Drug and Alcohol Recovery Pilots

Lessons learnt from Co-Design and commissioning with payment by results

Introduction

- This document is aimed at local commissioners, partners, providers and service users. It outlines the key findings and lessons learnt from the development of the eight pilots to help local partnerships design for themselves effective outcomes-based models for drug and alcohol recovery services.
- Over the last 12 months, eight pilot areas have worked with central government departments and invited experts to co-design local 'payment by results' (PbR) models for drug and alcohol recovery services. The intention now is to share the lessons we have learnt during this process for the benefit of other areas interested in adopting similar principles.
- The document includes: reasons for adopting payment by results; the basic model for the pilots; design details for the national outcomes; decisions on pricing and weighting and finally resource and support.

Co-Design Timeline

December 2010

April 2012

Co-Design: April 2011 – April 2012

- Invitations to participate
- Outcome options
- Define the National outcomes
- Modelling
- Data analysis
- **GO LIVE** 8 different models paying on the same key outcomes

Pilot area development

Procurement Process for new tenders

Negotiations with existing suppliers

Service user involvement

Contents

1. Why use payment by results?

2. Co-Designing models:
   - Key principles of model
   - LASARS
   - Different models (prime/framework)

3. Co-Designing Outcomes:
   - Freedom from drug(s) of dependence
   - Offending
   - Improved health and wellbeing
   - Employment

4. Pricing and weighting
   - Making decisions
   - Minimising gaming opportunities

5. Resources and support

Part 1: Why use payment by results?

Introduction

Payment by results is at heart extremely simple: it is about paying providers on the basis of the **outcomes achieved** rather than activities undertaken. Payment by results models should, when designed and implemented well, drive efficiencies, improve value for money, encourage new ideas and new entrants to the service provision, and deliver better outcomes for service users.

The Drug Strategy 2010 committed to introduce pilots to test how payment by results could work for drug services. The intention is that by on the basis of the outcomes we expect to see – recovery – we help free up providers to innovate rather than follow target-driven processes, and encourage them to support more people to full recovery.

After an intensive bidding process involving Drug and Alcohol Action Teams (DAATs) across England eight areas were selected to be pilots for Drug and Alcohol recovery:

Bracknell Forest, Enfield, Lincolnshire, Oxfordshire, Kent (west Kent only), Stockport, Wakefield and Wigan.

Assessors of the bids looked for…

- Specific focus on the recovery outcomes
- Innovative responses to local needs
- Evidence of a potential local market of willing providers

Part 1: Why use payment by results?

Local reasons for adopting payment by results

The eight pilots areas were keen to adopt PbR for a variety of reasons:

- To put the principle of outcome-based payment at the heart of a re-designed and re-commissioned new recovery system
- To challenge historic performance and attract new providers
- To build on a developing recovery system already in place
- To create a more efficient and effective recovery system
- To take a broad “whole world” approach to recovery
- To support clients in their recovery ambitions
- To achieve a measurable increase in the number of people exiting the services in a successful and planned way

Part 2: Co-Designing operating models

Purpose of Co-Design

Designing a PbR scheme for something as complex as drug and alcohol recovery needs extra care, attention and time to manage the risk and deliver the benefits.

The Co-design process was a new way of working where central government and local areas came together to look at risks, issues and concerns as a joint team.

The process enabled us to strike a balance between the Drug Strategy and wider Government aims being met and local areas having autonomy over designing their own models.

We designed a generic model for PbR which pilot areas were able to modify to suit their own aims and objectives.

Through co-design we agreed on the definition and measurement of a set of national outcomes.

