

Improving drug treatment services in England

Models for commissioning and accountability

Report from The King's Fund to inform Dame Carol Black's
Independent Review of Drugs

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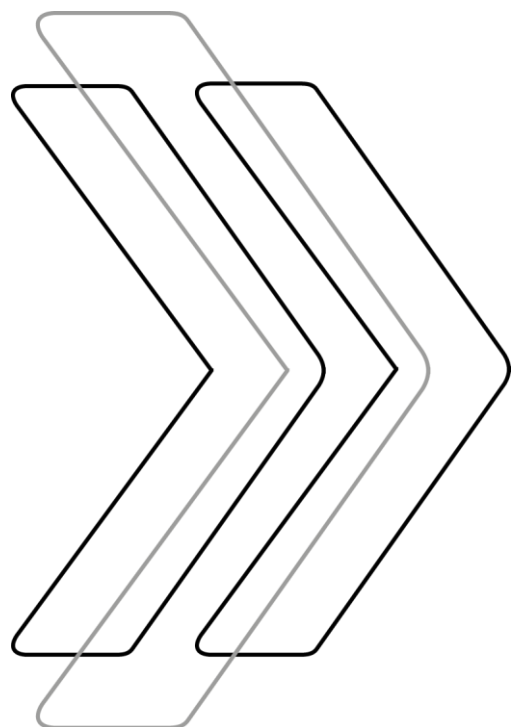
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1 Introduction

In September 2020, the Department of Health and Social Care commissioned The King's Fund to conduct a rapid evidence synthesis of the likely strengths and weaknesses of different models of commissioning and accountability for drug treatment services in England, to inform Dame Carol Black's Independent Review of Drugs.

Within the rapid evidence synthesis, we were asked to explore five research questions.

- What are the strengths and limitations of different approaches to commissioning drug treatment services in England?
- What are the strengths and limitations of different approaches to accountability for drug treatment commissioning?
- What can be learnt from other services with comparable commissioning and accountability arrangements – such as sexual health services in England – about the overall design of commissioning and accountability arrangements for drug services?
- What does current practice tell us about the wider conditions needed at a system level to ensure the effectiveness of commissioning and accountability mechanisms generally and what does this imply for drugs?
- How would different approaches to commissioning and accountability align with the broader policy direction of integrated care systems (ICSs) in England and what are the broad implications of this for drugs?

The scope of this report is to consider drug treatment services. In practice, it is often hard to disentangle the commissioning of drug treatment services from the commissioning of alcohol treatment services – for example where both are funded from a single budget – and readers may need to consider our analysis in that context.

This report was completed before the publication of the Integration and Innovation White Paper and plans for the future of the public health system in March 2021, therefore our analysis does not consider the detail of these proposals and their implication for drug treatment services.

Our approach

Owing to limitations on time to complete this work, we worked with the Department of Health and Social Care and Public Health England review team to narrow down the scope. For example, we addressed the research questions in the context of drug services in England and primarily focused on adult services. We also identified five topics that the review team were particularly interested in. These were: funding models, joint commissioning, contracting models, commissioner capacity and capability, and accountability.

We conducted several targeted literature searches relevant to our lines of enquiry using bibliographic databases (The King's Fund's database, Medline and PsycINFO) and the internet. We also checked relevant organisational websites and the references of key documents for further relevant material. In addition, we examined evidence submitted to the Department of Health and Social Care as part of the second call for evidence for the Independent Review, and drew on insights from experts at The King's Fund, plus a small number of interviews with commissioners and representatives from national bodies. As a research team, we identified key case studies and models, and developed insights through discussion.

Structure of this report

Section 2 of this report provides an overview of our assessment of the evidence about the components of an effective system, the implications of the development of ICSs for drug services and areas we think would benefit from further study. This section can be used as a 'standalone' document by the review team for ease of reference.

Section 3 outlines our detailed findings about the components of an effective system. It is divided into several subsections, based on the priorities we identified with the review team:

- funding
- joint commissioning
- new contracting approaches
- commissioner capacity and capability
- accountability.

In this section we sought to draw out the strengths and weaknesses of different models, but in practice that was easier to achieve for some areas than for others. Discrete issues such as funding, or what contract model to use, have identified 'models' with their own advantages and disadvantages. Other areas

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such as joint working and accountability are highly interconnected and have so many components that there are not discrete 'models' to compare. Therefore, these themes are explored in a more discursive way.

Section 4 presents case studies that provide insights on different aspects of the components of an effective system. These cover:

- child and adolescent mental health services (CAMHS)
- the Troubled Families programme
- sexual health services
- the National Treatment Agency
- other UK nations.

In section 5, we discuss the development of ICSs across the NHS and local government, and draw out the relevant learning for drug treatment services.

2 Overview

The Department of Health and Social Care commissioned The King's Fund to conduct a rapid evidence synthesis of the likely strengths and weaknesses of different models of commissioning and accountability for drug treatment services in England. This work was conducted to inform Dame Carol Black's Independent Review of Drugs for the Secretary of State.

Because of the short timeframe for this research, we worked with the review team to identify priorities for investigation within this scope. These were: approaches to funding, joint commissioning, contracting, commissioner capacity and capability, and accountability.

This overview provides a high-level summary of our findings on these topics and looks across them to discuss key issues that emerge when the system is considered as a whole. It also sets out key issues relating to the development of integrated care systems (ICSs) across the NHS and local government that are pertinent to drug treatment services. Finally, it identifies areas that the research team believe would be amenable to further study to inform the ongoing development of policy in this area. More details on each of these topics, as well as case studies that provide useful lessons for drug services, are contained in the sections that follow.

Our work is drawn from multiple sources, it is evidence informed but also includes the insight we have from understanding the wider development of health policy and health systems.

Drugs policy is highly complex. It spans public health through to treatment services; responsibility sits across different commissioning organisations; and oversight spans multiple government departments. Designing a commissioning and accountability system for such a complex area can never be based on evidence alone – each 'system' has a different context, and evidence of 'what works' is always partial and context specific. Our findings should therefore be interpreted in this light.

There are four key findings and a strategic question that arise from our work in the round. In implementing Dame Carol Black's final report, these are the areas that we believe are most important to address.

- **How the system fits together is more important than any single issue itself.** Funding, commissioning and accountability interact – they

are not separable in terms of 'let's fix this first'. For example, the drugs system requires stronger and clearer accountability, but if this is not accompanied by improvement support (including funding), areas cannot improve, and accountability risks becoming penalty only.

- **The desired characteristics of individual components of the system can be in opposition to each other, and trade-offs must be considered and addressed to ensure the overall model is effective.** For example, bottom-up approaches rather than top-down direction may be the most facilitative of effective collaboration between partner organisations at place level, but without expectations and scrutiny from above they would also have the loosest accountability.
- **There is not enough money in the system, whatever the future funding mechanism** (eg the existence and nature of a ring-fence). The overall amount of funding available will have an impact on design decisions. Significant additional funding is needed given the range of improvements required across service provision and the underpinning system, including commissioning, accountability, user involvement and service improvement. Without a step-change in funding, development will be more marginal and decisions such as ring-fencing within the public health grant could have unintended wider impacts, such as denuding other valid public health goals.
- The commissioning of drug treatment services has been through a unique process of change in recent years, which is separate from policy changes that have been taking place to integrate the wider health and care sector. However, **upcoming wider policy changes will have a significant impact on the environment in which drug services are commissioned.** The design, governance and scope of ICSs will change significantly in 2021–22. Some of the changes may help support changes in drug services – for example: intentions for joint budgets across the NHS and local government, clearer accountability structures including at the regional level, further deepening of the commitment to work in partnership and a focus on population health, not just the process of treatment.
- **There is a strategic framing issue for drug services.** One view could be 'exceptionalism' – ie drug treatment requires a bespoke and unique end-to-end service and its own specialist workforce. At the other extreme, given that drug users' needs often go far beyond just treatment for addiction, drug treatment could be seen as an exemplar of what a broader, more integrated health system is now seeking to achieve. Ways need to be found to hold both ways of thinking and define an approach that strikes the right balance between them.

Below is a summary of the findings on the individual components of an effective system that we examined in our research. We sought to draw out the strengths and weaknesses of different models but in practice that was easier to achieve for some areas than for others. Discrete issues such as funding, or what contract model to use, have identified 'models' with their own advantages and disadvantages. Other areas like joint working and accountability are highly interconnected and have so many components that there are not discrete 'models' to compare. Therefore, these themes are explored in a more discursive way.

Funding

- There are various possible funding mechanisms that could be applied to drug treatment services, but they will only be effective if an adequate overall level of funding is available.
- Although some people talked to us about 'simply' giving funding and commissioning back to the NHS, this is not a straightforward option in practice: it would require significant reorganisation, with the creation of new structures.
- A specific drug treatment budget, which is co-ordinated with partners' budgets towards a joint place-based strategy, is used in other countries and merits further exploration. There are, however, risks associated with it, which include disruption and unintended effects on local authorities' ability to manage the remainder of the public health grant effectively. There is also a need to avoid over-engineered processes.
- Ring-fencing could be put in place to protect drug treatment budgets, but it can be difficult to define ring-fences without loopholes and it may be difficult to avoid unhelpfully narrowing down the definition of treatment (without important but broad public health interventions). In addition, the government has previously committed to removing ring-fences in the public health grant (although this remains uncertain given the challenges of the Covid-19 pandemic and the knock-on impacts on local business rates as a source of local government finance). This means ring-fencing may not be a long-term option. Strengthening accountability and transparency may be alternatives to creating additional financial processes and structures.
- There is a case for considering funding specialist ('high-cost/low-volume') services differently from others, for example by commissioning on a regional basis by groups of local authorities in response to need across a sufficiently large population. Even if funded differently, local commissioners would need to retain a central role in ensuring a join-up with locally commissioned services.

Joint commissioning

- In 2013, joint commissioning arrangements for drug services (cross-sector drug actions teams) were disbanded. The sector is looking for new ways to get commissioners from the NHS, local government, the police and probation services to work together effectively. Evidence linking commissioning approaches to improvements in quality and outcomes is very limited, and therefore no single model emerges from the literature as the best approach.
- There is agreement that different services should be commissioned over different population footprints, depending on their characteristics. Therefore for specialised inpatient drug treatment and rehabilitation services, which are low in volume, it might be appropriate to commission across multiple local authorities or an ICS. Most drug treatment services need to be commissioned at the local authority level because this is the geography at which effective joint working between public health teams, other parts of local authorities, the NHS, prisons and probation services is most easily facilitated.
- Following the abolition of drug action teams, health and wellbeing boards were envisaged as the body that would develop integrated strategies for local areas. However, they cover all of health and wellbeing, and were not designed to have the commissioning or operational responsibilities that would be necessary to play a significant role in planning and delivering drug services across sectors. Other measures are therefore needed to ensure the effective joint commissioning of drug services across sectors.
- There is consensus across other UK nations (and formerly England) that some form of formal partnership is needed to support effective drug treatment commissioning, including a local plan, aligned or pooled budgets, and collective accountability.
- Differences in the geographies, relationships and resources in different parts of the country mean locally developed approaches to joint commissioning that build on existing system strengths are likely to be the most effective. The first step to effective joint working is agreeing what local partners want to achieve through consultation between commissioners, providers, patients/service users and communities. A plan can then be created that includes the right combination of governance and funding mechanisms to support achievement of that vision. However, an entirely bottom-up approach will not provide the accountability needed to reduce variation and provide the necessary assurance on spend.
- Strong leadership and investment in building relationships across sectors are key success factors for joint commissioning (and system development more broadly). This takes time and requires stability in the system, which

points to the need to invest in leadership development and commissioner capacity (see below) and not undertake major restructuring exercises unless the case for change is undeniable.

New contracting approaches

- New contracting approaches – such as ‘prime’ and ‘alliance’ models – have been developed to promote better joint working between commissioners and a range of providers across the NHS and local authorities. However, they will not – by themselves – overcome differences in organisational interests and relationship problems.
- ‘Prime’ contract models, which devolve responsibility for commissioning to a provider or group of providers who then subcontract with others, require the prime provider to have the capacity and skills to undertake commissioning tasks. In some local areas these skills may not be present and the model will not be viable.
- Developing and implementing these new contracting models is usually a long and costly process and meaningful outcome measures can be difficult to define, particularly for complex populations like drug users. These models can also be particularly difficult for small organisations to engage with, and this can be a barrier to the involvement of some third sector organisations. Commissioners must ensure that whatever contracting approach they choose, valuable input from small charities is not lost.
- Rather than focusing on developing contracts to promote integration, some commissioners are starting to take a more collaborative and facilitative approach – working with providers to jointly agree a local vision and develop services rather than focusing on arm’s-length contract negotiations. Collaborative approaches are in their early stages, but there are examples of NHS and local authority commissioners and providers starting to work together in this way to make best use of scarce system resources and minimise unnecessary transaction costs. More broadly, NHS policy development is moving away from transactional approaches to commissioning towards more collaborative models, and legislation has been proposed to remove some of the competition requirements that currently affect the sector.
- If contract models are going to be used to promote integration, the first step should always be a dialogue between commissioners, providers, patients and the wider community to develop a vision for the service area/group. Commissioners can then work backwards from that vision to build a contracting model that delivers its aspirations.

Commissioner capacity and capability

- The capacity and capability that commissioners need to be effective is determined by the models of care and outcomes a system wants to achieve through commissioning. The number of commissioners needed and how specialised their skills should be cannot be assessed in isolation but require some form of local strategy to be in place.
- More evidence is needed, but that available so far suggests that there needs to be national policy leadership for the approach to drug treatment, with a workforce strategy to support it. There are choices about how much detail to set out from the centre, but the evidence we have seen suggests that, in any option, a degree of national infrastructure will need to be built up over time to assess and promote effective approaches and to support workforce development.
- Whatever approach is taken, it is essential to assure basic capacity for effective commissioning, such as access to knowledge about substance use and treatment services, sufficient time to develop relationships with providers and both time and skills (eg data analysis) to carry out thorough needs assessment.
- This report focuses on the capacity and capability of commissioners, but we noted that there are also concerns about the capacity and capability of the wider drug treatment workforce.
- Although NHS commissioning support units do not offer a model because of the variable ways in which they have been implemented, the basic concept of a national framework of ambitions/expectations for commissioning together with regional centres of support and expert advice for commissioners warrants consideration. Public Health England's regional centres appear to have something potentially approaching that regional role in some cases.

Accountability

- Since the 2013 reforms, there are now just two main levers for local authorities' accountability – sector-led improvement and formal intervention by the Secretary of State – with a large gap between them. There is a lack of confidence that sector-led improvement is robust in ensuring accountability, but our research suggests it is under-used, and perhaps not used at all in drug services, related to a lack of central funding for it; doing so could be an opportunity for testing and evaluating the approach.
- For public health functions, lines of accountability have become diffuse and complex. National datasets of public health and drug treatment

outcomes and performance indicators are available, but they are not currently used for accountability.

- More evidence is needed, but comparing drug treatment services to a five-point framework for types of accountability in health and care suggests that:
 - the consistency of focus and follow-through by scrutiny committees could be improved
 - it is difficult to achieve accountability through performance-based contracts, with a risk of over-engineering, selection bias and limited impact
 - management accountability is currently entirely within individual local authorities, and is potentially just one item on a broad performance dashboard – some external oversight and a specific focus on drug services may be needed
 - regulatory accountability is only possible for registered providers and not for commissioners or the system as a whole – however, although they do not have enforcement sanctions, whole-system thematic reviews by the regulator could be useful in shining a light on issues
 - drug treatment services may be perceived as lacking political impact, but our research on rough sleeping and associated health issues suggests that building local political commitment could create positive electoral accountability as a positive force for improvement.
- There is a case for considering a regional role for accountability in services, such as drug treatment services, which have complex local accountability and poor connection to national accountability.
- There are caveats about transferring learning from the NHS to local authorities. However, there are examples that may offer useful principles for consideration – such as the arrangements for ensuring that funding for additional increased access to child and adolescent mental health services (CAMHS) is conditional on an approval process for local plans and routine external monitoring of performance and outcomes.
- Radical changes in 2013 in England contrast with the other UK countries' evolutionary approaches to drug treatment services. There is significant potential to learn from Scotland, Wales and Northern Ireland as they progressively embed and mature approaches to accountability for outcomes, performance and quality.

