Norfolk Alcohol and Drug - Behaviour Change Service - Specification -
# Executive Summary

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A Whole Systems Approach for Norfolk

Norfolk County Council wishes to procure an integrated alcohol and drug behaviour change service, which includes treatment, recovery and builds community resilience for Norfolk adult aged 18 + years. The new service will be outcome based and recovery focused, delivering a shift towards prevention and early interventions, demonstrates innovation and implements evidence based good practice to deliver the best possible outcomes for individuals and their families. There will be a sharp focus on reducing associated harms caused to children.

The new service will be responsible for delivery of a comprehensive and dynamic range of services, to address the alcohol and drug related needs of adults and the consequent impact on their families and wider communities in Norfolk. This will include a flexible range of programmes and interventions across all modalities in each locality.

The new service will be a fundamental partner to improve the health and wellbeing of Norfolk residents across a wide range of domains. It will build on current provision:

- Align service within NCC strategic priorities: public health, social care, dementia, criminal justice, public safety, children services and learning disabilities, mental health.
- Lead the development of community based recovery and asset based community development (ABCD).
- Ensuring the right support is available and co-ordinated for people with complex needs e.g. older adults and those with long term conditions, poor mental health, co-morbid disorders, homelessness, experiencing domestic abuse or those engaged in sex work.
- Offering greater integration across the local authority and wider partners
- Responding proactively to emerging trends and issues such as exploitation and safeguarding
- Integrate with wider lifestyle behaviour changes including stop smoking, weight management, physical activity, mental and physical wellbeing.
- Address wider health inequalities experienced by underserved populations such as people returning to the community following a period in detention, etc

The new service must show how a truly integrated assessment, treatment and asset based community recovery service will be delivered to meet the requirements and outcomes of the service in Norfolk, paying attention to the need to deliver equitable access, quality and outcomes in all the communities. It needs to show an increased focus on alcohol and brief interventions and opportunities to intervene at the earliest possible point.

The recovery outcomes will be realised by the achievement of the following:

- A reduction in crime and reoffending
- Sustained education, training and volunteering activity leading to employment
- The ability to access and sustain suitable accommodation
- Improved relationships with family members, partners and friends
- A reduction in harm caused by misusing parents/carers on children and young people
- Improving the chances for children and young people to reach their potential
- Increase of safeguarding for vulnerable children, young people and adults.
- Freedom from dependence on alcohol and drugs where possible
- Prevention of drug related deaths and infection by blood borne viruses
- Improvement in mental and physical wellbeing
- A reduction in alcohol and drug related hospital admissions as a result of alcohol, illicit drug use and misuse of prescribed medication

**Stronger Families and Safeguarding Focus**

The new integrated system will target individuals posing the highest risks due to their drug and alcohol use i.e. risk to themselves, to their families and to the wider community. The new service will actively seek to support families through local engagement with early help and stronger families programmes during the recovery process. By delivering the right services and interventions at the right time in a family’s journey, NCC and the new service can better manage ‘complex dependency’ and reduce later service demands. Furthermore, this approach will ensure a sharp focus on reducing associated harms caused to children. The new service will work with the current young peoples’ service to include targeted prevention to reduce the number of young people at risk of developing problematic use and adults who drink above recommended or at harmful levels. The integrated service will address the hidden harm to children of their parents/carers substance misuse.

**A Single System**

The integrated alcohol and drug behaviour change service will be procured through a single, joint or consortia bid. Bidders will define the pathways for transition from young people to adults focused services based on evidence and best practice.

The new integrated service will have the main components of:

- Information and advice for those directly or indirectly impacted by substance use (including professional consultation provision)
- Ease of access through multiple channels
- Screening and early and targeted intervention Identification and proactive engagement of clients
- Assessment, care co-ordination and recovery package co-ordination
- Harm minimisation and reduction services including needle exchange
- Proactive engagement and retention
- Evidenced based structured psychosocial interventions
- Recovery focused, safe and effective clinical treatments and interventions
- Shared care
- Effective pathways to recovery support and aftercare
- Positive engagement in mutual aid support
- Opportunities for volunteering, peer mentoring and training

**The following services are out of scope:**

- Young people’s services
- Prison services
Motivational milieu

The integrated behaviour change service will deliver a ‘motivational milieu’, defined as ‘the physical and social setting in which people live or in which something happens or develops. It includes the culture that the individual was educated or lives in and the people and institutions with whom they interact’. The integrated service will build individuals ‘readiness to change’ and then support to sustain change.

Saving lives and saving costs

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As well as saving lives, there will be savings in overall costs to the council in terms of increasing effectiveness, improved outcomes, improved value for money and a reduction in demand over the longer term. The current treatment system comprises 6 buildings and delivery sites across the county being utilised. As a new single integrated system, it is anticipated it will rationalise and reduce the building and infrastructure costs. An overall reduction in infrastructure and management costs associated with inflationary and cost of living increases will form part of the budget profile. The intention of the integrated behaviour change system is to increase access and availability through work in both rural and urban areas across the county. Seeing people in locations and times convenient to them and proactively engaging with local communities, through local services and resources, particularly for those who have historically been resistant to or have difficulty in accessing or sustaining treatment and recovery.

In line with the national Drug and Alcohol strategies and our local ambition, the new integrated service will increase the number of people able to achieve sustained positive changes in their lives, build recovery from dependence, contribute to their families and communities through both employment and voluntary action. The service will achieve these aims and outcomes by providing bespoke individual support, targeted and recovery focused treatment and individualised and person centred packages of care based on the individual needs and heightened aspirations of service users.

Service users will be fully engaged and involved in the development and delivery of their individual and personalised packages of care with identified clear aims, goals and objectives and as a result there will be a phased move from a high cost centralised medical model, currently in place, to a greater community focused social model where clinical intervention is part of the support rather than the main focus and facilitates improvements in social functioning and development of recovery capital. The single system will increase opportunities to continue behaviour change within the community and by providing further support to affected families and friends. The shifting from a higher cost medical/clinical service towards a community and primary care focus reflects the further savings anticipated in 2021 to 2026.
Lifestyle links

The integrated alcohol and drug behaviour change service will fully integrate with wider healthy lifestyle behaviour change interventions, that support people to improve their, mental and physical wellbeing e.g. stop smoking, weight management, mental health and physical activity interventions.

The service will work with a wide range of health and public health agencies to promote healthy lifestyles and address common risk factors associated with poor and chaotic lifestyles characterised by long term dependence on drugs or alcohol that leads to increased mortality and morbidity.

Physical, social care and mental health links

The integrated alcohol and drug behaviour change service will provide a wide range of physical, social care and mental health screening. It will then deliver intervention and pathways provision designed to recognise and address the wider impacts of substance use on physical, social care and mental health and address the needs of vulnerable, disadvantaged and excluded groups that routinely miss healthcare, social care and mental health interventions.

The new service will take a much more proactive approach with an ‘outward facing’ approach to alcohol and drug misusers, their families and the wider community.
1. Introduction and context

1.1 Nature of specification

1.1.1 This specification has been developed to set out the Norfolk County Council (NCC) Public Health requirements for services in line with an adult alcohol and drug behaviour change system (“the system”) which is commissioned to deliver the required outcomes. This specification details the system objectives and interventions to address identified alcohol and drug related needs and to contribute towards delivering the aims and outcomes outlined. The chosen Provider will establish and provide the system in accordance with this specification and to the contract.

1.1.2 Following contract award NCC reserves the right to review and amend the content and detail of the Service Specification on an annual basis (or more frequently if appropriate) to take account of changes in national policy, funding and local alcohol and drug needs. The specification will be reviewed annually during the lifetime of the contract in order to reflect the changing terms and emerging needs and priorities.

1.1.3 This specification has been written in accordance with the principles and expectations outlined within the Drug Strategy 2010(2017), Modern Crime Prevention Strategy 2016, National Treatment Agency (NTA) Commissioning for Recovery (2010), Models of Care (2006), Medications in Recovery: Re-orientating drug dependence treatment (2012), Drug misuse and dependence, UK guidelines on clinical management (2007/2017) and other cited relevant guidance and protocols. (Both the National Drug Strategy and Clinical Guidelines are expected to be revised prior to the commencement if this contract.

1.1.4 All system elements and services will be delivered in line with these current and future expectations and will also need to be delivered in line with the forthcoming local or national frameworks.

1.1.5 Where there is ambiguity regarding the content or meaning of any part of this specification the NCC public health commissioner will provide clarity.

1.2 System introduction

1.2.1 NCC wants to reshape the current adult drug and alcohol service provision into a whole-systems approach in line with the partnership’s vision for the Norfolk Alcohol and Drug Behaviour Change Service. The new service will include all aspects of alcohol and drug interventions ranging from needle exchange, harm reduction, targeted prevention, early interventions, shared care, engagement and treatment including residential detox and rehabilitation and measures to reduce drug and alcohol related deaths.

1.2.2 The new service will have recovery and behaviour change at its core, which involves three overarching principles – wellbeing, citizenship and freedom from dependence. It puts more responsibility on individuals to seek help and overcome dependency and:

- seeks to support families and reduce harm to children and support NCC’s wider responsibilities to families and communities, including safeguarding
- places emphasis on providing a more holistic approach, by addressing other issues and barriers to positive health and recovery in addition to treatment in order to support people dependent on drugs or alcohol, such as offending, employment, mental or physical health and housing
- aim to reduce demand and the impact of highly dependent users
- fully involve service users and recovery graduates in contributing to de-stigmatisation and community cohesion
- takes an uncompromising approach to those involved in drug dealing and supply
- puts power and accountability in the hands of local communities to tackle drugs and the harms they cause

1.2.3 To have an alcohol and drug behaviour system in Norfolk, that increases the number of people able to achieve sustained recovery from dependence by providing individual support and treatment packages of care. These will be enhanced by increasing opportunities for individuals to use their engagement in treatment to build their recovery within the communities within which they live by engaging in mutual aid and other recovery opportunities and by providing further support to affected family and friends.

1.2.4 NCC want an alcohol and drug behaviour change system that supports the Norfolk residents of all ages to be able to develop their potential, work productively and creatively, build strong relationships with others, and contribute to their community. Overall wellbeing will be enhanced when the residents are able to fulfil their personal and social goals, contribute to and achieve a sense of purpose in society.

1.2.5 The single integrated system forms a key part of realising Norfolk County Council vision. The system will be delivered to Norfolk residents aged 18 years and over, their families and significant others who are experiencing issues with drug and/or alcohol use. The transition from young peoples to adults will be based on each individual needs, competencies and circumstances.

1.2.6 Both adults and young people’s services will actively seek to support families and to reduce the risk of harm to children through integrated working with early help and stronger families programmes.

1.2.7 The principles of resilience and recovery will underpin the whole system. NCC want to maximise help for all alcohol and drug users to achieve and sustain recovery from addiction or dependency, irrespective of the lengths of using careers or substance types. Those who enter the recovery service should expect to see improvements in their overall physical health and psychological wellbeing, support to address wider health inequalities and harmful behaviour (such as smoking), reduce barriers to education, training and employment opportunities and improve the ability to work (where appropriate), be encouraged to participate in education, training and volunteering and their ability to support their families. The new service needs to include:

- Integrated links with the NCC early help and Norfolk Family Focus programmes
- Links with Norfolk healthy lifestyle services
- Integrated Mutual Aid delivery and facilitation or other self-help groups
- Working with the planned recovery cafe
- Housing and employment improvement
- Mental and physical health improvement
- Continuity of care from police, courts, probation and prisons

NCC wants to support its residents to build a lifestyle that promotes health and wellbeing, social and personal capital as well as tackling social exclusion that arises from problematic alcohol and drug use, dependency and addictions.
1.2.8 The Norfolk integrated behaviour change system will be outcome and recovery focused, building on users’ motivations and aspirations where the expectations for recovery and reintegration are explicit from the outset and characterised by the ability to motivate and support clients to achieve short and longer term goals, move through the system and into mainstream provision free from dependency.

1.2.9 The service will be expected to provide a balance of provision for drug and alcohol users on evidence of need but also focusing on those with highest risk to themselves, risk to others or risk to the wider community. The service will provide relevant and accessible services across all areas of Norfolk.

1.2.10 The new system will ensure that it is easy for all clients to access and navigate using a Single Assessment and Case Management System (SACMS) and through delivery of a person centred co-ordinated care from end to end of the recovery journey. The system will also rely on the recruitment and support of significant numbers of peer mentors and volunteers to help support and motivate movement within the new service.

1.2.11 The Provider will need to demonstrate a holistic approach to care and treatment in which a broad range of evidence based interventions are available in a variety of settings (including community and Criminal Justice and hospital settings)

1.2.12 Support and/or structured treatment will be provided in a safe and effective way to those residents whose alcohol and or drug use is causing them harm, causing harm to those around them or causing harm to the wider community

1.2.13 Core to system delivery will be the development, support and supervision of recovery mentors and volunteers.

1.2.14 In order to achieve this we expect the Provider to demonstrate excellent care co-ordination and service cohesion. The system must be closely integrated with other local services and support networks for children, adults and local communities and have experience in identifying and engaging hard to reach and resistant users.

1.2.15 The service Provider will be required to develop and adopt innovative methods to deliver the required system outcomes. In order to support this, the Provider will be required to agree to an innovation payment framework. Each year 5% of the contract value will be paid as part of an agreed innovation payment framework (see Appendix 7) based on agreement between commissioners and the Provider to address specific identified needs and challenges within the system. The innovation programme will be developed and changed annually with previous innovations being embedded in the treatment system delivery once established.

1.2.16 As part of the supply chain it is specified that a number of small or ‘micro’ organisations are funded and managed, these organisations are likely to be of the third sector. A minimum 1.5% of the total contract value is to be administered on a ‘grant aid ‘basis by the lead provider to these small or micro third sector organizations who will typically have a low turnover. The amount administered through this grant aid method may well be small amounts of money (i.e. as little as a few hundred pounds to no more than several thousand). This is to facilitate the utilization of flexible and innovative organizations capable of engaging with the diverse communities of the county, testing new and innovative approaches and to realize the new recovery and family agendas. The Provider will agree with NCC commissioners the process of administrating Grant Aid (see Appendix 6).
1.3 Adult System outcomes

1.3.1 The Provider will work in partnership with the NCC to deliver its Public Health strategic priorities and Public Health Strategic Framework indicators and objectives, support and contribute towards NCC duties and responsibilities in the delivery of the National Drug Strategy 2010 and the alcohol element in the Modern Crime Prevention Strategy 2016 aims and outcomes and consider all opportunities to enhance the aims of the service outcomes and those of its key strategic partners, such as; the NHS and CCGs, Police and Crime Commissioner and constabulary, local Borough and District Councils and commissioned services.

Aims:
- To reduce illicit and other harmful drug use including New Psychoactive Substances (NPS), Image and Performance Enhancing Drugs (IPEDs) and ensure alcohol use is within lower risk levels
- To increase the numbers of people successfully completing structured treatment and overcoming dependence
- Reduce harm and risk, including risk of acquisition of blood borne viruses
- Reduce the number of drug and alcohol related deaths
- Reduce risks and improve resilience of young adults and prevent experimentation, escalation to problematic use and development of dependency
- Reduce alcohol and drug related violence, anti-social behaviour and domestic violence
- Reduce alcohol and drug related hospital admissions

Successful delivery of the following outcomes:
- Freedom from dependence on drugs or alcohol
- Prevention of drug related deaths and infection by Blood Borne Viruses
- A reduction in crime and re-offending
- A reduction in drug and alcohol related anti-social behaviour
- A reduction in those requiring specialist alcohol and drug treatment
- A reduction in those requiring long-term specialist treatment
- Building skills and remove barriers to employment and sustained employment
- The ability to access and sustain suitable accommodation
- Improvement in mental and physical wellbeing
- Improved relationships with family members, partners and friends
- The capacity to be an effective and caring parent

1.4 System objectives for the adult element

1.4.1 To enable and support recovery from problematic alcohol and drug use and dependency.

1.4.2 To support Norfolk population to reduce the use of drugs with the aim to achieve abstinence where possible and to drink alcohol within safe limits or abstinence if required.

1.4.3 To improve and increase access and engagement into the system for those needing support in regard to alcohol and drug use (including legal, illegal and New Psychoactive Substances).

1.4.4 To ensure that the system develops and delivers mechanisms to provide equitable coverage of accessibility, quality and outcomes across all delivery areas.
1.4.5 To effectively co-ordinate and deliver a personalised package of care based on the recovery principles of Recovery for all people entering structured treatment and ensure continuity of care on entry, during and upon leaving the system.

1.4.6 To proactively work to re-engage service users who have left structured treatment prematurely.

1.4.7 To deliver a ‘whole family’ model of working thereby ensuring that service users, their family and friends are central to the development, delivery and the evaluation of services and that they are appropriately involved in the recovery process and supported to access services.

1.4.8 To develop and provide support for volunteering, peer mentoring, education, training and work placements and effectively direct those resources in order to build recovery capital.

1.4.9 To support and promote the use of peer recovery networks across all stages of system delivery and beyond.

1.4.10 To improve the health and wellbeing of service users and their friends and family by developing strong working relationships with primary and secondary health and social care services and Lifestyle services to ensure clear referral pathways and the delivery of effective shared care, secondary and tertiary healthcare services for alcohol and drug related conditions (e.g. Hepatitis, HIV and liver disease)

1.4.11 To reduce drug and alcohol related hospital admissions and A&E attendances.

1.4.12 To reduce the harms associated with alcohol and drug use to the individual, the family and the community including social exclusion, stigma, those related to offending, drug and alcohol related illnesses and accidents and the risks of TB, HIV, Hepatitis A, B and C and other blood borne infections.

1.4.13 To reduce the risks of primary and secondary alcohol and/or drug related deaths and to implement the findings of Drug and Alcohol Related Death and Serious Untoward Incident reviews, Serious Case reviews and coroner’s inquests.

1.4.14 To support the reduction in drug and alcohol related crime and anti-social behaviour in Norfolk through the delivery of effective drug and alcohol interventions across the whole criminal justice pathway, including transfer from custody to the community.

1.4.15 To safeguard adults, children and young people by developing effective practices and integrated approaches to safeguarding, in accordance with related national guidance, Norfolk Safeguarding Children’s Board and the Norfolk Safeguarding Adults Board procedures and protocols.

1.4.16 To promote and raise the profile of the full range of drug and alcohol services delivered within the system with potential service users and other agencies/professionals.

