Lancashire County Council

Lancashire Specialist Substance Use Rehabilitation Services

Service Specification

May 2024

Definitions

Term	Definition
5 Ways to Health and Wellbeing	1. Connect: Build and maintain positive relationships with others. 2. Be active: Look for ways to be active everyday and enjoy the benefits of physical activity. 3. Take notice: Be aware of the world around you and what you are feeling, and appreciate the present moment. 4. Keep learning: Try something new, learn new skills, or expand your knowledge and interests. 5. Give: Giving to others is good for you, and can be as simple as a smile, a thank you, or a kind word.
Adverse Childhood Experiences (ACEs)	Adverse Childhood Experiences (ACEs) are "highly stressful, and potentially traumatic, events or situations that occur during childhood and/or adolescence. They can be a single event, or prolonged threats to, and breaches of, the young person's safety, security, trust or bodily integrity." (Young Minds, 2018).
Assessment and Access plan	A plan that describes an individual Service Users level of educational attainment and aptitude.
Authority Footprint	This covers the 12 districts that comprise of the Lancashire County Council area.
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.
Community Treatment Provider	The local community Substance use Treatment Provider for the Service User's home area.
Complex Needs	Service users who have physical and/or psychological dependency on one or more Substances with physical or psychiatric complications (co-morbidity).
Contract Review Meetings	Quarterly meetings held between representatives of The Authority and the Provider to review performance data, contract variations, commissioning intentions for the purpose of contract management.
Discharge Plan	A personalised plan developed by the Provider for a Service User leaving the Service. It is a collaborative process that involves the Service User, the caregiver, and the Discharge Planner.
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)
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 who works for the Provider? assigned to a Service User.
MHA	The Mental Health Act 1983
Motivational Interviewing	Counselling approach to help people find the motivation to make a positive behaviour change.
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

Non-Residential Programmes	Service Users who are attending daily Rehabilitation Programmes that come in various forms and varying intensity levels and provide an array of Services, with the main focus being on group work and psychosocial Interventions.
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
PMF	Performance Management Framework
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.
Recovery	Recovery is defined as a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. It can and does include people who pursue abstinence but is not restricted to that goal.
Recovery Capital	The concept of Recovery Capital reflects a shift in focus from the pathology of addiction to a focus on the internal and external assets required to initiate and sustain long-term Recovery from alcohol and other drug problems.
Regular Reviews	Reviews that take place periodically to understand progress through Treatment based on Service User need and the Provider model.
Referrer	The person who refers the Service User to the Service, the Referrer, will be a social worker employed by Lancashire County Council.
Rehabilitation Programme	Services and Interventions delivered by the Provider to support Service Users to rehabilitate
Residential Programme	The provision by a Provider of a residential unit with staff supervision for people who need accommodating within a structured residential Rehabilitation Programme.
Secure Estate	Prisons
Service	The Specialist Rehabilitation 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
Specialist Rehabilitation Service	Residential rehabilitative Treatment provides a safe environment, a daily structure, multiple Interventions and can support Recovery in some people with drug use disorders who have not benefitted from other Treatment options (NICE, Quality Standard QS23)
Substance/Substances	Including but not limited to Alcohol, Illicit drugs, New psychoactive Substances (NPS), Problematic use of prescription/over the counter medicines.
Support Plan	A Support Plan is a document held by Adult Social Care that explains what a Service User wants to change about their life, what is important to them, and what sort of care and support they need to live their life.
Staff	People employed or who volunteer for a Provider.
The Authority	Lancashire County Council
Therapeutic Programme	Services and Interventions that aim to help individuals living with mental illnesses.
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 Care Plan	A plan agreed with a Service User for what they wish to address in their treatment and recovery, and how.

Transfer Plan	A plan to transfer an individual Service User from one Provider to another.
Unplanned Discharge	The unplanned release of a Service User from the Service.
Unit	Where the Service is delivered from

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's 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 Recovery-orientated rehabilitation Services for people who have experienced problematic dependant Substance use and require dedicated and specialist support either through residential or daily attendance in specialist rehabilitation Services.

1.1.5 Specialist rehabilitation Service provision can provide effective responses to Substance use in treating people with long term dependency, and people with Complex Needs who may have other co-existing physical and/or mental health needs. These Services are delivered in settings where illicit drug and/or alcohol use is not permitted. It enables Substance users to move towards long-term abstinence when and where appropriate. Specialist rehabilitation Service provision may also have an important role to play in diverting individuals away from long-term Substance using careers by intervening early.

1.1.6 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 ensuring that they achieve 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 Specialist Rehabilitation Service. This Service has an important role to play in diverting individuals away from long-term Substance use by enabling Substance users to move towards Recovery and long-term abstinence.

1.2.2 Delivery of Specialist Rehabilitation is intended to change behaviour, improve health, and deliver positive outcomes for individuals, families and communities affected by Substance use.

1.2.3 The overall objectives of this Service are:

1.2.3.1 To assist drug and alcohol users who wish to abstain from using illicit drugs and alcohol.

1.2.3.2 To assist the Service Users to remain healthy and achieve a drug/alcohol-free life.

1.2.3.3 To assist the Service Users to identify and achieve their Recovery goals.

1.2.3.4 To maximise Treatment gains and enable re-integration into local communities.

1.2.3.5 To improve overall personal, social and family functioning.

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 Service Users, 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 of the Specification.

1.3.12 This evidence forms the bedrock on which we will build a high quality, Recovery-focused Treatment system and will underpin Provider of Specialist rehabilitation and detoxification Services.

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 Office for Health Improvement and Disparities (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.

1.4.5 Following the 2021 National Drug Strategy, The Authority has received several grants to support more individuals into Substance use Treatment. For 2024/2025, The Authority has allocated £138,163 from one of these grants towards funding residential rehabilitation placements. However, this allocation is specific to those Service Users in contact with the criminal justice system only. It is also yet to be confirmed by the Government whether this grant funding will continue beyond 2024/2025.

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 6,119 adults were in Treatment for Substance use in 2021/22. Of these, 289 attended Rehabilitation Programmes with 234 attending residential and 55 attending as day participants.

1.5.3 In Lancashire in 2021-22, hospital admissions for alcohol specific conditions were significantly higher than the England rate (DSR (directly standardised rate) for Lancashire was 749/100,000 compared to 626/100,000 for England). The rate of hospital admissions for alcohol related conditions is similar to England (DSR was 487/100,000 for Lancashire and 494/100,000 for England).

1.5.4 Lancashire recorded 654 hospital admissions due to drug poisoning for all ages (crude rate of 53.3 per 100,000 residents), for the period 2020-21. This was similar to the England rate of 50.2 per 100,000 residents.

1.5.5 In Lancashire, there is estimated to be 14,364 individuals of all ages with alcohol dependency. 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 number of individuals in Treatment across all drug groups have increased by 2.8% from 2021/22 to 2022/23. Of particular note, there 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 was 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.

