LEVEL 1 Investment Proposal Template REVENUE FUNDING up to £50,000

HSCB IPT Ref No	**SE/AC-011/1516**
Source of Funding (Year / ref)	**2014/15** **2015/16**
Allocation value	£89,778 (CYE and FYE)
HSCB Representative name and contact details	**Aidan Murray**
Trust Representative name and contact details	**Don Bradley, Assistant Director Mental Health**
Project Title	**Substance Misuse Liaison Services: Acute in-patient settings**
Total Cost	2014/15 £19,444 CYE Non-recurrent 2015/16 £89,778 (CYE and FYE)
Start date	**01/01/15**
Completion date	**31/03/2016**

Complete this section if bid is for new funding i.e. funding is not currently in the Trust baseline

BID FOR NEW FUNDING	
Is this bid for new funding (Y/N)	***Yes***
How much total funding required?	2014/15 £19,444 CYE Non-recurrent £89,778 (this amount is the FYE and the CYE for 2015/16)
How much funding required per year?	2014/15 £19,444 CYE Non-recurrent 2015/16 = £89,778 – FYE/CYE 2016/17 – Amount to be confirmed
Is this funding to be made recurrent?	***Recurrent***

Complete this section if funding available within existing allocation i.e. funding is currently in the Trust baseline

Funding available within existing allocation (Y/N)	
Total cost of proposal	
Cost of proposal per year	
Is this cost within recurrent allocation?	

Is this business case	***Y/N***
(a) Standard	**Standard**
(b) Novel	
© Contentious	
(d) Setting a precedent	
If yes to (b) or (c) or (d) , requires Departmental & DFP approval ***Is Departmental / DFP approval required***	

Approval & submission by Trust

This section to be completed by **Trusts** for all submissions

Prepared by

Name Printed Roisin Coulter (signed)

Grade/ Title Director of Performance, Commissioning and Informatics

Date 21 October 2015

Approval of Investment Proposal Template by HSCB

Approval by Commissioning Lead (LCG or regional) – to be completed for all submissions

I confirm that all relevant parties – including, as appropriate, LCGs / regional leads, professional leads etc. – have been consulted and have confirmed in writing their support for the proposed investment.

Approved by

Name Printed Paul Turley

Grade/ Title AD Commissioning

Date 21 October 2015

Complete this section if Department / DFP approval required

Date submitted to Department

Department/ DFP approval (y/n)

Date approved

SECTION 1: Commissioner Specification to include strategic context and need (to be completed by the Commissioner)

Commissioning Plan Directions (2014/15) identify the further development of alcohol/substance misuse liaison services within acute Trust settings:

- *By March 2015, services should be commissioned and in place that provide seven day integrated and co-ordinated substance misuse liaison services within all appropriate HSC acute hospital settings undertaking regionally agreed Structured Brief Advice Intervention Programmes. During 2014/15 the HSCB and PHA will work with Trusts to establish effective substance misuse liaison services within appropriate acute hospital settings.*

Up to 30% of all hospital admissions (adult population) potentially demonstrate some degree of alcohol/substance misuse (definition: exceed weekly DoH/CMO 'safe thresholds'). This, however, is often not detected: local hospital admission statistics bear out a detection level of around 3%. Most 'at risk' individuals within the acute in-patient setting are not 'addicted or dependent' but rather are 'hazardous/harmful' and/or 'binge-pattern' users (ie. *social drinkers* and/or *recreational* substance misusers). Failure to identify even modest alcohol/drug misuse has direct consequences in terms of higher morbidity/mortality, longer in-patient stay and poorer outcomes. This translates to higher costs & increased likelihood of re-admission.

- *With 4200 acute PoC in-patient beds in N.Ireland, extrapolating the '30%' statistic implies there are 'hundreds' of beds across various medical, surgical, other acute settings occupied each day by people with some degree of alcohol/substance misuse (which frequently goes undetected).*

NICE (PHG-24) state that the required intervention is not specialist substance misuse or mental health but *structured advice and guidance* delivered by alcohol/substance misuse liaison teams. Such teams, delivering 'Screening-Brief Interventions', can prevent admissions, reduce length of stay, improve clinical outcomes and generate cost savings.

