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## Editor's letter



### Future of drug services

COMMISSIONERS are change agents, and need brain food and support to help them with multiple agendas.

Drug Action Teams (DATs) and Primary Care Trusts are now at the centre of commissioning drug treatment services for their local populations. Both are under increasing pressure to ensure that treatment systems are commissioned effectively and that capacity and outcomes increase. Depending on the circumstances, joint commissioners have the unenviable role of ensuring not only that the local investment priorities are met, but also that NTA performance targets are hit, and the service system meets the needs of the local population.

*Commissioning News* is designed to support commissioners to bring about better, fairer and quicker treatment for those they care for. It will bring you news and articles and DAT round-ups to help share best practice, and we also hope to help raise the level of the debate about the commissioning of drug treatment services.

Drug misuse is a multi-factorial problem and crosses a range of policy areas. We hope to show commissioners what's there to be learned from other sectors, and which innovations are transferable. We're also taking a look at how other sectors cope with the sheer pace of change, and the renewed focus on customer-choice and payment by results.

Commissioners have to keep informed about many issues that impact on the commissioning of services. We want *Commissioning News* to provide them with the up-to-date information they need, to enable them to share good practice, and to cast light on the many issues that are driving developments.

P. G. Mason

Peter Mason, Editor

# What are you like?



## Commissioning News asks you to respond to the first-ever survey of commissioners' working lives

**H**AVE you ever thought who else is out there when you are trying to balance the budget or introduce a new service change? Wouldn't you like to know what your colleagues are thinking about and their plans for the future ...?

Like Darwin setting off on a voyage of discovery to classify life forms and new species, we at *Commissioning News* are starting an ambitious project to discover more about you, our customers, the many different specialist commissioners of drug, alcohol and crime reduction services.

We are keen to understand who you are, what makes you tick and what you see as the challenges and opportunities for the future of drug treatment and allied services. But – most importantly – what you think you need to help you to do your job.

We know that there are many types of specialist commissioners in health, DATs, criminal justice and local authority settings at a central, regional and local level. We also know that your portfolio responsibilities might be small or large. For instance you might be covering adults, young people, drugs, alcohol, prisons health, mental health, homelessness, criminal justice services, etc. Whatever, you are

responsible for making investments, and for working in partnership with service providers to get results.

### Tell us

*Commissioning News* is asking you to take part in the first ever national survey of substance misuse and specialist commissioners and their working lives.

Our full survey will be reported in our next issue, and will inform our news digest over the coming months. Please take some time to be part of this new initiative and help us to support your developments. We would also welcome contributions from you to make this your very own journal.

For a flavour of what we are looking for – some of the questions we ask are shown in the box below. You will find the questionnaire at [www.publicinnovation.org.uk/?page=survey](http://www.publicinnovation.org.uk/?page=survey) – it shouldn't take more than 15 or 20 minutes to complete.

Please complete the questionnaire in the early weeks of September if you can – so your views are represented in the next issue of this magazine. All information submitted will be in confidence, and will only be reported in aggregate form.

### Key questions

- Rate the progress of the NTA in supporting commissioners on local systems / on regional systems / on national systems.
- Which issues will be priority to you and your colleagues in the next 2–3 years?
- In your opinion what are the top 3 core priorities for funding over the next 2–3 years?
- What are the top 3 key policy developments that will impact on your commissioning ability in the next 2–3 years?
- What are the main problems you face?
- What support services do you need?
- How satisfied are you with the level of service from your current providers?



# Treatment effectiveness strategy

By Sipho Mlambo

**T**HE launch of the National Treatment Agency's new drug treatment effectiveness strategy took place in London on 30 June 2005. In the course of the launch, there were calls for improved commissioning to manage the multi-million pound drug treatment budget. However, some commissioners present felt that the implied criticism of their work was unfair.

They pointed out that there were still major blockages in treatment systems – mainly due to provider deficiencies, and to problems encountered as they struggle to change the behaviour of NHS providers – whose working procedures they often find slow, unnecessarily complicated and inflexible. There was also concern about the broad range of functions that commissioners were required to carry out to meet the changing NHS and social care landscape.

