Bristol City Council

Substance Misuse

Commissioning Strategy 2017

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Version Control

Document Review		
Section	**Amendment**	**Pg**
1.1	Added sentence to Introduction section highlighting this is now the final commissioning strategy following the consultation period	9
1.1	Removed paragraph relating to consultation approach and replaced with paragraph directing to formal consultation section	9
1.1	Updated dates to reflect the final timeline	9
1.1	Removed paragraph relating to the publication of new national drug strategy due to its delay	9
1.3	Updated paragraph to reflect that the projects key milestones have been signed off at the relevant points	12
2.3	Updated paragraph to reflect that the annual budget has now been confirmed and implementation contingency budget has been added	14
5	Added new section 'Formal Consultation' to outline the results of the consultation period and removed previous section that detailed the consultation approach.	21
6.1	Revised in and out of scope contracts and intentions for direct award.	27
6.2	Updated paragraph to reflect that the model has been shaped by information that is outlined in the 'Formal Consultation' section	30
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8	Findings from Equalities Impact Assessment added as Appendix	

Contents

1 Introduction

1.1 Background

Substance misuse services in Bristol currently provide a wide range of treatment and support under the Recovery Orientated Alcohol and Drugs Service (ROADS) brand. This treatment system is commissioned by the Substance Misuse Team (SMT) in line with the current National Drug Strategy (2010) and other key guidance from Public Health England (e.g. Medications In Recovery, NICE Guidelines etc.). These contracts were commissioned in November 2013 until March 2016 with the option of a further two years. Contract extensions have subsequently been agreed and expire in November 2017.

Following the commissioning of the community contracts, a tender process took place for Bristol clients to access residential rehabilitation provision across the country. A framework agreement was implemented in 2014 to deliver this provision and this is also due for renewal in 2017.

In 2010 the Substance Misuse Team commissioned an integrated, multi-agency, caseload system for the management of substance misuse clients across the city. There are approximately 20 teams who use the system and around 200 active Theseus users. The contract for the system (Theseus) expires in 2018 and having explored procurement options a competitive tendering process will be run. The expectation is that commissioned treatment providers will be required to use this system. Whilst this strategy makes reference to the commissioning of the case management system this will be run as a separate/interrelated procurement process.

This document outlines the development of a new model for substance misuse provision to meet the needs of those who misuse substances in the city and replaces the current substance misuse contracts, rehab framework agreement and case management system.

These will be commissioned and procured by the Substance Misuse Team by following BCC's Enabling Commissioning Framework (Fig.1). This is the agreed four stage commissioning cycle that has been adopted from the IPC joint commissioning model for public care. This approach will enable Bristol City Council to comply with European Union (EU) procurement law, and provide assurance that it is commissioning substance misuse services in line with best practice.

Fig.1. BCC Enabling Commissioning Framework

This document seeks to provide additional information in relation to this specific commissioning activity and is intended for use by a range of stakeholders in order to develop a cooperative approach to the commissioning model that will go out to tender in 2017. In particular, this document is intended for:

- Existing and potential providers who will be able to use the information presented to identify the role they can play. We hope that this document will enable providers to respond to the identified service model, identify potential opportunities for collaborative working, as well as bring forward new and innovative ways of working in the future.

- Voluntary and community sector (VCS) organisations and mutual aid groups who make a key contribution to building and maintaining resilience, recovery and reintegration. We hope these stakeholders, who may or may not deliver currently commissioned services, will be able to use this document to understand the proposed changes to the commissioned service provision and to develop links between commissioned and non-commissioned support.

- Members of the public, including but not limited to people who need support relating to substance misuse, who wish to contribute to the development of a treatment system for Bristol.

The period of formal consultation took place between 16th January 2017 until the 16th April 2017. Please see Chapter 5 – Formal Consultation for a collation of the feedback that we received during this period and how it shaped the final commissioning model and approach.

We will be commencing a competitive procurement exercise (where relevant) during July and August 2017 with the aim of awarding contracts to deliver the new services from the 1st December 2017. We recognise the challenges of moving to a newly commissioned treatment system for our stakeholders. Details of key milestones can be found in the final timeline in Section 7.

A glossary and definition of the key terms used in this strategy can be found in Appendix 1 and 2.

A number of legal acts and national strategies influence the provision of substance misuse services. This commissioning process will work within these parameters; further detail on the legal and national policy context is included in Appendix 3.

Update: This document is the final version of the Commissioning Strategy following a twelve-week consultation period. This consultation period has helped to inform and develop the final treatment system model outlined in this strategy that will be commissioned this year.

1.2 Local Context

Bristol has an estimated 5,400 opiate and/or crack users. This equates to approximately 18 of every 1000 adults in Bristol using opiates and/or crack. Bristol has the highest estimated rate of opiate and crack users of all English core cities and the largest proportion of very high complexity clients which makes them more likely to be in treatment for longer and need specific support. Accordingly, substance misuse is one of Bristol Public Health's top 10 priority work areas to improve and protect the health and wellbeing of people in Bristol, and to reduce health inequalities within the population.

The current substance misuse contracts were commissioned in November 2013 under the Recovery Orientated Alcohol and Drugs Service (ROADS) brand. These contracts were initially commissioned until 31st March 2016. Subsequently, contract extensions have been agreed with the current contract holders to continue to deliver ROADS until 30th November 2017.

Although procurement regulations stipulate that public services should be regularly put out to competitive tender, the Substance Misuse Team did consider alternative options (e.g. re-negotiating with current contract holders). A number of factors were taken in to account before deciding on the process of re-tendering these contracts. These included, but were not limited to:

- Expected reductions in levels of funding. The Council has consulted on a proposed Corporate Strategy for 2017-2025 which aims to make £92m savings. This is required due to changes in Government funding and increasing demands for services. The Council will have to look at all areas of spend, including commissioned services, to determine what areas have priority and where to make savings. Furthermore the removal of the ring fence for the Public Health Grant from 2017/18 has meant there is currently less certainty around funding for substance misuse provision in Bristol. Given the level of uncertainties it was considered that a newly commissioned treatment system to reflect any new funding levels would be required. Please see Section 2.3 for expected funding levels for the new system.

- The changing needs of clients accessing substance misuse treatment. Current ROADS providers have adapted well to the shifts in the profiles of those accessing treatment, particularly around the increase in primary alcohol users. However there is a recognition that system wide changes brought about by re-designing services through re-commissioning is now required to fully meet these emerging demands.

-The transfer of Public Health contracts. Due to internal restructures within the Council, the Substance Misuse Team will be managing a number of additional substance misuse related contracts (e.g. GP and Pharmacy Substance Misuse Public Health Service contracts, formally known as Local Enhanced Services) that have historically been contract monitored by the Public Health team.

-The publication of a new National Drug Strategy. It was anticipated that a new national drug strategy would be published at the start of 2017. In order for services to align with national policy it was considered that services should be re-commissioned to reflect any developments included in this.

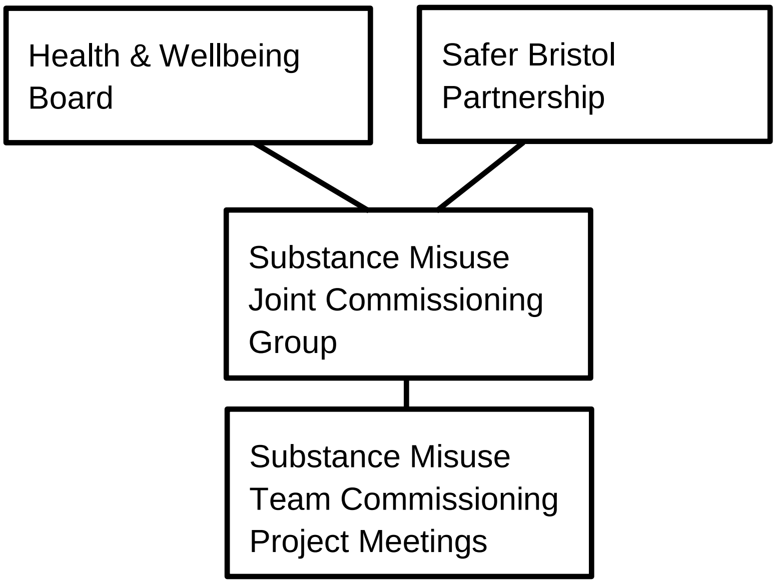
Our focus is on providing the best possible services for the people that need them and throughout the commissioning process we will be working with service users to help ensure services are accessible, appropriate and acceptable.

In line with the approach developed by Bristol City Council's Adult Social Care it is the Substance Misuse Team's intention to develop and commission a system that focuses on helping people in the most appropriate way dependent on an individuals need.

1.3 Governance and Decision Making

The Substance Misuse Joint Commissioning Group is a multi-agency governance group that oversees the work of the Substance Misuse Team. It has been agreed that this group will oversee the delivery of this commissioning process, whilst also reporting back through the Council's Health and Wellbeing Board and the Safer Bristol Partnership for sign off at key milestones of the project.

Fig.2 Governance Pathway



The Substance Misuse Team has also complied with the Council's decision making pathway process. Key milestones of the project have been presented to Bristol City Council's Senior Leadership Team, People and Neighbourhoods Directorate Leadership Teams, CCG (Clinical Commissioning Group) and Public Health's Management Team. Positive feedback has been received from these sessions and input has helped to shape the commissioning intentions included in this document.

Overall these Boards support the proposals outlined in this strategy and support the need to strategically align with some of the wider agendas in Bristol City Council through joint working and co-commissioning. It is recognised that this project has a number of interdependencies with other commissioning projects currently taking place in the Council, namely the Preventing Homelessness Strategy. More detail on the drug and alcohol accommodation as part of the Preventing Homelessness recommissioning can be found in the Commissioning Model section. We are working closely with colleagues in the Council to ensure that there is a strategic alignment in our project plans.

These commissioning intentions have also been brought to Bristol City Council's CPG (Commissioning and Procurement Group). This group has responsibility for the implementation of the corporate strategy that relates to commissioning and procurement which requires a saving of £30m to be achieved over the next five years.

2 Financial Analysis

2.1 Funding Streams

The Substance Misuse Joint Commissioning Group is accountable for the substance misuse budget. The 2016/17 funding streams that are relevant for this commissioning strategy includes:

Funding	2016/17	2017/18
Bristol City Council Contribution	1,623,590	1,461,231
Substance Misuse Public Health	7,709,220	6,938,298
Public Health GP, Pharmacy and Wet Clinic Contracts	1,702,505	1,532,254
Community Rehabilitation Company	87,000	30,000
South Gloucester Partnership Funding	40,000	40,000

As detailed above we have built in a reduction in the BCC contribution and the Public Health income as part of the ongoing BCC corporate budget consultation. A 10% reduction has been factored into the funding available for BCC and Public Health funding for recommissioning.

2.2 Current ROADS annual contract values 2016/17

Contracts	2016/17 (£ annual)
Engagement Cluster	1,701,751
Change Cluster	4,023,960
Completion Cluster	1,371,350
Support Cluster	433,030
Housing Support	882,190
Residential Rehabilitation	800,000
Primary Care Costs[1]	1,650,000
Hosted Case Management System[2]	27,546

[1] This includes GP drug and alcohol public health services, pharmacy public health service and prescribing costs

[2] Based on current hosting and admin costs and excluding perpetual software license, migration and set up costs

Please note that there are a number of other commitments, contracts and infrastructure costs that are considered out of scope for the recommissioning that make up the value of the total income streams listed above.

2.3 Funding Envelope for the new treatment system

An annual budget of £8.7 million has been allocated to the newly commissioned treatment system.

An additional £750,000 has been allocated to redefine the substance misuse accommodation pathway as part of the commissioned adult homelessness prevention services.

A budget of £27,500 is allocated to the hosting and maintenance of our case management system. We anticipate that if recommissioning a new provider there may be additional set up costs to include licenses, migration of data etc and a budget has been allocated accordingly.

At the JCGs recommendation an implementation contingency budget has been set aside to cover the potential cost of a short overlap between incoming/outgoing provider following contract start. This also includes an amount if a new case management system licence fee is incurred.

See Section 6.3 for the proposed allocation of resources across the new treatment system.

3 Needs Assessment and Stakeholder Engagement

3.1 Needs Assessment Approach

The Substance Misuse Team adopted Bristol City Council's Public Health template when producing the substance misuse needs assessment. This approach considers a number of factors including who is at risk and why, what is the level of need, what services/assets we have to meet and prevent this need, what do staff/users/carers think and what is the evidence base.

Given that substance misuse impacts on a wide range of areas in an individual's life, the Substance Misuse Team applied this template to the sections below to inform the commissioning of services and improve partnership working across the city:

- Physical Health
- Mental Health
- Housing
- Relationships
- Training, Education, Employment and Volunteering
- Criminal Justice

The draft substance misuse needs assessment was published in July 2016 and feedback was sought by all stakeholders on this document throughout this month. After consideration of the feedback the final needs assessment was published by the Substance Misuse Team in October 2016. This document can be found here: https://www.bristol.gov.uk/social-care-health/substance-misuse-treatment-services-tender

3.2 Needs Assessment Key Recommendations and Predictive Analytics

Recommendations were drawn from the evidence presented within each section of the needs assessment and can be found in Appendix 4. It should be noted that not all of the recommendations outlined are within the remit of the newly commissioned treatment system but have been included to inform and shape the wider commissioning and partnership working of services that work with people who use drugs and/or alcohol in Bristol.

Two overarching recommendations were developed to address the need to commission an effective treatment system:

1. Bristol needs a structured treatment system that provides a range of evidence based interventions to maximise recovery opportunities. Commissioners need to ensure the system can manage a broad range of conditions and client complexities. Treatment options should include access to a range of psychosocial and pharmacological interventions, including relapse prevention.

2. Within structured treatment there needs to be an enhanced focus on the delivery of health protection and harm reduction interventions.

Further to the Substance Misuse Needs Assessment, (which took a retrospective look back at various sources of data) the Substance Misuse Performance Team also developed a 'predictive analytics' approach (that took a prospective view of the ROADS substance misuse treatment data). This 'predictive analytics' approach considered what stage a service user was currently in their treatment journey and depending on the various stages they would go through what the likelihood of their future outcomes would be.

This data overwhelmingly demonstrated the importance of receiving effective aftercare support following structured treatment interventions to support them in maintaining their recovery. These findings were also considered as part of the proposed treatment model development work.

