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Monday, 10 September 2018

DIRECTOR OF LEGAL AND GOVERNANCE

Southampton City Clinical Commissioning Group

Integrated Commissioning Unit

SOUTHAMPTON CITY COUNCIL

Substance Misuse Services Review and Redesign

Final Report

'Commissioning specialist services for people concerned by their own or someone else's use of drugs and/ or alcohol'

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AUGUST 2018

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1. Overview

The impacts of problematic use of drugs and alcohol to individuals, their friends, families and communities are well known. Problematic use of drugs can negatively impact physical and mental health and drive people to engage in criminality, become homeless, and disrupt personal relationships and negatively impact child development.

As well as the human cost of substance use people's use and misuse of drugs have financial implications to the public purse, whilst difficult to estimate due to the range of impacts our government has presented a number of estimates in recent years

1.1 The Impact of Drugs - National

- In **2014** the National Treatment Agency estimated that the overall annual cost of drug misuse was around £15.4 billion. £13.9 billion was due to drug-related crime, while around £0.5 billion was NHS costs for treating drug misuse.
- A **2014** report from Public Health England reported that every pound spent on drug treatment saves £2.50 in costs to society.
- In **2012**, the National Treatment Agency for Drug Misuse estimated that drug treatment and recovery systems in England prevented 4.9 million crimes in **2010-2011**, saving £960 million.
- In a **2009** policy paper on the families of drug misusers, the UK Drug Policy Commission estimated that:
    - nearly 1.5 million adults will be significantly affected by a family member's drug use;
        - the cost of the harms they experience as a result amounts to about £1.8 billion per year; and
        - the support they provide would cost the NHS or Local Authorities about £750 million to provide if it was not available.

Human and financial cost of drug addiction: House of Commons Debate Pack Nov 2017

- In **2017** Southampton City Council (SCC) Drug Health Needs assessment indicated
    - '…for each £1m disinvested from services, there could be an annual increase of 9,860 drug related crimes each year, resulting in societal costs of over £1.8million.'

Drugs Health Needs Assessment: Southampton City Council (2017)

1.2 The Impact of Alcohol - National

- Alcohol harms are estimated to cost the NHS around £3.5 billion annually
- Alcohol-related crime in the UK is estimated to cost between £8bn and £13bn per year

https://www.alcoholconcern.org.uk/alcohol-statistics

1.3 Southampton Drug and Alcohol Strategies

Alcohol Strategy - Southampton Alcohol Strategy
Drug Strategy - Southampton Drug Strategy

2. What is the 'need' in Southampton?

This section considers a wide range of national and local data to identify the scale of the issues to be addressed. The range and variety of data available are often limited. The following information provides a snapshot to inform the current commissioning planning.

2.1 Data available

3 key pieces of work already describe need (to a limited extent), demand and activity in Southampton:

1. Public Health England (PHE) Commissioning Support Toolkit, based on National Drug Treatment Monitoring Service (NDTMS) data
2. SCC Drugs Health Needs Assessment 2017
    - The Drugs Health Needs Assessment is available as an attachment in the Reference section at the end of this document.
3. SCC Alcohol Health Needs Assessment 2015
    - The Alcohol Needs Assessment is available here Southampton Needs Assessment (Public Health)

This review therefore will consider the key points from above and data from other sources both local and national. In the main nationally produced data is reported by the National Drug Treatment Monitoring Service (NDTMS). NDTMS forms part of the work of the Public Health England for Substance Misuse. All services that

provide structured treatment for drug and/or alcohol users are asked to submit data to NDTMS. This information is analysed by the National Drug Evidence Centre to produce the figures published. This interim report highlights data from the Diagnostic Outcome Monitoring Executive Summary (DOMES), Adult Successful Completions and Representations, Adult Activity Reports, Young People's Executive Summary and the Young People's Outcome Report. It should be noted that the publication of data reported by NDTMS has restrictions. In particular, a proportion of the data reported on activity and outcomes from 2017/18 has restrictions imposed. This means that data from this period cannot be included in publically available documents. This document, therefore, does not include this data. For the purposes of this document we have included unrestricted data from 2016/ 17.

2.2 Findings

2.2.1 Drugs, adults aged 18+

People who use opiates and/ or crack

- An estimated 1273 people in Southampton use opiates.
- When considering the last 'full year' data that we can publish (DOMES Q4 2016/17) the National Drug Treatment Monitoring Service (NDTMS) evidences 738 people receiving structured treatment to address their use of opiate type drugs.
- We have more need (prevalence estimates) but similar percentage of unmet need, for Opiate and or Crack Users, to the national average, i.e. a local unmet need of 49.0 % (Lower Confidence Interval (LCI) 31.6% - Upper Confidence Interval (UCI) 59.6%) compared to 50.1% (LCI 49.6% - UCI 51.8%) for England.
- The largest cohort of people who use opiates and or crack fall within the age group 35-64yrs with an estimated 821 people in this cohort.
    - The penetration rate, by age group can be seen in the table below

					Penetration Rate		
AGE	**Prevalence estimate (LCI)**	**Prevalence estimate**	**Prevalence estimate (UCI)**	**No in Treatment 2016/ 17**	**Based on highest estimated prevalence**	**Based on average estimated prevalence**	**Based on lowest estimated prevalence**
15-24	30	96	226	19	8%	20%	63%
35-64	598	821	1084	499	46%	61%	83%
65+	Not available	Not available	Not available	4	Not available	Not available	Not available

People aged over 65 who use drugs

Older people with drug problems in the UK fail to get the same attention as young people and this neglect may be fuelled by systemic ageism identified in this study. This includes, exclusion of older people from national drug prevalence surveys and treatment data, upper age limits in some substance misuse treatment services, "age-blindness" in some national substance misuse strategies and a constellation of ageist attitudes and prejudicial assumptions that may prevent professionals identifying and taking action with regard to drug problems. Drug prevention programmes targeted at older people have the potential to create substantial cost savings as well as reducing unnecessary suffering and loss of life but most are targeted at young people. Older people respond well to treatment for drug problems - 62% of people aged 60 and over who receive treatment in a substance misuse service complete treatment free of dependency compared to 47% of 18-59 year olds. They are half as likely to drop out of treatment as younger people. Evidence suggests that treatment outcomes can be improved further if treatment is delivered by a substance misuse service specifically for older people but few of these services exist in the UK and most that do exist are only commissioned to deliver alcohol treatment.[1]

[1] **The Forgotten People: Drug Problems in Later Life -A Report for the Big Lottery Fund University of Bedfordshire (July 2014)**

People who use other drugs

Estimates for the problematic use of other drugs are harder to identify. It can be reasonably assumed that people using particularly harmful drugs like opiates and or crack have a treatment need. A proportion of people who use other drugs will also have a treatment need but it is harder to identify the proportion. But it may be useful, still, to understand the estimated level of use of other drugs. All the following data is taken from the 2015/16 Crime Survey for England and Wales and extrapolated, in the SCC 2017 Drugs needs Assessment, to local data based on Office of National Statistics (ONS) mid-year population estimates for 2015. Some individuals will have used multiple substances.

- There are 161 901 residents of Southampton aged between 16 and 59.
  An estimated:
  - 56,665 people have taken an illicit drug in their lifetime
  - 13,600 people took an illicit drug last year
  - 10,524 people took cannabis
  - 3,562 people took powder cocaine
  - 2,429 people took ecstasy

Southampton has experienced, in recent years, the impact of synthetic cannabinoid use. Anecdotally, it is a limited cohort that use this drug, predominantly people who use opiates and who are experiencing homelessness, however, the impact on their mental and physical health and the associated anti-social behaviour of the use of this drug are significant.

2.2.2 Drugs, under 18

The prevalence of drug use in young people (YP)

All the following data, which provides the prevalence of drug use in young people, is taken from the 2015/16 Crime Survey for England and Wales and extrapolated, in the SCC 2017 Drugs needs Assessment, to local data based on ONS mid-year population estimates for 2015. Some young people will have used multiple substances.

- There are 47,666 residents of Southampton aged between 16 and 24
  An estimated:
  - 8,580 young people took an illicit drug last year
  - 7,531 young people took cannabis
  - 2,145 young people took ecstasy
  - 2,097 young people took powder cocaine

- PHE 'Estimates of opiate and crack cocaine use prevalence: 2014 to 2015', published in 2017 estimates that there are 96 (LCI 30 UCI 226) people aged between 15 and 24years who use opiates and or crack resident in Southampton

- On average our current YP Substance Misuse services provides structured treatment to 218 young people and brief interventions to 1864 young people over the course of a year. 1214 young people received an educational session at school, and over 3000 young people received substance support through targeted outreach. Of those accessing structured treatment:
  - 40% are female
  - 71% are aged between 19 and 24
  - Cannabis is the most commonly presenting drug (75%)
  - Alcohol is the second most commonly presenting drug (55%)
  - Nicotine and Cocaine are the third and fourth most commonly presenting drug (22% and 17 % respectively)

- A recent snapshot of a single quarter's (Q4 201718) activity, from our YP provider database, evidenced
  - 96 people on the DASH caseload in this quarter
    - Gender
      - 38 (40%)female
      - 58 (60%) male

- Age
    - 33 (34%) were aged18 or under
    - 63 (66%) were aged 19 – 24
- Drug
    - 54 (56%) reported cannabis as the primary problematic drug
    - 19 (20%) reported alcohol as the primary problematic drug

2.2.3 Women

PHE 'Estimates of opiate and crack cocaine use prevalence: 2014 to 2015', published in 2017, estimates that 343 (LCI 219-UCI 471) women in Southampton use illicit opiates. The same report estimates that 930 (LCI 735-UCI 1257) men in Southampton use illicit opiates.

NDTMS reports that of the 738 people who use opiates, who engaged in structured treatment in 2016/17, 209 were women. 529 men engaged in structured treatment in the same period
This would suggest a penetration rate of 60.93% (LCI 95.43% UCI 44.37 %) for women who use opiates. This compares with a male rate of 56.88% (LCI 71.97% - UCI 42.08%)

- Southampton Commercial Sex Worker Support Forum recently compared databases and client lists and, through this work, estimated that 60 individual women are engaging in on street prostitution in a six month period
    - Through engagement with these women we understand that women engaged in 'on street' drug use are often people with complex lives including substance use and mental health disorders.
    - The current provider provides an outreach offer to these women with multiple vulnerabilities, but further work needs to be considered to assess treatment need and improve pathways to and through substance use disorder services

2.2.4 People who Inject drugs

PHE 'Estimates of opiate and crack cocaine use prevalence: 2014 to 2015', published in 2017, estimates 636 (LCI 491 – UCI 778) people in Southampton inject drugs.
On average, 350 people access the needle exchange hub each quarter, i.e. c55% of those injecting. The actual proportion of injecting drug users using needle exchange is likely to be higher. We cannot count the number of people using pharmacy provision as the service is open access and service users do not need to give their name. Some people using the hub will pass sterile needle supplies on to others.

2.2.5 Blood Borne Virus

It is estimated that over half of people who inject drugs (PWID) in the South East of England have Hepatitis C (58%). It is estimated that nearly 47% of known Hepatitis C (HCV) cases in Southampton are PWID. A tool to estimate the burden of HCV by Local Authority area indicates that there were 636 individuals currently injecting drugs in Southampton although it must be emphasised that this is an estimate. The prevalence of Hepatitis B and HIV amongst PWID in England is estimated at 0.85% and 3% respectively.

The most recent data that we can present publically [DOMES Q42016/17 – NDTMS] indicates that Southampton's Drug and Alcohol Recovery Partnership performs well in inoculation and testing for BBV when compared with national performance

- Clients with no record of completing a course of HBV vaccinations as a proportion of eligible clients in treatment at the end of the reporting period
    - Southampton = 58.6%
    - National = 71.4%
- Clients with no record of a HCV test as a proportion of all clients in treatment at the end of the reporting period who were eligible to receive one
    - Southampton = 7.4%
    - National = 17.3%

2.2.6 Alcohol, adults aged 18+

PHE's Local Alcohol Profiles for England, estimates Southampton had **3459** (LCI 2732 UCI 4643) people drinking dependently in 2014/15[2]. The profile also shows that 1.76% of the local adult population is estimated to be a dependent drinker, broadly similar to other authorities with a similar degree of population deprivation (1.66%) but higher than England (1.39%) but not quite to the extent of being statistically significant. It means we have an estimated 196 more dependent drinkers than if the rate for England applied.

NDTMS 'Adult Activity Report' (Q4 2016/17) indicates 587 people accessing structured treatment with an alcohol or alcohol and other drug concern

- This indicates that we are engaging with **17.0%** of our estimated dependent drinking population – leaving an 'unmet treatment need' of **83%** (LCI 78.5% UCI 87.4%)
- This correlates with nationally reported (DOMES 2017/18) unmet need for alcohol that indicates that we have a higher rate of unmet need (**87.6%)** than the national average (**82.1%)** and the difference is statistically significant.
    - Similarly, 80%-90% of people engaging with Alcohol Care Team (ACT-UHS) in University Hospital Southampton are not already known to services.

2.2.7 Alcohol use in people aged 65+

PHE's Local Alcohol Profile for England, when considering evidence from 2016/17, evidenced that Southampton experienced significantly 'worse' incidence of alcohol related admissions for people and men aged over 65 when compared to the South East Region and when compared to England as a whole. The incidence of women over 65, presenting for the same issues was regarded as 'similar' when compared to the South East Region and when compared to England as a whole.

	Rate per 100 000		
	England	South East Region	Southampton
Admission episodes for alcohol related conditions (narrow) – Over 65s (Persons)	**871** per 100 000	**825** per 100 000	**1188** per 100 000
Admission episodes for alcohol related conditions (narrow) – Over 65s (Male)	**1283** per 100 000	**1233** per 100 000	**1823** per 100 000
Admission episodes for alcohol related conditions (narrow) – Over 65s (Female)	**542** per 100 000	**491** per 100 000	**690** per 100 000

Prevalence rates for people with dependant alcohol use who are aged over 65 are not available

- It is estimated that 349 (260 male – 89 Female) people aged 55 and over experience dependant use of alcohol
- In 2017/18 72 people aged 55 and over accessed structured treatment and support for alcohol use. Of those 12 were aged 65 or over

[2] https://fingertips.phe.org.uk/profile/local-alcohol-profiles/data#page/0/gid/1938133118/pat/6/par/E12000008/ati/102/are/E06000045

2.2.8 Alcohol Use in people aged under 18

PHE's Local Alcohol Profile for England, when considering evidence from 2016/17, evidenced that Southampton experienced significantly 'worse' incidence of alcohol related admissions for people, men and women aged under 18 when compared to the South East Region and when compared to England as a whole.

	Rate per 100 000		
	England	South East Region	Southampton
Admission episodes for alcohol related conditions (narrow) – Over 65s (Persons)	**34.2** per 100 000	**33.9** per 100 000	**50.8** per 100 000
Admission episodes for alcohol related conditions (narrow) – Over 65s (Male)	**27.4** per 100 000	**26.5** per 100 000	**43.3** per 100 000
Admission episodes for alcohol related conditions (narrow) – Over 65s (Female)	**41.3** per 100 000	**41.7** per 100 000	**58.8** per 100 000

	Yes			No		
	Boys	Girls	All	Boys	Girls	All
England	59.7	65.2	62.4	40.3	34.8	37.6
Southampton	60.9	65.9	63.3	39.1	34.1	36.7

What About Youth 2014 'ever had an alcoholic drink'

For the year 2017/2018 the number of young people engaged with No Limits and receiving a brief intervention around their own problematic alcohol use was 2809. Of these, 599 were over 18, and 2210 were under 18.
99 young people were engaged in structured treatment around alcohol use. Of these, 54 had alcohol as their main or only problematic substance.

