

**Method Statement Section 3B, a: Single Point of Contact/Advice and Information/Assessment**

Method Statement Reference number	Spec Reference	Method Statement
<p>1. Section 1.0 Sub headings a – c</p> <p><b>Weighting 4</b></p> <p><b>Maximum word count of 1000 words</b></p>	<p>Definition of SPC/Advice and Information Service</p>	<p>Please demonstrate and detail how this part of the service will work.</p>
<p><b>Contractors response:</b></p> <p><u>Service Outline</u></p> <p>The Single Point of Contact (SPOC), advice, information and assessment elements of the Cambridgeshire Adult Drug Treatment Service will operate Monday – Friday 9am until 5pm with one late evening until 8pm and Saturday morning opening between 9am and 1pm. This service will be available from the operational bases in Cambridge, Huntingdon, Wisbech, St.Neot's and Ely. Eligibility criteria for the service will be any adult over the age of 18 in the Cambridgeshire area wishing to access recovery-focussed drug treatment services.</p> <p>Inclusion regards open access services of this nature as central to Cambridgeshire's recovery strategy because this service will often be a user's first experience of treatment and the point at which behaviour change is actively considered. We see our role as facilitators of that change and so this element of service will emphasise the engage, assessment, motivation enhancement and case management of service users. The service will also offer a safe, warm and welcoming environment for all service users.</p> <p>Whilst the service will be publicised as the 'front door' to treatment and recovery, we will prioritise exit planning from the point of engagement. We will explore the service user's educational and employment history, their accommodation status, their family and social networks; we will assist service users to recognise their existing recovery capital and to build more.</p> <p>The service will target specific groups using drugs across Cambridgeshire;</p> <ul style="list-style-type: none"> <li>• BME groups</li> <li>• Stimulant users</li> <li>• Homeless drug users</li> <li>• Women with children</li> <li>• Service users with complex needs including those with Dual Diagnosis</li> </ul> <p>The service will operate some outreach capacity in particular to services where we know users access. We will develop links with all community pharmacies and explore the need for outreach services to sex workers in consultation with commissioners, partner agencies and service users. The service will facilitate home visits where the service user is pregnant or</p>		

there are child safeguarding concerns. It is likely that a number of primary alcohol users may approach the service. After a brief screening discussion, we will refer these individuals in to the Addaction Alcohol Service. Our accommodation strategy for Cambridgeshire includes negotiating with Addaction to take over their existing premises and we intend to offer space to Addaction Alcohol Service staff under the new arrangements. This will help to facilitate alcohol referrals from the SPOC.

#### Advice, information & support

We will ensure that the service users are given timely, accurate and relevant information about substance misuse and other related issues. Inclusion recognises that service users will access the service often in crisis and be seeking help for problems other than their drug use. Service users will be made aware of their rights and responsibilities including our approach to confidentiality, when the service is open and how to access the service. Our aim is to provide sound advice, information and support as the first stage in engaging service users in our wider service provision.

#### Needle Exchange & BBV Interventions

Each service site will operate needle exchange. There will be access to needles, syringes and sharps bins. Pre-packed injecting packs will be available with sterile swabs, Vitamin 'C' sachets and sterile water. All packs will also include relevant harm reduction literature. Service users will be encouraged to make regular returns. The service will offer a range of condoms alongside sexual health advice and information. Inclusion will also operate nurse-led BBV testing and vaccination clinics at each service site.

#### Assessment, Care-Planning, Reviews & Key Working

Assessment and key working processes will be user-friendly to ensure the engagement process is a positive one. We know from experience, that if service user's initial experience of a service is positive, this will be relayed to other users. The assessment will determine and prioritise need and be underpinned by clear harm reduction advice and information. All service users will receive an initial assessment with 5 working days. However we would expect the majority of initial assessments to take place that day or the next.

Following assessment a Recovery Plan will be agreed that clearly identifies the priority needs, short term goals, the interventions or actions required to achieve the goals and who is responsible for undertaking each action (e.g. key worker, service user, other professional). The plan will include a contingency in relation to disengagement. Recovery Plans will address the four domains of substance use, health, social functioning and offending also taking into account the gender, ethnicity, sexuality and cultural background of the service user and any special needs they may have, for example, child care, working hours, religious observance. In order to be effective, the service will ensure that the service user is actively involved in the formulation of the Recovery Plan.

The Recovery Plan will also:

- Consider risks and develop a risk management plan.
- Agree information sharing arrangements by gaining a service user's consent.
- Identify a review date and circumstances where an earlier review may be necessary.

<p><u>Recovery Plan Reviews</u></p> <p>Plans will be reviewed regularly and will include:</p> <ul style="list-style-type: none"> <li>• The relevance of the plan as it stands and whether any new interventions or treatment options need to be added or considered. It will also include exit planning including development of an aftercare package and onward referral.</li> <li>• Any unmet needs</li> <li>• The service user's satisfaction with treatment and interventions received</li> <li>• Review of risks and risk management plan.</li> <li>• Review of information sharing agreements.</li> </ul> <p><u>Keyworking</u></p> <p>Inclusion key workers will help service users set specific, realistic and time-limited goals, which are then reviewed on each visit. This gives the whole treatment episode a structure, on which other interventions can be built. The service will use BTEI node-link mapping techniques, where the service user is encouraged to consider all the potential problem areas in their life, and prioritise the ones that are important to them (even if these don't relate to drug or alcohol use). This ensures that the whole process is collaborative, and involves joint input from worker and service user.</p>		
<p>2. Section 2.0 Sub heading 2.1</p> <p><b>Weighting 4</b></p> <p><b>Maximum word count of 500 words</b></p>	<p>Aim of the Service</p>	<p>Please demonstrate how the telephone reception point will be able to make appointments for clients in any part of the county.</p>
<p><b>Contractors response:</b></p> <p>Booking arrangements for appointments with any element of the Cambridgeshire Adult Drug Treatment Service will operate as follows:</p> <ul style="list-style-type: none"> <li>• A free phone Single Point of Contact telephone number will be available for callers to make all external bookings during normal office hours.</li> <li>• The SPOC telephone number will be advertised widely via posters, leaflets and electronic media in a wide range of community venues.</li> <li>• The SPOC line will be operated by a combination of practitioner and administration staff on a rota basis.</li> <li>• Each booking request via telephone will be screened to ascertain whether the booking is for an existing service user or new referral. Basic advice and information in support of the individual taking up the booking will be given during the call.</li> <li>• The service will operate an electronic diary system covering all service delivery sites to ensure that available appointments are easily accessible.</li> </ul> <p>Staff will be trained and expected to uphold basic communication standards when answering the SPOC telephone line. These are:</p> <ul style="list-style-type: none"> <li>- Attempts should be made to answer the telephone within five rings</li> <li>- In circumstances where the telephone is left unmanned, arrangements should be made to transfer calls to another member of staff or message system.</li> <li>- A verbal handshake should be given, e.g. 'good morning' and 'hello'.</li> <li>- Identify the name of the service.</li> </ul>		

- The person answering the phone should identify himself or herself by name and job title.
- If a call needs to be transferred to another person, ascertain the name of the caller and the nature of the call
- If the caller needs to be kept waiting: keep them informed of the progress, apologise for any inconvenience and thank the caller for waiting
- If necessary, take accurate messages which should include: date of call, time of call, callers name, agency name, what the call is about, the telephone number of caller and the action to be taken, e.g. you will ring back at ...

3. Section 2.0 Sub heading 2.2	Objective of the Service	Please demonstrate the methods by which advice and information and referrals will be provided or accepted by the service. E.g., telephone, verbal, electronic
<b>Weighting 4</b>		
<b>Maximum word count of 500 words</b>		

#### ***Contractors response:***

##### Provision of Advice & Information

The service will supply a full range of relevant, contemporary, accurate and localised advice information in the following forms:

- The service will sign post requests for advice and information to other more appropriate services when callers have misunderstood the nature of the service on offer.
- Telephone advice and information on drug use and treatment services will be available during normal working hours to all callers. We would expect telephone advice to be provided by a combination of service staff, volunteers and Recovery Mentors.
- Telephone requests for advice and information will also be sign posted to relevant internet sites as appropriate. Telephone callers, particularly family and carers seeking help in relation to a loved one's substance use, will be encouraged to call into the service for face-to-face conversations as much as possible to aid potential future referral.
- The service will display industry standard posters and wall charts relating to drugs, their use and their effects.
- The service will stock and distribute a full range of industry standard information leaflets and pamphlets available to all service users and other visitors
- The service will maintain a publically accessible computer to enable service users and other visitors access to appropriate websites for advice and information purposes
- The service will maintain a closed loop television and video player for the purposes of showing advice and information films and marketing materials

##### Referrals to the service

The service will accept referrals in the following ways:

- Self Referral

Any potential service user may 'drop-in' to the service during opening times and self-refer on the spot. They will be seen within minutes by a Recovery Mentor who will make them feel welcome and provide them with a hot drink and basic information about the building and its amenities. A triage assessment will take place within a maximum of one hour after drop-in. Self-referral may also be made via telephone in the first instance at which point an

appointment for a triage assessment can be made that day. If the new service user wishes to be accompanied by a family member or carer the service will support and facilitate this.

- Referrals from other services

The service will take written referrals from all other services and professionals across Cambridgeshire. Telephone referral will be possible when verbal information is back up with a completed referral form within 24 hours.

- Criminal Justice referrals

Referrals from all parts of the Criminal Justice System will be accepted. Where a Drug Intervention Record can be shared we will encourage this.

The service will develop and circulate a basic referral form to all potential referring agencies. It will include the following details:

- Name and address
- Contact telephone number
- GP details if applicable
- Basic details of current drug use
- Any known risk factors
- Service user awareness of referral

Referral forms will be accepted by hand, by fax delivery and by secure email.

<p><b>4. (Section 3B)</b> Section 2.0 Sub heading 2.1 – 2.2</p> <p><b>(Section 3A)</b> Section 7.0</p> <p><b>Weighting 4</b></p> <p><b>Maximum word count of 1000 words</b></p>	<p>Aims and Objectives of the Service</p> <p>Referral and Assessment</p>	<p>Please demonstrate the referral mechanisms that will be used both internally and externally to the drug treatment system once an initial assessment or triage has taken place.</p>
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***Contractors response:***

Internal Referrals

Internal referrals between elements of the Cambridgeshire Adult Drug Treatment Service will be handled in a uniform manner across all service sites and modalities. Each referral:

- Can be initially be made verbally via direct contact between staff in each element of service
- All referrals will be accompanied by up to date assessment, risk assessment, recovery plan and any supporting documentation via an internal mail system
- All service user records will be updated on the HLAO system in recognition of referral, to allow for proper case management and to facilitate NDTMS reporting where appropriate.
- Upon each referral, where Care Co-ordination sits will be reviewed and changed as appropriate.
- Each service user will have a disengagement plan in place should they drop out of service during a referral
- Confidentiality agreements and consent to share information will cover all aspects of

the service to facilitate referral.

- Where service users are expected to access a different locality due to the nature of a referral Recovery Mentors will be available to smooth the transition and guard against treatment drop outs.

#### External Referrals

- In-patient Detoxification

Inclusion will ensure that the service works closely with Cambridgeshire Alcohol Treatment Service to manage the county's in-patient detoxification waiting list. Inclusion recognises the value and necessity of in-patient provision for some service users will seek to access current hospital based detoxification provided by Cambridgeshire & Peterborough NHS Foundation Trust (CPFT).

To support service users accessing in-patient detoxification we will;

- Ensure service users understand the remit if in-patient detoxification
- Support service users to prepare for in-patient detoxification through key work and group work based interventions
- Involve family and carer's in planning for in-patient detoxification
- Agree care co-ordination arrangements with CPFT
- Make treatment information available to CPFT in line with confidentiality agreements signed by service users
- Ensure comprehensive aftercare is in place for service users after in-patient detoxification including relapse management, ETE provision, accommodation advice, family/carers support, links to mutual aid groups and access to social & leisure opportunities.

#### Residential Rehabilitation

During the implementation phase following contract award Inclusion will consult with commissioners and service users to review current residential rehabilitation pathways. Inclusion's strategy in respect referral to residential rehabs is likely to include:

- Appropriate referral of service users to relevant organisations, local or otherwise, based upon need, service user choice, available funding and the host organisation's track record in achieving outcomes.
- Inclusion will develop excellent joint working relationships with those rehabs where service users are referred. This will facilitate supportive pre-admission recovery planning, service user awareness & ownership of the rehabs approach to treatment, robust aftercare and contingency planning in the event of an unplanned discharge.
- Inclusion understands that a number of service users will arrive at local rehabs independent of the local drug treatment system. This is important in that some of those service users may drop out of treatment and leave a rehab but remain in the Cambridgeshire area still misusing drugs and in need of treatment services. Inclusion will establish clear working protocols with all rehabs that will encourage service users to access the Adult Treatment Aftercare Service when leaving residential treatment.
- Where service users not from the local area leave rehabs in an unplanned way, Inclusion will seek to engage this group and where appropriate, facilitate a return to **their** normal town of residence. For some this will be inappropriate as they may have left their home town as a way of dealing with substance misuse and related issues. However for some, a return to a supportive network of family and friends may be the best option. This will be explored in each service user's recovery plan.

<u>Mutual Aid</u> Peer support initiatives will be promoted and all staff will actively discuss mutual aid as a referral option. We will open up service premises for use by NA, AA and Smart groups and provide staff and service users with appropriate training about mutual aid programmes. Where allowed, service users referred to mutual aid will attend the first meeting with the individual.		
5. Section 3.0 Sub heading b  <b>Weighting 4</b>  <b>Maximum word count of 1000 words</b>	Provision of the service	Please demonstrate how this element of the service will deliver "other structured treatment"
<b><i>Contractors response:</i></b> Inclusion will offer 'other structured treatment' interventions at each service site across Cambridgeshire. It is our intention to have Recovery Mentors available in all reception areas to meet and greet new referrals prior to initial assessment. Other structured treatment interventions will include:  <u>Harm Reduction</u> The service will offer harm reduction interventions as a core component of service deliver. This will include: <ul style="list-style-type: none"> <li>• Verbal and written information about tolerance to drugs and safer injection and access to sterile injecting equipment.</li> <li>• Verbal and written information about the physical, psychological and social implications of drug use</li> <li>• Health examinations that will include checks on injecting sites and wound dressing</li> <li>• Providing intelligence about the purity and contamination of illicit drugs supplied locally.</li> <li>• Recovery Mentors will be trained to make harm reduction advice and information available including overdose management.</li> <li>• Advice and information safer sexual practices and sexually transmitted diseases.</li> <li>• Advice and information in relation to Blood Borne Viruses including pre and post counselling and vaccination opportunities.</li> <li>• Harm reduction interventions will always be supported by attempts to engage service users in structured treatment where appropriate</li> </ul> <u>Brief Interventions &amp; motivational enhancement</u> All staff will be trained in Brief Interventions including Motivational Interviewing and Brief Solution Focussed Therapy. These interventions can increase a service user's motivation to address their substance misuse and increase numbers into treatment. We will work with service users to consider how their lives have been affected by substance misuse, look at alternatives and plan for the future. Our approach to enhancing motivation is to build the individual's understanding of their substance misuse, raise the possibility of a different life style and support the service user in closing the gap between they are and where they want to be. We will do this through; <ul style="list-style-type: none"> <li>- Providing feedback to service users in the form of clear advice &amp; information</li> </ul>		

- Ensure that the ownership of the need for change is placed on the service user
- Outline the menu of possible courses of action
- Ensure our responses are always empathetic and non-judgmental
- Re-enforce in the self-efficacy inherent in service users
- Developing social and life skills
- Pro-social modelling and ownership of social responsibility
- Peer support from Recovery Mentors during opening hours and via telephone out of hours.
- Crack Cocaine and other stimulant specific interventions will be offered in the form of short-term, focused sessions.
- Relapse management - for many service users accessing this element of the service managing lapses and relapses will be an important skill.

#### Pathways to other services

- The service will ensure excellent links to mutual aid organisations including NA, AA and SMART Recovery are in place and easily accessible for all service users
- Emergency, temporary and longer term accommodation options will be explored. We will make advice & information available on access to local Housing Association and private sector housing.
- Welfare Benefits advice and information will be available to help service users claim benefits they are eligible for. Staff will assist with form filling and signposting to services.
- Service users without a current GP practice registration or those who do not routinely access their GP will be encouraged to take up general medical services via primary care. We will advocate and support service users to do this.
- Mental Health services. The Adult Drug Treatment service will liaise with the Home Treatment Team to ensure that service users with mental health issues access treatment and receive the correct level of care co-ordination.
- Education, Training and Employment (ETE) pathways will be open to all service users. Service staff will provide a level of ETE advice and information and we will broker in support from ETE agencies in the form of outreach clinics at all service sites.
- Referral and signposting to other services including Genito-Urinary Medicine clinics, Maternity services and Smoking Cessation advice.

#### Family & Carer Support

Inclusion understands the impact that drug misuse can have families and carers including the risk of domestic violence, accidents in the home, relationship problems, theft, housing and employment problems, lack of money for basic essentials, damage to unborn children, hospitalisation, imprisonment or death. The service will identify the needs and risks faced by families and carers affected and ensure that they receive appropriate services. Wherever family and carers will be involved in engaging the drug user into treatment and in the Recovery Plan. Service users will be encouraged to involve their families and significant others in their care in order to achieve successful treatment outcomes, except in cases where this is not in the interest of the service user and may hinder their treatment. The service user is asked at assessment for written consent that family members or partners can be involved treatment and they are named on the confidentiality consent agreement.

#### Complimentary Therapies

Inclusion will support the provision of complimentary therapies limited to Aromatherapy, massage, Reflexology and Auricular Acupuncture. The use of detox and sleep teas will also be considered.

**Method Statement Section 3B, b) Harm Reduction, b.i) Needle Exchange**

Method Statement Reference	Spec Reference	Method Statement
1. Section 1.0  <b>Weighting 5</b>  <b>Maximum word count of 2000 words</b>	Definition of the service	Please demonstrate how the service intends to support and retain current pharmacies, all associated costs and how it intends to develop growth in this area.
<p><b>Contractors response:</b></p> <p>Inclusion supports the maintenance and further development of pharmacy needle exchange across Cambridgeshire and believes the basis of doing this is will be to focus our attention on three key themes; support for pharmacies, reasonable payments and the provision of training.</p> <p><u>Pharmacy Support</u></p> <ul style="list-style-type: none"> <li>• Our partnership work with community pharmacies will stress the valuable role they play in the county's overall approach to substance misuse. Our aim here is to underline the important role pharmacies can play in the aims and objectives of community safety and health promotion.</li> <li>• Pharmacies are businesses and all good businesses want to expand their customer base and meet their customer's needs. For Inclusion, drug users should be able to access pharmacy provision to meet their needs as much as any other group and in this sense we have a shared goal – to increase the numbers of people accessing needle exchange and to improve the quality of the service they provide. Our support for pharmacies will facilitate this.</li> <li>• Each community pharmacy taking part in the needle exchange scheme will be supplied by the Adult Drug Treatment Service with regular re-stocks of agreed injecting equipment. The Adult Drug Treatment Service will also organise the delivery of needle exchange clinical waste and sharps at regular intervals to be agreed with each pharmacy. Re-stocking procedures will be simple and straight forward using weekly faxed forms detailing delivery requirements.</li> <li>• Each community pharmacy will be supplied with an agreed proforma for recording all needle exchange transactions. This will include basic details relating to individual service users and will also be used as a record for making payments to each pharmacy for the exchanges they have carried out. Where possible, we will encourage pharmacies to record this information direct onto a bespoke database they the service will make available.</li> <li>• We will encourage community pharmacies to be represented at relevant Cambridgeshire DAAT forums, meetings and seminars to ensure they play a full part in the local strategy and action plans in relation to drug misuse.</li> <li>• We will help local pharmacies plan their out-of-hours opening rota by supplying information relating to the opening times of the specialist service.</li> <li>• A designated member of the Adult Drug Treatment Service staff team will regularly visit all community pharmacies engage in the needle exchange scheme to ensure everything is operating well in terms of equipment deliveries and clinical waste collection. This will also be an opportunity to discuss any issues with service users, take service user feedback and provide ad-hoc advice, information and training to pharmacy staff.</li> </ul>		

- All community pharmacies will be able to on the spot advice and information by using the SPOC contact telephone number and the name of a designated staff contact for any enquiries they may have.
- We will work with pharmacies to assist them to drive up the levels of safe return of injecting equipment. They will be encouraged to urge all service users to return all the equipment supplied on a regular basis using the sharps bins provided.
- The service will supply appropriate harm reduction and health promotion materials to all community pharmacies for distribution with injecting equipment. Stocks will be replenished regularly by service staff.
- We will support pharmacy staff to encourage and record service user feedback about needle exchange interventions and unmet needs to continuously improve the services we can offer across the county.
- We will act as a central 'library' of good needle exchange practice and ensure that this information is cascaded to all pharmacies via briefings, ad-hoc verbal updates and occasional seminars for pharmacy-based staff.
- Inclusion is aware that not all pharmacy staff will have a positive attitude towards work with service users accessing needle exchange. In this case, we will work with such staff to raise awareness, answer any questions they may have, underline the benefits of needle exchange and drug treatment in an effort to bring them on-board.
- The service will encourage responsible and pro-social behaviours amongst our client group as they go about accessing community pharmacy provision. If a service user present a persistent problem in the way they behave this will be address in key work sessions at the specialist service.

#### Pharmacy Payments

- Community pharmacies will not be charged for the supply of injecting equipment or the collection of clinical waste generated by the needle exchange scheme. These costs will be born centrally by the Adult Drug Treatment Service and have been included in the annual service budget.
- Community pharmacies will not be charged for the supply of harm reduction marketing materials. These materials will be supplied from stocks held centrally by the Adult Drug Treatment Service and have been included in the annual service budget.
- Inclusion wil analyse all existing payment agreements with community pharmacies across Cambridgeshire. We will negotiate the best prices possible for exchanges but would expect to pay each pharmacy an annual retainer somewhere in the region of £xxx and the sum of £x.xx for each exchange that is provided. We will expect each pharmacy to invoice the service on a monthly basis and will ensure payment is made in full with 30 days.

#### Pharmacy Training

- It is possible that community pharmacies may come into contact with some groups of drug users seeking needle exchange facilitates that have been under-represented in many drug services. These groups include women and steroid users as well as harder to reach groups such as the homeless. With this in mind, we will ensure that community pharmacies carry harm reduction materials relevant to these groups and are strongly encourage to link these types of users in specialist services where they can access a broader range of services. The training will highlight the risks that these and other groups face in relation to their drug and injecting in particular and emphasise the interventions that can be provided.
- The service will work with community pharmacy staff to ensure they understand the need for confidentiality in respect of needle exchange. We understand that in busy

pharmacies that lack space, absolute privacy is sometime difficult to guarantee.

- We will offer training to all pharmacy staff in the safe handling, storage and disposal of all injecting equipment.

#### Developing Pharmacy Needle Exchange

It is Inclusion's intention to audit the current geographical spread and range of pharmacy needle exchange in Cambridgeshire during the early stages of the contract. We will consult with commissioners, service users and other partners to a pharmacy development strategy over the next three years. The precise nature of the strategy will emerge through analysis and consultation but the broad thrust is likely to include;

- Ensuring that all Cambridgeshire residents have access to some form of needle exchange service within 10 miles of their home.
- In consultation with commissioners, we will consider whether to approach particular pharmacies about developing level 2 needle exchange services. This would involve the provision of an enhanced service including access to BBV vaccination and would attract an additional payment for the pharmacies involved
- Where a community pharmacy has the available space but is unable to provide enhanced services itself, Inclusion will negotiate use of that space to deliver Hepatitis B vaccinations, wound management clinics and advice and information about safer injecting techniques from one of trained staff.
- We will work with all community pharmacies to expand the range of injecting equipment available until unmet needs become apparent. Inclusion intends to encourage more local injecting steroid users to access services and this will necessitate pharmacies adapting the syringes and needles they offer. We will agree an expanded range of equipment as required with each pharmacy.

2. Section 2.0 Sub headings a – b	Location of the service	Please demonstrate and detail how this service will be delivered in house, in pharmacies and beyond.
<b>Weighting 4</b>		
<b>Maximum word count of 1000 words</b>		

#### ***Contractors response:***

The aims of all Inclusion's needle exchange provision across Cambridgeshire will reflect the service specification, National Treatment Agency (NTA) guidance and NICE Public Health guidance. Inclusion will deliver needle exchange services that::

- Reduce BBV rates among the local population and encourages injectors not engaged with services to do so.
- Offers a service that injectors feel comfortable accessing.
- Works with IV users to minimise harm until such time as they can move away from injecting.
- Offers a full range of injecting equipment so that the service is relevant to local need
- Promotes safe disposal and return of injecting equipment and discourages dangerous discarding
- Proactively delivers harm reduction messages including safer injecting and reduces incidences of overdose and high risk poly-drug use

- Provides excellent health care interventions for injectors
- Seeks to attract and retain IV users in services to promote harm reduction and encourage service users into structured treatment.

We will meet these aims by delivering needle exchange services in the following ways:

#### In-House Needle Exchange Provision

Service users will be able to access in house needle exchange across the 5 fixed service sites between 9am and 5pm Monday to Friday, with late opening on at least one evening. Services will also be able to facilitate exchanges on Saturday mornings between 9am and 1pm. Each needle exchange facility will be covered by a designated, trained member of staff on a rota basis, supported by a trained volunteer. All service users will be asked to register their basic details but as a minimum needle exchanges will be recorded by each service user having a unique identifier made up of their initials and date of birth. The 'level 3' (as per NICE Guidelines) needle exchange service that will be made available to all service users at fixed sites will include:

- Access to a full range of injecting and associated equipment detail in the answer to question 3 below.
- The provision of sharps bins and advice on how to dispose of needles and syringes safely.
- Up to date harm reduction advice and information safer injecting practices
- Regular, on-site nurse-led clinics where injection-sites can be assessed and infections treated
- Advice and information on overdose prevention and alternatives to injecting
- Access to pre and post test counselling for Hepatitis A, B and C and HIV
- Hepatitis A and B vaccination
- Advice and information about sexual health and the provision of condoms
- Pathways into structured treatment

Needle exchange facilities will be maintained and available via the Cambridge Access Surgery clinics at set times to be agreed during contract implementation.

#### Community Pharmacy Needle Exchange Provision

Service users accessing community pharmacies can do so during their normal publicised opening hours and late openings that are available on a rota basis. Service users will be able to access a range of injecting equipment and return used items. Pharmacy staff will be trained to give basic harm reduction advice and information and signpost service users to specialist services.

As described above, Inclusion will, in consultation with commissioners and service users, review the current geographical spread of community pharmacies offering needle exchange but as a minimum, we intend to continue to support needle exchange services at the following community pharmacies (detailed on the Cambridgeshire DAAT website):

#### Cambridge City

Superdrug, 38 Fitzroy Street, Cambridge, CB1 1EW  
Boots, Unit 5-6, Grafton Centre, Cambridge, CB1 1PS  
Petersfield, 56 Mill Road, Cambridge, CB1 2AS

Kumar, 2 Adkins Corner, Cambridge CB1 3RU  
Boots, 237 Cherry Hinton Road, Cambridge, CB1 7DA  
Kumar, 15 Rectory Terrace, Cherry Hinton, CB1 9HU  
Lloyds, 30 Trumpington Street, Cambridge, CB2 1QZ  
Superdrug, 59 Sidney Street, Cambridge, CB2 3HX  
Rowlands, 189 Histon Road, Cambridge, CB4 3HL  
Boots, Unit 3, Retail Park, Newmarket Road, Cambridge, CB5 8WR

#### East Cambridge

Lloyds, 22 Main Street, Littleport, CB6 1PJ  
Lloyds, 19 High Street, Ely, CB7 4LQ  
Boots, 6-8 Market Street, Ely, CB7 4PB  
Lloyds, 31 High Street, Soham, CB7 5HA

#### Fenland

Boots, Unit 15, The Horsefair, Wisbech, PE13 1AR  
R.Fairbrother, 5 Church Terrace, Wisbech, PE13 1BJ  
National co-op, 25 St Augustine's Road, Wisbech, PE13 3AD  
Boots, 8 De-Havilland Road, Wisbech, PE13 3AN  
Boots, 6 Kirkgate Street, Walsoken, Wisbech, PE13 3QR  
Boots, Marylebone Road, March, PE15 8BG  
Boots, 17-19 Broad Street, March, PE15 8TP  
Lloyds, 22-24 High Street, Chatteris, PE16 6BG

#### Huntingdonshire

Boots, 33 High Street, St Neot's, PE19 1BW  
Tesco, Barford Road, St Neot's, PE19 2SA  
Lloyds, 20 Great Whyte, Ramsey, PE26 1HA  
Lloyds, Unit 2, Stocking Fenn Road, Ramsey, PE26 1SA  
Lloyds, 5 The Pavement Market Hill, St Ives, PE27 5AD  
Boots, 5-6 Sheep Market, St Ives, PE27 5AH  
J.G.Clifford, 3 The Causeway, Godmanchester, PE29 2HA  
Boots, 42 High Street, Huntingdon, PE29 3AQ  
Lloyds, 72A Ermine Street, Huntingdon, PE29 3EZ  
Boots, 8-10 High Causeway, Whittlesey PE7 1AE

#### Other Needle Exchange Initiatives

Inclusion will explore the opportunities for outreach and peer needle exchange. Outreach needle exchange can be provided using portable supplies distributed by trained staff and volunteers for example in rural areas. Outreach needle exchange has also been shown to be effective during street-level interventions with sex workers. Peer needle exchange services can also be effective – service users are trained in needle exchange and then through their social networks approach other users and facilitate exchanges & returns.

<p>3. Section 3.0 Sub heading 3.2 a – j</p> <p><b>Weighting 4 Maximum word count of 500 words</b></p>	<p>Objectives of the service</p>	<p>Please detail what the service intends to offer in terms of paraphernalia for needle exchange.</p>
<p><b>Contractors response:</b></p> <p>Inclusion is an experienced provider of Needle Exchange services through specialist services and the co-ordination of community pharmacy exchange programmes. The principles underpinning our delivery of needle exchange include:</p> <ul style="list-style-type: none"> <li>• Syringes larger than 1ml or 2ml should be supplied with specific reasons such as steroid use or where ampoules are being prescribed for injection</li> <li>• Service users should receive sufficient equipment in order to ensure that they do not need to share or re-use equipment</li> <li>• Service users supplying equipment to others i.e. secondary exchange should be encouraged and given more equipment to do this. Staff should also encourage such service users to bring the other injectors into the agency. Time should be spent with the Needle Exchange staff to discuss relevant harm reduction information that can be cascaded to other injectors they are in contact with.</li> </ul> <p>The range of paraphernalia available will include:</p> <ul style="list-style-type: none"> <li>- A range of syringes including 2ml and 5ml</li> <li>- A range of needles including 0.5ml, 1.0ml, 'orange', 'green' and 'blue'</li> <li>- Sterets</li> <li>- A range of sharps bins</li> <li>- Tourniquets</li> <li>- Citric acid</li> <li>- Spoons</li> <li>- Water ampoules</li> <li>- Condoms</li> </ul> <p>In addition to injecting equipment, all service users accessing Needle Exchange will receive either verbal or written information on:</p> <ul style="list-style-type: none"> <li>- Safer injecting techniques</li> <li>- Their drug of choice;</li> <li>- The transmission of Blood Borne Viruses</li> <li>- Information on Hepatitis A/B vaccinations</li> <li>- Sexual health advice &amp; information</li> <li>- Overdose prevention</li> <li>- Safe storage and disposal of injecting equipment</li> <li>- Referral into structured treatment;</li> <li>- Other local services</li> </ul>		

<p>4. Section 3.0 Sub heading 3.2 a – j</p> <p><b>Weighting 4</b></p> <p><b>Maximum word count of 1000 words</b></p>	<p>Objectives of the service</p>	<p>Please evidence the harm reduction messages the service wishes to promote and the method(s) by which these will be promoted.</p>
<p><b>Contractors response:</b></p> <p>Inclusion approach to delivering harm reduction messages is based on the following principles:</p> <ul style="list-style-type: none"> <li>• People use drugs for different reasons and interventions designed to reduce harm and move an individual away from drug use must take into account an element of cost-benefit consideration individuals may make when considering a change in behaviour.</li> <li>• When our services engage a drug user, it should be our aim to understand and prioritise their needs. For some, very modest behaviour change may be the first step towards more significant, longer terms changes but even modest changes are of value in of themselves. Consequently our goal setting must be realistic as we do not wish to set people up to fail. At the same time we expect our services to be ambitious for our service users and work with them towards recovery at a sustainable pace wherever this is a possibility.</li> <li>• We aim to deliver respectful services at all times. Whilst we exist to help people to change problematic behaviour and live more productive, happier lives we will respect all service users human rights and ensure service users experience our unconditional positive regard. The decision to make changes involving drug use will not arise in a user from condemning their drug use per se.</li> <li>• We want to deliver recovery-orientated drug services with abstinence as a goal that many users can aspire to and achieve. However, we do recognise that for some, abstinence may not be realistic at a particular moment in time, in which case we will continue to work with the individual as supportively as possible.</li> <li>• We are interested in identifying and delivering interventions that work rather than endlessly debating the tensions between harm reduction and recovery lobbyists. For Inclusion, harm reduction is the foundation of everything we do and this is no way comprises our ability to help as many service users strive for abstinence as possible.</li> </ul> <p>With these principles informing our approach, Inclusion recognises and will effectively promote harm reduction messages based upon a hierarchy of goals for drug misuser's, namely:</p> <ul style="list-style-type: none"> <li>✓ Stopping the sharing of injecting equipment – we will highlight the inherent risks of sharing and make every effort to make it unnecessary for anyone to have to share equipment.</li> <li>✓ Stopping the use of harmful injecting sites – we will explain the health risks to IV users, provide health-related interventions such as wound care and educate injectors about alternatives</li> <li>✓ Moving from injecting to smoking – we will educate users about the benefits of stopping injecting and discuss alternatives such as smoking as a short term gain. We are aware of the health risks associated with smoking and will work with users to stop this method of use also. We wil also offer interventions around route transition to prevent the move to injecting.</li> </ul>		

- ✓ Decreasing drug misuse – our interventions such as stabilisation on prescribed medication, detoxification and psycho-social interventions will be designed to encourage service users to reduce their drug use safely and sustainably. We will work with stimulant users to reduce their drug use aimed to counteract the crash from stimulant use
- ✓ Abstinence – we will promote the possibility of a drug free life with our service users and offer interventions that support individuals to stop their drug use altogether.

We will deliver these harm reduction messages in a variety of ways:

- All staff and volunteers will be trained in the delivery of harm reduction messages and be expected to deliver these at every appropriate opportunity
- All services will display and provide access to a wide range of harm reduction materials including leaflets, posters, information booklets, drug cards and service marketing literature.
- We will make other health promotion advice and information available through nurse-led clinics and written materials
- The service will contribute to county wide awareness campaigns around harm reduction through media involvement, stalls at roadshows and support for DAAT led initiatives
- Our Recovery Mentor programme will include elements covering harm reduction messages and Recovery Mentors will be supported to deliver appropriate advice and information.
- The service will hold open sessions for families, carers and other professionals & agencies where harm reduction messages will be promoted.
- The service website will carry harm reduction messages and links to other web-based harm reduction resources.

5. Section 3.0  
Sub heading  
3.2 a – j

Objectives  
of the  
service

Please demonstrate how the service will engage with service users in harm reduction interventions such as checking of wound sites.

**Weighting 4**

**Maximum  
word count of  
1000 words**

***Contractors response:***

Inclusion's work with injecting drug users within our other community and custodial services has highlighted a range of injecting related health related issues that commonly occur. These include:

- Overdose as a result of excessive amounts of a drug being used, lack of user tolerance to the drug being used and combining drugs during speed balling for example
- Short term and long term mental health problems associated with drug use
- Damage to the user due to adulterants or contaminants in drug supplies
- Poor injecting practice leading to wounds, bacterial infections and septicaemia
- The spread of Blood Borne Viruses due to the sharing of equipment including Hepatitis A, B and C and HIV
- Poor nutrition and unsuitable accommodation impacting upon a person's immune system leading them more susceptible to infections

- Sexually acquired infections

To deal with these type of health concerns, the service will run regular nurse-led health clinics at each service site offering the following interventions:

- All health clinics will re-enforce harm reduction messages via discussion with service users and the provision of harm reduction and health promotion leaflets and posters
- Our approach to health clinics will be to create a 'one stop shop' format where service users can address as many of their health needs at once.
- Wound-care assessment and basic wound dressing
- Testing for HIV and Hepatitis, including pre and post test counselling and referral to specialist services as appropriate
- Hepatitis B Vaccination for all service users regardless of test results
- Doppler leg assessments will be under taken for service users with a history of IV drug use and Deep Vein Thrombosis and for those service users who are currently groin injecting
- Any pregnant users will be immediately referred to our Mother & Baby service and linked in with maternity services at Addenbrookes and Hitchingbrooke hospitals.
- The service will also work with both hospitals to create pathways into Vascular and Tissue Viability services for ongoing care and treatment.
- We will offer nurse prescribing to include broad spectrum antibiotics for infected wounds. This can also be done at pharmacy BBV/wound clinics but only where they have an independent pharmacist prescriber.
- On-site Chlamydia testing, condom provision and contraception advice & information
- Nutritional advice

6.Section 3.0 Sub heading 3.2 e	Objectives of the service	Please demonstrate how the service will ensure the return rates of exchange are high across the service including pharmacies.
<b>Weighting 4</b>		
<b>Maximum word count of 1500 words</b>		

**Contractors response:**

Inclusion understands the importance of achieving and maintaining high rates of return of injecting equipment. High rates of return will contribute to the overall objectives of needle exchange services and increase public confidence by helping to minimise the dangerous discarding of injecting equipment as described below. The Cambridgeshire Adult Drug Treatment Service will achieve and maintain high rates of return with the following initiatives:

- All staff and volunteers operating needle exchange services will be expected to undertake or regularly refresh training in harm reduction, safer injecting and exchange operation to ensure the service is meeting service user's needs and maximising engagement. We will make this training available to staff working in community pharmacies. This training will be adaptable to ensure that pharmacy staff are able to attend.
- All needle exchange staff will undergo initial or refresher training in Motivational Interviewing techniques as a starting point for engaging service users in discussion about

injecting equipment return rates. We will adopt a contingency management approach by 'incentivising' users to return injecting equipment safely through positive reinforcement and in some cases rewarding service users with vouchers.

