NHS

National Treatment Agency
for Substance Misuse

Treatment journeys

Annual report 2004/05

National Treatment Agency for Substance Misuse

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“ Our ultimate goal is to improve service users’ journeys into and through drug treatment – to ensure it is accessible, effective and centred around their needs ”

Introduction

Welcome to the National Treatment Agency’s annual report for 2004/05

Our ultimate goal is to improve service users’ journeys into and through drug treatment – to ensure it is accessible, effective and centred around their needs.

We believe that, in partnership with national, regional and local partners, we have made that journey easier over the last year.

Record numbers of people are now in treatment – up almost 90 per cent since 1998, to 160,450, and a 27 per cent increase on last year alone.

The National Drug Treatment Monitoring System (NDTMS) now provides regular, useable information on a monthly basis, to help service providers and commissioners drive the treatment agenda forward.

Waiting times continue to fall, with average waits for treatment down to two-and-a-half weeks.

NDTMS records show that by 31 March 2005, 120,700 people had either successfully completed or were continuing treatment – a massive increase of over 30,000 on the previous year. And services are getting better at keeping clients. Of those who left treatment in 2004/05, 53 per cent, or 55,650 individuals, had stayed in treatment for at least 12 weeks – the stage when evidence indicates you are more likely to have long-term benefits from treatment. This is almost 34,000 more people than in 2003/04.

In our first four years, expanding availability was the key priority. It is now widely recognised that we have made very significant progress on this front.

Our next challenges are to further improve the effectiveness of treatment and enable drug users to rebuild their lives within their communities – with real education and employment opportunities, stable relationships and secure housing. This is the focus of our treatment effectiveness strategy, launched by the Prime Minister and public health minister this summer.

Improving drug treatment continues to have cross-government support. Central government funding continues, with an 18 per cent increase in funding in 2005/06 and a further 42 per cent in 2006/07.

This additional finance, combined with improved performance management via NTA regional teams, Government Offices, the Healthcare Commission and the NHS, as well as the personal commitment of the Prime Minister, gives us a real opportunity to build on recent successes.

Finally, we would like to acknowledge the valuable contribution that service users, carers, commissioners, drug workers, government colleagues, NTA staff and Board members have made to these achievements. Their commitment, dedication and ability have meant the journey through treatment is becoming easier to negotiate.

Baroness Massey of Darwen
Chair

Paul Hayes
Chief executive

More treatment, better treatment, fairer treatment

The National Treatment Agency for Substance Misuse (NTA) is a special health authority within the NHS, established by Government in 2001, to improve the availability, capacity and effectiveness of treatment for drug misuse in England.

Treatment can reduce the harms caused by drug misuse to individuals’ well-being, to public health and to community safety. The Home Office estimates that there are approximately 250,000-300,000 problematic drug misusers in England who require treatment. The NTA is responsible for meeting the treatment-related drug strategy targets to:

- double the number of people in effective, well-managed treatment between 1998 and 2008
- increase the percentage of those successfully completing or appropriately continuing treatment year on year.

2004/05 at a glance

- 160,450 people received specialist drug treatment
  Up 27 per cent from 2003/04, and 89 per cent from 1998/99
- 53 per cent of people who left treatment had stayed for at least 12 weeks
- 75 per cent either successfully completed or were still in treatment as at 31 March 2005
- 2.5 weeks was the average time someone waited for treatment
- 10,025 people were working in the drug treatment sector.

“ **The drug treatment journey often starts with a crisis – overdose, family breakdown, debt or arrest. In 2004/05, a record 160,450 people started or continued their treatment journey – up 27 per cent from the previous year** ”

Dr Emily Finch
Clinical lead, NTA



Getting in

Effective treatment is about lifestyle change. It is fundamental, complex and long term. Getting into treatment should not be an additional obstacle – in the last year there have been more drug users in treatment than ever, more services for young drug users, reduced waiting times and moves to raise the profile of harm reduction.

“ **If I hadn't have got in touch with Face It, I'd have probably been injecting by now. Sometimes I wouldn't want to meet my worker, but he'd be phoning up, saying he really wanted to help me. I started to see him again, then he got me on a college course…I never expected to be going to college** ”

Naomi
Service user, Face It, Nottinghamshire

Increased access

Twenty-seven per cent more drug users were reported to be in contact with specialist drug treatment services in England in 2004/05, compared to 2003/04. There were 160,450 individuals recorded in 850 services in 2004/05, against 125,545 individuals in 650 services in 2003/04.

The Government's drug strategy target is to double the number of individuals in treatment services, from an estimated 85,000 in 1998 to 170,000 by 2008. More funding and improved performance management mean we are ahead of our trajectory to meet this target. The challenge is now to sustain this increase in capacity, while simultaneously improving the effectiveness of treatment.

Reducing harm

Easy-to-access facilities, such as needle exchanges and drug advice services, are often a drug user's first point of contact. In the first four years, the NTA has focused on improving more structured forms of treatment, such as prescribing, counselling and residential care. Following consultation, the updated *Models of care for the treatment of adult drug misusers* will place a greater emphasis on harm reduction. The update will advocate the strengthening of interventions such as harm reduction and needle exchanges. This is likely to include measures such as more flexible access, vaccination against hepatitis B and greater support for clients following treatment.

We are currently conducting, with support from the Department of Health, the first national audit of needle exchange services. Initially intended to cover England, the review is now UK-wide and has the support of the devolved administrations. The audit will investigate the strengths and weaknesses of needle exchange services and issues relating to practice and data collection. It will provide managers and commissioners with vital information to enable future funding and service planning. The findings will also inform the 2006/07 Healthcare Commission /NTA improvement reviews on harm reduction services.