2.2.9 Impact of parental substance use on the child

Local

Whilst it is acknowledged that this data may include some inconsistencies, identifying the number of episodes with drugs or alcohol noted as a factor in assessment information, within a recent consideration of Single Assessments Completed on Southampton's Children's Social Service records (PARIS), during the period 01/04/2017 and 31/03/2018, indicates the incidence and burden of individual and 'parental' substance use in Southampton as

- 2356 have parental factor recorded in the assessment
- 531 (22.5%) were recorded with alcohol as a factor = 531 (22.5%)
- 623 (26.4%) recorded with drugs as a factor = 623 (26.4%)

This indicates an average burden when compared with statistical and regional neighbours

20180314
Substance Misuse -.

Nationally reported prevalence

Problem parental alcohol and drug use: A toolkit for local authorities (PHE 2018) reports the estimated prevalence and percentage of met need and compares with national estimates.

Alcohol

Table 1: Annual met treatment need estimates, alcohol dependency 2014/15 to 2016/17

Adults with an alcohol dependency	**Southampton**			**Benchmark**	**National**
	Prevalence	*Treatment*	*% met need*	*%*	*%*
Total number of adults with a dependency who live with children	675	76	11%	18%	21%
Total number of children who live with an adult with a dependency	1261	124	10%	17%	21%

Drugs

Table 2: Annual met treatment need estimates, opiate dependency 2014/15 to 2016/17

Adults with an opiate dependency	**Southampton**			**Benchmark**	**National**
	Prevalence	*Treatment*	*% met need*	*%*	*%*
The number of women with a dependency who live with children	119	69	58%	61%	60%
The number of children who live with a woman with a dependency	207	127	61%	60%	60%
The number of men with a dependency who live with children	217	94	43%	45%	48%
The number of children who live with a man with a dependency	386	174	45%	44%	49%
Total number of adults with a dependency who live with children	336	163	49%	51%	52%
Total number of children who live with an adult with a dependency	593	301	51%	50%	53%

Children in Need

In 2016/17, there were 531 alcohol and 623 drug misuse episodes identified as a risk factor in children in need assessments, out of a total of 2356 records in Southampton.

Regional and national proportions are provided below for comparison.

	Risk factors identified in CIN assessments				
	Alcohol	Drugs	Alcohol misuse	Drug misuse	Total assessments
Southampton	22.5%	26.4%	531	623	2356
Regional average	18.7%	19.4%	14557	15076	77791
National average	18.0%	19.7%	18	19.7	-
Note: An assessment may have more than one factor recorded.					

2.2.10 Adult Social Services – Impact of adult substance misuse

- There is limited data available from ASC systems
    - 2,590 adult social care clients
        - 2,150 of these are in long term care (duration more than 12 months).
- 67 (3%) of these 2150 people in long term care with substance misuse as an identified care reason
    - 21 (31%) of this 67 in permanent residential or nursing care
    - 46 (69%) of this 67 receive domiciliary care in their own accommodation
    - 10 (15%) of this 67 have substance misuse as a Primary Support Reason
        - 3 (30%) of this 10 are in permanent residential or nursing care
        - 7 (70%) of this 10 receive domiciliary care in their own accommodation

2.2.11 Co Occurring Conditions

Substance use disorder with a mental health disorder

Adults and young people with coexisting severe mental illness and substance misuse have some of the worst health, wellbeing and social outcomes. It is not clear how many people in the UK have a coexisting severe mental illness and misuse substances, partly because some people in this group do not use services or get relevant care or treatment.

The National Collaborating Centre for Mental Health document, 'Severe mental illness and substance misuse (dual diagnosis): community health and social care services Draft Review 1', published in 2015 states:

> *Dual diagnosis refers to people with a severe mental illness (including schizophrenia, schizotypal and delusional disorders, bipolar affective disorder and severe depressive episodes with or without psychotic episodes) combined with misuse of substances (the use of legal or illicit drugs, including alcohol and medicine, in a way that causes mental or physical damage). Recent studies have estimated prevalence rates of 20-37% in secondary mental health services and 6-15% in substance misuse settings (Carrà & Johnson, 2009). However, methodological challenges including differing definitions of dual diagnosis, varying timescales for assessing comorbidity, difficulties with diagnosis including diagnostic overshadowing, and the lack of a good theoretical model of the association between severe mental illness and substance misuse, mean that it is still unclear how many people in the UK have a severe mental illness and comorbid substance misuse problems.*

A proportion of people with substance misuse needs have depression, anxiety or other more common mental health conditions too. SCC Drugs needs assessment reports that:

"27% (n= 103) of people accessing adult drug treatment services in Southampton had received care from a mental health service for reasons other than substance misuse (compared with 20% nationally). The proportion of people with a comorbid mental health problem was highest in those clients using non-opiates and alcohol (40%, n= 30)."

Adverse Childhood Experience are often a significant factor in substance misuse and mental distress and ill-health. Adult trauma can also cause mental health and/or substance misuse issues, such as having served in conflict in the armed forces.

Substance use disorder with a learning difficulty

PHE guidance 'People with learning disabilities: making reasonable adjustments' (2018), states

Overall, the evidence indicates that people with learning disabilities are less likely to misuse substances than the general population. However, some people believe that when people with learning disabilities do drink alcohol, there's an increased risk that they will develop a problem with it.

As increasing numbers of people with learning disabilities are living more independently in local communities they're more likely to have access to alcohol and other drugs and, therefore, there's a need for appropriate services to support those who misuse substances. It can be difficult to recognise that someone has mild learning disabilities, but they may still need a different approach to their treatment and support[3].

Prevalence figures are unavailable to understand the impact of substance use disorders, in Southampton, for this cohort.

2.2.12 Drug Related Deaths (DRD)

The number and rate of drug related deaths in each local authority is available from the Office for National Statistics here : 46 people died in the 3 years from January 2015 to December 2017. This compares to 43 from January 2014 to December 2016.The significant majority of deaths are related to Alcohol, Benzodiazepines and Heroin in some combination

Rates are calculated to take account that the size of our population is growing and to allow us to compare ourselves to other areas.

The rates of drug related deaths in Southampton has increased slightly over the last 10 years, although the increase is not statistically significant. The rate of drug-related deaths in Southampton is similar to the rate in like authorities but became higher (worse) than the England average in 2014-16. In statistical terms, numbers are still small and some fluctuation is to be expected. We understand that our local increase is likely to correlate with the reasons associated with the increase nationally, which are thought to be related to an ageing population of heroin users and drops in numbers accessing treatment. People who use drugs are particularly vulnerable on release from prison, or after any other period of (near) abstinence.

Engagement in treatment is evidenced as a significant protective factor. Comprehensive naloxone provision, including for people not actively engaged in treatment, is also a key offer that needs to be available across all cities/settings.

2.2.13 People who are Lesbian Gay Bisexual Transgender Questioning + (LGBTQ+)

There is national evidence of increased alcohol and recreational drug use among people who identify as other than heterosexual or as different to their cis-gender.

[3] **https://www.gov.uk/government/publications/reasonable-adjustments-for-people-with-learning-disabilities/substance-misuse**

Public Health England (2017) synthesised the results from a range of national surveys and estimates that 2.5% to 5.9% of adults across the country publicly describe themselves as lesbian, gay or bisexual[4]. More people again will be lesbian, gay or bisexual but not happy or ready to share it in a survey. Rates are thought to be higher in cities. The analysis did not look at transgender or queer people as national surveys have not recorded this to date.

Public Health England recently reviewed the health needs of men who have sex with men (2016[5]) and of women who have sex with women (2018[6]). Men who have sex with men are twice as likely to be dependent on alcohol and young people who are LGBT are almost twice as likely to use drugs and alcohol compared to their heterosexual peers. Women who have sex with women are also more likely to drink heavily, although the increased rate was not quantified. Additionally, a review of the needs of the LGBTQ+ community in London reported from the literature that 62% of transgender people may be dependent on alcohol[7]. The work by PHE does not identify any increased risk of opiate and/or crack use, but there may be a paucity of research in this area.

It is clear from numbers of people, who identify as LGBTQ+, entering treatment that more work needs to be done to understand the needs and to engage more people, who identify as LGBTQ+, in support and treatment

Southampton Q4 2016/17 Sexuality (new treatment journey/ episode 1/4/16 - 31/5/17)			
	Southampton		**National**
Heterosexual	439/514	85.4%	84.8%
Gay/ Lesbian	6/514	1.2%	2.3%
Bi- Sexual	12/514	2.3%	1.3%
Person asked and does not know or is not sure	1/514	0.2%	0.2%
Not stated	51/514	9.9%	6.9%
Other	5/514	1.0%	0.9%
Missing/ inconsistent	0/514	0%	3.5%
All clients entering treatment within the date parameters shown and sexuality as recorded at the start of their treatment journey.			

NDTMS Adult Activity Report Q4 2016/17

2.2.14 People concerned by someone else's use of drugs and alcohol

Members of the individual's social network (such as family and friends and concerned significant others) may have support needs of their own but may also be able to contribute to the treatment process. Supporting the needs of carers is now recognised as an essential component of delivering effective public health and social care services.[8]

4 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/585349/PHE_Final_report_FINAL_DRAFT_14.12.2016NB230117v2.pdf

5 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/324802/MSM_document.pdf

6 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/713566/improving_health_and_wellbeing_LBWSW.pdf

7 https://www.london.gov.uk/sites/default/files/The%20Health%20and%20Wellbeing%20of%20LGBT%20London%20FINAL.pdf

8 https://www.gov.uk/government/publications/drug-misuse-and-dependence-uk-guidelines-on-clinical-management

It is difficult to quantify the number of people affected by someone else's use of drugs and or alcohol, anecdotally it is estimated that 75% of people accessing support for substance misuse disorders are maintaining contact with family.

2.2.15 Conclusion of local need

This report indicates that Southampton has higher need (larger prevalence rates) and similar or higher unmet need (people not accessing support or treatment) than the national average.

The needs of an aging population will require specific work to consider how best to meet their needs, particularly the cohort of older people with complex and entrenched use of alcohol.

Drug Related Deaths continue to cause concern, this is reflected as a priority of Southampton's Drug Strategy and commissioned services will be a key contributor to this work. The costs associated with Alcohol Use Disorders to individuals, their families, friends and communities and the impact on Southampton as a whole use are significant. Reducing alcohol-related harm is a priority of Southampton's Alcohol Strategy and commissioned Substance Use Disorder services will be required to work with other stakeholders to reduce the burden.

Continuing to develop strong, joint working relationships, with Mental Health Services is key to addressing the needs of people with co-occurring conditions

Our services need to consider specific interventions to encourage more women to access treatment and support

There is clear evidence of unmet need when considering the impact of 'parental' substance misuse on the child.

3. Current Service Performance

This section considers the impact our services have in reducing the harm caused by individual's use of drugs and or alcohol. Outcome data tends to focus on numbers of people exiting treatment in a positive way (successful completion). It is much harder to evidence the positive impact our services have in reducing harm.

3.1.1 Southampton is currently underperforming on successful completions and representation outcomes (NDTMS DOMES Q4 2016/17)

3.1.2 Public Health Outcome Framework (PHOF) 2.15 (Successful completions not representing in 6 months)

	Local (%)	Local (n)	National (%)	National (Top quartile for Comparator LAs)	Number to achieve Top Quartile
Opiate	6.3%	47/748	6.6%	7.21%-9.39%	54 - 70
Non Opiate	26.4%	67/226	37.1	42.5% - 57.61%	102 - 137
Alcohol	28.9%	38.3%	No data	No data	No data

3.1.3 Successful Completions

	Local (%)	Local (n)	National (Top quartile for Comparator LAs)	Number to achieve Top Quartile
Opiate	6.4%%	47/738	7.89% - 9.64%	59 to 71
Non Opiate	35.7%	43.37% - 62.18%	43.37% - 62.18%	49 to 69
Alcohol	34.1%	95 / 279	39.98%*	No Data
Alcohol and Non Opiate	27.3%	41 / 150	39.37% - 57.52%	60 to 86

*National Average

3.2 Waiting Times - Adults

The most recent data, that we are able to publish publically [DOMES Q42016/17 – NDTMS], indicates that Southampton's Drug and Alcohol Recovery partnership performs well in terms of waiting times for individuals to engage with 'first interventions' with no incidence of people waiting longer than the target of 3 weeks wait for first interventions

Locally reported waiting times indicate that, in the most recent period with data available (Q4 201718) the times between comprehensive assessment and first prescribing appointment for all new referrals to Opiate Substitution Therapy (OST), in working days, were

- Shortest 0 working days
- Longest 6 working days
- Average 0.2 working days

3.3 Treatment Exits - Young people

Young Person's NDTMS reports can split data for people aged 24 and under and people aged under 18.
Treatment exits (24 and under and under 18)

	Under 18		24 and under	
	Southampton	National	Southampton	National
Planned	68%	82%	51%	79%
Treatment Completed – drug free	14%	33%	13%	31%
Treatment Completed – occasional user	55%	49%	39%	48%

Young People's Activity Report Q4 2016/17 (NDTMS)

3.4 Waiting Times (24 and under)

Our commissioned young people's service consistently meets (100%) its 3 week target for first intervention following assessment compared to a national average of 98% (Young People's Activity Report Q4 2016/17 (NDTMS))

3.5 Ethnicity

The census data from 2011 indicates that 77.7% of people (whole Southampton population/ all ages) identify themselves as White British of these, 70% of people, who are aged under 18 and accessing structured treatment, identify themselves as White British. For those aged 18 and over 83.4% who are accessing treatment identify themselves as White British

3.6 Conclusion of current service performance

Analysis of the data shows that fewer people leave our services in a planned way, drug free than the national average. Our current services are working hard to reduce the harm and facilitate recovery. More recent locally generated data indicates some significant improvements to most measures. Some further focus needs to be given to understanding the impact of substance use disorders on non-White British communities to ensure needs are met.

4. How support and treatment should be delivered

4.1 National Guidance

Commissioned services working with and within the Public Health function are required to deliver against outcomes as set out in the Public Health Outcomes Framework (PHOF). Public Health England have stated that an effective substance misuse treatment system supports the PHOF vision, "To improve and protect the nation's health and wellbeing, and improve the health of the poorest fastest" and impacts directly on the wider PHOF outcomes.

