Appendix 6 – Consultation Responses

Sheffield Drug & Alcohol Co-ordination Team

Commissioning & Procurement Plan Public & Stakeholder Consultation Responses

Introduction

A formal 8 week consultation was launched by Sheffield DACT on 4th November 2013 which asked 16 questions about the DACT's proposed plan, including question 16 which was an open invitation to make further comments.

51 individuals attended the consultation event on 4th November and comments on flipchart "graffiti" boards for each question were recorded.

15 written submissions were received on the pro-forma questionnaire by the deadline of 27th December 2013. These were predominantly from Sheffield NHS organisations (2 from the Clinical Commissioning Group, 5 from GPs working in substance misuse, 1 from the Local Medical Committee representing GPs, 1 from Primary Care Addiction Service Sheffield and 1 from Sheffield Health & Social Care NHS Foundation Trust current providers of substitute prescribing for opiates in the city, 1 from Yorkshire Ambulance Service).

Four other written responses were received: 1 from a local MP, 1 from Lifeline – a VCF substance misuse service not currently providing services in Sheffield, 1 from an independent employment mapping organisation and 1 anonymous submission.

There was also internal consultation within Sheffield City Council which informed strategic commissioning decisions.

Questions & responses

Q1 Do you agree with the model of "end to end" services where an individual has all their needs met within a single service rather than having to transfer as their needs change?

11/15 respondents agreed with the model of end to end services.

- Yes, lots of benefits not being "passed on – hand offs", more integrated care, prescribing with PSI (as per NICE) happening, more single keyworker
- Yes, to a certain extent although sometimes a specific service is needed during times where specialisms would support the service user e.g. moving into aftercare provision
- Yes, but need to accommodate poly use and ensure the different services opiate/non opiate and alcohol work together where needed
- Yes, but I'm not sure the two drug pathways describe this e.g. if you go to the needle exchange service, then after PSI wish to enter prescribing do you then have to go into the opiate pathway? Surely, end to end would be the whole thing with possible a separate path for actual non-opiates ie. Cannabis, khat, steroids etc

- Yes, it would offer a “journey” for the client rather than a disjointed pathway. They would have the opportunity to access all aspects of care in one place, hopefully improving retention and recovery.
- Yes
- Obviously it is advisable that patients with addiction problems are seen by the appropriate people with appropriate expertise and, therefore I would support a service with a degree of specialism in each area. However, in many cases clients have more than one addiction problem and a number of allied health problems, and therefore, I do think it is important to have a funded link to Primary Care for the benefit of the patient as a whole.
- Yes
- No. I believe that informed choice should be available. Specifically, informed by service users. If those in early recovery have only one option they are likely to think that any failure to recover or relapse is down to their own inadequacy. They are more likely to opt out of any but emergency treatment with ominous results.
- I am not entirely clear what this means in practice. I am unclear what problem this solves. At present patients/service users are able to access e.g. nurse/drug worker across all providers and transfer of prescribing between providers does not appear problematic from my direct experience.
- Yes, although there are disadvantages as well as advantage for clients as well as providers. One of the main disadvantages for patients is that having one provider limits some of the choices currently open to patients.
- We agree with the principle of end to end services and welcome the commissioner’s view on this. There are two ways of defining end-to-end service – one by the substance of choice and one by level of dependence or complexity of addiction. It is welcomed that the proposed models offer a service user of a single substance end to end care. An important consideration however, is for the increasing population of poly drug/alcohol users and how the whole treatment system will need to work cohesively to coordinate care for this complex and often chaotic group. The complexity of commissioning end to end services, when constrained by separate drug and alcohol funding streams and national data set requirements is recognised and it will be important for successful providers to work with commissioners to address this to ensure we are able to track and coordinate progress through treatment. End to end as defined by level of dependence rather than the substance of misuse could be another consideration for particular cohorts of substance misuses, and if well defined, in the case of dual diagnosis of poly drug/alcohol services users. This could still be delivered by multiple contractors all contributing to a clear care pathway.
- Yes, Lifeline agrees with the model of end-to-end services, in which an individual has all their needs met with a single service rather than having to transfer as their needs change. Benefits of the end to end model – we take the view that central to service users’ needs are a sense of consistency, stability and ease of progress through their recovery journey. The alternative of providing a fragmented service through which a service user must navigate in order to make progress, poses unnecessary barriers to engagement, which could stall recovery journeys. Lifeline always puts the needs of service users first and has considerable experience of very successfully delivering end-to-end services. There is clear benefit to the commissioner in commissioning end to end services. Thus model provides a single point of accountability and streamlined monitoring arrangements. It also provides clarify of the offer to both the commissioner and the service users. A genuinely end-to-end service will include signposting to other wraparound agencies, to provide holistic solutions to individuals’ diverse and

complex needs, such as housing, employment, education and training. In particular, there is a clear need for effective links with the criminal justice system. The end-to-end model would need to be delivered across multiple, strategic locations, in order to ensure access for all.

- I believe primary care is ideally suited to provide a smooth, efficient, well structured, holistic, boundaried but flexible service for clients [patient example redacted] we can take into account employment, family, housing and physical health challenges in one place.
- Yes. I support the overall direction with 3 pathways. Currently we have some really good services, that are working well. This is an opportunity to improve patients' experience, but I hope that the pathways do not work in isolation, as that will not be an overall improvement on what we have now.

Q2 Do you agree with the model of separate services for opiate and non-opiate users?

There was a mixed response to this question with the majority (6) being "not sure", 5 distinct "yes" responses and 3 firm "no" responses.

- Generally yes, although sometimes breaking down the stigma – even between substance misusers is useful i.e. NA/SMART Recovery
- Yes and no, views of service users should be listened to and acted upon, but more could be done to tackle stigma and perceptions , rather than separating services, this is the same for alcohol
- Yes – not sure if it's possible to change stigma at treatment stage
- Non-opiates need a different approach to alcohol users. But better to have a single point of entry and multiple responses from within one overall treatment service
- They need different responses not necessarily different service provision
- Yes
- I do not feel that I have sufficient expertise on the benefits or risks of separate services for opiates and non-opiates but I do think it would be sensible to gain the view of those doctors with considerable experience.
- No, I think a service that looks after both opiates and non-opiate uses would be the best model. In most patients there is overlap between opiate and non-opiate use. I think that it is important that the service reaches out to patients either by satellite services or GP shared care.
- No. This suggests that addiction to substance misuse is OK if you can get by switching from one substance to another. My experience of alcohol addiction was of switching from beer to spirits and then anything believing that I would eventually find something I could get by with.
- I think this is sensible at a specialist service level as many non-opiate users see association with opiate users as stigmatising and this is likely to reduce engagements. However, at the primary care/general practice level services provided in general practice are non-stigmatising as patients are seen alongside non-drug using patients.
- Yes. These are generally very different client groups with different needs and different demands on services (although we recognise that patients often need to be referred between the two.)
- Whilst we acknowledge a full integration of all drug services at this point may be too much of a change to the treatment system, there are clinical benefits to having a current/future aspiration of an integrated opiates/non opiates services. It is well recognised that the pattern of drug use is changing in society and poly-drug use is the norm (with or without alcohol). The