Caring for young drug users

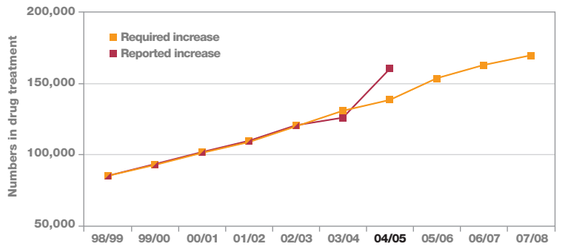
Most young people's drug problems can and should be managed within generic young people's services. However, some will require specialist treatment and our role is to ensure these services are available. We work with local partnerships and treatment agencies to protect investment for this highly specialised field, improve and expand services for young people, and enhance data collection. We have made significant progress – funding has increased from £19.5 million in 2003/04 to £23 million in 2004/05. Over 10,000 under-18s received treatment in 2004/05 – up 60 per cent on the previous year and well ahead of target.

Ninety per cent of all local authority areas have access to a comprehensive range of young people's drug services. Additionally in 2003/04, 92 per cent of young people, in contact with youth offending teams, received a treatment intervention within ten days of a comprehensive assessment.

Improved information about young people in treatment and greater funding will allow partnerships to improve services further.

Numbers in drug treatment

Required and reported increase 1998/99–2007/08



“ If it hadn’t been for DIP, I’d still sitting in jail over the road. I think catching people at a low point really makes you take stock of your life. Everything has come together and the speed at which you can get your medication has a big part to play ”

Derek Krauze
DIP client,
Peterborough Nene

Reaching out

Not all drug users actively seek treatment and some are unaware of what’s available. The Drugs Interventions Programme (DIP) reaches out to drug misusing offenders, offering them the opportunity to tackle their drug use. Eighty per cent of those coming through the programme had never been in treatment before.

“If someone has got an addiction and they are not prepared to seek help with it they are, I am afraid, a risk to other members of society. So the idea is to give a set of conditional offers to people all the way through ”

The Rt Hon Tony Blair MP
Prime Minister, speaking at the northern launch of the NTA treatment effectiveness strategy

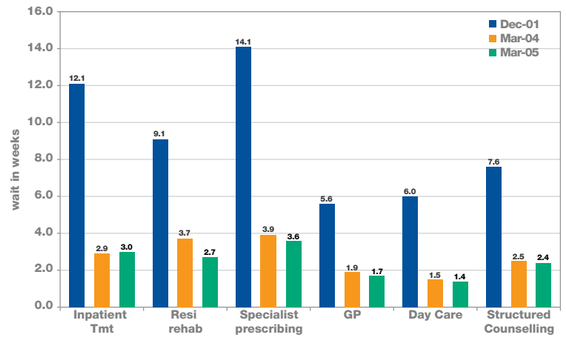
“We have become much better at getting entrenched offenders from the criminal justice system into treatment. From a healthcare point of view, we’re also getting to people who have been in and out of treatment for years, but never effectively stuck with it. These were people who had been traditionally written off as unworkable ”

Ian Britton
DIP programme manager, Peterborough Nene

Drugs Intervention Programme
DIP creates opportunities at every stage of the criminal justice system for drug-misusing offenders to move into treatment and away from drug use and crime. Criminal justice and treatment agencies work together, to provide a tailored solution. Special measures for young offenders are also being introduced. Since its inception in 2003, DIP now operates in 67 areas.

National average waiting times for treatment

1 week = 5 working days



In these areas, over 1,900 offenders are engaged in treatment each month – many for the first time. Indications suggest a positive impact, not only for individuals, but also for the community, as crime rates appear to be falling faster in DIP areas.

Rapid prescribing
A key component of DIP is facilitating rapid access to prescribing services. NTA regional teams are working with DIP areas to ensure clients in need can access a prescription for substitute medication within five working days.

Waiting times
Waiting times continue to be an important issue for drug misusers. Progress has been significant, but there are still variations. NTA regional teams are working closely with the Healthcare Commission, Department of Health and strategic health authorities to challenge underperformance and share best practice.

In March 2005, the average wait was two-and-a-half weeks, down from over nine weeks in 2001. Waiting times in DIP areas have fallen even more sharply for all clients – not just offenders – with average waits of just under two weeks. From October 2005, we will expect all areas to carry out local investigations if a client waits more than six weeks to enter treatment.

“ We've ensured clients are at the centre of treatment. We are now more flexible and have given people more opportunity to engage with us – we're planning more evening appointments and are moving towards weekend sessions ”

Geoff Dennis
Operations manager, West of Berkshire Substance Misuse Service



Staying in

All forms of contact with treatment services can have a positive effect, but evidence indicates that clients need to stay in treatment for at least 12 weeks, in order to obtain long-term benefits. Therefore, we can use measures of retention as a proxy indicator of treatment effectiveness.

“ **The user forum pushed for new guidelines for practitioners, GPs and pharmacists, to treat users with trust, compassion and respect. Things have got much better and there is more feeling for users and a better understanding of their needs. Agencies are sharing information with each other, which makes things easier for the user** ”

John Howard
Co-ordinator, Reading User Forum

Improving retention
According to a recent NTA study, the main influence on retention is the quality of the service itself – not the service user. The study has shown that the best performing services are seven times more successful at retaining clients than the worst performing services.

