Headspace

...drugs from the left field

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A service by any other name...?

There have been a number of articles recently, as well as considerable comment, surrounding the commissioning of drug services resulting in NHS trusts losing contracts. Indeed, the last edition of *Druglink* added to that list in its attempt to deal with the retendering of services in Manchester. As a major provider of third sector clinical services, I regret that CRI was not given the opportunity to inject a modicum of balance in articles that directly address our performance and reflect upon our reputation.

Like other charities, CRI has taken over a number of drug service contracts in recent years from NHS Trusts. I would also point out, at the risk of muddying the waters, that we subcontract to and are subcontracted by, several NHS trusts. All of these contracts have to be judged quite simply by the quality of our governance, clinical work and the outcomes we achieve, otherwise we would not be awarded more. Contract award is not simply a question of 'cheapness'; NHS trusts compete within the same financial envelope and it is increasingly a question of approach.

Amongst the whole range of issues thrown up in the debate about charities taking over drug and alcohol services from the NHS, there are two points I would like to make.

First, the 'bogey' that only the NHS 'can do it well'. I welcome the move to the commissioning of integrated systems and the move away from predominantly maintenance based services that now require service providers to demonstrate ambition, vision, real engagement with service users, and flexibility in responding to their needs.

It does not necessarily follow that new systems are inherently inferior to those that are being replaced

The inclusion of Payment by Results (PbR) in that process is a real challenge for organisations – from all sectors – to adapt, focus upon a wider range of outcomes and successfully deliver and consequently 'stay in business'.

It is clear to me that the third sector has developed expertise and the clinical governance to deliver safely within this environment – and that this is not the exclusive domain of the NHS, who have, in many areas, shown less ability to move quickly and respond to the demands of the whole range of stakeholders, or indeed deliver the necessary quality outcomes.

Making sure that service users are safe and retained during this process of change is a responsibility on all organisations, out going and newly commissioned, when implementing new services. It does not necessarily follow that new systems are inherently inferior to those that are being replaced, indeed there is a wealth of examples over the large number of transfers we have undertaken that the opposite is true. CRI is compliant with the NHS Information Governance toolkit.

The real task for us is to continue to strive to get it right, to do it better, and that includes the transfer of information in the contract implementation phase that ensures continuity of service. I am convinced that CRI clinical services can demonstrate major improvements in outcomes following implementation.

The second issue is one which is shared across all sectors. This is the challenge of preserving and nurturing the specialist skills, clinical and medical skills necessary to ensure the long term ability to deliver high quality services. CRI recognises its responsibility to participate in the wider task of enabling specialists to acquire and develop these skill bases. Developing critical mass in medical services allows for us to facilitate research and training opportunities that can only benefit the whole sector.

It is clear that the changes over the past few years are delivering better outcomes for service users. It is also clear that NHS trusts able to rise to the challenge are being successful in winning contracts in this environment. CRI's passion is to deliver quality and effective services, the success of our mission – along with other providers – and the outcomes we achieve will eventually settle this debate.

CRI just concentrates on doing what we do best: helping service users achieve their full potential and realise their ambitions; providing stability, support and structure for their journey to recovery; helping to improve their physical and mental wellbeing; and helping them become contributing members of their communities.

These are clear, simple goals that should be at the centre of all drug and alcohol recovery provision. Ultimately, it is the service user that comes first and that commitment cannot be compromised.