The implications of the development of integrated care systems

- The NHS is moving away from using competition as a tool for improvement and is firmly focused on collaboration as the best route to fulfilling the health and care needs of local populations. ICSs are partnerships that bring together providers and commissioners of the NHS, local authorities and other local partners in a geographical area, to collectively plan and integrate care to meet the needs of their population.
- Given the focus of ICSs is integrating care across complex system boundaries, for patients with complex needs, it is important that drug treatment services align with commissioning and accountability in ICSs and vice versa.
- ICSs have been developing at different rates in different parts of England, and are expected to cover all of England by April 2021 (there will be around 44). Significant change is planned in 2021 and 2022 and is outlined in plans published at the end of November 2020. This includes stronger, but locally flexible, governance and accountability – bringing in wider partners including local government and the voluntary sector. It also includes proposals to formalise ICSs in legislation by April 2022.
- The emerging partnership structures being created through ICSs might be an effective place to consider situating any new accountability mechanisms being developed. However, there is a big question about scale and the appropriate footprint of a regional accountability role for drug services (as well as the formal powers) and whether that matches ICSs, or other footprints. This is an open question, but ICSs are sub-regional structures in the NHS that are being formed and this is a factor to be taken into account in any regional new structure that supports commissioning and accountability around drug services.
- As part of the plans for the future of ICSs, all NHS providers will join provider collaboratives. Well-designed provider collaboratives are the mirror of joint commissioning and partnership approaches to planning. Given the complex needs of most people with drugs issues, these collaboratives are likely to have an implication for the services people with drugs problems receive. Drugs commissioners therefore need to understand and engage with these collaboratives as they are formed.
- The government has announced a new National Institute for Health Protection as a response to the Covid-19 pandemic, which has implications for the rest of Public Health England, and potentially the public health system it oversees. There is an opportunity to rethink the public health system in England, including commissioning and accountability, and the role of national and regional tiers and the

connection to ICSs. Those responding to Dame Carol Black's review will need to engage and influence public health reform, alongside the development of ICSs.

Further work

We believe that the review team could usefully explore some key areas following Dame Carol Black's report, to inform the shape of the response to it in future policy development. From our work, the areas below would be priorities, in our view.

First, the role of a regional tier. The case for a regional tier is discussed across our topic areas as a way to strengthen vertical accountability, to support improvement, to make the most of scarce expertise, and potentially as the level for commissioning specialised services, as ICSs will operate at the regional or sub-regional level in the future. It would need to be designed carefully, with a role in reducing unwarranted variation, while also supporting innovation and ideally engaging with ICSs and any regional structure in the future public health system.

Second, further investigation into what an external directed improvement support offer could look like. This could range from supporting current models such as peer-to-peer sector-led improvement in local government and commissioning support units in the NHS, to models such as the former national support teams, which were connected to reaching public service agreement targets, to more directed models. There is clearly a need for such an approach in drug services and commissioning; and without an effective and systematic means of improvement, other changes will founder. Whether this should be national, regional or local should also be looked at.

Third, a more in-depth investigation into the strengths and weaknesses of, and transferability of learning from, the drug commissioning and provision systems in the devolved nations. There is clearly experience of direct relevance to England, but the systems are different. In some ways they have characteristics of where the wider health policy context within which drugs commissioning sits is heading in England – ie more integrated systems.

And finally, more consideration of the implications of the development of ICSs in 2021–22, as they progress further, into population health systems. Many of the developments that are planned for ICSs over the next two years could be very helpful. Clearly, there is a strategic decision to be taken about the extent to which drugs policy and implementation wish to join or align with this direction of travel, or go on their own path.

3 Components of an effective system

Funding

Key points

- There are various possible funding mechanisms that could be applied to drug treatment services, but they will only be effective if an adequate overall level of funding is available.
- Although some people talked to us about 'simply' giving funding and commissioning back to the NHS, this is not a straightforward option in practice: it would require significant reorganisation, with the creation of new structures.
- A specific drug treatment budget, which is co-ordinated with partners' budgets towards a joint place-based strategy, is used in other countries and merits further exploration. There are, however, risks associated with it, which include disruption and unintended effects on local authorities' ability to manage the remainder of the public health grant effectively. There is also a need to avoid over-engineered processes.
- Ring-fencing could be put in place to protect drug treatment budgets, but it can be difficult to define ring-fences without loopholes and it may be difficult to avoid unhelpfully narrowing down the definition of treatment (without important but broad public health interventions). In addition, the government has previously committed to removing ring-fences in the public health grant (although this remains uncertain given the challenges of the Covid-19 pandemic and knock-on impacts on local business rates as a source of local government finance). This means ring-fencing may not be a long-term option. Strengthening accountability and transparency may be alternatives to creating additional financial processes and structures.
- There is a case for considering funding specialist ('high-cost/low-volume') services differently from others, for example by commissioning on a regional basis by groups of local authorities in response to need across a sufficiently large population. Even if

funded differently, local commissioners would need to retain a central role in ensuring a join-up with locally commissioned services.

The issue

Drug treatment services are now funded via the public health grant. The public health grant per head of population has reduced by almost a quarter between 2014/15 and 2019/20 (Buck 2019). Prior to 2013, drug treatment services had their own protected funding source, which was overseen by the National Treatment Agency for Substance Misuse (NTA) and grew significantly year on year during the NTA's existence.

The public health grant as a whole is ring-fenced and certain 'prescribed services' set out in regulations are legally required to be provided, but they are not individually ring-fenced. Drug and alcohol treatment is the second largest component of the public health grant. The government has committed itself to removing all ring-fencing in future reforms of the public health grant and business rates retention; however, implementing that commitment has been delayed several times and there is no clear timetable at present.

Budgets for drug services are often combined with budgets for alcohol services even though the two are different and can compete for priority on different public health criteria (ie large numbers of people requiring alcohol services versus smaller numbers of drugs users but with more acute health risks). Furthermore, combined budgets are in contrast to historical arrangements that had allocated separate funding for opioid users (who have different needs, associated social and criminal issues, and treatment outcomes compared with non-opioid users).

Funding pressures and cuts are a key part of the concerns about drug treatment services, including concerns that current accountability arrangements are not strong enough to ensure that any additional funding is spent on drugs rather than on other competing public health priorities.

Concepts/models

In Table 1 we outline the different potential funding options (or models) for drug treatment services as well as their strengths and weaknesses.

Table 1 Potential funding models and their strengths and weaknesses

Model	Description	Pros	Cons
Leave as is but strengthen accountability	Keep existing arrangements but increase how councils are held to account for use of the public health grant and for access to and the effectiveness of drug treatment services	<ul style="list-style-type: none"> • Least disruptive option 	<ul style="list-style-type: none"> • Not clear how to increase accountability rigorously as councils are autonomous, so high risk – although the ‘Troubled Families’ initiative is a possible example of how it could be possible to strike a balance (see section 4)
Separate discrete funding	As in the past, have a unique bespoke arrangement for funding drug treatment instead of the current general public health grant funding plus various national ‘pots’	<ul style="list-style-type: none"> • Widely used elsewhere • Can recognise the complexity of the sector and ensure a sustained focus • Can be designed as one overall system with performance monitoring, leading to greater accountability • Protects budgets even if the government removes the public health 	<ul style="list-style-type: none"> • Moderate to high disruption • If not the route of a special health authority (as the NTA was), it could require legislation • Even a non-legislative route would require new processes and systems and reorganisation (including others potentially ‘giving up’ their aspects of drug-related budgets)

grant ring-fencing in future

- An 'exceptionalist' approach can be at odds with the need to integrate drug treatment with related services
- Could remove flexibility in the public health grant and create new pressures on other aspects, eg sexual health services

Bespoke ring-fence

Keep the current system as it is but create a ring-fence for drug treatment funding (all of it or a portion of it)

- Low disruption
- Protects budgets

- May not be politically acceptable; runs counter to the government's commitment to ending ring-fencing and further reduces councils' autonomy
- May not be 'future proof' if the government removes the public health grant ring-fences as promised
- Could remove flexibility in the public health grant and create new pressures on other

			<p>aspects, eg sexual health services</p> <ul style="list-style-type: none"> • Difficult to define to remove all gaps or gaming
<p>Different arrangements for different types of services</p>	<p>The main example is to fund clinical services through the NHS and non-clinical services through councils</p>	<ul style="list-style-type: none"> • Protects high cost/low volume clinical services, with minimal disruption to the commissioning of non-clinical services 	<ul style="list-style-type: none"> • Risk of creating a fragmented system – but arguably specialist clinical services are already discrete – in Wales, this is mitigated against by requiring the NHS to be a member of a local group co-ordinating all relevant budgets and plans • NHS England is reducing rather than increasing central specialised commissioning, thus future arrangements are uncertain and may include options that councils consider radical – but could also help integrate into wider ICS approaches

			<ul style="list-style-type: none"> • Only solves limited issues on its own and may still need to increase accountability or ring-fencing and could be potentially disruptive
<p>All funding through the NHS</p>	<p>Often described as giving the funding role back to the NHS (as the NTA was a special health authority), all funding would be via the NHS budget</p>	<ul style="list-style-type: none"> • No benefits when framed as 'giving back to the NHS' (see cons) but if framed as creating a bespoke funding system instead, then pros and cons could apply as in model 2 (see above) 	<ul style="list-style-type: none"> • Funding was not in mainstream NHS arrangements before and the NTA was a special type of NHS body used as a vehicle for working across the NHS and councils – without the NTA, none of the structures, systems or knowledge exist anymore in the NHS • Concerns from our interviews that the NHS is not well placed to commission non-clinical services or to promote 'join-up' with the full range of partner services

Evidence

The Independent Review of Drugs has described a recent history of real-terms reductions to the public health grant and, within that, reductions in expenditure on the drugs budget (Black 2020). Submissions to the call for evidence appear unanimous in claiming a need for additional funding.

Drug treatment services when added to alcohol treatment services (as they are not separate budget 'pots') are the second largest area of expenditure in the public health grant, behind services for children aged 0–5, and with expenditure on sexual health services in third place, 'miscellaneous' in fourth and all other categories much smaller (The Health Foundation 2020). Making changes to the drugs budget that protect it could increase risks to the other budget lines for other services funded through the public health grant.

Previous arrangements in England channelled the whole drug treatment budget through the NTA, separate from other NHS or council budget lines. And there was ring-fenced funding for opioid treatment services, linked to crime-reduction strategies. During this time the NTA's budget increased from £50 million to £467 million (source: review team evidence).

In addition to the formal drug treatment budget, interviewees told us that some councils and some NHS bodies funded certain services from their 'general' budgets, although this was thought to vary widely. The NTA estimated that in its last year of operation (2012/13) this 'general' funding contribution was £200 million (source: review team evidence). In addition, interviewees said that there are often one-off 'pots' of national funding for short-term projects or specific issues that local areas can apply for (eg, services for people who sleep rough, Public Health England's capital grants). We do not have a total figure for these national pots, but they appear not insignificant.

There is very limited published description of other countries' approach to funding drug treatment services, but it appears that the approach of a bespoke arrangement is not as 'exceptionalist' as it might initially appear. Several countries, including other UK countries, appear to take this approach as a way of funding diverse services that can go across administrative boundaries, requiring a range of partners to develop plans jointly and account for the money together. However, some approaches appear to be very complex (see, for example, Victoria State Government 2020). In England, piloting was carried out of a very complex (and unsuccessful) process for Payment by Results (Donmall et al. 2019) and we heard in interviews that, as bespoke budgets became more embedded, so duplication increased (eg drugs-specific housing workers, employment advisers and so on in addition to the wider resources for these functions). Even in Wales, where the approach appears well co-ordinated so that various agencies come together to develop, fund and oversee local plans, we

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were told that the system is still complex and challenging (although that is based on individual views, not on a formal evaluation). It appears that care should be taken to keep the system simple and to avoid over-engineering.

We heard that none of the infrastructure from the NTA exists now, so any creation of a bespoke budget would need to create processes and systems, as well as the national vehicle for allocating and tracking the money. There would be choices to make over whether a bespoke system only covers the formal treatment budget, or also includes other allocations and national 'pots' of funding.

We considered ring-fencing of (some or all of) the drugs budget within the public health grant. We did not find examples of this elsewhere but that may just reflect the general sparsity of literature.

Ring-fencing can potentially have the unintended consequences of ossifying service assumptions and inhibiting innovation, or undermining partnership approaches, but it equally has strong advocates, particularly in times of austerity. It is difficult to define ring-fences so tightly that there are no gaps or opportunities for gaming. Although ministers may criticise ring-fencing, in fact various budgets are ring-fenced, such as school budgets, and it is not an exceptional policy (Robertson *et al* 2017; Appleby and Hunter 2010).

We looked into whether there could be a case for funding specialist services (inpatient detoxification, residential rehabilitation) differently from other services given their different (more clinical) nature and their high-cost/low-volume profile. We identified two main options.

- In Scotland and Wales, the NHS retains the budget for these services. Budgets are not pooled but are aligned through local co-ordinating groups that plan, fund and oversee services for an area and are collectively accountable (source: review team evidence).
- In English child and adolescent mental health services (CAMHS), there are similar concerns about the small number of providers able to offer high-cost/low-volume specialist inpatient ('tier 4') services and a new approach has been developed, which although still new – it is too early to be definitive about impacts – has three key issues of interest.
 - Services are commissioned across several ICS areas – the equivalent of groups of upper-tier local authorities – because individual ICSs cannot guarantee sufficient volumes on their own to make a provider viable and will only use spot-purchasing, which lacks stability for providers, but by grouping together they can create a viable market.

- Although the tier 4 services are commissioned through a separate mechanism, local commissioners retain a central role in making sure that they join up with non-specialist services. It is not a case of simply taking them out of local commissioners' responsibilities.
- The approach in CAMHS is to make providers (both NHS and independent sector providers) responsible for working together to plan and assure access to tier 4 services (ie no commissioner). This may not be directly applicable to drug services as most CAMHS providers are NHS trusts with substantial capacity and connections into ICSs, but the potential to consider radically different approaches may be of interest (although in our interviews we did not discern an appetite for that) (Niche Health and Social Care Consulting 2019).

We looked at Improving Access to Psychological Therapies (IAPT) as a potential model for commissioning tiers of services of different intensity across England. However, it quickly became apparent that this was a case of scaling up highly standardised services across areas with a known and relatively stable prevalence of needs, and would be unlikely to offer significant learning for drug services, which are more diverse, more tailored than a whole-population approach and where it is more challenging to assess needs (Department of Health 2008).

Discussion

Any discussion of funding systems must be within the context of the need to assure adequate levels of funding – a sophisticated funding system will not solve anything if funding levels are inadequate. For example, sexual health services are prescribed and whereas the legal mandate may have offered a degree of protection compared with non-prescribed services, ultimately services are still at risk due to significant budget cuts (see the case study in section 4).

Equally, funding arrangements are not enough on their own unless other parts of the overall system design are in place – notably a definition of the outcomes that the funding is to be used for and accountability arrangements. Those other parts of system design are not discussed here but in the relevant sections of this report.

A number of other countries (including other UK countries – see the case studies in section 4) have a bespoke system for funding drug treatment services (and prevention). This option might, at first glance, appear more effective, but in fact there is a risk that if not intentionally kept simple it will become overly complex (eg with a complex design to allow value-for-money assessments across different service types as in Australia, and Payment by Results – often abbreviated to PbR – as in England and the United States). Even the Welsh model – which appears good on paper – has been described to us as 'unwieldy'.

Two significant downsides of a bespoke budget are:

- potential overheads due to having to design and negotiate new processes, which could include negotiating for occasional funding from others' budgets (eg rough sleeping services), with this being 'taken off' them and put into the drug treatment budget, which could create the risk of duplication (eg funding related to housing within the drug treatment budget, when there is also a wider housing department within the council)
- the impact on the wider public health grant if drug treatment funding is taken out and treated separately.

Ring-fencing all or some of the drug treatment budgets within the public health grant is the simplest option for protecting budgets, but it will not work in the longer term if the government removes ring-fencing of the public health grant. It is still unclear whether the government will actually remove the ring-fencing after repeated false starts (but we note the government has also made repeated commitments to do so in future) (Ministry of Housing, Communities and Local Government 2020a). Ring-fencing also has a similar effect to the bespoke budget option on the wider public health grant, removing councils' flexibility, which in turn may create additional pressures on other budgets (such as sexual health) if councils need to create flexibility from them. Apart from its unpopularity with councils and the government, ring-fencing could potentially have the unintended consequences of ossifying service assumptions (discouraging innovation) or undermining the sense of equal partnership across the full range of partners. There are likely to be significant challenges in defining what would be within the ring-fence so that:

- there are no gaps or opportunities for gaming
- the definition is not narrowed down to just clinical interventions, with the risk that broader public health interventions that are important in the overall range of services for substance users could fall down a gap between different funding arrangements for drug treatment and health improvement.

