Healthcare Commission

NHS

National Treatment Agency for Substance Misuse

Improving services for substance misuse

A joint review

Improvement review

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The Healthcare Commission

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

In England, the Healthcare Commission is responsible for assessing and reporting on the performance of both NHS and independent healthcare organisations, to ensure that they are providing a high standard of care. The Healthcare Commission also encourages providers to continually improve their services and the way they work.

In Wales, the role of the Healthcare Commission is more limited and relates mainly to working on national reviews that cover both England and Wales, as well as our annual report on the state of healthcare. In this role, the Healthcare Commission works closely with the Health Inspectorate Wales, who are responsible for the NHS in Wales, and the Care Standards Inspectorate Wales, who are responsible for 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 our decision making, and consultative about our processes

The National Treatment Agency for Substance Misuse

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. In other words, to ensure that there is more treatment, better treatment and fairer treatment available to all those who need it.

The NTA has nine regional teams whose role is to manage the performance of drug treatment systems throughout England.

Seven underlying principles inform the activities of the NTA:

- to serve the needs of drug treatment service users, their unpaid carers and the communities in which they live
- to work in partnership with service providers, commissioners of treatment services and communities to improve the quality and effectiveness of treatment
- to be open, accessible and responsive to the needs of all the diverse communities living in England
- to be independent, rigorous and fair
- to operate according to the best available evidence
- to apply expectations of continuous improvement to our own operations
- to communicate in a clear and timely way with our stakeholders

Executive summary

The number of people receiving specialist treatment for drug problems has increased dramatically in recent years. In 2004/2005, around 160,450 people entered treatment, nearly twice as many as in 1998/1999.

Drug problems are most common in England's vulnerable and disadvantaged communities. Improving drug treatment services will benefit people in these communities. For example, it will reduce the spread of blood-borne viruses such as HIV and hepatitis and increase safety by reducing drug-related crime.

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* (Models of Care).[1] These guidelines explain how organisations can work together to deliver better drug treatment services. The NTA and the Healthcare Commission then agreed to work together to review drug treatment services nationwide and promote improvements where needed.

The improvement review

Our review assessed the performance of 149 local drug partnerships against national standards. It looked at whether local services prescribe drugs safely and appropriately and how well they plan treatment and coordinate services. These partnerships are responsible for drug treatment services in England and are made up of representatives from NHS mental health and primary care trusts, local authorities, the police, the probation service, and the voluntary sector.

The review focused on two key areas:

- provision of community prescribing services, which provide specialised drug treatment, including planning of care and prescribing of drugs to treat drug misuse
- care planning and care coordination, which refers to the processes that need to be in place to ensure that drug treatment services work together effectively to meet service users' individual needs

Within these areas, the review looked at the 11 criteria that are of most significance in the effective delivery of drug treatment services. These include access to community prescribing services, procedures to administer and manage the use of controlled drugs, and the involvement of service users in the planning of care and treatment. Thirty-three questions were used to assess how well local drug partnerships performed against these criteria. The answers were scored on a four-point scale from 'weak' to 'excellent'.

The review was the first of three reviews of substance misuse to be conducted by the NTA and the Healthcare Commission. Its findings contributed to the Healthcare Commission's 2005/2006 annual health check. The annual health check assesses and rates NHS trusts on their performance during the year, including the quality of the services they provide to the public and how well they manage their finances and other resources.

Conclusions

The results of our review showed that improvements can be made across all areas of community prescribing services and care planning and care coordination. These improvements would be supported by strengthening the commissioning of services, ensuring that clinical governance arrangements are in place in all organisations, and ensuring that in large provider organisations they extend to substance misuse services. More emphasis on clinical governance is needed to improve the use of clinical audit to drive improvement, ensure staff competence and training, and improve adherence to best clinical practice. By having appropriate policies in place, improvements could also be made to ensure that services are able to work in partnership to meet the needs of people accessing treatment.

Improvements can be made in relation to the prescribing of methadone and buprenorphine. Although the majority (95%) of services have good policies on prescribing, some are still prescribing insufficient doses to maintain service users and prevent the use of street drugs.

The review measured whether drug treatment services are giving people treatment for at least 12 weeks. Most service users who drop out of treatment do so at a very early stage. If a person has received treatment for 12 weeks, it increases the chance of them remaining in treatment for the full length of time needed to meet their individual needs. There have been great improvements in this area, with 72% of local drug partnerships improving on the 2004/2005 national average for retention. However, in 2005/2006, 14% had fewer people in treatment for 12 weeks than the national average for 2004/2005.

When looking at clinical governance, we found that 27% of prescribing services had not undertaken any clinical audit in the 18 months before our review. This equates to 46% of local drug partnerships having at least one prescribing service that has not undertaken any clinical audit during that period. Clinical audit is a mechanism for ensuring that people are receiving care based on best practice.

The review revealed the positive benefits of involving service users at all levels: in their own treatment, in planning specific services, and in planning the treatment system at a strategic level. Thirty-seven per cent of local drug partnerships scored 'good' or 'excellent' for supporting involvement and 7% scored 'weak'. This suggests that some systems are much better developed than others.

Improvements could also be made in relation to the consistent use of individual care plans. Every service user should have a comprehensive assessment of their needs and a personal care plan outlining the best course of treatment for them. The review found that not enough service users had a plan, with 48% of local drug partnerships being 'weak' in this area, and 32% scoring 'fair'. In particular, the level of risk assessment was low with 70% of partnerships scoring 'weak' when assessing and managing risks for service users. The satisfaction of service users is strongly linked to having an up-to-date care plan, which they understand and feel involved in, which meets their individual needs and which is reviewed regularly and as needed. It is therefore crucial that services improve the way they explain and agree care plans with service users.

Local drug partnerships, including primary care trusts (PCTs), could improve their commissioning of drug treatment. Sixty-three per cent of them were scored 'weak' or 'fair' when we assessed the detail of their specifications for community prescribing interventions.

Key recommendations

The NTA and the Healthcare Commission's key recommendations are that:

- all commissioners and service providers review their activity in relation to the national and local results of our review
- community prescribing services ensure that clinical governance arrangements are in place, that mechanisms to monitor their practice against guidelines are established, and that they undertake regular reviews or audits to ensure that all staff are treating all service users according to these guidelines
- all services review their assessment and care planning tools, making use of best practice guidance from the NTA
- all services ensure that they develop an individual care plan for each service user, involving them in the development and regular review of the plan. They should also ensure that the comprehensive assessment of each person who accesses treatment adequately covers any aspects of risk and looks at how these risks will be managed
- strategic health authorities and regional NTA teams with responsibility for managing the performance of local drug partnerships and healthcare organisations (NHS and voluntary sector) should ensure that action plans are developed to address all areas of weak performance in the review assessment, and closely monitor the implementation of these plans
- service users and carers should be involved in all stages of the treatment process, including developing individual care plans, planning of new services, feeding back on treatment, and monitoring the quality of services

Promoting improvements

The NTA's regional teams have used the results of the review to manage the performance of local drug partnerships (including PCTs). The partnerships have used the results to improve their commissioning and management of local services.

We encouraged all local drug partnerships to review the results in their local area and produce action plans for improvement. The NTA's regional teams will monitor the progress on action plans and improving performance. Approximately 10% of the weakest performing local areas were required to produce an action plan, with subsequent progress to be monitored by the Healthcare Commission, the NTA and strategic health authorities. This review was the first of three joint reviews into substance misuse by the Healthcare Commission and the NTA. The next review, to be conducted in 2006/2007, will look at reducing harm and commissioning. In 2007/2008, our third improvement review will look at diversity and residential services (inpatient and rehabilitation services).

Introduction

In England and Wales, 11 million people have used drugs in their lifetime, and just under four million people have used drugs in the last year. Cannabis is the most commonly used drug, while only 1% of the population report using heroin or crack-cocaine.[2] Of those people who use drugs, a small number will develop problems that require treatment.

