CollectiveVoice

The National Alliance of Drug and Alcohol Treatment and Recovery Charities

Collective Voice response to 10-year health plan consultation

December 2024

Q1. What does your organisation want to see included in the 10-Year Health Plan and why?

Set long-term commitments and funding

The health and care system needs clear priorities and leadership, with long-term direction setting and funding commitments. Therefore the health plan itself must be not only a 10 year plan in name, but understood as a long-term driving force for health and care across the country.

Funding from DHSC for substance use treatment has generally been passed to local authorities as time-limited grants, which poses challenges in delivering a stable, sustainable service. Each year, the nature of the provision is determined by the announcement shortly before the new financial year, limiting the opportunity for providers or commissioners to take a strategic, long-term view of how to treat people with substance use issues.

Whether through specific ringfenced grants such as the Supplementary Substance Misuse Treatment and Recovery grant or the main Public Health grant itself, funding for treatment is seen as fundamentally uncertain by key figures in local authorities. While local authority finance directors see other policy areas as an enduring commitment, albeit with the level and type of service responding to changing need and resource, we have been informed that treating people with substance use issues is seen as outside of local authorities' 'core' business, and therefore wholly dependent on each year's grant announcement.

It is almost as if, until a grant allocation is confirmed for each year, there is a sense that there might not be any provision for people with a substance use treatment need. Yet the need for treatment has never been clearer, with over 340,000 people estimated to be currently using heroin or crack, and over 600,000 dependent on alcohol.

Clear and secure funding is essential to provide the stability and care that should be at the core of effective treatment. It generally takes people with opiate problems over three years of treatment to complete this successfully , and we know that stability of provision is essential to make a difference for people who use substances, their families and the wider community. The therapeutic relationship between client and staff is at the heart of treatment, but it is challenging to build this with high staff turnover and unstable contacts, which are the inevitable result of time-limited grant funding.

Ensure funding and regulation support the full range of evidence-based options and innovation and research

Currently, government oversight of substance use treatment and recovery funding tends to focus on community-based treatment for people who use opioids. It is challenging to fund innovative projects – or even a wider range of options that already have a strong evidence base but are limited by regulations or funding conditions. Examples include:

- Residential treatment for substance use issues
- Injectable diamorphine as a form of opioid agonist treatment, whether under supervision or

prescribed as a take-home medication
- Enhanced harm reduction facilities with supervision of substance use

In the first two of these cases, the high cost and low volume nature of these interventions mean that it is not always efficient to commission them on a local authority footprint – which is how community-based substance use treatment is currently commissioned. National frameworks and structures should be considered to ensure there is appropriate use of all these interventions.

Programmes like the Addiction Healthcare Goal should also be supported to ensure there is innovation where required to keep the field up to date as the patterns and availability of substances is continually evolving.

Support recruitment, retention and development to ensure the workforce is fit for the future
The drug and alcohol field requires specialist skills, knowledge and functions across range of professions, both within the NHS and in partner organisations including local authorities and charities. The Government should build on the current NHSE drug and alcohol workforce plan to ensure it is focused on practical, achievable actions both for specialists in drug and alcohol treatment and recovery services and for the wider workforce that make an impact by supporting people facing issues with alcohol and other drugs.

Delivering on the aspirations of the workforce plan requires central leadership on issues including training, accreditation and quality assurance, so ensure consistency and coverage throughout the sector across different organisations and professions, many of which are not currently formally regulated.

Ensure there is appropriate and proportionate outcomes monitoring
There are several grants, projects and contracts that currently fund treatment and related services in England. Each of these grants uses a different method to calculate local authority eligibility and the amount each will receive. They also ask for different data and monitoring information, which are to be returned at varying frequency through different routes. In addition, there are several evaluation and research projects in place to determine the effectiveness of the previous Government's drugs strategy.

There are opportunities to rationalise the number of different grant schemes and harmonise reporting and monitoring processes, to reduce the administrative burden placed both on local authorities and providers of treatment. The resource committed to these processes – and therefore not to frontline delivery – is significant and the processes should be designed to ensure there is value for money for the taxpayer. After three or more years of some of these processes, the specific learning is not yet clear, nor how this might have been applied to subsequent grant-giving and oversight.

Moreover, the core data monitoring system for substance use treatment has not been fundamentally reviewed in over 20 years. While it provides an unrivalled dataset compared to other areas of health and social care, it is not clear that as substance use and treatment evolves it is capturing the full

range of support provided in the most effective and efficient way to monitor activity and impact. Given that a wide range of departments and organisations should support people with substance use issues – and recoup the benefits of this – the impact of treatment should be monitored across departments. For example, treatment is currently funded through the Department of Health and Social Care, but while many benefits are received by health agencies, treatment also reduces pressure on the criminal justice system.