Having a range of different funding arrangements for different types of services could risk fragmenting where local areas have developed overall coherent approaches and is probably not a serious option other than for the particular case of inpatient detoxification and residential rehabilitation – the main high-cost/low-volume services. Given the un-co-ordinated reduction in inpatient facilities that has been seen, there could be a case for commissioning these separately and, given their more (but not exclusively) clinical nature, for them to be commissioned in the NHS, as happens in other UK countries. Experience with tier 4 CAMHS suggests that it is possible to do so, with local commissioners (in

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this case, the local authority drug treatment commissioners) retaining a central role in making sure the overall pathway of services coheres – in the case of CAMHS this may if anything have increased coherence rather than leading to fragmentation. Experience in Wales, where the NHS, the council and other partners each sit as members of a local board that collectively owns the approach, also suggests a potential mitigation of the fragmentation risk (although we do not have formal evaluation evidence).

Learning from CAMHS also suggests it could be possible to conceive of different arrangements for specialist services so that they are commissioned separately from others but with the commissioning function still staying within councils, eg on a regional basis co-ordinated across several councils. If commissioning for these specialist services is delegated to the NHS, apart from potential short-term disruption and the potential for fragmentation, there are two main risks to consider.

- The future direction for specialist commissioning in the NHS is very uncertain and it would not be a case of adding them into a pre-existing, stable arrangement.
- Some of the options being developed in the NHS – such as provider collaboratives and strategic decisions made within ICSs – may not be the options that local authorities would have selected.

We looked at the IAPT programme as an interesting framework that systematically ensured a range of tiered services in each area, and a workforce pipeline for them, but it does not seem likely that a similarly 'formulaic' approach could work across drug treatment given the wider range of services with a lack of standardisation.

The model of 'returning funding to the NHS' is only included here for completeness. It is not realistic to frame it as a return to the NTA model; to do so would in effect require a new bespoke approach (the second model in Table 1). Furthermore, interviewees expressed concern at the prospect of the NHS commissioning lower-tier non-clinical interventions and questioned whether the NHS was as well placed as councils are to promote partnership with the range of partner organisations that need to be involved.

Joint commissioning

Key points

- In 2013, joint commissioning arrangements for drug services (cross-sector drug action teams) were disbanded. The sector is looking for new ways to get commissioners from the NHS, local government, the police and probation services to work together effectively. Evidence linking commissioning approaches to improvements in quality and outcomes is very limited, and therefore no single model emerges from the literature as the best approach.
- There is agreement that different services should be commissioned over different population footprints, depending on their characteristics. Therefore for specialised inpatient drug treatment and rehabilitation services, which are low in volume, it might be appropriate to commission across multiple local authorities or an ICS. Most drug treatment services need to be commissioned at the local authority level because this is the geography at which effective joint working between public health teams, other parts of local authorities, the NHS, prisons and probation services is most easily facilitated.
- Following the abolition of drug action teams, health and wellbeing boards were envisaged as the body that would develop integrated strategies for local areas. However, they cover all of health and wellbeing, and are not designed to have the commissioning or operational responsibilities that would be necessary to play a significant role in planning and delivering drug services across sectors. Other measures are therefore needed to ensure the effective joint commissioning of drug services across sectors.
- There is consensus across other UK nations (and formerly England) that some form of formal partnership is needed to support effective drug treatment commissioning, including a local plan, aligned or pooled budgets, and collective accountability.
- Differences in the geographies, relationships and resources in different parts of England mean that locally developed approaches to joint commissioning that build on existing system strengths are likely to be the most effective. The first step to effective joint working is agreeing what local partners want to achieve through consultation between commissioners, providers, patients/service users and communities. A plan can then be created that includes the right combination of governance and funding mechanisms to support achievement of that vision. However, an entirely bottom-up approach will not provide the

accountability needed to reduce variation and provide necessary assurance on spend.

- Strong leadership and investment in building relationships across sectors are key success factors for joint commissioning (and system development more broadly). This takes time and requires stability in the system, which points to the need to invest in leadership development and commissioner capacity (see below) and not undertake major restructuring exercises unless the case for change is undeniable.

The issue

The Health and Social Care Act 2012 radically changed the way drug treatment services are commissioned and removed some of the mechanisms that supported joint working. Drug action teams – a structured approach to local commissioning and cross-sector co-ordination that involved senior leaders from health, local authorities, the police and probation services – were disbanded and the drugs-specific pooled budget they controlled was subsumed into the public health grant.

Local authorities now hold responsibility for co-ordinating commissioning efforts and health and wellbeing boards are envisaged as the body that will develop integrated strategies for local areas. There is a widely held view that this vision has not been realised in most parts of the country as health and wellbeing boards do not have the commissioning or operational responsibilities previously held by drug action teams. The result is a fragmented system in which people with complex needs – include people with mental health problems, people with long-term conditions, homeless people and people with drug problems – are in some cases not having those needs met.

To address this, the Advisory Council on the Misuse of Drugs (ACMD) highlights the need for better links between drug treatment and clinical commissioning group (CCG) and sustainability and transformation partnership planning (Advisory Council on the Misuse of Drugs 2017)

Commissioning approaches differ across the country. We heard during interviews that some areas have managed to maintain a degree of partnership working following the reforms created by the Health and Social Care Act 2012. This was largely attributed to cultural factors, such as long-standing good working relationships and partners having 'faith' in each other. In other areas, previous arrangements have disappeared and planning has suffered as a consequence.

Concepts/models

In Table 2 we outline the strengths and weaknesses of different potential models for joint commissioning. We have included a mix of formal and informal models

– some relate to joint strategic planning and some to joint commissioning (which includes planning, procurement and monitoring). The table is not based on a comprehensive analysis of every option; rather, we have brought together key points from our analysis so far.

Table 2 Potential joint commissioning models and their strengths and weaknesses

Model	Description	Pros	Cons
Drug-specific formal joint commissioning structure	A cross-sector partnership or other forum where senior leaders with responsibilities relating to drug services come together to jointly plan and commission drug services – the drug action teams in place before 2013 are an example of this	Can bring together senior leaders from all relevant sectors Provides significant capacity to plan and commission co-ordinated drug services across sectors	Would require extra investment as it represents an increase in capacity from current commissioning arrangement Would require significant extra capacity to recreate and cause disruption to current staff roles and responsibilities Could promote siloed thinking of drug services (rather than considering alongside other elements of an individual’s health and wellbeing)
Generic joint planning structure: the health and wellbeing board	A health and wellbeing board is a formal committee of the local authority that brings together leaders from the local health and care system to work together to promote integration and improve	Broad membership that covers the areas pertinent to drug services – involves leaders from across the NHS, local authorities and third sector	It is a partnership forum, not an executive decision-making body Does not have the commissioning or operational

	health and wellbeing for their local population	Has a broad lens and can therefore consider drug services alongside other issues affecting the health and wellbeing of local populations Existing forum so no disruption associated with the model continuing	responsibilities required Wide agenda across health and care, so does not have the bandwidth to undertake significant work on drug services Wide variation in how health and wellbeing boards are operating across England
Generic joint planning structure – ICSs	Partnership between NHS providers and commissioners, local authorities and other local partners to collectively plan and integrate care to meet the needs of their population The geographical footprint of ICSs varies but they tend to cover a larger area than a health and wellbeing board, meaning most cover an area of more than one local authority.	An ICS might be the right geography for commissioning low-volume services like inpatient detoxification and rehabilitation – this allows efficiencies from pooling staff expertise and resources	The area covered by an ICS is in many cases too large to facilitate effective joint planning for most aspects of drug service commissioning Services are better commissioned closer to users where local commissioners and providers can collaborate to address local needs and those involved in designing a service are closer to the communities they serve Local authorities have little influence over the development of sustainability and

			<p>transformation partnerships/ICSSs in most places</p> <p>Work on 'place'-level planning is devolved to local authorities/CCGs or CCG locality groups</p>
<p>Delegating commissioning responsibilities to a lead commissioner</p>	<p>This is usually accompanied by a pooled or aligned budget arrangement – either the local authority or CCG commissions a range of connected services on behalf of the other organisation</p>	<p>Supports a focus on outcomes across the pathway</p> <p>Relatively straightforward to set up using section 75 agreements</p> <p>Can generate efficiencies by removing duplicated effort by multiple commissioners</p>	<p>May not be possible depending on the alignment or geographical boundaries of CCG(s) and local authority</p> <p>Commissioner still needs to develop an approach for working with other sectors to ensure services provided across the NHS, local government, probation services and prisons address the needs of drug users</p>
<p>Bespoke local planning approaches</p>	<p>Rather than mandating a particular approach to joint working, local areas can be required to work out the arrangements that work best for them – sexual health services is an example of an area where NHS England and NHS Improvement have asked commissioners to collaborate but the format for this has been</p>	<p>Allows areas to design joint planning arrangements around local geographies and strengths</p> <p>Evidence shows no single model is effective in supporting joint planning and that impact depends on</p>	<p>More difficult to oversee and hold to account as no one model to test progress against</p> <p>Requires high levels of trust</p>

left to local areas to decide (see section 4) local history and context

Evidence

The past three decades have been characterised by repeated reorganisations of the way health, social and public health care are commissioned across the NHS and local authorities in England. These have brought changes to who commissions what, the area over which they commission, the financial arrangements used to reimburse providers for care, and the approaches taken to encourage joint working between commissioners.

No single model has emerged as an effective way of delivering high-quality, efficient care that is co-ordinated around patients' needs. Evidence that links commissioning approaches to the cost and quality of health care services is very limited (Gardner et al. 2016). This challenge is not restricted to England – health and care systems around the world have struggled to develop effective commissioning arrangements (Klasa et al. 2018; Ham 2008).

Commissioning over different geographical footprints

One recurring challenge for commissioners is finding the optimal geographical footprint for commissioning. This requires a balance to be struck between the economies of scale that flow from commissioning over large areas (which includes the ability to pool expertise and patients in service areas with low volumes), and the local insight, engagement and tailoring that can occur when services are commissioned at a smaller scale, closer to the community being served. The current prevailing view is that different types of services should be commissioned over different population footprints (Lorne et al. 2019; National Audit Office 2018).

Figure 1 identifies three distinct service types:

- regional (low-volume, high-cost services that are highly interdependent with others)
- local multi-agency (where joint working is key)
- local simple (which can be commissioned in a fairly discrete and simple way).

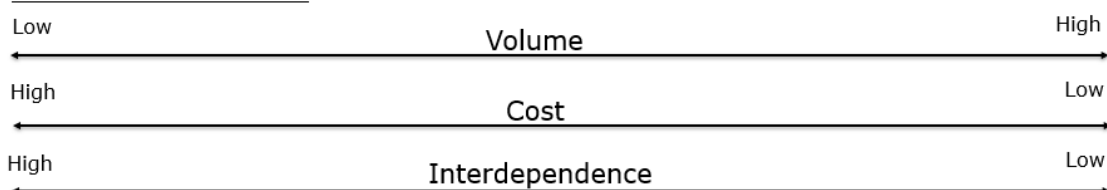
Figure 1 Different levels and types of commissioning

Insights to date: Commissioning

Regional single service	Local multi-agency service	Local simple service
– jointly commissioned on behalf of regional partners ✓ Concentration of scarce expertise ✓ Clear boundary around scope ✓ Joint budget arrangements possible if required x Less local insight	– jointly planned and commissioned on behalf of local partners ✓ Breadth of expertise across issues/services ✓ Wider budget possible ? Stronger accountability required	– commissioned by single organisation ✓ Simplicity ✓ Clarity ? Is this approach suitable for drugs services? ? Could be inward-looking

Supported by strong national commissioning support function re evidence, benchmarking, model development

Service characteristics



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Broadly speaking, it would appear that specialist drug treatment services may fit the criteria for regional single services and local multi-agency services reflect the landscape when drug action teams existed. Further, although it may seem that drug treatment services sit under 'local simple service', we appreciate they are far from 'simple'. Overall, it is important to consider full use of all the options shown.

Over the past year, ICSs, which bring together commissioners and providers from the NHS and local authorities to plan collectively, have been rethinking commissioning arrangements and mapping out which services should be commissioned over which population footprint. NHS England and NHS Improvement have defined footprints over which services can be commissioned as neighbourhoods, places or systems (NHS England and NHS Improvement 2019).

The King's Fund has recently analysed the planning approaches within ICSs, and found that they have been approaching this question with a strong emphasis on subsidiarity – the idea that decisions should be made as close as possible to the local communities they affect, and that they should only be led across larger geographies where there is a clear reason to do so, or they cannot be carried out at a local level (Charles et al. forthcoming).

The work of ICSs is at an early stage and, as yet, there is no 'right' approach. However, it is clear that the division of responsibilities must be left to local areas to determine, given the wide variation in their characteristics and geographies.

The level at which a service is commissioned affects which planning organisation within the NHS a local authority should seek to work with. The process of identifying the right NHS partner is complicated by frequent changes to NHS planning structures. In November 2020, NHS England and NHS Improvement proposed further changes backed up by proposals for new legislation, which are currently being consulted on (see section 5 for more detail) (NHS England and NHS Improvement 2020). For NHS commissioning, it is proposed that CCG functions may be subsumed into ICSs and that joint working at the place level between NHS commissioners and local authorities is strengthened. It is proposed that the role of commissioning will change in three ways:

- ensuring a single, system-wide approach to undertaking strategic commissioning, including assessing population health needs and planning how to address those needs
- provider organisations and others, through partnerships (including provider collaboratives), agreeing the future service model and structure of provision jointly through ICS governance
- greater focus on population health and collective system ownership of the financial envelope.

The implications for drug treatment services of the evidence on joint commissioning are twofold.

- It is important to explore commissioning specialist services across a larger population footprint, eg groupings of local authorities or at the ICS level.
- It is important for drug treatment service commissioners to understand the impact of subsidiarity on health services that drug treatment needs to join up with, eg mental health care.

Current structures for joint planning

Before 2013, drug service commissioning was conducted via a bespoke model of joint planning, through drug action teams – cross-sector partnerships of senior leaders from local authorities, the NHS, the police and probation services that were responsible for planning and commissioning services paid for with a ring-fenced pooled budget. Following implementation of the Health and Social Care Act 2012, the sector moved to a generic model where commissioning is increasingly conducted by commissioners who span a number of areas, and joint planning and strategic co-ordination are left to the health and wellbeing board, which is responsible for joint partnership working across health and care.

Health and wellbeing boards have a statutory duty to produce a joint strategic needs assessment with CCGs and a joint health and wellbeing strategy for their local population, but their formal powers are limited – they are constituted as a partnership forum rather than an executive decision-making body (Humphries 2019; Humphries and Galea 2013). This means that they do not have the operational or commissioning responsibilities necessary to be effective in ensuring co-ordinated joint commissioning arrangements for drug services.

Health and wellbeing boards vary in how they operate and how effective they are across the country. However, in most places, there is little evidence that health and wellbeing boards have had a significant influence over the development of sustainability and transformation partnerships and ICSs (Humphries 2019). For drug service commissioners looking to engage more with the NHS and its current planning structures, they do not appear to be the best route at the moment in most parts of the country.

Based on separate analysis by the review team of the structures for drug treatment service commissioning and planning in place in Northern Ireland, Scotland and Wales (as well as the evidence about former structures in England such as the NTA and drug action teams) (see section 4 for more detail), it is clear that some form of formal partnership is necessary. This partnership would need to be ‘corralled’ around a place-based plan and would require the co-ordination or pooling of different budgets as well as a mechanism for holding partners to account. According to the drug treatment service commissioners we spoke to, this has been made possible in some areas through strong relationships that had been built up over time. However, an entirely ‘bottom-up’ approach does not automatically include collective accountability and there are serious risks to consider, such as major variation in quality and weak mechanisms for co-ordinating or pooling budgets.

Different approaches to joint working

Joint planning is a key element of an effective commissioning function – but there is no single ‘model’ for doing this. Joint commissioning arrangements can include a mix of collaborative approaches to needs assessment, decision-making and paying for services. In Table 3 we have outlined some of the common features of joint commissioning arrangements identified in a review of joint working across health and social care (Humphries and Wenzel 2015; Dickinson *et al* 2013). Where possible, we have also provided examples of what these features look like in practice.

