DrugScope response to the Health Premium Incentive Scheme 2014/15 – technical consultation.

About DrugScope

DrugScope is the leading UK charity supporting professionals working in drug and alcohol treatment, drug education and prevention and criminal justice. It is the primary independent source of information on drugs and drug related issues.

DrugScope has just under 400 members, primarily treatment providers working to support individuals in recovery from drug and/or alcohol use, local authorities and individuals. Its member agencies are among those providing support to over 200,000 people receiving community and residential treatment, plus harm prevention, advice, education and related recovery services.

About this response

The consultation document[1] has a target audience of local authority Directors of Finance, Directors of Public Health and members of Health and Wellbeing Boards; most of DrugScope's membership falls outside these categories. However, our members are direct stakeholders in the drug and alcohol treatment system and are committed to providing an effective and robust service to all who need it, including providing prevention advice and guidance, family support and a range of activities in and with the broader community. This response reflects discussions between DrugScope and our members.

Key message

DrugScope strongly supports the proposal that the successful completion of drug treatment, with combined data for opiate and non-opiate users, should be used as the national measure for the incentive pilot. This is the principal indicator in the Public Health Outcome Framework that has the potential to incentivise local investment in evidence based drug treatment and signal the Government's commitment to ensure the local capacity to deliver the Drug Strategy 2010 in a period of uncertainly and significant risk of disinvestment.

Pre- and post-April 2013 Public Health reforms

Prior to April 2013, drug and alcohol treatment services (including the then Drug Interventions Programme or DIP) were in large part funded via the Pooled Treatment Budget (PTB), allocated by the National Treatment Agency (NTA) as a Special Health Authority and, de facto rather than de jure, ring-fenced for the purpose.

The factors included in the allocation calculation included numbers in effective treatment, indicators of deprivation, socio-economic factors, local health characteristics and, from 2012-13, a component (amounting to 20% of the overall sum) reflecting increases in the number of adults successfully completing treatment and not re-presenting within 6 months. This compound measure provided a degree of assurance that allocations broadly reflected clinical need and social factors while incentivising performance.

[1] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/352511/Consultation_Document.pdf

In April 2013, upper tier and unitary local authorities assumed responsibility for funding and commissioning most drug and alcohol treatment services, with local Directors of Public Health being responsible for delivering strategies laid out by Health and Wellbeing Boards through the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy process. The functions of the NTA (a special health authority) have mostly been assumed by Public Health England (PHE - an executive agency).

The funding for most services is now distributed to local authorities via the Public Health Allocations. While the component relating to drug and alcohol treatment (including the proportion that would previously have been included in the PTB) is significant at around a third of the total, it is not effectively ring-fenced within that allocation, although the public health budget itself is currently ring-fenced for the purposes of public health. Concerns have been expressed to DrugScope that the proportion of the local allocation related to drug and alcohol treatment (including reporting of actual spend) is less visible than previously, potentially making local scrutiny more challenging. This is particularly the case where multiple contracts have been rolled into larger lots, or where specialist services have been replaced with integrated services.

The current funding and commissioning environment

There is significant pressure on local authority funding and consequently spending; this is likely to continue for the foreseeable future[2]. This has led to concerns, supported by some evidence, that ostensibly ring-fenced public health funding is increasingly being used to support activities that while potentially improving local public health outcomes and addressing determinants of public health, are not themselves public health interventions.

Examples found in early 2014 by the British Medical Journal include local services such as trading standards, parks and green spaces and leisure facilities[3]. While accepting the point that such decisions are potentially creative solutions that will reap rewards in terms of population-level health, this provides little reassurance for those with a particular interest in the health of and outcomes for a relatively small, often highly socially marginalised and comparatively entrenched group such as people who misuse drugs (in particular) and/or alcohol. As it is currently unclear if the Public Health Allocations will remain ring-fenced beyond 2015-16, the possibility exists that continuing pressure on local authority finances may tempt further diversion of funding into non-clinical, whole population interventions or into entirely separate areas of public service delivery..

Additionally, in October 2014, PHE and the Association of Directors of Public Health (ADPH) published *A Review of Drug and Alcohol Commissioning*[4]. This review found a mixed picture – while around 62% of participating Directors of Public Health indicated that spending in 2014-15 would be the same or above that of the previous year, almost 28% indicated that they were expecting a reduction, with the remainder either being unable to say or indicating that the decision was dependent on other factors.

The outlook for 2015-16 is less clear, with 43% not knowing or stating that no decision had been made, compared to 4% anticipating an increase, 17% a reduction and 28% anticipating no change. This lack of certainty is understandable as inquiries were made of Directors of Public Health before the 2015-16 Public Health Allocations had been published. As the coming year's allocations show a

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[2] http://www.local.gov.uk/documents/10180/5854661/L14-340+Future+funding+-+initial+draft.pdf/1854420d-1ce0-49c5-8515-062dccca2c70

[3] *Raiding the public health budget* BMJ 2014;348:g2274

[4] http://www.nta.nhs.uk/uploads/review-of-drug-and-alcohol-commissioning-2014.pdf

net increase of almost £5.5m on a budget of £2.79bn, it would be a leap to assume that the uncertainty earlier this year will necessarily translate to disinvestment next.

