SSA EQUALITY IMPACT AND NEEDS ANALYSIS

Directorate	**Adult Social Services**
Service Area	**Commissioning – Substance misuse**
Service/policy/function being assessed	**Richmond Integrated Recovery Service**
Which borough (s) does the service/policy apply to	Richmond
Staff involved	
Date approved by Directorate Equality Group (if applicable)	
Date approved by Policy and Review Manager All EINAs must be signed off by the Policy and Review Manager	2019
Date submitted to Directors' Board	

SUMMARY

Please summarise the key findings of the EINA.

The current Richmond service is a sing provider, provided by Change, Grow, Live (CGL). In support of this service are:

- A network of 10 community pharmacies actively providing support of opiate dependent clients with supervised consumption of medication (7 pharmacies also provide needle exchange for a range of injecting drug users, e.g. opiate users, Chemsex clients, image and performance enhancing drug (IPED) users;
- Separately commissioned inpatient detoxification services (with Social Interest Group until March 31st 2019).

The partnerships 189 new presentations to treatment in the year to 31/12/2018 and 483 in treatment during the same period. These could be broken down as follows[1]:

Cohort	New presentations	All in treatment
Alcohol	79	163
Alcohol & Non-opiates	32	54
Non-opiates	31	51
Opiates	47	215

The service has a larger grouping within the age range 35-59, where the local population has a large preponderance of young people. While the service has a slightly better ratio of male to females (65% to 35%) the mix is still lower when compared to the general population and consequently this also needs to be an area of focus for the new service. Other ethnic groups than white may be underserved in the current service and so the new offer will seek to realign doors to ensure appropriate access.

Finally, older adults and especially male, suffer with extensive co-morbidity of physical health conditions. This group's vulnerability is supported by local drug and alcohol related deaths review findings.

[1] Public Health England, Adult Activity Report Q3 2018-19

1. Background

Briefly describe the service/policy or function:
The proposal is to purchase substance use disorder services for the adult population of Richmond, covering unstructured, structured community and structured complex interventions, together with associated primary care and recovery support services. The offer will be presented by a single provider or consortium. The successful contractor will:

- Be responsible for all services focussed on the delivery of community-based substance use disorder interventions, including arrangements to treat those from criminal justice;
- Develop sub-contract arrangements for primary care (GP and pharmacy) services and inpatient detoxification;
- Support service user support services, including peer mentoring and recovery support;
- Support an independent service user forum for planning, challenge and development of appropriate services;
- Ensure good cross-discipline and multi-agency working that supports successful individual outcomes and partnership outcomes;
- Implement and secure connectivity with local hospitals for drug and alcohol liaison; criminal justice services (IOM, DIP and prisons) and mental health offers (IAPT and CMHT) to achieve the above;
- Develop online interventions for information and advice that support unstructured treatment, support self-managed treatment and access to and efficacy of structured treatments;
- Improve open access low threshold interventions identifying and opportunistically treating individuals through careful alignment with key partners;
- Develop options for people to be able to self-select and self-serve for non-dependent issues with substances;
- Develop interventions which assist people to achieve sustainable change at the earliest point of identified dependency;
- Provide a range of interventions which support people who have formed dependency over a wide range of substances both legal and illegal (to include prescription medications).

This service will run in conjunction with a similar service in Richmond. The services will share a common management and administrative structure but will be a different offer to Wandsworth.
The current budget envelope for the whole of Wandsworth contracts is: £1,287,922 which encompasses all of the identified services in part 1.