- We will work with commissioners, service users and other stakeholders to ensure a 'mixed economy' of needle exchange facilitates continues to be available. In essence this will mean maintaining the present spread of exchange capability across the county at drug service sites and community pharmacies. The geographical spread of exchange services should be complimented by co-operation around opening times to ensure coverage is maximised.
- We will ensure that all needle exchange services across Cambridgeshire stock a full range of recognised injecting equipment as described in the answer to question 3 above. This will maximise the number of service users engaging with the service because the range of equipment on offer meets local needs, which in turn, offers the service the chance to engage with more users and exploit their social networks to encourage others to return injecting equipment safely. With this in mind we will consult regularly around the range of injecting equipment available across the county.
- Each occasion that a service user accesses a needle exchange facility is an opportunity to discuss injecting equipment return rates. All staff and volunteers will be trained and encouraged to raise the issue of return rates during all interventions and wherever possible, these discussions will take place in a confidentiality way to increase their impact. Our experience in other services tells us that regularly repeating message relating to the safe return of injecting equipment does bear fruit – service users will respond to such reinforcement. Indeed, it is possible to exceed a 100% return rate by encouraging service users to return needles from their social networks.
- To ensure the safety of service users and to increase return rates, we will provide impromptu advice relating to the safe handling of injecting equipment. This advice will be reinforced by written information in our service posters and leaflets.
- Needle exchange stocks will be monitored and replenished on a timely basis to ensure the needs of service users are which in turn will help to keep injecting drug users engaged.
- All service users will be asked to speak with any using friends, acquaintances or family members to encourage those not engaging with needle exchange to do so. We know that 'word of mouth' marketing is very powerful.
- Return rates will be a regular theme of supervision for staff working in the needle exchanges. If services have low rates of return this will be analysed through supervision and team meetings with action plans put in place to increase return rates. Similarly, when examples of good practice are seen, these will be cascaded across the Cambridgeshire service.
- The service will establish a needle exchange database accessible at all service locations, capable of recording basic client details including a unique identifier and the number and type of equipment distributed. The database will also be able to record the number and type of equipment returned allowing the service to track individual service users and their return rates as well as producing monitoring reports for service managers and commissioners.
- The needle exchange database will be capable of recording exchange data generated by external sites including all of Cambridgeshire's community pharmacies taking part in the scheme. We will explore the potential for databases to be updated on-site by pharmacy staff and where this is not possible, a manual updating system will be introduced. Any outreach or peer-led needle exchange activity will be manually recorded and entered

on the database as soon as practicable.

- All service users accessing needle exchange services will be given a discreet identity card to allow staff to retrieve records and update the needle exchange database accordingly.
- All staff and volunteers operating in needle exchanges will be given training in database management. This will include community pharmacy staff where on-site database updating is possible.

7. Section 3.0  
Sub heading  
3.2 h

Objectives  
of the  
service

Please demonstrate how the service will ensure that local communities will not be affected by the dangerous discarding of injecting equipment.

**Weighting 4**

**Maximum  
word count of  
1000 words**

***Contractors response:***

Inclusion will work diligently across Cambridgeshire to ensure that incidences of discarded injecting equipment are minimised. This will be achieved by:

- Ensuring that all staff, volunteers and service users are fully aware that the starting point for minimising the dangerous discarding of injecting equipment is to maximise equipment needle exchange return rates across the county. All our interventions with service users accessing needle exchange will stress the need for personal responsibility and the safe return of all injecting equipment. The role of Recovery Mentors will be important in this respect as they can reinforce safe disposal messages from a peer perspective. Our complete approach to maximising return rates is detailed above but in essence we will aim for very high percentage return rates to minimise any community disruption or concern.
- Inclusion will seek to engage the public across Cambridgeshire by providing information about the aims and objectives of needle exchange. It is our experience that when drug services take public engagement seriously, provide relevant information and engage in real consultation, then the public can be supportive and understanding can develop. We believe that previously, drug treatment services have often not engaged with the public, perhaps for understandable reasons, but that this has had the effect of 'mystifying' drug treatment, breeding misinformation and mistrust. By engaging with the public, we can spread the message about the measures we take to minimise dangerous discarding of injecting equipment and provide information to the public about what to do if they do see discarded equipment.
- Our community pharmacy needle exchange services will provide countywide opportunities to return injecting equipment. We will ensure that all community pharmacies have sufficient equipment supplies and collections of clinical waste to facilitate as many safe returns as possible.
- We will make information available in all the sites we operate relating to what the public should do if they find discarded injecting equipment. This will include advice not to touch the equipment without proper safety precautions and relevant training. It will also include information about how to contact the nearest district environment team managed by the County Council to arrange collection.
- The service will liaise closely with the Community Safety Partnership's Anti-Social Behaviour team to co-ordinate messages relating to the need for high exchange rates and a

zero tolerance policy towards dangerous discarding. During the implementation phase following contract award we will consult with local Police commanders to make them aware of the range of injecting equipment we intend to make available and the measures we will take to minimize dangerous discarding.

- The Needle Exchange service will liaise with the district environmental teams in Cambridge, South Cambridge, East Cambridge, Fenland and Huntingdonshire to share information. From this we can become aware of any discarding hotspots that arise and work with service users to raise awareness and spread messages about equipment returns. We will ask our staff to take part in joint clean up initiatives with district environmental teams to increase public confidence and build community good will.

- Inclusion will ensure that information posters, leaflets and pamphlets are widely available across Cambridgeshire in public and community venues with details of needle exchange services and contact details for district environment teams.

- We recognise that some members of the public may take it upon themselves to remove discarded injecting equipment despite the advice not to do this. With this in mind our marketing materials and general advice via the SPOC contact line will reflect basic good practice in relation to safe disposal of equipment namely;

- Waste should be handled very carefully
- Protective gloves and suitable equipment such as brushes should be used.
- Re-sheathing needles is not recommended.
- Sharps boxes should be used if to hand and not over filled.

- Our marketing materials will also carry advice and information relating to needle stick injuries and what steps to take including:

- Encourage bleeding by squeezing the wound gently.
- Do not suck the wound.
- Wash area with warm water and soap for several minutes.
- Visit the Accident and Emergency department of your local hospital immediately and get advice about any the injury and treatment including immunisation.

8. Section 4.0 Sub heading f	Provision of the Service	Please demonstrate how the service will deal with the conflict between needle exchange and concurrent specialist prescribing for some clients.
<b>Weighting 4</b>		
<b>Maximum word count of 1500 words</b>		

**Contractors response:**

As an organisation experienced in the delivery of both needle exchange and prescribing services, Inclusion is well placed to offer a working solution to this issue. Our services have either directly delivered or supported community pharmacies to deliver needle exchange services at levels 1, 2 and 3 as suggested by NICE Public Health Guidance 18 'Needle and syringe programmes: providing people who inject drugs with injecting equipment' and also deliver a full menu of prescribing interventions for dependent drug users.

Our community services have developed a clear policy in regards to the sharing of information in this area, the principles of which are as follows:

- The primary purpose of needle exchange programmes is to promote harm reduction and reduce the spread of blood borne viruses. In order to maximise this, confidentiality is an important element in ensuring engagement. However, needle exchange is also an

important gateway into more structured treatment and recovery services and it is our responsibility to promote those pathways.

- To ensure that the harm minimisation and 'gateway' objectives of needle exchange are pursued, Inclusion's approach is as follows:

1. Those not in receipt of prescribing services

No case specific information will need to be passed on to other elements of the service or other agencies unless we are in receipt of information that is of a child safeguarding nature or information that constitutes a potential danger to others. In such cases the service user will be informed that this information will be passed onto the relevant authorities, except where informing them may potentially increase the risk to self or others. The Adult Drug Treatment Service will operate a needle exchange database to record basic details of service users accessing the service and this will be cross referred to our HALO treatment records to trawl for service users who are being prescribed to, whilst using the needle exchange. All needle exchange clients will be strongly encouraged to divulge that they are accessing prescribing services if they have not previously done so.

2. Those in receipt of prescribing services

When we are aware that a service user is in receipt of prescribing services and is accessing needle exchange, information will be shared between the different elements of the service and the key worker will be informed. All service users will be made aware of this policy from their first engagement with the service. Information regarding child safeguarding will be shared as above. It is not uncommon, particularly in the early stages of treatment, for service user to access needle exchange whilst stabilising on substitute medication. However, when the service becomes aware of needle exchange use whilst prescribing is taking place, we will quickly organise a three way meeting between the needle exchange worker, the prescribing key worker and the service user to consider appropriate next steps and a review of the recovery plan.

Inclusion are well aware of the conflicts that have existed around the sharing of information in relation to service users accessing needle exchange particularly where concomitant prescribing may be taking place. We understand that the history of needle exchange provision is closely associated with the societal stigma attached to drug use and infectious diseases, most notably HIV/Aids and that historical confidentiality arrangements developed to ensure engagement with needle exchange was not affected by fears of information disclosure and opprobrium. However we have arrived at the operational procedures outline above because;

- We believe that when the need for appropriate information sharing is explained to service users, then this need not dissuade IV users from accessing needle exchange. Our approach is to 'sell the benefits' of information sharing and re-assure service users that information exchange between needle exchange and prescribing services is not in place to punish the service user. Rather information is exchanged to ensure that the treatment package is safe and is meeting the service user's needs. In other words, if someone is 'using on top' our responsibility is to explore the reasons for this and adjust treatment if necessary. In some case this may mean an increase in prescribed medication alongside a revised package of psycho-social interventions.

- Simultaneous use of needle exchange and prescribing services can also, in some circumstances, be an indicator of the diversion of prescribed medication. Our approach here will be to discuss any concerns we have with the service user and liaise with the prescribing key worker to establish control measures if necessary that may include further

drug testing and supervised consumption.		
9. Section 4.0 Sub heading h  <b>Weighting 4</b>  <b>Maximum word count of 1000 words</b>	Provision of the Service	Please demonstrate how the service will encourage service users to access specialist treatment services.
<p><b>Contractors response:</b></p> <p>Inclusion see harm reduction services and needle exchange in particular as having inherent value for their ability to promote service user safety &amp; health and a reduction in the spread of BBV's. However, these services are also an excellent gateway into more structured, specialist treatment services. At the core of the service's ability to encourage users into specialist services are the skills of practitioners. In order to maximise engagement and retention in services all staff must be able to:</p> <ul style="list-style-type: none"> <li>- Work with clients in a confidential and non-judgmental manner.</li> <li>- Communicate clearly and empathetically</li> <li>- Deliver a range of harm reduction and relapse management interventions including facilitating needle exchanges and the provision of condoms</li> <li>- Understand the importance of accurate assessment and goal-orientated recovery planning built upon the service users central involvement in these processes</li> <li>- Understand the nature and seriousness of risks facing service users and professional and contribute to risk management plans and strategies</li> <li>- Help users develop self-awareness, self-efficacy and self-confidence.</li> <li>- Handle effectively discussions around risk taking behaviours and provide advice &amp; information relating to BBV testing and vaccination.</li> <li>- Recognise that service users often have complex needs that one single agency cannot meet necessitating a partnership approach.</li> <li>- Work with and contribute to the training of volunteers and Recovery Mentors</li> <li>- Understand and be able to explain the range and benefits of specialist treatment available to service users.</li> <li>- Maintain excellent service records and case files.</li> <li>- Ensure regular consultation with each service user.</li> <li>- Reflect on their own practice through supervision and appraisal, with the completion of training courses and academic learning as agreed in professional development planning.</li> </ul> <p>Our aim across Cambridgeshire will be to ensure that staff possess this full range of skills. Beyond this Inclusion will look to establish other initiatives to encourage service users into structured treatment:</p> <ul style="list-style-type: none"> <li>• Inclusion will promote and establish a vibrant Recovery Mentor service across the county. Our approach to this is described in detail in the overarching service delivery method statements. Our view is that recovery is all the more realistic for individuals when they can see visible examples of how other people have changed their lives – recruiting Recovery Mentors to work in our services is the best way to do this. Recovery Mentors will be encouraged to approach other service users and discuss their experiences of treatment in an effort to attract more people into structured interventions. The involvement of volunteers who have graduated through the Recovery Mentor programme will further re-enforce service user's perception of the possibilities for their own recovery.</li> </ul>		

- During the implementation phase we will review all screening, assessment and referral processes to ensure that as few barriers to structured treatment exist. For example, we will adopt a common assessment tool to minimise the number of times a service user has to answer the same questions and to maximise information sharing between different elements of the service.
- The speed with which we assess all service users will be important. Our emphasis will be upon speedy referral and access to structured treatment whether that be substitute prescribing, detoxification or day programmes.
- All service users who are initially assessed will have their information entered onto the HALO system to support care co-ordination and case management.
- To maximise the uptake of structured treatment the service must also minimise disengagement. Each service user will have a re-engagement plan agreed in case they do drop out of service. The re-engagement plan will include:
  - Each element of the service will have a staff member whose remit will include keeping re engagement issues on the team agenda. All team members will have responsibility for encouraging re engagement in relation to their own clients.
  - At the point of initial assessment all service users will be asked if they are content to receive texts, letters or phone calls from their key worker either during their treatment or even after completion.
  - If a disengaged service user wishes to re-enter treatment he\she will be given a shortened assessment and each will be given a priority appointment to ensure that their motivation to re-engage does not wane.
  - Protocols will be agreed, with key partner agencies to include rapid response systems for referring ex-service users.
  - We will also consult service users to circulate the message that disengaged service users are welcome to return to treatment programmes and to obtain feedback about aspects of the service which might not be meeting service user needs.
- The service will deliver a range of 'pre-treatment' interventions, via 1:1 and groups, designed to break down some of the barriers to taking up structured treatment. This will cover:
  - Expectations & fears of treatment
  - What 'recovery looks like'
  - The pro's and con's of treatment
  - Goal setting
  - Addressing ambivalence
  - Engaging others in support – family and carers.
- Our Structured Day Programmes that will be available across the county of are designed to be easily accessible to service users making the move into specialist treatment interventions. The programmes are rolling and modular meaning that new referrals can join the induction phase of the programme at any point. The programme will also allow service users to attend a small number of individual groups at the start of their structured treatment to allow for adjustment and orientation to be consolidated.

10. Section 5.0  <b>Weighting 4</b>  <b>Maximum word count of 1500 words</b>	Groups served	Please demonstrate how the service will respond to changes in drug using behaviour, e.g. steroid use.
<p><b>Contractors response:</b></p> <p>Inclusion understands that the needs of populations are dynamic and that individual drug use and presenting issues can differ over time and ward by ward. We will adapt to the changing needs of communities across Cambridgeshire by;</p> <ul style="list-style-type: none"> <li>- Utilising data from assessments, user consultations and partnership working to identify emerging trends in drug use and associated areas of need.</li> <li>- Sharing information as widely as possible with partners and commissioners to identify areas of unmet need and potential service developments.</li> <li>- Using an Action Research approach, piloting innovative approaches to meeting changing needs including aspects relating to accessibility, treatment options, recovery planning, referral to other agencies and joint working.</li> <li>- Ensure that services continuously adapt and improve to meet the needs of service users rather than expect service users to fit within static, inappropriate interventions and strategies.</li> <li>- Identifying new training courses and learning materials aimed at emerging drug trends and needs and ensure staff and volunteers have access to these</li> <li>- Ensure that the service is represented as widely as possible at industry forums, seminars and conferences so that topical information relating to changing needs is gathered and cascade to teams</li> <li>- Provide copies of industry magazines, briefing papers and web-based sources of information so that all staff can stay abreast of developments in the field.</li> </ul> <p><u>Swindon Drug Services &amp; Legal Highs</u></p> <p>An excellent example of Inclusion responding to changes in drug taking behaviour is the very recent response in Swindon to the use and impact of 'legal highs'. Our staff were noticing very different behaviours in some of our clients, in some cases very passive clients were becoming aggressive and even violent. Through discussions with clients and by monitoring client self report we were able to identify the increased use of 'legal highs' as a common factor. We obtained the names of the drugs/substances being purchased and researched the composition and effects of the substances, both in terms of the effect they were designed to mimic in relation to drug type (i.e. stimulants etc.) and also the behavioural and health effects on individuals.</p> <p>We raised the concerns with the Community Safety Partnership (CSP) and local other agencies and called for toxicology reports to establish inter drug reactions with prescribed medications. We alerted the Police and the Coroner's Office through the CSP and undertook 'mystery shopper' exercises to confirm outlets were selling legal highs, informing the CSP and Police of our findings.</p> <p>We issued a joint press release with the Police which was followed up by the local press which informed the public of the risks and dangers associated with these substances. We</p>		

have produced and distributed information leaflets for pharmacists and local agencies which advises them of the names and descriptions of the substances known to be available locally. The local MP followed up the press release and as a result our work was submitted via the Police to the Home Office Minister for Crime Prevention and Anti-Social Behaviour. An email from Police Inspector Paul Saunders of Swindon Police captures the excellent work our service in Swindon was involved in:

“As you know, Robert Buckland MP raised the issue of legal highs, in particular Methoxetamine, with the Home Office due to the concerns that have been raised by all of us. He has now received a reply from Baroness Browning, Home Office minister for Crime Prevention and ASB. I only have a hard copy, but shall transcribe the most salient parts:

She has confirmed that this substance is under investigation by the ACMD. She commends us on recognising the threat posed by new psychoactive substances and praises the engagement work that we have undertaken, stating that our local contribution is helpful to inform the national response. She also states that she will ensure that the ACMD make further contact with us to fully establish the local picture so that this can feed into the ACMD's recommendations.

I see this as a real step forwards in terms of public safety and the protection of the vulnerable in society and would like to thank each of you for your valuable contribution to the process of investigating this substance. As it stands we have agreed protocols with the legal outlets in Swindon and I have negotiated the withdrawal of powdered legal highs, including Methoxetamine, from these stores, and we are looking to target the more nefarious suppliers of these substances, though obviously our powers are limited in this area”.

The expected outcome in this case is that the ACMD will place Methoxetamine on the banned list. Our Swindon service is developing interventions to engage effectively with this group of service users.

#### Increasing Steroid Use and Adapting Services Accordingly

In many parts of the UK steroid use continues to increase and is associated with performance improvement in relation to sport and bodybuilding, as well as with some professionals such as doormen and security guards. For many steroid users this is about body enhancement and is seen very much as a positive thing. Steroid users do not typically associate themselves with the label ‘drug user’. Consequently this presents needle exchange services with the challenge of making interventions relevant and accessible to this group. This is important because anyone injecting steroids is at risk of infection with BBV's if injecting equipment is shared. Poor injecting practice can also lead to significant health problems.

To effectively engage steroid users across Cambridgeshire, the service will

- Map the location of and assertively outreach all bodybuilding gyms to make link with steroid users training at these establishments. The essence of our approach will be to encourage injecting steroid users to access either the needle exchanges at Adult Drug Treatment Service sites, or more likely, via community pharmacies

- We will provide training around Steroid Use and Safer Injecting to both adult service and pharmacy based staff
- We will provide leaflets and targeted information to pharmacies and local gyms including posters advertising needle exchange facilities within gyms and fitness centres
- We will develop a specific exchange pack for Steroid Use not containing Citric but with larger barrels and needles as well as larger sharps bin)
- We will make all staff aware of training cycles and promote return of used equipment as users re-present at the end/start of each cycle

11. Section 5.0	Groups served	Please demonstrate how socially excluded groups will be able to access harm reduction services.
<b>Weighting 5</b>		
<b>Maximum word count of 2000 words</b>		

***Contractors response:***

Inclusion services seek to make harm reduction interventions available to excluded groups through social marketing techniques. Social marketing places the primary focus on the service user - on learning what people want and need rather than trying to persuade them to take what the service happens to be offering. The process takes the service user into account by constantly examining ways to improve access and construct partnerships with other agencies and stakeholders. Underpinning our social marketing strategy is recognition of the crucial role of research in designing and delivering respectful and effective services: Inclusion proposes three research foci:

1. To discover the perceptions of service users on the nature of their difficulties and what the service offers to assist with these difficulties: for example the emphasis disabled service users place on improving their housing and employment opportunities, in promoting recovery.
2. To determine the activities and habits of potential service users, as well as their experience and satisfaction with the delivery system: this will allow the service to pinpoint effective locations, opening hours and potential partner agencies:
3. To determine the best ways of reaching potential service users: for example building links with other services to build access to excluded groups.

***Putting Social Marketing into Practice***

Opening hours, eligibility criteria, the range of services available and contact/referral information will be advertised through our project marketing literature, information posters and via inter-agency presentations. We will target primary client groups by ensuring that project literature is printed in a range of languages appropriate to the ethnic make up of Cambridgeshire. The Adult Drug Treatment Service will work closely with other providers, commissioners and partner agencies to disseminate written information outlining the scope of services to be offered.

Information posters and programme literature will be strategically placed in public reception areas such as GP waiting rooms, Police custody cells, Accident & Emergency suites and local agencies to ensure that as many service users as possible learn about the Adult Drug

Treatment Service and how to access it. To ensure that referral agencies have a clear understanding of the aims, objectives, methodology and delivery of the service, Inclusion will make presentations to all partner organisations, liaise with relevant service managers and arrange the attendance of key referral staff

Inclusion also propose to utilise information technology to market the service including:

- using text reminders prior to service user appointments
- providing knowledge access to self-help and information websites that service users can utilise to increase their awareness of alcohol issues and seek help from the correct agency

### *Women*

Nationally women tend to be underrepresented in substance misuse services. This is attributed to factors such as stigmatisation experienced by women users, child care responsibilities and concerns that they will come to the attention of Social Services plus the perception that services are heavily orientated towards the needs of men. In response, Inclusion services for women are aimed, through social marketing, at understanding the different experiences of women and to put in place staffing structures, materials and interventions, which have a clear focus on female issues.

In our experience women users are not a homogenous group, who have identical needs simply because of their gender and drug use. Nor should women's needs be defined solely in relation to pregnancy, childcare or ethnic background. Key elements of ensuring that we deliver a respectful service to women include:

- Taking into account the varying needs of women in terms of race, culture, age, sexuality and pattern of drug/alcohol use.
- Offering the choice of worker's gender, wherever possible and ensure that the client knows when that worker will be available.
- Service provision will pay particular attention to issues of low self-esteem, domestic violence, self injury, eating disorders, sexual abuse and sexual health.
- Developing attractive written material giving information specifically targeted at women alcohol users.
- Staff are/will be trained in women specific issues, self harm, benzodiazepine dependency etc.
- Offering single sex provision that will include supports groups and counselling.
- Developing working relationships; joint care arrangements, joint training and referral pathways with mental health services and women's counselling agencies.
- Design and plan treatment intervention with female service users.
- Inclusion would wish to provide an open ended woman's support group one day a week at school friendly times supported by crèche facilities: visiting speakers will be invited.

It is Inclusion's view that we need to strive not to replicate the dynamics of stigmatisation or lack of options experienced by many women who have drug related problems. The provision of staff who understand the specific requirements of women with drug problems need to include those from BME groups. Attention will be paid to promoting access for women from BME groups. Inclusion understands that some will face additional barriers to

seeking treatment due to a sense of shame and going against women's perceived position and expected role in their own and wider society.

Monitoring performance will include female health issues such as the presence of depression, eating disorders, self injury. General health issues will include antenatal care co-ordination and sexual health linking up with GUM clinics and maternity units.

Inclusion acknowledges that drug services have vital roles in assessing and/or responding to drug using parents and their children; acting as advocates for service users who have responsibility for the care of children and in promoting the welfare of children.

Inclusion does not believe that all drug users who are women, necessarily make poor parents and drug use in itself should not be automatically be taken to imply poor parenting or abuse. However lack of attention to the possible effects of drug use on parenting and therefore the lives of children may lead to them suffering neglect and/or abuse.

It is essential that our staff are competent and sensitive to the needs of drug using mothers, whilst vigilant and uncompromisingly aware that the needs of the child is paramount and must take precedence over any other consideration. We will ensure training and liaison with social services to ensure competency to deliver safe practice consistent with 'Safe Guarding Children' and Local Safeguarding Children's Board guidelines.

#### *BME Service Users*

An appropriate strategy for implementing working with black and minority ethnic communities needs to take account of the local demographics and the impact of drug and alcohol use within Cambridgeshire. To reach attract and retain as many as possible Inclusion will market the service as follows:

- Provide a welcoming environment, which offers clear information to service users on what is being offered, both verbally and in writing, including provision of locally spoken languages.
- Provide access to appropriate interpreting and translation services in order to ensure culturally competent and sensitive services to effectively meet need.
- Work collaboratively and develop networks with other services and any specific black and minority ethnic groups, carers and advocates in order to inform culturally appropriate service delivery.
- Promote services and advertise staff vacancies in black and minority ethnic specific newspapers, radio stations, community forums and other services.
- Promote black and minority ethnic communities at all levels of policy, planning, staffing and provision based on review.
- Provide evidence of involving and consulting black and minority ethnic community groups and service users in the review and planning of services and the drive to improve quality.

Inclusion has a clear view that a key way forward in terms of appropriate service development for black and ethnic minority residents in Cambridgeshire is via the community itself. Inclusion aspires to:

- Develop partnerships with community groups
- Establish satellite services in popular BME venues
- Foster BME volunteer schemes to provide peer support and mentoring
- Secondments into our service from BME community agencies

- Second Inclusion workers to BME community agencies to support learning

Perhaps the single most important strand of providing quality services to black and minority ethnic people is to recognise the importance of communication and mutual understanding in addressing drug related issues and needs. Such communication represents the essence of social marketing.

*Needs of Service Users with Physical or Sensory Impairments*

Since December 2006 all public bodies and voluntary and private sector organisations that provide services for public sector organisations, have a legal duty to promote equality of opportunity for disabled people in all aspects of their work. To ensure respectful services are delivered to disabled groups Inclusion will put into practice social marketing principles as follows:

- Emphasis on specific advice and information to support choice in decision making.
- In order to support service user decisions about treatment options advocacy will be required.
- Support and assist disabled service users to become advocates themselves.
- Where there are mobility issues home visits built into care planning.
- Assistance with phone calls and other communication tools will be offered.

Working closely with carers may be important if an impaired service user feels this is appropriate and desirable to support intervention. More time may need to be spent with young disabled alcohol users in the transition overlap from young person's services to adult services. Flexibility with rules is vital for some e.g. waiving 'no dog' policy for service users to be accompanied into clinics by a guide dog or a hearing dog.

Whilst additional support might well be required to facilitate access and maintenance of disabled people in treatment it is also important to remember that this needs to be balanced. Understanding ordinary independence is not about being entirely self-sufficient, none of us are, but simply about being in control of what happens to you. Conveying the values and practice as defined above will be a key component of Inclusion's approach to the marketing of the service.

*Learning Disabilities*

1.5 million people in the United Kingdom have a learning disability, which is defined as a neurological disorder that affects the way person learns, communicates and does every day tasks. A person has a learning difficulty for all of their life, which can be categorised as mild, moderate or severe. There are many types of learning difficulty and some conditions whilst not diagnosed as 'learning disabilities' affect many alcohol users particularly young service users. These include those affected by Asperger's Syndrome, Autism, Epilepsy, Dyspraxia and severe Dyslexia

Some of these conditions can affect some or all areas of development including intellectual, emotional, physical, language, social and sensory. Sufferers appear to have poor understanding, difficulty relating to others and present as hesitant and awkward. It is no wonder that some from this group are rejected by their peers and seek comfort in drug use. Vigorous marketing of the service to those experiencing learning disabilities is especially important because of the communication difficulties outlined above.

12. Section 6.0 Sub heading 6.1  <b>Weighting 4</b>  <b>Maximum word count of 1000 words</b>	Exceptions (Young People)	Please detail how the service will adhere to guidance regarding under 18 year olds.
<p><b>Contractors response:</b></p> <p>Inclusion recognises that the age of use of drugs amongst young people continues to drop and that for a small subset of young drug users, injecting is the preferred method of use. For this cohort access to needle exchange facilities remains an important harm reduction intervention. However, there are specific issues relating to the supply of needle exchange services to people under the age of 18. Therefore the essence of Inclusion's approach to the provision of needle exchange services to young people across Cambridgeshire under the 18 will be as follows:</p> <ul style="list-style-type: none"> <li>• Where a young person under the age of 18 presents to a needle exchange operated by the Adult Drug Treatment Service, staff will make every effort to persuade the young person to attend Cambridgeshire Adolescent Substance Use Service (CASUS). Staff will explain that CASUS are best place to offer the young person appropriate advice, information and support. When the young person accepts this advice we will make an immediate referral to CASUS. Where practicable, and the young person consents, a volunteer will accompany them to CASUS to facilitate a referral.</li> <li>• When the young person refuses to accept a referral to CASUS and is adamant that they wish to access the needle exchange at the adult service, then we will facilitate this with the caveats described below. Our aim here is to balance harm reduction with child protection. Young people who are 16 or 17 are normally able to consent to their own treatment. When the Young Person is under the age of 16 the 'Fraser Guidelines' (Mental Health Act 1983 Code of Practice 1999) will be followed, namely that: "Young people under 16 years of age have a right to confidential medical advice and treatment provided that: <ul style="list-style-type: none"> <li>- The young person understands the advice and has the maturity to understand what is involved.</li> <li>- The doctor/health professional cannot persuade the young person to inform parents/carers with parental responsibility, or allow the doctor to inform them.</li> <li>- The young person's physical and/or mental health will suffer if they do not have treatment.</li> <li>- It is in the young person's best interests to give such advice/treatment without parental consent.</li> <li>- The young person will continue to put themselves at risk of harm if they do not have advice/treatment."</li> </ul> </li> <li>• If the service decides that the young person is competent and still cannot persuade them to access CASUS then an injecting history will be taken to establish the young person's needs and any consider any risks involved. Advice on safer injecting techniques will be offered by Needle Exchange staff along with information on safer sex and other harm reduction messages.</li> <li>• In line with the operating protocols of CASUS and other young people's needle exchange services, when the adult service does facilitate needle exchange for a young person, we will only give out a small amount of injecting equipment to encourage rapid</li> </ul>		

return and a greater frequency of visit. This will offer the opportunity to actively encourage the young person to engage with CASUS. When we anticipate the return of a young person for additional needle exchange services, we will liaise with CASUS. This may involve CASUS assertively outreaching the young person at one of the Adult Drug Treatment Service venues.

- In the unlikely scenario that the Adult Drug Treatment Service cannot persuade a young person to access CASUS for longer term advice, information and support we will agree an inter-agency support package for the young person. The service, in consultation, with CASUS, will also consider what steps need to be taken in respect of child safeguarding.
- All Adult Drug Treatment Service sites will carry range drug related information and details of CASUS with the explicit intention of ensuring all young people have the opportunity access an age appropriate service.
- Where a young person is in transition from CASUS to the Adult Drug Treatment Service as they reach the age of 19, and injecting drug use is a current concern, then the young person's on-going recovery plan will reflect their injecting status and inform future interventions.

13. Section 8.0  <b>Weighting 4</b>	Polices, Protocols and Written Strategies	Please provide copies of all policies, protocols and strategies as set out in Section 8.0.
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***Contractors response:***

Inclusion's policies have been included:

- Engagement & Re-engagement
- Safer Injecting
- Infection Control Policy

**Method Statement Section 3B, b) Harm Reduction: bii) Blood Borne Virus Service**

Spec Reference	Method Statement Reference	Method Statement
1. Section 2.0 Sub heading 2.2 a – d  <b>Weighting 4</b>  <b>Maximum word count of 2000 words</b>	Objectives of the Service	Please demonstrate how the service will provide testing and vaccinations for BBV's.
<p><b>Contractors response:</b></p> <p>Inclusion has significant experience of working with drug users to provide testing and vaccination programmes for Blood Borne Viruses (BBV's). We have continuously developed our BBV interventions and our approach is based on the following principles:</p> <ul style="list-style-type: none"> <li>• The main BBV's of concern to our client group are Hepatitis B virus (HBV), Hepatitis C virus (HVC) and Human Immunodeficiency virus (HIV).</li> <li>• HBV and HVC are both highly infectious and can cause chronic liver damage and liver cancer. Both viruses can remain active and a potential source of infection for several weeks in dried blood and some body fluids. HIV can lead to Acquired Immune Deficiency Syndrome (AIDS) that causes a range of serious infections and cancers, often becoming fatal. A person with HIV can remain healthy for many years but be infectious via their blood and body fluids.</li> <li>• All Inclusion staff and volunteers working with drug using populations are encouraged to take up HBV vaccination via their General Practitioner, the costs of which are reimbursed by the organisation. Inclusion recognises that day to day social contact with drug users has very little risk attached in terms of BBV infection. However instances such as needle stick injuries, working with an open wound, bites and splashes of body fluids should be regarded as a potential risk. With this in mind Inclusion staff will always observe basic infection control procedures to minimise the risk of infection. Whilst the safety and protection of our staff and volunteers is a high priority, it is important that these infection control procedures are carried out sensitively with service users to guard against a climate of fear, mistrust and disrespect.</li> <li>• Those who inject drugs are at high risk of infection with BBV's. Delaying vaccination can do harm because a drug user may become infected before the next visit or may not return. If a drug user wishes to be tested the first dose of vaccine should be offered at the same time. Every time a drug user contacts the service, the worker should consider whether vaccinations should be offered.</li> </ul> <p>To ensure we delivery excellent BBV interventions across Cambridgeshire the service will:</p> <ul style="list-style-type: none"> <li>• Designate a lead member of staff responsible for the promotion, delivery and training relating to BBV interventions.</li> <li>• The service will provide one off vaccinations as we recognise that incomplete vaccination schedules offer more protection than no vaccination at all.</li> <li>• The service will ensure that a lack of certainty of vaccination status does not act as a</li> </ul>		

barrier to vaccination.

- The service will not rely on an individual's recall of their history of vaccination.
- The service will use an accelerated schedule of HBV vaccination (0, 1 and 2 months or 0, 7 and 21 days).
- Current best practice is to give a booster at twelve months if an accelerated schedule is used. However pragmatism is best: when a drug user attends the service the worker should seize the moment and consider whether this is an opportune time to offer a booster dose. People with an immune disorder, e.g. due to HIV infection, are at higher risk of failing to respond and may need regular testing and a booster injection.
- The following steps will be taken to maximise uptake of vaccination:
  - We will prominently display posters and leaflets at all service locations that promote BBV awareness and vaccination programmes
  - Require that BBV screening takes place at assessment, medical reviews and key working sessions with on-site vaccination sessions being offered at all service sites.
  - Weekly, well publicised vaccination clinics will be held at all service sites to augment opportunistic vaccination during other interventions.
  - We will ensure all staff and volunteers are trained in BBV prevention and infection control procedures.
  - We will reinforce the importance of BBV vaccination through staff and volunteer supervision & appraisal.
  - We will work closely with service users to reinforce the importance of BBV vaccination programmes.
  - We will liaise with partner agencies to promote BBV awareness and vaccination programmes.
  - Where a service user has poor venous access, the service will have the capacity to offer dry blood spot testing as an alternative.
- Hepatitis A (HVA) Vaccination

Injecting drug users are at higher risk of Hepatitis A infection due to poor living conditions with spread probably occurring through faecal contamination of drugs or injecting paraphernalia. Blood to blood spread through needle sharing is also possible. HVA vaccination of users infected with hepatitis C and / or with chronic liver disease has been recommended for many years because of the risk of more serious illness if they became infected. The Public Health Laboratory Service Advisory Committee on Vaccination and Immunisation expanded this recommendation in 2001 to include all Intravenous Drug Users. As for HBV, all service users should be offered HVA vaccine without pre-testing because of the risk that the opportunity to vaccinate may be lost.

HVA vaccine is available as a single component vaccine or combined with HBV vaccine. The likelihood of a drug user returning for a subsequent dose needs to be taken into account when selecting the single vaccine or the combined vaccine. One dose of HVA vaccine confers greater protection against HVA than one dose of the combined vaccine because the combined vaccine only has half the amount of HVA antigen than the single component vaccine. For this reason the use of the single component vaccine is recommended. However this has to be weighed against the likelihood of the service user attending twice.

- BBV Testing
  - Inclusion's approach is to focus on protection through vaccination rather than testing per se. However, testing for HBV will be routinely offered following discussion with the

service user.

- Inclusion staff will work with service users to ensure fully informed consent is obtained before testing for HCV and HIV. Reasons for testing will include;
  - Anyone who has ever injected drugs.
  - Current injecting drug users.
  - Recipients of blood (before Sept 1991), or blood products (before 1986 in the U.K.) – if not already tested.
  - Regular sexual partners of those with HCV or HIV
  - Children born to mothers with HCV or HIV
  - People who may have had unsterile medical treatment abroad.
  - People who may have had ear piercing, body piercing, tattooing or acupuncture with unsterile equipment.

Inclusion staff will explore with service users the potential benefits of testing:

- Testing can allay anxiety even if the result is positive.
- A positive test allows early monitoring and intervention by specialist treatment services if required.
- Opportunity to immunise against Hepatitis B and A. (co-infection significantly worsens prognosis).
- Testing can encourage the patient to change patterns of behaviour such as injecting drug use or excessive drinking whether the result is positive or negative.

