Public Health
England

NDTMS provider survey
February 2014

National report

About Public Health England

Public Health England's mission is to protect and improve the nation's health and to address inequalities through working with national and local government, the NHS, industry and the voluntary and community sector. PHE is an operationally autonomous executive agency of the Department of Health.

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Introduction

The National Drug Treatment Monitoring System (NDTMS) captures data on the numbers of people presenting to English services with problematic drug and alcohol misuse. There are 8 regional NDTMS teams based across the country supporting the processes required for ensuring that the ongoing primary data collection is maintained and that monthly deadlines and quality targets are met.

In January 2014 all drug and alcohol treatment providers in England, reporting to NDTMS were requested to complete a national survey relating to topic areas as agreed with the central and regional NDTMS teams. The survey included questions around software providers, information governance, business continuity, the frequency of reviews and mutual aid referrals. It also recorded the respondent's name, contact details, NDTMS region, parent organisation and agency codes.

Aims

The aim of the survey was to provide information to regional and central NDTMS teams, PHE Alcohol & Drug team colleagues and individual partnerships with regards to the ongoing timely delivery of high quality data around drug and alcohol treatment in England.

Objectives

To gather information on a national, regional, DAT and organisational level in relation to:
- Systems: To verify software systems used, how they are accessed and to obtain information in relation to planned migrations of data from or to NDTMS or Case Management systems.
- Information Governance: To verify awareness and use of the NDTMS Consent and Confidentiality Tool Kit V6.3 and to assess password security.
- Business Continuity: To verify the presence of a Business Continuity plan for each provider, including a timetable for backups and information in relation to the resilience of data entry.
- Frequency of Reviews: To verify the frequency of Sub Intervention Reviews and Outcomes Records (TOP, AOR, YPOR).
- Mutual Aid: To verify that services are referring clients to mutual aid organisations and that these referrals are being recorded on NDTMS systems.

This report will be made available to NDTMS teams, PHE alcohol and drug leads and alcohol and drug commissioners.

Unless otherwise stated, this report includes all English alcohol and drug treatment providers in the community, for young people and adults reporting to NDTMS.

Please note, percentages may not always add up to 100% due to rounding. Percentages are based on the denominator of the number of providers completing the survey.

Overall survey completion rates

Table 1. Survey completion rates

Region	Number of providers	Number of providers with completed surveys	Completion rate %
Northern & Yorkshire – Yorkshire & Humber	187	124	66.3
Northern & Yorkshire – North East	98	68	69.4
North West	149	118	79.2
South East	148	126	85.1
South West	79	66	83.5
London	246	158	64
West Midlands	103	80	77.7
East Midlands	67	22	32.8
Eastern	94	50	53.2
Total	**1172**	**812**	**69.3**

The national rate of completion of this survey was 69.3%. Completion rates varied across NDTMS regions. The highest completion rate was in the South East where 85% of providers completed the survey. The lowest completion rate was in the East Midlands where 32.8% of providers completed the survey.

Where returns have been made, there can be some reassurance to the commissioning local authority that there is less chance of system changes being made or planned without the knowledge and involvement of regional NDTMS teams and any resulting discontinuity in national statistics and monitoring information.

This survey has followed on from practice prior to NDTMS transition to PHE of varying degrees of information gathering at regional level and has been the first year that a national survey has been completed. It is hoped that there will be an improvement in completion of this survey next year and teams are continuing to pursue completion for this year outside of this analysis.

Provider profiles

What client group does your provider treat?
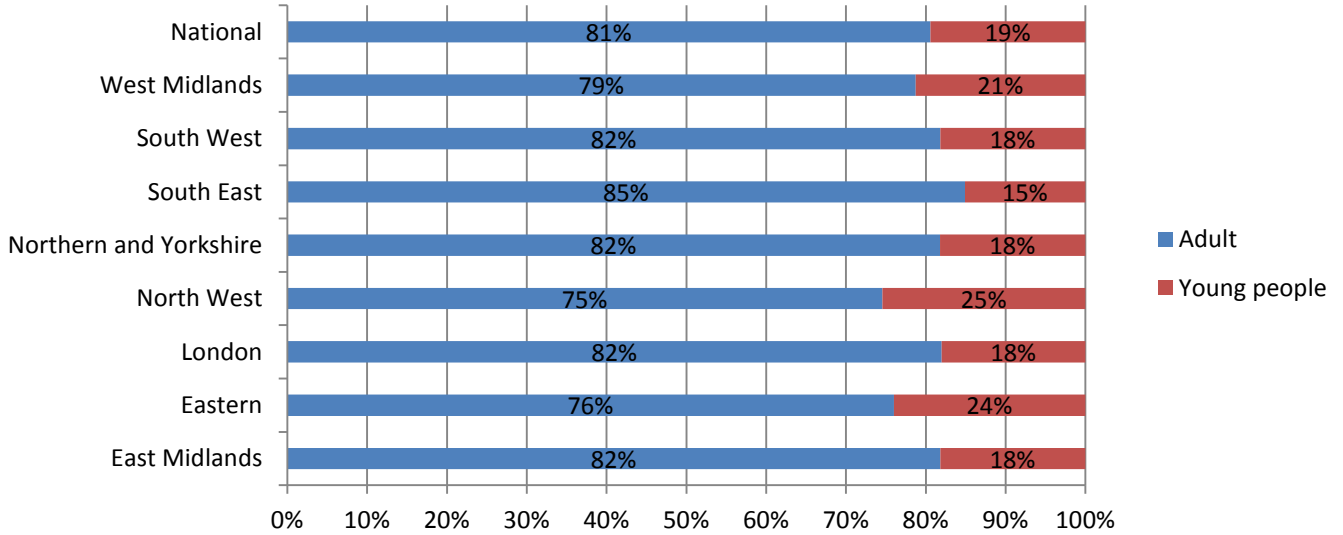
Figure 1. Client group, nationally and by NDTMS region

Nationally, of the 805 providers who completed the survey, 81% report that they treat adult clients and 19% report that they treat young people. This distribution is generally consistent across the different NDTMS regions.

What treatment service/s do you provide?
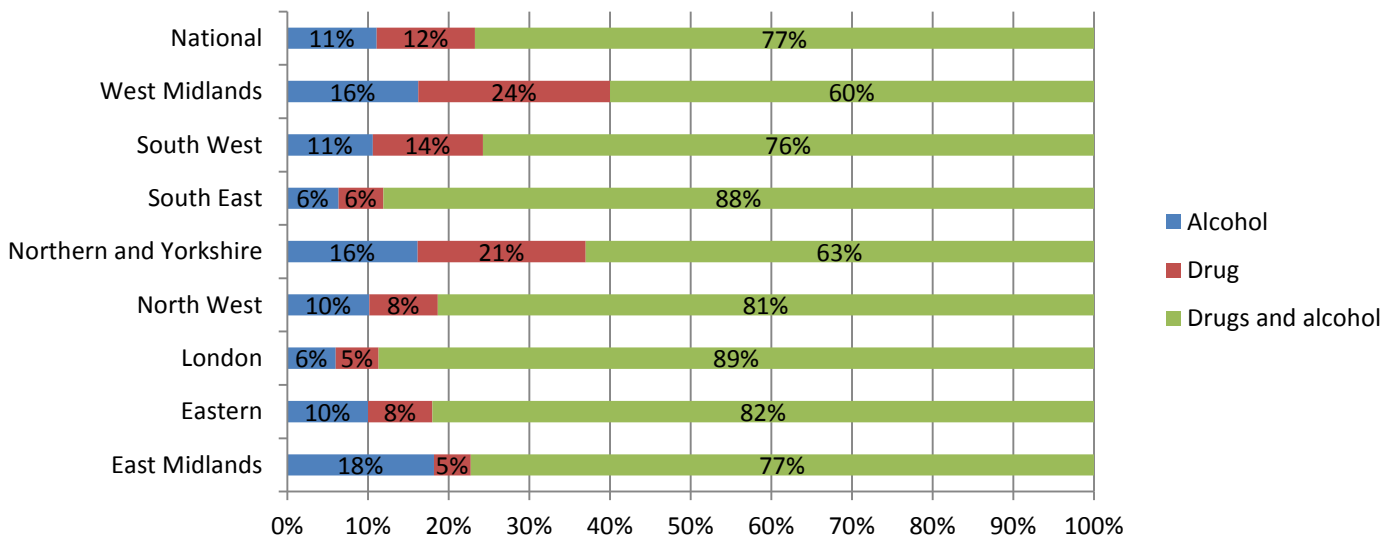
Figure 2. Treatment service offered, nationally and by NDTMS region

Figure 2 shows that of the providers that completed the survey, 11% offer alcohol treatment, 12% offer drug treatment and 77% offer both drug and alcohol treatment. This distribution is generally consistent across the NDTMS regions with the exception of West Midlands and Northern & Yorkshire services who have the least percentage of services delivering combined substances misuse treatment.

