# Invitation to Tender
# for
# Provision of Adult Drug Treatment Services in Cambridgeshire

## Cambridgeshire Drug and Alcohol Action Team (DAAT)

*Comprising:*

***PART A – THE COUNCIL'S REQUIREMENTS***

**Information for Contractors** **(Section 1)**
**Instructions to Contractors** **(Section 2)**
**Service Specifications** **(Section 3)**

*Including:*

**3A OVERARCHING PROVISION**

**3B SPECIFIC PROVISION**

a. Single Point of Contact/ Advice and Information/ Assessment
b. Harm Reduction
   - Needle Exchange
   - Blood Borne Virus
   - Clinical Waste
c. Specialist Prescribing
d. GP Shared Care
e. Supervised Consumption
f. Structured Psychosocial Interventions
g. Structured Day Programmes
h. Family Support
i. DIP (including j.DRR)
k. Prison

Glossary of terms

Appendices

**Contract Documents** **(Section 4)**

***PART B – TENDER DOCUMENT***

| | |
|---|---|
| **Form of Tender and Pricing Schedule** | **(Section 5)** |
| **Tendering Certificate** | **(Section 6)** |
| **Guarantee Undertaking** | **(Section 7)** |
| **Supporting Documents** | **(Section 8)** |
| **Response to Specification** | **(Section 9)** |
| **Response to Contract Terms** | **(Section 10)** |

**Date of despatch of Invitation to Tender: 19th August 2011**
**Tender return date: 30th September 2011**

**Tender shall be returned to:**
Deputy Chief Executive
Corporate Services
Cambridgeshire County Council
RES1011
Shire Hall, Castle Hill
Cambridge CB3 0AP

## PART A – THE COUNCIL'S REQUIREMENTS

The following 4 sections set out general information about the project, the Council's bidding, specification and contract requirements.

Contractors are asked to make their response to these requirements by completing and returning the Tender Document in Part B of this Invitation to Tender.

# Section 1 – Information for Tenderers

**Cambridgeshire County Council (the Council) is acting as lead commissioner on behalf of itself and Cambridgeshire Primary Care Trust (PCT) for the procurement of Drug Treatment Services.**

## 1.0 Cambridgeshire County Council – its background and structure

1.1 Cambridgeshire County Council was formed in 1974 and quickly established a reputation for managerial innovation. This included medium term planning, local financial management (the County Council pioneered the delegation of budgets to schools), the development of an internal market for support services, and imaginative approaches to service delivery including the out-sourcing of a number of Council services.

1.2 The Council is composed of 69 councillors elected every four years.

1.3 The political composition of the County Council as at 21 March 2011

- Conservative 41
- Green 1
- Labour 2
- Liberal Democrat 21
- UKIP 1
- Independent 2
- Vacancy 1
- Total 69

1.4 The Cabinet, comprising up to ten councillors, including the Leader, is responsible for most day-to-day decisions for the Council. Organisationally, the Council is managed by a Chief Executive, Mark Lloyd, and three front line services Executive Directors:

a. Children and Young People's Services Adrian Loades

b. Community and Adult Services Pat Harding (Acting role)

c. Environment Services John Onslow

These are supported by three Corporate Directorates:

a. Customer Service and Transformation

b. Finance, Property and Performance

c. People, Policy and Law

## 2.0 The Council's Vision

The vision for Cambridgeshire is to create communities where people want to live and work; now and in the future. The Council is keen to work with contractors who are prepared to support both these Core Visions and Values:

- **A robust local economy** with a diverse job base across the County, which includes a growing manufacturing base and well-developed low-carbon technologies, building on the acknowledged strengths of the Cambridge Sub-Region for innovation.

- **Communities that are safe, healthy and socially inclusive** through the relationship between homes, jobs and services, providing a high standard of accessibility of the whole population which is well served by sustainable transport and well developed information technology infrastructure.
- **A sustainable environment** with exemplary low carbon living, founded on the retention of Cambridge as an efficient compact city with sustainable fringe developments and on the balanced expansion of market towns closely linked to surrounding village communities, with:
  - provision of extensive green infrastructure
  - energy and water efficient buildings
  - efficient use of resources, including renewable energy and
  - prepared for the impact of climate change and highly adapted to its effects.

## 3.0 The Council's Core Values

The Council's Core Values are the commitment to local people and our partners and that we always try to act according to our values and would expect our contractors to support these values:

- **Accountability** – we will be open and transparent, listening and communicating clearly and taking responsibility for our actions.
- **Respect** – in working with each other, our partners, residents and service users, we will treat each other as we would like others to treat us, recognising and embracing differences and taking account of the full range of opinions.
- **Integrity** – we will behave honestly and demonstrate reliability by promising only what we can deliver and delivering what we promise.
- **Value for money** – we will balance the cost and quality to make sure that all our resources make the maximum possible impact.
- **Excellence** – working with partners where appropriate, we will ensure you receive services of the highest quality.
- **Equity** – we will treat people fairly, valuing and responding to their diverse backgrounds and needs.

## 4.0 Cambridgeshire

4.1 The population in Cambridgeshire is estimated at 600,800 (County and district population estimates mid-2009: Cambridgeshire County Council Research Group, 2010). There are five district councils within the Drug and Alcohol Action Team (DAAT) area:

- Cambridge City
- South Cambridgeshire
- East Cambridgeshire
- Fenland
- Huntingdonshire

Cambridgeshire Primary Care Trust (PCT) was created on 1 October 2006, which replaces the former Cambridge City, East Cambridgeshire and Fenland, Huntingdonshire and South Cambridgeshire PCTs. There is one police force, divided into two divisions (Central and Southern), with resources serving specific areas of Cambridgeshire.

## 5.0 Cambridgeshire Drug and Alcohol Action Team (DAAT)

5.1 The Cambridgeshire Drug and Alcohol Action Team is a multi-agency partnership working to implement the National Drug Strategy. The Cambridgeshire DAAT comprises senior staff from the main organisations in the county involved in tackling drug related issues: County Council (including Education and Social Services); NHS Primary Care Trusts; Police; Probation; District Councils; HM Prison Service; representatives of local services.

5.2 Cambridgeshire has two prisons HMP Littlehey (Category C) and YOI Littlehey for young offenders and HMP Whitemoor (Category A and B) IDTS went live in both adult establishments in early 2011.

5.3 It is estimated that there were 2,195 opiate and/or crack cocaine users in Cambridgeshire in 2009/10. 1,261 clients were known to the treatment system in Cambridgeshire in 2009/10, which is equivalent to 57 % of the drug using population.

## 6.0 The 2012/13 drug treatment system contract period/delivery requirements

6.1 The contract will be for an initial period of 36 months which will be extended for a further period of 24 months followed by an additional 24 months up to a maximum of 84 months (7 years), subject to recurrent funding being available and satisfactory measurable performance. During the life of the contract there may be extensions to service delivery to incorporate related housing, mental health and general life skills services. It is anticipated that there will be continuous development throughout the life of the contract in response to changes in legislation, government initiatives and the Cambridgeshire DAAT funding allocation.

## 7.0 Location of drug treatment services from 2012

7.1 The location of services within the new treatment system will be based on the Cambridgeshire County Council area (excluding Peterborough).

## 8.0 Structure of drug treatment services from 2012

8.1 Our vision for the provision of drug treatment services is for a single system that is recovery orientated and delivered by a single provider, or small number of providers working in partnership/ consortia, which will contain all elements of the drug treatment system.

The service model will be:

- Recovery focused
- Inclusive
- Shaped by the needs and views of local service users.
- With access and support that will be available at any point within a client's recovery journey.

It is stressed that the provider should demonstrate that they promote a culture that is *'recovery focused'* and shared by the entire workforce.

Important, relevant local information that gives further details is available at:

Cambridgeshire DAAT website: http://www.cambsdaat.org This includes:

- Needs Assessment 2011/12
- Treatment Plans 2011/13

- Safeguarding Practice Guidance

In addition, national information is available at: NTA http://www.nta.nhs.uk

## 9.0 Groups Served

9.1 This service must be offered to all Cambridgeshire residents over the age of 18 years of age with primary drug misuse issues. Alcohol issues may be addressed if alcohol is used as a secondary substance and then referred to appropriate services.

9.2 There must be no discrimination regarding: co-morbidity, gender, sexuality, ethnic background and religion.

## 10.0 Service Specification

The service specification been developed on the understanding that the service will:

- Be provided by one provider *or*
- by consortia with a lead agency.
- Encompass *all* drug treatment modalities as defined by Models of Care Update 2006[1].
- Align with the Building Recovery in Communities Consultation Document 2011[2].

It includes:

**Section A: Overarching provision** (relevant to all of Section B)

**Section B: Specific provision**

a. Single Point of Contact/Advice and information/Assessment

b. Harm Reduction
   - Needle Exchange
   - Blood Borne Virus
   - Clinical Waste

c. Specialist Prescribing

d. GP Shared Care

e. Supervised Consumption

f. Structured Psychosocial Interventions

g Structured Day Programmes

h. Family Support

i. DIP (including j. DRR)

k. Prisons

## 11.0 Funding Arrangements

11.1 Cambridgeshire County Council will be contracting as lead commissioner jointly with the Cambridgeshire Primary Care Trust (PCT). If adequate funding for subsequent years of the contract is or is not secured then the Council may terminate the Contract. The current cost for providing the Drug Treatment System as detailed in the Service

[1] NTA (2006) Models of care for treatment of adult drug misusers: Update 2006 http://www.nta.nhs.uk/uploads/nta_modelsofcare_update_2006_moc3.pdf

[2] http://www.nta.nhs.uk/recovery.aspx

Specifications is in the order of £4.2 million annually. However Cambridgeshire County Council and the Primary Care Trust is seeking improvements to service provision for example by added value to this budgetary amount.

## 12.0 The Transfer of Undertakings Regulations 1981 (TUPE)

12.1 The Council believes that TUPE may apply to the contract. Please refer to Section 8 for further information.

# Section 2 – Instructions to Tenderers for the Provision of Adult Drug Treatment Services in Cambridgeshire

## 1.0 General Information and Instructions

1.1 Compliance with Instructions:

Tenders submitted shall be in accordance with and subject to the terms of these instructions and other documents comprising the Invitation to Tender.

**Tenders not complying (or which cannot promptly be rendered compliant) with any mandatory requirement will be rejected. A mandatory requirement is indicated by the word "shall" or "must.**

**Any queries about the tender documents or Tendering Certificate which may affect the preparation of the tender shall be raised without delay (preferably in writing) with the Contact Officer.** If the Council considers a query may have a material effect on the tendering process, all Tenderers will be notified without delay in writing.

1.2 The Council is seeking offers by issuing this Invitation to Tender in pursuance of the Public Service Contracts Regulations 1993 restricted procedure.

1.3 **This invitation to tender does not constitute an offer and the Council does not undertake to accept any tender. The Council reserves the right to accept any part of any tender.**

**The Council will not reimburse any tendering costs.**

1.4 The **Contact Officer** for this procurement is:

Anthony Paul

Contract Monitoring Officer

Cambridgeshire Drug and Alcohol Action Team (DAAT)

Castle Court,

CB3 0AP

Telephone: 01223 699680

Fax: 01223 699801

## 2.0 Confidential Nature of Tender Documentation and Bids

2.1 Tenderers shall not discuss the bid they intend to make other than with professional advisers or joint bidders who need to be consulted. Bids shall not be canvassed for acceptance or discussed with the media or any other tenderer or member or officer of the Council.

2.2 If a tenderer does not observe paragraph 2.1, the Council will reject the tender and may decide not to invite the tenderer to tender for future work.

## 3.0 Preparation of Bid

3.1 If the Council considers that a cover price (i.e. a bid that is not intended to be considered seriously) has been submitted, the Council may reject the tender and may decide not to invite the tenderer to tender for future work. The Office of Fair Trading encourages local authorities to look out for any evidence of price fixing arrangements.

3.2 Where the Council regards an amendment to the original tender documents as significant, an extension of the closing date may, at the discretion, of the Council be given to all Tenderers.

3.3 No alteration or addition shall be made to the Form of Tender, pricing schedules or any part of the Invitation to Tender except where expressly allowed or as provided below in paragraph 3.5.

3.4 Tenders shall not be qualified or accompanied by statements that might be construed as rendering the tender equivocal. Only unqualified tenders will be considered. The Council's decision as to whether or not a tender is in an acceptable form will be final.

3.5 Tenderers must obtain for themselves all information necessary for the preparation of their tender and satisfy themselves that the quality and standards specified by themselves or the Council are appropriate. Information supplied to Tenderers by the Council's staff or contained in the Council's publications is supplied only for general guidance in the preparation of the tender. Tenderers must satisfy themselves as to the accuracy of any such information and no responsibility is accepted by the Council for any loss or damage of whatever kind and howsoever caused arising from the use by Tenderers of such information.

3.6 Tenders and supporting documents shall be in English and any contract subsequently entered into and its formation, interpretation and performance shall be subject to and in accordance with the law of England and Wales.

3.7 The Invitation to Tender includes in Section 4 the Council's Contract Terms.

This is the Council's preferred contractual base for the supply.

Tenderers may state any amendments to the terms, which they consider necessary to clarify the basis of their bid in their response to the contract documents contained in Section.

**4.0 Submission of Tender**

4.1 Requirements for submission of information are as follows:

4.1.1. All submissions shall be made on the Form of Tender (Section 5) and be accompanied by the response to the Specification to be detailed (Section 9) Response to Specification. Only information relating to the Tenderer should be submitted unless otherwise requested.

Every item shall be priced in sterling and the submission totalled.

4.1.2 In order to evaluate the tender, the following documents will also be needed:

- The Tendering Certificate (Section 6)
- If the Tenderer is a subsidiary company, the Guarantee Undertaking duly completed and executed by the Tenderer's ultimate holding company in the form set out in Section 7.

4.2 All tenders shall be returned in the envelope provided in Part C. The envelope shall be marked: *Tender for the provision of Adult Drug Services within Cambridgeshire DAAT Partnership Area* and addressed to *Resources Directorate, Cambridgeshire County Council, Shire Hall, Castle Court, Cambridge, CB3 0AP* and shall arrive there by 4 pm on 30th September 2011.

Tenders shall ensure that their tender arrives on time. No tender will be accepted if it is received after any of the other tenders have been opened.

4.3 Where tenders are delivered by courier or by any method other than by Royal Mail, they must be delivered to Shire Hall main reception during normal working hours (8.30

am to 5.20 pm Monday to Thursday and 8.30 am to 4.20 pm on Friday excluding statutory holidays) and a pre-numbered official receipt obtained. Tenders shall not be handed to any other Council officer or member. Tenders delivered by hand to any other location or not receiving a receipt will not qualify and will be rejected.

Whichever method of delivery is used, Tenderers shall ensure that the envelope or any franking thereon does not bear any marks or signs or any reference which may indicate who the tenderer is. (Post Office bar coding does not count as marking.)

4.4 Tenders shall not be sent and will not be accepted by fax or e-mail.

4.5 If there appears to be an error in a submission or supporting information the Tenderer will be invited to confirm or withdraw its bid. Where the error relates to the tender total as calculated from tendered rates and variable quantities, the bid will be regarded as the tender total bid and the rate adjusted accordingly. The tenderer will be invited to confirm or withdraw the bid and resulting rate.

4.6 The Form of Tender shall be submitted by the organisation which it is proposed will enter into a formal contract with the Council if awarded the contract. It shall be signed by persons authorised to submit tenders and make contracts for the tenderer normally:

4.6.1 Where the tenderer is a partnership, by two (2) duly authorised partners;

4.6.2 Where the tenderer is a company, by two (2) directors or by a director and the secretary of the company, such persons being duly authorised for that purpose.

4.7 All tender documentation issued to enable the tenderer to submit a bid shall be returned with that bid.

## 5.0 Award Criteria

5.1 Any tender that is accepted will be awarded to the most economically advantageous tender in accordance with the following award criteria in descending order of importance:

- Quality of Method Statements including operational purposes
- Resources Allocation
- Price
- Any proposed amendments to Contract Terms
- Any other relevant matters

## 6.0 Award Process

6.1 The Council expects to decide award of contract within 90 days of the closing date for submission of tenders (see paragraph 4.2). Bids shall remain open for acceptance for a minimum of 90 days.

6.2 The Council may, if necessary, extend the 90-day period for completing the award process.

6.3 Tenderers will be notified simultaneously and as soon as possible of any decision made by the Council during the tender process, including award. When the Council has evaluated the bids, it will notify all Tenderers about the intended award

6.4 The Council generally debriefs all those who tendered about the characteristics and relative advantages of the leading bidder. Such details may also be stated in any published contract award notice.

6.5 Acceptance of the tender by the Council shall be in writing and shall be communicated to the tenderer. Upon such acceptance the Contract shall thereby be constituted and become binding on both parties and, notwithstanding that, the Tenderers shall upon request of the Council execute a formal contract in the form contained in the Contract Documents.

6.6 Tenderers must not undertake work without written notification that they have been awarded the contract and are required to start work. This is usually after contract documents have been executed.

## 7.0 Tenderer's Warranties

In submitting its tender, the tenderer warrants, represents and undertakes to the Council that:

7.1 All information, representations and other matters of fact communicated (whether in writing or otherwise) to the Council by the tenderer, its staff or agents in connection with or arising out of the tender are true, complete and accurate in all respects, both as at the date communicated and as at the date of tender submission;

7.2 It has made its own investigations and research and has satisfied itself in respect of all matters (whether actual or contingent) relating to the tender and that it has not submitted the tender and will not be entering into the contract (if the same be awarded to the tenderer by the Council) in reliance upon any information, representation or assumption which may have been made by or on behalf of the Council;

7.3 It has full power and authority to enter into the contract and perform the obligations specified in the Contract Documents and will, if requested, produce evidence of such to the Council;

7.4 It is of sound financial standing and has and will have sufficient working capital, skilled staff, equipment and other resources available to it to perform the obligations specified in the Contract Documents;

7.5 It will not at any time during the Contract Period or at any time thereafter claim or seek to enforce for the purposes of this contract any lien, charge, or other encumbrance over property of whatever nature owned or controlled by the Council and which is for the time being in the possession of the tenderer.

# Section 3 – Specification

## Introduction

### Service Specification inclusion

The service specification been developed on the understanding that the service will:

- Be provided by one provider *or*
- by a consortia with a lead agency.
- Encompass *all* drug treatment modalities as defined by Models of Care Update 2006[3].
- Align with the Building Recovery in Communities Consultation Document 2011[4].

This includes:

**3A Overarching provision**

**3B Specific provision**

a. Single Point of Contact/Advice and information/Assessment

b. Harm Reduction
   - Needle Exchange
   - Blood Borne Virus
   - Clinical Waste

c. Specialist Prescribing

d. GP Shared Care

e Supervised Consumption

f Structured Psychosocial Interventions

g Structured Day Programmes

h. Family Support

i. DIP (including j. DRR)

k. Prisons

**Glossary**

**Appendices**

Throughout Section 3, the terms *drug misuser*, *service user* and *client* have been used to denote changing 'status'. This is intended as a help when reading the specification and is not intended to be a definitive use of the words.

[3] NTA (2006) Models of care for treatment of adult drug misusers: Update 2006 http://www.nta.nhs.uk/uploads/nta_modelsofcare_update_2006_moc3.pdf

[4] http://www.nta.nhs.uk/recovery.aspx

# Section 3A – Specification: OVERARCHING PROVISION

**Information to Tenderers:**

Please read section 3A in conjunction all parts of section 3B of this document. Information written in 3A is relevant to ***all*** these sections and has not been repeated within them.

**Activity data 2009/10**

*This data given below is not exhaustive but is intended to give a snapshot of activity.*

a. Number of opiate and/or crack users in Cambridgeshire: 2,195
b. Number of OCUs known to the treatment system: 1,261
c. Percentage of drug using population in treatment: 57%
d. Number of clients in treatment (Tier 3/ 4): 1,739
e. Number of above engaged in effective treatment: 1,418 (82%)
f. Percentage in treatment system between 2-4 years: 10%
g. Percentage in treatment system for more than 4 years: 12%
h. Number exiting from treatment: 451 out of 1,739 (26%)
i. The number of new referrals to the treatment system (Tier 3/4): 650
j. Primary drugs used by clients: heroin - 77%, cannabis - 7%, methadone – 5%
k. Service amenities are currently delivered from: Cambridge city, Ely, Huntingdon, St. Neots and Wisbech

**Needle Exchange 2010/11**

a. Total number of pharmacies engaged in the scheme: 32
b. % of community pharmacies providing Needle Exchange: 48%
c. Total number of fixed site Needle Exchange services: 54
d. Total number of clients per month – pharmacies: *data not available*
e. Total number of clients per month – fixed sites: approx 177 (2008/09 data)

**BBV**

a. Hep B: 77% offered, 32% accepted, 11% started course and 11% finished
b. Hep C: 75% offered, 41% accepted and had tests

**Clinical Waste**

*Data is not available*

**Specialist Prescribing**

51% of all modalities were specialist prescribing.

**GP Shared Care**

5% all modalities were GP prescribing.

**Supervised Consumption**

In September 2010, 264 clients were observed at pharmacies.

**Structured Psychosocial Interventions**

14% of all modalities were Structured Psychosocial Interventions.

**Structured Day Programmes**

6% of all modalities were Structured Day Programmes.

**Family Support**

There are five family and carers groups commissioned by the DAAT: Cambridge, Ely, Huntingdon, Wisbech and Chatteris.

**DIP**

a. Number of clients engaged with CDIP: 397
b. Of the overall 397 clients, 26% were DRR referrals and 26% from CARAT referrals.
c. The target is 75%. The monthly average for DIP clients engaged in effective treatment is 70% although the range has varied from 50% to 82%.
d. Successful completions were 10% and successful completions and transfer to mainstream an additional 12%.

## 1.0 Overarching Provision: Definition of the Service

Our vision for the provision of drug treatment services is for a single system that is *recovery focused* and delivered by a single provider, or small number of providers working in partnership/ consortia, which will contain all elements of the drug treatment system.

The service model will be:

- Recovery focused
- Inclusive
- Shaped by the needs and views of local service users
- With access and support that will be available at any point within a client's recovery journey
- Evidence based

It is stressed that the provider should demonstrate that they promote a culture that is *recovery focused* and shared by the entire workforce.

Cambridgeshire DAAT have set out their values, principles and overall service objectives in the DAAT Three Year Strategy and DAAT Treatment Plan. All services provided will be in agreement with these plans and further the implementation of them. Important, relevant

information giving further details is available on the Cambridgeshire DAAT website: http://www.cambsdaat.org This includes:

- Needs Assessment 2010/11
- Treatment Plans 2011/13
- Safeguarding Practice Guidance

Additional national relevant information is available on the NTA website: http://www.nta.nhs.uk

## 2.0 Location of service

a. The service will cover the county of Cambridgeshire (excluding Peterborough).

b. The service will operate in a variety of locations to facilitate the needs of residents in Cambridgeshire.

c. The service will be offered to all individuals presenting to this service fulfilling the relevant referral criteria.

d. The service must be delivered and achieved in supportive collaboration with partner agencies including the Cambridge Access Surgery.

## 3.0 Aims and Objectives of the Service

### 3.1 Aim

The overall aim of the service is to provide an effective, recovery focused drug misuse treatment system to enable clients to access appropriate and timely treatment resulting in a planned exit from treatment following cessation of drug misuse[5].

- This will include the delivery of effective Aftercare and support.

### 3.2 Objectives

Objectives include:

a. The promotion and maintaining of effective partnership links that ensure that a client's specific holistic needs are responded to.

b. The expectation that the provider will publicise and promote its activities across Cambridgeshire with approval from the DAAT and in line with the County Council's communication guidelines. This includes:

   - Production of leaflets and other appropriate materials giving contact details of the services provided, taking into account the needs of diverse communities, and particularly groups under represented in drug misuse treatment services.
   - Attendance at local events as agreed with the DAAT.
   - Service details should also be available via the 'Frank' national website/ helpline and the NTA Treatment Directory.
   - The DAAT will support the provider in the publicity work described above and ensure that that the Cambridgeshire County Council website, DAAT website and any publications produced internally by the County Council contain accurate information about the service.

[5] *This should be in line with NDTMS definitions*

## 4.0 Targets

The table below shows the targets that the service will be measured against by Cambridgeshire DAAT per quarter. These are in addition to those set by the National Treatment Agency (NTA), thus some modalities do not have additional measures stated here.

It includes existing targets and new targets set for 2012 onwards. These may be subject to changes/ updates.

| Service | Description of existing and new targets | Target |
|---|---|---|
| **Needle Exchange** | Maximum number of miles a Cambridgeshire resident should reside from Pharmacy Needle Exchange provision | 10 miles |
| | Percentage of pharmacies engaging in the Needle Exchange schemes | 50% |
| **Clinical Waste** | Maximum number of days following request for clinical waste to be collected | 2 |
| **Specialist Prescribing** | *New target 2012/13:* % of clients receiving Psychosocial Interventions alongside Specialist Prescribing | 100% |
| | *New target 2012/13:* Numbers receiving and completing a home detox per year | 150 |
| | *New target 2012/13:* Minimum number of appointments arranged during first 3 months of prescribing | 1 per week |
| | *New target 2012/13:* Minimum number of appointments arranged following first three months | 1 per fortnight |
| **GP Shared Care** | *New target 2012/13:* Number of drug users receiving specialist prescribing via GP Shared Care | 250 |
| **Structured Day Programmes** | *New target 2012/13:* Number of individuals (including DRRs) commencing Structured Day Programmes | 200 |
| **Family Support** | *New target 2012/13:* Number of carer groups in the county | 5 |
| | *New target 2012/13:* Number of meetings of carer groups per month | 1 |
| | *New target 2012/13:* Number of family members (of drug misusers) receiving intensive six-session support per year | 100 |
| **DIP** | Number of new Class A drug users taken onto the DIP caseload per month (including DRRs) | 25 |
| | Number of DIP clients engaging with Tier 3 services per year | 225 |
| **DRR** | Number of commencements | 93 |
| | Minimum number of completions | 45% |
| **Prisons** | *New target 2012/13:* % of all new receptions assessed for drug and alcohol needs | 100% |
| ***Additional*** | | |
| **Training** | *New target 2012/13:* Minimum number of training sessions delivered with other agencies, according to need, to partner agencies per year. *This includes, but is not restricted to groups such as pharmacies, LSCB* | 100 |

| | | |
|---|---|---|
| | *and should cover but is not restricted to: harm reduction, overdose, BBV, domestic violence, dual diagnosis* | |
| **Recovery mentors** | *New target 2012/13:* Number of volunteers trained to become Recovery Mentors | 45 |
| **Recovery groups** | *New target 2012/13:* Minimum number of peer support recovery groups (e.g.SMART) meeting per week | 2 per location |
| **Service user groups** | *New target 2012/13:* Number of service user groups to be in operation around the county to inform future service structure and commissioning | 3 |
| | *New target 2012/13:* Expected minimum attendance per group meeting | 5 |
| **Treatment Exits** | Numbers leaving the drug treatment system free of their drug of dependency. | 250 |
| | Percentage of all those in treatment leaving as a "successful planned discharge"<br>Opiate and Crack Users (OCU) | 9.1%+ |
| | Non OCU | 45.2%+ |
| | All Adults | 16.1%+ |
| **TOPs** | TOPs compliance levels | 100% |
| **ETE** | Client' seen per year | 1300 |
| | Work outcomes | 10% |
| | Course outcomes | 15% |
| | Myguide online course | 30% |

**Table 1: Cambridgeshire Drug Treatment System targets**

## 5.0 Provision of the Service

The service will:

a. Operate Monday to Friday for 52 weeks a year, excluding bank/ public holidays.

b. Operate core service hours daily. A minimum once a week "out of hours" access for clients is expected at each site. (Either weekends and/or evening access).

c. Operate in selected locations on Saturday mornings for four hours for prescribing provision.

d. Ensure that provision is equitable throughout Cambridgeshire and meets the needs of diverse groups. This includes gender specific provision where appropriate.

e. Ensure that access is straightforward and timely to all modalities including highly specialised treatment such as residential rehabilitation.

f. Ensure that provision and access to harm reduction interventions, including BBV interventions is straightforward and promoted *throughout* the recovery focused treatment system.

g. Provide complementary therapies to meet individual needs throughout all parts of the recovery focused treatment system.

h. Promote a strong emphasis on client engagement in service improvement throughout the entire treatment system.

i. **Outreach:** There is an expectation that where feasible, clients will receive at least one 'home' visit as part of their treatment. ('Home' in this case refers to place of residence and therefore includes for example hostels). This must occur where children are living at the address given by the client.

- Outreach work should also include delivering interventions in venues the potential client may be already accessing such as GP surgeries, hostels, Children's Centres etc., based on local intelligence.

j. **Partnership working**: Whilst specialised drug misuse treatment is delivered by the treatment agency, in order to deliver a holistic response to client needs, it is expected that effective partnership links will be in place and utilised. This will include regular attendance at locality groups and partner meetings as appropriate.

k. Key partnership working is expected to be demonstrated with the following range of services. It is expected that there will be a designated 'lead' within the drug treatment service that covers each of the following:

- Safeguarding vulnerable children
- Safeguarding vulnerable adults
- Child and adolescent/ young people's services (including those in Children's Centres).

  *This must include adherence to CAF process and protocols within the county. See DAAT Safeguarding Practice Guidance[6].*
- Mental health services
- Alcohol treatment services (including liaison regarding inpatient detoxification bed management).
- Maternity services
- General medical services
- Accident and emergency / Hospital liaison in all relevant hospitals

  *(Effective partnership working at a strategic and operational level should be promoted)*
- Sexual health / communicable diseases services (see below)
- Housing agencies
- Homeless hostels
- Disability services
- Employment, training and education services
- Domestic violence / sexual violence/ prostitution services
- Integrated Offender Management
- Prisons
- Specialist GP Surgery providing Health Services to the Homeless population (example Cambridge Access Surgery)

l. **Sexual health**

It is expected that the new service will increase the effectiveness of interventions to improve sexual health. This will include:

[6] http://cambsdaat.org/?q=content/safeguarding-children

- Effective identification, assessment and care planning at the earliest stage that is followed through and regularly reviewed.
- Training to the provider and non-provider workforce to highlight the sexual health issues for drug misusing men and women.
- Liaison with GUM clinics to initiate regular sessions for clients in treatment agencies.
- Accompanying of clients to sexual health appointments where appropriate.

m. **Pregnancy liaison**

- Service provision for pregnancy liaison should adhere to the principles and practice set out in the DAAT Safeguarding Practice Guidance[7] Section 5: 'Working with substance misusers who are pregnant'. (This is in Appendix 1).
- All females assessed should be offered pregnancy testing.
- All men and women should be offered contraception.

n. **Hospital Liaison**

- The service must work closely with both Addenbrookes and Hitchingbrooke Hospitals
- This service must work closely with the hospitals to ensure that individuals are not missed between referral and access.
- This service will work closely with the hospitals to ensure that Opiate and Crack User's (OCU's) known to the service are seen whilst in hospital on the wards and both teams work closely, joint planning discharge back into the community
- This service will ensure that regular meetings are held with both hospitals to facilitate positive working practice

  The service will ensure that clear Information Sharing Protocols exist with both hospitals to facilitate patient care.

o. **Drug Related Deaths and Serious Untoward Incidents**

- Service provision should adhere to the principles and practice set out in NHS Cambridgeshire Serious Incidents (NHSC SI) guidance.

p. **Care Quality Commission (CQC)**

- The Service Provider must be registered with the Care Quality Commission (CQC)

## 6.0 Groups served

a. This service must be offered to all Cambridgeshire residents aged 18 years and over with primary drug misuse issues.

b. There must be no discrimination regarding: co-morbidity, gender, sexuality, ethnic background and religion (meeting the requirements of the Equality Act 2010).

c. All clients must receive specific service user information that meets the needs of the diverse populations living in Cambridgeshire.

## 6.1 Priority Groups/Target Groups

This service must prioritise the following client groups:

[7] http://cambsdaat.org/?q=content/safeguarding-children

a. Clients or potential clients with dependents. (*Consideration should be given to the provision of or access to childcare facilities such as crèches etc).*

b. Pregnant women.

c. Clients with significant psychiatric and/or physical co-morbidity.

d. Protocols must be in place to maximise access to socially excluded groups.

### 6.2 Exceptions

The service must make every effort to ensure that potential clients can engage in treatment. Only in exceptional circumstances (such as serious risk to staff) should a client be excluded from the service, and only after consultation between the service provider and the DAAT has taken place.

## 7.0 Referral and Assessment

a. All drug users requiring a structured treatment pathway must be offered a Triage assessment with a risk assessment within 5 working days of referral. The Triage assessment is an initial assessment; this will subsequently be developed into a comprehensive assessment and care plan.

b. The Triage and comprehensive assessment must be carried out by a suitably qualified and competent staff member and must assess as a minimum the potential service user's motivation. (Models of Care Update Guidance 2006).

c. It is expected that Triage assessment must include assessment of:

- general health care
- substance use
- risk (including domestic violence issues)
- physical health
- psychological health
- family/ carer needs
- children of or children living with the drug misuser[8]
- social, legal, housing, debt and other related issues

d. Where a referral is received from another agency, the drug treatment service will read relevant paperwork from that agency to reduce possible replications.

e. At the Triage assessment, in order to speed up the process and ensure client safety for clients who require specialist prescribing, it is expected that the assessor will contact the GP to inform him/her of the potential treatment to be delivered. This will be with appropriate regard for confidentiality issues and with the permission of the client. At this point the GP will also be asked to verify whether or not the client is registered with them.

f. Where necessary, an additional assessment may be required for a family member/ carer/ significant other.

g. Particular care should be taken to ensure that young carers are identified and assessed for support where appropriate.

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[8] *Thorough assessment should occur in all cases where children are living with the drug user. Please refer to the DAAT Safeguarding Practice Guidance.*

### 7.1 Referrals from the young people's specialist substance misuse service

*See section 8.2 below 'Care plans for young people referred from the young people's specialist substance misuse service'.*

## 8.0 Care Planning

### 8.1 Care plan expectations

It is expected that care plans will be an integral part of a client's care *with active client participation in* their development. They will be commenced as soon as the assessor and client agree that structured treatment is required and reviewed on a timely basis.

It is expected that all individuals requiring treatment will be allocated an identified key worker who will work liaise with the care coordinator overseeing the client's treatment.

