Scoping & Feasibility Report
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Written by

the PbRDR Evaluation Team

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Preface
The reporting arrangements for the Drug and Alcohol Recovery Payment by Results Evaluation include a requirement for the evaluation team to provide a comprehensive Scoping & Feasibility Report in the first year of the evaluation. Release of funding beyond a 24 month break point in the contract is conditional on satisfactory assessment and review of the scoping and feasibility report, including refined proposals for the evaluation of outcomes.

This report provides an integrated overview of this multi-strand project, each of which is led by different partners within the consortium. Chapters 1, 2 (except section 2.3) and 3 have been peer-reviewed in accordance with RAND Europe’s quality assurance processes. In addition, the report has been subject to peer review by Department of Health reviewers.

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Executive Summary

In April 2011 the Department of Health announced that eight local areas had been selected to pilot a new approach to commissioning and delivering drug and alcohol misuse treatment. Under these ‘payment by results drug and alcohol recovery pilots’, a proportion of the payments to providers are linked to specified outcomes for service users. The ultimate outcome that providers are expected to achieve under the PbR pilots is ‘recovery’ from problems relating to drug and alcohol misuse. The purpose of the PbR Pilots is to develop and test out new approaches to the commissioning and delivery of drugs and alcohol recovery systems that reward achievement of this outcome. The ‘expected benefits’ of PbR include: improved commissioning and more productive and outcome focussed discussions between commissioners and providers; more investment in clinically and cost-effective interventions; greater use of benchmarking; more innovation, market entry and competition; improvements in efficiency; and greater choice for service users.

The DH (jointly with other government departments) has commissioned an evaluation of the PbR Pilots programme. This evaluation will support future policy-making by providing a rigorous and independent, formative and summative, evaluation of the pilots programme. The aims of the evaluation are to: robustly assess the effectiveness of the PbR pilots; undertake an economic evaluation of the PbR pilots programme; and disseminate lessons for ensuring the quality, effectiveness and efficiency of Drug Recovery PbR models in the future.

To meet these aims, the evaluation includes process, impact and economic components, will be carried out in all eight pilot sites, and will compare provision before and after the introduction of the PbR pilots. The evaluation will analyse data from in-depth interviews with a range of stakeholders, economic data about the pilots and centrally-available outcomes and impact data.

This report is the first publication from the evaluation team, designed to meet the requirement to provide a comprehensive Scoping and Feasibility Report within the first year of the evaluation. It describes issues emerging in the early implementation phase and the lessons learned from the stakeholder liaison undertaken to ensure and document mutual understanding of requirements, data availability, and key outcome measures.

The original research questions have been refined in the light of four main areas of activity: review of the policy background and the interest in PbR across a range of government departments; a critical assessment of the existing evidence and literature on outcome measures for individuals in drug and alcohol treatment; initial analysis of the main themes arising from the first key stakeholder interviews; and scoping contacts on data availability and discussion of the feasibility and appropriateness of the proposed research methodology.

The scope of the proposed evaluation has been extended to address the research questions that have arisen in the evidence reviews and the initial stakeholder interviews. The overall project design is robust to this extended scope and the proposed analyses have been confirmed as feasible. To account for the re-scheduled start of the pilot programme, we propose a (no-cost) six month extension to the quantitative elements of the evaluation.
Chapter 1 Introduction

In April 2011 the Department of Health (DH) announced that eight local areas had been selected to pilot a new approach to commissioning and delivering drug and alcohol misuse treatment. Under the ‘payment by results drug and alcohol recovery pilots’ (‘PbR Pilots’), providers are funded on a payment by results (PbR) basis: rather than being paid in-full for services up-front, at least some of the payment will only be made if providers improve outcomes for service users.

The ultimate outcome that providers are expected to achieve under the PbR pilots, and which is central to the current Drug Strategy (HM Government, 2010b), is ‘recovery’ from drug and alcohol use – living a drug-free life, no longer dependent on drugs or alcohol or on substitute prescribing. The purpose of the PbR Pilots is to develop and test out new approaches to the commissioning and delivery of drugs and alcohol recovery systems that reward achievement of this outcome.

In the Invitation To Tender for the evaluation of the PbR Drug and Alcohol Recovery Pilots, the DH set out the following ‘expected benefits’ of PbR:

- More productive and outcome focussed discussions between commissioners and providers, and improved joint commissioning of services
- More investment in proven interventions, with best practice service models underpinned by evidence of clinical and cost effectiveness
- Bench-marking for providers and commissioners
- More innovation, new entrants to the market, and increased competition
- Improved efficiency, with money following the individual
- A more user led and focussed approach, with greater choice through an incentivised market.

1.1 Evaluation of the PbR Pilots programme

The DH, in partnership with the Home Office, Ministry of Justice, Department for Work and Pensions, Cabinet Office and National Treatment Agency for Substance Misuse, commissioned an evaluation of the PbR Pilots programme. This evaluation aims to support the programme by providing a rigorous and independent, formative and summative, evaluation of (a) the extent to which these anticipated benefits are realised across the pilot sites, and (b) whether there are (positive or negative) unintended consequences of introducing financial incentives focused on outcomes.
The aims of the evaluation are to:

- Robustly assess the effectiveness of the PbR pilots against key process and outcome measures in the domains of treatment, offending, employment, and wider health & wellbeing.
- Undertake an economic evaluation of individual PbR pilots and the PbR pilots programme as a whole.
- Identify and disseminate (in collaboration with DH and government partners) lessons for ensuring the quality, effectiveness and efficiency of Drug Recovery PbR models in the future.

The research questions that will be addressed by the evaluation include:

- What funding model is used in each of the pilot schemes, what services do they provide and how effectively have these been implemented?
- What other services are provided that may impact on the PbR service provision and outcomes?
- Has the introduction of PbR commissioning resulted in new or additional services or otherwise changed the landscape of provision?
- What is the level and nature of referral to, take up of and engagement with the appropriate services? Does this vary across different types of service users, and has the introduction of PbR had any impacts on treatment accessibility?
- What are participants’ and stakeholders’ perceptions of the services and their impact, and are users satisfied with the services?
- What do these services cost to set up and run?
- How do changes in recovery based outcomes, achieved by the PbR pilot sites, compare to non PbR services within the study timeframe?
- Is there a significant difference in the time taken to achieve these outcomes?
- To what extent can the differences between the two groups be attributed to PbR?
- What is the impact of PbR on commissioner and provider behaviours? Does an agreed recovery focus lead to pooling of budgets, reduced duplication, more innovation, and stimulation of the provider market?
- Are there unintended as well as intended consequences of adopting PbR? Are any spillovers positive or negative and, on balance, are the consequences beneficial?
- What are the direct and knock-on cost consequences of the schemes, in terms of treatment services and related health and criminal justice services?

To achieve these objectives and address the aims and research questions, the evaluation of the PbR pilots includes both process and outcome components, will be carried out in all eight pilot sites, and will compare provision before and after the introduction of the PbR pilots in the pilot and non-pilot sites. The evaluation will analyse data from in-depth interviews (with commissioners, providers, services users and wider stakeholders) alongside monitoring data, economic data about the pilots and centrally-available outcomes and impact data.
1.2 The aim and structure of this report

This report is the first publication from the evaluation team, designed to meet the requirement to provide a comprehensive Scoping and Feasibility Report within the first year of the evaluation. Release of funding for the evaluation beyond 24 months is conditional on satisfactory assessment and review of the scoping and feasibility report, including refined proposals for the evaluation of outcomes.

The structure of this report is as follows:

- Chapter 2 details the relevant policy background, including the call for a recovery focus in the delivery of drug and alcohol treatment, the drive for localism in service delivery and the interest in PbR across a range of government departments.
- Chapter 3 provides a critical assessment of existing evidence and literature on outcome measures for individuals in drug and alcohol treatment and implications for the evaluation.
- Chapter 4 offers a narrative overview of the main themes arising from the first key stakeholder interviews undertaken as part of the process evaluation.
- Chapter 5 describes our scoping of the future stages of, and our development of refined approaches to, the evaluation.
- Chapter 6 concludes with a summary of the feasibility of the proposed research.
Chapter 2 Background and policy context to Drug and Alcohol Recovery Pilots

This chapter focuses on the background and policy context to the Drug and Alcohol Recovery Pilots in two sections. The first section reviews the relevant policy background to the development of the PbR pilots. This background includes the recovery focus in the current Drug Strategy as well as the encouragement of locally-driven and outcome-focused approaches to commissioning public services.

The second section sets out findings from a Rapid Evidence Assessment (REA) of the literature on Payment by Results (PbR) with the aim of describing the contexts in which PbR has been used and in which it is currently being piloted. The section also reviews available evidence as to the potential effects and impacts of PbR, and identifies any critiques of PbR by researchers and others working in relevant fields.

2.1 The recovery agenda

The 2010 Drug Strategy aims to change the way in which treatment for drug and alcohol misuse is delivered. Whilst the previous Drug Strategy included a stated intention for ‘drug users to achieve abstinence from their drug … of dependency’ (HM Government, 2008, p. 28; National Treatment Agency for Substance Misuse, 2010, p. 5), the 2010 Strategy claimed that the emphasis had been on harm reduction, encouraging individuals to enter and stay in treatment. In particular, the current Strategy acknowledges that substitute prescribing continues to have a role to play in the treatment of heroin dependence, both in stabilising drug use and supporting detoxification, but aims to ensure that all those on a substitute prescription engage in recovery activities:

“We will create a recovery system that focuses not only on getting people into treatment and meeting process-driven targets, but getting them into full recovery and off drugs and alcohol for good. It is only through this permanent change that individuals will cease offending, stop harming themselves and their communities and successfully contribute to society” (HM Government, 2010b, p. 18)

1 The methodology and approach to the REA is summarised in Appendix A.

2 Harm reduction typically refers to interventions, programmes and policies that aim to ‘reduce the health, social and economic harms of drug use to individuals, communities and societies’ EMCDDA (2010).
Of course, substitute prescribing and the goal of drug recovery are not mutually exclusive, but the relative focus on these goals has differed between Strategies.  

“We need to ensure OST is the best platform it can be, but focus equally on the quality, range and purposeful management of the broader care and support it sits within.” (NTA 2012b)

‘Recovery’ and ‘recovery capital’ (Dennis, Foss, & Scott, 2007) are not new terms to the drugs and alcohol field. Whilst there remains some divergence of views about what exactly recovery entails and how it is measured (Daddow & Broom, 2010), the term is intended to represent a holistic approach to improving outcomes for those who go through treatment (Wise, 2010), typically including:

- A focus on the individual drug user, their family and community
- Meeting needs for housing, education, training and employment
- Support from peers and family
- Addressing labelling and stigmatisation (UKDPC, 2008)

A recovery focus is, therefore, part of the contemporary drug policy landscape in England and Wales. As far as possible, the evaluation of the PbR Pilots aims to investigate the effect of the financial incentives provided by PbR, as compared to an outcomes-focused commissioning approach without financial incentives.

2.2 Localism

The PbR Pilots are part of the localism agenda, the ‘key principles’ of which are:

“To free up local authorities to enable them to be innovative in the delivery of services, rather than merely seeking to raise performance against centrally established criteria to achieve good inspection results. Local authorities will have the freedom to deliver services in ways that meet local needs, and will be accountable for those services to their electorates. These principles are key elements of localism” (Department for Communities and Local Government, 2011, p. 7).

The Coalition Agreement set out a commitment to ‘promote decentralisation’, moving power from central government to ‘local councils, communities, neighbourhoods and individuals’ (HM Government, 2010a, p. 11). There followed a Localism Bill and similar commitments to decentralisation in the Open Public Services White Paper (HM Government, 2011, p. 11) and the 2010 Ministry of Justice White Paper, which noted a desire to ‘free local managers, professionals and volunteers from central control’ (Ministry of Justice, 2010, p. 5). A number of policy announcements - abolishing the Audit Commission, the introduction of GP (General Practitioner) commissioning, and proposals to replace police authorities with directly elected Police and Crime Commissioners (PCCs) – are all policies with stated aims of handing power to local-level decision makers (Lowndes & Pratchett, 2011).

Drug policy also has features of ‘localism’. The Home Secretary’s introduction to the Drug Strategy states that it ‘sets out a shift in power to local areas’ (HM Government, 2010b, p. 2). Of course, commitments to devolve power locally are not necessarily new or exclusive to the 2010 Strategy. For example, the 2008 Drug Strategy stated that ‘local areas will have more flexibility to determine their response to the drugs which are causing the greatest harm to their communities’ (HM Government, 2008, p. 12).

The PbR Pilots ‘fit’ with localism to the extent that treatment services are commissioned locally, Drug (and Alcohol) Action Teams or local authorities select the providers, and areas are accountable for delivery. At the same time, outcome measures for the pilots as well as the development of the models used by local pilot areas, were devised through a ‘co-design’ process, involving both government and local stakeholders. The process evaluation of the PbR pilots will investigate the balance of local and central leadership in the design, development and implementation of the pilots and, to the extent possible, the impact of this balance.

2.3 Payment-for-performance in health care: international evidence

One mechanism adopted in health and social care systems in which there is a separation of the purchaser and provider roles is the linkage of payment to aspects of performance. This mechanism is known by several labels including payment-for-performance (P4P) and payment by results (PbR). Under such systems providers are reimbursed on a conditional basis, usually based on their achievement of specific scores on process targets or outcome measures. The particular objectives and tariff structure has varied between schemes but generally schemes have conformed to the above definition. Such an approach has been identified as a means by which the purchaser can create conditions whereby the provider may not behave as though there is an absence of competition by explicitly linking payment to achievement of given targets (Cabinet Office, 2011)

The international evidence base in relation to P4P is mixed and inconclusive. Evidence from the United States and UK suggests that P4P improves particular process aspects of chronic disease management (Rosenthal et al. 2006; Doran et al. 2006), but these effects are often short-term only (Christianson et al. 2008; Campbell et al. 2008). Flodgren et al (2011) conducted a Cochrane review of the effects of P4P in health care, finding four previous literature reviews relating to 32 studies. Their review indicated that financial incentives may be an effective instrument for changing the behaviour of health care providers, but that the current evidence base is methodologically weak and limited in its generalisability and completeness. In general, studies have examined the impact of P4P on process measures of clinical quality and not the impact on health outcomes. An earlier systematic review, which included a wider range of studies, concluded that evaluations showed the full spectrum of possible effects, with the effects depending on design choices and the context in which P4P was introduced (van Herck et al, 2010).

The largest payment-for-performance scheme introduced in the UK is the Quality and Outcomes Framework (QOF), which was introduced for general practices in 2004. The QOF rewarded providers of primary care services for achievement on a large number of evidence-based quality indicators, particularly emphasising the management of common cardiovascular conditions. The introduction of
this P4P scheme was intended to encourage: (i) greater plurality of provision of primary care services; (ii) greater access to care and patient choice; (iii) more flexible contractual arrangements; and (iv) increased focus on paying for ‘performance’ (DH, 2000). There is a large volume of papers that have considered the effects of the QOF, with modest effects shown on the process aspects of quality that were incentivised and uncertain effects on costs, professional behaviour and patient experience (Gillam et al, 2012). The key lesson from this evidence base is that attribution is troublesome – a problem exacerbated by the lack of control sites as the QOF was adopted universally by all general practices at the same time.

2.4 “Payment by Results” in the UK: a brief overview

The earliest use of PbR in the UK was by the Department for Work and Pensions in the New Deal initiative (Cumming, 2011), and in subsequent years PbR schemes were introduced in ‘welfare to work’ policies (Department for Work and Pensions, 2008). Under these arrangements, the Department for Work and Pensions held outcome-based contracts with private and voluntary providers of ‘Pathways to Work’ programmes. These providers were paid 30% of the contract value on taking on a client, and further payments to the provider are made if clients found and stayed in a job (Hudson et al, 2010).

PbR has also been central to the system through which hospital care, and increasingly other care, is financed in England. This financing system, in place since 2003, is termed ‘Payment by Results’, and ensures hospitals are paid according to the number and type of patients that they actually treat, rather than through up-front block grants. Below, we provide a simplified account of how this system works, and identify any potentially relevant lessons for the Drug and Alcohol PbR Pilots.

The PbR system for healthcare is based on assigning each individual patient’s stay in hospital into a payment category. This is done through the use of Healthcare Resource Groups (HRGs). These HRGs are groupings of clinically-similar treatments that use common levels of healthcare resources (Audit Commission, 2005; Farrar et al., 2007). Each HRG is assigned a national tariff, which determines the amount that NHS purchasers (currently, Primary Care Trusts) pay for a stay in hospital of a particular type. Hospitals are thus paid for both the volume of work they do and the complexity of the work they do.

The NHS financing system is described as ‘payment by results’. However, it does not make payments conditional on achieving particular improvements or specified outcomes. Arguably such a system might be better called ‘payment for activity’ or ‘activity-based financing’ to ensure it is distinguished from current understandings of PbR used in the Drug and Alcohol Pilots. Nevertheless, the introduction of this payment system in health represented a departure from previous financing based on block grants, under which providers were paid a fixed amount regardless of activity undertaken or volume of outputs (Marini & Street, 2007).

The HRG-based tariff has some similarities to the ‘Complexity Tool’ in the Drug and Alcohol PbR Pilots, which assigns a payment tariff to each service user depending on their likelihood of achieving outcomes. Like the HRG-tariff more complex cases are assigned a higher tariff in recognition that their treatment will be more expensive, but the focus is on outcomes rather than costs.
2.4.1 The aim of introducing payment by results for hospitals

A review of policy documents and academic literature highlights four main aims of introducing PbR for hospitals:

- **To increase efficiency and volume of activity**: Under PbR providers have incentives to do more work (to increase their income) and reduce costs (to maximise ‘profit’) from their activity (Street & Maynard, 2007). One way in which they can increase the volume of work they are able to undertake is to reduce the length of individual stays in hospital, to free up capacity and accommodate more patients (Propper, Wilson, & Burgess, 2006).

- **To decrease overnight stays in hospital**: There is a financial incentive to decrease overnight stays. The National Tariff is the same whether or not a patient stays overnight, even though overnight care is more expensive to deliver. Therefore a provider can make more ‘profit’ if a patient does not stay overnight (Farrar, et al., 2007; Street & Maynard, 2007).