Do you have a Care Quality Commission (CQC) registration number?
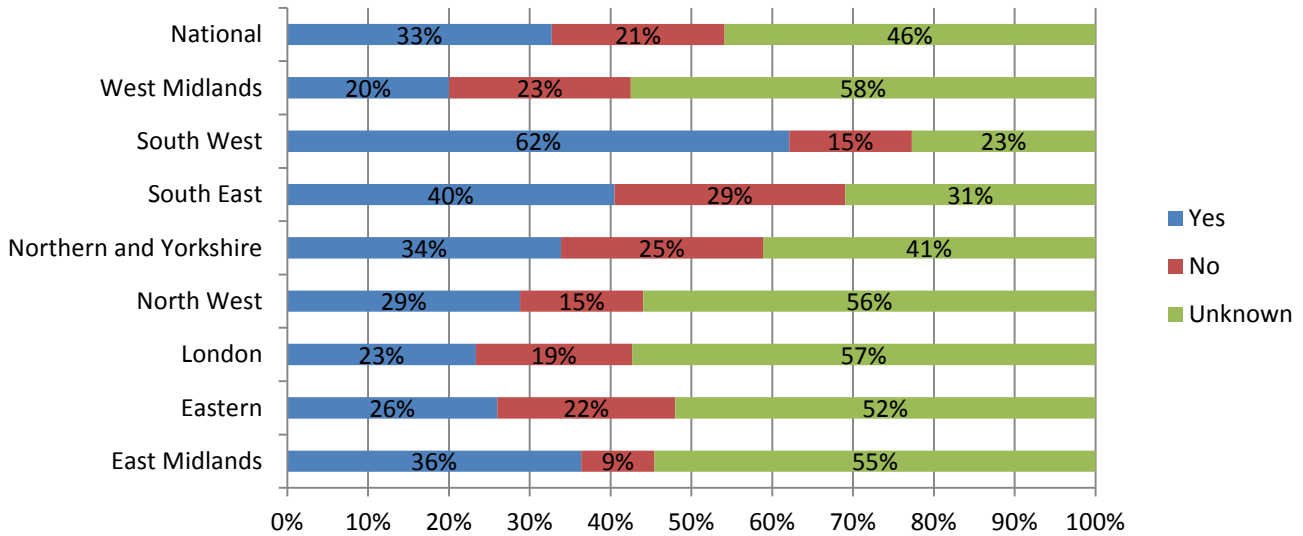
Figure 3. CQC membership, nationally and by NDTMS region

Thirty three percent of survey respondents stated that they have a CQC registration number. Twenty one percent stated that they did not have a CQC registration number and a further 46% did not know. Due to the number of providers who reported that they did not know caution should be exercised when interpreting these results. We will endeavour to improve on this information in next years' survey.

It should be noted that all residential drug and alcohol treatment providers should be registered and all community-based providers with nurses, doctors, social workers or psychologists employed as such are also required to be CQC registered.

NDTMS systems

What software system does your treatment service use to collect NDTMS data?
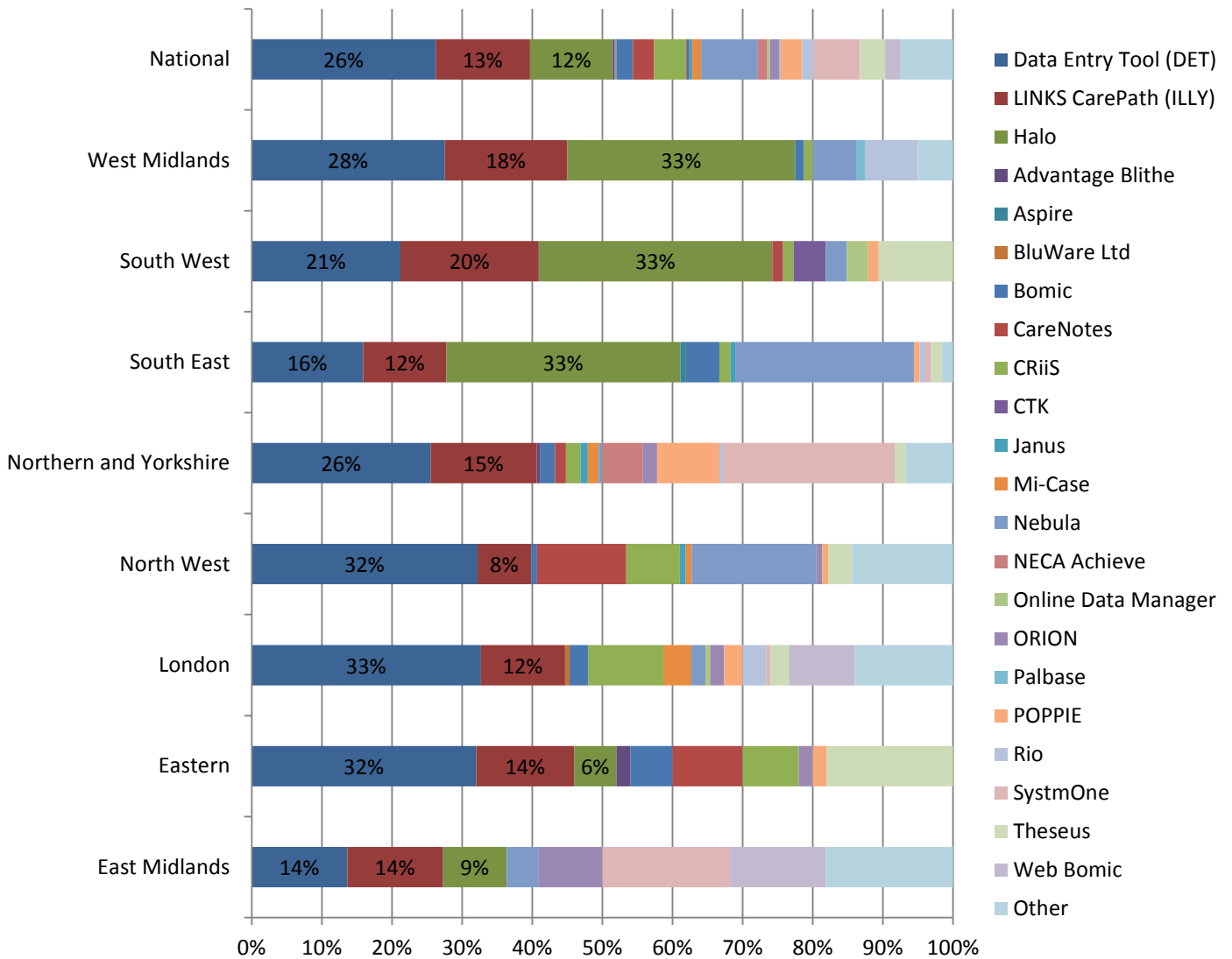
Figure 4. Software provider, nationally and by NDTMS region

Surprisingly, there are at least 22 systems apart from the NDTMS Data Entry Tool (DET) reported as in use to generate a data extract for NDTMS purposes. There was wide variation in the use of these software systems nationally. The most popular software system is the NDTMS DET with 26.2%. The next most popular is LINKS Care Path (ILLY) with 13.4%, closely followed by Halo with 11.8%.

The three regions where DET is not the most popular tool, West Midlands, South West and South East, all had one third of their services using Halo. Whereas in the Northern & Yorkshire, the North West and London no one reported using Halo.

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Illy had representation in all regions with the greatest proportion in the South West.

The DET was reported used in all regions but most substantially in London, the North West and the East. It is used least of all in the East Midlands region.

SystmOne was reported used by 24.5% of Northern & Yorkshire services, the second largest system use in that region. In the East Midlands it was reported as the largest system in use. However, the only other region to reports its use at all was the South East

Nebula (17.8%) and Theseus (18%) are the second most common systems reported in the North West and East respectively.

From where can staff access the system that you use to submit your NDTMS data?
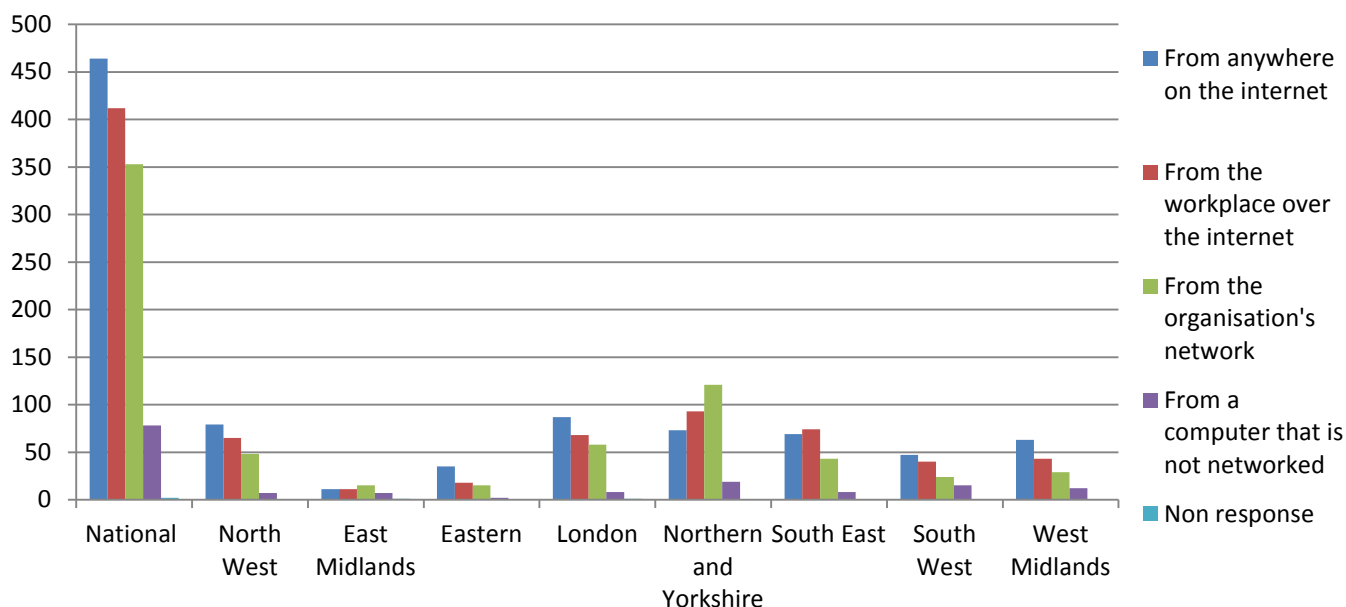
Figure 5. System access methods, nationally and by region (please note, respondents could select as many options as applicable for this question, therefore the categories are not mutually exclusive). Please note, where necessary answers have been corrected for DET Users who are able to access DET from anywhere over the internet.