3.3 Stakeholder Engagement

A series of stakeholder events took place during September and October 2016 across the city. These events were designed to both inform stakeholders on the recommendations from the needs assessment and the prioritised commissioned functions as a result of these recommendations. These events helped to shape the proposed treatment model development work. Details of these events can be found below:

Location	Venue	Number of confirmed attendees
South	Gatehouse Centre	52
Central*	Unitarian Chapel	24
North	Greenway Centre	12
East	Barton Hill Settlement	22

*A drop in session was also held here to encourage additional input from members of the public and service users.

In addition to this a number of thematic events took place during this period that followed a similar approach which gained feedback from stakeholders and further informed the commissioning intentions. These included:

- Dual Diagnosis Workshop
- GP Best Practice Event
- Complex Needs Network

Following these events, we invited all attendees to consider the proposed functions discussed in these sessions in more detail and reply with any further feedback to assist in developing our commissioning intentions.

A wealth of useful feedback was given and has informed the development of the proposed model. A summary of the key messages from the Stakeholder Engagement sessions is included in Appendix 4.

4 Models of Delivery and Lessons Learned

4.1. Models of Delivery

Following the completion of the needs assessment, the Substance Misuse Team contacted substance misuse commissioners in both the core cities and Local Outcome Comparators (LOCs: areas defined by PHE with similar opiate and non-opiate caseload complexity to Bristol) to gain an understanding of the range of treatment systems commissioned across the country. See the table below for the areas contacted for information requests:

LOC opiate/non-opiate	Core Cities
Barnsley	Birmingham
Calderdale	Leeds
Cambridgeshire	Liverpool
Derbyshire	Manchester
Leicestershire	Newcastle
Lincolnshire	Nottingham
North Yorkshire	Sheffield
Nottinghamshire	
Wigan	
York	

Not all of these areas responded to this information request however Bristol Public Health Team did complete an additional information gathering exercise with the core cities to address some of these gaps. Some of the main findings from this exercise included:

-A strong trend for areas to deliver a more integrated approach to address both drugs and alcohol related harm.

-A strong trend for areas to offer services from GP surgeries and/or locality hubs to ensure that services are more accessible across a region for service users rather than being centrally based.

-A strong trend for areas to commission multi-agency treatment systems

- Some trends of areas commissioning a ‘single point of access’ for entry in to substance misuse treatment.

-Some trends for areas to commission specialist nurse prescribers to address needs around dual diagnosis.

-No trends of commissioning specific drug and alcohol housing provision. Instead mainstream housing is expected to meet the needs of drug and alcohol users.

4.2 Market Analysis

The market is well developed and there are a number of national providers who are currently delivering similar services to neighbouring local authorities and core cities across England; as well as small and medium sized local organisations who are providing specialist services with well-developed community links.

In the last round of substance misuse commissioning, 16 bids were received for the five ROADS lots from eight different organisations (with multiple subcontracting organisations). Following discussions with other commissioners, Public Health England and provider networks we are confident that there is the market to deliver substance misuse services for Bristol. It is important to be mindful of the potential for 'market failure' i.e. setting commissioning expectations too high and at too low a cost for any provider to feasibly deliver and this has been considered throughout the consultation period.

4.3 Lessons Learned

As part of the re-commissioning process, the Substance Misuse Team conducted a lessons learned exercise. The aim of this exercise was to improve the current commissioning project by having a retrospective look back over the previous commissioning process and subsequent contract monitoring to understand what steps could be built in to improve the current project. Some of the main issues identified here are outlined below:

-More detail to be included in the Commissioning Strategy document, including details of the key components and funding. This information was only available at the invitation to tender stage and stakeholders have fed back that this made it difficult to meaningfully comment on the commissioning strategy and the viability of the model. See Sections 5.2 and 5.3.

-We have received consistent feedback from stakeholders that contracts should be commissioned for a longer duration during this commissioning cycle to give services the opportunity to develop their new models of delivery and improve partnership working with wider stakeholders. The Substance Misuse Team also recognise that short commissioning cycles can be unsettling for both service users and employees of currently commissioned services and wish to address this by commissioning longer contracts in the new system. See Section 5.5.

- The SMT would like to support collaborative working and encourage innovative practice. Where appropriate, specifications will not be overly prescriptive about service delivery to allow for innovation. BCC is committed to full-cost recovery (a principle of the Bristol Compact) and as such recognises that, in some cases, overhead costs may be different in collaborations. As we are keen to encourage collaboration between providers, we will take into account different costs of effective collaborative and managing multiple relationships and will ask bidders to provide details.

-The Substance Misuse Team received feedback from colleagues in Primary Care that they were not effectively consulted during the last round of commissioning. Given the particular pressures currently being experienced in primary care and the need to have effective working relationships to address the needs of substance misusers in this setting, the Substance Misuse Team have looked to address this need by being more targeted in the pre-consultation period whilst building in plans to target this cohort in the formal consultation period.

5 Formal Consultation Stage

A formal consultation period was held with stakeholders between January and April 2017. A number of events were held as well as an online survey.

We asked Stakeholders attending events and completing an online survey to tell us about themselves to ensure our consultation was fair and accessible. 77% said they worked or had worked in substance misuse services and 19% said they worked for another type of service. 24% had used substance misuse services themselves and 22% were carers of someone who had experienced drug/alcohol problems. 14% of participants told us they had experienced problems with drugs/alcohol but not accessed ROADS services.

Participant demographics: Gender was split evenly between male and female. 90% were aged 18-64 with no responses from children. 13% were BME. 32% told us they held a religion or belief. 7% were disabled. 14% said they were lesbian, gay or bisexual. No participants told us they were transgendered.

Stakeholders	Method	Number of participants
All stakeholders	Online survey	82
All stakeholders	4x locality consultation events	96
Service users including peer supporters and family/carers	11 x focus groups and interviews	109
Staff / workforce of commissioned services	3 x Staff Meetings	113
GPs and primary care liaison workers	Events and meetings	35
Residential rehab providers	Event	19
Written responses from agencies and individuals	Email	18
Relevant professionals	Equalities Impact Assessment Workshop	12
Relevant professionals	VOSCUR hosted Event	7

Stakeholder feedback	Our response
System wide	
• The proposed model for service delivery is generally positive • Ensure that transition between services is as smooth as possible • Mixed views about where to hold assessment coordination function • Need a ROADS website and main contact phone number, with increased digital offer to maximise accessibility	We will • Clarify the proposed assessment process and referral pathways in the final commissioning strategy and tender documents • Ensure commissioned providers work with BCC to demonstrate how equalities groups are supported both as service users and within the workforce.

Stakeholder feedback	Our response
• Include provision for NPS / other drugs	• Make sure there are ROADS services suitable for people using NPS / other drugs
Commissioning approach and allocation of resources	
• Concern that all services will be underfunded because of spending cuts • Commissioning and implementation timescale is too short • Strong support for longer contracts but concern about lack of inflationary uplift as staff and resource costs will increase over time. • The financial evaluation method used by the council may be unfair for smaller providers.	We will • Consider tenders using a revised financial evaluation to make it fairer for smaller organisations • Ensure contracts have variation and termination clauses which allow for changes over time. • Have an annual review process to manage funding fluctuations. • Where possible allow extra time for commissioning and implementation • Review our financial evaluation process
Specialist Nursing Provision	
• Need to ensure that midwives are able to work across the service – community and acute • Substance misuse liaison nurses at BRI + Southmead are currently quite separate from the rest of the treatment system • There is no 'addiction' expertise clinically in BRI or Southmead – the staff need to be supervised by addition doctors from ROADS	We will • Include that midwives are able to engage with clients at the most appropriate location • Increase information sharing and liaison with the ROADS system • Ensure close collaboration in the development for the service specifications for specialist nursing provision and the Complex Needs service
In-Patient (Detox & Stabilisation) and Residential Rehab	
• Need to ensure that an inpatient facility remains local to Bristol in order to treat the most complex clients • Concerns that all rehabs do not have the governance and structures to perform detoxes for some clients.	We will • Work with the current inpatient facility to support the viability of this service remaining. • Ensure that rehabs can demonstrate that they are effective in delivering detoxes and ensure that services are enabled to assess clients for this level of detox.
Complex Needs Service	
• Concerns were raised regarding a 20% caseload being too high for this service which would not allow it to work in an enhanced way.	We will • Remodel the service to case-hold the top 10% of complex clients in the system. In addition to this an enhanced liaison role will be

<table>
<tr><th>Stakeholder feedback</th><th>Our response</th></tr>
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- Risks that the service would be too clinical in its delivery
- Concerns raised that the service would not work with risks in a proactive way which could lead to barriers in accessing the service.
- Risk of the service becoming ‘clogged up’ that would prevent new clients entering this service.

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expected of the service, which will work with more clients across the system to reduce complexity.

- Ensure that the service has a multi-disciplinary team to meet the multiple needs of clients.
- Specified that the service will need to demonstrate how they will proactively work with risks and overcome any barriers for clients who are not engaging in treatment.
- Ensure that integrated pathways are developed with other ROADS elements and develop agreed threshold guidance.

</td></tr>
<tr><td colspan="2">Community Recovery Service</td></tr>
<tr><td>

- Agreement for increasing local delivery
- Mixed views about the best locations to deliver locality services from
- Providers should share premises flexibly with other local community services rather than committing to separate premises.
- Good idea to offer relapse prevention following all detox but need to ensure there is capacity and a smooth transition between services
- Risk that treatment will be too short with not enough aftercare
- Increased peer support service very positive but need to ensure peers have suitable resources, a central hub, and host agencies must provide meaningful roles and workplace support
- Lack of TEVE service may reduce positive outcomes so link with outside services that support training, work and volunteering.
- Workforce development function will help make links with outside organisations and overcome stigma/discrimination
- The working title of CRC is confusing

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We will

- Make sure there is a flexible local offer that works in partnership with existing community resources.
- Provide anonymised maps showing where current service users are located to help providers make realistic proposals
- Liaise with VOSCUR and BCC Employment, Skills and Learning Team to identify links with training education and employment opportunities
- Ask CRCs to include open-access and low-threshold aftercare interventions
- Rename to a working title of the Community Recovery Service

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Stakeholder feedback	Our response
Substance Misuse (Alcohol & Drugs) Liaison	
• 4-6 weeks is a tight timeframe to prepare someone for alcohol detox and deliver post detox care • Specialist support will be needed to support primary care delivery • Limited amount of psychosocial interventions will be possible in alcohol detox shared care model • Can peer supporters boost capacity in GP surgeries and help support transition to aftercare etc? • Most opiate clients are poly drug users – how will this be addressed?	We will • Make sure timeframes are linked with need and ensure clients with increased complexities are seen by the appropriate service. Post-detox support pathway to Community Recovery Service will be established at the pre-detox stage to ensure continuity of care. • Ensure the Complex Needs service will be able to offer liaison and advice to primary care • All clients will have a package of care agreed prior to detox to ensure appropriate access to psychosocial interventions from ROADS services • Make sure Peer support workers are an essential part of supporting clients through detox and into the Community Recovery Service • Set an expectation that Opiate Substitution Therapy includes the provision of interventions that reduce the harm, and increase cessation, of all substances being used (including crack, alcohol and NPS)
GP Public Health Service (Alcohol & Drugs)	
• Payment needs to properly cover the cost of an alcohol detox • Room Space is an issue within practices and additional clients may put strain on the system	We will • Introduce a two tier approach to alcohol detox. Initially starting with mild to moderate dependencies in primary care followed by an enhanced approach with interested practices – including enhanced payments once primary care detoxes established • The service will operate within the capacity of the participating practices.
Pharmacy Public Health Service	
• Concern about large cohort on OST being maintained for years – impact on their health and future wellbeing. Model assumes	We will • Ensure that all maintenance prescribing is reviewed (at least 3 monthly in line with guidance) and

Stakeholder feedback	Our response
capacity for primary care based on maintenance clients being seen infrequently – but they still need thorough regular reviews	ensure the offer of a detox is regularly reviewed.
Early engagement and intervention	
• Need to make it explicit that this is for people at all levels of need who are not already engaged in services • Little money available for staffing the service. Large non-staff costs (NSP stock, BBV tests, naloxone, clinical waste, etc.) • Very opiate focussed. Missing explicit reference to provision for people using NPS and where it fits in the model • Needs a specific focus on engaging equalities communities	We will • Ensure the service is targeted to work with people actively using drugs and alcohol in order to increase contact with ROADS services • Increase the funding for the service to ensure it can be staffed appropriately • Include NPS, non-opiates and alcohol in service specifications • Make explicit reference to the need to address the needs of people with protected characteristics
Families and Carers Support	
• Most people agree joint commissioning with South Glos. and B&NES is good idea but if this is not possible the service will be underfunded.	We will • Commission a new service with South Glos and B&NES. • If we are not able to jointly commission this service with other local authorities we will include the functions as part of Community Recovery Service to maximise efficiency.
Substance Misuse Accommodation Pathway	
• Agreement for increasing amount of prep housing • Complex clients may not have their needs met if substance misuse floating support is decommissioned • If abstinent housing is decommissioned there may not be enough suitable accommodation for people in early recovery • Agreement for commissioning homelessness prevention peer support together with ROADS	We will • Review the needs of all long-term floating support clients and potentially refer some to the Complex Needs service • Allocate some appropriate low support accommodation for newly abstinent tenants. • Nb These proposals are part of a separate commissioning process: Preventing Homelessness Accommodation Pathways – families and adults (22+)
Hosted Case Management System	
• Avoiding disruption to ROADS services is a priority	We will • Award new contract separately

Stakeholder feedback	Our response
• Need to have a system that will work across multiple sites.	from other ROADS contracts to avoid disruption • Ensure that successful the provider has a comprehensive training and implementation plan

6 Commissioning Model

6.1 In and Out of Scope

In Scope – Competitive

The funding from the following contracts will contribute to the re-commissioning budget. The activity that each of these contracts provides has been considered and has informed the development of the future model that is being put out to the market for competitive tender.