The benefits of testing will be weighed alongside the challenges it may present:

- HCV test is for antibodies only: Positive test indicates that there has been infection at some time. 80% continue with active infection – this can only be confirmed by PCR test (test of viral load). A liver biopsy may be required to decide about treatment.
- Antibodies can develop up to 6 months after exposure, the 'window period'. Therefore negative test may need to be repeated.
- Natural history and disease progression in the majority of those who become infected with HCV are unaware of it at the time and 20% will clear the virus within 2-6 months. The other 80% will develop chronic hepatitis C and 60% of the total will develop some liver disease, 16% of these will develop cirrhosis and 1-2% may go on to develop Hepatocellular Carcinoma or liver failure. Even without significant liver damage, some people with HCV have symptoms of headache, chronic fatigue etc. possibly due to infection of the CNS.
- HCV treatment is difficult to take and has side effects, especially tiredness and depression. This needs expert referral and assessment at tertiary referral centre.
- Life insurance and mortgage issues: A negative HCV test has no impact on ability to get life insurance or a mortgage. Positive test may make it more difficult to get life insurance policy or mortgage linked to a life policy.
- Is the timing right? Negative result could give false reassurance if sample is taken within window period. Are there issues behind request for a test that should be dealt with first such as worries about drug use or relationships?
- Anxiety whilst awaiting the result.
- Coping with a positive result will require adaptation. The uncertainty of the prognosis of HCV, even with treatment, social stigma and concerns of transmitting the infection to others can cause depression and anxiety leading to risk of increased drug use, relationship problems. Rehearse with them how they will feel if result is positive or negative.

When results of BBV testing are given, it will be based on the following:

- Test results ideally in person by the person who has done the test
  - The service user may want to have someone with them when they receive result.
  - If negative, check if retesting required (window period); discuss and consider how to avoid future risk
  - If positive review pre-test discussion; check PCR if they haven't had one; and referral to specialist.
- Staff and Volunteer Training
    - All staff and volunteers will undergo regular in-house training around BBV awareness raising, vaccination, testing and counselling.
    - Recovery Mentors will be trained in BBV awareness and encouraged to raise the importance of testing and vaccination in discussions with service users
  - The service will collect the following data to support the monitoring of the effectiveness of the vaccination programme and allow enhancements to be made where necessary.
    - The number and percentage of drug users who have received 1 dose of hepatitis B vaccine (HBV).
    - The number and percentage of drug users who have received 2 doses of HBV.
    - The number and percentage of drug users who have received 3 doses of HBV.
    - The number and percentage of drug users who have been offered hepatitis B vaccination.
    - The percentages of drug users who have received 1 and 2 doses of Hepatitis A vaccine.
    - The number and percentage of drug users who have been offered hepatitis C testing.
    - The number and percentage of drug users who have been offered HIV testing

2. Section 2.0 Sub heading 2.2 a – d  <b>Weighting 4</b>  <b>Maximum word count of 1000 words</b>	Objectives of the Service	Please demonstrate how this service will ensure service users are supported through their BBV treatment, including hospital based treatment.
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***Contractors response:***

Hepatitis A & Short Term Hepatitis B Infection - Support

At present, there is no specific treatment for Hepatitis A and short term Hepatitis B and the majority of users will recover completely within a couple of months. During this period the service user should be encouraged to get plenty of rest, eat a balanced diet and avoid the use of alcohol whilst the liver repairs itself. With this in mind, service users who are known to be infected with Hepatitis A should be monitored closely through normal key working and other interventions taking place as part of their drug treatment recovery plan. Along side this

the service user should be encouraged to attend regular health checks.

### Chronic Hepatitis B and Hepatitis C Treatment Support

For those users who have contracted chronic HVB or HVC, access to treatment may be an option. It is important to understand the nature of these treatments and the effects on the person being treated to inform how the service will shape its interventions in support of the service user.

- Chronic HBV treatment may include:
  - Interferon to prevent the virus multiplying inside the body, in the form of pegylated interferon injected once a week and interferon alfa injected three times a week. These treatment can be self-administered by injection. There are often side effects, such as flu-like symptoms, especially in the early stages of treatment.
  - Antiviral drugs also stop the hepatitis B virus from multiplying in your body. They include Lamivudine, Tenofovir, Entecavir, and Adefovir. These may sometimes be taken in combination. During long-term antiviral treatment the virus can become resistant to the drug. It is therefore very important that courses of treatment are completed. The side effects associated with these drugs include headache, fatigue, dizziness, nausea and flatulence.
- HIV treatment may include:  
HIV combination therapy using antiretrovirals can slow the progression of the condition and prolong life significantly. A combination of medicines is used because HIV can quickly adapt and become resistant to one single medicine. Common side effects of HIV medication include nausea, tiredness, diarrhea, skin rashes and mood changes.

Service users accessing treatment for these conditions will require specific support from the Adult Drug Treatment Service. The service will:

- Ensure the lead for BBV interventions has a working knowledge of relevant treatments to facilitate support for service users
- Create excellent links with secondary services including hospital liver unit and Genito-urinary Medicine services. By doing this the service will be fully aware of the pathways into treatment for those service users affected
- Create excellent links with the Home Treatment Mental Health service. Some service users may not be considered for treatment due to underlying mental health issues such as depression and anxiety.
- Where a service user is receiving treatment ensure that the recovery plan reflects outstanding needs.
- Recovery Mentors and volunteers will support service users engaging in specialist treatment services particularly by accompanying service users to initial appointments to allay fears and anxieties.
- The service will facilitate Hepatitis C support groups and work with relevant voluntary sector agencies to broker in additional resources and support.

### Expert Patient Programmes

For service users with long term conditions, Inclusion will look to establish pathways into Expert Patient Programmes (EPP). This could include enrolment on an EPP 6 week course or accessing EPP materials on-line. All EPP course are designed to help those with long term conditions manage their condition as well as possible.

3. Section 2.0 Sub heading 2.2 a – d  <b>Weighting 4</b>  <b>Maximum word count of 500 words</b>	Objectives of the Service	How will the service encourage clients to complete the programme of Hep B vaccinations?
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**Contractors response:**

Inclusion services across Cambridgeshire will encourage the uptake and completion of Hepatitis A and Hepatitis B vaccination programmes by adopting a contingency management approach. Our aim is to identify and reinforce health conscious, pro-social and recovery orientated behaviours. Drug users are people and people respond to incentives. Contingency management is recognised in NICE Clinical Guideline 51 – Drug Misuse: Psychosocial Interventions. The service will adopt the following initiatives:

- All service sites will display a full range of eye catching harm reduction advice and information relating to BBV's in clear, straight forward easily readable formats. This will include awareness raising in relation to BBV's, the services available and next steps.
- All staff will be trained and supervised to raise approach the issue of BBV's during all interventions from a contingency management perspective.
- The service will offer vaccination without testing wherever appropriate. Delaying vaccination whilst testing takes place can do harm because a drug user may become infected before the next visit or may not return to the service at all for other reasons such as imprisonment or disengagement. If a service user does wish to be tested then first dose of vaccine should be offered at the same time as the test takes place.
- All staff and volunteers will the use reward and recognition as part of key working interventions in relation to BBV's. Where a service user has made strides in changing risky behaviour or successfully completes a vaccination programme, we will acknowledge this, remark upon it and compliment the service user on their progress. This could also involve the use of individual star charts and certificate awards.
- The use of monetary incentives will be piloted, following consultation with commissioners. This could involve offering incentives to services users to undertake and complete BBV vaccination programmes. The incentives could take the form of food vouchers or small cash payments in some circumstances.
- The service will offer vaccinations to a service user's family or carers if there are concerns about infection.
- The service will adopt a holistic approach to BBV vaccinations for example by offering physical health checks and chronic disease management interventions. This would encourage services users to engage more regularly with the service therefore creating more opportunities for vaccination courses to be completed.
- We will use BTEI mapping techniques to examine service user attitudes and behaviour in relation to BBV's and to explore strategies for harm reduction and vaccination programme compliance.
- The use of groupwork can be valuable in raising awareness of BBV's and the importance & availability of vaccination programmes. Some service users may resist discussion of BBV issues in 1:1 keyworking due to the perceived stigma involved. Group

discussions can deal with the subject in a depersonalised way and contribute to educating service users in this area.

- Accurate health records will be kept for all service users that include details of BBV vaccinations. These in turn will be used to trigger diary prompts for booster vaccinations.

4. Section 2.0 Sub heading 2.2 a – d  <b>Weighting 4</b>  <b>Maximum word count of 1000 words</b>	Objectives of the Service	Please demonstrate how the service will work with Pharmacies to assist in the delivery of BBV interventions.
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***Contractors response:***

Inclusion's approach to working with community pharmacies across Cambridgeshire to delivery BBV interventions will be one of partnership, joint working and agreeing common goals. We will do this through:

- Asking all community pharmacies to display the range of harm reduction materials in the form of posters and leaflets as will be available at Adult Drug Treatment Service sites. This will have the effect of reciprocal 'seed-planting' with service users exposed to more relevant messages leading to positive action being considered. This information should include material aimed at cocaine users, who often engage less with drug services and who may be unaware of the risks associated with sharing snorting tubes and the risks of infection.
- Working with community pharmacies to influence the needle exchange paraphernalia available is important for at least two reasons. Firstly, the equipment must be relevant to the injecting needs of local users to meet their needs and secondly if equipment is not sufficient or readily available this will impact on the numbers and frequency of users accessing pharmacies. We will consult with local pharmacies about the menu of exchange equipment that is available and the contents of pre-packed exchange kits.
- Similarly, the quality of advice and information available to drug users accessing community pharmacies must be of a high standard. This will increase the take up of pharmacy services and build trust between drug users and pharmacy staff.
- Increased needle exchange activity at community pharmacies also dictates that the pathways into the Adult Drug Treatment Service must be strengthened. We will work with pharmacy staff to ensure they are signposting and referring drug users into the Adult Drug Treatment Service at every opportunity.
- To support all community pharmacy based initiatives, relevant training will be provided by the service. We will offer ad hoc and structured training for all pharmacy staff at regular intervals. This will include basic drug awareness, safer injecting advice, BBV risks and interventions and awareness of treatment pathways. We will ensure that all community pharmacies carry up to date information about the Adult Drug Treatment Service including the SPOC contact number, service addresses and opening times.
- Community pharmacy staff will receive advice, information and training about how to structure pre and post test counselling. This is important to ensure drug users are supported before, during and after a BBV test and result.
- We will agree the use of a database with all community pharmacies to capture

<p>relevant information relating to service uptake and frequency of exchanges. We will use this information to identify areas of Cambridgeshire where community pharmacy provision appears inadequate so that additional pharmacies may become involved. This will in turn increase the uptake of BBV interventions.</p> <ul style="list-style-type: none"> <li>• The use of dry blood spot testing at community pharmacies will be encouraged by the service. We know that barriers to conventional blood testing exist in the form of poor venous access, fear and anxiety on behalf of drug users and sometimes staff, a lack of venapuncture training and time constraints. By promoting dry blood spot it is likely that more BBV testing can take place in community pharmacies as the process is quicker, less invasive and requires minimal training of staff.</li> <li>• Inclusion's lead for BBV interventions will offer venapuncture training to community pharmacy staff to facilitate conventional testing.</li> <li>• Inclusion will provide opportunities for community pharmacy staff to visit services across the county to broaden their understanding of drug misuse, treatment services and in particular the importance of expanding BBV interventions for drug users.</li> <li>• Inclusion will seek to formalise BBV interventions delivered by community pharmacies into existing Service Level Agreements.</li> </ul>		
<p>5. Section 2.0 Sub heading 2.2 a – d</p> <p><b>Weighting 3</b></p> <p><b>Maximum word count of 1000 words</b></p>	<p>Objectives of the Service</p>	<p>Please demonstrate how the service will support GP's in the delivery of BBV interventions as part of shared care.</p>
<p><b>Contractors Response</b></p> <p>As described in our Shared Care method statements, Inclusion see our partnership with Cambridgeshire GP's around BBV interventions as having some key themes – training, support and finance. We understand that primary care professionals can have misgivings about working with drug users and in particular BBV interventions including resistance, fear, lack of knowledge, lack of confidence, concerns over sample handling, confusion about referral pathways, whether specialist treatment is available locally and an unwillingness to perhaps raise false hope in patients. Added to this are the frequent worries service users have about confidentiality and stigma.</p> <p>Inclusion remain convinced that expanding and developing primary care based interventions for drug users including for BBV's is in the best interests of all stakeholders. Through the provision of the right training &amp; support, the agreement of policies &amp; procedures and a willingness to overcome barriers, BBV interventions in primary care can:</p> <ul style="list-style-type: none"> <li>- Provide more opportunistic discussion</li> <li>- Offer more services to women and their children who use primary care more</li> <li>- Offer other necessary healthcare services at the same time</li> <li>- Promote opportunistic immunisation against HAV &amp; HBV</li> </ul> <p>To facilitate this, the service will make the following support available to GP's</p> <ul style="list-style-type: none"> <li>• All GP surgeries will be supplied with and asked to display a range of harm reduction materials in the form of posters and leaflets as will be available at Adult Drug Treatment</li> </ul>		

#### Service sites.

- Each GP practice taking part in Shared Care will have a designated liaison worker from the Adult Drug Treatment Service attached to it. Liaison workers will operate on a geographical patch basis allowing for efficient use of resources and the development of longer term working relationships
- GP liaison staff will be available outside of their designated primary care sessions via telephone and email to offer on-going advice, information and support.
- GP's engaged in Shared Care will be able to access support, advice and information from the service Consultant Psychiatrist as part of their Continuous Professional Development arrangements.
- The service lead for BBV interventions will provide training for GP's in BBV interventions and liaise with each GP regarding pathways into specialist hospital based treatments. It is often the case that GP's are better able to establish links with secondary care such as liver units and GUM clinics and can facilitate referral for service users.
- Where a GP practice is reluctant to deliver BBV interventions, our BBV lead will offer clinics to 'kick-start' service delivery at that practice with a view to bringing the GP on board.
- The service lead for BBV interventions will offer training to practice nurses as part of their chronic disease management and Quality and Outcomes Framework (QOF). This rewards practices financially for the provisions of quality care and helps fund further improvements in the delivery of clinical care.
- GP's will be able to access training provided by the service in partnership with the Cambridge Access Clinic. It is our experience that on occasion GP's respond better to peer-led training initiatives.
- The service will work closely with all GP practices engaged in Shared Care to maximise the efficient use of resources in respect of the ordering of and payment for HVA and HVB vaccinations. Ordering in bulk and operating a centralised system of distribution can be cost effective.
- Inclusion will support GP's to undertake the Royal College of General Practitioner's (RCGP) Certificate in the Management of Drug Misuse Part 1 and Part 2 to enhance their knowledge around d BBV interventions. The service budget contains an element to pay for access to local and national courses.
- Inclusion are uniquely placed as our Community Services Lead is Jim Barnard, former Substance Misuse Management in General Practice (SMMGP) advisor and now chair of the organisation. Jim brings a wealth of experience to Inclusion in relation to engaging, supporting and training GP's.
- Inclusion will seek to form a county wide forum around BBV interventions open to GP's and other interested professional to develop good practice, policy and procedure and treatment pathways.

**Method Statement Section 3B, b) Harm Reduction, biii) Clinical Waste**

<b>Spec Reference</b>	<b>Method Statement Reference</b>	<b>Method Statement</b>
Section biii  <b>Weighting 5</b>  <b>Maximum word count of 1000 words</b>	Information to Tenderers	Please demonstrate and detail how this service will be delivered.
<p><b>Contractors response:</b></p> <p>Inclusion and SSSFT will ensure that all waste of is disposed of safely and complies with relevant regulations in respect of waste management and recycling. A specialist clinical waste collector will be engaged to handle the collection and disposal of all clinical waste products generated at service sites. Used injecting equipment will be collected from all community pharmacies taking part in the needle exchange scheme. Inclusion are aware that current specialist clinical waste collection services are provided by SRCL. In consultation with commissioners, Inclusion will in principle look to extend use of this service unless a better quality, better priced provider can be sourced at the contract renewal date.</p> <p>The principles informing our approach to clinical waste collection are in line with Care Quality Commission (CQC) core standard: C4e – ‘clinical waste’, namely “Healthcare organisations keep patients, staff and visitors safe by having systems to ensure that the prevention, segregation, handling, transport and disposal of waste is properly managed so as to minimise the risks to the health and safety of staff, patients, the public and the safety of the environment”.</p> <p>To meet CQC requirements and the service specification we will:</p> <ul style="list-style-type: none"> <li>• Ensure all staff and volunteers are made aware of clinical waste policy and procedures</li> <li>• Routinely review all clinical waste procedures to audit staff compliance</li> <li>• Provide all staff and volunteers working in Inclusion services with training related to clinical waste procedures including segregation, storage and collection</li> <li>• All staff and volunteers will be encouraged to minimise the generation of waste at source</li> <li>• All staff will be encouraged to constructively challenge colleagues not observing clinical waste policies and procedures</li> <li>• Ensure all waste is clearly identified as clinical, package correctly, stored safely and securely and all documentation relating to its nature and disposal is completed.</li> </ul> <p>All clinical waste will be immediately disposed of into yellow or orange clinical waste bags secured in a large metal receptacle. Most of the waste generated by the service will fall into the orange bin criteria such as urine collection and related waste. However anything involving blood soiling would be disposed of in yellow. When around ¾ full bin liners will be sealed and taken out of the building to a locked area waiting collection. Used sharps will be put into a large sharps bin which when full will be sealed, dated and signed and stored in the same area waiting collection.</p>		

**Method Statement Section 3B, c) Specialist Prescribing**

Spec Reference	Method Statement Reference	Method Statement
1. Section 1.0  <b>Weighting 5</b>  <b>Maximum word count of 2000 words</b>	Information to Tenderers/ Definition of Service	Please demonstrate how the service will manage clinical costs, related to need, whilst keeping within budget.
<p><b>Contractors response:</b></p> <p>Inclusion is part of an NHS Foundation Trust that regularly scores an excellent for financial governance in its 'Monitor' ratings and has in the recent past had the accolade 'Foundation Trust of the year'. This means that we have a very rigorous and robust finance department who put great effort into ensuring all services are delivered within budget. Any overspends are highlighted immediately and measures put in place to resolve these issues. Our finance department itself is rigorously scrutinized through internal and external audit. As a result we have a very detailed and comprehensive set of standing financial instructions which can be viewed on our web site</p> <p><a href="http://www.southstaffsandshropshealthcareft.nhs.uk/getattachment/4071aa28-5e77-4b3d-b410-e04e6bee40e7/F-RED-01.aspx">http://www.southstaffsandshropshealthcareft.nhs.uk/getattachment/4071aa28-5e77-4b3d-b410-e04e6bee40e7/F-RED-01.aspx</a></p> <p>Also as a Foundation Trust we also regularly score excellent on the quality of our services. This demonstrates that we have managed to achieve the balance between keeping our services on budget whilst meeting service user need. Our finance directorate advise management what is affordable and possible within budget and also give a realistic view of the monies available. It is a management responsibility to keep the scheme within budget. However the finance department give managers monthly reports and will require action plans to resolve any overspends.</p> <p>In terms of the practical steps that we will take to keep our clinical spend in check, we will ensure that we are only meeting the clinical costs for substance misuse and that other medications are prescribed and paid for by the appropriate agency. For example we have previously carried out a clinical prescribing audit of one of our new services which was overspent on its prescribing costs. We found that we were prescribing some medications that should have been prescribed by GP's and some by mental health services. We subsequently ensured that all these prescriptions were transferred which significantly reduced our spend. Ensuring this is carried out also improves quality as it means that people will have more contact with their GP, thus meaning more of their primary health care needs are likely to be met and more contact with mental health services which also should enhance their overall care.</p> <p>Also by working to a recovery orientated agenda we would expect that our prescribing costs would be lower per patient. This is because people will be spending a shorter period in treatment than previously and whilst there may be higher one off costs for drugs like Lofexidine and Naltrexone the overall medication costs will be significantly lower. We will in some cases where people are coming into treatment for the first time not be considering a substitute prescription but initiating a Lofexidine detoxification with</p>		

a recovery package including structured day programmes and aftercare in place.

We will be assuring this approach through our supervision of clinicians and Recovery Workers which will include reviewing all prescriptions on at least a monthly basis and highlighting where people are ready to move on to their next stage in the recovery journey. Through this process we will be maximising the amount of people exiting drug treatment and thus keeping prescribing costs low. Every year there will be a full clinical audit by our audit team which will further identify prescribing issues that may not have been addressed

Having said this we will be prescribing according to clinical need and will not withhold medically indicated treatment on the basis of budgetary considerations. This would put us in breach of NICE technology appraisals on Methadone, Buprenorphine and Naltrexone which are audited against to by the Care Quality Commission.

Whilst we will be increasing the availability of supervised consumption in Cambridgeshire we will be ensuring that it is only continued post 3 months when there is a clinical need. Keeping people on supervision can be detrimental to their recovery especially in terms of employment, education and training opportunities. In fact the clinical guidelines suggest that supervision can be relaxed before 3 months in order to facilitate employment. We will be flexible with this on a case by case basis. So whilst the availability of supervision will be increased we will ensure that it only continues whilst clinically appropriate. This is a good example of where cost effectiveness and quality can go hand in hand.

Weighing clinical need against budgetary control is a constant pressure for NHS services and our Trust has been regularly assessed as having the right balance in this regard.

<p>2. Section 1.0</p> <p><b>Weighting 5</b></p> <p><b>Maximum word count of 1000 words</b></p>	<p>Definition of Service</p>	<p>How will recovery be promoted throughout this element of the service?</p>
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***Contractors response:***

Inclusion will promote recovery through its specialist prescribing interventions in the following ways:

- Recovery Workers will provide a menu of options at a service user's initial assessment and effectively assess whether substitute prescribing is the best option for this service user; we know historically that prescribing was the first and only option some service users were made aware of. We will discuss with service users at an early stage their stabilisation, detoxification and maintenance options.
- At assessment, our Recovery Workers will take in account a service user's recovery capital whilst completing a thorough assessment of their prescribing and drug history. Where the service user only has a recent history of heroin use and at low doses we will discuss and assess whether Lofexidine or symptomatic treatment would be an appropriate option instead of substitute opiate prescribing.
- Leaflets and DVD's on prescribing options, community detoxification and structured psycho-social interventions will be available in all reception areas to provide

service users with knowledge; our aim is to empower service users by explaining the choices open to them prior to their initial and medical assessments.

- Recovery Mentors and volunteers will be based at all sites to chat to new and existing service users about their recovery journey and how they made progress in treatment. Seeing others do well is a great incentive.
- All staff will be trained in assessment skills and be able to determine whether prescribing is the best option for that service user and if so have the knowledge and skills to discuss all possible treatment options with the service user.
- On going key work will continually review and assess service users current treatment plans and discuss with the service user possible options for detoxification or a slow reduction if their prescribing dose is too high for a safe and effective detoxification.
- We will deliver regular workshops, using staff and Recovery Mentors, on prescribing for recovery and abstinence. The workshops will discuss options for detoxification and prepare service users for what they can expect throughout their detoxification. For example in our Birmingham service there is a specific workshop for those clients embarking on Lofexidine detoxification. This workshop is facilitated by a Nurse Practitioner and outlines all the necessary health checks and health implications. Family and carers are asked to attend this workshop as they play a significant role in a service user's community detoxification.
- Detoxification handbooks will be made readily available to all service users highlighting all the options and pit falls to avoid.
- We will encourage and motivate those service users who are on existing high dose maintenance or stabilisation scripts whilst injecting or using illicit substances on top of their prescription to engage in recovery focused treatment. Harm reduction work is delivered through specific workshops, peer support and key working which results in setting new recovery goals.
- All staff will identify those service users suitable for home detoxification and initiate a joint home detoxification plan with the service user and nursing staff. Our Birmingham service is currently piloting a community home detoxification project where service users agree to a prescribed detoxification regime which is flexible to their needs and involves home visits and reviews by their local pharmacy. These clients are provided with structured psychosocial support by their key worker or are engaged in day programmes throughout Birmingham as well as daily nursing and medical support. Protocols and pathways have been set up which include working with local GP's , structured day care services , inpatient rehabilitation and detoxification units and local pharmacies. Service users are supported through their home detoxification by Recovery Mentors.
- Service users currently stabilising in treatment will be provided with Recovery Mentors to support them through their recovery journey with the aim of discussing goals for detoxification and abstinence when appropriate.
- All service users will have access to wrap around services such as family support, supporting people, housing, employment and training and education. Our Birmingham Service currently provides monthly road shows which are run at the service alongside prescribing clinics. Professionals from a range of health and wrap around services attend the Community Drug Team with the aim of engaging the client and meeting their specific needs.
- All service users have access to nurse clinics where they can have a full health "MOT" including electro-cardiographs, liver function tests, sexual health advice and

<p>testing, injecting advice, wound care treatment, mental health awareness and assessment, alcohol assessment and brief interventions, BBV testing and treatment. This specific service aims to keep the service user healthy throughout their recovery journey and link them in with other health related agencies such as primary care and specialist centres including alcohol services and specialist liver units.</p> <ul style="list-style-type: none"> <li>• All service users will be reviewed by the prescribing team every 3 months as a minimum requirement. At this review the key worker and any other external related health agencies will be present or sent minutes with the service user's permission.</li> <li>• We will carry out home visits to those service users who have acute physical health problems, who are pregnant or have young children. This will allow service users to be reviewed regularly and provide them with the necessary support to engage in a more recovery focused approach to their treatment.</li> <li>• All prescribing will be evidence based and follow guidance outlined in the Department of Health (DOH) Drug Misuse &amp; Dependence – UK Guidelines on Clinical Management (referred to as the 2007 Clinical Guidelines) and in NICE guidance namely: <ul style="list-style-type: none"> <li>✓ NICE Drug misuse (CG52) Opioid detoxification</li> <li>✓ NICE Drug Misuse (CG51) Psycho-social Interventions</li> <li>✓ NICE Drug Misuse (TA114) Methadone &amp; Buprenorphine</li> <li>✓ NICE Drug Misuse (TA115) Naltrexone</li> </ul> </li> </ul>		
<p>3. Section 1.0</p> <p><b>Weighting 5</b></p> <p><b>Maximum word count of 1500 words</b></p>	<p>Definition of Service</p>	<p>Please demonstrate how this service will always be delivered in conjunction with psychosocial work.</p>
<p><b>Contractors response:</b></p> <p>Prescribing will always be delivered in conjunction with psycho-social interventions. We will approach service users new to prescribing by opening alternative recovery routes that promote abstinence as a realistic option. For service users who have been involved in substitute prescribing for some years, we will review treatment goals and attempt to raise their aspirations where possible. We will achieve this through:</p> <ul style="list-style-type: none"> <li>• All service users will have a dedicated key worker who will provide psychosocial interventions such as motivational interviewing, solution focused therapy and BTEI mapping interventions. All staff will be trained and regularly updated in all of these approaches.</li> <li>• Substitute prescribing will be offered as a treatment option alongside psycho-social interventions and not as an alternative.</li> <li>• Service users will have access to time limited structured psychosocial interventions such as Cognitive Behavioural Therapy and counselling therapies provided by fully qualified professional staff.</li> <li>• Workshops will be run in conjunction with prescribing clinics and these will look at topical issues relevant to service user need.</li> <li>• Service users accessing prescribing services will have sessions provided by their key worker specifically for psychosocial work as often as their need demands.</li> <li>• Service users will have access to psychological support where necessary</li> <li>• The service will have a specific Dual Diagnosis lead who will be trained in delivering psycho-social work when a mental health need is identified. This may include</li> </ul>		

<p>anxiety, paranoia, stress related illnesses and thought disorder concerns. This work will not only be delivered in conjunction with substitute prescribing but also alongside the service user's GP and the Home Treatment mental health team. The Dual Diagnosis lead will liaise with the service user's consultant, community mental health nurse and GP so all partnership agencies involved can set an agreed care plan.</p> <ul style="list-style-type: none"> <li>• Key workers and prescribing staff will keep partnership agencies such as GP's and mental health teams updated with medication reviews and changes.</li> <li>• All staff will be trained in BTEI node link mode mapping and a variety of mapping tools will be available to all staff to assist in psychosocial work. In our Birmingham service all staff including prescribers are trained in BTEI mapping techniques which uses maps to challenge and change the way service users think about their treatment and recovery as a whole.</li> <li>• Monthly clinical meetings will take place where the prescribing team will be present alongside all staff. These meeting will allow key workers to present and review their service user's care and treatment and will ensure that the service users prescribing plan compliments the psycho-social work.</li> <li>• As part of a service users prescribing appointment, the prescriber will be trained in delivering brief psycho-social interventions. This will involve motivational interviewing and can be used to address alcohol use, anxiety, relapse prevention and harm minimisation.</li> </ul>		
<p>4. Section 1.0</p> <p><b>Weighting 5</b></p> <p><b>Maximum word count of 1000 words</b></p>	<p>Definition of Service</p>	<p>Please demonstrate how the service will engage with clients who are reluctant or refuse to engage with Structured Psychosocial Interventions (SPI) alongside prescribing.</p>
<p><b>Contractors response:</b></p> <p>For those service users reluctant or refusing psycho-social interventions we will:</p> <ul style="list-style-type: none"> <li>• Our prescribing staff will use Motivational Interviewing techniques and provide Brief Interventions as a short term measure to address psycho-social needs and motivate the service user to engage with their key worker for further psycho-social interventions.</li> <li>• Offer workshops and group work alongside prescribing clinics providing psycho-social interventions on a variety of topical issues related to need. Service users who attend their prescribing appointment will be encouraged to take part. The workshops can be seen as a more relaxed approach to psychosocial interventions by the service user compared to 1/1 Key working.</li> <li>• Home visits where appropriate will be carried out to encourage service users to engage in psycho-social work. This may be done in conjunction with a prescriber, in particular a Nurse Prescriber.</li> <li>• Volunteers and Recovery Mentors will be used to support these clients and encourage them to engage in group work, workshops and key working.</li> <li>• Service users who regularly disengage with psycho-social interventions will be placed in a specialist supportive prescribing clinic which will run weekly and that will allow service users the opportunity to drop in between flexible time slots e.g. 1pm-4pm rather than a specific appointment time. Throughout this time Recovery</li> </ul>		

<p>Workers will be available to engage with the service user along with external professionals from housing, employment, family and supportive people.</p> <ul style="list-style-type: none"> <li>Weekly team meetings will provide staff with the opportunity to discuss service users who do not engage in psychosocial interventions and set plans. These may include not posting out prescriptions to pharmacies so that the service user must come into the service to collect their prescription. This will allow key workers and Recovery Mentors the opportunity to sit down with the service user in an attempt to increase engagement</li> <li>There maybe some cases where a service user is scripted but continuous with very heavy illicit use whilst refusing to engage with psycho-social interventions. In these circumstances we will consider reducing or stopping prescribed treatment if no benefit is seen in continuing the script.</li> <li>During the early stages of the contract, Inclusion will initiate the process of a full caseload review and this will include analysis of those service users refusing or reluctant to engage with psycho-social interventions as part of their treatment. It is our intention, due to the large number of clients transferring, to establish three small working groups to drive the caseload review. In carrying out a full caseload review of all clients, we will have in mind the following principles: <ul style="list-style-type: none"> <li>Is the service user being seen by the correct service?</li> <li>Is a harm minimisation approach balanced with interventions that are recovery-orientated?</li> <li>Are interventions being delivered safely?</li> <li>Are risks understood and appropriately managed?</li> <li>Are organisational policies and procedures being followed?</li> <li>Can the client move to nurse-led prescribing?</li> <li>Are interventions for Criminal Justice System clients aimed at reducing re-offending?</li> <li>Are the client's mental health needs being met and is Care Co-ordination sitting with the correct agency</li> <li>Is current prescribing in line with clinical guidelines</li> <li>Are care plan goals co-opting the support of external agencies with an interest in recovery and re-integration?</li> </ul> </li> </ul>		
<p>5. Section 1.0</p> <p><b>Weighting 5</b></p> <p><b>Maximum word count of 500 words</b></p>	<p>Definition of Service</p>	<p>Please demonstrate how nurses will be utilised in the prescribing process.</p>
<p><b>Contractors response:</b></p> <ul style="list-style-type: none"> <li>Nurses and Nurse Prescribers will be present in clinics allowing clients to be triaged first by the nurse to identify and carryout any necessary health checks and procedures before they see a Doctor. This may include monitoring for withdrawals and advising on titrations. This allows clinics to run more efficiently and for clients who drop in that day in crisis or who are motivated to discuss detoxification to be seen.</li> <li>A nurse led outreach health service will provide access to general medical assessment for our most physically ill patients. All clients entering the service will be offered a general medical consultation by our nurses and include a full clinical and</li> </ul>		

physical examination including electro-cardiograph screening for those clients on more than 100mls of methadone or for those service users reducing on a detoxification programme as well as those prescribed antidepressants alongside their methadone script.

- All service users have access to nurse clinics where they can have a full health “MOT” including electro-cardiograph, liver function tests, sexual health advice and testing, injecting advice, wound care treatment, mental health awareness and assessment, alcohol assessment and brief interventions, BBV testing and treatment. This specific service aims to keep the service user healthy throughout their recovery journey and link them in with other health related agencies such as primary care and specialist centres including alcohol services and specialist liver units.
- SSSFT promotes nurse prescribing within Inclusion and all are supported through forums, training, ongoing development and regular supervision. Inclusion and SSSFT have an independent nurse prescribing lead who is responsible for the ongoing support and development of all Nurse Prescribers. The Trust has developed a Nurse Prescribing policy and formula.
- Supplementary Nurse Prescribers will run prescribing clinics alongside the Consultant Psychiatrist and carry out reviews, titrations and detoxification for service users on substitute medication. The Consultant Psychiatrist will assess the service user and then agree a treatment plan that will incorporate a clinical management plan. Specific nurse prescribing formulas will be set up with a list of medications that can be prescribed depending on the experience of the Nurse Prescriber. All titrations will follow guidance outlined in the DOH Clinical Guidelines.
- In our Birmingham team, nurse prescribing has been embedded within the service over the last five years and there have been Specialist Nurse Prescribing clinics running twice a week producing around 100-150 prescriptions for service users per month. Nurse prescribing has allowed for rapid same day prescribing as it frees up medical time that can be spent seeing new referrals and those service users wishing to start a detoxification.
- Nurses will also play a lead role in developing home detoxification throughout the area. Service users will be assessed by the Consultant Psychiatrist and a prescribing template set up in conjunction with a clinical management plan. Nurse Prescribers will then be able to visit service users at their home or in the local community and implement the detoxification regime. Nurses will also carry out all the necessary physical health checks required such as daily blood pressure checks if the service user is on a Lofexidine detox.
- Home detoxification will be embedded within clinical governance as Nurse Prescribers and Recovery Workers would be supported by the Consultant Psychiatrist and medical team. By working in partnership with GP practices in the shared care scheme an environment would be created where clinical excellence and best practice can flourish through continuous benchmarking. A significant events audit would be set up allowing any problems to be identified, monitored and plans put in place to reduce their reoccurrence.

