

How do the budget figures stack up?

Following weeks of speculation, drug action teams finally received the letter they had been waiting for from the NTA, confirming their pooled treatment budget. Chief executive Paul Hayes answers DDN's questions about how the budget should work.



DDN: What was the reason for allocating less money than originally promised for the PTB? Is the message that DATs don't need the money because they didn't spend it last year, or because they've already met targets two years early – or is the reduction directly related to funding restrictions on the NHS?

PH: It's a combination of things. It would be naïve to believe we can operate in a system that's divorced from what's happening elsewhere in the NHS. We're part of the NHS and they're experiencing financial difficulties. So it's incumbent on everyone to demonstrate that they're making best use of the money that's available.

The position we're in is that we've met most of the top line targets. The money was planned to be delivered to us between now and 2008 to meet those targets, so the fact that we've met them two years early suggests, on the surface, that we didn't need the money. And given that the rest of the NHS did need the money, we obviously then had to make out a case for why we should have it.

Other factors that certainly the Department of Health take into account, is the fact the not only have we delivered the targets two years early, but we've delivered them in a context in which a lot of DATs have under spent year on year. That again would suggest we'd need to make a strong case for why we needed as much money this year.

The third thing that comes into play, is that some people seem able to deliver good quality services for less money per head than others. So if you're a minister or DH official, you put all of those things in the mix. And you come to people like me and say 'how can you justify a 40 per cent uplift in these circumstances?'

DDN: How did you come to a decision on the figure allocated?

PH: I felt I could justify an uplift. Because although we've got 200,000 people in treatment this year, there are anything between 250,000 and 350,000 who need to be in treatment, so we still need to grow towards that. Everyone agrees we still need to improve the quality of treatment. And although we've met most of the targets, the crucial one we haven't yet met is to deliver 750 offenders a week into treatment. It's a Home Office target rather than a DH target, but obviously HO wouldn't be able to meet it unless DH continued to expand the treatment system.

Putting all those arguments together and doing our sums again, we came up with a figure of a PTB of £385m – a 30 per cent uplift – an amount that would give us the ability to continue to expand the treatment system, continue to improve retention, continue to improve quality overall, and give the HO their 750 a week into treatment.

DDN: Is there any scope for negotiation, if an area had a complete crisis – around young people for example – but were only allowed to direct money towards it if they'd got a surplus?

PH: There are two sides to fall off the tightrope in answering that question. I would never want to say that somebody couldn't come and say 'this has happened and we therefore need to revisit our plans'.

But on the other hand, I wouldn't want people to think that we will be sympathetic to wholesale revisiting of treatment plans. We won't. People have got 93 or 94 per cent of the money they thought they were going to get. Many of them historically have under spent, very many of them are not getting the best value for money out of what they've got at the moment. We're aware of two or three places in the country where there may be particular circumstances. But it would need to be a very powerful case, argued very cogently.

DDN: How do DATs make up for the fact that a quarter of the year's gone? Are you saying there's enough slack in the budget to compensate?

PH: Ah, that's a rather different issue! People complaining about this process are on much stronger ground if they complain about the timing of the announcement rather than the amount of money. I think it's unfortunate that it's taken this long. The early delays were about the agreement on the amount. And if we'd announced it on time, people would not have been

happy because they'd have got much less money than they're getting now.

But obviously the further into the financial year it goes, the more difficult it becomes. It will be particularly difficult for people to guarantee that they can spend all the money. People inevitably will have been hedging their bets over the last two or three months. Some of them will have been taking worst case scenarios of what the uplift would have been. I think there are very few people who were expecting to get the 40 per cent, and acting as though they were going to. There are probably more who have been unduly cautious over the last three months.

I think that people will be surprised that it's rather more than they might have thought. But there will be some people who will have to get their skates on in order to make best use of the money they've got. And we appreciate that, and we'll be working with them to help them do that. I certainly wish that the announcement had been made about a month ago.

DDN: Were you concerned that some areas weren't spending their budget because they weren't very good at it, rather than because they'd got too much cash?

PH: Absolutely. There are very few places that aren't spending the money because they've got too much money. There are probably one or two places where they're probably over-resourced for what they need. Most places are either not spending enough per head, or are sitting on unplanned under spend – planned under spends are fine. If someone's actually got a capital project and they've effectively saved up money from one year to spend in the next, then I've got no difficulty with that.

There are some people who can't get their act together to spend the money well, and that's a problem. And there are people who've got too much money largely because they can't get people into their treatment system. Obviously what we need to do is get them organised so they can do that.

DDN: You said in your letter to DATs that areas need to prioritise what they do, and that the emphasis should be very much on getting people into treatment, and keeping them in treatment. Are you concerned that some of the poorer performing areas will see it as a case of meeting targets and be let off the hook on some of the detail?

PH: There's always that risk. One of the dilemmas is, if you don't set targets people tend to do very little. And if you

do set targets, it can result in only the targets being achieved and nothing else. That very rarely delivers the outcomes that you actually want from the targets. We're very aware that you can hit the target and miss the point – and we're not in that business at all.

The overarching message is that most people should be able to deliver their treatment plan in full. Even though they're not getting as much money as they thought they were going to get, we believe that most of them can identify savings so that they can deliver all the things that they were planning to do this year.

Those that genuinely can't deliver everything need to prioritise, we'll work with them to identify which of the other things they still can do. We believe there will only be a few places that can only do the priorities.

DDN: Will it be down to your regional managers to make sure service users aren't penalised in areas of bad treatment?

PH: Absolutely, that's the last thing we want. It will show in the retention indicator in the NHS performance management system – people who are receiving a lousy service will vote with their feet.