1.4.17 To work with a range of statutory and voluntary and community sector organisations to deliver the required outcomes. Developing information and data sharing protocols to enhance partnership working and demonstrate outcomes where needed.

1.4.18 To have in place a robust performance management system supported by a web based information management system (that will give timely information to NCC (via an information
sharing agreement) in order to manage performance against agreed outcomes and targets and support service delivery and development. The system must be and remain compliant with current and future NDTMS and national reporting requirements and data requirements in order to upload the data for national analysis. The system should also provide the capacity to enable bespoke reports to support local needs assessment and treatment segmentation and understanding treatment pathways.

1.4.19 To work with NCC and its partners to continually improve services to alcohol and drug users, their family and friends in accordance with identified and changing needs and taking into account changes in national and local guidance, policy, evidence and practice

1.4.20 System performance in relation to the above outcomes and objectives will be evaluated and evidenced by the provider’s achievements against the required delivery and performance framework expectations contained within this specification and wider contract.

1.4.21 To seek additional funding from national or international grant/fund givers to add capacity to the recovery system.

**1.5 Components of the integrated behaviour change service**

1.5.1 The components that will be delivered are:

- Primary and secondary prevention
- Information and advice
- Screening and identification
- Early and targeted interventions
- Harm reduction and minimisation
- Proactive engagement and retention
- Effective structured treatment
- On-going mutual aid and recovery support
- Inpatient and community detoxification and residential rehabilitation provision

Recovery, aftercare and community resilience support will cross all interventions.
2. System Framework

2.1 System design

2.1.1 The intended model of service delivery has not defined geographical delivery areas. How and where the integrated behaviour change service is delivered will be agreed between the Provider and NCC based on identified local needs.

2.1.2 In addition to the agreed community delivery areas, services will also be provided in the relevant criminal justice settings which might include Police Investigation Centres (PICs), courts and local prisons.

2.1.3 The Provider is required to deliver equity of service in terms of accessibility, quality and outcomes. Access will be mapped and measured in relation to the demographics of the local community, locality and community assets, and against understanding of local needs.

2.1.4 System delivery will be developed in line with and tailored to the identified needs across the different Protected Characteristics under the Equality Act 2010, and geographical delivery areas paying particular attention to the challenges faced within Norfolk.

2.1.5 The Provider will deliver flexible, adaptive and innovative approaches to system provision, reviewing and shaping provision against need, emerging and changing trends.

2.1.6 Delivery in geographic areas and settings will also take into account the wider delivery systems of key partner agencies and services. The Provider will be required to work closely with NCC to develop services that are tailored to the local populations, including co-location (with NCC and partner agencies) where appropriate, in order to provide the highest likelihood of engaging and retaining those in need of provision.

2.1.7 The provider is required to aim for a physical presence (at least in one site) seven days a week open 8am to 8pm. There will be some specific services relating to gender, or other specific needs/characteristics. Services will need to be flexible and as such, have opening times outside of traditional working times in order to provide a service for a range of people including nocturnal client groups such as sex workers.

2.1.8 The Provider will be expected to provide a balance of provision for drug and alcohol users on evidence of need but also focusing on those with highest risk to themselves, risk to others or risk to the wider community. The provider will deliver relevant and accessible services across all areas of Norfolk.

2.2 Support for Recovery

2.2.1 Support for recovery and behaviour change will be embedded across all aspects of system delivery. This will include ensuring that the system supports the development of each individual’s personal, social and recovery capital across all four domains:

1. Social capital - the resource a person has from their relationships (e.g. family, partners, children, friends and peers). This includes both support received, and commitment and obligations resulting from relationships;
2. Physical capital - such as money and a safe place to live;
3. **Human capital** – skills, mental and physical health, and a job;
4. **Cultural capital** – values, beliefs and attitudes held by the individual.

It is vital the system reflects and responds to the demographic, cultural, ethnographic and religious attitudes, values and beliefs of local communities in developing these aspects.

2.2.2 One of the principles for the new system is a Single Assessment and Case Management System. The system should make full use of mainstream and wider support services to support service users and their families and make improvements against the required outcomes. Key in this process will be the housing support services as part of the integrated commissioning activity. These services cover a range of key client groups, such as; homeless men and women, offenders and young people. The provider will positively engage with these services and tailor its delivery in order to ensure a clear pathway and engagement for service users in need of housing support.

2.2.3 Whilst acknowledging that service users should remain in structured specialist treatment whilst there is a demonstrable need and impact, it should also be acknowledged that this is only a small part of the recovery journey. There will be a clear focus on enabling service users to maximise their use of structured and groupwork interventions whilst appropriate but to move on to lower intensity support within the single system as soon as possible and ultimately to be enabled to move on to mainstream and wider community provision and support. There are certain measures that the provider should take to facilitate this process:

- Treatment should aim always to reduce and then remove illicit or problematic use, enable independence and be focused on supporting recovery capital, health and wellbeing.
- Treatment planning and interventions should be person centred and based around the needs of individuals
- Service users should be supported, encouraged and enabled to identify their own recovery goals and objectives and fully involved in their assessment and treatment care/recovery plan
- Planning for recovery and community re-integration should be a considered from the outset of the treatment/recovery journey and reviewed regularly, with clear goals, aspirations and timescales.
- Treatment should be intensive at the beginning, reducing over time and supported by greater engagement and involvement in recovery support activities
- Recovery check-ups should be common practice for both services and users
- The transition from the structured treatment system will be supported with opportunities to access peer support and mentoring, mutual aid and wider community support. This will require the Provider to match individual client needs and interests to the available community resources e.g. mental health, supporting people and sexual health services.

2.2.4 The Provider will work with NCC to make productive links with local businesses and local communities to ensure that service users have improved opportunities to progress in their economic and social situation (e.g. work placements, apprenticeships and internships), and that the whole range of resources available across the partnership and the local community contribute to the individual’s package of care. Barriers to recovery, independence and employment should form a key part of the ongoing assessment and care planning.

2.2.5 The Provider will include the key deliverables outlined in the Public Services (Social Value) Act 2012 and demonstrate its social value in services provided, pathways with partners and promotional and marketing material as appropriate.
2.2.6 The partnership has a role in addressing stigma and educating and supporting mainstream services to improve access for those recovering from alcohol and drug dependency. It is expected that the provider will work in close co-operation with NCC, its partners and their commissioned providers to realise this ambition and address barriers to access.

2.2.8 The Provider will also support the objectives of NCC Community Safety Partnership:
- Reduce the incidences of anti-social behaviour
- Tackle domestic abuse and sexual violence
- Prevent extremism
- Build community resilience

2.2.9 The Provider will work with each districts Operational Partnership Teams which enable joint working between partners to reduce anti-social behaviour affecting the most vulnerable people.

2.2.10 The Provider will also support the following:
- Children’s Sexual Exploitation Panel
- Multi Agency Safeguarding Hub (MASH)
- MARAC
- Police operations including Gravity tackling Organised Crime Gangs (OCGs)
- Other community safety meetings as required
- Sex Working Strategic Group
- Norwich Local Alcohol Action Area (2017-2019)
- Early Help Improvement Board

2.2.11 The Provider will support the development of the new PHE funded Recovery Café in Norwich delivered by The Mathew Project

2.3 Partnership working and joint delivery

2.3.1 NCC requires the provider to take account of the following pathways to recovery when delivering services:
- Accommodation and support
- Housing support services
- Education, training and employment
- Mental and Physical, Health and wellbeing
- Drugs and Alcohol
- Finance, benefits and debt
- Children and Families
- Attitudes, thinking and behaviour

These pathways have been illustrated in Appendix 5, in relation to clients from within the criminal justice system but there will be other additional pathways within the SACMS. The provider will need to consider pathways for underserved groups including women, BME, older people, rural isolation and LGBT.

2.3.2 The core business of the SACMS is to deliver outcomes. However, alcohol and drug misuse is a complex and cross cutting issue; the importance of considering and working across the full range of the pathways as part of the overcoming of dependence and development of recovery capital is vital.
in supporting service users and the wider system in enabling progress against the required outcomes.

2.3.3 The Provider will need to take all 8 pathways into account when designing service delivery, planning care and will build productive working relationships with those agencies including early help and Norfolk Family Focus programme, whose core business is providing support and interventions within the other 6 pathways.

2.3.4.8 This pathways approach is also recognised within prison establishments and the Provider will develop productive working relationships with partners who deliver these services to prisoners.

2.4 The provider will work alongside the vibrant Norfolk voluntary and other 3rd sector groups services, and initiatives to support service users to access the most appropriate support to meet their needs. It will be included in all relevant directories.

2.5 The provider will work towards becoming a smoke free organisation. It will work closely with Norfolk stop smoking services to support both staff and service users to become smoke free and for any building used for delivery to be smoke free http://www.smokefreenorfolk.nhs.uk
3. Overarching delivery requirements

3.1 Core system delivery requirements

3.1.1 In working towards delivering the Norfolk Alcohol and Drug Behaviour Change System aims, objectives and outcomes, the system must, as a minimum, provide the following elements. Further explanation, delivery requirements and detailed objectives for each of these elements are described below or in Appendix 1.

3.2 Single Assessment and Case Management System (SACMS):

The new service will have a single assessment and case management system accessible across all delivery areas. SACMS will include:
- Screening and multi-dimensional assessment of needs
- Harm reduction information and advice
- Recovery planning, aspirations and goal setting
- Early/brief interventions
- Engagement and care co-ordination services
- Treatment services (Clinical, Psychosocial and behaviour change)
- Recovery support and aftercare will cover all four of the above.
- Facilitated access to Mutual Aid

3.2.1 There will also be a multi-media single point of contact for the entire behaviour change system. Contact will be made via a Freephone, text, website and other accessible media alongside drop-in and other face to face contact. This will be available to anyone wishing to make contact/access with the system. It will include the previous Drug Intervention Programme (DIP) Single Point of Contact for service users being referred from the Criminal Justice System. SACMS will also offer direct access or ‘drop in’ points of contact. The first point of access will offer the Motivational Milieu approach. There will be a warm, welcoming, empathic response to all direct contacts. The service will operate a corporate ‘No wrong door’ policy for those seeking help and support, for whatever reason, and the service will facilitate access/referral to other services more appropriate to the needs of those presenting to it.

3.2.2 The SACMS needs to be able to respond to all Norfolk residents, whether permanent or temporary, so will need to be able to respond to those for whom English is not their first or only language or have other communication needs (Ref: Mental Capacity Act/Reasonable Adjustment(LD)).

3.3 Early Interventions

3.3.1 It is common sense to try to prevent people developing problems in the first place. The new single integrated behaviour change system will need to work with a wide range of other services and partners to prevent people developing problems, or to help those who are currently misusing drug and/or alcohol to prevent them from developing more complex problems. Prevention can include:

- Opportunistic or short duration opportunities such as MECC and IBA
- Information for families coping with problematic drug and alcohol use
- Sexual health promotion
- Mental health promotion
• Blood Borne Virus transmission prevention
• Co-ordinated actions on domestic abuse
• Work with Children and adults safeguarding services to identify those at risk
• GPs and health centres providing prevention activities
• Training to frontline staff working with vulnerable individuals and groups (including e.g. employment, housing and healthy lifestyle services)
• Work with responsible authority’s groups on licencing, alcohol availability, night-time economy and other initiatives e.g. Purple flag status
• Information for steroid and other Image and Performance Enhancing Drugs
• Working sensitively in communities where alcohol/drug use is forbidden or other cultural norms and expectations are a barrier to engagement
• Social marketing and communications

3.3.2 Low Intensity Intervention and Outreach: Assertive and proactive outreach and in-reach which will be able to:
- Provide screening, harm reduction/minimisation and low intensity interventions
- Engage with people who are not currently accessing other systems or services
- Engage and motivate people to enter structured treatment in accordance with identified needs
- Support people leaving structured treatment to promote independence and continue in their recovery

3.3.3 Harm Reduction Interventions: A full range of harm reduction information, advice and support will be available at all times including; needle exchange, facilities and measures to prevent drug related deaths, (including routine availability of Naloxone) particularly on release from prison or following discharge from detoxification or residential rehabilitation. These will also include screening and referral pathways for Blood Borne Virus interventions, TB, COPD and other respiratory conditions associated with dependent drug or alcohol use, poor housing/homelessness etc.

3.4 Engagement

3.4.1 The new alcohol and drug behaviour change service will be dynamic and responsive to the individual’s needs, skills and assets. It will encourage and enable access to other support services, including housing support services, life skills programmes and interventions as appropriate. The motivation to change addictive behaviours is variable and the new service will be available at the right time and the right place to respond quickly to requests for help and support. The new service will build and enhance the individual’s motivation to change. Engagement will need to take place in a wide range of settings including: Criminal Justice, women only services, BME and faith groups, general hospitals and health centres, young adults and older people’s services, 3rd sector and community, and employment services.

3.5 Treatment

3.5.1 Psychosocial Interventions: A full range of evidence based and NICE recommended psychosocial interventions delivered from a range of settings including primary care, users’ homes and other safe community venues. (DH Clinical Guidelines 2007/17). This will include individual one to one, family and groups and the development and provision of family focused and life skills interventions.
3.5.2 Clinical Interventions: The service a range of flexible, evidence based recovery focused clinical interventions; including prescribing interventions and community detoxifications (Medication in Recovery: re-orientating drug dependence treatment 2012) (NICE Alcohol CG 115 and 100). It will include psychological support and link with mental health services where appropriate.

Prescribing interventions should be viewed as of a package of measures designed to support recovery and behaviour change, not as an end in itself. Prescribing should be delivered with the clear aim and purpose of support the overcoming of illicit use and set in the context of clear expectations of reducing dependence over time. Prescribing regimes should be established to ensure optimal dosing to achieve this aim and reviewed and adapted regularly based on client progress and personal goals.

3.5.3 Community Rehabilitation or Day Programmes: The Provider will deliver a step change in structured day care or community rehabilitation programmes. NCC wish to see a significant increase in the availability and numbers engaging in meaningful structured intensive or day care programmes and activities. Expectations regarding contact with services and the meaningful engagement in treatment should not be limited to short clinical appointment of 30 minutes a week or fortnightly.

The intensity of interventions should be matched to presenting needs, aims goals and aspirations to optimise treatment from the outset. The treatment ‘contract’ needs to encompass the wide range of services and interventions, commensurate with the assessed needs of users. Users need to have a greater degree of structure and activity in their day to day activities whilst addressing the issues of dependency e.g. links to education and training, life skills programmes, Health and wellbeing and fitness activities. The Provider will develop innovative programmes and partnerships for service users to engage in real or virtual community rehabilitation programmes through which users can graduate and become part of thriving recovery communities throughout Norfolk.

3.5.4 Inpatient detoxification: Currently inpatient detoxification/stabilisation is delivered on a spot purchased basis. The Provider will meet the costs of any in-patient detoxification placements following appropriate assessments. It is anticipated that there will be an increase in community detoxification and then less use of residential detoxification. The three general hospitals currently provide emergency alcohol detoxification if patients are admitted with a primary medical problem. Arrangements have also been made for planned alcohol detoxification in the hospitals on a case by case basis.

3.5.5 Residential Rehabilitation: The Provider will manage the placements of residential or community rehabilitation services. The Provider will meet the costs of any residential rehabilitation placements following appropriate assessments including aftercare packages. It is anticipated that there will be an increase in community rehabilitation programmes and then less use of residential rehabilitation. The commissioning and purchasing of residential rehabilitation placement will be compliant with the LA duties and responsibilities under the care act.

3.5.6 Primary and Secondary Health Care Liaison and Diversion: The Provider will ensure that it’s services extend into all areas of the community where high risk alcohol and drug use is present. The provider will develop productive pathways with primary care and secondary health care services to ensure service user access and make full use of these services, support primary and secondary care in working with alcohol and drug misusers to identify other health related and undiagnosed conditions that contribute to increase in morbidity and mortality among these groups and to reduce the incidence of unplanned and managed drug and alcohol related hospital admissions and attendances. The Provider will deliver an alcohol and drug liaison service within the three acute hospitals and their satellite services. The Provider will also develop effective pathways for sexual
health and contraception services. The provider will work with identified GP practices and their respective Clinical Commissioning Groups to develop a new Shared Care provision and protocol for GPs across Norfolk based on the more focused clinical delivery and recovery focused provision. GPs should be seen as key partners and collaborators as well as service providers within the delivery of the new system.

3.5.7 **Volunteering and Peer Mentoring Programme:** The system will develop and coordinate the delivery of a volunteering and peer mentoring programme. Volunteering is a natural and logical progression for those aiming toward recovery but, as yet, unable to enter the labour market directly. It provides an ideal opportunity to develop personal and social skills, relevant experience and qualifications. This progression should be seen as a key part of recovery planning to support the aspirations and goals of users in treatment.

Whilst the volunteering and mentoring programme will primarily be designed for existing and past service users it should also be open to family and friends and people from the wider community who may have direct or indirect experience of substance misuse in the past and may also have been in recovery for some time. It will create positive and mutually beneficial links with relevant statutory agency and 3rd sector volunteering programmes and the forthcoming PHE funded Recovery Café delivered by the Matthew Project and NCC Public Health.

### 3.6 Criminal Justice Pathway

3.6.1 The Provider shall deliver services across the whole Criminal Justice pathway, from arrest referral, pre-sentence, courts and custody (subsuming former DIP/CJIT functions) and the assessment, care coordination (across all structured treatment interventions) and recovery support functions for those sentenced to community sentences or post custody supervision via probation or Norfolk & Suffolk Community Rehabilitation Company (Norfolk & Suffolk CRC) and its sub-contracted providers.

3.6.2 The pathway will include:
- The successful identification of substance misusing offenders, through sharing intelligence within police and court custody settings;
- Ensuring opportunities to identify and address substance related offending is not missed and the right intervention is given to the right offender at the right times;
- Assertive outreach to optimise the engagement of those in the criminal justice system at all points in the criminal justice pathway; particularly those subject to supervision or restrictions on liberty in the community
- Early assessment and treatment as part of an out of court disposal by police
- In conjunction and partnership with CJ providers provide dedicated treatment and intervention programmes for offenders

3.6.3 The provider will work in partnership with Norfolk & Suffolk CRC to deliver effective Drug Rehabilitation Requirement (DRR) and Alcohol Treatment Requirement (ATR) provision as part of a structured intervention to address alcohol and/or drug related offending.