- **To bring more transparency to the hospital funding system**. Compared to block-grants, the current system links activity to income and expenditure, making it clearer what hospitals are spending (Audit Commission, 2008; Farrar, et al., 2007).

- **To improve quality**. It was expected that PbR, through a nationally-set tariff, would improve quality as a result of competition between NHS providers (Department of Health, 2002). The hope was that in the absence of price competition, revenue would be indirectly linked to quality as hospitals would compete for Primary Care Trust-commissioned services and individual patients, both of which would be chosen in part on the basis of quality.

2.4.2 Evaluation of the use of PbR for hospitals in England

We reviewed studies of the implementation and effects of the NHS PbR system in order to identify potentially relevant lessons for the Drug and Alcohol Recovery Pilots. In identifying lessons we note important differences between the incentive structure in NHS PbR and that in the Drug and Alcohol Recovery Pilots: in the NHS, providers are paid a fixed amount regardless of outcome, whereas in the Drug and Alcohol Recovery Pilots at least a proportion of the payments are linked to outcomes.

The ‘National Evaluation of Payment by Results’ commissioned by the Department of Health (Farrar, et al., 2007) used quantitative and qualitative methods (econometric analysis and semi-structured interviews with key stakeholders in the NHS) to examine the process and impact of PbR implementation.

As regards increasing efficiency in NHS hospitals, the national evaluation found that NHS PbR was associated with a reduction in provider unit costs. Nevertheless, a number of studies have warned about the increase in administrative costs due to the recruitment of additional staff for management posts (Brereton & Vasoodaven, 2010; Marini & Street, 2007). Thus one lesson for the Drug and Alcohol Recovery Pilots is the possibility that, while the implementation of new funding mechanisms may encourage some savings, it may also incur other kinds of costs related to administration and administration.

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4 11 studies into NHS PbR conducted between 2003 and 2010 were identified through the REA.
data collection. It is therefore important that assessments of the Drug and Alcohol Recovery Pilots attend to the range of possible impacts. One way in which the evaluation intends to do this is to investigate the impact of implementation on the wider landscape of provision in each pilot area.

In terms of reducing overnight stays, PbR in the NHS seems to have had the desired impact of increasing the proportion of elective spells dealt with as day cases. The national evaluation found evidence that day case rates were increasing more quickly in hospitals where PbR was implemented. This finding seems to be supported by evidence collected by other studies (Audit Commission, 2008; Brereton & Vasoodaven, 2010). However, the Audit Commission argued that other policies also encouraged such trends, and that, at most, PbR contributed to these developments (Audit Commission, 2008). The national evaluation observed that while there were efficiency gains in the NHS following the introduction of PbR, savings were seen more as a result of already existing incentives (Farrar, et al., 2007). This has an important implication for the evaluation of the Drug and Alcohol Recovery Pilots, as it indicates the importance of isolating the effect of PbR from the effects of service redesign and/or the introduction of new models of drug and alcohol treatment. The evaluation should investigate whether any change in drug and alcohol treatment outcomes might have been achieved without the PbR incentives.

In relation to quality of care, the studies reviewed agreed on the lack of association between the introduction of NHS PbR and the quality of care (Audit Commission, 2008; Brereton & Vasoodaven, 2010; Farrar, et al., 2007; Farrar et al., 2009). This indicates that there was a reduction in unit costs without any apparent negative impact on the quality of care provided. This was interpreted as an indication that the fixed price system did not compromise the quality of care.

The concern with the emergence of ‘gaming’ or ‘up-coding’ phenomena was prevalent in the academic literature on ‘payment for activities’ in the NHS (Brereton & Vasoodaven, 2010; Farrar et al, 2007; Propper et al, 2006; Rogers et al, 2005; Sussex & Farrar, 2009). This means that there is a concern that the system could induce a re-classification of activities into higher priced HRGs in order to capture higher tariffs. However, the National Evaluation did not reveal any considerable change in the pattern of coding related to PbR. The evaluation of the Drug and Alcohol Recovery Pilots has as one of its key research questions investigating any opportunities for ‘gaming’ which might compromise the equity of drug and alcohol treatment provision, for example through providers ‘cherry picking’ service users who are perceived as easier to help and ‘parking’ or leaving to one side those with more complex needs.

2.4.3 The growth in Payment by Results since 2010

More recently, there has been the greater interest in developing PbR more widely (NCVYS, 2011a). In December 2010, the Government’s Commissioning Green Paper promised to look for “opportunities to expand the use of PbR” (Cabinet Office, 2010), and a similar statement of intention followed in the 2011 Open Public Services White Paper (HM Government, 2011). This called for open commissioning of public services and the implementation of PbR schemes with the aim of spurring innovation. It was thought that PbR could facilitate innovation because service providers would be
incentivised to provide the most effective services and given scope to try out new approaches (HM Government, 2011).

The Ministry of Justice was one of the first departments to commit to the implementation of PbR schemes after 2010. The *Breaking the Cycle* Green Paper (Ministry of Justice, 2010) promised to pay providers working in the area of offender management according to the outcomes they delivered. The Competition Strategy for Offender Services (July 2011) envisaged relying on competition principles in commissioning and focusing on outcomes (Ministry of Justice, 2011a). In 2010 the Ministry of Justice launched its first PbR pilot at HMP Peterborough. This pilot was designed to be funded through what was called a Social Impact Bond (SIB), a form of PbR in which private, non-government investors pay for public services. As in other forms of PbR, government only pays if certain outcomes are achieved. However, under SIB rather than service providers funding those services at the outset and until outcomes are achieved, it is private investors who pay for the services up front as an investment. If those services achieve agreed outcomes investors receive a ‘return’ on their investment which the government then pays (Disley et al, 2011).

This SIB was soon followed by the implementation a Ministry of Justice PbR scheme (but one that was not funded through SIBs) at HMP Doncaster (Ministry of Justice, 2011d) and four pilot Youth Justice Reinvestment Pathfinders programmes. These pathfinder programmes aim to develop a local approach to PbR which is designed to test the extent to which local partners can work together more effectively to reduce crime and re-offending (Ministry of Justice, 2011c). Further PbR initiatives are to be implemented in HMP Leeds and HMP and YOI High Down (Ministry of Justice, 2011b). Each of the Ministry of Justice PbR pilots is subject to external evaluation.

Outside the area of criminal justice, the largest (in terms of the number of service users) outcome-based PbR programme introduced since 2010 is DWP’s Work Programme, launched in June 2011 (Department for Work and Pensions, 2010). This invites voluntary and private sector organisations to tender to deliver interventions to help people into work. The remit of the Work Programme was broadened in March 2012 to automatically include ex-offenders claiming Jobseeker’s Allowance (Department for Work and Pensions, 2012b).

Other recent and current PbR initiatives in the UK in social and welfare policy include:

- A £200m scheme which was launched in January 2012 to help troubled families using funding from the European Social Fund which was launched in January 2012 (Department for Work and Pensions, 2012a).
- A trial of PbR for children’s centres in nine local authorities that will reward providers for reaching the most vulnerable families, improving family health and wellbeing and raising attainment of children at age five (Department for Education, 2011).
- A second SIB, seeking to address problems of rough sleepers in London, was announced in March 2012 (Department for Communities and Local Government, 2012).

Therefore the Drug and Alcohol Recovery PbR Pilots programme is one of a number of PbR pilot programmes currently being implemented. In current policy, the term PbR refers to two different approaches and models: outcome-based contracts and/or SIBs (NSPCC, 2011). With SIBs, private and non-governmental investors bear the risk of paying up-front for the provision of services by
providers. Outcome-based contracts, by contrast, are funded directly by Government. One type of outcome-based contract is a ‘prime provider model’, under which a single provider holds a contract with the commissioner and thus bears the risk for outcome delivery. In these instances providers usually have subcontractors who might also bear some risk (ACEVO, 2011).

2.4.4 Potential advantages and disadvantages of PbR

A review of policy documents and other sources highlights potential strengths and limitations of PbR. It should be emphasised however that there is, as yet, little evidence as to whether or not the benefits hoped for PbR will be realised.

2.4.5 Payment by results and ‘cashable’ savings

PbR schemes may result in savings to public services budgets. The potential for this saving arises because commissioners should no longer pay for inefficient or failing services, programmes and interventions, instead only paying for “what works” (NCVYS, 2011b; NSPCC, 2011). PbR is an attractive option for commissioners of services because it transfers financial risk away from them, either towards providers (in traditional PbR models), or towards social entrepreneurs and other investors (in SIB models). The NHS PbR was associated with reduced unit costs, but it is not yet clear whether the programmes currently being piloted can achieve such a dramatic improvement in outcomes or significant reduction in demand for government resources – for example, enabling a court or prison to close – in order to allow central or local government to actually spend less or divert resources to other spending priorities. Of course, PbR may eventually deliver large-scale savings, but it has not yet been tested widely enough to know whether or not it can.

2.4.6 A focus on outcomes

PbR may lead to commissioners’ goals being clearer to providers and the public, since commissioners need to state intended policy goals precisely and upfront, and must be clear about how those goals are going to be measured. Providers, in turn, are incentivised to maintain good and transparent recording practices in order to demonstrate the impact of their work. This focus on defining the outcomes desired, and on improved recording practices, arguably increases overall accountability in public commissioning (Dicker, 2011). Those implementing PbR hope to align the incentives for providers with those of commissioners and service users, to the extent that all parties derive financial benefits from increased efficiency and improved outcomes (Fox & Albertson, 2011).

2.4.7 Payment by results, competition and innovation

Competition between providers is often, although not always, part of PbR arrangements. At a minimum, providers usually compete in tendering exercises to win PbR contracts. Further, a commissioner might contract two or more providers on a PbR basis in an area, so the providers are in competition with each other for clients and outcome payments. These forms of competition might encourage providers to increase quality in order to win contracts in the first place, and to deliver results once they have been commissioned.
Some commentators hypothesise that increased competition among providers may boost innovation, as market mechanisms may encourage the identification of more effective and efficient ways of improving social outcomes (Audit Commission, 2012; NSPCC, 2011). Another route through which PbR might encourage innovation is through commissioners’ focus on outcomes, rather than the mode of service delivery. This means providers are free to propose new ways of doing things which would not have been possible under service contracts which closely defined processes and outputs.

However, whether or not PbR will foster innovation is an open question. A counter-argument is that providers might equally choose to stick to existing methods and approaches that have worked in the past, rather than testing innovative approaches which carry new risks (Collins, 2011). One potential concern is that the introduction of market mechanisms could also inhibit dissemination of knowledge and exchange of good practice between providers. This is because individual providers could be driven to retain what could come to be seen as intellectual property about ‘what works’, thus prioritising maintaining their competitive edge and maximising their own profits over the sharing of effective approaches.

2.4.8 Implications for smaller providers

Some PbR schemes have little or no up-front funding for providers, as payments are only made after services have been delivered and agreed results have been achieved. In the Drug and Alcohol PbR Pilots the ratio of up-front funding to funding dependent on results varies between pilot areas; one area pays 100% of the contract value on results, another 30%, and another 5%.

In schemes which have little or no up-front funding, provider organisations need to have enough working capital to deliver their services before they are paid for results. Smaller providers, who do not have such funding or working capital, might therefore be prevented from competing for PbR contracts, whereas better funded, larger organisations are more likely to be able to operate on other capital until they are paid for any results achieved (Fox & Albertson, 2011; Frazer & Hayes, 2011). One model which aims to ensure providers do not need up-front capital is being tested in the Enfield Pilot. There, payments are made to providers up-front but commissioners have the ability to ‘claw back’ funding to correct for under performance (Enfield Council and NHS Enfield, 2012).

Another solution is for smaller providers to act as subcontractors to large ‘prime providers’ who bear the financial risk. One possible disadvantage of this approach is that risk could still be transferred to smaller providers through subcontracting arrangements, either directly, through the inclusion of PbR in the sub contract, or indirectly, if they are required to meet demanding performance targets or to work with particularly hard-to-reach groups (ACEVO, 2011; NCVYS & Clinks, 2011; Nicholson, 2011).

2.4.9 Perverse incentives, unintended consequences and cherry picking

The risk of service providers “cherry-picking” clients that are perceived as easier to work with and “parking” harder-to-reach clients is a concern noted by many authors writing about PbR (Department for Health, 2012, p. 4; NSPCC, 2011). That is, there is a risk that PbR programmes may
create certain perverse incentives for individual providers. For instance, providers may offer a bare minimum of services sufficient to satisfy the outcome measure without taking into account the wider scope of clients’ needs. PBR might encourage a narrow focus on one problem, whereas available evidence indicates that re-offending, drug use, and unemployment are often linked to a number of issues in an individual’s life. Providers could be incentivised, for example, to encourage individuals to take a job (or other measured outcome) when that individual is not ready to do so. If this were to occur, it could lead to achievement of short-term results that are unsustainable in the longer term, and may do more harm than good if service users eventually ‘fail’ to sustain the positive outcomes towards which they were working.

2.4.10 Measurement issues in PBR design

Numerous sources reviewed for the REA identify the setting of outcomes measures as one of the biggest challenges in designing successful PBR schemes (Audit Commission, 2012; Collins, 2011; Disley, et al., 2011; Fox & Albertson, 2011; Nicholson, 2011; Roberts, 2011). There are two key elements to measurement in PBR, which are, broadly:

- deciding how to be confident that it is possible to attribute changes (improvements or worsening) in outcomes to providers’ efforts; and
- deciding what indicators or outcomes will be measured, and using which data.

In relation to the former, those designing PBR schemes want only to pay for outcomes which result from the providers’ interventions, rather than those which would have happened anyway. For example if offending rates are reduced in a local area, it is important to know if there were significant changes in policing practice, economic conditions or other events that might have caused or contributed to that change. Being able, confidently, to say what caused a change is known as the attribution of causality – attributing the cause of the outcome to the intervention in question. For example, in the Peterborough SIB pilot a control group approach is used to help assess causality: comparing those offenders receiving the SIB-funded intervention to a similar group of offenders who are not receiving the intervention. If both groups achieve better outcomes then this would suggest that the outcomes may have improved anyway (for example, because of a change in the external environment, such as changes in the economic climate that may affect levels of crime). If the group receiving the intervention achieves better outcomes than the control group, then this improves confidence that it was the SIB-funded intervention that caused the change. Other PBR schemes may simply compare outcomes amongst the population before and after the intervention. Defining a methodology which will allow outcomes to be attributed may require specialist input and can be a labour-intensive and time-consuming process (Disley et al., 2011).

In relation to the latter, those designing PBR schemes need to select metrics and measures. For many of the Ministry of Justice PBR programmes the metric is the number of recorded offences, using data from the Police National Computer. The advantages of this metric are that it is already measured and centrally collected, and it is clear and readily understandable. Commissioners face trade-offs between the simplicity of measures and the comprehensiveness of such measures. For example, binary outcome measures such as ‘convicted of a further offence or not convicted of a further offence’, are relatively simple to understand, implement and monitor, and send a clear
message regarding the harm caused by even a single conviction. However, there is concern that they may miss important aspects of changes or improvements. For example, if an offender continues to offend but does so less frequently or commits offences of lesser severity then this could be seen as an improvement in outcomes that would not be captured by the most simple binary ‘reconviction or no reconviction’ measure. Measures based on a client’s “journey travelled” could better reflect the complex nature of service provision and individual change by capturing changes and improvements along the way to an ultimate goal of, for example, not being reconvicted (Dicker, 2011). Similarly, longer measurement periods may better capture any potential impact of interventions, but may not be acceptable to those who expect to see results quickly, or to providers or investors (in SIB models) who are waiting for outcomes to be achieved before receiving payment (DrugScope & UKDPC, 2011).

2.4.11 Valuing outcomes

As well as appropriate and robust metrics, a PbR programme must be based upon some estimation of the value of the outcome. The question to be addressed here is how much the government should pay for one extra person in employment, one person free from drugs or one person not reoffending. The accuracy of these estimates is central to the value for money of PbR schemes. This is because whoever will ultimately make the payments if the agreed outcomes are achieved needs to also agree what a fair price is for a particular improvement in outcomes. If this price is too high then the intervention does not represent good value for money. If the agreed price is too low then this may make providing the service unattractive or infeasible for providers.

2.4.12 Risk of paying twice as PbR proliferates

With the rising number of programmes, interventions and services provided through PbR, there is an increasing risk that programmes overlap in their provision. As PbR schemes expand and roll out, the same person may, for example, be provided with a PbR service to reduce their drug and alcohol misuse as well as a service to help reduce their likelihood of reoffending. Because these schemes may share some of the same aims and seek to improve similar behaviours, it becomes increasingly difficult to attribute any impact achieved to individual providers (Disley et al., 2011; DrugScope & UKDPC, 2011). Lastly, it is not clear how external factors (such as economic downturn leading to higher numbers of unemployed) or, in the case of nation-wide initiatives, local specificities, should be accounted for in the set-up of PbR programmes.

2.4.13 Evaluation of payment by results

Largely due to the fact that PbR schemes are a relatively recent development, there is a paucity of evaluations of such programmes and related social investment vehicles (Ministry of Justice, 2010; Mulgan et al, 2011; NAYJ, 2011). The few evaluations which have been conducted generally demonstrate the difficulties inherent in attempting to attribute effects to PbR implementation and offer a mixed picture regarding the advantages and disadvantages of PbR. For instance, the evaluation of the Daedalus Programme (which aims to support young people due to be released from custody in London) found an improvement in governance structures in place, but noted that
there was a tension between meeting targets and meeting the complex needs of young clients (Ipsos MORI, 2011).

Similarly, a report on the Pathways to Work programme concluded that client support and stakeholder relationships worked well. However, the programme exhibited signs of the perverse incentives described above: concerns were raised about pressure to achieve targets at the cost of acceptable quality of service, providers were seen to make little effort to work with ‘harder to help’ clients, and clients with greater needs appeared to be referred on to partner agencies (Hudson, et al., 2010). Department for Work and Pensions payment by results contracts also demonstrated that concerns about barriers to market entry have some basis, as only very substantial organisations (mostly private, few voluntary of community sector providers), with large amounts of working capital at their disposal, have been able to take the risk of becoming prime contractors (Frazer & Hayes, 2011).

