Lancashire Specialist Substance Use Detoxification Services

Service Specification

May 2024

Definitions

Term	Definition
Advanced Practitioner	A healthcare professional who has completed a Masters level education and training in clinical practice and has the authority to act autonomously in the assessment, diagnosis and Treatment of patients
Aftercare Plan	A plan derived between the Service User and Community Treatment Provider to determine the support the Service User will receive after their period of Substance Use Treatment.
Appropriate Representative	A person who has been chosen to act or make decisions on behalf of another person.
Audit Programme	A detailed plan of the auditing work to be performed. It specifies the procedures to be followed in the conduct of audit more efficiently
Authority	Lancashire County Council
Brief Intervention	A structured, client-centred, non-judgemental therapy by a trained interventionist using 1-4 counselling sessions of shorter duration (typically 5-30 minutes).
Care Plan	A document that identifies care orders for a Service User and serves as a guide to care. The Care Plan includes details from conversations between the person and the Community Treatment Provider and Provider about the impact their condition has on their life, and how they can be supported to best meet their health and wellbeing needs in a whole-life way. The Service User Care Plan is owned by the Service User and shared with others with their consent.
Clinical Governance	A framework through which NHS organisations are accountable for continuously improving the quality of their services and safe-guarding high standards of care by creating an environment in which excellence in clinical care will flourish.
Commencement Date	The Commencement Date according to the Call off Contract
Community Treatment	Treatment provided by the community treatment provider or another health care provider such as a General Practitioner. In the case of a community treatment provider it may include substitute prescribing, psychosocial, and harm reduction interventions e.g., needle exchange.
Complex Needs	Service Users who have physical and/or psychological dependency on one or more Substances with physical or psychiatric complications (co-morbidity).
Detoxification Facility	A section of a hospital or a specialist medical facility where patients are admitted for medical care and attention. Patients are typically admitted to detox if they require a higher level of care than can be provided in the community, or if they need to stay in the hospital overnight or longer.
Detoxification Programme	A programme designed to remove toxic Substances from the body
Discharge Plan	A personalised plan for a Service User leaving the Service. It is a collaborative process that involves the Service User, the caregiver, and the Provider.
Doctor	A person who is qualified with a medical degree to treat people who are ill
GMC	General Medical Council
Health and Social Care Assessment	An assessment under the Care Act is an assessment of needs for care and support (including transition assessments)

Hidden Harm	Refers to the actual and potential effects of parental Substance use, domestic abuse, and mental health issues on dependent children. Hidden Harm is often hidden from public view or is not recognised or reported.
House Rules	Mutually agreed set of rules for the conduct of Service Users whilst undertaking a Placement within an In-patient Detoxification Service.
Inpatient Detoxification Service	The Service delivered to the Service User by the Provider to remove toxic Substances from the body.
Initial Assessments	An initial assessment is a short assessment at the beginning of a health care Service. It is used to determine the level, needs, and goals of the Service User.
Interventions	The action or process of intervening
Key Partners	Those organisations and/or their representatives which the Provider is required to work with in delivery of the Service.
Key Worker	A dedicated member of staff assigned to a Service User.
Medically Managed	Medically Managed services, such as Inpatient Detoxification Facilities as per section 4.3 of the specification
Medically Monitored	Medically Monitored services, such as psychosocial residential settings, as per section 4.4 of the specification,
Minimum Data Set	See https://www.gov.uk/government/collections/alcohol-and-drug-misuse-treatment-core-dataset-collection-guidance
Mood-Altering Substances	Drugs that change your brain chemistry.
Mutual Aid	Support or aid provided by collective effort within a community, especially in an emergency or to help those in need
NDTMS	National Drug Treatment Monitoring System
NHSE Regional Team	NHS England » Controlled drugs accountable officer – alerts etc.
NMC	Nursing and Midwifery Council
Opening Hours	The time during which the Service is open for Service Users.
Out of Hours	The time during which the Service is not open for Service Users.
Placement	The Service User being placed within a Detoxification Programme/the Service.
Planned Admission	The admission of a Service User into the Service which is scheduled in advance.
Planned Discharge	When a Service User has achieved their current Treatment goals and are ready to move to the next Intervention and/or have completed Treatment.
Primary Care	Healthcare provided in the community for people making an initial approach to a medical practitioner or clinic for advice or Treatment
Provider	The organisation providing the Service under this contract.
Psychological Therapies	Sometimes referred to as 'talking therapies'. They involve exploring psychological difficulties that are getting in the way of how we would like to act or feel.
Psychosocial Interventions	Nonpharmacological Interventions that include a variety of psychological and educational components.

Recovery Plan	A plan to support someone in their early recovery, prevent relapse, and help them as they work toward their life goals (also includes any aftercare) please see section 4.1.4 of the specification. This is initially created by the Community Treatment Provider and further developed by the Provider.
Regular Reviews	Periodic progress reviews that take place between the Service User and the Provider.
Referrer	The person who refers the person to the Service, in the majority of cases the Referrer will be the Community Treatment Provider.
Service	The Inpatient Detoxification Service delivered by the Provider.
Service User	A user of the Service
Severe Substance Use Disorder	Six or more symptoms indicate a Severe Substance Use Disorder
Substance/Substances	Including but not limited to Alcohol, Illicit drugs, New Psychoactive Substances (NPS), Problematic use of prescription/over the counter medicines.
Successful Completion of Detoxification	When the Service User has completed their detoxification/stabilisation goals in this current episode of Treatment.
Treatment	Interventions that support individuals to address, reduce harm and / or achieve abstinence from Drug use and alcohol disorders are defined as intoxication by, dependence on, or regular, excessive consumption of psychoactive substances leading to social, psychological, physical or legal problems.
Treatment and Recovery Plan	A written document that outlines the goals, methods, and expected outcomes of therapy or healthcare services. It is created by the Provider in collaboration with the Service User, and it serves as a guide to direct the steps to take in treating the Service User's condition.
Unit	Where the Service is delivered from to the Service User.
Unplanned Discharge	The unplanned release of a Service User from the Service.

Contents

1. Introduction and Background

1.1. Introduction

1.1.1 The Authority has a core purpose to ensure that the services it commissions not only reduce poverty, discrimination, and inequality, but also improves the quality of life for Lancashire's residents.

1.1.2 Building the prevention and wellbeing offer in our local communities is central to the Authority Public Health aims.

1.1.3 Lancashire is a complex County with 12 districts, diverse communities, one Integrated Care Board (ICB) and an Integrated Care System (ICS). See link - https://www.lancashireandsouthcumbria.icb.nhs.uk/about-us/what-integrated-care-board-icb.

1.1.4 This Service specification describes the requirements of a Medically Managed and Medically Monitored Detoxification Facility.

1.1.5 This specification refers to the provision of services for people who are residents within the Authority's footprint, are aged 18 years plus and have Substance use issues. It is based on the needs and aspirations of Service Users with a view to ensuring the achievement of their recovery goal(s).

1.2. Aim

1.2.1 The Authority requires the Provider to improve health outcomes and reduce inequalities by delivering a detoxification Service that complies with available best practice, that is in line with national /local guidance and relevant guidelines in clinical practice.

1.2.2 The Provider will ensure Service Users have access to effective and evidence based harm reduction and prevention strategies to improve their health and wellbeing, whilst being supported to achieve their personal recovery outcomes and goals.

1.2.3 The Provider will support Service Users entering residential services to overcome current problems and to develop strategies for dealing with future challenges and to live healthy and fulfilling lives as equal standing members of the community.

1.2.4 Access to a detoxification provision, is a part of Lancashire's recovery focussed and evidence-based treatment systems within our treatment and recovery system. As part of the delivery of these services, the Provider will deliver Medically Managed/Monitored Inpatient detox that allows Service Users to be treated in a suitable environment to their needs.

1.3. National Context

1.3.1 The 2021 National Drug Strategy 'From Harm to Hope' builds on the 2017 National Drug Strategy and has 3 key themes:

(i) Break drug supply chains,

(ii) Achieve a generational shift in demand for drugs and

(iii) Deliver a world-class treatment and recovery system.

1.3.2 To achieve the third ambition, additional funding has been made available by the Office for Health Improvement and Disparities (OHID) to increase capacity in rehabilitation services.

1.3.3 The 2021 Drug Strategy estimates the financial cost of Substance use is staggering. It currently costs society almost £20 billion a year, approximately £350 for every man, woman, and child in England. In 2018, alcohol harm was estimated to cost society £21.5 billion per annum.

1.3.4 Reducing levels of drug and alcohol use will improve health outcomes and reduce offending behaviour, one of the key components of the response to the problem being the commissioning of effective treatment services.

1.3.5 The Government's Alcohol Strategy (2012) documents an overarching approach to alcohol harm reduction and has implications for national and local delivery. An element of this relates to the delivery of treatment services but also encompasses preventative approaches which the Provider will need to be aware of and engage in as appropriate. In particular, the Provider will contribute towards the following aims:

(i) A change in behaviour so that people think it is not acceptable to drink in ways that could cause harm to themselves or others.

(ii) A reduction in the number of people 'binge drinking'.

1.3.6 The Advisory Council on the Misuse of Drugs (ACMD) report '*What recovery outcomes does the evidence tell us we can expect?* (2013)' states that to recover from Substance use and sustain change, there are several domains an individual must address. These include collateral damage in the following domains; economic, social, cultural and health.

1.3.7 The Authority endorses the views expressed by the ACMD: *'UK and USA consensus groups, and UK drug strategies define recovery from drug and alcohol dependence as a process, which is different for each person, which has key components of overcoming dependence, plus maximising health, wellbeing, and social integration and contributing to society.*

and

The ACMD Recovery Committee believes that the concept of recovery clearly covers several outcome domains and is a wider concept than purely overcoming drug and alcohol dependence. We take the view that overcoming drug or alcohol dependence alone, is not recovery and definitions of recovery that do not include reference to wider outcome domains are inadequate and may lead to ineffective intervention strategies.'

ACMD. What recovery outcomes does the evidence tell us we can expect? Second report of the Recovery Committee, November 2013.

1.3.8 People in sustained recovery are less likely to offend, can rebuild family relationships, improve their health and increase positive engagement within society; all factors that can impact public spending on specialist services in the future.

1.3.9 The Provider will adhere to the revised UK guidelines on clinical management (2017) which provide guidance on the treatment of drug use and dependence

in the UK. They are based on current evidence and professional consensus on how to provide drug treatment for most patients, in most instances.

1.3.10 People in sustained recovery are less likely to offend, can rebuild family relationships, improve their health and increase positive engagement within society; all factors that can impact public spending on specialist services in the future.

1.3.11 The evidence base for recovery in the UK is emerging, though historically it is well evidenced in American literature. Likewise, the evidence base for Asset-Based Community Development (ABCD) is extensive and growing. A selection of key documents can be seen in Section 16 Relevant National Documentation.

1.3.12 This evidence forms the bedrock on which we will build a high quality, recovery-focused treatment system and will underpin Providers of Specialist rehabilitation and detoxification services.

1.3.13 In addition to the core funding related to this contract the Authority is has also received additional funding through a grant process associated with the 2021 National Drug Strategy. This has delivered enhanced funding to Local Authorities to fund additional In-Patient Detoxification (IPD) places. Table 1 below provides a breakdown of the total IPD funding the Authority has received so far up until 2023 and the funding for 2024-2025.

Table 1: IPD – Lancashire Total Grant

2022/23	2023/24	2024/25
£220,493	£220,493	£220,493

1.4. Local Context

1.4.1 Lancashire is the fourth largest local Authority in England and has one of the most complex treatment populations in the Country as evidenced by the large amount of additional investment offered by OHID.

1.4.2 The Authority has developed a long-term strategic plan, Lancashire 2050. This framework aims to bring people together with a shared vision, shared ambition, shared goals, and shared priorities. The Provider will contribute to these shared priorities and work with local partners to realise this vision. These shared priorities include:

1.4.2.1 To give our children the best start in life and support better choices.

1.4.2.2 To improve quality of life and reduce health inequalities.

1.4.2.3 To provide better opportunities to stay healthier for longer.

1.4.2.4 To make sure public bodies properly join up their services to focus on Lancashire people's needs.

1.4.2.5 To improve multi-agency working to make sure all our children have the best possible start in life.

1.4.3 The Lancashire County Council corporate priorities (2021-25) seek to make Lancashire the best place to live, work, visit and prosper. The council will seek to secure the best possible future for Lancashire residents and deliver better outcomes for local people.

1.4.4 This commission will support the delivery of the Lancashire County Council vision by reducing inequalities and protecting our most vulnerable people from the harms caused by Substance use, and by helping people recover and stay healthy.

