Local zeroes

The government is ambitious for solving the problems they see inherent in delivering public services. But could local disinvestment leave drug services struggling to cope? In the first of two articles assessing impact of these changes on the sector, **Sara McGrail** looks at the risk factors

With the announcement of the Pooled Treatment Budget (PTB), many were relieved, in a time of cuts, that no area was left completely devastated. Yet there are significant financial threats on the horizon for the sector and we mustn't assume that simply because the axe hasn't fallen yet, it won't.

A major threat is disinvestment of mainstream monies – local funding that supports and supplements the PTB. In 2008, in some areas, 50 per cent of treatment spend came from local mainstream funds. Local investment has been critical to many partnerships, not simply by increasing budgets, but also because it provides the flexibility to develop interventions that cannot be funded by the PTB. Local funding can support employment and housing projects and services for families – as well as delivering equitable access to treatment for alcohol users. This means that in those areas with high levels of mainstream funding, the value of central investment increases significantly.

When the current formula for the PTB was first set in 2008, it included an incidental incentive for local investment. Areas that had higher levels of local investment looked more efficient and so received higher levels of central investment. If next year's formula includes the same bias, then areas from which local partners are disinvesting – maybe because of increased pressure on other services – will face additional disinvestment from the centre. This will act as a double whammy, further eroding services and creating a spiral of decreasing funding. Local Drugs Partnerships will need to work hard to retain mainstream investment over the next few years. For many located within Crime and Disorder Reduction Partnerships (CDRPs), this could prove impossible.

In a letter to local authorities and police in February the Home Office delivered some bad news for CDRPs. Core Community Safety funding (the Home Office component of the Safer Stronger Communities Fund, the Young Persons Substance Misuse Funding and the Community Call for Action) will be cut by 20 per cent in 2011/12 – from an allocation of just under £75 million to £58.8 million. In 2012/13, funding will fall to just £28.8 million – a reduction of 60 per cent on this year's baseline.

These budgets will not be ring-fenced and from April 2012 will no longer be allocated on a borough basis, but transferred to the Police and Crime Commissioners (PCCs) – the newly created elected posts that will take on the functions of Police Authorities. In London this shift of funding from boroughs will take place in April, when for the first time community safety funding for Greater London will be allocated to the Mayor and the GLA. This is devastating for CDRPs. Without doubt it will lead to redundancies in community safety units affecting core services (data analysis, crime mapping etc) and will have a similar impact on community services supported by CDRPs including young people's services, victim support and initiatives tackling hate crime and anti-social behaviour.

It appears that Home Office DIP funding will be shifted from local authorities to the PCCs and from

April 2012 will again be included in an unringfenced single pot to enable PCCs to meet local priorities

There will be significant pressure on PCCs to increase investment in the kind of frontline services that quickly improve public confidence and reduce the fear of crime. PCCs will be directly accountable to their electorate, and they will need to be convinced that investment in drug treatment can bring about the kind of increased confidence that will lead to re election. Gaining investment from PCCs will depend to a large part on the results that can be demonstrated to the community.

And what of the ubiquitous yet ill defined Payment by Results (PbR) – the single most important factor in reshaping the public sector over the next few years? In a report he co-authored for accounting firm KPMG in 2010 entitled Payment for Success, KPMG, 2010, newly appointed Downing Street policy supremo, Paul Kirby said: "Where payment by results exists it should be made enhanced and where it does not exist it should be hurried into existence, even if it is crude to start with."

Drug treatment PbR pilots begin in October. A central commitment to developing our understanding of shared outcomes is very positive – as long as it is intelligently evaluated. The field has been waiting for a system that lets us demonstrate real impact. The challenge then is to deploy this new system on a short timescale, but hurrying it into existence – against a background of reducing funding and likely (given the impact of the recession on many people) increased demand, will be tricky.

The difficulties of developing a universal measure for recovery sophisticated enough to reflect individual experience is notoriously difficult. Defining recovery by the relationship of an individual to a chemical substance or a drug treatment service is simple and seductive for people making policy up on the trot, but it's also reductive of that individual experience and thus likely to misrepresent the real Value for Money (VfM) of public investment. If the only measures we can muster are those available at the point of discharge – like successful treatment completions, or almost arbitrary success markers like the magical 13 weeks – then we are not really much further advanced from the process indicators we've been using for the past decade.

Sustainable VfM gains from PbR will also be dependent on the extent to which we can resolve the difficulties of engaging effectively with smaller local third sector groups. PbR demands that providers cover the costs of the intervention until such time as the state can be sure the outcomes it wants to pay for are achieved. For many smaller organisations the financial risks of this are unsustainable. Many voluntary sector agencies are extremely worried that they will not be able to compete in the new market place unless the risk is managed by a bigger private sector organisation like SERCO or Reed or a statutory provider. And the problems faced by providers in the voluntary sector add to the pressure to be hurried and simplistic about outcomes. If PbR is to be a success for drug treatment then we need the time and space to develop an outcomes framework and financial systems that genuinely reflect individuals and communities experience, not just an approximated measure of VfM and some crude targets.

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These pressures to rapidly demonstrate VfM are evident in the letter sent to Local Partnerships announcing the new PTB allocations. The PbR pilots have only just been announced, but a new formula for relating funding allocations to performance against a key indicator has already been announced as well. This in effect will bypass some of the critical findings of the pilots and instead impose on local areas a financial incentive to meet a central process target. Exactly what the government said they didn't want to do.

Next year's PtB allocation will be set on the basis of a formula which for the first time will include a financial incentive for treatment completions and as the money will be based on this years' performance in getting people out of treatment, we can expect this work-in-progress to begin to have an immediate impact on our commissioners and treatment systems. A commissioner faced with a budget allocation predicated on increasing the numbers of people leaving treatment will apply levers and pressures on their service providers to do just that. The potential for the reinstallation of the revolving door into our treatment systems is suddenly very real.

This is an ambitious government, and there can be no doubt that many of the reforms they propose have the potential to solve very real problems in the delivery of public services – and not least in the area of drug strategy. What is not clear is whether the impact of such fundamental change deployed across such a range of services at a time of massive public sector funding cuts has been adequately anticipated. The impact assessment of the new drug strategy is largely incomplete suggesting an absence of real planning. In the drugs field like many others, the multitude of reforms to structures, local and national responsibilities and commissioning are falling at a time of redundancies and funding cuts. These changes could in the end affect our communities, clients and services in ways we do not want – and rather than meet the governments broad outcomes of more recovery and less drug use, bring us the opposite.

But we have been through difficult times before in the drugs field and most likely we will come through these. The resourcefulness of local services and commissioners – though diminished by a decade of central hand holding – will be key as they develop effective public health led partnerships and protect services that we have spent too long building to allow to simply fall by the wayside now. Our strong tradition of peer support and volunteering makes the drugs field a positive arena in which to look at new ways of delivering public services. In part two of this article, I'll be looking at how local areas might manage the cuts – and what opportunities changing commissioning structures, the Big Society and the move to public health could bring to the field in the long term.

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