2.5 Conclusions/Implications for the evaluation

This Chapter has described the ways in which PbR has been used over the last decade, placing the Drug and Alcohol Recovery Pilots in their policy context and identifying lessons from implementation of similar schemes and related research. The limited empirical evidence base means that the review poses research questions and hypotheses that are yet to be tested.

This evaluation of the PbR Drugs and Alcohol Recovery Pilots programme offers a good opportunity to add to the evidence base on these research questions. The issues raised in this review are reflected in our research questions and will be addressed by our planned future research.

The next Chapter examines the assembled literature to consider the extent to which the ‘recovery’ aims of the PbR Pilots are supported by research evidence.
This chapter presents findings from a review of relevant literature, conducted in order to provide context to the Drug and Alcohol Recovery Pilots and generate hypotheses for exploration in the evaluation, it aims to answer the following questions:

- What estimates exist for rates of abstinence and/or drug-free discharge following treatment? Is there evidence that achievement of these outcomes is feasible?
- Are there any critiques of the strengths and limitations of using recovery, abstinence or drug-free discharge from treatment as key outcome metrics?
- Have outcome measures other than recovery, abstinence or drug-free discharge from treatment been used in other treatment programmes, and if so, how are they operationalised?

The Chapter starts with a review of the Co-Designed Outcome Definitions agreed for the Drug and Alcohol Recovery Pilots. It then addresses each of the four questions above.

3.1 Co-Designed Outcome Definitions for the Pilots

The Co-Designed Outcome Definitions have three main domains which relate to dependence on drugs, offending, and health and well-being (Department of Health, 2012).

3.1.1 Free from drug dependence: recovery and abstinence

The first domain is ‘free from drugs of dependence’. Alcohol is considered a drug of dependence. The ‘of’ is important, since it indicates that an individual in recovery might still be classified as someone with drug dependence as an issue, but not actually using any drugs. Individuals who are free from drugs of dependence are formally defined as those who are:

"Discharged from treatment successfully (free of drug(s) of dependence) and do not represent in either the treatment system or in the criminal justice system (taken onto the DIP/prison caseload) in the following 12 months“ (Department of Health, 2012, p.1).

Thus, an outcome is achieved when an individual is discharged and out of treatment for 12 months. The NTA defines successful treatment completion (when someone will be discharged) as when they are:

Judged by a clinician to be free of dependency from the drug for which an individual was being treated, and in addition not using either heroin or crack. It does not rule out occasional use of other drugs (on which the clinician judges the client is not dependent), but cannot
In the PbR pilots, abstinence from all presenting drugs or alcohol is an interim outcome. The term ‘abstinence’ is intentionally not used in the final outcome definitions. Part of the reason for this is that abstinence could indicate a narrower focus than that which is indicated by the term ‘recovery’; the latter is taken to involve a broader focus, beyond merely abstaining from the use of drugs, to include improvements in the range of problems faced by someone who is also misusing alcohol or drugs.

In addition, ‘free from drugs of dependence’ encompasses three ‘initial outcomes’:
- A significant decrease in drug or alcohol use for all presenting substances
- Abstinent from all presenting substances at two reviews
- Planned exit from treatment.

These measures complement the final outcome by offering some indication of the distance travelled.

### 3.1.2 Offending
The second outcome domain relates to offending – providers are incentivised to work with clients to reduce offending. There is a considerable and growing body of evidence demonstrating a correlation between offending and drug use (Bennett & Holloway, 2009; Bennett et al, 2008; Hayhurst et al, 2012) and some evidence that engagement in treatment is associated with a reduction in offending (Jones et al., 2009, pp 10-12).

Under the Co-Designed Outcome Definitions, pilot areas were able to choose whether to measure offending on an individual or cohort basis, but were ‘strongly recommended to use a cohort basis as this minimises the risk of paying for outcomes that may have occurred anyway’ (Department of Health, 2012). All pilot areas did choose the cohort basis for measurement and are thus using one outcome measure which is both interim and final:

“Reduction in average offending of cohort compared against baseline, calculated and paid quarterly. Cohort to be made up of those individuals in and recently discharged from treatment (details to be determined with pilot areas)” (Department of Health, 2012, p.2).

The alternative individual measurement, not taken up by any of the pilot sites, consisted of two measures:
1. Interim: no proven offending in 6 months
2. Final: no proven offending in a 12 months period.

### 3.1.3 Health and wellbeing
The third outcome domain relates to four areas categorised as ‘health and well-being’.
• **Reducing injecting:** of those injecting at the start of treatment, those who reported 0 days injecting at two review points\(^5\) within the last 12 months.

• **Securing appropriate housing:** of those who are of no fixed abode or with a housing problem\(^6\) at the start of treatment, those who no longer had any housing problem on any two review points in the last 12 months or on exit from treatment.

• **Completing Hepatitis B vaccination course:** of those eligible, those that had completed appropriately a course of Hepatitis B vaccinations within the previous 12 months.

• **Health and wellbeing:** achieving a normative quality of life score\(^7\) at two reviews.

### 3.2 Rates of abstinence following treatment: what might be expected?

Data recently published by the NTA indicate that of all individuals starting drug treatment in England between 2005 and 2012 (n=366,217), 29 per cent successfully completed treatment and did not return, 35 per cent were still in treatment or had returned to treatment, and 36 per cent had dropped out of treatment and not returned (National Treatment Agency for Substance Misuse, 2012d, p. 8). As part of the REA we reviewed abstinence rates found in other studies of drug treatment outcomes, in order to make some assessment of the likelihood and feasibility of achieving the Co-Designed Outcome Definitions.

#### 3.2.1 Rates of remission and treatment discharge: drugs

Our starting point was findings from the Drug Treatment Outcomes Research Study (DTORS) (Jones et al, 2009; Donmall et al, 2012) a longitudinal study based on data collected through interviews with adult treatment seekers in England. Table 3-1 shows study participants’ self-reported use of heroin, crack, cocaine and cannabis at 3-5 months after the start of treatment and 11-13 months after the start of treatment. These data were weighted to take into account bias introduced through non-response rates (those who refused to participate in the DTORS at all) and those who could not be contacted for follow-up interviews. These data indicate rates of ‘abstinence’ (although that term is not used in the DTORS report) of between (approximately) 60 per cent and 45 per cent of users.

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\(^5\) Reviews are conducted using the Treatment Outcomes Profile (TOP). This is a tool developed by the National Treatment Agency. It is designed to be completed by the key worker and with the client, at the start of treatment, periodically throughout treatment and at the end of treatment, and is therefore used to monitor the effectiveness of drug treatment. The TOP is a 20 item measure that focuses on substance use, injecting risk behaviour, crime, health and social functioning. National Treatment Agency for Substance Misuse. (2012c).

\(^6\) There are questions in the Treatment Outcomes Profile which ask whether the person has no fixed abode or if they have a housing problem.

\(^7\) Based on questions on the Treatment Outcomes Profile.
Table 3-1: Results from DTORS: Percentage of users who had stopped using after 3-5 months and after 11-13 months

<table>
<thead>
<tr>
<th>Drug</th>
<th>Percentage of users who reported that they had stopped using at first follow-up (3-5 months) (n=886)</th>
<th>Percentage of users who reported that they had stopped using at second follow-up (11-13 months) (n=504)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heroin</td>
<td>44%</td>
<td>49%</td>
</tr>
<tr>
<td>Crack</td>
<td>53%</td>
<td>61%</td>
</tr>
<tr>
<td>Cocaine</td>
<td>75%</td>
<td>68%</td>
</tr>
<tr>
<td>Cannabis</td>
<td>48%</td>
<td>45%</td>
</tr>
<tr>
<td>Amphetamine</td>
<td>59%</td>
<td>71%</td>
</tr>
</tbody>
</table>

Source: Jones et al, 2009

As a second source of information about likely abstinence rates, we looked to a longitudinal analysis of monitoring data relating to 26,415 drug users in treatment between 1997 and 2005 in the North-West of England (Beynon, Bellis, & McVeigh, 2006). The findings are set out in Table 3-2. They show that (approximately) 7-10 per cent of individuals in the sample dropped out of treatment, and between 3.5 and 10 percent of individuals were discharged drug free.

Table 3-2: Proportion of individuals dropping out of treatment and discharged drug free, by year

<table>
<thead>
<tr>
<th></th>
<th>1998</th>
<th>1999</th>
<th>2000/1</th>
<th>2001/2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proportion of individuals dropping out of treatment a</td>
<td>7.2%</td>
<td>6.8%</td>
<td>8.3%</td>
<td>9.6%</td>
</tr>
<tr>
<td>Proportion of individuals discharged drug free b</td>
<td>5.8%</td>
<td>9.9%</td>
<td>4.4%</td>
<td>3.5%</td>
</tr>
</tbody>
</table>

a *defined as unplanned discharge from services before treatment completion*
b *defined as a planned discharge from treatment following cessation of drug use and treatment completion*

Source: Beynon, et al., 2006.

Beynon et al (2006) also look at re-presentation to drug treatment services. The findings are set out in Table 3.3 and show that (approximately) 27- 44 percent of those who were discharged from treatment re-presented in the following year.

Table 3-3: Proportion discharged drug free and dropped out of treatment who represented to treatment services in the following year

<table>
<thead>
<tr>
<th></th>
<th>Treated in 1998</th>
<th>Treated in 1999</th>
<th>Treated in 2000/1</th>
<th>Treated in 2001/2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discharged drug free</td>
<td>27.8%</td>
<td>33.6%</td>
<td>26.9%</td>
<td>44.5%</td>
</tr>
<tr>
<td>Dropped out</td>
<td>22.9%</td>
<td>26.3%</td>
<td>31.8%</td>
<td>48.6%</td>
</tr>
</tbody>
</table>

Source: (Beynon, et al., 2006)
Thirdly, we looked at rates of ‘remission’ reported in a recently conducted systematic review (Calabria et al., 2010). This review included studies conducted internationally – including Australia, Brazil, Israel, Pakistan, Slovakia, and Spain. Only one study was from the UK. Remission was defined as ‘no longer meeting diagnostic criteria for drug dependence or abstinence from drug use’. The review included only prospective studies with a follow-up of at least three years; ten studies of opioid use, one of amphetamines, four of cocaine and three of cannabis. One of the main conclusions of the review was that there is a limited evidence base as to the rates of remission or abstinence. There are few prospective studies and even fewer that have follow-up periods of three years or more. There are also significant drop-out rates from such studies, so that final results are drawn from the proportion of the sample who could be followed-up, rather than all those who began a course of treatment (as was the case for the DTORS, although sample drop-out was statistically controlled for). Further, definitions of remission vary between studies.

Bearing in mind these caveats and pooling findings across the studies reviewed, Calabria et al. estimate one-year remission rates, which are set out in Table 3-4. Comparing these rates to those reported by Beynon et al in the UK, the ‘discharged drug free’ rate in the UK-only cohort is lower than the remission rate estimated from international studies in Error! Reference source not found.

<table>
<thead>
<tr>
<th>Drug</th>
<th>Estimate of the proportion of dependent users who will remit from active drug dependence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amphetamine</td>
<td>25%</td>
</tr>
<tr>
<td>Cocaine</td>
<td>20%</td>
</tr>
<tr>
<td>Heroin</td>
<td>15%</td>
</tr>
<tr>
<td>Cannabis</td>
<td>10%</td>
</tr>
</tbody>
</table>

Source: (Calabria, et al., 2010)

To contextualise these findings, we note that evidence from retrospective and prospective treatment studies suggest that most participants who do achieve abstinence or recovery do so after three to four episodes of treatment over multiple years (Hser et al., 1998; Scott & Dennis, 2009). Data from DTORS support this, indicating that individuals in the sample who were new to treatment had significantly lower levels of treatment retention (Jones et al., 2009, p. 5) and finding that previous treatment experience was the only factor to predict retention in treatment for 9 months (Jones et al., p. 6). Similarly, recent work with the UK Drug Data Warehouse found, in a very large sample of approximately 166,000 individuals, that 34% who completed a treatment journey over a two year period, re-presented for treatment within 12 months (Millar et al., 2012).

### 3.2.2 Rates of remission and treatment discharge: alcohol

For alcohol we drew on two systematic reviews that reported abstinence rates in various alcohol treatment settings. Both of these reviews look at treatment for alcohol dependence using drugs as well as psychosocial interventions.

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8 For UK-only data on outcomes from treatment see National Treatment Agency, 2012a.
9 We have not used data from DTORS because individuals whose primary substance was alcohol were not eligible for inclusion in the study.
The first systematic review (Mann et al, 1994) was a meta-analysis of the efficacy of acamprosate in alcohol-dependent individuals.\textsuperscript{10} It used as its primary outcome measure ‘continuous abstinence’, defined as abstinence from randomisation to study end (continuous abstinence throughout the trial equates to success, whereas any drinking denotes failure; patients leaving the trial prematurely, irrespective of the reason, were considered to have failed). Table 3-5 summarises the findings of the meta-analysis at three follow-up points. The biggest methodological drawback of included studies was their high attrition rate, averaging 51\%. However, as the authors pointed out, this is a frequent occurrence in studies with alcohol-dependents (as with drug users) due to the difficulty of retaining them in treatment programmes.

Table 3-5: Estimates of rates of continuous abstinence

<table>
<thead>
<tr>
<th></th>
<th>3 months</th>
<th>6 months</th>
<th>12 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acamprosate</td>
<td>45.7%</td>
<td>36.1%</td>
<td>27.3%</td>
</tr>
<tr>
<td>Placebo</td>
<td>33.7%</td>
<td>23.4%</td>
<td>12.6%</td>
</tr>
</tbody>
</table>

Source: (Mann, et al., 1994)

The second review (Srisurapanont & Jarusuraisin, 2000) aimed to determine the relative effectiveness of opioid antagonists in comparison to placebo, other medications, and psychosocial treatments for attenuating or preventing the recommencement of alcohol consumption in people with alcohol dependence.\textsuperscript{11} The results for abstinence rates in naltrexone and nalmefene interventions, which were usually accompanied by some type of psychosocial treatment, are summarised in Table 3-6. There were two principal limitations to the review’s findings - the duration of treatment in the included studies was short and the discontinuation rate was rather high (53\% for naltrexone and 39\% for nalmefene within 3 months).

Table 3-6 Estimates of abstinence rates in naltrexone and nalmefene interventions

<table>
<thead>
<tr>
<th></th>
<th>Short term (less than 3 months)</th>
<th>Medium term (3 to 12 months)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Naltrexone vs.</td>
<td>Naltrexone 51.3% (4 studies)</td>
<td>Naltrexone 22.5% (1 study)</td>
</tr>
<tr>
<td>Placebo</td>
<td>Placebo 35.8% (4 studies)</td>
<td>Placebo 15% (1 study)</td>
</tr>
<tr>
<td>Nalmefene vs.</td>
<td>Nalmefene 60% (1 study)</td>
<td>Nalmefene n/a</td>
</tr>
<tr>
<td>Placebo</td>
<td>Placebo 40% (1 study)</td>
<td>Placebo n/a</td>
</tr>
</tbody>
</table>

Source: (Srisurapanont & Jarusuraisin, 2000)

Findings from these meta analyses suggest that:

- Around 22 to 27 per cent of clients receiving treatment (mainly drug-based) for alcohol dependence are abstinent for a year following treatment.
- Around 12 to 15 per cent of clients who had a placebo were abstinent for a year following treatment.

\textsuperscript{10} The review included studies published to date, supplemented, where possible, by data obtained from the manufacturer’s in-house reports. It based its findings on 17 randomized placebo-controlled trials from several European countries and South Korea, all published between 1992 and 2003.

\textsuperscript{11} This is a Cochrane review. Its meta-analysis included eleven studies published between 1992 and 1999. Of these, ten were randomised trials and one clinically controlled. Two of the included studies were not double-blind but open-label.
3.2.3 Implications for Drug and Alcohol Recovery Pilots

Given the caveats around the estimates for both drug and alcohol abstinence and treatment discharge rates, we are cautious in identifying implications for the PbR pilots. However, there are a number of issues which could be relevant to the current evaluation and these are drawn out below.

- **Estimated remission rates appear to differ by drug.** There is some evidence that the prevalence of opiate and crack cocaine use differs across the regions of England (Hay et al, 2011). Pilot areas with a high proportion of heroin users, for example, could possibly face a more challenging task in achieving outcomes among their population than those in areas which have higher proportions of amphetamine or stimulant users. However, this is to some extent taken into account in the tariffing of service users.

- **Estimates of rates of remittance or abstinence from drugs and alcohol vary widely.** Depending on the drug used, rates were between 45 and 71 per cent after approximately 12 months in DTORS (Jones et al, 2009) and between 10 and 25 per cent in the systematic review by Calabria et al. (2010). The meta analyses of alcohol treatments reviewed above estimate 12-month abstinence at between (approximately) 12 and 27 per cent. This indicates that, typically, a minority of service users participating in treatment might be expected to achieve abstinence or successfully complete treatment in a 12 month period.

- **‘Shorter follow-up studies may overestimate remission by including cases with a temporary lull in the course of their disorder’** (Calabria, et al., 2010, p. 742). This is supported by Beynon et al’s analysis. When they look at cumulative presentation rates, of those discharged drug free in 1998, 57% had re-presented at treatment services in at least one subsequent year by 2004/05, and of those who dropped out in 1998, the equivalent proportion re-presenting by 2004/05 was 54%. The 12-month follow-up period is informed by NDTMS evidence that the majority of people who relapse following successful completion, do so in the first year following treatment exit. This is supported by findings that recovery is achieved after several bouts of treatment (Scott & Dennis, 2009).

These are issues worth noting and testing in the evaluation of the PbR Pilots.

3.3 Pros and cons of abstinence as the main goal of treatment

We reviewed reasons given by study authors as to why abstinence was used as an outcome measure in evaluations of drug and alcohol treatment programmes. The purpose of this was to generate hypotheses about the adopted Outcome Definitions, in particular the ‘free from drugs of dependence’ outcome, to be tested in the evaluation of the PbR pilots. Primarily, this testing will be through the exploration of the views of various stakeholders in the PbR pilots (commissioners, providers and service users) regarding the recovery focus.

