Healthcare Commission

NHS

National Treatment Agency for Substance Misuse

Improving services for substance misuse

Commissioning drug treatment and harm reduction services

Service review

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Contents

The Healthcare Commission

The Healthcare Commission works to promote improvements in the quality of healthcare and public health in England and Wales.

In England, the Commission assesses and reports on the performance of healthcare organisations in the NHS and independent sector, to ensure that they are providing a high standard of care. It also encourages them to continually improve their services and the way they work.

In Wales, the Healthcare Commission's role is more limited. It relates mainly to national reviews that include Wales and to the yearly report on the state of healthcare. In this work, the Commission collaborates closely with the Healthcare Inspectorate Wales, which is responsible for the NHS and independent healthcare in Wales.

The Healthcare Commission aims to:

- safeguard patients and promote continuous improvement in healthcare services for patients, carers and the public
- promote the rights of everyone to have access to healthcare services and the opportunity to improve their health
- be independent, fair and open in its decision making, and consultative about its processes.

The National Treatment Agency

The National Treatment Agency for Substance Misuse (NTA) is a special health authority, created by the Government in 2001 to improve the availability, capacity and effectiveness of treatment for drug misuse in England.

The NTA's purpose is to work with local partnerships and health commissioners to deliver high-quality, effective drug misuse treatment that improves individuals' physical and mental health and wellbeing. In turn, this improves public health, reduces crime and helps make communities safer.

The Government set the NTA a target of doubling the number of people in structured treatment programmes between 1998 and 2008. This has been exceeded two years ahead of schedule.

The NTA is now concentrating on the quality agenda, improving services for people in treatment and improving outcomes for those who leave.

Summary

In 1998, the Government introduced its 10-year drug strategy. This implemented a range of interventions that concentrated on the most harmful drugs and on the individuals whose misuse of drugs and chaotic lifestyle caused the most harm to society or themselves. A key aspect of the strategy was to provide more and improved drug treatment, as this had been shown to be effective at improving the health and wellbeing of service users and their families and at reducing crime related to substance misuse.

As a result, drug treatment services in England have expanded considerably and have received substantial investment. Since March 2002, central government has tripled the amount of new funding for drug treatment. The number of people receiving specialist treatment for drug problems has increased dramatically. During 2006/2007, there were 195,400 people in treatment, an increase of 130% on the 1998/1999 baseline of 85,000.

About this review

Drug treatment is provided by a network of services, commissioned by local partnerships of statutory agencies within a particular locality, rather than being provided by individual organisations. These networks or 'local drug partnerships' are aligned to local authority boundaries. There are 149 partnerships in England that bring together representatives of local organisations involved in the delivery of the drug strategy, including primary care trusts, local authorities, the police and the probation service.

However, evidence points to a variation in the quality and availability of care in different areas. In 2005, the National Treatment Agency for Substance Misuse (NTA), in partnership with the Healthcare Commission, embarked on a joint three-year programme of annual service reviews as part of an initiative to enhance the quality, consistency and effectiveness of drug treatment. Topics for the reviews are:

- Community prescribing services and care planning and coordination (conducted in 2005/2006)
- Commissioning drug treatment systems and harm reduction services (this review)
- Diversity and residential services (inpatient and rehabilitation services) (to be carried out in 2007/2008).

The service reviews are designed to assess the provision and commissioning of drug treatment against key indicators. They provide a benchmark of the quality of drug treatment and information on areas of weakness, against which improvement can be planned.

This report presents the results of the second in the series of reviews. It was carried out in 2006/2007 and covered commissioning and systems management of drug treatment and harm reduction services.

Local drug partnerships received their individual assessment results in November 2007 while this report was being prepared, so that they could begin targeted work to improve their performance.

Service reviews are based on a standardised approach and consist of two parts. In the first part, we assess the performance of all local drug partnerships. In the second part, we work with the minority of partnerships (about 10% to 15%) that have the weakest assessment scores and may require help to develop action plans to improve their performance. The service reviews also provide broader information on the progress being made in drug treatment and on the priorities that need further development.

For this review the key outcome and quality measures were developed around two themes:

- **Commissioning and systems management:** we reviewed how local drug treatment partnerships plan, procure and manage the drug treatment system and manage the performance of drug treatment services. Effective commissioning is key to the delivery of effective drug treatment, to ensure that it meets local need and is planned, integrated and strategic.
- **Harm reduction services:** we reviewed how local drug treatment partnerships deliver services that reduce physical harm caused by drug use. Blood-borne virus rates are high among drug users, particularly those who inject drugs. Over 90% of diagnoses of hepatitis C are associated with injecting drug use in England and reported drug-related deaths in the UK are among the highest in Europe.

Within these two themes, the review established 10 criteria as indicators of effective commissioning and harm reduction provision. We used 45 questions to assess the criteria, and each question was scored on a scale of:

- Weak
- Fair
- Good
- Excellent.

These question scores were then used to calculate criteria level scores and overall scores for each local drug partnership, using the same scale.

Overall findings

The review shows that the majority of partnerships are performing within acceptable levels, although there was room for improvement. No partnerships had an overall score of 'weak', but the majority of partnerships had some shortfalls in key areas.

The review highlighted the need for local drug partnerships to develop targeted action plans to address gaps in the way they commission services and provide harm reduction services.

There are clear regional variations in the results. In general, the north of the country performed better, having the two top-performing regions (North East and North West) and none represented in the bottom five. The North West region came top against both commissioning and harm reduction criteria. The South East region was the lowest performer against both commissioning and harm reduction criteria. The top four regions – the North West, the North East, Yorkshire and London – were the same for both the commissioning and the harm reduction elements of the review.

Key messages for commissioning and systems management

The review provides a helpful picture of the national strengths and weaknesses in relation to this area and highlighted some significant progress:

- **Local commissioning partnerships have developed strong performance management structures for drug treatment.** The contract monitoring of treatment providers, performance management of partnerships and effective data monitoring were all in place in the majority of local drug partnerships. Eighty-six per cent of partnerships were assessed as 'excellent' against this criterion. This was attributed to partnerships having an increased focus on these areas, supported by relevant guidance, strategies and the work of NTA's regional teams in assuring that they met these standards.
- **Drug treatment partnerships have made significant progress in relation to care planning and discharge systems.** Local partnerships have shown recent improvement, particularly in retaining service users in drug treatment, with 99% achieving or exceeding 70% of their local target.
- **There is a good reported standard of financial management across the sector.** Sixty per cent of local drug partnerships achieved the maximum score in relation to financial management.

However, there were also some key areas for improvement, particularly in relation to the assessment of need and strategic leadership, which are essential to effective commissioning and form the foundation on which an effective drug treatment system is founded.

- **Many local drug partnerships did not undertake a systematic assessment of local need.** Over a quarter (26%) of local drug partnerships did not undertake a needs assessment to inform their commissioning of services in 2006/2007.
- **The strategic leadership of local drug partnerships could be enhanced.** The review highlighted a lack of seniority and attendance of senior representatives from statutory partners at local drug partnerships' strategic board meetings. Fifteen per cent of local drug partnerships had board members that were below assistant director level. However, the review did show that service providers and service users were involved in strategic planning within local drug partnerships. Ninety four per cent of local drug partnerships stated that they held meetings with service users.
- **The commissioning of residential and inpatient services needs to be improved.** The review showed that almost half (48%) of local drug treatment partnerships did not commission residential and inpatient treatment in line with national guidance. The primary shortfall related to the lack of requirements for aftercare services in service contracts, indicating a lack of integrated care.
- **There is a need for a continuing focus on strategic workforce development within local drug partnerships.** Over one third (37%) of partnerships did not have workforce development strategies in place. This is a severe shortfall in the context of the recent rapid expansion of the sector's workforce.

Key messages for harm reduction services

The review shows some good progress relating to harm reduction services:

- **Community prescribing services were assessed as providing a mainly good range of harm reduction interventions.** In particular, partnerships provided good advice on safer injecting and preventing overdoses.
- **Strategic planning for harm reduction services was assessed as generally good.** However, in the context of the scale of both preventable and treatable blood-borne virus infections and the shortfalls in relation to testing, vaccination and treatment, additional action from local drug treatment partnerships to increase the rates of testing and vaccination is called for.
- **Local drug partnerships have made significant progress in developing systems and protocols to reduce the number of drug-related deaths** but more needs to be done to reduce these drug-related overdoses even further. The systems and protocols need to be drawn together more effectively in multi-agency strategic plans. Only 68% of local drug partnerships had a multi-agency strategic plan for reducing drug-related deaths.

However, there are still a number of areas for improvement on vital issues:

- **Vaccination for hepatitis B and testing and treatment for hepatitis C was not provided widely enough by local drug treatment partnerships.** Almost all (95.3%) partnerships offered less than three-quarters (75%) of their service users a hepatitis B vaccination and 29% did not have a protocol relating to hepatitis B. The majority (95.3%) of partnerships reported that less than 50% of their service users had a recorded test date for hepatitis C. In the context that over a third (34%) of all cases of hepatitis B and over 90% of hepatitis C diagnoses are associated with injecting drug use in England, this is a clear national priority.
- **Harm reduction interventions were not provided broadly enough across the treatment system or sufficiently integrated into it.** Just over a third (37%) of local drug partnerships did not have access to HIV testing with access to pre and post-test counselling integrated with their inpatient drug treatment services. In addition, 36% of partnerships did not have hepatitis C testing integrated into their open access services.
- **There is a clear national shortfall in the provision of out-of-hours needle exchange.** Just under half (44%) of local drug partnerships scored 'weak' in this area. Only 21% of partnerships opened most of their needle exchange services on Saturdays and only 2% opened them on Sundays.
- **Nearly half (48%) of the service users surveyed thought that the harm reduction services they received were not comprehensive enough.** This related particularly to wound and abscess dressing, advice on alcohol and training to deal with overdose.

Promoting improvements

The review identifies a clear agenda against which to plan improvement in relation to commissioning and harm reduction. The review team from the Healthcare Commission and the NTA supported approximately 17% of the weakest-performing partnerships to develop effective action plans, carrying out 40 strategic meetings and facilitating 18 workshops. The NTA's regional teams and strategic health authorities will monitor their performance against these plans.

It was encouraging that the review also found widespread improvement against the shortfalls identified by the first joint service review, which covered community prescribing and care planning, particularly in relation to the consistent use of care plans. This shows that the drug treatment sector responds positively to the service reviews and uses them to improve quality.

This review was the second of three joint service reviews into services for substance misuse carried out by the Healthcare Commission and NTA. The final review will be carried out in 2007/2008 and will look at diversity and residential services (inpatient and residential rehabilitation services). Together, all three reviews will provide a key tool to improve the provision of drug treatment services to support the Government's drug strategy.

The scores achieved by each local drug partnership are published on the Healthcare Commission's website: **www.healthcarecommission.org.uk**

Introduction

Over recent years, the number of people receiving specialist treatment for drug problems has increased dramatically. There were 195,464 people receiving treatment in England during 2006/2007 – an increase of 130% on the 1998/1999 baseline of 85,000. This group of people has clear links to social deprivation, making this topic a political priority.

In 2002, the National Treatment Agency for Substance Misuse (NTA) and the Department of Health published *Models of Care for substance misuse treatment: promoting quality, efficiency and effectiveness in drug misuse treatment services,*[1] which provides a national framework for the delivery of services. This guidance was updated in 2006.[2] *Models of Care* explains how integrated services should be provided in local settings.