National guidance will be used to underpin and inform future commissioning intentions, supported by local strategies, intelligence & performance. They will also shape and inform the services that are commissioned meaning

services will be delivered from an evidence based position using all available guidance and in doing so accepting and adopting relevant updates to existing guidance as well as new guidelines as and when issued.
This is a comprehensive, but not exhaustive, list of national guidance

Drugs

- Drug misuse and dependence: UK guidelines on clinical management. Department of Health. 2017 https://www.gov.uk/government/publications/drug-misuse-and-dependence-uk-guidelines-on-clinical-management.
- Routes to Recovery, (Psychosocial Interventions in Substance Misuse) a framework and toolkit for implementing NICE recommended treatment interventions; NTA http://www.nta.nhs.uk/uploads/psychosocial_toolkit_june10.pdf
- Medications in Recovery – Re-orientating Drug Dependence Treatment, NTA 2012 http://www.nta.nhs.uk/uploads/medications-in-recovery-main-report3.pdf
- NICE Guideline CG51: Drug Misuse – Psychosocial Interventions https://www.nice.org.uk/guidance/cg51
- Models of Care (2002) and Models of Care Update (2006): http://www.nta.nhs.uk/uploads/nta_modelsofcare_update_2006_moc3.pdf
- NICE Public Health Guidance PH52 (Needle and syringe programmes: providing people who inject drugs with injecting equipment), 2014 http://guidance.nice.org.uk/PH52
- NICE Guideline CG110: Pregnancy and Complex Social Factors http://guidance.nice.org.uk/CG110/NICEGuidance/pdf/English
- NICE Guideline NG58: Coexisting severe mental illness and substance misuse: community health and social care services https://www.nice.org.uk/guidance/ng58
- Towards successful treatment completion: A good practice guide; NTA 2009 http://www.nta.nhs.uk/uploads/completions0909.pdf
- NTA Overdose and Naloxone training programme for families and carers http://www.nta.nhs.uk/uploads/naloxonereport2011.pdf
- Take-home naloxone for opioid overdose in people who use drugs. Public Health England. 2017. http://www.nta.nhs.uk/uploads/phetake-homenaloxoneforopioidoverdoseaug2017.pdf.
- NICE guideline [NG64] Published date: February 2017 - Drug misuse prevention: targeted interventions https://www.nice.org.uk/guidance/ng64.
- Drug misuse in over 16s: opioid detoxification (Clinical guideline [CG52] Published date: July 2007) https://www.nice.org.uk/guidance/cg52.
- Drug use disorders in adults (Quality standard [QS23] Published date: November 2012) https://www.nice.org.uk/guidance/qs23.
- Better care for people with co-occurring mental health and alcohol/drug use conditions: A guide for commissioners and service providers. Public Health England. 2017 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/625809/Co-occurring_mental_health_and_alcohol_drug_use_conditions.pdf

Alcohol

- Models of Care for Alcohol Misuse (MOCAM), Department of Health. 2006. https://www.alcohollearningcentre.org.uk/_assets/BACKUP/DH_docs/ALC_Resource_MOCAM.pdf.
- Alcohol-use disorders: diagnosis and management (Quality standard [QS11] Published date: August 2011) https://www.nice.org.uk/guidance/qs1.
- Alcohol use disorders: Diagnosis and clinical management of alcohol-related physical complications (Clinical Guidance 100) Updated April 2017. NICE https://www.nice.org.uk/guidance/cg100.
- Alcohol use disorders: Diagnosis, assessment and management of harmful drinking and alcohol dependence. , (Clinical Guideline 115). 2011. NICE. https://www.nice.org.uk/guidance/cg115.

- Alcohol use disorders: Preventing harmful drinking (Public Health Guidance 24). 2010. NICE. https://www.nice.org.uk/guidance/ph24

Young People

Practice standards for young people with substance misuse problems. The Royal College of Psychiatrists. 2012. http://www.rcpsych.ac.uk/pdf/Practice%20standards%20for%20young%20people%20with%20substance%20misuse%20problems.pdf.

Harm Reduction

- NICE Clinical Guidance 52: Needle & Syringe Programmes. 2014 http://guidance.nice.org.uk/PH52
- NICE technical analysis 114 "Methadone and Buprenorphine for the Management of Opioid Dependence" 2007 https://www.nice.org.uk/guidance/ta114/resources/methadone-and-buprenorphine-for-the-management-of-opioid-dependence-82598072878789.
- Drug misuse prevention: targeted interventions. NICE guideline [NG64] Published date: February 2017 https://www.nice.org.uk/guidance/ng64
- Public Health England. Widening the availability of Naloxone. 2017. https://www.gov.uk/government/publications/widening-the-availability-of-naloxone/widening-the-availability-of-naloxone.

Carers

- AdFam A Partnership Approach: Supporting Families with Multiple Needs. 2011. **https://www.adfam.org.uk/files/docs/adfam_partnership_2011.pdf**

4.2 The views of stakeholders

A range of surveys have been conducted to seek the views of people who use drugs, people who engage in treatment and support, people who deliver that support and other stakeholders. This is a brief overview of what we learnt. The full reports from each of these surveys are available on request.

4.2.1 People who use our services - ADULT

There were 72 responses with a significant proportion of the responses being very positive about the services they receive

- Where there were concerns the following issues were raised
  - Need for more staff time
  - Very positive response to group work and psychosocial provision
  - Identifying (with a few exceptions) empathetic/ effective and supportive workers
  - A number of service users identified limited access to workers could be improved with more resources/ funding
  - Waiting times, particularly for 'restarts' too lengthy
  - Confusion around what provider does what

4.2.3 People who use our services – young people (YP)

There were 20 responses, again with a significant proportion very positive about the services they receive

- Issues raised
  - Don't like going to New Road Centre (NRC – Adult Services hub) for health interventions
  - Need for more space for private conversations
  - Reconsider scripting arrangements with more assessments and interventions being delivered away from NRC

4.2.4 People who engage with Needle Exchange (NEx)

There were no responses from Pharmacy NEX.
22 responses from hostel or day service settings were received which were all positive about NRC NEx

- Issues raised
    - Desire/ need for more flexible, expanded, offer with more opportunities in the community, including mobile outreach
    - Response to question re Drug Related Litter (DRL) was uniformly a request for more community provision of sharps bins
    - Respondents also indicated the need to consider direct intervention with those it is able to identify who are unwilling or unable
    - Some negative comments re staff availability
        - all who mentioned this indicated this was a resource issue not a staff one

4.2.5 Staff

- A staff representatives group was formed and has provided the following thoughts and opinions
    - Current model can feel disjointed
    - Improved psycho social interventions are beneficial
    - Data management is over burdensome
    - Communication re serious incidents to frontline staff is not always good
    - Group delivery should be time limited
    - YP should have interventions delivered separately from adults
    - Differing views about the age services should move into adult setting (from age 18 or 25)
    - Alcohol work is specialised and should have a specific team
    - Harm reduction/ NEx work is specialised and should have a specific team
    - DRR/ Criminal Justice work is specialised and should have a specific team
    - Placement of MH worker in team would be very beneficial

4.2.6 Stakeholders

- 12 responses
    - Generally positive
        - Strong stakeholder relationships
    - Some confusion about multiple provider model
    - Need for more joined up working with Mental health Services
    - Need for flexible services for older people
    - Need for better local detoxification provision
    - Need to drug in reach to hospital
    - Contacting services can prove difficult

4.2.7 Primary Care

- Issues raised
    - The feedback was generally positive about current services and service model and recent improvements in the last 12 months were noted.
    - But feedback was mixed. Some said that services are responsive. Others said there was insufficient capacity – waiting times and insufficient support for clients - and not enough feedback from specialist services to primary care.
    - Dual diagnosis and community detox were noted as unmet needs.
    - Shared care was cited positively. Some respondents asked for more primary care providers to be able to offer the LCS services, including for all pharmacies to be able to offer supervised consumption.

4.2.8 Carers

- 16 responses received from people engaging with Parent Support Link
    - Most responses included positive reflections around provision of services to their family member/ friend
        - Services are accessible (5)
        - Services are effective (9)
    - A number of concerns were raised when asked 'what doesn't work so well?'
        - Open access area can be chaotic/ intimidating (6)
        - Staff can be unhelpful (3)
        - Poor family involvement/ communication (6)
        - Not enough staff/ resources (4)
        - Rehab is difficult to access (3)
        - 'Unfriendly staff'

4.3 Other recent pieces of work (adult and YP)

4.3.1 Street Based Vulnerable Adult Review (SBVAR)

Southampton City Council and Clinical Governance Group's Integrated Commissioning Unit (ICU) recently conducted a review to

- Gain an understanding of issues that compound and increase the current rise of street based vulnerable adults, often noticeable through increased levels of street begging and homelessness.
- Explore evidence based/best practice options to reduce the prevalence of street based vulnerable adults leading to street begging and homelessness
- Inform commissioning intentions for homelessness, substance misuse and other related areas.
- As part of this review 41 people, experiencing homelessness and/or engaging in begging behaviours were surveyed. The findings from this survey included
- 74% (20) of the 27 people who said they were 'rough sleeping' reported alcohol use or dependence and/or drug use or dependence.
- 13 of this 27 reported a substance use problem were already known to the local service.
    - An additional 3 had engaged previously.
- Of the 26 people who were engaging in begging behaviours 92% (24) reported alcohol use or dependence and/or drug use or dependence
    - 22 stating they used the funds raised to acquire drugs and or alcohol, although 14 said they also used the funds for other things including food, accommodation, bills, debts and phone credit.
- 15 were known to substance misuse services
    - 4 had engaged with substance misuse services previously
    - 5 were 'not known to substance misuse services'.
- In narrative responses a significant number of people recognised that drugs and alcohol were negatively affecting their life chances
- A small proportion identified that they found it difficult to engage with support
- SBVAR Recommendations
- **To continue to do what we do well.** We must not lose sight of the current levels of support and work within Southampton helping those who find themselves homeless, or on the brink of homelessness.
- **To engage people with complex needs better.** We need to look at options to address issues around complexity and in doing so
    - Recognise the role substance misuse services will have during the initial points of contact**.**
    - Improve existing and new pathways
    - Provide a responsive mechanism (e.g. Collaborative Assessment panel) for people with complex needs
    - Ensure staff training provides a good understanding around supporting individuals with mental ill health

- **To investigate further new models of support and their potential in Southampton.**
    - Coordinate and promote local support services
    - Explore the use of housing first and alternative housing models (e.g. containers)
- **To target information to young people who experience adverse childhood experiences to prevent future homelessness**
    - Incorporate awareness and targeted support in new relevant tenders (e.g. counselling in schools, Safe House & Team House, a new peer support model and CAMHS transformation project)
    - Build on current work at No limits, engaging with Homeless young people, joint working with HVAST, specialist crisis worker providing harm reduction and brief interventions and enabling pathway into treatment, as well as access to health, sexual health services and basic needs such as shower, laundry. Also undertaking risk assessments and supporting young people affected by exploitation.
- **Coordinate enforcement with support.**
- **Sign up to a local charter for homeless individuals.**

Conclusion

Recommendations from this report highlight the need, for services commencing support and treatment in 2019, to work with services for people experiencing homelessness to improve pathways and joint working.

4.3.2 Learning from the Homeless Vulnerable Adult Support Team

SCC were awarded £398 000 from the Department of Communities and Local Government (DCLG) 'Rough Sleepers Grant' to tackle the complex, multiple factors that can drive treatment resistant drinkers and/or illicit drug users toward a life of entrenched rough sleeping, utilising Alcohol Concern's 'Blue Light Principles'. Based in Southampton's Homeless Day Centre, the Homeless Vulnerable Adult Support Team (H-VAST), delivered by Two Saints Ltd, commenced support in April 2017.

Although only half way through this Department of Communities and Local Government funded project, significant, positive outcomes are already being delivered.

The role of services, for people concerned by their use of drugs and/or alcohol, working innovatively and flexibly with bespoke interventions based on 'Blue Light' (Alcohol Concern) principles has been fundamental to the initial success of this project. Any future service will be informed by the learning delivered by this project.

4.3.3 SCC Scrutiny Enquiry into Drug Related Litter (DRL)

SCC recently conducted a scrutiny enquiry into DRL to understand the reasons for the prevalence and impact of drug related litter in Southampton, to review progress being made in Southampton to tackle drug related litter and to scope what more could be done.

This enquiry concluded that whilst the prevalence of this problem is not a pervasive as some other areas the incidence of this type of activity still has an impact on individuals and communities and presents a potential health risk, particularly to the people who inject drugs and those working with people who inject drugs and clean-up drug litter. The enquiry acknowledged the good work is already being delivered.

The enquiry recommendations included that consideration should be given to the provision of Needle exchange (NEx) services, in particular to ensure the best possible provision is delivered within the resources available.

In addition to the considerations given to the provision of NEx, the enquiry also recommended consideration of the provision of sharps bins, a robust evaluation to fully assess the potential benefits a medically-supervised pilot drug consumption room could bring to Southampton and a need to assess the possible benefits, to Southampton, of including Heroin Assisted Therapy (HAT) and/ or injectable methadone as part of our provision of services for people with Substance Use Disorders

4.4 Other considerations

Homelessness, UHS and Behaviour Change

During the early stages of the review and redesign, three themes emerged

- Substance misuse and homelessness and exploring the option of merging some or all of homeless & substance misuse contracts.
- The possible configurations of both community substance misuse services with hospital based alcohol services.
- Substance misuse and behaviour change approach, again exploring the option of merging some or all of the behaviour change & substance misuse contracts

To take a first look at these emerging themes a small focus group was held involving key staff within the ICU (Associate director, 2 senior commissioners and the service development officer working on the review and redesign). The following outlines the key discussion points and proposals.

4.4.1 Substance Misuse and Homelessness

Driver

The concept of merging homeless and substance misuse contracts originated from the Leader of the Council learning about changes in other local authority areas and exploring the potential to amalgamate a range of voluntary sector funded by the Council.

Considerations

- Since the initial idea was raised, there has been an increased understanding and awareness about the complexity within both service areas and limited overlap between the two services.
- There is a high number of homeless who have a substance misuse disorder, but not all homeless are using substances.
- The numbers in substance misuse service who are homeless or living in unstable accommodation is low (snapshot shows 87 individuals out of a caseload of circa 700).
- There may be an argument for a stronger (contractual) relationship between the alcohol accommodation and the substance misuse service.
- A number of options were explored
    - Improving the level of integration between service areas for example homeless workforce being able to respond better to substance misuse issues, and substance misuse staff have greater understanding and skills regarding accommodation issues
    - Partial merging of service areas. For example some of the homeless services (assessment centre) within substance misuse services or moving some of the substance misuse service within the homeless contracts.
    - Full integration of services whether homeless contracts merged with substance misuse or vice versa.
- A single workforce working with those who are homeless and have a substance misuse disorder has resulted in positive benefits for the service in Portsmouth (one case holder addressing and supporting the individual on multiple issues, albeit not specialist areas of substance misuse)
- There are equal, if not greater challenges in the pathways and joint working with mental health services for both substance misuse and homeless services. Concerns this could get worse if homelessness and substance misuse services were combined.
- Two large service areas should not be designed around a smaller element of the services.
- If combined, there would need to be a lot of clarity and detail in the service specification.
- No evidence base for merging these service areas. While not a reason, it was recognised there is existing fragility in the current substance misuse services. There should be greater certainty before a new approach is tested.
- The overall performance of substance misuse is poor. There is scope to source more data specific to those who are homeless or in unstable accommodation. This could include information from the Street Based Vulnerable Adult work and H-VAST (Homeless Vulnerable Adult Support Team), identify how pathways could make things better. These could be added as KPI's to contracts.

- Any significant change would require formal consultation. This would result in a further request to extend the current contracts. This is likely to be met with a challenge from legal services.
- More capacity is needed to work with the group of individuals with more complex needs (substance misuse, homeless and no recourse to public funds (NRPF)).