6. Section 2.0 Sub heading 2.1 b <b>Weighting 5</b>  <b>Maximum word count of 1000 words</b>	Aims of the Service	Please demonstrate how the service will manage the expectation of those prescribed to and ensure that clients understand that prescribing is a short term intervention as part of a recovery based treatment plan.
<p><b>Contractors response:</b></p> <p>Inclusion will manage expectations and promote prescribing as a short term element of recovery through:</p> <ul style="list-style-type: none"> <li>• At assessment key workers will discuss a service user's recovery capital and from this formulate a treatment recovery care plan in agreement with the service user.</li> <li>• Staff will inform service users of all prescribing options with an emphasis on detoxification and reduction once stabilisation is reached. Service users who have a high degree of existing recovery capital will be encouraged away from maintenance and offered structured psycho-social support with Recovery Mentoring and will be linked in with wrap around services such as education, training and employment.</li> <li>• We will prescribe non opiate medication where appropriate to service users who have only a recent history of opiate use or are only using small amounts. This cohort will be offered an intense package of psycho-social interventions and social support alongside medical and nursing support where options of Lofexidine and symptomatic medications will be offered.</li> <li>• Service users will be linked in with Recovery Mentors who will support the service user in achieving their recovery goals by attending meetings with them such as NA, and programmes. Service users will be encouraged to engage in peer support groups and share their experiences and how their recovery journey is progressing.</li> <li>• Service users will be encouraged to Structured Day Programme group sessions on topical recovery issues such as detoxification, coping with anxiety and adopting healthy lifestyle choices.</li> <li>• Service users will be given recovery information packs and leaflets on detoxification to take home and we will promote service user involvement projects such as the allotment project running in our Birmingham service.</li> <li>• We will involve wrap around services by having them provide road shows at the service. This will include agencies from employment, housing, family centres and other support groups.</li> <li>• Service user involvement will be promoted in the form of peer support group, workshops and a local SUI newsletter as part of the recovery journey.</li> <li>• Key workers will incorporate a service user's prescribing plan into their recovery plan and discuss options such as reduction and detoxification. Prescribers will be involved as part of this review.</li> <li>• For those service users on existing long term maintenance scripts, key workers will engage them in more structured psycho-social interventions with the aim of increasing a service user's motivation to make small recovery steps with slow reductions off their substitute medication where appropriate.</li> </ul>		

<p>7. Section 2.0 Sub heading 2.1 b <b>Weighting 5</b></p> <p><b>Maximum word count of 1000 words</b></p>	<p>Aims of the Service</p>	<p>Please demonstrate how the service will ensure that a culture of short term, recovery focused prescribing has been understood and will be practiced by staff, rather than long term maintenance prescriptions.</p>
<p><b>Contractors response:</b></p> <p>Inclusion will promote a culture of short term, recovery focused prescribing through:</p> <ul style="list-style-type: none"> <li>• Recovery training packages – training staff in the effective provision of recovery-orientated opioid substitution and other drug treatments as part of broader personalised recovery plans. For some individuals with heroin addiction, the best treatment may include substitute medication, while for others this may be inappropriate or unnecessary. In all instances, the objective is to enable individuals to achieve their fullest personal recovery. Staff will be trained and provided with support to gain the competences to improve the quality of regular review and restructuring of personalised care to support recovery.</li> <li>• Ensure that staff are trained and supervised to deliver psychosocial interventions of a type and intensity appropriate to their competence. Effective keyworking entails not only recovery care planning, case management, advocacy and risk management, but also collaborative interventions designed to raise the insight and awareness of patients and help them plan and build a new life. This will often involve attention to employment and housing 11. Review the quality of recovery care planning and take steps to improve it, through staff supervision and team meetings.</li> <li>• For staff to be updated in new prescribing options and access Inclusion prescribing training which provides specific training on prescribing for recovery and considers detoxification options.</li> <li>• The service to set up clinical protocols to guide staff including prescribers so they can help individuals make progress towards personal recovery, improve support for long-term recovery, and avoid unplanned drift into open-ended maintenance prescribing. The service will review its mission statement, aims and objectives to reflect the move to recovery based treatment provision. The following will be considered</li> <li>• The prescribing of any medication especially opiate substitute medication must not be allowed to become detached and delivered in isolation from other crucial components of effective treatment. These include individual recovery care planning, psychosocial interventions and integration with mutual aid and peer support. All of these, in different combinations with different patients, and adjusted over time, can and do support recovery.</li> <li>• A comprehensive assessment of need is an essential early and ongoing step in the planning of personalised treatment and it should also be an integral part of the therapeutic process.</li> <li>• A recovery care plan that results from the assessment when progress is reviewed, must be developed collaboratively so that it is personally relevant and 'owned' by the patient. This will increase the likelihood that they commit to, and are motivated by, a personal recovery care plan that is meaningful to them. Repeated reviews should result not only in a personalised assessment but also the optimised treatment for the individual. This should include – but certainly not be limited to – attention to elements of the medication component of treatment. If an individual is</li> </ul>		

<p>deriving little or no benefit from an intervention, then it should be modified and tailored in partnership with the patient so that the provision of the treatment delivers identified and valued benefit.</p> <ul style="list-style-type: none"> <li>• Supervision and appraisals - staff to have formal supervision on a monthly basis from their manager to review how they are adapting to a new recovery focused model. Staff to also have a clinical mentor who they can go to for specific clinical and prescribing support and advice.</li> <li>• Performance management – For those staff who are struggling to change their practice to incorporate recovery into their practice to be managed and supported through performance management procedures.</li> <li>• Audits – regular caseload audits to be done by management to review service user progress through treatment. The audit will also review whether the service user is making progress on opiate substitute medication.</li> </ul>		
<p>8. Section 2.0 Sub heading 2.2</p> <p><b>Weighting 5</b></p> <p><b>Maximum word count of 2000 words</b></p>	Objectives of the Service	Please demonstrate how home detoxification will be delivered and supported.
<p><b>Contractors response:</b></p> <p>The service will be led by Inclusion Nurse Prescribers. Service users will be assessed and clinical management plans for controlled drug medications will be signed off by the Consultant Psychiatrist and nursing team. Nurse Prescribers will then carryout the detoxification in the home and be supported by the team who will ensure regularly health checks are carried out and that psycho-social interventions are provided.</p> <p>Detoxification will be offered utilising 3 different medications. Methadone, Buprenorphine and Lofexidine. NICE (2007) recommend that service users are detoxified using Methadone or Buprenorphine as first line treatments. In deciding between the two the team will take into account:</p> <p>A) Which of the two (if any) the service user has been stabilized on</p> <p>B) The preference of the service user.</p> <p>Some service users prefer to be transferred to Buprenorphine from Methadone to complete detoxification. NICE found no evidence for the effectiveness of this but it is catered for through service user choice and Inclusion will be offering that option.</p> <p>Lofexidine is the third line treatment recommended by NICE. NICE state it should be considered for people who:</p> <ul style="list-style-type: none"> <li>○ Have made an informed and clinically appropriate decision not to use methadone or Buprenorphine</li> <li>○ Have made an informed and clinically appropriate decision to detox in a short timeframe</li> <li>○ Have mild or uncertain dependence (including young people).</li> </ul> <p>Lofexidine may also be used as an adjunct to Methadone and Buprenorphine detoxification either as a tool for more rapid detoxification or at the final stages to</p>		

increase comfort.

Home detoxification may be identified as a suitable treatment pathway at initial assessment. All referrals will then be examined by a specialist nurse to ensure suitability.

Community (home) opioid detoxification should be a readily available treatment option and forms a key part of the recovery journey. Opioid detoxification refers to the process by which the effects of opioid drugs are eliminated from dependent opioid users in a safe and effective manner, such that withdrawal symptoms are minimised. This process varies from person to person but recommendations are 4-12 weeks in a community setting. In some cases this may be shorter depending on the level of dependence.

Effective preparation and service user selection is key to a good outcome. It is important to have informed consent and detailed information about the detox.

- Service users will be provided with detailed information about the physical and psychological aspects of opioid withdrawal and with information on managing symptoms
- Service users will be made aware of the risks following detoxification including the loss of tolerance and overdose
- Service users will be made aware of the risks of increased alcohol and benzodiazepine consumption post detoxification
- Service users will be made aware of the importance of continued support and possible pharmacological interventions such as Naltrexone
- Advice will be given on lifestyle choices whilst detoxifying e.g. exercise, sleep hygiene, diet, and hydration.
- We will ensure there are good key working systems in place – key workers have a central role in co-ordinating a care plan including social and psychological support. This includes offering day services and aftercare support our Structured Day Programme and SPOC. An aftercare package will be in place for all service users accessing detoxification

An ideal home detox candidate will be a service user that:

- Is fully committed, informed and motivated to detoxification
- Is aware of the potentially high risk of relapse
- Has a supportive and stable social environment
- Has stable physical and mental health
- Is aware of risks of loss of tolerance post detox and potential overdose
- Has no concurrent poly-drug use such as alcohol or benzodiazepines

In line with NICE Guidelines (2007) exclusions to community detoxification would include service users who:

- Have not benefited from previous community detoxification
- Are reluctant to engage in detox – coercion is likely to lead to relapse
- Have significant social circumstances which limit the benefit of community based detox
- Have severe mental health problems
- Have significant physical health problems
- Have complex poly drug use

With concurrent benzodiazepine dependence NICE recommend that usually benzodiazepine detoxification should be prioritized so that opioids are maintained during the benzodiazepine detox. Whether this is done separately or concurrently is the service user's preference and the severity of dependence should be considered.

With concurrent alcohol dependence NICE state that in a community setting alcohol detoxification should be offered first and this should be done before opioid detoxification. If people desire concurrent alcohol and opioid detoxification this should be done in an inpatient setting. Inpatient opiate detoxification is an option to consider for service users for whom community detox is unsuitable.

Detoxification using Methadone -The Clinical Guidelines (DH 2007) state:

*'Following stabilisation on methadone the dose can be reduced at a rate which will result in zero in around 12 weeks. This is usually a reduction of around 5 mg every one or two weeks. Patients often prefer a faster reduction at the beginning although there is no research evidence to indicate the superiority of a linear or exponential dose reduction.'*

Inclusion are aiming to detoxify more rapidly than 12 weeks. As a result we are recommending that service users only enter detoxification when they are down to a dose of 30mg of methadone. We will consider people on up to 40mg after careful assessment. A typical methadone detoxification would last 6 weeks reducing by 5mg a week from 30mg. There will be flexibility within this and the rate of reduction can be accelerated or slowed down according to service user need and preference. If accelerated we will consider the concurrent use of Lofexidine which has been shown in our other services to increase comfort in those circumstances. Lofexidine may also be considered in the last week of detoxification.

Buprenorphine is also a useful option for home detoxification from heroin/methadone. It has a high safety profile and service users report that they can detoxify more rapidly and more comfortably on this although NICE found no difference in effectiveness for detoxification between Buprenorphine and Methadone. Buprenorphine will be considered for service users who are currently prescribed Buprenorphine, have made an informed choice to swap to Buprenorphine from Methadone and for people using street heroin entering treatment for detoxification without stabilization first. We would require those currently prescribed Buprenorphine to have already reduced to a dose of no more than 16mg.

Lofexidine with or without adjunctive symptomatic medication can be used for those people who have successfully decreased down to around 20-30mls Methadone and 8mg or less of Buprenorphine, and from this want to detox with appropriate pharmacological support. The detox will last between 7-10 days but can be extended up to 14 days. The service user must be reviewed daily whilst the dose is titrated up. Once the dose is stable or reducing, the service user must be reviewed twice a week or as needed. A detailed physical health history will be taken by the nursing team prior to detoxification taking place.

In recognition of the inherently destabilizing effect of a detox regime, every effort will be made to ensure the service user's prescribing is continuous and the detox is not

interrupted. Service users will be marked as 'vulnerable' for the period of the detox to ensure they have same day access to a clinician. However, in some circumstances it will be necessary to stop the detox. These may be:

- Persistent non attendance at detox appointments
- Persistent use of illicit drugs or alcohol during the detox period.
- Change in stability of social circumstances.

In this situation, titration back to stability with the opiate substitute of choice is recommended.

Relapse Prevention - Naltrexone will be offered to service users on completion of Opiate detoxification as recommended by the NICE technology appraisal on Naltrexone (NICE 2007). Prescribing of Naltrexone will commence 7 -10 days after completion of the detoxification. This will need to be continued by the persons GP or other prescribing doctor. In order to be suitable for Naltrexone treatment service users will need to be highly motivated to remain in an abstinence programme and have access to adequate supervision in taking it ideally from a family member or significant other, but also possibly by a community pharmacist

It is important that detoxification is seen as one step to recovery and abstinence and not the final process. Should the detox fail at any point the service user must be offered seamless access back into treatment

Aftercare - All Service users will have a care plan with a robust package of recovery support post detoxification. This will have been developed prior to detoxification. There will be a range of support options available including 1-1 support, peer recovery support, group work and residential rehabilitation. Serviced users will be encouraged to access self help groups such as Narcotics Anonymous.

9. Section 2.0 Sub heading 2.2  <b>Weighting 5</b>  <b>Maximum word count of 1000 words</b>	Objectives of the Service	Please identify the risks associated with home detoxification and what mechanisms will be put in place to reduce such risks.
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***Contractors response:***

Proper detoxification preparation is important. We will ensure that service users receive structured planning prior to their detox and aftercare on completion to guard against relapse. Key workers, detox nurses and prescribing staff will discuss the service users individualised detox plan to ensure that the service user understands the process, pitfalls and what to do if they are struggling. Service users will be given a community detoxification handbook which provides information on the following

- Why do a detox? What can Inclusion do to support you?
- Methadone and Buprenorphine detox - the options
- General advice for a Methadone, Buprenorphine and Lofexidine detox.
- Managing withdrawals (symptomatic relief)
- How can I choose which is best for me?
- Is a community detox appropriate for me?
- Advice on Residential detox and rehabilitation.

- Doing a detox
- My Community detoxification plan.
- Destabilisation - In recognition of the inherently destabilizing effect of a detox regime, every effort must be made to ensure the service user's prescribing is continuous and the detox is not interrupted. Service users will be marked as 'vulnerable' for the period of the detox to ensure they have same day access to a clinician. However, in some circumstances it will be necessary to stop the detox. These may be:
  - Persistent non attendance at detox appointments
  - Persistent use of illicit drugs or alcohol during the detox period.
  - Change in stability of social circumstances.

In this situation, titration back to stability with the opiate substitute of choice is recommended. It is important that detoxification is seen as one step to recovery and abstinence and not the final process. Should the detox fail at any point the service user must be offered seamless access back into treatment.

- Risk of relapse - Naltrexone will be offered to service users on completion of Opiate detoxification as recommended by the NICE technology appraisal on Naltrexone (NICE 2007). Prescribing of Naltrexone will commence 7-10 days after completion of the detoxification. This will need to be continued by the persons GP or other prescribing doctor. In order to be suitable for Naltrexone treatment service users will need to be
  - Highly motivated to remain in an abstinence programme
  - Have access to adequate supervision in taking it ideally from a family member or significant other, but also possibly by a community pharmacist.
- Aftercare - All service users will have a care plan with a robust package of recovery support post detoxification. This will have been developed prior to detoxification. There will be a range of support options available including 1-1 support, peer recovery support, access to structured day programmes, group work and residential rehabilitation. This is a matter for detailed discussion and planning with the service user. Serviced users will be encouraged to access self help groups such as Narcotics Anonymous.
- Unplanned Discharge – service users who drop out of the detoxification and then do not engage back with the service will be visited at home by their key worker and nurse prescriber to attempt to re engage back into treatment quickly and reduce the Service user feeling a sense of lack of self worth and that they have let people down.
- A common problem associated with detoxification is underlying psychological disorders. Access to psychology and structured day care would support Service Users through their community detoxification.
- Community opioid detoxification should be a readily available treatment option and forms a key part of the recovery journey. Opioid detoxification refers to the process by which the effects of opioid drugs are eliminated from dependent opioid users in a safe and effective manner, such that withdrawal symptoms are minimised.
- Provide the service user with detailed information about the physical and psychological aspects of opioid withdrawal as well as information on managing symptoms

- Make service users aware of risks following detoxification – loss of tolerance and overdose
- Make service users aware of risks of increased alcohol and benzodiazepine consumption post detoxification
- Make service users aware of the importance of continued support and possible pharmacological interventions such as Naltrexone
- Advise on lifestyle whilst detoxifying e.g. exercise, sleep hygiene, diet, and hydration.
- Ensure there are good key working systems in place – key workers have central role in coordinating a care plan including social and psychological support. This includes offering day care and aftercare support. An aftercare package must be in place for all service users accessing detoxification.

An ideal community detox candidate would be one who:

- Is fully committed, informed and motivated to detoxification
- Is aware of high risk of relapse
- Has a supportive and stable social environment
- Has stable physical and mental health
- Is aware of risks of loss of tolerance post detox and potential overdose
- Has no concurrent poly - drug use such as alcohol or benzodiazepines

NICE (2007) have suggested that exclusions to community detoxification would include service users who:

- Have not benefited from previous community detoxification
- Are reluctant to engage in detox – coercion is likely to lead to relapse
- Have significant social circumstances which limit the benefit of community based detox
- Have severe mental health problems
- Have significant physical health problems
- Have complex poly drug use

With concurrent benzodiazepine dependence NICE recommend that, usually benzodiazepine detoxification should be prioritized, so that opioids are maintained during the benzodiazepine detox. Whether this is done separately or concurrently the person's preference and the severity of dependence should be considered. With concurrent alcohol dependence NICE state that in a community setting alcohol detoxification should be offered first and this should be done before opioid detoxification. If people wish concurrent alcohol and opioid detoxification this should be done in an inpatient setting.

10. Section 3.0 Sub heading c	Provision of Service	Please demonstrate how the service will use titration to ensure effective levels of medication.
<b>Weighting 5</b>		
<b>Maximum word count of 1000 words</b>		
<b>Contractors response:</b>		

Methadone

There is a need to start at a low dose and titrate up until an optimal dose is reached, but too high an initial dose and/or too rapid increases also add to overdose risk in this period because of the accumulative effect before steady state is reached. This titration process and the reason for being cautious must be explained to the patient. The starting dose of methadone should be between 10 and 30 mg daily, depending on the amount of heroin or other opiates being used, and titrated upwards to optimal levels, usually between 60 and 120 mg.

Start with 10 to 30 mg methadone daily, based on the assessment of the person's opioid tolerance, the frequency of use, the route of administration and the use of other drugs such as benzodiazepines and alcohol, whilst bearing in mind the long but variable half-life of methadone of between 13 and 112 hours in first few days. If tolerance is low or uncertain, then starting doses of 10 to 20 mg should be used and increased more slowly.

Methadone increases of between 5 and 10 mg a day, with a maximum of 30 mg a week for the first two weeks, are recommended. After that the increases can be slightly quicker. When undertaking induction, it is preferable to see the patient frequently at the outset, so that a series of further assessments can be made to judge the cumulative dosing effects. Nurse Prescribers will do this alongside the medical team. Involve the pharmacist who is providing supervised consumption in the assessment process during titration.

Patients who have a long history of use, including past and current injecting heroin use, and higher levels of drug use, those who are well known to services and those in whom there is clear evidence of high tolerance may benefit from a slightly faster induction. Patients who are non-injectors, have a shorter history of drug use and /or lower levels of drug use, and in whom evidence of high tolerance is lacking need a more cautious approach.

Risk of overdose is increased by low opioid tolerance, too high an initial dose, too rapid increases and concurrent use of other drugs, particularly alcohol, benzodiazepines and antidepressants. Daily assessment by a pharmacist using supervised consumption is the best safeguard to prevent undetected over-sedation in a patient, and arrangements should be made to ensure sharing of this information in a secure and confidential manner.

Methadone patients should be informed of the 'increasing effect of a dose' as steady state is achieved, so that they do not excessively 'top up' with street drugs. During induction, psychological factors and psychiatric morbidity/ illness need to be taken into consideration on the premise that depression may contribute to suicidal ideation.

Buprenorphine

To avoid precipitated withdrawal, delay the first dose of Buprenorphine until the patient is experiencing features of opioid withdrawal (This typically means at least eight and preferably 12 hours after last heroin use, or 24 to 48 hours after last methadone use.)

Titration on to Buprenorphine from heroin or low-dose methadone (30 mg or below) can usually be accomplished with minimal complications, although restlessness, insomnia, headache, diarrhoea and other mild opioid withdrawal-like symptoms are not

uncommon in the first one to three days.

Lofexidine may be helpful with these unpleasant effects. Steady state in the blood concentration levels of Buprenorphine is reached after about five to eight days. Advice about sleep hygiene should be given. Nurse prescribers to see the patient frequently throughout the week and increase the Buprenorphine dose on subsequent days, or later the same day. Dose increases of 2 to 4 mg per day at a time are usually adequate, although dose increases of up to 8 mg are safe and can be used.

Ensure frequent review of the patient and supervision of doses, where available, through induction and until stability. Provide a full explanation to the patient and their partner/carer, if appropriate, supported by written information to include: the properties of the drug, how it works, the induction period and the possible side effects (Provide a patient information leaflet).

Ensure that patients understand that most people take several days to stabilise on their medication, particularly if transferring from methadone (where stabilisation can take one to two weeks). Precipitated withdrawal will also be explained.

#### Lofexidine

Lofexidine with or without adjunctive symptomatic medication can be used for those people who have successfully decreased down to around *20-30mls methadone and 8mg or less of Buprenorphine*, and from this want to detox with appropriate pharmacological support. Lofexidine will not be started if BP < 100/<60 and Pulse <55 bpm.

Treatment with Lofexidine should start at 200-400 micrograms twice a day, increased daily as necessary, to control withdrawal, in dosage increments of 200–400 micrograms, to a maximum of 2.4 mg daily in 2-4 divided doses. The dose is then gradually reduced over subsequent days as withdrawal eases. This avoids rebound hypertension. Failure of Lofexidine detoxification regimes is often due to under-dosing.

Precipitated withdrawal occurs only on the first dose, and the longer after the last opiate use this first dose is taken, the lower this risk. To achieve this, give the first dose (only) of Buprenorphine to the patient as a take-home dose to be taken at an appropriate time of their choosing as the onset of withdrawal occurs. Commence with an initial Buprenorphine dose of between 4 and 8 mg.

Please see the table below highlighting 2 possible dosing regimes. The first reaches a maximum of 8 tablets (total daily dose 1.6mg) on day 3. A typical regime detox regime using Lofexidine 0.2mg:

Day of detox	Maximum tablets am	Maximum tablets lunch	Maximum tablets 6pm	Maximum tablets at night
1	0	1	0	1
2	2	1	1	2

4	2	2	2	2
5	2	1	1	2
6	2	1	1	2
7	0	1	0	1

The second reaches a maximum of 12 tablets (total daily dose 2.4mg – the maximum licensed dose) on day 5.

Day of detox	Maximum tablets am	Maximum tablets lunch	Maximum tablets 6pm	Maximum tablets at night
1	1	1	0	2
2	2	1	1	2
3	2	2	2	2
4	3	2	2	3
5	3	3	3	3
6	3	1	2	3
7	2	0	2	3
8	2	0	1	2
9	1	0	0	1
10	0	0	0	1

It is important that this regime allows for flexibility and each service user's symptoms are taken into account with dosage increased accordingly if necessary. A typical detox lasts from 7-10 days with Lofexidine. If a service user is struggling this can be extended up to 14 days. Withdrawal from heroin is at a maximum at day 2 and methadone withdrawal is at a maximum at day 3 to 5.

11. Section 3.0 Sub heading d	Provision of Service	Please demonstrate and detail how the service will ensure that current provision within the Cambridge Access Surgery (CAS) is maintained and developed
<b>Weighting 5</b>		
<b>Maximum word count of 1500 words</b>		

**Contractors response:**

From our tender research it is clear that the Cambridge Access Service plays an important role in the local drug treatment system, particularly with homeless drug users.

Consequently we will seek to develop an excellent working relationship with CAS and continue to develop the service through:

- Meeting with CAS during the implementation phase to agree an action plan which would honour the current agreement, review systems and carryout a needs analysis to explore any areas of service development. We will review the current payment schedule with CAS to ensure maximum value for money is being obtained.
- Inclusion will instigate and lead regular quarterly meetings with CAS to ensure good communication pathways are in place and to facilitate continuous service development and treatment improvements.
- Ensuring a Shared Care Monitoring Group is set up and represented by commissioners, service managers, CDIP, shared care GP's, GPwSI's and a lead pharmacist. These meetings will be used to discuss prescribing practice not only in shared care but throughout the whole treatment system and will be the forum where prescribing audits, protocols and pathways such as those for community detoxification are discussed and improved.
- Agreement that CAS carryout clinical audits which are then fed back to the wider treatment service and Shared Care Monitoring Group.
- Discuss the possibility of CAS providing peer mentoring / supervision to GP's in the shared care scheme. In Birmingham this has proved an effective way of engaging other GP's to enter the shared care scheme.
- We will ensure that all payments due to CAS are made promptly in line with the service level agreement. Payments will be made quarterly in arrears.

Inclusion expects the range of services available to service users via CAS to include:

- Advice, information & support
- Needle exchange & BBV interventions
- Assessment, recovery planning, reviews & key Working
- Care co-ordination
- Substitute prescribing
- Psycho-social interventions
- Recovery Mentoring
- Referral to the Structured Day Programme
- Support for home detoxification and referral to in-patient detoxification
- Referral to Residential Rehabilitation

CAS clinics will continue to be supported by staff from the Adult Drug Treatment Service – one designated worker will act as lead for communication with CAS and be the point of contact for all day to day issues. We will detail Recovery Workers to facilitate CAS clinics as follows:

- Tuesday – 10am until 12 noon and 2pm until 6pm
- Wednesday - 10am until 12 noon
- Thursday – 10am until 12 noon and 2pm until 6pm
- Friday – 10am until 12 noon

- Inclusion will make contact with all homelessness agencies across Cambridge and surrounding areas to build and improve pathways into relevant support services for

this group. This will include strong links with CRI's Street Outreach Team to encourage referral of homeless drug users into treatment. We will explore with CRI the option for CAS staff to accompany their staff on specific outreach sessions to market the drug treatment service with homeless service users. Similarly, we will invite CRI outreach staff to shadow treatment staff at CAS to enhance their understanding of local treatment services and improve future joint working and information sharing.

- Our understanding is that CAS staff currently provides health-related advice, information and training to Adult Drug Treatment Service staff. As a large health provider and specialists in drug treatment our approach would be to engage CAS staff in meeting, in partnership with ourselves, the wider educational needs of shared care staff across Cambridgeshire. As we have described in other method statements, our aim is develop shared care across the county and CAS staff could play an important educational and support role along side Inclusion.

<p>12. <b>(Section 3B)</b> Section 3.0 Sub heading e</p> <p><b>(Section 3A)</b> Section 7.0</p> <p><b>Weighting 4</b></p> <p><b>Maximum word count of 500 words</b></p>	<p>Provision of Service</p> <p>Care Planning</p>	<p>Please demonstrate how service users will be reviewed and that client's prescriptions will be regularly monitored.</p>
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**Contractors response:**

We will ensure prescriptions are regularly reviewed and monitored through:

- Medical reviews will be carried out every 3 months as a minimum requirement however in order to meet recovery goals and objectives these reviews should where possible take place more frequently.
- Nurse Prescribers will ensure that all service users they are prescribing for are reviewed by a member of the medical team every 3 months.
- At each service user's prescribing review, the prescriber will discuss recovery focused treatment options such as reduction and detoxification if the service user is stable on their treatment. A service user's key worker will be present at the review. If a service user is deemed as making little progress on the prescription and they continue to use illicit substances on top, further structured psycho-social interventions will be discussed with the service user as well as a review of their social needs. The key worker will then update the service user's care plan to reflect any new recovery goals and objectives set.
- A full clinical audit will be undertaken yearly.
- Monthly audits will be carried out reviewing prescribing and key workers caseloads and this will be fed back as part of staff's supervision. The audit will focus on service user's progression in relation to their recovery journey and whether their prescribing reviews reflect this. At supervision, action plans will be drawn up to support the member of staff in adopting a more recovery focused treatment plan with their service users. If staff continue to make no progress then options such as performance management will be considered.
- Staff will discuss individual cases at monthly clinical meetings where all staff will be

<p>present. Staff in conjunction with the medical team will review the case in a person centred way ensuring that all areas of a service user's treatment and recovery are reviewed.</p> <ul style="list-style-type: none"> <li>• Key workers will be responsible for monitoring their service user's prescriptions and liaising with the pharmacist on a regular basis to review dispensing and compliance.</li> <li>• We will undertake partnership working with local pharmacies to build strong communication links and protocols to be set where pharmacies will contact the service to report missed pick ups or any concerns they have.</li> </ul>		
<p>13. Section 3.0 Sub heading g</p> <p><b>Weighting 5</b></p> <p><b>Maximum word count of 1500 words</b></p>	<p>Provision of Service</p>	<p>Please demonstrate the mechanisms that are in place to ensure that clients are not prescribed controlled medication from more than one source.</p>
<p>Contractors response:</p> <p>We will ensure controlled medications are not prescribed concurrently by more than one source through:</p> <ul style="list-style-type: none"> <li>• We have robust checks to ensure that correct medication is prescribed by our services. Prescriptions are checked by a doctor, administrator, drug worker, client and pharmacist before issue and every prescription number is logged on our medicine cards.</li> <li>• Preventing prescriptions also being issued by other doctors is more complex. We use a range of measures concerning this which we outline below. However since the end of the Addicts Index in 1996 no national check list is available. So whilst our systems are robust for checking for double prescribing in a locality if a person manages to get a prescription from a doctor outside of the area or a private practitioner then it is very hard to find out apart from through word of mouth. In this case, where we know a service user has a local connection elsewhere we will contact treatment agencies there to check whether the person is known to them and in receipt of medications.</li> <li>• In one of Inclusion's other prescribing services in Birmingham we utilise a system known as the NDTMS prescribing check where all agencies fax a form requesting prescribing information and this goes to a central database. Services then receive a fax back confirming if any other agencies in the West midlands conurbation (as opposed to the region) have prescribed for this service user in the last 12 months. As far as we are aware this system is only currently available in Birmingham. We will negotiate with the East of England NDTMS to see if a similar arrangement can be set up for Cambridgeshire. This system provides as robust information as is possible within the present system.</li> <li>• At treatment entry a letter is sent off to each service user's GP to inform them of the opiate substitute medication that we are prescribing to ensure that they do not double script.</li> <li>• When clients are being transferred from outside agencies, we ask for a copy of their current prescription to confirm handover dates. The pharmacy is then contacted and informed of the transfer. The referring agency is contacted when the service user attends their first prescribing appointment to avoid any double scripting.</li> </ul>		

- Once the service user has attended their initial assessment, a list of all services in the local area is used to telephone agencies to ensure no other prescribing is on-going for that service user.
- PACT data provided from the PCT would highlight which GP's are prescribing opiate substitute medication per se - we would ask if this information could be supplied to us or others under the auspices of the Shared Care Monitoring Group. We would contact each practice prescribing controlled drugs outside of the shared care scheme to assure ourselves that individuals prescribed for were not ones that we engaged with the Adult Drug Treatment Service.
- We will monitor any service users we become aware of that are prescribed out of area or by private health clinics. Such information usually comes to us through word of mouth from other service users. Mindful of confidentiality we will investigate any such claims that are made.
- We would engage in any national initiatives that attempted to make this system more robust. However it is our experience that since the GP contract began nearly all GP's now only prescribe through shared care enhanced services and as long as the shared care systems are robust then double scripting is very unusual. Within our shared care schemes this is prevented by all service users being entered on our secure database which highlights any double entries. In order to make the system in Cambridgeshire robust we would also need to have details of people prescribed through Cambridge Access Surgery entered on our database or details cross referenced. The simplest answer would be for us both to use the same database but we would not wish to pre-empt negotiations. This will be a matter that we will negotiate during our discussions with CAS prior to set up and will form part of our service level agreement with them.

**Method Statement Section 3B, d) GP Shared Care**

<b>Spec Reference</b>	<b>Method Statement Reference</b>	<b>Method Statement</b>
1. Section 1.0  <b>Weighting 4</b>  <b>Maximum word count of 1000 words</b>	Definition of Service	Please demonstrate how the service will support GP's working within shared care to retain clients.
<p><b>Contractors response:</b></p> <p>Inclusion believes that primary care is the most appropriate venue to treat the majority of service users. Within our management team we have expertise of helping to develop GP involvement in treatment throughout the country. This experience and our research on GP's needs identifies the elements GP's need in place in order to feel able to take on and retain service users in shared care.</p> <p>The number one thing that GP's identify themselves as needing is 'competence' in other words training. Inclusion would enable all GP's working in shared care to undertake the Royal College of General Practitioners (RCGP) part 1 certificate in the Management of Drug Dependency which is the qualification all GP's should undertake before entering into this line of work. We would also encourage GP's to undertake other certificates provided by the RCGP such as 'The RCGP Certificate in Reducing Harm; Maximising Health, Recovery and Well Being for People Using Drugs and Alcohol' and the 'The RCGP Certificate in the Detection, Diagnosis and Management of Hepatitis B and C'. We would also expect GP's to undertake a certain level of Continuing Professional Development in this field (the RCGP recommend 4 hours per year for shared care GP's) and this would be covered either by attendance at one of the regular RCGP Continuing Professional Development (CPD) events or at CPD events that we will provide on a regular basis (we would also open these events to pharmacists and other primary care staff).</p> <p>Some GP's may develop a special interest in this area and if so we would encourage them to undertake the RCGP certificate part 2. We would also encourage them to undertake a greater amount of CPD (the RCGP recommend 15 hours a year for GP's with a special interest (GPwSI's)). Inclusion has its finger on the pulse of what is available through the RCGP as our Community Service lead Jim Barnard is the chair of Substance Misuse Management in General Practice (SMMGP) who develop the certificate courses for the college, organise the CPD events and organise the college's annual conference.</p> <p>Secondly GP's feel they need adequate support to provide services. We would be offering bespoke drug worker support to practices involved in shared care. The amount of support required will vary due to the complexity of clients and the expertise of the practice. Whilst we will offer to take clients back into specialist services if the GP feels they can no longer manage them we will do all we can to support the practice to retain them. Our experience is that nearly all clients can be managed in primary care with the right level of support and the right level of GP</p>		

confidence and competence. A good example is in our services in Swindon we manage some of the most challenging patients that we have in a shared care arrangement with the violent patients' practice where the GP (who is now a GPwSI) works alongside one of our most experienced workers. This has proved very successful with one of the patients being nominated by the GP for one of our recovery awards.

Thirdly GP's say they need to feel safe medico-legally to undertake this sort of work due to perceived risks of General Medical Council action. This will be addressed by high quality support from our drug workers, expert medical advice from our specialist doctors or non-medical prescribers and production of clinical protocols and shared care guidelines based on sound national good practice and evidence for them to refer to. Finally what has proved successful in many areas are peer support/group supervision sessions for GP's involved in shared care. We will offer these on a quarterly basis.

Fourthly GP's feel that they need to feel what they are doing is worthwhile and that they are genuine stakeholders in the treatment system. We will always emphasise the important role primary care has to play and that people are best treated in their own community by their own GP where they have access to the whole range of primary care medical services as well as easier referral routes to specialist medical services. We will ensure that all GP's in shared care receive the free quarterly SMMGP newsletter which champions the value of primary care based treatment as well as keeping abreast of the field. We will ensure there is a robust Shared Care Monitoring Group (SCMG) which involves all stakeholders such as GP's, the LMC, pharmacists, the LPC and commissioners. Through the SCMG we will ensure that GP's feel they have ownership of the scheme rather than being dictated to by us.

The fifth main thing that GP's identify as important for them is appropriate remuneration for the work that they do. We would ensure that our administration systems are robust so Local Enhanced Scheme payments are correct and on time. We have an efficient finance department who will ensure this. We will also review the current payment scheme and discuss potential improvements with GP's – for instance we could explore introducing a higher payment for GPwSI's who take on a larger workload and deal with more complex cases.

Finally other members of the primary care team need to be engaged in the process. We will encourage practice nurses and health visitors to take an interest and attend our CPD events. Pharmacists are critical in the provision of high quality services as they often see clients on a daily basis and as well as inviting them to CPD events we will provide bespoke training. Another crucial group are receptionists. Short training events for receptionists prove effective in changing attitudes and creating a positive atmosphere within practices. We would be offering training events for practices primarily aimed at receptionists for all practices in shared care and for those thinking of joining.

To put it simply what we will be developing will be a confident and competent General Practice workforce that feels that they are major stakeholders in the scheme, have support to do the job, are safe in doing the job and are valued both professionally and financially.

<p>2. Section 1.0</p> <p><b>Weighting 5</b></p> <p><b>Maximum word count of 1000 words</b></p>	<p>Definition of Service</p>	<p>Please demonstrate and detail how the service will recruit more GP's to shared care.</p>
<p><b>Contractors response:</b></p> <p>Inclusion recognises that Shared Care across Cambridgeshire is under-developed. We believe that the preferred location for the treatment of drug dependency should always lean towards primary care by developing the expertise and capacity of general practices to work with substance misuse. We also believe that this cannot be done effectively or safely without recognising clear principles of primary care development and adhering to them.</p> <p>Inclusion has extensive experience of developing and operating primary care based treatment systems: Our Community Services Lead, Jim Barnard, is also currently Chair of the Substance Misuse Management in General Practice (SMMGP) network, in partnership with the Royal College of General Practitioners (RCGP) and the National Treatment Agency (NTA). Previously Jim spent 8 years as an SMMGP Advisor, building shared care schemes across England and developing the RCGP certificate courses for GP's.</p> <p>There are several reasons why primary care is the optimal venue for treatment:</p> <ul style="list-style-type: none"> <li>• Drug misuse carries with it, for many people, a wide range of other physical, psychological and social problems: in many ways it is an 'all aspects of your life' problem, therefore the ideal medical practitioner to manage these problems is one specialising in general medicine. In primary care all the many physical health problems can be addressed such as Blood Borne Virus screening and vaccination, wound care, sexual health intervention as well as other general health need often neglected within a drug using lifestyle.</li> <li>• Secondly, people stay with their general practice often for life: this not only means the practice will have known the patient and their family for many years and will have a greater understanding of their social situation but will always be there, once they have completed treatment.</li> <li>• Thirdly it is more local and convenient for users. Travelling to a central treatment centre can be very disruptive to someone's life, especially on a long term basis.</li> <li>• Research has shown that treatment in general practice, in terms of purely drug dependency outcomes are equally good to those in specialist treatment.</li> <li>• It normalises drug use. In other areas of medicine people are referred to specialists for clinical opinion and sometimes stabilisation of their condition after which ongoing treatment is conducted by their general practitioner: Increasingly this expert opinion and stabilisation is provided by a local GP with a special interest. There is no reason that drug use should not be treated in the same way.</li> <li>• Drug users when surveyed overwhelmingly prefer being treated by their G.P.</li> </ul>		

With this philosophy in mind, Inclusion will seek to recruit more GP's and develop Shared Care across Cambridgeshire by:

- Ensuring that Shared Care takes into account local treatment needs. Having a predefined model of Shared Care which is imposed on a locality is usually doomed to failure. Models need to be developed through consultation with all stakeholders.
- Providing GP's with appropriate support, dependent on their experience and level of need. This support needs to be credible, timely and appropriate to need. Such support will be provided by the Consultant Psychiatrist and other experienced Adult Drug Treatment Service staff.
- Ensuring GP's receive appropriate remuneration. The mechanisms for this are dealt with below.
- Involving Primary Care stakeholders in the planning and development of the local scheme to increase levels of ownership. We will promote this through the Shared Care Monitoring Group, local strategic planning forums and bilateral practice level meetings.
- Designing clear referral pathways to ensure service users receive the level of care they need, in the right place at the right time.
- Agreeing robust local guidelines, protocols and supervision arrangements within our clinical governance framework to ensure GP's feel safe medico-legally.
- Developing the competence of General Practitioners in primary care through access to the level of training appropriate with their role. This will be underpinned by arrangements for continuing professional development and appraisal.
- Encouraging those GP's involved in Shared Care to talk to professional colleagues who are not. In our experience, GP's are better placed to decide to join Shared Care schemes when hearing first hand from other GP's about their experiences.

