

The Public Health Reforms: What they mean for drug and alcohol services



A DrugScope briefing for the Recovery Partnership (February 2013)

In April 2013, the National Treatment Agency for Substance Misuse will be abolished and its key functions transferred into Public Health England. Most of the current budget for drug and alcohol services will be transferred to Directors of Public Health employed by Local Authorities, who will also be statutory members of the new Health and Wellbeing Boards. These are important and far-reaching changes that will impact on the planning, commissioning and delivery of services. This DrugScope briefing for the Recovery Partnership is intended to provide a digestible summary of the public health reforms and to inform and guide thinking about how your organisation can most effectively prepare to meet the challenges of this new environment.

In brief, what are the reforms?

In April 2013, upper-tier local authorities will assume lead responsibility for improving public health, for coordinating local efforts to protect the public's health and wellbeing, for ensuring health services effectively promote population health and for addressing health inequalities.

Directors of Public Health (DPH) will be responsible for delivering public health outcomes in their local area, will control the bulk of drug and alcohol funding and will oversee a department or directorate that will be responsible for delivering the outcomes from the local Health and Wellbeing Strategy. Health and Wellbeing Boards (HWBs) will set out local strategies through the development of Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies (JHWSs). A new executive agency, Public Health England (PHE), will take the national lead on public health issues from April 2013. It will have

direct responsibility for some services, such as vaccination programmes for blood borne viruses, health protection and information and raising awareness, and will support local public health commissioners - for example, through research, monitoring and data collection and the training and development of the public health workforce. PHE will operate through 15 centres operating in four regions.

The NHS will have an important role in public health. Clinical Commissioning Groups (CCGs) are statutory members of HWBs. Local authorities and CCGs have an equal and joint duty to prepare JSNAs and JHWSs through the HWB. In addition, there is a requirement for a representative of the NHS Commissioning Board to sit on the HWB when it is developing the JSNA and JHWS. The Department of Health has said that this responsibility may be delegated by the NHS Commissioning Board with the HWB's agreement – for example, to someone from a CCG.

The Public Health Outcomes Framework, published in January 2012, sets out a range of indicators for public health. It is intended that this should be aligned with the NHS Outcomes Framework and the Adult Social Care Outcomes Framework. There is a question mark, however, over the precise status of these national frameworks given the Government's commitment to localism. The Department of Health's draft guidance on JSNA and JHWS said that these national outcome frameworks 'will be useful to help inform joint priorities, although they should not overshadow local evidence'.

To further complicate matters, prison health services (including drug and alcohol treatment) will be the responsibility of the NHS Commissioning Board (NHSCB).¹ One NHSCB local area team (LAT) in each of ten regional areas will be designated to take the lead commissioning role for prison health care – including drug and alcohol treatment - in that region.²

There is a lot of discussion of the role of Health and Wellbeing Boards – how will they work exactly?

Currently operating in shadow form, HWBs will from April 2013 be formally established in every upper-tier local authority and will be responsible for providing the overall strategic direction for improving wellbeing in their area. Members of the board will be expected to work together to try and understand the needs of the local population, and will be statutorily responsible for producing a local JSNA and JHWS.

The statutory membership of the HWB (i.e. the offices that it is legally required to include in its membership under the Health and Social Care Act 2012) comprises:

- at least one local elected representative;
- a representative of the local Healthwatch organisation;
- a representative of each local clinical commissioning group;
- the local authority Director for Adult Social Services;
- the local authority Director for Children's Services; and
- the Director of Public Health for the local authority.

A survey of local authorities undertaken by the Kings Fund indicated that Council leaders, Directors of Adult Social Care or Directors of Children's services are most likely to chair the

HWB. Many appear to have included one or more voluntary and community sector representatives in the membership as well as the local Healthwatch representative.

The involvement of other partners such as Police and Crime Commissioners, criminal justice agencies, youth justice services, housing services, schools and the voluntary and community sector may also be sought by the HWBs. Boards are also expected to develop a sub-committee system, with scope for strategic partners to hold key posts. For instance, an operations manager for a homelessness charity was appointed the social inclusion lead by the HWB of an east London borough.

HWBs will have a statutory duty to involve local people in the preparation of their JSNA and JHWS. While the approach to community engagement will vary in different local areas, this will provide one important route for drug and alcohol services to engage with the HWB and influence decision-making processes that will ultimately determine commissioning priorities.

What are JSNAs and JHWSs?

The Joint Strategic Needs Assessment (JSNA) is a local assessment of current and future health and social care needs that could be met by the local authority and the DPH, CCGs and/or NHS Commissioning Board.

A Joint Health and Wellbeing Strategy (JHWS) is the plan set out to meet the needs identified in the JSNA. The strategy will consider how services might be reshaped and redesigned, and how health and social care services might be joined up with other services such as housing. Both JSNAs and JHWSs should aim to reduce health inequalities, and consider the 'needs of the whole community,' including those who experience inequalities and

1. For more details on the arrangements for offender health, see the Clinks Briefing on the new health commissioning landscape (August 2012) at www.clinks.org

2. The following LATs will be responsible for directly commissioning prison drug treatment:

North of England: Durham; Darlington and Tees; Lancashire, South Yorkshire and Bassetlaw.

Midlands and East: East Anglia; Hertfordshire and S. Midlands; Shropshire and Staffordshire.

South of England: Bristol; North Somerset; Somerset and South Gloucestershire; Kent and Medway; Wessex.

London: The senior leadership of the LAT will sit on health and wellbeing boards.

The NTA has produced a set of JSNA resources for healthcare professionals and partners to support the development of JSNA processes, noting that 'it is important that work already underway to build effective recovery systems is accelerated' and that 'planning is key and successful plans will be based on the local needs and community assets assessment, and will reflect evidence'. These resources include a resource pack for commissioners and three targeted at strategic partners: for adult drug services, adult alcohol services and young people's drug and alcohol services respectively. There are available at www.nta.nhs.uk/healthcare-JSNA.aspx

What about Clinical Commissioning Groups?

CCGs will be the new health commissioning bodies for England, with responsibility for the design of local health services – including acute hospital services, mental health services, ambulance services, continuing care and arranging emergency and urgent care services. All GP practices must belong to the local CCG. CCGs are required by the Health and Social Care Act 2012 to consult HWBs to ensure that their commissioning plans take proper account of the JHWS.

CCGs will not hold local drug and alcohol budgets, although GPs and others will often have a role and interest in substance misuse interventions. They will have a responsibility for overlapping issues – principally, mental health and treatment of infectious diseases - and may assume some wider responsibilities for substance misuse commissioning if these are delegated to them by the local authority. They may have a particular contribution to make to local alcohol commissioning. For example, the Alcohol Strategy 2012 says that CCGs and DsPH might consider jointly commissioning Alcohol Liaison Nurses in hospitals.