The Audit Commission undertook national studies into the commissioning and provision of drug treatment in 2002 and 2004[3], which found opportunities for improving services. There is good evidence to show that effective treatment services are clearly linked to benefits for service users and the public[4]. As a result, drug treatment services have received significant investment since the introduction of the Government's 10-year drug strategy in 1998. Figures from the NTA's national database show that the average national waiting time for drug treatment in England has fallen from 9.1 weeks in December 2001 to 2.4 weeks in March 2006. In addition, a new suite of clinical guidelines from the Department of Health and the National Institute for Health and Clinical Excellence (NICE) was published in 2007[5], which reinforces the view that much of the current practice in drug treatment is in line with the evidence.

It was in this context that the NTA and the Healthcare Commission agreed to work in partnership on a series of three reviews into key aspects of services for substance misuse.

The two organisations worked jointly to set up the process for the reviews and the work is governed by a memorandum of understanding. The NTA is a specialist sponsor and the Healthcare Commission is the inspector and regulator.

Service reviews look at whether healthcare organisations are improving the care and treatment they provide to patients. They focus on particular aspects of healthcare that are of national importance and where there are opportunities for organisations to make substantial local improvements to the quality of services. Their aim is to encourage each organisation taking part, or in the review of substance misuse services, each local drug partnership, to improve the quality of services it provides to service users.

The topics for the reviews are:

- Community prescribing services and care planning and coordination (conducted in 2005/2006)
- Commissioning drug treatment systems and harm reduction services (this review)
- Diversity and residential services (inpatient and rehabilitation services) (to be carried out in 2007/2008).

This work has been groundbreaking in terms of reviewing and improving the quality of drug treatment services in England.

This review focuses on two themes: commissioning drug treatment systems and harm reduction services. The context of these themes is outlined as follows.

Commissioning drug treatment systems

There has been unprecedented investment in drug treatment over the past few years, combined with the release of a wide range of guidance documents and new performance management systems for those who commission and provide services, which all prioritise drug treatment. This has resulted in a significant change in the roles of commissioners and commissioning groups in a short space of time. The importance of ensuring the quality of joint commissioning mechanisms at a local partnership level is therefore crucial to the success of the national drug strategy and its aim of increasing the capacity and quality of drug treatment.

Improving commissioning is also a key aspect of the 2006 treatment effectiveness strategy[2], which seeks to improve the effectiveness of drug treatment and the journeys or pathways taken by service users through treatment. The treatment effectiveness strategy reinforced the need for good local systems to assess the needs of those who misuse drugs, to plan coherent local drug treatment systems based on local need and to assess the competencies of local joint commissioning structures and managers. This review addressed many of these aspects of commissioning drug treatment services.

Harm reduction services

Blood-borne virus (BBV) infections and drug overdoses account for a significant number of drug-related deaths and poor health among drug misusers and particularly drug injectors. Recent concerns about the rates of BBV infections and overdoses led the Government to launch a new Reducing Harm Action Plan in May 2007.[6]

This review is a key element in the action plan, as it assesses the performance of each local drug partnership and seeks to help the poorest performers to improve, thereby reducing the number of drug-related deaths in each area.

Drug-related deaths in the UK are among the highest in Europe. To demonstrate its commitment to reducing them, the Government set a national target in 2001 to reduce the number from 1,538 deaths by 20% by 2004. Although the previous steep increase in drug-related deaths during the 1990s was halted, the target itself was not met.

The rates of drug-related deaths caused by BBV infections among drug misusers, particularly those who inject drugs, have recently increased, together with the rates of sharing injecting equipment.

In 2006, the Health Protection Agency reported that drug injecting accounts for 5.6% of the reported diagnoses of HIV. The overall prevalence of HIV among injecting drug users (IDUs) in England remains relatively low at one in 50, but the prevalence in London is much higher at one in 25. There is concern at the recent increase in HIV among IDUs outside London, which has risen by 500% in two years from one in 400 IDUs in 2003, to one in 65 in 2005.[7] Homeless people who inject heroin and crack have higher rates of infection.

Over 90% of hepatitis C diagnoses are associated with injecting drug use in England. In 2006, the Health Protection Agency reported that the current prevalence of hepatitis C among IDUs in England was 44%: almost one in two IDUs were infected. There is a wide geographic variation, ranging from 58% in London to 20% in the North East. Recent research indicates that those injecting crack have a much higher prevalence of hepatitis C (67%) and cohort studies indicate that the incidence of hepatitis C has recently increased.[7]

Over a third (34%) of all cases of hepatitis B in England are associated with injecting drug use. The prevalence in England is around 32% but with wide regional variation (ranging from 32% in the North West region to 5.5% in Yorkshire). IDUs who inject crack have a much higher prevalence of hepatitis B (43%). The rate of self-reported hepatitis B vaccination has doubled since 1998, from 25% to 59% in 2005.

Reducing drug-related harm: An action plan

A three-year action plan to reduce drug-related deaths was introduced in 2001. This was supported by the Government's wider drug strategy. However, although data suggested it had a significant impact on previous trends, the number of drug-related deaths did not reduce by as many as originally intended and indications show that rates of some blood-borne virus infections may have begun to rise. Such drug-related deaths and illness associated with these infections are an enormous waste of life and the Government is determined to reduce the tragic effects suffered by drug misusers, their friends and families.

The new action plan, launched in May 2007, was designed to be delivered using an integrated approach at national, regional and local levels. The Department of Health and the NTA are jointly overseeing its implementation.

Key aspects of the action plan also feature in this service review on commissioning and harm reduction. This includes improving surveillance and delivery of harm reduction services by:

- Benchmarking all local drug partnerships in terms of the commissioning and provision of harm reduction services.
- Developing and implementing local action plans to improve harm reduction in the poorest-performing areas identified through the joint service review published this year.
- All local drug partnerships working with regional NTA teams to address specific harm reduction issues identified in the service review.
- Providing guidance to commissioners, including sharing good practice, from sites identified through the service review (published by the NTA in January 2008).

Department of Health/National Treatment Agency for Substance Misuse, *Reducing Drug-related Harm: An Action Plan*, 2007

Methodology of the review

Service reviews are based on a standardised approach that is information-based and targeted. The method is designed to encourage significant improvement without imposing a large burden on healthcare organisations.

There are two parts to a service review. Firstly, we assess the performance of all organisations taking part. As drug treatment is provided within partnerships or treatment communities, as opposed to individual services, we focused on treatment across these partnerships. These were defined as local drug partnerships or action teams (referred to throughout this report as local drug partnerships).

Secondly, we work with the minority (approximately 10% to 15%) of organisations (or systems) that have the weakest assessments and may require help to develop action plans to improve their performance.

The assessment checks performance against key outcome and quality measures that provide an indication of the effectiveness of local drug partnerships. These measures are developed through engagement with service users, carers, providers (including clinicians and other experts) and commissioners of services. The measures are then cross referenced with national policy, guidance and standards of good practice.

In the review of substance misuse services, an overall score of 'weak' (1), 'fair' (2), 'good' (3) or 'excellent' (4) was applied to each local drug partnership. Ranges of scores were set for each scoring band. It was possible to achieve a maximum score of 40 in this review. See the appendix for a more detailed explanation of the scoring method.

PCTs are key members of local drug partnerships. As such, they are given the same score as that achieved by the local drug partnership to which they belong. (The exception to this is for the 11 PCTs whose score is based on the average aggregated score from multiple partnerships.)

Criteria used in the review

The assessment framework consisted of 10 criteria (or key headings) across the two themes (commissioning and systems management and harm reduction) and 45 questions were clustered around these criteria, shown in Box 1. Further detail on the methodology and the development of the review can be found in the appendix.

Box 1: Assessment criteria for the service review

Theme A: commissioning and systems management

The following criteria were developed to assess the performance of local drug treatment partnerships on commissioning and systems management:

Local commissioning partnerships:

1. Have formal strategic partnerships with key stakeholders including health, social care, housing and employment services, drug treatment providers, and local drug users and carers.
2. Have a shared understanding of the local need for drug treatment, based upon annual needs assessment reports in line with a nationally agreed methodology. This methodology required the needs assessment to profile the diversity of local need for drug treatment, including rates of morbidity and mortality (such as infection with blood-borne viruses), the degree of treatment penetration, and impact of treatment on individuals.
3. Develop local drug treatment system plans annually in line with the *Models of Care for Treatment of Adult Drug Misusers: Update 2006* (NTA, 2006) with focus on reducing harm to individuals and communities, improving clients' journeys through treatment, predicting client flow through local systems and improving the effectiveness of local drug systems.
4. Demonstrate best practice in handling public money, contracting with providers and monitoring service level agreements.
5. Performance-manage local systems of drug treatment using data and key performance indicators in partnership with local strategic partners and plans.
6. Are 'fit for purpose', have involvement from key stakeholders at an appropriate level of seniority and ensure commissioners are competent against national quality standards and other relevant professional frameworks.

Theme B: harm reduction

The following criteria were developed to assess local drug treatment systems' performance on the provision of harm reduction services:

7. Service providers deliver harm reduction interventions embedded in the whole treatment system.
8. Service users have prompt and flexible access to needle exchange services, vaccination and testing and treatment for blood-borne viruses.
9. Service providers take action to reduce the number of drug-related deaths.
10. Service providers have staff competent to deliver effective harm reduction services.

Key overall results

Overall scores

The following analysis of results covers all 149 local drug partnerships that we assessed. The scores provide a numeric summary of the performance in each partnership. They show that while the majority of partnerships are performing within acceptable levels, there is some room for improvement. The appendix describes how we calculated scores for the overall rating.

Figure 1 shows the distribution of total scores out of a highest achievable score of 40. The colours show the thresholds for overall scores of 1 to 4: 'fair' (2), 'good' (3) or 'excellent' (4). No local drug partnerships or primary care trusts (PCTs) scored (1) or 'weak' in this review.

Table 1 shows the number and percentage of overall rating scores awarded to partnerships and PCTs. Just over a fifth of local partnerships and PCTs scored 'fair', which indicates that there is some room for improvement. Just over a third scored 'excellent'.

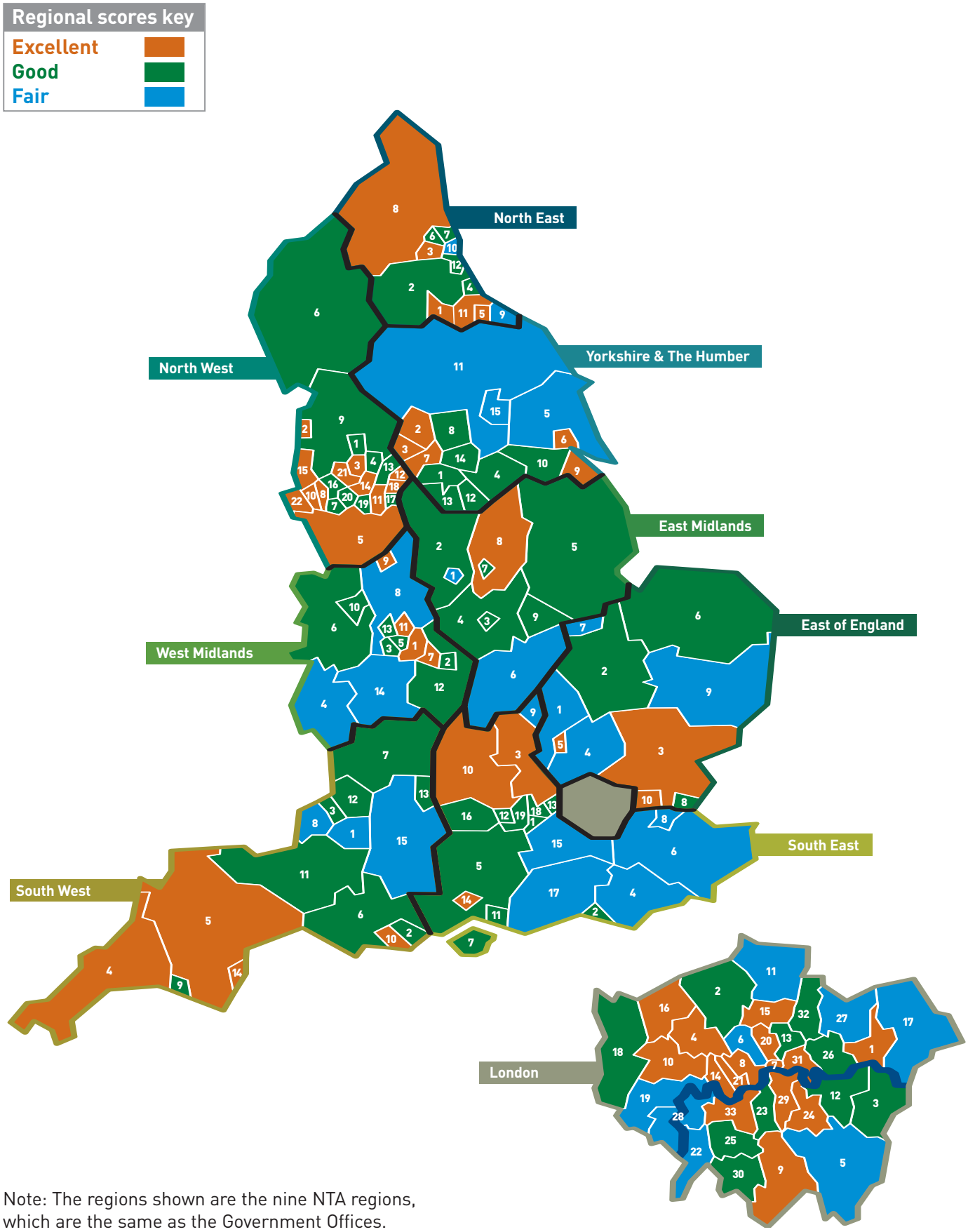
Table 1: Distribution of overall ratings