The NTA briefing stated that the quality of drug treatment was still 'very variable' in England. But it did highlight a

**Change is called for in the drug treatment system – but are commissioners receiving the support they need to deliver it?**

number of key factors found to be vital for success in improving drug treatment. These were mainly connected to the clients' experience through treatment and to improvements in local drug treatment systems. The strategy called for increased energy from commissioners and providers, and for closer working partnerships to bring about improvements.

Some commissioners identified a need for more legitimacy in the system to allow them to actively commission and manage performance at the local level. This included a need for improved understanding about what was involved in commissioning, and how joint and

specialist commissioners and DATs and DIPs could co-operate to get things done.

## Service expansion

The launch of the strategy comes at a time when commissioners, at all levels, are making plans to expand drug treatment services, and to integrate intervention programmes. It is also the time of the introduction of new market mechanisms in the NHS, and of user-led social care budgeting developments. One leading commissioner at the conference said:

'Although I welcome the new strategy, without high quality commissioning guidelines to plan, purchase, contract, assure quality and monitor services, it may have little impact'.

More than ever, new tools, techniques and commissioning models are needed to help bring about transformation of the drug treatment system. Commissioners are looking for, and deserve, improved support to deliver the changes that will lead to better client outcomes – changes such as higher rates of staff retention, better training for drug professionals, and a greater focus on organisational development and infrastructure. ●

*Sipho Mlambo is senior consultant at the Centre for Public Innovation.*

**'... without high quality commissioning to plan, purchase ... and monitor services [the project] may have little impact.'**

### Budgets direct to users

People with chronic conditions could get NHS cash to pay for their own treatment, giving them the ultimate say in where money is spent. Professor Julian Le Grand, health policy advisor to the prime minister, has revealed that this is being considered. It will result in people choosing their own provider and making their own arrangements for their care. He said that patients could buy their own care directly, or GPs could buy blocks on their behalf. This comes as health secretary Patricia Hewitt begins consultation on the white paper on choice in primary care.

### And what after 2008?

Funding decisions need to be properly informed, and the government has about 12 months to find out what commissioners will need after 2008. The top issue for services in the future is whether government is going to continue to invest post-2008 as it has so far.

The £50bn injection of funding into the NHS over recent years has created a need to deliver faster, better and to a higher quality. The debate will continue.

### Unrealistic targets – make savings?

Many councils around the country are missing finance savings targets handed down by central government. The Institute of Public Finance has reported that the £180m savings this year will need to rise to £250m in each of the next two years for the Department of Health target to be met.

The Department of Health's target is set at £684m. Care service efficiency teams have been sent in to 31 councils to identify savings, but it is thought that there is little if any slack in the system.



■ Voluntary organisations make a real difference to people's lives – how should commissioners encourage them to apply for government funding?

## Creative commissioning

By Richard Gutch

### Futurebuilders – a great opportunity for commissioners

Voluntary and community organisations (VCOs) have the potential to meet many of the most intractable needs faced by commissioners in the drug and crime field. Their links to the local community, their ability to involve users, their flexibility, their specialist knowledge and their involvement of volunteers are all ways in which they can bring added value to public services.

Okay, but can they deliver? Can they deliver on the scale commissioners require? Can they provide the right kind of monitoring data, in terms of outputs and outcomes? Are they sufficiently business-like in their approach? Indeed, are they efficient? Do they really have the capacity to deliver effectively?

The more local and the more community-based the organisation under consideration, the more questions of this kind commissioners like you and me are likely to ask – and yet it is precisely these kind of organisations that perhaps have the greatest potential to add value to public service delivery, and to make a real difference to people's lives.

### Realising potential

Futurebuilders is a project that has been designed to address exactly these issues, and to help voluntary and community organisations realise their potential to deliver public services. It is a Home Office backed £125 million Investment Fund, which aims to improve public service delivery through long-term investment in the voluntary and community sector in England.

Futurebuilders England Ltd (FBE) is a not-for-profit company set up by Charity Bank, the National Council for Voluntary Organisations, Northern Rock Foundation and Unity Trust Bank – following their successful tender to run the Futurebuilders Fund on behalf of the Home Office.

We are operating in five public service delivery areas set for us by the Government – these consist of:

- community cohesion
- crime
- education and learning
- health and social care
- support for children and young people.

