Public Health England

Protecting and improving the nation's health

Review of Drug and Alcohol Commissioning

A joint review conducted by Public Health England and the Association of Directors of Public Health

About Public Health England

Public Health England exists to protect and improve the nation's health and wellbeing, and reduce health inequalities. It does this through advocacy, partnerships, world-class science, knowledge and intelligence, and the delivery of specialist public health services. PHE is an operationally autonomous executive agency of the Department of Health.
www.gov.uk/phe
Twitter: @PHE_uk
Facebook: www.facebook.com/PublicHealthEngland

About the Association of Directors of Public Health

The Association of Directors of Public Health is the representative body for directors of public health in the UK with the aim of maximising the effectiveness and impact of directors of public health as public health leaders.
www.adph.org.uk
Twitter: @ADPHUK

Prepared by: Julian Brookes (julian.brookes@phe.gov.uk)

Published October 2014
PHE publications gateway number: 2014011

Contents

About Public Health England 2
About the Association of Directors of Public Health 2
1. Purpose 4
2. Executive summary 5
3. Background 6
4. Methodology 7
5. Findings 7
Delivery data 2013-14 8
Joint strategic needs assessment 9
Commissioning intentions for drug and alcohol services 10
Intended outcomes 12
Measuring outcomes 12
What went well this year? 13
Commissioning of residential rehabilitation 15
Further joint working 15
Services for young people 16
What has not gone so well 16
The biggest challenges 17
Providing support to enable service improvement 17
Views from providers – DrugScope 18
View from Association of Chief Police Officers (ACPO) 20
6. Conclusions 20
Appendix 1. Terms of reference for the review 22
Appendix 2. Core script for drug and alcohol review 23
Appendix 3. Summary of key indicators of current provision 24

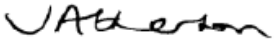
Foreword

The continuing importance and emphasis attached to improving outcomes for those who require treatment for alcohol or drug use has further intensified following the changes made to commissioning responsibilities in April 2013. A year on, this focus has led to a snapshot review, jointly undertaken by Public Health England and the Association of Directors of Public Health, of commissioning across local authorities in England. The aim has been to identify where there have been changes to commissioning and its impact on outcomes, together with a look at plans for the coming two years.

The review has provided an important opportunity for collaborative working between public health and health and social care across local authorities and Public Health England, together with a chance to assess the developing plans across the sector. It is a testament to the dynamic climate of cooperation and collaboration between organisations and provides a baseline from which local government can develop its sector-led improvement approach, with support from Public Health England, to strengthening the quality of substance misuse services in the coming years.

What has been particularly encouraging is the high level of participation in the review and the enthusiasm of those taking part for sharing their information and experience. In addition, the collective determination to deliver improved outcomes and the level of priority attached to this bode well for the future.

Duncan Selbie
Chief Executive
Public Health England



Dr Janet Atherton
President
Association of Directors of Public Health

1. Purpose

1.1 The purpose of this paper is to report the findings of the joint review conducted by Public Health England (PHE) and the Association of Directors of Public Health (ADPH) into the commissioning of drug and alcohol services. It looks at the plans and intentions of local authorities for 2014-15 and beyond. This paper is submitted to the Department of Health (DH), which requested the review.

2. Executive summary

2.1 Despite the review being conducted rapidly, the level of cooperation between local authorities, led by ADPH and PHE, has been excellent, with a high response rate, and open and honest discussions of the current position and future intentions. Ninety-four per cent of upper-tier authorities were actively engaged in the review.

2.2 The review identified the following key themes:

- except where there had already been retendering exercises underway or recently introduced, 2013-14 has been a year of steady state for drugs and alcohol commissioning
- 2014-15 and 2015-16 will see a focus on reassessing current service provision with the view to recommissioning services
- over 70% of respondents indicated that they were not planning to reduce funding in 2014-15. Of the 70%, over 50% reported no change, nearly 10% an increase in funding, while the remainder indicated uncertainty as to future plans
- the public health grant has not yet been announced for 2015-16. Fifty per cent of localities said they have not yet decided funding levels, but over 30% said that, in advance of the national funding announcement, they were not planning reductions
- there were planned realignments of resources between alcohol and drug services – with alcohol assessed as the greater need
- there was a focus on improving outcomes, continuing the move to a recovery model
- improved delivery and performance by providers was a clear aim in all recommissioning, with a focus on improving treatment completions

