

Business plan 2008/09

**National Treatment Agency
for Substance Misuse**

8th floor, Hercules House,
Hercules Road,
London SE1 7DU
Tel 020 7261 8801
Fax 020 7261 8883
Email nta.enquiries@nta-nhs.org.uk

NTABP2008/09

Design www.wilddogdesign.co.uk

Printed Using the waterless process with ISO 14001 environmental certificate on Revive Recycled paper 

Further copies of this publication may be ordered online at www.nta.nhs.uk. Product code [NTABP2008/09](#)

Written orders [Prolog, PO Box 777, London SE1 6XH](#) Fax orders [01623 724 524](#) Phone orders [08701 555 455](#) Email orders NTA@prolog.uk.com

Contents

1 Drug Strategy	3	6 Young people's delivery plan	29
1.1 The NTA's role	3	6.1 Budget	29
1.2 Drugs: Protecting Families and Communities	4	6.2 Commissioning	30
		6.3 Planning and inspection	30
		6.4 Practice development	31
		6.5 Outcomes	32
2 Role of treatment	5	7 Supporting delivery	32
3 Context	7	7.1 Communication strategy	33
3.1 Ambition	7	7.1.1 Communication objectives	33
3.1.1 Adults	7	7.1.2 Approach	34
3.1.2 Young people	7	7.1.3 Communications Directorate	34
3.2 Localism in the NHS and local government	7	7.1.4 Director of communications	34
3.3 Resources	8	7.1.5 Media	34
3.4 The challenge of changing patterns of drug use	8	7.1.6 Public affairs	34
3.5 Communicating success	9	7.1.7 Publications and events	34
		7.1.8 Internal communications	34
		7.1.9 Policy and interface	34
		7.1.10 Gateway	35
		7.1.11 Evaluation and next steps	35
4 Accountability	10	7.2 Human resources	36
4.1 Substance misuse pooled treatment budget	10	7.2.1 Performance information	36
4.2 Commissioning	11	7.3 NTA business processes	36
4.3 Value for money	12	7.3.1 Corporate service reviews and efficiencies	36
4.4 Adult drug treatment planning	13	7.3.2 Information technology capacity and efficiency	36
4.5 Delivery assurance	14	7.3.3 Shared business services – finance and payroll	36
4.6 Inspection	15	7.3.4 Human resources	37
		7.3.5 Accommodation	37
		7.3.6 Sustainable development	37
		7.3.7 Governance, risk and controls	37
5 Practice improvement	16	7.4 Finance and resources	38
5.1 Targeting those most at risk	16		
5.1.1 Improving treatment for stimulant users	16	8 Budget allocations	39
5.1.2 Removing barriers to access	17	9 Selected bibliography	41
5.2 Improving the quality and effectiveness of treatment	17		
5.2.1 Reducing drug related deaths and blood-borne virus infections	17		
5.2.2 Implementing clinical guidelines	18		
5.2.3 Supporting the workforce	19		
5.2.4 Clinical governance	19		
5.2.5 Completions and outcomes	20		
5.3 A wider use of new treatment approaches	21		
5.3.1 Research into injectable opioid treatment	21		
5.3.2 Developing evidence and research	22		
5.3.3 Treatment incentives	23		
5.3.4 Mutual aid support networks	23		
5.4 Helping drug users to re-establish their lives	24		
5.4.1 Employment	24		
5.4.2 Housing and accommodation	24		
5.5 Criminal justice	24		
5.5.1 Drug Interventions Programme	24		
5.5.2 Drug Rehabilitation Requirements	25		
5.5.3 Prisons	26		
5.6 A new package for families	28		

1 Drug Strategy 2008–2011

1.1 The NTA's role

The National Treatment Agency is a special health authority created by the government in 2001 to improve the availability, accessibility and effectiveness of treatment for drug dependency in England.

The NTA is formally responsible to the Department of Health but is also jointly accountable to the Home Office as the lead for drug policy with government, the Department for Children, Schools and Families as the lead for young people and the Ministry of Justice, which shares responsibility for treatment in prison with the Department of Health.

The delivery of timely, effective treatment has been key to the success of the 1998–2008 Drug Strategy and is central to the delivery of the government's new strategy. Effective, well-delivered treatment improves the health and social functioning of individual drug misusers, reduces the risks to public health resulting from the spread of blood-borne viruses – such as HIV and hepatitis – and significantly improves the safety of communities by reducing re-offending among drug-misusing offenders.

The creation of a treatment system to deliver these societal benefits demands that the NTA works in partnership with colleagues on a national, regional and local level. These key stakeholders include the Department of Health, Home Office, Department for Children, Schools and Families, Ministry of Justice, Healthcare Commission, National Institute for Health and Clinical Excellence (NICE), National Offender Management Service, strategic health authorities, HM Prison Service, drug treatment service user and carer umbrella groups, Royal Colleges, researchers and academics.

The NTA's role is to ensure that:

- The local partnerships charged with delivering drug treatment in the 149 local authority areas in England – usually, drug action teams (DATs), crime and disorder reduction partnerships (CDRPs) and children's trusts – understand the needs of their populations and create a treatment system able to match it
- Treatment providers deliver high-quality, evidence-based treatment that is readily accessible and appropriate to need
- Service users have appropriate access to services that support, consolidate and sustain the benefits of treatment, including access to employment, education, housing and family support provided by agencies that are not part of the formal treatment system
- Management information is available about the operation of the drug treatment system to enable partnerships, providers and the NTA to be held to account by service users, communities and the government
- Service users and their carers have an appropriate role in determining their own treatment goals and influence over the shaping of policy
- The different treatment needs of young people are understood, and the contribution of mainstream children's and young people's services to meeting their needs is recognised and owned locally, ensuring that an integrated system of support, treatment and associated intervention is available for young people with substance misuse problems or at risk of developing substance misuse problems.

Although the NTA is charged with delivery against these aspirations, ultimately the success of the NTA and its partners will be judged by the performance of drug treatment providers, the experience of service users, and the perception of communities affected by drug misuse.

2 Role of treatment

1.2 Drugs: Protecting Families and Communities

The NTA's work over the next three years needs to be located within the context of the delivery of the government's new ten-year Drug Strategy, Drugs: Protecting Families and Communities. The strategy builds on the successes of its predecessor in reducing overall levels of drug use, expanding and improving the treatment system and reducing drug-related crime. In addition to actions to sustain these improvements, the strategy indicates significant shifts in emphasis and prioritisation, in part made possible by the achievements of the previous ten years.

Reflecting the conclusions of the ACMD's Hidden Harm report, there is recognition that the potential for parental substance misuse to damage the life opportunities of children may have received insufficient priority in the previous strategy. Reducing the negative impact of parental drug use on families will therefore be a key priority for the new strategy and the treatment system will be crucial to delivering this.

Alongside the emphasis on families, there will be a stronger role for communities, maximising their potential contribution to influencing and shaping their local environment. The role of carers of those in treatment will need to be at the core of this.

The strategy acknowledges the significant improvements that have occurred in the treatment system, builds on them and identifies a new set of ambitions for treatment. Local treatment systems will become more focused on the individual, tailoring packages of care to respond to each service user's needs and meet personal needs, rather than routine, one-size-fits-all provision. Part of this will include greater emphasis on treatment outcomes, completion and exit, so that all those who are able to leave the treatment system and sustain an independent life are supported and enabled to achieve this as swiftly as possible. However, some individuals are not able to achieve abstinence for some time and local systems therefore need to be able to respond appropriately to those who need to be supported in treatment for longer periods while receiving substitute opioid medication.

The strategy recognises that treatment in isolation from efforts to address other aspects of individuals' lives is unlikely to deliver sustainable change. Access to stable accommodation is a key underpinning of treatment success. Improving the employability of those in treatment and helping them benefit from the dignity, respect, discipline and opportunities that flow from work is one of the key messages of the strategy. As part of this, drug misusers will need to accept their responsibilities as citizens to contribute to society through work, if they are capable of doing so, and local partnership treatment providers and government agencies will need to co-operate to facilitate access to the labour market.

The success of the past few years and the aspirations of the current strategy are built on a variety of funding streams and regulatory structures, which have evolved to support different initiatives. The strategy commits government and its agencies to examine current funding and accountability, reduce bureaucracy and introduce flexibility whenever possible, to deliver best value for the taxpayer and focus resources on service users and communities.

The key mechanisms through which the Drug Strategy's aims will be delivered are the government's three year public service agreements (PSAs) for 2008/11. The provision of effective drug treatment will make a significant contribution to the delivery of three PSAs:

- **PSA 14:** Increase the Number of Young People on the Path to Success, which seeks to address not only young people substance misuse but also the impact of parental drug misuse on their children
- **PSA 23:** Making Communities Safer, which focuses on crime reduction
- **PSA 25:** Reduce the Harm Caused by Alcohol and Drugs

The most significant target for the NTA is indicator 1 of PSA 25, which sets the ambition by 2011 to have increased the number of heroin and crack users in effective treatment by three per cent. This business plan identifies how the NTA will deliver this and the remainder of the commitments in the Drug Strategy across this period with particular emphasis on the first year 2008/09.

The government's 2008 Drug Strategy describes the purpose of treatment as follows:

“The goal of all treatment is for drug users to achieve abstinence from their drug – or drugs – of dependency. For some, this can be achieved immediately, but many others will need a period of drug-assisted treatment with prescribed medication first. Drug users receiving drug-assisted treatment should experience a rapid improvement in their overall health and their ability to work, participate in training or support their families.”

Some drug misusers can overcome drug problems within short periods of time, for example less-severe cannabis or stimulant misusers. However, for some, drug dependency can be a chronic condition characterised by many relapses. Some drug misusers, such as severely dependent heroin or polydrug misusers and those with complex needs such as co-existing mental health disorders, can take several years to overcome their dependency and pass successfully through treatment. It is important not to lose sight of the evidence that most drug misusers do eventually recover and become free of their drug dependency. Evidence from UK and US longitudinal studies show that even among entrenched heroin and polydrug misusers, 10–15 per cent of people will be abstinent from their drug of dependency after one year, 25–40 per cent by five years and 64 per cent by 12 years. Twenty years after starting heroin use, research suggests only 25 per cent of heroin misusers will still be dependent.

However, the benefits of drug treatment are not restricted to those who overcome their addictions. While in treatment, individuals will be less likely to offend, less likely to harm their own or others' health, and will use significantly fewer drugs.

They will also be more likely to be in employment or education, more likely to meet their responsibilities as parents and will be better integrated into their families and communities. Research undertaken by the University of York commissioned by the Home Office concluded that for every £1 spent on treatment, £9.50 worth of benefits accrue to the community. This benefit is delivered not primarily when individuals leave treatment but from the changes in behaviour that occur while they are stable and in drug treatment.

Treatment has a number of benefits that need to be acknowledged. Drug treatment minimises the damage and harm associated with illegal drug dependency while individuals tackle dependency. For the majority, drug treatment provides accelerated pathways to full recovery and abstinence from dependency. For those who require maintenance on substitute medication for long periods, it can provide safety and stability that enable family life and employment that would not otherwise be possible.

The 1998–2008 Drug Strategy concentrated on building a treatment system with increased capacity, ease of access and services of a good enough quality to maximise the numbers of people able to be retained in treatment, who could derive the benefits of improved health and social functioning, reduced drug use and lower levels of criminality already outlined.

The treatment element of the 1998–2008 Drug Strategy has been a clear success. The target to double the number of people in treatment has been exceeded with provisionally over 200,000 people in treatment in 2007/08 compared to 85,000 in 1998 (see Figure 1).

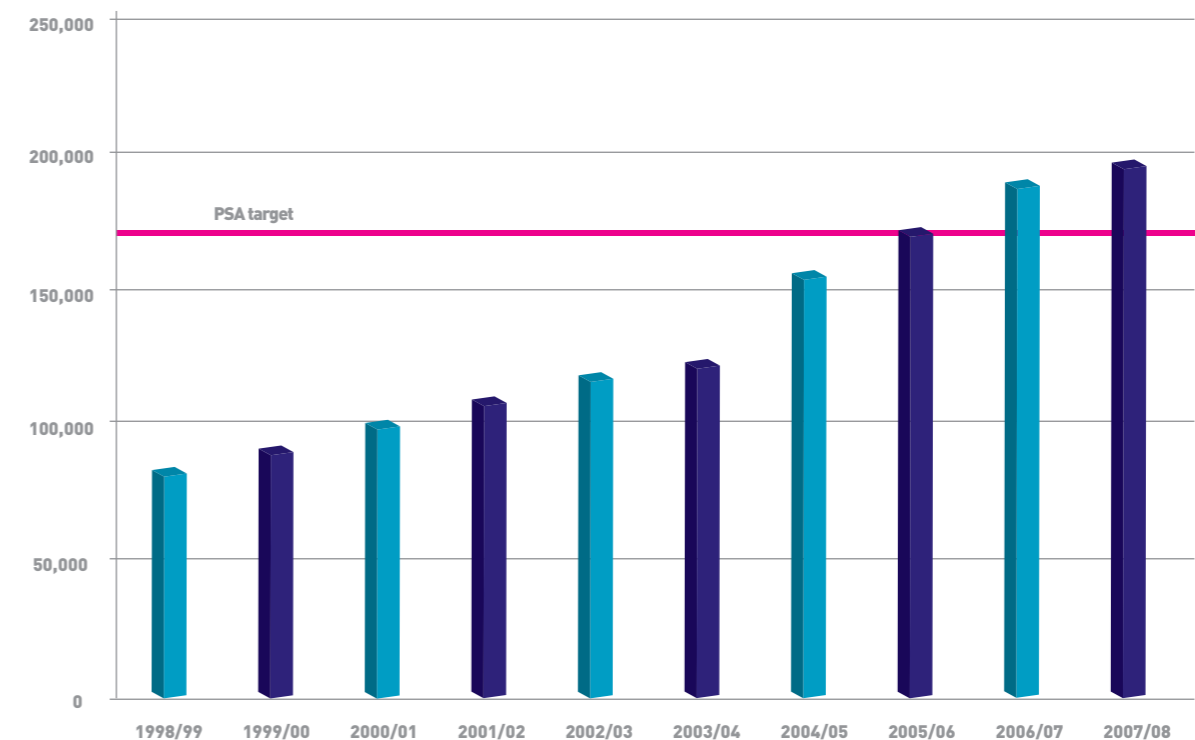


Figure 1: Numbers in treatment 1998–2008

3 Context

Waiting times have fallen significantly over the same period. In 2001, the average wait to access any form of treatment was nine weeks and the wait to access specialised prescribing services was 14 weeks.