emphasis for treatment providers should be placed on having a competent workforce able to deliver interventions to a variety of addictions/addictive behaviours across all substances, contributing to “end to end” care. Both assessment and interventions must match the individual need rather than the substance. A future single assessment function would ensure a cohesive approach to treatment, irrespective of the drug or drugs of choice. There are opportunities to ensure that the two front doors to the referring public are hidden behind one public facing front door, in order to facilitate referral and pathway navigation. This could be considered as a requirement within the procurement of opiates/non opiates services. There are also economic benefits to the current/future integration of opiate/non opiate treatments, to respond to reducing public spend. Any current/future integration would need to evidence the benefit to front line service capacity, quality and provision due to a more streamlined management/organisational infrastructure.

- Yes, Lifeline agrees with the proposed model of separate services for opiate and non-opiate users. Benefits of separate services – we are aware that when opiate and non-opiate services are integrated, there is potential for non-opiate provision to become an add-on to the opiate service, with opiate provision taking up much of the provider’s focus. In such instances, the risk is that the non-opiate provision could become increasingly marginalised. Given the emergence of Novel Psychoactive Substances (NPS) and the rapid pace of growth and change with such substances, it is crucial that providers maintain a focus on delivering appropriate services. With the nature of NPS and their expanding and diverse supply, their risks are largely unknown and un-quantified. It is a distinct non-opiate service that will best place the commissioner and provider to scope and address this significant challenge. It is Lifeline’s view that opiate and non-opiates services should be separated, in order to address and mitigate the emerging risks posed by NPS.
- A holistic approach would suggest that GPs are ideally placed to not only oversee these problems, but provide services to clients on one place close to their homes. Travel and transport costs can deter clients from follow up.
- Yes. I support the overall direction with 3 pathways. Currently we have some really good services, that are working well. This is an opportunity to improve patients’ experience, but I hope that the pathways do not work in isolation, as that will not be an overall improvement on what we have now.

Q3 Do you agree with the model of a separate service for alcohol, not co-located with any drugs service?

A small majority (7) agreed with the model of separate services for alcohol, not co-located. 3 were firmly opposed. 6 were unsure and could see both benefits and drawbacks.

- No, service user feedback is critical, and it is understandable if they feel more comfortable with a separate service. However, innovations and Value for Money that come from integration [may be lost?] and as well as up skilling the workforce and catering for poly drug use is lost in this model. With this in mind, a solution could be to offer various shared care/community outreach arrangements.
- Yes, during treatment it facilitates focussed offer of services. There is a lot of innovation already coming from solely alcohol based services!

- Yes, during active use stage, but no during recovery/aftercare. I think combining people in recovery from anything is beneficial but understand the potential need for separate services if 'alcohol' only from the start.
- During active use and also as part of education and brief interventions/but PSI should be combined
- Apart from patients in the opiate pathway who are also using alcohol. Clarification needed
- No, I think there needs to be a place where a client can access alcohol and drug services for those significant number of problematic drug users who also have an alcohol problem. If such a client needs medical intervention for alcohol, as is often the case, they need to have their drug use managed alongside this with a team who can provide both aspects of care. Perhaps, there should be a pathway that offers this within the opiate/non opiate service that doesn't mean that client needs to be seen at an alcohol AND a drug service.
- Yes
- The LMC's view is that alcohol services should have an intimate link to Primary Care. We would support the Single Entry and Assessment Point (SEAP) and PCASS model, but there should still be a link with individual practices where doctors wish to undertake community detoxification for their patients and feel they have the interest and expertise, much as with the current model. In your document you highlight the number of unidentified alcohol users within the city and I think the best way to screen these patients and signpost them to the most appropriate people is through Primary Care. Where there is a need to more expert intervention, then I think this should be available as a separate service.
- Yes. This service could either be co-located or separate to the drug service. I think however the service should have outreach into the community either via GP Shared Care or other means.
- No, the shared experiences of recovery are extremely valuable and can help prevent the switching process that lengthens or ends the process of recovery.
- Co-location of specialist services is a barrier to engagement – however provision of services in general practice is not stigmatising.
- Yes – for service users who have alcohol but no other drug issues. Alcohol services certainly need to be delivered from a different location to opiate services as we need to continue to remove barriers to treatment for alcohol users. We are concerned however that compartmentalising services in this way can increase costs and reduce the amount of resource available for direct patient care.
- Separate service – there are presently different funding streams for the provision of alcohol related treatments within the local health economy. It is important that the alcohol agenda and its health and social care impacts are more widely understood and its separate funding from drugs services supports this. Whilst acknowledging the addiction similarity with drug services, those experiencing alcohol misuse also have very different clinical presentations, including the increase of more complex physical health complications. The interdependencies and pathways for alcohol services also differ and there is much opportunity within Sheffield for further development both into and within treatment. A model of a separate service for alcohol at present would support the development of these pathways. Not co-located with drug services – As the current incumbent of drug and alcohol services we are able to recognise and appreciate both the challenges and the opportunities created by co-locating drug and alcohol services. We recognise for some services, receiving alcohol treatment from a building also providing drug services, this can be off-putting and a deterrent to accessing treatment. For others, this has not proved a challenge. It has to be recognised however, that funding

availability for treatment is decreasing, even more evidencing the need to use resources to maximise the availability of front line services. Building costs continue to rise and there are economies of scale to be reached in sharing buildings. It is how services operationalise the use of buildings which is key. Satellite premises and outreach facilities provide the opportunity for alternative facilities and recognise that not one building will provide the right solution for all service users. There are clinical benefits to having a co-located/premises solution between drug and alcohol services. This includes the more holistic management of poly drug/ alcohol service users, a cohort that is on the increase; sharing of clinical knowledge and expertise and maximum use of resource.