1.5.13 For indicative demand for residential and non-residential services, please refer to Annex 1 (section 17 of the service specification).

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 engage with Key Partners across Lancashire (see section 5.2 for 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 The Provider 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 Substance use Community Treatment Provider.

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.

2.1.11 Lancashire seeks to build strong and effective working relationships and cultural alignment between other Providers including Detoxification Service Providers, Rehabilitation Programme Providers, the Community Treatment Provider, community Services and the Recovery community with shared values and vision regarding the delivery of Services to meet the needs of individuals/Service Users and their families.

2.1.12 Rehabilitation is an essential process that works to develop personal Recovery Capital. The Provider must evidence outcomes of the Service User's improvements and development in the following areas: Recovery, lifestyle and maintenance divided into 5 modalities.

Figure 1 – Elements to maintain Recovery

Maintaining Recovery	•Avoiding triggers and stress •Outcomes: Evidencing impact of Provider (signposting/facilitating)
Training & Development	•Assessment and Access Plan (as a minimum address basic numeracy and literacy) •Outcomes: Increased number of those accessing education and training
Volunteering & Employability	•Facilitating opportunities •Outcomes: Liaising with local Services within the community. Increased number of people volunteering/engaging with local Services
Five ways to Health & Wellbeing	• Connect, Be Active, Take Notice, Keep Learning and Give •Outcomes: Demonstrating and evaluating how Service Providers have engaged with the 5 ways to wellbeing
Life Skills	•communication, negotiation skills, Personal skills – managing with stress, building self-esteem, Literacy, numeracy, personal presentation and appearance. Cooking, managing money, paying bills. •Outcomes: Document change of Service User aiming to address the above i.e. accessing specific Services.

2.2. Deliverables

2.2.1 The Provider will deliver a Specialist Rehabilitation Service to the eligible population identified at section 5.1 of the Service Specification. In partnership with The Authority's social work staff, the Provider will ensure the timely placement of Service Users in Rehabilitation Programmes appropriate to Service User need.

2.2.2 The Provider will deliver a model which meets the requirements of this specification, which includes two strands of Service delivery:

2.2.2.1 Strand 1: Level 1 – Core Interventions

2.2.2.2 Strand 2: Level 2 – Enhanced Interventions

2.2.3 The Provider will work with The Authority to develop and define delivery in line with the two strands (please see sections 4.3 and 4.4 of this Service specification) within the first 6 months of the Agreement.

2.2.4 The Provider will deliver a Rehabilitation Programme that addresses Service User needs within a 3–6-month period.

2.2.5 The Service Provider can be based anywhere in the mainland UK but close proximity to Lancashire is likely to be more appealing to Service Users.

2.2.6 The Provider will ensure a safe, supportive, and enabling environment that both encourages and supports Service Users (many of which may be termed vulnerable individuals) to overcome their dependency on Substances.

2.2.7 The Provider must deliver a recognised Rehabilitation model (please refer to Guidance-on-Residential-Rehab-and-Inpatient-Detox.pdf (adph.org.uk) and Drug misuse and dependence (publishing.service.gov.uk) for further information). This can include but is not limited to:

2.2.7.1 12-step

2.2.7.2 Therapeutic community.

2.2.7.3 Cognitive behavioural therapy.

2.2.7.4 Personal and skills development.

2.2.7.5 Eclectic/Integrated

2.2.8 Some Rehabilitation Programmes may target specific groups of Service Users and provide programmes tailored to the needs of that group i.e., drug using pregnant women, Service Users with severe and enduring mental illness, families, and drug/alcohol users in crisis.

2.2.9 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.

2.2.10 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).

2.2.11 The Provider will work with Service Users to maximise strengths, develop assets and build resilience and sustainable outcomes. This will require a focus on behaviour change and the building of Recovery Capital. Recovery Capital is comprised of the following key elements:

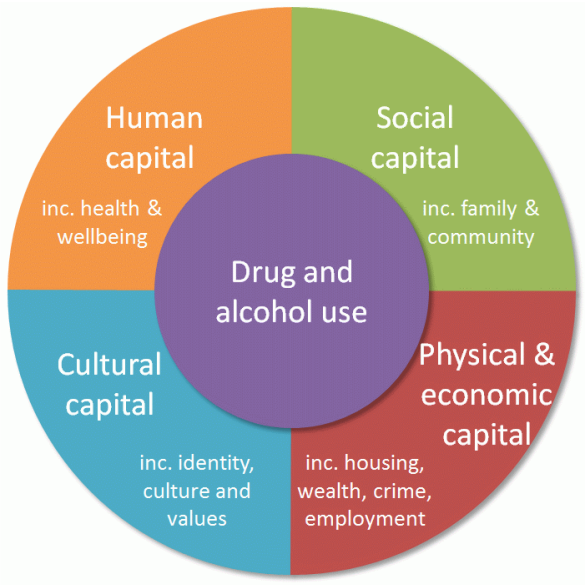

Figure 3. ACMD. What Recovery outcomes does the evidence tell us we can expect. 2013

"Recovery is a process which involves achieving or maintaining outcomes in a number of domains, not just overcoming dependence on drugs or alcohol. People generally are not able to sustain drug and alcohol outcomes without having gained or maintained Recovery Capital in other domains such as having positive relationships, having a sense of wellbeing, meaningful occupation of their time, adequate housing, etc."
(ACMD. "What Recovery outcomes does the evidence tell us we can expect? Second report of the Recovery Committee", November 2013)

2.2.12 The Providers Rehabilitation Programme will deliver a resilience focussed approach that will enable individuals to:

- 2.2.12.1 Understand and manage feelings and emotions.
- 2.2.12.2 Develop coping skills to deal with emotions.
- 2.2.12.3 Improve problem solving skills to support daily living.
- 2.2.12.4 Improve self-efficacy.
- 2.2.12.5 Develop skills to reduce the avoidance of problems.
- 2.2.12.6 Develop Interventions to build and sustain confidence.

2.2.13 The Provider will work collaboratively as part of the Lancashire Public Health Coalition (see section 8.1 for more detail).

2.2.14 The Provider must comply with all requirements stipulated in appendix H: information provision. Part b – data processor agreement of the contract.

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) in The Authority's Footprint age 18 years 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 24 hour staffed residential rehabilitation.
- 3.2.1.2 None 24 hour staffed residential rehabilitation.
- 3.2.1.3 Non-residential day case unit (excluding provision already delivered by the Community Treatment Provider)

3.2.2 The Provider must work collaboratively with the Referrer and/or Detoxification Service Provider to ensure that appropriate Transfer Plans and transport arrangements are in place for the Service User to travel to and from the Service.

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

3.2.4 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.