If respective commissioning strategies are not integrated, there is a potential gap in provision for the commissioning of services for people experiencing dual diagnosis and complex needs. Responding to a NICE consultation, DrugScope called for a greater degree of visibility for substance misuse and mental health co-morbidity in the Commissioning Outcomes Framework for CCGs. DrugScope has produced a briefing on 'Dual

diagnosis: a challenge for the reformed NHS and public health system', working in partnership with the Centre for Mental Health and UK Drug Policy Commission (available on the DrugScope website at www.drugscope.org.uk).

What opportunities will voluntary and community sector organisations and their service users have to influence public health?

There is no statutory seat on the Health and Well-being Board for voluntary and community sector representation, nor for specialist representation for the drug and alcohol sector.

However, HWBs are being encouraged to involve the VCS in the development of local strategies. The draft guidance on JSNAs and JHWSs published by the Department of Health for consultation in July 2012 explained that the local VCS could be represented on the HWB, and highlighted the potential for additional members, such as the VCS, service providers, health and care professionals, and representatives of criminal justice agencies 'to bring expert knowledge to enhance JSNAs and JHWSs'.

What is the role of Healthwatch in providing representation for service users?

Healthwatch will be a consumer champion acting on behalf of patients and service users, and has a statutory place on the HWB. Local Healthwatch organisations will be commissioned by local authorities, and will be operational from 1 April 2013. They will replace Local Involvement Networks (LINKs), which were established in 2008 to scrutinise health and social care services. Local Healthwatch bodies will be contractually obliged to reflect the needs of the local community. The Government has allocated £3.2 million for local authorities to set up Healthwatch in their areas.

Healthwatch England went operational on 1 October 2012, and will provide a national leadership role for Local Healthwatch organisations.³ It operates as a statutory committee within the Care Quality Commission (CQC), with a seat on the CQC Board and a direct line to Government. Government has said that it expects Healthwatch to 'harness the expertise of the voluntary sector and others at the local level'.

3. Its recently appointed chair, Anna Bradley, has a consumer rights background, and previously worked in drug policy where she was Director at the Institute for the Study of Drug Dependence (ISDD).

Healthwatch England will gather information about service user experiences from local Healthwatch. This is intended to 'provide collective views and experiences of people who use services to influence national policy, advice and guidance'. Its location within the CQC will help to ensure that any failings in the quality and safety of care locally identified by Healthwatch are addressed by the CQC. Information from Healthwatch should also inform risk management systems and the CQC's work at national level.

Healthwatch will provide advice – including potentially reports - to the Secretary of State, NHS Commissioning Board, Monitor (the body that authorises and regulates NHS Foundation Trusts) and local authorities. It should be noted that bodies that receive advice from Healthwatch will be required in law to respond in writing.

The Healthwatch website states that local Healthwatch organisations will:

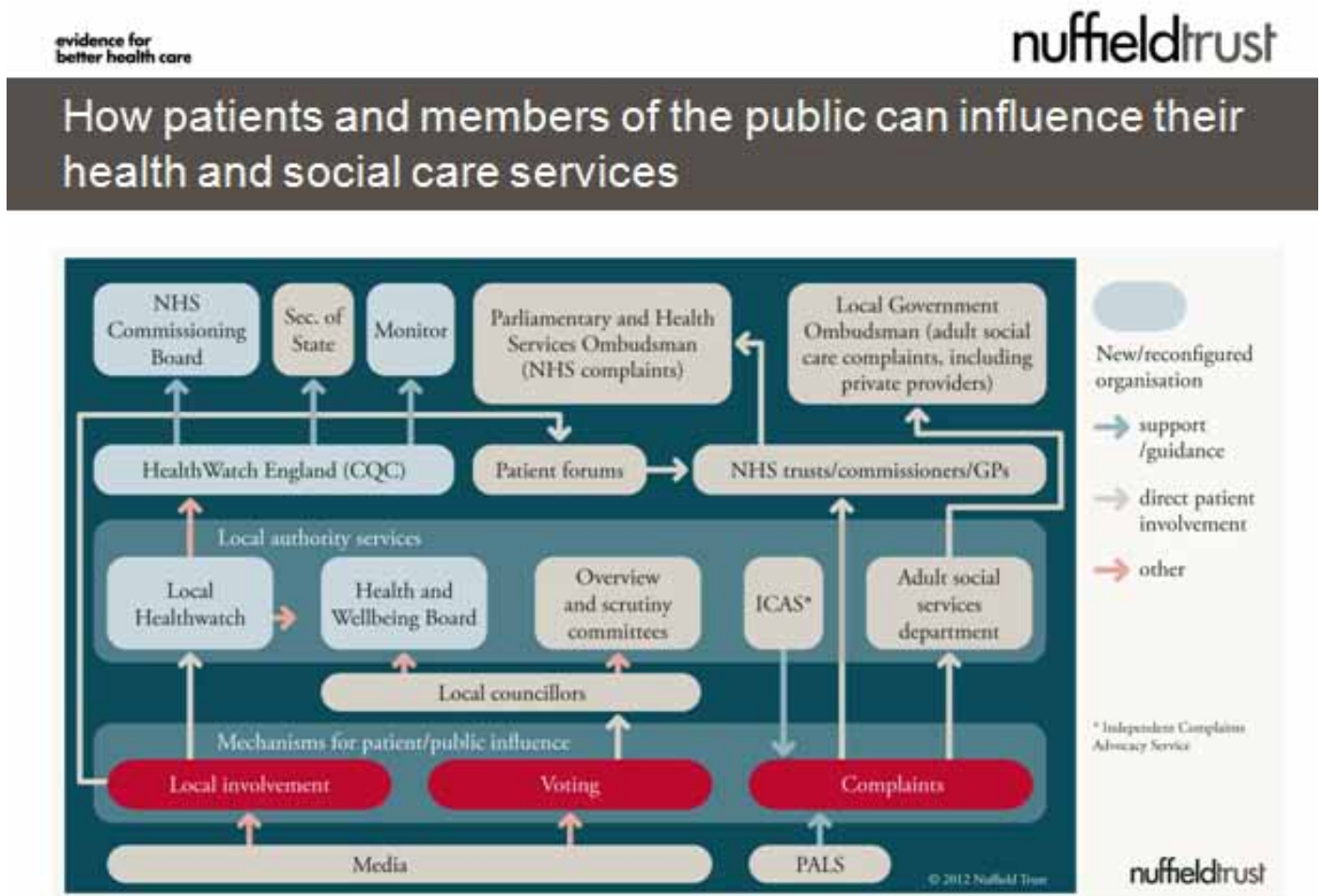
- have the power to enter and view services;
- influence how services are set up and commissioned by having a seat on the local health and wellbeing board;
- produce reports which influence the way services are designed and delivered;
- provide information, advice and support about local services; and
- pass information and recommendations to Healthwatch England and the Care Quality Commission.