Nationally, the most common method to access the system that is used to submit NDTMS data was from anywhere over the internet (n=464).

An NDTMS extract system that is able to provide access from anywhere over the internet may be less vulnerable to disruption following certain types of critical incidents requiring the short term relocation of administrators/ key workers.

Responses from DET users indicated that there are misconceptions about the capabilities of DET, which may in fact be accessed from anywhere over the internet. It would be beneficial

for managers of DET system services to understand this and factor it into their own business continuity planning.

Are you considering changing your NDTMS systems?
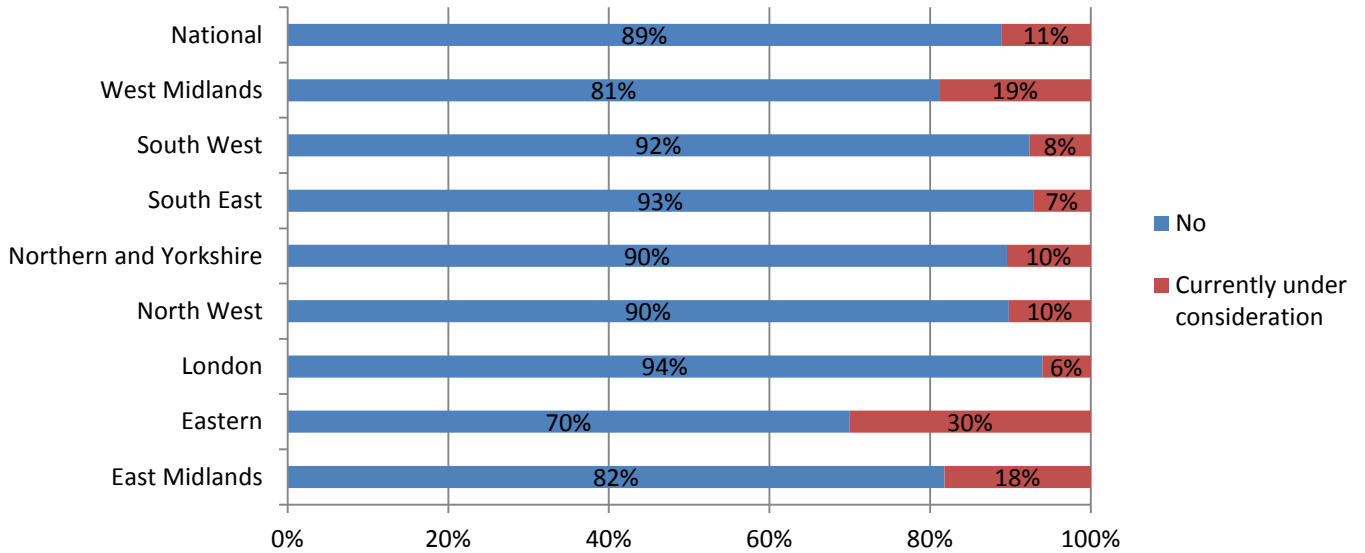
Figure 6. Software migration intentions, nationally and by NDTMS region

Figure 6 shows that nationally only 11% of providers reported currently considering changing their software system. This can give NDTMS teams some confidence that software use remains relatively stable, particularly in the South West, the South East and London. The main exception to this is the Eastern region where 30% of providers are considering changing their software. This is considerably higher than the national average and a potential resource issue for that team.

With the required movement of commissioning into local authorities from April 2013, regional NDTMS teams are reporting a significant increase in their support for projects facilitating movement of data from system to system and creation of new agency codes due to new provision. This is expected to form an increasingly significant part of NDTMS regional team activity next year.

Are you considering changing your Case Management System?

Chart showing intentions to change Case Management System, nationally and by NDTMS region, with "No" (blue) and "Currently under consideration" (red):

Region	No	Currently under consideration
National	86%	14%
West Midlands	84%	16%
South West	91%	9%
South East	90%	10%
Northern and Yorkshire	87%	13%
North West	84%	16%
London	87%	13%
Eastern	64%	36%
East Midlands	82%	18%
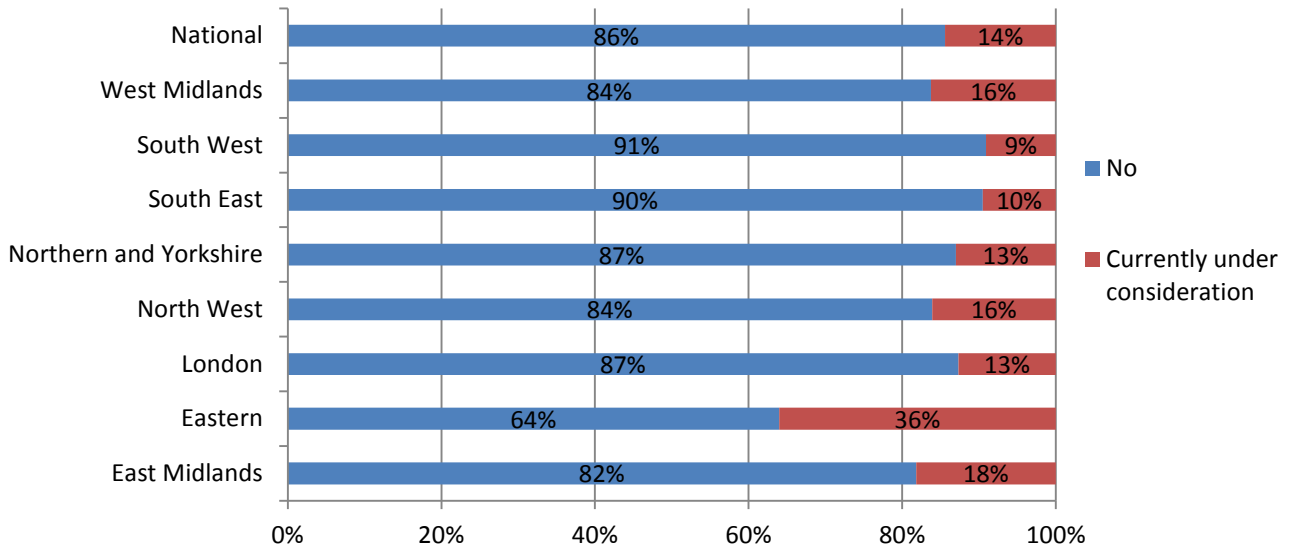
Figure 7. Intentions to change Case Management System, nationally and by NDTMS region

Figure 7 shows that only 11% of providers nationally are currently considering changing their case management system (CMS). This can give the NDTMS teams some confidence that CMS system choice remains relatively stable, particularly in the South West and the South East. The main exception to this is, again, the Eastern region, where 36% of respondents reported that they were considering changing their case management system. This is considerably higher than the national average.

Information governance

Respondents were asked whether staff at their organisation allowed other people to use their login details for the following systems (n/a indicates that the provider does not have access to that system).

It is strongly recommended that staff are not permitted to share passwords to any of these systems in the interests of security and information governance.

Drug and Alcohol Monitoring System (DAMS)
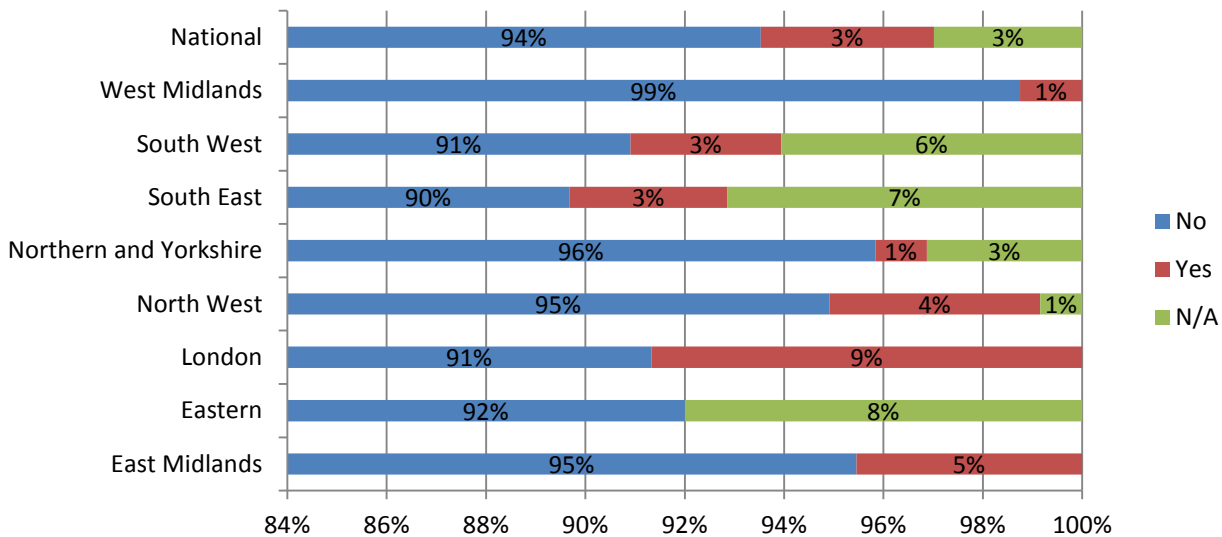
Figure 8. DAMS password sharing among staff, nationally and by NDTMS region

Nationally, only 3% of respondents stated that DAMS passwords were shared amongst staff at their organisation. Whilst this figure is low, this practice is not appropriate and should cease as it poses an information governance risk. This level is relatively consistent across the NDTMS regions, with the highest level of password sharing occurring in London. Those respondents who have stated that they do share passwords will be contacted by their regional NDTMS team to provide support and guidance if required including the creation of new DAMs accounts where needed.