All care plans must:

a. Be clear that the treatment is 'recovery focused' and time bound with the expectation that effective treatment will lead to a successful treatment exit.

b. Ensure that the recovery focus is promoted in early stages of work with a client.
   - Long term treatment (such as specialist prescribing) will only be appropriate in a limited number of cases.

c. Reduce problems and dangers associated with drug misuse including:
   - Health, social, psychological and legal problems.
   - Risk of BBV issues, overdose and drug related deaths.
   - Duration and frequency of episodes of substance misuse.
   - Prescribed drugs being diverted into the illegal drug market.
   - Criminal activity to finance substance misuse.

d. Aim for an overall improvement in personal, social and family functioning.

e. Follow a recognised methodology for care planning – e.g. International Treatment Effectiveness Project (ITEP)[9].

f. Be based on a thorough assessment as per Models of Care. This must include:
   - a full healthcare assessment.
   - an assessment of the parenting capacity of clients who have children (including children living permanently or semi-permanently with the client as well as children they are less regularly in contact with).
   - an assessment of the client's recovery and social capital.

g. Make explicit reference to risk management and identify the risk management plan.

h. Reflect the cultural and ethnic background of the client as well as their gender and sexuality (where appropriate).

i. Identify information sharing requirements.

[9] http://www.nta.nhs.uk/pirl-ITEPmanual.aspx

j. Set out SMART goals/ outcomes of treatment and milestones to be achieved with clear care plan review points where these goals may be revised.

k. Identify who is responsibility for undertaking actions identified in the care plan, including the client. This will include the drawing up of a *'recovery compact'* between client and provider (key worker) that defines responsibilities. This should be for all clients engaged in structured treatment.

l. Ensure that the care plan is agreed and signed by both the client and key worker/ care coordinator.

m. Clearly record the referral onwards to the identified structured treatment pathway.

n. Ensure that the care plan involves all relevant services that will contribute to the client's holistic care.

o. Identify and put in place Aftercare support during the latter stages of treatment (e.g. mutual aid, peer support).

### 8.2 Care plans for young people referred from the young people's specialist substance misuse service

a. In such cases, a transitional care plan shall be developed and reviewed by the young people's service. A transitional worker within the young people's service should liaise with the service to ensure a stepped approach to the transition.

b. The young person and where appropriate, parents or carers should be involved in developing the care plan, to ensure that all parties understand what to expect when moving from a young people's service into an adult one, and expectations/concerns are managed.

c. The transitional plan must include the following considerations:

- Acknowledgement of the move from a young people's service to an adult service.
- Share information with the adult team about current circumstances, with consent.
- Introduce the young person to the adult key-worker and who will attend a number of joint appointments.
- Introduce young people's parents or carers to the new adult service and discuss their role in their child's care, where a young person agrees to this.
- The young people's service should be developing a new care plan in tandem with the service.
- Ensure that wider needs are addressed within the care plan.
- Ensure a review date is set that the young person, the key workers at the service and their previous specialist young person's worker will attend.

### 8.3 Care Co-ordination

The level and intensity of care co-ordination must depend upon the complexity of individual need and will follow Models of Care guidance. It is expected that the responsibilities listed below will be a minimum standard adhered to for care co-ordination by the service:

a. Provide a network of care and ensure that clients have access to a comprehensive range of interventions across health, social care, criminal justice and housing agencies (including Supporting People Floating Support) where applicable.

b. Ensure the co-ordination of care across all agencies involved with the client.
c. Develop, manage and review written care plans.
d. Ensure continuity of care and to support the client throughout their contact with treatment and facilitate any changing relationship between them and those providing interventions.
e. Instigate referrals to detoxification and Residential Rehabilitation services if appropriate.
f. Facilitate the re-engagement of clients who have dropped out of treatment through effective liaison with appropriate services.
g. Aim to avoid the duplication of assessment and interventions.
h. The agreed care coordinator is expected to complete TOPs returns at regular intervals as set out nationally.

## 9.0 Service Principles

The service must provide a robust, recovery focused, drug misuse treatment service in the Cambridgeshire area. The service must:

a. Be competent to deal with a range of drug misuse and associated issues presented by the client.
b. Be appropriate and accessible to the individual needs of diverse populations and offer appropriate advice, information and treatment interventions.
c. At all times operate within a high level of quality assurance and clinical governance.
d. Ensure that staffing levels and competency are appropriate to deliver this service.
e. Ensure that clients are given opportunities to contribute to service development.
f. Display a charter of service user's rights and responsibilities.
g. Ensure that the client's holistic needs are met as effectively as possible by linking and working with community groups.

## 10.0 Onward Referral/ Aftercare and Support

### 10.1 General principles

As a minimum, general practice delivered by the service must include the following:

a. Facilitate and actively encourage joint working, allocation meetings and /or case review processes.
b. Ensure that effective information sharing policies and procedures are in place with other services to facilitate the effective referral of clients.
c. Ensure that clear links are in place with the criminal justice services to meet the needs of clients in the criminal justice system. This includes Integrated Offender Management.
d. Ensure that clear liaison and referral pathways are established with generic services. e.g. maternal health, probation, Primary Care, social care, mental health, housing and children's services.
e. Ensure clients are referred to appropriate generic and specialist services as per individual needs identified at in their care plan.

### 10.2 Aftercare

a. Aftercare is an integral part of a recovery focused system. Whilst it commences following a planned exit from treatment, support should be identified and in place prior to the end of treatment to ensure that it follows in a timely and seamless manner.

b. Types of Aftercare offered must include:
   - Phone contact
   - One to one work
   - Group work, including peer support
   - Peer mentoring

c. The appropriate package of Aftercare and support shall assist clients in maintaining abstinence and may include:
   - Community prescribing within the GP liaison service
   - Abstinence based Structured Day Programmes (SDP) groups
   - Mutual aid groups that meet regularly per week
   - Housing services (including Supporting People Floating Support)
   - Benefits and welfare services
   - ETE including volunteering opportunities

## 11.0 Competencies and Training of Staff

### 11.1 Provider workforce

It is expected that the provider workforce will consist of both *employees and volunteers* (for example, in a capacity as mentors).

The service must ensure that staff are competent in their roles and are actively engaged in staff development procedures. The service must:

a. Ensure that all employees and volunteers working for the provider shall agree to be bound by the conditions of their *Terms and Conditions* which will outline specific training and competency requirements.

b. Be able to demonstrate their compliance with Quality in Alcohol and Drugs Services, Drug and Alcohol National Occupational Standards and to any additional standards expected by the National Treatment Agency (NTA) and Department of Health (DOH).

c. Staff the service with a wide range of professional backgrounds.

d. Ensure that all staff have knowledge, skills and training appropriate for the needs of delivering this service. This will adhere to national guidance[10] as well as training in accordance with the organisation's mandatory training programme and programme of induction.

e. Identify and make available resources for ongoing training needs and professional development.

f. Ensure that there is at all times a sufficient level of staff to provide a safe, effective and accessible service.

g. Ensure that staff have appropriate and regular supervision appropriate to their role.

[10] *For example Substance Misuse Skills Consortium* http://www.skillsconsortium.org.uk/default.aspx

h. *Working together to Safeguard Children - A guide to inter-agency working to safeguard and promote the welfare of children*[11] states:

> ”Employers are responsible for ensuring that their staff are competent and confident in carrying out their responsibilities for safeguarding and promoting children’s and young people’s welfare. It is the responsibility of employers to recognise that in order for staff to fulfil their duties in line with Working Together, they will have different training needs which are dependent on their degree of contact with children and young people and/or with adults who are parents or carers, their level of responsibility and independence of decision-making.”

i. Paragraph 4.8 states:

> “Employers should ensure that their employees who work or have contact with children are appropriately trained in child development and in how to recognise and act on potential signs of child abuse and neglect. Training should also include associated vulnerability and risk factors and resilience and protective factors, identifying potential violent behaviour and assessing the capacity of a parent or carer to meet a child’s needs, taking into account their own needs/circumstances/ history/illness/addiction. Increasingly, professional bodies are requiring their members to demonstrate relevant education and training as part of revalidation.”

j. Develop opportunities for volunteers, overseen by a Volunteer Coordinator.

k. Ensure that all staff and volunteers shall have an enhanced, up to date CRB check.

### 11.1.1 Recovery Mentors/Champions

Recovery Mentors/Champions will assist and support vulnerable adults[12] entering the treatment system and those already established but struggling in their treatment journey.

a. To ensure that safe service is provided, it expected that Recovery Mentors/Champions will work closely with the relevant treatment service to ensure an effective, well supervised working relationship is maintained.

b. The service will take account of safeguarding and promote the individual’s welfare at all times.

c. The drug treatment service will retain responsibility for the client and maintain their role in case management and care planning.

d. This scheme will identify and assist the most vulnerable individuals with the engagement process and promote:

- Recovery focused support/ treatment.
- Harm reduction and abstinence orientated treatment.
- Improvement in the client’s health and social functioning in relation to drug misuse.
- Friendly, confidential support, within clear information sharing protocols.
- Attendance at relevant appointments, including drug treatment, housing, education, or other relevant appointment by accompanying the client where appropriate.

[11] DfES, 2010 Paragraph 4.5 and 4.6
https://www.education.gov.uk/publications/standard/publicationdetail/page1/DCSF-00305-2010
[12] A comprehensive description of ‘vulnerable adult’ can be found at:
http://www.homeoffice.gov.uk/agencies-public-bodies/crb/glossary/

e. Clients who express a wish to be mentored and could benefit from the service should be referred by keyworkers, DIP keyworkers or Offender Managers. The service will then follow this with an assessment of suitability.

f. The service will identify those who may be appropriate to become Recovery Mentors. This should include clients successfully completing Structured Day Programmes.

g. A Comprehensive package of training and support shall be given to identified mentors before they have contact with clients accompanied by a risk assessment and CRB checks.

   The core training should include, but not exclusive, the following

   - Drug and Alcohol Awareness
   - The Drug Treatment system (inc all elements from referral through to tier 4)
   - Adult/child safeguarding policies
   - Boundary setting
   - introduction to counselling skills
   - harm reduction
   - managing risk

h. The initiative will be promoted throughout the county to ensure that provision is equitable in all areas.

### 11.1.2 Social workers

a. The provider will ensure that a minimum of three social workers are seconded from their host agency. The secondment arrangements will be reviewed in the first year of the contract.

b. The host agency will provide professional development and supervision with the provider providing operational management including day to day supervision.

c. It is expected that they will work as part of a team providing assessment and intervention to clients and their carers with both drug and alcohol issues. They will however be situated within drug treatment services and it is expected that they will be well integrated within the workforce.

d. Part of the social worker's responsibility will be to ensure that policies, procedures and practice in relation to the Community Care Act, Children and Adult Safeguarding, and Human Rights etc. are understood by drug and alcohol treatment services.

e. It is expected that most social workers either have or will undertake additional training regarding the Mental Health Act.

f. They will provide specific expertise to colleagues regarding family/ child protection issues and carry a case load that includes such cases.

g. Work may be direct with carers to enhance the support system of a family member who misuses drugs or alcohol.

h. Social workers will lead on Self Directed Support.

i. Referral to social workers to act as care coordinators should be considered for the following:

- Residential rehabilitation referrals: This includes reviews and support for re-integration back into the community following rehabilitation.
- Care management: This includes support to ensure a client can live safely in the community – most usually in the form of a care package.
- Where there are issues of capacity in relation to decision making.
- Where a client lives in a family group which is suffering breakdown.
- Where there are concerns about abuse of a client which falls within the remit of Safeguarding of Vulnerable Adults (SOVA) legislation. This includes financial, physical, psychological and institutional abuse.
- Where there are issues of dual diagnosis.
- Where there are issues of physical disability or mental impairment.

## 12.0 External workforce

(See section 4.0 targets)

## 13.0 Policies, Protocols and Written Strategies

a. The service shall be required to demonstrate that it has an adequate range of policies, protocols and strategies as defined in Quality in Alcohol and Drugs Services (QUADS) and that these have designated leads. Where they are absent the service must demonstrate steps being taken towards their development.

b. The service must ensure that all staff and service users are aware of all relevant policies and the impact this may have on them.

c. As a minimum the service shall be expected to evidence the following policies:

- Child protection
- Safeguarding[13]
- CAF (Common Assessment Framework)
- Complaints
- User involvement
- Information sharing
- Confidentiality
- Drugs and alcohol in the workplace
- Lone working
- Exclusions from the service
- Maximising access to underserved / socially excluded groups
- Social care
- LSCB
- Domestic Violence
- Dual Diagnosis

[13] http://cambsdaat.org/?q=content/safeguarding-children

- Adult Safeguarding

### 13.1 Clinical Governance

It is expected that the service provider will adhere to standards set out in the following:

- Department of Health (2007) *Drug misuse and dependence. UK guidelines on clinical management*[14]. (Orange book)
- NTA (2009) *Clinical governance in drug treatment. A good practice guide for providers and commissioners*[15].

### 13.2 Adult Safeguarding

It is expected that the provider as well as following national guidelines, will adhere to the local policy: *'Cambridgeshire County Council – Adult Safeguarding Policy, Guidance and Procedures'*[16].

### 14.0 Data Collection Requirements

The service shall be expected to have in place appropriate software to be able to submit reports on a monthly basis to the National Drug Treatment Monitoring System (NDTMS).

As reporting requirements are subject to change from the NTA and DoH and MUSE (Monitoring Unit for Substances in the East), the service shall be expected to comply with additional reporting requirements as requested by the above organisations, through the DAAT, as they occur.

Data required by the DAAT that is in addition to NDTMS requirements will be negotiated per treatment modality. It includes for example, the following. Please also see 'Section 4: Targets'.

| Service | Data collection |
|---|---|
| **Needle Exchange** | The service shall be required to submit all records (anonymous) of registered service users attending the service.<br>On a monthly basis the following (as a minimum) is required:<br>• Attendance by gender (initials), date of birth and postcode where appropriate<br>• Sharps bins distributed<br>• Equipment issued and returned by type<br>• Numbers reporting sharing<br>• Referrals to other service-by-service type |

[14] http://www.google.co.uk/search?hl=en&source=hp&biw=1065&bih=804&q=orange+book+clinical+guidelines&q=0&aqi=g1g-b1&aql=&oq=orange+book+clinic&safe=active

[15] http://www.nta.nhs.uk/uploads/clinicalgovernance0709.pdf

[16] http://www.cambridgeshire.gov.uk/social/adultprot/Adult+Safeguarding+Policy+Guidance+and+Procedures.htm

| | |
|---|---|
| | • New, re-joiners or ongoing<br>This must be uploaded onto the NEXMS system or equivalent database. |
| **Family Support** | • Number of people (or families) receiving support from the family support service. *Support is defined as an intervention via: 1:1 support (including counselling); any support group; telephone helpline; drop-in.*<br>• Number of carer support groups held and numbers attending<br>• Number of families receiving overdose prevention training<br>• Number of clients positively completing 1:1 support programme<br>• Number of new volunteers recruited and volunteering for the family support service<br>• Number of Carer's Assessments completed |
| **DIP** | The service shall be expected to adopt current data collection systems currently employed by the DIP, specifically within the police custody environment. Adherence to the completion of local and national documentation, including Drug Interventions Records and Activity Forms is essential.<br>The service shall be required to contribute to the following data sets;<br>▪ Numbers of adult detainees assessed<br>▪ Number of drug screens offered<br>▪ Number of drug screens accepted<br>▪ Number of positive tests<br>▪ Number of referrals to DIP from VDOD<br>▪ Numbers signposted to other services |
| **Prisons** | HMP Whitemoor – Performance indicators for DAAT contract inclusion<br>*All measures are monthly totals unless otherwise stated.*<br>1. Total number of new receptions<br>2. Number of receptions triaged<br>3. Number of new receptions from transfers<br>4. Total number of new receptions identified as needing treatment<br>5. Number of care plans completed<br>6. % of care plans completed within 5 working days<br>7. Number of prisoners refusing assessment<br>8. Number of prisoners refusing to engage after assessment<br>9. Structured 1:1's conducted (including IDTS)<br>10. Number of prisoners engaged in structured group-work<br>11. Number of prisoners referred to CJIT (rolling 12 month total)<br>12. Number of prisoners picked up by CJIT (rolling 12 month total) |
| **Recovery Mentors** | Number of RMs trained<br>Number of service users supported |

**Table 2: Cambridgeshire Drug Treatment System data collection**

## 15.0 Monitoring and Review

a. Monitoring shall form an integral part of the agreement between the provider and the DAAT. The provider shall be required to attend quarterly performance monitoring meetings with the DAAT. This shall include all aspects of NTA / NDTMS data outcomes and individual service performance targets.

b. Submission of retrospective (previous quarter) expenditure profiles shall be submitted with quarterly invoice submissions to the DAAT.

c. Specific areas of data collection shall be requested on a quarterly basis including:
   - Workforce and workforce development (including vacancies)
   - Drug related deaths
   - Service user involvement
   - Housing and accommodation
   - Education, Training and Employment (including Jobcentre Plus data)
   - Nacro data
   - Needle Exchange
   - Supervised Consumption

d. The DAAT as part of its ongoing auditing work may 'spot check' any modality of provision at any time including the audit of care plans.

### 15.1 Contract monitoring

Throughout the contract, the service will be monitored against a variety of performance measures. If consortia deliver the service, the lead agency will report on the measures.

a. Quarterly review meetings will be held between Cambridgeshire DAAT and the provider.

b. In order to inform the review meeting, the service provider will forward to Cambridgeshire DAAT a report on the performance of the contract two weeks prior to the review meeting, containing the following information:
   - **Introduction:** A brief statement on the operation of the Contract.
   - **Performance:** A report on the Performance Indicators outlined in the service specification.
   - **Quality Controls:** Details of the quality assurance mechanisms currently in operation and a report on their outcomes.
   - **Users' Views:** Details of processes used to obtain service users' views of the services, and a report on their outcomes.
   - **Complaints:** Details of complaints received during the review period and the outcome of each.
   - **Health and Safety:** A report on any H & S Incidents during the review period.
   - **Staff Support:** Evidence of staff supervision and support during the review period.
   - **Training:** Evidence of induction and training undertaken during the review period
   - **Agenda Items:** Details of issues to be included on the agenda for the review meeting, including any proposed amendments to the contract or service specification.

c. The following documents should also accompany the report:
   - An income and expenditure statement for the review period.

- A certified statement of income and expenditure incurred on the services for the preceding year signed by either the manager or trustees.
- A copy of current Insurance Documentation: Public and Employers Liability.
- A copy of any amendments to the Quality Assurance Policy and Procedures.
- A copy of any amendments to the Complaints Policy and Procedures.
- A copy of any amendments to the Health and Safety Policy and Procedures.
- A copy of any amendments to the Equal Opportunities Policy.
- A copy of any amendments to the Action Plan to oversee and review the implementation of Policy.
- A copy of the current Fire Risk Assessment.

## 16.0 Additional Standards

### 16.1 Working Together to Safeguard Children (2010) DfES[17]

a. The service is expected to adhere to local policies including:
   - Social care
   - Adult Safeguarding
   - LSCB
   - Domestic Violence
   - Dual Diagnosis

b. *Working together to Safeguard Children - A guide to inter-agency working to safeguard and promote the welfare of children*[18] states:

> "PCTs must co-operate with the local authority in the establishment and operation of the LSCB and, as partners, must share responsibility for the effective discharge of its functions in safeguarding and promoting the welfare of children".

c. Paragraph 2.62 states:

> "All health professionals working directly with children and young people should ensure that safeguarding and promoting their welfare forms an integral part of all elements of the care they offer. Other health professionals who come into contact with children, parents and carers in the course of their work also need to be fully informed about their responsibility to safeguard and promote the welfare of children and young people. This is important as even though a health professional may not be working directly with a child, they may be seeing their parent, carer or other significant adult and have knowledge which is relevant to a child's safety and welfare. A National Institute for Health and Clinical Excellence (NICE) clinical guideline, 'When to suspect child maltreatment', is a resource to help healthcare practitioners who are not specialists in child protection".

d. The provider shall operate in line with Cambridgeshire Local Safeguarding Children Board (LSCB) Protocols and Cambridgeshire Adult Safeguarding Policy.

[17] https://www.education.gov.uk/publications/standard/publicationdetail/page1/DCSF-00305-2010 Paragraph 2.60
[18] https://www.education.gov.uk/publications/standard/publicationdetail/page1/DCSF-00305-2010

## 17.0 Service Users (Clients) and Carers

a. It is expected that that clients and their carers will be encouraged at all times to contribute to a recovery based treatment service, regardless of the modality of treatment they are accessing.

b. To facilitate this, the service shall:

- Provide a range of mechanisms for clients and carers to be involved in service development. This must be equitable throughout the county.
- Promote and ensure pro-active feedback opportunities for clients, family and carers to ensure and facilitate client-centred drug treatment. This includes agreeing and delivering a structure whereby local groups can meet monthly and can feed into a county wide group.

c. Inform the DAAT on a quarterly basis the outcome of client/ carer feedback to inform the treatment planning and commissioning process.

d. Designate a member of staff to coordinate the client and carer work.

## 18.0 Local Community and Businesses

a. It is expected that the provider will consistently attend relevant meetings around the county and will send a representative of an appropriate seniority for the meeting.

b. The service manager is expected to attend commissioning meetings when requested.

c. Appropriate groups include but are not limited to external agency meetings with:

- Housing providers, hostels, Supporting People.
- ETE providers (Job Centre Plus, Daphne Project).
- Cambridgeshire Criminal Justice Agencies – Police, Probation and DIP.
- Forums including Domestic Violence Forum, locality Drug and Alcohol groups.
- Dual Diagnosis Steering Group (Service Manager is expected to attend this group and facilitate direct referrals to the Home Treatment Team at the Mental Health Service).
- Parenting groups will link with CAMHS.

d. The provider is expected to deliver this service with due respect and consideration to both the local residents, communities and businesses. In the event of a dispute or conflict within the locality, directly related to this service provision, the provider must take a positive and pro-active stance to attain a mutually acceptable resolution. This must be undertaken in consultation with Cambridgeshire DAAT and other stakeholders as needed.

e. The provider will be expected to provide timely input to media enquiries regarding local community issues.

# Section 3B – Specification: SPECIFIC PROVISION

## a) Single Point of Contact/ Advice and Information/ Assessment

**Information to Tenderers:** Please read in conjunction with Section 3A 'Overarching Provision'.

### 1.0 Definition of the SPOC/ Advice and Information Service

*See 3A plus:*

a. The service must provide a Single Point of Contact (SPC) for all those requiring an assessment, induction and/or referral into the Cambridgeshire drug treatment service.

b. Referral is via self, professional or criminal justice pathways.

c. The service will be offered to all individuals presenting to this service fulfilling the relevant criteria.

### 2.0 Aims and Objectives of the Service

*See 3A plus:*

### 2.1 Aim

The aim of the SPC is to provide an efficiently run, central resource for the engagement of drug users into the drug treatment service, to offer Triage assessment and appropriate interventions. Individuals not deemed appropriate for the service will be signposted appropriately.

### 2.2 Objectives

The service must:

a. Stress that the service is recovery-focused.

b. Offer direct, open access to a safe and welcoming environment to drug misusers, family and friends.

c. Offer outreach interventions to drug misusers.

d. Offer by phone, electronic means, written information and in person, up to date advice and information to drug misusers, family, carers and professionals on issues including:

- Reduction of drug related harm including drug related death and overdose prevention.
- Treatment pathway options and interventions available.

e. Facilitate immediate access to harm reduction interventions as appropriate including BBV interventions.

f. Offer Triage assessment to all presenting primary drug misusers wishing to access structured treatment.

g. Refer primary alcohol misusers directly to alternative appropriate services.

h. Allocate all potential clients having undertaken a Triage assessment to a key-worker.

i. Facilitate access to mutual aid groups and support mechanisms.

j. Carry out motivational work to encourage retention and support clients and potential clients into structured treatment.

k. Provide pre-treatment preparation and group work to prepare and engage potential clients for structured treatment.

l. Offer time limited complimentary therapy interventions to engage drug misusers and encourage and support them into structured treatment.

m. Promote the use of volunteers including Recovery Mentors to support clients.

n. Ensure that family work is offered to drug misuser's families.

o. Provide a client-centred service that promotes recovery through active engagement with clients and their family/ significant others.

### 3.0 Provision of the Service

*See 3A plus:*

a. Potential clients must be offered access to booked Triage assessment appointments within a maximum of five days.

b. Key working, "other structured treatment" and /or care co-ordination interventions must be offered for all clients having completed a triage assessment in this treatment phase.

c. There must be no waiting time for drop in access to this service.

d. This service may offer service users "other structured treatment" as part of this service. This intervention may be particularly relevant for non-opiate users and those receiving criminal justice interventions. Interventions used must be identified and documented in their care plan. Examples of this may include:

- A crack user receiving regular sessions with a key worker and attending day care sessions to address a range of social and health related needs.
- Drug misusers attending regular key-working sessions and structured day care for 1-2 days a week.
- An opiate user who has received community detoxification and is receiving ongoing support to maintain abstinence prior to referral or discharge, as part of their care plan to address health and social related needs.
- An uncomplicated cannabis user who is receiving a short period of care planned regular brief interventions (complimentary therapy, life skills, and training) to deal with problematic cannabis use.

e. The key-working role is important to this intervention, and the building of a therapeutic relationship is fundamental. Interventions within this modality should include:

- Developing and agreeing a care plan of identified interventions and goals with the client.
- Harm reduction brief interventions.
- Motivational interventions to enhance retention.
- Liaison and referral to other services within and external to the drug treatment system.

# b) Harm Reduction

This comprises the following sections:

- Needle Exchange
- Blood Borne Virus Service
- Clinical Waste

# b.i) Needle Exchange

**Information to Tenderers:** Please read in conjunction with Section 3A 'Overarching Provision'.

### 1.0 Definition of the service

*See 3A plus:*

The service must provide Needle Exchange facilities for all those requiring exchange of clean needles, syringes and associated injecting paraphernalia. This service can also act as a referral route into drug treatment interventions.

It is expected that the service will support and retain current pharmacy provision and all associated costs and will undertake as a key responsibility, growth and development in this area of provision.

### 2.0 Location of the service

*See 3A plus:*

a. Needle Exchange services must be provided from multiple sites across the county of Cambridgeshire including the provision of service within community pharmacies and the Access Surgery.

b. It is expected that Needle Exchange should be delivered in a variety of formats.

## 3.0 Aims and Objectives of the Service

*See 3A plus:*

### 3.1 Aim

The overall service aim is to reduce the incidence and prevalence of blood borne diseases (most notably HIV and Hepatitis) and injecting related harm. This must be undertaken with the provision of harm reduction advice and support.

### 3.2 Objectives

a. Reduce the incidence and prevalence of blood borne infections among drug misusers. This includes promoting BBV services to drug misusers who are not currently engaged with drug treatment services.

b. Offer a user friendly, non-judgemental, user- centred and confidential service.

c. Assist drug misusers to remain healthy until they are ready and willing to cease injecting.

d. Offer sterile syringe and needle distribution and other related paraphernalia.

e. Offer safe syringe and needle disposal, usually by return.

f. Offer focused harm reduction advice, information and initiatives including:

- Overdose prevention and response
- Risks of poly drug use
- Advice on wound care and management

g. Promote safer injecting practices through induction work and training.

h. Ensure that drug misusers are aware of their responsibility in regards to the safe disposal of drug paraphernalia.

i. Provide and reinforce harm reduction messages to help drug misusers access drug treatment services.

j. Aim to maximise the access and retention of all injectors, especially the highly socially excluded.

## 4.0 Provision of the Service

*See 3A plus:*

a. Provision must be low threshold, open access, user- friendly service and flexible to meet changing demand.

b. Availability and access for this service is extremely important and it is expected that a range of opening times must be made available.

c. Access to full Needle Exchange service provision must be available, as open access across the county for a minimum of 5 days a week.

d. Access to basic or limited Needle Exchange services must be available within locality areas to cover weekend and out of hour's access for drug misusers. (This is not expected to cover 24hours).

e. Special consideration must be given to the local community and businesses in the delivery of this service: The providers must ensure that users of this service(s) are discouraged from congregating outside the service's premises.

f. When a Needle Exchange Client is known to be in receipt of substitute prescribing their key worker must be informed.

g. The service must advocate the following hierarchy of goals for drug misusers:
   - Stopping the sharing of injecting equipment
   - Stopping the use of harmful injecting sites
   - Moving from injecting to smoking
   - Decreasing drug misuse
   - Abstinence

h. The service will encourage access to BBV services and structured treatment and refer a drug misuser on to these when appropriate.

i. The service will consider the use of Naloxone when clinically appropriate.

### 5.0 Groups served

Needle Exchange facilities must be available to all adult drug misusers. This service is currently under-used by steroid users and the newly commissioned provider will be expected to identify how Needle Exchange can be extended to this group.

### 6.0 Exceptions

*See 3.A plus:*

### 6.1 Young People

The service must be provided to anyone accessing the service who is 18 years or older who requires clean injecting equipment.

a. Should the service user disclose that they are under 18, or the service suspects that they are under 18, the service must endeavour to obtain details from the young person about their injecting behaviour and either make a referral to the Cambridgeshire Adolescent Substance Use Service (CASUS) or facilitate the opportunity for the young person to self refer.

b. If the young person refuses to disclose personal information and does not want to be referred to CASUS, information about CASUS should be given to the young person about the service with encouragement to attend at a later date.

c. Where an injecting history is established, a limited supply of equipment can be provided, as long as no Child Protection issues have been identified that indicate that this would be inappropriate.
   - If needles are given out in such circumstances, a telephone call to CASUS should be made to make them aware of the action. Any details that can be shared with CASUS should be in order to safeguard the well-being of the young person.

- If the same young person presents again, whilst the process should be repeated, it should be strongly emphasised to the young person that they should see a young people's worker.

### 7.0 Referral and Assessment

a. A Triage assessment is not necessary for drug misusers accessing this service.

b. However, there is an expectation that drug misusers will be encouraged to register with the provision. Basic demographic, current and historical drug use and injecting history must be taken. More detailed information may be required when referring the drug misuser on to another service, which should include a comprehensive risk assessment.

c. Drug misusers should be encouraged wherever possible to engage with the harm reduction support.

### 8.0 Policies, Protocols and Written Strategies

*See 3A plus:*

As a minimum the service shall be expected to evidence the following protocols:

- Service user re-engagement
- Provision of injecting equipment to those under 18
- Working with other services in the Cambridge drug treatment system
- Shared protocols with other care organisations as appropriate
- Materials/ injecting equipment dispensed
- Formalised response to reports of discarded used equipment and resultant community concerns

## b.ii) Blood Borne Virus Service

**Information to Tenderers:** Please read in conjunction with Section 3A 'Overarching Provision'.

### 1.0 Definition of the service

*See 3A plus:*

Preventing the spread of blood borne virus (BBV) diseases is a major goal of drug treatment services and a major contribution to individual and public health. The service must engage drug misusers across Cambridgeshire in order to increase their awareness of BBV issues and enable them to gain access to specific harm reduction interventions.

## 2.0 Aims and Objectives of the Service

*See 3A plus:*

### 2.1 Aims

To provide and promote at all points in the treatment system a comprehensive pathway of care for drug misusers and those recovering from drug misuse requiring interventions relating to BBV issues.

### 2.2 Objectives

The service must:

a. Provide a co-ordinated, county- wide response with equitable access for all clients wishing to access the service.

b. Provide the service in multi-site, fixed and/ or mobile facilities across Cambridgeshire.

c. The service should include:

- Access to harm reduction advice and information and education at any point in the drug treatment system.
- Health screening and risk assessment for BBV issues for all referred drug misusers attending drug treatment services in order to identify health needs.
- Access to and/or provision directly to Hepatitis B and C screening and treatment.
- Access to HIV testing.
- Appropriate counselling (pre and post test counselling as standard) for Hepatitis B, C and HIV screening.
- Interventions for Hep B vaccinations, if considered appropriate, should commence at the point need is identified at the initial assessment.
- Supporting client through BBV treatment whilst they are engaged within the treatment system.
- Close working with local hospitals including accompanying clients to appointments where this will facilitate greater uptake of treatment.
- Close working with pharmacies to facilitate the delivery of BBV interventions on pharmacy premises.
- Liaison and referral to additional services including general health and Primary Care where appropriate.

d. The service should provide information and advice to families and carers of drug misusers and professionals regarding harm reduction and BBV related issues.

## 3.0 Care Planning

a. It is expected that each client undertaking BBV treatment will be allocated an identified key worker.

b. The key worker will liaise with the client's care coordinator to ensure that the client's holistic needs are met.

## b.iii) Clinical Waste

**Information to Tenderers:** Please see current Service Level Agreement in Appendix 2 *(following section 3B).*

## c) Specialist Prescribing

**Information to Tenderers:** Please read in conjunction with Section 3A 'Overarching Provision'.

Provision for Specialist Prescribing must include *all costs* relating to prescribing of substitute medication including prescription charges (FP10s) and supervised consumption.

### 1.0 Definition of the Service

*See 3A plus:*

The service must provide a Specialist Community Prescribing service for all those requiring structured, medically supervised, substitute prescribing treatment or detoxification in the Cambridgeshire drug treatment system, across a variety of locations including the Cambridge Access Surgery (CAS). The provision of a dominant site for the issuing of medical prescriptions will be actively discouraged in this tender.

It is expected that the service will work closely with the Cambridgeshire Alcohol Treatment Service to manage the County inpatient detoxification bed waiting list. There must be good communication and agreed protocols with regards to admittance and discharge planning for clients accessing inpatient/residential detoxification provision.

It is expected that drug misusers requiring Specialist Prescribing will receive this in conjunction with Structured Psychosocial Interventions and not in isolation. This agreement between client and the service will be set out in the client's 'Recovery Compact' as part of care planning. (See section 3A 8.1k)

It is expected that the Nursing staff shall support the Consultant Psychiatrist in delivering a comprehensive treatment pathway that promotes recovery including nurse prescribing options.

## 2.0 Aims and Objectives of the Service

*See 3A plus:*

### 2.1 Aims

a. The overall aim of this service is to provide recovery focused, community based facilities that provide treatment to adult drug misusers whose primary drug problem level is moderate to severe.

b. The emphasis will be on encouraging drug misusers using the service to view specialist prescribing as a timely, short term, recovery based, care planned intervention.

c. It is stressed that prescriptions should not be seen as a treatment in isolation but delivered in conjunction with psychosocial interventions.