Healthwatch could prove an important vehicle for ensuring service users have a say in the local design, commissioning and delivery of drug and alcohol services, and in promoting service users rights. It will, however, have a broad representative function for service users across a spectrum of health services.

As part of its activity to identify and target local decision makers in order to maximise the opportunities for influence, the drug and alcohol sector will need to be proactive to ensure its voice is helping to shape the Healthwatch agenda, both nationally and locally.

In addition, the Department of Health's draft guidance on JSNAs and JHWSs says that 'Health and wellbeing boards must involve the local Healthwatch organisation and the local community, and this should be continuous throughout the JSNA and JHWS process. When involving the local community, health and wellbeing boards should consider inclusive ways to involve people from different parts of the community to ensure that differing health and social care needs are reflected and can be addressed by commissioners, *recognising the need to engage with parts of the community that are socially excluded and vulnerable*' (emphasis added). This should include individuals, families and communities who are affected by drug and alcohol problems. DrugScope will be supporting calls for greater assurances that the voice of drug and alcohol service users and their families will be given an appropriate platform in the new commissioning environment to enable them to shape and hold to account local services provision. At present, available policy documents and guidance are light on the details of how service users involvement and participation will work.

Figure 2: Structures and mechanisms for influencing health and social care services



<http://www.nuffieldtrust.org.uk/talks/slideshows/new-structure-nhs-england>

What does all this mean for the drug and alcohol sector?

In April 2013, the NTA will be abolished with its main functions (and much of its personnel) absorbed into Public Health England, nationally and regionally. The 'pooled treatment budget' along with other current spending on drug and alcohol services, will be absorbed into the new public health budget. Historic spend on drug and alcohol services makes up a significant proportion of the £2.66 billion in 2013 -14 and £2.79 billion in 2014-15 that has been allocated to the budgets available for local investment in public health.⁴

In its response to the *Healthy lives, healthy people* white paper, DrugScope recognised the potential the new system might offer. By bringing drug and alcohol policy into the broader public health

remit, there is scope to create new opportunities for innovative local approaches that will help to support the delivery of the drug strategy and other Government policy objectives.

However, until the new systems, such as HWBs are in place, it is difficult to gauge how they will operate, how the local public health budget will be allocated locally, and how services will be commissioned. Particularly against a background of substantial, ongoing cuts to local authority budgets, there is a risk that the shift of responsibilities could result in disinvestment in drug and alcohol services which could adversely impact vulnerable individuals, families and communities.

The challenge for services will be to find the capacity to influence decision-making at local level and ensure that provision for people affected

4. Full details and information are available at <http://www.dh.gov.uk/health/2013/01/ph-grants-las/>

by drug and alcohol problems is given sufficient priority at a time when there will be competing demands on public health funding. These issues are compounded by the relatively brief scope that drug and alcohol treatment has been given in some of the Government's public health documents, including the Public Health Outcomes Framework (PHOF), which is intended to inform local priorities. In the PHOF drugs and alcohol specifically account for only three out of a total of 66 indicators, although 34% of the public health funding formula is influenced by substance misuse need. Drug and alcohol services will, of course, contribute to a wide range of other public health outcomes.

While the Department of Health has offered support and guidance, particularly with the new public health section on its website, there is still uncertainty as to how the new system will work, and how it will be integrated with other changes in local planning and commissioning structures (for example, elected Police and Crime Commissioners). DsPH (and HWBs), even supported by PHE, will have a lot to consider as they look to prioritise public health considerations. Not all drug and alcohol related commissioning will be their responsibility either. Mental health services will fall under the remit of the CCGs, while the public health needs of the prisoner population, including drug and alcohol treatment, will become the responsibility of the NHS Commissioning Board (see above).⁵

To further complicate matters, different planning and commissioning structures will cover different geographical and administrative areas. For example, DsPH and HWBs will operate at upper-tier local authority level, Public Health England through 15 local centres, Police and Crime Commissioner by police authority area and offender health through 27 local teams.

What will happen to Drug (and Alcohol) Action Teams (DATs)?

During this transition phase to the new public health system it may not be entirely clear whether current DATs will continue and how they may

fit into the new local system. A UK Drug Policy Commission survey of DATs conducted between February 2011 and March 2012 found that 63 per cent of respondents knew only 'a little' or had 'no information' as to where they would sit in the public health structure. Perhaps the best we can say is that each local authority will have the commissioning team and capacity it considers to be most fit for purpose, given local conditions and constraints. There is evidence that many DATs are being effectively prepared for and will be incorporated into the new public health structures. (Do contact us about your own experiences.)

What about the role of Public Health England (PHE) in providing the sort of national co-ordination that the NTA has provided?

The Department of Health published a document setting out the structure of PHE in July 2012. Strategic responsibility for drugs and alcohol will sit within the Health Improvement and Population Health Directorate. Drug treatment monitoring (e.g. NDTMS/NATMS) will sit within the Knowledge and Intelligence Directorate. There will also be a drug and alcohol function in local PHE centres (reporting to the Centre's Director), although it is stated that these will be 'working across more than one Centre'.

While PHE will absorb many of the functions of the NTA, its role in the planning, commissioning and delivery of drug services is expected to be rather different.

It is difficult to be certain how it will all work in practice, but much of the work that the NTA has done will carry on as before under the auspices of PHE. For example, PHE will assume responsibility for NDTMS/NATMS, and service providers will still be required to report into this system, which will be used to measure progress against the drug PHOF indicator and will potentially influence the allocation of the substance misuse component of the public health grant. However, as part of the Government's commitment to localism it is intended that PHE should have a more 'hands off' relationship with local system design and DsPH will be employed by

5. <http://www.nta.nhs.uk/uploads/ntahascsupplementarynotepriprisondrugtreatment.pdf>

local authorities with a 'dotted line' to public health – in other words, PHE will support, influence and monitor local provision, but DsPH will be employed by and responsible to local authorities, and not PHE as such.

In an interview in *Druglink* magazine (September/October 2012), Duncan Selby, the Chief Executive of Public Health England, emphasised that 'our commitment to local action led by local government is absolute', adding that 'our objective in PHE is to support this in every way we can'. Specifically, PHE would 'support commissioners by providing expertise, bespoke support, benchmarking performance and through sharing best practice'. He concluded that 'local authorities will be able to access ... high quality information about drugs and alcohol as now, including NDTMS, but this may be enhanced through greater integration with other public health functions, for example understanding the drug and alcohol issues in a wider context of the determinants of health'. This, he added, 'will be made possible through closer working with other public health knowledge and intelligence expertise, such as those currently in public health observatories and the cancer registries'.