Our aim is to make 250 investments by the end of 2006, with at least 10% of our investments in each of our five public services areas. Our investment decisions are completely independent of the Government.

### Approach to investments

Futurebuilders provides an investment package to help voluntary and community organisations get fit for the purpose of contracting with public agencies. The investments could be for the recruitment

and training of staff, the development of a building or purchase of equipment, and/or the introduction of new systems. It could include consultancy support for advice on business planning, governance, marketing or contract pricing and negotiation.

### Do they really have the capacity to deliver effectively?

The major part of each main investment is in the form of a loan for working capital or asset development. The terms of the loan are related to the likely terms of the contract or fee income to support the service. A loan repayment holiday usually forms part of the package, to reflect the fact that contract income may not start flowing for one or two years. When pricing their services in contract negotiations, VCOs need to include the cost of capital, as well as relevant overheads and direct costs, to enable them to repay our loan over time.

Applicants are asked to say who they expect to purchase their service. Futurebuilders consults with prospective purchasers as part

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#### Nowhere to move to

The homeless charity, Homeless Link, have found that nearly half of all beds in homeless hostels in England and Wales are being used by people waiting to move on to other accommodation. With average waits of between six to twelve months, the system is being silted up. Some people have even been waiting for up to two years.

#### Stability at the top

The appointment of the new health secretary, Patricia Hewitt, could show stability for the NHS. NHS leaders see her as a consensus builder, and she is described as the 'listening' health secretary. She plans to 'get around all parts of the NHS, finding out for myself what patients feel about the care they are receiving, and shadowing staff as they carry out their duties. I will listen to everyone.'

#### Pockets full – no plans to spend

With new investment being made available in 2006, local Drug Action Teams should be beavering away planning for new treatments for adult drug users. With the end of the government's ten-year drug strategy looming in 2008, money is being poured into the system to achieve targets for people accessing treatment and reducing waiting times. However, many areas will struggle to make the extra places available, if urgent plans and discussions with treatment providers do not take place soon.

On your radar...

# Payment by results

By George Pasmore

■ It is not clear what the impact of PbR will have on the acute care sector, but this should not stop us getting to first base – which is unit costing of drug treatment

COMMISSIONERS will have recently seen the 'Dear colleague' letter from the NTA, introducing a forthcoming NTA and Audit Commission joint initiative to establish unit costs for treatment. This should be welcomed, as we move into the real world of knowing what we are paying for and what things cost to supply. We should be wary of acute care models being easily applied to the substance misuse world, but commissioners should get behind the quest for unit costs, and work with their providers to shine some light in this murky area.

Currently drug services are funded using a block contract or a cost and volume arrangement whereby a service puts forward a budget to deliver a given service, often broken down by modality, and then gets on with delivering it. Once the number of units of service have been delivered, or the service is full, then waiting times start to develop.

NHS mental health trusts see themselves as being paid a budget, taking on the financial risk to deliver services and take clinical responsibility and paying out any sub-contractors, such as rehabilitation providers. Other reimbursement models operate to pay for services in primary care.

## Model of funding

The model of funding we use is an activity-output based system, which rewards providers who get people into services and keep them in, but this is not very robust when it comes to measuring outcomes and longer-term impacts. The nearest we get is some form of proxy for length in treatment, and judgements are made about success and completion.

Payment by results is a form of funding which relates activity to tariffs for groups of similar treatments, technically known as healthcare resource groups. This would work towards trying to set a tariff or rate for all methadone detoxification's or all structured counselling interventions. One danger is that we set up system with perverse incentives to admit or provide high cost treatments when they are not required. We might work against pooled treatment budgets and integrated systems.

Some commissioners think that PbR is probably a step too far for all substance misuse treatment, as the long-term service model differs from that of acute care. But some elements might be more suited, particularly for those treatments that are more intervention than case management, such as in-patient detoxification. A mix of PbR and programme based budgeting could co-exist in the system.

What all commissioners agree is that they need better cost information and the unit cost exercise will go along way to start the process of getting some form of clarity across the piece. Commissioners need to have more robust information on what things cost, how these costs are calculated and what we are buying.



## Lever for change

But one lever for change is the possibility of mental health foundations status becoming a reality for a number of large Trusts. The DoH insists that mental health trusts will come under the PbR system by 2008-9.