- many areas are exploring the integration of services – integration with alcohol services, and with wider services such as housing, younger people services, criminal justice, and local health delivery
- the involvement of public health and PHE has been welcomed, particularly the advice and support on commissioning. Further support from PHE on evidence based interventions was requested- particularly about the impact that investment in drug and alcohol services may have on improving wider health and wellbeing and reducing demand on other services
- the view of DrugScope, representing service providers, was similar to the views that had been expressed locally. There was a focus on the volatility of funding during this time of change, the continuous drive to reassess and retender services, and the need for commissioners to understand the impact frequent tendering processes have on providers
- the Association of Chief Police Officers (ACPO) emphasised the value it places on the importance of effective drug treatment services to the criminal justice agenda and the need to ensure any reductions in investment or changes to current provision do not reduce the effectiveness of services, as this could prejudice the crime-reduction benefits of the current approach

3. Background

3.1 The lead responsibility for commissioning drug and alcohol services now rests with local authorities. In partnership with the ADPH, PHE has undertaken a review of every local authority to capture the progress they are making in improving prevention programmes and rates of drug and alcohol recovery through their expertise and focus on commissioning for outcomes and value for money. The review reflects significant national interest in seeing continuous improvements in both these crucial public health concerns and an interest in understanding how the transfer of responsibility to local authorities will enhance services.

3.2 The review gives the new public health system the opportunity to demonstrate its commitment to tackling alcohol and drug misuse. The findings will be available to DH in its discussions with the Cabinet Office, the Home Office and the Ministry of Justice.

4. Methodology

4.1 DH commissioned this study. The terms of reference it agreed with ADPH and PHE are in appendix 1.

4.2 The review was conducted in two main parts; firstly a series of structured interviews between PHE centres and directors of public health, and secondly an interview with DrugScope to discuss the views of providers of services. In some instances, case studies were provided by commissioners in support of the information provided within the structured interviews. As part of the evidence from DrugScope, their recent report on the 'State of the sector' was used.

4.3 The structured interviews were based on a core script, agreed by PHE and ADPH. This covered needs assessment, commissioning intentions, tendering, planned service changes and integration of drug and alcohol services with other related provision such as mental health, criminal justice and housing. The core script is in appendix 2.

4.4 In addition, an analysis of key indicators of current provision was undertaken. A summary table of this information is in appendix 3.

4.5 From the information gathered from the above sources, a report was drafted and agreed with ADPH and other organisations where relevant. The overall response rate from the exercise was high, with 94% of all directors of public health and their teams responding to the request for information. Responses varied in length and detail, but have provided sufficient information to enable key themes to be identified.

5. Findings

5.1 Response rates to the review were excellent – 94% of the 152 upper-tier authorities in England replied. Responses followed discussions with directors of public health, their teams and senior members of local authorities. The discussions were undertaken by PHE centre directors and senior members of their teams.

5.2 The information gathered by the review has provided an exceptional resource, which has now been analysed. The key findings are summarised in this report.

5.3 The chief executive of DrugScope was also interviewed. His comments, in conjunction with the findings of DrugScope's report 'The State of the sector', produced on behalf of the Recovery Partnership and launched on 10 February 2014, have been included in this report to reflect the service provider's view of the current state of play.

5.4 The findings of this report follow the areas of discussion arising from the core script.

Delivery data 2013-14

5.5 2013-14 has been the first year of transition to the new system. This has included local authorities assuming the responsibility for commissioning and delivering drug and alcohol treatment and recovery services, a change from the previous partnership approach that included funding and commissioning resting with either the PCT or formally delegated to the local authority. Delivery and performance by providers in 2013-14 has been measured against a set of key performance indicators.

5.6 Appendix 3 considers five indicators, selected for providing a balanced quantitative assessment of the impact of the change in the commissioning landscape for drug and alcohol treatment since 1 April 2013.

5.7 The data uses a nine-month baseline (April to December 2012) and compared this to the same time period in 2013.

5.8 Indicators used are:

- waiting times (% over six weeks and % over three weeks) – to identify any possible issues with access and people having to wait longer to access treatment
- early drop outs from treatment – to identify where there might be possible issues with the engagement of clients at the start of treatment as this tends to be the more resource-intensive period
- access to residential services – these are the most costly form of treatment and a reduction in use may indicate changes in funding especially in community care budgets
- successful completions of treatment – the key proxy indicator for levels of recovery in an area

5.9 Indicators were looked at separately for opiate users, non-opiate users and people requiring treatment for alcohol because the service responses and outcomes for the three groups tend to vary.