This monitoring should be accompanied by a clear and updated economic assessment of the harms related to alcohol and other drugs.

There is a need for more systematic monitoring of instances in which people with issues with alcohol and other drugs are turned away from other services, to inform multi-agency working and ensure that the goal of 'no wrong door' is realised in practice.

Given that Dame Carol Black's review specifically identified that support needed to be more accessible and effective for women and people from minoritised ethnic backgrounds, there should be more open publication and discussion of how these groups experience harm, and the performance of support services in serving these groups.

Include alcohol and other drugs as key priorities for improving health

Within this plan, harm from alcohol and other drugs should be acknowledged and addressed as a whole system priority.

The impact of alcohol and other drugs on the healthcare system is extraordinary. In 2022-23, there were 262,094 hospital admissions where the main reason was directly attributable to alcohol, and this figure rises to 942,260 if we add in secondary diagnoses.

Most strikingly, there were 5,448 deaths related to drug poisoning registered across England and Wales in 2023, and this is a growing issue: the mortality rate for deaths related to drug poisoning has been getting worse since 2012.

But we know that treatment works in helping people turn their lives around. It can have a transformative impact for individuals, families and communities.

Acknowledge and support the role of charities in the provision of health and social care

Charities are the main providers of substance use treatment in England, accounting for 80% of the sector, and there should be a recognition that charities are a key part of the health and social care sector more broadly. This should entail a greater and clearer commitment to partnership working across different sectors, including shared care pathways and joint care and service planning, as well as data and information sharing.

Understand and respond to people in the wider context of their lives

Rather than interactions and care for people being shaped by a view through the lens of a particular

condition, organisation or budget, people should be viewed – and treated –with an awareness of the wider context of their lives, including their families and communities.

Addiction is perhaps an archetype of where this approach is most appropriate and impactful, given the direct way in which it can be shaped – and resolved – by social context and connections, such as mutual aid, and wider life skills and activities can be central to 'recovery capital'.

Ensure alcohol and other drugs are seen as part of 'core business' for the whole system
Prevention and treatment of issues with alcohol or other drugs must be supported by a range of organisations across different sectors, and needs to be seen as core business across the system, rather than the role of a single organisation or budget.

Structured treatment is a key intervention available to us, but identifying, assessing and supporting people who are facing issues with alcohol and other drugs (including those around a person using substances) should be seen as 'core business' of all health and social care services - with each contributing in their own way.

In practice, this means that all NHS trusts – acute hospitals and community trusts, whether they provide substance use treatment or not - should have in-house expertise in substance use, and be clear on how to link into wider support services.

Similarly, the role of community pharmacies in the dispensing and supervision of opioid agonist medication should be codified and coordinated to ensure this essential medication is consistently available across the country. At present, pharmacies are required to dispense prescribed opioid agonist prescriptions, but not required to supervise the consumption of these medications – even though this is required by NICE guidelines.

GPs should feel confident and willing to screen and support people with substance use issues, including supporting the prescribing for alcohol detoxification. This should not be a postcode lottery, as it is at the moment, where individual practices (and practitioners) can choose whether or not to support certain treatments.

These issues, and the centrality of addressing harm from alcohol and other drugs, should be emphasised in relevant contractual arrangements and service design, as well as data capture and monitoring.

Address health inequalities proactively and directly
If the health plan is to address health inequalities, it will need to address those associated with substance use. Deaths related to alcohol and other drugs are avoidable, and in 2923 the average age at death for drug misuse deaths was 44.5 years for males and 47.5 for females.

The plan should also aim to address inequities in the accessibility and effectiveness of support for different groups in society. Dame Carol Black's independent review of drugs noted that the current

service model does not adequately support women and people from minoritised backgrounds. While individual services can work to improve their own accessibility and treatment offer, these inequities are also shaped by wider systems and approaches that mean people are less likely to be identified

Q2. What does your organisation see as the biggest challenges and enablers to move more care from hospitals to communities?

If we are to effectively shift more care for people who use alcohol and drugs from hospitals to the community, we need to identify people earlier and ensure effective screening for issue is more widespread. This will require:

- improved training for staff across the health and care system;
- an understanding that issues around alcohol and other drugs are 'core business' for all relevant agencies and professionals; and
- an understanding that people's care should be shaped with an acknowledgement of the wider context of their lives, involving the full range of support agencies and community organisations.

