North Yorkshire County Council

Equality Impact Assessment Template

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যদি আপনি এই ডকুমেন্ট অন্য ভাষায় বা ফরমেটে চান, তাহলে দয়া করে আমাদেরকে বলুন।

如欲索取以另一語文印製或另一格式製作的資料，請與我們聯絡。

اگر آپ کو معلومات کسی دیگر زبان یا دیگر شکل میں درکار ہوں تو برائے مہربانی ہم سے پوچھئے۔

Undertaking an Equality Impact Assessment

Equality Impact Assessments (EIA) should be undertaken at the business case stage when:-

- You are developing a new service or policy
- You are reviewing an existing service or policy
- You are proposing a change to an existing service or policy
- You are reviewing a service or policy carried out on behalf of the council or another organisation
- Your service is re-organised.

They should be referenced in your final recommendations on the service changes so that decision makers can reach an informed decision on the service/policy.

An EIA should cover all the social identity characteristics protected by equality legislation – referred to as **'protected characteristics'** or equality strands. These are;

- Sex
- Sexual orientation
- Religion or belief
- Race – this include ethnic or national origins, colour and nationality
- Disability – including carers
- Pregnancy and maternity
- Gender reassignment
- Age
- Marital/civil partnership status

There is a lot of information available to support you in completing this assessment on the EIA pages on the NYCC intranet

Equality Impact Assessments are public documents. Full EIAs accompanying reports going to County Councillors for decisions are published with the committee papers on our website and available in hard copy for people attending the relevant meeting. To make it easier for people to find equality impact assessments the Council will publish also publish full equality impact assessments on the NYCC website in line with

statutory requirements.

Name of the Directorate and Service Area	Public Health- Substance Misuse			
Name of the service/policy being assessed	Adult Drugs and Alcohol Treatment Services Reconfiguration			
Is this the area being impact assessed a	**Policy & its implementation?**		**Service?**	
	Function		**Initiative?**	
	Project?	√	**Procedure & its implementation?**	
Is this an Equality Impact Assessment for a (Note: the Equality Impact Assessment (EIA) is concerned with the policy itself, the procedures or guidelines which control its implementation and the impact on the users)	**Existing service or a policy and its implementation?**			
	Proposed service or a policy and its implementation?			√
	Change to an existing service or a policy and its implementation?			
	Service or Policy carried out by an organisation on behalf of NYCC?			
How will you undertake the EIA? Eg team meetings, working party, project team, individual Officer	Through review and consultation with Public Health team staff, and the Procurement project working group.			
Names and roles of people carrying out the Impact Assessment	Public Health team staff: Caroline Townsend, Assistant Commissioning Manager Angela Hall, Commissioning Manager			
Lead Officer and contact details	Caroline Townsend- Assistant Commissioning Manager (01609) 535491			
Date EIA started	3/6/13			
Date EIA Completed	5/7/13			
Sign off by Assistant Director (or equivalent)	Signed off by Dr Lincoln Sargeant, DPH			
Date of Publication of EIA	21/8/13			
Monitoring and review process for EIA	Regular review through Procurement project steering group			

1. Operating Context

Please consider issues around impacts (positive or negative) raised for **all protected characteristics** and show your evidence

1.1 Describe the service/policy What does the service/policy do and how? How would you describe the policy to someone who knows very little about Council Services? If there is a proposal to change the service or policy, describe what it looks like now and what it is intended to look like in the future. What are the drivers for this proposed change? Who does it benefit? What are its intended outcomes? Who is affected by the policy? Who is intended to benefit from it and how? Who are the stakeholders? identify those protected characteristics for which this service is likely to have an impact (positive or negative) Are there any other policies or services which might be linked to this one? Have you reviewed the EIA for these policies/services? What do they tell you about the potential impact? How will the policy be put into practice? Who is responsible for it?	It is the intention to procure and implement a new integrated, recovery-focused adult drugs and alcohol treatment system for North Yorkshire. (Please note that further information on this project including the relevant documents referred to in this EIA are available from www.nypartnerships.org.uk/smpb) The project has been developed following a review of local commissioning arrangements by the North Yorkshire Substance Misuse Partnership Board (SMPB) This review was influenced by a number of factors including national policy drivers – particularly the UK drugs strategy (2010). This requires that drug and alcohol treatment services have much more of a focus on long-term recovery from substance misuse, and recommends local partnerships support the development of local "recovery champions" and recovery communities. Needs assessment has identified that there are some clear areas of duplication within services, which could be eliminated with the implementation of a more integrated model. Also pathways into services have been identified as being unclear in some localities – particularly Scarborough which has the most providers (currently 5). In 2012 the SMPB agreed that they wished to undertake an engagement exercise to explore what a recovery-focused treatment system for North Yorkshire might look like. Based on the findings from the engagement exercise a number of proposed models for delivery of services were produced, and a preferred model was chosen following consideration by the SMPB. The new proposed model for delivery of drug and alcohol treatment services represents an innovative way forward – with the implementation of 2 different service lots: Lot 1= Recovery Mentoring Service, Lot 2= Community Treatment Service (please refer to the Community Treatment Services and Recovery and Mentoring Service specifications for further details).