Best practice guidance indicates (a) liaison services should operate on a 7 day per week basis, and (b) services should encompass both acute in-patient settings (in particular, admission wards) and the Emergency Dept (ED). Existing liaison services operate on a 5 day Mon – Fri basis and, given their relatively small scale (1-3wte per Trust), focus mainly upon the Emergency Dept setting. To enable a 7 day liaison service encompassing both ED and in-patient settings would require a team resource of circa 5-7wte per Trust.

Building upon the existing liaison teams in place, a 2 year service development approach is proposed (see schemata:

In Phase 1 (15 month period: 1st Jan 2015 to 31st March 2016), the aim is to improve alcohol/substance misuse liaison input to ***acute admission wards and move from a 5 day to a 7 day per week provision***. Building upon existing substance misuse resources already in place, ie. 2 wte, an additional 2.0 wte posts should be created increasing the overall team resource to 4.0 wte.

- Phase 1 continuing over the 2015/16 period, would be enabled by an allocation of £89,778 FYE. This amount will also be available in year as the CYE figure. This builds on previous funding allocated in 2014/15 of £19,444.

Note – as referenced above, the main focus is harmful/hazardous substance misuse among acute hospital admissions: the majority (>95%) who screen positive exhibit harmful *but non-dependent* misuse, ie. do not require access to addiction-specific interventions. The liaison service should therefore be considered as integral within the acute care process and not addiction/mental health specific (<5% of those screening positive fall within this category). Liaison team members, while primarily nursing, can therefore encompass a range of backgrounds including medical, emergency department, primary/community care, mental health/addiction.

SECTION 2: OBJECTIVES (To be completed by HSCB)

Objectives (SMART)

Aims: working within a 7 day model, the main aims of the service are:

1. Screening - *case finding*
   - Implement a formal screening programme - by end of phase 2 (ie. March 2017), screen 90% of all (adult) non elective acute admissions per year and 25% (ie. specific higher risk cases dictated by clinical risk) of ED attenders per year.
   - Screening based upon the AUDIT / AUDIT-C (alcohol) and DUDIT (drug) tools – over time these should be incorporated within in-patient and E.Dept assessment/admission procedures.
   - Liaison practitioners will initially take the lead role in terms of undertaking screening . However, over time, as admission staff are trained/become more experienced, it is anticipated that these latter staff will assume greater responsibility for such duties with the former assigning a greater proportion of their time to provision of Structured Advice/Intervention and referral to appropriate services as required.

2. *Structured Brief advice* and *structured interventions* - *to those 'screening positive'*:
   - Best practice guidance emphasises the importance of intervening promptly at the 'treatable moment', ie. promptly after the assessing practitioner 'detects' an individual with hazardous/harmful substance misuse (or within 24rs); the individual is more likely to reflect upon the impact of their substance misuse and are open to change future behaviour.
   - Where longer term follow-up and more specialist interventions are required, subsequent consultation and referral if required to a specialist service/agency should be within 24-48hours (otherwise dis-engagement & non-attendance are more likely and the opportunity to intervene is lost).

3. Direct care of more complex patients: advising on care/management, for example, medical detoxification of in-patient

4. Aftercare/follow-up:
   - Where moderate-to-severely *dependent* individuals are identified they will require referral to specialist substance misuse services. In this respect, the liaison practitioner has a key role in terms of motivational work, preparation and overseeing transition/referral to specialist addiction services (or specialist comm/Vol sector partners)
   - Handling other concerns and key issues when identified, eg. mental health, self-harm, child/family care or social care issues, ensure appropriate links and liaison with other relevant services.
   - Repeat attenders/admissions – for example, working with frequent attenders (more intensively) to moderate drinking/develop contingency plans