Recommendations

Future commissioned services will aim to address the following recommendations. Any recommendations that are 'out of the scope' of commissioned services will be considered in the broader work of Southampton City Council's Public Health and Integrated Commissioning Unit

To improve the level of integration between service areas and in doing so consider:

- Critical look at contracts and ensure there are requirements around improved integrated working between service areas.
- Improved integrated working between services areas is reflected in robust KPI's, including evidence of improved pathways.
- Pursue a more dedicated resource, located within homeless healthcare to work with the cohort of homeless individuals who also have substance misuse disorder.

4.4.2 Reconfigure community substance misuse services & hospital based alcohol services.

Driver

Historically the hospital based alcohol service has been developed in isolation from the wider substance misuse contracts. A question raised during discussions challenged whether this should change. Two distinct areas were discussed; detox and in-reach services.

Considerations

- Since the closure of Portsmouth based detox, individuals are required to travel to Poole to access a more specialist detox. The use of the local hospital in Southampton could be easier for most clients needing specialist detox.
- Current working between community and hospital based services is improving, but has taken time to establish. A change of provider in the future, without change in service configuration set back the current working relationships. The use of honorary contracts has helped.
- Locating in-reach staff within a larger team (e.g. community) allows for more flexibility to cover work requirements.
- Psychiatric liaison teams elsewhere are quite large. Initially appeared Southampton was a smaller team, but the sum of all service areas actually resulted in a comparable resource. Ensuring all service areas sit under one structure and seen as one team could address this issue.
- Merging of services within one contract may result in savings.
- There are 3 detox options locally
    1. Those engaging in community who need detox find a detox provider, usually rehab or other settings. For complex problems they usually go to Poole at a cost of £2800 per client.
    2. Those who present to hospital settings for other reasons (leg break, operation), and identified as needing a detox, are commenced on relevant medication for withdrawals. Usually UHS charge for these as a complex case, attracting a higher tariff. There is no guarantee the detox will be completed - once injury sorted, or presenting issue is sorted - they are discharged.
    3. Home detox - small provision of community detox. Engaged in Sub M service (6 per month est.)

  Ideally these three options would be linked up, particularly at the point of discharge from hospital to home detox. However, this isn't happening.
- Other areas have shown that an ambulatory detox in the local hospital for those discharged from hospital have a higher rate of engagement than those referred to community detox. Concerns about the cost of this service and the overlap with UHS charging extra for detox cases (as set out in point 2 above)

- Pathways out of hospital to community detox need to be improved.
- The community provider has a strong influence over who gets in to what detox.
- Any additional detox capacity in UHS would need to be contracted separately and ensure issues of double payment and market rates are addressed.

Recommendation
Future commissioned services will aim to address the following recommendations. Any recommendations that are 'out of the scope' of commissioned services will be considered in the broader work of Southampton City Council's Public Health and Integrated Commissioning Unit

To retain a degree of separation between the hospital and community based substance misuse services and in doing so

- Review and improve pathways from hospital treatment into community detox
- Invite UHS to present business case for ambulatory detox, with clear evidence financial benefits greater than investment.
- Explore the use of local hospital setting for specialist detox provision at comparable market rates.

4.4.3 Substance misuse and behaviour change
Driver
Elements within the behaviour change service overlaps with substance misuse services, notably alcohol and possibly smoking cessation. This raised a query whether there was potential to merge some of the behaviour change contract with the substance misuse service. The focus could only be on specific elements; alcohol and smoking cessation so could never be a full integration of behaviour change (which includes weight management, physical activity, mini health checks and other activities) with substance misuse.
IAPT and behaviour change would require a separate discussion.
Considerations

- There could be opportunities for substance misuse staff to link into other services and upskill their workforce around alcohol and smoking.
- Work has been undertaken in recent years to establish a strong early intervention and prevention approach. Putting the alcohol and smoking elements into the substance misuse contract detracts from this.
- Previous discussions looking at moving some resources from substance misuse budgets to community navigation was not pursued because of the importance attached to the early intervention and prevention agenda.
- Current timescales are not aligned; with behaviour change running to 2020 (substance misuse runs July 2019).
- The CCG, ICU and Public Health are exploring how smoking cessation can be delivered across all commissioned providers
- Public Health keen to keep a community offer smoking cessation as there is no strong evidence and it isn't a national driver to move smoking cessation services into substance misuse services.
- The Public Health grant ends in March 2020. If future funding arrangements offer less funding, then the behaviour change offer might need to change. The evidence base is less clear for some behaviour change activities than for substance misuse treatment and harm minimisation. Many areas across the country already offer less behaviour change support than Southampton.
- Current services have a history of providing alcohol brief interventions. Since this has been transferred into mainstream services it has diluted the focus. Currently brief interventions are provided by phone by 2 whole time equivalent staff members. This could be expanded or they could train up other staff.
- Providers should be delivering behaviour change within their service delivery model. Smoking cessation is important to reduce drug-related deaths, reduce deaths attributable to smoking, increase social inclusion and support people in their recovery from substance misuse difficulties. Emerging evidence shows it is harder to be abstinent from drugs or alcohol if you continue to smoke.
- It could be possible for some funding to move to substance misuse to pick up some brief intervention at broader scale.

Recommendations

Future commissioned services will aim to address the following recommendations. Any recommendations that are 'out of the scope' of commissioned services will be considered in the broader work of Southampton City Council's Public Health and Integrated Commissioning Unit

To ensure the current and future substance misuse services incorporate brief interventions around smoking cessation into service delivery model for both service users and staff. Ideally future services will also support their service users in 'quit attempts' directly too.

For future services to continue to provide a range of alcohol support and for them additionally to be local experts, and possibly trainers, in brief interventions for alcohol.

There was no support to bring elements of the current commissioned behaviour change service within the substance misuse contract.

4.5 Finance

Overview

SCC currently, directly commissions three providers, under five different contracts

Adult contracts • Adult Care Coordination and Health Interventions (ARM) • Adult Tier 1 & 2 Alcohol Service (Southampton Brief Advice and Counselling Service – SABICS) • Adult Psychosocial Interventions Service)	£2,226,022	Includes support for carers and advocacy services Provides young people clinical interventions
Young people contracts • Young Peoples Service (DASH) provided by No Limits • DASH Structured Interventions Service	£541,568	

NB – The Public Health Grant will be withdrawn from April 2020. There is no information currently as to where funding for services will be drawn from although commitment from SCC to fulfil the life of the contract.

NB – Office of the Police and Crime Commissioner (OPCC) grant is subject, currently, to an annual review and application process.

These contracts share two additional budgets

Budget Name	Purpose	Value (2018/19)
Care Management Budget	Residential Rehabilitation	£151 800
Purchased Services Budget	Detoxification, externally provided 'Day Rehab' and other groups and interventions not directly commissioned based on need of service users	£177,800

In addition Southampton Clinical Commissioning Group (CCG) are currently funding 2 x WTE equivalent posts

- 1 x WTE In Reach Worker – SSJ - £35 000
- 1 X WTE Hospital/ Alcohol Care Coordinator – CGL - £35 000

In addition SCC provide 1.5 WTE seconded Social workers – CGL - £55 700

In addition SCC funds a MASH navigator post - CGL

Current Staffing Levels

Service	**Staff WTE**		
No Limits	Non Clinical	11	
CGL (incl CCG Funded Care coordinator and 1.5 WTE seconded social workers and separately funded MASH Navigator)	Data/ Admin	3.6	**30.7**
	Clinical	6.2	
	Non Clinical	20.9	
SSJ (incl CCG funded 1 x WTE In Reach worker)	Non Clinical	9.55	
TOTAL		Total YP	11
		Total Adult	41.25
		Total	**52.25**

Other financial considerations

Care Management Budget (CMB)

Currently only to be used to fund residential rehabilitation. This budget was subject to a significant reduction this year and is currently under some strain. Further conversations, already in train, need to be had with the Care Management Budget holder to consider the best use of this budget including the consideration of the provision of Day Rehab, perhaps combining elements of CMB and purchased service budget to fund

OPCC funding

OPCC funding is awarded annually and contributes to the adult contracts. There is a need to engage with OPCC to secure longer term commitment of funding to meet need

CCG funding

CCG have committed £35k per annum through the life of the contract to support a reduction in hospital admissions. Further discussion with CCG should explore any additional funding opportunities

5. Buildings

Services for people concerned by their use of drugs and alcohol are delivered from a city centre hub that is comprised of three buildings. Commissioned services rent these 3 buildings from private landlords. The three different buildings have three separate tenancies that are due to end in the near future. Current providers have previously raised concerns that the current buildings are limited in their suitability. Historically, providers have found acquiring permission to deliver services from new buildings difficult

6. The Model for specialist services for people concerned by their or someone else's use of drugs and/ or alcohol' 2019

It is our intention to commission services that have harm reduction as the principle aim and 'recovery' as a desirable and achievable outcome.

In Southampton, recovery is defined as

Voluntarily - sustained control over problematic substance use which maximises health and wellbeing and participation in the rights, roles and responsibilities of society.

Services will be tasked with improving successful completions, reducing representations whilst maintaining robust and effective harm reduction interventions to reduce drug related deaths, the incidence of blood borne virus infections and the broader harms to individuals, their friends, families and communities

Services will be expected to work proactively, flexibly and collaboratively with stakeholders to increase engagement and improve outcomes of those impacted by substance use disorders

Futures services are expected to provide a comparable service offer to our current provision albeit with some, variation in the way the service model is configured.

SCC will seek to commission services that provide support and interventions that engage with people over the life course.

There is no intention, currently to separate alcohol from drug services. However it is an intention to work with providers to consider how better to 'present' alcohol services to the population with consideration to be given to deliver a distinct route of entry into support and some separation of interventions for people with alcohol use disorder, some of whom have, historically, been reluctant to approach integrated services.

All services will work with people with the following problematic substance use:

- Alcohol
- Opiates and crack cocaine and other illegal substances
- Prescribed medication that is being used problematically
- Prescription medication that is being used illicitly
- Performance and Image Enhancing Drugs
    - Interventions to reduce harm including needle exchange
      Interventions to address any other, identified, drug use

Services will be delivered in the following way

- Services will continue to be open access.
- Shared care, needle exchange and supervised consumption will continue to be provided in primary care through different contracts.
- Services will be required to work with and within the criminal justice setting
- Services will be required to engage with safeguarding adult and children processes
- Services will contribute in local and national drug and alcohol campaigns and will champion the needs of people with drug and alcohol concerns at every opportunity and will work to reduce the stigma and promote their needs.
- Services will be delivered using principles as set out in the Department of Health's Drug misuse and dependence UK guidelines on clinical management.
- The core of our treatment system will be the building of good therapeutic alliances between staff and people engaging in treatment and support.

> *Therapeutic alliance*
> *A good therapeutic alliance is crucial to the delivery of any treatment intervention, medical or psychosocial. When a stronger helping relationship is established, service users are more likely to complete treatment, actively explore problems, experience less distress and a more pleasant mood, abstain from alcohol and drugs during treatment, and achieve better long-term substance use outcomes[9].*

[9] Drug misuse and dependence: UK guidelines on clinical management [DOH:2017]

5.1 How services will be structured

It is our intention to procure services in two lots with the possibility of one provider bidding for both Lots 1 and 2.

- Lot 1: **Young person service** (24 years of age and under)
- Lot 2: **Adult service** (25 years of age and over) including carer support
- Lot 3: **Advocacy** (18 years and over)

It is our intention to ensure the provision of Independent advocacy for people engaging with services for people concerned by their own or someone else's use of drugs and/ or alcohol.

It is our intention, subject to approval, for these new services to be procured to commence on the 1st of July 2019 for a maximum period of 7 years (5 years with a possible extension of 2 years)

The following services will continue to be sourced through partners or other commissioning routes

- Shared care, Pharmacy needle exchange and Pharmacy based supervised consumption
- Hepatology nurse
- Social workers
- MASH worker
- Alcohol team within UHS
- YP Worker in Youth Offending Service (YOS)

APPENDIX / Further Reading

1. Human and financial cost of drug addiction: House of Commons Debate Pack Nov 2017 **Link**

2. **YP Substance Misuse Commissioning Guidance (PHE)**

Young_people_sub
stance_misuse_comr

3. **Drugs Health Needs Assessment: Southampton City Council (2017)**

Drugs needs
assessment CMT brie

4. Our Invisible Addicts - RCP **Link**

5. SCC. Drug Related Litter Report **Link**

6. **Street Based Vulnerable Adult Report**

SBVA REPORT FINAL
VERSION.pdf

Equality and Safety Impact Assessment

The **public sector Equality Duty** (Section 149 of the Equality Act) requires public bodies to have due regard to the need to eliminate discrimination, advance equality of opportunity, and foster good relations between different people carrying out their activities.

The Equality Duty supports good decision making – it encourages public bodies to be more efficient and effective by understanding how different people will be affected by their activities, so that their policies and services are appropriate and accessible to all and meet different people's needs. The Council's Equality and Safety Impact Assessment (ESIA) includes an assessment of the community safety impact assessment to comply with section 17 of the Crime and Disorder Act and will enable the council to better understand the potential impact of the budget proposals and consider mitigating action.

Name or Brief Description of Proposal	**Drug and alcohol Treatment services** The Public Health Grant has historically been used to deliver a number of contracts and services to improve health and support behaviour change. Under the Health and Social Care Act 2012, local authorities have the duty to reduce health inequalities and improve the health of their local population by ensuring that there are public health services aimed at reducing drug and alcohol misuse. The 2015/16 public health ring-fenced grant included a new condition that requires that local authority must, in using the grant, "…have regard to the need to improve the take up of, and outcomes from, its drug and alcohol misuse treatment services…" Following a strategic review of drug and alcohol treatment services in Southampton in 2018, it is proposed that drug and alcohol treatment services, for both Young Peoples and Adults continue to be commissioned and in doing so, provide an integrated drug and alcohol treatment system for Southampton which will provide drug and alcohol treatment for all age groups from 11 years old upwards.

