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Local alcohol treatment and recovery service commissioning practices and their perceived outcomes for service provision: An in-depth exploration

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Opinions and recommendations expressed in this report are those of the authors.

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Executive summary

- Best practice treatment for alcohol dependence is both effective and cost effective.
- Despite this, only about one in five of those who could benefit from treatment actually attend.
- In England, there are substantial geographic disparities in access rates for alcohol treatment. These differences in treatment access rates are longstanding.
- Local authorities have been responsible for the procurement of alcohol services since 2013.
- Local authorities have recently faced unprecedented funding cuts, affecting their capacity to provide public health services, including those for alcohol.
- To understand how local authority areas approach the task of commissioning, we undertook an in-depth comparative case study of five local authority areas.
- Case study sites were selected for diversity in their socio-demographic, geographic and alcohol use characteristics.
- Interviews were conducted with 32 stakeholders to the commissioning process, with participants including commissioners, providers and people with direct experience of service use.
- Documents such as needs assessment reports, local alcohol strategies and service specifications were used to supplement interview material in building the case studies.
- While there were many location-specific factors at play, for example the need to address shortcomings of a previous delivery model, it was still possible to identify several commonalities across case studies.
- Common commissioning drivers included the requirement to make savings, the desire to create a single co-ordinated system, address under-representation of alcohol clients, improve access pathways, ensure minimum standards, improve engagement with family and hard to reach groups, and enhance recovery options.
- Commissioners consulted widely to inform specification development, often communicating to stakeholders at the outset the scale of cuts to be absorbed along with ideas for how these could be mitigated. Other issues which could be addressed by system improvements were also mooted.
- Commissioning processes are perceived to be rigorous, transparent and highly scrutinised, while simultaneously being regarded as time-consuming for commissioners and service providers and potentially anxiety provoking for service providers and clients.
- Common system developments included integration of different services types, reconsidering the location of provision, redesign/streamlining of treatment models, reductions in staff numbers and/or review of staff roles, increased opportunities for peer workers, and consolidation of delivery to fewer providers with greater responsibility for system co-ordination.

- Participants tended to avoid quantifying the outcomes of their recently commissioned alcohol service system in terms of routine indicators, recognising that simple before and after comparisons were complicated by the reduction in funding, fundamental changes to the service system and other local factors.
- However, participants were able to provide qualitative accounts of what they perceived to have worked well or been a challenge in implementing the system and improving alcohol service delivery. Specifically:
- Integration: merging alcohol and drug misuse services was generally seen to deliver efficiency savings, but there were concerns alcohol clients may be reluctant to attend a combined service.
- Outreach: this approach was seen to potentially deliver efficiency savings (on fixed sites) and improve service accessibility, however, there had been challenges to implementation in those sites where outreach was a substantial feature of service delivery.
- Redesign of treatment models: this generally involved streamlining previous models of intervention, so that they were shorter, involved less intensive use of resources, and/or were more oriented towards recovery outcomes. It was not always clear what evidence source was used to underpin service treatment model redesign.
- Lead provider: In some cases, local authorities appointed a lead provider to not only develop a single system and co-ordinate client flow through it, but also to assume some of the responsibilities previously held by commissioners. This presented both advantages and disadvantages to the lead provider.
- Contract length: these varied from three to nine years, with shorter contracts perceived to be less attractive due to overly-frequent recommissioning.
- Special groups: Service specifications for all sites revealed local priorities to support inclusion of families and hard to reach groups. However, interventions and progress in these areas were rarely mentioned.
- It was felt that it would be helpful to the role of commissioners if alcohol were more strongly reflected in national strategy documents as this would allow commissioners to make stronger representations for investment to council decision makers.
- Joint commissioning (for example with Mental Health Trusts) is seen as an opportunity to strengthen provision for clients with more complex needs such as dual diagnosis.
- Despite the scale of cuts, there appears to be mutual recognition that stakeholders have worked together to develop their vision for a new service system and commitment to continuing to do so.

Introduction

There is good evidence that 'best practice' treatment is both effective and cost-effective in responding to alcohol dependence (Raistrick, Heather, & Godfrey, 2006), and this evidence is summarised in National Institute for Health and Clinical Excellence (NICE) clinical guidelines (NICE, 2011a). Successful treatment can not only improve lives of individuals, but also those of their wider social network. In 2017/18, there were 131,008 people who received treatment for alcohol problems[a] in England (PHE, 2018a). Despite the potential benefits of alcohol treatment, however, it is estimated that each year the number of people accessing treatment represents only about one in five of those who are alcohol dependent (PHE, 2018a). Access for some groups may be especially difficult; for example, many people with alcohol dependence have complex needs requiring additional support including other physical or mental health conditions and homelessness (Bell & Britton, 2014; Brière, Rohde, Seeley, Klein, & Lewinsohn, 2014; Debell et al., 2014; Fitzpatrick, Johnsen, & White, 2011; Homeless Link, 2014; Rehm et al., 2010). There are also large and persistent geographic disparities in treatment access rates across England (Brennan et al., 2016; Drummond et al., 2005). There has been a 17% reduction in the number of people accessing specialist treatment services since 2013/14, including a 6% drop in 2017/18 alone (PHE, 2018a). During this same period there have been substantial cuts to public health budgets, including for alcohol services (Alcohol Concern & Alcohol Research UK, 2018; British Medical Association, 2018; Local Government Association, 2016). It has been reported that local cuts to substance misuse services may in fact be larger than published financial data indicate and are unevenly distributed, potentially widening inequalities (Advisory Council on the Misuse of Drugs, 2017; British Medical Association, 2018).

To understand differences in treatment access across the country and over time, it is necessary to consider local commissioning practices. Primary responsibility for commissioning alcohol services in England was transferred to local authorities from Primary Care Trusts in 2013-14 (Great Britain Department of Health, 2012; PHE, 2014), with these services to ideally meant to be *"…accessible, matched to local need and NICE-compliant"* (PHE, Undated). Service provision may encompass prevention activities, treatment interventions and 'recovery' oriented supports, with the latter addressing broader life concerns such as relationships and wellbeing, as well as reduced substance use (Neale et al., 2016; Neale et al., 2015). The transfer in responsibility for alcohol service procurement and monitoring was part of a larger change to public health service provision, with responsibility for several other areas also being transferred to local government at this time, including services relating to other drugs, smoking cessation, sexual health, obesity and physical activity. It was hoped that by co-ordinating efforts for each of these public health concerns with activity in other areas such as housing, education and employment, local authorities would be able to better address the wider determinants of health for their populations (Davies, Keeble, Bhatia, & Fisher, 2016).

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[a] Of these, 75,787 were in treatment in relation to alcohol use only and no other substances

Prior to the transfer in commissioning responsibility to local authorities there were some national level documents available which informed service system planning, for example around models of care and implementation of NICE guidelines (Department of Health, 2006; Joint Commissioning Panel for Mental Health, 2013; NICE, 2011b). Since the transfer, Public Health England (PHE) have been specifically tasked with providing information and support to local authority commissioners. PHE have developed several resources for this purpose, including a document released in 2018 outlining commissioning principles and indicators (PHE, 2016, 2018b). Such information, while potentially useful, is only one aspect of what might be considered in the complex 'art of commissioning', with other factors such as history, competing agendas and power relationships within a locality also being important (Wye et al., 2015). In practice, each local authority decides what alcohol services to provide and determines its own commissioning priorities, procedures and cycle. Across localities, alcohol policy may be further influenced by 'policy transfer', or learning from the practice of others (Gavens et al., 2017).

While the shift in responsibility for commissioning substance misuse services (including alcohol) to local authorities was received positively by many in the sector, there have also been concerns raised that given the breadth of responsibility and limited resources of public health departments, expertise may be diluted (Alcohol Concern & Alcohol Research UK, 2018). Related to this, financial constraints are a key driver of commissioning decisions: as early as 2014, local authorities signalled their intention to focus on maintaining quality while reducing costs i.e. 'doing the same for less', 'doing more for the same' or 'doing more for less' (PHE, 2014). The issues faced by local authorities are mirrored in the experience of service providers: with increasing concerns regarding budget cuts and rapid commissioning cycles evident across the four *State of the Sector* reports published from 2013 to 2017 as well as in the 2018 *The Hardest Hit* report (Adfam, 2015; Alcohol Concern & Alcohol Research UK, 2018; DrugScope on behalf of the Recovery Partnership, 2013, 2015; Recovery Partnership & Adfam, 2017). Frequent recommissioning is seen by many stakeholders to be destabilising and resource intensive, with some smaller providers considered unlikely to remain competitive in this environment (Adfam, 2015; Advisory Council on the Misuse of Drugs, 2017). Recent trends in the provision of services, including the merging of individual alcohol and drug services into combined substance misuse services and changes in workforce profile (i.e. fewer specialists, more peer mentors and volunteers), are perceived as being partly driven by funding cuts, even though there may also be other sound reasons for adopting these changes (Alcohol Concern & Alcohol Research UK, 2018).

Given the geographic disparities in alcohol treatment need across the country and the relative freedom of local authorities to determine how to respond to these, local commissioning practices are of key importance in redressing current inequities in provision. However, local authority public health budgets are currently shrinking, and the resources available for alcohol service provision are consequently also diminishing or under threat. It is currently not well understood the variety of ways in which individual local authorities, through the commissioning process, try to address alcohol treatment needs within their communities in the context of declining budgets.

Aims

The aim of this project was to examine recent experience of alcohol service commissioning processes at a local authority level in five diverse localities.

Specifically, we aimed to explore:

- Differences/similarities between areas in commissioning drivers and processes
- Stakeholder perceptions regarding the strengths and weaknesses of local commissioning processes with a focus on perception of outcomes for alcohol service provision
- Stakeholder perceptions regarding key changes in the alcohol service commissioning landscape since 2013/14 and likely future risks and opportunities

Design

We adopted an in-depth multiple case study approach to explore the commissioning process in detail from multiple stakeholder perspectives. Over nine months we engaged with commissioners, providers and service-users from five different local authorities in England, in which there has been substantial recommissioning of alcohol services since 2014.

We selected this approach because commissioning processes are complex, related to relevant contextual factors (e.g. past provision, scale of need, resources available), and are likely to be perceived differently by different stakeholders even within the one area. The phenomenon of *alcohol treatment and recovery service commissioning* in circumstances of devolved responsibility and increased funding pressure is not yet well understood, and further, is intrinsically linked to location. According to Holloway and Wheeler (2010)(Holloway & Wheeler, 2010), *"the case study is a way of exploring a phenomenon … in context"* (p. 250) and can be used to *"…investigate cases that are tied to a specific situation and locality…"* (p. 251). Case studies are not intended to produce generalisable findings across locations, but can generate transferable ideas relevant to other places, as well as informing theoretical development and future research directions. Generating multiple case studies enabled us to explore differences and similarities between cases.

Another advantage of the multiple case study approach is that it allows purposive selection of sites on the basis of variation in important contextual factors. Baxter and Jack (2008) highlight the importance of 'binding the case', e.g. by time, place, activity and definition, to ensure manageable scope. We therefore restricted our case studies to commissioning at the local authority level since 2014 where that commissioning wholly or substantially included alcohol services.

Methods

Case descriptions were developed using information from:

- Routinely available socio-demographic information and alcohol use, harms and treatment data
- Interviews with key stakeholders to the commissioning process in each site
- Review of documents provided by key stakeholders or publically available regarding the commissioning process

Recruitment of Case Study Sites and Participants

Case study sites were purposively selected for diversity in terms of urbanicity (e.g. being predominantly rural or urban) and 2014 estimates of prevalence of dependence and alcohol treatment access rates (the latter calculated as treatment uptake relative to prevalence of alcohol dependence) (Brennan et al., 2016). Additionally, consideration was taken to 1) avoid selecting a set of cases dominated by one or two major treatment providers, 2) selecting cases from across England, and 3) recruiting sites of varying levels of deprivation (measured using the Index of Multiple Deprivation 2015) (Department for Communities and Local Government, 2015). Finally, we identified sites that had commissioned at different points in time over the preceding 3 years to capture variation in experience over time.

We considered 152 upper tier local authorities on the basis of the variables outlined above for inclusion. We excluded any local authority in which the research team or advisory panel operated as well as the Isles of Scilly (for practical reasons). From the remainder, we identified a diverse short list of 13 potential study sites taking into account the characteristics identified above (e.g. nine were predominantly urban and four predominantly rural). From the shortlist we then began to approach sites to participate. Where possible, we used existing networks (e.g. colleagues at Public Health England) to identify the key contact for substance misuse treatment commissioning in our chosen sites, for example the commissioning lead or consultant in Public Health. This enabled us to make a direct approach to a person for whom the aims of the study would be relevant. Where a site declined to participate, we then moved to contacting one of our other shortlisted local authorities with similar characteristics. Five sites agreed to be involved (two immediately declined to participate, a further two responded to initial contact but ultimately did not participate, one did not respond at all and we did not approach the final three as five sites were sufficient). Although it was made clear to participating sites that they were likely to be identifiable from the details of the case, it was also indicated that actual site names would be replaced with pseudonyms in project outputs. We have also ‘rounded’ the figures relating to case study site characteristics to prevent easy identification (Table 1, **Error! Reference source not found.**).

Table 1 Pseudonymised case study sites and their characteristics

Local Authority	Urban/ Rural	Deprivation Rank of 152 LAs[a]	Dependence Number [b] Rate [c]	Treatment Access Rate[c] (2014)	Year commissioned (mobilised)	Lead provider organisation
Rellington	Urban	1-10	20,300 2.5%	10.5%	2014 (2015)	National
Frampton	Partly Rural	51-60	9,300 2.5%	12.5%	2017 (2018)	Regional
Goughs-borough	Partly Rural	41-50	4,800 2%	11%	2014 (2015)	National
Sandley	Urban	41-50	4,800 3%	12.5%	2017 (2018)	NHS
Kelgate	Urban	51-60	4,000 2.5%	15%	2016 (2016)	Local

[a] In increments of 10 out of 152 Local Authorities (LAs), where smaller rank numbers mean more deprived
[b] Rounded to the nearest 100
[c] Rounded to the nearest 0.5%

In each case study site, the person with primary responsibility for commissioning substance misuse services (hereafter referred to as a “commissioner”) was identified and invited to participate. The need to also interview at least one “service provider” participant in order to constitute a case was explained. In some cases study sites the commissioner made contact with the provider and asked them to contact us, in others the research team were provided with contact details to make a direct approach. Once the participation of these two key people had been secured, we then sought contact details of other people within the local authority directly involved in commissioning. These people were then also approached to take part, with further snowballing of participants as the study progressed. Where possible, people with direct experience of service use were included. While the specific roles and job titles of participants varied across sites, we have grouped them into three categories, as shown in Table 1Table 2. Although we did not purposively recruit for it, in all sites, there was at least one commissioner participant who had specialist knowledge and experience of substance misuse services, having commissioned in this area before and/or having previously worked in service delivery.

Table 2 Broad categories of study participant and examples of the roles or role function included under each category

Commissioners x 15	Service providers x 12	People with personal service use experience x 5
Public Health Portfolio Lead (Drug and Alcohol) Local Authority Officers e.g. Policy, Planning, Strategy Directors of Public Health Councillors (elected member) External consultants	Director (or Assistant) Service Manager Recovery Coordinator Service Delivery (client facing) Service Development Business Development Bid Writer	Recovery support volunteers Service user forum member People accessing services: - at time of commissioning - during mobilisation of new contract

Topic Guides

Three topic guides were developed: one each for commissioners, providers and people with direct experience of service use (Appendix 2-4). The main topic areas included local commissioning drivers and processes, strengths and challenges of the commissioning process for service delivery outcomes, developments in the wider commissioning landscape (from 2013/14 onwards), and future risks and opportunities. While these topic areas were consistent for each group of participants, there was some variation in the content and phrasing of key questions across the different guides. Topic guides were reviewed by members of a Project Advisory Group (see page 10) and pilot tested with a commissioner from a non-case-study site prior to use. Following Wye et al (Wye et al., 2015), the topic guide was intended to be used flexibly throughout the data collection phase, as new areas of enquiry emerged.

Data Collection

In depth, semi-structured interviews were conducted with between four and nine stakeholders in each case study site (total n=32). Most interviews were face-to-face, although some were conducted by telephone to accommodate busy schedules. Interviews lasted between 20 and 90 minutes (on average just under an hour); interviews with Councillors were generally shortest and commissioning managers longest. Informed consent was obtained from each participant before interview. Each participant consented to be audio recorded. Both before and during the interview, participants were also invited to provide any local documentation related to recent alcohol treatment commissioning, for example Health Needs Assessments and Service Specifications (**Error! Reference source not found.**).

Data Management & Analysis

For each case study site we have developed a rich case description, generated from interview data and supplemented with information available from documentary analysis and

routinely available demographic and health data (Department for Communities and Local Government, 2015; Office for National Statistics, 2018a, 2018b). The cases describe *"the context within which the phenomenon is occurring as well as the phenomenon itself"* (Baxter & Jack, 2008) (p. 555).

To achieve this, verbatim transcripts were pseudonymised by the research team prior to data analysis. Transcripts were then imported into NVIVO 12 (QSR International) to facilitate the management and analysis process. The first stage of analysis was to read and re-read transcripts to ensure familiarity with the data. Next, initial codes were developed that were 'grounded' in the data (Holloway & Wheeler, 2010). Initial coding identified over 300 codes that we then reviewed to identify emerging concepts to build categories. We used the method of 'constant comparison' (Bryman, 2012) throughout the analytic process to test and understand the emerging findings. Over time, through studying the data and discussions between members of the research team, final themes were agreed. Additionally, quotations from participants are used to illustrate emerging themes. Due to the case study nature of the research we could not guarantee that participating sites would not be identifiable in research outputs.

Documents provided by stakeholders were also imported into NVIVO. Given the volume and diversity of documentation provided (**Error! Reference source not found.**), d ocuments were initially skimmed for relevance to the most recent commissioning round. In particular, the documents were reviewed for contextual information about the case study site (such as previous service provision) and for information about commissioning processes or outcomes which corroborated, deepened, or contradicted that provided in the interviews (Bowen, 2009). This included, for example, identification of additional commissioning priorities not mentioned in interviews and further detail regarding consultation processes such as dates and numbers of people involved. Related documents, such as a series of needs assessment reports over time, or a consultation survey form and separate summary of results were considered together. The memo function of NVIVO was used to record a precis of document contents and what new information (if any) they contributed to the case study. Instances within a case study where the information presented draws primarily upon documentary evidence (rather than interview data) are identified within the case summaries. In some instances participants provided documents on the understanding that these would not be reported on in detail. However, these were still useful, for example, to corroborate a participant's description of a consultation exercise. Although we received Service Specification and / or Invitation to Tender documents from four out of five sites, we have not undertaken a detailed comparative analysis of these as some were for reporting in overview only and others did not include appendices which would be required for full comparison (e.g. detailed service components). Rather, these documents have been treated in the same way as all others and simply reviewed for additional information to contribute to individual case studies.

Terminology: information, consultation and engagement processes

In the interviews, participants described the interaction processes between commissioners and various stakeholders using a variety of language. While we recognise the difference between information, consultation and engagement processes (i.e. those processes

intended to simply convey information, to promote dialogue about a set of options [consultation], or to enable participation in decision making [engagement]), our topic guide included only general prompts about commissioning processes rather than specific questions about each of these types of interaction. In practice, interviewees used these phrases somewhat interchangeably, especially “consultation” and “engagement”. In presenting the case studies we have therefore done likewise, although the additional information provided gives insight into the nature and purpose of the interaction.

Ethics Approval

Ethical approval for this study was granted from the School of Health and Related Research Ethics Committee at the University of Sheffield.

Project Advisory Group

A project advisory group was established at the outset to provide feedback on study materials, emerging data, interpretation of results, dissemination plans, and future research. The panel was comprised representatives from local authority public health, Public Health England, clinical commissioning groups, primary care, people with direct experience of service use and service providers. The group provided invaluable feedback throughout the research process, including on the study materials and interpretation of results.

Patient and Public Involvement (PPI)

We sought PPI input via the Sheffield Addiction Recovery Research Panel (ShARRP) attending four meetings throughout the project to seek feedback and advice on study design, site selection, the topic guides, and emerging findings. Members of ShARRP also contributed as co-facilitators of a “conversation café” stakeholder dissemination event in September 2018.

Findings

Structure of Findings

In this section we first describe common stages and experiences of the commissioning process which were identified across sites. This is to orient the reader to what commissioning typically involves before presentation of the more detailed individual case studies.

Each of the five case studies comprises a snapshot of the local demographic and health profile, a summary of data sources used to build the case, and an overview of recent alcohol service commissioning in that location, including:

- Past service provision
- Drivers of the most recent commissioning process (i.e. which issues or factors were influential in shaping the model of service provision)
- Key features of the commissioning process (specific to the case study site)
- How savings were achieved
- Current service provision
- Perceptions of the commissioning process and (actual or anticipated) outcomes

Each case concludes with a 'Horizon scanning' section which summarises any recent developments or perceived future risks and opportunities for the case study site. We then draw together key findings across the sites in the Case Study Synthesis and Discussion section.

Common Stages of the Commissioning Processes

Participant accounts of commissioning processes revealed some broadly similar steps were followed across all five locations. For simplicity, we present these as six sequential stages (information gathering; priority setting and developing a vision; securing support and approval; tendering; mobilisation and ongoing service delivery; and monitoring), although in practice several of these overlap and involve interlinked activities. In addition, consultation and engagement activities were centrally important, coinciding with and feeding into most of the other stages (**Error! Reference source not found.**). Many of the s tages are commissioner-driven, though requiring substantial interaction both within council and with external stakeholders.

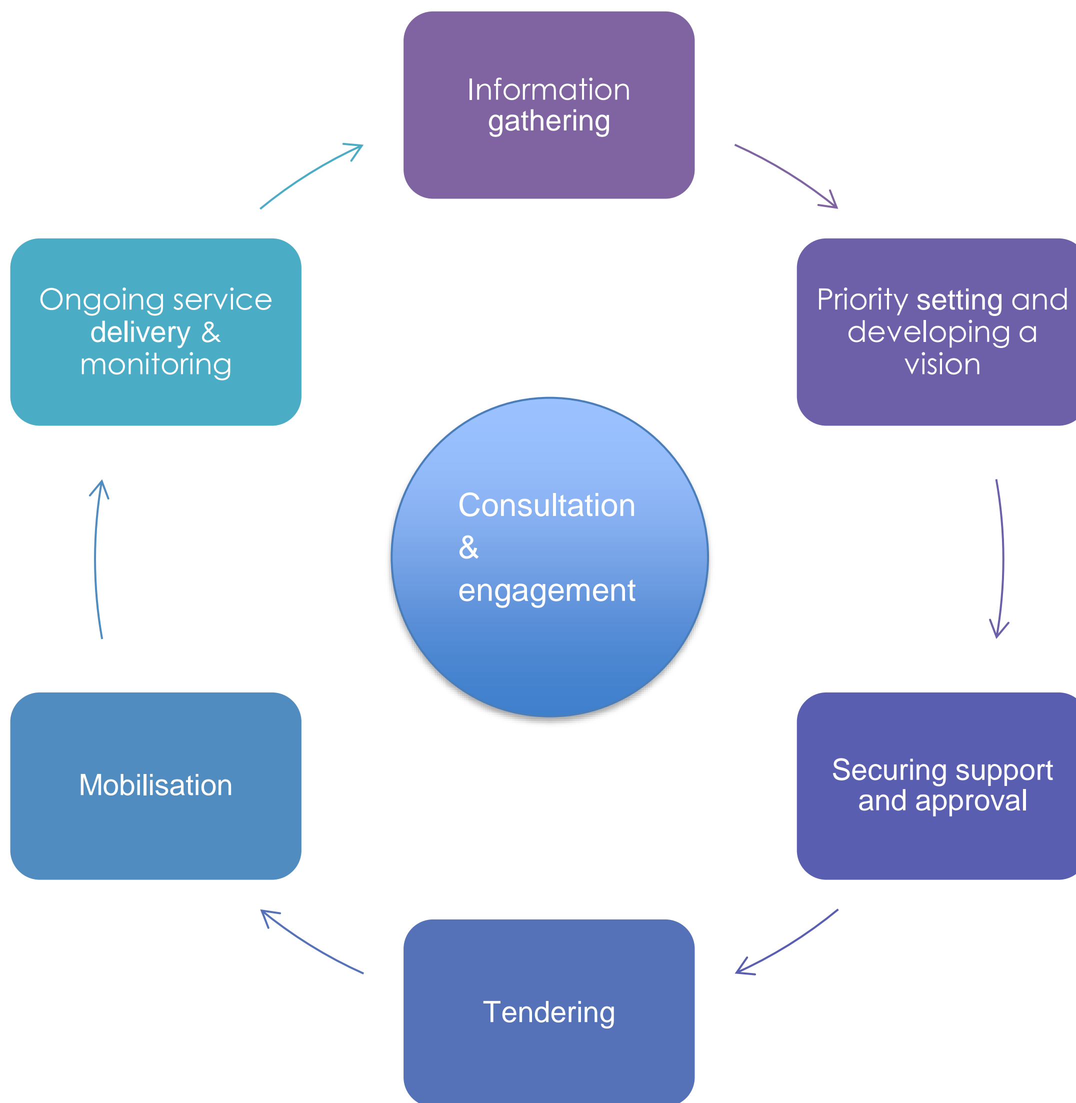

Figure 1 Stages of the commissioning process

Information gathering - need, system performance, opportunities and constraints

All local authorities engaged in an information gathering and synthesis phase in the lead up to re-procuring services. This generally included assessment of need (which in some but not all areas included preparing a formal "Needs Assessment" document) based on local information about socio-demographics, alcohol consumption and harms. The performance, strengths and weaknesses of the existing system were also considered, with a formal service review sometimes conducted and the views of stakeholders invariably sought - see 'consultation and engagement' below. Commissioners also took account of current opportunities and constraints operating at a local level (e.g. other council strategies and priorities, budget) or more widely (e.g. change in national strategic direction regarding alcohol) which could influence commissioning possibilities.

