DrugScope

Bitesized briefing

Localism

What does localism mean?

Decentralisation, handing power back, freedom for communities – all phrases that have been used by the Prime Minister since he took up leadership of the Conservative party in 2005. For him, Labour's reliance on centralised targets and planning has stifled local democracy, and limited the freedom of schools and hospitals to innovate. Joint Area Assessments, ring-fencing, Public Service Agreements, key instruments of the Labour Government, are being abandoned by the Conservative-Liberal Democrat coalition as it works to enact an agenda that emphasises local decision making and local democracy.

In reality, centralised targets were already steadily falling out of favour prior to the 2010 election and though there are disagreements over its exact meaning and how it might be implemented, it is fair to say that some form of 'localism' is now fairly well accepted across the political divide.

What are the reforms?

While much of the language and impetus is found in the Localism Act, which received Royal Assent on the 15 November, the government's full localism agenda is set out across several pieces of legislation. Some elements, such as the elected Police and Crime Commissioners, have already been legislated for, while others, such as Health and Wellbeing Boards, are still being scrutinised in Parliament. Other reforms include the creation of Public Health England, which will, from April 2013, incorporate the National Treatment Agency, and community budgets, pooled local authority funding used to target families with multiple needs.

The Localism Act 2011 includes provisions to enable voluntary and community bodies to challenge local authority run service provision through something called 'The Community Right to Challenge', and to allow referenda in major cities on whether or not to introduce directly elected Mayors. Perhaps of most immediate re-levance for our sector are changes to housing policy. These include giving local authorities greater freedom to set priorities and criteria for social housing waiting lists, reform social housing tenure so lifetime tenancy is no longer guaranteed, and allow local authorities to meet their homelessness duty by offering private rented accommodation to homeless people.

Other reforms are already being implemented even where the legislation is still in parliament. Local authorities and health bodies have been encouraged by the government to act as 'early adopters'. For instance, while they currently lack any formal statutory powers, shadow Health and Wellbeing Boards have already been set up by at least 132 local authorities. The likelihood is that the main planks of the reforms will see gradual implementation. In some areas, this means that the ground is already shifting, even if the various pieces of legislation are not all yet in place.

Public Health England

Formally announced in July 2010 in the *Equity and Excellence: Liberating the NHS* white paper, Public Health England is a new executive agency tasked with leading on public health. The new organisation will absorb the National Treatment Agency along with other public health bodies such as the Health Protection Agency. Though the final details have yet to be announced, the total public health budget was mooted, based on current spending estimates, to be around £4 billion, which includes the £1 billion currently spent on drug and alcohol treatment in England. It has been suggested that around half of this total budget will be available to PHE, with the other half invested locally.

The Health and Social Care Bill will give upper tier and unitary authorities a new duty to improve local health outcomes, with Directors of Public Health taking a central role. This means they will lead discussion about how the ring-fenced money is spent, with the goal of enhancing health and wellbeing. Crucially, there is no formal guarantee that the billion subsumed from the current spend on drug and alcohol treatment will be protected under the new arrangements. We are currently awaiting the publication of a public health outcomes framework which will place some requirements on local decision-makers to invest in drug and alcohol services. We understand that other forms of accountability are being considered to ensure continued investment in this area (including making future funding dependent on investment in drug and alcohol services through Grant Conditions and requirements for close monitoring of local activity on substance misuse). There is, however, widespread concern about the potential for significant disinvestment in drug and alcohol services given a number of competing public health priorities during a period of significant local spending constraints.

This obviously raises a number of questions. On the positive side, there are undoubtedly benefits in bringing together a number of distinct public health initiatives under the direction of a single body. The opportunity to co-ordinate working and bring together issues may yield novel approaches benefiting everything from the client to workforce development. The worry

is that the current drug and alcohol allocation may be subsumed within the wider public health budget. As DrugScope has previously pointed out, drug and alcohol treatment is conspicuous by its virtual absence as a theme in the public health documents published by the government so far (for example, the *Healthy Lives, Healthy People* White Paper).

New Directors of Public Health, based locally but potentially employed there by PHE, will be faced with a number of overlapping priorities. Unless drug and alcohol treatment is accurately reflected in these priorities, there is a serious risk of disinvestment.

Health and Wellbeing Boards

Likely to be operational from the beginning of 2013, though anticipatory shadow bodies have already been set up in 132 local areas, Health and Wellbeing Boards (HWBs) will have strategic responsibility for tackling local health inequalities and will have a key leadership role in delivering local public health outcomes. They will also have lead responsibility for conducting Joint Strategic Needs Assessments (JSNAs). Clinical Commissioning Groups, who will have the main responsibility for setting NHS commissioning strategies, will be obliged to consult with the boards on health and wellbeing factors. Given these responsibilities, HWBs should be a key platform in determining the drug and alcohol strategy locally.

Statutory HWB members include local authority Directors of Adult and Children's services, at least one local elected member, the local Director of Public Health, a representative from the local Clinical Commissioning Group, and a Healthwatch volunteer. It is likely that the boards will also comprise of additional non-statutory members, which may include criminal justice representation such as Police and Crime Commissioners. The Drug Strategy 2010 says that HWBs will be expected to work with local partnerships – including Police and Crime Commissioners, employment and housing services and prison and probation services – to 'increase the ambition for recovery'.