Drug dependency has been called a chronic relapsing condition.[3] However, evidence shows that most people with drug problems recover successfully from their dependency or addiction. The majority make several attempts, lapsing or relapsing into drug misuse before they overcome their addiction.

Drugs that are misused include opiates such as heroin and illicit methadone, stimulants such as amphetamines, cocaine and crack-cocaine, and alcohol. Many people who misuse drugs take a cocktail of drugs and alcohol including, for example, hallucinogens, cannabis and prescribed drugs such as benzodiazepines.

They often have a range of other problems in relation to their addiction, including:

- physical health problems - for example, thrombosis, abscesses, overdose, hepatitis B and C, HIV, weight loss, respiratory problems
- mental health problems - for example, depression, anxiety, paranoia, suicidal thoughts
- social problems - for example, relationship problems, unemployment, homelessness
- criminal problems - which may result in legal and financial problems

To help meet these needs, a range of health, social care and other services is required. Local drug partnerships have made good progress on expanding the availability of drug treatment and making it more accessible. Most local drug partnerships have the essential building blocks of a successful drug treatment system - including a range of treatment interventions.

In 1998, the Government set a target to double the number of people participating in structured drug treatment programmes by 2008. In 2005/2006, there were 181,390 people using drug treatment services, an increase of 13% from 2004/2005 and 113% from 1998/1999. This means the Government's target has been achieved two years ahead of schedule.

Why did we look at substance misuse services?

There is strong evidence-based guidance about the most effective ways of providing drug treatment services. Nevertheless, practice varies across England. The Government estimates that drug misuse costs between £10 billion and £18 billion a year, 99% of which is accounted for by problem drug users.[4] Drug misuse affects a large number of people. It has a major impact on the individual, their families and the communities in which they live. Effective treatment services work to reduce the negative impacts of drug use for both individuals and society. People who receive treatment substantially reduce their risk of contracting infections, being physically harmed and developing psychological problems and improve the quality of life for themselves and those around them.

The key to the Government's drug strategy is to provide more and improved treatment. In 2006/2007, it increased new funding for drug treatment by 28% from the previous year. Since March 2002, new funding from central Government for drug treatment has tripled. This reflects the continuing high political significance that the Government places on the delivery of drug treatment services.

In 2002[5] and 2004[3], the Audit Commission undertook national studies, which found opportunities for improving drug treatment services. Effective treatment is clearly linked to a wide range of benefits for service users and the public. In 1998, the Government introduced a 10-year strategy that has led to significant financial investment in drug treatment services.

In 2002, the NTA and the Department of Health published *Models of Care for substance misuse treatment - promoting quality, efficiency and effectiveness in drug misuse treatment services* (Models of Care).[1] These guidelines outline how organisations should work together to provide effective drug treatment services. Substantially revised in 2006, they include a national framework for commissioning drug treatment to meet the needs of diverse local populations, to achieve equity, equality and consistency in the provision of drug treatment and care in England.[6] The NTA and the Healthcare Commission then agreed to work jointly to review substance misuse services, with the role of the NTA as a specialist sponsor, and the Healthcare Commission as the inspector or regulator.

The review was the first of three reviews of substance misuse to be conducted by the NTA and the Healthcare Commission. It aimed to promote improvements in drug treatment services by focusing on two key areas:

- **Provision of community prescribing services**. Drug treatment is provided through treatment systems or treatment communities instead of a single service. Large numbers of people receive treatment through community prescribing services. They involve a range of voluntary and NHS organisations working together to treat people with drug problems, including the prescribing of treatment drugs
- **Care planning and care coordination**. A study by the Audit Commission in 2004 indicated that action and improvement in care planning and care coordination should be given high priority.[6] Care planning and care coordination refers to the processes that structured services need to have in place to ensure that the different services in the system of treatment work together effectively. A person accessing treatment requires a thorough assessment of their needs, which should be captured in an individual care plan and agreed with them. The plan should, if necessary, include treatment offered by other providers, and should be reviewed regularly with the service user

Results from the review fed into the Healthcare Commission's 2005/2006 annual health check. The annual health check is a comprehensive assessment of how the NHS in England is performing. It scores NHS trusts on many aspects of their performance, including the quality of the services they provide to patients and the public, and how well they manage their finances and other resources.

Improvement reviews

The Healthcare Commission's improvement reviews look at whether healthcare organisations are striving to improve the care and treatment they provide to patients. They focus on aspects of health and healthcare where there are substantial opportunities for improvement, helping organisations to identify where and how they can perform better.

An improvement review involves two key areas of activity:

- a comprehensive assessment of the performance of each organisation taking part in the review
- follow-up work targeted at those organisations deemed to have greatest need of improvement

This report looks at our first improvement review of substance misuse, which we carried out in 2005/2006. During this period, we also carried out reviews of: children in hospital, tobacco control and adult community mental health. The results contributed to the annual performance ratings of NHS trusts, published in October 2006.

From 2006/2007 onwards, the Healthcare Commission's improvement reviews will be part of a wider programme of service reviews. Under this new programme, we will be reviewing services to treat people with heart failure and diabetes, adult acute inpatient mental health services and maternity services, as well as two more reviews of substance misuse.

About the review

Our review of substance misuse services looked at the performance of 149 local drug partnerships, made up of representatives from primary care and mental health NHS trusts, local authorities, the police, the probation service, and the voluntary sector. These partnerships are responsible for providing drug treatment services to meet the needs of communities in England.

Each local drug partnership was assessed against 11 criteria, which covered issues such as access to community prescribing services, procedures to administer and manage the use of controlled drugs, and the involvement of services users in the planning of care and treatment. These criteria were based on *Standards for Better Health* published by the Department of Health in 2004.[7] However, the focus for the review was determined largely by feedback from a reference group, comprising more than 70 representatives from professional and membership bodies, other regulatory bodies, organisations in the NHS and voluntary sector, as well as service users and their carers. This reference group was established by the NTA and played an important role in the development of the review. The full criteria are set out in figure 1.

A final score, using a scale of 'weak' to 'excellent', was awarded to each partnership on the basis of our assessment. This score was fed into the overall annual performance rating for primary care and mental health trusts involved in the review. It was also used to determine which partnerships needed additional help to improve the way they provide and commission drug treatment services for their local population.

Further information about how we scored drug partnerships and NHS trusts, and about how the review was carried out, is available at www.healthcarecommission.org.uk or www.nta.nhs.uk

Figure 1: Assessment criteria for the improvement review

Community prescribing services

1	Community prescribing services are commissioned in line with *Models of Care for substance misuse treatment - promoting quality, efficiency and effectiveness in drug misuse treatment services*[1] (Models of Care) and *Drug Misuse and Dependence – Guidelines on Clinical Management*[8] (the Clinical Guidelines).
2	Service users have prompt, equitable and flexible access to community prescribing services.
3	Service users have a personalised care plan that incorporates a comprehensive assessment of their physical, psychological, social and legal needs and preferences.
4	Prescribing practice is in line with Models of Care.[1]
5	Community prescribing services have procedures in place to ensure controlled drugs are administered and managed in accordance with best practice.
6	Community prescribing services are delivered by competent practitioners who are appropriately trained and supervised and work in a supported and managed environment.

Care planning and care coordination

7	Service users are integrated partners in the entire treatment planning process and are fully informed about the range of treatment options, choice and access available.
8	Service users have prompt, equitable and flexible access to an appropriate range of drug treatment services.
9	Service users have a personalised care plan that incorporates a comprehensive assessment of their physical, psychological, social and legal needs and preferences.
10	The pathways of service users through treatment are clear, coordinated and continuous.
11	Services have systems in place to minimise client did not attend/drop out rates and support clients being retained in treatment.

Key findings

In the review, the majority of local drugs partnerships scored 'fair' overall. This means that they are meeting minimum requirements and the reasonable expectations of patients and the public. However, improvements can still be made within the key areas.

