Derby City Council

COUNCIL CABINET
2 April 2014

ITEM 11

Report of the Cabinet Member for Adults and Health

Integrated Drug & Alcohol Treatment System retender – 2015/16

SUMMARY

1.1 In May 2013, Cabinet approved the tendering of Derby's alcohol treatment system. Following a procurement process undertaken during 2013/14 contracts were successfully awarded to two providers (DCC LiveWell and ADS) in respect of two components of delivery.

1.2 Due to external factors the community alcohol treatment service tender lot was not awarded. Consequently, an interim arrangement (a contractual extension of some of the existing treatment components – along with newly awarded elements) has been put in place for 2014/15 to ensure residents of Derby can still access ongoing support.

1.3 The current adult drug treatment contracts are due to expire in March 2015 and opportunity now exists to tender for an integrated drug and alcohol treatment system with an aspiration of delivering efficiency savings through economies of scale and scope.

1.4 The adult drug treatment funding compromises of directly commissioned support services and additional funding relating to the cost of medications, prescriptions and associated activities.

1.5 The requirement to provide adult drug and alcohol treatment services is a statutory responsibility un-repealed within the Crime and Disorder Reduction Act 1998. Furthermore from a Public Health perspective individuals requiring support from substance misuse services represent the most deprived groups in the city. Treatment services not only contribute to the health and wellbeing of deprived groups but also to reduced offending (estimates of 22,000 crimes per year saved in Derby) and to greater community cohesion, supporting elements of the Derby Plan.

1.6 Current contracts for drug and the interim alcohol services expire on 31st March 2015. A retendering exercise to secure a new treatment system needs to take place throughout 2014 to meet our numerous requirements.

1.7 Funding for drug and alcohol services constitutes part of the Public Health ring-fenced grant allocation. The component of funding related to these services is calculated on a performance framework. In order to maintain existing levels of funding it is imperative funding for these services continues and similarly, that they continue to perform to a high level.

RECOMMENDATION

2.1 To authorise the undertaking of a tendering exercise to deliver a new integrated drug and alcohol treatment system during 2014 – with no more than the same level of investment - so that new service delivery commences on 1st April 2015

2.2 To utilise the integrated model to strive to explore opportunities which may exist to offer efficiency savings to Public Health and consequently to the Council.

2.3 To give delegated authority to the Director of Public Health and the Strategic Director of Adults Health & Housing in consultation with the delegated Cabinet Member, to authorise the publication of relevant tender documentation and to oversee the undertaking of the procurement exercise.

REASONS FOR RECOMMENDATION

3.1 An effective drug and alcohol treatment is both a statutory requirement and an example of best value spend to save practice. The investment yield a saving of £2.50 for every £1 spend by the Council per annum, as a result of reduced hospital admissions, reduce crime and improved community cohesion to benefit all residents..

3.2 Derby's central government allocation – the Public Health grant – is currently contingent on the city providing effective alcohol treatment and achieving performance against the respective Public Health outcome framework measures

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SUPPORTING INFORMATION

4.1 Alcohol

The Department of Health estimates that Derby's adult population has 32,500 drinkers who drink above the recommended limits; over 9,000 'high-risk' drinkers; 5,900 dependant drinkers; and 33,000 'binge drinkers'. Despite the recent unparalleled reduction in alcohol related admissions, in 2010/11 Derby's health economy spent £3.1 million on accident emergency attendances; £10.9 million on inpatient admissions; and £3 million on out-patient hospital actively - where alcohol was a contributory factor. Further examination shows that of the £10.9 million, £2.9 million of that was wholly attributable to drinking (intoxication, falls, liver disease, etc.) whereas £8 million was partially attributable to alcohol *i.e*. high blood pressure, cancer and other disease caused by drinking.

4.2 Drugs

It is estimated that Derby has 1,950 problematic drug users (heroin and/or crack), of whom 1,350 are in contact with drug treatment services. The cost of providing treatment to a drug user in Derby, including all medications. Without treatment support the cost to Derby in terms of offending, hospital admissions and community disorder is £6,650 per drug user.

In addition to heroin and crack use, drug treatment agencies also provide support to any form of illicit drug (cannabis, ketamine, mephedrone, legal highs).

4.3 Timeline

During April 2014, subject to receiving prior Cabinet approval a public consultation will be undertaken in accordance with Council procedures to inform the new integrated model. At this time, the proposed 100% payment by outcomes model will be finalised. Throughout the months of May and June 2014, the payment by results model will be tested against existing service activity, consultation findings will be published and a series of stakeholder and potential bidder events will be held.

The formal tender is planned to be launched in August 2014, closing in November 2014 at which point the selection of preferred providers based upon the outcome of tender scores will be identified. January to March 2015 will be utilised for the implementation of the new model together with managing any changes in provider.

OTHER OPTIONS CONSIDERED

5.1 Do nothing *i.e*. end all drug and alcohol treatment. This is out of the question in reality due to the statutory obligations under the Crime Disorder Reduction Act 1998. Furthermore individuals who are in receipt of treatment and support have a duty of care to continue to receive support, therefore it is not possible to cease all activity without incurring the realistic option of litigation.