5.10 Change in performance between the baseline and at nine months into the year has been identified using a 95% confidence interval. This method allows as much as possible to denote that change is actually likely to be based on performance rather than possible unexplained variance (or noise) in the data.

5.11 The analysis of this information concludes that there is no consistent picture of impact emerging from the data, which shows a generally stable picture in 2013-14. This resonates with intelligence that suggests that in the majority of cases contracts were transferred unchanged in 2013-14 while local authorities took stock. This position is supported from the evidence provided through the discussions with directors of public health. This is discussed later in this report.

5.12 The interviews with directors of public health and their teams were conducted from a core script to give consistency and allow comparison. The responses to the questions are summarised in the sections below.

5.13 Detailed below is a summary of the key findings from the structured interviews with directors of public health and other local authority staff.

Joint strategic needs assessment

5.14 The first discussion focused on the current needs as identified within the joint strategic needs assessment (JSNA). Producing a JSNA has been a statutory requirement since 2007. Changes made in 2012 placed the duty with health and wellbeing boards. The JSNA forms the basis of the new joint health and wellbeing strategy that is agreed by the health and wellbeing board. The strategy informs the commissioning plans for local government and the NHS.

5.15 JSNAs had been completed at various times over the last two or three years, and consequently were either being refreshed or had recently been reviewed. Drug and alcohol services were reflected as key areas in the vast majority of JSNAs. However, some JSNAs focused more on overall health improvement and have drug and alcohol as integrated themes, looking at lifestyle risk factors, complex needs and family provision.

5.16 Alcohol services were being reassessed and their priority increased in some parts of the country. This reflected a growing awareness of the need to increase alcohol provision to reflect the wider range of need, from identification and brief interventions to treatment for dependency. Specific initiatives have been developed to meet this need, including targetted

provision and integrating planning and commissioning with offender services and domestic violence provision. Localities indicated a desire to maintain and accelerate the recovery focus of drug treatment, particularly for opiate users, but also want to address emerging issues such as new psychoactive substances, (eg, legal highs) and addiction to medicines.

5.17 The JSNAs reflected work undertaken jointly with the NHS. This focused in many areas on reducing alcohol-related A&E admissions, initiatives on heart disease, diabetes, TB and respiratory problems, hepatitis B and C, and other health-related problems. This was complemented with a strong prevention theme.

Commissioning intentions for drug and alcohol services

5.18 Directors of public health were asked about their commissioning intentions and whether they had any plans to retender/recommission drug and/or alcohol services in 2014-15 or 2015-16.

5.19 The question revealed active assessment of drug and alcohol services with a view to retendering/recommissioning. Approximately 20% of commissioners have recently undertaken recommissioning exercises for drug and alcohol services, many had happened before the transfer of commissioning responsibilities and in most cases, where indicated, this had been a joint approach with previous commissioners.

5.20 Approximately 40% of respondents said they did not intend to recommission services in the near future. However, of the remaining respondents, 50% intended to review and recommission services, with the remainder (10%) either having recently retendered services or being undecided about future arrangements. Of the 50% re-tendering, 60% plan to re-tender in 2014-15 and 40% in 2015-16. While there were some recommissioning exercises that were specific to drug services, many were to be based on both drug and alcohol needs and often with a view to creating a more integrated joint treatment and recovery service for those with dependency and significant levels of harm.

5.21 There was also a described aim to improve the contracting arrangements with providers. Legacy contracts were often seen as overly complex, limited in timescale and without clear outcome indicators by which success could be measured.

5.22 All respondents stressed the significant financial pressures they were under and the potential impact this was having on all services.

5.23 The discussion on funding intentions has been open and frank. The outcomes are summarised in table 1.

Table 1. Analysis of responses to question 4 of core script

Are you planning any changes to your investment in drug and alcohol services?	2014-15		2015-16	
	Total	(%)	Total	(%)
No change	**70**	**52.2**	**37**	**27.6**
Actual no change	55	41.0	26	19.4
No change expected expected/anticipated	5	3.7	4	3.0
No change, but efficiency savings	10	7.5	7	5.2
Reduction	**37**	**27.7**	**23**	**17.2**
Actual reduction	25	18.7	14	10.4
Reduction expected/anticipated	12	9.0	9	6.7
Increase	**13**	**9.7**	**5**	**3.7**
Actual Increase	12	9.0	5	3.7
Increase expected/anticipated	1	0.7	0	0.0
Dependent on…	**3**	**2.2**	**10**	**7.5**
Outcomes/review/evaluation	2	1.5	7	5.2
Funding	1	0.7	3	2.2
No decision made/don't know	**9**	**6.7**	**57**	**42.5**
Missing data	**2**	**1.5**	**2**	**1.5**
Total	**134***	**100**	**134**	**100**

*Greater Manchester submitted a composite response. The total number of responders to the review was 143 of 152.