1.5. Population Needs

1.5.1 The following data provides a broad overview of the Substance use treatment and Recovery population in Lancashire. See Annex 1 for more detailed information.

1.5.2 In Lancashire 6297 adults are in treatment in 2022/23. Of these, 265 number attended detoxification with 93 Women compared to 163 males.

1.5.3 In Lancashire in 2021-22, hospital admissions for alcohol specific conditions is significantly higher than the England rate (DSR (directly standardised rate) for Lancashire is 749 and 626 for England). The rate of hospital admissions for alcohol related conditions is similar to England (DSR is 487 for Lancashire and 494 for England).

1.5.4 Lancashire recorded 654 hospital admissions due to drug poisoning for all ages (crude rate of 53.3 per 100,00), for the period 2020-21. This was similar to the England rate of 50.2.

1.5.5 Prevalence rates for alcohol dependant people in Lancashire is estimated to be 14,364 individuals. Unmet alcohol treatment need is approximately 81.3% which is slightly higher than the England average.

1.5.6 Prevalence rates for opiate and crack cocaine Users (OCU) in Lancashire in 2022/23 was estimated to be 6,567. The unmet need was estimated to be 46.3% which is lower than the England average of 57.9%.

1.5.7 In Lancashire, the numbers of individuals in treatment across all drug groups have increased by 2.8% from 2021/22 to 2022/23. Of particular note, has been in increase in crack only users which has increased by 16% in the period.

1.5.8 The number of adults in community alcohol treatment in 2022-23 is 1,733 which has been in decline but is now on an upward trajectory since 2022. The gender split for those in community treatment for alcohol is 57% male and 43% female.

1.5.9 The peak age group of those in treatment for drug use is the 30-49 year olds which represent 46% of the drug treatment population. Similarly, the peak age group for those in alcohol treatment is 30-49 representing 51% of the alcohol only treatment population.

1.5.10 Lancashire has a higher percentage of people in community drug treatment with a disability than the England average with the figure being 38% for Lancashire as opposed to 31% for England. In terms of alcohol use the figures are 36% for Lancashire as opposed to 29%for England.

1.5.11 In terms co-occurring mental health conditions, 80% of adults in treatment in Lancashire expressed a need for support. In terms of gender, for those accessing alcohol only support, 41% of males and 36% of females had a mental health treatment need.

1.5.12 The ONS Census 2021 describes the ethnic breakdown in Lancashire as 88.9% White British, 8.1% Asian/Asian British, 1.6% mixed/multiple ethnic groups (including White & Asian, White & Black African and White & Black Caribbean), 0.6 Black/African/Caribbean and 0.1% Gypsy/Irish Traveller. Since the 2011 ONS Census there has been an increase in the BME population in Lancashire. The ethnic profile of those in treatment is 86% White, 2.15% Asian/Asian British, 1.87% mixed/multiple ethnic groups, 0.57% Black/African/Caribbean and 0.03% White Gypsy/Roma/Traveller.

2. Service Overview

2.1. Overview – brief description

2.1.1 The Provider will deliver the requirements set out in this specification.

2.1.2 The Provider will work and engage with Key Partners across Lancashire (see section 5.2 Interdependencies).

2.1.3 The Service will be proactive, flexible, and responsive to changes in the evidence base and local and national developments.

2.1.4 All Interventions will be fully explained to Service Users, pathways in place and options will be offered where appropriate for the Service User to make an informed choice.

2.1.5 Providers will actively involve, where appropriate, the Service User and family/carers/supporting others in their journey to improve their wellbeing.

2.1.6 The Provider will provide relevant information on different Interventions to enable the Service User to make an informed choice based on the range of support and Interventions available to them.

2.1.7 The Provider will be responsive to local population health needs and diversity and will contribute to reducing health inequalities in Lancashire through treatment and prevention.

2.1.8 The Provider will provide leadership, management and coordination between the Service and community providers as well as the Authority's commissioned services.

2.1.9 The Provider will work strategically and flexibly with the Authority and Key Partners to develop the Service and pathways as required for the duration of the contract.

2.1.10 The Provider will attend any relevant partnership meetings identified by the Authority.

2.2. Deliverables

2.2.1 The Provider will deliver a residential Medically Managed and/or Monitored Inpatient Detoxification Service to the eligible population identified at Section 5.1 of the Service Specification.

2.2.2 The Provider must understand the bio-psychosocial model of addiction and deliver treatment that addresses Service Users' holistic needs.

2.2.3 The Provider will use Psychological Therapies to assist Service Users in starting to address underlying issues, including Brief Interventions and cognitive behavioural therapies, in line with NICE CG 52 (2007).

2.2.4 Providers may also use Interventions that have a strong evidence base to demonstrate their effectiveness in supporting Service Users through their recovery journey such as Mutual Aid groups, complementary therapies (such as auricular acupuncture and mindfulness) and psycho-educational groups utilising node-link mapping.

2.2.5 The Provider must liaise closely with the Authority from where the Service User was referred to ensure that there is:

2.2.5.1 Clarity about what medications have been prescribed before

2.2.5.2 Good continuity of care from local Community Services at the start of the detoxification as well as post-detoxification

2.2.5.3 An agreed structured recovery and Aftercare Plan in place.

2.2.6 The Provider must have clear detoxification protocols for alcohol, opiates and benzodiazepines and have a protocol for detoxification from other drugs including novel psychoactive Substances. All prescribing protocols must adhere to NICE guidelines, e.g. Clinical Guidelines 115 and 100 (CG115 and CG100).

2.2.7 The Provider must demonstrate a flexible approach to detoxification dosing and associated psychosocial and medical support that is based upon severity of withdrawals.

2.2.8 The Provider will work with Service Users who wish to become free/ stabilised from their drug and alcohol use. The Provider will provide the following:

2.2.8.1 A Detoxification Service provided in accordance with national and local guidelines.

2.2.8.2 A comprehensive assessment for each Service User, in keeping with related protocol/suitability criteria.

2.2.8.3 A Care Plan for all Service Users entering treatment, which will address factors such as the Treatment package, specific needs and goals and arrangements for aftercare.

2.2.8.4 Aftercare Plans which include contingency management for those who leave treatment unplanned.

2.2.8.5 Utilise national recognised tools as identified in NICE guidance (e.g. WEMWBS, CIWA) to monitor and clinically record mental and physical health.

2.2.8.6 A named Key Worker for all Service Users in treatment, who will be the Service User's main point of contact and who will ensure that the Care Plan is implemented and co-ordinated with care managers and referring Service.

2.2.8.7 A multi-disciplinary team working within a **Medically Managed Service** must include; Addiction Consultant Psychiatrist, Physicians, Registered Nurses, Therapy staff and a workforce with visible lived experience. Desirable members of the team would be; Psychologist, Physiotherapist, Dieticians, Occupational Therapists. (Please see section 6 of this specification)

2.2.8.8 A multi-disciplinary team working within a **Medically Monitored Service** must include Physicians, Registered Nurses, Therapy staff and a workforce with visible lived experience. Desirable members of the team would be; Psychologist, Physiotherapist, Dieticians, Occupational Therapists. (Please see section 6 of this specification)

2.2.8.9 Evidence based group programme and 1:1 psycho-social Interventions.

2.2.8.10 Competent staff who have access to regular clinical supervision, training and development that meets with nationally accredited occupational standards and any other relevant criteria for workforce development and governance.

2.2.8.11 The Provider will develop a trauma informed approach to Treatment, understanding the causes and contributing factors involved in Substance use and work to address trauma effectively.

2.2.8.12 The Provider will assess for, monitor, and work with Adverse Childhood Experiences (ACEs) and other forms of trauma such as Post Traumatic Stress Disorder (PTSD).

2.2.8.13 Staff and volunteers will be monitored and supervised on a regular basis based on an agreed staff and volunteer development framework.

3. Geographic Coverage

3.1. Footprint

3.1.1 The Provider will ensure the Service is available to the eligible population (see Section 5.1 Acceptance and Exclusion criteria) in the Authority footprint age 18 and over.

3.1.2 The Provider will deliver the Service for the residents of the following areas listed below. The Provider may be given the opportunity to deliver the Service to residents from outside of Lancashire as provided for in the PDPS agreement including in other local Authority areas such as Blackpool.

3.1.2.1 Burnley

3.1.2.2 Chorley

3.1.2.3 Fylde

3.1.2.4 Hyndburn

3.1.2.5 Lancaster

3.1.2.6 Pendle

3.1.2.7 Preston

3.1.2.8 Ribble Valley

3.1.2.9 Rossendale

3.1.2.10 South Ribble

3.1.2.11 West Lancashire

3.1.2.12 Wyre

3.1.3 The Service must be accessible to all eligible people. Those with protected characteristics covered by The Equality Act 2010 must not be disadvantaged.

3.1.4 The Service must be sensitive to the cultural needs and backgrounds of all Service Users and people living in Lancashire.

3.2. Premises

3.2.1 The Provider must deliver the Service in one or more of the following settings only:

3.2.1.1 Medically Managed

3.2.1.2 Medically Monitored

3.2.2 Any costs associated with buildings used, including operational costs, overheads, information technology systems and telecoms will be met by the Provider.

3.2.3 The Provider will ensure that all premises used for Service delivery meet all legislative requirements. The Service does not need to be delivered in Lancashire and the Provider does not need to be physically based in Lancashire to deliver this Service.

3.2.4 The Provider will conduct regular risk assessments on all premises utilised.

3.2.5 Provider's premises will be accessible from the referring area and must be:

3.2.5.1 Manageable for Service Users who need to travel alone.

3.2.5.2 Accessible by public transport.

3.2.6 All premises will meet the statutory buildings requirements, be suitably furnished, and have refreshment facilities.

3.2.7 The Provider must ensure that the premises:

3.2.7.1 Comply with the CQC requirements or the relevant regulatory body.

3.2.7.2 Comply with any relevant regulations.

3.3. Days, Opening Hours and Contact Details

3.3.1 Telephone access to the Service and internet-based information will be available at all times. With a recorded message and signposting to digital support Out of Hours.

3.3.2 Any closures or changes to Opening Hours must be agreed with the Authority.

3.3.3 The Provider will ensure that any changes will be clearly communicated with Service Users and Key Partners in a timely manner.

3.3.4 The Provider will have a single telephone number, text (SMS) number, a dedicated email account, social media messaging channels, and website referral system.

3.3.5 An Out of Hours telephone answering machine will be available and all the contacts will be responded to on the next working day.

3.3.6 Providers are not required to hold bed spaces but must advise of availability for acceptance to a referral within a maximum of 5 working days of a request being

made, advising at that time when a bed will be available subject to initial assessment.

4. Service Scope

4.1. Treatment Pathway Description

4.1.1 Referral Routes

4.1.1.1 A valid referral must originate from one of the Community Treatment Provider Services (based in each local Authority area including Lancashire and Blackpool). The details for each Local Authority will be confirmed after applicants are confirmed on the PDPS. For a summary of the referral and call off process, please refer to Annex 3 (section 16 of the specification).

4.1.1.2 A referral shall be complete when the following information has been provided to the Provider:

- 4.1.1.2.1 Minimum Data Set (see National Drug Treatment Monitoring System (NDTMS) – Adult drug and alcohol treatment business definitions CDS-O (publishing.service.gov.uk))about the Service User; demographics, other health issues, current Substance misuse concerns and problems.
- 4.1.1.2.2 Relevant physical health examination / investigation results.
- 4.1.1.2.3 Holistic needs and risk assessment and Treatment and Recovery Plan.
- 4.1.1.2.4 Details of the proposed post-discharge arrangements for the Service User.
- 4.1.1.2.5 Details of any safeguarding requirements specific to the Service User**.**

4.1.1.3 Information about the Service will be provided by the Provider for commissioners and Referrers, and Service Users prior to admission and to Service Users on admission.

4.1.1.4 The Provider will be issued with written referral information outlining the Service User's current treatment and up-to-date risk assessments by the current Community Treatment Provider. Treatment and Recovery Plans and contingency considerations must be incorporated at the referral stage.

4.1.1.5 The Provider must ensure that they receive up-to-date blood results or other specific clinical information prior to agreeing treatment.

4.1.1.6 Once a Treatment and Recovery Plan is agreed, this will be shared with the Service User and with the referring service. This will form part of or contribute to the overall Recovery Plan.

4.1.1.7 The Provider will work with the Community Treatment Provider to develop a plan for Service Users to travel to and from the Provider's Detoxification Facility and that this is agreed in the referral/acceptance information. The Provider may be required to fund the Service Users transport to the Service, where needed.