As these comments highlight, drugs and alcohol will be only one of a number of responsibilities for PHE (although substance misuse issues will be relevant to many of its other priorities), and personnel from the NTA (and other drug and alcohol specialists) will only make up a relatively small proportion (around 150) of PHE's estimated 5,000 to 5,500 staff, with many more being transferred from the Health Protection Agency.

It also remains to be seen whether PHE will produce an equivalent range of statistical, research, good practice and guidance documents as the NTA has done in the past. It is fair to say that in general the Government appears to be of the view that the production of prescriptive guidance is contrary to the intentions of localism. This may partly account, for example, for the failure to produce a practical 'roadmap' for local commissioners on 'building recovery in communities' to replace 'Models of Care', following extensive consultation with the drug and alcohol sector led by the NTA in 2011.

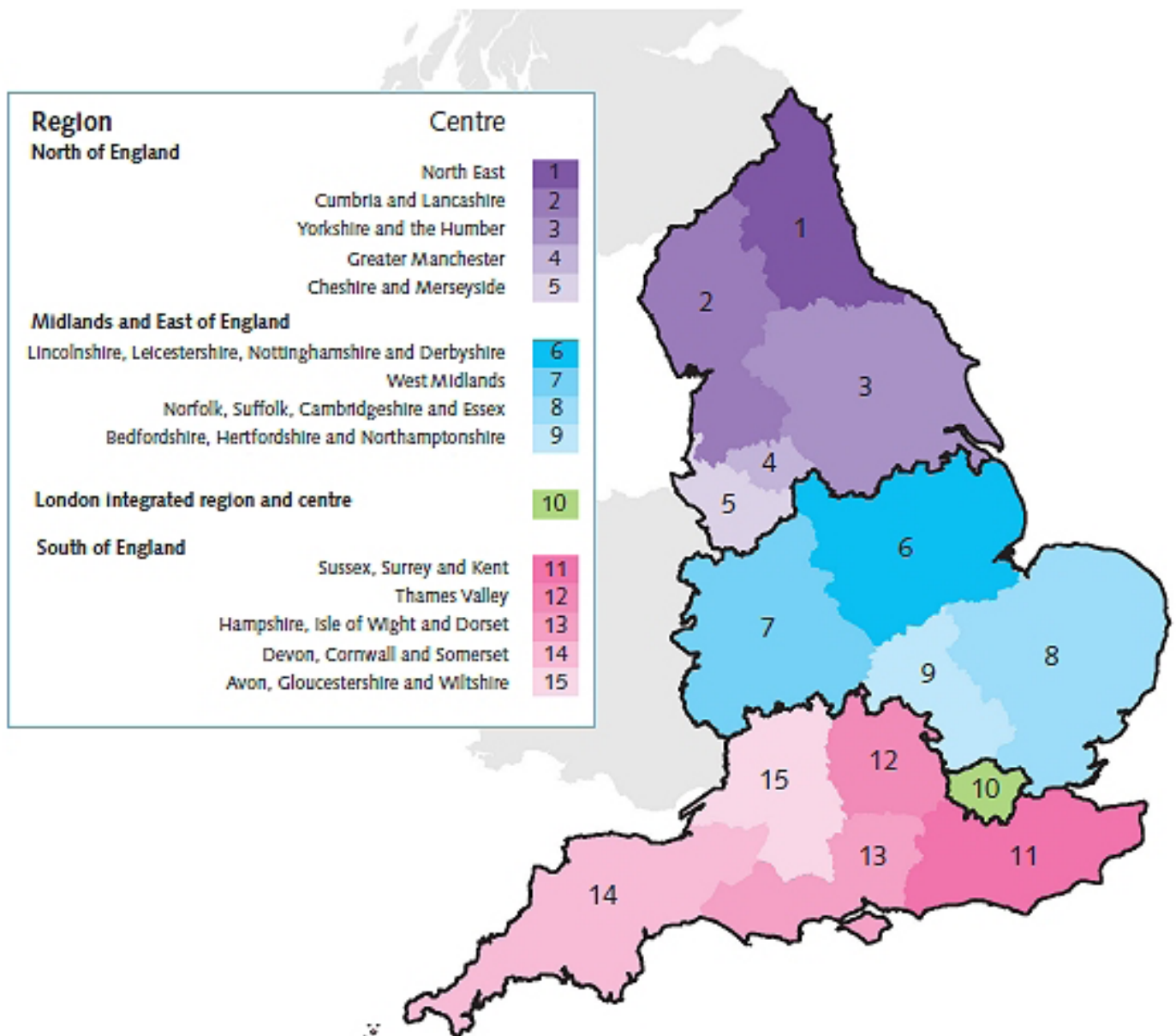
What about national standards and clinical guidance on drugs and alcohol?

It remains to be seen precisely what safeguards and constraints will guide local decision-makers and protect service users and other beneficiaries given the commitment to localism. Presumably, there is an expectation that local commissioners will have regard to national drug and alcohol strategies, but this was not explicit, for example, in the Department of Health's draft guidance for HWBs on developing JSNAs and JHWSs. As noted above, there are national outcome frameworks for public health, adult care and the NHS, but the indications are that Government intends these to inform, rather than to dictate, local priorities and activity. In addition, a range of regulatory and other national bodies will continue to have a role, including PHE, CQC and NICE, although it remains unclear precisely how this will work.

DrugScope has taken a particular interest in the NHS Constitution, which we believe could be more important for our sector than is recognised. The Department of Health has recently consulted on ways to strengthen the NHS Constitution. The text of the revised NHS Constitution states that 'The Secretary of State for Health, all NHS bodies, private, independent and voluntary sector providers supplying NHS services, *and local authorities in the exercise of their public health functions* are required by law to take account of this constitution in their decisions and actions. References in this document to the NHS and NHS services include *local authority public health services*. Where there are differences in detail these are explained in the Handbook to the Constitution' (emphasis added).

How the NHS Constitution might apply to the drug and alcohol sector following the transition to public health remains to be seen. In January 2013, DrugScope responded to the Department of Health consultation on strengthening the NHS constitution. Our response argued that 'the NHS Constitution should have a significant role in the substance misuse sector in a period of change. But awareness of the Constitution is low and there is a lack of clarity about its application to drug and alcohol services. It is important that the significance of the NHS Constitution outside of 'mainstream'

Figure 3: Map of PHE's regional structures (Department of Health, 2012)



NHS health care provision is not neglected, including for our sector' (the full response is available on our website at www.drugscope.org.uk).

What about the role of the Care Quality Commission?

It is already the case that all providers of regulated health and social care activities in England must be registered with the Care Quality Commission and are required to meet sixteen registration requirements, which set out essential levels of safety and quality of care and treatment. This includes residential and inpatient drug treatment

6. <http://guidance.nice.org.uk/QS23>

and community based drug treatment where the service employs a doctor, nurse or social worker.

The CQC is expected to align any future work it does with NICE Quality Standards (QS). These are a set of specific, concise statements that distil, and if necessary add to published NICE recommendations about evidence based practice – read together these statements are intended to set out what high quality care looks like. The NICE quality standards on *Drug Use Disorders QS23* were recently published building on the existing substance misuse specific NICE publications.⁶ NICE is planning to produce a guide for Local

The NHS Constitution – its importance for drug and alcohol services

The Department of Health completed a consultation on a 'strengthened version' of the NHS Constitution in January 2013.

It doesn't simply apply to NHS services

It is stated that 'The Secretary of State for Health, all NHS bodies, private, independent and voluntary sector providers supplying NHS services, and local authorities in the exercise of their public health functions are required by law to take account of this Constitution in their decisions and actions'.

'References ... to the NHS and NHS services include local authority public health services'.

The rights of patients and the public include:

- assessment of the health requirements of your community and to commission and put in place the services to meet those needs as considered necessary;
- to be treated with a professional standard of care, by appropriately qualified and experienced staff, in a properly approved or registered organisation that meets required levels of safety and quality;
- to expect NHS organisations to monitor and make efforts to improve continuously;
- to drugs and treatments that have been recommended by NICE for use in the NHS, if your doctor says they are clinically appropriate for you;
- to expect local decisions on funding for drugs and treatments to be made rationally following a proper consideration of the evidence;
- to be involved in all discussions and decisions about your health and care;
- to make complaints and seek redress through NHS and local authority processes.

There is also a 'right to make choices about your NHS funded care and to information to support these choices' – however, this right does not apply to local authority public health services as they are not covered by NHS choice legislation.

The Constitution also includes rights and pledges for staff.

The draft of the 'strengthened' NHS Constitution is at <https://www.wp.dh.gov.uk/publications/files/2012/11/Consultation-on-strengthening-the-NHS-Constitution.pdf>

Authorities that will present their recommendations. NICE has also produced quality standards on *Alcohol dependence and harmful alcohol use QS11*.⁷

How much will be invested in drug and alcohol services in the new system?

On 10 January 2013, the Government announced the ring fenced public health grants for upper tier and unitary local authorities for 2013-14 and 2014-15. A total of £2.66 billion in 2013 -14 and £2.79 billion in 2014-15 will be available to local authorities to spend on public health services for their local populations. This money absorbs an estimated £800 million to a £billion plus of current drug and alcohol funding. This means that approximately a third of the local authority grant for public health will be comprised of money that has to date been invested in drug and alcohol interventions, including what was contained in the 2012-2013 pooled treatment budget and the former health support component of DIP (total around £460 million).

The grant conditions and reporting arrangements that will apply to the grant from April 2013 have also been published.

Partly as a consequence of the lobbying work of DrugScope and the Recovery Partnership, the Department of Health's Advisory Committee on Resource Allocation (ACRA) recommended that the existing approach to allocating the pooled treatment budget is retained as a component part of the public health grant formula, excepting a slight change in the underlying need component. The Department of Health has accepted this. This has had the effect of influencing the amount of money an area has received overall in the allocation of the new public health budget but, critically, it does not provide a visible, centrally funded contribution to drug treatment in the same way as the pooled treatment budget used to and this presents grounds for concerns about potential disinvestment, particularly in a period of austerity. DrugScope is currently seeking clarification of how the promised 'protection' for former pooled treatment budget funding within the overall public health budget can

7. <http://guidance.nice.org.uk/QS11>

operate if this money is not clearly identified to local authorities in their budget allocations.

In addition, DrugScope noted in its response to the *Healthy Lives, Healthy People* strategy that, as of April 2011, over £200 million was invested in drug and alcohol treatment from non PCT local sources. There is evidence that local funding is being diverted from the drug and alcohol sector in some local areas. The removal of the Supporting People ring-fence on housing support has already seen cuts of 25 to 30 per cent, while in 2011 DrugScope reported that as much as 50 per cent of investment was being cut from young people's services in some local areas. (To date, however, national Government investment in young people's drug and alcohol treatment has been maintained at £25 million worth of specialist support for 24,000 young people.)

There is a particular issue about future investment in residential rehabilitation services, as these have been primarily funded using local authority community care budgets. A recent NTA document suggests that new commissioning arrangements provide opportunities for more integrated commissioning of residential and community drug and alcohol services, as local authorities 'could choose to align the historical community care funding – usually available for residential treatment – with the local drug and alcohol component of the new public health grants'.⁸ However, during a period when local authorities are experiencing significant cuts and therefore a squeeze on community care budgets, the future funding for residential rehabilitation services is uncertain. The NTA is working with the Recovery Partnership to 'help prepare providers for forthcoming changes to the public health commissioning framework to help them find their appropriate market in a time of change'.

The prison treatment budget, which for 2012-13 was just over £110m, will be absorbed into the NHS Commissioning Board's (NHSCB) budget and overseen by Offender Health. The Department of Health's expectations of the NHSCB are set out in a number of service specifications, including *Service specification 29 – Public health services for people in prison or other places of detention, including those held in the Young People's Secure Estate*. This document states that for adults 'all commissioned services will be fully integrated, recovery-orientated and outcome-focused treatment services in line with the vision set out in the National Drug Strategy (2010), the Government's Alcohol Strategy (2012) and the Patel Report (2010)'. It explains that for the Young People's Secure Estate 'the emphasis should be on preventing any escalation of drug/alcohol related risk, and delivering substance specific interventions to avoid progression to adult dependency'. Detailed aims and objectives are set out for substance misuse services in adult prisons and the Young People's Secure Estate.⁹

8. NTA (2012), 'The role of residential rehab in an integrated treatment system' at <http://www.nta.nhs.uk/uploads/roleofresi-rehab.pdf>

9. This document is available at <https://www.wp.dh.gov.uk/publications/files/2012/11/29-People-in-prison-specification-121025.pdf> A section 7a agreement between NHS CB and the Department of Health setting out the accountabilities behind this arrangement is at www.dh.gov.uk/health/2012/11/sector-7a It is anticipated that NHCB guidance on commissioning for NHS CB local area teams will emphasise the need to focus on the integration with community services in their commissioning of prison treatment.

Future funding for drug and alcohol services – some key messages

- Drug and alcohol misuse prevention and treatment for dependence are an important part of public health responsibilities.
- The primary budget for this is the ring fenced public health grant but there may well be other local investment in services and Local Authorities will wish to identify, maintain and or look for opportunities to lever in investment from elsewhere.
- Activity and performance on drug treatment has had an impact on how much money an area has received in the public health budget.
- To date, 34 per cent of national spend on public health has been on substance misuse, and this has been recognised in the target formula for the public health grants, which illustrates the significance of the agenda.
- Local authorities will be required to report spending on an annual basis. There are categories for adult drugs, adult alcohol and young people's drug and alcohol spending. Any disinvestment in drug and alcohol services will be evident.
- Given ACRA's endorsement of the former Pooled Treatment Budget approach and the direction of travel on the 'health premium' it is probable that activity and performance will continue to affect allocations, at least in the immediate future.
- Drug treatment remains a key priority for the government and this is unlikely to change.

What about the links to criminal justice?

The link between public health and criminal justice is important for investment in and development of substance misuse services. There is a good evidence-base for the impact of drug treatment on offending (and, specifically, acquisitive crimes like bag snatching, theft from vehicles, cheque or credit card fraud and shoplifting). The NTA's 'Why invest?' resource states that the annual cost of drug-related crime is nearly £14 billion and that drug treatment can prevent around 4,900,000 crimes a year, with a cost saving of £960 million. There is also a strong relationship between alcohol consumption and crime and disorder. It has been estimated that alcohol may be a factor in as many as a half of all violent crimes.

There is no statutory provision for criminal justice representation on HWBs, although the NHS Commissioning Board with overall responsibility for offender health is a member (precisely how commissioning of community and prison treatment services will be integrated through the HWBs and other local structures remains to be seen). It should be acknowledged, however, that some of the messages and language in key Department of Health documents do actively encourage HWBs to engage with other partners. For example, the Local Authority Circular that accompanied the announcement in January 2013 of the public health grant allocations highlights the need for consultation in developing JSNAs and JHWSs, saying that 'local authorities, as members of HWBs will have a duty to work with CCGs and other partners such as the police and community safety partnerships to undertake Joint Strategic Needs Assessments (JSNAs) – an assessment of the current and future health and social care needs and assets of the local community'.¹⁰

There is a particular issue about the relationship between emerging public health structures and elected Police and Crime Commissioners (PCCs). PCCs have no statutory representation on HWBs, and it is questionable whether it would

10. This document is available at www.wp.dh.gov.uk/publications/files/2013/01/LA-Grant-cir-and-allocations1.pdf

be practicable for them to be members of all HWBs, partly because they are responsible for police authority areas that cover a number of local authorities, and therefore HWBs. However, PCCs might be expected to have a strong interest in substance misuse services given the links to crime. Conversely, the Drug Strategy 2010 states that Directors of Public Health will work with local partners including PCCs (and prisons and probation services) to 'increase the ambition for recovery'. In addition, PCCs will receive the Home Office share of the current budget for the Drug Interventions Programme (DIP) from April 2013 (around £32 million) with the remainder of current DIP spend (around £60 million) absorbed into the public health budget. With DIP effectively finished as a nationally mandated and managed Home Office initiative, the continuation of DIP-style work will now depend on local strategic priorities. (PCCs will be free to invest the money they will receive from current DIP budgets in other community safety projects, and from April 2014 directly for policing.)¹¹

This said, public health will have a direct interest in criminal justice issues. In 2011, the Department of Health identified 17 local commissioning responsibilities for public health, including 'promotion of community safety, violence prevention and response'. The Public Health Outcomes Framework includes a number of relevant community safety outcomes, including domestic abuse, violent crime (including sexual violence) and re-offending. The Department of Health published 'Protecting people, promoting health: A public health approach to violence prevention in England' in November 2012. It explains that violent crime costs the NHS an estimated £2.9 billion annually and that the total costs to society are estimated at £29.9 billion. It concludes that the 'changes to public health and other public structures should help facilitate violence prevention', and specifically that 'the establishment of Public Health England and

locally accountable health and wellbeing boards; the movement of public health teams into Local Authorities and the election of police and crime commissioners, can be used to create multi-agency plans for violence prevention in all localities'. Substance misuse interventions for both offenders and victims are highlighted as a key issue.

The Government believes that the new local structures provide opportunities for effective collaboration between public health and criminal justice, but how this plays out on the ground will be critically dependent on local discussions and approaches. A recent document developed as part of the National Learning Network for HWBs – a programme funded by the Department of Health – considers how HWBs and criminal justice agencies can 'build effective engagement'.¹² It identifies 10 questions that 'every HWB should ask about working in partnership with CJS agencies' and '10 questions that CJS agencies should ask about working in partnership with HWBs' (see Appendix 2). The effectiveness of local engagement will partly depend on whether these questions are asked and pursued by the relevant decision-makers at local level.

What about other public health responsibilities and HWB priorities?

The transition to public health will provide opportunities for drug and alcohol service commissioning to be linked up with other local initiatives and agendas. Drug and alcohol treatment potentially links to other public health responsibilities such as sexual health, smoking cessation, public mental health services, accidental injury prevention, prevention of cancer and long-term conditions, promotion of community safety and violence prevention.

11. Indeed, there is no ring fencing that would prevent PCCs from diverting investment from community safety to policing budgets in 2013-14.

12. National Learning Network for HWBs (November 2012 – supported by Department of Health, Local Government Association, NHS Confederation and NHS Institute for Innovation and Improvement), "Health and wellbeing boards and criminal justice system agencies: building effective engagement" available at <http://www.nhsconfed.org/Publications/Documents/criminal-justice-system-agencies.pdf>

In addition, there are inter-relationships with the responsibilities of other statutory members of HWBs. Of particular importance, the Drug Strategy 2010 explains that ‘Directors of Public Health and Directors of Children’s Services will be empowered to take an integrated and co-ordinated approach to determine how best to use their resources to prevent and tackle drug and alcohol misuse’ among children and young people. In addition, drug and alcohol services will have an important contribution to make to initiatives like ‘Troubled Families’ and to the child protection responsibilities of Directors of Childrens and Adult Service (i.e. the ‘Hidden Harm’ agenda).

What are the opportunities?

With so much fundamental change going on and a background of continuing cuts to public funding it is understandable that many service providers have concerns about the impact of the transition to public health. But there are many potential positives too. Many in the substance misuse sector have welcomed the opportunities to develop drug and alcohol services within a public health framework that speaks to local concerns and priorities, to develop a dialogue with local communities and to develop and diversify their service ‘offer’. While the risks of disinvestment are real, there has been a commitment to providing protection for the core drug treatment budget, at least for an interim period (although, as explained above, clarification as to how this will apply in practice is still being sought). Above all, drug and alcohol services are well-placed to make a strong, evidence-based case for the work they do, the benefits it delivers for individual, families and communities and its cost effectiveness (as set out, for example, in the National Treatment Agency’s ‘Why Invest?’ resource). We also know that drug and alcohol treatment remains a priority for national government, as demonstrated by the Drug Strategy 2010 and Alcohol Strategy 2012.

To conclude, some of the ‘positives’ include:

- The potential of a public health approach led by local authorities to ‘join up’ drug and alcohol commissioning as well as to develop the links with other local authority responsibilities, such as housing and support for employment.