	There has been an extensive consultation on the proposed new treatment model, which has resulted in a large amount of (mostly positive) responses from a range of stakeholders. Because substance misuse is a problem with many cross-cutting issues, the new model's success will be dependent on providers maintaining excellent partnership working with a wide range of partners and stakeholders. Stakeholders who were involved in both the engagement and consultation exercises included the following: local councillors, GP's, Clinical Commissioning Groups (CCG's), housing services, current and potential providers, mutual aid groups, voluntary sector services, people using/who had previously used services, carers, criminal justice organisations (including Police, Probation and representatives from HMP/YOI Northallerton) and Childrens and Young People's services. It is now anticipated that there will be a procurement process for the 2 service lots, following which new services are expected to be in place by 1st May 2014. The project is being led by the Public Health team within NYCC, with leadership from the NY Director of Public Health, Dr Lincoln Sargeant. Progress will be monitored through the North Yorkshire Substance Misuse Partnership Board. Overall the new model is expected to help more people successfully recover from drug and alcohol dependence in North Yorkshire, and it will be based on a community asset development approach which will improve health and wellbeing outcomes for local communities. It is intended to provide a more personalised and accessible service to all, however protected characteristics which could potentially be affected may be age, gender, and people with physical disabilities. See 3.1 for further details. **(Please refer to the project's Consultation Background paper for further information on rationale for and background to project).**
1.2 How do people use the policy/service? How is the policy/service delivered? How do people find out about the policy/service? Do they need specialist equipment or information in different formats? How do you meet customer needs through opening	One of the key aims of the reconfiguration of services is to make the system more accessible to all groups. People will be able to access information on recovery and the options open to them through the Recovery and Mentoring "meet and greet" service or by contacting the single point of contact telephone number.

times/locations/facilities? Can customers contact your service in different ways? How do you demonstrate that your service/policy is welcoming to all groups within the community? Does the policy/service support customers to access other services? Do you charge for your services? Do these changes affect everyone equally? Do some customers incur greater costs or get 'less for their money'? Are there eligibility criteria for the service/policy? How do you ensure that staff/volunteers delivering the service follow the Council's equality policies? Does the Council deliver this policy in partnership or through contracts with other organisations? How do you monitor that external bodies comply with the Council's equality requirements?	The Recovery and Mentoring Service will hold regular drop-in sessions in community venues in order to engage/re-engage people with recovery support appropriate to them. At the drop-in sessions workers will provide information on options which may, or may not include drug or alcohol treatment. If a need for treatment is identified then access to this will be facilitated in conjunction with the Community Treatment Service. However if drug/alcohol treatment is not seen as necessary they may continue to work with the Recovery Mentoring Service if this is seen as being required to support their long-term recovery from substance misuse. People will access the Recovery Mentoring Service either via self-referral, referral from the Community Treatment service or other professionals. There will also be the route into the Community Treatment Service via either self-referral or professional's referral. It will deliver a range of drug and alcohol treatment interventions, and will refer people to the Recovery and Mentoring Service for additional support whilst they are receiving treatment from them if appropriate. In order to achieve long-term recovery from dependence on substances those accessing the treatment system will need to receive support from a range of community resources dependent on their needs. Service specifications will make it clear that both the Community Treatment and Recovery and Mentoring services will facilitate access to these for individuals where required. The Recovery and Mentoring Service will be required to lead on mapping and building local community assets to support recovery, however the Community Treatment Service will also need to build links with these, to include: health and social care, housing, training/employment, community groups, and benefits advice. Service specifications will make it clear that Provider(s) are expected to ensure that service opening times and locations are accessible by all who need them. They will also indicate that providers are required to ensure that information about services is easily accessible by all in a range of formats, locations and sources, including other organisations. They will be required to have a communications strategy in place to support this, and will need to be able to provide evidence of this.

