Substance Use Services for Bristol

Draft Commissioning Plan for Consultation

For publication 30 October 2023

Contents

Background and Purpose

This draft commissioning plan sets out our proposals for the procurement of Substance Use services for Bristol.

Local Authorities are responsible for commissioning substance use treatment services as part of their mandated public health responsibilities.

Bristol City Council commissions a wide range of inpatient and community substance use services including early engagement, treatment, and support. These are currently provided by a multi-agency Recovery Orientated Alcohol and Drugs Service (ROADS), and targeted youth service.

Policy context

Corporate Strategy 2022-2027

The Council's Corporate Strategy sets out our contribution to the city and is our main strategic document. It informs everything the council does and sets out our main priorities for 2022 to 2027. The Corporate Strategy outlines a vision of driving an inclusive, sustainable and healthy city of hope and aspiration where everyone can share the city's success. It also describes the activities we must do by law. Corporate Strategy (2022 to 2027) (pdf, 9.02 MB)

Drug and Alcohol Strategy for Bristol | 2021-2025

This strategy sets out our city-wide vision for drug and alcohol services, and the priorities on which we are focusing. It has been developed and will be delivered in partnership, with oversight from members of the Keeping Communities Safe group (a delivery group of the Keeping Bristol Safe Partnership) and Bristol's Health and Wellbeing Board. Drug and Alcohol Strategy 21.pdf (bristol.gov.uk)

From harm to hope: A 10-year drugs plan to cut crime and save lives

This Home Office policy paper sets out a 10-year plan to cut crime and save lives by reducing the supply and demand for drugs and delivering a high-quality treatment and recovery system. From harm to hope: A 10-year drugs plan to cut crime and save lives - GOV.UK (www.gov.uk)

BNSSG Principles for Trauma Informed Practice

Principles for Trauma Informed Practice (and supporting framework and resources) are intended to be used by all organisations across Bristol, North Somerset and South Gloucestershire, as we aim to embed a system-wide trauma informed approach.

- **Safety** - supporting emotional and physical safety, free form harm and threat and avoiding re-traumatisation
- **Trustworthiness** - transparency across policies and procedures with an objective of building trust
- **Choice** - A meaningful voice and choice in decision making
- **Collaboration** - Valuing lived experience and developing peer to peer models (Ambassadors)
- **Empowerment and Inclusivity** - Shared power, giving people a voice in decision making

The Challenge

Our substance use services are primarily funded through the Public Health grant, and we are grateful to have also secured additional funding from the Supplemental Substance Misuse Treatment and Recovery grant, which enables us to implement a wide array of interventions in alignment with our local drug strategy. However, there are significant challenges locally and nationally due to the cost of living and operating crisis that shows little sign of ending soon. These difficulties are in the context of unprecedented levels of inflation and the lingering impact of the COVID-19 pandemic. As a result, an immense strain has been placed on all services, including many aligned services that support our clients to achieve stability and embark on their journey to recovery.

How we make decisions

On 4 July 2023 Cabinet 4 July 2023 Cabinet approved an extension of our current substance use treatment services so we can procure and award a new contract from 1st April 2025 Bristol City Council Cabinet Meeting 4 July 2023 - ModernGov - bristol.gov.uk

The Bristol Substance Use Collaborative Commissioning Board will oversee the delivery of the commissioning process, reporting to the Bristol City Council internal commissioning processes, including the Public Health Department Management team and the Executive Director for Adults and Communities (who will have delegated authority on behalf of the Cabinet) for agreement and sign off at key milestones.

Our evidence base

Bristol Combatting Drugs Partnership – Joint Strategic Needs Assessment 2023

The aims of the Joint Strategic Needs Assessment are:

- To meet the requirements of the Government's 10-year drugs plan by completing a joint needs assessment through our established Combatting Drugs Partnership in Bristol.
- To conduct an initial assessment of evidence and data to understand better the local issues and patterns of alcohol and other drug-related harm in Bristol.
- To identify how we can reduce alcohol and other drug related harm, supply, and related crime.
- To assess the needs of this population, identifying health inequalities, unmet need, and barriers to accessing services.
- To outline what best practice looks like, to explore how we can improve outcomes of the current service delivery model and impact, including service user feedback.

This needs assessment has key recommendations which we have used to inform our thinking for our commissioning plan.

Early Engagement

In June-July 2023 we held multiple focus groups and carried out a survey on our Visions Values and Principles for recommissioning substance use services.

Most participants agreed with our overall proposed approach, reflecting that there was a good balance between harm reduction and recovery orientated treatment, with a much-needed emphasis on creating person-centred services and improving pathways and flow.

Some people thought there needed to be more emphasis on overcoming barriers to treatment. There were also concerns that commissioning a single provider may have negative consequences for the existing workforce.

We had a number of specific comments and recommendations from providers and people with lived expertise which we have used to refine our proposed service model for this draft commissioning plan.

Additionally, recent feedback from The Care Forum from their in-person engagement with people with lived experience has provided valuable insight into the support needs, experiences of accessing current ROADS services, and particular barriers faced. For example, less than half of people interviewed said they thought it was easy to understand what services are available, and 52% said the current way services are accessed had delayed their recovery.

Performance Reporting

We monitor the performance of existing ROADS contracts through ongoing data and narrative reporting using a standardised contract management framework. This includes meeting regularly with providers to review progress against KPI (key performance indicator) metrics and discuss any barriers to performance and reasons for underperformance. Performance monitoring for our existing service helps us to understand where we may need to make changes to our approach for future commissioning.

Clinical Guidelines for Drug Treatment Services

The drug use and dependence UK guidelines on clinical management prepared by Clinical Guidelines on Drug Misuse and Dependence were last updated in 2017. New clinical guidelines for alcohol treatment are being consulted on. Local commissioners and providers have a responsibility to develop services that enable the guidelines to be applied.

Other evidence sources

Original ROADS Substance Misuse Commissioning Strategy 5b - Appendix A - Commissioning Strategy.pdf (bristol.gov.uk). This document outlines the development of the existing model for substance use provision in Bristol.

NDTMS - ViewIt - Adult NDTMS (National Drug Treatment Monitoring System) reporting provides additional insight into differences in levels of representation for adults presenting to treatment in Bristol compared to other areas and nationally. Regional estimates of unmet need are calculated by comparing the number of people in types of treatment by the prevalence estimate for the relevant area.

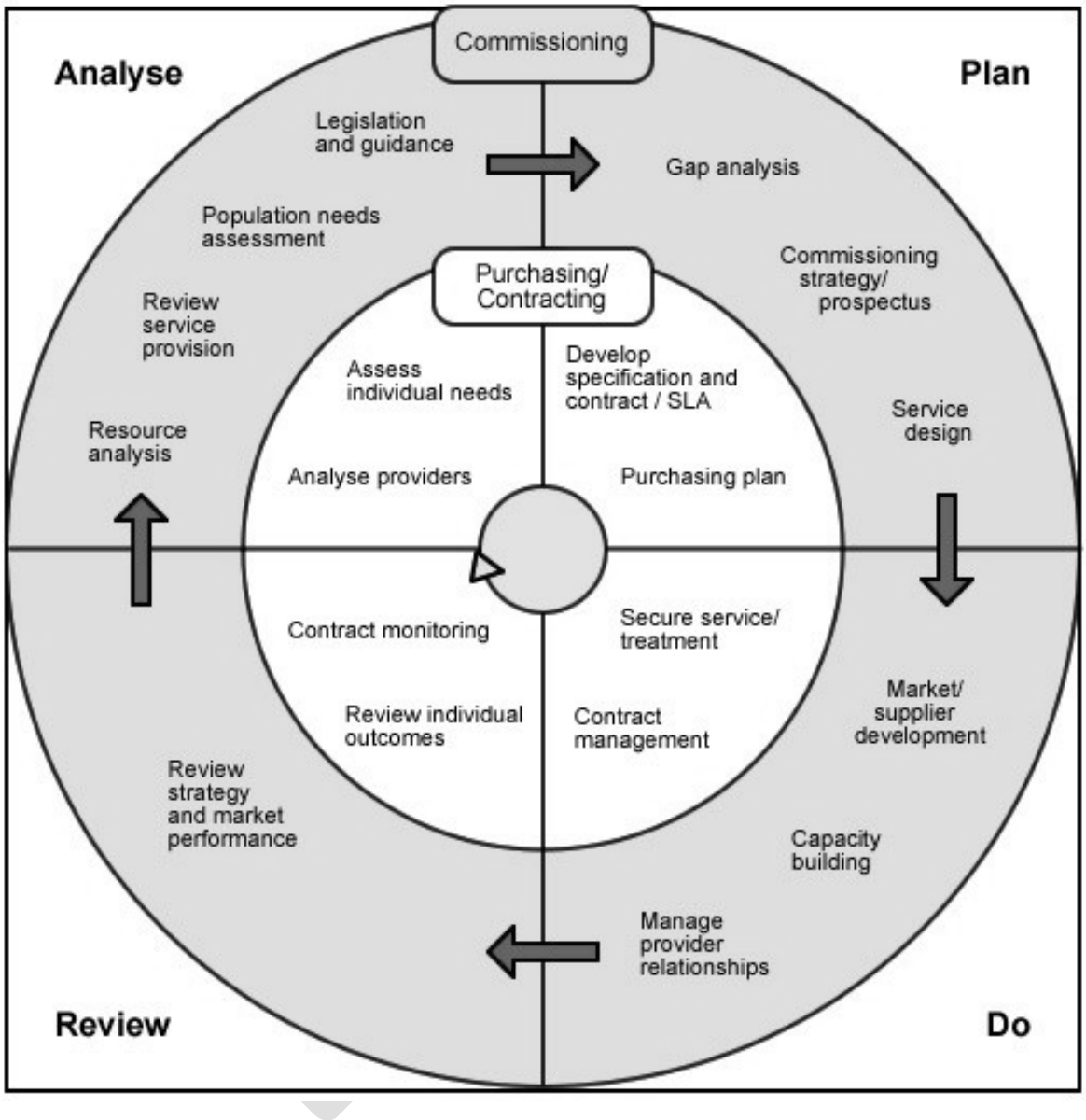
ROADS profiles of client and primary substance: This is based on information that is collected by providers at assessment and throughout treatment our case management system. If a client presents with more than one substance the provider is responsible for clinically deciding which substance is primary.