- Yes. It is difficult to make a definitive answer to this question as there are numerous benefits to a combined treatment system that could be drawn out and highlighted such as integrated care for those with multiple misuse issues and the idea that recovery has general features that are similar across all substances, including those that are drinking at hazardous and harmful levels but are ambiguous about change and would not consider themselves as having any problem with alcohol, is so diverse demographically that it requires a unique and more flexible treatment offer. This will include multiple points of access, screening, IBA, prevention and awareness raising delivered via efficient partnership working with GPs, Hospital trusts and other Primary Care services to attract and engage this large and for the most part, treatment naïve client group. This requires a specifically focussed and targeted service which is best delivered by a separate alcohol service.
- Primary care offers an ideal place to consider all aspects of the challenges facing patients. If we ignore the threats related to alcohol in an opiate user, especially in one who is trying to be free from opiates, we cannot understand the problem fully and advise accordingly.
- Yes, [as long as alcohol as part of poly drug use is addressed within drug misuse services]. I suspect that many people with alcohol problems may not want to enter a building known for alcohol services either.

Q4 Do you agree that alcohol misuse as part of poly drug use is best addressed within drug misuse services?

9/11 agree that alcohol misuse as part of poly drug use is best addressed within drug misuse services. A further response is supportive. One response is firmly opposed. One response praises GPs ability to deal with alcohol as part of poly drug use.

- Yes, if used in conjunction or as a substitute to substances because the underlying drivers/triggers may be the same and can be dealt with through PSI
- Yes, provided separate drug workers are sufficiently trained in alcohol treatment, this is a risk with separate services
- Yes, for those on methadone
- Yes
- Yes
- Yes
- The idea that “at least I’m not” or “at least I do not do that” is self-deception. As an alcohol abuser I considered that I had a great way to fall before using drugs. Depending on the legitimacy you justify your addiction, with peers, social media etc it is likely that this sort of thinking would play an important role in putting service seekers off.
- Yes. Evidence shows us that many clients develop co-dependencies on alcohol and other drugs. To have a separate alcohol service for this group would mean that care would be

fragmented. The overlap in terms of skills and knowledge for workers means that the integration of these services makes functional and financial sense and means that workers will be able to work with a patient holistically.

- SHSC is of the view that alcohol use is best addressed within drug services, where poly-drug use is present. Increased alcohol use is a recognised complication of abstinence from opiates, and individuals stabilised on maintenance treatment. Supporting the service user's needs within one service provides a better experience for the service user as well as better management of the care pathway. Addressing alcohol use within a drug service supports the development of a workforce skilled to deal with all types of addiction, not just alcohol or drugs.
- Yes, Lifeline agrees that alcohol misuse as part of poly drug use is best addressed within drug misuse services. The benefits of this model – in designing our delivery model, we always place the service user at the centre of our thinking. A delivery model is most effective when it offers the service user a sense of consistency, stability and ease of access to provision across all of their needs. The model should also facilitate the building of trust between the service user and the provider, allowing the service user to be completely open about their needs. Such openness gives the provider the opportunity to take a holistic approach to an individual's requirements and address them in full. Keyworkers from drug misuse services have the skills, knowledge and experience to deal with alcohol misuse issues from their client group and should be tasked to do so. To work with a client on drug issues but then need to refer out for an associated alcohol issue is fragmented, inefficient and likely to have a negative rather than a positive effect on the client. This is also likely to deskill the drugs workforce and de-motivate workers.
- Many of the addicts I have treated have reduced and stopped their opiate use but go on to abuse alcohol. We [GPs] can offer them support for this if this problem arises.
- Yes

Q5 Is the commissioned capacity sufficient to meet local need?

The majority (6/10) are uncertain, but with a strong feeling that more capacity for alcohol may be required.

- Might need more SEAP places
- For drugs – very likely. For alcohol – if done well, more may be needed.
- I can see no mention of those patients in GP Shared care in the new figures in the consultation document? Also that secondary care may not need 950 places. I am unaware of any "rezoning" that has taken place by any external clinicians at the current secondary care provider, so I'm not certain how those figures have come about. They are based on current clients in that service. Do all those clients need secondary care services?
- No, what is the point of recovery if you are only going to return to the place that your addiction began. Getting better is fine but the prospect of finding work (recovery bread winner status) can seem a mountain to climb in the mind of those in early recovery. There has to be some specific help and hope, role models and peers who can assist and demonstrate that this is possible. Help for job seekers in recovery, enterprise, community business support and an agency to address, investigate and promote these issues. Something solids to recovery towards.
- I do not know enough about the accuracy of the figures presented to comment.

- The capacity (although under-used at present) may be insufficient for alcohol users as we know this to be an expanding group. Reduced investment in Drug services is a huge issue.
- Yes. Based on current demand for services and the needs assessment processes in place within the city, commissioned capacity appears to be sufficient particularly around the drugs services. There may be a need for increased capacity in alcohol services as prevalence increases and identification in mainstream services improves. The local drugs needs assessment process and local intelligence suggests there are1,000 treatment naïve opiate and crack users in Sheffield. Current practice informs us however that the complexity of service users in secondary care continues to increase and create management challenges. Clinical experience also reveals that those treatment naive service users who do present after years of non- contact, tend to be difficult to engage, more complex and have previously unidentified co-morbidities including complex acute, physical and mental health challenges. These are important considerations when considering an operational and workforce model fit for purpose.
- Yes, we are aware that local drug trends have shifted since the previous render in 2009/10, and that commissioning intentions are informed by these changes. Having considered the proposed volumes of care across al three contracts, it is our view that they seem appropriate to meet existing need. However, this observation would be subject to due diligence going forward.
- I am aware that neither Guernsey House nor Fitzwilliam have room to accommodate all the addicts scripted across the city. The costs of re-housing services would be substantial. New primary care buildings already established across the city provide good quality, local facilities that not only provide place for addiction problems but also support occupational, housing and benefit support (such as SOHS) under one roof.
- Probably yes, but you have identified problems with identification and referral into services, so if care planning and other initiatives continue, we should see more screening and therefore referrals for substance misuse or alcohol over the next few years.

Q6 Is the level of investment in drug and alcohol treatment services sufficient to meet local need?

The majority 9/13 are uncertain. There are three distinct “no” responses.

- No, not enough for alcohol of course, need more community based alcohol
- Interested in the proposals on payment per capita and how that will work
- Drugs – possibly ok, but may need more. Alcohol –no. More funding definitely needed.
- I don’t know until those services are up and running.
- The proposed service looks reasonable to me but with little reference to Primary Care.
- We should not be reducing investment in drug and alcohol services as the need is not reducing.
- Yes. Further funding required, help for self-sufficiency for exit strategy and contingency.
- No. I am concerned that the proposed 25% “savings” will be in practice not be met from a reduction in overhead costs and there will be a resultant reduction in funding for the service.
- No. The reductions in the levels of investment in drug and alcohol services mean that providers will be unlikely to be able to deliver services as comprehensively or to the quality that we aspire. The demand for alcohol services in particular are expected to outstrip capacity. PCASS hopes that the tender documentation will allow bidders the freedom to describe their own, affordable model of care. If the tender documentation is too specific about

the model of care, then we are concerned that will limit bidders' ability to describe a high quality service that will fit within the financial constraints.