7 day service model - existing liaison services are largely Monday to Friday / 9am to 5pm based. The aim is to establish a 7 day service model in each Trust. Taking account of national guidance / published reports and direct advice from other Trusts (in England), the priority focus should be to cover the **8am-to-4pm period daily** Beyond the core 8am-to-4pm period, service models need to ensure linkage with other appropriate services, in particular, mental health/self-harm/crisis response, child/adolescent and social care services. In parallel to this specific work, Trusts should therefore consider their wider 24/7 service model for this wider range of liaison service

Where possible, agreed regional approaches will be identified, including:

- Screening Tools
- 'Structured Brief Advice' - content of the circa 5-10 mins (duration) advice and 'Interventions', (30-60mins) - to be delivered by specialist liaison practitioners,
- 'Take away' resources following discharge (eg. Advice and drinking diary packs),
- Pathways for potential follow-up interventions (post detoxification and/or higher risk and/or vulnerable clients), including telephone follow up (undertake re-AUDIT / provide additional advice)

SECTION 3: LIST AND DESCRIBE AT LEAST 2 OPTIONS (INCLUDING STATUS QUO)

OPTION NO.	BRIEF DESCRIPTION OF OPTION
1 (Status quo)	Maintaining the status quo will mean no additional services are provided - the Trust will maintain existing services. As noted above, failure to address substance misuse within the acute Trust settings is associated with higher rates of admissions, increased length of stay and more frequent re-admissions. Liaison services have been identified, at a national level, as a means to achieving efficiency saving (in addition to health improvement benefits).
2	Enhance current Trust liaison services to acute admission wards and move from a 5 day to a 7 day per week provision- the priority focus should be to cover the **8am-to-4pm period daily,** with subsequent service expansion to encompass the wider range of admission wards, including enhanced Emergency Dept. cover through the recruiting of additional staff over the next two years.
3	**(if applicable)**

SECTION 4: PROJECT COSTS

Option	**Year 1** **(£'000)** **CYE**	**Year 2** **(£'000)** **FYE of Year 1**	**Year 3** **(£'000)** **Additional FYE** **YEAR 3**	**Total** **(£'000)** **FYE**
1 Status Quo – continue with existing arrangements	88,038	88,038	£88,038	264,114
2 Enhance Trust liaison services	£19,444	£89,778	TBC	TBC
	confirmed		***Above cannot be confirmed yet***	***Above cannot be confirmed yet***

Cost Assumptions – *Trust to insert breakdown of costs*

Costs are based on HSCB allowable costing.

SECTION 5: NON-MONETARY BENEFITS

- Implementation of a formal screening programme - by end of phase 2 (ie. March 2017), screen 90% of all (adult) non elective acute admissions per year and 25% (ie. specific higher risk cases dictated by clinical risk) of ED attenders per year.
- Provision of screening using AUDIT / AUDIT-C (alcohol) and DUDIT (drug) tools – over time these will be incorporated within in-patient and E.Dept assessment/admission procedures.
- Liaison practitioners will initially take the lead role in terms of undertaking screening . However, over time, as admission staff are trained/become more experienced, these latter staff will assume greater responsibility for such duties with the former assigning a greater proportion of their time to provision of Structured Advice/Intervention and referral to appropriate services as required.

- Provision of 'Structured Brief Advice' - content of the circa 5-10 mins (duration) advice and 'Interventions', (30-60mins) - to be delivered by specialist liaison practitioners,
- Provision of 'Take away' resources following discharge (eg. Advice and drinking diary packs),
- Implementation of Pathways for potential follow-up interventions (post detoxification and/or higher risk and/or vulnerable clients), including telephone follow up (undertake re-AUDIT / provide additional advice).

SECTION 6: PROJECT RISKS

- Failure to secure recurrent funding –
  Given the current financial pressures, without appropriate recurrent funding, the Trust would not be able to provide / develop the service as outlined. Existing staff would not be able to provide 7 day working and ultimately extend the service to be inclusive of inpatient / admission wards. Failure to develop the service could result in increased admissions , increased length of stay and poor clinical outcomes for patients.