2. Analysis of need and impact

Protected group	Findings

<table>
<tr><td>Age</td><td>
Richmond's adult population is 150,558, whose 30-54 profile makes up 51% of the adult population[i].
Younger adults (18 – 29) account for 23% of the general population and 10.3% of the treatment population. The treatment population is over-represented by the 35-59 age group. Service users did not identify any gaps due to age.
<table>
<tr><th>Age group</th><th colspan="2">ONS estimate</th><th colspan="2">Richmond data</th></tr>
<tr><td>All adult</td><td colspan="2">150,558</td><td colspan="2">483</td></tr>
<tr><td>18</td><td>2013</td><td>1.34%</td><td>3</td><td>0.6%</td></tr>
<tr><td>19</td><td>1542</td><td>1.02%</td><td>3</td><td>0.6%</td></tr>
<tr><td>20-24</td><td>7949</td><td>5.28%</td><td>19</td><td>3.9%</td></tr>
<tr><td>25-29</td><td>10184</td><td>6.76%</td><td>25</td><td>5.2%</td></tr>
<tr><td>30-34</td><td>13078</td><td>8.69%</td><td>47</td><td>9.7%</td></tr>
<tr><td>35-39</td><td>16735</td><td>11.12%</td><td>72</td><td>14.9%</td></tr>
<tr><td>40-44</td><td>17190</td><td>11.42%</td><td>58</td><td>12.0%</td></tr>
<tr><td>45-49</td><td>15848</td><td>10.53%</td><td>76</td><td>15.7%</td></tr>
<tr><td>50-54</td><td>14432</td><td>9.59%</td><td>75</td><td>15.5%</td></tr>
<tr><td>55-59</td><td>11795</td><td>7.83%</td><td>53</td><td>11.0%</td></tr>
<tr><td>60-64</td><td>9616</td><td>6.39%</td><td>32</td><td>6.6%</td></tr>
<tr><td>65-74</td><td>16958</td><td>11.26%</td><td>17</td><td>3.5%</td></tr>
<tr><td>75-84</td><td>8809</td><td>5.85%</td><td>3</td><td>0.6%</td></tr>
<tr><td>85-94*</td><td>4409</td><td>2.93%</td><td>0</td><td>0%</td></tr>
<tr><td>95 or over</td><td></td><td></td><td>0</td><td>0%</td></tr>
</table>
</td></tr>
<tr><td>Disability</td><td>
Broad data[ii] estimates that mental health issues affect approximately 21% of the Richmond population, ranging from common disorders to personality and psychotic disorders. A further 5% are estimated to have some form of learning disability, while 1% may have autism spectrum disorder. 39% of the Richmond population, 18-64, are predicted to have some form of moderate physical disability, with a further 11.5% estimated to have a severe disability.
Self reporting of people in service indicates that 67.7% of those accessing service believe they have no form of disability; 21.2% consider they have a behavioural or emotional disability, while 5.3% considered they had a mobility and motion issue. Learning disability was recorded in 6.3% of cases. A mental health treatment need was recorded in 58.3% of cases seen by the main provider[iii].
Service user feedback identified that there was difficulty of access to rooms for group work, for those who had mobility issues, at the main site. Other service users, who had mobility issues, complained that getting to the only site in the borough could be very difficult. Mental health treatment was acknowledged as difficult to access.
</td></tr>
<tr><td>Gender (sex)</td><td>
According to the ONS MYE for 2017, the gender distribution of the borough was 52% female and 48% male. Within the service itself the split is 65% male and 35% female. This is slightly better than the national treatment systems gender distribution of 70% male and 30% female[iv].
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Gender reassignment	**This information is not currently compiled by services for national data processing. However, there is no indication that the service is discriminating against individuals who are undergoing gender reassignment.**
Marriage and civil partnership	**Marriage and civil partnership is not reported upon separately through NDTMS and therefore it is not possible to identify any particular issues. Nothing has been raised with regards to individuals being unable to access services due to the marital or civil partnership status.**
Pregnancy and maternity	**The service caters for women who are pregnant without any discrimination due to their condition.**
Race/ethnicity	**The current information identifies that 79.7% of individuals claimed White British, White Irish or Other White ethnicity. This is slightly lower than estimates by IPC/Oxford Brookes of 85.88% of the local population being white, however it may be because 12% of those asked would not state their ethnicity. This is because they have elected not to disclose under GDPR.** **Those from Asian ethnic groupings appear slightly under represented in the service, including Asian at 2.8% (IPC/Oxford Brookes = 8.10%). Black/African ethnic groups were very under-represented at 0.6% (IPC/Oxford Brookes = 1.68%).**
Religion and belief, including non belief	**3.2% of people declined to disclose their religion to the service, 6.9% had the status "patient religion unknown", while 49.2% stated they had no religion. 28.6% of people accessing services recognised themselves as Christian, as against 55.3%[v] of the wider population, while Muslim is also proportionally underreported. However, Sikhs made up 1.6% of the treatment population but only 0.8% of the wider population. Recording of religion has become much better than in 2016-17, but the figures are not robust. Despite this there appears to be no discrimination with regards to religion or belief.**
Sexual orientation	**The majority, 87.8%, of individuals accessing treatment identified with heterosexual. Only 0.5% saw themselves as either gay or lesbian, and 2.1% as bisexual. No-one reported they didn't know while 6.3% decided not to state a sexual orientation.** **Local reporting estimates that 5-7 per cent of a population will identify as lesbian, gay, bisexual. As a consequence, those who identify as gay, lesbian, bisexual may be underserved in the provider's treatment profile. It is slightly unclear, as the NDTMS reporting process does not provide for a full understanding of who classifies themselves as LGBT. Commissioners and provider have no control over what is asked by NDTMS.**
Across groups i.e. older LGBT service users or bme young men	**The service can make itself more apparent and available to individuals from a range of ethnic backgrounds. While not discriminatory, the service would benefit from being more visible to**

	communities that currently do not access it and may have a requirement to do so.