As demonstrated in Figure 2, the average wait for all treatment types is now one week and 96 per cent of service users now wait three weeks or less to access treatment. Ninety-six per cent of service users now wait three weeks or less to access treatment.

There has also been significant improvement in the numbers of people retained and successfully completing treatment. Drawing on the international evidence, the NTA Treatment Effectiveness strategy, launched in 2005, identified 12 weeks as the minimum time in treatment at which the long-term entrenched users of opiates and crack cocaine, who comprise 77 per cent of those in treatment, derive sustainable benefit. Retention in treatment for a minimum of 12 weeks has been used over the past three years as the benchmark of the effectiveness of treatment; the entry point at which lasting benefit begins to be delivered to individuals and society.

In 2006/07, of the 195,000 people in contact with the treatment system, 180,000 were successfully engaged as follows:

- 27,000 completed treatment successfully (compared to 13,000 in 2004/05)
- 86,000 were retained in treatment throughout the year
- 67,000 were retained for 12 weeks or longer.

Of the individuals who commenced treatment in 2006/07, 75 per cent were retained for 12 weeks or longer. A further eight per cent successfully completed short-duration treatment programmes, usually for cannabis problems. The proportion of new entrants dropping out of treatment without deriving benefit fell to 17 per cent.

The 2008 Drug Strategy seeks to build upon these achievements. Alongside consolidating improvements in capacity, access and retention there will be increasing focus on accelerating the process of recovery in order to maximise the number of individuals able to complete treatment, having overcome dependency. To achieve this, the treatment system needs to become more responsive to individual needs. Personalised packages of care constructed around individuals' aspirations and capabilities need to be developed, drawing on good professional care planning, and treatment systems need to be responsive to what service users want from treatment. Most individuals come into treatment wanting to become free of their drug of dependency and the treatment system needs to achieve an appropriate balance, equally comfortable with quickly routing those who are capable of benefiting quickly through abstinence-based treatment, and retaining those who are not yet able to leave treatment supported in substitute prescribing services. At the same time, individuals need to be assisted in achieving their aspirations in respect of other aspects of their lives, including accommodation, employment and other physical and mental health issues.

This plan sets out how the NTA will continue to focus on improving the quality and outcomes delivered by drug treatment systems across England in line with Drugs: Protecting Families and Communities.

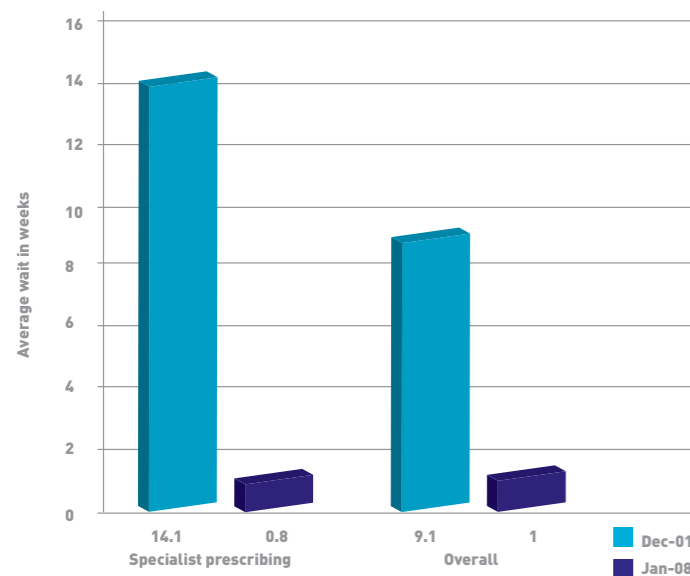


Figure 2: Average waiting times (Dec 2001 to Jan 2008)

3.1 Ambition

The overall ambition for treatment is to help individuals overcome drug dependency, enhance their life experiences, improve the contribution they can make to the community and minimise the risks they pose to themselves and others. To deliver this, the drug treatment system needs to continue to deliver the improvements that have been achieved since 2001:

- Increased capacity
- Rapid access
- Lower early dropout
- Improved treatment completion
- Demonstrate continued improvement in the effectiveness and outcomes of treatment.

The NTA anticipates information from the Treatment Outcomes Profile (TOP) becoming sufficiently robust over the next three years to form the basis of judgements about the effectiveness of treatment nationally and locally. While TOP is bedding in, the overall effectiveness of treatment will be judged by the achievement of PSAs 14, 23 and 25.

3.1.1 Adults

PSA 25 indicator 1 measures the growth in the number of drug users recorded as being in effective treatment and sets out the national minimum improvement required as three per cent by 2011.

This indicator measures the change in the number of drug users using crack and opiates in treatment in a financial year, those still in continuous treatment, those discharged from the treatment system after 12 weeks or, if discharged before then, those who were successfully discharged in a care planned way as a change from baseline performance in 2007/08. This will include all problem drug users (PDUs), including young people under 18.

As PSA 25-1 is mirrored in NHS Vital Signs (VSB14) and the LAA National Indicator Set (NI40), each local partnership will be required to set local targets for the performance against the indicator. This will reflect their own scales of ambition and will be influenced by the explicit link now established between treatment activity and future pooled treatment budget funding.

Ready access to effective treatment for offenders contributes to the achievement of PSA 23.

3.1.2 Young people

PSA 14, "increasing the numbers of children and young people on the path to success", sets out in more detail how local areas should best approach reducing young people's substance misuse, alongside other linked issues for young people. The NTA's role in working with DCSF is to ensure that through partnership working with local authorities and other key stakeholders, there are substantial improvements in the effectiveness, quality and accessibility of young people's substance misuse treatment systems across England, ensuring that these services are commissioned and delivered within an integrated children's services framework.

3.2 Localism in the NHS and local government

Drug treatment provision is commissioned through 149 local partnerships of local authorities, the local NHS and criminal justice agencies. The relationship between central government and local authorities and local health structures is changing, with an increasingly devolutionary and localist agenda, which asserts that powers are best exercised at the lowest effective and practical level.

In October 2006, the government published Strong and Prosperous Communities, a white paper on the future of local government in England, which set out a number of measures to reform the way of managing performance between local and central government, giving local partners more opportunity to respond to local needs and giving local authorities a strengthened role as local strategic leaders. Specifically, the white paper set out plans for a new inspection regime, the comprehensive area assessment, based around 198 national indicators, and designed to be a more proportionate, risk-based regime allowing for more targeted intervention when required. In addition, the local area agreement (LAA) system has recently been strengthened, and each local area will now select up to 35 priorities, tailored to local need. The aim of these initiatives is to reduce the number of national targets, and introduce a less-intrusive inspection and performance management system. This means a change to the role of organisations working with local government, including the NTA, and demands a more participatory and consultative approach characterised by locally determined ambition and priority setting. In response to this approach, the NTA has rationalised the treatment planning process for 2008/09 to reflect this changing relationship and correspond to the government's new, devolved role in local priority setting.

Central and local government will also work together to deliver the Public Service Agreements (PSAs). PSA 25 – "reduce the harm caused by alcohol and drugs – sets out the government's vision to produce a long-term and sustainable reduction in the harms associated with alcohol and drugs, and includes an indicator on the number of drug users recorded as being in effective treatment (indicator 1 reflected in the LAA national indicator set (NI 40)). This indicator will be a key driver in the reduction of drug related crime thereby making a contribution to the PSA 23 "making communities safer", alongside the reduction of the harms caused to health and wellbeing by frequent use of illegal drugs. The delivery agreements for PSA 25 and PSA 14 confirm the NTA's role in relation to the PSA in providing assurance of local drug partnership plans for both adults and young people, via a process of annual agreement and quarterly review, as well as ongoing publication of treatment performance information via the National Drug Treatment Monitoring system (NDTMS), and production of core guidance and support for local drug partnerships.

In December 2007, the Department of Health published The NHS in England: The Operating Framework for 2008/09, which set out a new performance management framework for primary care trusts and strategic health authorities. This document includes a number of mandatory top-level priorities that will be measured nationally and also lists the arrangements for performance management of other national and locally

determined health priorities. Further details of specific priorities and indicators, as well as measurement definitions for local health bodies, are set out in the Department of Health document, published in January 2008, Vital Signs. Among the list of indicators in Vital Signs (VSB14) is the number of drug users recorded as being in effective treatment, which mirrors national indicator 40 for local authorities. Primary care trusts will be required to report progress against this indicator to their strategic health authorities. During 2008/09, NTA regional teams will work with Government Office and strategic health authority colleagues to ensure that local ambition in relation to this indicator is aligned across health and other local bodies.

3.3 Resources

A total of £398m will be made available by central government to support local delivery of drug treatment in 2008/09. This compares with £59m in 2000/01. These resources, together with the c.£200m committed from local budgets and the additional resources provided by Department of Health, Home Office and Ministry of Justice to support access to treatment for offenders in custody and in the community mean that in total c.£800m will be invested in drug treatment systems in England during the year. The NTA is confident that this level of resource is sufficient not only to deliver against PSA 25, but also to make progress towards delivering the government's wider ambitions for treatment including:

- Development of the young people's specialist substance misuse treatment system to match treatment need (delivering against PSA 14)
- Expansion and improvement of the provision of drug treatment in prisons
- Maximising the use of community sentences with Drug Rehabilitation Requirements
- Improvement in the arrangements for continuity of care of prisoners on discharge and reception
- Respond to the continuing challenges presented by overdose and transmission of blood-borne viruses
- Maximisation of the number of individuals who leave treatment each year having overcome their dependency
- Delivery of increasingly effective services to those already engaged in the treatment system demonstrated through the Treatment Outcomes Profile
- Improving access for previously underserved groups
- Proactively responding to the needs of the children of drug-misusing parents.

The field's capacity to deliver these outcomes with these resources will be strengthened through the changes to the way the pooled treatment budget (PTB) is now allocated, which will see the progressive matching of resource to activity over the next three years.

To consolidate and embed the improvements in individuals' lives that effective treatment can deliver, local partnerships need to ensure that their treatment systems are able to work closely with other relevant services providing access to services such as employment, housing, mental health services and social support. The commitment of adequate local resources in support of this provision is as crucial to long-term effective delivery as the resources directly committed to treatment.

3.4 The challenge of changing patterns of drug use

Local drug treatment systems need to be flexible and responsive to adapt to fluctuations in patterns of drug use and misuse. These are driven by a variety of factors including fashion, technology, migration, economics and politics. Dependency on more than one drug (and alcohol) is the norm among many who seek drug treatment. This is still not adequately responded to in all drug treatment services, some of which still focus too narrowly on opiate use. In the future, better data on drug use and outcomes, especially with full implementation of the Treatment Outcomes Profile (TOP), will help identify where services are not responding adequately to service users' range of needs. This will feed directly into local commissioning decisions as data becomes more robust. Opiate and crack use continue to cause the most harm to individuals and communities, and this is reflected in the new pooled treatment budget funding arrangements. However, there are increasing numbers of people whose patterns of drug use focus on alcohol and cocaine, a proportion of whom will require treatment support. Although local treatment systems will be expected to prioritise treatment for those dependent on opiates and crack, they need to continue to respond to the whole range of treatment need identified within their population, resulting from cannabis, amphetamine or cocaine use, for example. Up-to-date needs analysis, as the basis of sound commissioning decisions, is as fundamental to responding appropriately to communities' needs as the appropriate delivery of the services that are commissioned.

As England becomes an ever more diverse society, commissioners and service providers will need to become ever more competent in understanding how to match delivery to need. This may challenge historical assumptions around who drug service clients are and challenge thinking about how to respond to diversity. To operate effectively in the England of the 21st century, policymakers, commissioners, service providers and those representing service user and carer groups will need to develop sophisticated approaches able to respond to the complex interaction of race, language, ethnicity, religion, disability, gender, legal status, class and age if they are to genuinely meet the aspiration to serve the needs of the whole community.

3.5 Communicating success

Until recently there was a broad political consensus shared across the front benches of all political parties in support of the expansion and improvement of the treatment system. This consensus has now fractured with powerful voices in politics and the media allying themselves to those within the treatment field who espouse an abstinence-led treatment system. The NTA has promoted a balanced treatment system able to respond to those who are ready and able to achieve abstinence, but also recognising that for many entrenched users this may take years to achieve, during which time treatment can nevertheless deliver dramatic benefits to individuals and society promoting stability and reducing the harm associated with chaotic use outside the treatment system.