In addition to the evidence of competing priorities identified by the BMJ and the lack of certainty found in the joint PHE/ADPH report, there is evidence from the sector itself. In early 2014, DrugScope (on behalf of the Recovery Partnership) released the first State of the Sector report[5]. Summarising the findings of a large survey of treatment providers, a series of consultation and engagement events and a number of interviews with service managers and agency chief executives, it found a resilient and adaptable sector, albeit one affected by degrees of volatility and uncertainty and adversely affected by recommissioning and retendering, at least some of which may be led by the structural reforms and overall challenging funding environment.

The proposed Health Premium Incentive Scheme

In the context of the 2015-16 Public Health Allocations of almost £2,8bn, the description in the consultation document of the incentive budget of £5m as 'modest' is arguably correct. Introducing an incentive at a relatively low level may be advantageous in some respects, allowing the concept and its effects to be tested thoroughly. Both the current scale of the proposed payment and introducing the payment as a positive rather than negative measure (i.e. successful authorities will receive additional money) may offset the downside of lack of absolute certainty about how much additional funding a given area might expect.

The introduction of an incentive scheme would also appear to meet a number of objectives. Alongside meeting the commitment in *Healthy lives, healthy people: our strategy for public health in England*[6] to introduce such a scheme, selecting successful completion of drug treatment as the pilot measure would send an unambiguous message of the government's continued interest in investment in drug treatment. It would also be consistent with PHE's priorities for 2013-14[7] and business plan for 2014-15[8], both of which reflect a strong commitment to improving successful completions of drug treatment and a general commitment to reducing the health impact and harmful consequences of drug (and alcohol) misuse.

Having above referred to potential tensions between traditional public health priorities which tend to focus on population level factors, drug and alcohol treatment sits within rather than distinct from the broader Public Health Outcomes Framework (PHOF)[9]. Outcomes from and activity by substance use service support and are supported by a range of other activities and outcomes. Analysis by DrugScope in consultation with members and stakeholders found that over half of the 66 indicators are positively impacted by substance use treatment, while a further number are impacted through improved access to health services through engagement with treatment services. These relationships[10] are summarised below.

Key to indicator domains	
	Health improvement

[5] http://www.drugscope.org.uk/POLICY+TOPICS/StateoftheSector2013

[6] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216096/dh_127424.pdf

[7] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/192676/Our_priorities_final.pdf

[8] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/319696/Business_plan_11_June_pdf.pdf

[9] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/263658/2901502_PHOF_Improving_Outcomes_PT1A_v1_1.pdf

[10] I.e. where there is evidence or a logical argument that can be made that substance misuse treatment makes a contribution to an indicator.

	Improving the wider determinants of health
	Health protection
	Healthcare, public health and preventing premature mortality

Treatment specific	**Wider impact of treatment**	**Contribution through increased access to other services**
• Successful completion of drug treatment (opiate and non-opiate users) • Alcohol related admissions to hospital • People entering prison with substance dependence issues who were not previously known to community treatment	• Falls & injuries over 65s • Excess weight in adults • Diet • Self-reported wellbeing • U18 hospital admissions – unintentional & deliberate injuries • Low birth rate of term babies • Emotional wellbeing of looked after children • Hospital admissions as a result of self-harm • Take-up of the NHS Health Check Programme	Under-18 conceptions Smoking status at time of delivery Smoking prevalence (adult) Recorded diabetes Breastfeeding Access to non-cancer screening programmes Cancer screening coverage Cancer diagnosed at stage 1 & 2
	• Pupil absence • Killed or injured casualties on England's roads • Children in poverty • First time entrants to youth justice system • Older people's perceptions of community safety • Re-offending • Employment for those with a long-term health condition including those with a learning disability/difficulty or mental illness • 16-16 year old NEET • People in prison who have a mental illness or significant mental illness • Statutory homelessness • Sickness absence rate • Domestic abuse • Violent crime (including sexual violence)	

Treatment specific	Wider impact of treatment	Contribution through increased access to other services
	• People presenting with HIV at a late stage of infection	• Treatment completion for TB • Population vaccination coverage • Chlamydia diagnoses (15-24 year olds)
	• Mortality from causes considered preventable • Mortality from communicable diseases • Suicide • Hip fractures in over 65s • Emergency readmissions within 30 days of discharge from hospital • Health related quality of life for old people • Mortality from respiratory diseases • Mortality from liver disease • Mortality from cancer • Excess under 75 mortality in adults with serious mental illness • Mortality from cardiovascular diseases • Infant mortality	• Preventable sight loss

Additionally, there are financial argument for retaining investment. In 2009, the Home Office found that each £1 spent on drug treatment generates £2.50 of savings to society[11], largely but not only due to reduced offending and safer communities. The positive impact of treatment on offending and reoffending was endorsed by the Association of Chief Police Officers, who commented on "the value and importance the police place on the availability of effective drug treatment services to the criminal justice agenda, to crime reduction and, more broadly, to local communities' sense of wellbeing".