This will put pressure on the MH trusts to develop robust unit cost setting frameworks. The problem with some trust funding is that the trusts take the pooled treatment funding in as part of their mental health funding. Ring fencing has done a lot to prevent dedicated funds from evaporating but the whole system of mental health budgets needs to be examined to 'unbundle' treatment costs for drug treatment.

Although the NHS information authority's case mix service is developing a set of HRG's for in-patient and community-based mental health services for adults and older people, substance misuse is not a priority for the time being.

But to help things along the NTA has developed a model framework to calculate unit costs which satisfies best practice requirements for the NHS and other services, and this work should be strongly supported by the field.

## The NTA has developed a model framework to calculate unit costs which satisfies best practice requirements

One commentator said: 'To achieve this by 2008, we will need to approach this in a learning framework that allows us to really get beyond the activity-based funding trap we now find ourselves in'.

The NTA might wish to look at more imaginative funding solutions, which might include the possibilities of moving to programme-based outcome funding, and also experimenting with individualised budgets for drug users to enable users to buy their own care. The problem with PbR as it stands is that it is not anything to do with outcomes.

It is not clear what the impact of PbR will have on the acute care sector, and already the plans to fully implement it have been stalled. So we need to be wary of PbR, but this should not stop us getting to first base – which is unit costing of drug treatment. ●

# What's in your in-tray?

By Ann Maguire



David Eccles

**M**Y new Drug Action Team chair recently asked me to describe a day in the life of a Drug Action Team co-ordinator, then came the request from *Commissioning News* about what's in my in-tray in a normal working week. The coincidence of the two similar requests was quite useful in making me focus on my daily work-load – and I'm hoping that a look at my in-tray will enlighten other commissioners, let alone myself, about why it is that our working day always seems so short.

## 75 emails a day

On a daily basis I can expect about 75 emails from a range of different sources – including regional and national government offices such as NTA, DfES, ODPM, DoH, SHA, PCT, NTDS (in this context I'm confident the acronyms will be as familiar to you as the names of your own nearest and dearest) – plus a whole raft of work around DIP/DIR. Other emails come from treatment providers, conference organisers, advertisers, people conducting surveys and other Drug Action Team co-ordinators trying to find solutions to issues posed by the many emails.

There is a problem from the start in dealing with this stream of information, often compounded by the number of large attachments accompanying much of it – it can take most of the day to print this off on my small and overworked printer. Almost on a daily basis the planned work schedule goes out of the window, while an immediate response is made to the urgent emails.

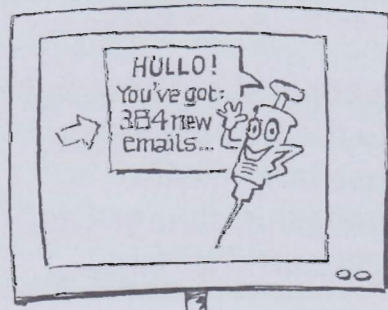
After this, if there's the chance to fit in 'proper' work between meetings, I'm likely to find requests in my in-tray for any number of written plans on a variety of subjects. These will cover anything from treatment-based planning issues, to the broader crime and drugs agenda, with a seamless shift to alcohol and its links to violent crime and anti-social behaviour.

As I work in an integrated partnership there is a clear expectation that joint work will take place to address these issues, but even trying to get the ever increasing number of partners together to discuss local issues is a difficult task in itself, with diaries being full for weeks in advance. The in-tray has many reminders in it relating to the setting up of such discussions.

## Priorities

Without doubt the work is diverse and interesting but the modest capacity of a small Drug Action Team, with low levels of funding, makes prioritising difficult. One of the main areas of work being undertaken locally is around improving healthcare for substance users in prison, and ensuring that there is seamless treatment for them, between the community and prison services.

This results in additional work to try and ensure equality of access for all clients – we want to limit the feeling in the community that the best way to ensure rapid access to treatment is to commit crime. Alongside the health issues we also remember the additional services required – including supported housing, education and employment – and try to ensure that the harm minimisation services that we all take for granted in the community are also available to those in prison.