Most evaluations of drug treatment programmes reviewed for this Chapter did not provide reasons for the choice of outcome variables.12 Three main arguments in favour of using abstinence as an outcome measure were identified:

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• Abstinence is the only acceptable goal when the aim is to move toward a ‘drug free’ society (Owen & Marlatt, 2001)

• Abstinence is a definitive measurement which is comparable across studies, unlike, for example, ‘quality of life’ measurements (Halterman et al, 2011)

• Abstinence is the goal most commonly expressed by drug treatment service users (McKeganey, 2005).

Three main arguments against using abstinence as the main goal of drug treatment were identified in the literature:

• For some drug users abstinence is not a feasible or achievable outcome (McKeganey, 2005), or at least, that it can take a long time to achieve (Hickman et al, 2011). Similar arguments are advanced about the relative lack of feasibility of abstinence in alcohol treatment (Carmen et al, 2004), given the recurrent nature of alcohol dependence (Roozen et al, 2004). Questions about the feasibility of treatment can, in part, be supported by the empirical evidence discussed above which shows that a relatively small proportion of participants remain drug free after treatment. Evaluations of drug treatment interventions in which the length of follow-up extends beyond twelve months show treatment programmes have low levels of efficacy in terms of participants remaining drug free, even though other kinds of progress or improvement may be achieved (Critchlow & Nadeem, 2006; Edelen et al, 2010; Trautmann & Wittchen, 2012).

• There is such a thing as non-problematic drug use (Kleiman et al, 2011), and therefore the aim to bring treatment participants below the threshold of problematic or dependent patterns of drug use is an acceptable goal. Similarly, in relation to alcohol individuals can be encouraged to moderate their drinking rather than abstain altogether (Heather et al, 2010).

• Abstinence from the substance for which a person is being treated may not mean abstinence from other harmful substances (e.g. heroin abstinence, but continued use of marijuana or alcohol (Gastfriend et al, 2007; Neale et al, 2011). The Co-Designed Outcome Definitions focus on an individual’s presence in the treatment system. In the evaluation it will be important to test how this is interpreted and applied by the pilots. For example, we might hypothesise alcohol consumption at some agreed acceptable level would not warrant retaining an individual in treatment if that treatment had primarily been for use of heroin.

### 3.4 Alternative outcome measures in drug and alcohol treatment

The purpose of the Drugs Recovery Payment by Results pilots is to develop and test out new approaches to the commissioning and delivery of drugs (and alcohol) recovery systems that reward achievement of outcomes, that is, free from drug(s) of dependence, offending, and health and wellbeing. This is in line with the vast majority of drug and alcohol studies covered in the REA which include outcome measures in addition to abstinence.

Most common in the literature were harm reduction measures operationalised through measures such as decreased usage, HIV risk or mortality and mental health indicators such as depression. In
the Co-Designed Outcome Definitions, cessation of injection and vaccination against hepatitis are harm reduction indicators.

**Quality of Life** measures were prevalent in reviewed studies, often operationalised by measuring aspects related to physical health, psychological health, degree of independence and social relationships (Hansson et al, 2007; Rus-Makovec & Čebašek-Travnik, 2008; Torrens, 2008). Employment and housing outcomes are sometimes used to evaluate treatment programme effectiveness and are often considered as part of the quality of life suite of measures. There is a demonstrated correlation between housing and drug use (Jason et al, 2006; Kertesz et al., 2007). A housing outcome measure is included in health & wellbeing outcome domain. The inclusion of offending as an outcome measure is supported by the available evidence as to a correlation between offending and drug use. For example, a study conducted by the National Treatment Agency for Substance Misuse (2011) which looked at conviction rates of known offenders (using data from the Police National Computer) who started a new course of drug treatment in 2006-07 (using data from the National Drug Treatment Monitoring System). The study compared convictions in the two years before their initial assessment for drug treatment with convictions in the two years after. This study found an inverse correlation between retention in treatment and a reduction in reconvictions.

There are limitations in using Police National Computer data, which omits a large proportion of crime which does not result in conviction. However, findings from the National Treatment Agency study are supported by self-reported data from the Offending, Crime and Justice Survey of young people aged between 10 and 25 (Wilson et al, 2005). This confirmed drug use (self-reported by respondents to the Survey) was statistically significant a risk factor associated with self-reported offending (p. 38), as was reporting having been drunk once a month or more in last 12 months’ (p.35).

Similarly the Arrestee Survey (Boreham et al, 2007), a nationally-representative survey of people arrested and held in police custody, found that respondents who reported using heroin or crack cocaine in the last 12 months were significantly more likely to report committing a crime in the last 12 months (p.58). Again, this is an association, rather than a finding of a causal relationship. However, the Arrestee Survey also asked respondents whether they had committed ‘any crimes in the last four weeks in order to buy or get hold of drugs’. Those who reported taking heroin or crack cocaine in the last 12 months were much more likely to report committing a crime to get drugs (36 per cent compared with 2 per cent of those not reporting taking heroin or crack cocaine). Whilst these self-reported data could be unreliable, they suggest a possible causal relationship between drugs and acquisitive crime.

**Self-efficacy**, which is largely related to motivation and one’s ability to complete the treatment and recover from addiction, has also been used as a common supplemental outcome measure to abstinence or reduced drug use, but is not part of the Co-Designed Outcome Definitions. Though the evidence is mixed (Gossop et al, 2007; Kavanagh et al., 2004; Stewart et al, 2007) a number of studies have found positive effects in motivating participants (Smedslund et al, 2011).

### 3.5 Conclusions
This chapter has reviewed available evidence to address topics relevant to the evaluation of the PbR pilots and highlighted a range of issues to be tested and further explored in the evaluation of the PbR pilot. These can be summarised as follows:

- **What estimates exist for rates of abstinence and/or drug-free discharge following treatment?** Is there evidence that these outcomes are or are not feasible? Studies reviewed found relatively low proportions of drug and alcohol users are discharged, drug-free from treatment in a given year. This confirms that the ‘free from drug(s) of dependence’ outcome set by the DH is a challenging goal for providers in the PbR Pilots. However, reviewed studies combined results from a wide range of treatment programmes using very different approaches that might not have professed the ‘recovery focus’ which underlies the Drug and Alcohol Recovery Pilots.

- **Are there any critiques of the use of recovery, abstinence or drug-free discharge from treatment as key outcome metrics?** What are the strengths and limitations of these measures? The REA identified a range of arguments for and against the use of treatment discharge or abstinence as the key outcome measure. The evaluation of the PbR Pilots will investigate which, if any, of these arguments are mentioned by commissioners, providers and service users and how they affect the implementation and effectiveness of the Pilots.

- **Have outcome measures other than recovery, abstinence or drug-free discharge from treatment been used in other treatment programmes, and if so, are they operationalised in the same way?** Most of the evaluations of treatment programmes included in the REA used abstinence or discharge from treatment as the key measure of success. Outcomes related to offending and health & wellbeing (which are part of the Co-Designed Outcome Definitions) are also found in reviewed studies – albeit that a wide range of different metrics and scales are used to measure wellbeing. Self-efficacy is the only outcome included in reviewed studies which was not explicitly part of the Co-Designed Outcome Definitions.

In the next chapter we present information about evaluation activities conducted so far, including some emerging findings in relation to some of the issues raised in this Chapter.
Chapter 4 Preliminary themes emerging from Phase 1 Key Informant Interviews

In this chapter we provide an update on progress with the process evaluation, with a particular focus on Phase I research activities. We also provide a broad narrative overview of some of the main themes and issues to emerge from 31 key informant interviews completed between 15th March and 9th August 2012.

This overview has been informed through the use of interview notes and feedback from (four) researchers responsible for completing the fieldwork across the eight pilot sites (further details of the interviewees are provided below). This therefore represents only a partial and indicative picture from the data collected during the early stages of the research. Full transcripts from these and other Phase I interviews were being processed at the time of writing.

The results of systematic analysis of all Phase I interview data will be provided in subsequent reports. The application of an appropriate analytical framework which ensures this data synthesis and analysis reflects both the complexity and heterogeneity within and between the pilots are being explored and considered by the research team. Examples of such frameworks include Framework Analysis (Ritchie and Lewis, 2003) and Realistic Evaluation (Pawson, and Tilley, 1997). The use of these frameworks can also assist in synthesising and integrating data from both process and impact strands of the evaluation.

4.1 Research governance and ethical approval

Our NHS ethics application was approved by the London - Camden and Islington NRES Committee in March 2012, subject to clarification that there would be no linkage of data between the research detailed in the IRAS form and the research into police and criminal justice records. NDEC supplied a statement to this effect, and full approval was subsequently given.

Following this, R&D approval was been received from each NHS Trust piloting PbR. We also requested permission for research access in the thirteen third-sector provider organisations involved in the pilots.

4.2 Phase I key informant interviews
Key informant interviews have been undertaken to gather information on the background and early development of the pilots (the interview schedule used is included as Appendix B), with Drug Action Team (DAT) commissioners, Local Area Single Assessment and Referral System (LASAR) managers, partnership board leads and senior managers in provider organisations. The fieldwork undertaken across the eight PbR pilots was divided between the two research teams at ICPR and RAND, with ICPR taking responsibility for conducting interviews in Bracknell Forest, Enfield, Kent, Wakefield and Wigan, and RAND taking responsibility for interviews in the Lincolnshire, Oxfordshire and Stockport sites.

Interviews were undertaken in each site with at least one pilot coordinator/commissioner. In a number of the pilot sites interviews have also been completed with probation leads for substance misuse and service managers in provider organisations. Details of these initial key informant interviews are provided in Table 4.1, below.

**Table 4.1: Key informant interviews completed up to 9th August 2012 (N=31)**

<table>
<thead>
<tr>
<th>Pilot</th>
<th>Number of interviews</th>
<th>Organisation</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Site 1</td>
<td>3</td>
<td>Drug and Alcohol Action Team (DAAT)</td>
<td>Commissioners</td>
</tr>
<tr>
<td>Site 2</td>
<td>3</td>
<td>Primary Care Trust (PCT) / National Health Service (NHS), Police</td>
<td>Head of Public Health, Superintendent</td>
</tr>
<tr>
<td>Site 3</td>
<td>5</td>
<td>PCT/NHS</td>
<td>LASAR manager, Commissioners</td>
</tr>
<tr>
<td>Site 4</td>
<td>2</td>
<td>PCT/NHS</td>
<td>Commissioner, Service manager</td>
</tr>
<tr>
<td>Site 5</td>
<td>3</td>
<td>PCT/NHS</td>
<td>Commissioners</td>
</tr>
<tr>
<td>Site 6</td>
<td>4</td>
<td>Probation, DAAT</td>
<td>Probation Lead, Commissioners, LASAR manager</td>
</tr>
<tr>
<td>Site 7</td>
<td>2</td>
<td>DAAT</td>
<td>Strategy manager, LASAR manager</td>
</tr>
<tr>
<td>Site 8</td>
<td>2</td>
<td>DAAT</td>
<td>Commissioner, Development Officer,</td>
</tr>
<tr>
<td>Other</td>
<td>7</td>
<td>Home Office, Ministry of Justice, Dept. of Health</td>
<td>Policy (various)</td>
</tr>
</tbody>
</table>

Members of the research team have also attended co-design meetings and the provider and commissioner focussed events organised by the Department of Health. As a consequence, we have created the standardised summaries of each of the pilot sites included in Appendix C using the most up-to-date information available to us at the time of writing. These descriptions were informed using a combination of interview data, submissions by the pilot sites themselves (e.g. via the dedicated PbR discussion forum) and published documentary data (a full inventory of these documentary sources will be provided and reported in Phase II). As pilots it is to be expected that changes will be implemented to service delivery. As such the models described may not necessarily be reflective of
current or future practice. A narrative account of the developmental process of each site over the life of the pilot will be provided as part of Phase II of the evaluation.

In order to get a rounded view of the development of the pilots and the co-design process, in addition to 24 interviews with key informants in the eight pilot sites, telephone interviews have also been conducted (between July and August 2012) with six key policy stakeholders with responsibility for the PbR pilots from across central government (DH and the Ministry of Justice - MoJ). In addition a telephone interview was carried out with a representative from a national drug policy organisation who was involved in the expert group that informed the development of the pilots and in the co-design process (see Table 4.1, above).

As part of the interview process, commissioners and other respondents were asked to describe:

- local decision-making processes when applying for PbR drug and alcohol recovery pilot status;
- their experiences of the co-design phase; and
- their views on both the opportunities and challenges presented by PbR and the ‘recovery’ agenda more broadly.

Central government actors were asked to describe:

- their role in the development of the pilots;
- their views of the co-design process; and
- how outcome measures were arrived at and their views of this process.

4.3 Emerging main themes

4.3.1 Considerations when applying for PbR pilot status

It was widely acknowledged by respondents that all areas have for some time been progressively moving towards ‘recovery’ and outcomes focussed systems, and that the pilots are seeking to develop different approaches to test whether offering financial incentives are an effective way of achieving this. PbR was therefore often viewed in the context of successive policies which have sought to promote a greater emphasis on the attainment of ‘recovery’-orientated outcomes (the systems change pilots were highlighted as another recent example of this). Consistent with the findings from our Rapid Evidence Assessment, the evidence base supporting and informing the development of PbR approaches was considered by some to be limited, however:

“There is a belief that Payment by Results is the answer to more efficient and effective services. But I think that the evidence isn’t there for that” (Policy stakeholder #5, Phase I interview).

It was acknowledged and accepted that there were very varied reasons for the sites applying for pilot status:
“The pilots came into it for different reasons and that’s always been really clear all the way through from the first time we started working with them” (Policy stakeholder #3, Phase I interview).

In one pilot site, interviewees commented that they had elected to bid to become a PbR pilot largely in response to the broader policy shift towards the introduction of outcomes-based commissioning that has emerged over time. As such, commissioners in this particular site stated that they were resigned to PbR rather than welcoming of it, and felt it was important that they should be a part of the PbR process at an early stage. Overwhelmingly, however, DAAT commissioners welcomed the introduction of PbR and described the pilots as an opportunity to both learn from and influence the development of a policy which was aligned with existing strategic priorities with regard to ‘recovery’ outcomes, and a model of commissioning they had been keen to introduce. There was then an acknowledgement that the present system of delivering drug treatment had not adequately incentivised providers to move specific groups of intractable service users out of the treatment system and promote progress towards improved wellbeing and ‘recovery’-orientated goals.

4.3.2 Experiences of the co-design process

Central government participants emphasised that the uniquely collaborative nature of the co-design phase of the drugs recovery PbR pilots - between central government, key stakeholders and the sites themselves - was a highly innovative and challenging process. The intention was to conceive and develop PbR models which were tailored to local needs and priorities. As such it represented a new approach to policy-making, since there was no pre-conceived model for areas to implement:

“The pilots were surprised when they entered the co-design period that government didn’t have a model that we wanted them to go and implement. And I suppose...that was kind of the point. Ministers were really, really keen from very early on in the process...that this was about co-designing; this wasn’t about central government saying, ‘Here is a model, go away and implement it’. This is about us working with local areas to actually understand what will work, take their ideas and work with them to co-design something; and it was definitely...a very new experience because we don’t usually do it like that and it was definitely a very new experience that whole 12-month period” (Policy stakeholder #3, Phase I interview).

In keeping with the ‘localism’ agenda, the desire was for PbR to provide pilots with an opportunity to incentivise those outcomes deemed most appropriate to their local circumstances and priorities. As such, PbR intentionally sought to avoid a prescriptive top-down model of implementation. In practice however, there were numerous challenges encountered in attempting to balance central policy imperatives against local concerns within this framework:

“I think localism is one of those things that can mean different things to lots of different people. I think even within the ministers who have been involved there’s been quite a variation in what they think localism is and how far they would like to control what or

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13 One respondent described localism as providing “a degree of local autonomy to ensure that the processes and practices that you are putting in place really suit local needs rather than dictated by central government policy”.
perhaps would have liked to have done... I think it’s been a learning curve definitely for officials but I think also for ministries as well and localism sounds great but then you find that you’ve got eight completely different pilots” (Policy stakeholder #2, Phase I interview).

There seemed to have been variable expectations from the pilot sites regarding the co-design process, but an over-riding perception that most expected it to have been more prescriptive and further developed by the time they came on-board. There was acknowledgement too on the part of the central government participants that there was a ‘steep learning curve’ for both government actors and local commissioners as to how to do co-design. The degree of autonomy afforded to the pilot sites was viewed as being a unique feature of the co-design phase and the extent to which they had a free-hand in adapting their PbR arrangements according to local needs was both unexpected and unfamiliar. Such innovation in devolving decision-making to the pilot sites may in part explain why some commissioners reported being surprised at being given little guidance on implementing mechanisms for developing PbR.

The establishment of national outcomes and measures for PbR were justified in order to ensure consistency and comparability in assessing the impacts of different PbR models and approaches. The outcome domains were largely described as being aspirational at the start of the co-design process. As such the specifics around formulating definitions and outcomes, and identifying ways of measuring these, still had to be determined:

“We were very clear that we couldn’t design something from the centre and simply impose it on them. But we needed to work in partnership with them. And also the fact that we didn’t actually have all the answers, this is a really new way of thinking and of working” (Policy stakeholder #7, Phase I interview).

Though the overall policy objectives were set by government, the outcome domains were initially developed by key expert/stakeholder groups and, once selected, the pilot sites themselves also became involved in the process:

“We put together an expert group, which consisted of a number of experts in the field...and we sort of developed the model further...We had a subgroup that looked at each of the outcome domains, and the sort of data that we could use to measure outcomes within those...domains... once the pilots had been selected, staff from the pilot sites were invited to join the expert groups, at which point we started calling it the co-design group” (Policy stakeholder #3, Phase I interview).

The challenges of developing appropriate outcome measures and a system of payments to incentivise progress towards meeting these was summed up by one DAT commissioner in the following way:

“It is easy to think of great outcomes, but it is really difficult to figure out how to measure them and, even worse, how to design a payment system around them” (Commissioner, Phase I interview).
In devising the outcome domains, the key challenges related to ensuring a balance was struck between offering sufficient incentives to providers to target sought after outcomes, and ensuring these were achievable in a meaningful timescale:

“No I would argue that because you have all these outcomes, you’re reducing the possibility of them actually incentivising anything because it’s so complicated. But there again, there was also the important point that if you only had outcomes that were very far down the line, that would be potentially disastrous to suppliers who wouldn’t get paid for anything for ages, and so create cash flow issues” (Policy stakeholder #5, Phase I interview).