3.6.4 In line with Government strategy, policy and guidance, and local partnership initiatives to increase access for offenders in the Criminal Justice System the provider will ensure access to structured treatment interventions within agreed time frames and in line with Probation National Standards and the probation service good practice standards.
3.6.5 The Provider will work within the Integrated Offender Management (IOM) system to identify and engage substance misusing offenders and direct them toward appropriate alcohol and drug structured treatment or recovery support, including PPOs (prolific and priority offenders).

3.6.6 The Provider will have an agreed time spent within the IOM team in Norfolk, the 180 PPO Team or other relevant teams working with offenders.

3.6.7 Information sharing and integrated pathways are crucial to the delivery of effective integrated case management of service users in the Criminal Justice System and all efforts must be made to ensure that these service users do not fall through the net.

The service will work proactively with NHS England, the Prisons Service, local prisons and is providers to deliver a seamless pathway for those both entering and leaving prison with an identified treatment need to ensure clear and safe continuity of care at these critical times. The service will establish a dedicated liaison function in order to facilitate close working relationship and mutually beneficial outcomes for both service users/prisoners, the provider, prison service and local communities.

3.7 Service Access

3.7.1 Delivery will be on an open access basis, enabling and supporting self and wider agency referrals via SACMS and a prompt and equitable response to those in need.

3.7.2 The Provider shall, in consultation with partners, service users, family and friends actively seek ways to increase access to services. This applies to all sections of the population, especially to those who are currently under represented in the system, have the highest need or are from a priority group.

3.7.3 The Provider shall work closely with other agencies (particularly primary and secondary care health services, social care providers and third sector providers) to improve access to SACMS, which shall include, without limitation; having drop in sessions and appointment slots in relevant and appropriate settings, that other professionals can communicate to service users and that are widely publicised.

3.7.4 The Provider shall ensure that waiting times for assessment, interventions and structured treatment are as short as possible, ideally with 5 days and within expected national standards, particularly for priority groups. It is anticipated that following initial contact with SACMS they will receive a response within 15 hours. Users will then be offered an initial triage/assessment appointment within a maximum of 5 working days. Specific waiting times for clients within the criminal justice system are outlined separately.

3.7.5 Travel to services: The service should be available within 60 minutes’ travel (either by car or public transport) of each residents’ home, though the service user might choose to travel further away from their local community to access SACMS. Homeless users will be able to access any of the single system sites across the county.

3.7.6 Norfolk & Suffolk CRC will cover the travel costs for any appointment that is deemed an integral part of the DRR and ATR.
3.8 Eligibility Criteria

3.8.1 The primary target group is all Norfolk residents (either permanent or temporary) aged 18+ who wish to address their issues of alcohol and/or drug use, whether this is a structured treatment need or lower level non-structured intervention. The new service will also place an increased focus on alcohol and drug users who present the highest risk to themselves, their immediate family and the wider community. The new service will be available free of charge to all adults (18+) residing in Norfolk or who are registered with a Norfolk General Practitioner. It will also offer community services to those individuals who have no recourse to public funding (NRPF) within Norfolk County Council.

3.8.2 In exceptional cases where it is assessed that a service user who resides outside Norfolk County Council boundaries (and does not fit within the outlined exception categories) should be able to receive services delivered by the new single system, the Provider shall seek the written agreement for this to take place from NCC. Individuals who are in prisons elsewhere but usually resident in Norfolk should receive a service, maybe not face to face but in liaison with existing provision at the prison.

3.9 Exclusions

3.9.1 Although in normal circumstances every effort will be made to engage service users in treatment and support services being delivered, the Provider will have in place a clear policy, which describes circumstances in which specific services may be withdrawn and ensures that this contains appropriate risk management processes. This may include circumstances where service users are violent or highly aggressive, refuse to adhere to clear risk policies and safe treatment regimes. In these circumstances the service must be satisfied that it has developed and implemented a risk management plan, that it has not been possible to reduce the level of risk to manageable levels before withdrawing services. Alternative provision will need to be put in place. If a service user subject to a DRR or ATR is excluded the service will notify probation as soon as possible (at least 24 hours of exclusion) in order to comply with probation enforcement proceedings. Where there is a threat or perceived threat of violence the provider will comply with its general duty of care and make other professional involved with the client aware of the circumstances as soon as practically possible. The Provider will work with the commissioners to review and/or establish a local protocol with other services, particularly health services, where the excluded client is receiving a prescribing intervention and a managed withdrawal/reduction cannot be established within the exclusion period.

3.10 Priority groups

3.10.1 Those at higher risk of harming themselves, causing harm to their family or friends or harm to the wider community. It also needs to include those who are vulnerable to serious harm from others. Priority groups will also include:

- Older people 50+ years
- Pregnant women and those with parenting responsibilities
- Service users with a history of self-harm or attempted suicide
- Family and carers
- Service users who are also offending
- Clients with co-existing mental health and alcohol or drug use problems (dual diagnosis)
- Users with a history of accidental or deliberate overdose
- Service users who are injecting
- Street drinkers and those with critical levels of alcohol dependence
- Those in inappropriate accommodation, at risk of eviction, or homeless
- Drug and/or alcohol users who sell sex
- People fleeing domestic abuse
- Treatment naïve – individuals who have not previously accessed services
- Those receiving support from multiple organisations and support services
- BME
- LGBT
- British Military Veterans
- Those at risk of radicalisation
- Those in transition from young peoples to adult services (19-25 year olds)

3.11 Equality

The Provider will work within the NCC equality framework and adhere to any relevant legislation and guidance conferred on the local authority and its providers

3.12 System opening times and delivery settings

3.12.1 The Provider shall formally consult with service users, friends and family and NCC to develop opening times that meet the needs of the service users and potential service users, particularly those traditionally hard to engage and retain. The aim is that the recovery service will be available in at least one geographic area (accessible to as many service users as possible) seven days a week and there will be a woman only clinic/facility six days a week. Minimum opening times will be daily 8am – 8pm. Opening times will be flexible and in some cases accessible without appointment e.g. ‘drop in’. Public transport links and other issues such as child care arrangements will need to be taken into account. It is not envisaged that each location will need to be open seven days for the full 12 hours but there will be an opportunity for service users to access services during the extended hours in at least one location in the county. The single assessment and case management system will be accessible during the 8-8 opening seven days a week.

3.12.2 Opening times for all services shall be communicated widely to ensure that the people with alcohol and drug misuse needs, their families and friends are well informed of the services available and when and how to access them. They will be in a format and language suitable for the demographics and populations within Norfolk.

3.12.3 The Provider will deliver services from a variety of settings and venues; shared accommodation and co-location with other services in contact with key priority groups and the delivery of services from within wider range services to improve access and visibility is encouraged. These will include health and social care settings, places of worship or other community venues, statutory agency partner settings (e.g. Job Centres and Housing providers), locality hubs, and public places. The Provider will meet all costs associated with service delivery in these settings and agree terms with other providers as appropriate. All provider buildings will be fit for purpose and compliant with relevant legislation.

3.12.4 Staff working from Police Investigation Centres, in Courts, Prison liaison or any other criminal justice setting will be required to have the appropriate police/probation/prison clearances before commencing delivery.
3.13 Service user, families and friends involvement

3.13.1 Service user engagement and involvement will be at the heart of system development and delivery. The Provider will develop and deliver a service user engagement and involvement strategy as part of its quality assurance and governance processes and operated in a way such as to foster a spirit of co-production, involving service users and their family and friends in the planning, developing and evaluation of services and considering proposals for changes in the way those services are provided based on service user feedback. The aim of the strategy will be to strengthen accountability for the service, develop services that genuinely respond to the needs of users and family members and build a sense of ownership and trust.

3.13.2 The Provider will have an identified service user involvement, carer and engagement lead, ideally with a reasonably senior position and with the ability to influence the direction of service provision. They will be responsible for ensuring that these expectations are in place and any changes required as part of ongoing contract and performance management are communicated effectively to service users and others. They will support both service user and carer engagement within the agency and within NCC. They will also be the main point of contact for all partnership and individual agency related matters in this area.

3.13.3 An agreed service users’ Charter of Rights and Responsibilities will be clearly displayed within all premises and delivery settings.

3.13.4 Service users must be involved in their individual care/recovery planning and service providers must be able to provide evidence to this effect within care/recovery plans. Ideally all service users should be requested to sign and agree consent, care planning and other key documentation. NCC reserves the right to undertake both focused and general audit activity within the service as part of its general responsibilities and own quality assurance processes.

3.13.5 The Provider shall be able to evidence that the nature of the services provided has been strongly informed and regularly reviewed by appropriate service user groups and will complete an annual Service User Satisfaction Survey comprising at least 10% of the active caseload at the time and covering all elements of service delivery. Feedback from users, staff and partner organisations regarding distinct elements (e.g. Criminal Justice, Hospital Liaison etc.) will provide important feedback to key strategic partners etc.

3.13.6 As part of building a supportive recovery network around individuals, family understanding, support and attitudes towards individual are key to sustaining motivation and progress. The involvement of families, with service user’s consent, should become an integral part of recovery planning. Where feasible, the service user’s family and friends shall be invited to become involved in the service user’s treatment programme. Specific groups for carers and loved ones of treatment clients, should be established to facilitate the involvement and support for carers helps to build recovery capital within the system and the wider community.

3.13.7 The system will have in place a process for reimbursing service users and/or family and friends for out of pocket expenses related to their involvement in any service user and/or family and friends engagement activities.

3.14 Information and Communication
3.14.1 The Provider will have a comprehensive communications plan and structure. It should include but not be limited to:
- Proactive communications;
- Quick and effective responses to media enquiries, of which NCC must be informed and kept up to date at all times;
- Innovative communications and marketing activity to effectively engage service users;
- Regular communications with partners regarding on-going service provision and service access.

3.14.2 The Provider will support and participate in wider NCC communications and public health campaigns and/or initiatives.

3.14.3 Information concerning the services on offer must be made available in a variety of forms and take account of the diverse needs of Norfolk residents, including being presented in different languages, to reflect local ethnic minority populations, as appropriate. The Provider shall make arrangements for all translation, telephone, one to one and British Sign Language interpretations. Signage for translation services should be clearly visible and accessible for service users.

3.14.4 The provider will work with other specialist organisation and agencies to make any relevant and reasonable adjustments to accommodate the needs of clients with special or particular needs, e.g. Learning Disabilities, Learning Difficulties or Autism and will ensure appropriately trained and supervised staff are available to deal with these specific needs and the involvement of parents, carers and advocates is encouraged.

3.15 Reducing drug and alcohol related deaths

Norfolk has a higher than expected rate of drug related deaths relative to its population and economic position. Reducing drug and alcohol related mortality and morbidity is a key aim of this service specification and requires a number of interventions and approaches. The causes of early deaths as a result of drugs and alcohol use and misuse are many, varied and complex but rarely involve the use of drugs or alcohol directly, and thus many deaths are potentially avoidable, if not predictable.

3.15.1 Key to the reduction of drug and alcohol related deaths are:
- Identification of high risk individuals and clear and robust information sharing systems, care coordination and the delivery of integrated pathways;
- Staff training and commitment to ensure that service users have access to the appropriate harm minimisation advice and support;
- Service delivery that focuses on recovery focused engagement and interventions addressed at cessation of harmful and risky drug use;
- Appropriate risk assessments and risk management processes;
- Provision and wide availability of take home naloxone, particularly among actively using cohorts.
- Clear clinical governance processes and reporting arrangements
- A no blame and learning culture within the organisation that utilises clear process for identifying and implementing learning from risk profiles, near misses, serious and untoward incidents (SUIs) and drug and/or alcohol related deaths, including service user feedback, coroner inquests and other sources of information outside the service.

3.15.2 Moving in and out of the criminal justice system and following detoxification or rehabilitation are periods of high risk to which the Provider shall pay particular attention. The Provider will work within the guidance issued by the NTA/PHE www.nta.nhs.uk/drd-guidance-providers.aspx and any forthcoming learning and guidance from national enquiries.
3.15.3 The provider will develop and implement plans to reduce drug and alcohol related deaths, following any recommendations highlighted to clinical governance leads from confidential enquiry panels or similar mechanisms. The provider will fully co-operate with supplying information to the NCC regarding any service user or former service user death and critical and serious incidents.

3.15.4 The Provider will contribute to the annual PHE Health Protection Unlinked Anonymous Monitoring Injecting Drug User Survey (UAM PWID) that provides valuable insight into the injecting behaviours and infection and viral profile of people who inject drugs.

3.15.5 The Provider will attend the proposed NCC Drug Related Deaths meetings/ Safeguarding meetings as required.
4. Integrated digital marketing and behaviour change approach

4.1 Outline

4.1.1 NCC vision for the alcohol and drug digital marketing and behaviour change approach is to put into practice a better way to harness the potential of digital

4.1.2 It is expected that a coordinated approach to using digital technologies should support and enable the service to achieve its aims more effectively. In part by facilitating low cost ways to better engage with more Norfolk residents and support them to make and sustain changes that benefit their health. For example, digital channels can be:
- used to engage with higher volumes of residents than traditional channels and in a more engaging and participative way.
- more effective at engaging with targeted populations. For example, the power of social media to target (by geography and demographics as well as other means) is more accurate and cost effective than more traditional means of advertising.

4.1.3 But also in allowing the service to free up capacity to use traditional methods to engage with residents for who the digital approaches are not the most suitable. For example:
- Automating some email and SMS communication can free up resources to focus on delivering face to face or over the phone interactions with those that need it.

4.1.4 Digital approaches also facilitate deeper engagement and peer-to-peer interaction. For instance, a stop smoking online community facilitated by a specialist Facebook group would enable service users to continue to support and motivate each other during and upon completion of traditional support.

4.1.5 We expect the new single system to use digital approaches to:
- Recruit new users
- Retain existing users
- Re-activate users
- Improve appointments attendance rates/reduce missed appointments
- Remotely motivate and support behaviour change attempts
- Reinforce motivation and adherence to treatment goals
- Monitor user engagement with communications
- Facilitate user engagement with other local services
- Present a “joined up” approach to communications and service provision
- Make available digital therapeutic interventions and self-help materials

4.2 Scope for the alcohol and drug digital marketing and behaviour change approach

We expect a digital approach to consist of:
- The new Norfolk Alcohol and Drug Behaviour Change Service website
- Use of digital and social media to recruit new users and engage with Norfolk residents
- Use of social media to facilitate peer to peer interactions
- Supporting residents to use online behaviour change tools such as those provided by PHE and those being developed locally.
- Use of digital communication channels such as emails and SMS (text messages) to recruit and continually engage residents. For example, to reduce “did not attends” (DNA’s) for appointments, or to provide ongoing motivation during detoxification, or to provide self-reported feedback after completion.
- Forums, text, google, Facebook, twitter and other platforms as appropriate
- Develop other alternative communication between residents and experts

4.3 Tactics
4.3.1 A number of tactics will be required to achieve the aims. So, for instance Facebook could be used to do the following:

- Recruit new users as a result of targeted advertising
- Re-activate users as a result of advertising targeted at a custom audience (using email addresses of lapsed users)
- Retain existing users via motivational and informative content on the current services page and service-specific Community Groups

Use of tactics to Recruit, Retain and Re-engage service users

4.3.2 The Provider needs to ensure the target populations are engaged. It is recognised that there might be some barriers to the digital approach to overcome. The Provider will work with NCC to develop specific approaches to engage and retain underserved populations and hard to reach groups within the county.

4.4 Principles
In order to deliver this digital marketing and behaviour change approach it is suggested the following principles are followed:
4.4.1 Very little original content will be required to be produced by the new integrated service. For example, NHS Choices and Public Health England (PHE) produce an extensive set of resources that can be repurposed. Similarly, other alcohol and drug services material can be re-used (e.g. articles, tweets, links to “found” content). The recommended approach is to repurpose PHE and other relevant content but intersperse with personal and relevant localised material that emphasises the nature of activities.

4.4.2 Use technology to streamline processes and consider reducing human input and to keep costs down. Approaches such as email and SMS rather than physical mailings will be employed to keep costs down. Such automation, once set up, minimises the need for repetitive staff input. Automation can also help to improve outcomes. For example, evidence shows that SMS reminders can be very effective ways to increase adherence to behaviour change programmes and can contribute to therapeutic engagement.

4.4.3 Make it EAST (Easy, Attractive, Social, Timely). Throughout all communication, and in particular design of the website, the provider should follow the EAST principle. In particular focus should be placed on making it easy for users to achieve the desired outcome (e.g. registering, or completing a feedback survey).

4.4.4 Test, learn and adapt. Digital offers the opportunity to rapidly test different approaches to identify what works. I.e. testing 2 different subject headings in an email to see which version more people open. Changes can be made very quickly (at no cost) and most digital tools come with extensive monitoring capabilities. Therefore, via observation and scientific measurement, the provider should continue to improve and refine digital marketing approaches and messaging.

4.5 Set up

4.5.1 In order to deliver this vision, budget and time will need to be allocated for setting up the technology and development of the existing websites. As well as time to create content and communication plans for the digital marketing channels. These will need to be developed during the mobilisation period and to be ready for the first day of service.

4.5.2 Once the systems are set up there will need to be an ongoing role to manage the channels and ensure they are best used to continually engage and reengage Norfolk residents. Provision should be made for this within staffing.

4.6 Branding

4.6.1 The Provider and NCC will agree the brand for the new service. Digital channels will be agreed with NCC during mobilisation. There will be links with broader Lifestyle services.

4.6.2 Digital channels are expected to be heavily used to promote the service and to provide support to Norfolk residents to make changes that improve their health.

4.6.3 The website should be hosted independently and has 2 main purposes. It serves as a first point of contact for Norfolk residents (and referrers) to begin engaging with the new integrated system and provide a simple referral form.

Secondly, it should support Norfolk residents to access information, advice, online behaviour change tools and local directories of service. This content will include NHS Choices, PHE behaviour change
products and local online behaviour change products as well as local directories, and links to other public health service websites (e.g. sexual health and stop smoking). The new website should not duplicate this but instead create a simple user experience which supports users of the website to access the above content. Thus development of the website will be required to ensure that it is easy and intuitive for residents to access the relevant content and products and that they are not overwhelmed by the breadth of information available.

4.6.4 The website should be developed during mobilisation and be available on the first day of the service. The development of the website will require consultation and usability testing and it is expected that the local authority will be involved during this process.