	Eligibility For individuals who have a primary drug or alcohol problem. Drugs include illicit, illicitly obtained prescription and new psychoactive substances. The service for primary alcohol users will be specifically for problematic and dependent drinkers only, based on an individual assessment. The Recovery and Mentoring Service is intended for those seeking recovery from drug or alcohol dependence- those who are not yet ready for recovery will be supported through the Community Treatment Service. Providers will be contractually obliged to be compliant with NYCC requirements and policy relating to equality, and will be expected to able to demonstrate this through contract monitoring.

2. Understanding the Impact (using both qualitative and quantitative data)

Please consider issues around impacts (positive or negative) raised for **all protected characteristics** and show your evidence

2.1 What information do you use to make sure the service meets the needs of all customers? What data do we use now? Is it broken down across protected characteristics (and are these categories consistent across all data sets)? How current is the data? Where is it from? Is it relevant? What engagement work have you already done that can inform this impact assessment? Who did you talk to and how? What are the main findings? Can you analyse the results of this consultation across the protected characteristics? Are there differences in response between different groups? How has this changed the plans for the policy/service?	Data for informing adult drug and alcohol treatment need is available from a number of sources both quantitative and qualitative. The main sources are as described below: - Local population and indices of multiple deprivation data. - Estimates of individuals misusing drugs and alcohol misuse -NDTMS/NATMS The NDTMS/NATMS (National Drug/alcohol Treatment Monitoring System) provides statistical data on individuals accessing structured drug and alcohol treatment throughout England, and is used to evaluate effectiveness of drug treatment and identify trends. NDTMS/NATMS data is managed by Public Health England, and reports produced on national datasets are used to guide national drug treatment policy and guidance. The dataset can be broken down by the following protected characteristics on a national level: age, ethnicity, gender and pregnancy.

	Local NDTMS/NATMS data A number of local NDTMS/NATMS reports can be accessed for data on treatment services in North Yorkshire Quarterly drug and alcohol performance monitoring reports break down numbers of individuals accessing structured treatment by gender, age and ethnicity. (Please refer to the project Consultation Background Paper for further information on quantitative data sources) Qualitative data in NY is mainly received through feedback from providers, service users and stakeholders. There has been extensive engagement and consultation work undertaken as part of the reconfiguration process so far, which has provided invaluable information on how services can be improved, and how the new model might achieve this. The engagement exercise identified a number of key issues: including the fact that recovery is a personalised journey, the need for a clear point of access into treatment, a wish for there to be more use made of mutual aid networks and peer mentors, the need for a more consistent approach to supporting those with alcohol problems, and more utilisation of community assets (see the Consultation Background Paper for further details). The consultation feedback indicated that overall there was overwhelming support for a recovery focussed substance misuse service across North Yorkshire, and optimism that the re-configuration project could support delivery of this. In addition to this it suggested that service specifications could be clearer in a few key areas – specifically the expected interface between the two services, and in the role and scope of both service lots. As a result of the information gathered consideration is being given as to how this may shape the new substance misuse service model.
2.2 What does the information tell you? Are there any differences in outcome for different groups e.g. differences in take up rates or satisfaction levels across groups? Does	Please see the Consultation Background Paper pages 9-17 for summary of NY treatment demographics & data.

it identify the level of take-up of services by different groups of people? Does it identify how potential changes in demand for services will be tracked over time, and the process for service change? **Please include data and analysis as an appendix**	NY data tells us the following regarding protected characteristics: **Gender-** the NDTMS Q4 2012-13 adult partnership performance report states that of those accessing structured drug treatment in that year 69% were male and 31% were female. These percentages are roughly consistent with the average gender distribution nationally. However in the Q4 NATMS report there was a higher % of women accessing alcohol treatment – with 44% of those in treatment women and 55% of those men (is assumed missing 1% is due to missing data). **Ethnicity**- only 7.6% of the NY population are non-white, significantly below the national average. According to the latest NDTMS and NATMS quarterly performance reports (Q4, 2012-13) only 3% of those in structured drug treatment identified their ethnicity as other than "white british." And for those in alcohol treatment only 1% did. **Age**- according to the NDTMS Q4 2012-13 adult partnership performance report the highest numbers of people accessing structured drug treatment were in the age groups 30-34 &35-39 (22% for each age group). Only 11% were aged 18-25 and there were very few individuals aged 60+ (less than 1% of those accessing structured treatment) For those in alcohol treatment the age group with the highest numbers in treatment was 40-44 yrs (17%), and again there were relatively few people in the 18-25 age group (9%). There were more people accessing alcohol than drug treatment aged 60yrs + - 9% Data has identified the potential for negative impact from the new model to the following groups (please see 3.1, 3.2, & 3.3 for information on how it is planned these will be addressed): **Those in treatment for several years** Data suggests that NY services have a significant number of people who have been in drug treatment 6yrs+. National evidence suggests that those who have been in drug treatment longer, been in treatment more than once or have longer drug using careers find it more difficult to exit treatment. This group of people tend to have more complex issues compared to those who successfully exit treatment more quickly.