It was also noted with concern that 3% of providers nationally stated that they do not have access to DAMS. As this is the sole way of submitting data to the NDTMS it seems likely that these respondents are mistaken. Again, this may highlight a training need and those respondents who stated 'N/A' to this question will be contacted by their regional NDTMS teams to see if we are able to provide further training on the DAMS system.

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Data Entry Tool (DET)
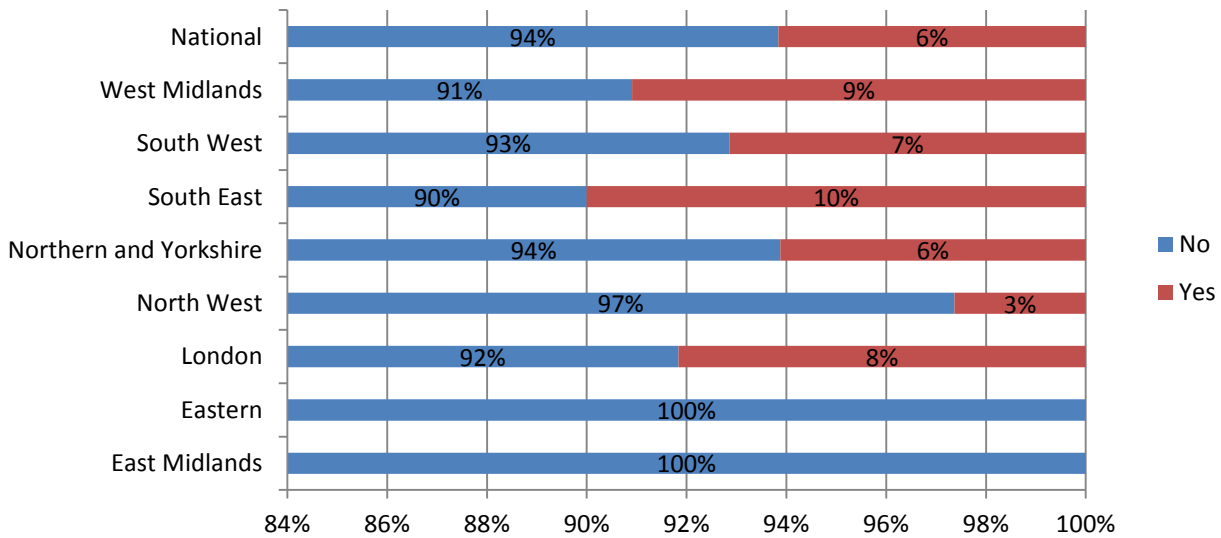
Figure 9. DET password sharing among staff, nationally and by NDTMS region (please note, for those who stated they were on a system other than DET their responses have been corrected to N/A where necessary) (n = 211)

For the majority of respondents (74%) this question was not applicable as they were on a software system other than DET. Figure 9 therefore only shows responses for those who are on DET (n = 211).

Of respondents who are on DET, 94% nationally stated that DET password sharing does not occur within their organisation. Whilst it is positive that this figure is so high, the fact that 6% reported that staff do share their DET password with other staff members concerning as this could cause a potential information governance issue.

Both the East and the East Midlands reported that DET passwords are never shared which is the standard expected practice. The highest levels of shared DET passwords occur in the South East (10%), West Midlands (9%) and London (8%). This may indicate a requirement for additional information governance advice; DET passwords should never be shared between staff, accounts can be set up by the regional NDTMS teams for those staff members who require them. NDTMS regional teams will be in contact with those providers who reported that they do share their DET passwords to establish what further guidance or advice is required.

Prison DET

Unsurprisingly, the majority of respondents (85%) reported that they did not have access to Prison DET as only community based services were included within this survey. One hundred percent of respondents who also supported NDTMS in prisons and did have access to Prison DET (n = 117) stated that passwords were not shared among staff.

CJIT Data Entry Tool (CJIT DET)

Similarly, it is not surprising that the majority of respondents reported that this question was not applicable to them as they did not have access to CJIT DET as they were not CJIT providers (72%). Of those who did have access to CJIT DET (n = 224), 98% reported that staff did not share passwords. The few respondents who stated that staff did share their DIRDET passwords were in the West Midlands, the Northern & Yorkshire and the North West.

PHE Secure File Transfer System (SFT) (*aka DropBox*)
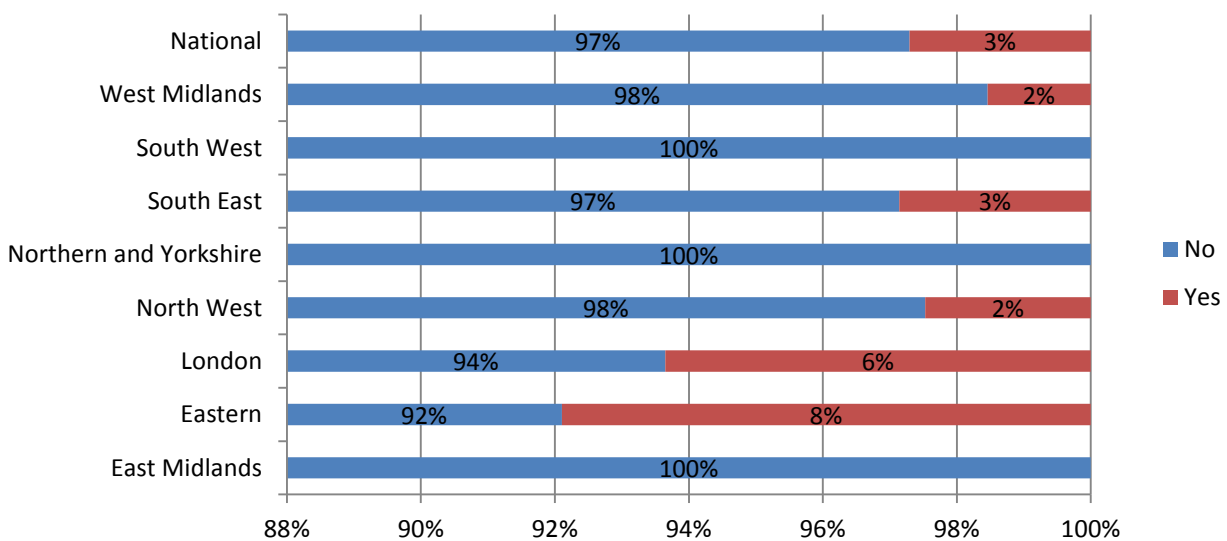
Figure 10. SFT password sharing among staff, nationally and by NDTMS region (n = 628)

Twenty two percent of respondents stated that this question was not applicable to them as they did not have access to the SFT.

Of those who did have access to the SFT (n = 628), 97% nationally said that staff did not share their password with other staff members. However, 3% stated that they did.

Looking across the regions, the South West and the East Midlands reported that their passwords were never shared which is expected practice. The East region and London had the highest levels of SFT password sharing with 8% and 6% respectively. Again, whilst these figures are relatively low, SFT passwords should not be shared between staff. Accounts can be set up by the regional NDTMS teams for those who require them. Providers who have stated that their staff do share SFT passwords will be contacted by their regional NDTMS team to establish what further guidance or advice is required.

Needle Exchange Monitoring System (NEXMS)

The majority of respondents (77%) reported that they did not have access to NEXMS as not all areas have elected to use this dataset. One hundred percent of respondents who did have access to NEXMS stated that passwords were not shared among staff.

