BUY ONE – GET ONE FREE

In this second part of her two-part feature on commissioning, **Sara McGrail** offers a personal view on the growing supermarket model of service provision and how changes in commissioning have impacted on service users in England.

The scale of substance misuse contracts, coupled with a cumbersome and expensive approach to procurement, inevitably favours larger organisations. The expansion of the super-charities and mega-trusts happens at the expense of smaller local providers or local NHS services. It also happens at the expense of our workforce, with salaries paid by the larger providers being pegged, volunteers replacing paid staff and safety being compromised to enable them to deliver the cost reductions without impacting on central management structures. Fundamentally it happens at the expense of people who use and benefit from services.

For example, in the area I discussed in my last article, the new contract has made dramatic reductions in the level of clinical support available for blood-borne virus (BBV) and harm reduction work. In an area that has a large, very diverse, transient at risk population, specialist services will no longer provide basic interventions like liver function tests, infection and wound care and cancer surveillance for people with viral hepatitis or cirrhosis. Nor will they provide emergency sexual health interventions (critical for a group who often sell sex), undertake TB screening or undertake supplementary prescribing (for example, for initiation of naltrexone, acamprosate and disulfrim, which help GPs deliver sustained recovery in the community).

Concerns have been raised by the Clinical Commissioning Group about the very narrow focus within the service, which seems at odds with NHS England priorities to reduce deaths through hepatitis C-related cirrhosis and liver cancer by joining up service responses for vulnerable groups. This is essential healthcare for a very vulnerable population – many of whom have little or no contact with primary care, who are unlikely to consistently access specialist care and who have in many cases a profound suspicion of mainstream services. The cost of delivering sub-optimal care to this group will far exceed any savings in this single contract – with increasing hospital admissions and deaths, and a likely increase in the number of new transmission of BBVs.

Across the country, service users and communities are finding choice restricted, as more contracts are left to those large agencies with the resources to bid for them. Local areas, used to a plurality of provision, are finding themselves with a one-size-fits-all treatment option and, in this conservative climate, a mandated approach to recovery that leaves many people prematurely detoxed, inappropriately supported or simply out on their ear.

The National Council for Voluntary Organisations (NCVO) identified bundling as a significant problem to the UK voluntary sector in its response to the proposals to amend European legislation saying:

"One of the main barriers facing VCSE organisations in public procurement is the increased use of large scale contracts. This is leading to a diminution of local knowledge and expertise to the detriment of public services and the people that use them."

The urge to bundle has a number of drivers. While budgets for substance use services may seem to have plateaued, many have experienced substantial cuts. Partly due to the inclusion of alcohol in main contracts and partly due to pressure on mainstream budgets, substance misuse commissioners are being expected to buy much more for substantially less.

The absence of coherent central guidance on substance use commissioning – a national service framework, the inclusion of the right to treatment for drug and alcohol problems under the NHS constitution and the inclusion of substance misuse under the auspices of healthcare regulator Monitor – reinforces the difficulties of austerity.

Commissioning the larger organisations may mean that commissioners kill off their own local voluntary sector, but when there is an unwritten consensus among your peers that 'best practice' commissioning equals buying services from super charities or mega trusts, this provides a sense of security for pressurised commissioners.

The shift from a central to a local focus for service commissioning was predictable – and predicted – from the early part of this century. In our sector, however, the approach of localism was identified as a distant threat, not an opportunity. Rather than working to build relationships that would enable local ownership of drug and alcohol issues, we became more inward looking – our agenda so obscure and complex that only 'experts' could understand it. We reduced the power of local partnerships in favour of an all powerful central dictatorship. This left us hopelessly ill-prepared for both localism and austerity.

Today in many areas, local partnerships no longer commission services collectively. Drug Action Teams (DATs) and Joint Commissioning Groups (JCGs) have fallen by the wayside, subsumed by sub-groups of sub-groups of Community Safety Partnerships, or sludged up in the labyrinthine bowels of the largely dysfunctional Health and Wellbeing Boards. By losing these partnerships, we have lost our local strategic focus and the scrutiny of commissioning and service provision.

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Another rationale offered for commissioning treatment services in single lot contracts is that it supports integration. Of course having a single provider can support integration – but it is by no means bound to, nor is it the only option for achieving this. What it does do, however, is enable the service provider to commission and operate the care pathways. This once again limits scrutiny of the treatment system and restricts the opportunities for commissioners to intervene in failing systems. As the smaller local agencies close down or are allowed to act as "sub-contractors", the local market is irreparably damaged. Choice is restricted, leaving communities, individuals – and ultimately commissioners to "take what they're given".

The range of substances available in our communities has probably never been higher and the range of ways in which people use them is expanding. Would we ever have considered, 20 years ago, that we would have people injecting tanning agents or using undetectable cannabis substitutes in prisons? Or, indeed, that our high streets would be spawning pubs on a pound-shop model? Given this, the demand for substance use interventions is likely to increase over the next few years – despite what we understand about trends in heroin and crack cocaine use. We have not yet even partly accurately anticipated the demand for alcohol services, but it is likely to be massive.