Priority setting and developing a vision for the new service system

Taking into account existing service provision, information about what else might be needed, opportunities/constraints, and stakeholder preferences, commissioners worked to develop a plan for what the service system could look like to address locally identified priorities. While this could mean simply keeping things as they were, in our all case study sites substantial changes in system focus or configuration were proposed, including fundamental system redesign. The approach to the task of developing the new system ranged from commissioner-led with stakeholder input through to co-production with service users setting the vision for the service system.

Securing support and approval

In addition to service user and wider stakeholder support (see 'consultation and engagement' below) commissioners also described undertaking considerable behind-the-scenes work to inform, update and seek advice from other council staff and elected members about commissioning progress.

> *"This was like a massive process throughout the Council" – Commissioner*

These interactions were at times strategic and/or political, such as presenting evidence in support of continued investment or discussing with elected members and senior staff the implications of different service system options for the community and other areas of council (e.g. social care). This preparatory work to ensure "buy-in" to the developing Service Specification was essential as commissioning intentions needed to be approved by Cabinet. Other within-council interactions were operational, for example working with colleagues to ensure all aspects of the commissioning process were compliant with procurement regulation and council policy, including issuing the agreed Service Specification and Invitation to Tender (ITT). There was some variation between sites in the extent to which dedicated procurement teams and infrastructure were available to support these processes.

Tendering

Once agreement was reached on the Service Specification, participants generally described a highly standardised process for tendering. Participant accounts and documents supplied to us show that while Service Specifications and ITTs differ between local authorities, there are some elements or sections commonly included such as background/contextual information; high level system aims, objectives, or intended outcomes; information about the scope of the contract; a description of the intended system framework, design or model; more specific description delivery requirements, targets or outcomes; and other more general system requirements or information (e.g. location of service, data management and information sharing, staff and partnership working) (Appendix 5, Docs 1.3, 2.3, 3.12, 3.13a, 3.13b, 4.5, 5.6).

Invitations to Tender were advertised via web portals and potential bidders generally already knew from consultation processes when this would occur and what service model to expect. The providers we interviewed indicated they had already been working towards their bid prior to the ITT, for example in approaching potential partners or

considering what would be achievable within the available funding envelope. Interested bidders then had about a month to prepare their bid which required written responses addressing each component of the tender. Service providers confirmed this involved intensive work from a team of people, often in addition to their usual duties, and that the high stakes nature of the task was stressful.

> *"We have to invest really heavily in a bid, it costs us a lot of money and a lot of energy and a lot of time" – Provider*
> *"You're writing bids, that's a massive responsibility, you don't want to be getting it wrong" – Provider*

Bids were typically assessed by a panel using a standard scoring matrix. In addition to commissioners, scoring panels included other partners such as GPs and service user representatives. In some cases, the award decision was based entirely on the submitted bid, whereas others there were additional components to the assessment, such as bidder presentations, site visits or dialogue processes where bidders could be invited to provide more information. Irrespective of the site-specific approach taken, commissioners frequently stressed the integrity of the commissioning process overall, and the tendering aspect in particular, commenting that it was highly scrutinised and open to appeal, and therefore handled very carefully.

> *"it's not some mystical art…we have to clearly demonstrate to our procurement board the rationale for the decisions and the scorings" – Commissioner*

Mobilisation

Once a contract was awarded, there followed a further period of very intensive activity (ranging from about 3 months up to a year) during which the successful bidder assumed responsibility for service provision and implemented any changes to the system. In situations where a new provider was appointed this entailed transfer of clients and staff (and potentially data and buildings) from the existing provider. Although providers and commissioners mentioned having transition plans to guide this process, participants from all three groups (service users, providers and commissioners) described this as a period of uncertainty during which relationships, job roles, systems and procedures were in a state of flux. It was noted that although service managers strove to communicate well with staff and clients about the changes and to maintain "business as usual" while the new system was embedding, in practice this was challenging in many sites:

> *"In an ideal world I wish I could just like click my fingers and we'd all be back to normal" – Service user*
> *"Change has a cost associated with it. So now we're going in and you want to deliver from day one, but you can't , because you know…you're busy changing those structures"- Provider*

Ongoing service delivery and monitoring

While our study focused on the time at which alcohol service provision contracts were being considered for renewal or change, re-procurement is of course only an intermittent task. In between commissioning rounds the system (ideally) settles into regular operation. However, even during this 'non-commissioning' time it was apparent that the system is under ongoing review with commissioners and service providers in regular communication; for example, for routine performance monitoring and discussion of issues and opportunities arising, and with the possibility of some contract variation being negotiated. The length of this 'delivering and monitoring' phase usually depended on the terms of the contract, but could be shortened, for example, if a service provider were unable to continue the contract or a local authority needed to review expenditure. For instance:

> *"…we were kind of forced into that tender process because of budgets" – Commissioner*

External consultation and engagement

Participants in every site described a range of consultation and engagement stakeholders and activities in relation to their most recommissioning (see also individual case studies). People with direct experience of service use and service providers in particular were invited to contribute in all sites, as well the general public and various representatives from wider networks, including partners working in health, crime and social services. The timing, purpose and intensity of consultation and engagement varied depending on the context and ranged from early exploration of system possibilities and preferences through to ensuring difficult conversations are had, for example about how to best reduce spending or manage a challenging change process. Irrespective of the details of who, when, where, how and why consultation and engagement occurred within a local authority, these processes were described by at least one commissioner or service provider participant in each site as 'extensive', 'wide' or 'thorough'. However, there were a small number of service provider and service user participants who expressed concerned about the extent to which the service users were reached (while generally acknowledging that the views of at least some people with direct experience of service use had been sought). Public involvement in commissioning, scrutinising and improving care services is a statutory requirement(HM Government) and the outcomes appeared to be taken seriously by commissioners with interview accounts clearly revealing instances in which stakeholder consultation was influential in shaping the service system.

Case studies

Case study 1: Rellington

Site snapshot

Location and population

Rellington is one of the largest English cities outside London. It has an ethnically diverse population (58% White, 27% Asian, 9% Black, all other groups <5%). The median age is 32 years, somewhat younger than the national median of 39 years (Office for National Statistics, 2018a). According to government data regarding deprivation, over half the population (56%) of Rellington live in the most deprived 30 per cent of Lower-layer Super Output Areas (LSOAs) in England, placing it among the top ten most deprived local authorities on this measure (Department for Communities and Local Government, 2015). In 2017/18, approximately 8% of the population were unemployed (compared to the national average of 4.3%) and about 18% of households with at least one person aged 16-64 were workless (compared to the national average of 14.5%) (Office for National Statistics, 2018b). The Council has had a Labour majority since 2012.

Alcohol-related health profile and treatment need

Despite almost a third of Rellington's population being abstinent from alcohol, this local authority is worse than the national average on a range of key alcohol indicators, including alcohol-related hospital admissions and mortality (see

Doc number	Document type Author type	Year(s)	Pages/ slides	Contribution to case study (if relevant)[†]
Rellington				
1.1	Drug and Alcohol Needs Assessment *Council staff*	2013-14	174	*This document is consistent with interview accounts of system complexity prior to recommissioning and broad results of the consultation with some additional detail provided regarding needs assessment consultation methods. The document identifies 14 issues/areas of recommendation, almost all of which were mentioned in interviews with the exception of use of non-commissioned, charitable services to increase in-patient capacity and introduction of complex needs measure. This implies the subsequent recommissioning did in fact address most if not all of the recommendations.*

Doc number	Document type Author type	Year(s)	Pages/ slides	Contribution to case study (if relevant)†
1.2	Substance Misuse Consultation Document *Council staff*	2013	9	*This document was consistent with interview accounts that the Rellington treatment system was seen to require "fundamental" review. Additional information not covered in interviews: Shift of responsibility to LAs seen as opportunity to articulate with other local strategies, desire to improve accessibility for hard to reach groups, number of people consulted*
1.3	Service Specification (excluding appendices) *Council staff*	Undated	20	*The Specification identifies system goals that are consistent with interviews. Additional points include:* *- That the provider would engage with diverse communities, potentially through the inclusion of specialist third sector organisations working with BME, LGBT and other populations* *- The Rellington City Council Strategic Commissioning Group reserve the right to amend the content and detail of the specification annually (or more often if needed) to take into account changes in policy, funding and needs.* *- The specification includes the full spectrum of interventions plus mentions several key areas of partnership working, priorities ease of access and navigation, and emphasises role of peer mentors and volunteers*
Frampton				
2.1	Alcohol and Drugs Harm Reduction "Plan on a Page" *Council staff*	2017	1	*This plan indicates the vision for Frampton in to reduce inequalities caused by alcohol – whereas reducing inequalities was not a strong feature of the interviews. Many of the priorities mentioned in interviews reflect those listed in the plan (for example partnership working), although the plan depicts a broader set of priorities not all of which featured strongly in the*

Doc number	Document type Author type	Year(s)	Pages/ slides	Contribution to case study (if relevant)†
				interviews (for example, achieving joint targets across substance use, mental health, housing and employment)
2.2*	Drug and Alcohol Consultation Update *Council staff*	2017	20	*This document is not for detailed analysis, but confirms interview account of extensive consultation feeding into specification development. Includes information about who was consulted and when, how they were consulted, what the outcome was and where and how this has been reflected in the service specification*
2.3*	Invitation to Tender – Service Specification *Council staff*	2017	45	*This document is not for detailed analysis, but is broadly consistent with interview accounts*
2.4	Members Briefing for Drug and Alcohol - powerpoint slides *Council staff*	Undated	25	*This presentation to council is highly consistent with interview accounts. One aspect less strongly covered in interviews was the working with families priority*
Goughsborough				
3.1	District Alcohol Related Harm Profile *External consultant*	2009	67	*Through its reference to previous strategies, superseded commissioning arrangements and organisations, etc, this document reinforces the idea of an evolving commissioning landscape. However, it shows some issues are perennial e.g. assertion that wrap around services are required, need for more engagement with underrepresented groups, need to improve data systems, etc. Confirms some interview content e.g. changes since then in national govt strategy, alcohol relatively under-funded*
3.2	Joint Strategic Needs Assessment *Council and Primary Care Trust staff*	2009	132	*This report provides local data for a broad range of health conditions and behaviours. Not sufficiently focussed on alcohol or recent enough to add to the case study*
3.3	District Alcohol Strategy	2012-15	38	*In relation to the Health and Treatment aspects of the strategy,*

Doc number	Document type Author type	Year(s)	Pages/ slides	Contribution to case study (if relevant)†
	Council staff			*this document confirmed commitment to ALS and PbR at that time, as well as support for linking with dual diagnosis and other MH services*
3.4	Goughsborough Health Profile *Council staff*	2013	4	*This profile document is in keeping with our characterisation of Goughsborough having a mixed alcohol profile relative to the national average*
3.5a 3.5b	Drug and Alcohol Community and Criminal Justice Service Review Questionnaire Survey Results *Council staff*	2013 2013	11 111	*Together, these documents confirmed consultation included a survey completed by 125 people, though this one was mostly completed by professionals/workers, rather than service users. Results showed a clear majority against PbR and in favour of local residential services, but only just over half favoured integration*
3.6a 3.6b	Service User Questionnaire Service User Results *Council staff*	2013 2013	2 2	*In contrast to service provider survey, less support for outreach (prefer fixed sites), but in favour of service integration and development of more recovery opportunities such as activities to stave off boredom and offer support*
3.7	Letter to Provider – Service Review *Council staff*	2013	1	*Letter confirms invitation to services to encourage staff, volunteers and service users to be involved in consultation (sent to service)*
3.8	Letter to Provider – TUPE *Council staff*	2013	1	*Letter seeking information potential TUPE liabilities demonstrates this information would have been given to any new bidders*
3.9	Results from Consultation Events *Council staff*	2013	18	*This feedback to stakeholders is consistent with that already covered by Doc 3.5a/b and 3.6 a/b). Support for increasing recovery opportunities and mixed views regarding service integration was reflected in the interviews*
3.10	Service Review Workshop powerpoint	2013	35	*The content of this presentation is consistent with other consultation*

Doc number	Document type Author type	Year(s)	Pages/ slides	Contribution to case study (if relevant)†
	Council staff			*summary documents and interviews*
3.11	Cabinet Paper: Substance Misuse Procurement *Council staff*	2014	11	*This document adds to the case study because it shows that cabinet were presented with three options (procure same service, procure integrated service with same budget, procure redesigned integrated service with efficiency savings), with the third being the recommended option and the one followed*
3.12	Substance Misuse Service Specification *Council staff*	2014	26	*The service specification is consistent with interview data regarding the intentions for the system, the scope and length of the contract, and (broadly speaking) the outcomes required. Additional useful information:* *- The maximum cost of the service is clearly identified. The price is to be fixed for a year and thereafter subject to annual review with provider encouraged to make within contract efficiencies.* *- Identifies that there will be TUPE liabilities* *- States that it is responsibility of provider to identify locations for service delivery, but encouraged that this should be a mix of fixed and community settings with co-location encouraged.* *- A highly detailed service framework is provided and interventions are required to be evidence-based, with reference made to relevant national standards*
3.13a 3.13b	Substance Misuse Recovery Service (Drugs & Alcohol): Invitation to Tender Part 1 Invitation to Tender Part 2 *Council staff*	2014 2014	17 28	*The document gives instructions to tenderers and information about rigour and transparency of process. Confirmed weighting between price and quality* *This document confirms bidders are required to prepare a written response for each aspect of the contract and that these are*

Doc number	Document type Author type	Year(s)	Pages/ slides	Contribution to case study (if relevant)†
				assessed according to a standard scoring matrix
3.14	Alcohol Liaison Service Exception Request *Council staff*	2015	5	*This document concerns extending the contractual arrangements for the Alcohol Liaison Service for an additional 2 years. This contract is separate to the main alcohol service contract. Extension allowable under EU procurement regulations*
3.15	Alcohol Liaison Service Review *Council staff*	2016	19	*This document confirms that the ALS is utilised and valued and there is a recommendation that ALS be continued*
3.16	State of the District Report *Council staff*	2017	44	*This document contains general health and wellbeing date for Goughsborough*
3.17	Local Alcohol Action Area (LAAA) Action Plan – spreadsheet *Council staff*	2017	1	*This document confirms interview accounts of a service system review*
Sandley				
4.1	Sandley Demographic profile *Unknown*	2013	6	*The sociodemographic profile of Sandley presented in this document is consistent with our information drawn from more recent government data sources*
4.2	Health & Wellbeing Strategy: Draft for consultation *Council staff*	2017-20	24	*The strategy has a specific section on alcohol, which is consistent with interview accounts of drive to improve linkage between primary care, hospital and services and focus on families*
4.3	Transformation of Sandley Substance Misuse Services – presentation to Health & Scrutiny Committee *Council staff*	2017	7	*Corroborated interview data by identifying the same context and drivers for system transformation (e.g. budget reduction, system complex and inefficient) as well as the same priorities (e.g. focus on improving recovery outcomes, single point of contact)*
4.4	Procurement Strategy for Transformation of Sandley Substance Misuse Services	2017	24	*None of the content contradicted interview data, however, additional points included:* - *Residential detoxification & residential services currently under a separate contract.*

Doc number	Document type Author type	Year(s)	Pages/ slides	Contribution to case study (if relevant)†
	Council staff			*This is to remain, but proposed that management of referral and expenditure be overseen within new contract* - *Commissioning with other boroughs (e.g. of resi rehabilitation services) was considered but not pursued due to differences in the population to be served and need to prioritise within-borough integration* - *Risks of failed procurement due to lack of interest mitigated through market testing and risk associated with TUPE implications managed by longer than standard contract submission and mobilisation periods*
4.5	Drug & Alcohol Recovery Service Specification *Council staff*	2017	36	*The specification was consistent with interview data. Additional information of note included:* *- the specific wording of the vision for the service* *- a specific point indicating that service provision was expected to be evidence based or where innovative, to be expert-led* *- providers should work to maximise the value offered by peer mentors (skills development, all service users offered peer mentor)*
4.6	Engagement, Involvement & Co-production in Sandley *Council staff*	2017	2	*The types of involvement described in this document are consistent with the interviews. The document confirms that service user involvement should be underpinned by wider insights and evidence to ensure the service best meets their needs*
4.7	Drug & Alcohol Treatment Pathways Map *Unknown*	Undated	2	*This is consistent with participant interviews describing multiple providers under the previous model*
Kelgate				

Doc number	Document type Author type	Year(s)	Pages/ slides	Contribution to case study (if relevant)†
5.1a	Kelgate Alcohol Harm Reduction Strategy	2006-09	28	*Taken together, these strategy documents are consistent with interview accounts of an increased focus on and investment in alcohol services, building up to a service system "heyday"*
5.1b	Kelgate Alcohol Strategy *Council staff*	2009-13	37	
5.2a	Kelgate Alcohol Misuse Needs Assessment Study Report *External consultant*	2009	147	*Taken together, these needs assessment documents are consistent with interview accounts of an increased focus on and investment in alcohol services followed by substantial disinvestment. Descriptions of change to the configuration of services and trends in alcohol indicator data over time were also consistent with interview accounts* *Doc 5.2b Describes a planned Assessment and Recovery Hub through which people can be signposted or referred to the most appropriate services*
5.2b	Kelgate Alcohol Health Needs Assessment *Public health registrar*	2012	104	
5.2c	Strategic Assessment of Crime, Antisocial Behaviour, Substance Misuse and Reoffending *Council staff*	2014-15	84	
5.3	Feedback to Kelgate *Alcohol Harm Reduction National Support Team (Department of Health)*	2010	46	*Given the date of this document (2010) and that it comments on a system that has since been remodelled following disinvestment, it does not contribute new material to the case study, other than to say external review of the Strategy suggested progress was being made. However, it is consistent with interview accounts of previously high levels of investment. Some of the suggestions made in this review are known to have been subsequently implemented. It is possible others may have either been implemented or superseded by a changing financial and strategic environment.*
5.4	Treatment Model Summary *Council staff*	2011	1	*This diagram is consistent with interview accounts of multiple providers within an alcohol specific (i.e. non-integrated) system*

Doc number	Document type Author type	Year(s)	Pages/ slides	Contribution to case study (if relevant)†
5.5a	Safer Kelgate Partnership Plan *Council staff*	2013-18	27	*Taken together, these safety partnership documents refer to many of the same alcohol harm reduction aspirations, actions and achievements outlined in other Kelgate strategy and needs assessment documents and are likewise consistent with interview accounts of the recent history of the local alcohol treatment system* *Doc 5.5b Data reported for alcohol hospital and numbers accessing treatment consistent with needs assessment documents (see Docs 5.2a-c)* *Doc 5.5 c adds to the case study by showing that: the integration of alcohol and other drug services into a single substance misuses service as a consequence of budget cuts has been acknowledged in a council report, further progress against some indicators is listed as requiring resource, one indicator has been abandoned as impossible, and that further budget cuts are anticipated*
5.5b	Safer Kelgate Partnership Delivery Plan *Council staff*	2014-15	28	
5.5c	Safer Kelgate Partnership Plan – 2016 Update *Council staff*	2016	25	
5.6	Alcohol Commissioning Plan – 2010/11-2014/15 *Council staff*	2009	24	*This document reports on a previous local alcohol plan and confirms there was previously wider activity*
5.7a*	Consultation Survey Report *Council staff*	2015-16	9	*These documents confirm interview accounts that a consultation survey was done (not for detailed reporting)*
5.7b*	Consultation Survey Comments	2016	5	
5.8*	Workforce Forecasting Document *Provider*	2016	4	*This document corroborates interview data regarding dialogue between commissioner and provider regarding provision options under reduced budget*
5.9	Award Entry *Council staff*	Undated	6	*Although the award entry was not a feature of the interviews, this document confirms the sense of pride some interviewees expressed in previous alcohol*

Doc number	Document type Author type	Year(s)	Pages/ slides	Contribution to case study (if relevant)†
				service investment in Kelgate, which has since been scaled back

* Document provided to the research team on the understanding that contents would not be reported in detail

† This appendix shows a summary of the key points arising from the documents relevant to the case study descriptions. A more extended version of the table showing more detail regarding document contents is available upon requ) (PHE, 2018c). In 2014/15, the estimated proportion of the population potentially in need of specialist treatment due to alcohol dependence was 2.5% (compared to the English average of 1.8%) and the estimated treatment access rate among those potentially in need of treatment was 13% (compared to the English average of 10.6%) (Brennan et al., 2016).

Case study data sources

Stakeholder interviews (Feb-Apr 2018)

- 5 x Commissioners
- 2 x Providers
- 2 x People with experience of service use before and after the change in provider

Documents

Three documents were provided relating to needs assessment, consultation processes, and service specification (**Error! Reference source not found.**, Doc 1.1-1.3).

Case overview

Past service provision

Prior to 2015, there were almost 30 different providers of alcohol and drug services across Rellington, with the service system overseen by the Drug and Alcohol Action team and funded via the pooled budgets of three Primary Care Trusts. Contracts were held by a range of third sector and NHS organisations with funding for alcohol services (of approximately £5 million) required to be distinct to that for other drug services.

The system was considered by participants to have been fragmented and confusing, with considerable duplication of expenditure. This view echoed the findings of a 2013-14 needs assessment [Doc 1.1]. A 2013 public consultation document [Doc 1.2] released by the local authority stated that the configuration of services needed to be “fundamentally reviewed” to develop a “coherent system”. Interview participants also reported concerns that the system inadvertently incentivised retaining clients who may have been better served elsewhere and also some concerns about minimum standards of practice, for example, with regards to safeguarding.

Drivers of the most recent commissioning process (2014-15)

The following factors were identified as influential in the most recent commissioning:

System co-ordination	There was a perceived need to establish a single, streamlined system to make it easier to access the system and to promote appropriate progression through it There was a desire to assign responsibility for some of the commissioning functions to a lead provider
Standardisation	There was a need to ensure consistent and appropriate responses across the service system, for example, in relation to working with families and safeguarding children
Budget cuts	Savings of approximately 35% were required in the substance misuse budget
Growing the recovery sector	Consistent with National level strategy and the local social values charter, there was a desire to strengthen this sector to help people prepare for employment and to better engage with hard to reach communities
Shift in commissioning responsibility	The shift in responsibility for the system from NHS to local authorities under the Health and Social Care Act 2012 (Great Britain Department of Health, 2012) was seen as an opportunity to ensure a consistent approach with other local level strategies and legislation [Doc 1.2]
Underrepresented groups	There was a desire to improve access for groups underrepresented in treatment compared to need, such as BME and LGBT [Doc 1.2]

Key features of the commissioning process

Duration	In keeping with the size of the system and the fundamental reconfiguration anticipated, the commissioning process in Rellington was lengthy, with consultation taking place in Sept 2013, the contract starting in March 2015 and the mobilisation process estimated by participants to have taken 8-12 months
Consultation / Engagement	Extensive consultation processes involved >150 stakeholders representing a range of roles within council (e.g. adult social care) and externally (e.g. police, probation, voluntary groups) Over 300 people using treatment services were consulted regarding their service delivery preferences [Doc 1.2] Consultation documents were made available on council website during the process
Specification development	Specification development was led by the local authority substance misuse lead, taking into account consultation feedback A multi-agency commissioning group, chaired by the Director of Public Health reviewed the specification

Elected members	Commissioning intentions required approval by Cabinet Commissioners ensured Cabinet Members were informed throughout the process, firstly about issues to be addressed and then about the developing approach so members would know what they were "signing up" for
Use of consultants	External consultants were appointed to support specification development, consultation and assessment of tenders. This enabled a temporary boost to commissioning capacity
Tender & selection process	Standard procurement processes were followed Consortia bids were encouraged as there was a need to demonstrate substantial turnover in order to take on an exceptionally large contract 4-5 bids were received A dialogue process between commissioners and bidders allowed tenders to be revised to better meet the commissioning requirements In assessing bids, weighting of responses was split between price, quality and social value The successful bidder was large enough to lead the contract on their own, could demonstrate how they would achieve the savings required and was able support staff development in key areas of practice

How savings were achieved

Consolidation of services and a shift to outreach working enabled savings to be made on "bricks and mortar".