Our new treatment effectiveness strategy emphasises the importance of keeping clients in treatment and ensuring services are attractive to them.

Monitoring performance
Of the clients who left treatment in 2004/05, 53 per cent (55,650 individuals) had remained in treatment for at least 12 weeks. In 2003/04, the figure was 21,900, representing 52 per cent of discharged clients. We will expect to see year-on-year increases at local level, with rates between 51 and 61 per cent. These relatively low targets take into account the fact that some types of treatment, such as inpatient detoxification, can be appropriately completed in less than 12 weeks.

Crucially, retention rates in drug treatment are now a performance indicator for drug action teams and other mainstream NHS organisations, such as strategic authorities, primary care trusts and mental health trusts, via the Healthcare Commission's performance ratings and NHS local delivery plans.

Evidence and guidance
Over the last year, we have produced a number of reports to provide treatment agencies and commissioners with the evidence and guidance they need to improve retention.

These include a detailed study of retention rates in north-west England and a guide that summarises the existing evidence and clarifies monitoring issues. *Retaining clients in drug treatment* focuses on the need to retain clients in the very early stages of treatment – the point at which almost a quarter of clients drop out.

The report emphasises the importance of helping clients enter drug treatment, engaging and retaining specific client groups, building alliances between workers and users, responding to the full range of service users' needs, getting prescription dosages right and involving service users in their own treatment.

We are currently producing a guide to enable services to review their own performance, in relation to client engagement and retention. We will publish the guide online in the autumn and it will allow services to identify strategies to improve performance in these areas, and use their existing resources to support improvements.

We are also working with service user groups to improve peer support for those in treatment and to increase understanding of what makes services attractive to clients.

Retention rates
NDTMS 2003/04 and 2004/05

	2003/04	2004/05
Percentage retained for 12 weeks or more	52%	53%
No. retained for 12 weeks or more	21,900	55,650

Retention rates are based on discharged clients who had remained in treatment for 12 weeks or more.

Successful completions and retention beyond 31 March
NDTMS 2003/04 and 2004/05

	2003/04	2004/05
Percentage completion and retention	72%	75%
No. completions and retentions	90,500	120,700

Successful completions include 'successfully completed – drug free', 'completed' or 'referred on'. Retention as at 31 March indicates that client was continuing treatment at the end of the year.

“Since the data from the NTA has become more robust, we can take action where there might be a problem. It’s really helpful to us, it’s information about ethnic breakdown of people accessing services, injecting status, age groups and it’s now collected in a consistent way”

Shelley Shenker

Strategic commissioning manager for substance misuse, London Borough of Hammersmith and Fulham

Informing treatment improvement

One of the historic weaknesses in the drug treatment system was the limited performance information available to track progress and tackle problems. In the last year, significant improvements were made and further improvements planned, to ensure that the effectiveness, as well as the quantity, of treatment can be managed.

“The London NDTMS team has visited drug treatment agencies, establishing relationships, training staff and providing technical advice. We have expanded the amount of data collected and increased our support to young people's services”

Dick Daby

London National Drug Treatment Monitoring System (NDTMS) manager

Real-time information

The NTA is providing treatment managers, commissioners and users with more detailed and frequent performance information than ever before. Since taking responsibility for the National Drug Treatment Monitoring System (NDTMS) in 2003, the NTA has consistently improved its provision of regular, accurate information. This means we can now hold local drug treatment systems to account for their performance and can establish a baseline against which to measure improvements.

Regular reviews

In 2004/05, we were able to deliver quarterly information on individuals in treatment and since April 2005, this information has been available on a monthly basis. This allows local partners to review their performance information in real time and enables the NTA to report progress to ministers and other stakeholders.

Greater detail

Improvements in the quality and comprehensiveness of performance data mean we have been able to publish the most detailed analysis yet of clients in drug treatment. The analysis, which covers 2003/04, enables commissioners and managers of services to develop a more sophisticated understanding of complex issues such as women and Black and minority ethnic communities’ use of treatment.

Assessing local needs

The NTA requires all areas to commission treatment systems to meet the needs of drug users in their communities. We are producing a standard needs assessment framework to develop a better understanding of drug misuse and treatment needs. The framework will bring together central government information, NTA performance information, findings from the NTA national user satisfaction survey and locally gathered information. The aim is to enable local partnerships to identify unmet needs in their areas and how systems can be improved to engage, retain and successfully treat local drug users. This information will be used to develop treatment plans for all 149 partnership areas in England.

User satisfaction survey

The ultimate aim of the NTA is to meet the treatment needs of drug users. Their views are therefore crucial. This year, we have conducted the first national survey of service users’ views of treatment, with responses from over 5,000 clients across England. The survey, which is due to report in autumn 2005, will form part of the aforementioned needs assessment work and will also inform the Healthcare Commission reviews of drug treatment. We aim to carry out the survey on an annual basis, to enable us to track progress.

Targeting treatment groups

We are working with the Prime Minister’s Delivery Unit (PMDU) to gain better insights into the differing treatment needs of diverse treatment populations. This will enable us to provide local partnerships with guidance on planning their treatment systems, maximising the benefits to individuals and making best use of their resources. For example, it will enable us to project what percentage of drug users are likely to require which types of treatment, for how long and at what stage of their treatment journey. This, in turn, will inform future commissioning and planning.