	Local drug partnership		PCT	
	Number	%	Number	%
Weak	0	0	0	0
Fair	31	21	34	22
Good	67	45	63	41
Excellent	51	34	55	36
Total	**149**	**100**	**152**	**100**

Note: Some PCTs have a different score to the partnership as they have multiple partnerships within their boundary. The scores for these PCTs are calculated as the average of all partnerships covered.

Figure 1: Overall distribution of scores

Figure 2: Distribution of regional scores



Note: The regions shown are the nine NTA regions, which are the same as the Government Offices.

North West

1 Blackburn with Darwen
2 Blackpool
3 Bolton
4 Bury
5 Cheshire
6 Cumbria
7 Halton
8 Knowsley
9 Lancashire
10 Liverpool
11 Manchester
12 Oldham
13 Rochdale
14 Salford
15 Sefton
16 St Helens
17 Stockport
18 Tameside
19 Trafford
20 Warrington
21 Wigan
22 Wirral

North East

1 Darlington
2 Durham
3 Gateshead
4 Hartlepool
5 Middlesbrough
6 Newcastle upon Tyne
7 North Tyneside
8 Northumberland
9 Redcar & Cleveland
10 South Tyneside
11 Stockton-on-Tees
12 Sunderland

Yorkshire & The Humber

1 Barnsley
2 Bradford
3 Calderdale
4 Doncaster
5 East Riding of Yorkshire
6 Kingston upon Hull
7 Kirklees
8 Leeds
9 North East Lincolnshire
10 North Lincolnshire
11 North Yorkshire
12 Rotherham
13 Sheffield
14 Wakefield
15 York

East of England

1 Bedfordshire
2 Cambridgeshire
3 Essex
4 Hertfordshire
5 Luton
6 Norfolk
7 Peterborough
8 Southend-on-Sea
9 Suffolk
10 Thurrock

West Midlands

1 Birmingham
2 Coventry
3 Dudley
4 Herefordshire
5 Sandwell
6 Shropshire
7 Solihull
8 Staffordshire
9 Stoke-on-Trent
10 Telford and Wrekin
11 Walsall
12 Warwickshire
13 Wolverhampton
14 Worcestershire

East Midlands

1 Derby
2 Derbyshire
3 Leicester
4 Leicestershire
5 Lincolnshire
6 Northamptonshire
7 Nottingham
8 Nottinghamshire
9 Rutland

South West

1 Bath & NE Somerset
2 Bournemouth
3 Bristol
4 Cornwall
5 Devon
6 Dorset
7 Gloucestershire
8 North Somerset
9 Plymouth
10 Poole
11 Somerset
12 South Gloucestershire
13 Swindon
14 Torbay
15 Wiltshire

South East

1 Bracknell Forest
2 Brighton & Hove
3 Buckinghamshire
4 East Sussex
5 Hampshire
6 Kent
7 Isle of Wight
8 Medway
9 Milton Keynes
10 Oxfordshire
11 Portsmouth
12 Reading
13 Slough
14 Southampton
15 Surrey
16 West Berkshire
17 West Sussex
18 Windsor & Maidenhead
19 Wokingham

London

1 Barking & Dagenham
2 Barnet
3 Bexley
4 Brent
5 Bromley
6 Camden
7 City of London
8 City of Westminster
9 Croydon
10 Ealing
11 Enfield
12 Greenwich
13 Hackney
14 Hammersmith & Fulham
15 Haringey
16 Harrow
17 Havering
18 Hillingdon
19 Hounslow
20 Islington
21 Kensington & Chelsea
22 Kingston upon Thames
23 Lambeth
24 Lewisham
25 Merton
26 Newham
27 Redbridge
28 Richmond upon Thames
29 Southwark
30 Sutton
31 Tower Hamlets
32 Waltham Forest
33 Wandsworth

Regional variations in results

The map shown in figure 2 illustrates the location of local drug partnerships within the nine regions. Regional differences in scores were clearly evident and are shown in Figure 3.

The regional variations cover a mean score range of 2.8 to 3.5. In general, partnerships in the north of England performed better than either the midlands or the south of the country, having two of the top-performing regions and no regions represented in the bottom five. The three northern regions (North West, North East and Yorkshire) scored an average of 3.3, compared to a score of 2.9 for the East Midlands and West Midlands, and an average score of 3 for London, the South East, South West and East of England regions. Figures 4a and 4b show the average scores for regions in the area of commissioning and harm reduction.

Figure 3: Mean category score (1 to 4) for each region

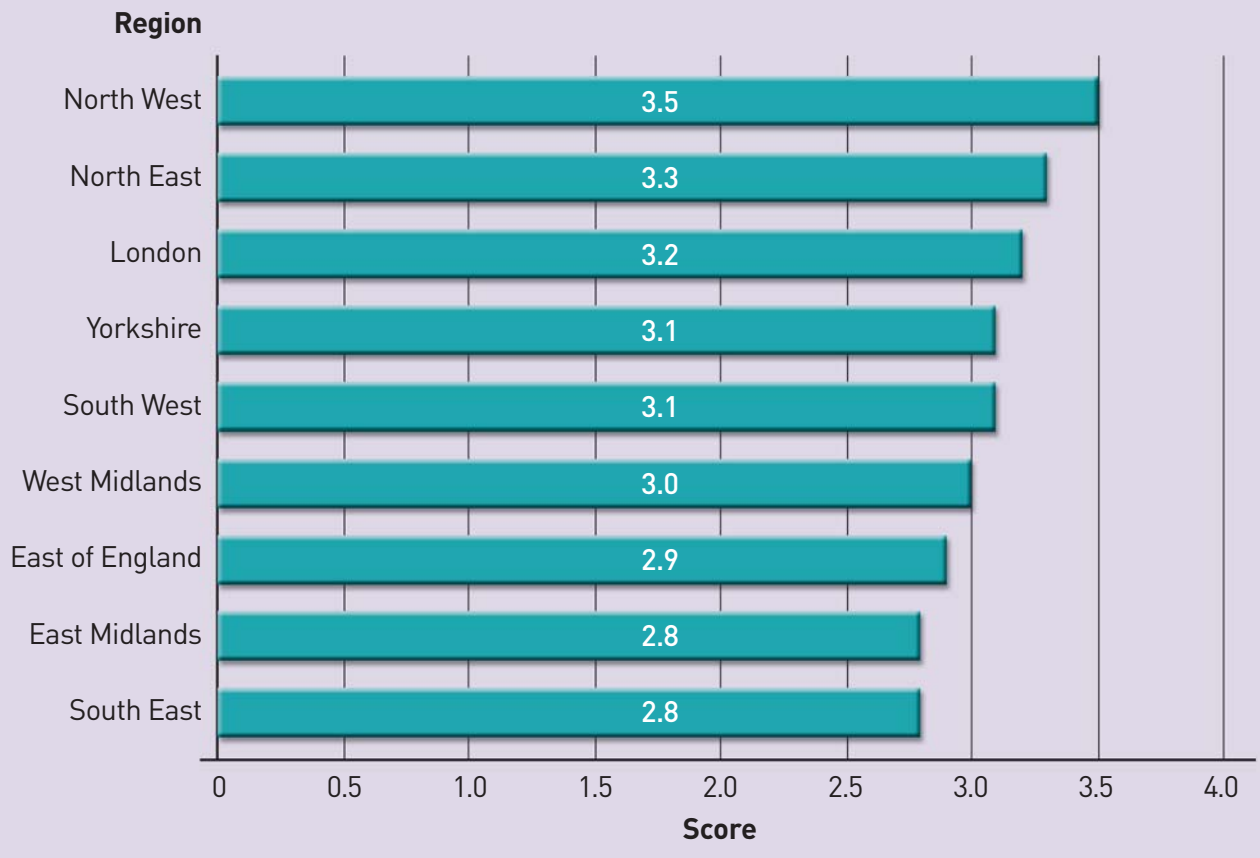


Figure 4a: Average score per region for commissioning (out of a total available score 24)