Contract	Provider
Engage Cluster	St Mungos
Change Cluster	AWP
Completion Cluster	BDP
Support Cluster	DHI
Residential Rehabilitation	Various spot providers through a framework
Homeless Health Prescribing Service (SMART services)	Brisdoc
Child minding/support to access services	BCC
Probation – Drug Rehabilitation Requirements	CRC
Eden House dual diagnosis service	Eden House
Maternity Drug Service – Social Worker Element	BCC
Hosed Case Management System	Cybermedia Solutions Ltd
Wet Clinic	Brisdoc

In Scope – Not Competitive

The funding from the following contracts contributes to the re-commissioning budget but will not be put out for competitive tendering. The * denotes that the activity that each of these services has been considered and deemed most appropriate to re-negotiate with current contract holders given the settings. Whilst it is our intention to take this approach and re-model the services in line with the newly commissioned system this is subject to the approval of the Health and Wellbeing Board and BCC's Commissioning and Procurement Group.

Contract	Provider
Maternity Drug Service- Midwife Element*	UBHT and NBT
Hospital Based Alcohol Nurses*	UBHT and NBT
Hospital Based Drug Liaison Nurses*	UBHT and NBT
Inpatient Stabilisation and Detox Unit*	AWP

In Scope – Procurement Approach To Be Confirmed

Primary Care is an integral part of the treatment system in delivering opiate substitute prescribing, alcohol detox prescribing and supervised consumption services. We are currently exploring procurement options and are not in a position to ask the H&WBB to take a key decision on this element of the ROADS model. We will return at a later date and will update the commissioning strategy accordingly.

Contract	Provider
Pharmacy contracts	Participating pharmacies across Bristol
GP contracts	Participating GP surgeries across Bristol

In Scope – Preventing Homelessness

Funding from the following contracts is contributing to the commissioned adult homelessness prevention services.

Contract	Provider
ROADS Housing Support	ARA
Housing Solutions	BCC

Out of scope

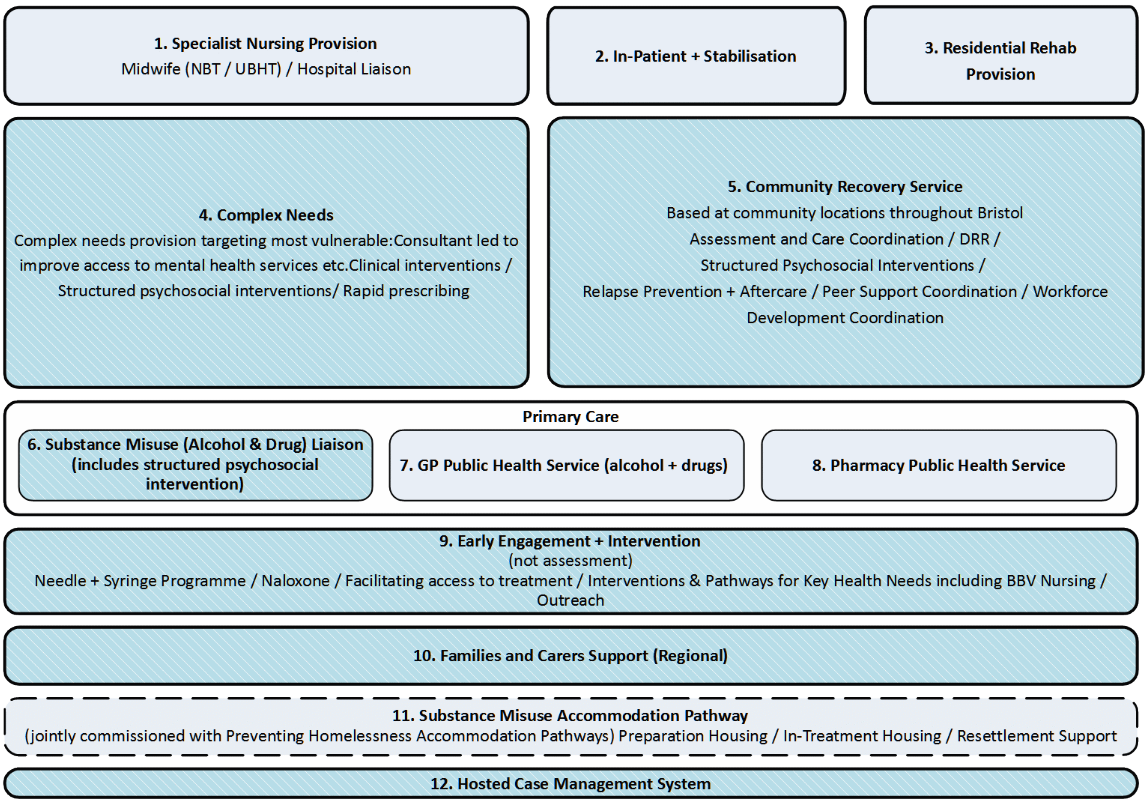
Within the Substance Misuse budget there are a number of elements that are not directly related to service delivery and as such these are out of scope.

Contract
Contribution to Integrated Healthy Lifestyle Service
GP with special interest
West of England High Risk Offenders Floating Support
Contribution to Violence Against Womens and Girls specialist Refuge
Contribution to Drugs & Young People Project (DYPP).
Contribution to CAMHS YP service
Substance Misuse Team
RCGP training - alcohol and drugs
Drug Testing Court Orders (CRC delivered)

6.2 Proposed treatment model - ROADS

The intention is to keep the ROADS brand for the newly commissioned treatment system. Stakeholder feedback has highlighted that this brand is now well known across the city to both service users and referrers.

The model has been designed based on the findings outlined in Sections 3,4 and 5 alongside national guidance, local policy and best practice for substance misuse treatment and support.



The new ROADS model will consist of 11 integrated elements:

1) Specialist Nursing Provision

Substance Misuse Midwife

Substance misuse specialist midwives will operate from the city’s maternity units to co-ordinate the midwifery care for women who misuse substances in pregnancy or pregnant women who are in substance misuse treatment. The midwives will liaise closely with the consultant obstetricians, neonatologists and Complex Needs service when planning care for these women and their families.

Hospital Substance Misuse Liaison Nurses
A team of substance misuse specialist nurses will operate from Bristol Royal Infirmary and Southmead Hospital. The team will improve health outcomes for people admitted to hospital who use drugs and/or alcohol; reduce repeat attendance and admissions to hospital; and ensure continuity of care with community substance misuse services (including ROADS for Bristol residents) upon discharge from hospital.

2) Inpatient Detox & Stabilisation

This element will need to provide a clinically safe inpatient detoxification or stabilisation regime to the most complex individuals whose needs cannot be met in the community or through a residential rehab detox.

This provision will be required to provide a planned regime of 24-hour medically directed evaluation, care and treatment of substance related disorders in an acute care inpatient unit. This will be staffed by designated addiction accredited physicians, as well as clinicians and recovery workers.

This service will provide medically supervised prescribing, assessment, care and treatment to individuals requiring detoxification from either drugs or alcohol or stabilisation on opiate substitution therapy (OST) where abstinence is not the goal.

3) Residential Rehab(Detox, Primary and Secondary)

Residential rehabilitation is a specialised service offering accommodation, support and rehabilitation to people with complex drug and/or alcohol and other health needs. This will be provided according to a recovery plan and will include intensive and structured programmes delivered in a residential environment.

The Substance Misuse Team intend to commission a range of residential rehab across the country in order to meet individuals needs for this type of intervention. The following placements will be commissioned from residential rehab providers:

- Detox placements which will usually be provided for up to 2 weeks.
- Primary stage one placements which will usually be for 12 weeks, with a minimum of 6 weeks and a maximum of 16 weeks.
- Secondary stage two placements which will usually be for 12 weeks, with a minimum of 6 weeks and a maximum of 16 weeks.

Residential rehab providers who are placed on the dynamic purchasing system will be required to form close working relationships with the Complex Needs provider of the ROADS system to ensure prompt access in to rehab, joint care coordination during the placement and effective aftercare planning at the end of the placement.

A dynamic purchasing system (open framework) is being proposed as a way of commissioning these elements to ensure value for money and to provide a greater degree of competition and transparency in the market place. It is envisaged that a formal tender process will be carried out to establish a Res Rehab and Detox Framework of approved support providers through this process. The Substance Misuse Team will be considering both block and spot purchases on this framework to ensure we get the best value for money for this provision and propose to continue to manage the placing of clients in rehab.

4) Complex Needs

In order to reflect the increasing levels of complexity for substance misusers at both a local and national perspective, this complex needs provision will be required to identify and case hold the most vulnerable and chaotic clients across the city who are affected by substance misuse (we predict this cohort to be in the region of 10% of the overall treatment population).

This service will need to demonstrate how it can provide an enhanced offer to those most severely affected by physical and mental health needs that are unable to engage in mainstream substance misuse provision and have multiple barriers to working towards recovery. Key to this success will be how the service proactively links in with local physical and mental health services to collaborate and optimise the treatment offer for complex clients. This service will need to demonstrate how it intends to meet the needs of 'dual diagnosis' clients, particularly around trauma and post traumatic stress disorder in relation to their substance misuse.

It will need to deliver high level consultant led treatment for these clients whilst also providing clinical leadership and advice through a liaison style approach to support partners in the substance misuse system as well as primary and secondary care support across Bristol. We envisage this service to have a skills mix of professions to most effectively engage with these complex clients. This will include but not be restricted to non-medical prescribers, social workers and psychiatrists. It will also need to work closely with the 'Specialist Nursing' provision element of ROADS to care coordinate pregnant women alongside specialist midwives and hospital discharges with drug liaison nurses.

This service will be required to offer a range of specialist drug related interventions to including rapid and relapse prevention prescribing, community detoxification, BBV services and drug testing in order to engage these complex clients. This service will also need to demonstrate how it will work with homeless health services to meet the prescribing needs of this population. Furthermore intensive psychosocial interventions will be delivered in either a one to one or group setting for both service users who are receiving medically prescribed and non medically prescribed treatment as part of their recovery care plan.

Facilitating Access to Res Rehab

This element of the Complex Needs service will lead on facilitating access to residential rehab placements for clients in need of this higher intensity by utilising the newly commissioned Res Rehab and Detox Framework. They will need to demonstrate how they will deliver this element to both clients open in the Complex Needs service and those in other parts of ROADS where community relapse prevention has been unsuccessful and they require additional support in their recovery.

Transitions

The Complex Needs service will include a named worker who will work closely with young people's substance misuse services. This person will support the most vulnerable young people (from age 17) to make the transition from young people to adult services and provide for ongoing structured treatment support as required. The transitions service will be required to engage with the Bristol Young People Friendly quality standard process and to have achieved this within a year of the contract being awarded. Close working links with young people's substance misuse treatment services and other services engaging with the most vulnerable young people will be required and clear information sharing agreements will be put in place to support the transition between providers.

5) Community Recovery Service

The Community Recovery Service will deliver a range of one-to-one and group-work psychosocial interventions in line with best practice to support individuals in their recovery. Interventions will include those suitable for service users referred from criminal justice e.g. Drug Rehabilitation Requirements (DRR). The use of digital interventions should also be utilised where appropriate at all stages of an individual's recovery journey.

The Community Recovery Service will play an essential role in ensuring there is enough capacity to deliver relapse prevention support for all individuals who undertake detoxes (both opiates and alcohol) within ROADS. Facilitating access to mutual aid and linking in with wider recovery support across the local community will also be key in delivering this element successfully.

We recognise the importance of individuals accessing support around their substance misuse at locations that are easily accessible to them. We will commission a flexible service that works in partnership with existing community resources to provide a locality based Service situated across various sites in Bristol.

The Community Recovery Service will be required to comprehensively assess an individual's needs to support them in their recovery. This will include all assessments that will take place in a primary care setting. An individually tailored package of treatment and support will need to be offered to reflect their levels of need and stage of recovery. Recovery care plans will need to be collaboratively developed with individuals and reviewed periodically to ensure that they are continuing to benefit from treatment and support.

Peer Support

We recognise that peer support plays a pivotal role in supporting recovery and contributes to a wide range of positive outcomes including tackling discrimination and stigma; advocacy; providing opportunities for education training and employment etc.

We will commission a Peer Support Coordination function as part of the Community Recovery Service to support peers and facilitate a high quality training programme. The service will have strong links with all other ROADS functions to ensure that peer support is available throughout the entire recovery journey. Adult homelessness prevention services will contribute additional funding to increase the capacity of the peer support element to recruit, train and supervise people with experience of homelessness, and match them to support people in homelessness services.

To facilitate the peer support element of the Community Recovery Service we will require all ROADS providers to be accountable for facilitating placements and overcoming barriers with appropriate targets in place to ensure this happens.

Workforce Development

We are committed to ensuring that ROADS has a skilled workforce and that other organisations in Bristol have a good understanding of substance misuse and are able to work with people who use drugs and alcohol or who are in recovery. Whilst all ROADS providers will be expected to contribute to delivering internal and external workforce development to support this we plan to commission a new workforce development role. Based in the Community Recovery Service this role will co-ordinate activity and work with partners to maximise the training, development and equality good practice that is embedded within all ROADS services.

This role will facilitate collaborative working, skill-sharing and emerging good practice between ROADS agencies; coordinate substance misuse awareness training for other professionals; promote equality of opportunity and anti-discriminatory practice by establishing strong links with statutory and non-statutory organisations, local business, communities and faith based groups.

6) Substance Misuse (Alcohol and Drugs) Liaison

The substance misuse liaison service (SML) will operate out of GP practices participating in the Alcohol Detox and/or OST primary care local enhanced contracts. The SML will care coordinate primary alcohol and opiate clients attending their GP practice for pharmacological interventions, deliver appropriate psychosocial interventions commensurate to need and facilitate pathways with the Community Recovery Service.

It is intended that this will be an integrated service with practitioners' caseloads comprising primary alcohol and primary opiate clients to maximise capacity and ensure the greatest geographical coverage.

Community Alcohol Detox

The SML will be expected to enable capacity for 1,488 primary alcohol clients to undertake community alcohol detoxes per year. It is expected that the SML will prepare clients for detox, support them through the withdrawal process and offer brief post-detox support to facilitate access to the Community Recovery Service for ongoing psychosocial interventions, relapse prevention and aftercare. It is envisaged that the SML will work with clients for 4-6 weeks (although this may be longer dependent on the needs of the client).

Effective working relationships with GP practices participating in the Community Alcohol Detox GP Public Health Service will be vital for the success of this function.

Opiate Substitution Therapy

The SML will be expected to enable capacity to case manage approximately 1,600 opiate clients accessing opiate substitution therapy at any given time. Care coordination, strategic reviews and packages of psychosocial interventions will be delivered by the SML to all clients accessing primary care for OST.