Figure 2: Distribution of overall scores across local drug partnerships

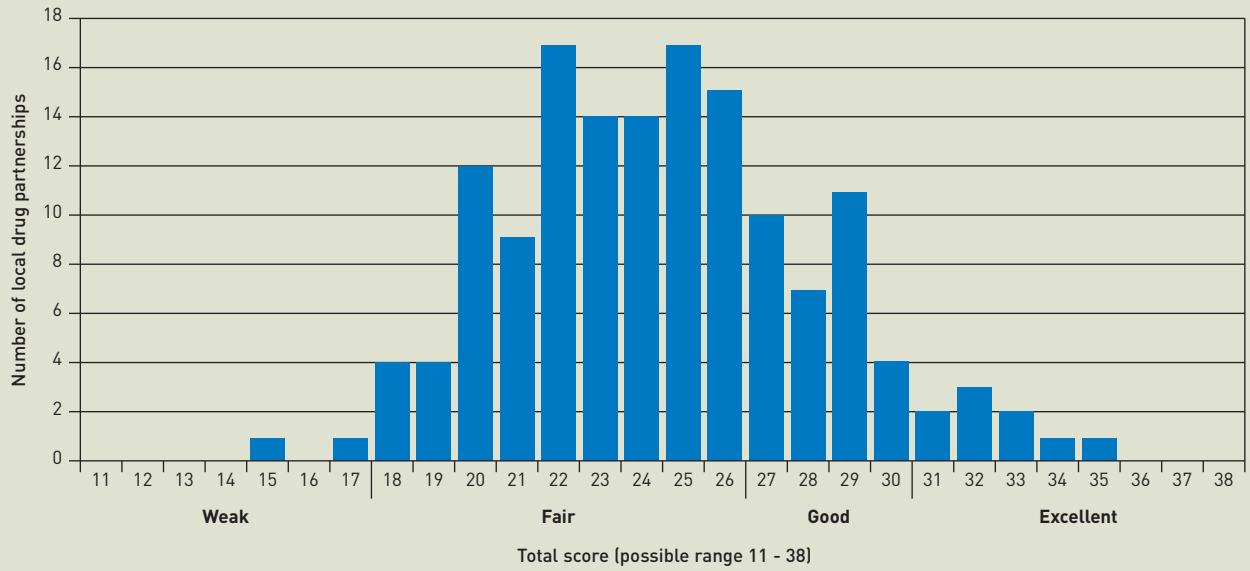


Figure 3: Distribution of overall scores

	Local drug partnerships		Mental health NHS trusts		Primary care trusts	
	Number	Percentage	Number	Percentage	Number	Percentage
Weak	2	1%	0	0%	6	2%
Fair	106	71%	34	61%	210	69%
Good	33	22%	21	37%	73	24%
Excellent	7	5%	1	2%	13	4%

When calculating the overall scores, some information was summarised. When considering areas where local drug partnerships could improve, the scores at criteria and question level should also be taken into consideration, as well as the full results that are presented at provider level, available at www.healthcarecommission.org.uk and www.nta.nhs.uk

Results for the provision of community prescribing services

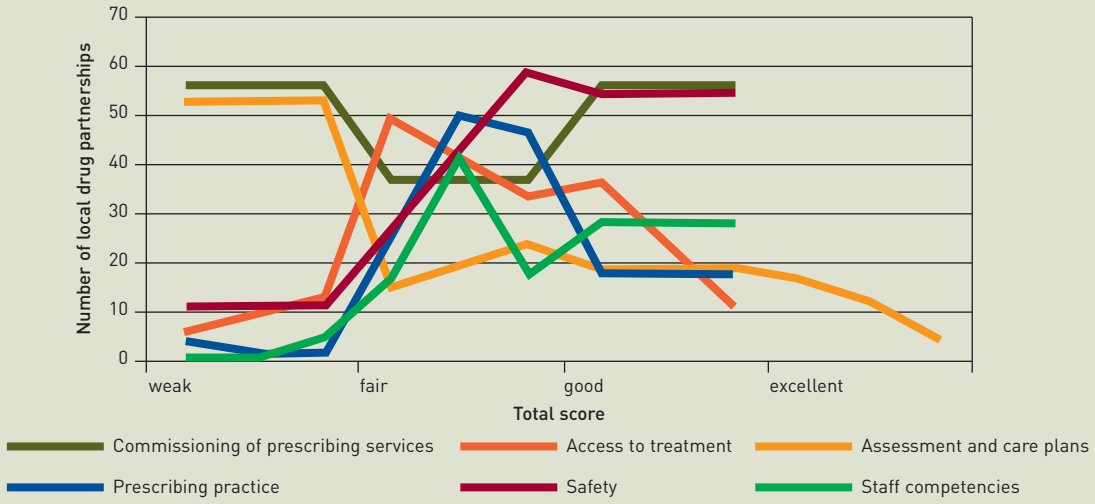
We found strong evidence about the most effective ways to provide drug treatment services. However, practice varies across England. Community prescribing services are best provided through partnerships between specialist organisations, for the provision of care for people with severe or complex needs, and in support of services provided in primary care-led settings.

Figure 4: Distribution of scores for community prescribing for local drug partnerships

Criteria	Weak	Fair	Good	Excellent
Commissioning of prescribing services	38%	25%	37%	-
Access to treatment	13%	56%	31%	-
Assessment and care plans	36%	27%	13%	22%
Prescribing practice	6%	50%	43%	-
Safety	7%	55%	37%	-
Staff competencies	18%	64%	17%	-

Note: Not all criteria could be scored 'excellent' because it was not always possible to collect enough data to substantiate excellent practice.

Figure 5: Total distribution of scores for each criteria across community prescribing



Commissioning of prescribing services

Thirty-eight per cent of local drug partnerships scored 'weak' in this area, with 37% scoring 'good' (the top mark for this criterion). These results suggest that practice varies across England. Responses from providers suggested weaker service level agreements and/or contracts than responses from commissioners, which indicates that improvements could be made to agreeing contracts with providers.

The stakeholders with whom we engaged during the development stage of the review thought that unless drug treatment services were commissioned to provide a particular level of service, providers' services could not reasonably be measured against quality standards. Clarity of commissioning is therefore fundamental to the provision of good quality services. It sets the expectations for what is delivered locally and allows for services to be performance-managed against a set of locally agreed performance measures.

Within community prescribing services, the criteria with the lowest scores were those relating to commissioning. Commissioning involves assessing needs, resources and current services, and determining how to make the best use of available resources to meet the identified needs in a given area. It involves determining priorities, purchasing of appropriate services and evaluating them. Commissioning is also the mechanism for managing the performance of services locally. We assessed commissioning by looking at the service level agreements and/or contracts used by local drug partnerships.

Models of Care sets out seven elements that should be included in service level agreements and/or contracts.[1] We assessed this criterion against these elements:

- definition of service (core)
- description of services (core)
- eligibility criteria (core)
- aims and objectives
- priority groups
- exclusions and contradictions
- policies and protocols

Local drug partnerships scored well if it was agreed by the providers and commissioners that all seven elements were in the service level agreements and/or contracts. A score of 'fair' was awarded if the three core elements shown above were agreed, and a score of 'weak' was given if these core elements were missing in the self-assessment from either the provider or the commissioner.

Access to treatment

Drug treatment services can be accessed easily if services are delivered promptly, equitably and flexibly across a geographical area.

This criterion of the review measured the three-week waiting time target for community prescribing services, access to primary care-based services, and out-of-hours access.

There has been widespread improvement in waiting times over the last five years. However, 32% of local drug partnerships reported waiting times longer than the three-week target for specialist community prescribing. We compared these reported waiting times with data returned to the national database, which allowed for a validation of reported waiting times. The set of calculated waiting times showed 50% of local drug partnerships had waiting times longer than the three-week target for specialist community prescribing. The equivalent figures for primary care-led prescribing showed that 13% of local drug partnerships had waiting times of more than three weeks, and 26% had calculated waiting times of more than three weeks. In addition, data was used from the NTA's national survey of service user satisfaction, undertaken in 2005. In three local drug partnerships, more than 80% of the respondents to the survey reported unacceptably long waiting times.