Data gaps

Data gap(s)	How will this be addressed?
Marriage and civil partnership	**This is not currently reported to the national drug treatment monitoring system. Review will be made to understand how it can be captured.**
Gender reassignment	**This is not currently reported for the national drug treatment monitoring system. Any changes around this will be a national requirement, notified to Public Health, commissioners and providers.**

3. Impact

Protected group	Positive	Negative
Age	**The new service, based on need identified at the point of contact, should ensure that the service delivers across the whole spectrum of adult ages. It will extend its reach through working with GPs to attract those younger adults (e.g. recreational and image and performance enhancing drug users) and older adults (e.g. prescription only medicine misusers) who would not naturally attend at a traditional drug service. Enabling those accessing the traditional style service to be seen in the community will be an important stage in reducing stigmas and increasing relations across the age groups.**	**As a traditional drug service, the current Richmond service caters primarily for individuals in a defined age band, typically from 35 to 59. By increasing working in the community, through GPs and other outlets, this could be effectively challenged, and the service helped to deliver a more balanced offer.** **Reduction in resources (budget and workers) may mitigate against being able to achieve this level of working.**
Disability	**It was identified by several service users that this was one significant area in which the provider was not enabling those with mobility and motion issues, towards recovery. The service will be encouraged to work in**	**The service currently operates from a building which is difficult to access for those with mobility problems – the new provision should enable disabled groups to access more appropriate services designed for their specific needs.**

	disability appropriate points of access across the community. With regards to mental health issues the current provider is a Most Capable Partner to the Richmond MH-OBC and this is being encouraged to enable more multi-disciplinary responses for individuals with co-occurring mental health and alcohol/drug conditions. This work will help to reduce barriers and stigmas for those with psychological and physiological disabilities.	**Those with co-occurring mental health conditions may continue to experience issues because of the issues relating to dual diagnosis. It is expected that cross-disciplinary working will alleviate this pressure. Reduction in resources (budget and workers) may mitigate against being able to achieve this level of working. It is noted that the age of current service users is also linked with physical health issues which will require appropriate access points across the borough to ensure health and end-of-life services are tailored appropriately.**
Gender (sex)	**The service is better represented by females than nationally, but this is in the traditional cohorts and work will be carried out going forward to ascertain the need in the wider community. This will include in cohorts including those using prescription-only and over-the-counter medications, image and performance enhancing drugs, etc. Outreach will be explored in GP practices in identified areas. The service will expand on their current women's offerings to ensure that women are able to access services that are appropriate to their needs, including those who have suffered DV, sexual harassment and other**	**There may be instances of perceived reduction in service for men. There will need to be careful consideration of service design given to those who are considering or pursuing gender reassignment to ensure they are not disadvantaged and that this element achieves its goal of increasing women's interaction with treatment and recovery.**
Gender reassignment	**Currently, data concerning gender reassignment is not collected by services. The proposal to work with the provider over the next two years will include identifying cohorts in the borough, potential barriers to service and how better early**	**As noted above, there may be instances where this group may consider itself disenfranchised. The new service will maintain and build on the current good connectivity with sexual health services and primary care and developing relations with Mental**

	intervention and structures to develop access, assessment and treatment can be planned.	**Health services to ensure a high standard of access and care.**
Marriage and civil partnership	**The service will seek to monitor the marriage or partnership status of individuals who access it. This is not currently a recording a requirement for NDTMS.**	**Not being aware of a person's civil partnership or marital status can lead to incorrect professional relationships. We will work with the contractor to ensure the requirements of the Council's equality policy, and their own policies are adhered to and inform procedure and practice.**
Pregnancy and maternity	**The contractor will be encouraged to work closely and open good lines of communication with local maternity providers and professionals to ensure timely coordination of care in the case of service users who are pregnant.**	**Overcoming stigma in other parts of the health and wellbeing system is a key priority to ensuring this group is cared for appropriately. (See data gaps later. In conjunction with Public Health, the new service will provide information and appropriate training to support better care. This will be catered for by careful implementation and the use of a main contract period allowing the cultural change required to ensure it is embedded.**
Race/ethnicity	**The service has a good record of connecting with ethnic and race minorities. However, there are 6.9% of individuals who elect not to disclose their ethnicity. With the contractor, we will work to identify barriers to individuals disclosing and publicise ways in which disclosure can help to get more ethnically appropriate treatment.**	**There is under-representation of the Asian community in the service. The new service model will seek to engage with local groups to identify how the service can better respond through community connectivity (community centres, GPs, etc).**
Religion and belief, including non-belief	**There is a significantly different profile of individuals accessing the service, compared to the wider community. Working with the contractor, this is a piece of work related to ethnicity and should be tackled as such. Working with community leaders the service will profile need and**	**It is acknowledged that there may be some groups for whom it is difficult for individuals to engage with treatment services where their disorder is at variance with their religious values. Online and select "neutral" venues would dispel issues in this regard.**