“ Care plans are very individual. We look to develop individual action plans based on a person’s situation and specific needs. We do a holistic assessment – if we can’t help them here, we try to refer them to outside agencies who can ”

Patrick McSweeney
Senior case worker,
Outlook East, Manchester

Delivering better treatment

Our treatment effectiveness strategy aims to improve the quality – as well as the quantity – of treatment. We provide managers and commissioners with the evidence-based information they need to improve their practice. This year, a key theme has been monitoring and improving care planning.

Improving care planning and co-ordination

We want to ensure that all clients have a written care plan. This sets out what they aim to achieve during treatment, the care they will receive and the related support which they require, such as help with housing or benefits. This plan should be jointly agreed between the client and the drugs worker and, crucially, reviewed on a regular basis to assess progress and plan the next steps.

Effective care planning is central to improving treatment, which is why we are producing a care planning toolkit to assist drug workers. We have also made care planning one of the topics for the first NTA/Healthcare Commission improvement reviews in 2005/06.

The aim of the reviews is to implement a system to independently assess the quality of substance misuse services in each local partnership area. The Healthcare Commission provides the statutory remit to carry out the review, while the NTA provides the specialist drug treatment knowledge to support the reviews.

The first review, which focuses on care planning and co-ordination, and community based prescribing services, was piloted in 14 areas in 2004/05, and will be rolled out to all areas in 2005/06. As part of the process, we will work with the minority of areas with the weakest assessments, to develop action plans to improve their performance. This may involve working with a local partnership or healthcare organisation, to understand better the issues underlying performance and to help services generate their own solutions.

Providing the evidence

Our research programme has increased dramatically in the last year, with a strong focus on improving the quality of care. Our research briefings have included an examination of:

- drug misuse and drug treatment among women
- inpatient treatment, its cost-effectiveness and potential role
- future needs for inpatient detoxification and residential rehabilitation
- changes in offending behaviour after drug misuse treatment
- the role of psychological therapies.

As well as distilling the evidence from existing research, we have also carried out our own major research projects. This year we commenced three key national audits of needle exchange services, prescribing practice and user satisfaction. All of these audits will report in 2005/06 and will make a significant contribution to our understanding of these key issues.

As part of our continuing drive to improve treatment effectiveness, we are also working with international colleagues. The US Government’s National Institute of Drug Abuse (NIDA) has funded the Institute of Behavioural Research in Texas, to work with us on our treatment effectiveness strategy. This includes piloting frameworks for assessing how treatment providers work as organisations and how this impacts on the care they deliver. The institute is also working with us to adapt and implement manuals on specific psychosocial treatment interventions, which have been tried and tested in the United States and can also enhance treatment in England.

“You definitely need aftercare: if you come out of detox and you haven’t got support and a care plan, then it’s virtually impossible. If you’re just sending people out afterwards, then you’re wasting your money. You might as well just throw it away ”

Susan Donnelly
Volunteer and former service user,
Outlook East, Manchester

“You need ex-users to be involved with users, because it’s going to show them it can be done. As a drug user, you learn so much off the professionals and they learn from you. That’s when the respect starts to come”

Alan Davies
Addiction mentor and former user, Middlesbrough



Involving users and carers

Drug users, along with their families and friends, are the real experts in the drug treatment field. We are committed to ensuring their personal knowledge is more widely used, which enables the NTA, service providers and commissioners to keep in touch with what is really happening on the ground.

Developing national and regional groups

This year has seen important developments in the work of our National User Advisory Group and the National Carer Advisory Group, characterised by increased representation and a broadening of the scope of the issues they consider. Members of these groups have been invited to take part in steering groups for a number of research projects and policy developments – particularly the client satisfaction survey. They have been active in challenging the NTA about policy matters and have been involved in the development of *Models of care: Update 2005*.

Regional networks

We have strengthened regional user and carer forums in the last year, with increased representation from each of the local networks. Greater participation serves as a reality check for the NTA. All networks were involved in the treatment planning review process and have had considerable influence over the development of this year’s plans. There has been a notable increase in funding for user and carer involvement in the review of DAT action plans for 2005/06 and a rise in the number of involvement workers at local level, which will further support effective participation.

Advocacy

Service users can act as advocates on behalf of other service users. Their knowledge of treatment and the systems which monitor them can enable other users to get a better service. As part of our plan to strengthen advocacy, we have worked with The Alliance (a national advocacy and service user representative group) to train NTA regional staff, local partnerships and individual users on developing advocacy services. For example, the NTA’s South East region funded a course for 18 participants, providing support and mentoring for local user groups.

We are continuing to support The Alliance and other advocacy schemes’ work across England over the next three years. As part of this, we are producing commissioning guidance on advocacy for local partnerships, by the end of 2005.

“There is more support for families available now in the last couple of years. It’s mainly the women who come forward – not the men. Drug misuse can really divide families. But I set up a men’s carer support group, which is now quite well attended”

Eddie Concannon
SYPADS volunteer and Relatives of Drug Abusers (RODA) support worker

“When I found out my son was using, I felt very isolated. I had an overwhelming sense of inadequacy that I couldn’t find a solution. I think it is vital for your own sanity to get support for yourself. The support I’ve had has helped me realise I may not be able to change my son’s behaviour, but I can change the way I deal with it myself”

Lynn
Client of South Yorkshire Parents and Drugs Support (SYPADS)

“ We’re encouraging all staff to build a portfolio of evidence, which not only sits with them here, but wherever they might go. They can say ‘Look at the fantastic stuff I’ve done’. There was a real sense of excitement when people could actually see what they were doing ”

Harbinder Kaur
Director of resources, Phoenix House

Developing the workforce

We have exceeded our target for workforce expansion. In March 2005, there were 10,025 people working in the sector – well ahead of the April 2008 target of 9,000. While this increase will continue, we are focusing on retaining workers, developing skills and competencies, and improving their relationships with service users.

