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1. Background Information

Somerset covers an area of 3,452 square kilometres (1,333 square miles) and is divided into five Districts/Boroughs: Mendip, Sedgemoor, South Somerset, Taunton Deane and West Somerset.

Somerset County has a resident population of approximately 530,000 of which:
- 87,500 are aged 14 or under
- 21,400 are aged between 15 and 17
- 39,900 are aged between 18 and 24
- 81,900 are aged between 25 and 39
- 187,500 are aged between 40 and 64
- 111,700 are aged 65 or above
Source: ONS Census 2011 population estimates by single year of age

1.1 Somerset Drug and Alcohol Partnership

In Somerset the work to tackle the harm associated with drugs and alcohol is co-ordinated through Somerset Drug and Alcohol Partnership (SDAP). This is a strategic group of public sector organisations who work together to implement the national drugs and alcohol strategies.

It is made up of representatives from:
- Somerset Primary Care Trust
- Somerset County Council
- Avon and Somerset Constabulary
- Avon and Somerset Probation Trust

It aims to ensure that effective partnership responses are developed and delivered to tackle drugs and alcohol issues for people resident in Somerset.

A comprehensive summary of the treatment statistics for Somerset based on recent data can be found in Appendix A. However, the latest figures from the National Drug and Alcohol Monitoring System (NDTMS) show that,

- 1,221 adults were in effective treatment in Somerset between September 2011 and August 2012.
- 389 adults have exited treatment with 212 (54%) successful completions between September 2011 and August 2012.
- 1,102 Opiate and Crack users (OCUs) were in effective treatment in Somerset between September 2011 and August 2012.
- 300 OCUs have exited treatment with 155 (52%) successful completions between September 2011 and August 2012.
- There have been 52 young people in treatment between April and September 2012.
- 21 young people have exited treatment between April and September 2012 with 15 (71%) successful completions.
- There have been 214 adults in primary alcohol treatment between April and September 2012.
• 100 adults have exited primary alcohol treatment between April and September 2012 with 57 (57%) successful completions.

The new NTA Prevalence Service User Ratio (PSUR) measure for alcohol clients suggests that 8% of higher-risk (would score 20+ on an AUDIT) drinkers in Somerset are in structured treatment.

Latest figures from the new public health outcomes framework show that:

• There were 192 successful completions between June 2011 and May 2012 by clients who did not re-present to treatment within six months. This represented 14.85% of all adult clients in treatment.

• There were 143 successful completions for OCUs between June 2011 and May 2012 by clients who did not re-present to treatment within six months. This represented 12.30% of all adult clients in treatment.

1.2 Strategic Position Statement for Commissioning of Drug and Alcohol Services in Somerset

This strategic statement commits Somerset Drug and Alcohol Partnership (SDAP) and all of its partners and stakeholders to improving the outcomes for individuals and communities affected by the misuse of alcohol and drugs in Somerset.

It recognises that alcohol and drug misuse affects everyone in one way or another and that for the harm caused by alcohol/drugs to be minimised, tackling misuse is everyone’s business.

The strategic statement for commissioning drug and alcohol services is part of the realisation of the wider health and wellbeing strategy for Somerset for ‘people to live healthy and independent lives, supported by thriving and connected communities, with timely and easy access to high-quality and efficient public services when they need them’.

The commissioning framework for drug and alcohol services relates to the health and wellbeing strategy key priorities, namely:

Priority 1: People, families and communities take responsibility for their own health and wellbeing.
Priority 2: Families and communities are thriving and resilient.
Priority 3: Somerset people are able to live independently for as long as possible.

It recognises that drug/alcohol misuse is a cross cutting theme which links to both:

• Other themes such as domestic violence, safeguarding children and adults, community safety, troubled families etc.

• Other commissioning strategies such as Pathway for Socially Excluded – Accommodation and Support Services for Vulnerable People, Pathway to Independence – Accommodation and Support Services for Vulnerable Young People aged 16 – 24 years, Somerset Reducing Re-Offending Strategy.
- Other agency specific work areas such as police, probation, children’s social care, school nursing, mental health services.

Appendix A provides further background information on the vision and principles behind the commissioning of drug and alcohol services in Somerset.
2. Relationships

2.1 Somerset Drug and Alcohol Partnership (formerly DAAT) is the commissioning body for drug and alcohol interventions and treatment in Somerset. Contracts are issued by Somerset County Council on behalf of the Somerset Drug and Alcohol Partnership.

2.2 The partnership’s strategic vision sets out the need to establish delivery of alcohol and drug related information and interventions throughout the wider workforce. Providers will be expected to support this delivery but will not be responsible for it.

2.3 Providers will work in collaboration and partnership to deliver this service model. Key local partnerships will be, but are not limited to: Somerset County Council Children’s and Adults Services, further education establishments, training and employment agencies (including work programme providers), local health providers including primary and secondary care agencies, mental health services and criminal justice agencies, local providers of housing support and accommodation and voluntary and community services.