5.24 The interpretation of responses to question 4 requires some explanation. The responses to investment in 2014-15 should be seen as separate to the responses for 2015-16. The percentages and numbers are not cumulative. Some local authorities plan to reduce spend in 2014-15 and not reduce further in 2015-16. Some will only reduce in 2015-16. Some plan to reduce funding in both 2014-15 and 2015-16. Twelve local authorities intend to reduce funding in both years. Overall figures need to be adjusted to take this into account. This means that 48 councils are planning to reduce or change funding levels over the next two financial years – a total of 36% of respondents.

5.25 There was a focus on cost reduction while maintaining quality, with references to "doing same for less", "doing more for the same" and "doing more for less". Some local authorities indicated that where cost savings were to be implemented this would be focused on corporate and administrative services, protecting where possible investment in front line

services. There was a common view that these services had not had the same focus in quality innovation productivity prevention (QIPP) programmes as other NHS services in the years before 1 April 2013.

5.26 There was no data collected on changes in the associated spend by other local agencies, such as police and crime commissioners, though some localities mentioned the impact of changes in this spending.

Intended outcomes

5.27 The focus for the future was described in two main categories: improved efficiency and improved outcomes. Many saw the opportunity to redesign their services and to make them more cost efficient. Redesign in many areas focused on integrating drug and alcohol services, and integrating them with other services, such as housing, criminal justice and young people. There was also a focus on clinical integration, particularly with mental health services. Cost effectiveness and value for money was the prime aim of service retendering.

5.28 The simplification of service contracts and reduction of cost for better outcomes was highlighted. In some local areas, outcomes focused on improved quality of service to clients, with increases in completion rates and a focus on recovery. Another key aim was in reduction – reducing harm, drug and alcohol deaths, criminal activity and alcohol-related A&E admissions.

5.29 Cost reduction was also a driver, but not the primary driver. It was clear that drug and alcohol services were valued, but needed, as with all local provision, to justify its investment in terms of outcomes achieved. There was a clear view that current service configurations did not meet this criterion on all counts. There were requests for more evidence-based information to support commissioning decisions as local authorities went through retendering processes.

Measuring outcomes

5.30 There is a clear focus on outcomes and measurement. All respondents were clear on how they would measure success and were building outcome measures into their contracting. A range of indicator sets were quoted. The overarching of these is in the public health outcomes framework.

The National Drug Treatment Monitoring System (NDTMS) data is used by PHE to produce a wide range of performance, output and outcomes data for use by local authorities and other partners. The most commonly referenced were:

- Diagnostic Outcomes Monitoring Executive Summary (DOMES) – a quarterly report of main indictors benchmarked against similar local authorities
- Treatment Outcomes Profile (TOP) – used to produce a quarterly report at local authority and provider level, measuring changes in key outcome indicators such as substance use, and physical/psychological health at start, during, and end of treatment
- local indicator sets
- Local Alcohol Profiles for England (LAPE) – provides information about need
- JSNA support packs for drugs and alcohol – annually produced and local authority bespoke

5.31 The collection of data was supported by analytical tools and processes. Local review of delivery was via clinical audit, academic review and, where appropriate, linked to client satisfaction surveys and qualitative analytical tools.

5.32 The information and support provided by PHE was seen as helpful in enabling local authorities to analyse their current commissioning and to identify areas for improvement.

What went well this year?

5.33 The review asked what had gone well in the last year. There was a wide range of responses to this question: 1% were neutral or negative, thinking little has improved and there has been some deterioration in drug and alcohol services, but the vast majority were more positive. While it was recognised that the focus in 2013-14 had been on “safe transition”, the most frequent response was how the integration of drug and alcohol services had improved the overall offer to clients. This took the form of closer working between teams and a better approach to handling dual diagnosis. Other frequent responses focused on better collaborative working and improved engagement – with external partners and local authority members, who were providing strong political support and the benefits derived from expert public health advice.