Effective working with colleagues in Primary Care and the Early Engagement and Intervention service will be vital to ensure there is access to priority interventions including hepatitis B vaccinations and testing for hepatitis B, hepatitis C and HIV. Supporting clients to access healthcare to ensure early identification and treatment of conditions, such COPD and other respiratory illness, to minimise the impact of ill-health will be a key deliverable of the SML.

After undertaking a period of assessment and stabilisation commensurate with their level of need clients receiving OST will have access to maintenance and detox pathways.

Opiate detox pathway
The detox pathway will require the SML to deliver a 12 week reduction programme for clients identified as motivated and clinically appropriate to undertake withdrawal from their opiate substitute medication. This will include the delivery of higher intensity treatment and will be expected to facilitate access with the Community Recovery Service for relapse prevention and aftercare as a prerequisite of undergoing detox.

Community Maintenance Pathway
The community maintenance pathway will be available to those clients not yet appropriate for detox but who meet the agreed definition of being in medically assisted recovery. Due to clients' adherence to treatment a lower intensity and frequency of treatment would be expected to be delivered within this pathway. The SML will be expected to continuously assess the suitability for detox alongside clients' strategic care plan reviews.

7) GP Public Health Service (Alcohol and Drugs)

Primary Care Alcohol Detox – GP Public Health Service

A 'shared care' service is the preferred model to be commissioned for the delivery of community alcohol detoxes. A GP Public Health Service is being negotiated to increase the availability of prescribing for alcohol withdrawal within Primary Care. The Substance Misuse Liaison service will support the delivery of this service by delivering care coordination, psychosocial interventions and facilitating the onward pathway to other services to support the success of the detox.

Primary Care Opiate – GP Public Health Service

A GP Public Health Service is being negotiated to provide the prescribing for opiate substitution therapy in Primary Care settings for people who are opiate dependent. Access to the wider services on offer in health centres, e.g. vaccinations for HBV, will be enabled through the service. The Substance Misuse Liaison service will support the delivery of this service by delivering care coordination, psychosocial interventions and facilitating the onward pathway to other services.

8) Pharmacy Public Health Service

A Pharmacy Public Health Service is being negotiated for the supervision of opiate substitution therapy in pharmacies. It is not envisaged that this will be significantly different to the supervised consumption arrangements that are currently in place.

9) Early Engagement and Intervention

The Early Engagement and Intervention service will operate across Bristol in order to engage with active substance users, including those who are not in contact with ROADS services. As well as alcohol, opiates and crack cocaine, this will include engaging with people who use non-opiates, Novel Psychoactive Substances, and performance and image enhancing drugs.

Interventions to improve health and reduce the harms associated with drug and alcohol use will be delivered as well as supporting those furthest away from services to access treatment in a timely manner.

Outreach/early engagement and intervention
Contact with non-treatment seeking drug and alcohol users will be established to ensure early interventions can be delivered to reduce health complexities and support people to access services to improve the wellbeing of individuals not currently accessing ROADS services. This will need to include in-reach to hostels and non-commissioned dry-houses as well as effective partnership working with allied services (e.g. homelessness, mental health, etc.) and facilitate access to help meet individuals' needs.

Facilitating access to treatment
Opportunistic interventions will be delivered to increase motivation to change and, where need necessitates, assess clients to ensure speedy access to structured treatment. Early reengagement pathways for clients dropping out of opiate substitution therapy and alcohol detox treatment will be developed to ensure clients can be rapidly reengaged

Needle and Syringe Provision (NSP)
NSP will be delivered across Bristol to ensure availability of injecting paraphernalia to reduce blood borne viruses and infections in people who inject opiates/crack, non-opiate drugs (including emerging/novel psychoactive substances) and image and performance enhancing drugs (IPED). NSP will be supplied through a range of sites, including pharmacy, agency based and mobile (including outreach), all of which will be coordinated by the contract holder.

Over one million needles were supplied to people who inject drugs in Bristol in 2015/16, with an approximate 50:50 split between pharmacy and agency/outreach provision. The coverage rate of needles supplied per estimated injection stood at 66% for 2015/16 and increasing the coverage rate of needle supply will be a key deliverable of this contract.

The NSP will be expected to identify clients not accessing any form of structured treatment and ensure motivational interventions and referral pathways are effective in engaging people into ROADS. Additionally, early re-engagement pathways with providers of opiate substitution therapy for clients dropping out of treatment will need to be in place to ensure clients no longer benefitting from the protective factors of treatment can be rapidly reengaged.

Naloxone supply to individuals at risk of overdose
The supply of naloxone to opiate users and those likely to be in contact with people at risk of overdose will be coordinated through this contract. This will include, but not limited to, targeting people who inject drugs; families and carers of people using opiates; hostel/supported housing workers; and supporting providers of OST and community & inpatient detox to ensure their clients receive naloxone. Opiate clients dropping out of treatment will be a priority group.

Interventions and pathways for key health needs
Interventions to support the identification and prevention of blood borne viruses will be coordinated through the Engagement contract. Dry blood spot testing and venous blood specimens will be available for the detection and diagnosis of hepatitis B, hepatitis C and HIV for those clients identified as being at risk. Care pathways will be established for clients receiving positive results and supporting clients to engage in services. A clinical lead will be responsible for ensuring the quality and effectiveness of interventions and ensure pathways with NHS services are accessible for the client group.

Clinical support will be available for clients experiencing harms associated with drug and alcohol use. This will include wound care and injecting related infections as well as coordinating ROADS responses to emerging health needs and working with health protection colleagues in the event of an outbreak scenario.

Utilisation of peers will be critical to increase the reach of health protection and harm reduction messages to hard to engage clients.

10) Families and Carers Support (Regional)

We are keen to jointly commission a sub-regional Families and Carers service alongside neighbouring local authorities South Gloucestershire and Bath & North East Somerset. This service will work with adults[3] who are affected by someone else’s substance use, including significant others and close friends as well as families and carers.

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[3] Children in Bristol who are affected by someone else’s substance misuse are currently supported by Hidden Harm services provided by Bristol Youth Links and Drugs and Young People Service.

The Family and Carers service will help affected others learn more about substance misuse and treatment, and give them new skills to better cope with problems as they arise. The service will also offer opportunities for peer support, and promote affected others' involvement in treatment services where appropriate.

A joint regional service will need to have a strong local offer with good links to community organisations and area based support. To increase accessibility we expect that the Families and Carers service will offer a wide range of support e.g. information and training, advice and signposting, support groups, one to one support, online and telephone support.

11) Substance Misuse Accommodation Pathway

Providing housing support for drug and alcohol users working towards recovery continues to be a priority and we have allocated £750,000 to redefine the substance misuse accommodation pathway as part of the commissioned adult homelessness prevention services.

Because there are already established providers of these accommodation based services, and a very limited supply of accommodation that can be used for the purpose, we plan to negotiate new contracts with the current providers. This has been approved by Cabinet.

Our proposal is to maintain the current overall number of accommodation units, increase the units of preparation accommodation to meet increased demand, and keep in-treatment accommodation. To do this we will no longer provide abstinence housing, or have a substance misuse specific floating support service.

The risks posed by stopping providing a substance misuse specific floating support service can be partly mitigated by better equipping people during the preparation and in-treatment services to maintain independent living as well as ROADS providing support in their recovery planning. There are also generic floating support services in Bristol that may be able to provide support to ROADS service users, and the Council is currently reviewing all commissioned floating support services to address a potential gap in provision for complex clients.

ROADS providers and other nominated referrers, including the Rough Sleepers Team and prisons, will be able to make a direct referral into substance misuse housing (where assessment has already taken place and been approved). Links between ROADS and other preventing homelessness provision will be improved through workforce development and integrated peer support coordination.

Full details about the proposals for new accommodation pathways can be found in a separate draft commissioning plan “Preventing Homelessness Accommodation Pathways (families and adults 22+)” https://www.bristol.gov.uk/housing/commissioning-homelessness-prevention-services.

12) Hosted Case Management System

In 2010 we commissioned Cybermedia Solutions Ltd to provide an integrated, multi-agency, caseload system (‘Theseus’) for the management of substance misuse clients across the city. There are over 20 agencies / teams registered on the system including non-ROADS and housing providers, and around 200 active Theseus users.

Our case management system allows practitioners to record details of their work with substance misuse clients and share this information securely with other providers and commissioners. The software also collates provider performance information for commissioners, and facilitates the reporting of all required data to Public Health England etc.

We feel it is important to maintain these functions and for BCC to remain the Data Owner. As our contract expires in 2017 we plan to recommission our hosted case management system and this interrelated procurement process will take place to ensure that the contract starts prior to the ROADS go live date.

6.3 Proposed Tendering Approach and Allocation of Resources

Contract	Proposed Contract Value	Proposed Purchasing Option
Specialist Nurse Provision (hospital based)	£260,000	Direct Award
Inpatient	£550,000	Direct Award
Residential Rehab	£680,000	Open Framework (Dynamic Purchasing System)
Early Engagement & Intervention	£1,000,000	Competitive Tender
Substance Misuse Liaison	£1,400,000	Competitive Tender
Primary Care Costs[4]	£2,100,000	Direct Award
Community Recovery Service	£1,450,000 (Preventing Homelessness to contribute additional £50,000 for peer support)	Competitive Tender
Complex Needs	£1,120,000	Competitive Tender
Families & Carers Support	£80,000 (South Glos & B&NES to make additional contributions)	Competitive Tender (regional)
Hosted Case Management System	£30,000[5]	Competitive

[4] This includes drug and alcohol public health services, pharmacy public health service and prescribing costs

		Tender
Substance Misuse Accommodation Pathway	£750,000	Co-Commission with Homelessness Team. Negotiate with current providers

For planning purposes the proposed competitive tender contract values have been calculated by considering the posts required to deliver the proposed functions and 40% on costs/management fees have been applied.

6.4 Evaluation Approach

The proposed evaluation criteria are 80% quality and 20% price. A panel will be formed to include a range of stakeholders and perspectives and the views of service users will form part of the evaluation. Details of the panel will be released in the tender documents.

Bids will be invited up to the contract ceiling, this amount is the maximum available for the contracts and bids must not exceed this figure unless the bidder brings in significant other resources.

There will be no inflationary uplift for the duration of the five year contract. Bidders are expected to factor in any increased costs into their proposals. Annual contract reviews will take place throughout the life of the contract and the financial position and changes will be considered as part of this.

[5] Based on current hosting and admin costs and excluding perpetual software license, migration and set up costs

In line with BCCs Social Value policy[6] providers must also consider how they can provide additional social value to Bristol. This could include, for example, tackling stigma of people who misuse substances, creating apprenticeships, using local contractors including those with social objectives. As a minimum 10% of the quality score will be related to adding social value. Bidders may wish to refer to the Social Value Toolkit[7] to consider how they could incorporate social value into their proposals.

Furthermore BCC aims to spend at least 25% of the Council's total procurement budget with micro, small and medium size businesses, social enterprises and voluntary / community organisations (less than 250 employees). Within this commissioning process we intend to encourage that at least 25% of the funding available in the competitively tendered contracts goes to micro, small and medium size businesses, social enterprises and voluntary / community organisations. This could be achieved through collaborative bids from providers working together in, for example, lead partner collaborations or sub-contracting arrangements.

Sub-contracting arrangements are welcomed with the expectation that the majority of the activity will be carried out by the main provider as opposed to being sub contracted out which makes the contract management convoluted. Where collaborative bids or sub-contracting arrangements are proposed details will need to be provided at the Invitation to Tender stage where the role(s) of the subcontractors/collaborators will need to be provided with the approximate percentage of contractual obligations assigned to the subcontractor/collaborators.

Part of BCC's procurement process requires an assessment of the financial risk of individual providers. Further detail is included in Appendix 6. As part of this assessment to be designated low risk it is advised that a provider's annual turnover should be one and a half times the contract value. It is also recommended that this financial assessment is based on the total of all the contracts the provider is bidding for i.e. if an organisation applies for several contracts their risk should be assessed on the combined contract values. The Joint Commissioning Group will decide what level of risk would be acceptable prior to contract award.

[6] https://www.bristol.gov.uk/documents/20182/239382/Social+Value+Policy+-+approved+March+2016-1.pdf/391b817b-55fc-40c3-8ea2-d3dfb07cc2a0

[7] https://www.bristol.gov.uk/documents/20182/239382/Creating+Social+Value+-+Social+Value+Toolkit+-+approved+March+2016-1.pdf/a596f490-ab73-4827-9274-5025ca5a4f1b

6.5 Contract Duration

In line with evidence presented by the Advisory Council on the Misuse of Drugs[8] in relation to reducing drug related deaths the intention is to provide more stability by entering into five year contracts with the option to extend for a further two periods of two years each i.e. potentially nine years in total. This has been strongly supported by professionals and service users throughout the consultation, particularly with reduced funding. Strong 'no fault' break clauses will be included and an annual review process will be established to manage funding fluctuations and changes in service users' needs during the contract period.

6.6 Performance Monitoring

The Local Authority is responsible for ensuring that appropriate quality governance is in place for commissioned services and it is measured by Pubic Health England on the achievement of the following national Public Health Outcomes Framework (PHOF) indicators:

- 2.15i - Successful completion of drug treatment - opiate users
- 2.15ii - Successful completion of drug treatment - non-opiate users
- 2.15iii - Successful completion of alcohol treatment
- 2.15iv - Deaths from drug misuse
- 2.16 - Adults with substance misuse treatment need who successfully engage in community-based structured treatment following release from prison

The newly commissioned treatment system will contribute towards meeting these outcomes, in conjunction with other partners (e.g. prisons), by providing high quality services. Key to this will be the treatment system's ability to deliver on the eight best practice outcomes outlined in the Government's current Drug Strategy (any changes to these in the upcoming Drug Strategy will be updated accordingly):

- Freedom from dependence on drugs or alcohol;
- Prevention of drug related deaths and blood borne viruses;
- A reduction in crime and re-offending;
- Sustained employment;
- The ability to access and sustain suitable accommodation;
- Improvement in mental and physical health and wellbeing;
- Improved relationships with family members, partners and friends; and

[8] Advisory Council on the Misuse of Drugs, Reducing Opioid-Related Deaths in the UK: December 2016

- The capacity to be an effective and caring parent.

In order to ensure ROADS services are delivered to the highest standards and achieve the best outcomes the Substance Misuse Team intends to implement a performance management framework based on the domains of Safety, Accessibility & Effectiveness, and Quality. All audits, performance measures and service user feedback will focus on these three strands.