Current service provision (launched March 2015)

Overarching goal	Creating a single system
Contract	Length is 5 + 2 years A small portion of the contract (10%) is Payment by Results
Provider type	The lead provider is a major national provider with a small consortia of organisations who provide specialist support in areas such as housing and employment Aspects of commissioning function previously undertaken by the local authority were "delegated" to the lead provider via their management of multiple subcontracts
Service provision	The service, available on an open access basis includes "all aspect of alcohol and drug interventions" [Doc 1.3] ranging from harm reduction, early interventions and engagement through to treatment including psychosocial interventions,

	clinical services, community interventions (e.g. day programmes) and residential services The provider is further required to demonstrate effective links with other services and recovery supports including mutual aid, criminal justice, and services specialising in family, housing, employment, and mental and physical health [Doc 1.3]
Location	The new model places greater emphasis on outreach work with a mobile workforce The service has a hub building in the centre of Rellington with outreach provision in GP practices and a variety of other community-settings such as libraries
Treatment model	A shortened treatment model developed by the national provider was implemented whereby clients can start and end treatment within 12 weeks
Paid staff	Staff were transferred from multiple previous providers following a detailed process of role matching There are now approximately 100 recovery coordinators working across the city (with varying proportions of alcohol clients on their caseloads)
Recovery options	Increased emphasis on involving people in recovery in supporting service delivery, with a large pool of peer mentors The Specification also emphasised a family approach [Doc 1.3]
Mobilisation	The mobilisation process started 12 months prior to the service going live The provider had an Implementation Team to plan and oversee the mobilisation process, drawing on the national-level resources and experience of the organisation An 'opt out' process of consent was followed for transferring client information from the outgoing providers to the new provider

Perceptions of the commissioning process and outcomes

This case study describes an unusually large scale commissioning exercise, with several participants spontaneously commenting on the overall size of the contract and the scale of system redesign that needed to be achieved. Given the time elapsed since the commissioning took place in 2014/15, a number of participants indicated they were now better able to comment on commissioning outcomes rather than processes. Among those able to comment on the process, it was generally perceived to have been well and transparently conducted, benefitting from experienced commissioners. The successful bidder committed to tendering for the work only after going through an internal 'due diligence' process of determining whether the specification requirements were a good fit

with their organisational position (for example in terms of the proposed system not being exclusively oriented towards either a recovery or harm reduction approach) and was financially viable to deliver. The successful bidder had a team of approximately 10 content experts (including, for example, safeguarding and finance).

The consolidation of the system was generally perceived to have reduced duplication and inefficiency. The lead provider now manages a supply chain of subcontractors (e.g. prescribing) and has greater strategic oversight (e.g. homelessness). Although it was not mentioned in the interviews, Specification also indicated that the provider would engage with diverse communities, potentially through the inclusion of specialist third sector organisations working with BME, LGBT and other populations [Doc 1.3]. This “delegation” of commissioning function was perceived by some as beneficial in the face of reduced capacity within the local authority to commission and manage the supply chain and was also seen to allow the provider some “flex” in responding to emerging demand across the system (and from the Specification it was apparent the local authority could require changes in the content of the contract, should changes in national policy, funding or local need necessitate this – Doc 1.3). However, such delegation was also recognised to place increased responsibility on the provider, with the cost and effort of fulfilling these functions incorporated within the total (reduced) contract value. It was also recognised that commissioners now have less direct contact with the market.

In terms of outcomes, the service delivery contract is monitored against a “high level” outcomes framework and there is also quarterly reporting against about 130 key performance indicators. A small portion of the contract (10%) was based on Payment by Results (PbR). The four areas included under this are successful completion of treatment, employment, criminal justice, and engagement with families in treatment planning, with each area having its own target (for example, for successful completions the aim is to perform in the top quartile within a comparable group of services). Otherwise, it was not clear from the interviews or Specification how prescriptive the contract is, for example, whether the contract requires a specific quantum of services to be delivered or specifies the number of posts required. There were mixed views about PbR, with some acknowledging the tension for providers in meeting targets in these areas while also trying to reduce harm among those clients who are currently unable to fully engage in treatment. Nonetheless, the service is perceived to be performing well against three of the targets and to have only been slightly under target in terms of successful completions. Interview participants indicated there was ongoing dialogue between the commissioners and providers regarding contract performance, with annual renegotiation of specific targets. Substantial improvements are also recognised to have been made in relation to safeguarding protocols and procedures, particularly around safeguarding of children. A view was also expressed that for staff consolidation may contribute to job security and standardisation of conditions and training.

There appears to have been a growing role within the system for people with direct experience of service use, either as a representatives, for example at local fora, or in mentoring others with alcohol problems. The skills and role of this group are seen to complement rather than replace the paid workforce. Participants generally favoured fostering the further growth of mutual support options in Rellington and the provider

organisation was said to be proactive “both politically and strategically” with the goal of strengthening opportunities for service users. A recovery training programme has been implemented with some participants since moving into employment.

It was acknowledged there have been challenges in realising the ambitions of the new service system model. For example, the new contract required a substantial cultural shift for many staff from working in separate, smaller services into a single large service. Further, although the model was underpinned by the notion delivering services to the communities “where people live”, the level of “transformational change” required was a difficult leap for some staff, especially the shift from general fixed location working to mobile outreach working, with just one “touch down” day a week. Such concerns were further compounded by technical issues regarding connectivity and equipment. At the time of interview, the service was responding to these challenges by putting in place some key locations for open access and clinical services, with the recovery-focussed elements remaining based in local communities and this was seen to be desirable for both staff and clients.

Regarding partnership working, as the provider has now been in place since 2015, their presence is well known among other relevant health, wellbeing and criminal justice services in Rellington. It was stated that there are “transparent pathways” for alcohol clients from these services into treatment (such as hospital liaison workers and links to primary care), although specific cases require dialogue to establish clarity about the roles of different organisations. An issue identified by several stakeholders as potentially requiring further attention was the acute alcohol-related workload of local Emergency Departments and the expectation by some in the community that this demand could or should be addressed by the provider, rather than through broader public health and other measures. However, participants themselves tended to reflect that while there was a role for the service provider in ensuring strong pathways to specialist treatment services, there were limits to the alcohol-related demand reduction work falling within their remit.

Horizon scanning

Going forward, the contract in Rellington is due for renewal in 2020 and commissioners anticipated that work towards this would begin in earnest in 2018. However, concerns were raised about the impending removal of the ring fence on public health grant money and the implications of this for the amount allocated to substance misuse. Efforts are already being made to protect funding by evidencing service impact and value for money. Additionally, some participants were keen to explore opportunities for joint commissioning to better address areas of need. For example, it was thought the provision of dual diagnosis services could be strengthened through partnering with Mental Health Trusts commissioned via Clinical Commissioning Groups and conversations were already underway regarding colocation with mental health workers. Similarly, conversations were underway with three hospitals to ensure coordination of actions with the local NHS trust area regarding use of bed space and other resources. Rellington is also taking up opportunities to take part in trials and initiatives developed elsewhere. For example, the local authority is to participate in a trial of personalised employment support for people accessing alcohol and drug treatment, and for the wider population, an intervention intended to reduce the serving of intoxicated people in on-licence venues.

Case study 2: Frampton

Site snapshot

Location and population

Frampton is a large rural county in the north of England with a population of approximately half a million people distributed across a large geographic area. The population is predominantly white (>98%) with a median age of 42 years (Office for National Statistics, 2018a). A quarter of Frampton's population (26%) live in the most deprived 30 per cent of LSOAs in England (i.e. 51-60/151 of local authorities ranked by deprivation on this measure) (Department for Communities and Local Government, 2015). Compared to national data, the rate of unemployment (5%) is slightly higher and the proportion of workless households (20%) much higher (Office for National Statistics, 2018b). The Council is controlled by Labour.

Alcohol-related health profile and treatment need

Frampton is worse than the national average on key alcohol indicators of alcohol consumption, hospitalisations and mortality (see

Doc number	Document type Author type	Year(s)	Pages/ slides	Contribution to case study (if relevant)†
Rellington				
1.1	Drug and Alcohol Needs Assessment *Council staff*	2013-14	174	*This document is consistent with interview accounts of system complexity prior to recommissioning and broad results of the consultation with some additional detail provided regarding needs assessment consultation methods. The document identifies 14 issues/areas of recommendation, almost all of which were mentioned in interviews with the exception of use of non-commissioned, charitable services to increase in-patient capacity and introduction of complex needs measure. This implies the subsequent recommissioning did in fact address most if not all of the recommendations.*
1.2	Substance Misuse Consultation Document *Council staff*	2013	9	*This document was consistent with interview accounts that the Rellington treatment system was seen to require "fundamental" review. Additional information not covered in interviews: Shift of responsibility to LAs seen as*

Doc number	Document type Author type	Year(s)	Pages/ slides	Contribution to case study (if relevant)[†]
				opportunity to articulate with other local strategies, desire to improve accessibility for hard to reach groups, number of people consulted
1.3	Service Specification (excluding appendices) *Council staff*	Undated	20	*The Specification identifies system goals that are consistent with interviews. Additional points include:* *- That the provider would engage with diverse communities, potentially through the inclusion of specialist third sector organisations working with BME, LGBT and other populations* *- The Rellington City Council Strategic Commissioning Group reserve the right to amend the content and detail of the specification annually (or more often if needed) to take into account changes in policy, funding and needs.* *- The specification includes the full spectrum of interventions plus mentions several key areas of partnership working, priorities ease of access and navigation, and emphasises role of peer mentors and volunteers*
Frampton				
2.1	Alcohol and Drugs Harm Reduction “Plan on a Page” *Council staff*	2017	1	*This plan indicates the vision for Frampton in to reduce inequalities caused by alcohol – whereas reducing inequalities was not a strong feature of the interviews. Many of the priorities mentioned in interviews reflect those listed in the plan (for example partnership working), although the plan depicts a broader set of priorities not all of which featured strongly in the interviews (for example, achieving joint targets across substance use, mental health, housing and employment)*
2.2*	Drug and Alcohol Consultation Update	2017	20	*This document is not for detailed analysis, but confirms interview account of extensive consultation*

Doc number	Document type Author type	Year(s)	Pages/ slides	Contribution to case study (if relevant)†
	Council staff			*feeding into specification development. Includes information about who was consulted and when, how they were consulted, what the outcome was and where and how this has been reflected in the service specification*
2.3*	Invitation to Tender – Service Specification *Council staff*	2017	45	*This document is not for detailed analysis, but is broadly consistent with interview accounts*
2.4	Members Briefing for Drug and Alcohol - powerpoint slides *Council staff*	Undated	25	*This presentation to council is highly consistent with interview accounts. One aspect less strongly covered in interviews was the working with families priority*
Goughsborough				
3.1	District Alcohol Related Harm Profile *External consultant*	2009	67	*Through its reference to previous strategies, superseded commissioning arrangements and organisations, etc, this document reinforces the idea of an evolving commissioning landscape. However, it shows some issues are perennial e.g. assertion that wrap around services are required, need for more engagement with underrepresented groups, need to improve data systems, etc. Confirms some interview content e.g. changes since then in national govt strategy, alcohol relatively under-funded*
3.2	Joint Strategic Needs Assessment *Council and Primary Care Trust staff*	2009	132	*This report provides local data for a broad range of health conditions and behaviours. Not sufficiently focussed on alcohol or recent enough to add to the case study*
3.3	District Alcohol Strategy *Council staff*	2012-15	38	*In relation to the Health and Treatment aspects of the strategy, this document confirmed commitment to ALS and PbR at that time, as well as support for linking with dual diagnosis and other MH services*
3.4	Goughsborough Health Profile	2013	4	*This profile document is in keeping with our characterisation of*

Doc number	Document type *Author type*	Year(s)	Pages/ slides	Contribution to case study (if relevant)†
	Council staff			*Goughsborough having a mixed alcohol profile relative to the national average*
3.5a 3.5b	Drug and Alcohol Community and Criminal Justice Service Review Questionnaire Survey Results *Council staff*	2013 2013	11 111	*Together, these documents confirmed consultation included a survey completed by 125 people, though this one was mostly completed by professionals/workers, rather than service users. Results showed a clear majority against PbR and in favour of local residential services, but only just over half favoured integration*
3.6a 3.6b	Service User Questionnaire Service User Results *Council staff*	2013 2013	2 2	*In contrast to service provider survey, less support for outreach (prefer fixed sites), but in favour of service integration and development of more recovery opportunities such as activities to stave off boredom and offer support*
3.7	Letter to Provider – Service Review *Council staff*	2013	1	*Letter confirms invitation to services to encourage staff, volunteers and service users to be involved in consultation (sent to service)*
3.8	Letter to Provider – TUPE *Council staff*	2013	1	*Letter seeking information potential TUPE liabilities demonstrates this information would have been given to any new bidders*
3.9	Results from Consultation Events *Council staff*	2013	18	*This feedback to stakeholders is consistent with that already covered by Doc 3.5a/b and 3.6 a/b). Support for increasing recovery opportunities and mixed views regarding service integration was reflected in the interviews*
3.10	Service Review Workshop powerpoint *Council staff*	2013	35	*The content of this presentation is consistent with other consultation summary documents and interviews*
3.11	Cabinet Paper: Substance Misuse Procurement *Council staff*	2014	11	*This document adds to the case study because it shows that cabinet were presented with three options (procure same service, procure integrated service with same budget, procure redesigned*

Doc number	Document type Author type	Year(s)	Pages/ slides	Contribution to case study (if relevant)†
				integrated service with efficiency savings), with the third being the recommended option and the one followed
3.12	Substance Misuse Service Specification *Council staff*	2014	26	*The service specification is consistent with interview data regarding the intentions for the system, the scope and length of the contract, and (broadly speaking) the outcomes required. Additional useful information:* *- The maximum cost of the service is clearly identified. The price is to be fixed for a year and thereafter subject to annual review with provider encouraged to make within contract efficiencies.* *- Identifies that there will be TUPE liabilities* *- States that it is responsibility of provider to identify locations for service delivery, but encouraged that this should be a mix of fixed and community settings with co-location encouraged.* *- A highly detailed service framework is provided and interventions are required to be evidence-based, with reference made to relevant national standards*
3.13a	Substance Misuse Recovery Service (Drugs & Alcohol): Invitation to Tender Part 1	2014	17	*The document gives instructions to tenderers and information about rigour and transparency of process. Confirmed weighting between price and quality*
3.13b	Invitation to Tender Part 2 *Council staff*	2014	28	*This document confirms bidders are required to prepare a written response for each aspect of the contract and that these are assessed according to a standard scoring matrix*
3.14	Alcohol Liaison Service Exception Request *Council staff*	2015	5	*This document concerns extending the contractual arrangements for the Alcohol Liaison Service for an additional 2 years. This contract is separate to the main alcohol service contract. Extension*

Doc number	Document type Author type	Year(s)	Pages/ slides	Contribution to case study (if relevant)†
				allowable under EU procurement regulations
3.15	Alcohol Liaison Service Review *Council staff*	2016	19	*This document confirms that the ALS is utilised and valued and there is a recommendation that ALS be continued*
3.16	State of the District Report *Council staff*	2017	44	*This document contains general health and wellbeing date for Goughsborough*
3.17	Local Alcohol Action Area (LAAA) Action Plan – spreadsheet *Council staff*	2017	1	*This document confirms interview accounts of a service system review*
Sandley				
4.1	Sandley Demographic profile *Unknown*	2013	6	*The sociodemographic profile of Sandley presented in this document is consistent with our information drawn from more recent government data sources*
4.2	Health & Wellbeing Strategy: Draft for consultation *Council staff*	2017-20	24	*The strategy has a specific section on alcohol, which is consistent with interview accounts of drive to improve linkage between primary care, hospital and services and focus on families*
4.3	Transformation of Sandley Substance Misuse Services – presentation to Health & Scrutiny Committee *Council staff*	2017	7	*Corroborated interview data by identifying the same context and drivers for system transformation (e.g. budget reduction, system complex and inefficient) as well as the same priorities (e.g. focus on improving recovery outcomes, single point of contact)*
4.4	Procurement Strategy for Transformation of Sandley Substance Misuse Services *Council staff*	2017	24	*None of the content contradicted interview data, however, additional points included:* - *Residential detoxification & residential services currently under a separate contract. This is to remain, but proposed that management of referral and expenditure be overseen within new contract* - *Commissioning with other boroughs (e.g. of resi rehabilitation services) was*

Doc number	Document type Author type	Year(s)	Pages/ slides	Contribution to case study (if relevant)†
				considered but not pursued due to differences in the population to be served and need to prioritise within-borough integration - *Risks of failed procurement due to lack of interest mitigated through market testing and risk associated with TUPE implications managed by longer than standard contract submission and mobilisation periods*
4.5	Drug & Alcohol Recovery Service Specification *Council staff*	2017	36	*The specification was consistent with interview data. Additional information of note included:* *- the specific wording of the vision for the service* *- a specific point indicating that service provision was expected to be evidence based or where innovative, to be expert-led* *- providers should work to maximise the value offered by peer mentors (skills development, all service users offered peer mentor)*
4.6	Engagement, Involvement & Co-production in Sandley *Council staff*	2017	2	*The types of involvement described in this document are consistent with the interviews. The document confirms that service user involvement should be underpinned by wider insights and evidence to ensure the service best meets their needs*
4.7	Drug & Alcohol Treatment Pathways Map *Unknown*	Undated	2	*This is consistent with participant interviews describing multiple providers under the previous model*
Kelgate				
5.1a 5.1b	Kelgate Alcohol Harm Reduction Strategy Kelgate Alcohol Strategy *Council staff*	2006-09 2009-13	28 37	*Taken together, these strategy documents are consistent with interview accounts of an increased focus on and investment in alcohol services, building up to a service system "heyday"*
5.2a	Kelgate Alcohol Misuse Needs	2009	147	*Taken together, these needs assessment documents are*

Doc number	Document type Author type	Year(s)	Pages/ slides	Contribution to case study (if relevant)†
	Assessment Study Report *External consultant*			*consistent with interview accounts of an increased focus on and investment in alcohol services followed by substantial disinvestment. Descriptions of change to the configuration of services and trends in alcohol indicator data over time were also consistent with interview accounts*
5.2b	Kelgate Alcohol Health Needs Assessment *Public health registrar*	2012	104	
5.2c	Strategic Assessment of Crime, Antisocial Behaviour, Substance Misuse and Reoffending *Council staff*	2014-15	84	*Doc 5.2b Describes a planned Assessment and Recovery Hub through which people can be signposted or referred to the most appropriate services*
5.3	Feedback to Kelgate *Alcohol Harm Reduction National Support Team (Department of Health)*	2010	46	*Given the date of this document (2010) and that it comments on a system that has since been remodelled following disinvestment, it does not contribute new material to the case study, other than to say external review of the Strategy suggested progress was being made. However, it is consistent with interview accounts of previously high levels of investment. Some of the suggestions made in this review are known to have been subsequently implemented. It is possible others may have either been implemented or superseded by a changing financial and strategic environment.*
5.4	Treatment Model Summary *Council staff*	2011	1	*This diagram is consistent with interview accounts of multiple providers within an alcohol specific (i.e. non-integrated) system*
5.5a	Safer Kelgate Partnership Plan *Council staff*	2013-18	27	*Taken together, these safety partnership documents refer to many of the same alcohol harm reduction aspirations, actions and achievements outlined in other Kelgate strategy and needs assessment documents and are*
5.5b	Safer Kelgate Partnership Delivery Plan *Council staff*	2014-15	28	

Doc number	Document type Author type	Year(s)	Pages/ slides	Contribution to case study (if relevant)†
5.5c	Safer Kelgate Partnership Plan – 2016 Update *Council staff*	2016	25	*likewise consistent with interview accounts of the recent history of the local alcohol treatment system* *Doc 5.5b Data reported for alcohol hospital and numbers accessing treatment consistent with needs assessment documents (see Docs 5.2a-c)* *Doc 5.5 c adds to the case study by showing that: the integration of alcohol and other drug services into a single substance misuses service as a consequence of budget cuts has been acknowledged in a council report, further progress against some indicators is listed as requiring resource, one indicator has been abandoned as impossible, and that further budget cuts are anticipated*
5.6	Alcohol Commissioning Plan – 2010/11-2014/15 *Council staff*	2009	24	*This document reports on a previous local alcohol plan and confirms there was previously wider activity*
5.7a*	Consultation Survey Report *Council staff*	2015-16	9	*These documents confirm interview accounts that a consultation survey was done (not for detailed reporting)*
5.7b*	Consultation Survey Comments	2016	5	
5.8*	Workforce Forecasting Document *Provider*	2016	4	*This document corroborates interview data regarding dialogue between commissioner and provider regarding provision options under reduced budget*
5.9	Award Entry *Council staff*	Undated	6	*Although the award entry was not a feature of the interviews, this document confirms the sense of pride some interviewees expressed in previous alcohol service investment in Kelgate, which has since been scaled back*

* Document provided to the research team on the understanding that contents would not be reported in detail

† This appendix shows a summary of the key points arising from the documents relevant to the case study descriptions. A more extended version of the table showing more detail regarding document contents is available upon requ) (PHE, 2018c). In 2014/15, the

estimated proportion of the population potentially in need of specialist treatment due to alcohol dependence was approximately 2.5% and the estimated treatment access rate among those potentially in need of treatment was 12.5% (Brennan et al., 2016).

Case study data sources

*Stakeholder Interviews (Feb-Apr 2018)**

- 2 x Commissioners
- 2 x Providers
- 1 x Person with experience of service use

*Interviews occurred during the mobilisation phase of the current contract

Documents

Four documents were provided including a summary harm reduction plan, consultation update, service specification, and elected members' briefing (**Error! Reference source not found.**, Doc 2.1-2.4), although we were requested not to report in detail on two of these.

Case overview

Past service provision

Prior to 2015, there were 23 different providers in Frampton, with alcohol and drug services typically provided separately and a lack of standardisation in delivery across services. The 2015 contract "pulled together" services under one integrated contract and staff began working across both alcohol and drugs with the intention that delivery be "about the person, rather than the substance". Some pathways were decommissioned at that time, including hospital liaison, the subsequent absence of which was particularly felt.

Between 2015 and 2017 the service was delivered by major national provider across six sites over a large geographic area, with prescribing subcontracted to an NHS Trust. There were three recovery programmes, one of which was 12-step based and offered residentially. The main provider went into administration in June 2017 and the contract was novated to another major national provider. In the meanwhile, consultation was underway regarding the next service provision contract.

Drivers of the most recent commissioning process (2016-17)

The following factors were identified as influential in the most recent commissioning:

Budget cuts	Interview accounts indicated cuts in the wider Public Health budget meant there was a need to reduce funding by £1.3 million. Figures from a Sept 2017 Cabinet report indicate this equates to an approximately 18% cut
Alcohol client numbers	Commissioner review of NDTMS data indicated alcohol clients were under-represented in the system compared to need

Reducing inequalities	Although not a strong feature of interview accounts, a substance misuse harm reduction plan summary (2017-20) states the vision Frampton is to "reduce the health, social and economic inequalities caused by alcohol and drugs posed to individuals, families and communities" [Doc 2.1]
Pathways into treatment	There was a desire to build/reintroduce more robust pathways into treatment (e.g. from criminal justice, primary care, hospital) and to strengthen links with partner agencies
Improving access over large geography	Although the existing services were previously delivered from six dispersed sites, these were not easily accessible from some areas of this large county. There was a desire to improve geographic accessibility

Key features of the commissioning process

Duration	The process was lengthy, lasting well over a year, partly due to extended consultation, as well as periods of 'purdah' The Invitation to Tender was issued Sept 2017, and the contract awarded in Nov 2017
Market testing	Initial market testing of potential providers was undertaken to inform specification development e.g. views on what services could and couldn't deliver, whether likely to form consortia
Consultation / Engagement	"Thorough" consultation was reportedly undertaken with a range of services, recovery groups, partner agencies and other stakeholders The consultation was fully documented (i.e. who consulted, when, by what method, what was the outcome, and where was this outcome reflected in the service specification, if relevant) [Doc 2.2]
Specification development	Specification development was driven by the Public Health portfolio lead, with in-house support from a Commissioning Officer and a 'fluid' procurement panel contributing expertise as required The specification was shared among senior Council management teams (e.g. public health, adults' social care and health, young people's health, etc) before sign off A specification checklist was used to ensure all elements covered and scrutinised by relevant departments (e.g. legal)
Elected members	Members were keenly interested and were briefed several times throughout the commissioning process [e.g. Doc 2.4]

	Members were very involved, to the extent they requested additional consultation before approving commissioning intentions
Tender & selection process	Bids were assessed by panel against set criteria. No presentation of bid was required 4 bids were received, of which 2 were competitive. The interim provider was unsuccessful The successful organisation had a business development team who ensured they met tender requirements, but the bid team also drew on other departments within their organisation to prepare tender e.g. young people and families The successful organisation were able to provide assurance about their ability to deliver community outreach services, including demonstrating links with partner agencies

How savings were achieved

There was a strong desire to protect service delivery and to enable this the decision was made to "claw back" expenditure on buildings rather than staff.