Another exciting initiative is the move to introduce local prescribing by pharmacists and nurses – and around this, work is taking place to include dedicated training, adequate funding, links with new pharmacy and GP contracts and joint working with specialist teams and GPs. This work needs a great deal of dedicated time to ensure that it delivers the required outcomes, and involves sheaves of papers waiting in my in-tray.

When there are a few minutes spare, it may be possible to concentrate on the requests for information about the 'Every Child Matters' agenda, and the move to integrated children's services and children's trusts. Topics I'm asked to report on might

## This results in a seeming lack of a joined-up approach at national level

be whether the common assessment framework fits with the assessment process of the young people's specialist service, or whether all practitioners working with young people are confident to identify substance misuse issues at the earliest opportunity.

There is a huge amount of productive work going on across agencies, but we are all bound by different priorities. This results in a seeming lack of a joined-up approach at national level, and can lead to tensions between partners who are trying hard to put coordinated services in place – tensions that are sometimes reflected by another flurry of emails needing my attention.

Hopefully, however, my in-tray reflects the fact that there is some good work taking place, and that there's a real willingness from partners to provide the best service, and get the best outcomes, for the people we are all responsible for. ●

Ann Maguire is DAT coordinator, Poole

■ There's been a seismic shift in the prison drug treatment sector commissioning process – and this has led to interesting times for commissioners

# All change for prison drug services

By Peter Mason

**T**HE Prison service has dropped its multi-million pound contracts with both Cranstoun and Compass drug services. Each of these voluntary sector organisations has lost all its prison Counselling Advice Referral and Through Care (CARAT) contracts worth over £10m. The news was broken to bidders, after a protracted bidding process, when all prison service contracts came up for renewal, before the start of the new financial year.

Cranstoun Chief Executive Steve Rossell said, 'We are disappointed to lose the contract, having worked effectively within prisons for over 20 years, but Cranstoun remains committed to delivering quality services to drug users, and we will continue to do so through our community and residential services'.

The change in the purchasing portfolio did, however, bring in a number of new organisations, including several from NHS statutory sector providers. The Rehabilitation of Prisoners Trust (RAPT), also gained substantially, by winning a number of new contracts in prisons.

This seismic shift in the prison purchasing portfolio comes amidst prison service calls for more risk sharing from providers, to meet the costs of full staff cover for holidays and sickness, and to increase overall capacity. Other factors that influenced the new round of contracts included the costs of services and a desire to have more reliance on local providers rather than national organisations.

## Cost of the loss

The cost of the loss will be felt most acutely by the two drug treatment services who are now dealing with the impact on their management structures and in the transfer of undertakings for public employees (TUPE). Under European law, this requires incumbent staff, in the wake of public sector contract changes, to be transferred over to the relevant new organisations.

However, Ian Robinson, of the EATA has said that people should not fall into the trap of seeing these large-scale purchasing

changes as cost neutral. He stresses that they are resource intensive, disruptive for prisoners, and that there is a cost in getting new providers up to speed.

The potential for change in the community drug treatment market at such a scale is something that many commissioners are grappling with, as they broker integration between the drug intervention programme and their community-based service systems. Many commissioners are now reviewing their service systems to



prepare for new investment. As Lola Triumph, the Strategic Head of Commissioning in Kent, says: 'There is a need to ensure that we have the infrastructure right, with the big money coming into the service system in 2006/07'.

In the past year several DATs have been out to large-scale tender for services to displace incumbent providers, or to buy in additional services to meet capacity requirements. This trend looks likely to continue in a market that seeks increased capacity, and where there are often limits on local workforce numbers. Key areas under

**... people should not fall into the trap of seeing these large-scale purchasing changes as cost neutral ...**

increasing pressure are prescribing services and expert case management.

It is also recognised that many DATs and commissioners struggle to know what to do when they have services that are not improving, or who are quite frankly not up to the mark. And it is easy enough to 'railroad' the voluntary sector, both in terms of cutting funding and riding the political fall out. But it is far more complicated to do this when it comes to the NHS statutory sector with its protected status.

But commissioners should be aware that the Government is keen on 'contestability' – that is the ability to challenge any service that is not providing quality and value for money.

Work is also underway to develop the voluntary sector in the same way as the private finance initiatives has developed the private sector, to create more substantial 'level playing field' partnerships when it comes to public sector service provision.

