Report for: ACTION
Item Number: 6iv

Contains Confidential or Exempt Information	**No – Part I apart from Appendix B – Part II – not for publication by virtue of paragraphs 3 and 4 of Schedule 12 A of the Local Government Act 1972.**
Title	**Drug and Alcohol Service – Substitute Prescribing and Recovery Service Contract Procurement**
Responsible Officer(s)	Christabel Shawcross, Strategic Director of Adult and Community Services
Contact officer, job title and phone number	Sue Longden, Interim Head of Public Health. 01628 683532
Member reporting	Cllr David Coppinger, Lead Member for Adult Services and Health (including Sustainability)
For Consideration By	Cabinet
Date to be Considered	24 September 2015
Implementation Date if Not Called In	Immediately
Affected Wards	All
Keywords/Index	Drug, Alcohol. Recovery, Prescribing, Prevention

Report Summary

1. A keystone of RBWM's public health vision, which aligns with the Joint Health and Wellbeing Strategy, is an integrated approach that emphasises prevention, early intervention and targeted support to provide maximum benefit to residents, whilst ensuring a cost-effective use of resources. Consistent with that approach, this report requests approval to procure a new three-year joint substitute prescribing and recovery service contract to tackle drug and alcohol dependency. This will form a key element of RBWM's integrated approach to the prevention and treatment of drug and alcohol misuse.

2. RBWM currently holds two separate contracts for the delivery of substitute prescribing and recovery services. Both of these contracts are due to expire in March 2016.

3. This report proposes the procurement of a joint substitute prescribing and recovery service contract (hereafter referred to as the RBWM Community Drug and Alcohol Recovery Service). The proposed specification is included in

Appendix A.

4. If approved, a procurement process will commence in October 2015. A tender award paper would be presented back to Cabinet for decision in December 2015.

5. To provide context, this report summarises RBWM's integrated approach to the delivery of other RBWM drug and alcohol services. A second report, providing detail of the proposed integrated arrangements will be presented to cabinet.

If recommendations are adopted, how will residents benefit?	
Benefits to residents and reasons why they will benefit	Dates by which residents can expect to notice a difference
Residents who require treatment for drug and alcohol related problems will be able to access substitute prescribing and recovery support services from a single provider	1 April 2016

1. Details of Recommendations

RECOMMENDATION: That Cabinet:

i. **Approve the proposed specification included in Appendix A, subject to consultation.**
ii. **Agree to tender for a new three-year RBWM Community Drug and Alcohol Recovery Service contract to commence from 1 April 2016.**
iii. **Note a tender award paper will be presented to Cabinet for decision in January 2016.**

2. Reason for Recommendation(s) and Options Considered

Policy context

2.1. In April 2013, the Health and Social Care Act placed local government at the heart of public health. As national and local government continue to face financial challenges, it is imperative to ensure that all investment in public health is targeted to areas of greatest need and impact to maximise benefits to residents.

2.2. The National Drugs Strategy 2010-2015 empowers local government to develop its own way of improving public health that meets the needs of local communities, with local commissioners maintaining appropriate levels of investment in drug and alcohol services to ensure these adequately meet local needs.

2.3. Whilst recovery remains at the heart of the National Drugs Strategy, reducing demand is a key priority, with the explicit aim of preventing people from using drugs from the outset. The strategy emphasises the importance of improving

recovery outcomes and local authorities are urged to consider the impact of wider factors, such as employment and housing, when designing local services which to support the full recover and integration of drug users back into society when planning local services.

2.4. The 2014/15 review of the National Drugs Strategy identified a determination amongst local authorities to deliver and improve outcomes. To continue this direction, a new Health Premium Incentive Scheme was launched, offering a financial incentive for progress in improving the health of the local populations and in particular substance misuse. The incentive budget is modest; £5m nationally, with all successful local authorities receiving a share if they are able to show an improvement of around 2% in the number of people who recover from drug dependency (measured by an increase in the proportion who successfully complete treatment with no return within six months).

2.5. In 2015/16, the National Drugs Strategy introduced a new condition within the Public Health Grant to encourage investment in the provision of high quality drug and alcohol services. The condition requires local authorities, when using their grant, to have regard to the need to improve the take up of, and outcomes from, drug and alcohol services. It does not prescribe how much local authorities should spend or the type of services they should commission leaving the local authority discretion to commission those services it considers are necessary to meet the needs of its local population. The strategy mandates Public Health England (PHE) to supporting local commissioners and practitioners in implementing evidence-based prevention activity.

2.6. A joint review conducted by PHE and the Association of Directors of Public Health, published in October 2014, reported that a large number of local authorities were planning realignments of resources between alcohol and drug services, with alcohol assessed as the greater need. The review found that there was a focus on improving outcomes and continuing the move to a recovery model. Over half of local authorities were recommissioning drug and alcohol services (or planned to). Improved delivery and performance by providers was a clear aim in all recommissioning, with a focus on improving treatment completions. Many areas were integration drug and alcohol services with wider services such as housing, younger people services, criminal justice, and local health delivery. [i]

2.7. The evaluation of the National Drugs and Alcohol Recovery Payment by Results Pilot Programme identified a drive to deliver more holistic interventions which address broader needs than just substance misuse (Interim Summary Report June 2014).

2.8. The Advisory Council on the Misuse of Drugs (ACMD) makes recommendations to Central Government on the control of dangerous or otherwise harmful drugs. In February 2015, ACMD reviewed current evidence in the field of drug prevention.[ii] The briefing paper makes a number of recommendations, including:

- Some approaches – such as drug education in schools and mass-media publicity campaigns – were found to have little impact on preventing substance abuse when used in isolation from other initiatives to promote healthy lifestyles.
- Those involved in commissioning prevention work should be mindful that standalone projects will have little impact on substance abuse unless they are considered as part of wider strategies promoting healthy living.
- Policy-makers should recognise the health and social impacts of drug abuse can be reduced without users abstaining entirely.

