Title of Function:	Integrated Drug and Alcohol Recommission under the Provider Selection Regime (PSR)

Evidence based equality analysis

Aims

The aim of the recommissioning of the Integrated Drug and Alcohol Service for adults and young people in Cheshire West and Chester, undertaken through the Provider Selection Regime (PSR), is to secure a service model that supports equitable access, experience and positive treatment outcomes across the local population.

The recommissioning aims to improve outcomes for those who are underserved, under-represented or experience multiple forms of disadvantage, and to ensure the future service continues to reduce inequality and unmet need across the borough.

Purpose

The purpose of this Equality Analysis is to provide a structured and proportionate review of how the current service model and proposed future delivery arrangements address equality considerations. It examines whether there are differences in access, engagement, progression and outcomes for people based on their protected characteristics and identifies opportunities to strengthen equity within the service through the recommissioning process.

Methodology and Evidence Base

The Equality Analysis draws on a robust and triangulated combination of quantitative and qualitative intelligence to assess the potential impact of the recommissioning on people with protected characteristics and those experiencing disadvantage.
Quantitative evidence includes the local needs assessment, service performance management information, assessment against the Provider Selection Regime (PSR) Key Criteria, and National Drug Treatment Monitoring System (NDTMS) data, benchmarked against local, regional and national comparators.

Qualitative insight has been gathered through a structured programme of engagement undertaken as part of the recommissioning process. This includes resident and professional surveys, informal drop-in engagement across service hubs, engagement with voluntary and community sector organisations, attendance at youth sessions and youth forums, and focus groups with young people. This approach ensures that the Equality Analysis is informed by lived experience and practitioner perspectives alongside routine performance data.

Together these data sources provide a comprehensive picture of access, engagement, progression and outcomes across different population groups.

In addition, Healthwatch Cheshire West was commissioned to independently gather the views and experiences of people and residents across Cheshire West and Chester who are impacted by drug and alcohol dependency. This included individuals with lived experience of substance use, as well as family members, carers, friends and wider community members affected by another person's substance use. The engagement was intentionally designed to capture perspectives beyond current service users, with a particular focus on the wider impacts of substance use on individuals, families and communities, including issues relating to stigma, access to support, safety, wellbeing and community experience. This independent evidence provides important contextual insight to complement service performance data and ensures that the Equality Analysis reflects both direct and indirect impacts of drug and alcohol dependency.

The Fair Access Review will continue to operate as an ongoing mechanism within the service, using local, regional and national benchmarks to analyse access, engagement, progression and treatment outcomes by protected characteristic. This provides assurance that equality of access is monitored in practice and supports the identification of any differential impacts that may require targeted or proportionate action during contract delivery.

Outcomes

The intended outcomes of the Equality Analysis and PSR-led recommissioning process are to ensure that equality considerations are embedded within core service delivery and strengthened over time. The current service specification and future commissioning arrangements are intentionally designed to embed equality through inclusive access, prioritisation of vulnerable groups, culturally responsive and trauma-informed practice alongside needs-led pathways to address wider determinants of health.

Access and outcomes for protected characteristics will be routinely monitored through a Fair Access Review embedded within the specification on a three-year cycle, using local, national and regional benchmarking. Findings from this review, alongside performance data and service user feedback, will inform service development plans and support continuous improvement in equity of access and outcomes over the life-cycle of the contract.

Statutory Responsibilities

In recommissioning the Integrated Drug and Alcohol Service, Cheshire West and Chester Council is exercising its statutory public health functions and responsibilities, including duties under:

- The Equality Act 2010 to eliminate unlawful discrimination, advance equality of opportunity and foster good relations for people based on their protected characteristics;
- The Health and Social Care Act 2012 in relation to improving population health and reducing health inequalities;
- The Care Act 2014 including duties relating to adult wellbeing, prevention and safeguarding;
- The Children Act 1989 and Children and Families Act 2014 to safeguard and promote the welfare of children and young people; and
- The Human Rights Act 1998 to protect and promote the rights of individuals accessing services.

The recommissioned service will remain registered with the Care Quality Commission (CQC) and aligned with national policy and accountability frameworks, including the National Drug Outcomes Framework, the 10-Year Drug Strategy (*From Harm to Hope*) and the Public Health Outcomes Framework. This ensures the recommissioning supports the Council's wider organisational aims to improve population health, reduce inequality and deliver safe, effective and inclusive services for residents of Cheshire West and Chester.

Lead officer: Umarah Choudhary
Stakeholders: Via – the commissioned integrated drug and alcohol service

For each of the areas below, an assessment needs to be made on whether the policy has a positive, negative or neutral impact, and brief details of why this decision was made and notes of any mitigation should be included. Where the impact is negative, this needs to be given a high, medium or low assessment. It is important to rate the impact of the policy based on the current situation (i.e. disregarding any actions planned to be carried out in future).