Current service provision (launched February 2018)

Overarching goal	Improved service visibility and accessibility via community outreach and a mobile workforce
Contract	Length is 2 + 1 years Provision of different aspects of service is mandated in contract, though not necessarily with specific targets attached (e.g. numbers entering treatment)
Provider type	The new lead provider is local charity based in Frampton, but providing services across the region in education, health and social care Two subcontractors (both not for profit social enterprises)
Service provision	The service covers full spectrum psychosocial and clinical treatment, community-based detoxification and recovery, with (some) residential rehabilitation Prescribing and recovery elements are subcontracted, residential detoxification places are spot purchased
Location	As the new service becomes fully operational, 3/6 fixed sites will close and the main hub will be open access with a duty worker There will instead be increased outreach to 7 satellite areas i.e. 10 locations served overall, some quite rural

Branding	Although there was a new provider appointed, the branding of the service was kept the same in order to provide continuity
Treatment pathways/model	A core aim is to strengthen pathways into treatment e.g. via primary care, hospital The treatment model currently under review, for example: The "Recovery Academy" is to be redeveloped and relaunched into an (up to) 6-month structured day programme, rather than 12-month residential programme People with less severe problems will be able to 'bypass' prolonged structured treatment and instead be linked directly to recovery services
Paid staff	Staff will have their employment, including terms and conditions transferred to the new provider and will be role-matched. Some redundancies are possible
Recovery options	There will be increased opportunities for recovery volunteers with greater scope of responsibilities (e.g. some now permitted to work alone) A small grant scheme will be established to which agencies for groups to develop further mutual aid/ recovery programmes/activities
Mobilisation	This process had just commenced at the time of interview, with details such as staff positions, outreach provision, and treatment model all still to be resolved

Perceptions of the commissioning process and anticipated outcomes

There was a recognition among participants that it had been "a very bumpy ride" for service provision in Frampton over the last three years. While the participants did not raise any concerns about the earlier 2015 decision to move from a multiple provider to a lead provider system, the ramifications of the failure of the first provider under this newly integrated system were still being felt at the time the third provider of this system was mobilising.

As elsewhere, the Frampton commissioner had the challenge of accommodating a substantial budget reduction. The purpose of the extensive engagement and consultation process described in this site was to firstly convey a realistic expectation of cuts, and then to "broker that conversation" about how to make savings while retaining service provision. The portfolio lead overseeing the commissioning drew on feedback from this process, as well as ongoing dialogue with internal and external partners and her own considerable experience of the sector to develop a "pragmatic" solution. This was to maximise ongoing provision through the decommissioning of buildings, rather than the decommissioning of services. It was reported that some people who access services were initially unhappy with the thought of specific sites closing, but found this to be more acceptable once the reasons and proposed alternative colocation and outreach plans

were explained. As not everyone likely to be affected by this change necessarily participated in the consultation, it was anticipated that further reassurance and "key messages" will be required in the transition to more outreach service delivery. Overall, there was a perception among participants that a good job had been done in protecting resources in the face of inevitable cutbacks.

At the time the Invitation to Tender was issued, some participants had anticipated that the national provider to whom the contract had been novated on an interim basis would most likely be the successful bidder. However, ultimately this was not the case and it was felt that the winning provider made the strongest case for a community based approach to delivery, helped by their existing local presence and footprint in the region. In preparing the tender, the organisation was able to convincingly demonstrate existing activity, links and resources within Frampton (for instance, they already work across a range of areas such as education, housing, and traveller engagement). They were therefore able to present themselves as a "safe" option.

A particularly important feature of this case study was the fact that the both the branding of the service and its information systems were 'owned' by the local authority. Therefore, at the time of any change in provider, the outward facing identity of the service should remain consistent and client data transfer simplified. Maintaining a constant identity was seen to contribute to keeping the service accessible, and therefore more resilient.

While this unchanging front face was seen to be particularly important for clients, the substantial disruption experienced by staff over the last few years was freely acknowledged, with some service staff reportedly on their fourth employer in three years. Uncertainty in the lead up to retendering had caused some staff to leave the previous provider organisation, affecting the delivery of recovery services in the short term. The prospect of further redundancies was mentioned in more than one interview, although views about the likely scale of this differed between participants. Efforts were being made to be sensitive to staff needs: for example, the intended gradual approach of the incoming provider to closing buildings, restructuring the staffing profile and role matching had been reviewed as a consequence of staff indicating they would prefer to "just get on with" the change process. The role of the volunteer recovery workforce was seen to have "blossomed" under the new contract, with further training provided, more days of work available and an increased scope of practice, for example, to run groups alone. This was anticipated to be a pathway to employment.

As the interviews in Frampton were conducted in the early stages of the mobilisation process, the outcomes of the new service provision arrangements for clients were not yet known. However, participants expressed both optimism and some reservations about the anticipated impact of moving to an increasingly outreach model of service delivery. For example, participants were mainly of the view that this model would help in reaching previously underserved populations, although some were concerned about how accessible services would really be, particularly among those who had lacked awareness about the available services even when they had been provided in fixed locations. Several participants commented favourably on the reinstitution of the hospital liaison role, believing from previous experience that this was an important pathway to services, and there were positive expectations of strengthened pathways into treatment from other

routes such as primary care and criminal justice. There were mixed views about reviewing the treatment model, in particular, the proposed shortening of the length of time in treatment and lesser use of residential services. Those who were positive about this felt many clients were well suited to shorter, community-based treatment in the “real world” rather in an institutional “bubble”, whereas others felt the more intensive options had previously worked well.

Horizon scanning

It was recognised that the role of the commissioner in Frampton had already expanded beyond substance misuse and was likely to do so further, which could in future limit capacity to manage this portfolio as closely as before. It was felt that with a 2 + 1 year contract, the first year would be taken up with embedding the new service and in the second year the provider would need to begin working towards securing the extension. Also considering resources, several participants identified the ongoing threat of reduced funding through the Public Health grant as a risk to service provision, with one commenting that this and increased provider workload could affect system performance. Nonetheless, there was some optimism about future commissioning, for example, the specification for the current contract deliberately promoted linkages between services and one person identified that these could be built on by future joint commissioning opportunities. A “brilliant” regional commissioning network was seen to provide an opportunity to give and receive support and share ideas.

Case study 3: Goughsborough

Site snapshot

Location and population

Goughsborough is classified as a rural-urban local authority and has a population of almost 350,000 people. The population ethnicity is mostly white (95%) and the median age is 41 years (Office for National Statistics, 2018a). A third of the population (31%) live in the most deprived 30 per cent of LSOAs in England (i.e. 41-50/152 most deprived local authority on this measure) (Department for Communities and Local Government, 2015). The unemployment rate in 2017/18 was almost 5%, slightly higher than the national average, while the proportion of workless households slightly lower (13.5%) (Office for National Statistics, 2018b). The Council is under Labour control.

Alcohol-related health profile and treatment need

Goughsborough has a mixed profile compared to the national average on a range of key alcohol indicators, for example having lower admission rates for alcohol specific conditions, but a higher rate of deaths from liver disease (PHE, 2018c) (also see

Doc number	Document type Author type	Year(s)	Pages/ slides	Contribution to case study (if relevant)†
Rellington				
1.1	Drug and Alcohol Needs Assessment *Council staff*	2013-14	174	*This document is consistent with interview accounts of system complexity prior to recommissioning and broad results of the consultation with some additional detail provided regarding needs assessment consultation methods. The document identifies 14 issues/areas of recommendation, almost all of which were mentioned in interviews with the exception of use of non-commissioned, charitable services to increase in-patient capacity and introduction of complex needs measure. This implies the subsequent recommissioning did in fact address most if not all of the recommendations.*
1.2	Substance Misuse Consultation Document *Council staff*	2013	9	*This document was consistent with interview accounts that the Rellington treatment system was seen to require "fundamental" review. Additional information not covered in interviews: Shift of responsibility to LAs seen as*

Doc number	Document type Author type	Year(s)	Pages/ slides	Contribution to case study (if relevant)†
				opportunity to articulate with other local strategies, desire to improve accessibility for hard to reach groups, number of people consulted
1.3	Service Specification (excluding appendices) *Council staff*	Undated	20	*The Specification identifies system goals that are consistent with interviews. Additional points include:* *- That the provider would engage with diverse communities, potentially through the inclusion of specialist third sector organisations working with BME, LGBT and other populations* *- The Rellington City Council Strategic Commissioning Group reserve the right to amend the content and detail of the specification annually (or more often if needed) to take into account changes in policy, funding and needs.* *- The specification includes the full spectrum of interventions plus mentions several key areas of partnership working, priorities ease of access and navigation, and emphasises role of peer mentors and volunteers*
Frampton				
2.1	Alcohol and Drugs Harm Reduction "Plan on a Page" *Council staff*	2017	1	*This plan indicates the vision for Frampton in to reduce inequalities caused by alcohol – whereas reducing inequalities was not a strong feature of the interviews. Many of the priorities mentioned in interviews reflect those listed in the plan (for example partnership working), although the plan depicts a broader set of priorities not all of which featured strongly in the interviews (for example, achieving joint targets across substance use, mental health, housing and employment)*
2.2*	Drug and Alcohol Consultation Update	2017	20	*This document is not for detailed analysis, but confirms interview account of extensive consultation*

Doc number	Document type Author type	Year(s)	Pages/ slides	Contribution to case study (if relevant)†
	Council staff			*feeding into specification development. Includes information about who was consulted and when, how they were consulted, what the outcome was and where and how this has been reflected in the service specification*
2.3*	Invitation to Tender – Service Specification *Council staff*	2017	45	*This document is not for detailed analysis, but is broadly consistent with interview accounts*
2.4	Members Briefing for Drug and Alcohol - powerpoint slides *Council staff*	Undated	25	*This presentation to council is highly consistent with interview accounts. One aspect less strongly covered in interviews was the working with families priority*
Goughsborough				
3.1	District Alcohol Related Harm Profile *External consultant*	2009	67	*Through its reference to previous strategies, superseded commissioning arrangements and organisations, etc, this document reinforces the idea of an evolving commissioning landscape. However, it shows some issues are perennial e.g. assertion that wrap around services are required, need for more engagement with underrepresented groups, need to improve data systems, etc. Confirms some interview content e.g. changes since then in national govt strategy, alcohol relatively under-funded*
3.2	Joint Strategic Needs Assessment *Council and Primary Care Trust staff*	2009	132	*This report provides local data for a broad range of health conditions and behaviours. Not sufficiently focussed on alcohol or recent enough to add to the case study*
3.3	District Alcohol Strategy *Council staff*	2012-15	38	*In relation to the Health and Treatment aspects of the strategy, this document confirmed commitment to ALS and PbR at that time, as well as support for linking with dual diagnosis and other MH services*
3.4	Goughsborough Health Profile	2013	4	*This profile document is in keeping with our characterisation of*

Doc number	Document type Author type	Year(s)	Pages/ slides	Contribution to case study (if relevant)†
	Council staff			*Goughsborough having a mixed alcohol profile relative to the national average*
3.5a 3.5b	Drug and Alcohol Community and Criminal Justice Service Review Questionnaire Survey Results *Council staff*	2013 2013	11 111	*Together, these documents confirmed consultation included a survey completed by 125 people, though this one was mostly completed by professionals/workers, rather than service users. Results showed a clear majority against PbR and in favour of local residential services, but only just over half favoured integration*
3.6a 3.6b	Service User Questionnaire Service User Results *Council staff*	2013 2013	2 2	*In contrast to service provider survey, less support for outreach (prefer fixed sites), but in favour of service integration and development of more recovery opportunities such as activities to stave off boredom and offer support*
3.7	Letter to Provider – Service Review *Council staff*	2013	1	*Letter confirms invitation to services to encourage staff, volunteers and service users to be involved in consultation (sent to service)*
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3.10	Service Review Workshop powerpoint *Council staff*	2013	35	*The content of this presentation is consistent with other consultation summary documents and interviews*
3.11	Cabinet Paper: Substance Misuse Procurement *Council staff*	2014	11	*This document adds to the case study because it shows that cabinet were presented with three options (procure same service, procure integrated service with same budget, procure redesigned*

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				integrated service with efficiency savings), with the third being the recommended option and the one followed
3.12	Substance Misuse Service Specification *Council staff*	2014	26	*The service specification is consistent with interview data regarding the intentions for the system, the scope and length of the contract, and (broadly speaking) the outcomes required. Additional useful information:* *- The maximum cost of the service is clearly identified. The price is to be fixed for a year and thereafter subject to annual review with provider encouraged to make within contract efficiencies.* *- Identifies that there will be TUPE liabilities* *- States that it is responsibility of provider to identify locations for service delivery, but encouraged that this should be a mix of fixed and community settings with co-location encouraged.* *- A highly detailed service framework is provided and interventions are required to be evidence-based, with reference made to relevant national standards*
3.13a 3.13b	Substance Misuse Recovery Service (Drugs & Alcohol): Invitation to Tender Part 1 Invitation to Tender Part 2 *Council staff*	2014 2014	17 28	*The document gives instructions to tenderers and information about rigour and transparency of process. Confirmed weighting between price and quality* *This document confirms bidders are required to prepare a written response for each aspect of the contract and that these are assessed according to a standard scoring matrix*
3.14	Alcohol Liaison Service Exception Request *Council staff*	2015	5	*This document concerns extending the contractual arrangements for the Alcohol Liaison Service for an additional 2 years. This contract is separate to the main alcohol*

Doc number	Document type Author type	Year(s)	Pages/ slides	Contribution to case study (if relevant)†
				service contract. Extension allowable under EU procurement regulations
3.15	Alcohol Liaison Service Review *Council staff*	2016	19	*This document confirms that the ALS is utilised and valued and there is a recommendation that ALS be continued*
3.16	State of the District Report *Council staff*	2017	44	*This document contains general health and wellbeing date for Goughsborough*
3.17	Local Alcohol Action Area (LAAA) Action Plan – spreadsheet *Council staff*	2017	1	*This document confirms interview accounts of a service system review*
Sandley				
4.1	Sandley Demographic profile *Unknown*	2013	6	*The sociodemographic profile of Sandley presented in this document is consistent with our information drawn from more recent government data sources*
4.2	Health & Wellbeing Strategy: Draft for consultation *Council staff*	2017-20	24	*The strategy has a specific section on alcohol, which is consistent with interview accounts of drive to improve linkage between primary care, hospital and services and focus on families*
4.3	Transformation of Sandley Substance Misuse Services – presentation to Health & Scrutiny Committee *Council staff*	2017	7	*Corroborated interview data by identifying the same context and drivers for system transformation (e.g. budget reduction, system complex and inefficient) as well as the same priorities (e.g. focus on improving recovery outcomes, single point of contact)*
4.4	Procurement Strategy for Transformation of Sandley Substance Misuse Services *Council staff*	2017	24	*None of the content contradicted interview data, however, additional points included:* - *Residential detoxification & residential services currently under a separate contract. This is to remain, but proposed that management of referral and expenditure be overseen within new contract* - *Commissioning with other boroughs (e.g. of resi*

Doc number	Document type Author type	Year(s)	Pages/ slides	Contribution to case study (if relevant)†
				rehabilitation services) was considered but not pursued due to differences in the population to be served and need to prioritise within-borough integration - *Risks of failed procurement due to lack of interest mitigated through market testing and risk associated with TUPE implications managed by longer than standard contract submission and mobilisation periods*
4.5	Drug & Alcohol Recovery Service Specification *Council staff*	2017	36	*The specification was consistent with interview data. Additional information of note included:* *- the specific wording of the vision for the service* *- a specific point indicating that service provision was expected to be evidence based or where innovative, to be expert-led* *- providers should work to maximise the value offered by peer mentors (skills development, all service users offered peer mentor)*
4.6	Engagement, Involvement & Co-production in Sandley *Council staff*	2017	2	*The types of involvement described in this document are consistent with the interviews. The document confirms that service user involvement should be underpinned by wider insights and evidence to ensure the service best meets their needs*
4.7	Drug & Alcohol Treatment Pathways Map *Unknown*	Undated	2	*This is consistent with participant interviews describing multiple providers under the previous model*
Kelgate				
5.1a 5.1b	Kelgate Alcohol Harm Reduction Strategy Kelgate Alcohol Strategy *Council staff*	2006-09 2009-13	28 37	*Taken together, these strategy documents are consistent with interview accounts of an increased focus on and investment in alcohol services, building up to a service system "heyday"*

Doc number	Document type Author type	Year(s)	Pages/ slides	Contribution to case study (if relevant)†
5.2a	Kelgate Alcohol Misuse Needs Assessment Study Report *External consultant*	2009	147	*Taken together, these needs assessment documents are consistent with interview accounts of an increased focus on and investment in alcohol services followed by substantial disinvestment. Descriptions of change to the configuration of services and trends in alcohol indicator data over time were also consistent with interview accounts* *Doc 5.2b Describes a planned Assessment and Recovery Hub through which people can be signposted or referred to the most appropriate services*
5.2b	Kelgate Alcohol Health Needs Assessment *Public health registrar*	2012	104	
5.2c	Strategic Assessment of Crime, Antisocial Behaviour, Substance Misuse and Reoffending *Council staff*	2014-15	84	
5.3	Feedback to Kelgate *Alcohol Harm Reduction National Support Team (Department of Health)*	2010	46	*Given the date of this document (2010) and that it comments on a system that has since been remodelled following disinvestment, it does not contribute new material to the case study, other than to say external review of the Strategy suggested progress was being made. However, it is consistent with interview accounts of previously high levels of investment. Some of the suggestions made in this review are known to have been subsequently implemented. It is possible others may have either been implemented or superseded by a changing financial and strategic environment.*
5.4	Treatment Model Summary *Council staff*	2011	1	*This diagram is consistent with interview accounts of multiple providers within an alcohol specific (i.e. non-integrated) system*
5.5a	Safer Kelgate Partnership Plan *Council staff*	2013-18	27	*Taken together, these safety partnership documents refer to many of the same alcohol harm reduction aspirations, actions and achievements outlined in other Kelgate strategy and needs assessment documents and are*
5.5b	Safer Kelgate Partnership Delivery Plan *Council staff*	2014-15	28	

Doc number	Document type Author type	Year(s)	Pages/ slides	Contribution to case study (if relevant)†
5.5c	Safer Kelgate Partnership Plan – 2016 Update *Council staff*	2016	25	*likewise consistent with interview accounts of the recent history of the local alcohol treatment system* *Doc 5.5b Data reported for alcohol hospital and numbers accessing treatment consistent with needs assessment documents (see Docs 5.2a-c)* *Doc 5.5 c adds to the case study by showing that: the integration of alcohol and other drug services into a single substance misuses service as a consequence of budget cuts has been acknowledged in a council report, further progress against some indicators is listed as requiring resource, one indicator has been abandoned as impossible, and that further budget cuts are anticipated*
5.6	Alcohol Commissioning Plan – 2010/11-2014/15 *Council staff*	2009	24	*This document reports on a previous local alcohol plan and confirms there was previously wider activity*
5.7a*	Consultation Survey Report *Council staff*	2015-16	9	*These documents confirm interview accounts that a consultation survey was done (not for detailed reporting)*
5.7b*	Consultation Survey Comments	2016	5	
5.8*	Workforce Forecasting Document *Provider*	2016	4	*This document corroborates interview data regarding dialogue between commissioner and provider regarding provision options under reduced budget*
5.9	Award Entry *Council staff*	Undated	6	*Although the award entry was not a feature of the interviews, this document confirms the sense of pride some interviewees expressed in previous alcohol service investment in Kelgate, which has since been scaled back*

* Document provided to the research team on the understanding that contents would not be reported in detail

† This appendix shows a summary of the key points arising from the documents relevant to the case study descriptions. A more extended version of the table showing more detail regarding document contents is available upon requ). In 2014/15, the estimated

proportion of the population potentially in need of specialist treatment due to alcohol dependence was almost 2% and the estimated treatment access rate among those potentially in need of treatment was 11% (Brennan et al., 2016).

Case study data sources

Stakeholder interviews (Dec 2017- May 2018)

- 3 x Commissioners
- 4 x Providers

Documents

Twenty documents were provided relating to needs assessment, consultation processes and feedback, service specification and invitation to tender (**Error! Reference source not found.**, Doc 3.1-3.17)

Case overview

Past service provision

Goughsborough has been served by a voluntary sector organisation for over 20 years, with historically separate provision of alcohol and drug services (i.e. prior to 2015). The alcohol service provided a comprehensive range of interventions including psycho-social interventions, group work, outreach worker, GP liaison worker, hospital liaison worker and community detoxification and referral for residential treatment. Clinical services were provided by another organisation via the local NHS Primary Care Trust. From 2012-2015 Goughsborough participated in a pilot "Payment by Results" (PbR) scheme [as consistent with the Local Alcohol Strategy of the time – Doc 3.3].

Drivers of the most recent commissioning process (2014-15)

The following factors were identified as influential in the most recent commissioning:

Budget cuts	Cuts of 20-30% were required for the 2015 contract
Gap in alcohol service provision	There was perceived under provision of alcohol services, which some participants partly attributed to previous funding arrangements whereby the budget allocation from the National Treatment Agency (which has since been merged with PHE)was earmarked for other substance use services rather than alcohol
Underrepresented groups	There was a perceived need to better engage with and overcome barriers to access for certain populations including families and BME
Strategic focus on recovery	The recovery focus of the 2010 National Drug Strategy (as opposed to the previous focus on maintenance and harm reduction) was adopted locally to give greater emphasis to those factors perceived to support recovery e.g. employment

Key features of the commissioning process

Duration	Overall the process took approximately 18 months
Consultation / Engagement	A 2013 service review involved consultation via online survey as well as face-to-face meetings and events with members of the public, staff from the current service providers and service users This consultation found service users were generally supportive of integrating services while providers had mixed views Service users favoured strengthening recovery opportunities and had reservations about outreach working A clear majority of providers were opposed to PbR [Docs 3.5a, 3.5b, 3.6a, 3.6b, 3.9, 3.10]
Specification development	The development of the specification was led by the Public Health principal responsible for substance misuse services with support from colleagues with procurement expertise Commissioners drew on a range of information sources such the “evidence base”, published literature, guidelines, consultation feedback and personal experience to understand the scale of need and to decide the preferred way forward The specification was also shaped by pragmatism; from an initial service provision “wish list”, some aspects were scaled back in order to be realistic for a service provider to deliver within budget The specification identified the maximum budget for the service, the service delivery requirements and TUPE liabilities, and made it clear that there may be further within contract cuts [Doc 3.12]
Elected members	Given the value of the contract and relevance to all council wards, approval of the specification rested with Cabinet Regular briefings were provided to the elected member with relevant portfolio responsibility before being taken forward for discussion with the full Cabinet Cabinet were presented with three options. Broadly these were; procure the same service, procure an integrated service with same budget, or procure a redesigned integrated service with efficiency savings, with a recommendation for the third option, which was followed [Doc 3.11]
Tender & selection process	The tender process was perceived to be well-managed and with clear expectations

	The ITT documentation clearly laid out the scoring matrix and tender assessment weighting (80:20 quality to price) [Docs 3.13a, 3.13b] Although it was hoped the Invitation to Tender would attract several bids, there was only one bid received and this was from the existing provider

How savings were achieved

Savings were primarily achieved via the integration of alcohol services with substance misuse services.