2.4 Collaboration and working in partnership is a key element of this model and will be evaluated through the tendering process. This will be monitored through the performance management framework.

2.5 CQC Registration is a requirement of providers of health services which includes community drug and alcohol treatment and so may be a requirement of a provider.
3. Purpose of the Service Model

3.1 This service model is for young people, adults, drugs and alcohol users. This includes legal and illegal drugs, novel psychoactive substances (known as “legal highs”) and misuse of over the counter and prescribed medicine.

3.2 The service model will be commissioned to meet the strategic outcomes agreed by Somerset Drug and Alcohol Partnership. These are to:

- Intervene early to prevent problems with drugs and alcohol developing
- Reduce the chances of drug and alcohol related deaths
- Reduce drug and alcohol related offending
- Improve the mental and physical health of drug and alcohol users
- Increase the numbers of people achieving abstinence from drug and alcohol use
- Support drug and alcohol users to access safe and stable accommodation
- Promote positive social and family relationships for drug and alcohol users
- Promote access to education, training and employment for drug and alcohol users
- Promote independence, and the development of independent support networks, for people recovering from drug and alcohol problems
4. The Characteristics of the Service Model

4.1 Design of the service model will be required to meet the outcomes listed in section 6. This will entail responding to the measurable outputs, success characteristics, best practice guidance and design elements listed.

4.2 There are characteristics of the service model which are expected in order to meet these outcomes. These are:

4.2.1 Service User and Carer Involvement

A provider will enable the full participation and involvement of service users and carers in the development, review and assessment of services.

This includes, but will not be limited to, service users and carers participation in service development and planning meetings, participation on interview panels and attendance at review meetings.

A provider will have a service user and carer engagement and participation strategy.

A provider will clearly demonstrate how ex service users and people in recovery contribute to the development and delivery of the service. This will include volunteering, training and employment opportunities.

A provider will help to raise the profile of recovery by supporting service users to participate in service delivery. This will include employment of service users in recovery.

A provider will have a clear policy in place to provide additional support to service users, ex-service users and carer “recovery champions”, recognising the potential additional pressures of this role.

4.2.2 A Harm Reduction System

The principles of harm reduction are consistent with the recovery focused treatment system. A provider will deliver interventions to reduce the risk of harm. These will be identified as appropriate to the individual, but will include needle and syringe exchange and blood borne virus testing and vaccination.

4.2.3 A common assessment approach for young people and for adults

In collaboration with SDAP, a provider will put in place a common assessment approach which will ensure assessments and interventions for substance misuse are carried out in a variety of locations by the wider workforce are used effectively by the provider of treatment.

Assessments undertaken by the wider workforce will use the SDAP common assessment tool for young people. There may be a common assessment for
adults in the future. A provider of this service model will provide an assessment approach which complements the use of common tools.

4.2.4 Transparency of access

A provider will have a publicly available policy which will enable service users and referrers to understand how referrals will be prioritised for interventions and treatment.

This will be in line with the Somerset Alcohol Step by Step guide.

The common assessment approach for adults and young people will enable staff from other organisations clarity over the prioritisation and waiting times for all “Tier 3” (structured treatment) interventions.

4.2.5 Delivery of drug and alcohol interventions at the earliest point and at the most appropriate location, specifically in police custody suites and district general hospitals

The service model will support the delivery of brief and extended brief interventions by supporting the wider workforce with specialist expertise. In specific locations, this specialist expertise may be best delivered through the presence of designated workers.

A provider will work with local police and district hospital staff to ensure that liaison work is undertaken in both hospitals and police custody suites. This will include supporting the wider workforce to deliver identification and brief advice and providing liaison to support quick access to treatment for drug and alcohol users in both locations. This process may also take place in other locations that are suitable.

4.2.6 Specialist psychosocial and prescribing treatment (including detoxification)

In line with all relevant clinical guidance, specialist treatment will be expected for people identified as requiring it through the common assessment approach.

It is expected that a provider will be able to demonstrate the evidence base for the psycho-social interventions delivered in community treatment, and that these interventions provide a consistent, recovery focused, treatment model.

A provider will deliver a community detoxification service for alcohol and drug users, providing appropriate medical assessment and support to enable this to be delivered safely.

A provider may deliver or may contract sufficient in-patient detox capacity for drugs and alcohol. This should be delivered / contracted from an appropriate facility with an appropriate level of medical cover.
Community prescribing should be delivered as part of a recovery orientated treatment service.

In line with clinical guidance, interventions for young people are delivered at a time and location where adults receiving treatment for drug and alcohol problems are not present.

4.2.7 Additional support to those most at risk, including younger people in the transition to adult services, care leavers, people in the criminal justice system and those needing support from mental health services

Identified vulnerable groups should be targeted with additional support. This additional support should be directed in a consistent way by a named care co-ordinator.

Whilst a provider may not always be the named care co-ordinator, a framework to deliver enhanced care co-ordination to those identified as requiring additional support is expected.