- Needs assessments indicate that there is still significant numbers (800-1,000 treatment naïve individuals) not accessing formal drug treatment and the current treatment system has capacity for only 13-26% of Sheffield's dependent drinking population. We are seeing changes in the pattern of drug and alcohol use and age of presentation, as well as a stark increase in complexity. A proposed 25% reduction in investment over 3 years will place a challenge on the treatment system to work as efficiently and effectively as a whole rather than as separate providers in a pathway. It is acknowledged however that budget reductions are being applied to all areas of the public purse but in doing so also creating opportunities to think creatively in the way services work together. An important component to continue to address drug and alcohol misuse within a decreasing budget, is to work in partnership with other health, social and third sector organisations to improve earlier identification, screening and refer on as appropriate, as well as increasing awareness and understanding of drug and alcohol misuse. To do this, focus from the city wide Right First Time Agenda would greatly support opportunities for other commissioning colleagues to explore ways in which the wider system can support/bring about transformation further upstream and avoid more expensive use of resources e.g. hospital admission, frequent/repeat attendance in health/social care services.
- Whilst the level of funding would appear reasonable, without a detailed service specification and an assessment of current service costs (e.g. Non pay, staff and TUPE costs) it is difficult to be authoritative on this matter. WE also note that the efficiency gains of over 10% in Years 1 and 2 would appear very challenging.
- I believe if you are looking for overall cost savings primary care offers value for money as well as high quality care for most addicts.
- I think there needs to be more explicit mention of access and services having some responsibility for holistic care, even if they aren't providing all the elements of it. Harm reduction team is there for some with high needs, but many clients need GP, mental health or hospital services and don't manage to access them. Support workers who can prompt by phone, arrange appointments or transport, or even accompany people are necessary for some.

Q7 Do you think that the services and model described in the DACT Commissioning & Procurement Plan will meet local need?

There are 4 "no" responses which are majority of the 11 responses. Three respondents were unsure and three agreed the services and model would meet local need. There is strong support from GP respondents for the continuation of GP led treatment offers.

- Drugs – more thought needed about end to end pathway. Need to extract non-opiates and provide NEX and PSI to those. Plus have provision of NEX to opiates so patients can move seamlessly through the pathway. Alcohol – given the likely increase in figures/number needed to treat (NNT) then need to design a pathway that uses GPs very strongly and works much more closely with hospitals than currently to ensure sufficient capacity in the system.
- No, what about the 472 clients currently being looked after in GP Shared Care
- I accept there should be a centralisation of specialist services, but I think to meet local needs it would be important to have a local provider, which should be those GPs with expertise and an interest, where clients are already familiar with attending.

- It is possible for the model to meet the local need as long as patients are able to continue to get a service close to home.
- No
- No, I am concerned that GP services will be lost. These are highly valued by patients and have significant benefits in terms of integration with care for physical health needs and mental health needs below the threshold of CMHT both of which are common within the cohort of patients especially as the cohort of opiate users who have been unable to become opiate free become older and develop more long term conditions. Current GP shared care means that approx 150-200 patients in North Sheffield receive care locally at their GP practice. If their care was transferred to a centrally located provider this may result in people dropping out of treatment increased DNAs, increased travel costs for often impoverished patients and so potentially worsening health inequalities. If a single provider does not intend to include GP shared care I would suggest satellite centres in areas of greatest.
- No. The services and model described will contribute to meeting local need but the reduction in investment mean that it will be difficult for providers to deliver those services to the highest quality.
- Yes, at current and proposed levels of activity.
- Yes, we think that the services and the model described in the DACT Commissioning & procurement Plan appear to meet local need. The service and model appear strategically sound, in that they are consistent with, and appropriate to successful delivery of the aims of the National Drug Strategy and Government Alcohol Strategy. It is clear that the services and model have been informed by identified shifts in local need since the ender of 2009/10. In particular, the service and model appear to be service-user focussed, and designed for maximum provider accountability.
- GPs are well placed to understand the problems encountered in their own neighbourhood. Often GPs know other members of families troubled by the addict's behaviour. Often GPs are aware of friendships that help or threaten improvements in conditions (for example when one addict on a list is ill, relapses, self-harms or occasionally dies this knowledge is immediately shared across the full primary health care team (who have often known these families for many years), so that appropriate support can be co-ordinated for family members, and other addicts who often know the problems of the addicts involved. GPs are in liaison with local pharmacies and help together to negotiate challenges to addicts' improvement.
- Cautious yes, taking other comments into account.

Q8 Will the non-opiates service meet the needs of local non opiate users, including cannabis, powder cocaine, ecstasy, ketamine, new psychoactive substances, steroids and new emerging non opiate drugs of misuse?

The majority (5/10) agreed, two disagreed and three were uncertain.

- Is there capacity for group work? This seems to work well with some non-opiate users?
- Consider number of personal recovery budgets. Not ideal to base on the number being discharged – need to look at allocating to those who would be discharged if they were enabled by help like this i.e. it makes the difference.
- Yes
- Yes
- No

- No. The services and model described will contribute to meeting local need but the reductions in investment mean that it will be difficult for providers to deliver those services to the highest quality. The very emergent nature of this sector means that it is difficult to do long term needs assessments and service planning.
- Yes, although it is recognised that local intelligence is still being gathered at this stage – the focus in the past has been on Opiate and Crack use so it will be important to continue to monitor to ensure services are appropriately available and commissioned.
- Yes, it is our view that the model for services for non-opiate users appears to be appropriate. The statistic, mobile and embedded needle exchange is thorough, and offers sufficiently variable means of delivery to cater for the diverse needs of service users. It is target-drive and the process for identification of unique individuals will, as is appropriate, safeguard against duplication of effort and dual funding. We take the view that open access is essential to any effective delivery model and is key to assessment and the appropriate sequencing of interventions going forward. The outreach measures are crucial and it is reassuring to read that the commissioner intends to focus on khat users, amongst others, as this is an area that can be overlooked. The combined offer of full and briefer packages of Psychosocial Interventions (Drugs) gives the opportunity to tailor provision to specific needs. Plans for personal recovery budgets are reassuring, as they are based upon previous experience of local implementation.
- We [GPs] often build up a relationship with addicts as children (before they start using), and when they become parents we need to take into account safeguarding issues for the benefit of all our patients. Smoking and alcohol use though legal, is a considerable health challenge. Discussions re cannabis use and abuse may take place before and during opiate abuse. We are aware of other family circumstances that might help or prevent improved outcomes for addicts. An awareness of how one addict behaves under stress if often built up after years of a relationship. I have recently seen not only previous opiate abusers and alcoholics who now having gained some control of their primary addiction problem, and no longer needing opiate substitution prescription, welcome the continued support and questioning of the GP who saw them through some of the hard and challenging times of their previous chaotic drug use. If I had not supported them personally, I very much doubt that I could have asked them so directly about problems that were not directly related to their new presenting complaint.
- Not my area but probable yes

Q9 Will the opiates service meet the needs of local opiates users, including heroin, opium and prescribed and over the counter products?