Current service provision (launched April 2015)

Overarching goal	Inspiring recovery
Contract	Length is 3 + 1 + 1 years
Provider type	The contract was awarded to an existing social enterprise provider Clinical services were subcontracted a second existing social enterprise provider Both providers operate beyond Goughsborough, but have a longstanding local presence
Service provision	The main integrated substance misuse contract includes one-to-one case management support, group work, family support, peer mentoring programme, a recovery worker, outreach and satellite services, needle exchange, education, training and employment support, aftercare activities, preparation for and referral to residential rehabilitation and criminal justice linkage Clinical services include nurse led detox clinics, prescribing services, and shared care The subcontractor is also separately commissioned by the local authority to provide alcohol liaison services at the acute NHS trust. A recent review indicates this is a valued service [Docs 3.14, 3.15]
Location	The service was consolidated into a single building, with one other building being closed It was the responsibility of the bidder to identify service delivery location(s), though a mix of fixed and community sites were recommended in the Specification [Doc 3.12]
Branding	The decision was made to rebrand the newly integrated service entirely, so that alcohol clients would not be dissuaded from attending a service they perceive to be for drug clients

	Responsibility for rebranding rested with the provider, although Council will from now on retain the name [Doc 3.12]
Treatment pathways & model	Each client has an individualised care plan and an assigned worker who helps ensure there is appropriate treatment 'wrap-around' e,g. risk assessment, safeguarding, pre-detox preparation & support, mutual aid, post treatment training & employment support Greater use of group work than previously, with different options available depending on need (e.g. whether or not dependent)
Paid staff	There were a small number of workers made redundant Alcohol & drug workers are now called 'recovery workers' Recovery workers all now have an integrated caseload (i.e. both alcohol and drug)
Recovery options	There is an aspect of the service is intended to help people "connect" recovery supports and opportunities, such as hospitality training There is an increased offer around maintaining abstinence, including a mindfulness group and online interventions accessible via a special link
Mobilisation	Estimated from documents to be 5 months [Doc 3.12, Doc 3.13a - procurement to be completed by Oct 2014 and contract to 'go live' in April 2015]

Perceptions of the commissioning process and outcomes

This commissioning process was the first to be conducted in Goughsborough since responsibility for provision of alcohol services transferred to the local authority. While the scale of budget cuts required were seen to be a key driver of the efficiency savings delivered under the new contract, there was nonetheless general agreement among interview participants that consolidating resources into an integrated, recovery-focussed service was the right direction for this local authority to take. The views of a wide range of stakeholders were sought during the consultation stage. Survey and meeting feedback revealed the increased emphasis on recovery support was widely favoured, and further, that service users in particular were supportive of system integration [Docs 3.5a, 3.5b, 3.6a. 3.6b]). Views amongst service providers were reportedly more mixed with some misgivings about the potential implications of combining alcohol and drug services for people seeking treatment primarily for alcohol use. Stakeholders did not favour continuation of the PbR approach as this was seen to focus on a narrow set of indicators [Doc 3.5a, 3.5b], a preference which was ultimately reflected in the new contract. Interview participants indicated elected members were keenly interested in and regularly updated about the commissioning process and were particularly concerned about the potential implications of budget reductions for different groups (e.g. as defined by locality or vulnerability) and how these risks could be mitigated.

The opportunity to tender for the contract was shared via a portal monitored by a range of service providers. However, to the disappointment of commissioners who wanted there to be at least some competition to compare with, the existing provider was the only organisation to bid for the contract. Despite it being a one horse race, the standard assessment process was implemented, with the bid being scored by a panel against a pre-determined matrix, including minimum quality requirements (e.g. in relation to safeguarding). This transparent and rigorous process showed the existing provider to be a worthy winner of the contract and the provider interview participants confirmed they had invested considerable time and energy in preparing their submission. It was speculated that other providers may have been deterred from bidding by the longstanding presence of and partnership between the main provider and subcontractor in Goughsborough.

The specification [Doc 3.12] required the development of a fresh brand for the newly integrated recovery service (with the service reception to be located in what had been the drug service). This was to address concerns regarding potential reluctance among clients with alcohol problems to attend a service they perceived to be for people who use drugs. However, the intention to achieve this rebranding within a 4-5 month mobilisation time frame proved too ambitious. In practice it took a year before all aspects of the rebranding were achieved - including service user involvement in developing a new name and visual identity to convey a sense of optimism, changing signage and literature, updating the website and marketing. At the time of interviews, the rebranding was perceived to have been only partially successful in making the service more broadly appealing; participants felt there may have been a fall in the number of alcohol-related referrals to the integrated service compared to the previous alcohol service. However, a participant also commented on the difficulty of assessing the short term impact of the service reconfiguration and rebranding using standard national indicators such as treatment intake and successful completion rates. It was felt that with a reduced budget, merged services, and a different treatment model, “we’re not comparing like with like”. The contract also includes quarterly reporting on service user feedback and other recovery outcomes such as employment, although participants did not discuss these outcomes in depth.

Consistent with the recovery orientation of the service, participants also reported that a cultural shift was required in how staff work with clients, from a model of longer-term treatment (with a stronger focus on maintenance and harm minimisation approaches), to a generally far more time limited and goal directed approach (with an explicit focus towards positive treatment exits). This change in orientation has been challenging for some staff and there were a small number who chose to leave. Aside from this, participants were largely positive about the opportunity the recovery model offered to work more innovatively with clients and families. Another perceived consequence of the reduced funding has been more limited capacity for the service to undertake outreach work or to provide additional service such as interpreters. There was also a view expressed that going forward it will be important that ‘upstream’ work (for example GP intervention) continues even in a recovery-oriented system.

Horizon scanning

It was noted that the involvement of some local partners in the alcohol agenda had weakened in recent years, coinciding with the move in responsibility for the provision of alcohol services to Public Health and the drop in public sector capacity more generally (for example, participants mentioned previously stronger links with probation, mental health, police and housing). Pooled treatment budgets with partner organisations had in the past helped to support pathways to treatment and such arrangements have not been fully replaced, although there are some opportunities through the Better Care Fund(NHS England) to work with the local CCG to address the needs of vulnerable people. In terms of the hospital pathway, plans to screen more patients for alcohol problems may generate an increase in referrals and it is not yet clear what capacity will be needed to meet this. It was felt that due to a growing portfolio of responsibility and reduced administrative support local authority commissioners commonly now have fewer opportunities to meet with and learn from colleagues in other local authority areas. However, participants were optimistic that this will change as a group of commissioners in the region have recently begun meeting informally to share experiences. Concerns were expressed about needing to commence the next procurement process in 2018 when services and the people who use them have only just adjusted to the new integrated model. It was suggested that providers may not be able to absorb further budget cuts without negatively affecting capacity, penetration and quality of services. Some felt short contract lengths coupled with more budget cuts could make future provision untenable and influence decisions to tender.

Case study 4: Sandley

Site snapshot

Location and population

Sandley is a densely populated London borough of almost quarter of a million people. The majority of Sandley's population is White (68%), with 13% Black and 9% Asian (and all other groups <5%). Compared to national data, Sandley has a young population (median age of 31 years compared to 39 years) (Office for National Statistics, 2018a). Forty-two percent of the population live in the most deprived 30 per cent of LSOAs nationally (i.e. 21-30/152 most deprived local authority on this measure) (Department for Communities and Local Government, 2015). The 2017/18 rate of unemployment (approximately 5%) was slightly higher than the national average as was the proportion of workless households (16%) (Office for National Statistics, 2018b). The Council has been under Labour control since 2010.

Alcohol-related health profile and treatment need

Sandley is similar to the national average on consumption and alcohol related mortality indicators although worse in terms of hospitalisations (also see

Doc number	Document type Author type	Year(s)	Pages/ slides	Contribution to case study (if relevant)†
Rellington				
1.1	Drug and Alcohol Needs Assessment *Council staff*	2013-14	174	*This document is consistent with interview accounts of system complexity prior to recommissioning and broad results of the consultation with some additional detail provided regarding needs assessment consultation methods. The document identifies 14 issues/areas of recommendation, almost all of which were mentioned in interviews with the exception of use of non-commissioned, charitable services to increase in-patient capacity and introduction of complex needs measure. This implies the subsequent recommissioning did in fact address most if not all of the recommendations.*
1.2	Substance Misuse Consultation Document *Council staff*	2013	9	*This document was consistent with interview accounts that the Rellington treatment system was seen to require "fundamental" review. Additional information not covered in interviews: Shift of*

Doc number	Document type Author type	Year(s)	Pages/ slides	Contribution to case study (if relevant)[†]
				responsibility to LAs seen as opportunity to articulate with other local strategies, desire to improve accessibility for hard to reach groups, number of people consulted
1.3	Service Specification (excluding appendices) *Council staff*	Undated	20	*The Specification identifies system goals that are consistent with interviews. Additional points include:* *- That the provider would engage with diverse communities, potentially through the inclusion of specialist third sector organisations working with BME, LGBT and other populations* *- The Rellington City Council Strategic Commissioning Group reserve the right to amend the content and detail of the specification annually (or more often if needed) to take into account changes in policy, funding and needs.* *- The specification includes the full spectrum of interventions plus mentions several key areas of partnership working, priorities ease of access and navigation, and emphasises role of peer mentors and volunteers*
Frampton				
2.1	Alcohol and Drugs Harm Reduction "Plan on a Page" *Council staff*	2017	1	*This plan indicates the vision for Frampton in to reduce inequalities caused by alcohol – whereas reducing inequalities was not a strong feature of the interviews. Many of the priorities mentioned in interviews reflect those listed in the plan (for example partnership working), although the plan depicts a broader set of priorities not all of which featured strongly in the interviews (for example, achieving joint targets across substance use, mental health, housing and employment)*

Doc number	Document type Author type	Year(s)	Pages/ slides	Contribution to case study (if relevant)†
2.2*	Drug and Alcohol Consultation Update *Council staff*	2017	20	*This document is not for detailed analysis, but confirms interview account of extensive consultation feeding into specification development. Includes information about who was consulted and when, how they were consulted, what the outcome was and where and how this has been reflected in the service specification*
2.3*	Invitation to Tender – Service Specification *Council staff*	2017	45	*This document is not for detailed analysis, but is broadly consistent with interview accounts*
2.4	Members Briefing for Drug and Alcohol - powerpoint slides *Council staff*	Undated	25	*This presentation to council is highly consistent with interview accounts. One aspect less strongly covered in interviews was the working with families priority*
Goughsborough				
3.1	District Alcohol Related Harm Profile *External consultant*	2009	67	*Through its reference to previous strategies, superseded commissioning arrangements and organisations, etc, this document reinforces the idea of an evolving commissioning landscape. However, it shows some issues are perennial e.g. assertion that wrap around services are required, need for more engagement with underrepresented groups, need to improve data systems, etc. Confirms some interview content e.g. changes since then in national govt strategy, alcohol relatively under-funded*
3.2	Joint Strategic Needs Assessment *Council and Primary Care Trust staff*	2009	132	*This report provides local data for a broad range of health conditions and behaviours. Not sufficiently focussed on alcohol or recent enough to add to the case study*
3.3	District Alcohol Strategy *Council staff*	2012-15	38	*In relation to the Health and Treatment aspects of the strategy, this document confirmed commitment to ALS and PbR at that time, as well as support for*

Doc number	Document type Author type	Year(s)	Pages/ slides	Contribution to case study (if relevant)†
				linking with dual diagnosis and other MH services
3.4	Goughsborough Health Profile *Council staff*	2013	4	*This profile document is in keeping with our characterisation of Goughsborough having a mixed alcohol profile relative to the national average*
3.5a 3.5b	Drug and Alcohol Community and Criminal Justice Service Review Questionnaire Survey Results *Council staff*	2013 2013	11 111	*Together, these documents confirmed consultation included a survey completed by 125 people, though this one was mostly completed by professionals/workers, rather than service users. Results showed a clear majority against PbR and in favour of local residential services, but only just over half favoured integration*
3.6a 3.6b	Service User Questionnaire Service User Results *Council staff*	2013 2013	2 2	*In contrast to service provider survey, less support for outreach (prefer fixed sites), but in favour of service integration and development of more recovery opportunities such as activities to stave off boredom and offer support*
3.7	Letter to Provider – Service Review *Council staff*	2013	1	*Letter confirms invitation to services to encourage staff, volunteers and service users to be involved in consultation (sent to service)*
3.8	Letter to Provider – TUPE *Council staff*	2013	1	*Letter seeking information potential TUPE liabilities demonstrates this information would have been given to any new bidders*
3.9	Results from Consultation Events *Council staff*	2013	18	*This feedback to stakeholders is consistent with that already covered by Doc 3.5a/b and 3.6 a/b). Support for increasing recovery opportunities and mixed views regarding service integration was reflected in the interviews*
3.10	Service Review Workshop powerpoint *Council staff*	2013	35	*The content of this presentation is consistent with other consultation summary documents and interviews*

Doc number	Document type Author type	Year(s)	Pages/ slides	Contribution to case study (if relevant)†
3.11	Cabinet Paper: Substance Misuse Procurement *Council staff*	2014	11	*This document adds to the case study because it shows that cabinet were presented with three options (procure same service, procure integrated service with same budget, procure redesigned integrated service with efficiency savings), with the third being the recommended option and the one followed*
3.12	Substance Misuse Service Specification *Council staff*	2014	26	*The service specification is consistent with interview data regarding the intentions for the system, the scope and length of the contract, and (broadly speaking) the outcomes required. Additional useful information:* *- The maximum cost of the service is clearly identified. The price is to be fixed for a year and thereafter subject to annual review with provider encouraged to make within contract efficiencies.* *- Identifies that there will be TUPE liabilities* *- States that it is responsibility of provider to identify locations for service delivery, but encouraged that this should be a mix of fixed and community settings with co-location encouraged.* *- A highly detailed service framework is provided and interventions are required to be evidence-based, with reference made to relevant national standards*
3.13a	Substance Misuse Recovery Service (Drugs & Alcohol): Invitation to Tender Part 1	2014	17	*The document gives instructions to tenderers and information about rigour and transparency of process. Confirmed weighting between price and quality*
3.13b	Invitation to Tender Part 2 *Council staff*	2014	28	*This document confirms bidders are required to prepare a written response for each aspect of the contract and that these are assessed according to a standard scoring matrix*

Doc number	Document type Author type	Year(s)	Pages/ slides	Contribution to case study (if relevant)†
3.14	Alcohol Liaison Service Exception Request *Council staff*	2015	5	*This document concerns extending the contractual arrangements for the Alcohol Liaison Service for an additional 2 years. This contract is separate to the main alcohol service contract. Extension allowable under EU procurement regulations*
3.15	Alcohol Liaison Service Review *Council staff*	2016	19	*This document confirms that the ALS is utilised and valued and there is a recommendation that ALS be continued*
3.16	State of the District Report *Council staff*	2017	44	*This document contains general health and wellbeing date for Goughsborough*
3.17	Local Alcohol Action Area (LAAA) Action Plan – spreadsheet *Council staff*	2017	1	*This document confirms interview accounts of a service system review*
Sandley				
4.1	Sandley Demographic profile *Unknown*	2013	6	*The sociodemographic profile of Sandley presented in this document is consistent with our information drawn from more recent government data sources*
4.2	Health & Wellbeing Strategy: Draft for consultation *Council staff*	2017-20	24	*The strategy has a specific section on alcohol, which is consistent with interview accounts of drive to improve linkage between primary care, hospital and services and focus on families*
4.3	Transformation of Sandley Substance Misuse Services – presentation to Health & Scrutiny Committee *Council staff*	2017	7	*Corroborated interview data by identifying the same context and drivers for system transformation (e.g. budget reduction, system complex and inefficient) as well as the same priorities (e.g. focus on improving recovery outcomes, single point of contact)*
4.4	Procurement Strategy for Transformation of Sandley Substance Misuse Services *Council staff*	2017	24	*None of the content contradicted interview data, however, additional points included:* - *Residential detoxification & residential services currently under a separate contract. This is to remain, but proposed that management*

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				of referral and expenditure be overseen within new contract - *Commissioning with other boroughs (e.g. of resi rehabilitation services) was considered but not pursued due to differences in the population to be served and need to prioritise within-borough integration* - *Risks of failed procurement due to lack of interest mitigated through market testing and risk associated with TUPE implications managed by longer than standard contract submission and mobilisation periods*
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4.6	Engagement, Involvement & Co-production in Sandley *Council staff*	2017	2	*The types of involvement described in this document are consistent with the interviews. The document confirms that service user involvement should be underpinned by wider insights and evidence to ensure the service best meets their needs*
4.7	Drug & Alcohol Treatment Pathways Map *Unknown*	Undated	2	*This is consistent with participant interviews describing multiple providers under the previous model*
Kelgate				

Doc number	Document type Author type	Year(s)	Pages/ slides	Contribution to case study (if relevant)†
5.1a 5.1b	Kelgate Alcohol Harm Reduction Strategy Kelgate Alcohol Strategy *Council staff*	2006-09 2009-13	28 37	*Taken together, these strategy documents are consistent with interview accounts of an increased focus on and investment in alcohol services, building up to a service system "heyday"*
5.2a 5.2b 5.2c	Kelgate Alcohol Misuse Needs Assessment Study Report *External consultant* Kelgate Alcohol Health Needs Assessment *Public health registrar* Strategic Assessment of Crime, Antisocial Behaviour, Substance Misuse and Reoffending *Council staff*	2009 2012 2014-15	147 104 84	*Taken together, these needs assessment documents are consistent with interview accounts of an increased focus on and investment in alcohol services followed by substantial disinvestment. Descriptions of change to the configuration of services and trends in alcohol indicator data over time were also consistent with interview accounts* *Doc 5.2b Describes a planned Assessment and Recovery Hub through which people can be signposted or referred to the most appropriate services*
5.3	Feedback to Kelgate *Alcohol Harm Reduction National Support Team (Department of Health)*	2010	46	*Given the date of this document (2010) and that it comments on a system that has since been remodelled following disinvestment, it does not contribute new material to the case study, other than to say external review of the Strategy suggested progress was being made. However, it is consistent with interview accounts of previously high levels of investment. Some of the suggestions made in this review are known to have been subsequently implemented. It is possible others may have either been implemented or superseded by a changing financial and strategic environment.*
5.4	Treatment Model Summary *Council staff*	2011	1	*This diagram is consistent with interview accounts of multiple providers within an alcohol specific (i.e. non-integrated) system*

Doc number	Document type Author type	Year(s)	Pages/ slides	Contribution to case study (if relevant)†
5.5a	Safer Kelgate Partnership Plan *Council staff*	2013-18	27	*Taken together, these safety partnership documents refer to many of the same alcohol harm reduction aspirations, actions and achievements outlined in other Kelgate strategy and needs assessment documents and are likewise consistent with interview accounts of the recent history of the local alcohol treatment system* *Doc 5.5b Data reported for alcohol hospital and numbers accessing treatment consistent with needs assessment documents (see Docs 5.2a-c)* *Doc 5.5 c adds to the case study by showing that: the integration of alcohol and other drug services into a single substance misuses service as a consequence of budget cuts has been acknowledged in a council report, further progress against some indicators is listed as requiring resource, one indicator has been abandoned as impossible, and that further budget cuts are anticipated*
5.5b	Safer Kelgate Partnership Delivery Plan *Council staff*	2014-15	28	
5.5c	Safer Kelgate Partnership Plan – 2016 Update *Council staff*	2016	25	
5.6	Alcohol Commissioning Plan – 2010/11-2014/15 *Council staff*	2009	24	*This document reports on a previous local alcohol plan and confirms there was previously wider activity*
5.7a*	Consultation Survey Report *Council staff*	2015-16	9	*These documents confirm interview accounts that a consultation survey was done (not for detailed reporting)*
5.7b*	Consultation Survey Comments	2016	5	
5.8*	Workforce Forecasting Document *Provider*	2016	4	*This document corroborates interview data regarding dialogue between commissioner and provider regarding provision options under reduced budget*
5.9	Award Entry *Council staff*	Undated	6	*Although the award entry was not a feature of the interviews, this document confirms the sense of pride some interviewees expressed in previous alcohol*

Doc number	Document type Author type	Year(s)	Pages/ slides	Contribution to case study (if relevant)†
				service investment in Kelgate, which has since been scaled back

* Document provided to the research team on the understanding that contents would not be reported in detail

† This appendix shows a summary of the key points arising from the documents relevant to the case study descriptions. A more extended version of the table showing more detail regarding document contents is available upon requ) (PHE, 2018c). In 2014/15, the estimated proportion of the population potentially in need of specialist treatment due to alcohol dependence was almost 3% and the estimated treatment access rate among those potentially in need of treatment was 12.5% (Brennan et al., 2016).

Case study data sources

*Stakeholder Interviews (March-June 2018)**

- 4 x Commissioners
- 1 x Provider
- 2 x People with experience of service use

*Interviews occurred during the mobilisation phase of the current contract

Documents

Seven documents were provided including a health and wellbeing strategy, members' briefing presentation, substance misuse procurement strategy, service specification, and an information sheet defining engagement/coproduction (**Error! Reference source not found.**, Doc 4.1-4.7).

Case overview

Past service provision

Service provision in Sandley had arisen "organically" by piecemeal development over several years and separate commissioning cycles and individual project funding opportunities. At the time of the most recent commissioning, local alcohol and drug services were delivered by several different providers across nine contracts [Doc 4.4], with NHS Trust led services providing specialist alcohol treatment for people with complex needs and less intensive services for those accessing treatment via primary care services as well as an Alcohol Liaison Service at the local hospital. A direct access alcohol service was provided by a charity based in the south of England while drug services were run jointly by an NHS integrated care organization and a national level charity. There was no in-area provision for medically assisted detoxification.

Drivers of the most recent commissioning process (2017-18)

The following factors were identified as influential in the most recent commissioning:

Streamlining the system	There was a perceived need to: Address disjointed service provision Encourage stronger partnership working, particularly around addressing an individual's broader needs Reduce duplication of costs, buildings, assessment procedures and data systems
Addressing disadvantage	There was an interest at Council level in taking a co-ordinated approach to addressing multiple needs and disadvantage across a range of areas of responsibility, including substance misuse (e.g. housing, safety)
Unmet needs	Needs assessments identified high alcohol-related hospital admission and poor treatment completion rates
Budget cuts	Cuts of approximately 23% were required to 2016/17 substance misuse contract values [Doc 4.3]. Interview accounts suggest here have been cuts of approximately 30% since 2014/15

Key features of the commissioning process

Duration	There has been a major programme of substance misuse service transformation and redesign underway since 2014 The re-procurement was announced late 2016 for new contract to take effect April 2018 [Doc 4.3]
Aligning contract end dates	Some recent (1-2 years) contracts were waived to align all end points to a single time period in order to re-procure the whole system at once
Consultation / Engagement	Extensive service user engagement throughout the process ultimately resulted in commitment to a co-produced service system, as is consistent with council policy [Doc 4.2, 4.6] "Warm up" work was done with providers to ensure the specification did not come as a surprise, as well as with residents and other community groups
Specification development	The specification drew directly on the consultation phase with members of a service user forum setting the service vision The specification was also developed so as to link with the council priority of addressing multiple need [Doc 4.2] Participants described the specification as focussed on the structures required to ensure system co-production, responsiveness and effectiveness, rather than quantifying the specific interventions to be delivered
Elected members	Members signed off on the proposed service system model and, importantly, the extended contract length

	Members agreed to the extended (up to 9 years) contract knowing that the successful service provider would need sufficient time to achieve such a fundamental system redesign
Tender & selection process	7 bids were received, 6 assessable, several good The bid assessment team included four to five members of a service user forum Bids were assessed 70% on quality and 30% on cost The successful bidder was seen to bring added value and to be aspirational regarding service improvement

How savings were achieved

Moving to an integrated system meant duplication of costs was substantially reduced, for example, through some building closures and some staff redundancies

Current service provision (launched April 2018)

Overarching goal	An evolutionary, client-centred, co-produced service system
Contract	Length is 5 + 2 +2 (9 years, compared to 3 + 2 +2 previously)
Provider type	The lead provider is the local NHS Foundation Trust Services are delivered in partnership with two regional charitable organisations
Service provision	Integrated alcohol and drug services provision, with 'family' embedded within all aspects of the service, as per council priorities [Doc 4.2, 4.3] Services include 1-to-1 key working; group work and day programme; psychological therapy, counselling and group work; treatment in GP's surgeries; women's groups and support; BBV testing and treatment; reintegration and aftercare; education, training and employment support; and family and carers' support and advice Although residential services fall under a separate contract, management of referrals and expenditure comes under the main contract [Doc 4.4]
Location	2/5 buildings sites will close and a single contact point established
Treatment pathways/model	The system is to be co-produced with service users and is intended to be flexible in response to emerging needs The system has a single entry point, but include stronger links to partner organisations It is intended clients will have an individual keyworker to help them navigate the system

Paid staff	Some staff were made redundant
Recovery options	Increased emphasis on recovery and social resilience
Mobilisation	The system was mobilising at the time of interviews A 4 month mobilisation period was set in order to allow time for TUPE processes [Doc 4.4]

Perceptions of the commissioning process and anticipated outcomes

Stakeholders in Sandley were generally agreed that the most recent round of commissioning presented an opportunity to address a system which had become disjointed and inefficient. In particular, there was a concern that people receiving treatment were not being consistently connected into other, broader social supports. There was also seen to be a need for greater family and peer support. To address these perceived shortcomings, people with direct experience of service use were "embedded in the process from the very beginning" to ensure the commissioning was led by "their voice and their needs". This focus was reflected by participants, with discussion of consultation and engagement processes being a strong feature of all interviews, particularly the extent to which this involved service users, not only in shaping the specification but also in assessing bids (for example, leading on assessment of service user involvement presentations) and contributing to ongoing service development and monitoring.