	Data also suggests that the current NY treatment system does less well at exiting people with complex needs (i.e heroin users) than those with less complex needs (i.e. cannabis users) (from the NY Recovery Diagnostic Toolkit - please contact NYCC Public Health team for further details). In the consultation feedback both stakeholders and service users agreed that they felt it was more difficult to support the move onto long-term recovery for those who had been in treatment for several years. They suggested that these people would benefit from more intensive support in order to help them achieve long-term recovery. **Supporting those not yet ready for recovery** Although the new system is intended to improve recovery outcomes, it is acknowledged that some individuals that the system comes into contact with may not be ready or willing to work towards recovery. The consultation highlighted some concerns about how this group would be supported within the new "recovery –orientated" system. This group of people (many with chaotic substance misuse lifestyles) are known to pose significant risks to themselves (i.e. risk of overdose or self-harm) and to local communities (i.e crime, antisocial behaviour), therefore it is important that the new treatment system will provide support in order to reduce the risk of these harms. **Younger service users** Managing transitions from young people's to adult services was noted as an issue from both the engagement & consultation exercises. There is also evidence to suggest that the new system will need to take into account differing "recovery" needs of those aged 18-25. Data shows that this age group are significantly less likely to use drugs such as heroin[1], but more likely to use cannabis or other recreational drugs including legal highs. It is also anticipated that this age group will have different needs with support in building social capital- for example they will have different aims with regards to education and training as opposed to older service users.

[1] Falling Drug Use: The Impact of Treatment, NTA (2013)

	Those requiring alcohol treatment & support The number of alcohol users in treatment in NY set against the estimated number of dependent drinkers suggests a very low penetration rate of treatment services (less than 6%). Alcohol treatment capacity in NY is seen as inadequate to address need currently, and this was reflected in feedback from the engagement exercise. Waiting times for access to alcohol treatment in NY have been increasing, and the Q4 Alcohol Treatment Data Executive 2012-13 shows that the proportion of people waiting more than 3 weeks to start a treatment intervention was well above the national average It is expected that the integration of drugs and alcohol treatment within the new system will significantly improve access to alcohol treatment for people across the county. However there will still need to be effective joint working between NYCC, the new provider(s) and other partners to ensure that provision of lower threshold alcohol interventions is adequate across the county. This will be required to support individuals who present to services with low-medium risk drinking so they do not develop more harmful or dependent drinking (where they will require treatment) later on. **Those living in rural areas** A few people raised concerns within the consultation about how the new system would effectively deliver a quality service to all given the rural nature of North Yorkshire. **Women** Evidence suggests that women drug misusers may often have more complex issues and different support needs to that of men[2]. The Corston report[3] provides recommendations for working with women in the criminal justice system, including supporting local women's centres. Consultation feedback has suggested that women drug users would benefit from specific support, and reference was made to the success of the women's resource centre in Scarborough, which provides a wide range of support to women aged 16+ who have a history of offending or are at risk of offending.

[2] Women in drug treatment: What the latest figures reveal, NTA (2010)

[3] The Corston Report, Home Office (2007).