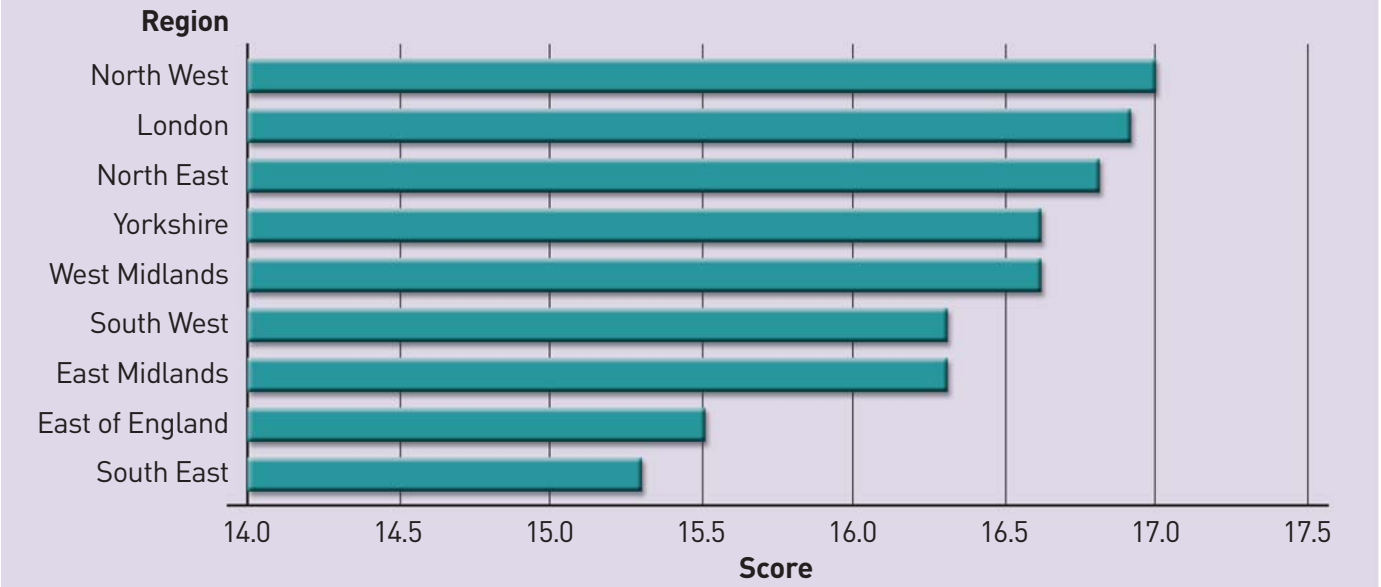


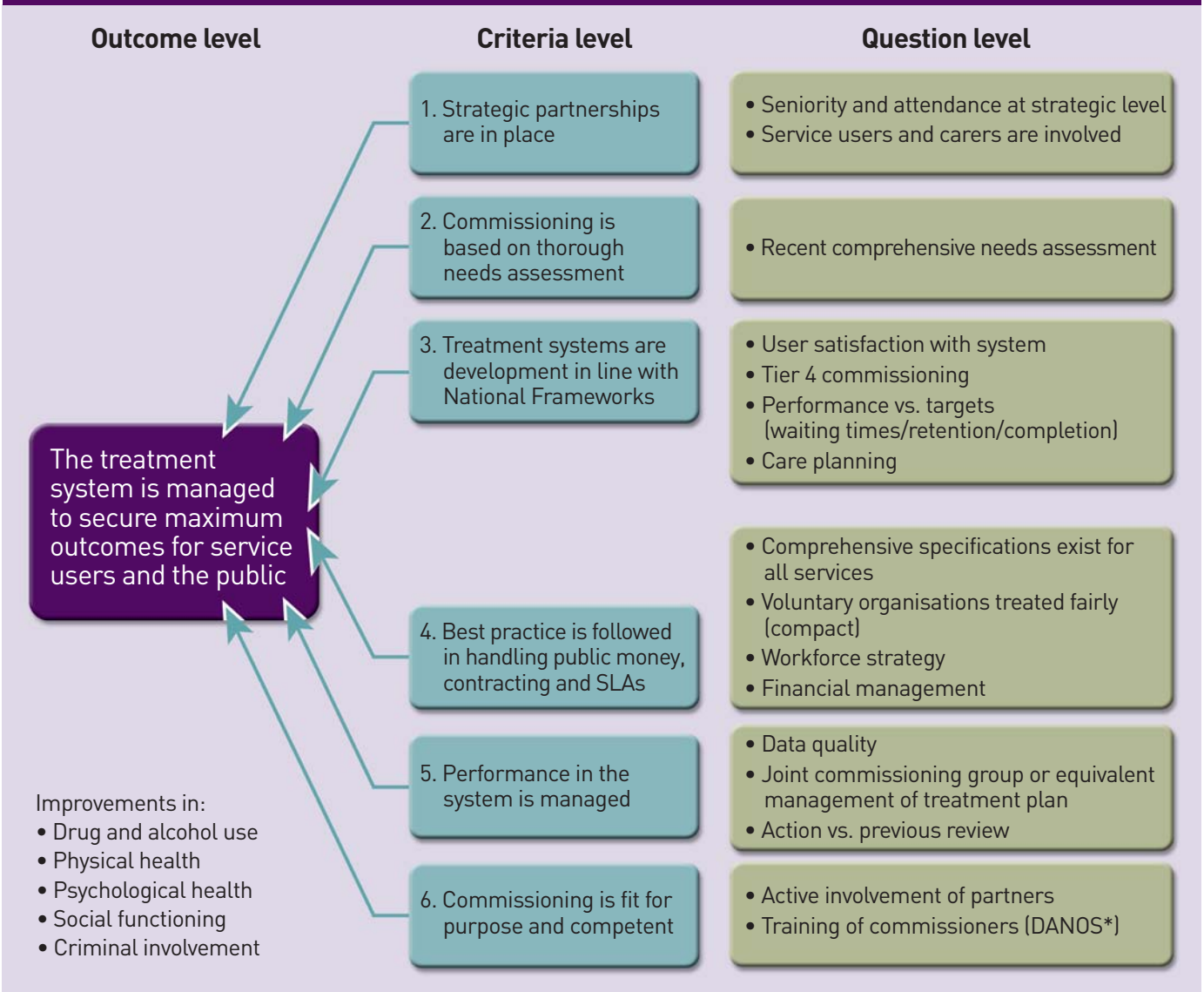
Figure 4b: Average score per region for harm reduction (out of a total available score of 16)

The West Midlands, London and the East Midlands regions all performed better against the commissioning criteria than against the harm reduction criteria. The South East region was the lowest performer against both the commissioning and harm reduction criteria, whereas the North West region came top against both commissioning and harm reduction. The top four regions are the same for both commissioning and harm reduction.

Results for commissioning and systems management

The criteria for this theme of the review are shown in box 1 on page 12. Figure 5 shows how these fit into the assessment framework.

Figure 5: The assessment framework for commissioning and systems management at both criteria and question level

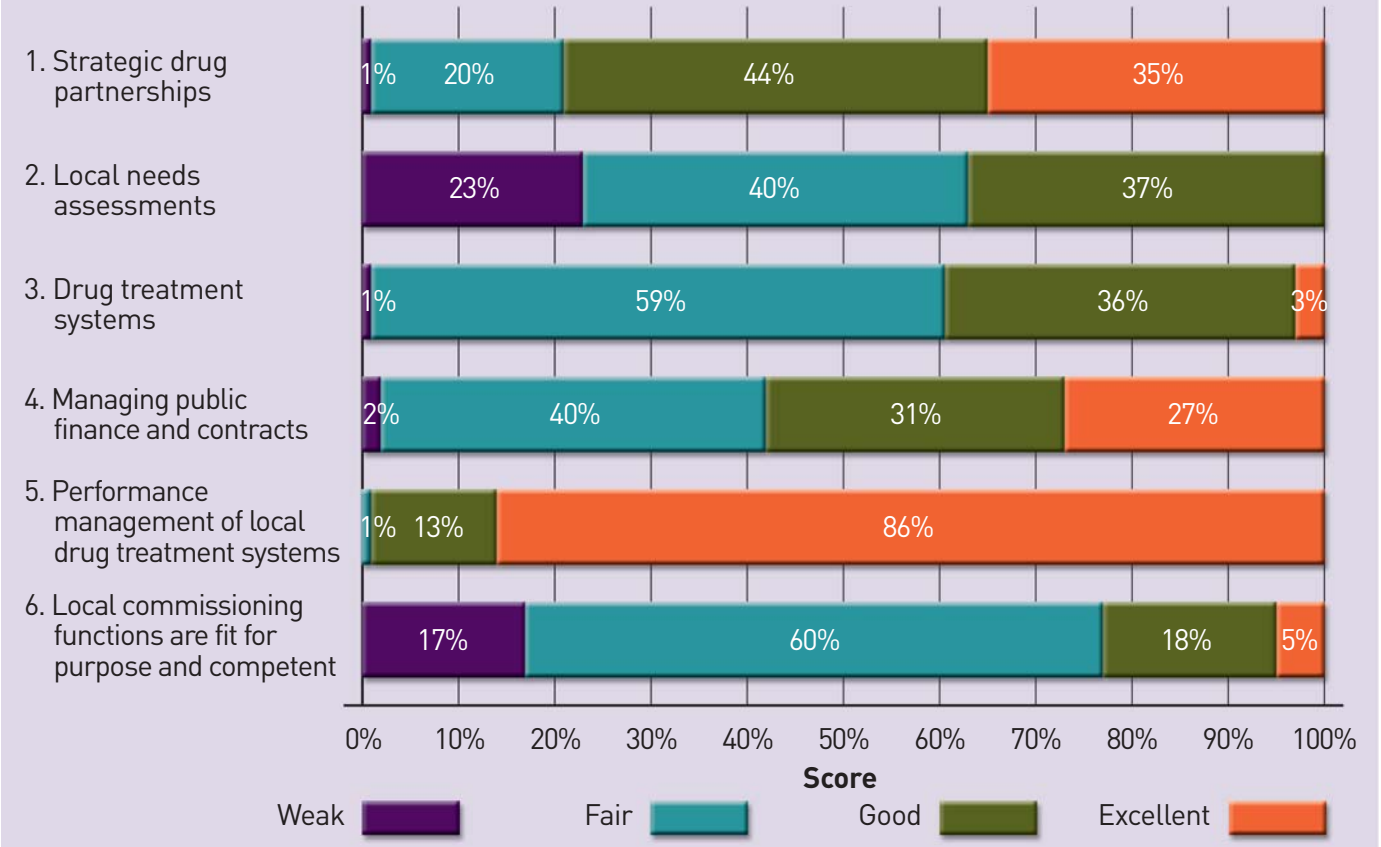


* Drugs and Alcohol National Occupational Standards

The strongest commissioning criterion at a national level related to the performance management of local drug treatment systems, where the majority (86%) of local drug partnerships scored 'excellent', only 1% scored 'fair' and none scored 'weak'. The second strongest criterion was whether local areas had formal strategic partnerships with key stakeholders; just over a third (35%) scored 'excellent' and 44% scored 'good'. Another strong criterion was whether partnerships demonstrated good financial management and contracting arrangements, with just over a quarter (27%) scoring 'excellent', just under a third (31%) scoring 'good' and only 2% scoring 'weak'.

The weakest commissioning criterion at a national level related to whether local drug partnerships demonstrated a shared understanding of the local need for drug treatment, based upon annual needs assessments in line with a nationally agreed methodology. Almost a quarter (23%) of partnerships scored 'weak' and none scored 'excellent' on this criterion. The second weakest criterion related to whether local commissioning partnerships were judged as being 'fit for purpose' and had the involvement of senior level key stakeholders and competent commissioners.

Figure 6: Distribution of scores for each criterion on commissioning and systems management at a local drug partnership level



The following section takes each of the commissioning criteria in turn and looks at the responses of the local drug partnerships.

Strategic partnerships

Criterion 1: Local commissioning partnerships have formal strategic partnerships with key stakeholders including health, social care, housing and employment services, drug treatment providers, and local drug users and carers.

This criterion was chosen because the involvement of a range of key stakeholders is crucial to the commissioning of drug treatment. Drug misusers often have needs that cross professional boundaries, such as health and social care. Strategic commissioning and planning of drug treatment therefore ideally involves a range of agencies including health providers, social care providers, housing providers and the criminal justice system. In addition, the involvement of service users and carers in the design and planning of local services is good practice. This ensures that services are responsive to the needs of local drug users and their families.

Three key questions formed this criterion:

1. What is the level of seniority and attendance of members of the strategic partnership board which takes responsibility for substance misuse?
2. How does the partnership involve service users and carers in strategic planning?
3. How does the partnership involve service providers in strategic planning?

Table 2: Results of criterion 1 by question

	Q1	Q2	Q3
Weak	36%	15%	1%
Fair	48%	16%	1%
Good	11%	11%	19%
Excellent	5%	58%	79%
Mean	1.9	3.1	3.8

Analysis of results in relation to criterion 1:

- The weakest performance in criterion 1 related to the involvement of key statutory partners in local drug partnerships, with just over a third (36%) scoring 'weak' and almost half (48%) scoring 'fair'. In 14.8% of local drug partnerships, there were board members that were below assistant director level. In 11.5% of partnerships, PCT board members did not attend any meetings, while in 16% of partnerships, probation representatives attended only one meeting in a year.
- The strongest performance for this criterion related to the involvement of local providers in local strategic planning where almost four out of five (79%) partnerships scored 'excellent' and only 2% scored 'weak' or 'fair'. Nearly 100% of commissioners stated that they met and consulted with service providers and that drug treatment clinicians are invited to treatment advisory groups or equivalent groups.