5.34 The ongoing support of PHE's alcohol and drugs teams were also acknowledged as a valuable source of expertise, support and advice.

5.35 Overall the transition was seen as having been managed well and that after a year of bedding in, there was now a real enthusiasm to work within the new system to improve service provision. However, some recognised that the changes surrounding the transition – change in leadership and commissioning roles, along with the retendering of services in the first year – had impacted on delivery. Many referenced a short-term dip in performance by providers but were now seeing improvements. This is consistent with the data returns in appendix 3.

Integration of drugs and alcohol with wider public health

5.36 There was evidence that the commissioning for drugs and alcohol had been integrated with commissioning of related services. The ambition for closer links with sexual health, criminal justice, and housing and youth services were consistently mentioned. There was also mention of integration with family focused initiatives, closer links with GPs, improved coordination on domestic violence, and a strong and consistent link to sexual health – teenage conception and sexually transmitted diseases. It was clear that the level of integration was symptomatic of inherited positions. Some areas had had a close working relationship with public health prior to transfer and this had continued after transition. Where this was not the case, closer links were being developed.

5.37 While the majority of those interviewed identified good working links with licensing, others reported poorer links and plans for stronger collaboration. A significant number of respondents reported that better links with directors of public health had been established since transition and they were working collaboratively on specific initiatives – such as "proof of age" schemes and joint reviews with police and licensing.

5.38 There was almost universal reporting of strong links with criminal justice, with many stating it was "very strong" and "good" and "positive" – again symptomatic of inherited positions but supportive of the view that substance misuse services remain easily accessible by people from within the criminal justice system. There were also references to specific initiatives such as pilots on mental health and criminal justice.

Commissioning of residential rehabilitation

5.39 Historically, funding for residential rehabilitation was part of an adult social care responsibility and funded from community care budgets. In many cases this was supplemented by contributions from the drugs pooled treatment budget (PTB). With the inception of the public health grant (PHG) some local authorities have taken the opportunity to pool previous community care funding with the drug and alcohol spend from the PHG. In a third of cases responsibility for residential care sits within adult social care and is not managed directly by the director of public health.

5.40 There was a clear trend to tightly manage the use of residential rehabilitation services. Funding methods varied from spot purchasing to block funding and agreed contracts. A significant number of respondents were looking at stricter criteria for residential rehabilitation, and were looking to more community-based rehabilitation and abstinence services. Some reported an increasing number of requests for residential rehabilitation, which was increasing pressure on commissioners.

5.41 Funding of residential services was under pressure, but the vast majority (66%) of responses indicated that funding levels were being maintained, with a further 28% describing uncertainty about future plans. However, a small proportion (6%) indicated that funding would reduce. Contracting models varied between spot purchasing and contracted services. Again services were under review with the aim of improving efficiency.

5.42 From a commissioning perspective there was a clear focus on improving the pathways for residential rehabilitation and rebasing the eligibility criteria. In some cases this was being achieved as part of the recommissioning of the service.

Further joint working

5.43 As part of the discussions, directors of public health were asked whether they would welcome further discussions on integration, particularly on mental health. The response was overwhelmingly in favour of further discussions (95%). Of the topics felt to be the most beneficial, there was a clear interest in discussing mental health and dual diagnosis. There were also clear links to mental health and wellbeing services for younger people.

Services for young people

5.44 Discussions on services for young people show a mixed pattern of commissioning arrangements across the country, largely reflecting the diversity of arrangements in PCTs before 1 April 2013. In some cases there was a clear separation between commissioning young people's services and drugs and alcohol, and in others there were established working arrangements. However, some respondents had identified little need for alcohol and drug services for young people.

5.45 All areas had committed to prevention as a top priority. There were initiatives in school-based settings and one area referred to a "School Life Study" to inform commissioning. There was also some discussion of improving the links between the drug and alcohol agenda and the school nursing services. There was a focus on binge drinking in some areas, and on the links between drug and alcohol services and sexual health services in many localities.

5.46 Many areas recognised that more work was required to align drug and alcohol provision with services for young people. Many areas were looking at this as part of recommissioning drug and alcohol services. Often this was part of whole system design, taking into account the differing needs of young people and recognising that different settings were needed to deliver services.

What has not gone so well

5.47 Directors of public health were asked what had not gone so well in the last 12 months. The responses focused on three main themes: impact of transition, provider performance, and establishing new governance arrangements. Note that the focus on these three areas is not unique to drug and alcohol services, but symptomatic of organisations moving through transition.

