

One size can fit all

Service users in rural districts often have to contend with services spread across large areas. In Somerset, however, a single organisation is providing integrated services across the county, with cost savings to boot.

David Gilliver reports



The popular image of drugs and deprivation is one of inner city streets and estates. But, as several reports have highlighted in recent years, rural areas also face significant problems – with the added barrier of distance to access often fractured and fragmented services, where they exist.

Somerset, however, is breaking the mould – for a year now a single provider has managed all aspects of drug and alcohol treatment, from prescribing and needle exchange to inpatient detox and residential rehab, with single points of access. And what's more that provider is a charity, Turning Point.

Somerset is a large rural county with a few main towns and large areas of deprivation. 'For years there'd been three distinct drug and alcohol services in Somerset so those areas would have two or sometimes three offices – a Turning Point office, an NHS office and a DIP office,' says manager for Turning Point, Darren Woodward. 'Plus a couple of staff who did a bit of alcohol work.'

Throw lack of adequate public transport into the mix and it adds up to a serious problem. 'In the main towns like Bridgewater it's not so bad but travel five miles outside and you're talking about literally two buses a day,' he says. 'It's a massive issue for clients. Then factor in childcare and other responsibilities – it can be hard to get to one appointment in a rural county, but more than that and it starts to look like a spider's web.'

Clearly things needed a shake up so the DAAT undertook a long consultation process with the PCT, *Waits and measures*, to decide what new a service provision model should look like. Service users favoured an integrated drug and alcohol service and Turning Point, with input from Drug Treatment Ltd, put in a bid.

Integration was a key word from the start, he says, not just in terms of drugs and alcohol but having all services under one roof. 'That way people don't have to travel around on buses that run about once a week. All the partners, providers and services users were clear that what needed to be commissioned was a one-stop shop. The commissioners had already devolved responsibility to existing providers, so when they re-commissioned the service they said "if you do integrate we expect you to make efficiencies".'

However, make efficiencies they did. While the average wait in March 2008 was almost three weeks, the service now sees 50 per cent more people with no wait. 'It's not only quicker and more accessible for service users, it's cheaper,' he says. 'But that's just tier 3 prescribing alone, and we've got a range of new services.'

So how did they do it? 'Before, you had criminal justice drugs workers who worked in a custody suite, and that's what they did. You had a specialist nurse in a prescribing clinic, and that's what she did. You had a tier 2 drop-in worker, and that's what they did. Combine all of them and forget the titles – they're now project workers – so they do a bit of arrest referral, a bit of core prescribing, a bit of group work, a bit of everything. It's meant huge efficiencies.'

Perhaps unsurprisingly, however, the commissioners needed some convincing that this was the right path. 'Having a third sector provider, a charity, doing specialist prescribing always raises eyebrows,' he says. 'People say "can they do that – surely it's got to be the PCT or someone like that?" We said "no, we're going to provide all the doctors, the nurses and we've got the governance arrangements to do it.'

The most resistance came from clinicians and others who felt threatened, he says. 'You've no idea. We had a press and communications strategy with the council and the PCT, but we completely underestimated the scale of the ferocity we'd come up against. It was "is this safe? What does national guidance say? What policy is there that says they can't do this?" The strategic health authority, the NTA, the DAAT, all the local MPs were written to by people saying "this is outrageous and terrible." They were very disparaging about Turning Point's capacity.'

The NTA, however, were supportive of the model and backed the DAAT, and were rewarded with a successful service and praise from service users. 'They played a very fair hand,' he says. 'The best answer to all of it is to do well, and the numbers speak for themselves.'

From 406 in 2008 the number of people being prescribed to has risen to 644 this year, with 12-week retention in tier 3 rising to nearly 90 per cent. 'There's no new money in this – that's the key thing,' he says. 'We met our target for the number of problematic drug users in treatment by the end of the first quarter, and we met our third year target by the end of the year. We're far exceeding the number of people we used to support, we're getting more referrals for alcohol than drugs and we've got blood borne virus nurse services, community detox nurse services, a five-day group work programme across the county. These things weren't there before.'

The service now gets between 5 and 10 per cent more referrals for people with a primary alcohol problem than a drug problem, people who previously would have had nowhere to go for help. 'With a service structure that didn't support people

with alcohol problems, it was difficult to know categorically what the unmet need was,' he says. 'With a service that's commissioned to support those people we can now unequivocally demonstrate that unmet need.'

Doubts and resistance aside, the main hurdle in achieving integration was the sheer practical issue of bringing all the practitioners together, he says. 'Probably the biggest challenge is how to harmonise teams when you transfer them' he says. 'People might have been working in the NHS or Turning Point or the probation service for ten or 15 years – very different ways of working, different performance management processes and different policies. It's the challenge of having everyone skilled, trained and aware – some people hadn't worked with alcohol, for example, or methadone, so we had to try to get everyone to the same level. That's

'All the local MPs were written to by people saying "this is outrageous and terrible". They were very disparaging about Turning Point's capacity.'

a tough job, and there are huge HR implications that take the management team away from what they need to be doing. But we've got big plans.'

These include the development of psychosocial interventions, with an in-house counselling service about to be launched, along with more family-focused work and two new A&E alcohol liaison posts. How does Turning Point see the service developing from here on?

'I'd like to present the picture that – ad infinitum – we can carry on seeing more people and having no wait, but there comes a point when you reach capacity and we've probably got to that point. Our services are now beginning to get waiting lists, largely because of people with alcohol problems who need our support. Alcohol is the elephant in the room. In Somerset there are five times more people with alcohol problems that need treatment than with drug problems. We need to be able to mobilise funding to meet that need we're now demonstrating.'

However, the services are moving in the right direction, he believes. 'We've exceeded all the targets in the first year when we didn't even expect to meet them. We thought all the responsibility of the HR issues would eat into our ability to do that, but we have.'

If another area was thinking of attempting something along these lines, what would be the best advice? 'It's not always right for everywhere, and I don't think that's down to the rural/urban question – I think there's always good enough reasons to have a one-stop shop,' he says. 'I think the issue is consultation – you need adequate time for everyone to agree this is what they want. If the public or service users or providers don't expect it, it won't work.'

Anyone considering a combined a drug and alcohol service also needs to be aware of the long-term funding implications, he stresses. 'You're going to demonstrate unmet need for a service that the PCT or council will commission, which means they're going to have to find more money. But by doing it, by taking a punt, you can demonstrate that efficiencies naturally come out of it. But you need a future proof management structure. It's obvious, but you can't have too many silos – if there's a change of government or local or national policies then you need a structure that can withstand that.'

At the moment it's one service with one manager and five offices across the districts of Somerset, but the ultimate aim is a single phone number for everything. 'We will get to that stage,' he says. 'I don't know of any other service as big that's run by the third sector. There are things that are close, but it's a new model.'

And other areas have definitely started to take notice, with commissioners asking to see the service with a view to potentially designing their own new model. Could it be a future template for services across the country? 'I don't see why not. One of the questions we're asked is whether we'd now exclude partnerships. My response is that if people – despite the evidence and assurances we give them – still don't want to put all their eggs in one basket then you have to listen to that. It's very important to go with what the local area's about. But you've got a very fractured, disparate approach at the moment, across the country. I believe this makes sense.'