Hard Edges: Mapping Severe and Multiple Disadvantage in England – Lankelly Chase This report draws together previously separate datasets from homelessness, offending and substance misuse treatment systems. It also takes into account available data around mental health and poverty. We have summarised some of the important finding in our equality impact assessment.

Our approach

The Substance Use services for Bristol will be commissioned and procured by the public health team, following Bristol City Council's Enabling Commissioning Framework (Fig.1).

Figure 1: Bristol City Council Enabling Commissioning Framework



This is the agreed four stage commissioning cycle that has been adapted from the Institute for Public Care Joint Commissioning Model for public care. The approach will enable Bristol City Council to comply with European Union (EU) procurement law and UK Public Contract Regulations 2015 and provide assurance that it is commissioning services in line with best practice.

What we have done and what we will do

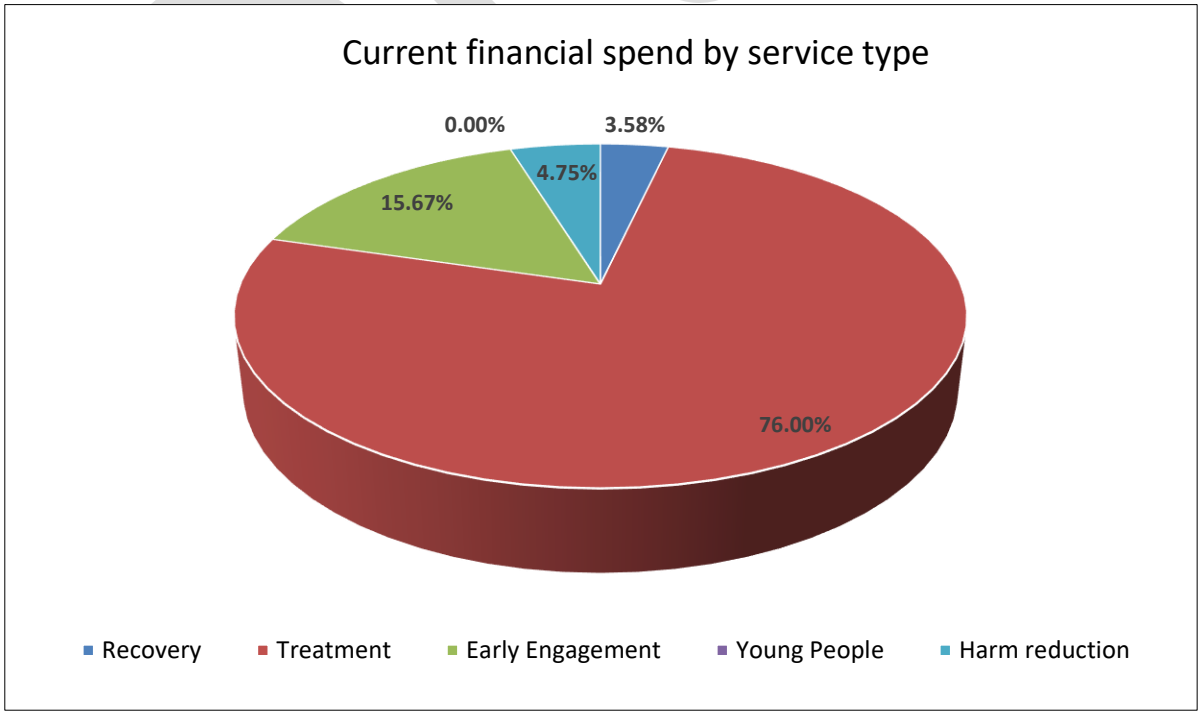
Current issues and context	• Conducted a needs assessment and gap analysis on current services. • Obtained the views of providers, service users and other communities across Bristol on our Vision, Values and Principles.
Understanding the drivers	• Considered the financial implications and context. • Considered BCC Corporate Strategy and other relevant policy
Applying the evidence	• Reviewed the international, national and local evidence. • Reviewed the implications of findings in the Gap Analyses/Health Needs Assessments. • Considered the best commissioning and procurement approaches that are suitable for our proposed approach. • Reviewed how other local authorities and organisations are providing substance use services to their population, and lessons learnt.
Consultation	• We are holding a public consultation to share our draft commissioning plan with stakeholders to seek their view on our proposals. • We will hold market engagement events with potential providers after the consultation.

Current Contracts and Financial Envelope

Current Contracts and Expenditure – in Scope

Current financial year expenditure for services that are considered in scope is shown in the table below:

Contracts and Service Providers	Annual Value
Complex needs and specialist advisory support (Avon and Wiltshire Mental Health Partnership)	£325,720
Inpatient detox (Avon and Wiltshire Mental Health Partnership)	£599,888
Early engagement and intervention service (Bristol Drugs Project)	£1,230,420
Substance misuse liaison service (Bristol Drugs Project)	£2,041,382
Blood borne virus testing (Bristol Drugs Project)	£8,000
Alcohol WET clinic (Brisdoc)	£32,600
Community recovery service (Developing Health and Independence)	£1,616,706
Families and carers service (Developing Health and Independence)	£109,876
Substance use specialist nurses (University Hospitals Bristol)	£226,320
Residential rehabilitation (various)	£680,000
Current Total	**£6,870,912**



Contracts and Service Providers for aligned services[1]	Annual Value
Primary care services (GPs and pharmacists)	£1,110,000
Medicines cost	£550,000
Total	**£1,660,000**

Aligned services

The elements listed below are closely connected to the proposed service delivery outlined in this commissioning plan. It is essential that services within the scope of this plan are well aligned to these elements and hold joint responsibility for achieving shared outcomes.

Homelessness Prevention

The Council funds services that provide support to prevent people from becoming homeless and to help people recover from homelessness. These include substance misuse preparation and in-treatment housing Commissioning homelessness prevention services (bristol.gov.uk). The Homeless Health Service provides primary care health advice and treatment to people who are homeless Homeless Health Service – Primary Healthcare for homeless people**.**

Criminal Justice pathway

Additional grant funding has allowed us to develop a criminal justice team with a range of functions which include ensuring continuity of care from prison into community treatment, working with courts and probation to support the delivery of community sentence treatment requirements (ATR and DRR), and the delivery of interventions for those who test positive for drugs on arrest. This program of work includes case coordination with Probation and other criminal justice stakeholders, risk management, and individualised treatment and interventions to support engagement in treatment and reduce reoffending.

Specialist services for children and young people

Specialist substance use treatment services for children and young people who have higher levels of complexity including CAMHS and Social work involvement are commissioned separately through the Community Childrens Health Partnership (CCHP) contract and BCC internal agreement respectively.

Primary Care contracts

We are currently considering options for primary care contracts. This covers medical interventions and support from GPs for the Substance Misuse Liaison (SML) service, supervised consumption and the like. These have been directly awarded in previous commissioning exercises.

Medicines support

People experiencing dependency or difficulties arising primarily from medicines which are currently being prescribed or dispensed to them in a primary care setting (i.e. not obtained illicitly) should seek treatment via their primary care setting, usually their GP Surgery. However, people seeking help for alcohol or other drugs use who experience additional difficulties with prescribed medications are in-scope of proposed new services.

Consortium inpatient detoxification

The medically managed and medically monitored inpatient detoxification and stabilisation

[1] This does not include the annual maintenance and support costs of our case management system

provision purchased through the consortium is beyond the scope of this procurement.

Case management system

Since 2010 we have commissioned an online integrated, multi-agency, caseload system for the management of substance misuse clients across the city which is used by current service providers and managed/administered by Bristol City Council. This includes National Drug Treatment Monitoring (NDTMS) return and reporting features.