4.6.5 In addition the following criteria are expected to be included.

- The website design should take a ‘mobile-first’ approach ensuring that it displays well and all key content is usable on mobile devices.
- It should include a search facility and comply with Disability Discrimination Act criteria.
- The website needs to be sensibly optimised for SEO (search engine optimisation) to ensure that it sits high in the search engines.
- It should incorporate a translation facility for priority content (such as registration forms). This could be done manually or through the use of automatic tools such as Google Translate.
- The website should have the ability to use A/B testing of webpages in order to test different messaging.
- The website should include an assessment and RAGing facility

4.6.6 The role of automated emails and SMS (text messages) is three-fold. Firstly, they should be used to confirm appointments and send timely reminders to maximise service attendance. Secondly users should be able to sign up to a sequence of motivational messages or newsletters. Finally, they can be used to help evaluate the success of the services and capture follow up data such as whether the behaviour change has been maintained.

The system (or systems) used should enable the secure storage and transfer of service user data between different elements of the service and with referring organisations in accordance with the Data Protection Act 1998.

4.7 Social Media

4.7.1 Social media channels will be used to advertise the service and engage with Norfolk residents. For example, by creating (and repurposing) engaging content they can be used to generate interest and awareness and recruit new users. They can also be used for targeted paid advertising and as a 2 way communication channel. Social channels are a great way to demonstrate the sociable side of recovery activities and services, and reduce concerns by providing transparency before attendance.

4.7.2 The provider will be expected to manage a select number of social media profiles:

**Facebook**

We anticipate the Norfolk behaviour change service using Facebook in a number of ways:

- A Norfolk Alcohol and Drug Behaviour Change Facebook Page
- Private Facebook Groups for key service areas (e.g. mutual aid)
● Facebook advertising

**Twitter**
A Norfolk Behaviour Change Twitter account should be set up and populated with tweets at least daily. Much of the content created on Facebook can be repurposed here as well as retweeting other relevant tweets (including “success” tweets of followers). Paid for advertising in the form of ‘Promoted Tweets’ should also be trialled.

**Pay Per Click (PPC) / Cost Per Click – Search Marketing**
PPC advertising should be used to isolate searches from within the county and return a Google Ad to the user to a relevant landing page within the Norfolk alcohol and drug behaviour change website.

**Online behaviour change tools**
The provider should identify relevant digital tools or apps and promote their use to Norfolk residents. Norfolk alcohol and drug behaviour change website role is to create coherent user journeys into evidence based products that motivate and support residents to make changes that benefit their health.

**4.9 Sign off and reporting**
Most digital tools come with extensive monitoring capabilities. The Provider will be expected to collate and report back the metrics identified in the data dashboard within the specification. As above the metrics should also be used to continually test and refine approaches and messaging.
Appendix 1

System Component Specifications
These sections describe the specific delivery areas and cross cutting services of the adult alcohol and drug behaviour change system that are required to be delivered.

A1A Single Assessment and Case Management System (SACMS)

A1A.1 Overview
- Single assessment and case management system, accessible within all localities across Norfolk.
- Assessment and recovery focused care planning using a pathway approach for all residents requiring structured interventions including those within the criminal justice system.
- Care/recovery co-ordination from end to end of the client journey and working flexibly and from a variety of settings.
- Family focused approach.
- Single point of contact that will include Freephone, text, web based and other media including social media formats.
- Integrated service delivery with other agencies and services.
- Preparation for, access and support, to all structured treatment interventions and wider support services including, community or inpatient detoxification and residential rehabilitation.
- A robust review process with reviews carried out at least every twelve weeks.
- An outcome focused approach

A1A.2 Objectives

A1A.2.1 To provide a county wide single assessment and case management system for alcohol and drug users entering the system.

A1A.2.3 To motivate alcohol and drug users to access and engage with services to meet their recovery objectives.

A1A.2.4 To provide initial and comprehensive recovery focused assessment, care planning, care co-ordination for all alcohol and drug users. Including:
- Court based assessment for service users potentially suitable for DRRs and ATRs
- Meeting the needs of immediate Criminal Justice requirements (e.g. court reports)

A1A.2.5 To ensure that the numbers of individuals successfully completing DRRs and ATRs is maximised.

A1A.2.6 To ensure the individual is engaged with the most suitable interventions of care to meet their needs as soon as possible.

A1A.2.7 To co-ordinate the care of individuals throughout their recovery journey; maintaining a focus on outcomes; integrating and co-ordinating service delivery by adopting a phased and layered approach matching intensity to presenting need and working jointly with other agencies and services to develop and deliver a comprehensive package of care. Making use of peer mentors and digital media to support people through their recovery journey.
A1A.2.8 To put in place a robust process of joint care/recovery plan reviews with all service users receiving structured treatment to monitor outcomes of treatment interventions and adjust care plans as appropriate at least every 12 weeks.

A1A.2.9 To provide ease of access into the SACMS and ensure seamless continuity in the treatment journey.

A1A.2.10 To provide a combination of open access assessment clinics and appointments at flexible times and within a variety of venues.

A1A.2.11 To actively plan for and manage individuals’ movement on from structured treatment as part of the service users recovery care plan.

A1A.3 Service description and parameters

A1A.3.1 Service description

A1A.3.1.1 The Provider will establish a single assessment and recovery system (SARS), which will be delivered by a wide range of appropriately trained workers (paid staff, volunteers or peer mentors).

A1A.3.1.2 Everybody in a structured treatment intervention will have a named care or recovery coordinator who is part of the SACMS.

A1A.3.1.3 The Provider will be responsible for the development of a robust single referral, screening, assessment, care/recovery planning and review framework, that as a minimum will:
- Be in line with NCC vision for a behaviour change focused alcohol and drug system
- To identify parents and assess for risk to children, young people and families
- Include referral, initial and comprehensive assessment, care planning and review tools, recovery support planning
- Ensure an assessment of each client’s recovery capital
- Ensure compliance with NDTMS, TOP, SIR (sub-intervention reviews) and other relevant local performance management requirements
- Be accessible and help to support service user engagement.

A1A.3.1.4 The framework and all associated documentation will be developed in partnership with NCC and other relevant stakeholders.

A1A.3.1.5 All service users will have a single case file throughout their engagement with the system. It will be reviewed and updated throughout their recovery journey within the system but not duplicated.

A1A.3.1.6 Any practitioners or member of the public wanting to make initial contact with the system or make a referral will have access to a single point of contact, which includes Freephone, text, website and other media including social media (Twitter, Facebook etc). This will be available during system wide core delivery hours agreed with NCC. All contacts will be responded to in a kind, caring, empathic way.

A1A.3.1.7 The SACMS will be responsible for collation of all service user care plan/recovery plan information through a single web based information management system, compatible with NDTMS.
A1A.3.2 Information and Advice -

A1A.3.2.1 During the first contact with the service user, the Provider must ensure the service user is aware of the full extent of the behaviour change system and also provide an age appropriate welcome pack containing information in writing including:
- Information about the full behaviour change system
- What can be expected from the System in the first few days and what should be expected in the longer term
- How to provide feedback
- How to complain
- What is expected from the service user

A1A.3.2.2 Information will be provided about all pathways into recovery and other relevant services available in Norfolk to service users, their family and friends. The information will be in a format that is accessible to the majority of service users in Norfolk.

A1A.3.3 Referral and SACMS Access

A1A.3.3.1 All referrals for structured treatment and recovery support will be managed and delivered within SACMS.

A1A.3.3.2 Once a referral has been made a response will be sent within 15 hours (actual hours and not working hours). If required, an assessment appointment will be offered to the client within 2 working days. This will be made (as far as is reasonably possible) at a location convenient to them.

A1A.3.3.3 There will also be opportunities for those wishing to access recovery or treatment services to do this at ‘drop in’ venues that are held within well-publicised locations and times throughout Norfolk. The locations will include both rural and urban and targeted at areas of highest need. There should be multiple doors into the Norfolk single system and no ‘wrong doors’.

A1A.3.3.4 The Provider should ensure that they notify the referrer in writing of the outcome of the first assessment appointment attended within 3 working days of the appointment. The referrer shall also be informed in writing and by other means within 24 hours if the Service user does not attend the appointment.

A1A.3.3.5 Referral times for DRRs and ATRs will be set by the courts. Under Transforming Rehabilitation it is expected that assessments will be dealt with on the same day.

A1A.3.4 Assessment

A1A.3.4.1 Where appropriate the full comprehensive assessment may be commenced at the first appointment attended by the client. However, it is expected that for most clients an initial screening assessment will be conducted first to establish the most appropriate course of action. This will be done in small groups or individually.

A1A.3.4.2 Initial assessment will determine the seriousness and urgency of the individuals needs and to identify the most appropriate type of intervention for them.
A1A.3.4.3 Following initial assessment if a need for structured treatment is identified the client will then be allocated a care co-ordinator who will take forward a comprehensive assessment and coordinate the client’s package of care.

A1A.3.4.4 If a structured treatment/psychological intervention need is not identified the client may be offered low intensity support and/or referrals to other appropriate services such as mutual aid, AA, NA, SMART etc.

A1A.3.4.5 The comprehensive assessment may take several sessions to complete. This should not delay the start of structured treatment and an initial care plan should be developed in the meantime to ensure immediate needs are addressed.

A1A.3.4.6 Initial care plans (where relevant) shall focus on enhancing motivation and outcomes that encourage the service user to engage in treatment.

A1A.3.4.7 Assessments will be recovery and outcome focused. They will include an assessment of the client’s recovery capital and will also include a full risk assessment. Assessments will include a general health care assessment ensuring appropriate referral to a service user’s GP for further management of any identified wider primary health issues, or referrals to sexual health services, stop smoking services or advice on diet and exercise.

A1A.3.4.8 Emphasis shall be given to ensure the process of assessment is meaningful for the service user and focuses on enabling the service user to remain engaged throughout the assessment period and start of treatment.

A1A.3.4.9 Joint assessments should also be conducted collaboratively with other agencies where this is in the best interests of the service user and agreed by them to do so. This will include: mental health service providers, social services, children and family services, probation and housing providers or other relevant agencies.

A1A.3.4.10 Information from the assessment shall be shared with all agencies to which the service user is subsequently referred with service user consent and in line with information sharing protocols.

A1A.3.4.11 Where service users do not attend for an assessment appointment, SACMS workers shall seek to follow-up and proactively re-engage the service user using appropriate procedures.

A1A.3.4.12 All Criminal Justice clients, who in the past were DIP eligible will, access SACMS.

A1A.3.4.13 All assessments shall include information about family makeup and relationships, proactively take into account the needs of the family, including the parenting capacity for all service users who live with or have regular access to children.

A1A.3.4.14 The Provider must work with children and young people’s services to contribute to multi-agency assessments or submit a Family Support Plan for children and families where necessary. The Provider will need a presence in the Multi-agency safeguarding hub (MASH). This is likely to be around three days a week but will be negotiated with the MASH team. Staff will need to have appropriate security clearance to access the MASH.

A1A.3.4.15 If potential additional needs are identified for any children cared for by a service user that do not require a child protection referral the provider will ascertain if a Family Support Plan is in
place and if appropriate contribute to the Early Help Hub process or if not in place work with the service user to complete one.

A1A 3.4.16 The Provider with work within the Norfolk Safeguarding Adult’s Board policies and procedures. Ensuring that safeguarding issues are considered and addressed. This will include an understanding of the Care Act, some understanding of mental capacity and the safeguarding referral and engagement route.

A1A.3.4.17 Particular consideration will be paid to service user and or family and friends with caring responsibility. Carers (including young carers) are entitled to an assessment of their own needs and to advice and support; access to this assessment will be facilitated through this system. The Provider will actively sign post or refer affected others to appropriate support and carers’ services.

A1A.3.5 Care Co-ordination

A1A.3.5.1 Once it has been identified and agreed with the client that it is necessary for them to engage in structured treatment, all service users will be allocated a named care co-ordinator within 5 working days (this would generally be 5 working days from first assessment appointment attended). All service users in structured treatment will have an allocated care coordinator at all times.

A1A.3.5.2 Care co-ordinators will be based at a range of locations across Norfolk.

A1A.3.5.3 Once allocated, service users shall be advised of the name and contact details of their care co-ordinator immediately.

A1A.3.5.4 Service users shall be kept informed at all times of who their allocated care co-ordinator is and shall be informed in writing in advance of any change to this (and reason for change). If a care co-ordinator is on leave or off on sick leave, then an alternative co-ordinator will be put in place.

A1A.3.5.5 If the allocated care co-ordinator is changed, all agencies involved in the delivery of care shall be informed in writing, including contact details of the new care co-ordinator.

A1A.3.5.6 In the event of change of care co-ordinator, the new care co-ordinator shall use the existing care plan until review stage to ensure continuity for the service user.

A1A.3.5.7 The care coordinator will be responsible (as part of the care-planning and reviewing responsibilities) for the implementation and collation of Treatment Outcomes Profile (TOPs) returns.

A1A.3.5.8 All service users accessing the system have only one named care co-ordinator plus an allocated key worker in each treatment intervention they are in contact with.

A1A.3.6 Care planning/Recovery Planning

A1A.3.6.1 Following completion of a comprehensive assessment, all service users accessing structured treatment must have a written and structured care plan or recovery plan resulting from assessment. This will build on any existing care plans completed during the comprehensive assessment phase.
A1A.3.6.2 Care plans will focus on developing recovery capital, by ensuring that there are integrated recovery pathways for each service user that maps identified treatment and wider needs.

A1A.3.6.3 All care plans shall make explicit reference to risk and identify how it shall be managed within organisational risk management structures.

A1A.3.6.4 With consent, refer service users to and support their engagement with other relevant services to meet those identified needs. Sharing care plans and proactively fostering partnership working with such agencies to develop appropriate services; jointly monitor progress and develop the care plan.

A1A.3.6.5 All care plans should be developed and agreed with the service user and the service user should receive and sign a written copy. Where appropriate GPs will receive a copy.

A1A.3.6.6 Unmet need shall be recorded on all care plans and the single information management systems. This will be reported back to the NCC to support needs assessment processes and planning.

A1A.3.6.7 Service user responsibilities and actions in relation to aspects of the care plan shall be specified and agreed.

A1A.3.6.8 Carers, family and significant others should be actively encouraged and supported to be included as partners in the care planning process.

A1A.3.6.9 The provider will undertake an annual care plan audit against national guidelines and/or NCC expectations. Key findings from the annual care plan audit including action plans for improvement shall be presented and discussed at contract monitoring meetings.

A1A.3.6.10 Exit planning shall be discussed with the service user at the earliest stage of the care planning process, and relevant activities shall be included within the care plan to support this.

A1A.3.7 Review

A1A.3.7.1 Care plans will be reviewed frequently in the early stages of recovery interventions. If the plan is for longer term care then the care plan reviews will take place at 12 weekly intervals or sooner when necessary, to take account of progress and/or change in circumstances. Care plans will be updated to reflect changes and to maintain a recovery focus.

A1A.3.7.2 The provider will develop protocols and processes with other professionals to ensure coordinated delivery and effective review of care plans.

A1A.3.7.3 The provider will maintain seamless continuity in the treatment journey at all times, by ensuring service users returning to Norfolk from residential rehabilitation/hospital/prison are engaged or re-engaged into services swiftly.

A1A.3.8 Residential rehabilitation and in-patient detoxification

A1A.3.8.1 The Provider is required to provide assessment and care coordination for access to in-patient detoxification and residential rehabilitation. Ensuring continuity of care for service users is particularly important with respect to unplanned discharges.
A1A.3.8.2 The funding for inpatient detoxification and residential rehabilitation is included in the main grant.

A1A.3.8. The SACMS care co-ordinator will still remain responsible for tracking the service users progress on their treatment journey whilst they are in an inpatient setting, including TOPs recording and other data collection and recording.

A1A.3.8.5 The provider to deliver the new innovative delivery of stepped detoxification from all three general hospitals into community setting.

A1A.3.8.6 The provider will also work with NCC to look at the development of community based rehabilitation options and sober living housing options.

A1A.3.9 Transition from young peoples to adults’ services

A1A.3.9.1 When a young person is nearing their 18th birthday and structured treatment for drug or alcohol use is still required, they will be reviewed jointly by a care coordinator from the adult system and the young people’s service. Care co-ordination will be carried out by specialist trained staff within the SACMS who have a sound working knowledge of young people’s services and treatment needs in Norfolk. Care should be taken to ensure the young person does not become disengaged. The transitional SACMS care coordinator will work with young people’s specialist alcohol and drug providers to ensure engagement within the adult system where appropriate. No young person under the age of 18 should be in the adult treatment system.

A1A.3.10 Employment Referrals: The Provider will support client engagement with employment support services. Job Centre Plus will have dedicated substance misuse champions in some of their offices. The Provider will ensure the single system has effective pathways into JCP and able to accept rapid referrals from advisers. Where appropriate the single system will have a regular presence in the Job Centres. In addition, the Provider will establish support mechanisms that keeps people in work whilst they are receiving support.

A1A.3.11 Criminal Justice

4A.3.11.1 Within the SARS function the provider will ensure that there are an adequate number of workers able to co-ordinate care for criminal justice clients.

A1A.3.11.2 Prisons: For care co-ordination arrangements for drug using offenders in prisons this will be agreed with prison alcohol and drug providers and the SACMS. The priority is to pick up offenders leaving prison as soon as possible. There may be a role for peer mentors or volunteers in supporting the transition for those leaving prison to engage with community treatment pre-and post release, including gate pick-ups for more vulnerable clients.

A1A.3.11.3 Working with Probation and CRC: The provider will work with National Probation Service and Norfolk & Suffolk CRC, to jointly assess and co-ordinate care for those on DRRs or ATRs. The Provider will deliver care co-ordination for the alcohol or drug use element of the care of service users who have an offender manager, including those in prison, particularly for those receiving drug treatment in prisons but shortly due for release to ensure continuity of care.
A1A.3.12 Drug Rehabilitation Requirements

A1A.3.12.1 Within the assessment/care planning process agree details of testing to include frequency and substances to be tested for in line with testing protocols. Treatment must be commenced within 48 hours of the court making a DRR order.

A1A.3.12.2 Ensure a named care coordinator is available for the management of DRR service user’s treatment in each service locality to enable continuity.

A1A.3.12.3 Ensure DRR assessments are jointly completed where possible. It will be expected that written feedback and recommendations will be sought from the provider to enable sentencing to proceed on the day.

A1A.3.12.4 On rare occasions when a service user who needs to be assessed for DRR is remanded in custody, time restrictions around prison visits shall be managed by the use of local video links or similar to ensure assessment are conducted within the necessary timeframe.

A1A.3.12.5 Service users with a DRR will be encouraged to access all appropriate services within the SACMS and mainstream services to meet their needs and reintegration provision.