4.1.1.8 If the Provider provides transport for the Service User to travel to its Detoxification Facility, the Provider is responsible for ensuring that the Service User is transported safely. This will mean that the Provider:

4.1.1.8.1 Will ensure that all vehicles and equipment used to transport the Service User are maintained in a safe state and according to the manufacturer's instructions.

4.1.1.8.2 The vehicles will be taxed and comprehensively insured. Drivers of the vehicles will have passed a driving test and possess a valid current licence appropriate for the vehicle.

4.1.1.8.3 Will ensure that seat belts are available to all Service Users and that they are used at all times during transportation of Service Users.

4.1.1.9 Upon acceptance of a Service User to be admitted to the Service, the Provider is responsible for understanding the Service User's physical, psychological, social, and forensic needs.

4.1.1.10 In specific cases, there may be the requirement for the Referrer and Provider to meet with the Service User preadmission to discuss expectations of treatment and collaborate in developing the Service Users Care Plan.

4.1.1.11 For Detoxification Programmes that are likely to last longer than the NICE guidelines, advance written notification including the reasons for length of stay must be provided to the relevant Authority for agreement.

4.1.2 Community Treatment Provider Pre-admission

4.1.2.1 The Community Treatment Provider will undertake a holistic health, social needs and risk assessment that addresses the appropriateness of treatment for Substance use. The Provider must ensure that this assessment is sent to them as part of the Pan Lancashire Referral Form (please refer Annex 2) to activate the referral process.

4.1.2.2 The Community Treatment Provider will recognise the difference between a Medically Managed and Medically Monitored Detoxification Programme and ensure the Service User is clinically appropriate for the chosen Detoxification Programme.

4.1.2.3 The Community Treatment Provider must ensure that an overall Treatment and Recovery Plan is in place and that this is being delivered and coordinated effectively. The Treatment and Recovery Plan must be sent as part of the referral to activate the referral process.

4.1.2.4 The Community Treatment Provider will support the Provider in gathering Service User feedback following discharge (where required)

4.1.2.5 The Community Treatment Provider will develop appropriate arrangements to transport the Service User to and from the Service where the Service does not provide this.

4.1.2.6 The Community Treatment Provider will ensure that the Service User arrives for any pre-admission assessment. Or is supported to do this virtually.

4.1.2.7 The Community Treatment Provider will inform the Provider of any relevant changes in the Service User's circumstances including, but not limited to, the Service User's availability for admission.

4.1.2.8 The Community Treatment Provider will make arrangements for the Service User on discharge, including the provision of after care. This includes ensuring that assessments for aftercare Interventions and/or residential rehabilitation are undertaken.

4.1.2.9 The Community Treatment Provider must facilitate assessment and arrangements in respect of safeguarding children and vulnerable adults. However, in the event that any safeguarding issues emerge during the Detoxification Programme the Provider is responsible for following the relevant safeguarding policies and procedures and will inform the Referrer about the issues without delay.

4.1.2.9.1 For example, in the event of a Service User reporting a safeguarding issue that is about the Provider, then the Provider will take responsibility for reporting this to the safeguarding team in their local Authority area and follow their policies and procedures. They will also inform the referring agency.

4.1.3 Assessment

4.1.3.1 On admission, the Provider will deliver a full and comprehensive medical examination to the Service User. This must be undertaken by a Doctor or an Advanced Practitioner.

4.1.3.2 The Provider will undertake appropriate investigations which must be cross referenced with those taken in the community setting.

4.1.3.3 The Provider will refer to SADQ (Severity of Alcohol Dependence Questionnaire) when assessing level of dependence and determining detoxification (CG115).

4.1.3.4 The Provider will ensure that any assessments are used as motivational tools.

4.1.3.5 The Provider will ensure that assessment of physical and mental health is ongoing throughout admission by both medical and nursing staff and will be documented at all times and discussed in Regular Reviews.

4.1.3.6 The Provider must work in-line with the Service User's individual Treatment and Recovery Plan during admission and throughout the period of stay at the Service.

4.1.3.7 The Provider's Doctor or Advanced Practitioner must discuss any medical test results and feedback from investigations with the Service User along with and the implications for their future health in the context of changing behaviour.

4.1.3.8 The need for the provision of vitamin supplements must be assessed and nutritional supplements prescribed by the Provider as required.

4.1.3.9 The Provider must ensure that Intramuscular (IM) or Intravenous (IV) Pabrinex are available and provided routinely for individuals with a history of poor nutritional intake or long-term heavy alcohol consumption.

4.1.3.10 The Provider must ensure that psychological screening, assessment, and intervention take place during the Service User's Detoxification Programme (as required), including psychometric and neurological assessment.

4.1.3.11 During admission, the Provider will ensure that the Service Users' nutritional needs, sleep hygiene and overall wellbeing is assessed and managed.

4.1.4 Administering the Detoxification Programme

4.1.4.1 During the Detoxification Programme the Provider must ensure that observations are undertaken by registered nursing staff to meet Service Users' needs (and in accordance with NICE guidance). This will ensure early detection of adverse signs, for example, withdrawal symptoms.

4.1.4.2 The Provider will use detailed treatment schedules and evidence-based tools for assessing withdrawal (e.g., Clinical Institute Withdrawal Assessment (CIWA).

4.1.4.3 The Provider will ensure that Zopiclone or Promethazine is provided for the short-term relief of sleep difficulties in line with British National Formulary (BNF) guidance, where required.

4.1.4.4 The Provider will ensure that, where necessary, nutritional supplements are provided to Service Users.

4.1.4.5 The Provider must offer Service Users advice on aspects of lifestyle that require attention during the Detoxification Programme, including hydration, exercise, sleep and a balanced diet.

4.1.4.6 The Provider must actively support and encourage Service Users to engage with Psychosocial Interventions (structured group work and 1:1 sessions).

4.1.4.7 The Provider must facilitate Mutual Aid groups to attend the Detoxification Facility to facilitate introductory sessions (Narcotics Anonymous, Alcoholics Anonymous, Cocaine Anonymous and SMART Recovery).

4.1.4.8 The Provider must ensure that alongside the group programme; one-to-one therapeutic Interventions that focus on coping strategies, CBT-based Brief Interventions, motivational interviewing and self-soothe approaches will be provided to Service Users following assessment.

4.1.4.9 The Provider will inform the Referrer if the Service User does not engage with their Detoxification Programme, treatment, and support at the Service.

4.1.4.10 The Provider will conduct psychological and physical re-assessments as appropriate to establish any additional complications that may have been masked by Substance use.

4.1.4.11 The Provider's medical and nursing staff shall, where necessary, work alongside staff from acute hospitals to monitor and treat complex physical problems.

4.1.4.12 In both alcohol and opiate dependence, relapse prevention medications need to be considered by the Provider following completion of detoxification (as per CG115 and CG52, NICE guidance).

4.1.4.13 The Provider must ensure that Service Users and support networks have access to verbal and written information to support Successful Completion of Detoxification and encouraging sustained rehabilitation post treatment.

4.1.4.14 The Provider will ensure that the Service is inclusive and can meet the treatment needs of the diverse populations that it serves.

4.1.4.15 The needs of a Service User in relation to specific ethnic, religious, gender, sexual orientation, health, literacy, or cultural requirements must be identified in the Treatment and Recovery Plan. This must include, but is not limited to, the following:

4.1.4.15.1 Arranging for the services of an interpreter at Initial Assessments and other meetings for Service Users whose English is not sufficient to understand what is being said.

4.1.4.15.2 Arrangements for contact with an Appropriate Representative of the Service User's choice.

4.1.4.15.3 Identification in Care Plans of Service Users' needs in relation to gender and sexual orientation and how these will be met appropriately and sensitively.

4.1.4.15.4 Understanding of religious and cultural preferences in relation to food, dress and worship.

4.1.4.15.5 Arrangements for access for Service Users with a disability.

4.1.4.16 The Provider will take positive action to combat discrimination on any grounds and will be expected to apply requirements and good practice in line with the Equality Act 2010.

4.1.4.17 The Provider must be able to demonstrate their Clinical Governance arrangements and must adhere to CQC and NICE guidelines.

4.1.5 Complex Needs Service User Care Planning

4.1.5.1 Service Users who have physical and/or psychological dependency on one or more Substances with physical or psychiatric complications (co-morbidity) are deemed as complex cases when considering detox.

4.1.5.2 The Provider must have governance arrangements whereby complex cases can be discussed pre-admission with a Consultant Psychiatrist and relevant members of an Multi Disciplinary Team (MDT). These discussions must inform Treatment and Recovery Plans and ensure the upcoming admission is safe and well-prepared.

4.1.5.3 The Provider must demonstrate close working relationships with local health and social care services to support Service Users with complex and / or multiple support needs. The Provider must have established pathways in place, whereby a Service User may need to be transferred to an acute care bed for either their physical or mental health care needs.

4.1.5.4 The Provider must be able to respond to those who have needs under the Mental Health Act, Mental Capacity Act and Deprivation of Liberties Safeguards. There must be strong risk management plans in place to either exercise these legal frameworks or transfer someone to the appropriate facility urgently.

4.1.5.5 When Service Users are transferred or have an appointment at another healthcare facility; the Provider will ensure that a suitably trained member of staff will either accompany or escort them.

4.1.5.6 The Provider shall ensure they have 24-hour access to a Psychiatrist if required (this may be on site or through local on call arrangements).

4.1.5.7 The Provider must ensure that there is suitable access to their accommodation and the environments support those who have physical disabilities and/or health needs.

4.1.5.8 The Provider will demonstrate to commissioners and Community Treatment Providers what additional services are available for those Service Users who

are admitted with 'Complex Needs' i.e., mental health issues, physical disabilities, learning difficulties or health issues.

4.1.6 Planned Discharge

4.1.6.1 At the time of Planned Discharge, the Provider must ensure that the clinical team provides information to the Service User, prior to leaving the Detoxification Programme, about the potential risk of overdose and about reduced tolerance to alcohol.

4.1.6.2 The Provider will ensure that Planned Discharge processes will work to ensure that there is not a negative impact on Service User progress.

4.1.6.3 The Provider will ensure that Planned Discharge will support a safe transfer back to either other residential (including Substance Use Rehabilitation Services) provision or a return to community-based support, including housing.

4.1.6.4 The Provider will ensure that upon Planned Discharge, the referring Service must be advised of the discharge so as to minimise gaps in care and for any reports from the Provider to be sent back to the referring Service within 5 working days.

4.1.6.5 The Provider will ensure provision of sufficient (prescribed) medication prior to a Planned Discharge for the Service User if they are re-entering community addiction services or GP care for treatment.

4.1.6.6 The Provider must ensure that details of any continued treatment requirement risks and safeguarding requirements are provided to residential rehabilitation services, Community Treatment Services or any other organisation the Service User is discharged to.

4.1.7 Unplanned Discharge

4.1.7.1 The Provider must aim for all discharges from the Service to be planned.

4.1.7.2 The Provider will make every effort to retain the Service User in treatment for the duration of the Detoxification Programme.

4.1.7.3 The Provider will inform the Referrer of the likelihood of the Placement breaking down as soon as possible. The Provider must make it clear regarding the potential reason for the breakdown.

4.1.7.4 The Provider will liaise closely with the Referrer to find alternative treatment for the discharged Service Users.

4.1.7.5 The Provider will ensure that the Discharge Plan will also address housing, continuity of benefits and any other need that may be identified at the time of discharge.

4.1.7.6 The Provider will ensure that the Discharge Planning at the termination of Placement allows time for implementing the Discharge Plan, including suitable accommodation.

4.1.7.7 Providers need to be aware of their duties under the Homeless Reduction Act (2017) and their Duty to Refer.

4.1.7.8 Every effort must be taken to mobilise the Discharge Plan before, or key elements of it, before the residential Detoxification Programme is terminated or ended early.

4.1.7.9 Where the Placement is being terminated due to significant breaches of agreed "House Rules" the Service User will be advised of appropriate alternative

treatment options and of the need to contact their care manager/ Key Worker / duty manager if Out of Hours.

4.1.7.10 The Provider will deliver support to enable the Service User to successfully engage with the alternative provision, including making appointments at Community Treatment Providers for continuation of prescribing and/or other treatment.

4.1.7.11 The Provider will contact the Referrer by telephone and send a follow up email prior to discharge whenever possible.

4.1.7.12 In the event that the Provider has safeguarding concerns relating to a Service User who self-discharges they will follow the safeguarding procedures in the district or borough to which the Service User is discharged.