“ Managers were confused about the best courses to send people on. We set up a co-ordinated regional approach, which also fitted nationally. The students were so proud when they completed the course and many were able to progress their careers. Not only did they question their own practice, but also that of their services ”

Suzanne Fisher
Regional drug training development officer, Solihull Metropolitan Borough Council

Joint workforce planning strategy
Many professionals, not just drug workers, have an important role to play in enabling drug users to recover.

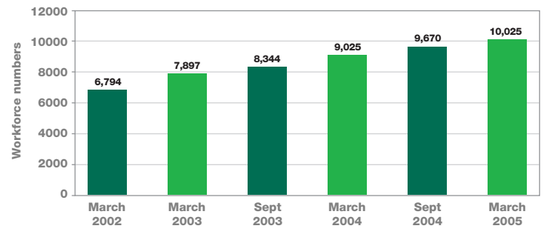
In recognition of this, the Home Office and NTA have produced a joint workforce strategy outlining the development needs of all health, social care, education and criminal justice staff, in relation to substance misuse. It aims to increase the effectiveness of specialist and non-specialist workers who may encounter drug users, such as employees of the police, prison and education services.

Advanced apprenticeships
Our apprenticeship schemes aim to create the drugs workers of the future. Skills for Justice have developed a number of schemes, designed to attract, train and retain young people – between the ages of 18 and 25 – into the drug treatment workforce. Over 40 young people have now participated in the scheme. The course lasts two years and consists of a Level 3 NVQ and a modular learning programme, offering the potential for progression into higher education and a key skills programme. Apprentices are salaried for two years and supported by assessors and line managers.

Doctors’ roles and nurse prescribing
The NTA expects commissioners to ensure that local treatment systems have a complete spectrum of medical services available to drug users in their area. This will normally involve a range of doctors, including GPs providing general healthcare services, GPs with a specialist interest in addiction and addiction specialists. The Royal College of General Practitioners and the Royal College of Psychiatrists have clarified the different roles and responsibilities these different groups of doctors can appropriately perform within the drug treatment sector, and we have published a summary of the colleges’ position on this issue.

We have also published a briefing to clarify how nurses can now agree clinical management plans with doctors, allowing them to initiate, change or terminate medication used in treating substance misuse.

Numbers in the drug treatment workforce*



*Excludes shared care GPs, GP liaison workers and admin staff

“It’s easy to come off drugs but hard to stay off them. When you’ve got goals in your life, it blanks out dark thoughts. Going to work makes me feel important again – saying to someone ‘I have to go, I’m at work’ makes me feel really good ”

Jay
Client of Red Kite, Southwark, London

Moving on

We want to ensure that clients make genuine progress throughout treatment and that they have the support their need to either remain in treatment, or to safely and appropriately move out. Whatever path they choose – be it maintenance treatment or abstinence – they are likely to need assistance with other areas of their lives.

Help with reintegration

In order for drug users to move on with their lives, they need more than just drug treatment. They need an alternative journey, with stable housing and relationships, and educational and employment options – without this, the risk of relapse is high. As part of the treatment effectiveness strategy, the NTA is working with other government departments and local partners to ensure that commissioners, drug workers and generic services provide appropriate support to drug users.

Maintenance support

Service users who are stable, but who wish to be maintained on substitute medication, should have opportunities to receive social support, education and employment. This group will also require exits from specialised drug treatment into maintenance and monitoring in primary care settings, and receive ongoing community integration and other necessary support. We will ensure service users have explicit accessible pathways back into specialised structured drug treatment if they require it.

Residential and inpatient provision

Hospital inpatient services and residential rehabilitation services can act as a valuable route out of treatment. We anticipate that, as more people start the treatment journey, demand for these types of services – known as Tier 4 services within *Models of care* – will increase. In the last year, we have investigated current and future take-up of these services, and started work on how they can be expanded and improved.

Only around five per cent of treatment is reported as taking place in inpatient or residential settings. We believe the use of these services should be increased as part of a range of safe, planned exit routes from treatment.

Our reviews of Tier 4 services revealed that, despite some individual examples of excellence, the current level of provision and quality is insufficient to meet future demand. We estimate that inpatient detoxification places need to increase by 90 per cent, and residential rehabilitation places by one-third. We are aiming for continuing improvements in the commissioning, management and flexibility of existing services, to ensure facilities are used as part of a coherent, long-term treatment plan.

We are currently discussing funding issues with the Department of Health and are optimistic that next year will see significant developments, such as jointly commissioning Tier 4 services at a regional, rather than a local, level.

Models of care: Update 2005 – the framework for commissioning and delivering treatment – will place a greater emphasis on the role of Tier 4 services in the overall drug treatment system.

The end of the journey?

Each drug user’s journey through treatment will be different. The NTA wants to ensure that every client – regardless of how complex their needs or what journey they choose – makes genuine steps forward during and after treatment. We believe that considerable progress has been made and plans are in place to continue these improvements.