Inclusion also see the development of other Primary Care based staff as important in driving the involvement of more GP Practices:

- Practice nurses may choose to take a special interest in drug dependency treatment. Nurses are encouraged to take a special interest by the Department of Health and are able to access RCGP training. Their role may vary from offering general healthcare and harm reduction such as immunisation or sexual health advice, to supporting the treatment process itself.
- Reception staff have an important role to play as they are in the front line. If receptionists are welcoming and accepting to drug users, particularly those entering treatment for the first time, this will increase the likelihood of successful engagement in treatment. Training for reception staff can help to reduce conflict and enable staff to understand and take pride in their role as well as contribute to a good quality treatment environment.
- Health visitors, midwives and district nurses may develop a special interest in drug use, particularly in specialist practices. Community nurses can be crucial in the identification of a drug or a potential drug problem in a family and can facilitate access into treatment. As providers of support to families and carers of drug users in and out of treatment they are ideally placed to offer health education and harm

reduction advice.		
Inclusion seeks to maximise support to all primary care based staff and encourages them to develop their roles. We have expertise in the development of training programmes for reception staff and employ specialist midwives and health visitors in our services.		
3. Section 2.0 Sub heading f  <b>Weighting 4</b>  <b>Maximum word count of 500 words</b>	Objectives of Service	Please demonstrate how the service will provide GP's with necessary training.
<p><b>Contractors response:</b></p> <p>As outlined in section 1 we will be expecting all GP's in shared care to have undertaken the RCGP part 1 certificate in drug dependency or equivalent. These can be delivered either by going to a national RCGP event or by delivering it locally using an accredited RCGP trainer. We have accredited RCGP trainers in our service and we will be running the RCGP certificate locally (one of our team was one of the authors of the course) although we would also facilitate GP's going to national events on an individual basis. The GP's also had to do some online learning to complete the course.</p> <p>We will encourage GP's to undertake other certificates provided by the RCGP outlined above. We would also expect GP's to undertake a certain level of Continuing Professional Development in this field (the RCGP recommend 4 hours per year for shared care GP's) and this would be covered either by attendance at one of the regular RCGP Continuing Professional Development (CPD) events or at CPD events that we will provide on a regular basis (we would also open these events to pharmacists and other primary care staff). GP's with a Special Interest will be encouraged to undertake the RCGP certificate part 2 and make a larger commitment to CPD.</p> <p>We will run regular CPD events ourselves on a variety of topics which will include blood borne virus prevention and treatment, prescribing for recovery (which involves an interactive session with peer mentors and other drug users in recovery) and drug misuse in pregnancy. However we expect the agenda for CPD events to be set largely by the GP's themselves.</p> <p>We will provide short (2 hour) training events for practice staff in particular receptionists. However we will be encouraging GP's to attend these as our experience is that their attendance helps practice cohesion on the issue. Also such events will be instructive for GP's whose practice is deciding whether to join the scheme or not. Our experience is that offering these sessions encourages practices into schemes and this will be one of our strategies for further developing shared care.</p> <p>In terms of funding the training, this is a matter for negotiation between Inclusion</p>		

and GP's. We will set aside a budget for GP training and we will negotiate with GP's on an individual level basis regarding who pays for what. We will also arrange sponsorship for events that we run to offset the cost.

In terms organisation a member of staff will have responsibility for GP and primary care training and development. They will be supported by our central administrator in terms of booking people onto the course and booking venues. They will have access to the range of expert professionals within Inclusion who can both deliver the training and advise on topics and strategy.

In the first 3 months of the projects life we will do a primary care training needs analysis and produce a primary care training strategy for presentation to the shared care monitoring group.

4. Section 3.0 Sub heading a	Provision of Service	Please evidence the funding proposals for GP Shared Care payments.
<b>Weighting 4</b>		
<b>Maximum word count of 500 words</b>		

***Contractors response:***

As stated above GP's require an appropriate level of remuneration to provide treatment for drug dependency, as this is an enhanced service under the GP contract. We acknowledge that without a fair remuneration scheme we will not be able to substantially develop shared care.

It would be wrong on two counts to state at this point what funding structures we would implement in Cambridge for shared care. Firstly we will need to negotiate any changes to existing funding arrangements with local GP's or risk destabilising the existing shared care arrangements. Secondly, through experience, just taking a funding model that has been seen to work elsewhere and imposing it on a local primary care system nearly always ends in failure - a model needs to take account of local need, history and politics to be successful with knowledge of other areas providing a useful pool of knowledge to draw on.

We will, on start up, initially honour the existing LES payment system for GP's. We will convene the shared care monitoring group at the earliest opportunity and under their auspices conduct a shared care needs analysis and construct a shared care strategy using the principles outlined in previous sections.

Part of the needs analysis will be whether the current payment system is fit for purpose or needs to be renegotiated to better utilise the resources within primary care. We are aware of a whole range of LES payment models throughout the country, in previous employment one of our managers regularly researched and published on this subject. We will use this experience and the particular needs of Cambridge to suggest a payment model for the future. Examples of the types of schemes we might consider are a two tier payment system dependent on workload, competence and the complexity of cases and paying for 'treatment slots' for shared care as opposed to a headcount payment.

Whatever system of payments we end up recommending for Cambridge will have been developed alongside GP's and will ultimately need to be signed up to by the GP's themselves ideally through the Local Medical Committee

We will register all GP's involved in shared care with our finance department and initially use existing activity reporting structures to trigger payments. However we will review these structures within 3 months of start up, again under the auspices of the shared care monitoring group, to assure ourselves that activity reports are fit for purpose and that we are getting value for money.

We have set aside monies in our budget for financing the existing shared care scheme and some extra monies for further development. We aim to develop shared care to the fullest extent possible, and given our expertise in this area we are very optimistic about success. In order to develop beyond the limits that our fund for development allows we will find efficiencies within the service. Shared care development will in itself present opportunities for efficiency savings.

<p>5. Section 3.0 Sub heading c</p> <p><b>Weighting 3</b></p> <p><b>Maximum word count of 1000 words</b></p>	<p>Provision of Service</p>	<p>Please demonstrate how shared care will be delivered alongside other interventions.</p>
<p><b>Contractors response:</b></p> <p>People in shared care will have access to the same range of interventions as all clients of the service. We will have dedicated experienced staff delivering shared care support to GP's and offering 1:1 psycho-social interventions to clients. As need is identified the member of staff will be able to facilitate access to all the other additional services in the same way as other staff. In particular our structured day care service will be useful for those who have stabilise but are now ready to consider moving on in their recovery and coming off their prescribed medication.</p> <p>Those in shared care in theory can have better access to service provision as all their general health needs are more likely to be met through regular contact with their practice. It is a particularly effective venue for ensuring BBV interventions are carried out as well as wound care and referrals to specialities such as hepatology and pain clinics.</p> <p>Those in shared care are often those with the most recovery capital and the highest likelihood of achieving sustainable recovery. We have developed a Red Amber Green audit tool which identifies those who have more or less complex needs. Those who score a green are the ones we will mostly prioritise for more intensive interventions aimed at recovery and we expect many of these to be in shared care. Due to this we will be supporting home detoxification within the general practice setting. We have already developed robust community detoxification protocols for use in primary care covering all the pharmacological options and their recommended regimes. We, as we have elsewhere, will link this to structured day care, where intensive recovery preparation work will be undertaken utilising peer support through peer mentors and volunteers. We will support GP's through the</p>		

medical aspects of detoxification and we will have provided training to them beforehand if needed. Post detoxification support will continue in structured day care and peer self-help groups. Clients may then choose to join our volunteer scheme.

We would expect many of the clients in shared care to engage in our Recovery Mentor schemes and help in the peer support of other clients who have not progressed as far in their recovery. We will be running a service user awards scheme for those who have progressed in their recovery. This has proved a great success in our other community services. What was also inspirational were service users being nominated for awards by their GP and some of those GP's attending the event. This is something we will encourage.

In short there will be no difference between what a client in shared care can expect from us from other clients except perhaps better access to services from their surgery and an even greater focus on recovery as opposed to stabilisation. Also they will not be discharged by their GP practice once recovered one of the biggest advantages of treatment in primary care.

<p>6. <b>(Section 3B)</b> Section 5.0</p> <p><b>(Section 3A)</b> Section 10.0 Sub heading 10.1</p> <p><b>Weighting 4</b></p> <p><b>Maximum word count of 500 words</b></p>	<p>Onward referral/Aftercare and support</p>	<p>Please demonstrate the referral arrangements that will be in place between GP shared care and other modalities within the treatment system.</p>
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**Contractors response:**

People treated in shared care will have access to the whole range of services offered within the treatment system. The shared care worker will be offering one to one support but will be able to refer into all other services we reply like all our other workers. However we would expect services such as Blood Borne Virus prevention and treatment would be delivered within the practice, however if not we will deliver the service to them ideally in the practice on an outreach basis. As described above clients will have access to the full range of structured day care opportunities.

GP's or shared care workers will also be able to refer into our central services for a specialist medical review and for restabilisation if necessary. However in most cases we expect to be able to support GP's to retain patients in their practices throughout their treatment journey through expert liaison support and specialist medical advice from our doctors. We run a shared care scheme in Swindon where this arrangement works very well and transfers back in to our specialist doctors are very low.

Services such as home detoxification will be delivered alongside the GP as already described and specialist nursing support will be available.

Should a service user in shared care become pregnant they will immediately be referred to our mother and baby worker in the same way as other clients with the advantage that being already closely involved with their GP surgery they will find it easier to access the range of ante natal services on offer.

GP's are in a better position to refer to many services outside of the treatment system and we will try and maximise this opportunity to benefit clients. One example that we have found useful is referral to primary care counselling (IAPT) services which provide CBT for anxiety, depression and post traumatic stress disorder. Many of our clients find this very beneficial as many suffer from these conditions. We have had to fight for their right, like any other citizen, to access these services in the past. These services almost always require a GP referral

All clients whether in shared care or not will have robust care plans developed with them and their needs for services within and without the treatment system will be identified. If an external referral is necessary that will be done as for any other client and an internal referral the same.

We will run one integrated drug treatment service, where you're medical treatment is delivered will not effect the range of service available to be accessed. The only difference will be the possibly wider range of external services our shared care clients can access due to close contact with their GP practice.

**Method Statement Section 3B, e) Supervised Consumption**

<b>Spec Reference</b>	<b>Method Statement Reference</b>	<b>Method Statement</b>
1. Section 1.0  <b>Weighting 4</b>  <b>Maximum word count of 1000 words</b>	Definition of the Service	Please demonstrate how the service will increase the number of pharmacies offering Supervised Consumption in Cambridgeshire.
<p><b>Contractors response:</b></p> <p>Inclusion conduct a geographical needs analysis under the auspices of the Shared Care Monitoring Group, to establish where the county needs to have supervised consumption services in place. This will take account of the need for provision in rural areas as well as urban. We will combine this with a needs analysis looking at the potential of pharmacists to become involved the scheme. In the first instance though and as part of our needs analysis we will visit local pharmacies not involved in the scheme to both gauge their needs and encourage them to join the scheme. Our experience, having done this elsewhere, has shown us that these visits are best undertaken by a doctor and we will assign one of the service doctors to do this work.</p> <p>We will then negotiate with local pharmacies and the Local Pharmaceutical Committee (LPC) to agree where more services can be provided. Our experience has shown us that national chains such as Boots and Lloyds are very enthusiastic to expand this side of their business and Lloyd's in particular has a national substance misuse strategy. We would engage with these and other pharmacy providers at a regional level. We will also engage with smaller pharmacy businesses on a local level, in particular where the pharmacy is in an important strategic location.</p> <p>We will offer robust support to pharmacies. This will include a dedicated pharmacy phone line for an immediate response to any issues around dispensing or concerns about clients. We have established such a service in Swindon and this has proved very popular with local pharmacies; all pharmacies in Swindon are engaged in supervised consumption. We will also assign a member of staff to take a lead on pharmacy liaison who will regularly visit pharmacies and ensure that we are meeting their needs.</p> <p>As with General practitioners the main reason pharmacists cite for not being involved in this form of work is lack of competence. Therefore we will offer various training opportunities. Initially we will offer an expert session from a leading pharmacist non-medical prescriber who is employed by SSSFT and this will be aimed at enthusing pharmacists, give them basic knowledge and this will be delivered jointly with specifically trained Recovery Mentors. Research has evidenced that the more positive the pharmacist's attitude the more rewarding they find it and the less problems they experience. A particularly important point that will be stressed is the proven role supervised consumption has played in the reduction of methadone related deaths. We will offer access to the RCGP certificate part I alongside GP's. We would also expect all Pharmacists to do the distance learning/on-line CPPE course on substance misuse which is the basic course all pharmacists should do in this field. Pharmacists will also have access to the CPD events we will organise for GP's and we will organise other events purely for pharmacists if a need is highlighted.</p> <p>We will also be offering training to pharmacy staff similar to that we will be offering to GP</p>		

practice staff aimed at making them feel more confident and positive about offering services to drug users.

We will negotiate with the LPC using the present contract as a baseline to eventually agree a new contract for Cambridgeshire concerning all aspects of substance misuse service delivery including supervised consumption.

Some pharmacists do not deliver supervised consumption due to the lack of a private area to deliver the service. Our experience is that with some innovation this problem can usually be overcome. Examples of this include curtaining off a corner of a pharmacy, applying for grants or convincing the pharmacy to invest in building work (this is usually more successful with the large chains).

Possibly the most crucial aspect in developing supervised consumption is our attitude to pharmacists. We see pharmacists as a crucial part of the treatment team and we always ask for their involvement in care planning and case reviews. The pharmacist sees many clients on a daily basis and can often develop an excellent picture of a service user's progress. We will always be emphasising how invaluable pharmacists are in the delivery of a successful drug service and helping them to understand their own importance in the local strategy.

<p>2. Section 1.0</p> <p><b>Weighting 3</b></p> <p><b>Maximum word count of 500 words</b></p>	<p>Definition of Service</p>	<p>Please describe what an effective working relationship with pharmacies looks like.</p>
<p><b>Contractors response:</b></p> <ul style="list-style-type: none"> <li>An effective working relationship with pharmacies is characterised by the pharmacist understanding they are a crucial and competent member of the treatment team who is involved in care planning and case review and the delivery of a range of services to drug users. The pharmacist will be seeing many of the clients daily, in particular those with the highest levels of need and will be in contact with appropriate members of the drug treatment service on a regular basis about many matters including the progress of the client, client behaviour, dispensing and prescription issues.</li> <li>This relationship will be facilitated by robust training for pharmacists and their staff as outlined above. This will increase their confidence and competence in operating in this field. Also they will feel well supported by regular liaison from a named lead worker, contact with our doctors and non-medical prescribers and a rapid response to any urgent issues that arise (we intend to provide this through a dedicated phone line).</li> <li>The pharmacists will feel that they are fairly treated and a service level agreement will have been agreed by their representatives under locally enhanced services. If working for a chain they will feel fully supported by their regional management to undertake this activity. They will value the service as a business opportunity.</li> <li>Drug service staff will see pharmacists as an important member of the team and be contacting them on a regular basis to discuss progress but also see them as a resource to gain pharmacological information.</li> <li>Pharmacists will be engaged in strategic meetings (usually the shared care monitoring group) where developments and issues with the service are discussed in an open and honest manner and works with other stakeholders to resolve issues and take developments forward</li> </ul>		

- Pharmacists would feel valued and engaged with this line of work and recognise their own importance to the system. Some pharmacists would develop a special interest in this field and go on to provide a wider range of services which would include brief interventions, non-medical prescribing and blood borne virus interventions.
- Pharmacists would have full confidence in the medical expertise of the drug service and its medical staff and feel confident that they will get a respectful response at all times as well as access to high quality medical advice. At the same time they would feel confident to bring their own ideas to the care planning of clients and be able to challenge any prescriptions they found unusual or that they didn't understand.
- Pharmacists would use their power to change minor mistakes in prescriptions but be confident enough to challenge the service if they felt they were breaking the law by dispensing.
- In summary, an effective working relationship is where pharmacists feel they are a member of the team, are valued, seen as competent and as able to contribute as any other, bringing their own expert knowledge and training into play for the benefit of the service and its users.

3. Section 2.0 Sub heading b  <b>Weighting 5</b>  <b>Maximum word count of 500 words</b>	Aims and Objectives of the service	Please demonstrate how the service will promote a recovery focussed model.
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**Contractors response:**

All our training events described above will have a recovery focus and impart our vision of recovery to pharmacists. We will be delivering our initial training for pharmacists with service users in recovery utilising SSSFT's expert pharmacist. The best way to imbue any group of people with a recovery focus is for them to interact and be trained by service users in recovery and we will work with Recovery Mentors to do this. We will also be offering more in depth CPD days on recovery which will be open to both GP's and pharmacists

We would also expect pharmacists to pick up more about our recovery focused model through regular interaction with our staff whether it be Recovery Workers, the designated liaison workers or our doctors and management. They would also witness 'recovery in action' through involvement in care planning and case reviews.

All pharmacies will receive our pharmacy liaison pack which we will tailor to the needs of Cambridgeshire; this will explain our model and protocols and outline what we expect from pharmacies involved in the scheme and what they can expect from us (and reflect existing service level agreements).

We will be expecting trained pharmacists to be interacting with clients on a regular basis giving them encouragement towards reaching their goals of abstinence through brief recovery focussed interventions as well as useful advice and information on basic recovery tips as well as on medication, issues around blood borne viruses and other pharmacological matters. Some pharmacies will develop a special interest and may take a greater role in aspects of therapy and prescribing (should they become NMPs) and we will offer enhanced support to these pharmacists and offer supervision. We have developed a very effective pharmacy based community detoxification service in Swindon based on this approach which has proved popular with service users due to its accessibility, locality and the expertise of the pharmacist.

We will also encourage and facilitate the development of a pharmacy peer support group so that pharmacists can learn from each other, share experiences and swap ideas. This has proved successful elsewhere especially with pharmacists who develop a greater interest in the field.

We will be assuring that our pharmacies are delivering recovery focused services through feedback from our service user group who will be in contact with our service users. Any problems with service delivery we will address by visiting pharmacies and offering more support and training. If ultimately pharmacies persistently fail to deliver the services needed then we reserve the right not to buy services off them.

4. Section 2.0 Sub heading f  <b>Weighting 4</b>  <b>Maximum word count of 1000 words</b>	Aims and Objectives of the service	Please demonstrate how the service will ensure that the pharmacist will contribute to the client's care plan and also provide support with brief interventions.
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**Contractors response:**

Inclusion consider pharmacists as part of the treatment team. As such they will have a copy of the care plan and be encouraged to contribute to it where appropriate. In many cases this will be through face to face communication with service users and phone communication with the key worker. Sometimes it will be appropriate that the pharmacist is physically present at the care plan review – this may be because the case is particularly complex or because the pharmacist has a special interest and wants to have a more intensive role in delivering the care plan – in such cases we would endeavour to hold the review at the pharmacy.

Service users will sign a confidentiality agreement at the start of treatment which will include the agreement to share all relevant information with their pharmacist, this is necessary for the pharmacist to play an active role. We note that at the moment there is a three way agreement in place in Cambridgeshire between the service user, drug worker and pharmacist. If the pharmacists wish this to continue it we will consider it. However this document like most others like it focuses a lot on the behaviour of users and to quote one of our service users *'you sign an unwritten contract as soon as you walk into a pharmacy, or any shop, not to misbehave or nick stuff – why do we need to sign this?'*. We do find these documents somewhat discriminatory and prefer to have information sharing agreements and patient information leaflets outlining procedures such as why dispensing might cease if pick ups are missed (loss of tolerance) and why medication cannot be dispensed if someone is intoxicated. We will negotiate with pharmacists on this issue

The pharmacist will be in regular contact with the Recovery Worker, especially in more complex cases or where a detoxification is under way. This regular contact will be vital in informing the care planning process as the pharmacist usually has the better picture of the person's real progress due to the frequency of contact.

Our initial training package, delivered by SSSFT's expert pharmacist alongside service users in recovery which has been described above will cover among other things the delivery of Brief Interventions that can be used in pharmacies with service users. These will be recovery focussed brief interventions in line with NICE guidance:

*“Opportunistic brief interventions focused on motivation should be offered to people in limited contact with drug services (for example, those attending a needle and syringe exchange or primary care settings) if concerns about drug misuse are identified by the service user or staff member. These interventions should:*

- normally consist of two sessions each lasting 10–45 minutes*
- explore ambivalence about drug use and possible treatment, with the aim of increasing motivation to change behaviour, and provide non-judgemental feedback.*

As per the NICE guidance Brief Intervention may be most useful when directed at people using the needle exchange service and not in touch with the treatment service. However we would extend this to people who are having difficulty in engaging in the service, those with complex needs and those new to the service – Brief Interventions would form part of their care plan. We would also see a role for Brief Interventions for people who are going through detoxification or have completed detoxification (and potentially picking up prescriptions for Naltrexone) to bolster confidence, motivation and enthusiasm.

Experience elsewhere has shown us that pharmacists who engage with clients and deliver Brief Interventions improve the outcomes for clients and increase referral rates into structured treatment. We would encourage some pharmacists to take on a special interest and to seek to deliver more than just brief interventions. We would also expect all pharmacists to already be able to deliver competent advice and information on medicines and medicines management. We will negotiate with pharmacist’s remuneration they may require for these services as part of our negotiations around supervised consumption.

<p>5. Section 3.0 Sub heading a</p> <p><b>Weighting 4</b></p> <p><b>Maximum word count of 500 words</b></p>	<p>Provision of service</p>	<p>Please detail how the service envisages working with the LPC to deliver this element of the service.</p>
<p><b>Contractors response:</b></p> <p>Inclusion would seek to meet with the LPC at the earliest opportunity once we have completed our needs analysis of pharmacy service provision. The agreement of the LPC to any scheme is usually crucial to its success as their agreement makes the job of ‘selling’ the concept of delivering services for substance misuse far easier. We would undertake these negotiations at senior management level with a member of our finance department present. We would use the present contracting arrangements as a starting point and discuss future arrangements in the light of the needs analysis and budgetary affordability.</p> <p>We have a great deal of experience within our senior management of negotiations with LPC’s and we will bring this expertise to the table. We understand the need to respect pharmacies as businesses that must be profitable but also balancing that against our duty to get value for money for commissioners and service users.</p> <p>Having agreed contracts with the LPC we would hope to have ongoing formal meetings with the full group on at least a yearly basis where we would normally give a presentation on our service progress and then have a feedback session. We have found these invaluable in our Swindon service for gauging the satisfaction of pharmacists that we work along side.</p>		

<p>We would also expect to meet a representative of the LPC on a regular basis at the shared care monitoring group. We will take responsibility for ensuring this group exists and is functional. This group needs to oversee the development and smooth running of services in primary care. When the new contract starts, there will be much to discuss, negotiate and put in place and we would expect this group to meet at least monthly in the first 6 months of the contract with the potential for sub-groups to be created to ensure action on specific topics which may well include pharmacy provision. In the first instance a representative of our senior management will attend these groups; subsequently this role will be delegated to the Cambridgeshire Service Manager.</p>		
<p>6. Section 3.0 Sub heading c</p> <p><b>Weighting 4</b></p> <p><b>Maximum word count of 1500 words</b></p>	<p>Provision of service</p>	<p>Please demonstrate what processes the service has in place to ensure that pharmacies will raise any concerns regarding vulnerable adults and child protection.</p>
<p><b>Contractors response:</b></p> <p>Pharmacists have a duty like all professionals to raise concerns regarding child protection and vulnerable adults. The Royal Pharmaceutical Society of Great Britain has published guidance for pharmacists on both topics and is quite clear about the duties of pharmacists:</p> <p><i>“Pharmacists and pharmacy staff regularly come into contact with children and their families in the course of their work and may come across families who are experiencing difficulties in looking after their children. Child protection legislation places a statutory duty on organisations and professionals to work together in the interests of vulnerable children. All healthcare professionals, including those who do not have a role specifically related to child protection, have a duty to safeguard and support the welfare of children. This means actively promoting the health and well-being of children and also protecting vulnerable children in collaboration with other organisations and authorities. Pharmacists need to be alert to potential indicators of abuse and neglect, be familiar with local procedures for promoting and safeguarding the welfare of children, and understand the principles of patient confidentiality and information sharing.</i></p> <p>Similarly:</p> <p><i>“Pharmacists and registered pharmacy technicians are likely to have regular contact with vulnerable adults or their carers, and in the course of their professional duties may become aware of situations where a vulnerable adult is at risk of abuse, or is being abused. It is important that pharmacists and registered pharmacy technicians are alert to signs of abuse and take appropriate action to safeguard vulnerable adults.</i></p> <p>Inclusion will have an expectation that pharmacists will fulfil their duties in this respect. To assure ourselves that this is the case we will make it part of our service level agreement that pharmacies have up to date local safeguarding and POVA training at the appropriate level. We will require evidence of completion.</p> <p>We would also expect and assure ourselves that all pharmacies have copies of Cambridgeshire child protection protocols. Staff will ask to see copies during our liaison visits.</p> <p>Obviously pharmacies have a duty to report child protection concerns to Social Services.</p>		

However we would expect to have ongoing feedback about any information regarding the children of our service users and our Recovery Workers will routinely bring this up in their discussions with pharmacists. If Pharmacists want any guidance about child protection concerns they can also call SSSFT's expert child protection service based at Trust headquarters.

In terms of vulnerable adults we would expect concerns to be discussed with our Recovery Workers and a decision made as to whether we would involve Social Services. This would be informed by whether there was anything we could do practically to remove the risk of abuse ourselves. We have robust procedures for dealing with vulnerable adults and all our staff are trained in both child protection (to at least level 2) and the Protection of Vulnerable Adults. However all of this will be carried out within the framework of locally agreed POVA protocols.

As part of the training we deliver to pharmacists we will cover their responsibilities regarding these issues and through our pharmacy liaison visits we will assure ourselves that all pharmacists are aware of their responsibilities and know the procedures to follow.

If any pharmacist fails in their duty regarding either of these issues we will raise it as a major concern to commissioners and in the case of pharmacy chains to their regional management. This is an issue that is wider than just their duties within our LES contract. We have experience of a case where a pharmacist for a major chained expressed the wish 'that our clients were dead' – we reported it to commissioners and regional management and the pharmacist was subsequently removed from the post.

All of these duties and responsibilities will be make quite clear in our service level agreement.

7. Section 3.0 Sub heading g	Provision of service	Please evidence the payment schedules that will be put in place for pharmacies.
<b>Weighting 4</b>		
<b>Maximum word count of 500 words</b>		

***Contractors response:***

Inclusion intends to honour the existing pharmacy payment schedules until we have completed our needs analysis of provision across the county. We will then negotiate with the pharmacists and the LPC to agree a payment structure as necessary to fit with the need to develop the scheme. To lay down a payment structure without negotiation with local pharmacists and without having done an analysis of the needs of Cambridgeshire would be foolish and doomed to failure. We have knowledge of payment schemes around the country and we will bring this experience to inform the kind of model we propose as a result of the needs analysis.

Most payment schedules for supervision are paid for on a 'per dispense basis'. However other types of payment do exist such as payment per 'client supervised', a lump sum payment for the service, a mixture of a lump sum and 'per dispense' payment, and giving pharmacists a percentage of an agreed overall pot based on the amount of work they do. We would tend to favour the per dispense fee as it is less open to abuse in our experience and is simpler.

The existing payment structure also has a £4.00 payment for making a phone call to report missed pick ups. In our relatively wide experience we have never heard of this type of payment

being delivered before. This is, in our experience, always considered to be a safety issue regarding the enhanced service of supervision and should be delivered as a core duty within that service just as pharmacist will alert GP's of any dangers they perceive concerning other medications they dispense. However, what should be being paid for is Brief Interventions over and above the interventions one would expect during supervised consumption, as we have outlined above, in addition to the range of other services Pharmacies can provide.

Payments will be made through registering all participating Pharmacists with our finance department who will make payments on a monthly basis based on submitted payment returns evidencing services provided. We have calculated a budget for this based on the existing payment structures but with capacity to expand numbers of service users and pharmacists in the scheme.

8. Section 3.0 Sub heading h	Provision of service	Please describe the process which will ensure this service will be provided within budget.
<b>Weighting 5</b>		
<b>Maximum word count of 1000 words</b>		

***Contractors response:***

Inclusion are part of an NHS Foundation Trust that regularly score an excellent for financial governance in its 'Monitor' ratings and has in the recent past had the accolade 'Foundation Trust of the year'. This means that we have a very rigorous and robust finance department who put great effort into ensuring all services are delivered within budget. Any overspends are highlighted immediately and measures put in place to resolve these issues. Our finance department itself is rigorously scrutinized through internal and external audit. As a result we have a very detailed and comprehensive set of standing financial instructions which can be viewed on our web site

<http://www.southstaffsandshropshealthcareft.nhs.uk/getattachment/4071aa28-5e77-4b3d-b410-e04e6bee40e7/F-RED-01.aspx>

This will mean in the first instance all formal negotiations with LPC's and pharmacists generally will have a member of our finance directorate present to advise management what is affordable and possible within budget and also give pharmacists a realistic view of the monies available. This will assure that whatever package is agreed is possible to deliver within budget. Subsequent to this it is a management responsibility to keep the scheme within budget. To support this, our finance department give managers monthly reports and will require action plans to resolve any overspends.

Inclusion recognise the importance of supervision consumption to treatment systems and will look to develop the scheme wherever possible. By promoting a recovery orientated treatment system service users will spend less time in prescribing services bringing costs down in the long run. We will ensure that pharmacy services are utilised appropriately within this strategy and always within budget.

<p>9. Section 6.0 Sub heading a – b</p> <p><b>Weighting 4</b></p> <p><b>Maximum word count of 500 words</b></p>	<p>Competencies and Training of Staff</p>	<p>Please demonstrate what training will be provided to both members of staff and pharmacists working within this element of the service.</p>
<p><b>Contractors response:</b></p> <p>Inclusion will expect that all Pharmacists involved in the scheme will have completed the latest version of the Centre for Pharmacy Postgraduate Education (CPPE) open learning package. This is the basic, bottom line training that all pharmacists should undertake to operate enhanced services in this field.</p> <p>Like GP's the main reason pharmacists cite for not being involved in enhanced service provision in this field is lack of competence. We will offer various training opportunities to address this. Initially we will offer an expert session from a leading pharmacist non-medical prescriber employed by SSSFT. This will be aimed at enthusing pharmacists into the field and give them basic knowledge and include training on delivering brief recovery focussed interventions with service users. This will be delivered jointly with service users in recovery. Research has evidenced that the more positive the pharmacists attitude the more rewarding they find it and the less problems they experience, meeting positive service users who talk positively about recovery will help to bolster a positive attitude . A particularly important point that will be stressed is the proven role that supervised consumption has played in the reduction of methadone related deaths. We will also facilitate access to the RCGP certificate part I alongside GP's. We would also expect all Pharmacists to do the distance learning/on-line CPPE course. Pharmacists will also have access to the CPD events that GP's will attend and will encourage them to go to a CPD session Inclusion will deliver on recovery orientated services. We will organise other events purely for pharmacists if a need is highlighted.</p> <p>Informal, on the job training will be delivered via our pharmacy liaison workers who will be ensuring that pharmacists understand our recovery focussed services and understand our aims and objectives.</p> <p>We will also be offering training to pharmacy staff similar to that we will be offering to GP practice staff aiming at making them feel more confident and positive about offering services to drug service users. This is very important because in some cases they will be seeing more of our service users than the pharmacists. We have found such training very useful elsewhere. This will also give a chance to imbue all pharmacy staff with our vision for recovery. The training covers basic drug awareness including information on substitute medications and the basic concepts of recovery focussed treatment and medical and psycho-social interventions within that.</p> <p>Inclusion will not levy a charge against Pharmacists for the in-house training provided. Payment for external training will be a matter of negotiation between the service and pharmacists.</p>		

**Method Statement Section 3B, 3f) Structured Psychosocial Interventions**

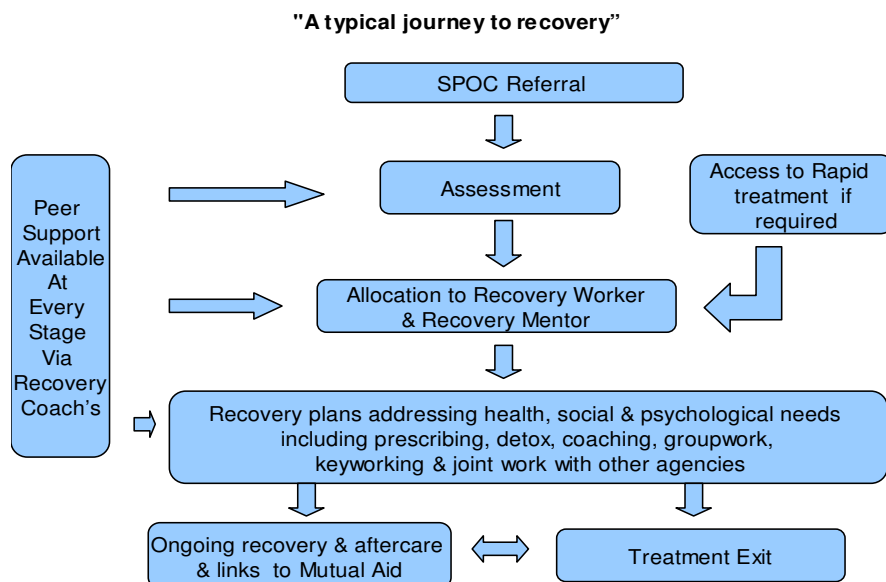
Spec Reference	Method Statement Reference	Method Statement
1. Section 2.0 Sub heading 2.2 a – i  <b>Weighting 5</b>  <b>Maximum word count of 1000 words</b>	Objective of Service	Please detail how the service will promote a recovery focus model throughout all Structured Psychosocial Interventions.

**Contractors response:**

Inclusion's approach to delivering community drug services, in line with national and local policy imperatives recognises the need to:

- Engage drug users in treatment.
- Hold drug users in treatment long enough to make a difference.
- Reintegrate drug users into a life style, which is not characterised by dependence

Our approach to recovery is summarised as a typical journey in the diagram below:



From our local research and reading of the tender documentation Inclusion is clear that the existing substance misuse workforce must undergo significant development if it is to deliver improved reintegration and recovery outcomes. It is likely that areas of workforce good practice and quality in service delivery exist. However, it is clear that many staff will need to broaden their skills and knowledge as the nature of services moves from the relatively static provision of pharmacological therapies characterised by a culture of low

expectation to a more dynamic, holistic service delivering a menu of psycho-social interventions that challenges service users to make positive changes in their lives. In short, Inclusion will expect its staff to become *Recovery Workers* capable of raising and meeting the aspirations of service users.

Developing a recovery orientated workforce will require a concerted approach involving:

- Strong leadership starting at the point of consultation and transfer with staff subject to TUPE or for those recruited to any vacancies. Our aim is to win the hearts and minds of new staff and have them buy into our reintegration and recovery vision.
- Excellent supervision and objective setting in support of reintegration and recovery
- Tailored learning and development for all members of staff particularly around the delivery of psycho-social interventions.
- Individual performance management and additional support for those members of staff struggling to make the transition to a recovery orientated culture.
- We will establish a Recovery Practice and Quality Assurance post within our staffing structure. We see this role as crucial in supporting the Cambridgeshire Service Manager in developing a recovery culture. The role will be responsible for an initial 'recovery audit' of the inherited service, followed by a programme of practice observation that feeds into staff supervision. Findings from the recovery audit and staff observations will contribute to an overall training needs analysis and subsequent delivery of a comprehensive training programme that will enhance reintegration and recovery outcomes.

#### Worker Client Relationships

We know that service users 'buy into' services and engage in treatment when they feel that they are being listened to, understood, and are being given helpful, positive responses. The 'therapeutic alliance' between key worker and client is consistently found to have more influence on treatment completion. Rapport, therapeutic alliance and empathy are all features of positive relationships that help individuals to move forward. It is our expectation that staff:

- Recognise the differing needs that people have and respond to each client as an individual.
- Understand what is important to an individual and that there are no short cuts.
- Fully acknowledge that problem drug use means that for some will require many attempts to fully engage with the treatment process.
- Respect a person's decision to continue to use whilst continuing to work creatively with them to limit risk.
- Be aware that there could be gender generated difference that may require different responses e.g. some women may need an emphasis on feeling cared for, whilst some men may value helpfulness more.
- Be aware and do not make assumptions about difference in terms of disability, sexuality, gender, culture, ethnicity, religion, social class, age.
- Remember people like to feel respected and understood, drug users are not different.
- Ease of interaction and accuracy of information is crucial, fostering good personal communication skills can contribute to positive engagement.
- Where clients do not have the concentration skills &/or are not articulate enough to engage well with verbal interaction seek different ways of conveying harm reduction messages.
- At all times, even under pressure be respectful.

In terms of the delivery of psycho-social interventions on a daily basis, the Cambridgeshire Adult Drug Service will develop:

- An approach to individual care planning that builds on the recovery capital held by service users.
- Much better integration with local recovery networks and mainstream services.
- Service user involvement in service planning, delivery and monitoring.
- Minimising the number of unplanned exits.

Alongside these our workforce learning & development initiatives and service delivery improvements we will establish a peer-led approach to service delivery and development in Cambridgeshire. We are convinced that recovery in local communities is more likely to succeed when those prospering and graduating from drug treatment are visible to people still coming to terms with addiction and dependency. To this end we will seek to establish a network of Recovery Champions drawn from local peer mentors, volunteers and family members with an active interest in supporting local recovery. Training in supporting people through drug treatment and on recovery journeys will be given to Recovery Champions along with opportunities to have learning recognised with formal qualifications where possible. Recovery Champions will be offered support and supervision with clear links to the objectives contained in individual recovery plans. Once trained, our Recovery Coaches will;

- Be present in services to help engage service users, offer pertinent advice and information and remove barriers to treatment entry
- Take an active role in delivering elements of recovery plans particularly where access to partner agencies and community resources is objective
- Contribute to service development through participation in meetings, training provision and the facilitation of group programmes

### Mutual Aid

Take up of Mutual Aid is actively promoted across all our services. We will open up service premises for use by NA, AA and Smart groups and provide staff and service users with appropriate training. Inclusion recognises that whilst 12 step and SMART recovery options are not suited to all clients, that there is emerging evidence suggesting that support from peer networks is a central component of successful recovery journeys.

