JOINT INTEGRATED SUBSTANCE MISUSE TREATMENT AND RECOVERY SERVICE FOR BOLTON, SALFORD AND TRAFFORD

SERVICE SPECIFICATION

DRAFT VERSION 6 (28/10/16)

Bolton Council

Salford City Council

TRAFFORD COUNCIL

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1. BACKGROUND

1.1 Introduction

a. Drug and alcohol misuse has a profound impact on individuals, families and communities across Bolton, Salford and Trafford (hereafter referred to as the BST cluster). This specification outlines an integrated drug and alcohol treatment and recovery service to be delivered across the BST cluster. The service is orientated around supporting service users to initiate and sustain meaningful and durable recovery. It will also improve public health and community safety through the early detection and treatment of drug and alcohol misuse.

b. The BST substance misuse service will ensure that people are actively supported throughout their treatment and recovery journey. A Case Management Team will ensure that the scope and pace of this support is tailored to the needs and complexity of individual service users. This will include users of alcohol and other drugs (legal and illegal, prescribed and non-prescribed).

c. Recovery is a complex phenomenon, and relapse is common. Granfield and Cloud[1] describe four main enablers of recovery:

   i. Human capital (e.g. health and wellbeing, skills, aspirations)
   ii. Social capital (e.g. family and community relationships)
   iii. Cultural capital (e.g. identity and values)
   iv. Physical and economic capital (e.g. education, employment, housing, money)

d. The total contribution of each attribute determines an individual's *recovery* capital. In order to develop recovery capital throughout a treatment and recovery journey, the service will integrate treatment and recovery services throughout, including housing, employment and education interventions. There will also be a focus on the development of a supportive recovery community, which can support service both during and after treatment.

e. It is proposed that a Lead Provider model be chosen because it allows for diversity of provision whilst avoiding the duplication of provision between competing providers. Since they are not in competition with each other, providers will have no interest in retaining service users unnecessarily but instead ensure that each individual moves seamlessly between services during the course of their recovery journey. The Lead Provider will hold the contract for the entire service and can choose to sub-contract areas of service delivery to other organisations as appropriate.

f. Bolton, Salford and Trafford are neighbouring Local Authorities with a combined population of over 760,000[2]. A unified substance misuse service can improve the quality of services provided across the three areas by maximising existing assets, sharing best practice and ensuring common standards of provision and governance. It also offers the potential to maximise economies of scale across the three areas.

[1] Granfield, R. and Cloud, W. (2001) Social Context and "Natural Recovery": The Role of Social Capital in the Resolution of Drug-Associated Problems. Substance Use and Misuse, Vol. 36, pp1543-1570

[2] ONS (2015) Mid-year population estimates

1.2 National guidance and standards

a. The principle of evidence-based treatment will underpin the delivery of services, which will be designed in accordance with existing national guidelines and strategies. The Lead Provider will be expected to have systems in place to audit existing services against national standards, and to ensure that new evidence can be rapidly identified and incorporated within its treatment model.

b. It is expected that the following list of resources (which should be considered indicative rather than exclusive) should directly influence the development and delivery of services.

- **Advisory Council on the Misuse of Drugs**
  - Recovery from drug and alcohol dependence: An overview of the evidence (2012) - link
  - What recovery outcomes does the evidence tell us we can expect? (2013) - link
  - How can opioid substitution therapy (and drug treatment and recovery systems) be optimised to maximise recovery outcomes for service users? (2015) - link
  - Prevention of drug and alcohol dependence (2015) - link
- **Department of Education**
  - The Munro review of child protection: final report. A child-centred system (2011) - link
  - Working together to safeguard children (2013) - link
- **Department of Health**
  - Drug misuse and dependence: UK guidelines on clinical management (2007) - link
  - Signs for improvement – Commissioning interventions to reduce alcohol related harm (2009) - link
  - Practical approaches to safeguarding and personalisation (2010)- link
  - You're welcome - Quality criteria for young people friendly health services (2011) - link
  - The Green Book: Immunisation against infectious diseases (2014) - link
  - Widening the availability of Naloxone (2016) - link
- **Home Office**
  - Drug strategy: Reducing demand, restricting supply, building recovery (2010) - link
  - The Government's alcohol strategy (2012) - link
  - New psychoactive substances review: Report of the expert panel (2014) - link
- **Local Government Association (LGA)**
  - A glass half-full: How an asset approach can improve community health and well-being (2010) – link
  - Guide to commissioning for maximum value (2012) - link

- **National Treatment Agency (NTA)**
  - NTA guidance for local partnerships on user and carer involvement (2006) - link
  - Models of care for alcohol misuses (2006) - link
  - Models of care for treatment of adult drug misusers: Update (2006) - link
  - Review of the effectiveness of treatment for alcohol problems (2006) - link
  - Supporting information for the development of joint local protocols between drug and alcohol partnerships, children and family services (2011) - link
  - Building recovery in communities: A summary of the responses to the consultation (2012) - link
  - Medications in recovery: Re-orientating drug dependence treatment (2012) - link
  - NDTMS data set J: Implementation guide for adult drug and alcohol treatment providers - link
  - Parents with drug problems: How treatment helps families (2012) - link
- **National Institute for Health and Care Excellence (NICE)**
  - CG51 Drug misuse in over 16s: Psychosocial interventions (2007) - link
  - CG52 Drug misuse in over 16s: Opioid detoxification (2007) - link
  - PH4 Substance misuse interventions for vulnerable under 25s (2007) - link
  - PH6 Behaviour change: General approaches (2007) - link
  - PH7 Alcohol: School-based interventions (2007) - link
  - TA114 Methadone and buprenorphine for the management of opioid dependence (2007) - link
  - TA115 Naltrexone for the management of opioid dependence (2007) - link
  - CG100 Alcohol-use disorders: Diagnosis and management of physical complications (2010) - link
  - NICE CG110 Pregnancy with complex social factors: a model for service provision for pregnant women with complex social factors (2010) - link
  - PH24 Alcohol-use disorders: Prevention (2010) - link
  - CG115 Alcohol-use disorders: Diagnosis, assessment and management of harmful drinking and alcohol dependence (2011) - link
  - CG120 Psychosis with substance misuse in over 14s: Assessment and management (2011) - link
  - QS11 Alcohol-use disorders (2011) - link
  - QS23 Drug use disorders in adults (2012) - link
  - PH50 Domestic violence and abuse: Multi-agency working (2014) - link
  - PH52 Needle and syringe programmes (2014) - link
  - QS83 Alcohol: Preventing harmful use in the community (2015) - link
  - NG33 Tuberculosis (2016) - link

- **NHS England**
    - Serious incident framework: Supporting learning to prevent recurrence (2015) - link

- **Novel Psychoactive Treatment UK Network**
    - Guidance on the clinical management of acute and chronic harms of club drugs and novel psychoactive substances (2015) - link
- **Public Health England (PHE)**
    - Medications in recovery: best practice in reviewing treatment (2013) - link
    - Supporting information for developing local joint protocols between drug and alcohol partnerships and children and family services (2013) - link
    - Advice for prescribers on the risk of the misuse of pregabalin and gabapentin (2014) - link
    - New psychoactive substances: A toolkit for substance misuse commissioners (2014) - link
    - Non-medical prescribing in the management of substance misuse (2014) - link
    - The role of addiction specialist doctors in recovery orientated treatment systems (2014) - link
    - Young people's hospital alcohol pathways: Support pack for A+E departments (2014) - link
    - Quality governance guidance for local authority commissioners of alcohol and drug services (2015) - link
    - Service user involvement: A guide for drug and alcohol commissioners, providers and service users (2015) - link
    - Take-home Naloxone for opioid overdose in people who use drugs (2015) - link
    - The international evidence on the prevention of drug and alcohol use: summary and examples of implementation in England (2015) - link
    - Supporting information for developing local joint protocols between drug and alcohol partnerships and children and family services (2013) - link
    - Substance misuse services for men who have sex with men involved in chemsex (2015) - link
    - Adults – drugs JSNA support pack 2017-18: commissioning prompts (2016) - link
    - Adults – alcohol JSNA support pack 2017-18: commissioning prompts (2016) - link
    - Mapping blood borne virus services across the NW community drug and alcohol services (2016)
    - Young people – Substance misuse JSNA support pack 2017-18: Commissioning prompts (2016) - link

- **Royal College of Psychiatrists**
    - Delivering quality care for drug and alcohol users: the roles and competencies of doctors (2012) - link
    - Substance misuse in older people: an information guide (2015) - link

1.3 Local guidance and standards

1.3.1 Local Authority

a. It is expected that this service will be designed with reference to the existing Locality Plans for each Local Authority area. These are documents created as part of the Greater Manchester devolution process and which outline the strategy for each area in relation to health and social care:
    - Bolton Locality Plan
    - Salford Locality Plan
    - Trafford Locality Plan

b. Each Local Authority will also have its own policies and procedures which the Lead Provider will need to observe including in relation to:
    - Equality and diversity
    - Safeguarding (child and adult)
    - Social value
    - Governance (see Section 4.7)

1.3.2 Greater Manchester

a. Bolton, Salford and Trafford Local Authorities are all situated within Greater Manchester (GM). Following the GM devolution agreement in 2014, a number of responsibilities have been transferred to GM, including in relation to health and social care, criminal justice, transport, planning and housing[3]. A directly elected mayor will oversee this work and will lead the Greater Manchester Combined Authority (GMCA).

b. The Public Sector Reform (PSR) agenda represents a GM-wide approach to review and restructure the delivery of public services in the region to maximise effectiveness and efficiency. There are six constituent themes:
    i. Health and social care integration
    ii. Employment and Skills
    iii. Complex Dependency / Troubled Families
    iv. Place Based Integration
    v. Justice and Rehabilitation
    vi. Housing and Homelessness

c. Each of these PSR themes can be linked to services which we expect to be delivered as part of the BST substance misuse service. As such, we would expect the Lead Provider to demonstrate a willingness to engage with, and support, developments at a GM level. Over the duration of this contract this may involve (in collaboration with Commissioners) redesigning aspects of service delivery to reflect changes at a GM level.

[3] GMCA (2016) Devolution - link

d. Further information about the devolution of health and social care in GM can be found in the strategic plan for GM Health and Social Care Devolution entitled '*Taking charge of our health and social care in Greater Manchester*[4]*'*

[4] GMCA (2015) Taking charge of our health and social care in Greater Manchester - link

1.4 Overview of Lead Provider Roles and Responsibilities

The Lead Provider will have responsibility for the whole BST substance misuse service. Overarching and strategic responsibilities are listed in this section, with additional responsibilities outlined throughout the sections of this service specification.

1.4.1 Responsibility for the system

The Lead Provider will:

i. Ensure the delivery of a recovery orientated system of treatment, support and care.

ii. Develop a system that offers individuals and families a choice of accessible and relevant services that enable them to recover from the damage caused by substance misuse.

iii. Ensure the delivery of high quality health and social care for both abstinence and non-abstinent routes to recovery.

iv. Oversee the whole supply chain of treatment and recovery provision, sub-contracting service delivery as appropriate

v. Develop pathways to identify and manage complex cases within the system including those with chronic health conditions

vi. Work with partner agencies to develop appropriate local housing infrastructure for service users including (but not limited to) the provision of recovery housing, stepdown housing and tenancy support according to local need

vii. Ensure that service users are encouraged to engage with education, training and employment opportunities as part of the recovery process

viii. Ensure the delivery of services that dovetail with pathways to and from Tier 4 services and HMP based provision.

ix. Manage access to residential detoxification and rehabilitation via a panel with representation from Bolton, Salford and Trafford Local Authorities, ensuring that arrangements align with the Greater Manchester Tier 4 framework

x. Establish a 'Recovery Fund' for the development of recovery and mutual aid at a system level and a 'Personalisation Fund' for individuals in all forms of recovery.

xi. Demonstrate a reduction in demand on costly acute services via cost benefit analysis

1.4.2 Responsibility for meeting need

The Lead Provider will:

i. Develop services based on the findings of the Needs Assessment

ii. Deliver appropriate interventions across the range of substances used in Bolton, Salford and Trafford; across the full spectrum of need.

iii. Ensure that emphasis is placed on case profiling, risk stratification and long term case management of the most severe, complex cases, with the lowest levels of motivation and assets

iv. Consider the needs of service users living at the boundary of the BST cluster who may frequently present to out-of-area hospitals and other services

v. Ensure the development of an assertive approach to seeking and finding new service users and reaching service users who are not engaging in treatment

vi. Understand emerging threats to the wellbeing and safety of the community through analysis of emerging drug trends including (but not limited to) Chemsex and the use of New Psychoactive Substances and performance-enhancing drugs.

vii. Ensure that services are designed to meet the health and social needs of an aging cohort of opiate users, including through close partnership working with General Practices and specialist services.

viii. Conduct surveillance of emerging local and national drug trends. This will include assuming responsibility for Salford's existing Early Warning System and expanding its scope to include Bolton and Trafford. The Lead Provider will also be expected to collaborate in the potential development of an Early Warning System for Greater Manchester.

1.4.3 Responsibility for budget

The Lead Provider will:

i. Ensure that the system is affordable, sustainable, represents value for money and is informed by the notion of 'invest to save' so that the effectiveness of the treatment system can be linked to savings elsewhere in local partnerships

ii. Provide economies of scale across Bolton, Salford and Trafford and ensure effective integration with services essential to promoting recovery (e.g. housing, employment, education and training)

iii. Ensure that the costs of designing and delivering substance misuse services in each Local Authority equate to the financial contribution of each Local Authority into the service.

iv. Avoid duplication and service blocking by ensuring that service users are referred as soon as is practicable for each individual recovery journey

1.4.4 Responsibility for recovery

The Lead Provider will:

i. Ensure that there is a rise in the volume of people achieving recovery alongside decreases in relapse rates and longer periods of remission.

ii. Improve and strengthen service users' parenting capacity and enable their recovery.

iii. Reduce the harm or neglect experienced by children and increase their life chances.

iv. Allow service users' families and/or significant others to support them in their recovery.

v. Reduce the long term impact of substance misuse for young people in Salford and Trafford.

vi. Develop an assessment and care planning process that includes measures of recovery potential and assets. Specifically, an account of each client's *complexity*, *motivation*, *severity* and *capital* (human, social, cultural and physical) will be incorporated into comprehensive assessments and treatment reviews and monitored over the course of each recovery journey

vii. Be the focal point of a system that will boost the human, social, cultural and physical capital of Bolton, Salford and Trafford for the benefit of those moving through the system from treatment to recovery to mutual aid.

viii. Ensure that all reasonable efforts are made to follow up all substance users who have completed specialist treatment in order to review their needs and risks for at least five years

ix. Draw people into mutual aid and recovery communities and engage with wider community recovery activities and assets.

1.4.5 Responsibility for people

The Lead Provider will:

i. Oversee the development of a balanced workforce with volunteers and paid staff in recovery supporting others on their recovery journeys

ii. Ensure the provision within the workforce of some trainee and apprentice posts to enable career progression from Peer Mentors into full time employment.

iii. Place emphasis on working with commissioners in developing Service User Representation and actively involving service users, their families and neighbours in the development and delivery of services in an equal and reciprocal relationship.

1.4.6 Responsibility for performance and governance

The Lead Provider will:

i. Deliver routine reports on the performance of the entire system and undertake longitudinal evaluation of its effectiveness.

ii. Report on the governance of the whole system for the whole contractual supply chain.

iii. Ensure that there is an effective governance system in place around the delivery of services so that providers comply with the requirements of the commissioners and stakeholders.

iv. Work closely with commissioners and other agencies to develop implement and monitor consistent, appropriate, effective and efficient processes in line with all relevant national frameworks and guidance.

v. Represent the substance misuse service at strategic board meetings (including, but not limited to Children's services) and to produce relevant strategic reports as requested by the Commissioners

1.5 Out of scope

1.5.1 General exclusions

The following services fall outside the scope of this tender in all three Local Authority areas:

i. **Tier 4 provision** (see Section 1.6.1)
   - With the exception of the local residential rehabilitation service detailed in Section 3.15
   - The Lead Provider will manage the budget for Tier 4 detoxification and residential rehabilitation services. This budget is separate to the contract value of this tender.

ii. **HMP based services**

iii. **Young People's Secure Estate**

iv. **Universal health and wellbeing services**

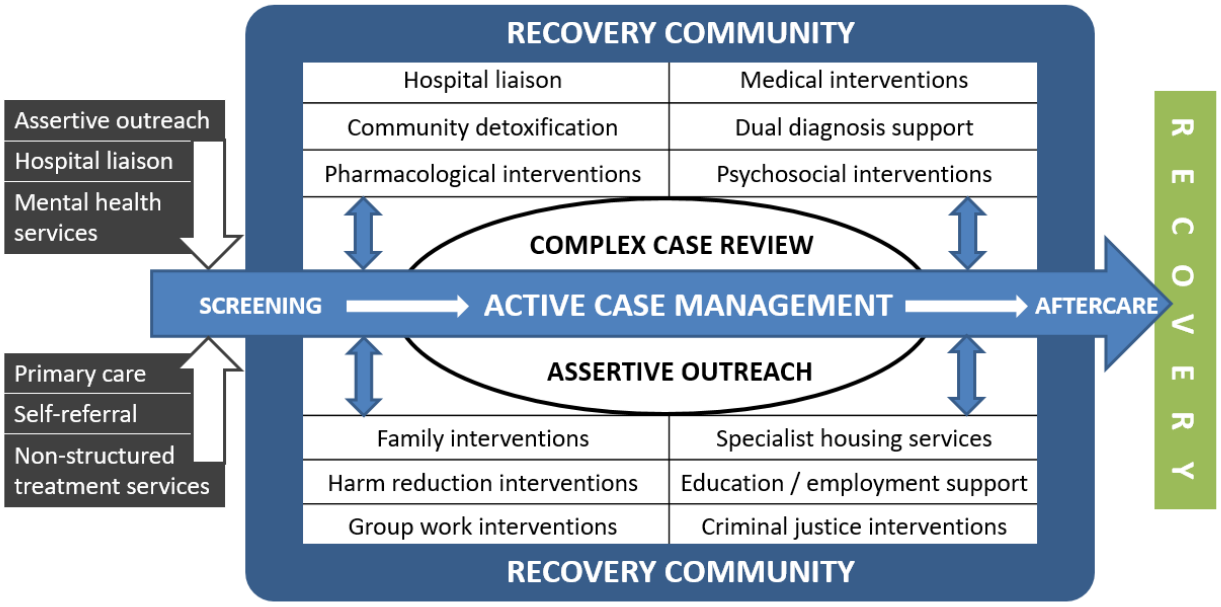
1.5.2 Specific exclusions

a. Due to existing arrangements, Bolton Council will not currently be commissioning a Young People's service (with the exception of Pharmacological interventions, as per Section 3.4) or a Hospital in-reach and liaison team.

1.6 System details

1.6.1 System diagram

a. The Lead Provider is expected to deliver a recovery orientated treatment system that addresses harm reduction at every level. The diagram below gives an indication of the intended structure of our model with similar, but separate, pathways existing for adults (all areas) and young people (Salford and Trafford only).