	Expected outcomes: • Effective harm reduction provision ensuring that people with a drug and/or alcohol problem are enabled to safeguard their health and that service users are encouraged to engage fully in treatment services; • Service users are enabled to become abstinent from their substance of dependence where appropriate; • Improved numbers of service users who are successful in reliably reducing their use of drugs and/or alcohol; • Fewer service users re-presenting to treatment following discharge from services as a result of successful cessation of substance use; • Reduced re-offending: • Effective prevention work with young people; • Better utilisation of community resources; • Personalised services (choice and control) and maximising independence for those who need more specialist health/care services; • A market that is diverse, sustainable and provides quality services on an individualised basis or contract basis as necessary; • Better value for money. Many outcomes can be monitored via the National Drug Treatment Monitoring system both for Adults and Young People which reports on a monthly basis to Local Authority Public Health teams. Other outcomes can be monitored locally.
Brief Service Profile (including number of	The **Drug and Alcohol Treatment System** will provide: • Assessment, review and monitoring and case management. • Recovery planning • Clinical interventions including substitute prescribing and

customers)	general health assessments • Psycho-social interventions • Structured interventions and activities to promote structured use of time and interaction with non user groups and contacts • Peer support, mentoring and advocacy • Support for families and carers of people with substance misuse problems • Assertive outreach • Harm reduction services including needle exchange and testing advice and treatment for people at risk of contracting blood borne viruses. • Frequent attendees service • End of life care **Eligibility criteria:** Residents of Southampton City aged 11 years upwards, who are experiencing difficulties with substance misuse.
Summary of Impact and Issues	The current drug treatment system was commissioned in 2014 in accordance with national drug and alcohol strategies. **Positive Impacts identified:** The Integrated Commissioning Unit has undertaken a thorough review of all current services and believes that as a result of continuing to commission an integrated drug and alcohol substance misuse treatment system we will be able to deliver a treatment system which will enable service users to build social and recovery capital. It will also retain the variety of structured interventions available to them. As a result, the outcomes identified in section 1 will be achieved. National statistics indicate that improved treatment pathways, which enables service users to work in partnership with treatment services and to build appropriate "recovery networks" have improved outcomes, with many becoming abstinent and

	maintaining their abstinence in the long term. Peer support, mentoring and advocacy is a very important part of the service users' recovery network. This provides "visible recovery" for new service users entering treatment and is a powerful tool for re-engagement when the service user is at risk of dropping out of treatment. Peer support services provide opportunities for a wide variety of service users and ex-service users to volunteer and to build self-esteem through providing role models to others. Therefore it is vital that peer support networks represent a wide range of service user cohorts. Most importantly underrepresented groups such as Asian ethnic minorities, women and stimulant users are encouraged to take on the roles of volunteers and mentors in the new services. **Negative impacts identified**: Commissioning the entire existing treatment system could result in a degree of instability in the run up to the tendering exercise and for a period after the new contracts are awarded. Both existing staff and service users in the current system are bound to feel anxious and uncertain about their future prospects. Staff could seek alternative employment and vacancies will be difficult to fill due to the uncertainty generated by the temporary nature of existing services. This will in turn impact on the capacity of the current services. Reduced capacity of treatment services will clearly impact upon all service users. However, some of the most chaotic or those who have complex needs and who require greater support and motivational work undertaken with them in order to keep them engaged in treatment may be affected disproportionately. Groups who may fall under this category could be chaotic opiate, crack and alcohol users, those involved in offending to maintain their addiction, young people, people with mental health problems, poly drug users.

Potential Positive Impacts	Continuing to commission a single substance misuse treatment system will allow Southampton City Council to align the new system with national strategy and guidance and re-focus treatment on harm reduction, recovery and abstinence. It also offers an opportunity to test the market for new and innovative providers and to obtain best value for money by increasing service capacity. These proposals will allow treatment services to improve the number of service users, including those with protected characteristics who successfully complete treatment and who have been able to become abstinent. It will also increase the number of service users who reliably reduce their drug use during treatment. National prevalence figures tell us that there are still fewer drug users seeking treatment as a proportion of the number potentially existing in the city. An improved integrated service will make use of assertive outreach, easily accessible services, personalisation and effective communication within the community to improve the numbers of service users entering treatment. Data collected by the treatment services indicate that there are fewer Asian ethnic minorities and women accessing treatment than would be expected from the demographic profile of the city. This is an area of work that will be addressed by the new services. This will enable increased numbers from these cohorts to reliably improve their current drug use. In relation to Young People, services will continue to ensure that fewer young people drop out of treatment prior to transferring to adult services, and they will also have the capacity to work with young people in the context of their families, rather than as individuals who are seen outside of the context of their everyday lives.

Responsible Service Manager	Stephanie Ramsey
Date	11.7.18

Approved by Senior Manager	Sandra Jerrim
Signature	
Date	

Potential Impact

Impact Assessment	Details of Impact	Possible Solutions & Mitigating Actions
Age	It is more effective to provide intervention to people with substance misuse problems as early as possible whatever age they enter treatment. Current services target all adults and young people over the age of 11 years who are experiencing problems with substance misuse.	Service specifications will ensure that brief/early intervention is prioritised for both adult and YP services.
Disability	Current services target adults who are experiencing problems with substance misuse regardless of their state of health or disability.	Service specifications could specify that providers will be required to prioritise certain groups including adults with long term physical and / or mental health conditions. This will include ensuring that buildings are accessible for people with sensory and mobility needs. Substance misuse services are also increasingly dealing with older service users and will therefore need to consider how to deal with conditions specific to old age. The service specification will outline the basic requirements for working with people with learning disabilities and autism.

Gender Reassignment	Current services target adults who are experiencing problems with substance misuse whatever their gender or the diversity issues they present.	Service specifications will require providers to identify how they will ensure that services are welcoming and able to offer appropriate services to those who have undergone gender re-assignment
Marriage and Civil Partnership	People's problematic use of drugs and alcohol has a direct impact on relationships. In particular the relationship between Alcohol and Domestic Abuse is well evidenced. Both current and new drug and alcohol treatment system address the strains and difficulties caused by alcohol and drugs on relationship breakup.	The Domestic abuse Prevention Programme scheme has been working with substance misuse services to address the issues of identifying perpetrators and domestic abuse victims engaging in treatment
Pregnancy and Maternity	The drug and alcohol treatment system maintains good relationships with the Southampton maternity services and will continue to maintain opportunities to optimise health in the perinatal period. Drug and alcohol use in pregnancy are likely to lead to physical and social problems in pregnancy, still birth and low birth weight. Women who are pregnant or who have children are often reluctant to approach statutory services due to the fear of child protection proceedings. The current funding arrangements includes a post whose role is to proactively engage women in these situations.	The current service requires the provider to prioritise certain groups including pregnant women and their partners. Joint work with children and families Identified as priority area in service specification.
Race	There is no specific impact for people of a particular race. However, there is under representation of BME communities in many services in the city and adults from these communities may be more disadvantaged if they do not feel comfortable accessing treatment for cultural or community reasons.	Service specifications could require providers to prioritise certain groups including Black and Minority ethnic groups and to provide active outreach to minority ethnic communities. In addition, providers will be encouraged to show how they will ensure that their workforce will be sufficiently diverse to mirror the needs of the local

		population and optimise uptake and outcomes. This will include the recruitment of volunteers. Contract monitoring and data capture which ensures all parts of the community can access services
Religion or Belief	It is acknowledged that some religions forbid drug and alcohol use and that services therefore need to be aware and sensitive to the impact that this will have on the individual seeking treatment.	Service specifications will emphasise that providers, as well as being sensitive to the issue, open to all religions and beliefs and non-judgemental in approach, will also need to take this into account in the way that they promote their service and deliver interventions.
Sex	No specific impact.	Maximum use of personalisation/Direct Budgets and referral to community care funding where Fair Access to Care (FACS) applies. Contract monitoring and data capture which ensures all parts of the community can access services Joint work with children and families Specification to ensure gender specific issues are considered in style of provision.
Sexual Orientation	Similar issues to other groups suffering discrimination due to diversity issues and reluctance to access other mainstream services.	The current specification ensures that diversity is addressed by provider. As indicated above service specifications could also encourage providers to recruit a diverse and representative workforce.

		Maximum use of personalisation/Direct Budgets and referral to community care funding where meet the Care Act eligibility
Community Safety	Current and future drug and alcohol treatment systems are designed to deliver appropriate interventions and strategies to service users involved in the criminal justice system. This includes the provision of treatment under a Drug Rehabilitation Requirement, Alcohol Treatment Requirement and other court orders as necessary. Services have close links with criminal justice agencies and have much experience of joint working The drug and alcohol treatment system is aware of the links between alcohol and domestic violence and works with domestic abuse agencies to identify perpetrators and protect survivors of abuse. Similarly, drug and alcohol services work with the homeless and homelessness agencies, with the Vulnerable Adult Safeguarding team providing assertive outreach to vulnerable groups including sex workers.	Current service specification includes the expectation of joint work with criminal justice agencies. Data is monitored as part of quarterly monitoring.
Poverty	Unhealthy behaviours are known to cluster in populations and are a key driver of health inequalities. People who have drug and/or alcohol problems often have considerable issues around poverty which treatment addresses. Individuals on a low income and unemployed individuals are more heavily represented in problematic drug and alcohol use	Current services are required to promote the engagement of service users in structured activities in order to encourage employability following recovery. This is particularly beneficial for those who are unemployed or who have never worked.
Other Significant Impacts	There is overwhelming evidence that addressing substance misuse issues can have a major positive impact on	Service specifications will ensure that providers are required to offer holistic

	mortality and morbidity and thus reduce demand for health and care services. Unhealthy behaviours such as long term drug or alcohol use are known to cluster in populations and are a key driver of health inequalities. A reduced substance misuse treatment offer is likely to lead to higher demand on future health and social care services and may increase health inequalities.	services to address substance misuse, social issues, and physical and mental health problems.

SOUTHAMPTON CITY COUNCIL

What is a Data Protection Impact Assessment?

A Data Protection Impact Assessment ("DPIA") is a process that assists organisations in identifying and minimising the privacy risks of new projects or policies.

Projects of all sizes could impact on personal data.

The DPIA will help to ensure that potential problems are identified at an early stage, when addressing them will often be simpler and less costly.

Conducting a DPIA should benefit the Council by producing better policies and systems, and improving the relationship with individuals.

Why should I carry out a DPIA?

Carrying out an effective DPIA should benefit the people affected by a project and also the organisation carrying out the project.

Whilst not a legal requirement, it is often the most effective way to demonstrate to the Information Commissioner's Officer how personal data processing complies with data protection legislation.

A project which has been subject to a DPIA should be less privacy intrusive and therefore less likely to affect individuals in a negative way.

A DPIA should improve transparency and make it easier for individuals to understand how and why their information is being used.

When should I carry out a DPIA?

The core principles of DPIA can be applied to any project that involves the use of personal data, or to any other activity that could have an impact on the privacy of individuals.

Answering the screening questions in **Section 1** of this document should help you identify the need for a DPIA at an early stage of your project, which can then be built into your project management or other business process.

Who should carry out a DPIA?

Responsibility for conducting a DPIA should be placed at senior manager level. A DPIA has strategic significance and direct responsibility for the DPIA must, therefore, be assumed by a senior manager.

The senior manager should ensure effective management of the privacy impacts arising from the project, and avoid expensive re-work and retro-fitting of features by discovering issues early.

A senior manager can delegate responsibilities for conducting a DPIA to three alternatives:

a) An appointment within the overall project team;
b) Someone who is outside the project; or
c) An external consultant.

Each of these alternatives has its own advantages and disadvantages, and careful consideration should be given on each project as to who would be best-placed for carrying out the DPIA.

How do I carry out a DPIA?

Working through each section of this document will guide you through the DPIA process.

The requirement for a DPIA will be identified by answering the questions in **Section 1**. If a requirement has been identified, you should complete all the remaining sections in order.

The Data Protection Impact Assessment Statement in **Section 7** should be completed in all cases, and a copy of this document should be sent to the Information Lawyer (Data Protection Officer) to record and review.

The Information Lawyer (Data Protection Officer) will review the DPIA within 14 days of receipt, and a draft DPIA report will be issued within 28 days. The report will confirm whether the proposed measures to address the privacy risks identified are adequate, and make recommendations for additional measures needed.

These measures will be reviewed once in place to ensure that they are effective.

Advice can be found at the beginning of each section, but if further information or assistance is required, please contact the Information Lawyer (Data Protection Officer) on 023 8083 2676 or at information@southampton.gov.uk.

Section 1 - Screening Statements

The following statements will help you decide whether a DPIA is necessary for your project.

Please tick all that apply.

- ☑ The project will involve the collection of new information about individuals.
- ☑ The project will compel individuals to provide information about themselves.
- ☑ Information about individuals will be disclosed to organisations or people who have not previously had routine access to the information.
- ☐ You are using information about individuals for a purpose it is not currently used for, or in a way it is not currently used.
- ☐ The project involves you using new technology which might be perceived as being privacy intrusive. For example, the use of biometrics, facial recognition, or profiling.
- ☑ The project will result in you making decisions or taking action against individuals in ways which can have a significant impact on them.
- ☑ The information about individuals is of a kind particularly likely to raise privacy concerns or expectations. For example, health records, criminal records, or other information that people would consider to be particularly private.
- ☐ The project will require you to contact individuals in ways which they may find intrusive.
- ☐ The project involves making changes to the way personal information is obtained, recorded, transmitted, deleted, or held.

If any of these statements apply to your project, it is an indication that a DPIA would be a useful exercise, and you should complete the rest of the assessment, including the Data Protection Impact Assessment Statement in **Section 5**.

If none of these statements apply, it is not necessary to carry out a DPIA for your project, but you will still need to complete the Data Protection Impact Assessment Statement in **Section 5.**

Section 2 - Identifying the Need for a DPIA

Briefly explain what the project aims to achieve, what the benefits will be to the Council, to individuals, and to other parties.

The project aims to commission a new substance misuse service for Southampton, replacing an existing commissioned service, whose contract expires in July 2019. The commissioning of a new service will be driven by the findings from a review process carried out in early 2018.

Once commissioned, the new service will provide an integrated substance misuse service that will have harm reduction as the principle aim and ‘recovery’ as a desirable and achievable outcome. In Southampton, recovery is defined as 'Voluntarily - sustained control over problematic substance use which maximises health and wellbeing and participation in the rights, roles and responsibilities of society'.

Services will be tasked with improving successful completions, reducing representations whilst maintaining robust and effective harm reduction interventions to reduce drug related deaths, the incidence of blood borne virus infections and the broader harms to individuals, their friends, families and communities.

Services will work pro actively, flexibly and collaboratively with stakeholders to increase engagement of those impacted by substance use disorders. There will be 2 distinct service areas; A Young People’s substance use disorder service and an Adult substance use disorder service .

Section 3 - Describe the Information Flows

The collection, use, sharing, and deletion of personal data should be described here.

Once commissioned, the service will gather information from the individual enabling an assessment to be completed. Following assessment the information will be used to develop a care and support plan with the individual. This may entail the onward sharing of information to a range of other providers with the explicit consent of the individual except in safeguarding or other permissible circumstances.

Information will be held in accordance with the commissioned providers data protection policies, which in turn will be compliant with the terms and conditions of the contract.

Section 4 - Identifying the Privacy Risks

Answering the questions below will help identify the key privacy risks, and the associated compliance and corporate risks.

The questions cover the key data protection principles, and whilst all may not be relevant to your project, they may prompt you to consider areas of risk which aren't initially apparent.

Principle 1

Personal data shall be processed lawfully, fairly and in a transparent manner in relation to the data subject.

What personal data will be collected and/or shared?

Information about the individual will be collected, including information about their health, substance use, financial circumstances and social and family relationships pertinent to their substance misuse needs.

Information collected may include information about significant others in the individuals life, but in the context of the individual themselves. For examples any children or family members living with the service user to take into account what extent the use of substances may be having an impact on them.

With whom will the personal data be shared?

Individuals engaging with the service will asked to complete a permission to share form, which will set out the agencies and individuals with whom their information can be shared. The collection and sharing of information will be compliant with the terms and condition of the contract awarded to the provider by the city council.

Information, via the permission to share protocol are likely to be health professionals (GP's community nurses, hospital staff), agencies within the criminal justice system (probation, police) and local community providers (e.g activities, counseling)

How will individuals be told about the use of their personal data?

Individuals will be informed during their first engagement with the service and subsequent reviews or assements, whether face to face or over the telephone. The permission to share form will be the responsibility of the commissioned provider, but will be compliant with the requirements set out in the terms and conditions of the contract.