Enhanced care co-ordination should exist irrespective of the service user currently accessing substance misuse treatment interventions. It is expected that those who are most vulnerable will enter and exit treatment on more than one occasion.

A provider should work jointly with mental health services to identify the most effective way of providing additional support to those people requiring support from mental health services. This does not mean replicating the work of mental health services.

4.2.8 Support for family members affected by someone else’s drug or alcohol use, support for children of drug and alcohol using parents and support in parenting for drug and alcohol users.

A provider will be expected to work with people as members of families. This means working with family members as carers, carrying out carers assessments and providing evidence based family interventions.

A provider will be expected to maximise the benefits of treatment by involving family members.

A provider will be expected to provide an evidence based support programme to the children of drug and alcohol misusing parents and specific support for the parents themselves.

A provider will participate fully with the Somerset Troubled Families work programme.
4.2.9 Access to residential rehabilitation

A provider will provide access to residential rehabilitation.

This will require additional assessment and care co-ordination. A residential rehab pathway will be produced by a provider which will be available to service users, carers and other agencies.

A provider will manage a devolved budget for residential rehabilitation as part of the service model. This budget is flexible and a provider will use it to respond to need. A provider will manage this element of the service to ensure that those requiring residential rehabilitation receive it. SDAP will not provide additional funding if a provider over spends.

A provider may deliver residential rehabilitation itself or may contract from an appropriately suitable and qualified provider. In this case a provider is expected to conduct all quality assurance checks and contract management.

4.2.10 Accommodation based support and work with those in supported housing

A provider will provide a support service to those living in designated drug and alcohol supported accommodation. This will be connected to, but not dependent on, the provision of treatment or aftercare for these people.

A provider will link with housing providers to ensure the delivery of the outcomes listed in section 6. Specifically, a provider will work alongside, but will not replicate, provision commissioned by Somerset County Council under the contracts for “P2I” and “P4SE”. Partnership working with providers of these contracts will be essential.

Additionally a provider will provide accommodation based support to those living in drug and alcohol specific supported accommodation. This currently comprises 20 units of “dry house” accommodation.

4.2.11 Aftercare support

A provider will deliver support to those people that have completed structured treatment. This will include supporting people to establish meaningful activities and reduce the risk of relapse.

The provision of aftercare services will not be at the same time / location as the provision of treatment services.
4.2.12 Management of the central multi-agency client information database, including all necessary reporting, information sharing protocols with other agencies and with the SDAP

A provider will commission or deliver a computerised record keeping system that enables recording and reporting of all outputs listed in section 6.

Further, this information system will be accessible to other agencies delivering drug and alcohol interventions to ensure that there is one case management system for drug and alcohol users in Somerset.

This system will also be accessible to SDAP to enable real-time audit and report generation.

A provider will ensure that all required consent and information sharing agreements are in place to enable this to take place.

4.3 A provider will ensure that ‘Medications in Recovery: Re-Orientating Drug Dependence Treatment’ (Strang et al 2012) is fully implemented to ensure that for service users receiving opioid substitution therapy, it is always delivered in line with clinical guidance. This will be in order to optimise its effectiveness, enable service users to quit street drug-use and support recovery from addiction. This is in response to the Government’s 2010 Drug Strategy which said too many people risked remaining on a substitute prescription, when it should be the first step on the road to recovery. A provider will:

- Review all existing service users to ensure they are working to achieve abstinence from problem drugs;
- Ensure treatment programmes are dynamic and support recovery, with the exit visible to service users from the moment they walk through the door;
- Integrate treatment services with other recovery support, such as mutual aid groups, employment services and housing agencies.

4.4 Section 6 suggests particular areas of best practice and quality standards information connected to each outcome area. This list is not meant to be exhaustive. A provider will comply with all current and future relevant legislation, regulations and statutory circulars which are applicable to the services provided. These include but are not restricted to:

The Equality Act 2010 which replaces all previous anti-discrimination laws and provides a framework covering nine ‘protected characteristics’ (race, gender, disability, religion/belief, sexual orientation, age, gender reassignment, pregnancy and maternity, marriage and civil partnership)

- Misuse of Drugs Act 1971
- Medicines Act 1968
- Fair Access to Care 2002
- Local Authority Act 2000
Medical (Professional Performance) Act 1995
Health and Social Care Act 2001
NHS and Community Care Act 1990
The Children Act 1989, 2004
Working Together 2010
Health Act 1999
The Mental Health Act 1983, 2007
The Mental Capacity Act 2005
Carers (Recognition and Services) Act 1995
Human Rights Act 1998
AIDS Control Act 1987
Health and Safety at Work Act 1974
Rights of Third Party Act 1999
Data Protection Act 1998
The Client Access to Personal Files Act (1987)
Employment Law and Relevant EU Legislation
Control of Substances Hazardous to Health
Environmental Health and Hygiene
And any relevant European Union Legislation