Information governance - consent

Does your organisation's consent policy include the latest version of the NDTMS Consent and Confidentiality Tool Kit version 6.3?
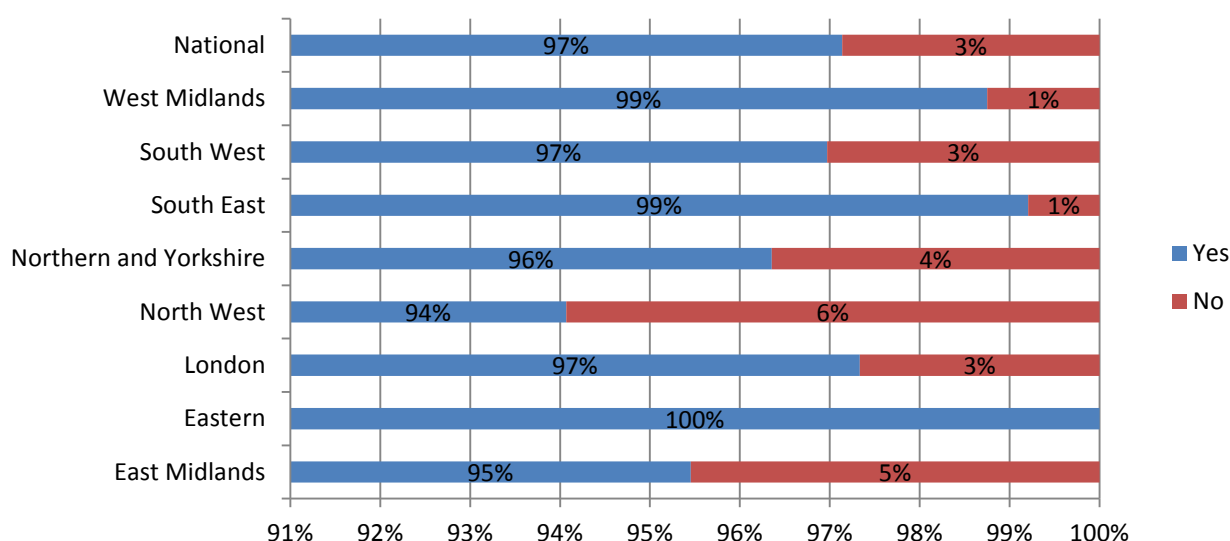
Figure 11. Inclusion of NDTMS Consent and Confidentiality Toolkit V6.3 within organisation's consent policy

As can be seen from figure 11, the vast majority of services (97%) reported including the NDTMS Consent and Confidentiality Toolkit V6.3 within their organisation's consent policy. One hundred percent of providers in the Eastern region reported including it, whereas only 94% of providers in the North West did.

Unlike most health datasets, NDTMS is a 'consented-to' dataset and it is extremely important that clients' data in NDTMS is appropriately used according to the consent provided by individuals. The use of the most recent wording for consent is an intrinsic element of the agreement between the NDTMS programme and the Confidentiality Advisory Group (CAG) in granting Section 251 permission for the programme's continued use of the data following transition into PHE.

All regional teams will be making this element of the survey the highest priorty in ensuring we have accurate information and where necessary, that organisation's consent policy is amended in line with the requirement.

Business continuity

Does your organisation have an effective Business Continuity plan covering how your agency will continue to provide NDTMS data if your NDTMS system should fail?
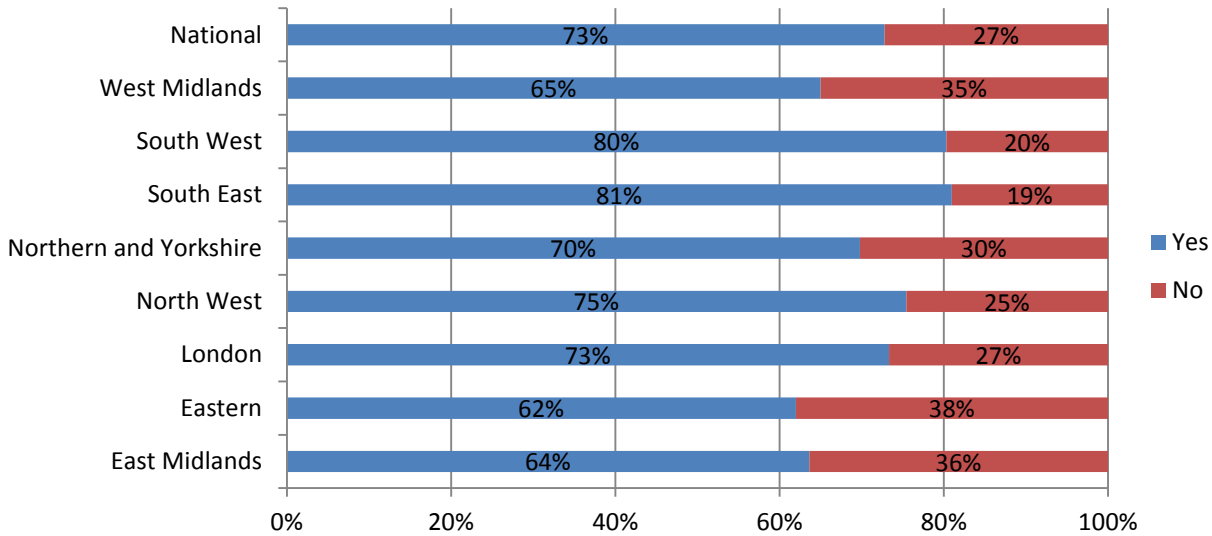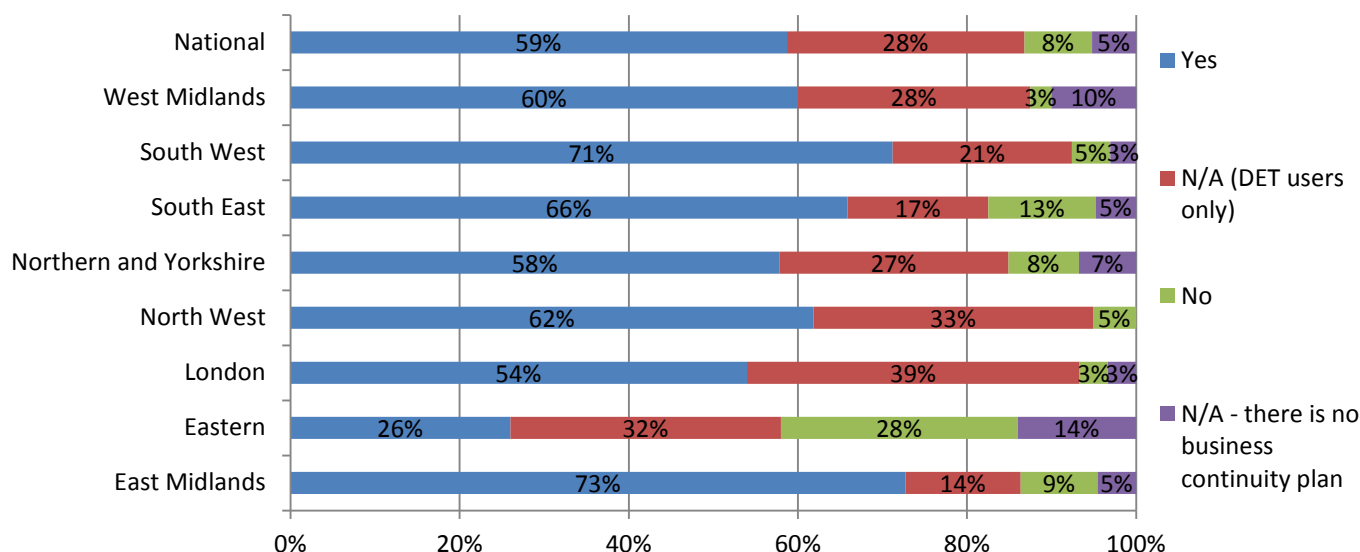

Figure 12. Presence of a Business Continuity plan covering how services will submit data to the NDTMS if their NDTMS system should fail

Nationally, 27% of services have a potential risk of non submission due to Business Continuity plans either not being in place or not being known to the member of staff who completed the survey.

The East, East Midlands and West Midlands regions are most at risk with 38%, 36% and 35% of respondents respectively stating that they do not have an effective Business Continuity plan.

Partnerships where there is no Business Continuity plan should seek reassurance with regard to the continued capability of these services to provide NDTMS data on behalf of their treatment systems in a timely fashion regardless of the impact of staff absences, power shortage, structural damage to premises, etc. The NDTMS regional teams can assist with such planning if required.

Does your Business Continuity plan incorporate a timetable for taking backups of your NDTMS data?

Figure 13. Presence of a Business Continuity plan which incorporates a timetable for taking backups of NDTMS data (please note, responses have been corrected for DET users where necessary)

Nationally, 87% of respondents have a timetable for data backups (including DET users).

Whilst we encourage all system users to incorporate daily backup procedures into their operational plans, this may not always be required e.g. if there are only a handful of people in treatment and the agency's data remains unchanged from one day to the next.

Data entered on the DET is backed up nationally, overnight on a daily basis by the NDTMS central team. This may provide some reassurance to service managers using the DET. Those managers, however, might also consider that if their agency operates a 'paperless' office policy, whereby paper forms get shredded after they are input, then the data input during the previous days may risk being lost forever. Such loss might occur if the central team's backup processes were to fail or if they had to restore data back to an earlier point in time. Similar considerations may apply to users of other systems (although those users may have greater control over backup and restoration processes).

Of most concern are those services that use DET but are not aware of the NDTMS backup procedures and therefore are unlikely to have a robust Business Continuity plan for recovering data. Services representing 7.5% of respondents nationally incorrectly reported that they did not have a Business Continuity plan which incorporated backups of data.