- The opportunity to diversify and develop the drug and alcohol sector ‘offer’ to local communities, highlighting the potential to contribute to a range of local policy objectives, including crime reduction, health and public health, social exclusion, support for families and young people’s services.
- The potential to ‘build recovery in communities’ within the frameworks provided by national policy documents and drivers, pooling resources outside the public health grant and leveraging in other partners (for example, Police and Crime Commissioners or troubled families co-ordinators).
- The opportunity for ‘joining up’ of services through the HWBs, including community and prison services and provision for young people and developing drug and alcohol provision as part of a coherent local strategy for health and well-being.

None of this is to underestimate the challenges ahead. But the drug and alcohol field has a history of effective adaption and innovation in response to changing conditions. The immediate challenge is to map out key strategic decision makers in local areas, understand their priorities and lobby them on the benefits of continued investment in substance misuse treatment and recovery in a way that is meaningful to them and speaks to their aims and priorities.

KEY REFERENCES AND RESOURCES

The Department of Health's **Healthy lives, healthy people** website (which includes many of the publications discussed in this document) is at www.dh.gov.uk/health/tag/healthy-lives-healthy-people

DH (2012), 'Improving outcomes, supporting transparency – a public health outcome framework for England 2013-16' is at www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_134580.pdf

DH (2012), 'Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies – draft guidance' is at www.wp.dh.gov.uk/publications/files/2012/07/Joint-Strategic-Needs-Assessment-and-Joint-Health-and-Wellbeing-Strategy-draft-guidance-a-consultation.pdf

DH (2012), 'Healthy lives, healthy people – update on public health funding' is at www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_134580.pdf

DH (2011), 'Healthy lives, healthy people – update and way forward' is at http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_129334.pdf

The **Healthwatch** website is at www.healthwatch.co.uk

The **NHS Constitution** is at <http://www.dh.gov.uk/health/category/policy-areas/nhs/constitution>

The **NTA 'Why invest?'** resource is at www.nta.nhs.uk/uploads/whyinvest2final.pdf

The NHS Commissioning Board (2012) has produced a helpful guide to the respective commissioning responsibilities of different bodies within the new local structures in its 'Commissioning fact sheet for clinical commissioning groups' at www.commissioning-board.nhs.uk/files/2012/07/fs-ccg-respon.pdf

The Public Health England webpage is at <http://www.dh.gov.uk/health/tag/public-health-england/>

King's Fund – Health and Wellbeing Boards – making them work

The King's Fund have produced a set of excellent resources, including a searchable directory of Health and Wellbeing Boards at www.kingsfund.org/projects/health-and-wellbeing-boards?gclid=COL7s4CFqbQCF7MtAodpy4A4gg

Relevant DrugScope resources

A companion briefing on 'Police and Crime Commissioners' (2012) is available at www.drugscope.org.uk/Resources/Drugscope/Documents/PDF/Policy/SFC-PoliceCrimeCommissionersBSBriefing.pdf

DrugScope, Centre for Mental Health and the UK Drug Policy Commission (2012), 'Dual diagnosis: a challenge for the reformed NHS and for Public Health England' is at www.drugscope.org.uk/Resources/Drugscope/Documents/PDF/Policy/DSDualDiagnosisDiscussionPaper.pdf

DrugScope's response to the DH consultation on JSNAs and JHWSs (2012) is at <http://www.drugscope.org.uk/Resources/Drugscope/Documents/PDF/Policy/DrugScopeResponseJSNAandJHWSconsultation.pdf>

DrugScope's comments on the Commissioning Outcomes Framework for Clinical Commissioning Groups is at www.drugscope.org.uk/Resources/Drugscope/Documents/PDF/Policy/Drugscope%20response%20to%20NICE%20ConsultationonPotentialIndicatorsforCOF.pdf

DrugScope's submission to the Health Select Committee inquiry on public health (2011) is at www.drugscope.org.uk/Resources/Drugscope/Documents/PDF/Policy/DrugScopeResponse-HealthSelectCommitteePublicHealth.pdf

DrugScope resources on public health and localism are at

<http://www.drugscope.org.uk/POLICY+TOPICS/Public+Health+and+Localism>

DrugScope response to the Department of Health consultation on Strengthening the NHS Constitution at

<http://www.drugscope.org.uk/Resources/Drugscope/Documents/PDF/Policy/DrugScopeResponseDHconsultationonNHSConstitution.pdf>

Other relevant briefings on the public health reforms

Clinks (2012), 'Clinks Briefing on the new health commissioning landscape' is at

www.clinks.org/assets/files/PDFs/Briefings/Members%20Briefing%20-%20Offender%20Health%20August%202012.pdf

Homeless Link (2012), 'The new landscape of healthcare provision in England' is at

<http://homeless.org.uk/sites/default/files/Homeless-Link-Health-Glossary.pdf>

Making Every Adult Matter coalition (2012)

'Navigating change: using new crime, health and financial structures to tackle multiple needs and exclusions: A briefing for voluntary organisations across homelessness, mental health, substance misuse and offending' is at

www.meam.org.uk/wp-content/uploads/2012/07/Emerging-Structures-FINAL.pdf

Research documents

The most detailed independent evaluation of the early impact of the shift to localism is provided by UK Drug Policy Commission (2012), 'Charting new waters' at

www.ukdpc.org.uk/publication/charting-new-waters

See also UKDPC, DrugScope and Mentor (2012), 'Domino Effects: The impact of localism and austerity on services for young people and on drug problems' at

www.ukdpc.org.uk/publication/domino-effects

APPENDIX 1

Preparing for and engaging with the public health reforms – To do list

1. Develop an organisational strategy for adapting to and engaging with public health structures. For instance:

- Senior Management Team develop an organisational strategy for effective adaption to and engagement with public health and other new structures (such as Police and Crime Commissioners). Progress and developments are reviewed as a standing item at meetings of the Senior Management Team.
- The Board of Trustees is briefed on the potential impact of public health reforms for the organisation and involved in the organisational strategy. (Do any of your trustees have relevant expertise, information or contacts?)
- Relevant staff receive information and training to prepare for the transition to public health and understand its significance for their role and service. (Would it be helpful to involve staff in facilitated discussions about how their projects and services are addressing public health issues and outcomes, for example?)
- If you are a national organisation working in different local areas then consider whether you have appropriate organisational arrangements for information sharing (for example, if a service in one locality has produced a resource or successfully influenced the public health structures how can you ensure that any learning is shared with colleagues in other local areas?)