We are currently exploring various options for how a case management system should be commissioned and administered from April 2025. Options include requiring our strategic partner to provide and administer their own system with limited access for Council commissioners.

Alternatively, we could continue to commission a case management system as a stand-alone contract which could be administered by a strategic partner with a commissioning view and overall audit responsibility by the Council, to enable scrutiny of data and manage issues, or with the Council retaining reporting and system administration responsibilities (as is currently the case).

Financial Envelope

The expected annual value available for services is **£7,214,500** per annum for a period of five years with provision for a two-year contract extension followed by another possible two-year extension (5 + 2 + 2 years). The funding available for these services comes from the annual ringfenced public health grant that we use to fund our public health functions, including drug and alcohol services. The amount of future funding is allocated to local authorities in England is not guaranteed and will continue to be subject to ongoing spending review by Central Government.

Bristol is currently in receipt of additional funding to help improve drug and alcohol treatment and recovery systems (SSMTR Grant Funding). This additional funding is on top of the annual ringfenced public health grant that we use to fund our public health functions, including drug and alcohol services. This figure is not included in the core financial envelope (£7,214,500) of this commissioning plan, and not currently confirmed beyond March 2025. Furthermore, supplemental grant funding is contingent on the performance of substance use services overall, and the Council reserves the right to award any supplementary funding to the most appropriate provider.

Extra funding for drug and alcohol treatment: 2023 to 2025 - GOV.UK (www.gov.uk)

Should additional funding be available from April 2025 there may be changes to the volume of current activity or additional scope of service provision. It is not possible at this stage to anticipate which areas of delivery will be the focus of future additional funding arrangements, as these are likely to be influenced by future policy, emerging issues and any changes to the legal status of certain interventions (such as new prescribing options).

Our vision

Our vision is to recommission a specialist alcohol and other drug early intervention, treatment and recovery system for children, young people, adults which is person centred, preventative, inclusive, innovative and aspirational.

Our values

- ✓ The client at the centre of service delivery.

- ✓ A system that is preventative, aspirational, and inclusive.
- ✓ A system that works with a range of partners and its commissioners.
- ✓ A system that recognises people's strengths, not only their problems.
- ✓ A system that meets the needs of all ages and has the needs of children at its heart.
- ✓ A system where harm reduction and recovery are equally valued and prioritised.
- ✓ A system that self-reflects and strives to continuously improve services and is informed by the experience of people who use those services.
- ✓ A system who is innovative, flexible, and able to work in partnership to respond to changing needs and circumstances.
- ✓ A system that builds resilience and reduces vulnerability.

Proposed Commissioning Model

Key principles of service delivery

Services operating within the alcohol and drug early intervention, treatment, and recovery support system will be…'*Personalised, Accessible, and Inclusive.'*

- Services will be for all ages, with distinct and age-appropriate responses for children, young people and their families.
- Services will protect vulnerable children and adults.
- Services will make every contact count to ensure that people get the right service at the earliest opportunity.
- Recovery will be visible and promoted within all parts of the service and stages of the treatment journey.
- Harm reduction from alcohol and other drug use is visible throughout abstinence-based treatment services.
- Services will be emotionally intelligent, trauma-aware and psychologically informed, addressing social, psychological and mental health needs as core business.
- Services will participate in partnership working to increase understanding of shame sensitive practice and stigma amongst this group.
- Service Provider(s) will be visible in particular settings - including education, health and social care services, criminal justice, housing providers etc.
- Services within the system will respond to the Armed Forces Community Covenant including understanding and responding to the particular context for alcohol and other drug harms experienced by veterans and their families.
- Services will identify and respond appropriately to the individual needs of its Service Users, including but not restricted to, gender, age, ethnicity, sexuality, emotional and mental health, housing status and substance(s) used, physical health and provide access to registration with General Practice.

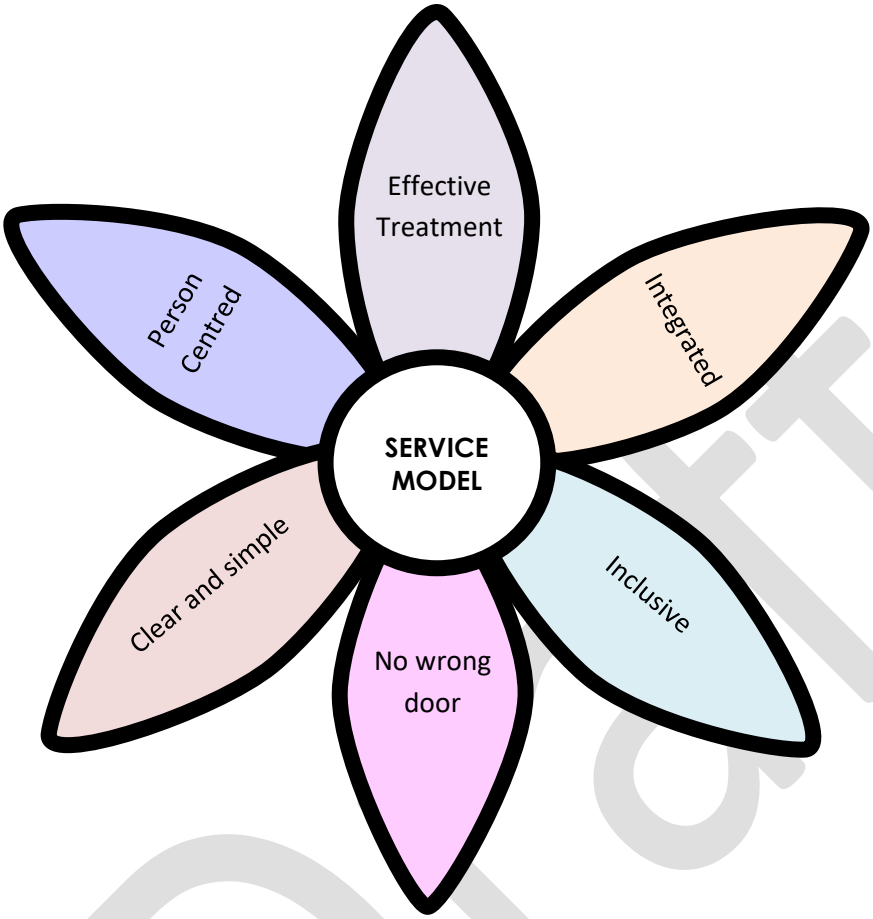
- Services will offer a ‘visible’ menu of interventions that are evidence-based and ensure that clients have options in how they put their treatment programme together to aid their treatment and recovery. This will include maintaining a home, developing wider community relationships and support into training, education and employment opportunities.
- Services will make best use of technology to deliver interventions and communicate with clients, their families and professionals.
- The Provider(s) will ensure that clients and their families/carers are at the centre of the Service.
- Services will look to engage with and attract people who have an alcohol or other drug need but are not engaged with services, linking with Homelessness Outreach Teams, Primary Care, and referrals from other services such as acute trusts, The Loop (Drug checking service) etc.

Who is the service for?

- People who use alcohol problematically or dependently
- People who use drugs problematically or dependently
- People who are occasional users of other drugs that may be putting their health and wellbeing at risk
- People experiencing homelessness with an alcohol and drug need
- People in the criminal justice pathway with an alcohol and drug need
- People with an alcohol and drug and mental health need that needs joint treatment and support
- Early engagement and prevention for children, young people and their families
- People who are affected by a parent or other family members’ drug or alcohol use.

Characteristics of a new service model

Based on feedback from our early engagement and findings from our needs analysis and other research, we have identified the elements which we think should make up the characteristics of a new service model for substance use services in Bristol.



Effective treatment

- ✓ Provides building blocks for recovery
- ✓ Supports timely progression
- ✓ Is innovative and adaptive
- ✓ Has a wide range of flexible interventions
- ✓ Is engaging and attractive
- ✓ Clients see positive change

Person centred

- ✓ Client view is at the centre of the treatment plan
- ✓ Addresses the impact of trauma and deprivation
- ✓ Considers the local view and community concerns
- ✓ Client feedback is used and valued
- ✓ Workforce reflects the diversity of our city
- ✓ Builds meaning, purpose, love and hope

Clear and simple

- ✓ Clearly promoted and signposted
- ✓ A place to go
- ✓ Menu of interventions
- ✓ Easy map of pathways
- ✓ Help to find your way
- ✓ Single branding (instead of multiple agencies)

Integrated

- ✓ Based on a One City approach[2]
- ✓ Plugged into communities
- ✓ Has a knowledge and resource hub
- ✓ Co-production is build-in
- ✓ Specialist embedded offer
- ✓ Collective ownership and governance

No wrong door

- ✓ Easy way in to start treatment quickly
- ✓ Multiple ways in e.g. visit a hub, online, phone
- ✓ Awareness and promotion
- ✓ A non-judgemental environment
- ✓ Recognises motivation for change
- ✓ Outreach advice and liaison