Specialist community prescribing services working in conjunction with primary care-led prescribing enables service users with stabilised drug use to receive treatment from primary care. This often makes services more accessible geographically, and makes available a larger number of specialised treatment places. Primary care-led prescribing services are delivered in a variety of ways. We were seeking to measure whether a geographical area had more than 30% of practices involved in delivering drug treatment services. In other words, if drug treatment services were delivered from the practice, or were made available to service users registered with it. Despite our allowance for flexibility in the ways this might be achieved, 28% of local drug partnerships scored 'weak' on this question.

Offering some out-of-hours provision is important to minimise disruption to service users who are employed or seeking employment. In 40% of local drug partnerships, all services offer some out-of-hours provision. However, 12% of partnerships did not have any community prescribing services offering out-of-hours appointments.

This means that a substantial number of local drug partnerships are offering a poor service and must improve this aspect of service delivery.

We asked some of the local drug partnerships that performed well in the review to give feedback on what they think contributes to their 'good' performance. Here are some of their comments relating to access:

"Services are readily accessible to people wanting treatment, being locally positioned and offering self referral routes. Because a high number of treatment providers exist, individuals have choice in access and a wide range of services available across the tiers."

Bradford

"The community drugs team has increased its prescribing capacity, more than doubling numbers in treatment, through using GPs with a special interest. Work is being carried out to increase GP participation."

Coventry

Assessment and care plans
A service user accessing treatment requires a thorough assessment of their individual needs. This assessment should be captured in a care plan and agreed with them. Where necessary, it should include treatment offered by other service providers. The person accessing treatment should be offered a copy of the care plan.

This criterion assessed the documents used for planning of care, triage, comprehensive assessment and risk assessment. These documents were scored against a set of best practice expectations for comprehensive assessment and risk assessment. We recognise that good documentation does not guarantee a good assessment, and that experienced workers may be able to provide a very good assessment without the aid of a standard tool. However, in a field characterised by staff turnover and expansion, consistency is important in the documentation used to make assessments.

The overall score attributed to each local drug partnership was based on its combined percentage across services. A score of 'weak' was given if a combined percentage of less than 70% of the standards were in place.

Comprehensive assessment: 38% of local drug partnerships scored 'weak 'and 41% scored 'good' or 'excellent'. At an individual service level, the range of scores for best practice expectations being in place was 11% to 97%, showing great variation in the quality of assessment tools being used nationally. Out of 457 services, 35% scored 'weak' and 46% scored 'good' or 'excellent'.

Risk assessment: 50% of local drug partnerships scored 'weak' on risk assessment and 25% scored 'good' or 'excellent'. At an individual service level, the range of scores for best practice expectations being in place was 8% to 100%. Forty-four per cent of services scored 'weak', and 30% of services scored 'good' or 'excellent'.

Figure 6: Service level scores for comprehensive assessment

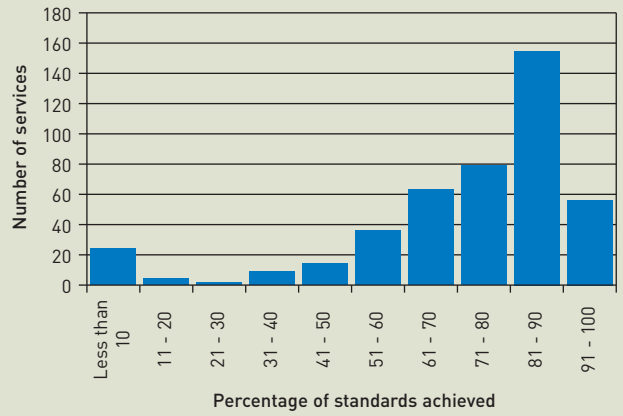
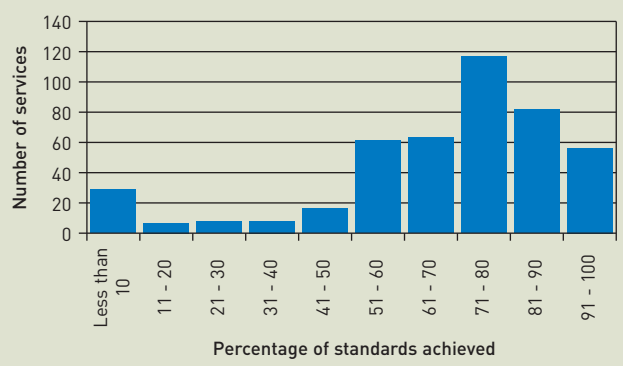


Figure 7: Service level scores for risk assessment



Some of the areas for assessment within the set of best practice expectations were frequently missing across all services. With comprehensive assessments, 21% of services did not assess overdose history, despite the need to reduce drug-related deaths (normally associated with accidental overdose). Sixty-one per cent did not assess domestic violence history, an important factor in assessing risk of harm. Twenty per cent did not include a risk management plan, or a plan of how to ensure the risks identified in an assessment were addressed, checked and minimised. Thirteen per cent did not ask about contact with mental health services. A further 13% of services did not ask about alcohol use and 47% did not assess for symptoms of alcohol dependency. This is a cause for concern because use of alcohol can compound and make worse other substance misuse problems and is particularly associated with dual diagnoses, suicide and overdose. Nineteen per cent did not record pregnancy, which if present would indicate a treatment priority. Finally, 52% did not assess for abscesses, which occur at injecting sites on the body and cause physical health problems.

Within risk assessments, 15% of services did not assess sharing of injecting equipment, a significant risk in transmission of blood-borne viruses. Thirty per cent did not ask about where people inject their bodies, so were not enabling the provision of advice to reduce harm. Thirty-eight per cent did not assess safer sex practices - another issue in blood-borne virus transmission, and 62% did not assess transmission of blood borne viruses. Finally, 48% did not check which other people lived in the same house as the service user, even though this could have an impact on a range of issues, including child welfare.

We found that some local areas and services need to review their assessment and care planning systems, to include how comprehensive their documentation is, whether it prompts workers to ask all the questions needed to establish risks to the service user and whether the care planning documents used to plan treatment interventions allow for all the relevant information to be recorded, including how risks will be managed.

In 2006, the NTA published a care planning practice guide[9] and e-learning toolkit[10], which would assist local areas in reviewing their performance in this area, alongside other best practice guidance, for example Models of Care.[7] These NTA materials are designed to keep service providers up-to-date with best practice in care planning, including the service user's treatment journey, key working, confidentiality and consent, developing a care plan, risk assessment, goal setting and harm reduction.

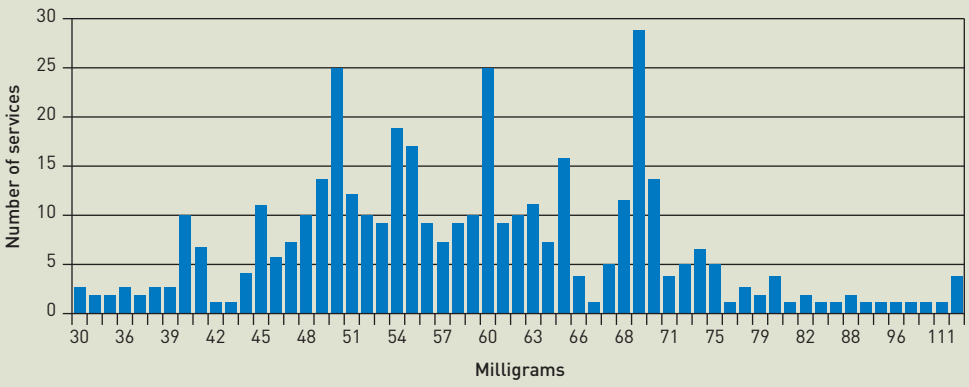
Prescribing practice

A person entering treatment requires the best evidence-based treatment that complies with national guidance. Drug treatment services should have local governance arrangements that ensure and check that individuals are receiving this type of treatment.