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

3.2.6 The Provider's premises used for the Service will be accessible from the referring area and must be:

3.2.6.1 Manageable for Service Users who need to travel alone.

3.2.6.2 Accessible by public transport.

3.2.7 All premises used for Service delivery will meet the statutory buildings requirements, be suitably furnished, and have refreshment facilities.

3.2.8 The Provider must ensure that the premises:

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

3.2.8.2 Comply with any relevant regulations.

3.3. Days, Opening Hours, and Contact Details

3.3.1 The Residential Programme will run for 7 days per week (including structured leisure activities and attendance at Mutual Aid groups (with a provision for weekends and evenings).

3.3.2 Non-Residential Programmes are structured Core Interventions (see section 4.3 for Core Interventions and section 4.4 for Enhanced Interventions) that run over 5 days (Monday to Friday) and support Service User access to structured leisure and Mutual Aid.

3.3.3 In some circumstances, individual Service Users may attend Rehabilitation Programmes on a part-time basis. For example, a parent with caring responsibilities.

3.3.4 Telephone access to the Service and internet-based information will be available at all times. As a minimum, the Service will be contactable during normal office Hours 9am-5pm Monday - Friday. A recorded message and signposting to digital support must be available Out of Hours (specified Out of Hours varies between different Provider) Out of Hours must not exceed 5pm – 9am Monday to Friday.

3.3.5 Any closures or changes to Opening Hours must be agreed with The Authority.

3.3.6 The Provider will ensure that any changes to Opening Hours will be clearly communicated with Service Users and relevant Key Partners in a timely manner.

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

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

4. Service Scope

4.1. Treatment Pathway Description

4.1.1 According to 'Models of care for Treatment of adult drug users: Update 2006' (NTA), Specialist rehabilitation Interventions will include provision of residential specialised drug Treatment, which is care planned and care coordinated to ensure continuity of care and aftercare. For a summary of the referral and Treatment pathway, please refer to Annex 3

4.1.2 Referral Routes

4.1.2.1 The Provider will ensure that there are no barriers to access, the Provider will as a minimum accommodate people with disabilities, and support people to overcoming travel issues and language barriers when accessing the Service.

4.1.2.2 The Provider will work with Lancashire County Council social workers and any other staff making referrals to provide them with training on referral into the Service.

4.1.2.3 The Provider must work flexibly with the Referrer and give confirmation of acceptance or non-acceptance within 5 working days to the Referrer. In the case of non-acceptance, the Provider must give a full explanation of the reasons why in writing via email and provide details of the reasons for declined referrals to the nominated person from The Authority. This information will also be included within the quarterly report on activity (Please refer to Appendix C of the Contract).

4.1.2.4 As part of the referral process, representatives of The Authority will:

4.1.2.4.1 Undertake Service User assessments for care and support in line with the Care Act 2014 (including a financial assessment)

4.1.2.4.2 Complete a comprehensive assessment of Service Users covering a range of domains including: physical and mental health, social needs, safeguarding (children and vulnerable adults), offending history.

4.1.2.4.3 Identify potential risks to the Service User or others i.e., other users of the Service and staff.

4.1.2.4.4 Assess motivation and readiness for Treatment, and work with Service Users to explore Treatment options and make an informed choice whilst identifying the most appropriate placement.

4.1.2.4.5 Work with Service Users to develop a Treatment and Recovery Plan containing both Recovery and aftercare elements ensuring housing needs are addressed.

4.1.2.4.6 Send the assessment information and Treatment and Recovery Plans to the Provider as part of the referral process.

4.1.2.4.7 Work with other appropriate community substance use treatment staff including those who work for/with the Community Treatment Provider, to support the Service User to prepare for admission to the Service. This must include input from the Provider where appropriate.

4.1.2.4.8 Work with the Referrer and the Service User to plan for travel to the Service, including making the most appropriate arrangements for transport and/or travel costs.

4.1.2.4.9 Inform the Provider of any relevant changes in the Service User's current circumstances including, but not limited to, the Service User's availability for admission.

4.1.2.4.10 Make arrangements for the Service User on discharge, including the provision of aftercare in collaboration with the Provider where appropriate. This includes ensuring that assessments for aftercare support and Interventions in the community are undertaken and working with Provider on departure planning prior to the end of a placement.

4.1.2.4.11 Support the Provider in gathering Service User feedback following discharge.

4.1.2.5 If the Provider provides transport for the Service User to travel to its Rehabilitation facility, the Provider is responsible for ensuring that the Service User is transported safely. This will mean that the Provider:

4.1.2.5.1 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.

4.1.2.5.2 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.

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

4.1.2.6 The Provider must inform the Referrer if a Service User does not engage with their Rehabilitation Programme, and if there are any identified underlying issues. The Provider will liaise with the Referrer about appropriate responses in collaboration with the Service User. In cases of Unplanned Discharge (including Service Users absconding from the Service), the Provider must inform the Referrer at the earliest possible opportunity, including informing

during Out of Hours if required. As of December 2023, the number for Out of Hours adult social care is 0300 123 6720. The Provider must periodically check this number is active. If not, the Provider must contact The Authority for a replacement contact number.

4.1.2.7 In all circumstances, a risk management approach will be followed for Unplanned Discharges.

4.1.3 Pre-Admission Assessment

4.1.3.1 The Provider will work with representatives of The Authority and/or other Service Providers including Specialist Rehabilitation Service and/or Detoxification Service Providers and the Community Treatment Provider to undertake pre-admission assessments that cover a range of domains including physical, psychological, social, and forensic problems. The assessment will follow a motivational counselling approach and identify potential Treatment outcomes for the Service User.

4.1.3.2 The Provider will ensure Service Users engage with the required pre-admission assessments. As a minimum, the Provider will:

4.1.3.2.1 Provide a description of the service model to the Service User and the Referrers prior to admission.

This information allows Service Users and Referrers to make informed decisions about the suitability of the Rehabilitation Programme and may reduce the likelihood of unplanned discharge. This supports Service User choice.

4.1.3.2.2 Explain the house rules and expectations (e.g., digital access restrictions).

4.1.3.2.3 Provide a review of all rehabilitation options available to the Service User.

4.1.3.2.4 Provide pre-admission introductions which could include in-person visit, virtual tour of sites, introduction to staff members and peer support.

The Provider must ensure they provide high quality accessible information to prospective Service Users including the Service offered, and referral, admission, and discharge arrangements.

4.1.2.4.5 Facilitate assessment and arrangements in respect of safeguarding children and vulnerable adults and alert the appropriate Authority if any concerns arise.

4.1.4 Care Coordination

4.1.4.1 The Provider is responsible for delivering Therapeutic Programmes that support the outcomes defined in the Service User's Treatment and Recovery Plan. For example, this may include gender specific group work.

4.1.4.2 The care planning process must be completed upon admission and be clearly documented in a written format, include outcome targets, Service User induction process, code of conduct and behavioural boundaries for both the Service User and Provider.