Inclusive

- ✓ Targeted work with under-represented communities
- ✓ For a wide range of substances and need
- ✓ Includes pre and post treatment support
- ✓ Flexible to meet emerging needs
- ✓ Appropriate for different age, ethnicity, gender etc.
- ✓ Workforce cultural awareness

Key Relationships

Some of the key relationships that the provider(s) must work in partnership with include, but are not exclusive to:

- Adult social care, social worker teams and social care providers
- Children and Young People
- Community peer and mutual aid systems
- Courts, Custody and Probation
- Employer and employment support

[2] The One City Approach - Bristol One City

- Hospitals A+E and Maternity
- Housing and Homelessness Prevention Services
- Mental health services
- Outreach teams
- Police
- Primary care
- Safeguarding
- Services users and lived expertise organisations
- Sexual health services

Proposed Key Service Outcomes

- ✓ The prevention of problems with alcohol and drugs developing and escalating (which includes the recognition of the impact of adverse childhood experiences)
- ✓ The reduction of alcohol and drug related deaths
- ✓ The reduction of alcohol and drug related offending
- ✓ The improvement of mental and physical health for alcohol and drug users
- ✓ Increasing the numbers of people achieving positive change in their drug and alcohol use including sustaining abstinence
- ✓ Increasing the number of people in recovery and supporting them to remain in recovery
- ✓ Improving alcohol and drug users social and family relationships
- ✓ Increasing engagement with education, training and employment
- ✓ Reducing the numbers of people in criminal exploitation and sexual exploitation
- ✓ Promoting the development of independent support networks

Expectations Of Each Delivery Strand

We are aligning our descriptions for each delivery strand where possible with NDTMS definitions. Please see NDTMS: community alcohol and drug treatment business definitions - GOV.UK (www.gov.uk) for further details.

Referral, assessment, and progress

To improve the accessibility of our services for people who use alcohol and other drugs (including groups that are less well engaged in treatment and recovery support services) we propose to work with our newly commissioned strategic partner(s) and those with lived experience to reshape the way in which people are referred to and access treatment, ensuring there are quick and effective routes into treatment that account for the city's geography and transport links.

To make our services more accessible to individuals who use alcohol and other drugs, especially those who are not currently well-connected to treatment and recovery support services, our plan is to collaborate with newly commissioned strategic partner and people with lived expertise to reshape the way in which people are referred to and access treatment, ensuring there are quick and effective routes into treatment that also account for the city's geography and transport links.

This will include referral routes for professionals and will require both in-person and digital solutions for referral and assessment, where appropriate.

Improving the referral and assessment process may include transitioning from the existing single point of contact to a 'no-wrong-door' approach, meaning people could present at any point in the system and receive or be guided to the right support without delay.

We propose that the newly commissioned services will operate a rapid assessment framework where people can refer (or self-refer) and be triaged and comprehensively assessed the same day. Areas that have implemented a rapid assessment process have reported a welcome boost to their numbers in treatment by reducing the attrition that often occurs between referral, assessment and modality start.

Services will prioritise engagement and the development of a safe and effective therapeutic relationship. If the worker completing the assessment is not going to be the person's key worker, then every effort should be made to introduce the client to their allocated key worker without delay. We propose that our new services will minimise transfer between workers unless there is a clinical, therapeutic or safety reason for doing so.

Good quality assessment underpins the identification of treatment needs and forms the basis of an agreement with the client of their treatment and recovery goals. It also informs an assessment of risk and associated management planning. We propose to continue the single integrated assessment process which is shared with relevant professionals across the treatment system and with relevant partners to avoid duplication and the need for service users to repeatedly provide the same information.

Everyone who chooses to engage in a period of reportable structured treatment will receive a comprehensive, strengths-based, and trauma informed assessment at the commencement of their treatment, recovery support to identify individual need, and goals to aid recovery and ensure the service user is involved in planning for their own care. Assessment will result in clear referral pathways with regular care plan reviews and progress monitoring (3–6 month intervals).

Bristol offers a wide range of substance use treatment and support however, feedback from people with lived experience suggests that service users are not particularly well informed about the full range of interventions and support available to them. To better communicate what is on offer our new services will ensure that all clients are presented with a full menu of treatment and recovery support options, including information on eligibility and access. We will work with our new partner to develop a practitioner's resource library, this will provide access to a range of therapeutic tools, and guidance. It will also include a local directory of services, pathways, and access criteria.

People who use substances (and other parties as required) will be invited to co-produce a holistic person-centred recovery care plan that focuses on what is important to them as an individual and how the service can help them make life better. Recovery care planning will be integrated into the service user's treatment pathway as soon as possible and ideally from the point of engagement. The service will build individual resilience to sustain positive behaviour change beyond the intervention period. Planned reviews will take place at least every 3-6 months, and more frequently for those with elevated risk scores and those showing early signs of disengagement e.g., irregular attendance.

To ensure people experience seamless care pathways we propose to work with our new services to implement an effective care coordination procedure for those with an active reportable structured treatment episode. Our new services will contribute to elements of the mental health care plan where people have a mental health and substance use comorbidity and a parallel care plan, that is fully aligned with the mental health care plan is maintained by the substance use service.

Progress towards an individual's recovery goals will be monitored using valid and reliable tools and we would strongly encourage our new services to offer visual feedback, where possible. Change during treatment can be adequately monitored using the Treatment Outcomes Profile (TOP) which has the benefit of being incorporated into the NDTMS core dataset however, we propose to explore other, complementary progress measures that provide a more holistic view of recovery.

Complex support

Bristol has increasing numbers of people who use alcohol and other drug users that require complex support. This is often a result of alcohol and other drugs use combined with severe co-morbid medical conditions including both physical and mental health conditions. Histories of trauma, repeat homelessness, criminal justice involvement and being a marginalised woman (including, domestic violence, sex working and unplanned pregnancy) may exacerbate the complexity of a case and require greater attention than their substance use needs in the early stages of treatment. It is crucial that an individual's basic need for food, safety and shelter is met to enable them to focus on achieving personal recovery goals.

Due to increasing levels of complexity and finite resources we propose to work with our newly commissioned services to ensure resources are allocated proportionally, reflecting the levels of acute need in our population.

With the support of Public Health, our new strategic partner will develop services that are designed to attract and support people into treatment through effective partnership approaches with primary care, secondary care, mental health, housing, and criminal justice etc, building on the work of our current providers. Services will be designed to attract and support people into treatment through effective partnership approaches with other statutory and non-statutory agencies.

Psychosocial - Talking Therapies

Psychosocial interventions, or 'talking therapies' as they are commonly known, refer to a broad range of processes aimed at bringing about change in a person's thinking, behaviour, and social circumstances and form the cornerstone of structured treatment for alcohol and other drug dependencies. Psychosocial interventions may be delivered as either a standalone intervention or as a component of a wider recovery care plan.

Interventions aimed at psychological change will range from less structured forms of support and simple motivational interviewing techniques integrated into key working to more highly structured psychological techniques and therapy delivered by specialists. Whereas interventions aimed at social change may include assistance with basic needs such as food, clothing, and accommodation; supporting engagement with healthcare services, pro-social activities, and employment; and supporting the development of positive friendship, family and community relationships and networks.

We propose to work with our newly commissioned strategic partner to enhance the capacity and accessibility of a range of evidence-based psychosocial interventions, ensuring everyone who may benefit is given the opportunity to do so.

We propose to commission three levels of psychosocial interventions ranging from less structured to highly specialist psychological interventions.

1. Low-level psychosocial interventions integrated into key working.
2. Structured psychosocial interventions delivered by competent drug and alcohol workers.
3. Specialist psychosocial interventions delivered by trained psychologist/assistant psychologist(s).

We propose to work with our newly commissioned partners to ensure that structured treatment always contains a regular psychosocial component with all clients able to access regular low-level psychosocial interventions integrated with key working. Structured and specialist psychosocial interventions will be made available to people assessed by the service(s) as requiring more intensive or specialist provision.

Our new services will design and deliver interventions that are accessible and effective at engaging different groups e.g., alcohol dependent drinkers, harmful drinkers, non-opiate users, opiate and crack users. Structured and specialist psychosocial interventions will be available on a 1:1 and groupwork basis using a mix of in-person, digital and hybrid solutions to enhance the accessibility of services for marginalised groups.

Instead of having the North and South Hub model we propose to work with our strategic partner to explore cost-efficient options for delivering interventions (predominantly talking therapies) within the community, at times and locations that are mutually convenient to the client and the worker. More integrated services may appeal to those with privacy concerns and people wishing to avoid the stigma that is often perceived to be associated with accessing specialist services.

We are considering the possibility of providing a high intensity reportable structured day programme for adult clients. This would be a programme that runs 3-5 days per week, but clients return home each evening rather than reside at the facility (as they would in residential rehab).

Inpatient detox and stabilisation

Our existing inpatient provision offers our current service providers 5 beds for medically managed inpatient detoxification and stabilisation which equates to approximately 120 inpatient treatment episodes per year. A further 24 bed weeks of medically managed and 32 bed weeks of medically monitored inpatient provision is available via the consortium however consortium contracts are beyond the scope of this exercise. The annual spend on inpatient detoxification and stabilisation is currently in the region of £600,000 per annum. The cost of inpatient provision has outpaced that of other community-based services and continues to place inflationary pressures on the substance use budget.