“The staff are all on the ball here. It’s quite a tight ship – if you ain’t got rules, it just goes really mad. They make sure that they don’t just leave people to go out there after treatment without a real plan ”

Neil Connell
Resident, Clouds House, Wiltshire

Summary financial statement

The financial statement in the table below provides a summary of the NTA's accounts for 2004/05. A full set of accounts are available from the NTA website www.nta.nhs.uk

Operating cost statement	2004/05 £000	2004/05 £000	2003/04 £000	2003/04 £000
Non-executive members' remuneration	68		47	
Others salaries and wages	5,254	5,322	3,097	3,144
Auditors' remuneration	35		36	36
Depreciation and amortisation	76		25	
Capital charges interest	8		10	
Supplies and services – general	0		30	
Establishment expenses	994		723	
Transport and moveable plant	35		55	
Premises and fixed plant	663		477	
External contractors	4,791	6,602	4,669	5,989
Programme costs		11,924		9,169
Operating income		(1,406)		(233)
Net operating cost before interest		10,518		8,936
Net resource outturn		10,518		8,936
Cashflow statement				
Net cash (outflow) from operating activities		(10,356)		(7,604)
(Payments) to acquire fixed assets		(69)		(203)
Net cash outflow before financing		(10,425)		(7,807)
Financing				
Net parliamentary funding		10,436		7,763
(Increase)/decrease in cash in period		(11)		(44)
Balance sheet				
Fixed assets				
Intangible assets		8		0
Tangible assets		163		178
		171		178
Current assets				
Debtors		1,105		928
Cash at bank and in hand		12		1
		1,117		929
Current liabilities				
Creditors: amounts falling due within one year		(1,077)		(822)
		(1,077)		(822)
Net current assets/liabilities		40		107
Total assets less current liabilities		211		285
Taxpayers' equity				
General fund		211		285
		211		285

Paul Hayes
Chief executive
4 November 2005

Better Payments Practice Code

The Better Payment Practice Code target is to pay non-NHS trade creditors within 30 days of receipt of goods or a valid invoice (whichever is the later), unless other payments terms have been agreed. Of total relevant bills during 2004/5, 80.4%, representing 79.6% by value, were paid within the target. Payments for 2004/2005 were processed by West Yorkshire Shared Business Services on the Agency's behalf.

Name of auditor

The accounts have been audited by the comptroller and auditor general in accordance with the National Health Service Act 1977 as amended by the Government Resources and Accounts Act 2000 (audit of Health Services Bodies) Order 2003 No. 1324. The auditors' remuneration of £35,000 was for the statutory audit and services, carried out in relation to the statutory audit.

Equal opportunities

The National Treatment Agency is committed to action to ensure equal access to relevant and appropriate drug treatment services for the whole population, the eradication of unlawful discrimination and the promotion of equal opportunities with respect to ethnicity, age, culture, gender, sexuality, mental ability, mental health, geographical location, offending background, physical ability, political beliefs, religion, health or status or any other specific factors which result in discrimination.

Resources outturn

In 2004/05, the NTA incurred expenditure in excess of its revenue resource limit. The overspend was £152,000 and principally relates to an overspend within the information management budget. Discussion to ensure that additional funding is made available to meet the costs incurred in providing data through NDTMS has taken place with the Department of Health. Additional funding has been made available in 2005/06.

Board members' remuneration

Name	Title/Age	Salary in £5k bands (£000s)	Real increase in pension at age 60 in £2.5k bands (£000s)	Total accrued pension at age 60 at 31/3/05 in £5k bands (£000s)	Other remuner in £5k bands (£000s)
DE Massey	Chair, 66	20–25	0	0	0
PJ Hayes	Chief executive, 53	115–120	5–7.5	135–140	0
A Dale-Perera	Director of quality, 43	65–70	2–5.5	5–10	0
R O'Connor	Director of regional management, 55	65–70	2–5.5	5–10	0
S Hodges	Director of corporate services (from 01/11/04), 48	25–30	0	0	0
C Somani	Director of finance (until 31/05/04), 48	10–15	0	50–55	80–85
A Buck	Non-executive director, 45	5–10	0	0	0
B Beaumont	Non-executive director, 58	5–10	0	0	0
KA Davies	Non-executive director, 42	5–10	0	0	0
GM Haynes	Non-executive director, 46	5–10	0	0	0
KK Patel	Non-executive director, 44	5–10	0	0	0
G Scally	Non-executive director, 49	5–10	0	0	0
T Williams	Non-executive director, 55	5–10	0	0	0
P McDermot	Non-executive director, 49	5–10	0	0	0

Statement on internal control 2004/05

1. Scope of responsibility

As accounting officer, together with the Board, of the National Treatment Agency, I have responsibility for maintaining a sound system of internal control that supports the achievement of the organisation's policies, aims and objectives. I also have responsibility for safeguarding the public funds and the organisation's assets for which I am personally responsible as set out in the Accounting Officer Memorandum issued by the Department of Health.

There is a comprehensive reporting and accountability system in place both with the sponsor branch at the Department of Health, the Home Office and extensive ministerial engagement to manage key risks. Checks and balances are provided by internal and external audit and are overseen by the Board's Audit & Risk Sub-Committee.

2. The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to:

- identify and prioritise the risks to the achievement of the organisation's policies, aims and objectives.
- evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

The system of internal control has been in place in the National Treatment Agency for the year ending 31 March 2005. The Agency's external auditor, the National Audit Office (NAO), has however, identified a number of weaknesses in internal controls which I agree need to be addressed.