This criterion of the review was measured through a number of audit questions on prescribing practice. The scoring was based on the expectations as defined in the Department of Health's Clinical Guidelines.[8]

Nationally, the mean methadone dose (for maintenance prescribing) was 57mg, and only 30% of services had a mean dose above 60mg. The Clinical Guidelines state in relation to maintenance doses: "there is a consistent finding of greater benefit from maintaining individuals on a daily dose between 60mg and 120mg." We would therefore expect a mean dose within this range, while accepting that individual doses should be tailored to the service user's needs.

Figure 8: Average doses of methadone for maintenance prescribed by local drug partnerships



Sixty-four per cent of services had more than 60% of continued maintenance doses below 60mg or above 90mg. This raises concern about the flexibility of practice or that prescribing is being undertaken according to a standard dose policy rather than individual need. Seventy-six per cent of services have less than 60% of service users in the ideal range for buprenorphine doses for maintenance prescribing. A likely outcome of doses prescribed below the ideal level is the continued use of street drugs.

In relation to methadone, the Clinical Guidelines[8] state that 'supervised consumption is recommended for new prescriptions for a minimum of three months, and should be relaxed only when the patient's compliance is assured. If the patient is clearly making progress on a daily dispensing regimen, the dispensing intervals can be reduced gradually to thrice weekly, twice weekly, etc. Methadone is a controlled drug subject to prescription requirements. Supervision of its use reduces the risks of methadone being diverted to the illegal drug market and, for example, being sold on to other drug users.

Forty-three per cent of services had less than 70% of people being supervised for three or more days in the first 12 weeks of treatment. Setting the cut-off at 70% provides flexibility for individual cases to be treated outside of the guideline in specific circumstances. This finding suggests that too many areas do not provide sufficient supervision in the first 12 weeks of treatment.

As service users progress with treatment, supervision can be relaxed, based on individual circumstances. Thirty-nine per cent of services had 90% of people being supervised for more than four days, or less than one day after 12 weeks for methadone prescriptions. This finding suggests a generic decision rather than a decision based on the service user's individual circumstances. The results indicate that most services have a policy to either supervise individuals daily or not at all.

Sixty-four per cent of local drug partnerships had less than 70% of service users being supervised on buprenorphine for three or more days in the first 12 weeks. In fact, 15% of services stated that none of their service users were supervised at all. Sixty per cent of services had 90% of people being supervised for more than four days or less than one day, again suggesting a policy decision rather than a decision based on individual circumstances.

The majority of services are prescribing more than 80% oral mixture methadone in line with the Clinical Guidelines.[8]

Clinical audit: our assessment showed that 27% of prescribing services had not undertaken any clinical audit in the 18 months before the review. This equates to 46% of local drug partnerships having at least one prescribing service that had not undertaken any clinical audit in that period. Given that clinical audit is a requirement of a clinical governance framework to ensure that care is provided based on best practice, we would expect prescribing services to have this embedded in organisational practice.

The findings in this section show that local areas should review their clinical practice against the Clinical Guidelines[8] and establish

ongoing processes for assuring that service users are receiving treatment that is in line with best practice.

We asked some of the local drug partnerships that performed well in our review to give feedback on what they think contributes to their good performance. Here are some of their comments relating to clinical practice:

"We have innovative practices and have set up: case-load weighting systems, case-load monitoring systems, titration/induction clinics, regular review appointments, low intervention groups for more stable clients, low threshold treatment in satellite service for hostel residents, and a crack-cocaine programme."

North Camden Drug Service

"We have established a prescribers group, directing, and obtaining sign-up to best practice, problem solving, efficiency and promoting governance. This includes the development of district-wide prescribing guidelines."

Bradford

"We have full integration between primary and secondary care prescribing, backed up by clear policies to reduce any element of inconsistent prescribing practice. This is supported by a GP advisor to the PCT, who supports GP colleagues with their prescribing practice."

Rotherham

"Clinical governance and leadership comes from a lead consultant with the local mental health trust, combined with a GP with Special Interest (GPwSI) lead for primary care."

Salford

"A multi-agency clinical governance group has been in place for two years and this directly supports good practice across the treatment system."

Wirral

Safety

Methadone is a controlled drug that is subject to prescription requirements, and procedures must be in place to ensure that it is prescribed and administered in accordance with best practice and the law.

This criterion measured whether the key policies and procedures shown below were in place, the numbers of reported untoward incidents, and the confidence of staff about reporting incidents. Confidence about reporting was measured through a survey of NHS data and is therefore only relevant to statutory providers. The key policies and procedures checked were:

- adverse incidents procedure
- prescribing policy
- prescribing review procedure
- complaints procedure/practice protocols
- meetings with pharmacists to discuss issues (for example, adverse incidents)

- risk assessment protocols (for example, in the case of overdose)
- formal dose titration process for methadone
- formal dose titration process for buprenorphine

The majority of services had these policies in place, suggesting widespread implementation of the Clinical Guidelines.[8] Forty-six per cent of local drug partnerships had all these in place across all services. The policies most likely to be missing were meetings with pharmacists (21% of services) and dose titration protocols (14% of services for methadone and buprenorphine).

Pharmacists, particularly those undertaking daily dispensing, are often among those professionals most frequently in contact with service users. They therefore offer a potential source of information to service providers, including how to ensure services can be most effective.

Dose titration policies provide services and clinicians with a clear procedure for getting service users to the most effective dose, both to stabilise them, and for ongoing maintenance. Given the findings about low methadone maintenance doses, titration policies provide a safe procedure to improve clinical practice.

Staff competencies

The drug treatment sector has expanded rapidly over the last few years and with it, the workforce. Much work has been achieved to produce occupational standards for those working in drug treatment. However, the increasing demand for drug treatment workers has resulted in a high proportion of inexperienced staff entering the field. In addition to competent and appropriately trained staff, policies are required to ensure that case loads are distributed in a way that ensures maximum benefits to service users without overburdening particular staff members.

The criterion on staff competence was measured against the levels of trained and experienced staff, the involvement of a sufficiently trained doctor within the local drug partnership system, rates of vacant and temporarily filled posts, systems for managing case loads and feedback from staff and service users.

The majority of these questions were analysed through a method of national benchmarking, looking for outliers from the national distribution. As a result, some questions were only scored out of two and many of these questions produced results bunched within the category of 'fair' (score of two). This suggests that most services are performing in a similar way nationally, although this does not mean that practice is universally good. The drugs treatment field is expanding rapidly and continues to work hard to ensure that competent staff are recruited and retained. If services were outliers on these questions, they are likely to be experiencing particular difficulties and we would expect them to review their workforce strategy.

At the local drug partnership level, the percentage of staff with more than three years' experience or accredited training in substance misuse ranged from 25% to 100%. (Staff were defined as practitioners who spent more than 20% of their time in direct client

work.) In 11% of local drug partnerships, less than half of the staff were experienced or trained practitioners.

In many areas of health and social care, experienced practitioners are sometimes promoted to management roles without any management experience or training. At the local drug partnership level, the percentage of managers (defined as spending less than a fifth of their time in direct client work) with more than three years' experience or accredited training in management, ranged from 0% to 100%. In 8% of local drug partnerships, less than 50% of those working as managers had previous experience of management.

This criterion placed particular emphasis on whether, within each local drug partnership, there was a clinical lead with sufficient specialist training to undertake advice, complex assessment, supervision and complex management of patients. The roles defined as competent to undertake these tasks were defined within the 2005 guidelines issued by the Royal College of General Practitioners/Royal College of Psychiatrists and the NTA.[11]

Twelve per cent of local drug partnerships did not have a doctor with sufficient specialist training working within the local drug partnership area.[11] As the scoring here was at local drug partnership level and not service level, this is a significant issue in those local drug partnerships. Ideally, at least every provider or clinical network would have an appropriately trained lead clinician.

