, and primary care drug treatment practitioner	
Care Plan Reviews	The number of care plan reviews at which the Provider submits a report, either written or verbal, on the progress made in the patient's care plan.	The Provider to submit a report for all care plan reviews held on patients known to them. Care plan reviews should take place every 6 months with the primary care drug treatment practitioner	Quarterly reports from key workers.
Named lead GP	All Providers will ensure that, at all times, they have a nominated lead GP for the Service.	At all times, the Provider will have a nominated GP in place.	Annual update to Commissioner Lead – ongoing review
General health reviews	The Provider will complete regular health reviews in respect of patients	All patients will have, as a minimum, an annual health review conducted by the Provider. The details of the review are included in 5.17. Any referrals for ongoing care should also be recorded.	Annual update meeting with Commissioner Lead (or captured on EMIS if possible)
BBV testing and vaccinations	The Provider will complete BBV testing and administer any vaccinations necessary. Patients can request that blood tests be carried out by a BBV nurse within the drug treatment service.	The Provider will offer BBV testing to all patients and administer any vaccinations, as required. The provider will make referrals to local Hep C treatment pathways where required.	Quarterly EMIS report

Appendix 4 - GP SHARED CARE Drug Misuse LCS

Additional Required SNOMED codes (Read codes included for reference)

This code creates the practices patient register and needs to be added EACH TIME a patient is seen and treated under the LCS:

176811000000105 (9k5) – Drug Misuse – Enhanced Services Administration.

If a patient Does not Attend an appointment:
Add the code **176811000000105** (9k5)**,** *plus* one of the following codes**:**
185326000 (9N41) Did not attend - reason given
270426007 (9N42) Did not attend - no reason

Shared Care / Care Predominantly by Practice (needs to be added at least once)**:**
305455009 (9NN6) Under Care of GP
415522008 (8BM5) Shared Care Prescribing

Maintenance
200031000000103 (8B2P) - Drug addiction maintenance therapy – methadone
206121000000104 (8B2Q) - Drug addiction maintenance therapy – buprenorphine

Reducing dose prescribing
One of the above maintenance read codes PLUS
304771000000101 (8B3A4) - Drug dose reducing regime

Detoxification:
205231000000102 (8Bad) Opiate dependence detoxification
200021000000100 (8B2N) Drug addiction detoxification therapy - methadone
206131000000102 (8B2R) Drug addiction detoxification therapy - buprenorphine

Pharmacy Information
507041000000101(9k53) Pharmacy attended for drug misuse - enhanced services administration (free text indicating which pharmacy being used by client)

Successful Completion of drug treatment incentive
200411000000100 (8FB0) - Drug detoxification programme completed