BRIEFING NOTE

Drug and Alcohol Recovery Payment by Results (PbR) pilots – National Service Providers Summit
DrugScope/the RSA, 21 May 2013

BACKGROUND

In April 2012 the Government launched eight 'payment by results' pilots in Bracknell Forest, Enfield (London), Lincolnshire, Oxfordshire, Stockport, Wakefield, West Kent and Wigan. The Department of Health (DH) published early performance data from these pilots in May 2013, 'Performance of Payment by results pilot areas: April 2012 to February 2013'. The initial picture is mixed, with improvements in abstinence from illicit drug use offset by a reduction in successful completions.

The DH is funding a three year independent evaluation of the pilots led by the University of Manchester. A scoping and feasibility report from the evaluation team was published in December 2012. The DH accepted the scoping report's recommendation that the evaluation should be extended for a further six months on a no-cost basis to allow for the rescheduled start of the pilots.

On 21 May 2013, DrugScope and the RSA facilitated a 'national service providers summit' in London to bring together provider representatives from the eight pilot areas to discuss the provider experience over the first 12 months and to share good practice, which was attended by provider representatives from all of the eight pilot areas.¹ The purpose was not to revisit the general arguments about PbR, but to focus on implementation issues, particularly where it was possible to make some practical recommendations. It was not attended by officials or commissioners and was conducted under the Chatham House rule.²

The purpose of this briefing is to capture key messages from the summit that relate to implementation in the first twelve months.

¹ The RSA acted both as a neutral facilitator in its remit as an institution concerned with research and innovation, and as one part of the consortium of providers in the West Kent PbR pilot.
² The meeting was also attended by observers, including representatives of the independent evaluation team. Some service providers involved in delivering the PbR pilots were not represented at the meeting, although all the pilot areas were represented by one or more provider.
KEY MESSAGES

1. **Building recovery in communities.** A number of providers commented that PbR was supporting a recovery approach by providing an initial catalyst and ongoing focus for system change. For example, the high profile of PbR could support the engagement of other sectors and more integrated approaches - for example, housing and employment support (but see point 7 below). It was recognised, however, that the precise impact of PbR on recovery is difficult to isolate, and that a full evaluation is needed, to include comparison with progress outside the pilot sites. A particular question was raised about how well PbR is supporting the mobilisation of community resources, including families and friends and of how service users were involved. Some providers managing multiple services felt that there had been similar improvements in support for recovery in other areas where they were not working to PbR contracts.

2. **The context: system change.** PbR is being implemented during a period of policy and system change for drug and alcohol services, including the increased focus on recovery, the abolition of the National Treatment Agency and the absorption of its functions into Public Health England, and the transfer of responsibility for drug and alcohol services to local authorities. If recovery is about wider economic and social inclusion then the evaluation of the PbR pilots also has to take into account a range of economic and social resource factors, including public service cuts. This contributes to the challenge of isolating the impact of PbR and places significant demands on both providers and commissioners to navigate new systems and adapt to a changing environment. This will impact on implementation and performance of the PbR pilots in a number of ways, and will need to be taken into account in evaluation.3

3. **Transition costs and data issues.** All the pilot areas emphasised the time and resources required to manage the transition to PbR arrangements – system change ‘comes at a cost’. These included data collection and management, introducing assessment processes and supporting workforce to adapt to PbR. This was compounded where PbR contracts had been awarded to new providers who were simultaneously managing a transfer of clients, staff transferred in accordance with TUPE requirements, etc.4 A recurring issue was the development and management of data systems for PbR. In addition,

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3 A particular issue is the proliferation of PbR schemes that impact on drug and alcohol treatment – including the Work Programme, plans for Transforming Rehabilitation, Troubled Families and a range of local PbR schemes and initiatives. It was felt that it is often falling to providers to ‘make the connections’, where this might be more effectively co-ordinated by commissioners (Health and Wellbeing Boards could provide one vehicle for this). It was noted that there is an increase in more ‘generalist’ commissioning at local level (for example, responsibility for substance misuse transferring to public health), and that this creates opportunities to ‘join up’ initiatives, alongside risks of loss of specialist knowledge and experience.