2. Section 2.0 Sub heading 2.2 d  <b>Weighting 4</b>  <b>Maximum word count of 500 words</b>	Objective of Service	Please detail the range of Structured Psychosocial Interventions that will be delivered.
<b>Contractors response:</b>  Delivery of psycho-social interventions will include;  <i>Motivational Interviewing</i>  Motivational Interviewing (MI) is an approach that is a characteristic of all our interventions. Staff will be trained in MI techniques and encouraged to help develop the motivation to		

change in our service users through exploring and addressing ambivalence towards on-going substance use. This is achieved by employing open-ended questions, reflective listening, and helping individuals to balance decisions. In these ways, staff will assist service users to consider thoughts, feelings, triggers and future choices.

### *Brief Interventions*

Brief Interventions will be utilised across services but are likely to have particular value with people around risky drug or alcohol consumption before dependent patterns of use are established. Our aim here will be to set small goals for service users following the provision of accurate advice and information relating to their use of substances; our experience tells us that where individuals set relatively modest goals they are likely to go on to make further positive changes.

### *Node-link Mapping*

Mapping is now routinely used in many of our services. We have trained a range of staff in both International Treatment Effectiveness Programme (ITEP) and Birmingham Treatment Effectiveness Initiative (BTEI) mapping techniques and currently employ mapping as part and parcel of recovery planning. Node-link mapping has been shown to be effective in increasing treatment engagement, recovery plan ownership amongst service users and subsequent treatment outcomes.

### *Groupwork*

Our groupwork programme is explained in detail in method statement 3B3g. In summary, entry to group work will be on a rolling basis to avoid long waiting times. Group work will include:

- Recovery fears and expectations
- Addressing ambivalence
- Physical & psychological effects of drugs, depression and anxiety management.
- Triggers, high-risk situations and cravings
- Mistaken beliefs, decision making and scenario planning.
- Positive self-statements, core beliefs and psychological traps
- Dealing with lapse/relapse
- Recognising and deploying recovery capital

### *Contingency Management Approaches*

Contingency Management (CM) is recommended in the NICE guidelines on psycho-social interventions, being the most effective intervention reviewed. CM is also recommended in clinical guidelines and the latest national drug strategy. Inclusion see CM as a useful tool in drug services because it;

- Is a reward based system aiming to promote positive outcomes rather than punish poor compliance
- Is cost-effective involving very small rewards - as little as £2 has been shown to bring significantly improved outcomes. However NICE recommend rewards of £10.
- Can be deployed across a range of interventions including Blood Borne Virus vaccination.
- Reinforces a sense of achievement for clients.
- Improves engagement with service.

<p>3. Section 2.0 Sub heading 2.2 g</p> <p><b>Weighting 5</b></p> <p><b>Maximum word count of 2000 words</b></p>	<p>Objective of Service</p>	<p>Please demonstrate how the service will assess and manage care for dual diagnosis clients.</p>
<p><b>Contractors response:</b></p> <p>For clarity, Inclusion understands the term Dual Diagnosis to refer to service users who have co-existing mental health and substance misuse problems which can be due to:</p> <ul style="list-style-type: none"> <li>• A primary mental health problem precipitating and leading to an episode of substance misuse</li> <li>• An increase in the use of illicit substances which has an effect on the service user's mental health</li> </ul> <p>Inclusion, as part of South Staffordshire &amp; Shropshire Foundation Trust (SSSFT), have invested heavily in developing policies and procedures to support the assessment, management and care co-ordination of service users with Dual Diagnosis. All Inclusion staff receives regular Dual Diagnosis training as part of their professional development. Staff subject to TUPE transfer from Addaction and Phoenix Futures will have their Dual Diagnosis learning needs audited immediately post-transfer.</p> <p>As part of our service implementation in Cambridgeshire, Inclusion will seek to agree joint working protocols and information sharing arrangements with the Home Treatment Team at the Mental Health Service. However, our experience in other localities indicates the following approach is most likely to succeed in Cambridgeshire:</p> <p><u>Referrals to the Cambridgeshire Adult Drug Service</u></p> <ul style="list-style-type: none"> <li>• Where referrals are clearly inappropriate, signposting to another suitable service will take place. Inclusion will agree a list of other agencies for this purpose as part of its service implementation.</li> <li>• For seemingly appropriate or unclear referrals, the Single Point of Contact (SPOC) will undertake an initial screening and risk assessment immediately. If practicable, a joint screening and risk assessment with a Mental Health worker can be arranged.</li> <li>• Where the initial screening and risk assessment indicates that any mental health problems are directly attributable to drug misuse and hence anticipated to be of short duration then a worker from the Adult Drug Service will assume the role of care coordinator and responsibility for delivery of all care and interventions. The Adult Drug Service will in this case seek ad hoc advice from an identified Mental Health worker in the Home Treatment Team as necessary.</li> <li>• Where the initial screening and risk assessment indicates that there are significant mental health problems requiring specialist input and high level drug/alcohol use, a Mental Health worker will be identified as the care co-ordinator under the Care Programme Approach (CPA). A joint assessment of substance misuse and mental health needs will be carried out. Arrangements will be put in place for treatment/specialist input from the Adult Drug Service. There will be close joint working by the Mental Health care co-ordinator and the Adult Drug Service, with a Drug Worker attending all subsequent case reviews.</li> </ul>		

- Where the initial screening and risk assessment indicate that there are significant mental health problems requiring specialist input but there are low levels of level of substance misuse then a referral will be made to the Home Treatment Team on the day. The Mental Health service will assume the role of care co-ordinator under the CPA, and also responsibility for the delivery of all care, with ad hoc advice from an identified Drug worker as necessary. If required the Adult Drug Service can provide relevant education and regular supervision with attendance at case reviews as necessary.

### Care Programme Approach

Working to these protocols it follows that at no stage will Cambridge Adult Drug Service staff act as Care Co-ordinators under the CPA. However, it is important to demonstrate a clear understanding of the CPA and how it will affect services users also in receipt of drug treatment services. Inclusion understanding of the CPA is as follows:

The term Care Programme Approach has been used since 1990 to describe the framework that supports and co-ordinates effective mental health care for people with severe mental health problems in Secondary Mental Health Services. In 2007/08 the Care Programme Approach was subject to a national review and in March 2008 the Department of Health published 'Refocusing the Care Programme Approach' – Policy and Positive Practice Guidance'

The review removes the two-tier CPA system (Standard & Enhanced) but reinforces the need for the Care Programme Approach for Service Users with complex needs. Those Service Users with less complex or straightforward needs will not come under the Care Programme Approach requirements although the requirement for care planning and record keeping standards remain. The support for people with less complex needs will be delivered via a process referred to as Standard Care (SC). The CPA and SC are at the heart of an inclusive and effective Health & Social Care Mental Health service which aims to optimise service user's health and well being whilst supporting carers and families. The principle of person centred care is key to the operation of CPA. Individuals' accounts of their needs and their views and wishes must be at the centre of all decisions that are made. The strengths and abilities that individuals can bring to bear on their needs and circumstances must be acknowledged and taken into account, together with an identification of any external or environmental factors that may have precipitated or exacerbated their mental health needs.

The main requirements of the CPA are:

- An assessment of the service user's health and social care needs, including an assessment of any jeopardy to their safety or the safety of others.
- A multi-disciplinary care plan stating how the assessed needs are going to be met, including crisis and contingency plans.
- Allocation of a Care Co-ordinator to oversee the implementation of the plan of care and to link the Service Users to other appropriate Services as necessary
- Regular Reviews to ensure the continuing appropriateness of the plan of care.

CPA is a process for managing complex and serious cases; there are a number of characteristics to consider when deciding if support of CPA is required. The key areas are;

- Mental Disorder
- Current or potential risks
- Current or significant history of severe distress/instability or disengagement
- Presence of non-physical co-morbidity
- Multiple service provision
- Currently/recently detained under MH Act or referred to CRHT
- Significant reliance on carer(s) or has significant caring responsibilities
- Experiencing disadvantage or difficulty

The assessment process therefore ensures the systematic assessment of an individuals' health and social care needs and for those service users accepted into Secondary Mental Health Services, the development and review of a formal detailed outcome focused well-being/Recovery Plan to address the eligible needs

#### What People should expect from Specialist Mental Health Services

- At the point of referral Specialist Mental Health Services will undertake a screening assessment. If the outcome indicates that, the person requires the further intervention of Secondary Mental Health Services they will be invited to engage in an assessment that examines their circumstances in greater depth.
- The referral process will include the opportunity for people to carry out a self-assessment. The self-assessment will inform subsequent assessments.
- The assessment, and any subsequent planning process, will aim to meet service user's aims and choices. The assessment process will be undertaken collaboratively with service users, and where appropriate, carers and examine the range of their health and social care issues.
- The outcome of the assessment will determine whether the support of specialist mental health services is required and if so at what level, Standard Care or the Care Programme Approach.
- Outcomes of assessments will be communicated to service users, and referrers in ways in which they understand.
- All Service Users will receive a statement of what their identified needs are, what is required to support them in addressing those needs, who is responsible for actions relating to requirements and provided with a date when they will be asked to feedback whether the interventions are effective or not.
- Service Users will be offered the opportunity to complete the statement themselves. If they decline the offer, it will be the responsibility of the Care Co-ordinator to complete the statement on the service user's behalf. In either case it will be the responsibility of the Care Co-ordinator to ensure that statements of care are entered on informatics systems, and copies forwarded to relevant parties.
- Reviews of statements of care will be co-ordinated to promote inclusion and participation. Their composition, location, and timing will take into account the individual needs and responsibilities of service users and carers. The outcomes of reviews will be communicated to all relevant parties and records will be amended to reflect their content.
- Practitioners should always work to the principles of recovery and personalisation and assist service users in moving away from reliance on service providers.
- Service users and carers should lead the assessment and intervention process as equal partners with professionals and others who may be involved in the provision of support. Any decisions made during clinical processes should be preceded by a

consultation with service users and carers, consultations should be meaningful and enable all parties involved to present their opinions in an atmosphere of co-operation. Any differing opinions or disagreements should be clearly documented and service users and carers should be fully informed of the compliments and complaints processes and procedures implemented by provider organisations and, where required, supported in submitting compliments or complaints.

#### Case Load Audit During Implementation

As part of our service implementation Inclusion would undertake a full clinical audit of the inherited Cambridgeshire Adult Drug Service case load. We will audit all cases for evidence of co-existing substance misuse and mental health issues, ensure that care co-ordination sits with either Home Treatment Team or the Adult Drug Services as described above and review all psychiatric medications prescribed by the service medical staff.

4. Section 2.0 Sub heading 2.2 h  <b>Weighting 4</b>  <b>Maximum word count of 1000 words</b>	Objective of Service	Please demonstrate how the Treatment Outcome Profile Tool (TOPs) will be used as part of this service.
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#### ***Contractors response:***

Inclusion's brings a nuanced understanding of the use of the Treatment Outcome Profile (TOP) in drug treatment services. We understand that when used properly TOP can be:

- Utilised by the National Treatment Agency to monitor and assess the effectiveness of the national drug treatment system
- Analysed by Cambridgeshire commissioners to drive improvements in the local drug treatment system
- A useful motivational tool and adjunct to the case work carried out with service users.

By incorporating the use of TOP into 1:1 interventions, staff in Cambridgeshire Adult Drug Service will be able to increase service users understanding of their drug use and enhance their motivation to change. TOP can be used to show service users how their scores have changed during treatment episodes (the Progress Tracker adds visual impact here), care plans can be modified where TOP progress is less obvious and TOP can be utilised as a starting point for key work sessions drawn from the key domains of substance use, risky injecting behaviour, criminality and health & social functioning.

The use of the TOP Progress Tracker lends itself well to further key working sessions using Node Link Mapping. We have described the use of Node Link Mapping more fully in method statement 3B3f.

To ensure TOPs compliance Inclusion have developed a number of initiatives that include management checks, administrative overview and computer system validation that offer Cambridgeshire commissioners assurance that we can meet the 100% target of TOPs completion for starts, reviews and exits.

All new clients that enter the Cambridge Adult Drug Service will receive a full assessment and this will include the initial start TOP forms (unless they have transferred from another service that has started the TOP process, then a review form will be completed at this stage). In our other community services, Inclusion operates a computerised client record system (HALO) which requires the completion of TOP before a new or transferred client can be entered on the system.

Within the Cambridgeshire administration team there will be a nominated “TOP Champion” who will record all new assessments that have taken place and run weekly checks to ensure that all those that have been assessed have all the required paperwork completed and that this has been accurately recorded on HALO. If there are missing fields on the record or missing paperwork that needs completing then the caseworker will be notified and asked to fill in any gaps. This will be followed up at weekly team meetings where missing paperwork is highlighted.

At the point of upload to the National Drug Treatment Monitoring System (NDTMS) data will be checked again to ensure that it meets the data set requirements and this will include TOP requirements for new starts, reviews and exits. If a problem arises with individual case record the caseworker will be asked to address this as a matter of urgency.

Within line management supervision TOP completion will be routinely discussed with individual workers. If the “TOP Champion” identifies individual workers that are not completing starts, reviews or exits on time or accurately then this will be raised with that individual as a performance issue.

A similar system will be put in place for reviews. HALO will send a notification to the nominated key worker that a review is due. A similar message will be sent to the “TOP Champion” who will send an email reminder to the worker. They will also prepare a list of reviews that should have taken place each week for discussion at the weekly team meetings. Within supervision any missing reviews will be discussed with the individual worker and an explanation for the delay and a timeframe to get the review completed will be agreed.

Before a client case can be closed a TOP exit form must be completed. HALO will not allow the case to be closed without a TOPs exit form. All closed cases will need to be checked and signed off by one of the management team and this includes confirmation of the exit form being completed.

To ensure that cases are not left artificially open by individual case workers the “TOP Champion” will also run checks on HALO for clients that have not had any contact for over four weeks. This identifies clients that have not been in contact with the service and highlights these discrepancies to both the individual case worker and their line manager.

These systems are currently utilised in our services in Swindon and Birmingham. Both regularly achieve 100% compliance against TOPs. The figures for Birmingham community team in August were 89% for new starts and 100% for reviews and exits. Inclusion average, across a twelve month period, over 90% compliance in starts, reviews and exits.

These systems have proved effective and ensure that TOP completion is seen by staff members as a core requirement of their work. By discussing it in supervision and weekly

team meetings, and designing the systems around the need to complete these returns, it has ensured that TOP is fully embedded within the daily work of individual staff rather than seen as an additional task.

**Method Statement Section 3B, 3g) Structured Day Programmes**

<b>Spec Reference</b>	<b>Method Statement Reference</b>	<b>Method Statement</b>
1. Section 1.0  <b>Weighting 5</b>  <b>Maximum word count of 1500 words</b>	Definition of Service	Please demonstrate how this service will deliver Structured Day Programmes (SDP).
<p><b>Contractors response:</b></p> <p>We intend to delivery a full modular, rolling Structured Day Programme in the Cambridge, Huntingdon and Wisbech localities. The configuration of the programme comprises Induction, Aiming for Abstinence and Re-integration &amp; Recovery phases. It is our proposal to deliver the Induction phase of each programme from within the service hubs: this is because by definition, the Induction phase involves engaging and stabilising service users in a group work programme and by delivering on-site, we aim to minimise barriers to involvement and maximise progression to the Aiming for Abstinence phase. The Aiming for Abstinence and Re-integration &amp; Recovery phases will be delivered away from the service hubs at community venues. These elements of the programme are designed to consolidate the early treatment gains that are made by a service user and explore each person's potential for full recovery.</p> <p>During the contract implementation period Inclusion will identify rentable space in suitable community venues in Cambridge, Huntingdon and Wisbech from which to deliver the Aiming for Abstinence and Re-integration &amp; Recovery elements of the programme. We will consult with commissioners, new partners, the existing staff team and service user reps before securing appropriate accommodation. We are likely to target community venues, churches and perhaps space in partner agencies. By splitting the Structured Day Programme in this way Inclusion believes we can meet the service specification, incentivise engagement, use scarce resources most efficiently and deliver the best recovery outcomes for service users.</p> <p>Referral into the Structured Day Programme will need to be via the Single Point of Contact or one of the other Cambridgeshire service elements – it will not be possible to refer directly from an external agency. When a direct referral is made the SPOC wil process this and referral into the Structured Day Programme maybe agreed. All service users subject to a Drug Rehabilitation Requirement (DRR) will join the same group as voluntary referrals. If a comprehensive assessment has not been carried out at the point of referral it will be completed by programme staff. This will include an updated risk assessment. All recovery plans will reflect engagement with the programme, its goals and an evaluation of progress.</p> <p>The service will deliver groups every day from Monday to Friday between the hours of 11 am and 4pm at the three locations. Ideally all elements of the programme would be available at other service locations across the county. However, for the programme to be viable and affordable within the service budget, we feel a three-site delivery model is the best fit. The service will operate between 9am and 5pm – staff time not spent delivering groups will be taken up with keyworking and individual sessions in support of the programme delivery. It is likely that one group per site per week will run on an evening basis and a weekend support group will operate on Saturday mornings will operate at each site. Any mutual aid meetings</p>		

that run from service sites will be over and above our stated programme commitments. We are confident that our delivery proposals can accommodate 200 annual programme starts.

Although the overall programme delivery is configured with Induction at service sites and Aiming for Abstinence & Re-integration & Recovery in community venues, we see the programme as a whole entity that addresses drug use and related needs in a holistic and common sense fashion utilising a cognitive behavioural approach. The aim of each phase are as follows:

#### Induction

The aim of the induction phase is to encourage service users to engage with the programme, develop their motivation for taking part in structured treatment and begin to set future goals. For many, the induction group will be a challenge and we will ensure that all service users become familiar and adhere to the basic requirements of the programme including timekeeping and acceptable behaviour ground rules. Service users will be able to join the induction phase at any point due to its rolling, modular nature. It will take 6 weeks for service users to attend all of the sessions on offer. Sessions can be repeated as required and for those that require it, the Induction phase can be repeated in full.

#### Aiming For Abstinence

As service users complete the induction phase and satisfy the progression criteria they can move into the Aiming for Abstinence phase. We have purposely entitled this phase 'Aiming for Abstinence' to encourage just that aspiration amongst service users. This phase will involve programme delivery at sites separate to the main service base. It will take 6 weeks for service users to attend all of the sessions on offer. As we expect service users to be involved in other interventions outside of the service for example appointments with Offender Managers, the modular rolling nature of the programme will allow group sessions to be designed around a service user's other commitments as they progress in treatment. Sessions can be repeated as an individual's progress and recovery plan demand.

#### Re-integration & Recovery

Once a service user has successfully negotiated the Induction and Aiming for Abstinence phases they will move into the Re-integration & Recovery phase. Having made significant progress in terms of drug use and associated offending behaviour, the Re-integration & Recovery phase will allow service users to broaden their horizons and build skills and knowledge in a wider range of living skills to facilitate full community re-integration. The Re-integration & Recovery phase will once again utilise a combination of 1:1 keyworking and group based work, but will be somewhat less structured in the sense that service users will 'pick and mix' which areas to concentrate upon. This also makes allowance for service users increasing their responsibilities elsewhere such as volunteering, educational course attendance or work placements. No set time scale is attached to Re-integration & Recovery involvement. However, recovery plan goals will be regularly reviewed and the service will not become a day by day 'drop-in' for those who have completed the programme but are not constructively moving on.

2. Section 2.0 Sub heading 2.1  <b>Weighting 4</b>	Aims of the service	Please demonstrate the range of interventions that will be delivered within this service.
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<b>Maximum word count of 500 words</b>		
<p><b><i>Contractors response:</i></b>  The Structured Day Programme service will deliver individual and group based interventions. These will include:</p> <p><u>Key Working &amp; ad hoc Psycho-social Interventions.</u>  Individual key working for all service users accessing the Structured Day Programme will be a condition of successful engagement. Key working will include all assessment, risk assessment, recovery planning, reviews and reporting to outside agencies such as Probation. The service will employ a combination of Inclusion's assessment tool and the full range of BTEI mapping tools for recovery planning. Key workers will also be able to provide ad-hoc, opportunistic psycho-social interventions along side of group work in support of recovery plan goals including contingency management. In this way, key work sessions can serve as useful, short-span group preparation and de-briefing to deal with issues that arise for a service user. The Structured Day Programme will act as Care Co-ordinators as agreed with elements of the service.</p> <p><u>Induction Group Work</u>  Our aims in the induction phase are to introduce, stabilise and retain service users. We will build on the work under taken in pre-treatment service user development groups that will include:</p> <ul style="list-style-type: none"> <li>- Awareness of personal skills</li> <li>- Awareness of time management</li> <li>- Stress management</li> <li>- Dealing with criticism</li> <li>- Self-confidence</li> <li>- Body language</li> <li>- The 'passive/aggressive' pendulum.</li> </ul> <p>The additional work will include sessions designed to address:</p> <ul style="list-style-type: none"> <li>- The 'passive/aggressive' pendulum</li> <li>- Service user expectations and programme rules</li> <li>- Substance awareness</li> <li>- Recognising triggers, managing cravings, coping strategies</li> <li>- Reflections on current situation including debt management, housing, health &amp; offending</li> <li>- Addressing ambivalence to change</li> <li>- Recovery goal setting</li> <li>- Family and friend support networks</li> </ul> <p><u>Aiming for Abstinence Group Work</u>  During the Aiming for Abstinence phase we want to deliver groups that consolidate treatment progress and prepare service users for a life without drugs. Groups delivered will include:</p> <ul style="list-style-type: none"> <li>- Maintaining motivation</li> <li>- Improving communication skills</li> <li>- Improving social networks/relationships</li> <li>- Managing emotions</li> </ul>		

- Problem solving & thinking skills
- Improving time management
- Budgeting
- Healthy lifestyles & nutrition
- Relapse prevention/management

#### Re-integration & Recovery Elements

The elements of the Re-integration & Recovery phase will help to equip service users with skills for life and open up opportunities for re-integration in to the community and a life without drugs. The elements on offer will include

- Relapse management
- Mutual Aid & SMART Recovery groups
- Recovery Mentoring & volunteering training programmes
- Education, Training & Employment (ETE) pathways
- Accommodation advice, information and advocacy
- Welfare benefits
- Independent living skills

#### Stimulant Work

Programme staff will offer stimulant, in particular crack/cocaine interventions using Conference on Crack and Cocaine (COCA) materials. Sessions will look at:

- How crack and cocaine work
- Health implications of its use
- Patterns of use
- Triggers
- Cravings
- Euphoric recall
- Crack / cocaine and offending
- Coping strategies
- Harm reduction

3. Section 2.0 Sub heading 2.1	Aims of the service	Please demonstrate the evaluation criteria that will be used for clients accessing this service
<b>Weighting 3</b>		
<b>Maximum word count of 500 words</b>		

#### ***Contractors response:***

We have detailed how the induction phase will be delivered within the main services sites with the Aiming for Abstinence and Re-integration & Recovery components delivered in physically separate surroundings. To enable service users to join the programme and progress from one phase to another the entry level criteria for all phases are:

#### Entry to the Induction Phase

- The Structured Day Programme must identified in recovery plan as a goal
- Completed risk assessment with no serious concerns about engagement in a group

must be in place

- Positive feedback from attendance at service user development sessions must have been received
- Each candidate must demonstrate some basic treatment compliance including drug testing and supervised consumption if considered clinically appropriate

#### Progression to the Aiming For Abstinence Phase

Progression to the Aim for Abstinence phase will not simply be a matter of attending each group work session in the induction phase. Progression will be a discursive decision made by the programme staff, the service user and in the case of service users attending the programme as part of a Drug Rehabilitation Requirement (DRR), their Offender Manager from Probation. Progression is likely to be based on:

- Good time management and attendance at sessions
- Good feedback about group participation and respect for others
- Some evidence of a positive change in drug use such as test results
- TOP scores
- A demonstrable understanding of treatment completed so far and an appreciation of what has been learned
- Engagement in key working
- Tangible progress in terms of recovery goals identified in each plan

#### Progression to the Re-integration & Recovery Phase

As with the induction phase, movement into the Re-integration & Recovery phase will require tangible evidence of progression. Service users will need to demonstrate:

- Good time management and attendance at sessions
- Good feedback about group participation and respect for others
- Discontinued use of illicit drugs confirmed by test results
- TOP scores
- Evidence of reductions in re-offending
- A demonstrable understanding of treatment so far and what has been learned
- Engagement in key working
- Tangible progress in terms of recovery goals identified in each plan

#### Service Use Contracts

All service users taking part in any phase of the Structured Day Programme must understand, accept and sign a programme contract covering their treatment. This will include:

- Behaviour and attendance expectation
- Exclusion criteria
- Recovery plan goals
- Recovery Mentor & volunteer support arrangements
- Drug testing regime
- DRR compliance and reporting (if CJS client)
- Rights & Responsibilities
- Named key worker
- Signatures of service user and key worker

<p>4. Section 2.0 Sub heading 2.2 b</p> <p><b>Weighting 4</b></p> <p><b>Maximum word count of 500 words</b></p>	<p>Objectives of the service</p>	<p>Please demonstrate how the service will provide preparation groups prior to SDP.</p>
<p><b>Contractors response:</b></p> <p>To enable service users to engage fully with Structured Day Programmes we will operate a 'development' approach in the form of pre-treatment groups that are consolidated in the induction phase of the programme. These development groups will consider the following elements:</p> <ul style="list-style-type: none"> <li>• <b>Awareness of personal skills</b> We will encourage service users to map and understand their own strengths and weaknesses. Importantly this process is validated by the need to feed back to others and the necessity to provide a rationale for self-assessment. Where the exercise identifies strengths these will be acknowledged and consolidated. Where weaknesses are identified, the service user will be encouraged to think of ways of striving for improvement. A simple example might be to 'count to 10' before reacting to a perceived criticism from another person.</li> <li>• <b>Awareness of time management</b> For many service users, fully appreciating that they have responsibilities around the management of their daily routines can be a challenge. This aspect will look at positive ways to manage time, consider strategies for minimising time wasting or procrastination and reinforce the responsibility to others of managing time well.</li> <li>• <b>Stress management</b> Managing stress is an important tool for all, no less a service user undergoing drug treatment and most likely dealing with a number of daily stressors. Sessions will cover what stress is, how techniques for dealing with stress can be learnt by everyone and the consequences of leaving stress unchecked, particularly the links to relapse. Learning two or three simple stress management techniques can have a positive impact upon self-confidence and help to reduce anxiety.</li> <li>• <b>Dealing with criticism</b> For many service users, criticism will be part of daily life as will unhelpful responses to it. Our work here will seek to consider why people criticise others, how to deal with a reasonable level of criticism and some self-awareness relating to justified criticism. We will explore some of the psychological traps that people fall into in the face of criticism that often lead to further drug use.</li> <li>• <b>Self-confidence</b> Many users will present with obvious issues around self-confidence whilst others will employ a number of tactics to convince those around that they are self-confident. We will encourage service users to reflect on what a sustainable level of self-confidence entails and how this will affect their dealings with other people.</li> <li>• <b>Body language</b> Sessions will look at the various ways in which people communicate non-verbally and how other people perceive different types of body language. Our emphasis will be on generating self-awareness amongst service users, promoting congruence between what someone says and how they present themselves and the encouragement of appropriate body language for use in the treatment setting and beyond.</li> </ul>		

<ul style="list-style-type: none"> <li>• The ‘passive/aggressive’ pendulum</li> </ul> <p>For many service users, a swing between outwardly passive and aggressive presentation is common. Programme facilitators will consider what properly assertive behaviour looks like, using ‘I’ statements, influencing others in constructive ways and learning to ‘agree to disagree’. We will attempt to model assertive behaviours and demonstrate how these are perceived by others.</p>		
<p>5. Section 2.0 Sub heading 2.2</p> <p><b>Weighting 4</b></p> <p><b>Maximum word count of 500 words</b></p>	<p>Objectives of the service</p>	<p>Please demonstrate the pathway for individuals who are completing Residential Rehabilitation or detoxification who want to access SDP</p>
<p><b>Contractors response:</b></p> <p>It is crucial that recovery plans reflect the need to provide effective support post-detoxification or as residential rehabilitation programmes come to an end. Inclusion will ensure that keywork, psycho-social interventions and aftercare options are available to service users completing detoxification or rehab programmes. We recognise post-detoxification and rehabilitation as a vulnerable time for service users with the possibility of relapse and overdose present. However, we will seek to build on the confidence service users derive from completing detoxification and rehabilitation programmes through access to diversionary activities, engagement with mutual aid groups and the use of education, training and employment opportunities including volunteering within our own services.</p> <p>When a service user is preparing for detoxification, whether in the community or as an in-patient, a detoxification risk assessment will take place and this will consider key indicators of likely success including accommodation, family &amp; friends and peer support. The detox aftercare plan will include reference to the Structured Day Programme and specific joining details for the service user upon completion of the detox programme. All service users undergoing detoxification will have support from Recovery Mentors and volunteers that will include regular home on in-patient visits (to fit in with in-patient visiting restrictions) and accompanying the service user to the Structured Day Programme during their early engagement.</p> <p>For those service users entering Residential Rehabilitation programmes we will ensure that all post-treatment aftercare plans include access to Structured Day Programmes. As part of the service user’s engagement with Residential Rehab, a member of staff will act as a named link worker for the rehab and wherever practicable, be involved in 3 way meetings with the rehab provider and service user to review treatment progress. As the treatment programme nears completion, the service user will be introduced to a trained volunteer who will act as a ‘buddy’ to promote take up of the Structured Day Care programme and accompany the service user from the rehab back home.</p>		

6. Section 2.0 Sub heading 2.2 d  <b>Weighting 5</b>  <b>Maximum word count of 500 words</b>	Objectives of the service	Please describe how clients can access mutual aid groups.
<p><b>Contractors response</b></p> <p>The Cambridgeshire service will pro-actively promote pathways into mutual aid opportunities for as many Structured Day Programme clients as possible. We will do this in a number of ways:</p> <ul style="list-style-type: none"> <li>• By ensuring that up to date information about mutual aid groups is readily available in all service locations</li> <li>• By ensuring that all staff are fully cognisant of the remit of mutual aid groups and actively sell the benefits of such groups to service users during key working sessions</li> <li>• By encouraging all staff to deepen their own understanding of mutual aid groups through reading, discussion and attendance at local 'open' meetings.</li> <li>• We understand that a number of 12 step groups are in existence across the county at             <ul style="list-style-type: none"> <li>○ Cocaine Anonymous group currently operates from the Vestry Christchurch Street, Cambridge</li> </ul>             and that Narcotics Anonymous groups operate from             <ul style="list-style-type: none"> <li>○ Mill House, Mill Road, Cambridge</li> <li>○ Bermuda Road Community Room, Histon Road, Cambridge</li> <li>○ Neighbourhood Centre, Ross St, Cambridge</li> <li>○ St Columba's Hall Downing Street, Cambridge</li> <li>○ St Mary's Church, Brook Street, St Neot's</li> <li>○ Maple Centre, 6 Oak Drive, Huntingdon</li> </ul> </li> </ul> <p>Wherever practical, we will continue to support these groups by making service premises available for meetings and encouraging service users to attend.</p> <p>For those service users not wishing to engage with 12 step groups or for service users who may want to attend additional support along side 12 step meetings, we will facilitate the delivery of Smart Recovery at all Structured Day Programme sites. Smart Recovery is a secular, cognitive behavioural alternative to 12 step mutual aid and is growing in popularity. Our approach to developing Smart Recovery across Cambridgeshire will be twin-track:</p> <ul style="list-style-type: none"> <li>• The service will identify 6 treatment graduates annually to go forward for Smart Recovery Training. We will provide funding and support to these peer group leaders and encourage the development of Smart Recovery groups.</li> <li>• Smart Recovery's experience across the UK is that the ad-hoc training of small numbers of peers is worthwhile but can take a long time to spread across an area. Therefore to supplement the training of individual peer group leaders Inclusion proposes to become a SMART Recovery 'partner' in Cambridgeshire. This entails staff members having access to 20 hours of on-line SMART Recovery training that equips them with the skills and knowledge to 'kick-start' SMART Recovery groups and to become 'Champions'. In turn, as groups become established, more peer group leaders can be trained and the network of SMART Recovery groups will grow across the county.</li> </ul>		

<p>7. Section 2.0 Sub heading 2.2 e</p> <p><b>Weighting 4</b></p> <p><b>Maximum word count of 1000 words</b></p>	<p>Objectives of the service</p>	<p>Please demonstrate how the service will link with non-drug organisations in their contribution to SDP.</p>
<p><b><i>Contractors response:</i></b></p> <p>Part of our strategy for involving non-drug organisations in increasing the effectiveness and capacity of the structured programme will be to generally raise the profile of treatment services. In doing this we aim to create a positive image in the minds of the local community and influence local people. To do this we will engage with;</p> <ul style="list-style-type: none"> <li>- Local businesses</li> <li>- Residents near services</li> <li>- Parish and County Council representatives</li> <li>- Neighbourhood teams and residents associations</li> <li>- Churches and faith based groups</li> </ul> <p>The Structured Day Programme will develop a series of excellent working links with a number of non-drug provider agencies to enhance the delivery of re-integration and recovery services across the county. These links will include:</p> <p><u>Local &amp; National Educational, Training &amp; Employment (ETE) Services</u></p> <p>Establishing sound pathways for service users into ETE opportunities will be a central feature of the programme. It is our proposal that all Structured Day Programme Project Workers will have an ETE element to their role. Where ETE related recovery goals are identified and agreed, then the Project Worker will seek to broker in services to meet the service user's ETE needs. During the Re-integration &amp; Recovery phase of the programme on-going key work and group sessions will help to clarify needs in terms of basic skills and knowledge, motivation, barriers to employment, personal interests and strategies to increase employability via relevant education and training opportunities. We will also consider employment potential by looking at previous experience and qualifications, recovery capital and opportunities within the local labour market. Service users will have access to internet enable computers to utilise the world wide web for job searches, CV and application preparation, research and presentations.</p> <p>The Locality Manager with a development brief for structured programmes and project staff on the ground will make and maintain links with external ETE organisations across Cambridgeshire as well as national resources and will build a library of relevant information within the project. We will develop partnerships with:</p> <ul style="list-style-type: none"> <li>- Jobcentre Plus</li> <li>- Ingeus &amp; Seetec for access to The Work Programme</li> <li>- Learn Direct</li> <li>- Direct.gov Next Step</li> <li>- Cambridge &amp; Peterborough Learning Trust</li> <li>- Community colleges and learning centres</li> </ul>		

Housing Services

Our proposed staffing structure retains the current Homelessness Co-ordinator role and our expectation is that Project Workers in the structured programme will be able to offer advice, information and limited case work in respect of accommodation issues with consultancy and advice from the Homelessness Co-ordinator in support of this. Beyond that, we will look to broker in support from a number of housing related services including:

The meeting will comprise of the following agencies:

- Street Outreach Mental Health Outreach Team
- Cambridge City Council Housing Options and Advice
- Riverside Tenancy Sustainment Team
- Housing providers including Granta, Stonham, Riverside ECHG, Cyrenians, Jimmy's Night Shelter, and King Street Housing.

The Structured Programme through a combination of in-house key working, in-reach advice & information clinics provided by external agencies and links with accommodation providers will build excellent resettlement and re-housing support to service users.

Welfare Benefits Advice & Information

We will approach the Citizen's Advice Bureaux and negotiate for them to deliver regular clinics at structured programme locations to provide service users with advice and information about welfare benefits. The service will also establish good relationships with all local Benefits Agency offices. All members of project staff will be trained in basic welfare rights issues and completion of benefit claim paperwork.

Health Services

The service will form excellent pathways into a range of health provision including:

- The Home Treatment Mental Health Team
- Cambridge Access Clinic
- GUM clinics
- Dentistry services
- GP surgeries

Family Support Services

The service will link with family support organisations including those working with Black & Minority Ethnic population groups.

8. Section 2.0 Sub heading 2.2 g	Objectives of the service	Please demonstrate how the service will utilise volunteers and Recovery Mentors within this service.
<b>Weighting 5</b>		
<b>Maximum word count of 1000 words</b>		

***Contractors response:***

Inclusion's general approach to utilising Recovery Mentors and volunteers is covered in detail in the overarching method statements. Specifically, the Structured Day Programme will too include Recovery Mentor and volunteer input. Inclusion see this as important in enhancing the service to clients but also in providing excellent opportunities for Mentors and volunteers

to develop their own skills and knowledge as well as 'put something back'. To this end we will recruit Recovery Mentors and volunteers to take part in all aspects of our day care programme.

Inclusion is very clear about the distinction between Recovery Mentors and volunteers. By definition Recovery Mentors are still service users, albeit ones who have made progress in treatment, have stabilised and decreased their drug use, have undergone a specific Mentor training programme and induction. Mentors all report to an on-site named member of staff who supervises the Mentor. By contrast volunteers, who may include former Recovery Mentors that have graduated from their mentoring placement and completed treatment, are by definition, no longer service users. Volunteers are similarly required to undergo training and are supervised by the Volunteer Co-ordinator. Consequently, volunteers are able to take part in a wider range of duties than Recovery Mentors and we see this as an incentive in itself towards recovery.