3. Capacity to handle risk

Risk identification and management is reviewed and monitored by the Board's Sub-Committee for Audit and Risk. The formal risk processes was implemented in 2003/04 within the Agency. The process identifies and registers key risks to the organisation through to the Audit and Risk Committee jointly with executive directors. These key risks are then embedded within and monitored through the corporate strategy, business plans and resultant work plans across the organisation. As part of the risk assessment, ownership of each key risk by executive directors is identified.

Key risks are monitored collectively by the Executive Management Team, with senior managers providing formal reports and presentations on a quarterly basis. Risk reporting to the Board and key stakeholders is embedded within highlight and status reports provided monthly where necessary to ministers or steering groups and quarterly at Board meetings.

4. The risk and control framework

The Audit and Risk Sub-Committee has been engaged in developing the risk management and assurance framework within the Agency. The committee has appointed a director to oversee these processes. Action plans to address gaps in controls and assurance are identified by the various operational and audit functions within the agency and are monitored by the committee.

In 2004/05 a review of risk management arrangements was undertaken following the departure of the director of finance and planning in May 2004. Work has been carried out throughout 2004/05 to ensure that an adequate and robust risk management strategy and subsequent processes are in place within the NTA.The risk management strategy sets out the Agency's approach to risk management and monitoring including objectives and a fully mapped risk process. Roles and responsibilities across the organisation are identified, requirements for action planning and the review processes clearly outlined.

5. Review of effectiveness

As accounting officer, I have responsibility, together with the Board, for reviewing the effectiveness of the system of internal control. My review is informed in a number of ways. The work of the internal auditors provides me with an opinion on the overall arrangements for gaining assurance through the Assurance Framework and on controls reviewed as part of the internal audit work. Executive managers within the organisation who have responsibility for the development and maintenance of the internal control provide me with assurances. The Assurance Framework itself provides me with evidence that the effectiveness of controls that mange the risks to the organisation achieving its principal objectives have been reviewed. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Audit & Risk Committee. A plan to address weaknesses and ensure continuous improvement of the system is in place.

The Audit and Risk Committee meets quarterly and reports to the Board on all aspects of financial control, risk management, internal and external audit and financial reporting. In 2004/05, membership of the committee has been widened to include a number of new non-executive board members. Executive directors have responsibility for monitoring and managing risk within their respective directorates. They are responsible for ensuring that risks are identified and appropriate action plans are in place to mitigate.

Internal audit ensures the effective operation of internal audit review and reporting. This function reviews, confirms and reports to the Audit & Risk Sub-Committee on the internal audit programme who considers the major findings of internal audit investigations and managements' response confirming any action. In 2004/05, the Agency was impacted by the absence of a director of finance and planning for a number of months, the migration of its financial processing to a new provider and continued expansion of staff numbers. As such, my review of the system of internal control in conjunction with internal and external audit has identified the following weaknesses:

- In 2004/05 the NTA established for the first time a comprehensive financial management reporting structure reflecting the increased size and complexity of the organisation and to ensure adequate analysis and monitoring of budgets. The first review of this system has highlighted the need to improve variance analysis and ensure that timely information is available to decision makers
- The migration of the financial processing functions within the Agency required that payroll processing was sub-contracted to a new provider. In the first year of operation, the Agency has identified weaknesses in the level of reporting currently available from the new provider. Negotiations are underway to resolve this issue
- Similarly, with growth in the number of fixed assets held by the organisation has identified the need to review the fixed asset and inventory registers to ensure an adequate audit trail and ensure clear identification of individual assets
- In 2004/05, the NTA incurred expenditure in excess of its revenue resource limit. The overspend was £152,000 and principally relates to an overspend within the information management budget. Discussion to ensure that additional funding is made available to meet the costs incurred in providing data through NDTMS has taken place with the Department of Health. Additional funding has been made available in 2005/06.

These control weaknesses have been discussed in detail at the Audit & Risk Committee and action plans are in place to ensure that they are addressed as soon as possible.

Paul Hayes
Chief executive
5 October 2005

Statement of the Comptroller and Auditor General to the Houses of Parliament

I have examined the summary financial statement for the National Treatment Agency, as set out on pages 20–22, which has been prepared in a form consistent with the full financial statements.

Respective responsibilities of the chief executive & auditor

The summary financial statement is the responsibility of the chief executive as accounting officer.

My responsibility is to report to you my opinion on its preparation and consistency with the full financial statements and foreword. I also read the other information contained in the annual report and consider the implications for my report on the summary financial statement, if I become aware of any apparent mis-statements or material inconsistencies with the summary financial statement.

Basis of audit opinion

I conducted my work having regard to Bulletin 1999/6, *The auditors' statement on the summary financial statement*, issued by the Auditing Practices Board for use in the United Kingdom.

My opinion on the Agency's full financial statements was qualified as a result of the National Treatment Agency exceeding its revenue resource limit. As the National Treatment Agency has no power to exceed its revenue resource limit for the period, I therefore concluded that this excess expenditure had not been applied to the purposes intended by Parliament and was not in conformity with the authorities that govern it.

Details of the circumstances giving rise to that opinion are set out under the heading 'Resources outturn', on page 21 of the summary financial statement.

In my opinion

In my opinion, the summary financial statement on pages 20–22 is consistent with the full financial statements and foreword of the National Treatment Agency for the year ended 31 March 2005 and has been properly prepared in a form consistent with the full financial statements.

I have no observations to make on these financial statements.

John Bourn
Comptroller and auditor general
4 November 2005

National Audit Office
157-197 Buckingham Palace Road
Victoria, London SW1W 9SP

NTA Board

The NTA Board comprises the chair, eight non-executive members, four ex-officio members and four executive members, including the chief executive.