5.48 While it was recognised that overall transition had been managed well, there had been some issues at first. These related mainly to budget transfers, lack of clear service specifications, and contractual arrangements that needed resolving – such as subcontracting and loss of organisational memory. Some respondents mentioned knock-on consequences, such as impact on capacity, retaining key commissioning staff, and low morale.

5.49 Provider performance had reduced in about a quarter of localities, particularly relating to a decline in successful completions from treatment. This was by far the most referred to disappointment from the transition to new arrangements in 2013.

5.50 Governance was often mentioned in relation to inherited contracting arrangements. Some respondents raised concerns about the quality of the contract information, service specifications and general management arrangements inherited from previous commissioners. Where this was an issue it was intended that retendering the services would address the matter. In one case the public health team identified concerns about clinical governance and patient safety, which have since been dealt with.

The biggest challenges

5.51 Respondents said one of the biggest challenges they face is ensuring the sustainability of drug and alcohol services. This manifested in uncertainties over resources: particularly future funding and the potential impact of removing the public health ring-fenced grant; commissioning efficient and effective services to give better value to taxpayers; and the impact of short commissioning cycles on creating a sustainable service.

5.52 Some expressed concerns about the unstable political environment and the potential impact this could have on services: specifically, the lack of political focus on supporting prevention and treatment, and the need to deliver cultural change that continues to support recovery orientated services.

5.53 Some respondents also called for the evidence base (especially the “return on investment” evidence) to be further developed to support service commissioning and to provide evidence that investment in these services is an effective way to improve the health and wellbeing of the population.

Providing support to enable service improvement

5.54 Finally, there was a useful discussion with directors of public health and their teams about areas where sector support would be beneficial. The areas discussed included:

- improved access to evidence-based information and models to improve procurement and enable needs based service design
- sharing of evidence of the impact of adoption of new models of provision

- A request for support on emerging drug and alcohol related needs – in addition to support for opiate based interventions which were better understood.
- access to quantifiable evidence of health and wellbeing improvements associated with investment in drug and alcohol provision

5.55 Directors of public health also thought that PHE had a vital role as an influencer, nationally and locally. There was a view that PHE could do more with local members to help them understand the benefits of investing in drug and alcohol services. There was also a call for PHE to be more visible, leading from the front in the national debate.

5.56 Finally, respondents asked for PHE to help them stabilise the funding streams for public health related services. Some expressed concern that services would be under threat if the ring-fencing of the public health grant was removed.

Views from providers – DrugScope

5.57 This report has identified key themes arising from discussions with local authorities as commissioners of drug and alcohol services. It has also looked at the views of providers, as represented by DrugScope. The report draws on two sources: an interview with DrugScope chief executive Dr Marcus Roberts, and its recent publication on behalf of the Recovery Partnership, ‘State of the sector 2013’.

5.58 These discussions identified themes similar to those in the local authority review: the volatility of funding; the drive to reassess, redesign and recommission drug and alcohol services; and the need to engage with the new and varied partners and structures that came into existence on 1 April 2013, to enable the delivery of the best possible drug and alcohol services.

5.59 DrugScope reports significant concerns among service providers about future investment levels in the light of the loss of previous mechanisms to incentivise spend on drug and alcohol treatment; the financial challenges for local authorities; and competing demands on public health and other local budgets. Thirty five per cent of providers responding to the ‘State of the sector’ 2013 survey said they had experienced a decrease in funding in the previous 12 months, with 20% reporting an increase and 33% no change. Respondents to the survey also highlighted difficulties and “gaps” in accessing “recovery capital”, particularly housing, employment and support for mental and physical wellbeing.

5.60 Evidence suggests that resilience is strongly embedded in services, and providers are responding innovatively to a changing environment. However, during a period of budget restraint DrugScope highlights the risks to services that work with marginalised and stigmatised people, and the need for local decision makers to consider the strong evidence-base for the positive impact (including recovery, public health and crime reduction outcomes) and cost effectiveness of drug treatment services for local communities.

5.61 The discussions with local authorities an*d* DrugScope highlighted the variance in JSNAs, identifying this as an area for discussion in the coming year as the JSNAs are refreshed. DrugScope's survey highlighted a perception that JSNAs have tended to focus on population-level harm and less on services for small groups with acute and entrenched health needs. DrugScope highlighted the importance of including drug and alcohol services in police and crime plans; recognising, and being encouraged by, the growing awareness among police and crime commissioners; and seeing this as an area of fruitful partnership with public health. DrugScope noted that police and crime commissioners would have a stake and interest in drug and alcohol services given that treatment reduces crime and improves community safety.