- The involvement of service users and carers is very important in planning and commissioning local drug systems and 58% of local drug partnerships scored 'excellent' for this question. Ninety-four per cent of local drug partnerships stated that they held meetings with service users, in order to invite their input into the development of annual commissioning strategies and treatment plans. However, 15% scored 'weak' and 16% scored 'fair' on user and carer involvement, which illustrates some room for improvement. It was the lack of reported involvement of carers that generally lowered partnerships' overall scores.

We asked some of the better performing local drug partnerships to give feedback on what they think contributed to their good performance. The following are some of their comments relating to strategic partnership:

"The DAT (drug action team) has established collaborative and strategic partnerships and regularly reviews the structures and membership of meetings to ensure we are able to respond effectively to the changing need locally and in response to statutory changes."
Kensington & Chelsea

"The strength of our commissioning strategy comes from the strength of our partnership and the involvement and commitment of our partners, service users, family members and carers in the joint commissioning group."
Nottinghamshire

Assessment of need

Criterion 2: Local commissioning partnerships have a shared understanding of the local need for drug treatment, based upon annual needs assessments in line with a nationally agreed methodology.

This criterion was chosen because the commissioning of effective local drug treatment systems is heavily dependent upon the local drug partnership having a clear profile of the diversity of local need for drug treatment. This includes rates of illness and death (for example infection with blood-borne viruses), the degree of treatment penetration and the impact of treatment on individuals. Drug problems vary tremendously between different population groups and in different localities. It is therefore very important to adapt local drug services to meet the needs of the local population and ensure that there is no differential negative impact on any individuals or population groups who need drug treatment.

Three key questions formed this criterion:

1. Had the partnership carried out or updated a local needs assessment during the financial year 2005/2006 to inform the 2006/2007 commissioning?
2. Did the local needs assessment contain the required elements as defined in national guidance?
3. What was the quality of the local needs assessment and how was the information used in developing local plans for commissioning drug treatment systems?

Table 3: Results of criterion 2 by question			
	Q1	Q2	Q3
Weak	21%	32%	26%
Fair	79%	15%	52%
Good	N/A	19%	21%
Excellent	N/A	34%	1%
Mean	1.8	2.5	2.0

Analysis of results in relation to criterion 2:

- There was clear room for improvement on the quality of needs assessments with over a quarter (26%) judged as 'weak' and over half (52%) as 'fair'. We assessed local drug partnerships' needs assessments against a number of criteria. These included: how effectively they used available statistics; how effectively they identified different patterns of drug use by the different drugs used and the geography; and the ethnicity, age and gender of users. Just over a quarter of local drug partnerships did not score above 45% of the achievable score in this assessment, demonstrating significant shortfalls in the robustness of needs assessments that were carried out in 2005/2006.
- The question with the most varied response was whether the local needs assessment was in line with national guidance. Just under a third (32%) of local partnerships scored 'weak', just over a third (34%) scored 'excellent' and the remainder scored 'fair' or 'good'.
- In relation to question 1 (completion of a needs assessment), 79% of partnerships had undertaken them in 2005/2006 to inform their commissioning in 2006/2007 and 21% had not.

Comments from some better-performing local drug partnerships on what contributed to their good performance relating to needs assessment:

"We have developed an effective needs assessment process by utilising effective data analysis capacity within partner agencies such as the police and probation. Close links to our partners, particularly within the NHS, made information collection more straightforward."
Kirklees

"The Crime and Disorder Partnership, supported by the public health directorate of the PCT and the NTA, have developed a detailed harm reduction needs assessment. This has been based on the NTA needs assessment model, together with qualitative consultation from partner agencies and key service user forums. We have plans to enhance this information base on an annual cycle."
Tameside

Drug treatment systems

Criterion 3: Local drug treatment system plans are in line with national frameworks including *Models of Care for Drug Misusers* (2006).

This criterion was chosen to indicate whether drug treatment services are being commissioned in line with evidence-based guidelines that focus on reducing harm to individuals and communities, improving clients' journeys through treatment, predicting client flow through local systems and improving the effectiveness of local drug systems. These elements are all key indicators of good quality drug treatment.

Five key questions formed this criterion:

1. How did the area's waiting times compare with national targets?
2. How many service users who started treatment had a care plan?
3. How did the area's retention performance compare with local targets?
4. How did the area's planned discharge performance compare with local targets?
5. Were residential and in-patient services commissioned in line with national guidance?

Table 4: Results of criterion 3 by question

	Q1	Q2	Q3	Q4	Q5
Weak	21%	28%	1%	7%	48%
Fair	13%	46%	0%	48%	11%
Good	54%	19%	99%	43%	35%
Excellent	11%	7%	N/A	2%	6%
Mean	2.5	2.1	3.0	2.4	2.0

Analysis of results in relation to criterion 3:

- The strongest national performance was on the question relating to retention of people in treatment, where almost all (99%) of local drug partnerships scored 'good' (the highest score available for this question). This indicates that in these local drug partnerships, retention rates meet or exceed 75% of the local targets. This indicator is part of the public service agreement (PSA) target on drug treatment, and relates to the evidence that drug treatment needs to last three months or more before it gives long-term benefit to people with severe drug misuse problems, such as heroin misuse. Local drug partnerships have focused on improving retention in drug treatment over the past few years, and these results have shown clear improvement in line with local targets.
- The weakest performance was evident for question 5, which related to whether local commissioning for residential and inpatient treatment was in line with national guidance. Almost half (48%) of local drug partnerships scored 'weak' and only 6% scored 'excellent', illustrating significant room for improvement. The main reason for the low scores achieved by partnerships was because residential and inpatient service contracts did not include requirements for aftercare or integrated care pathways with subsequent interventions. Added to this, 35% of local drug partnerships did not have appropriate contracts for these services in place.
- In relation to care planning, the results showed that just over 5% of local drug partnerships had care plans in place for less than half of their service users.

Comment from a better-performing local drug partnership on what contributed to its good performance relating to care planning:

"Key to our success is the shared ownership of the drug treatment system plans and how these interface with the mainstream agencies and their strategies, such as families and children's services, housing and environmental health."
Kensington & Chelsea

Commissioning practice

Criterion 4: Local commissioning partnerships demonstrate best practice in handling public money, contracting with providers and monitoring service level agreements.

This criterion was chosen because the significant investment in local drug treatment systems requires good governance over discrete and pooled budgets. In addition, previous reports noted that contracting and monitoring by commissioners of drug treatment providers was seen to be patchy (Audit Commission, 2002), which resulted in national guidance being issued.

This criterion consisted of four questions:

1. Were detailed service specifications agreed with service providers for the full range of services?
2. (Question removed: Were contracts with voluntary sector providers in line with National Compact expectations? This question was removed because the data submitted by partnerships could not be analysed. The design of the question did not account for the possibility that one organisation could have more than one contract and did not ask for the total number of contracts. This resulted in a percentage of returns giving a greater number of contracts than there were organisations and as such, rendered the question impossible to score.)
3. Did the partnership have a workforce development strategy and a plan to respond to the needs identified for developing the workforce?
4. What is the NTA's assessment of the partnership's financial management?

Table 5: Results of criterion 4 by question

	Q1	Q2	Q3	Q4
Weak	5%	Question	37%	5%
Fair	18%	removed	7%	35%
Good	52%		25%	60%
Excellent	26%		31%	N/A
Mean	3.0		2.5	2.5

Analysis of results in relation to criterion 4:

- The weakest performance related to partnerships' workforce development strategies. Over a third (37%) of local drug partnerships scored 'weak', showing room for improvement. These local drug partnerships did not have workforce development strategies in place, which is a severe shortfall in the context of the recent rapid expansion in this sector's workforce. However, just under a third (31%) scored 'excellent' and a quarter scored 'good' for this question, illustrating very variable performance in England.
- Local drug partnerships generally scored well on the question of whether local commissioning partnerships had detailed service specifications, with over three-quarters (78%) scoring 'good' or 'excellent'. Comprehensive and clear service specifications are key mechanisms by which service commissioners can ensure the quality and drive the performance of drug treatment services. The high scores for this question are indicative of significant progress in commissioning practice and provide a good foundation for the provision of effective drug treatment services.
- The question relating to financial management showed good performance, with 60% of areas scoring 'good' (the maximum score available for this question) and only 5% scoring 'weak'.

Comments from some better-performing local drug partnerships on what contributed to their good performance relating to needs commissioning practice:

"We have excellent financial support to the commissioning process from within the PCT and have an experienced team of commissioners and a joint commissioning group attended by senior commissioners from partner agencies. This enables excellent forward planning and puts us in a strong position to address underperformance by providers and budget problems."
Kirklees

"The Crime and Disorder Partnership has a rigorous and detailed process for monitoring financial and activity-based performance. This takes place at different levels, against agreed service level agreements and within the partnership structure. All partners are provided with this information at least quarterly and monthly where required."
Tameside

Performance management

Criterion 5: Local commissioning partnerships performance-manage local systems of drug treatment by using data and key performance indicators in partnership with local strategic partners and plans.

This criterion was chosen because drug treatment is a priority for the Government, which has set targets as part of the public service agreement (PSA) on drug treatment. As part of this mechanism, local drug partnerships have all set local targets and are performance-managed by the NTA and regional partners on a quarterly basis. The quality of the data collected by the National Drug Treatment Monitoring System (NDTMS) is therefore critical.

Active participation of local drug partnerships in the NTA's performance monitoring of joint commissioning and thereby of local providers is, therefore, very important.

This criterion consisted of six questions:

1. What was the quality of the data submitted for NDTMS by structured treatment providers?
2. Does the joint commissioning group receive, discuss and agree actions in relation to the NTA quarterly performance management report?
3. What action did the commissioning partnership take as a result of the 2005/2006 joint improvement review by the Healthcare Commission and the NTA?
4. What was the content of discussions between the joint commissioning manager and the NTA's regional team at the last quarterly performance meeting?

5. What was the experience of providers of the commissioning system?
6. What was the content of discussions during the course of the last two contract monitoring meetings between commissioners and service providers?

Table 6: Results of criterion 5 by question

	Q1	Q2	Q3	Q4	Q5	Q6
Weak	1%	8%	5%	1%	1%	1%
Fair	5%	3%	2%	1%	9%	14%
Good	79%	85%	80%	6%	19%	15%
Excellent	15%	3%	13%	92%	71%	70%
Mean	3.1	2.8	3.0	3.9	3.6	3.6

Analysis of results in relation to criterion 5:

- Local drug partnerships generally scored very well on this criterion and on each of the questions within it.
- Outstanding performance was evident on question 4, which related to the content of discussions between the commissioners and the NTA regional team at recent quarterly performance meetings. Over 90% of local drug partnerships scored 'excellent' in this area. This indicates that the vast majority of local drug partnerships have robust discussions about the area's performance with the NTA and explore approaches to enhance the delivery of services.
- For questions 5 and 6, the vast majority (over 70%) of local drug partnerships scored 'excellent' on their relationships with providers and the content of contract monitoring meetings. This indicates that the commissioning relationships and performance management of treatment services are generally good and well developed.
- Question 3 asked what action had been taken as a result of the 2005/2006 joint improvement review on prescribing services, care planning and care coordination. Four-fifths (80%) of local drug partnerships were rated as 'good' on this question and 13% were rated 'excellent'. Only 5% of local drug partnerships scored 'weak'. Eighty per cent of local drug partnerships had an action plan in place to address shortfalls revealed by the 2005/2006 review. A further 13% stated that no action plan was required because best practice was already in place, or it had been agreed that no action plan was required as there was already one in place. The sector has clearly responded to the shortfalls in service provision highlighted by the 2005/2006 review and has undertaken significant planning to address these.
- The quality of data given to the National Drug Treatment Monitoring System (NDTMS) was high, with almost 79% rated as 'good' on this area and 5% rated as 'excellent'.
- The weakest area in this criterion concerned whether the joint commissioning group received, discussed and agreed actions in relation to the NTA quarterly performance management report. Eight per cent of local drug partnerships scored 'weak' and a further 3% scored 'fair'. However, 85% demonstrated that the report was utilised at a senior strategic level.