4 It was also reported that some providers might use model change to subvert TUPE, which could destabilise workforces and put at risk people who may be in recovery themselves.
the pilot sites are ‘trailblazers’ for new approaches and learning and this is placing additional costs on service providers (and commissioners), which need to be recognised and supported.

4. **Gaming.** Some providers commented on ‘gaming’ that occurred before the implementation of PbR, particularly inheriting data from previous providers that recorded people as ‘in treatment’ who had not been in contact with services for some time. This has had a direct impact on the projections that have informed the implementation of PbR, including financial modelling and assessment of performance.

5. **Assessment and referral (LASARs).** Some areas reported that service users had questioned the purpose of LASAR (Local Area Single Assessment and Referral Service) assessments. Issues were raised about the standard and quality of LASAR assessments; training, supervision and support for LASAR assessors; and the impact on providers (including withholding payments) where service users failed to attend LASAR reviews (particularly final reviews). It was commented that service user experience of LASAR assessment is a factor in attrition and quality of treatment engagement (with implications for assessment of provider performance). The LASAR approach can mean that a service user’s first contact with the system is not therapeutic, but part of payment validation. LASARS were perceived to have made inappropriate referrals in some areas. This impacts on provider (and PbR) performance, and may have contributed to low figures for successful completions.

6. **Workforce engagement.** Some drug and alcohol workers are suspicious of PbR, which they perceive as prioritising ‘profit’ over care for service users. A significant early challenge for providers had been to get staff teams ‘on board’ with PbR (including staff who may have been TUPE-ed into services following competitive tendering of PbR contracts) as there can be mixed messages and misperceptions. There is a particular need for training and support for staff on the implications of PbR for their work with service users. For example, there were reports of staff being over cautious about exiting service users from treatment because of misplaced concerns about re-presentation.

7. **Reputational issues.** It was observed that PbR remains a ‘suspect approach’ for some VCSE organisations in health and social care. This can contribute to negative reactions to service providers with PbR contracts, as well as an assumption that they are making significant income from PbR and therefore have substantial resources to buy in support. Where service providers have rejected referrals from other services on clinical grounds, for example, this can be misperceived as ‘gaming’ to exclude service users less likely to achieve PbR outcomes.
8. **Relationships with commissioners.** There was an expectation that following the national co-design process there would be local co-design with provider involvement, but this was not felt to have happened in many areas. There were also reports of strained relationships between commissioners and providers in some areas with increased potential for disputes over data and performance outcomes and payments. Once relationships deteriorated this could be difficult to reverse, particularly given the strain on relationships due to the pressures of commissioning cycles. It was commented that tendering exercises during pilots could make it more difficult to build trust, share learning and achieve genuine co-production, as well as diverting the energies of commissioners and providers from PbR implementation. It was noted that there is a lot of good commissioning, and providers need to consider how they recognise and support this. Where commissioners were effectively engaging with and responding to partners, an open dialogue and willingness to be flexible and change initial assumptions/tariffs when the data suggests models are not working seems to be key to effective PbR implementation. It was acknowledged that the high profile of PbR places political pressures on commissioners who have responsibility for a ‘flagship’ initiative, and may therefore find it difficult to loosen control over delivery or acknowledge and address problems identified by providers.

9. **Inclusion of alcohol.** A particular concern was raised about the adequacy of PbR outcomes and tariffs for alcohol, particularly as this is a substantial case load for some PbR providers. It was felt that alcohol was an ‘add on’ to PbR. The outcome framework was not felt to capture progress other than abstinence, and the tariff structure was not felt to work for alcohol. The alcohol tool’s effectiveness was questioned.

10. **Cash flow.** Cash flow was an issue for some smaller services, particularly where contracts were 100 per cent payment by results (i.e. no ‘upfront’ funding). One commented that should another PbR contract be offered in an area where they could work and build on their experience, they would not be able to bid for the contract as they would not be able to manage the additional risk and up-front investment.

**RECOMMENDATIONS AND LEARNING POINTS**

There were different overall assessments of the merits and potential of PbR. A common theme was a sense that PbR had been introduced rapidly (a ‘full throttle’ approach), which has been an issue for implementation, and that it is therefore important to reflect upon early lessons. The political interest in PbR was welcome, but it was felt that it could make it more difficult for providers and commissioners to identify and address implementation problems, given the political capital invested in
the ‘success’ of PbR. A number of practical recommendations were made by service providers or implicit in the discussions.