Assessment of need

2.9. RBWM, in partnership with local residents and NHS colleagues, has developed the Joint Health and Wellbeing Strategy (JHWS). This is a plan to improve the health and wellbeing outcomes for residents and those who come into the Borough. The strategy has three themes:

- Supporting a healthy population.
- Prevention and early intervention.
- Enabling residents to maximise their capabilities and life chances.

2.10. The JHWS highlights a need for local drug and alcohol prevention services to be targeted at younger people and to increase focus on improving the number of residents successfully completing their treatment.

2.11. The Joint Strategic Needs Assessment (JSNA) assesses the current and future health healthcare and wellbeing needs of the local population in Windsor, Maidenhead and Ascot. The JSNA states that around three people in every 1,000 people living in the Royal Borough of Windsor and Maidenhead are in drug treatment. Out of 279 clients currently in drug treatment, the most prevalent drug in use is heroin followed by cannabis and then cocaine.

2.12. There is a growing awareness of the impact of alcohol on health and wellbeing While most people who drink can do so without causing harm to

themselves or others, the problems related to alcohol misuse range from physical and mental health issues to social issues (complex families, homelessness, and domestic abuse), and can result in unemployment and loss of workplace productivity. Nationally, levels of alcohol-related health problems are increasing year on year, and particularly affect deprived communities thereby contributing to health inequalities. Around 11 in every 100,000 people under 75 across RBWM die as a result of liver disease. Around 20 people of working age in every 100,000 are claiming Incapacity Benefit or Severe Disablement Allowance, with the main reason to not work being alcoholism. Overall, the numbers of adults accessing treatment is rising (141 in 2011/12) to 215 in 2012/13).

Current provision

2.13. RBWM spends £1.1m on services to prevent, treat and support recovery in relation to drugs and alcohol. The majority of this funding derives from the Department of Health Public Health Grant and accounts for approximately 32% of RBWM's public health expenditure. In addition to funding via the public health grant and included in the £1.1m total budget, there is £63k of ring-fenced income from the Police and Crime Commissioner (PCC); funding work with people on Probation orders, prison releases and in the Integrated Offender Management Scheme, supporting commissioning and working with young people in the Youth Offending Service.

2.14. Current drug and alcohol provision in RBWM comprises a number of services that support people to recover from drug and alcohol addiction by offering a range of interventions from detox and residential rehab to supported living and ongoing support. These include:

Prescription

The Substitute Prescribing Service, delivered by Claremont Surgery, offers heroin users methadone or buprenorphine to replace their heroin use. It also provides drug testing. The service supports complex clients in the community. The Shared Care Scheme supports clients who are more stable to be managed in a GP setting.

Recovery

SMART drug and alcohol recovery service for adults over 18, offering substance misuse advice, information and treatment, drop in sessions, groups and activities, needle exchange, harm minimisation advice, screening / vaccinations, acupuncture and detox for alcohol clients.

RBWM Drug and Alcohol Action Team (DAAT)

The DAAT commissions adult drug and alcohol services and delivers the young people's drug and alcohol team (YPDAAT) for under 18s needing help with drug or alcohol use and supporting young people who have a family member with a drug or alcohol problem. The team provides drug awareness talks and runs the RBWM's Peer Education Programme. The DAAT also works in partnership with police, probation and wider partners to reduce crime and anti-social behaviour arising from substance misuse.

The Needle Exchange

This pharmacy based service enables injecting drug users (including those who use anabolic steroids) can safely return their used needles and collect new sterile needle packs from accredited locations.

2.15. This report refers to the prescription and recovery elements. RBWM currently holds contracts with separate providers for these services. Both contracts are due to expire on 31st March 2016.

2.16. In 2014/15 there were a total of 515 adults in treatment, with 300 of those being new referrals. In terms of the breakdown of the new referrals the largest group were the 122 alcohol clients (41%) (An increase from 89 (36%) in 2013/14) with 95 opiate users following closely behind (32%). One hundred and eleven service users (22%) successfully completed their treatment. Completion is assessed as the number of service users not re-presenting themselves within six months of leaving their treatment.

2.17. Although RBWM's completion rate compares favourably with national outcomes, there is scope for improvement in supporting individuals to successfully complete their drug treatment and re-integrate back into their local communities for example, by maintaining their own homes and acquiring education, training and employment.

New commissioning focus

2.18. The strategic direction of RBWM's drug and alcohol services is an integrated approach to prevention and targeted support, consistent with the JHWS. The new model for integrated drug and alcohol services must reflect the range of need from identification and brief interventions to treatment for dependency. RBWM's public health expenditure on drug and alcohol services has been reviewed and it is proposed that the new integrated approach is delivered as follows:

- The procurement of a RBWM Community Drug and Alcohol Recovery Service
- The remodelling of the DAAT, including integration of services aimed at preventing substance misuse and addiction (drugs, alcohol and smoking) into the new framework for children's services
- Greater targeting of residential rehabilitation placements to maximise successful outcome

2.19. This report deals with the procurement of a RBWM Community Drug and Alcohol Recovery Service. The remodelling of the DAAT, integration of prevention into children's services and proposals regarding residential rehabilitation placements will be covered in a subsequent report to cabinet.

2.20. The report proposes a tender for a RBWM Community Drug and Alcohol Recovery Service via a new three-year contract that combines both the substitute prescribing and drug and alcohol recovery functions at a reduced contract value. In other parts of the country, integration of drug and alcohol services has improved the overall offer to clients. Once approved by Cabinet, the new contract would commence from 1 April 2016. If approved, the RBWM Community Drug and Alcohol Recovery Service will be commissioned in accordance with best practice outcomes as recommended within the National Drug Strategy 2010:

- 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
- The capacity to be an effective and caring parent.

2.21. In order to achieve the required efficiencies and meet these objectives, the newly commissioned RBWM Community Drug and Alcohol Recovery Service will prioritise clients for treatment and recovery services according to assessed need:

- Priority clients will include those on statutory supervision orders, Drug Rehabilitation and Alcohol Treatment Requirements, people with complex mental health problems and people having contact with children who were at risk of harm. Initial modelling by the DAAT suggest that this would refocus

the service to around 200 individuals with high level of need rather than the current 515 who receive a variety of support services.