New scenarios to increase treatment provision could be found in a range of ways including the rise of the private treatment sector alongside large-scale voluntary sector providers; new primary care activity through alternative primary medical services and new drug services from foundation mental health trusts. All this makes for interesting times for commissioners. ●

*Peter Mason is chief executive at the Centre for Public Innovation*

## Creative commissioning continued

of the assessment process, to make sure that the proposed service fits with their priorities and there is a realistic prospect of them purchasing it.

Investments can also include a grant element, either to help the applicant develop their business plan, or to pay for start-up or development costs, which the purchaser would be unlikely to pay for as part of the contract.

Futurebuilders website ([www.futurebuilders-england.org.uk](http://www.futurebuilders-england.org.uk)) provides full details of the application and assessment process, and investment offers we have made to date. It also gives our investment plan for 2005/2006, and our Annual Review for 2004/05. Investments to date include:

- Pecan (£189,150) – for an employment training and job brokerage programme for ex-offenders
- Equinox Care (£272,00) – for short term residential stabilisation and treatment service for offenders and ex-offenders with substance misuse problems
- Broadreach House (£610,00) for day services and supported housing for people who have undergone treatment for drug and/or alcohol dependence.

We are open for applications until the end of September, and again in mid-2006 – so please have a word with those VCOs in your area that you want to do business with, and encourage them to apply! ●

*Richard Gutch is chief executive of Futurebuilders*

On your radar...

### Cuts to care – supporting people?

The money made available for the care of people in supported accommodation is being drastically reduced, making cuts to services inevitable for many areas. Peter Walters, chief executive of English Churches Housing Group, said that as a result his organisation's finances were on a 'knife edge'. Some councils are demanding the same level of service despite the reduction in Supporting People funding.

### Local or not really bothered

The Department of Health has reported that 49,100 homeless people were placed outside their own area in 2004, representing an increase of 3% between 2003 and 2004. This was on top of government statistics showing that there

are fewer people going in to residential care, which should leave more spaces available where they are needed.

### Life after youth offending

The Youth Justice Board is trying to persuade councils to pay attention to failures in the provision of housing for young offenders after their release. Last year 15% of young offenders coming out of custody were left homeless. The Audit Commission reports that 9,000 young offenders were badly housed, and that one in ten young offenders in custody were there only because no suitable accommodation was available for them.

### Nurses walk

The Sainsbury Centre for Mental Health have studied over 300 in-patient wards

over 50 NHS Trusts in England, and have found an over-reliance on agency staff. Nearly half of all wards do not have a lead Consultant Psychiatrist, and 13% do not have ward managers or senior nurses. Fear of violence, substance abuse by inmates, and low staffing levels are blamed for staff leaving the NHS psychiatric sector.

### Complaints overwhelm the commission

The Healthcare Commission is struggling to keep up with the complaints it is receiving, with one in five complaints taking more than 6 months to be resolved. The commission has now employed a private company to help clear the backlog. Marcia Fry, head of operational development, says that since August things have started to improve.

**Your invitation to  
Change Commissioning Culture**  
**26th October '05 – London 4th November '05 – Birmingham**

You are invited to a free informal discussion with Peter Mason of the *Commissioning News* team – have your say about the challenges commissioners face – tell us what you need, how we can help and best inform you.

Peter is well known for his expertise in commissioning and is keen to help practitioners develop and progress.

For more information contact Laura Hollis-Ryan on 020 8675 5777 or on [laura.hollis-ryan@publicinnovation.org.uk](mailto:laura.hollis-ryan@publicinnovation.org.uk)



## Legal corner

### Procurement – avoiding advertisements

ONE topical problem which both contracting authorities and courts face is the issue of exclusivity in awarding contracts. A common situation which arises is where two parties have previously entered into a public service contract, and either it is shortly expiring and they both wish to extend the contract, or as part of a project the commissioning authority wishes to award a further contract to the same provider.

Common reasons for doing this are to save costs of going through long and bureaucratic procurement process, as well as to develop the relationship between the parties. The contracting authority feels satisfied with the work carried out by the provider, and there is a mutual understanding between both parties of each other's needs.