High impact – a significant potential impact, risk of exposure, history of complaints, no mitigating measures in place etc.

Medium impact –some potential impact exists, some mitigating measures are in place, poor evidence

Low impact – almost no relevancy to the process, e.g. an area that is very much legislation led and where the Council has very little discretion

	Neutral	**Positive**	**Negative**
Target group / area			
Race and ethnicity (including Gypsies and Travellers, refugees, asylum seekers etc.)	NDTMS data demonstrates treatment access broadly proportionate to CWAC population demographics (predominantly White British). Minority ethnic groups appear in small numbers consistent with local population size. The Healthwatch engagement captured views from residents across all Community Partnership areas, with the majority identifying as White British, broadly reflecting local demographics.		

	Healthwatch engagement did not identify evidence of race-based exclusion; however, community feedback highlighted stigma and fear of judgement as barriers to help-seeking, reinforcing the importance of culturally sensitive and inclusive engagement approaches.		
Disability (as defined by the Equality Act - a physical or mental impairment that has a substantial and long-term adverse effect on a person's ability to carry out normal day-to-day activities)		The last fair access review and exits highlighted disabled service users demonstrate strong treatment outcomes, performing at least as well as non-disabled cohorts. This indicates the current service model is effective in supporting people with disabilities. Healthwatch engagement reinforces the Fair Access conclusion that people with disabilities, including those with mental health needs, can achieve positive outcomes where engagement is sustained. Community-level feedback was consistently positive about the value of trauma-informed, compassionate and non-judgemental approaches. This supports the current service model and provides additional assurance that the emphasis on trauma-informed practice contributes positively to engagement, experience and outcomes for disabled residents.	
Sex (male or female)	**Men:** For opiate cohorts, men demonstrate comparable and, in some instances, stronger treatment outcomes than women, reflecting an older and more treatment-experienced	**Women:** The Fair Access & Exit Review demonstrates that women consistently achieve stronger successful completion outcomes compared to men across the service overall. This is particularly evident within	

	population. However, the Fair Access Review identifies that men have lower engagement and retention overall, particularly outside the core opiate cohort, with higher likelihood of early disengagement. This is characterised as an engagement and retention challenge rather than an access barrier, as men continue to represent the majority of people entering treatment. Peer-led recovery service has now developed a men's group to offer further support, and a consultation will take place to understand challenges to continue development	alcohol and non-opiate cohorts, where women are more likely to complete treatment successfully and less likely to disengage early. Performance monitoring through NDTMS provides ongoing assurance that outcomes for women remain strong. Healthwatch engagement provides additional qualitative insight into gendered experiences of substance misuse, including the disproportionate impact on women through domestic abuse, financial instability and caring responsibilities, and wider community harms more frequently articulated by men. This supports the Fair Access finding that differences relate primarily to experience and engagement rather than access. There is no evidence of reduced access or conversion for women, indicating that the current service model effectively supports women to engage and achieve positive outcomes.	
Gender identity (gender reassignment)	Gender reassignment is not consistently recorded in NDTMS or needs assessments, limiting ability to evidence access and outcomes for trans and gender-diverse people. This represents a data and assurance gap rather than evidence of exclusion, with no systemic disadvantage or barriers to access identified in the Fair Access Review or needs assessments.		

	Service will check if it has been recorded. If not it will be part of the future recommission. Healthwatch engagement did not identify gender identity–specific barriers to access or experience; however, wider feedback highlighted the importance of non-judgemental, inclusive practice in supporting disclosure and engagement for all residents.		
Religion and belief (including lack of belief)	No evidence of systemic disadvantage is identified in the Fair Access Review or needs assessment. While small numbers and incomplete recording limit detailed analysis, no adverse impacts or barriers to access are evident. Services are delivered on a non-faith basis with flexibility to meet cultural and religious needs, with monitoring through NDTMS where recorded. Strong partnership with faith-based organisations is in place, with some peer-led recovery and support groups delivered in community faith venues, such as St Michael's Church, supporting inclusive access within local communities.		
Sexual orientation (including heterosexual, lesbian, gay, bisexual and others)			The Fair Access Review identifies lower conversion and poorer treatment outcomes for Gay and Lesbian service users, alongside limitations in routine recording, indicating engagement and retention

			challenges. Anecdotally, this cohort is predominantly recreational use. Healthwatch engagement highlights the impact of stigma, fear of judgement and concerns about disclosure on help-seeking, which may disproportionately affect LGBTQ+ residents. This community-level insight reinforces evidence of lower engagement and poorer outcomes for gay and lesbian service users, supporting the identification of a negative impact focused on experience and retention rather than access. This has been recognised within the service development plan, which is reviewed every quarter with mitigation focused on developing a brief intervention such as RENEW, improving recording, strengthening inclusive practice, and reinforcing partnerships with organisations supporting LGBTQ+ communities to improve access, experience and engagement. RENEW is delivered as a lifestyle coaching intervention, providing support to help individuals access and engage with treatment.