- Potential clients with a lower assessed priority would need to be supported to access self-care services, including Narcotics Anonymous, Alcoholics Anonymous and Cocaine Anonymous.

2.22. A period of transition will be necessary. There is scope for negotiation within the exisiting contracts to begin to reduce the numbers of clients in treatment in preparation for a new contract from April 2016. An action plan will be agreed and this will require skilled clinical oversight in order to safely discharge clients and avoid adverse incidents.

2.23. This proposed change is being implemented at a time of great challenges for public services, which places an increased focus on the need to work together in partnership to maximise use of resources. However, there is a challenge of delivering better outcomes for people with drug and alcohol-related problems within a reduced budget. Success will be dependent on the promotion of, and access to, self-help and self-care through online assessment and advice, telephone support, charity and/or social media routes. The voluntary and community sector support for people with drug and alcohol problems is not as strong in RBWM as elsewhere in England and this would benefit from development.

2.24. Early education is essential to inform young people to help them make healthy decisions and keep themselves safe. There are some excellent resources available to support young people in making healthy choices, including:

- 'Rise Above' (an online resource and social movement for young people) designed to build young people's resilience and empower them to make positive choices for their health (including drugs, alcohol, smoking, body confidence, relationships and exam stress). Aimed at 11-16 year olds (http://riseabove.org.uk/ accessed 03.09.15).

- 'Frank' the national drug education service jointly established by the Department of Health and Home Office (http://www.talktofrank.com/ accessed 03.09.15).

2.25. In some families, early identification and intervention is necessary to protect children and young people from alcohol-related harm, and preventing them from mirroring their parents' behaviours and substance misuse. There are potential synergies within RBWM; for example RBWM Intensive Family Support Project, School Nursing and Youth services. Capitalising on these synergies is another important wider component of this new strategy.

Options

Option 1	**Comments**
The proposed specification is approved and the Council proceeds to procure a new RBWM Community Drug and Alcohol Recovery Service, based on a three-year joint prescribing and recovery service contract **Recommended**	This option is recommended. Procuring a new contract combining both functions will provide an integrated approach that is consistent with RBWM's strategic direction helping to maximise benefits to residents while optimising resources.
Option 2	
The Council proceeds to procure two separate substitute prescribing and recovery service contracts.	This option is not recommended. Procuring two separate contracts fail to maximise effective use of resources

3. Key Implications

Defined Outcomes	Unmet	Met	Exceeded	Significantly Exceeded	Date they should be delivered by
Percentage of successful completions of opiate clients based on a cohort of approximately 100 clients	Below 10%	10-12%	13-15%	Above 15%	31 March 2017
Percentage of successful completions of non-opiate clients based on a cohort of approximately 50 clients	Below 38%	38-40%	41-43%	Above 43%	31 March 2017
Percentage of successful completions of alcohol clients based on a cohort of approximately 50 clients	Below 35%	35-37%	38%-40%	Above 40%	31 March 2017

4. Financial Details

4.1. The Current budget for all RBWM drug and alcohol services is £1,110k which is funded by a £1,047 contribution from the Public Health Grant and £63k from the Police & Crime Commissioner. The proposal in this report, combined with those referred to in paragraph 2.18 would reduce the Public Health grant funding for drug and alcohol services by £550k to £497k.

4.2. The reduction in funding for dual diagnosis clients who have a mental health need as well as a drugs or alcohol problem will impact upon the social care budget for people with mental health problems. It is not clear as to the extent of the financial impact of this on the Council's community mental health service, however assuming this budget will need to fund four additional rehabilitation placements per annum at £9k per case it is estimated that the additional annual cost to that service will be £36k.
This £36k can be met from the released £550k Public Health funding noted above; therefore the net saving from these proposals reduces to £514k.

Estimate	Year 1: 2016/17	Year 2: 2017/18	Year 3: 2018/19
	Revenue	Revenue	Revenue
Addition			
Reduction	£514K	0	0

5. Legal/Procurement Implications

Public Health Statutory Duty

5.1. The National Health Service Act 2006 ("the 2006 Act") (as amended by the Health and Social Care Act 2012 ("the 2012 Act")) imposes a statutory duty on the Council in respect of public health.

5.2. Section 2B(1) of the 2006 Act imposes the core statutory duty. This provides that "*each local authority must take steps as it considers appropriate for improving the health of the people in its area*".

5.3 Therefore the Council has discretion to decide what steps it considers "appropriate" to take for improving the health of the people in their particular area. When exercising its discretion the Council must act in accordance with public law principles of rationality, i.e. it must take into account all material considerations, omit immaterial considerations, act in accordance with its legal requirements and act fairly and in accordance with requirements of natural justice. Therefore the Council must have regard to the JSNA and the JHWS.

Required Consultation

5.4 There is no specific requirement to undertake statutory consultation under s 2B in deciding what steps the local authority considers appropriate for improving health. However, there are detailed provisions in Part 14 (esp ss 221-2) of the 2007 Act for the involvement of local people in decisions regarding the commissioning, provision and scrutiny of local care services (including health and social services functions).

5.5 Therefore, if the Council is considering reviewing its commissioning of local health services, it will be necessary for it (regardless of how this fits in with the JSNA/JHWS process) in the light of s 221-2 to undertake some form of public consultation. It should, at the very least, consult the Local Healthwatch organisation. In light of the level of consultation required by ss 116/116A and the provisions of s 221 above, quite apart from the basic requirements of fairness, it would be strongly advisable to undertake a general consultation exercise with the public of the local area.

5.6 Best practice would also suggest that the Council should undertake some form of "outreach" (via public events, social media or group meetings) with the particular groups and/or organisations likely to be most affected by changes to the service.