4.5 **A provider is required to have in place effective policies and procedures which promote the well-being and safety of service users and staff.**

These should include but are not restricted to:

- Complaints procedure (for service users)
- Safeguarding
- Working with families and carers
- Information Sharing
- Confidentiality
- Clinical Governance
- Infection Control
- Transition of young people into adult services
- Complaints/grievance procedure, (for paid staff and volunteers)
- Reporting and monitoring of accidents to staff, volunteers and service users
- Equal opportunity in service provision, recruitment and employment
- Occupational health
- Policies relating to confidentiality of information
- HIV/AIDS policies including employment
- Accidents and incidents in the workplace
- Management of violence
- Fire safety
- Codes of conduct and rights of service users
- Equal opportunities in staff recruitment and service provision
- Training and staff development

These policies and procedures must have clearly stated objectives, stipulate who is responsible for their implementation and make arrangements for monitoring, review and development.
4.5.1 Policy and Standard Initiatives - National and Local

A provider will be expected to acknowledge the significance of the following policies and standard initiatives and work to achieve them:

4.5.2 National:


HM Government’s Alcohol Strategy (2012)


National Treatment Agency – Minimum Data Set for Drug Treatment

National Treatment Agency - Building Recovery in Communities (2012)


National Treatment Agency – Opening doors to Treatment

Health of the Nation (1992)


National Institute for Health and Clinical Excellence (NICE) guidelines for treating substance misuse:

CG51 Drug Misuse Psychosocial Interventions;

PH18 – Needle Exchange and Syringe Programme;

PH24 Alcohol-use Disorder – Preventing Harmful Drinking;

CG115 – Treating Harmful Drinking and Alcohol Dependence;

CG52 – Drug Misuse Opioid Detoxification;

CG100 – The Treatment of Physical Health Problems caused by Drinking Alcohol;

Implement NICE Guidance for the management of common mental health problems eg CG22

Medications in Recovery : Re-orientating drug dependence treatment’ (NTA, Strang et al 2012)

Routes to Recovery (NTA, 2009)

Drug Treatment and Recovery (NTA, 2010)

Drug Misuse and Dependence : UK Guidelines on Clinical Management (Department of Health, 2007).

This list is not exhaustive.
4.5.3 Local:

A provider MUST comply with:

- Somerset’s Local Safeguarding Children Board
- Somerset County Council Safeguarding Adults Procedures

In particular this includes: the Somerset Multi-Agency Policy for Safeguarding Vulnerable Adults and Somerset Multi-Agency Protocol for Working with Substance Misusing Parents.
5. Scope of the Service Model

The service model as described in this specification differs to the current configuration.

The following does not provide a description of the service model to be commissioned but represents those contracts and areas of service which are or are not being considered in relation to this service model.

5.1 In scope

The current contracts which are in scope for this service model are:

- Open Access Community Based Drug and Alcohol Service (adults)
- Community Access Programme (aftercare service for adults)
- Integrated substance misuse treatment service (young people)
- Support for adults living in drug and alcohol supported accommodation schemes
- Dual Diagnosis Specialist Psychiatrist service (adults)
- GP “Shared Care” enhanced service (adults)
- In-patient detoxification (adults)
- Pharmacy needle exchange

SDAP has commissioned a range of pilot projects to provide identification and brief advice around alcohol misuse. The pilots will have ended when this service model commences, however, as set out in section 4 and section 6, the interventions they deliver may fall within the scope of this new service model.

5.2 Out of scope

The current contracts not considered as part of this service model are:

- Targeted Youth Support Service (young people)
- Contracts for GPs with Specialist Interest in substance misuse
- Pharmacy supervised administration of medication

5.3 Out of Scope services

The training and development of the wider workforce to raise drug and alcohol awareness and deliver drug and alcohol interventions is out of scope for this service model.

Grant funding provided by SDAP to voluntary groups is not considered in this model.
6. The Services to be provided:

6.1 The following lists the measurable outputs, milestones and design elements for each of the service outcomes.

6.2 Outcome 1: Intervene early to prevent problems with drugs and alcohol developing

6.2.1 Expected outputs:

| Recorded numbers of screenings and assessments undertaken to identify and sign post to support young people using substances |
| Recorded numbers of screening and assessment undertaken to identify and respond to adults using substances |
| Recorded numbers of alcohol brief interventions which are undertaken by wider non-drug/alcohol specific services |
| Recorded numbers of drug brief interventions which are undertaken by wider non-drug/alcohol specific services |

6.2.2 Characteristics of success in delivering this outcome will be:
- Screenings undertaken to identify and sign post to support young people using substances
- Assessment undertaken to identify and respond to young people using substances
- Young people and adults access to drug and alcohol information and services available locally
- Adult screening and assessment undertaken to identify and respond to people using substances
- Alcohol brief interventions undertaken by wider non-drug/alcohol specific services
- Drug brief interventions undertaken by wider non-drug/alcohol specific services
- Timely access to appropriate interventions and treatment

6.2.3 Measurable milestones will be:
- Numbers of staff competent to screen and identify drug misuse and refer into local specialised drug treatment
- Number of people provided with drug-related advice and information
- Numbers of standard assessments recorded
- Records on “system” of standard assessments (and appropriate resulting action)

6.2.4 Governance and best practice requirements which should be considered are:
- CCQI 2012 Practice standards for YP with substance misuse
- HAS 2001 substance of young needs
• SIPS 2012
• DH 2009 Signs for improvement
• NICE CG 115 (Feb 2011) Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence
• NICE PH 24 Alcohol use disorders: prevent harmful drinking
• Models of Care (NTA 2006)
• Drug Misuse & Dependence. UK guidelines on clinical management 2007

6.2.5 Key elements in a service responding to this outcome are expected to be:
• Agreed common/standard screening /assessment tool for adults
• To support a stepped approach in agencies to have staff groups trained to deliver Identification and Brief Advice (IBA) and teams have alcohol and drug champions
• Specialist workers in key locations to support the delivery of IBA by the wider workforce

6.3 Outcome 2: Reduce the chances of drug and alcohol related deaths

6.3.1 Expected outputs:

<table>
<thead>
<tr>
<th>Expected Outputs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lower numbers of reported opiate overdose deaths</td>
</tr>
<tr>
<td>Measured infection rates of HIV / Hepatitis B / Hepatitis C</td>
</tr>
<tr>
<td>Waiting times for treatment are within agreed limits</td>
</tr>
<tr>
<td>An agreed proportion of people are retained in treatment for 12 weeks</td>
</tr>
</tbody>
</table>

6.3.2 Characteristics of success in delivering this outcome will be:

• A strategy in place to support the distribution of naloxone and training in overdose prevention
• Needle exchange saturation (1+ needle for every injection)
• Reducing rates of Hepatitis C infection in Injecting Drug Users (IDUs)
• Quick access to treatment (< 3 weeks)
• Opiate users receiving maintenance prescribing achieve stability
• People do not drop out / disengage from treatment
• Targeted work or specialist support for vulnerable groups
• Transitions between young people and adult services are well established and effective
• Care is co-ordinated

6.3.3 Measurable milestones will be:

• Numbers of people provided with training on naloxone use / overdose awareness
• Numbers of doses of naloxone prescribed
• Ambulance data on overdoses attended
• Numbers accessing needle exchange
• Numbers of needles & other resources distributed
• Hepatitis B vaccination rate
HIV, Hepatitis B and Hepatitis C testing rate
Numbers waiting
Wait from referral to assessment
Wait from assessment to treatment start
Wait for secondary treatment modality
Retention rates for maintenance prescribing are over 85% staying in treatment 12 weeks plus
Rate of drop out / disengagement
All clients have a named care co-ordinator, this can be observed on the case management system

6.3.4 Governance and best practice requirements which should be considered are:

- ACMD Consideration of Naloxone (May 2012)
- NICE QS23:1 People who inject drugs have access to needle and syringe programmes in accordance with NICE guidance
- NICE PH 18 (Needle and Syringe Exchange)
- Models of Care (2006)
- NICE QS23: 2 People in drug treatment are offered a comprehensive assessment
- Models of Care (NTA 2006)
- Drug Misuse & Dependence. UK guidelines on clinical management 2007
- Royal College of Psychiatrists Centre for Quality Improvement (June 2012)
  Practice standards for young people with substance misuse problems

This is not an exclusive list; all other relevant best practice and clinical governance guidance should apply.

6.3.5 Key elements in a service responding to this outcome are expected to be:

- A naloxone strategy for prescribing agencies and pharmacies
- Overdose prevention training programme for service users / carers / others
- Geographical spread and location diversity of needle exchange to promote uptake. Training and development of staff involved.
- Use of a standard assessment tool
- Assertive engagement / re-engagement for those at risk of drop-out.
- Substitute opiate maintenance prescribing
- An identified care co-ordinator for everyone accessing support or treatment

6.4 Outcome 3: Reduce drug and alcohol related offending

6.4.1 Expected outputs:

| Reduction in drug related acquisitive crime rate |
| Reduction in alcohol related violent crime rate |
| Reducing re-offending binary measure |
6.4.2 Characteristics of success in delivering this outcome will be:
- IBA reduces alcohol related arrests
- Treatment for drug users reduces acquisitive crime
- Drug users are targeted to access treatment through the criminal justice system
- Interventions with alcohol users reduces violent crime associated with the night time economy
- Interventions are targeted via criminal justice system
- People offending with drug and alcohol issues are targeted and do not re-offend

6.4.3 Measurable milestones will be:
- Numbers receiving IBA in custody suites
- Numbers accessing treatment through criminal justice routes
- Outcomes of treatment for those above
- Numbers of alcohol interventions delivered through arrest referral
- Follow up information on those above
- DRR – orders made and completions
- ATR – orders made and completions

6.4.4 Governance and best practice requirements which should be considered are:
- Models of Care (NTA 2006)
- Models of Care for Alcohol Misuse (Dept of health 2006)
- All relevant Home Office DIP circulars and guidance
- All relevant Probation circulars and guidance
- All relevant Youth Justice Board (YJB) circulars and guidance

This is not an exclusive list; all other relevant best practice and clinical governance guidance should apply.

6.4.5 Key elements in a service responding to this outcome are expected to be:
- Appropriate level of arrest referral / courts referral / transfer from prison/ Youth Offenders Institute (YOI) to enable drugs intervention / engagement with treatment
- Appropriate level of arrest referral / courts referral / transfer from prison/Youth Offenders Institute (YOI) to enable alcohol intervention / engagement with treatment
- Treatment service works with probation and Youth Offending Team and provides information to support sentencing / reviews

Other elements of service design may include the use of peer mentors, partnership working with police and probation staff and other voluntary agencies (including 12 step fellowships).
6.5 Outcome 4: Improve the mental and physical health of drug and alcohol users

6.5.1 Expected outputs:

<table>
<thead>
<tr>
<th>Reduction in drug and alcohol reported deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduction in drug and alcohol related hospital admissions (including standardised alcohol related hospital admission data and hospital episode statistics ((HES) related to drug / alcohol use)</td>
</tr>
<tr>
<td>Self reported improvements in mental health and wellbeing (Treatment Outcome Profiles (TOPs))</td>
</tr>
</tbody>
</table>

6.5.2 Characteristics of success in delivering this outcome will be:

- IBA reduces alcohol related hospital admissions
- Drug and alcohol treatment services provide appropriate healthcare assessments and support to access primary care medical services
- “Dual diagnosis” (clients with both mental health and substance misuse issues) cases are managed in an integrated way with a clear sense of accountability

6.5.3 Measurable milestones will be:

- Numbers receiving IBA in primary care and hospital settings
- Numbers of general healthcare assessment undertaken in treatment
- Mental health outcome information on completion of treatment

6.5.4 Governance and best practice requirements which should be considered are:

- SIPS
- Models of Care (2006)
- Dual Diagnosis guidance e.g. DH Policy Implementation Guide: Mental Health Policy: Dual Diagnosis Good Practice Guide
- Royal College of Psychiatrists Centre for Quality Improvement (June 2012) Practice standards for young people with substance misuse problems

6.5.5 Key elements in a service responding to this outcome are expected to be:

- Primary care works as part of the system through delivering IBA, assessing people’s drug and alcohol use and supporting treatment delivery
- IBA is delivered in hospital settings
- Integrated training for mental health and drug and alcohol workers
- Joint assessment clinics are delivered between mental health and drug and alcohol services
- Nominated dual diagnosis specialists work as part of the service and with mental health services

Joint working with primary and secondary healthcare and, in particular, with mental health services is essential in delivery of this outcome.
6.6 Outcome 5: Increase the numbers of people achieving abstinence from drugs and / or alcohol

6.6.1 Expected outputs:

| Numbers completing treatment drug / alcohol free and not returning within 6 and 12 months |

6.6.2 Characteristics of success in delivering this outcome will be:
- Recovery orientated community treatment system
- Effective preparation, pathway to and from community and inpatient detoxification and residential rehabilitation

6.6.3 Measurable milestones will be:
- Numbers accessing community detoxification
- Numbers accessing inpatient detoxification
- Numbers entering residential rehabilitation
- Numbers leaving Shared Care having successfully completed treatment

6.6.4 Governance and best practice requirements which should be considered are:
- Building Recovery in Communities (NTA, 2010)
- Somerset shared care guidelines (updated 2012)
- Drug Misuse & Dependence. UK guidelines on clinical management 2007
- Royal College of Psychiatrists Centre for Quality Improvement (June 2012)
  
  Practice standards for young people with substance misuse problems

6.6.5 Key elements in a service responding to this outcome are expected to be:
- Evidenced based community psycho-social treatment (recovery focused)
- Community detoxification
- Inpatient detoxification
- Residential rehabilitation

Whilst it is not expected that a commissioned provider will necessarily provide the modalities listed above, they will be expected to provide access to them (through assessment and care management) and to establish relationships that enable a range of placements to be made. This may mean contracting with in-patient or residential treatment providers.

6.7 Outcome 6: Support access to safe and stable accommodation

6.7.1 Expected outputs:

| Self reported accommodation status on completion of treatment (TOPs) |
| Numbers of rough sleepers (counted) |
6.7.2 Characteristics of success in delivering this outcome will be:

- Accommodation options exist for people wherever they are in their drug / alcohol use or recovery
- A pathway exists to support rough sleeps to engage with drug and alcohol services
- Drug and alcohol services work together with accommodation providers to support people to develop independence

6.7.3 Measurable milestones will be:

- Numbers accessing supported accommodation with identified drug and alcohol issues
- Numbers of these moving from supported to independent accommodation
- Numbers engaging with drug and alcohol services from supported housing

6.7.4 Governance and best practice requirements which should be considered are:

- A guide to improving practice in housing for drug users [Home Office, 2009]
- Clean break [Homeless Link, 2008]
- The role of housing in drugs recovery: a practice compendium [CIH, 2012]

6.7.5 Key elements in a service responding to this outcome are expected to be:

- Accommodation for those still using / drinking and those abstinent but still needing support
- Training and joint working with accommodation providers
- Training and joint working with housing officers

6.8 Outcome 7: Promote positive social and family relationships

6.8.1 Expected outputs:

<table>
<thead>
<tr>
<th>Successful completions of treatment (without re-entry)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self reported better familial / social relationships (TOPs / follow up studies)</td>
</tr>
<tr>
<td>Numbers of children subject to Children Services involvement whose parents use drug or alcohol services</td>
</tr>
</tbody>
</table>

6.8.2 Characteristics of success in delivering this outcome will be:

- Family members are engaged with their loved one’s treatment
- Family members receive their own support
- Peer support enables people to develop their own positive social support network
- Children are protected from harm related to parental drug and alcohol use
- People are given appropriate contraceptive and sexual health advice in drug and alcohol services
- Parents are supported to understand the impact of their drug or alcohol use on children and reduce risk and promote positive parenting

6.8.3 Measurable milestones will be:

- Numbers of family members accessing support groups
• Carers assessments completed
• Numbers of peer mentors recruited by service
• Numbers of social activities undertaken by service users supported by the service
• Successful completion of treatment for parents
• Numbers of drug and alcohol users in contact with specialist midwives

6.8.4 Governance and best practice requirements which should be considered are:
• NICE QS23: 3 Families and Carers
• NTA Routes to recovery (2009)
• ACMD 2003/2007 Hidden Harm – Responding to the needs of children and problem drug users

6.8.5 Key elements in a service responding to this outcome are expected to be:
• A carers assessment is undertaken with carers of drug and alcohol users
• Family support groups are delivered appropriate to different areas and populations
• Family peer support is encouraged
• Peer mentoring training is delivered as part of service
• All service users are allocated an appropriate mentor
• Aftercare service supports users to develop social activities
• Training and joint working with children’s services
• Contraception and sexual health work is integrated into drug and alcohol services
• Parenting support is delivered to parents in treatment

6.9 Outcome 8: Support to access education, training and employment

6.9.1 Expected outputs:

| Measure of the number of JSA / ESA (Universal Credit) claimants citing drug or alcohol use |
| Self reported education / training / employment outcomes (TOPs) |

6.9.2 Characteristics of success in delivering this outcome will be:

• JSA / ESA claimants are identified and referred to treatment
• Work programme providers and treatment providers work together to deliver joined up working
• Pathways to ETE are accessible for everyone in recovery / completing treatment.

6.9.3 Measurable milestones will be:

• Referrals from Jobcentre Plus to treatment
• Work programme entries and completions for identified drug and alcohol users
• ETE outcomes for aftercare service

6.9.4 Governance and best practice requirements which should be considered are:

• Employment and recovery: a good practice guide [NTA, 2012]
Joint-working protocol between Jobcentre Plus and treatment providers [NTA, 2010]
Working towards recovery: getting problem drug users into jobs [UKDPC, 2008]

6.9.5 Key elements in a service responding to this outcome are expected to be:
- Training and joint working with Jobcentre Plus staff and work programme providers.
- Aftercare service supports ETE entry without duplicating mainstream provision.

6.10 Outcome 9: Promote independence, and the development of own support network, for people recovering from drug and alcohol problems

6.10.1 Expected outputs:

| Self reported follow up from former service users (post completion survey) |
| Successful completion of aftercare provision |

6.10.2 Characteristics of success in delivering this outcome will be:
- Service users are empowered to make choices about their own treatment.
- Aftercare delivers personalised “treatment” that enables independence to develop
- Aftercare service supports service users to develop independent support network

6.10.3 Measurable milestones will be:
- Audit of information available to service users as they enter treatment
- Use of personalised budgets in delivery of aftercare
- Numbers accessing aftercare service
- TOPs outcomes information for aftercare service

6.10.4 Governance and best practice requirements which should be considered are:
- NICE QS 23: 9 Continued treatment and support when abstinent

6.10.5 Key elements in a service responding to this outcome are expected to be:
- Information is available and provided to people at all points of the treatment system.
- Aftercare service operates a personalised budget system to enable service users to choose how to embed their recovery
- An aftercare service that has sufficient capacity to support those leaving treatment.
7. Geography and Premises

7.1 Services will be delivered across the whole county of Somerset, with equal access to services available for people wherever they live.

7.2 Services must be delivered from venues that are accessible to people, including (but not restricted to) those with disabilities and parents with children.

8. Staff Competence and Training

8.1 The Service model will be provided by appropriately qualified/ experienced workers who have an understanding of the diverse range of needs of young people and adults who misuse substances. This includes appropriately qualified medical professionals.