Four respondents agreed. Four were uncertain. One disagreed.

- I would suggest that if capacity allowed there should be more PSI and more regular 1-2-1 appointments and suggest a minimum of one per month, this is when people seem to get stuck on scripts
- Yes
- Yes
- I am concerned that the proposed 25% “savings” will be in practice not be met from a reduction in overhead costs and there will be a resultant reduction in funding for the service. I am concerned that a valuable service provided by GPs will be lost as these are highly valued by patients and have significant benefits in terms of integration with care for physical health

needs and mental health needs (below the threshold of CMHT) both of which are within the cohort of patients.

- No. The services and model described will contribute to meeting local need but the reductions in investment mean that it will be difficult for providers to deliver those services to the highest quality. PSI – There is little evidence of a significant qualitative difference between formal and informal psychosocial interventions. There is evidence that service users can benefit from a wide range of modalities (beyond cognitive behavioural approaches) where the "therapeutic alliance" (NTA, 2007) is the focus if care. Therefore, flexibility in the specification around this area would be welcomed in order to allow providers to offer and deliver services that meet the needs of individuals. Personal recovery budgets – we support the idea in principle although we are concerned that the management of many personal budgets by keyworkers could be labour intensive and complex. Therefore, we recommend that the investment could be better used to support projects that support a number of clients in recovery *community* projects e.g. SMART groups, access to education, art and music projects etc. We believe more benefit could be gained by using the investment to support peer groups of service users to access recovery activities while they are in treatment – rather than focussing on individual activities for service users who have completed treatment. We support the integration of PSI activities and harm reduction into the opiate contract as the division of these elements previously has been unhelpful. As described previously – the reduction of investment in services is of great concern and we believe providers will find it difficult to meet the need of service users, to the quality that we aspire to , within the financial constraints. We are concerned the investment reductions are likely to result in reductions in front line staff and on 'soft targets' like training and development budgets.
- Based on current service delivery and uptake in both primary and secondary care, the proposed service would be expected to meet the need of the local population.
- Yes, it is our view that the model for delivery of an opiates services appears appropriate. The clinical nurse-led single point of assessment and referral, along with the plans for pharmacological interventions are consistent with Lifeline's approach to such provision. The 30% cap on formal psychosocial interventions for those in prescribing treatment appears appropriate, but this observation would be subject to due diligence going forward. Plans for personal recovery budgets are reassuring, as they are based upon previous experience of local implementation. The plans to offer specialist harm reduction interventions in satellite location addresses the needs of hard to reach service users, and the small re-active team of specialist nurses and social workers is a positive innovation.
- Boundaries are vital; however some negotiated flexibility when "hard times" intervene may be essential. GPs are ideally placed to provide a sensitive but boundaries service that will provide good care and follow up for all clients. If clients are aware that support for physical health is provided in a non-judgemental way, if a No (or a negotiated, contractual yes) is required for opiate substitute prescription, clients are more likely to carry on and return in a more trusting fashion to a known GP, rather than to a drug only service that can only say No because of restricted protocol issues.
- Probably yes, see comments around access [I think there needs to be more explicit mention of access and services having some responsibility for holistic care, even if they aren't providing all the elements of it. Harm reduction team is there for some with high needs, but many clients need GP, mental health or hospital services and don't manage to access them. Support workers who can prompt by phone, arrange appointments or transport, or even accompany people are necessary for some]. Also, although opiate presentations may not be

rising, we are recognising more problematic analgesia and related issues.

Q10 Will the alcohol service meet the needs of local people drinking above Department of Health guideline safe limits, including binge drinkers, those drinking at increasing and harmful levels and dependent drinkers?

The majority of respondents (6/11) were uncertain. There were two "no" and three "yes" responses.

- What about running groups as brief interventions? Would capture more numbers ad build recovery communities and recovery capital.
- Because the problem is potentially huge, it is important to set up a system that has capacity to grow. Patients with alcohol problems are unlikely to attend a centralised service and this very much needs to be planned in conjunction with the CCG. Suggest central support with expectation that majority of care provided in the community, strong liaison with secondary care – does not necessarily need to be a psychiatrist for inpatient detox.
- Yes, we need to ensure that there's a safe, speedy and effective route into alcohol services much like the current SPAR model for drug services
- I think the Alcohol Service will provide a centre of expertise for those patients who have been identified, who have a serious problem and need support. However, you do refer in your document on a number of occasions to GPs and GP pharmacological intervention and I do think that the best point of identification of people with need and early intervention is in Primary Care.
- No, unlikely as our most vulnerable people are increasingly marginalised.
- I feel it important the option of GPs providing this service is included. Many problem drinkers are very reluctant to engage with specialist alcohol services will engage with GP services.
- No. This is an area where demand for services in increasing and the impact on society is significant and therefore where more and more investment will be needed. We would be pleased to see more focus on community outreach (recognising the need for more useful tools to identify and attract people into treatment) and more focus on in-reach into hospitals.
- The enormous impact of alcohol on society as a whole (health, crime, society, economy etc.) means that demands cannot be met within a single 'alcohol treatment service' provider. The issues need to be tackled in a joined up way at a public health level and the local alcohol strategy should consider this. We recognise the constraints of the available budgets, and therefore see the importance of multiple agencies/stakeholders working together to ensure work to tackle alcohol issues is joined up and provides the best opportunities for service users and the population of Sheffield. Alcohol Identification and Brief Advice (IBA) – 2400 individuals identified and receiving brief advice would not meet local need, given general prevalence figures suggest there are between 9,000-18,000 dependent drinkers in Sheffield (2-4% pf adult population), if a more joined up strategy was coordinated across the city to identify, refer and uptake treatment. Further investment would be needed to bridge the gap between those currently identified and referred and the 2-4% of adult population that are drinking dependently & Nice guidance/clinical guidelines. There is a drive to make every contact count, and it is recognised that not all "alcohol interventions" can or should be provided by specialist alcohol services. There is a need however, to up skill and educate all health & social care professionals, specifically those staff working in universal services at the 'front line' in order to offer IBA for alcohol. A further important consideration is to reduce the need for a large numbers of individuals undertaking alcohol detox within the general hospital population, either as a result of enforced admission, as an admission for detox alone, or as

an admission with co-morbid complex physical health needs. The opportunity to consider transformation to invest in early intervention, community provision would be very much welcomed.