5.7 This would also assist in meeting the Council's duty to have regard to the need to reduce inequalities between the people in its area (Condition 7 of the Circular) and generally the public sector equalities duty under s 149 of the Equalities Act 2010 to have due regard to the need to eliminate unlawful discrimination against those with protected characteristics. A full consultation exercise will assist in preparing an accurate evidence base for the purpose of carrying out an Equalities Impact Assessment which will be required.

Commissioning

5.8 The Council is enabled, by section 111 of the Local Government Act 1972, to do anything which is calculated to facilitate, or is conducive or incidental to, the discharge of any of its functions. The Council therefore has a general power to enter into contracts for the discharge of any of its functions; including the proposed contract for Community Drug and Alcohol Recovery Services.

6. Value for Money

The redesign and tender process will follow OJEU and will be fully evaluated by Procurement for value for money.

6. Sustainability Impact Appraisal

N/A

7. Risk Management

Risks	Uncontrolled Risk	Controls	Controlled Risk
Result of the tender for the new service is a service that presents risks due to gaps in service or quality	High	Clear service specification on quality and target groups should ensure tenders address requirements.	Medium
No providers offer a service within budget allocated	High	Discuss extending existing service under a new specification at lower costs	Medium
Risk of reduced numbers able to access the service	High	The service will focus on risk, outcomes and more move on from the service	Medium
Risk of transitioning people off the service in timeframe being detrimental to their health	High	Planned transition to the new model to start in year	Medium
Challenge by PHE and PH reclaiming grant	High	Consult with PH and PHE throughout the process	Medium
CQC inspection fails	High	Consult with CQC to mitigate	Medium
Higher costs for stakeholders	High	Consult with stakeholders to look at and invest in joint mitigations	Medium

8. Links to Strategic Objectives

The objectives of the DAAT and the services it commissions are in line with the following Royal Borough Strategic Objectives:

Residents First

- Support children and young people.
- Encourage healthy people and lifestyles.
- Work for safer and stronger communities.

Value for Money

- Deliver economic services.
- Invest in the future.

Delivering Together

- Deliver effective services.
- Strengthen partnerships.

The Joint Health and Wellbeing Strategy (JHWS) themes are:

- Supporting a healthy population
- Prevention and Early Intervention
- Enable Residents to Maximise their Capabilities and Life Chances.

10. Equalities, Human Rights and Community Cohesion

The aim of the DAAT and its' services is to ensure that those with drug or alcohol problems are able to access services in order to promote harm reduction and ultimately abstinence and recovery. All such activities will ensure that residents, who have been impacted upon by such issues, are able to become healthy, productive and contributing members of the community and therefore enhancing community cohesion. Changing the service has required a full Equality Impact Assessment which has been completed and is attached at the end of the report as Appendix 3.

11. Staffing/Workforce and Accommodation Implications

Some current staff within SMART are likely to be eligible for TUPE. RBWM commissioning staff will be subject to formal consultations on options.. Where possible, redeployment options will be sought.

12. Property and Assets

The current service is based at Reform Road which has limited life span as part of regeneration plans for Maidenhead. A new RBWM Community Drug and Alcohol Recovery Service will need to find alternative accommodation.

13. Any Other Implications

N/A

14. Consultation

Legal advice in Section 5 addresses the need for consultation on the policy change. Best practice would indicate a full consultation over 12 weeks on the proposed changes, engaging with all members of the Community Safety Partnership which includes all key partners namely the Police, Probation, Clinical Commissioning Group and Public Health. The urgency of the need to address the model means that a 12 week period is unfeasible. As the requirement for consultation is not a statutory one, the period and type of consultation could be reduced. It is proposed to consult over a reduced period of 3 weeks, by means of targeted stakeholder meetings to include CCGs, Healthwatch and current service provider and users..

15. Timetable

The proposed procurement implementation timetable is included below:

Event	**Date**
Cabinet approval to tender	24th September 2015
Finalise all tender documentation	29th September 2015
Issue Invitation to Tender	Monday 5th October 2015
Deadline for receipt of written questions (by 12:00 hours)	Monday 26th October 2015
Issue answers to questions	Thursday 29th October 2015
Deadline for submission of final tenders	Wednesday 4th November 2015 (12 noon)
Evaluate tenders	4th- 9th November 2015 Consensus scoring meeting 9th November 2015
Clarification/Interview Meetings/Presentations (if required)	12/13th November 2015
Write Award Report	November 2015
Contract award decision made by the Council	December 2015
Standstill Period: notify Suppliers of contract award decision and award contract to supplier	December 2015 (10 days minimum for both Council and OJEU requirements)
Issue contract to Supplier to sign	December 2015- January 2016
Implementation/ Mobilisation/TUPE	January 2016- March 2016
Contract Signed by the Council and commences	1st April 2016

16. Appendices

- Appendix 1 - Proposed Service Specification
- Appendix 2 - Part II Information
- Appendix 3 – Equality Impact Assessment

17. Background Information

- HM Government Drug Strategy 2010: Reducing Demand, Restricting Supply, Building Recovery: Supporting People to Live a Drug Free Life.

18. Consultation (Mandatory)

Name of consultee	Post held and Department	Date sent	Date received	See comments in paragraph:
Internal				
Cllr Burbage	Leader of the Council			
Cllr Coppinger	Lead Member for Adult Services and Health	02.09.15	02.09.15	
Cllr Carroll	Deputy Lead Member for Public Health	02.09.15	02.09.15	
Christabel Shawcross	Strategic Director for Adult and Community Services	26.09.15	02.09.15	
Lise Llewellyn	Director of Public Health	01.09.15	03.09.15	
Alan Abrahamson	Finance Partner	02.09.15	02.09.15	
Elaine Browne	Shared Legal Services	03.09.15	03.09.15	
Michael Llewelyn	Cabinet Policy Assistant	01.09.15		

Report History

Decision type:	Urgency item?
Key decision	Yes

Full name of report author	Job title	Full contact no:
Sue Longden	Interim Head of Public Health	01628 683532

[i] Review of Drug and Alcohol Commissioning A joint review conducted by Public Health England and the Association of Directors of Public Health

[ii] Prevention of drug and alcohol dependence
Briefing by the Recovery Committee
February 2015

Service Specification for the Royal Borough of Windsor and Maidenhead's Community Drug and Alcohol Recovery Service

April 2016

Contents Page

1. Introduction

The Royal Borough of Windsor and Maidenhead

The Royal Borough of Windsor and Maidenhead is one of six unitary authorities within Berkshire. It is in the South-East region in the Thames Valley, one of the most prosperous regions in the country and about twenty miles west of London. Most people live in the two urban centres of Windsor and Maidenhead, with Maidenhead being twice the size of Windsor. There are fourteen rural parishes, one of which includes Ascot, the Royal Borough's third town, and Eton Town Council, with similar status to a parish council.