4.1.7.13 The Provider will ensure that all opiate dependent Service Users will be offered a naloxone kit (and advice on its appropriate use) prior to discharge. In addition, the Provider will issue harm reduction advice and information to all Service Users leaving the Unit.

4.1.7.14 The Provider will ensure provision of sufficient medication following Planned Discharge prior to Service User re-entering Substance Use Community Treatment Services or GP care for treatment must be completed.

4.1.8 Aftercare

4.1.8.1 Aftercare will be addressed and planned for as an integral part of the Care Plan, the Provider must ensure that this is done as soon as possible, ideally prior to admission and certainly prior to Planned Discharge. This includes drug/alcohol and nondrug/ alcohol related aftercare needs.

4.2. Strands Outline

4.2.1 The Authority seeks to commission services that offer a stepped approach to meeting the needs of Service Users in their detoxification and include provision of three levels of care divided into the following three strands:

4.2.1.1 Strand 1: Medically Managed Detoxification

4.2.1.2 Strand 2: Medically Monitored Detoxification

4.2.1.3 Strand 3: Medically Managed and Monitored Detoxification

4.3. Strand 1 – Medically Managed Detoxification

4.3.1 Acceptance Criteria

4.3.1.1 Service Users must be referred by the Community Treatment Provider.

4.3.1.2 Service Users must be aged 18 years or over.

4.3.1.3 Service Users must be physically and/or psychologically dependant on one or more Substances with physical or psychiatric complications or co-morbidity and not able to complete a detoxification in the community.

4.3.1.4 Service Users who have a serious complex physical co-morbidity where continued Substance use consistently exacerbates the illness or undermines its effective clinical management and require 24-hour clinical supervision.

4.3.1.5 Any pregnant Service Users will be accepted onto Medically Managed detox only.

4.3.1.6 Service Users with a history of severe and enduring mental illness will be accepted only if the presenting mental illness is stabilised prior to admission * **or** if the Provider is confident that the Service User's symptoms are manageable within the Service setting. (* However, Referrers may refer Service Users who are not stabilised to determine the level of mental illness when Substance free)

4.3.1.7 For Complex Needs (such as acute and serious physical or mental co-morbidity), there must not be an automatic exclusion. Providers will assess each individual referral based on the following criteria:

4.3.1.7.1 The Service User is mentally and physically able to participate in the Treatment and demonstrates a clear understanding of what the Treatment entails. The Referrer will be required to demonstrate that a comprehensive health and social needs and risk assessment has been taken place prior to admission.

4.3.1.7.2 When a Service User has a history of presenting a risk of harm to others, the decision as to whether accept a referral will rest with the Provider. In making the decision, they will consider capacity to manage presenting risk and implications for others engaged with the Service.

4.3.2 Intervention Outline

4.3.2.1 The Provider will ensure that Medically Managed Detoxification Interventions include:

4.3.2.1.1 A planned programme of medically supervised evaluation, care, and Treatment of mental and Substance-related disorders, delivered in an acute care inpatient setting by clinicians (including Consultant Psychiatrist(s)) with appropriate Substance misuse qualifications).

4.3.2.1.2 24-hour Doctor-led clinical cover for medically supervised evaluation and withdrawal management.

4.3.2.1.3 Out of Hours, there must be on call cover arrangements that can provide access to medications, respond to medical emergencies and overall be able to manage acute withdrawals. There must be a Duty Doctor/Consultant Psychiatrist on call system to support this.

4.3.2.1.4 Assessment of Substance use, physical and mental health and social issues (including any safeguarding concerns)

4.3.2.1.5 Management of drug and/or alcohol withdrawals

4.3.2.1.6 Stabilisation of prescription/or substitute medication and screening

4.3.2.1.7 Supporting those with co-morbidities to safely meet their recovery aims.

4.3.2.1.8 Preventing harm and supporting the wider public health agenda.

4.3.2.1.9 Engagement and partnership working with other agencies to rec-connect Service Users to wider health services.

4.3.2.1.10 To promote long term, sustainable abstinence from all Mood-Altering Substances.

4.3.2.1.11 To promote the successful social integration of individuals and enable them to live as independently as possible.

4.3.2.1.12 To improve the overall wellbeing of Service Users and their carers and dependants.

4.3.2.1.13 To provide recovery focussed support tailored to meet individual needs and preferences.

4.3.2.1.14 To ensure a smooth and effective Service User pathway flow.

4.3.2.1.15 There will be Out of Hours duty pharmacist support.

4.3.2.1.16 Routine availability of both detoxification and stabilisation as is clinically indicated.

4.3.2.2 Treatments will include a range of Detoxification Programmes that offer flexible treatment packages suitable for the differing level of Service User need and complexity.

4.3.2.3 There is a clear differentiation in the needs of those who require inpatient detoxification for:

4.3.2.3.1 Those who have Complex Needs and require 24-hour specialist support.

4.3.2.3.2 Those who do not have Complex Needs, but who are unsuitable for community detoxification because of unsuitable accommodation and/or lack of family or social support. However, it is recognised a Medically Monitored Unit may be more appropriate for this cohort (depending on Service User choice, geography etc).

4.4. Strand 2 – Medically Monitored Detoxification

4.4.1 Acceptance Criteria

4.4.1.1 Service Users must be referred by the Lancashire Community Treatment Provider.

4.4.1.2 Service Users must be aged 18 years and over.

4.4.1.3 Service Users must be physically and/or psychologically dependant on one or more Substances with physical or psychiatric complications or co-morbidity and not able to complete a detoxification in the community.

4.4.1.4 Service Users who have a serious physical co-morbidity where continued Substance use consistently exacerbates the illness or undermines its effective clinical management.

4.4.1.5 Any pregnant Service Users will be accepted onto Medically Managed detox only.

4.4.1.6 Service Users with a history of severe and enduring mental illness will be accepted only if the presenting mental illness is stabilised prior to admission * **or** if the Provider is confident that the Service User's symptoms are manageable within the setting. (* However, Referrers may refer Service Users who are not stabilised to determine the level of mental illness when Substance free).

4.4.1.7 For Complex Needs (such as acute and serious physical or mental co-morbidity), there must not be an automatic exclusion. Providers will assess each individual referral based on the following criteria:

4.4.1.7.1 The Service User is mentally and physically able to participate in the treatment and demonstrates a clear understanding of what the treatment entails. The Referrer will be required to demonstrate that a comprehensive health and social needs and risk assessment has been taken place prior to admission.

4.4.1.7.2 When a Service User has a history of presenting a risk of harm to others, the decision as to whether accept a referral will rest with the Provider. In making the decision, they will consider capacity to manage presenting risk and implications for other engaged with the Service.

4.4.2 **Medically Monitored Detoxification (not usually on a hospital site)**, is characterised by:

4.4.2.1 Care Planned assessment, stabilisation and assisted withdrawal/detoxification delivered in non-acute residential settings, under clinically approved and monitored policies, procedures and protocols.

4.4.2.2 The facility may have a non-medical prescriber (NMP), 24 hour nursing or suitably competent HCAs in addition to qualified recovery workers, and volunteers with lived experience.

4.4.2.3 Medical supervision is delivered via a General Practitioner/Non-Medical Prescriber or a Physician.

4.4.2.4 Care for Service Users with lower levels of dependence, without severe medical and/or psychiatric problems.

4.5. Strand 3 – Medically Managed and/or Monitored Detoxification Units

4.5.1 Both Medically Monitored and Managed Detoxification Units will:

4.5.1.1 Provide detoxification from one Substance whilst maintaining treatment for another dependently used Substance (e.g., maintenance on a methadone prescription whilst detoxing from alcohol). However most Medically Managed Units can support concurrent detoxes.

4.5.1.2 Are registered with the Care Quality Commission (CQC) and are able to demonstrate effective response to recommendations from inspection.

4.5.1.3 Provide a Care Plan for care and treatment, relevant information, consent to treatment following acceptance of referral and agreement by the Service User.

4.5.1.4 Have quality systems in place to report on and monitor the performance of the Service provision against the Service specification and quality criteria.

4.5.1.5 Comply with NDTMS reporting.

Table 2 – Medically Managed vs Medically Monitored Detoxification Summary

Medically Managed	Medically Monitored
There is 24-hour, medically directed evaluation, care and treatment of substance misuse disorders on site;	Enough medical supervision is provided by a visiting GP/other doctor, who is appropriately trained, with sufficient knowledge of and competence in the management of addiction problems.
Treatment will be offered to those with severe substance misuse disorders/ complex needs, including pregnant women. It often takes place in an inpatient unit.	Treatment is likely to be delivered in residential rehabilitation settings, but some may offer medically managed treatment. Services must not accept referrals of people whose needs they are not competent to meet.

Please refer to the CQC brief guide on substance misuse services – detoxification and Guidance for Commissioners on the procurement of Tier 4 Interventions.

5. Service Conditions

5.1. Acceptance and Exclusion criteria

5.1.1 For specific acceptance criteria, see strand 1 and 2 above (section 4.3 and 4.4)

5.1.2 Service Users will not be accepted into the Service if they are:

- 5.1.2.1 Service Users under 18 years of age.
- 5.1.2.2 Service Users not referred by the agreed referral method for that Service/network (see sections 4.1.1 and 4.1.2 in the specification for referral method)
- 5.1.2.4 Service Users that have clear risks that may put other Service Users on the ward 'at risk' and cannot be suitably managed.
- 5.1.2.5 In need of treatment for **acute** medical emergencies which are outside the scope and abilities of the Service.
- 5.1.2.6 In need of treatment for acute psychiatric emergencies that preclude normal assessment. This may include Service Users who are detained under the Mental Health Act 1983 (amended in 2007) or who are liable to be detained due to risk to self or others at the time of Planned Admission.
- 5.1.2.7 In need of medium or high secure conditions of treatment (i.e., forensic settings)
- 5.1.2.8 Where the primary purpose of admission is not the assessment and treatment of a Substance Use Disorder.

5.1.3 There may be cause for exclusion if the Service User has failed to complete a Detoxification Programme more than once within the last 12 months. However, these decisions must always be made with the both the Community Treatment Provider, the Provider and relevant key professionals.

5.2. Interdependencies

5.2.1 The Provider must ensure that, where appropriate to the Service, interdependencies and positive relationships are built with Key Partners including but not limited to the following:

- 5.2.1.1 Local Authorities / Public Health Teams
- 5.2.1.2 Substance use Treatment and Recovery Services
- 5.2.1.3 Mental Health Services
- 5.2.1.4 Other Detoxification Units/Providers
- 5.2.1.5 Social Care
- 5.2.1.6 Urgent Care systems
- 5.2.1.7 Specialist Liver Wards in Acute Care

5.2.1.9 Service Users, carers and family support services

5.2.1.11 Other Provider services e.g., Psychological Therapies

5.2.1.12 Criminal Justice services (including Lancashire Constabulary, National Probation Service, , HMP Prison Service, secure Units, Courts

5.2.1.13 Domestic abuse and refuge services

5.2.1.14 VCFS Organisations working with Rough Sleepers and the homeless e.g. Foxton Centre in Preston

5.2.1.15 District Council Housing departments, Providers and agencies and accommodation services across all sectors including social housing and Complex Needs provision

5.2.1.16 Sexual Assault Referral Centres

5.2.1.17 Victim Services

5.2.1.18 Mutual Aid Groups

5.2.1.19 Primary Care: General Practitioners, Pharmacy and Primary Care Networks

5.2.1.20 Recovery communities and organisations including Red Rose Recovery, the Lancashire User Forum and The Well

5.2.1.21 Women's Centres

5.2.2 The Provider is required to collaborate with other Detoxification Programme Providers to share best practice and ensure effective governance.

5.3. Safeguarding

5.3.1 The Provider will follow (as appropriate) current national and local guidance around the effect of Substance use on the whole family in relation to appropriate information sharing, referral, and assessment procedures in connection with Hidden Harm whether in terms of Lancashire Children's Safeguarding Assurance Partnership or Well Being, Prevention and Early Help requirements. Details on Provider requirements in relation to safeguarding are outlined in Appendix F of the contract.

5.3.2 The Provider shall:

5.3.2.1 Ensure it has a clear commitment to the safeguarding and the promotion of children's welfare.

5.3.2.2 Ensure that the Hidden Harm agenda is embedded into the overall Service provision.

5.3.2.3 Ensure it has a clear a commitment to safeguarding vulnerable adults.

5.3.3 Ensure clear signposting for families and parenting skills for parents/carers are made, specifically linked with the Authority's Children and Family Wellbeing Service.

