Commissioning of Drug and Alcohol Treatment

Briefing No 4

CROSS PARTY GROUP ON DRUG AND ALCOHOL TREATMENT AND HARM REDUCTION

Accountability for the use of public funds is welcomed by the majority of treatment providers, as is the measurement of performance against targets as a means of being called to account. Performance monitoring helps to sustain investment in an important area of public policy and contributes to service improvement. Since the introduction of the internal health market in the early 1990s, targets have played an increasing part in service contracts, particularly for third sector organisations.

Historically, contract targets were negotiated between local purchasing agencies and providers, taking account of local needs and the local circumstances for delivery. Since the introduction of the National Treatment Agency (NTA) targets have been centrally set and they are now used to measure the performance of local Drug Actions Teams (DAT's) and providers. Recently, the NTA have matched a DAT's performance data to unit cost data for its providers to support payment by results.

In order for targets to be effective they should be relevant and proportionate, reflecting service users needs and the type of care that is delivered as well as having a realistic expectation of inputs, outputs and outcomes.

Many providers believe that the current process for setting targets is contributing to a reduction in quality of provision and the flaws in the process rest on three things:

1) The rapid investment and equally rapid development of provision since 1999 has created an increase in volume but a paucity of quality, primarily because we still have a naive workforce. Setting targets that apply to optimal conditions in circumstances that are sub optimal creates dangerously skewed expectations of performance and overloads the system.

The situation is made considerably worse because we have not invested in the evaluative research that would provide evidence not only that modalities in Models of Care work but would also give understanding, to commissioners and providers alike, of the factors that are critical to a modality being effectively applied.

There is a wealth of evidence on effectiveness for some treatment modalities, notably substitute prescribing and residential rehabilitation, and very little on others such as harm reduction and the low intensity talking therapies. Too little of the research addresses the quality factors in how modalities achieve the required outcomes. Much is made of the need for evidence based treatment

yet we are not investing in the research that will develop the evidence base for all the treatments on offer in the UK.

2) Commissioning has been poor for a very long time. It suffers from the same workforce weaknesses that affect providers but it has also been disrupted by continuous and badly managed reorganisation of the NHS and overburdened by a glut of policy initiatives. The NTA did little to address the workforce and process weaknesses in commissioning on its inception, relying on out of date and inadequate guidance from the Department of Health until midway through the last strategy before taking steps to tackle some of the problems. By the time the NTA acted, many of the performance problems had been built into the new development.

Commissioning by DATs has improved in recent years but not as a result of leadership from the centre; change has mostly occurred in areas where the DAT partners take an active interest in drug misuse and the DAT officers have a high level of expertise. Competitive tendering is increasingly used to iron out current poor performance or previously poor commissioning decisions but too often the tender process is inexpertly run. The use of competitive tendering to correct past mistakes and the frequency of tendering is creating a considerably unstable market.

Whilst increasingly many commissioners do follow EC Public Procurement guidelines the application of competitive tendering is hampered by their lack of knowledge about treatment. Guidance from the NTA relies upon process descriptions of modalities and the measurements of value rely too heavily on cost and output; as a consequence too many commissioners cannot properly evaluate tenders to purchase the outcomes and impact they look for.

3) Setting national targets centrally, in isolation from local delivery and without proper consultation with service users and providers has led to inappropriate targets, some of which are in conflict in certain circumstances. For example, where demand for care is high, such as in community prescribing, reducing waiting times and increasing retention can only be achieved with limitless investment to increase capacity.

In loading unrealistic targets on DATs and linking their performance to Pooled Treatment Budget allocation, the NTA is putting greater pressure on those it considers to be slow or poor, without taking account of local conditions that may explain the slowness or paucity.

Payment by results has been introduced by stealth, on the back of unreliable data from NDTMS and questionable data on unit costs.

Switching funds between DATs on this basis increases instability and exacerbates the impact of poorly set targets.

Setting payment tariffs for Problem Drug Users (£1440) and Non Problem Drug Users (£770), based on the premise that a problem drug user is a Class A heroin or cocaine (and crack) user, misunderstands problem drug use, which is not substance specific. The damage done by applying these tariffs may be serious and long lasting.

The solutions lay in significantly improving commissioning, taking steps to engineer a competent workforce and transparent and effective systems. Commissioning as a process entirely separate from purchasing, should engage service users and providers in working with commissioners to assess local need and respond by jointly designing the treatment system. It's only at the local level that the complexity of need and the circumstances that will affect provision can be understood and responded to both in terms of the nature of treatment, its volume and the expectations of what it will deliver.

Government has recognised with Local Area Agreements that it should have a light touch with the Local Strategic Partnerships, outlining only the areas of performance and not laying down detailed targets. The Drug Strategy needs the same arrangement but the barriers are the problems of commissioning, the lack of accountability in DATs and the failure by the NTA to address effectively the systemic weaknesses.

For more information on the issues covered in this briefing in the first instance please contact Andrew Fisher fishera@parliament.uk