Results for care planning and care coordination

Care planning and care coordination refers to the processes that services must have in place to ensure that the system of treatment works together to meet the needs of individuals. It is essential that service users and their carers are involved in planning their treatment and that services are accessible so that service users can get the aspects of treatment they need. Services should work together to ensure that the routes through treatment are clear to those using them, including involving service users in providing feedback on the system.

A service user should receive treatment based on a thorough assessment of their individual needs. The assessment should be captured in a care plan, agreed with them, and, where necessary, include treatment that is offered by other service providers. This care plan should be reviewed with the service user at regular and agreed intervals and as necessary, as they progress through treatment. A copy of the care plan should be offered to the service user.

Care planning and care coordination was identified as an important theme because the underdevelopment of care planning at practice level was identified in the Audit Commission's first report on substance misuse and treatment, published in 2002.[5] The need to develop individual care plans for service users, and for coordination of the care of those with complex needs, was also highlighted. A second report from the Audit Commission, published in 2004, identified further improvements needed to ensure that service users could achieve stability and move out of treatment.[3] This included health, social

Figure 9: Distribution of scores for care planning and care coordination for local drug partnerships

Criteria	Weak	Fair	Good	Excellent
Involving service users	7%	55%	26%	11%
Access to treatment	21%	46%	27%	6%
Assessment and care plans	48%	32%	6%	13%
Pathways through treatment	15%	58%	16%	11%
Did not attend (DNA)/drop-out system	1%	23%	74%	-

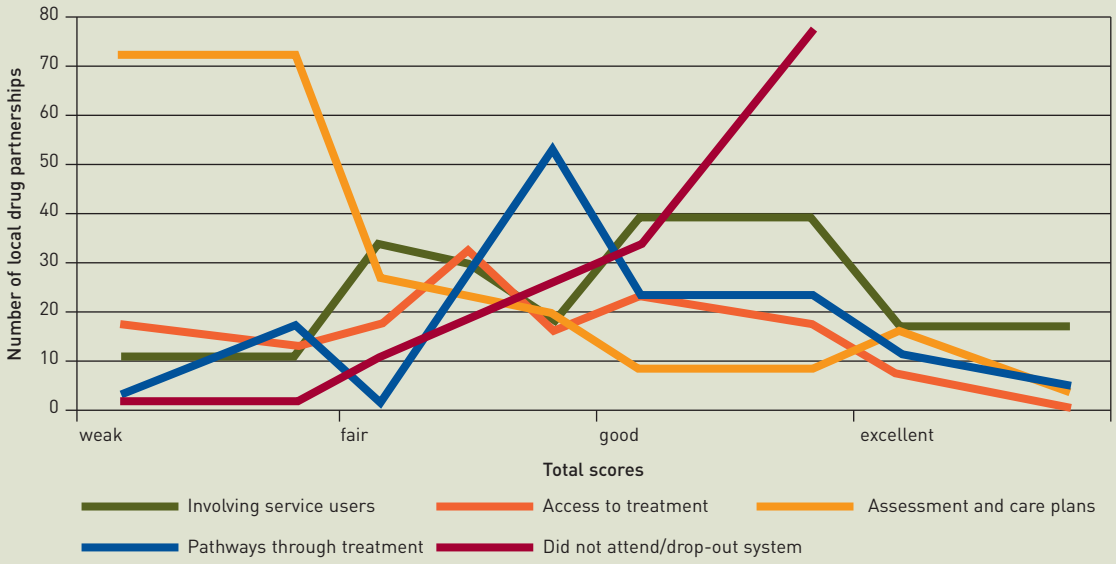
functioning, employability and housing status. The report noted that service users were often unsure about their treatment and were not fully involved as active partners in their care.

The criterion looked at delivering good quality care planning and care coordination through:

- involving service users
- access to treatment
- assessment and care plans
- pathways through treatment
- did not attend (DNA)/drop-out system

The data used to assess a local drug partnership was collected from all the specialist services within the partnership.

Figure 10: Total distribution of scores for each criteria across care planning and care coordination



Involving service users

Integrated treatment ensures that service users are involved in the whole treatment planning process and are fully informed about the range of treatment options, choice and access available. Involving service users at all levels of the treatment system is fundamental to ensuring that services meet their needs. This means involving them in strategic and service planning as well as enabling them to become active partners in their individual care.

This criterion was measured by providers' support for involvement of service users, the provision of information to them about the range of services available, their involvement in treatment planning and delivery at a strategic level, and the experience of service users in having their views taken into account, and their involvement in care planning. The results showed that some systems are much better developed than others, with 7% of local drug partnerships scoring 'weak' but 37% of local drug partnerships scoring 'good' or 'excellent'.

In particular, 17 local drug partnerships have not published a directory of services (as recommended by the Models of Care[1]), to inform service users and their carers about the range of services available and how to access them. Twenty-seven per cent of the 1,108 services do not offer financial support to people who participate in service delivery and monitoring. Twenty-three per cent of services do not have local user forums, where people can meet to share their views on the services they receive. Thirty-one per cent of services do not have access to strategic planning groups for service users. Forty per cent of services do not offer training and/or mentoring to enable people to participate in planning and monitoring services. This could include meeting with people in advance of forums or

business meetings, to go through the agenda and discuss issues they may wish to raise or need support to raise.

Access to treatment

The access criterion ensures that service users have rapid, equitable and flexible access to an appropriate range of drug treatment services. Accessibility includes whether services are delivered promptly, equitably and flexibly across geographical areas, and whether the right combination of services or interventions is available within the treatment system.

This criterion was measured by the length of time that people waited for access to drug treatment service interventions. It was also measured by the availability and accessibility of the full range of treatment options, to the whole local drug partnership population, as described in Models of Care[1] and reported in treatment plan returns produced annually by local drug partnerships.

Performance statistics collected by the NTA show that average national reported waiting times for drug treatment in England have fallen from an average of 9.1 weeks in December 2001 to 2.4 weeks in September 2005.[12, 13] However, there is still a need for continued improvement, particularly for residential services.

Sixty-six per cent of local drug partnerships had two or more modalities (or interventions) that were not meeting the target of a three-week waiting time (based on waiting times reported to, and verified by, the national data set). In particular, there are difficulties with access to residential interventions, with 30% of local drug partnerships reporting a waiting time of more than three weeks for both residential rehabilitation and inpatient detoxification. Interestingly, significantly more local drug partnerships stated that they did not have contracts for residential services than for other types of service intervention. Forty-nine per cent of local drug partnerships said that contracts for residential rehabilitation were either not applicable or not specified in the set of contracts held by the local drug partnership, and 33% said the same about inpatient detoxification. The NTA has recently produced guidance to improve commissioning of residential services.[14]

Assessment and care plans

Individual care plans ensure that service users have personalised care based on a comprehensive assessment of their physical, psychological, social and legal needs and preferences. This assessment should be agreed with them, and where necessary include treatment that is offered by other service providers. A copy of the care plan should be offered to the service user.

In a similar way to the key area of community prescribing services, this criterion was measured by all structured community services being asked to supply the documents they use for care planning, triage, comprehensive assessment and risk assessment. The documents were scored against a set of best practice expectations for comprehensive assessment and risk assessment. The score attributed to the local drug partnership was based on the combined percentage across services. A score of 'weak' was given if a combined percentage of less than 70% of the standards were in place.

The results for all structured community

services are not as positive as community prescribing services on their own.

Comprehensive assessment: 50% of local drug partnerships scored 'weak' and 23% scored 'good' or 'excellent' for comprehensive assessment. At an individual service level, the range of scores was 11% to 97%; 366 out of 846 services (43%) scored less than 70%, 333 out of 846 services (39%) scored at 'good' or 'excellent'.

Risk assessment: 70% of local drug partnerships scored 'weak' on risk and 15% scored 'good' or 'excellent' for risk assessment. At an individual service level, the range of scores was 8% to 100%; 438 out of 846 services (52%) scored less than 70%, 224 out of 846 services (26%) scored 'good' or 'excellent'.