In terms of Structured Day Programme delivery the types of tasks Recovery Mentors and volunteers will take part in include:

Status	Types of task
Recovery Mentor	<ul style="list-style-type: none"> <li>• Reception, meet and greet duties</li> <li>• On-site mentoring of other service users</li> <li>• Support for groupwork delivery</li> </ul>
Volunteer	<ul style="list-style-type: none"> <li>• Administration duties</li> <li>• Off-site buddying, social support and advocacy</li> <li>• Co-delivery of all aspects of the day programme</li> <li>• Detoxification and Residential Rehabilitation link work</li> </ul>

Each of the three service delivery locations for Structured Day Programmes - Cambridge, Huntingdon and Wisbech will have a minimum of 5 trained Recovery Mentors and 5 volunteers available to support service delivery at any one time. This will ensure that the service has adequate coverage each day of the week and allow volunteers to leave site as they undertake outreach type duties.

### Training

Recovery Mentors will under go training in the following subjects before they can support aspects of the Structured Day Programme. This will include:

- Role of the Mentor & Mentor Contract
- Basic Drug & Alcohol Awareness/ Harm Minimisation.
- Supervision & Support
- Communication Skills
- Group Work Skills.
- Motivational Interviewing
- Assertiveness
- Mentoring in Support of Recovery Goals
- Safeguarding
- Managing Challenging Situations.
- Equality & Diversity.

Volunteers will also undergo a specific training programme. The programme will have similarities in content to the Recovery Mentor training put will be pitched differently to take account of the cohort's 'volunteer' status. The training will include:

The training course will include session on:

- Role of the Volunteer & Volunteer Contract
- Basic Drug & Alcohol Awareness/ Harm Minimisation
- Supervision & Support
- Communication Skills
- Group Work Skills.
- Motivational Interviewing
- Assertiveness
- Volunteering in Support of Recovery Goals
- Safeguarding
- Managing Challenging Situations.
- Equality & Diversity
- OCN/NVQ Orientation

9. Section 2.0 Sub heading 2.2 h  <b>Weighting 5</b>  <b>Maximum word count of 1000 words</b>	Objectives of the service	Please demonstrate how the service will encourage SDP clients to become recovery mentors or volunteers.
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***Contractors response:***

The Structure Day Programme will encourage service users to become Recovery Mentors and/or then volunteers by highlighting the progression pathway available to all and the opportunities that this will bring. We have talked in other method statements about the inherent value and basic requirement to have a range of service user involvement initiatives in place to improve service delivery and aid service development. However, Inclusion also regards meaningful service user involvement as the foundation stone upon which the Recovery Mentor, volunteering and Education, Training and Employment (ETE) pathway is built. Without a commitment to service user involvement that includes tangible opportunities to take part, it is all the more difficult to encourage service users to become Recovery Mentors and volunteers by completing the necessary training & induction and consolidating learning that these roles require.

For many service users, making the transition to Recovery Mentor status is a significant step. Whilst some service users may achieve this spontaneously or be fortunate enough to be able to call on existing skills and knowledge that have fallen into disuse, others need to look specifically at the sorts of attributes that they will need to develop to take part in future Recovery Mentor or volunteer training courses with a reasonable chance of success.

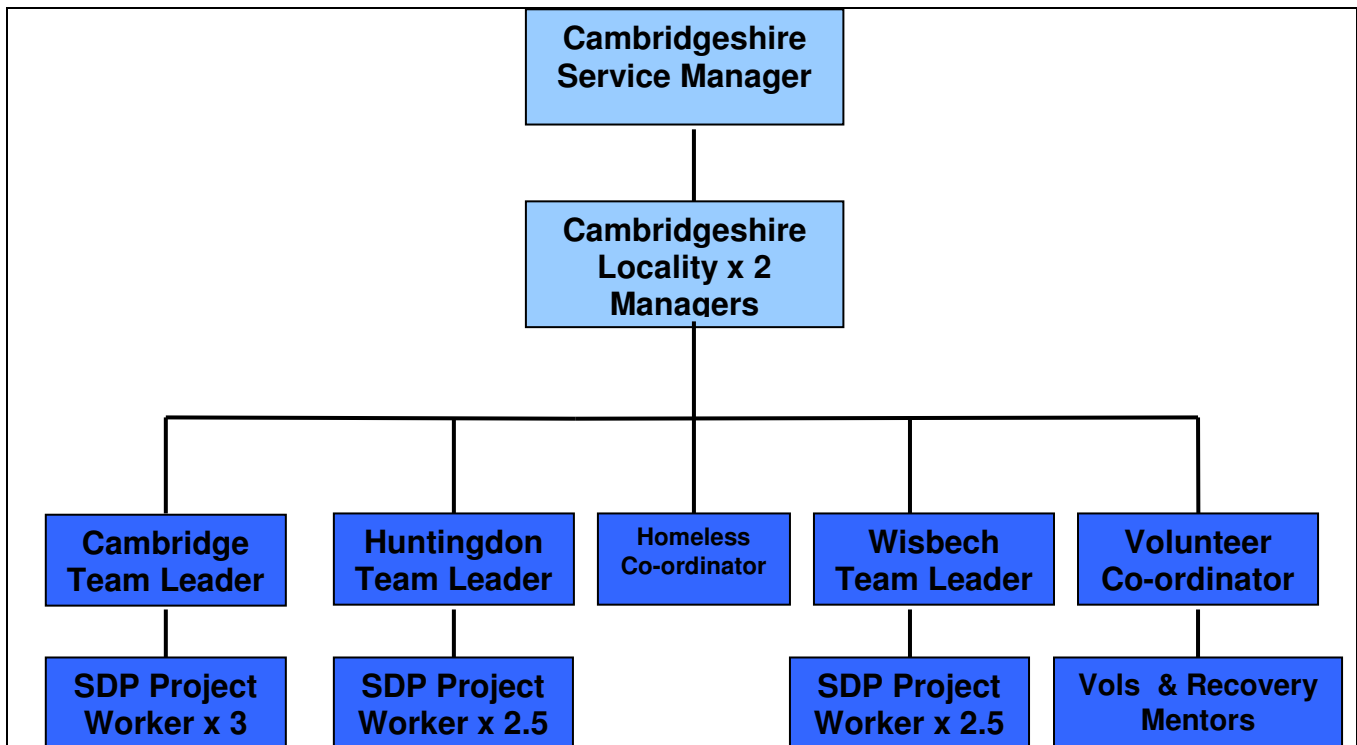
In taking part in the Structured Day Programme, service users will witness at first hand, how Recovery Mentors and volunteers have been given the opportunity to support programme delivery. Service users will be able to talk to Recovery Mentors and volunteers about their experience of taking part, what the training experience was like and the rewards that each individual has gained from their involvement. They will be able to explore some of the pitfalls

faced by others and make an informed choice about their own involvement in Recovery Mentor or volunteer programmes in future.

Inclusion will encourage service users to become Recovery Mentors and volunteers through:

- All service sites will display posters and leaflets marketing Recovery Mentor and volunteer opportunities. Information will include an outline of the role, the service's expectation of someone taking part and the potential benefits to those completing the training.
- All service staff will talk to service users, families and carers regularly to encourage involvement in one of the training programmes. We will help service users who have concerns about their ability to learn by providing access to education course including literacy and numeracy.
- We recognise that making the leap from being a service user to a Recovery Mentor can be a significant challenge. We will facilitate peer network meetings at all Structured Day programme sites where service users interested in undergoing Recovery Mentor training can meet and discuss the opportunity with other service users who have become mentors.
- To meet our governance and safeguarding requirements all Recovery Mentors and volunteers will need to undergo CRB checks. We will stress to potential Recovery Mentors and volunteers that possessing a criminal history is far from being an automatic barrier to taking up a mentor role.
- As service users progress in their treatment they will have access to the Recovery Mentor and volunteer programmes as described in overarching method statements 28 and 29.

10. Section 3.0 Sub headings a – d  <b>Weighting 5</b>  <b>Maximum word count of 500 words</b>	Provision of service	Please demonstrate what the structure of the service will look like.
<b>Contractors response:</b> The Structure Day Programme service will be comprised of:		



- **Locality Manager**

In Inclusion's re-modelled management structure, one of the Locality Managers will assume a Structured Day Programme development lead. The Locality Manager will work with the Service Manager and the Implementation manager to enhance the current programme through identification and procurement of community venues, programme re-design, staff training and brokering in support from other mainstream agencies.

- **Team Leaders**

Team Leaders will have significant relevant experience of developing and delivering 'front line' treatment and support services to substance misuser's in the community and will have experience of delivering PSI's plus an appropriate qualification. They will also require previous experience of managing staff teams and developing partnership working and developing programmes.

- **SDP Project Workers**

SDP Workers will be required to have demonstrable experience of delivering front line substance misuse services, group work skills and knowledge of individual care planning with substance misuser's. They will have a relevant qualification and will be skilled in a range of current structured intervention strategies including mapping techniques. Each SDP Project Worker will have a generic brief of basic ETE and accommodation advice & information.

- **Homelessness Co-ordinator**

The Homelessness Co-ordinator role will offer Project Workers in the structured programme consultancy and guidance around providing advice, information and limited case work in respect of accommodation issues to service users. The role will lead on developing a range of pathways into local housing provision.

- **Volunteer Co-ordinator**

<p>The VMC will have previous experience of co-ordinating volunteers and demonstrable people management skills. Volunteers will play an important role in the delivery of the service and the Co-ordinator will be required to develop and integrate these programme elements.</p> <ul style="list-style-type: none"> <li>• <b>Volunteers &amp; Peer Mentors</b></li> </ul> <p>The service will seek to recruit a number of volunteers and Recovery Mentors to actively support programme delivery and development. Supervised by the Volunteer Co-ordinator or other named members of programme staff, volunteer and Recovery Mentors will be expected to take part in relevant learning &amp; development opportunities as part of their own progression.</p>		
<p>11. Section 3.0 Sub headings a – d</p> <p><b>Weighting 4</b></p> <p><b>Maximum word count of 500 words</b></p>	<p>Provision of service</p>	<p>Please demonstrate how some elements of SDP will be available for individuals who are not engaged with SDP as a whole.</p>
<p><b>Contractors response:</b></p> <p>There are some elements of the Structured Day Programme that will be accessible to service user who are not necessarily engaged with programme as a whole. A range of interventions will be available to these groups. The service will still expect interventions to be part of a service user's recovery plan. The groups that this likely to apply to will include:</p> <ul style="list-style-type: none"> <li>- Service users leaving prison who are drug free and wish to consolidate their community re-integration</li> <li>- Residential Rehabilitation returners who have completed their programme</li> <li>- Cannabis users who wish to access certain aspects of aftercare following a Brief Intervention</li> <li>- We have described above those service users who are not yet able to engage with the full structured programme – we will run development groups as a way of readying these services users for enrolment on the programme.</li> </ul>		
<p>12. Section 6.0 Sub headings A – b</p> <p><b>Weighting 4</b></p> <p><b>Maximum word count of 500 words</b></p>	<p>Onward Referral/Aftercare and Support</p>	<p>Please detail the referral pathway into Aftercare from the service.</p>
<p><b>Contractors response:</b></p> <p>As explained in the previous method statement response, our Structured Day Programme includes a bespoke Re-integration &amp; Recovery phase. All service users engaging with the programme will have access to the structured Re-integration &amp; Recovery phase that includes:</p> <ul style="list-style-type: none"> <li>- Relapse management</li> <li>- Mutual Aid &amp; SMART Recovery groups</li> <li>- Recovery Mentoring &amp; volunteering training programmes</li> <li>- Education, Training &amp; Employment (ETE) pathways</li> </ul>		

- Accommodation advice, information and advocacy
- Welfare benefits
- Independent living skills

Involvement in the Re-integration & Recovery phase is in theory open ended and designed to meet all the outstanding needs of service users.

**Method Statement Section 3B, 3h Family Support**

<b>Spec Reference</b>	<b>Method Statement Reference</b>	<b>Method Statement</b>
1. Section 2.0 Sub heading 2.1	Aim of the service	Please demonstrate how the service will identify family members and significant others for this service.

**Weighting 4**

**Maximum word  
count of 500  
words**

***Contractors response:***

Our vision for Cambridgeshire is to create a “think family approach” and encourage the engagement of families and carers in a service user’s treatment along side the provision of family and carer support services. Families and carers will be identified and engaged in support services through the following

- A clear communication strategy will be devised to attract media attention to the impact of substance misuse upon family members. These media messages will ensure that our strategy for meeting the needs of families and carers is communicated to a wide audience.
- Through the use of digital media there will be a link on the service website with a link to a film exploring the issues for those affected by substance misuse and explaining the pathways into accessing the family support service, relevant carers group meetings and the SPOC phone number
- Information and advice about substance misuse and treatment including written publications and fact sheets will be made available at all service locations to encourage families and carer’s to identify themselves and access support.
- Recovery mentors and volunteers will talk to service users about how their use has impacted on their significant others and if interested offer to contact family members to encourage them to take up the support offered by the family service, or at the very least provide them with literature and more information.
- Each service area will host a family and carers group monthly. This will allow families and carers to come forward as stigma is reduced by the knowledge others are in the same situation – this will increase engagement.
- Our assessment tools will have specific questions relating to families and carers and trigger whether the service user would like a member of staff to contact them to offer support.
- Service users will be asked for consent for us to provide information about drugs and support services to their carers and family.
- All staff will be briefed on Social Behaviour Network Therapy. This therapy seeks to encourage family and carers to become actively involved in a persons treatment which in turn can help with their own needs.
- We will ask Tier 1 services such as GP’s, Probation, Maternity, prison visitor centres and hospital Accident & Emergency departments to display posters and leaflets advertising the service.
- We will seek to advertise the service through mediums such as local radio and through local community networks such as faith groups and the lesbian & gay

community.

- We will consult with families and carer's who have already accessed support services to ascertain what works for them and importantly what barriers they think exist to other family and carers accessing support. Our aim will be to provide support to all that identify outstanding needs.

2. Section 2.0  
Sub heading 2.2 d

Objectives of  
the service

Please demonstrate how the service will provide  
the one to one sessions within this service.

#### **Weighting 4**

**Maximum word  
count of 500  
words**

#### ***Contractors response:***

Once identified, the service will offer an assessment of need to the family member(s) and develop a support plan. The assessment will consider:

- What sort of information or support the family member requires as a result of the person's drug use.
- The dynamics of the family member's relationship with the person in treatment
- How the person's drug use or offending behaviour is affecting family life
- The impact of the person's drug use upon any children in the family
- What coping strategies the family member has developed in the face of the person's drug use
- How to meet the family member's outstanding needs through a support plan.

Support plans will be structured and identify what measures the service will put in place, how and where these will be delivered and by whom. The service will regularly review the family members support plan. From our experience of working with family members, support plans are likely to include aspects such as:

- strategies for dealing with risk in relation to the home environment and the person's drug use
- self-care in terms of physical and psychological health with advice on relaxation techniques, nutrition and exercise
- generating ideas for gathering additional resources and increasing social networks
- Confidence and self-esteem building interventions
- Practical support and help to access education, training or employment opportunities, accommodation support or welfare benefits.

For families with a high level of need six structured counselling sessions will be available delivered by trained counselling staff. Through the use of the Clinical Psychologist based at our Birmingham service an appropriate carers assessment scale will be devised to ascertain those most in need to be prioritised for these intensive sessions. To augment the formal counselling staff operating in the service we will explore involving second year counselling degree volunteers who wish to gain practical experience from placements at the service.

3. Section 2.0  
Sub heading 2.2 e

Objectives of  
the service

Please demonstrate what training/information will  
be provided.

## **Weighting 4**

**Maximum word  
count of 500  
words**

### ***Contractors response:***

Inclusion's approach to training families and carers will involve using a combination of project staff, Recovery Mentors and volunteers (ideally including some with experience of familial drug use) and external agency professionals to deliver regular workshops at all our operational sites. The workshops will be very much designed to empower family and carers in their 'management' of a loved one's drug use and highlight skills, knowledge and resources to meet family and carer's own needs. We will run workshops including:

#### Harm Reduction

The provision of harm reduction information is important in equipping families and carers with an improved understanding of drug misuse and treatment, as well as helping family members who maybe using drugs as a coping mechanism to consider there own treatment needs. We will train families and carer's in drug awareness, broaden their understanding of treatment interventions, look at issues relating to safer injecting, BBV's and sexual health.

#### Overdose training

Overdose training will be made available to service users and their families. The basics relating to drug tolerance, signs & symptoms, recovery positions and next steps will be covered. In consultation and agreement with local commissioners, Inclusion are also able to provide Naloxone training for families and carer's who are in contact with someone potentially vulnerable to an opiate overdose. The training will cover the context for Naloxone use, administration and basic first aid principles.

#### Domestic Violence

As we have articulated in other method statements there is often a link between drug and alcohol misuse and the incidence of Domestic Violence. It is for this reason that families and carers can benefit from training in Domestic Violence issues. We will raise awareness of Domestic Violence support services and resources so that family or carers faced with Domestic Violence can make informed choices about how to resolve the situation.

#### The setting and maintaining of boundaries

For the families and carers of those with substance misuse issues, setting and maintaining appropriate boundaries can be a major challenge. Whilst the nature of the actual boundaries that an individual family put in place will vary, there are some common skills and knowledge that will assist in this important area. We will deliver workshops that help families and carers to develop planning and coping strategies, problem solving skills, dealing with change, confidence building and assertiveness. By helping families to develop their own recovery capital in these ways, families will be better placed to consider what boundaries are in the best interests of the service user and themselves and to keep such boundaries in

place. An important example of this will be for families estranged from the service user who wish to re-establish a relationship contingent upon progress in drug treatment.

4. Section 2.0 Sub heading 2.2 i	Objectives of the service	Please detail how the service will encourage family members to identify themselves as carers.
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#### **Weighting 4**

**Maximum word  
count of 500  
words**

#### ***Contractors response:***

The service will encourage the self-identification by families and carer's through:

- Information and advice about drug misuse and treatment including written publications and fact sheets will be made available in all service sites to encourage families and carer's to access support.
- Recovery Mentors and volunteers will talk to service users about how their use has impacted on their significant others and if interested offer to contact them to encourage them to take up the support offered by the family service, at the very least provide them with literature.
- Service sites will carry marketing information about Cambridgeshire Families Anonymous contact line and support groups as an alternative pathway for families and carers seeking support. ADFAM materials will also be made available.
- Inclusion will replicate and further develop the current network of family and carer support group meetings taking place across the county. This will be an opportunity for anyone concerned about the drug use of a family member to identify themselves and seek support through self or other agency referral. The groups will be open to all and widely publicised. Groups will run monthly during early evening times at locations in Cambridge, Ely, Huntingdon, Wisbech and Chatteris.
- Inclusion understands that carers may be entitled to receive a local authority carer assessment. If considered appropriate a support plan can be agreed by the County Council and this will include links to local voluntary agencies and groups providing support. In some limited circumstances the carer's assessment may provide access to allowances and grants. Inclusion will ensure that this source of potential support is known to all carers and that the Adult Drug Treatment Service has excellent relationships with Cambridgeshire Adult Social Care Team to ensure that this pathway is utilised.
- All staff and volunteers will be trained in Adult Social Care team processes in respect of carers. Information will be placed on the website and in service locations. Service users will be encouraged to pass this information to significant others. Staff and volunteers will be able to discuss fully the benefits that may apply to them through accessing this assessment such as ensuring that their support needs are met via local agencies or access to personal budgets for example to allow them respite time away from their everyday situation.

5. Section 2.0	Objectives of	Please demonstrate how the service will utilise
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Sub heading 2.2 k      the service      volunteers within this service.

**Weighting 4**

**Maximum word  
count of 1000  
words**

***Contractors response:***

Inclusion is committed to the use of volunteers throughout its services. The family support element of the Adult Drug Treatment Service will utilise volunteers in the following ways:

- We will explore the potential for establishing a small number of counselling placements for students studying for relevant counselling qualifications at local education centres. Ideally, working towards United Kingdom Register of Counsellors (UKRC) recognised qualifications 2<sup>nd</sup> year counselling students offering long term placements will be targeted and they will support the work of the counselling staff employed by Inclusion.
- We will facilitate monthly family and carer support groups across the county. These will be lead by a combination of staff and trained volunteers. Volunteers will be drawn from our local pool and will include people who have personal experience of drug use or supporting a drug user in their family.
- Recovery Mentors and volunteers will be trained to co-facilitate training workshops for families and carers in harm reduction, overdose prevention, Domestic Violence and boundaries along side project staff and external agency professionals.

**Method Statement Section 3B, 3i) Drug Intervention Programme including  
3j) Drug Rehabilitation Requirement (DRR)**

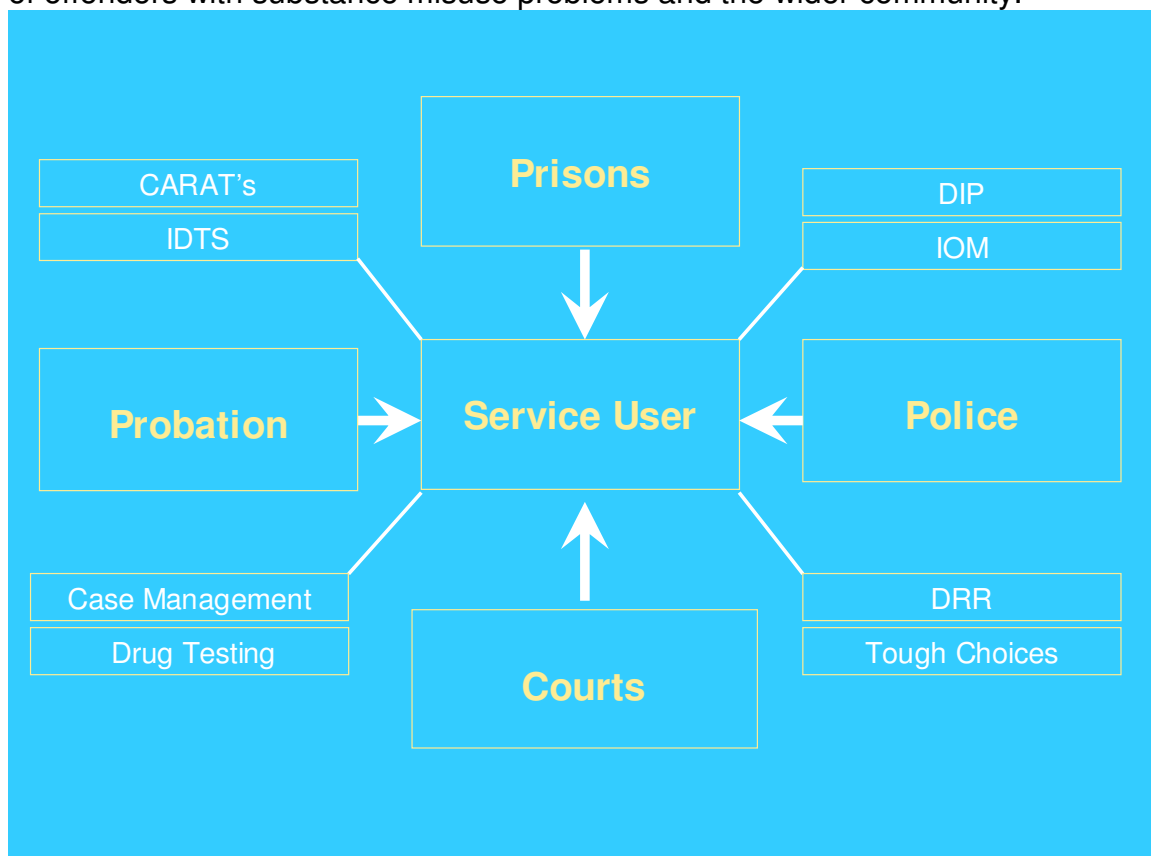
Spec Reference	Method Statement Reference	Method Statement
1. Section 1.0 Sub headings a – c	Definition of Service	How will the service work with partners within the criminal justice sector to ensure all appropriate adult drug misusers are referred into DIP?

**Weighting 5**

**Maximum word  
count of 1500  
words**

***Contractors response:***

Inclusion's approach to working with drug misusing offenders is to assertively outreach and engaged with all aspects of the criminal justice system and maximise the timely movement of service users into our recovery services. We are clear that the criminal justice agencies we work with are partners with whom we seek to find common ground and agreed ways of joint working in the interests of offenders with substance misuse problems and the wider community.



Cambridgeshire Drug Interventions Programme (CDIP) staff employed by Inclusion will contribute to the aims of the programme through a commitment to partnership work. We will work in partnership with agencies from across the CJS including:

- Cambridgeshire Constabulary

- Cambridgeshire & Peterborough Probation Trust
- Courts Service
- Crown Prosecution Service
- HM Prison Service

CDIP will work closely with these key partners as part of an Integrated Offender Management approach that has proved successful in reducing re-offending rates. By being part of a de-facto single entity response to substance misuse related offending, the service can provide a range of interventions to enable and support offenders to engage with recovery based treatment options at all possible entry points within the CJS. By supporting rapid access to treatment from the point of arrest the service will enable DIP to engage offenders in psycho-social and pharmacological treatment as early as possible to contribute to reductions in offending with service users assessed and commencing prescribing within 3-4 days.

Examples of partnership working are:

- Development of excellent working relationships at operational level in custody suites, courts, PPO teams and all other settings.
- Agreed working protocols that will ensure the provision of an effective service that targets in particular trigger offences and PPO's through a clear understand of agency roles and responsibilities
- Participation in Police special operations as required
- Support Probation staff with timely information sharing, assessment and recovery pathways.
- The provision of accurate and timely information to support sentencing and case dispersal options in the community.
- Efficient and timely compliance testing for service users on court ordered Drug Rehabilitation Requirements.
- Ensuring employees are vetted and security cleared as necessary to maximise staff deployment

There are a variety of ways in which we will ensure drug misusing offenders are referred into CDIP, assessed and offered interventions:

- Police Custody – CDIP staff will screen and assess offenders identified through
  - Offenders testing positive or requesting an intervention following Voluntary Drug Testing on Detention (VDOD)
  - Those given DIP Conditional Cautions or where a Required Assessment is imposed

Our aim with custody suite interventions is to ensure that CDIP staff are present when offenders are available to be seen. We will work closely with Police custody suite staff to develop a clear understanding of offender flows and build our staff shifts around peak times.

- Court – CDIP staff will screen and assess offenders identified through
  - Restrictions on Bail imposed following arrest in other DIP areas for people returning to a Cambridgeshire court
  - DRR assessments will be completed by CDIP staff

The key to CDIP's success here will be to ensure that all agencies contributing to the programme are integrated including co-location, agree working protocols and

information sharing agreement.

- Probation
  - CDIP will accept referrals for all clients on a Probation License or as part of a community order.
  - CDIP will ensure Probation Bail Hostels can make referrals
- Prison
  - CARAT's – Referrals from carats in prisons to engage in treatment at DIP on release.
- Other referral routes:
  - Prolific & Priority Offender team
  - Integrated Offender Management team
  - Self-referral
- SPOC

The CDIP SPOC will be widely publicised and offer a free phone number to all agencies can contact during normal working hours. Out of hours calls to the SPOC will be picked up by staff on a rota.

### CDIP Staff Team

The CDIP staff team, lead by the county wide DIP Manager will be co-located with CJS partner agencies in a continuation of the existing arrangements and be deployed in two teams – Central and Southern. Operational coverage will include:

- Arrest referral coverage at Parkside and Huntingdon custody facilities to maximise contact with drug misusing offenders
- Coverage of courts including Cambridge, Ely, Wisbech and Huntingdon as agreed with Probation and commissioners
- Generic CDIP staff working across locality teams to ensure all duties are covered including Required Assessment, Restrictions on Bail Assessment, DRR & ATR screening and suitability assessments, input to PPO & IOM, prison in-reach and resettlement.
- Refresher training of all staff with each owning their own development plan
- 'Custody and court craft' workshops for those staff new to criminal justice environments
- Ownership of service targets by all operational staff through team briefings, information provision and objective setting in supervision and appraisal
- The effective use of Management Information to ensure the optimal deployment of staff and the identification of under-performance and remedial measures.

2. Section 2.0  
Sub heading 2.2 a

Objectives of  
the service

How will the service motivate drug misusing  
offenders in the Cambridge custody suite to  
engage with the service?

### **Weighting 5**

**Maximum word  
count of 1000  
words**

### ***Contractors response:***

CDIP staff will operate in the main Parkgate custody suite in Cambridge and utilise the following methods of maximising the opportunity to engage and motivate drug misusing offenders:

- Staff will ensure they operate at times agreed with the Police to maximise

the chances of engagement. CDIP will agree and widely publicise staffing rota's and contact details to ensure custody suite staff can maintain communication as necessary

- CDIP staff will consult custody notice boards/sheets to identify those arrested for trigger offences, priority crimes and those already known to CDIP. Inclusion will ensure that all CDIP staff are able to access custody records by prior negotiation and agreed with the Police to actively target drug misusing offenders
- CDIP staff will pro-actively see the benefits of information sharing and gain written consent of service users for the purposes of effective case management, recovery planning and onward referral.
- CDIP staff will always wear their SSSFT and Cambridgeshire Constabulary ID badges making clear who they are to both detainees and custody suite staff, increasing the incidence of opportunistic engagement
- Inclusion will provide DIP and arrest referral awareness workshops for all custody suite staff on a regular basis to promote the aims of the programme and maximise support from custody staff.
- CDIP staff will understand and comply with all legal process and custody suite procedures to ensure the service is respected and supported by custody suite staff. This will include taking advice in relation to safe working in the custody suite at all times.
- CDIP staff will conduct regular cell sweeps and engage target prisoners in conversations about treatment at every opportunity. CDIP staff will liaise closely with custody suite staff in terms of VDOD procedures and the use of private interview rooms.
- CDIP will make service promotional materials available at all times in the custody suite and will approach custody staff about stencilling CDIP contact details on the walls of holding cells.

When a CDIP worker interviews an offender, building the motivation to engage with treatment will be our priority. CDIP staff will explain that there are not custody staff, are there to provide advice, information and support, referral into treatment and can offer a confidential service. CDIP workers will explain that they are able to co-ordinate care for detainees beyond the custody suite and broker in a range of support services to meet their needs.

CDIP workers will use Motivational Interviewing (MI) techniques in the custody suite. The purpose of using MI will be to:

- Expressing empathy with service users. Our role is not to make judgments about an individual's drug use or offending but to explore the circumstances which led the detainee to be where they are, build rapport and trust with the detainee, understand their drug treatment and wider needs and agree a plan of action to begin to address those needs either in custody or the community depending upon the outcome of the arrest.
- Developing discrepancy in service users. We will do this by using arrest as a window of opportunity to explore with the detainee their current situation and their aspirations for the future focusing on the gap between these two states.
- Rolling with the service user's resistance. CDIP workers will acknowledge the ambivalence of many service users to changing their circumstances and rather than confront this head on, will seek to work with ambivalence and offer an alternative perspective.

- Supporting self-efficacy. CDIP workers will recognise that all detainees have some choice in their future actions. This includes how they decide to interact with the CJS for example by accepting a Conditional Caution or returning for a Required Assessment and whether or not to engage with treatment in both the short and long term. We will aim to build confidence in detainees that life can be different in future because they decide to invest in behaviour change.

CDIP staff will also seek to engage and motivate detainees through the provision of practical advice, information and support. By providing practical help and assistance CDIP workers will build rapport with detainees and increase the chances of further engagement. We will provide information about:

- Harm reduction information covering drug tolerances, safer injecting, safer sex, BBV's and general health
- Pathways into primary health care, emergency accommodation, welfare benefits and ETE opportunities.
- CDIP workers will be able to assist in detainees attending initial appointments either through direct transportation subject to staff availability and risk assessment or through limited travel expenses.

3. Section 5.0  
Sub heading  
a – c

Referral and  
Assessment

How will the service work with prisons and predominantly HMP Peterborough to facilitate the referral process into DIP to minimise the drop out of clients between the two services?

### **Weighting 5**

**Maximum word  
count of 1000  
words**

#### ***Contractors response:***

Inclusion understand the importance of ensuring that service users leave prison and are picked up CDIP with no drop outs. Our experience in this area has been developed through provision of specific prison in-reach services across the Birmingham conurbation linking HMP Birmingham releases in local DIP teams.

CDIP will ensure minimal attrition between prison and community services through a number initiatives:

- CDIP will deliver an in-reach function to HMP Peterborough and will ensure that all CDIP staff are trained and able to offer in-reach via prison visits or through specifically negotiated wing-based pre-release clinics if activity levels suggest this is necessary. We will aim to engage with prisoners well before release to maximise service take up. Where possible volunteers will be used to augment in-reach duties.
- We will work closely with prison CARAT administrators to ensure procedures are place to refer all Cambridgeshire prisoners to the DIP SPOC at the earliest moment
- All prison releases will have a named DIP worker as their primary contact in the community
- All prison releases will have an up to date recovery plan in place to ensure continuity of care and support resources available in the community. If the stay in custody has been very short and no comprehensive assessment exists this will be completed prior to release if possible but if not, immediately post release.

- CDIP will use a case management approach to track all DIP service users by gathering and recording court dates, prison release dates and an up to date location within the prison system for all service users.
- Where a DIP client has taken part in prison based group work relating tot heir substance misuse and offending, CDIP staff will attend reviews where possible but at a very minimum seek written feedback fro programme facilitators as to treatment progress.
- Where a prisoner is being prescribed substitute medication CDIP will arrange for this to be continued in the community. CDIP staff will liaise with prison Healthcare to ensure a smooth transition from prison to the community. We will do this by sharing prescribing information and organising appointments with prescribing services immediately post-release
- Where a DIP service user will access a residential rehabilitation placement straight from prison, CDIP will liaise with CARAT's and the rehab provider to ensure tracking information is updated and post-placement aftercare is in place including a re-engagement strategy should the service user leave the placement before completion.
- Gate pick ups will be considered for particularly vulnerable clients where there are concerns about drop out immediately prior to release. The process for this will include:
  - A release plan and risk screening will be completed
  - Risk screening will be undertaken by CDIP in conjunction with the CARAT service utilising the prison LIDS system wherever possible
  - Gate pick ups will be undertaken by two workers and this can include a trained volunteer
  - Upon completion of the risk screening, a gate collection risk minimisation plan will be agreed.
- When a DIP service user does drop out of contact during the transition from custody to community we will assertively outreach the service users in an attempt to re-engage them in treatment.

4. Section 6.0  
Sub headings  
a – c

Assessment

How will the service ensure clients who are not engaging effectively are encouraged to do so, including how the service will work with criminal justice partners to ensure non engagement is communicated to ensure risk of re-offending is mitigated.

## **Weighting 5**

**Maximum word  
count of 1000  
words**

### ***Contractors response:***

#### Encouraging Engagement

Successfully engaging service users is critical at the beginning of recovery journeys. We will do this through combining a harm reduction approach with enhancing motivation and raising the aspirations of service users towards recovery and re-integration. By addressing priority needs such as injecting behaviour, we are laying the foundation for future recovery.

Harm reduction advice, information and interventions will be inherent to all service delivery. From the first contact, staff will address harm reduction with all service

users utilising an educational and motivational approach. We will develop and deliver:

- Written and verbal information explaining tolerances and safer injecting
- Information on problematic or contaminated supplies of street drugs
- Advice and information about safer sex and sexually transmitted diseases.
- Advice & information regarding Blood Borne Viruses (BBV), pre/post counselling and immunisation programmes
- Education about the physical, psychological and social impact of problematic drug use.
- Sterile injecting equipment and the return of used injecting equipment
- Distribute appropriate injecting paraphernalia as specified in Section 9a of the Misuse of Drugs Act 1971
- Advice on the storage, handling and use of injecting equipment.
- Offer health examinations, including checks on injecting sites, dealing with minor infections and dressings or referral to appropriate services.
- Advice that prevents or curtails the transition into injecting for current injectors and smokers of substances that can be injected.
- CDIP staff will be creative about providing access for service users – we can use a variety of venues for interventions including public places and other agencies where service users may go. We can meet service users at pharmacy needle exchanges, hostels, community centres, job centres and doctor's surgeries.
- All staff will be trained in brief interventions including Motivational Interview and Brief Solution Focussed Therapy. This can increase a service user's motivation to address their substance misuse and increase numbers into treatment. We will work with service users to consider how their lives have been affected by substance misuse, look at alternatives and plan for the future.
- CDIP staff will actively use Recovery Mentors and volunteers to approach those not engaging well or at all so that the benefits of treatment and recovery can be spelt out.
- Where a service user is in receipt of a prescription but is otherwise not engaging it will be made clear by CDIP staff that failure to pick up after a 3 day break will mean the scripts are likely to be withheld until the service user presents and engages.

Our approach to enhancing motivation and increasing engagement is to build the individual's understanding of their substance misuse and offending behaviour, raise the possibility of a different life style and support the service user in closing the gap between where they are and where they want to be. We will provide feedback to service users in the form of clear advice & information, ensure that the ownership of the need for change is placed on the service user and outline the menu of possible courses of action. We will ensure our responses are always empathetic and non-judgmental in a way that re-enforces self-efficacy.

#### Communication with the CJS

When a CDIP service user is engaging poorly we recognise our responsibility to our CJS partners to communicate clearly about this. We will:

- Ensure all service users are tracked through the use of case management principles as they move through the CJS.

- Ensure that CDIP and the wider Adult Drug Treatment Service are signed up to local information sharing protocols and that all staff are fully aware of their responsibilities in respect of information sharing
- We will ensure that the Police are made aware of progress when a service user is instructed to engage with DIP via a Conditional Caution or a Required Assessment is imposed
- All Offender Managers will be kept informed of how service users are engaging with treatment including drug test results. When a service user does not attend we will communicate immediately with the Offender Manager to enable Probation Service breach procedures to be followed where appropriate.
- Where CDIP provide services to PPO or IOM referrals, CDIP provides regular reports as to the service user's progress or otherwise in treatment.
- Where CDIP are clear a service user has disengaged and a re-engagement plan is in place, this must be agreed with CJS partners are timely update reports provided.