So what are we going to do to ensure our practice is nimble and effective and a market can provide the services that we're going to need?

The Social Value Act was much heralded by many in the government and voluntary sector as the means with which we could "level the playing field" for smaller local charities. Unfortunately, as many have observed, it lacks teeth. It allows commissioners to consider a wider range of social benefits in commissioning a particular provider – including the impact on local businesses and the local economy. However commissioners are not bound to do this, and in the face of pressures on costs and time, may opt to consider the state of the local voluntary sector – and then forget it.

Ironically it is the supposed centralists of the European Union who are doing most to ensure we can keep our services small, local, and responsive. With national legislation due in the summer for implementation within the next two years we cannot be sure how much of the liberalising agenda the government will adopt. However, the new Public Sector Directive can potentially lift the barriers that prevent small organisations bidding for and winning tenders.

With the new EU directive, the government could require public services to split contracts into smaller lots to encourage small local charities, social enterprises and mutuals to bid for services. It will simplify the resource intensity of the procurement process itself, meaning it will cost small charities less to take part in bidding. It will allow public bodies to reserve certain areas of work to charities, social enterprises and mutuals. It could give some teeth to the Social Value Act meaning that those procuring public services will consider more than the price when looking at economic value. We will know more when the government places its draft legislation before parliament this summer. But there is more we need to do to ensure that the drug and alcohol sector is capable of delivering the services people need.

We need to protect our sector and those who benefit from it from the worst vicissitudes of the free market. Contrary to current political doctrine, the market does not protect the consumer. Left to

its own devices, the market exploits the consumer to enable the service provider to profit. For a market-driven approach to any kind of health or social care to be effective, we need to put in place robust safeguards of quality and choice. This has been recognised in every other area of market-focused healthcare provision. Drug and alcohol services should be no exception.

We should – as has been agreed and mandated in other areas of healthcare and as is regulated by Monitor – restrict the bundling of services within procurement to those circumstances in which it is directly beneficial to the person using those services. Where bundling does support integration, we should be able to use it. But where it is just about cutting corners and costs and making the world a brighter place for lazy commissioners, it should be prevented.

Drug and alcohol treatment needs to be included in the NHS constitution. Those who benefit from it should be able to challenge and engage with treatment as recipients of NHS services. We need a new national framework for substance use – one that places the individual at its heart, that impels us to operate not on the basis of what substance people use, but that uses **what we know works** in a way that is safe, cost effective and individualised. A well-conceived framework for the provision of NHS drug and alcohol services would enable commissioners to act confidently to provide services that work, responding to the articulated needs of service users.

We also need to work within the spirit of the Public Health Outcomes Framework – protecting people from ill health, helping them achieve better health, tackling the determinants of poor health and doing so in a way that reduces inequalities in life expectancy. Tacking moral and political imperatives onto public investment in people's health can only end in disaster.

But it is not just government who can change things. As a sector we can mobilise around some critical commitments to preserve quality and choice. Firstly, the large providers need to take some responsibility for growth strategies that advance their own position but are lethal for smaller locally based charities. As well as better recognising the impact of their

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approaches on smaller providers, they have both the weight and influence to support local charities' challenges to poor commissioning practice – and could provide muscle and expertise to build a sustainable and diverse sector.

Commissioners can and should explore the impact of market-limiting practices on their local communities and, where appropriate, handicap larger charities and foundation trusts within procurement processes – an approach likely to become a statutory duty if the government deploys the full force of the new regulations.

Service users need to make their voices heard, not just to advise commissioners on service specifications, but to campaign and lobby for effective local providers. In return, those providers should offer genuine engagement and involvement in service provision.

Smaller providers need to strike out too. It is hard to fight back when your only contract is with the Local Authority. But simply kowtowing to your commissioner will no more preserve your service than your sanity. Challenge commissioners' actions. Mobilise your service users. Engage local communities – and open up what you do to scrutiny. Establishing outcome monitoring systems is expensive, but by working closely with other small providers, you can improve management infrastructure and compete better.

Local areas need to look at how they strategically manage drug and alcohol issues – and how and where they integrate that strategy with other health and social care issues. If these issues lack priority at the Health and Wellbeing Board table, you will find them making themselves a priority before long. The day of the DAT may be long gone, but right now we need joined up local thinking more than ever.

As for commissioners – well, you have my sympathy. There has never been a worse time to be commissioning local services. It's hard, it's often depressing and financially it is set to become more challenging. But do yourself a favour. The next time you go out to tender and one of the big boys comes up and promises you the earth, consider the other implications of bringing them in. Ask them what they understand about your area, what local contacts and networks they have access to, how they will ensure management is local and responsive. And then ask someone else who has commissioned them – in their references – if any of it is true. Marketing is clever stuff. Finally, ask yourself a question – if you commission them and your local providers shut down, and your commissioning process effectively devolves to them, if it all goes pear-shaped – who will you turn to next?

This is a great field. It was built to meet people's needs through innovation and investment in local communities and has become the envy of the international drug and alcohol community. Let's keep it that way by managing our markets – and not letting them manage us.

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