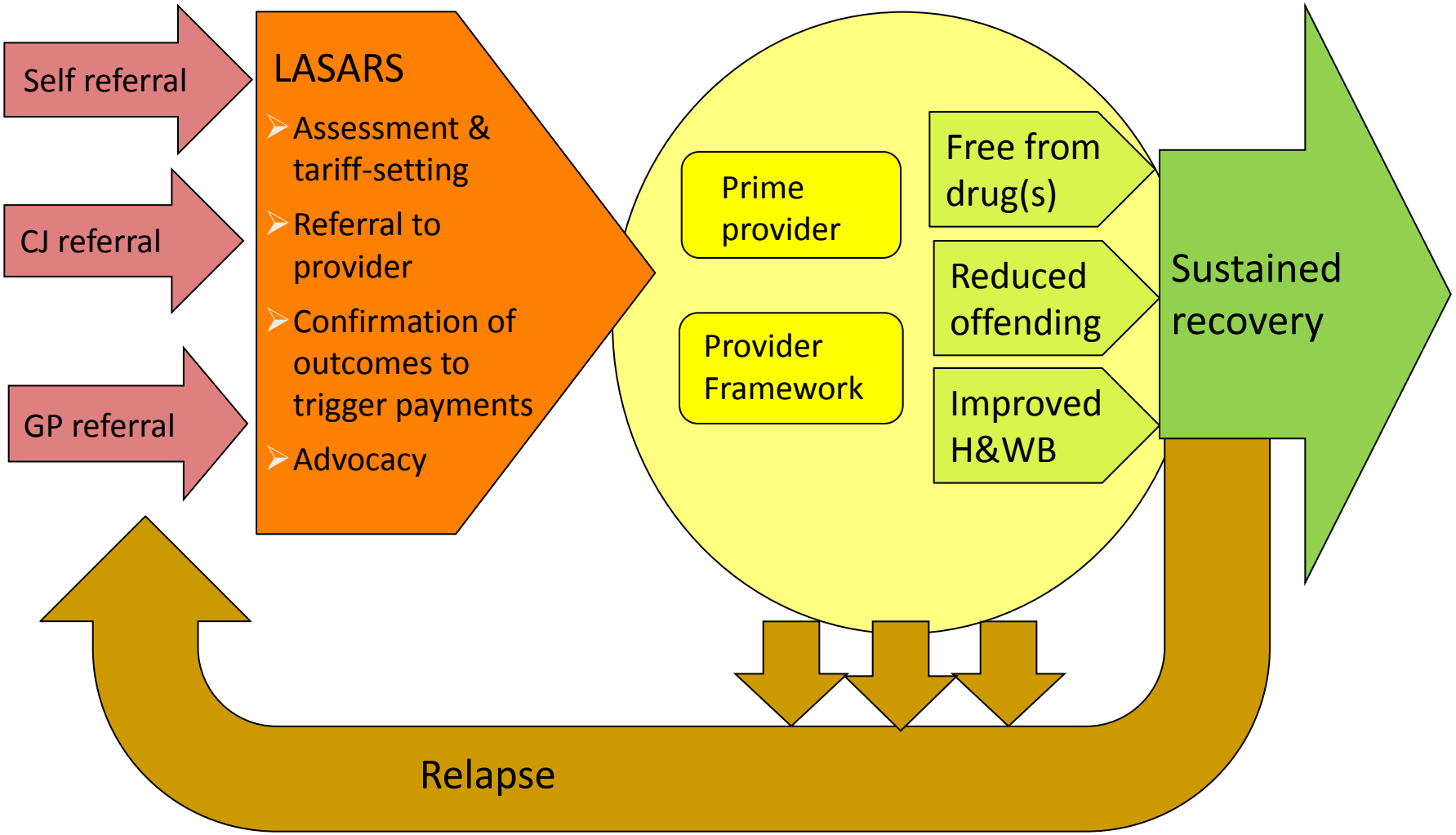
Central government departments provided baseline data for local areas on which to model future outcome-payment systems.

Pilot areas developed the payments attached to the agreed national outcomes based on their local needs.

Part 2: Co-Designing operating models

Generic model

We originally started with a generic model on how payment by results for drug and alcohol recovery could be implemented.



Part 2: Co-Designing operating models

Role of Local Area Single Assessment & Referral Service (LASARS)

LASARS are essential to the payments by results model, ensuring that service users are assessed consistently and tariffs are assigned fairly.

LASARS are required to have 3 key features:

- They need to be competent to assess and segment the treatment population
- They need to be financially independent
- They need to provide an element of service user advocacy.

Like all aspects of the pilot models LASARS have developed differently in each area to represent the needs of the service user population and the requirements of the local system and the resources available. Some are completely independent, some sit within the DAAT, and some sit within providers themselves. Some LASARS build on the long established DIP model for assessment and referral.

For those pilots who do not have independent LASARS they are implementing essential audit functions to ensure service users are being assessed correctly and to protect the financial integrity of the system.

Part 2: Co-Designing operating models

Locally determined models

The pilot areas have developed their models independently, allowing for considerable local discretion. This has resulted in eight different models reflecting the needs of the treatment populations and maturity of local treatment systems, and the different speed with which the areas expected to achieve full implementation.

The next few pages capture some of the comments, lessons learnt and questions raised by the pilot areas whilst they have been tailoring the generic model to meet local needs.

A lot of these will be familiar to commissioners, but they become increasingly important when looking at a payment by results model.

They look at 5 themes:

- Vision/Strategy
- Design
- Stakeholders
- Time/Resource
- Data and Measurement

Part 2: Co-designing operating models

The 8 models at a glance

Bracknell Forest
LASAR
Located in the DAAT
Providers
1 prime provider delivering an end to end service.
Interesting fact
Out of all 8 models Bracknell Forest have placed the largest stretch on their providers to reduce re-offending.

Enfield
LASAR
Located in the DAAT.
Providers
1 prime provider supported by an IOM provider (also commissioned on a PbR basis)
Interesting fact
Enfield have included lots of local outcomes to reflect local needs.

Kent
LASAR
Located in the DAAT.
Providers
1 prime provider delivering an end to end service.
Interesting fact
A holistic view to recovery means providers only get paid after progress on the full range of client needs.