1. Safety: Assurance mechanisms to monitor the safety of service delivery will include:
   - Safe prescribing of medication
   - Appropriate prescribing and dispensing
   - Safeguarding for children, young people and vulnerable adults
   - Adverse Incidents including drug related deaths

2. Accessibility and Effectiveness: Services will be monitored to demonstrate their ability to meet the needs of the population. Measures will include:
   - Waiting times
   - Service user retention rates
   - Successful completion rates
   - Representation rates

3. Quality: A programme of quality improvement activities will include:
   - Evidence based practice
   - Clinical audit
   - Continuing professional development
   - Research and development

In times of reducing resources, we recognise the need for outcomes of the treatment system to be both achievable and realistic. Therefore we propose:

1) To increase the use of standardised PHE outcome reports and tools (e.g. DOMES, NDTMS Reports) to measure the health of the treatment system. Bespoke local reports will be utilised to enable an immediate local focus on areas of interest to mitigate the time delay in PHE reporting processes.

2) That outcomes and key performance indicators will be developed and refined with the successful providers, as both part of the implementation period and formal contract review periods, to demonstrate the effectiveness of the contract.

6.7 Case Management System

Commissioned providers will be required to use BCC's commissioned substance misuse case management system and for client records to be accessible, where appropriate, across the treatment system. Please see Section 6.2 for more information about recommissioning of this case management system.

6.8 TUPE

Current and potential providers will need to be aware of the implications of both the Transfer of Undertakings (Protection of Employment) Regulations 2006 (TUPE) as well as the updated "Collective Redundancies and Transfer of Undertakings (Protection of Employment) (Amendment) Regulations 2014.

When a service activity transfers from one provider to another, the relevant employees delivering that service may transfer from the old to the new provider on the same contractual terms and conditions of employment. In these cases, the new provider/employer takes on all the liabilities arising from the original employment contracts.

Bidding providers will need to consider the cost and other implications of TUPE. The council will obtain from current providers basis information about the employees who will potentially be affected by this commissioning process. It is our intention to provide such information in advance of the 28 days (prior to contract start) required by current regulations so that bidders can develop accurate proposals and budgets. Providers must seek their own legal and employment advice on TUPE. It is the responsibility of bidders/ providers to satisfy themselves regarding TUPE requirements.

In future contracts, we intend to include requirements of the contract holder to provide workforce information at earlier stages.

7 Timeline

This is the timeline we intend to follow. Please note that dates below are subject to change through the life of the project.

- Sign off final commissioning strategy at Health & Wellbeing Board: 28th June 2017
- Publish final commissioning strategy: 6th July 2017
- Provider tender events: 14th July 2017
- Invitation to tender: 18th July 2017 – 25th August 2017
- Award decision: Week commencing 9th October 2017
- Contract award: Week commencing 23rd October 2017
- Contract start: Week commencing 1st December 2017
- Implementation period: 1st December 2017 – 1st March 2018

After contract award time is needed for implementation to enable the safe transfer of clients and for staff organisation. An implementation budget has been established to factor in an overlap between incoming and outgoing provider.

As previously stated an implementation period has also been budgeted for.

Appendix 1: Glossary

ACMD – Advisory Council on the Misuse of Drugs

ARA – Addiction Recovery Agency

B&NES – Bath and North East Somerset

BCC – Bristol City Council

BDP – Bristol Drugs Project

BSDAS – Bristol Specialist Drug and Alcohol Service

CCG – Clinical Commissioning Group

DHI – Developing Health and Independence

DOMES – Diagnostic Outcome Measurement Executive Summary

IPED – Image and Performance Enhancing Drug

NDTMS – National Drug Treatment Monitoring System

NHS – National Health Service

NICE – The National Institute for Health and Care Excellence

NSP - Needle and Syringe Provision

OST – Opiate Substitution Therapy

PHE – Public Health England

PHOF - Public Health Outcomes Framework

ROADS – Recovery Orientated Alcohol and Drug Service

SML – Substance Misuse Liaison

SMT – Substance Misuse Team

UKPDC - UK Drug Policy Commission

VCS – Voluntary and Community Sector

Appendix 2: Definitions

Substance Misuse Definition

Substance misuse is defined by the World Health Organisation as: "…the harmful or hazardous use of psychoactive substances, including alcohol and illicit drugs … [which] can lead to dependence syndrome." Throughout this strategy where the term 'substance' is used, it is referring to both drugs and alcohol.

Recovery Definition

The Substance Misuse Team have adopted the UK Drug Policy Commission (UKDPC) definition of recovery which explains "the process of recovery from problematic substance use as characterised by voluntarily-sustained control over substance use which maximises health and wellbeing and participation in the rights, roles and responsibilities of society" (UKDPC, 2008).

Commissioning Definition

The Institute of Public Care (IPC) defines commissioning as the "process of identifying needs within the population and of developing policy directions, service models and the market, to meet those needs in the most appropriate and cost effective way". Each year Bristol City Council commissions or procures approximately £360 million (14/15) worth of goods, services and works. Commissioning and procurement are a vital area of the Council's operations.

Procurement Definition

The National Procurement Strategy for Local Government defines procurement as "the process of acquiring, goods, works and services, covering both acquisition from third parties and inhouse providers. The process spans the whole cycle from identification of needs through to the end of a services contract or the end of the useful life of an asset. It involves options appraisal and the critical 'make or buy' decision which may result in the provision of services in-house in appropriate circumstances".

Appendix 3: Legal Context and National Policy

Health and Social Care Act (2012) describes the local authorities' statutory responsibilities for public health services which conferred new duties on local authorities to improve public health. It abolished primary care trusts and transferred much of their responsibility for public health to local authorities from 1 April 2013. From this date local authorities have had a duty to take such steps as they consider appropriate to plan for improving the health of the people in their areas, including services to address drug or alcohol misuse.

The Care Act (2014) aims to improve people's quality of life, delay and reduce the need for care, ensure positive care experiences and safeguard adults from harm.

Local authorities are required to consider the physical, mental and emotional wellbeing of the individual needing care, and assess the needs of carers. They must ensure the provision of preventative services and carry out their care and support functions with the aim of integrating services with those provided by the NHS or other health-related services.

The EU Public Contracts Directive (2014) sets out the legal framework for public procurement. This directive includes the procedures which must be followed before awarding a contract to suppliers, where the contract value exceeds the thresholds set, except where specific exclusions apply. The fundamental principles of the EU Treaty are: free movement; non-discrimination; fairness; transparency and proportionality.

Public Services (Social Value) Act 2012 requires all public bodies in England and Wales to consider how the services they commission and procure might improve the economic, social and environmental wellbeing of the area. To comply with the Act commissioners must think about how what they are going to buy, or how they are going to buy it could address these benefits, and must also consider whether they should consult on these issues.

The Local Government Act (2000) provides a general duty of best value to make arrangements to secure continuous improvement in the way in which its functions are exercised, having regard to a combination of economy, efficiency and effectiveness.

Equality Act (2010) requires that when carrying out commissioning/procurement activity public bodies have regard to the: elimination of discrimination, harassment, victimisation and other analogous conduct; advancement of equality of opportunity between those who share protected characteristics and those who do not; and fostering of good relationships between those who share protected characteristics and those who do not.

National Drug Strategy (TBC) It is anticipated that a new National Drug Strategy will be published around the end of the calendar year of 2016 by the Home Office. Early indications suggest that it will build on and strengthen the approaches taken in the National Drug Strategy 2012 to reduce demand, restrict supply and build recovery. Any guidance and recommendations included in this document will be considered alongside local need in the development of the final Commissioning Intentions document:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/98026/drug-strategy-2010.pdf

National Alcohol Strategy (2012) intended to change attitudes towards alcohol and reshape the approach towards tackling alcohol related harm. In terms of dependant drinkers, it aimed to increase the number accessing effective treatment in order to reduce the number alcohol related admissions and to reduce NHS costs.

Modern Crime Prevention Strategy (2016) sets out how to reduce drug-related crime prevention by focusing on three areas: treatment; diversion; and enforcement. It recognises that getting users into treatment is key, as being in treatment itself reduces levels of offending. It advocates for full recovery from dependence being the aim of treatment and that this is more likely to be achieved and sustained if users are given support to improve their 'recovery capital' – particularly around housing and meaningful employment. For a small cohort of entrenched, long-term opiate users who have not achieved recovery through optimised oral substitution treatment, there is evidence that heroin assisted treatment (supervised injectable heroin) reduces crime.

The National Compact (2010) is an agreement between the government and the voluntary and community sector (VCS) which sets out a way of working that improves their relationship for mutual advantage. It considers areas such as involvement in policy design, service design and delivery, funding arrangements, promoting equality and strengthening independence. Bristol City Council is fully committed to the Compact and elements of the Bristol Compact are integrated into this commissioning process.

Appendix 4: Recommendations from Substance Misuse Needs Assessment 2016

Physical Health

1. Continue to support the provision of naloxone.

2. Continue to support the police/coroner coordination to ensure that timely analysis of deaths and changes in trends inform treatment delivery.

3. Increase strategic priority for delivery of health protection and harm reduction interventions (including optimised doses and maintenance prescribing in line with PHE/ACMD advice) within structured treatment and opiate substitution therapy (OST).

4. Clear governance structures are needed to ensure auditability of key interventions (naloxone supply, optimised prescribing, etc.).

5. Request a full, public health led, health needs assessment, including matching of health/hospital records, of the opiate and crack using cohort

6. Consider the retention of primary care based provision of OST to ensure easy access to healthcare and to reduce burden on secondary health care, particularly Emergency Departments.

7. Continue to support homeless health services.

8. Retain a hospital based service to provide support to drug and alcohol users who are admitted to wards.

9. Continue to support a maternity service for pregnant substance misusing women and their partners. Investigate effectiveness and efficiency of various delivery options to maximise outcomes for both drug and alcohol users.

10. Continue to support needle and syringe provision to be delivered within NICE guidance. Investigate effectiveness and efficiency of various delivery options to maximise outcomes.

11. Ensure chemsex/slamsex participants and IPED are included in priority groups for targeting interventions.

12. Continue to support hepatitis specialist clinical leadership within treatment services.

13. Continue to support dry bloodspot testing– including HCV, HBV and HIV.

14. Explore ways of increasing opportunistic availability of HBV vaccinations throughout the treatment system.

15. Ensure HBV vaccinations are included in GP contract as a priority intervention and that data is recorded and shared appropriately.

16. Continue to work with PH colleagues to improve access to HCV treatment for clients.

17. Explore opportunity with sexual health commissioners of co-commissioning accessible services for MSM/LGBT clients with focus around chemsex/slamsex.

18. Continue to support hospital based alcohol liaison work.

19. Continue to support homeless alcohol services.

20. Ensure investment enables the provision and uptake of evidence-based specialist treatment for at least 15% of estimated dependent drinkers in line with DH guidance.

21. Ensure capacity allows comprehensive assessments for all individuals scoring 16 and over on Alcohol Use Disorders and Identification Test (AUDIT).

Mental Health

22. Explore opportunities for increased joint working with the CCG (BMH Commissioners) to develop more effective service provision for dual diagnosis clients going forward. There is a need here to focus on how to work with substance misusers with less severe MH needs.

23. Improved data monitoring is required to understand the needs of dual diagnosis in Bristol. Further work is required as to how we can demonstrate good outcomes for this cohort in order to build these in to future service specifications.

24. There needs to be further consideration regarding the offer of services for dual diagnosis clients when presenting in primary care to ensure that their needs are being best met.

25. Explore opportunities for co-location of staff to improve joint working and improve outcomes for dual diagnosis clients.

26. Explore opportunities for joint referral meetings between SM and MH services to improve joint recovery care planning.

27. Explore how feasible it is for social prescribing services to work with substance misuse clients with low level mental health needs and link with commissioners.

28. There is a need for improved workforce development for both substance misuse and mental health professionals around dual diagnosis issues. This needs to encourage confidence of when to refer between services and how to manage levels of risk appropriately.

29. Increase the strategic priority of dual diagnosis across SM and MH by holding 6 monthly dual diagnosis workshops with key stakeholders.

Housing

30. Consider the possibility of having an outreach team for engaging substance misusing people into community treatment.

31. Co-locate SM professionals in Level 1 hostels to engage potential clients

32. Deliver a training package to preventing homelessness staff/staff in frontline services receiving prison leavers, such as hostels and homeless health services, in Spice use, it’s effects and treatment options.

33. Explore the potential for co-commissioning substance misuse housing with Preventing Homelessness services to benefit from economies of scale, fewer contracts and better pathways.

34. Further work with the Preventing Homelessness is required to explore the increases in homelessness in Bristol.

35. Work with BCC colleagues to understand whether substance misuse is a factor in evictions as well as whether substance misuse is a refusal reason for housing providers in the Preventing Homelessness pathway.

36. Consider increasing Preparation housing units to respond to levels of demand.

Relationships

37. Safeguarding children is paramount and remains a key priority within substance misuse services.

38. Review what happens when children who have been exposed to parental substance misuse are taken into care.

39. Continue to link with the commissioners of young people’s substance misuse services and the Drugs and Young People project to meet the needs of children effected by parental substance misuse.

40. Maintain close working with young people’s treatment services to ensure a smooth transition for young people moving from young peoples into adult treatment.

41. Work closely with young people's services to identify young adults coming into treatment who are unknown to young people's services. This will identify gaps and strengthen prevention and harm reduction

42. There is a continued need to support clients to be good parents and to address the stigma that parents face as this could continue to prevent vulnerable clients accessing appropriate services.

43. The Think family/Early Help overlap with substance misuse services should be reviewed. All practitioners need a clearer view of the support clients are receiving to ensure services can work together effectively.

44. Work with colleagues in Children and Family Services to ascertain whether the following challenges that have been identified in research are in issue in Bristol. For professionals working with families where substance misuse is a factor the barriers presented were: engagement, conflicting agency focus, inter-agency communication, conflicting assessment needs, children having significant needs but remaining largely invisible.

45. Review the substance misuse knowledge/skills of those practitioners who are the main contact with families to meet the parents and children's needs. This needs to consider drug and alcohol awareness.

46. Further work is needed to map out how information sharing does/does not take place when working with families who have substance misuse issues.

47. Treatment services have a relationship with over 100 suspected domestic violence perpetrators and could be well placed to address the issues that contribute to the cycle of abuse.