4.1.4.3 The Provider must ensure that the Service User understands what is expected of them. Rehabilitation is a collaborative process and Service Users must commit to engaging in the programme. This may involve Service Users signing a written agreement.

4.1.4.4 The Provider must ensure that the programme considers the changing needs of the Service User, liaising and working with the Referrer and other relevant providers e.g., Mental Health, Recovery Housing etc.

4.1.5 Treatment and Recovery Planning

4.1.5.1 In line with the UK Guidelines on Clinical Management: Drug Misuse and Dependence (section 2.2.4), all Service Users will have a Treatment and Recovery Care Plan. Initially, the Service Users needs will be assessed and highlighted by the Referrer. The Provider will use this information in addition to their own assessment to develop a Treatment and Recovery Care Plan which describes a range of Therapeutic, recreational, and rehabilitative plans to address individual need. The Provider is required to ensure the Treatment and Recovery Care Plan is complete upon admission to the Service and that it is kept up to date throughout the Rehabilitation Programme.

4.1.5.2 The Provider will ensure Service User involvement and choice will be supported in all stages of the rehabilitation journey. Upon agreement, the Treatment and Recovery Care Plan will be shared with all appropriate services.

4.1.5.3 As a minimum, the Treatment and Recovery Plan will include:

4.1.5.3.1 Clear goals and aims of overall Treatment and support Interventions which must be set and agreed with the Service User.

4.1.5.3.2 A named Key Worker who is responsible for the delivery and coordination of the Treatment and Recovery Plan.

4.1.5.3.3 Risk assessment of the Service User and contingency plan for the Service

4.1.5.3.4 Confidentiality and information sharing protocols in line with GDPR.

4.1.5.3.5 Standard demographic information in relation to the Service User

4.1.5.3.6 Interventions required to target non-Substance use domains of functioning (such as housing, employment, family support, independent living skills, debt management)

4.1.5.3.7 Arrangements must be in place to support Service Users prior to discharge in accessing open-access relapse prevention and Mutual Aid support groups, including for example the Lancashire Recovery Infrastructure Organisation (RIO) and Lancashire User Forum (LUF), and non-Substance use related support.

4.1.5.3.8 Arrangements for 3 and 6 month follow ups with the Service User following completion of Treatment by the Provider.

4.1.5.4 The Provider will work with Service Users to regularly review progress and needs and amend Treatment and Recovery Plans accordingly. Review meetings must be undertaken at a minimum of once per fortnight.

4.1.5.5 The Provider will give the option for carers and family members, where appropriate, to attend review meetings and will ensure that reasonable notice is given to enable family/carers to decide to attend.

4.1.5.6 The Provider will ensure that the Referrer is also invited to attend review meetings and pre-discharge reviews. Information about these and invitations to attend will be sent to the Referrer routinely by the Provider.

4.1.5.7 The Provider must invite the Referrer to a review meeting midway through the Service Users Treatment Programme and a pre-discharge planning meeting.

4.1.5.8 Provider must ensure that there is regular communication with family/carers (where appropriate) and Referrers, particularly in cases where physical attendance at review meetings is not possible due to geographical distance. Where the Service is not geographically close to the Service User's family/carer, the Provider will work flexibly to support input from a distance by using digital platforms e.g., video conferencing and / or other communication channels.

4.1.6 Interventions

4.1.6.1 The Provider will actively involve the Service User and family/carers/supporting others in the Treatment journey, allowing them to make informed choices based on the range of support and Interventions available to them.

4.1.6.2 All Interventions will be fully explained, and options will be offered (where appropriate) in order for the Service User to make an informed choice.

4.1.6.3 The Provider must adhere to the following requirements for Interventions listed below. See NICE CG51 and UK Guidelines on Clinical Management: Drug Misuse and Dependence for further detail.

4.1.6.4 Please refer to sections 4.3 and 4.4 for further information.

4.1.7 Discharge Processes

4.1.7.1 All discharges should be planned.

4.1.7.2 The Provider will make suitable arrangements for the Service User on discharge, including the provision of aftercare where appropriate. This includes ensuring that Treatment and Recovery Care Plans are updated, and

Service Users have access to Recovery support and Interventions in the community. Working with the Referrer on departure planning, prior to the end of a placement.

4.1.7.2.1 Where possible, the Provider will support the Service Users to undertake home visits prior to discharge if returning to their home area and make referrals to housing options teams including supported/Recovery housing in a timely manner and support with the resultant assessments.

4.1.7.3 All Planned Discharges will be preceded by a discharge care plan meeting and a discharge letter including details of Treatment provided and recommendations for the future which will be shared with the Service User, Referrer, and a representative of The Authority by letter or by secure email.

4.1.7.4 Some proportion of discharges will be unplanned and will fall into the following two categories:

4.1.7.4.1 Unplanned self-discharges

4.1.7.4.2 Disciplinary discharges

4.1.7.5 In both circumstances, at pre-admission, the Treatment and Recovery Care Plan will detail proposed contingency plans in the event of unplanned self or disciplinary discharges e.g., provision of Naloxone advice, a referral to Community Treatment Provider and the implementation of a risk management plan.

4.1.7.6 When an Unplanned Discharge takes place, a risk analysis must be carried out by the unit and sent to the Referrer and where appropriate the relevant Community Treatment Provider. At least two staff members (including a senior manager) will agree any unplanned or disciplinary discharge.

4.1.7.7 The Provider Service manager must contact the referring representative of The Authority, Community Treatment Provider, the Service User's next of kin and the Recovery Infrastructure Organisation (RIO) (if appropriate) to immediately to inform them that the Service User's Treatment has not been completed. In addition, the Provider must inform any other agencies which the Service User has been engaging with such as mental health Services and Probation.

4.1.7.7.1 Services should be contacted at the first available opportunity, where possible including Out of Hours.

4.1.7.8 Discharge routes may include:

4.1.7.8.1 Disciplinary discharge with reasons given to the referring Service.

4.1.7.8.2 Discharge to community Services.

4.1.7.9 The following discharges may be a temporary 'freezing' of Treatment until the Service User has been reassessed for suitability to re-engage with Services:

4.1.7.9.1 Detention under the Mental Health Act (MHA), (2007)) with transfer to acute ward.

4.1.7.9.2 Detention under the MHA with transfer to Psychiatric Intensive Care Unit (PICU) or other high dependency wards.

4.1.7.9.3 Informal admission to a mental health ward.

4.1.7.9.4 Removal by police (with or without arrest).

4.1.7.9.5 Emergency transfer to acute medical facility.

4.1.7.10 Unplanned Discharge from the Provider to the community at night must be avoided (see section 4.1.2.6).

4.1.7.11 Unplanned Discharges are distinguished from planned transfers or discharges to general medical or psychiatric facilities.

4.1.7.12 In the event that an Unplanned Discharge occurs Out of Hours, a brief discharge summary, including current medication (and risk assessment) shall be sent to the referring Social Worker and the Service Users General Practitioner; this must be followed up by a telephone call at the earliest opportunity. Depending on circumstances, Out of Hours Services and/or emergency duty team will be notified.

4.1.7.13 Within 24 Hours of all discharges, a complete discharge summary shall be sent by secure email to the referring social worker/or identified shared mailbox and the Community Provider (if appropriate) should be informed.

4.1.7.14 Any Service Users discharged and deemed at risk of opiate overdose will be provided with Harm Reduction advice and subject to consent, will be referred back to the Community Treatment Provider prior to discharge. At admission to the unit, the Provider will ask the Service User to consent to this process.

4.1.7.15 If there is a risk of homelessness then the Provider must involve the local district council applicable to the Service User's local connection (as per the Homeless Reduction Act 2017). This will usually be the local Authority in which the Service User was resident prior to admission.

4.1.7.16 Service Users that successfully complete the Specialist Rehabilitation must be followed up by any appropriate method post discharge at 3 and 6 month periods as a minimum.

4.1.8 Housing and Returning Home

4.1.8.1 The Provider will support The Authority and Key Partners, including the 12 District Housing Authorities, housing Provider, Community Treatment Provider, voluntary sector partners, Mutual Aid organisations, the Recovery infrastructure organisation and people in Recovery to develop a vibrant, strong, and visible Recovery community.

4.1.8.1.1 The aim is to entrench Recovery in all our communities in Lancashire and this is best served by supporting people to gain, develop

and sustain their own Recovery in their communities of residence.

4.1.8.1.2 The Authority strongly supports the principle that 'successful' Recovery needs to be shared and promoted and that this can be best achieved by encouraging and supporting individuals to return and join in with their own Recovery community.

4.1.8.3 The Provider will work with Service Users to support them to return to their home area of local connection, preventing homelessness and reducing the risk of rough sleeping.

4.1.8.4 The Provider will link Service Users into their local Recovery community through developing pathways of referral and partnership working with housing Provider and their local district/borough council.

4.1.8.5 The Provider will evidence the pathway to returning home is in place and fully operational. The outcomes will be evidenced and reported in the Performance Management Framework (See Appendix C in the Contract). 'Returning home' is recognised as a positive outcome for the individual and a valuable contribution to the whole Recovery community in that local area.

4.1.8.6 For community day rehab, supported housing will be required to maximise Treatment outcomes. Provider will need to provide or work jointly with housing Provider to ensure suitable accommodation is in place.

4.1.8.7 In some instances, Service Users will have appropriate and stable accommodation and will not require supported accommodation.

4.2. Strands Outline

4.2.1 The Provider must offer a stepped approach to meeting the needs of Service Users in their rehabilitation and provide one or both of the two levels of care divided into the following two strands:

4.2.1.1 Strand 1: Level 1 - Core Interventions

4.2.1.2 Strand 2: Level 2 - Enhanced Interventions

4.3. Strand 1: Level 1 - Core Interventions

4.3.1 The Core Interventions delivered by the Provider will include the availability of the following, but it is not an exhaustive list:

4.3.1.1 Comprehensive individual assessment and care planning, including updating and informing staff from other Services of progress / updating on Treatment and Recovery Care Plans.

4.3.1.2 Risk management plan (Please refer to section 2.2.2.2 of the UK Guidelines on Clinical Management of Drug Misuse and Dependence).

4.3.1.3 Provision of harm reduction advice and information in accessible formats.

4.3.1.4 To support Service Users to understand the impact of Substance use in their lives, and the effect on themselves and their carers/families/friends.

4.3.1.5 Psychosocial Interventions, (including but not limited to Motivational Interviewing and Treatment engagement tools to reduce Substance use, prevent relapse, and cope with cravings) these may be provided through a combination of one-to-one work and structured group work.

4.3.1.6 To offer a comprehensive Therapeutic Programme, which will deliver health and social support whilst promoting responsibility, self-worth, life and social skills.

4.3.1.7 Physical and mental health screening and support. Joint working with any involved Key Partners (As identified in Section 5.2 of the Service Specification e.g., Probation, CMHT etc).

4.3.1.8 Promotion of independent living skills (budgeting, daily living).

4.3.1.9 Promote the evidence based 5 Ways to Health and Wellbeing.

4.3.1.10 Medical Interventions:

4.3.1.10.1 The Provider must ensure that existing physical and/or mental health conditions must be supported through the Service User's Treatment journey.

4.3.1.10.2 The Provider must ensure that all Service Users must have access to Primary Care including registration with a local GP.

4.3.1.10.3 The Provider must ensure that all Service Users will have access to Blood Born Virus (BBV) advice, screening, and Treatment (if required).

4.3.1.11 Recreational activities (e.g. physical activity, communal spaces)

4.4. Strand 2: Level 2 - Enhanced Interventions

4.4.1 The Level 2 offer will include all Interventions detailed in Strand 1, in addition to one or more Enhanced Interventions as outlined below (the list below is not exhaustive):

4.4.1.1 Cognitive Behavioural Therapy (CBT), Dialectical Behavioural Therapy (DBT), Family Therapies or other means of counselling delivered by a qualified counsellor.

4.4.1.2 Provision of specialist structured counselling for issues that are related to the Service User's Substance use i.e. Post Traumatic Stress Disorder (PTSD), Co-occurring conditions.

4.4.1.3 Co-working with external Services and Key Partners regarding complex Physical Health / Mental Health / Learning Disability needs.

4.4.2 For the purposes of this specification Enhanced Interventions can also include more targeted specialised substance use residential rehabilitation Units. For example, those units that offer an integrated detoxification programme and / or are family focused Units that provide rehabilitation services and accommodate parents with children.

5. Service Conditions

5.1. Acceptance and Exclusion Criteria

5.1.1 The eligibility for the Service is as follows:

5.1.1.1 People aged 18 or over on the date of admission, have a need for Rehabilitation as identified by the Referrer, and are motivated to engage with Treatment, achieve and maintain abstinence.

5.1.1.2 Resident in the Lancashire County Council boundary and / or able to demonstrate ordinary residence i.e., a Service User in the Secure Estate.

5.1.1.3 Admissions within this Service will be voluntary.

5.1.2 Service Users most likely to benefit from a Rehabilitation Programme will have one or more of the following (however need will be assessed on an individual basis):

5.1.2.1 Serious physical and or mental health co-morbidity where Substance use will consistently exacerbate the illness or undermine its effective clinical management.

5.1.2.2 Substance use impacts on social and psychological functioning.

5.1.2.3 Complex social risk factors.

5.1.2.4 Difficulty achieving or maintaining abstinence in community settings.

5.1.2.5 Commitment to their own rehabilitation and are motivated to engage with the Service.

5.1.3 Service Users accessing the Service must be abstinent from mind altering Substances including opiate substitution Treatment. In cases of physical dependency on one or more Substances with physical or psychiatric complications or co-morbidity, the Service User must have undergone detoxification prior to being admitted.