Unemployment is very low compared to other Berkshire and national rates and the population is generally affluent, healthy and mobile. However, there are pockets of deprivation in some wards (Oldfield, Clewer North and South, South Ascot, Horton and Wraysbury, Hurley, Walthams, Datchet) and the general high standard of living can mask these.

The 2011 Census indicated that the Borough has 144,560 residents, which is an increase of 8.2% in the last decade. In terms of overall age breakdown, the population is showing signs of ageing in line with national trends, with 16.7% of the population aged 65+. The majority of the population living in the Borough are White British (79%). The next largest ethnic group is Asian or Asian British - primarily Pakistani and Indian at 2.9% and 4.1% respectively.

The Future Treatment System

The Royal Borough of Windsor and Maidenhead wishes to contract a single Provider to deliver an outcome based, integrated drug and alcohol tier two/three treatment service, including opiate substitution therapy. The ethos of 'recovery' will be at the heart of delivery and this will be understood and owned by all those working for and contributing towards the service, including the service users themselves.

The primary objective of the RBWM Community Drug and Alcohol Recovery Service will be to achieve the outcomes set through national and local targets whereby service users successfully complete treatment and therefore are no longer dependent on drugs or alcohol. The service must adhere to national policy in substance misuse as well as local policy and strategy development and must work in close partnership with the DAAT and their wider Partners in order to achieve the defined outcomes for the clients. The areas to be covered by the service, reflect those expected nationally by Public Health England, however the delivery model will be decided upon by the Provider, giving freedom for innovation, whilst continuously striving for greater efficiency.

2. Performance Outcomes

2.1 The service will be measured on the following outcomes. It is expected that whilst compliance with national standards are met, the delivery method utilised in order to achieve against these indicators is designed by the Provider.

Table 1: Performance Measures and Expected Outcomes		
Performance Indicator	Descriptor	Target
PHOF 2.15 i Successful completion of drug treatment.	The number of users of opiates that left drug treatment successfully, who do not then re-present to treatment within 6 months, as a percentage of the total number of opiate users in treatment.	Top quartile for the cluster group as detailed in the NDTMS DOMES report
PHOF 2.15 ii Successful completion of drug treatment.	The number of users of non- opiates that left drug treatment successfully, who do not then re-present to treatment within 6 months, as a percentage of the total number of non- opiate users in treatment.	Top quartile for the cluster group as detailed in the NDTMS DOMES report
Alcohol Successful Completions	The number of alcohol users that left treatment successfully as a percentage of the total number of alcohol users in treatment.	38% in borough Balanced Score Card
Waiting times	% of clients receiving an initial screening within 5 working days of referral.	100%
	% of clients who access treatment within 21 days of referral	100%
	% of clients who engage with the service post initial assessment	90%
Numbers in treatment	Number of opiate clients open to the service Number of non-opiate clients open to the service Number of alcohol clients open to the service	To be set using baseline data from quarter 4 of 2014/15.
New presentations	Number of new opiate clients presenting to the service Number of new non opiate clients presenting to the service Number of new alcohol clients presenting to the service	To be set using baseline data from quarter 4 of 2014/15.
Care Plans	% of clients with a mutually agreed and signed Care Plan % of Care Plans reviewed after 6 weeks	100% 100%
Effective treatment	% of clients in 'effective treatment' (retained for 12 weeks or more)	To be set using baseline data from quarter 4 of 2014/15.

Planned exits	% of drug clients with a planned exit % of alcohol clients with a planned exit	40% 50%
Recovery interventions	% of clients open to 'recovery interventions' as recorded on ndtms	To be set using baseline data from quarter 4 of 2014/15.
TOPS	% of service users with a start TOPs % of service users with a 6 weekly review of TOPs % of clients with an exit TOPs	100% To be set using baseline data from quarter 4 of 2014/15. To be set using baseline data from quarter 4 of 2014/15.
NDTMS date submission	% of data quality uploaded to the national core database ndtms % of data completeness uploaded to the national core database NDTMS	100% 100%
BBV	% of clients offered a Hep B vaccination % of clients who start a course of Hep B vaccination % of clients who start and go on to complete a course of Hep B vaccination % of clients offered a Hep C test % of clients offered a HIV screening	100% 75% 75% 100% 100%
Substitute Prescribing	% reporting a reduction in opiate use after 6 months in treatment	To be set using baseline data from quarter 4 of 2014/15.
DRRs and ATRs	Number of clients commencing DRRs % of clients successfully completing DRRs Number of clients commencing ATRs % of clients successfully completing ATRs	To be set using jointly agreed Probation targets for 2015/16.
Community alcohol detox	Number of community alcohol detoxes commenced % of community alcohol detoxes successfully completed	To be set using baseline data from quarter 4 of 2014/15.
Child protection	% of Child Protection Conferences where the worker has been in attendance or report written	100%

Table 2 below contains additional information that will be required from the Provider on a **quarterly** basis by the DAAT for monitoring.