Comments from some better-performing local drug partnerships on what contributed to their good performance relating to performance management:

"Performance management is embedded throughout the partnership in Wigan. All agencies provide local monitoring, which can be used in conjunction with NDTMS. A local research and information unit enables effective performance management across all partnership plans."

Wigan

"Robust information systems and analytical skills within the partnership to interpret the information, provides effective monitoring. Together, user feedback and effective monitoring is the best performance monitoring tool."

Nottinghamshire

Commissioning partnerships

Criterion 6: Local commissioning partnerships are 'fit for purpose', have involvement from key stakeholders at an appropriate level of seniority and ensure commissioners are competent against national quality standards and other relevant professional frameworks.

This criterion was chosen for a number of reasons. Firstly local drug partnerships are more effective if they have the involvement of senior level stakeholders, particularly in health, social services, probation and the police. If drug partnerships have no multi-disciplinary involvement at a senior level, they are rarely able to be the influential decision-making body they were designed to be. Secondly, the competence of the local joint commissioning manager or team is crucial to a local drug partnership's ability to commission local drug treatment systems appropriately and in line with evidence-based guidance. Finally, the satisfaction of service users was directly correlated to self-reported outcomes in the NTA's surveys of service users from 2005 and 2006, with greater satisfaction associated with greater reductions in drug misuse and crime.

Criterion 6 consisted of three questions:

1. Which agencies are actively involved in implementing commissioning decisions in, for example, a joint commissioning group or other equivalent structure?
2. What competencies do commissioners have?
3. How satisfied overall are service users with the services provided?

Table 7: Results of criterion 6 by question			
	Q1	Q2	Q3
Weak	34%	23%	28%
Fair	34%	43%	52%
Good	31%	9%	19%
Excellent	1%	25%	1%
Mean	2.0	2.3	1.9

Analysis of results in relation to criterion 6:

- Local drug partnerships showed considerable variation in responses to these questions.
- Question 3 had the lowest mean score of 1.9. Over a quarter (28%) of local drug partnerships scored 'weak' in terms of whether service users were satisfied with local services, around half (52%) scored 'fair' and around a fifth (19%) scored 'good'. Only 1% scored 'excellent'. The scores were derived by combining service users' responses to 28 questions, which gauged their satisfaction with a range of different aspects of service provision. This clearly has implications for local drug partnerships and needs extensive planning to improve satisfaction.
- Similar variation was shown for question 1, concerning which agencies were actively involved in implementing local commissioning decisions. Around a third (34%) of partnerships scored 'weak', and a further third (34%) scored 'fair'. Just under a third scored 'good'. The main reason for these low scores was that partnership board members involved in commissioning decisions were not at a senior manger level. This lack of seniority clearly has the potential to compromise the effectiveness of local drug partnerships in addressing drug-related need.
- Local drug partnerships had the most marked range of responses to question 2 on the competency of local commissioners. Just under a quarter (23%) scored 'weak' and a quarter (25%) scored 'excellent'; 43% scored 'fair' and 9% scored 'good'. Twenty per cent of local drug partnerships did not have commissioners who were competent, through training or experience, in the following competencies: drawing up service specifications; inviting tenders and awarding contracts; monitoring and evaluating the quality, outcomes and cost-effectiveness of services and in procuring services. These are vital competencies required to commission effective drug treatment systems.

Comments from some better-performing local drug partnerships on what contributed to their good performance relating to being 'fit for purpose':

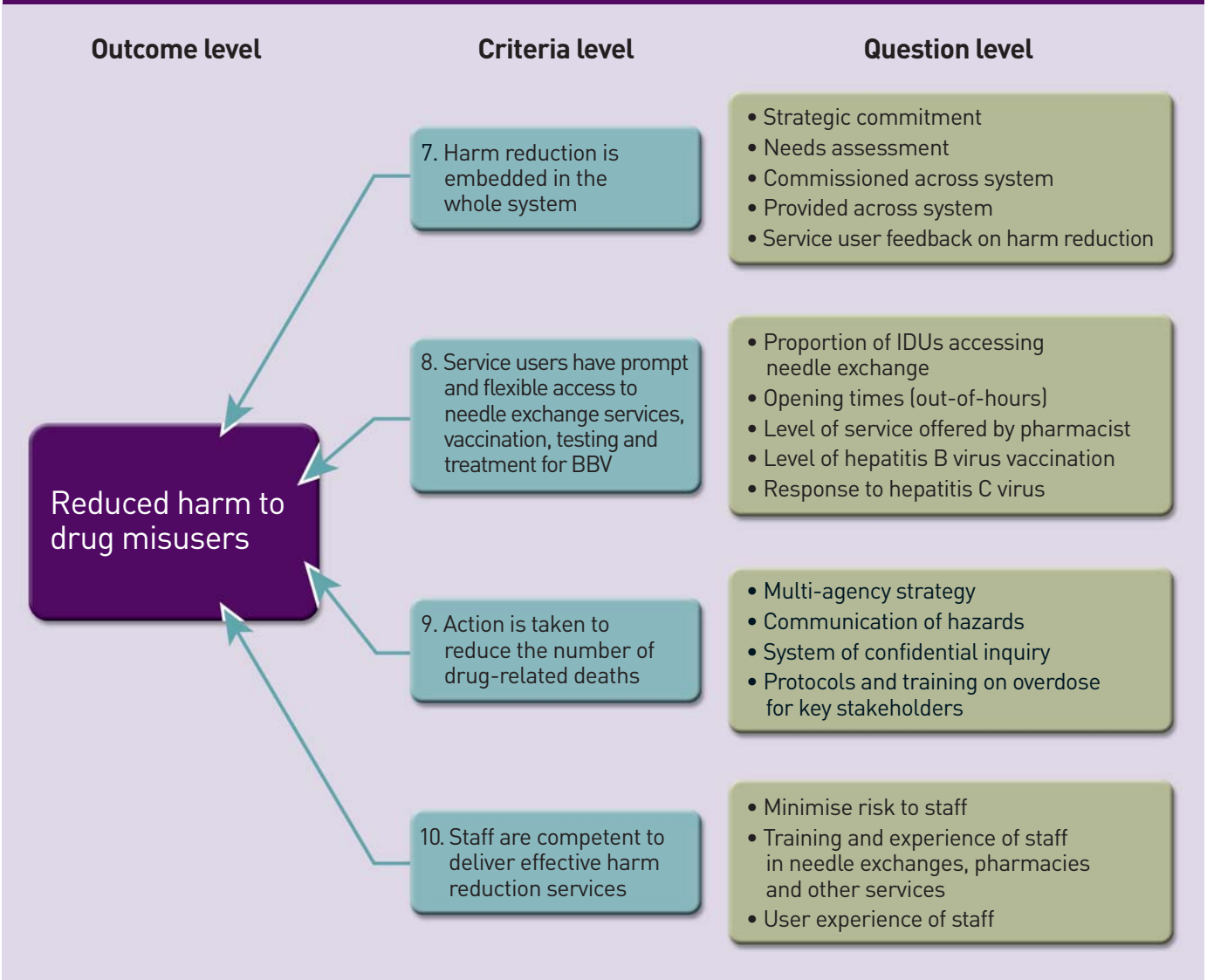
"There is commitment from local senior managers to ensure the success of the DAAT (drug and alcohol action team) business plans, and councillors also take a keen interest in the work of the DAAT partnership. External and internal audits are periodically carried out to ensure there is full understanding of strengths and weaknesses across the system."
Kensington & Chelsea

"Overall improvement in service delivery is coordinated by a highly integrated commissioning and performance management system within the DAT (drug action team). This provides both strategic direction and a strong point of reference for providers to ensure that services meet the population needs in a coordinated and managed framework where each service has a clear understanding of its role and that of others."
Knowsley

Results for harm reduction services

The criteria used to measure performance in relation to harm reduction services are set out in Box 1 on page 12. Figure 7 shows how they fit in the assessment framework.

Figure 7: The assessment framework for harm reduction at both criteria and question level

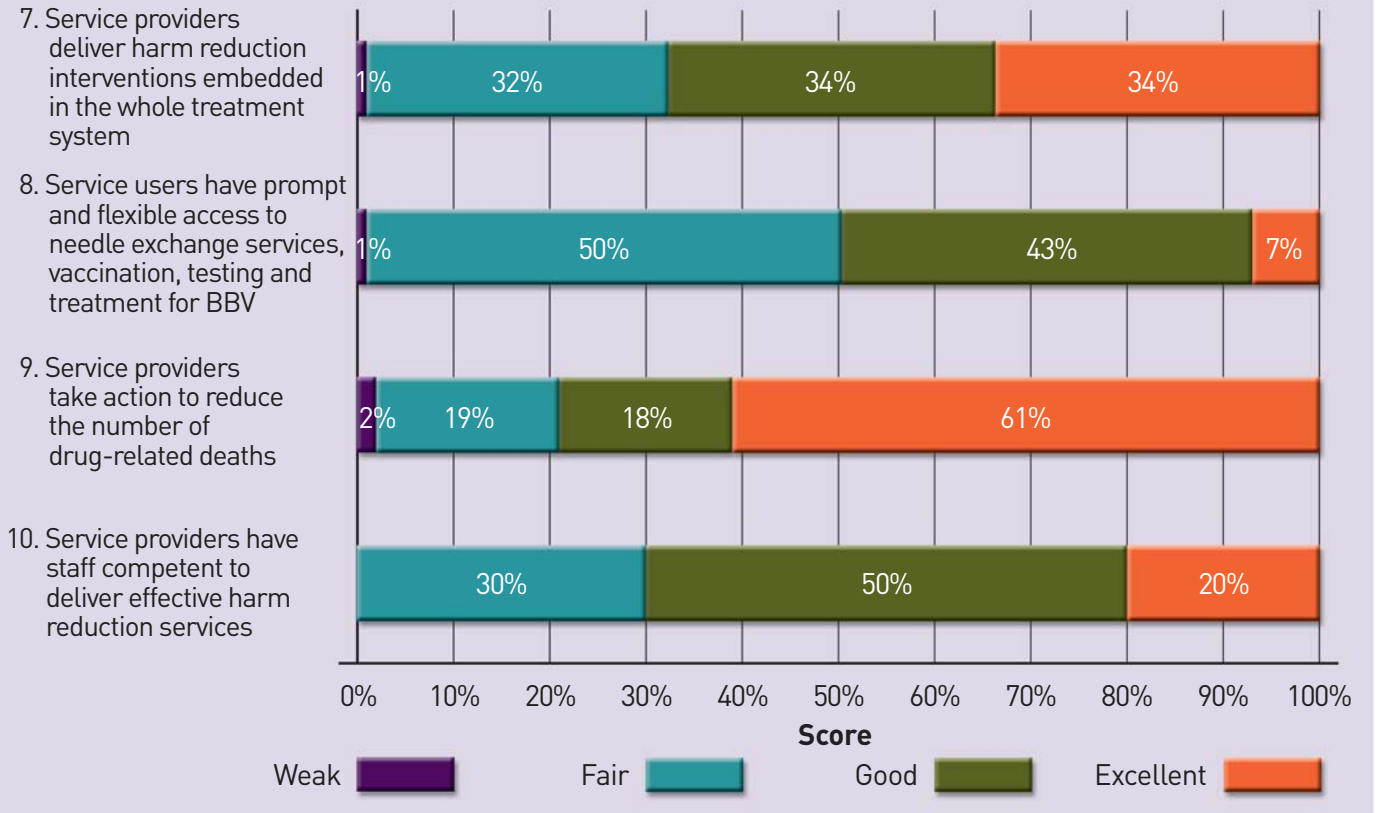


The strongest criterion related to action taken to reduce drug-related deaths, with 61% scoring 'excellent' and 18% scoring 'good'. This criterion looked at: strategic planning to reduce drug-related deaths, training of ambulance crews in the use of naloxone (a drug used to counter the effects of heroin overdose), training of police custody officers in managing overdose incidents, and training for parents and carers in dealing with overdose. Another strong criterion related to whether the service providers' staff were competent to deliver effective harm reduction services, with 50% scoring 'good' and 20% scoring 'excellent'.