2. Make contact and build relationships with relevant bodies and decision makers

- As part of the organisational strategy ensure that the appropriate people in your organisation and services are finding out who is who in the new local commissioning environments and building relationships as appropriate. You'll need to give some thought as to how to do this most constructively as there'll be a lot of demands on the local public health structures.
- Health and Wellbeing Boards are likely to include sub and advisory groups. It would be helpful to find out what structures are in place in particular local areas and make contact with the Chairs of relevant groups to ensure that there is consideration and representation of drug and alcohol issues.
- Health and Wellbeing Boards may include a representative for the voluntary and community sector, although they are not required to do so. If there is a voice for the VCS and you are not already in contact with them, then get in touch and ensure that they are aware of the contribution and concerns of local drug and alcohol services.
- Make contact with and, if possible, become a member of the local Healthwatch service. Healthwatch has a particular role in providing representation for people who use health services, and it is important to ensure the voice of users of drug and alcohol services are heard.
- Many of the new local commissioners may have limited experience of the drug and alcohol sector, so you could consider producing some information packs (or a video) about local issues and services and/or inviting local councillors and other HWB members to visit projects and meet with staff and service users – for example, by holding Open Days in services.

3. Identify opportunities to influence the development of the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy

- The Health and Wellbeing Board has a particular responsibility to engage with people from disadvantaged areas and vulnerable groups in developing the JSNA and JHWS, and to consider the likely impact of its decisions on people with protected equality characteristics. Help to hold them to account.
- Gather evidence of the impact of your services and feed this into the JSNA and JHWS processes. As well as the statistical data, building a stock of personal testimonies from service users, families, local communities and professionals who have positively benefited from the work of drug and alcohol services is an effective way of engaging and influencing commissioners.
- Know your rights (and those of service users)! While a lot of decisions will be at the discretion of local decision-makers these will still be framed by a range of legal duties and protections – such as equalities duties and clinical governance. For example, it will be useful to be familiar with the framework of rights and responsibilities set out in the NHS Constitution as these will apply to public health.

4. Develop your 'service offer' to speak to local priorities and public health

- It may be useful to hold an internal workshop or forum to enable staff to consider the range of ways in which your services can contribute to public health priorities and outcomes or could be developed to do so (for example, by contributing to sexual health or smoking cessation or the reduction of domestic abuse). The Public Health Outcomes Framework could help to inform and structure this discussion.
- In business planning you may want to give consideration to how your organisation can diversify its service offer to address public health priorities where there are opportunities to provide services (for example, around harmful and hazardous drinking). For example, are their implications for workforce development, the development of job descriptions and staff recruitment or the presentation and 'branding' of services. This is also an opportunity to build on partnerships with other organisations or to develop new ones (for example, sexual health, domestic violence and BME services).

5. Work with DrugScope (and the London Drug and Alcohol Network) and the Recovery Partnership (Substance Misuse Skills Consortium and the Recovery Group UK).

- As the national membership organisation for the drug and alcohol fields, DrugScope is committed to supporting our members to adapt as successfully as possible to the new commissioning environment. We will be producing resources that will be available on our website. DrugScope members will also benefit from information, discussion and support provided in Druglink magazine, LDAN News and the DrugScope e-bulletin (and you can sign up for our daily news services DS Daily on our website, and have a free news summary delivered to your inbox every day).
- Please get in touch with DrugScope's policy team to let us know about developments in your local area and if you believe there is support that we could provide (including raising issues with national government, parliamentarians, Public Health England and other key national agencies). Our resources are limited too, but we will do what we can to inform and support your work.

APPENDIX 2: HEALTH AND WELL BEING BOARD and CRIMINAL JUSTICE SERVICES

(From NHS Confederation 'Health and wellbeing boards and criminal justice system agencies: building effective engagement' Nov 2012)

	Ten questions every HWB should ask about working in partnership with CJS agencies		Ten questions CJS agencies should ask about working in partnership with HWBs
1.	Do board members have an awareness and understanding of the positive local health outcomes linked to improving the health of people in contact with the CJS, including offenders and those at risk of offending or re-offending as well as victims?	1.	Do you understand how JSNAs and JHWSs and commissioning plans fit together in the new local health and care system?
2.	Does the board have a good understanding of how current investment in the health of people in contact with the CJS is deployed, and the levels of access this provides?	2.	Do you know how to input into and influence JSNAs and JHWSs?
3.	Is there a local needs assessment incorporated into JSNAs that identifies the health and social care needs of people in contact with the CJS?	3.	Has the health and wellbeing board been made aware of the responsibilities across local CJS for delivery of local offender and ex-offender health outcomes?
4.	Do local commissioning plans explicitly recognise the service needs of offenders and ex-offenders including health and re-offending prevention services?	4.	Is key evidence (including quantitative data and analysis and qualitative information) on health and health inequalities among people in contact with the CJS, shared with the health and wellbeing board and member organisation?
5.	Is there a coherent and agreed partnership strategy with CJS agencies for offender and ex-offender health?	5.	Do CJS agencies share an awareness and acceptance of the benefits of integrated planning, commissioning and delivery of health and care services across the CJS?
6.	Do health and wellbeing board members recognise that new ways of partnership working are required and has consideration been given to how partnership links with local CJS agencies can be strengthened?	6.	Is there a coherent and agreed partnership vision across local CJS agencies for offender and ex-offender health priorities and outcomes that can be shared with the health and wellbeing board?
7.	Is integrated care for people in contact with the CJS commissioned through providers and other organisations with clear shared priorities and vision?	7.	Are all CJS partners open and willing to explore new ways of partnership working?
8.	Are primary care services aware of the wider needs of people in contact with the CJS and are they able to signpost and refer, for example, for housing, employment and benefits etc?	8.	Are local CJS leaders clear about their roles and responsibilities in terms of fostering joint working between CJS agencies and the health and care system at local level?
9.	Are offenders supported to maintain continuity of health and social care from prison to community?	9.	Are CJS agencies willing and able to align their priorities for delivering improved health outcomes in the CJS with those of JHWSs?
10.	Is there active engagement with the different local community groups in contact with the CJS, including offenders and those at risk of offending or re-offending as well as victims, through local Health-watch and other agencies?	10.	Is there recognition of the benefits from strong and effective leadership, able to influence and motivate across organisational boundaries to translate locally agreed health and wellbeing priorities into action?

This briefing was produced by Dr Marcus Roberts, Director of Policy and Membership, DrugScope and Michael Simpson, Policy Officer, DrugScope

DrugScope is the UK's leading independent centre of expertise on drugs and drug use and the national membership organisation for the drug and alcohol field. We represent around 450 member organisations involved in drug and alcohol treatment, young people's services, drug education, criminal justice and related services, such as mental health and homelessness.

DrugScope is a registered charity (number: 255030). Further information about DrugScope - including becoming a DrugScope member and membership benefits - is available at www.drugscope.org.uk

The Recovery Partnership is comprised of the Substance Misuse Skills Consortium, the Recovery Group UK and DrugScope. It provides a collective voice and channel for communication to Ministers and Government on the achievement of the ambitions in the drug strategy.

More information about the Recovery Partnership is available at:
www.drugscope.org.uk/partnersandprojects/Recovery+Partnership