### 2.2 Objectives

The objectives of the service are to:

a. Provide needs led care that is regularly monitored and reviewed in a structured care plan of treatment.

b. Assist clients to remain healthy, with appropriate support, until they can achieve abstinence.

c. Stabilise drug misusers where appropriate on substitute medication to alleviate withdrawal and to reduce craving and related harm.

d. Provide detoxification/reduction treatment for drug misusers.

e. Instigate the delivery of home detoxification.

f. Provide secondary alcohol use brief interventions and appropriate referral to community alcohol services.

g. Provide continuation prescribing for purposes of stabilisation for clients with complex needs.

h. Ensure that clients have access to free, safe and secure lockable storage as required.

i. Identify appropriate services and refer/ facilitate service users into those services both within and external to drug treatment services as needed.

j. Ensure that mental health co-morbidity (including low level anxiety, depression and acute mental health problems) is identified and managed appropriately.

k. Assess the parenting capacity of drug using parents and assess the needs of children living with problem drug users and provide appropriate support.

l. Promote the use of peer support and Recovery Mentors to encourage client's focus on recovery.

m. Provide additional peer support during stabilisation.

n. Liaise and work in partnership with services within the Cambridgeshire drug treatment system.

### 3.0 Provision of the Service

*See 3A plus:*

The service must:

a. Provide continuation treatment for all clients currently receiving specialist prescribing interventions in this locality area from the start of this contract. At no point should the tendering process compromise the access to or continuity of medical treatment for these clients.

b. Reassess existing clients within three months of the commencement of the new service contract. Where appropriate, this will include encouraging engagement with psychosocial interventions alongside a prescription and putting in place a Recovery Compact for each client.

c. All clients should be titrated in accordance with 'Orange Book' Guidance.

d. Ensure that current provision is maintained with the Cambridge Access Surgery and it is expected that growth and development is undertaken as a key responsibility by the service.

e. Ensure that it is the exception rather than the norm that non drug related prescribing occurs. All primary healthcare needs will be met via the client's GP.

f. As good practice, the Specialist Prescribing Service should contact the client's GP to inform them of the prescribing decisions, and communicate as appropriate throughout treatment. Clients must be reviewed at regular intervals to ensure that their prescription is appropriate.

g. Ensure drug misusers are offered access to treatment within 10 working days from referral.

h. Ensure that mechanisms are in place to avoid duplicate prescriptions being issued.

i. Ensure that an Information Sharing Agreement and agreed mechanisms are in place with Addenbrookes and Hitchingbrooke Hospital to ensure that clinical information (inc prescription information) is shared between parties to facilitate care whilst in hospital and discharge planning. Additionally to ensure that agreed mechanisms are in place to cancel prescriptions with community pharmacies when clients are admitted to hospital.

### 4.0 Referral and Assessment

*See 3A plus:*

6.1 Triage assessment

a. All potential clients must have undertaken a Triage and risk assessment and have a written care plan.

b. This service will accept referrals from the GP liaison service where the client has been assessed and identified as having moderate to severe substance misuse issues, or other complex physical or psychological issues that can no longer be managed within a Primary Care setting.

c. Triage assessment may be carried out directly by this service (rather than via the SPC) where a priority access client group has been identified i.e. Mental Health, Accident and Emergency (A & E) and homeless person services.

### 5.0 Care Co-ordination

*See 3A plus:*

The service must work in partnership with community pharmacists regarding the supervised consumption and collection of medication.

### 6.0 Service Principles

*See 3A plus:*

This service must provide a range of medical, prescribing treatment interventions. This includes the following:

a. Adherence to clinical governance principles.

b. Provision of an accessible, appointment based and user-friendly service.

c. Clear communication with the client to inform them of circumstances under which dispensing regimes are initiated and revised and where exceptions are made.

d. Consideration to issues of confidentiality in relation to Supervised Consumption and prescription collection.

e. Have formal systems for supporting participating pharmacists.

f. Adopt formal standards for urine/ saliva/ blood testing.

### 7.0 Onward Referral/ Aftercare and Support

*See 3A plus:*

Onward referral, Aftercare and support must be a planned element undertaken by the service.

## d) GP Shared Care

**Information to Tenderers:** Please read in conjunction with Section 3A 'Overarching Provision'.

### 1.0 Definition of the Service

*See 3A plus:*

General Practitioners (GP) and Primary Care play an important role in the recovery focused treatment for drug misusers. Shared Care provision within the county is currently limited. It is expected that the service will undertake as a key responsibility, growth and development in this area of provision.

It is expected that the Service will support GPs within this area of provision to retain clients in treatment via GP shared care at the time of contract commencement.

Liaison workers (nurse, clinical nurse specialist or experienced drug workers) should support GPs in delivering a comprehensive treatment pathway that promotes recovery.

## 2.0 Aims and Objectives of the Service

*See 3A plus:*

### 2.1 Aims

The aim of the GP liaison service is to provide locality based, accessible provision for clients assessed within the Single Point of Contact (SPC). These clients must have been identified as low risk and appropriate for this service. In addition this must include clients who have stabilised on a maintenance community prescription and want to move on in their recovery.

### 2.2 Objectives

The objectives of this service are to:

a. Maintain existing services and further develop and support an increase in Shared Care provision across Cambridgeshire.

b. Offer a range of evidence based prescribing regimes.

c. Deliver all treatment interventions as part of a structured, written care plan for each client.

d. Undertake time limited and structured psychosocial interventions by suitably qualified staff alongside Shared Care and as part of a written care plan.

e. Provide liaison workers within GP practices to support the General Practitioner.

f. Provide senior medical support to GP's from a consultant. It is preferably, but not mandatory that they should have a Certificate of Completion of Specialist Training (CCST) in Psychiatry, or be a specialist drug treatment practitioner.

## 3.0 Provision of the Service

*See 3A plus:*

The provider must:

a. Negotiate and agree the local contractual arrangement with surgeries for all costs related to Shared Care including any prescription charges and GP Payments.
b. Provide this service to both generalist and specialised generalist (GPSi) general practitioners.
c. Continue to deliver a liaison service to those GP's already delivering community substitute prescribing regimes, supported by specialist drug treatment liaison staff.
d. Facilitate access to RCGP training in substance misuse.
e. Integrate and deliver the use of home detoxification.
f. Ensure that clients can access all other drug treatment in conjunction with GP prescribing.

## 4.0 Exceptions

*See 3A plus:*

The following drug misusers must not be accepted under these circumstances:

a. Where the drug misusers needs are assessed to be too complex within the level of GP competency and training. The service must accept re-referrals once stabilised.
b. Where the treatment includes injectable formulations or Diamorphine.
c. Where there is a sentence or licence condition requiring treatment that is provided elsewhere.

Exclusions directly relating to community detoxification are:

a. Those presenting with a co-morbidity of mental health
b. Pregnant drug users
c. Rough sleepers *(supported service users in hostels etc can be considered)*
d. Those assessed as co-dependent on alcohol
e. Those receiving high doses of Methadone (over 70mls)
f. Those using large quantities of illegal drugs

## 5.0 Onward referral/ Aftercare and Support

*See 3A plus:*

Onward referral, Aftercare and Support must be a planned element undertaken by the service.

## 6.0 Data Collection Requirements

*See 3A plus:*

Issues to be considered:

a. Data must not be centralised in the GP practice.

b. The service shall be expected to have in place appropriate software to enable the submission of monthly reports to the National Drug Treatment Monitoring System (NDTMS). Reporting requirements are subject to change from the National Treatment Agency and Department of Health, and the service shall be expected to comply with additional reporting requirements as requested by the above organisations, through the DAAT, as they occur.

c. All clients accessing this service MUST be recorded via the National Drug Treatment Monitoring System as receiving 'GP Shared Care', and NOT recorded as 'Specialist Prescribing'.

## e) Supervised Consumption

**Information to Tenderers:** Please read in conjunction with Section 3A 'Overarching Provision'.

### 1.0 Definition of the Service

See 3A plus:

It is expected that the Service will support pharmacies in the delivery of this area of provision and undertake as a key responsibility, growth and development in this area of provision.

### 2.0 Aims and Objectives of the service

a. The service will require the pharmacist or delegated member of the pharmacy's staff to supervise the consumption of prescribed medicines at the point of dispensing in the pharmacy, ensuring that the dose has been administered to the client.

b. Pharmacies will offer a user-friendly, non-judgemental, client-centred and confidential service that promotes a recovery focussed model.

c. The pharmacy will provide support and advice to the client, including referral to Primary Care or specialist treatment where appropriate.

d. Examples of medicines which may have consumption supervised include Methadone and other medicines for the management of opiate dependence.

e. All medicines should be prescribed according to 'Orange Book' guidance.[19]

f. It is expected that where appropriate the pharmacist can and will contribute to the client's care plan and support with brief interventions.

### 3.0 Provision of the service

[19] http://www.google.co.uk/search?hl=en&source=hp&biw=1065&bih=804&q=orange+book+clinical+guidelines&aq=0&aqi=g1g-b1&aql=&oq=orange+book+clinic&safe=active

*See 3A plus:*

a. It is the provider's responsibility to ensure that Supervised Consumption is provided through pharmacies in liaison with Cambridgeshire LPC (Local Pharmacy Committee).

b. The supervised administration of prescribed Methadone, Suboxone and Buprenorphine will be available to adults in drug treatment with the provider, the Drug Intervention Programme or Cambridge Access Surgery (CAS).

c. The Pharmacist must raise any concerns regarding intoxicated clients, Child Protection and Safeguarding of Vulnerable Adults (SOVA) to the provider and/or DIP and/or CAS (Cambridge Access Surgery).

d. The part of the pharmacy used for the provision of the service must provide a sufficient level of privacy and safety.

e. Pharmacists will share relevant information with other health care professionals and agencies in line with locally determined confidentiality arrangements.

f. The pharmacy will present the medicine to the client in a suitable receptacle and will offer the client water to facilitate administration and/or reduce the risk of doses being held in the mouth.

g. The fee per supervised administration is currently as follows:

| | |
|---|---|
| Methadone (liquid or tablets), Suboxone: | £1.50 |
| Buprenorphine (i.e. Subutex) | £2.00 |

h. It is the responsibility of the provider to run this provision within budget and to cover all associated costs ensuring that all appropriate clients receive Supervised Consumption within clinical best practice guidelines.

## 4.0 Exceptions

*See 3A plus:*

a. Methadone, Suboxone, Buprenorphine should not be dispensed to clients who are intoxicated with drugs and/or alcohol. Refusal will be at the pharmacists' discretion and will be due to risk factors and clinical safety. If a client is suspected of intoxication they should be asked to come back at a later time when they are no longer intoxicated. The pharmacist should inform the client of the risk of overdose as a result of taking Methadone whilst intoxicated.

b. The Pharmacist will provide supervised consumption of methadone, buprenorphine and suboxone to young people (under 18 years old) in treatment with the Cambridgeshire Adolescent Substance Use Service (CASUS) and the service will be able to re-charge the DAAT for the costs associated with this.

## 5.0 Referral and Assessment

Terms of Agreement must be set up between the prescriber, pharmacist and client to agree how the service will operate, what constitutes acceptable behaviour by the client and what action will be taken by the provider and pharmacist if the client does

not comply with the agreement. Please see Appendix 3 (following Section 3B) for the agreement currently used).

### 6.0 Competencies and Training of Staff

a. The provider has a duty to ensure that pharmacists and staff involved in the provision of Supervised Consumption have relevant knowledge, and are appropriately trained in the terms of the contract and operation of the service. This includes locums and temporary staff members.

b. Pharmacists are encouraged to complete the open learning module *'Substance misuse and opiate treatment: supporting pharmacists for improved patient care'* (Centre for Pharmacy Postgraduate Education (CPPE) in England). Pharmacists who have completed the Part 2 Royal College of General Practitioners (RCGP) in the '*Management of Drug Misuse in Primary Care'* may be eligible in the future to apply for posts as pharmacists with special interest in drug misuse (PhwSI).

### 7.0 Policies and Protocols and Written Strategies

*See 3A plus:*

a. The provider must ensure that pharmacists and staff involved in the provision of Supervised Consumption are aware of and operate within local protocols. This includes locums and temporary staff members.

b. Pharmacies are governed by the Medicines Act 1968 and Medicines, Ethics and Practice Guidance.

c. The pharmacy will run a confidential service. This includes:

- Informing the client that no information will be shared with parties not involved in the client's treatment without his/ her written consent. Exceptional circumstances when information may be shared are in Appendix 3.
- The pharmacy will inform the client that the completed Daily Individual Patient Supervised Consumption Forms will be shared with the DAAT for commissioning and administration purposes.

# f) Structured Psychosocial Interventions

**Information to Tenderers:** Please read in conjunction with Section 3A 'Overarching Provision'.

### 1.0 Definition of the service

*See 3A plus:*

This service must offer clear, recovery focused programmes of defined, structured psychosocial activities for a fixed period of time for clients meeting attendance criteria.

It is expected that Structured Psychosocial Interventions will be delivered alongside all prescribing interventions.

## 2.0 Aims and Objectives of the Service

*See 3A plus:*

### 2.1 Aims

a. To provide a range of Structured Psychosocial Interventions to give opportunities for clients to make changes in their drug misusing behaviour.

b. The service should aim to improve client's outcomes regarding engagement in therapeutic drug treatment and reducing/ abstaining from drug misuse.

c. It is expected that interventions will be delivered to all clients in receipt of substitute medication.

### 2.2 Objectives

The service must:

a. Provide 'needs led' care that is supported by a care plan that links all holistic interventions within the plan, which is regularly monitored and reviewed.

b. Promote a recovery focus in the early stages of work with a client.

c. Facilitate access to and provide treatment for potential clients and those already assessed but awaiting other care planned interventions.

d. Provide a range of Structured Psychosocial Interventions in both individual and group modalities that includes (but is not limited to):

- Cognitive behavioural therapy
- Relapse prevention therapy
- Individual and group counselling
- Motivational interviewing
- 12 step/ abstinence counselling
- Family approaches
- Peer support / mutual aid
- Brief interventions

e. Ensure that interventions are available in a variety of different locations and not solely within primary prescribing or drug services.

f. Use psychosocial interventions to improve overall personal, social and family functioning including increasing confidence and self esteem.

g. Ensure that assessment covers mental health co-morbidity that is subsequently managed appropriately with referral to and liaison to relevant mental health services.

h. Use TOPS as a motivational tool.

i. Use volunteers and Recovery Mentors where appropriate to assist in the delivery of this service.

### 3.0 Provision of the Service

*See 3A plus:*

**Main provision of service**

a. The service can be delivered in community, outreach, fixed main sites or multiple sites within other drug treatment services, supported by a multi skilled staff group.

b. This service must provide and ensure the following:

- A range of Structured Psychosocial Interventions available to all clients in both individual and group modalities. This will include telephone work and counselling where appropriate.
- Opening times are sufficient to meet the needs of clients. Either weekends and/or evening access are of particular importance for relapse prevention and abstinence based interventions.
- Ensure service users are offered access to treatment within 10 working days from referral.

### 4.0 Onward Referral / Aftercare and Support

*See 3A plus:*

Onward referral, Aftercare and support must be a planned element undertaken by the service together with the client and, as a minimum must include the following:

a. An appropriate package of support to assist client's in maintaining abstinence.

b. Links with:

- Community prescribing within the GP liaison service.
- Abstinence based SDP programmes/ groups, and other community support groups (i.e. Alcoholics Anonymous / Narcotics Anonymous/ Families Anonymous).
- Housing, benefits and welfare services to meet the needs of the client moving on from this service.

# g) Structured Day Programmes

**Information to Tenderers:** Please read in conjunction with Section 3A 'Overarching Provision'.

### 1.0 Definition of the Service

*See 3A plus:*

To increase the effectiveness of a recovery focused system, it is expected that the contractor will provide Structured Day Programmes in an environment that is *physically separate* to the mainstream service.

Structured Day Programmes (SDP) (as defined by Models of Care) provides intensive community based support, treatment and rehabilitation within a holistic approach. This service must offer clear programmes of defined activities for a fixed period of time with specified attendance criteria.

## 2.0 Aims and Objectives of the Service

*See 3A plus:*

### 2.1 Aims

a. To provide a broad range of structured interventions based around abstinence and recovery for clients who have reached a *position of stability* with their drug reduction. This encompasses the following areas of speciality:
   - Therapeutic (complimentary therapies, counselling, relapse prevention etc)
   - Education, training and employment
   - Life skills
   - Parenting and family support
   - Aftercare support – accessible for clients who have completed the programme as well as stand alone aftercare support for those who have not.

b. This must enable service users to:
   - Aim for abstinence based recovery.
   - Reduce the duration and frequency of episodes of substance misuse and the need for criminal activity related to this.
   - Improve personal and social functioning and community rehabilitation.
   - Participate and develop skills in vocational or educational goals.
   - Gain personal independence and responsibility.
   - Facilitate and maintain family and social support networks while in treatment.
   - Facilitate participation and engagement in other areas of drug treatment intervention programmes.

### 2.2 Objectives

a. Provide ‘needs led’ individually tailored, recovery focused treatment, supported by a written care plan developed with the client and regularly monitored and reviewed.

b. Provide potential clients with access to low threshold or open access pre-treatment ‘preparation’ groups for SDP (once assessed and engaged with the service).

c. The programme will assess and provide for those exiting residential rehabilitation/In Patient detoxification.

d. Provide a range of “rolling” and “fixed” (i.e. 12 week duration) group work programmes throughout treatment. including, but not limited to:

- **Training:** (education) literacy, IT skills, drug awareness/ education, pre treatment education, overdose prevention, harm reduction.
- **Life-skills:** debt management, budgeting first aid, benefits and housing/ tenancy advice, printing, video/ media.
- **Therapeutic**: anger management, relapse prevention, aftercare / abstinence based groups.
- **Complimentary Therapies**: a range complimentary therapies; auricular acupuncture, shiatsu etc.
- **Family** / **significant others:** focused access groups; family based group work, drug education, overdose prevention, accessing treatment.

d. Provide mutual aid groups as part of the programme.

e. Deliver the programme in conjunction where appropriate with existing non-drug specific organisations with whom strong links should be evident. In particular this includes:

- educational, training and vocational services in addition to national programmes
- housing services (including Supporting People Floating Support)
- welfare (benefit advice) services
- health related services
- family support related services

f. Undertake named care co-ordination responsibilities as needed.

g. Use staff and volunteers from a wide range of professional backgrounds, including volunteers / mentors where deemed appropriate, co-ordinated by a SDP development manager for the county.

h. Actively promote the role of volunteer or Recovery Mentor to clients successfully completing the programme.

### 3.0 Provision of the Service

*See 3A plus:*

a. Provide a range of SDP programmes available to all appropriate clients.

b. Deliver SDP interventions available for 3-5 day attendance.

c. Ensure opening times are sufficient to meet the needs of clients. Core service hours must be in operation daily. A minimum once a week “out of hours” access for service users is expected. (Either weekends and/or evening access; this is of particular importance to relapse prevention and abstinence based interventions).

d. The service must ensure clients are offered access to treatment within 10 working days from referral.

### 4.0 Exemptions

*See 3A plus:*

Clients will be excluded from the treatment intervention if their behaviour adversely affects other participants in the group.

### 5.0 Referral and Assessment

*See 3A plus:*

a. New referrals can be taken via the Single Point of Contact (SPC), or from other key workers. This service must not take direct or open access referrals.

b. This service must complete a comprehensive assessment, and a risk assessment of the potential client following referral.

### 6.0 Onward Referral/ Aftercare and Support

*See 3A plus:*

a. Onward referral, Aftercare and support must be a planned element undertaken by the service.

b. The service must develop and provide, with the agreement of the client, an appropriate package of Aftercare and support that must assist them in maintaining abstinence. This will include:

- Specialist prescribing within the drug treatment system
- Community prescribing within the GP liaison service
- Abstinence based community support groups (e.g. Alcoholics Anonymous / Narcotics/ Families Anonymous).
- Housing, benefits and welfare services to meet the needs of the service user moving on from this service.
- Generic education/ vocational training services
- Formally close/ discharge cases where the client has achieved abstinence, completed a care-planned episode/ intervention, or left the programme prior to completion. Where possible this must include a client 'outcome' feedback.

## h) Family Support

**Information to Tenderers:** Please read in conjunction with Section 3A 'Overarching Provision'.

### 1.0 Definition of Service

The service is intended for the support of family members and significant others who have a drug misusing relative or friend. The drug using relative may or may not be in treatment.

## 2.0 Aims and Objectives

### 2.1 Aims

To support families, friends and carers of drug misusers experiencing the effects of someone else's drug problem both individually and in a group setting.

### 2.2 Objectives

a. To support individuals affected by another's drug misuse to address their own circumstances and improve their mental, emotional and physical health and well-being.

b. To support individuals affected by another's drug misuse to support their drug misusing relative/ friend.

c. To deliver "carers groups" across the county, at regular intervals, which will also provide access to those who are concerned about the alcohol misuse of their friend / family member.

d. Provide a six session one-to-one support service, for family members/ carers with a high level of need.

e. To offer advice, support information and training to families and carers on a range of issues, including drug misuse, overdose, relapse and harm reduction.

f. To work with carers to encourage drug misusers to enter co-ordinated treatment.

g. To support carers to become included in client's treatment care plans.

h. To support the needs of young carers, ensuring they have relevant information specific to their age.

i. To support family members/ carers to identify themselves as carers, and access appropriate support, through the use of the formalised County Council Carer Assessment.

j. Raise awareness within the overall drug treatment service of carers of drug misusers and the resources available for their support.

k. Encourage and support volunteers, to promote the capacity of family support where appropriate.

## 3.0 Accessing the Service

a. Develop clear referral pathways into the project from relevant services and organisations.

b. Promote the Family Support work to other services and individuals affected by another's drug misuse, with a focus on targeting those most at risk.

### 4.0 Monitoring

The agreed Quality Controls will include the following components:

- An annual satisfaction survey of a sample of service users.
- An annual report of outcomes achieved by service users.
- Planned, regular supervision of staff.

### 5.0 Provision of the Service

*See 3A plus:*

a. There may be family members/ carers in existing groups that are attending because a family member/ friend is misusing alcohol. It is expected that such individuals can remain in the groups after the new contract is awarded. Thereafter, new membership will be restricted to family members/ carers of drug misusers only.

b. The provider will be expected to:
   - Provide carer groups around the county.
   - Provide appointment based one to one work.
   - Ensure that family members can be trained/ receive information on:
     - harm reduction
     - overdose training
     - domestic violence
     - the setting and maintaining of boundaries

### 6.0 Referral and Assessment

Referral to family work will be via the Single Point of Contact. Such referrals will be responded to in a sensitive, timely and appropriate way suitable to each location.

## i) Drug Interventions Programme

This includes the provision of:

- Voluntary Arrest Referral Service &
- Drug Rehabilitation Requirement

**Information to Tenderers:** Please read in conjunction with Section 3A 'Overarching Provision'.

### 1.0 Definition of the Service

*See 3A plus:*

a. There is an expectation that the provider will co-locate with other Drug Intervention Programme (DIP) Partners in the provision of this service.

b. The DIP aims to reduce drug related crime by taking advantage of opportunities within the criminal justice system for accessing and engaging class 'A' drug-misusing offenders (heroin, cocaine, crack cocaine and amphetamines when injected) and moving them into and retaining them in treatment, and supporting them away from drugs and crime. This includes:
    - In-reach with prisons
    - Integrated Offender Management
    - Joint care planning and joint exit planning.
c. In line with all drug misuse treatment, the goals will be:
    - Abstinence based
    - Recovery focused
d. This specification seeks to outline the requirement for the delivery of treatment based interventions to underpin the aims of the overall service. This will include:
    - Accessing and engaging drug misusing offenders at all stages of the criminal justice system and assessing their needs, offering, and delivering when required, prescribing or non prescribing interventions and/or onward referral as appropriate through an integrated throughcare approach, which is defined as *"the arrangements for continuous support of a drug misuser from entry, at any stage, into the criminal justice system, until they leave the criminal justice system, through the adoption of a case management approach".*
    - Providing a Drug Rehabilitation Requirement (DRR) service including assessment and drug screening.

## 2.0 Aims and objectives of the service

*See 3A plus:*

### 2.1 Aim

The key aim of this service element is to provide adequate coverage for triage and assessment of client referrals, including Drug Rehabilitation Requirements, through the DIP Single Point of Contact (SPoC) referral pathway and the delivery of Voluntary Drug Testing on Detention, in order to proactively facilitate engagement and retention of drug misusing offenders in treatment.

### 2.2 Objectives

The key objectives of the services to be provided are to:

a. Conduct voluntary drug assessments and offer/conduct drug screening of those detained persons within the Cambridgeshire police custody suites who meet the initial eligibility criteria.

b. Act as the formal Cambridgeshire DIP agency responsible for carrying out any Required Assessments and Conditional Cautions with a DIP requirement.

c. Conduct Drug Rehabilitation Requirement assessments at the request of Cambridgeshire Probation Services and provide information to inform court reports.

d. Conduct all other triage assessments for non statutory client referrals to the DIP service.

e. Form part of the wider Cambridgeshire Drug Interventions Programme team.

f. Complete all necessary Drug Interventions Record and Activity forms pertaining to the Cambridgeshire Drug Interventions Programme team caseload and ensure they are sent to the designated data collection body by the required date.

## 3.0 Provision of the service

**Main provision offered**

a. Proactive targeting of arrested Opiate and Cocaine Users (OCUs).

b. Triage Assessment.

c. Harm reduction advice and interventions.

d. Low threshold treatment interventions, e.g. motivational engagement.

e. Screening and signposting of those referred through the DIP Single Point of Contact and Voluntary Drug Testing on Detention (VDOD).

f. Risk assessments.

g. Pre-release planning.

h. Appropriate interventions for crack cocaine users.

i. DIP drug screening including VDOD and Drug Rehabilitation Requirement.

j. The service must operate in a variety of locations to facilitate the needs of residents of Cambridgeshire.

k. The service must operate Monday to Friday for 52 weeks a year, excluding Bank Holidays and Public Holidays.

l. The service will ensure opening times are sufficient to meet the needs of clients. Core service hours must be in operation daily. A minimum once a week “out of hours” access for service users is expected, (either weekends and/or evening access, this is of particular importance to relapse prevention or abstinence based intervention).

m. The service must ensure that clients are offered access to treatment within 10 working days from referral.

n. The provider shall adhere to the concept of the whole system approach.

o. The provider shall place the client in the centre of the service, and ensure that all elements of the service work effectively to support a continuum of need.

p. A key aspect of the services provided by the provider shall be earlier detection of substance misuse problems, assessment and early intervention or referral to an appropriate service. Liaison, referral and, where appropriate, shared care protocols to respond to the individual needs of the client and the presenting problems should be in place with a range of services, including:

- mental health services
- maternity services
- child protection agencies
- general medical services
- social services
- accident and emergency
- housing agencies
- child and adolescent/young people services
- learning disability services
- homeless hostels
- sexual health/communicable diseases units
- crisis intervention agencies
- domestic violence support services
- Integrated Offender Management

## 4.0 Groups served

### 4.1 Priority / target Groups

a. All phases of the DIP drug treatment system will be available to all adults (over 18) who are Cambridgeshire residents with a primary, Class 'A' drug misuse issue and are involved within the Criminal Justice system. Alcohol issues may be addressed if alcohol is used as a secondary substance and then referred to appropriate services.

b. The service will be expected to give priority to Prolific and Priority Offenders and those arrested for trigger offences.

## 5.0 Referral and Assessment

a. The DIP will take referrals from the following:

- Cambridgeshire Prolific and Priority Offenders scheme.
- Integrated Offender Management.
- Appropriately screened detainees from DIP, Voluntary Drug Testing on Detention (VDOD) staff currently located in Cambridge Parkside police custody suite.
- Police Custody on whom a DIP Conditional Caution or Required Assessment has been imposed.
- Other professionals in the field e.g. the Prison Counselling, Assessment, Referral, Advice and Throughcare (CARAT) service team.
- Probation (pre sentence clients).
- Out of area Drug Intervention Programme teams particularly those pertaining to Restriction On Bail and Testing on Arrest.
- Self referral via SPoC.

b. All referrals will be managed through the DIP Single Point of Contact (SPoC), including those identified by the service provider undertaking the VDOD role.

c. There is in place clear eligibility criteria, incorporating inclusion, exclusion and contra-indications.

### 6.0 Assessment

The service will undertake the following:

a. Undertake a triage substance misuse assessment, in accordance with Models of Care for Drugs, for all clients referred to the service. Triage assessment must only be undertaken by competent assessors.

b. The triage assessment process within the Drug Interventions Programme will utilise the approved Drug Intervention Record form and further activity noted and reported using the approved Activity Report Form.

c. The provider must complete a comprehensive assessment, and a risk assessment of the client following referral the DIP Single Point of Contact (SPoC). The provider must not take direct or enable open access referrals.

### 7.0 Care planning and coordination

*See 3A plus:*

a. All clients completing a comprehensive assessment must have a written care plan and identified key worker.

b. DIP will care coordinate all DIP cases.

### 8.0 Service principles

**Proactive targeting of arrested problem drug users**

The provider shall provide the following services in relation to Cambridgeshire DIP's Voluntary Drug Testing on Detention scheme:

a. Provision of adequate coverage of Cambridge (Parkside) police custody suite.
   - In the case of Prolific and Priority Offenders it may be necessary to engage Clients prior to arrest, following referral from Police Prolific and Priority Offender Coordinators, in which case these Clients should be given priority over other Clients.

b. Contact all those arrested by approaching the individual in the cell.

c. Offer, in full or in part, of a brief explanation of the Drug Interventions Programme with an overview of the role of the individual worker and that of the wider team.

d. Offer a voluntary drug screen to the individual where all DIP eligibility criteria have been met. Where accepted, the outcome will be recorded on the DIP VDOD database to inform future comprehensive assessment.

e. Offer, in full or in part, a brief overview of the help and support available for the individual

f. Offer, in full or in part, responses to questions from the individual to enable them to make an informed decision about options

g. Offer, in full or in part, an explanation as to how information gathered about the individual will be used.

h. Explain when and how information may be shared with others, including issues around confidentiality and informed consent.

i. Provide assurances that the assessment (if in the police station) is independent of the police.

j. Record the final outcome of the contact on the appropriate Drug Interventions Record, Activity or Initial Contact form.

k. If the provider initiates a contact with a person who does not meet the CDIP VDOD referral eligibility criteria, it will be appropriate to carry out an initial screening of that person in order to signpost him or her to the relevant service to meet any identified needs. This will include alcohol services when appropriate.

l. Offer harm minimisation advice and support routinely to all clients who attend appointments. This includes:

- A range of accurate, appropriate, and factual information will be provided. This should be accessible and meaningful in terms of context, language, literacy level and comprehensibility.
- The provider will be competent to deal with users of the whole range of illicit drugs and alcohol plus those who abuse volatile substances and prescribed tranquillisers.

### 9.0 Onward Referral/ Aftercare and Support

*See 3A plus:*

Clients assessed as having a housing related need will be referred to DIP/ IOM tenancy support staff. Ongoing floating support needs, identified at this stage, will need to be referred on to service providers identified within the Supporting People accommodation support framework.

### 10. DIP Additional Provision: Specialist Prescribing

*See also Section 3Bc and general DIP information above plus:*

**Aim and Objectives**

The overall aim of this service is to provide community based facilities that provide treatment for drug misuse to adult drug misusers whose primary drug problem level is moderate to severe.

**Target groups**

a. This service must be offered to Cambridgeshire residents who are DIP clients aged 18 or over with substance misuse/dependency issues, who are not currently accessing any other specialist prescribing service for drug misuse.

b. Referral is via DIP SPoC.

c. The service must offer provision that is complimentary to other services within the Cambridgeshire drug treatment system.

**Provision of the Service**

a. The service must provide continuation treatment for all DIP service users currently receiving Specialist Prescribing interventions in this locality area from the start of this contract. At no point should the tendering process compromise service user's access to or continuity of their medical treatment.

b. This service must also provide this service for new or potential service users referred from the Cambridgeshire DIP Single Point of Contact (SPoC).

c. The service must engage a minimum of 225 service users each year whose primary substance is illegal drugs.

d. The commissioned service provider will manage the budget for prescription (FP10) costs in relation to DIP Clients.

e. The service provider will enable provision of 'emergency' prescribing to accommodate clients released early from prison when notification is limited.

**11. <u>DIP Additional Provision: Structured Psychosocial Interventions</u>**

*See also Section 3Bf and general DIP information above plus:*

**Provision of the Service**

a. The service must take new referrals via the DIP Single Point of Contact (SPoC), including existing clients i.e. those already engaged with prescribing services.

b. It is expected that all clients receiving prescriptions will be also receive structured psychosocial interventions.

c. This service must provide interventions for clients with a range of problematic drug use over a range of substances (including stimulant users), which can take place independently of or in conjunction with substitute prescribing.

## j) Drug Rehabilitation Requirement (DRR)

**Information to Tenderers:**

The contractor must provide a service which achieves all of the objectives set out in this section.

This section provides the requirements, performance indicators and targets for the delivery of the National Probation Service's Drug Rehabilitation Requirement (DRR) programme through Cambridgeshire DIP.

**Cambridgeshire current service activity**

a. The provider will deliver the programme to all active clients on DRR orders at 01 April 2012.
b. In 2011/12 the expectation is for 93 new DRR commencements.
c. The current target for successful completions over the year is a minimum of 45%
d. Each care plan developed will be submitted to the relevant offender manager within 10 working days of the referral being received by the provider indicating; the prescription arrangements and reduction plan and timings, numbers of tests per week, the hours of programming input including the starting dates.
e. Treatment will commence no more than 2 working days from the order being made.

## 1.0 Definition of the Service

The DRR is a community based sentence requiring the consent of the offender. It can be imposed for a minimum of 6 months and a maximum of 36 months.

A DRR should only be used when the court is satisfied that there is a 'propensity to use drugs' and a 'susceptibility to treatment'.