To ensure that our newly commissioned inpatient detoxification and stabilisation services are sustainable we propose that our newly commissioned community-based services direct people to medically monitored inpatient provision in the first instance with medically managed inpatient provision available to those who have been assessed by the service as requiring more specialist provision.

The inpatient element of the new services will provide a clinically safe detoxification or stabilisation regime for people whose complex needs cannot be met within the community. We propose to continue commissioning adequate levels of inpatient provision to meet the needs of our population and recognise the need for 24-hour medically directed evaluation, care and treatment for alcohol and other drug dependencies that is staffed by designated addiction accredited physicians, clinicians, and recovery workers to meet the needs of an aging population with significant physical and mental health comorbidities.

We propose to commission the following inpatient provision:

- 40% medically monitored inpatient detoxification and stabilisation (or approximately 48 treatment episodes per year).
- 60% medically managed inpatient detoxification and stabilisation (or approximately 72 treatment episodes per year).

Inpatient provision will provide medically supervised assessment, prescribing, care, and treatment to individuals requiring detoxification from either drugs or alcohol or stabilisation on opioid substitution therapy (OST) where abstinence is not the immediate goal. Access to inpatient treatment will be a clinical decision that is made and monitored by a multidisciplinary team of key partners.

To support people to sustain the gains they make during a period of inpatient treatment, reduce the likelihood of readmission, and reduce the risk of fatalities following a period of abstinence, we propose to work with the new strategic partner to ensure that all inpatient treatment episodes are followed by an appropriate period of continued treatment and recovery support, either in the community or a residential setting including access to both psychosocial and pharmacological relapse prevention, and naloxone where appropriate. To support people is achieving longer term success services will be required to facilitate access to mutual aid, peer support and an agreed period of recovery check-ups as well as facilitate access to employment, training, and education support.

In recognition that some of the most marginalised groups continue to face significant barriers to accessing treatment in inpatient and residential settings we propose to work with our newly commissioned strategic partner to continue the work of the substance use support team and others in advocating for and supporting people to access such services.

Residential Rehabilitation

BCC currently commissions a residential rehabilitation ‘open framework’ which enables substance use clients to access specialist services offering accommodation alongside talking therapies and wider recovery-based support for those with complex needs including, drug and alcohol use, co-occurring physical, mental health and social care needs. The annual budget for residential rehabilitation placements is currently £680,000 per annum which enables approximately 34 clients to benefit from up to 24-weeks of residential treatment.

The main route for accessing residential rehabilitation is via the specialist interventions team who work with the client to establish a need for treatment in a residential setting and assess the client’s suitability against locally agreed criteria. Assessments are reviewed by a multidisciplinary team of drug and alcohol, health, and social care professionals who collectively agree the funding decision. Specialist interventions workers act as care manager and provide end-to-end support including pre-treatment preparation and facilitating access to post-treatment recovery support. There are several other routes into residential

treatment for specific groups, for example, criminal justice, specialist maternity, women sex-workers, and those experiencing homelessness.

We are proposing that from April 2025 our newly commissioned strategic partner will administer all aspects of the residential rehabilitation pathway on behalf of Bristol City Council including assessment, eligibility, funding decisions and brokering appropriate placements with CQC registered providers, and monitoring progress.

We propose to work with our newly commissioned strategic partner to explore alternative options to the existing model of panel-based decision-making while retaining appropriate governance and progress and performance monitoring capabilities. The new services will be expected to make approximately 70 residential treatment placements each year to meet national targets and will require supplemental funding to support this ambition.

The newly commissioned services will ensure that everyone accessing higher intensity abstinence-based services will receive appropriate harm reduction information advice and guidance, including naloxone where appropriate together with a comprehensive and personalised post-treatment aftercare/recovery support plan – this includes psychosocial and pharmacological interventions for relapse prevention.

There is currently no comparable community-based equivalent to residential rehabilitation meaning those who are unable to reside away from home for long periods may be disadvantaged when it comes to accessing higher intensity treatment options. For this reason, we are keen to explore your views on the possibility of using the residential rehabilitation budget to provide an alternative treatment option, where funding could be used to support people in accessing longer-term (up to 12 months) evidence-based psychological interventions e.g. cognitive therapy, trauma therapy such as EMDR, psychodynamic, or family therapy, within the community and delivered by professional therapist.

Recovery support services

Recovery support services offer support to people in their recovery journey, their families and benefit the wider community. They offer practical and emotional support to meet a person's needs, build on their strengths, and may be delivered by treatment providers of lived experience recovery organisations, separately or by working in partnership. We will also explore the role of the Council community teams in supporting this activity.

We propose to work with our new strategic partner to ensure that philosophies of harm reduction and recovery are equally valued, promoted and priorities among the substance use workforce. We will endeavour to ensure that recovery is visible throughout the newly commissioned system and services, and that interventions to support people in their recovery are identified and engagement supported at the earliest opportunity. Emerging evidence from the US shows that interventions to support people to stay in recovery had the greatest potential to reduce the number of people with substance use disorder over a 10-year period[3].

[3] Stringfellow, et al., (2022)

Parenting support

The provider will identify at treatment start whether clients have parental responsibility for a child aged under 18. There is a continued need to support clients to be good parents and to address the stigma that parents face as this could continue to prevent vulnerable clients accessing appropriate services. We propose that the new treatment model will include a worker (or workers) who can provide specialist parenting support alongside key working, and substance use treatment for clients who have parental responsibility for a child who is subject to a child protection plan.

Mutual Aid

Mutual Aid groups including SMART recovery and 12 Step fellowship organisations make a vital contribution to building and maintaining resilience, recovery, and reintegration for many service users. The service will be required to proactively facilitate access to appropriate mutual aid groups, and link in with wider recovery support across the local community.

Peer support

We recognise that peer support plays a pivotal role in supporting recovery and contributes to a wide range of positive outcomes including tackling discrimination and stigma; advocacy; providing opportunities for education training and employment etc. The service will include a peer support function to support peers and facilitate a high-quality training programme.

The service will have strong links throughout substance use services to ensure that peer support is available throughout the entire recovery journey. The provider will be required to ensure peers have suitable resources and a base, as well as meaningful roles and appropriate support.

Recovery check-ups and continuing care are types of post-treatment recovery management and are crucial for ensuring people have access to the right support and for a duration that is commensurate with their individual strengths and needs. For some a short period of recovery support may suffice whereas others will benefit from remaining engaged with recovery support services for multiple years.

We propose to work with our new strategic partner to deliver a programme of post-treatment monitoring and feedback through the implementation of recovery check-ups. The recovery check-up involves a series of planned motivational sessions that focus on:

- Checking in with people to find out how they are.
- Offering support, encouragement, information, and advice to help people to address any needs.
- Using motivational interviewing techniques to support the person to re-engage in treatment where appropriate.
- Identifying and addressing barriers to accessing support, including treatment.

In addition to the recovery check-ups, we propose to work with our new strategic partners to ensure the availability of continuing care which will be available to those with an assessed and care planned support need. This will require treatment and recovery services offering lower intensity interventions after a person has met their treatment goals and mainly involves ongoing assessment and psychosocial intervention and reducing the frequency of sessions over time.

We propose that recovery check-ups and continuing care are delivered in-person, by phone, using digital technology.

Harm Reduction

To turn the tide on increasing levels of harm being experienced by people who use alcohol and other drugs in Bristol, and to reduce the burden on hospitals and blue-light services, we propose that harm reduction remain a strategic priority for Bristol and its commissioned services.

We will work with our newly commissioned strategic partner to ensure the philosophy of harm reduction is embedded across the full spectrum of prevention, treatment, and recovery services. We will also seek to ensure that harm reduction and recovery are equally valued, promoted and prioritised among the workforce for the purpose of maximising choice and opportunity for the people who benefit from our services.

We propose resourcing a variety of evidence-based policies and interventions that seek to prevent overdose and infectious disease transmission; improve physical, mental, and social wellbeing; and offer clearly defined and low barrier options for accessing healthcare services, including substance use and mental health.

Needle and Syringe Provision (NSP) will be delivered across Bristol to ensure availability of injecting paraphernalia to reduce blood borne viruses and infections in people who inject opiate/crack, non-opiate drugs, and performance and imagine enhancing drugs. NSP will be delivered in a variety of settings including pharmacy, specialist or agency-based, custody suites, and via outreach. There will be effective referral pathways between NSP providers and treatment with and expectation that NSP's will identify, motivate, and refer those who aren't accessing treatment to treatment. people into treatment.