It is not clear that this approach is currently supported by central leadership, funding models or technology.

Ensure funding models support the shift from hospital to community
It is not clear that hospitals themselves see screening and addressing people's issues with alcohol or other drugs as their role. This requires a push from the centre, but also ensuring funding structures are properly understood and facilitate this shift.

First, there may be a tendency to see issues related to alcohol and other drugs as a 'public health' issue, with the funding from local authority public health grants, and therefore sitting within a particular organisation and set of contracts. In reality, specialist substance use treatment is just one element of the support required across the system.

Second, there should be a benefit to a hospital in ensuring people are promptly screened, identified and moved into more appropriate care settings. Currently there is not always a funding incentive for hospitals to look for opportunities to screen and refer people to community-based support.

This is partly due to the number of different funding streams and the ways these are distributed and monitored. Greater partnership work and pooling benefits as well as funding at a system level would help organisations take this holistic approach not just for the patient but for the wider system. This requires a commitment and coordination at the level of central government to ensure there is coordination and collaboration between different government departments and arms-length bodies.

Ensure technology helps identify opportunities – both for individuals and at a population level – for early intervention and targeted community-based care
There are barriers around technology – where different case management systems don't talk to each

other – which affects how well staff can work across different specialties, departments and organisations in and outside of hospital.

If different datasets were linked, then we would be more able to spot patterns of service use that predict future issues, and care could be more integrated and therefore both effective and efficient. Someone's use of community services (or lack of use) can help predict future use of acute services, and so if this pattern is identified and acted on at an earlier stage, their issues may not escalate to the level of acute care.

While there are local systems that help integrate care records, there is considerable variation in the specific systems and data items that are included, and how these systems are used by professionals. Greater consistency and clarity on the format and use of such systems should be encouraged.

On substance use specifically, it is currently not guaranteed that each part of the health and social care system will be aware if an individual has a substance use issue or is being treated for it, as this would require sharing of data both across the NHS and beyond, as most substance use treatment is provided outside of the NHS, with 80% of the workforce in the field employed in the third sector. This is not just about identifying individuals, but also coordinating care when they have been identified.

Ensure hospital policies encourage effective, integrated care
Current policies also do not always facilitate effective continuity of care between hospital and community. Again, this is partly about training and confidence, and partly about data sharing. On opioid agonist treatment (OAT) specifically, there are still hospital trusts where, if someone is admitted with an OAT prescription, the hospital may not be aware or may even refuse to continue it, and prescribe instead an alternative opioid – typically oramorph – which could in fact pose a higher level of risk for the patient. This will then disrupt their treatment and the continuity of care back into the community, and often leads to early self-discharge. (See https://pubmed.ncbi.nlm.nih.gov/35418095/)

Q3. What does your organisation see as the biggest challenges and enablers to making better use of technology in health and care?

There are several factors that with the right resourcing and approach can be enablers of better care, but without this act as blockers.

Ensure existing technology is applied consistently to all settings where helpful
There are areas where relatively basic, existing technology is not applied as widely as it could or should be. For example, outside of the NHS, substance use treatment prescribing has to be done by paper - which is both less efficient and less safe than electronic prescribing - because the electronic facility is only set up for prescribing of controlled drugs within GP systems, not those used by substance use treatment.

This could be resolved swiftly by some relatively straightforward work through NHSE Digital to

approve and enable the substance use IT systems to access the relevant processes. The IT systems used by substance use treatment services are themselves required and approved by DHSC as part of the national requirements for substance use treatment, so this is a case of requirements and processes in different parts of the health and care system actively working against each other.

There are also opportunities to make more use of telehealth services for people who use alcohol and other drugs.

Ensure there is central leadership and appropriate resourcing locally and nationally to promote accurate data entry and effective analysis

The substance use sector has an unparalleled level of detail and accuracy in its treatment data. This originates in the National Drug Treatment Monitoring System (NDTMS), which was established in the early 2000s and set clear requirements for local services to record a wide range of data items for key interactions with all clients.

Compliance with these requirements was monitored and supported by central and regional staff of the National Treatment Agency (NTA). In addition, commissioners and providers had staff dedicated to data quality and analysis, ensuring that trends could be identified early and acted on.