5.3.4 All of the Provider's workforce will have the relevant level of safeguarding training appropriate to their role.

5.3.5 The Disclosure and Barring Service (DBS) was established under the Protection of Freedoms Act 2012 and merges the functions previously carried out by the Criminal Records Bureau (CRB) and Independent Safeguarding Authority (ISA). Under the provisions of the Safeguarding Vulnerable Groups Act 2006, the DBS will make decisions about who should be barred from working with vulnerable groups. The Provider must comply with such requirements.

5.3.6 The new Prevent Duty (section 26 of the Counter-Terrorism and Security Act 2015) came into force in July 2015. Safeguarding from extremism is no different to how practitioners would share a concern about drugs, physical and sexual abuse or any other form of criminality. Providers must ensure that staff complete this nationally accredited e-learning programme.

5.3.7 The Provider must be aware of the aims, objectives and priorities of the Lancashire Safeguarding Adult Board and be able to make appropriate referrals based on the Board's policies and procedures in order to protect vulnerable adults.

5.4. Communications, Branding and Marketing

5.4.1 The Provider will design all materials in collaboration with Service Users and appropriate Key Partners as part of a co-production approach.

5.4.2 The Provider will work with Lancashire County Council's Communications Service to appropriately manage reputational issues, provide a joint response to media related issues and harness positive media opportunities.

5.4.3 The Provider will respond effectively to media enquiries and work with the Authority and other Key Partner organisations.

5.4.4 The Provider will provide self-help materials in a range of formats and languages tailored to meet the needs of the Services' target audience.

5.4.5 The Provider will recruit a proportion of staff from local communities, where possible this will include people who are able to speak languages spoken in those communities so that the Service provided is as accessible and inclusive as possible.

5.4.6 If this is not possible, the Provider will use an appropriate interpretation service or language line, and provide information materials in other languages and formats, as and when required. Friends, relatives, or other carers should be not relied upon by the Provider to provide interpretation and/or translation services unless no other option is available.

5.4.7 Local communication and marketing initiatives will aim to:

5.4.7.1 Deliver consistent coherent and co-ordinated communication.

5.4.7.2 Support and enable local communities and volunteers to engage with the Service.

5.4.7.3 Improve understanding of what the Service can offer and where help is available.

5.4.7.4 Trigger behavioural change and signpost to the Service. Sustain participation in the Service

5.4.7.5 Provide information that is accessible to all people in Lancashire, this must include alternate languages, braille etc.

5.4.8 The Provider must have a website which as a minimum will provide:

5.4.8.1 Easy access and be responsive to Service User need.

5.4.8.2 A single telephone number for the Service.

5.4.8.3 General information about the Service including telephone, email, text options, Opening Hours.

5.4.8.4 Promote case studies.

5.4.8.5 Enable compliment and complaints reporting.

5.5. Service User Involvement

5.5.1 The Provider will embrace co-production principles and demonstrate how decisions are made with the Service User in the centre and also how those with living/lived experience are collaborated with on service level decisions and improvements.

6. Staffing and Workforce Competencies and Requirements

6.1 The Provider will have an effective workforce strategy in place for the development of all staff (including volunteers, peer mentors etc.) to ensure a highly competent and motivated workforce.

6.2 Providers will ensure they are fully compliant with guidance such as the Drug Use and dependence: UK guidelines on clinical management (2017) section A2. The wellbeing of the workforce must be a priority for the Provider to ensure a positive experience for those accessing the Service.

6.3 The Provider must ensure that all staff across the supply chain are paid, as a minimum, the National Living Wage or the Minimum Wage if the individual employee is aged 20 or under.

National Minimum Wage and National Living Wage rates - GOV.UK

6.4 The Provider must ensure that peer mentors/volunteers/those with lived experience have Regular Reviews by their line manager and be kept up to date with best practice and guidance.

6.5 The Provider must ensure that staff are qualified as appropriate to the work they undertake. (Please see sections 2.2.8.7 and 2.2.8.8 of this specification)

6.6 The Provider will ensure that clinical skills in the workforce are kept up to date and reviewed accordingly.

6.7 The Provider must ensure that the workforce are competent in dealing with issues concerning Safeguarding for both children and vulnerable adults.

6.8 The Provider will ensure it can provide a clear DBS Certificate (Standard, Enhanced or Enhanced and DBS Barred List at the Provider's discretion) for each of the Staff (paid and unpaid) engaged in the Services.

6.9 The Provider will ensure that its workforce is trained to the forthcoming new occupational standards being developed by Health Education England as part of their developing Drug and Alcohol Treatment and Recovery Workforce Programme | Health Education England (hee.nhs.uk).

6.10 The Provider will ensure there are sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed to meet peoples care and treatment needs in line with Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

6.11 The Provider will work with Lancashire County Council commissioners and help to support the principles and actions being taken to rebuild the professional workforce and will ensure that staff are trained and supported to develop their skills and knowledge in line with the aspirations and emerging standards enshrined within the 2021 Drug Strategy, "From harm to hope: a 10-year drugs plan to cut crime and save lives".

7. Monitoring and Evaluation

The Provider will routinely collate and analyse their own performance. The Provider will work with Lancashire County Council to develop the performance monitoring and associated outcomes framework (Appendix C and J of the contract). The Provider will report a clear supporting narrative which details current position relative to requirements as specified within the Service specification, detailing the areas of underperformance/concern; underlying reasons and what actions are being taken to overcome this now and in the future (see format for exception reporting in the table below). These reports will inform routine joint contract monitoring and broader quality and oversight discussions with any subsequent more detailed analysis being undertaken as appropriate (see section 12.1 Contract Management for full details).

All Providers are responsible for recording and documenting Compliments and Complaints, Safeguarding Alerts and Serious Reportable Incidents. These must be submitted in parallel with the quarterly performance reports and can be submitted using the online submission form (see section 12.1).

Exception Reporting
The issue of over/under performance or concern to be raised
Description of what the issue is
What the impact on the Service is
Explanation of why it is happening
An overview of the key actions being taken to address the issue (short-term
An overview of the key actions being taken to resolve/mitigate the issue (long-term)

7.1. Health Equity/Foundations for Wellbeing

7.1.1 The Provider is required to work with the Authority to periodically review the impact of the Service on health inequalities.

7.1.2 The Authority is committed to ensuring that the impact of policies, services and projects on health inequalities is understood, and where appropriate addressed. This approach is referred to as Foundations for Wellbeing.

7.1.3 The development of this commission has been informed by the Health Equity and Improvement Screening Tool.

7.1.4 The Health Equity and Improvement Screening Tool considers the impact the Service has on health inequalities by considering the following components of equity:

- Availability
- Accessibility
- Quality
- Acceptability
- Affordability
- Safety
- Responsiveness to people's needs

7.1.5 The Provider is required to actively engage in discussions with the Authority and review the Health Equity and Improvement Screening Tool in relation to the Service with the aim of maximising the impact the Service has on reducing health inequalities and limiting any unintentional impact on widening health inequalities. This assessment must be reviewed and updated annually.

8. Lancashire Public Health Coalition (LPHC)

8.1. Where the Authority deems it necessary, the Provider is required to work with the Lancashire Public Health Coalition.

8.1.1 The LPHC is convened and hosted by the Authority's Public Health Team under the direction of the Director of Public Health. The Coalition is a collaborative space designed to deliver and support outcomes relating to prevention and wellbeing for the county's residents and local communities; the fundamental aim is keeping people well. The Coalition is charged with delivering prevention outcomes in our local communities over and above the individual contractual requirements of its members. The key aims of the LPHC are as follows:

8.1.1.1 To deliver 'more than the sum of the parts' by collaborating with partners and their collective resources.

8.1.1.2 To create a joined up and enabled wider Public Health workforce across the county, organisational staff identifying as part of that workforce.

8.1.1.3 To enable all partners to learn and work together for benefits beyond their core contract, in the interests of our residents and communities.

8.1.1.4 To utilise public health tools to improve health equity.

8.1.1.5 To be visible and ensure the offer from the organisation/partner is absolutely realised to the broader Lancashire/ICS health and social care system.

8.1.1.6 To promote prevention and support health and wellbeing improvement of residents in our neighbourhoods.

8.1.1.7 To create a collective endeavour to 'nudge' towards greater impact and outcomes for individuals in local communities.

8.1.1.8 To enable all parties to flex resources and not be rigid in their approach to meet the needs of residents, based on collaboration.

8.1.1.9 The LPHC will operate at both the county and local levels, with a membership of public health commissioned services and partners, plus other stakeholders.

9. Family Hubs

9.1 The Authority has developed an expanding network of Family Hubs where agencies will support children and young people in Lancashire. The Family Hubs will improve multi-agency working, provide high-quality and holistic support to children, young people and families from pregnancy through to the age of 19. For those with special educational needs and disabilities (SEND) this will range up to the age of 25.

9.2 The main aims include, but not limited to the following:

9.2.1 To enhance the existing professional offers and networks.

9.2.2 To work collaboratively and enhance current Service provision.

9.2.3 To align Service delivery to avoid duplication.

9.2.4 To share resources for training purposes across the Family Hubs and network.

9.2.5 To ensure families have access to the appropriate support.

9.2.6 To ensure children and young people are healthy, happy, and developing well.

9.2.7 To connect individuals and families with services and their communities at a place-based level.

10. Applicable Service Standards

10.1. Governance, Risk Management and Quality Standards

10.1.1 The Provider will have strong and robust governance structures and ensure they are in alignment with the Authority to develop the services held within this Service specification; Requirements include the following (as a minimum):

10.1.1.1 Safeguarding

10.1.1.2 Patient Safety (SRI's)

10.1.1.3 Care Quality Commission (CQC)

10.1.1.4 Clinical Governance

10.1.1.5 Information governance

10.1.1.6 Internal governance

10.1.1.7 External governance

10.1.1.8 Contract Management

10.1.1.9 Quality Assurance Framework

10.1.2 The Authority expects to build a strong and effective working relationship with the Provider.

10.1.3 Appropriate arrangements must be in place for the supervision of all staff, including clinical supervision where required.

10.1.4 The Provider is expected to work within a continuous quality improvement model and will develop, meet and monitor the agreed quality standards, and/or performance indicators/targets.

10.1.5 The Provider is required to meet and monitor compliance with all relevant NICE Quality Standards.

10.1.6 The Provider must ensure services are delivered in a safe manner and ensure that a Service User's needs are central to providing appropriate quality service Interventions.

10.1.7 The Provider will have robust mechanisms and processes in place to manage all aspects of Clinical Governance including the management of medicines. Any prescribing the Service undertakes must be conducted in line with the relevant NICE guidelines.

10.1.8 The Provider will demonstrate openness and transparency in accordance with Francis recommendations including commissioner, Service User and public and collaboratively including other Service Providers.

10.1.9 The Provider will demonstrate its priority to Service User privacy (in line with the 1998 Data Protection Act) and dignity seeking and responding to the patient voice.

10.1.10 The Provider will maintain oversight of Clinical Governance arrangements and will provide The Authority with assurance about service compliance with relevant legislation, national and local standards or guidance and any updates to guidance which may affect the operation of the Service.

10.1.11 The Provider must comply with all clinical standards and practices and evidence there is a relevant reference point within the organisation for medicines management information and advice.

10.1.12 The Provider will develop a risk register which will be made available to The Authority prior to the Commencement Date and available on request thereafter.

10.1.13 The Provider shall have in place and be able to evidence appropriate and workable Clinical Governance arrangements including: (to be defined by you for this Service)

10.1.14 The Provider will be registered with Care Quality Commission (CQC) and meet their Fundamental Standards for Quality and Safety for the delivery of Substance use Treatment.

10.1.15 The Provider will follow the CQC quality standards (or any successor organisation to the CQC) and/or equivalent bodies compliant with the regulatory frameworks that exist in Scotland and Wales. The Provider will update standards/guidance as necessary. Bidders are advised to go on the CQC website www.cqc.org.uk, Health Inspectorate Wales (HIW) www.hiw.org.uk or Care Inspectorate (CI) www.careinspectorate.com

10.1.16 The Provider must share any CQC, HIW or CI inspection reports with the Authority and inform the Authority of any planned inspections.

10.1.17 Appropriate Clinical Governance is of paramount importance to the Authority. As a result, the Provider will have robust mechanisms and processes in place to manage all aspects of Clinical Governance including the management of medicines.

10.1.18 These governance arrangements will cover, but not be limited to, safeguarding, untoward incidents, risk reduction and prevention, dissemination of alerts, training and monitoring of services. Processes will include immediate escalation and notification of events to the Authority commissioner and/or the Accountable Officer for Controlled Drugs in NHSE Regional Team as appropriate.