	Priority groups for access to treatment It has been agreed that the following groups will be prioritised for fast-tracking into treatment: Pregnant drug users It is advised that services fast-track pregnant women into drug treatment (DoH 2007)[4] to reduce risks to both mother and child. Groups who have reduced tolerance to opiates These include those recently released from prison, or who have been recently detoxed from opiates. Evidence shows that these groups are at significant risk of drug overdose[5]. **Making services accessible to all** Feedback from the consultation suggested that improvements could be made to make services more accessible to all groups, especially for those with young children and people with disabilities. There was also a clear request for services to deliver assertive outreach, to engage those who would not normally access services, or those who had disengaged.
2.3 Are there areas where we need more information? How could we get this information? What data is available? Do other directorates, partners or other organisations hold relevant information? Is there relevant information held corporately e.g. compliments and complaints? Are there national datasets that would be useful? Is there relevant census data? Do you need to collect more data? How could you do this? Do you need to do more engagement work to inform this impact	**Ethnicity/Religion** Although data indicates that there are very few people from ethnic groups other than White British accessing local treatment services, there is virtually no information regarding whether other ethnic groups have differing substance misuse treatment needs in NY. Nationally data indicates that in general drug misuse is lower overall in Black and Minority Ethnic (BME) groups than it is for those who are White British. There is evidence to suggest that some groups may find it more difficult/be less willing to access treatment services because of cultural stigma around substance misuse- which may be linked to their religious beliefs also[6].

[4] Drug Misuse & Dependence: UK Guidelines on Clinical Management, Department of Health (2007).
[5] Reducing Drug-related Deaths: Guidance for Drug Treatment Providers, National Treatment Agency (2004)
[6] Drugs & Diversity: Ethnic Minority Groups (policy briefing), UK Drug Policy Commission (2010)

assessment? Have you identified information in other sections of this EIA that you need to assess the impact on different groups of people? What do you want to find out? Which existing mechanisms can you use to get this information? Please refer to the Community Engagement toolkit on the NYCC intranet	**LGBT (Lesbian, Gay, Bisexual and Transexuals)** National data shows that drug misuse is higher in LGBT groups that in heterosexuals, and suggests that LGBT groups may be early adopters of new drugs or patterns of drug use[7]. There is currently no specific information about LGBT substance misuse needs in NY **Those with disabilities** There is not a large amount of data available relating to substance misuse by this group. However the information that is available suggests that a fairly low level of substance misuse was found in a number of disability groups (though it was felt that use may have been underestimated). **Learning disabilities** There is very little data on the prevalence and severity of substance misuse by this group in the UK. A study by Burgard et al (2000)[8] found that people with learning disabilities were more likely to abuse cannabis and alcohol rather than drugs such as heroin. Again there is no local data on need for this group. Accessing additional information relating to the above groups will be explored with providers once the new model is implemented.
2.4 How will you monitor progress on your policy/service, or take-up of your service? What monitoring techniques would be most effective? What performance indicators or targets would be used to monitor the effectiveness of the policy/service? How often does the policy/service need to be reviewed? Who would be responsible for this?	Performance monitoring of the new service will be undertaken by NYCC using the outcomes framework and through analysis of relevant local data (including but not restricted to NDTMS/NATMS data).

[7] Drugs & Diversity: LGBT groups (policy briefing), UK Drug Policy Commission (2010)
[8] Prevalence & Treatment of Substance Abuse in the Mentally Retarded Population: An Empirical Review, Burgard et al (2000)

3. Assessing the Impact

Please consider issues around impacts (positive or negative) raised for **all protected characteristics** and show your evidence.

3.1 Has an adverse impact been identified for one or more groups? Has this assessment shown anything in the policy, plan or service that results in (or has the potential for) disadvantage or discrimination towards people of different groups? Which groups? Do some needs/ priorities 'miss out' because they are a minority not the majority? Is there a better way to provide the service to all sections of the community?	The new model, although designed to improve recovery outcomes, may be at risk of achieving less successful outcomes for the following groups- as identified in 2.2). See noted alongside these proposed actions to avoid/minimise the risk of impact to groups. **Those in treatment for several years** The new treatment system will be expected to focus on improving recovery outcomes for those with complex needs and who have been in treatment for several years. Provider(s) will be monitored on their performance regarding successful treatment exits for those who have been in long-term treatment **Those not yet ready for recovery** It will be made clear within the service specifications that although the system is recovery-orientated, it will still need to ensure that individuals who are not yet ready for recovery will have access to support. **Younger service users** Service specifications will make it clear that provider(s) need to make strong links with Young People's substance misuse services to ensure that transitions from Young people's to adults services are managed effectively. Providers will also be expected to demonstrate how they will ensure that recovery and treatment needs of those aged 18-25 are met, given that they are likely to have different needs to older substance misusers. This will be reviewed with providers as part of ongoing contract monitoring arrangements. **Those requiring alcohol treatment & support** Although it is anticipated that the integration of drugs and alcohol treatment within the new system will improve access to alcohol treatment, there will need to be effective partnership working with to ensure that lower-threshold alcohol interventions provision is adequate throughout the county. Providers will be expected to demonstrate how they will work together with Public Health and other partners to help achieve this. The Public Health team at NYCC will have an ongoing responsibility to support the development of alcohol strategy in NY.

	People living in rural areas The expectation of providers to ensure access to services for those living in rural areas will be made explicit within service specifications, and providers will need to demonstrate how they will manage this. **Women** Service specifications will state an expectation for providers to maintain strong working relationships with local women's centres, including the women's resource centre in Scarborough (this also links into the identified need to ensure accessibility of services noted below). **Making services accessible to all** The service specifications will make it clear that provider(s) will need to ensure accessibility of services to all who need them, and actively seek ways to increase access to services -particularly for priority groups and groups which appear under-represented in the service (e.g. BME groups).The Community Treatment Service specification will also include the requirement to deliver assertive outreach to engage/re-engage those who would benefit from services.
3.2 How could the policy be changed to remove the impact? Which options have been considered? What option has been chosen?	It is expected that all the potential impacts described above in 3.1 should be able to be addressed through the following actions: -Clarity regarding roles and responsibilities added to service specifications -Making it clear where necessary in the additional information made available to providers prior to bidding that they will need to address issues relating to specific groups (e.g. ensuring that support remains available for those not yet ready for recovery). -Through structuring the provider bid evaluation process to ensure that it explores how providers will address equality issues for specific groups. -Regular performance monitoring of providers once the new treatment model has been implemented following 1st May 2014.
3.3 Can any adverse impact be justified? If the adverse impact will remain, can this be justified in relation to the	It is expected that by implementing the actions described above in 31. & 3.2 that adverse impact will be minimised.

wider aims of the policy or on the grounds of promoting equality of opportunity for one target group? **Please seek legal advice on whether this can be justified.**	There may be some issues with users of services finding it difficult to adapt to a recovery- based model. However the new model should make efforts to support people with this.
3.4 Are you planning to consult people on the outcome of this impact assessment? When and how will you do this? How will you incorporate your findings into the policy?	The impact assessment has been informed by the engagement and consultation exercises from the process so far. The outcome will be reviewed by the Procurement project steering group
3.5 How does the service/policy promote equality of opportunity and outcome? Does the new/revised policy/service improve access to services? Are resources focused on addressing differences in outcomes?	The new system model should improve access to services, as the requirement for providers to reduce barriers to access will be made explicit in the service specifications, and providers will need to demonstrate how they will intend to address this. Both services will be expected to have a role in addressing stigma around substance misuse in NY (the Recovery and Mentoring Service will lead on this). Additionally it is expected that provider(s) will have communications strategies in place detailing how they will ensure that information about services and how to access them is made available to all who require them. The mobilisation of community assets within the new proposed model should improve the range of support available locally to help people to recover from dependence on substances, and this in turn should improve recovery outcomes for all groups across the county.
Don't forget to transfer any issues you have identified in this section to the Equality Action Plan	

Action Plan					
What are you trying to change (outcome)?	**Action**	**Officer responsible**	**Deadline**	**Other plans this action is referenced in (e.g. Service Performance Plan, work plan)**	**Performance monitoring**
Ensure that identified potential negative impact to a number of groups from the procurement is minimised	Service specifications and outcomes framework to be amended where required to ensure that the successful providers deliver services in a way that maximises successful outcomes for all groups	Public Health team	15/7/13	Reconfiguration project plan	Revised service specifications to be signed off by project board.
	Dialogue with providers on how they will address risk of negative impact for specific groups (e.g those in rural areas, those not yet ready for recovery). This will be as part of the evaluation of provider bids, and will also be included in post-contract award negotiations with the successful provider(s).	Public Health team/ Contracts & procurement team staff	1/5/14	As above	Evidenced in provider bid evaluation Evidenced in records of post-contract award discussions with successful provider(s).
	Recovery Mentoring Service to lead on community asset development –to include building links with relevant local services to support	Recovery Mentoring Service	New service to be in place 1/5/14	As above	To be evidenced in records of performance monitoring with providers.

	equality of access & outcomes for all groups				
	Regular performance monitoring of contracts with providers- to include performance in successful completions of service users in long-term treatment	Public Health/ Contracts team	Will be ongoing following 1/5/14	As above	As above
Access further information on treatment need for specific groups	The Public Health team will explore with providers delivering the new system obtaining data on need where gaps have been identified	Public Health/ Contracts team/Providers	To be negotiated with new providers once contracts awarded (date TBC)	As above	To be evidenced in records of performance monitoring with providers