5. (Section 3B)  
Section 9.0

Onward  
Referral/  
Aftercare and  
Support

Please demonstrate how the service will ensure clients who are stable within treatment and no longer suspected of offending are moved on to mainstream services

(Section 3A)  
Section 10.0

### Weighting 3

Maximum word  
count of 500  
words

#### **Contractors response:**

It is important to ensure that service users who have ceased offending move on appropriately from CDIP so that their outstanding needs are met by an appropriate service(s) and to ensure that CDIP's caseload does not continue to grow unnecessarily and block access for new CJS referrals.

When a CDIP service user has ceased offending and is stabilised in treatment the case will be closed by CDIP and care co-ordination assumed by the element of the service best placed to do this. To facilitate moving the service user into other services we will:

- Update the service users risk assessment to reflect any changes in their situation and communicate these to services or agencies that become involved
- Re-visit the recovery plan to ensure goals remain relevant, challenging and achievable.
- Prepare the service user for the move into new services by discussing with them progress made, any anxieties they may have, practical suggestions for dealing with change and updating information sharing & consent to share agreements
- Where possible a 3 way meeting involving the CDIP, the service user and the new service or agency to discuss handover and on-going recovery needs. An up to date assessment, recovery plan and other relevant information such as drug test results will be made available.
- With the service users consent we will discuss the movement into new

services with their families or carer. This will help to provide additional support and encouragement for the service user.

- When a service user is attending a new service for the first time, we will use volunteers to accompany them to the first appointment.

- Transition to mainstream services can be a time of potential relapse as the nature of support changes. We will ensure all service users know how to access additional short term support if needs be including input from the SPOC, by dropping into any of the service venues, through volunteers and also with information about national telephone help lines.

- Some service users will find long-term benefit by participation in 12 step fellowship groups. We will therefore encourage and host AA / NA meetings at the service or support clients to access 12 step meetings in the community. For those service users unable to engage with the 12 step approach Smart Recovery will be developed. Smart Recovery is a mutual aid movement based on a form of CBT, which developed as an alternative to 12 step based fellowships such as AA / NA. Smart Recovery groups are facilitated by a service user familiar with the approach, initially with the support of a professional but aiming to be freestanding over time.

6. Section 10.0  
Sub heading e

**Weighting 4**

**Maximum word  
count of 500  
words**

DIP Additional  
provision:  
Specialist  
Prescribing

Please demonstrate how the service will ensure that referrals from prison are able to access emergency clinic appointments to facilitate continuation of prescribing if released to the community with limited notification.

***Contractors response:***

Where a prisoner is being prescribed substitute medication in prison this medication has to be continued in the community. Each prison Healthcare service will provide prisoners with their medication on the day of release from custody. A smooth transition from prison to the community is essential because service users are potentially at their most vulnerable on release from prison with an increased risk of overdose. Support has been a constant whilst a service user has been in custody so continuation of care reduces anxiety, decreases the risk of relapse into illicit drug usage, and decreases overdose risk.

Inclusion's approach to facilitating the continuity of prescribing will be:

- Each week a small number of prescribing clinic appointments will be kept open and dedicated to prison releases in particular on Fridays. This arrangement will cover the majority of prison releases.
- If for some reason a service user cannot be seen by a prescribing doctor or a Non Medical Prescriber in the service, a bridging prescription can be issued for up to but no longer than 7 days. Good practice around bridging prescriptions is described below.
- The prescription will be available for the service user to collect from the CDIP team on the day of or the day after their release.
- A bridging prescription will be dated to start the day after a service user's release, as they receive their final dosage from the prison on the morning of their release, prior to release. Prescribing records from the prison healthcare team is required so that the prescribing Doctor at DIP can verify exactly what medication

and what dosage has been prescribed for the service user whilst they have been in prison.

- A continuation of this medication will be prescribed, until the date that the service user can be next seen by a Doctor in a clinic at DIP.
- NDTMS prescribing register checks must be completed, to ensure that there are no treatment concurrent prescribing at other local services..

#### Procedure for Arranging a Bridging Prescription

- An alert form will act as the referral for the service user
- Court or prison release date will be confirmed
- Prescribing information will be requested by fax from Prison Healthcare to CDIP Team
- Communication with NDTMS prescribing register by fax to ensure that the service user is not being scripted by any other agencies.
- A further prescribing clinic appointment will be arranged within 7 days of release date.
- A bridging prescription request form is completed
- Communicate with nominated pharmacy to ensure that they supervise consumption. Checks made that the pharmacy is open on a Saturday.
- All documentation is passed to the prescribing doctor and the prescription double checked on receipt.

#### Good practice around issuing a Bridging Prescription

- Obtain a urine sample to check current drug use
- Always provide harm reduction information regarding tolerance levels and overdose risk
- Contact pharmacy and ensure that the service user can collect from there.

#### **j) Drug Rehabilitation Requirement (DRR)**

7. Section 1.0	Definition of Service	Please demonstrate how the service will work with Probation Services and Courts to ensure the appropriateness of offenders for DRR assessment.
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**Weighting 4**

**Maximum word  
count of 1000  
words**

#### ***Contractors response:***

Inclusion will agree a joint assessment tool with our CJS partners to ensure that suitable DRR candidates are identified and a community disposal can be considered for disposal. Any comprehensive DRR assessment will include:

- Basic details and demographic data
- Treatment history
- Offending history
- Recent drug use and drug use history
- Physical & mental health
- Social functioning and support

- Areas of current need
- Recovery goals

Assessment for DRR requires informed decision making by the treatment provider, the Probation Service and the court officers and therefore suitability for an order will be determined by a range of factors including:

- Problematic drug use most likely Heroin and/or Crack Cocaine. In some limited circumstances other drug use maybe suitable for a DRR.
- The offender's drug use must be shown to be clearly linked to their offending behavior;
- The offender's drug use must be susceptible to drugs treatment
- There is demonstrable evidence of willingness and motivation to comply with a DRR including likelihood of keeping appointments, programme engagement

Joint training of all stakeholder staff involved in identifying suitable DRR participants will ensure that consistent and required quality standards are achieved and maintained. Joint assessments between staff will contribute to developing consistency within the assessment process. This will also ensure that the requirements of both parties are met so that the Probation Service are able to meet core standards. The offender, as a service user of the DRR programme is also central to the DRR assessment process. It is important that all aspects and requirements of the DRR programme are clearly explained and understood so that the offender is supported in making an informed appropriate choice (within acceptable parameters) regarding whether to undertake, request or decline the offer of a DRR.

Similarly it is important that Solicitors and Magistrates are fully informed of the requirements and provision of the options available within sentencing to a DRR. By providing training to these key groups the service will support the assessment and sentencing of appropriate DRR's which meet the requirements of the court, the Probation Service, the Adult Drug Treatment Service, the offender and the wider public.

By working closely with the court, Offender Manager and the IOM team, assessment for DRR will dovetail with existing or newly formed packages of support for offenders. By assessing the offender's ability to respond to different types of intervention, the DRR can be tailored within acceptable parameters to meet the specific requirements of the individual offender that will, in turn, provide the best opportunity for a successful outcome.

Where an offender has had a previous DRR or Drug Treatment & Testing Order (DTTO), the outcomes of these will be discussed within the assessment process to determine which elements were more effective, as well as what areas need more detailed work. Assessment for DRR will need to be informed of previous or current plans for the offender under IOM. PPO status will need to be taken into consideration as will the nature and types of offences committed. Any continuing requirements from the IOM programme of support for the offender will need to be considered when identifying the appropriateness and intensity of the DRR.

Current and previous drug treatment will also be examined within the assessment process in order that the most effective treatment interventions can be identified. The assessment process may also at this stage begin preparing the offender for drug treatment, indeed the offender may already be in treatment in which case the DRR programme will need to be pre-eminent within the overall treatment programme that the offender undertakes.

Clear, precise and effective communication between all parties involved in the delivery, monitoring and reporting of the DRR is essential. This will include the communication between the service, the Probation Service, the courts and IOM. The service will provide where required contributions toward pre-sentence reports to enable those involved in determining the intensity of the DRR to make a suitable and appropriate decision.

8. Section 1.0	Definition of Service	How will the service work with the Probation Service Offender Managers to ensure that the relevant and appropriate drug treatment interventions, including drug testing and clinical appointments are structured to meet the needs of the client and the minimum hours of the level of order applied by the court?
<b>Weighting 4</b>		
<b>Maximum word count of 1000 words</b>		

***Contractors response:***

Inclusions strategy for engaging, retaining and delivery high quality treatment interventions for offenders sentenced to DRR's in Cambridgeshire is based upon each offender having full access to our Structured Day Programme. The programme is described in full in the SDP method statements. However in summary service users subject to a DRR will have access to:

Key Working & ad hoc Psycho-social Interventions.

Individual key working for all service users accessing the Structured Day Programme will be a condition of successful engagement. Key working will include all assessment, risk assessment, recovery planning, reviews and reporting to outside agencies such as Probation. The service will employ a combination of Inclusion's assessment tool and the full range of BTEI mapping tools for recovery planning. Key workers will also be able to provide ad-hoc, opportunistic psycho-social interventions along side of group work in support of recovery plan goals including contingency management. In this way, key work sessions can serve as useful, short-span group preparation and de-briefing to deal with issues that arise for a service user. The Structured Day Programme will act as Care Co-ordinators as agreed with elements of the service and co-ordinate drug testing.

Induction Group Work

Our aims in the induction phase are to introduce, stabilise and retain service users. We will build on the work under taken in pre-treatment service user development groups that will include:

- Awareness of personal skills
- Awareness of time management
- Stress management
- Dealing with criticism
- Self-confidence
- Body language

- The 'passive/aggressive' pendulum.

The additional work will include sessions designed to address:

- The 'passive/aggressive' pendulum
- Service user expectations and programme rules
- Substance awareness
- Recognising triggers, managing cravings, coping strategies
- Reflections on current situation including debt management, housing, health & offending
- Addressing ambivalence to change
- Recovery goal setting
- Family and friend support networks

#### Aiming for Abstinence Group Work

During the Aiming for Abstinence phase we want to deliver groups that consolidate treatment progress and prepare service users for a life without drugs.

Groups delivered will include:

- Maintaining motivation
- Improving communication skills
- Improving social networks/relationships
- Managing emotions
- Problem solving & thinking skills
- Improving time management
- Budgeting
- Healthy lifestyles & nutrition
- Relapse prevention/management

#### Re-integration & Recovery Elements

The elements of the Re-integration & Recovery phase will help to equip service users with skills for life and open up opportunities for re-integration in to the community and a life without drugs. The elements on offer will include

- Relapse management
- Mutual Aid & SMART Recovery groups
- Recovery Mentoring & volunteering training programmes
- Education, Training & Employment (ETE) pathways
- Accommodation advice, information and advocacy
- Welfare benefits
- Independent living skills

#### Stimulant Work

Programme staff will offer stimulant, in particular crack/cocaine interventions using Conference on Crack and Cocaine (COCA) materials. Sessions will look at:

- How crack and cocaine work
- Health implications of its use
- Patterns of use
- Triggers
- Cravings
- Euphoric recall
- Crack / cocaine and offending

- Coping strategies
- Harm reduction

The DRR care plan will be a three way agreement between the Offender Manager, the client and the service. Regular three way meetings will be held to ensure that all are informed of the progress of the DRR. The exact nature and structure of these meetings will be determined by agreement between the service and the Probation Service. It may be that these are meetings between the Offender Managers, the DRR worker and the client or it may be that the Probation Service nominates and Offender Manager to be the Single Point of Contact (SPOC) for discussing cases with the Inclusion service.

Within the agreed care plan for the DRR the requirements of the Probation Service National Minimum Standards will need to be met, ensuring where appropriate daily contacts with a review at 8 weeks and 16 weeks to determine progress. Testing is an integral part of the programme and reports will be regularly provided to Offender Managers, together with attendance at appointments for drug treatment. This allows the Offender Managers to monitor compliance with the requirements of the order.

DRR clients benefit particularly from peer support and peer challenge. This is provided very effectively in group based interventions. The use of group work programmes using the BTEI node mapping tools is proven to be effective in this regard. The system provides a diagrammatic representation of the behavioural changes the client makes against a developed baseline which is individual to the client based upon their own responses against a range of areas including drug use, offending behaviour, anxiety and depression. The BTEI assessment identification of anxiety and depression issues offers a further opportunity to identify the potential need for referral or engagement with the mental health services. This is particularly important for the high proportion of offenders in Cambridgeshire identified as lacking appropriate mental health support.

By utilising group work it is possible to provide the required number of hours and the appropriate level and type of intervention to meet client need and Probation Service requirements. The service will provide where required contributions toward pre sentence reports to enable sentencer's to determine whether a low, Medium or high intensity DRR is appropriate.

9. Section 4.0  
Sub heading h

Access to the  
Programme

Please demonstrate how the service will provide feedback to the Probation Service in respect of progress made, emerging needs or non compliance with the order.

**Weighting 3**

**Maximum word  
count of 500  
words**

***Contractors response:***

The service will liaise closely with Probation Service Offender Managers and provide regular information on the progress of those service users subject to a DRR through the following initiatives:

- We will submit weekly proforma attendance sheets to demonstrate

attendance and compliance with the requirements of the order.

- As soon as staff become aware of a service user's absence this will be reported by telephone immediately on the day to enable the Probation Service to work within its service standard framework should a breach be necessary.
- Weekly drug test results for each service user will be provided to the Offender Manager.
- We will provide regular summary updates on each service user's progress against the agreed recovery plan goals
- We will provide the required 8 week and 16 week reviews to each Offender Manager with detailed information on the progress of the DRR.

The service will conduct its own review with the client after week 4 and week 12 in addition to those conducted with the Probation Service at week 8 and week 16. This will enable the service and the service user to discuss (the lack of) progress and determine appropriate action. In addition where clients are non-compliant with treatment early motivational based interventions will be delivered in an attempt to enable the client to engage.

The DRR care plan will be a three way agreement between the Probation Officer, the service user and the service. Regular three way meetings will be held between the service and the Probation Service and the service user to ensure that all are informed of the progress of the DRR. The exact nature and structure of these meetings will be determined by agreement between the service and the Probation Service. It may be that these are meetings between the OM, the DRR worker and the client. It may be that the Probation Service nominates and OM to be the Single Point of Contact (SPOC) for discussing cases with the Inclusion service.

10. Section 6.0  
Sub headings  
6.1 – 6.2

Care Planning

On completion of the DRR, how will the service ensure the client is encouraged to maintain contact with DIP or mainstream services to support future recovery?

**Weighting 4**

**Maximum word  
count of 500  
words**

***Contractors response:***

When a Cambridgeshire offender successfully completes a DRR sentence, then they may be referred back into CDIP or via the SPOC services and taken back onto the case load to access on-going treatment or aftercare services in a bid to meet outstanding needs and consolidate reintegration and recovery. We will encourage this to happen by ensuring that all recovery plans recognise the impending end of the DRR by reviewing recovery goals. All service users will be encouraged to understand that whilst the completion of the DRR is a significant achievement that are likely to have outstanding needs and will also have more time on their hands following completion of the sentence. This will require thought and planning and in all likelihood result in take up of aftercare services to help avoid relapse. All DRR completers can become Recovery Mentors and volunteers as described elsewhere and will have access to aftercare services including:

- .Mutual Aid & SMART Recovery

The Cambridgeshire service will pro-actively promote pathways into mutual aid opportunities for as many service users as possible. We will do this in a number of ways:

- By ensuring that up to date information about mutual aid groups is readily available in all service locations
- By ensuring that all staff are fully cognisant of the remit of mutual aid groups and actively sell the benefits of such groups to service users during key working sessions
- By encouraging all staff to deepen their own understanding of mutual aid groups through reading, discussion and attendance at local 'open' meetings.
- Wherever practical, to work jointly with mutual aid groups: for example to make service premises available for meetings, to facilitate attendance at team meetings and the share information appropriately in support of recovery and re-integration recovery plan objectives.

- Education, Training & Employment (ETE)

ETE support aftercare will include:

- learning and support plans with service users
- provision of on-going individual support
- access to further appropriate learning
- identification of employment opportunities
- Information Advice and Guidance
- Psychometric testing
- Labour market information
- Personal and social development
- Preparation for work
- confidence and motivation building
- CV and interview preparation,
- identifying and negotiating work placements
- positive disclosure training
- Communication and team work skills

- Housing

Aftercare service will offer general advice and information relating to local accommodation opportunities but will also seek to broker in support from housing agencies including Cambridgeshire County Council's Home Link, Registered Social Landlords and Housing Associations.

- Benefits

We will ensure that all service users have access to a comprehensive range of advice and information relating to welfare benefits. This will be available from the staff team in general but will be supplemented by specific benefits clinics held in the service by the Citizen's Advice Bureaux and The Benefits Agency.

- Independent Living Skills

The service will offer service users support in a range of independent living skills including; personal budgeting and managing bills, nutritional advice, cooking, accessing leisure and cultural facilities and managing relationships.

**Method Statement Section 3B, 3k HMP Whitemoor**

Spec Reference	Method Statement Reference	Method Statement
1. Section 1.0 Sub headings a – i	Overarching Provision	How will this service be delivered and made accessible to all prisoners?

**Weighting 4**

**Maximum word  
count of 1500  
words**

***Contractors response:***

Inclusion are experienced providers of non-prescribing and prescribing drug and alcohol services across the prison estate. In preparing our response to these method statements, we have considered the Category A status of HMP Whitemoor and the needs of the prison population including those housed within the Dangerous & Severe Personality Disorder and Close Supervision Units. Our proposals are designed to build on the work of the current service provider, Phoenix Futures, and utilise our own organisational expertise in prison based treatment to drive service improvements and better outcomes for prisoners.

Services that will be made available to prisoners within HMP Whitemoor will include:

- A replica of the current staffing arrangements namely, two on-site Inclusion staff, one seconded Prison Service practitioner and a Prison Service Administrator. Upon award of contract, Inclusion will seek to ensure these secondment arrangements are preserved through negotiation with HMP Whitemoor. Inclusion will provide access to our own training programmes for those seconded staff to promote shared understanding and joint working. The service will operate Monday to Friday for 37.5 hours to fit in with the core regime hours.
- To ensure satisfactory staffing cover during annual leave and sickness absence, Inclusion will establish a small bank of staff, employed in the community element of the Cambridge Adult Drug Service, with security clearance to operate in HMP Whitemoor. This bank of staff will be trained in prison based policies and procedures. These arrangements will provide continuity of service and care for HMP Whitemoor prisoners and promote mutual understanding and awareness between community and custodial staff. Inclusion will explore the feasibility of longer fixed term 'job swaps' between community and custodial based staff following contract implementation.
- As with all our prison-based treatment services, Inclusion's approach to service delivery is to recognise, understand and work within the local establishment regime. We will develop excellent working relationships and joint working protocols with all HMP Whitemoor departments and seek to build organisational influence whilst advocating for the needs of prisoners. Inclusion is very clear, that at all times, security-related matters are the absolute priority for all staff operating within the prison.

- Inclusion delivers recovery-orientated services that do not overlook the need to deliver robust harm minimisation interventions. We help prisoners to strive for recovery through goal setting, challenging unhelpful thinking and behaviour, raising aspirations and working towards positive change. At the same time, we recognise that some prisoners arrive at treatment with abstinence and recovery somehow in the future. With this in mind we will work with the prisoner 'where they are', so this will include accurate harm minimisation information and advice. In essence we will always challenge prisoners to change but never set anyone up to fail by imposing unrealistic expectations upon any individual.
- Prisoners will be able to easily self-refer to the service using the normal prison application process. Referrals will also be taken from all other prison departments and the Visitor's Centre. We will work closely with the Prisoner Action on Drugs (PAD) movement to promote service uptake. The service will seek every opportunity to promote the service, its objectives & the types of treatment available for prisoners, to staff working in other departments & disciplines who have direct prisoner contact. We will deliver staff awareness sessions as part of the establishment's staff training calendar. Staff will then be ideally placed to inform prisoners & encourage referrals.
- The service will operate using a case-management approach. This will entail individual and group-based interventions available to all prisoners as required alongside referral to a range of other prison-based supports including Healthcare, Education, employment & skills for life services. Inclusion recognises that substance misuse issues are often only part of the presenting needs of many prisoners and as such care plan goals must address the whole person and their needs. We will refer into the FOCUS high intensity programme to address substance related offending, specific to the high security estate.
- The service will deploy Substance Misuse Node Mapping Assessment (I-MAPS) and Structured Care Planning (Care Plan and I-Plan) for all prisoners accessing the service. Confidentiality agreements will be fully explained and informed consent statements signed by all prisoners accessing the service. All interventions will be recorded on Casework Record Sheets.
- All interventions will be delivered within a care plan built upon SMART objectives identified during individual sessions. Care Plans will be reviewed on a regular basis to measure progress against agreed objectives – this will ensure interventions remain focussed and relevant. Reviews may highlight the need for new objectives to be agreed. Each prisoner accessing the service will receive a copy of his care plan with a further copy passed to each prisoner's Offender Manager.
- The service will be marketed throughout the prison to ensure that all prisoners and staff within HMP Whitemoor understand what the service offers and how it can be accessed. This will include the times the service is available to prisoners, and what to do if an issue arises outside of these times. We will audit existing service marketing materials and advertising locations to ensure contemporary information is available to all prisoners and staff.
- A range of literature & posters advertising the service will be developed in 'easy to understand' pictorial style, in eye catching colours designed to attract drug & alcohol users with language & literacy difficulties. Leaflets will be printed in English & in the main non-English languages found in the prison. For those who are blind/visually impaired, audio recordings will be available containing all the 'need to know' information. Bright eye catching colours printed in cartoon style are

more likely to attract those with learning difficulties. The posters & leaflets will be displayed in all key locations such as Healthcare, in the prisoners' library, reception and wings.

- Inclusion will ensure that clear referral criteria are advertised to all prisoners and prison staff. Establishing clear referral criteria is important in reducing the number of inappropriate referrals which could otherwise waste valuable resources. The service will participate in the prisoner induction process to ensure that all prisoners are fully aware of the service when they first arrive at the prison.
- We know from experience that written marketing materials must be backed up by regular staff briefings and by our involvement in sentence planning, Home Detention Curfew applications and Release on Temporary Licence boards where appropriate. It is also our intention to ensure that the service is represented and plays a full part in HMP Whitemoor's wider drug strategy and supply/demand reduction meetings.
- With a small staff team in operation it is impossible to state categorically that staff ethnicity will reflect that of the prison population. However Inclusion will ensure that all staff receives excellent training in Equal Opportunities, Diversity and Anti-Discriminatory Practice as part and parcel of delivering culturally sensitive services. Staff will attend 'Challenge It, Change It' training to ensure we work within the prison's Diversity awareness guidelines.
- Inclusion will work with the prison, commissioners & partner agencies to ensure that prisoners who do not speak English can access interpretation when required. We will work creatively with Disability Liaison, the Diversity Board & faith group leaders to lend their support & help us develop a service that is attractive to & respectful of disability & to diverse religious, cultural & ethnic groups.
- It is our intention to negotiate with HMP Whitemoor to retain use of the current office on B Wing and the designated groupwork room (we understand that there are on-going discussions regarding service co-location with IDTS and Inclusion would seek to contribute to these discussions). The service would be delivered as it is currently, with staff using landing interviews rooms following liaison with discipline staff to allow for unlocking of prisoners and subsequent return to cells (Inclusion would not seek to have staff draw cell keys).
- For those prisoners housed in the Dangerous & Severe Personality Disorder and Close Supervision Units within HMP Whitemoor, a service will still be provided. Inclusion staff will liaison closely with Prison staff to provide structured, time limited 1:1 interventions utilising isolation booths and taking into account multiple-staff unlocking procedures. Where security advice allows, groupwork sessions may also be provided.
- 1:1 interventions will be offered to all prisoners accessing the non-prescribing drug and alcohol service. The range of interventions on offer, delivered by appropriately trained staff will include Motivational Interviewing, Solution Focussed Therapy, focussed harm minimisation work, Brief Therapy and key working and relapse prevention sessions.
- Groupwork will be available to all prisoners subject to liaison and approval from the Security Department. Groups will include work on Harm Minimisation, Relapse Prevention, motivation to change and peer support opportunities.
- The service will link prisoners into Healthcare for the provision of Blood Borne Virus testing and Hepatitis B immunisation.

- The service will offer limited Auricular Acupuncture interventions to prisoners to promote anxiety management and relaxation. Auricular Acupuncture is viewed as a complimentary therapy, and not a replacement for structured psycho-social interventions and case work.
- The service will be clear as to what prisoners can expect. We explain all treatment options to prisoners and enable them to develop their own achievable recovery goals. We expect our staff to work alongside prisoners so that they are in control of their treatment and are aiming for the goals they have set for themselves.

2. Section 3.0  
Sub heading 3.2 m

Objectives of  
the service

How will this service work with the prison visitors  
centre to provide advice and information?

#### Weighting 4

**Maximum word  
count of 1000  
words**

#### ***Contractors response:***

Inclusion recognises the importance of close links with the Visitor Centre at HMP Whitemoor. Through the provision of accurate advice and information to the family members of prisoners with substance misuse issues, we can improve service take up and encourage family members to support their loved one's recovery journey. For long term prisoners, the added motivation of family support in overcoming dependency may be of central importance. The non-prescribing drug and alcohol service will develop and maintain such links through a range of initiatives:

- Marketing information about drug and alcohol services will be provided for display in both the Visitor Centre and within the visit room so that prisoners' families can understand the range and availability of support services within the prison. This information will be visually impactful and use straight forward language.
- The free availability of service marketing literature will naturally raise questions for many visitors in relation to drug and alcohol services. In our experience, the opportunity to answer such questions presents an excellent opportunity to engage with families and carers and promote services. Inclusion will ensure that staff maintain a presence in the Visitor Centre at well publicised times so that direct contact can be made with visitors wanting information and advice. Typically this is likely to be for short periods between the opening of the Visitor Centre at 12.15pm and the actual start of visits at 2pm. Service staff will make them visible and approachable and provide confidential advice and information as required.
- Inclusion understands that visitors wanting drug/alcohol advice and information may not necessarily approach staff directly at first until some degree of trust is established. With this in mind, Inclusion will ensure that staff are equipped with information and advice relating to a range of prison-related issues that may prove helpful to visitors: this could include local transport details, the prison regime and security requirements, as well as visiting times and frequencies. In this way, without replacing the role of Visitor Centre staff, we can build rapport with visitors and promote the drug and alcohol service. We are aware of the particular need to perhaps tread carefully with the visitors of

Category A prisoners who may seek a higher degree of confidentiality before engaging with the service.

- Our service will take part in the HMP Whitemoor Visitor Centre annual Family Day. We would take along marketing materials and staff a stall on the Family Day and be available to answer questions raised on the day.
- We will work closely with Visitor Centre staff and volunteers to provide informal support and advice relating to substance misuse issues. This make take the form of information about the signs of drug or alcohol use, the role of families in treatment and recovery, or procedures for supporting referral to services.
- At all times, Inclusion staff offering any information or advice in the Visitor Centre will be governed by the same attitude to the absolute priority of maintaining prison security.
- We know that families can be extremely reluctant to engage in the visits centre. As a way of addressing this at Swinfen Hall where we provide services currently, families come in for a look around at the prison and meet the staff who will be looking after and working with their son. The families who accept the invite to this visit are typically the ones who are engage in the support and rehabilitation work. For this reason it is good practice for our staff to be visible at case conferences and post treatment reviews where the family is invited to take part.

3. Section 4.0  
Sub heading d

Client Group  
Served

What safeguards will be employed for those  
prisoners who are excluded from the service?

### **Weighting 3**

**Maximum word  
count of 500  
words**

#### ***Contractors response:***

The decision to exclude a prisoner from taking up the non-prescribing drug and alcohol service will never be taken lightly. When the team receives information relating to a prisoner's history that casts doubt upon them receiving a service, a risk assessment will be under taken and appropriate information shared with Security and other prison departments before the decision to exclude is taken.

The starting point for all attempts to safeguard prisoners who are excluded from the service must be the provision of harm minimisation advice and information. If the opportunity presents itself to deliver this information in a 1:1 intervention or a group setting it will be taken; indeed our staff will approach the engagement of all prisoners on the working assumption that contact time may be limited to one session for unforeseen reasons. However, it is more likely that the information will have to be provided in the form of leaflets and other service literature, easily accessible to all prisoners.

As such, our service will seek to prioritise the delivery of harm minimisation messages that include:

- Advice and information on a wide range of drugs, their effects and safer use including alcohol
- Advice and information relating to primary & poly-drug use including alcohol consumption

- Health promotion advice and information
- Advice and information relating to overdose prevention, blood borne viruses, safer sex & sexual health
- Information around treatment services and referral pathways both in prison and in the community
- Brief motivational interventions designed to reinforce harm minimisation messages and promote the subsequent uptake of treatment services.
- Specific information around the risks of using in prison i.e. debt, diversion and misuse of controlled substances for example crushing Subutex and storing in the mouth to be sold later, hooch, missing medication meant for someone else.

Where prisoners are not able to access interventions from non-prescribing service staff we will promote the uptake of Peer Support. Many prisoners believe the most credible people to support & advise them are other users. Inclusion supports this where Peer Supporters are well motivated and properly trained. From experience, we know that effective peer support can contribute to safer prisons, improve health & reduce anxiety. In several of our prison services we have established Peer Supporter networks as follows:

- Peer Supporter prisoners give up to date advice, information & support on drug and alcohol issues.
- They encourage other prisoners to engage in their own self-care and take up other services where possible.
- They provide an informal listening service to prisoners with drug and alcohol issues.
- They can encourage regular compliance testing & be committed to the Compact Based Drug Testing programme (voluntary drug testing).
- They promote referral to the service
- They can access the hard to reach prisoners who may not wish to engage

Inclusions takes the view that Peer Supporters:

- Must be committed to abide by the confidentiality guidelines.
- Are vetted by the security department.
- Undertake basic training in listening & communication skills.
- Are supervised by an identified worker on a regular basis.
- Attend monthly peer supervision meetings.
- Positively advertise the service

Where a prisoner is excluded from the non-prescribing drug and alcohol service, we will ensure that they are signposted to other relevant services within the prison that may help to meet their needs. Such sign posting will, where appropriate, be accompanied by information sharing that includes reasons for exclusion.

4. Section 6.0  
Sub heading 6.3.1  
iv

Liaison with  
other service

How will the service work with Healthcare to ensure prisoner's treatment is recovery focussed and regular joint care plan reviews are conducted?

### Weighting 5

### Maximum word

**count of 1000  
words**

***Contractors response:***

Inclusion understands that the majority of prisoners will have already undergone detoxification before arrival at HMP Whitemoor. However, for those prisoners who do detoxify on-site, are in receipt of some form of substitute prescribing or other clinical intervention delivered by the prescribing service staff based in Healthcare, the service will prioritise recovery-focussed joint working. This will also apply to any prisoner identified as being at risk of self harm or suicide. Inclusion are clear that prescribing and non-prescribing prison services must work in close collaboration in the interests of the prisoner and the wider establishment. We understand that there is a possibility of co-locating the prescribing and non-prescribing services in future and Inclusion will actively support this in principle.

To foster recovery focussed joint working we will:

- Agree working protocols with Healthcare managers & staff and ensure that these are ratified by the Establishment Drug Co-ordinator, with regular reviews taking place.
- Supply a copy of the confidentiality agreement in all cases, and offer a copy of the care plan where treatment is an agreed objective to inform continuity of care and avoid duplication of advice and information
- Agree resource contribution to strands of joint working, which should include staff cover arrangements in times of sickness absence.
- Establish joint planning structures involving Inclusion managers, Head of Healthcare Russ Edwards and front line staff to support communication, debate and problem solving.
- Agreed areas of activity between ourselves and Healthcare.
- Develop a clear understanding of boundaries: this is particularly important to ensure good working relations.
- Jointly agreed target setting and jointly agreed objectives.
- Agree a system to evaluate the joint work and working arrangements on a regular basis.
- Jointly developing a system which incorporates seeking the views of service users and others regarding interagency collaboration.
- We know that effective multi-agency partnership work based on good will and a shared ethos to deliver the best provision will reduce fragmentation within the treatment/care system. However written agreements and regular meetings are of little worth if there does not exist a deeper understanding and appreciation of the values and roles of partner agencies. We believe that energy put into understanding partner agencies early in the start-up phase will prevent a silo mentality emerging and will further reduce the risk of fragmentation. The team will also be encouraged to attend the RCGP1 certificate to gain an understanding of treatment planning and prescribing processes.
- Ensure that the non-prescribing drug and alcohol service retains a clear case management lead for all prisoners who are receiving prescribing or other clinical interventions.
- Facilitate joint team meetings involving prescribing and non-prescribing service staff at regular intervals to promote information sharing, discussion of good practice, case reviews and service development.
- For those prisoners undergoing detoxification, ensure a robust package of

psycho-social interventions are delivered throughout the detoxification period and beyond.

- Operate an agreed, joint approach to record keeping to ensure all prisoners have up-to-date case files detailing all substance misuse related interventions and relevant case histories. This will be of particular importance upon prisoner release where communication with CJIT's is of high priority to ensure continuity of treatment.
- We will ensure that Healthcare staff involved in prescribing and other clinical interventions are familiar with the full suite of node link maps used by the service.
- Clearly defined exit strategies will be agreed with all those involved in care packages including Healthcare, Offender Management Unit, Compact Based Drug Testing team and Safer Custody.
- Where possible, we will seek opportunities to co-facilitate groupwork sessions with the prescribing service to promote harm minimisation, support care plan goals and develop joint transfer/release plans.
- Where resources allow, non-prescribing service staff will maintain a presence within the Healthcare Unit specifically to allow joint working with prisoners receiving prescribing or other clinical interventions.
- Conversely, we will expect all prisoners in receipt of prescribing or other clinical substance misuse interventions from Healthcare to have a named Nurse assigned to their care to promote communication, information sharing and joint working.
- As an experienced provider of both community and custodial prescribing and other clinical services we are in the position to offer Healthcare colleagues training at different levels as required. This can include general educative information around substance misuse, recovery-orientated prescribing packages, Blood Borne Virus information, Relapse Prevention, Overdose prevention, and substance misuse & mental health. Training\support can also be delivered on a more informal basis; this can include providing Healthcare staff with opportunities to spend time in the Cambridge Adult Treatment Service observing clinics, dispensing & shadowing practice. These opportunities can also help to improve experience of recognition of physical & emotional indicators of withdrawal, problematic alcohol issues such as delirium tremens or coping with aggressive behaviours, recognising injecting sites, wounds & infections associated with intravenous drug use, recognition of those who are still intoxicated, differences in the way drug users present, cold like symptoms for those who sniff crack/cocaine, runny nose and general nose irritation.

5. Section 6.0  
Sub heading  
6.3.5

Throughcare

How will the service ensure that prisoners are effectively referred on to another prison establishment and care coordination/treatment planning is maintained on transfer? How will CJIT be informed of any changes?

**Weighting 4**

**Maximum word  
count of 500  
words**

***Contractors response:***

Inclusion is an experienced provider of prison-based prescribing & non-prescribing treatment services and the Drug Intervention Programme in the

community. We are therefore well placed to ensure that effective care co-ordination and treatment planning is maintained when prisoners move within in the prison estate, through effective working procedures and information sharing agreements. Given the nature of the Category A population within HMP Whitemoor, we understand that prisoner transfer destinations are likely to be numerous and well dispersed across the country, rather than a significant number of purely local releases. With this in mind, robust communication with a wide range of receiving establishments and CJIT's will be required.

To ensure effective prisoner transfer arrangements are in place we will:

- Develop and maintain excellent working relationships with Observation Categorisation & Allocation (OCA) at all times to promote the flow of timely, accurate information about planned prisoner transfers and an awareness of overcrowding drafts and security-related transfers in and out of HMP Whitemoor. The service will also cultivate effective links and develop protocols with Security, Offender Management and other prison departments influencing prisoner transfer.
- In all cases, completed prisoner Transfer Plans will be included in the Prisoner Core Record upon transfer, or in cases where transfer has taken place before we have been informed (this is quite likely in a high security estate due to the issues surrounding secure escorting - transfer often take place quickly and covertly), using recorded mail delivery systems within 5 days of the actual transfer taking place. The receiving prison Single Point of Contact (SPOC) will also be notified via secure email. At this point, the relevant CJIT will be informed of the prisoner transfer. Wherever practicable, the Transfer Plan will be completed with the prisoner present to ensure ownership, completeness and continuity of care. .
- The service will ensure it completes are relevant 'alert forms' in the stipulated timescales and share this information promptly with the relevant CJIT.
- Where prisoners are transferred into HMP Whitemoor, the non-prescribing drug and alcohol service will see the prisoner within 5 working days and take up outstanding assessment, care planning and case work interventions as appropriate to each prisoner. Where relevant, joint working with Healthcare around prescribing and other clinical needs will be prioritised.
- Ensure all case files are accurate and up-to-date upon transfer to another establishment. This will give the receiving prison the best possible opportunity to build on the prisoner's progress to date and should include information such as completed assessments, current care plan and progress against agreed goals, psycho-social interventions delivered and testing results.
- Given the geographical nature of the wide range of CJIT's HMP Whitemoor is likely to liaise with, attendance at community forums and CJIT meetings will be limited. However, this will place the emphasis upon clear lines of communication using email, fax, telephone and post. DIP workers can be invited in visit and telephone assessments can be arranged prior to release.
- The Administrative support provided to the service by HMP Whitemoor will serve an important function with respect to transfer arrangements. Our expectation is that the Administrator will enjoy good relations with a range of prison departments, in particular OCA, and these relationships will help relevant information flow to and from the service as required.