10.1.19 The Provider must comply with all legislation around the use of controlled drugs and adhere to guidance from the General Medical Council (GMC) and Nursing and Midwifery Council (NMC) as appropriate. Legislation includes:

- 10.1.19.1 The Use of Drugs Act 1971
- 10.1.19.2 Use of Drugs Regulations 2001
- 10.1.19.3 The Health Act 2006
- 10.1.19.4 The Controlled Drugs (Supervision of Management and Use) Regulation 2013

10.1.20 The Provider, where they hold a stock of controlled drugs on the premises, will be expected to have, and comply with, an approved Standing Operating Procedure (SOP). The SOPs must be made available to the NHSE regional Accountable Officer for controlled drugs.

10.1.21 The Provider must ensure they have a Home Office licence to hold stocks of controlled drugs. Arrangements must be in place to manage any delegated possession of the stock of controlled drugs if Doctors or pharmacists are not involved in processes, as only Doctors and pharmacists are legally able to possess controlled drugs unless under arrangements.

10.1.22 The Provider will submit a periodic declaration and self-assessment to the NHSE Regional Accountable Officer for Controlled Drugs (CDAO) as requested by the CDAO.

10.1.23 The Provider is responsible for maintaining a risk register and for ensuring that there are systems in place to bring any strategic risks, or risks to business continuity to the attention of The Authority as soon as these are identified.

10.1.24 The Provider will support and provide appropriate input as required in any emergency situation and/or pandemics.

10.1.25 The Provider will have a defined and accessible incident reporting and management system, which will be clearly outlined in an incident reporting policy. This will be shared with The Authority prior to the Commencement Date.

10.1.26 The Provider must have a clear procedure for the investigation of and procedures to act upon any findings for Serious Reportable Incidents (SRIs).

10.1.27 The Provider is required to report such instances as per the contract within 2 working days of it being discovered; this must be the trigger to investigate the incident. All SRIs need to be reported via the Authority's secure online portal. Part A should be filled out as a minimum. If further investigation is required, Part B must also be filled out. For a fuller description of the SRI process, please see Appendix G in the Contract.

10.1.27.1 Part A: https://clickquestion.lancashire.gov.uk/runQuestionnaire.asp?qid=757254

10.1.27.2 Part B: https://clickquestion.lancashire.gov.uk/runQuestionnaire.asp?qid=757336

10.1.28 The Provider will have a strong internal governance structure and organisational governance plan. This must cover issues including: communication between Service Users/carers/families and staff (including managers and clinicians), communication between staff across the Service, effective reporting mechanisms, client records, service data, incident reporting, health and safety and safeguarding. Such governance arrangements will take into account all current or any future legislation that applies, for example the Data Protection Act (2018).

10.1.29 The Provider will build and maintain high quality governance arrangements with partner/stakeholder agencies including LCC, and other Providers/agencies and the community. A strong partnership of all related agencies and stakeholders will lead to better outcomes for all.

10.1.30 The Provider will have a clearly identified and accessible and compliments procedure and will act on all complaints in complaints a timely manner. All complaints and compliments will be shared with the Authority as part of performance and quality reporting.

10.1.31 The Provider will attend and contribute to the following meeting structures, and others as requested:

10.1.31.1 Contract management

10.1.31.2 Safeguarding boards on request

10.1.31.3 Preventable Harms

10.1.31.4 Service User/recovery forums

10.1.31.5 Partnership meetings such as housing panels, Community Safety Partnership meetings, Recovery partnerships and Health and Wellbeing partnerships or successor meetings.

10.2. Business Continuity

10.2.1 The Provider will report any service impact or disruption of service delivery to the Authority.

10.2.2 The Provider will ensure business continuity in the event of reduction in capacity or any circumstances which may affect service delivery.

10.2.3 The Provider will produce a contingency plan and implement procedures to ensure service delivery is not impacted due to sickness or other absences or any other occurrences.

10.2.4 Minor disruption (1 day) - The Sub-Contractor will assess the severity of the incident and its possible consequences. If the incident is unlikely to escalate, then control of the incident will be undertaken locally.

10.2.5 Medium/short term (2-7days) disruption - Where the incident is deemed to result in minor disruption to the Service, and the incident is unlikely to escalate, the Sub-Contractor will then inform the Head Provider and of the decision to manage the incident locally.

10.2.6 Major/long term (>7 days) disruption - Where the incident is deemed to result in a major/long term disruption to the Service, the Sub-Contractor must inform the Head Provider immediately and convene a meeting to discuss the continuity of the Service.

11. Data Collection, Analysis, and Submission

11.1. Data Collection

11.1.1 The Provider must have a robust case management system for service and Service User management and data collection in place prior to the Commencement Date.

11.1.2 The system must be compliant with NDTMS and the Provider must be familiar with the following:

11.1.2.1 NDTMS Technical Definitions

11.1.2.2 NDTMS Reference Data

11.1.2.3 CSV File Format Specification

11.1.2.4 YP Community Business Definitions

11.1.2.5 Adult Community Business Definitions

11.1.3 The performance data required under this specification and the contract are subject to change by the Authority. The Provider shall comply with any such changes required by the Authority.

11.1.4 The Provider will submit as required to all national datasets (including any new datasets that come into existence during the period of contract) including NDTMS. The Provider must use the Treatment Outcome Profile (TOPS).

11.1.5 Data quality is of paramount importance in the delivery of this contract, and the Provider will achieve the following compliance rates as a minimum:

NDTMS core data set	100% data compliance
TOPS	90% data compliance minimum

11.1.6 The Provider will comply with the PMFs that support this specification; full data compliance is required.

11.1.7 The Provider will ensure that the Service keeps within any national/local targets.

11.1.8 Initial targets and service volumes are subject to change (see Annex 1 for current levels of use).

11.1.9 The Provider will implement distance travelled self-perception questionnaire such as the Outcome Star for each Service User and use it to measure and evidence behaviour change and report accordingly.

11.1.10 The following table shows the Provider's reporting requirements:

Performance Tool	Reporting
NDTMS core data set	Monthly
TOPS	On-going
Self-perception questionnaire e.g,. Outcome Star	Quarterly
PMF	Quarterly
Qualitative Report	Quarterly
Quality framework	Quarterly/Annual compliance reporting

11.1.11 The Provider will be expected to comply with requests for other data from the Authority, who will aim to give a minimum 4 weeks' notice period for such requests. However, in exceptional circumstances the Provider will be required to work with the Authority to produce data as required (including within shorter timescales than the usual 4 weeks).

11.1.12 The Provider will conduct Service User (and carer/family) satisfaction surveys every 12 months for each Service User.

11.1.13 Summaries of the Provider's performance data under the contract may be shared by the Authority to relevant partnership Boards (both internal to the Authority and external bodies) as required to inform other public sector bodies decision making and planning.

11.2. Minimum Data Set Requirements

11.2.1 Section 149 of the Equality Act 2010 sets out the general duty on the Authority (as a public Authority)[1],[2]. In summary, this duty is for the Authority to have due regard to the need to:

- Eliminate unlawful discrimination, harassment and victimisation and any other conduct that is prohibited by the Act.
- Advance equality of opportunity between people who share a relevant protected characteristic (as defined in the Act) and those who don't.
- Foster good relations between people who share a relevant protected characteristic and those who don't.

[1] https://www.legislation.gov.uk/ukpga/2010/15/section/149
[2] https://www.equalityhumanrights.com/en/advice-and-guidance/public-sector-equality-duty

11.2.2 The Provider must ensure that the Services are delivered in compliance with the Equality Act 2010 and provide support as required to enable the Authority to discharge its statutory responsibilities regarding people with relevant protected characteristics outlined in Section 149 of the Equality Act 2010.

11.2.3 The Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 [3], requires the Authority to publish at regular intervals the information required to show that it is meeting its duty under Section 149 of the Equality Act e.g., through Equality Analysis/Impact Assessments. In order to facilitate the Authority's obligation in these respects, there is a requirement for a Minimum Data Set to be submitted which will contain a common set of agreed definitions to enable data aggregation to be undertaken and comparisons to be made.

11.2.4 On this basis:

11.2.4.1 The Provider shall collect, collate and report on a Minimum Data Set that contains relevant protected characteristics as stipulated by the Authority together with residential postcode.

11.2.4.2 The format of the data fields within this Minimum Data Set is outlined in the PMF and, where possible, has been aligned with the NHS Data Model and Dictionary.

11.2.4.3 If individual Service Users do not wish to disclose these details the Provider will formally record 'prefer not to say' for each of these fields.

11.3. Data Analysis

11.3.1 As set out in section 7, it is the responsibility of the Provider to routinely analyse their own performance and develop a performance monitoring report which details current performance against local KPI's, agreed targets, local and national outcomes, and the Quality Assurance Framework (QAF) (See Appendix C in the Contract). This report will be sent to the Authority two weeks prior to each quarterly contract review meeting.

11.3.2 The Authority reserves the right to conduct audits on the Provider or to bring in external auditors to monitor elements of the Service; the Authority reserve the right to conduct such audits without prior notice to the Provider (see contract).

11.4. Data Submission

11.4.1 The Provider will agree an Audit Programme with the Authority as outlined in the QAF.

11.4.2 The Provider will keep an active risk register, to be shared with the Authority regularly.

11.4.3 Line level pseudonymised data (unless there is a significant risk of individual Service Users being identified) will also routinely be made available by the Provider to the Authority to promote population health approaches and/or explore particular issues or challenges raised through the routine performance and quality reporting processes of the Service as and when required.

11.4.4 It is the intention of the Authority to develop automated methods to exchange information between the Authority and the Provider. Once finalised the Provider will be expected to submit data, accordingly, hence minimising the degree of

[3] https://www.legislation.gov.uk/uksi/2017/353/regulation/4/made

manual intervention that is required by either party for example through a web enable API (Application Programme Interface) or FTP (File Transfer Protocol). Any such automated method to exchange data between the Authority and the Provider must:

11.4.4.1 Be secure and compliant to UK Data Protection regulations.

11.4.4.2 Minimise manual intervention – enabling efficiency savings and increased data reliability.

11.4.4.3 Be shared at an agreed frequency.

11.4.4.4 Ensure data is provided in a common format during the contract and any changes are pre-agreed to allow integration and reduce the chance of errors.

11.4.4.5 Be able to cope with change as the Service and data requirement evolve.

11.4.4.6 Be cost effective to implement and operate including costs to manipulate data.

11.4.4.7 Allow reasonable changes to the range of indicators submitted that might be required throughout the life of the contract and for these changes to be absorbed within the current contract value.

11.5. Information, Privacy and Access Issues

11.5.1 The Provider must comply with the Data Protection Act 2018 and the UK General Data Protection Regulations (UK GDPR).

11.5.2 The Provider will comply with all Information Governance standards required by the Authority and the requirements of the Contract.

11.5.3 The Provider must obtain consent from all Service Users regarding the collection, retention, sharing and reporting of data, specifically for the purpose of this Service.

12. Quality

12.1. Contract Management

12.1.1 The Authority will manage this contract via contract management arrangements.

12.1.2 The Provider will keep a risk register for all risk factors relating to this contract, which will be reported to the Authority.

12.1.3 The Provider will be transparent in all areas of contract delivery and provide early warnings with an accompanying action plan for any areas of underperformance, detailed in an assurance framework.

12.1.4 The Provider is expected to fully cooperate with any investigations that partner agencies are undertaking such as serious incidents, serious case reviews including the sharing of appropriate records.

12.1.5 The Provider will manage all budgets associated with this contract and provide 'open book' accounting.

12.1.6 Quarterly Contract Review meetings will be held with the Provider and representatives from The Authority either in person or virtually as appropriate. In instances of on-going remedial action plans or dispute, meetings will be held according to need.

12.1.7 The Contract Review meeting will consider:

12.1.7.1 The effectiveness of delivery for key service elements as set out in this Service specification.

12.1.7.2 Quality and performance based on a range of quantitative and qualitative evidence as outlined in contract appendices.

12.1.7.3 Iterative service developments to meet the support needs of Service Users.

12.1.8 The Provider will nominate appropriate representation at Contract Review meetings and shall identify a member of staff who will provide a single point of contact for the Authority for quality, performance, and service effectiveness issues.

12.2. Performance Oversight

12.2.1 The Provider may be required to provide additional performance information not linked to the formal management of the contract, at the request of the Authority.

12.2.2 Performance reviews will involve a joint approach with the Provider to understanding and interpreting data as an ongoing evaluation process to inform and improve practice and delivery.

12.2.3 The Provider will utilise the Performance Management Framework (PMF) (see Appendix C in the Contract) to report activity.

12.2.4 The Provider will supply a qualitative report detailing events, case studies, impact and developments that are not apparent in the performance reporting template in line with the requirements laid out in the Quality Assurance Framework (QAF).