It was recognised by all participants that Sandley commissioners had engaged with members of a service user representative forum early in the re-procurement process and had then connected with a wider group of service users (for example by forum representatives introducing commissioners at further consultation meetings within individual services). Additionally, commissioners met face to face with partner organisations, family groups and the wider community, making particular effort to reach stakeholders with whom they had not previously connected, such as a young carers group. Service provider engagement also occurred (e.g. market testing, information sharing) and reportedly fed into the specification, however, these events were mentioned in interviews to a lesser extent than service user engagement, which was clearly the focus during re-procurement. Service user forum members worked with commissioners to develop the vision (i.e. *"Service users are navigated around the treatment options of their choice by one worker who is knowledgeable of what's available, can offer hope, is straight-forward, honest and genuinely cares about their empowerment, recovery and future well-being"* [Doc 4.5] and aims of the service, taking into account consultation feedback. Participants agreed it was through the above processes that a widely (if not universally) shared commitment to a co-produced service system was reached among stakeholders. Given the focus of the interviews on co-production, the role of best practice evidence or guidelines in shaping the specification was unclear from the interviews, with only a couple of participants mentioning these. However, the service specification document specifically stated that provision should be evidence-based or, where innovative, should be expert-led [Doc 4.5] and this is consistent with Council policy regarding service user co-production [Doc 4.2, 4.6]. A small number of participants couple commented on the difficulty of providing quality services in the face of budget cuts.

Participant reflections on the extent of service user and other stakeholder engagement by commissioners were generally positive. A non-commissioner participant reported that "they [the commissioners] did their best to get a wide scope" and consultation was seen to be done "for the purposes of improving and making appropriate changes rather than just tick boxing". However, the process was not without challenges. For example, one person felt that there could have been better communication with a broader base of service users throughout (i.e. beyond the members of the service user forum), rather than increased interaction towards the end. Several participants also reflected that adequately supporting service user involvement required a heavy time investment from commissioners. This was exemplified during the scoring of tenders: although forum members received training for this unpaid role by a third sector advocacy and capacity building organisation, further commissioner input and flexibility was required to ensure the volume and complexity of the work involved in scoring the "technical and jargon" aspects of the bids was not too great. This support included scoring in a room together with someone available to answer queries, having regular breaks, and reducing the number of questions forum members were asked to score. This was seen to help everyone contribute to the best of their ability and was considered useful learning towards improving service user involvement in the future. It was also acknowledged that promoting service user involvement is resource intensive for service providers, for example, in contacting, encouraging, and supporting people to attend relevant meetings. Irrespective of these challenges, however, there was a shared sense across the Sandley interviews that service user involvement in shaping the service model and in ongoing co-production demonstrated a commitment to a more equal relationship between people who use services, providers and commissioners.

Several participants talked at length about the integration of alcohol and drug services. It was reported that it was not assumed at the beginning of the commissioning process that integration would necessarily be the outcome, with consultation questions on this topic being deliberately worded so as to be broad and non-leading. To the surprise of some participants who had expected opposition to integration, there was generally a "lack of challenge around the notion", particularly among service users who reportedly saw commonalties in the problems people face, irrespective of the substance. The greatest reservations to integration raised during consultation were reportedly among alcohol service providers concerned about loss of specialty expertise, while others felt this area of expertise could be retained even in an integrated service. It was also reported that relevant portfolio leads (e.g. public health) and elected members supported integration, believing that it could mitigate some of the losses of budget reduction. Interview participants generally agreed that integration may somewhat reduce duplication, inefficiency and confusion regarding how to access the system. However, a small number also expressed concerns that even after accounting for efficiencies, reduced budgets were likely to mean fewer staff, which may have consequences for the quality of service provision. There were also anxieties expressed about the impact of redundancies and changes in working practice and service delivery location on both staff and clients. Participants commented that some clients and staff were unhappy with the disruption to the system during the transition phase, while others were more accepting of the changes. It was suggested that improved communication could mitigate the disruption.

Interview participants were supportive of the unusually long contract of up to 9 years, seeing this as a more flexible and sustainable approach to commissioning and service delivery than more frequent commissioning of short contracts. One participant argued providers would be more motivated to put effort and resources into long term, innovative projects to meet unmet demand, rather than simply focussing on achieving short term targets. However, it was reported that council endorsement of this approach (i.e. a long-term, co-produced model) was “not a foregone conclusion”, but rather had required commissioner persistence in briefing management teams, elected members, and committees (e.g. scrutiny committee) regarding options as well as discussion of the risks and benefits of a longer contract. Ultimately, given the desire for a radically different approach to service provision, council decision makers agreed to support offering a contract long enough for transformation to occur and to allow the system to evolve and adapt to emerging trends. There was cautious support among participants for the changes to contract monitoring processes, with recognition that this will require the development of new practices (for example, reporting will be required on fewer routine indicators, but there will be more in-depth discussion about performance against the overall service aims). In keeping with the commitment to a co-produced service system, meetings are intended to foster providers, service users, and commissioners working in partnership.

Horizon scanning

The Sandley commissioning process and the resulting model of a co-produced service system is regarded by stakeholders as innovative and is envisaged to provide an “evolving offer” for clients and their families. There are high expectations of the model, with the hope that it will deliver recovery focused care, genuinely directed by the service user's idea of what recovery is, although as the interviews coincided with the mobilisation process it is too early determine how well providers and service users are adapting to the approach or to measure outcomes. Overall, stakeholders appear invested in and energised by their commissioning and service transformation and believe Sandley is being watched by other local authorities and providers as a ‘new direction’. In terms of further developments, through this procurement commissioners tried to improve the extent to which the voluntary sector were engaged or partnered with by bidding organisations, however in hindsight felt a more structured approach to linking organisations may have better enabled this to happen. A perceived benefit of the flexible model and an innovation fund is that such partnerships could be forged during the contract. As elsewhere, Sandley participants expressed concerns about the impact of any further budget cuts on the quality of service provision.

Case study 5: Kelgate

Site snapshot

Location and population

Kelgate is a largely urban local authority on the coast with a population of just over 200,000. The population is predominantly white (88%) and a further 6% identifying as Asian. The median age is 34 years (compared to 39 years nationally) (Office for National Statistics, 2018a). A quarter (24%) of the population live in the most deprived 30 per cent of LSOAs in England (i.e. 61-70/152 most deprived local authority on this measure) (Department for Communities and Local Government, 2015). The 2017/18 unemployment rate was 4.5%, which is similar to the national average, while the proportion of workless households (13.5%) was slightly lower than the national average (Office for National Statistics, 2018b). The Council administration has been Conservative since 2014.

Alcohol-related health profile and treatment need

Kelgate is slightly worse than the national average in terms of key alcohol indicators (

Doc number	Document type Author type	Year(s)	Pages/ slides	Contribution to case study (if relevant)†
Rellington				
1.1	Drug and Alcohol Needs Assessment *Council staff*	2013-14	174	*This document is consistent with interview accounts of system complexity prior to recommissioning and broad results of the consultation with some additional detail provided regarding needs assessment consultation methods. The document identifies 14 issues/areas of recommendation, almost all of which were mentioned in interviews with the exception of use of non-commissioned, charitable services to increase in-patient capacity and introduction of complex needs measure. This implies the subsequent recommissioning did in fact address most if not all of the recommendations.*
1.2	Substance Misuse Consultation Document *Council staff*	2013	9	*This document was consistent with interview accounts that the Rellington treatment system was seen to require "fundamental" review. Additional information not covered in interviews: Shift of responsibility to LAs seen as*

Doc number	Document type Author type	Year(s)	Pages/ slides	Contribution to case study (if relevant)†
				opportunity to articulate with other local strategies, desire to improve accessibility for hard to reach groups, number of people consulted
1.3	Service Specification (excluding appendices) *Council staff*	Undated	20	*The Specification identifies system goals that are consistent with interviews. Additional points include:* *- That the provider would engage with diverse communities, potentially through the inclusion of specialist third sector organisations working with BME, LGBT and other populations* *- The Rellington City Council Strategic Commissioning Group reserve the right to amend the content and detail of the specification annually (or more often if needed) to take into account changes in policy, funding and needs.* *- The specification includes the full spectrum of interventions plus mentions several key areas of partnership working, priorities ease of access and navigation, and emphasises role of peer mentors and volunteers*
Frampton				
2.1	Alcohol and Drugs Harm Reduction "Plan on a Page" *Council staff*	2017	1	*This plan indicates the vision for Frampton in to reduce inequalities caused by alcohol – whereas reducing inequalities was not a strong feature of the interviews. Many of the priorities mentioned in interviews reflect those listed in the plan (for example partnership working), although the plan depicts a broader set of priorities not all of which featured strongly in the interviews (for example, achieving joint targets across substance use, mental health, housing and employment)*
2.2*	Drug and Alcohol Consultation Update	2017	20	*This document is not for detailed analysis, but confirms interview account of extensive consultation*

Doc number	Document type Author type	Year(s)	Pages/ slides	Contribution to case study (if relevant)†
	Council staff			*feeding into specification development. Includes information about who was consulted and when, how they were consulted, what the outcome was and where and how this has been reflected in the service specification*
2.3*	Invitation to Tender – Service Specification *Council staff*	2017	45	*This document is not for detailed analysis, but is broadly consistent with interview accounts*
2.4	Members Briefing for Drug and Alcohol - powerpoint slides *Council staff*	Undated	25	*This presentation to council is highly consistent with interview accounts. One aspect less strongly covered in interviews was the working with families priority*
Goughsborough				
3.1	District Alcohol Related Harm Profile *External consultant*	2009	67	*Through its reference to previous strategies, superseded commissioning arrangements and organisations, etc, this document reinforces the idea of an evolving commissioning landscape. However, it shows some issues are perennial e.g. assertion that wrap around services are required, need for more engagement with underrepresented groups, need to improve data systems, etc. Confirms some interview content e.g. changes since then in national govt strategy, alcohol relatively under-funded*
3.2	Joint Strategic Needs Assessment *Council and Primary Care Trust staff*	2009	132	*This report provides local data for a broad range of health conditions and behaviours. Not sufficiently focussed on alcohol or recent enough to add to the case study*
3.3	District Alcohol Strategy *Council staff*	2012-15	38	*In relation to the Health and Treatment aspects of the strategy, this document confirmed commitment to ALS and PbR at that time, as well as support for linking with dual diagnosis and other MH services*
3.4	Goughsborough Health Profile	2013	4	*This profile document is in keeping with our characterisation of*

Doc number	Document type Author type	Year(s)	Pages/ slides	Contribution to case study (if relevant)†
	Council staff			*Goughsborough having a mixed alcohol profile relative to the national average*
3.5a 3.5b	Drug and Alcohol Community and Criminal Justice Service Review Questionnaire Survey Results *Council staff*	2013 2013	11 111	*Together, these documents confirmed consultation included a survey completed by 125 people, though this one was mostly completed by professionals/workers, rather than service users. Results showed a clear majority against PbR and in favour of local residential services, but only just over half favoured integration*
3.6a 3.6b	Service User Questionnaire Service User Results *Council staff*	2013 2013	2 2	*In contrast to service provider survey, less support for outreach (prefer fixed sites), but in favour of service integration and development of more recovery opportunities such as activities to stave off boredom and offer support*
3.7	Letter to Provider – Service Review *Council staff*	2013	1	*Letter confirms invitation to services to encourage staff, volunteers and service users to be involved in consultation (sent to service)*
3.8	Letter to Provider – TUPE *Council staff*	2013	1	*Letter seeking information potential TUPE liabilities demonstrates this information would have been given to any new bidders*
3.9	Results from Consultation Events *Council staff*	2013	18	*This feedback to stakeholders is consistent with that already covered by Doc 3.5a/b and 3.6 a/b). Support for increasing recovery opportunities and mixed views regarding service integration was reflected in the interviews*
3.10	Service Review Workshop powerpoint *Council staff*	2013	35	*The content of this presentation is consistent with other consultation summary documents and interviews*
3.11	Cabinet Paper: Substance Misuse Procurement *Council staff*	2014	11	*This document adds to the case study because it shows that cabinet were presented with three options (procure same service, procure integrated service with same budget, procure redesigned*

Doc number	Document type Author type	Year(s)	Pages/ slides	Contribution to case study (if relevant)[†]
				integrated service with efficiency savings), with the third being the recommended option and the one followed
3.12	Substance Misuse Service Specification *Council staff*	2014	26	*The service specification is consistent with interview data regarding the intentions for the system, the scope and length of the contract, and (broadly speaking) the outcomes required. Additional useful information:* *- The maximum cost of the service is clearly identified. The price is to be fixed for a year and thereafter subject to annual review with provider encouraged to make within contract efficiencies.* *- Identifies that there will be TUPE liabilities* *- States that it is responsibility of provider to identify locations for service delivery, but encouraged that this should be a mix of fixed and community settings with co-location encouraged.* *- A highly detailed service framework is provided and interventions are required to be evidence-based, with reference made to relevant national standards*
3.13a 3.13b	Substance Misuse Recovery Service (Drugs & Alcohol): Invitation to Tender Part 1 Invitation to Tender Part 2 *Council staff*	2014 2014	17 28	*The document gives instructions to tenderers and information about rigour and transparency of process. Confirmed weighting between price and quality* *This document confirms bidders are required to prepare a written response for each aspect of the contract and that these are assessed according to a standard scoring matrix*
3.14	Alcohol Liaison Service Exception Request *Council staff*	2015	5	*This document concerns extending the contractual arrangements for the Alcohol Liaison Service for an additional 2 years. This contract is separate to the main alcohol*

Doc number	Document type Author type	Year(s)	Pages/ slides	Contribution to case study (if relevant)†
				service contract. Extension allowable under EU procurement regulations
3.15	Alcohol Liaison Service Review *Council staff*	2016	19	*This document confirms that the ALS is utilised and valued and there is a recommendation that ALS be continued*
3.16	State of the District Report *Council staff*	2017	44	*This document contains general health and wellbeing date for Goughsborough*
3.17	Local Alcohol Action Area (LAAA) Action Plan – spreadsheet *Council staff*	2017	1	*This document confirms interview accounts of a service system review*
Sandley				
4.1	Sandley Demographic profile *Unknown*	2013	6	*The sociodemographic profile of Sandley presented in this document is consistent with our information drawn from more recent government data sources*
4.2	Health & Wellbeing Strategy: Draft for consultation *Council staff*	2017-20	24	*The strategy has a specific section on alcohol, which is consistent with interview accounts of drive to improve linkage between primary care, hospital and services and focus on families*
4.3	Transformation of Sandley Substance Misuse Services – presentation to Health & Scrutiny Committee *Council staff*	2017	7	*Corroborated interview data by identifying the same context and drivers for system transformation (e.g. budget reduction, system complex and inefficient) as well as the same priorities (e.g. focus on improving recovery outcomes, single point of contact)*
4.4	Procurement Strategy for Transformation of Sandley Substance Misuse Services *Council staff*	2017	24	*None of the content contradicted interview data, however, additional points included:* - *Residential detoxification & residential services currently under a separate contract. This is to remain, but proposed that management of referral and expenditure be overseen within new contract* - *Commissioning with other boroughs (e.g. of resi*

Doc number	Document type Author type	Year(s)	Pages/ slides	Contribution to case study (if relevant)†
				rehabilitation services) was considered but not pursued due to differences in the population to be served and need to prioritise within-borough integration - *Risks of failed procurement due to lack of interest mitigated through market testing and risk associated with TUPE implications managed by longer than standard contract submission and mobilisation periods*
4.5	Drug & Alcohol Recovery Service Specification *Council staff*	2017	36	*The specification was consistent with interview data. Additional information of note included:* *- the specific wording of the vision for the service* *- a specific point indicating that service provision was expected to be evidence based or where innovative, to be expert-led* *- providers should work to maximise the value offered by peer mentors (skills development, all service users offered peer mentor)*
4.6	Engagement, Involvement & Co-production in Sandley *Council staff*	2017	2	*The types of involvement described in this document are consistent with the interviews. The document confirms that service user involvement should be underpinned by wider insights and evidence to ensure the service best meets their needs*
4.7	Drug & Alcohol Treatment Pathways Map *Unknown*	Undated	2	*This is consistent with participant interviews describing multiple providers under the previous model*
Kelgate				
5.1a 5.1b	Kelgate Alcohol Harm Reduction Strategy Kelgate Alcohol Strategy *Council staff*	2006-09 2009-13	28 37	*Taken together, these strategy documents are consistent with interview accounts of an increased focus on and investment in alcohol services, building up to a service system "heyday"*

Doc number	Document type Author type	Year(s)	Pages/ slides	Contribution to case study (if relevant)†
5.2a	Kelgate Alcohol Misuse Needs Assessment Study Report *External consultant*	2009	147	*Taken together, these needs assessment documents are consistent with interview accounts of an increased focus on and investment in alcohol services followed by substantial disinvestment. Descriptions of change to the configuration of services and trends in alcohol indicator data over time were also consistent with interview accounts* *Doc 5.2b Describes a planned Assessment and Recovery Hub through which people can be signposted or referred to the most appropriate services*
5.2b	Kelgate Alcohol Health Needs Assessment *Public health registrar*	2012	104	
5.2c	Strategic Assessment of Crime, Antisocial Behaviour, Substance Misuse and Reoffending *Council staff*	2014-15	84	
5.3	Feedback to Kelgate *Alcohol Harm Reduction National Support Team (Department of Health)*	2010	46	*Given the date of this document (2010) and that it comments on a system that has since been remodelled following disinvestment, it does not contribute new material to the case study, other than to say external review of the Strategy suggested progress was being made. However, it is consistent with interview accounts of previously high levels of investment. Some of the suggestions made in this review are known to have been subsequently implemented. It is possible others may have either been implemented or superseded by a changing financial and strategic environment.*
5.4	Treatment Model Summary *Council staff*	2011	1	*This diagram is consistent with interview accounts of multiple providers within an alcohol specific (i.e. non-integrated) system*
5.5a	Safer Kelgate Partnership Plan *Council staff*	2013-18	27	*Taken together, these safety partnership documents refer to many of the same alcohol harm reduction aspirations, actions and achievements outlined in other Kelgate strategy and needs assessment documents and are*
5.5b	Safer Kelgate Partnership Delivery Plan *Council staff*	2014-15	28	

Doc number	Document type Author type	Year(s)	Pages/ slides	Contribution to case study (if relevant)†
5.5c	Safer Kelgate Partnership Plan – 2016 Update *Council staff*	2016	25	*likewise consistent with interview accounts of the recent history of the local alcohol treatment system Doc 5.5b Data reported for alcohol hospital and numbers accessing treatment consistent with needs assessment documents (see Docs 5.2a-c) Doc 5.5 c adds to the case study by showing that: the integration of alcohol and other drug services into a single substance misuses service as a consequence of budget cuts has been acknowledged in a council report, further progress against some indicators is listed as requiring resource, one indicator has been abandoned as impossible, and that further budget cuts are anticipated*
5.6	Alcohol Commissioning Plan – 2010/11-2014/15 *Council staff*	2009	24	*This document reports on a previous local alcohol plan and confirms there was previously wider activity*
5.7a*	Consultation Survey Report *Council staff*	2015-16	9	*These documents confirm interview accounts that a consultation survey was done (not for detailed reporting)*
5.7b*	Consultation Survey Comments	2016	5	
5.8*	Workforce Forecasting Document *Provider*	2016	4	*This document corroborates interview data regarding dialogue between commissioner and provider regarding provision options under reduced budget*
5.9	Award Entry *Council staff*	Undated	6	*Although the award entry was not a feature of the interviews, this document confirms the sense of pride some interviewees expressed in previous alcohol service investment in Kelgate, which has since been scaled back*

* Document provided to the research team on the understanding that contents would not be reported in detail

† This appendix shows a summary of the key points arising from the documents relevant to the case study descriptions. A more extended version of the table showing more detail regarding document contents is available upon requ). The estimated alcohol dependent

population in 2014 was almost 2.5% of the population (compared to the English average of 1.8%) (Brennan et al., 2016). At that time, the estimated specialist alcohol treatment access rate among those dependent on alcohol was 15%, placing Kelgate 21-30/151 out of local authorities in terms of the population in need actually accessing treatment services.

Case study data sources

Stakeholder interviews (Aug-Sep 2017)

- 1 x Commissioner
- 3 x Providers

Documents

Fifteen documents were provided including alcohol harm reduction and safety partnership plans, the Service Specification) and a consultation survey (see **Error! Reference source not found.**, Doc 5.1-5.9).

Case overview

Past service provision

Prior to the latest commissioning round in 2016, Kelgate experienced substantial expansion followed by contraction of local substance misuse treatment provision. Between 2002 and 2010 there was a gradual increase in investment for alcohol treatment and wider harm reduction campaigns and strong connections existed to other organisations such as the local hospital and probation service. The reported increased emphasis on treatment was consistent with the content of Kelgate alcohol strategy, needs assessment and safety partnership documents [Docs 5.1a, 5.1b, 5.2a, 5.2b, 5.5a, 5.5b] and was reported to be associated with a reduction in hospital admissions for alcohol-related conditions, in contrast to the national, increasing trend. This created the perception that heavy investment in alcohol services was generating positive local outcomes (i.e. the service provision "heyday"). Indeed, Kelgate submitted an entry to a national-level Local Government awards scheme based on their 2009-2013 alcohol strategy which named treatment as a priority area [Doc 5.9, 5.1b] and in 2010 was deemed by an external review to be making strong progress against this (albeit with some suggestions for further improvement) [Doc 5.4].

However, in the 2013 commissioning round, the budget was reduced by approximately 20%. The previously separate Drugs Service and Alcohol Service were combined into one service (split between 4 different contracts across the NHS and third sector) [partly in response to savings requirements – Doc 5.5c]. This was perceived to present some challenges; in particular, fragmented client pathways because different elements of the service (e.g. pharmacotherapy and psychosocial interventions) were delivered by different providers.

Drivers of the most recent commissioning process (2016)

The following factors were identified in interviews as influential in the most recent commissioning:

Budget cuts	Further budget reductions of approximately 20-25% were required by Council (on top of those in the previous contract)
Shortcomings of previous model	The recommissioning was perceived as an opportunity to address the shortcomings of the previous model, particularly fragmented pathways
Local knowledge	The commissioning manager and a number of other key stakeholders involved in the commissioning process had worked in the field and geographical area for many years A new Health Needs Assessment was not conducted for the 2016 commissioning round

Key features of the commissioning process

Duration	The process lasted 1 year from initiation of dialogue around a new service model to launch of the new service
Consultation / Engagement	Consultation focussed on ways to generate savings, for example, considering options for integration of services Activities included a service user and family survey and a quarterly substance misuse treatment forum There was ongoing interaction between commissioner and provider, with the latter proactively providing an estimate as to what the available funds could buy [Doc 5.8]
Specification development	Specification development was led by a small commissioning team in the local authority, informed by the data collected through stakeholder engagement processes, particularly regarding integration preferences
Tender & selection process	4 bids were received Submitted applications judged by a large panel of stakeholders (e.g. public health commissioners, lay representatives, adult social care, etc) Bidders were visited by a small group of commissioners to observe service in action The successful bidder had existing local knowledge and presence, and importantly, demonstrated that they understood the requirement to align substance misuse and housing service provision

How savings were achieved

The scale of cuts prompted innovative thinking regarding the model of service provision to maximise the service available to clients and reduce overheads. This involved considering how to merge contracts, such as by combining substance use provision with mental health or housing providers, with housing eventually selected as the preferred option.

Current service provision model (launched November 2016)

Overarching goal	We will make our housing support workers recovery workers
Contract	Length is 3 + 2 years with fixed budget Anticipated need to make further in-contract savings (e.g. in 2019-20)
Provider type	The lead provider is an existing local voluntary sector organisation One subcontractor (local NHS)
Service provision	An important new feature is integration with the local supported housing service. Otherwise, the service was described as a “slimmed down” version of what was previously on offer Substance misuse services provided include drug and alcohol assessment, case management, psychosocial interventions, access to detoxification, rehab and aftercare, mental health nurse Pharmacotherapy and inpatient detoxification assessment are subcontracted
Location	Much of the provision is run out of a single building
Additional local services	There is a separate Alcohol Specialist Nurse Service at the local hospital (in place for nearly 10 years). There is also a Tier 2 Integrated Wellbeing Service to support people with lower-level alcohol consumption problems
Treatment pathways/model	The integration of substance misuse services with housing has enabled shorter residential detox. Rather than a 7-8 day in-patient stay, many clients are ‘stepped down’ after 3 days, either to residential rehab, or to the supported housing service with access to a day programme
Paid staff	There has been a redesign of staff roles to allow progression, but also to accommodate budget reductions
Recovery options	There is a separate recovery service that works closely with the treatment provider
Mobilisation	The contract had a 3 month mobilisation period

Perceptions of the commissioning process and outcomes

Participants in this site were very candid in their discussions regarding the process of commissioning. While it was generally agreed to be a rigorous, well-run and transparent process, it was also experienced as intensively time consuming for both commissioner and bidders. Despite this, the year-long process was felt to be a relatively short time frame in which to consult on, develop a specification and tender for such a large service. Although the commissioner made efforts to protect funding, and was supported in this by partner agencies, it was apparent that at a council level budget cuts were inevitable. The necessary focus throughout the process was therefore on what could be achieved with “this little pot of money”. This was described as “depressing” and there was a clear sense of loss among some participants in relation to the level of services previously available during the ”heyday”.

Commissioners sought engagement with a range of stakeholders and by a variety of means throughout the commissioning process. An issue addressed through this process was which services to integrate. Although there was serious consideration given to integration with mental health, the feedback from stakeholders was that substance use might get “lost” with this pairing and so integration with housing was the preferred option. Some participants felt that engagement with people with direct experience of service use may not have represented a wide range of views, particularly the voice of those whose primary substance is alcohol (as opposed to other drugs). However, there were positive views of the extent to which senior management of provider organisations were able to contribute to the conversations around the developing specification. The challenges for a small local organisation with limited staffing resource in preparing the tender were noted, as were the challenges of mobilising the new service. In particular, as some staff were transferred from direct employment with the local authority (and with superior terms and conditions) to the new provider, there was a substantial additional Human Resources load, as well as disquiet among some staff at the outcome of the commissioning process.

There was the perception that the most recent commissioning had a negative impact on the breadth and depth of the service provision in Kelgate. For example, the number of alcohol clients seen per year has decreased by over two thirds. This is consistent with a council report which states that the progress indicator of treating at least 15% of the alcohol dependent population annually has been abandoned as no longer possible to achieve due to resource constraints [Doc 5.5c]. However, some interview participants felt that because a greater proportion of alcohol clients listed as entering treatment actually complete it than previously, the overall ‘success’ rate has improved, even though the absolute number treated is lower (though it was also acknowledged that this apparent success may be partly to do with changes to who is counted). There was a perception that the service is now “geared up for crisis”. Specifically, people who drink heavily and who are otherwise stable are possibly less well served in the new model. There were several factors identified as contributing to the reduced numbers of alcohol clients in treatment including an increased focus by the Integrated Wellbeing Service on smoking and weight management clients (and so less on people potentially requiring alcohol services), a decrease in capacity for outreach, and weakened links with probation and the hospital alcohol liaison service (and even where clients are identified and referred,

there is limited service capacity). At the time of interview, there were moves afoot to redress the perceived under-provision for ‘high functioning’ alcohol clients through the establishment of a peer support group, using a community meeting space available at a major chain supermarket.

The integration of the substance misuse service with housing has meant that the service has been able to make use of existing supported housing as part of the treatment pathway (i.e. a shortened length of hospital stay) and therefore spot purchase of residential rehabilitation places is less common than previously. This is seen to have resulted in considerable savings. There is a perception of improved progression between different aspects of the service (e.g. case management into psychosocial services) and there is some optimism that the presence of the mental health nurse on the two clinic assessment days has helped to “open the doorway” to mental health services, although there is still room to improve linkages. At the time of recommissioning, an existing peer-led recovery organisation was included as a subcontractor to the main service. However, it was always the intention that this should become independent as this was perceived by all parties as a more appropriate and workable option and this has now occurred.

Horizon scanning

Some interview participants indicated that, ideally, they would prefer to return to having a separate alcohol service and for longer contracts to be awarded. However, with uncertainty around future funding this is perceived as just not feasible. Indeed, some felt the risk of further cuts in the near future (a risk also identified in a council report – Doc 5.5c) is a big threat to the continued provision of services. In the face of this likelihood the provider was looking to other funding streams to ensure sustainability. Participants noted that simultaneous to disinvesting in treatment funding, the local authority has also become more liberal towards alcohol licensing (and so potentially contributing to alcohol related problems). There were mixed views as to the usefulness of national level strategies (for example, the 2010 Drug Strategy(Government, 2010) and the 2012 Alcohol Strategy(HM Government, 2012)) in guiding the sector, with one seeing the such strategies as “nice words”, but lacking in follow through. Similarly, there were mixed views about the “recovery agenda” with some very committed to the idea of peer-supported recovery while others were concerned this excluded those unable to sustain or otherwise not interested in abstinence and so preferring a wider scope including non-abstinent and harm minimisation approaches.

Case study synthesis and discussion

In this section we briefly draw together findings across the case studies sites, including commonalities in commissioning drivers, processes, system developments and their perceived outcomes, and future risks and opportunities. Where relevant we discuss issues with reference to the existing literature. Study strengths and challenges are also identified.

Commissioning drivers

All case study sites faced substantial funding cuts at their most recent commissioning which fundamentally influenced decisions regarding service system design. However, in

addition to reducing costs, several other common drivers were identified, including the desire to create a single co-ordinated system, address under-representation of alcohol clients, improve access pathways, ensure minimum standards, improve engagement with family and hard to reach groups, and enhance recovery options. Commissioners consulted widely to inform specification development, often communicating to stakeholders at the outset the scale of cuts to be absorbed along with ideas for how these could be mitigated, while still also trying to make other system improvements.

Commissioning processes

Re-procurement processes followed a common pattern which we have summarised from our data as a cycle and which is consistent with commissioning summary diagrams published elsewhere (e.g. NHS England Commissioning Cycle) (NHS England, Undated). Our participants, particularly commissioners themselves, described local authority commissioning processes as rigorous, transparent and highly scrutinised and could give examples of practice and provide documents which supported this view. This perception is also consistent with an earlier report of stakeholder views following the transfer of commissioning responsibility for many public health services to local government (Davies et al., 2016). Rigour was valued not only as being fair, but also as necessary to avoid or overcome challenges to the award decision from unsuccessful applicants. Commissioning processes were viewed by some participants to have provided an opportunity to think innovatively about service provision for their community. However, the process was simultaneously regarded as having been time consuming, burdensome, and insecurity-provoking. It was also widely recognised that the mobilisation period of a new contract is pressurised and can be deeply unsettling for both service users and staff, even where efforts are being made to ensure it runs as smoothly as possible. These accounts of disruption are consistent with other reports of negative impacts of re-procurement on substance misuse service provision, lasting for several months either side of a new contract starting (Advisory Council on the Misuse of Drugs, 2017).

As presented in Section 0 and individual case studies, commissioners consulted extensively with a range of internal (to council) and external stakeholders in order to gather suggestions, establish priorities, communicate commissioning intentions and seek official approval. However, it became clear during our interviews that elected members were centrally important to commissioning decisions because ultimately they were able to veto the proposed service system and expenditure. In recognition of the non-expert status of elected members, commissioners in our study expended considerable effort in communicating with relevant portfolio leads and the wider cabinet, with some taking a "back to basics" approach to educating their local members. Commissioners prepared evidence and arguments to protect budgets by referring to the wider costs of alcohol to the community and potential cost savings of an effective treatment system. It was common to bring the developing service system model to members to identify any concerns or issues they had, for example, the possible impact of system changes for particular locations and/or population subgroups within the local authority or links to other policy or actions. The personal views and experiences of elected members were seen to be important factors in their response to commissioning proposals and it was said that

some members found anecdotes and personal stories particularly salient. Some commissioners described there being an alcohol "champion" among the members who was prepared to advocate to achieve the best for the system. The commissioning teams in this study all included experienced staff, with specialist knowledge about substance misuse. Commissioners in other areas may be less experienced(Alcohol Concern & Alcohol Research UK, 2018; Recovery Partnership & Adfam, 2017) and so less well-placed to support council decision-making.

System developments and their perceived outcomes

All sites redesigned their service system to some extent during the most recent commissioning round. Common system developments included integration of different services types, reconsidering the location of provision (e.g. fewer buildings, changed level of outreach), redesign/streamlining of treatment models, reductions in staff numbers and/or review of staff roles, increased opportunities for peer workers, and consolidation of delivery to fewer providers with greater responsibility for system co-ordination. Although we enquired specifically about the consequences of commissioning decisions, we noticed that participants tended not to make made definitive statements about quantifiable client outcomes following changes to the service system. Even where participants referred to routine monitoring indicators such as treatment entry and completion rates or expressed a view, for example, about a lack of improvement in the number of people attending treatment for alcohol problems (as has been reported elsewhere(Alcohol Concern & Alcohol Research UK, 2018)), they usually qualified their statements. This suggested participants were wary of making simplistic before and after comparisons of routine monitoring indicators such as treatment entry and completion rates. In a context of reduced funding, fundamentally altered system design, and other local factors such as changes to reporting practices, such comparisons may indeed be misleading. However, in those sites where re-procurement had occurred long enough ago for the new system to have embedded, participants provided candid reflections on what they perceived to be working more or less well, as shown in relation to the specific system developments discussed below.

Integration most frequently involved merging alcohol and drug services, but in one site where that had already happened further merging of services occurred with housing. Ahead of their re-commissioning, stakeholders could see the potential advantages of integrating services, however in practice integration entailed both benefits and challenges. In several sites there was a perception that alcohol clients were somewhat dissuaded from presenting to treatment and also that the newly commissioned system now caters to the most critical end of the spectrum rather than serving those who are functioning relatively well in their lives. Under-representation of alcohol clients was a concern for stakeholders and in some areas efforts were being made to redress this perceived imbalance. It is interesting to note that while merging with mental health services was considered in at least one site, in the end no local authorities pursued this option despite better coordination of mental health and substance misuse services generally being seen as desirable. In some sites people commented that there was previously better integration with mental health services when local Clinical Commissioning Groups were more involved in the delivery of alcohol services.

Outreach provision was frequently mentioned as a way of both reducing costs, for example through limiting expenditure on bricks and mortar, and also as a way of improving service accessibility by taking services directly into communities as needed and increasing visibility among hard to reach populations. However, some sites faced challenges in effectively implementing this approach and there are mixed views as to whether it is cost saving (e.g. fewer fixed sites are required) or cost incurring (e.g. more staff time is required).

Sites commonly described introducing (or planning to introduce) ***redesigned treatment models***. This generally involved streamlining previous models of intervention, so that they were shorter, involved less intensive use of resources (for example, being non-residential or bypassing clinical treatment), and more oriented towards recovery outcomes. It was acknowledged these modifications would save costs, however, several participants also discussed the importance of people managing their issues with dependence in the "real world" rather than a treatment "bubble". Providers tended to speak with confidence about the new or developing model, though it was not always clear from the interview how it was evidenced. Other authors who have noted similar trends in the local development of treatment models suggested that national guidance be developed (similar to the "orange book" which guides drug treatment) and minimum common standards established (Advisory Council on the Misuse of Drugs, 2017; Alcohol Concern & Alcohol Research UK, 2018). Such standards would not only help prevent poor practice, but if followed could help minimise geographic variation in the quality and quantity of provision (British Medical Association, 2018).

Along with integration of services and the redesign of treatment models, there was commonly a review of ***staffing profiles***, with new position descriptions being written and some redundancies occurring among paid staff (although it was not clear which levels of expertise were targeted). This was concurrent with increased opportunities for volunteers in recovery to contribute, although participants generally did not describe a causal link between loss of paid jobs and the development of volunteer roles. Participants in our study were generally enthusiastic about people with direct experience of service use taking on mentorship and other roles, seeing this as potentially positive for others entering treatment and the individual's own recovery. Participants did not voice the concerns raised in other reports about an over-reliance on volunteers or an under-investment in workforce development more generally (Advisory Council on the Misuse of Drugs, 2017; Alcohol Concern & Alcohol Research UK, 2018).

Some case study sites included in this study reflected a trend away from engaging with multiple providers to deliver a service system and towards having either a single provider or a ***lead provider*** managing a chain of subcontractors – an approach which has also been noted elsewhere (Recovery Partnership & Adfam, 2017). This "delegation" of commissioning function is perceived to help avoid a "bitty" system and to support coordination between the different system elements and partners, aiding the flow of individuals through the system by ensuring people are not inadvertently held in a single service whose offer is no longer well-suited to their needs. At a system level, this arrangement is also perceived to allow increased in-contract flexibility and to substantially reduce the contract management load on already over-stretched local authority

commissioning teams. While providers on the one hand appeared to somewhat welcome the increased responsibility and control lead-provider arrangements allow and were sympathetic to the plight of commissioners in trying to manage decreased budgets and increased workloads, it was also clear, however, that in fulfilling some of the functions that previously fell to the local authority, providers were also shouldering additional costs in an already reduced funding pool. Nonetheless, in all sites, there was recognition that commissioners were "not to blame" for budget reductions, and there was considerable goodwill expressed by both commissioners and providers towards working "in partnership" for the benefit of the local community, albeit with very serious misgivings about how much further budgets could stretch. It was also acknowledged that when all organisations in a system are under strain (e.g. financial, workforce) it can be harder for partnership working to flourish as each focuses on their own core business. Delegation of commissioning function also seems likely to contribute to the consolidation of the market into a smaller number of larger providers who could plausibly claim to be able to manage a whole system, with smaller providers being reliant on being sub-contracted in order to remain viable.

Total possible ***contract lengths*** varied from 3 to 9 years with different combinations of base length plus potential extension (5+2, 2+1, 3+1+1, 5+2+2, 3+2). The longest contract length (Sandley) was advocated for on the basis that it would not be possible to fairly assess the impact of a fundamental system redesign otherwise (or perhaps even to attract a provider willing to implement it). Participants expressed similar views about contract lengths as have been reported elsewhere, that is, too-short contract lengths are viewed as destabilising and mean services barely have time to embed before the commencement of the next expensive procurement exercise (Advisory Council on the Misuse of Drugs, 2017). However, some felt that a too-long contract could encourage complacency or present difficulties in the case of an under-performing provider, whereas others thought these issues could be addressed if needed through contract management processes.

It was also clear from local authority documents, particularly Service Specifications, that greater inclusion of ***families*** was a priority in all areas with many requiring a "Think Family" (Cabinet Office (Social Exclusion Task Force), 2018) approach. Similarly, improving engagement with BME, LGBT and other ***hard to reach groups*** was a common objective. However, these issues tended to be only briefly mentioned in interviews and so it is not clear how they were addressed in practice and with what effect. Further investigation of these areas would be valuable.

Future risks and opportunities

Consistent with other reports (Advisory Council on the Misuse of Drugs, 2017; HM Government, Undated; Recovery Partnership & Adfam, 2017), our study showed alcohol commissioning stakeholders are very concerned about the future of funding for the sector. As mentioned above, service providers and service users described working in partnership with commissioners to identify the preferred way of managing funding cuts that were described to them as unavoidable, with some taking a more positive view of the "innovative" solutions reached than others. However, it was also recognised that once efficiency savings are made, further cuts can only result in reduced quantity of treatment

provision, provision of lesser quality treatment, or alternatively, the lack of a provider willing to take on an unviable contract. This is consistent with others' description of the capacity of the sector to make further efficiency savings as being "exhausted" (Recovery Partnership & Adfam, 2017).

Participants across case study sites noted the lack of focus on alcohol in recent national level strategy. This absence was seen to be an impediment alcohol issues and service provision being prioritised locally, even though the commissioners in our study provided arguments for the wider benefits of investing in alcohol services to council decision makers in an effort to protect budgets. Related to this, a number of commissioner and service provider participants spontaneously mentioned the National Treatment Agency (NTA); an organisation formed in 2001 with the role of improving "availability, capacity and effectiveness"(HM Government, Undated) of drug treatment, but which was absorbed by PHE in 2013. Although the NTA focussed on drugs, rather than alcohol and participants revealed mixed feelings about it (for example, perceiving it as both constraining innovation and protecting the sector), some participants regarded it as having usefully raised the profile of treatment. It seems therefore that there is an appetite for a clearer prioritisation of alcohol-related issues at the national level in order that the case for investment can be better made locally. A Government announcement in 2018 regarding the development of a new national alcohol strategy presents an opportunity for these arguments to be made (Alcohol Policy UK, 2018). As recommended elsewhere, this could mean ensuring a new strategy includes treatment-related objectives, as well as taking national-level action to address funding inequities and shortfalls (Alcohol Concern & Alcohol Research UK, 2018). Several participants felt there were opportunities to further develop partnerships, with a view to joint commissioning. Specific groups mentioned included Mental Health Trusts, Clinical Commissioning Groups (CCGs) and other areas of public health responsibility within the local authority. Since our interviews were undertaken, the NHS has indeed announced that the 25% of hospitals "worst affected" by admissions for alcohol dependence will be supported to work in partnership with their local authority to establish Alcohol Care Teams, utilising funds allocated to their CCG (NHS, 2019).

Strengths and limitations of this study

Through the use of case studies chosen for their diverse profiles, we have been able to describe not only what service provision looks like before and after the commissioning process in a given location and common problems and solutions across locations, but also how the context itself influences the commissioning decisions made. We have also been able to triangulate our data by capturing multiple perspectives on the same events within a location and interrogating relevant documents.

Our study is limited to those sites and individuals willing to take part. Other locations may be influenced by other drivers for change or respond to these differently. It is also possible that our findings of rigorous and transparent commissioning processes and willingness of commissioner and provider stakeholders to work in partnership despite current funding pressures are less in evidence elsewhere. Although we included one NHS-led site in our study, we opted not to interview a representative due to the difficulty

we would have had in obtaining the relevant NHS ethics and governance clearances required within the timeframe for the study.

Implications for policy

This study reinforces the conclusions of other recent reports that recent funding cuts to local authority substance misuse budgets are substantial. Commissioners are responding to these by steering a course through both efficiency savings and system redesign. While some of the system changes implemented address the shortcomings of previous arrangements and so are viewed positively (for example, simplifying overly complicated systems, focussing on the development of recovery opportunities), many stakeholders are of the view that their community has reached the limit of funding cuts that can be absorbed without significant impacts upon the availability of services and client outcomes.

While the logic behind and appeal of integrated systems and lead provider arrangements is clear, it will be important to watch how they function and evolve in order that local authorities and providers can learn from one another. In particular, it is important to better understand whether perceptions of under-representation of alcohol clients in integrated systems are accurate, and if so whether efforts to strengthen referral pathways (for example, from hospital and primary care) are successful in addressing this.

In discussing lead provider arrangements, commissioners in particular tended to focus on the advantages, with relatively less said about the potential risks. Should this trend continue, it will be important for example, to better understand what proportion of total contract value is required to cover this role, what expertise and governance measures are required for service providers to adequately fulfil it, and how this could be assessed at bid stage. *The Hardest Hit(Alcohol Concern & Alcohol Research UK, 2018)* report recommends that local authority commissioning teams should include specialist expertise in substance misuse (as was the case in all our sites). Likewise, it may be argued that where lead providers are taking on commissioner-like responsibilities, they need to have the appropriate skills to manage a system, rather than an individual service.

The contribution of people with direct experience of service use as system planning stakeholders, peer workers, and in service monitoring is highly valued and increasingly sought. Supporting such participation requires planning and resources. It is also important to better understand the impact of different approaches to involvement on treatment uptake and outcomes.

Local authority alcohol service commissioners and other stakeholders appear to take into account multiple drivers and explore different options in the process of shaping their local service specification. Learning from the practice of other local authorities was a valued part of this process, however, opportunities for commissioners to have such conversations were variable.

Conclusions

The local authority alcohol service commissioning processes described in this report were generally seen to be thorough and transparent, a view supported by commissioning documentation. Commissioning was seen as a major exercise, placing considerable

demands on council and service provider resources. Recent commissioning efforts, while directed towards improving service systems to meet the needs of local communities, were also largely concerned with mitigating the effects of substantial funding cuts. In some cases, commissioning was an opportunity to address known inefficiencies and duplication in the system, although going forward there is thought to be little or no room for further cost savings while maintaining current levels and quality of service provision. In terms of system developments, common approaches includes service integration, appointing a lead provider with greater oversight responsibility, review of treatment models with a view to streamlining these, enhanced recovery options and increased involvement of people with direct experience of service use in system planning and service delivery. Local authorities have taken different approaches to the provision of outreach services and enhancing service visibility, for example, through rebranding. Commissioners, while monitoring system progress against routine indicators, are mindful of contextualizing these against changing budgets and the time it takes for service system changes to embed. Nonetheless, there are concerns that alcohol clients may be under-represented in services. There is some frustration regarding the lack of prioritization of alcohol problems both nationally and locally given their connectedness to a range of other health, social and economic costs. Partnership working, for example, joint commissioning with CCGs is seen as offering potential to improve local systems.

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Appendix 1 Alcohol-related health profile and treatment need

Indicator		Time period	England	Rellington	Frampton	Goughs-borough	Sandley	Kelgate
Local Alcohol Profiles for England (LAPE) indicators(PHE, 2018c)								
Hospital admissions alcohol-related conditions broad measure[a] / 100,000		2016/17	2200	2600	2500	2600	3000	2100
Hospital admission episodes alcohol-specific conditions[b] / 100,000		2016/17	560	650	640	510	840	750
Alcohol-related mortality[c] / 100,000		2017	45	55	55	55	40	50
Mortality chronic liver disease / 100,000[d]		2015-17	12	15	17	16	14	16
Volume of pure alcohol sold off trade [e]		2014	5.5	5.0	7.0	7.5	5.5	6.5
Percentage of adults who abstain [d]		2011-14	15	31	11	20	18	7
Adults drinking > 14 units a week (%)[d]		2011-14	26	19	34	25	24	19
Alcohol dependence and treatment access rates(Brennan et al., 2016)								
Estimated prevalence of dependence	- Number [f] - Rate [g] - Rank of 151 LAs [h]	2014/15	734,800 2%	20,300 2.5% 21-30/151	9,300 2.5% 31-40/151	4,800 2% 61-70/151	4,800 3% 11-20/151	4,000 2.5% 31-40/151
Treatment access	- Number [f] - Rate [g] - Rank of 151 LAs [i]	2014/15	77,500 10.5%	2,100 10.5% 71-80/151	1,200 12.5% 41-50/151	500 11% 51-60/151	600 12.5% 41-50/151	600 15% 21-30/151

Compared with England average: Better | Similar | Worse

[a] Admissions to hospital where the primary diagnosis or any of the secondary diagnoses are an alcohol-attributable code, rounded to nearest 100
[b] Admissions to hospital where the primary diagnosis or any of the secondary diagnoses are an alcohol-specific (wholly attributable) condition, rounded to nearest 10
[c] Deaths from alcohol-specific conditions, all ages, rounded to nearest 5
[d] Rounded to nearest 1
[e] Average litres of pure alcohol sold per adult (18+) through the off-trade by alcohol product type: all alcohol sales, rounded to nearest 0.5
[f] Rounded to nearest 100
[g] Rounded to nearest 0.5
[h] In increments of 10 out of 151 Local Authorities, where smaller rank numbers indicates a greater proportion of people are dependent
[i] In increments of 10 out of 151 Local Authorities, where smaller rank numbers indicates a better treatment access rate

Appendix 2 Topic guide: Commissioner focused questions

Local alcohol treatment and recovery service commissioning practices and their perceived outcomes for service provision: an in-depth exploration

Topic guide stakeholder interviews – commissioner focused questions (version 1.3: 11 Aug 2017)

Case study site: ________________________ Date of interview: ______/______/________

Job title of interviewee: ____

Researcher:
Thank you for agreeing to take part in an interview about how alcohol treatment services have been commissioned in [INSERT SITE NAME]. As you know, we have chosen [INSERT SITE NAME]to be one of up to six in-depth case study sites. This interview relates to the commissioning process which occurred here in [INSERT YEAR], but also on changes over recent years in alcohol commissioning. We want to understand this process from a variety of perspectives. As we are talking to people in different roles, some of the questions may be more relevant to you than others. We can skip more quickly through those aspects which fall outside your role or for which you don't feel you can offer an opinion.
The interview covers four broad topic areas:

1. How local commissioning for alcohol services occurred here in [INSERT SITE NAME].
2. Strengths and challenges of the commissioning process for service delivery outcomes
3. Recent changes in the wider commissioning landscape relevant to local commissioning
4. Future opportunities and challenges for commissioning alcohol services in [INSERT SITE NAME].

1. Local commissioning processes

a) Firstly, we want to get a picture of what the alcohol service provision 'looks like' in [INSERT SITE NAME]. Please briefly describe the range and nature of services provided 'before' the most recent commissioning exercise and what is in place now 'after'.

b) Briefly, what was your role in the commissioning process? *Prompts: Responsibilities? Objectives? Key links to other people involved? Capacity/expertise?*

c) At an overview level, please describe the commissioning process that occurred here in [INSERT YEAR]. *Prompts: Was there a consultation phase? Call for tenders?*

d) Now to look at the commissioning process in more detail…
   (i) Determining the specification:
   - Which factors do you think shaped decisions about what service(s) to commission? How did they shape it? **What is the model of provision and why?** *Prompts:*
     - *Historical service provision? Health versus crime and social disorder focus?*
     - *Available resources? (For treatment? For commissioning? Competing demands?)*
     - *Response to need? (How was this evidenced? What is classed as evidence? Where do you find evidence? Special populations e.g. families?)*
     - *Consultation processes? (Who and what did this involve? Outcomes?)*
     - *System emphasis or focus? (e.g. shift in orientation towards early intervention, treatment or recovery? Rehab? Integration/stand-alone services? Drugs/alcohol?)*
     - *Legal requirements? (e.g. Procurement law re contract length and value)*
     - *Other factors?*

   - Who were the decision makers and influencers in determining the specification? Who else could have contributed?