How many people in your organisation are expert system users whose role includes maintaining the NDTMS data extraction system and DAMS, or supporting other system users?
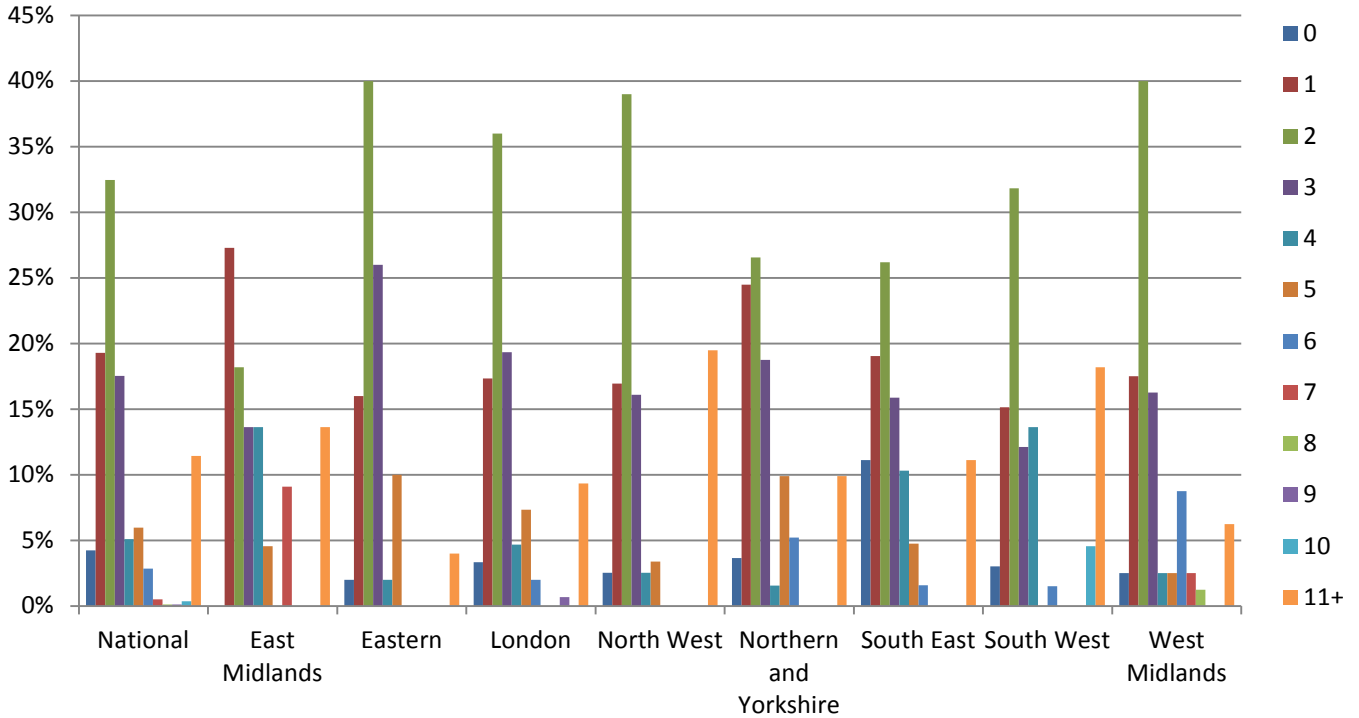
Figure 14. Number of expert NDTMS system users per provider, nationally and by region

Figure 14 shows that 75% of providers nationally have at least two staff members responsible for NDTMS systems. Nineteen percent of providers nationally only have one person responsible for NDTMS systems. This lack of resilience to cover systems in the case of staff sickness and leave means that NDTMS data maybe at risk of non submission from these providers. This may be particularly problematic in the East Midlands and the Northern & Yorkshire where 27% and 24% of services respectively only have 1 staff member responsible for NDTMS systems.

Is your organisation able to continue to update and submit NDTMS data in the absence of the person(s) usually tasked with doing so?
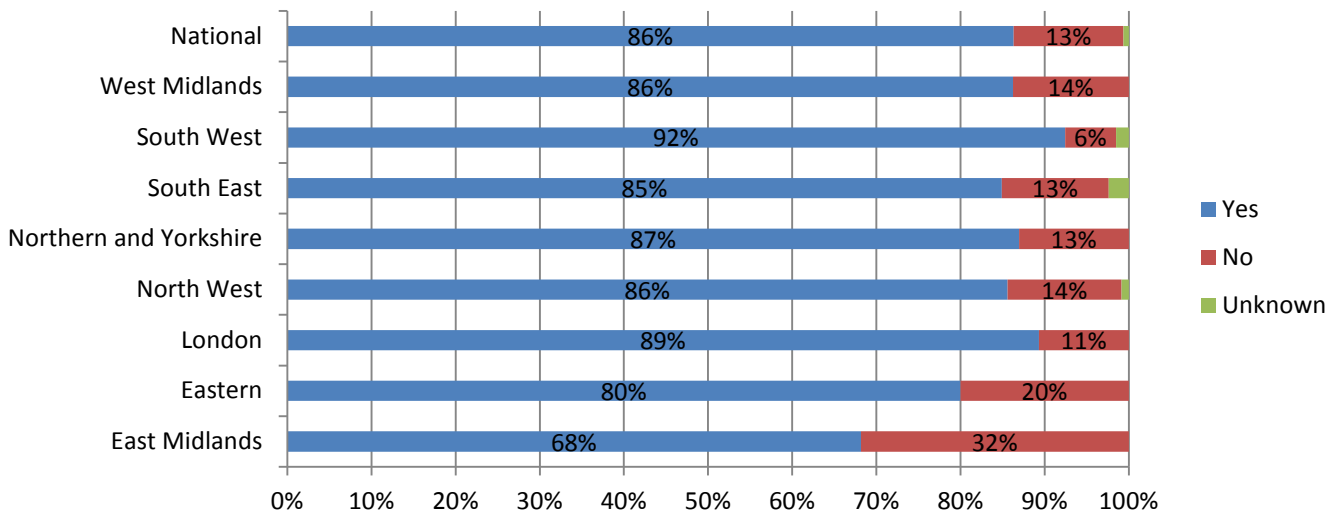

Figure 15. Resilience of NDTMS submission in case of staff absence, nationally and by region

Of particular concern, thirteen percent of respondents nationally stated that in the absence of the person usually responsible for submitting their NDTMS data they would not be able to continue to submit to NDTMS (as illustrated in figure 15). As staff absence cannot always be anticipated this means that NDTMS is at risk of non submission from these providers.

This is particularly concerning in the East Midlands and the East region where 32% and 20% of providers respectively stated that they would not be able to submit to NDTMS in the absence of the person usually tasked with doing so.

Frequency of reviews

Approximately how frequently does your organisation complete Sub Intervention Reviews?
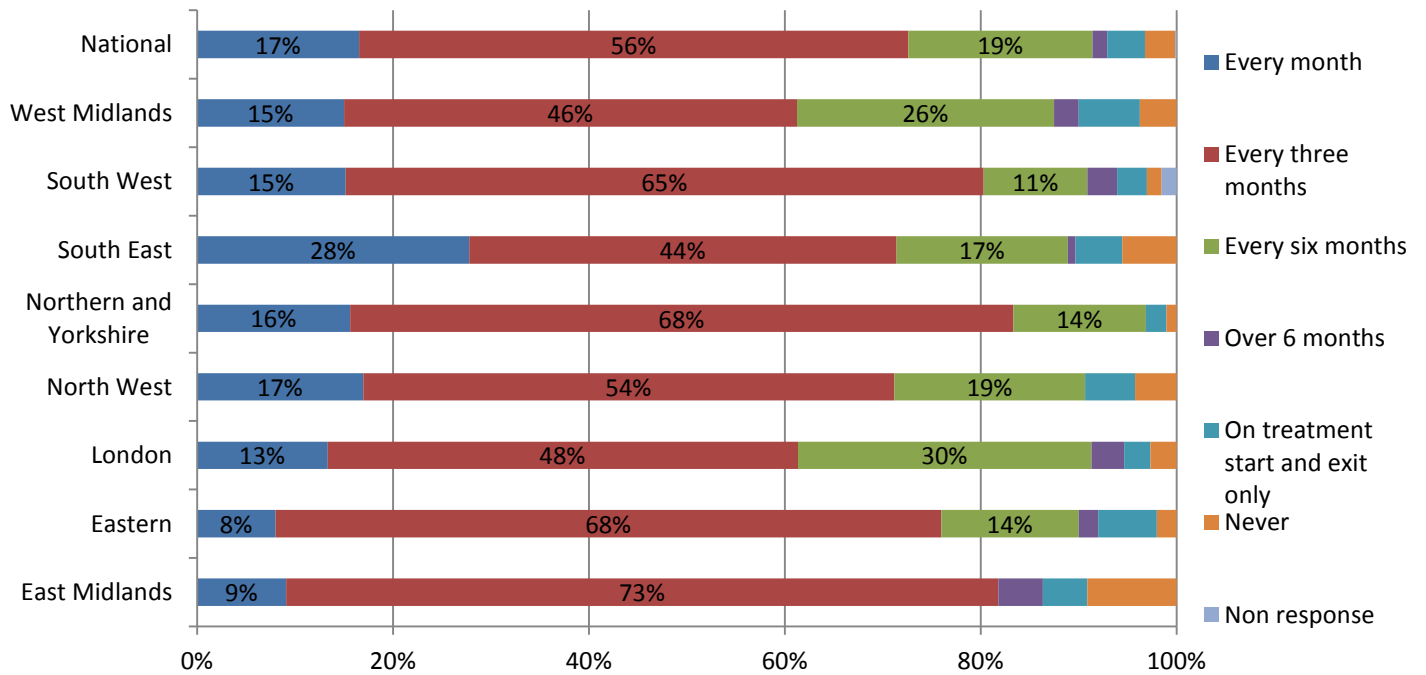
Figure 16. Frequency of Sub Intervention Review (SIR) completion, nationally and by NDTMS region
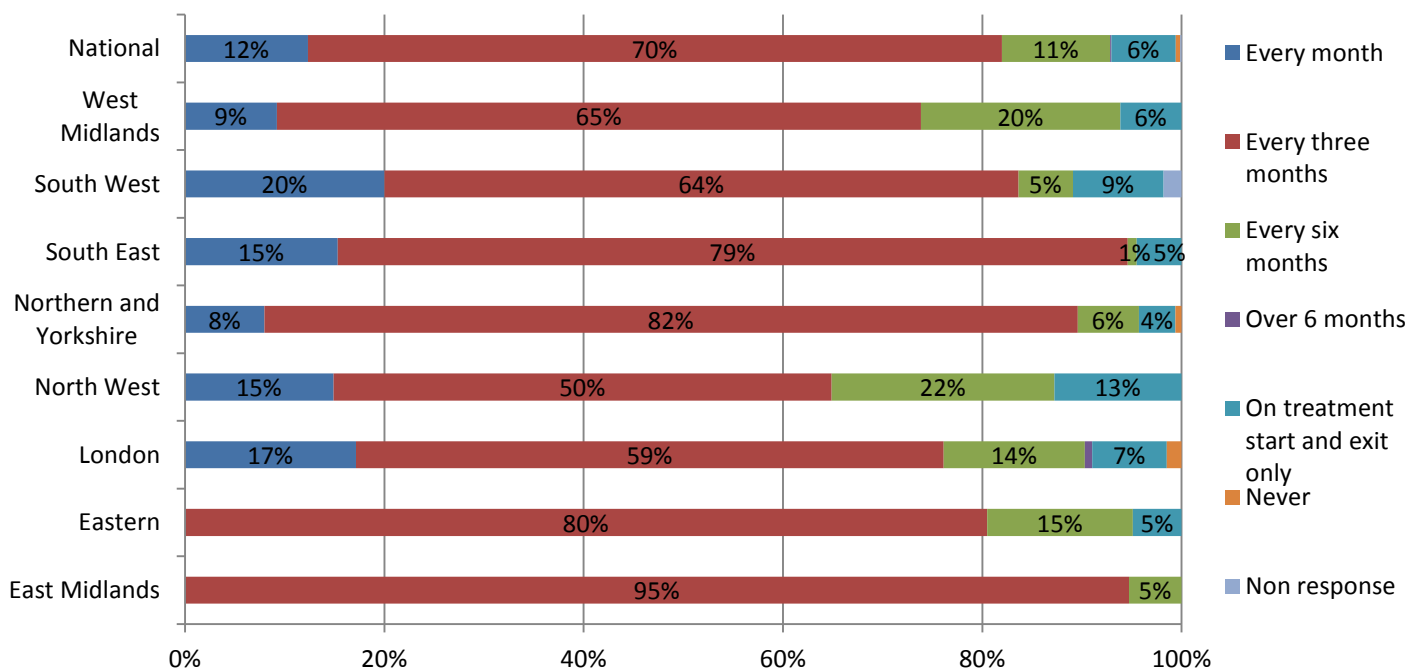
NDTMS guidance states that Sub Intervention Reviews should be completed at least every six months, but facilitates more frequent reporting.