12.2.5 The performance reporting template and the qualitative report will be submitted quarterly by the Provider to the Authority.

12.2.6 The Provider will evidence engagement with system partners, e.g., the local Substance use Community Treatment Providers.

12.2.7 The Provider will be compliant with the following performance requirements set out in Table 3 below.

Table 3 – Performance Requirements

Performance Indicator	Indicator	Threshold	Method of Measurement	Consequence of breach
Feedback report	A governance and quality review summary, detailing Service Users' feedback from questionnaires issued. There must be evidence of how learning is achieved and shared following Service User /and carer feedback.	95%	Quarterly	
Treatment completeness	Service Users completing Treatment programme / who have a successful transfer (% of all Treatment exits)	95%	Monthly - based on Service User referral	
Care Plan	Service Users with a Care Plan	100%	Monthly - based on Service User referral	
Staff Supervision	Staff who have access to regular staff supervision in accordance with their organisation's HR policies and practices.	100%	Monthly - based on Service User referral	
Audit	NICE standards service audit – by agreement	100%	Annual	

12.3. Key Outcomes

12.3.1 The following outcomes are presented as a way of identifying the broad potential of detoxification Services in supporting broader public health outcomes. The Authority do not expect the Provider to initially report against all these outcomes but wish to work with the Provider to develop a robust mechanism for identifying the key outcomes where detoxification can prove its impact and a reporting framework to capture the relevant outcome data.

12.3.2 Treatment outcomes and KPI's (see PMF, QAF and Service Outcome documents – sections 11 and 12).

12.3.3 The Provider will support Service Users to achieve and maintain long term abstinence.

12.3.4 The Provider will support Service Users to reduce or stop offending behaviour.

12.3.5 The Provider will support Service Users to improve physical health.

12.3.6 The Provider will support Service Users to improve health and wellbeing (Marmot principles, 5 Ways to Health and Wellbeing and the Carers Act).

12.3.7 The Provider will promote Service Users to engage in physical activity.

12.3.8 The Provider will promote Service Users to improve their nutrition.

12.3.9 The Provider will contribute to reducing hospital admissions.

12.3.10 The Provider will facilitate access to smoking cessation services.

12.3.11 The Provider will support Service Users to access Community Treatment Provider for those that fall out of treatment.

12.3.12 The Provider will support Service Users to increase personal resilience.

12.3.13 The Provider will support Service Users to access the Lancashire Recovery community through engagement with the Lancashire Recovery Infrastructure Organisation (RIO) and the Lancashire User Forum (LUF).

12.3.14 The Provider will work with partner organisations to provide information and advice to enable people to plan for their future including ways to meet their ongoing care and support needs.

12.3.15 The Provider will work to Public Health Outcomes, including better health, wellbeing, and relationships, by increasing access to evidence-based Interventions underpinned by National Institute of Clinical Excellence (NICE) guidance and provide robust information sharing post discharge to ensure a continuation of Recovery work.

12.3.16 The Provider will reduce harm within individuals, families, and communities through delivering Interventions that address Substance use and develop Recovery.

12.3.17 The Provider will promote Recovery through integrated treatment with the Community Treatment and recovery system in Lancashire.

13. Public Services (Social Value) Act 2012

13.1 The Provider acknowledges that, under the Public Services (Social Value) Act 2012, the Authority is required to consider how goods, services and works that it procures, improve the economic, social and environmental well-being of the county, and furthermore, that as a matter of procurement policy and practice, the Authority requires any supplier, Provider, consultant or contractor providing goods, services and works to the Authority to use all reasonable endeavours to assist the Authority to improve the economic, social and environmental well-being of the County.

13.2 The Provider must consider the employment needs within their local community when recruiting and selecting staff and as such must give consideration to how their recruitment processes support the local economy in accordance with the Authority's social value framework.

13.3 In accordance with the Authority's social value framework (Social Value Policy Lancashire.gov.uk), the Provider is required to meet the following social value outcomes for the Service:

13.3.1 Promote equity and fairness.

13.3.2 Promote training and employment opportunities for the people of Lancashire.

13.3.3 Build capacity and sustainability of the voluntary and community Sector.

13.4 The Provider will work with the Authority to evidence Social Value from the delivery of the Service. This includes sustainable employment and investment in the workforce with the aim of minimising the use of zero hour contracts and paying the 'Living Wage'. This requirement is referenced in the accompanying QAF and will be evidenced via the quality reports presented quarterly by the Provider to the Authority.

14. Communicable Diseases/Pandemics

14.1 The Provider will operate in line with national and local guidance and legislation concerning communicable disease outbreaks or future pandemics.

14.2 The Provider will develop contingency plans to deal with COVID (or other) outbreaks including how Service Users will be supported to isolate, can individuals isolate or does the Unit need a 'household' approach.

14.3 The Provider will work with Key Partners to ensure supply of food and medicines accordingly.

14.4 The Provider will have an appropriate testing policy in line with best practice and government guidelines.

14.5 The Provider will support system efforts to test and vaccinate as appropriate.

14.6 The Provider will ensure a digital engagement option is available for Service Users and utilise this should further communicable disease/pandemic restrictions come into force.

14.7 The Provider will develop contingency plans to deal with outbreaks and/or pandemics; including how Service Users will be supported to isolate, whether individuals are able to isolate themselves or if co-horting arrangements are required – i.e., a 'household' approach.

14.8 The Provider will support any appropriate testing policy(ies) for communicable diseases (as dictated by national/local guidance) put in place as and when outbreaks or pandemic conditions apply.

14.9 The Provider will support system efforts to test and vaccinate against communicable diseases as appropriate.

15. Policies and Procedures

15.1 The Provider must have an adequate range of evidence-based policies, protocols and strategies in place to deliver a safe and effective service. If they are absent at contract award the Provider must demonstrate steps being taken towards their development and a timetable for delivery, ensuring full compliance prior to the Commencement Date.

15.2 The Provider will share policies, including any relevant updates with The Authority as soon as they are available.

15.3 As a minimum the Provider must evidence the following policies:

15.3.1 Equal opportunities - A clear policy that ensures equal access for all regardless of disability,

gender reassignment, marriage and civil partnership, sex or sexual orientation and race – this includes ethnic or national origins, colour or nationality, religion belief or lack of belief.

15.3.2 Equality and Human Rights Commission (2002) Equality Impact Assessment (EIA) guidance. The Provider will be required to conduct an EIA in accordance with the Equality Act 2010 and EIA Guidance and submit a copy to the Authority prior to the Commencement Date.

15.3.3 Health and safety (staff and Service Users).

15.3.4 Staff training and development (including mandatory NCSCT training and train the trainer programmes).

15.3.5 Safe staffing.

15.3.6 Safeguarding, adults, and children's protocols.

15.3.7 Complaints and compliments

15.3.8 Service User and carer involvement and experience.

15.3.9 Records management.

15.3.10 Risk management.

15.3.11 Information Governance and GDPR.

15.3.12 Confidentiality and Caldicot procedures.

15.3.13 Drugs and alcohol in the workplace.

15.3.14 Human resources.

15.3.15 Exclusion from the Service.

15.4 The Provider must ensure that Service Users and carers are aware of the range of policies which may impact upon their support and be given access to them should they wish to review them; all documents to be available in print and electronic formats.

15.5 All policies will be Equality Impact Assessed (EIA) and evidenced at contract implementation and following policy review.

16. Relevant National Documentation

16.1. Standards

- From Harm to Hope – a 10 year drugs plan to cut crime and saves lives 2021 (From harm to hope: A 10-year drugs plan to cut crime and save lives - GOV.UK (www.gov.uk)
- Modern crime prevention strategy - GOV.UK (www.gov.uk)
- Alcohol strategy - GOV.UK (www.gov.uk)
- Independent review of drugs by Professor Dame Carol Black - GOV.UK (www.gov.uk)
- ACMD. What recovery outcomes does the evidence tell us we can expect? Second report of the Recovery Committee, November 2013

(2013):https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/262629/Second_report_of_the_Recovery_Committee.pdf

- An asset approach to community wellbeing - glass half full | Local Government Association and A glass half-full: 10 years on review | Local Government Association
- Public Health Outcomes Framework for England Public Health Outcomes Framework - GOV.UK (www.gov.uk)
- Alcohol and drug prevention, treatment and recovery: why invest? - GOV.UK (www.gov.uk)
- Lancashire Health and wellbeing strategy: lancashire-health-and-wellbeing-strategy.pdf
- Lancashire Director of Public Report 2019/20. Report of the Director of Public Health 2019/20 (lancashire.gov.uk
- The Principles of Behaviour Change Communications, Government Communication Service. The Principles of Behaviour Change Communications - GCS (civilservice.gov.uk)
- Granfield and Cloud 2001 (Granfield, R. and Cloud, W. (2001) Social Context and "Natural Recovery": The Role of Social Capital in the Resolution of Drug-Associated Problems, Substance Use and Misuse, Vol. 36, pp1543-1570) describe four main enablers of recovery
- Fair Society Healthy Lives (The Marmot Review) - IHE (instituteofhealthequity.org) and Health Equity in England: The Marmot Review 10 Years On - The Health Foundation
- What good looks like – supporting high quality in Alcohol and Drug Prevention and Treatment ADPH What Good Looks Like - ADPH

16.2. Evidence base

- Abulrahim D & Bowden-Jones O, on behalf of the NEPTUNE Expert Group. Guidance on the Management of Acute and Chronic Harms of Club Drugs and Novel Psychoactive Substances. Novel Psychoactive Treatment UK Network (NEPTUNE.) London (2015)
- Care Quality Commission (CQC), Brief guide: Substance misuse services – detoxification or withdrawal from drugs or alcohol (2016)
- Public Health England, Quality governance guidance for local Authority commissioners of alcohol and drug services (2015)
- Royal College of Psychiatrists CR173 Delivering quality care for drug and alcohol users; the roles and competencies of Doctors (Sept 2012)

16.3. NICE Guidance

- NICE Guideline CG115 "Alcohol-use disorders: diagnosis, assessment and management of harmful drinking (high-risk drinking) and alcohol dependence "(2011) https://www.nice.org.uk/guidance/cg115
- NICE Guideline CG100 "Alcohol-use disorders: diagnosis and management of physical complications" (2017) https://www.nice.org.uk/guidance/cg100
- NICE Guideline CG120 "Coexisting severe mental illness (psychosis) and Substance misuse: assessment and management in healthcare settings" (2011) https://www.nice.org.uk/guidance/cg120
- NICE Guideline CG52 "Drug misuse in over 16s: opioid detoxification" (2007) https://www.nice.org.uk/guidance/cg52

- NICE Evidence Summary ES19 "Opioid dependence: buprenorphine prolonged release injection (Buvidal)" 2019 https://nice.org.uk/advice/es19
- NICE Guideline CG 51 “Drug misuse: Psychosocial Interventions” (2007)
- NICE Quality Standard 23 “Drug use disorders in adults” (2012)
- NICE Guideline TA115 “Naltrexone for the management of opioid dependence” (2007) https://www.nice.org.uk/guidance/ta115
- NICE Guideline TA114 “Methadone and buprenorphine for the management of opioid dependence” (2007) https://www.nice.org.uk/guidance/ta114
- NICE Guideline 58 "Co-existing severe mental illness and Substance misuse: community health and social care services" 2016 https://www.nice.org.uk/guidance/ng58
- NICE Guideline NG214 "Integrated health and social care for people experiencing homelessness" 2022 https://www.nice.org.uk/guidance/ng214

17. Annexes

Annex 1 - Treatment and Recovery Background

1. Numbers in treatment

	2019/2020	2020/2021	2021/2022	2022/2023
Total	5,678	6,054	6,119	6,297

1.2 Number of IPD placements per year

	Managed	Monitored	Total
20/21	161	25	186
21/22	194	11	205
22/23	290	42	332

2. New presentations to treatment

	2019/2020	2020/2021	2021/2022	2022/2023
18-29	459	465	451	491
30-49	1,414	1,523	1,495	1,617
50+	592	612	602	641
Total	2,465	2,600	2,548	2,749

The main sources of referrals were Self, family and friends, health services and social care, criminal justice, Substance misuse services and other. The trend has remained stable throughout all reporting periods and mirrors the national picture.

3. Treatment completed/retained for 12 weeks or more

	2020-21	**2021-22**	**2022-23**
Opiate	97.60%	96.70%	96.20%
Non-opiate only	94.40%	91.10%	87%

Alcohol only	87.90%	89.20%	92%

4. Main drug of choice

Drug of choice	2020/2021	2021/2022	2022/2023
	1. Alcohol 2. Opiates 3. Cannabis 4. Cocaine 5. Crack 6. Benzodiazepines 7. Amphetamines 8. Hallucinogens 9. Prescription drugs 10. Ecstasy 11. Other (exc NPS) 12. NPS 13. Solvents	1. Opiates 2. Alcohol 3. Cannabis 4. Cocaine 5. Crack 6. Benzodiazepines Amphetamines 7. Hallucinogens 8. Other (exc NPS) 9. Prescription drugs 10. Anti-depressants 11. NPS 12. Ecstasy 13. Solvents	1. Alcohol 2. Opiates 3. Cannabis 4. Cocaine 5. Crack 6. Hallucinogens 7. Amphetamines 8. Benzodiazepines 9. Other (exc NPS) 10. Ecstasy 11. Anti-depressants 12. NPS 13. Prescription drugs 14. Solvents

Polydrug use remains a prevalent trend across all time periods with opiates and crack cocaine use being the primary form (benzodiazepines and cannabis also used in conjunction with opiates) and alcohol and cocaine use being secondary (cannabis also used in conjunction with alcohol).

5. Treatment completion

In Lancashire in 2022/2023, circa 44% of alcohol only and 36% of alcohol and non-opiate Service Users completed treatment. Circa 5% of opiate users and 35% of non-opiate users completed treatment.

6. Protected characteristics

In 2022-23 the majority of Service Users accessing drug treatment are male, circa 65%. The predominant age group is 45-49 years old and circa 88% describe their ethnicity as White-British. Approximately 37% report having a disability, the top 3 stated as "Behaviour and emotional", followed by "Mobility and gross motor" and "Progressive conditions and physical health".

7. Parental status

Of all Service Users accessing Substance misuse support in 2022-23, circa 28% are parents and approximately 33% of those had all children residing with them and 4.7% had some children living with them. Of those parents who had children living with them, circa 12% were subject to a child protection plan. The approximate rate of pregnancy for all females starting a new treatment journey is 1.5%.

8. Support for wider needs

Of all Service Users in treatment in 2022-23, additional Interventions were offered to support education and training (3.4%), housing support (8.1%), family support (7.9%), parenting support (2.6%) and smoking cessation (4.1%) which were higher than the national average.

9. Mental health

In 2022/23, circa 76% starting a new treatment journey had a mental health treatment need identified, with 62% of that cohort accessing treatment from their GP.

Annex 2 – Pan-Lancashire Detox Referral Form

Name of Service Provider	
Name of Community Treatment Service / Authority	Inspire North and Central Lancashire
Referrer contact number/ email address	All correspondence to: InspireIPD@cgl.org.uk
Date referral received	
Clinic / assessment date	
Medically Monitored / Managed	
Please specify reason for admission / Treatment and Recovery Plan	**Priority** ☐ Drug detox only ☐ Alcohol detox only ☐ Alcohol & drug detox ☐ Stabilisation of alcohol, opiate, crack / cocaine, amphetamine, benzodiazepine, other ☐ Dual diagnosis assessment ☐ Other ☐
Proposed length of Stay	
Please specify any identified complex issues that may indicate a possible higher risk in patient detox	
Please specify if there is requirement to remain on any prescribed medication such as Diazepam or other drug	
Who prescribes this medication:	
General Practitioner Name, Address & Contact details	
Pharmacy Name, Address & Contact details	

Please confirm that an up-to-date RISK ASSESSMENT has been provided with this application	Yes ☐ No ☐

PAN LANCASHIRE INPATIENT DETOX PROVIDER REFERRAL FORM

Please continue with referral form. The additional Information sheet at the end of the referral form can be utilised for any further comments / concerns / issues (please use headings) the referrer might wish to make which could benefit the Service Provider's knowledge and understanding of the Service User's needs and therefore promote a successful Treatment and Recovery Plan.

SERVICE USERS SIGNATURE IS REQUIRED

Confidentiality and Information Sharing

All the Substance Misuse Providers aim to offer a confidential service. If we need to speak to other professionals outside this service, we will always seek your permission. There are exceptions when this confidentiality may need to be broken, these being: if we believe you are a risk to yourself or others or if we are concerned a child may be vulnerable or at risk. If you are subject to an alcohol or drugs rehabilitation requirement under a court order, there are information sharing arrangements which you would have to agree to.

Service User's Name:

Service User's Signature ..... …….. (to be signed on admission)

Date:

PLEASE ENTER SERVICE USER'S NAME IN THIS SECTION AND ENSURE THIS IS UNDERSTOOD PRIOR TO SENDING REFERRAL. SIGNATURES WILL BE REQUIRED ON ADMISSION.

SERVICE USER DETAILS			
NHS Number		Title	
Full Name		Date of Birth	
Gender		Registered Disabled	Yes ☐ No ☐
Preferred Language		Religion	
Ethnicity		Country of Birth	
Marital Status			
Sexuality		Contact Address inc. postcode	

SERVICE USER DETAILS			
Contact tel. & emergency contact tel.		Employment Status	Employed ☐ Unemployed ☐
Dietary Needs e.g., Kosher, Muslim, Vegetarian		Spiritual needs/requirements (e.g., prayer times, worship):	
Please specify if service user has any special needs	Mental health and or physical health disabilities Learning disability ☐ Literacy / numeracy need ☐ Any related transport requirements for attendance at detox unit ☐ Financial /transport concerns in relation to units outside of Lancashire and local surrounding area ☐ Other: ☐	Please specify if Service User has any known allergies	

NEXT OF KIN DETAILS			
Name		Relationship	
Address inc. postcode		Tel Number	
Are they aware of this referral and reasons for admission? Yes ☐ No ☐			

SOCIAL SITUATION			
Is the service user's accommodation stable?		Please provide details of person/ persons the Service User lives with, i.e., friends, partner etc	
Following in-service user treatment what address would the service user return		Does the service user have any dependent children under 16?	Yes ☐ No ☐
If yes, please provide details	Name	M/F	Date of birth
What are the childcare arrangements during admission?		Are social services involved?	Yes ☐ No ☐
If yes social worker name & contact details			

SUBSTANCE MISUSE INFORMATION			
Has the service user been tested for BBV?	Yes ☐ No ☐	If yes what tests have been taken?	
Date and result of each test			
Has the service user been vaccinated against HEP B?	Yes ☐ No ☐	If yes what was the date?	

The Community Treatment Provider has advised that the following service would be suitable for the Service User:	
Medically Managed	
Medically Monitored	
The Provider has agreed with this assessment:	Yes/No

OTHERS INVOLVED i.e., Social Worker, CPN, Psychiatrist, Health, Support Worker, Midwife, Other:		
Name	Service	Telephone Number
RATIONALE FOR REFERRAL / REASON WHY COMMUNITY SERVICES ARE NOT APPROPRIATE		

CURRENT ALCOHOL USE			
Alcohol Units Daily		Continuous binge drinking	
Daily drinking pattern/include strength % ABV			
HISTORY OF WITHDRAWAL SYMPTOMS AND PREVIOUS PROBLEMS			

Please detail history of DTs, fits or seizures, withdrawal symptoms, any recent LFTs and any other serious physical issues.			
INJECTING HISTORY			
Does the service user currently inject?	Yes ☐ No ☐	Where? Highlight as appropriate	Arms ☐ Legs ☐ Hands ☐ Feet ☐ Groin ☐ Neck ☐
Does the service user currently share injecting equipment?	Yes ☐ No ☐	Has the client ever shared injecting equipment?	Yes ☐ No ☐
Please detail injection related problems			

DRUG USING HISTORY & PREVIOUS TREATMENT - including periods of abstinence, triggers to relapse etc:					
CURRENT DRUG USE Yes ☐ No ☐ If YES, please include prescribed medication and specify in order of dependence					
Substance	**Amount**	**Frequency**	**Route**	**Prescribed by**	**Non-Prescribed**

PHYSICAL HEALTH			
Has the Service User any health issues? Include dietary and sleep concerns if relevant:			
Has Service User been screened for Chlamydia?	Yes ☐ No ☐	Is Service User Pregnant?	Yes ☐ No ☐ If yes how many weeks?
Ante Natal Care – please specify		Midwife contact details	

Please ensure pregnancy notes are included with referral

PSYCHIATRIC HISTORY			
Please identify any current / previous mental health needs / problems - including self-harm / suicidal idealisation. Please also identify if Service User has had a dual diagnosis?			
Is Service User receiving care from Mental Health Services for reason other than substance misuse?	Yes ☐ No ☐	Does Service User have CPA? Please forward current CPA documentation, if any.	

LIFE HISTORY/SIGNIFICANT EVENTS
Please provide details of family background, childhood experiences, schooling, adult relationships, support networks, contact with parents and siblings, and identify if any drug/alcohol misuse within family
*Under the Mental Health National Guidance on Safeguarding please confirm if Service User has ever experienced any physical, sexual, or emotional abuse at any time in their life. If yes, please detail:

LIFE HISTORY/SIGNIFICANT EVENTS

FORENSIC LEGAL SITUATION	
Has the Service User any forensic history i.e. • Convictions / prison sentences • Violent offences • Arson • Pending court cases - nature of offence and dates of Court Hearing • Security Tags Please provide as much information as possible	

PREPARATIONS FOR TREATMENT
What preparations has the Service User made to date? Please give details regarding attendance at pre detox groups, attending abstinence groups, peer support groups, completion of ITEP mapping.
Evidence of stability on prescribed medication / reduced stopped illicit use / reduction in alcohol consumption

DISCHARGE PLANS (Please identify and specify for both planned and unplanned)

Is client expected to return home?	Yes ☐ No ☐	If yes, will client be alone?	Yes ☐ No ☐
To using partner or using others?	Lives alone.	Is aftercare in place?	Yes ☐ No ☐
If yes, please specify	Day care ☐ Residential ☐ Other ☐		
CONTINGENCY PLAN			

RISK ASSESSMENT – current up to date risk assessment to be included however, please summarise any risk identified in the following areas: self, others, serious neglect, vulnerability.
ADDITONAL INFORMATION

PLEASE NOTIFY THE ADMISSIONS TEAM OF ANY CHANGES IN YOUR SERVICE USERS CIRCUMSTANCES.

We regret to inform you that your referral may be delayed if this form is incomplete. We appreciate your support in providing comprehensive information, which is essential in providing the most appropriate treatment and care to your client.

Many Thanks

Annex 3 – Referral Process

1) Prior to referral, the CTP must assess the physical and mental health needs of the Service User, their readiness to engage in detoxification, and will have prepared the Service User to engage in a Residential Detoxification Treatment Programme (please see section 4.1.2 of the service specification).
2) The CTP, in conjunction with the Service User, will identify the most appropriate Detoxification Provider on the PDPS based on their health and social care needs.
3) In the event that a suitable Provider cannot be identified from the PDPS Providers, the Relevant authority reserves the right to contract with a Provider for the Services outside of the PDPS.
4) The CTP will complete the Pan Lancashire Detox Referral Form and send to the identified Provider via Email (or other mechanism as agreed). The Provider must ensure the Pan Lancashire Detox Referral Form is fully completed by the CTP. Part

of this process can include the Provider contacting the Service User for further information to establish if they can meet their needs.

5) The Provider will confirm via telephone to the CTP their decision for acceptance or non-acceptance of the referral of the Service User within 5 working days.
6) In the event that the chosen Provider does not accept the referral the Referrer will start the process again at point 2.
7) The Provider and the CTP will use the information from the Pan Lancashire Detox Referral Form to formulate and agree a Treatment and Recovery Plan including the anticipated length of stay and category for admission (e.g. emergency, priority, or routine).
8) The Relevant authority will need to agree the funding for the Service before the Service can commence.
9) The CTP will inform the Service User of their acceptance. The CTP and the Provider will prepare the Service User for admission to the Detoxification Unit (including making arrangements for transport).
10) The Service User will be admitted to the Detoxification Unit.
11) The Provider will assess the Service User and review, update, and implement the Treatment and Recovery Plan (please see section 4.1.4 of the Service Specification).
12) The Provider will undertake regular re-assessments and reviews of the **Treatment and Recovery Plan**.
13) The Provider will make every effort to retain the Service User in treatment for the duration of the Detoxification Programme. The Provider will inform the CTP of the likelihood of a placement breaking down as soon as possible (please refer to section 4.1.7 of the service specification).

The Provider will discharge the Service User to either community care via the CTP and/or will work with any aftercare providers (e.g. Residential Rehabilitation Unit) to facilitate the onward referral of the Service User where appropriate (please refer to section 4.1 of the service specification).