Table 3 Common features of joint commissioning arrangements, with practice examples

Feature	What this looks like in practice
Formalised structures	<ul style="list-style-type: none">• Integrated organisations, management teams or formal partnerships• Drug action teams were an example of this, as are the arrangements in place in other parts of the UK (see Table 2 earlier in this section, and case studies from other UK countries in section 4)
Pooled budgets	<ul style="list-style-type: none">• Associated with a particular population or disease group with needs that span organisations• Some organisations choose to align rather than pool their budgets, which means information is shared between organisations and priorities and strategies are agreed jointly, but management of the individual budgets, monitoring and reporting remain separate – this is often an interim step to pooling. Sometimes used because of difficulties in accounting rules around pooled budgets.• See the sexual health services case study in section 4 for an example of this• In terms of drug treatment services, budgets could potentially be pooled across a whole drugs strategy or for specific aspects of treatment, such as mental health care
Lead commissioning arrangements	<ul style="list-style-type: none">• One partner takes the lead on commissioning on behalf of the others, to a jointly agreed set of

	<p>aims – permitted by section 75 of the NHS Act 2006</p> <ul style="list-style-type: none">• Often accompanied by a pooled budget• See the sexual health services case study in section 4 for an example from Lambeth, Southwark and Lewisham• In terms of drug treatment services, there could be a lead commissioner where there are co-existing substance misuse and mental health (or other) issues
Co-location of staff involved in joint commissioning	<ul style="list-style-type: none">• CCG and local authority commissioning teams working in the same location• Can be accompanied by a vision or ambition for 'one system, one budget' (Institute of Public Care 2018)• In Brighton and Hove, CCG and local authority commissioners found some advantages to co-location, although they acknowledged co-location on its own is not the answer – partnership working requires effort
Hybrid roles	<ul style="list-style-type: none">• Staff that span more than one organisation
Integrated/streamlined needs assessments	<ul style="list-style-type: none">• Health and wellbeing boards are responsible for producing a joint strategic needs assessment and a joint health and wellbeing strategy that meet the current and future needs of the local population• They are also required to consider using NHS Act 2006 flexibilities, such as pooled budgets, in order to meet these needs

The impact of these arrangements tends to be dependent on implementation and the local context within which they are operating. Formal partnership structures that might appear to break down barriers between organisations sometimes do not have that impact in practice. For example, the drug action teams that undertook the joint commissioning of drug services before 2013 did not always manage to break out of organisational silos. Evaluation and commentary at the time highlighted issues with a lack of co-ordinated care (Valios 2004) and all stakeholders participating in decisions (Commission for Healthcare Audit and Inspection 2008). Sometimes the least formal aspects of a joint commissioning model can be critical to promoting collaboration – the box below outlines an informal approach to collaboration in South Tyneside that is seen as the crucible of its whole-system working across the NHS, local government and beyond.

An informal collaborative approach to planning in South Tyneside

South Tyneside has developed a collaborative approach to planning and decision-making that involves leaders from across its health and care system. It includes formal structures, like the Alliance Business Group, which oversees integrated working and is accountable to the health and wellbeing board, and the Joint Commissioning Unit, which is jointly run by the CCG and council and manages around a quarter of the CCG's budget.

However, the most innovative part of the model is also the least formal – the Alliance Leadership Team. This is a concept borrowed from the Canterbury health system in New Zealand – an international innovator on integrated working (Charles 2017). The Alliance Leadership Team includes senior leaders from the CCG, local authority, acute trust, mental health trust, commissioning support unit, voluntary and community sector, local Healthwatch and primary care networks. The team holds a three-hour meeting each month, which has no agenda, no papers, no minutes and no decision-making power. Discussions at the meetings focus on 'themes' and are more about *how* the different organisations work together as a system than *what* they do. When the team identify opportunities to improve things in the system and eliminate blockages, these are then passed on to others for action.

This approach has been credited with creating a positive culture of collaborative working among senior staff and with supporting real improvements in their system. One participant described it as the 'crucible' for joint working in the area, helping to shift staff mindsets from protecting the interests of their organisation to protecting the interests of the whole system. The approach has also been linked to tangible changes, such as improvements to South Tyneside's

continuing healthcare programme, which has delivered significant savings (although clearly causality is difficult to prove).

The new way of working required a significant investment of staff time and the relationships between the group and ways of working took time to develop (and this work was supported by an independent facilitator). The approach was greeted with quite a lot of scepticism at first, but much of this has fallen away as some of the tangible benefits of the approach have become clearer.

For more information about the approach to collaborative planning in South Tyneside, see Robertson and Ewbank (2020).

Research about joint commissioning mostly describes local approaches and examines key barriers and enablers to joint working. There is very little rigorous evidence of the impact of joint approaches on the cost and quality of care and each example of joint working is different in the combination of factors that come together to make up the joint commissioning model. Therefore, this area is not amenable to a list of alternative models with pros and cons. Instead, it is an area where components of a model can be set out along with key factors for success.

Key success factors for joint commissioning include the following.

- **Strong and stable leadership** and a commitment to joint working from senior leaders and middle management are seen as essential (Newman et al. 2012). Because of the need to navigate all the processes for joint commissioning and make them 'fit' to local circumstances, it is very important to have this strong and stable leadership. Leadership is also the key to ensuring that all the other success factors (described below) are in place. However, leadership is a factor that is often not present due to repeated reorganisation of the commissioning system and the loss of experienced staff that accompanies those changes.
- A **clear shared vision** is the critical first step. Local areas can then work back from that to develop arrangements that will help facilitate the agreed goals. If commissioners start by designing the joint commissioning model, and agree on its purpose after that, they risk collaboration becoming an end in itself (Dickinson and Glasby 2013).
- Whatever approach is taken it should focus on the **development of long-term relationships** between commissioners and providers and the communities they serve, and this requires investment over many years (Robertson and Ewbank 2020). Almost every case study of joint commissioning arrangements cites long-standing positive relationships as a key factor underpinning success because of the trust required to make

these approaches work, which must be built up over time (Newman *et al* 2012; Miller *et al* 2011; Audit Commission 2009).

- It is important to have a **shared vision** and a common set of objectives agreed by the partners (Newman *et al.* 2012).
- **Clinical involvement** is a key feature of effective commissioning arrangements. It supports innovation and adds value through bringing frontline insights into planning decisions (McDermott *et al* 2015; Miller *et al* 2015). The NHS has tried numerous different approaches to effectively involving clinicians in commissioning over the past three decades and is yet to settle on a best approach. Some drug treatment services are clinical in nature and any new system for effectively commissioning them must involve a range of clinicians who deliver this type of care.
- **Engagement with patients, service users and the local community** is important (Naylor and Wellings 2019; Newman *et al* 2012). Wigan is an example of a local authority that has taken a radical approach to working with the community and working jointly to shape their agenda.
- There is emerging evidence that a shift away from the more 'transactional' model of commissioning towards a '**collaborative**' approach, where commissioners work to facilitate joint working between commissioners and providers, rather than promoting competition, can be effective (Robertson and Ewbank 2020; Collins 2019b; Davidson-Knight *et al* 2017). We conducted research in 2019 with three English areas that were starting to develop this approach – the key elements of this new collaborative approach to commissioning are outlined in Table 4 (Robertson and Ewbank 2020). This move away from top-down commissioning to approaches that involve a different set of skills (facilitation, clinical expertise, etc) and involve others in making commissioning decisions (clinicians, providers, service users) may point to a need for external support for commissioners to develop in a fast-changing environment. We discuss this in Section 3, 'Commissioner capacity and capability', p 50.

Table 4 A changing approach to commissioning

From...	To...
Health care focus	Population health focus
Organisational focus	System focus
Contract enforcer	System enabler

Improving drug treatment services in England

Transactions	Relationships and behaviours
Decision-maker	Convener for collective decisions
High bureaucracy, low trust	Low bureaucracy, high trust
Monitoring organisational performance	Monitoring system-wide performance and providing improvement support
Following national guidance	Developing local solutions

Source: Robertson and Ewbank 2020

New contracting approaches

Key points

- New contracting approaches – such as ‘prime’ and ‘alliance’ models – have been developed to promote better joint working between commissioners and a range of providers across the NHS and local authorities. However, they will not – by themselves – overcome differences in organisational interests and relationship problems.
- ‘Prime’ contract models, which devolve responsibility for commissioning to a provider or group of providers who then subcontract with others, require the prime provider to have the capacity and skills to undertake commissioning tasks. In some local areas these skills may not be present and the model will not be viable.
- Developing and implementing these new contracting models is usually a long and costly process and meaningful outcome measures can be difficult to define, particularly for complex populations like drug users. The models can also be particularly difficult for small organisations to engage with, and this can be a barrier to the involvement of some third sector organisations. Commissioners must ensure that whatever contracting approach they choose, valuable input from small charities is not lost.
- Rather than focusing on developing contracts to promote integration, some commissioners are starting to take a more collaborative and facilitative approach – working with providers to jointly agree a local vision and develop services rather than focusing on arm’s-length contract negotiations. Collaborative approaches are in their early stages, but there are examples of NHS and local authority commissioners and providers starting to work together in this way to make best use of scarce system resources and minimise unnecessary transaction costs. More broadly, NHS policy development is moving away from transactional approaches to commissioning towards more collaborative models and legislation has been proposed to remove some of the competition requirements that currently affect the sector.
- If contract models are going to be used to promote integration, the first step should always be a dialogue between commissioners, providers, patients and the wider community to develop a vision for the service area/group. Commissioners can then work backwards from that vision to build a contracting model that delivers its aspirations.

The issue

Some drug services are not co-ordinated around the needs of service users. Budgets have been cut and commissioners in some areas are no longer working effectively together across the NHS, local authorities, prisons and probation services. There is a question as to whether new contracting approaches could help support better joint working and overcome some of these issues.

Concepts/models

A range of new contract models have been developed in the NHS and local authorities to incentivise providers to work together and deliver more co-ordinated care and better outcomes. They tend to include whole-population budgets (that cover a particular age group or disease group, for example), transfer both risk and reward to providers and reward providers for good performance. In Table 5 we have outlined the strengths and weaknesses of each contractual approach.

Table 5 New contractual models and the strengths and weaknesses of each

Contract type	Description	Pros	Cons
Prime contractor model	The commissioner contracts with a single organisation (or group of organisations) known as the 'prime contractor'. They are typically given a fully capitated budget, a proportion of which is dependent on achieving certain outcomes, and the prime contractor subcontracts with other providers to deliver the agreed service. The prime contractor takes responsibility for designing a delivery model and patient pathway that will most effectively meet the terms of the contract.	<p>Simple for the commissioner to manage – they outsource their contract management function to a prime contractor</p> <p>Enables the prime contractor to manage care across a pathway</p> <p>Can stimulate transformation of the delivery model</p> <p>To facilitate this, money can move within the pathway</p> <p>Shifts clinical accountability to the</p>	<p>High financial and relational risks for the prime contractor</p> <p>Concern over the management of co-morbidities and over issues that cross boundaries</p> <p>Providers may lack sufficient skills in contracting, supply chain management and commissioning</p> <p>Can create perverse incentives – it may limit patient choice and encourage 'cream skimming'</p>

	The prime contractor becomes the service 'integrator'. In the 'prime provider' variant of this model, the 'prime contractor' also provides services.	prime contractor and providers Contracts/subcontracts create clear governance arrangements	
Prime provider model	This is a variant of the prime contractor model where the prime contractor also provides some or all of the services within the contract.	In addition to what's above Intended to limit fragmentation that would be caused by introducing a new actor	In addition to what's above Could lead to a provider monopoly if it decides to provide all of the services itself
Alliance contracts	A set of providers enter a single agreement with the commissioner. The commissioner and all providers in the alliance share risk and responsibility for meeting the terms of the single contract. There are no subcontracts and internal governance arrangements manage the relationships and delivery of care. Sometimes an alliance of providers (without commissioner involvement) contracts with the commissioner. These contracts are most suitable where there are well-established provider relationships.	Strong incentives to collaborate and work together to identify efficiencies across the system (rather than just within their organisation) Avoids the dominance of a single organisation Strengthens the relationship between commissioners and providers Retains the active involvement of commissioners	Shared financial and clinical risk is reliant on the performance of other providers More complex for commissioners to manage Reliant on high trust and existing strong relationships Possibility of weak governance and accountability if appropriate governance arrangements are not established

Outcomes-based contracting	Links a proportion of payment to the achievement of a set of defined outcomes. These outcomes are shared across multiple providers. Contracts vary in the proportion of the payment that is dependent on performance against outcomes.	Incentivises providers to work together, shifting their focus from organisational to system outcomes	Defining meaningful metrics that can be accurately measured is challenging Potential for gaming outcomes Withholds funds from providers that achieve worse outcomes, which could lead to a vicious cycle of decline
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Source: Lewis and Agathangelou 2018; Addicott 2014

Evidence/discussion

A number of places around the country are exploring the use of new contracting models to support collaboration – both within the NHS and across the NHS and local authorities (Sanderson et al. 2016). The empirical research base on the impact of these models within the NHS is still developing – some areas seem to have found using them helpful (Clark et al. 2015).

However, evidence from evaluations of the use of different contracting approaches shows that a contractual model is ‘scaffolding’ and does not replace or short-cut the need to build trust and good relationships to deliver co-ordinated care for patients (Addicott 2014). New contractual models can play an important role in facilitating reconfiguration and the better use of resources. However, they do not address the underlying problems that organisations experience when they try to work together – they are a mechanism to help strengthen attempts at collective working, but will not overcome significant differences in individual organisations’ interests (Sanderson et al. 2019).

Case studies from the NHS and local authorities found that pre-existing difficulties in the relationships between providers and commissioners were not remedied by the development of these new contractual models, although there was some evidence that relationships between providers improved as they gained more familiarity with and understanding of each other by working together (Sanderson et al. 2019). Financial incentives – however they are engineered – rarely deliver the hoped-for integration benefits. Successful case studies are often the result of factors like positive relationships between sectors that have been built up over years and stable leadership across sectors.

New approaches need to be developed through continual dialogue with providers, patients and the wider community. Once a vision is agreed, commissioners and providers can work backwards from that point to build a model that delivers on the aspirations of the vision (Addicott 2014).

Designing and implementing new contractual models is a long and costly process and does not always result in the agreement of formal contractual arrangements (Sanderson et al. 2019; Addicott 2014). The amount spent devising elaborate incentive schemes can outweigh the likely benefits – the most obvious case being the UnitingCare contract in Cambridgeshire and Peterborough for older people's and adult community services, which collapsed after eight months and cost £9.8 million to develop (National Audit Office 2016). The Payment by Results pilots undertaken in drug and alcohol services were costly to implement and did not achieve improvements in some of the outcome measures targeted by the approach (University of Manchester et al. 2017). It is therefore critical that any new contracting approach is designed in a way that means the costs of development do not outweigh the benefits of implementation.

The number of commissioners for drug services has reduced in recent years, raising the issue of whether there is sufficient capacity to implement this kind of contracting approach. One of the commissioners we spoke to as part of this research highlighted the value of regional specialist support from Public Health England on the design of contracts.

Contractual models that involve providers coming together to bid for services require each provider to have the capacity and skills to get involved in that process. This means it can be difficult for small providers – such as small community-based charities that hold critical links and knowledge about the needs of local users – to engage in these types of contractual arrangements (Sanderson et al. 2019; Baird et al. 2018). Commissioners must work to engage smaller organisations and facilitate their involvement if these contractual approaches are to be successful.

Outcomes-based contracting – where a proportion of the payment given to a group of providers is contingent on achieving a set of system-wide outcomes – has the potential to provoke collaboration between providers and to shift their focus from organisational interests to the system as a whole (and the people within that system). However, evidence so far suggests that outcomes-based contracting is harder to implement than may have been anticipated, partly because outcomes are not easy to specify (Collins 2019b), and some important elements of care are not easily captured in an outcome measure (Collins 2019a). These challenges have also been identified beyond the health, care and public health system, in other public service areas like employment and probation services (Tomkinson 2016). In the NHS, these contracts have often only made a

small proportion of the payment dependent on outcomes, limiting the incentive to work jointly towards system goals (Sanderson et al. 2019). The failure of the Payment by Results pilot for drug services to lead to improvements in some of the specified measures shows how difficult it is to make this approach work in complex service areas like drugs (University of Manchester et al. 2017).

Reasons why contracting processes like this in the NHS have stalled include: providers not trusting the financial model, a lack of robust activity data and a lack of alignment in providers' interests (Sanderson et al. 2019).

If commissioners are considering adopting these models they need to:

- clarify the capacity of participating organisations to share risk
- consider how resource intensive the process is likely to be
- consider the implications of the chosen model for third sector involvement (small providers may find it difficult to take part)
- think about whether the system is ready for this type of model – are organisational interests aligned and are providers willing to work together (Sanderson et al. 2019)?

The underlying principles or 'terms' of the contracts can be more important than the broad contracting model. These must include outcomes being built into the contracts and the contract terms requiring providers to focus on service integration (and not just organisational integration), including streamlining care and working across the gaps between providers, and working together efficiently for the benefit of patients (Addicott 2014).

Some commissioners are developing new approaches that focus on collaborative relationships rather than arm's-length contracting negotiations. This means resources that were previously dedicated to contracting can be shifted to improvement support. There are examples of NHS and local authority commissioners starting to develop this model of working (see the box on the South Tyneside approach in subsection 3.2) (Robertson and Ewbank 2020; Collins 2019b).