- Failure to recruit staff –
  The Trust will endeavour to advertise the posts within a timely manner. Increased awareness of the new posts will be highlighted in key areas including Addictions Teams, Mental Health teams, Emergency Departments and Medical Admission Wards. Successful candidates will he held on a waiting list pending subsequent release of additional posts.

- Failure to secure appropriate hospital base for staff due to accommodation pressures
  Existing staff are based on the Ards Hospital Site and within the Ulster Hospital. This arrangement will remain until further expansion of the team, with the plan to provide office based accommodation at the Ulster site.

SECTION 7: PREFERRED OPTION AND EXPLANATION FOR SELECTION

Option two is the preferred option as enhancement of the current service will allow the achievement of the benefits described in section 5 namely;

- Implementation of a formal screening programme - by end of phase 2 (ie. March 2017), screen 90% of all (adult) non elective acute admissions per year and 25% (ie. specific higher risk cases dictated by clinical risk) of ED attenders per year.
- Provision of screening using AUDIT / AUDIT-C (alcohol) and DUDIT (drug) tools – over time these will be incorporated within in-patient and E.Dept assessment/admission procedures.
- Liaison practitioners will initially take the lead role in terms of undertaking screening . However, over time, as admission staff are trained/become more experienced, these latter staff will assume greater responsibility for such duties with the former assigning a greater proportion of their time to provision of Structured Advice/Intervention and referral to appropriate services as required.

- Provision of 'Structured Brief Advice' - content of the circa 5-10 mins (duration) advice and 'Interventions', (30-60mins) - to be delivered by specialist liaison practitioners,
- Provision of 'Take away' resources following discharge (eg. Advice and drinking diary packs),
- Implementation of Pathways for potential follow-up interventions (post detoxification and/or higher risk and/or vulnerable clients), including telephone follow up (undertake re-AUDIT / provide additional advice).

SECTION 8: ADDITIONAL ACTIVITY

Specify the additional activity commensurate with the value of the Investment Proposal Template (expand as required where more service lines are involved.) Please ensure that any changes in activity arising from productivity and efficiencies associated with the investment are also recorded.

Performance monitoring is integral to Ministerial Targets / Commissioning Direction targets. The continuation of funding beyond 2016/17 is therefore contingent upon performance monitoring data to evidence the benefit of these liaison services (and note requirement to produce Phase 1 and Phase 2 report on subsequent page):

OUTPUTs

- The proportion of acute PoC (adult) admissions/E.Dept attenders screened – as referenced above, by end of phase 2 (ie. March 2017), screen 90% of all (adult) non elective acute PoC admissions per year and 25% (ie. specific higher risk cases dictated by clinical risk) of ED attenders per year.
  - Proportion screening positive (data stratified by AUDIT outcome/category): data to yield 'Standardised Rate of Alcohol-related Admissions
  - Proportion offered formal 'Brief Advice/Interventions'
  - Proportion accepting formal 'Brief Advice/Interventions'
  - Referrals to: other services, including to Trust / other (community/voluntary agencies)

EFFICIENCY GAINS

To evidence the benefits of these liaison services and to enable funding to continue beyond 2016/17, Trusts are required to evidence efficiency gains in terms of potential admissions avoided, reduced length of stay and earlier discharges enabled – this is likely to require discrete study / analysis / audit. Such evaluation should be incorporated into local service initiative from the outset. This may include, for example:

- Frequent attender/admissions case management, ie. targeted strategies and follow up – intensive follow up of discrete cases to moderate alcohol consumption and reduce attendance / admissions

SECTION 9: MONITORING AND EVALUATION (To be completed by HSCB)

Who will manage the implementation?	**Insert name – HSC.Board**
Who will monitor and evaluate the outcomes?	Dr Stephen Bergin & Briege Quinn – PHA
When will this take place?	Phase 1 report - by quarter April/June 2016 Phase 2 report - by quarter April/June 2017