The NTA will continue to promote routes to abstinence and will seek to enhance pathways to full recovery from drug dependence in each local area. However, the history of drug policy in this country and the international evidence both suggest that an exclusive commitment to abstinence-based treatment too often results in relapse, disengagement, and a return to chaotic use, with the potential to increase rather than reduce harm.

The NTA will respond to this changing environment to champion the rationale behind this approach and communicate effectively the extensive evidence base in support of a comprehensive drug treatment system. The NTA intends to improve its own capability to engage with the media and cultivate stronger alliances with the wider drug treatment sector, especially the third sector (charities and NGOs), clinicians, service users, and the police so as to present a concerted response to the critique of current policy.

To deliver this, the NTA will restructure during 2008/09 to expand its communication resources, with the expectation that the NTA will be better equipped to respond to the media, better placed to advise government, better able to co-ordinate a concerted response to the critique of current policy and better able to proactively shape the media environment to more accurately reflect the achievements of current policy.

4 Accountability

4.1 Substance misuse pooled treatment budget

The substance misuse pooled treatment budget for drug treatment in 2008/09 is being maintained at the 2007/08 level of £398m.

Changes to the way funding is allocated to local drug partnerships will mean that over the coming years, the local variation in pooled treatment budget spend per person in treatment will continue to narrow. Funding will be redirected from partnerships that have historically received a higher than average share per person in treatment, towards those who have received a lower than average allocation. Funding received by partnerships will largely depend upon the number of individuals in the area in effective treatment, but other factors will be taken into consideration, including the number of crack and opiate users being treated, the complexity of local caseloads and the varying costs involved in providing treatment in different areas of the country. This will provide local partnerships with powerful incentives to maximise the efficiency of their local treatment systems to the benefit of their local service users and communities. Overall it is anticipated that this process will generate £50m worth of local efficiency savings each year by 2010/11.

The NTA is confident that local partnerships will be able to draw on these efficiencies to deliver not only the PSA 25 indicator 1 requirements but also on the aspirations identified for treatment in the Drug Strategy, Drugs: Protecting Families and Communities.

4.2 Commissioning

The commissioning of effective and responsive local services that deliver value for money is central to delivery of key elements of the new national Drug Strategy. Since 2001, the NTA has seen significant improvements in the quality of commissioning of drug treatment services.

The NTA will continue to lead improvements in commissioning by ensuring that partnerships have the best possible information and models to develop robust local needs assessments. The unit costs and emergent outcomes data, together with the updated clinical guidelines, will be key to the ongoing commissioning of effective and efficient local drug treatment services. As it develops, the NTA's suite of commissioning and needs assessment guidance will reflect the principles espoused in World Class Commissioning, and will complement additional Department of Health guidance on joint strategic needs assessment.

Local needs assessment: Drugs: Protecting Families and Communities highlights the responsibility local areas have to meet the needs of all communities, and their duty to proactively tackle discrimination via appropriately commissioned services which meet the needs of all communities. The NTA will support this through provision of bespoke needs assessment guidance and data, described by race, gender and age, while regional teams will work with partnerships to support the development of systems to determine the baseline level and nature of needs (where this information is not available through existing local and national datasets).

Commissioning skills: Drugs: Protecting Families and Communities identifies the competence of the workforce as having a crucial relationship to the achievement of the aims of the Drug Strategy. The NTA will continue to drive improvements in the drugs workforce by supporting the ongoing development of the scope and availability of commissioning skills training for a wide range of local partnership representatives and NTA regional teams. Furthermore, extensive workforce data, which can be directly compared with effectiveness, efficiency and value of locally commissioned drug treatment services, will be collected as part of the unit costs data set, to drive improvements in commissioning and delivery at local level.

Clinical guidelines: The publication in 2007 of the updated clinical guidelines provided the field with a comprehensive and updated guide to appropriate interventions based on the existing evidence base of currently available technologies. This presents a major challenge to the commissioners of treatment systems in that full implementation of these guidelines will present major reconfiguration challenges for many areas.

Tier 4: The NTA has developed specific guidance to support improvements in the availability and provision of Tier 4 treatment services in England. This guidance will give further support to local areas on how to make best use of £54.3m of new capital funding that was made available to strategic health authorities by the Department of Health during 2007/08 and 2008/09, following a strategic bidding process. Additionally, the NTA is exploring the means of supporting further improvements in commissioning nationally by developing a cluster-based commissioning approach across the Tier 4 sector delivered via

regional forums. The NTA will share good practice across regions and will promote the integration of Tier 4 commissioning into mainstream NHS regional commissioning structures where appropriate.

Families: The NTA, working closely with DCSF, will publish guidance to improve the commissioning of family and carer services, including family friendly drug treatment services, which will promote the involvement of families and carers in the shaping and delivery of drug treatment support. We will also encourage local areas to audit practice in line with the clinical guidelines and NICE psychosocial guidance, both of which emphasise couples and families interventions.

2008/09	Action
Quarter 1	Publication of best practice commissioning practice examples from 2006/07 Healthcare Commission and NTA improvement review
	Oxford Brookes University to review and update commissioning training to reflect new priorities in NTA business plan and World Class Commissioning guidance
	Publish guidance on improving the involvement of families and carers in drug treatment, including them in the shaping and delivery of treatment support
	Publication of best practice guidance on commissioning of Tier 4 services, including use of regional specialised commissioning arrangements and other regional and sub-regional arrangements
Quarter 2	Publication of guidance on commissioning and delivery of treatment services with a greater focus on the needs of families
	Publication of updated needs assessment guidance
Quarters 2,3,4	Publication of guidance on family interventions in line with NICE
	NTA to run a series of action learning sets for partnership chairs in collaboration with Oxford Brookes University
2009/10	Action
Quarter 1	Publication of commissioning guidance to accompany clinical guidelines
Quarter 3	Review of national commissioning arrangements with regional teams to identify future training and guidance needs across community and prison settings
Quarter 4	Action plan for 2010/11 drawn up to take forward findings of the review
2010/11	Action
Quarter 1	Implementation of action plan to improve commissioning arrangements

4.3 Value for money

The NTA is developing a model to enable local partnerships to assess whether or not their services deliver value for money. The tool will provide initial benchmark figures relating to value for money and it is ultimately intended to provide commissioners with the best information available to assist decision-making about what to commission and why, how much drug treatment should cost and what outcomes can be expected. The value for money model will use the new suite of clinical guidance and other evidence including professional consensus, together with unit costs data to model cost-effective local treatment systems.

2008/09	Action
Quarter 1	Site visits and initial consultation regarding assumptions behind model
	Redraft model and present to expert group
Quarter 2	Web-based submission of unit costs data
	Sampling of unit costs for primary care, Tier 2 and residential rehabilitation services
	Consult upon, test and revise assumptions. Present revisions to expert group. Train regional teams in use of model
Quarter 3	Agency and treatment system unit costs data published on website and guideline costs for primary care, Tier 2 and residential rehabilitation service costs
	Publish model and guidance as an adjunct to planning, inviting early adopters to test the model
	Guidance on how to use unit cost data to populate value for money model, interpret in context of TOP data and pilot in 2009/10 needs assessment and treatment planning processes
	Publication of unit costs and workforce data to support efficiency savings
Quarter 4	Analyse initial response to model
2009/10	Action
Quarter 1	NTA to rank partnerships by value for money and test with regional teams and expert group. Publish revised model for consultation
Quarter 2	Brief regional teams on revised model
Quarter 3	Roll out model as part of treatment planning template
	Publication of unit costs and workforce data to support efficiency saving
Quarter 4	If data sufficiently robust, rank treatment systems in order of value for money provided
2010/11	Action
Quarter 2	Embed value for money with treatment planning processes for 2011/12
Quarter 4	Value for money evidenced within treatment plans and commissioning strategies

4.4 Adult drug treatment planning

Adult community and prison based drug treatment (the Integrated Drug Treatment System (IDTS)) planning guidance for 2008/09 has been significantly revised to reflect changes to local government and NHS performance management frameworks, and now allows for a greater degree of local determination of ambition and priority setting. Treatment plans will continue to remain at the centre of effective commissioning and planning of local drug treatment systems, and will reflect how local areas plan to address local needs as identified by the local partnership needs assessment.

2008/09	Action
Quarter 1	Review needs assessment guidance
Quarter 2	Review of treatment planning processes
	Publish revised needs assessment guidance
	Provide NDTMS data set to partnerships
Quarter 3	Publication of documentation for 2009/10
	Publish Hidden Harm checklist and guidance on fast track arrangements for pregnant drug users with treatment plan guidance
Quarter 4	Treatment plans submitted and approved
2009/10	Action
Quarter 1	Review needs assessment guidance
Quarter 2	Review of treatment planning processes
	Publish revised needs assessment guidance
	Provide NDTMS data set to partnerships
Quarter 3	Publication of documentation for 2009/10
Quarter 4	Treatment plans submitted and approved
2010/11	Action
Quarter 1	Review needs assessment guidance
Quarter 2	Review of treatment planning processes
	Publish revised needs assessment guidance
	Provide NDTMS data set to partnerships
Quarter 3	Publication of documentation for 2009/10
Quarter 4	Treatment plans submitted and approved

4.5 Delivery assurance

The NTA's nine regional teams, based within Government Offices for the regions, will continue to engage regional and local partners to ensure that local community and prison-based drug treatment systems are fit for purpose, reflect local need and offer value for money. In particular, established reporting mechanisms for performance assurance of local treatment systems will continue to operate, with three levels of delivery assurance reporting arrangements operating during 2008/09:

1. Monthly national reporting and analysis in relation to PSA 25 indicator 1 – the number of drug users recorded as being in effective treatment – produced each month at partnership and agency level
2. Internal monthly national reporting at partnership and regional level for use by NTA regional teams
3. Quarterly summary performance assurance, data reports and quarterly criminal justice reports for use at regional team level for performance assurance of adult drug treatment plans.

The role of the regional teams will be expanded during 2008/09 to include responsibility for the oversight and delivery assurance of the Integrated Drug Treatment System (IDTS) in the prisons where IDTS has already been introduced, plus the responsibility for leading and supporting the implementation of IDTS in the 38 prisons included in the third wave of prisons during 2008/09.

2008/09	Action
Quarterly	Regional teams to ensure that local drug partnerships meet the agreed 2008/09 treatment plan objectives on implementing clinical guidelines and governance including workforce and training goals and monitor via normal quarterly performance assurance arrangements
	Quarterly summary performance assurance, data reports and criminal justice reports for use at regional team level with drug partnerships and prisons. Recovery or action plans agreed with partnerships by regional managers as required
Quarter 1	Publication of performance assurance arrangements for current year
Quarter 3	Mid-year reviews in all partnerships
2009/10	Action
Quarterly	Regional teams to ensure that local drug partnerships meet the agreed treatment plan objectives on implementing clinical guidelines and governance including workforce and training goals and monitor via normal quarterly performance assurance arrangements
	Quarterly summary performance assurance, data reports and criminal justice reports for use at regional team level with drug partnerships and prisons. Recovery or action plans agreed with partnerships by regional managers as required
Quarter 1	Publication of performance assurance arrangements for current year
Quarter 3	Mid-year reviews in all partnerships
2010/11	Action
Quarterly	Regional teams to ensure that local drug partnerships meet the agreed treatment plan objectives on implementing clinical guidelines and governance including workforce and training goals and monitor via normal quarterly performance assurance arrangements
	Quarterly summary performance assurance, data reports and criminal justice reports for use at regional team level with drug partnerships and prisons. Recovery or action plans agreed with partnerships by regional managers as required
Quarter 1	Publication of performance assurance arrangements for current year
Quarter 3	Mid-year reviews in all partnerships

4.6 Inspection

During 2008/09 the NTA's Standards and Inspection team will complete the third in a series of Service Reviews (formerly Improvement Reviews), in partnership with the Healthcare Commission and supported by the Commission for Social Care Inspection (CSCI), focusing on Tier 4 services and diversity.

The results of the final improvement review on diversity and Tier 4 will be published in autumn 2008. The bottom 10–15 per cent of performers will be targeted for improvement work and best practice will be identified from the top ten per cent of performers.

During 2008/09, the Healthcare Commission and CSCI will merge into a new health and social care inspectorate body, the Care Quality Commission. The NTA will develop a close working relationship with the Care Quality Commission. Comprehensive area assessments (CAAs) are intended to provide a holistic independent assessment of the prospects for local areas and the quality of life for people living there. The CAA will aim to draw together evidence and information from a wide range of sources, including information drawn from the new national indicator set and will take account of progress being made towards targets in local area agreements, which lie at the centre of the government's new performance framework. The NTA will explore how to align its work with CAAs and other inspectorate body initiatives.

2008/09	Action
Quarters 1 and 2	Work with the inspectorates on developing comprehensive area assessment (CAA) framework
Quarter 3	Joint NTA/Healthcare Commission Improvement Review on Tier 4 and diversity anonymised results published
Quarter 4	Final data set published for joint NTA and Healthcare Commission Improvement Review on Tier 4 and diversity
	Planned improvement interventions completed at partnership level
Quarters 1 and 2	Work with the inspectorates on developing comprehensive area assessment (CAA) framework
Quarters 3 and 4	NTA input to 2nd joint national consultation on CAA methodology

5 Practice improvement

5.1 Targeting those most at risk

Drugs: Protecting Families and Communities acknowledges and widens the context of barriers to access to effective drug treatment and commits the NTA and the drug treatment system to improve their responses to groups who have not previously received an adequate service.