The DRR has a minimum treatment contact hours per week for the different community band tiers in line with National Standards as follows:

- 15 hours for offenders with high seriousness offences
- 8 hours for medium seriousness offences (Tier 2 & 3)
- 2 hours for low seriousness offences (Tier 1 & 2)

*(It is anticipated that the profile in terms of DRR intensity will be in the region of 20% low, 75% Medium and 5% High, based on recent caseload statistics, May 2009).*

Treatment contact hours include drug treatment interventions, accredited programmes and meetings with the Offender Manager. The minimum hours of contact apply to the first 16 weeks only.

## 2.0 Aims and Objectives of the Service

### 2.1 Aim

The DRR is intended to reduce or stop offenders' dependency on, or propensity to use illegal drugs and to assist offenders in working towards an offending free life. The DRR is particularly aimed at those who misuse Class A drugs, including heroin, crack cocaine, cocaine and amphetamines (by injection).

### 2.2 Objectives

a. A DRR must always be considered as a priority requirement in those instances where there is evidence that drug misuse is linked to offending. (Risk will be scored through Probation Services models – OGRS and OASys).

Where there is clearly identified treatment need, the DRR shall take precedence over any other possible supporting requirements.

b. A proposal for a DRR may not be appropriate if:
   - The offender explicitly declines consent.
   - Following assessment by DIP/CPA and their consultation and discussion with the Offender Manager preparing the Court Report the offender is identified as lacking in motivation.

c. A client receiving a DRR will be managed by the Probation Offender Manager who is responsible for reporting conformity to the order to the courts.

d. The DIP DRR key-worker is responsible for delivering 1:1 key-working sessions, during which drug testing is conducted. Additionally, they will work with the Probation Offender Manager at report preparation stage and throughout the course of the Order to agree other interventions required for the client and ensure the client has a planned, calendar of events each week and that attendance is monitored and fed back to the Offender Manager.

e. DRR clients with a drug treatment need will be allocated a DIP clinical worker to accommodate any harm reduction, specialist prescribing or structured psychosocial interventions. DIP clinic attendance will contribute towards the minimum hours required by the intensity of the order.

| **Intensity of Order** | OM Session | Drug tests per week | 1:1 Keyworking/ counselling Sessions | Drug work Sessions | Complementary therapies | Psycho-educational work (e.g. anger management, coping strategies) | Healthy living and lifestyle interventions | **Total Hours per week** |
|---|---|---|---|---|---|---|---|---|
| **Low** | *1* | 1 | *A one-off, 2 hour drug education and harm reduction session | | | | | |
| **Medium** | *1* | 2 | 1 | 1 | *1* | *1* | *1* | **8** |
| **High** | *2* | 2 | 2 | 2 | *3* | *2* | *2* | **15** |

**Table 1: DRR Delivery Schedules**

*Note; hours identified in italic are presently delivered external to DIP

## 3.0 Programme Delivery

The programme will be delivered to the standards and quality framework detailed in the main body of the specification.

a. The programme will be delivered over 52 weeks.
b. The programme will deliver services to the 3 intensities of DRR order: low, medium and high
c. For clients with a low intensity DRR the programme will provide a one-off 2 hour drug education and harm reduction session. Additionally, low intensity DRR clients will attend for one drug test per week
d. For clients with medium and high intensity DRR's the programme will deliver a programme of interventions as detailed in the table below (Table 1: DRR Delivery Schedules). Where additional interventions, including Structured

Daycare, are identified that are not delivered by the DIP, these must be sourced through mainstream service providers and agreed with the Offender Manager. Additional, occasional drug testing may be required to verify anomalous test results or at the request of the courts.

e. Drug testing may be carried out less frequently than identified in the above table if this is agreed as appropriate at case review between the provider and the offender manager.

f. Medium and High intensity orders require a twice weekly testing regime for the first 16 weeks of the order by the provider. Each case will be reviewed after this period and the frequency reduced if appropriate.

g. The methods of drug testing will be undertaken according to the specification set by the DAAT or to any specification subsequently amended by the Ministry of Justice.

## 4.0 Access to the Programme

a. The programme will be delivered from the provider's premises at times that are accessible to clients and potential clients.

b. Access to the service will be within the required timeframe as stipulated within National Probation Service procedures, under no circumstances must any eligible person have to wait to be admitted to the service.

c. The provider shall accept referrals of any eligible person to this service from the courts, probation officers and the named offender manager.

d. The provider shall be required to undertake a comprehensive assessment and risk assessment consistent with Models of Care and other relevant standards identified by the NTA or professional bodies.

e. While contributing to the assessment process the provider has no autonomy in admitting people to the programme. Such decisions are made only in conjunction with the named offender manager. Where a significant risk is assessed by the provider in relation to a particular case, that case will be referred back to offender managers as inappropriate for the programme.

f. The provider will manage specific instances should DRR clients fail to maintain the Probation Service's behavioural standards and will report back to offender managers.

g. The provider will contribute to court review reports as requested by offender managers.

h. The provider will compile and provide weekly timetables to DRR clients detailing programme attendance requirements. Other DRR or Probation Service attendance or breach requirements will be included if they are provided within a reasonable timeframe. The timetables will be forwarded to the offender managers by the Friday of the preceding week.

## 5.0 The staffing of the service

a. The Service staffing capacity should be such that it can provide sufficient administrative and management support to facilitate the delivery of the service.

b. Service staffing will be sufficient to enable delivery of the following:
   - The service must operate in a variety of locations to facilitate the needs of residents of Cambridgeshire.
   - The service must operate Monday to Friday for 52 weeks a year, excluding Bank Holidays and Public Holidays.

- The service will ensure opening times are sufficient to meet the needs of service users. Core service hours must be in operation daily. A minimum once a week “out of hours” access for service users is expected, (either weekends and/or evening access, this is of particular importance to relapse prevention or abstinence based intervention).
- The service must ensure service users are offered access to treatment within 5 working days from referral.

## 6.0 Care Planning

All clients completing a comprehensive assessment must have a DRR written care plan and identified key worker.

## 6.1 Contents of Care Plans

It is expected that all care plans must:

a. Set out the goals of treatment and milestones to be achieved.
b. Indicate the interventions planned and which service and key worker / professional is responsible for carrying out the interventions.
c. Clearly record the referral onwards to the identified structured treatment pathway.
d. Make explicit reference to risk management and identify the risk management plan.
e. Identify information sharing requirements.
f. The care plan should reflect the cultural and ethnic background of the service user as well as their gender and sexuality (where appropriate).
g. Be developed with the active participation with the client.
h. Be agreed and signed by both the client and care co-ordinator (where appropriate).
i. Identify and record review dates.
j. Record current goals and needs of the service user, unmet needs and the client’s satisfaction with their care.

## 6.2 Care Co-ordination

a. It is expected that some service users may be care co-ordinated via this service as identified during continuous assessment as identified within the Models of Care Guidance.

b. It is expected that those responsibilities listed below, and identified as a minimum standard, be adhered to for care co-ordination by the service:
   - To provide a network of care and ensure that substance misusers have access to a comprehensive range of interventions across health, social care and criminal justice agencies where applicable.
   - To ensure the co-ordination of care across all agencies involved with the service user
   - To develop, manage and review written care plans.
   - To ensure continuity of care and to support the service user throughout their contact with treatment and facilitate any changing relationship between the service user and .those providing interventions.

- The service must aim to maximise the retention of service users within the treatment system and minimise the risk of loss of contact with the service/s.
- To facilitate the re-engagement of service users who have dropped out of treatment through effective liaison with appropriate services.
- The service must aim to avoid the duplication of assessment and interventions

**7.0 Monitoring and Reporting Requirements**

a. The provider will identify a staff member to act as a single point of contact for all operational and case management communications relating to the DRR programme.
b. The principle form of communication between the provider and the Probation Service will be via email through the two Single Points of Contact. Any electronic documents containing DRR client names will be sent via encrypted documents.
c. Probation will issue a weekly calendar for each DRR client to the provider for completion with all planned treatment based interventions as agreed with the Offender Manager. The DRR keyworker will complete the intervention hours, times and dates in line with the agreed level of input for the intensity of the order. All completed calendars will be returned to Probation for issue to the relevant client unless there is a local arrangement where the calendar can be handed to the client, on behalf of Probation, by the DIP keyworker.
d. The provider will provide weekly attendance and drug test result reports to the offender managers for each DRR client. The weekly report will follow a template agreed between the provider and the Probation Service and will record all attendances for the agreed treatment interventions within the client calendar.
e. The provider will inform offender managers of any absences of DRR clients on the day of absence
f. The provider's DRR keyworkers will attend case review meetings with offender managers on a regular basis and as agreed between the keyworker and offender manager. Additionally the DRR keyworkers will attend and contribute to weekly case meetings with the DIP as required
g. The provider's keyworkers will cooperate with reasonable requests to attend court to give evidence as required.
h. The provider will provide relevant evidence and information, if required by court, to offender managers as requested within reasonable timescales.
i. The provider will respond to any reasonable requests for further information from either the DAAT or probation service.
j. The provider will carry out admin relating to referrals, case management of drug treatment, drug testing and communicate programme compliance and progress to offender managers
k. The Provider will ensure robust information sharing protocols between agencies
l. The Trust and Provider will agree a schedule of operational management meetings to examine procedures and performance as required.

**8.0 Performance monitoring**

The service shall be required to contribute to the following targets as part of the Cambridgeshire Adult Drug Treatment System:

- Expected number of DRR commencements (93
- Expected ratio of DRR completions (45%)
- Number of drug screens per client/week including result
- Number of non attendances for scheduled events

## 9.0 Protocol

The protocol is inserted here to ensure that the provider of the DRR service is clear of the exact protocol that is expected to be adhered to.

### *9.1 Introduction*

*9.1.1 The provider will be contracted by the Cambridgeshire Drug and Alcohol Action Team (CDAAT) to deliver the Drug Rehabilitation Requirement (DRR) programme in Cambridgeshire. The DRR is supervised by the National Probation Service and is the main delivery route for drug interventions within community sentences for adult offenders. It involves treatment (either in the community or in a residential setting) and regular drug testing.*

*9.1.2 This protocol will be established between the Cambridgeshire and Peterborough Probation Trust (The Trust), and the provider to facilitate the exchange of information and to describe the mechanism for the delivery, monitoring and evaluation of the DRR programme in Cambridgeshire.*

*9.1.3 For the avoidance of doubt, the Parties do not intend that this Protocol be a legally binding document.*

### *9.2 Principles*

*9.2.1 The Trust and the provider will work together in an atmosphere of mutual respect, with an understanding and commitment to the shared aims of the programme.*

*9.2 .2The Trust, in pursuance of it's statutory functions has an obligation to monitor the standards and quality of services provided to offenders subject to probation supervision within the Cambridgeshire and Peterborough areas.*

*9.2.3 The provider is obligated to achieve the service levels agreed under contract arrangement with CDAAT for the delivery of the DRR programme in Cambridgeshire.*

### *9.3 Programme Delivery*

*9.3.1 The provider will deliver the DRR programme through the Cambridgeshire Drug Interventions Programme (DIP)*

*9.3.2 To facilitate the successful supervision of offenders subject to a DRR, the provider will agree to:*

- *Immediately notify a representative of the Trust if there are any areas of concern about public protection or safeguarding children issues regarding DRR participants.*
- *Report on a daily basis or within 24 hours of the stipulated contact on the attendance of offenders referred to the service to a representative of the Trust.*

*9.3.3 To facilitate the timely sentencing of offenders identified as potential DRR participants and related court requirements, the provider agrees to:*

- *Assess offenders identified as potential DRR participants and report their suitability and suggested intensity to the court through the Pre-Sentence Report author or representative appointed by the trust within the agreed adjournment period. The report shall confirm the consent of the offenders found suitable and contain an outline of the treatment plan proposed; including hours and type of programming.*
- *If requested by a representative of the Trust, provide a written Section 9 statement in the event of any contested breach proceedings associated with offender compliance with the DRR and attend court if necessary to give evidence if the breach is contested.*

*9.3.4 The Trust will:*

- *Assign a Team Manager to act as the representative of the Trust who will be responsible for the operational liaison with the provider.*
- *Retain responsibility for the management of the Community Order in accordance with the Criminal Justice Act (2003), the Ministry of Justice National Standards and any relevant policies adopted by the Trust.*
- *Receive and record information from the provider with regard to the offenders' attendance and progress relevant to the programme.*
- *Facilitate the referral of potential DRR participants utilising the agreed pathway.*
- *Allocate an Offender Manager to each DRR case and notify the provider of this information.*
- *In liaison with the provider, plan for on-going support as an offender comes to the end of their requirement.*

### *9.4 Confidentiality and Data Security Policies*

*9.4.1 All parties must keep confidential information received from or about participants on the programme and treat this data as 'RESTRICTED' in accordance with the National Probation Service Protective Marking Policy. Such information may only be used by the parties for the purpose of carrying out their obligations related to the delivery of the DRR programme and it must not be passed to third parties without the prior written consent of the Trust.*

*9.4.2 Any exchanges of information relevant to the delivery of the DRR programme shall require both parties to act in accordance with the Data Protection Acts 1984 and 1998, or any superseding or amending statutory requirements and neither party shall act in any other manner or way which is deemed to be unlawful.*

*9.4.3 All parties must use the Criminal Justice Secure email service (www.cjsm.net) or Government Secure Intranet (GSI) to send emails containing information up to an equivalent of 'Restricted' (i.e. sensitive data).*

### *9.5 Health and Safety*

*9.5.1 All parties shall take all measures necessary to comply with the requirements of the Health and Safety at Work Act 1974 and any other acts, orders, regulations*

*and codes of practice relating to health and safety which apply to the DRR programme.*

***9.6 Notices and Communications***

*9.6.1 The respective operational managers or nominated deputies of both agencies will meet as required to facilitate the successful delivery of the programme.*

*9.6.2 In the event of a dispute arising out of or in connection with the management, delivery, monitoring and evaluation of the DRR programme, the respective operational managers or nominated deputies shall meet and attempt in good faith to negotiate a settlement.*

# k) Prisons: Non prescribing drug and alcohol services in HMP Whitemoor

*(Formerly referred to as CARAT)*

NB: Details for HMP Whitemoor are as follows. The equivalent service for HMP Littlehey is not yet ready to go out for tender.

**HMP Whitemoor**

Whitemoor is a Category A prison within the secure estate and has an operational roll of 448 category A and B male prisoners serving a minimum of 4 years. The Prison also has a Dangerous and Severe Personality Disorder unit and a Close Supervision unit, this unit is a specialist unit funded by the National Health Service for the treatment of Severe Personality disorders and is an abstinence based unit.

The current service provision is based around three CARAT team members. Two team members are employed external to the prison establishment and one member is a uniform prison officer seconded to the CARAT team.

The team is supported by a prison based substance misuse administrator. This post does not form part of the services within the tender.

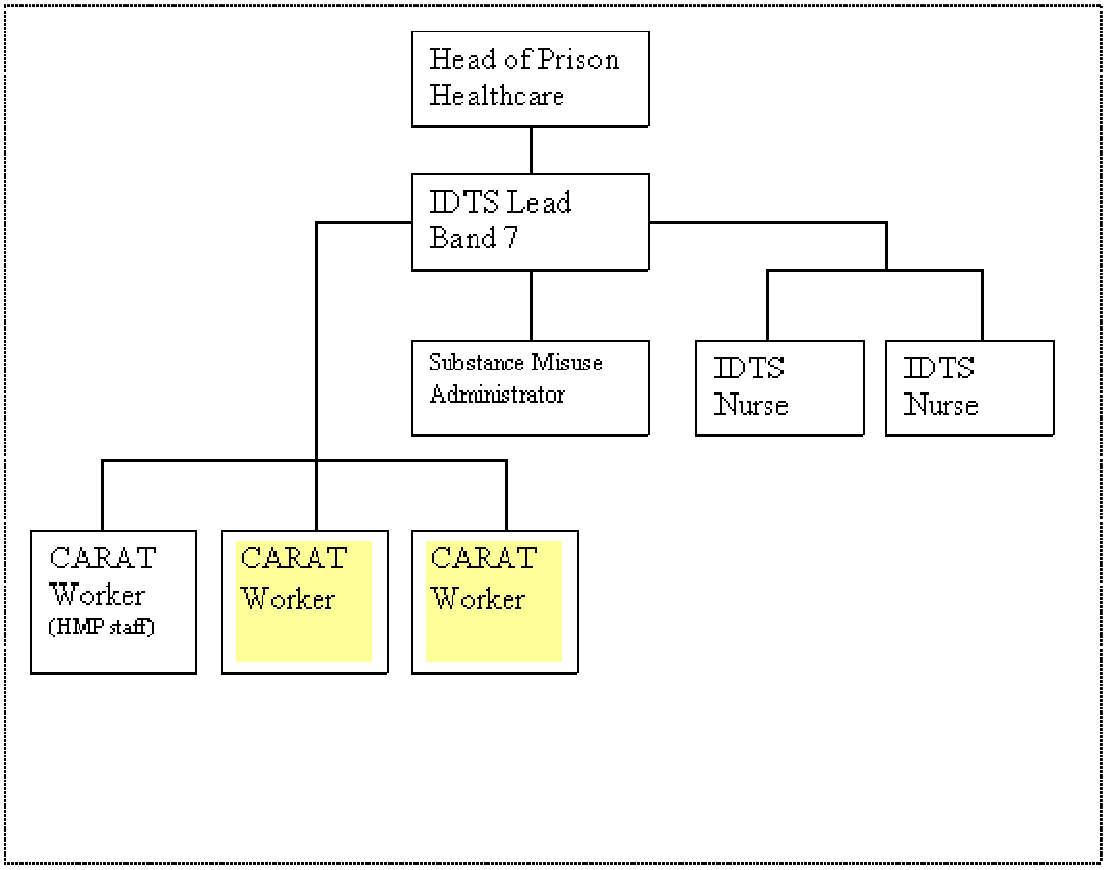



**Table 1: Staff structure**

## SECTION 1

### 1.0 Overarching Provision

(See also service process map in Section 6 of 'Prisons')

a. The service will apply to the provision of 2 team members as part of the wider HMP Whitemoor substance misuse services. (See above service structure)

b. To ensure continuity of service provision, annual leave and sick absence cover, the service provider will ensure additional competent and security cleared staff are available within the wider organisation.

c. The service will be made available to all prisoners who require it. For some prisoners this service may be the only intervention into their drug or alcohol problem whilst they are in prison and it may be the first time they have ever had assistance with their substance misuse related problems.

d. Services must be easily accessed by any prisoner, and will be the foundation for more intensive drug treatment programmes when appropriate and when sentence

length permits. The service will retain the case management responsibility whilst prisoners are undergoing more intensive treatment; they will make referrals into treatment and provide post-treatment support and follow-up so that gains made in treatment are not lost.

e. The multiple problems that prisoners face shows that dealing with substance misuse in isolation is not enough. To enable referrals to and from other services in prison to be made, and assessments/Care Plans developed that take into account the multifaceted needs of prisoners, the service provider must ensure that they develop effective working relationships with other departments in establishments and with external agencies.

f. All assessments and Care Plans need to establish the complexity of the substance misuse and prisoner's history in relation to past treatment. The Care Plans need to set out clear goals with the prisoner in terms of re-integration which take into consideration the prisoner's recovery capital on release which will establish the relevant re-integration pathways to the community. These may include but not be limited to; local drug treatment agencies, mutual aid including AA/NA, housing, benefits system, education, training, employment. Other areas for inclusion should focus on the prisoner's relationships with family and significant others as well as parenting skills for those prisoners who will be returning to the family unit where children are present.

g. Care Plans must be consistent with the overarching aims of the NTA's Building Recovery In Communities 2011 service framework.

h. The service specification will be used in conjunction with the core elements of the CARATs Practice Manual which provides an overview of how non prescribing drug and alcohol services may be delivered in the prison setting. It describes the different components that make up the service and the different responsibilities of those involved in its delivery. It also outlines detailed good practice when working with different groups and categories of prisoners. The guide should be read in conjunction with this specification and relevant Prison Service Orders (PSO's), which are referred to throughout[20].

i. The casework system for non prescribing services, provided by the Prison Service is described in the Practice Manual. This description includes the casework documentation relevant to the operation of the service.

## 1.1 Service delivery

All services will be based around the emerging needs within an annually reviewed drug and alcohol needs assessment;

### *1.1.1 Intensive Programmes - Rehabilitation Programmes and Therapeutic Communities*

[20] http://www.gos.gov.uk/497648/docs/300069/806738/890265/CARATsManual

There are currently a mixture of intensive drug treatment programmes being run in prisons - by external providers and Prison Service staff. Currently, in HMP Whitemoor, “Focus” accredited programmes are delivered by the Prison Psychology Department.

### *1.2.1 Drug Testing*

There are two main types of testing, Mandatory and Compact. Both are currently delivered by prison staff.

**SECTION 2**

### 2.0 Definition of the Service

a. The non prescribing drug & alcohol service will provide Tier 2 and 3 drug treatment services consistent with the NTA’s Models of Care framework.

b. The service will provide multidisciplinary drug treatment in the prison that provides a gateway to drug treatment and other services for those in custody who misuse substances or who have previously misused substances. It will include low intensity non-clinical treatment services offering a number of low - medium level interventions, which are aimed at reducing the demand for and harm from drug misuse. The Service will act as the case managers for substance misuse treatment in the prison and provide the contact point for the through-care and aftercare elements of community based Criminal Justice Intervention Teams (CJIT).

c. As a minimum, the service must include:

- A Referral System (Into the service)
- Substance Misuse Node Mapping Assessment (**5 mandatory** I-MAPS)
- Liaison with other services inside and external to the Prison Service
- The Provision of Advice and Information (including Harm Minimisation)
- Structured Care Planning (**Care Plan and I-Plan**)
- Case Review
- Structured 1:1 work
- Groupwork
- Relapse Prevention
- Transfer between prisons
- Referral to other departments or agencies
- Release Planning
- Referral to Criminal Justice Intervention Teams (CJITs) to facilitate continuity of care

e. The amount of work undertaken with an individual will depend on a number of factors including level and type of substance misuse, motivation to change, previous services used, length of sentence and access to external services on release. Services may only be delivered where consent from the prisoner has been given in writing.

**SECTION 3**

### 3.1 Aims and objectives of the service

**Aims**

a. The provider must aim to deliver a Tier 2/3 drug-treatment service, which is accessible to all prisoners and recognises the diversity of the prison population. It will provide:

- A gateway service to enable access to a range of drug-treatment and wrap-around (e.g. education, access to library, employment and skills for life) services.
- Assessment, care planning and case management within the Models of Care (MoC) framework.
- A low threshold, low to medium intensity, non-clinical substance misuse treatment service for prisoners in order to reduce the harm caused by illicit substances to themselves, others and society as a whole.

### 3.2 Objectives

a. To provide services that are delivered equitably to prisoners from all cultural, sexual and ethnic backgrounds, to prisoners with disabilities and to vulnerable prisoners.

b. To provide the same quality of service to prisoners who are poly-drug users (including alcohol) or primarily stimulant users as to those who are opiate users.

c. To motivate prisoners to engage with treatment services throughout the custodial period and on transfer.

d. To provide a timely, coordinated and comprehensive method of identifying prisoners who have substance misuse issues.

e. To assess individual needs and identify substance misuse treatment requirements

f. To assist & motivate prisoners to access drug treatment and other relevant services in prison and on release

g. To engage and provide a Tier 2/3 treatment service to prisoners who need and voluntarily accept it

h. To provide a range of accurate, relevant and factual information on drugs and their effects to prisoners, and to professionals within prisons, that is accessible and meaningful in terms of context, language, and literacy.

i. To liaise with appropriate services to ensure continuity of treatment and support, for those receiving treatment prior to custody, during custody, on transfer, including being the main lead for CJIT whilst the prisoner is in custody.

j. To reduce the levels of risk of overdose due to reduced tolerance

k. To provide information and enable prisoners to develop skills to assist in preventing relapse

l. To facilitate the prisoners move from HMP Whitemoor to other prisons with no loss or break of treatment and support.

m. The provider will ensure links to the visitors centre to ensure families/relatives receive sufficient and appropriate information and advice in respect of substance misuse services available to the prisoner, and if Cambridgeshire residents, family support services within the community. The provider will also be expected to deliver ongoing training and support to visitor centre staff/volunteers in respect of Harm Reduction advice and information to highlight the risks of attempting to supply illicit substances to prisoners.

**SECTION 4**

**4.1 Client group served**

The target group for the service is:

a. Illicit drug & alcohol misusers who are in custody and who are 18 or above.

b. The service will provide a non prescribing, drug treatment service for prisoners aged 18 or over and must cater for all types of drug user including, but not exclusively, those who use – alcohol, cannabis, stimulants, MDMA, crack and opiates.

c. The service must cater for the needs of a diverse range of drug misusers including those from Black and Minority Ethnic (BME) communities and those with varying literacy levels.

d. **Eligibility criteria:** All prisoners, over 18, who require and who voluntarily accept it are eligible to use the service.

e. **Service exclusions:** Prisoners may be excluded as a result of a professional risk assessment and if they pose a serious risk to staff, and or others. This will take into account and operate within the Prison Service's security guidance policies which will be notified to Providers from time to time.

**SECTION 5**

**5.1 Referral pathways**

**5.1.1 Access and referral**

a. The service will offer an open access low threshold service for prisoners. This may be based on self referral or referral by other prison staff.

b. The utilisation of the service is primarily voluntary but referral to the service may not always be voluntary e.g. from Sentence Planning, Mandatory Drug Testing.

c. Services must be easily accessible to prisoners and Referral Forms must be readily available. Any prisoner identified as having drug related issues/problems should be referred to the service subject to their consent, where possible.

d. Integrated Care Pathways as defined in Models of Care must be followed to ensure continuity of care between the different components of drug-treatment services. Referral Pathways must therefore be set up to ensure continuity in treatment between:

- Prison to prison
- One treatment modality to another treatment modality

e. Service providers must take into consideration and be sensitive to prisoners other activities and commitments. Care must be taken when planning appointments. Negotiations with other departments/disciplines may be required.

### 5.1.2 Initial contact and ongoing advice and support

a. Following referral a two-stage approach to assessment is commenced: the Substance Misuse Node Mapping (I-MAPs) and the Substance Misuse Care Planning (Structured Care Plan and I-PLAN). The full process involves the completion of five mandatory maps and a separate structured Substance Misuse Care Plan. A further care planning tool in the form of the I-Plan can be used to detail specific goals identified on the structured Care Plan.

b. A Substance Misuse Node Map (I-MAP) assessment must take place within three days of receipt of referral unless there is a specific reason not to do so. This involves the completion of the first three I-Maps as detailed within the current CARAT guidance document. The remaining two I-Maps must be completed within 5 working days of the date of referral unless there is a specific reason not to do so. The Care Plan must be commenced by the 5th day from initial contact with the service and completed within 15 working days. The Node Maps and Care Plan must capture the minimum information to inform treatment planning and set out the goals and aspirations of the prisoner towards an individual, recovery based treatment journey.

c. Where the prisoner declines ongoing work the following harm reduction advice must be provided as part of the screening process:

- Engaging clients to discuss harm reduction strategies and change
- Safer injecting/blood borne diseases advice if relevant
- Information on not sharing equipment, or needles
- Reduced tolerance
- Information on the various treatment programmes available in custody
- Overdose awareness, including what to do in the event of an OD
- Problems associated with drug paraphernalia (e.g. Crack pipes)

d. The information provided must be in a format relevant and appropriate to the prisoner.

### 5.1.3 Care Planning: Development of agreed goals

A care plan is not required for all prisoners who present to the service. A care plan should only be done when:

- The assessment has shown that this is the best way forward.
- The prisoner has given his/her consent.

### 5.1.4 Care co-ordination

a. The service providers will be the care coordinators for prisoners who have substance misuse problems and who wish to receive treatment. The service

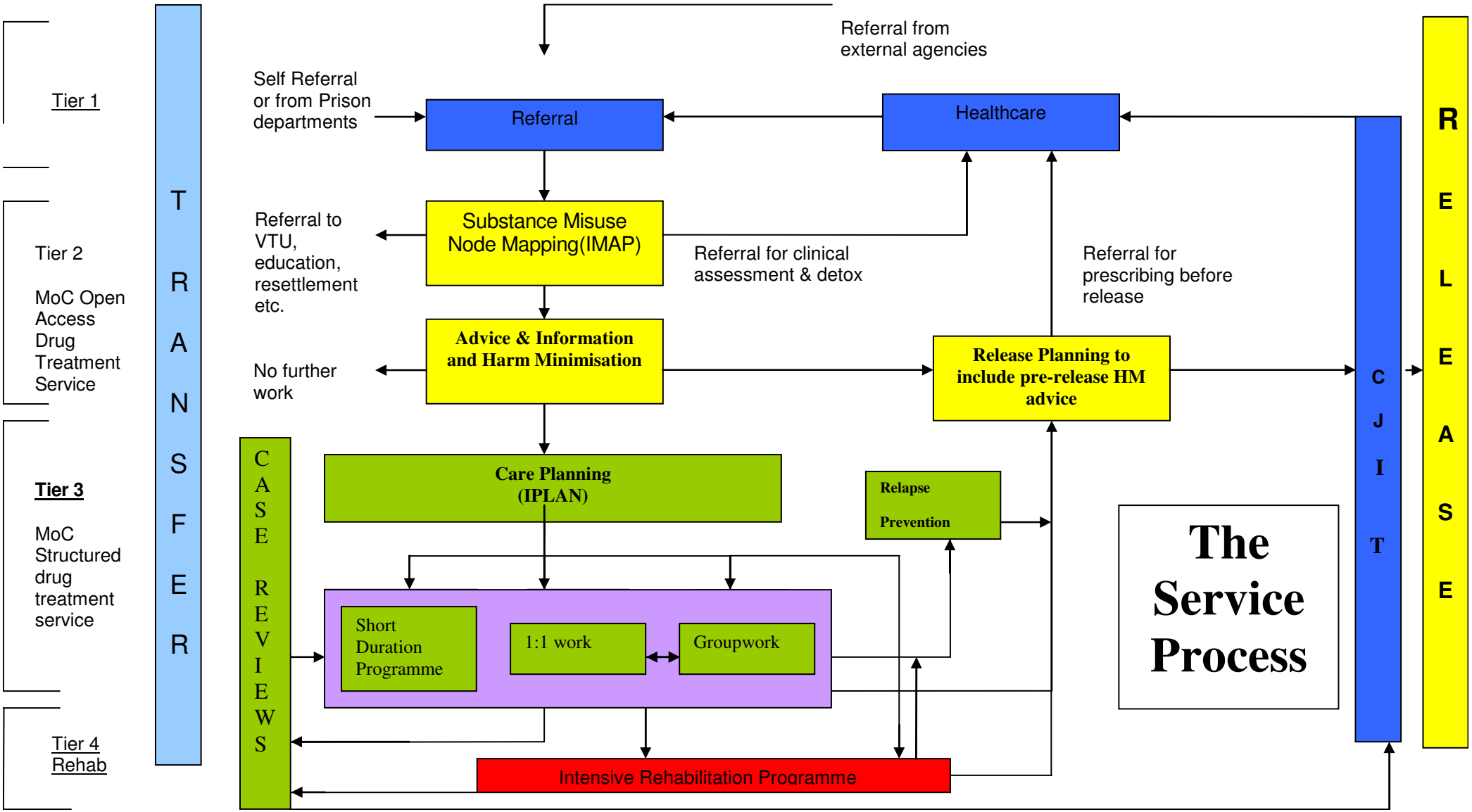
must maintain contact with every prisoner who receive drug or alcohol treatment interventions.

b. The service must liaise with IDTS (Integrated Drug Treatment System) clinical services in prisons to ensure continuity of care. This will entail engaging with and maintaining contact with those prisoners who are undergoing clinical treatment at any stage of their sentence. Relevant information may be shared between the prescribing and non prescribing services with the consent of the prisoner.

c. If the prisoner has been referred to a prison based intensive treatment programme (tier 4), the service provider must ensure that relevant information is passed to the programme workers. Programme staff must have access to information on the providers' files where this is appropriate to providing ongoing treatment and with the prisoners consent. The provider should continue engagement with the prisoner during the programme by attendance at case reviews. On completion of the programme, the service provider should maintain engagement with the prisoner. Any prisoner who leaves a programme prematurely must be given the opportunity to re-engage with the service at the earliest possible time.

**SECTION 6**

## Process, Description of services, care and interventions provided



### 6.1 Process, Description of services, care and interventions provided

#### *6.1.1 Component elements of the non prescribing services;*

i. Referral System
ii. Substance Misuse Assessment
iii. Liaison with services inside and external to the Prison Service
iv. Advice and Information
v. Comprehensive Substance Misuse Assessment
vi. Care Planning and Case Review
vii. Structured 1:1 work
viii. Groupwork
x. Relapse Prevention
xi. Transfer between prisons
xii. Referral (out from the service)
xiii. Release Planning

### 6.2 Casework system

The current CARAT service has a national casework system that should be used when providing the service. These are currently in the process of being updated and consists of a casework file that holds:

- A Confidentiality Form CF1
- A Referral form RF1
- Substance Misuse Node Maps x 2
- A Casework Record sheet CR1
- Care Plan Node Maps x 3
- Written Care Plan CP1
- A Transfer Plan TP1
- A Release Plan RP1
- A Research Sheet RS1
- Other information/correspondence relating to the case

### 6.3 Definition, goal and outcome of each component

#### 6.3.1 Referral System (into the service)

A referral Form – RF1 – will be used to refer into the service. The referral system will allow:

**i. Open access to the service**

- For anyone identified or identifying themselves as having a substance misuse problem a referral to the service will be made with the agreement of the prisoner where possible.
- The service must easily be accessible to prisoners

- The service will be responsible for ensuring Reception and other departments are provided with regular information and equipped with leaflets and referral forms in respect of services provided
- The service provider must complete the required Activity Minimum Data Set forms to record all structured treatment interventions on DIRWeb
- The service will be responsible for publicising and marketing the service to raise awareness for both prisoners and staff.
- The service provider must have a system in place to be able to accept referrals from a wide range of sources. This will include self, CJIT, healthcare, Sentence Planning and OASys and MDT.
- Healthcare should, with prisoners consent, refer all those identified with drug misuse issues to the service. This will be especially important for those on maintenance prescribing.