Lincolnshire
LASAR
Located in the providers with an independent audit.
Providers
2 providers delivering the same end to end service.
Interesting fact
Strong focus on working with current providers to deliver a new service.

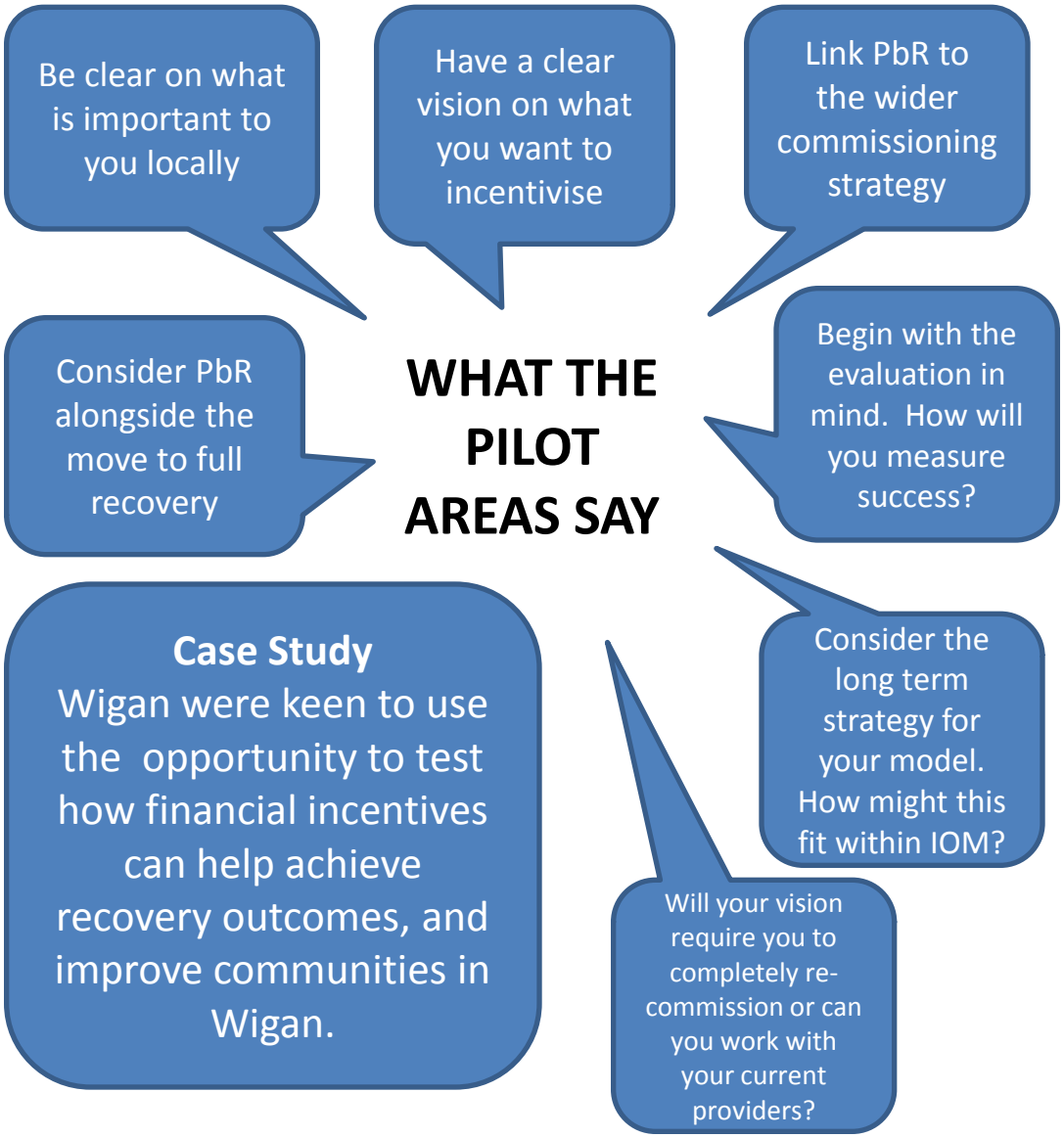
Oxfordshire
LASAR
Independent provider: Aquarius
Providers
2 providers. 1 focusing on harm minimisation and 1 on recovery.
Interesting fact
Oxfordshire use a local incentivisation scheme aimed at moving people from harm minimisation and into recovery.

Stockport
LASAR
Located in the DAAT/IOM team
Providers
4 providers offering different services to different client groups.
Interesting fact
Providers will not be in competition with each other. Instead they will be assigned different areas of service; young people aged 18-25, prescribing, psychosocial, with an overlap of 26+ service.

Wakefield
LASAR
Located in the providers with auditing taking place in the DAAT.
Providers
2 co-dependent providers.
Interesting fact
Wakefield have developed a local employment metric.

Wigan
LASAR
Located in providers. Will be audited and payments agreed by the DAAT.
Providers
3 providers. Wigan are investigating bringing in more.
Interesting fact
Wigan are assessing all clients on a cohort basis for all the outcomes.