The weakest criterion for harm reduction was criterion 8, which relates to access to harm reduction services, including needle exchange, harm reduction interventions offered by services, and blood-borne virus vaccination and testing. Over half (51%) of local drug partnerships scored 'fair' or 'weak' for this criterion. The second weakest criterion related to whether harm reduction interventions were embedded in the whole system, with 33% of partnerships scoring 'fair' or 'weak'.

The following section takes each harm reduction criterion in turn and looks at the responses of local drug partnerships.

Figure 8: Distribution of scores for each criterion on harm reduction



Harm reduction embedded in the treatment system

Criterion 7: service providers deliver harm reduction interventions embedded in the whole treatment system.

This criterion was chosen as it is vital that interventions to reduce drug-related harm are a key and integral part of the local treatment system. They should be accessible to service users from a range of access points. Their provision should also be based on a comprehensive understanding of need, which informs robust strategic plans. Harm reduction encompasses a broad range of interventions and the criterion also assessed the breadth of local drug partnerships' provision. The criterion also assessed how commissioning practice drove the provision of harm reduction interventions. Overall, the criterion indicated the robustness of a local drug partnership's approach to harm reduction.

Criterion 7 was composed of six questions:

1. Does the local drug partnership have a harm reduction strategy that is informed by internal and external data?
2. Did the local needs assessment establish the level of need for harm reduction interventions?
3. Where are harm reduction interventions provided in the treatment system?
4. Which harm reduction interventions are provided in community prescribing services?
5. Do service contracts include harm reduction?
6. How comprehensive are harm reduction interventions as experienced by service users?

Table 8: Results of criterion 7 by question

	Q1	Q2	Q3	Q4	Q5	Q6
Weak	25%	15%	15%	23%	11%	21%
Fair	9%	7%	83%	7%	29%	48%
Good	17%	23%	2%	20%	39%	31%
Excellent	50%	55%	0%	49%	21%	0%
Mean	2.9	3.2	1.9	2.9	2.7	2.1

Analysis of results in relation to criterion 7:

- Question 3 was the weakest element in criterion 7, with a mean score of 1.9. The majority (83%) of partnerships scored 'fair' and 15% scored 'weak'. The results demonstrated that harm reduction interventions were not provided broadly enough across the treatment system. Almost a quarter (22%) of local drug partnerships did not have a needle exchange service within their drug treatment services, with most being located in open access services. Just over a third (37%) of local drug partnerships did not have access to HIV testing with access to pre and post-test counselling integrated with their inpatient drug treatment services. Just over a third (36%) of partnerships did not have hepatitis C testing integrated into their open access services.
- Question 6 also showed generally weak performance. It measured service users' perceptions of how comprehensive harm reduction interventions were. No partnership scored 'excellent' for this question and almost half (48%) scored 'fair'.
- The strongest performance for this criterion was on the use of needs assessments to establish the need for harm reduction services. Just over half (55%) of local drug partnerships reported that they used needs assessment data to inform their commissioning of a range of six different harm reduction interventions.

- The criterion also demonstrated that in general, community prescribing services provided a good range of harm reduction interventions, particularly advice on safer injecting and preventing overdoses.
- Strategic planning for harm reduction was generally good, with half (50%) of the partnerships scoring 'excellent'. However, 25% of local drug partnerships did not have a harm reduction strategy in place, indicating a lack of a strategic or planned approach to reduce drug-related harm in these partnerships.

Comments from some better-performing local drug partnerships on what contributed to their good performance relating to embedding harm reduction in the whole treatment system:

"Harm reduction is a priority of all staff within all commissioned service providers, not just a specific team. It is also included in all staff job descriptions including DAAT clinical leads, commissioners and other officers. We have a harm reduction strategy and a subgroup of the joint commissioning group to specifically focus on harm reduction issues."
Kirklees

"The partnership in Nottinghamshire has demonstrated its commitment to a treatment system underpinned by harm reduction with the appointment of a harm reduction lead and a harm reduction champion. Harm reduction is a standing item on the agenda for all service reviews. Delivery across all the objectives within our harm reduction strategy is dependent upon work with our colleagues in primary care, public health and the Health Protection Agency."
Nottinghamshire

Access to harm reduction services

Criterion 8: Service users have prompt and flexible access to needle exchange services, vaccination, testing and treatment for blood-borne viruses.

This criterion assessed service users' access to a range of harm reduction services. Providing needle exchange services is vital to reducing the transmission of blood-borne viruses and access to these services is key to their effectiveness. Needle exchange services are also an effective delivery point for other harm reduction interventions, including advice, information, vaccination and testing.

This criterion consisted of six questions:

1. What proportion of injecting drug users access needle and syringe exchange services?
2. Do dedicated and pharmacy-based needle and syringe exchange services provide out-of-hours services to service users?
3. Is harm reduction fully covered in the needle exchange services?
4. What services do pharmacy-based needle and syringe exchange services offer to needle exchange clients?
5. How many service users have been tested and/or vaccinated against hepatitis B virus?
6. What is the partnership's response to hepatitis C & HIV?

Table 9: Results of criterion 8 by question

	Q1	Q2	Q3	Q4	Q5	Q6
Weak	24%	44%	9%	5%	26%	95%
Fair	14%	44%	4%	9%	70%	3%
Good	14%	12%	28%	30%	0%	1%
Excellent	48%	NA	58%	56%	4%	0%
Mean	2.9	1.7	3.4	3.4	1.8	1.1

Analysis of results in relation to criterion 8:

- There was a clear shortfall in the provision of out-of-hours needle exchange, with under half (44%) of local drug partnerships scoring 'weak'. Only 1.7% of partnerships opened most of their services after 7pm and only 21% opened most of their needle exchange services on Saturdays, with the percentage falling to 2% on Sundays. This clearly has access implications for service users who need injecting equipment during the evenings and at weekends.
- Question 5 related to policies and service penetration around testing and vaccination for hepatitis B. Almost all (95.3%) local drug partnerships offered less than three-quarters (75%) of their service users a hepatitis B vaccination and 29% did not have a protocol relating to hepatitis B. The majority (70%) scored 'fair' for this question and just over a quarter (26%) scored 'weak'.
- Question 6 related to testing and treatment for hepatitis C. This is a clear national priority due to the scale of infection among injecting drug users. The scores for this question showed a national shortfall in testing and treatment provision – no local drug partnerships scored 'excellent'.

  The question asked what proportion of injecting service users had been tested for hepatitis C. The national mean for the percentage of injecting drug users that had been tested for hepatitis C was 21.5%. The vast majority (95.3%) of partnerships reported that less than 50% of their service users had a recorded test date for hepatitis C. This question also asked about hepatitis C testing and treatment protocols: 65.1% of partnerships reported that they had these in place.
- In relation to questions 3 and 4, which tested the range of harm reduction services provided in pharmacy needle exchanges and specialist needle exchanges respectively, the results were very positive with 58% and 56% of local drug partnerships scoring 'excellent'. This indicates that generally, pharmacy and specialist needle exchanges provide a wide range of harm reduction information and advice.

Comments from some better-performing local drug partnerships on what contributed to their good performance relating to flexible access to harm reduction services:

"To promote uptake of our vaccination and screening programme, our service offers open access services with harm reduction nurses available to discuss blood-borne virus issues with clients at the point of request."
Tameside

"We have highly accessible needle exchange outlets offering an effective harm reduction service. We currently have 43 participating outlets, including 35 community pharmacies, and have developed an extensive database that not only enables accurate data collection, but also links the outlets to provide an effective working network."
Bradford

Reducing drug-related deaths

Criterion 9: Action is taken to reduce the number of drug-related deaths.

This criterion was chosen as it indicates the steps that local drug partnerships have put in place to reduce the number of drug-related deaths, which is a key principle of national strategy. Drug-related deaths in the UK are among the highest in Europe. In 2001 the Government set a national target to reduce the number from 1,538 by 20% deaths by 2004. Although the previous steep rise in drug-related deaths during the 1990s was halted, the target itself was not met.

This criterion consisted of four questions:

1. Does the partnership have a written multi-agency strategic plan for reducing drug-related deaths?
2. What proportion of paramedics in emergency ambulance crews in the area have been trained in the use of naloxone (a drug used to counter the effects of heroin overdose)?
3. What proportion of police custody officers have been trained to deal with overdose incidents?
4. How many service users and carers have been trained during 2005/2006 to deal with overdose incidents?

Table 10: Results of criterion 9 by question

	Q1	Q2	Q3	Q4
Weak	6%	22%	25%	10%
Fair	33%	3%	11%	23%
Good	37%	1%	3%	67%
Excellent	24%	74%	61%	N/A
Mean	2.8	3.3	3.0	2.6

Analysis of results in relation to criterion 9:

- This was the strongest-scoring criterion relating to harm reduction. The mean scores were above 2 for all questions indicating that, nationally, local drug partnerships have made significant progress in developing systems and protocols to reduce the number of drug-related deaths.
- Only 24% of local drug partnerships scored 'excellent' for question 1, which related to having a strategy for reducing the number of drug-related deaths. Only 68% of local drug partnerships had a multi-agency strategic plan for reducing the number of drug-related deaths and only 64% had a policy for making confidential enquiries into drug-related deaths.
- Three quarters (74%) of local drug partnerships scored 'excellent' in relation to paramedics being trained in the use of naloxone. This indicated that over 60% of paramedics in those partnerships had been trained and that ongoing training in the use of naloxone was available.
- 61% of partnerships scored 'excellent' in relation to police custody officers being trained to deal with overdose, indicating that in those partnerships over 60% of police officers had been trained.

- With regard to service users and carers being trained to deal with incidents of overdose, the majority (67%) scored 'good', the maximum available for this question, indicating that training was available and that they had an agreed training policy. Service users and carers are the people most likely to be first at the scene of an overdose, therefore training them to respond appropriately can reduce the number of drug-related deaths.

Comments from some better-performing local drug partnerships on what contributed to their good performance relating to reducing drug-related deaths:

"We have a clear drug-related deaths process that is linked to our harm reduction strategy group, which enables an early response. We review all local drug-related deaths every six months and have good links with the coroner."
Kirklees

"Bradford operates a robust system for directing the confidential review of drug-related deaths. The system ensures that all involved in direct or indirect exposure to death which may be attributed to the misuse of drugs are aware of the necessary action which must be taken and information collected is used to identify trends and patterns, causes and outcomes and to promote learning."
Bradford

Staff competence

Criterion 10: Staff are competent to deliver effective harm reduction services

This criterion was chosen because having competent staff to deliver harm reduction interventions underpins the effectiveness of harm reduction services. The ability to recognise risks and work with service users to change their behaviour is vital, and the entire initiative to reduce drug-related harm hinges on the competence of staff. National strategy has focused on the competence of staff, particularly in the context of the rapid expansion of drug treatment services.

This criterion consisted of five questions:

1. Are there protocols in place to ensure staff safety in relation to blood-borne viruses?
2. What training and experience in harm reduction do staff in non-pharmacy fixed based needle and syringe exchanges have?
3. What training and support is provided for pharmacy staff providing needle exchange services?
4. Do service users feel respected by pharmacy staff?
5. What is the level of training or experience in harm reduction amongst staff working in specialist community prescribing services?