48. Victims of domestic violence and abuse may also benefit from targeted support.

49. The combined impact of domestic violence, substance misuse and mental health is recognized. The services offered to these vulnerable individuals need to be sufficiently resourced. Learning from the Golden Key initiative will be critical in informing the approach.

50. Peer support offers considerable benefits to both the peers and those receiving their support. This should be considered as a fundamental part of a treatment system.

51. The availability of peer supporters does need consideration to ensure plans are realistic.

52. Explore the possibility of co-commissioning peer support with other commissioners in recognition of the fact that people using drugs and alcohol are likely to experience a number of issues.

53. It is important to continue to support those who are caring for friends/family members with substance misuse issues. Commissioners could consider whether on line support would be viable for carers services and the role that peer support could play within carers and family services.

54. Explore the opportunity for joint commissioning carers and family services with substance misuse commissioners from neighbouring authorities.

Training, Education, Volunteering and Employment

55. Opportunities for training, education, volunteering and employment are a critical part of recovery and the specific challenges that substance misuse presents need to be catered for either in specific TEVE services or within wider TEVE provision.

56. Communication between all relevant agencies including commissioners, JCP and WP should be written into protocols which are acted upon and included in performance management of agencies.

57. Consider a one stop shop so that clients who are more chaotic and have more difficulty accessing training can be engaged in TEVE services and other training opportunities across the city.

58. Continue close working relationships with VOSCURs Sustain Programme.

59. Explore joint working opportunities to address the stigma faced by former drug users from potential employers, relating to previous drug use and criminal history.

Criminal Justice

60. As a result of the new licensing arrangements as directed by the Transforming Rehabilitation Act, there is a need for clear working protocols and information sharing agreements between treatment providers and the National Probation Service and the Bristol Gloucestershire Wiltshire and Somerset Community Rehabilitation Company in order to ensure that the needs of service users’ substance misuse needs are met.

61. Commissioners of SM treatment within HMP Bristol to ensure that referrals to existing psychosocial services as well as substitution therapies are offered to clients. Pathways to OST are good, whereas fewer people attend psychosocial services.

62. Commissioners of AIRS and ROADS to develop a joint working protocol to better meet the needs of clients leaving the custody suites. Consider an in-reach services by ROADS or a peer led meet and greet service in custody.

63. Targeted work by ROADS for AIRS clients already in treatment.

64. There should be guaranteed and immediate ongoing substitute prescribing for people returning to Bristol from custody, including locally, regionally and nationally.

65. Further explore how Substance Misuse services and Streetwise teams can work better together.

Appendix 5: Stakeholder Engagement - Main Themes/Findings

Below is a summary of key messages from the Stakeholder Engagement feedback:

Advocacy: People need access to advocacy to help them understand and assert their rights regarding treatment and challenge referral criteria – both within ROADS and for other services e.g. mental health. Tackling stigma and discrimination should be the responsibility of all ROADS services.

Assessment: Have a single integrated assessment process which is shared with relevant professionals across the treatment system and with relevant partners to avoid duplication. Assessment should lead to clear referral pathways. Medical assessment should allow GPs to refer people to ROADS depending on their level of complexity.

Commissioning and procurement: A small number of contracts are appropriate, rather than one big contract, or many small contracts. Several ROADS functions are cross-cutting and need to be shared across more than one Lot / Provider. As the commissioning cycle will be longer, allocate funding for small grants in response to emerging trends and challenges.

Communication: We need clearer information about what ROADS services are and how to access them, including treatment pathways and referral criteria.

Community Alcohol Detox Pathway: The Local Enhanced Service has to be reworked and we need to ensure that capacity can meet demand. Community detox should only be offered with aftercare in place. We need to consider provision for people who have physical health complexities.

Community Opiate Detox Pathway: Detox needs to be supported by relapse prevention – consider a group work element alongside this service. Co-deliver with pain management service where required.

Community Opiate Maintenance Pathway: Recognise the value of medication in recovery where clinically appropriate. GPs may not have the capacity to hold maintenance clients who have increased risk. Improve the identification of potential maintenance clients to free up capacity. Proactively offer other interventions as appropriate.

Families and carer support (regional): A joint regional service will need to have a strong local offer with good links to community organisations and area based support. Having a digital component would increase accessibility.

GP Local Enhanced Contract (drug and alcohol): Use the same model for alcohol as for OST[9] shared care and integrate where possible, but consider the feasibility and capacity of GP practices. Be aware of other key elements that may impact e.g. Rapid Prescribing. There will need to be extra support for people with complex needs. We should examine need at a locality level if not offering the alcohol service in every surgery.

Harm reduction and healthcare: Have pathways for key health needs including BBV[10], pain management and liver disease. Promote the use of Naloxone. Needle and syringe provision should be accessible out of hours and in a range of ways including static, detached and via pharmacies. Make sure needle exchange service is appropriate for people who inject image and performance enhancing drugs.

Homeless substance misuse provision: GP led drop in sessions, supervised methadone and resettlement and wet clinic are highly valued. Homeless people often have complex needs and a history of trauma so the service needs to be person centred as well as addressing physical needs.

Hospital Liaison: Need to work across hospital and community. Consider if this could be done with a rapid prescribing model rather than in all hospitals. Some clients avoid hospital admission for fear of being abruptly detoxed.

Hosted Case Management System In November 2016 we asked current Theseus users in Bristol to give us their views on the existing case management software via an online survey. We had 86 responses – mostly from practitioner / client facing staff, and also from managers and administrators who use the system. 96% of respondents told us that is was 'absolutely essential' or 'very important' for all ROADS services to share the same case management system. They also told us that 'avoiding disruption' and 'performance' should be our most important priorities when recommissioning a case management system.

Maternity substance misuse provision – midwife: This should always be a high priority as the service is effective at reducing risk and keeping service users engaged and on script. It might be better to have a Bristol wide service with a midwife based at St Michael's Hospital as a centre of excellence.

Non community detox pathway – residential and inpatient: Provides a higher level of safety for people with complex needs and can address physical health problems. Inpatient admission is needed for some people with high risk in order to access residential rehab e.g. sex workers and pregnant women. Both local and single sex provision are required.

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[9] Opiate substitute prescribing

[10] Blood borne viruses e.g. Hepatitis and H.I.V.

Peer support: Peer support plays a pivotal role in supporting recovery. All providers should be accountable for facilitating peer placements and overcoming barriers. Having peer support as a separate service from treatment providers can lead to a greater emphasis on peer supporter's needs.

Pharmacy local enhanced contract: Pharmacies are the main point of contact for some people on scripts, so increase liaison with shared care workers as appropriate. Ensure supervised OST is available during all pharmacy opening hours for people with daytime commitments.

Preparation and In-Treatment Housing: More prep housing is urgently needed. If housing comes out of the ROADS contract we need to ensure good communication across agencies including training and information sharing. Can non-ROADS floating support services support tenants using drugs and alcohol to maintain their tenancy?

Psychiatric led complex needs provision: This would deliver improvements to joint working with mental health services. A consultant led service is important for diagnosis and mental health reviews to support treatment and referrals. Requires a community presence and links into outreach and street based working. There may be a gap in provision for people with 'medium level' mental health needs because of rising thresholds to accessing mental health services.

Rapid access to prescribing for vulnerable groups: The service is working well, but needs to be very accessible and flexible as many people with complex needs struggle with appointments. There should be a service for street sex workers with links to One25.

Recovery planning: We need more joined-up care planning with an aftercare plan that includes relevant services outside ROADS.

Relapse Prevention / Aftercare: There needs to be capacity to offer relapse prevention support for every detox. Providers can promote training, education, volunteering and employment opportunities by having strong links with community organisations. All services are responsible for facilitating access to mutual aid e.g. SMART Recovery/12 step fellowships.

Residential Rehab: We should have a quick and straightforward process for accessing residential rehab for those that need it. Preparation sessions are beneficial when they focus on increasing motivation and commitment. People leaving residential rehab require a clear aftercare plan including appropriate housing.

Social value: Providers can demonstrate added value through having strong links with local community organisations. Providers are likely to have a preventative role reducing the citywide need for social care, policing etc. Social value can be direct and indirect - influencing emotional wellbeing, reducing social isolation etc.

Structured psychosocial interventions (including clinically led interventions): One-to-one support is needed because not everyone is group-ready. Interventions should be linked to level of need and there should be a wide range of evidence based interventions offered e.g. CBT, Contingency Management, Behavioural Couples Therapy, DBT and Motivational Interviewing. Appoint clinical leads to deliver / supervise interventions. Encourage the use of technology e.g. web-chat to deliver interventions.

Substance Misuse (Alcohol and Drug) Liaison: Workers need to have realistic caseloads, with client complexity and levels of need linked to intensity and duration of treatment. This includes structured psychosocial interventions.

Workforce development: Have a workforce development and training function within ROADS to share skills and increase understanding of substance misuse for outside organisations including generic ETE[11], volunteering and Floating Support services.

[11] Education, Training and Employment

Appendix 6: Financial Standing Appraisal

The Financial Information provided will be used by the Authority to assess whether the bidders possess the necessary economic and financial capacity to perform the contract.

When undertaking the assessment the Authority looks at the bidders most recent financial statements along with those of any ultimate parent company (if appropriate). These would be checked for general audit issues and then analysed to give an indication of profitability, net worth, liquidity, capacity and general stability.

The Authority reserves the right to use a variety of indicators as it considers appropriate including those from credit agencies. The Authority will also consider any additional information submitted by the applicant should the applicant consider this necessary for the Authority to have a fuller understanding of its financial position. This may be appropriate, for example, to obtain a fuller understanding of an applicant's financial structure or funding arrangements. The Authority would expect any such information to be verified by an independent source, for example, the applicant's auditors. Furthermore the Authority may (but is under no obligation) request further information or explanation from a bidder

Initially basic checks are made on a bidder's name and any relevant registration details (e.g. registered number at Companies House). The Authority would check whether the bidder is trading or dormant and whether it has a parent company. The status of the financial statements is also determined to check whether information submitted is for the last accounting period.

When considering profitability the Authority looks at whether the organisation has made a profit or a loss in the year, which indicates the efficiency of the organisation. A loss in the year would be looked at in conjunction with the balance sheet resources available to cover this loss.

The Authority would look at the bidder's balance sheet and determine the net worth of the organisation and that element that can be mobilised in a financial crisis. To do this the Authority looks at net assets and also at the net tangible worth (excluding intangible assets) of the organisation.

When looking at liquidity the Authority uses the current ratio and the acid test ratio. The current ratio is a measure of financial strength and addresses the question of whether the bidder has enough current assets to meet the payment schedule of its current debts with a margin of safety for possible losses in current assets. The Acid Test ratio measures liquidity and excludes stock to just really include liquid assets. Generally the Authority would expect a bidder to have a current ratio of at least 1:1.

Contract limit is the size of contract that is considered ‘safe’ to award to a bidder, based on a simple comparison of the estimated annual contract value to the annual turnover of the organisation. This gives an idea of financial strength to ensure that the bidder can cope financially with this size of contract. The Authority assesses the capacity issue of whether the bidder has the resources to carry out the work and also considers whether the bidder will become over-dependant on the contract in question. Generally the Authority would expect a bidder to have a turnover of 1.5 times the annual contract value. It is also acknowledged that the Authority may use its discretion in the application of the contract to turnover ratio.

The Authority would consider <u>all</u> of the above in relation to the bidder and that of any ultimate parent company and then a judgement would be made as to the risk that the organisation would represent to the Authority. If the Authority decides that the financial and economic standing of the bidder represents an unacceptable risk to the Authority then the bidder will be excluded from further consideration in this process.

Appendix 7: Equalities Impact Assessment

Step 1: What is the proposal?

1.1 What is the proposal?

The substance misuse team is currently developing the commissioning strategy for the tendering opportunity for adult substance misuse services (ROADS).

The budget for ROADS contracts is £8.7million and a further £750k has been allocated to the Preventing Homelessness commissioning exercise (for which a separate EqIA is being conducted). This is a 10% reduction on the 2016/17 budget, which itself contained a 10% reduction from the 2014/15 allocation received from Public Health.

Following a series of stakeholder engagement events, a proposed model for the new treatment system has been developed to enable BCC to procure the necessary services. 11 contracts are proposed to be awarded to respond to the recommendations from the Substance Misuse Needs Assessment [BCC, 2016]:

- Specialist Nursing Provision
- Inpatient detox
- Residential rehab provision
- Complex Needs
- Community Recovery Service
- Substance Misuse Liaison (shared care)
- GP Public Health Service contract for opiate substitution therapy
- GP Public Health Service contract for community alcohol detox
- GP Public Health Service contract for supervised consumption
- Early Engagement & Intervention
- Regional Families and Carers Support (co-commissioned with B&NES and South Glos Councils)

The newly configured ROADS system will be aimed at engaging people with support needs around the use of alcohol, opiates and non-opiate drug groups. The current government Drug Strategy sets out 8 best practice outcomes which all substance misuse treatment services should work towards achieving:

- Freedom from dependence on drugs or alcohol;
- Prevention of drug related deaths and blood borne viruses;
- A reduction in crime and re-offending;
- Sustained employment;
- The ability to access and sustain suitable accommodation;
- Improvement in mental and physical health and wellbeing;
- Improved relationships with family members, partners and friends; and
- The capacity to be an effective and caring parent

The government are due to publish a new drug strategy in early 2017 and we await to see if there is a change in the outcomes which are expected to be met, although information received thus far points towards the new strategy being broadly in line with that currently in place.

Step 2: What information do we have?

2.1 What data or evidence is there which tells us who is, or could be affected?

According to the Public Health England Value for Money calculation every £1 spent on substance misuse in Bristol will derive £2.50 of benefit in terms of crime reduction and increased health and wellbeing. This benefit is above the national average of £2.

The reduction in funds available to procure substance misuse services has potential to lead to additional costs for criminal justice and the health system as there is the potential for less effective mitigation of offending behaviours and harms associated with drug and alcohol use.

The “Bristol ROADS Workforce Diversity –Training Needs Analysis 2015-16” [Diversity Trust, May 2016] identified that ROADS providers have approximately 200 members of staff working as part of individual contracts or across lots (excluding volunteers).

As the largest proportion of spend within ROADS contracts is staffing costs, the reduction in budget is likely to result in either decreased pay rates to sustain current employee levels or a smaller workforce.