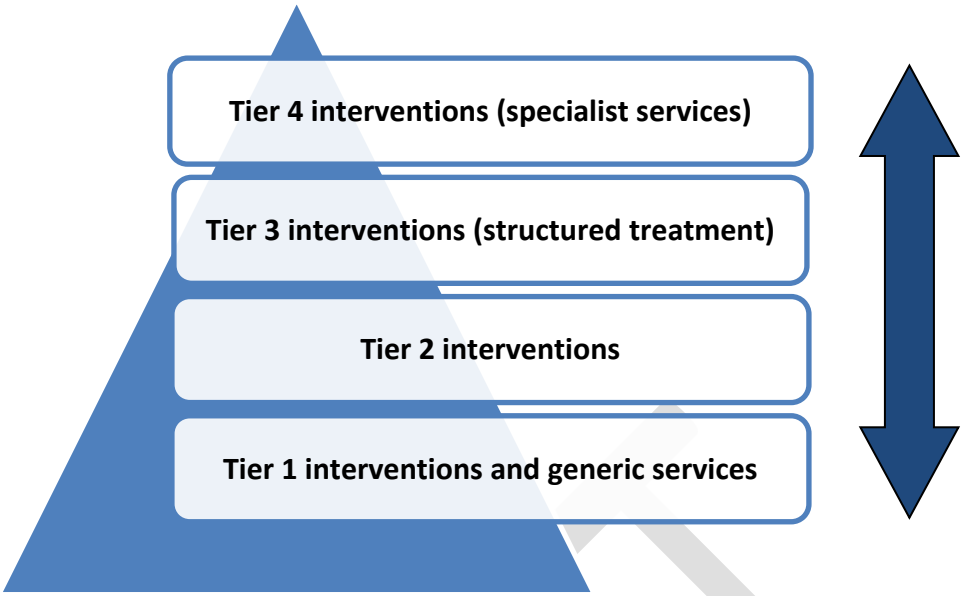
b. There will be several referral routes into the service in order to allow early identification of those at risk from drug and alcohol misuse. The Lead Provider will be expected to allow referrals from the following sources (as a minimum offer):

i. Assertive outreach teams (Section 2.2)
ii. Hospital liaison teams (Section 3.3)
iii. Mental health services (see Dual Diagnosis: Section 3.7)
iv. Primary care
v. Self-referral
vi. Non-structured treatment services (e.g. Aftercare services, Specialist housing services)

c.

d. Upon referral service users will be undergo screening, the structure and content of which will be agreed with Commissioners. It is expected that an appropriately skilled professional will conduct an holistic assessment of each service user to determine their level of need, level of risk and recovery capital. The person conducting the screening review will then determine which level of intervention the service user is likely to require initially. This will be based upon the four-tier model described by the National Treatment Agency[5]:

[5] National Treatment Agency. *Models of care for treatment of adult drug misusers: Update* (2006) - link



b. Higher tiers in the model correspond to increasing levels of need and complexity. The purpose of the treatment and recovery model is to allow service users to move between tiers (either up or down) dependent on a dynamic assessment of their needs and any associated risks. There is a degree of overlap between tiers but they can be broadly summarised as follows:

i. Tier 1

- Services supporting the drug and alcohol service provided by generic providers
- Examples may include:
  - Tier 1 screening and brief interventions (3.9.1)
  - Housing support (3.15)
  - Education, employment and training interventions (3.14)

ii. Tier 2

- Drug and alcohol interventions out-with structured treatment
- May require a lower degree of commitment from the client
- Examples may include:
  - Interventions to engage people into drug treatment
  - Interventions to support people prior to structured treatment
  - Interventions to help retain people in the treatment system
  - Harm reduction interventions (Section 3.7)
  - Tier 2 screening and brief interventions (Section 3.9.2)

iii. Tier 3

- Planned interventions that meet the threshold for structured treatment, which is defined according to the requirements of NDTMS reporting[6]
- Service users accessing Tier 3 services will accepted by the *Case Management Team* (Section 2.1) and have regular reviews of a personalised care plan
- Requires completion of NDTMS returns
- Examples include:

[6] NTA (2012) NDTMS data set J: Implementation guide for adult drug and alcohol treatment providers: Page 20 - link

- Pharmacological interventions (Section 3.4)
- Community detoxification (Section 3.2)

- Other interventions (e.g. Psychosocial interventions) may be considered a Tier 3 treatment if a specified treatment course is required and the level of need and/or risk requires service users to be subject to a Care Plan and regular reviews by a Case Manager

iv. Tier 4

- These are specialist drug and alcohol services, including:
  - Residential rehabilitation
  - Inpatient detoxification
- These services are not in the scope of this tender (with the exceptions outlined in Section 1.5.1
- The Lead Provider will be expected to offer support to service users entering and exiting Tier 4 services (Section 3.1)

c. Service users accepted into structured treatment will be allocated to a Case Manager who will co-ordinate their journey through BST substance misuse service. The Case Manager will work with the service users to develop a personalised care plan including referral for interventions available within the substance misuse service. Service users will be actively supported including regular reviews at a frequency dependent on the level of need and risk, to be agreed with the Commissioners.

d. Where appropriate, the Case Manager will ensure that service users who are not engaging with structured treatments are referred to the *Assertive Outreach Team* for support (Section **Error! Reference source not found.**).

e. Service users with high levels of complexity will be managed in collaboration with the Complex Case Review Team (Section 0). This will provide an enhanced level of support until service users can be stepped-down to the *Case Management Team*.

f. When appropriate, service users will be stepped-down from the *Case Management Team* and receive a package of aftercare as part of their ongoing recovery journey for a further five years (Section 2.5). Pathways to recovery are often not straightforward and the Case Manager and Aftercare services will ensure that service users experiencing difficulties, including relapse, are referred back in to the appropriate components of the service, depending on their needs.

g. It may be decided that some service users will not be eligible for structured treatment when they are initially screened. This will be documented in a Care Plan and the service user will still have access to other components of the delivery model, including the Recovery Community and Group Work interventions. The Lead Provider will work with Commissioners to develop a system whereby these cases will still undergo periodic review to identify any increasing risks or needs that may require users to access structured treatments or other aspects of the system. It is expected that the intensity and frequency of these reviews will be less than that for service users in structured treatment.

1.6.2 Eligibility

The following general eligibility criteria will be applied across the system:

a. **Residence**
   i. Service users will be resident in either Bolton, Salford or Trafford Council areas

b. **Age**
   i. In **Salford and Trafford:**
      - Service users aged under 21 will be considered young people
      - Service users aged 21 and over will be considered adults
      - In exceptional cases service users aged 21 to 24 may be considered eligible to remain in, or access, the Young People's service as determined by their Case Manager.

   ii. In **Bolton:**
      - Service users aged 19 and under will be managed by a separately commissioned service which is outside the scope of this contract (except for Pharmacological interventions)
      - Service users aged 20 and over will be considered adults

c. **Family**
   i. Family and extended family of service users are eligible for those parts of the treatment system specifically aimed at families

   ii. All family members will be strongly encouraged to access appropriate levels of treatment within the wider system where appropriate

1.6.3 Exclusion criteria

All relevant need and risk will be assessed and managed within the *Case Management Team* with support from the *Complex Case Review Team* where necessary. No one will be excluded from recovery entirely.

1.6.4 Operational details

The service will be delivered in accordance with the following overarching requirements:

a. Location

   i. Unless otherwise specified each element of the treatment and recovery system will be located at convenient points throughout Bolton, Salford and Trafford accessible by public transport

   ii. Access points will be determined by service user consultation and provider engagement with the Joint Strategic Needs Assessment.

   iii. Account must be taken of the mandated facilities (Section 4.6)

b. Hours of operation

i. Unless otherwise specified the Lead Provider and Commissioners will agree and confirm the hours of operation during the transition period.

ii. Any subsequent change to the hours of operation requires the agreement of Commissioners.

1.6.5 Admission criteria

a. Admission to each aspect of the BST substance misuse service will be based on need and suitability. Denial of access must be reasonable, proportionate and timely. All procedures governing exclusions must be available to view, easy to understand, fair, hear both sides, allow for representations and have a clear process of review and appeal, with a clearly described chain of governance.

b. Eligibility will be determined at an initial screening interview. Cases involving significant complexity will be referred to the Complex Case Review service which will work under existing NHS and Local Authority procedures (CPA, MDT, MAPPA, MARAC, and Safeguarding, Child Protection etc) to provide support to the service user and their Case Manager, as outlined in Section 0.

1.6.6 Discharge Process

a. Planned completions

i. The Lead Provider will agree a consistent discharge process with all partners contracted to deliver within the treatment system.

ii. Conditions of the discharge process include that:

- Case Managers will take responsibility for appropriately stepping service users down to lower threshold parts of the system
- Service users completing structured treatment will be referred on to Tier 2 Aftercare services (Section 2.5) and will have the opportunity to access personalised budgets for a period of up to 3 years (Section 0).
- Complete discharge from the system will occur after a five year period post-treatment during which time there will be ongoing contact from the telephone aftercare service (Section 2.5)
- National guidance regarding discharge from NDTMS must be followed.

b. Unplanned completions

i. These cases will be referred on to the *Assertive Outreach Team* (Section **Error! Reference source not found.**).

ii. Cases with high risk features will trigger a formal inter-disciplinary case management review, co-ordinated by the *Complex Case Review Team* (Section 0).

- This will determine risk and need in relation to set criteria including (but not limited to) child protection, safeguarding, prescribing, community safety (prison, police and probation), physical and mental health risks.

iii. Discharge of service users against professional advice will only occur following an appropriate risk and needs assessment by the *Complex Case Review Team*

1.7 Acronyms

AA	Alcoholics Anonymous
ACMD	Advisory Council on the Misuse of Drugs
AUDIT	Alcohol Use Disorders Identification Test
BBV	Blood Borne Virus
BME	Black and Minority Ethnic
BST	Bolton, Salford and Trafford
CAF	Common Assessment Framework
CAMHS	Child and Adolescent Mental Health Services
CDAO	Controlled Drugs Accountable Officer
CISS	Christo Inventory for Substance-misuse Services
CJS	Criminal Justice System
CPA	Care Programme Approach
DAAT	Drug and Alcohol Action Team
DAMS	Drug and Alcohol Monitoring System
DANOS	Drugs and National Occupational Standards
DBS	Disclosure and Barring Service
DIRDET	Drug Intervention Record Data Entry Tool
DRR	Drug Rehabilitation Requirements
EIP	Early Intervention and Prevention Service
ETE	Education, Training and Employment
FACS	Fair Access to Care Services
GMC	General Medical Council
GMCA	Greater Manchester Combined Authority
GP	General Practitioner
HIV	Human Immunodeficiency Virus
HMP	Her Majesty's Prison
IBA	Identification and Brief Advice
ITEP	International Treatment Effectiveness Project
JSNA	Joint Strategic Needs Analysis
LGBT	Lesbian, Gay, Bisexual and Transgender
LES	Local Enhanced Services
LIN	Local Intelligence Network
MAPPA	Multi Agency Public Protection Arrangements
MARAC	Multi-Agency Risk Assessment Conference
MASH	Multi Agency Safeguarding Hub
MDT	Multi-Disciplinary Team
MHRA	Medicines and Healthcare products Regulatory Agency
NA	Narcotics Anonymous
NDTMS	National Drug Treatment Monitoring System
NEXMS	Needle Exchange Monitoring System
NHS BSA	National Health Service Business Services Authority
NICE	National Institute for Health and Care Excellence
NTA	National Treatment Agency for Substance Misuse (PHE)

OCU	Opiate and/or Crack Cocaine User
PGD	Patient Group Direction
PHE	Public Health England
PHOF	Public Health Outcome Framework
PMF	Performance Management Framework
PPO	Prolific and Priority Offenders
PSR	Public Sector Reform
QuADS	Quality in Alcohol and Drug Services
RADAR	Rapid Alcohol Detox Acute hospital Referral
RAG	Red, Amber, Green rating system
RAID	Rapid, Assessment, Interface and Discharge
RCPsych	Royal College of Psychiatrists
RE-AIM	Reach Efficacy Adoption Implementation Maintenance
ROTL	Release on Temporary Licence
SAR	Specified activity requirements
SCH	Secure Children's Home
SOP	Standing Operating Procedure
STC	Secure Training Centre
TOP	Treatment Outcome Profile
YOI	Young Offenders Institute
YOS	Youth Offending Service
YPOR	Young Peoples Outcome Record

2. CASE MANAGEMENT

Active Case Management is fundamental to the BST substance misuse service. All service users accepted into structured treatment (see Section 1.6) will be assigned a Case Manager who will co-ordinate the interventions and support which they will receive while in structured treatment.

To ensure effective case management for young people and adults throughout the treatment system the Lead Provider is expected to create and develop the following teams:

i. Case Management Team (Section 2.1)
ii. Assertive Outreach Team (Section **Error! Reference source not found.**)
iii. Complex Case Review Team (Section 0)
iv. Young People's Team (Section 2.4)
v. Aftercare and Discharge Team (Section 2.5)

2.1 Case Management Team

a. The *Case Management Team* will offer consistent support to service users during their treatment and recovery journey, which may span multiple parts of the service. Its aim is to ensure that the right treatment is offered, at the right time, in the right place, for the right amount of time to the right person. It also provides a gate-keeping function for the treatment system.

b. The key functions of the *Case Management Team* are:

   i. Screening
   ii. Assessment of risk
   iii. Determination of need
   iv. Allocation of resources

2.1.1 New cases

a. New cases will undergo a screening interview which will determine their eligibility for the service based on an assessment of their needs and any risks identified. In order to be eligible for the *Case Management Team*, service users must be entering structured treatment (see Section 1.6 for definition). As outlined in Section 1.6.1, the Lead Provider is expected to work with Commissioners to agree a system whereby service users not in structured treatment can also benefit from periodic review of their needs.

b. Cases accepted by the *Case Management Team* will then be allocated a Case Manager within five working days, who will be the primary contact for the service user whilst they remain in the BST substance misuse service.

2.1.2 Existing cases

a. The Case Management Team will be involved with all elements of the treatment system across all Tiers. The Lead Provider should ensure that each component of the BST substance misuse service has access to the *Case Management Team* in order to refer new cases or discuss existing ones (for example, in the case of escalating risk).

b. The scope and frequency of support provided by Case Managers to their clients depends on a dynamic assessment of the levels of needs and risk of individual service users and should be based on national guidance, including from PHE. Functions of the Case Manager include:

i. **Needs assessment and risk assessment**
- All service users will be subject to regular assessment by their Case Manager (at a frequency to be agreed with the Commissioner)
- The provider will ensure close working relationships with partners to ensure that those with a mental health dual diagnosis receive appropriate interventions (see Section3.7)

ii. **Care Planning**
- All service users will have regular care-planning sessions (at a frequency to be agreed with the Commissioner)
- The provider will actively encourage the involvement of carers and families in the care plan
- Care plans will include the setting of appropriate goals and their content will include (but not be limited to):
  - Clinical and non-clinical interventions
  - Mental and physical health (see Section 3.6.1)
  - Finances
  - Housing
  - Family
  - Social relationships
  - Education, training and employment
  - Offending behaviour, where appropriate

iii. **Treatment reviews**
- For those in structured treatment
- This will include TOP and NDTMS sub-intervention updates.

iv. **Recovery support**
- Tailored support to improve recovery capital of service users
- This will include support relating to individual care and recovery (e.g. family and carer information, employment support, housing advice, physical and mental health advice, social care)

v. **Safeguarding**
- Case Managers will be trained to appropriately identify and act upon any Safeguarding concerns, including in relation to domestic violence

vi. **Care co-ordination**

- The *Case Management Team* will ensure effective communication with the wider clinical network, especially GPs and Pharmacists - including regular updates on reviews and/or significant changes to the care plan
- Case Managers will ensure that all service users have a named GP
- Significant updates will be provided in writing.
- All unsuccessful completions and unplanned discharges will be referred on to the *Assertive Outreach Team* (Section **Error! Reference source not found.**)

vii. **Aftercare**

- The Case Management service will oversee aftercare services including telephone aftercare (see Section 2.5)

2.2 Assertive Outreach Team (AOT)

a. The provision of an *Assertive Outreach Team* (AOT) is a fundamental requirement of the integrated treatment and recovery system. The Lead Provider is required to deliver a creative and flexible way of working with people who have problems relating to substance misuse who may be hard to engage or resistant to services.

b. The approach is characterised by work with clients in their own environment, wherever that may be. It will have two key, complementary functions:

   i. Identifying and engaging people not known to services with drug and alcohol problems in communities which may not engage with traditional services

   ii. Reaching and engaging with service users who drop out of treatment

c. It is expected that the AOT will contribute to a decrease in the numbers of high risk individuals that we lose contact with, reduce unplanned completions, and increase previously unknown entrants.

d. Many of these individuals and families will have very poor recovery assets but this is not necessarily their defining feature, as troubled individuals and families exist across the social and health gradient. . The AOT must reach and engage with service users in understandable language and behaviour.

e. The service must also work in close partnership with other aspects of the treatment and recovery system including (but not limited to):

   i. Harm reduction services

   ii. Medical intervention services

   iii. Dual diagnosis services

   iv. Hospital liaison services

   v. Pharmacological intervention services

   vi. Housing support

   vii. Criminal justice interventions

   viii. A+E

   ix. RAID

   x. Social Work teams

      - Currently in **Salford** there is an arrangement whereby the Drug and Alcohol service funds a social worker who is based within Salford Council's Social work department
        - This worker links both services and is able to use intelligence within the Social Work team to support outreach work targeting socially vulnerable and isolated individuals
        - It is recommended that the incoming Lead Provider continue this working arrangement

2.2.1 Identifying people not engaging with services

a. The AOT will work in a highly innovative way across Bolton, Salford and Trafford (in the home, on the street, in community venues) to implement approaches that proactively seek out drug and alcohol users unknown to services and provide persistent and intensive support. Priority will be given to specific at-risk populations including (but not limited to):

   i. Those within the Criminal Justice system (see Section 3.16)

   ii. Veterans

   iii. Homeless populations

   iv. BME communities and travellers

   v. Those with severe and enduring mental health problems (see Section **Error! Reference source not found.**)

   vi. Women and men suffering from domestic violence

   vii. Sex Workers

   viii. LGBT Groups

   ix. Disabled people – including mental, sensory, learning and physical

   x. Young people from the following groups:
      - Looked after children
      - Young offenders
      - Persistent absentees / excluded
      - Children of substance misusing parents
      - Young people with mental health issues

b. The Lead Provider will be expected to consider how best to meet the needs of these groups, involving collaborating with existing organisations including (but not limited to) community groups and housing providers where appropriate.

c. The aim of the service will be to bring people into structured treatment where appropriate and practical. However, it is recognised that there may be individuals (judged to have capacity to decide) who are in need of help but decline structured treatment despite exhibiting high-risk characteristics. The AOT will continue to engage with such individuals and provide appropriate support for as long as it is felt to be beneficial.

2.2.2 Engaging with service users who drop out of treatment

a. The service will look to re-engage those who have dropped out of treatment. Case managers will refer such cases into the AOT. Cases will be prioritised based upon perceived needs and levels of risks with particular priority given to those with:

   i. Complex needs

   ii. High levels of risk, including safeguarding concerns

   iii. Frequent drug and alcohol related admissions and attendances at Accident and Emergency departments

b. The Provider will be expected to develop information sharing agreements and pathways with A+E departments to allow frequent attendees with substance misuse problems (both drugs and alcohol) to be highlighted and referred into this service. An example of this approach can be seen in the current Salford Alcohol *Assertive Outreach Team* model[7]

c. It is expected that many of these service users will come from high-risk populations including those listed in Section 0, hence the development of relationships with these at-risk groups will be vital to the success of this service.

d. Allocation to the AOT will be decided by a Multi-disciplinary team (MDT), the members of whom are to be agreed with Commissioners. At the point of acceptance the MDT will determine the types of intervention felt most important for an individual service user. Examples may include (but are not limited to):

   i. Encouragement to engage with specialists (e.g. Psychologists, Psychiatrists, Forensic Services, Gastroenterologists, GPs, Police, Probation, Housing, Children Services, Adult Services, Third Sector Organisations)

   ii. Acting as bridge to recovery services and fellowship organisations

   iii. Building resilience and self reliance.

   iv. Brief interventions

   v. Specialist harm reduction support

   vi. Healthcare assessments

   vii. Support with paying bills etc.

e. Service users accepted by the AOT will be allocated a support worker who will work in collaboration with the Case Manager to provide appropriate interventions. The support worker will make regular contact with the service user. In cases of high need and risk this may require daily input initially. It is expected that the amount and frequency of support provided will gradually reduce over time as measurable risk and need reduce, until the service user no

[7] Hughes et al. (2013*) Salford alcohol assertive outreach team: a new model for reducing alcohol-related admissions*. Frontline Gastroenterology. 4(2):130-134

longer requires support from the AOT (but will continue to be supported by the *Case Management Team*).

2.2.3 Overarching service delivery requirements

a. Responsibilities of the Lead Provider

In respect to the AOT, the Lead Provider will be required to:

i. Conduct an asset-mapping exercise to identify existing support groups working with at-risk groups within Bolton, Salford and Trafford

ii. Conduct surveillance of the needs arising from highly complex and extreme forms of drug and alcohol use in Bolton, Salford and Trafford

iii. Assist Case Managers to manage the transition of service users between services

iv. Assist Case Managers to reach out to troubled families, considering the safeguarding of both adults and children (including those who become subject to formal child protection procedures).

v. Implement lone working policies to ensure that staff carrying out assertive outreach activities are not placed at risk

vi. Accurately record assertive outreach activity for service users known to the system within the Case Management IT system to ensure staff who may come into contact with the service user are fully aware of the current status of the case. Outreach work attempting to engage service users unknown to the substance misuse service will need to be recorded in alternative ways, to be agreed with Commissioners.

vii. Escalate concerns to appropriate authorities (for example, the Council, the probation service or the police) when service users have disengaged and increased risks are identified

b. Operational details

The service will be delivered in accordance with the following delivery requirements:

i. *Referrals*

The Lead Provider should ensure that the following referral routes are available:

- Routine referrals by the Case Manager (it is expected this will account for most referrals)
- Emergency referral from anywhere in the recovery system.
- Former AOT users may self-refer

ii. *Access*

- The Service will have a central base with access points determined by service user consultation and provider engagement with the Joint Strategic Needs Analysis.

- A range of techniques will be employed to contact and engage with Service Users including home visits, telephone calls, text messaging and liaison with other key partners (for example Police, Probation, Hospital, Housing, Jobcentre Plus).

iii. *Workforce*

- Consideration will be given to the role of employing former service users as peer mentors (see Section 3.14) within the workforce of the AOT in order to enhance outreach work, encourage the distribution of harm reduction advice and promote referrals into the service.

iv. *Discharge Process*

- Cases will typically be stepped down from the AOT by Case Managers.
- National guidance regarding discharge from NDTMS must be followed.
- The AOT will only discharge service users into Tier 2 and above services
- Unplanned completions in this service represent an immediate risk which will require mitigation, including the creation of risk management plans, via a multi-disciplinary process.
- In the case where a service user continues to be disengaged from treatment, the Provider will share all relevant information with Criminal Justice agencies, Children's Services or key stakeholders as appropriate within 24 hours.