Figure 11: Scores for comprehensive assessment

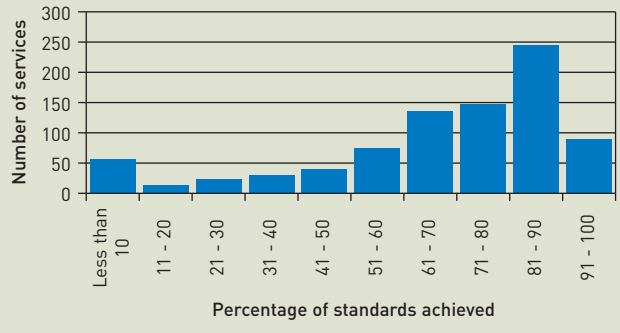
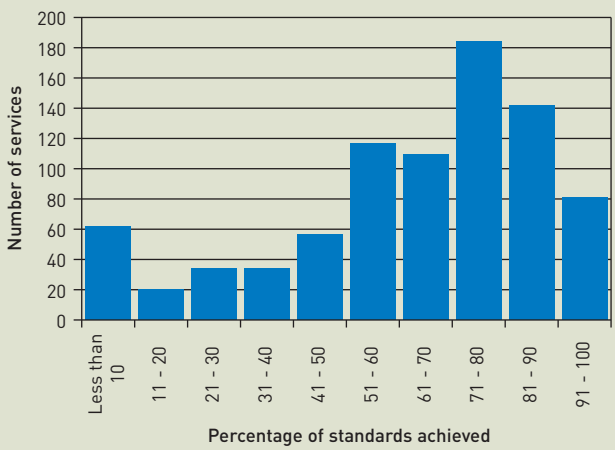


Figure 12: Scores for risk assessment



We asked some of the local drug partnerships that performed well in the review to give feedback on what they think contributes to their good performance. Here are some of their comments relating to assessment and care planning:

"Within Hull there is a well established and embedded approach to common comprehensive assessment and risk management processes. This has assisted in matching the need to the intervention. Stakeholders across the Hull treatment system designed, implemented and reviewed the system of care planning, there was an event to launch the system and practitioners were helped to embed the system."

Hull

"The local drugs partnership has led on a joint paperwork system across the drug and alcohol treatment services and all the services are using the same paperwork and have joined up assessment and review processes. Our risk management tools are also used across all services."

Devon

Pathways through treatment

People accessing treatment require options for all the different elements of their care and they may need to move between services. It is important that the pathways between organisations, and through the system of care, are clear and continuous, and that policies are in place to enable services to work jointly. For example, if a service refers someone on to a different service, it is better for that person if they do not have to repeat all the information they have already given to the first service.

The measures used to assess this criterion were: the existence of key policies to enable inter-agency working, for example information-sharing policies; personal experience of referrals to support services, for example employment and housing; the existence of clear and appropriate protocols for care planning and care coordination across agencies, and how regularly care plans were reviewed. The results of the survey of service users' satisfaction suggested a strong link between recent and regular reviews of care plans and user satisfaction.

In relation to policies supporting care planning, the results showed that 15% of the services did not have a policy to ensure that information can be shared rather than repeatedly gathered from the same person.

Thirteen per cent of services do not have a child protection policy; however, such a policy needs to be agreed with the local child protection board. Thirty-six per cent of services do not have a policy on care coordination. This recommendation of Models of Care[1] ensures that service users with complex needs receive care across the different agencies. These policies help to ensure that service users get the treatment that they need from across the whole system of treatment provided. They ensure that the right organisations and services are involved, that these services communicate with each other and know what their individual roles are. They also minimise the likelihood of the service user falling into the gaps between services or having to repeatedly provide the same information to different professionals.

When we looked at how regularly care plans were reviewed, 74% of local drug partnerships reported having excellent policies, which involved reviewing care plans within the first three months and at six-monthly intervals. However, 35% of people in structured services reported that they did not have a care plan (or didn't know if they did) and 32% said that their care plan had not been reviewed within the last three months. The satisfaction of service users is strongly linked to having an up-to-date care plan, which they understand and feel involved in, which meets their individual needs and which is reviewed regularly and as needed. It is therefore crucial that services improve the way they explain and agree care plans with service users.

Did Not Attend (DNA)/drop-out system
Evidence shows that if service users are assessed properly and provided with care that meets their needs, they are more likely to remain in treatment. There is also good evidence that service users retained in treatment for at least 12 weeks will have better outcomes. Improving retention has been a target for local drug partnerships over the last two years.

This criterion was measured using nationally collected data on retention of service users in the local drug partnership treatment system and successful discharges from treatment. (Successful discharge is defined as treatment completed, treatment completed drug-free, or being referred on.) There has been a national focus on increasing retention rates, which has led to vast improvements in this area, with 72% of local drug partnerships improving on the 2004/2005 national average for retention. Nevertheless, there is still a minority of local drug partnerships that are scoring 'weak' on these measures, performing worse in 2005/2006 than the national average for 2004/2005 and not showing significant improvement.

Figure 13: Drop-out rates per annum

	Retention	Completion
Weak – 2005/2006 rates are lower than the national mid point in 2004/2005 and have not significantly improved in the last 12 months	14%	11%
Fair – 2005/2006 rates are lower than the national mid point in 2004/2005 but have significantly improved in the last 12 months	13%	19%
Good – 2005/2006 rates are higher than 2004/2005 national mid point	72%	69%

Conclusions

Our review showed that improvements can be made across all areas of community prescribing services and care planning and coordination. These improvements would be supported by strengthening the commissioning of services, ensuring that clinical governance arrangements are in place in all organisations, and in large provider organisations that they extend to substance misuse services. For example, improving the use of clinical audit to drive improvement, ensuring staff competence and training, and adhering to best clinical practice. Having appropriate policies in place would also enable improvements to be made to ensure that services are able to work in partnership to meet the needs of people accessing treatment. In addition, the report shows the positive benefits of involving service users at all levels in their own treatment, in planning specific services, and at a strategic level in planning the treatment system.

The results also demonstrate the impact of the Government's national focus on improving target areas. This is reflected in reduced waiting times and increased retention of services users.

Improvements can be made in relation to methadone and buprenorphine prescribing. People who use heroin are often prescribed methadone as part of their treatment. The majority (95%) of services have good policies on prescribing, but some services are still prescribing insufficient doses to maintain service users and prevent the use of street drugs. Local drug practices have developed 'blanket' policies which lead to each service user being prescribed the same amount of methadone or according to a pre-determined maximum. They would benefit if prescribing was linked more closely to their individual need. In addition, more people need to be supervised during methadone consumption in the early stages of treatment.

The review measured whether drug treatment services are keeping people in treatment for at least 12 weeks. Most service users who drop out of treatment do so at a very early stage. If a person has received treatment for 12 weeks, it increases the chance of them remaining in treatment for the full length of time needed to meet their individual needs. Although there have been vast improvements in this area, a minority of local drug partnerships scored 'weak' on these measures. Fourteen per cent who scored 'weak' had fewer people in treatment for 12 weeks in 2005/2006 compared to the national average for 2004/2005.

The results show that 27% of prescribing services had not undertaken any clinical audit in the 18 months before the review. This equates to 46% of local drug partnerships having at least one prescribing service that had not undertaken any clinical audit during that period. Clinical audit is a mechanism for ensuring that people are receiving care based on best practice. It is a key element of clinical governance, the system through which healthcare organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care.

Drug treatment services are more likely to succeed if people receiving treatment have greater involvement in the process. Thirty-seven per cent of local drug partnerships scored 'good' or 'excellent' for supporting involvement and 7% scored 'weak'. This

suggests that some systems are much better developed than others. Twenty-three per cent do not have local user forums, 31% do not have access to strategic planning groups for service users and 40% do not offer training and/or mentoring for service users to enable participation in service planning and monitoring.