The question is whether such arrangements are acceptable under the procurement rules. Ultimately each decision will depend on individual facts and how well the parties can argue the case. If a contracting authority wishes to award a further contract to the same provider, they need to strongly establish justification for doing so with as much evidence as possible.

With 'contestability' increasing in public services commissioners would be well advised to review their rules on when contracts and agreements expire and ensure they do not place themselves in breach when they should be publishing contract notices. ●

**Mark Johnson**

*The author is Managing Director and Solicitor with The Projects Partnership – a firm providing legal advice and information for the development of public-private partnerships.*

# Profile of a (joint) commissioner

## Andy Bishop



### Background

I worked for 12 years in the Probation Service as a probation officer and senior probation officer working in Haringay and Hackney. I moved into the drugs field about 16 years ago and have since managed both statutory and non-statutory drug services. I have been in my current role as a planning and commissioning manager for adult drug and alcohol treatment services for around 6 years.

I work in Hertfordshire, which is a large county with a rural-urban mix. It is a two-tier authority with 10 district councils and 8 PCTs, and has a total population of over 1 million. Hertfordshire has a progressive partnership arrangement whereby, a Joint Commissioning Team has been established which covers four care groups: Drug & Alcohol, CAMHS, Learning Disability and Mental Health. Budgets between Health and Social Care have been pooled and a Joint Commissioning Partnership Board oversees the expenditure and performance management of these care groups.

### Current concerns

There is a continued lack of central government investment in alcohol services. Despite the publication of the National Alcohol Strategy and the draft Models of Care for Alcohol there is real concern about the ability to offer effective alcohol services that will meet the potential local demand for treatment. Most of our community drug and alcohol teams would clearly indicate that they currently receive referrals on the basis of around 70% primary alcohol problems, as against 30% primary drug problem.

The National Treatment Agency's Effectiveness Strategy, launched at the end of June, is to be the main focus of work for the next two financial years. There will need to be greater focus on the ability of treatment providers to access and retain drug users and to offer effective treatment outcomes.

User/carer involvement is developing,



### Andy Bishop CV

**Job title** Planning and Commissioning Manager for Adult Drug & Alcohol Treatment Services

**Born** June, 1954, Bath

**Education** Bath Technical College / Manchester Polytechnic

**Professional qualification** Post-Grad Diploma in Social Work, Diploma in Drug & Alcohol Studies

**First job** Probation officer, London

**Marital status** Married, one son, one daughter

and I think will become an extremely critical element in the development of effective service provision. At all levels of the treatment system there needs to be greater consultation with service users and carers over the development of treatment provision. At a very basic level this happens with effective and well planned assessment and care management systems – but it also needs to involve users' participation in a whole range of activities.

Concerning the Workforce Development Strategy – all DATs will be receiving substantial uplifts in their Pooled Treatment Budget from '06/07, and I think there will be the predictable problems over the recruitment and retention of staff. The DANOS framework has clearly helped in terms of producing a competency based approach to ensuring the right staff are in the right place to deliver the right kinds of services. However, I think there

are still real issues about the development of comprehensive workforce strategies. It has been interesting to visit colleagues in DATs where there has been a strong HR lead in this, as for example in West Sussex, and I am sure that this is a way forward.

### Drug treatment systems

My view of the development of integrated drug treatment systems is that there have always been real challenges with the Models of Care Framework – in moving from the delivery of simply agency-based services to the development of integrated drug treatment systems with clear care pathways. I think there continues to be challenges on the whole issue of partnership and joint working, and in the delivery of a consistent level of service provision. Hertfordshire, in particular, has the real dilemma of a large county area with mixed populations and the difficulty of ensuring appropriate access and consistency of provision is challenging.

Criminal justice interventions also concern me, and I think the development of the Drug Intervention Programme has been a really positive move forward for effective working with drug-related offenders.

### Many changes

Anyone who has been in the drugs field over the last 5 or 6 years has seen many changes from a field that was largely neglected to one which has now received considerable investment. Predictably, however, along with major investment have come increased demands in terms of data on activity and outcomes. I think there are clear issues for drug services being accountable to their management structures but also increasingly their need to be accountable in a more effective way to the local population they serve. The link with partners such as CDRPs and PCTs is a critical element in ensuring that there is local accountability and local responsiveness. ●



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**Editorial**

**Executive editor** Peter Mason

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