Office for Health Improvement & Disparities

National Commissioning Quality Standard for drug and alcohol treatment and recovery
Consultation on draft standard – deadline for comments 5pm on 1 March 2022
Email: DAconsultation@dhsc.gov.uk

Please read the checklist for submitting comments at the end of this form. We cannot accept forms that are not filled in correctly.

We would very much like to hear your views on the draft Commissioning Quality Standard. There are spaces for your comments on specific sections and then some broader questions about the standard. But first some questions about you:

Organisation name	
Organisation type	*Please select one option (just click on a box)* ☐ Local authority / public health / commissioner ☐ NHS commissioner ☐ **Drug and alcohol treatment provider** ☐ Provider of other services ☐ A partner organisation ☐ None, responding as individual ☐ Other, specify:
Name of person completing form	
Role (if this response is independent of any organisation)	*Please select one option (just click on a box)* ☐ A commissioner ☐ **Drug and alcohol treatment service manager/staff** ☐ Manager/staff in another service ☐ Person who may use treatment services ☐ Carer/partner/family of someone who may use treatment services ☐ Other, specify:
Type	[office use only]

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Specific comments on the draft standard

Comment number	Section number or **'general'** for comments on whole document*	**Comments** Insert each comment in a new row. Do not paste other tables into this table, because your comments could get lost – type directly into this table.
1	1.1	We welcome the focus on people with lived experience in the criteria and would like to see Lived Experience Recovery Organisations being integral in every partnership and decision-making layer.
2	1.1	The examples of evidence provided could be more comprehensive and detailed in order to support 'monitoring', and to ensure commissioners are able to know their partnerships are effective.
3	1.1	We welcome the inclusion in the criteria that each partner has to ensure their organisational approaches align, incorporate and complement the partnership's activity to reduce alcohol and drug harm, and opportunities to jointly commission services are pursued where appropriate. However, it is not clear how commissioners will have oversight of this for all of the partners, especially when some of these partners will be commissioned outside of the public health grant.
4	1.2	Regarding access to specialist training and support, as mentioned in criteria 1.2, it would be helpful if there was more clarity as to what the minimum standards will be and how these should be met e.g. by service provider or externally. Does the training and development of the entire workforce lie within the remit of the substance misuse provider? Does this need to be factored into service delivery capacity?
5	1.2	Commissioners should engage with NHS England's Hepatitis C elimination programme and actively seek partnerships with the local specialist clinical services responsible for the treatment of blood borne viruses.
6	1.3	It would be helpful if a clear definition of what is meant by a high quality service was included in this standard. We know that this will involve looking at additional measures beyond NDTMS data, so additional clarity around these additional measures is

		important to ensure service providers are aligned with commissioners in their understanding of best practice and how it can be reached.
7	2.1	As the frequency of assessments are not included in this criteria, what is the expectation of commissioners and local authorities to review and update this in-line with the annual review mentioned elsewhere?
8	2.1	On processes being put in place to review relevant alcohol and drug related deaths and near misses in a timely manner, this strand may be challenging depending on the local structures and partnerships. In some areas, coroners do not share information and alcohol and drug-related death information can be limited to treatment cohort only. We hope this standard will support commissioners to influence partnership working with other relevant professions (e.g. police, coroners) to prevent these delays in reporting deaths and near misses, which has a significant impact on how treatment providers are able to respond.
9	2.2	A partnership developing and championing a strategy outlining its priorities to reduce stigma should include lived experience input.
10	2.3	Reducing the use of competitive tendering to only when required to improve local provision is welcome and will provide greater stability for providers and will reduce the administrative costs of developing tenders. However, it would be helpful if greater clarification was provided around what 'good' looks like? And how will these decisions be made under the standards? In relation to reducing competitive tendering, we'd also welcome some certainty of contract duration if extended and with annual reviews or assessments of 'good' provision. Rolling year on year contract extensions would create a degree of uncertainty for providers.
11	2.3	Does the annual partnership commissioning and delivery plan suggest an annual review cycle? If so, this would improve the ability for services to be re-designed in order to address any evolving trends and changes in local needs.
12	3.1	Though we welcome the positive step in embedding lived experience in strategic design and development, this could go further and include recognition of the value of women's lived experience. This could include a definition of pathways to ensure women's voices are fully included in lived experience groups and activity at both national and local levels, with performance targets set to support this. This could also include recognition that stigma can be a particular feature for women's ability to access and sustain treatment and recovery, and commissioned services should provide women with multiple methods to access and engage in support.
13	3.1	The transition from young person to young adult has many different transitional points (e.g.early intervention/prevention; primary/secondary; transition from 16-18/higher education, transition from 16 - 18 for care leavers, transition from 18/adult

		services, transition from 18/criminal justice services. Therefore it would be helpful if a clear definition of this transition was provided.
14	3.1	The examples of evidence for this strand could include evidenced based screening tools for both adults and young persons.
15	3.1	Effective opt-out testing programmes for blood borne viruses should be appropriately resourced for all at risk clients, and enhanced testing budgets may be required to meet and maintain NHS England elimination targets. Resources should be made available to support re-testing for high-risk clients, in-line with the latest guidance to achieve elimination targets.
16	3.2	We are concerned that health services being given targets to reach people affected by problem alcohol and drug use and provide accessible support, including evidence of co-location or in reach, could present a delivery challenge as well as having a significant impact on service capacity. There is a risk that this could result in inappropriate referrals, or an influx of referrals that services are not able to appropriately manage. Furthermore, it is not always possible to respond to all the unmet needs. Greater clarity on how unmet need is calculated, updated and how this may impact on service commissioning, would be welcome. The unmet need of a locality needs to better inform the budget and size of services/service specification.
17	4.2	We would like to see more investment into research and quality markers in order to improve the assessment of quality and delivery of evidenced based work.
18	4.2	The example of evidence for this strand only lists adult clinical guidelines. We would welcome reference here to the ‘Practice standards for young people with substance misuse problems (2012)’.
19	4.2	Family-related support is only mentioned once in this strand and additional clarity as to what appropriate support refers to for this group would be helpful.
20	4.2	We would like to see specialist women’s drug and alcohol provision to be specifically included in all commissioned Service Level Agreements.
21	4.3	We would welcome the inclusion of workforce competencies which speak specifically to the needs of women, including, trauma informed staff in all community and residential settings, and training in domestic abuse, sexual exploitation and adverse childhood experiences (ACEs) for all front line staff within the first year of employment

22	4.3	With reference to caseloads that are clinically safe and appropriate to be able to deliver quality treatment, as there is no agreed definition of 'clinically safe caseloads', we would welcome any additional information as to how commissioners expect service providers to monitor and manage this.
23	4.3	Additional clarity would be welcome around how smaller service providers should implement mandatory training and development plans that comply with treatment workforce standards, whether there should be dedicated sufficient funding to implement this, or whether this will be in addition to the ring fenced grant or as part of the core contract value?
24	4.3	As current grants are not sufficient to provide salaries able to compete with NHS salaries and terms and conditions for psychiatrists, there is a risk that this standard could disadvantage non-NHS providers. There are also regional challenges in recruiting certain clinical/psychology posts which would contribute to a holistic varied workforce e.g. pharmacy technicians.

*Also see questions overleaf
Insert extra rows as needed

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In addition to your comments above on specific parts of the CQS, we would like to hear your views in response to the following questions:

Question	Your answer (type directly into this table)
1. Which areas of the standard (strands 1-4) will have the biggest positive impact on commissioning practice and service provision?	● We welcome the focus on people with lived experience in the criteria and the inclusion of LERO's as standard at commissioning level as well as dedicated commissioning plans for young persons, including early intervention. This will have a significant impact on commissioning practice and service provision. ● The annual review cycle is a positive development and will improve the ability to allow services to be re-designed in order to address changing and evolving local needs and trends. ● One of the biggest positive impacts on commissioning practice and service provision will be reducing the use of competitive tendering to only when required to improve local provision.This will provide greater stability for providers, and will reduce the administrative costs of developing tenders and help ensure that the process does not favour larger providers. ● The focus on harm reduction services as a core integrated part of service commissioning/delivery is also welcomed, however we feel 'BBV elimination' is missing (as this aligns to national NHS strategy)
2. Which aspects of the standard (standard statements and criteria) will be more challenging to implement? Please say for whom and why, and how the challenge could be mitigated.	● In standard and criteria 3.2, we are concerned that health services being given specific targets could be challenging to implement, both in terms of delivery and capacity. We think this has the potential to result in inappropriate referrals being made to services, and an influx of referrals being made to that services that they are not able to appropriately manage. ● Some of the examples of evidence are not tangible or quantifiable. How will commissioners know that providers and wider partnership are meeting this standard?
3. The standard was developed during the coronavirus pandemic but please tell us if there are any particular issues relating to COVID-19 that we should take into	● Greater attention could be given to the critical role of different forms of accessing services, such as digital. Services should continue to provide a mixed-model approach post-pandemic, developing their digital offer and providing choice and flexibility based on people's needs. We know digitalisation can increase access for women experiencing

account when finalising the standard for publication.	social anxiety, childcare responsibilities or limited access to treatment in their area/building.
4. What, if anything, is missing from the standard?	● Integrated Care Systems/Boards are not referenced throughout the standard and given the focus of ICSs is integrating care across complex system boundaries, it is important that drug treatment services align with commissioning and accountability in ICS's and vice versa. ● This standard focuses on a partnership approach at commissioner level, however, ensuring there is a strong partnership approach at provider level is also important and this is an area that could do with further elaboration. ● The standard does not address the NHS Hepatitis C elimination programme and we would welcome the opportunity of working to support the development of joint nationally agreed standards for Hep C elimination. ● The need for services to be trauma informed is also not addressed in this standard. ● We would welcome a clear definition of what is meant by a high quality service that looks beyond just using NDTMS data. Understanding "what good looks like" in relation to competitive tendering is very important as this will likely be different in every locality.
5. Does the mix of strands and statements provide a useful summary of key aspects that support effective commissioning of high-quality treatment services?	● The strands and statements do provide a useful summary of key aspects that will support effective commissioning of high quality services, however it is likely that many commissioners will already be working at or very closely to this as 'best practice'.

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Checklist for submitting comments

- Use this comment form and submit it as a **Word document (not a PDF)**.
- Complete the disclosure about links with, or funding from, the pharmaceutical industry.
- Include **strand/statement number** of the text each comment is about.
- We **can** accept more than 1 response from people in each organisation but please be clear in what capacity you are responding.
- Do not paste other tables into this table – type directly into the table.
- Ensure each comment stands alone – do not cross-refer within one comment to another comment.
- **Clearly mark any confidential information or other material that you do not wish to be made public. Also, ensure you state in your email that your submission includes confidential comments.**
- **Do not name or identify any person or include medical information about yourself or another person** from which you or the person could be identified as all such data will be deleted or redacted.
- Spell out any abbreviations you use
- For copyright reasons, **do not include attachments** such as research articles, letters or leaflets. We return comments forms that have attachments without reading them. The stakeholder may resubmit the form without attachments, but it must be received by the deadline.
- **We do not accept comments submitted after the deadline stated for close of consultation.**

Note: We reserve the right to summarise and edit comments received during consultations, or not to publish them at all, if we consider the comments are too long, or publication would be unlawful or otherwise inappropriate.

Comments received during our consultations are published in the interests of openness and transparency, and to promote understanding of how recommendations are developed. The comments are published as a record of the comments we received, and are not endorsed by OHID or DHSC, its staff or advisory groups.

Data protection

The information you submit on this form will be retained and used by OHID and its staff for the purpose of developing the standard and may be passed to other approved third parties. Please do not name or identify any individual patient or refer to their medical condition in your comments as all such data will be deleted or redacted. The information may appear on the GOV.UK website in due course in which case all personal data will be removed in accordance with DHSC policies.

By submitting your data via this form you are confirming that you have read and understood this statement.

(This form is adapted from NICE template, with thanks)

Please return to: DAconsultation@dhsc.gov.uk