Figure 16 shows that nationally 92% of respondents complete SIRs at least every 6 months, and 73% of respondents complete them at least every 3 months. One percent stated that they do them less frequently than six monthly and 4% submit them on treatment start and exit only. Three percent stated that they never report this information.

This is a relatively consistent level of reporting across the NDTMS regions. Northern & Yorkshire have the best SIR completion rate with 98% of respondents stating that they are completed at least every 6 months. The West Midlands had the lowest completion rate with only 87% of respondents completing SIRs six monthly or more.

It should be noted that due to individual treatment system configuration, some services may not be completing SIRs due to arrangements for their completion by peer services.

Approximately how frequently does your organisation complete TOP?

Figure 17. Frequency of Treatment Outcome Profile (TOP) completion, nationally and by NDTMS region (n = 682)

NDTMS guidance states that Treatment Outcome Profiles (TOPs) should be completed at least every six months but facilitates more frequent reporting.
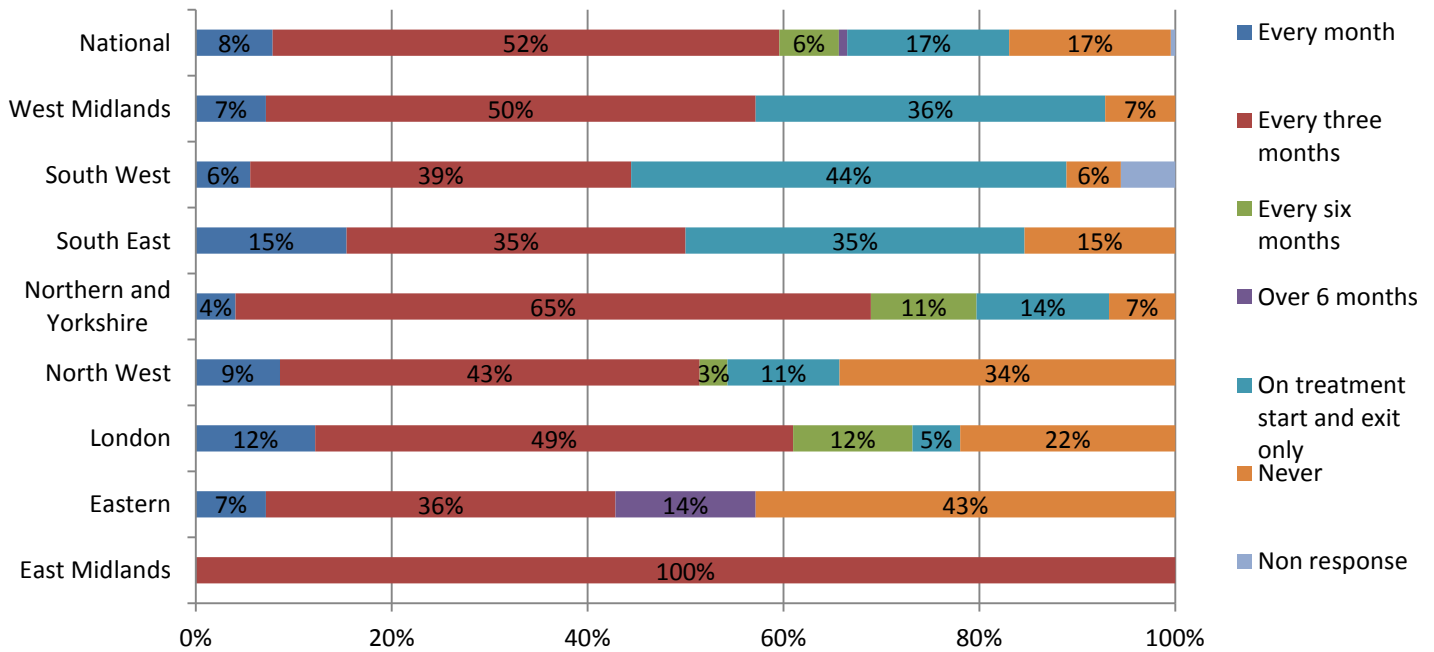
Fifteen percent of respondents stated that TOP is not applicable for their service (suggesting they use AOR or YPOR instead).

Of those who do use TOP, 93% stated that they complete them at least every six months whilst 82% stated that they are done at least every three months. Six percent stated that they do them less frequently than six monthly and less than 1% stated that they never do TOP.

This is relatively consistent across the regions. One hundred percent of respondents in the East Midlands reported that they submit TOPs at least every six months. The lowest reported level of at least six monthly TOP completion was 87% and this occurred in the North West where 13% also stated that they only do TOP on treatment start and exit.

It should be noted that due to individual treatment system configuration, some services may not be completing TOPs due to arrangements for their completion by peer services.

Approximately how frequently does your organisation complete AOR?

Figure 18. Frequency of Alcohol Outcome Record (AOR) completion, nationally and by NDTMS region (n = 230)
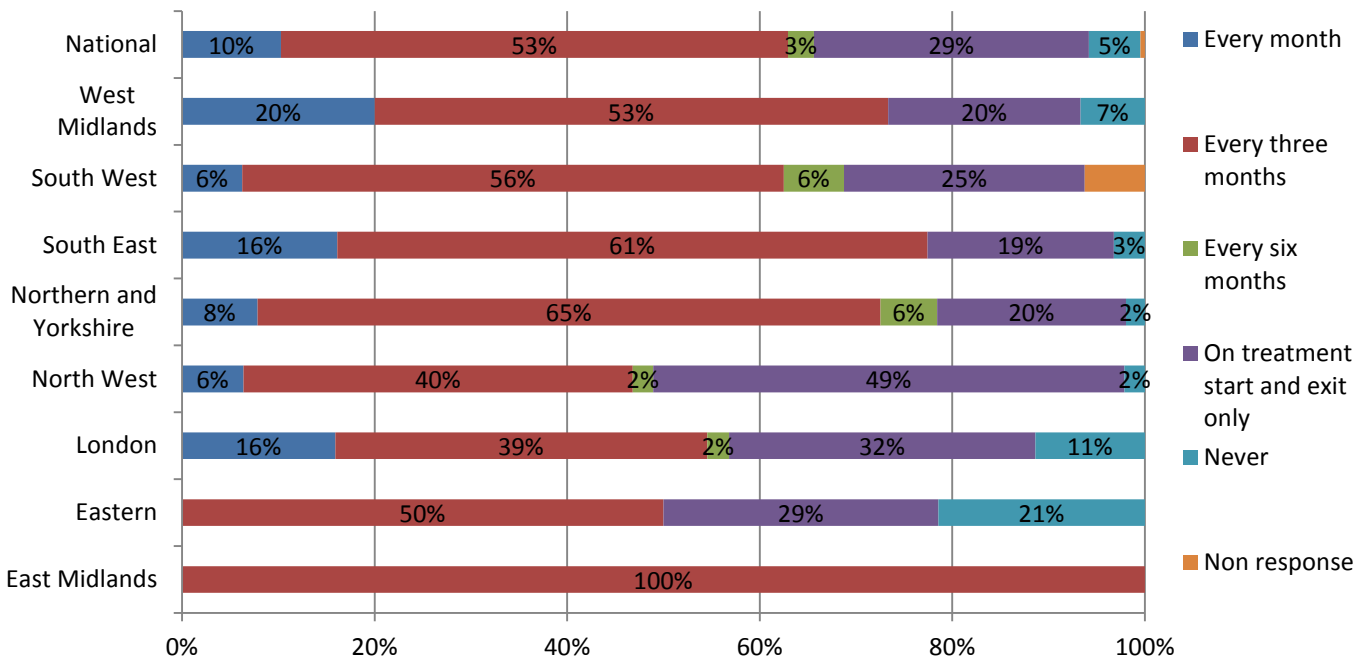
NDTMS guidance states that Alcohol Outcome Records (AORs) should be completed at treatment start and exit, and more frequently if required. They are required for clients whose primary problematic substance is alcohol.