Overdose awareness and prevention interventions will be a key priority with information advice and guidance tailored to specific audiences e.g., opiate users, non-opiate users, polydrug users etc. The supply of naloxone, in various preparations, to opiate users and those likely to be in contact with people at risk of overdose including, but not limited to, targeting people who inject drugs; families and carers of people who inject drugs; hostel/supported housing workers; Police, substance use treatment workers and those exiting community, inpatient or residential treatment. All fatal and non-fatal overdoses will be reported to Bristol's Public Health team who will work collaboratively with relevant stakeholders to monitor and review drug and alcohol related deaths and implement identified learning outcomes.

Interventions and pathways for key health needs: we propose to work with our new services, clinical lead(s), primary and secondary health care providers to establish care pathways for physical and mental health related comorbidities. This will include a team of substance use specialist nurses that operate from the Bristol Royal Infirmary and Southmead Hospital. The team will improve health outcomes for people admitted to hospital who use drugs and/or alcohol; reduce repeat attendance and admissions to hospital; and ensure continuity of care between secondary care and community substance use services upon discharge from hospital.

Our new substance use services will offer interventions to support the identification and prevention of blood borne viruses including dry blood spot testing and venous blood specimens for the detection and diagnosis of hepatitis B, C and HIV where risk has been identified.

Local drug information system: we propose to work with our strategic partner to develop and implement a local drug information system to monitor risk and issue drug alerts, where appropriate for the purpose of preventing harm to individuals, families, and communities.

Drug safety checking: we will work with our new strategic partner to ensure people who use drugs have access to forensic testing service(s) and evidence-based information advice and guidance based on the content and purity of a given substance. The information gathered by this service will be used to inform a proactive public health response to emerging risks.

Alcohol harm reduction: we propose to work with our new strategic partner to ensure that evidence-based alcohol harm reduction interventions are available to support people in achieving their immediate goals which may include safer drinking, reduce alcohol intake, or abstinence from alcohol and other substances. We propose to increase the accessibility of alcohol harm reduction by developing a suit of digital resources for people to access at a time of their choosing.

To increase the reach of health protection and harm reduction messages we propose using peers and digital solutions to reach specific populations including historically less engaged groups and occasional users.

Community prescribing interventions

Most of the community prescribing for adults happens through GP shared care where people who use drugs are prescribed by their GP practice and supported by a substance misuse liaison worker who provides subject expertise, key working and psychosocial support in almost every surgery in Bristol. We also have several additional pathways for complex cases and inclusion health groups e.g., prison leavers, people who are homeless and marginalised women, whose needs are unable to be met effectively within primary care.

We propose that our newly commissioned community prescribing service delivers a full range of prescribing interventions for people who use opiates, people dependent on alcohol, and symptomatic prescribing for other dependencies e.g., stimulants and Spice where appropriate. Regimes for stabilisation, maintenance, reduction, withdrawal, detoxification, relapse prevention will be available together with the option to move between them in accordance with the individuals progress and personal recovery ambition. All prescribing interventions will be delivered in line with Drug misuse and dependence: UK guidelines on clinical management, and guidance from the National Institute of Clinical Health Excellence (NICE) ensuring psychosocial interventions are included and integrated within the individual's recovery plan.

We propose continuing our investment in shared care including the function of the substance misuse liaison service, and bringing together all other adult community prescribing pathways into a single specialist prescribing service led by a Consultant Psychiatrist that will work with the most complex cases. The specialist prescribing service will work with people to achieve a period of stabilisation prior to transitioning into shared care and people showing signs of deterioration while in GP shared care will be promptly transferred to the specialist service for additional support and until such time they can be safely returned to primary care.

The specialist service will deliver:

- A low threshold offer to those less well engaged clients who may be at highest risk overdose death.
- A robust rapid prescribing pathway for people being released from prison. Those subject to a planned prison release will be offered an appointment to coincide with the day of release.
- A women's specific service for street sex workers.
- An annual health check for all community prescribing clients.

We would also like to explore the possibility of co-locating the substance use liaison service and specialist prescribing service, bringing all community prescribing interventions together into a single service with the substance misuse liaison element continuing to work in primary care. Co-locating this service may help to enhance the client experience by providing a fully joined up service.

We, like many large urban areas, have a growing number of aging heroin and crack users who experience multiple additional risk factors due to deteriorating physical and mental health, difficulty navigating complex health and social care systems, and experience stigma. We propose to implement a programme of health checks for all community prescribing clients. Health checks will be completed by a competent medical practitioner on an annual basis who will facilitate access to further treatment as required.

We propose to work with our newly commissioned strategic partner(s) to ensure our community prescribing services:

- Are flexible.
- Are accessible including out of hours for those in full time employment.
- Prescribe doses that are safe and within optimal ranges.
- Provides a full range of OST medication including the expansion of prolonged release buprenorphine.
- Promote recovery.
- Have a multidisciplinary team of trained staff with positive, non-judgemental attitudes towards treatment, recovery and harm reduction and participate in continuing professional development and clinical supervision.
- Regularly review clients progress towards recovery goals.
- Will work proactively with service users to encourage recovery ambition which may or may not include abstinence.
- Be available for all clients for a length of time appropriate to their needs and risks.
- Provide primary health care services for people who are not registered with a GP practice.
- Will make use of community-based resources to offer appointments across the city at a location that is convenient for the client.
- Regularly explore the benefits of different treatment options including inpatient detox and residential rehabilitation.

Early Engagement and Intervention

It is estimated that Bristol is home to approximately 4,989 opiate and crack users[4] and 6,677 dependent drinkers[5], many of which have additional comorbidities and are at increased risk of early mortality due to their substance use and associated lifestyle factors.

Engaging people who use alcohol and other drugs in structured substance use treatment has been shown to be effective in reducing harm and saving lives[6]. For this reason, we propose to with our newly commissioned strategic partner to build on the work of existing providers and deliver a comprehensive early engagement and intervention (EEI) service. The early engagement and intervention service will operate under a harm reduction philosophy while ensuring that recovery is highly visible to people from the outset of their engagement. This may be achieved through effective partnerships with lived experience recovery organisations, mutual aid, and other peer support mechanisms.

The early engagement and intervention service will work with relevant partners to establish an assertive outreach programme primarily targeting historically less engaged groups of alcohol, opiate and crack cocaine users i.e., those that cause the most visible harm to themselves and others. The service will focus on developing effective therapeutic relationships in the first instance, followed by supporting engagement with other open access and supportive services e.g., needle syringe programme, alcohol harm reduction, overdose prevention, BBV testing and referral for treatment, drug safety checking, wound care, and crisis management and facilitating access to substance use treatment via the low threshold prescribing offer from the newly proposed specialist prescribing service.

Public health will work with our new strategic partner to identify systemic barriers to access, for those with higher levels of problem severity and complexity. Once identified we will actively engage with relevant stakeholders overcome barriers to access and support people to get the treatment they need when they need it.

In our early engagement exercises people consistently highlighted the need to retain a physical space for people who use alcohol and other drugs to drop in for support on an open-access basis, so we propose that the EEI service develop and operate a comprehensive and highly effective outreach arm who's brand is familiar to partners right across the city while retaining a physical space for to drop-in for support on an open-access basis. This may include 24/7 crisis management support with a view to reducing fatalities and demand on other blue light services.

Children and Young People

The service for children and young people will focus on early intervention and the prevention of escalation into more harmful patterns of drug and alcohol use.

Early intervention

The children and young people's element of the newly commissioned services will be part of a wider substance use system that supports young people aged 11-17 at all levels of need. This newly commissioned element will target those who are most vulnerable to substance use, providing support at the earliest opportunity, and preventing escalation into more

[4] Estimates of the prevalence of opiate and/or crack cocaine use (2019). Opiate and crack cocaine use: prevalence estimates by local area - GOV.UK (www.gov.uk)

[5] Estimates of the number of adults in England with an alcohol dependency and potentially in need of specialist treatment. Alcohol dependence prevalence in England - GOV.UK (www.gov.uk)

[6] Preventing drug related deaths: turning evidence into practice. Public Health England (2014). Available at, Preventing drug-related deaths: turning evidence into practice - GOV.UK (www.gov.uk)

harmful and risky behaviour. Young people who are already engaging in the riskiest behaviours will be supported elsewhere in the system.

The new service will be operational every mainstream secondary school in Bristol as well as all appropriate special schools and alternative learning provision settings across the city.

The service will also work closely with other agencies including, health, youth services and other VCS organisations, aiming to identify young people who use drugs and alcohol and encourage referrals into the service.

Interventions will include cognitive and behavioural interventions; motivational interventions; and some structured harm reduction. These interventions will be reported to National Drug Treatment Monitoring Service, increasing the number of young people in the city who are identified as being in structured treatment.

Out of scope:

- drug and alcohol education (this is provided by qualified teaching staff through the new PSHE school curriculum)
- pharmacological interventions,
- safeguarding interventions,
- mental health support (these are all offered by CYP specialist treatment services)

The new service will be required to refer young people into these specialist treatment services according to their level of need.

Young people who are affected by a parent or carer's substance use.

This service will support young people who are affected by parental substance use, recognising that these young people are particularly vulnerable to substance use themselves, and to other poor health outcomes. Support will include drug and alcohol education; including understanding addiction; developing strategies for staying safe; linking with support for young carers; understanding healthy relationships; maintaining engagement with education etc.

Out of scope of this service are children and young people who are engaged with social care, as these young people are supported in the specialist safeguarding substance misuse service.

Transition to adult services

Separately from the early intervention service, we propose that the service model will include named workers who will work closely young people's substance misuse services. This part of the service will support those young people who need ongoing support past their 18th birthday ensuring their needs are met as they make the transition from young people to adult services and provide for ongoing structured treatment support as required. The transitions service will be required to meet the Young People Friendly quality standard criteria. Close working links with young people's substance misuse services and other specialist services engaging with the most vulnerable young people will be required and clear information sharing agreements will be put in place to support the transition between providers.

Families and Carers

Our proposed service model will routinely assess the family support needs of substance use clients as part of a comprehensive assessment, or on-going review of their treatment

package. Agreed actions can include arranging family support for the family or family support that includes the individual in treatment.

Additionally, we would like the service to work directly with adults who are affected by someone else's substance use, including significant others and close friends as well as families and carers in their own right (independently of whether their loved one is engaged with substance use services). The Family and Carers function will help affected others learn more about substance use and treatment and give them new skills to better cope with problems as they arise. The function will also offer opportunities for peer support and promote affected others' involvement in treatment services where appropriate.

This aspect of the current provision is jointly commissioned with neighbouring local authorities South Glos. and Bath and North East Somerset. As it may not be possible to jointly commission this in the same way from April 2025 onwards, our current proposal is to include this in the main contract with a strategic partner. Our current view is this is an essential part of the service. However, there may be a case for decommissioning this if family and carers needs could be adequately met in other services e.g. carers support, national charities.

Workforce development

We are committed to ensuring that our commissioned substance use services have a skilled workforce and that other organisations and professionals in Bristol have a good understanding of substance use issues and are able to work with people who use drugs and alcohol or who are in recovery (including within their own workforce) to overcome barriers including stigma and discrimination.

We would like our strategic partner to contribute to deliver internal and external workforce development and co-ordinate activity and work with partners to maximise the training, development and equality good practice that is embedded within all commissioned substance use services.

This function will facilitate collaborative working, skill-sharing and emerging good practice between different teams with the commissioned service; coordinate substance misuse awareness training for other professionals (for example social work teams); and promote equity and anti-discriminatory practice by establishing strong links with statutory and non-statutory organisations, local business, communities, and faith-based groups.

Enabling joined up systems and support.

To identify and effectively respond to the diverse range of presenting problems experienced by people who use alcohol and other drugs it will be essential that our locally commissioned specialist substance use services are part of a broader system of effective integrated pathways and packages of care, with quality and performance regularly reviewed against locally agreed outcomes.

Alcohol is a prime example of the need for effective joined up systems, and services that provide a seamless journey through the pathway for service users. Bristol is estimated to

have between 7,164[7] and 14,690[8] dependent drinkers with the rate of unmet need among the population being 88%.

Alcohol is one of the most harmful substances available and is a causal factor in more than 60 medical conditions including circulatory and digestive diseases, liver disease, several cancers and depression which places increasing strain on already stretched community health and social care services. According to data from the NDTMS there were 1,057 people admitted to hospital in Bristol due to alcohol specific conditions and the number of admissions is increasing year-on-year as the substance population grows older and sicker.

If we are to better meet the needs of people that use alcohol harmful and dependently it will be essential that specialist substance use services, primary care, hospitals work in an integrated and seamless way to prevent progression from hazardous to harmful or dependent levels of drinking, improve the identification of alcohol use disorder and better engage people in treatment for their alcohol and associated physical and mental health comorbidities.

We propose to work with our newly commissioned strategic partner to develop specialist alcohol treatment services for those with an identified alcohol use disorder i.e., higher risk harmful and dependent drinkers.

We propose to support primary care and people who are drinking hazardously by working with our new partners to develop a suite of digital information, advice, guidance, therapeutic tools, and signposting to peer support and mutual aid. Improving access to digital resources may also benefit those with a more severe alcohol use disorder e.g., harmful, and dependent drinkers who are less likely to engage with specialist substance use services due to accessibility issues or perceptions of stigma.

We propose to work with colleagues in primary and secondary care to improve the identification of alcohol use disorder with routine screening being an integral part of practice in primary care when registering a new patient, screening for other conditions, managing chronic disease, during medication reviews, promoting sexual health, antenatal appointments and treating minor injuries and ensure clear referral pathways into specialist services.

We will work with our new services and primary care to implement NICE CKS guidelines for the management of alcohol dependence including the availability of the following interventions via primary care.

- A session of structured brief advice on alcohol consumption using an evidence-based resources based on FRAMES principles.
- An extended brief intervention if the person has not responded to structured brief advice.
- A psychological intervention for harmful drinkers with mild dependence.
- Community-based detoxification supported by substance misuse liaison workers.
- Provide appropriate information, advice, and guidance.

[7] NDTMS - ViewIt - Adult

[8] BNSSG system-wide dataset

- Arrange a follow-up appointment.
- Provide a referral for specialist alcohol treatment for those with more moderate and severe dependence.

We will work with our new strategic partners, and local hospitals to ensure that patients admitted to UHBWT and NBT in need of medical interventions linked to substance use are identified and where possible, assessed and referred into and appropriately supported to access specialist substance use treatment and recovery support services.

We intend to expand the role of drug specialist nurses to include alcohol. Drug and alcohol specialist nurses will help improve prescribing regimes for alcohol and other drug users admitted to hospital, help to reduce repeat attendance and admissions, and improve care pathways between hospitals and our newly commissioned substance use service(s).

Quality and standards

All interventions delivered by our new services will comply with all relevant service quality standards and will be expected to accept or adopt relevant updates to existing guidance and new guidelines when issued.

It is the responsibility of public health to ensure appropriate quality governance is in place for our newly commissioned services. For adults' system-wide performance will be monitored by public health using NDTMS metrics including the Local Outcomes Framework. OHID have negotiated ambitious targets for improvement in several areas including:

- Increasing the number of adults receiving NDTMS reportable structured substance use treatment (alcohol and drugs)
- Reducing the number of deaths among those in treatment
- Improving continuity of care between prisons and community-based services and reducing attrition leading to reoffending.
- Improving the proportion of people who are showing substantial progress.
- Increasing the number of people engaging in meaningful activity through work, education & volunteering.
- Reducing levels of unmet need for mental health treatment; stable and suitable housing; parental support and improving treatment exits and referrals.
- Reducing the wider harms associated with substance use including alcohol-related hospital admissions, hospital admissions for drug poisoning, and hospital admissions for substance use.

Multi-agency leadership is essential if we are to deliver highly effective substance use services that are fully integrated within a broader system of care. Therefore, we propose that system leadership is provided through a multi-agency partnership that includes all partners involved in the planning and delivery of services for substance users. The multi-agency partnership will agree local targets for their respective organisations and regular review the quality and performance of the services for which they are responsible. The multi-agency partnership will also receive regular intelligence from local and national sources to monitor the emergence of new, higher strength, adulterated, or contaminated drugs and respond proactively to save lives.

To ensure our new services are delivered to the highest standards and achieve the best outcomes for our service users we propose to work with our new strategic partners to

establish and maintain an effective contract/performance focusing on quality, safety, accessibility, and effectiveness of services.

Lotting and allocation of resources

The Commissioning Board has sought opinion on the commissioning process and concluded that a competitive tender process is the most appropriate method to procure the programme. We plan to precure the service using an Open Procedure so that any interested service provider will be provided with tender documentation and can bid, and all bids once submitted are final.

Sometimes when the Council is procuring services for external suppliers we break down what we want to buy into separate 'lots' which different providers can bid for. For comparison we have considered two simple options for tendering through lots, versus one single contract for all providers; However, we acknowledge that there may be other hybrid options we have not considered at this stage. these options are set out in the table below.

Lots	Potential advantages	Potential risks
A single lot for whole programme including all services in scope – with one lead service provider	• Simplifies commissioner/provider relationship • Joined up services • Cost efficient • Still allows for localisation and more intensive support in high need areas • Potential economy of scale	• Too centralised • Increased risk of performance failure "all eggs in one basket" • Less flexibility in changing programme emphasis • May shut some suppliers out of the market
Multiple lots for different functions of the service	• May attract a wider range of smaller providers • Spread the risk • May support diverse approaches and innovation	• May reduce competition of small lots unattractive to providers • Increased contract management • Risk providers may not work well together

Our proposal is to commission a single strategic partner provider, or a single lead provider of a consortia approach. This is to provide clear leadership and accountability that promotes effective collaboration different elements of the service. The provider will ensure an easily recognisable, and navigable treatment system.

We will ensure the lead provider is of sufficient size and expertise to hold the contract. However, we welcome partnership work with smaller local agencies for the purpose of retaining skills, knowledge and experience of local delivery and enhancing social value throughout the life of the contract. We recognise and value the historical contribution of the local voluntary and community sector organisations in promoting the alcohol and drugs agenda in Bristol.

The strategic partner will need to demonstrate they understand the diversity of the Bristol population and provide inclusion in service delivery with a workforce that is representative of the Bristol population, as well as a person-centred and holistic approach that is evidenced based, and trauma informed.

We plan to encourage organisations to submit collaborative bids following the Bristol City Council's guidance on Collaborative Arrangements/Commissioning Procurement in relation to formation and risks. The four models of collaborative working arrangements that are acceptable include:

- ✓ Lead partner consortium
- ✓ Joint and several liability consortium
- ✓ Sub-contracting
- ✓ SPV – special purchase vehicle (formation of a new organisation/new company for the purposes of tendering)

To encourage collaborative bids, we will allow more time in the process and take an approach to be flexible with our assessment approaches. For example, Bristol City Council is committed to full-cost recovery (a principle of the Bristol Compact) and as such recognises that, in some cases, overhead costs may be different in collaborations. As we are keen to encourage collaboration between providers, we will take into account different costs of effective collaborative and managing multiple relationships and will ask bidders to provide details.

Bristol City Council aims to spend at least 25% of the Council's total procurement budget with micro, small and medium size businesses, social enterprises and voluntary / community organisations (less than 250 employees), as per the Social Value Policy.

Within this commissioning process we intend to encourage that at least 25% of the funding available in the competitively tendered contracts goes to micro, small and medium size businesses, social enterprises and voluntary / community organisations. This could be achieved through collaborative bids from providers working together in, for example, lead partner collaborations or sub-contracting arrangements. We are open to hearing ideas and suggestions about this from providers in this consultation.

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

Part of Bristol City Council's procurement process is an assessment of the financial risk of individual providers. This involves looking at a range of measures including, for example, the bidders most recent financial statements (along with those of any ultimate parent company if appropriate), the general liquidity and assets held. We anticipate the assessment will be on combined contract values where the organisation applies for several contracts at the same time.

We will require the provider to ensure that there will be a presence/visibility in locality areas.

Our proposed timeline

- Public Consultation – 30 October 2023 to 24 December 2023
- Tender launch – 11 March 2024
- Tender close – 3 May 2024
- Notification of decision – 1 July 2024
- Contract award – 31 July 2024
- Service start date – 1 April 2025
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Appendix A – List of Pharmacological Interventions

Alcohol

Naltrexone (oral) – Alcohol relapse prevention/consumption reduction
Client prescribed naltrexone to prevent relapse to alcohol use or to limit the amount of alcohol a client drinks.

Chlordiazepoxide – Alcohol withdrawal
Client prescribed chlordiazepoxide to treat acute alcohol withdrawal (do not record chlordiazepoxide prescribed to treat anxiety or for any other purpose)

Diazepam – Alcohol withdrawal
Client prescribed diazepam to treat acute alcohol withdrawal (do not record diazepam prescribed to treat anxiety or for any other purpose).

Carbamazepine
Client prescribed carbamazepine to treat acute alcohol withdrawal (do not record carbamazepine prescribed for any other purpose).

Acamprosate
Client prescribed acamprosate to prevent relapse to alcohol use.

Disulfiram
Client prescribed disulfiram to prevent relapse to alcohol use.

Other prescribed medication for alcohol withdrawal
Alcohol withdrawal Client prescribed other medication to treat acute alcohol withdrawal.

Vitamin B and C
Prescribed supplement to prevent/treat Wernicke's encephalopathy/ Wernicke-Korsakoff's.

Opiates

Methadone (Oral Solution) - Opioid Assessment and Stabilisation
Client is prescribed oral methadone to stabilise the use of illicit drug(s), following and alongside continuing appropriate assessment. It also includes re-induction onto opioid substitution treatment prior to prison release, in the limited circumstances where this is appropriate.

*Methadone (oral solution) * – Opioid withdrawal*

*Client is prescribed oral methadone to facilitate medically assisted withdrawal and to manage withdrawal symptoms. This would usually be for up to 12 weeks in the community or 28 days as an inpatient. Methadone (oral solution) * – Opioid maintenance*

*Methadone (oral solution) * – Opioid maintenance*
Client is prescribed oral methadone under a stable dose regimen to medically manage physiological dependence and minimise illicit drug use. Maintenance prescribing may be provided to support the individual in achieving or sustaining medication assisted recovery.

Buprenorphine (tablet/wafer)# – Opioid assessment and stabilisation
Client is prescribed buprenorphine tablet/wafer (for instance, mono-buprenorphine) to stabilise the use of illicit drug(s), following and alongside continuing appropriate assessment. It also includes re-induction onto opioid substitution treatment prior to prison release, in the limited circumstances where this is appropriate. Subutex should be recorded as buprenorphine.

Buprenorphine (tablet/wafer) # – Opioid withdrawal
Client is prescribed buprenorphine tablet/wafer (for instance, mono-buprenorphine) to facilitate medically assisted withdrawal and to manage withdrawal symptoms. This would usually be for up to 12 weeks in the community or 28 days as an inpatient. Subutex should be recorded as buprenorphine.

Buprenorphine (tablet/wafer) with naloxone# – Opioid assessment and stabilisation
Client is prescribed buprenorphine tablet with naloxone (for instance, Suboxone) to stabilise the use of illicit drug(s), following and alongside continuing appropriate assessment. It also includes re-induction onto opioid substitution treatment prior to prison release, in the limited circumstances where this is appropriate.

Buprenorphine (tablet/wafer) with naloxone# – Opioid withdrawal
Client is prescribed buprenorphine tablet with naloxone (for instance, Suboxone) to facilitate medically assisted withdrawal and to manage withdrawal symptoms. This would usually be for up to 12 weeks in the community or 28 days as an inpatient.

Buprenorphine (tablet/wafer) with naloxone# – Opioid maintenance
Client is prescribed buprenorphine tablet with naloxone (for instance, Suboxone) under a stable dose regimen to medically manage physiological dependence and minimise illicit drug use. Maintenance prescribing may be provided to support the individual in achieving or sustaining medication assisted recovery.

Buprenorphine depot injection (rods or fluid) – Opioid withdrawal
Client is prescribed buprenorphine depot injection to facilitate medically assisted withdrawal and to manage withdrawal symptoms. This would usually be for up to 12 weeks in the community or 28 days as an inpatient.

Buprenorphine depot injection (rods or fluid) – Opioid maintenance

Client is prescribed buprenorphine depot injection under a stable dose regimen to medically manage physiological dependence and minimise illicit drug use. Maintenance prescribing may be provided to support the individual in achieving or sustaining medication assisted recovery.

Diamorphine injection – Opioid assessment and stabilisation/opioid withdrawal/opioid maintenance
Client is prescribed diamorphine injection (for instance, injectable ampoules) for opioid assessment and stabilisation, withdrawal or maintenance.

Methadone injection – Opioid assessment and stabilisation/opioid withdrawal/opioid maintenance
Client is prescribed methadone injection for opioid assessment and stabilisation, withdrawal or maintenance.

Naltrexone (oral) – Opioid relapse prevention
Client prescribed oral naltrexone to prevent relapse to opiate use.

Non Opiates

Benzodiazepine – Benzodiazepine maintenance
Client is prescribed benzodiazepine for benzodiazepine maintenance.

Benzodiazepine – Stimulant withdrawal
Client is prescribed benzodiazepine for stimulant withdrawal.

Benzodiazepine – GHB/GBL withdrawal
Client is prescribed benzodiazepine for GHB/GBL withdrawal.

Stimulant (for example, dexamphetamine) – Stimulant withdrawal
Client is prescribed stimulants such as dexamphetamine for stimulant withdrawal.

Pregabalin – Gabapentinoid withdrawal
Client is prescribed pregabalin for gabapentinoid withdrawal.

Gabapentin – Gabapentinoid withdrawal
Client is prescribed gabapentin for gabapentinoid withdrawal.

(This is not an exhaustive list)

Psychosocial interventions — structured "talking therapies".
Pharmacological interventions — structured "community prescribing":

These refer to the use of drugs to treat medical conditions and can be involved in different stages of treating substance use problems. Medication is recognised as an adjunct to psychosocial treatment to provide an optimal treatment package. To improve physical and mental health. Prescribed medications are not a standalone treatment option and are only recommended as part of care plan treatment. See Appendix A – List of Pharmacological Interventions below for details.

Recovery support interventions – non-structured:

Peer support involvement

Facilitated access to mutual aid

Family support

Parenting support

Housing support

Employment support

Education and training support

Supported work projects

Recovery check-ups

Evidence-based psychosocial interventions to support relapse prevention

Complementary therapies

Mental health interventions

Smoking cessation

Client provided with domestic abuse support for victim/survivor

Client provided with domestic abuse support for perpetrator

Has the client been provided prescribing for relapse prevention?

Note: it is expected that all interventions are delivered according to national guidelines including, Drug Misuse & Dependence: UK guidelines on clinical management; and relevant guidelines from the National Institute of Health and Clinical Excellence (NICE)