Conditions for processing

For all data (tick all that apply):

- [x] The data subject has given consent to the processing.
- [x] The processing is necessary for the performance of a contract to which the data subject is party or in order to take steps at the request of the data subject prior to entering into a contract.
- [x] The processing is necessary for compliance with a legal obligation to which the Council is subject.
- [ ] The processing is necessary for the performance of a task carried out in the public interest or in the exercise of official authority vested in the Council.

Does your project involves the processing of the following?

Tick all that apply:

- [x] data revealing racial or ethnic origin
- [ ] political opinions
- [ ] religious or philosophical beliefs
- [ ] trade-union membership
- [ ] genetic data or biometric data for the purpose of uniquely identifying a natural person
- [x] data concerning health
- [x] data concerning a natural person's sex life or sexual orientation

If so, which of the following apply?

- [x] The data subject has given explicit consent to the processing.
- [ ] The processing is necessary for the purposes of carrying out the obligations and exercising specific rights of the Council or of the data subject in the field of employment and social security and social protection law.
- [ ] The processing is necessary for the establishment, exercise, or defence of legal claims, or whenever courts are acting in their judicial capacity.
- [ ] The processing is necessary for reasons of substantial public interest.
- [ ] The processing is necessary for the purposes of preventive or occupational medicine, for the assessment of the working capacity of the employee, medical diagnosis, the provision of health or social care or treatment or the management of health or social care systems and services.
- [x] The processing is necessary for reasons of public interest in the area of public health, such as protecting against serious cross-border threats to health or ensuring high standards of quality and safety of health care and of medicinal products or medical devices.
- [ ] The processing is necessary for archiving purposes in the public interest, scientific or historical research purposes or statistical purposes.

If you are relying on consent to process personal data, how will this be collected and recorded?

Individuals will be asked to complete a permission to share agreement at the point of engagement with the service and at regular intervals thereafter, but no less than annually.

What will you do if consent is withheld or withdrawn? How will this be recorded?

Consent may be withheld in regards to specifc areas of information, for example financial circumstances, or restrictions placed on who the information can be shared with, for example local voluntary agencies. This will be recored and complied with by staff providing the service. However, as a service offering treatment that is integral to a number of health, social and criminal justice service, it will be necessary for individuals to agree to information being shared with a number of

Can an alternative condition for processing (see page 7) be used instead of consent? If yes, please provide details. See conditions on page 6 for options.

No

How will individuals be informed at the point of collection about how their personal data will be used?

Individuals will be asked to complete and sign a permission to share agreement at the point of engagement with the service and at regular intervals thereafter, but no less than annually. When asking the individual to sign the permission to share they will be informed about how their personal data will be used.

Will any personal data be published on the Internet or in other media? If yes, please provide details.

No

Will a third party contractor be processing the personal data on our behalf, or involved at any stage in the data processing process?

The information will be collected and held by an external provider on award of contract. The handling, storage and use of information will need to be compliant with the requirements set out in the terms and conditions of the contract. Discussions about data protection form part of quarterly contract meetings and breaches are notified to commissioners.

Principle 2

Personal data shall be collected for specified, explicit, and legitimate purposes, and not further processed in a manner that is incompatible with those purposes.

Do you envisage using the personal data for any other purpose in the future? If so, please provide details.

No additional use of data (that has not been covered in the permission to share arrangements) anticipated.

Principle 3

Personal data shall be adequate, relevant, and limited to what is necessary in relation to the purposes for which they are processed.

Are you satisfied that the personal data processed is of good enough quality for the purposes proposed? If not, why not?

The handling, storage and use of information will need to be compliant with the requirements set out in the terms and conditions of the contract. Within Substance Misuse services a considerable amount of data is collected in response to government requirements (National Drug Treatment Monitoring System - NDTMS), which has a robust data protection framework.

Is there any personal data that you could not use, without compromising the needs of the project? If yes, please provide details.

All data collected is proportionate and relevant to the service being provided.

How will you ensure that only personal data that is adequate, relevant, and not excessive in relation to the purpose for which it is processed?

The handling, storage and use of information will need to be compliant with the requirements set out in the terms and conditions of the contract. The terms and conditions of the contract clearly sets out the requirements to be compliant with data protection laws, including ensuring that only personal data that is adequate, relevant, and not excessive in relation to the purpose for which it is processed is collected.

Principle 4

Personal data shall be accurate and, where necessary, kept up to date.

Are you able to update and amend personal data when necessary, after it has been collected and recorded? Please provide details.

Individuals will be asked to complete and sign a permission to share agreement at the point of engagement with the service and at regular intervals thereafter, but no less than annually. When asking the individual to sign the permission to share they will be informed about how their personal data will be used.

How will you ensure that personal data obtained from individuals or other organisations is accurate?

Individuals are offered a copy of their care plan to sign. This is an opportunity for the provider to check all personal data obtained from individuals or other organisation is accurate.

Principle 5

Personal data shall be kept in a form which permits identification of data subjects for no longer than is necessary for the purposes for which the personal data are processed.

What retention periods are suitable for the personal data you will be processing?

Retention periods will be set by the providers own data protection policies, but will be, at a minimum compliant with relevant legislation as set out in the terms and conditions of the contract.

How will you ensure the personal data is deleted in line with your retention periods?

Retention periods will be set by the providers own data protection policies but will be, at a minimum compliant, with relevant legislation as set out in the terms and conditions of the contract.

What processes will be put in place for the destruction of the personal data?

The destruction of personal data will be set by the providers own data protection policies, but will be, at a minimum compliant with relevant legislation as set out in the terms and conditions of the contract.

Principle 6

Personal data shall be processed in accordance with the rights of data subjects under this Act.

If an individual requested a copy of the personal data held about them, detail how this would be provided to them.

Access to files will be set out in the providers own policies and procedures but will be, at a minimum compliant, with relevant legislation as set out in the terms and conditions of the contract.

If the project involves marketing, have you got a procedure for individuals to opt out of their personal data being used for that purpose?

The provider will have this in place.

Principle 7

Personal data shall be processed in a manner that ensures appropriate security of the personal data, including protection against unauthorised or unlawful processing and against accidental loss, destruction or damage, using appropriate technical or organisational measures.

Where, and in what format, will the personal data be kept?

Personal data will held by the providers. Storage will be, at a minimum compliant, with relevant legislation as set out in the terms and conditions of the contract. Providers will hold electronic and paper files to support the delivery of substance misuse services.

Will an IT system or application be used to process the personal data? Please provide details.

Providers will hold electronic and paper files to support the delivery of substance misuse services. A number of IT systems or applications are available to providers. The specific system will be secured by the provider once the contract is awarded. IT systems will need to reflect the requirements as set out in the service specification.

How will this system provide protection against security risks to the personal data?

Security of information and protection of risks to personal data will be, at a minimum compliant, with relevant legislation as set out in the terms and conditions of the contract.

What training and instructions are necessary to ensure that staff know how to operate the system securely?

These requirements are set out in the terms and conditions of the contract. Staff training is monitored during quarterly contract monitoring meetings.

Will staff ever process the personal data away from the office (e.g. via paper files, on laptops, tablets, or smart phones)? If so, please provide details.

Yes. The handling of data taken away from the office will be managed in line with data protection legislation. As with the handling and holding of personal information, personal data that is taen away from the office will be, at a minimum compliant, with relevant legislation as set out in the terms and conditions of the contract.

How will access to the personal data be controlled?

Access to personal data will be by the provider and in accordance with their data protection policies. Compliance with data protection legislation form a part of the contract terms and conditions.

Principle 8

Personal data shall not be transferred to a country or territory outside the European Economic Area (EEA) unless that country of territory ensures and adequate level of protection for the rights and freedoms of data subjects in relation to the processing of personal data.

Will the project require you to transfer personal data outside of the EEA? If yes, please provide details.

No

If you will be making transfers, how will you ensure that the personal data is adequately protected?

N/A

If a contractor is being used to process the personal data, where are they (and their data stores) based?

The provider will be responsible for ensuring any personal data retained is held securely by themselves or other agencies.

Section 5 - Data Protection Impact Assessment Statement

This statement must be completed for all projects, regardless of whether a DPIA was deemed to be necessary on completion of the screening questions in Section 1.

Name:

Sandra Jerrim

Position:

Senior Commissioner

Project Summary:

To commission a new Substance misuse service for young people and adults.

Estimated date of project completion:

July 2019 (when new commissioned services commence)

Please choose one of the following options:

- ◯ None of the screening statements in Section 1 of this document apply to the above project, and I have determined that it is not necessary to conduct a Data Protection Impact Assessment.
- ◉ Some of the screening statements in Section 1 of this document apply to the above project, and a need to carry out a Data Protection Impact Assessment was identified. The assessment has been carried out, and the outcomes will be integrated into the project plan to be developed and implemented.

Date:

23.07.2018

Once completed, please send a copy of this document to Corporate Legal.

Email: information@southampton.gov.uk

Internal post: Corporate Legal, Civic Centre, Municipal, Ground Floor West

Document Information

Title: Data Protection Impact Assessment

Author: Chris Thornton, Senior Legal Assistant (Information)

Version: v2.7

Owner: Information Governance Board on behalf of the Council's Management Team

Agreed by: Information Governance Board on behalf of the Council's Management Team

Effective from: 31st January 2017

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10/03/15 - Version 2.0 - Reviser: Chris Thornton - Updated to PDF form format

17/07/15 - Version 2.1 - Reviser: Chris Thornton - Added information re report in introduction

14/01/16 - Version 2.2 - Reviser: Chris Thornton - Added screening question

27/01/16 - Version 2.3 - Reviser: Chris Thornton - Added project completion date to S7

24/01/16 - Version 2.4 - Reviser: Chris Thornton - Added service level for issuing reports

29/04/16 - Version 2.5 - Reviser: Chris Thornton - Removed sections 5 and 6, and revised questions

22/02/17 - Version 2.6 - Reviser: Chris Thornton - Changed wording to reflect GDPR

26/05/17 - Version 2.7 - Reviser: Chris Thornton - Changes made to consent to reflect GDPR

Equality and Safety Impact Assessment

The **public sector Equality Duty** (Section 149 of the Equality Act) requires public bodies to have due regard to the need to eliminate discrimination, advance equality of opportunity, and foster good relations between different people carrying out their activities.

The Equality Duty supports good decision making – it encourages public bodies to be more efficient and effective by understanding how different people will be affected by their activities, so that their policies and services are appropriate and accessible to all and meet different people's needs. The Council's Equality and Safety Impact Assessment (ESIA) includes an assessment of the community safety impact assessment to comply with section 17 of the Crime and Disorder Act and will enable the council to better understand the potential impact of the budget proposals and consider mitigating action.

Name or Brief Description of Proposal	Draft Home to School Transport and Post-16 Travel Arrangements Policy
Brief Service Profile (including number of customers)	The Education Act 1996 places a statutory duty on local authorities relating to the arrangement of suitable transport assistance for children of compulsory school age. The Education Act 1996 requires that transport assistance is provided to children who meet the following criteria: • Children in Year R to 8 years old who live at least 2 miles from their catchment school • Children aged 8 years old to 16 years old who live at least 3 miles from their catchment school • Children over the age of 8 who live between 2 and 6 miles from their catchment school and meet the means testing criteria • Children with a Special Educational Needs and/or disability/EHCP • Children who attend an educational setting based on religious preference, providing they meet the distance criteria • Children who live under the statutory walking distance but whose walking route to school is deemed unsafe. There is no legal requirement to provide transport assistance to Early Years children or Post-16 students.

	However, since May 2014, local authorities have had to adhere to the statutory guidance on Post-16 Transport, as well as taking into account the Equalities Act 2010 when it provides information for post-16 students on how to access transport assistance. This includes: • Transport arrangements or financial assistance necessary to facilitate young people's access to further education and training • Young people having the choice of different education and training providers, as well as the course that they wish to study • The length of journey from their home to their educational or training provision • Attention to families who are on low incomes and require support in order to access education and training • Specific consideration of young people who have Special Educational needs and/or Disabilities. Currently, Southampton City Council supports 800 children and young people with transport assistance. This includes 627 children and young people with an EHCP, which is expected to rise in line with increasing numbers of children with EHCPs. The average cost per child and young person is £4,450.
Summary of Impact and Issues	The draft Home to School Transport and Post-16 Travel Arrangements Policy 2019/20 updates the previous policy, and provides a clearer document that will enable service users to better understand Southampton City Council's travel assistance offer and any assistance that they may be entitled to. In addition there are a number proposed changes to specific policy provisions: Early years (The Cedar School, Rosewood Free School and Early Learning Group) It is proposed to align the policy with statutory guidance so that children attending nurseries or other Early Years settings will not receive transport assistance if they are under the statutory school age. The new policy proposal will remove the automatic entitlement to transport assistance to all children attending Rosewood and Cedar Special Schools, and the Early Learning Group, from the ages of 2 if the placement is agreed by the local authority. Children of statutory age attending Rosewood and Cedar Special Schools are likely to have travel needs associated with their Special Educational Needs and/or Disability and therefore will receive travel assistance under the SEND

	eligibility criteria. Children under statutory school be will be able to apply for travel assistance under the exceptional circumstances criteria where SEND needs will be taken into account. For a small number of families, this policy change could result in the withdrawal of transport where they currently receive it. High level assessments suggest this will effect very few families, and children who need transport because of their Special Educational Need and/or Disability will be assessed for transport assistance. However, children who live within walking distance to their education placement without a physical impairment could lose transport assistance. Post 16: Previously, transport assistance was provided to young people with SEND to the nearest college or school with a sixth form offering an appropriate course. The amendment to the new policy will no longer offer free transport assistance for post-16 student. Instead, transport assistance will be available to eligible students aged between the ages of 16 and 18, but will be subject to a flat rate contributory charge: • £600 per annum, payable in 3 termly instalments of £200 • £495 per annum, payable in 3 termly instalments of £165 for young people whose families meet the low income criteria set out in the policy. Southampton City Council is also committing to resourcing two additional independent travel trainers. Students from Year 9 plus will be identified for the suitability of this scheme which will enable young people to develop the skills to travel independently. The impact of this policy change will mean that 110 young people who currently receive free transport provision will no longer do so. Instead, families will have to pay a contribution towards the cost of the transport provision. This could have a negative impact upon families who could not afford the cost of transport, and could have a negative effect on the attendance level of young people at college/sixth form. However, low income families may be assisted with transport assistance if they meet the exceptional circumstances criteria, which should assist the poorest families. Independent travel training:

	Independent travel training is referred to in the current policy, but it is not highlighted as a preferred option to be considered for all children and young people where appropriate. The proposed policy 2019/20 explicitly references the expectation of engagement with independent travel training from year 9 plus for children and young people who are assessed through EHC Annual Review processes to achieve this skill, leading to positive outcomes. This will require additional resources to be put in place to support independent travel training, but will mean that more young people can travel independently aged 16+.
Potential Positive Impacts	The proposals seek to clarify in a more understandable format who is entitled to local authority funded transport assistance as set out in the statutory guidance. There is increasing demand on the service, with 3.4% of statutory school aged children in Southampton with an EHC Plan, against a backdrop of 2.9% nationally. Additionally, the rate of statutory school aged children with an EHC Plan is rising at a rate of 4.8% annually, increasing the overall cost of delivering the service. These proposals will ensure that Southampton City Council is able to effectively provide transport assistance for the most vulnerable children and young people in the city, both now and in the future.
Responsible Service Manager	Tammy Marks - Service Manager: Special Educational Needs and Disabilities
Date	16/08/2018

Approved by Senior Manager	Felicity Ridgway
Signature	
Date	20/08/2018

Potential Impact

Impact Assessment	Details of Impact	Possible Solutions & Mitigating Actions
Age	The service users of Home to School Transport are between the ages of 2 and 18. Transport assistance will be provided in line with local authorities' statutory duty. The main impact will be on children and young people outside of the statutory school age. These are children under the age of 5 (early years), and young people between the age of 16 and 19. For children of statutory school age, the policy will remain the same as previous, with clarification in line with the legislation that the distance criteria is based on age and not school year. <u>Early Years:</u> Children under statutory school age attending Early Years provision will no longer be considered eligible for travel assistance, except in exceptional circumstances. The policy no longer provides for automatic entitlement to travel assistance for children attending Rosewood or Cedar Schools or Early Learning Group under statutory school age. This may affect up to 23 children currently receiving travel assistance to an Early Years setting. <u>Post-16</u>	Children attending Early Years provision may be eligible for help under the 'Exceptional Circumstances Criteria'. Children attending Rosewood or Cedar Schools, are likely to have travel needs associated with SEND, they will therefore continue receive transport assistance on the basis of exceptional need.