5.2 Reduce level of investment. This would in essence destabilise an already effective and efficient treatment model by reducing essential components. The model gains efficiency year on year indicating that to meet the challenge of the burgeoning alcohol problem the same level of investment is required to sustain the level of return on investment and gain. Zero growth - in actual terms is a reduction in investment and keeping the level of investment the same is equally a zero growth option.

5.3 Increase level of investment. This is not currently necessary due to the synergies and economies of scope and scale by having an integrated drug and alcohol treatment system

This report has been approved by the following officers:

Legal officer	Janie Berry
Financial officer	Eloise Keeble (procurement lead)
Human Resources officer	Liz Moore
Estates/Property officer	
Service Director(s)	Professor Derek Ward –Director of Public Health
Other(s)	Dr Richard Martin – Assistant Director of Public Health

For more information contact:	Professor Derek Ward 01332 643069 Derek.ward@nhs.net
Background papers:	None
List of appendices:	Appendix 1 – Implications Appendix 2 – Glossary of terms Appendix 3 – Proposed integrated model and options to generate efficiencies.

Appendix 1

IMPLICATIONS

Financial and Value for Money

1.1 The cost of the new treatment system is estimated to be the same as the existing treatment system: 3 year contracting cycle - with the possibility of 2 twelve month extensions. Sustaining treatment is a prima facie case of value for money and 'spend to save' logic.

Legal

2.1 The contracts will be let by Derby City Council using the new Public Health contracting framework. Provision of alcohol related harm strategic activity is a statutory requirement under the Crime and Disorder Act 1998 (and 2012 amendment)

Personnel

3.1 Current drug and alcohol treatment services are not provided by DCC staff; it therefore not anticipated that there will be a TUPE transfer of staff into or out of the DCC as a result of this retendering exercises. There may be a transfer of staff from existing suppliers of alcohol treatment suppliers to new suppliers of such services following the retendering exercise and DCC will work with existing suppliers to facilitate the provision of relevant employee liability information to interested bidders.

Equalities Impact

4.1 An equalities impact risk assessment is in place for the current treatment system and will be refreshed as part of strategic planning, public consultation and the commissioning process

Health and Safety

5.1 None

Environmental Sustainability

6.1 Not applicable

Property and Asset Management

7.1 No liabilities exist for Derby City Council with respect to property or assets

Risk Management

8.1 A full risk assessment has been undertaken – risk register – detailing the wider economic, health and political implication of not securing a new treatment system

8.2 The transition to a model that is effectively 100% payment by outcomes reduces risk to the Council of paying providers for services not delivered. However, subject to Cabinet approval, this proposed approach requires soft testing with existing providers to ensure such an approach does not create a significant barrier to potential bidders for services.

Corporate objectives and priorities for change

9.1 The alcohol treatment system serves to discharge the council's corporate function in respect of the newly acquired Public Health directorate, the Health and Wellbeing board priorities and the Sustainable Communities (Derby Plan) strategic objective relating to reducing alcohol harm

Appendix 2

Glossary of terms

Hazardous drinker
Hazardous drinking is defined as when a person drinks over the recommended weekly limit of alcohol (28 units for men and 21 units for women).

Binge Drinker
It is also possible to drink hazardously by binge drinking, even if you are within your weekly limit. Binge drinking involves drinking a large amount of alcohol in a short space of time – eight units in a day for men and six units in a day for women.

Harmful drinking – **high risk drinking**
Harmful drinking is defined as when a person drinks over the recommended weekly amount of alcohol and experiences health problems that are directly related to alcohol

Dependant drinker
Alcohol is both physically and psychologically addictive. It is possible to become dependent on it. Being dependent on alcohol means that a person feels that they are unable to function without alcohol, and the consumption of alcohol becomes an important, or sometimes the most important, factor in their life

Appendix 3

The existing drug and alcohol treatment system is integrated and multi-component - covering all Department of Health recommended interventions expected to be available in localities in England.

Current contracts are weighted 80:20 in respect of core contract and payment by results respectively. It is proposed for the 2015-18 commissioning period that a new model is developed effectively working to 100% payment by outcomes, spanning domains of:

- Health and wellbeing
- Reduced offending
- Recovery from drug/alcohol problems
- Improved education, training and employment
- Organisational domains (i.e. evidencing the organisation is working effectively)

The change in ethos of payment by results will see a transition from rewarding the attainment of set targets to incentivising providers to evidence holistically all work they are undertaking to support those in receipt of services. This is appealing to both the Council as payments will only be made in cases where individuals are benefiting from services provided. Public Health will undertake soft market testing to ensure this approach does not create barriers which may preclude significant numbers of providers from bidding for services.

Essentially, this approach will see investment remain at the same as within previous years, however, providers will only receive payment where they evidence the individual has benefitted from the services provided. This approach is anticipated to offer an annual efficiency saving of 10% of the commissioned service contract value. The costs associated with medications, prescriptions etc are fixed national costs and as such it is not possible to generate efficiency savings on these.

The proposed new model is summarised pictorially as: