

**Cheshire East**

**Recovery Oriented,**

**Substance Misuse Service Specification**

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**Section 1.0**

**Introduction to the Service Specification**

* 1. **Contract Summary**

Cheshire East Council is committed to supporting our most vulnerable residents, whilst enabling others to support themselves. A core ambition is to empower individuals and communities to thrive independently in a supportive environment; working together with partners, with the voluntary sector, with business, and most importantly, with residents themselves. This specification focuses on early intervention, prevention, harm reduction and aims to change behaviour, improve health and improve outcomes for individuals, families, communities and Cheshire East Council.

Cheshire East Council is flexible in our approach to service delivery, always seeking solutions that will offer quality and value for money, and working with delivery partners who share our values and commitment to the success of the area. The Corporate Strategy sets out clear priorities, all Providers will be required to contribute towards the corporate objectives and improve outcomes for the people of Cheshire East.

Like all local authorities, Cheshire East faces a significant financial challenge. A combination of reductions in the grant we receive from central government, alongside increasing demands on our services, and increased costs through inflation. This service is therefore commissioned during a time of significant change and uncertainty in public finances. Therefore the contents of this specification will be subject to review over the lifetime of the contract, with expectations for a flexible and community focussed approach by the Provider[s].

This service specification describes a recovery-orientated, integrated, community substance misuse treatment service for adults and young people in Cheshire East. Integrated service elements include:

* drug and/or alcohol services (substance misuse);
* prevention, treatment, harm reduction, and recovery services;
* young people, transition to adults, adults, family/carers.
  1. **Contract Term and Whole Life Costs of the Contract**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Year 1**  **1st Nov 2018 – 31st Oct 2019** | **Year 2**  **1st Nov 2019 – 31st Oct 2020** | **Year 3**  **1st Nov 2020 – 31st Oct 2021** | **Year 4**  **1st Nov 2021 – 31st Oct 2022** | **Year 5**  **1st Nov 2022 – 31st Oct 2023** |
| **Total Contract Value** | £2,957,152 | £3,040,568 | £3,040,568 | £3,040,568 | £3,040,568 |
| **Core Service Provision** | £2,797,152 | £2,880,568 | £2,880,568 | £2,880,568 | £2,880,568 |
| **Incentivised Payment** | £150,000 | £150,000 | £150,000 | £150,000 | £150,000 |
| **Ringfenced D&A testing** | £10,000 | £10,000 | £10,000 | £10,000 | £10,000 |
| **Community Investment** |  | 2% | 2% | 2% | 2% |

The contract value range for the Substance Misuse Service for Cheshire East will cost up to £3,040,568 annually. Cheshire East Council are continually seeking best value and service improvement; therefore expect bids to be lower than the £3,040,568 allocated. A separate ring fenced allocation of £10,000 per annum has been allocated for family court requested drug testing. Tenders received above this figure will be disregarded.

See section 4.10 for further information on incentive, community and ring fenced budgets.

We wish to see clear evidence of investment in the recovery community that impacts on long term recovery and the effectiveness of the service. The Provider is expected to invest a minimum of 2% of the annual budget into the development of recovery communities, Commissioners expect to see range of options implemented over the lifetime of the contract.

The incentive payment will be made dependent at the end of each financial year, on the achievement of agreed KPIs. See the Performance Management Framework in the appendices.

The initial contract term is 3 years with the option to extend for up to 2 years.

* 1. **Financial Ability of the Organisation**

The successful Provider[s] must assure the commissioner of their organisational financial stability [surplus, reserves, income streams and liabilities]. The successful Provider[s] must put in place such financial checks prior to awarding sub commissioned contracts to other providers.

All Provider[s] will have appropriate insurances in relation to the service to be delivered and their business. This will need to be based on financial intelligence and the services to be delivered and will be assessed through the tender evaluation stage.

* 1. **Service Specification Review (process for review)**

The commissioner reserves the right to review the content and detail of this service specification at any time to take account of national policy changes, funding availability, local need, specific service trends that inform continuous development of the service. This may also include the inclusion or exclusion of specific service elements.

* 1. **How to use this Specification**

This specification has the following sections:

1. Introduction to the Service Specification
2. Summary
3. Scope of Services to be Commissioned
4. Service Requirements
5. Quality Requirements
6. Governance Requirements
7. Guidance
8. Appendices
9. Definitions and Abbreviations

This is an outcome focused specification and every section is of importance. The Provider [s] are strongly advised to be familiar with the requirements as set out for the avoidance of doubt as to what is required and what they will be accountable for.

In addition to the specification there will be extensive contact with the Commissioner and Contract Manager through regular service review and contract management meetings. It is likely that these will be more numerous at the commencement of the contract in order to explore and explain aspects of the service that are more easily examined during a direct dialogue. However, these discussions should be considered an enhancement rather than a replacement for the content of this specification. Any amendments to the service will be enacted through normal variation to contract procedures.

**Section 2.0**

**Summary**

* 1. **Service Vision**

Our vision for substance misuse services in Cheshire East is for a high quality, effective, safe integrated drug and alcohol service, which is value for money. The service must focus on early intervention and prevention for young people and adults, while empowering people to achieve and maintain recovery, improve life chances, health and wellbeing outcomes.

The service transformation requires a shift towards a stronger recovery oriented system, while understanding that some clients will have complex physical and mental health needs that require careful support and management and may influence their short term goals. This will also require the development of a visible recovery community, which builds on our local strengths and assets. We believe that people who use services and their families are our strongest assets and therefore should be empowered to have a strong voice at the heart of service design, delivery and evaluation.

The complexities of substance misuse means that no single organisation can tackle it alone, therefore a strong partnership and whole system approach is needed to ensure strong leadership for improved pathways and outcomes for local people.

* 1. **National Context**

The **Public Health Outcomes Framework (PHOF)**[[1]](#footnote-1)identifies specific indicators in relation to drug and alcohol misuse.

* Successful completion of drug treatment
* Alcohol related admissions to hospital)
* Adults who successfully engage with SMS following prison: Cheshire East = 26 and the England Average = 30.3
* Deaths from drug misuse

**The 2017 National Drug Strategy**[[2]](#footnote-2) sets out the Government’s intentions for delivery across the UK. The strategy highlights that in 2015-16, around 2.7 million (8.4%) 16-59 year olds in England and Wales reported using drugs. The Strategy also suggests that the trend is similar for younger people, but the proportion of them taking drugs is higher at 18% of 16-24 year olds. The Strategy recognises that drug misuse continues to cost £10.7bn per year, £6bn of which being drug related crime. It is clear that the numbers of adults who successfully complete treatment services has increased since 2009-10, however theses rates have leveled off in recent years, with a decline in the number of opiate users successfully completing treatment services. This decline is due to a number of issues including the aging population of opiate users, with increased mental health and related chronic health conditions associated with long term drug use.

The strategy associates the aging cohort of opiate users with an increase in drug related deaths. There were 2248 drug misuse deaths registered nationally in 2014, the highest on record. Deaths involving heroin were 64% higher than in 2012.[[3]](#footnote-3) Data from the Office for National Statistics (ONS)[[4]](#footnote-4) shows that the number of deaths from drug misuse registered in 2015 increased by 10.3% to 2,479. This follows an increase of 14.9% in the previous year and 19.6% the year before that. Deaths involving heroin, which is involved in around half the deaths, more than doubled from 2012 to 2015. Public Health England[[5]](#footnote-5) suggest that an ageing cohort of heroin users, many of whom started to use heroin in the 1980s and 90s, are now experiencing cumulative physical and mental health conditions that make them more susceptible to overdose. Other factors include increasing suicides, increasing deaths among women, an increase in New Psychoactive Substances (NPS) and alcohol use, and an increase in the prescribing of some medicines. The highest mortality rate from drug misuse was in the North East with 77.4 deaths per 1 million population, a 13% increase from 2015.

The Strategy also highlights the link between drug misuse and mental health, with up to 70% of people in community substance misuse treatment also experiencing mental illness with a high prevalence of drug use among those with severe and enduring conditions such as schizophrenia and personality disorders. The Strategy identifies the need to act at the earliest opportunity to prevent people from starting to use drugs in the first place and prevent escalation to more harmful use, as well as providing evidence-based treatment options that can be tailored to individual need, to provide people with the best chance of recovery. The Strategy sets out four key strands to tackle drug use in the UK:

* Reducing Demand;
* Reducing Supply;
* Building Recovery;
* Global Action

The **2012 National Alcohol Strategy** [[6]](#footnote-6) states “Our ambition is clear – we will radically reshape the approach to alcohol and reduce the number of people drinking to excess”. The outcomes we want to see are:

* A change in behaviour so that people think it is not acceptable to drink in ways

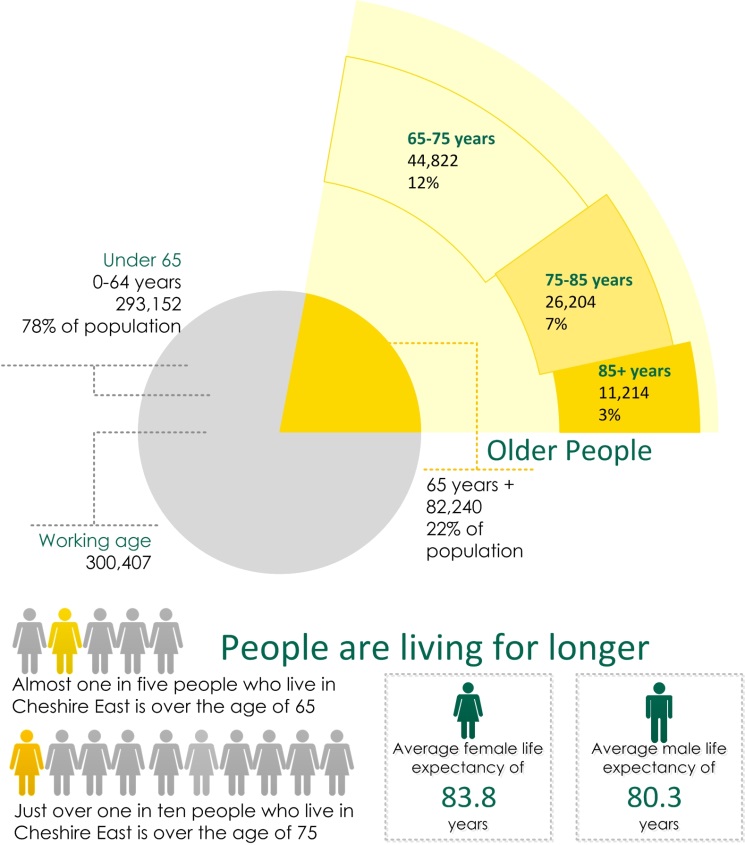
that could cause harm to themselves or others;

* A reduction in the amount of alcohol-fuelled violent crime;
* A reduction in the number of adults drinking above the NHS guidelines;
* A reduction in the number of people “binge drinking”;
* A reduction in the number of alcohol-related deaths; and
* A sustained reduction in both the numbers of 11-15 year olds drinking alcohol and the amounts consumed.

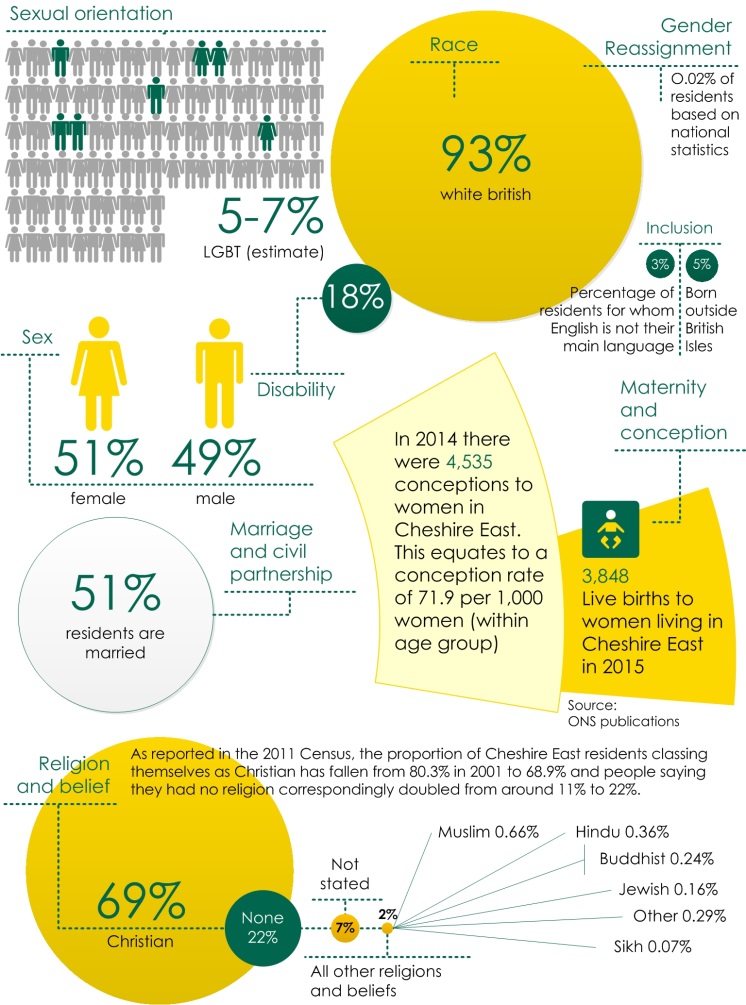
With the publication of the **PHE Alcohol Evidence Review**[[7]](#footnote-7) in 2016 and the changes to the Chief Medical Officers low risk alcohol guidelines[[8]](#footnote-8) in 2016, the new National Alcohol Strategy may soon be published. The PHE Alcohol Evidence Review7 indicates that there are currently over 10 million people drinking at levels which increase their risk of health harm and that alcohol is now the leading risk factor for ill-health, early mortality and disability and the fifth leading risk factor for ill-health across all age groups. The PHE evidence also shows that there has been an increase in the sale of alcohol since 1980, which has increased by 42%, from roughly 400 million litres in the early 1980s, with a peak at 567 million litres in 2008, and a subsequent decline. The review suggests that this is due to increased consumption by women, increased affordability, a change in the way that alcohol is sold in the UK, and more people drinking at home. This increase in consumption has led to an increase in alcohol related harm, and there are now over 1 million hospital admissions relating to alcohol each year in the UK, half of which occur in the lowest three socioeconomic deciles.

* 1. **Local Context**

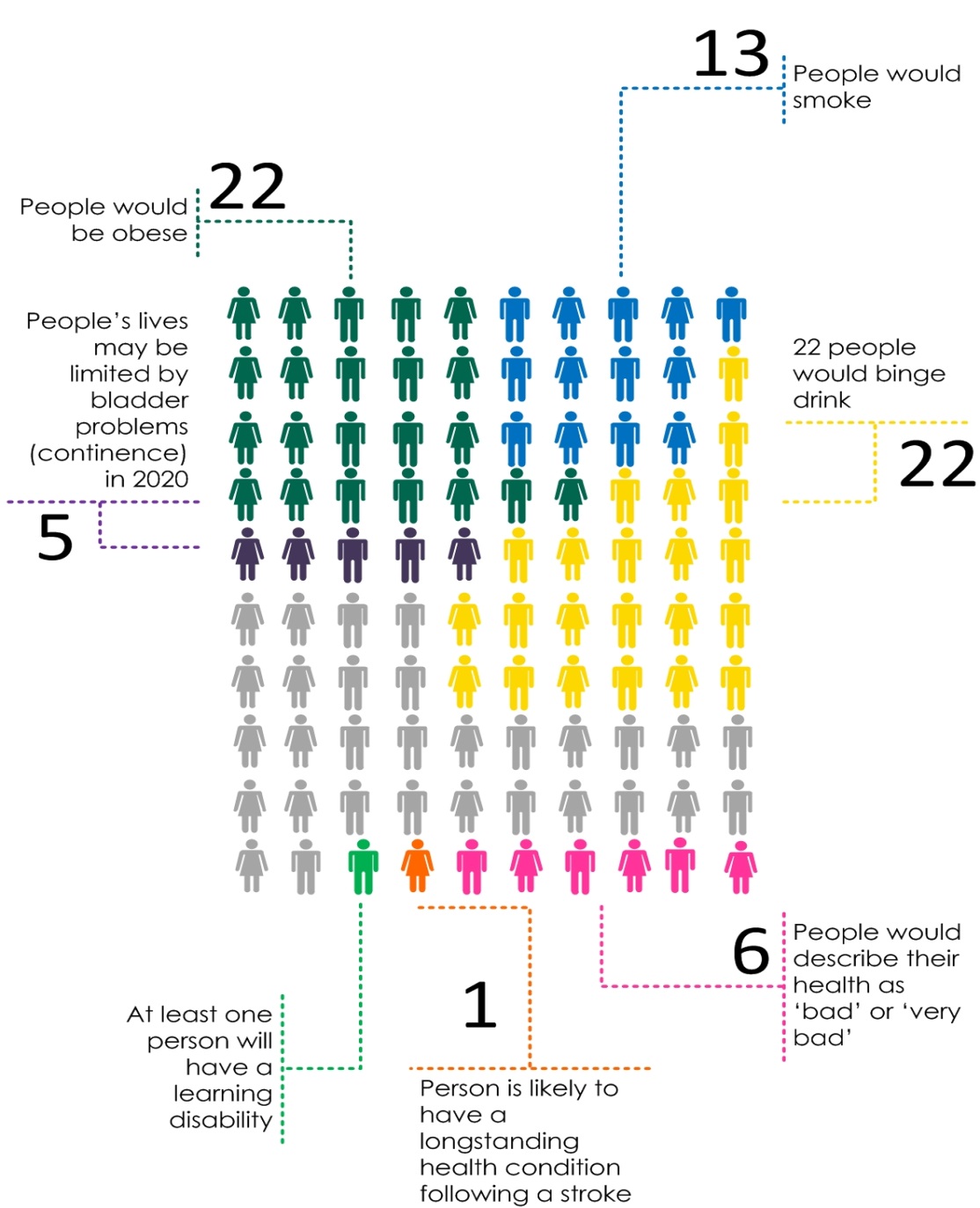
The borough of Cheshire East is a mix of rural and urban environments, covering an area of over 1,100km2 and has a population of 372,700 people.[[9]](#footnote-9)



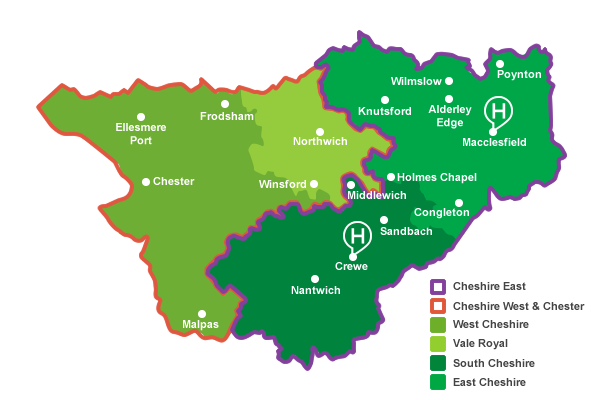
The service transformation and re-commissioning of Substance Misuse Services is a priority within the **Cheshire East Council People Live Well for Longer Commissioning Plan (2017)**[[10]](#footnote-10) which states that there is an aging population in Cheshire East. The aging population means that by 2020, over a quarter of the Cheshire East population will be aged over 65, greater than the UK average. Our challenge when commissioning local services is to enable people to live well and for longer and that we have the right service in place to respond to peoples changing needs and expectations.



**If Cheshire East was a village of 100 people:**

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There are **82 elected members in Cheshire East** with **52 Wards** and **7 Local Area Partnerships (LAPS)**. The **Cheshire East Connected Communities Strategy (2017)**[[11]](#footnote-11) describes how Cheshire East Council are undertaking community development activities through assets based approach (ABCD) to develop Connected Community Centres, Neighbourhood Partnerships and Town and Community Partnerships.

The following map indicates the boarders for Cheshire East Council, Cheshire West and Chester Council and CCG areas:

The **Cheshire East Council Corporate Plan (2016-2020)**[[12]](#footnote-12) consists of 6 priority outcomes which include:

**Live Well Cheshire East**[[13]](#footnote-13) is a new online resource developed by the Council launched Spring 2017, providing an asset map of local services and support, giving residents choice and control of available services and information on:

* Staying healthy;
* Community activities;
* Living independently;
* Care and Support for Adults;
* Care and Support for children;
* Local offer for special educational needs and disability;
* Education and employment.

Live Well is a platform that the Council will build on further providing self-assessment of care needs, and people portals linking services to people. Residents will be able to access Live Well via the dedicated ‘live well’ web address.

The **Cheshire East Alcohol Harm Reduction Strategy (2017)**[[14]](#footnote-14) sets out how Cheshire East will work in partnership to reducing excess alcohol consumption, with the following priority outcomes:

* To reduce alcohol-related health harms;
* To reduce alcohol-related hospital admissions;
* To reduce alcohol-related crime, anti-social behaviour and domestic abuse;
* To support a diverse, vibrant and safe night time economy;
* To improve our co-ordination/partnership work to ensure that all the other priorities are achieved efficiently and effectively.

The Cheshire East Alcohol Harm Reduction Strategy focuses on **Prevention, Protection, Treatment, Recovery, and Enforcement and Control**, demonstrating the range of work that is already underway, while setting out clear ideas and plans for improvement. The Plan is overseen by the Cheshire East Health and Wellbeing Board, but with a reporting line for information to the Cheshire East Community Safety Partnership. The Cheshire East Substance Misuse Provider Forum (SMPF) contributes to the delivery of the implementation Plan that underpins the Strategy. The governance for the Cheshire East Alcohol Harm Reduction Strategy sits with the [Health and Wellbeing Board](http://www.cheshireeast.gov.uk/council_and_democracy/your_council/health_and_wellbeing_board/health_and_wellbeing_board.aspx) and the [Safer Cheshire East Partnership](http://www.cheshireeast.gov.uk/environment/community_safety/safer_cheshire_east.aspx) (SCEP)

The **Cheshire East Substance Misuse Provider Forum (SMPF)** was established in June 2016. This is a partnership forum which has been established to lead a collaborative approach to improve performance and outcomes for substance misuse services across Cheshire East. The four key work programmes currently being developed by the SMPF include:

* Communications;
* New Psychoactive Substances (NPS);
* Frequent Flyers – defined by the SMPF as people who cross multiple services e.g. housing, substance misuse, police, A&E etc. Also that regardless of multiple interventions with multiple providers, nothing seems to break the cycle, often due to organisations working in isolation rather than taking a collective and joined up approach;
* Service User Engagement and Co-coproduction.

The Cheshire East Children and Young People’s Plan 2015-2018 priorities include:

1. Embedding listening to and acting on the voice of children and young people throughout services (same as having a voice)
2. Ensuring frontline practice is consistently good, effective and outcome focused (feeds into feel and be safe)
3. Improving senior management oversight of the impact of services on children and young people
4. Ensuring the partnership effectively protects and ensures good outcomes for all children and young people in Cheshire East (feeds into feel and be safe)

Further information can be found from**:**

<http://www.cheshireeast.gov.uk/livewell/care-and-support-for-children/working-in-partnership/childrens-trust/childrens_trust.aspx>

The local picture in Cheshire East for the substance use related PHOF indicators in comparison to the England average and performance of the existing drug and alcohol system (including gaps and areas for improvement) can be found in the Cheshire East Alcohol and Drug Joint Strategic Needs Assessment[[15]](#footnote-15).

**Section 3.0**

**Scope of Service to be Commissioned**

**3.1 Service Aims and Outcomes**

The overarching aims of the service are to;

* Improve outcomes and life chances for young people, adults, families and communities who are effected by drugs and/or alcohol;
* Prevent drug and alcohol use;
* Maintain recovery from drug and/or alcohol use;
* Reduce the harmful impacts of drugs and alcohol on individuals, families and communities;
* Prevent drug and/or alcohol related deaths;
* Prevent of substance misuse related blood born viruses and infections;
* Improve physical health of people in treatment and recovery;
* Improve the 5 Ways to Wellbeing: Connect, Be Active, Take Notice, Keep Learning, and Give;
* Build personalised recovery capital, strengths and assets for individuals from assessment through to maintaining recovery, including housing and accommodation, friends, family, employment, education, training, volunteering;
* Reduce crime and re-offending of people in treatment and recovery;
* Reduce the stigma the people in treatment and recovery from drugs and alcohol experience;
* People in treatment and recovery feel that they have a strong voice and are able to contribute positively to the design, delivery and evaluation of drugs and alcohol services;
* Improved access to drug and alcohol services;
* Contribute to the delivery of Cheshire East Children & Young Peoples Plan Priorities: Having a voice; Feel and be safe; Happiness and Mental Health; Being Healthy & Making Positive choices; Best Skills & Qualifications; Additional Needs & Additional Chances;
* Build safer, stronger, more resilient communities;
* Increase the economic prosperity of Cheshire East.

**3.2 Service Delivery Expectations**

In order to achieve the service overarching aims and outcomes the Provider[s] will achieve

delivery of the following service expectations:

* A ‘Hub and Spoke’ model with a community based focus, ensuring an accessible service;
* A ‘No Wrong Door’ approach to early help and brief intervention to support improved health and wellbeing and avoidance of crisis, assuring timely access to structured treatment and recovery support through a range of options;
* A ‘Recovery Oriented’ and ‘Person Centred’ approach, which empowers and enables personal responsibility particularly peer based and volunteering opportunities;
* A ‘Whole System’, collaborative leadership approach, ensuring that seamless pathways are achieved;
* A ‘Holistic’ ‘Whole Familiy’ approach for adults, young people, their families and communities;
* A safe, effective, ‘Harm Reduction’ approach, while ensuring with a balance between treatment and recovery;
* A ‘Strengths’ based approach, building individual and community recovery capital, community resilience and community safety;
* A core focus on engagement, co-production, co-design, co-delivery and co-evaluation with service users and their families;
* Ensuring a focus on ‘Quality’ through compliance with Care Quality Commission (CQC) registration and inspection arrangements, and contribute towards the system wide Safeguarding Inspections of Children and Family Services led by OFSTED;
* A strong emphasis on effective ‘Outcomes’ based performance monitoring, while ensuring that robust data gathering and inputting systems are in places for the National Drug Treatment Monitoring System [NDTMS], Treatment Outcomes Profile [TOP] and Young Peoples Specialist Substance Misuse Outcomes Record (YPOR);
* An effective ‘Evidence Based’ service based on National Institute of Clinical Excellence (NICE) guidance for Substance Misuse, Drug misuse and dependence: UK guidelines on clinical management (Orange Book) and other national standards and best practice guidance.

**3.3 Key Challenges**

A number of key challenges have been identified based on feedback from local people who use services, local need, and national guidance. Provider[s] must ensure that the following challenges are met across all areas of service activity:

* Prevention, early intervention, and ongoing community based recovery support to maximise the potential for improved outcomes and life chances through achieving a substance free life;
* Responsive and flexible approach to evolving and changeable substance misuse, behaviours, local needs, and demand which require a range of interventions for all substances including stimulants, opioids, empathogens, psychedelics, depressants (including alcohol) cannabinoids, dissociatives. Legal or illegal, prescribed or not;
* Improved access using a flexible, community and assets based approach, as well as innovative solutions such as technological approaches to address the vast geography of the borough, with a mix of different needs and assets across rural and urban areas of Cheshire East;
* Building a strong, sustainable and visible ‘Recovery Community’ to support sustained recovery at a community level while reducing stigma;
* A person centred approach, understanding that service users can have multiple needs, with responsibilities such as employment, education, being a parent, partner or a carer within a wider family context. The service must take a ‘holistic’ ‘whole family’ approach to substance misuse services. Partnership working for improved transition and pathways is essential;
* Family members (Carers) are essential to recovery and must be supported in their own right. Carers support must be embedded within the substance misuse service delivery and not just a bolt on or sign posting activity. The substance misuse service must develop seamless pathways with wider Carers services in Cheshire East;
* In addition to needs, the person centred approach must also focus on strengths and outcomes, build personalised recovery capital, strengths and assets for individuals from assessment through to maintaining recovery, including housing and accommodation, friends, family, employment, education, training, volunteering;
* Continuity of care for people entering and leaving the criminal justice system is an area where community based services will need to work seamlessly with custody, probation and prison services. The needs of the individual and those of their family and wider community will require co-ordinated support and action to ensure effective protection, and reintegration upon release;
* Continuity of care for people entering and leaving hospital;
* Increasing, promoting, strengthening and empowering the service user voice to ensure that the service meets the needs and aspirations of local people;
* Mental health and dual diagnosis of substance misuse and mental health;
* The ageing population and increasing physical health complications of individuals in treatment and recovery.

**3.3.1 Key Challenges for Young People**

The Provider[s] is required to ensure that they meet specific requirements in relation to young people (YP):

* Support and build resilience for YP to reduce escalation of harm and vulnerability. The service must understand the multiple risk factors faced by YP such as crime, sexual behaviour and exploitation, and self-harm;
* A clear evidence based, early intervention and prevention programme for YP including working with schools and colleges to support early intervention and prevention work, building on existing infrastructure such as the Cheshire East Emotionally Healthy Schools programme, which has a focus on building resilience;
* A full range of evidence based treatment is available to young people in need, including appropriate specialist interventions;
* A strong, seamless transition and pathway from children and young people’s services to adult services must be developed;
* Reducing drug and alcohol related crime, admission to hospital and deaths through specialist interventions, earlier help services, and through involvement in positive activities, building resilience, confidence and self-esteem, to reduce risk taking behaviours and improve attendance at school and the potential of personal achievement;
* Working collaboratively with others to minimise the effects of parental substance misuse on children, young people’s health and wellbeing, and education.

**3.3.2 Key Challenges for Adults**

The Provider is required to ensure that they meet specific requirements in relation to Adults:

* Ensure that care plans are co-produced with individuals, with regular ‘meaningful’ review in line with national guidance (reference clinical guidelines) and a core focus on the achievement of goals and outcomes;
* Targeted interventions for cohorts who are disengaged/poorly engaged;
* Community based interventions should be prioritised ‘where appropriate’ however the need and use of bed based detoxification and rehabilitation treatments will require a collaborative review as currently all such provision is outside of Cheshire East footprint;
* Shifting the balance between treatment and recovery while ensuring harm reduction and safe effective delivery of services, taking an asset based community development (ABCD) approach, promoting self-care and actively supporting the development of and linkage with mutual aid, peer support, and volunteering opportunities;
* Key contributing factors for recovery are family, social connections, visible recovery, having a home, employment, volunteering, and supportive networks. Effective recovery planning will be essential and needs to embrace these factors in addition to treatment and wider health and wellbeing considerations. Strong partnerships are needed to improve recovery pathways which is a key issue highlighted by service users e.g. access to [Cheshire East Housing Options](http://www.cheshireeast.gov.uk/housing/housing_options/housing_options.aspx);
* Ensuring a safe and effective ‘Harm Reduction’ reduction approach in response to the national and local trend in terms of the increase in drugs and alcohol related deaths;
* There is significant unmet need for alcohol treatment in Cheshire East.
  1. **Service Areas**

**3.4.1 Specialist drugs and alcohol services for young people (YP);**

The Provider[s] is required to develop a Children and Young Person’s Substance Misuse Service element within the wider Service structure; ensuring delivery of a comprehensive range of specialist substance misuse interventions; that meet the range of children and young people’s needs. Children and Young People’s needs must be addressed as distinct to those of adults; the Provider[s] is expected to take a holistic whole family approach that is integrated with early years services, family support services, youth services and targeted and specialist services for children and young people.

Key components for the Children and Young Person’s Substance Misuse Service element include;

* Effective evidence based interventions which address universal and targeted need; these interventions should focus on reducing risk and increasing resilience
* A programme of early intervention and prevention work; focusing on factors such as raising educational achievement, training and employment, promoting positive health and wellbeing, positive relationships and meaningful activities
* Work with schools to develop “whole school approaches”, complimented by engagement with parents and carers. (Work with schools must be closely aligned to the Cheshire East Emotionally Healthy Schools Programme)
* Aligning early intervention and prevention programmes to the European drug prevention quality standards (EDPQS)[[16]](#footnote-16) and Rise Above campaign[[17]](#footnote-17) as a minimum
* Ensuring all young people have access to accurate, relevant and timely information about the health harms of alcohol, drugs and tobacco, through a range of formats including contribution to school PHSE delivery and development of awareness raising materials for young people
* Working in partnership with other LA services to prevent the under age and proxy sales
* Targeted prevention for young people who may be at increased risk of harm; closely aligned with other services to enable a multi-agency response
* Targeted brief interventions offered in appropriate settings for young people; such as youth and community settings, A&E, GP practices, housing providers and via school nurses
* A&E and hospital care pathways in place for those young people presenting with drug and alcohol related problems, including those jointly presenting with a mental health problem or violence related injury
* Clear joint working practices and protocols (where appropriate) developed with other services, in Cheshire East, working with young people (including Youth Support Service, Troubled Families team, CAMHS, Safeguarding Teams etc); these services should also be involved in the design and delivery of the Young People’s Substance Misuse Service
* Comprehensive assessment of need, this will include the development of a CAF plan for young people where appropriate, interventions for young people should vary in intensity and duration according to changing needs and understanding of risk and resilience factors, high intensity support should be made available to vulnerable young people with complex need and multiple risk factors
* Individual packages of care-planned support for young people in the most need; this could include medical; psychosocial or specialist harm reduction interventions that build the young person’s resilience and reduce the harm caused by substance misuse
* The Young Persons service should be accessible to young people at times that suit them eg; outside of school or college hours, the Provider[s] should utilise the “You’re Welcome” standards[[18]](#footnote-18) to ensure they are meeting the needs of young people and improving access particularly for vulnerable and at risk groups of young people
* The transition from children and young people’s services to adult services is often cited as a risk for individuals and their families, in delivering future services this must be addressed. See the practice standards for young people with substance misuse problems;
* Specialist Justice post which is co-located within the substance misuse service and the East Cheshire Youth Justice Service (YJS);
* Working collaboratively with others to minimise the effects of parental substance misuse on children, young people’s health and wellbeing, and education.

The Young Person’s Substance Misuse Service will need to engage and intervene with vulnerable young people early to stop the escalation of risk and harm from substance misuse. Therefore the Provider[s] should offer:

* Support to universal services;
* Assessment and case co-ordination, including leading on CAFs where appropriate;
* Harm reduction and treatment [inclusive of all modalities];
* Health and wellbeing assessment and specialist interventions for young people that will lead to a reduction in the potential of longer term problems, with improvements in their educational results, employability, general health and mental wellbeing, and family relationships;
* Mechanisms to capture the views of children, young people in assessment, with bespoke support planning;
* Involvement, advice, training and guidance to system wide professionals involved in the child, or young person’s care and protection;
* Interventions that ensure the child and young person have a support network that they co-design;
* Support for the child, young person to grow and transition towards the adult they want to be;
* Successful transition to adult service support and professionals through co-produced transition plans;
* Peer support, and information for children and young people that is age appropriate;
* Contributions to wider education, training and employment sector, including workforce development for the health, education and social care economy that facilitates earlier intervention reducing risk taking behaviours and substance misuse;
* A specific targeted approach and focus on early intervention and prevention for young people accessing Youth Justice Services (YOS) and Youth Engagement Services (YES).
* An approach that ensures that Children and young people’s needs are addressed as distinct from the needs of adults, recognising the importance of seamless transition between care co-ordination and service support arrangements for the young person and their parent carer.

The Provider[s] is also expected to ensure that all services address cyclical familial substance misuse.

The Provider is expected to provide drug testing capability to respond to needs of Social Workers in order that they are able to complete their court reports. These tests should include: breath and urine testing for alcohol, oral/urine testing for drugs and urine testing for steroids. Testing costs shall include collection fees and expert witness reporting. An allocation has been included in the budget for the service and should be managed as a ring-fenced budget accessed to be controlled in liaison with CYP commissioner at Cheshire East.

* + 1. **Specialist drugs and alcohol service for adults**

The Provider[s] is required to ensure that they meet specific requirements in relation to Adults:

* Ensure that regular, meaningful review is central to all treatment delivery to ensure that service users do not experience a stalling of their progress with little or no change to their overall health/recovery. Ensuring that all service users meet the goals within their care plan, and leave services in a planned way. Review periods should be appropriate for clients e.g. those with higher health risks, or with previous inconsistent engagement should have more frequent reviews.
* The service will be orientated towards recovery, building recovery communities with a focus on Assets Based Community Development (ABCD), promoting self-care and actively supporting the development of and linkage with mutual aid. Key contributing factors for recovery are having a home, employment / volunteering, and supportive networks. Effective recovery planning will be essential and needs to embrace these factors in addition to treatment and wider health and wellbeing considerations.

The adult substance misuse services will need to engage and intervene with those that are using substances early to reduce escalating dependency, risk and harm from their substance misuse. These services will include the following:

* Support to universal services;
  + - A ‘personalised’ approach to assessment, service/care planning and case management, ensuring that care plan objectives are met, that the Treatment Outcome Profile (TOP) is fully implemented and that regular reviews take place;
    - Health and wellbeing assessment. Building recovery capital and strengths for individuals based on the 5 Ways to Wellbeing, from assessment to recovery;
* The involvement of carers/family in the care plan where appropriate and provide sufficient support to families/carers;
* Capturing the views of adults in assessment, and bespoke, co-produced (with the service users and other agencies) support planning;
* Innovative solutions for improved access to drugs and alcohol services through a Hub and Spoke model, including face to face, drop-ins, technological solutions, and outreach e.g. in GP surgeries and hospitals;
* Building sustainable community approach for alcohol identification and brief advice (IBA);
* Evidence based treatment and harm reduction, including psychosocial interventions, Inpatient and community detoxification and rehabilitation, substitute prescribing, maintenance and reduction plans.
* A range interventions for all substances including stimulants, opioids, empathogens, psychedelics, depressants (including alcohol) cannabinoids, dissociatives. Legal or illegal, prescribed or not;
* Community based interventions including detoxification, drug misuse shared care in general practice, alcohol pathways with general practice and supervised consumption and needle exchange in community pharmacies;
* Involvement, advice and guidance to system professionals involved in the persons care;
* Interventions that ensure the person has a support network (recovery community) that they co-design and own;
* Effective pathways for a choice of Mutual Aid and Peer based interventions;
* Where a person cannot identify a supportive social network actively support them to develop this through linkage to mutual aid, peer support and other social opportunities;
* Support for the person to fulfil their adult life roles, and to secure accommodation and meaningful activity e.g. employment, voluntary roles; Note we have commissioned recovery based accommodation outside of this service specification. We expect the new provider to develop pathways to and from this provision.
* Ensure that mutual aid, peer support, and recovery information for adults promotes abstinence and recovery;
* Enable and contribute towards wider workforce development for health, housing, employment and social care economy to facilitate earlier intervention to reduce risk taking behaviours and substance misuse
* Meaningful review and adaptable intervention and support that seek to prevent individuals stalling in their recovery progress and address the reasons why this has happened for a significant number of individuals.

**3.4.3 Evidence Based Treatment and Harm Reduction**

The Provider will provide services offering harm reduction and appropriate health assessment for blood borne viruses and sexually transmitted disease, to help with recovery from addiction, behaviour change (including psychosocial therapies), and support to withdraw and remain drug and alcohol free (including substitute prescribing and other pharmacological interventions).

The provision of structured **psychosocial interventions** should be seen as the key element of the treatment system. All service users will be offered a range of interventions at the start of the treatment journey, including both one to one key working sessions and interventions aimed at recovery, including group work.

The Provider is responsible for all **community prescribing** (including **dispensing** fees) and the overall budget within the contract value (excluding GP prescribing). This includes pharmacy developments, prescribing, needle exchange and supervised consumption for all drug and alcohol related services and costs within the community setting.

**Substitute prescribing** will be developed within the Cheshire East recovery system to facilitate and sustain recovery. Substitute prescribing will be offered where required but should not be seen as the main element of treatment. Community prescribing interventions should be delivered in accordance with the Orange Book and NICE guidelines including:

* Substitute prescribing for: maintenance; withdrawal and to prevent relapse;
* Stabilisation and withdrawal from sedatives such as benzodiazepines where this is a secondary presenting issue for drug users and/or chronic alcohol users;
* Treatment for stimulant, non-opiate, prescription drug and psychoactive substance users, which may include prescribing to help relieve symptoms;
* Non-medical prescribing including nutritional supplements and high dose parenteral thiamine for the prevention and treatment of individuals with Wernicke’s encephalopathy.

**Needle Exchange**: Within Community Pharmacies to assist service users to remain healthy until they are ready to cease injecting to achieve a drug free life with appropriate support and to also protect the wider community from harm by ensuring the safe and responsible disposal of injecting equipment [inclusive of Image and Performance Enhancing Drugs].

**Supervised Consumption:** The Provider will be responsible for commissioning supervised consumption services from community pharmacy providers as part of an agreed service specification, which will include training and administration. Supervision should be done in collaboration with the client and should not be punitive. The Provider will ensure that supervised consumption is based on good practice, is used for induction, where use on top and or diversion is a risk, and where there are concerns about safe storage at home. The Provider will work with service users to identify the most appropriate pharmacy for them, and will develop strong partnership working with local pharmacies. The provider will be aware of the financial implications of supervised consumption and will monitor its use accordingly. Supervised consumption services must be reviewed by the Provider on a quarterly basis to ensure that there is equitable access to services across the foot print of Cheshire East.

The Provider will be responsible for commissioning **Shared Care** services from GPs as part of an agreed service specification, which will include training and administration. The Provider is expected to deliver a Shared Care model of service provision for all substance misuse service users, as appropriate to their clinical/personal needs in conjunction with local GPs. The provider will work with Cheshire East Council, South Cheshire CCG, Eastern Cheshire CCG and the Local Medical Committee (LMC) to review the model of shared care.

The Provider is expected to offer robust community-based **detoxification** for suitable cases, only making effective referrals to inpatient detoxification where appropriate. Detoxification should be positively promoted as part of a recovery pathway and not used as a standalone intervention to be accessed when the service user is ready.

The Provider should link to recovery based accommodation service and housing providers in order to ensure clients accessing these services are able to obtain timely support from the service should this be required to maintain their tenancy.

Substance misuse **testing** should be based on therapeutic requirements only and will support other interventions and progress the individual’s recovery journey as appropriate.

The Provider will aim to reduce the risk of **drug-related deaths** by identifying patients known to be at higher risk and taking actions to engage such individuals safely in the protective effects of treatment, including:

* older patients, males, heroin users in the first four weeks of their treatment, those with co‑existing alcohol and mental health problems, individuals with a recent overdose;
* those who use heroin who are currently out of treatment;
* opioid dependent individuals with high risk due to recent reduction in their opioid tolerance – such as following prison release, discharge from hospitalisation or residential care, a planned detoxification programme or following recent cessation of naltrexone.

Follow the national drug related deaths enquiry recommendations, the Provider[s] should:

* ensure that drug treatment is easy to access and attractive, especially to those currently not being reached;
* rapidly optimise interventions for people coming into treatment;
* keep people in treatment for as long as they benefit;
* strengthen governance and competence in treatment services;
* share learning between services who have contact with those at high risk;
* promote effective risk management;
* intervene following non-fatal overdoses;
* promote adequate dosing of opioid substitution treatment and supervised consumption;
* support improved access for people who use drugs to broader physical and mental health care services;
* promote stop smoking services in drug treatment;
* lead on local reviews of deaths including better links with coroners and improving information recorded and transferred between agencies.

**Naloxone** will be provided for high risk opiate injectors, those leaving treatment, having left prison, recently detoxed inconsistent engagement with service and those with poor respiratory health. This must include the delivery of training around overdose prevention, relapse prevention, Naloxone administration and basic life support for users and their families/carers/supporting others. Training in the use of naloxone should be widespread, particularly in first responders likely to be available to administer naloxone e.g. hostels and family members. Legislation allows anyone to use naloxone available in an emergency to reverse a suspected opioid overdose. Wherever possible training should be peer led and community based.

The Provider[s] will work with Cheshire East Council, **Criminal Justice** agencies including the National Probation Service (NPS), Prisons, Courts, Community Rehabilitation and Cheshire Police to ensure that services are developed specifically for the use of Criminal Justice clients. The Provider[s] will ensure that all substance misusing offenders receive appropriate and co-ordinated interventions at every point of the Criminal Justice System. The Provider will work with **Prison based substance misuse Services** within custodial estates in the North West including HMP Altcourse, HMP Kennet, HM YOI Stoke Heath, HMP Risley, HMP Styal and also MHP Berwyn. The Service must to deliver Criminal Justice Services, in line with the Transforming Rehabilitation agenda. The range of Criminal Justice Services will cover, as a minimum:

* Court Referral/Restriction on bail;
* Alcohol Treatment Requirements (ATR);
* Drug Rehabilitation Requirements (DRR);
* Other Requirements that have been introduced as part of the Offender Rehabilitation Act 2014

The Provider[s] will support service users who have a **dual diagnosis of mental illness and substance misuse**. Responding to dual diagnosis within the service user groups served will be regarded as core business for the provider, be recognised and acted on by the workforce. This will require an approach consistent with the following principles:

* Dual diagnosis is common and should be expected rather than be seen as exceptional;
* Avoiding debate on what is the primary problem and agency ‘ownership’ of the client/service user and intervention;
* As dual diagnosis service users present with multiple needs they will require expert and high quality responses from a range of services, including:
* Joint assessment and joint working between services to jointly proactively learn and develop dual diagnosis and related issues with key agencies through a single Care co-ordinator;
* Providing effective care for dual diagnosis service users can only be achieved by collaboration and joint working between mental health, substance misuse and social care services. Services provided concurrently will result in improved engagement and outcomes as opposed to the serial or parallel model of service delivery.

Commissioners would expect to see the **creation of a single care co-ordinator post** working between SMS and mental health services

The collaborative model facilitates and enables care co-ordination and enhanced communication. When work is undertaken by different organisations or different parts of one organisation a clear mutual understanding of roles is essential, and there is a requirement that:

* There is a commitment to workforce development, providing comprehensive training, and developing competencies around dual diagnosis;
* Dual diagnosis service users are viewed and treated holistically;
* Liaise with Forensic Services as appropriate.

The Provider[s] will work with Cheshire East Council, Cheshire and Wirral Partnership NHS Trust, South Cheshire CCG and East Cheshire CCG in order to improve and enhance links with mental health services in order to maximise treatment outcomes. The Provider[s] will work with Cheshire East Council and key stakeholders to ensure integrated delivery with mental health services; this should lead to integrated and embedded joint working.

**Pathways between services** -The Provider[s] will ensure that service users being transferred into/out of/between services are supported through transition in a fully engaging manner. The service user must be kept fully informed of the overall process and current situation, and all relevant information (e.g. care plan, assessment documents, current prescribing, and medical history) will be requested/shared in order to ensure a smooth transition of care.

The Provider[s] is specifically expected to demonstrate evidence of good transition management as required by the performance management framework, and to provide exceptions reports to highlight inconsistencies or errors in order to promote learning.

When making referrals into other services the provider will always follow up the referral to ensure completion. With any transfer of care the Provider[s] will liaise with all relevant partners to ensure continuity of care. This is especially relevant to prison and criminal justice work.

* + 1. **Recovery**

The Provider[s] will provide services that support retaining / obtaining appropriate housing / accommodation, increasing positive social interaction, making a positive contribute through volunteering and or work, managing own income and expenditure, fulfilling life roles such as (grand) parenting to promote overall health and wellbeing with particular reference to NEF: Five ways to Wellbeing 2010.

**Recovery Communities** - The Provider[s] will work collectively with Cheshire East Council, established Mutual Aid groups and service users, families and carers to ensure support networks and recovery communities flourish both within and external to the service provision. The Provider is expected to take an asset-based community development approach to supporting local grass roots organisations develop independently of treatment provision; such organisations will be essential in sustaining treatment gains in health, wellbeing and desistance. The Provider[s] will support visible recovery in local communities to become a strong ‘independent’ voice. The Provider[s] will also understand the needs of those who do not wish to engage with visible recovery and promote mutual aid as appropriate.

**Family / Carers** – The Provider[s] must ensure that a Whole Family approach is considered in determining support arrangements for the individual, and support family/carers by providing early help support. The family/carers needs must be considered through assessment and care planning. The Provider[s] must ensure that the family/carer are able to have time away from their caring/cared for role, and that their employment, leisure and care needs are recognised maximising their health and wellbeing.

The Provider[s] must work in partnership with the Cheshire East Carers Hub to ensure that carers and family are made aware of and are supported to make contact with other existing support resources outside the services provided as part of this contract. The Provider[s] must ensure that family/carers views are taken into account when working with the child, young person or adult that they support, unless there are recognised and recorded reasons for not doing so that have been communicated to the parent & carer.

The Provider[s] must take a proactive role in **Building Recovery in Communities.** In order to build sustained recovery and real opportunities for service users in local communities the Provider will:

* Develop links and build relationships between the Provider[s] and the public/ private/ third sector in the locality in order to promote and sustain the recovery agenda;
* Develop relationships that build on the mutual (or symbiotic) opportunities for supporting service users and or those in recovery to sustain their recovery;
* Develop opportunities between Provider[s] and the public/ private/ third sector in the locality that supports each other’s organisational aims around recovery;
* The Service will be expected to work closely with Job Centre Plus Advisers to ensure all service Users have access to good quality information, advice and guidance. The Service is encouraged to provide training and awareness raising to Jobcentre Plus staff and a Single Point of Contact to facilitate partnership working. The Service will effectively implement the protocol agreed between Jobcentre Plus and the National Treatment Agency for Substance Misuse (Joint-Working Protocol Between Jobcentre Plus and Treatment Providers: [www.nta.nhs.uk](http://www.nta.nhs.uk));
* Support service users and those in recovery to develop opportunities that sustain recovery by providing meaningful activities, education and skill development and/or employment;
* Act as a link between the Provider[s], public/ private/ third sector in the locality, service users/those in recovery and Cheshire East Council in order to identify opportunities for development and access any financial/other resources that may be available to support such outcomes;
* Find new ways of working that promote sustainable recovery and the recovery agenda including the adoption of asset-based working methods.
* Promote any specific health promotion campaigns as stated by Cheshire East Council and engage with additional support where appropriate;
* As part of integrated delivery with Cheshire East Council the provider may be requested to facilitate additional engagement (e.g. focus groups) to obtain intelligence of the service user community;
* Support the development of recovery-orientated social networks;
* The Provider[s] will ensure that aftercare support is provided to all individuals completing structured treatment interventions as appropriate to ensure successful and sustainable recovery can be achieved. Aftercare should be in line with the client’s needs and aspirations, with a follow up to check the status of individuals for at least 12 months post discharge.
  + 1. **General Service for Adults and Young People**

The service required will include the following functions for both adults and young people:

* Communication, Information and Advice - to ensure services provide information and advice to support service users, parents, partners, families and carers, and the wider public to understand drug and alcohol dependency and the services available and self-help approaches;
* Early Help - To provide evidence based prevention and harm reduction interventions for children, young people and adults in appropriate settings to ensure they are able to make informed choices about their approach to drugs and alcohol
* Universal Services - Effective interface with universal agencies including communications, prevention campaigns, training, information, advice and referral pathways (with a specific focus on schools, college, universities and social care practitioners). This should ‘not’ include one off sessions and should be evidence based, providing input only as part of broader programmes relating to pupil wellbeing and resilience such as the emotionally healthy schools programme;
* Safeguarding - that the Provider[s] work with safeguarding leads to protect vulnerable children and adults through effective whole system protective actions targeting those at risk from familial/inter-generational misuse;
* Engagement & Co-production - that the services routinely engage with all stakeholders, including service users and carers to monitor their individual effectiveness and system wide performance. That this information is shown to inform continued system improvement. Service user and family engagement, co-production, co-design, co-assessment and co-delivery will be embedded at the heart of the service;
* Substance Misuse Related Offending - that services ensure that those involved in the criminal justice system support a cohesive ‘Case Management’ approach working with the Youth Offending Service, Integrated Offender Management Team, National Probation Service & Community Rehabilitation Companies, Police & Custody suites and Young People Secure Estates / Prison based substance use services.
* Whole System Effort - that drug and alcohol services work effectively with the wider system to achieve appropriate service access and case coordination. That GPs and Primary Health Care Service, Secondary Care, A&E, the Police and housing/social care partners as well as schools / education are well informed and empowered to risk assess and make timely referrals to the service at the least intensive level of intervention that is appropriate. Helping to realise improved recovery, discharge performance whilst maximising system wide value for money.

**3.5 Outcomes Local, Public Health, National**

The Provider[s] must contribute to the corporate outcomes identified in section 2.3 (local context) through improving the outcomes and life chances of children, young people, and adults, families and communities who are effected by drugs and/or alcohol. The core outcomes for the Cheshire East Substance Misuse Service include:

* Prevent drug and alcohol use;
* Maintain recovery from drug and/or alcohol use;
* Reduce the harmful impacts of drugs and alcohol on individuals, families and communities;
* Prevent drug and/or alcohol related deaths;
* Prevent and support treatment of substance misuse related blood born viruses and infections;
* Improve physical health of people in treatment and recovery;
* Build personalised recovery capital, strengths and assets for individuals from assessment through to maintaining recovery, including housing and accommodation, friends, family, employment, education, training, volunteering;
* Reduce crime and re-offending of people in treatment and recovery;
* Reduce the stigma the people in treatment and recovery from drugs and alcohol experience;
* People in treatment and recovery feel that they have a strong voice and are able to contribute positively to the design, delivery and evaluation of drugs and alcohol services;
* Improved access to drug and alcohol services;
* Improve the 5 Ways to Wellbeing: Connect, Be Active, Take Notice, Keep Learning, and Give

We would expect the Provider[s] to contribute to the co-production of a robust set of performance indicators. Some work has been done on this within the existing contract see appendix 3.

The Provider[s] must also contribute to the drugs and alcohol related indicators within the [PHOF](http://www.phoutcomes.info/) , as well as the outcomes identified within the [National Drugs Treatment Monitoring System](https://www.ndtms.net/default.aspx) (NDTMS), including:

* Diagnostic and Outcomes Monitoring Executive Summary (DOMES);
* Treatment Outcome Profiles (TOP);
* Young Peoples Outcomes Report (YPOR).

Some service activity, gaps in service and areas for improvement are highlighted in the Cheshire East Alcohol and Drugs JSNA [[19]](#footnote-19)

**3.6 Implementing the Service (Assets, TUPE, Equipment, Facilities, Project Plan & Monitoring Meetings)**

**3.6.1 TUPE**

Provider[s] must satisfy themselves in relation to the application of TUPE and will be expected to ensure the necessary compliance with TUPE from any subcontracted Provider[s]. Note – there is likely to be a range of TUPE implications where services have been provided by an NHS organisation.

**Note TUPE & Pensions -** NHS England issued guidance [on the HM Treasury Guidance October 2013] “Fair Deals for Staff Pensions”[[20]](#footnote-20). Fair deals for Staff confirms that employees due to be transferred to the private sector are entitled to remain in their current public sector pension plan and the guidance must be followed in all cases from April 2015. The NHS England Guidance is specific to NHS staff and should be adhered.

This guidance is relevant in outsourcing situations where, the transferring staff has originated from an NHS Body or other employer which participates automatically in the NHS Pension Scheme and remain employed in connection with outsourced Public Services for more than 50% of their employed time with their new employer.  These staff may have been through several changes of employer but they have been and remain continuously employed for more than 50% of their employed time in connection with the Services.  These protected staff are referred to in the Schedule as “Eligible Employees”.  NHS England has issued guidance and amendments to the Standard NHS contract to protect Eligible Employees. The contract amendments can be used by the Council in situations where the guidance applies. The guidance needs to be adhered to in any new contract where as a result of the award there is a transfer of Eligible Staff under TUPE. Failure to comply with the direction will constitute an event of default allowing the contracting authority to terminate the service contract.

**3.6.2 Equipment / Assets** / **Facilities**

Provider[s] will ensure that any equipment supplied by them for use under this contract is safe, used for the purpose its intended, and is properly serviced and maintained. Faults with equipment will be addressed in a timely manner and safety precautions will be implemented to prevent inappropriate use during these times.

Provider[s] will keep accurate records of equipment being used by service users / patients, and reference to the new technology section should be made when considering the development of replacement schedules.

Where Provider[s] are providing accommodation / care or support they will ensure that the accommodation is fully-furnished with clear information for service users / patients on their responsibilities for the use of this equipment and or for any bespoke equipment provision to meet individual requirements.

**3.6.3 Mobilisation**

In preparation for the period of mobilisation, the Provider[s] shall produce a development plan identifying what actions they intend to achieve in relation to the requirements set out within this Specification.

The Council require the Provider[s] to carry out certain initial Services prior to formal commencement of the Service. These initial Services or Mobilisation Services will include (but not be limited to) the following actions:

1. Transition planning
2. Identified key contacts
3. Service delivery model
4. IT implementation and data transfer
5. Recruitment
6. Management and staffing structure
7. Set up including locations and resources
8. Communication and engagement plans
9. Governance arrangements and agreements
10. Robust planning, risk and project management
11. Templates and appropriate paperwork to be in situ (including at the local  branch and within the Service Users’ property)

The Provider will be required to submit a detailed mobilisation plan to be agreed with the Council and allocate project management support for the critical transition from the current service to the newly commissioned service**.**

These Mobilisation Services will be performed from the Mobilisation Date as detailed in the Agreement and will need to be completed by the formal Commencement Date of the Agreement. No payment will be made for these services during mobilisation

**3.6.4 Exit Management and Transition Plan**

A draft Exit Management and Transition Plan for the end of the contract period must be submitted as part of the tender process and must:

* support an orderly, controlled transition of responsibility for the provision of the Services from the Provider to a new provider with the minimum of disruption to the service users and delivery of the service in general and so as to prevent or mitigate an inconvenience by means of the implementation of the plan.
* Contain all necessary detail to effect a smooth and orderly termination of the services and handover to a new provider.

Within 5 months following contract award the Provider will further develop and submit a revised Exit Management and Transition Plan to the Council in accordance with the above principles and for agreement as part of the contract management and monitoring process.

Thereafter the Exit Management and Transition Plan be reviewed annually and any updates agreed with the Council prior to adoption

**3.6.4 Monitoring Meetings**

During the mobilisation period, a programme of meetings will be arranged with the current care provider and the other scheme partners to review roles, responsibilities and working practices. These will be planned in more detail once the contract has been let.

**3.7 Communications, Marketing and Branding**

**3.7.1 Service Branding**

It is vital that the Cheshire East Substance Misuse Service has a relevant, strong and trusted identity / brand:

* Provider[s] are expected to develop a single strong identity / brand for service delivery;
* Provider[s] must work with the service users / patient groups and the commissioner to ensure the brand is one that is relevant and resonates with the different audiences who will use and have contact with service[s];
* Provider[s] are expected to develop robust brand guidelines to ensure the brand is effectively implemented across the service as a whole, and is in line with Cheshire East expectations for this commissioned service.

**3.7.2 Communication & Marketing**

The Provider[s] will ensure that there is comprehensive Communication Plan, which includes marketing strategy, that sets out a robust approach to the mobilisation of the newly commissioned service for wider professionals, current service users / patients, potential service users / patients, MPs, Cllrs, LSCB, LSAB, HWB, LHW will be required.

The Communications Plan must be refreshed once the Service is mobilised, by the Provider[s] and will be updated and reviewed quarterly during the contract review meetings. The Communications Plan will clearly describe ongoing activities for the promotion of the Service, as well as local external facing campaigns for example Dry January and Recovery Week.

The Provider[s] will ensure proactive and innovative approaches to marketing and communications with all stakeholders to provide information & advice and ensure social marketing is maximised and behaviour change secured within Cheshire East.

Communication methods and materials need to be suitable for a variety of audiences – children, young people, adults, families, parents, partners, carers, professionals, general public, businesses – providing timely and straight forward information and guidance accounting for language and a range of literacy levels.

The Communication Plan will be reviewed annually to ensure approaches’ are current and in line with evidence based practice in achieving behaviour change and in providing safe care and support. Provider[s] will work with commissioners and take account of service user / patient, parent, partner, carer, and wider stakeholder experiences in the review of the Communications Plan. As well as work proactively with others involved in health, Care and Wellbeing campaigns to ensure communication coherence.

Communication channels for all professionals are required, and Provider[s] will ensure communications are in place and current service information / developments are shared. The Provider[s] will ensure the maintenance of an effective, efficient, proactive and robust professional network – linking closely with other connected service providers on a regular basis to ensure the highest quality of care / support for service users / patients, parents, partners, families and carers.

**3.8 Service Interdependencies**

Provider[s] will ensure that the service establishes working arrangements, care and support pathways that will deliver integrated and collaborative interventions for wider health and wellbeing benefits, crime reduction, community safety as well as the prevention, treatment, recovery and or care and support. Successful Provider[s] will have clear care pathways in place within the mobilisation phase of the contract for communication with key other services as follows:

* Primary Care, and specifically General Practice;
* Secondary Care;
* Specialist Health Care Services e.g. Mental Health, Learning disability, Maternity;
* Clinical Commissioning Groups;
* Pharmacies;
* Children & Families Early Help commissioned Services, Social Care & Safeguarding;
* Adult Social Care & Safeguarding;
* Domestic Abuse Services;
* Carers Services;
* Community Developments including the Cheshire East Connected Communities Strategy developments e.g. Connected Community Centres;
* Relevant voluntary sector provider agencies;
* Social enterprises;
* Mutual Aid Groups;
* Active Voice: Independent Service User Forum;
* The Cheshire East Multi-Agency Action Group (MAAG);
* The Cheshire East Substance Misuse Provider Forum;
* National Probation Service & Community Rehabilitation Companies;
* Youth Offending / Engagement Prevention;
* Police;
* Prisons;
* Voluntary Community Faith Sector Services;
* Local Employers;
* Job Centres;
* Sexual Assault and Referral Centre;
* Cheshire East Lifestyle Services e.g. Sexual Health, Stop Smoking, Falls Prevention, Physical Activity
* Education and training providers including Schools, Colleges and Universities;
* Hostel and Homelessness Services;
* Social Housing Providers;
* Local Self Help forums and other support forums;
* Local HealthWatch.

(This list is not exhaustive)

Provider[s] are required to note that there may well be other significant interdependencies and therefore this is not restrictive. The service will establish clear interface working arrangements with wider services to ensure that we maximise system wide outcomes for children, young people, families, adults and communities. With clear and safe transition arrangements from this services involvement with service users / patients.

**3.9 Equality of Access to Services and Rural Geography**

Provider[s] will ensure that access to services by individuals, considers the needs of specific groups to ensure that disadvantage does not occur. Provider[s] will need to demonstrate their understanding of the population and geography of Cheshire East to inform their marketing and service delivery approaches. This applies equally to the specific needs of distinct ethnic groups, gender, age, disability, and sexuality as it does for our towns, villages and rural populations. Provider[s] understanding of modes of transport and transport routes, acceptable service delivery locations for children, young people, families, adults and communities will be vital in ensuring flexible, mobile, and outreach service delivery, at accessible times, and in locations that best meets need.

Provider[s] will ensure that the needs of service users / patients from under-represented groups and priority groups are fully considered in the planning and delivery of service arrangements, these groups are as follows*:*

* Young People;
* Ex-service Personnel;
* People with a Learning Disability;
* Lesbian, Gay, Bisexual, Transgender;
* Black and minority ethnic groups;
* Where a referral is made by an Independent Domestic Abuse Advisor or an Independent Sexual Violence Advisor or via the Sexual Assault Rape Centre;
* Those who make themselves vulnerable e.g. Homelessness, Drug / Alcohol use, and sex workers;
* Those who are involved in Family Focus, Child In Need, Child Protection or Complex Dependency Programmes.

*Please note that this list is not exhaustive and may not apply in full in some service delivery locally (as agreed by the Commissioner)*

Provider[s] will ensure that the service provides adequate consideration to specific service venues, any satellite venues such as in primary care and other universal settings, outreach settings, and to service opening times.

Interpretation services for non-English speaking people, hearing impaired/deaf or blind must be a part of the services provided.

**3.10 Social Value**

Provider[s] will be expected to identify targets within their model aligned to one or more of the following social value objectives:

* **Promote employment and economic sustainability** – tackle unemployment and facilitate the development of skills;
* **Raise the living standards of local residents** – working towards living wage, maximise employee access to entitlements such as childcare and encourage Providers to source labour from within Cheshire East;
* **Promote participation and citizen engagement** – encourage resident participation and promote active citizenship;
* **Build the capacity and sustainability of the voluntary and community sector**– practical support for local voluntary and community groups;
* **Promote equity and fairness** – target effort towards those in the greatest need or facing the greatest disadvantage and tackle deprivation across the borough;
* **Promote environmental sustainability** – reduce wastage, limit energy consumption and procure materials from sustainable sources.

Provider[s] will undertake Cost Benefit Analysis (CBA) for their identified social value targets, which will be monitored through the contract monitoring process by the end of the first quarter following contract award. Benchmarking for CBA will be undertaken by the Provider[s] once the contract has been awarded.

**3.11 Using Information Technology**

The use of new technology in the provision of the new service for service user records, making appointments, reminding about appointments will be delivered in a way that supports the new service delivery model reflecting how service users now access information and services. The Provider[s] will provide evidence based, innovative services whilst maximising both physical and virtual service access options through the use of new technology. Service information will be maintained and accessible via the services web page, and via smart phone application. Leaflets and other forms of information such as contact cards will be provided.

**Section 4.0**

**Service Requirements**

**4.1 Service Model**

The Provider[s] will be responsible for the management, co-ordination and delivery of the Integrated Recovery Oriented Substance Misuse Service.

**Hub and Spoke**

The treatment and recovery support must be of a high standard and provided locally in local communities and facilities e.g. see Connected Community Centres and the Live Well website for local community assets in Cheshire East. The service will be delivered across the borough of Cheshire East as a ‘Hub and Spoke’ model ensuring a single point of contact that is delivered at a local level making best use of multiple access points and locations including community based venues. The Hub and Spoke model will provide support on both a virtual and a physical basis.

**Whole System Approach**

The Provider[s] will be required to co-ordinate and work in partnership with other providers in order to deliver a planned, coherent and efficient service. This includes streams and services across the health and social care economy, other local authority divisions as well as within the voluntary and statutory sectors.

**Whole Family and Personalisation Approach**

The Integrated Recovery Oriented Substance Misuse Service is a holistic model that offers a coordinated approach to access and support for service users aligned to their needs and strengths, tailored according to them as an individual. It is not a one size fits all approach and should focus on an individual’s outcomes and recovery assets.

The Provider[s] will adopt a holistic family approach to work with young people, adults and their families working in partnership to meet the service aims and the personalised care plan.

The Provider[s] to develop a wide range of interventions and support services using providers through sub-contracting or partnership arrangements and collaborations, who have the expertise, knowledge and flexibility to help deliver a holistic service model.

**Assets Based Community Development (ABCD)**

The Provider[s] will take an Assets Based Approach to Assessment and Care Planning. This will include the identification of ‘individual’ strengths and recovery assets of the service user such as their skills, knowledge, experience, employment, training, learning, volunteering, as well as their ‘community’ assets such as friends, wider family networks, neighbours, community based activities and networks. Once individual and community assets have been identified the service user will be supported and empowered to build on these assets to improve the outcomes identified within their personalised assessment.

Service users should be empowered to build on their assets and supported through a journey to become as independent as possible, with moderate to high levels of support delivered for a time limited period and a step down approach applied. Service users should also be aware that they are able to return for additional support if their circumstances change. The Provider[s] should aim to co-produce and co-deliver support with service users, and where possible service users and former service users should be encouraged and supported to share their skills, knowledge and experiences through engagement, co-production, volunteering, peer support activities and networks with other service users.

The Provider[s] will proactively seek to develop a local ‘Recovery Community’ developing recovery at a community level support, which builds on existing local assets to ensure a ‘Sustainability’ approach is applied and to achieve added value.

* 1. **Service Description/Pathways**

The Provider[s] will develop formalised and documented pathways to support equitable access to services and onward referral where appropriate. The Provider[s] will accept referrals including self-referral, GPs, pharmacies, hospitals, family members, social care, probation and other services etc. Service pathways are to be fully developed over the first 6 months of this contract and agreed by Cheshire East Council.

Key elements for inclusion within the Cheshire East Substance Misuse Service pathway include:

* Specific pathways for Adults;
* Specific pathways for Young People;
* Specific pathways for families/carers;
* Single point of access;
* Referral and discharge mechanisms;
* Information sharing;
* Assessment and Care Planning;
* Early Intervention and Prevention;
* Treatment Interventions;
* Recovery Interventions;
* Harm Reduction: Needle exchange, BBV services, Naloxone;
* Transition from young people to adults services;
* Joint working protocols with organisations such as: housing, employment, education, training, carers/family support, social care, Domestic Abuse services, and Sexual health services etc;
* Dual diagnoses between substance misuse and mental health;
* Community prescribing: Maintenance, reduction, detox, observed consumption;
* GP Shared Care;
* Peer Outreach: Hospitals and GP Surgeries;
* Criminal Justice System;
* Inpatient and Community Detoxification and Residential Rehabilitation.
  1. **Service Opening Times and Locations**

The service must be flexible to meet the needs of local people, including people who are in education, employment, have caring roles and responsibilities. The service will be expected to operate flexible opening hours to meet local needs and demand Monday to Friday plus out of hours evenings and weekends. The service will develop innovative and technological solutions to accessibility such as web based, telephone, text, social media, chat, skype/facetime and community activity/interventions. Cheshire East Council expects to be kept fully informed regarding opening hours and expect out of hours provision to take place.

Evidence of demand or lack of demand will be required to support opening hour arrangements. The service must be contactable by telephone and email 24/7 to provide advice and support and to receive referrals from any parties including self-referrals. The exception would be for statutory bank holidays, where we would anticipate a reduced service based on risk assessment and risk planning with existing service users and other professionals for potential service users.

The service will be based at the heart of communities, responding to the geographical challenges of the Cheshire East borough to ensure fair and equitable access. The Provider[s] will take an assets based approach working with communities to identify a range of community based venues for service delivery including:

* Connected Community Centres;
* Outreach work to engage local people in neighbourhood areas;
* Family/vulnerable groups settings (e.g. Children’s centres, youth hubs, homeless/drop in centres, women’s refuges);
* Primary care settings;
* Secondary care settings;
* Criminal justice settings;
* Co-locating with lifestyle services including healthy weight, physical activity and NHS Health Check programmes.
* Specialist premises as required
  1. **Population Covered**

The service will operate across the borough of Cheshire East. Residents living in the borough are eligible to access the service, not GP registration.

* 1. **Referral and Discharge**

The Provider[s] will formalise clear and visible, easily understandable care and support pathways that are widely available to service users to support self-referral and referrals from the wider professional groups e.g. Social Care, Police, Domestic Abuse Family Support Unit & Specialist Services, IDTS, Community Health Services, Community Rehabilitation Companies. There is an expectation that proactive and meaningful connections with hard to reach communities and underrepresented groups and groups were there is higher prevalence of substance misuse. The service as a whole will accept referrals from individuals, families, parents, carers and professionals. The Provider[s] will be responsible for the maintenance of an effective and timely referral pathway explained within an open access policy.

The Provider[s] will maximise the number of individuals who ‘successfully’ complete treatment and reduce ‘unplanned’ discharges and re-presentations. The service will empower service users to build their recovery capital through regular review (minimum 6 monthly) follow-up and access to visible recovery communities to prevent re-lapse and re-presentations to treatment services.

* 1. **Exclusions**

If a service user poses a serious risk to staff, other service users or members of the public they may be excluded from the service. The Provider[s] must ensure that every effort is taken to maintain or re-engage the service user in the service while ensuring the safety of all concerned.

* 1. **Location and Access to Services**

The Provider[s] will ensure that accessibility is a priority and will work with service users, carers and family members and Cheshire East Council to reduce the barriers to access. Working with volunteers and peers will support a positive culture of engagement at the point of access. The Provider[s] will work with criminal justice agencies to maximise the accessibility of treatment services to this group.

The Provider[s] will respond to evidence of need including access to services during evenings and weekends across the borough of Cheshire East. Services must be available 52 weeks/365 days per year.

The Provider[s] will ensure that all contact details are widely promoted and publicised, targeting but not exclusive to areas of greatest need, in a variety of formats. The ‘Hub and Spoke’ model will offer a central point[s] of contact (Hub) and wider community access points (Spokes) in various forms including face to face, telephone and web based contacts.

The Provider[s] will create referral and service user care pathways to a Single Point of Access (SPA) and work in conjunction with a range of other custody based staff including mental health/criminal justice liaison nurses, to ensure access to a range of other tier 3 services such as mental health and universal support services (e.g. housing, benefits etc.). The Provider[s] must consider childcare arrangements and or other carer responsibilities when dealing with service users and family/carers/supporting others.

* 1. **Waiting Times and Prioritisation**

The Provider[s] will work towards a culture of proactive engagement and ensure waiting times are kept to a minimum, in line with NDTMS and local targets. Priority access will be provided for:

* Parents;
* Sex workers;
* Pregnant service users, or those planning to conceive (including partners);
* Veterans;
* Young people under 18 years;
* Looked after children;
* Young people not in education, employment or training (NEET);
* Children living in poverty;
* Young carers;
* All parents or carers where there is a child protection issue or a suspected or confirmed child in need;
* Where a referral is made by an Independent Domestic Abuse Advisor or an Independent Sexual Violence Advisor;
* Those with a positive HIV or Hepatitis B or C diagnosis, or who present with other severe physical co morbidity such as high risk injecting behaviour, poor respiratory health, liver disease;
* Those referred by and/or who are case managed by mental health Services, or who present with a significant mental health issue;
* Those being referred by a criminal justice agency, particularly with regards to Drug Rehabilitation Requirements (DRR), Alcohol Treatment Requirements (ATR), Conditional Cautions, Integrated Offender Management and prolific and priority offender (PPO), treatment requirements under the Offender Rehabilitation Act. To include non-convicted perpetrators of Domestic Abuse;
* Those recently discharged from prison, regardless of sentence length;
* Those who have relapsed during or after inpatient or residential treatment.
* Homeless or lacking stable accommodation;
* Those who have been identified as regularly engaging in street drinking/substance misuse;
* Those identified as having multiple alcohol or drug related hospital admissions.
* Those known to have had previous non-fatal overdose
  1. **Accommodation**

All accommodation used by the Service will be welcoming, of a high standard and fit for purpose for the delivery of treatment and recovery services. Accommodation must ensure appropriate access for service users with differing needs, and comply with current legislation. The Service will be responsible for securing and paying for the accommodation.

Using the ‘Hub and Spoke’ approach, accommodation must be available at a community level and should build on existing community assets. Cheshire East Council are committed to ensuring services reach the heart of our communities. Working with a range of venues ensuring the right level of governance is in place we now have over 30 Connected Community Centres across the borough. These Centres are recognised as flagship venues for service delivery and would recommend any new service (where appropriate) to consider as them outreach/delivery points when tendering for contracts.

* 1. **Funding Recovery in the community and Incentive Programmes**

In order to, facilitate and enable transition, mobilisation and the embedding of the

newly commissioned service there will be nor requirement for community investment in Year 1.

In subsequent years the Provider[s] will be required to demonstrate investing 2% of the contract value into the sustainable development of recovery communities. This could take many forms for example vocational training courses, micro-business opportunities and sustainable housing options. In yeaars 2 to 5 the provider[s] fails to evidence 2% investment into the sustainable development of recovery communities the commissioner reserves the right to claw back this allocation.

The contract also includes an Incentive Programme, attributing payment to the successful achievement of identified indicators. These have been designed to focus the Provider[s] on issues for improvement highlighted in the JSNA. The Incentive Programme will run in each contract year, with approximately 5% of the total contract value being set aside for the programme. The indicators included in the programme will be subject to annual review and any slippage will be required to be repaid to the commissioner.

A separate ring fenced budget has been created to pay for family court requester drug testing. This fund will be managed in line with quarterly reporting with any underspend re-paid to commissioner annually

**4.11 Workforce Issues Including Wider Workforce Development**

Staff recruited to work within the service should be competent to perform the role they are employed for. Job roles should be mapped to the National Occupational Standards [Drug Alcohol National Occupational Standards – DANOS www.tools.skillsforhealth.org.uk].

Addiction specialists such as Consultants and GPs who will work in the service should have had appropriate training in line with the Royal College of Psychiatrists, Royal College of General Practitioners [RGCP Management of Substance Misuse Certificate 1 & 2 as a minimum and DANOS]. Pharmacists who provide needle exchange, and supervised consumption services should have as a minimum DANOS and Needle and syringe Programme L1 & L2. The Centre for Pharmacy post graduate education provides on line continued professional development for pharmacists.

The workforce make up should be structured to ensure the most appropriately skilled / trained person[s] undertakes the assessment, treatment and support functions for children, young people, adults and parent / carers. Specialist posts will be developed for young people including Youth Justice which will be collocated with the Youth Justice Service (YJS).

Appropriate levels of medically trained personnel to supervise clinical processes and to administer prescriptions is the responsibility of the Provider[s] taking account of the prevalence and demand intelligence, and the geography of the borough will be essential.

The Provider[s] must demonstrate effective continued professional development of their directly employed workforce and those that they sub contract with for the delivery of services. The workforce are required to have the skills to deliver a whole system approach to substance misuse, that inspires motivation, confidence and trust from an individual, parent / carer through their recovery journey.

The service user, parent, partner, family, carer will be at the centre of the services practice, their views and wishes will be valued and will support the co-production of treatment and recovery arrangements that enable progress towards a future without substance misuse.

The Provider[s] will ensure that good communications are embedded throughout the whole service for staff, volunteers, service users, parents, partner, family, carers, and other professionals.

The Provider[s] will ensure that supervision is viewed as an important contribution towards continued professional development and that supervisors have the appropriate level of training to supervise staff delivering specific interventions e.g. motivational interviewing, cognitive behavioural therapy.

The Provider[s] will assure the commissioner that robust arrangements are in place for the assessment of workforce skill mix, qualification, continued professional development, and structured supervision and appraisal. The Provider[s] will submit an audit, ongoing training schedule and attendance as part of the contract monitoring process.

The Provider[s] will also collaborate with wider workforce development to build brief intervention and awareness of the new substance misuse service across the whole service system. This will lead to wider professional understanding of services to support early help, and harm and risk reduction.

The Provider[s] will build in opportunities for other professionals to shadow substance misuse workers, and allow substance misuse workers to shadow other key professional e.g. Independent Domestic Violence Advocates.

**4.12 Managing Performance**

The Provider[s] must ensure that a dedicated ‘Performance Management Function’ is established as part of the contract to provide system wide reporting for prevention, structured treatment and recovery. The Provider[s] will ensure the effectiveness of such reporting, demonstrating assurance processes for systems and procedures to commissioners and other key stakeholders, and support the continued development of both output and outcome monitoring for the whole system substance misuse service.

See performance management framework document.

**Section 5.0**

**Quality Requirements**

**5.1 Managing Information**

**5.1.1 Commissioner rights to information**

The commissioner requires the Provider[s] to provide timely information to support commissioning activities locally, sub regionally and nationally. The information must comply with none identifiable information requirements. This applies to the provision of service return information, and invoice payment backing data. However where there are specific safeguarding, operational risks relating to individual service users and or employees then the Provider and the commissioner must share information to determine the appropriate management of the situation to ensure appropriate safeguarding actions.

The service brand name will be determined with the commissioner and the commissioner will own the name. The Provider[s] in connection with the delivery of the service will not, use, manufacture, supply or deliver services that may infringe any intellectual property rights. All intellectual property rights developed for the purpose of providing services under this contract shall belong to the commissioner.

The Provider[s] must fully indemnify the commissioner against losses, action, claims, proceedings, expenses, costs and damages arising from a breach of information governance. The Provider[s] must defend at its expense any claim or action brought against the commissioner alleging that there has been, in connection to the delivery of the service infringements of copyright, patent, registered design, design right or trademark or other intellectual property rights and must pay all costs and damages.

**5.1.2 Commissioner Information Requests**

The Provider[s] will be responsible on behalf of the commissioner for preparing responses to MP letters, Compliments and Complaints, Freedom of Information requests for the commissioner’s approval where these relate solely or partially to substance misuse.

**5.1.3 Expectations in using systems**

The Provider[s] will operate an appropriate IT system that enables safe prescribing, safe storage of clinical information and case records, allows for effective data collection and analysis for both local, sub regional and national monitoring requirements. This should include service user consent to store and share information with significant others as part of the treatment and support arrangements e.g. for example with family, parents and carers, and subject to effective governance and secure transfer arrangements with other partners involved in supporting their recovery.

The Provider[s] will need to understand the IT systems used by the local Health, Social Care, and Criminal Justice system to consider the most effective system for the service to be delivered.

Systems for the recording of client information should be NDTMS compliant. If they are not it is expected that submissions will be made to NDTMS via the Data Entry Tool. Any electronic case management system will be required to be updated in line with NDTMS Core Data Set updates and these will have to be completed within specified timeframes.

**5.1.4 Record Keeping**

The Provider[s] will:

* Create and keep records which are adequate, consistent and necessary for statutory, legal and business requirements;
* Achieve a systematic, orderly and consistent creation, retention, appraisal and disposal procedures for records throughout their life cycle;
* Provide systems which maintain appropriate confidentiality, security and integrity for records and their storage and use;
* Provide clear and efficient access for employees and others who have a legitimate right of access to the records in compliance with current Information Governance (IG) legislation;
* To provide training and guidance on legal and ethical responsibilities and operational good practice for all staff involved in records management;
* Compliance to current Cheshire East policies and NHS Code of Practice;
* Comply with IG requirements for any future service transition arrangements.

**5.1.5 Storage of information**

The Provider[s] have a duty to make arrangements for the safe-keeping and eventual disposal of their records [note – legal compliance for disposal of records must be set out in the policy for approval under the governance framework].

**5.2 Quality Requirements**

The Provider[s] is expected to have in place robust governance framework and supporting processes, which ensure that it is compliant with appropriate legal requirements and standards. We would expect the governance framework to include but not be limited to the following:

* Communication between service users, families, parents, carers and staff (including managers and clinicians);
* Communication between staff across wider services, including clinicians and managerial staff;
* Effective reporting and monitoring mechanisms for issues of concern whether relating to the service users, or people connected or employees;
* Service user recording;
* Working with families and carers;
* Transition of young people into adult services;
* Service IT / data recording and storage systems;
* Incident reporting and health and safety matters;
* Child Protection & Adult Protection – Safeguarding;
* Reporting and monitoring of incidents and accidents to staff, volunteers and service users [including the management of violence and domestic violence];
* Health & Safety Inspection, and fire safety;
* Clinical Governance;
* Infection Control;
* Inspections by CQC, OFSTED, or LHW or Commissioners;
* Complaints and Compliments management for paid staff, volunteers and service users;
* Service user engagement and co-production;
* Records Management;
* Equality of opportunity in service provision, recruitment and employment;
* Occupational health;
* Information sharing and Information Security;
* Policies relating to confidentiality of information;
* Codes of conduct for staff and service users;
* HIV & AIDS policies including employment;
* Drugs and Alcohol in the workplace;
* Treatment and medicines management.

All appropriate policies and protocols must be in place following contract award and prior to the service mobilisation phase being completed. The Commissioner would expect to receive information and assurance that these are current and in place [including with sub contracted services]. Clear and routine review arrangements to maintain effective governance would also be expected. Service users must be made aware of the range of policies which may impact upon their support and be given access to them should they wish.

**5.3 Safeguarding**

Provider(s) willensure services comply with safeguarding procedures outlined by Cheshire East Council through the Local Safeguarding Children Board and Local Safeguarding Adults Board, and Cheshire East’s Domestic Abuse Partnership:

<http://www.cheshireeast.gov.uk/care-and-support/healthy-lifestyles/domestic_abuse/domestic_abuse.aspx>

<http://www.cheshireeastlscb.org.uk/professionals/procedures-and-guidance.aspx>

<http://www.cheshireeast.gov.uk/care-and-support/vulnerable-adults/vulnerable-adults.aspx>

The operational policies of Provider[s] will address the following:

* Safe provision and storage of medication;
* How to initiate a CAF and/or act as lead professional (if appropriate);
* How to make a referral for a children in need, or a vulnerable adult, under safeguarding procedures;
* How to raise a concern in relation to domestic abuse;
* How to report and respond to safeguarding concerns about the practice of staff or volunteers;
* Set out how they will manage a complaint investigation and how the learning will inform practice and continuous development of the service;
* Set out how the management and reporting of Sudden Untoward Incidents and the reflective learning from such events informs future practice and continuous service development.

Provider[s] will be responsible for informing the commissioner of their practice through routine contract monitoring arrangements or earlier where it relates to a critical incident and or is deemed to be an emergency that warrants this step as a matter of urgency.

**5.3.1 Exceptional Service Exclusion**

Provider[s] may at times need to consider whether a service user may need to be excluded from the service. A professional risk assessment must be undertaken to assess the risk to other service users, staff and or members of the public. This risk assessment should be undertaken on a multi-agency basis to ensure wider safety actions being determined across health, social care and the criminal justice system.

Every effort must be made to maintain and or secure re-engagement of the service user once the safety actions have been implemented.

Any exclusions, and or safety actions put into place must be reported to the Commissioner in a timely manner to allow for their direct involvement and or advice /guidance.

**5.3.2 Safeguarding for Vulnerable Children and Adults**

The safeguarding of children and vulnerable adults must underpin all practice and Providers are expected to adhere to relevant legislation and guidance:

* The Care Act 2014 <https://www.gov.uk/government/publications/care-act-2014-statutory-guidance-for-implementation>
* Safeguarding Children and Young People <https://www.gov.uk/government/publications/working-together-to-safeguard-children--2>
* as well as statutory responsibilities within 1989 and 2004 Children Acts, critically:

*‘’ Local agencies, including the police and health services, also have a duty under section 11 of the Children Act 2004 to ensure that they consider the need to safeguard and promote the welfare of children when carrying out their functions.*

*Under section 10 of the same Act, a similar range of agencies are required to cooperate with local authorities to promote the well-being of children in each local authority area (see chapter 1). This cooperation should exist and be effective at all levels of the organisation, from strategic level through to operational delivery.*

*Professionals working in agencies with these duties are responsible for ensuring that they fulfil their role and responsibilities in a manner consistent with the statutory duties of their employer. ‘’*

Cheshire East Local Safeguarding Children Board and Local Safeguarding Adults Board have policies that must be adhered too and evidenced within Providers own policy, practice documents and records. The primary principle[s] here is that Providers have robust policies, practices and pathways in place to escalate matters should this be required, therefore being able to: **Recognise, Respond, Record, Recruit Safely and Risk Assess well in respect of service user wellbeing and safety**.

Compliance with Local Safeguarding Children’s Board’s and Local Safeguarding Adults Board’s policy, procedures and protocols which must be regularly audited (including case recording audit) by the Provider[s].

Providers are required to complete annually the self-assessment as set out in the Safeguarding Standards for Children and Adults at risk.

The Safer Recruitment and selection of Staff, and Volunteers must be robust and include appropriately the undertaking of Disclosure and Barring Scheme checks [DBS]. If these checks reveal information which would make the person unsuitable for work with children or vulnerable adults the Provider[s] shall not employ or otherwise use such persons in any way.

Workforce training on the prevention of abuse and safeguarding practice as well as domestic abuse must be given to all employees as a part of their induction and continued professional development.

**5.3.3 Provider and Named Safeguarding Lead**

The Provider[s] will identify a named safeguarding lead. The ‘named’ safeguarding lead will have arrangements in place to ensure they are able to access enhanced safeguarding advice, support and knowledge.

The successful Provider[s] and their safeguarding lead must have in place:

* Clear referral and access criteria and documented pathways;
* Arrangements for the management of escalating risk;
* An information sharing and confidentiality policy in place that is clear regarding when, legally, information can be shared without consent and explains service users’ rights and responsibilities;
* A risk assessment process that accounts for a history of abuse and the person’s vulnerability to abuse, including predatory behavior or sexual vulnerability
* A Quality Audit / Performance Monitoring system for safeguarding activity, that complies with contract and safeguarding performance reporting / monitoring requirements
* A clear process for reporting and managing allegations in relation to a member of staff or volunteer.

**The service must immediately notify the Commissioner of any improper conduct by any of its staff or by one service user towards another, in connection with any part of this contract.**

***Note examples of improper conduct of staff or Volunteers include:***

* ***Neglect / Acts of Omission / Self-Neglect*** *- Causing harm by failing to meet needs e.g. ignoring physical or medical care needs, withholding food, medicines, failure to provide adequate supervision*
* ***Physical*** *- Hitting, pushing, slapping, and using inappropriate physical restraint, burning, drowning, and suffocating, with holding medical care, feigning the symptoms of ill health or deliberately causing ill health.*
* ***Sexual*** *- Sexual activity of any kind where the vulnerable person does not or is not able to give consent.*
* ***Psychological*** *- Including verbal abuse, humiliation, bullying and harassment. Persistent emotional ill treatment, cyber-bullying, seeing or hearing the ill-treatment of others, Domestic Abuse (see the below section)*
* ***Discriminatory Abuse*** *- Treating a person in a way which does not respect their race, religion, sex, disability, culture, ethnicity or sexuality.*
* ***Organisational Abuse*** *- Where routines and rules make a person alter his/her lifestyle and culture to fit in with the institution.*
* ***Financial*** *- Taking money and/or property without permission. Using pressure to control a person’s money/property/ benefits. Taking or offering any financial inducements.*
* ***Modern Slavery / Trafficking*** *-* Smuggling is defined as the facilitation of entry to the UK either secretly or by deception (whether for profit or otherwise). Trafficking involves the transportation of persons in the UK in order to exploit them by the use of force, violence, deception, intimidation, coercion or abuse of their vulnerability.
* ***Radicalisation*** *-**is a process by which an individual or group comes to adopt increasingly extreme political, social, or religious ideals and aspirations that (1) reject or undermine the status quo or (2) reject and/or undermine contemporary ideas and expressions of freedom of choice.*

Any staff member who is the subject of allegations must be suspended from providing any services under this contract until the matter is resolved to the satisfaction of the Commissioner. Where appropriate a report should be made to the local authority – for those working with children and young people to the LADO [Local Authority Designated Officer].

Providers will ensure that they have mechanisms in place to fulfil their duty with regard to the Independent Safeguarding Authority where they have dismissed an individual, or an individual has resigned, because they harmed or may harm a vulnerable person. Consideration of subsequent reporting to professional registering bodies will also be needed e.g. GMC, NMC.

**5.3.4 Domestic Abuse and Sexual Violence**

Domestic Abuse is defined by the Home Office as:

*‘Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse: psychological, physical, sexual, financial, and emotional’.*

The Provider[s] will recognise the linkages to their service delivery and practice of those they support who are subject to domestic violence, including harm caused to primary victims and to their children. It is essential that the Provider[s] ensures the safeguarding lead has oversight of domestic and sexual violence also. This will ensure a clear single point of contact for all safeguarding matters with wider system partners.

The Provider[s] are expected to engage with the Domestic Abuse Partnership and Multi Agency Risk Assessment Conference [MARAC] where the safety of those at high risk is co-ordinated across agencies.

There is a requirement that the Provider[s] use the CAADA-DASH RIC [Risk Identification Checklist], and refers on to MARAC for those at high risk and or supports access to specialist support for lower risk victims as appropriate.

The Provider[s] will promote specialist service access for staff, communities and families through the 24/7 Domestic Abuse Hub so that specialist support can be offered at the earliest indications of abuse.

The Provider[s] will be particularly attentive to the links between domestic abuse, mental ill health and substance misuse and seek to be involved in integrated responses so that families experience co-ordinated interventions and support, particularly where these issues constitute risks to children.

The Provider[s] will always consider the potential risks to children caused by domestic abuse and other adult issues and follow their safeguarding procedures as a priority.

The Provider[s] will promote pathways to sexual abuse support services including the Sexual Assault Referral Centre and the commissioned aftercare Provider. The Provider[s] are expected to be knowledgeable about sexual violence and exploitation and the appropriate referral pathways for children and adults. Specialist support services for sexual violence are commissioned at sub regional level, and include the Sexual Assault Referral Centre (SARC) at St Marys Hospital in Manchester and the Rape and Sexual Abuse Support Centre (RSASC). While support is commissioned at a pan Cheshire level support services are delivered locally in bases accessible by victims.

It is known that those who are abused and those who abuse will also be among the service user group and the Provider must take all steps to support staff in their work with service users. The Provider[s] will also recognise that staff may be personally affected by domestic abuse and this will be accounted for in their own HR policies.

The Provider[s] practice approach must include support to those who are harmed andaccountability for those who harm others including promoting the use of criminal sanctions and voluntary change programmes.

**5.4 Prevent and Channel Duties**

The Provider[s] must ensure that they adhere to Prevent and Channel duties. The national Let’s Talk about it campaign[[21]](#footnote-21) describes Prevent as being about safeguarding people and communities from the threat of terrorism. Prevent is 1 of the 4 elements of CONTEST, the Government’s counter-terrorism strategy. It aims to stop people becoming terrorists or supporting terrorism. Channel provides support across the country to those who may be vulnerable to being drawn into terrorism. The overall aim of the programme is early intervention and diverting people away from the risk they may face.

**5.5 Service Feedback, Engagement and Co-production**

Engagement and co-production with stakeholders (particularly Service User engagement and co-production) must be a core principle within the Cheshire East Substance Misuse Service. Engagement and co-production must be embedded within the service practice to ensure that Service Users feel valued and listened to. The Provider[s] must demonstrate how engagement and co-production has contributed to service development and improvement. The Provider[s] must engage with Service Users as follows:

* The design, development and improvement of the service (co-design);
* The evaluation and review of service performance and pathways (co-evaluation);
* The delivery of services e.g. peers, champions and volunteers (co-delivery).

**5.6 Referral, Assessment and Support Planning**

The Provider[s] must capture the views of children, young people and adults in assessment, with bespoke ‘person centred’ and co-produced support planning.

The Provider[s] will formalise clear and visible, easily understandable care and support pathways that are widely available to service users to support self-referral and referrals from the wider professional groups e.g. Social Care, Police, Domestic Abuse Family Support Unit & Specialist Services, IDTS, Community Health Services, Community Rehabilitation Companies.

There is an expectation that there will be proactive and meaningful connections with hard to reach communities and underrepresented groups and groups were there is higher prevalence of substance misuse.

The service as a whole will accept referrals from individuals, families, parents, carers and professionals. The Provider[s] will be responsible for the maintenance of an effective and timely referral pathway explained within an open access policy.

The Provider[s] will ensure the delivery of a case management system for those using substance misuse services in Cheshire East. The principles underpinning case management we would expect to see would be as follows:

* Comprehensive assessment of individuals utilising proven assessment tools taking account of their assets (strengths), any protected characteristic group needs, culture, language needs, religion, belief, pregnancy and maternity and family circumstances;
* Co-production of care and support plans that build on individuals assets (strengths);
* Risk assessment and risk management that contributes to the care and support plan and accounts for crisis and crisis management;
* Connected case management where individuals have a dual diagnosis or multiple presenting health needs;
* Consideration and resolution of housing related needs with appropriate provider/commissioner partners;
* Organisation of resources to meet the needs of service users accessing the service and to contribute towards formal professional meetings and service planning;
* Ensure treatment requirements are complied with e.g. general health assessment, Hepatitis and HIV testing;
* Review of the recovery plan using the YPOR, TOP, 5 Ways to Wellbeing, Cheshire East Children’s Plan Priorities to monitor progress along with other outcome monitoring requirements of the commissioner
* Discharge, after care provision and continuing recovery in the community (Recovery Community).

**5.7 Service Development**

The Provider[s] will work with the commissioner on a programme of service developments throughout the lifetime of the contract, the programme will be regularly reviewed and up dated. Areas for service development are likely to include, but are not limited to, the following:

* Co-produce Quality indicators focussing on the needs of vulnerable groups,
* Joint working with the Police and Crime commissioner to respond to any issues raised within the PHE Commissioning Support Pack in relation to substance use and offending
* Joint working with NHSE commissioners on offender healthcare
* Response to emerging substance misuse for example fentanyl
* Increasing the proportion of substance misuse clients with an identified mental health need who are actively engaged with mental health services
* Reducing DNA rates
* Adding value to needle exchange programme by ensuring users are targeted with harm reduction information
* Children and Young People’s element of service delivery including increasing the number of CAFS initiated or contributed to by the Provider[s].
* Further development of shared care arrangements with primary care to reflect increased numbers of clients in recovery
* Further development of work with pharmacies.

The initial service development plan should be provided within 5 months of contract start and reviewed 6 monthly thereafter.

**Section 6.0**

**Governance Requirements**

**6.1 Legal compliance**

The Provider[s] will ensure that the service is fully compliant with all relevant legislation and regulations. The service will lead to improvements in health and wellbeing, abstinence and recovery. The service will be delivered within the allocated budget. Failure to meet agreed targets would result in the commissioner requiring a remedial time specific action plan to address the issues of concern. Continued underperformance may lead to contract termination in line with the contract terms and conditions. For services that are not registerable, inspection arrangements will be through other routes such as Local Health Watch, and via the commissioners right to enter services at any time.

**6.2 Lead Provider/ Consortia / Multiple or Joint Providers**

The Provider[s] must ensure strong organisational governance and compliance of any/all sub-contracted services covering all aspects of service delivery in the community and from exit from inpatient treatment and or release from custody / prison. This should include but not be limited to:

* confidential and appropriate communication between services;
* communication with service users, parent / carers and families;
* communication between staff and services;
* effective reporting arrangements;
* effective service user record keeping;
* service data and access to record arrangements;
* data protection;
* incident reporting;
* safeguarding;
* health and safety;
* whistle blowing;
* recruitment;
* risk management;
* compliance with the human rights act;
* Equal opportunities.

**6.3 Reslience and Business Continuity**

The Provider[s] will produce a Reslience and Business Continuity plan prior to the commencement of the contract that is then subsequently reviewed at least annually.

Key personnel, particularly managers, must be familiar and up to date with the legislation, the Plan should include how the Service will achieve the following:

* Compliance with the requirements of the Climate Change Act (2008) and all other environmental legislation;
* Compliance with the Sustainable Development Strategy for the NHS, Public Health and Social Care System 2014-2020 and any future updates.

Resilience and business continuity plans are essential and it is expected that the Provider[s] will report at least annually to the Commissioner on their currency and use.

**6.4** **Strategic Governance**

The service is expected to maintain an effective and proactive stakeholder network and strategic partnerships, including Clinical, Criminal Justice, Social Care partners in order to inform improvement and development of the service within the wider system.

**6.5 Information Governance**

The Provider[s] will comply with the Information Governance (IG) Toolkit <https://www.igt.connectingforhealth.nhs.uk/requirementsorganisation.aspx>.

This integrates the overlapping obligations to ensure confidentiality, security and accuracy when handling confidential information set out in:

* + The Data Protection Act 1998;[[22]](#footnote-22)
  + The common law duty of confidentiality;
  + The Confidentiality NHS Code of Practice;
  + The NHS Care Record Guarantee for England;
  + The Social Care Record Guarantee for England;
  + The ISO/IEC 27000 series of information security standards;
  + The Information Security NHS Code of Practice;
  + The Records Management NHS Code of Practice;
  + The Freedom of Information Act 2000.

Patient identifiable data (PID) will only be accessed by authorised staff where the service user has given explicit consent. Where consent is not given by the individual service user only anonymised or aggregate data will be accessed. Patient confidential data (PCD) will only be accessed where it is absolutely necessary to support or facilitate the service user’s care. All PCD will be handled in accordance with the Information Governance (IG) Toolkit <https://www.igt.connectingforhealth.nhs.uk/requirementsorganisation.aspx>.

This includes:

* Ensure that agencies comply with their responsibilities to inform service users of the uses of their information and the agencies it is shared with;
* Protect and keep in the strictest confidence all information;
* Use the confidential information only for the purpose of supporting or facilitating the care of the service user;
* Notify the Commissioner immediately upon learning of any improper disclosure or misuse of any confidential information, login and passwords. Also to take whatever steps are reasonable to halt and otherwise remedy, if possible, any such breach of security. Also to take appropriate steps to regain the confidential information, and to prevent any further disclosures or misuses;
* Ensure that the service Provider has a current data protection notification, which is updated on an annual basis;
* Ensure that all members of staff are contractually bound by confidentiality agreements and are aware of their responsibilities to adhere to these e.g. the NHS Confidentiality Code of Practice;
* Appropriate technical and organisational measures will be taken against unauthorised or unlawful processing of personal data and against accidental loss or destruction of, or damage to, personal data;
* Regular confidentiality audits will be carried out to ensure that security measures remain appropriate and up to date. All audits will be carried out in accordance with the Information Commissioner’s Office ([ICO) Confidentiality Audit Guidance](http://www.google.co.uk/).

**6.6 Clinical governance**

Appropriate and robust clinical governance arrangements are of paramount importance to the commissioner and it is intended that these will be monitored through contract monitoring arrangements and through any other Clinical Governance forum arrangement deemed appropriate by the commissioner. We would expect compliance with NHS Standards and Clinical Governance arrangements and protocols in line with NICE, NHS and Public Health England guidance, local Government Association.

The Provider[s] will ensure that the service has robust mechanisms in place to manage all aspects of clinical governance including medicines management and other aspects of shared care and complete care pathway services. Such arrangements will account for but not be limited to:

* Safeguarding incidents and concerns – suspected and occurred abuse / violence;
* Serious untoward incidents (SUI) – clinical incidents that do not fall under the definition requiring safeguarding processes to be followed, including staff vacancies and absences that cause service disruption and compromise minimum safety requirements determined by the Provider[s];
* Risk prevention and management;
* Medicines management;
* Service Inspection and Registration;
* Safe service transitions between Provider[s];
* Policies and procedures including Audit and Clinical Governance, and Clinical Supervision;
* Medical and clinical interventions it delivers including psychosocial interventions ensuring that these are evidence based and delivered by appropriately qualified, experienced and supervised practitioners;
* To utilise evidence based assessment tools to assess the nature and severity of substance misuse.

All processes should include escalation and notification of events to the Provider[s] who will be responsible for assuring the commissioner of the services compliance with clinical governance standards and policies and learning from any breaches or serious incidents.

The Provider[s] must report all serious and untoward incidents (SUIs), complaints and compliments to the commissioner. Where compliments and less serious complaints occur these can be reported as part of the quarterly monitoring cycle. However serious complaints, untoward incidents and safeguarding occurrences must be reported to the commissioner at the first available opportunity.

The Provider[s] must adhere to local prescribing governance arrangements and ensure compliance with requirements of the relevant Controlled Drugs Accountable Officers (CDAOs)

**6.8 External Inspections**

The Provider[s] will be responsible for registration and meeting the inspection requirements of inspectorates including CQC. There is an expectation that the service will contribute to wider children and families OFSTED inspections required by the commissioner. Local Health Watch also have enter and view responsibilities for adult health and social care services and compliance here is also expected.

**Section 7.0**

**Guidance**

This section sets out the key guidance that the Council expects the Provider[s] to adhere to during the delivery of the contract and the key strategic issues that arise out of them. It is expected that policy and practice will develop and change over the period of the contract and the Provider[s] must ensure that they take a positive approach to strategic proposals made by the commissioner. This section cannot be considered to be exhaustive but sufficient to guide the Provider[s] in delivering the specified service. The commissioner will raise issues of approach and strategy during the course of formal contract monitoring meetings and at other times as required. The following guidance has been referred to as supporting the development of the specification:

* National Drug Strategy expectations;
* National Alcohol Strategy expectations;
* Joint Health and Wellbeing Strategy expectations;
* Clinical service guidance;
* Behaviour change service guidance;
* Psychosocial interventions service guidance
* Criminal Justice service guidance;
* Assets Based Community Development (ABCD);
* Recovery service guidance;
* Workforce.

Other links – Joint Health & Wellbeing Strategy; Director of Public Health Annual Report; Live Well for Longer in Cheshire East; Public Health outcomes framework; and all relevant other statutory legislation for Children & Families and Adult Services but will ultimately be finalised with the Provider[s].

**7.1 National and Local Guidance**

The Provider[s] shall at all times conform to relevant external standards or best practice guidance as issued by Department of Health, Public Health England, National Institute of Care and Excellence [NICE], the Local Government Association and other respected evidence based evaluation bodies.

The Provider[s] will monitor changes in local and national policy and to adapt the service, performance, outcome and output monitoring arrangements to reflect continued service development in line with such policy. The Provider[s] through work with sub commissioned providers will ensure that the services delivered in Cheshire East reflects such best practice and are compliant.

**7.2 Key Standards, Policies and Procedures**

**7.2.1 Clinical**

* NICE Public health guidance 4: Interventions to reduce substance misuse among vulnerable young people (March 2007)
* NICE Public health guidance 7: School-based interventions on alcohol (November 2007)
* NICE Public Health Guidance 18 2009 – Needle and Syringe Programmes: enhanced by PH 52 (2014)
* NICE Public health guidance 20: Social and emotional wellbeing in secondary education (September 2009)
* NICE Public health guidance 24: Alcohol-use disorders: preventing harmful drinking (June 2010)
* NICE Public health guidance 28: Looked-after children and young people (October 2010, modified: April 2013)
* NICE guidelines CG51:-Drug Misuse: Psychosocial Interventions
* NICE guidelines CG52: Drug Misuse: Opioid Detoxification
* NICE guidelines CG62: Antenatal Care (2008 as amended)
* NICE guidelines CG: 100 (Alcohol use disorders: Diagnosis and clinical management of alcohol-related physical complications)
* NICE guidelines CG115: Alcohol dependence and harmful alcohol use
* National Institute for Clinical Excellence (NICE) guidelines Drug misuse and dependence:- UK guidelines on clinical management
* NICE Technology appraisal guidance TA114: Methadone and buprenorphine for the management of opioid dependence (January 2007)
* NICE Technology appraisal guidance TA115: Naltrexone for the management of opioid dependence (January 2007)
* NICE Technology appraisal TA325: Nalmefene for reducing alcohol consumption in people with alcohol dependence (November 2014)
* NICE Diagnosis and Clinical Management of Alcohol Related Physical Complications (2010)
* NICE Preventing the development of hazardous and harmful drinking (2010)
* NICE QS 11 Quality Standard Alcohol dependence and harmful alcohol use
* National Institute for Clinical Excellence; public health guidance 18: Needle and syringe Programmes (February 2009)
* NICE QS 23 Quality standard for drug use disorders
* NHS National Treatment Agency for Substance Misuse (2009b) Guidance for pharmacological management of substance misuse among young people
* NICE Hepatitis B and C: ways to promote and offer testing to people at increased risk of infection 2012 <http://www.nice.org.uk/guidance/ph43/chapter/recommendations#/recommendation-6-testing-for-hepatitis-b-and-c-in-drugs-services>
* Models of Care for Alcohol Misuse 2006 (MOCAM)
* Review of effectiveness for the treatment of alcohol problems 2006
* Drug misuse and dependence: UK guidelines on clinical management, July 2017
* Public Health England 2014 ‘Medications in recovery: best practice in reviewing treatment: Supplementary advice from the Recovery-orientated Drug Treatment Expert Group’ DoH, 2007
* Recovery-Orientated Drug Treatment An Interim Report by Professor John Strang (2010)
* Medications in Recovery. Re-orientating drug dependence treatment. NTA 2012
* Delivering quality care for drug and alcohol users: the roles and competencies of doctors: A guide for Lancashire County Council, providers and clinicians. College Report CR173. Royal College of General Psychiatrists. September 2012
* Medications in Drug Treatment: Tackling the Risks to Children. ADFAM 2014
* Drug Misuse and Dependence – UK Guidelines on Clinical Management 2007
* Medications in recovery: Re-orientating drug dependence treatment. Strang, J, et al. National Treatment Agency. 2012.
* National Treatment Agency, Review of the effectiveness of treatment for alcohol problems (2006)
* World Health Organisation, Alcohol Use Disorders Identification Test (AUDIT)
* National Institute for Clinical Excellence; clinical guideline 51: Drug misuse: psychosocial interventions (July 2007)
* Commissioning treatment for dependence on prescription and over the counter medicines: a guide for NHS and Lancashire County Council commissioners. Public Health England 2013

**7.2.2 Behaviour Change**

* NICE (2012) Public health guidance 6 ‘Behaviour change at population, community and individual levels’.
* NICE Public Health Guidance 49: Behaviour change: individual approaches
* NICE (2007) Behavior Change. Public Health 6 London: National Institute for Health and Clinical Excellence;
* NICE (2010) Alcohol Use Disorders: Preventing the Development of Hazardous and Harmful Drinking. Public Health Guidance 24. London: National Institute for Health and Clinical Excellence;

**7.2.3 Psychosocial interventions**

* NICE Clinical Guidance 51 Drug Misuse: Psychosocial interventions 2007
* National treatment Agency (NTA) Integrated Drug treatment System. The first 28 days: Psychosocial support: Update 2009
* NTA guidance Route to Recovery Part 1 ITEP: Challenging and Changing the Ways we Think (2009)
* NTA guidance Routes to Recovery: Psychosocial Interventions for Drug Misuse (2009)
* NTA guidance Route to Recovery via criminal justice: Mapping User Manual (2010)
* NOMS Substance Misuse Accredited Interventions (August 2011)
* Routes to Recovery: Psychosocial Interventions for Drug Misuse - a framework and toolkit for implementing NICE-recommended treatment interventions

**7.2.4 Criminal Justice**

* Ministry of Justice What Works to Reduce Alcohol-Related Offending (March 2010)
* Ministry of Justice What Works with Offenders who Misuse Drugs? (May 2010)
* UK Drug Police Commission (2008) The Treatment and Supervision of Drug-dependent Offenders
* Department of Health, Update Guidance for prison based opioid maintenance prescribing (2010)
* Patel Report, Reducing Drug Related Crime and Rehabilitation of Offenders (September 2010)
* Ministry of Justice, Breaking the Cycle, Effective Punishment, Rehabilitation and Sentencing of Offenders (December 2010)
* Corston (2007) A Review of Women with Particular Vulnerabilities in the Criminal Justice System
* Prison: the facts. Bromley Briefings summer 2015. Prison Reform Trust 2015

**7.2.5 Assets Based Community Development (ABCD)**

* Cheshire East Connected Communities Strategy (2017)
* Asset-based places: A model for development, Social Care Institute for Excellence (SCEI), 2017
* A glass half-full: how an asset approach can improve community health and well-being. Improvement and Development Agency, Local Government Association, 2010
* 5 Ways to Health and Well-being, New Economics Foundation, 2010
* Commissioning for Outcomes and Co-Production, A practical guide for Local Authorities New Economics Foundation; June 2014

**7.2.6 Recovery**

* Service user involvement: A guide for drug and alcohol commissioners, providers and service users, 2015
* What recovery outcomes does the evidence tell us we can expect? ACMD; Second report of the Recovery Committee November 2013
* Whole Person Recovery: A user-centred systems approach to problem drug use. Rebecca Daddow and Steve Broome, November 2010
* The Role Of Housing In Drugs Recovery: A practice compendium. Chartered Institute of Housing. September 2012
* The Contribution of Clinical Psychologists to Recovery orientated Drug and Alcohol Treatment Systems, The British Psychological Society 2012
* Granfield, R. and Cloud, W. (1999) Coming clean: Overcoming addiction without treatment. New York: New York University Press
* Best, D, Laudet, A. 2011. The Potential of Recovery Capital. Royal Society of Arts (RSA).
* Best, Dr David Reader in Criminal Justice, University of the West of Scotland Mapping routes to recovery and the role of recovery groups and communities
* Factors Influencing Recovery, Wired In, 2011, www.wiredintorecovery.org
* Best, Dr David and Laudet, Alexandre B, 2011 The Potential of Recovery Capital, RSA Recovery Capital Project in Peterborough
* United Kingdom Recovery Foundation. Principles of Recovery: <http://www.ukrf.org.uk/>
* White, W. 2009. The recovery paradigm and the future of medication-assisted treatment.
* Emerging Drug Trends: Phase Four Report: The Reorientation towards Recovery in UK Drug Debate, Policy and Practice Exploring Local Stakeholder Perspectives Measham etal LDAAT 2013
* Implementing recovery through organisational change, Recovery, Personalisation and Personal Budgets. Centre for Mental Health 2012
* A fresh approach to drugs; final report of the UK Drugs Policy Commission 2012
* The potential of recovery capital. RSA Projects
* Commissioning for recovery - drug treatment, reintegration and recovery in the community and prisons; a guide for drug partnerships. NTA 2010
* Facilitating access to mutual aid: three essential stages for helping client's access appropriate mutual aid support. Public Health England 2013

**7.2.7 Workforce**

* Drug and Alcohol National Occupational Standards

**7.3 Needs Assessment and Asset Mapping**

The Cheshire East [**Drugs and Alcohol** **Joint Strategic Needs Assessment (JSNA)**[[23]](#footnote-23)](http://www.cheshireeast.gov.uk/council_and_democracy/council_information/jsna/living_well_working_well.aspx#LifestyleChoices) was updated March 2018. Local need identified within the JSNA shows that the following areas need to be addressed:

* More **young people** in Cheshire East have tried alcohol at age 15 compared to the national average. Therefore **parental influence** and **preventing or delaying the age of first use of alcohol or drugs for young people** needs to be a priority;
* **Female adolescent drinking is one of our biggest concerns in Cheshire East** Alcohol specific hospital admissions in under 18s are high in Cheshire East compared to other areas of the country;
* We need to understand more about why people in Cheshire East spend a longer time in Drug Treatment compared to the national average;
* **Maintaining recovery** – We need a stronger focus on building individual ‘**recovery capital’ for adults, particularly housing and employment;**
* **Peer support** is a key factor in **maintaining recovery for adults.** Local **young people** also say that they would prefer to talk to their **peers** about drug and alcohol issues;
* There is a larger proportion of individuals living in Cheshire East who are in drug treatment, compared to the number of individuals in alcohol treatment, in contrast to the higher level of need for alcohol misuse in comparison to drug misuse.

In addition to local need it is also important to understand local strengths and assets, which are particularly important to enable the Provider[s] to take an asset based approach to build local recovery communities. The **Live Well Website**13 provides an evolving asset map of local services and support. The website provides information about local drugs and alcohol services, as well as wider community assets such as faith groups, community centres, sports groups, and housing support etc.

The **Connected Community Strategy**[[24]](#footnote-24) sets out the Council’s ambition for an assets based community development approach. One of our strongest assets are people who use services and their families, therefore the Service Specification has been co-designed by Service Users through the development of the Cheshire East **Service User Journey**. People who are at various stages of their treatment and recovery journey in Cheshire East have been talking to commissioners about their journey and experiences of substance misuse, local drug and alcohol services and support.

Common issues identified by local people who use substance misuse services and their families include:

The Cheshire East Substance Misuse Service User Journey sets out the following areas for the Service to address;

|  |
| --- |
| **Access**  We are concerned about **waiting times** to access drug and alcohol services (particularly alcohol).“*I had to wait a few weeks for appointment which in my eyes is too long when you reach an all-time low*”.  *“It makes you feel that nobody cares.”*  *“Our Peers understand us, why can’t we have support from Peers while we wait?”*  There are too many **barriers** which stop us from accessing services (particularly for alcohol) for example if someone is referred by their **GP** or **Hospital**, while waiting for an appointment/assessment and following a drink down plan, by the time we get an appointment/assessment we are not eligible for support. As a result people are often discharged without accessing community recovery support e.g. Recovery in Cheshire East (RICE).  We need for more **flexible opening times** it is sometimes difficult to access services that are Monday-Friday 9-5, due to employment, education, child care responsibilities, or caring roles and responsibilities.  It is difficult to use public **transport** or to **travel** between the two main sites in Macclesfield and Crewe*. “I need to get 3 buses which costs £15 every time I attend my recovery group.”*  Services need to **“Capture the Moment”** when we are ready to change and in need of support, fast access to services and support is needed to give us the best chance for engagement and recovery. *“The longer it takes to get an appointment the less likely I am to engage.”* |
| **Treatment**  We have experienced **differences in treatment** across the 2 treatment sites **at Macclesfield and Crewe**.  We are confused about the availability and eligibility for **detox** and **rehab**.  *“A 3 day detox is not enough”*  The needs to be **better communication between services**, especially when we have been transferred from another area or from released from custody.  We feel that **Key Workers** are too busy anddon’t have enough much time to help us. *“One to ones with key workers are too short.”*  We feel that there is a **general approach to treatment** which doesn’t consider our personal needs or strengths. *“What is a Care Plan” “I didn’t know that I had a Care Plan” “My Care Plan has never been discussed with me.”* There needs to be a more holistic approach to treatment. Treatment services should not be provided in isolation. |
| **Recovery**  **Mutual Aid, Peer Support** and **Psychosocial Support** has had the **biggest / most positive impact**. It has helped me to understanding addiction, challenges my behaviour and helped with my self- reflection/awareness which has been **key to gaining and sustaining abstinence.** *“The service has improved over the past 2 years.”*  **Mutual Aid** groups are **important** to us, and we feel that we need **choice** for example faith based groups work for some people but are not always right for everyone.  *“the scaffold that supports my recovery”*  *“saved my life”.*  *“Peer support has helped maintain recovery.”*  *“You are not forced to come.”*  *“This is the first time that I have been drug free for 15 years”*  *“I have friends that understand me.”*  *“It has given me confidence.”*  Maintaining or getting back into employment is key to my recovery.  “*Intuitive thinking has given me a different look on life and which I am extremely grateful for. I now have more control and more determination over my way of thinking and my life.”*.  “*Employment, training, and family & friends have maintained my recovery journey.”*  *“Help with CVs is needed.”*  **Bereavement** counselling would help our recovery by helping us to deal with loss.  **Volunteering** is important to us and our recovery. *“We want more volunteering opportunities.”*  *“There is a big jump to employment which is why volunteering helps.”*  Help with employment and managing budgets can help with our recovery. “Could the service work with the CAB, the Job Centre or DWP?”  There needs to be a stronger recovery community in Cheshire East. When you “step out” are discharged from the services you think “**what next?”** How will I maintain my recovery? |
| **Pathways**  We feel that **services don’t talk to each other**, especially prisons, police, mental health, GPs, hospitals and housing.  Some **GPs** need a better understanding of the substance misuse service, addiction, treatment options and referral pathways.  *“I went to GP practice 5 times before I was referred to the SMS, then it was only because I saw a different GP the others had no idea of the SMS and I didn’t know about it”*  *“GP’s did nothing so I attended AA meeting, where a guy there referred me to ROAR”*  *“GP did not know of RAMP or services available”*  *“GP has no understanding of addiction..”*  *“I had to change my GP before I got help.”*  *“My GP was great and referred me straight to CWP.”*  There needs to be better working between and links between the service and…  - **Mental health** and substance misuse services to improve outcomes for both. *“If I have alcohol needs I can’t access mental health services.”*  - **Housing** services, there are too many barriers *“no address, no help”.*   * **Criminal justice services/prisons** to keep us engaged. There is a gap between being released from prison to accessing substance misuse services. * **Employment,** **education and training** providers. * **Voluntary and community organisations**. *“I want to volunteer but don’t know where to go.”* * **Carers** and **Social Care** services. *“My family need help too.” “Where does my mum go to for help?”*   *“Why can’t we do it? Why can’t Peers be available in GP surgeries, hospitals, prisons and police stations etc to help people to go to drug and alcohol services?”* |
| **Stigma**  We feel that more awareness of recovery is needed to help to reduce stigma locally. Stigma stops people from accessing support, volunteering opportunities, and employment and housing etc.  *“Stigma is a big issue, people don’t understand substance misuse and recovery.”*  *“The stigma hangs over you like a cloud.”* |
| **Families**  **Family members / Carers** of people in treatment and recovery said:  **Peer support** is important to us; we support each other, listen, share information and tips, and learn from each other. The family group helps us to feel less isolated and that we are not alone.  The Family groups give us the **tools** and help us to build resilience, to cope and **understand addiction**.  There are lots of barriers to getting support for addiction, organisations don’t talk to each other and there are key points when help should be available, such as going to the GP, Hospital and the Police.  *“We are kept out or ignored, until there is a problem, and then people want to talk to us.”*  *“Where is the help for us?”*  *“We feel the stigma too”*  *“It’s not just about tea and cake, we need practical tools and understanding of addiction to help us to cope.”* |

The Cheshire East Service User Journey is also available in interactive visual format via the: <https://prezi.com/view/YNwyBjaHV1NHDlXajFp8/>

1. Public Health Outcomes Framework (PHOF) 2013-16 <http://www.phoutcomes.info/public-health-outcomes-framework#page/0/gid/1000042/pat/6/par/E12000002/ati/102/are/E06000049> [↑](#footnote-ref-1)
2. HM Government (2017) Drug Strategy <https://www.gov.uk/government/publications/drug-strategy-2017> [↑](#footnote-ref-2)
3. Public Health England (2017) Drug and Alcohol Services: Why Invest <http://www.nta.nhs.uk/uploads/why-invest-2014-alcohol-and-drugs.pdf> [↑](#footnote-ref-3)
4. ONS (2017) Deaths related to drug poisoning in England and Wales <https://www.gov.uk/government/statistics/deaths-related-to-drug-poisoning-in-england-and-wales-2016-registrations> [↑](#footnote-ref-4)
5. Public Health England (2016) Understanding and preventing drug-related deaths <http://www.nta.nhs.uk/uploads/phe-understanding-preventing-drds.pdf> [↑](#footnote-ref-5)
6. HM Government (2012) Alcohol Strategy <https://www.gov.uk/government/publications/alcohol-strategy> [↑](#footnote-ref-6)
7. PHE (2016) The Public Health Burden of Alcohol and the Effectiveness and Cost-Effectiveness of Alcohol Control Policies: An evidence review <https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/583047/alcohol_public_health_burden_evidence_review.pdf> [↑](#footnote-ref-7)
8. HM Government (2016) Advise on Low Risk Drinking <https://www.gov.uk/government/publications/alcohol-consumption-advice-on-low-risk-drinking> [↑](#footnote-ref-8)
9. 2013 mid-year population estimates, Office for National Statistics [↑](#footnote-ref-9)
10. Cheshire East Council People Live Well for Longer Commissioning Plan (2017) [↑](#footnote-ref-10)
11. Cheshire East Connected Communities Strategy (2017) <http://www.cheshireeast.gov.uk/council_and_democracy/connected-communities/connected-communities.aspx> [↑](#footnote-ref-11)
12. The Cheshire East Council Corporate Plan (2016-2020) <https://moderngov.cheshireeast.gov.uk/documents/s45997/CEC%20Corporate%20Plan%202016%20d.pdf> [↑](#footnote-ref-12)
13. Live Well Cheshire East <http://www.cheshireeast.gov.uk/livewell/livewell.aspx> [↑](#footnote-ref-13)
14. The Cheshire East Alcohol Harm Reduction Strategy (2017) <https://moderngov.cheshireeast.gov.uk/documents/g6186/Public%20reports%20pack%2028th-Mar-2017%2014.00%20Cheshire%20East%20Health%20and%20Wellbeing%20Board.pdf?T=10> [↑](#footnote-ref-14)
15. Cheshire East Alcohol and Drug Joint Strategic Needs Assessment <http://www.cheshireeast.gov.uk/council_and_democracy/council_information/jsna/starting_and_developing_well.aspx#SupportingYoungPeople>

    <http://www.cheshireeast.gov.uk/council_and_democracy/council_information/jsna/living_well_working_well.aspx#LifestyleChoices> [↑](#footnote-ref-15)
16. European drug prevention quality standards <http://prevention-standards.eu/position-paper/> [↑](#footnote-ref-16)
17. Rise Above campaign <https://campaignresources.phe.gov.uk/schools/topics/rise-above/overview> [↑](#footnote-ref-17)
18. You’re Welcome standards <http://www.youngpeopleshealth.org.uk/yourewelcome/> [↑](#footnote-ref-18)
19. <http://www.cheshireeast.gov.uk/council_and_democracy/council_information/jsna/starting_and_developing_well.aspx#SupportingYoungPeople>

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20. <https://www.gov.uk/government/publications/fair-deal-guidance> [↑](#footnote-ref-20)
21. Let’s Talk about it: Working together to prevent terrorism <http://www.ltai.info/what-is-prevent/> [↑](#footnote-ref-21)
22. General Data Protection Regulation (GDPR) Guidance <https://ico.org.uk/for-organisations/guide-to-the-general-data-protection-regulation-gdpr/> [↑](#footnote-ref-22)
23. Cheshire East (2017) Drugs and Alcohol JSNA <http://www.cheshireeast.gov.uk/council_and_democracy/council_information/jsna/starting_and_developing_well.aspx#SupportingYoungPeople>

    <http://www.cheshireeast.gov.uk/council_and_democracy/council_information/jsna/living_well_working_well.aspx#LifestyleChoices> [↑](#footnote-ref-23)
24. Connected Community Strategy <http://www.cheshireeast.gov.uk/council_and_democracy/connected-communities/connected-communities.aspx> [↑](#footnote-ref-24)