A1A.3.12.6 Operational aspects of DRR
- The assessment is usually provided alongside a pre-sentence report (PSR) and is undertaken jointly by NPS and SACMS.
- The provider should also take into account any additional information from other relevant parts of the CJS – e.g., Liaison and Diversion Teams in the PICs if they have completed a triage assessment.

The comprehensive assessment and should include the following:
- A statement that the service user has been assessed as being susceptible to the kind of treatment being proposed
- A treatment plan, including the name and address of the service provider, and whether the treatment will be residential or non-residential
- Confirmation that arrangements for this treatment are in place
- The suggested intensity and length of the treatment

The length of the DRR does not have to correlate with the length of the supervision requirement – e.g., a six month DRR can be imposed alongside a twelve-month supervision requirement.

- The intensity and length of the DRR should be reflective of treatment need. Other requirements are added to the Community Order by NPS to reflect seriousness of offence and which add value to the DRR. The length of the overall Order (not just the DRR) should be sufficient to allow progress to be made in relation to addressing drug use, risk of harm and other criminogenic needs – this is a Probation responsibility.
- DRR assessments completed by other service providers within Norfolk & Suffolk CRC boundaries will be accepted by SACMS. If an offender outside Norfolk (but within Norfolk & Suffolk CRC boundaries) appears in a local court (and may be suitable for a DRR), SACMS will assess the offender on behalf of the external service provider.
- After the assessment SACMS will including prescription needs; drug testing results in preparation for first court review; completion of a recovery plan and contribution to Probation/CRC sentence plan.
A1A.3.12.7 Drug Testing:
- The cost for drug testing for DRR is paid by the CRC
- Drug testing should always be at least weekly and can be increased according to the needs of the individual case. It is the responsibility of SACMS to ensure that results are fed back to CRC on at least a weekly basis and included in reports for court reviews.
- A full confirmation and levels test may be sought in order to assist with particular cases where the range and levels of drugs misuse needs to be ascertained. Individuals must also be tested intermittently for other drugs to identify poly-drug use.
- SACMS with the agreement of the probation offender manager will make use of the procedure whereby offenders sign a declaration to admit misuse of drugs, thus on occasions, precluding the need for a test to be administered. Though cost issues are important this should never take precedence over clinical need. An offender will only be allowed to sign a declaration (and not be tested) on two consecutive occasions before being required to be tested again. If self-declarations are used within this criterion, results should be fed back to CRC in the same format as if a complete test were administered (i.e., and not just reported as a self-declaration). Self-declarations must never be used when the offender is stating they have not misused drugs.
- Drug testing will be undertaken with the service user in accordance with clinical guidelines for the purpose of safe prescribing and monitoring treatment outcomes. Drugs testing may also be applied when, in the SACMS assessment, having test results will aid the motivational work of the intervention, or when there is dispute regarding the result of a test or as an aid to prescribing. In both circumstances a test to provide an immediate result may be utilised. Drug tests can only be urine or oral drug tests.

A1A.3.12.8 Joint Reviews:
- Joint review meetings must be carried out as a minimum on a monthly basis between the SACMS recovery coordinator and CRC Offender Manager to assess issues of risk, motivation, contact time and potential early revocations for justice and good practice. These joint reviews must be co-facilitated by the SACMS coordinator.

Three-way Reviews:
- Three-way review meetings must take place between the CRC Offender Manager, SACMS care/recovery worker and offender as a minimum at the start of the DRR and every three months thereafter.
- If mental health is also an issue for the offender, then the review will also include representative from mental health services
- Following the joint review and the three-way review meeting, a copy of the notes should go to:
  - The Offender Manager
  - The SACMS Care/Recovery Co-ordinator
  - A copy placed on the offender’s file
- Where appropriate information from review meetings should be shared with the offender.

A1A.3.12.9 Appointments and Feedback of Information:
Offenders are required to attend for all appointments for treatment and testing and will face enforcement action in the event of failure to comply. Accordingly, SACMS will work with the CRC to ensure the following is achieved:
- All appointments offered are recorded and proof of the appointment is retained. For example, a photocopy of the appointment card is kept or a copy of the dispatched letter is kept. Offenders must also sign for appointments.
- A record of attendance at the single system must be kept.
- Probation must be given a record of attendance on at least a weekly basis. Also, contact to be recorded and notified to the CRC DRR Team in respect of onward referrals e.g. structured day care.
- All attendances (including failures) must be notified to the CRC by 10am the following working day. This is to ensure proper supervision and enforcement of the Order and so must be timely.
- Any reasons or explanations for failed appointments must be recorded and notified to Probation, along with any supporting evidence.
- Information on the progress of offenders as required for offender court reviews (SACMS staff to contribute to the CRC court review form). Updates must be sent to Probation one week prior to the court review taking place or within a timescale agreed by Probation.
- Records of contact, which may need to be relied upon in connection with future enforcement proceedings, must be made contemporaneously in the course of working with the offender by someone having personal knowledge of the subject matter of the entry. Any person who makes such an entry must also legibly sign off the entry using their signature (initials will not suffice).
- Where the SARS wishes to exclude any offender for good reason from treatment they must consult with the appropriate CRC Offender Manager before taking action whenever it is possible to do so. If action to exclude must be taken urgently the SACMS recovery coordinator must inform the CRC Offender Manager of the circumstances as soon as possible and in any event, within 24 hours of the exclusion taking place.
- All offender records to be stored securely in lockable cabinets.
- All information exchanged cannot be used for any other purpose without prior discussion with the CRC Offender Manager.

A1A.3.12.10 Contact Levels:
The DRR relates contact levels to intensity (low = 1 contact per week; medium = 8 hours per week; high = 15 hours per week). Offender managers however have full discretion on when contact is reduced/increased in line with the needs of each individual case. This discretion can be exerted at any point of the DRR. If the Offender Manager is seeking to reduce contact time this will be done in consultation with SACMS.

A1A.3.12.11 In the event of enforcement proceedings:
Records referred to above must be made available to the CRC and Legal Adviser and Offender Manager. Witness statements in proper form (as deemed by CRC) should be submitted to the Offender Manager. SACMS staff must be prepared to attend court and give evidence if required.

A1A.3.12.12 The Provider will sign and agree an Information Exchange and Communication Protocol with Norfolk & Suffolk CRC

A1A.3.12.13 Following Completion:
The service user needs to be prepared for end of DRR and what process will be put in place to access other recovery services prior to completion. Following the successful completion of a DRR, the provider will make all efforts to retain the service use in treatment on a voluntary basis where it is assessed as being of benefit to the service user. Involvement in recovery support activities alongside
DRR supervision and attendance will be beneficial in supporting this transition and continued involvement.

**A1A.3.13 Alcohol Treatment Requirements**

A1A.3.13.1 Ensure a named care coordinator is available for the management of Alcohol Treatment Requirement (ATR) service user’s treatment in each service locality and court to enable continuity.

A1A.3.13.2 Ensure ATR assessments are jointly completed. It will be expected that oral feedback and recommendations will be sought from the provider to enable sentencing to proceed on the same day.

A1A.3.13.3 On rare occasions when a service user who needs to be assessed for ATR is remanded in custody, time restrictions around prison visits shall be managed by the use of local video links or similar to ensure assessment are conducted within the necessary timeframe.

A1A.3.13.4 Service users with a ATR will be encouraged to access all appropriate services within the SARS and mainstream services to meet their needs and reintegration provision.

A1A.3.13.5 Operational aspects of the ATR:
- Treatment to commence within two working days of sentence
- The Provider shall develop a secure electronic communication process to enable the most effective exchange of information between the agencies involved in delivery of the ATR
- The SACMS shall ensure the named Offender Manager is informed of non-attendance of any aspect of the programme as soon as possible but at the latest within 24 hours of failed appointment for the purposes of enforcement. The will also feedback to the Offender Manager after each session attended
- Joint recovery plans between the Provider, Offender Manager and the service user
- Where applicable the Care coordinator may be required to provide a written or oral statement to the court detailing the offenders lack of engagement or unacceptable behaviour
- Discharge, suspension or enforcement of the order shall be managed through joint working between the Provider agency and Offender Manager.

A1A.3.13.6 For ATR orders service users shall be referred to the appropriate part of the treatment system for:
- Minimum 8-week programme, to be reviewed based on need
- Minimum of half hour treatment per session
- Minimum of monthly reviews to look at progress and planning
- Full review at end of 8 weeks and refer into treatment where required

A1A.3.13.7 Following Completion:
Following the successful completion of an ATR, the provider will make all efforts to retain the service use in treatment on a voluntary basis where it is assessed as being of benefit to the service user.

A1A.3.13.8 For ATRs the provider will provide alcohol misuse assessment, care coordination and clinical treatment including community and inpatient detoxification and rehabilitation. They will contribute to the risk management of offenders and share appropriate risk information in a timely manner. Norfolk & Suffolk CRC will provide offender management.

A1A.3.13.9 The Provider will sign and agree an Information Exchange and Communication Protocol with Norfolk CRC.
A1B Early Interventions and Outreach

A1B.1 Overview

- Delivery of flexible low intensity interventions and outreach.
- Focus on hard to reach to groups who are not engaging with support or structured treatment.
- Initial assessment, brief intervention and onward referral to SACMS within Police Investigation Centres and courts where appropriate.
- Support to enter treatment, retain engaged with and leave structured treatment interventions including aftercare and links with peer led recovery and community support.
- Delivery of a range of brief interventions in line with identified needs.
- Outreach – particularly to vulnerable groups including but not exhaustive:
  - Street drinkers including those who don’t speak English
  - Women drug users who sell sex
  - Long term unemployed
  - Coexisting mental health conditions
  - Military veterans
  - Hidden BME groups
  - Those who have dropped out of treatment in an unplanned way
  - Older adults

A1B.2 Objectives

A1B.2.1 To deliver the early interventions and outreach services.

A1B.2.2 To proactively engage with vulnerable groups and under-served groups, to increase the numbers of people entering and engaging within the SACMS.

A1B.2.3 To effectively support and prepare individuals to access and engage with structured services.

A1B.2.4 To provide aftercare support and encourage access to recovery support within the wider community or prison establishment including mutual aid, volunteering and the peer mentoring following structured treatment.

A1B.2.5 To accept referrals form the Liaison and Diversion service in Norfolk PICs.

A1B.2.6 To ascertain why alcohol and drug users prefer not to attend a service centre or access structured treatment.

A1B.2.7 To provide initial assessment of need and risk ensuring access to structured interventions via the SACMS.

A1B.2.8 Getting people ready/stable for psychosocial interventions.
A1B.3 Service description and parameters

A1B.3.1 Proactively engage with and provide low intensity interventions for those individuals who are not engaged with structured treatment or whose drug and alcohol related needs do not require a structured treatment package of care (particularly where their addiction has led to offending).

A1B.3.2 Deliver assertive outreach and endeavour to re-engage with people who have left or at risk of leaving structured treatment prematurely or in an unplanned way. Paying particular attention to the re-engagement of alcohol and drug misusing offenders particularly if at risk of entering enforcement proceedings and others who are at most risk of harm to themselves or causing harm to others (for example pregnant women).

A1B.3.3 Provide initial triage assessment of need and risk in a variety of settings and timings to meet the diverse needs of people with alcohol and/or drug misuse issues across the county, without the need for appointment where possible but this should not constitute a barrier to service utilisation.

A1B.3.4 Delivery will be on an open access basis within the agreed service opening times. There should be no waiting times to access low intensity support interventions.

A1B.3.5 Provide a range of low intensity interventions to meet identified needs including without limitation:
- Advice and information;
- motivational interviewing;
- relapse prevention;
- brief Interventions;

A1B.3.6 Develop and deliver brief interventions appropriate for those who use performance and image enhancing drugs.

A1B.3.7 Address needs holistically via referral/sign posting to support services for example; education, training, housing, physical health (including Blood Borne Virus support), mental health, family and carer support, social networks and advocacy. Develop joint working with other providers.

A1B.3.8 Via in-reach and outreach activities, informally gather information which supports developments within the wider system, for example reasons given by service users who are not accessing more structured treatment.

A1B.3.9 Identify target groups and areas for in-reach and outreach activities and develop and provide appropriate services in negotiation with NCC.

A1B.3.10 Work in conjunction with peer support and mutual aid groups to enable on-going recovery.

A1B.3.11 The Provider will ensure appropriate levels of in-reach into hostels including probation approved premises and to other homelessness service areas to work to ensure that those at risk of homelessness or who are homeless who also have alcohol and/or drug misuse issues have access to low intensity support and structured treatment where necessary and also to minimise threat of eviction.
A1B.4 Police Investigation Centres and Courts

A1B.4.1 NHS England currently commission a Liaison and Diversion service to provide in-reach to adults in detention in Norfolk PICs by the Liaison and Diversion teams include: -
- Identifying offenders in the PICs who misuse alcohol or drugs
- Provide advice and support and harm reduction interventions and encourage them to enter the treatment system
- Provide motivational interviewing and brief interventions where relevant
- Work in partnership with the police who identify and encourage offenders to access the system
- Liaise with the SACMS care co-ordinators who co-ordinate the offenders’ treatment plan in the community or through prison and back to the community
- Address their immediate alcohol and drug related needs and how it relates to offending
Liaise with the CRC (who will broker the provision of treatment and/or other appropriate support if the individual is sentenced to a community sentence, or released from prison on licence and subject to statutory supervision).

A1B.4.5 A memorandum of understanding with Norfolk & Suffolk CRC will be developed and agreed to ensure robust care-pathways are in place and ease of access into structured treatment for clients detained within prisons.

A1B.4.6 Work in partnership with the police and other partners to identify and provide suitable treatment for offenders who are subject to any type of out of court disposal.

A1B.5 Sex workers

A1B.5.1 The Provider to support vulnerable service users who sell sex in which will include:
- A focus on vulnerable women including an understanding of sexual exploitation, and the government strategy tackling violence against women and girls
- Late night outreach in order to provide services to women who do not access services during the day
- Supporting women in safe community settings to develop self esteem
- Support women and men to engage into structured treatment including prescribing and psychological support
- Support women to access primary care services
- Work in partnership with the Norfolk IOM Team
- Rapid access prescribing clinic one evening a week
- Support to women to find safe housing options
- Work in Partnership with Norfolk Police and the office of police and crime commissioner
- Work effectively to encourage women to report sexual violence and access the SARC
- Develop effective partnership working with other relevant agencies

A1B.5.2 The provider will ensure the complete safety of staff carrying out any outreach work outside of normal working hours in the evenings.

A1B.5.3 The staff working with this vulnerable service users group should have appropriate supervision and support
**A1C Engagement and Structured Psychosocial Interventions**

**A1C.1 Overview**

This part of the system will provide a menu which includes a wide range of psychosocial interventions designed to meet the many and varied needs of service users, particularly those receiving structured pharmacological interventions (prescribing) where interventions will be provided concurrently. Interventions will be evidence based and will include the following: -
- International Treatment Effectiveness Programme (ITEP)
- Counselling
- Cognitive behaviour therapy
- Motivational Interviewing
- Group work/structured day programmes focused on recovery and providing a wider menu of options, including abstinence focus
- Family focused interventions/parenting programme(s)

Pathways need to be established with existing mental health providers including community teams and Wellbeing (IAPT).

**A1C.2 Objectives**

A1C.2.1 To provide a wide range of evidence based psychosocial interventions in a variety of settings which will meet the assessed needs of all alcohol and drug users within Norfolk.

A1C.2.2 To ensure that services are accessible and inclusive and relevant to priority and underserved groups.

A1C.2.3 To ensure that services offered do not duplicate or replace existing mainstream services and promote social inclusion by ensuring that service users can move on as soon as possible to using mainstream services.

A1C.2.4 To ensure that the structured psychosocial interventions delivered, contributes towards achieving goals in each service users care plan.

A1C.2.5 For community rehabilitation/day programmes:
- To manage the various aspects of recovery including ending alcohol and drug use, physical and psychological health and wellbeing, life skills and maintaining positive family and social networks;
- Enable service users to use their time constructively, engaging in meaningful activities and working towards volunteering, education, training or paid work;
- Offer service users the opportunity to develop new skills and individual strategies to build sustainable recovery capital;
- Provide opportunities for service users to engage with agencies which will promote health, economic and social wellbeing and reintegration. This could include Norfolk Healthy Lifestyle services and local colleges.
A1C.3 Service description and parameters

A1C.3.1 Service description

A1C.3.1.1 The following interventions will be provided within the outlined parameters. Evidence based structured psychosocial interventions which comply with NICE guidance 52 such as ITEP, Cognitive behavioural therapy (CBT) and care planned counselling as defined as ‘formal structured counselling approaches with assessment, clearly defined treatment outcomes and regular reviews’ to service users who have been assessed as needing this intervention.

A1C.3.1.2 A range of delivery methods shall be employed to suit specific users and user groups.

A1C.3.1.3 All service users accessing a psychosocial intervention shall have a named keyworker, who will liaise with the service users SACMS care coordinator. The key worker will update the care co-ordinator regularly with service user progress as appropriate, bringing to the attention of the care co-ordinator any significant changes in circumstances or newly identified treatment needs.

A1C.3.1.4 Structured psychosocial interventions shall be provided as either a primary treatment intervention or as part of a wider treatment package e.g. structured day programme or as an aftercare intervention to consolidate and maintain gains obtained in another treatment setting. Interventions will be delivered in a one to one basis, in small group, or larger groups.

A1C.3.1.5 Work in partnership with a range of local providers. This will include Wellbeing Norfolk and Suffolk for the provision of counselling and IAPT for mild to moderate depression and anxiety. For more complex individuals they will be referred to mental health specialist services.

A1C.3.1.6 Where an appropriate mainstream service is available but it is assessed that the service user needs a specific alcohol or drug related intervention, the service user will be moved over to mainstream services as soon as possible. Consideration needs to be taken regarding joint assessment, outreach as a number of clients will be shared.

A1C.3.2 Parenting Programmes

A1C.3.2.1 The Provider will work in partnership with Early Help & Norfolk Family Focus programme, to develop and deliver parenting programmes which will meet the needs of alcohol and drug using families.

A1C.3.2.2 Where appropriate service users will access available mainstream parenting courses. This will usually be following some preparatory work to address specific alcohol and drug related need and ensure the family are ready for group work.

A1C.3.2.3 In situations where it is assessed that the parent/family need to access a specialised and specific parenting programme for those who use alcohol and/or drugs this will be delivered jointly with other appropriate professionals. The provider will provide appropriate staff to be trained to deliver the programme.