The needs analysis identified the following demographics of the workforce:

Gender

- 72% (n=99) Female
- 25.5% (n=35) Male

Sexual orientation:

- 6.5% (n=9) staff were Lesbian, Gay or Bisexual (LGB).
- 84.7% (n=116) staff identified as Heterosexual.
- 8.8% (n=12) answered ‘prefer not to say’.

Ethnicity

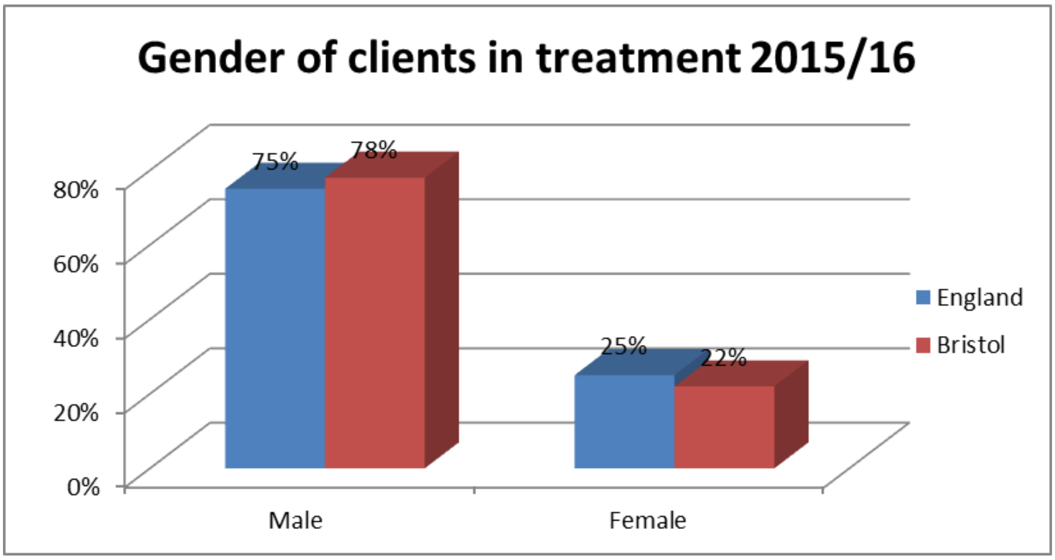
- 18% BME
- 78% White British
- 4% Prefer not to say

Disability

- 76% (n=108) individuals do not identify as being a disabled person
- 22% (n=32) individuals identified as disabled people
- 2% (n=3) of individuals prefer not to say

The recently published National Drug Treatment Monitoring System (NDTMS) Treatment Bulls Eye Data for England reports on demographics and key characteristics (such as proportion of people injecting) of people accessing treatment in 2015/16.

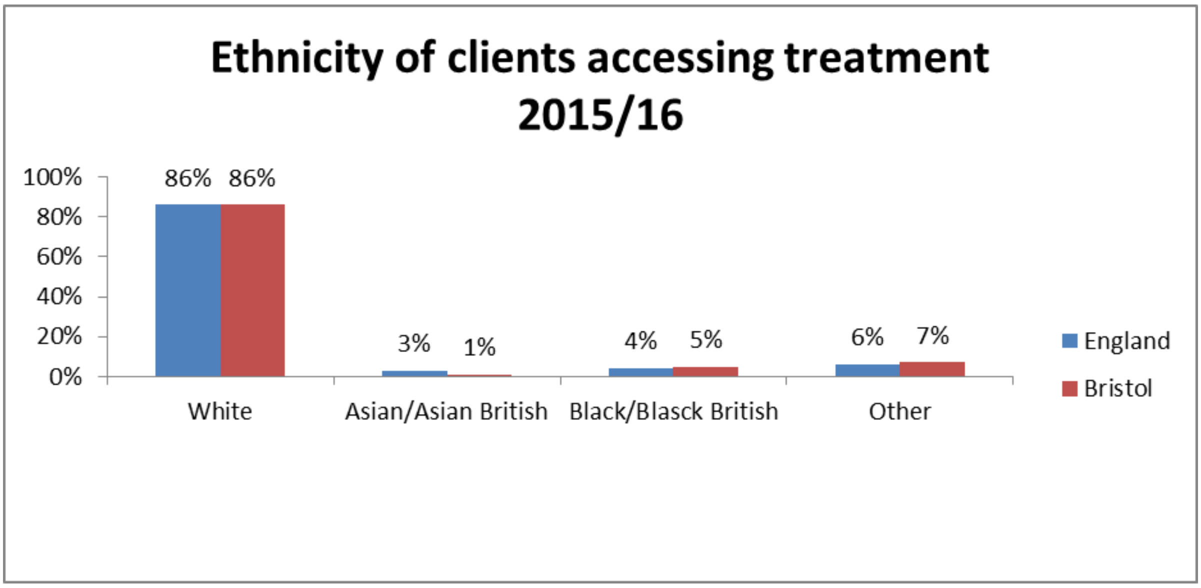
The gender split for people accessing treatment in England is reported as being 75% Male and 25% female. Bulls Eye data for Bristol shows a greater proportion of male clients (78%) to female (22%).



Bristol's gender proportions may indicate that currently treatment is not perceived as accessible for females in Bristol.

86% of clients in treatment in England in 2015/16 identified as White; 3% Asian or Asian British; 4% Black or Black British; and 6% Other.

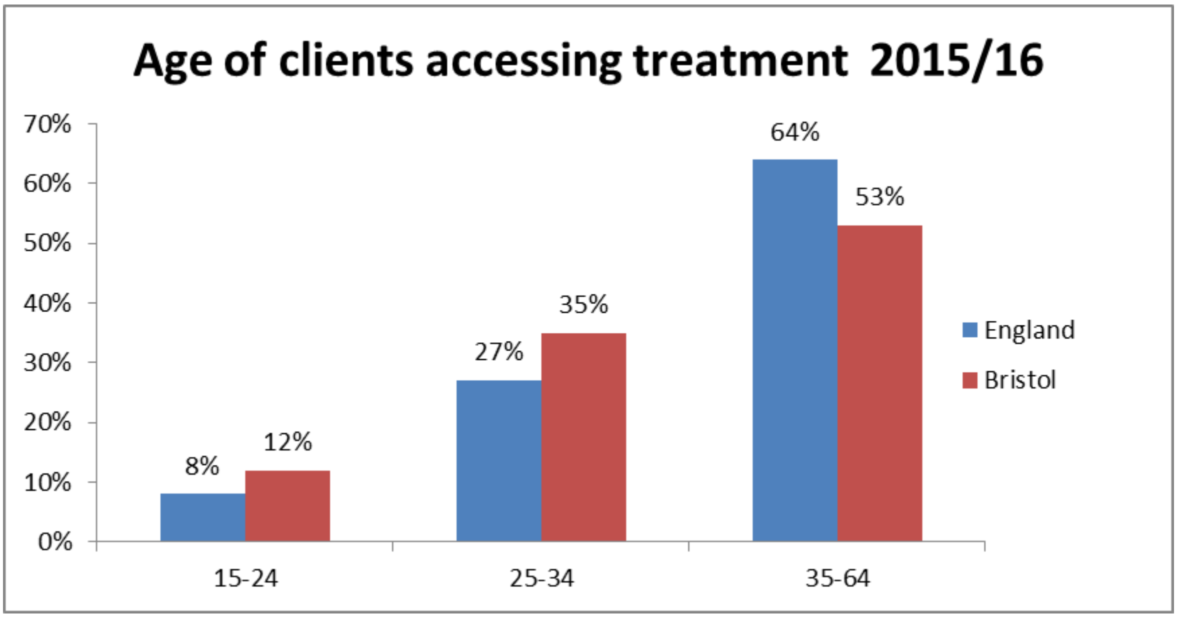
In Bristol 86% identified as White; 1% as Asian or Asian British; 5% as Black or Black British; and 7% as Other. Whilst this is broadly in line with the England representation this is significantly below the BME proportion of Bristol's population of 16% (2011 census data).



Substance misuse levels are not estimated as equal within differing ethnic groups, with White British and people of dual heritage (reported within "Other" above) suffering the highest levels. The "Prevalence of Drug Use Among BME Communities in Bristol" report [Safer Bristol, 2012] identified the following real and perceived barriers to treatment:

- Lack of trust in the cultural competence of drug services
- Low level of confidence in drug service from the BME communities
- Stigma surrounding drug use if the users from these groups attempt to access drug services
- Taboo on discussing drug use
- Fear that disclosing drug use would negatively affect immigration status. (It was a commonly held belief that drug services work with law enforcement and immigration agencies, and that contact with drug services would lead to deportation, suggesting a high level of discomfort at the thought of using statutory services.)
- Waiting time is often reported as a key barrier to accessing services.

In England 8% of people in treatment were aged 15-24; 27% 25-34 and 64% 35-64. Bristol's proportions were 12% were aged 15-24; 35% were 24-34; and 53% 35+. The smaller representation of younger clients in Bristol is primarily due to the focus on engaging opiate and alcohol users in treatment. These groups have an older profile compared to non-opiate drug users who tend to be younger.



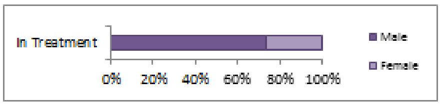
Due to the historic collection of the data we are able to produce performance reports on the successful completion of treatment by gender and ethnicity to identify whether there is equality of outcomes for the relevant groups.

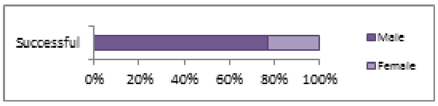
Male opiate clients have significantly better outcomes, measured against 2.15i of the PHOF Outcome Framework, than their female counterparts (7.1% and 5.8% respectively).

2.15i Number of users of opiates that left drug treatment successfully (free of drug(s) of dependence) who do not then re-present to treatment again within 6 months as a percentage of the total number of opiate users in treatment.

Completion period: 01-Apr-2015 to 31-Mar-2016
Representations up to: 30-Sep-2016

	Male: Successful / In treatment	Male: Percentage	Female: Successful / In treatment	Female: Percentage
Successful target 244	142 / 2008	7.1%	42 / 728	5.8%



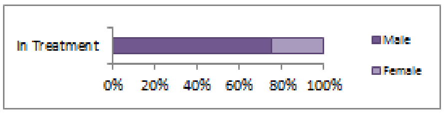


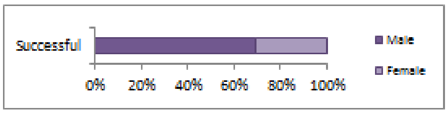
Female non-opiate clients have significantly better outcomes, measured against 2.15ii of the PHOF Outcome Framework, than their male counterparts (42.9% and 28.1% respectively).

2.15ii

Number of users of non-opiates that left drug treatment successfully (free of drug(s) of dependence) who do not then re-present to treatment again within 6 months as a percentage of the total number of non-opiate users in treatment.

	Male		Female	
	Successful / In treatment	Percentage	Successful / In treatment	Percentage
Successful target 322	82 / 292	28.1%	42 / 98	42.9%





Female and male alcohol clients have similar outcomes (27% and 27.9% respectively) for the proportion of clients in treatment who successfully complete alcohol treatment.

Successful Completions as a proportion of all in treatment (rolling 12 months)

Latest completion period: 01-Apr-2015 to 31-Mar-2016

	Male		Female	
	Completions/In treatment	Percentage	Completions/In treatment	Percentage
2.9 Alcohol: Target 368	201 / 720	27.9%	92 / 342	27%

BME clients have significantly poorer outcomes across all drug groups compared to their White British and White Irish counterparts. BME opiate clients are 2.2% and 6% below the outcomes for White British and White Irish/Other respectively; 15.7% and 22% poorer for non-opiate clients; and 5.6% and 9.6% poorer for alcohol.

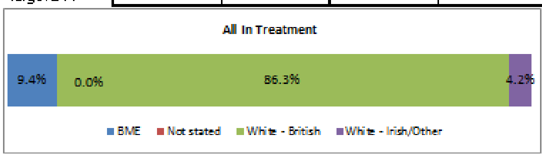
Public Health Outcome Framework

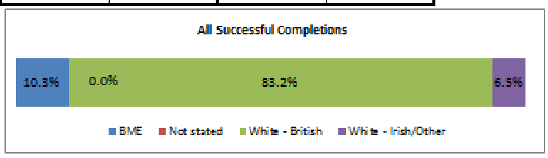
2.15i

Number of users of opiates that left drug treatment successfully (free of drug(s) of dependence) who do not then re-present to treatment again within 6 months as a percentage of the total number of opiate users in treatment.

Completion period: 01-Apr-2015 to 31-Mar-2016
Representations up to: 30-Sep-2016

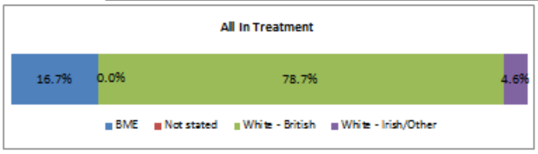
	BME		Not stated		White - British		White - Irish/Other	
	Successful / In treatment	Percentage	Successful / In treatment	Percentage	Successful / In treatment	Percentage	Successful / In treatment	Percentage
Successful target 244	11 / 257	4.3%	0 / 1	0.0%	153 / 2362	6.5%	12 / 116	10.3%

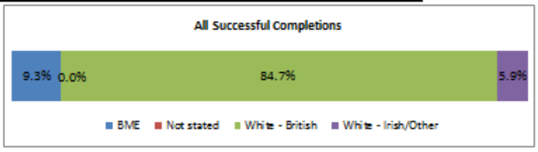




2.15ii Number of users of non-opiates that left drug treatment successfully (free of drug(s) of dependence) who do not then re-present to treatment again within 6 months as a percentage of the total number of non-opiate users in treatment.

	BME		Not stated		White - British		White - Irish/Other	
	Successful / In treatment	Percentage	Successful / In treatment	Percentage	Successful / In treatment	Percentage	Successful / In treatment	Percentage
Successful target 322	11 / 65	16.9%	0	0.0%	100 / 307	32.6%	7 / 18	38.9%





Alcohol: Target 368	Completions/ In treatment	Percentage	Completions/ In treatment	Percentage	Completions/ In treatment	Percentage	Completions/ In treatment	Percentage
	19 / 85	22.4%	1 / 3	33%	245 / 886	28%	28 / 88	32%

2.2 Who is missing? Are there any gaps in the data?

ROADS providers are mandated to complete monthly returns to NDTMS which collects, collates and analyses information from and for those involved in the drug treatment sector. Public Health England and Local Authorities use this data to monitor the performance of the treatment systems against local and national targets.