   - Is there anything that was not included in the specification that, with hindsight, could have been considered?

1

(ii) The tender process:

- Thinking now about the call for tenders, how did this process run? *Prompts:*
  - *Time and resources required to develop ITT*
  - *Establishing selection criteria and tender response requirements*
  - *Weighting of criteria (e.g. cost, sustainability, etc)*
  - *Bidders (e.g. Time to prepare response? How many? Type?)*
  - *Opportunity for negotiation or dialogue?*
  - *Procedures for assessing submissions (Who? How? Feedback provided?)*
  - *Consideration of risk (e.g. in transition to new provider)*

- From your point of view, which aspects of the tender process worked well? Which aspects were challenging?

- Once the preferred provider(s) was identified, what was the process for conversion of the successful tender into a service provision contract? *(e.g. agreement of KPIs)*

- What has your organisation learnt from the tender process for next time?

2. Strengths and challenges for service delivery outcomes

Thinking about the commissioning process that took place in in [INSERT SITE NAME]and the service system that is now in place, what do you think are the outcomes for service provision? What makes you think that? (Or if it is still too early to say, what outcomes do you anticipate?) *Issues to prompt:*

- *Access to services (e.g. availability, acceptability, appropriateness, timeliness, etc)*
- *Access to services for specific populations (e.g. families, hard to reach groups, dual diagnosis)*
- *Quality of service provided (e.g. in accordance with recommended best practice)*
- *Service user experience and outcomes, transition to new providers*
- *Workforce (e.g. skill base, local knowledge, staff recruitment and retention)*
- *Service provider organisational issues (e.g. governance mechanisms, sustainability)*

3. Recent developments in the wider commissioning landscape (since 2013/14)

a) [Aside from issues already discussed] What important changes or developments have you seen in the wider alcohol commissioning landscape (locally, regionally, or nationally) since 2013/14?

b) What impact have these had locally? Across the sector? *(e.g. provider mix)*

4. Future risks and opportunities

a) Looking ahead to the next commissioning round: when do you anticipate recommissioning again?

b) What do you see as the likely future risks and opportunities arising for the local commissioning of alcohol services? *Prompts: Transition to new providers, emerging requirements, opportunities for innovation*
   - Risks
   - Opportunities

Anything else?

Is there anything else you think it is important for us to understand about the process or outcomes of alcohol service commissioning in [INSERT SITE NAME]?

Anyone else?

And finally, is there anyone else you think would be able to offer a different perspective on local commissioning of alcohol services in [INSERT SITE NAME]? We are interested in capturing the views of anyone who has been substantially involved in the process from any angle.

Name: ______________________________ Role: ______________________________
Name: ______________________________ Role: ______________________________

Appendix 3Topic guide: Service provider focused questions

Local alcohol treatment and recovery service commissioning practices and their perceived outcomes for service provision: an in-depth exploration

Topic guide stakeholder interviews – provider focused questions (version 1.2: 17 Aug 2017)

Case study site: ________________________ Date of interview: ______/______/________
Job title of interviewee: ____

Researcher:
Thank you for agreeing to take part in an interview about how alcohol treatment services have been commissioned in [INSERT SITE NAME]. As you know, we have chosen [INSERT SITE NAME]. to be one of up to six in-depth case study sites. This interview relates to the commissioning process which occurred here in [INSERT YEAR]. We want to understand this process from a variety of perspectives. As we are talking to people in different roles, some of the questions may be more relevant to you than others. We can skip more quickly through those aspects which fall outside your role or for which you don't feel you can offer an opinion.
The interview covers four broad topic areas:

1. How local commissioning for alcohol services occurred here in [INSERT SITE NAME].
2. Strengths and challenges of the commissioning process for service delivery outcomes
3. Recent changes in the wider commissioning landscape relevant to local commissioning
4. Future opportunities and challenges for commissioning alcohol services in [INSERT SITE NAME].

1. Local commissioning processes

a) Firstly, we want to get a picture of what the alcohol service provision 'looks like' in [INSERT SITE NAME].. Please briefly describe the range and nature of services provided 'before' commissioning (so far as you know this) and what is in place now 'after' commissioning

b) At an overview level, please describe the commissioning and tendering process which occurred here in [INSERT YEAR]. *Prompts: Was there a consultation phase? Call for tenders?*

c) Briefly, what was your role in the commissioning/tendering process? *Prompts: Responsibilities? Objectives? Key links to other people involved?*

d) What capacity and resources does your organisation have in regard to tenders? *(e.g. regional or national bid writing team)*

e) Now to look at the commissioning process in more detail…

(i) Determining the specification:

- What factors do you think shaped decisions about what service(s) to commission? How did they shape it? *Prompts:*
    - *Existing provision? Resources available? Need?*
    - *Was there a consultation process? (Who and what did this involve? Outcomes?)*
    - *Other factors?*

- Who do you think decided the specification? Who else could have contributed?

- Is there anything that was not included in the specification that you think it would have been preferable to include?

(ii) The tender process:

- Thinking now about the tendering process, how did this run? *Prompts:*
    - *Time and resources required respond to ITT, impact on your organisation*

1

- *Capacity to understand and meet selection criteria*
  - *Competition (e.g. How many? Who? What type?)*
  - *Understanding of how submissions were assessed (Who? How? Weighting of criteria [e.g. cost, sustainability, etc])*
  - *Impression of transparency, accountability, feedback, communication with bidders*
  - *Consideration of risk (e.g. in transition to new provider)*

- From your point of view, which aspects of the tender process worked well? Which aspects were challenging?
- Once identified as a preferred provider, what was the process for conversion of the successful tender into a service provision contract? *(e.g. agreement of KPIs)*
- What impact did mobilisation *(e.g. transfer of workforce, etc)* have on your organisation?
- What has your organisation learnt from the tender process for next time?

2. **Strengths and challenges for service delivery outcomes**

   Thinking about the commissioning process that took place in [INSERT SITE NAME] in [INSERT YEAR] and the service system that is now in place, what do you think are the outcomes for service provision? What makes you think that? (Or if it is still too early to say, what outcomes do you anticipate?) *Issues to prompt:*
   - *Access to services (e.g. availability, acceptability, appropriateness, timeliness, etc)*
   - *Access to services for specific populations (e.g. families, hard to reach groups, dual diagnosis)*
   - *Quality of service provided (e.g. in accordance with recommended best practice)*
   - *Service user experience and outcomes, transition to new providers*
   - *Workforce (e.g. skill base, local knowledge, staff recruitment and retention)*
   - *Service provider organisational issues (e.g. governance mechanisms, sustainability)*

3. **Recent developments in the wider commissioning landscape (since 2013/14)**

   a) [Aside from already discussed] As a service provider, what important changes or developments have you seen in the wider alcohol commissioning landscape (locally, regionally, or nationally) since 2013/14?

   b) What impact have these had on your service? Your local area? Across the sector?

4. **Future risks and opportunities**

   a) Looking ahead to the next commissioning round: when do you anticipate recommissioning will occur? ____

   b) What is the vision for the future? *(e.g. focus in certain locations? treatment vs recovery? If unsure, is there anyone in the organisation, perhaps at a national level, that we might be able to talk to?)*

   c) What do you see as the likely future risks and opportunities arising for the local commissioning of alcohol services? *Prompts: Transition to new providers, emerging requirements, opportunities for innovation, etc…*
   - Risks
   - Opportunities

Anything else?

Is there anything else you think it is important for us to understand about the process or outcomes of alcohol service commissioning in [INSERT SITE NAME]?

Anyone else?

And finally, is there anyone else you think would be able to offer a different perspective on local commissioning of alcohol services in [INSERT SITE NAME]? We are interested in capturing the views of anyone who has been substantially involved in the process from any angle.

Name: ______________________________ Role: ________________________________

Appendix 4Topic guide: Service user focused questions

Local alcohol treatment and recovery service commissioning practices and their perceived outcomes for service provision: an in-depth exploration

Topic guide stakeholder interviews – service user focused questions (version 1.0: 17 Aug 2017)

Case study site: ________________________ Date of interview: ______/______/________

Gender interviewee *(circle one)*: Male/Female Age *(circle one)*: 18-29, 30-39, 40-49, 50-59, 60+

Researcher:
Thank you for agreeing to take part in an interview about how alcohol treatment services have been commissioned in [Local Authority] (i.e. the process during which it is decided what services will be offered and who will provide them). Shrinking budgets mean local councils need to make careful decisions about which alcohol services to offer. There are big differences between areas in the types of alcohol services that are available. This interview relates to the commissioning process which occurred here in [month x to month y, year(s)]. We want to understand this process from a variety of perspectives, including service users, service providers and commissioners. [Local Authority] has been chosen as one of up to six in-depth case study sites. The project will provide information about which approaches to commissioning have been more or less useful. The interview covers four broad topic areas: 1. How local commissioning for alcohol services occurred here in [Local Authority] 2. Strengths and challenges of the commissioning process for service delivery outcomes 3. Recent changes in the wider commissioning landscape relevant to local commissioning 4. Future opportunities and challenges for commissioning alcohol services in [Local Authority]

1. **Local commissioning processes**
   a) Firstly, we want to get a picture of what the alcohol service provision 'looks like' in [Local Authority]. The most recent commissioning process occurred here in [month x to month y, year(s)]:
   - Did you notice any changes in services during this time? Or since then?
   - What changes did you notice?
   - Which of the services have you used/do you use?

   b) Next, it would be helpful to understand to what extent you or other service users were consulted:
   - What kind of information (if any) was provided to you during the commissioning process?
   - What opportunities (if any) did you have to contribute to the commissioning process?
   - What about other people who use alcohol services – what opportunities to contribute do you think others may have had?
   - What difference do you think your contribution has made?
   - What other opportunities for information sharing and/or consultation would you like to see next time services are recommissioned?

   c) If you have attended a service in another area in the last 2-3 years, what differences have you noticed compared to here? For example, in how the service was set up, how easy or difficult it was to get a place

1

2. **Strengths and challenges for service delivery outcomes**

Thinking about the commissioning process that took place in [Local Authority] in [month x to month y, year(s)] and the service system that is now in place, what do you think are the outcomes for service provision? What makes you think that? (Or if it is still too early to say, what outcomes do you anticipate?) *Issues to prompt:*

- *Access to services (e.g. availability, acceptability, appropriateness, timeliness, etc)*
- *Access to services for specific populations (e.g. families, hard to reach groups, dual diagnosis)*
- *Quality of service provided (e.g. in accordance with recommended best practice)*
- *Service user experience and outcomes, transition to new providers*
- *Workforce (e.g. skill base, local knowledge, staff recruitment and retention)*
- *Service provider organisational issues (e.g. accountability/governance mechanisms, sustainability)*
- *Anything else?*

3. **Recent developments in the wider commissioning landscape (since 2013/14)**

a) [Aside from the issues we have already discussed] What important changes or developments have you seen in the wider alcohol commissioning landscape (locally, regionally, or nationally) since 2013/14?

b) What impact have these had locally? For you personally?

4. **Future risks and opportunities**

a) What do you see as the likely future risks and opportunities arising for the local commissioning of alcohol services? *Prompts: Transition to new providers, emerging requirements, opportunities for innovation, etc.*

- Risks
- Opportunities

Anything else?

Is there anything else you think it is important for us to understand about the process or outcomes of alcohol service commissioning in [Local Authority]?

Anyone else?

And finally, is there anyone else you think would be able to offer a different perspective on local commissioning of alcohol services in [Local Authority]? We are interested in capturing the views of anyone who has been substantially involved in the process from any angle.

Name: ________________________________ Role: __________________________________

Name: ________________________________ Role: __________________________________

Appendix 5 Documents provided by stakeholders and their contribution to case studies

Doc number	Document type *Author type*	Year(s)	Pages/ slides	Contribution to case study (if relevant)†
Rellington				
1.1	Drug and Alcohol Needs Assessment *Council staff*	2013-14	174	*This document is consistent with interview accounts of system complexity prior to recommissioning and broad results of the consultation with some additional detail provided regarding needs assessment consultation methods. The document identifies 14 issues/areas of recommendation, almost all of which were mentioned in interviews with the exception of use of non-commissioned, charitable services to increase in-patient capacity and introduction of complex needs measure. This implies the subsequent recommissioning did in fact address most if not all of the recommendations.*
1.2	Substance Misuse Consultation Document *Council staff*	2013	9	*This document was consistent with interview accounts that the Rellington treatment system was seen to require "fundamental" review. Additional information not covered in interviews: Shift of responsibility to LAs seen as opportunity to articulate with other local strategies, desire to improve accessibility for hard to reach groups, number of people consulted*
1.3	Service Specification (excluding appendices) *Council staff*	Undated	20	*The Specification identifies system goals that are consistent with interviews. Additional points include:* *- That the provider would engage with diverse communities, potentially through the inclusion of specialist third sector organisations working with BME, LGBT and other populations* *- The Rellington City Council Strategic Commissioning Group*

Doc number	Document type Author type	Year(s)	Pages/ slides	Contribution to case study (if relevant)†
				reserve the right to amend the content and detail of the specification annually (or more often if needed) to take into account changes in policy, funding and needs. *- The specification includes the full spectrum of interventions plus mentions several key areas of partnership working, priorities ease of access and navigation, and emphasises role of peer mentors and volunteers*
Frampton				
2.1	Alcohol and Drugs Harm Reduction "Plan on a Page" *Council staff*	2017	1	*This plan indicates the vision for Frampton in to reduce inequalities caused by alcohol – whereas reducing inequalities was not a strong feature of the interviews. Many of the priorities mentioned in interviews reflect those listed in the plan (for example partnership working), although the plan depicts a broader set of priorities not all of which featured strongly in the interviews (for example, achieving joint targets across substance use, mental health, housing and employment)*
2.2*	Drug and Alcohol Consultation Update *Council staff*	2017	20	*This document is not for detailed analysis, but confirms interview account of extensive consultation feeding into specification development. Includes information about who was consulted and when, how they were consulted, what the outcome was and where and how this has been reflected in the service specification*
2.3*	Invitation to Tender – Service Specification *Council staff*	2017	45	*This document is not for detailed analysis, but is broadly consistent with interview accounts*
2.4	Members Briefing for Drug and Alcohol - powerpoint slides *Council staff*	Undated	25	*This presentation to council is highly consistent with interview accounts. One aspect less strongly covered in interviews was the working with families priority*
Goughsborough				

Doc number	Document type Author type	Year(s)	Pages/ slides	Contribution to case study (if relevant)†
3.1	District Alcohol Related Harm Profile *External consultant*	2009	67	*Through its reference to previous strategies, superseded commissioning arrangements and organisations, etc, this document reinforces the idea of an evolving commissioning landscape. However, it shows some issues are perennial e.g. assertion that wrap around services are required, need for more engagement with underrepresented groups, need to improve data systems, etc. Confirms some interview content e.g. changes since then in national govt strategy, alcohol relatively under-funded*
3.2	Joint Strategic Needs Assessment *Council and Primary Care Trust staff*	2009	132	*This report provides local data for a broad range of health conditions and behaviours. Not sufficiently focussed on alcohol or recent enough to add to the case study*
3.3	District Alcohol Strategy *Council staff*	2012-15	38	*In relation to the Health and Treatment aspects of the strategy, this document confirmed commitment to ALS and PbR at that time, as well as support for linking with dual diagnosis and other MH services*
3.4	Goughsborough Health Profile *Council staff*	2013	4	*This profile document is in keeping with our characterisation of Goughsborough having a mixed alcohol profile relative to the national average*
3.5a 3.5b	Drug and Alcohol Community and Criminal Justice Service Review Questionnaire Survey Results *Council staff*	2013 2013	11 111	*Together, these documents confirmed consultation included a survey completed by 125 people, though this one was mostly completed by professionals/workers, rather than service users. Results showed a clear majority against PbR and in favour of local residential services, but only just over half favoured integration*
3.6a	Service User Questionnaire	2013	2	*In contrast to service provider survey, less support for outreach (prefer fixed sites), but in favour of*

Doc number	Document type Author type	Year(s)	Pages/ slides	Contribution to case study (if relevant)†
3.6b	Service User Results *Council staff*	2013	2	*service integration and development of more recovery opportunities such as activities to stave off boredom and offer support*
3.7	Letter to Provider – Service Review *Council staff*	2013	1	*Letter confirms invitation to services to encourage staff, volunteers and service users to be involved in consultation (sent to service)*
3.8	Letter to Provider – TUPE *Council staff*	2013	1	*Letter seeking information potential TUPE liabilities demonstrates this information would have been given to any new bidders*
3.9	Results from Consultation Events *Council staff*	2013	18	*This feedback to stakeholders is consistent with that already covered by Doc 3.5a/b and 3.6 a/b). Support for increasing recovery opportunities and mixed views regarding service integration was reflected in the interviews*
3.10	Service Review Workshop powerpoint *Council staff*	2013	35	*The content of this presentation is consistent with other consultation summary documents and interviews*
3.11	Cabinet Paper: Substance Misuse Procurement *Council staff*	2014	11	*This document adds to the case study because it shows that cabinet were presented with three options (procure same service, procure integrated service with same budget, procure redesigned integrated service with efficiency savings), with the third being the recommended option and the one followed*
3.12	Substance Misuse Service Specification *Council staff*	2014	26	*The service specification is consistent with interview data regarding the intentions for the system, the scope and length of the contract, and (broadly speaking) the outcomes required. Additional useful information:* *- The maximum cost of the service is clearly identified. The price is to be fixed for a year and thereafter subject to annual review with provider encouraged to make within contract efficiencies.*

Doc number	Document type Author type	Year(s)	Pages/ slides	Contribution to case study (if relevant)†
				- Identifies that there will be TUPE liabilities *- States that it is responsibility of provider to identify locations for service delivery, but encouraged that this should be a mix of fixed and community settings with co-location encouraged.* *- A highly detailed service framework is provided and interventions are required to be evidence-based, with reference made to relevant national standards*
3.13a 3.13b	Substance Misuse Recovery Service (Drugs & Alcohol): Invitation to Tender Part 1 Invitation to Tender Part 2 *Council staff*	2014 2014	17 28	*The document gives instructions to tenderers and information about rigour and transparency of process. Confirmed weighting between price and quality* *This document confirms bidders are required to prepare a written response for each aspect of the contract and that these are assessed according to a standard scoring matrix*
3.14	Alcohol Liaison Service Exception Request *Council staff*	2015	5	*This document concerns extending the contractual arrangements for the Alcohol Liaison Service for an additional 2 years. This contract is separate to the main alcohol service contract. Extension allowable under EU procurement regulations*
3.15	Alcohol Liaison Service Review *Council staff*	2016	19	*This document confirms that the ALS is utilised and valued and there is a recommendation that ALS be continued*
3.16	State of the District Report *Council staff*	2017	44	*This document contains general health and wellbeing date for Goughsborough*
3.17	Local Alcohol Action Area (LAAA) Action Plan – spreadsheet *Council staff*	2017	1	*This document confirms interview accounts of a service system review*
Sandley				

Doc number	Document type Author type	Year(s)	Pages/ slides	Contribution to case study (if relevant)†
4.1	Sandley Demographic profile *Unknown*	2013	6	*The sociodemographic profile of Sandley presented in this document is consistent with our information drawn from more recent government data sources*
4.2	Health & Wellbeing Strategy: Draft for consultation *Council staff*	2017-20	24	*The strategy has a specific section on alcohol, which is consistent with interview accounts of drive to improve linkage between primary care, hospital and services and focus on families*
4.3	Transformation of Sandley Substance Misuse Services – presentation to Health & Scrutiny Committee *Council staff*	2017	7	*Corroborated interview data by identifying the same context and drivers for system transformation (e.g. budget reduction, system complex and inefficient) as well as the same priorities (e.g. focus on improving recovery outcomes, single point of contact)*
4.4	Procurement Strategy for Transformation of Sandley Substance Misuse Services *Council staff*	2017	24	*None of the content contradicted interview data, however, additional points included:* - *Residential detoxification & residential services currently under a separate contract. This is to remain, but proposed that management of referral and expenditure be overseen within new contract* - *Commissioning with other boroughs (e.g. of resi rehabilitation services) was considered but not pursued due to differences in the population to be served and need to prioritise within-borough integration* - *Risks of failed procurement due to lack of interest mitigated through market testing and risk associated with TUPE implications managed by longer than standard contract submission and mobilisation periods*

Doc number	Document type Author type	Year(s)	Pages/ slides	Contribution to case study (if relevant)†
4.5	Drug & Alcohol Recovery Service Specification *Council staff*	2017	36	*The specification was consistent with interview data. Additional information of note included:* *- the specific wording of the vision for the service* *- a specific point indicating that service provision was expected to be evidence based or where innovative, to be expert-led* *- providers should work to maximise the value offered by peer mentors (skills development, all service users offered peer mentor)*
4.6	Engagement, Involvement & Co-production in Sandley *Council staff*	2017	2	*The types of involvement described in this document are consistent with the interviews. The document confirms that service user involvement should be underpinned by wider insights and evidence to ensure the service best meets their needs*
4.7	Drug & Alcohol Treatment Pathways Map *Unknown*	Undated	2	*This is consistent with participant interviews describing multiple providers under the previous model*
Kelgate				
5.1a 5.1b	Kelgate Alcohol Harm Reduction Strategy Kelgate Alcohol Strategy *Council staff*	2006-09 2009-13	28 37	*Taken together, these strategy documents are consistent with interview accounts of an increased focus on and investment in alcohol services, building up to a service system "heyday"*
5.2a 5.2b 5.2c	Kelgate Alcohol Misuse Needs Assessment Study Report *External consultant* Kelgate Alcohol Health Needs Assessment *Public health registrar* Strategic Assessment of Crime, Antisocial Behaviour, Substance Misuse and Reoffending	2009 2012 2014-15	147 104 84	*Taken together, these needs assessment documents are consistent with interview accounts of an increased focus on and investment in alcohol services followed by substantial disinvestment. Descriptions of change to the configuration of services and trends in alcohol indicator data over time were also consistent with interview accounts* *Doc 5.2b Describes a planned Assessment and Recovery Hub through which people can be*

Doc number	Document type *Author type*	Year(s)	Pages/ slides	Contribution to case study (if relevant)†
	Council staff			*signposted or referred to the most appropriate services*
5.3	Feedback to Kelgate *Alcohol Harm Reduction National Support Team (Department of Health)*	2010	46	*Given the date of this document (2010) and that it comments on a system that has since been remodelled following disinvestment, it does not contribute new material to the case study, other than to say external review of the Strategy suggested progress was being made. However, it is consistent with interview accounts of previously high levels of investment. Some of the suggestions made in this review are known to have been subsequently implemented. It is possible others may have either been implemented or superseded by a changing financial and strategic environment.*
5.4	Treatment Model Summary *Council staff*	2011	1	*This diagram is consistent with interview accounts of multiple providers within an alcohol specific (i.e. non-integrated) system*
5.5a	Safer Kelgate Partnership Plan *Council staff*	2013-18	27	*Taken together, these safety partnership documents refer to many of the same alcohol harm reduction aspirations, actions and achievements outlined in other Kelgate strategy and needs assessment documents and are likewise consistent with interview accounts of the recent history of the local alcohol treatment system*
5.5b	Safer Kelgate Partnership Delivery Plan *Council staff*	2014-15	28	*Doc 5.5b Data reported for alcohol hospital and numbers accessing treatment consistent with needs assessment documents (see Docs 5.2a-c)*
5.5c	Safer Kelgate Partnership Plan – 2016 Update *Council staff*	2016	25	*Doc 5.5 c adds to the case study by showing that: the integration of alcohol and other drug services into a single substance misuses service as a consequence of budget cuts has been acknowledged in a council report, further progress against some*

Doc number	Document type Author type	Year(s)	Pages/ slides	Contribution to case study (if relevant)†
				indicators is listed as requiring resource, one indicator has been abandoned as impossible, and that further budget cuts are anticipated
5.6	Alcohol Commissioning Plan – 2010/11-2014/15 *Council staff*	2009	24	*This document reports on a previous local alcohol plan and confirms there was previously wider activity*
5.7a*	Consultation Survey Report *Council staff*	2015-16	9	*These documents confirm interview accounts that a consultation survey was done (not for detailed reporting)*
5.7b*	Consultation Survey Comments	2016	5	
5.8*	Workforce Forecasting Document *Provider*	2016	4	*This document corroborates interview data regarding dialogue between commissioner and provider regarding provision options under reduced budget*
5.9	Award Entry *Council staff*	Undated	6	*Although the award entry was not a feature of the interviews, this document confirms the sense of pride some interviewees expressed in previous alcohol service investment in Kelgate, which has since been scaled back*

* Document provided to the research team on the understanding that contents would not be reported in detail

† This appendix shows a summary of the key points arising from the documents relevant to the case study descriptions. A more extended version of the table showing more detail regarding document contents is available upon request