A1C.3.2.4 The Provider will contribute to the facilitation of existing non-specialist parenting programmes within Norfolk. This will entitle the provider to refer their service users to mainstream core programmes.
A1C.3.2.5 The Provider will ensure that appropriate staff attend relevant parenting programme training course to enable them to deliver interventions that prepare parents for a parenting course.

A1C.3.2.6 The Provider will work with NCC Young Peoples services to offer awareness raising training around meeting the needs of alcohol and drug using parents and their children in the context of parenting programmes.

A1C.3.2.7 The Provider will work actively to increase referral rates from the integrated treatment system to relevant parenting programmes.

A1C.3.3 Structured community Rehabilitation/ Day Programmes

A1C.3.3.1 Provide a step change in the numbers and range of flexible structured day/community rehabilitation programmes which distinguish between cohorts who are abstinent, stable or active in their substance use and be focused on increasing recovery capital.

A1C.3.3.2 Particular attention will be given to developing structured day/community rehabilitation programmes that enable female clients, older Adults, LGBT clients or BME clients to engage with and programmes which support clients post community or in patient detoxification.

A1C.3.3.3 Provide day and/or group work programmes which will (as a minimum) meet the needs of service users who are on a DRR, in accordance with Probation National Standards and in collaboration with Norfolk & Suffolk CRC.

A1C.3.3.4 For other service users’ day programmes will be for a minimum of 12 weeks, length of other groups work programmes will be determined by client group need and the focus of the programme itself. Hours of attendance will be based on assessed individual need.

A1C.3.3.5 In community rehabilitation/structured day care provide or arrange for provision of a range of practical sessions including getting people ready for recovery, life skills, education and training, relapse management and harm minimisation and other provision in line with identified service user need.

A1C.3.3.6 In community rehabilitation/structured day programmes, one to one support shall be more intensive at the beginning of the treatment journey, particularly for service users who need to build up the ability to benefit from group work.

A1C.3.3.7 Particular attention will be paid to ensuring that structured day and group work programmes are developed and delivered in a way which supports easy client access and minimum waiting times (for example flexible entry points within a programme or preparation groups).

A1C.3.3.8 Consideration should be given to developing distinct community rehabilitation/structured day programmes for older (over 50 years) alcohol and drug users.

A1C.3.3.8 Consideration should be given to developing distinct community rehabilitation/structured day programmes for specific BME groups or faith based groups of alcohol and drug users (e.g. Eastern European, Muslim, or Sikh)
A1D Clinical Interventions and Treatment -

A1D.1 Overview -

- Delivery of prescribing interventions for stabilisation, reduction, withdrawal, detoxification and relapse prevention.
- Community detoxification – further developed in partnership with housing providers.
- BBV testing and vaccinations.
- Develop shared care with GPs and practices.

A1D.2 Objectives

A1D.2.1 For Community Prescribing

A1D.2.1.1 To deliver comprehensive clinically safe, efficient and effective specialist community prescribing services.

A1D.2.1.2 To actively work towards recovery and limiting the use of long-term maintenance prescribing where possible and become clinically safe.

A1D.2.1.3 To ensure that individual community prescribing regime contributes towards achieving goals in each service users care/recovery plan.

A1D.2.2 For Shared care

A1D.2.2.1 There is currently a reduction in numbers in shared care in Norfolk. The Provider will plan, develop, manage and run the shared care scheme in Norfolk, developing new specifications and contracts with GP and practices.

A1D.2.2.2 To actively work towards recovery and avoid long-term prescribing in primary care services.

A1D.2.2.3 To develop a range of models which will extend the provision of high quality shared care arrangements.

A1D.2.2.4 To ensure that an individual’s Primary Care prescribing regime contributes towards achieving goals in each service users care/recovery plan.

A1D.2.2.5 To improve physical health through regular checks and monitoring.

A1D.2.3 For drug and alcohol testing

A1D.2.3.1 To manage, deliver and coordinate the drug and alcohol testing arrangements.

A1D.2.3.2 To evidence compliance with treatment and progress made.

A1D.2.3.3 To evidence the nature of current and recent drug misuse.
A1D.2.4 For community detoxification

A1D.2.4.1 To provide community detoxification within a range of settings in line with NICE guidance 51, extending the use of community detoxification.

A1D.2.4.2 To provide continuity of detoxification for service users leaving the three general hospitals. There should be no gaps between hospital and community

A1D.3 Service description and parameters

A1D.3.1 Prescribing

A1D.3.1.1 All service users accessing prescribing interventions shall have a named key-worker, who will liaise with the service user’s SARS care coordinator. The key worker will update the care co-ordinator regularly with service user progress as appropriate, bringing to the attention of the care co-ordinator any significant changes in circumstances or newly identified treatment needs.

A1D.3.1.2 To provide specialist prescribing for stabilisation, reduction, withdrawal, detoxification and relapse prevention to clients with an assessed and established need across the following groups:
- Opiate users;
- Dependant alcohol users;
- Dependant stimulant use, including symptomatic prescribing where appropriate alongside individual support;
- New psychoactive substances

A1D.3.1.3 It is expected that the percentage of clients on a reducing prescription or on detoxification will increase and it is expected that detoxification is carried out in the community in line with NICE guidance. Drug costs should then be reduced over the length of the contract.

A1D.3.1.4 Develop clear agreements and goals of the prescribing regime with all service users in accordance with overarching care/recovery plan goals, monitor progress regularly and report to care co-ordinator.

A1D.3.1.5 All services provided shall be within agreed prescribing protocols drawn up by clinical leads in the prescribing service and agreed with NCC.

A1D.3.1.6 Prescribing interventions shall have clear protocols around prescribing regimes, reviews, purpose and function. This information shall be shared and agreed with all service users prior to the start of the intervention.

A1D.3.1.7 For service users who are released in a planned or unplanned way from prison on a maintenance prescription, the prescribing programme shall continue without any interruptions to the service user
A1D.3.1.8 For service users referred to above, prescribing interventions shall be reviewed at the earliest opportunity with the care coordinator to ensure that they are contributing towards overall care plan goals.

A1D.3.1.9 For DRR service users, prescribing shall commence at the most 7 days after the first treatment appointment.

A1D.3.1.10 Other groups of service users may also need to be prioritised based on need, priority status and risk assessment (e.g. pregnant women, women drug users who sell sex).

A1D.3.1.11 For all other service users, waiting times for prescribing shall not exceed 5 working days from referral to intervention.

A1D.3.1.12 NCC will be consulted on any significant proposed changes to prescribing practice prior to them being implemented to ensure potential system impact can be assessed.

A1D.3.1.13 A clinical assessment is mandatory prior to prescribing. This will build on and contribute to the comprehensive assessment undertaken by the client’s care coordinator.

A1D.3.1.14 Prescribed drug, amount and dispensing frequency for each service user must remain a clinical decision based on service user need and risk. However, Providers shall need to evidence within this, that prescribing is carried out in an efficient, effective and cost effective manner.

A1D.3.1.15 Ensure discharge from specialist prescribing is managed in a planned way with the clients care coordinator and that measures have been taken to avoid risk of overdose.

A1D.3.1.16 Ensure there is rapid referral back into treatment if required.

A1D.3.1.16 Regularly review prescribing regimes (at least every 12 weeks) with the care coordinator to ensure they are in line with care-plan goals, clinical need, progress made and service user preference.

A1D.3.2 For Shared Care

A1D.3.2.1 To develop, manage, coordinate and fund the shared care scheme, including:
- Work with GP’s to engage them to deliver shared care services and monitor uptake numbers
- To manage, promote and review all aspects of the shared care scheme in Norfolk
- Undertake activities to raise awareness and promote the benefits of the Shared Care Scheme to GP’s, specialist providers and service users with the purpose of increasing uptake
- Support GP’s to access training including RCGP training, or deliver the training
- Design shared care contracts and payments to GP for the delivery of shared care services
- Ensure efficient and effective referral pathways to shared care are developed, reviewed and maintained

A1D.3.2.2 In agreement with the care coordinator and service user, referral to GP shared care prescribing for service users whose substance use is stable in accordance with agreed criteria.

A1D.3.2.3 In partnership with GP, develop clear goals of prescribing regime with all service users in accordance with overarching care plan goals, monitor progress regularly and report to Care coordinator. Including prompt referral back to specialist prescribing where needed.
A1D.3.2.4 In partnership with the GP regularly review prescribing regime to ensure it is in line with care plan goals, clinical need, progress made and Service user preference.

A1D.3.2.5 The SACMS care co-ordinator to ensure that regular drug screening is undertaken in line with agreed prescribing protocols and national guidance, ensuring that results are communicated as appropriate to all professionals involved in the service user’s care.

A1D.3.2.6 Ensure a smooth transition for the service user between secondary and primary care prescribing services. Developing, clear agreed referral criteria and protocols for the pathway between specialist prescribing and primary care prescribing

A1D.3.3 Drug and Alcohol Testing

A1D.3.3.1 The Provider shall fund, develop, manage and deliver all aspects of the drug and alcohol testing in Norfolk for SACMS service users.

A1D.3.3.2 The Provider shall manage all activity in relation to providing the Service including the procurement, storage, distribution, monitoring and disposal of all stock/equipment.

A1D.3.3.3 The Provider shall provide drug testing for all service users subject to DRR’s in line with national standards.

A1D.3.3.4 The Provider shall provide drug testing and alcohol testing for all other service users as appropriate in line with guidance and clinical need.

A1D.3.3.5 The Provider will produce written procedures on the collection and storage of biological samples, their despatch to a laboratory and the discussion and management of the reported results as shall be available including:
- Instructions on storage of test devices
- The calibration of equipment
- The recovery of results
- Infection control procedures
- Disposal of biological fluids
- Appropriate facilities for sample collection
- Appropriate facilities for testing within all clinical delivery sites

A1D.3.3.6 For service users other than DRR’s, drug testing protocols shall be written, in place and adhered to which identify:
- The purpose or intention of diagnostic drug testing
- The criteria by which a Service user shall be deemed eligible for diagnostic drug testing
- The frequency of diagnostic drug testing
- The type of substances that shall be tested for
- The collection of biological samples, their storage and despatch to a laboratory
- The discussion and management of reported results relating to the testing of biological samples
- Maintaining the safety, security and integrity of biological samples, test
- Recording of the time of samples and recording of consumption of prescribed and illicit drugs in the days leading up to the sample being provided
- Obtaining of Service user consent
- Sampling under a ‘Chain of Custody’ for confirmatory testing
Inter-agency protocols on the implementation of all aspects of this specification

A1D.3.7 For service users subject to DRRs, similar drug-testing protocols meeting national standards shall be developed and agreed with Norfolk & Suffolk CRC. Frequency and confirmation testing will need to be agreed.

A1D.3.8 All test results shall be shared as appropriate with other organisations involved in delivery in line with protocols referred to above.

A1D.3.9 The Provider shall work jointly with other agencies to enable drug and alcohol testing to take place in flexible locations to suit the treatment journey of the Service user.

A1D.3.10 All drug and alcohol testing should be referred to on care plans identifying a clear rationale.

A1D.3.4 For community detoxification

A1D.3.4.1 Community detoxification will be delivered in line with NICE guidance 51 for those who are opioid or alcohol dependent and wish to become abstinent. In most cases community based detoxification will normally be offered. Exceptions to this are for those who will require in-patient detoxification or a combination of in-patient followed by community detox are set out below and will be in line with NICE guidance 51:
- Not benefited from previous formal community detoxification;
- Significant co-morbid physical or mental health conditions requiring medical/nursing care;
- Complex poly detoxification requirements eg alcohol or benzodiazepines;
- Significant social issues which will limit efficacy.

A1D.3.4.2 The provider will work closely with housing agencies to optimise the number of people where housing support can facilitate community detoxification.

A1D.3.4.3 Ultra rapid opiate detoxification using anaesthesia or short term sedation over 1-5 days, shall not be carried out.

A1D.3.5 Other delivery requirements

A1D.3.4.1 Refer to and liaise with pharmacies in relation to supervised consumption in line with clinical guidelines and agreed protocols.

A1D.3.4.2 Liaise with referrers and relevant others including the care coordinators.

A1D.3.4.3 Provision of the Service shall include all costs relating to prescribing such as FP10 costs, prescription pick-up costs and clinical waste collection.

A1D.3.4.4 All costs in relation to providing the service including the procurement, storage, distribution and disposal of all stock/equipment (including needles, syringes and medicines) and all laboratory testing as required shall be met by the provider.

A1D.3.4.5 To manage and co-ordinate the pharmacy needle exchange and supervised consumption. To develop new pharmacy contracts and payments to pharmacists for needle exchange, supervised
consumption and other relevant support services. Training or accreditation will be included in the contracts.

A1D.3.4.6 All locations for the service shall meet the requirements for clinical use and service user’s privacy.
A1E Cross Cutting Delivery Areas

This section of the specification provides outlined expectations relating to cross cutting service delivery areas. The areas are to be embedded within the system delivery. These can be system wide or incorporated within the most appropriate system delivery service areas.

A1E.1 Harm Reduction

A1E.1.1 Harm reduction information advice and guidance: This will include but not be limited to:
- Advice and support on safer injecting, on reducing frequency of injecting and on reducing initiation of others into injecting;
- Advice and information to prevent the transmission of BBVs and other drug and alcohol related infections;
- Advice and support on preventing risk of overdose and drugs and alcohol related deaths.

A1E.1.2 Needle exchange

A1E.1.3 The Provider shall deliver needle exchange and harm minimisation services in line with NICE Guidelines (PH18) http://guidance.nice.org.uk/PH18, in appropriate settings and at appropriate times, manage all activity in relation to providing the service. The co-ordination of the needle exchange services including the procurement and funding of sterile injecting equipment and paraphernalia is included in this specification. Storage and safe disposal of all stock/equipment for the open access needle exchange, and other support as well as promoting safer injecting practices including safe disposal of equipment is a requirement of the provider. Return rates should be monitored.

The provision of needle exchange to adults who inject non-prescribed anabolic steroids and other performance and image-enhancing drugs is included in this specification

Naloxone will be made available for distribution through the needle exchange

A1E.1.4 The Provider will work with NCC Environmental Health where there is increased reporting of sharp finds.

A1E.1.5 If a young person under 18 presents to the needle exchange she/he should be encouraged to enter a treatment programme. The young person should be encouraged to access the young people’s service. This situation cannot be achieved immediately, in which case it will be necessary to supply injecting equipment to reduce substance related harm. Injecting equipment and advice should only be supplied to a young person where there is evidence that withholding it would a greater risk than continued or increased injecting drug misuse.

A1E.1.6 Under such circumstances, fewer needles and syringes should be given to a young person than an adult would receive, to increase contact with the practitioner so the situation can be frequently monitored and efforts made to change behaviour. The provision of injecting equipment should form part of a treatment intervention and not be an alternative to it. All young people receiving injecting equipment should have a written care plan. This is best done by a specialist young people’s worker.
A1E.1.7 Young people should not be encouraged to access injecting equipment from adult needle exchange facilities as these services operate in a low-threshold environment that is inappropriate for young people.

**A1E.1.7 Blood Borne Virus (BBV) interventions**

4E.1.8 The provider will deliver interventions that specifically aim to prevent diseases due to blood borne viruses (BBV), infections and other drug related harm, including over dose and drug related deaths and TB. And also:
- Provide advice, information and counselling, as appropriate, for viral hepatitis and HIV testing (pre and post-test)
- Test for blood borne viruses including Hepatitis B and Hepatitis C and HIV screening
- To provide referrals for service users to access Hepatitis B vaccinations, sexual health and BBV screening
- Provide the opportunity in-reach sexual health staff to deliver vaccinations
- To provide referrals for service users to access treatment for hepatitis B, C and HIV infection and sexual health services

**A1E.2 Telephone support**

A1E.2.1 The single integrated system will provide telephone support 7 days a week including bank holidays, 8am to 8pm. Adequately trained and supported staff will answer the calls and give advice and support to service users, potential service users, family and friends and professionals and will sign post callers to other appropriate services. The help line will fully integrate with the new website.

A1E.2.2 Where it is assessed as necessary, urgent referral to other services will be made for example, to social services emergency duty team or for emergency health care needs. Staff in police cells may call the help line number to make a referral for an in custody assessment or to notify the SACMS of the movement of a service user within the Criminal Justice System.

A1E.2.3 Out of hours 8pm to 8am, automated messages will be given directing individuals to the relevant national 24 hour helplines and emergency number for health and social care. Service access time will also be given and voice message can be given. Response to voice messages shall be responded to within 10 hours.

A1E.2.4 The Provider will provide NCC with quarterly reports of usage of the telephone help line, broken down into categories as requested in the Performance Management Framework (Appendix 4).

**A1E.3 Primary and secondary health care pathways and liaison**

A1E.3.1 **Primary Care:** The Provider will work proactively with and where possible, within primary health care settings to:
- Develop clear and robust referral pathways supporting client access and engagement. The system of particular importance is the further development of alcohol care-pathways with primary care services
- Build strong joint working relationships with health care staff including, GPs, Dentists, Nursing Staff, Midwives and Health Visitors support client care pathways, improved outcomes and
recovery. This is particularly important and in the work taken forward within the system to support those affected by the clients’ alcohol and drug misuse and in the delivery of family focused services. The staff need to be part of the GP practices’ Multi-Disciplinary team meetings.

- Build and maintain links with primary care teams, GPs and other health staff in order to optimise a joint approach to low intensity, brief interventions and harm minimisation in the community and to encourage referrals to the recovery system
- Support the development and delivery of shared care services
- Raise awareness of the issues relating to alcohol and drug misuse amongst primary care staff, the necessity for improving detection rates and responding appropriately to the findings of assessments
- Deliver support to primary care teams to build confidence in their ability to assess and instigate appropriate interventions around alcohol and drugs primary care and community settings, including building awareness of the services available and the pathways for recovery
- Through screening processes or receiving referrals from the primary care services or health trainers, identify patients at risk from harmful or hazardous drinking or dependant drinkers and ensure they have brief intervention support where indicated and are referred to SARS for a comprehensive assessment and structured intervention where indicated.

A1E.3.2 Support primary care professionals to develop and deliver brief interventions for those who require help with the misuse of prescribed or over the counter medicines. The Provider will offer expert advice to GPs and other primary care professionals on the safe management of prescribed or over the counter medications. This is likely to include benzodiazepines or opiate based pain relief. Individuals will remain under the care of primary care.