2.3 Complex Case Review Team (CCRT)

a. The Lead Provider is expected to ensure that in Bolton, Salford and Trafford complex cases can be referred into a *Complex Case Review Team* (CCRT). Taking a co-ordinated approach to managing complex cases is a key aspect of the Public Sector Reform agenda. The CCRT will sit above the BST substance misuse service and accept referrals from the Case Management Team for service users with highly complex needs. They will then perform a strategic role in ensuring that all agencies involved in supporting complex service users are working collaboratively to meet shared objectives outlined within a personalised care plan.

b. Service design

i. This will be a highly specialist multi-disciplinary and multi-agency local service which manages complex and severe cases posing the greatest risk to themselves and others. A list of case characteristics necessitating referral to the *Complex Case Review Team* will be agreed with Commissioners. Examples of these may include (but are not limited to):

- Safeguarding concerns
- Domestic violence
- Severe and enduring mental illness
- High-risk medical co-morbidities

ii. The Lead Provider will ensure that there are clear protocols and training provided to Case Managers to enable them to identify and refer such cases on appropriately. Following referral, service users will remain under the *Case Management Team* while receiving input from the CCRT, but it is expected that their Case Manager will provide an increased degree and frequency of support and the *Assertive Outreach Team* will be expected to play a supportive role where necessary.

iii. The CCRT will be led by a Consultant or Specialist-Generalist and will be required to demonstrate specialist expertise from areas including (but not limited to):

- Substance misuse
- Clinical Medicine
- Psychiatry
- Social work (both adult and children's expertise)
- Any other appropriate partners

iv. The CCRT will meet regularly, at a frequency to be agreed with the Commissioners. The Case Manager of the service user will be expected to attend these meetings. At each MDT, the care plans and risk assessments of accepted service users will be reviewed and changes made as necessary. Cases will be stepped-down following an agreement at the MDT that the level of risk has improved. These cases will continue to get support from the *Case Management Team*.

v. In addition to this MDT input, service users managed under the CCRT will be eligible for referral to a clinical psychologist who should be based within the team.

c. **Responsibilities of the Lead Provider**

The Lead Provider will be expected to ensure that:

i. Specialist Governance procedures are created in liaison with the Responsible Consultant, local Safeguarding and Child Protection teams, Clinical Commissioning Groups. These should be in accordance with existing recommendations from PHE and NICE (Section 1.2)

ii. Necessary data sharing arrangements are in place to allow each access and sharing of clinical and risk information between Agencies, in accordance with Information Governance requirements

iii. A small number of high-risk cases (the critical few) will be managed under special measures dictated by clinical and community safety requirements Denial of access to such services must be reasonable, proportionate and timely, and be clearly described in the processes laid down by service governance

iv. Processes for the more complex cases, families and groups are fully integrated with existing NHS and Local Authority MDT arrangements (e.g. CPA, MDT, MAPPA, MARAC, Safeguarding, Child Protection etc).

v. The service works closely with the *Assertive Outreach Team* (Section **Error! Reference source not found.**) to ensure that high risk cases are supported up in the most appropriate location

d. **Operational details**

The service will be delivered in accordance with the following delivery requirements:

i. Referral process

- Referrals to the CCRT will normally be via the *Case Management Team*

ii. Waiting times

- The Lead Provider will ensure that waiting times for assessment, interventions and structured treatment are as short as possible

iii. Discharge

- Unplanned completions with high risk features will be referred directly to the AOT where a formal inter disciplinary case management review will take place and the risks and needs in the case are considered from a cross sectional viewpoint, to include child protection, safeguarding, prescribing, community safety (Prison, Police and Probation), physical and mental health risks (Severe and Enduring Mental Health cases).
- Planned completions will be stepped down to the *Case Management Team*
- The discharge processes for the more complex cases and families / groups will be best managed by a multi-disciplinary forum under existing NHS and Local Authority procedures (for example: CPA, MDT, MAPPA, MARAC, Safeguarding, and Child Protection).

2.4 Young Person's Service

DUE TO EXISTING ARRANGEMENTS THIS SERVICE IS NOT BEING COMMISSIONED FOR BOLTON LOCAL AUTHORITY AREA AS PART OF THIS TENDER PROCESS

The young person's substance misuse service will target vulnerable young people most at risk of developing serious and persistent substance misuse problems. The service for young people will function independently from the service for adults but the referral pathways and structure of provision will essentially be the same. Young people must be able to access high-quality, age-appropriate and evidence-based specialist substance misuse treatment interventions as a part of packages of care-planned support tailored to the individual, including social and health care interventions. In order to support a young person to change their pattern of substance misuse, it may also be important to involve parents, family and significant others with aspects of care and provide them with support.

2.4.1 Case Management

a. The young person's substance misuse service should have a *Case Management Team*, which is separate from the adult team. There will be specialist Case Managers who are trained to work with young people specifically. The functions of the Young Person's *Case Management Team* will otherwise be the same as the adult equivalent (outlined in Section 2.1)

b. Young people will also be able to access the *Assertive Outreach Team* (Section **Error! Reference source not found.**), which will be expected to provide dedicated support workers to engage young service users at risk of dropping out of treatment. These support workers will also be expected to attempt outreach activities at times and in places where there are likely to be young people (unknown to services) requiring support in respect of drug or alcohol problems

a. Young people will also be able to benefit from the **Complex Case Review team** (Section 0). Case Managers for the young person's service will be able to access the CCRT according to guidelines to be agreed with the Commissioners. The Lead Provider will ensure that the CCRT has specialist expertise in working with young people.

2.4.2 General interventions

a. Young people will have access to all interventions offered within the general substance misuse service. All interventions within the young person's service will be delivered separately from adult services.

b. The Lead Provider will be expected to ensure that all interventions provided to young people are specifically designed to meet the needs of this population. With regards to the substance misuse service this will require adaptions to services including (but not limited to):

   i. *Hospital liaison* (Section 3.3). The Lead Provider should ensure that members of the hospital liaison team have received appropriate training to work with young people presenting acutely to hospital with drug and alcohol problems.

ii. *Pharmacological Interventions* (Section 3.4). These interventions should cover both alcohol and substance misuse and be delivered in accordance with relevant national guidelines.

iii. *Healthcare Assessments* (Section 3.6). All young people engaging with treatment should receive a regular comprehensive assessment including a healthcare assessment which is tailored to the needs of young people (Section 3.6.1), at a frequency to be agreed with Commissioners

iii. *Dual diagnosis support and psychosocial Interventions* (Sections 3.7 and 3.10). Young people within the service should be able to access Counselling, Cognitive behavioural therapy, Motivational interviewing, Relapse prevention and Family work. Depending on the age of the young person, this may involve collaborative working with local CAMHS providers.

iv. *Harm Reduction* (Section 3.8). Specialist advice and support targeted at young people will be provided, including in relation to injecting, overdose and accidental injury

v. *Group work interventions* (Section 3.12). The Lead Provider will develop specific groups for the young person's service

2.4.3 Youth Offending Service (YOS)

- The service will work with the YOS in developing substance misuse provision that meets both local needs and national standards, increases drug and alcohol awareness among young people involved in the criminal justice system, reduces levels of substance misuse amongst YOS clients, and identifies all YOS clients requiring specialist substance misuse support.

- The service will:

  i. Provide dedicated and specialist Tier 2 / 3 substance misuse resources to Youth Offending Services in all three boroughs.

  ii. Provide Specialist Tier 3 key work support to YOS clients with significant substance misuse issues.

  iii. Support group work sessions for clients.

  iv. Support diversionary activities with YOS clients.

  v. Support the development of service activity days.

  vi. Support parenting work and interventions where appropriate.

  vii. Offer specialist information, advice and training for YOS staff.

  viii. Offer training for staff of other services working with the YOS (e.g. Looked After Children and Pupil Referral Units).

2.4.4 Secure estate

a. Substance misuse within the Young People's Secure Estate is **not in scope** for this tender. The young people's specialist treatment service will work with the secure estate to ensure the smooth transition between custody and community for young people from Salford or Trafford with a substance misuse need.

b. This will involve attending case conferences and liaising with the YOI / SCH / STC following release and throughout the licence period as applicable.

2.4.5 Training requirements

a. The service will provide training to local authority and voluntary sector staff working with vulnerable young people from the priority groups. The training will cover:

   i. Age-appropriate screening of young people for substance misuse issues

   ii. Delivery of brief interventions

   iii. Referral process and pathways within the system.

b. The number of training sessions and individuals trained will be agreed with commissioners.

c. Training will be targeted at those services and staff most in need. It will be informed by regular reviews of referral numbers and pathways and by consultation with partners. It will ensure young people can quickly and easily access the full range of help and support they need from other agencies. It will increase the appropriateness of referrals and reduce the time between the identification of a substance misuse issue and the delivery of specialist interventions. Training provided by the service should be routinely evaluated.

d. Staff will be appropriately skilled and have the ability to successfully engage and maintain positive relationships with young people and their families/carers.

2.4.6 Overarching service delivery requirements

a. Responsibilities of the Lead Provider

In respect to the Young Person's service, the Lead Provider will be required to:

   i. Developing joint working protocols with Children's services in Bolton, Salford and Trafford Local Authorities

   ii. Encourage early identification in order to intervene early to avoid crisis and safeguarding risks and improve outcomes for vulnerable young people; including in relation to substance misuse, educational attainment, teenage pregnancy, offending and family support

   iii. Managing the smooth transition from young people's services to adult services.

   iv. Establish data sharing arrangements to determine the extent of crossover between substance misuse services and Child Protection, Child In Need, Early Intervention and Prevention and care proceedings

   v. Help young people to strengthen their resilience by developing the factors that promote it, such as educational achievement, training and employment, good health, positive relationships and meaningful activities.

   vi. Act responsively to changes in patterns of substance use amongst young people in Salford and Trafford.

   vii. Ensure that the voice of the child is central to the model and evidenced in reporting.

viii. Work in partnership with other agencies to address wider needs and optimise successful onward referrals, including (but not limited to):

- Leaving Care Services
- Youth Offending Service
- Alternative and mainstream education
- Hospital and other health services including school nursing
- Adult substance misuse services
- Connexions
- Helping families
- Safeguarding services
- Targeted youth services
- Relevant voluntary sector organisations
- Neighbourhood teams
- Housing services
- Sexual health services
- Children and Adolescent Mental Health Services (CAMHS)
- Emotional health services
- Early Help Hub 0-11 and 11-19
- Stronger Families

ix. Salford only:

- Work with the *Leaving Care* Service
  - This service employs a worker to provide substance misuse provision including routine screening to all young people within that service. This post is not in scope for this tender. The service will work closely with this worker
- Provide an appropriately trained worker to be based at *The Bridge* (a multi-agency hub which screens all contacts concerning the welfare or safety of a child. This will allow early detection of children and families requiring support and will also facilitate collaboration and appropriate data-sharing for complex and high-risk families

b. Operational details

The service will be delivered in accordance with the following delivery requirements:

i. Eligibility

- All service users aged under-21 will be considered young people. This will be reflected in the treatment and recovery offered. Young people in the structured treatment system will be reported on using the Young People's NDTMS core data set.
- In exceptional circumstances the service will work with clients resident in Salford and Trafford with alcohol and/or drug problems up to the age of 25, at the discretion of the *Case Management Team*.

ii. Priority groups

- The service will prioritise those young people most in need. This will take account of age, vulnerabilities and deprivation and also the following key groups:
    - Young people with mental health issues
    - Looked after children
    - Young offenders
    - Persistent absentees / excluded
    - Children of substance misusing parents

iii. Referrals

- The service will develop a clear threshold for access and ensure these are passed on to partners agencies. Referral pathways will be established with relevant agencies. Referrals should come with a CAF and / or Early Help Assessment (EHA).
- Key referral agencies include, but are not limited to:
    - Youth services
    - Children and families services
    - Looked After Children
    - Education, including alternative education
    - Youth Offending Service
    - Health and mental health services
    - Sexual health services

iv. Response and waiting times

- Responses will be rapid and proportionate to risk. No response time will exceed five days. Waiting times will not exceed three weeks.

v. Case management

- Case management and care coordination will sit outside the adult Case Management function whilst utilising common IT systems.
- The service will utilise the same Case Management IT system as the other parts of the treatment and recovery system. It will be fully compliant with the latest version of the Young People National Drug Treatment Monitoring System (NDTMS) core data set including the Young People's outcome record (YPOR) and will accommodate any changes to the core data set.

vi. Access

- Provision for young people must be available in a friendly environment that is acceptable, accessible and non-stigmatising for service users. It must also be delivered from locations that are separate from adult delivery.
- The hours of operation must be flexible and will include the provision of out-of-hours services to ensure that young people in education/employment can access treatment.

vii. Discharge

- All successful discharges will include an onward referral to a named service.

- Unplanned exits will be referred on to the *Assertive Outreach Team*. The referring source must be informed and consultation and support provided where appropriate.
- The Lead Provider will develop an agreed process for service users who need to transition between the Young Person's team and the Adult *Case Management Team*

c. Performance management

The service will work towards delivering PHOF and PHE outcomes for Salford and Trafford. The service will be required to:

i. Evidence the improvement of outcomes for young people in specialist treatment.

ii. Record additional locally agreed outcome data in addition to the NDTMS YPOR at treatment start, review and planned exit. This will be reported on quarterly.

iii. Design local performance indicators and targets to demonstrate effective delivery of the service outcomes, to be agreed with commissioners.

2.5 Aftercare and Discharge

a. Recovery from substance misuse is a lengthy process, particularly for those with comorbid health and social problems. The evidence suggests that it can take five years to determine whether a sustained recovery has been established after someone has overcome their dependence on drugs or alcohol[8].

b. The Aftercare and Discharge service will be light touch but perform a vital function in linking treatment and recovery for adults and young people. It will work alongside other elements of recovery provision in the system, acting as a contact point for other parts of the recovery community. Aftercare will be orientated around a telephone support service.

c. Service detail

i. Service users completing structured treatment will be referred on to Tier 2 Aftercare services where they will have the opportunity to access personalisation budget within the Recovery Fund for a period of up to 3 years. Complete discharge from the system will occur after a five year period post-treatment during which the telephone aftercare service will provide regular contact.

ii. The telephone aftercare service will ideally staffed by trained volunteers and peer mentors who will:

- Call members of the recovery community to see how their recovery is progressing.
- Make referrals back into the treatment service via the Case Management team where there are concerns about an individual, either directly or via the wider recovery community
- Engage people with the recovery community through invitations to recovery events or an invitation to a mutual aid event

iii. Level of contact will be determined by risk and complexity. Any cases requiring input from the CCRT during treatment will be managed as Complex during the Aftercare period. The table below shows the recommended frequency of contact for the five years following successful completion of structured treatment:

Time since discharge	Complex	Non-complex
0-12 weeks	Weekly	Weekly
12-52 weeks	Monthly	Quarterly
Year 2	Quarterly	Six monthly
Year 3	Six monthly	Six monthly
Year 4	Six monthly	Six monthly
Year 5	Six monthly	Six monthly

iv. We expect services to obtain consent from service users to be contacted throughout their recovery. This will include consent to pass details on to the AOT when genuine concerns are raised.

d. Responsibilities of the Lead Provider

[8] ACMD (2013) What recovery outcomes does the evidence tell us we can expect? - link

The Lead Provider will be required to:

i. Remain in contact with former service users in recovery for five years following discharge
ii. Support mutual aid opportunities in the recovery community and promote recovery events
iii. Signpost people in recovery to universal health and social care services.
iv. Re-engage those suffering from relapse as appropriate
v. Alert the AOT (Section **Error! Reference source not found.**) if further support is recommended
vi. Agree a consistent discharge process with all partners contracted to deliver within the treatment system

e. Performance management

Reporting will be minimal and will consist of the following:

i. Referrals received
ii. Call attempts and contacts made
iii. Numbers in recovery
iv. Numbers experiencing relapse
v. Referrals made

f. Operational details

The service will be delivered in accordance with the following overarching requirements:

i. Referral process

- Referrals will come from treatment services including recovery elements such as step-down care via the *Case Management Team*
- Both young people and adults can be referred

ii. Response times

- First contact should occur within the first week after successful completion of specialist treatment. Contact with individuals of concern should be attempted immediately in conjunction with the AOT.

iii. Waiting times

- There should be no waiting times for this service.

iv. Access

- The service will be telephone based.
- The hours of operation will be flexible based on need.

v. Priority groups

- Those previously managed by the CCRT
- Those who have left treatment most recently
- Parents

vi. Discharge

- Discharge will occur five years after the successful completion of treatment.

3. SERVICE COMPONENTS

This section will outline the key services which the Lead Provider will be expected to deliver within the integrated treatment and recovery system. The order in which they are presented approximates to the Tiered treatment model outlined in Section 1.6, starting with the highest intensity interventions.

3.1 Support for Tier 4 Detoxification and Residential Rehabilitation

a. Service design

i. The Provider will be expected to establish a panel to review applications for detoxification and residential rehabilitation in Bolton, Salford and Trafford. This will be done in collaboration with the Commissioners, who will hold the budget for these services.

ii. The Lead Provider will create and maintain positive relationships with Tier 4 providers to ensure smooth and effective transfer of treatment between Tier 4 and community services, including:

- Preparation pre-detoxification (working with families and carers wherever possible).
- Assessment and referral to Tier 4 services.
- Discharge and post-detoxification prescribing.
- Relapse prevention prescribing.
- Development of an exit plan for clients when discharged from Tier 4 services.

b. Responsibilities of the Lead Provider

In relation to Tier 4 services, the Lead Provider will be expected to:

i. Work closely with commissioners with regard to the Greater Manchester Framework arrangements for inpatient detoxification to ensure assessment and access procedures are in place.

ii. Work closely with Social Services to ensure assessment procedures are in place for access to inpatient rehabilitation and to provide access to young people's, families and adult social care, including specialist mental and physical health services.

iii. Monitor service user journeys following Tier 4 interventions, and report back to Commissioners

3.2 Community Detoxification

a. Community Detoxification is considered to be a Tier 3 intervention within this system. The Lead Provider is expected to ensure the offer of robust community detoxification for suitable cases (in relation to drug and alcohol misuse), in line with national and local guidance, policies and procedures. The nature of this service will be agreed with Commissioners.

b. Consistent with NICE guidance[9], community-based opioid detoxification should be offered to all eligible service users except those who:
   i. Have previously had an unsuccessful community-based detoxification
   ii. Require additional medical or nursing care due to physical or mental health comorbidities
   iii. Require polydrug detoxification
   iv. Have significant social problems which would restrict the benefit of community-based approaches

c. Before recommending detoxification, Case Managers will be expected to work with service users to identify their recovery capital and agree the most appropriate time to attempt detoxification. The Lead Provider will be required to demonstrate effective clinical governance arrangements to ensure that service users undergoing community detoxification are receiving appropriate levels of medical and psychosocial support.

d. Pathways will exist to facilitate timely referrals into inpatient detoxification where appropriate.

[9] NICE (2007) CG52 Drug misuse in over 16s: opioid detoxification - link

3.3 Hospital liaison service

VARIANCE – This service is not being commissioned in Bolton, due to existing arrangements

a. Alcohol and drug misuse is associated with increased rates of emergency presentations to hospital, often through Accident and Emergency departments. This is a group who often do not engage with other services. Furthermore, the point at which a person with drug or alcohol problems presents acutely to hospital represents a critical moment at which they may be more receptive to targeted support, including referral into treatment services where appropriate.

b. Having an effective hospital liaison service has three complementary functions:

   i. Identifying and engaging new service users, previously unknown to treatment
   ii. Working with established service users to reduce unplanned admissions

Supporting the medical care of service users following admission to hospital

c. Salford currently has a well-established hospital-based Alcohol Assertive Outreach Team which provides a liaison service, in addition to aspects of Complex Case Review and Assertive Outreach support[10].

d. ***Service details***

The Lead Provider will be expected to work in collaboration with NHS Clinical Commissioning Groups and NHS Trusts to develop a specialist service to provide the following functions:

i. Brief screening and interventions (see Section 3.9.2) through A+E and other appropriate settings (e.g. fracture clinics)

ii. Specialist drug and alcohol liaison support for services on inpatient wards

iii. Appropriate information sharing with hospital services regarding service users.

iv. Referral of new service users into the *Case Management Team* (Section 2.1)

v. Co-ordinated discharge planning for known service users in collaboration with the *Assertive Outreach Team* (Section **Error! Reference source not found.**) and Housing support services (Section 3.15)

vi. Ensure appropriate continuation of detoxification with psychosocial interventions following discharge from hospital, including transfer to inpatient detoxification units

vii. Developing a surveillance function to identify high-risk cases based on records of admissions relating to drug and alcohol problems

viii. Developing a service to engage and follow-up service users presenting out-with normal operating hours

ix. Ensuring that information on acute presentations through A+E suspected to be related to New Psychoactive Substances is reported on the local Early Warning System

[10] Hughes et al. (2013*) Salford alcohol assertive outreach team: a new model for reducing alcohol-related admissions*. Frontline Gastroenterology. 4(2):130-134

e. **Responsibilities of the Lead Provider**

In order to deliver the above service, the Lead Provider is expected to:

i. Ensure that patients presenting through A+E are appropriately screened for drug and alcohol problems in accordance with national guidance and standards
ii. Develop protocols to describe how service users should be managed when attending A+E or after being admitted to hospital, including where detoxification is required
iii. Ensure that all relevant hospital wards and departments have contact details for the BST substance misuse service,
iv. Develop information-sharing arrangements with hospital services to ensure the timely sharing of information when service users present to hospital services (e.g. in relation to needs, risks and medication dosages). Consideration will need to be given to how this will happen outwith the working hours of the liaison service.
v. Ensure that the named Case Manager of a service user is contacted following admission to hospital.
vi. Ensure that the BST substance misuse service is informed prior to the discharge of a known hospital patient, in order to contribute to safe and appropriate discharge planning.
vii. Ensure that alcohol liaison nurses are involved in delivering training in alcohol screening and brief interventions to hospital staff
viii. Ensure that the liaison service is equipped to support both adults and young people where necessary
ix. Work with the Specialist Housing and Support service (Section 3.15) to identify appropriate accommodation for homeless service users being discharged from hospital
x.

f. **Operational details**

The service will be delivered in accordance with the following delivery requirements:

i. *Location*
- The Lead Provider will be expected to deliver all of the above functions at Salford Royal NHS Trust
- Trafford does not have its own acute hospital. The Lead Provider will be expected to work with Commissioners to develop an appropriate model of support to Trafford residents being admitted through the University Hospital of South Manchester NHS Foundation Trust (Hospital)

ii. *Access*
- The service based at Salford Royal should provide a seven-day service led by alcohol nurse specialists according to set times agreed with Commissioners
- Access at other sites will be developed and agreed with Commissioners.

iii. *Workforce*
- The workforce of the hospital liaison service will vary depending on local need but it is expected to be led by alcohol nurse specialists.
- The liaison service will also have specialist medical and psychiatric support and oversight, provided by an appropriate specialist.

iv. *Discharge*

- Hospital liaison nurses will liaise with the Case Manager of known service users prior to discharge to ensure safe and co-ordinated discharge planning
- People presenting with drug or alcohol problems who are unknown to the service may be referred into the *Case Management Team* at discharge by the hospital liaison team
- GPs will be informed of each admission prior to discharge
- Based on the clinical scenario, liaison nurses will consider referring unplanned discharges to the Assertive Outreach Team (Section 2.2)

3.4 Pharmacological interventions

The Medical Intervention Service is expected to be able to provide specialist prescribing interventions for alcohol and substance misuse problems, as appropriate. Substitute prescribing will be offered where required but be provided as part of a broader recovery focused treatment package, since evidence suggests that the success rates of pharmacological interventions are dependent on treatments being delivered alongside psychosocial and recovery interventions.[11] Prescribing interventions will be reviewed at frequent intervals to ensure that they are contributing towards recovery goals.

3.4.1 Prescribing in substance misuse

a. The Service will be responsible for the following substance misuse pharmacological interventions:

i. Prescribing interventions (adults)

- Stabilisation prescribing
- Substitute prescribing
- Maintenance prescribing
- Detoxification prescribing (outwith Tier 4 settings)
- Overdose prevention prescribing (e.g. Naloxone)
- Relapse prevention prescribing (e.g. Disulfiram and Naltrexone)
- Prescribing to reduce or prevent withdrawal symptoms

ii. Prescribing interventions (young people)

- The service will need to consider local need for prescribing in young people across Bolton, Salford and Trafford
- A joint working arrangement will need to be agreed with the existing Young Person's service in Bolton (which is not being commissioned within this model)
- The Lead Provider will ensure there is sufficient expertise to deliver this service in accordance with national, evidence-based guidelines and safeguarding policies.
- Appropriate multi-agency pathways will be required to ensure that this activity is fully integrated with the activities of the Young Person's service.

iii. Supervised consumption

- Based on PHE guidance,[12] supervised consumption should be available to:
  - Service users starting opioid substitution treatment
  - Cases where it is felt service users will benefit either from continued supervision, or a return to supervision
- The service will work with service users to identify the most appropriate pharmacy

[11] ACMD (2015) How can opioid substitution therapy (and drug treatment and recovery systems) be optimised to maximise recovery outcomes for service users? - link

[12] PHE (2016) Adults – drugs JSNA support pack 2017-18: commissioning prompts - link

- The Lead Provider will develop strong partnership working and contract management arrangements with local pharmacies to ensure the effective utilisation of supervised self-administration.

iv. Support to Tier 4 services

- Preparation pre-detoxification
- Assessment and referral to Tier 4 Services
- Discharge and post detoxification prescribing
- Relapse prevention prescribing following discharge from Tier 4 services

b. In addition to managing opioid dependency, the Medical Intervention Service is also expected to provide specialist support to those suffering with other types of substance misuse, including (but not limited to) in relation to Benzodiazepines, New Psychoactive Substances and prescription medications (including Gabapentin and Pregabalin[13].

3.4.2 Prescribing in alcohol misuse

a. The Service will be responsible for the following alcohol misuse pharmacological interventions:

i. Prescribing in support of community based detoxification (including symptomatic needs)

ii. Nutritional supplements including vitamin supplements for dependant drinkers, in line with national guidance[14]

3.4.3 Overarching service delivery requirements

a. **Responsibilities of the Lead Provider**

The Lead Provider will be required to:

i. Work with Commissioners to developing arrangements to manage prescribing budgets on behalf of each member of the cluster, where appropriate

ii. Comply with relevant guidance from professional bodies including PHE and NICE, and adapt service provision in accordance with updates

iii. Register with the NHS Business Services Authority (NHS BSA) and inform the NHS BSA of all their prescriber details for ePACT, in order to obtain prescription pads. The Lead Provider will co-operate with the commissioners around access requirements to ePACT and prescribing data

iv. Have a clear evidence based and cost-effective prescribing policy and formulary

v. Ensure that significant changes to substitute prescribing interventions are presented to the commissioners before being implemented (unless of urgent medical need)

vi. Regularly review those receiving substitute medication in line with national guidance, including from PHE[15]

[13] PHE (2013) Advice for prescribers on the risk of the misuse of pregabalin and gabapentin - link

[14] NICE (2010) CG100 Alcohol-use disorders: Diagnosis and management of physical complications - link

[15] PHE (2013) Medications in recovery: best practice in reviewing treatment - link

vii. Ensure that testing is based on therapeutic requirements only and testing to support other interventions will only be delivered as appropriate - notably in line with Probation requirements for court led interventions.

viii. Communicate all instances of prescribing and changes to prescribed interventions with the service user's GP on the same day.

ix. Work with GPs to ensure that prescriptions being delivered by the BST substance misuse service are also coded on primary care record systems to reduce the risk of drug interactions

x. Take responsibility for the appropriate therapeutic monitoring of all service users being prescribed medication within the treatment system in accordance with national guidance including from the MHRA. This monitoring will include, but not be limited to, periodic ECG monitoring for those on specified doses of Methadone[16]. The Lead Provider will ensure there are clear protocols for acting upon abnormal results and sharing this information with necessary partners, including the GP of the affected service user.

xi. Ensure that comprehensive patient clinical records, including all prescribing, are maintained.

xii. Inform the Regional Accountable Officer for controlled drugs of all incidents where a controlled drug is involved even if the incident is later resolved. The reporting will be in the format required of the Accountable Officer. The Lead Provider will co-operate with the regional Accountable Officer as required around prescribing data and any investigations.

xiii. Ensure that service users who are carers for children or have contact with children, are provided with information about the risks to children from medications and the importance of safe storage. Home environments should be visited to assess risk and ensure suitable storage, including the provision of storage boxes.

b. **Operational details**

The service will be delivered in accordance with the following delivery requirements:

i. Referral Process

- Referrals to the service are normally via the *Case Management Team* although they may come from anywhere in the system where time, need or risk justify it.

ii. Response and waiting Times

- The Service is expected to adhere to Waiting Times set by PHE. The Commissioners must agree with any deviation from these priorities. All deviations must be documented so that public health and community safety concerns may be best managed in a safe manner.
- The Service will prioritise all referrals according to an assessment of need and risk

iii. Access

[16] Department of Health (2007) Drug misuse and dependence: UK guidelines on clinical management - link

- Substitute prescribing services will be delivered in a range of settings to maximise engagement which should be centrally located and accessible by public transport in Bolton, Salford and Trafford
- The Service will operate flexibly in line with clinical hours. Emergency services will be available at all hours.

3.5 Shared care

The Lead Provider will work closely with primary care providers and commissioners to provide an appropriate level of shared care interventions, within the primary care setting for alcohol and drug users (inclusive of those using drugs other than heroin). Shared care interventions will be recovery-orientated and in keeping with the principles of harm reduction.

a. **Service Design**

Key features of the Shared Care system include:

i. Delivery of Shared Care clinics

- The Lead Provider will provide dedicated Shared Care substance misuse practitioners to manage clinics within the primary care setting, and support GPs where there is clinical need
- Specialist clinical support for General Practitioners and other primary health care staff will be provided by secondary care service providers as required.
- All staff seeing service users within the Shared Care system should be trained to deliver brief and extended brief interventions
- Shared Care substance misuse practitioners should meet with GPs on a minimum 3-monthly basis to review their caseload
- The Lead Provider will conduct an independent review of Shared Care service users on a minimum 6-monthly basis. This will be done in order to ensure service users remain eligible for shared care and to determine whether they would benefit from any additional support or recovery interventions.

ii. Prescriptions

- GP primary care teams will be encouraged to generate prescriptions for their shared care clinics, however where this is particularly difficult or is not possible for any reason, the Lead Provider will generate shared care prescriptions on behalf of the practice.
- Shared Care teams should liaise regularly with community pharmacists.

iii. Testing

- The Provider will conduct regular drug and or alcohol testing of patients attending as appropriate to clinical need.

b. **Responsibilities of the Lead Provider**

In relation to Shared Care, the Lead Provider will be required to:

i. Contribute to the development and improvement of substance misuse Shared Care models in collaboration with commissioners, including the development of service specifications, service level agreements and performance indicators to meet local needs and in line with national and local guidance.

ii. Ensure appropriate therapeutic monitoring occurs where appropriate (see Section 3.4.1)

iii. Ensure that the Clinical Governance of Shared Care services is fully supported in liaison with the commissioners, assessing compliance against national quality standards including the National Drug Strategy, NICE and PHE guidance, National Service Frameworks and other relevant national and local policies and guidance.

iv. Alert the GP, related primary care services and others as appropriate to changes in the patient's healthcare or other emerging needs.

v. Facilitate collaborative working between primary and secondary care Substance Misuse Services to ensure the effective service delivery across the locality.

vi. Ensure those seen in Shared Care also have full access to services delivered by the Lead Provider including psycho-social interventions, specialist Tier 3 services and detoxification. It should also include screening and vaccination for communicable diseases as outlined in Section 3.6.2, which should be delivered in conjunction with the Shared Care GP

vii. Develop a Shared Care Substance Misuse Training Strategy, including content relating to client care, risk management and developments in substance misuse treatment. Bespoke training should also be delivered where required across the BST cluster, including to clinical staff, GPs and Pharmacists

viii. Lead on the promotion of Shared Care services, advising and contributing to the development of a range of marketing and communications materials to inform consistent development and delivery of Shared Care services.

ix. Develop and administer payment systems for primary care substance misuse treatment providers.

x. Provide Contract Management of GPs who provide Shared Care on behalf of the Lead Provider

c. **Performance management**

The Lead Provider will be expected to:

i. Work with commissioners to develop performance management systems, undertake analysis of data and use to inform long term strategic plans for performance and service improvement.

ii. Provide robust monitoring data to inform the commissioners and to satisfy NDTMS national requirements.

iii. Contribute to an annual review of the Shared Care service, in partnership with Commissioners in each area of the BST cluster.

iv. Liaise with Medicines Management representatives to provide clinical and prescribing data for relevant meetings as requested by commissioners.

v. Be accountable to the commissioners for the management of the Shared Care budgets; oversight of this will be maintained in the contract management function

d. **Operational details**

The service will be delivered in accordance with the following delivery requirements:

i. Eligibility Criteria

- All clients will initially be referred into the Integrated Treatment and Recovery system via the Case Management Team
- The Lead Provider will work with Commissioners to agree a set of eligibility criteria which Case Managers will then use to determine who is eligible for Shared Care
- These will consider patient preference and also include (but not be limited to) adults aged over 18 with stable mental health
- It is considered meeting these criteria with long-term health conditions will particularly benefit from Shared Care arrangements. Where this cannot be organised, Case Managers will be expected to ensure that service users receive regular clinical reviews for their long-term health conditions.

ii. Discharge

- The service will ensure immediate transfer back of service users to the *Case Management Team* where they become inappropriate for treatment within Shared Care as a result of clinical need or inappropriate behaviour or where the Shared Care provider becomes unwilling to continue to manage the service user for any other reason.

3.6 Medical intervention services

a. The Lead Provider will deliver a multi-disciplinary Medical Intervention Service which can be accessed by service users from the BST cluster.

b. The service will have the following objectives:

   i. To identify and manage the physical and mental health needs of service users, collaborating with GPs wherever possible and making referrals to specialist services when appropriate.
   ii. To ensure evidence-based screening and treatment of service users for blood-borne viruses and other infections.
   iii. To consider the needs of service users for smoking cessation interventions.
   iv. To work collaboratively with other clinical services including Pregnancy services and Gastroenterology departments to deliver services in accordance with the principles of harm reduction.

c. It is expected that all service users accessing structured treatment will be able to access the different components of the Medical Intervention service, at a frequency dependent on need and to be agreed with the Commissioners.

d. The Medical Intervention service will develop criteria to identify drug and alcohol users with high levels of medical need as part of routine healthcare assessments - these cases will be referred into the *Complex Case Review Team* (Section 0). The Lead Provider should ensure that there is joint working between the Medical Intervention Service and the *Complex Case Review Team* in order to best serve the needs of these individuals

e. The service should develop links with Specialist hospital-based colleagues where appropriate to provide specialist support for service users and direct referral pathways into specialist services. For example:

   i. The Gastroenterology team at Salford Royal Foundation Trust currently run joint clinics with the Alcohol Assertive Outreach Team and arrange Fibro-scanning for high-risk service users.
   ii. Bolton have developed a Hepatitis C support group which accompanies patients to fibro-scanning appointments at North Manchester General Hospital

3.6.1 Healthcare Assessments

a. In line with current NICE guidance[17] the Lead Provider should ensure that service users accessing structured alcohol or drug treatment services should receive a comprehensive health assessment. The content of this assessment will be based on levels of need and complexity but will reflect existing national guidance, including in relation to specific subgroups, such as older people.[18] The degree of support will depend on the age of the service user and their location within the Substance Misuse Service:

b. **Adults in structured treatment (Section 2.1)**

i. The Lead Provider will that service users in structured treatment (being managed by the *Case Management Team*)are provided with a regular health assessment within the treatment system as appropriate, arranged in liaison with specialist medical services

ii. This should include an assessment of physical and mental health, informed by national guidance. This should be conducted by an appropriate practitioner with content including (but not limited to):

- Diet and nutrition
- Cardio-vascular health (e.g. BP checks, BMI).
- Tobacco / cannabis use.
- Mental health
- Sexual health
- Dental health
- Wound care
- Immunisation status and need for additional vaccinations (see Section 3.6.2)
- Cervical screening eligibility (female service users)

iii. This may lead to onwards referral to primary, secondary or tertiary healthcare.

iv. Service users with concurrent mental health problems will be assessed for their suitability for psychosocial interventions (see Section 3.10) or referral into the specialist Dual Diagnosis service (see Section3.7).

c. **Adults not in structured treatment**

i. Service users not in structured treatment will be supported to access routine health checks via their GP, Pharmacy or Dentist, including a review of their vaccination status. This signposting will occur through:

- The Tier 2 brief interventions service (Section 3.9.2)
- Periodic reviews of service users not in structured treatment (as outlined in Section 1.6.1.g

ii. The following groups will be prioritised, where practical:

- No evidence of GP / Dentist / Pharmacist engagement within last 3 months.
- No evidence of an annual health screening and check-up in last 12 months.

[17] NICE (2011) QS11 Alcohol-use disorders (2011) - link
NICE (2012) QS23 Drug use disorders in adults (2012) - link

[18] DoH (2007) Drug misuse and dependence: UK guidelines on clinical management - link
RCPsych (2015) Substance misuse in order people: an information guide - link

- 3rd party risks as to physical and mental health (significant others, children).
- Frequent case management within Tier 3 and 4 services.
- Recent discharge from Tier 3 and 4 services.
- Prison releases.

d. **Young People's service (Section 2.4)**

   i. The Lead Provider will ensure the provision of a specialist healthcare assessment for all young people in receipt of specialist substance misuse provision. This will be delivered flexibly in age-appropriate settings

e. General Practice will play a pivotal role in managing the increasing medical comorbidities of an aging cohort of opiate users, and the Lead Provider will be expected to develop close relationships between General Practice surgeries and the BST substance misuse service. There must be clear pathways to ensure the timely sharing of information between services. The BST substance misuse service will be expected to provide a contact number which GPs can ring to request further information about any patients managed under the substance misuse service.

f. The service will also be expected to develop joint working arrangements with local sexual health services, including referral pathways, in order to address the needs of those presenting to the service with problems related to Chemsex[19] or any other issue requiring specialist input. This will include the provision of appropriate harm reduction advice and equipment within sexual health clinics, with consideration given to the co-location of needle exchange facilities.

3.6.2 Communicable Diseases: prevention and management

[19] PHE (2015) Substance misuse services for men who have sex with men involved in chemsex - link

a. Service details

The Medical Intervention Service will ensure the following interventions are available to service users, where appropriate:

i. *Screening*

- Service users entering structured treatment should be screened for:
  - Hepatitis B
  - Hepatitis C
  - HIV
- These tests should be repeated annually if initially negative for a service user who remains at risk
- In line with PHE guidance, the Lead Provider is expected to adopt on-site dried blood spot testing[20]
- The service should consider the need to provide screening for Tuberculosis as part of their treatment model on accordance with NICE guidance[21]

ii. *Vaccination*

- Based on Green Book guidance[22], service users should be considered for vaccination against:
  - Hepatitis A
  - Hepatitis B
  - Tetanus
  - Seasonal influenza.
- The need for the children of service users, family, carer and household contacts to receive vaccinations should also be considered

iii. *Treatment*

- The Lead Provider will ensure robust care pathways are in place to ensure service users with a positive test for Hepatitis B, Hepatitis C,HIV or TB are referred into effective treatment

b. Responsibilities of the Lead Provider

The Lead Provider should ensure that:

i. The service has a named lead for blood-borne viruses

ii. Staff involved in testing for blood-borne viruses (BBVs) receive appropriate training in delivering pre-test and post-test counselling to service users.

iii. There are clearly documented policies on the delivery of vaccinations, including the use of Patient Group Directions. These will be in accordance with local protocols and Green Book guidance.

iv. A proactive approach is taken when addressing the immunological health of vulnerable groups. This may involve assertive outreach and engagement with primary care services to ensure the maximum uptake of BBV services.

[20] PHE (2016) Mapping blood borne virus services across the NW community drug and alcohol services
[21] NICE (2016) NG33 Tuberculosis - link
[22] Department of Health (2014) The Green Book: Immunisation against infectious diseases - link

v. New screening and testing technology is identified as it develops and working practices are adapted accordingly, in conjunction with Commissioners and local clinical governance.

vi. All relevant staff have adequate and repeated training to provide BBV advice, support and testing to services users

vii. The service should establish BBV champions and peer support groups, working in close collaboration with local needle exchanges

viii. Joint working arrangements are developed with communicable disease treatment services, with consideration given to co-location of outreach treatment services within BST substance misuse service premises

3.6.3 Smoking Cessation Services

a. Rates of smoking among those who misuse drugs and alcohol are known to be high and evidence suggests that smoking cessation can contribute to improved drug treatment outcomes[23].

b. In line with national guidance[24], the Lead Provider will consider ways to offer smoking cessation support to service users, including:
   i. Nicotine-replacement therapy
   ii. Psychosocial interventions
   iii. Harm reduction advice
   iv. Referral to primary care or specialist services when necessary.

c. This support should be fully integrated within the treatment system. A recent pilot study supported by PHE gives an example of the type of integrated approach which the Lead Provider will be expected to deliver[25].

3.6.4 Maternity Services

a. Attracting and maintaining pregnant women who misuse substances in treatment programmes will enable better outcomes for pregnancy, childbirth and infant development.

b. The Lead Provider will be required to:

   i. Ensure that pregnant women have fast-track access to the BST Substance Misuse Service
   ii. Engage in close dialogue with substance misuse midwives where appropriate to ensure effective shared care arrangements throughout pregnancy and the postnatal period[26].
   iii. Involve workers from the Specialist Children and Family service (Section 3.11) with pregnant service users, where appropriate

[23] Department of Health (2007) Drug misuse and dependence: UK guidelines on clinical management - link

[24] PHE (2016) Adults – drugs JSNA support pack 2017-18: commissioning prompts - link

[25] PHE smoking cessation pilot evaluation report (2016) - link

[26] NICE (2010) Pregnancy with complex social factors: a model for service provision for pregnant women with complex social factors - link

iv. Ensure that all relevant information on needs and risks is communicated with Maternity services in the event that a service user becomes pregnant, based on agreed data sharing arrangements

v. Ensure that women being prescribed medication within the BST substance misuse service are rapidly reviewed by the Pharmacological Interventions service to ensure the ongoing safety, efficacy and appropriateness of their regime, in accordance with national guidance.[27]

3.6.5 Overarching service delivery requirements

a. **Operational details**

The service will be delivered in accordance with the following delivery requirements:

i. *Referral process*
- Referrals to the service are normally via the *Case Management Team*
- Referrals will be accepted from anywhere in the system, if justified by time pressures or risk status
- The Service will RAG rate all referrals to prioritise the order in which they are seen

ii. *Response and waiting times*
- The Service is expected to adhere to waiting times set by PHE.
- The Commissioners must agree with any deviation from these priorities.
- All deviations must be documented so that public health and community safety concerns may be best managed in a safe manner

iii. *Access*
- The Service will operate flexibly in line with clinical hours and the activities of the Assertive Outreach Team.

3.7 Dual diagnosis service

[27] Department of Health (2007) Drug misuse and dependence: UK guidelines on clinical management - link

a. Service users entering substance misuse services are at increased risk of experiencing mental health problems, especially anxiety and mood disorders. People with coexisting substance misuse and mental health problems are considered to have a 'dual diagnosis'. There is evidence that the treatment of mental problems during treatment improves recovery potential[28].

b. The Lead Provider will be expected to work in partnership with the wider integrated care system within the localities of Bolton, Salford and Trafford. This will involve actively and assertively working with acute, community, adult social care and mental health providers to ensure that when adults or young people need support, the experience will be as seamless, efficient and effective as possible, helping the individual to remain independent and self-managing as much as they can.

c. Owing to the co-morbidity of drug and alcohol misuse and mental ill health, the Lead Provider will be expected to work in close partnership with existing providers of specialist mental health services in the BST cluster, to share experience and expertise, and develop reciprocal arrangements enabling individuals presenting through mental health services to receive support and treatment for drug and alcohol problems and for those presenting through the drug and alcohol service to receive support for any mental health needs.

d. For those individuals open to both mental health services and drug and alcohol services, it is expected that the Lead Provider will facilitate an integrated dual diagnosis pathway, giving a single point of access for the individual, thus improving the patient experience and improving efficiency across both services.

e. The Lead Provider will be expected to deliver training to appropriate members of the treatment and recovery system (e.g. Case Managers and Care Co-ordinators) to help identify and support people presenting with mental health problems.

f. Consistent with NICE guidance, the Lead Provider will be expected to work closely with secondary care mental health services to develop local protocols for adults and young people with coexisting psychosis and substance misuse[29]

g. Details of this partnership arrangement, such as the provision of dedicated Dual Diagnosis clinics, will be agreed in collaboration with the Commissioners.