5.1.1 Improving treatment for stimulant users

Drug treatment services are generally more effective at engaging and retaining primary opiate users in treatment than stimulant users, and the estimated percentage of stimulant users in treatment varies across the 149 partnerships. Polydrug use, including crack, is prevalent in most partnerships. The NTA has previously issued guidance on commissioning and treating crack misuse and guidance will be updated in the light of recently published Department of Health clinical guidelines and NICE guidance, and also incorporate guidance on other stimulants.

2008/09	Action
Quarter 2	Provide crack-specific data to partnerships for needs assessment (and annually thereafter)
Quarter 3	Regional teams to review usefulness of crack data with partnerships Regional teams to provide additional focus on crack treatment at mid-year reviews
Quarter 4	Identify crack data requirements for partnerships for next year Regional teams to ensure treatment plans have appropriate and sufficient focus on crack treatment
2009/10	Action
Quarter 1	Guidance on the treatment of stimulant users published
Quarter 2	Publication of a briefing on the use of treatment incentives with crack users following results of the research project on implementation of treatment incentives

5.1.2 Removing barriers to access

The NTA is committed to developing services better adapted to the needs of groups who currently have poor access. This includes those with childcare needs, some BME groups, sex workers and those with complex needs – such as serious mental health problems – and pregnant substance misusers. Treatment services need to improve accessibility for parents with dependent children, drug-misusing offenders who enter through the Drug Interventions Programme and people leaving prison or completing the Drug Rehabilitation Requirement of a community sentence or a period on licence. Barriers to access include:

- Waiting times in excess of three weeks to access services
- Lack of appropriate services to meet specific needs (for example, abstinence-based services and crack services)
- Lack of geographical spread of services
- Attitude, culture and history of existing services
- Processes and procedures that can inhibit access to services, such as appointment procedures, movement between services and buildings
- Poor care pathways between services, including DIP, open access services and pathways between Tier 3 and Tier 4 services
- Failure to retain clients in effective treatment, in line with the evidence base for 12 weeks or more (which is a significant area to deliver against PSA 25).

Overcoming barriers to access fundamentally requires each partnership to have a thorough and cyclical process of needs assessment, planning, implementation and review. The identification of these barriers should provide a shared understanding by the partnership of local need, which then informs treatment planning and resource allocation. The NTA annual agreement of plans with partnerships includes the identification of differential impact on diverse groups in local areas and is designed to ensure that overall plans contain actions to address negative impact where applicable. The 2007/08 joint NTA and Healthcare Commission Service Review asks specific questions as to whether race, gender and disability equality impact assessments, specifically for substance misuse services, have been undertaken. The information from this review will be the subject of improvement plans led by the NTA where necessary and, given the positive impact of previous improvement reviews in other areas of drug treatment, will make a significant contribution to service improvements for these groups.

2008/09	Action
Quarter 1	NTA, as part of review of needs assessment guidance, to identify areas of development that cover all barriers to access identified in Drugs Strategy action plan
Quarter 2	Publish additional guidance on barriers to access to complement needs assessment guidance as required. Cross reference to treatment plan guidance
Quarter 3	Develop action plan in each region in relation to Tier 4 waiting times building on findings of Tier 4 improvement review
Quarter 4	Develop new regional checklist for assessing treatment plans to ensure attention is paid to barriers to access listed above and contained within Drugs Strategy action plan

5.2 Improving the quality and effectiveness of treatment

Drugs: Protecting Families and Communities acknowledges the significant benefits that have been delivered by the drug treatment system in recent years and builds on this to achieve better outcomes for those entering treatment by improving retention in treatment, with more individuals overcoming drug dependence, successfully completing treatment programmes and reintegrating into communities.

5.2.1 Reducing drug related deaths and blood-borne virus infections

In May 2007, the Department of Health launched the new joint Department of Health, NTA and Home Office Action Plan to build on the progress that has already been made in reducing drug-related deaths and stabilising the proportion of drug users contracting blood-borne virus infections. The action plan has three strands:

- Surveillance and improving needs assessment
- Improving delivery of harm reduction interventions
- Campaigns.

The results of the NTA and Healthcare Commission Improvement Review 2006/07 on harm reduction have been published, and the NTA regional teams will continue to work with partnerships to improve needs assessment around injecting, blood-borne viruses and overdoses; and incorporate responses into the treatment planning process. A range of other programme elements are due for delivery this year.

2008/09	Action
	Programme to improve harm reduction interventions in IDTS and other prison service health promotion/ harm minimisation initiatives Co-ordinate national reducing drug-related harm campaign
Quarterly	Regional teams improved performance management around harm reduction to include addressing the results of the NTA and Healthcare Commission 2006/07 Improvement Review
Quarter 1	Training of nine regional service user harm reduction champions at International Harm Reduction Association conference
Quarter 2	Publish improved guidance on local enquiries into drug related deaths Review and update if necessary, the partnership self audit tool for assessing harm reduction at a local level as part of treatment plan review
Quarters 2 and 3	Campaign to reduce blood-borne virus and overdose amongst targeted groups of users, including injectors, heroin and crack users and homeless injectors
Quarter 3	Provision of hepatitis C surveillance data to inform local needs assessment Programme to increase hepatitis B vaccination specifically targeting IDTS prisoners most at risk (Department of Health lead)
Quarter 4	Launch of Royal College of General Practitioners (RCGP) training programme for harm reduction in primary care settings
Quarter 4	Full implementation of national monitoring scheme for needle exchange launched April 2008 Peer education initiatives with drug misusers at risk drawing on current evidence Implementation of targeted naloxone programmes for users and carers

5.2.2 Implementing clinical guidelines

During 2007, a range of key, independent, evidence-based clinical guidelines and technology appraisals were published with the aim of improving the quality and practice of substance misuse treatment that included:

- The NICE technology appraisals of methadone, buprenorphine and naltrexone
- The NICE guidance on psychosocial interventions for drug misuse and opioid detoxification
- The Department of Health's Drug Misuse and Dependence: UK Guidelines on Clinical Management

A key priority for the NTA is enabling the implementation of the suite of clinical guidance published in 2007 and creating robust mechanisms in local systems to assure the quality and effectiveness of evidence-based treatment. This will be achieved in a number of ways by improving clinical governance with the publication of guidance, and encouraging subsequent implementation and monitoring by local partnerships and NTA regional teams. The NTA will also produce a series of guidance and toolkits to enable implementation of various aspects of the new suite of clinical guidance, including reducing unplanned discharge; contingency management; promoting the use of mutual aid (including 12-Step approaches), implementing formal psychosocial interventions to address anxiety, depression and family or couples therapy, improving keyworking; improving the co-ordination of care across systems (particularly interface between community treatment and prisons) and guidance on working with drug-misusing parents to protect children.

The International Treatment Effectiveness Programme (ITEP) has produced encouraging results in Greater Manchester and the West Midlands. The NTA will publish results, practitioner toolkits and briefings, and encourage further implementation of ITEP, which includes focusing on the quality of treatment service management as well as the implementation of discrete evidence-based psychosocial interventions to improve care planning and keyworking.

Guidance and toolkit implementation will be supported and encouraged by a range of strategies including communications strategies, NTA regional team inputs and work with key stakeholders. The NTA will also continue to work in partnership with existing professional networks such as the Royal Colleges, the Federation of Drug and Alcohol Professionals (FDAP) and the European Association of Treatment Agencies (EATA).

The NTA will continue to project manage and host support networks for clinicians – the Specialist Clinical Addiction Network (SCAN) for psychiatrists; and for GPs and those working in primary care Substance Misuse Management in General Practice (SMMGP). We will also explore how to better support nurses working in drug treatment.

2008/09	Action
Ongoing	NTA regional teams and professional networks support implementation of guidance and toolkits Contract management and hosting SCAN Contract management and hosting SMMGP
Quarterly	NTA regional teams to ensure that local drug partnerships meet the agreed 2008/09 treatment plan objectives on reviewing clinical governance arrangements implementing the clinical guidelines via quarterly performance assurance arrangements.
Quarter 1	Guidance on unplanned discharges published Revised International Treatment Effectiveness Programme (ITEP) toolkits and briefings published to improve key working and psycho-social interventions Revised guidance on care planning published
Quarter 2	Guidance on improving co-ordination of care (particularly the interface between prison and drug treatment) published Toolkit on cognitive behavioural therapy (CBT) treatment for anxiety and depression for drug services published Toolkit on family and couples interventions for drug services published Consultation on mechanism to support nurses in drug treatment and implement mechanism (if resources available)
Quarter 3	Publication of guidance on working with drug-misusing parents to protect dependent children Publication of NTA draft guidance on commissioning drug treatment systems in light of the 2007 suite of clinical guidelines
Quarter 4	Publication of final NTA guidance on commissioning drug treatment systems in light of the 2007 suite of clinical guidelines Scrutiny of 2009/10 treatment plans by regional NTA teams to ensure that outstanding actions and gaps in implementation are addressed as part of 2009/10 treatment plans
2009/10	Action
Quarter 1	Review of 2008/09 treatment plan objectives in relation to implementation of the UK clinical guidelines
Quarter 2	Development of regional improvement plans to address shortcomings in clinical guidelines implementation at a regional level.
Quarters 3 and 4	Implementation of improvement plans
2010/11	Action
Quarter 1	Stock take of further actions required to support best practice in line with the clinical guidelines and implementation of any further actions required.

5.2.3 Supporting the workforce

The necessity to have a workforce sufficiently skilled and supported to commission and deliver the highest quality drug treatment and care is a consistent and underlying imperative in all the NTA's programmes for the next three years. To achieve the objectives set out in Drugs: Protecting Families and Communities, it will be essential that employers and commissioners review and improve the relevant competences and experience of staff in drug treatment agencies and in the wider health, social care, social inclusion and criminal justice sectors, which provide direct drug treatment support or act as important gateways to care. The NTA will provide guidance and examples of good practice, and work with a range of regulatory and training bodies to support this process.

The formation of the Independent Safeguarding Authority (ISA) presents a further and welcome opportunity to assure the safety and protection of individuals and their families who come into contact with the drug treatment system. The NTA will work with the ISA to ensure that the drug treatment field can play its full and appropriate part in this important initiative to protect vulnerable adults and children.

NTA regional teams will work with partnerships to review local workforce plans and policies to ensure they meet the requirements set out by the Drug Strategy and that they reflect the evidence provided by ongoing local partnership assessment of need which informs commissioning and investment decisions.

A workforce appendix will be added to Clinical Governance in Drug Treatment, which will include recommendations on how to incorporate workforce development successfully within local strategies, commissioning and delivery. Future work will also include consideration of volunteer issues.

2008/09	Action
Quarters 1 and 2	NTA to consult with national bodies responsible for qualifications, curricula and registration regarding relevant proposals for change Work with regulatory and training bodies for professional groups (including the Royal Colleges, FDAP, BPS) to devise 'skills escalators' to facilitate workforce development and succession planning NTA to develop a clinical governance workforce checklist for use by regional teams NTA appendix on Workforce in New Clinical governance guidance: Clinical Governance in Drug Treatment published
Quarter 3	Regional teams to brief local commissioners and providers regarding workforce requirements
Quarter 4	NTA regional teams to adopt a consistent approach by the use of a clinical governance workforce checklist

5.2.4 Clinical governance

Clinical governance mechanisms will be a key delivery mechanism for improving the quality of drug treatment and ensuring adherence to the new suite of clinical guidance. Clinical governance already has structures and processes in the health service. Our challenge is to ensure that drug treatment has robust clinical governance that includes all sectors of drug treatment provision (NHS, voluntary sector, criminal justice treatment and independent treatment) and that local drug treatment systems have appropriate mechanisms of multi-agency clinical governance in place.

2008/09	Action
Quarter 1	Completion of consultation phase on Clinical Governance in Drug Treatment, amend as required and publish Publish guidance on audit with which to assess compliance with the new suite of clinical guidance and good prescribing practice
Quarter 2	Publish an appendix to Clinical Governance in Drug Treatment providing guidance on workforce development necessary to underpin implementation
Quarter 3	NTA regional teams to oversee a local drug partnership review of existing clinical governance structures and the development of improvement action plans where required

5.2.5 Completions and outcomes

Completion

The NTA is committed to maximising the opportunities for service users to complete treatment appropriately and with the best possible outcomes, and to minimising dropout and unplanned discharges. Following publication of new clinical guidelines, the NTA has developed new guidance on reducing unplanned discharges. This will be disseminated during 2008/09 and an added focus will be given to improving treatment completion by NTA regional teams. The NTA also aims to improve the National Drug Treatment Monitoring System dataset in order to better capture how service users leave treatment. These combined actions will enable local providers and commissioners to analyse the data and identify consistent practice to enable action plans to be put in place to increase the numbers of service users appropriately completing treatment and thereby tackle inappropriate or unnecessary discharge and dropout.

Outcomes

It is anticipated that 2008/09 will see the Treatment Outcomes Profile (TOP) provide information that will gradually become central to how drug services in England are commissioned, provided and delivery assured by the NTA. The NTA is keen to move away from process and output-based indicators to having objective, comparable and meaningful data on outcomes at local, regional and national levels: TOP is designed to deliver this.

The period 2008/09 will be the first full year that TOP will be collected from all structured treatment services. When data is sufficiently robust, TOP data will provide an insight into what drug treatment works best for which sort of clients, allowing the personalisation and tailoring of interventions in a way that has not previously been possible – at both a local and national policy level.