5.1.4 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.

5.1.5 Referrals are unlikely to be made in the following cases:

5.1.5.1 Where there have been previous admissions to Rehabilitation Services in the last 12-month period for concurrent episodes of Treatment and the client has not engaged with or successfully completed Treatment. This may preclude further admissions.

5.1.5.2 Where a Service User's mental health is unstable and may hinder their ability to engage and successfully complete a period of rehabilitation.

5.1.5.3 Where the primary purpose of admission is to receive a Specialist Rehabilitation Service for a Severe Substance Use Disorder. For example, to provide a place of safety for the Service User.

5.1.5.4 Where the Service User may pose a risk. For example, criminal history, schedule 1 offences, previous instances of arson.

5.1.6 Provider will assess each Service User with Complex Needs (such as acute and serious physical or mental co-morbidity), based on the following criteria:

5.1.6.1 The Service User is mentally and physically able to participate in the Rehabilitation Programme and demonstrates a clear understanding of what this entails. The Referrer will be required to demonstrate that a comprehensive Health and Social Care Assessment has taken place prior to admission, including an assessment of risks in relation to mental and physical health.

5.1.6.2 Where a Service User has a history of presenting a risk of harm to others, the decision as to whether to accept a referral will rest with the Provider; however, the Provider must undertake risk assessments in conjunction with Referrers. In making the decision, they will consider capacity to manage presenting risk and implications for others engaged with the Service.

5.1.6.3 There must not be any automatic exclusions as a result of Complex Needs.

5.1.7 The Provider must ensure that they can provide appropriate access and support for people with one or more of the 8 protected characteristics in the Equality Act (2010) – see section 11.2 of the Service Specification.

5.2. Interdependencies

5.2.1 The Provider will ensure that the Service is outward looking and seeks to engage with all relevant Key Partners as described below and throughout this specification, to achieve better lives for Lancashire residents.

5.2.2 The Provider will work in partnership to find new ways of working, to deliver Services differently and engage with Service Users/individuals and families earlier to help reduce the demand on Services in the long term.

5.2.3 The Provider will work with any relevant organisation in local communities to maximize the outcomes for the eligible population. Along with the organisations referred to in this specification, the following list identifies Key Partners that will be crucial to effective delivery, including but not limited to:

5.2.3.1 Acute Services

5.2.3.2 Criminal Justice Services (including Lancashire Constabulary, National Probation Service, HMP Prison Service, secure units, Courts

5.2.3.3 Department of Work and Pensions / Job Centre plus – Work Programme

5.2.3.4 Domestic abuse and refuge Services

5.2.3.5 Education Provider

5.2.3.6 Family support Services

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

5.2.3.8 District Council Housing departments, Provider and agencies and accommodation Services across all sectors including social housing and Complex Needs provision.

5.2.3.9 Fire and Rescue Departments

5.2.3.10 Police and Crime Commissioners

5.2.3.11 Sexual Assault Referral Centres

5.2.3.12 Victim Services

5.2.3.13 LCC commissioned Treatment and Recovery Services.

5.2.3.14 Education and training Provider

5.2.3.15 Employers

5.2.3.16 NHS Integrated Care Board/Systems (ICB/ICS)

5.2.3.17 Mental Health agencies and Provider of community emotional health and wellbeing Services

5.2.3.18 Mutual Aid Groups

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

5.2.3.20 Recovery communities and organisation including Red Rose Recovery, the Lancashire User Forum and The Well

5.2.3.21 Relevant voluntary sector Provider agencies e.g., CVS

5.2.3.22 Services in neighbouring areas.

5.2.3.23 Social enterprises

5.2.3.24 Women's Centres

5.2.4 The Provider will develop and maintain working relationships with all stakeholders and Key Partners. It is of particular importance that relationships with GP practices, Pharmacy staff and other Primary Care staff groups are well maintained to achieve the maximum benefits of Service Users being seen in Primary Care settings.

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. Provider 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 Key Partners as part of a co-production approach.

5.4.2 The Provider will work with Lancashire County Council 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.
- 5.4.8.5 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 Provider 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 and be kept up to date with best practice and guidance.

6.5 The Provider must ensure that Staff are qualified as appropriate for the work they undertake.

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 Provider will work with 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

It is the Provider's responsibility to routinely collate and analyse their own performance. The Provider will work with The Authority 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 where indicated.

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 will 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 Provider will build a strong and effective working relationship with the Authority.

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 Provider.

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 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 must be properly 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 must 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.

- 10.1.26.1 Part A: https://clickquestion.lancashire.gov.uk/runQuestionnaire.asp?qid=757254
- 10.1.26.2 Part B: https://clickquestion.lancashire.gov.uk/runQuestionnaire.asp?qid=757336

10.1.27 The Provider will have a strong internal governance structure and organisational governance plan. This will 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).

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

10.1.29 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.

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

10.1.30.1 Contract management.

10.1.30.2 Safeguarding boards on request.

10.1.30.3 Preventable Harms.

10.1.30.4 Service User/Recovery forums.

10.1.30.5 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.

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 the National Drug Treatment and Monitoring System (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 will 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 Performance Management Framework (PMF) 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 (e.g. Lancashire Drug and Alcohol Partnership) 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.

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.

11.2.3 On this basis:

11.2.3.1 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.

11.2.3.2 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.

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

[1] https://www.legislation.gov.uk/ukpga/2010/15/section/149
[2] https://www.equalityhumanrights.com/en/advice-and-guidance/public-sector-equality-duty
[3] https://www.legislation.gov.uk/uksi/2017/353/regulation/4/made

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 reserves 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 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 (see Annex 2 for more information).

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 Quarterly Contract Review Meetings 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 Quarterly 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 Authority will consider and develop an appropriate level of performance management and quality assurance process as part of this Service and confirm the arrangements prior to the Commencement Date.

12.2.2 The Provider must comply with any additional requests for information not linked to the formal management of the contract.

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

12.2.4 The Provider will utilise the performance reporting template to report activity.

12.2.5 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).

12.2.6 The performance reporting template and the qualitative report will be submitted quarterly.

12.2.7 the Provider will evidence engagement with system Key Partners, e.g., the local Substance use Community Treatment Provider.

12.2.8 The Provider will contribute to the following Public Health Outcome Framework (PHOF) indicators which are used to benchmark system performance:

12.3.8.1 2.15i Successful completion of drug Treatment – opiate users

12.3.8.2 2.15ii Successful completion of drug Treatment – non opiate users

12.3.8.3 2.15iii Successful completion of alcohol Treatment

12.3.8.4 2.15iv Deaths from drug use

12.3. Key Outcomes

12.3.1 The following outcomes are presented as a way of identifying the broad potential of rehabilitation 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 rehabilitation 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).