8.2 Where additional training needs are identified for staff, a provider will arrange training and supervision to help staff to develop the necessary skills and competence to provide effective support: i.e. in respect to safeguarding children and adults, mental health, offending behaviour, etc.

8.3 The Service model will adhere to the Safeguarding Vulnerable Groups Act 2006 and any subsequent changes that are implemented. All staff will have an enhanced CRB check.

8.4 A provider will collaborate with other services and agencies, for example but not limited to, mental health and sexual health services and Job Centre Plus. This will enable the sharing of capacity and skills and to maximise successful outcomes.

8.5 A provider will undertake regular training and development with their staff.

8.6 A provider shall not employ any individual who has been included in a Government held barred list for the purpose of providing any Service directly to a vulnerable adult or the provision of a Service which is likely to involve contact with a vulnerable adult.

8.7 A provider will ensure that the appropriate level of Criminal Records Bureau (CRB) check is made for all employees who will be working with vulnerable adults and children. Employees must not be allowed to work unsupervised with vulnerable people until the CRB disclosure has been received.

8.8 A provider will ensure that they follow safe recruitment practice as exemplified in ‘Recruiting Safely – safer recruitment guidance helping to keep children and young people safe’, (Children’s Workforce Development Council, 2009).
9. Equalities and Diversity

9.1 A provider will adopt a policy to comply with its statutory obligation under The Equality Act 2010 and will ensure that it does not treat one group of people less favourably than others because of their colour, race, nationality, ethnic origin, sex, sexual orientation, religion or belief, age, or disability.

10. Data Security

Data is owned by, and is accessible to, the Somerset Drug and Alcohol Partnership. A provider manages the data and is responsible for complying with all relevant legislation. A provider is responsible for ensuring that Somerset Drug and Alcohol Partnership have access to the data in order to generate reports and audit the services.

A provider must in relation to all data held relating to service users:

10.1 Comply with the law, and have its own registration under the Data Protection Act 1998, if any information concerning the service user is stored in a structured filing system, (either electronic or paper).
10.2 Ensure that all information and data sharing policies are in place
10.3 Share information regarding the service user only where it is in the best interest of the service user and where the consent has been obtained for this information to be shared
10.4 Ensure that staff, whether employed or voluntary, are bound by a provider's code of confidentiality.
10.5 Keep all computers, laptops and other electronic devices, which hold information, locked and secure and never leave data in an unattended vehicle.
10.6 Store all paper files in a locked cabinet within a secure area.
10.7 Have a procedure to challenge any unauthorised or unknown individuals seen on their premises.
10.8 Ensure any data is disposed of properly and securely.

A provider will not:

10.9 Leave data in any unsecured area.
10.10 Take data out of the office unless agreed with the commissioner.
10.11 Transmit, or exchange data by any means, unless previously agreed with the commissioner.
10.12 Hold data for longer than required.
11. Roles and Responsibilities

11.1 Somerset Drug and Alcohol Partnership

- Annual Monitoring and assessment of services provided
- Contract Management
- Organise and minute quarterly performance reviews
- Organise and minute annual contract review as agreed

11.2 Somerset County Council

- Receive invoices from service providers, check and issue payment
- Financial monitoring of pooled budgets
- Ensure contracts and funding are administered in a timely fashion

11.3 Service provider/s

Duties and responsibilities are covered by this specification and all other documents covered in the Terms and Conditions “Entire Contract”.

12. Reporting – Statistics and Analysis

12.1 A provider will provide the Contract Manager with reports that relate to the outputs specified in section 6 of this contract.

12.2 A provider will use the standardised pro-forma and recording mechanisms, as developed and agreed by SDAP.

12.3 Every effort will be made to ensure that all reporting required is meaningful and essential in order to demonstrate the outcomes for alcohol and drug users and their progression through the pathway.

12.4 A provider will prepare and make available reports for the quarterly performance review meetings and annual reviews.

13. Feedback Mechanisms

13.1 A provider will be expected to fully participate in annual and random service audit. This includes ad-hoc requests for data and information. These services will respond to requests from the SDAP service users’ forum and support them to carry out independent monitoring.

13.2 A provider will engage regularly with service users and other Stakeholders (including SDAP partners) to seek their views and ensure that this feedback is used to improve the services they are contracted to supply.

13.3 A provider must undertake an agreed regular anonymous quality assurance survey. A provider must use these findings to shape their service.

13.4 The Comments Compliments and Complaints policy of a provider must be aligned to SCC’s policy and procedures.

13.5 The service will participate in any other independent monitoring, feedback or survey system as determined by SDAP.
14. Marketing and Promotion of the Service Model

14.1 A provider will make available and promote all services to relevant agencies, young people and to the general public on a regular basis.

15. Social Value

15.1 With regard to The Social Value (Public Services) Act 2012, from January 2013 all service contracts should deliver some further benefit back into the community, above and beyond the services being paid for.