This year we will develop a method whereby TOP data can be presented within a context of client mix – to ensure that comparisons can be made between treatment services and systems that have similar levels of client complexity. In time, TOP data will also be used as the frame of reference for the NTA's value for money project, in order to triangulate quality with cost and caseload complexity.

Building on the successful development and validation of TOP, in 2008/09 the NTA will continue to performance manage the implementation of TOP, will analyse and discuss with key stakeholders the emerging data and will disseminate emerging treatment outcome data. This will begin to give an insight into trends in data and the performance of drug treatment systems. The use of TOP as a follow-up tool will be explored, together with its potential use within criminal justice drug treatment settings. The NTA will also develop additional quality assurance mechanisms to ensure data is robust and reliable.

The NTA will also undertake work to analyse available data sources to assess the long-term impact of treatment.

2008/09	Action
Quarter 1	<p>Publish first six months of baseline TOP data to assist agencies in improving data collection</p> <p>Publish criteria by when TOP data will be deemed robust enough to allow its use for commissioning and planning purposes</p> <p>Publish guidance on improving unplanned discharges</p>
Quarter 2	<p>NTA research team to begin post discharge follow up TOP study</p> <p>Publication of article on TOP validation in internationally recognised journal</p>
Quarter 3	<p>Hold second national consultation event to inform ongoing implementation of TOP and interpretation of data</p> <p>Publish national TOP data on outcomes of those discharged from treatment</p>
Quarter 4	<p>Develop quality assurance programme to randomly check reliability and accuracy of submitted TOP data</p>
2009/10	Action
Quarter 1	<p>Regional teams to develop planned discharge improvement plans with partnerships</p> <p>As the reliability of TOP data strengthens it will increasingly come to be one of the main driver of decision taking and accountability</p>

5.3 A wider use of new treatment approaches

Drugs: Protecting Families and Communities identifies the need to build on new evidence of what works and maximise the range of approaches used, and makes a commitment to develop and deliver a significant new initiative to support research that will boost understanding of addiction and identify opportunities for new forms of treatment.

5.3.1 Research into injectable opioid treatment

The NTA (on behalf of the government) will continue to contract manage the ongoing multi-site randomised controlled trial comparing the effectiveness of opioid maintenance (injectable heroin, injectable methadone and optimised oral methadone treatment) in highly structured clinics. This trial, known as RIOTT (Randomised Injecting Opioid Treatment Trial), hopes to have preliminary findings on the effectiveness and cost-effectiveness all three treatment arms available at the end of 2008. The NTA will also examine other treatment models of injectable opioid substitution. This evidence will inform the future decisions on the wider availability of injectable opioid treatment.

2009/10	Action
Quarter 1	Quarterly contract management meetings of RIOTT project
Quarter 3	RIOTT trial interim findings report on initial sample to government
Quarter 4	RIOTT trial report received
	Publication of an audit of non-clinic provision of injectable opioid treatment

5.3.2 Developing evidence and research

The NTA will contribute to developing evidence by conducting research and analysis of NDTMS, TOP and other data to analyse treatment impact and evidence around what drug treatment is effective.

There are large gaps in knowledge that need to be addressed. These include:

- A better understanding of the dynamic nature of addiction
- The protective factors which secure and maintain positive outcomes for individuals in treatment
- The relationship between employment, offending and drug use
- The impact treatment has on psychological and social outcomes; the effective role of users and carers in treatment and reducing harms
- The characteristics of problem drug users who are not engaged with treatment.

For drug services, gaps in knowledge include:

- The relative impact of various interventions
- How clinical treatment choices can achieve a more effective matching of the drug user to appropriate treatments
- The characteristics of successful and effective treatment services and the effects which organisational functioning can have on treatment outcomes
- What constitutes value for money in drug treatment systems
- The effects which family and peer support, mutual aid and psychosocial treatments can have on drug use among young people (and where appropriate, their parents)
- The impact of access to employment and accommodation services on successful clinical outcomes
- How offending behaviour should be addressed when designing individualised treatment programmes.

The NTA will address some of these gaps by analysis of the emerging monitoring data on treatment outcomes. The monitoring data will be derived from NDTMS, including TOP data, and examined, together with data from the Service Reviews, unit costs analysis, service users' surveys and other survey and audit work to help begin to answer key questions. Targeted survey or audits on specific areas highlighted in the Drug Strategy will also be considered.

During 2008/09, the research team will focus on key issues arising from the Drug Strategy – evaluating the contingency management demonstration programme, supporting the RIOTT heroin trials, publishing findings from International Treatment Effectiveness Project (ITEP) and exploring the development of a programme research on understanding treatment journeys and treatment outcomes. The team will also build on the initial Tipping Point work carried out in 2007/08 on the treatment system's capacity to reduce overall numbers of problem drug users.

Coupled to this, the team will also be producing a series of thematic briefings on the 2007 user survey and a report on the three years of the user survey, as well as using TOP and NDTMS data to generate further ad hoc research projects on the characteristics, for instance, of effective treatment services and of service users with unplanned discharges, and on the effects of treatment on non-drug-related outcomes.

2008/09	Action
Ongoing	<p>Management and publication of a series of briefings from the Department of Health drug misuse research initiative</p> <p>Management of treatment incentives research programme (see 5.3.3)</p>
Quarter 1	<p>Publication of a series of briefings on 2007 user survey</p> <p>Report on three years of the user survey</p> <p>Publication of results of ITEP West Midlands</p> <p>Development and implementation of a research programme on treatment journeys and treatment outcomes</p>
Quarter 2	Publication on annual diversity screening report from NDTMS and other data sources
Quarter 4	<p>Publication of findings of initial criminal justice treatment research</p> <p>Analysis of annual NDTMS annual frozen dataset to look for differential impact of treatment on diverse groups</p> <p>Publication of two best practice briefings, on Tier 4 and diversity, based on improvement review 2008</p> <p>Publication of an audit of non-clinic provision of injectable opioid treatment</p>

5.3.3 Treatment incentives

The core principle behind treatment incentives is that positive behavioural change is incentivised. The new clinical guidelines, Drug Misuse and Dependence: UK Guidelines on Clinical Management, provide the following definition: "contingency management operates by providing a variety of incentives in the form of vouchers, privileges, prizes or modest financial incentives to modify a person's drug misuse or to increase health promoting behaviours". It also indicates that "contingency management should be introduced to drug services in a phased implementation programme led by the NTA, in which staff training and the development of service delivery systems are carefully evaluated. The outcome of this evaluation should be used to inform the full-scale implementation of contingency management."

There are three broad types of treatment incentives which form part of the demonstration programme:

- Attendance incentives to promote engagement with services, encouraging clients with poor attendance records to change their behaviour
- Drug-free incentives to reduce illicit drug use, encouraging clients who record positive either for opiates or stimulants to change their behaviour
- Blood-borne virus incentives to encourage harm reduction, encouraging clients to undertake and complete testing for TB, hepatitis B and C and HIV, and hepatitis B immunisation.

2008/09	Action
Quarter 1	Six-month demonstration project commences
Quarter 2	Mid-point NTA site visits and London-based site Quarter 2 meeting to share good practice
Quarter 3	Evaluation of post-incentive behaviour
Quarter 4	Report on programme implementation
2009/10	Action
Quarter 1	Consultation with the sector
Quarter 2	Publication of best practice guidance
Quarter 3	Best practice roadshows
2010/11	Action
Quarter 1	Treatment incentive
Quarter 2	Publication audit

5.3.4 Mutual aid support networks

The NICE guideline on psychosocial interventions and the clinical guidelines identify the use of mutual aid support networks and 12-Step mutual aid as associated with improved treatment outcomes and reduction in drug use. The evidence relates particularly to 12-Step networks (especially Narcotics Anonymous), which encourage initial daily attendance at meetings, access to mentors and a wider support network with a common aim of reducing and stopping drug dependence. These networks are typically provided outside formal treatment systems but are nevertheless the most commonly travelled and evidence-based pathways to recovery characterised by reduced drug use and abstinence. Evidence indicates that access to and use of mutual aid (for those that may benefit) is enhanced if drug treatment staff positively prepare and facilitate service user contact.

Current coverage of mutual aid and 12-Step networks in England is patchy. The NTA aims to support and encourage the development of mutual aid or recovery networks in each area – particularly Narcotics Anonymous. We also seek to build upon our existing national links with Narcotics Anonymous and Alcoholics Anonymous and consult on how we can achieve this aim.

2008/09	Action
Ongoing	<p>Meet regularly with key stakeholders particularly Narcotics Anonymous pilot and review regional and sub-regional events to promote recovery or mutual networks</p> <p>NTA regional teams plan introduction of recovery events following pilots</p>
Quarter 1	Identify and purchase existing 12-Step materials to disseminate to local drug treatment systems
Quarter 2	<p>Map existing mutual aid networks in England in partnership with stakeholders</p> <p>Work with other government departments to support family self-help groups through work with the third sector to provide improved advice and guidance</p>
Quarter 3	Disseminate the national mapping of provision of mutual aid groups to inform treatment planning
Quarter 4	<p>Local areas and regions plan to build capacity of recovery networks where gaps are found</p> <p>Publication of good practice guidance on drug treatment and mutual aid</p>

5.4 Helping drug users to re-establish their lives

Drugs: Protecting Families and Communities identifies the need to couple effective treatment with focused effort to deliver social integration if individuals are to be helped to sustain the benefits of treatment.

5.4.1 Employment

Enabling individuals to re-enter the labour market is recognised in the Drug Strategy as one of the key components required to help them break out of a cycle of drug dependency. During the early months of 2008/09, the NTA will work closely with the Department of Work and Pensions, the Department of Health, Home Office and the Prime Minister's Strategy Unit to explore how this aspiration will be delivered. In the first instance this will focus on engaging Jobcentre Plus managers in participating in the local treatment planning processes for 2009/10.

5.4.2 Housing and accommodation

The NTA currently provides local partnerships with quarterly monitoring data from the Department of Communities and local government in relation to Supporting People returns, showing levels of primary and secondary drug use among those living in supported accommodation in local areas. Improving access to suitable and sustainable accommodation for drug users in treatment and on discharge is a key component in minimising the likelihood of relapse. The NTA welcomes the intention within Drugs: Protecting Families and Communities to improve access to accommodation for drug users by updating guidance to local authorities on their strategic housing role, publication of a rough sleeping strategy and continuing investment in the Supporting People programme, which contribute significantly towards the accommodation needs of drug users across England. NTA regional teams will ensure that these initiatives are incorporated into planning considerations of local drug partnerships and that drug misuse is highlighted appropriately for inclusion in relevant local pathways.

5.5 Criminal justice

Drugs: Protecting Families and Communities makes a commitment to further reduce drug-related offending through more effective targeting and offender management. The NTA will work with the Ministry of Justice and the Home Office to ensure that effective drug treatment continues to contribute to the optimum use of the Drug Interventions Programme community sentences with Drug Rehabilitation Requirements; and within the prison system, ensuring that all prisoners have access to a minimum standard of clinical drug treatment; and other initiatives which will impact on reducing drug misuse and other related harms.

The NTA will work closely with the Department of Health, Ministry of Justice and Home Office to contribute towards the drug system change pilots, identified in Drugs: Protecting Families and Communities, which will examine the potential for the pooled treatment budget to deliver better value for money.

In addition, the NTA will work with the Ministry of Justice and Home Office on the improving interface between CARATs and CJITs project that is currently being commissioned.

5.5.1 Drug Interventions Programme

Drugs: Protecting Families and Communities builds on the success of the Drug Interventions Programme (DIP), which has targeted those who commit crime in connection with their drug misuse by using compulsory testing on arrest and assessment by a drugs worker. This is backed up by tough sanctions for those who do not comply and has contributed to a fall in recorded acquisitive crime of around 20 per cent. Following the contribution made by the NTA to supporting the delivery of the Home Office PSA Target of 1,000 new offenders a week accessing treatment, the NTA will continue to work with the Home Office to continue improvements in the number of offenders engaging in effective treatment via DIP including priority and prolific offenders. In addition to ensuring that there is sufficient capacity to accommodate the increasing number of offenders engaging in treatment via DIP, the NTA is also committed to improving the quality and effectiveness of those interventions as measured by retention and TOP data.

2008/09	Action
Quarter 1	Final report on DIP treatment engagement project with recommendations for improving take up of specialist treatment following DIP referral
Quarter 2	Contribute towards Drugs: Protecting Families and Communities work on establishing integrated offender management framework and project on improving interface between CARATs and CJITs
Quarter 3	Initial NTA report available indicating benchmark of DIP delivery of effective treatment
2009/10	Action
Quarter 2	Treatment plan guidance includes clear indicators on performance expectations regarding offenders entering and sustained in effective treatment based on upper quartile performance for 2010/11
Quarter 3	Consider findings of baseline data for the first cohort of offenders in relation to the rate of drug related re-offending and brief regional teams accordingly
2010/11	Action
Quarter 1	Introduce any additional performance measures for DIP that may be required following receipt of baseline data on drug related re-offending levels at partnership level
Quarter 3	Review implications of drug related re-offending levels for second cohort in terms of the delivery of effective drug treatment

5.5.2 Drug Rehabilitation Requirements

There is a growing body of evidence that shows that retaining offenders in treatment through the criminal justice system is effective in reducing drug-related offending. Drug Rehabilitation Requirements (DRRs), as part of a community sentence, can reduce offending by engaging offenders in treatment and addressing the underlying causes of their offending. Drugs: Protecting Families and Communities increases the target for these orders by 1,000 for 2008/09. NTA regional teams will work in partnership with local partnership commissioning groups, the regional offender manager and probation areas to ensure that sufficient treatment capacity is available to meet this commitment. This area of delivery will form part of the drugs pathway in each region as part of regional reducing re-offending strategies.

2008/09	Action
Quarter 1	Regional teams to ensure that appropriate commissioning arrangements are in place to deliver the drug treatment element of DRRs in line with local targets
Quarter 2	In light of publication of revised reducing reoffending strategy, ensure appropriate liaison in all regions with regional offender managers to integrate drugs pathway into core work of regional NTA team to support the performance management of DRRs
Quarter 3	Regional teams to review treatment element and completion rates of DRRs at midyear reviews to ensure that appropriate delivery and monitoring arrangements are in place against relevant targets
2009/10	Action
Ongoing	Identify need for joint work with NOMS on developing performance metric that ensures substance misuse needs are a key element of offender management sentence plans
Quarter 1	Regional teams to ensure that appropriate commissioning arrangements are in place to deliver the drug treatment element of DRRs in line with local targets
Quarter 3	Regional teams to review treatment element and completion rates of DRRs at midyear reviews to ensure that appropriate delivery and monitoring arrangements are in place against relevant targets
2010/11	Action
Quarter 1	Regional teams to ensure that appropriate commissioning arrangements are in place to deliver the drug treatment element of DRRs in line with local targets
Quarter 3	Regional teams to review treatment element and completion rates of DRRs at midyear reviews to ensure that appropriate delivery and monitoring arrangements are in place against relevant targets

5.5.3 Prisons

Drugs: Protecting Families and Communities emphasises that engagement in treatment in prisons leads to reduced re-offending and reduced illicit drug use in prisons. The action plan prioritises the further roll out of the Integrated Drug Treatment System (IDTS), minimum standards of clinical care in all prisons, improved continuity of care between prison and community, and improved reporting of prison treatment through the National Drug Treatment Monitoring System (NDTMS).

The current prison population is over 82,000 with an annual turnover of 135,000. Around 55 per cent of those received into prison are problem drug-users (PDUs) – with some local prisons reporting up to 80 per cent testing positive for class A drugs on reception. Demand for drug treatment is significant, with around 75,000 problem drug users passing through prisons annually, and 40,000 present at any one time.

Despite the expansion in services, it is still thought that only a third of clinical drug treatment meets minimum standards and the quality and access to other treatment interventions varies widely across the prison estate.

IDTS seeks to improve the volume and quality of drug treatment in prisons, with a particular emphasis on the first 28 days in custody and better integration with the community services to which most drug-misusing prisoners will return. The NTA has been at the forefront of policy development and implementation of the Integrated Drug Treatment System (IDTS) in the first 53 prisons and since April 2008, has assumed full responsibility for the implementation of IDTS.

Drugs: Protecting Families and Communities signals a renewed focus on strengthening the interface between community-based criminal justice intervention teams (CJITs), case managers in the prison estate (CARATs) and local probation areas in order to achieve more effective joint working and improved continuity of care arrangements for drug-misusing offenders from community into custody and back into the community. The NTA will be working closely with the National Offender Manager Service (NOMS) and Home Office partners centrally and regionally to improve performance assurance arrangements and with local drug partnerships to ensure that adequate provision is commissioned to meet the needs of this client group.

As part of the drive to better integrate treatment in prisons and the community, data collection via NDTMS will begin to be introduced across the prison estate. This will eventually enable TOP to be extended to prisons. The Department of Health and Ministry of Justice are committed to achieving this and the NTA will be working with prison service partners to pilot a model for initial implementation in 2008/09.

The review of funding for prison-based drug treatment, commissioned by the Department of Health and Ministry of Justice, was completed in December 2007 and draws attention to the considerable investment in prison-based drug services over the last ten years leading to major improvements and acknowledges many examples of excellent practice. However, the report also identifies a lack of a clear inter-departmental strategy; fragmented organisational arrangements for funding, commissioning, performance managing and delivering services; the lack of a clear evidence base for some services currently offered; and process inefficiencies and gaps in services. The report puts forward a range of proposals including the establishment of minimum standards, commissioning models, pooled funding streams and options for prioritisation and identifying efficiency savings.

The NTA will work with partners across government to address the deficits identified, to ensure drug treatment in prison reflects best practice in the community, and that community and prison-based treatment systems are as well integrated as possible.

2008/09	Action
Quarter 1	<p>IDTS treatment plans in place for first and second wave prisons</p> <p>Funding announced for third wave prisons Publication of revised implementation guidance for third wave prisons</p> <p>Review needs assessment guidance</p>
Quarter 2	<p>Review of treatment planning processes</p> <p>Publish updated needs assessment guidance</p> <p>Contribute to the national group to agree a single set of priorities and compile national guidance around the streamlining of the commissioning, delivery, funding and performance management of drug treatment for offenders in prison and the community</p>
Quarter 3	<p>Majority of third wave prisons have commenced drug treatment</p> <p>Publication of treatment planning documentation for 2009/10</p> <p>Mid-year reviews with partnerships identifies areas requiring improvement plans for IDTS for first two waves</p>
Quarter 4	<p>Successful implementation of all third wave IDTS prisons</p> <p>NDTMS pilots undertaken in selected prisons</p> <p>Treatment plans for IDTS prisons submitted and approved</p>

2009/10	Action
Quarter 1	<p>National audit of IDTS treatment plans for all three waves to assess gaps in delivery at regional level</p> <p>Publication of revised implementation guidance for final wave prisons</p> <p>Review needs assessment guidance</p> <p>Identify reporting arrangements that will start to support continuity of care for those entering prison who are already in drug treatment and for those leaving prison who need to access drug treatment services in the community</p>
Quarter 2	<p>Review of treatment planning processes</p> <p>Publish updated needs assessment guidance</p>
Quarter 3	<p>Publication of treatment planning documentation for 2009/10</p> <p>Mid-year reviews with partnerships identifies areas requiring improvement plans for IDTS for first three waves.</p>
Quarter 4	<p>Subject to the outcome of the pilots, NDTMS implemented across the prison estate</p> <p>The achievement of minimum standards of treatment provision for all prisons included within treatment planning process</p>
2010/11	Action
Quarter 1	<p>Review needs assessment guidance</p> <p>Performance assurance system developed to fully include continuity of care into prison and on discharge from prison to community drug treatment services</p>
Quarter 2	<p>Review of treatment planning processes</p> <p>Publish updated needs assessment guidance</p>
Quarter 3	<p>Majority of remaining prisons have introduced clinical elements of IDTS</p> <p>Publication of treatment planning documentation for 2009/10</p> <p>Mid-year reviews with partnerships identifies areas requiring improvement plans for IDTS for first three waves</p>
Quarter 4	<p>The achievement of minimum standards of treatment provision successfully rolled out across the prison estate</p> <p>The achievement of minimum standards of clinical treatment provision for all prisons included within treatment planning process</p>

6 Young people's delivery plan

5.6 A new package for families

Drugs: Protecting Families and Communities has a key ambition to focus more on families, address the needs of parents and children as individuals, as well as working with whole families to prevent drug use, reduce risk and get individuals into treatment.

The NTA recognise the significant impact on and role of families and carers in relation to drug misuse. Supporting families and carers can significantly improve their ability to deal with the impacts and consequences of drug misuse. Involving families and carers can also improve the outcomes for those who are engaged in treatment. Ensuring rapid access to effective treatment for drug-misusing parents can reduce risk to children and improve outcomes for parents and children.

The NTA is committed to improving services for drug misusers, their families and carers both within the treatment system and through improved links and pathways to mainstream health, carer and children's services. In conjunction with DCSF, the NTA will further develop the Hidden Harm checklist as part of the adult treatment planning process.

2008/09	Action
Quarterly	Regional teams to monitor that drug misusing parents have ready access to treatment with all problem drug user parents whose children are at risk having prompt access to treatment, with assessments taking account of family needs
Quarter 2	<p>Work with DH to ensure the needs of substance misuse carers are incorporated into mainstream carer resources and services</p> <p>In conjunction with DCSF, consider how best to improve access for substance misuse carers to mainstream carer resources and services</p> <p>Participate in a cross government working group to drive forward work on families and substance misusers across the Drugs Strategy</p> <p>Work with other government departments to support family self help groups through work with the third sector to provide improved advice and guidance</p>
Quarter 3	<p>Work with DCSF to publish guidance to help the commissioning and delivery of treatment services with a greater focus on the needs of parents and families</p> <p>Work with DCSF to establish protocols between local Safeguarding Children boards and adult treatment services to ensure that the needs of children of drug misusing parents are identified early and that they are supported.</p>
Quarter 4	Provide guidance on establishing closer working between drug treatment and maternity services
2009/10	Action
	Review progress against Drugs: Protecting Families and Communities and identify gaps in relevant NTA guidance. Draw up a further action plan to address these gaps during 2009/10 and 2010/11

Drugs: Protecting Families and Communities includes a commitment to make "improvements to the treatment system for young people". It gives the Department for Children, Schools and Families (DCSF) responsibility for specialist substance misuse treatment for young people, including those subject to community sentences, and will work with the NTA and DH to make this treatment more effective.

By the end of March 2011, the NTA working with other government departments envisages substantial improvements in the young people's substance misuse treatment system and in its interface with other targeted and universal children's and young people's services, thus contributing to PSA 14.

6.1 Budget

The Department for Children Schools and Families, the Home Office and the Department of Health have agreed to change how their contributions to the former young people's substance misuse partnership grant are dispersed to local areas. Patterns of drug, alcohol and volatile substance use by young people vary greatly from place to place and the government is moving towards a more flexible and locally needs-led approach to tackling the problem, supported by funding (for the next three years) going to all areas through the area-based grant and to youth offending teams, and £24.7m in 2008/09 to PCTs through the pooled treatment budget.

2008/09	Action
Quarter 1	New memorandum of understanding agreed with Department of Children, Schools and Families and NTA
	New memorandum of understanding agreed with YJB
Quarter 3	Review of young people's pooled treatment budget allocation completed
2009/10	Action
Quarter 1	Review of memorandum of understanding
2010/11	Action
Quarter 1	Review of memorandum of understanding

6.2 Commissioning

In line with the Children's Plan (DCSF, 2007), the commissioning of specialist treatment will be brought within a much more integrated delivery approach through children's trusts. In some partnerships, this may require a move away from a local drug partnership lead. The NTA will support these moves through a mapping of commissioning structures in 2008/09 followed by a report to the Department of Children, Schools and Families, and then continuing reviews on progress through NTA regional team's delivery assurance mechanisms in conjunction with regional Government Office colleagues.

NTA regional teams will be involved in the commissioning strategies of specialist treatment with all local children's partnerships. In addition, to fulfil the obligations outlined in PSA 14 and the Drug Strategy, they will have a key role in supporting other regional government stakeholders. By the beginning of year two, NTA regional teams should be working closely with health partners through regional public health groups and strategic health authorities. They will also be working closely with Government Offices to assist in local authority priority setting through local area agreements (LASS) and also in agreeing joint improvement support plans (JISPs) with local authorities to set out what support the authority will get to help meet their priorities in the year ahead.

Within three years there should be new throughcare, aftercare and transitional arrangements for all young offenders in the secure estate with identified treatment need. Quality in service delivery should be consistent with Department of Health's You're Welcome quality standards. The NTA will work with other government departments to produce guidance in 2008/09. This will include guidance on service specifications, throughcare and commissioning. The NTA will ensure community treatment services have protocols in place in 2009/10 and continually monitor these arrangements ensuring that any shortfalls are included in commissioning strategies for 2010/11.

2008/09	Action
Quarter 1	Commissioning guidance published
Quarter 2	Assist in developing national specification for young people's substance misuse services in secure settings
Quarter 3	Briefing on commissioning services for young people with complex needs published In conjunction with Offender Health
Quarter 4	Review effectiveness of guidance for transition from secure estate to community-based treatment services with NTA regional teams and other government departments
2009/10	Action
Quarter 3	Review of national commissioning arrangements with regional teams to identify future training and guidance needs
Quarter 4	Action plan for 2010/11 drawn up to take forward findings of the review
2010/11	Action
Quarter 1	Implementation of action plan to improve commissioning arrangements

6.3 Planning and inspection

Good-quality treatment should be available to all young people with treatment needs in all areas and, through the implementation of guidance, the NTA will ensure that all treatment services meet the Department of Health's You're Welcome quality standards. Guidance will be produced in year one – services will be reviewed by NTA regional teams and by the NTA's Standards and Inspection team on quality measures in 2009/10 and in 2010/11. Partnerships, supported by regional teams, will be asked to provide evidence on how suggested improvements or shortfalls have been implemented.

By April 2011, young people and parents and carers will be integrated into the planning of specialist service delivery. In year one, the involvement of young people, parents and carers in the planning process will be reviewed and discussed in the regular regional commissioning and provider groups. On the basis of this in 2009/10, models of good practice will be distributed to commissioners and members of needs assessment expert groups. In year three, all expert groups should have young people, parents and carers involved and their involvement when new services are developed or re-tendered should be the norm.

2008/09	Action
Quarter 1	<p>Publication of performance assurance arrangements for current year</p> <p>Poor performing partnerships reported to DCSF on an exceptions basis</p> <p>Review and audit involvement of young people, carers or parents and other user or carer groups in the young people's planning process</p>
Quarters 1 and 2	Refresh of young people's needs assessment to inform strategic direction of children's plans
Quarter 2	<p>2008/09 treatment planning process reviewed by NTA and DCSF</p> <p>Review whether transitional arrangements for young people to adult services are adequately provided via review of treatment plans</p> <p>New information reports based on NDTMS developed for publication</p> <p>Develop guidance for partnerships on how to involve young people and parent and carer groups in the design and planning of services</p>
Quarter 3	<p>Treatment planning arrangements for 2009/10 published jointly by NTA and DCSF</p> <p>Produce briefing on effective transitional arrangements from young people to adult services</p> <p>Mid-year reviews completed by regional NTA teams (may move to Quarter 4)</p>

Quarter 4	<p>Delivery plans for young people's specialist substance misuse services completed and assessed by NTA and regional partners</p> <p>Review of young people's needs assessment and treatment planning system to assess level of involvement of young people, parents and carers – and make recommendations as required to improve practice</p> <p>Review adequacy of transitional arrangements from young people's services to adult services through NTA regional team assessment process</p>
2009/10	Action
Quarter 1	<p>Publication of performance assurance arrangements for current year</p> <p>Poor performing partnerships reported to DCSF on an exceptions basis</p>
Quarters 1 and 2	Refresh of young people's needs assessment to inform strategic direction of children's plans
Quarter 2	<p>2009/10 treatment planning process reviewed by NTA and DCSF</p> <p>Information reports based on NDTMS developed for publication</p>
Quarter 3	<p>Treatment planning arrangements for 2010/11 published jointly by NTA and DCSF</p> <p>Mid-year reviews completed by regional NTA teams (may move to Quarter 4)</p>
Quarter 4	Delivery plans for young people's specialist substance misuse services completed and assessed by NTA and regional partners
2010/11	Action
Quarter 1	<p>Publication of performance assurance arrangements for current year</p> <p>Poor performing partnerships reported to DCSF on an exceptions basis</p>
Quarters 1 and 2	Refresh of young people's needs assessment to inform strategic direction of children's plans
Quarter 2	<p>2010/11 treatment planning process reviewed by NTA and DCSF</p> <p>Information reports based on NDTMS developed for publication</p>
Quarter 3	<p>Treatment planning arrangements for 2009/10 published jointly by NTA and DCSF</p> <p>Mid-year reviews completed by regional NTA teams (may move to Quarter 4)</p>
Quarter 4	Delivery plans for young people's specialist substance misuse services completed and assessed by NTA and regional partners

6.4 Practice development

All services will be focused on considering family issues by 2011. A considerable number of services already offer systemic or family-focused work. The NTA will develop links with family focused practitioners and training organisations to consider the specific issues around substance misuse. In addition it will work closely with the Department of Children, Schools and Families to look at improving family-focused competence within the children's workforce.

By 2011, at local, regional and national levels, there should be joint working between CAMHS and substance misuse practitioners and officials. The NTA will assist this by issuing guidance to promote the need to work together, identify parameters of good practice and governance and also consider the role of CAMHS practitioners in the clinical management of pharmacological treatment need. In 2008/09 and 2009/10, this guidance will be disseminated at regional level and regional teams in 2009/10 will focus on CAMHS involvement through the review of commissioning plans. In 2010/11, regional teams will work with children's trusts to consider barriers to delivery.

The NTA will also continue to build on the developing relationship with CAMHS available to the young people treatment system to improve capacity. Clinical governance guidance will also ensure that the legal requirements that exist for involving parents in treatment decisions are fully explained. This will be monitored through the young people's treatment performance assurance arrangements.

2008/09	Action
Quarter 1	Guidance on different models of CAMHS involvement with substance misuse services published
Quarter 2	<p>Guidance on community prescribing for young people published</p> <p>Briefing on Young People's clinical governance produced</p> <p>Briefing on findings from young people's clinical audit produced</p>
Quarter 3	<p>Guidance on applying the evidence base to young people's services published</p> <p>In conjunction with regional CAMHS and children's advisors, deliver regional workshops aimed at improving governance and clinical audit.</p>
Quarter 4	CAMHS parameters of good practice published
2009/10	Action
Quarter 1	<p>Produce clinical governance guidance re unqualified family worker roles and responsibilities</p> <p>Review of 2008/09 treatment plan objectives in relation to implementation of the clinical guidelines</p>
Quarter 2	<p>Produce clinical governance guidance on legal requirements that exist for involving parents in treatment decisions</p> <p>Development of regional improvement plans to address shortcomings in clinical guidelines implementation at a regional level.</p>
Quarter 3	Introduction of improvement plans
2010/11	Action
Quarter 1	Stock take of further actions required to support best practice in line with the clinical guidelines and implementation of any further actions required.

6.5 Outcomes

The children's sector will have meaningful, robust and outcome-focused data systems available for all young people under 18. The NTA will continue to produce Treatment Outcomes Profile (TOP) data and review its effectiveness in 2008/09. In 2008/09, the NTA will also consider whether data from NDTMS provides useful outcome measurements for under-16s. In 2009/10 and 2010/11, the forthcoming changes to the NDTMS core data set will be reviewed and pragmatic changes will be implemented to ensure the system functions properly.

By December 2008, targeted youth support services should be in place in all areas. The NTA will continue to ensure that NDTMS data is available at national, regional and local levels to inform how such services interact with specialist services.

2008/09	Action
	New business definitions for NDTMS returns for 2008/09 published
Quarter 1	Planning for revised NDTMS core data set for young people to commence
Quarter 2	TOP data for 16-18 year olds reviewed to establish TOP milestones for young people
	In conjunction with the Department of Children, Schools and Families identify key components of NDTMS returns that can be used as outcome measures for under 16s.
Quarter 4	Notification to NDTMS regional teams, software suppliers and providers regarding new core data set from April 2009
2009/10	Action
Quarter 1	Introduction of new data set and production of new information reports as required

7 Supporting delivery

Corporate services help the NTA get the best from staff through effective human resource functions, efficient use of finance and resources, as well as IT, information systems and communications. Both internal and external audits demonstrate continued improvements in processes, particularly within finance where substantial assurances have been given on core financial controls and payroll. Other audits on internal processes have shown improvements generally and this has been in line with commitments within the 2007/08 business plan to improve corporate business processes.

During 2007/08, a number of organisational reviews were undertaken with a view to refocus some aspects of corporate services. The review of the human resources function identified the need for improvements in the way that a number of activities were undertaken. In addition, it was apparent that the resources available within the team were inadequate given the workload, particularly relating to recruitment, introduction of new payroll and finance systems (ESR), and increased staffing within the NTA as a result of increased funding for a number of initiatives funded outside of core DH funding. These improvements will continue to be built on in 2008/09.

From April 2008, the NTA information team will be restructured and there will be changes in the resourcing of teams to reflect the need to improve quality of information and to respond to increasing demands being made for all types of management information. There will also be changes to the NDTMS development team and IT functions which will merge with the aim to provide improved capabilities and synergy between both functions. The London NDTMS team, presently managed by the information function, will transfer to the London regional team in line with other NTA in-house NDTMS teams.

The increase in the media and political profile of drug treatment has demanded a review of the NTAs communication function, as outlined in Section 3. The period 2008/09 will see both a significant expansion in capacity and a change in orientation to become much more proactive.

7.1 Communication strategy

Introduction

The NTA has a responsibility not only to ensure that high-quality, effective drug treatment is available to all who need it but also to ensure that the benefits delivered to communities and individuals by treatment are effectively communicated to and understood by the public. As part of this role the NTA should be seen to be leading and shaping debate about drug treatment.

When the NTA was established the dominant narrative about drug treatment concerned under-resourcing, lengthy waits and early dropout. Although these challenges have largely been overcome, the NTA faces a new, even more challenging communication environment.

The government's new ten-year Drug Strategy recognises the successes of the treatment system in expanding capacity, improving accessibility and reducing early dropout, and now anticipates similar improvement in quality and outcomes. The

purpose of treatment is to help individuals overcome dependency, assume control over their own lives and make an active contribution to society. Alongside a continued commitment to maximise treatment's potential to reduce crime, the strategy emphasises the enormous benefit that effective treatment can deliver to society by addressing the long-term harm accruing to the children of drug-dependent parents. The strategy also identifies two new important roles for the NTA. Working within a memorandum of understanding with the Department of Children, Schools and Families, the NTA has assumed responsibility for oversight of the delivery of treatment to under-18s and from April, the NTA will assume lead responsibility for the implementation of the Integrated Drug Treatment System in prisons. Providing leadership in these two key areas adds to the NTA's communication challenge.

In making the case for the benefits accruing from investment in treatment, the NTA faces a changing context. There has been a breakdown in the previous political consensus about the purpose and content of treatment. The NTA is under criticism for promoting a treatment system focused on managing addiction rather than regarding complete abstinence from all drug use as the only legitimate objective of treatment. This debate is taking place as pressure increases on the government to justify its significant additional investment in treatment and demonstrate that the outcomes are successful enough to justify the additional cost to the taxpayer.

The challenge for the NTA is to effectively engage this debate, communicating the success of treatment to the public, service users and their families and key stakeholders such as treatment providers.

7.1.1 Communication objectives

- To champion the benefits of drug treatment
- To ensure the public has a good understanding of the NTA's work, approach to, and achievements in drug treatment, thereby increasing public confidence
- To deploy performance information and research, to enable the NTA to generate, lead and drive forward the drug treatment debate
- To ensure the NTA is well networked with other organisations and stakeholders in the field of drug treatment including young people's treatment and prisons
- To achieve excellent internal communications.

7.1.2 Approach

In order to inform the shaping of the communications strategy, an audit of stakeholder attitudes to the current delivery of drug treatment in England will be commissioned. This will enable the NTA to tailor information better to its audiences and ensure it is delivered in a more accurate, timely, clear and comprehensive way. This information will be supported by a good evidence base.

The NTA will organise itself in a more effective and efficient way to ensure a better flow of information and the delivery of it through the most appropriate channels. Additionally, we will ensure the NTA is well networked and able to keep ahead of the issues surrounding the drug treatment debate.

Equally important for the NTA is to enhance the channels of communication to stimulate more opportunities for consensus building, ensure transparency and increase the ease of access to information. These will range from developing the website, to participation at events and promotion of our publications.

When the NTA was first established, its organisational structures were appropriate for the time. However, changing times present new challenges and within the current environment the NTA now needs to put more resources into its communication function. A separate Communications Directorate will be created to provide greater strategic co-ordination and improve effective communication across the organisation, leading to better overall services. Additionally, all senior managers in externally facing roles will receive training in media skills.

7.1.3 Communications Directorate

The new Communications Directorate will be responsible for internal and external communications. It will sit alongside the current directorates – Corporate Services, Quality and Regional Management – and report directly to the chief executive.

7.1.4 Director of communications

A new position of director of communications will lead the directorate. Working closely with the director of quality who has responsibility for policy and the head of information, this senior board level appointment will ensure communication is given due emphasis in the stewardship of the NTA. This person will be a member of the senior management team and will sit on the NTA board.

The director of communications will have management responsibility for four functions; media, internal communications, publications, and events and public affairs, each of which will be charged with developing its own delivery plan in keeping with the overall strategy. In addition, the NTA information and policy teams will be reconfigured to provide an improved, dedicated resource committed to supporting the Communications Directorate.

7.1.5 Media

The role of the media team will be to ensure the communications strategy, as set out by the director of communications, is effectively implemented. It will deal with the day-to-day demands from the media and will ensure a strong proactive and reactive function, both nationally and across the NTA's regional teams.

7.1.6 Public affairs

The public affairs function will have responsibility for managing and building relationships with stakeholders across the drug treatment sector, for example Royal Colleges, third sector providers, think tanks and parliamentary bodies.

Accountable to the director of communications, but working closely with all members of the senior management team, it will create opportunities for consensus building and will ensure the NTA keeps ahead of developing debates and new thinking in drug treatment.

Additionally, it will ensure excellent communications between the NTA and its stakeholder departments: Department of Health, Home Office, Ministry of Justice and Department for Children, Schools and Families.

7.1.7 Publications and events

The publications and events team will support the communications strategy by providing a regular flow of statistics and reports and organising a range of forums, seminars and conferences to allow the NTA to lead the debate on drug treatment.

In a new development, the NTA will publish quarterly statistics. We will ensure our explanation of these figures is expressed accurately, clearly and simply in a language that is easily understood. Priority will be given to redeveloping the website so it becomes the central point of access to information for stakeholders and the media.

7.1.8 Internal communications

The role of the internal communications function will be to ensure the entire workforce and internal stakeholders are kept fully informed about the NTA's approach to drug treatment, the debates around it, its achievements and where it could do better. Additionally, regular board and management briefings will be conveyed across the organisation.

7.1.9 Policy and interface

The communications director needs to be able to draw together elements of research policy and performance information to drive strategic communication. To facilitate this, posts will be created within reconfigured Policy and Information teams dedicated to serving the Communications Directorate's needs. This restructuring will ensure that information available to the NTA from NDTMS and the Treatment Outcomes Profiles is managed and used more effectively to inform the public and media, showing what works and the success that investment in treatment delivers.