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

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

12.3.4 The Provider will support Service Users to Improve physical health.

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

12.3.6 The Provider will support Service Users to engage in physical activity.

12.3.7 The Provider will support Service Users to improve their nutrition.

12.3.8 The Provider will contribute to reducing hospital admissions.

12.3.9 The Provider will facilitate access to smoking cessation Services.

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

12.3.11 The Provider will support Service Users to access to education, training and employment.

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

12.3.13 The Provider will facilitate access to Mutual Aid groups during Treatment and post discharge.

12.3.14 The Provider will support Service Users to achieve a planned resettlement into the community.

12.3.15 The Provider will support Service Users to access appropriate and sustainable housing.

12.3.16 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).

12.3.17 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.

12.3.18 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.

12.3.19 The Provider will reduce harm within individuals, families, and communities through delivering Interventions that address Substance use and develop Recovery. Contributing to a reduction in proven re-offending.

12.3.20 The Provider will promote Recovery through integrated Treatment that involves family and carers and includes coordinated care and re-integration support that enables individuals to exit Treatment in a successful and planned way, improve Service Users functioning across all domains.

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.

15.3.16 Medication Management Policy

15.3.17 Infection Control Policy

15.3.18 Consent and Mental Capacity Act

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

The Provider will adhere to the principles and standards documented in the current national guidance documents and legislation and make appropriate changes to the Service delivery in order to reflect any updates or changes in guidance and standards.

16.1 Policy & Guidance - Rehabilitation

- 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 Alcohol

- Models of Care for Alcohol Users (National Treatment Agency, 2006)
- Signs for Improvement – Commissioning Interventions to Reduce Alcohol-related Harm (Department of Health, 2009)
- Review of the effectiveness of the treatment of alcohol problems (NTA, 2006)
- "The public health burden of alcohol: evidence review" (PHE 2016, updated 2018) https://www.gov.uk
- NICE Guideline CG100 "Alcohol-use disorders: diagnosis and management of physical complications" (2017) https://www.nice.org.uk/guidance/cg100
- 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 Guidelines QS11 Alcohol-use disorders: diagnosis and management (NICE, 2011 Updated 2023) https://www.nice.org.uk/guidance /QS11

16.3 Drugs

- Models of Care for the treatment of adult drug users (National Treatment Agency 2002, updated 2006)
- Models of residential rehabilitation for drug and alcohol misusers (National Treatment Agency, 2006)
- Improving Services for Substance Use – Joint Service review (National Treatment Agency 2009) (Department of Health 2008)
- Improving the quality and provision of Specialist rehabilitation Interventions as part of Service User treatment journeys - A best practice guide (NTA, September 2008)
- Residential Drug Treatment Services: Good practice in the field (NTA, May 2009)
- Commissioning for Recovery Drug treatment, reintegration and Recovery in the community and prisons: a guide for drug partnerships (NTA, January 2010)
- National Institute for Health and Clinical Excellence (NICE) guidelines Drug use and dependence: UK guidelines on clinical management
- Improving Services for Substance Use – Joint Service review (National Treatment Agency 2009) (Department of Health 2008)
- Psycho-social Interventions for drug use: a framework and toolkit for implementing NICE treatment Interventions (NTA 2009)
- Commissioning for Recovery Drug treatment, reintegration and Recovery in the community and prisons: a guide for drug partnerships (January 2010)
- Routes to Recovery: Psychosocial Interventions for drug use (NTA 2008)
- The International Treatment Effectiveness Project: Implementing psychosocial Interventions for adult drug users (NTA 2007)
- Naltrexone for the Management of Opioid Dependence NICE technical appraisal guidance TA115 (2007)
- Understanding the Costs and Savings to Public Services of Different Treatment Pathways for Clients Dependent on Opiates, Jan 2015, Government Social Research
- Good Practice Guide for pathways into, through and out of residential Rehabilitation in Scotland (November 2021)

16.4 General

- Commissioning Quality Standard: alcohol and drug treatment and Recovery guidance (August 2022) https://www.gov.uk
- Routes to Recovery: Psychosocial Interventions for drug use (NTA 2008)
- Models of care (drug use update) NTA 2006
- NTA (2002) Models of Care for Treatment of Adult Drug Users: Part 2- Full Reference Report DoH/NTA: London
- Confidentiality and information sharing (NTA 2003)
- The care planning practice guide NTA 2006
- Good Practice in Care Planning (July 2007) NTA

- General healthcare assessment guidance (August 2006). NTA
- Good practice in harm reduction (NTA 2008)
- Treatment effectiveness strategy (NTA 2005)
- NTA guidance for local partnerships on user and carer involvement (June 2006)
- Towards successful treatment completions: a good practice guide (NTA 2009)
- Improving planned exits (NTA 2009)
- Residential Drug Treatment Services: good practice in the field (NTA 2009)
- Retaining Service Users in drug treatment: a guide for Provider and commissioners, June 2005, NTA
- Guidance for local partnerships on user and carer involvement (NTA 2007)
- Treating cocaine/crack dependence, August 2002, NTA
- Psycho-social Interventions for drug use: a framework and toolkit for implementing NICE treatment Interventions (NTA 2009)
- Drug and Alcohol National Occupational Standards (DANOS)
- Quality in Alcohol and Drug Services Organisational Standards (QuADS)
- Standards for Better Health (Department of Health 2006)
- LCC Safeguarding Children Board (LCCSCB) Safeguarding Children Procedures (LCCSCB)
- Safeguarding Adults, Multi Agency Safeguarding Policy
- Standard text detailing the quality and governance standards required of all commissioned Provider (NHS LCC, Jan 2012/version 5.1)
- DAST Serious Untoward Incident (SUI) Reporting Procedure and Guidance (2011)
- National Institute for Health and Care Excellence (NICE) guideline on managing medicines I care homes. Published in March 2014
- "Safe and secure handling of medicines" The Royal Pharmaceutical Society of Great Britain 2018

16.5 Legislation

- Misuse of Drugs Act 1971 Misuse of Drugs Act 1971 (legislation.gov.uk)
- Dangerous Drugs Act 1920
- Medical (Professional Performance) Act 1995
- Care Act 2014 Care Act 2014 (legislation.gov.uk)
- Children Act 2004 Children Act 2004 (legislation.gov.uk)
- Health Act 2009 Health Act 2009 (legislation.gov.uk)
- Mental Health Act 1983 (up to date with all known changes 2023) Mental Health Act 1983 (legislation.gov.uk)
- Control of Substances Hazardous to Health (COSHH)Control of Substances Hazardous to Health (COSHH) - HSE
- Human Rights Act 1998 Human Rights Act 1998 (legislation.gov.uk)