Modelling of National Drug Treatment Monitoring System data to inform this work illustrated the challenges faced in efforts to ensure patients attained a ‘free from drugs of dependence’ status on successful discharge from treatment. This provided some of the impetus to incentivise interim measures which reflect incremental progress towards meeting this overall policy objective:

“Our point was that for drug dependency this is a journey. For some people, or on average even, it takes five to seven years to overcome a dependency and particularly if you want to pay on outcomes, not many providers are going to bid for a contract where they’ve got to wait 5 to 7 years for any money. You’ve got to have proxy measures along that journey, that are indicators of this person will recover” (Policy stakeholder #7, Phase I interview).

While attainment of the final outcome requires a discharge from structured interventions and evidence of ‘freedom from drugs of dependence’ (“You can’t be on a script and not in treatment”, Policy stakeholder #6, Phase I interview), providers can nevertheless be rewarded for outcomes achieved while a patient is on opioid substitution treatment:

“There was criticism too from...people who thought we were not going to put any incentives in to recognise that people who stopped using street drugs and were stable on methadone were making progress, and there is an interim outcome now to reward that so that we recognise that progress and...give those people a value. So, if it takes a couple of years to make...progression...to reducing a methadone prescription to being discharged, and that can take a long time, that we recognise that progress...I think some people just didn’t even understand that and I think others perhaps willfully misunderstood that” (Policy stakeholder #3, Phase I interview).

Whether this operates in any way against progress towards recovery interventions, remains to be seen (see Chapter 2). Incentivising outcomes was seen as both a source of optimism and concern for commissioners. Commissioners certainly saw PbR as a means of making substance misuse treatment more cost-effective and efficient.

“[PbR] felt like an opportunity to introduce a system where the onus is on getting client outcomes. Why should the taxpayer pay for something that does not deliver?” (Key informant, Phase I interview).
“I like the fact that we’re focusing on people recovering. Because I think for too long we’ve counted people in and we’ve kept them here and not paid enough attention to the fact that actually do we want these people to stay in treatment for the rest of their lives?” (Key informant, Phase I interview).

Compared to how PbR models have been developed in other policy areas, however, the timescales for establishing the drugs recovery pilots were invariably described as ‘challenging' and 'tight', and were considered not to adequately reflect the complexities inherent in commissioning and delivery processes:

“The speed of implementation was incredibly fast...If you look at other PBR processes, for example... alcohol treatment...they have been developing the clinical groupings and the understanding of complexity over years. So to develop an entire PBR model and process in one year is very fast, and the issues around defining the outcomes, understanding them, seeing how you can measure them, was almost inevitable in that respect” (Policy stakeholder #5, Phase I interview).

Given the challenging timescales, for some interviewees the focus of the co-design phase was pre-occupied as much with identifying what could be measured as establishing what the most appropriate outcomes might be (e.g. in relation to better parenting):

“I think that was one of the biggest challenges with these pilots, was the timeframe we were given. It became not what are the outcomes we want to achieve, but what is it we can measure! You know, we were given six months to work this out, and that’s not always enough time. And so I think it would be really interesting to see what other local areas take from this” (Policy stakeholder #7, Phase I interview).

As a collaborative and developmental process, answers to questions posed by the pilot sites were not always readily available. As it transpired the co-design phase was more protracted than originally envisaged for a range of reasons relating to the complexities of negotiating often contentious outcomes between ministers, government departments and local areas, and identifying appropriate measurements and data sources.

The re-scheduled publication of both outcome domains and case complexity tools for PbR arose for these same reasons. Respondents with policy responsibilities described the delays that had been encountered during the course of developmental work undertaken to implement and deliver PbR, arising from problems related to data access, modelling of those data identified as accessible and appropriate, and ministerial sign-off for decisions:

“We then had two months of going back and forth between ministers and the pilots over something they disagreed on, which is sort of part of the free from drugs dependence outcome... that added right there nearly 10 weeks to the process, just to get that one part of the outcomes agreed... we always knew how long it would last but different aspects of the process of co-design were much longer than we anticipated” (Policy stakeholder #2, Phase I interview).
This meant that in some cases, pilot coordinators developed their own outcome definitions which they found were very distinct from those eventually published for the programme as a whole. Other pilot sites reportedly went ahead and developed a system of delivery within which they then sought to integrate the final PBR outcomes once these were published. One of the three pilots that had re-commissioned their services found that the late provision of outcome measures for PBr meant they could not inform prospective bidders about how much they would be paid and for which activities, reportedly resulting in less interest at the tendering stage and a reduction in competition.

Despite these difficulties and challenges the main achievements of the co-design phase described to us included: (i) agreeing and defining what outcomes were being sought; (ii) establishing how these could best be measured; and (iii) devising a system of incentives to encourage progress towards achieving these outcomes.

"Defining what we wanted to achieve...then working out how we were going to measure it, which took much, much longer, and then the third stage was working out with areas how much money they were going to put on [outcomes] and how much stretch they were going to put on [outcomes]" (Policy stakeholder #3, Phase I interview).

The overall process was also perceived by some to have been an empowering one for the providers concerned, which had helped foster greater buy-in, loyalty and ownership of PBr from those who had invested in the co-design phase:

"It was almost shock. I think they were just so used to being told what to do, that they couldn’t quite get their heads around it at first. What was really interesting was just seeing that shift of attitudes, as we moved forward in the co-design, and actually realising that they have power here, and that they could argue for what they wanted" (Policy stakeholder #3, Phase I interview).

"I would say engagement and hopefully understanding that people aren’t just having something imposed on them centrally. They are involved in the development of it; their local needs in mind. It gives you much more engagement. I think it gives you much more insight into it, and sort of loyalty to the decisions that are made, if you like. Ownership of the decisions made” (Policy stakeholder #6, Phase I interview).

4.3.3 Developing and implementing LASAR

There was considerable diversity across the eight sites in the extent to which a Local Area Single Assessment and Referral System (LASAR) had been developed independently of provider organisations. Further details of these approaches are provided in Appendix C.

A range of mechanisms had been explored and developed to address gaming issues, for instance. In three of the sites there was a strong emphasis reportedly placed by commissioners on the need for LASAR to be staffed by well-qualified, experienced and well-managed staff as a fully professionalised function independent of – although perhaps co-located within – provider organisations.
One pilot site had commissioned a separate voluntary sector provider to carry out the LASAR function that would deliver both an office-based and mobile/outreach assessment function. This was the only independently-contracted LASAR that operated under a PbR model, reportedly offering appropriate incentives for the provider to make referrals, complete assessment processes, and fill in Treatment Outcomes Profile (TOP) reporting in a timely manner.

In three of the pilots the LASAR function was performed by the provider organisation, with the integration of tariff-setting into the comprehensive assessment process. This was justified by the desire to cut down on multiple assessments. In one of the pilots where the provider was carrying out the LASAR function, an assessment tool had been independently developed and commissioned for this purpose, but was being deployed by the service provider. In another site, which had no separate LASAR function, an external agency had been commissioned to develop a governance service to audit one third of tariffs, treatment plans and outcome achievements. The research team will gather copies of LASAR assessment tools in Phase II of the research for each site in order to describe existing tariff-setting systems in greater detail.

4.3.4 Opportunities and challenges posed by transition to PbR model

Though described in more detail below, the main opportunities afforded by a move towards PbR described to us during the in-depth Phase I interviews completed to date can be summarised as follows:

- there is a perception that PbR can play a role in increasing the effectiveness and cost-effectiveness of treatment services;
- there is enthusiasm that the transition towards PbR models in the eight pilot areas will serve to streamline and integrate previously fragmented services and reduce duplication; and
- the policy focus on PbR and the broader ‘recovery’ agenda complement existing strategic priorities for many areas.

By contrast, the main challenges described to us have related to:

- developing appropriate outcome measures and a system of payments to incentivise progress towards meeting these (as described in point (iv) above);
- a concern that the outcomes-based focus of PbR fails to reflect the complex and intractable nature of many substance misusers’ lives;
- managing and allaying staff and service users’ concerns and fears about PbR; and
- ensuring that small and innovative providers are not excluded from the PbR process, but are instead proactively encouraged and assisted to become involved.

Commissioners expressed both optimism and anxiety about their early experiences of the transition to PbR, with ‘recovery’ as overarching commissioning objectives. As stated above, a number of commissioners described PbR and the broader ‘recovery’ agenda within which it is situated as already complementing existing strategic priorities. A number of interviewees were also positive about the opportunity the pilot provided to properly fund alcohol service provision, for instance, which in the view of many had been the poor relation of substance misuse services for far too long.

Where pilot sites had taken the opportunity to re-commission services with a prime provider, they
were very positive about the opportunity this afforded them for the streamlining of previously fragmented services and reducing the need for multiple key workers and assessments.

There was nevertheless some concern expressed that the outcomes-based focus of PbR often fails to reflect the complexities of substance misusers’ lives. The development of ‘recovery capital’ via a range of aftercare and referral services was therefore considered key:

“Recovery from substance misuse is not like getting a hip replacement ... People use drugs for lots of reasons, and we still need to tackle those wider determinants of health in order to get people through” (Key informant, Phase I interview).

The interview data also illustrated how a number of the pilot sites were grappling with how best to ensure that PbR:

- incentivises interim recovery outcomes;
- develops a system designed to encourage provider organisations to work with more complex clients; and
- allays service users’ fears that they may, for example, be ‘pushed off scripts’ before they were ready:

“You wouldn’t want to rush people out of treatment. Because if they do and then they relapse .. our provider would not get another payment. So it’s up to the provider to work as long as required to achieve the outcome. We’re...facilitating interim payment, because we want to acknowledge the distance that service user has travelled” (Key informant, Phase I interview).

In another pilot area, the commissioner described how PbR could potentially be used to incentivise a range of interim public health outcomes that under previous block contracts were considered a cost to providers.

A number of the commissioners interviewed (and all providers interviewed thus far) expressed concern about one possible negative impact which PbR may have on the market. One commissioner suggested that it was possible, for example, that PbR “will encourage a culture of beating up providers”. There was a perceived danger expressed by this interviewee and others that PbR would in effect ‘de-stabilise the system’ and in particular exclude smaller providers who would not have the capital and resources to take on the risks associated with a system of funding linked to performance and (longer-term) outcomes. Commissioners were concerned then that there was a danger that the diversity in the market could in fact be limited by PbR. The small number of providers that had reportedly gone through to the tendering stage for those pilots who had re-commissioned services seemed to have borne this concern out:

“If I have one criticism... it’s the fact that I think that it basically excludes smaller organisations or smaller providers for bidding for the contracts because they just don’t have the financial base” (Key informant, Phase I interview).
One example was also given of a small organisation that had lost its contract to provide local treatment services and, as a consequence, its experienced treatment staff had transferred across to the new provider. Attachment fees for clients, interim payments and sub-contracting/partnership bidding were proposed as possible ways of encouraging smaller providers to continue to be involved in PbR contracts and service delivery (and these issues featured prominently in discussions as part of the co-design phase).

The drug treatment commissioning cycle means that substance misuse treatment staff may find themselves redeployed under TUPE (Transfer of Undertakings (Protection of Employment) arrangements. These issues are clearly not unique to PbR, but can present significant barriers for voluntary sector providers in bidding for NHS contracts, re-designing delivery or encouraging market development. Consideration needs to be given to the impact of PbR arrangements on staff, particularly since workplace culture and models of working with addiction may be radically different in the organisations winning new PbR contracts (which of course have implications for service users, too).

There was felt then to be a need to address staff insecurity about the implications of working in a performance led provider market. In some pilot areas, staff had reportedly been systematically informed about such changes to practice and contracts brought about by the introduction of PbR, but in the view of some commissioners this was considered variable and very much the responsibility of the provider organisation to manage effectively.

One final concern highlighted during Phase I interviews related to securing the confidence and investment of newly elected Police and Crime Commissioners in treatment as an effective form of crime reduction. Uncertainty about subsequent changes to DIP funding was also seemingly a source of some uncertainty and anxiety:

"I suppose the kind of big game-changer...is the advent of police and crime commissioners and the changes to the drug intervention programme... I know the PbR pilots feel particularly vulnerable about this and I understand that, because they are doing what they see as a two-year pilot and, you know, halfway through that two-year period, an element of their funding is put at risk and that’s a really, really difficult situation to be in. So, we’ve tried to kind of address it upfront and kind of talk about what you can do to mitigate the risk" (Policy stakeholder #3, Phase I interview).

4.4 Concluding remarks

Emerging themes from the on-going Phase I interviews as part of the process evaluation, describe both the opportunities and challenges posed by the transition to a PbR model of commissioning and delivery. These data revealed how, despite there being various considerations for sites when applying for PbR pilot status, the decision to do so was overwhelmingly perceived as an opportunity to both learn from and influence the development of a policy which was aligned with existing strategic priorities.
Some of the key emerging themes and issues can be summarised as follows:

- The pilot process seeks to provide areas with an opportunity to incentivise those outcomes deemed most appropriate to their local circumstances and priorities.

- The uniquely collaborative nature of the co-design phase of the drugs recovery PbR pilots was a highly innovative and challenging one.

- There seemed to have been variable expectations from the pilot sites regarding the co-design process.

- In devising the outcome domains the key challenges related to ensuring a balance was struck between offering sufficient incentives to providers to target sought after outcomes and ensuring these were achievable within a meaningful timescale.

- There was considerable diversity across the eight sites in the extent to which a Local Area Single Assessment and Referral System (LASAR) had been developed independently of provider organisations.

- The timescales for establishing the drugs recovery pilots were invariably described as 'challenging' and 'tight'.

- Some uncertainty and anxiety was evident persisted regarding the impact of PbR on small providers and as a result of staffing issues related to the re-commissioning of services. Concerns were also raised about the potential impacts on staff morale of a perceived shift towards a target-driven culture within services as a consequence of PbR.

- Delays that had been encountered during the course of developmental work undertaken to implement and deliver PbR were largely described as the result of problems related to data access, modelling of those data identified as accessible and appropriate, and ministerial sign-off for decisions.

- Despite these difficulties and challenges the main achievements of the co-design phase described to us included: (i) agreeing and defining what outcomes were being sought; (ii) establishing how these could best be measured; and (iii) devising a system of incentives to encourage progress towards achieving these outcomes.
Chapter 5  Scoping future stages of the research

In this chapter we provide an update on our scoping of the future stages of the research, within the context of the aims of the study, and the research questions that have been identified. The research questions originally proposed have been extended to take account of the issues raised in our evidence reviews, the initial stakeholder interviews, and further work on scoping the evaluation.

5.1  Approach to the evaluation, aims and research questions

The aims of the evaluation are to:

- Robustly assess the effectiveness of the PbR pilots against key process and outcome measures in the domains of treatment, offending, employment, and wider health & wellbeing.
- Undertake an economic evaluation of individual PbR pilots and the PbR pilots programme as a whole.
- Identify and disseminate (in collaboration with DH and government partners) lessons for ensuring the quality, effectiveness and efficiency of Drug Recovery PbR models in the future.

Following our preliminary work in the first phase of this study, the identified research questions (indicated by Q), and supplementary questions (indicated by SQ) that have emerged, have been grouped into the following main areas:

**Pilot schemes, funding models and running costs**

Q. 1:  What funding model is used in each of the pilot schemes, what services do they provide and how effectively have these been implemented?

Q. 2  What do these services cost to set up and run?

Q. 3  What are the direct and knock-on cost consequences of the schemes, in terms of treatment services and related health and criminal justice services?

SQ.4  What are the costs of the drug recovery services and other health, social and criminal justice services used by participants?

SQ.5  What is the health status and associated quality of life of participants?

SQ.6  What are the net effects of PbR on costs and benefits?

**Service provision and impact of recovery based outcomes**
Q. 7 What other services are provided that may impact on the PbR service provision and outcomes?

Q. 8 Has the introduction of PbR funding resulted in new or additional services, or otherwise changed the landscape of provision (including the effect on smaller providers)?

Q. 9 What is the level and nature of referral to, take up of and engagement with the appropriate services? Does this vary across different types of service users, and has the introduction of PbR had any impacts on treatment accessibility?

Q. 10 What are participants’ and stakeholders’ perceptions of the services and their impact, and are users satisfied with the services?

Q. 11 How do changes in recovery based outcomes, achieved by the PbR pilot sites, compare to non-PbR services within the study timeframe?

Q. 12 Is there a significant difference in the time taken to achieve these outcomes?

Q. 13 To what extent can the differences between the two groups be attributed to PbR?

Q. 14 What is the impact of PbR on commissioner and provider behaviours? Does an agreed recovery focus lead to pooling of budgets, reduced duplication, more innovation, and stimulation of the provider market?

**Unintended impacts attributable to adoption of PbR**

Q. 15 Are there unintended as well as intended consequences of adopting PbR? Are any spillovers positive or negative and, on balance, are the consequences beneficial?

SQ. 16 Are particular groups/types of service users refusing to utilise the treatments available under the PbR schemes? If this is the case, what are the numbers and characteristics of the relevant parties?

SQ. 17 Have waiting times for treatments been impacted by the introduction of the PbR models?

SQ. 18 Has the time spent in treatment changed? For example, are providers reducing consultation/treatment lengths to drive down costs?

SQ. 19 Has the type and content of consultations changed as a result of PbR?

SQ. 20 How has PbR impacted on the budgets and cash flow of providers?

SQ. 21 Has ‘volume’ for a given period changed since the adoption of PbR?

SQ. 22 What is the performance of LASARs as regards the appropriate setting of tariffs? What are the consequences of adoption of inappropriate tariffs and how frequently does this happen?

SQ. 23 How are providers resolving cases of individuals whose costs exceed the revenue yielded by the tariff? Are they requesting additional funding or simply not treating these clients?

To achieve these objectives and address the overarching research question, the evaluation of the PbR pilots includes both process and outcome components, will be carried out in all eight pilot sites, and will compare provision before and after the introduction of the PbR pilots in the pilot and non-pilot sites. The evaluation will analyse data from in-depth interviews (with commissioners, providers, services users and wider stakeholders) alongside monitoring data, economic data about the pilots and centrally-available outcomes and impact data. In the section that follows, we describe our approach to these research questions in more detail.

5.2 Pilot schemes, funding models and costs to run
Q. 1: What funding model is used in each of the pilot schemes, what services do they provide and how effectively have these been implemented?

5.2.1 Phase I interviews: systematic analysis of data
As noted above, the results of systematic analysis of all Phase I and II interview data will be provided in subsequent reports. The application of an appropriate analytical framework which ensures that this data synthesis and analysis reflects both the complexity and heterogeneity within and between the pilots are also being explored and considered by the research team.

Updated details of Phase I research activities up to 22nd November 2012 are set out in Table 5.1, below. All outstanding Phase I interviews will be completed by the end of December 2012.

Table 5.1: Phase I interviews completed up to 22nd November 2012 (N=117)

<table>
<thead>
<tr>
<th>Pilot</th>
<th>Number of interviewees</th>
<th>Professional</th>
<th>Service User</th>
<th>Focus group</th>
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<td>0</td>
<td>0</td>
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<td>2</td>
</tr>
<tr>
<td>Site 3</td>
<td>13</td>
<td>13</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Site 4</td>
<td>23</td>
<td>23</td>
<td>0</td>
<td>0</td>
</tr>
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<tr>
<td>Total</td>
<td>117</td>
<td>103</td>
<td>14</td>
<td>5</td>
</tr>
</tbody>
</table>

Interviews with service users were intended to provide an early stage view of provision pre and post-PbR implementation. The interviews will also inform the development of UserVoice activities in Phase II (i.e. identifying potentially relevant themes and issues to explore with a larger sample of interviewees). The sampling criteria for Phase I service user interviews sought problem users of alcohol, heroin and/or crack/cocaine who had also experienced local treatment provision prior to the introduction of PbR in April 2012. Interviewees were self-selecting in that they chose to respond to notices and posters displayed in PbR services.

Potential professional interviewees were identified initially in consultation with the pilot co-ordinator in each site.

5.2.2 Phase II interviews
The issues identified in the Phase 1 key informant interviews and the themes raised by the Rapid Evidence Assessment will be further investigated in Phase II interviews with staff in provider and commissioner organisations (ICPR and RAND) and with service users, carers and their families (via individual and focus group interviews conducted by UserVoice). This will build on information and findings gathered in the earlier phase. For example the phase one analysis of documents relating to the development and planned implementation of the PbR pilots will enable us to explore what arrangements work and which didn’t on a site by site basis.
Development, implementation and delivery of PbR

- Collation and analysis of local and national routine monitoring data. Comparison of before and after the introduction PbR caseload, throughputs, treatment type and length of contact and intermediate outcome measures.

- Up to 120 interviews with purposively sampled stakeholders to gauge a range of views and experiences of the implementation and early delivery processes in order to identify facilitators and barriers to success. The approach to conducting these interviews has been described above. Interview questions will include:
  - understanding of policy intent of PbR;
  - interpretation of how PbR has been implemented;
  - expectations of what PbR interventions are supposed to deliver;
  - views on challenges confronting successful implementation;
  - compliance and monitoring;
  - the implementation and delivery of LASARS;
  - development of approaches/interventions;
  - service delivery issues;
  - management and organisation;
  - staff training needs;
  - inter-agency working relations;
  - views on effectiveness of PbR and its various components;
  - unintended consequences (particularly those potentially arising from including or not including particular targets within the model - for example employment);
  - strengths and weaknesses of PbR and components.

- Up to 30 interviews with those not directly involved in the PbR pilots from the wider sector. For example those working in non-PbR drug and alcohol services, resettlement services and the criminal justice and health services. The interviews will concentrate on their perspective on the topic areas listed above.

5.2.3 Analysis of Phase II interview data

Qualitative data collected though open-ended questions in key person interviews and focus groups will be subject to thematic analysis using N-VIVO. This will involve assigning codes, allowing us to collate data under key headings (for example, based on issues discussed in key informant interviews). This will generate a list of common themes for discussing implementation, operation and experience of the PbR pilots.

The combination of information collected via review of monitoring data, key policy and practice documents, and individual and focus group interviews conducted throughout the study period, will

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This is an upper bound and in practice the number of Phase II interviews may be lower if data saturation is reached at an earlier stage. Any decisions on this would be reached in consultation with the funder.
provide both a national and local perspective on the implementation and development of PbR. We will describe:

- what is expected to happen, why and at what stage;
- to the extent possible, explain why certain things happen (or not); and
- understand how, and in what ways, the delivery of PbR recovery pilots can be improved.

Based on the work conducted above, we anticipate offering the following process information on the eight schemes:

1. description and assessment of the early stages of service delivery;
2. early implementation problems and how/if these were overcome;
3. procedures for delivery of the interventions;
4. management and organisation structures (including extent and nature of effective protocols for service delivery);
5. good practice points on service delivery, management and organisation;
6. extent of integration with existing structures, processes and systems (e.g. drug treatment);
7. process maps and logic models
8. throughputs (based on monitoring data).

Intelligence will also be sought on the effect on provider budgets and cash-flow and the use of gain-sharing arrangements between the incentivised providers and the collaborating agencies and programme participants.

Interviews and focus groups with service users will provide evidence of service user views and experience of PbR.

**Heterogeneity among pilot schemes**
During the scoping phase, it has become clear that there is considerable heterogeneity with respect to the PbR models that have been adopted by pilot areas. Some pilot areas have opted to adopt different approaches with respect to the outcomes aligned to provider payments than those being put in place nationally. In addition, the contribution that PbR makes to provider payments varies very considerably between areas.

We anticipate that there will be interest in segmenting the impact findings in order to determine whether some models have exerted a greater impact than others. Our approach to analysis will, where possible, include covariates to take account of between-area heterogeneity. It will be possible to test for statistically significant differences between sites for the more common events. However, as the area-specific sub-samples will be small and some events will be very rare, we may not have sufficient power for some outcomes to determine whether apparently large differences between sites are statistically significant.

**5.2.4 Costs and cost-effectiveness**
Q. 2 What do these services cost to set up and run?

Q. 3 What are the direct and knock-on cost consequences of the schemes, in terms of treatment services and related health and criminal justice services?

A key question relating to PbR is whether the policy is cost-effective: are the benefits generated by PbR large enough to justify the costs of implementing PbR? We will consider this question in our analysis, and the variation in the design of the incentive scheme between commissioning areas will also allow for potential analysis of how cost-effectiveness varies with design and other characteristics: for example, it may be that PbR payments equal to five percent of revenue are cost-effective but payments equal to sixty percent are not cost-effective.

We will consider the net cost of the schemes and the net benefits which will allow us to construct estimates of the cost-effectiveness of the pilots. Our approach to estimating the costs and benefits will build on work in DTORS undertaken by Davies et al. (2009) and will include the unit costs of Tier 3 and Tier 4 drug treatment services, including daycare services; triage assessment; GP prescribing; counselling etc., the costs of generic health care, accommodation, children in care, criminal activities, and quality of life (measured in QALYs). We will consider the following questions:

Q.4 What are the costs of drug recovery services and other health, social and criminal justice services used by participants?

Q.5 What is the health status and associated quality of life of participants?

Q.6 What is the net effect of PbR on costs and benefits?

We will use the DTORS evaluation data to map health (self-assessed physical and mental health) and social functioning measures in TOP, to utility scores to create QALYs. We will estimate changes in costs and benefits for pilots and compare these to changes in non-PbR comparator sites to provide evidence on the additional economic impact of PbR in the pilot sites compared to what would have happened otherwise. In addition, we will incorporate the estimated costs of managing and monitoring the PbR contracts as revealed during the Phase II interviews.

The scope of the economic evaluation will be broad, taking into account a wide range of costs and benefits including wider economic consequences, such as the impact of the change on productivity. For each of the impact measures we will obtain unit-costs from published literature to create an overall measure of the economic value of the impact.

5.2.5 Impact on commissioning

We have also observed that it will be important to examine the extent to which PbR arrangements lead to pooling of available drugs-related funding, reduced duplication and de facto shifts in expenditure between sectors. This will be examined in the pilot sites through the Phase II interviews.

5.2.6 Impact on the provider market
We will look to estimate the impact of PbR on competition between providers. There are multiple approaches to competition in economic theory, one of which is the theory of contestable markets (Baumol, 1983) which argues that contestability is determined not merely by the number of firms operating in a market, but also by the number of potential entrants (threat of competition). In the PbR pilot, competition in each local market, as defined by the local commissioning boundaries, will be measurable both by the competition for the market (which would be the number of bidders for contracts with the local commissioner) and competition in the market (which is the number of providers in receipt of contracts with the commissioner).

For this part of the evaluation, it will be important to define the context of the local commissioning market by characteristics including barriers to entry and exit for each region (e.g. sunk costs) and access to the equivalent levels of technology. We will also use ND/ATMS agency codes to assess changes in the types and ranges of providers operating in the markets in the pilot and comparator sites.

Purchasers have a number of policy levers available to attempt to improve the performance of providers, two of these are: (i) competition; and (ii) payment-for-performance. We will undertake market analysis in the pre- and post-intervention periods and in the pilot and comparator sites using a variety of measures of market concentration.

We will also consider whether DATs were more or less likely to adopt P4P in areas with a less competitive market structure. This will provide us with evidence of whether commissioners are selecting to use the P4P mechanism based on the provider market structure in their local area.

### 5.3 Service provision and impact of recovery based outcomes

**Q. 7** What other services are provided that may impact on the PbR service provision and outcomes?

**Q. 8** Has the introduction of PbR funding resulted in new or additional services or otherwise changed the landscape of provision?

**Q. 9** What is the level and nature of referral to, take up of and engagement with the appropriate services? Does this vary across different types of service users, and has the introduction of PbR had any impacts on treatment accessibility?

**Q. 10** What are participants’ and stakeholders’ perceptions of the services and their impact, and are users satisfied with the services?

**Q. 11** How do changes in recovery based outcomes, achieved by the PbR pilot sites, compare to non PbR services within the study timeframe?

**Q. 12** Is there a significant difference in the time taken to achieve these outcomes?

**Q. 13** To what extent can the differences between the two groups be attributed to PbR?

**Q. 14** What is the impact of PbR on commissioner and provider behaviours? Does an agreed recovery focus lead to pooling of budgets, reduced duplication, more innovation, and stimulation of the provider market?
5.3.1 Distributional impact

To examine the distributional impact of PbR, we will examine whether adoption of PbR changes the distribution of treatment across different types of service users. Such analysis will take the form of a multinomial logit regression where the categorical outcome (received treatment; did not receive treatment; and ineligible for the scheme) is related to service user characteristics. Such an approach will allow us to estimate whether and how user characteristics such as age, gender and historical risk impact on the relative probabilities of being assigned to a given outcome. Estimating the distributional impact also requires some consideration of individuals that have been excluded from treatment as a result of PbR, if such exclusions are allowed.

As well as evaluating variations in participation rates, we will seek to estimate variations in the average impacts of the scheme. We will relate the probability of successful outcomes to the characteristics of service users. The parameter estimates will indicate whether the gains from treatment under PbR are shared out equitably, or whether certain types of service users have benefitted more than others.

5.3.2 Benchmarking and impact

A key component of our future research will involve the use of anonymised and routinely reported treatment modality start data derived from National Drug and Alcohol Treatment Monitoring Systems (NDTMS and NATMS), Treatment Outcomes Profile (TOP) and Local Area Single Assessment and Referral System (LASAR) sources for each of the eight PbR pilot sites. The intention is to use these data to describe and assess the nature and extent of any change in the relevant treatment caseload profiles before and after the introduction of PbR in April 2012. This will include consideration of:

- rates of referral, assessment and treatment take-up;
- client demographics;
- referral sources;
- personal circumstances (housing and employment);
- main drug of concern;
- self-reported substance use;
- injecting risk;
- health and wellbeing;
- composite complexity scores; and
- the nature and extent of structured interventions delivered.

The evaluation of impact will assess the extent to which key outcomes in PbR pilot areas differ to those in non-pilot, non-PbR, areas. It will be based on the analysis of NDTMS data, case-linked with other secondary datasets that provide suitable indicators of outcome at the individual, client, level. Outcomes both during and after the end of treatment will be considered.

The NDTMS dataset will be used as the basis of sampling. Discussions with the NTA indicate that this source will be capable of indicating which clients are engaged in the PbR process, enabling accurate identification of ‘cases’ and ‘controls’. In addition, the NTA maintains a record of the extent to which
non-pilot areas are operating within a similar model to that employed by pilots. Thus it will be possible to include or exclude from the comparison those non-pilot areas that are already moving towards the PbR model. Details of the secondary datasets, to be employed in the evaluation as indicators of outcome, are outlined.

5.3.3 Datasets
Our proposal indicated that we would consider linkage between NDTMS and the following secondary datasets for the purpose of developing additional outcome indicators:

- Department of Work and Pensions (DWP) database
- Police National Computer (PNC)
- ONS Mortality Data
- Drug Interventions Programme (DIP) Data

During the pilot phase we have further considered the feasibility of linkage with these datasets. Based on previous work and information gathered during the pilot phase we are satisfied that case-linkage is feasible on the basis of the available attributor information (initials, date-of-birth, gender & area, where appropriate). Thus, we intend to include employment, offending, death, and contact with DIP as outcome indicators.

There is a lag in the ONS mortality data between the date of death and the registration of death, particularly in respect of registration of deaths with coroner involvement (e.g. deaths related to overdose). This delay may be a year or more after death has occurred. Hence ONS mortality data for the (distant) pre-pilot period will be more complete than that for the (recent) post-pilot period. This may obstruct longitudinal analysis changes in mortality rates but will not affect cross-sectional analysis, as we expect data completeness for both the pilot and non-pilot areas to be similarly affected.

There is also a lag of around six months before the Police National Computer dataset is sufficiently complete to support the outcome analysis and we will need to allow a period of one month to obtain the up-to-date PNC data from the Ministry of Justice, based on the assumption that permissions and procedures for data release have been put in place. Advice from the Ministry of Justice PNC team is that it takes at least three months for an offence to be recorded on the PNC and a further three months for conviction data to be recorded. Thus, a six-month lag will account for the vast majority of recorded offences that occur and should account for approximately 90% of conviction data. It will be necessary to analyse the data available at 6 months, without adjudications for cases where these are ‘pending’. We expect that the lag period will be the same for both the pilot and comparison areas. Thus, this should not confound geographical analysis for the same time period. In addition, we can correct the temporal analysis for this, based on available data regarding the proportion of charges that result in a ‘not guilty’ verdict.

Our proposal also indicated that we would consider case-linkage with:
- Hospital Episodes Statistics (HES) Data
- Infectious Diseases Data
For HES data it would be necessary to establish a ‘bridge’ between the ‘attributor’ code (initials, date of birth, and gender) available to link cases to NDTMS and the NHS number, which is the only ‘identifying’ data available within HES. Initial discussions indicate that it might be feasible to obtain a suitable national list of NHS numbers and ‘attributor’ codes to provide this ‘bridge’, although prior experience suggests that this may not be possible within the timescale for the evaluation. Furthermore, because many millions of individuals are recorded within HES and the NDTMS ‘attributor’ code is non-unique, and because there is a high degree of case-heterogeneity (i.e. the vast bulk of the HES data relates to non-drug users), the likelihood of false case-linkage is high.

With respect to infectious disease surveillance data; we understand that this operates within a ‘sentinel’ system, whereby selected laboratories contribute cases to the national dataset; thus geographical coverage will be highly partial with respect to the pilot /non-pilot areas, carrying a risk that positive linkages will reflect differences in geographical coverage of the surveillance data rather than in true incidence. Furthermore, because cases are recorded according to date of diagnosis, whilst infection will have occurred at an undetermined date in the past, case-linkage of these data are unlikely to prove useful in assessing the short-term impact of PbR.

In view of the potential pitfalls, complexity, and timescales involved in obtaining the HES and infectious disease datasets, we consider that their inclusion poses a risk of non-delivery for the core elements of the impact strand of the evaluation. We therefore propose to treat inclusion of these two datasets as second-order priority. They will be pursued, but not to the detriment of the analysis of the other datasets for which linkage is more accurate and data availability more reliable.

5.3.4 Study Design

Our original application proposed, for the impact element of the evaluation, a cross-sectional comparison of PbR pilot sites with non-pilot sites, whereby outcome indicators would be examined for cohorts of clients entering or leaving treatment after the introduction of the PbR pilot. During the scoping phase, stakeholders have suggested that it would be of interest to include an additional temporal component, comparing pilot and non-pilot areas before and after the introduction of PbR. This reflects a belief that the treatment system as a whole has been shifting over time towards a more recovery- and results-focussed model, regardless of the PbR initiative.

In the last two decades a great deal of research has been undertaken relating to the identification of casual effects from policy interventions. The central problem studied in this literature is that of evaluation of the effect of exposure to treatment of some given set of units to a policy or treatment on some given outcome (Imbens & Wooldridge 2009). In the case of the PbR Drug and Alcohol Recovery Pilots, these units are individuals and the outcomes are multiple, measuring various dimensions of ‘recovery’.

For the economic strand of the evaluation, we originally set out our intentions to use a difference-in-differences approach to identify the impact of the policy intervention. The basic premise of difference-in-differences methods is to identify areas with similar characteristics, some exposed to the policy, other areas not exposed, and to measure the differences between changes in performance of treatment and control sites. The average change in performance over time in the
non-pilot sites will be subtracted from the average change in performance over time in the pilot sites. This double differencing removes biases in second period comparisons between the treatment and the control group which could be the result of permanent differences between those groups, as well as stripping out bias created from comparisons over time in a treatment (pilot) site which could be caused by time trends unrelated to PbR (Imbens & Wooldridge, 2009).

Therefore, we propose to undertake the analyses for the impact and economic strands using methods that examine the effect of PbR whilst controlling for national trends in treatment outcomes (pre and post PbR introduction). Thus, we will consider whether the changes observed in the pilot areas are different to those observed in non-pilot areas, distinguishing whether the introduction of PbR has exerted an impact that is over and above those changes already underway within the treatment system. This has the additional advantage of accounting for between-area differences both before and after the introduction of the pilot schemes.

Where applicable, the revised design will employ the same approach to data analysis as originally proposed, whereby we shall utilise time-to-event analyses to describe the, individual-level, ‘hazard’ associated with positive/negative outcomes in pilot versus non-pilot areas, accounting for area differences prior to and post-PbR introduction and other potential confounders. This will show whether clients treated within a PbR model in pilot areas have different probabilities of experiencing positive outcomes compared to those treated, within a standard treatment model, in non-pilot areas or in pilot areas prior to PbR launch. This will quantify, for example, the extent to which the likelihood of offending is different for PbR clients, together with measures of associated statistical uncertainty (i.e. 95% confidence intervals). This type of analysis is commonly used to assess whether the risk of occurrence of an outcome, which may or may not occur during a finite follow-up/observation period, differs according to the presence/absence of an intervention. The approach will allow us to include covariates in the analysis, accounting for casemix and other factors.

However, many non-pilot sites have now adopted some element of recovery focused services based on a PbR model. Therefore, the policy intervention or treatment will require careful definition. Originally, eight pilot sites were planned whereby local commissioning agents would commission drug and alcohol recovery services based on funding at least partially dependent on outcomes rather than simply based on activities. However, since the drafting of the initial research proposal, it has become clear that local commissioners in some non-pilot areas have recommissioned drug and alcohol recovery services based on a new funding model comprising at least some element of PbR. This development creates additional complications but also opportunities for the analysis. Variation in the design of the local incentives structures provides an opportunity to identify the effects of particular design features; for example, the proportion of income tied to PbR and the indicators covered.

Whilst this variation is potentially informative, it will also create complications. This creates a methodological issue known as ‘endogenous selection into treatment’: commissioners who choose to adopt a PbR approach are by definition different to those who choose not to adopt PbR payments. If the reasons for such differences are unobserved they may invalidate causal comparisons of outcomes by treatment status, potentially even after controlling for observable characteristics (Imbens & Wooldridge, 2009).
Endogenous selection into treatment will not be created by the existence of these non-pilot PbR sites provided their selection into PbR funding arrangements is random. However, this seems unlikely, even in theory. Whilst it could be that non-pilot PbR sites have only adopted a new funding model as a consequence of the incidental timing of their commissioning cycles, the decision to switch from block contracts towards the PbR model is not random and thus we can, a priori, estimate that our analysis will have to take account for the effects of endogenous self-selection.

Endogenous self-selection is a common problem in policy evaluations as assignment into the policy is frequently non-random. Consequently there are multiple potential approaches to consider when addressing selection bias. ‘Matching’ can solve this selection problem: provided we are able to measure the variables which are influencing treatment assignment, we can condition on observables. Matching requires the assumption that there are no unobservables influencing treatment assignment. Alternatively, the ‘propensity score’, which is a scalar summary of the covariates, can be used as it provides the probability of being assigned to the program group conditional on the provider/commissioner’s covariate values. This improves the capacity of the analysis to produce accurate causal estimates due to its nonparametric approach to the balancing of the covariates between the programme and control group, which removes bias due to observable variables (Imbens & Wooldridge, 2009). It yields an estimate of the impact of a programme variable on an outcome variable that is principally free of bias arising from the relationship between status and observable variables.

5.3.5 Outcomes
The consequences for service users will be measured on three sets of metrics: the incentivised metrics; metrics that are related to the incentivised metrics in the key domains of interim and final treatment outcomes; and measures that reflect aspects of social value outside these key domains. The latter two groups will be analysed to see whether providers ‘focus on the targets but miss the point’ and whether there is:

- diversion of effort away from unincentivised domains and into incentivised domains;
- whether there are positive spillovers onto these areas.

We intend to align, where appropriate, the key incentivised outcome measures for the evaluation with those that are being put in place nationally to inform provider payments. Hence, our measures of outcome will include:

Abstinence/Recovery:
- Abstinence at any two TOP assessments (28 days apart) within 12 months
- Successful treatment completion (as assessed via NDTMS at discharge)
- Non-representation to treatment within 12 months

Offending:
For offending, we plan to use individual level data on time from treatment entry/discharge to next offence rather than the aggregated cohort measure used for tariff payments. This approach will
enable us to determine whether there are statistically significant differences in the probability of recorded offending between pilot and comparison areas or over time. We will include as covariates the same range of factors employed in the tariff cohort measure. We will also test whether any changes in the risk of offending are more likely among high or low rate offenders and whether PbR affects the volume as well as incidence of offending.

Health/Well being:
- Cessation of injecting at any two TOP assessments (28 days apart) within 12 months
- Housing improvement at any two TOP assessments (28 days apart) within 12 months
- Provision of Hepatitis B vaccination

Past experiences with pay-for-performance and other incentive schemes have found that whilst schemes tend to be designed with a set of clear intended consequences (i.e. improvement on the incentivised outcomes), they can additionally produce unintended consequences. These spillover effects can be positive or negative. Many plausible hypotheses (see Chapter 2) exist regarding why PbR would cause positive spillovers (for example: ‘stimulating innovation’) or negative spillovers (for example: diversion of effort to maximise revenue). In assessing the impact of PbR on non-incentivised domains, we intend to focus on two specific areas: metrics that are related to the payment domains (offending, health and wellbeing); and metrics that reflect important aspects of social values which are not reflected within the payment categories. These indicators will be selected from the following list based on further consideration and analysis of their reliability:
- Waiting times for first and subsequent interventions
- Numbers of clients leaving treatment not free from dependency
- Average days of drugs use at six month review
- Changes in employment status
- Changes in educational status
- Numbers of clients discharged in custody
- Numbers of clients retained in treatment for at least 12 weeks.

5.3.6 Sampling
The original specification for the research suggested that the PbR pilot schemes would be launched during October 2011. Our original research plan was based on the assumption that cohort sampling from NDTMS could commence around that date. An NDTMS cohort sampling period of around one year was planned, in order to secure sufficient cases to power the proposed analysis, with follow-up of outcomes among this group over a further year.

The introduction of the pilot schemes was re-scheduled to April 2012, which has truncated the period available for cohort sampling, outcome follow-up, analysis, and write-up. It will not be possible to adhere to the timescale for sampling and follow-up that was originally proposed. Twelve months sampling from April 2012 to March 2013, with twelve months follow-up from April 2013 to March 2014, and a six months lag in obtaining data sets such as the PNC, would take the data gathering phase alone to the planned project end date, October 2014.
Thus, within the current timescale, the time available to undertake the quantitative strands of the research has been reduced by six months. Matching methods, inclusion of person-level risk factors, inclusion of the non-pilot PbR sites and joint modelling of the multiple outcomes will be used to reduce bias and increase the power of the statistical analyses. Nevertheless, we have some concerns about the power of analysis with a truncated follow-up period to detect statistically significant impacts of PbR in some outcomes.

We have given very careful consideration to contingency arrangements in order to accommodate the re-scheduling of the introduction of PbR. We suggest that it would be highly inadvisable to truncate the NDTMS cohort sampling phase as this would reduce the cohort size, thus reducing statistical power.

Additionally, recent discussions indicate an emerging policy view that the evaluation should consider some outcomes for individuals entering the PbR recovery system during 2013/14 as well as during 2012/13, in light of the proposed changes to PbR weightings. This would require that the cohort sampling phase, previously planned to cover 2012/13, also be extended, so that it includes cases that enter the system during 2013/14.

Our recommendation is to delay the time at which we will obtain the follow-up data to September 2014. This reduces the planned time period for analysis and write-up, but can be accommodated by re-scheduling the input of researcher time. For many of the outcome indicators, particularly those obtained from within NDTMS, this will enable us to provide results for the cohorts subject to the revised PbR tariff weightings in 2013/14. For the offending measures obtained from the PNC data we propose to focus on those clients exposed to the revised PbR tariff weightings in the first six months of 2013/14. For these clients, taking into account the six month data lag in the PNC data, we will still be able to analyse offending risks over a full one-year period. For the ONS data on mortality, we need to allow for the lag in recording of deaths where a coroner is involved. For the clients exposed to the revised PbR tariff weightings in the first six months of 2013/14, the ONS data on mortality that are likely to be available as at September 2014 only enable analysis of the risk of mortality over a six-month period.

As a result, for the offending and mortality measures, it is important to emphasise that the outcomes in the PbR pilot sites cannot be compared between clients in the first (2012/13) and second (2013/14) years. We will focus our evaluation on the comparisons between the PbR pilot and the non-PbR sites separately in the two years. Comparisons of these outcomes in the PbR pilot sites between the two years will be confounded by the differences in sampling and follow-up periods.

5.4 Unintended impacts attributable to adoption of PbR

Q. 15 Are there unintended as well as intended consequences of adopting PbR? Are any spillovers positive or negative and, on balance, are the consequences beneficial?

Concern has been expressed that the adoption of PbR could induce gaming by providers. Gaming is a potential risk for all incentive schemes, but is more of a concern with the complexity of multiple
outcomes and multiple severity groups. The list of research questions below reflects the recommendations of the Gaming Commission.

One important form of gaming is risk selection. Risk selection describes behaviour in which, for clients offering equivalent revenue, providers of the service select the clients that are expected to be easier to treat. The incentive for risk selection may be mitigated by the case-mix weighting of the payment tariff. The payment tariff has been adjusted to reflect the complexity of the individual case. If this risk-adjustment is wholly successful, there will be no incentive for providers to select for risks as they will be remunerated equivalently to the case complexity. However, this is a complicated task and whilst effective system design is the primary opportunity for minimising gaming – effective monitoring will also likely be required as effective system design is complex and difficult to achieve.

Q. 16 Are particular groups/types of service users refusing to utilise the treatments available under the PbR schemes? If this is the case, what are the numbers and characteristics of the relevant parties?

Q. 17 Have waiting times for treatments been impacted by the introduction of the PbR models?

Q. 18 Has the time spent in treatment changed? For example, are providers reducing consultation / treatment lengths to drive down costs?

Q. 19 Has the type and content of consultations changed as a result of PbR?

Q. 20 How has PbR impacted on the budgets of providers (e.g. cash flow)?

Q. 21 Has ‘volume’ for a given period changed since the adoption of PbR?

Q. 22 What is the performance of LASARs as regards the appropriate setting of tariffs? What are the consequences of adoption of inappropriate tariffs and how frequently does this happen?

Q. 23 How are providers resolving cases of individuals whose costs exceed the revenue yielded by the tariff? Are they requesting additional funding or simply not treating these clients?

Questions 16-19 and 20 will be assessed by quantitative analysis of the compositions of client groups in the pilot and comparator sites and use of the engagement measures, waiting times and treatment pathways reported in NDTMS. These, and the remaining questions, will also be examined through the Phase II interviews.
In general, the project is progressing as originally planned. For the Process Strand, our NHS ethics application has now been approved and the process for obtaining R&D ‘passports’ for NHS and Local Authorities is at an advanced stage. Key informant interviews have been undertaken at each of the eight pilot sites. These have revealed substantial differences in design and implementation, with some sites adopting their own outcome definitions in advance of the publication of guidance by the DH.

A full draft of the Rapid Evidence Assessment has been produced. The issues raised by this review will be further investigated, along with follow-up on the themes identified in the Phase I interviews, in the Phase II interviews with staff in provider and commissioner organisations. We foresee no problems with these Phase II interviews taking place as planned.

For the Impact Strand, the NDTMS dataset will be used as the basis of sampling. We have confirmed that this source will be capable of indicating which clients are engaged in the PbR process. In addition, the NTA’s database of the extent to which non-pilot areas are operating within a similar model to that employed by pilots will allow us to include or exclude from the comparison those non-pilot areas that are already moving towards the PbR model.

Our original application proposed a cross-sectional comparison of PbR pilot sites with non-pilot sites. Subsequent discussions with stakeholders have revealed a widespread view that treatment agencies have been increasingly moving towards a recovery model over time. Therefore, we propose to undertake an analysis that examines the effect of PbR whilst controlling for national trends in treatment outcomes (pre and post PbR introduction). Thus, we will consider whether the changes observed in the pilot areas are different to those observed in non-pilot areas, clarifying whether the introduction of PbR has exerted an impact that is over and above those changes already underway within the treatment system. This has the additional advantages of accounting for between-area differences both before and after the introduction of the pilot schemes and being consistent with the difference-in-differences design originally proposed for the Economic Strand.

Our proposal indicated that we would consider linkage between NDTMS and the following secondary datasets for the purpose of developing outcome indicators:

- Department of Work and Pensions (DWP) database
• Police National Computer (PNC)
• ONS Mortality Data
• Drug Interventions Programme (DIP) Data

During the pilot phase we have further considered the feasibility of linkage with these datasets. Based on previous work and information gathered during the pilot phase we are satisfied that case-linkage is feasible on the basis of the available ‘identifying’ information (initials, date-of-birth, gender & area, where appropriate).

Our proposal also indicated that we would consider case-linkage with:
• Hospital Episodes Statistics (HES) Data
• Infectious Diseases Data

With HES, the process for obtaining the data can be very slow and the probability of false case-linkage based on the available attributors is high. For the infectious diseases data the geographical coverage is highly partial. We therefore propose to treat inclusion of these two datasets as second-order priority. They will be pursued, but not to the detriment of the analysis of the other datasets for which linkage is more accurate and timely data availability more assured.

For the Economic Strand, the heterogeneity in the design of the PbR pilots offers the opportunity to examine whether aspects of the design of the incentives influence the outcomes. We have developed a taxonomy for the incentive schemes, which we propose to apply to the official pilot sites and the other areas identified by the NTA as adopting a PbR-style model. However, the adoption of different schemes in different areas raises the prospect that the evaluation will need to account for selection bias caused by endogenous selection into (form of) ‘treatment’. This will be addressed using a variety of matching techniques and further exploration of the decision-making process to identify possible exogenous causes of variation in the adoption and design of PbR schemes.

We have also further developed our plans for examining the impact on the provider market (separating competition for the market from competition in the market), the distributional consequences of PbR across different groups of service users (including the possibility of ‘cherry-picking’) and the identification of spillovers of PbR onto un incentivised aspects of care.

The re-scheduling of the start date of the pilots means that it will not be possible to adhere to the timescale for sampling and follow-up that was originally proposed. To take account of this re-scheduling and the planned changes to the PbR tariff weightings in 2013/14, we recommend a six-month extension to the project. With this extension, we would obtain the data available on the outcomes for clients as at September 2014. For most outcome measures and indicators we would be able to analyse data for all clients in 2012/13 and 2013/14. For the offending and mortality measures, however, the available follow-up periods for the 2013/14 clients would be curtailed, would have less statistical power, and would only be comparable between PbR and non-PbR sites at each point in time and not over time in the PbR sites. This change in the overall project plan could be accommodated as a no-cost project extension.

Overall, our assessment is that the plans described in our original application remain feasible and meet the original scope of the evaluation. We have adjusted our plans to the re-scheduled start of
the PbR pilots, provided options for possible extended periods of follow-up, and altered our proposed design to allow for the increasing adoption of recovery-orientated and PbR-style commissioning arrangements in the non-pilot sites.
Chapter 7 References


*The Effect of Pay-for-Performance In Hospitals: Lessons For Quality Improvement, Health Affairs, 30(4): 690-98.*


Appendix A: Methodology of the Rapid Evidence Assessment

A literature review was undertaken in the form of a Rapid Evidence Assessment (REA). An REA is conducted within a limited timeframe and involves an overview of existing research on a carefully defined topic. REAs aim to be rigorous and explicit in method and thus systematic, but make concessions to the breadth of the process by limiting particular aspects of the systematic review process\textsuperscript{15}. The search process is summarised in Figure 1.

Figure 1: Overview of REA methodology

<table>
<thead>
<tr>
<th>Stage in REA process</th>
<th>Steps taken by the research team</th>
</tr>
</thead>
<tbody>
<tr>
<td>STAGE 1</td>
<td>Identified electronic databases that had facilities to search academic and/or grey literature. Identified specialist websites to hand search. Defined combinations of search terms specific to each question.</td>
</tr>
<tr>
<td>STAGE 2</td>
<td>Entered search terms systematically into the databases. Created Endnote database of all ‘hits’.</td>
</tr>
<tr>
<td>STAGE 3</td>
<td>Removed duplicated hits. Applied the inclusion/exclusion criteria by reading title and abstract.</td>
</tr>
<tr>
<td>STAGE 4</td>
<td>Refined and applied inclusion/exclusion criteria specific to each research question, based on developing understanding of scope of literature and to ensure manageable number of hits.</td>
</tr>
<tr>
<td>STAGE 5</td>
<td>Extracted information relevant to research questions from each source using a data extraction template.</td>
</tr>
<tr>
<td>STAGE 6</td>
<td>Supplemented the systematic search by hand-search of contents and bibliographies of key sources.</td>
</tr>
<tr>
<td>STAGE 7</td>
<td>Synthesised findings/potentially transferable lessons.</td>
</tr>
</tbody>
</table>

Research questions

Payment by Results

1. Has PbR been used before in the UK? If so, how was the scheme set up?

2. Has PbR been evaluated? If so, were the evaluations robust and what were the findings?
3. Is there any critique of PbR by academics and/or researchers?

Drug treatment outcome measures
1. Have the outcome measures used in the PbR pilots been used in other treatment programmes?
2. If so, are they operationalised in the same way?
3. Is there any critique of these measures?
4. Is there any evidence that they have been achieved in previous programmes?
5. Is there any evidence that setting a goal of abstinence improves outcomes?
6. What estimates exist for rates of abstinence following treatment?
7. Is the term ‘recovery’ mentioned in the literature?
8. What evidence, if any, is there regarding the advantages and disadvantages of substitute prescribing?

Alcohol outcome measures
1. What outcome measures are most commonly used in alcohol treatment programmes which have been evaluated?
2. How are they operationalised?
3. Is ‘recovery’ mentioned – if so, how is it operationalised?
4. What are the strengths and limitations of these measures?
5. Is there evidence that setting a goal of abstinence improves outcomes?
6. Is there evidence that abstinence is/is not feasible?
7. What estimates exist as to rates of abstinence following treatment?

Sources for the search
To answer the research questions presented above, a list of search sources was developed for each of the three themes. It consisted of academic literature (through bibliometric databases and, where applicable, systematic reviews such as the Campbell collaboration), of grey literature (through portals such as Policy Hub or OpenSIGLE) and of specialist websites to be hand searched. Bibliographies of identified relevant literature were then searched for further material. Sources searched included:
- Campbell Collaboration Library
- Cochrane Library
- Google Scholar
- EBSCOhost
- Econlit
- Academic Search Elite
- CSA Illumina
- PubMed
- Policy hub
- Open sigle
- Department for Work and Pensions
- The Young Foundation
Search terms

The research team developed sets of search terms. While the first REA on payment by results used search terms ‘payment by results’ and ‘pay for success,’ the two REAs on outcome measures relied on a matrix of search terms.

**Search terms for drugs outcomes:** Abstinence OR Recovery OR Drug free OR Outcome OR Discharge OR Quality of life OR Well-being OR Housing OR Offending AND Drug treatment OR Drug intervention

**Search terms for alcohol outcomes:** Abstinen* AND Alcohol treatment OR Alcohol intervention.

Inclusion and exclusion criteria

Sources must be:

3. Published in English
4. Published in the last 12 years (since 2000)

In line with the aim of the review to contextualise the PbR Pilots, rather than review the ‘what works’ literature, the research team selected only studies which were directly relevant to the research questions, narrowing the criteria to ensure a manageable number of studies were included.

Data extraction

Downloaded literature was screened and information was entered in a data extraction template based on the ‘EPPI-Centre data extraction and coding tool for education studies V2.0’.\(^\text{16}\)

Summary of results: PbR

Overall, the search yielded 333 downloaded items. Among these, 32 duplicates were identified by EndNote and 29 additional ones by the research team. A hand search of contents and bibliographies of key literature led to an identification of further 16 items.

Summary of search results: drugs outcomes

A total of 2804 articles were reviewed. By eliminating duplicate articles and those that did not have prima facie relevance the sample was filtered down to 508 documents. These 508 articles were review by abstracts and filtered down to 116 relevant articles that provided information on outcome measures used in substance abuse treatment. A few additional articles were included through bibliographic reference searches.

Summary of results: Alcohol outcomes

A total of 300 studies were identified through the search, and screened by title and abstract.

\(^{16}\) Available at www.civilservice.gov.uk/wp.../data_extraction_form_tcm6-7398.doc, retrieved 13 September 2012.
Appendix B: Interview Topic Guide

This guide will be used during interviews with key informants who know about service provision in the area before the implementation of the pilots. Findings from these interviews will feed into the development of benchmarks of the areas before the pilots. This will help the evaluation to identify what, if anything has changed as a result of the pilots.

Section A: introductory questions

- Please could you describe your current role
- Can you describe what your day to day work entails?
- How long have you been doing this sort of work?
- How long have you been in this post?

Section B: involvement in PbR

- Are you aware of plans to develop payment by results pilots in this area
- [prompt] if so, what do you know, how did you find out, have you been involved in the development of the pilots at all

Section C: the existing landscape of provision

- Could you describe how drug and alcohol treatment is currently provided in this area?
- Commissioned/managed by whom?
- [prompt] community safety partnership, drug action team, multi-agency consortium (made up of which agencies)?
- How, if at all, have partnership arrangements between agencies for both commissioning and delivering services been managed?
- Could you estimate the number and range of local providers up until April 2012? (assessment/advice; prescribing; detox; alcohol treatment service)
- What kind of service providers are currently commissioned in this area [Prompt: small or large, presence across the UK or just working in this area]
- Do you know how long current service contracts are for [prompt: less than 6 months, a year, longer?]
- In your view, is there a good range of providers to choose from in this area? Or are there only a few providers available?
- Are there targeted services for e.g. women/parents, stimulant users, problem cannabis users
- Is there a local service user forum?

Section D: Strengths and weaknesses of existing provision

- Can you identify any gaps in provision locally?
• How effective in your view have the current service delivery methods been?
• Have there been any problems with the way in which services have been delivered?
• What would you say are the strengths of service provision in the areas?

Section E: Character of problem drug/alcohol use locally
• Do you know of any distinctive features in terms of drugs of misuse locally/local drug economy?
• Do you know how many referrals there were in 2008/9, 2009/2010
• [prompt] if possible, broken down from CJIT, DIP, arrest referral
• Do you know how many DRRs there were in 2008/9, 2009/2010?

Section F: Views on the recovery pilots
• What is your view on the pilot which will be/has been implemented in the area?
• Do you have any views on the PbR model that has been adopted?
• Do you foresee any particular challenges or unintended consequences of this model?
• What, if anything, do you hope the pilot will achieve?
• Are there any specific local issues which you hope the pilot will improve? If you were involved in the tendering process, what were your objectives in tendering for the recovery pilot?
• In what ways will recovery pilot represent new ways of providing drug and alcohol treatment services?

Description of Pilots
• Has the pilot started?
• If so, do you know which services have been commissioned? (single, multiple providers, which ones?)
• Which funding streams are being used?
• Links with which other local services? (Jobclub, housing, social care, volunteering, mentoring schemes?)
• Assessment and referral systems used?
• LASARS – description and rationale for selected measurement and payment mechanisms, developed in consultation with which other agencies
• How will PBR-related activities be measured; including which outputs and outcome measures?
• How are service users being informed and consulted about the PbR recovery pilot?

Section G: Closing questions
• Any suggestions for relevant documents, or other people we should speak with
• Any other comments to feed into the evaluation?
Appendix C: Descriptions of pilot sites

Standardised summaries of each of the pilot sites are provided below using the most up-to-date information available at the time of writing. These descriptions were informed using a combination of interview data, submissions by the pilot sites themselves (e.g. via the dedicated PbR discussion forum) and published documentary data (a full inventory of these documentary sources will be provided and reported in Phase II). As pilots it is inevitable that changes will be implemented to service delivery. As such the models described may not necessarily be reflective of current or future practice. A more detailed narrative account of the developmental process of each site over the life of the pilot will be provided as part of Phase II of the evaluation.
<table>
<thead>
<tr>
<th>Location of PBR pilot</th>
<th>Phase 1 interviews</th>
<th>Description of PbR model/tariff</th>
<th>Stage in commissioning cycle</th>
<th>Out-going providers</th>
<th>Incoming provider</th>
<th>LASAR model</th>
</tr>
</thead>
<tbody>
<tr>
<td>DAAT overseen by Bracknell Forest Crime and Disorder Reduction Partnership and the Health and Social Care Partnership Board.</td>
<td>DAAT coordinator LASAR manager</td>
<td>Individual tariffs set for each client based on Initial screening and risk assessment in six domains (Substance Misuse; Risk to self; Risk to others; Risk to children; Risk from others; and Offending) Bracknell Forest is 100% PBR and pays 30% attachment fee paid up-front; 39% payable on interim performance measures; and 31% on final outcomes.</td>
<td>Re-commissioning tier three services 2010/2011 (specialist prescribing, psychosocial interventions &amp; shared care)</td>
<td>SMART CJS (contracted 2008), Turning Point and CRI.</td>
<td>SMART CJS re-contracted as prime provider SMART will operate out of New Day/DAT/LASAR officers in Bracknell town centre. They have a mobile unit where appointments can take place in rural areas. Their staff will be called Recovery Facilitators SMART CJS will subcontract prescribing to GP surgeries.</td>
<td>LASARs independent of the provider and based within the Drug and Alcohol Team. LASAR will retain responsibility for TOP co-ordination so that progress can be tracked. For new clients initial screening and tariff setting will be followed by risk assessment via LASAR, recovery plan put into place and referral made into prime provider. All stock clients re-assessed in person using LASAR initial screening tool.</td>
</tr>
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<tr>
<td>Enfield borough DAAT</td>
<td>DAAT strategy manager; Performance manager for Westminster Drug project; and representative from provider of drug and alcohol treatment.</td>
<td>Two tariffs, one for prime provider, one for Integrated Offender Managers (IOM). WDP and Compass both paid under same model. If Compass do not give someone a Hep B vaccination, WDP won’t get paid that money either. If WDP don’t achieve the crime reduction they need to achieve, Compass won’t get paid. This is intended to maximise quality assurance and full collaboration to maximise outcome achievement. Focus is on achieving 100% outcomes against the four outcome domains: improved health and well-being; reduced crime; free from drugs of dependency; and sustained ETE.</td>
<td>New provider started in January 2010, previously CNWL and Foundation 66.</td>
<td>NHS Trust (Central and North West London NHS Foundation Trust) responsible for prescribing and Foundation 66 providing other tier 2, psycho-social support.</td>
<td>Compass</td>
<td>Assessment and Care Review Assessment and Care Review Team (ACRT), a DAAT officer function that would assess all patients coming through the system, went out to tender with a part activity/part outcome based contract; year 1 it was 15% outcome and year 2 rising to 25%). This was a form of PbR that was then put on hold when Enfield decided to bid for PbR pilot status. Interim arrangement in place, stock clients are being reassessed face-to-face, Team verifies outcomes achieved by prime provider and is responsible for triggering interim and final payments. Team made up of team leader, 5 senior practitioners (band 7 Nursing equivalent) and one administrator.</td>
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<td>DAAT board reporting to Safe and Strong Communities Board, Health and Wellbeing Board, Health Improvement Board Posts jointly funded by LA and PCT</td>
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<td>Kent County Council DAAT. KDAAT board probation, prison service, PCT, public health. Kent Police.</td>
<td>PbR co-ordinators (x 2) LASAR manager Probation lead for substance misuse Representatives from CRI, RSA and Sussex Partnership Trust</td>
<td>Described as an integrated service model. 25% PbR. Service users placed in one of four bands in terms of substance misuse: low, moderate, substantial, critical; banded in terms of subcategories of health and wellbeing. Social-driven tariff. Provider paid on evidence of improvements in outcomes in all domains. A service user in the highest tariff (“critical”) must reduce their needs by two bands (i.e. to “moderate”) to merit an interim payment. Based on what’s described as a ‘fair access to care’ model. Incentives to work with more complex clients and not to hold onto less complex clients.</td>
<td>Kent re-commissioned for the PbR pilot. Re-commissioning now taking place for prison drug treatment services</td>
<td>KCA CRI Turning Point Kenwood Trust Action for Change</td>
<td>CRI won the contract as part of a competitive tendering process. A two-year contract with option for extension to four years. They have the contract for all four tiers of drug and alcohol treatment services, ATR and DRRs. They have sub-contracts with RSA and Sussex Partnership Foundation Trust System of Delivery: ‘Hub and spoke’ system of delivery with hubs in Gravesend, Maidstone and Tonbridge with satellite provision across all six districts</td>
<td>Use of existing local authority care management team comprising nurses and social workers. LASARS is independent of the provider. Nine LASARS operate in three satellite sites, located within treatment services across pilot area. LASARs to carry out comprehensive assessment. Re-tariffing of stock clients as paper exercise</td>
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<td>Lincolnshire Public Health (previously Lincolnshire DAAT).</td>
<td>Interviews conducted: PbR co-ordinators (Public Health, Lincolnshire CC) (x3). Probation lead (member of DAT JGC). Provider service managers (x4). Representative from Public Health, Lincolnshire CC (Chair of local PBR Project Board).</td>
<td>In the first year 90% of payment is up-front to providers, 5% is on outputs (e.g. Hep C test/ Heb B vac / TOPS completion/ waiting times), 5% is for national outcomes. In second year will be 80% outcomes 20% interim/process. Two providers compete with each other – provide same range of services.</td>
<td>Commissioners kept existing providers rather than opting for an open procurement process. Providers are now on a one-year contract but there is an assumption that a second year will be commissioned. The reason for a one-year contract related to the impending abolition of PCTs.</td>
<td>Addaction and Lincolnshire Partnership NHS Foundation Trust (LPFT).</td>
<td>Same as before launching the pilot.</td>
<td>No LASARs for two reasons: 1) providers are the experts in position to assess the needs of a presenting client; 2) LASARs would be too large a budget item and as such would likely act as a barrier to service accessibility. An Independent Governance Service will be set up, auditing both providers, tariffs, treatment plans, and outcome achievements. NACRO will be commissioned to develop the service for £120,000.</td>
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<tr>
<td>Location of PBR pilot</td>
<td>Interviews conducted:</td>
<td>The model as two parts: 1) Harm Minimisation service 2) Recovery service</td>
<td>Oxfordshire completely re-designed and retendered all services</td>
<td>Pharmacies, SMART CJS and Cranstoun.</td>
<td>Harm Min: NHS (Oxford Health) in partnership with Oasis.</td>
<td>LASARS commissioned by tender, performed by Aquarius until 30th September 2012. Now operates as a partnership model with management and administration provided by probation and Assessment and Engagement Practitioners provided by Oxford Health and Lifeline.</td>
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<td>Oxfordshire DAAT</td>
<td>PbR co-ordinator (DAAT Director).</td>
<td>Harm min: 70% up-front, 30% on performance against locally defined outputs (e.g. motivating and moving people through to the Recovery Service).</td>
<td>Transition between old and new providers in April 2012.</td>
<td>Approximately 20 fewer GP practices (but as part of systems re-modelling not PbR).</td>
<td>‘Recovery’ services via Lifeline.</td>
<td>LASARS incentivised to fill in forms, carry out referrals and TOPs forms in a timely manner. Compensation will be 75% contract value and 25% local incentive scheme.</td>
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<td>Director of Adult Social Care (Chair DAAT Board).</td>
<td>Recovery: 100% PbR.</td>
<td>LASARS started operating in February (but since re-commissioned).</td>
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<td>Unusually LASAR function will be mobile and assertive, conducted in service users’ homes, clinics etc.</td>
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<td>Probation lead (member of DAAT Board).</td>
<td>For drugs using the national outcomes. For alcohol, payments for: attachment (local outcome), completion of structured treatment and non re-presentation (both national outcomes).</td>
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<td>Representative of District Councils in Oxfordshire on DAAT Board.</td>
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<td>Provider service managers (x3).</td>
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<td>Consultant Psychiatrist, Oxford Health.</td>
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| Stockport DAT        | Interview conducted:  
  Strategic Manager, DAT.  
  Police lead (Chair of JCG).  
  Probation lead (Assistant Chief Executive).  
  Stockport PCT lead (Chair JCG).  
  START Team (LASAR) manager.  
  Council representatives:  
  (Public Health alcohol lead, Commissioning Manager Adult Social Care, Supporting People lead).  
  Provider service managers (x2). | For tier 3: 70% core payment and 30% payment on outcomes.  
  There are no interim payments, but the core 70% is payable up-front. Furthermore, an array of fees are applicable (e.g. attachment fee of £25 when a client joins, £25 Hep B vaccination)  
  Tier 4: interim payments during first 24 weeks in treatment, outcome payment (approx. 15%) at 25 weeks for successful completion; final payment (approx 10%) at 25 weeks plus 12 months for sustained outcomes. | Stockport kept existing providers.  
  The pilot applies to Tiers 3 and 4 only.  
  PbR contracts are for 2 years, with the option to extend for further 2 years. The Joint Commissioning Group intends to re-tender everything once the pilot is over. | Tier 3: MOSAIC, Addiction Dependency Solutions, Pennine Mental Health Trust.  
 Tier 4: spot-purchasing basis. | Same as before launching the pilot.  
 Not all of Acorn’s provision is part of PbR pilot – only residential rehabilitation. | LASAR operates as START (Stockport Treatment – Access to Recovery Team).  
 Provides an independent assessment and referral service located within the local authority contact centre, criminal justice settings and community buildings. Modelled on pre-existing CJS and DIP assessment and referral functions. Staff are experienced in assessments and motivational work, and are employed by the local authority, and line managed by the Drug Action Team. LASAR provides assessment of needs, makes a client aware of his/her options and allocates an appropriate tariff. Their primary role is to motivate. Offers pre-booked appointments, drop-in and general group sessions, and has a role around facilitating entry into tier 4 provision. |
### Wakefield

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<td>NHS Wakefield District, PCT, Police, probation, Job Centre Plus, Housing, Wakefield Council Social Services, prisons</td>
<td>PbR co-ordinators (x 2), lead commissioner on behalf of PCT and community safety, and DAAT coordinator.</td>
<td>Used to be 100% of outcome payments were PBR. Now changed so that 20% of tier 3 contract value to be paid on outcomes. Retaining 80% payment to avoid “destabilising treatment system”. All existing service users clustered prior to 31st March, new users clustered upon entry. 4 clusters: Low Complexity and High Capital, Low Complexity and Moderate Capital, High Complexity and Moderate Capital, High Complexity and Low Capital.</td>
<td>Wakefield did not re-commission for PBR pilot. Current contracts for specialist treatment services expire 31 March 2014. Procurement process with the new providers to begin 2013. PBR pilot will end on 31 March 2013. New contracts starting on 1st April.</td>
<td>Turning Point and Spectrum</td>
<td>Did not commission new LASAR service. LASAR function within existing two PbR service providers, with a view to providing integrated service. LASAR Audit Tool commissioned to ensure independence.</td>
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### Wigan

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<td>DAAT located within the Community Safety Team</td>
<td>Commissioners x2, Mental Health trust staff x4, PETE (employment) project managers x2, Assistant Chief exec Greater Manchester Probation Trust</td>
<td>Cohort model with three outcome measures: abstinence; successful completions; and non-re-presentations within 6 months of planned and successful discharge. Three levels of complexity. The provider (GMWFT) gets paid quarterly depending on the performance in the previous nine months. Responsibility for achieving offending, education and training outcomes devolved to providers. Probation has a contract for £12,500, 10 per cent of which is based on performance (reduction of offences by 5% over 12 months). CRI/Work Solutions focusing on job/training outcomes, getting a client into work, sustaining in employment at 13 and 26 weeks. 20% income apportioned in terms of results, with 80% assured.</td>
<td>Wigan has not re-commissioned and continues with its main provider, Greater Manchester West Foundation Trust (GMWFT).</td>
<td>GMWFT remains the main provider for prescribing and psychosocial care. Re-modelling of service took place in 2008/9 with recovery focus. Work Solutions/CRI (PETE Project). Probation leads on Drug Intervention Programme and Integrated Offender Management. Provider Delivery model: GMWFT operates in three sites in Wigan and Leigh. Co-location of DIP programme in drug and alcohol treatment service.</td>
<td>LASARs not independently set up within GMWFT. LASAR filled out by dedicated staff in the course of the comprehensive assessment. Nine domains covering social/economic/physical health.</td>
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