Recommendations include:

1. The transition to PbR places significant burdens on service providers, particularly around data systems. The early performance of PbR may have been enhanced if these transitional challenges had been recognised at the design stage, with more support provided for implementation. One proposal was that PbR could operate in ‘shadow’ form for an initial phase (for example, the first 12 months) to support co-design, development and fine-tuning of systems before operationalisation of the payment system.⁵

2. The transition also places additional burdens on commissioners – particularly during the design phase – and potentially also on service users in the transition period where a new service is coming into delivery under PbR. Effective mechanisms (including service user involvement in co-design and evaluation processes) are needed to ensure system changes do not impact negatively on service users.

3. Data requirements to demonstrate outcomes and confirm payments are more onerous in pilot areas with large numbers of targets. It was commented that these costs should be taken into account in designing local PbR systems, and that there were lower transitional and data costs where PbR arrangements had a manageable number of clear and ‘easy to measure’ outcomes.

4. LASARs (and equivalents) were a particular concern for service providers in the first 12 months and arrangements should be reviewed. One proposal was that service providers should conduct assessments themselves, subject to an independent auditing process to address concerns about ‘gaming’. At least one pilot area is developing such an approach.

5. The need to explain PbR to the workforce and provide support for staff has been a key issue for service providers, but does not appear to have been considered during the national policy discussion. Guidance and resources for staff on how PbR works, ‘recovery in PbR’ and what it means for their day-to-day work with service users would be helpful, along with guidance for service managers on workforce issues around implementation of PbR, and provision for staff training.⁶ It would also be beneficial to engage service users on PbR, including addressing fears by providing information (including supporting staff to do this).

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⁵ Some pilot areas had intended to provide for an initial shadow period, but this had not happened in practice.
⁶ In particular, it would be helpful to engage staff in discussion of how PbR and recovery could be mutually supportive and complementary approaches, and not simply to focus on process and financial issues.
6. The impact of negative perceptions and misplaced expectations from other local services is an issue. Policy-makers, commissioners and providers should consider how they can develop information and communication tools to inform/engage other local stakeholders around PbR.

7. There is a particular need to review the approach to alcohol recovery in the PbR pilots.

8. Perhaps the biggest issue and challenge to emerge from the service provider summit was the need for local mechanisms and forums to support on-going co-design underwritten by constructive relationships between commissioners, providers and service users. We hope that the messages from the summit can contribute to initiating and framing constructive local dialogue. In addition, further consideration should be given to the relationship between tendering exercises and co-production with providers developing a ‘learning culture’ around PbR.

9. Providers said they could benefit from more support and training to equip them to work creatively with commissioners to develop opportunities in a PbR framework (for example, innovation). Conversely, this requires a ‘letting go’ by commissioners. The high profile of PbR had placed pressures on commissioners who may have been reluctant to loosen control over delivery. Further consideration needs to be given to how this can be best achieved.

10. Finally, one of the motivations behind the national providers’ summit was what was perceived as limited opportunity for service providers in different PbR areas to share their experiences, including exchanging ideas on good practice. Further support could be provided to support an on-going dialogue between service providers and dissemination of good practice (e.g. on working with LASARs, messages for workforce and approaches to local co-design). DrugScope and RSA would welcome opportunities to continue to support this work going forward.

About the RSA

The RSA (Royal Society for the encouragement of Arts, Manufactures and Commerce) is an enlightenment organisation committed to finding innovative practical solutions to today’s social challenges. Through its ideas, research and 27,000-strong Fellowship, it seeks to understand and enhance human capability so we can close the gap between today’s reality and people’s hopes for a better world.

And, potentially, elements of wider local ‘recovery systems’.
The RSA is registered as a charity in England and Wales no. 212424 and in Scotland no. SC037784.

Further information is on the RSA website at http://www.thersa.org/

About DrugScope
DrugScope is the national membership organisation for the drug and alcohol field and the UK’s leading independent centre of expertise on drugs and drug use. We represent around 450 member organisations involved in drug and alcohol treatment, young people’s services, drug education, criminal justice and related services, such as mental health and homelessness.

DrugScope is a registered charity (number: 255030).

Further information about DrugScope – including becoming a DrugScope member and member benefits – is available at http://www.drugscope.org.uk/

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