- Race Relations Amendment Act 2000 https://www.legislation.gov.uk/
- Data Protection Act 2018 Data protection: The Data Protection Act - GOV.UK (www.gov.uk)
- Relevant European Community legislation
- Public Health Act 1936 Public Health Act 1936 (legislation.gov.uk)
- The Employment Rights Act 1996 Employment Rights Act 1996 (legislation.gov.uk)
- Environmental Health and Hygiene regulations
- Registered Homes Act 1984 Registered Homes Act 1984 (repealed) (legislation.gov.uk)
- Equality Act 2010 Equality Act 2010: guidance - GOV.UK (www.gov.uk)

16.6 Supporting Documents

- Home Office (2008) *Drugs: protecting families and communities* London: Home Office
- Drug Misusing Offenders: Ensuring the Continuity of Care between prison and community Guidance Home Office - Published June 2009 as updated by Addendum March 2011NOMs drug strategy.
- Integrated Offender management Strategy 2020 Integrated Offender Management strategy - GOV.UK (www.gov.uk)
- PSA Delivery Agreement 23: Make Communities Safer: HMSO: London (2007) (includes National Indicator 30 Re-offending rate of Prolific and other Priority Offenders)
- National Standards for Management of Offenders NOMS 2015
- HM Treasury (2007) PSA Delivery Agreement 25: Reduce the Harm Caused by Alcohol and Drugs HMSO: London includes National Indicators Nl38 Drug related (Class A) offending rate; Nl39 Number of hospital Related Admissions; Nl 40 Numbers in effective treatment
- Preventing and reducing drug-related harm PHE 2021 Preventing and reducing drug-related harm - GOV.UK (www.gov.uk)
- 'Psychosocial Interventions for Drug Use-A Framework and Toolkit for Implementing NICE Recommended Treatment Interventions' NTA March 2009
- Treating drug use problems: evidence of effectiveness, April 2006 NTA
- Joint Guidance on Development of Local Protocols between Drug and Alcohol
- Treatment Services and Local Safeguarding and Family Services (Nov 2009) NTA
- Clinical Governance in drug treatment: A good practice guide for Provider and commissioners (2009) NTA
- Drug Services for homeless people: A good practice guide. Office of the Deputy Prime Minister and Home Office, November 2004
- "Drug related harms in homeless populations and how they can be reduced" ACMD 2019
- "Supporting Community Order Treatment Requirements" NOMS 2014
- NICE (2007) Methadone and Buprenorphine for the Management of Opioid Dependence. NICE TA114 London: National Institute for Health and Clinical Excellence
- NICE (2007) Drug Use: Opioid Detoxification. NICE clinical guideline CG52 London:

- Anxiety: Management of Posttraumatic Stress Disorder in Adults in Primary, Secondary and Community Care. Post-traumatic stress disorder NICE guideline NG116: December 2018
- Obsessive-compulsive Disorder: Core Interventions in the Treatment of Obsessive-Compulsive Disorder and Body Dysmorphic Disorder. NICE guideline 31. London (NICE) 2005b
- Depression: Management of Depression in Primary and Secondary Care. Depression in adults: recognition and management Clinical guideline CG90 October 2009 Updated: April 2018
- Anxiety: Management of Anxiety (Panic Disorder, With or Without Agoraphobia, and Generalised Anxiety Disorder) in Adults in Primary, Secondary and Community Care. Generalised anxiety disorder and panic disorder in adults: management Clinical guideline CG113 January 2011:Updated: July 2020
- Antenatal and Postnatal Mental Health: Clinical Management and Service Guidance. NICE Clinical guideline [CG192] December 2014 Updated: April 2020
- In-patient Treatment of Drug and Alcohol Users in the National Health Service: SCAN Consensus Project (SCAN 2006)
- Operating Framework for NHS England 2022 NHS England » NHS England operating framework

17. Annexes

Annex 1 - Treatment and Recovery Background

1. Number of Service Users in Substance Use Treatment

	2019/2020	2020/2021	2021/2022	2022/2023
Total	5,678	6,054	6,119	6,297
Non-Residential Rehabilitation	66	27	55	37
Residential Rehabilitation	246	242	234	213

2. New presentations to Substance Use 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 reflects 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 – Contract Management Arrangements

The Authority's contract management team will monitor Provider's performance via different processes. This will include at least one or more of the following:

- Request for an Annual Quality Assurance Checklist.
- Quarterly Reporting at Quarterly Contract Management meetings.
- Annual onsite monitoring for Providers based in the Lancashire area.
- Desktop monitoring for Providers based out of the Lancashire area.

Annex 3 - Referral procedure.

Rehabilitation services referral pathway

1) Prior to referral, the Referrer and the CTP must assess the physical and mental health needs of the Service User, their readiness to engage in rehabilitation, and will have prepared the Service User to engage in a Residential or Non-residential Rehabilitation Treatment Programme and must have completed a holistic health and social care needs and risk assessment and Recovery Plan (please see section 4.1.2 of the service specification).
2) The Referrer, in conjunction with the Service User, will identify the most appropriate Rehabilitation Unit, that is able to support and meet their health and social care needs including the length of placement and category for admission (e.g. emergency, priority, or routine).
3) The Referrer will complete the relevant referral form and send to the identified Provider(s) via email (or other mechanism agreed). The Provider is required to work with the Authority to develop a standard referral form for rehabilitation services, when requested.
4) The Provider will assess the Service User for suitability and will confirm via telephone (or other mechanism as agreed) to the Referrer their decision for acceptance or non-acceptance of the referral of the Service User within 5 working days.
5) Where the chosen Provider doesn’t accept the referral the Referrer will start the process again from point 2.
6) The Referrer, the Provider, and the CTP will use the information from the Referral Form to formulate and agree a Treatment and Recovery Plan.
7) The Referrer will confirm availability of funding for the full duration of the placement.

8) The Referrer will inform the Service User of their acceptance and will prepare them for admission to the Rehabilitation Unit, including making arrangements for transport (please see section 4.1.2 of the service specification).
9) The Service User will be admitted to the Rehabilitation Unit.
10) The Provider, the Referrer and the Service User will review the Support Plan and use the included information to develop a Treatment and Recovery Plan for the Service User, this process will be led by the Provider (please see section 4.1.5 of the Service Specification).
11) The Provider will undertake regular re-assessments and reviews of the Treatment and Recovery Plan.
12) The Provider will make every effort to retain the Service User in Treatment for the duration of the Rehabilitation Programme. The Provider will inform the Referrer and 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).
13) The Provider will undertake a discharge planning meeting and will write a discharge letter including details of treatment provided and recommendations for the future. The discharge letter will be shared with the Service User, the Referrer, and a representative of the Relevant Authority by letter or by secure email (please refer to section 4.1.7 of the service specification).
14) The Provider will discharge the Service User to either community care via the Referrer who will provide follow-up sessions by any appropriate method at 3 and 6 months following discharge.