The average time of clients in treatment
% of males and % of females in treatment
The ethnicity of clients in treatment

The average age of clients in treatment
The most prevalent presenting substances (top three as well as any emerging trends)
The number of IBAs delivered to those outside of the main service
The number of clients attending each modality the service offers
The number of clients attending each group
The outcomes of structure group programmes (as evaluated with those exiting groups)
The number of CIP assessments carried out (RAs and VAs)
The number of CIP assessments that result in referrals into the service
The number of referrals made to Children's Social Care
The number of referrals made to the Common Point of Entrance (entry point for mental health)
The number of referrals made to the Common Point of Entrance accepted for further support
The number of service users involved in consultation
The number of volunteers involved in the service
The number of service users who have become active 'recovery champions'
The number of clients who are NFA or homeless
The number of referrals to Housing Options
The number of people referred onto employment, education and training schemes and to the JCP
The number of clients who are considered to be NEET
Any reports of near misses or drug/alcohol related deaths
Any complaints or compliments and related outcomes

3. The aims of the Service

3.1 Alongside the requirement to perform well against the measures above, the service must:

- Support people who wish to become abstinent from drugs and/or alcohol to do so;
- Support people who are unable to stop using drugs and/or alcohol to reduce their use and minimise any potential associated risks or harms;
- Reduce the wider impact of drug and/or alcohol misuse on individuals, families and the communities of RBWM;
- Reduce the spread of blood borne infections;
- Maintain and improve the health and well being of people who use the service;
- Reduce levels of offending of people who misuse drugs and/or alcohol;
- Reduce levels of anti-social behaviour relating to the use of drugs and/or alcohol;
- Ensure that each person entering the recovery system has their individual needs met;
- Work in partnership with other key agencies to ensure that people who misuse drugs and/or alcohol can access and receive all services required;
- Improve the local economy by supporting and enabling people who misuse drugs and/or alcohol into employment, education or training;
- To promote a 'whole family' approach to recovery, engaging key members of the Service Users' support networks wherever possible.

4. Scope and Minimum Service Requirements

4.1 The following service areas must be delivered however, activity is not limited to that defined below. There must be room for flexibility, innovation and responsivity to local and national changing landscapes and needs:

- Assessment and Screening
- Opiate Substitution Therapy/Prescribing
- Harm Reduction
- One to One and Group Support
- Psychosocial Interventions
- Criminal Justice Interventions
- Recovery Aftercare And Mutual Aid
- Service User and Family Involvement
- Holistic Recovery Interventions

5. Core Service Competencies and Training Requirements

5.1 In the context of that outlined above, any model must ensure the following are in place:

- Robust clinical governance and/or other arrangements adhering to appropriate sector guidance and standards;
- Regular assessment of the Service Users' risk of intentional or accidental injury or drug and/or alcohol related death;
- Appropriate 'Serious Untoward Incident Procedures';
- The provision of basic life-saving information appropriate to Service Users to reduce the risks of serious harm and overdose;
- Mechanisms of rapid communication to advise Service Users, partners and other providers about any drug alerts;
- Competent, trained staff who have the knowledge and skills to provide health risk assessments, harm reduction/health promotion advice and prevent drug related death's (DANOS);
- Staff who are trained around safeguarding children, and adults best practice and procedures, making referrals and attending child protection case conferences and core groups as required or the equivalent adult safeguarding groups;
- Protocols and practice that are compliant with all relevant NICE guidance and other national standards (see appendices).

6 Additional Key Responsibilities for the Service

6.1 The following areas must be addressed within any model:

Partnership Working

The Service Provider shall build strong links with other local drug services and allied Services in pursuit of seamless provision for Service Users, developing partnership protocols and sharing good practice. The Service Provider shall ensure there is strong leadership, committed staff with an appropriate caseload and rapid, well-defined information sharing within their Service.

Key local partners shall include, but are not limited to:

- Residential detoxification and treatment centres;
- AA/NA;
- Community Mental Health Teams;
- Talking Therapies;
- Children's Social Care teams;
- Vulnerable adult teams;
- Domestic Abuse Services;
- Police
- Probation;
- Prisons;
- Courts;
- Hospital Trusts;
- GPs;
- Pharmacies;
- Housing Policy and Housing Associations;
- Antenatal services, clinic and community based services;
- Other local authority departments;
- Voluntary sector agencies;
- Colleges;
- Job Centre Plus.

6.2 Communication

Any concerns arising (serious incidents, unexpected absences, behavioural difficulties etc) regarding Service Users should be communicated to the Purchaser. Drug or alcohol related deaths or near misses should be communicated formally as soon as the service has been notified and an initial review of the case will be provided within 5 working days, after which a full multi agency case review may be required.

The DAAT Manager, on behalf of the Purchaser, shall be the identified lead for any such reports.

The Service Provider shall nominate a senior manager who will be the Purchaser's key point of contact for this Service who will be available in the normal working day.

6.3 Quality Assurance

The Service Provider shall be expected to demonstrate clear quality standards for the Service provided as determined by nationally agreed guidelines set out in the 'Drugscope QuADS' (organisational standards for alcohol and drug treatment services). The QuADS organisational standards shall apply until such time that these are revised and updated by a further set of agreed national standards, which shall then apply to this Contract.

The operational policies, health and safety, confidentiality and equalities policies shall all conform to the QuADS standards or future national standards for drug treatment services and successive nationally agreed operational standards.

6.4 Staffing

The Service Provider shall ensure, as far as is reasonable, that the staff appropriately represent the demographic diversity of the local population.

The Service Provider shall have in place appropriate management arrangements in order to provide direction and accountability to the Service and to manage its resources effectively.

The Service Provider shall operate an 'Equal Opportunity Policy' with regard to all aspects of staff employment, i.e. recruitment, training, policies and procedures.

When recruiting new staff, there shall be representation within interview panels from other partners (e.g. the DAAT's and Service Users) where appropriate.

The Service Provider shall provide effective cover arrangements to ensure the continuity of Service and safety of all Service Users and others.

All staff must be given a structured induction into the Service, receive regular supervision and ongoing management support. They should also be given robust training in order to assist them in their professional development and acquisition of relevant skills. At no time should staff exceed their level of professional ability by performing tasks for which they are not qualified or trained.