3.8 Harm reduction

[28] ACMD (2012) Recovery from drug and alcohol dependence: An overview of the evidence - link
[29] NICE (2011) CG120 Psychosis with substance misuse in over 14s: assessment and management - link

a. Harm Reduction will be part of the core philosophy of the integrated treatment and recovery system. The Lead Provider will work proactively and flexibly to reduce the harm caused by substance misuse and reduce the chances of substance misuse related death. The Lead Provider will work in partnership with other organisations as appropriate in order to work towards reductions in drug and alcohol related deaths, including in relation to medical comorbidities.

b. Harm reduction services must be available at all stages of the treatment journey in both the young person and adult services. Harm reduction should not be seen as a stand-alone service, but rather a range of interventions to be delivered as required.

c. The Lead Provider will ensure that all staff delivering harm reduction services receive adequate training and supervision. Consistent with national guidance[30], the Provider will ensure that all staff involved in needle exchanges are offered vaccination for Hepatitis B.

d. Specific consideration should be given to developing harm reduction advice should be available for the five main groups of New Psychoactive Substances:[31]

   i. Predominantly sedative drugs
   ii. Predominantly stimulant drugs
   iii. Hallucinogens and psychedelic drugs
   iv. Synthetic cannabinoids
   v. Dissociative drugs

3.8.1 Harm reduction advice

a. Harm reduction advice will be available to service users at every stage of their treatment and recovery journey. Case managers will review levels of need and risks at review appointments in order to ensure that service users are receiving appropriate harm reduction support.

b. Responsibilities of the Lead Provider

The Lead Provider will ensure that:

   i. Harm reduction advice is available from all aspects of the treatment systems (including through needle exchanges).
   Partnership arrangements with other services are developed where harm reduction messages are needed (e.g. in the context of people engaging in Chemsex presenting to sexual health services)
   ii. Harm reduction information is age-appropriate, with separate resources available for Young People

   iii. The following support is available to service users, when appropriate:

   - Brief advice, interventions and extended interventions for alcohol and drug use.
   - A full range of relevant information and advice covering related harms and risks.

[30] NICE (2014) PH52 Needle and syringe programmes - link

[31] PHE (2014) New psychoactive substances: A toolkit for substance misuse commissioners - link

- Needle exchanges
- Injection site assessment and management including basic wound care where required (and onward referral)
- Naloxone and Basic Life Support training
- Blood-borne virus services (see Section 3.6.2)
- Condoms
- Sexual health information, support and onward referral
- Smoking cessation advice and other health promotion advice
- Advice on how to access recovery groups and mutual aid
- Advice regarding the safe storage of medication

3.8.2 Needle exchanges

a. Needle exchanges will be delivered across the BST cluster in line with local and national policy and guidelines including NICE guidance[32]. Fixed Site, Outreach, and Community Pharmacy Needle Exchanges will be supplied and supported across the locality. Needle exchanges will include a range of equipment to meet the needs of the local population, in line with national evidence and local clinical governance guidance. This will include sharps bins and advice on the safe disposal of needles.

b. **Responsibilities of the Lead Provider**

The Lead Provider will:

i. Work towards full coverage of the injecting population inclusive of those injecting Performance and Image Enhancing Drugs and evidence this to commissioners.

ii. Ensure that needle exchange services are able to engage vulnerable groups (Section 3.8.2) such as those participating in Chemsex and those using a range of substances including (but not limited to) opiates, new psychoactive substances and performance-enhancing substances.

iii. Provide services at times and in places which meet the needs of service users.

iv. Consider outreach or detached services to meet the needs of the at-risk population who do not engage with traditional needle exchange programmes.

v. Ensure that the needle exchanges are fully integrated within the rest of the treatment system and providing other help including harm reduction advice and signposting to appropriate services.

vi. Perform Contract Management of Pharmacies delivering needle exchanges.

c. **Performance management**

i. The Lead Provider must ensure that activity is recorded at needle exchange sites. This will include client details, injecting drug use, treatment status, partial postcode and

[32] NICE (2014) PH52 Needle and syringe programmes - link

services received. Regular reports will be shared with Commissioners, including observations of trends in activity.

ii. This will be utilised by all needle exchanges whether fixed site, pharmacy based or peripatetic.

iii. They must also monitor the number and types of packs which they distribute.

3.8.3 Naloxone and Basic Life Support training

a. In line with national guidance[33], the provision of Naloxone will be considered for service users who are:

i. Currently using illicit opiates, such as heroin

ii. Receiving opioid substitution therapy

iii. Leaving prison with a history of drug use

iv. Who have previously used opiate drugs (to protect in the event of relapse)

b. Following discussion with the service user it will in some circumstances also be appropriate to train family members, friends and carers to administer Naloxone.

c. The Lead Provider will also consider supplying it to individuals based in settings where there is considered to be a high risk of overdose (e.g. hostel managers, outreach workers)

d. Responsibilities of the Lead Provider

The Lead Provider will:

i. Develop a system of Naloxone distribution across the BST cluster

ii. Develop a distribution strategy across the BST cluster to ensure the effective provision of Naloxone to both clients within the Substance Misuse Service and also those who are outside the treatment system but may be at risk, working with external partners where appropriate.

iii. Ensure the provision and training in the use of Naloxone to facilities and providers who regularly come into contact with the users of illegal substances such as homeless refuges, hostels, supported housing, relevant third sector charities.

iv. Monitor the usage of Naloxone kits and record the outcome of individual incidents.

v. Ensure this service is fully integrated with Harm Reduction advice to support service users to reduce and stop injecting drug use practices

vi. Provide the following training and support to service users (and family/friends/carers as appropriate):

- Training for Naloxone administration
- Overdose prevention training
- Basic life support training

[33] Department of Health (2016) Widening the availability of Naloxone - link

PHE (2015) Take-home naloxone for opioid overdose in people who use drugs - link

vii. Develop arrangements with HM Prisons to ensure that previously high risk opiate injectors are considered for Naloxone as part of their release plan

viii. Ensure appropriate clinical governance is in place to oversee the administration of Naloxone, including the use of Patient Group Directives where appropriate

3.9 Screening, brief advice and referrals

The Lead Provider will ensure the delivery of Tier 1 and Tier 2 alcohol screening and brief interventions consistent with current evidence and examples of best practice.[34] These should be available across the BST cluster.

3.9.1 Tier 1 services

a. The provider is required to ensure that universal patient screening, brief advice and onward referral is provided across the BST cluster.

b. The purposes of Tier 1 services are to:

   i. Screen members of the general population

   ii. Provide brief advice

   iii. Identify individuals in need of more in-depth treatment and refer them to the specialist services

c. Responsibilities of the Lead Provider:

   i. Develop referral pathways between the treatment and recovery system and universal services for the BST cluster.

   ii. Assist in the continued development of screening tools and interventions offered by universal services for Bolton Salford and Trafford.

   iii. Supply information on short training or e-learning (e.g. see www.alcohollearningcentre.org.uk) for Tier 1 (non-specialist) professionals to support the delivery of Identification and Brief Advice.

3.9.2 Tier 2 services

a. The aims of the treatments in Tier 2 are to:

   i. Engage drug and alcohol misusers into drug treatment

   ii. Make positive changes to drug and alcohol behaviour.

b. For many clients open access and Tier 2 services are the gateway into the wider treatment system providing an initial point of assessment and advice and, where required, referral into more structured interventions.

c. Tier 2 services provide open access to identification and brief advice for a wide range of drug and alcohol misusers referred from a variety of sources, including self-referrals. This tier is defined by its low threshold to access services, and limited requirements on drug and alcohol misusers to receive services. The Tier 2 services will increase people's levels of self-awareness,

[34] AERC Alcohol Academy (2013) Briefing Paper: Clarifying brief interventions - link
Drummond et al. (2012) Screening and Intervention Programme for Sensible Drinking' (SIPS) - link
Parkes T et al. (2011) An evaluation to assess the implementation of NHS delivered Alcohol Brief Interventions: Final Report – link

self-knowledge and self-efficacy to change. There will be congruence with the message from Tier 1 services.

d. **Service design**

i. The Tier 2 Brief Interventions Service will specifically target high risk populations and deliver bespoke messages of particular relevance to those individuals. Interventions will be targeted to those with the most chaotic patterns of drug and or alcohol misuse who have high levels of complex and unmet needs and poor levels of engagement with treatment services.

ii. Service delivery will focus on:

- General Practice sites
- Hospital sites
- Criminal Justice sites
- Community centres

iii. The above should list should be considered as indicative rather than exclusive.

iv. Tier 2 extended brief interventions differ from the IBAs or simple brief advice typically delivered by universal services outside the treatment and recovery system. Extended brief interventions are often described as brief motivational interviewing in order to clarify their purpose and the principles and skills required for their delivery.

v. These interventions will be offered by suitably trained non-specialists in general settings. Extended brief interventions can be substituted for simple brief advice where the professional has been suitably trained. This will also be dependent on the willingness of the client and the availability of sufficient time.

- Brief advice will be delivered by the provider, as appropriate to both drug and alcohol users, in a variety of settings to maximise engagement.
- All brief interventions will follow current national guidance and extended brief interventions will align to NDTMS descriptions and will be reportable to NDTMS
- Brief interventions will be followed up where possible to evaluate success.
- Motivational interviewing should be implemented for extended alcohol brief interventions, in line with Models of Care for Alcohol Misusers[35].

vi. The Lead Provider will ensure partnership working with other generic Tier 1 and Tier 2 health and wellbeing providers and align activity to the overall integrated drug and alcohol service specification (notably as to consistency of message and local feel of the offer made).

e. **Responsibilities of the Lead Provider:**

[35] NTA (2006) Models of care for alcohol misuses - link

i. Provide targeted identification and brief advice (IBA) services in public locations such as GP, Criminal Justice sites and other community locations.

ii. Focus on neighbourhoods where there is high prevalence of the most damaging kinds of drug and alcohol behaviour based on the Needs Assessment

iii. Work with service user groups to identify a range of "incentives" that will encourage service users to access the service. This could include washing facilities, hot meals, IT support, and access to complementary therapies.

iv. Provide a safe space for drug and alcohol users to access information, support and motivational interventions. The provider will signpost and refer individuals into related agencies and appropriate treatment depending on their needs including advice clinics on areas such as housing access and benefits.

v. Ensure that harm minimisation advice, information on treatment options and information around health and lifestyle for example nutrition, sexual health and smoking cessation are offered in a variety of methods and languages according to need

vi. Include identification and brief assessments and extended brief interventions for those individuals using alcohol and ongoing monitoring for those who are identified as having early signs of alcohol related harm to health

f. **Data collection**

i. The volume of brief intervention activity will be recorded and reported to commissioners. It is not expected that details of all those in receipt of brief interventions are recorded on the case management system. However, consideration should be given to the utility of recording individual details for follow-up purposes.

ii. Those individuals in need of more in-depth treatment or on-going support will be routinely entered on the case management system and NDTMS as appropriate.

iii. Recovery check-ups are recognised as a recovery support modality on NDTMS and should be recorded as such.

g. **Operational details**

The service will be delivered in accordance with the following delivery requirements:

i. Access

- Tier 2 services will be located at convenient points around the three localities covering key sites as outlined above
- Additional access points will be determined by service user consultation, provider engagement and the Joint Strategic Needs Analysis from each locality.
- Tier 2 services will be delivered in line with the operational hours of key sites

ii. Response and waiting times

- In the case of referrals for brief interventions, a quick response is required within the same hour, and as a minimum, the same day to maximise effectiveness.
- This will require flexibility and innovation to deliver, including the use of telephone technology.

3.10 Psychosocial interventions

a. The provision of psychosocial interventions should be seen as a key element of the treatment system. Psychosocial interventions will be available to all service users at all stages of their recovery journey including pre-contemplation, contemplation, active change and relapse prevention. Full consideration should be given to the family context of service users.

b. In line with NTA guidance[36], psychosocial interventions may be considered as structured treatments (requiring referral into the *Case Management Team*) dependent upon the type of assistance provided and level of need

c. **Service Design**

i. A range of psychosocial interventions will be offered that are person centred and recovery focused. They must be evidence-based, including in relation to guidance from the Department of Health[37] and NICE[38]. They will be delivered by appropriately trained and accredited staff to each service user according to need, progress and changing circumstances.

ii. Interventions will be provided to service users with a range of alcohol and drug problems (including in relation to New Psychoactive Substances[39])

iii. The offer will be regularly reviewed based on the changing needs of the client. This will include as a minimum:

- Motivational interviewing
- Cognitive behavioural therapy
- Coping skills training
- Relapse prevention therapy
- Contingency management
- Community reinforcement approaches
- Evidence-based psychological interventions for existing mental health problems
- Psychodynamic therapy (substance misuse focused)
- Counselling
- 12-step work

iv. Counselling will be provided or a referral made for specialist counselling requirements, where needed. The level and duration of counselling support provided will be based on a comprehensive assessment of need. It is anticipated that this will be reviewed after approximately six to eight sessions.

v. The Lead Provider will be expected to deliver specialist interventions addressing the issue of trauma within the treatment system.

[36] NTA (2012) NDTMS data set J: Implementation guide for adult drug and alcohol treatment providers - link

[37] Department of Health (2007) Drug misuse and dependence: UK guidelines on clinical management - link

[38] NICE (2007) CG51 Drug misuse in over 16s: psychosocial interventions - link
NICE (2012) QS23 Drug use disorders in adults - link

[39] New psychoactive substances: A toolkit for substance misuse commissioners (2014) - link

vi. The Lead Provider will be expected to ensure that service users with high levels of need are able to access clinical psychology services within the BST substance misuse service. Access to this resource will be via the *Complex Case Review Team* (Section 2.3)

vii. Where intensive psychological or counselling support is required, e.g. in relation to issues such as trauma, bereavement or post-traumatic stress disorder (PTSD), the Provider will identify and refer to alternative specialist services, where this support cannot be provided within the BST substance misuse service. The Provider should also ensure that staff appropriately signpost service users to local self-help groups, for example, Alcoholics Anonymous and Narcotics Anonymous and accompany them to meetings as appropriate.

viii. A full range of support programmes will be developed (1 to 1 and group where required) to build personal resilience and social capital, focusing on issues including:

- Substance misuse (including drug, alcohol and poly substance misuse).
- Relapse prevention.
- Pre detoxification / rehabilitation groups.
- Housing support.
- Relationships (including parenting).
- Education (including links with local educational providers).
- Employment (effective links with Job Centre Plus, pre-employment and voluntary work groups).
- Life skills (e.g. budgeting, basic cooking skills, nutrition, anger management, social skill development).
- Aftercare support for those successfully completing other treatment modalities.

d. All psychosocial interventions will be recovery-orientated, building on the recovery capital of each individual patient. Specifically the Provider will be responsible for delivering interventions designed to fully prepare clients for detoxification (community and inpatient) and residential rehabilitation in order to increase successful outcomes and reduce unplanned discharges.

e. **Responsibilities of the Lead Provider**

In relation to Psychosocial Interventions, the Lead Provider will be expected to:

i. Ensure that all psychological interventions offered are annually evaluated and updated in line with national guidance

ii. Employ or sub contract with staff who are accredited by the British Association of Counselling and Psychotherapy (BACP), and /or the United Kingdom Council for Psychotherapists (UKCP)

iii. Utilise both accredited and volunteer counsellors (who should be affiliate Members of an appropriate professional body and are working towards full accreditation) with the Provider ensuring that robust systems are in place for on-going training and supervision.

iv. Ensure staff receive regular supervision from individuals competent in both the intervention and supervision.

v. Ensure that staff use their professional bodies competence framework to quality assure their work.

f. **Performance management**

The Lead Provider will ensure that the Psychosocial Intervention service:

i. Monitors the number of sessions provided and develops appropriate outcome measures to evaluate the effectiveness of these sessions

ii. Ensures that service users are involved in reviewing the effectiveness of the interventions.

g. **Operational details**

The service will be delivered in accordance with the following delivery requirements:

i. Access

- The Provider will ensure that Psychosocial Interventions are offered in a range of locations including general practice and community facilities
- Home visits for initial assessment and/or interventions should be available within a clearly defined protocol, particularly for service users under the Assertive Outreach Team.

ii. Duration of treatment

- Psychosocial interventions will be provided for as long as is required to ensure successful treatment outcomes for individual service users.

3.11 Family interventions

a. The family will be central to BST's treatment and recovery system for both adults and children. Children of parents who are dependent on drugs or alcohol have an increased risk of emotional and physical neglect, and of having serious emotional and social problems in later life[40]. Engaging parents in treatment can lead to improved outcomes for both children and parents.

b. All aspects of the system must be designed, delivered and reviewed with the role of the family in mind. This will include a consideration of how the impact on each and every child of those in treatment is assessed. It will include the development of systems, pathways and interventions that minimise the negative impact that parental substance misuse can have on children. In short, the voice of the child must be central to our treatment system and evidenced in reporting.

c. It will also acknowledge the positive role families can play in successful treatment and recovery. It will capitalise on this in moving service users towards sustained recovery by involving families throughout. This will mean working not only with children, but other family members and significant others.

d. Seamless referral pathways should exist between Children's services and the treatment and recovery system. Referrals to the Family Intervention service can come via two different routes:

    i. **Children's services**: This will include those with drug and alcohol problems who are not known to the treatment and recovery system
    ii. **Treatment and recovery system**: Service users accessing structured treatment can be referred into the service by their Case Manager

3.11.1 Parental assessment and intervention

a. The parental status of all service users should be established upon commencement of structured treatment or entry into the *Assertive Outreach Team*. The needs of all children for whom service users have parental responsibility will be assessed and reviewed routinely. Where need is identified, appropriate action will be taken as a priority, in accordance with local policies and procedures, including those relating to child safeguarding.

b. Family interventions will be extended to service users within the wider system if significant risk has been identified. There will be a range of appropriate responses to the identified needs of the children of substance misusing parents within the treatment system.

c. All parents and carers of children and young people will be given harm reduction information and general advice including (but not limited to) the:

    i. Impact of substance misuse on children
    ii. Role of social services

[40] ACMD (2012) Recovery from drug and alcohol dependence: An overview of the evidence - link

iii. Positive parenting

iv. Safe storage of medication.

d. As suggested by PHE Good Practice, the Lead Provider will also work collaboratively and forge close links with local Stronger Families provision and Early Help services.

3.11.2 Family interventions

a. The Lead Provider will ensure that group work for service users with children at risk of poor outcomes due to parental substance misuse is delivered by workers from the Specialist Children and Family Service.

b. Group work with parents will explore general issues of drug and alcohol use as well as the effects this has on the lives of children and families. The sessions will support parents and carers to find new creative ways of communicating with their children with the aim of strengthening parenting capacity.

c. The Lead Provider will ensure that there is a Specialist Children and Family Service element of the treatment and recovery system. Parents in treatment who meet an agreed threshold will be referred on to this service for assessment and support. As part of agreed support plans, the service will work directly with children and their parents, provide activities for children and group work for parents and carers.

d. The service will provide additional support to families in their home. Family support will complement and be in addition to the 1:1 work with children and the group work with parent and carers.

e. The service will work directly with children to enable them to express their feelings, develop self-esteem and build resilience. It will also work in partnership with families in implementing a package of support.

f. The service will provide non-judgmental support, encouraging parents to work towards recovery and to be open about their substance use and other issues that affect them at home and in their parenting roles.

3.11.3 Overarching service delivery requirements

a. Responsibilities of the Lead Provider

In order to deliver the above service, the Lead Provider will be required to:

i. Identify the family arrangements of service users on entering the system through screening within the *Case Management Team*

ii. Assess the types and levels of needs in relation to the children and family of service users and conduct risk assessments specific to children and young people

iii. Tailor support around existing needs of the family and provide a care plan for the family.

iv. Work towards the prevention of family breakdown and children entering the looked after system.

v. Improve family's engagement with services relevant to the parents and child's needs.

vi. Promote recovery in parents and carers and/or to work towards managing their drug and alcohol use.

vii. Develop joint working protocols and data-sharing agreements with Children's services in Bolton, Salford and Trafford Local Authorities

viii. Help children to develop resilience and coping strategies in response to parental substance misuse and allow their voices to be heard by their parents and staff in the treatment service

ix. Raise awareness of family interventions throughout the treatment and recovery system

x. Highlight to the parent any significant harm caused by their drug or alcohol use
    - The service must follow BST specific Safeguarding Policy depending on the local authority the Lead Provider is working with, and refer into children's services if they feel a child is at risk of harm

xi. The Lead Provider must ensure that all services, including any sub-contracted services, have adequate training, including in relation to Safeguarding Policies

xii. Empower parents to make necessary changes that will improve the outcomes for their children and develop on the assets that already exist within families

xiii. Encourage parents to remain in treatment for their drug and alcohol use.

xiv. **Salford only:**
    - Work with the *Leaving Care* Service (Salford Local Authority only)
        - This service employs a worker to provide substance misuse provision including routine screening to all young people within that service. This post is not in scope for this tender. The service will work closely with this worker
    - Provide an appropriately trained worker to be based at *The Bridge* (a multi-agency hub which screens all contacts concerning the welfare or safety of a child. This will allow early detection of children and families requiring support and will also facilitate collaboration and appropriate data-sharing for complex and high-risk families

b. Operational details

The service will be delivered in accordance with the following delivery requirements:

i. Eligibility

- The service will work with parents and families with parental substance misuse issues resident in the BST cluster
- The Lead Provider will work with Commissioners to agree thresholds to each intervention based on need

ii. Access

- There should be a range of family-friendly, accessible and non-stigmatising venues across the BST cluster
- Home visits should be offered to those under the Specialist Children and Family Service and also for families being managed under the Assertive Outreach Team
- Evenings and weekend appointments should be available, in addition to routine times, to ensure that families in education/employment can access treatment.

iii. Priority groups

- Parents and carers with the highest threshold of need.
- Complex cases (such as those who have comorbidities and/or multiple presenting needs)

iv. Response and waiting times

- Families require access within reasonable timescales.
- A response and waiting list procedure will be agreed with commissioners.
- Baseline targets may be set after six months if deemed appropriate.

v. Discharge

- All successful discharges will include an onward referral to a named service.
- Unplanned exits will be referred on to the *Assertive Outreach Team* (Section 2.2)

c. Performance management

The service should be designed to address the following outcomes (in addition to those in Section 4.2):

i. Improve school attendance.

ii. Reduce the risk of children of service users becoming looked after.

iii. Improve the emotional well-being of children, young people and families.

iv. Improve parenting capacity.

v. Support adults on their recovery journeys.

vi. Reduce incidents of domestic abuse and anti-social behaviour

vii. 2010 Drug Strategy Outcomes relating to families:

- Improved relationships with family members, partners and friends
- The capacity to be an effective and caring parent.

The Lead Provider will also ensure that training and group work is routinely evaluated.

3.12 Group work interventions

a. Group Work Interventions are seen as critical to the successful journey of service users from treatment into recovery and it is expected that service users in the BST cluster are able to access these services.

b. Service design

The Lead Provider is expected to deliver a range of group work interventions with the following characteristics:

i. Groups will be available for both drug and alcohol users and developed in response to the needs of clients.

ii. Groups will be accessible (including by public transport) and delivered within walking distance for service users where possible.

iii. The range of groups offered will include SMART recovery and 12-Step recovery.

iv. It is desirable that over time the groups become peer led – however General Practice, Hospital and Criminal Justice targeted groups will need to be robustly designed, monitored and supported.

v. It is desirable that peer navigators and recovery champions take lead roles in delivering group work, within treatment and in recovery and mutual aid.

c. Responsibilities of the Lead Provider

In relation to Group Work Interventions, the Lead Provider will be expected to:

i. Provide different groups for different stages of recovery in a variety of settings.

ii. Allow service users greater choice in achieving their recovery objectives.

iii. Engage those who would not otherwise access treatment.

iv. Reduce isolation of service users and make others' recovery more visible.

v. Provide information about recovery events and encourage engagement.

vi. Promote and facilitate access to peer-led groups.

vii. Offer women's only sessions, where appropriate

d. Operational details

The service will be delivered in accordance with the following delivery requirements:

i. Location of service

- The service will be delivered from a range of community settings including, for example:
  - GP premises
  - Hospitals and Criminal Justice sites
  - Community Hubs & Gateways
  - Church halls

- The Lead Provider will focus on the neighbourhoods most affected by problematic drink and drug use.

ii. Days/Hours of operation

- The aim will be to provide groups during the day, in the evening and at weekends to ensure they are accessible.
- There will be service provision outside of regular office hours to encourage low complexity drinkers to practice moderated recovery and ensure the service is accessible for those in work.

iii. Referral Process

- There will be multiple referral routes to Group Work Interventions, including:
  - Referral from any component of the treatment and recovery service, including the *Case Management Team*
  - Self-referral (including via the treatment and recovery website – Section 0)
  - General Practice
  - Hospital and Criminal Justice delivery sites across the city
- Preferably there will be an opportunity to triage prior to attending group but that should not inhibit the attendance of newcomers who will otherwise be triaged once they have made themselves known.
- Where it is not possible to triage individuals in person prior to commencement, telephone triage is encouraged in order to not limit access.
- Most referrals will be low complexity / low severity but this is not a requirement – group entry will be determined on a case by case basis

iv. Response and waiting times

- The service will operate on a rolling basis – there will only ever be a waiting list if group capacity is exceeded and a new group is in formation.

v. Access

- The Groups should take place on at least a weekly rolling basis
- The aim will be to provide groups in a wide variety of locations, during the day, in the evening and at weekends.

vi. Aftercare

- The evidence-based Group-work Interventions will ideally be followed by life membership of the recovery community.
- This includes access to drink and drug free daily social activities, and recovery coaching.

vii. Discharge Process

- The intervention is a rolling group - members may join or leave at any stage.
- The *Case Management Team* may make onward referrals to Tier 3 or Tier 4 services.
- Decisions as to discharge e.g. breach of rules around sobriety or behaviour will be managed by permanent staff.
- When groups become self-managing arrangements as to arms-length support for group leaders will need to replicate these arrangements.

3.13 Development of a recovery community

a. The Provider will encourage and support the growth of an autonomous, local recovery community. The aim of the Recovery Community is to create a real community with a life of its own. The community will have a social life which features a developing range of drink and drug free activities that responds to the needs and ambitions of its Members. There will also be a focus on the development and delivery of drug and alcohol free social, leisure, sporting, arts and cultural activities every night of the week with a particular focus on weekends.

b. This work will be supported by a Recovery Fund. The Commissioners expect that 2% of the total budget envelope for each area will go to the Recovery Fund. The budget will be allocated in agreement with Commissioners locally and in agreement with service users.

c. It is expected that a proportion of the budget (to be agreed with Commissioners) will be apportioned to a 'Personalisation fund' which service users will be able to apply for to meet specific personal needs whilst in the treatment and recovery system (including Aftercare). This will be governed in accordance with requirements agreed with the Commissioners during transition to the new system.

d. Service design

i. The functions of a vibrant recovery community will include (but are not limited to):

- Fostering education, training and employment opportunities.
- Actively pursuing opportunities for the development of small businesses and social enterprise to provide further opportunities for the personal growth and development of Community Members.
- Offering a range of volunteering opportunities.
- Offering a pool of peer navigators and mentors right across the treatment and recovery system

ii. Recovery activities should be available for all; however it is critical to have some activities accessible only to those in abstinent recovery.

e. Responsibilities of the Lead Provider

In relation to the development of a recovery community, the Lead Provider will be expected to:

i. Identify and support existing networks of recovery including the advertisement of the contact details, availability and operating hours of mutual aid groups and recovery networks in Bolton Salford and Trafford.

ii. Provide opportunities to respond to the needs and ambitions of service users.

iii. Identify and support the development of Leaders within the Recovery community

iv. Support Community Leaders with the development of social enterprises to develop a sustainable income stream for the recovery community and provide additional opportunities for volunteering and employment for people in recovery.

v. Provide access to Advocacy for Service Users.

vi. Support the establishment of new 'self-sustaining' community support groups.

vii. Ensure that a live list of all support groups is kept and service users are signposted to these groups where appropriate.

viii. Provide support, training and where appropriate supervision for Recovery Community Leaders.

ix. Provide support to Recovery Community Leaders to identify and bid for other funding

f. Operational details

The service will be delivered in accordance with the following delivery requirements:

i. Referral Process

- Service users will be helped to engage with groups and activities within at all points within their recovery process. This will take account of the needs of the service user and requirements of the groups to ensure an appropriate match.

ii. Access

- The venues could be local service delivery points, gateway centres, church halls, people's houses, in the open air, in the countryside. A key consideration in planning services will be that people in recovery are unlikely to have significant disposable incomes to build personal social assets.
- The Lead Provider will ensure an activity is put on every night of the week with a particular focus on weekends.

3.14 Education, training and employment interventions

a. Research suggests that integrating education and training services within substance misuse services can improve employment outcomes and that undertaking voluntary work during treatment can help recovery[41]. A key part of the recovery system will be structured interventions to support education, training and employment (ETE) opportunities for service users all stages of the treatment and recovery system. It will act as a gateway to further formal learning and equip learners with the necessary skills to act as peer mentors/recovery workers or volunteers within services, if desired.

b. Service detail

i. The Lead Provider will organize interventions to allow service users to access education, training and employment interventions.

ii. The detail of these interventions will be agreed with Commissioners and the Recovery Community and should include the development of accredited training programmes according to the needs and aspirations of service users.

c. Responsibilities of the Lead Provider

In order to deliver the above services, the Lead Provider will be expected to:

i. Work with Commissioners to ensure that the ETE needs of service users are integrated within worklessness and employability strategies within each Local Authority.
ii. Work with Case Managers to ensure that service users are encouraged to consider ETE interventions from an early stage of their treatment and recovery journey
iii. Consult with commissioners and members of the recovery community to design and refine ETE interventions
x. Deliver training sessions in each area in collaboration with local Job Centres and Work Programmes and ensure that trainee and apprenticeship posts are made available to enable service users to make the step from Peer Mentor posts into full time employment within the drug and alcohol service.
iv. Develop the role of paid and voluntary positions (e.g. peer mentors) within the Substance Misuse Service
v. Consider establishing employment champions in each Local Authority area who can provide personalised support for service users looking to return to work[42]
vi. Develop and share case studies of successful ETE outcomes among service users
vii. Engage with local employers to address negative preconceptions and stigma about recruiting individuals with a history of substance misuse
viii. Ensure that all interventions delivered are consistent with the 'Working Well' theme of the GM PSR agenda[43]
ix. Ensure the development of ETE resources and programmes specifically focussed on service users in the Young Person's service (Section 2.4)

[41] ACMD (2012) Recovery from drug and alcohol dependence: An overview of the evidence - link
[42] PHE (2015) Alcohol JSNA support pack 2017-18: commissioning prompts - link
[43] GMCA (2016) Working Well annual report - link

x. Consider how to record successful ETE outcomes in service users in the recovery community who have left structured treatment

d. Operational details

The service will be delivered in accordance with the following delivery requirements:

i. **Referral process**

- Service users will be referred into this service by their Case Manager

ii. **Location**

- Where training courses are offered they should be delivered in a range of locations, including community facilities, according to identified need

3.15 Specialist housing and support services

Suitable, safe and secure accommodation is critical to supporting service users through treatment and into a sustained recovery.

a. In relation to this model the Commissioners have identified key groups of service users whose needs the Lead Provider will be expected to address:
    i. Dependent drinkers and drug users
    ii. Abstinent service users leaving inpatient detoxification units
    iii. Abstinent service users leaving residential rehabilitation units
    iv. Abstinent users moving towards independent living
    v. Street homeless (abstinent and non-abstinent)

b. Each of these groups has specific housing needs. In order to address the Lead Provider will be expected to provide an innovative housing offer which must include (but is not limited to):
    i. Tier 4 residential rehabilitation
    ii. Step-down housing
    iii. Floating support

c. It will be desirable to create a geographical sober living community of abstinent individuals in a discrete designated area. These people will likely have a fragile asset base, high problem severity, and need enhanced care.

3.15.1 Tier 4 Residential Rehabilitation

a. **Current provision:**

b.
- Salford - As part of the current Lead Provider model the THOMAS charity provide seven male and five female residential rehabilitation beds.

b. Residential rehabilitation is a Tier 4 service which provides accommodation and support to service users immediately following detoxification. The Lead Provider will ensure the continued presence of local Tier 4 Residential Treatment and Recovery provision to provide a focus for abstinent recovery and mutual aid.

c. It should be a highly specialized, entirely abstinent residential unit which features daily group work and 1:1 mentoring. This provision will operate from an explicit therapeutic community approach using validated methods clearly supported from the international evidence base. It will be supported by acute and specialist services as necessary.

3.15.2 Step-down housing

a. **Current provision**

- Salford - As part of the current Lead Provider model the THOMAS charity provide seven male and four female step-down housing beds.

b. Step-down housing acts as a bridge between rehabilitation and independent living. It should offer daily group work and support and will be expected to use and develop peer mentors. Provision of accommodation is expected to be for a minimum of 12 months.

3.15.3 Floating support

a. Floating support services can be effective at enabling those with drug and alcohol problems to sustain housing[44]. The Lead Provider will be expected to work with local partners to develop specialist housing support to service users who are living independently. The nature of this support will be agreed with Commissioners but may include:

i. Tenancy support

ii. Help with bills

iii. Home safety risk assessments

b. The support will be targeted based on level of need and complexity and will prioritise those coming from step-down housing. It will work closely with the *Assertive Outreach Team* (Section **Error! Reference source not found.**) and the Complex Case Review service (Section 0).

3.15.4 Overarching delivery requirements

a. **Responsibilities of the Lead Provider**

In order to deliver the above types of housing support, the Lead Provider will be expected to:

i. Name a social housing provider as a key partner to develop and jointly manage housing support services but also to develop flexible services e.g. pop up services in localities

ii. Understand the local housing market and supply of accommodation in the BST cluster, including access routes into all housing tenures

iii. Provide robust and reliable housing related information (both qualitative and quantitative) to help inform needs assessments and commissioning priorities.

iv. Liaise and engage in appropriate multi agency housing related forums e.g. homelessness and private landlord forums.

v. Liaise and work in partnership with Local Authority housing departments, registered social landlords and supported accommodation providers to ensure that the most appropriate housing solution is obtained for both abstinent and non-abstinent service users in housing need, homeless or in inappropriate housing.

[44] ACMD (2012) Recovery from drug and alcohol dependence: An overview of the evidence - link

vi. Build partnerships with the private rented sector in order to meet the housing needs of service users including linking into accreditation schemes and rent / bond guarantee schemes.

vii. Work in partnership with voluntary sector organisations and providers to complement existing services and maximise impacts, particularly with those that provide help and support to substance users with housing related problems.

viii. Ensure that appropriate support is offered for service users such as making arrangements on behalf of the service user, taking service users to appointments, providing substance misuse and other specialist counselling, ensuring medication is taken and medical appointments kept

ix. Align the housing support strategy with the 'Housing and Homelessness' stream of the GM Public Sector Reform Agenda (Section 1.3)

x. Work with the Hospital Liaison service (Section 3.3) to identify appropriate accommodation for homeless service users being discharged from hospital

b. **Operational details**

The service will be delivered in accordance with the following overarching requirements:

i. Eligibility
- Support will be provided to male and female service users and, where appropriate, families

ii. Referral process
- Referrals to Residential Rehabilitation and Step-down housing will come via the *Case Management Team*(Section 2.1)

iii. Response and waiting times
- Response times will be subject to a response and waiting list procedure agreed with commissioners

iv. Priority Groups
- The priority groups for the Tier 4 Recovery 'Dry' Residential Services and Tier 2 Abstinent Step Down Services are for service users with:
  - Low recovery capital
  - High problem severity
  - High complexity
  - Clear evidence of motivation for abstinence

3.16 Criminal justice interventions

a. The Lead Provider will ensure that all substance misusing offenders receive appropriate and co-ordinated interventions at every point of the Criminal Justice System (CJS). It is recognised that those within the Criminal Justice system often do not engage well with traditional treatment services. As such, it is expected that the Criminal Justice interventions will work closely with the *Assertive Outreach Team* (see Section **Error! Reference source not found.**) to deliver the services listed below.

3.16.1 Conditional Cautioning

a. Conditional cautions will be used as an opportunity to encourage substance misusing offenders to address their substance misuse problems. Joint working arrangements with the Police/CPS will be developed to ensure effective communication/referral pathways for Conditional Caution clients are established and maintained. Timely feedback will be provided to Greater Manchester Police on the outcome of the interview, (i.e. the offender has or has not taken up the offer of support).

3.16.2 Prison In-Reach

The Lead Provider will be expected to:

a. Provide sufficient prison link capacity to cover the engagement, release plan and reintegration requirements of clients due to and upon being released from prison (given available resources)

b. Identify and track all substance misusing offenders through custody until release.

c. Establish and maintain good and effective working links and relationships with HMP Substance Misuse teams at all HMPs - including identifying known points of contact within relevant HMPs and maintaining weekly liaison to track and update release dates.

d. Respond to and accept all HMP Substance Misuse Team referrals.

e. Secure notice of and respond effectively to any early releases.

f. Signpost all those offenders who are released on licence to the substance misuse service, either at the time of release or immediately prior to this.

g. Ensure engagement after release with other services that support re-integration back into the community.

3.16.3 Drug Rehabilitation Requirements (DRRs)

The Lead Provider will be expected to:

a. Conduct assessments of suitability for DRR.

b. Be responsible for the co-ordination of all delivery elements of the DRR including treatment appointments, lifestyle and health interventions.

c. Deploy a flexible approach in the delivery of the DRR, particularly with regards to an offender's treatment compliance and punctuality.

i. The decision to withdraw treatment services for clients must be undertaken in conjunction with the Offender Manager responsible for order enforcement.

d. Provide witness statements to support court proceedings where an offender has failed to attend an appointment.

e. Attend court if requested when breach proceedings take place.

f. Fully participate in sentence plan reviews.

g. Ensure, on successful completion of a DRR, that in conjunction with the offender manager a pathway into community treatment services is enabled.

3.16.4 Prolific and Priority Offenders (PPOs) or equivalent

The Lead Provider will be expected to:

a. Ensure that PPO and similarly risk-profiled / stratified offenders are provided rapid access to substance misuse treatment and interventions - such offenders must be given access to substance misuse treatment within 5 working days from referral.

b. Ensure that on release from custody; a PPO is drug tested, and as required during the duration of the licence.

c. Ensure that drug testing of clients including type of test and location is appropriate to the client's needs (e.g. offender in full time employment).

3.16.5 Alcohol Treatment Requirements (ATR)

The Lead Provider will be expected to:

a. Conduct assessments of suitability for ATR.

b. Co-ordinate and deliver the treatment element of ATR for the offender including treatment appointments, lifestyle and health interventions.

c. Provide treatment to offenders referred from the CRC who are assessed as alcohol dependent and who have committed offences.

d. Deliver a minimum of one treatment appointment per week.

e. Deploy a flexible approach in the delivery of the ATR, particularly with regards to an offender's treatment compliance and punctuality.

f. Provide witness statements to support court proceedings where an offender has failed to attend an appointment.

g. Attend court, if requested, when breach proceedings take place.

h. Fully participate in sentence plan reviews.

3.16.6 Integrated Offender Management (IOM/PPO)

a. Individuals who are the most prolific, causing harm and designated high risk will be referred for consideration to the IOM (Spotlight) team.

b. The purpose of this scheme is to provide additional support to this client group by monitoring engagement closely and providing an integrated, holistic support package to them to minimise chances of reoffending.

3.16.7 The DIP Team

a. This is based in Police Custody suites. Individuals who test positive for Class A drug misuse (Opiates and Cocaine) will receive an assessment by a designated member of the BST Substance Misuse Service whilst in police custody (Initial Assessment stage).

b. A further Follow-Up Assessment to attend in the community will then be made. These assessments are in accordance with the Drugs Act 2010. By providing intervention at arrest, it is hoped this will provide the motivation required to avoid longer-term contact with the criminal justice system. It is expected that drug-using offenders will have access to support with life skills, education, training and employment and housing.

3.16.8 Restriction on Bail

a. It is expected that individuals will benefit from operation of Restriction on Bail (or RoB) which is the name given to a specific bail condition which can be imposed on individuals by Criminal Justice Courts. The RoB condition legally compels those on Court bail to attend all appointments as directed by drug treatment agencies.

b. To be eligible for the bail condition, an individual must be:

   i. 18 or over

   ii. Have tested positive for Class A drugs upon arrest

   iii. Be appearing for an offence which the Court feels is drug use related.

c. The RoB Coordinator is based at Court premises and acts as an advisor to Judges and Magistrates on drug treatment, drug use and related offending. The RoB Coordinator will be expected to liaise with treatment services during bail periods to monitor the engagement of those subject to the condition. Treatment progress, whether good or bad, will be relayed to the Court by the Coordinator at any future hearings. Failure to attend RoB treatment appointments whilst on Court bail, may lead to an individual being arrested and having their bail revoked, leaving them remanded in prison custody.

3.16.9 Overarching service delivery requirements

a. In respect to Criminal Justice interventions, the Lead Provider will be required to:

i. Ensure that within the available budget the full range of services within the specification are available to Criminal Justice clients.

ii. Ensure that services are developed for the use of Criminal Justice clients, in consultation with the Probation and Police Services and the Commissioners

iii. Ensure that a pathway of end-to-end treatment is maintained (in partnership with other agencies and within available resources) through the Criminal Justice System into community services (HMP based services are out of scope in this tender).

iv. Ensure services for *high risk* offenders are delivered within appropriate venues including Probation Trust and related provider premises

v. Have a retention strategy in place to increase and maintain offender compliance

vi. Ensure that all users referred have offending identified through screening assessment or care planning, or have on-going community sentences i.e. DRR , ATR and cautions, and be coordinated through the Criminal Justice System

vii. Ensure effective partnership working with Criminal Justice agencies:

- Greater Manchester Police
- HM Courts
- CRC and NPS
- HM Prisons; specifically Prison Health Care and Substance Misuse teams to support users at point of release from custody
- Young People's Secure Estate

viii. Participate in the relevant multi-agency case meetings and case management arrangements in the wider partnership setting, including local Community Safety Partnerships / PPO schemes

ix. Within available resources, cover custody suites and courts to maximise opportunities for identifying, assessing, and approaching and engaging appropriate clients within services

x. Ensure staff are specifically trained to address re-offending

xi. Form and adhere to local agreements to communicate important information such as the appointment attendance / non-attendance of clients and provide feedback to link to enforcement / public protection to ensure consistency

xii. Seek to identify best practice and constantly strive to provide the highest level of service. However, any service processes for CJS services should not be changed without prior agreement.

xiii. Ensure that individuals subjected to an Alcohol Treatment Requirement or a Drug Rehabilitation Requirement receive treatment from the incoming provider in respect of their substance misuse needs.

xiv. Work in partnership with the new GM Liaison and Diversion Service to ensure a seamless pathway between both and that clients' needs are met

4. SYSTEM DELIVERY REQUIREMENTS

4.1 Universal IT system

a. The Lead Provider will have a single IT system able to deliver the required performance data expected across the whole integrated service in the BST cluster. This will require a process of data migration from the existing IT systems used in each area (see Appendix x) which will need to be factored into any transition period.

b. Responsibilities of the Lead Provider

The new system must incorporate the following functions and characteristics:

i. Clinical Management system

- All relevant information for service users in structured treatment should be recorded in a universal case management IT system. This will include (but not limited to): care planning, , health care assessments, BBV information and referrals
- The Lead Provider should work with Commissioners to develop appropriate mechanisms to report activity occurring outside of structured treatment (e.g. Tier 2 interventions, screening information)

ii. Needle exchange database

- There must be capability in place to record activity at needle exchange sites.
- This will include client attributer information (initials, DOB, gender), injecting drug use, treatment status, partial postcode and services received.
- This will be utilised by all needle exchanges whether fixed site, pharmacy based or peripatetic.
- There must also be a fully functioning reporting facility for the purposes of on-going monitoring and needs assessment.

iii. NDTMS systems compliance

- All NDTMS guidance must be adhered to in full.
- The system will be capable of recording, storing and reporting all NDTMS data for the treatment system
- Providers must have procedures in place to validate monthly NDTMS extracts prior to submission. This should ensure an accurate client count.
- This system must:
    - Have been validated and gained approval of PHE.
    - Be compatible with both the adult and young people's core data sets.
    - Be capable of managing multiple NDTMS agency codes whilst recording each treatment journey continuously.
    - Be accessible to all parts of the treatment system based on need to ensure continuity of care as client move through the treatment system.
    - Allow closer understanding of performance across the treatment system

iv. Performance reporting

- The system must also be capable of reporting on performance against local priorities (outline in Section 4.2)
- The system should also allow extraction of strategic data, and cohort data to be used for ad hoc studies and longitudinal research into effectiveness.

v. Accessibility and usage

- The Case Management IT System must be accessible to all parts of the system irrespective of location or specialism based on need - this will include any sub-contracted provision
- The Lead Provider must determine data responsibility roles and have agreements in place prior to the commencement of the contract.
- The treatment and recovery system must have sufficient licences for the number of users. Licence periods must be appropriate to ensure the continuity of service is not disrupted.
- Significant changes to clinical management systems must not take place without providing Commissioners with prior notification. Any changes, including upgrades, must be planned in order to avoid significant disruption to service delivery.
- The Lead Provider needs to ensure policies and protocols of all component parts of the system are aligned. This will include data flow across the treatment system.
- The Case Management IT system must be able to transfer records easily to a new system when required with minimum disruption to service delivery.
- The IT system must be able to assist with child protection and safeguarding needs

vi. Information governance

- IT procedures must be fully compliant with the Data Protection Act 1998, Caldicott Guidance and Practice and Information Commission Guidance and Practice
- Data sharing for the purposes of Community Safety must also comply with the overarching powers of the Information Commission.
- Development of information sharing agreements need to be factored into the implementation plan

4.2 Performance management

Please note the final set of outcomes (including target ranges) will be agreed with the provider following the award of the contract. A set of core indicators to measure service delivery will also be agreed with the provider.

a. Services need to show how the money they spend delivers sustainable outcomes by evidencing what they do, how they do it, and how well they do it. Specifically the service needs to evidence that *their* service/interventions have made a difference to the physical health, mental health and the overall wellbeing of the clients, families and communities they serve. The treatment and recovery system will work towards meeting the outcomes set out in the National Drugs Strategy 2010:

   i. Reduce illicit and other harmful drug use; and
   ii. Increase the numbers recovering from their dependence

b. The performance management of this contract will be done using a number of methods including:

   i. National and local data sets
   ii. Qualitative reporting
   iii. Financial and workforce reporting
   iv. Service user, family, and carer satisfaction surveys,

c. This will ensure that both hard and soft measures are utilised to monitor the delivery of the contract. The Lead Provider will be accountable for performance across all parts of the treatment system cover by this specification.

4.2.1 PHOF indicators

a. The following PHOF indicators are substance misuse specific and will be monitored by the Commissioners.

   i. PHOF 2.15i - *Proportion of all in treatment, who successfully completed and did not re-present within 6 months – opiate clients*
   ii. PHOF 2.15ii - *Proportion of all in treatment, who successfully completed and did not re-present within 6 months – non-opiate clients*
   iii. PHOF 2.16 - *People entering prison with a substance misuse dependence issue who are previously not known to community treatment*
   iv. PHOF 2.18 - *Alcohol admissions to hospital*
   v. PHOF 1.13i - *Re-offending levels - percentage of drug misusing offenders who re-offend*
   vi. PHOF 1.13ii - *Re-offending levels - average number of re-offences per drug misusing offender*

4.2.2 Service user outcomes

a. The Lead Provider will be expected to work with Commissioners and service users to develop an approach to monitoring treatment and recovery outcomes for individual service users. The chosen method will be designed to be completed in collaboration with service users with an emphasis on recovery outcomes.

b. An approach recommended by Commissioners is the use of the 'Outcome Star[45]', which is a measure that can be used to gather information from service users on a range of outcomes at different time points. These can be plotted and used to graphically compare progress through treatment and recovery.

c. The Lead Provider will ensure that service user outcome data is recorded systematically and submitted to Commissioners at regular intervals.

d. The Lead Provider will also be expected to produce case studies from different aspects of the BST substance misuse service, at a frequency to be agreed with Commissioners

4.2.3 Performance Management Framework

a. The Drugs and Alcohol Performance Management Framework will consistent of a number of national and local measures, including drug and alcohol specific indicators from the Public Health Outcomes Framework (PHOF). The local indicators will be based on what the commissioners and Lead Provider agree to be the best measures of performance, stretch and developmental work in a long term dialogue during the life of a contract. These will be developed and finalised during the transition phase.

b. The required outcomes are listed in the below, grouped by theme:

i. Motivation and Taking Responsibility
ii. Self-Care & living skills
iii. Managing Money & Personal Administration
iv. Social Networks & Relationships
v. Drug and alcohol Misuse
vi. Physical Health
vii. Emotional and Mental Health
viii. Meaningful Use of Time
ix. Tenancy and Accommodation

[45] 'Outcomes star' home page (2015) - link

4.2.4 Compliance

a. The performance data required under this specification and contract are subject to change by the commissioners; such changes will be discussed in advance and managed by the commissioners. During the post award pre commencement phase the following data extraction will be agreed in detail between the Lead Provider and Commissioner:

   i. Performance Management Framework (PMF).
   ii. Data derived from NDTMS and Local Data.
   iii. Range of Outcomes: process, clinical, & longitudinal evaluation.

b. A final agreement will be reached during the transition phase as to the precise monthly, quarterly and annual data returns and quality reporting required by the Commissioner.

c. The reporting of locally collected performance data will take place within an agreed timeframe. This will include some geographical reporting for headline indicators at sub-Local Authority level and TOP outcome data for the whole treatment population (e.g. local reporting of TOPS data will be more extensive than currently distributed nationally). Failure to comply with any targets will result in an exception report to include an action plan detailing how the Lead Provider identifies the problem and plans to resolve the problem.

d. In relation to overall compliance, the Lead Provider will be expected to:

   i. Comply with the performance management frameworks that support this specification. The Lead Provider will ensure that all parts of the system keep within any national and locally set targets.

   ii. Provide financial, performance and governance (inc. safeguarding) functions. An important element of this will be the collection, collation and reporting of whole supply chain:

      - Monthly and Quarterly and Annual data for Performance Management
      - Quality Data and Quality Standards compliance (upon request)
      - Information Governance Reporting (Quarterly and Ad Hoc)
      - Clinical Governance Reporting (in line with DoH and CCG requirements)
      - Financial Reporting (Quarterly)
      - Workforce Reporting (Quarterly)
      - Recovery and Personalisation Reporting (Quarterly)
      - Social Value Reporting (Quarterly)

   iii. Make full use of performance information as part of continuous service development.

   iv. Assist Commissioners in servicing strategic commissioning functions.

e. In relation to NDTMS compliance, the Lead Provider will be expected to:

i. Comply with all requirements of PHE and the Authority in maintaining accurate Patient records and uploading all monthly data and reports to meet in full the NDTMS Reporting requirements.

ii. Have internal processes to ensure data is validated prior to monthly NDTMS DAMS submission. This will include ensuring an accurate client count is submitted and discharge details are up-to-date. Sub intervention Reviews, including recovery support, and TOP forms must be completed at relevant points within the treatment system and input onto the data system in a timely manner.

iii. Have processes in place to update NDTMS data fields as appropriate. Relevant fields include Hepatitis C details, Hepatitis B details, Postcode and TOP care co-ordinator

iv. Ensure that discharges from NDTMS are linked to the service's discharge policy to ensure data is captured and reported in a timely manner.

v. Have a robust internal process for reviewing and utilising the full array of NDTMS reports, including the Recovery Diagnostic Toolkit and Reliable Change Index. Workers must have a full understanding of the requirements of NDTMS including why the data is collected and how the reports demonstrate activity.

vi. Have processes in place to ensure the timely and accurate submission of all relevant national datasets (including any new datasets that come into existence during the period of contract).

vii. Be accountable for timely and accurate data submissions across all parts of the treatment system cover by this specification. The minimum expected compliance rates are as follows:

- NDTMS core data set 100% data compliance
- TOPs 90% data compliance minimum
- YP outcome record 90% data compliance minimum
- NEXMS 100% data compliance
- DIRDET 100% data compliance

viii. Identify and agree a specific map of data collection events on NDTMS and any other agreed outcome tools across the supply chain. This will state which service elements collect data, when, and for what purpose. The map will inform audits and long term evaluation of performance and value for money and social return on investment by Bolton, Salford and Trafford Local Authorities and other funding partners.

ix. Complete full TOP data for all drug and alcohol clients within adult structured treatment.

4.2.5 Performance meetings

a. Performance meetings will be formal meetings with Terms of Reference drafted and agreed by both parties. They will take place on a quarterly basis. Prior to the performance meetings commissioners will inform the Lead Provider of any areas of underperformance or concern. The Lead Provider will provide exception reports to address these issues.

4.3 Service user involvement

a. Service user involvement has been shown to have a beneficial impact on treatment and recovery outcomes. The Lead Provider will ensure that services are flexible and responsive to the needs of service users. Services will actively involve the individual and significant others in the treatment journey, allowing them to make informed choices based on the range of interventions available to them. All interventions will be fully explained and choices will be offered where appropriate. All users of the services offered will be treated with respect at all times.

b. According to the National Treatment Agency[46], successful service user involvement should result in:

   i. Strengthened accountability to all stakeholders
   ii. Services that genuinely respond to the needs of users and carers
   iii. A sense of ownership and trust

c. In collaboration with Commissioners, the Lead Provider is expected to systems which facilitate service user involvement in the BST cluster which reflect the latest guidance from agencies including PHE[47] and the Care Quality Commission. This describes four levels of a substance misuse system at which service users can become involved:

   i. In their own care or treatment plan
   ii. In strategic development and commissioning
   iii. Developing and delivering peer mentoring and support
   iv. Developing and delivering user-led, recovery-focused enterprises

d. The Lead Provider will be expected to demonstrate ways in which service users are being encouraged to participate at each level and evidence of how service user feedback has been incorporated into service planning and delivery. In this regard there will be an overlap with some of the interventions being developed by the Recovery Community (Section 0). Particular efforts will be made to engage and receive feedback from young people, carers and other priority groups.

4.4 Social marketing and communication

[46] NTA (2006) *Guidance for local partnerships on user and carer involvement* - link

[47] PHE (2015*) Service user involvement: A guide for drug and alcohol commissioners, providers and service users* - link

a. The Lead Provider will develop an integrated Social Marketing and Communication programme across the BST cluster. It is intended that this will:

   i. Raise awareness of the treatment and recovery service and increase numbers of 'unknown to treatment' referrals into the case management system

   ii. Encourage self-treatment, primarily by raising self-knowledge, self-efficacy and self-help, by accessing facilities such as 1:1 support, groups, fellowships, along with web and text based resources.

   iii. To enable and equip people to engage in their own care both individually and collectively via formal groups, informal groups, associations and fellowships – ideally at both a Greater Manchester wide level and neighbourhood level

4.4.1 Communications Strategy

a. The Lead Provider will ensure the design and implementation of a communications strategy detailing how they will respond to the full range of communication requirements including:

   i. Responding to general enquiries

   ii. Complaints

   iii. On-going care management issues

   iv. The handling of crisis and emergency situations.

b. The strategy will be reviewed on an annual basis and will cover communications with

   i. Service users
      - The Provider will implement innovative communication systems to effectively engage with service users.
      - The Provider will also ensure that patients are aware of how to make a complaint, if necessary.
      - The provider will ensure the provision of a text messaging reminder function for all appointments.

   ii. Staff

   iii. Partner agencies
      - The Provider will ensure that all necessary data sharing agreements are in place between appropriate service providers
      - This will ensure that staff are in possession of all the relevant information and facts about a client prior to their first appointment.

   iv. The public

   v. Media (see Section 4.4.6)

   vi. Commissioners

4.4.2 Marketing Plan

a. The Lead Provider must explore and develop pathways with all partner organisations and agencies so they are aware of what is available, from whom, and how referrals can be made. They must develop a marketing plan to promote the services and increase engagement. The Provider will work with the commissioners to develop a brand for the treatment and recovery system.

b. The techniques used will include:

   i. Distributing leaflets, posters and flyers.
   ii. Consulting with key stakeholders.
   iii. Launching new tools, interventions and services.
   iv. Developing age-appropriate catchphrases, slogans or straplines to help engage local people.

4.4.3 Patient Information

a. The Lead Provider will employ innovative channels of communication, including the internet, mobile telephones and applications. This will include a website for the integrated substance misuse service. The website should incorporate content on treatment and recovery services including locations and opening times. It should also contain accessible and attractive health promotion advice regarding substance misuse, including harm reduction messages. The Provider should also include an online 'self-referral' function within the website.

b. A wide range of information on alcohol, drugs, harm reduction and related issues will be provided to service users, family members and carers, and concerned others at all sites used for service delivery. The Provider will give service users and their families/ carers with information about where to go for support outside of regular office hours and which services to access in the event of a crisis. This will be available in leaflets and in electronic formats as appropriate and reviewed annually. The Provider will ensure high quality information is directed at parents and children on the effects of problem drinking and drug use in families.

4.4.4 Social Marketing

a. The Lead Provider must ensure the development, implementation and continuous evaluation of a comprehensive marketing plan. It will utilise the full range of media available including all relevant social media (as a minimum this will include Facebook and Twitter).

b. The provider will embed targeted communications and an overarching and effective communications process into the heart of service design and delivery. This will involve the active promotion of all services under the contract, featuring high quality and accessible information, to the following audiences:

   i. The immediate service user group.
   ii. The families, carers and concerned others of service users.
   iii. The wider population of substance misusers including those who are considered treatment naïve.
   iv. Other Tier 2, 3 and 4 providers.

4.4.5 Promotional Activities

a. The Provider will develop a range of evidence based and locally relevant social marketing campaigns (3 per year) which will be delivered via multiple communication channels.

b. The campaigns will be based on regularly updated and reviewed social marketing insight analysis and public consultation exercises – including at a neighbourhood level as service coverage improves. Campaigns must be targeted at an appropriate audience, credible and realistic in their aims.

c. The Provider will work with the commissioners to support related public health initiatives in each locality.

4.4.6 Media

a. The provider will identify and develop effective and productive relationships with all media in Bolton, Salford, Trafford and the wider Greater Manchester conurbation. The Commissioners expect the Provider to be proactive and innovative in their approach to communications. The Provider will respond promptly to media enquiries and work with Commissioners and other partner organisations to generate a flow of positive, good news press releases (the target will be a minimum of 12 articles per year) and/or other media related issues.

b. The Lead Provider will also work with the Commissioners and the Council Press Offices, to where appropriate, jointly respond to media related issues. Press releases and responses to media enquiries will be approved by the relevant local Commissioner.

4.5 Finance

a. It is intended that the new integrated system will see reductions over time of established opiate and crack cocaine users and increases in those entering long term recovery. The system will remain open to any new problematic drug users but it is expected that the declining prevalence of opiate and crack cocaine users will free resources for recovery from treatment year on year. Accordingly, The Lead Provider will establish a Recovery Fund for the development of recovery and mutual aid at a system level. This recognises movement from treatment to recovery, which is the key claim the successful Lead Provider must deliver on.

b. Contributions to the treatment and recovery system vary by Local Authority depending on local factors.

	Budget per annum
Bolton	£2.5m
Salford	£3.5m
Trafford	£2.0m

c. The Commissioners expect the Lead Provider to ensure that the budget contributed by each Local Authority is spent within that area, and be able to demonstrate this to Commissioners.

d. It is expected that there are economies of scale which can be realised for shared functions of the service. The Lead Provider will work with Commissioners to agree a system whereby a proportionate contribution from each area is shared and used to deliver these functions

e. Mechanisms for the assessment of funding bids will be established by Commissioners and Lead Provider.

f. The final allocations will be subject to negotiations between the Lead Provider and the Commissioner and approval by the Commissioners.

g. The overall outcomes delivered by the Lead Provider will represent a social return on investment over the life of the contract. This will be evidenced in a wide range of social, public health and community safety outcomes for the BST cluster. Any efficiency savings will be redistributed to the Recovery Fund (Section 3.13) according to criteria agreed with the Commissioners.

h. **Contract value**

   i. The contract value is £8m per annum.
   ii. The amounts may be subject to change in the event that:
      - Local Authority budgets are reduced. In such circumstances the Commissioners would work with the Lead Provider to manage the cuts.
      - Additional Local Authorities wish to join the cluster in order to deliver drug and alcohol services in their area. Bury Local Authority may join the cluster during the term of the contract. Arrangements governing any such eventuality will be agreed with Commissioners during the transition period.

4.6 Mandated facilities and other costs

a. The Lead Provider is expected to provide and operate all required premises within the contract value. As a minimum, treatment venues will be available across the BST cluster in accordance with the picture of need described in the Drug and Alcohol Health Needs Analysis, either from a permanent or shared site to NHS clinical standards. Mobile provision from a centrally located site is another option.

b. It is anticipated that the delivery of services will be remodelled in Year 1 from this stable baseline position. The commissioners will be informed of premises to be used and of any changes to premises being used. The use of joint premises with other providers is encouraged.

c. The Lead Provider will ensure that all premises used for service delivery are of a high standard and meet all legislative requirements. The unavailability of appropriate accommodation shall not be a reason for service non-provision. The Lead Provider will conduct regular risk assessments on all premises utilised.

d. The Commissioners have mandated a number of premises as detailed below to ensure a stock of buildings. The costs for rent, rates and running costs are shown in the table below. The running costs are an estimate based on the last 2 years. All costs are to be paid from the total contract value.

4.6.1 Bolton Council

4.6.2 Salford Council

Building	Function	Costs
Opportunities Centre	Family Young People's Service	Rent / rates **£18,000** per annum plus running costs Due to the forthcoming relocation of a range of services operating from council owned premises, this venue is likely to change prior to contract award. As such the values are indicative only.
Acton Square (SCC Building)	Specialist Drug and Alcohol Treatment Centre	155 m^2 / 1668 sq ft. Estimated commercial rental value £13,500 p.a. based on full repairing and insuring terms i.e. repairs and insurance extra. Running costs responsibility of the tenant (circa £26,000), Non Domestic rates (circa £6,000). **Estimated total £45,500**
Eccles Town Hall Basement	Administrative	Estimated commercial rental value £8,428 p.a. based on internal repairing terms with service charge (circa £4,830 p.a.). Running costs approximately £22,000. **Estimated total £35,258**
Gloucester House	Recovery Centre	Rent of £18,070 p.a. plus running costs and repairs of approximately £30,000. **Estimated total £48,070**
King Street	Specialist Drug and Alcohol Treatment Centre	£12,500 p.a. actual rent plus running costs and repairs of approximately £22,000. **Estimated total £34,500**

a. An additional privately owned building, the Haysbrook Centre, located in Little Hulton is currently used to deliver specialist drug and alcohol services for adults. The landlord has agreed that the lease will run until the end of September 2014. Once the contract has been awarded there may be an option to lease the property to the Lead Provider. The current rent is £19,200 pa and running costs approximately £32,500 p.a.

b. There are other mandatory items which must be provided and paid for from the total value of the contract.

c. These are:

   i. Observed methadone consumption - This is currently in the region of £30,000 per annum. It has never exceeded this figure in the last 4 years.

   ii. Shared Care – Shared Care is currently under developed in Salford with costs not exceeding £10,000 per annum. The commissioners will want work with the Lead Provider to progress Shared Care in the future.

   iii. IT infrastructure and equipment. This will include the Case Management System and wider means of communications as set out within this specification.

4.6.3 Trafford Council

4.7 Governance

a. Strong governance arrangements are vital for the effective delivery of services within the treatment and recovery system. When developing policies and procedures, the Lead Provider will be expected to review, and ensure compliance with, relevant national guidance including from PHE (*Quality governance guidance for local authority commissioners of alcohol and drug services* - link).