Without this resource, the data collected will be of poor quality, and little use will be made of them. In recent years the data collection around substance use programmes has been disproportionate and has not then fed into

Ensure central requirements on data are reviewed and updated

Decisions on what data are recorded and monitored are inevitably based on the knowledge and priorities of any given moment. While consistency of datasets over time can be incredibly useful, no area of health and care will stand still, and data collection and analysis should reflect these changes.

In the field of substance use, the consistency and comprehensiveness of the National Drug Treatment Monitoring System (NDTMS) has been a great strength of the sector, but it was designed – and still reflects – a focus on a particular form of substance use (intravenous heroin use) and a particular form of treatment (prescribed opioid agonist treatment). Patterns of substance use have changed since this system was established, as have the needs of people accessing support, but the overall framework has remained consistent. This means that we do not fully capture information and trends related to other forms of substance use or support, including those recommended or required by DHSC or NICE, such as needle and syringe programmes or recovery support.

Central leadership should ensure systems record data items and link with each other effectively, while providing local flexibility to innovate and adapt

Currently there are many different systems, both within and outside of the NHS, and these do not link together. Linking takes place on a highly variable local basis, with different areas having made different levels of progress, and including different datasets and data items, with different uses for the systems (e.g. aggregate analysis or individual patient care).

If we want consistent, comparable information across different parts of the country, this will need active leadership and facilitation from the centre, and guidance on effective use of the relevant data.

Ensure the public understand what is being done, why, and how it benefits them and the wider population

There is understandable scepticism regarding the sharing of personal health information, particularly within the substance use sector where this may include information linked to stigmatised or even illegal activity; the same dataset that holds information about someone's prescribed medication also records historic reported answers on whether they have recently committed any crimes, and there is a known history of doctors being required to report data on drug treatment to the Home Office as part of the 'addicts index'.

At the same time, people expect to be able to have their prescribed medication continued if they have to go into hospital. At present, for technical and policy reasons noted above, this is not always the case for people in substance use treatment.

Therefore the case for sharing data can be made effectively if it is linked to improving people's care. The whole health and care system, from government and arms-length bodies to providers and community organisations, can be part of an informed conversation on this issue – if there is good communication and explanation, and this genuinely reflects positive, constructive motivation from the organisations involved, as well as a long-term commitment to be clear, open and person-centred in how any data are recorded and used.

Q4. What does your organisation see as the biggest challenges and enablers to spotting illnesses earlier and tackling the causes of ill health?

Health is a product and responsibility of whole communities

Spotting illnesses earlier and tackling the causes of ill health requires a whole range of individuals and organisations. Too often within the healthcare system different specialisms and organisations act in isolation from each other when they need to work together to ensure people receive the right support at the right time.

Moreover, tackling the causes of ill health requires communication and support that goes beyond 'health services' in a narrow sense. If we are to ensure people understand the issues and receive timely support, we need to engage with people through established, trusted routes, which are often charities and community organisations.

Stigma

In relation to substance use specifically, the way this is perceived within health and care systems and across wider society can often be a barrier to people seeking support, or professionals identifying and responding to issues.

For individuals themselves, dominant ideas of what a substance use problem looks like means that people often don't identify themselves as needing support until relatively late. And where they do identify a need for support, they can be discouraged by the idea that needing support for substance use is a personal failing.

Moreover, the experience of people who use drugs in accessing health and care services is not always positive. Their own experience or the advice of others can make them reluctant to seek support for unrelated issues. There is evidence that stigmatization of people who use drugs and people with alcohol-related health harm continues amongst health professionals and negatively impacts health outcomes.

This means that when people do present to health and care services, their issues are more advanced, more difficult to resolve, and most costly to services. We can prevent illness, improve care and reduce costs by tackling the stigma associated with substance use.

Staff awareness
To ensure patterns are spotted and people are supported throughout the health and care system requires awareness and training across a range of health areas. For example, to ensure that all professionals in the health and social care system see the use of alcohol and other drugs as a key part of their role, and feel confident in screening, supporting and referring people who use substances.

Structures and funding encouraging collaboration and thinking of a person's whole needs
As noted in other sections of this response, funding and monitoring processes often work against staff and systems seeing people's health in the context of the whole life, rather than a set of specific conditions to be managed by a set of specific agencies and professionals.

We know that there are links between issues such as substance use, mental health, physical health and wider social and economic factors such as housing. Effective support would therefore be connected across different professionals, interventions and organisations. But too often there are isolated funding streams and performance and contract management processes that only look at outputs and outcomes in one domain, when an effective substance use intervention, for example, might reduce use of mental health services, or an effective intervention in an acute hospital might reduce the pressure on housing or substance use support.