Improvements could also be made in relation to the consistent use of individual care plans. Every person should have a comprehensive assessment of their needs and a personal care plan outlining the best course of treatment for them. The review found that not enough service users have a care plan, with 48% of local drug partnerships being 'weak' in this area, and 32% scoring 'fair'. The level of risk assessment was of particular concern, with 70% of partnerships scoring 'weak' when assessing and managing risks for service users.

Local drug partnerships, including PCTs, could improve their commissioning of drug treatment, including substitute prescribing. Sixty-three per cent of local drug partnerships were scored as 'weak' or 'fair' when it came to assessing the detail of their specifications for community prescribing interventions.

We asked some local areas, across all ranges of performance, to give feedback on the review. Here are a selection of their comments:

"Wirral local drugs partnership has found this process extremely useful in driving forward local improvements in the treatment system it commissions."

Wirral

"Locally, the process focused attention on weakness within commissioning systems. As a result, it has enabled the partnership to direct resources to improve contracts and contract management. Changes have been put in place that are and will continue to improve service delivery. For example, development of new clear service specifications based on an outcome framework."

Bolton

"Change and improvement had already begun prior to the review. However, the process did ensure the full cooperation of some services at a very senior level. I believe that as a result of this process, partner agencies are even more committed to the change process that was underway and have a better understanding of the rationale behind it."

Barking and Dagenham

"The process has resulted in change already and has led to significant shifts in practice."

Salford

"The review has helped inform debate both within and between agencies. It reinforces the views already held that care planning and care coordination is vital for clients."

Cheshire

"The process has helped local services to think not just about the content of service delivery, but about some of the policies, procedures and principles that support the effective delivery of multi-agency services and are set up in a way that makes the services more robust than just relying on personal commitments and links between the services."

Rotherham

Recommendations

Local drug partnerships and commissioners

We recommend that local drug partnerships and commissioners:

1 ensure they have contracts in place with all service providers

2 review all contracts and service level agreements to ensure that they include detailed service specifications and expectations about service delivery

3 continue to monitor waiting times and take action to meet target waits of no longer than three weeks

4 work to ensure that primary care-led or GP prescribing is developed in partnership with specialist services to meet the need of service users, including the need for local and accessible services

5 commission and manage services to provide some out-of-hours services and enable flexibility in appointments

6 ensure that contracts require services to have appropriate clinical governance arrangements and participate in regular clinical audits

7 monitor the mix of staff competencies necessary to carry out specialist services, including doctors with a sufficient level of specialist training

8 involve service users and carers in planning what is commissioned, in new services, in providing feedback on the treatment system and in monitoring the quality of drug treatment being provided; they should also support service users and carers to be involved in this through appropriate mechanisms, such as forums, mentoring and funding

9 ensure that referral routes are in place to enable service users to have access to support services such as housing and employment

Community prescribing services

We recommend that community prescribing services:

1 ensure that contract negotiations result in contracts which provide clear specifications and expectations about service delivery

2 continue to monitor waiting times and take action to meet a target of waiting times of no longer than three weeks

3 provide some out-of-hours services and enable flexibility in appointments

4 review assessment and care planning tools making use of best practice guidance from the NTA, including the care planning toolkit[10], ensure all service users have a care plan that they have been involved in developing and which is reviewed regularly with them

5 ensure that each comprehensive assessment adequately covers all the key areas and aspects of risk and looks at how any risks will be managed

6 ensure that clinical governance arrangements are in place, establishing mechanisms to monitor their practice against guidelines, and undertaking regular reviews or audits to ensure that all staff treat all service users according to these guidelines

7 ensure that key policies and procedures are in place and followed in relation to prescribing practice, including dose titration policies

8 ensure the mix of staff competencies necessary to carry out specialist services including doctors with a sufficient level of specialist training

9 involve service users and carers in planning new services, in providing feedback on treatment and in monitoring the quality of services; support service users and carers involved in this via appropriate mechanisms, such as forums,mentoring and funding

All drug treatment services

We recommend that all drug treatment services:

1 ensure that contract negotiations result in contracts that provide clear specifications and expectations about service delivery

2 continue to monitor waiting times and take action to meet target waits of no longer than three weeks

3 review assessment and care planning tools in line with guidance from the NTA, ensuring that all service users have a care plan that they have been involved in developing and which is reviewed regularly with the service user

4 ensure that each comprehensive assessment adequately covers aspects of risk and looks at how any risks will be managed

5 ensure that policies and protocols are in place to enable joint work with other organisations, including information-sharing protocols

6 ensure that referral routes are in place to enable service users to access support services such as housing and employment

Service users and carers

We recommend that all service users and carers:

1 should be involved in agreeing what they need and how treatment will be provided

2 ask for a copy of their care plan, which should include details of who will provide the treatment and when the plan will be reviewed

3 check the Healthcare Commission website to see how well their local drug partnership has performed

4 are helped to engage in local service user forums or in other local projects, to help drive improvement in drug treatment services locally

Strategic health authorities and NTA regional teams

We recommend that strategic health authorities and NTA regional teams with responsibility for managing the performance of local drug partnerships and healthcare organisations (NHS and voluntary sector):

1 ensure that action plans are developed addressing all areas of weak performance in our improvement review assessment and ensure that implementation of these plans is closely monitored

Next steps

Regional NTA teams have used the results of our review to manage the performance of local drug partnerships. The partnerships (including PCTs) have used the results to improve their commissioning and manage the performance of local services.

We encouraged all local drug partnerships to review the results in their local area and to produce action plans for improvement. Approximately 10% of the weakest performing areas were required to produce an action plan to address any areas where they were scored 'weak', with the NTA and the Healthcare Commission providing resources to facilitate the process. We will monitor their progress, alongside strategic health authorities. The progress of partnerships' action plans and performance improvement will be monitored and performance-managed through the NTA's regional teams quarterly reviews and ongoing work with all local drug partnerships.

The information from this review will also be used to create a small number of 'sentinel indicators'. The indicators will focus on those areas most in need of improvement and will allow the NTA and the Healthcare Commission to track improvement in key areas. Performance on the indicators will be reported annually and in future years. Where there is no evidence of improvement, the NTA and the Healthcare Commission may intervene locally.

In addition, the NTA plans to do more work with the best performing areas to maintain the practice that contributed to their good performance.

This review was the first of three joint reviews into substance misuse by the Healthcare Commission and the NTA. The next review, to be conducted in 2006/2007, will look at reducing harm and commissioning. Reducing harm is an important area because of the increasing prevalence of blood-borne viruses. The Audit Commission reported in 2004 that delivery of effective services varies according to the commitment of local agencies and the quality of leadership, making commissioning systems an important area for improvement.[3]

In 2007/2008, our third review will look at diversity and residential services (inpatient and rehabilitation services). An assessment of the drug service provision for diverse groups is required urgently, so that these services can improve delivery, retention, and outcomes for the communities they serve. The Government's strategy on effective treatment addresses the need to develop residential services as a way of creating exits from drug treatment services.

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[9] National Treatment Agency (2006) *Care planning practice guide*

[10] National Treatment Agency (2006) *E-learning toolkit: care planning practice guide*

[11] Royal College of Psychiatrists and Royal College of General Practitioners (2005) *Roles and Responsibilities of Doctors in the Provision of Treatment for Drug and Alcohol Misusers*

[12] Full details of waiting times are available on the NTA website at www.nta.nhs.uk

[13] National Treatment Agency and the Department of Health (2005) *Statistics from the National Drug Treatment Monitoring System (NDTMS)*

[14] National Treatment Agency (2006) *Commissioning Tier 4 drug treatment: Guidance for purchasers and commissioners of inpatient treatment and residential rehabilitation*

This information is available in other formats and languages on request. Please telephone 0845 601 3012.

ENGLISH

આ માહિતી વિનંતી કરવાથી અન્ય રૂપે અને ભાષાઓમાં મળી શકે છે. મહેરબાની કરી ટેલિફોન નંબર 0845 601 3012 પર ફોન કરો.

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