DDN: You're introducing new money to increase capacity in inpatient and residential rehab. Will some of it be used to address the current problems with bed spaces and the criticism that the space isn't being used at the moment?

PH: Yes absolutely. What will happen is that consortia of DATs will be asked to bid for the capital money. Very often this will be to refurbish and expand existing premises – and some of it will be new build. But they won't be given that money unless they commit to taking up a certain number of slots each year, and to fund those slots from their revenue.

In that way we not only expand the capacity, but also make sure there's enough revenue funding for the current and new capacity. What looks like an apparent nonsense, that we're not making the most of what we've got at the moment and we're building some more, is actually a sensible response.

DDN: Are you still as committed to the workforce targets since restructuring the workforce development team?

PH: Well it's a bit like the other things we've been talking about – the original workforce agenda's been achieved. That was the first of our level targets

that we met, three or four years early. What we're doing is refocusing on our work around workforce with the regional teams. I've been in Nottingham today, and it's very clear that our regional team in the East Midlands has got a real grip on the workforce agenda locally, and that we're able to drive it forward better regionally than we were nationally. Essentially we've passed the baton to HO and DH nationally, and relocated the emphasis of our work regionally.

The NTA central role will be about policy, best practice, being a champion for drug treatment within government. The SHAs will be responsible to the DH for the delivery of drug treatment, along with all the other healthcare for their communities, and we will be the means through which DH will have the expertise to hold them to account.

We're championing from within, and will also be the eyes and ears of DH, to see whether things are good on the ground. And if they're not, we'll go in, find out why not, and do something about it.

DDN: What about the NTA beyond 2008? If management of the NTA regional structure is going to SHAs, will NTA regional managers lose their independent status? Will there be any breakdown of that structure that keeps them informed at the moment, and keeps them motivated?

PH: In all honesty, we don't know. The original plan was for the NTA to have disappeared by 2008. That now is not going to happen. The NTA as a national entity will continue beyond 2008.

There are no guarantees. We're already one of the longest established NHS bodies. We've been going since 2001, and most other bits of the NHS have been reformed twice. So there are no guarantees of anything in the NHS world. But the expectation is the NTA will continue past 2008, because the government recognises this is a very important agenda – but one that the NHS, left to its own devices, would never give the sort of priority to that the government would wish it to.

That's not a criticism of the NHS. If I was running a PCT, or an SHA, or the DH, I wouldn't give drug treatment very high priority, because it isn't that important a health matter, compared to many other aspects of health care. The amount of people involved, the amount of early deaths, pales into insignificance compared to, for example, tobacco and alcohol.

The NHS was probably giving drug treatment a legitimate amount of

resource and attention before the NTA came on the scene; what produced the additional funding is the concern about drugs and crime. The government's acknowledged that if it wants the NHS to continue to devote the attention and resources that we've been doing over the past five years, it needs to keep the NTA in existence in order to champion the drug misuse agenda, within the DH, within government offices, and within the NHS. So the NTA will continue to perform that function.

It's also acknowledged that the SHAs and the government offices will need some resource working with them to deliver that, post 2008. What hasn't been resolved, is what the bureaucratic relationship will be between the central NTA, the NTA regional teams, the government offices, and the SHA.

There will continue to be an NTA, there will continue to be a regional team charged with delivering the drugs agenda, but what we don't yet know is how that will be badged up.

DDN: What will happen next time around with the PTB? Will it be mainstreamed?

PH: I honestly don't know. There's been no discussion about what happens in 2007/8. The current situation is that all the money that DH used to hold centrally has now gone to SHAs. There are currently only two budgets in the DH – one that goes out to SHAs, and the PTB that stands entirely on its own.

The rationale for that is because of the nature of this agenda, it makes sense to keep it separate – we couldn't guarantee that the funding would have been spent on drug treatment, if it hadn't gone down as a separate budget line. We need to have this same discussion next year.

DDN: And you'll still personally be at the NTA to have this discussion, will you?

PH: Oh I'm not sure that's a fair question! I have no other plans.

DDN: Are you still as happy with your job after the last few weeks?

PH: I love all this stuff – that's what I'm here for! Most people recognise that given the context in which we're operating, the drug treatment field hasn't done at all badly out of it. We did our best to tell people as much as we could, but we didn't want to give false reassurance till everything was nailed down. Also, if you start leaking all over the place, you're not trusted to have the discussions again next year. **DDN**

Main points from the letter to DATs announcing their PTB allocation

The national PTB allocation for 2006/7 is £384.6m – a 28 per cent increase over 2005/6. This includes £10m from the DH for capital spend.

Additional capital resource will be available from DH for expanding tier 4 provision.

The uplift is intended to increase treatment numbers by 25,000 and improve retention by 5 per cent.

The rationale behind reducing uplift from an expected 41.5 per cent is: targets on treatment access have been achieved two years ahead of schedule; many partnerships have failed to spend their allocation in previous years; and cost of treatment varies dramatically between partnership areas.

Areas that struggle to deliver should prioritise as follows: by delivering Local Delivery Plan targets for retention and local stretch targets for increasing numbers in treatment; by meeting the criminal justice system target of 750 referral into treatment through the Drug Intervention Programme and Drug Rehabilitation Requirement; by expanding services for class A drug users referred via non criminal justice routes.

Where areas need more money for young people, on top of the Young People Substance Misuse Partnership Grant, they can redirect more resources from the PTB – as long as the priorities above are covered first.

Government is working out a different cost structure for next year, based on establishing a level playing field between different areas. The current formula will change, and funding will be based on the unit costs for each type of treatment.