Table 11: Results of criterion 10 by question					
	Q1	Q2	Q3	Q4	Q5
Weak	6%	13%	17%	30%	17%
Fair	37%	16%	3%	28%	26%
Good	5%	59%	26%	40%	43%
Excellent	52%	12%	55%	1%	14%
Mean	3.0	2.7	3.2	2.1	2.5

Analysis of results in relation criterion 10

- The weakest areas of performance in this criterion related to whether service users felt respected by pharmacy staff. Thirty per cent of local drug partnerships scored 'weak' for this question. This was largely because partnerships have made insufficient progress in providing training for pharmacy support staff (as opposed to pharmacists), who have the most contact with service users. There had been more progress, however, in relation to providing training to pharmacists themselves.
- Another area of weak performance related to the level of training and experience of staff working in specialist community prescribing services on harm reduction interventions, with 17% scoring 'weak' and 26% scoring 'fair'. The main shortfalls related to: whether staff were trained in providing treatments and dressings related to the care of wounds and lesions; the supply and exchange of injecting equipment; and supporting individuals to monitor their own healthcare.
- However, just over half (52%) of local drug partnerships scored 'excellent' in relation to protocols to ensure staff safety in relation to blood-borne viruses, when delivering needle exchange services, for example.

Comments from some better-performing local drug partnerships on what contributed to their good performance relating to staff competence to deliver harm reduction services:

"Staff are all well qualified and trained to deliver harm reduction services. The partnership has provided training on a range of issues such as stimulant use, blood-borne viruses, dual diagnosis, supervised consumption and risk assessment. The trainers go to GP surgeries, hospitals, custody suites, probation, communities and schools to provide on-site training."
Harrow

"Training programmes commissioned by the partnership include harm reduction for all services in contact with drug using clients, hepatitis training from our specialist hepatitis/ drug dependency service and specialist training on injecting related harm for all drug workers."
Nottinghamshire

Conclusions and key messages

Local commissioning systems

The service review provides a helpful picture of both the strengths and weaknesses of commissioning and systems management. Overall, the review indicates that the performance management of local systems and formal strategic partnerships is functioning well. Areas for improvement include the development of local needs assessment and aspects of delivering drug treatment systems and local commissioning functions.

The key messages from this review relating to commissioning are:

- There is evidence that local commissioning partnerships and the NTA have developed strong performance management structures for drug treatment.
- There is a good reported standard of financial management across the sector.
- Strategic leadership of local drug strategic partnerships should be strengthened. Increasing the level of seniority and attendance of members needs to be considered. The joint commissioning function would also benefit from all stakeholders participating more in implementing commissioning decisions.
- The effective commissioning of a drug treatment system is dependent on having a clear profile of the diversity of local needs. The review demonstrated a need to improve both the quality of local needs assessment and the use of information in developing local plans for commissioning drug treatment systems. Significant work is now underway to improve local needs assessments in order to inform the annual treatment planning process, and performance in this area is improving.
- Although partnerships are retaining clients in treatment, the review points to both care planning and planned discharge as areas that need continuing improvement. Reducing unplanned discharges and a continued focus on care planning are key areas of work for the NTA and the sector. Improvement in this area is also likely to improve the levels of satisfaction of service users reported in the review.
- The review also highlights the need to improve the commissioning of residential and inpatient services. The Department of Health and the NTA have a national programme of work to build on the capacity and commissioning of inpatient and residential services. This includes a programme of capital development, improved commissioning, including better-developed regional commissioning, and additional guidance.
- There needs to be a continuing focus on strategic workforce development within partnerships, which focuses on improving the local provider workforce and the continued development of the joint commissioning function. This will be supported by centrally-commissioned training for joint commissioners and other strategic partners.

Harm reduction services

The service review provides a helpful picture of both the strengths and weaknesses of harm reduction responses nationally. It indicates that progress is being made on these vital issues, but that there are still a number of areas for improvement. The results showed that harm reduction interventions were not provided broadly enough across the treatment system.

The key messages from the review relating to harm reduction services are:

- Vaccination for hepatitis B and testing and treatment for hepatitis C are not provided widely enough by local drug treatment systems. This is a clear national priority because of the scale of hepatitis C infection in England through injecting drug misuse, and also as hepatitis B is a disease which is preventable through vaccination programmes.
- Many service users do not perceive their harm reduction services to be comprehensive enough. A significant number also feel that pharmacy staff do not respect them.
- There is a clear national shortfall in the provision of out-of-hours needle exchange.
- Community prescribing services are, in general, providing a good range of harm reduction interventions.
- While strategic planning for harm reduction services is generally good, the scale of both preventable and treatable blood-borne virus infections and the high rates of deaths by overdose, mean that additional action is needed by local drug partnerships. The review's results on commissioning indicate that this may need to include improved profiling and assessment of local needs, particularly of groups more at risk of contracting blood-borne viruses and dying through overdose.

The results of this review provide essential benchmarking and a platform for improvement around the provision of harm reduction services as detailed in the Government's Reducing Drug Related Harm Action Plan 2007.

Next steps

The findings of this review, combined with the findings of the 2005/2006 review on care planning and community prescribing services, represent a significant assessment of performance and identify a clear agenda against which to plan improvement.

Local drug partnerships have already used their individual results to develop action plans to improve performance. These will be monitored by the NTA's regional teams and strategic health authorities. The Healthcare Commission and the NTA supported approximately 17% of the weakest-performing partnerships to develop effective action plans. The NTA's regional teams and regional stakeholders will also monitor overall improvement in performance on an ongoing basis through quarterly reviews with all local drug partnerships.

In relation to commissioning and systems management, the key messages of the review indicate that local drug partnerships should focus on: strengthening their strategic leadership, developing a clear understanding of need, and improving the movement of service users through the drug treatment system to planned discharge, supported by effective care planning.

Other priorities for development are improving practice in commissioning residential and inpatient drug treatment services and underpinning all work with a strategic and robust approach to workforce development.

In relation to harm reduction, local drug partnerships must ensure that there are effective integrated pathways of care into services for the vaccination, testing and treatment of blood-borne viruses – particularly for hepatitis C. Strategic planning regarding harm reduction, based on effective assessment of local need and reducing the number of drug-related deaths, are also areas for some local drug partnerships to develop.

Providing harm reduction interventions across the treatment system is an ongoing priority for all local drug partnerships and the review showed that many partnerships do not provide harm reduction services in all their drug treatment settings.

This review was the second of three joint reviews into substance misuse by the Healthcare Commission and the NTA. The final review will be undertaken in 2007/2008 and will look at diversity and residential services (inpatient and rehabilitation services). An assessment of the services provided to diverse groups will be vital to this sector, as substance misuse issues affect a broad range of communities and people with diverse needs. Developing and quality-assuring residential services is also a key developmental priority for the sector. The Commission for Social Care Inspection has supported and endorsed this review, as it will assess the provision of residential services and social care.

Appendix: the methodology and development process of the review

Assessment frameworks

The framework through which performance is measured is called an assessment framework. These frameworks are developed by working with those using and providing services, and other experts, to ascertain the key features that are important in delivering quality services to their service users. An assessment framework does not measure everything that must be in place to deliver a quality service. Rather, it focuses on key features that have a significant impact on the outcomes for service users. Assessment frameworks must relate back to the Department of Health's *Standards for Better Health* (Department of Health, 2004).

By working with the substance misuse sector (especially service users, commissioners and service providers), we generated key criteria and questions that captured the important distinguishing features for assessing the performance of services and treatment systems. This covers both the perspective of service users and outcomes of services. We needed to determine what information was required to answer these questions. When it did not exist in national datasets, it was collected from each local drug partnership. We made assessments of quality based on information collected from a variety of sources. We used this framework to make an initial assessment of the performance of each local drug partnership and participating healthcare organisation. We collected data to inform the assessment framework, and constructed scores for each criterion by applying pre-determined rules.

Background work

The NTA mapped the existing key standards used in the substance misuse sector against the Department of Health's standards. The mapping included a range of key standards, including *Models of Care for substance misuse treatment: promoting quality, efficiency and effectiveness in drug misuse treatment services*, national occupational standards, commissioning guidelines, a sector-specific set of standards developed by the Substance Misuse Advisory Service (SMAS) on commissioning, and organisational standards for providers from Drugscope and Alcohol Concern (QuADS). This mapping provided a platform to support the development of criteria and questions.

Engagement with the sector

The NTA established an expert group to support the development of the 2006/2007 review of substance misuse. The network included membership from all relevant professional and membership bodies, other regulatory bodies, NHS providers, voluntary sector providers, service users and carers, and commissioners. Members of the network were selected by an application process according to geographical spread, role, membership of the local networks (for dissemination and feedback) and relevant previous experience.

Drafting the assessment framework

Once we prepared an initial draft of the assessment framework, we carried out a process of peer review. This involved dissemination of the document to several groups of people and holding a series of meetings to consult on the document in detail. These groups included:

- the expert group
- staff from the NTA
- staff from the Healthcare Commission, including other pilot managers and the criteria development team
- drug treatment providers and commissioners.

Piloting the assessment framework

The initial drafts of the assessment framework, questionnaires and scoring construction were created from developmental work carried out with the expert group and development sites (a number of partnerships). The draft assessment framework was then piloted at four sites from January to early March 2006. The piloting work involved the sites that completed bespoke questionnaires, collecting of quantitative data and in-depth interviews by staff to gather qualitative information.

From April to June 2006, the findings from the pilot were reviewed and used to inform a redrafting of the assessment framework and questionnaires. Some of the changes included clearer wording and adjustments to the questions or scoring, in particular relating to data for the commissioning systems. We also produced a glossary of key words and phrases as a result of feedback from the pilot.

Final draft documents were further refined by the NTA, the Healthcare Commission, and the Department of Health. The final draft was then checked to make sure that it made sense by a specially constituted expert group in July 2006. The framework was finally subject to a modelling process in the Healthcare Commission to check data flow and scoring.

The final assessment framework and allied documents were signed off by the Healthcare Commission and the NTA, the Review of Central Returns (ROCR), the Department of Health and the Secretary of State for Health.

Data collection and analysis

Bespoke data was collected in October and November 2006. Other data was also used from the National Drug Treatment Monitoring System (NDTMS), the 2006 NTA annual survey of service users and the annual partnership treatment plans for 2006/2007.

Data input, analysis and quality assurance took place until June 2007. Anonymised data was published in a GEOWISE database in July 2007. Each local partnership had two weeks to submit queries and request their scores to be ratified if they had questions about their results. All requests for ratifications were answered by the first week in September and all partnerships were notified of their updated scores by the end of September. Final attributed scores were published in December 2007.

Assessment framework overview and scoring

The assessment framework consisted of 10 criteria (or key headings) across the two themes; 45 questions were clustered around these criteria. Each question was scored on a scale of 1 to 4 and question scores were aggregated via a standard set of rules into criteria scores and then again into overall scores using the same scale of 1 to 4.

In the review of substance misuse services, an overall score of 'weak' (1), 'fair' (2), 'good' (3) or 'excellent' (4) was applied to each local drug partnership. Ranges of scores were set for each scoring band. In this review a maximum score of 40 was possible. The overall performance ranges were:

Excellent:	31 to 40
Good:	25 to 30
Fair:	15 to 24
Weak:	10 to 14

A primary care trust, as a commissioning body, has significant influence over the performance of the local drug partnership and was, therefore, awarded the same score as the local drug partnership or partnerships. There were 11 PCTs with multiple partnerships. Their score was based on the average aggregated score for these partnerships.

The sum of scores for criteria was used to establish the overall score for each local drug partnership and the relative position or ranking of each partnership.

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