All staff shall be required to sign confidentiality agreements on commencing employment with the Service Provider. Staff should be informed that there cannot be absolute guarantees of confidentiality, as disclosure may be necessary to protect Service Users from 'significant harm'. The confidentiality policy should be reiterated to Service Users on a regular basis throughout the duration of their relationship with the Service Provider and staff should ensure young peoples understanding of the policy.

6.5 Policies, Protocols & Written Strategies

The Service Provider is required to demonstrate effective policies and procedures, which promote the well being and safety of Service Users and staff. These include but are not restricted to:

- Grievance procedures;
- Complaints procedure (for Service Users);
- Complaints/grievance procedure (for paid staff and volunteers);
- HIV/AIDS policies relating to employment;
- Accidents and incidents in the workplace (staff, volunteers & Service Users);
- Child protection;
- Occupational health;
- Policies relating to confidentiality of information;
- Management of violence;
- Training & staff development;
- Health and safety policy
- Fire procedures;
- Codes of conduct and rights of Service Users;
- Equal opportunities in staff recruitment and Service provision.

The Service Provider's policies and procedures must have clearly stated objectives, which stipulate who is responsible for the implementation of the policy/procedure and make arrangements for monitoring, review and development.

The Service Provider shall have written plans for managing and reducing waiting times for treatment and for improving access to the Service.

The Service Provider shall have written strategies in place on the reduction of drug-related death (blood-borne infections, immunisation and overdose prevention) which link in with the DAAT's 'Drug-Related Deaths' Strategy.

The Service Provider shall display a 'Service User Charter' detailing the Service Users rights and responsibilities whilst using the Service.

The Service Provider shall sign up to the Community Safety Information Sharing Agreement (COSISA), a copy of which is available from the DAAT Manager.

6.6 Complaints Procedure for Service Users & staff

The Service Provider shall have a written procedure for dealing with complaints. These procedures must include a record of all complaints and the action taken on them. Complaint records shall be available at any time for inspection by the DAAT Manager.

The Service Provider shall also ensure Service Users are informed that they can make a complaint through the Adults Service Complaints and Representation Procedure, if they wish to do so.

6.7 Record Keeping and Information Security

All Service Provider records shall comply with clinical governance audit standards. The Service Provider shall keep secure, up-to-date and confidential individual files on each registered Service User. These should contain all relevant information such as assessment, personal plan and goals, treatment and Service take up, progress reports, reviews, repeat episodes of care, correspondence/ communication with relevant others, links with organisations and practitioners and incidents. The file shall be maintained in partnership with the Service User concerned and give sufficient detail to be useful in a positive and proactive way as a tool for goal planning and key-working. These files shall be made available for audit purposes at the request of the Purchaser.

Service Users must have access to their individual records on request, in accordance with the Data Protection Act.

Records shall be made available to the Purchaser within a reasonable time upon reasonable request.

The Service Provider shall retain all original invoices, management information returns and any other documents necessary to verify Services provided by themselves or its sub-contractors in relation to this Contract.

In addition, all necessary data and information on Service Users and Services provided shall need to comply with the requirements of the NDTMS National Treatment Agency database. The Purchaser shall deem non-reporting of data to the NDTMS on behalf of and for the DAAT as non-compliance with this Contract and termination or financial penalty may be considered for ongoing failure to report appropriately.

The information system utilised by the Service Provider must also adhere to NTA requirements and be sympathetic to local need where possible.

6.8 Purchaser's Responsibilities

To provide insofar as it is able to do so, the agreed amount of funding as detailed in the pricing schedule.

To performance manage the Service Provider to ensure compliance with the Contract.

To provide guidance and updates on local strategy or policy updates which may impact upon, or be impacted upon by the service.

6.9 Contract Management Requirements

Variations to the Service may occur at any time period during the period of this Contract, by agreement between the parties. Variations in the terms of this Contract shall be agreed and confirmed in writing by the Purchaser.

7. References and Documents

https://www.gov.uk/government/publications/drug-strategy-annual-review-2012-to-2013
www.nta.nhs.uk/uploads/medications-in-recovery-main-report3.pdf
www.rbwm.gov.uk/
www.nta.nhs.uk/drug-treatment-2012.aspx
www.legislation.gov.uk/ukpga/2012/7/contents/enacted
www.legislation.gov.uk/ukpga/1998/37/contents
www.ndtms.net/
https://www.gov.uk/government/publications/alcohol-strategy
https://www.gov.uk/government/organisations/public-health-england
www.rbwm.gov.uk/web/jhws.htm

8. Appendix

National and Local Strategic Context

8.1 The first **National Drug Strategy was launched in 1998**, outlining a 10 year co-ordinated strategy to tackle drug addiction, the harms it causes our communities, the availability of illegal drugs and to improve related enforcement activities. In 2001 the Government invested in a drug treatment system for England which was based on the best available evidence.

8.2 The number of drug users in treatment increased from around 100,000 in 2001 to 210,815 in 2008-09. A co-ordinated approach to treatment based on both medical and psychological interventions was recommended and the borough followed suit, offering interventions such as counselling and other psychological modalities as well as substitute prescribing for those using heroin.

8.3 In October 2013, the National Treatment Agency (NTA) released their report, **'Drug treatment 2012: progress made, challenges ahead'**, outlining successes within the treatment sector and the changing patterns in drug use in England.

8.4 The number of new heroin addicts has sharply reduced: 9,249 started treatment for heroin addiction in 2011-12 for the first time, compared to 47,709 in 2005-06. However, at this stage, even with numbers falling, heroin still remains the biggest problem for those in treatment which is reflected locally.

8.5 Drug treatment services are achieving significant progress in enabling people to end their dependency on drugs and therefore the investment in services is producing results. Young people are now much less likely to use drugs than for a generation, and particularly less likely to use heroin or crack cocaine.