**ii. Substance Misuse Node Mapping (I-MAP)**

- A Substance Misuse Node Mapping assessment document (5 mandatory I-MAPs) must be used to conduct and record this piece of work.
- For all referrals I-MAP must be offered and conducted following the consent of the prisoner**.** For those who return to prison within six months (Revolving Door Prisoners) it may be more appropriate to review the file and offer an assessment review where past CARATs files are available. A common sense approach will be expected to be taken. Revolving door prisoners will however count as a new contact. (See Practice Manual for more information)
- This assessment serves as a filtering process, and is designed to quickly establish which intervention or tier of service would best suit an individual. Referrals at this point can be made to healthcare but not to Intensive Programmes, as these require the comprehensive assessment.
- Node Mapping will allow a timely assessment of the needs of those who are referred and it will enable:
    - Identification of immediate risks
    - Risk assessment
    - Assessment of client motivation
    - Assessment of drug/alcohol use
    - Assessment of social problems
    - Indication of need and referral of psychological problems, physical problems, and of legal problems
    - Suitability for referral to drug programmes
    - Suitability for referral to further non prescribing treatment interventions
    - Identification of need for clinical services
- All I-MAPs must be conducted within a 5-day time span (24 hrs for SCI, and 3 days for CJIT clients) from referral received unless there is a specific reason not to do so.
- The working concepts of Confidentiality and Informed Consent must be respected and adhered to (see section 8 for further information). A copy of the Confidentiality Form must be sent to Healthcare for all prisoners engaging with the service and this must be noted within the service case notes. If no ongoing work is required from the

non prescribing service, after the I-MAP, this must be noted. Referrals to other departments in the prison must also be noted.

**iii. Refusals to engage**

- Where a prisoner declines the offer of a drug & alcohol assessment the prisoner will be asked to sign a disclaimer. Where the client refuses to sign the disclaimer this should be noted on the disclaimer.

  The service provider will inform the prisoner that he will be offered another date for an assessment in one month time (this is to take into account that the prisoner may not be ready for engaging in treatment at present but may want to engage later) The date will be noted on the disclaimer.
- Where the client has been in contact with community agencies and where the prisoner gives consent, the service provider will liaise with those agencies to ensure appropriate information sharing and joint planning.

**iv. Liaison with other services inside and external to the Prison Service**

a. Contact with other agencies must be recorded on the Casework Record sheet – CR1.

b. The service must (subject to the prisoners consent) be the linkage between other services within the Prison Service and those external to the service. This will include connecting:
   - Other units/departments within establishments (Healthcare etc)
   - Other establishments upon transfer
   - Prisons with CJIT
   - With and be an integral part of the Sentence Planning process
   - Resettlement teams

c. Healthcare (IDTS) will be a key referral point and source for communication particularly in the local prisons and it is mandatory for establishments/areas to have protocols in place to ensure that an effective relationship exists between Healthcare and the service to deliver this. PSO 3550 (Clinical Services for Substance Misusers Annex F) and PSI 25/2002 (Promotion of Healthcare: The Protection and Use of Confidential Health Information in Prisons and Interagency Information Sharing Annex G) should inform this process.

**v. Provision of advice and information**

a. The Casework Record sheet – CR1 – must be used to record details of contact and content of meeting.

b. The provision of advice and information entails providing “accurate, appropriate and factual information, which is accessible and meaningful (in terms of context, language and comprehensibility) to the recipient” (MoC)

c. Advice and information is a core element of the service. It should always be structured and planned. The aim is to provide up to date information on all aspects

of drugs and alcohol misuse including relevant harm minimisation advice and information on drug services, and other appropriate services.

d. Advice and information may be provided through a number of means and using a variety of resources. Communication media may be verbal, written, audio, visual, telephone or face-to-face. Advice and information must be provided on any relevant issues identified in the Node Mapping assessment stage.

e. For all clients who present with a substance misuse problem (and for those who may not be seen again) essential harm minimisation information must be provided at the first meeting (i.e. at the first stage of substance misuse assessment). This may be followed up with further harm minimisation/information if time allows at subsequent meetings

f. A checklist must be used to prioritise what information may need to be given at the first meeting (see Practice Manual). Services and interventions provided can include, but are not limited to the following:

- Advice and information on the wide range of drugs, their effects; drug related problems and the minimisation of drug related harm. This should take into account the particular risks of the primary drug, other drugs used and poly-drug use.
- Advice and support for the reduction of drug related harm and health promotion advice. This includes advice on a wide range of issues including safer drug use, overdose prevention, blood borne infections, and safer sex, alcohol misuse, etc.
- Advice and support for the prevention of drug related death (immediate death from overdose and long term from blood borne infections)
- Information about available treatment and care with reference to tier 2, 3 and 4 drug treatment services, as appropriate.
- Motivating users for Focus programme for change and enhancing treatment readiness.
- Referral to other services (e.g. housing, welfare benefits and legal advice)
- HIV and hepatitis testing advice or referral to appropriate services
- Reinforcement of the harm reduction messages on a regular basis.

g. For all the above the diverse needs of the population must be taken into account.

h. The Practice Manual and assessment form will provide further direction on what information will be prioritised/ given.

**vi. Care Planning (I-PLAN) and Case Review**

a. Node Mapping (I-PLAN) where required and a Care Plan form – CP1 must be used in this piece of work; Case Reviews must be recorded on Casework Record – CR1.

b. The I-Maps should lead to the development of a Care Plan tailored to the specific needs of the individual and may include a number of structured one to one sessions, group-work sessions and/or referral to an intensive treatment programme. Any work following Care Planning must be structured with a clear set of objectives and must be reviewed at regular intervals. **Unstructured key work sessions that are not related to objectives within the Care Plan should be formally documented within the case notes and recorded as such.** The requirement for case

reviewing can only be met by the inclusion in the Care Plan of 1:1 meeting(s) for this purpose.

c. The principles of Care Planning and care co-ordination are outlined in depth in Models of Care (Section 1.4). The goal of Care Planning is to ensure a system of care that is flexible enough to be able to pull together and respond to individual requirements over time and across different organisations and treatment modalities.

d. Care Planning is a systems approach whereby those who have accessed services are offered a systematic approach to their treatment rather than disconnected episodes of treatment.

e. Effective Care planning systems must not be rigid but should be client focussed and flexible. The overarching principle of Care Planning and care coordination is that prisoners who enter structured drug services in prison (Tier 3 structured service and/or other Tier 3 programme) receive a Care Plan, which is agreed with the prisoner. Referrals must not be made in isolation and must be subject to client consent. Any Care Plan or assessment information of relevance must follow the client to the other modalities of care. Care Plan objectives must be SMART-Specific, Measurable, Achievable, Realistic and Time Bound.

f. Up to date Care Plans must be signed by the prisoner and must be made available if requested by that prisoner.

g. Consent must be obtained from the client *prior* to any alteration to the Care Plan. The Casework File must be noted accordingly.

h. A Care Plan Review should take place after a maximum of six 1:1 sessions and/or on completion of groupwork or a programme or at a minimum of six weeks, whichever is the sooner. Additionally reviews can take place at the request of the service provider or the prisoner. The date of the next review meeting should be set and recorded at each meeting. In reviewing the Care Plan the following should be assessed:

- The relevance of the Care Plan
- The effectiveness of Care Plans/outcomes
- Any unmet needs
- Client satisfaction with the care

i. Where appropriate, and with the consent of the prisoner, key parties (Probation, CJIT and families) should be invited to participate and be involved in the Care Plan Review process.

### 6.3.2 Structured One to One work

a. All contacts must be recorded on the Casework Record – CR1.

b. One to one work consists of providing support, advice and information to a prisoner on a one to one basis. Support can range from having regular or irregular contact depending on need. One to one work prior to Care Planning may be limited to providing advice, information and support.

c. Structured One to One work with the prisoner should be included in the care plan. The following activities may be included in one to one work and focus on Recovery based interventions:

- Motivational Interviewing
- Solution Focussed Therapy
- Focussed Harm reduction initiatives
- Brief Therapy
- Low level counselling
- Relapse Prevention
- Advice information and signposting

(See Practice Manual for further details)

### 6.3.3 Groupwork [CR1]

a. Details of Groupwork attendance must be recorded on Casework Record – CR1.

b. Groupwork enables the provision of short, semi-intensive and structured support. It should not be seen as a replacement for long-term intensive rehabilitation programmes. It allows prisoners to obtain valuable mutual support and allow them to share information and experiences with others going through similar life experiences.

c. Examples of group work may include relapse prevention work, drug awareness etc or can include peer support groups. Further guidance on this will be available in the Practice Manual but it must be either validated by an external body or seek internal validation from the prison strategic drug lead in line with PSO 4350 Effective Regime Interventions (Annex H).

d. PSO 4350 –Effective Regime Interventions (Annex H) sets out the full criteria and process relating to groupwork internal validation. In scope for the PSO are all groupwork interventions with a primary or major objective to change prisoners' behaviour where the intervention has not been approved or rejected by an independent external body.

e. The nine criteria that must be met by structured groupwork to obtain approval are:

1) Objectives –the purpose the intervention sets out to achieve
2) Rationale – why the methods set out can be expected to achieve the objectives
3) Structure – what the intervention will do; how it will do it; and, if appropriate, its sequence and intensity
4) Selection – the target group for whom the intervention is designed, how they will be assessed and selected
5) Achievement – how outcomes for prisoners will be assessed and recognised, including feedback from prisoners
6) Scale and Costs – how many places are to be provided and what the intervention will cost over and above the normal cost of the Services.
7) Staff selection, competence, management and support – Using relevant and recognised competencies.
8) Records, monitoring and audit – what records will be kept, how they will be used and what steps will be taken to ensure practice follows what has been approved
9) Evaluation – how the intervention's overall success at achieving its objectives will be assessed. This is broader than "achievement" which is concerned solely with outcomes for participants.

### 6.3.4 Care Plan

a. An opened Care Plan should be continued throughout the programme

b. Attendance of the case worker will also be required at the prisoner review meetings.

### 6.3.5 Throughcare

The service provider should work with prisoners throughout the programme on continuity and resettlement issues. This should involve at least two 1:1 contacts to address throughcare issues.

### 6.3.6 Relapse Prevention

a. All contact must be recorded on the Casework Record – CR1.

b. Relapse Prevention may be carried out, as part of Groupwork and/or structured one to one work or it could stand alone as a component session. It will be particularly appropriate for those leaving structured treatment programmes and/or structured intensive rehabilitation programmes.

c. The depth of relapse prevention work will depend on an individual's needs and the time and length of sentence left to serve. Its content will also depend on previous work carried out on any programme the prisoner has participated in. Relapse Prevention where possible must be provided to all those leaving custody as well as those leaving prison rehabilitation programmes. Further details are provided in the practice manual.

### 6.3.7 Transfer between prisons

A Transfer Plan – TP1 must be used to conduct and record this piece of work.

a. In the context of this service, this entails managing prisoners' transfers out to other establishments effectively and also efficiently managing transfer in from another establishment by ensuring that there is as little or no break or loss in treatment or support. Transfer Plan (TP1) must be used for this process.

b. Clients may be transferred to another establishment at any point of their time in prison. Transfer may be either planned (in which case Observation Categorisation & Allocation (OCA) should always inform the service provider in advance) or unplanned (due to overcrowding, security etc) in which event OCA should inform the service provider at the earliest opportunity. Where a prisoner on remand is sent to a different establishment following a court appearance the file must be transferred to the new establishment. The service provider will need to establish a system to track those on remand. Where CJIT court teams are in place they are required to notify the service provider in the initial establishment of the change.

c. Mechanisms must be in place to ensure that casework files are sent to the receiving establishment as the prisoner is transferred and checks are in place to ensure the successful and speedy receipt of these. A transfer plan must be completed and the Case File be placed in a sealed envelope (using a 'confidential' envelope) and put in the Prisoner Core Record to accompany the prisoner. Where this is not possible then files must be sent by **Registered Delivery** within 5 days of transfer. In all cases the receiving prison's assessment or referral teams must be notified, by email to the team Single Point

of Contact (SPoC), of all incoming transferees by the sending prison. All CJIT clients must have any transfers notified to the CJIT by the appropriate means and a record of this contact appended to the case file.

d. Incoming transferees must be seen by the service provider in the receiving establishment within 5 days of notification of transfer or arrival into the incoming establishment.

e. It is important to note that if clients are to be transferred (planned) from their local prison following a triage assessment then a Comprehensive Assessment and Care Planning should commence at the receiving prison and not at the local prison. If transfer takes place at any point it is important that casework follows the client promptly.

### 6.3.8 Referral (out from service)

a. Details of contact and referral to other agencies must be recorded on the Casework Record – CR1.

b. The service provider must have a system in place to be able to refer to other relevant services both in custody and to external services. This will include to Healthcare, Voluntary Testing (VT), Rehab Programmes, and Resettlement Units in custody and to CJIT or other treatment providers in the community. The service will use the referral process to identify prisoners for other services and further work. Any referrals to drug rehabilitation programmes must be after Care Planning has been initiated. Local Protocols must be in place to assist this process. The service provider must retain responsibility for case managing prisoners. Where CJIT is in place it will be a key referral source for ongoing treatment and wraparound services in the community. Further details on this are provided under Release planning and in the practice manual.

c. The service provider must have a system in place that allows them to refer to and from Resettlement Teams to ensure resettlement plans are coordinated and not duplicated.

d. The referral system out will allow:

- Identification of other services that may be appropriate to prisoners
- Identification of prisoners who require other further work
- Identification of referrals required for release

### 6.3.9 Release Planning

a. Release Plan – RP1 - must be used to conduct release planning.

b. Release planning must be initiated as early on in the sentence as possible but as an absolute minimum Release planning should take place no later than three weeks before release where possible.

c. Its aim is to ensure that there is a bridge between drug treatment services in custody and those in the community. Where CJIT is in place the service provider will need to ensure that they are involved in determining the release plan.

d. The service provider will be responsible for drawing up Release Plans and will include CJIT teams where possible. All prisoners engaged with the service will have a release plan drawn up which should be signed by the prisoner before information is released to the community. This information must be shared with other relevant bodies, i.e. CJIT, probation, resettlement departments and must not conflict with any licence conditions. With the development of Integrated Offender Management within the community, there may also be a requirement to share relevant and appropriate information with the IOM lead (Probation/Police) for those prisoners serving less than 12 months in custody. Further guidance is detailed in the practice manual.

e. The service provider is responsible for arranging release-planning reviews. Release planning should where possible be carried out in conjunction with outside providers.

f. When the prisoner is approaching release they must receive harm reduction work on the dangers of reduced tolerance and risk of overdose. Standard protocols will be provided on good practice and where possible this will be linked to local practice

g. The service provider will have a facilitative role in ensuring the prisoner's drug misuse is linked to the wider resettlement agenda such as housing, employment, education and family. The service provider will be responsible for ensuring that appropriate departments within the prison and Custody to Work (C2W), Progress to Work (P2W) etc are utilised for this function and that cases are delegated appropriately. Further details are provided in the Practice manual.

## SECTION 7

### 7.0 Performance monitoring

The service provider will be monitored monthly in accordance with the measures highlighted in section 3A.

# Glossary of terms

| | |
|---|---|
| CAF | Common Assessment Framework |
| CARAT | Counselling, Advice, Referral, Assessment and Throughcare |
| CAS | Cambridge Access Surgery |
| CASUS | Cambridgeshire Adolescent Substance Use Service |
| CJIT | Criminal Justice Intervention Teams |
| CCF | (Ex CARAT) Case File |
| C2W | Custody to Work |
| DAAT | Drug and Alcohol Action Team |
| DANOS | Drug and Alcohol National Occupational Standards |
| DIP | Drug Intervention Programmes |
| DoH | Department of Health |
| DRR | Drug Rehabilitation Requirement |
| DST | Drug Strategy Team |
| EDSM/C | Establishment Drug Strategy Manager/Coordinator |
| ETE | Education, Training and Employment |
| GP | General Practitioner |
| ITEP | International Treatment Effectiveness Project |
| LPC | Local Pharmacy Committee |
| LSCB | Local Safeguarding Children Board |
| MARAC | Multi Agency Risk Assessment Conference |
| MARU | Multi Agency Referral Unit |
| MAPPA | Multi Agency Public Protection Arrangements |
| MUSE | Monitoring Unit for Substances in the East |
| MoC | Models of Care |
| NDTMS | National Drug Treatment Monitoring System |
| NEX | Needle Exchange |
| NTA | National Treatment Agency |
| OCA | Observation Categorisation Allocation |
| OCU | Opiate and Cocaine User |
| PSO | Prison Service Order |
| PSI | Prison Service Instruction |
| P2W | Progress to Work |
| QuADS | Quality in Alcohol and Drug Services |
| RCGP | Royal College of General Practitioners |
| SMART | Specific, Measurable, Achievable, Realistic, Time bound |
| SDP | Structured Day Programme |
| SPoC | Single Point of Contact |

| | |
|---|---|
| SOVA | Safeguarding Of Vulnerable Adults |
| TOP | Treatment Outcomes Profile |
| VDOD | Voluntary Drug Testing On Detention |

# APPENDICES

## Appendix 1: Pregnancy liaison

*This is taken from the 'DAAT Safeguarding Practice Guidance*[21] *'Working with substance misusers who are pregnant'*

Service provision for pregnancy liaison should adhere to the principles and practice set out in this document.

Experienced practitioners report that most drug/alcohol using women have similar attitudes and motivations to pregnancy as non drug/alcohol using women; and it is important to note that most women with drug/alcohol problems are of childbearing age. However, those with drug/alcohol problems may also have poor general health, housing and financial problems.

Some pregnant drug/alcohol users do not come for antenatal care until late in pregnancy or when they are in labour. There are many reasons why drug/alcohol-using women may present late to antenatal services. The local service may not be able to meet their specific needs or it may be perceived to be inaccessible, their drug/alcohol use may place other demands on their time, which often take priority for the user. Some may feel that it is better not to reveal their drug/alcohol use to antenatal care staff as they fear the attitudes of staff and the possible involvement of statutory services.

Also due to the possibility of amenorrhoea caused by the drug/alcohol use, the woman may not know that she is pregnant, or may not be clear about the duration of the pregnancy. Many of these problems can be overcome if an appropriate service, which meets the needs of drug/alcohol-using women, is available, easily accessible and well publicised.

Agencies in the community can play a key role in supporting these women in range of ways. This includes identifying drug/alcohol use / pregnancy at an early stage, referring on to appropriate help and support, identifying risks, and providing support and advice around pregnancy and/or drug/alcohol use.

**Antenatal assessment and care**

Where appropriate drug/alcohol agencies and other agencies should offer and carry out a pregnancy test with the consent of the woman. If the woman is pregnant she should be encouraged to inform her GP as soon as possible and/or referred to Maternity Services.

Please refer to Appendix 8 (of the practice guidance) for factors to be considered when working with pregnant women who also substance misusers.

As a result of this assessment an analysis of risk will take place using Appendix 8 (of the practice guidance) which will determine the care plan. It is recognised that assessment is an on-going process and practitioners must ensure that the other key professionals involved with the women are aware of the following in line with confidentiality agreements:

- Changes in amounts, patterns, or routes of administration (injecting/smoking) of drug/alcohol us
- Changes in accommodation
- Changes in relationships / support networks

[21] http://cambsdaat.org/?q=content/safeguarding-children

A multi-agency meeting may be called at any point during the course of the pregnancy to coordinate the care plan.

Pregnancy and birth should be as 'typical' as possible however the social and medical problems that some drug/alcohol users face should be recognised: given the possibility of drug/alcohol related effects on the unborn baby, a visit to the Neonatal Intensive Care Unit (NICU) should be offered to all pregnant women who misuse drugs/alcohol; problematic users may find it difficult to keep appointments and services need to be flexible and antenatal care arranged to attract and retain the woman and her partner. This may include shared care with the GP, and/or the linked Health Visitor (who are often the first professionals to know that a drug/alcohol user is pregnant).

Within Maternity Services and drug/alcohol services a senior staff member should be identified to take responsibility for co-ordinating good practice in the care of pregnant drug/alcohol users and/or drug/alcohol users with dependent children. Regular meetings should be held between Maternity Services, Children's Services, drug/alcohol agencies and Primary Care to discuss further improvements to existing service provision. Agencies should develop an internal policy on how they work with women who misuse drugs and this policy should complement this best practice document.

**Planning meetings**

A planning meeting for the expectant mother may be called at any time to update and coordinate the multi-agency care plan. A meeting should always be held between the twenty eighth week and thirty-second week of the pregnancy to discuss the mother's and baby's needs for the last part of the pregnancy and after the birth. The meeting should look at the needs of the woman, the father and baby; and identify any likely problems, and the services that parent(s) need to care for the new baby. It is important to note that the birth of the baby may create further problems, particularly if there is an unstable relationship or financial or housing difficulties.

A decision on whether a Pre-Birth Child Protection Conference is required can also be made at this meeting. Children's Services, the GP, health visitor, staff from the maternity and neonatal services and drug/alcohol agencies, with the prospective parent or parents/family may be invited.

**Prescribing during pregnancy**

Some patients want to give up using drugs/alcohol when they become pregnant. However, this does not always happen. It is important to be flexible and respond quickly to changing use. All treatment options should be client led and therefore discussed with the woman (and her partner) and where possible their views should be taken into account.

Appropriate drug/alcohol treatment will depend on the amount and types of drugs/alcohol used, as well as the patient's motivation, current situation and past history. The care plan should aim to reduce risks to both parent and unborn child. Prescribing substitute or maintenance drugs should be carried out in conjunction with the drug/alcohol agency and Obstetrics Team. NICE guidance allows in certain circumstances, Nicotine Replacement Therapy to be prescribed.

**Labour**

Prescribed substitute medication (e.g. methadone) should be given in addition to routine pain relief. A medical alcohol detoxification regime may need to be considered on admission for dependant drinkers.

**After the birth**

The mother and baby should be admitted to the postnatal ward together. Neonatal admission will only occur if prematurity or a medical condition merits it.

- Encourage attachment and bonding – encourage positive parenting, swaddling and comforting the baby.
- Observe for signs of withdrawal. It is highly unusual for a baby to have withdrawal at birth. These symptoms may start soon after the birth, peak at four days and disappear by two weeks Benzodiazapines and methadone withdrawal symptoms may present later.
- Breast-feeding should be encouraged, as with any mother, so long as the drug and/or alcohol use is stable and the baby is weaned slowly. The actual amount of drug that is passed into baby is low and, in general, the advantages of breast-feeding far outweigh the disadvantages.
- Women who use crack cocaine or large quantities of Benzodiazapines may be advised not to breastfeed. Hepatitis B and Hepatitis C infection poses no additional risk to baby. Women who are HIV positive are advised not to breast feed due to the risk of transmission.
- If a mother discloses her drug use during labour or post birth the Specialist Midwife in Substance Use and/or the local Alcohol and Drug Team should be contacted immediately to discuss treatment options for mother so that she is more likely to stay on the ward. Observations of withdrawal are same as any baby. A multi-agency group should make an assessment of her home circumstances and support networks as soon as possible.
- The mother should be supported and encouraged to stay with her baby and to parent.
- Liaise with all agencies pre discharge
- Support postnatal from Midwifery Service, drug and/or alcohol agencies and Health Visitor
- Continue with any care plans in relation to the child (e.g. child protection or children in need).

# Appendix 2: Existing Clinical Waste Service Level Agreement

## Section 3 – Objective of Service Provision

3.1 To deliver safe handling, collection and disposal of clinical waste across the County of Cambridgeshire in line with current legislation and procedures.

3.2 The aim of a safe handling, collection and disposal system is to ensure that all clinical waste materials are removed from their point of generation at regular intervals and transported to the appropriate point of disposal for removal and subsequent incineration.

3.3 Frequency of collections and locations of collections sites will be determined by the Drug and Alcohol Action Team (DAAT) based on the current services provision.

3.4 Clinical waste it is defined, within the Controlled Waste Regulations 1992, as any waste:

- which consists wholly or partly of human or animal tissue, blood or other body fluids, excretions, drugs or other pharmaceutical products, swabs or dressings, or syringes, needles or other sharp instruments, being waste which unless rendered safe may prove hazardous to any other person coming into contact with it;

- arising from medical, nursing, dental, veterinary, pharmaceutical or similar practice, investigation, treatment, care teaching or research, or the collection of blood for transfusion, being waste which may cause infection to any person coming into contact with it.

Waste likely to be produced in by a special treatments business may include syringes, tattoo needles, soiled tissues and swabs and other similar materials.

3.5 For the purpose of this Service Level Agreement the clinical waste definition will be defined as all waste generated from participation in the Cambridgeshire Needle Exchange Scheme and is likely to be produced by pharmacies and agencies/bodies cooperating with Cambridgeshire Substance-Misuse services (i.e. sharps and wastes whose collection and disposal is subject to special arrangements in order to prevent infection).

## Section 4 – Provision

4.1 The Service Provider must be satisfied that the packaging is intact before removing the waste from designated premises.

4.2 Service Provider's driver/person collecting the waste shall instruct the staff on collection sites that the clinical waste bags must never be overfilled (two thirds full or less) not to make the closure and handling of the bag difficult.

4.3 Service Provider's driver/person collecting the waste must ensure that Sharps (Group B) are placed in a purpose made yellow rigid sharps container made to BS 7320 and UN3291 standard.

4.4 Only trained and authorised staff, suitably equipped, should handle infectious and potentially infectious waste, making it safe by containing the waste within yellow plastic bags or containers or by autoclaving, and finally incinerating the waste.

4.5 Service Provider's driver/person collecting the waste must be aware that only an authorised person should permit waste to leave the premises for final disposal and she/he must ensure that such waste is contained in yellow containers or bags. The authorised staff member is the person that drivers shall liaise with.

4.6 Service Provider's driver/person collecting the waste muse ensure that producer of waste clearly marked and displayed the origin of the waste (i.e. name of pharmacy, surgery or health centre and department) either by a permanent marker on the bag or a pre-printed label and that it is dated.

4.7 Service Provider's driver/person collecting the waste must check that the stored bags are effectively sealed at the beginning and end of the movement.

4.8 Service Provider's driver/person collecting the waste must handle bags by the neck only and never throw or drop them.

4.9 Service Provider's driver/person collecting the waste must know and follow the procedure in case of accidental spillage or sharps injury.

4.10 Service Provider's driver/person collecting the waste must report all accidents and incidents.

4.11 Service Provider must keep an up to date and accurate record of all movements of waste and collections made. These records must be kept in a register which must be retained for at least three years.

4.11.1 The record should include two copies of filled in Service Record Cards (please refer to Appendix 2) per each location. One is to be retained by the collection site and second shall be kept by SRCL and shared with the DAAT when required.

4.11.2 The Service Record Card should include:

- name of the location,
- address of the location,
- date of the service provided,
- number of units collected,
- type of units collected,
- service frequency,
- date of the next collection,
- DAAT telephone number – for queries regarding the contract, service delivery, collection frequency,
- Service Provider's telephone number
- Name and signature of the authorised person on collection site,
- Name and signature of the Service Provider's driver/person collecting the waste.

4.11.3 Copies of Service Collection Cards should be shared with the authorised person on the collection site. Those may be shared with the DAAT for administration, monitoring and commissioning purposes.

4.12 The Service Provider can arrange additional collections if requested at a particular site but only through communication with the DAAT and with DAAT's approval. In this case the Service Provider would require at least 48 hours notice and additional collection will be arranged only if it fits to the collection day schedule.

4.13 The Service Provider shall advise the site authorised person's to contact the DAAT contact officer when any alterations to the service are required.

**Section 5 - Responsibilities**

5.1 The Service Provider must be a registered carrier of waste.

5.2 The Service Provider must provide the DAAT with copies of all relevant documents or permits and confirm whether the waste management site permit allows for particular waste stream.

5.3 The Service Provider must inform the DAAT about any variations or transfer of rights to documents or permits allowing the Service Provider legal and safe service delivery.

5.4 The Service provider must inform the DAAT about any changes to its policies, procedures or operating conditions.

5.5 The Service Provider shall operate and deliver the service in accordance with duty of care and all relevant clinical waste handling and disposal procedures.

5.6 All clinical waste handling and disposal procedures of Service Provider must comply with:

- The Controlled Waste Regulations;
- The Environmental Protection Act including the Duty of Care Regulations;
- The Carriage of Dangerous Goods Regulations;
- The Hazardous Waste Regulations.

5.7 The Service Provider shall provide updates to the DAAT on a monthly basis regarding the following:

- the numbers of sites where no collection was made;
- locations of sites where service needs to be adjusted;
- any relevant feedback on the service delivery obtained from authorised persons on collection sites.

**Section 6 – Joint Responsibilities**

6.1 The parties must ensure regular liaison to confirm handling, collection and disposal systems are set up and monitored properly providing they continue to run service effectively.

6.2 Liaison includes Service Provider meetings on a quarterly basis as well as written reports/quality monitoring audits and financial statements upon request from Cambridgeshire Drug and Alcohol Action Team.

6.3 The DAAT will inform the Service Provider about any changes to the collection sites locations (.i.e. increase or decrease in the number of sites) or the frequency of collections required at particular site while Service Provider will adjust the service accordingly.

6.4 On monthly basis the Service Provider will provide the DAAT with the list of collections planned for the month ahead to allow them to be shared with pharmacies/surgeries/other collection sites.

# Appendix 3: Existing GP Shared Care Service Level Agreement

## 1. Purpose of Agreement

**This agreement outlines the service to be provided by the GP practice, called a GP Shared Care service for Drug Misuse.**

## 2. Duration of Agreement

This agreement is for a period of xxxxxxx, commencing xxxxxx and ending on xxxxx. This agreement will be reviewed and may be amended as a result for after this date.

## 3. Introduction

This service level agreement (SLA) outlines the more specialised services to be provided by those practices entering into a shared care arrangement with [Service] for the practice patients with drug misuse problems. This is in addition to the essential patient services already being provided for those patients registered with the practice.

## 4. Background

‘’Treatment reduces the harms caused by drug misuse to individuals, public health, and community safety. The Home Office estimates that there are approximately 332,000 problematic drug users in England…..Our task is to improve the quality of treatment in order to maximise the benefit to individuals, families and communities’’ (DoH, 2009)

There is a need for local agencies to ensure that drug treatment services delivered are effective, appropriate and accessible to the needs of the population. The treatment model promoted by [Service] is based on the recovery model; enabling service users to move through a system and support them to integrate into society.

At present there are many, very stable service users being maintained within [Service] Specialist Prescribing service, who could be more effectively and appropriately managed in primary care with the support of a specialist nurse.

## 5. Service outline

The following elements of the service would need to be in place already for the purpose of this SLA:

(i) ) a good knowledge of, and effective liaison with, local drug services and other agencies, both statutory and non-statutory.

(ii) links between local pharmacies, social services (including the Child Protection Service) and local mental and clinical health teams.

This SLA will fund practices to be able to:

(i) develop and co-ordinate the care of drug users and develop practice guidelines.

(ii) treat dependent drug users with support. This will be with support from [Service] shared care nurses, local GPswSIs, and Consultant Psychiatrist. It includes the prescribing of substitute (opiate and non-opiate) drugs or antagonists using best practice as outlined in the Department of Health's 'Drug misuse and dependence' clinical guidelines.

(iii) participate in structured drug treatment following specialist assessment and deliver holistic treatment according to a care plan, with clear goals, which is reviewed regularly with the patient.

(iv) participate in audit of prescribing practice

(v) act as a resource to practice colleagues in the care of drug users

(vi) demonstrate additional training and continuing professional development. RCGP Level 1 training: Certificate in the Management in Drug Misuse should be completed by at least one practice GP; this training is arranged and paid for by [Service].

(vii) maintain the safety and training of clinical and non-clinical staff

An annual review of service will be made to include the following:

(i) attendance rates
(ii) non-attendance rates
(iii) review against outcomes
(iv) financial review.

**6. Accreditation**

Those doctors who have previously provided services similar to those stipulated by this SLA and who have such continuing medical experience, training and competence as is necessary to enable them to contract for this service shall be deemed professionally qualified to do so.

A practitioner providing services in drugs misuse should have the skills to:

(i) identify and treat the common complications of drug misuse

(ii) carry out an assessment of a patient's drug use

(iii) provide harm reduction advice to a current drug user or his or her family

(iv) test (or refer for testing) for other viruses, including HIV, and immunisation for hepatitis B to at-risk individuals

(v) provide drug information to carers and users as to the effects, harms and treatment options for various common drugs of use

(vi) assess and refer appropriately, patients for drug misuse substitution treatment

(vii) utilise the range of commonly used treatment options available for treatment including pharmacological interventions

(viii) be aware of local policy

(ix) work in an appropriate multidisciplinary manner.

NB All of the above points are covered in the RCGP Level 1 certificate

**7. CPD requirements**

It is expected that the level of training required for a GP providing this service is identified in the GP's personal development plan and, where additional training is required, local mechanisms are found to address this.

**8. Submission of Activity**

Practices must submit quarterly activity in the prescribed format provided by <Specialist Treatment Provider> in accordance with the following invoice periods:

Payment will be made on the rate of £250.00 per patient per annum (i.e. £62.50 per patient per quarter). If the patient's treatment is completed or finishes at any point during the invoice period, the full quarterly amount will still be paid to the practice.

**NB invoices for each period must be submitted for payment no later than three months after the invoice period has ended.**

All data is subject to validation by [Service].

The timescale above is reflective of the end of the current xxxx arrangement that some practices had with the PCT.

Those practices not included in the xxxx but who have been involved in shared care with <Specialist Treatment Provider>, are able to invoice for the period xxxx –xxxxx at the above rate. Please ensure that invoices are submitted for this period no later than xxxx or they will not be processed.

**9. Termination**

Should either party wish to terminate this agreement, a minimum period of 3 months notice must be provided in writing.

**Signatories to the Agreement**

**Signed by ……Date……**

On behalf of

[Service].

**……..(**Insert practice name) agrees to participate in the Service Level Agreement as outlined within this contract.

**Signed by ……Date……**

Name ……

Authorised Signatory

## Appendix 4: Supervised Consumption

## Part A Supervised Consumption Service Level Agreement

# 20XX/20XX

# Service Level Agreement for the Provision of Supervised Consumption on the Premises

between

[Pharmacy name]

and

Cambridgeshire
Drug and Alcohol Action Team

# CONTENTS

**Section 1 – Parties**

This Agreement for Services is made between the:

Cambridgeshire Drug and Alcohol Action Team (DAAT)
2nd Floor, C Wing
Castle Court,
Cambridge
CB3 0AP

and

[Pharmacy name]
[Pharmacy address]

For the provision of supervised consumption on the premises

**Section 2 - Term of Agreement:**

2.1 This will commence on and end on.
Any contract extension will be subject to review.

2.2 This Agreement will be reviewed at the 6 month stage.

2.3 The contact officers throughout the duration of this agreement are as follows;

| | |
|---|---|
| Contact Officer:<br>(on behalf of Cambridgeshire DAAT) | Name: |
| Name of Responsible Person<br>(on behalf of Pharmacy) | Name:<br>…….. |

2.4 Notification will be given by either party if any alterations to the above should occur.

**Section 3 – Objectives**

3.1 This service will require the pharmacist or delegated member of the Pharmacy's staff to supervise the consumption of prescribed medicines at the point of dispensing in the pharmacy, ensuring that the dose has been administered to the service user.

3.2 Pharmacies will offer a user-friendly, non-judgemental, client-centred and confidential service.

3.3 The pharmacy will provide support and advice to the patient, including referral to primary care or specialist centres where appropriate.

3.4 Examples of medicines which may have consumption supervised include methadone and other medicines used for the management of opiate dependence.

3.5 New service users being prescribed Methadone (liquid or tablets) or Suboxone or Buprenorphine should be required to take their daily doses under the direct supervision of a Pharmacist or delegated member of the Pharmacy's staff for the first three months. The length of time can be extended if an ongoing assessment determines a client's vulnerability or if there is additional risk factors this will be clinically managed by <Specialist Treatment Provider>, the Drug Intervention Programme (DIP) and/or Cambridge Access Surgery (CAS). It may also take account of Drug Rehabilitation Requirement (DRR) Orders and treatment allied to arrest referral.

**Section 4 – Aims and intended service outcomes**

4.1 To ensure compliance with the agreed treatment plan by:

- Dispensing in specified instalments (doses may be dispensed for the patient to take away to cover days when the pharmacy is closed),
- Ensuring each supervised dose is correctly consumed by the service user for whom it was intended.

4.2 To reduce the risk to local communities of:

- Over usage or under usage of medicines;
- Diversion of prescribed medicines onto the illicit drugs market; and
- Accidental exposure to the supervised medicines;
- To reduce risk of over or under usage of medicines prescribers must state on the prescription "daily doses in individual containers".

4.3 To provide service users with regular contact with health care professionals and to help them access further advice or assistance. The service user will be referred to specialist treatment centres or other health and social care professionals where appropriate.

**Section 5 – Provision**

5.1 The supervised administration of prescribed Methadone/ Suboxone / Buprenorphine will be available to Adult Drug Treatment and Drug Intervention Programme (DIP) who are Service Users with <Specialist Treatment Service>. Any other medications must be agreed by Cambridgeshire DAAT in advance.

5.2 The Pharmacist must raise any concerns regarding intoxicated service users, Child Protection and Safeguarding of Vulnerable Adults (SOVA) to <Specialist Treatment Provider> and/or DIP and/or CAS.

**Section 6 – Responsibilities/Service Outline**

6.1 The part of the pharmacy used for provision of the service provides a sufficient level of privacy and safety.

6.2 The pharmacy will present the medicine to the service user in a suitable receptacle and will offer the service user with water to facilitate administration and/or reduce the risk of doses being held in the mouth.

6.3 Terms of agreement are set up between the prescriber, pharmacist and service user (a three-way agreement – please see Appendix 1) to agree how the service will operate, what constitutes acceptable behaviour by the service user and what action will be taken by the treatment service and pharmacist if the user does not comply with the agreement.

6.4 The pharmacy contractor must ensure that any locum community pharmacists employed are familiar with the terms and working arrangements regarding this contract.

6.5 The community pharmacist must contact the service user's key worker at the earliest opportunity, on the 1st day that a pick up is missed and/or if a service user misses three consecutive pick ups or a missed pick up results in 3 missed doses. In this instance the Pharmacist must STOP dispensing and the client should be referred back to <Specialist Treatment Service> to be clinically re-assessed. This could result in a maximum of two phone calls being made to <Specialist Treatment Service> regarding one client. If a client regularly misses 1 day pick ups, the pharmacist should also inform the key worker so that this can be addressed with the service user.

6.6 The pharmacy contractor has a duty to ensure that that pharmacists and staff involved in the provision of the service have relevant knowledge and are appropriately trained in the operation of the service. This includes locums and temporary staff members.

6.7 The pharmacy contractor has a duty to ensure that pharmacists and staff involved in the provision of the service are aware of and operate within local protocols. This includes locums and temporary staff members.

6.8 The pharmacy should maintain appropriate records to ensure effective ongoing service delivery and audit.

6.9 The individual client supervision record form (Appendix 3) must be completed every day, including:

- client's name or initial and gender clearly recorded,

- agency the client attends indicated (by ticking appropriate box on the form),
- any days when the client fails to attend to receive supervised Methadone/ Suboxone / Buprenorphine,
- or they are refused due to being under the influence of alcohol or drugs.

6.10 The monthly claim form (Appendix 4) shall be completed with the monthly total number of supervisions per client, and forwarded to the DAAT by the 8th day of the month as stated in clause 10.2 (Financial arrangements and duration).

6.11 The Cambridgeshire DAAT may select random claim forms and audit against the client supervision record form, which is retained, at the pharmacy.

6.12 Pharmacists will share relevant information with other health care professionals and agencies, in line with locally determined confidentiality arrangements.

6.13 Health and safety training must be provided to staff, including training on the handling of equipment.

6.14 Pharmacists are encouraged to complete the open learning module, *Substance misuse and opiate treatment: supporting pharmacists for improved patient care,* provided by the Centre for Pharmacy Postgraduate Education (CPPE) in England. Pharmacists who have completed the Part 2 Royal College of General Practitioners (RCGP) in the Management of Duty Misuse in Primary Care may be eligible, in future, to apply for posts as pharmacists with special interest (PhwSI) in drug misuse.

6.15 Pharmacies are governed by the Medicines Act 1968 and Medicines, Ethics and Practice Guidance.

**Section 7 – Joint Responsibilities**

7.1 Methadone/ Suboxone / Buprenorphine should not be dispensed to clients who are intoxicated with drugs and/or alcohol. Refusal will be at the Pharmacists' discretion and will be due to risk factors and clinical safety. If you suspect a client is intoxicated you may ask them to come back at a later time when they are no longer intoxicated. The pharmacist should inform the client of the risk of overdose as a result of taking methadone while intoxicated.

**Section 8 – Confidentiality and Consent to share data with DAAT**

8.1 The Pharmacy will run a confidential service.

8.2 The Pharmacy will inform the client that no information will be shared with parties not involved in the client's treatment without his/her written consent. Exceptional circumstances

when information may be shared are stated in Appendix 1 point 13 of this Service Level Agreement.

8.3 The Pharmacy will inform the client that completed Daily Individual Patient Supervised Consumption Forms (Appendix 3) will be shared with Cambridgeshire Drug and Alcohol Action Team for commissioning and administration purposes.

**Section 9 – Default and Termination**

9.1 Failure to comply with the Section 6 paragraphs 6.4 – 6.11 shall result in the withholding of payment by the DAAT.

9.2 Either party giving three months notice may terminate the contract.

**Section 10 – Financial Arrangements and Duration**

10.1 The fee per supervised administration is as follows:

£1.50 for Methadone (liquid or tablets) / Suboxone

£2.00 for Buprenorphine (i.e. Subutex)

A fee of £4.00 will be paid for one phone call per day to, <Specialist Treatment Service>. This call must be made at the earliest opportunity and should include all clients that have missed their first or third days pick up (please refer to 6.4). Subsequent phone calls made that day or a second call with regards to the same client (regarding a second consecutive missed pick up day) will not be paid by the DAAT. If a client misses their first appointment after 5pm, the Pharmacist should call the <Specialist Treatment Service> at the earliest opportunity on the next working day.

10.2 The Payment Summary Sheet (Appendix 4) must be submitted by no later than the 8th day of each month for payment to be processed within 30 days of receipt.

10.3 Fees will be agreed annually for each financial year.

**Section 11 – Signatories**

By signing this document both Parties are agreeing to the terms & conditions within the Agreement.

On behalf of Cambridgeshire Drug and Action Team.

Signature: ……

Date: .....

Name in Full: ……..

On behalf of ……..

Signature: ……..

Date: .....

Name in Full: ……..

**Standard Terms for the Supply of Goods, Services and Works**

The Contract shall be constituted by and comprise only the Contract Documents; **no terms or conditions put forward by the Supplier (including terms relating to hire, lease or loan) shall form part of the Contract unless signed by both parties.** In the event of conflict, the Order, Terms and Purchaser Specification prevails. Any supply made in response to this Order shall be taken as conclusive acceptance of this term and any inconsistent or additional terms accompanying the supply shall be deleted and ignored.

## 1.0 DEFINITIONS AND INTERPRETATION

1.1 **"Contract"** – The contract constituted by the Contract Documents

**"The Purchaser"** – Cambridgeshire County Council

**"The Supplier"** – The recipient of the Order

**"Supply", "Good", "Services" and/or "Works"** – The goods, services and/or works as described in the Contract Documents (including without limitation on the face of the Order).

**"Terms"** – These contract terms

**"Order"** – The order issued by the Purchaser for the supply which is the subject of the Contract

1.2 Further definitions are set out on the Contract Schedule annexed to the Order.

1.3 The headings to the Terms shall not affect their interpretation. The singular includes the plural; one gender includes all others.

## 2.0 THE SUPPLY OF GOODS, SERVICES OR WORKS - QUALITY STANDARDS

2.1 The Supply shall be to the reasonable satisfaction of the Authorised Officer and shall without limitation conform with and fulfill in all respects:-

- the Contract Documents
- any variation of the Contract agreed in writing by the parties
- the requirements of any relevant UK or EC statute, order, regulation, directives, standard, code of practice or bye-law from time to time in force which is relevant to the Supply
- any recommendation or representation made by the Supplier
- professional standards which might reasonably be expected of the Supplier

2.2 Unless otherwise agreed in writing, neither performance nor functionality of any part of the Supply will be impeded by entry into the European monetary union.

## 3.0 THE CONTRACT PRICE AND INVOICING

3.1 The Payment Date defines how the Contract Price is payable. The Purchaser shall make payment, provided the Supply complies with the Contract, within 30 days after receipt of an invoice submitted on or after a Payment Date.

## 4.0 DELIVERY AND TIME FOR PERFORMANCE

4.1 Time shall be of the essence. The Authorised Officer must be notified and his consent obtained to any extension of time.

4.2 Access to Purchaser premises, facilities or storage by the Supplier shall comply with the reasonable requirements of the Purchaser and shall be at the Supplier's risk.

4.3 If either party is unable to make or accept the Supply, through

- strike, lockout by employees, war or civil commotion
- cessation or serious interruption of land, sea or air communications or power supplies
- exceptionally adverse weather, fire or other unavoidable cause

It shall immediately notify the other party and then, the disabled party may decline to make or accept the Supply. The Purchaser shall notify the Supplier within 30 days of the end of that period whether it requires the Supply to be recommenced, varied or cancelled (without further liability to either party).

Where the Supply is recommenced the Contract shall be varied to extend the time for completion or delivery of the Supply by the period of disability.

4.4 At the completion of the Supply the Supplier shall remove all materials from the Site (unless otherwise instructed) and permanently reinstate any damaged areas or surfaces and leave the Site in a clean condition ready for occupation.

## 5.0 PROPERTY RISK AND ACCEPTANCE

5.1 Without prejudice to any of the rights or remedies of the Purchaser (including those under Clause 7), property and risk in any Goods shall pass to the Purchaser on delivery or when the Authorised Officer notifies acceptance in writing where the Goods are to be subject to testing, whichever shall be the later.

## 6.0 INTELLECTUAL PROPERTY RIGHTS AND CONFIDENTIALITY

6.1 The Supply shall not infringe the intellectual property rights of any third party.

6.2 All rights (including without limitation ownership and copyright) in any specifications, information, instructions, plans, drawings, patterns, models, designs or other material furnished to or made available to the Supplier by the Purchaser or obtained by the Supplier in connection with the Contract shall remain vested solely in the Purchaser and shall be kept confidential.

6.3 Where the Contractor has access to information about people, it shall ensure that in making the Supply, the provisions of the Data Protection Act 1998 are observed (and also Purchasers' data protection requirements notified to the Supplier).

6.4 This clause shall apply both during the Contract and after its termination.

6.5 The intellectual property rights (including without limitation copyright) in any thing arising out of the Supply shall vest in the Purchaser.

## 7.0 HEALTH AND SAFETY

7.1 Without prejudice to the generality of Clause 2.1 the Supplier in making the Supply shall have full regard to safety of persons who may be affected in any way and shall comply with the requirements of the Health and Safety at Work Act 1974 and its subordinate regulatory framework, and of any other Acts pertaining to the health and safety of persons.

7.2 Every registered Pharmacy is required to have a responsible pharmacist appointed, who has a legal duty to ensure the safe and effective running of the pharmacy in relation to the sale and supply of medicines. Pharmacists should refer to the professional standards and guidance for responsible pharmacists. Under Sections 70 and 71 of the Medicines Act 1968, a notice has to be conspicuously displayed in the registered pharmacy. The notice must detail the name of the responsible pharmacist, their registration number and the fact that they are for the time being in charge of business at those premises. The requirements relating to the responsible pharmacist are set out in the Medicines (Pharmacies) (Responsible Pharmacist) Regulations 2008. The responsible pharmacist is required to establish (if not already established), maintain and review pharmacy procedures that must cover certain matters as required by the Regulations. These include arrangements for the safe and effective running of the pharmacy in relation to the sale and supply of medicines.

7.3 Throughout the progress of any Works, the Supplier shall keep the Site in an orderly state and shall provide and maintain at its own cost all lights, guards, fencing and warning signs and any other systems required for the protection of the Works and the safety and convenience of the public and others.

7.4 There is a statutory duty on the Purchaser under the Civil Contingencies Act 2004 to maintain plans to ensure that it can continue to exercise all its functions in the event of an emergency so far as is reasonably practicable- therefore.

7.5 The Purchaser requires a demonstration of robust contingency plans by appropriate means by the Supplier. The Supplier must satisfy the officer commissioning the Service that it has a Business Continuity Planning Policy with tested contingency arrangements in place. Depending on the importance and scale of the Services to be provided the Purchaser reserves the right to request detailed evidence of the Supplier's Contingency plans such as sight of the Supplier's Business Continuity Plan, the supplier's attendance at any contingency exercise or to conduct an audit of the Supplier's contingency arrangements (examples of what an effective Business Continuity Plan should include can be provided on request).

## 8.0 INDEMNITY AND INSURANCE

8.1 Without prejudice to any rights or remedies of the Purchaser (including those under Clause 7) the Supplier shall indemnify the Purchaser against all matters of any kind arising in contract, tort, statute or otherwise directly or indirectly out of the wrongful act, default, breach of contract or negligence of the Supplier, its sub-contractors, employees or agents in the course of or in connection with the Contract. Without prejudice to the generality of the foregoing this indemnity shall extend to (and not be limited) in respect of death or injury to persons, damage to property, prevention of corruption, the infringement of intellectual

property rights, health and safety, race relations, data protection and Ombudsman investigations.

8.2 The Supplier shall effect, with a reputable company, public and employer's liability and other insurances necessary to cover the risks contemplated by the Contract and shall at the request of the Purchaser produce the relevant policy or policies together with receipts or other evidence of payment of the latest premium due thereunder. Public liability cover of at least £2 million shall be obtained, unless agreed otherwise with the Authorised Officer. Where the Supply is a supply of consultancy services the Supplier shall maintain professional indemnity insurance during the Contract period and for 6 years afterwards to cover its liability to the Purchaser under the Contract.

## 9.0 RACIAL DISCRIMINATION, OMBUDSMAN INVESTIGATIONS AND HUMAN RIGHTS SAFEGUARDING

9.1 The Supplier shall not unlawfully discriminate within the meaning and scope of the provisions of Race Relations Act 1976, Sex Discrimination Act 1975, and the Disability Discrimination Act 1995 or any statutory modification or re-enactment thereof relating to discrimination in the provision of services to the public or in employment or contravene the Human Rights Act 1998. The Supplier shall to the extent relevant to delivery of the Supply comply with the Purchaser's equal opportunities policies, which may be consulted at http://www.cambridgeshire.gov.uk. The Supplier shall take all reasonable steps to secure the observance of these provisions by all servants, employees or agents of the Supplier and all sub-contractors employed in the execution of the Contract.

9.2 If either the Purchaser's internal or external auditors or if the Commissioner for Local Administration (the Ombudsman) shall wish to investigate the Contract, then the Supplier shall provide such information, access and co-operation as those persons may reasonably require.

9.3 There is no (current legislative or procedural) requirement for applicants to undergo disclosures as a condition of registration. Identity checks and self-declarations of criminal convictions are part of the Royal Pharmaceutical Society's application procedure.

9.3.1 Society currently checks identity as described.

The Royal Pharmacological Society of Great Britain (RPSGB) currently requires:

- Birth certificate (or equivalent)
- Marriage certificate (if required)
- Copy of degree certificate
- Final declaration by tutor
- Health declaration (GP)
- Affirmation and self-declaration of convictions

## 10.0 FREEDOM OF INFORMATION

10.1 The Contractor acknowledges that the Council has obligations relating to the disclosure of information pursuant to the Freedom of information Act 2000.

10.2 The Contractor shall use its best endeavours to assist the Council in discharging its obligations under the Freedom of Information Act 2000 arising from any request for information which the Council receives in connection with this Contract, the Supply, Services or Works.

**11.0 PREVENTION OF CORRUPTION**

11.1 The Purchaser may terminate the Contract and recover all its loss if the Supplier, its employees or anyone acting on the Supplier's behalf do any of the following things:

- offer, give or agree to give to anyone any inducement or reward in respect of this or any other Purchaser contract (even if the Supplier does not know what has been done);
- or commit an offence under the Prevention of Corruption Act 1889 to 1916 or under Section 117(2) of the Local Government Act 1972;
- or commit any fraud in connection with this or any other Purchaser contract whether alone or in conjunction with Purchaser members or employees.

**12.0 TERMINATION**

12.1 The Purchaser may also by notice in writing terminate the Contract in whole or in part (and enter upon and expel the Contractor from any premises or site to which he has been given access) if any of the events specified in Clause 11.1 occur. No period of notice shall be required but the notice shall state the date on which it is to take effect.

12.2 The events referred to in Clause 11.1 are:-

- the Supplier has failed to make the Supply within the time specified in the Contract
- the Supplier has breached the Contract in a way which the Purchaser reasonably regards as irremediable, which may include, without limitation, repeated and/or persistent remediable breaches of the Contract
- the Purchaser has given the Supplier at least one month's notice to remedy a breach of Contract which can be remedied and the Supplier has failed to do so
- the Supplier has without reasonable cause failed to proceed diligently with or wholly suspends performance of any Services or Works
- the Supplier shall have a receiver appointed over all or substantial part of his or its assets or (if an individual) be declared bankrupt or (if a company) shall go into liquidation or have an administrator appointed to manage its affairs.

**13.0 ASSIGNMENT AND SUB-CONTRACTING**

13.1 The Supplier shall not without the written consent of the Authorised Officer assign or sub-contract the benefit or burden of the whole or any part of the Contract. No sub-contracting by the Supplier shall in any way relieve the Supplier of any of its responsibilities under the Contract.

**14.0 PURCHASE OUTSIDE THE CONTRACT AND THIRD PARTIES**

14.1 The Purchaser shall have the right to employ a person other than the Supplier to make supplies of the same type as is contemplated by the Contract if it shall in its absolute discretion think fit to do so.

14.2 The Contract shall not confer any benefit on any third party.

## 15.0 NOTICES

15.1 Any notice about the Contract may be sent by hand or by ordinary, registered or recorded delivery post or transmitted by facsimile transmission or other means of telecommunications resulting in the receipt of written communication in permanent form and if so sent or transmitted to the address of the party shown on the Contract, or to such other address as the party has notified to the other, shall be deemed effectively given on the day when in the ordinary course of the means of transmission it would be first be received by the addressee in normal business hours.

## 16.0 GOVERNING LAW

16.1 These Conditions shall be governed by and construed in accordance with English law and the Supplier hereby irrevocably submits to the exclusive jurisdiction of the English courts.

## Appendix 4 Part B: <Specialist Treatment Service> Three Way Contract
## PHARMACY AGREEMENT

**CLIENT NAME: ……..…….. DOB: ……..**

**Purpose**

This is a formal agreement between the client, prescriber, nurse/key worker and pharmacy. The purpose of this contract is to ensure all parties are clear on their responsibilities and to ensure that the prescribers and pharmacy adhere to the national framework of Clinical Governance.

**Responsibilities**

**Service User**

- To notify Prescriber/Nurse/Key worker and the Pharmacist of any changes to personal circumstances.
- To adhere to the guidance list below.
- To engage with Prescribing Service and the Pharmacy.
- To be responsible for own medication and only take as directed.
- To not display any violent, aggressive or abusive behaviour to any party involved in providing treatment.

**Prescriber/Nurse/Key worker**

- To act or respond to any reasonable request within a suitable timeframe.
- To ensure service user dignity, privacy and respect wherever possible.
- To engage and support the service user as appropriate.
- To openly discuss any concerns with the Service User and Pharmacy.

**Pharmacy**

- To provide the service as described.
- To provide a service and suitable environment which ensures Service User dignity privacy and respect wherever possible.
- To engage and support the service user as appropriate.
- To openly discuss any concerns with the Service User and Prescriber/Nurse/Key worker**.**
- To report any concerns to Prescribing Service without delay.

1. My prescription will be decided by my prescribing doctor, my key worker and me.

2. When attending the pharmacy for the first time

- I will be expected to show some form of identification.
- If my prescription is for 'supervised consumption' I will be asked where in the pharmacy I would like to consume my medication.

- I also need to be prepared to show some form of identification at any time.

3. I will attend the named pharmacy in person, at the time arranged by the pharmacist and myself.

4. The pharmacist, prescribing service and key worker have the right to refuse to see me if they believe I am intoxicated.

5. All parties involved in this treatment plan will be treated with respect and dignity at all times.

6. I understand that I can only obtain prescriptions for my medication from the Prescribing Service named in this contract. I cannot have my prescriptions dispensed by another pharmacy without negotiating this with my key worker first.

   Any changes required due to work or holiday arrangements will need to be negotiated with my key worker, with a least 14 days notice of changes required.

7. I am responsible for all drugs prescribed to me and, if I should lose them or take them other than as directed, they may not be replaced.

8. I understand that I must collect my prescription on the specified days. If I am unable to collect my prescription at all I need to notify my key worker who will advise the pharmacy. I understand that no-one else can collect my medication unless pre-arranged with my key worker.

9. I understand that if I do not collect my prescription for:

   - **three or more consecutive days** if I am on daily pick-up or
   - if a missed pick-up results in **three missed doses**

   the pharmacy will not dispense my medication until my treatment has been re-assessed. If this happens the pharmacist will contact the prescribing service and I will need to contact my key worker to have my treatment reviewed.

   The pharmacist will also advise my key worker if I regularly miss collecting on the specified days.

10. I agree to see my key worker, prescribing doctor and project worker regularly and will keep all appointments, unless by prior arrangement. If I do not attend appointments my treatment will be reviewed and may be suspended.

11. All persons involved in my treatment are expected to provide this service as discreetly as possible.

12. I understand that information will need to be shared between all those involved in my treatment as outlined below:

    - Prescribing Service Nurse/Key Worker.
    - Prescribing Doctor/Nurse.
    - Pharmacist.
    - Cambridgeshire Drug and Alcohol Team (for monitoring purposes).

13. I understand that agencies involved in my treatment will not share information and knowledge about me without my permission.

    I understand there are a few exceptional circumstances where agencies involved in my treatment would disclose information to an outside agency without my consent:

- If it is believed that the welfare and safety of children and/or young people under 18 and/or welfare of vulnerable adults are being put at risk;
- If I express intent to harm myself or agencies involved in my treatment have any concerns about my immediate welfare;
- If I express an intent to harm or cause injury to a third party;
- If the service is instructed by a court of law to reveal information about me.

I understand that under normal circumstances, written consent will be obtained from me before the information is disclosed.

I understand that no information will be shared with family or friends without my consent.

14. I have been informed and agree for the Daily Individual Patient Supervised Consumption Forms filled in by the Pharmacist to be shared with Cambridgeshire Drug and Alcohol Action Team for commissioning and administration purposes.

My contract will commence on: ……..

[Prescribing Service to enter start date]

- I will attend the pharmacy named below, at a pre-arranged time if appropriate.

(Pharmacist to state appropriate time) ……

- I have read, and agree to this contract.

| | | |
|---|---|---|
| **CLIENT** | **NAME:**<br><br>**ADDRESS:**<br><br>**PHONE NUMBER:** | **SIGNATURE & DATE** |
| **PRESCRIBER** | **NAME:**<br><br>**ADDRESS:**<br><br>**PHONE NUMBER** | |
| **NURSE/KEY WORKER** | **NAME:**<br><br>**ADDRESS:**<br><br>**PHONE NUMBER** | |
| **PHARMACIST** | **NAME:**<br><br>**ADDRESS:**<br><br>**PHONE NUMBER** | |

Nurse/Key Worker to ensure that copies go to:

- Pharmacy
- Client (if requested)
- G.P. [If client is shared care]

Original to be filed in the client's case notes.

**Appendix 4 Part C: Guidelines for communication between Pharmacist and Prescriber**

The Keyworker and Pharmacist should agree on a suitable time to discuss any issues, which arise from the daily dispensing to a client.

The Keyworker and Pharmacist should agree what information is to be communicated.

The Pharmacist should report to the Keyworker the following issues:

- The community Pharmacist must contact the Service User's Keyworker when the 1st days missed pick up occurs and ask the appropriate member of staff for advice;
- Patient is attempting to avoid supervised consumption;
- Three or more consecutive doses missed (must STOP dispensing refer client back to prescriber);
- Unacceptable behaviour;
- Intoxication (refer to dispensing guideline);
- Changes in health and or welfare concerns;
- Problems concerning the prescription.

Protocol for use by Keyworkers

When a decision has been made to prescribe for a patient who requires supervised Methadone/ Suboxone / Buprenorphine administration:

1. Explain to the patient what is involved in the supervised consumption of Methadone/ Suboxone / Buprenorphine

   The main issues to be covered by the Keyworker are:

- Methadone/ Suboxone / Buprenorphine to be taken supervised by the Pharmacist

- Missed doses cannot be dispensed at a later date

- The Pharmacist must STOP dispensing Methadone/ Suboxone / Buprenorphine if a Client has missed three pick ups or a missed pick up resulting in 3 missed doses, and the Client should be referred back to <Specialist Treatment Provider> to be clinically re-assessed.

- Methadone/ Suboxone / Buprenorphine will not be dispensed if Pharmacist suspects there is evidence of drug/alcohol intoxication. The risk of overdose in these circumstances will be explained to the client and he/she will be asked to return when no longer intoxicated.

- Provide patient information leaflet

2. Select a pharmacy

   The Client may choose from the list of participating pharmacists the most convenient pharmacy for them to attend.

3. Check with the Pharmacist that they are happy and able to take on a new Client

4. If the Pharmacist agrees, basic client details should be given over the telephone:

- Client name
- Date of birth
- Address
- Daily dose of Methadone/ Suboxone / Buprenorphine
- Any other prescribed medication e.g. diazepam
- Start date of prescription
- Confirm this is for supervised consumption
- Keyworkers/Prescribers name and contact number

5. The prescription should be marked ' FOR SUPERVISED CONSUMPTION'

6. Contact should be made with the community Pharmacist to agree a suitable time to discuss any issues, which arise from daily dispensing to a Client.

7. At the end of the period of supervised consumption the Keyworker should call the Pharmacist to confirm the last date of supervision.

8. The Pharmacist will communicate to the Prescriber/ Keyworker information about the Client. This will include: compliance to treatment, intoxication on other drugs/alcohol etc.

This referral process is designed to ensure that Clients and Pharmacists are kept informed so hopefully leading to the smooth running of this service.

The prescribing of Methadone/ Suboxone / Buprenorphine should be done within existing guidelines whether they are locally agreed guidelines or national guidelines.

# SUPERVISED METHADONE/SUBOXONE /BUPRENORPHINE ADMINISTRATION – CLIENT INFORMATION SHEET

**What the Client will do:**

- Treat the Pharmacy staff with respect;
- Attend the Pharmacy daily, alone and at agreed times;
- Not attend intoxicated with drugs or alcohol;
- Depending on circumstances, wait or return later if the Pharmacist is busy;
- See the Keyworker for a reassessment if you have not attended the pharmacy for two days or more;
- Not allow any other person to attend the pharmacy on your behalf unless previously arranged by the Keyworker;
- Be aware that the Pharmacist will pass on necessary professional information about your case to the Keyworker on a 'need to know' basis.

**What the Pharmacist will do:**

- Treat the Client with respect;
- Provide the service within a reasonable time bearing in mind other pharmacy customers/patients;
- Provide a private/quiet area for you to consume your medication;
- Keep records of your attendance;
- Dispense Methadone/ Suboxone/ Buprenorphine in accordance with your prescription;
- Liaise when necessary with your Keyworker with regard your treatment;
- Refer you back to your Keyworker and discontinue dispensing your prescription if you do not attend the pharmacy for three days or more. If you attend intoxicated with drugs and/or alcohol refusal will be at the Pharmacists discretion and will be due to risk factors and clinical safety. If the Pharmacist suspects that you are intoxicated you may be asked to come back at a later time when you are no longer intoxicated or attend the next day. If this happens on a Saturday the Pharmacist may dispense a Saturday and Sunday dose to take away and ask you to take the doses appropriately when not intoxicated. The Pharmacist should inform you of the risk of overdose as a result of taking Methadone/ Suboxone/ Buprenorphine while intoxicated;
- Provide you with health promotion information and education

## Appendix 4 Part D: Daily Individual Patient Supervised Consumption Form

**Daily Individual Patient Supervised Consumption Form**

Pharmacy Name/Address _____

(Or Stamp) _____

Client Name (please PRINT) _____

Client D.O.B _____ Gender _____

**Please √ service client attends**

| | |
|---|---|
| **<Specialist Treatment Provider>** | |
| **CDIP** | |
| **Access Surgery** | |

| **Date** | **Methadone (liquid or tablets) / Suboxone Amount** | **Buprenorphine Amount** | **Initials of Pharmacist** | **Record of telephone calls made to Agency (one call per episode)** |
|---|---|---|---|---|
| 1st | | | | |
| 2nd | | | | |
| 3rd | | | | |
| 4th | | | | |
| 5th | | | | |
| 6th | | | | |
| 7th | | | | |
| 8th | | | | |
| 9th | | | | |
| 10th | | | | |
| 11th | | | | |
| 12th | | | | |
| 13th | | | | |
| 14th | | | | |
| 15th | | | | |
| 16th | | | | |
| 17th | | | | |
| 18th | | | | |
| 19th | | | | |
| 20th | | | | |
| 21st | | | | |
| 22nd | | | | |
| 23rd | | | | |

| | | | | | |
|---|---|---|---|---|---|
| 24th | | | | | |
| 25th | | | | | |
| 26th | | | | | |
| 27th | | | | | |
| 28th | | | | | |
| 29th | | | | | |
| 30th | | | | | |
| 31st | | | | | |
| **Total Number of supervised doses** | | | | **Total number of telephone calls made** | |

**Pharmacist's comments & feedback:**

**Pharmacist's Name (Please print):**

**Appendix 4 Part E: Pharmacy Payment Summary Sheet Form**

# PAYMENT SUMMARY SHEET

## OBSERVED CONSUMPTION ON PREMISES

| | |
|---|---|
| **Pharmacy Name** | |
| Address & Postcode | |
| Month of Claim | |

| | Number | £ | |
|---|---|---|---|
| Total number of observed Methadone (liquid or tablets) /Suboxone consumptions @ £1.50 each | | £ | (1) |
| Total number of observed Buprenorphine consumptions @ £2 each | | £ | (2) |
| Total number of telephone calls @ £4.00 each | | £ | (3) |
| **Total Amount (sum of 1, 2 & 3)** | £ | | |
| Authorisation Signature | | | |
| Date | | | |

**Please return one payment summary sheet with all client record sheets at the end of each month to:**

**Cambridgeshire Drug and Alcohol Action Team**

**Box No CC1207**

**2ND Floor, C Wing**

**Castle Court**

**Castle Hill**

**Cambridge**

**CB3 0AP**

**Tel: 01223 699680**

**Fax: 01223 699801**

Please note this claim sheet should be used from April 2011. All previous copies should be destroyed

TELEPHONE CALL LOG

| Date | (1) Number of clients reported to | (2) Number of clients reported to | (3) Number of clients reported to | (4) Number of calls made each day |
|---|---|---|---|---|
| 1st | | | | |
| 2nd | | | | |
| 3rd | | | | |
| 4th | | | | |
| 5th | | | | |
| 6th | | | | |
| 7th | | | | |
| 8th | | | | |
| 9th | | | | |
| 10th | | | | |
| 11th | | | | |
| 12th | | | | |
| 13th | | | | |
| 14th | | | | |
| 15th | | | | |
| 16th | | | | |
| 17th | | | | |
| 18th | | | | |
| 19th | | | | |
| 20th | | | | |
| 21st | | | | |
| 22nd | | | | |

| | | | | |
|---|---|---|---|---|
| 23rd | | | | |
| 24th | | | | |
| 25th | | | | |
| 26th | | | | |
| 27th | | | | |
| 28th | | | | |
| 29th | | | | |
| 30th | | | | |
| 31st | | | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Total number of calls made to | (1) | Total number of calls made to | (2) | Total number of calls made to | (3) | Total number of calls made (sum of 1 & 2& 3) | (4) |

Please transfer total number of calls in (4) to front of sheet for payment.

Only one telephone call per agency, per day, should be claimed for reporting missed doses.

# Appendix 5: Cambridge Access Surgery (CAS)

## Agreement for the Provision of Services

COMMISSIONER:

PROVIDER: Cambridgeshire Community Services - Cambridge Access Centre (CAS)

**1. Interpretation:**

"Agreement" means this agreement concluded between Provider and Commissioner including all specifications, schedules and other documents which are agreed by the Key Managers.

"Key Manager" means the contact point for each Party listed at clause 14.

"Services" means those services set out in Schedule 1.