Commissioner capacity and capability

Key points

- The capacity and capability that commissioners need in order to be effective are determined by the models of care and outcomes a system wants to achieve through commissioning. The number of commissioners needed and how specialised their skills should be cannot be assessed in isolation but require some form of local strategy to be in place.
- More evidence is needed, but that available so far suggests that there needs to be national policy leadership for the approach to drug treatment, with a workforce strategy to support it. There are choices about how much detail to set out from the centre, but the evidence we have seen suggests that in any option a degree of national infrastructure will need to be built up over time to support workforce development.
- Whatever approach is taken, it is essential to assure basic capacity for effective commissioning, such as access to knowledge about substance use and treatment services, sufficient time to develop relationships with providers and both the time and skills (eg data analysis skills) to carry out thorough needs assessment.
- This report focuses on the capacity and capability of commissioners, but we noted that there are also concerns about the capacity and capability of the wider drug treatment workforce.
- Although NHS commissioning support units do not offer a model because of the variable ways in which they have been implemented, the basic concept of a national framework of ambitions/expectations for commissioning together with regional centres of support and expert advice for commissioners warrants consideration. Public Health England's regional centres appear to have something potentially approaching that regional role in some cases.

The issue

There are concerns about the capacity of commissioners to be effective in commissioning drug treatment services, and their skills (Advisory Committee on the Misuse of Drugs 2017). Those concerns are associated with factors such as short-term contracts and the weakness of strategic partnerships with NHS, justice and other related services.

In the past, the NTA's workforce strategy focused on increasing capacity, improving competence and career pathways, and mainstreaming drug and alcohol skills (Home Office and National Treatment Agency 2006). In interviews

and in literature this has been described as a significant move to professionalise drug treatment services, including commissioning (Duke 2010). The workforce strategy was part of the overall national infrastructure to deliver the NTA’s model of care (National Treatment Agency 2006) and built on a set of national occupational standards (Skills for Health 2014).

We have also considered the Improving Access to Psychological Therapies (IAPT) approach as another model for building up a specialist national workforce within the health sector. But other UK countries appear to be developing strategic frameworks for developing the workforce that may not be as detailed as the NTA or IAPT approaches (eg Scottish Government 2010).

The NHS has taken a different path to support the development of commissioners’ capacity and capability, establishing commissioning support units – which have evolved differently in different regions – and providing a national Commissioning Capability Programme (NHS England undated).

Concepts/models

In Table 6 we outline different potential options (or models) that we have reviewed for improving commissioner capacity and capability for drug services as well as the strengths and weaknesses of each.

Table 6: Potential models for improving commissioner capacity and capability and the strengths and weaknesses of each

Model	Description	Pros	Cons
Detailed NTA/Home Office workforce strategy	National plan, as part of a suite of initiatives, aiming to significantly increase capacity and capability	Appears to have driven change	This level of detail in a national role required national resources
IAPT approach	National assumptions and a funding formula for the number of staff at each tier of treatment for every 250,000 population	Has demonstrably delivered an increase in therapists across the country	Not easy to apply to drug treatment and commissioning – a very different content
Strategic framework eg Scotland	A framework (less detailed/prescriptive than the NTA strategy) designed to support and work with local approaches	Too early, not clear yet	Too early, not clear yet
Commissioning support units	Units contracted to support CCGs with advice and certain back-office functions	Arguably the variability in commissioning support units’ implementation has allowed adaptation to each	Commissioning support units are for all CCG commissioning – drug treatment is not big enough to

region's
circumstances

support this
structure/cost

Evidence

The joint NTA/Home Office workforce strategy sat alongside the NTA's models of care and guidance for local areas and the roles of NTA regional offices in supporting their implementation (Home Office and National Treatment Agency 2006). It was a key point in an ongoing trend since the 1980s, further accelerating a pattern of increasing the professionalisation and formality of drug treatment roles, as well as the number (Duke 2010). It built on national occupational standards that had been developed by Skills for Health, and commissioning standards developed by the Substance Misuse Advisory Service, and itself led to the development of National Vocational Qualifications (NVQ) in health and social care and working with offending behaviour, as well as other qualifications and certifications (Skills for Health 2014; Substance Misuse Advisory Service 2000; Duke 2010). It was therefore embedded within a multifaceted and dynamic approach.

Scotland appears to be taking a similar approach in the sense of setting out a strategy and then developing capabilities in the workforce, data and an 'outcomes toolkit' to support its implementation (Scottish Government 2010). As with the NTA's approach, this process has taken several years. At present it is too early to judge its effectiveness; a full workforce strategy is still in development (apparently forthcoming) and there is still only a 'statement'. However, the Scottish approach is intuitively appropriate in that it does not focus on workforce capacity or capability in isolation but in the context of clear strategic goals and the development of data to measure progress towards them. The English system currently lacks clarity of overall goals and while there is performance data, there is no mapping of who is commissioning what so that connections could be made between outcomes and different approaches to service provision and commissioning.

Our literature search on commissioners' capacity and capability returned 81 documents, none of which turned out to be specifically about the competencies that commissioners needed. Most documents seemed to focus on the drug treatment workforce as a whole or specifically in providers. In discussion with commissioners, participants were strongly of the opinion that drug treatment commissioning required specialist rather than generic knowledge and skills (although it should be noted they were mostly commissioners with specialist knowledge and skills). They indicated views that those specialist skills might be transferable to commissioning other services but that specialist skills in commissioning other service areas (eg sexual health) would not be sufficient for drug treatment. They criticised examples where they considered that individuals in certain local authority areas had been tasked with recommissioning drug

treatment as a 'project' without being personally connected to the local drug treatment system. Phase one of the Independent Review of Drugs noted a decline in skills, expertise and capacity in the drugs sector as a whole (not singling out commissioners), and of the responses to the review's call for evidence that we were able to review, a large number commented on the need to invest in training for the workforce but only two specifically focused on commissioners and the perceived need for specialist rather than generic skills (Black 2020). Overall, literature and information collected as part of the independent review support the need to further develop the drugs workforce and indicate concern about commissioners' capacity and capability within this, but without specific or rigorous evidence to reach a conclusion on commissioners.

The IAPT programme was of interest for this report as it rapidly increased both workforce capacity and capability across a sector (Department of Health 2008). However, it became apparent that parallels are limited; the treatments and workforce needed for IAPT are far more amenable to standardisation than drug treatment, and the focus of IAPT is exclusively on providers. We have not identified any other alternative models to the relatively long-term, interdependent approach of developing the workforce as part of a broad strategy, as exemplified by the NTA and the Scottish government.

We considered commissioning support units because of their role specifically in supporting commissioners' capability, but they similarly have few parallels other than the very high-level principle of potential value from regional sources of advice (NHS England undated). We do note, however, that the recent proposals from NHS England and NHS Improvement about the future of ICSs highlight the positive impact so far of commissioning support units in terms of 'quality and value for money'. It is also proposed that commissioning support units will continue to play an important role in supporting ICSs, for example by 'providing economies of scale which may include joining up with provider back office functions where appropriate and helping to shape services through a customer board arrangement' (NHS England and NHS Improvement 2020, p 24).

Discussion

Although there has been no formal evaluation, it appears that the NTA workforce strategy did lead to increases in staffing and perceived greater professionalisation of the sector. However, none of the infrastructure or resources at the national level that stood behind the workforce strategy are still available; replicating this approach would require new resources to be found at the national level.

The NTA approach and – so far as we can tell – those of the other UK countries position workforce strategies in support of overall outcomes to be achieved and models of care. We have noted before the interdependencies of elements that

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make up a drug treatment system, but at the risk of stating the obvious, without clarity about what the system is trying to achieve – such as specified outcomes and models of care – it will not be possible to determine with any specificity how many commissioners are likely to be required or what capabilities they will need. Interviewees highlighted to us that there is not an equivalent debate in the NHS about the numbers and skills of commissioners, which they ascribed to the focus in the NHS on monitoring outcomes and performance rather than inputs.

We heard in interviews some descriptions of areas with an extreme lack of commissioning capacity, with insufficient time to develop relationships with providers and insufficient resources for robust needs assessment. We do not know how representative these descriptions are, but they indicate that some issues may require priority for increases in investment – developing capability would not be sufficient on its own.

From the literature, the development of national standards for commissioners in 2000 and references in guidance to variations in quality and performance (National Treatment Agency 2006) suggest that current concerns about commissioner capacity and skills are not entirely new (or, put another way, that the situation was not perfect in the past). However, overall, the evidence does not indicate that concerns are just about commissioners: most of the literature on workforce appears to be focused more on providers, if anything, or on the whole system rather than just commissioners. In interviews, we heard concerns about capacity in the provider workforce and the lack of a reliable pipeline to ensure that staffing services with the right level of expertise would continue to be viable.

We have not found evaluations or other formal evidence in literature about whether drug treatment commissioners need specific expertise around drug services and addictions, or whether commissioning these services is a generic role that requires the same skills and knowledge as commissioners of other public health services. This is, however, an issue that has been raised before (Advisory Committee on the Misuse of Drugs 2017) and which was of great interest to interviewees. Interviewees (who had specialist knowledge) had clear opinions that specialist knowledge was necessary. In addition, there were clear views that specialist knowledge of information was necessary to understand drug treatment data and needs assessment (ie analysts).

We have briefly considered two NHS models: the roll-out of IAPT and the development of commissioning support units. IAPT does not seem to offer relevant learning for this issue, as it concerns providers more than commissioners, and – unlike drug treatments – IAPT treatments are relatively much more standardised, and needs are relatively more consistent across populations, so the issue is one of scaling up rather than bespoke development

based on local needs assessment. Commissioning support units as they exist in the NHS are complex because of their variability and would be excessively over-engineered for a relatively small sector such as drug treatments. However, the basic principle of their approach – a national framework of principles and expectations, together with regional centres of advice and support – merits further exploration. We heard Public Health England’s regional centres described as centres of advice, including an example of them advising on the detail of contract design, including requirements and the monitoring of guidance from the National Institute for Health and Clinical Excellence (NICE), which may offer a platform for further exploration.

Accountability

Key points

- Since the 2013 reforms, there are now just two main levers for local authorities' accountability – sector-led improvement and formal intervention by the Secretary of State – with a large gap between them. There is a lack of confidence that sector-led improvement is robust in ensuring accountability, but our research suggests it is under-used, and perhaps not used at all in drug services, related to a lack of central funding for it; doing so could be an opportunity for testing and evaluating the approach.
- For public health functions, lines of accountability have become diffuse and complex. National datasets of public health and drug treatment outcomes and performance indicators are available, but they are not currently used for accountability.
- More evidence is needed, but comparing drug treatment services to a five-point framework for types of accountability in health and care suggests that:
 - the consistency of focus and follow-through by scrutiny committees could be improved
 - it is difficult to achieve accountability through performance-based contracts, with a risk of over-engineering, selection bias and limited impact
 - management accountability is currently entirely within individual local authorities, and is potentially just one item on a broad performance dashboard – some external oversight and a specific focus on drug services may be needed
 - regulatory accountability is only possible for registered providers and not for commissioners or the system as a whole – however, although they do not have enforcement sanctions, whole-system thematic reviews by the regulator could be useful in shining a light on issues
 - drug treatment services may be perceived as lacking political impact, but our research on rough sleeping and associated health issues suggests that building local political commitment could create positive electoral accountability as a positive force for improvement.

- There is a case for considering a regional role in accountability in services, such as drug treatment services, which have complex local accountability and poor connection to national accountability.
- There are caveats about transferring learning from the NHS to local authorities. However, there are examples which may offer useful principles for consideration – such as the arrangements for ensuring that funding for additional increased access to child and adolescent mental health services (CAMHS) is conditional on an approval process for local plans and routine external monitoring of performance and outcomes.
- Radical changes in 2013 in England contrast with the other UK countries' evolutionary approaches to drug treatment services. There is significant potential to learn from Scotland, Wales and Northern Ireland as they progressively embed and mature approaches to accountability for outcomes, performance and quality.

Ingredients of accountability in health and care

What accountability 'is' in relation to public services, is a non-trivial question. There are various ways in which it can be conceptualised and defined (Maybin *et al* 2011; Leat 1988).

Maybin *et al*'s (2011) five types of accountability are particularly useful for thinking about health and care services:

- Scrutiny – where the account holder receives a detailed account of performance within a particular area for which the account giver is being held to account.
- Contract – account holders (eg commissioners) will hold account givers (eg providers) to account for meeting the agreed objectives as defined by the contract.
- Management – defined as answerability to an account holder in accordance with agreed performance criteria. Managerial accountability differs from regulation in that it may be applied *ex post facto* (ie responding to performance) as opposed to *ex ante* (ie defining a minimum standard of performance), and is usually based on a hierarchy of authority and control.
- Regulation – involves the setting of *ex ante* standards, in which the account holder has clearly defined *post hoc* intervention powers or sanctions. The regulator is typically independent. These standards are predominantly minimum standards, rather than developmental or focused on quality improvement.

- Electoral – defined as voters holding to account a representative that they have elected to a particular post.

Maybin *et al* suggest that these accountabilities may work in combination, so long as attention is given to avoiding potential overlaps, gaps and excessive burdens. The World Health Organization (WHO) notes that effective accountability – which should be constructive rather than just backward-looking and punitive – must be part of a wider approach to governance that connects with, and ensures a balance between, transparency, participation, the integrity of processes and policy capability (World Health Organization 2017).

Any approach to accountability needs to be underpinned by a clear ‘accountability map’, so that different actors know and understand what they are being held to account for, how and by whom. Important characteristics for a system of accountability to be effective include:

- a clear goal or goals (which may be around service delivery, or outcomes creation) that are the purpose and goal of the system
- an agreed understanding of the services required (if goals are primarily service focused) or the production function for outcomes (if goals are primarily outcomes focused)
- clarity over responsibility for service delivery or outcomes (or both as relevant)
- clear definitions of performance and transparency
- a balance of penalties for poor performance and incentives to improve, in terms of transparency, financial or other matters
- appropriate funding for expected goals to be delivered
- perhaps most importantly, the ability to respond to accountability, to improve delivery or outcomes.

When considering these characteristics from WHO in the context of drug treatment services in England, it is noticeable that their goal and purpose have changed over time – including, for example, at different times, priority to harm reduction, opioids and crime reduction, abstinence and journeys to recovery. The current situation allows for different local authority areas to define different purposes and goals, which WHO’s framework suggests would make national accountability problematic. Performance towards the broad goal of ‘recovery’ is also likely to be particularly difficult to measure, and especially to measure consistently, without some degree of nationally required indicators.

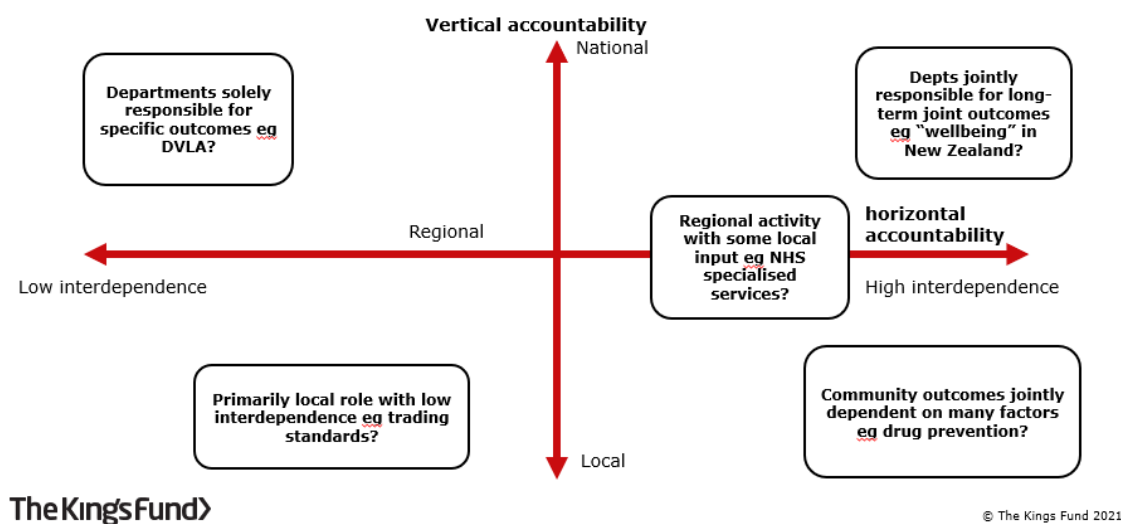
What are the design options for accountability in complex public service systems?

Gore *et al* (2020) set out a simple framework of public service accountability. In particular, in health and care systems, there is 'vertical accountability' and 'horizontal accountability'. The former refers to the accountability relationships between national organisations and decision bodies, through regional bodies, and into local bodies. The latter refers to how accountabilities relate within any tier, for example between government departments or local partnerships. These horizontal accountabilities are likely to differ by the degree of interdependence between services.

Figure 2 places various public services on this 'accountability map'. Drug services, summarised as a whole, are likely to sit at the bottom right – services that are primarily locally delivered and commissioned with high interdependence. However, elements of drug services commissioning sit at various points on the map – there are national, through regional and local roles and some services are more interdependent than others.