However, while there are several arguments both for providing effective drug and alcohol treatment and also for including successful completion of drug treatment as the initial national indicator, it is possible to anticipate both obstacles and dissenting views. We welcome the attention paid to the need to balance statistical robustness with achievability but also note that we are not considering an entirely static population. The effect of some aspects of welfare reform and housing affordability may make some movement of individuals and households more likely, although we are unable to speculate about scale and impact.

[11] http://www.dtors.org.uk/reports/DTORS_CostEffect_Implications.pdf

Similarly, some local authorities might prefer an alternative indicator (or indicators) or none at all. This makes the implementation of the Incentive Scheme particularly important and speaks more generally to the role of the Public Health Outcomes Framework in ensuring that good performance is incentivised and under-performance or under-investment is addressed with care, particularly where marginalised and socially excluded groups are concerned.

Developing an incentive scheme

DrugScope welcomes the references in the consultation document to being mindful of unintended consequences and ensuring that focus is maintained on complex clients rather than 'unintentionally [incentivising] treatment provision on low complexity substance users in order to boost successful completion figures'. While the compound opiate and non-opiate measure may accurately reflect the changing nature of substance use in England[12], as the Recovery Committee of the Advisory Council on the Misuse of Drugs noted in 2013[13], for heroin users in particular 'recovery can be much more difficult and many will not be able to achieve substantial recovery outcomes'.

Other potential unintended consequences might include moving clients through treatment at a faster than optimal pace. Introducing an incentive scheme at a comparatively low rate will allow these concerns to be tested in practice and will allow consideration to be given to any possible unwelcome interactions with other incentivisation measures, such as the eight formal drug and alcohol payment by results (PbR) pilots[14] and additional informal PbR initiatives elsewhere.

DrugScope notes the preference expressed in the consultation for an incentive scheme metric that keeps bureaucracy to a minimum and maximises transparency; a single indicator like successful completion of drug treatment seems likely to meet this objective and is consistent with the recommendations made by the Health Premium Incentive Advisory Group[15]. However; the 2010 Drug Strategy *Reducing demand, restricting supply, building recovery: supporting people to live a drug free life*[16] identifies 8 recovery outcomes. These are:

- Freedom from dependence on drugs or alcohol;
- Prevention of drug related deaths and blood borne viruses;
- A reduction in crime and re-offending;
- Sustained employment;
- The ability to access and sustain suitable accommodation;
- Improvement in mental and physical health and wellbeing;
- Improved relationships with family members, partners and friends; and
- The capacity to be an effective and caring parent.

DrugScope would not argue that any of these individual outcomes are more or less important than any others, although in State of the Sector 2013[17], accommodation, managing physical/mental health, and employment/employment support were mentioned as both the support needs most frequently presented with and also the most significant gaps in provision.

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[12] http://www.nta.nhs.uk/uploads/prevalence-commentary.pdf

[13] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/262629/Second_report_of_the_Recovery_Committee.pdf

[14] http://www.drugscope.org.uk/Resources/Drugscope/Documents/PDF/Policy/RSADrugScopePbRMeetingNote.pdf

[15] https://www.gov.uk/government/groups/health-premium-incentive-advisory-group

[16] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/118336/drug-strategy-2010.pdf

[17] http://www.drugscope.org.uk/Resources/Drugscope/Documents/PDF/Policy/SOS2013_Main.pdf

It would be optimistic to expect a service commissioned and funded to provide treatment for drug and/or alcohol use to also improve employment outcomes (there is some evidence that treatment alone without employment support does not improve employment rates) or housing. However, a move towards an incentive measure that reflects and supports the above, or recovery capital more broadly, might be worth considering should sufficiently robust data be available to support it. This would potentially mean giving some consideration to the definition of successful completion of drug treatment used in the PHOF, or else using a compound indicator drawing on other data sources.

Utilising an incentive scheme in this way would be consistent with the approach outlined in the Drug Strategy itself as well as related government strategies such as the Social Justice Strategy[18]. It might also serve to focus minds on the importance of commissioning – and sufficiently funding – integrated services that are able to address the needs of the whole person rather than more narrow or retrenched services that might struggle to provide that holistic service.

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[18] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/49515/social-justice-transforming-lives.pdf