While this mix of expertise does have potential, particularly around integrated working and connecting issues (and clients) across a range of services, the governance arrangements of HWBs are still unclear. Who, for instance, will chair the group, and how will decisions be reached? Ultimately, these arrangements will be made locally, meaning that priorities in one area may be different to those of another.

There are also questions to how the boards will be scrutinised. While the NHS Commissioning Board, which will be responsible for some national oversight, will have some scope, the likelihood is that local authority overview and scrutiny boards will have a prominent role. Similar to Parliamentary Select Committees in that they are made up of elected members and can launch investigations and compel witnesses, the boards should, in theory, be able to scrutinise local delivery, including tendering and commissioning processes. This leaves open an intriguing avenue for local lobbying.

Elected Police and Crime Commissioners

With the first election to be held in November 2012, and the first candidate already announced, Elected Police and Crime Commissioners (PCCs) are unusual, at least compared to most of the other reforms, in that a clear timeline and framework has already been published. Police authorities will be abolished, and the first elections will be held in November. PCCs will assume many of the powers of a police authority, including the power to appoint and dismiss chief constables, and determining local policing priorities through a five-year police and crime plan. PCCs will also be the recipients of the Home Office policing grant as well as various other government funding streams, putting them in a powerful position when determining a local police force's spending priorities.

Due to the unique governance arrangements in the capital, London will see the mayor assume the powers of the PCC from January 2012. It is likely that day-to-day responsibilities will fall under the mayor's police advisor.

The Home Office is funding a partnership of organisations, 'Safer Future Communities' (see December's Members' Briefing for more detail) to support voluntary and community organisations to prepare for the introduction of Police and Crime Commissioners. This work is being led by the charity Clinks, and DrugScope will be providing support around drug and alcohol issues.

While the government has insisted that PCCs will not lead to the politicisation of the police force, all the main political parties have now committed to fielding candidates. There are other questions over how the incorporation of elected PCCs will function within the democratic process. Voter turn-out for local authority elections outside of a general election year are typically low. There is a risk, especially given that the first

election will be stand alone, that a poor turn-out could jeopardise the electoral mandate of the new PCCs.

PCCs, especially those based in metropolitan areas, are likely to engage with the drug sector. The links between crime and drug use are well documented, and the police have an understandable interest in ensuring that treatment and diversion pathways are well-resourced. Police forces also encompass relatively large geographical areas, meaning that the scope for regional cross-working is greater than in some of the other localism reforms.

Community Budgets

While not strictly an invention of the new government, Community Budgets have been adopted by the Department for Communities and Local Government. Focussing on families with multiple problems, the initial raft of 16 pilots, announced in the Spending Review at the end of 2010, went operational in April 2011. A further 50 will be rolled out in 2012, and another 60 on top of that in 2013.

Around 120,000 of these families, or 1% of the population have been identified by the government, which argues that they cost the state around £4 billion a year in various state interventions. The idea is that Community Budgets, by stripping away the financial and legal barriers which inhibit different local services working together, will allow for greater local flexibility, and more co-ordinated support. This, it is argued, will have a positive impact on avoidable costs, negating the burden that these families place on local services. The budget will cover funding by Government departments which the Treasury, in discussion with these departments, considered most suitable for pooling or alignment to support families with multiple problems in Community Budget areas. On top of the wider roll-out, another two pilots have been commissioned to co-design a Community Budget that will bring all funding for local services into a single pot.

In December, the Prime Minister announced the establishment of a Troubled Families Team in the Department for Communities and Local Government, headed by Louise Casey, which is tasked with joining up efforts across Whitehall. This was backed by a pledge to invest £448 million, which is estimated to constitute 40% of the money needed by local authorities to work successfully with troubled families; the other 60% will need to be found by local authorities from other sources. While this initiative (which builds on the previous Government's Family Interventions Programme) has been welcomed, concerns have been raised about the ability of local authorities to raise sufficient funding locally, and the lack of reference to drugs and alcohol in the headline goals of the programme.

How do the reforms affect drug and alcohol services?

There is an inherent difficulty in trying to predict how new structures rooted in localism will operate, mainly because the specifics will largely be dependent on the needs and actions of any given local area. However, there are some things we do know. Elected councillors, as well as unelected health professionals, will be present on Health and Wellbeing Boards, meaning that their impetus will, to some degree, be dependent on the will of the local electorate. The same applies to elected Police and Crime Commissioners who, like other elected members in councils and Parliament, may have the best chance of winning office by running on a party ticket. Essentially, treatment providers will be opened up to a greater degree of democratic accountability, and will have to demonstrate quality to commissioners who come with an elected mandate and party loyalties.

The lifting of certain restrictions on how local authorities spend their budgets is also significant. The economic climate means that councils and health services, which are expected to be in the hands of clinical commissioners from 2013, will be forced to prioritise. The question is how high drug and alcohol treatment will come on that list of priorities.

In December, the Department of Health published a suite of new factsheets about the reforms of the public health system. For more, see: http://tiny.cc/Public-Health-factsheets

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