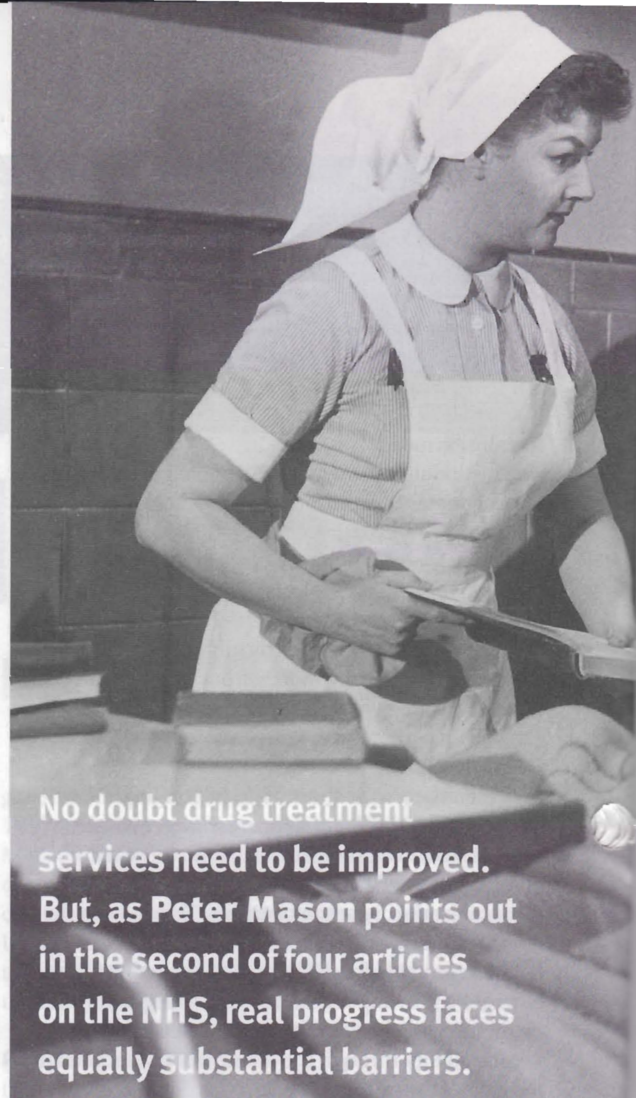
Carry on regardless

the battle to modernise NHS drug treatment services



No doubt drug treatment services need to be improved. But, as Peter Mason points out in the second of four articles on the NHS, real progress faces equally substantial barriers.

THE NHS plan is about delivering a modern service fit for the 21st century. The plan is to redesign treatment and care around the patient and promoting flexible working practices. In reality this means increasing 'productivity' – doing things faster to increase capacity. There is a real danger this might just force people to do more of the same, more quickly – rather than to innovate and do things differently.

WHY IS MODERNISATION SO HARD?

The term modernisation focuses on change. By definition, change challenges orthodoxy, conventional wisdom and the way it has always been done. Changing the culture and structure will take time. The sheer size of the NHS, the third largest employer in the world, after the Chinese Army and the Indian Railway, is a major barrier to the pace of change.

A number of barriers to change have been identified in poor performing NHS Trust hospitals. These are largely due to a provider focus with resistance to consumerism; a lack of clinician involvement; dysfunctional relationships between managers and clinicians; inadequate long-term finance; poor planning and implementation and slow and confusing care pathways. In addition, trusts preoccupied with mergers have also shown slow adaptation to change.

SPECIAL PROBLEMS

Many of these barriers can be found in some NHS drug treatment services, but they also have a number of distinct problems that need to be addressed.

Drug misuse is a political issue and the lack of clarity about what constitutes success for drug treatment services can create tensions. Treatments can be based more on personal preference than the evidence base and can come with a 'take it or leave it' attitude.

The location of drug treatment services within the mental health system often brings confusion and a lack of clear line-management. In many mental health trusts there is little interest from psychiatrists to be addiction specialists. As a consequence, vacancies exist. The financing of substance misuse services is often a mystery within the trust, which can lead to resentment between the drug treatment services and trust management.

The professional subcultures within drug treatment services can often create a clash of values between managers, doctors, nurses, social workers and other professionals.

The location and quality of NHS drug treatment buildings is often poor. Many are tucked away from sight, difficult to get to and constantly under pressure from local communities who are not keen to have drug users near them. Once inside, the working environments can be very unsatisfactory and with little space to see clients. Information systems and computer technology are not a high priority and decisions are often not supported by data.

Treatment technologies and processes have not changed for many years with slow systems, ways of working and often inflexible rules. It is also not clear who in the NHS is inspiring new ways of treating addictions.

User and carer involvement in decision making is not a high priority and there is much to be done to engage local communities to involve users, carers and the public in the design, delivery and development of local drug treatment services.

Many of these issues are now being addressed through a raft of NTA initiatives that include user involvement projects, waiting time initiatives, leadership training, and models of care implementation to improve treatment, capacity, care co-ordination and quality. But much more will need to be done.

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future, with an increase too in equipment and technology. Above all there will be a requirement for new ways of working and fundamental job design and work organisation among professionals.

It is clear that a new deal will need to be developed between drug users and carers. The NHS plan stresses the need for increased patient and public involvement in health services and from people in their own care. It seeks to enable client choice by giving information on alternative providers and to allow them to switch to services or hospitals with shorter waits. Clients should also be able to book appointments at both a place and time that is convenient to them. New democratic processes and involvement systems will need to be introduced to promote social inclusion and self-help. As with other health care groups. User self-management of their problems will be a key area for development.

All four tracks for change have a role to play to bring about change. In fact, without them all working together fundamental change is unlikely. This is a big challenge for NHS drug treatment services, nestled within the mental health system and one that will require a fundamental review.

UNHITCH THE HORSE

One approach might be to establish new structures for NHS drug treatment services to unhitch them from the mental health system. Some might even be bold enough to consider strategic alliances or partnerships with voluntary sector organisations or some other not-for-profit making models. The future could be drug treatment direct walk-in clinics and habit management services that are smaller, flatter and more entrepreneurial.

In the absence of such radical reform, trusts should ensure that NHS drug treatment services have independent advisory boards to inject new accountability, self-management and a consumer focus.

Modernisation does not come about through rhetoric or pleading with people to make it happen. It comes from people in organisations who want to make a difference and from organisations that remove barriers to change.

THE ROAD TO WELLVILLE

The DAT will need to provide strong leadership at a strategic and political level. They must be interventionist at critical points and come in very firmly to shake up the status quo. Many community barriers to change need to be unlocked by DAT leaders if services are going to expand and be sited in new areas.

The new commissioning agenda will require the development of an investment relationship with drug treatment services. This will ensure that all new money is linked to outcomes. Where outcomes are poor, investment must be made to buy change to deliver new ways of working. Commissioners will be required to purchase care from the most appropriate provider be they public, private or voluntary. There will also be more emphasis on project-based alliances and strategic partnerships with the voluntary and private sector. New incentive systems that reward innovation and learning and encourage self-help and user-managed systems should be encouraged.

The new provider agenda will require a marketing and business strategy that is outcome based and modelled on the more responsive illegal drug market. It will need to be rapidly accessible, flexible enough to develop new delivery mechanisms, capable of engaging and keeping clients based on modern interventions that can deal with complex needs.

In line with the NHS plan, services will need to enable user-choice, provide information on alternative providers and allow clients to switch to hospitals with shorter waits. A greater share of funding will need to be spent training new health professionals for the future...

FUTURE PERFECT?

A drug user walks into an NHS treatment service. They are met and screened by a worker and triaged onwards for a more detailed triage assessment from an addiction therapist. This is supported by state of the art and non-intrusive drug toxicology screening. Drug test results are verified in minutes. The patient treatment and care plan is then developed discussed and started immediately. The first dose of a modern substitute-prescribing drug, with low risk potential, is provided by a nurse who has prescribing powers. From walk-in to treatment in four hours and what's more this happened on a Saturday evening about 7.30 pm.

Modernisation is about re-thinking the service from the patient/client/user perspective. Providing services at the times when drug users require treatment will be a major part of the modernisation agenda. The current preoccupation with faster delivery might just give us more of the same. Instead of flogging the dead horse of throughput, perhaps we need a new horse. ■

> "These treatments can be based more on personal preference than the evidence base"