	establish working protocols that respond to individual and group need.	
Sexual orientation	**The service does operate an open-door policy with respect to sexual orientation, however, it is clear that the service does not represent one which those from the LGBT community will necessarily interact with. This may be because of the way in which this community is using drugs and alcohol, their profile and desire to interact with a "traditional" drug service. Working with the contractor, we will identify possible issues with provision, through survey and discussion with representatives of this characteristics group.**	**Providing services that are effective with all sexual orientations is a challenge. Individuals from the LGBT community have differing sexual and substance use profiles, often more recreational, and not viewing themselves as traditional drug users. The new service provider will promote a make any door the right door approach, supporting universal services to identify and work appropriately with this group.**

4. Actions

Action	Lead Officer	Deadline
Procurement of new functional service model that improves access to substance use disorder treatment and recovery services, through physical nodes across the borough, with "universal" service links (e.g. Jobcentre Plus and Hospitals) supporting through in-reach and training. This is to be "wrapped" with a suite of online offers for unstructured and structured treatments and interventions. Focus areas will include younger adults, women, ethnic groups and older men who have multiple physical health issues with end-of-life issues and suffer isolation.	Senior Commissioning Manager	April 2020
Agree reporting functions for measuring two key characteristics not currently reported on to the National Drug Treatment Monitoring System: marriage and civil partnerships and gender reassignment.	Senior Commissioning Manager	April 2020
Focus at a strategic level to ensure appropriate and effective frameworks exist to ensure the environment for cross discipline working exists. To be informed by the operational development of priority partnerships at the point of implementation, ensuring this is an organic process throughout the contract.	Senior Commissioning Manager and Senior Public Health Leads	Initial milestone April 2020, but to be developed in line with

		review of progress.

5. Consultation. (optional section– as appropriate)

Where a significant change is proposed to a service or where a new policy/service/service specification is being developed it is best practice to consult on the draft findings of an ENIA in order to identify if any impact or need has been missed.

During the period Spring 2018 to Autumn 2018 the commissioning team commissioned a number of surveys of service users, through the local service user network, and held a half day planning event in July 2018. The purpose of these was to understand the current situation concerning the delivery of interventions in the borough of Richmond.

From these exercises it was clear that the key issues for service users and carers was the lack of actual multi-disciplinary working that was undertaken by services of all persuasions. This was by far the biggest issue despite there being what the commissioning team considered to be gaps in delivery, for instance interventions which engaged with stimulant users. It became clear that we were thinking in a traditional way and that this would be unsustainable going forward.

What came up consistently was, particularly, joint working with all types of mental health delivery. Despite there being significant overlaps in treatment groups, there was still an unwritten rule of not working with people who might be from one discipline or the other. Similarly, engagement with hospital services and the wider general practice environment was seen as lacking consistency and effectiveness. Service users and GPs have also expressed concerns that general practice is not present within the current treatment offer. Including this could ensure that “every door is the right door”. It will also have the benefit of reducing stigma and raising access across the borough.

There was also a feeling that aftercare and post recovery support was much weaker than it should be, with very little in the way of coordinated longer term options. Current provision extends to an average of 10 weeks because of workforce pressures.

In acknowledging these issues, the commissioning team has elected to change the traditional view of services by designing a node and link model approach which will be based on need at the point of contact. This differs from the traditional hub and spoke model in that there can be multiple nodes which are staffed by a mix of disciplines and which utilise community (and universal) services to “link” service users to nodes and other “links”. While there would be an administrative hub for the service this would also be a node for the system. It does require a high degree of inter-agency commitment and pooled resources to succeed, but such synergies already exist in the borough. Drug and alcohol services are working more closely with Mental Health Teams, sharing working space. Similarly, relations exist with sexual health services and criminal justice functions. Local services are also trialling in-reach to organisations such as Jobcentre Plus. The evidence from these exercises will shape the future delivery model. It is proposed that the initial 3-5 years of contract will be key in firming these plans and deliverables. Concurrently, relationships will build with universal and community services. By the end of the principal contract period the delivery model and culture change should have been completed.

[i] Office of National Statistics, 2017, Mid-year estimates 2017

[ii] IPC, Oxford Brookes University 2017, projecting adult need and service information http://www.pansi.org.uk/

[iii] National Drug Treatment Monitoring System, 2017, Adult provider activity report, Quarter 3 2018-19 (NB, from 2017-18 new methodology for recording dual diagnosis was introduced by NDTMS)

[iv] Public Health England, 2017 Adult substance misuse statistics from the National Drug Treatment Monitoring System (NDTMS) 1st April 2016 to 31st March 2017

[v] http://localstats.co.uk/census-demographics/england/london/richmond-upon-thames, based on the 2011 Population Census