Figure 2: Accountability in complex public services

Accountability in complex public services



Accountability and local government

Local government as a whole

The Ministry of Housing, Communities and Local Government (MHCLG) has set out an accountability framework between it, its arm’s-length bodies and local government in some detail (Ministry of Housing, Communities and Local Government 2020b).

MHCLG only has two main levers for local authorities' accountability: sector-led improvement (structured peer-to-peer support arranged under the auspices of the Local Government Association; see Local Government Association undated) and the extreme circumstances where the Secretary of State intervenes. There is a large gap between these.

One way of helping to fill this gap could be the development of local public accounts committees, first proposed by the Centre for Governance and Scrutiny, which argued that since 2013, 'accountability arrangements are not strong enough for the increasingly complex landscape that characterises public service delivery in many localities' (Centre for Governance and Scrutiny 2018). The Centre for Governance and Scrutiny believes that each local place requires its own local public accounts committee to make sense of the complex accountabilities that exist horizontally and vertically to central government departments and arm's-length bodies. It argues that these bodies need oversight over *all public expenditure* in the local area, and this would provide assurance to central government that funding and the freedom to spend it in accordance with locally agreed plans can safely be devolved further.

MHCLG has set up a Local Authority Governance and Accountability Framework Review Panel (Ministry of Housing, Communities and Local Government undated), with terms of reference to assess how well the existing accountability system for MHCLG and its delivery chain are working as a whole. This met five times in the year to September 2020 and a review of the minutes shows the following areas of concern.

- There is a lack of data and metrics available consistently between services and across the country to inform governance. This drew on a report from the National Audit Office on local authority governance (National Audit Office 2019).
- The local audit market is weak; and there has been a missed opportunity to link local government and NHS audit.
- The current governance system has been in place since 1974 and has not adapted to new circumstances, including the emergence of combined authorities and the emerging role of mayors.
- There is a gap in the accountability system between national and local – to which local public accounts committees might be a solution.

The National Audit Office report referred to above noted some significant aspects of the accountability system that require improvement, such as:

The Department lacks the evidence base to assess rigorously whether governance issues are system-wide and this reduces the level of confidence it can have in the operation of the system... The Department is able to intervene both formally and informally in authorities where it has concerns about governance arrangements, but the process of engagement short of statutory intervention is not transparent. The Department told us that there was no fixed process for advising the Secretary of State about the use of formal intervention powers.

(National Audit Office 2019, pp 11–12)

Buck (2020) has questioned whether sector-led improvement is enough on its own to secure improvement, in the context of the public health system that sits within the local government accountability framework, concluding that:

[T]ransparency on its own is not enough to ensure improvement. In 2010, the incoming Coalition government abolished the National Indicator Set, the mechanisms behind it (such as Local Area Agreements) and the Audit Commission (whose role was to oversee local government performance). Funding was also cut for the Improvement and Development Agency for local government. This was a significant loss and Public Health England does not have a remit to police what local authorities choose to do, and beyond providing support and tools, intervenes only in ill-defined, exceptional circumstances. Into this gap, the main way that local government seeks to improve is through peer-to-peer improvement.

(Buck 2020, p 48)

This is not to argue with the fact that sector-led improvement is highly thought of by those who have gone through it, and it is a serious and intense process. For example, 94 per cent of leaders and 98 per cent of chief executives say support from the Local Government Association has a positive impact on their authority and the Local Government Association supported 129 peer challenges in 2019–20 (Local Government Association 2020).

Sector-led improvement is evolving over time and there are different models in use, including at local and regional levels. The Local Government Association and the Association of Directors of Public Health both publish very helpful summaries and case studies (Local Government Association and Association of Directors of Public Health 2018). However, given that some of the wider accountability and support mechanisms were removed by the 2010 reforms, there are valid questions to ask about whether sector-led improvement, and its key features, is enough on its own.

In particular, sector-led improvement is voluntary, so there is self-selection in its use and it asks a lot of those involved. The act of seeking to be involved in

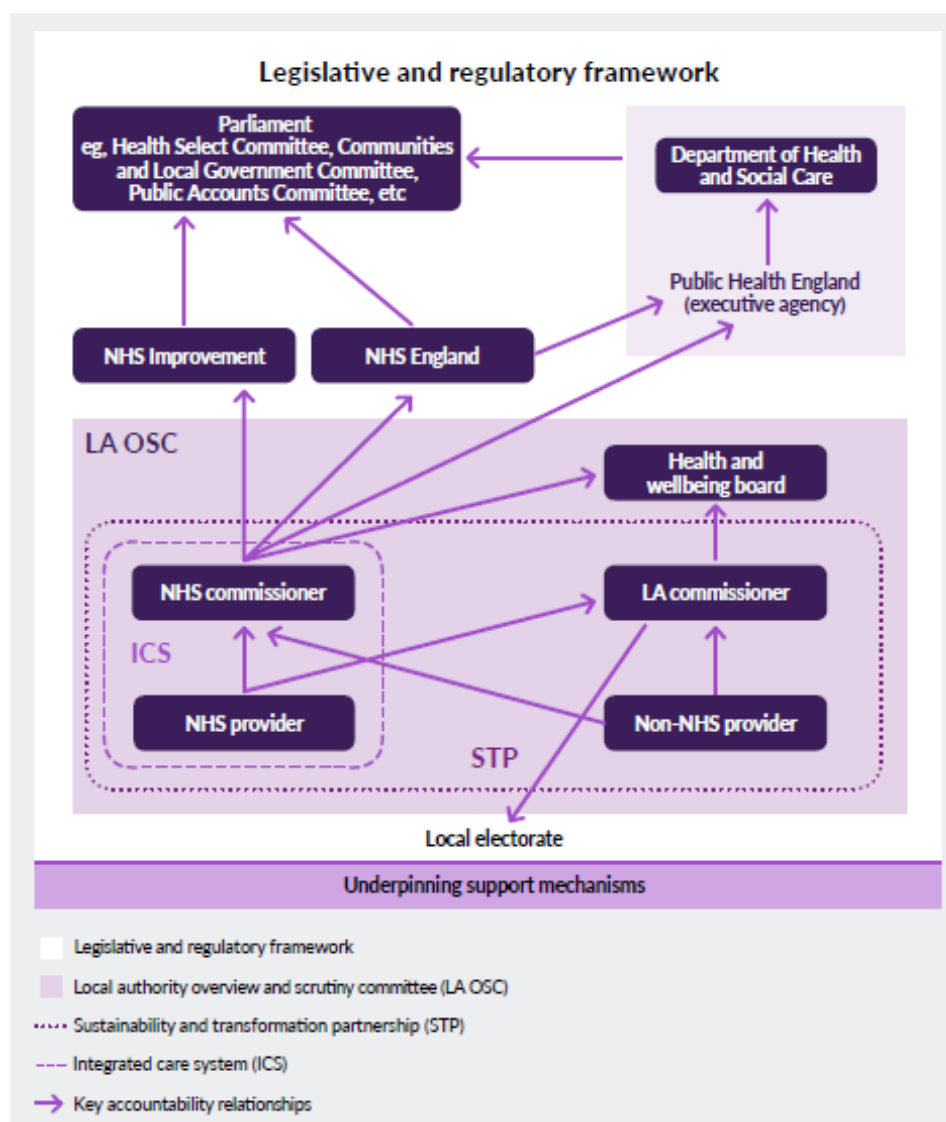
sector-led improvement is therefore a signal in itself of the desire to improve. The deeper question is what is happening in those areas that have not engaged with support for improvement in their public health services and outcomes? It is much less clear what happens when things go wrong in local government public health (as it was when it was in the NHS), and there is a lack of clarity over how that is actually defined. For example, if a key indicator (perhaps life expectancy) or a suite of Public Health Outcomes Framework (PHOF) indicators drop consistently and significantly in an area compared with experience in similar areas (in terms of population characteristics), what does this mean, would that be seen as failure, and if so, who's failure? What would be done, if anything? More generally, the Public Accounts Committee has been concerned about local authority governance at a time of increasing financial stress (National Audit Office 2019).

Public health functions

The King's Fund reviewed the 2013 public health reforms in an independent assessment, commissioned by the Local Government Association (Buck 2020). The overall assessment concluded that public health functions were in the right place, but progress had been severely hampered by cuts to the central government grant for public health, and the wider cuts that local government has been subjected to.

The King's Fund review found that, in general, accountability is highly complex. The problem is not that there is no accountability, it is that it is tangled and it is unclear how the various forms of accountability work together. Figure 3 is a stylised summary of how these accountabilities currently work.

Figure 3 Key accountability frameworks and relationships ‘in and around’ the public health system, England



Source: Buck et al 2018

There is a National Drug Treatment Monitoring System (NDTMS) dataset, but it is not used for the external performance management of local authorities. It is in fact not clear that it would currently be possible to link NDTMS data to different service models or commissioning arrangements so as to identify how they may be associated with outcomes. There is also a dashboard of wider comparative indicators – the Public Health Outcomes Framework (PHOF) – but Public Health England makes clear that its purpose is not accountability: ‘The Public Health Outcomes Framework is not a performance management tool for local authorities. PHOF data will enable local authorities to benchmark and compare their own outcomes with other local authorities’ (Public Health England 2013).

We have looked into how sector-led improvement has developed in public health functions. Searching for sector-led improvement experiences in drug services
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does not find any hits. This may be because sector-led improvement is funded through a memorandum of understanding between MHCLG and the Local Government Association, and there has not been funding specifically through the memorandum, or directly from the Department of Health and Social Care, for sector-led improvement in drug services. This requires further investigation.

However, the Department of Health and Social Care has recently commissioned the Local Government Association to deliver suicide prevention sector-led improvement work, child obesity trailblazers and work on ICSs. Most recently (June 2020), the Local Government Association has co-funded the Substance Misuse Commissioners Network (hosted by the Association of Directors of Public Health) to provide a forum for commissioners to come together to discuss the challenges they face and to support each other.

Drug treatment services

Overall, the 2013 reforms created accountability challenges for drug treatment and other services, so much so that Checkland *et al* (2013) questioned whether the twin aspirations of increased autonomy and increased accountability could be realised in practice.

Below, we have considered how drug treatment services relate to the five-point accountability framework developed by Maybin *et al* (2011).

Scrutiny

Interviewees told us that local government oversight and scrutiny committees can scrutinise drug treatment services and there have been instances when they have done so. There is a need to collate further evidence about the role of these committees and their impact with regard to drug treatment, as they clearly have potential to be a key part of an effective accountability system. The perception of those we spoke to appeared to be that oversight and scrutiny committees have rarely engaged with drug treatment and are not well placed to ensure any concerns are followed through.

Contract accountability

The literature available in this area relates to performance contracting and Payment by Results. Again, there is a need for further research in this area.

Overall, conclusions appear to be that contract assurance through payment for performance mechanisms is problematic. One study from the United States found that:

The economics literature notes that when patient outcomes are strongly influenced by factors beyond provider control and when risk adjustment performs poorly, pay-for-outcomes will increase provider financial risk...

There are special challenges in applying pay-for-outcomes to Substance Use Disorder treatment, not all of which could be overcome by developing better measures.

(Hodgkin *et al* 2020)

A study in England concluded that:

This 'Payment by Results' scheme was not associated with improvements for most drug recovery outcomes. Despite being a prime marker of recovery with a high payment tariff, comparative rates of successful completion of treatment without re-presentation worsened within the scheme... This finding is consistent with evidence from the payment for performance (P4P) evidence base, which has generally only shown improvements in indicators of processes to be weakly linked to the introduction of P4P.

(Jones *et al* 2018)

Other studies suggest that payment for performance contracting can increase capacity utilisation (in systems with spare capacity) (McLellan *et al.* 2008) but also lead to selection bias, ie providers treating less severe patients to improve measured outcomes (Shen 2003).

Management accountability

Interviewees described to us a system of management accountability that was within local authorities (in contrast to the NHS, for example, which has a hierarchy of local systems reporting up to regional and national bodies). We heard descriptions of local systems that were held to account against a very small number of indicators on a wider public health dashboard. Some of the interviewees (who were specialists from highly performing areas) regarded this as overly simplistic but an inevitability if drug services were monitored within the wide generic range of local authority responsibilities rather than through a bespoke system.

In complex systems with dispersed accountability relationships (such as drug treatment services, which are all accountable to different local authorities), and in complex accountability relationships (such as drug treatment services, which often form a complex 'pathway' with multiple interdependencies, and a wide range of factors that can influence their performance), Checkland *et al* (2018) make a case for stronger regional supervision:

Overall, our study suggests that decentralisation requires some degree of regional co-ordination and oversight by an organisation able to 'hold the ring' and support the myriad of local bodies that must work together to deliver increasingly complicated services in a resource-constrained environment.

There is currently little available research that explores the role of meso-level organisations in health systems.

(Checkland *et al* 2018)

Regulation

The Independent Review of Drugs has identified that although the Care Quality Commission regulates individual providers, there is no external regulation of drug treatment commissioners (Black 2020). This is a result of the Care Quality Commission's statutory remit. The independent review also identified that a large part of the drug treatment workforce is not subject to any professional regulation.

The Care Quality Commission is able to conduct thematic reviews and to do so on a 'whole system' basis (with the consent of the relevant Secretaries of State), as it has recently done for services for older people and its predecessor body the Healthcare Commission did for the commissioning of drug treatment services (Care Quality Commission 2018; Commission for Healthcare Audit and Inspection 2008). These reviews do not have enforcement powers but can shine a spotlight on different aspects of the health and care system.

Electoral accountability

We did not identify any examples of electoral accountability. Some interviewees we spoke to opined that drug treatment services had low political impact and so electoral accountability would be weak. However, in previous research we have found that where there was public concern about rough sleeping and associated issues including drug use, it could be possible to mobilise political commitment – including accountability if there was no improvement – and that this could make an important difference (Cream *et al.* 2020).

What can we learn from accountability arrangements in the NHS?

Local authorities and the NHS have very different structures and accountability arrangements and learning between them is likely to be at the level of principles rather than directly applicable approaches. For example, much of the work associated with Checkland *et al* referred to above is based on long-term studies of the accountability of primary care, which has resonance with drug services.

We have considered mental health support teams as an example that may illustrate some of those principles. Interviewees identified mental health support teams as having some parallels to the situation of drug treatment services insofar as they have been set up as a key way in which the NHS is seeking to increase funding for CAMHS and to increase partnership working, as part of a strategy to reverse under-investment after years of mounting concern about access to effective services (NHS England 2019).

Funding for mental health support teams is conditional on receipt of a plan that reflects national guidance, including cross-sector partnership, adherence to evidence-based standards and service user involvement. Some areas have been asked to improve and re-submit plans in order for funding to be unlocked. We were told in interviews that the principle of funding being conditional on the approval of plans was fundamental. Furthermore, areas are required to provide regular data returns. Again, interviewees told us that it was a firm principle that funding was linked to accountability for performance and outcomes.

What can we learn from accountability for drug services in other UK nations?

The English system can learn from how accountability works for drug services in the other UK nations (see the case studies in section 4).

In general, the other nations tend to have more integrated approaches to drug services and accountability for them through boards that cover multiple services and partners.

Each country also offers learning on specific aspects of accountability. For example, the regional approach adopted in Wales has useful learning about how to simplify accountability across multiple partners and sectors. Northern Ireland's review of its strategy includes designing cross-ministerial accountability and further developing the use of outcomes frameworks. Scotland meanwhile is developing metrics for accountability and has implemented quality standards. The Scottish government report *Quality principles: standard expectations of care and support in drug and alcohol services* (Scottish Government 2014) was broad reaching and set out an aspirational approach to service delivery at an organisational level. Two years after the quality principles were published, the Scottish government commissioned the Care Inspectorate to lead an evaluation, consisting of a programme of validated self-assessment, to determine how well the principles had been embedded, and assess their impact on supporting alcohol and drugs partnerships to assist their clients. In November 2016, each of these partnerships received individual reports detailing strengths and recommendations, which were developed into action plans.

As a result, a commitment was made in the 'Rights, Respect and Recovery Strategy' (Scottish Government 2018) to develop a new quality assurance and improvement framework. This is being designed to measure specific standards for service delivery through objective success indicators to ensure that services are delivered to required benchmarks. These can be applied at a service level or across a number of services as required.

The Welsh government has devolved powers for policies concerning health, education, housing and social care. The Substance Misuse National Partnership

Board guides and monitors progress of the Welsh Substance Misuse Delivery Plan 2019–22 (Welsh Government 2019). Prisons, policing and criminal justice are not devolved but close joint working is supported by a National Policing Board.

The Department of Health in Northern Ireland is responsible for leading and co-ordinating action on Northern Ireland’s substance use strategy. The current strategy – the New Strategic Direction for Alcohol & Drugs Phase 2 (Northern Ireland Department of Health undated) – has been in place since 2012, and a new strategy is in development and out for consultation.