- Yes, it appears to Lifeline that the proposed alcohol service will meet the needs of local people drinking above Department of Health guideline safe limits, including binge drinkers, those drinking at increasing and harmful levels and dependent drinkers. The Single Entry and Assessment Point (SEAP) is based on the use of validated clinical tools that are appropriate to the task, and we anticipate the personalised approach to individual service users will enhance outcomes. The options around formal psychological interventions (PSI alcohol) are appropriate to the varying degrees of need amongst a diverse group of service users. The focus on criminal justice and enforcement routes to alcohol treatment is crucial, particularly considering the Transforming Rehabilitation agenda.
- We now have alcohol worker at our practice and so with opiate users can get the client to see this worker in the same building. If clients need to travel, their care and follow up are more problematic. In this difficult client group, more challenge often means no follow up. While this may be cheaper, it is less good for them, and less good for the community if crime rates start to escalate because of poor follow up. I believe taking locally sensitive, long term care away from GPs with a long history of prescribing to these clients and families might add to the criminal justice costs, and crime costs within the neighbourhood.
- I welcome the extra investment, as care planning approaches become more embedded and screening tools used more, we may identify more people who need various interventions, but currently probably yes.

Q11 Are there any groups or individuals in Sheffield who misuse drugs or alcohol and who will not have their needs met by the services described in the Commissioning & Procurement Plan?

Four respondents felt that there were individuals whose needs would not be met. The majority (11/16) were uncertain and required clarification that certain groups needs would be met.

- Provision for EU/other nationalities etc…what would there be for translators for example when khat is made illegal
- Yes, education services for under 18s
- Also home based services for SU who are disabled etc.
- There is a risk that by having criminal justice programs all delivered by DIP that these clients fall through the cracks after their statutory requirement end and pathways/opportunities are not provided for further voluntary treatment
- Greater support and help from GP needed, more identification of alcohol use, care of those in recovery and blocker prescribing
- Alcohol recovery could also benefit from personal recovery budgets
- A lot of alcohol users have anxiety problems and self-medicate, more mental health co-working needed
- Alcohol – all the people who currently don't approach or attend the service as it exists now, as it looks very similar and the alcohol contract as it exists now is acknowledged by key stakeholders, not to work. Drugs – missing the opportunity to make the whole opiate pathway much simpler. Having NEX separately misses the change to engage those users into treatment.
- No

- I would welcome your reassurance with regard to special groups such as the homeless, migrants and asylum seekers, pregnant women and families with children on safeguarding registers.
- Yes, job seekers in recovery
- Yes. We are anticipating further increases in patients from Eastern European countries. This will impact on interpreter budgets and may also have an impact on training and development for staff. It would be helpful if the plan provided more clarity by ranking the current commissioning priorities, considering the impact on health and society as a whole.
- In considering this question, we have identified individuals whose needs to not appear to be mentioned specifically in the proposals, but for whom we assume there will be a duty on providers to support these needs appropriately: (i) those with co-morbid mental health issues (dual diagnosis) (ii) Individuals with complex physical health needs related to their substance misuse (iii) specific groups of service users such as those with Korsakoffs or alcohol related dementia (iv) fringe communities/groups (these may be communities isolated by a variety of factors, including ethnic minority, geographical location, substance use) who do not readily access mainstream services (v) an ageing population in general – but specifically of both heroin and alcohol users.
- Yes, whilst we have not identified any particular group of service users in Sheffield whose needs are not being met in this commissioning plan, we would like to emphasise the need to provide interventions to address the use of khat. We acknowledge the reference to this substance within the outreach model of the non-opiate service and would like to stress the importance of this provision.
- Consideration should be given to special groups such as the homeless, migrants and asylum seekers, pregnant women and families with children on safeguarding registers.
- See comments around access [I think there needs to be more explicit mention of access and services having some responsibility for holistic care, even if they aren't providing all the elements of it. Harm reduction team is there for some with high needs, but many clients need GP, mental health or hospital services and don't manage to access them. Support workers who can prompt by phone, arrange appointments or transport, or even accompany people are necessary for some.]

Q12 Is there a sufficient balance between services to reduce harm from drug or alcohol misuse for those not ready to engage in formal structured treatment; formal structured treatment services; services for those requiring longer term maintenance treatment for drug or alcohol misuse and services to support longer term recovery from drug or alcohol misuse?

(5/8) respondents agreed there was sufficient balance, three were uncertain.

- Perhaps need more input to supporting longer term recovery as this is key to preventing/reducing relapse.
- Yes
- There is an imbalance as have described because of a need for a purposed designed per supported job search provision as an alternative work related activity for those in early recovery.
- Yes. We agree that by splitting the contracts into opiates, non-opiates and alcohol.
- Yes. We agree that by splitting the contracts into opiates, non-opiates and alcohol it gives providers and service user the freedom to determine the right balance for each individual between harm reduction, treatment, maintenance and recovery, depending on where each

individual is at on their journey towards planned discharge. However, we do not find it helpful to be prescriptive about the numbers of clients that need to receive formal psychosocial interventions. We believe it is more helpful to be flexible about the psychosocial support offered to service users – enabling us to be responsive to their needs.

- Yes
- Yes, trend estimates for Sheffield show a shift away from opiate use in favour of non-opiates. Currently, the majority of those in treatment (approximately 2,100) are subject to prescribing treatment. The shift towards use of non-opiate substances will require more of an emphasis on psychosocial interventions and a movement away from clinical prescribing. We understand that despite the prevalence estimates of approximately 47,000 higher risk drinkers in Sheffield, alcohol services are considerably under-used. The model must be sufficiently balanced to ensure the city's aspiration of 75% take up is achieved across this modality. Lifeline takes the view that the current commissioning intentions appear to strike the right balance to ensure appropriate delivery across all aspects of the service. That said, as future demands unfold, the critical feature of any service is its capacity to respond swiftly and effectively to changing requirements. Lifeline has an extensive history of more than 40 years delivery in challenging and ever-changing operating contests. Throughout those 40 years we have met and exceeded expectations as a matter of course.
- Much of the resourcing for opiates could be mopped up by prescribing. It's easier to see how non opiates and alcohol services could offer education, outreach etc.