5.62 The survey of local authorities and the discussions with DrugScope both highlighted the need for greater partnership working, more holistic services and a "whole system" approach. The review of local authorities suggested that this was a strong driver supporting commissioning, as was integrating services that included criminal justice, mental health, sexual health, services for young people, housing and health provision.

5.63 The discussions with DrugScope raised the importance to providers of clarity in funding – in terms of the levels of funding and retaining consistency over the coming years. It was recognised that funding would continue to be placed under pressure, requiring greater outcomes for the same or reduced budgets ('more for less'), but short-term commissioning practices and constant retendering was seen as counterproductive, undermining long-term planning and sensible reorganisation. Indeed DrugScope cited the unintended costs to services of frequent retendering: this was money and resource that had to be redirected away from front line provision.

5.64 Finally, DrugScope highlighted the need to consider the impact of change on front line staff, staff morale, and retention. DrugScope highlighted the changes in front line numbers and in their skill mix, raising concern that the balance between professionally trained staff and other staff was changing

significantly, with consequences for service models and delivery . Almost half of participating services in the DrugScope survey reported a decrease in front line staff and six out of ten reported an increase in the use of volunteers. It was commented that volunteers make a critical and valued contribution, but it is important that the sector is able to retain specialist expertise and professional staff (and to invest in training and workforce development), to support the continued development of evidence-based practice and clinical governance and drive performance.

View from Association of Chief Police Officers (ACPO)

5.65 In an interview with Chief Constable Andy Bliss, National Policing lead for Drugs (ACPO), he commented on the value and importance the police place on the availability of effective drug treatment services to the criminal justice agenda, to crime reduction and, more broadly, to local communities' sense of wellbeing.

5.66 In referencing research, ACPO reminded us that significant benefits accrue from timely access to appropriate drug treatment services in terms of problem drug users desisting or reducing their criminality. Also, many chief constables, working closely with police and crime commissioners, are engaged with local senior health colleagues to ensure that some of the most problematic drug users are referred promptly to suitable drug treatment services.

5.68 Reductions in investment or changes to current provision should not be allowed to lessen the effectiveness of services, as this could prejudice the crime reduction benefits of the current approach. This would also increase harm to society in terms of more crime and transfer costs to the criminal justice system.

6. Conclusions

6.1 The snapshot provided by the review has provided insight into the current position across England. The response to the review has been positive and demonstrated a high level of co-operation and trust between directors of public health and PHE. The findings show that:

- the majority of commissioners want to transform and make services more efficient despite a difficult financial climate, and this is driving recommissioning, efficiency work, service improvement and looking at

service outcomes. This is to be expected and demonstrates a system taking its responsibilities seriously

- local authorities are adopting a variety of approaches but overwhelmingly want to make services more effective. If anything, there seems to be an element of trying to protect levels of investment while improving services
- there is a close scrutiny on current commissioning arrangements and this includes funding. However, there is a clear desire to ensure that services continue to improve, and that while value for money is a key driver, so is quality of service
- the review shows that there is little intention to simply disinvest in services, but to bring a rigour to their commissioning that is focused on the needs of the population and on outcomes for the services, which is based on evidence of what works
- there is a call for further support from PHE and other bodies such as ADPH for guidance on evidence. This evidence is seen as vital in demonstrating a clear return on investment, so that the outcomes and benefits to a local population can be understood. There has been a dip in provider performance in 2013-14 and some challenges in governance, but this is to be expected given the system-wide change. There is an expectation of improvement in 2014-15
- ADPH and PHE believe these needs can be best met as part of the sector-led improvement process. Target workshops, information sharing and peer-to-peer support will provide the vehicle for change
- there are massive opportunities for whole system approaches and integration once commissioners have got through the initial transfer, and respondents have a real willingness for PHE, local areas, providers and the Local Government Association to work together
- it is a changing and complex picture that needs leadership and advice. Directors of public health have an important leadership role in bringing partners and stakeholders together and in looking across the whole system to further their shared aspirations of integration

Appendix 1. Terms of reference for the review

- Describe the local approaches taken to improving drug and alcohol service commissioning and service outcomes.
- Provide evidence for a report for the Parliamentary Under Secretary of State for Public Health, which can be used to demonstrate the robustness of the approaches undertaken by local authorities and secondly, areas where national policy can be amended to support local commissioning.
- Identify areas with good/excellent commissioning practice and share the learning from these areas.
- Identify generic challenges faced by local government in further improving the outcomes from drug and alcohol services.