4 Case studies

Child and adolescent mental health services (CAMHS): provider collaboratives

Historical underinvestment and cuts to funding have impacted on access to mental health services and the quality of care (The King's Fund 2019). Any increases in funding have often been attached to individual programmes, fragmenting services and leaving core services without the investment they need.

Fragmented commissioning

There have been longstanding problems with NHS England's specialised commissioning for mental health; it covers a wide range of services but is not thought to be giving value for money. Two of the biggest areas of spending are adult secure services and tier 3 and tier 4 children and young people's services. In both cases, they are part of wider care pathways that are commissioned locally by clinical commissioning groups (CCGs). This split in the commissioning responsibilities of NHS England and CCGs means there is potential for 'gaming' and a lack of incentive for CCGs to invest in local services.

The *Five year forward view for mental health* proposed two 'new care models' for adult secure services and tier 3 and tier 4 children and young people's mental health services (The Mental Health Taskforce 2016). The idea was that NHS England would hand the current budget allocated for specialised commissioning of these areas to local provider partnerships across six regions in the first instance (Gammie 2016). The process involved providers applying and being selected.

The incentive was that the partnership would retain any expenditure gains to invest in improving patient pathways, including in the community. The total budget of the programme across two waves (covering 17 'sites' in total across the two waves) is approximately £650 million. The objectives are admissions avoidance, reducing lengths of hospital stay and the repatriation of patients from out-of-area placements. The second wave of the programme was announced in 2017 (Gammie 2017).

Early evaluation findings

It is very early days in the New Care Model programme. Some of the early learning indicates there was some positive impact on joint working. For example, in the South West region (working together on adult secure services),

partnership working is described as a success. Before the programme the providers in the region had the same goal but were working individually, often thinking in terms of their county rather than the South West as a whole. The providers developed a shared vision, clinical model and business model, which senior clinicians and leaders across the South West Regional Secure Services Partnership support. 'Crucially, this has led to a culture shift: we all now see ourselves as part of a whole region and are planning and supporting each other accordingly, and in real time' (Forbes and Fee 2018).

In South London, whereas previously there had been competition for funding or contracts, the three trusts have developed a more collaborative approach to joint pathways, processes and services.

The evaluation report notes some positive progress in terms of key outcomes such as admissions to inpatient services and treating people closer to home (Niche Health and Social Care Consulting 2019).

In terms of joint working, the evaluation found:

- 'a strong sense' that the New Care Model programme has created a greater willingness for organisations that had previously seen each other as competitors to work together as partners in the process of service improvement
- a sense of increased ownership and empowerment
- a clear aspiration (across most stakeholders) for the New Care Model programme to be taken forward into a more fully delegated process of local commissioning.

The five main factors deemed to have facilitated the implementation of the New Care Model pilot are (Niche Health and Social Care Consulting 2019, p 14):

- a clear ambition to do something different locally, not simply to take on additional responsibility with no clear vision and purpose in mind – indeed, some sites are ambitious to move beyond the current New Care Model arrangement to a much more integrated process of recommissioning and service reconfiguration
- strong relationships of trust between both local partners, and between those partners and regional NHS England staff
- clear governance and leadership, driven at a senior level by both managers and clinicians

- strong financial management, including clear agreements as to the distribution of costs, savings and investment
- effective processes for managing each part of the flow through the patient pathway – admission, case management and discharge – with a willingness to constructively challenge clinical custom and practice.

However, it is important to note that the evaluation cannot attribute any of the changes to the New Care Model programme alone. According to stakeholders interviewed as part of the evaluation, this approach to commissioning is, at best, a ‘transitional’ approach and not one that is sustainable in the longer term.

The Troubled Families programme

The Troubled Families programme is an example of a whole-system approach to addressing families experiencing disadvantage, with a particular focus on ‘worklessness’. It has so far run in two phases (2011 to 2015 and 2015 to 2020) and funding was confirmed into 2021 in the 2020 spending review. While both phases used a Payment by Results mechanism to incentivise local authorities to support eligible families, the second phase developed from the first phase following a critical evaluation, which highlighted concerns about the lack of evidence of impact on the programme’s intended outcomes (Day et al. 2016). While funding per family was reduced in the second phase, eligibility criteria were widened to capture more families needing support, and local authorities were required to show that they had actively worked with families to claim the financial incentive. The evaluation methodology for phase 2 was also altered and included regular reporting throughout the programme, 60 outcome indicators for the long-term tracking of outcomes and an independent advisory group who supported and scrutinised the evaluation (Loft 2020). Three potential insights from this work are of relevance to the commissioning of drug treatment services.

- The length of the funding period was viewed positively and as a key aspect of enabling local authorities to embed new ways of working across their local systems (Economy and Gong 2017).
- The programme had a national set of indicators, but allowed individual local authorities to contextualise these through their local outcome plans. While some local authorities still found this too restrictive (Economy and Gong 2017), the flexibility it did offer could be enabling, with an example in the evaluation where a local area ensured its local outcome plan ‘was aligned with changing local needs over and above national priorities for the programme’ (Ipsos MORI 2019, p15). Having national aims translatable to a local level is positive but there is a need to ensure this flexibility extends to areas being able to measure meaningful outcomes.

- According to the programme evaluation (Ministry of Housing, Communities and Local Government 2019) and one external review (Economy and Gong 2017), this is an example of a programme where the Payment by Results mechanism appeared to incentivise local authorities to improve how they measured outcomes, shared data and facilitated multi-agency collaborative working. In addition, in 2018, a small number of local authorities that had seen positive results were allowed, following a competitive bidding process, to transfer to a system of 'Earned Autonomy', where although outcomes are still tracked and reported, all the financial support is provided upfront to enable larger investment in their local systems (Ministry of Housing, Communities and Local Government 2018). The evaluation reported that local authorities that transferred to this model viewed it positively, allowing them a more meaningful focus on local outcomes (Ipsos MORI 2019).

Sexual health services

Sexual health services are a major component of the public health grant. Like drug and alcohol services, demand has increased in recent years while funding has been cut; re-procurement exercises have stimulated controversial service reconfigurations and affected staff morale; and a change to commissioning responsibilities following the Health and Social Care Act 2012 fragmented planning arrangements, and led to some patients experiencing a disjointed service (Robertson et al. 2017).

The experience of sexual health services provides several insights relevant to drug services. However, in most cases, these are issues that sexual health services are still struggling with and therefore the case study does not provide a clear model that can be transposed to drug services.

A legal mandate

There is a legal mandate that requires local authorities to provide a comprehensive, open-access sexually transmitted infection (STI) testing and treatment service for their local population. This may have provided some protection for the STI testing and treatment spend. Table 7 shows that other non-mandated sexual health services have experienced much deeper cuts: there has been a 38 per cent real-terms reduction in spending on (non-mandated) prevention, promotion and advice services since 2016/17, compared with a 12 per cent reduction in STI testing and treatment spend. However, there are a range of other factors that might explain this difference. One example is that prevention and promotion services are often provided by small charities on short-term contracts that are more easily terminated than the big NHS contracts (Robertson et al. 2017). We cannot tell from the data how much protection a legal mandate provides – the services have still experienced significant cuts.

To fulfil the legal mandate, commissioners are required to ensure a service is in place and to report on their spend. There are no specific requirements about the quality or extent of that service beyond it being 'open and comprehensive'. We know from interviews with sexual health commissioners conducted in 2016/7 that some were seeking legal advice on the definition of a 'comprehensive open access service' to help them understand what changes could be made to services within the law. This shows that the precise wording of a mandate will affect the actions commissioners take to fulfil it.

Table 7: Local authority net expenditure on sexual health and substance misuse services, 2016/7–2019/20

Service area	Net expenditure in 2019/20* £000s	Percentage change since 2016/7 (cash terms)	Percentage change since 2016/7 (real terms)**
Sexual health services – total	549.03	-10.18	-15.18
STI testing and treatment (prescribed functions)	335.15	-6.98	-12.15
Contraception (prescribed functions)	163.46	-6.33	-11.54
Promotion, prevention and advice (non-prescribed functions)	50.42	-34.05	-37.72
Substance misuse – total	663.38	-14.46	-21.2
Treatment for drug misuse in adults	348.27	-14.73	-19.48
Treatment for alcohol misuse in adults	171.15	-6.625	-11.82
Preventing and reducing harm from drug misuse in adults	63.56	-11.95	-16.84
Preventing and reducing harm from alcohol misuse in adults	41.91	7.92	1.91
Specialist drug and alcohol misuse services for children and young people	38.49	-31.92	-35.71

* 2019/20 data is provisional.

** Figures in real terms were calculated in 2019/20 prices using June 2020 Gross Domestic Product (GDP) deflators (available at: www.gov.uk/government/statistics/gdp-deflators-at-market-prices-and-money-gdp-june-2020-quarterly-national-accounts).

Source: Ministry of Housing, Communities and Local Government 2020b; Department for Communities and Local Government 2017

Fragmented commissioning arrangements

In 2013, responsibility for commissioning sexual and reproductive health services was split between CCGs, NHS England and local authorities. As with drug services, a number of major reports from parliamentary committees and other organisations have highlighted the impact this has had on planning and incentives, leading some patients to experience a disjointed service as they move between services commissioned by different organisations (Robertson *et al* 2017; House of Commons Health Select Committee 2016; APPG 2015).

There is no single approach that has been taken to improving joint working. NHS England has asked CCGs to work more closely with local authorities on sexual health commissioning – but the nature of this collaboration has been left to local areas (Department of Health and Social Care 2019). The collaborative approaches developed by local areas include things like the following (Local Government Association 2019; Local Government Association and Medical Foundation for HIV and Sexual Health 2015).

- **Commissioning a range of services via a single contract.** For example, in Teeside, the four councils, two CCGs and NHS England are partners on a single contract for sexual health services with a prime provider. A collaborative commissioning agreement between the seven partners underpins this, which sets out how they will work together to manage the contract. They say the new contract has improved access, generated savings and is highly rated by users and that it has enabled them to focus on prevention and addressing health inequalities.
- **Delegating responsibilities to a lead commissioner.** In Lambeth, Southwark and Lewisham, the local authority manages abortion service contracts on behalf of the three local CCGs, allowing them to develop a joined-up pathway for reproductive services and to focus on things like reducing unwanted pregnancies and addressing inequalities.

There is no robust evaluation data on the impact of these arrangements. As is the case with most analyses of joint commissioning arrangements, including many of those focused on drug services (Local Government Association 2018), they tend to describe the arrangements and the barriers and enablers to establishing them along with interviewee reports on impact. It is very difficult to generate robust evaluation data on this type of commissioning approach due to difficulties with attribution.

The information we have about barriers and enablers to this type of joint working points to the need to focus on local context and the conditions in which joint working is being pursued. A Public Health England review of joint sexual health commissioning pilots in four areas (Public Health England 2020) identified

the following factors that must be in place to support effective joint commissioning:

- clarity on the scope of the collaborative arrangements
- clarity on, and understanding of, decision-making processes in each organisation
- sufficient time to build local relationships and procure together
- recognition of the importance of starting small and tackling areas of work that are of a manageable size.

Re-procurement

Commissioners and providers have reported issues with the process for procuring sexual health services, which has involved retendering contracts through competitive procurement. While there are reports of positive changes implemented through successful tendering exercises, commissioners and providers have highlighted the difficulties frequent retendering brings, including disruption to services when new tenders are awarded, difficulty retaining the best staff and provoking innovation within an unstable environment, and the time spent preparing tender bids (APPG 2015; BASHH 2013). This shows that the issues reported with tendering exercises in drug services are not unique. They affect other public health services, and other areas of NHS procurement, like community services. Commissioners of sexual health services identified longer commissioning cycles and avoiding re-procurement where there is a clear benefit of staying with the incumbent as potential solutions (Local Government Association 2019).

The National Treatment Agency

The National Treatment Agency (NTA) existed from 2001 to 2013 and many still working in the drugs sector hold it in high regard (Department of Health and Social Care undated), with calls for a return to its model of working. However, NHS structures have changed significantly since the NTA was disbanded and it is therefore unclear how an NTA model would be possible to replicate in the 2020s. What it does offer is insights into strengthening accountability for drug services in England.

The NTA developed a four-tier model of services (National Treatment Agency 2006), together with investment in the drugs workforce and training, and advocacy to government and others, to support its approach.

It had both vertical and horizontal lines of accountability. Vertically, NTA was accountable to both Department of Health and Home Office ministers and given responsibility for overseeing spending of the pooled treatment budget from the The King's Fund

two departments. In turn, it held local drug partnerships (drug action teams) to account through nine regional NTA teams scrutinising their yearly annual commissioning plans (Advisory Council on the Misuse of Drugs 2017). Horizontally, at the local level, drug action teams had multiple partners – health, police, probation and local authority senior leaders – who had to jointly agree and sign off their strategic plans. A 2008 review from the Healthcare Commission (Commission for Healthcare Audit and Inspection 2008, p 5) found that these local commissioning partnerships and the NTA had ‘developed strong performance management structures for drug treatment’ and regional teams were holding quarterly reviews with all local drug partnerships to monitor performance.

This model was widely regarded as successful and represents significantly stronger lines of accountability than current arrangements. However, it also experienced some criticism for taking an overly centralised approach without enough recognition of local needs (House of Commons Health and Social Care Committee 2019; McGrail 2014) and an overly bureaucratic approach (Centre for Social Justice 2019; Valios 2004). Any new accountability arrangements will need to tread a fine line between local autonomy and national control.

Other UK nations

Scotland

In Scotland, integration authorities have a statutory responsibility to oversee the delivery of health and social care services at the local level. Integration authorities are responsible for the governance, planning and resourcing of social care, primary and community health care and unscheduled hospital care for adults. Some areas have also delegated additional services further to those that are required in statute, including children’s services, social work, criminal justice services and all acute hospital services. Integration authorities manage the budget for providing all integrated services.

Alcohol and drug services for adults are delegated to integration authorities across all of Scotland and all integration authorities are responsible for the planning and commissioning of drug and alcohol treatment and support services for adults, alongside other adult health and social care services.

Alcohol and drugs partnerships are responsible for developing and implementing a strategic plan to address alcohol and drug harms. In many areas of Scotland, they are responsible for the commissioning of adult treatment services, children’s services, housing and community justice services and this is done through local governance arrangements.

The Scottish government's report *Quality principles: standard expectations of care and support in drug and alcohol services* (Scottish Government 2014) was broad reaching and set out an aspirational approach to service delivery at an organisational level. Two years after the quality principles were published, the Scottish government commissioned the Care Inspectorate to lead an evaluation, consisting of a programme of validated self-assessment, to determine how well the principles had been embedded, and assess their impact on supporting mental health support teams to assist their clients. In November 2016, each of these teams received individual reports detailing strengths and recommendations, which were developed into action plans.

However, since this time, Scotland has seen some important changes to the context and service delivery, namely:

- a significant increase in drug deaths
- a new strategy with a clear focus on harm reduction for both alcohol and drug problems
- more integrated approaches to services involving a range of organisations
- the emergence of a cohort of people who are at a greater risk of drug deaths whose needs are not being met by existing services.

As a result, a commitment was made in the 'Rights, Respect and Recovery Strategy' (Scottish Government 2018) to develop a new quality assurance and improvement framework. This is being designed to measure specific standards for service delivery through objective success indicators to ensure that services are delivered to required benchmarks. These can be applied at a service level or across a number of services as required.

Wales

The Welsh government has devolved powers for policies concerning health, education, housing and social care. The Substance Misuse National Partnership Board guides and monitors progress of the Welsh Substance Misuse Delivery Plan 2019–22 (Welsh Government 2019). Prisons, policing and criminal justice are not devolved but close joint working is supported by a National Policing Board.

Area planning boards are responsible for the monitoring and delivery of commissioned services and are accountable in turn to the Welsh government. These boards operate on a regional basis, which is coterminous with health board boundaries, and they bring together a range of senior partners from their area, including representation from all local authorities, health, criminal justice, the police, including police and crime commissioners, and the third sector. They

are chaired by a senior leader (generally a director of public health or deputy chief executive of a local authority) and all are required to ensure that the experiences of service users are represented.

The decision to establish area planning boards has reduced partnership complexity as previously responsibility for commissioned services was with 22 community safety partnerships; these duties are now discharged via the area planning boards. An evaluation of the previous strategy, published in 2018, noted that area planning boards have significantly improved partnership working. By commissioning services at a regional level, economies of scale have been achieved as well as reductions in variance of support (Healthcare Inspectorate Wales and Care Inspectorate Wales 2018).

