Bitesize briefing

Public Health

DrugScope

This edition of Druglink covers a period of profound and far-reaching change in the structures and processes for planning, commissioning and delivering substance misuse services. So what are the principal changes?

Has the NTA really gone for good?

Yes. But that doesn't mean its functions and personnel have gone. They will be absorbed into Public Health England (PHE) - both nationally and regionally - and so will most of its personnel. But it is a comparatively small fish in a larger public health sea, with around 150 staff in an organisation employing over 5,000 people.

The NTA functions are split across three directorates in PHE. Strategic responsibility sits within the Health Improvement and Population Health Directorate, led by Rosanna O'Connor, formerly Director of Delivery at the NTA. The 15 local Public Health Centres, which absorb the NTA regional teams, sit under a separate Operations Directorate. The National Drug Treatment Monitoring System (NDTMS) and the National Alcohol Treatment Monitoring System (NATMS) are in the Knowledge and Intelligence Directorate. It remains to be seen how these bits of the jigsaw will fit together.

How does the creation of PHE fit with the commitment to localism?

The leadership and budgets for drug and alcohol services in communities is not held by PHE, but by Directors of Public Health (DsPH), employed by Local Authorities and accountable to local Health and Wellbeing Boards. This raises an obvious question of how the relationship between PHE and public health in local authorities will work. It would be contrary to the spirit of 'localism' for PHE to be too 'hands on' in terms of setting national outcomes or performance management.

It sounds complicated

Indeed - particularly when you add in, for example, the responsibility of offender health teams under the NHS Commissioning Board for drug and alcohol services in prison, the potential role for Clinical Commissioning Groups, and the other key changes, such as elected Police and Crime Commissioners.

What about the money for drug and alcohol services?

In January, the Government announced the public health grants for local authorities. A total of £2.66 billion in 2013-14 and £2.79 billion in 2014-15 is available to local authorities to spend on public health services for their communities. This money absorbs an estimated £800 million to a £billion plus of drug and alcohol funding. This means that approximately a third of the local authority grant is money that has to date been invested in drug and alcohol interventions, including the former 'pooled treatment budget'. It is absorbed into the overall budget.

DH have said that the overall amount allocated to local authorities for public health reflects activity and performance on substance misuse treatment. Critically, however, the new public health budget does not provide a visible, centrally funded contribution to drug treatment in the same way as the pooled treatment budget did, or any nominal 'ring-fencing'. This presents grounds for concerns about potential disinvestment, particularly in a period of austerity, and DrugScope is seeking clarification.

Are there any other protections for drug and alcohol services within public health?

Some. In particular, local authorities will be required to report spending on an annual basis, with categories for adult drugs, adult alcohol and young people's drug and alcohol spend. This should mean that disinvestment in drug and alcohol services will be evident.

There is also a national Public Health Outcomes Framework, with a total of 3 out of 66 outcomes directly concerned with drug and alcohol interventions (and many more to which substance misuse services can make a vital contribution - such as, for example, reducing liver disease and tackling domestic abuse). However, there are concerns that so few outcomes are substance misuse specific. In addition, Government has indicated that while local strategies should be informed by national outcomes frameworks, these should not 'trump' local decisions about priorities.

Any positives?

Well, it's a bit of a cliche but the transition to public health creates significant opportunities, including to respond more flexibly to local trends and priorities and to link up drug and alcohol strategies to other local authority responsibilities (for example, housing, social services and support for families) to 'build recovery in communities' and support social re-integration (for example, through Health and Wellbeing Boards and local health and wellbeing strategies).

The risks of disinvestment are real however, particularly in a period of financial austerity and public spending cuts. But as a sector, we are in a strong position to demonstrate our effectiveness in delivering (and contributing to the delivery of) a range of key outcomes for communities.