Vision and Strategic Focus



Key questions raised

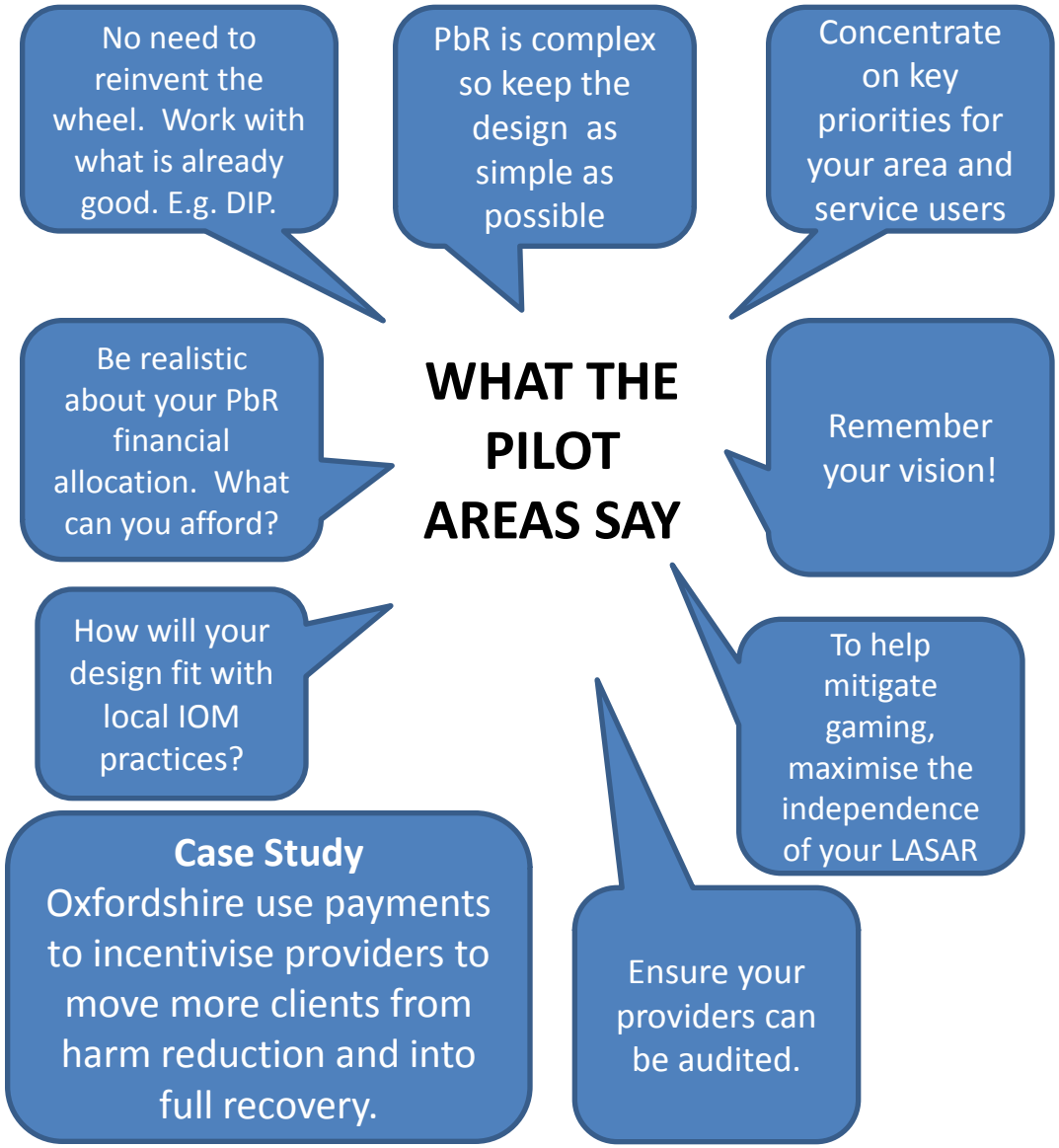
What is the motivation to do PbR?

Will the model actually change behaviours?

Is there enough competition in the market to drive performance efficiency?

Where does PbR fit into your plan?

Design of model



Key questions raised

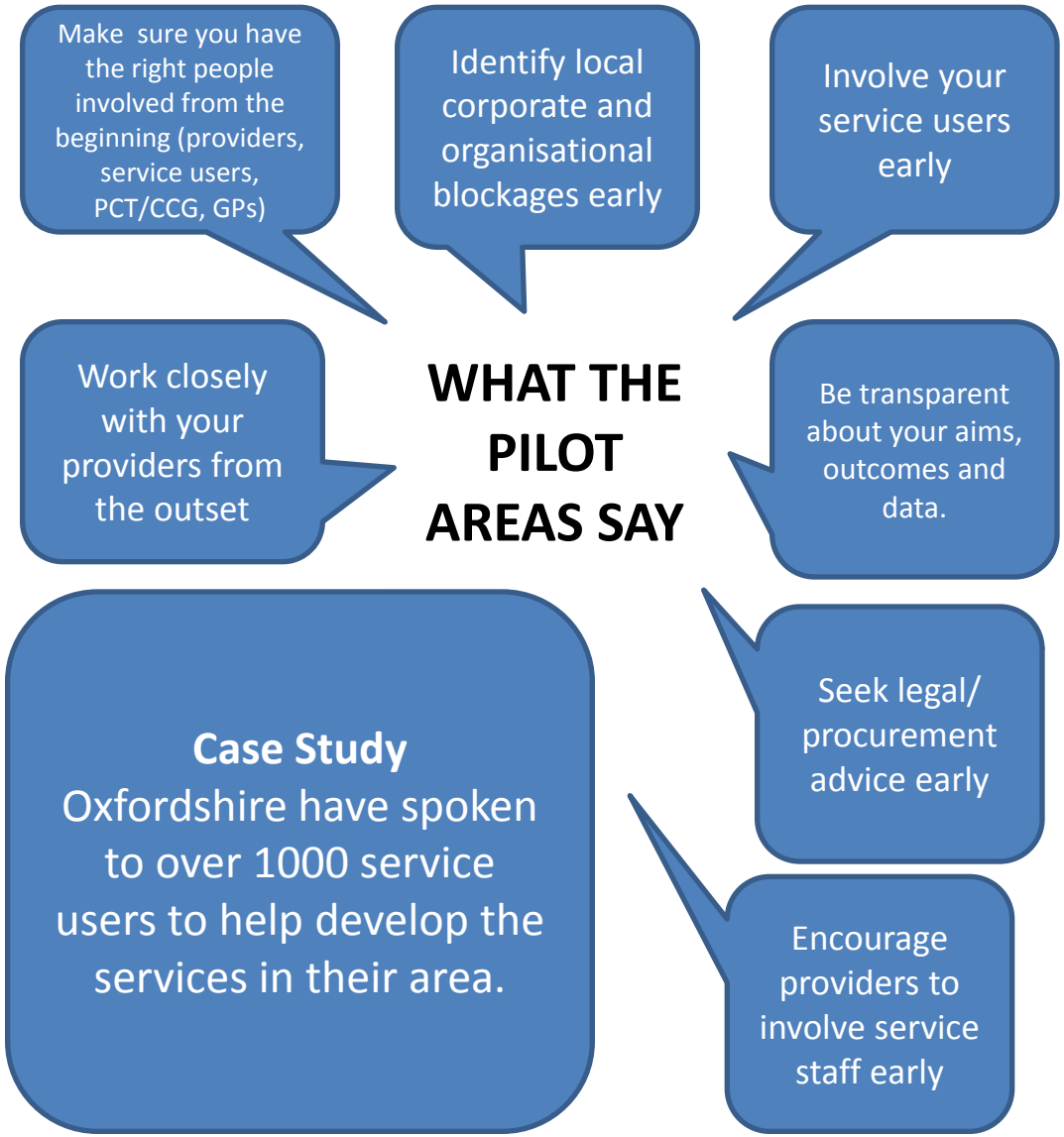
Does the design incentivise the right outcomes?

Does the design align with your budget?

Is the design stretching enough for providers?

Does your design mitigate against gaming opportunities?

Stakeholders



Key questions raised

Who are the key stakeholders? Work with those who are not engaged with PbR early.

Do you have strategic buy-in?

Is the plan to work with existing providers or re-tender?

Have you considered external stakeholders? Criminal Justice Service colleagues and Work Programme providers could be a source of additional investment.

Time and Resource

Allow plenty of time for planning. You will need more than you think

Understand the additional work this will generate (analysing data, modelling outcomes)

Tap into all the available resource you can. Finance, people etc.

Ensure staffing capacity – prioritise PbR

WHAT THE PILOT AREAS SAY

Things that took longer then expected:

- Finalising pricing and weighting
- Contract negotiations
- Designing the LASARS

Case Study

Enfield was very keen on having more local outcomes. Enfield managed to secure additional funding from the PCT in order to finance these.

Key questions raised

Commissioning on a PbR basis does take longer so give extra time to re-commisssion.

Do you have sufficient resources to design and run PbR?

Do you have the right skills in your team?

Data and Measurement

The Co-design group spent a lot of time looking at how we measured the outcomes and what data we would require to do this.

WHAT THE PILOT AREAS SAY

Work on Improving local and national data quality. E.g. improve TOPS performance

Study your baseline data. What does it tell you about past and projected performance?

Ensure data sources are robust and auditable

Have an efficient data capture and reporting system

Ask yourself if you can measure it. Do you have the right data and baseline information?

Case Study
Wigan will be measuring the re-presentation outcome on a 6 months basis. This is because they only have a 12 month contract and wish to test the outcome before re-commissioning in 2013.

Have a clear understanding of the tools to help you measure and calculate your payments

Is your measurement practical? Can it be verified and work in a tight timeframe?

Key questions raised

Do you have the right data available to measure your outcomes? Is it accurate enough and of sufficient quality?

Do you have the skills and expertise to model and analyse the data?

Part 3: Co-Designing outcomes

National outcomes

The original invitation to tender set out 4 outcome domains:

- Recovery
- Health and Wellbeing
- Reduced offending
- Employment

The full outcome definitions are available from the Department for Health website. The following section outlines the starting principles, what was considered and why we chose the option we did.

Part 3: Co-Designing outcomes

Freedom from drug(s) of dependence

Starting Principles

We wanted to incentivise providers to work with service users to reduce their drug use and work towards sustaining a drug free lifestyle

Options Considered

We considered paying only for abstinence and successful completion outcomes.

Why we chose what we did

Consultation showed commissioners and providers wanted to include some "in-treatment" improvement measures, so we included reliable change as an additional outcome.

Measuring whether successful completers re-present to treatment or CJ services was chosen as the best available proxy measure for sustained recovery

Part 3: Co-Designing outcomes

Reduced reoffending and continued non-offending

Starting Principles

We wanted to incentivise providers to work with drug and alcohol misusing offenders on their caseload to further reduce their re-offending.

Whilst we knew that drug treatment played a key factor in reducing re-offending we wanted providers to do more to address offending behaviour.

We wanted to incentivise better partnership working with local organisations such as probation, and re-engaging with prolific and priority offenders.

Options Considered

We considered measuring a reduction in offending at an individual and a cohort level.

We also considered having a binary or frequency measure.

Our advice to areas was to use a cohort, frequency measure. However we also published an individual measure for areas to use if they wished.

Why we chose what we did

We understand that the client group we work with will not always stop offending after one intervention. The cohort, frequency measure reflects this. It provides incentive for providers, whilst not unfairly penalising them for more chaotic clients.

In addition we are unable to provide data at an individual level from the centre. Areas wishing to use an individual measure will need to have robust data sharing arrangements in place locally, creating additional work and burdens.

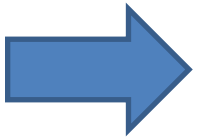
Part 3: Co-Designing outcomes

Improved health and wellbeing

Starting Principles

Helping service users to access and sustain suitable accommodation is highlighted within the 2010 Drug Strategy as a key outcome for drug and alcohol users to achieve.

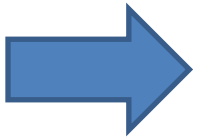
Beyond this, health and wellbeing outcomes were not included in the early prototype PbR models



Options Considered

A universal independent housing measure was impossible to identify, because of the locally-determined nature of housing support services and relevant data collection.

At a series of early stakeholder events, consistent calls were made by providers for an interim health outcome to incentivise engagement and recognise gains such as reductions in blood borne viruses



Why we chose what we did

Housing information collected on the TOP form is used to measure the housing outcome because it is a measure collected nationally, for which there is an adequate baseline available

For the same reasons TOP data is used for the general health & wellbeing outcome and the injecting outcome . These, along with the Hep B immunisation outcome, reflect the issues raised by stakeholders.

Part 3: Co-Designing outcomes

Employment - this did not become a nationally agreed outcome

Starting Principles

Understanding the links between drug and alcohol recovery and stable employment, we wanted to incentivise providers to work with service users to help them back into employment.

Options Considered

We considered having a national employment outcome on similar lines to the Work Programme.

We also considered outcomes that looked at getting service users ready for work through education, training and volunteer activities.

Why we chose what we did

We acknowledged that areas would need additional funding to fully realise a national employment outcome.

Therefore pilot areas have looked at adopting their own local outcomes based on getting service users ready for employment.

In addition government is exploring other ways in which drug and alcohol providers can work with work programme providers to help service users into employment.

Part 3: Co-Designing outcomes

The outcomes

Interim outcome

Final outcome

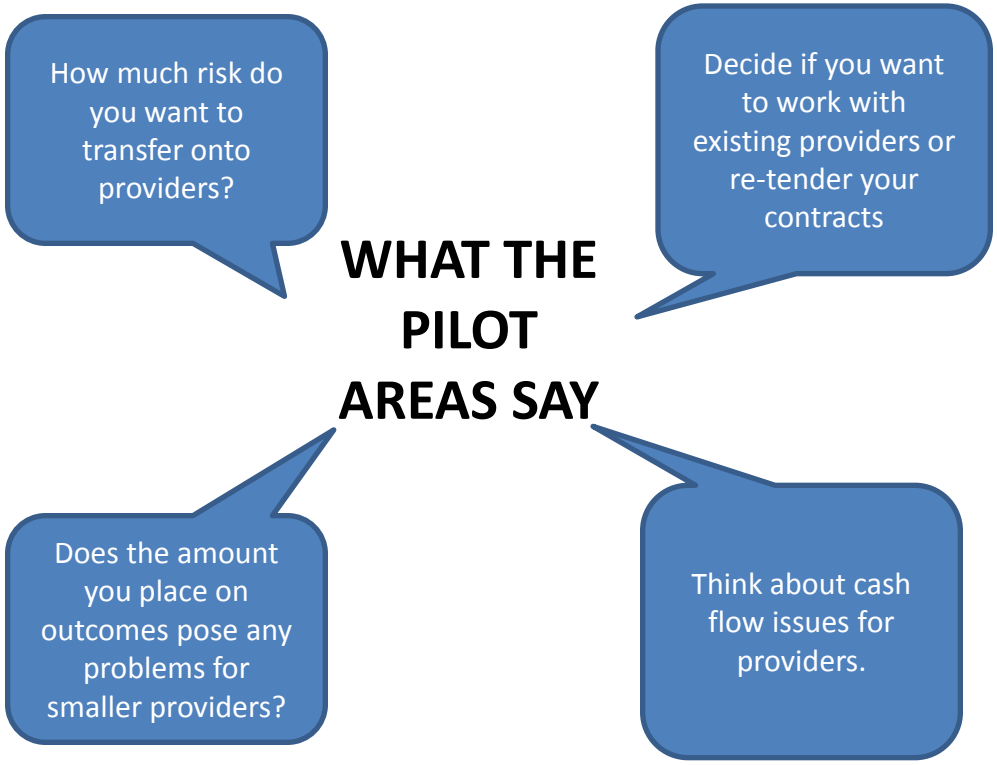
Free from Drug(s) of dependence	Reduced Reoffending	Health and Wellbeing
Drug and/or alcohol abuse significantly improved	INDIVIDUAL No offending in a 6 month period*	Ceased injecting
Abstinence	INDIVIDUAL No offending in a 12 month period*	Improved housing
Successful completion of treatment	COHORT Reduction in the average offending compared to the baseline	Hepatitis B course taken (3 injections)
Does not re-present in either the treatment or Criminal Justice System for 12 months		Health and wellbeing (client achieves a normative quality of life)

*None of the pilots chose to use the individual measures.

Part 4: Determining Pricing and Weighting

Deciding how much to place on outcomes

Each pilot area has placed very different percentages on outcome payments. The percentage of the budget being paid on outcomes ranges from 100% (with an attachment fee) to 5% in the first year.



Key questions raised

Should contracts include attachment fees?

Should larger organisations be made to sub-contract to smaller ones?

Can you strike the balance between initial, interim and final payments?

Part 4: Determining pricing and weighting

Setting tariffs

The most common approach used by all the pilot areas is to separate their caseload into complexity groups. Some clients need greater support and/or challenge to achieve outcomes than others, and should therefore attract a larger outcome payment, incentivising providers to work more intensively with them

The data plays a crucial role in setting tariffs. It allows you to look at your case mix and complexity groups, and the extent to which they have achieved certain outcomes over the baseline period. This allows commissioners to set tariffs that encourage providers to achieve outcomes for clients from all complexity levels.

This also helps to set tariffs that keep within the available budget.

Caps and floors are also helpful where there is doubt about the likely level of achievement within a fixed budget. All of our 8 pilot areas have incorporated caps and floors.

Part 4: Determining pricing and weighting

Determining payments

With the exception of the outcome for reliable change the pilot areas were free to set the price and weighting of each outcome.

As the focus on payment by results is on improving recovery outcomes it was agreed between the pilot areas and ministers that the reliable change outcome could account for only 20% of the money made available for the free from drug(s) of dependence outcome domain. 80% or more must be on sustained recovery.

In determining how much to pay on each outcome the pilot areas looked to ensure that recovery outcomes remained key, whilst at the same time ensuring sufficient incentive in the system to engage with clients who are least likely to achieve outcomes.

The payment structure also needed to reflect the provider market, making tenders attractive and competitive.

Different pilot areas have taken very different approaches in trying to achieve this. For example some have not paid on all the outcomes, concentrating on those that characterise the end result of recovery.

Part 4: Determining pricing and weighting

Using pricing and weighting to minimise gaming opportunities

Government set up a temporary Gaming Commission to look at the possible gaming opportunities in the pilots and how we can mitigate against them. The key findings of their report are:

Specific risks of Gaming fell into 3 main areas

- Assessment of clients
- Weighting and timing of payments for different PbR outcomes
- Misrepresenting or inflating success