Seventy one percent of respondents stated that the AOR form is not applicable to them (suggesting that they use TOP or YPOR instead).

Of those who do use the AOR form, 81% nationally stated that they complete AOR at least at treatment start and exit, with 66% stating that they complete them more frequently than this.

Looking across the NDTMS regions, in the East Midlands 100% of respondents stated that they complete AOR every three months. In the Eastern region 43% of respondents stated that they never complete AOR; it is possible that some of these respondents should have selected 'N/A' rather than 'never'.

Approximately how frequently does your organisation complete YPOR?

Figure 19. Frequency of Young Person Outcome Record (YPOR) completion, nationally and by NDTMS region (n = 224)

NDTMS guidance states that Young Person Outcome Records (YPOR) should be completed at treatment start and exit, and more frequently if required. They are applicable for young people aged under 18.

Seventy two percent of respondants stated that the YPOR form is not applicable to them (suggesting that they use TOP or AOR instead).

Of those who do use the YPOR form, 95% nationally stated that they complete YPOR at least at treatment start and exit, with 66% stating that they complete them more frequently than this.

Looking across the NDTMS regions, in the East Midlands 100% of respondents stated that they complete YPOR every three months. In the Eastern region 21% of respondents stated that they never complete YPOR; it is possible that some of these respondents should have selected 'N/A' rather than 'never'.

Mutual aid referral

Do you refer clients to mutual aid organisations?
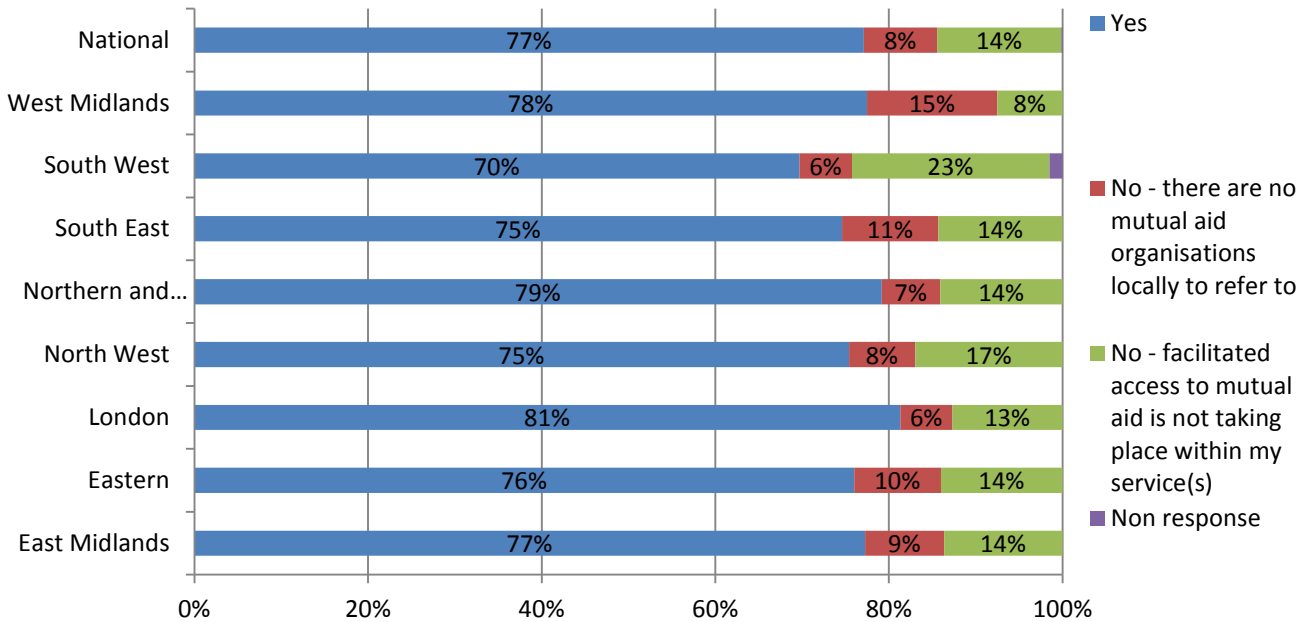
Figure 20. Occurrence of mutual aid referral, nationally and by NDTMS region

Nationally, 77% of providers reported that they refer clients to mutual aid organisations (as illustrated in Figure 19). Twenty two percent of respondents reported that they are not referring to mutual aid organisations. This level is relatively consistent across the NDTMS regions. The highest level of mutual aid referral occurs in London where 81% of respondents stated that they refer to mutual aid. The lowest level occurred in the South West where only 70% reported that they referred to mutual aid organisations.

The West Midlands had the highest reported level of no mutual aid services in their area at 15% and local commissioners across the country may find this question of interest.

Do you record mutual aid referrals on NDTMS?

Figure 21 shows that of those who do refer to mutual aid (n=621), 60% reported that they do record this on NDTMS systems. Of concern, 31% nationally reported that they do not record mutual aid referrals on NDTMS systems as they are unable to.

The lowest level of mutual aid referral being recorded on NDTMS systems was in the West Midlands where only 24% of providers who refer to mutual aid organisations record this on NDTMS. Forty seven percent stated that this was because they could not record it on the system and a further 27% stated that they did not record it for another reason.

The highest level of recording mutual aid referrals on NDTMS systems was in the South West where 77% of respondents who do refer to mutual aid stated that this is recorded on NDTMS systems. Nineteen percent stated that they did not record on NDTMS as they were unable to.
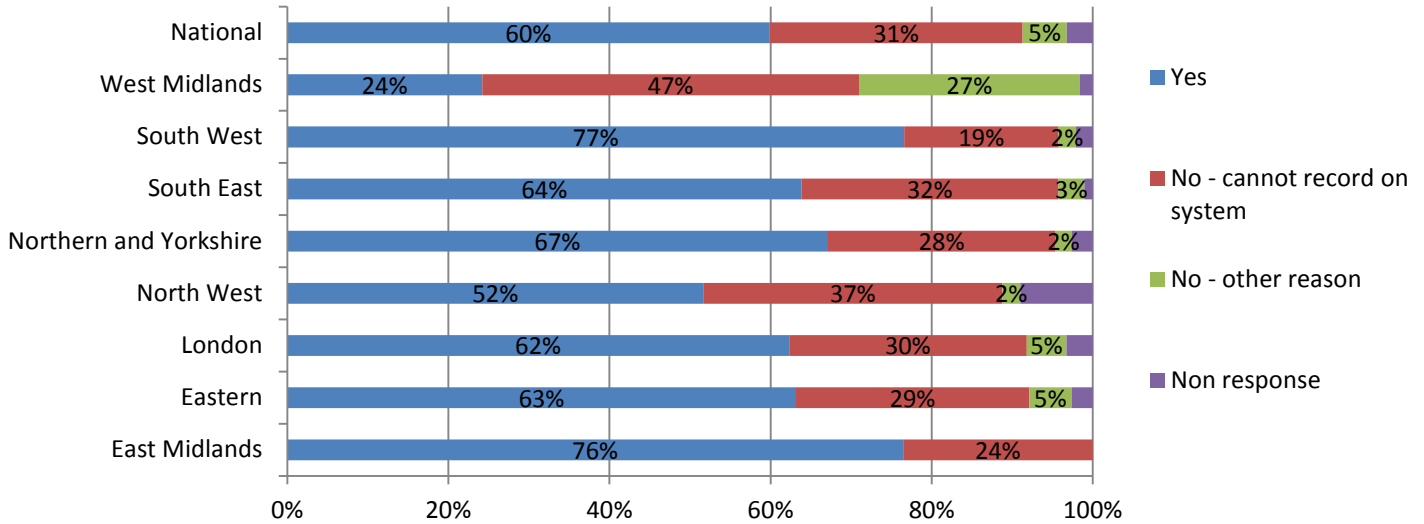
Figure 21. Recording of mutual aid referrals on NDTMS systems, nationally and by NDTMS region (n = 621)

Given the priority applied to the national Drug Recovery agenda and the intrinsic part that mutual aid is expected to play, regional NDTMS teams will be prioritising discussions with those services who are unable to report this activity to provide support and guidance either to the service or to the system supplier as appropriate.