At your service?

There are few subjects more fraught in our sector right now than the issue of how drug and alcohol services are commissioned. In the first of a two part article on commissioning in England, **Sara McGrail** reveals how smaller agencies are being forced out of the market.

It was the Monday before Christmas that the head of a small treatment service in the south-east heard that her agency had not got through the first stage of the tender. It wasn't really a surprise. Although the agency had been providing local services for over thirty years, commissioners had made it close to impossible for the charity to compete for its own services.

The commissioners had decided to "bundle" all 4 of the existing contracts into one mega-contract. This is an increasingly popular approach. Bundling – used primarily as a cost cutting mechanism by commissioners – is an approach that the healthcare regulator Monitor has concerns about. A case of putting "all your eggs in one basket", bundling means that just one provider manages and provides services across the whole of the care pathway in one area. It's attractive for commissioners as it takes all that pesky coordination out of their day job. However it also often rules out smaller organisations from bidding – as they may lack experience of delivering all of the services across the pathways. From a performance management perspective, bundling may look attractive. After all you only have one organisation to take care of – but in reality, bundling narrows the market, restricts choice and gives large providers significant advantages over commissioners. That's why it causes Monitor such concerns.

As a result of the bundling, the commissioners in this case set a turnover threshold (the level of existing funding those bidding must already have) of £20 million. This was later reduced to £12 million after a challenge. However for the charity – as for many charities dedicated to working in one area – their turnover was never even going to reach half of that specified.

Once again, they – and organisations like them – were excluded.

In research commissioned by Action on Addiction in 2012, *The Size and Scope of the Voluntary Addiction Sector in England and Wales*, the NCVO found that within the substance misuse field only 8 charities have a turnover in excess of £10 million. The commissioners' requirement that all bidders had a turnover of £20 million meant that less than 2.2% of non statutory providers nationally would be able to bid. So much for opening provision up to the non-statutory sector and Small to Medium Enterprises.

For a small local charity with a proud history of delivering high quality services, the cards were on the table. Their only possible way of defending the services they had provided – successfully – for over 30 years was to enter into a consortium arrangement with a larger provider.

When we talk about consortia in this context we need to be careful. Commissioners generally require one responsible agency to hold the contract to guarantee accountability. More often than not, when people refer to a consortium they actually mean a subcontracting relationship. In the long term this also crushes competition. It restricts the local and national market for services – driving smaller local charities and social enterprises out of business if unsuccessful, or effectively forcing merger if they are successful. This in turn reduces innovation, increases costs and limits choice for commissioners and service users.

Within the Procurement, Patient Choice and Competition (PPCC) regulations there is a clear understanding that this is problematic. Health regulator Monitor, whose role it is to police the PPCC regulations, advises that bundling should only be used where there is a demonstrable advantage to people using services that can only be achieved in this way. Using the regulations as its guide, Monitor should have been able to intervene in this commissioning – and press commissioners to alter their approach. However they couldn't. The reason for this is that drug and alcohol treatment (and sexual health services) are the responsibility of Public Health England and these two areas of healthcare are not only excepted from the PPCC regulations, they are also not commissioned under the NHS constitution. What's more, while nationally we are going through an exercise to establish a National Service Framework for Sexual Health Services – to set some ground rules down about what can and should be commissioned – no such exercise is taking place for drug and alcohol services.

CONTINUING TO SPEND THE AMOUNTS WE ARE ON PROCUREMENT PROCESSES THAT DON'T NATURALLY YIELD BETTER RETURNS FOR COMMUNITIES IS WASTEFUL IN THE EXTREME

The charity contacted PHE, the Department of Health, the Parliamentary and Health Service Ombudsman, Local Government Ombudsman and Monitor to ask who was responsible for oversight of commissioning of these services given their exclusion from the PPCC regulations. No one could answer the question. In the end they – like many other small charities – made the decision to seek legal advice.

According to the charity's lawyers, commissioning of drug treatment services is effectively unregulated. It is clearly set outside the framework of the PPCC regulations. As it is defined as a "Part B" contract under European legislation there is no requirement for the local authority to do much more than attend to some minor regulations with regard to advertising and notices. The Social Value Act which is meant to make local authorities consider the social and economic impact of their commissioning decisions – though likely in future to be augmented by additional European regulations – currently only requires authorities to consider the impact of procurement decisions rather than mandating this approach. There is no clinical oversight, and unlike other health services, as it is no longer considered an NHS service, the rights of people who use drug and alcohol treatment services to exercise choice and make decisions about their own healthcare are not protected.

For the charity, this meant the only legal recourse open to them would be to go to judicial review. However the costs of this (the process would have started at about £45k) are prohibitive – impossible and possibly unethical – for a small charity to fund. The only option was to bid within a subcontractual arrangement – and for the charity to acknowledge that its days of independence were probably gone.

Across the country this situation is being played out over and over. Small local charities are finding it hard to compete with the large national companies and relatively affluent Foundation Trusts. It seems that these are the organisations who will come to dominate the drug and alcohol service sector in England. These apparently straightforward commissioning decisions are bringing about a quiet yet irreversible revolution within the drug and alcohol sector.