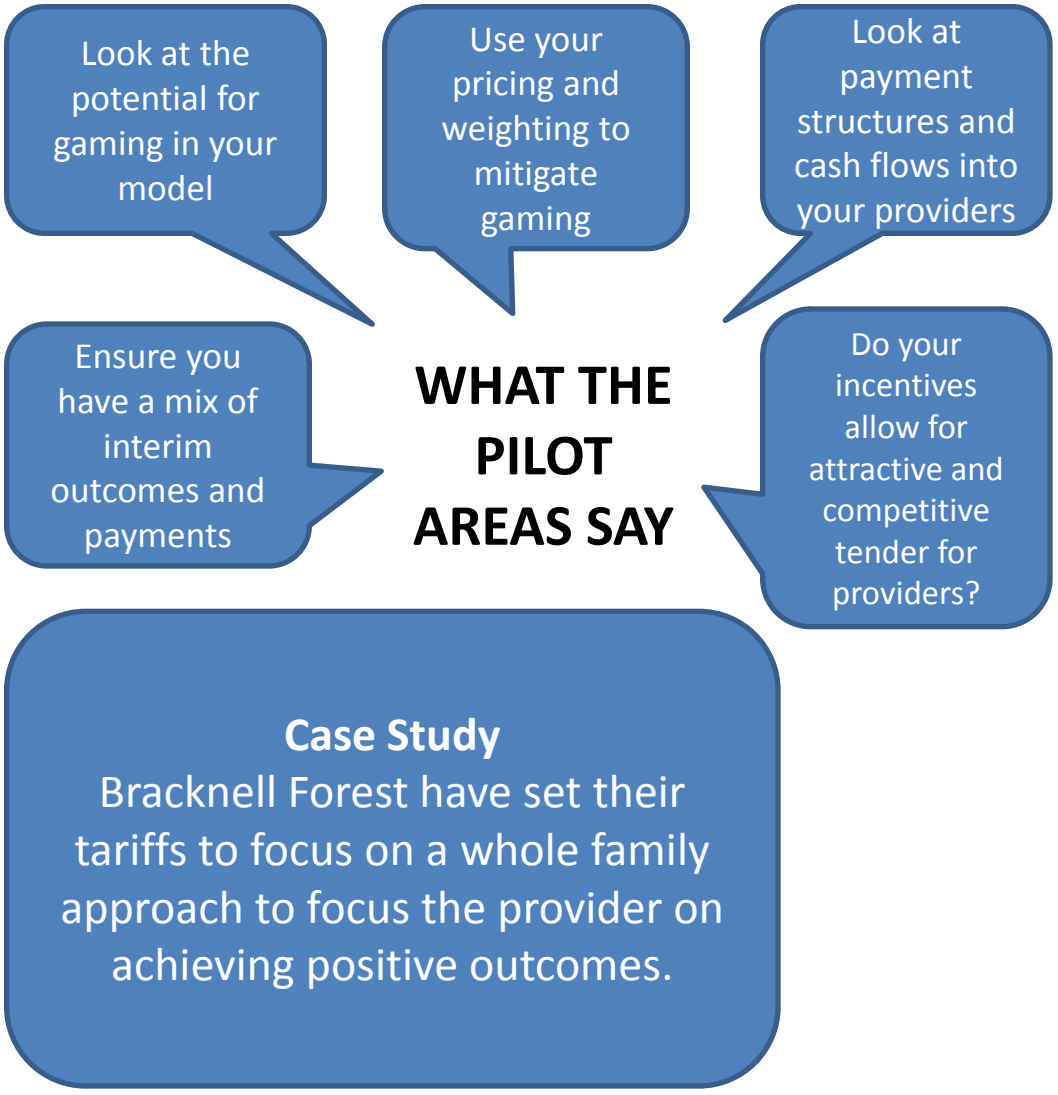
Identifying gaming and deterring it fell into 3 main areas

- Monitoring data
- Robust auditing and assessment of outcomes
- Involvement of service users in systematic, independent assessment of their views and experiences

Many of the gaming risks can be reduced or eliminated through effective setting of tariff weightings and payment structures.

Part 4: Determining pricing and weighting

Pilot areas' perspective



Key questions raised

Does your model provide any perverse incentives?

Do you want to include attachment fees?

Does your pricing and weighting reflect your vision?

Part 5: Resource and support

There are a number of sources of support available to DAATs/commissioning partnerships to help them implement PbR successfully.

Department for Health payment by results site
(http://www.dh.gov.uk/health/2011/10/drugs-recovery/)
Department for Health payment by results microsite
http://recoverypbr.dh.gov.uk/)
NTA payment by results site
(http://www.nta.nhs.uk/healthcare-pbr.aspx)
Final outcome definitions (pdf)
(http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_130714.pdf)
Gaming Commission Report (pdf)
(https://www.wp.dh.gov.uk/recoverypbr/files/2012/03/Gaming-Commission-Report.pdf)
Audit Commission "Local Payment by Results" Report
(http://www.audit-commission.gov.uk/nationalstudies/localgov/Pages/localpbr.aspx#downloads)
Integrated Offender Management
(http://www.homeoffice.gov.uk/crime/reducing-reoffending/iom/)
Drug Interventions Programme
(http://www.homeoffice.gov.uk/crime/reducing-reoffending/dip/)
Home Office payment by results site
(http://www.**homeoffice**.gov.uk/crime/reducing-reoffending/pbr/)

Thank you to everyone who contributed to the lessons learnt.

For further information please email: **pbrfordrugsrecovery@dh.gsi.gov.uk**