Q13 Are the proposed recovery interventions, the right interventions to meet local need?

The responses were equally balanced between those who agreed (4) and those who were uncertain (4). There were no negative responses.

- More personal recovery budgets for alcohol needed
- More general recovery interventions so people recover together in addition to the individual recovery budgets
- Reduction of funding in the second year for alcohol would not be sensible. If a service is working well and establishing a successful treatment pathway then regarding alcohol you would expect numbers to grow.
- Yes
- Yes. The right interventions are offered within these proposals when applied by the right skill mix of professionals. Prescribing interventions for stabilisation and then towards recovery and abstinence are essential tools and work best combined with key working and recovery focussed reviews. Helping service users move through their own recovery journey means individualised treatment for each one but as they move closer to abstinence and recovery, it is vital to utilise mentoring schemes, employment, education and training to help service users build up their recovery capital for a more sustained recovery. Personalised budgets create much more flexibility and choice for service users and have been heralded a real success in other areas of care delivery. It is important, however, to ensure that well managed processes are in place to ensure that personalised budgets are used to optimise a service user's wellbeing/recovery and are affordable. However, we should take care to ensure that 'recovery' is not purely focussed on treatment complete drug/alcohol free exits, as each individual's recovery should be measured by the system's ability to allow service users to achieve and sustain change and the goals they set for themselves.

- Yes, to fully address this question requires a complete range of data sets across all areas of misuse. As it is, there is no available data regarding prevalence estimates for non-opiate use e.g. cannabis, powder cocaine, ecstasy, khat, ketamine and steroids. It is therefore not possible to definitively state whether the intervention types and volumes are appropriate to meet the needs of those using these substances. There is more data to go in in relation to opiates. There are an estimated 4017 opiate/crack users in Sheffield, just over 2,000 of which are in formal prescribing treatment. On the basis of these figures, it appears that planned provision for his group is appropriate. As for alcohol, prevalence estimates indicate there are approximately 47,000 high risk drinkers in Sheffield. Despite the low take up of these services, Lifeline takes the view that the planned interventions appear appropriate.
- One the opiate addiction is stabilised, and often the prescription stopped, this client group needs continued support from a trusted supportive clinician. GPs who have provided the prescription often build up close trusting relationships with addicts. When members of this client group move on, start and maintain relations, have children etc., GPs can provide long term support through the recovery process.
- Recovery is as much about preserving relationships or holding down a job than becoming drug free. I'm not sure how much flexibility DACT has around outcomes though. Recovery more broadly is becoming increasingly important in all long term conditions, and I think this says all the right things around this in the non-opiate part. Much of the resourcing for opiates could be mopped up by prescribing.

Q14 Is there any good practice, services, interventions available from other areas which you think Sheffield should learn from and use to improve the local offer?

Three suggestions were made, two of which are currently implemented in Sheffield (ambulance pathway and alcohol screening tool).

- Shared care alcohol schemes. Primary care opiate services linking with community mental health teams rather than use of specialised psychiatry for substance misuse and dual diagnosis. Joint work between primary care and psychiatry is the model for all other mental health diagnosis rather than a specific psychiatry service for dual diagnosis and is a model used in other areas nationwide. It is an expensive model to continue with specialist psychiatry.
- No
- A partnership scheme involving YAS, Kirklees Council, West Yorkshire Police, West Yorkshire Fire and Rescue Service and Lifeline's *On-trak* alcohol service has been set up in the Kirklees area to reduce re-offending rates for alcohol-related crime. The course is offered through the Police custody suite at the point of release to adults considered suitable for a Penalty Notice for Disorder or caution. As an incentive to attend, the individual is offered the opportunity to halve their fine upon attending the course. All of the funds raised by the course are donated to local alcohol-related charities and causes. Information and advice are provided on alcohol-related behaviour and the physical, social, psychological and economic impacts this behaviour can have on the health and wellbeing of both the individual and those around them. The course also acts as a way of signposting individuals to further support services where a need is identified. For the period December 2012 – June 2013: 75 detainees have accepted a referral on to the course, 60% of those referred (45 detainees) actually attended a course, only 2.2% (1) of those who did attend have since re-offended,

33.3% (10) of those who did not attend have since re-offended. This course is a good example of local partnerships working together to deliver improved public health outcomes for the community. Initial data demonstrates very low re-offending rates in those individuals that attend the course. Offending is considerably higher in those that fail to attend the course after accepting a referral. Work is also underway to collect re-offending data for those individuals that opted out of the scheme when offered, to act as a comparison.

- Use of screening tools (Sheffield Alcohol Screening Tool) and adoption across drug services
- Yes, whilst we feel able to comment upon the commissioning plan, having made desktop observations of its content, we are not in position to offer comment on how Sheffield might benefit from best practice from elsewhere. Such comments could only be informed by a detailed understanding of current operations that we are not, at this stage, in possession of.
- I am aware of the DOH guidelines that encourage prescribing in primary care. So much of this document advises a holistic approach (e.g. "Services providing psychosocial interventions therefore need staff of sufficient seniority and competencies to provide effective supervision and to monitor the overall quality of treatment" (http://www.nta.nhs.uk/uploads/clinical_guidelines_2007.pdf)
- I have no information on other areas. I think we have good practice her in Sheffield to build on. I think the city centre outreach for students that alcohol services have done may be an example, and the current shared care team that supports GP practices offers a good level of service to patients and GP teams.

Q15 Do you have any views about the procurement process, for example procurement staggered over two rounds, 3-5 year contracts, open competitive tender?

- Interested to know why you have opted for Part A rather than Part B procurement? Part B procurement would be better for these types of services.
- 5 year contracts helpful as allow services to bed in and develop over time. Two rounds is fine but too close together. It may detract from mobilising a service if trying to do two things together.
- I have concerns about the contracts running for 3 years as this doesn't feel like an adequate time frame to allow new services to 'bed in'. It will obviously create services based on best value for the money available. This could allow an outside provider to offer a substandard service to a group of vulnerable clients who need holistic services with local knowledge to meet their need.
- I would welcome the view of the Sheffield Clinical Commissioning Group (CCG) members of the Health and Wellbeing Board with regards to the risk of 3-5 year contracts and an open competitive tender. I believe there is a significant risk of destabilising some practice who have provided this service to a significant number of patients for a significant number of years, both from the point of view of patients who require addiction services and their ordinary patient list. I think there is a fundamental argument that patient care is best contributed to in negotiation with the patient held record and details of other family members. There are models around the country where contracts have not been put out to open competitive tender because of the need to have access to the records.
- Yes. 3-5 year contracts continue to destabilise providers by causing difficulties with staff recruitment and retention. Only being able to offer short term contracts to staff has been a

particular problem. Competitive tender can cause tensions between providers and damage existing working relationships. It is helpful if proposed contract terms are described alongside the specification so that their implications can be considered as part of the bidding process. It is helpful if the specification describes outputs and outcomes whilst leaving bidders the freedom to design their own delivery models.