Since January 2011 the majority of drug and alcohol service commissioners in England have commenced procurement processes for their drug and alcohol treatment services – though this information is not collated anywhere. Even with a conservative estimate of the costs of this you can approximate a total spend on each one of around £120k (both bidder and commissioner costs). This suggests that over the past three years we have spent – in England alone – somewhere in the region of £17 million pounds just on the administrative processes that underpin procurement. If you add into that the costs of implementation of any new or recommissioned service – including TUPE – you are looking at costs averaging around £350,000 per area. This would give us a nationwide spend over the last 24 months of around £50 million.

To put this in context, according to DTORS treatment cost calculations from 2009, £50 million is enough money to provide an additional 8245 people with effective drug treatment from entry to successful completion, provide an additional 1500 staff within drug treatment services or to inflation proof

the current allocations for drug and alcohol treatment spending until 2019.

Public procurement is bound – at least in theory – by European and UK legislation. This legislation – aimed at guaranteeing fairness, transparency and equity in the spending of public money – in reality does little for health and social care services except to create work for lawyers, managers and consultants – and headaches for commissioners and providers. Very few people understand it fully. The language is arcane and legalistic, the processes are complex. An average set of tender documents will contain as a rule around 10000 words. The responses required from providers will usually lie somewhere between 18000 and 30000 words. So as well as being expensive, tenders are time consuming – with commissioners required to evaluate maybe up to 10 bids at a time.

For a small organisation, responding to a tender effectively overwhelms the whole management team. Larger organisations have the resources to employ full time bid writers – whose job is solely to sell the company's products at the highest price they can to whoever will buy them. Maybe this is why one of our largest providers advertises its management jobs saying "You don't need to know about substance use, you just need a good track record in sales". The question you have to ask is whether all of this serves any purpose at all?

Where services consistently underperform, where interventions don't meet basic quality standards, commissioners have to – maybe as a last resort – be able to withdraw investment and commission a different provider. However, a good commissioner working to a good specification should be able to drive improvement through effective contract management. When a contract reaches its natural end – and many can be extended to 5 years – commissioners have to go through a tender process. When the central direction of travel shifts, commissioners may also choose to re-procure the services they buy.

But even for a casual observer it is clear that there is currently much confusion in the central direction for local commissioning in drugs and alcohol. While the Government on one hand are publishing guidance on recovery services that categorically state that there should be no time limit for treatment, no arbitrary reductions of medication and no rationing of services (*Medications in Recovery*, July 2012); on the other they are dictating to the field that recovery must mean abstinence (*Putting Full Recovery First*, March 2012).

With conflicting central guidance, no national service framework, no regulation and no clinical oversight of commissioning, a provider sector dominated by multimillion pound businesses and an expectation that services will be provided progressively more cheaply through systems of PBR which have already been demonstrated to be hugely flawed – is it any wonder that commissioners are happier to re-procure than to make their current systems work? To compound the problem in many areas it is no longer specialist drug commissioners who are managing the process – but general local authority commissioners shifted into the new public health departments. Effective local partnerships – our old DATs and DAARTS – who may have moderated some of this nonsense – have all but disappeared after years of neglect and some would argue deliberate undermining by central government.

While no one wishes to see a return to the dogmatic style of the National Treatment Agency – whose reduction of local partnerships to mere contract managers on behalf of the Home Office has played a part in giving us the system we have today – it is clear that we cannot exempt the commissioning of drug and alcohol treatment from all regulations applying to other forms of healthcare.

Continuing to spend the amounts we are on procurement processes that don't naturally yield better returns for communities is wasteful in the extreme. Small innovative charities and SMEs have been for a long time the basis of many effective local treatment systems. To simply leave them by the wayside and hand services over to the big nationals is something we will come to regret – not least because it stifles cooperation and collaboration. Charities and trusts become rivals, not organisations united in the common interests of their service users. The collaborative approaches that defined the English substance use field have all but disappeared and even in those areas where there is no procurement process on the horizon, competition is the watchword and cooperation outside the direct requirements of the contract is increasingly rare.

When the charity head talks about the tender now, she is philosophical. Looking back over the last few years, she commented that the last time services were re-tendered, the service users really suffered as the treatment map became confusing and risky. As a result, one commissioner left abruptly, and the new provider prematurely ended an unworkable contract. Her charity and another were asked to pick up the key working functions and provide some continuity and safety for the clients. They did so. She wondered what might happen in the future if there is no alternative provider to help out.

And the future for the charity? "We started with nothing but a passion to provide good services for people in our area" she says, "One way or another we'll carry on doing just that". But with no local contract any more, the charity could struggle. "Our aim is to work with a small local team – paid for through charitable donations and grants – to continue to provide some of our basic services. We're looking at continuing our work with communities who find it hard to reach services. That's something we've always delivered and funded ourselves because the communities tell us they need it. There's other services too that the local authority don't fund, but that we provide. And we want to use our experience to build new services for people in need. One council may not want us, but others do and we have a number of innovative projects to build on and years of experience and reputation behind us. We do see a positive future for us as a charity."

In the next article, the author will be looking at the impact of commissioning decisions on treatment services – and how changes in commissioning have impacted on service users in England. She will also be looking at what alternative approaches could be used to ensure we use public money effectively to get the services we need to the communities who need them.

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