8.6 Alcohol treatment has now been given equal weight to drug treatment due to relatively recent, freedoms and flexibilities in funding. This move has enabled local commissioners of drug and alcohol services to tender for a fully aligned and integrated substance misuse service. In addition, there has been a change in the drug landscape, with new psychoactive substances, including legal highs, now posing a challenge for both prevention and treatment services.

8.7 Under the new National Drug Strategy, '**Reducing demand, restricting supply, building recovery: supporting people to live a drug-free life' 2010.** There is a recognition of the progress since the last strategy was released and a new focus on recovery as outlined in the following overarching objectives which each locality must achieve:

- ***Reduce illicit and other harmful drug use***;
- ***Increase the numbers recovering from their dependence on drugs or alcohol***

The Strategy describes recovery as follows:

> 'Recovery involves three overarching principles – wellbeing, citizenship and freedom from dependence. It is an individual, person-centred journey, as opposed to an end state and one that will mean different things to different people. We must therefore put the individual at the heart of any recovery system and commission a range of services at the local level to provide tailored packages of care and support. This means that local services must take account of the diverse needs of the community when commissioning services.
> One of the best predictors of recovery being sustained is an individual's 'recovery capital' – the resources necessary to start, and sustain recovery from drug and alcohol dependence.
> These are:
>
> - **Social capital** – the resource a person has from their relationships (e.g. family, partners, children, friends and peers). This includes both support received and commitment and obligations resulting from relationships;
> - **Physical capital** – such as money and a safe place to live;
> - **Human capital** – skills, mental and physical health, and a job; and
> - **Cultural capital** – values, beliefs and attitudes held by the individual.

8.8 In addition to the long established National Drug Strategy, the Government launched The National Alcohol Strategy, 2012, which outlines the need for a co-ordinated multi agency approach to tackling alcohol related harm. In terms of the need for treatment, the strategy

highlights the need to develop a range of local pathways including linking with the Troubled Family Agenda, developing the use of Alcohol Treatment Requirements and overall developing robust treatment pathways with models echoing and being integrated with drug treatment.

8.9 The lead for developments in substance misuse had sat with the National Treatment Agency (NTA) but this was disbanded and in April 1st 2013, the function of ensuring high quality, outcome focused treatment services was moved to Public Health England, creating a dedicated drug and alcohol national lead.

8.10 This change occurred in line with the move of Public Health into local authorities and overall a move towards localism. Under the terms of the ***Health and Social Care Act 2012***, upper tier and unitary authorities became responsible for improving the health of their population and the responsibility for public health was transferred from the NHS. Each top tier and unitary authority were responsible for developing a statutory Health and Wellbeing Board (HWB) which has strategic influence over commissioning decisions across health, social care and public health.

8.11 Furthermore, a **Joint Strategic Health and Wellbeing Strategy (2013 to 2016**) has been developed for each local authority. The DAAT's treatment services directly deliver against the following priority in RBWM's Strategy under theme 3: 'Enabling Residents to Maximise their Life Chances and Capabilities'

'With close to 500 residents receiving services a year, the Drug and Alcohol Action Team (through treatment services) will ensure that each resident receiving services receives a bespoke personal treatment plan, support and regular assessment of their own individual outcomes'.

8.12 In addition, outcomes for adult drug treatment services are defined as a part of the statutory **Public Health Outcomes Framework**, in the form of two indicators:

2.15 i Successful completion of drug treatment for opiate users.
2.15 ii Successful completion of drug treatment for non-opiate users

8.13 Drug and alcohol services must ensure that not only they contribute towards the aims of the National Drug Strategy and follow the guidance of Public Health England but they must ensure all relevant NICE guidance is adhered to including the following:

Drug Misuse: Methadone and buprenorphine for the management of opioid dependence:
http://guidance.nice.org.uk/TA114/Guidance/pdf/English
Drug Misuse: Psychosocial Interventions
http://guidance.nice.org.uk/CG51/NICEGuidance/pdf/English

Drug Misuse: Opioid detoxification
http://guidance.nice.org.uk/CG52/NICEGuidance/pdf/English
Alcohol dependence and harmful alcohol use quality standard
http://publications.nice.org.uk/alcohol-dependence-and-harmful-alcohol-use-quality-standard-qs11
Interventions for conditions comorbid with alcohol-use disorders
http://pathways.nice.org.uk/pathways/alcohol-use-disorders/interventions-for-conditions-comorbid-with-alcohol-use-disorders.pdf
QS23 Drug use disorders: NICE support for commissioners and others
http://guidance.nice.org.uk/QS23/CommissionerSupport/

8.14 In addition, to the changes within health, there were also changes in April 2013, around the oversight of local policing which resulted in the formation of Police and Crime Commissioners. The **Thames Valley Police and Crime Commissioner's Plan, (2013 to 2017)** identifies the need to tackle substance misuse under 'Priority 5' with the following two explicit objectives:

- ***Tackle drugs and alcohol using prevention, and rehabilitation***
- ***Work together to rehabilitate offenders to reduce their likelihood of re-offending.***

8.15 Local authorities also have a duty to deliver against **Section 17 of the Crime and Disorder Act (1998),** meaning that there is a duty to consider all crime and disorder implications within decision making. If drug and alcohol treatment services were not in place, this would result in an increase in crime and anti social behaviour within the local community due to the links with acquisitive crime and services provided for those on Probation statutory orders. The service is expected to provide interventions which meet the need of clients in the criminal justice system, including the provision of Alcohol Treatment Requirements and Drug Rehabilitation Requirement.

Service specifications for the delivery of the statutory Alcohol Treatment Requirements and Drug Rehabilitation Requirements, are published by the National Offender Management Service:

Support delivery of the Alcohol Treatment Requirement
https://www.gov.uk/government/publications/noms-service-specifications-for-interventions
Support delivery of the Drug Rehabilitation Requirement
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/278671/2014-01-20_DRR_Specification_P2.2.pdf

8.16 Overall, the service will, with direction from the DAAT Manager and Commissioner, be required to deliver treatment in line with all national and local policy developments as well a locally set plans and strategies.