"Price" means the price payable by the Commissioner for the full and proper performance of the Services by the Provider under the provision of this Agreement as agreed between the Parties and set out at Schedule 2.

**2. Service to be Provided:**

2.1 The Provider will supply:

2.2.1 Specialist prescriber and reception support to joint CAS/<specialist drug service> drug clinics at 125 Newmarket Road, Cambridge.

2.2.2 Nurse support to blood borne virus clinics at <specialist drug service>.

2.2.3 GP support to <specialist drug service> Education and Training Programme.

2.2 The services to be provided are detailed at Schedule 1.

2.3 The services will be supplied for the period <date> to <date> with potential for renewal in subsequent years.

**3. Management Meetings:**

Management Meetings will be held each quarter. The host shall alternate between the two Parties and the host shall provide a venue and produce and distribute minutes within 10 (ten) working days of the meeting.

**4. Activity, Invoicing and Payment:**

Invoices for the sums set out at Schedule 2 will be issued quarterly in arrears, unless shown otherwise, detailing the activities provided and fee due. Payment by the Commissioner to be made

**5. Quality of Service:**

The Provider shall ensure that the Services provided meet all statutory regulations. Any complaints received regarding the Services provided shall be referred to the Provider's Key Manager for investigation and prompt reply.

**6. Changes in Service Provision:**

Any Commissioner initiated changes should be discussed and confirmed in writing with the Provider's Key Manager. If the Provider and Commissioner jointly agree in writing to vary the Service, such modifications will be priced at a rate to be agreed by both Parties before the service provision is changed.

**7. Confidentiality:**

Both Parties shall comply with the NHS Code of Practice on Confidentiality in respect of all data supplied in connection with the Services.

**8. Obligations & Indemnities:**

8.1 The Parties shall each ensure that all accommodation and equipment used by the other Parties' staff meets all applicable regulations and statutes, including Health and Safety requirements and shall advise such staff of all safety and security regulations applicable to the site.

8.2 The Parties staff shall observe all safety and security procedures applicable to the other Parties' site. Each Party may request the immediate withdrawal of any personnel who fail to observe such procedures.

8.3 Each Party shall be liable to the other for and shall indemnify and shall keep indemnified the other Party against any liability, loss, costs, expenses, claims or proceedings whatsoever in respect of:

8.3.1 Any loss of or damage to property (whether real or personal).

8.3.2 Any injury to any person, including injury resulting in death.

in consequence of or in any way arising out of its negligence or breach of contract in connection with the performance of this Agreement or of the provision of the Services except insofar as such loss, damage or injury shall have been caused by any act or omission undertaken in strict accordance with the instructions of the other Party or by any act or omission or negligence on the part of the other Party, its agents, sub-contractors and anyone else involved in or employed or engaged by that Party.

## 9. Cancellation:

Charges, as set out at Schedule 2 will be made for the cancellation of services unless at least twenty four (24) hours' notice is given.

**10. Termination:**

Should a Party wish to terminate this Agreement a minimum of three (3) months notice must be given in writing to the other Party's Key Manager.

11. Conciliation:

If a Party is unable to comply with the Agreement, the other Party's Key Manager should be contacted without delay. Similarly, if a Party is dissatisfied with the operation of the Agreement, this should be made known to the other Party's Key Manager without delay. It shall be the duty of the Key Managers to use their best endeavours to resolve any dissatisfaction or differences that may occur.

**12. Dispute Resolution:**

Both Parties accept that it would be in their best interests for any disagreement to be resolved locally, firstly by the Parties Key Managers and, in the event of them failing agreement, then by referral to, and settlement by, the Parties Chief Executive Officers (or their nominated deputies).

**13. Force Majeure**

Neither Party shall be in breach of any obligation under this Agreement if it is unable to perform that obligation in whole or in part by reason of an event beyond either Party's control, including by way of illustration only and not exclusively any act of God fire act of government or state war or civil

commotion insurrection embargo prevention from or hindrance from obtaining energy or other supplies.

14. Contact Points:

| **Key Manager for Provider** | **Key Manager for Commissioner:** |
|---|---|
| **Name:** | **Name**: |
| Tel: | Tel: |
| email: | email: |

Signatories:

| On behalf of Provider: | On behalf of Commissioner: |
|---|---|
| **By: .....** | **By:.....** |
| **Name: .....** | **Name:.....** |
| **Position: .....** | **Position: .....** |
| **Date: .....** | **Date: .....** |

**SCHEDULE 1 – SERVICE SPECIFICATION**

# Table of Contents

| Service Description | CAS Responsibilities | Specialist Drug Service Responsibilities | Remarks |
|---|---|---|---|
| **1. Specialist Prescriber and Reception Support to Joint CAS/Specialist Drug Service Clinics at 125 Newmarket Road, Cambridge** | | | |
| **1.1 Frequency and duration of Joint CAS/Specialist Drug Service Clinics** | | | |
| Current Clinic Days/Timings<br><br>Joint CAS/Specialist Drug Service Clinics to be held twice weekly as follows:<br><br>Tuesday - 1000-1200 (PW) & 1400-1830 (PW & GP)<br>Thursday – 1000-1200 (PW) & 1400-1830 (PW & GP)<br><br>Clients are required to be off the premises by no later than 1800 hrs, when the Surgery closes. Staff may continue to work after this time.<br><br>(Days of the week are subject to the availability of Specialist Subscriber Support (GP) and may change from time to time – the above arrangements to change accordingly). | | | |
| **1.2 Infrastructure Support** | | | |
| | 1 x office with desk, chair, telephone and PC workstation providing access to CAS Medical Records System and Shared Drive at following times for Project Worker: | | |

| | | | |
|---|---|---|---|
| | All day Tuesday and Wednesday morning. All day Thursday and Friday morning. Days of the week are subject to the availability of Specialist Subscriber Support (GP) and may change from time to time. Outside of these times. The office may be used by other surgery staff/visiting clinical staff. A PC workstation in the Practice Manager's Office can be made available by prior arrangement. | | |
| **1.3 Staffing Levels and Working Arrangements** | | | |
| <u>Project Workers</u><br><br>Project Workers (PW) working arrangements from CAS will be as follows:<br><br>PW1 – Tuesday Clinics and Wednesday morning<br>PW2 – Thursday Clinics and Friday morning<br><br>PWs to cover each other's Clinics for Annual Leave, sickness and mandatory training etc.<br><br>PW1 will perform the function of Lead PW and be the primary interface between CAS and Specialist Drug Service for day to day issues. | CAS to provide input into Specialist Drug Service Annual Appraisals if requested**.** | To provide qualified Project Workers to meet the commitment of 2 x Clinics per week and completion of associated paperwork and record keeping. | Other commitments at Service Provider's base may have to be reduced to enable these working arrangements, particularly when a single PW is covering Clinics on both days. |
| <u>Specialist Prescriber (SP) Support</u><br>In addition to Joint CAS/Specialist Drug Service Clinics, the SP will also carry out additional work as required to support | Specialist Prescriber GP to be RCGP Management of Substance Misuse Certificate Part 2 qualified. | | |

| | | | |
|---|---|---|---|
| drug dependent patients, such as changes to scripts, off premise visits in emergencies and liaison with pharmacies. This work may be undertaken by CAS GPs in the absence of the SP. | GPs in the process of taking the Part 2 Certificate may run the Clinic as part of their training under the supervision of a Part 2 qualified GP. | | |
| <u>Reception Services</u><br>Reception of patients, door, waiting room and risk management. Telephone service in support of the clinic and general administrative support. Facilitating liaison with homeless agencies on behalf of PWs.<br>CAS completes the following duties which are in addition to Specialist Drug Service's normal expectations of GPwSI sessions (this is reflected in the payment schedule, which is adjusted to account for this):<br>• Production of prescriptions and administration processes to manage this<br>• Post-clinic administration including liaison with hospitals and homelessness agencies, clinic letters, management of DNAs.<br>• Appointments outside of clinic times in order to respond effectively to this chaotic client group<br>• Liaison with pharmacies regarding missed pick-ups, amendments to prescriptions, feedback to <Specialist Treatment Provider> staff. | | | |
| **1.4 Access to Records, Maintenance of Records and Joint Waiting List** | | | |
| <u>Access to Records</u> | Access to EMIS PCS/SystmOne for PWs. Both PWs to maintain records as required | Access to BOMIC (or replacement system - ORION) for CAS GP. | |

| | | | |
|---|---|---|---|
| Information Sharing Protocols<br><br>Information will be shared on a need-to-know basis between CAS and Specialist Drug service staff to facilitate patient care. This information must be transmitted using secure means. | | | |
| PW1 to Maintain Joint Waiting List | Input into Joint Waiting List (JWL) Reviews at monthly intervals. JWL to be maintained by PW1. | PW1 to provide Specialist Drug Service input into monthly JLW Reviews and disseminate updated list every calendar month. | |
| CAS Patients Accessing Drug Treatment at Service Provider Base | Liaison with <Specialist Treatment Provider> to discuss any issues arising from Initial/Periodic Reports on CAS patients. | Initial Reports when CAS patients first access <Specialist Treatment Provider> services at Service provider Base and Periodic Reports at 3 monthly intervals or for any significant changes thereafter – whichever is the sooner. | These reports are crucial for continuity of treatment for CAS patients, many of whom have very complex health needs. |
| Maintenance of Records | | PWs are responsible for the completion of records for the following:<br><br>NDTMS<br>Specialist Drug Service<br>CAS Clinical Records System | |
| **1.5 Clinical Governance – Meetings and Training** | | | |
| Clinical Governance<br><br>Quarterly Meetings with Specialist Drug service Specialist Prescriber<br><br>Prescriber Forums at 4 monthly intervals | Attend quarterly clinical meetings with <Specialist Treatment Provider> Specialist Prescriber, who will provide clinical supervision<br><br>Attend Prescriber Forums | Provide clinical supervision to CAS Specialist Prescriber at quarterly clinical meetings<br><br>Organise and host Prescriber Fora | |
| | | Specialist drug Service will fund | Dr – Specialist Drug |

| | | | |
|---|---|---|---|
| <u>Training</u><br><br>Funding for Part 1 and 2 RCGPs MSM Courses for CAS GPs<br><br><br><br>Continuous Professional Development and Conferences | | RCGP Management of Substance Misuse to Certificate Part 2 level for CAS GPs subject to budgetary constraints.<br><br><br><br>Specialist Drug Service to fund attendance at one conference per year for Part 2 qualified CAS GPs subject to budgetary constraints. | Service funded Part 2 in FY<br>Dr– Specialist Drug service funded Part 1 in FY |
| **2. Support to Blood Borne Virus Clinics at Service Provider Base** | | | |
| **2.1 Staffing Levels and Working Arrangements** | CAS to supply 1 x Practice Nurse to run fortnightly BBV Clinics at Service provider base from 1400-1600 hours on Wednesdays. Practice Nurse will ensure NHS standards of Clinical Governance are adhered to at all times | Specialist Drug Service to provide suitable clinical environment, reception support, vaccines, cold chain, testing arrangements and administrative support for record keeping. Specialist Drug service to conduct pre-test counselling | |
| **2.2 Record Keeping and Briefing Material** | Practice Nurse to ensure that records are accurately maintained for BBV clinic activity and that information is passed to GPs for recording in client medical records and advising GPs on appropriate management and referral of BBV patients. Additionally, to ensure that suitable briefing material is provided for clients attending clinics | <Specialist Treatment Provider> to provide administrative support to BBV Clinics | |
| **2.3 Counselling** | Practice Nurse to counsel clients regarding tests and results and discuss with GPs where appropriate | | |
| **3. GP Support to Specialist Drug Service Education and Training Programme** | | | |
| **3.1 Production and delivery of training material** | CAS GPs/Nurses to produce and deliver education and training material related to the health care of drug dependent clients to Specialist | Specialist Drug Service to provide competences for staff accessing the training and clearly defined training objectives | |

| | | | |
|---|---|---|---|
| | Drug Services staff at periodic intervals | | |

**SCHEDULE 2 - FEES**

**1. Fees for CAS Drug Clinics**

1.1 To be invoiced at £550 per Clinic (4.5 hours per clinic + reception cover and administrative support relating to prescription production and distribution), twice per week = £1,100

1.2 This includes additional work carried out outside Clinic time by Specialist Prescriber such as out of clinic hour's appointments, changes to scripts, off premise visits in emergencies and liaison with pharmacies etc

1.3 Number of patients/clients to be increased to maximum of 60 during the period Sep – Nov (5 per month).

**2. Payment for Drugs Prescribed by CAS**

2.1 Invoices to be presented to cover the cost of drugs prescribed by CAS.

2.2 Payment to be credited to NHS Cambs Prescribing Budget, not CAS.

**3. Support to Blood Borne Virus Clinics at Service Provider premises**

3.1 To be invoiced at £100 per 2 (two) hour clinic, including travelling time from CAS to Service provider premises.

**4. GP Support to Specialist Drug Service Education and Training Programme**

4.1 To be invoiced at £100 per hour for the production and delivery of training material.

4.2 Invoices to be presented by CAS following training delivery.

# Appendix 5 Recovery Champion Specification

### 1.0 Definition of the Service

The Service shall be provided to all Cambridgeshire residents who are over 18 years old who reside within Cambridgeshire who are current or former illicit drug users.

**Background**

Recovery champions (mentors) will assist and support vulnerable adults entering the treatment system and those already established but struggling in their treatment journey. This scheme will identify and assist the most vulnerable individuals with the engagement process and promote harm reduction and abstinence orientated treatment. It is recognised that this group of individuals (Vulnerable Adults), especially those with severe dependency and mental health issues, are most likely to struggle to access, engage and remain in drug treatment services. This group of clients may also have many complex problems, including involvement with the criminal justice system, poor educational and employment histories, family problems, and housing need. Some individuals may have poor social and personal resources upon which to build a new life. Having additional support to accompany them to appointments, completing forms, conducting home visits and providing peer support in a more 'informal' manner is more likely to ensure retention in the treatment system and improvements in health and wellbeing resulting in better outcomes in the treatment system. It will also empower individuals to achieve their personal goals which will build self confidence and help combat fear

This scheme will identify the needs of each individual to ensure that the support provided is personalised and is provided at the right level to meet the service user's needs. By maximising engagement opportunities and promoting harm reduction work and abstinence orientated treatment, this work will be providing 'added value' to the current commissioned treatment system.

This project will be in line with current National Treatment Agency (NTA) national strategic direction focusing clearly on the recovery agenda but recognising that some individual require that added 'helping hand' to assist them in their journey towards recovery.

### 1.1 Targets 2011/12

The Service shall be expected to train, develop, and support a minimum of 15 volunteer recovery champions across the county of Cambridgeshire.

The Service shall support a minimum of 30 vulnerable clients, across the county of Cambridgeshire, by accompanying them to appointments, completing forms, conducting home visits and providing peer support. We would expect these to be evenly split across the county as far as is practicably possible.

### 2.0 Aims and Objectives of the Service

The aims and objectives;

a. To work in conjunction with the relevant treatment service to ensure an effective working relationship.
b. To offer services which take account of safeguarding and promoting an individuals welfare at all times
c. To offer user friendly, confidential support, within clear information sharing protocols, to vulnerable clients in treatment.
d. To identify those who would be appropriate to become recovery champions
e. To train, develop and support those who become recovery champions.
f. To support vulnerable clients in improving their health and social functioning in relation to drug misuse.
g. To support vulnerable clients to encourage attendance at relevant appointments, including drug treatment, housing, education, or any other relevant appointment.

h. To contribute to the clients existing Care Plan by supporting the client to meet their treatment objectives
i. To work with clients in a 'recovery' based model incorporating goal setting and treatment aspirations

## 3.0 Provision of the Service

This service specification reflects the national move towards recovery and peer support as detailed in the National Drug Strategy 2010: Reducing Demand, Restricting Supply, Building Recovery and reflected in Cambridgeshire Drug and Alcohol Action Team's (DAAT) 3 year strategic priorities.
*http://www.homeoffice.gov.uk/drugs/drug-strategy-2010/,*
*http://www.cambsdaat.org/current_issues/*

## 4.0 Groups Served

This Service shall be offered to residents of Cambridgeshire over the age of 18 with drug misuse issues, or those registered with a GP in Cambridgeshire. The service shall be offered to vulnerable clients as a priority group attending drug treatment. The needs and characteristics of vulnerable adults will have significant overlap with the populations described either as "socially excluded" or "marginalised groups". See paragraph 4.1 for more details regarding "vulnerable adult".

## 4.1 Priority Groups/Target Groups

The Service shall be for:

a. Vulnerable adults, residents of Cambridgeshire over the age of 18 with drug misuse issues, or those registered with a GP in Cambridgeshire

There is no single recognised definition of a 'vulnerable adult' however the most commonly referred to definition of vulnerable adults (and also one of the oldest) is that provided by the "Who Decides" report published by the Lord Chancellor's Department in 1997, which defined a 'vulnerable adult' as

Vulnerable adults *"a person aged 18 or over who is or may be in need of community care services by reason of mental or physical disability, age, or illness, and who may be unable to take care of him or herself, or to protect him or herself against significant harm or exploitation".*

The Home Office Criminal Records Bureau (13/09/2010) provides a more comprehensive description of a vulnerable adult as a person who is aged 18 years or older who:

- is living in residential accommodation, such as a care home or a residential special school;
- is living in sheltered housing;
- is receiving domiciliary care in his or her own home;
- is receiving any form of health care;
- is detained in a prison, remand centre, young offender institution, secure training centre or attendance centre or under the powers of the Immigration and Asylum Act 1999;
- is in contact with probation services;
- is receiving a welfare service of a description to be prescribed in regulations;

- is receiving a service or participating in an activity which is specifically targeted at people with age-related needs, disabilities or prescribed physical or mental health conditions. (age-related needs includes needs associated with frailty, illness, disability or mental capacity)
- is an expectant or nursing mother living in residential care
- is receiving direct payments from a local authority/HSS body in lieu of social care services;
- requires assistance in the conduct of his or her own affairs.

There shall be no discrimination in regards to gender, race, sexual orientation, nationality, or physical disabilities. All clients shall receive information sharing agreements to allow open communication with the Treatment agency to assist the treatment process. All peer mentors will also be subject to a Criminal Records Bureau check to ensure effective risk assessment for those working with vulnerable groups and undertake appropriate training.

The characteristics likely to be prevalent amongst members of the target population group

- Are not in settled accommodation (and have spent significant periods of time without settled accommodation)
- Are not in employment (and have spent significant periods of time unemployed)
- Have a history of persistent offending and /or anti-social behaviour
- Have significant health and/or social care needs, particularly related to mental health and/ or drug / alcohol misuse
- May not be registered with a GP and /or have a poor history of engagement with mainstream health services
- Have involvement in the sex industry

**6.0 Referral into the service**

Referrals shall be accepted from <Specialist Service Provider> keyworkers and Drug Interventions Programme (DIP) keyworkers or offender managers. Clients will be identified as appropriate for this intervention through the initial comprehensive assessment undertaken by <Specialist Treatment Provider>.

The Service will retain responsibility for the client in terms of case management/care planning and the 'Recovery Champion' will assist the case manager by providing intensive support to the client encouraging retention in the treatment system and supporting the client through practical assistance and peer support. The Recovery Champion will support the service user in all aspects of their recovery promoting abstinence as the ultimate long term goal. If appropriate the Recovery Champion may attend joint meetings and contribute towards the care/recovery planning process in agreement with the client.

Where it is necessary to prioritise, priority will be given to those falling into different categories of vulnerability (defined in section 5).

**6.1 Exclusions/Risk Assessments**

Recovery Champions and those vulnerable clients being supported may be excluded for behaviour that breaches accepted rules and standards at the discretion of the service but within a structure of rights and responsibilities set out by the organisation.

Recovery Champions and those vulnerable clients being supported may be excluded as a result of a professional risk assessment and if they pose a serious risk to staff, other service users and members of the public.

The decision to exclude shall be clearly recorded and communicated to the relevant individual together with the circumstances that they would be allowed to re-engage with the service. Those who are

excluded shall be advised of / and/ or referred to alternative support routes that are available to them where possible.

The Service shall have a written plan on dealing with people who cause concern identified by a risk assessment, and refer them to appropriate services.

## 7.0 Publicising/ Promoting the Service

a. The Service shall publicise and promote its activities across the area it serves with approval from the DAAT and in line with County Council's communication guidelines.

b. The Service shall produce leaflets (and other appropriate materials) giving contact details of the service, eligibility criteria and services provided. The Contractor should gain the support of local community services.

c. The Service shall take into account the needs of diverse communities, and particularly look to target those traditionally seen as under represented in traditional drug and alcohol treatment settings (women, Black and Minority Ethnic (BME) groups etc.)

d. Service details shall be available via the 'Frank' national website/helpline, and the NTA Treatment Directory which is now accessed via the Talk to Frank website: www.talktofrank.com.

e. The DAAT shall support the Service in the publicity work described above, and shall ensure that the Cambridgeshire County Council website, DAAT website and any publications produced internally by the County Council contain accurate information about the service.

## 8.0 Staffing

8.1 Competencies and Training

a. The Service shall only employ staff who are suitably qualified and experienced or who are assessed as having the necessary personal attributes to undertake the role to which they are appointed.

b. All employees and any volunteers shall agree to be bound by the conditions of their contracts, which will outline specific training and competency requirements.

c. All staff whose shall be able to demonstrate a basic level of competence in the following areas:

- Multi-agency working
- Sharing information
- Safeguarding and promoting the welfare of the child
- Supporting those with drug dependency issues

d. All new practitioners within the service shall:

- Complete a planned programme of induction.
- Receive regular supervision and appraisal that covers training needs

e. The staff shall have knowledge of current legislation and demonstrable experience of delivering services to vulnerable client groups.

8.2 Staffing Structure

a. The Service shall employ a co-ordinator who will take overall responsibility for the strategic and operational delivery of the service.

b. The Service shall employ enough staff to deliver services across the area it serves. This may include volunteers.

8.3 Staff Supervision

Staff and volunteers must receive formal supervision from the service manager, it is expected that each member of staff (inc volunteers) shall the appropriate skills and knowledge to deliver and receive supervision.

- Formalised supervision shall be conducted on a minimum monthly basis and be recorded.
- Additional support should be provided to all staff as and when required.

## 9.0 Service Opening Times

a. The Service shall operate during appropriate hours to both meet the needs of potential peer mentors and vulnerable clients requiring the service and the demands of professionals who need to make referrals.

b. The service shall operate Monday to Friday for 52 weeks a year, excluding bank/ public holidays.

c. The Contractor shall be flexible and responsive to client need, operating peripatetically from satellite locations.

## 10.0 Policies, protocols and organisational standards

The service shall have written policies and protocols in place to support all the interventions provided and the context of working with vulnerable people. All policies shall have a named person with responsibility for implementation and monitoring and dates for review. As a minimum there should be policies regarding:

a. Safeguarding of Children
b. Adult Safeguarding
c. Management of Complaints
d. Health and safety
e. User involvement
f. Information sharing
g. Confidentiality
h. Drugs and alcohol in the workplace
i. Lone working
j. Exclusions from the service
k. Maximising access to underserved / socially excluded groups

Safeguarding

The Contractor shall operate in line with Cambridgeshire Local Safeguarding Children's Board (LSCB) Protocols and Cambridgeshire Adult Safeguarding policy

Policies on safeguarding children shall be agreed with the Local Safeguarding Children Board. All members of staff and volunteers shall have a Criminal Records Bureau check.

## 11.0 Data Collection Requirements

The Service shall be expected to comply with reporting requirements as requested by the DAAT, as they occur.

The Service will demonstrate outcomes in a format agreed with the DAAT before contract commencement.

## 12.0 Monitoring and Review

Monitoring shall form an integral part of the agreement between the service and the DAAT. The service shall be required to attend quarterly performance monitoring meetings with the DAAT. This shall include all aspects of individual service performance targets, as well as being an opportunity for the DAAT to pass on any new developments or directives from the NTA.

If there is any particular area of concern or certain targets are not being achieved, information on this area/ target may be requested more frequently at the discretion of the DAAT.

Where local milestones and targets are set to aid contract monitoring, these shall be developed and agreed with service providers. Performance information shall be submitted in a format agreed between the Service and the DAAT.

Submission of retrospective (previous quarter) expenditure profiles shall be submitted with quarterly invoice submissions to the DAAT.

Specific areas of data collection shall be requested on a quarterly basis, but not limited to:

a. Work force and workforce development (including vacancies)
b. Information about targeted work delivered during the preceding quarter.
c. Service user feedback data
d. Information about the training delivered.

## 13.0 Service User Involvement

There must be opportunities for Recovery Champions and Vulnerable Adults supported by the Mentors to provide feedback at all stages of the process.

The Service shall consult with service users regarding the delivery and development of the service. A charter of users' rights and responsibilities should also be displayed.

# Section 4 – Contract Documents

**DATED** **XXXX**

**(1) CAMBRIDGESHIRE COUNTY COUNCIL**

**-and-**

**(2)**

**CONTRACT**
**For the Provision of**
**Cambridgeshire Adult Drug Treatment Services**

Quentin Baker
Director of Legal Services LGSS Cambridgeshire County council
Shire Hall
Castle Hill
Cambridge CB3 0AP

**CONTRACT**

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CONTRACT

This Contract is made the day of 20XX
Between:
(1)

whose registered/principal office is at ("the Contractor") and

(2) CAMBRIDGESHIRE COUNTY COUNCIL
whose principal office is at
Shire Hall
Castle Hill
Cambridge
CB3 0AP ("the Council")

1.0 Purpose of the Contract

1.1 The purpose of this Contract is to secure the provision of the services set out and agreed in the Specification(s) set out at Schedule 1 to this Contract ("the Services") and the Contractor undertakes to provide the Services in accordance with the conditions of this Contract and the Specification(s) and to the satisfaction of the Council in consideration of the payments to be made by the Council as set out in Schedule 2 to this Contract.

2.0 Contract definitions/glossary

| | |
|---|---|
| TUPE | Application of Transfer Regulations – in the event any staff transfer from the current Contractor on retendering. |
| COSHH | Control of Substances Hazardous to Health |
| CRB | Criminal Records Bureau. |
| DAAT | Drug and Alcohol Action Team |
| Tender | means the document(s) submitted by the Contractor to the Council in response to the Council's invitation to suppliers for formal offers to supply it with the Services. |
| PTB | Pooled Treatment Budget – pooled funding streams from the Department of Health |

3.0 Duration of this Contract

3.1 The duration of the contract(s) will be initially for three years. An Annual Review will be undertaken. The following year's service delivery requirements are dependent upon a satisfactory Annual Review, budget availability, funding allocation. Subject to the above and any relevant changes in legislation, the DAAT reserves the option of extending for up to an additional four years, by way of two twenty four month instalments, to a total contract period of seven years. The contract will commence on Monday 2nd April 2012 and ending on 31st March 2015 unless terminated earlier in accordance with the terms of the contract.

3.2 The Contractor acknowledges that the Council has received no formal or informal indication from either the Department Of Health (DOH) or the National Treatment Agency (NTA) regarding the PTB allocation to be received by Drug and Alcohol Action

Team which is a team that sits within the Council for the years 2013 - 2015. The Contractor acknowledges that the Council is unable to guarantee funding for the Services for the years commencing 1st April 2013 and 1st April 2014.

4.0 The Contractor's Obligations

4.1 In providing the Services, the Contractor shall:

4.1.1 exercise all reasonable skill, care and attention to ensure that the highest possible quality Services are provided at all times and to ensure compliance with all terms of the Specification.

4.1.2 comply with all relevant legislation.

4.1.3 co-operate, liaise with and co-ordinate its activities with those of any other Contractor or Sub-Contractor of the Council and shall provide the Services in harmony with and at no detriment to any other services provided by or on behalf of the Council.

4.1.4 ensure that sufficient personnel are engaged in the provision of the Services and that such personnel are properly and suitably supervised, qualified and/or trained, competent, skilled, honest, courteous and experienced in the duties they are to perform and that they shall exercise care and are fully conversant with all matters that may affect the tasks they are to perform.

4.1.5 ensure that it manages its affairs in accordance with appropriate Regulatory Bodies (e.g. Charity and Company law) and abides by the Charity Commission's guidelines for trustees titled "Responsibilities of Charity Trustees".

4.1.6 provide agendas and minutes of the Contractor's Management Committee Meetings, relating to substance misuse, (properly recording recommendations and decisions) to the Council promptly upon request.

4.1.7 implement and maintain proper systems for recording and controlling expenditure and independently examined or audited accounts as required by legislation and provide the said accounts to the Council within 4 weeks of approval by the Contractor's Annual General Meeting or within 6 months of the end of each of the Council's financial years during the term of this Contract; whichever is the earliest. The Provider must inform the Council immediately when they recognise that they are unable to meet their liabilities.

4.1.8 within 14 days of request, where reasonably possible, to submit to the Council for inspection records of accounts and any other relevant supporting documentation the Council may require.

4.1.9 ensure that no person involved in the audit/certified accounts has any business or personal relationship to any persons involved in the day-to-day operation of the Contractor.

4.1.10 show separately in its accounts payments received under this Contract (as a restricted fund) and the way in which such payments have been applied.

4.1.11 on or before commencement of this Contract and every six months thereafter submit to the Council fully projected income and expenditure budgets for the next six months.

4.1.12 within seven months of the commencement of this Contract and every six months thereafter submit to the Council a full income and expenditure account for the previous six months in respect of which payments have been made by the Council under this Contract, related to funds supplied by the Council only.

5.0 Contract Manager

5.1 The Contractor shall appoint a Contract Manager empowered to act on behalf of the Contractor for all purposes connected with this Contract and shall forthwith give notification to the Council of the details of such person (and any subsequent appointment should that person cease to act). Any communication given or made to the Contract Manager shall be deemed to be made to the Contractor.

6.0 Contract Monitoring Officer

6.1 The Council shall appoint a Contract Monitoring Officer to act on behalf of the Council and notify the Contractor accordingly (and of any subsequent appointment). Any communication given or made to the Contract Manager shall be deemed to be made to the Contractor.

7.0 Financial Arrangements

7.1 The Contractor shall retain all prime financial records, relating to the period of this Agreement, for a period of no less than six years from the date of the end of this Agreement and allow authorised representatives of the Council access to these records on request (with reasonable notice given)

7.2 The parties agree that the charges for the Services set out in the Pricing Schedules (Section 5) hereto will be paid quarterly, 80% upfront and 20% in arrears following a certified satisfactory performance review and upon receipt of a valid invoice from the Contractor in accordance with the conditions of this Contract.

7.3 The charges for the Services may be reviewed in the event that the parties agree in writing to make any variation to this Contract or to the Services. The charges for the Services for the period following any agreed variation to the Services may be adjusted by written agreement between the parties acting reasonably.

7.4 If the parties are unable to agree the amount of the variation to the charges for the Services arising from any variation of the Services the matter will be resolved in accordance with the dispute procedure set out in clause 33.

7.5 Any such variation to the Contract or the Services any part thereof shall be in writing and shall be signed by both parties.

7.6 The Contractor shall:

7.6.1 Comply with all the financial requirements set out herein.

7.6.2 Notify the Council of any post funded through this Contract which remains vacant for three months or more. In these circumstances, the Council reserves the right to reduce the funding.

7.6.3 Provide the Council with audited copies of the Contractor's full annual accounts

8.0 Maximum fees payable under the Contract 2012 / 2013 will be the tendered sums.

8.1 The amount of funding available for 2012 / 2013 will be in the region of

- £4.2 million pounds

8.2 The sum specified in the Form of Tender be the maximum charge payable by the Council to the Contractor for the provision of the Services under this Contract and is inclusive of all costs and expenses incurred by the Contractor in providing the Services, specifically including the full clinical costs (including FP10s) associated with providing the Services.

8.3 The Contractor acknowledges that no charges other than those stated in the Form of Tender will be paid. The Contractor shall advise the Contract Monitoring Officer immediately if it becomes aware that an overspend may arise. The Provider will produce a plan to address the overspend in negotiation with the Council.

8.4 The total estimated charges payable for the Services in subsequent years 2013 / 2014 and 2014 / 2015 shall be submitted by the Contractor on or before 31st December of the preceding year, for the provision of Service in the following year for agreement by the Council.

8.5 The parties acknowledge that if the Council is unable to secure adequate funding from the Department of Health and other funding bodies to pay such charges for the Services for the years 2013 / 2014 and or 2014 / 2015 as may be agreed with the Contractor pursuant to sub-clause 8.4 then the Council may terminate this Contract pursuant to clause 20.

9.0 Invoicing arrangement

9.1 The Contractor must submit all invoices by the 14th day after each Quarterly Performance Meeting has occurred. The Council shall pay the received invoice as soon as is reasonably possible or within 30 days of receipt of invoices

9.2 All invoices should be sent to:

Invoice enclosed
FAO Cambridgeshire DAAT Coordinator
Box CC1207
2nd Floor, C Wing
Castle Court
Castle Hill
Cambridge
CB3 0AP

10.0 Assignment and Sub-Contracting

10.1 Neither the Council nor the Contractor may assign their rights under this Contract without the written agreement of the other, which shall not be unreasonably withheld or delayed.

10.2 The Contractor shall not sub-contract the Services or any part of them without the prior written agreement of the Council, such consent not to be unreasonably withheld or delayed.

11.0 TUPE

11.1 The Parties hereby acknowledge that, pursuant to the Transfer of Undertakings (Protection of Employment) Regulations 2006 ("TUPE"), there will be a relevant transfer on the Commencement Date and the contracts of employment for those employees who are wholly or mainly assigned in the Services immediately before the Commencement Date ("the Transferring Employees") will take effect as if originally made between the Contractor and the employees (save for those who object pursuant to Regulation 4(7) of TUPE).

11.2 The Council shall indemnify and keep indemnified and hold the Contractor harmless from and against all actions, suits, claims, demands, losses, charges, damages, costs and expenses and other liabilities which the Contractor may suffer or incur as a result of or in connection with:

11.2.1 any claim or demand by any Transferring Employee (whether in contract, tort, under statute, pursuant to European Law or otherwise) in each case arising directly or indirectly from any act, fault or omission of the Council in respect of any Transferring Employee on or before the Commencement Date.

11.2.2 any failure by the Council to comply with its obligations under Regulation 13 or 14 of TUPE or any award of compensation under Regulation 15 of TUPE save where such failure arises from the failure of the Contractor to comply with its duties under Regulation 13 of TUPE.

11.2.3 any claim (including any individual employee entitlement under or consequent on such a claim) by any trade union or other body or person representing any Transferring Employees arising from or connected with any failure by the Council to comply with any legal obligation to such trade union, body or person;

11.3 The Council shall be responsible for all emoluments and outgoings in respect of the Transferring Employees (including, without limitation, all wages, bonuses, commission, premiums, subscriptions, PAYE and national insurance contributions and pension contributions) which are attributable in whole or in part to the period up to and including the Commencement Date (including bonuses or commission which are payable after the Commencement Date but attributable in whole or in part to the period on or before the Commencement Date), and will indemnify/keep indemnified and hold the Contractor harmless from and against all actions, suits, claims, demands, losses, charges, damages, costs and expenses and other liabilities which the Contractor may incur in respect of the same.

11.4 The Contractor shall be responsible for all emoluments and outgoings in respect of the Transferring Employees (including, without limitation, all wages, bonuses, commission, premiums, subscriptions, PAYE and national insurance contributions and pension contributions) which are attributable in whole or in part to the period after the Commencement Date (including any bonuses, commission, premiums, subscriptions and any other prepayments which are payable before the Commencement Date but which are attributable in whole or in part to the period after the Commencement Date and will indemnify/keep indemnified and hold the Council harmless from and against all actions, suits, claims, damages, costs and expenses and other liabilities which the Council may incur as a result of the same**.**

11.5 Not later than twelve months prior to the end of the Contract Period, the Contractor shall fully and accurately disclose to the Council all information that the Council may reasonably request in relation to the Contractor's Staff including the following:

11.5.1 the total number of Staff whose employment/engagement shall terminate at the end of the Contract Period, save for any operation of law; and

11.5.2 the age, gender, salary or other remuneration, future pay settlements and redundancy and pensions entitlements of the Staff referred to in clause 11.5 (a); and

11.5.3 the terms and conditions of employment/engagement of the Staff referred to in clause 11.5.1, their job titles and qualifications; and

11.5.4 details of any current disciplinary or grievance proceedings ongoing or circumstances likely to give rise to such proceedings and details of any claims current or threatened; and

11.5.5 details of all collective agreements with a brief summary of the current state of negotiations with such bodies and with details of any current industrial disputes and claims for recognition by any trade union.

11.6 At intervals to be stipulated by the Council (which shall not be more frequent than every thirty days) and immediately prior to the end of the Contract Period the Contractor shall deliver to the Council a complete update of all such information which shall be disclosable pursuant to clause 11.5.

11.7 At the time of providing the information disclosed pursuant to clauses 11.5 and 11.6, the Contractor shall warrant the completeness and accuracy of all such information and the Council may assign the benefit of this warranty to any Replacement Contractor.

11.8 The Council may use the information it receives from the Contractor pursuant to clause 11.5 and 11.6 for the purposes of TUPE and/or any retendering process in order to ensure an effective handover of all work in progress at the end of the Contract Period. The Contractor shall provide the Replacement Contractor with such assistance as it shall reasonably request.

11.9 The Contractor shall indemnify and keep indemnified and hold the Council (both for themselves and any Replacement Contractor) harmless from and against all actions, suits, claims, demands, losses, charges, damages, costs and expenses and other liabilities which the Council or any Replacement Contractor may suffer or incur as a result of or in connection with:

11.9.1 the provision of information pursuant to clause 11; and

11.9.2 any claim or demand by any Returning Employee (whether in contract, tort, under statute, pursuant to European Law or otherwise) in each case arising directly or indirectly from any act, fault or omission of the Contractor or any sub-contractor in respect of any Returning Employee on or before the end of the Contract Period; and

11.9.3 any failure by the Contractor or any sub-contractor to comply with its obligations under Regulation 13 or 14 of TUPE or any award of compensation under Regulation 15 of TUPE save where such failure arises from the failure of the Council or a Replacement Contractor to comply with its duties under Regulation 13 of the Regulations; and

11.9.4 any claim (including any individual employee entitlement under or consequent on such a claim) by any trade union or other body or person representing any Returning Employees arising from or connected with any failure by the Contractor or any sub-contractor to comply with any legal obligation to such trade union, body or person; and

11.9.5 any claim by any person who is transferred by the Contractor to the Council and/or a Replacement Contractor whose name is not included in the list of Returning Employees.

11.10 If the Contractor becomes aware that the information it provided pursuant to clause 11.5 has become untrue, inaccurate or misleading, it shall notify the Council and provide the Council with up to date information.

11.11 This clause applies during the Contract Period and indefinitely thereafter.

11.12 The Contractor undertakes to the Council that, during the twelve months prior to the end of the Contract Period the Contractor shall not (and shall procure that any sub-contractor shall not) without the prior consent of the Council (such consent not to be unreasonably withheld or delayed):

11.12.1 amend or vary (or purport or promise to amend or vary) the terms and conditions of employment or engagement) (including, for the avoidance of doubt, pay) of any Staff (other than where such amendment or variation has previously been agreed between the Contractor and the Staff in the normal course of business, and where any such amendment or variation is not in any way related to the transfer of the Services);

11.12.2 terminate or give notice to terminate the employment or engagement of any Staff (other than in circumstances in which the termination is for reasons of misconduct or lack of capability);

11.12.3 transfer away, remove, reduce or vary the involvement of any of the Staff from or in the provision of the Services (other than where such transfer or removal:

(i) was planned as part of the individual's career development;

(ii) takes place in the normal course of business; and

(iii) will not have any adverse impact upon the delivery of the Services by the Contractor, (PROVIDED THAT any such transfer, removal, reduction or variation is not in any way related to the transfer of the Services);

11.12.4 recruit or bring in any new or additional individuals to provide the Services who were not already involved in providing the Services prior to the relevant period.

12.0 <u>Health & Safety</u>

12.1 The Contractor will comply with all British and European Health and Safety Legislation where appropriate.

12.2 The Contractor shall review its Safe Systems of Work and Risk Assessments as often as may be necessary and in the light of changing legislation, changing working practices, the introduction of new plant and technology etc. The Contractor shall notify the Council in writing of all such revisions to its health and safety documentation.

12.3 The Contractor shall keep all areas where its employees (or other personnel or sub-Contractor) are carrying out the Services in a safe condition, so far as the matters are under its control. The Contractor shall comply with the requirements of the Contract Monitoring Officer, the Council's Health and Safety Adviser or any other competent statutory Authority with respect to securing and maintaining the health, safety and convenience of the public or others.

12.4 Whilst undertaking the Services or working on premises owned or occupied by the Council, the Contractor shall ensure that its employees (and any sub-Contractor) comply with the Council's health and safety policy, the safe systems of work and risk assessments in place for the activity and the lawful requirements of the Council's Health and Safety Adviser.

12.5 The Contract Monitoring Officer or Council's Health and Safety Adviser shall be empowered to suspend the provision of the Services (or part of them) in the event of non-compliance by the Contractor with these Conditions or with its legal duties for health, safety and welfare matters. The Contractor shall not resume provision of the Services until the Contract Monitoring Officer is satisfied that the non-compliance has been rectified. The Contractor shall bear all costs associated with any suspension and resumption of the Services.

12.6 The Contract Monitoring Officer or the Council's Health and Safety Adviser may at any time during this Contract require the Contractor to provide copies of any Risk Assessments undertaken in accordance with the Management of Health and Safety at Work Regulations for the activities being undertaken under this Contract. The Contractor shall provide the same prior to or on the commencement of the Services.

12.7 The Council's Health and Safety Adviser or designated officers shall be empowered to access at any reasonable time any premises of the Contractor undertaking the Services under this Contract for the purpose of carrying out an inspection of health, safety and welfare standards. The Contractor shall fully co-operate with the reasonable requests of the Council's Health and Safety Adviser and shall provide access to all areas of the Services, health and safety documentation, welfare facilities, accident records, training records and certificates, equipment inspection records, statutory registers and notices, plant and equipment for the purposes of inspection. The Council's Health and Safety Adviser shall be empowered to take any photographs, measurements, samples, copies of health and safety related documents etc. which he deems necessary to determine the Contractor's compliance with health and safety legislation and best practice and as evidence of any non-compliance.

12.8 The Contractor shall record all accidents, which arise out of the Services in areas under its control. The Contractor shall keep those records for the minimum statutory time period and shall provide copies of accident forms and accident statistics to the Contract Monitoring Officer on request.

12.9 The Contractor shall notify the relevant health and safety enforcing Authority within the statutory time periods of any injury, dangerous occurrence or disease which is reportable under the current Reporting of Injuries, Diseases and Dangerous Occurrences Regulations arising from activities under its control. Copies of any such reports are to be provided immediately to the Contract Monitoring Officer and Council's Health and Safety Services Section.

12.10 The Contractor shall provide to the Contract Monitoring Officer, within 3 days of receipt, copies of any communication concerning the health, safety or welfare standards of the Services, which it receives from any statutory health and safety enforcing Authority.

13.0 Discrimination

13.1 The Contractor shall not unlawfully discriminate either directly or indirectly on such grounds as race, colour, ethnic or national origin, disability, sex or sexual orientation, religion or belief, or age and without prejudice to the generality of the foregoing the Contractor shall not unlawfully discriminate within the meaning and scope of the Sex Discrimination Act 1975, the Race Relations Act 1976, the Equal Pay Act 1970, the Disability Discrimination Act 1995, the Employment Equality (Sexual Orientation) Regulations 2003, the Employment Equality (Religion or Belief) Regulations 2003, the Employment Equality (Age) Regulations 2006, the Equality Act 2006, the Human Rights Act 1998 or other relevant or equivalent legislation, or any statutory modification or re-enactment thereof.

13.2 The Contractor shall take all reasonable steps to secure the observance of clause 13.1 by all Staff.

14.0 Environmental

14.1 The Contractor shall, when working on the Premises, perform its obligations under the Contract in accordance with the Council's environmental policy, which is to conserve energy, water, wood, paper and other resources, reduce waste and phase out the use of ozone depleting substances and minimise the release of greenhouse gases, volatile organic compounds and other substances damaging to health and the environment.

15.0 Prevention of Corruption

15.1 The Council may cancel this Contract and recover from the Contractor any amount the Council has lost in cancelling the same, if the Contractor or anyone acting on its behalf (whether with or without the knowledge of the Contractor) shall have:-

15.1.1 offered or given or agreed to give any person any gift or consideration of any kind as an inducement or reward for doing or forbearing to do or for having done or forborne to do any action in relation to the obtaining or execution of this Contract or any other contract with the Council, or;

15.1.2 shall have shown or forborne to show favour or disfavour to any person in relation this Contract or any other agreement with the Council;

15.1.3 committed any offence under:
the Bribery Act 2010 or
under legislation creating offences concerning fraudulent acts;
at common law concerning fraudulent acts relating to this Agreement or any other contract with the Council; or
defrauding or attempting to defraud or conspiring to defraud the Council

15.1.4 shall have given any fee or reward the receipt of which is an offence under Section 117 (3) of the Local Government Act 1972.

15.1.5 If any breach of Clause 16 is suspected or known, the Contractor must notify the Council immediately. If the Contractor notifies the Council that it suspects or knows that there may be a breach of Clause 16 the Contractor must respond promptly to the Council's enquiries, co-operate with any investigation, and allow the Council to audit books, records and any other relevant documentation. This obligation shall continue for six years following the expiry or termination of this Agreement.

16.0 Gratuities

16.1 The Contractor shall not, whether by itself or any of its personnel involved in the Services, illicit or accept any gratuity, tip, reward or charge for the Services except as may be properly approved by the Council in accordance with this Contract. The charging of fees for formal training services is in principle approved by the Council.

17.0 Monitoring

17.1 This Contract shall be subject to ongoing monitoring by the Contract Monitoring Officer who may from time to time also wish to carry out visits to the Contractor and/or inspect the Services being carried out.

17.2 This Contract shall also be subject to an annual review by the Contract Monitoring Officer covering all aspects of the operation of this Contract and the Services being carried out.

17.3 If, however, either party requires a review of this Contract or the Services, at any other time, then such a review shall take place at the earliest opportunity upon reasonable notice being given by the party requesting such a review.

17.4 In the final year of this Contract, the annual review will take place prior to 31/03/2xxx to assist the Council in considering whether or not it would wish to renew the Contract, any new Contract will be subject to the consent of the Contractor.

17.5 Any review meetings shall involve representatives of the Contractor (including the Chair and Contract Manager) and representative(s) of the Council (including the Contract Monitoring Officer).

17.6 Any review may include:-

17.6.1 details of the Services provided;

17.6.2 information on staffing (e.g. staffing levels, competence and qualifications);

17.6.3 information on volunteer involvement (e.g. their role and numbers);

17.6.4 information on the Contractor's finances;

17.6.5 proposals for development and improvement of the Services;

17.6.6 evaluation of the impact of Services provided;

17.6.7 barriers to progress; and

17.6.8 any other relevant matters.

17.7 The review process shall recognise the issues of confidentiality of the Contractor's affairs.

17.8 A copy of any reports on the outcome of all reviews will be provided to the Contractor with an opportunity for comment.

17.9 The Contractor shall allow the Council reasonable access to its premises, documents, records and personnel to enable the Council to undertake checks to ascertain that the Services are being provided in accordance with this Contract.

17.10 No additional charge shall be made by the Contractor for complying with the requirements of this clause.

18.0 Remedies for Unsatisfactory Performance by the Contractor

18.1 If the Council is of the opinion that the Services provided by the Contractor are Unsatisfactory, this includes financial performance as well as services delivered, discussion shall be held between the Council and the Contractor.

18.2 If following such discussion, the Council is of the opinion that the Services remain Unsatisfactory; the Council acting by its Contract Monitoring Officer may issue a Preliminary Letter setting out the particular respects in which the Services are Unsatisfactory.

18.3 Following the issue of a Preliminary Letter, the Council and the Contractor shall agree an Action Plan setting out what steps should be taken (and by when) by the Contractor to render the Services satisfactory.

18.4 If the Contractor, following the agreed Action Plan:

18.4.1 fails to comply with the Action Plan; or

18.4.2 performs other Services unsatisfactorily in a similar manner; the Council acting by its Contract Monitoring Officer may also issue a Default Notice.

18.5 A Default Notice shall set out the matters which, in the Council's opinion, constitute failure by the Contractor to satisfactorily carry out the Services or any of them.

18.6 Following the service of a Default Notice the Council and the Contractor shall discuss and agree an Advanced Action Plan.

18.7 The Contractor shall not be entitled to payment of any charges for agreeing or complying with any Action Plan or Advanced Action Plan.

18.8 For the purposes of this clause 18 the parties agree that Unsatisfactory shall mean that the Services have been provided or carried out inadequately or not in accordance with this Contract or the Specification.

19.0 Termination by the Council

19.1 The Council may by notice in writing terminate this Contract if any one of the following apply:-

19.1.1 the Contractor has failed to comply with this Contract in a way which the Council reasonably regards as incapable of being remedied;

19.1.2 the Council has given to the Contractor one month’s notice to remedy a substantial breach of this Contract and the Contractor has failed either to agree an Action Plan or to remedy the breach in accordance with the agreed Action Plan and for the avoidance of doubt the rights in this clause may be exercised by the Council separately from and in addition to the rights conferred by clause 18 of this Contract;

19.1.3 the Council has served three Default Notices at any time during this Contract;

19.1.4 the Contractor has failed to comply with an Advanced Action Plan

19.1.5 the Council is of the opinion that the Unsatisfactory provision by the Contractor of the Services is such as to undermine irreversibly the Council's confidence in the Contractor’s ability to provide the Services or is likely adversely to affect the image or reputation of the Council;

19.1.6 there has been a breach of Clause 15 (Prevention of Corruption);

19.1.7 the Council has failed to secure full funding for the Services and for the charges agreed by the parties to be payable to the Contractor for the Services from the

Pooled Treatment Budget (PTB) for the contract year commencing 1st April 2013 or for the contract year commencing 1st April 2014.

19.2 Subject to clause 19.3 no period of notice is required by the Council in respect of termination under sub-clause 1 above but notice shall state the date on which it shall have effect.

19.3 In the event of termination of this Contract by the Council pursuant to sub-clause 19.1.7 the Council shall give the Contractor at least two calendar months' notice in writing.

19.4 In the event of the termination of this Contract the Council shall be entitled to deduct from any sum or sums which would have been due to the Contractor under this Contract or any other Agreement or be entitled to recover the same from the Contractor as a debt for any loss or damage to the Council resulting from or arising directly or indirectly out of such termination.

19.5 On the termination of this Contract: (a) the parties shall be released from all future performance of their obligations under this Contract; and (b) determination shall not affect any right to damages which the Council may have in respect of any default giving rise to the determination or any other right.

20.0 Recovery upon Termination

On the termination of the Contract for any reason, the Contractor shall:

20.1 immediately return to the Council all Confidential Information, Personal Data and IP Materials in its possession or in the possession or under the control of any permitted suppliers or sub-contractors, which was obtained or produced in the course of providing the Services.

20.2 If the Contractor fails to comply with clause 20.1, the Council may recover possession thereof and the Contractor grants a licence to the Council or its appointed agents to enter (for the purposes of such recovery) any premises of the Contractor or its permitted suppliers or sub-contractors where any such items may be held.

21.0 Warranty

21.1 Each of parties warrants its power to enter into this Contract and that it has obtained all necessary approvals to do so.

22.0 Confidentiality

22.1 Except to the extent set out in this clause or where disclosure is expressly permitted elsewhere in this Contract, each Party shall:

22.1 treat the other party's Confidential Information as confidential and safeguard it accordingly; and

22.2 not disclose the other party's Confidential Information to any other person without the owner's prior written consent.

22.3 Clause 22.1 shall not apply to the extent that:

22.3.1 such disclosure is a requirement of Law placed upon the party making the disclosure, including any requirements for disclosure under the FOIA, Code of Practice on Access to Government Information or the Environmental Information Regulations pursuant to clause 34 (Freedom of Information);

22.3.2 such information was in the possession of the party making the disclosure without obligation of confidentiality prior to its disclosure by the information owner;

22.3.3 such information was obtained from a third party without obligation of confidentiality;

22.3.4 such information was already in the public domain at the time of disclosure otherwise than by a breach of this Contract; or

22.3.5 it is independently developed without access to the other party's Confidential Information.

22.4 The Contractor may only disclose the Council's Confidential Information to the Staff who are directly involved in the provision of the Services and who need to know the information, and shall ensure that such Staff are aware of and shall comply with these obligations as to confidentiality.

22.5 The Contractor shall not, and shall procure that the Staff do not, use any of the Council's Confidential Information received otherwise than for the purposes of this Agreement.

22.6 At the written request of the Council, the Contractor shall procure that those members of the Staff identified in the Council's notice signs a confidentiality undertaking prior to commencing any work in accordance with this Agreement.

22.7 Nothing in this Agreement shall prevent the Council from disclosing the Contractor's Confidential Information:

22.7.1 to any consultant, contractor or other person engaged by the Council or any government department or Regulatory Bodies;

22.7.2 for the purpose of the examination and certification of the Council's accounts; or

22.7.3 for any examination pursuant to Section 6(1) of the National Audit Act 1983 of the economy, efficiency and effectiveness with which the Council has used its resources or any examination pursuant to the Council's Best Value duties.

22.8 The Council shall use all reasonable endeavours to ensure that any government department, employee, third party or sub-contractor to whom the Contractor's Confidential Information is disclosed pursuant to clause 30.6 is made aware of the Council's obligations of confidentiality.

22.9 Nothing in this clause 22 shall prevent either party from using any techniques, ideas or know-how gained during the performance of the Agreement in the course of its normal business to the extent that this use does not result in a disclosure of the other party's Confidential Information or an infringement of IPR.

23.0 Force Majeure

23.1 Both parties shall be released from their respective obligations in the event of national emergency, war prohibitive government regulation or if any other cause beyond the

reasonable control of the parties or either of them, renders the performance of this Contract impossible whereupon all money due under this Contract up to the point of such release shall be paid immediately. Provided that this Clause shall have effect only at the discretion of the Council except when such event renders performance impossible for a continuous period of no less than three calendar months.

24.0 Notices

24.1 Any notice to be served on either of the parties by the other shall be sent by prepaid recorded delivery or registered post to the address of the relevant party shown at the head of this Contract.

25.0 Joint and Several

25.1 All agreements on the part of either of the parties which comprise more than one person or entity shall be joint and several and any singular gender throughout this Contract shall include all genders and the plural and the successor in title to the parties.

26.0 Proper Law and Jurisdiction

26.1 This Contract shall be governed by English Law in every particular respect including formation and interpretation and shall be deemed to have been made in England.

26.2 Any proceedings arising out of or in connection with this Contract may be brought in any Court of competent jurisdiction in England.

27.0 Waiver

27.1 The failure by either party to enforce at any time or for any period any one or more of the terms or conditions of this Contract shall not be a waiver of them or of the right at any time subsequently to enforce all terms and conditions of this Contract

28.0 Data Protection

28.1 The Contractor shall comply with obligations placed on it under the Data Protection Act 1998 (as amended or re-enacted from time to time) (including, where appropriate, obtaining or changing its registration) insofar as the performance of the Services gives rise to obligations under the 1998 Act.

28.2 The Contractor shall provide the Council with such information as the Council may reasonably require:-

28.2.1 to satisfy itself that the Contractor is complying with its obligations under Clause 28.1 above; and/or

28.2.2 in pursuance of any statutory duties and/or responsibilities that the Council may have in relation to Data Protection.

28.3 The Contractor shall not knowingly do anything which places the Council in breach of obligations under the 1998 Act. The Contractor shall indemnify and keep indemnified the Council against all actions and/or claims against the Council arising from the Contractor's alleged or actual breach of Data Protection legislation referred to in Clause 28.1 above, occurring as a result of the Contractor's conduct within the terms of this Contract.

29.0 Emergency Planning

29.1 The Civil Defence (General Local Authority Functions) Regulations 1983, Section 138 of the Local Government Act 1972, the Control of Industrial Major Accident Hazard Regulations 1984 and the Control of Industrial Major Accident Hazard (Amendment) Regulations 1988 and 1990 require the Council to prepare contingency plans to mitigate the effects of emergencies on the public of Cambridgeshire. In pursuance of these requirements, the Council reserves the right in accordance with such detailed instructions as may be issued to the Contractor by the Council or its Emergency Planning Officer to have at their disposal and under their direction, the Services of the Contractor and its employees for any purposes arising from such an emergency at any time during this Contract.

30.0 Third Party Rights

30.1 Nothing in this Contract shall create any rights for third parties under the Contract (Rights of Third Parties) Act 1999. No variation of this Contract and no supplemental or ancillary contract shall create any such rights unless expressly so stated in any such contract by the parties. This does not affect any right or remedy of a third party which exists or is available apart from the Act.

31.0 Disputes

31.1 The Parties shall attempt in good faith to negotiate a settlement to any dispute between them arising out of or in connection with the Contract within 20 Working Days of either Party notifying the other of the dispute and such efforts shall involve the escalation of the dispute to the [finance director (or equivalent)] of each Party.

31.2 Nothing in this dispute resolution procedure shall prevent the Parties from seeking from any court of competent jurisdiction an interim order restraining the other Party from doing any act or compelling the other Party to do any act.

31.3 If the dispute cannot be resolved by the Parties pursuant to clause 31.1 the Parties shall refer it to mediation pursuant to the procedure set out in clause 31.5 unless (a) the Council considers that the dispute is not suitable for resolution by mediation; or (b) the Contractor does not agree to mediation.

31.4 The obligations of the Parties under the Contract shall not cease, or be suspended or delayed by the reference of a dispute to mediation (or arbitration) and the Contractor and the Staff shall comply fully with the requirements of the Contract at all times.

31.5 The procedure for mediation and consequential provisions relating to mediation are as follows:

31.5.1 a neutral adviser or mediator (the "Mediator") shall be chosen by agreement between the Parties or, if they are unable to agree upon a Mediator within 10 Working Days after a request by one Party to the other or if the Mediator agreed upon is unable or unwilling to act, either Party shall within 10 Working Days from the date of the proposal to appoint a Mediator or within 10 Working Days of notice to either Party that he is unable or unwilling to act, apply to the Centre for Effective Dispute Resolution or other mediation provider to appoint a Mediator.

31.5.2 The Parties shall within 10 Working Days of the appointment of the Mediator meet with him in order to agree a programme for the exchange of all relevant information and the structure to be adopted for negotiations to be held. If considered appropriate, the Parties may at any stage seek assistance from the

Centre for Effective Dispute Resolution or other mediation provider to provide guidance on a suitable procedure.

31.5.3 Unless otherwise agreed, all negotiations connected with the dispute and any settlement agreement relating to it shall be conducted in confidence and without prejudice to the rights of the Parties in any future proceedings.

31.5.4 If the Parties reach agreement on the resolution of the dispute, the agreement shall be recorded in writing and shall be binding on the Parties once it is signed by their duly authorised representatives.

31.5.5 Failing agreement, either of the Parties may invite the Mediator to provide a non-binding but informative written opinion. Such an opinion shall be provided on a without prejudice basis and shall not be used in evidence in any proceedings relating to the Contract without the prior written consent of both Parties.

31.5.6 If the Parties fail to reach agreement in the structured negotiations within 60 Working Days of the Mediator being appointed, or such longer period as may be agreed by the Parties, then any dispute or difference between them may be referred to the Courts unless the dispute is referred to arbitration pursuant to the procedures set out in clause 31.6.

31.6 Subject to clause 31.2, the Parties shall not institute court proceedings until the procedures set out in clauses 31.1 and 31.3 have been completed save that:

31.6.1 the Council may at any time before court proceedings are commenced, serve a notice on the Contractor requiring the dispute to be referred to and resolved by arbitration in accordance with clause 31.7.

31.6.2 if the Contractor intends to commence court proceedings, it shall serve written notice on the Council of its intentions and the Council shall have 21 days following receipt of such notice to serve a reply on the Contractor requiring the dispute to be referred to and resolved by arbitration in accordance with clause 31.7.

31.6.3 the Contractor may request by notice in writing to the Council that any dispute be referred and resolved by arbitration in accordance with clause 31.7, to which the Council may consent as it sees fit.

31.7 In the event that any arbitration proceedings are commenced pursuant to clause 31.6:

31.7.1 the arbitration shall be governed by the provisions of the Arbitration Act 1996;

31.7.2 the Council shall give a written notice of arbitration to the Contractor (the "Arbitration Notice") stating:

(i) that the dispute is referred to arbitration; and
(ii) providing details of the issues to be resolved;

31.7.3 the London Court of International Arbitration ("LCIA") procedural rules in force at the date that the dispute was referred to arbitration in accordance with 31.7.2 shall be applied and are deemed to be incorporated by reference to the Contract and the decision of the arbitrator shall be binding on the Parties in the absence of any material failure to comply with such rules;

31.7.4 the tribunal shall consist of a sole arbitrator to be agreed by the Parties;

31.7.5 if the Parties fail to agree the appointment of the arbitrator within 10 days of the Arbitration Notice being issued by the Council under clause 31.4.2 or if the person appointed is unable or unwilling to act, the arbitrator shall be appointed by the LCIA;

31.7.6 the arbitration proceedings shall take place in London and in the English language; and

31.7.7 the arbitration proceedings shall be governed by, and interpreted in accordance with, English law.

32.0 Council Policies

32.1 Upon request by the Contractor to the Council, the Contract Monitoring Officer will make copies of the Council's own policies available to the Contractor.

33.0 Employees and Other Persons – Criminal Records Bureau Checks

33.1 Prior to employing or engaging a person in the provision of any part of the Services (including a volunteer or an employee of any sub-contractor) the Contractor shall ensure that an application for an Enhanced Criminal Record Certificate is made in respect of that person pursuant to Part V of the Police Act 1997 including;

33.1.1 where the provision of the Services may involve contact with children a search of the list held pursuant to the Protection of Children Act 1999 ; and

33.1.2 where the provision of the Services may involve contact with vulnerable adults a search of the list held pursuant to Part VII of the Care Standards Act;

33.1.2 and the Contractor shall ensure that no person who has a Relevant Conviction whether recorded on the Protection of Children Act 1999 list or the Care Standards Act 2000 list or the Enhanced Criminal Record Certificate is employed or engaged in the provision of any part of the Services.

33.2 The Contractor shall ensure that the Council is kept advised at all times of any person employed or engaged in the provision of the Services (including an employees of any sub-contractor) who subsequent to his commencement of employment or engagement received a Relevant Conviction or whose previous Relevant Convictions become known to the Contractor.

34.0 Freedom of Information Act 2000

34.1 Notwithstanding anything to the contrary contained or implied in any documents, negotiations leading to the formation of this Contract or in this Contract:

34.1.1 the Council shall be entitled to publish and/or release any and all terms or conditions of this Contract, the contents of any documents and/or information relating to the formation of this Contract under the provisions of The Freedom of Information Act 2000 as it sees fit;

34.2 The Contractor shall:

34.2.1 co-operate with the Council and supply to it all necessary information and documentation required in connection with any request received by the Council under the Freedom of Information Act 2000;

34.2.2 supply all such information and documentation at no cost to the Council and within seven days of receipt of any such request.

34.2.3 The Contractor shall not publish or otherwise disclose any information contained in this Contract or in any negotiations leading to it without the Council's previous written consent.

35.0 Business Continuity Planning

35.1 The Contractor acknowledges that the Council has a statutory obligation under the Civil Contingencies Act 2004 to maintain plans to ensure that it can continue to exercise all its functions in the event of an emergency so far as is reasonably practicable.

35.2 The Contractor shall implement and maintain a Business Continuity Planning Policy with tested contingency arrangements and shall provide a copy of the said policy to the Council upon request. The Business Continuity Plan shall address (without limitation) the following matters:

35.2.1 Provide a regular review and updating of the Business Continuity Planning documentation at least every three (3) years;

35.2.2 Provide for regular testing of the Business Continuity Planning Plan (at least yearly);

35.2.3 Provide details of the locations at which copies of the Business Continuity Planning documentation are held;

35.2.4 Provide details of the locations at which copies of any other important procedures and documents which form part of the Business Continuity Planning documentation are held;

35.2.5 Provide for IT systems recovery/backup arrangements and provision to ensure that these are carried out regularly and details of the locations at which these are held;

35.2.6 Provide for minimum contingency resources (for example access to reserve employees, IT hardware and systems, telephones) and details of any contingency site or location;

35.2.7 Provide contingency details relating to the loss of any key suppliers;

35.2.8 Provide contingency details relating to the loss or absence of any Employees;

35.2.9 Provide a Business Continuity Plan activation checklist;

35.2.10 Provide for communication processes and associated contact information covering key employees and suppliers/Contractor, and confirmation that the Council is included in the Contractor's priority customer list.

35.3 The Council reserves the right to require the Contractor's attendance at any contingency exercise or to conduct an audit of the Contractor's contingency arrangements.

36 Audit

36.1 The Contractor shall keep and maintain until 12 years after the end of the Contract Period, or as long a period as may be agreed between the Parties, full and accurate records of the Contract including the Services supplied under it, all expenditure reimbursed by the Council, and all payments made by the Council. The Contractor shall on request afford the Council or the Councils representatives or representatives of the Audit Commission such access to those records as may be requested by the Council in connection with the Contract.

36.2 The Contractor and its agents shall permit the Council and their appointed auditors and auditors appointed by the Audit Commission access free of charge during normal business hours on reasonable notice to all such documents (including computerised documents and data) for the purposes of the financial audit of the Council and for carrying out examinations into the economy, efficiency and effectiveness with which the Council has used its resources.

37.0 The Ombudsman

37.1 The Contractor acknowledges that the Commissioner for Local administration (the Local government Ombudsman) may investigate the performance of this contract by the Contractor and any act or omission in connection with this contract by the Contractor, its agent's employees or sub-Suppliers.

37.2 The Contractor shall at all times and without notice allow access to the Local Government Ombudsman or to any investigating officer appointed by the local Government Ombudsman in connection with any complaint to the local Government ombudsman in connection with this Contract. This shall extend to the Contractor's premises and all documentation and information relating to this contract. To which the Contractor has access.

37.3 The Contractor shall promptly make any payments resulting from any investigation, formal report or any local settlement proposed by the Local Government Ombudsman to the Council, as the Council may direct.

38.0 Indemnity and Insurance

38.1 The Contractor shall indemnify and keep indemnified the Council against all loss, damages, costs, charges and expenses at any time incurred or suffered by the Council and arising directly from any breach by the Contractor of this Contract or any of its obligations to the Council or from any negligence, negligent act, negligent omission, default or breach of duty on the part of the Contractor its employees, sub-Contractor's, agents or volunteers

38.2 The Contractor shall effect and shall maintain at all times during the continuance of the contract and for twelve months thereafter (or such longer period as, depending on the basis of claims covered by the insurance, will affect cover for the limitation period applicable to any relevant claim):

38.2.1 Public liability insurance in the minimum sum of five million pounds

38.2.2 Employers liability insurance of not less than ten million pounds

38.2.3 Professional indemnity insurance of not less than two million pounds

38.3 All levels stipulated shall be in respect of any one claim without limit in respect of the number of claims made in any 12 month period of insurance, such insurance to be effected with a reputable insurance company

38.4 In the case of professional indemnity insurance there shall be substituted the maximum amount of one million pounds if as a result of a joint risk assessment of the worst scenario giving rise to a claim it would appear that it would be reasonable and prudent level of cover.

38.5 The Contractor shall produce on demand to the Council the policy or policies of insurance, the schedules to such insurances and evidence of the payment of the last premium in respect thereof. If (but only if) the insurer's requirements prohibit the disclosure of the policy or the schedule the Contractor may satisfy the provisions of this sub clause by the production of next best evidence.

38.6 The Contractor shall not do anything or refrain from doing or omit doing anything, which might render any of the foregoing insurance policies void or voidable.

IN WITNESS whereof this Contract has been executed as a Deed and delivered the day and year first above written: -

THE COMMON SEAL of
CAMBRIDGESHIRE COUNTY COUNCIL
was hereto affixed in the presence of:-

Authorised Signatory

THE COMMON SEAL of (THE CONTRACTOR)
was hereto affixed in the presence of:-
OR
Executed as a Deed
on behalf of the Contractor:

Authorised Signatory
……

Position in Company (capital
letters)……

Date
……

Authorised Signatory ……..

Position in Company (capital letters)
……

Date……