A1E.3.3 The Provider will aim to ensure that all clients are registered with a GP and in particular pregnant service users supporting them to access antenatal care through continuation of the specialist midwifery clinic or through the GP and practice based midwife.

A1E.3.4 Secondary Care

A1E.3.4.1 Hospital liaison: Provide an alcohol and drug liaison service within the three general hospital for patients whose admission is alcohol and/or drug related. This will include;
- Working with existing hospital links to develop shared pathways and protocols for the identification and management of patients with alcohol and or drug related admissions and attendances;
- Identify, signpost and provide brief interventions for patients with drug and alcohol related hospital admissions with the objective of reducing length of stay and reducing readmissions;
- Reducing patients’ risk of future alcohol and or drug related admissions and/or attendances by discussing the reason for their admission, addressing lifestyle behaviour and choices and ensuring effective engagement with structured treatment and/or other support services to those who need it;
- Assessing patients prior to discharge to engage them into treatment services post discharge;
- Develop with existing hospital links a recognised management plan to complete community detoxification that has been commenced in hospital;
- Conducting bespoke training in relation to the identification and management of alcohol and drug problems with staff;
- Raise awareness of the issues relating to alcohol and drug misuse amongst hospital staff, the necessity for improving detection rates and responding appropriately to the findings of assessments;
- Deliver support to hospital teams to build confidence in their ability to assess and instigate appropriate interventions, including building awareness of the services available and the pathways for recovery.

**A1E.3.4.2 Sexual Health and Contraception Services**
- Working with existing sexual health and contraception services to develop shared pathways and protocols for identification and management of clients
- Deliver support to sexual health staff in both the community and hospital services to build confidence in their ability to assess and instigate appropriate interventions, including building awareness of the services available and the pathways for recovery
- Actively encourage the use of LARCs (Long acting reversible contraception)

**A1E3.6 Mental Health Pathways**

A1E.3.7 The Provider will work in partnership with community mental health teams, Wellbeing Norfolk and Suffolk and other providers of mental health services to provide the best co-ordinated care possible to manage service users with dual diagnosis.

A1E.3.8 The Provider will develop strong partnerships and where appropriate joint working arrangements with the county well-being/primary mental health service and secondary mental health services. To ensure that all clients requiring support and treatment for any identified mental health needs can access and are engaged in appropriate services.

**A1E.4 Volunteer and Peer Mentoring Programme**

A1E.4.1 The Provider will develop and co-ordinate an effective volunteering and peer mentoring programme.

A1E.4.2 Volunteers and peer mentors will supplement system delivery through (but not limited to):
- Supporting existing services users in their recovery journey
- Supporting the engagement of hard to reach groups and encourage engagement into structured services
- Raise awareness of the system its services and other support services

A1E.4.3 The Provider will provide appropriate supported placement opportunities for volunteers and mentors throughout the system.

A1E.4.4 The Provider will work with NCC to support the development of a network of mutual aid groups and peer led recovery support groups and encouragement for service users and carers to access those groups.

A1E.4.5 The Provider will pay travel costs and other out of pocket expenses to those that are engaged in mentoring or volunteering.

A1E.4.6 Volunteer and peer mentoring programme will be an integral part of DRR and ATR service delivery and will integrate with the single system whenever appropriate.

**A1E.5 Housing and Accommodation**
A1E.5.1 The Provider will work in partnership with all housing providers including supporting people type services to provide the best co-ordinated support possible to manage service user who are in inappropriate accommodation or at risk of eviction, or are homeless.

A1E.5.2 The Provider will develop strong partnerships and where appropriate joint working with housing or homeless providers. To ensure that all clients requiring support for accommodation can access and are engaged in appropriate services.

**A1E.6 Mutual Aid services**

A1E.6.1 The Provider will develop strong links with a wide range of mutual aid services including all the 12 step fellowships and Smart Recovery.

A1E.6.2 The Provider will deliver the three essential steps for facilitating access to Mutual Aid:
- Introduce the topic of mutual aid into sessions with service users and promote the value of attending meetings
- Help the service user to contact a current member of a mutual aid group who can accompany them to a meeting
- Take an active interest in the service user’s attendance at, engagement with and experience of mutual aid groups

A1E.6.3 The provider will offer practical steps to improve user’s access to mutual aid including:
- Provide space for 12-step and SMART recovery meetings
- Develop meetings that run while the service is open, allowing opportunistic attendance
- Give users access to literature on 12-step and SMART Recovery mutual aid groups
- Have list of local meetings available and ensure they are regularly updated
- Provide printed directions and maps to these meetings
- Ask service users which meeting they recommended
- Provide fares or incentives for users to attend groups
- Text or ring users to remind them to attend
- Escort service users to groups
- Ask all service users about any current or past attendance at self-help groups
- Consider which point in the treatment pathway provide the best opportunity to discuss mutual aid
- Actively promote the new Recovery Café and encourage attendance when the service user reach the appropriate time in their recovery journey
Appendix 2 – Service Standards, Governance and Workforce

A2.1 Service Standards

A2.1.1 The Provider shall contribute to the achievement of national and local priorities and targets. The Provider must provide the services to NCC in accordance with the terms of this specification and the Policy and Quality Statements.

A2.1.2 The following are the minimum required standards that the Provider is required to meet wherever a service schedule indicates that the function listed is part of that service. Service Provider will comply with these standards and any additional standards agreed by the commissioning parties of the contract.

A2.1.3 The current key references for all service standards include but are not limited to:
- Care Quality Commission (CQC) Essential Standards for Quality and Safety December 2010
- QuADS (Quality in Alcohol and Drug Services): Alcohol Concern, 1999
- Clinical governance in drug treatment: A good practice guide for providers and commissioners, 2009 (NTA)
- ‘Models of Care’ (National Treatment Agency, 2002 and 2006)
- Drug Misuse and Dependence UK Guidelines on Clinical Management, 2007 (DoH)
- DH 2003 NHS Code of Practice on Confidentiality
- DH 2004 Standards for Better Health (updated 2006)
- All relevant DH NICE Guidelines
- NHS Constitution

A2.2 Service Governance

A2.2.1 NCC is committed to the on-going implementation of Medications in Recovery: Re-orientating drug dependence treatment (2012)

A2.2.2 The Provider will be expected to comply with the any new relevant standards once they are published.

A2.2.3 The Provider shall be registered with the CQC where appropriate and provide NCC with evidence of their registration. The system will comply with CQC registration standards, where and when appropriate. The system will provide evidence of each notification sent to CQC as part of requirements under the registration. The Provider will notify immediately of any areas where non-compliance declared and provide action plan for these and any area where a risk of noncompliance identified.

A2.2.4 The Provider will be expected to adhere to the CQC regulations and co-operate fully in any inspections and audits. The Provider will inform NCC of the outcome of any inspection visits or other investigations and concerns regarding compliance against any of the CQC essential standards identified by the Provider or the CQC.

A2.2.5 The Provider will have nominated lead/leads for service governance. They will operate within a clear service governance framework that is agreed between the service provider and NCC. The service governance leads will be the main point of contact for NCC in relation Service Governance and will be requested to represent the agency at relevant public commissioning group meetings.
A2.2.6 The Provider will review their practice in line with NICE guidance documents and the UK Guidelines on Clinical Management 2007, or new guidelines to be published in 2017, through an effective clinical governance mechanism.

A2.2.7 The Provider will send NCC commissioners copies of all Service Governance Meeting minutes for information sharing purposes (ensuring that no confidential individual client information is contained) and may request NCC attendance at individual service governance meetings if required.

A2.3 Models of Care – quality criteria for drug* treatment
System development and service delivery will be in line with the above criteria. Service delivery will be measured against each of these quality criteria. This will be assessed by the NCC via the outlined contract and performance review processes.
*Within the terms of this specification the Models of Care quality criteria are to be applied to alcohol treatment services as well as drug treatment services

A2.4 Statutory and Other Regulations, Policies and Procedures

A2.4.1 The Provider is expected to comply with all relevant legislation, regulations, statutory circulars and National Quality requirements in so far as they are applicable to the service. Services will have robust processes for assessing, implementing and monitoring NICE technology appraisals, guidance and interventional procedures as appropriate. Outcomes of any non-compliance are to be made available to NCC with an Action Plan and timelines for compliance. A quarterly position statement will be provided detailing any likely concerns regarding compliance against any essential standards.

A2.4.2 All policies must have a named person with responsibility for implementation and monitoring and a date for review.

A2.4.3 The Provider will have written plans on improving the access, appropriateness and effectiveness of treatment to women, people with mental health, learning or physical disabilities, British military veterans, minority ethnic drug users and other groups under-using the services. These other groups should be determined locally, for example those using novel psychoactive substances. The plans must address anti-discriminatory employment practices.

A2.4.4 The Provider will have a written plan responding to people who cause concern identified by a risk assessment, and refer them to appropriate services.

A2.4.5 The Provider will have a written strategy on how to re-engage service users who have dropped out of treatment, where there is cause for concern identified by a risk assessment.

A2.4.6 The Provider will develop shared protocols with a range of other health, social care and other organisations including other drug and alcohol services not commissioned by NCC.

A2.4.7 Specific concentration will take place on agreeing protocols for clients moving to and from other structured alcohol and drug services.

A2.4.8 The Provider is required to have in place, or be clearly working towards effective written policies and procedures, which promote the wellbeing and safety of service users and staff and
which reflect the client group served. All policies should be dated and reviewed regularly. These should include but are not restricted to:
- Complaints/grievance procedure (for paid staff and volunteers)
- Confidentiality/Information sharing Protocol
- Service user’s charter of rights
- Service user involvement
- Care management
- Service provision for people with dual diagnosis
- Service provision for young people
- Service provision for older (over 50) people
- Service provision for people from ethnic communities
- Service provision for pregnant substance users
- Service provision for drug- using parents
- Smoking
- Drug use and supply
- Alcohol use
- Employment
- Equal Opportunity in service provision, recruitment and employment
- Occupational Health
- Health and safety, including - needle stick injury, infection control, HIV/AIDS, fire and accident recording (nominated health and safety officer)
- Appraisal system and supervision
- Staff drug and Alcohol use
- Grievance and disciplinary
- Redundancy
- Staff leave, sickness, absence and turnover
- Staff training and development strategy
- Working in the community (outreach, home visits, satellite working)
- Violence at work
- Fire policy
- Child Protection/Safeguarding
- Safety of staff involved in outreach work and lone working.
- Prescribing policy and procedure consistent with ‘Models of Care’ and Department of Health clinical guidelines (Drug Misuse and Dependence – Guidelines on Clinical Management (1999 and 2007))
- Risk assessment protocols (e.g. in the case of overdose)

A2.4.9 The above policies and procedures must have clearly stated objectives; stipulate who is responsible for the implementation of the policy/procedure and arrangements for monitoring, review and development.

A2.5 Confidentiality and Data Protection

A2.5.1 The Provider must be open about information stored on an individual and must follow good information sharing principles. (Including consent to NDTMS and a local data sharing protocol).

A2.5.2 The Provider must have a clear confidentiality and data handling policy, which is understood by all members of staff. The purpose of this policy is to prevent patient details being inappropriately disclosed when consent is given. The policy should be presented and clearly explained to the
client/patient, both verbally and in written form, before assessment for treatment begins. The policy may be outlined in the form of a simple leaflet and/or notice displayed within the provider.

A2.5.3 The Data Protection Act allows data sharing if ‘fair processing’ information is provided to the client. It should be explained on the client/patient’s first visit to the service and must describe:
- What information will be collected by the provider
- When and what information will be shared with any other services and organisations involved in their care
- Who information will go to and why
- In what circumstances confidentiality, may be breached.

A2.5.4 This policy will cover submissions to NDTMS and make provision for sharing data within NCC (in particular direct access by NCC to the provider client management system).

A2.5.5 The confidentiality/data sharing policy must comply with the Data Protection Act 1998, the Freedom of Information Act 2000.

A2.5.6 The Provider will develop clear and robust information sharing protocols with relevant partner agencies across Norfolk. The provider will work to develop good working relationships with relevant partners to make the transfer of client information easier and safer and to facilitate optimal treatment gains and recovery for service users. Agreed protocols must be in place for commencement of the service (see Appendix 3 – transitional arrangements).

A2.6 Complaints Procedure

A2.6.1 The service will have a clear and written complaints procedure in place which complies with both Local Authority and NHS standards. It will be made available to service users and their friends and family at commencement of engagement with the service.

A2.6.2 Where a service user or their friend or family member has a complaint or concern about the service offered the Provider will make efforts to address the issue as soon as possible, if the issue is not resolved to the satisfaction of the service user or their friend or family member they should be assisted to make a complaint via the mechanisms in section 5.

A2.6.3 The Provider will log all complaints and will return a quarterly collated report of the complaints received and resulting actions taken.

A2.7 Safeguarding

A2.7.1 Safeguarding Children: The Provider will work within Norfolk Local Safeguarding Children’s Board (LSCB) guidelines and ensure all staff are conversant with the guidelines, comply with them and have completed the required safeguarding training.

A2.7.2 In line with section 11 of the Children’s Act 2004 the provider will ensure their functions are discharged with the need to safeguard and promote the welfare of children by actively contributing to the development of needs assessment, strategies, protocols, training and other measures to further the safeguarding children response within Norfolk and by ensuring staff work with children and families in a child-centred way, which focuses on positive outcomes, is evidence based and takes account of the developmental needs of children.
A2.7.3 Where relevant, staff shall be involved in section 47 Safeguarding Children enquiries and attend safeguarding children case conferences where the child’s parents have been or are currently in treatment.

The provider will ensure that all staff are conversant with the Norfolk Thresholds Framework and fully utilise this tool to assess children and families (via the Early Help Assessment) enabling the right services to meet their needs at the earliest opportunity.

A2.7.4 Safeguarding vulnerable adults:

The Provider will work within Norfolk Safeguarding Adult Board guidelines and ensure that all staff have attended training on adult safeguarding and are conversant with and adhere to the Norfolk multi-agency safeguarding adults’ protocols.

A2.7.5 Multi Agency Safeguarding Hubs (MASH):

The provider will work within the new Multi-Agency Safeguarding Hubs (Input will be determined by the MASH). Sufficient staff will have achieved the required security checks to allow access to the police offices.

A2.8 Critical Incident Policy and Reviews

A2.8.1 The purpose of the Critical Incidents policy is to set out the definition of, and procedure for reporting and investigating critical incidents. The Provider will have in place a policy that ensures each incident is considered with the expected outcome that improvement will be made to services and/or clinical practice, or any organisational structure that needs to be remedied.

A2.8.2 The policy will meet the requirements of Clinical Governance and Clinical Risk Management. Services will provide quarterly reports, which should identify any themes/ trends. Reports should provide evidence of action plans that have been initiated with clear timelines for achievement.

A2.8.3 The investigation of critical incidents will be undertaken in a rigorous and constructive manner so that:
- Appropriate immediate action is taken to ensure the safety and wellbeing of the client and others involved in the incident
- The client and/or relatives are satisfied that the incident has been investigated and reported upon appropriately
- Critical incidents are used as a guide to improving service to clients in the future

A2.8.4 The reporting and investigation of critical incidents will ensure:
- Action to identify, minimise and manage risk
- Early, precise and unequivocal gathering of facts in a written report
- Early identification of emerging patterns and trends in the occurrence of critical incidents
- Clients, their relatives and staff are kept informed about the procedure and receive appropriate information at regular intervals
- The organisation learns from critical incidents and if necessary makes the appropriate changes to policies and service delivery
- Early warning to enable forecast of potential litigation costs

A2.8.5 Staff will fully participate in the National Confidential Enquiry into suicides and homicides. The Service will supply timely monthly reports of service user deaths and investigate the care
delivered by the service for that individual via the relevant critical incident policy. This report will be
provided to NCC and the 5 Norfolk Clinical Commissioning Groups and learning shared via the
Council across all partnership organisations.

A2.8.6 The Provider will have policies and procedures in order to undertake a review if serious harm
has occurred or has nearly occurred that may be associated with the provision of services under this
agreement to a service user, member of staff or any member of the public. Representation from the
Council should be sought at any such review.

A2.8.7 The Provider will notify NCC of the commencement and outcomes of all reviews undertaken.

A2.8.8 The Provider is expected to report any Rule 43 of the Coroners rules and will have in place
systems to address Coroners rule 43 judgements and systems of learning to prevent recurrence.

A2.9 Managerial and Organisation requirements:
Where the Provider is a Registered Charity, Trustees must ensure that they are aware of, and comply
with, Charity Commission regulations and legislation as established in The Charities Act (1993 and
2006). The Provider must keep up to date information on other services available for its service users
and maintain good links with outside agencies in order to facilitate referrals, ensuring that their staff
have access to this information and use it to encourage service user uptake of other appropriate
services.

A2.10 Workforce

A2.10.2 The service Provider will have in place robust workforce planning strategies, which include
but is not limited to:
- providing evidence of workforce continuity planning
- recruitment and retention strategies
- identifying and overcoming potential skills shortages
- achieving the most effective skill-mix whilst meeting quality standards identified by the
  specification
- developing workforce capacity in the alcohol and drug recovery field that is sustainable, realistic
  and affordable
- ensuring the workforce reflects the diverse populations it serves with appropriate recruitment
  strategies
- increasing the proportion of volunteers
- raising the profile of the alcohol and drug recovery field as a positive place to work
- to ensure all staff have access to induction and on-going professional development
- to develop leadership and managerial skills across the workforce

A2.10.3 The Provider must ensure that all staff and volunteers are appointed only after all
appropriate pre-employment checks are satisfactorily carried out. This will include the appropriate
criminal records checks for the role to which they are appointed and appropriate security clearance
in the case of those working in police custody suites and prisons. The provider should refer to
guidance issued by the General Medical Council and the Nursing and Midwifery Council regarding
the pre-employment checking and on-going monitoring of licence to practice for medical and
nursing staff and to the General Social Care Council in the case of qualified social workers.
A2.10.4 Staff shall support and assist service users with sensitivity and respect and take every opportunity to encourage and support the service user to maintain or improve their skill and ability to be autonomous.

A2.10.5 In order to protect both service users and staff, all operational staff must be issued with formal identification. This must be carried and used whenever staff are operating on behalf of the Provider.

A2.10.6 The Provider should monitor the workforce reporting on staff turnover and sickness, absence and vacancy levels. It will be reported to NCC commissioners on a quarterly basis.

A2.10.7 To support quality service delivery and clinical safety the provider will limit the use of agency staff. Only employing agency staff that deliver interventions directly to service users with prior consent from NCC. This consent will be given within 3 working days of request received. A process for this will be developed with NCC commissioners and agreed during the transition phase prior to delivery commencement.