			It is designed to reduce barriers to engagement and supports sustained connection to services.
Age (children and young people aged 0 – 24, adults 25 – 50, younger older people 51 – 75/80; older people 81+. Age bands are for illustration only as overriding consideration should be given to needs)	Age 18-29 The Fair Access Review identifies lower conversion from referral to assessment for adults aged 18–29 compared to older age groups, indicating challenges with early engagement rather than barriers to access. This is not attributable to service transition issues, as young people's and adult services operate within an integrated model, but reflects wider engagement and retention challenges commonly observed within this age group. This sits within the context of an ageing local treatment population, where older adults form a larger and more treatment-experienced cohort with stronger retention and treatment outcomes. Younger adults are more likely to disengage early, reflecting differing levels of readiness, perception of need and competing social or employment pressures. Mitigation is provided through the integrated young people and adult service model, which supports continuity of access, alongside the RENEW lifestyle coaching intervention. RENEW offers a flexible and less formal route into support, particularly	YP Young people under 18 in structured treatment demonstrate strong engagement and outcomes, with high successful completion rates and very low re-presentations within six months, performing better than regional and national comparators. Older Adults 51+ Older adults form a significant proportion of the treatment population in Cheshire West and Chester, reflecting the borough's ageing population. This group demonstrates good engagement, strong retention and stable treatment outcomes, particularly within opiate cohorts, with no evidence of access or outcome disparities identified. Adults – 30-50 Adults aged 30–50 demonstrate stable access, good engagement and consistent treatment outcomes across substance groups. No access, conversion or outcome disparities are identified for this age group in the Fair Access Review or adult needs assessment	

	for individuals who may be ambivalent about treatment or disengage at an early stage. Evidence also indicates that recovery from substance use is typically a long-term process, often taking between five and ten years. This reinforces the importance of early engagement, sustained support and age-appropriate interventions to improve long-term outcomes for younger adults.		
Care Experienced (all young people and adults who have been in the care of Cheshire West and Chester Council - for a period of 13 weeks or more - from the age of 14 years. This includes those children/young people for whom the Council currently or have previously held corporate parenting responsibilities)	The young people's needs assessment identifies care-experienced young people as a high-risk group; however, evidence on access, outcomes and early intervention is limited and fragmented, and adult datasets do not consistently capture care experience, constraining assurance. Think Family and safeguarding approaches are embedded within the service spec, with established partnerships to Children and Families Social Care. Where data is the primary limitation, performance management framework datasets will be reviewed and strengthened to improve visibility of access, engagement and outcomes for care-experienced cohorts		
Carers (people who care for others, informally or formally)	Carers are not consistently identified as a distinct cohort within treatment data; however, there is no evidence of restricted access or adverse impact, and caring		

	responsibilities are considered within individual care planning where disclosed. Healthwatch engagement highlights the significant emotional, financial and wellbeing impacts experienced by carers and family members affected by another person's substance misuse. This evidence reflects wider need and lived experience rather than an access barrier or differential impact arising from the service model. Caring responsibilities are considered within individual care planning where they are identified or disclosed. Improved recording of carers within the performance management framework will be explored.		
Rural communities		Cheshire West and Chester cover a large and diverse geographical footprint, including significant rural and semi-rural communities. No evidence of differential access or poorer outcomes for rural residents is identified within the Fair Access Review. The service model promotes geographic equity through a combination of community hubs, peripatetic delivery and digital provision, supporting access across both urban and rural areas. The service has developed and now delivers the RENEW lifestyle coaching offer, providing a flexible, non-stigmatising route into support that is particularly well suited to residents in rural	

		communities where anonymity, transport and distance may be concerns. Healthwatch engagement with residents living in villages and smaller communities highlights the importance of services being visible, approachable and delivered in a non-judgemental way. Ongoing partnership working, including with the Rural Alliance, supports continuous improvement and responsiveness to rural need.	
Areas of deprivation (include any impact on people living in poverty who may not live in areas identified as deprived)	A recognised challenge within Cheshire West and Chester is the presence of unmet need among individuals who do not live in areas of high deprivation and who may not identify with traditional substance misuse services. These individuals, including those in employment or professional roles, may experience hidden harm but are less likely to engage with services that are perceived as being designed for people with more complex or visible needs. Cultural perceptions, stigma and concerns about confidentiality can act as barriers to access and early intervention. The RENEW lifestyle service helps to address this gap by providing an alternative, non-stigmatising offer that supports engagement from individuals who may not view themselves as requiring formal treatment. Local intelligence also indicates higher levels of alcohol dependence within some	Adult and young people's data demonstrates a clear association between deprivation, substance misuse, hospital admissions, involvement with the criminal justice system and poorer health outcomes. While access to treatment services is not restricted by postcode or deprivation status, poorer outcomes are more commonly linked to higher levels of complexity, including homelessness, multiple disadvantage and wider structural inequalities rather than barriers within the service itself. The service works within a strong multi-agency framework to mitigate the impact of deprivation and complexity. This includes dedicated homelessness provision within the service, Dependency and Recovery workers embedded within probation, Individual Placement and Support (IPS) practitioners co-located within treatment teams, and partnership working with acute hospitals, primary care, community pharmacies, mental health services and	