7.1.10 Gateway

The NTA has agreed with the Department of Health that it will apply to the DH External Gateway team for approval to issue all national communications, publications and requests for information to an NHS audience or adult social care audience. The purpose of Gateway is to ensure that the Department and its arms-length bodies spread consistent and deliverable policy, which does not impose excessive burdens on frontline services. As such, the criteria covers – among other things – processes that ensure policies and guidance are impact assessed (both for equality and economic cost impacts), affordable, outcome focused, consistent with wider government policy (for example, the current priorities and the performance frameworks), clear in terms of purpose, and that they are communicated in a targeted and succinct manner.

7.1.11 Evaluation and next steps

It will be essential to track understanding and awareness of the NTA and its activities. Reports will be provided to each NTA board meeting and the accountability review process through which the NTA accounts to Whitehall stakeholders.

An independent media evaluation house will be commissioned to assess media coverage and separate surveys will also be carried out with stakeholders to monitor attitudes towards drug treatment, the delivery of the Drug Strategy and the NTA's role. The results of this evaluation will feed back into the revised strategy for forthcoming years.

To this end, the new communications director will review the approach set out above, with a view to developing a fully-fledged communications strategy that underpins the objectives of the business plan. The strategy will be evidence-based and may require further research in order to be able to provide full and adequate insight into the attitudes of all the NTA's customers, including the public as well as users and stakeholders. The strategy will identify the key audiences, messages and channels for NTA communications over the remaining period of the business plan, and establish a means of measurement to track progress across a range of key indicators.

2008/09	Action
Quarter 1	<p>Interim communications director takes up post</p> <p>Plans to reconfigure communications function and interface with Information and Policy teams actioned</p> <p>National Treatment Conference</p> <p>Headline messages and Q&A developed and agreed with Department of Health, Home Office and Department for Children, Schools and Families</p> <p>Media packs prepared</p> <p>New press cutting service established</p> <p>Third party advocate identified and engaged</p>
Quarter 2	<p>First quarterly statistical bulletin published</p> <p>Stakeholder survey undertaken</p> <p>First media impact report to NTA board and ministers</p>
Quarter 3	<p>Second quarterly statistical bulletin published</p> <p>Media impact report to NTA board and ministers</p> <p>Review of NTA communications strategy</p> <p>Recruitment process for permanent director post initiated</p>
Quarter 4	<p>Third quarterly statistical bulletin published</p> <p>Media Impact report to NTA board and ministers</p> <p>Permanent communications director appointed</p>
2009/10	Action
	<p>Revised communications strategy implemented</p>

7.2 Human resources

In 2008/09, the Human Resources team will monitor the effectiveness of Agenda for Change, as well as the new electronic staff record system introduced in 2007/08. As a consequence of these two projects, there were delays in implementing a number of other activities during procedures and finalising work on staff development and training. These will need to be carried over into 2008/09. Processes are in place to provide monitoring and performance management information on staffing, recruitment, sickness absence and other related data.

2008/09	Action
Ongoing	Review and update NTA staff policies and procedures as necessary Continue to build upon and develop the training and development programme for NTA staff
Quarter 1	Introduce and embed the new appraisal system throughout the NTA Embed and monitor the criminal record bureau procedures within recruitment processes
Quarter 2	Introduce an employee assistance programme for NTA staff

7.2.1 Performance information

Following the introduction of new software to manage NDTMS data (Drug and Alcohol Monitoring System or DAMS), the NTA information team will seek to continue to improve the software platform. The NDTMS programme, and the software that supports it, will be introduced throughout the specialist alcohol treatment sector throughout 2008/09. There will also be a pilot of the NDTMS in the prison service, which will be used to evaluate the potential for full implementation of NDTMS throughout the prison system in 2009/10.

Other extensions of the programme will be the introduction of an application to capture aggregate activity figures for needle exchange services, and we will continue to work with primary care system suppliers to embed the data set into GP software. The reporting function of NDTMS will need to be revised to incorporate outcomes monitoring from TOP, and will also be made consistent with the new Drug Strategy, including the revised PSA measure. Work will also be undertaken with primary care system suppliers to develop automated data extraction suitable for submission to DAMS.

7.3 NTA business processes

7.3.1 Corporate service reviews and efficiencies

The NTA has and will continue to work with the Arms Length Body Business Support Unit to meet the requirements of the arms-length body review and to ensure that corporate service runs efficiently and effectively.

7.3.2 Information technology capacity and efficiency

The NTA IT function has always compared favourably with the ALB target of an annual cost per internal user of less than £5,000. In 2007/08 this was under £2,000 and in 2008/09 is expected to be at a similar level. As a result of a review of the information function, the IT function will merge with information development with a view of creating a more integrated and streamlined service to users.

7.3.3 Shared business services – finance and payroll

NHS/Xansa Shared Business Services (SBS) has been used by the NTA since 2004. Both financial and payroll services are provided by SBS. A review of the services provided and the quality of services will be reviewed in 2008/09.

2008/09	Action
Ongoing	Further automation of routine reporting from NDTMS. Existing performance reports are partially automated. Throughout the year, NTA will revise exiting reports to meet new requirements, and continue to automate quarterly report suite
Quarter 1	Begin collecting data and reporting statistics from alcohol treatment from all structured alcohol treatment providers Implement national system of data collection from needle exchange co-coordinators that captures the volume of equipment exchanged by each exchange
Quarter 2	Work alongside NAC and NTA teams to agree and implement routine outcomes reporting formats
Quarter 4	Pilot introduction of NDTMS systems into about 15 prisons during course of 2008/09 Update core data set to version 6.0 (F). Code data set to include additions and revisions to support new requirements arising from initiatives such as the young people's strategy, introduction of NDTMS into prisons, rolling-out into alcohol treatment sector

7.3.4 Human resources

The costs of the NTA human resources function per whole time equivalent staff was approximately £790 in 2007/08. In 2008/09 this is expected to decrease as new income sources appear. This is higher than the benchmark public sector best practice figure identified by the arms-length body review, but is not significantly above the ALB average figure of £745. Increased workloads within HR as a result of organisational restructuring and recruitment, and central projects such as the electronic staff records and residual impact of the Agenda for Change implementation, have placed considerable pressure on the function. The centrally driven demands on the HR function are unlikely to reduce and as a consequence further resources will be made available in 2008/09.

7.3.5 Accommodation

The NTA head office is based at Hercules House in Lambeth North, London. Since 2005, the NTA has occupied these premises through a memorandum of occupancy (MOTO) agreement with the Central Office of Information (COI). The present MOTO came to an end in March 2008. Although COI indicated until recently that the MOTO will be renewed, the NTA has been advised that this will no longer be the case due to COI internal accommodation pressures. The NTA has been advised that the present MOTO will be extended until 30 September 2008 and that alternative accommodation will need to be found by that time. The NTA is in discussion with the Department of Health's Accommodation and Building Services team, who are assisting in the search for suitable accommodation. Presently the floor space occupancy of Hercules House compares very favourably with ALB targets with an allocation at nine square metres per person against the ALB benchmark standard of 15 square metres per person.

Regional staff employed by NTA, are based at Government Offices in each of the nine English regions. A standard fixed agreement with the regional co-ordination unit is in place and this agreement prescribes the unit cost for accommodation based on a formula per member of staff.

7.3.6 Sustainable development

In 2007/8, the NTA commenced work on considering how the organisation's environmental sustainability with regard to usage of energy and physical resources might best be approached. A report has been produced which will be submitted to the board early in 2008/09; as a consequence of this, an action plan has been produced for the 2008/09 financial year, and implementation of this plan will be taken forward during the year.

7.3.7 Governance, risk and controls

The NTA is committed to maintaining high levels of corporate governance and internal controls. Considerable work has been undertaken over the last two years with the board, internal audit and external audit to improve governance and risk assurance processes within the NTA. Business performance is measured through a variety of corporate monitoring processes reporting to the senior management team, NTA board, Department of Health and other government departments. Recent audit reports indicate that the NTA has been successful in improving performance and more particularly has worked with internal audit to integrate their 4Risk software into the NTA. Strategic high-level risks are reviewed quarterly by the NTA audit and risk committee and the NTA corporate risk register is the committee and the board. Further work will be required in 2008/09 to further integrate risk processes across all teams with the NTA but this will build on the work already carried out. In addition increased capacity within the finance team will ensure that improved financial reports are available to team managers.

7.4 Finance and resources

In 2008/09, the NTA's resource allocation or grant in aid will be £11,457,000. This is made up of the core revenue resource allocation (£10,687,000 – the same figure as the NTA received from the Department of Health in 2007/08) and an additional allocation (£545,000 in connection with the NTA's work on incorporating reporting on alcohol treatment as well as drugs within the National Drugs Treatment Monitoring System (NDTMS)). On top of the revenue resource, the NTA will be receiving a "non-cash" revenue resource allocation to meet depreciation associated with the NTA's capital programme. This will be £225,000. The NTA will also receive a capital resource allocation of £205,000 from the Department of Health in 2008/09.

Apart from the resource allocations referred to above, the NTA will also receive operating income during the new financial year. The main areas are as follows:

- The Drug Interventions Programme from the Home Office
- The Integrated Drugs Treatment System from the Department of Health in relation to multi-agency work with over-18s in prison

The NTA will continue to work, throughout 2008/09, on building further on the improvements achieved to date in relation to financial systems and administration, and to ensure that recommendations from both the internal and external auditors are fully considered and, where accepted, implemented. There has been a major reduction in the number of recommendations contained in the audit reports received from both Bentley Jennison, the NTA's internal auditors, and the National Audit Office during 2007/8. For the audit of the NTA's 2007/08 accounts, the National Audit Office has contracted the audit out to KPMG.

During 2008/09, a review of the IT strategy will be undertaken, while, at the same time, implementing the substantial IT capital programme that has been developed in order to ensure that the NTA has an IT infrastructure that provides improved resilience with cheaper running costs. In addition, the infrastructure that the NTA plans to introduce will enable the NTA to plan and test its IT business continuity arrangements in the event of a disaster recovery, allowing the NTA to pre-empt solutions and downtime in the event of a disaster occurring.

2008/09	Action
Ongoing	To implement agreed recommendations from the National Audit Office management letter for 2007/08 (following the annual audit of the NTA's accounts undertaken by KPMG on behalf of the National Audit Office)
	To implement agreed recommendations from 2007/08 and 2008/09 internal audit reports undertaken by Bentley Jennison, the NTA's internal auditors. Redevelop and relaunch NTA intranet
Quarter 3	Review of NTA IT strategy
Quarter 4	To implement the NTA's sustainable development action plan for 2008/09 and have Board approval for an action plan for 2009/10
	To be able to demonstrate that the NTA's substantial capital plan for 2009/10 has been implemented, equipment deployed according to schedule, and that the new infrastructure supports the NTA's Business Planning processes
	To be able to demonstrate satisfactory progress in regard to implementation of the NTA's Health and Safety Plan

8 Budget Allocation for 2008/09

Sources of Income	£'000
Grant in aid parliamentary funding	
Department of Health Core Funding (including £225k for 'non cash')	10,912
Additional DH funding for Alcohol NDTMS work	545
Sub total grant in aid parliamentary funding	11,457
Operating income (estimated)	
Drug Interventions Programme (DIP)	2,132
Non Intensive DIP	186
Integrated Drug Treatment System (IDTS)	545
Secondments	205
Other	38
Sub total operating income	3,106
Total	14,563

Expenditure

Staff Costs	
NTA salaries	8,981
Total Staff Costs	8,981
Operating Expenses	
Establishment expenses	1,495
Premises costs	1,276
External contracts	2,718
Other	93
Total Operating Expenses	5,582
Total	14,563

Capital allocation 2008/9	£'000
Income	
Baseline allocation	205
Expenditure	
IT Programme	150
Minor works, furniture and equipment	55
Total	205

The NTA is planning to spend its 2008/9 parliamentary funding and operating income against the following programmes and departmental heads.

Regional Management	£'000
Director's office and treatment delivery	706
Criminal Justice	272
Young People	203
Regional Teams	3896
Sub-total	5,077
Quality Management	
Director's office	164
Policy and Research	942
Standards and Inspection	345
Clinical	178
Scan and SMMGP	235
Sub-total	1,864
Corporate Services	
NDTMS and IT	3,370
Other central services	4,252
Sub-total	7,622
Total	14,563

NTA Staffing and Organisational Structure

The NTA proposed staffing profile is set out below. Compared to 2007/08 there has been an increase in staff appointed more particularly in regional offices. The increases are as a response to increased funding for IDTS where funding has been received by the NTA for the appointment of staff working in prisons as well as providing administrative support for teams.

Location	WTE
East Midlands regional office	11.00
East England regional office	6.00
Head Office – London	78.57
London regional office	15.80
North East regional office - Newcastle	7.50
North West regional office – Manchester	9.00
South East regional office – Guildford	6.89
South West regional office - Bristol	7.89
West Midlands regional office – Birmingham	6.50
Yorkshire and Humber regional office – Leeds	12.40
Total	161.55

9 Selected bibliography

Department of Health (2007). *World Class Commissioning: Vision*. London: DH

Department of Health (England) and the devolved administrations (2007). *Drug Misuse and Misuse: Guidelines on Clinical Management*. London: DH

HM Government (2007). *PSA Delivery Agreement 14: Increase the Number of Young People on the Path to Success*. London: TSO

HM Government (2007). *PSA Delivery Agreement 23: Make Communities Safer*. London: TSO

HM Government (2007). *PSA Delivery Agreement 25: Reduce the Harm Caused by Alcohol and Drugs*. London: TSO

Home Office (2008). *Drugs: Protecting Families and Communities: The 2008 Drug Strategy*. London: Home Office

Notes: