SHEFFIELD DRUGS & ALCOHOL
CO-ORDINATION TEAM

Sheffield DACT

Commissioning & Procurement Plan

CONSULTATION COPY – Stakeholder & Public

Contents

Sheffield DACT Commissioning & Procurement Plan

Introduction:

In 2009/10 Sheffield DACT began a planned tender of all services in the drug treatment system. The tender was staggered over three rounds starting in 2009/10 and completing in 2012/13.

Contracts which were awarded in 2009/10 are now approaching their end dates and have been extended for 1 year in order to plan and consult upon the re-tender. Contracts are 3-5 year contracts and can be extended for a further year, if necessary to manage capacity and resources through a staggered procurement process.

This document sets out the commissioning intentions of the Drug & Alcohol Co-ordination Team (DACT) for publicly funded community based Drug & Alcohol Recovery Services and will be used as a tool to facilitate full consultation with stakeholders and shareholders in treatment/recovery.

In the three years since the previous tender in 2009/10 drug trends have changed and there has also been a new National Drug Strategy and Government Alcohol Strategy. For this reason, contracts will not be re-tendered in their current form but will be updated to meet current need. The key change will be the creation of three end-to-end contracts creating a single pathway and customer journey for service users with Non opiate, Opiate and Alcohol misuse problems.

Re-specification of contracts will be the responsibility of the Drug & Alcohol Co-ordination Team within the Local Authority. The implementation of the procurement plan will be by Sheffield City Council Commercial Services in close collaboration with Sheffield DACT.

The combined value of current contracts discussed within this procurement plan is just over £5m. The combined value of new contracts is just under £5m creating a proposed 25% cost savings over 2 years. All contracts will require cabinet approval and will be subject to open competitive tender.

Contracts not requiring procurement during this timetable, including contracts under the procurement value threshold, and contracts with end dates beyond 2015 are not discussed in this plan.

Non treatment contracts (suppliers of urine tests, medical waste collection and hepatitis vaccinations etc) are not discussed in this plan but where appropriate will be included within contracts for services and the additional cost added to the overall envelope of the service.

Local Need (Summary)

The DACT produces detailed needs assessments for both drugs and alcohol which are available on the DACT website:
http://sheffielddact.org.uk/drugs-alcohol/resources/needs-assessments/

This section sets out how the DACT is using local need to plan the type and volume of service that is required.

Drugs

Drug misuse in Sheffield involves the misuse of a range of substances. There are an estimated 4017 opiate/crack users in Sheffield according to the latest prevalence estimates. There are currently just over 2,000 opiate users in prescribing treatment and therefore, based on the prevalence figure of 4,017 there are up to 2,000 opiate/crack users who are not in formal structured treatment. A proportion of these are known to harm reduction services e.g. needle exchange. There are no prevalence estimates for non-opiate use (e.g. cannabis, power cocaine, ecstasy, khat, ketamine, steroids).

Those using harm reduction services such as needle exchange and wound care are around 60:40 opiate and crack users and steroid users. Young users (<30) are predominantly alcohol, cannabis, powder cocaine, ecstasy (ACCE) profile users. There are discrete BAMER cohorts using illicit (soon to be illegal) drugs such as khat and illegal drugs such as opium. New Psychoactive Substances (NPS) and synthetic cannabinoids are rarely seen in those accessing treatment. NPS drugs are of growing concern amongst younger cohorts (18-25) particularly as injecting use is beginning to be seen in the city. Over the counter and prescription drug dependence is known to be a growing problem but these cohorts may be difficult to attract to treatment. These trends are detailed in the DACT annual needs assessment (drugs).

The majority of those in treatment (c.2,100) in Sheffield are opiate users in prescribing treatment. In future, as trends continue to shift towards non-opiate use we can expect to see a growth in demand for cognitive behavioural therapy based talking treatments (Psychosocial Interventions or PSI) which are the first line intervention for non-opiate use.

For this reason, DACT must commission a balanced treatment system which meets current demand which includes longer term maintenance prescribing and yet is responsive to the growth areas of problematic non-opiate use. Non-opiate use e.g. cannabis is known to be problematic in neighbourhoods in terms of anti-social behaviour and therefore requires an assertive partnership response from both enforcement and treatment services.

Opiates

For those using opiates the first line treatment is opioid substitution therapy with methadone, with other treatment options including other substitute medications, community or inpatient detoxification and/or residential rehabilitation.

Non-opiates

For those using non-opiates the first line treatment intervention is formal psychosocial interventions (PSI). This describes talking therapies, one to one or in groups e.g. cannabis smoking cessation.

Alcohol

For those with alcohol problems, a Single Entry & Assessment Point (SEAP) in the city provides a screening assessment, personalised tailored written advice and onward referral to treatment where appropriate. There is sufficient evidence (SIPS research) that a single session intervention of Identification & Brief Advice (IBA) comprising a SEAP assessment and personalised take home advice is sufficient for "binge" drinkers and the approximately 77,000 "increasing risk" drinkers in Sheffield. Fixed Penalty Waiver and Alcohol Conditional Bail are both successfully offered as a single 1 hour session of SEAP assessment and IBA.

Sheffield has an estimated 47,000 higher risk drinkers, however despite these high prevalence estimates alcohol services are currently under-used in Sheffield. The reasons for service under-use are complex and continue to be explored but it is considered that need estimates are accurate. Uptake of treatment is monitored against alcohol specific and alcohol related hospital admissions to interrogate patterns of demand versus need.

The city has an aspiration of 75% uptake of commissioned treatment for all modalities and is nearing achievement of this.

Community detoxification and medical services are well used suggesting late identification of those requiring treatment at the point of dependent drinking. Medical interventions should be commissioned at increased volume to reflect this local pattern of later access to treatment which requires medical interventions.

Psychosocial interventions are under-used by around 25% of commissioned capacity but this is likely to increase if more effective screening leads to earlier identification. PSI should be commissioned at current volumes.

Proposed Service Re-design

This plan makes a number of proposed changes to the current service design and pathways.

The key change is the creation of three end-to-end pathways for non-opiate, opiate and alcohol users. This means that a service user will start and finish their treatment journey within a single service receiving all necessary interventions within that service. “End to end” services for different cohorts of drug users will avoid barriers and “hand offs” in the process of seeking help and treatment.

Specialist needle exchange and harm reduction (wound care and blood borne virus) services sit as discrete services within the Non Opiates and Opiates contract respectively. The nurse based harm reduction service will offer in-reach clinics into the Specialist Needle Exchange.

The Specialist Needle Exchange will be operated from its own unique base separate from treatment and recovery services.

The Alcohol Service will not be co-located with any drugs service.

Streamlining and integration directs funds away from infrastructure costs (e.g. premises and overheads) towards front line service delivery. This will provide better value for public money.

All proposed services are commissioned based on estimated need using national prevalence estimates, balanced against local data showing patterns of demand.

All proposed services to be commissioned comply with the National commissioning and clinical guidance.

All proposed services to be commissioned comply with national key performance indicators and data capture requirements

A combination of national unit costs and regional benchmarking will be used to set a ‘fair price’ for contracts. National unit costs were developed in 2006 and have not been updated since so are not routinely applied.

Flat rates are paid for premises, overheads and non clinical pay costs benchmarked to current Sheffield city centre prices.

There is additional small investment in alcohol treatment in the city which has been resourced by a commensurate reduction in drug contracts.

The cost saving from the opiates contract is derived from the merger of two large prescribing services with separate premises, overheads and senior management structure.

The cost saving from the non-opiates contract is derived from the merger of a number of small and medium sized services and realistic assessment of numbers through based on 2013/14 data.

A per capita payment system allows additional activity to be funded at a fair payment if demand increases. This equally enables reduction in capacity to be made in response to changing need and demand during the 3-5 year contract.

This procurement plan has been configured in line with Sheffield City Council's cost savings targets, although these are subject to change. This plan creates a 25% cost saving over 2 years. Sheffield DACT through redesign of the treatment system will be able to deliver savings in Year 1 through service redesign without impacting on service quality. Savings in Year 2 have been achieved through a reduction in system capacity and the impact of this will be carefully monitored to ensure this does not result in increased waiting times.

Procurement route

The procurement route for all contracts will be open competitive tender. All contracts to be offered in this round are for healthcare and are therefore "part b services" in EU procurement law.

Although services are Part B, all Sheffield City Council Procurements are carried out to Part A standard. This means that timescales for the procurement are set in EU law and therefore time can't be made up in a late starting procurement. The effect of this is that some contracts will need to be extended up to the fifth and final year in order to conduct the procurement.

Contracts in excess of £500,000 must be under the Council's seal (Sheffield City Council Contract Standing Orders) and this applies to all three contracts to be let through this commissioning and procurement plan.

Proposed Procurement Rounds

The end dates of current contracts create two clear 'Rounds' staggered across the financial years 2013/14 and 2014/15. It is proposed to tender drugs services in Round 1 and alcohol services in Round 2.

The advantage of a staggered procurement to service users is that this minimises disruption and maximises retention in treatment and achievement of recovery goals.

Staggered procurement is beneficial to providers as it can create a greater likelihood of retention of skilled and experienced staff and allows time to stabilise operations between rounds.

The advantage for commissioners to providing greater time delays between planned re-tender rounds is lessen the impact on the capacity of the DACT, evaluators and

the ‘market’ of potential bidders and allows the ‘system’ as opposed to individual services to stabilise.

Staggered procurements can stimulate the market, as bidders competing for multiple contracts may need to mobilise to a contract which they have been awarded while bidding for another.

All current contracts are for up to 5 year terms with a “break clause” at Year 3. This allows sufficient time for contracts to “bed in” and begin performing. This length of contract term also allows sufficient time for a planned retender following the 3 year term. All new contracts awarded in these rounds will be for 3 -5 year terms, with the 2 year extension granted subject to satisfactory performance.

Proposed contracts

Current Contracts	Current provider(s)	Change in volumes of care commissioned Yr 1	Expected volumes (new contract)	Proposed contracts to be offered	Procurement Round
Tier 2	CRI (Arundel St Project)	Reduction in needle exchange capacity reflecting 2013/14 usage	400 registered needle exchange 400 Open Access/Assertive outreach 400 PSI 400 Recovery Support	**Contract 1** – Non Opiates Service (Drugs) including Specialist Needle Exchange (Drugs)	**Round 1** (Procurement to commence Q4 January 2013/14, contract award and mobilisation Q2 - including TUPE where relevant- contracts begin delivery Q3 2014/15)
Psychosocial Interventions 'PSI' (Drugs) Structured Daycare and Aftercare Carer Support	Turning Point RDASH	Increase in formal PSI Increase in recovery support.			
GP Deputising, Specialist Pregnancy Clinic & Shared Care Support - Drugs Specialist Prescribing Drugs Harm Reduction Service Drugs	PCASS (Guernsey House) SHSC (Fitzwilliam Centre)	No change in assessments Small reduction of 150 primary care prescribing places reflecting 2013/14 usage Increase in PSI provision	1,000 assessments 2,450 prescribing including 950 secondary care & 1,500 primary care 900 PSI	**Contract 2** – Opiates Services (Drugs)	**Round 1** (Procurement to commence Q4 January 2013/14, contract award and mobilisation Q2- including TUPE where relevant - contracts begin delivery Q3 2014/15)
SEAP & Tier 2 – Alcohol Medical Prescribing – Alcohol PSI (Alcohol)	SHSC (Fitzwilliam Centre) Turning Point	Increase of 250 medical places	2,400 Identification Assessment & Brief Advice 1,000 prescribing 500 PSI	**Contract 3** – ALCOHOL Services	**Round 2** (Procurement to commence Q2 2014/15, contract award and mobilisation Q4 - including TUPE where relevant - 2014/15 contracts begin delivery Q1 2015/16)

CONTRACT 1 Non Opiates Service – Drugs

Part A – STATIC and MOBILE and EMBEDDED Specialist Needle Exchange:
The service will provide a *separately located* specialist needle exchange.

The service will provide clean injecting and other drug use paraphernalia in line with current law and protocols agreed with South Yorkshire Police.

The service will collect and safely dispose of used paraphernalia with a high number of returns to reduce needle waste problems in the city.

The service will provide overdose prevention and safer injecting advice to reduce harm.

This service will be offered on a static and mobile basis (van and bicycles). Specialist static and mobile exchange will be supplemented by a weekly offer of embedded advisory drug workers within the busiest city centre pharmacy needle exchanges.

Professional advice and training to pharmacy needle exchange will be provided as part of this service.

The service will provide non clinical harm reduction advice to all drug users and brief motivational interventions to support them to engage with formal structured treatment. Medical community harm reductions commissioned through Contract 2 will in-reach into this service.

The provider will be given a target to achieve a minimum 30% modality start in formal structured treatment (Opiates or Non Opiates service).

Per capita payments will be made for each service user registered with the service. Registration with the service means that service users in regular contact with the service will receive an initial assessment, care plan including recovery goals and will provide personal data to identify them as unique individuals; this will reduce the risk of duplication of effort and dual funding for unique individuals.

Part B – Open Access will provide access without an appointment to drug users for a screening assessment of drug use, brief advice, motivational interviewing to engage in treatment and escorted formal handover to treatment services.

Part C - Targeted Outreach will focus on identifying and screening cohorts of drug users out in the community e.g. 18-30, steroid users, cannabis users, khat users, club drug users, New Psychoactive Substance (NPS) Users, sex workers, stimulants users.

As a minimum, the service will provide a screening assessment of drug use, brief advice, motivational interviewing to engage in treatment and escorted formal

handover to treatment services to these targeted cohorts will be provided on an outreach basis. Per capita payments will be made for each service user registered with the service.

Targeted outreach must be offered on a satellite co-located community/partnership settings e.g. safer neighbourhoods, housing offices.

Part D - Psychosocial Interventions (DRUGS) This service will provide up to 12 week packages of group and one to one interventions at different levels of intensity/complexity. Briefer packages e.g. 4-6 weeks can be provided as part of this offer ONLY where these will result in drug free completions with no re-presentation within 6 months.

Part E - Personal Recovery Budgets Self-directed aftercare/personal health budget style packages will be available on a supervised spend basis to those who have completed any treatment modality drug free in the first 12 weeks after leaving treatment. Drug workers will broker support, administer the budget and supervise spend. Lessons will be learned from previous pilots of this approach and from local experience in the implementation of this offer. A capped budget will be available and the provider must manage expectations and spend within this budget.

Part F - Universal Prevention/Education will focus on a universal offer of supported roll out of a simple drug screening tool for use in generic settings and information about how to refer into treatment (Sheffield Treatment Pathways).

Supported roll out will include induction into use of the tool, supported implementation for up to 2 weeks, monitoring of screening and activity levels by the setting and formal feedback after six weeks; if screening is not established in the setting up to a further 4 weeks support will be offered.

Part G - Learning Schemes including **Peer Mentor**, **Expert Patient** and the Service User and Carer **Ambassador** and **preparation for employment schemes** will be integrated within this contract as part of the broad PSI and recovery support offer.

CONTRACT 2 Opiates Service - Drugs

Part A - (SPAR) 'Single Point' of assessment and referral to drug treatment (opiates) will be a Clinical Nurse Specialist led service which provides single point of assessment and referral for professionals to refer opiate users for a full clinical assessment, general healthcare assessment, a personalised summary of recommended care, brief personalised advice and formal handover of care to community, residential or inpatient treatment as appropriate following appropriate clinical pathways.

Part B- Pharmacological Interventions (DRUGS) Providing prescribing interventions at different intensities according to recovery goals, complexity and need including Nurse/Pharmacist supplementary prescriber, GP and Consultant Psychiatrist.

All clients receiving prescribing interventions must be seen monthly, as a minimum, for a recovery based clinical and key working appointment. All prescribing treatment must include psychosocial components, either informal psychosocial interventions through key working, or formal Psychosocial Interventions commissioned through this contract or through access to IAPT where this is jointly care co-ordinated.

Part C –Formal Psychosocial Interventions will be provided within this contract for up to 30% of those in prescribing treatment. This service will provide stepped care based on clinical need of either one to one or group evidence based formal psychosocial interventions based on cognitive behavioural therapy or clinical psychology.

Part D - Personal Recovery Budgets to support aftercare and reintegration will be available to those in the first 12 weeks post treatment who have completed treatment drug free. Keyworkers will broker support, administer the budget and supervise spend. Lessons will be learned from previous pilots of this approach and from local experience in the implementation of this offer. A capped budget will be available and the provider must manage expectations and spend within this budget.

Part E- Specialist Harm Reduction Interventions/Vulnerable Adults - The service will assess eligibility for blood borne virus (BBV) screening and immunisation and provide nurse led BBV, wound-care and venous care services. These services will be offered on a satellite basis into a range of settings including a weekly clinic at the Specialist Needle Exchange /Non Opiates Service and day service for the vulnerable homeless.

A small reactive team of specialist nurses/social workers will troubleshoot problematic non engagement and support the management of vulnerable adults with substance misuse problems. The team will hold a caseload jointly with the main keyworker for a time limited period. The priority will be to provide specialist review,

support and oversight of care in order to reduce harm to self and others, stabilise the service users and support the service user back into mainstream care. This additional service is intended for those who are not eligible or not responsive to adult safeguarding, Vulnerable Adults Panel or Vulnerable Adults Risk Management Meeting (VARMM) arrangements and must add value to these arrangements rather be the default placement for vulnerable drug/alcohol users. This service will be required to offer home supervision of substitute prescribed medications for the minority of vulnerable adults for whom other arrangements (e.g. carer administration) are not possible.

CONTRACT 3 ALCOHOL Service

Part A - Single Entry & Assessment Point (SEAP) and Identification & Brief Advice (IBA) All individuals requiring interventions for increasing risk, binge or dependent drinking will be routed through SEAP.

As a minimum, all will receive a screening assessment using validated clinical tools AUDIT C, AUDIT PC or full AUDIT as appropriate. Personalised harm reduction advice will be given to all individuals. Individuals who are also using drugs will be assessed for primary substance of misuse and referred on to drug services where appropriate.

Those who following SEAP assessment require alcohol treatment will be offered medical prescribing interventions or psychosocial interventions as appropriate.

Those not requiring treatment will be offered a follow up review, which may be delivered by telephone, internet/smartphone application or face to face, in 6 weeks for re-AUDIT and then either discharged if drinking is within safer limits or offered referral to alcohol treatment if changes have not been implemented.

Part B - Pharmacological interventions which include community detoxification, prescribing interventions to reduce harm e.g. nutritional prescribing or prescribing to prevent relapse. Prescribing interventions may be Consultant Psychiatrist, GP, Non-medical prescribing nurse or non-medical prescribing pharmacist led dependent on complexity.

All clients receiving prescribing interventions must be seen monthly, as a minimum, for a recovery based clinical and key working appointment. All prescribing treatment must include psychosocial components.

Part C –Formal Psychosocial Interventions (PSI Alcohol) these will be either 3-6 weeks of Extended Brief Interventions or 6-12 weeks of Psychosocial Interventions based on clinical need. Patient placement criteria must be used to provide care at

the appropriate level and individuals should not receive both EBI and PSI within the same treatment episode.

Part D - Nurse Support Services (Alcohol) A&E/Hospital Liaison Nurse and GP/Primary Care Liaison Nurses for alcohol will be provided under this contract and will identify individuals in either GP or Hospital settings who may have alcohol misuse problems alongside any other health problems. Individuals will be screened, offered personalised harm reduction advice and offered referral into treatment where appropriate.

These post holders will equip professionals in generic health settings with the tools and skills to identify those with alcohol misuse problems and refer them through SEAP in order that this work becomes 'mainstreamed'.

Part E – Criminal Justice/Enforcement Routes to Alcohol Treatment : This service will provide appropriate interventions to those mandated to attend treatment appointments as part of criminal justice or other enforcement measures e.g. acceptable behaviour contracts, Fixed Penalty Notice Waiver, Conditional Caution, Alcohol Treatment Requirements and others that apply. This will be provided within resource using screening and treatment capacity described in Parts A,B,C.
Part E is subject to change and is likely to be included within the Drug Interventions Programme (DIP) contract when it reaches its "break clause" on 30th June 2015

Proposed contract prices

Current Contracts	Proposed contracts to be offered	Year 1 14/15 Proposed cost (↑/↓)	Year 2 15/16 Proposed cost
Tier 2 and Specialist Needle Exchange	**Contract 1** – Non Opiates Service (Drugs) including Specialist Needle Exchange	£733,481	£657,231
PSI (Drugs) Structured Daycare and Aftercare Carer Support Ambassador Scheme			
GP Deputising, Specialist Pregnancy Clinic & Shared Care Support -Drugs GP Shared Care Specialist Prescribing Drugs Harm Reduction Service – Drugs	**Contract 2** – Opiates Service (Drugs)	2,779,904	£2,512,886
SEAP & Tier 2 – Alcohol Medical Prescribing – Alcohol PSI (Alcohol)	**Contract 4** – ALCOHOL Service	£930,338	£833,000
Total	**-**	**4,443,723**	**4,003,117**

Conclusion:

This paper:

- describes the commissioning intentions of the DACT to create three “end to end” services for Non-opiates, Opiates and Alcohol to offer integrated treatment journeys from initial screening to recovery support/aftercare.

- describes how this further integration of drug and alcohol recovery services is clinically more efficient offering clearer treatment pathways;

- describes how this further integration of drug and alcohol recovery services provides better value for public money through redirection of funds away from infrastructure costs and towards front line delivery;

- sets out the type of services, the anticipated volumes which will be commissioned and outline envelopes for the contracts;

- sets out the procurement route of open competitive tender for the three main contracts described;

- sets out that all contracts must be under the Council’s seal according to Sheffield City Council Contract Standing Orders.

Recommendation:

- That this commissioning & procurement plan is submitted for public and stakeholder consultation from 4th November 2013 – 27th December 2013.

- That formal written feedback is provided by the public and stakeholders on the pro forma attached as Appendix 3.

- That stakeholder and public formal written feedback is used to inform the commissioning & procurement plan and service re-design.

- That consultation feedback is written up into a report by the DACT and made available to cabinet members.

Appendix 1 - Timetable

Consultation on DACT commissioning & procurement plan with internal Sheffield City Council key stakeholders	July 2013
Communities Portfolio Leadership Team	September 2013
Public Health Board Consultation	October 2013
Cabinet Member consultation	October 2013
Draft tender documentation prepared by DACT and Commercial Services	November 2013
External and Public consultation opens (8 week)	November 2013
Clinical panel consultation on clinical service specifications	November 2013
External and Public Consultation closes	December 2013
Consultation written up, service design amended and final EQIA by DACT	December 2013
Draft cabinet paper prepared	November 2013
Cabinet paper submitted to EMT/CET (11/25th November or 9th December)	November 2013
Cabinet paper submitted to Cabinet (18 December or 15 January)	Dec 2013/Jan 2014
Notice of planned tender given to Round 1 and 2 providers	December 2013
Round 1 Open Competitive Tender begins	January 2014
Round 1 Tender award	June 2014
Round 1 Mobilisation	July-Sept 2014
Round 1 Contracts start	Oct 2014 (Q3 14/15)
Round 2 Open Competitive tender begins	July 2014
Round 2 Tender Award	December 2014
Round 2 Mobilisation	Jan – March 2015
Round 2 Contracts start	April 2015 (Q1 15/16)

Appendix 2 - Five Levels of the Commissioning Landscape

	The five levels of the commissioning landscape	What does it mean to me?	What kinds of support are currently provided?	What might it look like in the future?
Promote lifelong health & wellbeing	1. Support for everyone	Places where I can get advice and information to manage my health & wellbeing.	Open access (no appointment needed) and community outreach at CRI Arundel St Project and SEAP (single entry and assessment point for alcohol)	Open access (no appointment needed) and community outreach (Non Opiates) Services, SPAR (Opiates) and SEAP (Alcohol)
Support targeted at vulnerable people: early intervention and re-ablement	2. Early intervention	Support targeted at people who are one or two steps away from needing significant help and support. Building up personal and community resilience.	Screening assessments, brief advice and onward referral for drugs and alcohol at CRI and SEAP Extended brief interventions for alcohol Alcohol Hospital and Primary Care Liaison Nurses Criminal Justice and enforcement routes to treatment Commissioned (Dragon's Lair) and non commissioned recovery community activities Non commissioned mutual aid	Screening assessments, brief advice and onward referral at Non Opiates, Opiates and Alcohol Services Extended brief interventions for alcohol Alcohol Hospital and Primary Care Liaison Nurses Criminal Justice and enforcement routes to treatment Recovery aftercare budgets Commissioned and non commissioned Recovery community activitires Non commissioned mutual aid
	3. Short-term intensive support (e.g. re-ablement and crisis response)	Short term support, usually less than 6 months. Aimed at building or rebuilding skills and confidence.	Psychosocial Interventions for drugs/alcohol Community detoxification for alcohol/drugs Commissioned Aftercare Commissioned (Dragon's Lair) and non commissioned recovery community activities Non commissioned mutual aid	Psychosocial Interventions for drugs/alcohol Community detoxification for alcohol/drugs Recovery aftercare budgets Commissioned and non commissioned Recovery community activitires Non commissioned mutual aid
Care and Support	4. Specialist care and support	Medium to long term care and support	Substitute prescribing for drugs Social work caseload for drugs/alcohol	Substitute prescribing for drugs Social work caseload for drugs/alcohol
	5. Intensive care and support	24 hour assistance to live safely Medium to long term care and support	Inpatient detoxification Residential Rehabilitation for drugs/alcohol Supported accommodation (commissioned by Housing Independence Service)	Inpatient detoxification Residential Rehabilitation for drugs/alcohol Supported accommodation (commissioned by Housing Independence Service)

