



## **Payment by Results for Drug Services: Some Key issues**

This short briefing highlights some of the issues that need to be considered if Payment by Results (PbR) is to be introduced to the drug treatment and rehabilitation sector. These have come out of a UK Drug Policy Commission (UKDPC) seminar held on 16<sup>th</sup> September 2010, which brought together a range of stakeholders and experts in the field to consider lessons from the introduction of PbR in other related sectors. The issues here are headline issues and not exhaustive – a more detailed report will follow shortly.

### **1. What results should be sought?**

- The overarching aim is to increase the efficiency of services in assisting people with drug problems to recover.
- There is also an appetite for using this change to encourage innovative approaches to service provision by focusing on client outcomes rather than specified treatment processes within the commissioning process.
- Within the current fiscal climate this will need to be done without increasing costs and there is the belief that it will lead to resource savings elsewhere from a reduction in drug harms, which may or may not be able to be realized and re-invested in drug services.
- Recovery involves improvements in multiple domains: substance use; health, social function (relationships and social networks), education, employment and housing. Recovery also delivers benefits to the individual, family and to society.
- Recovery is often a long and not always linear process with many types of support and services potentially contributing at different stages.
- This means any payment by results will need to:
  - Encompass a wide range of services not just drug treatment – contributions towards recovery are made by services from needle exchanges to residential rehabilitation, by education and employment providers, as well as by housing and peer support groups;
  - Reward progress ('distance travelled') across a wide range of domains and take account of different starting points and deficits in different domains - segmentation on complexity/severity will be needed to avoid creaming and parking;
  - Include measures of sustained recovery - to avoid the system focusing on acute care and neglecting vital aftercare and support.
- The PbR systems in operation elsewhere in the NHS appear to be essentially payment for activity rather than outcomes, with in some (mainly fairly simple) cases, eg hip replacements, premiums for undertaking this in ways that adhere to best practice. Recovery from addiction is more complex, multisectoral, the

evidence for best practice in many areas is weak and one of the drivers for PbR is to identify better ways of delivering outcomes.

- There are a number of issues to be considered in deciding what results to reward:
  - The environment and level of community social capital will vary from area to area, e.g. employment opportunities, so there will need to be flexibility in the system to allow for this.
  - There is some evidence suggesting that involving service users in setting their own targets and outcomes is important in building therapeutic relationships, motivation, and retention in treatment etc. How will this fit with contractually set targets for outcomes?
  - If payments are tied solely to outcomes and decisions on what activity to do is then left to the markets, how will this fit with NICE guidance and entitlements to NICE approved treatments, NHS Constitutions, etc?
  - No service should be left out of the system, including needle exchange/outreach plus services for those who also have mental health problems.
  - Where many providers contribute towards the final outcome how does one attribute the value of each contribution and, from a commissioning point of view, does this matter?
  - Given the long timeframe and non-linear nature of progress through recovery will some payment for activity be necessary alongside payment for outcomes and, if so, what should the right payment ratio be?
  - Should outcomes be measured at the individual or cohort level given the potential for variation in progress between individuals and between different domains and what balance should be struck between individual and community level gains eg reduced crime.
  - Is it necessary/possible to describe overarching recovery outcomes (domain absolutes) as the starting point, eg drug free, crime free, having work or other meaningful activity, health, to enable clarity about progression or distance travelled towards their achievement as well as achievements to be verified?

## **2. Measuring outcomes**

- It is important that standardised tools are used to define:
  - recovery related groups using risk factors and predictive factors;
  - a matrix: high, medium, low needs/severity could be designed to provide complexity factors for tariffs.
- TOP and NDTMS provides a national architecture but it is based on self report so may be open to 'gaming'. There is therefore a need local flexibility for providers and commissioners to agree additional verification tools based on local needs.
- There is a need for improved systems to track long term gains to verify improvements over time. It may be possible to use existing databases to look at whether people are coming back into the system as a proxy for sustained recovery.

- It is important that the outcome measures can provide information on 'distance travelled' or 'value added' on several domains rather than just absolute outcomes (the TOP can do this to some extent). "Employability" must be included.

### 3. Implementation issues

- It is important that we proceed with caution in implementing PbR because:
  - locally the service architecture is fragile
  - the complexity of the area and our lack of understanding of what works for whom means considerable work is needed on how to segment the population to prevent 'gaming', such as 'creaming and parking'<sup>1</sup>.
- There will be transition costs in moving from current commissioning systems to PbR, as well as sustained costs associated with the new system. The system should be kept as simple as possible to minimise bureaucracy and costs of the infrastructure. It may be best to have a transitional, staged approach.
- The assessments of individuals entering the system, the way they are triaged, clustered and referred to appropriate services will be key to improving delivery and preventing abuse. However, there are a number of ways this could be undertaken. It is not clear if this is best done by an independent assessment and care management service or as an integral part of a commissioned 'recovery care system'.
- Incentivising co-operation: It was felt that, if an appropriate model is used, PbR could encourage, and hence obtain added value from, integration. The flip side is that the "wrong" model could encourage unhelpful competition and fragmentation of services to the detriment of recovery.
- There is a need to consider the "level" at which contracts operate. Having contracts at a "local" level would allow adjustment of tariffs/outcomes to reflect local conditions (e.g. availability of housing/employment). There will be a need to balance having a national framework for PbR (to avoid postcode lotteries) with localism.
- Who bears the risks and costs is an important issue. The system needs to be set up in a way that does not disadvantage small VCS organisations embedded in communities (and their emergence) as these may be more responsive to local needs and more innovative. However, it is important that the system is able to distinguish between effective providers and more chaotic providers whether large or small.
- A balance between activity based payments, and outcome based payments may help deal with the issue of outcomes that require significant time frames (e.g. in criminal justice, reduced re-offending over 2 years). It may be appropriate to have a 'core'/base payment for activity + 'bonus'/incentive for recovery. It is important to include service user feedback on the outcomes/success to influence drug incentive payments. There are now systems to do this.

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<sup>1</sup> 'Gaming' may be defined as when participants find ways to maximise results without achieving the desired outcomes. 'Creaming' is a tendency to prioritise those for whom it is easy to achieve results and 'parking' is where more difficult cases are effectively ignored.

- A shift to recovery-focused PbR will require new skills and also attitudes and culture change. There will also be a need for skills specific to PbR, including 'new' workforce for setting up and running PBR.
- There are examples of innovative commissioning models that could provide learning for developing possible models for outcomes-focused PbR. These will then need proper trial & independent evaluation to see if these deliver improved outcomes and value for money and to sort out interface with other PbR systems.

#### **4. Conclusions**

- (i) The current system has already begun to move towards incentivising improved outcomes providing the opportunity for evolution into an incentive-based or PbR system. There are opportunities for learning from existing developments in commissioning around the country.
- (ii) The pace of change should be informed by thorough piloting to determine the effects of outcome and mixed outcome and activity incentives, and the administrative costs associated with such systems.
- (iii) All reform is social experimentation: given the fragmentation of funding (Justice/DWP/Home Office/Health) and the fragility of existing processes and clients, cautious development of incentive mechanisms would be wise.

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