A2.11 Staff competencies.

A2.11.1 The Provider must ensure all staff, practitioners and managers are competent to fulfil their roles. It is the responsibility of the Provider to monitor, manage and develop the performance of the workforce.

A2.11.2 Managers within the provider agency must be sufficiently competent, (at the level of ‘proficiency’ see definitions below) experienced and qualified to ensure that the organisation functions efficiently and the services are provided in line with the specification.

A2.11.3 The provider will ensure that all other staff who have unsupervised contact with service users will be ‘competent’ (see definitions) in the duties that they perform within their role. Any other staff or volunteers who are working at the level of ‘novice’ or ‘advanced beginner’ (see below) must be provided with adequate supervision and support when working with service users.

A2.11.4 All posts will meet the relevant criteria within a recognised and relevant occupational standard framework such as the Drug and Alcohol National Occupational Standards (DANOS), the NHS Knowledge and Skills Framework, 2004 (DH) or other relevant framework.

A2.11.5 The provider shall provide job descriptions and person specifications for all roles. In addition, there will be role profiles which map the job responsibilities to suites of occupational standards such as Drugs and Alcohol National Occupational Standards (DANOS) or equivalent. Within 12 months of the start of service provision the provider will be able to verify that all managers can provide evidence of performance of the specified standards applicable to their role at the level of ‘proficiency’ and at ‘competency’ level for all other staff.

A2.11.6 The Provider will be expected to implement processes to monitor the professional registration and continuing professional development records for professionally registered workforce.
A2.12 Qualifications

Staff will be expected to hold or be working towards a qualification suited to their role and will be able to demonstrate a commitment to on-going professional development (CPD).

A2.13 Formal clinical and professional supervision

A2.13.1 Formal clinical and professional supervision for all staff must be provided on a regular basis – at least monthly and in line with guidance from BACP, RCN and FDAP who are consistent in the view that there is an obligation for workers to engage with regular and on-going supervision to enhance the quality of the services provided and to commit to updating professional practice by continuing professional development.

A2.13.2 Also, in line with DANOS 2012. ‘a practical guide for commissioners and providers of drugs and alcohol services’ from the Federation of Drug and Alcohol Professionals recommends that; ‘those providing it (clinical supervision) as line managers or independently should be qualified to deliver the services they are supervising, even if they do not have a caseload themselves’

The Provider will adhere to these recommendations or any future recommendations that supersede them.

A2.13.3 Managers who provide clinical and professional supervision for other staff must be at the levels described below as ‘proficient’ in the DANOS competencies relevant for clinical and professional supervision and for the role that they are providing supervision.

A2.13.4 The purpose of supervision is to:
- ensure support for staff to carry out their role function effectively and safely
- check that case load mix and size are manageable and not causing work related stress or are too difficult to manage safely
- to identify training and development needs in individual workers
- to form the basis for reflective practice and learning
- to verify that workers are performing their role effectively
- To verify that workers are meeting performance criteria
- To ensure that care plans are recovery focused and contain clear negotiated short term and longer term outcome focused goals.

A2.13.5 In addition to the above the Provider must ensure that:
- All appropriate new and existing staff will receive training in respect of standard assessment, care planning and coordination tools including updates when required
- All new and existing staff should receive training in respect of any new national or local initiatives which may impact on their work
- All staff must have a current and accurate knowledge of all alcohol and drug services in Norfolk and a good knowledge about other local services which would be of benefit to service users (including eligibility criteria and referral routes)
- Staff should be trained in motivational interviewing techniques or similar to assist in enhancing service user engagement
- Staff undertaking assessments should receive training and be familiar with the dual diagnosis protocols used within Norfolk
- Ensure that all staff are fully trained and competent in both adult and children’s safeguarding issues including Norfolk policies and procedures
- All staff should have a working knowledge of local mutual aid groups and an updated list of where and when meetings are held

**A2.14 The support, development and supervision of volunteers and unpaid workers.**

A2.14.1 When working with volunteers; the Provider shall adhere to the QuADS standards which recommend that all services should have established and effective supportive procedures for the management and utilisation of volunteers. These will include:
- Written recruitment procedure / policy for volunteers
- Volunteering agreement
- Role descriptions
- Clear management / reporting lines for volunteers
- Regular supervision
- Code of conduct
- A mechanism for volunteer consultation
- Regular and adequate training
- Policy regarding volunteers who have / had drug and / or alcohol related problems.

A2.14.2 **Worker competency level descriptors**

**Novice**
The worker is learning the very basics for the task or skill and is not yet aware of their limitations. Therefore, at this level they will require supervision and learning support at all times through shadowing more experienced practitioners.

**Advanced beginner**
Building up the underpinning knowledge to do the task but not yet being competent to cope with every eventuality without checking with a more experienced practitioner. At this level supervision is required and the worker should not be left to do the task unsupervised. However, may be allowed in certain circumstances to perform parts of the task and report back.

**Competent**
At this level the worker is able to put underpinning knowledge into practice safely and adapt to a limited range of eventualities. They are able to make some choices about what, when and how to do a task, however will still need to check things out from time to time with a more experienced worker.

**Proficient**
The worker can predict events more precisely and drawing on experience and reflective practice can recognise patterns and predict outcomes. Out of a wealth of experience the worker has developed a recognition of what needs to be done in a wide range of circumstances and has the confidence and experience to manage the task alone and also teach others.

**Expert performer**
Can comfortably and proficiently perform the task without apparent conscious effort. Can deal with a wide range of eventualities without the need to refer to others. Can intuitively predict outcomes and mitigate through reflection and action.
A2.15 Workforce development

A2.15.1 The Provider shall have a staff training and development strategy that will include:
- Annual staff training needs analysis
- Individual development programmes including on-going training
- Updates on new legislation and developments in practice
- Workforce activities; induction, individual training and development plans. Performance supported through regular personal and professional supervision.
Appendix 3

Transition Plan

A3.1 During the period between signing the contract (Nov 2017) and commencing delivery to service user (1st April 2018) the contractor/s will be required to draw up a robust transition plan. This will be a comprehensive project managed process which will clearly detail the steps which will be taken to be ready to provide the service in full compliance with this service specification by 1st April 2018.

A3.2 A detailed risk assessment and risk mitigation measures will be included.

A3.3 The transition plan will need to be agreed with the NCC and will have detailed time lines and milestones which ensure that as a minimum the following expectations are met:

A3.3.1 By 1st Feb 2018
   i. Delivery premises secured and operational
   ii. All equipment is procured and ready for use
   iii. Single information management system procured, in place and all existing client data transferred
   iv. All required staff security and safeguarding checks and clearances completed.
   v. Staff job descriptions written and issued
   vi. Staff within their identified delivery teams
   vii. Staff induction programmes planned
   viii. Referral systems set up, conveyed to all stakeholders and referrals ready to be received
   ix. Single point of contact and telephone helpline in place
   x. Referral, assessment, care planning and care co-ordination framework developed and tools in place
   xi. Agreed branding and communications plan in place and being implemented
   xii. CQC registration completed

A3.3.2 By 1st March 2018
   i. Staff induction programmes completed

A3.3.3 By 31st March 2018
   i. The contractor will have assumed the care coordination role of all clients in structured treatment.
   ii. Minimum data quality targets achieved.

A3.3.4 By 1st May 2018
   i. All remaining system delivery requirements fully up and running.

A3.4 The plan will include, without limitation, the following considerations:

A3.4.1 Staffing and HR issues:
   - The TUPE process including terms and conditions including pensions and pay
   - Staff skills profile, the development of job descriptions, job roles and person specifications
- A skills gap analysis and a learning and development plan
- Staff recruitment plans

A3.5 Branding and Public Relations:
- Refinement of the single integrated behaviour change model
- Development of corporate branding in negotiation with NCC
- Communications strategy to ensure that all staff, key partners, local community and service users have an opportunity to understand the model for service delivery and the philosophy of the new service
- Building productive working relations with partner agencies including identifying key relationships between the provider’s senior management team and other agencies
- Plans to publicly launch the new system

A3.6 Premises and equipment
The provider should note that all premises, running costs, equipment and resources are to be provided and maintained by the contractor from within the funding envelope.

A3.7 Information and Governance Systems:
- The development of information sharing protocols – to be in place in advance of service delivery on 1st February 2018.
- Protocols procedures and policies as set out in the service specification to be drawn up in time for commencement of service delivery.
- Legal issues to be resolved and insurance and other indemnity policies to be in place for commencement of service delivery.

A3.8 Seamless Service
The Provider will deliver a seamless transition of clients into the system and ensure that the support and/or structured treatment provided to all existing clients continue unchanged on system commencement.
Appendix 4 - Outcomes framework

A4.1 The outcomes framework includes measures for adults. The outcomes framework will be agreed by NCC and the Provider during the mobilisation phase and agreed by April 2018.

A4.2 The Provider with NCC will produce a set of quality outcomes that will be in place by April 2018. The agreed outcomes will need to ensure that they meet the needs of the county. It is anticipated that we work towards achieving the top quartile in agreed timeframe.

A4.3 NCC and the Provider will negotiate and agree the:
- Data Source
- Baseline
- Target or Report only
- Frequency of reporting
for all outcome or quality measures by April 2018

A4.4 It is anticipated that the single integrated system outcome data contributes to other Norfolk partners’ targets. For example, towards CCG IAPT targets. Negotiation for sharing of performance data will be agreed by the Provider and NCC prior to any data being shared.

A4.5 Adult Outcomes:

1. Freedom from dependence on drugs or alcohol

1.1 Numbers in effective treatment:
- Opiates
- Non-opiates
- Alcohol
- Alcohol and non-opiates

1.2 Successful completions as a percentage of all in treatment
- Opiates
- Non-opiates
- Alcohol
- Alcohol and non-opiates

1.3 Proportion who successfully completed treatment in the first 6 months of latest 12 month period and represented within 6 months
- Opiates
- Non-opiates
- Alcohol
- Alcohol and non-opiates

1.4 Number of alcohol referrals

1.5 Number of alcohol detoxification starts

1.6 Number of community alcohol detoxification programmes completed

1.7 Number of IBA delivered
1.8 Number of EBI delivered

1.9 Percentage of 4 year plus cohort

1.10 Percentage of 6 year plus cohort

2. Prevention of drug related deaths and infection by Blood Borne Viruses -

2.1 Percentage of new presentations with a general healthcare assessment

2.2 Percentage of new presentation who were offered HBV vaccination

2.3 Percentage of clients that have accepted and completed a course of HBV vaccinations

2.4 Percentage of individuals who were offered and accepted a HCV test

2.5 Number of naloxone issued to service users

2.6 Percentage who have received an intervention with respect to promoting good sexual health so to prevent STI transmission

2.7 Overall reduction in the average number of days injecting at planned exit

3. A reduction in crime and re-offending

3.1 Percentage of criminal justice clients as a proportion of all in treatment
   Opiates
   Non-opiates
   Alcohol
   Alcohol and non-opiates

3.2 Percentage of ATRs successfully completed

3.3 Percentage of DRR successfully completed

3.4 Proportion of Criminal Justice clients who successfully completed treatment in the first 6 months of the latest 12 month period and representations within 6 months
   Opiates
   Non-opiates
   Alcohol
   Alcohol and non-opiates

3.5 The proportion of referrals from the prison treatment system to community treatment that are picked up for assessment within 21 days

3.6 IOM service users identified as having a alcohol and drug need in custody to successfully enter treatment on their release
4. Sustained education, training, volunteering activity leading to employment -

4.1 Number of service users successfully engaged in education

4.2 Number of service users successfully engaged in volunteer placements

4.3 Number of service users successfully employment

4.4 Opiate Clients working >=10 days in the last 28 days

4.5 Non-opiates working >=10 days in the last 28 days

5. The ability to access and sustain suitable accommodation

5.1 Number of service users achieving suitable accommodation on treatment exit

5.2 Opiate clients with no reported housing need at Exit TOP

5.3 Non-opiate service users with no reported housing need at Exit TOP

6. Improvement in mental and physical wellbeing

6.1 Percentage of clients with a physical and mental health check status recorded at start of treatment

6.2 Numbers of service users referred to CMHT

6.3 Number of service users referred to IAPT

6.4 Number of ex-service personnel commencing treatment

7. Improved relationships with family members, partners and friends

7.1 Number of service users accessing parenting support

7.2 Number of MARAC referrals

8. The capacity to be an effective and caring parent

8.1 Parental status recorded at treatment commencements
   Opiates
   Non-opiates
   Alcohol
   Alcohol and non-opiates

8.2 Numbers of clients who are referred to Early Help and Stronger Families Programme
Appendix 5

A5 Example of a Criminal Justice service users pathways

A5.1 Accommodation and support: A third of offenders do not have settled accommodation prior to custody and it is estimated that stable accommodation can reduce the likelihood of re-offending by more than a fifth. It also provides the vital building blocks for a range of other support services and gaining employment.

A5.2 Education, training and employment: Having a job can reduce the risk of reoffending by between a third and a half. There is a strong correlation between offending, poor literacy, language and numeracy skills and low achievement. Many offenders have a poor experience of education and no experience of stable employment.

A5.3 Health: Offenders are disproportionately more likely to suffer from mental and physical health problems than the general population and also have high rates of alcohol misuse. Previous NOMS studies have indicated that 31% of adult offenders have emotional wellbeing issues linked to their offending behaviour.

A5.4 Drugs and alcohol: Around two thirds of convicted and incarcerated offenders use illegal drugs in the year before imprisonment and intoxication by alcohol is linked to 30% of sexual offences, 33% of burglaries, 50% of street crime and about half of all violent crimes.

A5.5 Finance, benefits and debt: Ensuring that ex-offenders have sufficient lawfully obtained money to live on is vital to their rehabilitation. Around 48% of offenders report a history of debt, which gets worse for about a third of them during custody and about 81% of offenders claim benefit on release.

A5.6 Children and families: Maintaining strong relationships with families and children can play a major role in helping offenders to make and sustain changes that help them to avoid re-offending. This is difficult because custody places added strains on family relationships.

A5.7 Attitudes, thinking & behaviour: Successfully addressing attitudes, thinking and behaviour during custody or community sentence is known to reduce offending. It is also important to take into account the relationship between offending and substance
Appendix 6A6 Developing the Alcohol and Drug Behaviour Change System Supply Chain:

Grant Aid for Small or ‘Micro’ Organisations

A6.1 The commissioning of Norfolk alcohol and drug behaviour change services provides an opportunity for the development of a dynamic and responsive supply chain structure which should meet the needs of individuals within the county presenting with drug and alcohol problems. It is considered that small or ‘micro’ organisations which are typically third sector are best placed to deliver elements of the following objectives of the new single system:

- Engagement with the diverse communities of the borough
- Delivering services to the difficult to engage
- Developing mutual aid support initiatives post formal treatment
- Enabling social enterprise initiatives to flourish, hence supporting the employment agenda

It is expected that the supply chain will consist of a consortium of organisations fronted by a lead provider. It is also expected that the organisations within any consortia will directly deliver elements of the new single system, this includes the lead provider.

The grant aid should also allow for individual service users or a small group of service users to access small amounts of funding to support their recovery.

As part of the supply chain it is specified that a number of small or ‘micro’ organisations are funded and managed, these organisations are likely to be of the third sector. A minimum 1.5% of the total contract value is to be administered on a ‘grant aid ‘basis by the lead provider to these small or micro third sector organizations who will typically have a turnover of less than £100k. The amount administered through this grant aid method may well be small amounts of money (i.e. as little as a few hundred pounds to no more than several thousand). This is to facilitate the utilization of flexible and innovative organizations capable of engaging with the diverse communities of the county and to realize the new recovery and family agendas. The Provider will agree with NCC commissioners the
process of administrating Grant Aid. Any decisions to grant aid are to be agreed by the Norfolk County Council Public Health Commissioner.

A6.2 The expected benefits of the administration of this grant aid scheme include:

- The engagement of individuals into alcohol and drug interventions who for whatever reason struggle to access traditionally presented mainstream services.

- The utilisation of organisations who work with the range of community groups of the county to engage their service users into the appropriate alcohol and drug intervention when needed. This is especially relevant to Norfolk given the counties wide rural and urban mix.

- Engagement with other groups who may be difficult to engage with, examples include older people, younger people, the LGBT community and groups in specific geographic high need areas of the county. The inclusion of any small or micro third sector organization which works with offenders may also be of value to the supply chain objectives.

- To engage with organisations who have an intimate and detailed knowledge of specific areas and communities of the county.

- Support for the development of mutual aid groups and fledgling social enterprises.

The supply chain of small or micro third sector organizations may include the following types of organisation:

- Mutual Aid Groups
- Community groups
- Fledgling social enterprises
- Tenants and residents’ groups
- Faith groups
- Housing associations
- Sports organisations

It is essential that the award of any sums of money through this grant aid scheme can demonstrate clearly how it supports the aims and objectives of the Norfolk integrated behaviour change system which are detailed in the service specifications performance management framework. An example being a mutual aid support group which is funded for the benefit of service users who have left formal treatment services could demonstrate a contribution to the Public Health Outcome Framework – (successful completion of drug treatment without representations within six months).

Further examples of the use of grant aid could include the provision of funding for a room for the delivery of a group or one off capital payments for equipment. It is expected that careful consideration be given to the sustainability of those initiatives funded by grant aid organisations where necessary.

A6.3 There is an expectation that the lead Provider and any consortia will regularly review and refresh the small or micro third sectors organisations in their supply chain. This process should
be informed by identified need sourced from both formal and informal needs assessment data. Service users will inform the process of reviewing the supply chain.

A6.4 The lead provider and the consortia will be expected to liaise with the Norfolk voluntary groups and other representatives of the third sector to ensure there is a good understanding of need and supply.
Appendix 7

A7 Proposed innovation payment framework

A7.1 An innovation payment framework is to be applied to the contract. In the first year shadow arrangements are applied so to determine the measure and the associated baseline. In years two and onwards the proposed innovation payment is to be applied to 5% of the contract value. The innovation payment is intended to incentivise the delivery of the primary outcomes of the new integrated alcohol and drug behaviour system.

It is expected that within the first year, the new drug strategy will be produced by the government. Any changes in government priorities will be reflected in the innovation themes.

It is anticipated that in year one (2018/19) the innovation theme will be the development of a shared care scheme for GP practices in Norfolk.

The innovation programme will be developed and change annually with previous innovations being embedded in the treatment system delivery.