The partnership landscape in Wales remains complex and care has to be taken to ensure effective cross-partnership working and governance at the regional level. In Wales, criminal justice services for substance misuse are commissioned via the Office of Police and Crime Commissioners (OPCC). While there is good join-up in many areas, this undoubtedly creates both commissioning and operational difficulties. Area planning boards are voluntary partnerships, which can affect their influence, and services are commissioned by a local authority in each region acting as banker on behalf of the area planning board. Some cover large areas, for example North Wales, and with up to six local authorities to work with, which may have competing pressures, this can create some complexity. Given the split of area planning board and health board funding, joint working in some areas could be improved, although area planning boards have to approve health board spending plans. A number of area planning boards that are currently recommissioning services are seeking to improve this.

Northern Ireland

The Department of Health in Northern Ireland is responsible for leading and co-ordinating action on Northern Ireland's new Substance Use Strategy. The current strategy – the New Strategic Direction for Alcohol & Drugs Phase 2 (Northern Ireland Department of Health undated) – has been in place since 2012, and the new strategy is in development and out for consultation.

Drug and alcohol co-ordination teams, which operate in each of the legacy Health and Social Service Board areas, develop local action plans. They are made up of statutory and community agencies with an interest in addressing, or a need to address, drug and alcohol issues in their health trust area. There is a drug and alcohol co-ordination team for each health trust area in Northern Ireland. The action plans match and reflect New Strategic Direction priorities, and support the implementation of the New Strategic Direction at the local level. In order to deliver on these local action plans, the Public Health Agency tenders for the services they require in their respective areas, enabling all organisations

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to bid to provide these services. The Public Health Agency has established local delivery structures to oversee the implementation of the local action plans.

Northern Ireland's health and care structures are currently in flux, so the situation with regard to future accountability is current unclear. Proposed actions outlined in Northern Ireland's proposed new Substance Use Strategy (called 'Making Life Better – preventing harm and empowering recovery') include: developing or amending current monitoring mechanisms to ensure these are robust and fit for purpose; and for the Health and Social Care Board to develop an outcomes framework for all tier 3 and tier 4 services to monitor the impact and effectiveness of these services. Tier 1 and 2 services commissioned by the Public Health Agency will continue to be required to complete the Impact Measurement Tool (Department of Health 2020). The Department of Health will publish regular update reports on the implementation of the strategy, outlining progress against its outcomes, indicators and actions. This will include information on numbers in treatment and waiting for treatment, rates of alcohol- and/or drug-related hospital admissions, and outcomes for those in treatment.

A review of the New Strategic Direction (Phase 2) in 2018 found greater alignment between the strategic and operational elements, along with greater integration across the strategic agendas of other government departments should feature in any future strategy (Institute of Public Health in Ireland 2018). Also, by placing focus on acute service provision issues, more structured opportunities may have been missed for evidence-informed future planning. The review of the current strategy was incorporated into the development of the new Substance Use Strategy. This focuses on the importance of seeing substance use within the wider approach to improving health and addressing health inequalities. It proposes that the Cross-Departmental Ministerial Committee on Public Health, which oversees the delivery of the Making Life Better strategic framework at the executive level, provides the overall ministerial governance for this framework.

5 The development of integrated care systems: what are the implications for drug services?

Key points

- The NHS is moving away from using competition as a tool for improvement and is firmly focused on collaboration as the best route to fulfilling the health and care needs of local populations. Integrated care systems (ICSs) are partnerships that bring together providers and commissioners of the NHS, local authorities and other local partners in a geographical area, to collectively plan and integrate care to meet the needs of their population.
- Given the focus of ICSs is integrating care across complex system boundaries, for patients with complex needs, it is important that drug treatment services align with commissioning and accountability in ICSs and *vice versa*.
- ICSs have been developing at different rates in different parts of England, and are expected to cover all of England by April 2021 (there will be around 44). Significant change is planned for 2021 and 2022 and is outlined in plans published at the end of November 2020. This includes stronger, but locally flexible, governance and accountability – bringing in wider partners including local government and the voluntary sector. It also includes proposals to formalise ICSs in legislation by April 2022.
- The emerging partnership structures being created through ICSs might be an effective place to consider situating any new accountability mechanisms being developed. However, there is a big question about scale and the appropriate footprint of a regional accountability role for drug services (as well as the formal powers) and whether that matches ICSs or other footprints. This is an open question, but ICSs are subregional structures in the NHS that are being formed and this is a factor to be taken into account in any regional new structure that supports commissioning and accountability around drug services.

- As part of the plans for the future of ICSs, all NHS providers will join provider collaboratives. Well-designed provider collaboratives are the mirror of joint commissioning and partnership approaches to planning. Given the complex needs of most people with drug issues, these collaboratives are likely to have an implication for the services people with drug problems receive. Drugs commissioners therefore need to understand and engage with these collaboratives as they are formed.
- The government has announced a new National Institute for Health Protection as a response to the Covid-19 pandemic, which has implications for the rest of Public Health England, and potentially the public health system it oversees. There is an opportunity to rethink the public health system in England, including commissioning and accountability, and the role of national and regional tiers and the connection to ICSs. Those responding to Dame Carol Black's Independent Review of Drugs will need to engage and influence public health reform, alongside the development of ICSs.

What is an integrated care system?

Integrated care systems (ICSs) are partnerships that bring together providers and commissioners of the NHS, local authorities and other local partners in a geographical area, to collectively plan and integrate care to meet the needs of their population (Charles 2020). They have been developing at different rates in different parts of England, and are expected to cover all of England by April 2021, when there should be around 44 ICSs.

ICSs are the latest in a long line of initiatives aiming to integrate care across local areas. They have grown out of sustainability and transformation partnerships – local partnerships formed in 2016 to develop long-term plans for the future of health and care services in their area. Compared with sustainability and transformation partnerships, ICSs are a closer form of collaboration in which NHS organisations and local authorities take on greater responsibility for collectively managing resources and performance and for changing the way care is delivered.

Significant change is planned for 2021 and 2022 and is outlined in plans published at the end of November 2020 (NHS England and NHS Improvement 2020). This includes stronger, but locally flexible, governance and accountability – bringing in wider partners including local government and the voluntary sector. It also includes proposals to formalise ICSs in legislation by April 2022.

The proposals suggest that ICSs will have four aims in future:

- improving population health and health care
- tackling unequal outcomes and access
- enhancing productivity and value for money
- helping the NHS to support broader social and economic development.

So the purpose of ICSs is subtly beginning to develop beyond the provision of care itself (NHS England and Improvement 2020).

What are the different planning levels within integrated care systems?

A key feature of ICSs is the existence of different tiers or levels that focus on different aspects of the ICSs' objectives. This means there are 'systems within systems' – as most ICSs cover large footprints, some of the most important work across health and local government happens below ICS level. NHS England and NHS Improvement have adopted terminology to describe these different levels.

- **System:** the level of the ICS, typically covering a population of between one and three million people. Key functions include: setting and leading overall strategy; managing collective resources and performance; identifying and sharing best practice to reduce unwarranted variations in care; and leading changes that benefit from working at a larger scale, such as digital, estates and workforce transformation.
- **Place:** a town or district within an ICS, often (but not always) coterminous with a council or borough, typically covering a population of 250,000–500,000 people. This is where the majority of changes to clinical services will be designed and delivered, and where population health management will be used to target interventions to particular groups.
- **Neighbourhood:** a small area, typically covering a population of 30,000–50,000 people, where groups of GPs and community-based services work together to deliver co-ordinated, proactive care and support, particularly for groups and individuals with the most complex needs. Primary care networks and multidisciplinary community teams form at this level.

ICSs vary in size, as do the tiers underneath them. For example, Dorset ICS covers a population of around 800,000 people, and is therefore equivalent in size to Leeds, which is a 'place' within the much bigger West Yorkshire and Harrogate ICS.

What are the implications of these developments for drug services?

Given the focus of ICSs on integrating care across complex system boundaries, for patients with complex needs, it is important that drug treatment services align with commissioning and accountability in ICSs and *vice versa*.

Place-level collaboration

As outlined above, most ICSs have identified 'places' and smaller 'neighbourhoods' that sit within them as units for planning and providing services, and in many parts of the country, strong and effective 'place'-based partnerships exist across the NHS, local government and other partners (Charles *et al* forthcoming; Robertson and Ewbank 2020). 'Place' is also often the area over which the health and wellbeing board works, and therefore the area on which the local joint strategic needs assessment (JSNA) and local health and wellbeing strategy is focused – further facilitating efforts to collaborate to address local population needs. Some areas already have joint delegated budgets at 'place' level across the NHS and in aspects of local government spend, and plans are for this to increasingly become the case (NHS England and NHS Improvement 2020).

As discussed earlier in this report, collaboration and joint commissioning can be facilitated by local partners agreeing a joint vision and being held to account for that vision. Given the strong partnerships and cross-sector structures that are developing at 'place' level, this may be the level at which collaboration between drug treatment service commissioners and the NHS should be perused and monitored. Connecting with this structure could facilitate better joint working with the NHS, which has been highlighted as a particular issue for drug treatment service commissioners.

A bottom-up approach – and the connection with local government

The development of ICSs has been locally led and iterative – compared with the way that the NHS usually leads change. This was necessary in order to make the most of local assets, skills and existing relationships. It was also necessary because different parts of the country started at very different stages in the development of integrated ways of working, meaning the right model in one part of England would not have been effective in another. NHS England and NHS Improvement outlined broad parameters about the structures local systems needed to establish, but the detail on how these would work and the speed with which they developed have been largely left to local areas (NHS England and Improvement 2019).

Although the most recent proposals from NHS England and NHS Improvement (NHS England and Improvement 2020) seek to put ICSs on a more consistent

footing, there will continue to be significant differences in the scale and characteristics of ICSs and the local places within them, in different parts of the country.

Any changes to the way drug treatment services are commissioned across the local authority/NHS divide will need to account for and engage with the varied, locally driven structures that exist to support integrated planning. This means that the most effective approach to improving links between drug treatment services and NHS services such as mental health services is likely to be different in different parts of the country – depending on the nature of their integrated planning structures, their maturity and the geographical footprints that they cover. This makes developing a single approach tricky and highlights the need to allow flexibility within any framework for local areas to adapt their approach to local circumstances.

The experience of developing ICSs also shows that mandated structures for integrated planning and system development are unlikely to provoke change on their own. Bottom-up approaches that build on local strengths and include significant investment in developing relationships are likely to be the most successful, particularly when funding is tight.

Finally, the NHS's 'discovery' of place and bottom-up approaches for the future design and delivery of care also raises questions about the future relationship with local government. The fact that the key strategic footprint for the NHS is going to be more closely aligned with local government boundaries is a very positive principle. However, how this will work in practice is yet to be defined. The previous reforms introduced health and wellbeing boards (committees of local government), which were supposed to take on the role of assessing needs and designing a joint strategy with the NHS that would deliver policy and care to improve health. In practice, with exceptions, these have been under-powered (Hunter *et al* 2018), and the NHS has not seen them in this light. Instead, the NHS's national leaders developed ICSs and other structures (such as primary care networks) and expect local government colleagues to support them. The leading ICSs (eg West Yorkshire and Harrogate) have had strong partnerships with local government (and the voluntary and community sector) from the start, but this is new territory for many of the ICSs. In conclusion, the NHS is making substantive efforts to be more place-based but this comes from a command-and-control culture, very different from the more democratic structure of local government. How this will work, for planning, services and partnership, remains to be seen.

Commissioning and accountability across systems

The Health and Social Care Act 2012 abolished strategic health authorities and removed the regional tier of accountability in the health system. This left a gap that the new structures have been emerging to fill over the past five years.

Sustainability and transformation partnerships, and the ICSs that they are developing into, have taken on some of the responsibilities previously held by strategic health authorities for co-ordinating planning across a number of commissioning areas (multiple CCGs and local authorities).

Some specialised commissioning responsibilities in the NHS are increasingly being devolved to ICSs. In many cases, specialised services need to be commissioned across more than one ICS in order to capture a large enough population to support the development of these low-volume services. The same principle of looking across multiple commissioners in order to get the scale needed to effectively commission specialised services should also be applied to specialised drug treatment services.

Evidence in this report points to the importance of effective regional-level accountability structures. The emerging partnership structures being created through ICSs might be an effective place to consider situating any new accountability mechanisms being developed. These include any regional structure that might be developed to replace Public Health England, and the seven regional offices of NHS England and NHS Improvement, which have a role in health system oversight. However, there is a big question about scale and the appropriate footprint of a regional accountability role for drugs (as well as the formal powers) and whether that matches ICSs, or other footprints. This is an open question, but ICSs are subregional structures in the NHS that are being formed and this is a factor to be taken into account in any regional new structure that supports commissioning and accountability around drug services.

Provider collaboratives

All NHS providers will join provider collaboratives. These can be horizontal (between providers of the same type on an ICS or multi-ICS footprint – eg acute hospitals, specialist mental health trusts and ambulance trusts) or vertical (combining different types of providers at place level – eg community health, mental health and acute providers). Providers may find themselves part of both horizontal collaboratives at ICS level, and vertical collaboratives at place level.

Horizontal provider collaboratives will be expected to reduce unwarranted variation, reduce inequalities of access, improve workforce planning and make efficiencies in clinical support and corporate services. They will be expected to agree and implement clinical pathways and reconfiguration, and challenge and

hold each other to account with open-book approaches to finance. These horizontal provider collaboratives are mostly at an early stage of development and NHS England will provide further guidance in the NHS Operational Planning Guidance for 2021/2 alongside further preparatory support.

Well-designed provider collaboratives are the mirror of joint commissioning and partnership approaches to planning. Given the complex needs of most people with drug issues, these collaboratives are likely to have an implication for the services people with drug problems receive. Drugs commissioners therefore need to understand and engage with these collaboratives as they are formed.

System leadership

Repeated studies show that strong leadership is critical to developing effective services across sectors. Getting the right type of local leadership has been a key facilitator of NHS integration. However, this requires investment to support and develop leaders. It also means leaders need to have the time available to develop and build relationships. This is particularly important for drug services where the complex issues faced by service users means connections need to be made with a wide range of services and sectors.

A key challenge for drug services will be ensuring they are visible to system leaders. From the conversations we have had with commissioners, areas that seem to be succeeding in collaborating have a very engaged director of public health and elected member of the health and wellbeing board.

From competition to collaboration

The NHS is moving away from using competition as a tool for improvement and is firmly focused on collaboration as the best route to fulfilling the health and care needs of local populations. The latest proposals for legislative change reinforce previous suggestions to reduce the power of the market by, for example, reducing the role of the Competition and Markets Authority in the NHS and removing some of the rules and requirements relating to competitive procurement (NHS England and NHS Improvement 2020).

Commissioners and providers across the NHS and local government are increasingly working together to plan services collaboratively through ICSs and the local places within them, and the latest proposals from NHS England and NHS Improvement include strengthening the role of providers (working in networks) in commissioning and service development.

The problems caused by competitive procurement processes in the NHS and local government have been well documented (eg NHS England 2016; Robertson *et al* 2017) (although it is also important to remember that they have in some

cases driven innovation and transformation efforts). There is fairly universal agreement that the use of competitive tendering is sometimes inappropriate and detrimental to local services provision. The prevailing view is that commissioners should be given more discretion to enable them to use competitive procurement as a tool for improvement only where it is appropriate.

Working with patients, the public and communities

Some of the best examples of innovation around patients happen in systems that are taking a collaborative approach to commissioning (Robertson and Ewbank 2020). Collaboration – between commissioners and providers, and also with communities – taps into intrinsic motivations and enables strategies and services to be developed that focus on the needs of local populations and not on individual organisations (Davidson-Knight *et al* 2017).

Effective systems are based on a new relationship with the communities they serve. Any new approach to commissioning drug treatment services needs to have communities and service users at its heart.

There are examples across the NHS and local government of local systems working successfully with their local community to develop services that meet patients' needs. Some of the most impressive examples take an asset-based approach that builds on the strengths of individuals and communities to improve outcomes (Naylor and Wellings 2019).

Working with patients and communities is an area that the NHS has sometimes fallen short on in the past. Sustainability and transformation partnerships were initially criticised for a lack of patient and public involvement in their plans (Doughty 2016). However, it is an area that drug treatment services will need to get right if they want to develop services that meet service users' needs and the needs of the local community.

The new public health system

The government has announced a new National Institute for Health Protection as a response to the Covid-19 pandemic, which has implications for the rest of Public Health England, and potentially the public health system it oversees – on current timelines, decisions are due to be made by spring 2021 (Department of Health and Social Care 2020). Notwithstanding the wisdom of doing this now, there is an opportunity to rethink the public health system in England, including commissioning and accountability, and the role of national and regional tiers (Elwell-Sutton *et al* 2020; Sloggett 2020). This may include a stronger connection to the development of ICSs, in particular to ensure they are connecting strongly to other local partners in place and responding to community needs and assets. Those responding to Dame Carol Black's

Independent Review of Drugs will need to engage and influence public health reform, alongside the development of ICSs.

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