	professional groups, reinforcing the importance of flexible, inclusive pathways alongside core treatment services to reduce inequality and improve access.	safeguarding partners. These arrangements support coordinated responses to need and help reduce the impact of structural disadvantage on engagement and outcomes. A recognised challenge within Cheshire West and Chester relates to individuals who do not live in areas of high deprivation but who nonetheless experience harmful or dependent substance use. These individuals may be less likely to identify with traditional treatment services, which are often perceived as being designed for people with more complex or visible needs. This can result in hidden harm, delayed presentation and lower engagement, particularly among people in employment or professional roles. Cultural perceptions, stigma and concerns around confidentiality can act as additional barriers. The RENEW lifestyle coaching offer provides an important mitigation to this risk by offering a flexible, non-stigmatising route into support for individuals who may not perceive themselves as requiring formal treatment. Local intelligence also indicates higher levels of alcohol dependence within some professional and employed populations, reinforcing the importance of having accessible, discreet and proportionate pathways alongside core treatment services to reduce inequality and widen access.	
Human rights (see guidance note for key areas to consider)	Human rights considerations are positively embedded within the service specification		

	and evidenced through the PSR Key Criteria. Current and future arrangements will continue to actively promote access to treatment, dignity, confidentiality and safeguarding, with services operating in line with legal duties around consent, proportionality and protection from harm.		
Health and wellbeing and Health Inequalities (consider the wider determinants of health such as education, housing, employment, environment, crime and transport, plus impacts on lifestyles and effects on health and care services)		The current commissioned arrangements, and the future recommissioning of the service, will continue to deliver a strong service model that embeds evidence-based health and wellbeing interventions. This includes successful treatment outcomes and targeted harm-reduction activity such as naloxone training and kit distribution to service users, professionals and families, drug and alcohol awareness training to partner agencies, and physical health interventions including Hepatitis C micro-elimination, liver health checks and blood-borne virus screening. Robust clinical pathways, including access to inpatient detoxification where required, support ongoing risk reduction and recovery.	
Procurement/partnership (if project due to be carried out by contractors/partners etc, identify steps taken to ensure equality compliance)	The recommissioning of the service has been informed by triangulation of multiple datasets, including needs assessments, Fair Access analysis, performance data and engagement with professionals, residents and young people. The process is being progressed in compliance with the Provider Selection Regime (PSR) and overseen by a recommissioning project group including		

	procurement, legal, finance, children and families' services and adult social care. The PSR key criteria have been applied rigorously, with a robust evidence base supporting the recommissioning decision, which will be subject to formal governance.		

Action plan:

Actions required	Priority	Outcomes required	Officer responsible	Review date
Complete an updated Fair Access Review using NDTMS, local performance data and benchmarking against regional and national comparators	M	Improved understanding of access, engagement and outcomes across protected characteristics, with evidence-based identification of any inequalities	Via – Dave Targett CWaC – Umarah Choudhary	October 2026
Embed findings from the Fair Access Review into service development plans and contract management discussions	M	Equality considerations inform service delivery, improvement activity and commissioning decisions	CWaC – Umarah Choudhary Via – Dave Targett	Oct 2026
Continue to strengthen targeted engagement approaches for groups identified as having lower engagement or poorer outcomes (e.g. young adults, men, LGBTQ+ communities)	M	Improved engagement, retention and treatment outcomes for underrepresented groups monitored through contract management.	Via – Dave Targett CWaC – Umarah Choudhary	June 2026
Review and improve data completeness for protected characteristics, including gender identity, sexual orientation and care experience, in line with national guidance.	M	Improved quality of equality data to support future service planning and assurance	Via – Dave Targett CWaC – Umarah Choudhary	August 2026

Sign off	
Lead officer:	Umarah Choudhary
Approved by Tier 4 Manager:	Angela Lewis
Moderation and/or Scrutiny	
Date: 27 January 2026 (Moderation Panel)	
Date analysis to be reviewed based on rating (high impact – review in one year, medium impact - review in two years, low impact in three years)	L