Much of the data collected around client demographics/protected characteristics by treatment services are part of the dataset and so is collected in the fields stipulated by NDTMS.

Data on gender, age and ethnicity have been a consistent part of the dataset for many years but reliable information for sexuality, gender reassignment, disability and religion have only been collected since changes to the dataset were introduced in April 2016. This significantly impacts on our ability to understand the treatment profile and successful completion rate for these groups, either due the data not containing enough entries due to clients preferring not to answer given the nomenclature of options (e.g. sexuality recorded as being homosexual rather than lesbian, gay or bisexual) or the to the data not being collected at all (e.g. religion).

Work is currently underway nationally to update the treatment records of all clients in treatment in England to ensure their data is in line with the newly introduced nomenclature although this will not be completed in time to inform this EqIA.

Recognising the absence of reliable data the Diversity Trust was commissioned by ROADS providers in 2015 to publish the “Lesbian, Gay, Bisexual and Trans Research Report”. The report included the following key findings:

- Higher levels of health risk behaviours, such as alcohol misuse, substance misuse and smoking.
- LGB and Trans people are less likely to engage with generic interventions and services.
- LGB and Trans communities have higher levels of need for interventions and targeted support.

- LGB and Trans communities are more likely to experience health inequalities in relation to public health areas and preventing premature mortality.
- LGB people demonstrate a higher likelihood of being substance dependent, dependence is highest amongst gay men and bisexual men and women.
- 24% of Trans people have used drugs within the last 12 months.
- 10% of trans people indicated signs of severe drug abuse using the Drug Abuse Screening Test.
- LGB and Trans people may have different patterns of substance use.
- LGB and Trans substance users may use a wider range of illicit drugs not recorded in the British Crime Survey.

The report states that a lack of cultural competence of support agencies means LGB and Trans people believe generic services aren't appropriate for them and concludes:

- Many LGB and / or Trans people report feeling 'invisible', therefore access to services is often framed by a general lack of awareness or understanding either about gender identity and / or sexual orientation.

- Depending on issues such as attachment to LGB and Trans communities, being "out" in the environment, being resilient when accessing services will all depend on how LGB and / or Trans people feel when accessing support.

- "*The most disadvantaged sections of the LGBT community will always need LGBT-specific services that link them to the LGBT community. The more affluent, self-assured, LGBT people may not require LGBT services at all."*
- (Joe Lavelle, Projects Coordinator, OUTreach Liverpool / North Liverpool CAB)

The report goes on to make following recommendations for commissioners:

- The Joint Strategic Needs Assessment (JSNA) and Health and Wellbeing Strategy should include the specific health needs of gay, bisexual and other men having sex with men MSM); lesbian and bisexual women; Trans women and Trans men; including the specific substance misuse needs of these populations;
- Collection of sensitive gender identity and sexual orientation monitoring data should be consistent;
- Further research is required with Trans communities and substance misuse to better understand the prevalence amongst Trans communities;
- Service specifications should address LGB and Trans specific needs and outcomes;
- Carry out an LGB and Trans. audit of providers.

2.3 How have we involved, or will we involve, communities and groups that could be affected?

A formal consultation period was held with stakeholders between January and April 2017. A number of events were held, including one specifically focussed on the impact on equalities communities and protected characteristics, as well as an online survey.

We asked Stakeholders attending events and completing an online survey to tell us about themselves to ensure our consultation was fair and accessible. 77% said they worked or had worked in substance misuse services and 19% said they worked for another type of service. 24% had used substance misuse services themselves and 22% were carers of someone who had experienced drug/alcohol problems. 14% of participants told us they had experienced problems with drugs/alcohol but not accessed ROADS services.

Participant demographics: Gender was split evenly between male and female. 90% were aged 18-64 with no responses from children. 13% were BME. 32% told us they held a religion or belief. 7% were disabled. 14% said they were lesbian, gay or bisexual. No participants told us they were transgendered.

Stakeholders	Method	Number of participants
All stakeholders	Online survey	82
All stakeholders	4x locality consultation events	96
Service users including peer supporters and family/carers	11 x focus groups and interviews	109
Staff / workforce of commissioned services	3 x Staff Meetings	113
GPs and primary care liaison workers	Events and meetings	35
Residential rehab providers	Event	19
Written responses from agencies and individuals	Email	18
Relevant professionals	Equalities Impact Assessment Workshop	12
Relevant professionals	VOSCUR hosted Event	7

Step 3: Who might the proposal impact?

3.1 Does the proposal have any potentially adverse impacts on people with protected characteristics and can these impacts be mitigated or justified?

Feedback from commissioning consultation events held between January and April 2017

General equalities issues

What are different needs? Any discrimination or disadvantage?	How can we best meet these needs? / How to mitigate discrimination or disadvantage?
▪ Lack of advocacy service may impact on all protected characteristics ▪ Risks of hubs turning people off as buildings could be stigmatising ▪ Inequality of access in having GP only services if they don't have a GP	▪ Outreach is essential to engaging marginalised groups ▪ Services are able to ambassador for D&A clients with community services to overcome discrimination ▪ Balance between EE&I and CRC ▪ Look at the partnership between ROADS and community services (AA, children's centres, community health schemes, etc.) to increase outreach offer ▪ Holistic approach needed to ensure all needs are considered ▪ Link with community public health teams

Age

What are different needs? / Any discrimination or disadvantage?	How can we best meet these needs? How to mitigate discrimination or disadvantage?
▪ need to make sure offer is for people using NPS/other drugs not just heroin/crack/alcohol ▪ Reduction in funding means EE&I will not be able to engage as readily with older adults ▪ Older alcohol users will be disadvantaged if home visits not available (Isolation) ▪ More difficult for older people to travel further	▪ Expanding the alcohol provision will help with the physical health of older people ▪ YP/older people friendly approach ▪ Local services more accessible ▪ Connecting people to local social networks ▪ Link with local community provision (Fellowship, SMART etc.) ▪ Work out how to share client details, with consent, more easily ▪ Online presence

Disability

What are different needs? / Any discrimination or disadvantage?	How can we best meet these needs? / How to mitigate discrimination or disadvantage?
▪ Complex Needs service might be less flexible than primary care ▪ Reduction in in-patient detox will be worse for people with additional health needs ▪ Reduction in life expectancy for people with MH problem (lack of advocacy) ▪ Learning disability – struggle to engage/understand services	▪ Services need to be suitable for service users with brain damage and memory impairment ▪ Ensure hidden disabilities are considered (e.g. dyslexia and paperwork expectations) ▪ Linking in with existing support – referral pathways between ▪ Escalation of adult social care cases and increase/support understanding of roles and responsibilities within both ASC and SM teams ▪ Rely on community services to offer with access support (lifts etc). ▪ Ensure services compliant with access legislation

Gender reassignment

What are different needs? Any discrimination or disadvantage?	How can we best meet these needs? How to mitigate discrimination or disadvantage?
▪ None identified	▪ Trans community, THT closing in old market, need out of hours services e.g. prism ▪ AA/ARA run a LGBT meeting, publicise availability ▪ Ensure services accessible in relation to gender identity (e.g. unisex toilets) ▪ Increase/improve education/training around gender reassignment issues

Pregnancy and maternity

What are different needs? Any discrimination or disadvantage?	How can we best meet these needs? / How to mitigate discrimination or disadvantage?
▪ Delay in agreeing adult and child funds for rehab – consider framework	▪ Ensure training is a component of the maternity drug service – e.g. Day to day challenging peers attitudes/conduct towards D&A clients ▪ Ensure priority access to pregnant ▪ Provide sexual health advice to women who have had a child recently removed. Provide choices. ▪ Development of Pause project ▪ Make services accessible to parents (school times etc.)

Race

What are different needs? Any discrimination or disadvantage?	How can we best meet these needs? How to mitigate discrimination or disadvantage?
▪ Stigma around accessing services on your 'doorstep' ▪ Reduction in funding means EE&I will not be able to engage as readily with Somali community ▪ Lack of specific provision for drugs that affect BME clients e.g. Khat ▪ Some clients do not have recourse to public fund ▪ Stigma of D&A use within BME communities prevents access	▪ Services need to be accessible for people for whom English isn't their first language ▪ Education across all providers re recruitment and retention of BME/LGBT workforce ▪ Check criteria/requirements for accessing rehab/housing funds ▪ Develop links with organisations remitted to work with clients with no recourse to public funds ▪ Publicise services are free (yet quality)

Religion or belief

What are different needs? Any discrimination or disadvantage?	How can we best meet these needs? How to mitigate discrimination or disadvantage?
▪ Stigma with communities	▪ Engage with community leaders (i.e. Imams) ▪ 12 step programme being developed along the pillars of Islam/Sikhism ▪ Ensure choice within CRCs ▪ Primary care opens access ▪ Develop links with faith based services

Sex

What are different needs? Any discrimination or disadvantage?	How can we best meet these needs? How to mitigate discrimination or disadvantage?
▪ Men – additional barriers to accessing MH, increased suicide ▪ CCA process does not support women with complex needs	▪ Link with suicide prevention strategy ▪ Need for female only services to increase engagement ▪ Primary care services likely to increase attendance for women ▪ Strong links needed with DV provision and good education about issues ▪ Considerations about childcare ▪ Consider women who suffer day to day trauma (e.g. FSWs and PTSD) ▪ Rehab for female trauma/PTSD ▪ Keyworker led CCA process (stop referring to new worker to complete)

Sexual orientation

What are different needs? Any discrimination or disadvantage?	How can we best meet these needs? How to mitigate discrimination or disadvantage?
▪ Stigma if sexuality within religions can lead to greater prevalence of substance misuse ▪ Reduction in funding means EE&I will not be able to engage as readily with equalities communities (e.g. Prism for LGBT, older adults, Somali community) ▪ Chem sex, trans community, THT closing in old market, men who sell sex need out of hours services e.g. prism	▪ LGBT specific services needed ▪ Make services LGBT friendly

Street Homeless

What are different needs? Any discrimination or disadvantage?	How can we best meet these needs? How to mitigate discrimination or disadvantage?
▪ None identified	▪ Needs to be flexible to meet people at a location that is accessible ▪ Homeless Health Service ▪ CCA process needs to consider accommodation

Prison leavers

What are different needs? Any discrimination or disadvantage?	How can we best meet these needs? How to mitigate discrimination or disadvantage?
▪ Remand prisoners and those with short sentences – less planned releases = higher risk	▪ Ensure continuity – Through the Gate ▪ Sheltered provision

3.2 Does the proposal create any benefits for people with protected characteristics?

1) Ensuring ongoing compliance with the new NDTMS dataset will ensure that robust and relevant information is collected and collated to monitor the representation of the workforce as well as engagement, retention and successful completion of equalities groups in contact with ROADS.

2) By situating alcohol detox and opiate substitution therapy in primary care we envisage making the entry point into ROADS services more accessible for clients in need of services for whom the stigma associated with substance misuse is a continuing barrier to access support. This is particularly relevant for increasing the proportion of females and BME clients accessing ROADS.

3) Developing a locality based Community Recovery Service has the potential to make the recovery community in each locality more representative of the ethnic diversity of each area and increase BME representation with ROADS

4) Following the Social Value policy of ensuring 25% of procured services are awarded to SME organisations allows the opportunity for community organisations, including equalities groups, to be involved in the commissioning process in a consortia or sub-contractual basis.

3.3 Can they be maximised? If so, how?

Building an equalities performance monitoring framework will aid the focus on ensuring equality of outcome across equalities groups and enable us to highlight areas of inequality early to ensure improvement measure can be implemented to improve the situation.

<u>Additional feedback from the public as part of the BCC Financial Strategy budget proposals</u>

<u>Black South West Network</u>

Major concerns were expressed regarding the inter-related nature of the issues that individuals and families experiencing crisis have:

The stress caused by prolonged crisis can cause mental health issues, if undiagnosed, individuals won't get the necessary support under the Mental Health Act. Drug dependency can result for people experiencing crisis and mental health issues, which often leads to criminality and custodial sentences.

Whilst in prison, people either continue to use drugs, or begin to due to high levels of stress and the ease of availability. There is little support for people leaving prison with drug additions, and no ‘half-way house’ type accommodation available. This means that ex-offenders tend to be housed in hostels where many of the other residents are drug users. This often leads to ex-offenders continuing to use, or relapsing into use, and subsequently leading them back into criminality.

Young homeless people, and young people leaving care at 18 with nowhere to live are also often housed in hostels where drug and alcohol use is prevalent. This creates a significantly increased risk of these young people using, particularly if experiencing stress and crisis about the homelessness.

There needs to be an integrated prevention and early intervention service that combines housing support with mental health service, drug dependency services, ex-offender resettlement and support services, and care leavers services to seek to break these multiple cycles of crisis.

Step 4: So what?

4.1 How has the equality impact assessment informed or changed the proposal?

Anecdotal reports received by the Substance Misuse Team suggest that some equalities groups are reluctant to access mainstream substance misuse services due to the perception that services are not culturally competent or due to the stigma associated with substance misuse. Situating alcohol detox alongside OST in primary care and the development of locality based community recovery service are a response to calls to develop more accessible services.

The feedback from the Black South West Network reinforces the identified need to improve the pathway between substance misuse services and the mental health system to ensure people experiencing crisis are able to have their needs met.

Issues raised by the Black South West Network relating to combining housing support with mental health service, drug dependency services, ex-offender resettlement and support services, and care leavers services to seek to break these multiple cycles of crisis will be considered alongside the Preventing Homelessness Accommodation Pathways Families and Adults commissioning process.

Care leavers will be included as a priority group in the risk assessment process for clients accessing ROADS as they are already identified as a population with elevated prevalence of substance misuse.

4.2 What actions have been identified going forward?

Ensure monitoring of engagement with equalities communities will need to be an important part of developing the performance management framework for the new ROADS services

4.3 How will the impact of your proposal and actions be measured moving forward?

Monitoring of the levels of engagement ROADS has with equalities groups through NDTMS published reports

Development of equalities focussed performance reports to mirror the headline performance reporting mechanisms.

Engagement with service user groups to gain qualitative feedback from equalities groups' representatives