Appendix 3 – Stakeholder and Public Consultation Feedback Form

Sheffield DACT would like to know your view on the Commissioning & Procurement Plan. We have provided a number of questions on which we would like your comments. Please provide any **additional comments** in the box at **Q16**.

This consultation will be written up by the DACT in a report for cabinet members. If you would prefer for your (anonymised) comments not to be included, please tick this box ☐

We are asking for some information about who you are in order to group and in some cases follow up comments for further information to help inform our commissioning:

Name:

Agency:

Contact telephone number:

Contact e-mail:

I am happy to be contacted by Sheffield DACT in relation to my comments on the Commissioning & Procurement Plan ☐

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? **Yes/No*** **(delete as applicable)**

Further comments on Q1 – End to End Services:

Q2 Do you agree with the model of separate services for opiate and non opiate users? **Yes/No*** **(delete as applicable)**

Further comments on Q2 – Separate Services for Opiates/Non-Opiates:

Q3 Do you agree with the model of a separate service for Alcohol, not co-located with any drugs service? **Yes/No*** **(delete as applicable)**

Further comments on Q3 – Alcohol Service separate from drugs:

Q4 Do you agree that alcohol misuse as part of poly drug use is best addressed within drug misuse services? **Yes/No*** **(delete as applicable)**

Further comments on Q4 – Alcohol as part of poly drug use:

Q5 Is the commissioned capacity, as described on pg 9, sufficient to meet local need? **Yes/No*** **(delete as applicable)**

Further comments on Q5 – commissioned treatment places:

Q6 Is the level of investment in drug and alcohol treatment services, as described on pg15, sufficient to meet local need? **Yes/No*** **(delete as applicable)**

Further comments on Q6 – Investment:

Q7 Do you think that the services and the model described in the DACT Commissioning and Procurement Plan will meet local need? **Yes/No*** **(delete as applicable)**

Further comments on Q7 – Local Need:

Q8 Will the Non Opiates Service, as described on p10-11, meet the needs of local non opiates users, including cannabis, powder cocaine, ecstasy, ketamine, new psychoactive substances , steroids and new and emerging non opiate drugs of misuse? **Yes/No*** **(delete as applicable)**

Further comments on Q8 – Non Opiates Service:

Q9 Will the Opiates Service, as described on p12-13, meet the needs of local opiates users, including heroin, opium and prescribed and over the counter products? **Yes/No*** **(delete as applicable)**

Further comments on Q9 – Opiates Service:

Q10 Will the Alcohol Service, as described on p13-14, 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? **Yes/No*** **(delete as applicable)**

Further comments on Q10 – Alcohol Service:

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 and Procurement plan? **Yes/No*** **(delete as applicable)**

Further comments on Q11 – Unmet local need:

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 ? **Yes/No*** **(delete as applicable)**

Further comments on Q12 – balance of the treatment system:

Q13 Are the proposed recovery interventions the right interventions to meet local need? **Yes/No*** **(delete as applicable)**

Further comments on Q13 – recovery:

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? **Yes/No*** **(delete as applicable)**

Further comments on Q14 – good practice:

Q15 Do you have any views about the procurement process, for example procurement staggered over two rounds, 3-5 year contracts, open competitive tender ? **Yes/No*** **(delete as applicable)**

Further comments on Q15 – procurement process:

Q16 **Any further comments - DACT Commissioning & Procurement Plan:**