	The provision of free transport assistance for post-16 students up to the age of 19 will no longer be offered under the new policy. Transport assistance will still be available to eligible students aged between the ages of 16 and 19, but will be subject to a flat rate contributory charge: • £600 per annum, payable in 3 termly instalments of £200. • £495 per annum payable in 3 termly instalments of £165 for students whose families meet the low income criteria set out in the policy. This will impact up to 110 young people currently receiving free travel assistance.	Families of young people aged between 16 and 19 who are unable to meet the cost of travel assistance, or who experience other hardship or exceptional circumstances, may qualify for additional assistance up to the total cost of travel assistance.
Disability	The new policy aims to provide greater clarity on eligibility for children and young people with SEND. Where a child lives within walking distance of the nearest qualifying school (or designated school if it is not the nearest) but the route to school relies on parent/carer with a disability accompanying that child for it to be considered safe, and the parent/carer's disability prevents them from doing so, the child will be eligible for transport free of charge. This will be determined on a case by case basis, with medical evidence of the parent's disability being confirmed. <u>Early Years:</u> The new policy proposal will remove the automatic	N/A – positive impact N/A – no change to policy or provision All children of statutory school age attending

	entitlement to transport assistance to all children attending Rosewood and Cedar Special Schools, and children attending the Early Learning Group, from between the age of 2 and statutory school age. Up to 23 families could be affected in the first year. It is impossible to predict the future numbers as this will depend on the needs of the children and young people admitted, as well as their distance from school, age and the circumstances of the family.	Rosewood or Cedar Schools will have their needs assessed for the provision of home to school travel assistance as part of their ECHP. Children, including those outside statutory school age, who do not have an EHCP may be eligible for travel assistance under Exceptional Circumstances Criteria. Where the application is in relation to a disability an assessment will be undertaken to understand the individual's travel support needs.
Gender Reassignment	No identified impacts	N/A
Marriage and Civil Partnership	No identified impacts	N/A
Pregnancy and Maternity	Where pregnancy or maternity impacts a parent or carer's ability to support their child's transport to and from school, they may be eligible for travel assistance under the Exceptional Circumstances Criteria.	N/A
Race	No identified impacts	N/A
Religion or Belief	Children will be eligible for free transport under 'extended rights' where the pupil is entitled to free schools meals the school is between 2 and 15 miles and is the nearest school preferred on the grounds of religion or belief (aged 11-16).	N/A – no change to policy or provision
Sex	As of August 2018 there are more male children and young people eligible for travel assistance under the SEND entitlement provisions with 4	Although a greater number of male children and young people may be affected based on currently usage, the proposed changes do

	males with an EHCP, for every 1 female with an EHCP. Therefore, it is anticipated that more male children and young people will be affected by the proposed policy changes than females.	not offer different provisions based on sex or gender, and the proportions of individuals impacted will depend on current need.
Sexual Orientation	No identified impacts	N/A
Community Safety	No identified impacts	N/A
Poverty	The introduction of an annual charge for transport assistance for young people aged 16 to 19 may have negative financial impacts for families in this group. This will affect up to 110 young persons in the first year of the new policy being implemented.	Families of young people aged between 16 and 19 who are unable to meet the cost of travel assistance, or who experience other hardship or exceptional circumstances, may qualify for additional assistance up to the total cost of travel assistance.
Health & Wellbeing	No identified impacts	N/A
Other Significant Impacts	No identified impacts	N/A

SOUTHAMPTON CITY COUNCIL

What is a Data Protection Impact Assessment?

A Data Protection Impact Assessment ("DPIA") is a process that assists organisations in identifying and minimising the privacy risks of new projects or policies.

Projects of all sizes could impact on personal data.

The DPIA will help to ensure that potential problems are identified at an early stage, when addressing them will often be simpler and less costly.

Conducting a DPIA should benefit the Council by producing better policies and systems, and improving the relationship with individuals.

Why should I carry out a DPIA?

Carrying out an effective DPIA should benefit the people affected by a project and also the organisation carrying out the project.

Whilst not a legal requirement, it is often the most effective way to demonstrate to the Information Commissioner's Officer how personal data processing complies with data protection legislation.

A project which has been subject to a DPIA should be less privacy intrusive and therefore less likely to affect individuals in a negative way.

A DPIA should improve transparency and make it easier for individuals to understand how and why their information is being used.

When should I carry out a DPIA?

The core principles of DPIA can be applied to any project that involves the use of personal data, or to any other activity that could have an impact on the privacy of individuals.

Answering the screening questions in **Section 1** of this document should help you identify the need for a DPIA at an early stage of your project, which can then be built into your project management or other business process.

Who should carry out a DPIA?

Responsibility for conducting a DPIA should be placed at senior manager level. A DPIA has strategic significance and direct responsibility for the DPIA must, therefore, be assumed by a senior manager.

The senior manager should ensure effective management of the privacy impacts arising from the project, and avoid expensive re-work and retro-fitting of features by discovering issues early.

A senior manager can delegate responsibilities for conducting a DPIA to three alternatives:

a) An appointment within the overall project team;
b) Someone who is outside the project; or
c) An external consultant.

Each of these alternatives has its own advantages and disadvantages, and careful consideration should be given on each project as to who would be best-placed for carrying out the DPIA.

How do I carry out a DPIA?

Working through each section of this document will guide you through the DPIA process.

The requirement for a DPIA will be identified by answering the questions in **Section 1**. If a requirement has been identified, you should complete all the remaining sections in order.

The Data Protection Impact Assessment Statement in **Section 7** should be completed in all cases, and a copy of this document should be sent to the Information Lawyer (Data Protection Officer) to record and review.

The Information Lawyer (Data Protection Officer) will review the DPIA within 14 days of receipt, and a draft DPIA report will be issued within 28 days. The report will confirm whether the proposed measures to address the privacy risks identified are adequate, and make recommendations for additional measures needed.

These measures will be reviewed once in place to ensure that they are effective.

Advice can be found at the beginning of each section, but if further information or assistance is required, please contact the Information Lawyer (Data Protection Officer) on 023 8083 2676 or at information@southampton.gov.uk.

Section 1 - Screening Statements

The following statements will help you decide whether a DPIA is necessary for your project.

Please tick all that apply.

- ☐ The project will involve the collection of new information about individuals.
- ☐ The project will compel individuals to provide information about themselves.
- ☐ Information about individuals will be disclosed to organisations or people who have not previously had routine access to the information.
- ☐ You are using information about individuals for a purpose it is not currently used for, or in a way it is not currently used.
- ☐ The project involves you using new technology which might be perceived as being privacy intrusive. For example, the use of biometrics, facial recognition, or profiling.
- ☐ The project will result in you making decisions or taking action against individuals in ways which can have a significant impact on them.
- ☐ The information about individuals is of a kind particularly likely to raise privacy concerns or expectations. For example, health records, criminal records, or other information that people would consider to be particularly private.
- ☐ The project will require you to contact individuals in ways which they may find intrusive.
- ☐ The project involves making changes to the way personal information is obtained, recorded, transmitted, deleted, or held.

If any of these statements apply to your project, it is an indication that a DPIA would be a useful exercise, and you should complete the rest of the assessment, including the Data Protection Impact Assessment Statement in **Section 5**.

If none of these statements apply, it is not necessary to carry out a DPIA for your project, but you will still need to complete the Data Protection Impact Assessment Statement in **Section 5.**

Section 2 - Identifying the Need for a DPIA

Briefly explain what the project aims to achieve, what the benefits will be to the Council, to individuals, and to other parties.

Section 3 - Describe the Information Flows

The collection, use, sharing, and deletion of personal data should be described here.

Section 4 - Identifying the Privacy Risks

Answering the questions below will help identify the key privacy risks, and the associated compliance and corporate risks.

The questions cover the key data protection principles, and whilst all may not be relevant to your project, they may prompt you to consider areas of risk which aren't initially apparent.

Principle 1

Personal data shall be processed lawfully, fairly and in a transparent manner in relation to the data subject.

What personal data will be collected and/or shared?

With whom will the personal data be shared?

How will individuals be told about the use of their personal data?

Conditions for processing

For all data (tick all that apply):

- ☐ The data subject has given consent to the processing.
- ☐ The processing is necessary for the performance of a contract to which the data subject is party or in order to take steps at the request of the data subject prior to entering into a contract.
- ☐ The processing is necessary for compliance with a legal obligation to which the Council is subject.
- ☐ The processing is necessary for the performance of a task carried out in the public interest or in the exercise of official authority vested in the Council.

Does your project involves the processing of the following?

Tick all that apply:

- ☐ data revealing racial or ethnic origin
- ☐ political opinions
- ☐ religious or philosophical beliefs
- ☐ trade-union membership
- ☐ genetic data or biometric data for the purpose of uniquely identifying a natural person
- ☐ data concerning health
- ☐ data concerning a natural person's sex life or sexual orientation

If so, which of the following apply?

- ☐ The data subject has given explicit consent to the processing.
- ☐ The processing is necessary for the purposes of carrying out the obligations and exercising specific rights of the Council or of the data subject in the field of employment and social security and social protection law.
- ☐ The processing is necessary for the establishment, exercise, or defence of legal claims, or whenever courts are acting in their judicial capacity.
- ☐ The processing is necessary for reasons of substantial public interest.
- ☐ The processing is necessary for the purposes of preventive or occupational medicine, for the assessment of the working capacity of the employee, medical diagnosis, the provision of health or social care or treatment or the management of health or social care systems and services.
- ☐ The processing is necessary for reasons of public interest in the area of public health, such as protecting against serious cross-border threats to health or ensuring high standards of quality and safety of health care and of medicinal products or medical devices.
- ☐ The processing is necessary for archiving purposes in the public interest, scientific or historical research purposes or statistical purposes.

If you are relying on consent to process personal data, how will this be collected and recorded?

What will you do if consent is withheld or withdrawn? How will this be recorded?

Can an alternative condition for processing (see page 7) be used instead of consent? If yes, please provide details. See conditions on page 6 for options.

How will individuals be informed at the point of collection about how their personal data will be used?

Will any personal data be published on the Internet or in other media? If yes, please provide details.

Will a third party contractor be processing the personal data on our behalf, or involved at any stage in the data processing process?

Principle 2

Personal data shall be collected for specified, explicit, and legitimate purposes, and not further processed in a manner that is incompatible with those purposes.

Do you envisage using the personal data for any other purpose in the future? If so, please provide details.

Principle 3

Personal data shall be adequate, relevant, and limited to what is necessary in relation to the purposes for which they are processed.

Are you satisfied that the personal data processed is of good enough quality for the purposes proposed? If not, why not?

Is there any personal data that you could not use, without compromising the needs of the project? If yes, please provide details.

How will you ensure that only personal data that is adequate, relevant, and not excessive in relation to the purpose for which it is processed?

Principle 4

Personal data shall be accurate and, where necessary, kept up to date.

Are you able to update and amend personal data when necessary, after it has been collected and recorded? Please provide details.

How will you ensure that personal data obtained from individuals or other organisations is accurate?

Principle 5

Personal data shall be kept in a form which permits identification of data subjects for no longer than is necessary for the purposes for which the personal data are processed.

What retention periods are suitable for the personal data you will be processing?

How will you ensure the personal data is deleted in line with your retention periods?

What processes will be put in place for the destruction of the personal data?

Principle 6

Personal data shall be processed in accordance with the rights of data subjects under this Act.

If an individual requested a copy of the personal data held about them, detail how this would be provided to them.

If the project involves marketing, have you got a procedure for individuals to opt out of their personal data being used for that purpose?

Principle 7

Personal data shall be processed in a manner that ensures appropriate security of the personal data, including protection against unauthorised or unlawful processing and against accidental loss, destruction or damage, using appropriate technical or organisational measures.

Where, and in what format, will the personal data be kept?

Will an IT system or application be used to process the personal data? Please provide details.

How will this system provide protection against security risks to the personal data?

What training and instructions are necessary to ensure that staff know how to operate the system securely?

Will staff ever process the personal data away from the office (e.g. via paper files, on laptops, tablets, or smart phones)? If so, please provide details.

How will access to the personal data be controlled?

Principle 8

Personal data shall not be transferred to a country or territory outside the European Economic Area (EEA) unless that country of territory ensures and adequate level of protection for the rights and freedoms of data subjects in relation to the processing of personal data.

Will the project require you to transfer personal data outside of the EEA? If yes, please provide details.

If you will be making transfers, how will you ensure that the personal data is adequately protected?

If a contractor is being used to process the personal data, where are they (and their data stores) based?

Section 5 - Data Protection Impact Assessment Statement

This statement must be completed for all projects, regardless of whether a DPIA was deemed to be necessary on completion of the screening questions in Section 1.

Name:

Felicity Ridgway

Position:

Service Lead - Policy, Partnerships and Strategic Planning

Project Summary:

Launch of Home to School Transport & Post-16 Travel Arrangements Policy Consultation

Estimated date of project completion:

18th December 2018

Please choose one of the following options:

- (●) None of the screening statements in Section 1 of this document apply to the above project, and I have determined that it is not necessary to conduct a Data Protection Impact Assessment.
- ( ) Some of the screening statements in Section 1 of this document apply to the above project, and a need to carry out a Data Protection Impact Assessment was identified. The assessment has been carried out, and the outcomes will be integrated into the project plan to be developed and implemented.

Date:

20th August 2018

Once completed, please send a copy of this document to Corporate Legal.

Email: information@southampton.gov.uk

Internal post: Corporate Legal, Civic Centre, Municipal, Ground Floor West

Document Information

Title: Data Protection Impact Assessment

Author: Chris Thornton, Senior Legal Assistant (Information)

Version: v2.7

Owner: Information Governance Board on behalf of the Council's Management Team

Agreed by: Information Governance Board on behalf of the Council's Management Team

Effective from: 31st January 2017

Review Date: 31st January 2018

Revision History:

06/12/13 - Version 1.0 - Reviser: Vikas Gupta - Document Created

10/03/15 - Version 2.0 - Reviser: Chris Thornton - Updated to PDF form format

17/07/15 - Version 2.1 - Reviser: Chris Thornton - Added information re report in introduction

14/01/16 - Version 2.2 - Reviser: Chris Thornton - Added screening question

27/01/16 - Version 2.3 - Reviser: Chris Thornton - Added project completion date to S7

24/01/16 - Version 2.4 - Reviser: Chris Thornton - Added service level for issuing reports

29/04/16 - Version 2.5 - Reviser: Chris Thornton - Removed sections 5 and 6, and revised questions

22/02/17 - Version 2.6 - Reviser: Chris Thornton - Changed wording to reflect GDPR

26/05/17 - Version 2.7 - Reviser: Chris Thornton - Changes made to consent to reflect GDPR

SOUTHAMPTON CITY COUNCIL

Equality and Safety Impact Assessment

The **Public Sector Equality Duty** (Section 149 of the Equality Act) requires public bodies to have due regard to the need to eliminate discrimination, advance equality of opportunity, and foster good relations between different people carrying out their activities.

The Equality Duty supports good decision making – it encourages public bodies to be more efficient and effective by understanding how different people will be affected by their activities, so that their policies and services are appropriate and accessible to all and meet different people's needs. The Council's Equality and Safety Impact Assessment (ESIA) includes an assessment of the community safety impact assessment to comply with Section 17 of the Crime and Disorder Act and will enable the Council to better understand the potential impact of proposals and consider mitigating action.

Name or Brief Description of Proposal	Land Quality Strategy 2018-2023
Brief Service Profile (including number of customers)	
The Council has a statutory responsibility to continually inspect its area for land contamination and document how in intends to undertake that process in an 'Inspection Strategy'. Where significant contamination is identified the land must be remediated to prevent further harm. SCC's Land Quality Strategy 2018-2023 has been published to demonstrate how it will deliver its duties under Part IIA of the Environmental Protection Act 1990 (Part IIA) in the absence of central government funding. As well as fulfilling the responsibility to provide an "Inspection Strategy" it also details the Councils wider role in managing and maintaining confidence in the quality of land in the City.	
Summary of Impact and Issues	
The proposed land quality strategy aims to achieve statutory compliance by inspecting the land in its area and where appropriate ensure land is suitable for its current use. This means that residents will be less likely to be exposed to potentially harmful contaminants in, on or underground and will therefore see health in those areas affected by land contamination.	
Potential Positive Impacts	
• Improve confidence in the city's land quality. • Reduce the potential for land contamination to negatively impact human health and the wider environment. • Ensure the council achieves full legal compliance with Part IIA.	
Responsible Service Manager	Steve Guppy
Date	11/06/2018
Approved by	Mitch Sanders, Service Director – Transaction and

Senior Manager	Universal Services
Date	

Potential Impact

Impact Assessment	Details of Impact	Possible Solutions & Mitigating Actions
Age	Children aged 0-6 are considered those most at risk to the effects of land contamination. Implementation of the strategy will reduce the potential for children to be exposed to potentially harmful land.	N/A – positive impact
Disability	No impact	
Gender Reassignment	No impact	
Marriage and Civil Partnership	No impact	
Pregnancy and Maternity	Pregnant mothers and unborn children are sensitive to the effects of land contamination. Implementation of the strategy will reduce the potential for pregnant mothers to be exposed potentially harmful land and therefore reducing the potential for birth defects.	N/A – positive impact
Race	22.3% of the Southampton population are non-White British, including 14% which are residents from Black or Minority Ethnic backgrounds. Citywide improvements in land quality will also mean all ethnic groups across the city will experience positive health benefits.	N/A – positive impact
Religion or Belief	No impact	
Sex	No impact	
Sexual Orientation	No impact	
Community	No impact	

Impact Assessment	Details of Impact	Possible Solutions & Mitigating Actions
Safety		
Poverty	By determining land as 'contaminated land' the appropriate person will be required to fund remediation. Remediation costs could be significant depending on the level and type of contamination.	We will only look to recover the cost of remediation where doing so will not cause undue hardship
Health & Wellbeing	Health impacts associated age and pregnancy and maternity are previously discussed.	
	Wellbeing Determining land as contaminated land could increase stress levels to those who are either responsible for the remediation of the land and/or the owner/occupiers due to the financial implications and potential for property blight.	**Wellbeing** A communication strategy will ensure that accurate and clearly reported across all relevant groups. Costs will only be recovered where appropriate, Where there is evidence that cost recovery would cause undue hardship, the council will consider each matter on a case by case basis.
Other Significant Impacts		

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SOUTHAMPTON CITY COUNCIL

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Why should I carry out a DPIA?

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Whilst not a legal requirement, it is often the most effective way to demonstrate to the Information Commissioner's Officer how personal data processing complies with data protection legislation.

A project which has been subject to a DPIA should be less privacy intrusive and therefore less likely to affect individuals in a negative way.

A DPIA should improve transparency and make it easier for individuals to understand how and why their information is being used.

When should I carry out a DPIA?

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Who should carry out a DPIA?

Responsibility for conducting a DPIA should be placed at senior manager level. A DPIA has strategic significance and direct responsibility for the DPIA must, therefore, be assumed by a senior manager.

The senior manager should ensure effective management of the privacy impacts arising from the project, and avoid expensive re-work and retro-fitting of features by discovering issues early.

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a) An appointment within the overall project team;
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How do I carry out a DPIA?

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Section 1 - Screening Statements

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- ☑ The project will compel individuals to provide information about themselves.
- ☐ Information about individuals will be disclosed to organisations or people who have not previously had routine access to the information.
- ☐ You are using information about individuals for a purpose it is not currently used for, or in a way it is not currently used.
- ☐ The project involves you using new technology which might be perceived as being privacy intrusive. For example, the use of biometrics, facial recognition, or profiling.
- ☑ The project will result in you making decisions or taking action against individuals in ways which can have a significant impact on them.
- ☐ The information about individuals is of a kind particularly likely to raise privacy concerns or expectations. For example, health records, criminal records, or other information that people would consider to be particularly private.
- ☑ The project will require you to contact individuals in ways which they may find intrusive.
- ☐ The project involves making changes to the way personal information is obtained, recorded, transmitted, deleted, or held.

If any of these statements apply to your project, it is an indication that a DPIA would be a useful exercise, and you should complete the rest of the assessment, including the Data Protection Impact Assessment Statement in **Section 5**.

If none of these statements apply, it is not necessary to carry out a DPIA for your project, but you will still need to complete the Data Protection Impact Assessment Statement in **Section 5.**

Section 2 - Identifying the Need for a DPIA

Briefly explain what the project aims to achieve, what the benefits will be to the Council, to individuals, and to other parties.

The Council has a statutory responsibility to continually inspect its area for land contamination and document how it intends to undertake that process in an ‘Inspection Strategy’. Where significant contamination is identified the land must be remediated to prevent further harm. Southampton City Council (SCC) published its first strategy in 2001. Historically The Department of Environment and Rural Affairs (Defra) provided grants to fund the investigation and remediation of contaminated land where the polluter could not be identified. This funding stream was withdrawn in December 2013. Since this date the council has no budget or access to funding to undertake investigation and remediation and therefore has been severely restricted in how it can fulfil its statutory duties.

SCC’s Land Quality Strategy 2018-2023 has been published to demonstrate how it will deliver its duties under Part IIA of the Environmental Protection Act 1990 (Part IIA) in the absence of central government funding. As well as fulfilling the responsibility to provide an “Inspection Strategy” it also details the Councils wider role in managing and maintaining confidence in the quality of land in the City. It proposes to achieve this by;

- Using existing resources available in Scientific Service
- Recovering costs where appropriate
- Producing an annual business plan identifying future budget pressures.

Section 3 - Describe the Information Flows

The collection, use, sharing, and deletion of personal data should be described here.

This will be produced on a site by site basis as and when a site is determined as 'contaminated land'.

Section 4 - Identifying the Privacy Risks

Answering the questions below will help identify the key privacy risks, and the associated compliance and corporate risks.

The questions cover the key data protection principles, and whilst all may not be relevant to your project, they may prompt you to consider areas of risk which aren't initially apparent.

Principle 1

Personal data shall be processed lawfully, fairly and in a transparent manner in relation to the data subject.

What personal data will be collected and/or shared?

Name
Address
Contact details
Medical records

With whom will the personal data be shared?

Environmental Consultants

How will individuals be told about the use of their personal data?

A communication plan will produced on a site by site basis in collaboration with SCC's Communications Team.

Conditions for processing

For all data (tick all that apply):

- ☐ The data subject has given consent to the processing.
- ☐ The processing is necessary for the performance of a contract to which the data subject is party or in order to take steps at the request of the data subject prior to entering into a contract.
- ☑ The processing is necessary for compliance with a legal obligation to which the Council is subject.
- ☐ The processing is necessary for the performance of a task carried out in the public interest or in the exercise of official authority vested in the Council.

Does your project involves the processing of the following?

Tick all that apply:

- ☐ data revealing racial or ethnic origin
- ☐ political opinions
- ☐ religious or philosophical beliefs
- ☐ trade-union membership
- ☐ genetic data or biometric data for the purpose of uniquely identifying a natural person
- ☑ data concerning health
- ☐ data concerning a natural person's sex life or sexual orientation

If so, which of the following apply?

- ☐ The data subject has given explicit consent to the processing.
- ☐ The processing is necessary for the purposes of carrying out the obligations and exercising specific rights of the Council or of the data subject in the field of employment and social security and social protection law.
- ☐ The processing is necessary for the establishment, exercise, or defence of legal claims, or whenever courts are acting in their judicial capacity.
- ☑ The processing is necessary for reasons of substantial public interest.
- ☐ The processing is necessary for the purposes of preventive or occupational medicine, for the assessment of the working capacity of the employee, medical diagnosis, the provision of health or social care or treatment or the management of health or social care systems and services.
- ☐ The processing is necessary for reasons of public interest in the area of public health, such as protecting against serious cross-border threats to health or ensuring high standards of quality and safety of health care and of medicinal products or medical devices.
- ☐ The processing is necessary for archiving purposes in the public interest, scientific or historical research purposes or statistical purposes.

If you are relying on consent to process personal data, how will this be collected and recorded?

N/A

What will you do if consent is withheld or withdrawn? How will this be recorded?

N/A

Can an alternative condition for processing (see page 7) be used instead of consent? If yes, please provide details. See conditions on page 6 for options.

To be determined prior to the collection of any personal data.

How will individuals be informed at the point of collection about how their personal data will be used?

This will be included within the site specific communication plan.

Will any personal data be published on the Internet or in other media? If yes, please provide details.

No.

Will a third party contractor be processing the personal data on our behalf, or involved at any stage in the data processing process?

No.

Principle 2

Personal data shall be collected for specified, explicit, and legitimate purposes, and not further processed in a manner that is incompatible with those purposes.

Do you envisage using the personal data for any other purpose in the future? If so, please provide details.

No.

Principle 3

Personal data shall be adequate, relevant, and limited to what is necessary in relation to the purposes for which they are processed.

Are you satisfied that the personal data processed is of good enough quality for the purposes proposed? If not, why not?

Yes.

Is there any personal data that you could not use, without compromising the needs of the project? If yes, please provide details.

No.

How will you ensure that only personal data that is adequate, relevant, and not excessive in relation to the purpose for which it is processed?

Only personal data required to undertake actions under Part2A will be collected.

Principle 4

Personal data shall be accurate and, where necessary, kept up to date.

Are you able to update and amend personal data when necessary, after it has been collected and recorded? Please provide details.

Yes.

How will you ensure that personal data obtained from individuals or other organisations is accurate?

Principle 5

Personal data shall be kept in a form which permits identification of data subjects for no longer than is necessary for the purposes for which the personal data are processed.

What retention periods are suitable for the personal data you will be processing?

To be agreed prior to the collection of any personal data.

How will you ensure the personal data is deleted in line with your retention periods?

To be agreed prior to the collection of any personal data.

What processes will be put in place for the destruction of the personal data?

To be agreed prior to the collection of any personal data.

Principle 6

Personal data shall be processed in accordance with the rights of data subjects under this Act.

If an individual requested a copy of the personal data held about them, detail how this would be provided to them.

To be determined prior to the collection of any personal data.

If the project involves marketing, have you got a procedure for individuals to opt out of their personal data being used for that purpose?

N/A

Principle 7

Personal data shall be processed in a manner that ensures appropriate security of the personal data, including protection against unauthorised or unlawful processing and against accidental loss, destruction or damage, using appropriate technical or organisational measures.

Where, and in what format, will the personal data be kept?

To be determined prior to the collection of any personal data.

Will an IT system or application be used to process the personal data? Please provide details.

To be determined prior to the collection of any personal data.

How will this system provide protection against security risks to the personal data?

To be determined prior to the collection of any personal data.

What training and instructions are necessary to ensure that staff know how to operate the system securely?

To be determined prior to the collection of any personal data.

Will staff ever process the personal data away from the office (e.g. via paper files, on laptops, tablets, or smart phones)? If so, please provide details.

No.

How will access to the personal data be controlled?

To be determined prior to the collection of any personal data.

Principle 8

Personal data shall not be transferred to a country or territory outside the European Economic Area (EEA) unless that country of territory ensures and adequate level of protection for the rights and freedoms of data subjects in relation to the processing of personal data.

Will the project require you to transfer personal data outside of the EEA? If yes, please provide details.

No.

If you will be making transfers, how will you ensure that the personal data is adequately protected?

N/A.

If a contractor is being used to process the personal data, where are they (and their data stores) based?

N/A.

Section 5 - Data Protection Impact Assessment Statement

This statement must be completed for all projects, regardless of whether a DPIA was deemed to be necessary on completion of the screening questions in Section 1.

Name:

Steve Guppy

Position:

Service Manager - Scientific Service

Project Summary:

Implementation of a Land Quality /Contaminated Land Strategy as required by Part 2A of The Environmental Protection Act 1990.

Estimated date of project completion:

2023

Please choose one of the following options:

- ○ None of the screening statements in Section 1 of this document apply to the above project, and I have determined that it is not necessary to conduct a Data Protection Impact Assessment.
- ◉ Some of the screening statements in Section 1 of this document apply to the above project, and a need to carry out a Data Protection Impact Assessment was identified. The assessment has been carried out, and the outcomes will be integrated into the project plan to be developed and implemented.

Date:

29/08/2018

Once completed, please send a copy of this document to Corporate Legal.

Email: information@southampton.gov.uk

Internal post: Corporate Legal, Civic Centre, Municipal, Ground Floor West

Document Information

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Agreed by: Information Governance Board on behalf of the Council's Management Team

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10/03/15 - Version 2.0 - Reviser: Chris Thornton - Updated to PDF form format

17/07/15 - Version 2.1 - Reviser: Chris Thornton - Added information re report in introduction

14/01/16 - Version 2.2 - Reviser: Chris Thornton - Added screening question

27/01/16 - Version 2.3 - Reviser: Chris Thornton - Added project completion date to S7

24/01/16 - Version 2.4 - Reviser: Chris Thornton - Added service level for issuing reports

29/04/16 - Version 2.5 - Reviser: Chris Thornton - Removed sections 5 and 6, and revised questions

22/02/17 - Version 2.6 - Reviser: Chris Thornton - Changed wording to reflect GDPR

26/05/17 - Version 2.7 - Reviser: Chris Thornton - Changes made to consent to reflect GDPR