Appendix 2. Core script for drug and alcohol review

1 What are the key needs related to the drug and alcohol services that are in the JSNA?

2 What are your local commissioning intentions for drug and alcohol services – in 2014-15 and in 2015-16?

3 Do you have any plans to retender services for either drugs or alcohol?

4 Are you planning any changes to your investment in drug and alcohol services in 2014-15 and/or 2015-16?

5 What are the ambitions/intended outcomes from your commissioning intentions?

6 How do you intend to measure the impact of your decisions?

7 What has worked really well over the past 12 months and has a clear impact on improving outcomes in both drug and alcohol services from commissioning of services?

8 There are several areas that comments would be helpful on:

- integration of drug and alcohol services into the wider public health agenda and links with the licensing responsibilities of local government
- links with the criminal justice agenda locally, including pathways and provision for offenders, both in the community and on release from prison.
- how are you delivering against the aspiration in the Drug Strategy 2010 that drug services are more recovery oriented?
- what is your approach to the continuing purchasing/commissioning of residential rehabilitation services? Currently, the funding comes largely from the local authority community care grant.
- PHE would like the opportunity of a further conversation about the integration of drug services with other key programmes, such as mental health and offending. Would you be interested in participating in a further discussion on this subject?
- how are you developing improvements in services for young people? For harm reduction services – ie, needle exchanges and links to BBV/HIV/TB?

9 What has not worked well over the past 12 months and how are you planning to address this?

10 What is the biggest challenge that you face in the commissioning of drug services and alcohol services in the next two years?

11 We would very much like to include case studies in the report that demonstrate innovative approaches to service delivery. Do you have such an example and if so can we jointly produce a case study for inclusion in the report?

12 What help would you like from PHE in making further and sustained progress on drug and alcohol services locally?

Appendix 3. Summary of key indicators of current provision

Changes in the accessibility and capacity of drug and alcohol treatment

The direction of change in local authority performance across key indicators

Waiting times – six weeks or more Change in the proportion of clients that had to wait six weeks or more to start their first intervention	**Opiate**	**Non-opiate**	**Alcohol**
No. of local authorities that have seen no sig. change	136	146	112
No of local authorities that have seen a sig. increase	4	1	9
No of local authorities that have seen a sig. decrease	11	4	30
NATIONAL	Similar	Similar	Lower

Waiting times – three weeks or more Change in the proportion of clients that had to wait three weeks or more to start their first intervention	**Opiate**	**Non-opiate**	**Alcohol**
No. of local authorities that have seen no sig. change	127	139	95
No of local authorities that have seen an sig. increase	6	5	14
No of local authorities that have seen an sig. decrease	18	7	42
NATIONAL	Lower	Similar	Lower

Early drop outs Change in the proportion of clients that had an unplanned exit from treatment before 12 weeks	**Opiate**	**Non-opiate**	**Alcohol**
No. of local authorities that have seen no sig. change	147	136	119
No of local authorities that have seen a sig. increase	3	5	11
No of local authorities that have seen a sig. decrease	1	10	21
NATIONAL	Similar	Similar	Lower

Successful completions Change in the proportion of clients that successfully completed treatment	**Opiate**	**Non-opiate**	**Alcohol**
No. of local authorities that have seen no sig. change	128	115	107
No of local authorities that have seen an sig. increase	9	19	26
No of local authorities that have seen an sig. decrease	14	17	18
NATIONAL	Lower	Similar	Higher

Residential rehabilitation episodes Change in the proportion of clients that had a residential rehabilitation episode	**Opiate**	**Non-opiate**	**Alcohol**
No. of local authorities that have seen no sig. change	136	147	138
No of local authorities that have seen an sig. increase	6	1	5
No of local authorities that have seen an sig. decrease	9	3	8
NATIONAL	Lower	Similar	Lower

	OPIATE CLIENTS		**NON-OPIATE CLIENTS**	
Complexity of clients Change in the complexity of clients that presented to treatment	**High**	**Very high**	**Very low**	**Low**
No. of local authorities that have seen no sig. change	148	146	145	145
No of local authorities that have seen an sig. increase	1	3	3	3
No of local authorities that have seen an sig. decrease	2	2	3	3
NATIONAL	Similar	Similar	Higher	Lower