4.7.1 Partnership Working and Interdependencies

a. The Lead Provider will ensure that service design and delivery is transparent and informed by service user and community priorities. Services must be demonstrably accountable to commissioning partners and to the clients and communities they serve. The Lead Provider will ensure that services are outward looking and will engage with all relevant partners in order to achieve better lives for Bolton, Salford and Trafford residents. In doing so the Lead provider will take account of the following interdependencies:

i. Acute Trusts
ii. Clinical Commissioning Groups
iii. Community Safety Partnership
iv. Department of Work and Pensions / Job Centre plus – Work Programme
v. Education providers
vi. Facilitated self-help e.g. Drink Watchers
vii. General Practitioners
viii. Greater Manchester Fire and Rescue
ix. Greater Manchester Probation Trust
x. Greater Manchester Police
xi. Greater Manchester Police and Crime Commissioner
xii. Health and wellbeing boards
xiii. HM Prison Service
xiv. Housing departments, private agencies and social landlords
xv. Integrated Commissioning Board
xvi. Local Authorities
xvii. Local neighbourhoods
xviii. Mental Health Services
xix. Mutual Aid Groups
xx. National Commissioning Board
xxi. National Probation Service
xxii. Non-facilitated self-help groups
xxiii. Pharmacies
xxiv. Prison Health Care
xxv. Recovery communities
xxvi. Working Together with Families
xxvii. 360 children and young person's drug and alcohol service in Bolton (Part of the 5-19 integrated service)

b. In relation to Partnership working, the Lead Provider will be expected to:

i. Adopt a partnership approach to the delivery of the new contract so that partnership targets, expectations, and statutory requirements are met within the resulting system.
   - In particular, relationships with GP practices and pharmacy staff and other primary care staff groups are well maintained in order to achieve the maximum benefits of service users being seen in primary care settings.

ii. Work with Commissioners to align work:
   - Between Primary, Secondary, Acute and Specialist Care for the benefit of patient pathways and to enhance the prospects of successful treatment completions and the transition to recovery.
   - Across the key points of the system where the most vulnerable, high risk and high need patients will be identified – in General Practice, in Hospital, in children and young people and family services, and in the Criminal Justice System.
   - In neighbourhoods and directorates, notably adult social care and children's services, as well as health and wellbeing services and mutual aid.

iii. Develop flexible, localised, and mobile support for the whole range of drink and drug users in the BST cluster fostering relationships with Council Housing Departments, Social Landlords and the private sector landlords, as well as a range of social enterprises. It envisaged that the Lead Provider will make creative use of flats and neighbourhood offices in partnership with a local social care and housing providers.

iv. Contribute to the development of shared protocols with other health and social care organisations that are appropriate for the clients of the services. The Lead Provider will ensure all policies and procedures have clearly stated objectives and stipulate who is responsible for implementation and monitoring arrangements.

v. Work closely with any community organisation or group that shares the aims of this contract to ensure the service is fully embedded within the local economies and neighbourhood communities of the BST cluster.

4.7.2 Working with Children's Services

The Lead Provider will be expected to:

i. Establish a *Joint Protocol* with Children's Services in Bolton, Salford and Trafford Local Authorities, informed by PHE guidance[48] which will:

   - Promote effective communication between drug and alcohol services and children's services
   - Include a statement of purpose
   - Reference national policy and guidance
   - Set out clear information sharing arrangements and referral pathways
   - Ensure services identify need as early as possible and work collaboratively to help families and reduce risk.

[48] PHE (2013) Supporting information for developing local joint protocols between drug and alcohol partnerships and children and family services - link

- Be supported by an implementation plan and steering group to manage implementation of the protocol and monitor its progress. The protocol will state explicitly the questions to be asked at assessment to inform safeguarding and promote the welfare of children so that the need for action to protect children from harm is reduced, in accordance with national guidance[49]
- Establish data sharing arrangements to determine the extent of crossover between substance misuse services and Child Protection, Child In Need, Early Intervention and Prevention and care proceedings.

ii. Family services and the wider treatment system will also establish arrangements between family services, the wider treatment system and local Multi Agency Safeguarding Hub (MASH).

iii. Prepare reports as required for reviews, core groups, case conferences and courts.

iv. Facilitate a regular (initially six monthly) data matching exercise with Children's Services. This exercise will initially produce a summary of overlap between services

v. Establish reciprocal training arrangements with social workers in Children's Services to cover thresholds, services available to parents and referral processes.

vi. Deliver training to practitioners in the BST cluster to raise the awareness of the impact of parental substance misuse on children and enable staff to deliver appropriate brief interventions. The service will develop an initial screening tool for practitioners when working with children and families. The tool will be subject to evaluation and updating as required.

vii. Align Case Management functions with existing arrangements within Bolton, Salford and Trafford Local Authorities to promote joint working in order to achieve joint outcomes whilst avoiding duplication of function and resource allocation, ensure services are delivered as appropriate in family homes or in accessible community venues such as children's centres and schools.

viii. Work with Children's Services to monitor that training opportunities are fully utilised with an emphasis on training all staff in direct contact with high risk families.

4.7.3 Legal Compliance

a. The Lead Provider shall ensure that its employees, agents and sub-contractors comply with all relevant legislation, regulations and statutory circulars insofar as they are applicable to the service. These include, but are not limited to:

i. AIDS (Control) Act 1987
ii. Care Act (2015)
iii. Carers (Equal Opportunities) Act 2004
iv. Carers (Recognition and Services) Act 1995
v. Carers and Disabled Children Act 2000
vi. Children Act 2004
vii. Data Protection Act 1998
viii. Employment Act 2002

[49] Department of Education. *Working Together to Safeguard Children* (2013) - link

ix. Environmental Protection Act 1990
x. Equality Act 2010
xi. Food Hygiene Regulations 2006
xii. Food Safety Act 1980
xiii. Freedom of Information Act 2000
xiv. Health and Safety at Work Act 1974 (and subsequent regulations)
xv. Health and Social Care Act 2012
xvi. Human Rights Act 1998
xvii. Mental Health Act 2007
xviii. NHS and Community Care Act 1990
xix. Psychoactive Substances Act 2016
xx. Rehabilitation of Offenders Act 1974 (and subsequent reforms)
xxi. Work and Families Act 2006

b. The Lead Provider must demonstrate that it is compliant with appropriate legal requirements and must demonstrate that it has an adequate range of evidence based policies, protocols and strategies in place. Where they are absent the Lead Provider must demonstrate steps are being taken towards their development and evidence a timetable for delivery.

c. The Lead Provider will share all policies and updates with the commissioners.

4.7.4 Assurance framework

a. The Lead Provider is expected to:

i. Develop and maintain an Assurance Framework in consultation with the commissioners. This framework will allow all partners in the contract to share and manage risk effectively, thereby ensuring a high quality service is provided at all times. Any relevant investigations (internally, locally or nationally) will be incorporated into the Assurance Framework.

ii. Ensure that quarterly and annual compliance report are produced for the whole treatment and recovery system in respect of NICE Quality Standards 11 (Alcohol Dependence and Harmful Alcohol Use) and 23 (Drug Use Disorders).

iii. Work towards compliance with the Quality in Alcohol and Drug Services (QuADS) and any additional standards as developed by Public Health England.

b. The commissioner reserves the right to conduct audits on the Lead Provider or to bring in external auditors to monitor elements of service provision; the commissioners reserve the right to conduct such audits without prior notice to the provider.

4.7.5 Information Governance

a. Information Governance provides assurance to Commissioners as well as the provider. It is therefore essential that the Lead Provider has recognised assurance in the field by way of a current annual approved Department of Health Information Governance Toolkit with Satisfactory rating. This includes providing staff training in this field. This submission can be audited or inspected at any time by the commissioning organisation. In addition the Lead Provider must have a current Information Commissioners Registration Certificate. Information Governance must be supported by relevant and up to date Information Governance Policies. All significant breaches of information or confidentiality (e.g. DoH Level Two or above) must be reported to the commissioner.

b. All services should have a clear confidentiality and data handling policy that is understood by all members of staff and complies with:

   i. Data Protection Act 1998
   ii. Confidentiality: NHS Code of Practice
   iii. NDTMS Confidentiality Toolkit

c. All services should give consideration to the potential for a client to dispute whether they have given consent to share their data with NDTMS. The Lead Provider will ensure that services are able to evidence consent.

d. The Lead Provider will also ensure that appropriate consent policies are in place should Personal Identifiable Data be shared with external organisations. The sharing of Personal Identifiable Data must occur via secure methods of data transfer.

4.7.6 Internal Governance

a. The Lead Provider is expected to have a strong internal governance structure and organisational governance plan. This should cover issues including: communication between service users/carers/families and staff (including managers and clinicians), communication between staff across the service, effective reporting mechanisms, client records, service data, incident reporting and health and safety. Such governance arrangements will take into account all current or any future legislation that applies, for example the Data Protection Act 1998.

b. The Lead Provider will ensure all policies and other relevant documentation (e.g. assessment forms, care plans) are Equality Impact Assessed prior to use.

4.7.7 External Governance

a. The Lead Provider is expected to build and maintain high quality governance arrangements with partner agencies including the commissioners, and other providers/agencies and the community. A strong partnership of all related agencies and stakeholders will lead to better outcomes for all. The provider will have a clearly identified and accessible complaints and compliments procedure, and will act on all complaints in a timely manner. All complaints will be shared with the commissioners at contract management meetings, or earlier if the complaint impacts upon the Assurance Framework.

4.7.8 Clinical Governance

a. Appropriate Clinical Governance is of paramount importance to the commissioners and it is intended that Clinical Governance matters will be overseen by the commissioners as appropriate.

b. The Lead Provider is expected to:

i. Obtain and maintain accreditation with the Care Quality Commission (CQC). The Provider must meet the requirements of the CQC as well as all other statutory obligations, including in relation to any relevant sub-contracted services.

ii. Have robust mechanisms and processes in place to manage all aspects of clinical governance including the management of medicines.
- These governance arrangements will cover (but not be limited to):
  - Safeguarding
  - Untoward incidents
  - Risk reduction and prevention
  - Dissemination of alerts
  - Training
  - Monitoring of services.
- Processes will include escalation and notification of events to commissioners as required.

iii. Ensure that all clinical interventions will be delivered in line with national guidance such as NICE and or local guidance, where applicable. The provider has a responsibility to keep up to date with changes in guidelines.

iv. Comply with all legislation around the use of controlled drugs and adhere to guidance from the GMC and NMC as appropriate. Legislation includes:
- The Misuse of Drugs Act 1971
- Misuse of Drugs Regulations 2001
- The Health Act 2006
- The Controlled Drugs (Supervision of Management and Use) Regulation 2013
- Psychoactive Substances Act 2016

v. Ensure that those services stocking controlled drugs on the premises have, and comply with, an approved Standing Operating Procedure (SOP). The SOPs must be made available to the local lead Accountable Officer for controlled drugs.

vi. Ensure that there are clear quality governance structures supporting any Patient Group Directions within the treatment and recovery system in line with guidance from national bodies including PHE[50]

vii. Ensure there is a Home Office licence to hold stocks of controlled drugs. Arrangements need to be in place around delegated possession of the stock of controlled drugs if doctors or pharmacists are not involved in processes, as only doctors and pharmacists are legally able to possess controlled drugs unless under arrangements.

[50] PHE (2015) *Quality governance guidance for local authority commissioners of alcohol and drug services* - link

viii. Submit a periodic declaration and self-assessment to the local lead Accountable Officer for Controlled Drugs (CDAO); as requested by the CDAO.

ix. Actively support the work of the Greater Manchester Local Intelligence Network (LIN) for Controlled Drugs and adhere to the relevant legislation and guidance on the safe use and management of controlled drugs.

x. Accept unwanted medicines from service users in the community (known as patient returns) if requested and the person is covered to possess the medication under legislation (only doctors and pharmacists are legally able to possess controlled drugs). The Lead Provider will ensure that such returns are disposed of safely and comply with legislation and the environment agency. Best practice is to return the medication to the community pharmacy where it was dispensed. The Lead Provider is responsible for the collection of clinical waste from pharmacy needle exchanges.

xi. Ensure there is a policy and procedures regarding Infection Control for the whole treatment system.

xii. Deliver a Serious Untoward Incident Policy which is consistent with the guidance issued by the National Patients Safety Agency in April 2002. The Lead Provider (and all sub contracted agencies) will refer to Council led safeguarding arrangements for children and adults.

xiii. Have clear procedures for investigating and acting upon any Serious and Untoward Incidents findings.

xiv. Notify its partner within 24 hours of critical incidents (this must be the trigger to investigate the incident), and further provide quarterly reports to the commissioner.

xv. Produce reports on Serious Untoward Incidents, Adverse Health Care Incidents, and Near Misses, based on appropriate national guidance, including from NHS England[51]

4.7.9 Independent Case File Audit

a. The commissioners reserve the right to request an independent case file audit. The Lead Provider will facilitate access to the full case file on an agreed sample basis at critical parts of the system so that the commissioning aims and objectives and interests of the service users, funders and people of Bolton, Salford and Trafford are fully realised.

b. This will be undertaken in a sensitive manner, in the spirit of learning and improvement. Key findings and recommendations will be acted upon to increase quality and improve performance and service user experience.

c. Service users will have a role in designing case audit questions which the Lead Provider will then deliver on in a timely manner, in accordance with good data governance, but also public sector finance.

d. The Lead Provider will ensure the necessary permissions (to include permission of the Lead Provider organisation and all sub-contractors) are in place prior to the commencement of the contract.

[51] NHS England (2015) Serious incident framework: Supporting learning to prevent recurrence - link

4.7.10 Working with Children's Services

a. The Lead Provider will ensure that all staff employed across the system are fully aware of the service specification and performance managed as to the performance and quality requirements of this service.

b. The Lead Provider will be expected to:

   i. Evidence workforce development in an annual workforce analysis report.

   ii. Provide and maintain a detailed description of staffing structures across the treatment system inclusive of managerial relationships.

   iii. Ensure that all services have and adhere to a recruitment policy.

   iv. Ensure the workforce contains both generic substance misuse workers and more specialised drug and alcohol specific workers to deal with the range and complexity of interventions required, and medical professionals with relevant training.

   v. Ensure staff competence and professional development in line with DANOS and any nationally accredited occupational standards recommended by Public Health England. The workforce will be competent in dealing with issues concerning the children of service users and their families and carers.

   vi. Create opportunities for volunteers, as well as making use of the existing volunteer workforce and provide placements for students and trainees from a variety of professions and work settings (e.g. nursing, social work and care, counselling).

   vii. Ensure that increasing numbers of people moving from treatment to recovery become peer mentors and navigators (e.g. greeting and reassuring new service users) and community volunteers (e.g. recovery events and activities and wider community initiatives).

   viii. Be proactive in engaging volunteers in the delivery of the contract, and ensure that they receive the same support as paid members of the workforce.

   ix. Ensure that all services provide all staff an induction and basic training programme appropriate for the needs of service users within a reasonable period of taking up appointment.

   x. Ensure that all services are sufficiently staffed to ensure continuity of service, taking into account sickness, holidays and other absences.

   xi. Ensure that all staff have access to appropriate supervision and training to develop and maintain their professional competence and that staff qualifications are up to date, including those for whom periodic registration is required

   xii. Ensure that staff fulfilling a managerial role have appropriate management competencies and that specialists have training and competencies in line with guidance from the relevant professional bodies / royal college. The competence of practitioners with regard to prescribing interventions is paramount.

   xiii. Ensure that all services fully comply with statutory requirements (e.g. protection of vulnerable adults, safeguarding children, rehabilitation of offenders), conduct

Disclosure and Baring Service checks for all applicants and monitor the existing workforce in this respect.

4.8 Workforce

The Lead Provider will be required to:

i. Ensure that all staff employed across the system are fully aware of the service specification and performance managed according to the performance management requirements of this specification (see Section 4.2)

ii. Evidence workforce development in an annual workforce analysis report.

iii. Provide and maintain a detailed description of staffing structures across the treatment system inclusive of managerial relationships.

iv. Ensure that all services have and adhere to a recruitment policy.

v. Ensure the workforce contains both generic substance misuse workers and more specialised drug and alcohol specific workers to deal with the range and complexity of interventions required, and medical professionals with relevant training.

vi. Ensure staff competence and professional development in line with DANOS and any nationally accredited occupational standards recommended by Public Health England.

vii. Ensure that the workforce is competent in dealing with issues concerning the children of service users and their families and carers.

viii. Ensure that substance misuse workers receive domestic violence training, in accordance with NICE guidance[52]

ix. Create opportunities for volunteers, as well as making use of the existing volunteer workforce and provide placements for students and trainees from a variety of professions and work settings (e.g. nursing, social work and care, counselling). Volunteers should receive the same support as paid members of the workforce.

x. Ensure that increasing numbers of people moving from treatment to recovery become peer mentors and navigators (e.g. greeting and reassuring new service users) and community volunteers (e.g. recovery events and activities and wider community initiatives).

xi. Ensure that all services provide all staff an induction and basic training programme appropriate for the needs of service users within a reasonable period of taking up appointment.

xii. Ensure that all services are sufficiently staffed to ensure continuity of service, taking into account sickness, holidays and other absences.

xiii. Ensure that all staff have access to appropriate supervision and training to develop and maintain their professional competence and that staff qualifications are up to date, including those for whom periodic registration is required

xiv. Ensure that staff fulfilling a managerial role have appropriate management competencies and that specialists have training and competencies in line with guidance from the relevant professional bodies / royal college. The competence of practitioners with regard to prescribing interventions is paramount.

[52] NICE (2014) PH50 Domestic violence and abuse: multiagency working - link

xv. Ensure that all services fully comply with statutory requirements (e.g. protection of vulnerable adults, safeguarding children, rehabilitation of offenders), conduct Disclosure and Baring Service checks for all applicants and monitor the existing workforce in this respect.

4.9 Social value

a. Social Value is a process whereby organisations meet their needs for goods, services, works and utilities in a way that achieves value for money on a whole life basis in terms of generating benefits not only to the organisation, but also to society and economy, whilst minimising damage to the environment.

b. Social Value is imbedded in both commissioning and Procurement policies across Bolton, Salford and Trafford and stipulates that providers are to:

   i. Promote employment and economic sustainability
   ii. Raise the Living Standards
   iii. Promote Participation
   iv. Build the capacity and sustainability of the voluntary and community Sector
   v. Promote equity and fairness
   vi. Promote Environmental Sustainability

c. The Provider is expected to meet the following social value outcomes for all three boroughs:

   i. More Local People in Work
   ii. Thriving Local Businesses
   iii. Responsible Businesses that do their bit for the local community
   iv. A local workforce that is fairly paid and well supported.
   v. Communities supported to help themselves
   vi. An effective and resilient 3rd Sector
   vii. A reduction in poverty, health and education inequalities
   viii. Reduction in costs by investing in prevention
   ix. Protecting our environment and reducing climate change

d. The Provider will evidence how they have met the above outcomes in relation to substance misuse for Bolton, Salford and Trafford. Evidence will be submitted on a quarterly basis and will be discussed as part of the scheduled quarterly contract meetings between the Provider and Commissioner.
e. The outcomes to be reported on each quarter will be agreed with the Commissioners upon contract award.
f. Social value policies for the BST substance misuse service should be developed with reference to the Greater Manchester Social Value policy[53]

[53] GMCA (2014) Social value policy - link

4.10 Contract

4.10.1 Compliance

a. The Lead Provider is expected to meet the identified targets within the budget set for this contract. Failure to meet targets will result in the commissioners requesting an action plan to redress the unmet target. The commissioners reserve the right to issue a default notice in line with contractual requirements for failure to address performance issues following the implementation of an action plan.

b. The commissioners expect to build a strong and effective working relationship with the Lead Provider, with shared values and vision regarding the delivery of this contract; a cultural alignment between commissioner and provider.

4.10.2 Contract management

a. The commissioners will manage this contract via quarterly contract management meetings which will be open to all relevant commissioners and service users and recovery advocates as appropriate. The Lead Provider will be invited and expected to attend, produce relevant reports including finance and evidence of delivery and outcomes as required by the contract and the associated Performance Management Framework and other monitoring documents. It is the commissioners aim to ensure that the governance arrangements applied to this specification are outward as well as inward looking and therefore views and experiences of stakeholder organisations in terms of the delivery of this service specification will be sought as part of contract management.

b. The provider will keep a risk register for all risk factors relating to this contract, which will be shared openly with the commissioners.

c. The provider is expected to be transparent in all areas of contract delivery and provide early warnings with an accompanying action plan for any areas of underperformance, detailed in an assurance framework.

d. On the expiry or termination of this Contract or termination of any Service the Provider must co-operate fully with the Authority to migrate the Services in an orderly manner to the successor provider, which shall include the transfer of all relevant case files and clinical data as appropriate to individual cases to inform continuity of care, and the Provider will maintain its own copies of any such information.

e. Payments quarterly in advance with the retention element to be determined on award of contract.

4.10.3 Charges and Payment

a. Payment Options:

   i. The Authority shall pay within 30 days of receipt of invoice
   ii. The Authority shall pay via Purchasing Card

b. The Lead Provider shall invoice the Authority for payment of the Charges in advance at the beginning of each quarter

c. The Authority will retain 2.5% of the Charges each quarter; such sum will be paid over to the Lead Provider on satisfactory performance of its obligations in this Contract.

4.10.4 Review of the service specification

a. The commissioners may review and/or vary this Service Specification from time to time in the interests of service users. The service provider will be closely involved in this process to identify any implications (financial and human resources) for service delivery.

b. The commissioners will engage in a variety of change management processes with the Lead Provider in the light of performance and evaluation of outcomes.

c. The commissioners reserve the right to review the content and detail of this service specification on an annual basis to take account of changes in national policy, funding and local substance misuse trends. This may also include the inclusion or exclusion of specific elements of services.

4.11 Developing the specification post-procurement

a. Between x and x 2017 there will be a transitional period; during which the ideal service specification will be finalised to the satisfaction of both Commissioners and Lead Provider.

b. Post procurement, there will be a process of co-design of final treatment pathways between the Commissioners and Lead Provider. The commissioners hold the view that recovery is a broad concept requiring many pathways and that recovery is a journey not an end state.

c. As this service will commence during significant change and transition within the local and national public sector, elements of this service specification are subject to change. Commissioners will fully engage with the provider during the lifetime of this service to ensure the specification remains relevant to both those who use the service and the partnership it links into.

4.12 TUPE statement

The Lead Provider will ensure that:
'…Where TUPE applies to the existing employees within the service(s) the provider will comply with all of its obligations under the TUPE regulations…'

5. APPENDICES