Appointments
The chair was appointed by the Secretary of State for Health. The non-executive and ex-officio members were appointed by the Parliamentary Under-Secretary of State for Health. The chief executive was appointed by the Board.

Audit and Risk Committee
The NTA's Audit and Risk Committee provides an independent and objective view of arrangements for internal control within the agency.

HR Committee
The NTA's HR Committee is responsible for ensuring that policies and processes for performance review and remuneration of the chief executive, executive directors and senior managers are in place and agreed by the full Board.

Ex-officio members
The eight ex-officio members were appointed because of their current position within their organisations; therefore, their term of appointment is not fixed.

Baroness Massey of Darwen
Chair of NTA board and member of HR Committee

Occupation Labour working peer
Date of appointment January 2002
Term of appointment 3 years
Year of birth 1938
Ethnic background and gender White, female
Membership Co-chair of the All-Party Parliamentary Group for Children, member of the Advisory Council for Alcohol and Drug Education, the Trust for the Study of Adolescence, and all-parliamentary groups on alcohol, drugs and HIV/AIDS, and member of Lady Taverners

Dr Berry Beaumont
Non-executive director and member of HR Committee

Occupation North London general practitioner
Date of appointment July 2001 (Renewed in July 2003)
Term of appointment 3 years
Year of birth 1947
Ethnic background and gender White, female
Membership Fellow of Royal College of General Practitioners

Andy Buck
Non-executive director and member of Audit and Risk Committee

Occupation Chief executive, North Sheffield Primary Care Trust
Date of appointment February 2004
Term of appointment 3 years
Year of birth 1959
Ethnic background and gender White, male
Membership Board member, North Sheffield Primary Care Trust, board member, Burngreave New Deal for Communities, chair, Sheffield Drug Action Team

Kate Davies
Non-executive director and member of HR committee and Audit and Risk Committee

Occupation Senior manager of the Nottinghamshire County Drug and Alcohol Action Team, director of the Community Engagement Substance Misuse Programme, University of Central Lancashire
Date of appointment July 2001
Term of appointment 4 years
Year of birth 1962
Ethnic background and gender White, female
Membership Nottinghamshire Women and Drugs Forum, NDTMS Project Board, National Alcohol Mapping Project Board

Grantley Haynes
Non-executive director and member of HR committee and Audit and Risk Committee

Occupation Development manager, Birmingham Crack Strategy, Birmingham Drug Action Team
Date of appointment July 2001
Term of appointment 3 years
Year of birth 1959
Ethnic background and gender African/Caribbean, male
Membership Member, COCA (Conference on Crack and Cocaine)

Vic Hogg
Ex-officio member

Occupation Director of Drug Strategy Directorate, Home Office
Ethnic background and gender White, male

David Jeffrey
Ex-officio member

Occupation Deputy director in DfES's Supporting Children and Young People group
Ethnic background and gender White, male

Martin Lee
Ex-officio member

Occupation Head of Drug Strategy Unit, NOMS, Health Partnerships
Ethnic background and gender White, male

Sarah Mann
Ex-officio member

Occupation Head of Interventions Unit, National Probation Directorate
Ethnic background and gender White, female

Peter McDermott
Non-executive director and member of Audit and Risk Committee

Occupation Freelance consultant
Date of appointment February 2004
Term of appointment 3 years
Year of birth 1955
Ethnic background and gender White, male
Membership UK Harm Reduction Alliance

Prof Kamlesh Patel OBE
Non-executive director, chair of audit and risk committee, member of HR Committee

Occupation Director, Centre for Ethnicity and Health, University of Central Lancashire
Date of appointment July 2001
Term of appointment 4 years
Year of birth 1960
Ethnic background and gender Indian, male
Membership Chair of the Mental Health Act Commission, non-executive Board member of the Healthcare Commission (recently resigned from DrugScope), patron of the Men's Health Forum, national strategic director for BME Mental Health Programme (Department of Health secondment)

Ellie Roy
Ex-officio member

Occupation Chief executive of the Youth Justice Board
Ethnic background and gender White, female

Gabriel Scally
Non-executive director

Occupation Regional director of public health for the South West
Date of appointment February 2004
Term of appointment 3 years
Year of birth 1954
Ethnic background and gender Irish, male
Membership Director, Royal Society of Medicine Press

Tina Williams
Non-executive director

Occupation Project manager
Date of appointment February 2004
Term of appointment 3 years
Year of birth 1949
Ethnic background and gender White, female
Membership Parents and Addicts Against Narcotics in the Community (PANIC), vice-chair of FAMFED (National Federation of Families and Carers), chair of North-East Carers' Forum

Paul Hayes
Executive director

Occupation Chief executive, NTA
Date of appointment July 2001
Term of appointment Permanent
Year of birth 1951
Ethnic background and gender White, male
Membership Advisory Council on the Misuse of Drugs

Annette Dale-Perera
Executive director

Occupation Director of quality, NTA
Date of appointment October 2001
Term of appointment Permanent
Year of birth 1961
Ethnic background and gender White, female
Membership N/A

Stephen Hodges
Executive director

Occupation Director of corporate services
Date of appointment November 2004
Term of appointment Permanent
Year of birth 1957
Ethnic background and gender White, male
Membership N/A

Rosanna O'Connor
Executive director

Occupation Director of regional management, NTA
Date of appointment April 2003
Term of appointment Permanent
Year of birth 1950
Ethnic background and gender White, female
Membership Board member, Strutton Housing Association

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