We should therefore ensure that people's health – and the promotion and support of this – is considered across the system as a complex, interweaved and interacting set of elements. This should then entail the involvement of a wide range of organisations and perspectives in support, working together.

Data sharing / analysis
Given that a range of social and economic factors affect health, and different elements of health interact, it is important that we are able to consider these together to identify patterns and opportunities.

However, at present as noted above, data is often siloed in separate systems, which do not interact. And where there is data sharing, the real value only comes from joint analysis and subsequent strategic and operational action – all of which are limited by resource constraints.

Therefore we need a greater commitment to data sharing, joint analysis of data, and strategic commitment to use this data to inform not only individuals' care, but organisational and system-wide planning and cooperation. This requires national leadership through appropriate resourcing, strategic commitment and ongoing monitoring of local action.

Q5. Please use this box to share specific policy ideas for change. Please include how you would prioritise these and what timeframe you would expect to see this delivered in, for example:

Quick to do, that is in the next year or so

Enable electronic prescribing for controlled drugs through community prescribing outside of GP systems
This is a straightforward application of existing technology that is effectively blocked by a lack of priority placed on it by central NHS support, making it challenging for charities to take action themselves.

Ensure the regulatory and funding environment enables the expansion of checking of illegal drugs
The market in illegal drugs is complex and changeable. People who use drugs bought illegally cannot be sure what they are taking, and therefore it is hard for them to judge risk and reduce the chances of harm.

If people who use drugs understand what they are taking, they can take appropriate and proportionate action to reduce their exposure to risk. One key way this can be done is knowing with more certainty what they are actually about to take.

This is almost impossible at present, as there are vanishingly few 'front of house' testing facilities that allow people to test their own drugs prior to taking them.

This is also an issue for organisations that support people who use drugs, as we do not have accurate information about what is circulating in local or national markets, and therefore how risky certain substances are at any given time.

This can be addressed by simplifying the licensing process to expand local provision of drug checking, providing national leadership to drive the establishment and maintenance of a network of accessible labs for analysis, and ensuring there is sufficient funding allocated to these facilities across the country.

Given the emergence of synthetic drugs – notably opioids such as fentanyl and nitazenes – in the UK market at an unprecedented scale, this is an urgent issue as more and more people are dying from preventable overdoses related to these drugs.

A real difference could be made with relatively swift and straightforward action to update licensing processes and support local and regional commissioners and organisations – including the police – to ensure there are adequate testing facilities.

In the middle, that is in the next 2 to 5 years

Require key health and social care services to have training, screening and referral pathways for substance use - and monitor delivery of this (e.g. Alcohol Care Teams in acute trusts)
This has already been repeatedly recommended by research and guidance, but provision remains a varied patchwork across different NHS trusts, and often focuses only on alcohol when other substance use should also be considered.

Update GP and pharmacy contracts to include screening and supporting substance use issues (e.g. dispensing and supervising opioid agonist treatment) as a matter of course

Currently, individual GP surgeries and community pharmacies can choose whether to support substance use provision. Given that the foundation of treatment for opioid use disorder is prescribed opioid agonist treatment, if an individual lives in a town where the pharmacy refuses to supervise consumption of opioid medication, then they cannot realistically start the pharmacological element of their treatment.

This is a key priority for the system, as without accessible prescribing, dispensing and supervision, we cannot offer effective, evidence-based support to people with opioid use disorder, and the evidence suggests that this will lead to increased transmission of HIV and Hepatitis C, as well as increased crime.

Improve health and social care professionals' training to include substance use
We know that right across the health and care sector, whether for GPs, nurses or social workers, training in substance use issues is brief or absent. This affects the identification of issues and the care that people who use alcohol or other drugs receive. If we increased awareness and reduced stigma then we would improve health outcomes and reduce costs. This would require a long-term commitment, but at little cost, as charities and people who use drugs themselves are keen to support culture change through training and awareness activities – notably through the Anti-Stigma Network supported by charities, NHS trusts and individuals.

Long term change, that will take more than 5 years

Encourage wider cultural change around the use of alcohol and other drugs to reduce stigma and problematic use

While there can be effective anti-stigma work with professionals, the wider social context around the use of alcohol and other drugs makes health improvement challenging. The cultural and regulatory context around both alcohol and other drugs does not support harm reduction or an informed approach to substance use.

Population level action to improve knowledge and awareness might take some time to pay dividends, but work could begin immediately – and is already underway by a range of charities in this sector – but government and health professionals can accelerate this process with a clear visible commitment on this issue.