- Staggering of tenders supports providers to enable them to bid in both rounds effectively. It is important that mobilisation is managed robustly, particularly where a provider may bid for more than one tender consecutively and where service models mobilise to the new procurement arrangements. Competitive tender is health and encourages creativity and best value offers. It can however detract from the current system as providers are competing with each other for business and can stifle best practice in partnership/collaborative working. It will be important to manage transitions smoothly to ensure that services are not disrupted during the procurement process. Operational stability within the system is welcomed and this is offered by 3-5 year contracts. Changes to pathways can take time to embed across a whole system reconfiguration and settling in time is needed to truly appreciate the benefits to the new system.
- Yes, Lifeline would be very enthusiastic in engaging in whatever procurement format the commissioner deems appropriate.
- There is a fundamental argument that patient care is best contributed to in negotiation with the patient held record and details of other family members. There are models around the country where contracts have not been put out to open competitive tender because of the need to have access to the records. I believe the CCG's opinion, national guidance, and the opinion of Sheffield LMC is vital before major changes to addiction services are made across the city.
- As a GP provider, I welcome the extension in my contract, not least to be able to prepare my patients for a change they may not welcome if I do not continue in this role.

Q16 Any further comments – DACT Commissioning & Procurement Plan?

- How will you ensure consistency of services from all the separated services? E.g. workforce quality, qualification and consistent ethos and recovery focus?
- Payment model difficult to plan a service on – staff costs remain despite varying numbers. Need recognition to retain and develop staff teams.
- The ambulance service has access to people and places that other health and social care services can find it difficult to access and is often called by those with multiple problems who may not accept advice from other health providers. What thought has been given to how the ambulance service could/will be involved in services/service delivery? 2,400 Identification and Brief Advice assessments are proposed for the new alcohol service. Has it been considered that the ambulance service provides a unique route in to some patients and that some of these assessments could be carried out in the community, with the appropriate training, to assist referrals into the service?
- I was not aware of the 25 per cent reduction in funding mentioned in relation to drug education and intervention. Any light on this would be appreciated.
- I can see that the paper states that the changes will have a positive impact, rather than a negative one. I can see that, in relation to th3 model of service, and I think we can be

reassured by the volume changes described – have you anything else to reassure our GPs about the impact of the changes?

- Sheffield LMC would not support a reduction of 25% in funding for drug and alcohol services, particularly as there is a national drive to reduce NHS admissions due to alcohol and drug related illness. I am not sure that drug or alcohol treatments can necessarily be ring fenced, as a service does not take into account their holistic care with all the associated co-morbidities. At a national level from the General Practitioners Committee (GPC) and the Royal College of General Practitioners (RCGP) and at a local LMC level, it would be argued that the strength of Primary Care in the UK has always been the patient held record and continuity of care, with individual doctors that know patients and I would still support this view.
- It would be good to get the opinion of current drug/alcohol service users.
- The CCG would like to see more evidence of the DACT's overall strategy, in particular its role in the city wide response to ensuring patients/clients get the right level of service to avoid high level costly and inappropriate care. We would also like to see more evidence in the service specification of improvements to the pathways interlinking the various service providers, encouraging providers to work more in partnership with A&E, Community Mental Health Teams, Primary Care and those voluntary organisations all of which provide input into the care, support and recovery of the patients/clients involved. The CCG is intending to commission more services in the community. It would be helpful to know in the DACT's service specification, whether you are encouraging more partnership working in the community with other service providers working in the community, especially to those hard to reach client groups, who are socially isolated and vulnerable individuals. Given the strong interdependencies between the services we commission, we would like to be involved in the procurement and implementation of the services to promote good working across services.
- There has been no direct communication with the GP practices contracted to provide this service. "Key stakeholders" were invited to a meeting on 4th November, however this did not include the existing GP providers. I would have thought that providers contracted to provide services of an annual value of in several cases >20k should be informed directly of this contract going out to tender. There is minimal reference to GP practice provides in the consultation document despite these providers currently treating approximately 500 patients. GP practices are not listed as providers on page 9. The documents refers to this process excluding contracts of <£50k which would apply to all the GP practices. Given the paucity of references to general practice providers it is hard to avoid drawing the conclusion that the commissioners have already decided to exclude GP practice providers from any future service. I would be concerned that a centralised single provider service with a 25% reduction in funding risks becoming a rigid narrowly protocol driven service with an inflexible approach and low threshold to resort for "non-engagement". This could superficially appear to meet the recovery agenda whilst actually resulting in significant unmet need. At present GP shared care prescribing is funded via primary care budgets, my understanding is that this also applies to PCASS on a deputising basis. If the new service is not delivered on this basis these costs would need to be covered by the new provider.
- We should ensure that service users with Dual Diagnosis are jointly accounted for in the procurement of drug and alcohol and mental health commissioning. There is a risk of these individuals falling through unintentional commissioning gaps in service provision. With reference to Tier 4 interventions we would like to seek clarification of the relationship between community service provision and referral to Tier 4 interventions (IP detox and Resi-Rehab). It is important to recognise that the treatment system does not work in isolation and that the

service providers must work across the whole health and social care system, including multi agency liaison (health, social, criminal justice agencies) to reduce impact, unnecessary admission and target those smaller number of people that use the highest amount of resource.

- We are grateful for the opportunity to contribute to this process, but have no further comments to make at this stage.
- I support the overall direction with 3 pathways. Currently we have some really good services that are working well. This is an opportunity to improve patients experience, but I hope that the pathways do not work in isolation, as that will not be an overall improvements on what we have now.

Changes made following the consultation:

- A dual diagnosis nurse role was created within the Opiates service.
- 600 additional SEAP/IBA assessment places for alcohol were created
- Provision for needle exchange within appointments within both the opiates and non-opiates service was allowed.
- A distinct offer of GP led care for alcohol as well as for opiates has been specified.
- Personal recovery budgets have been removed and replaced with community based recovery support interventions.
- Perceived areas of unmet need (Q11) have been addressed within the specifications for services.

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