SERVICE SPECIFICATION

FOR THE PROVISION OF

AN ASSESSMENT REVIEW AND MONITORING SERVICE

AND

RECOVERY PLANNING

(Schedule 1 of the Agreement)

Southampton City Council

Contents

Overview of the new Drug and Alcohol Integrated Treatment Model:

Southampton and Hampshire DAAT areas were part of the National Treatment Agency (NTA) Systems Change Pilot in 2009-11, and pioneered the use of Self Directed Support and Personalisation in their substance misuse services. Southampton City Council now wishes to incorporate this approach into service provision. The new treatment pathway will therefore be commissioned in order to achieve more personalised outcomes for service users.

The new integrated substance misuse treatment system will comprise 3 elements:

- Early Support, Assessment and Planning service (ESAP) for young people aged between 11 – 24 years.
- Assessment, Review, Monitoring and Recovery Planning service (ARM service - for adults aged 25 years and over)
- Service delivery

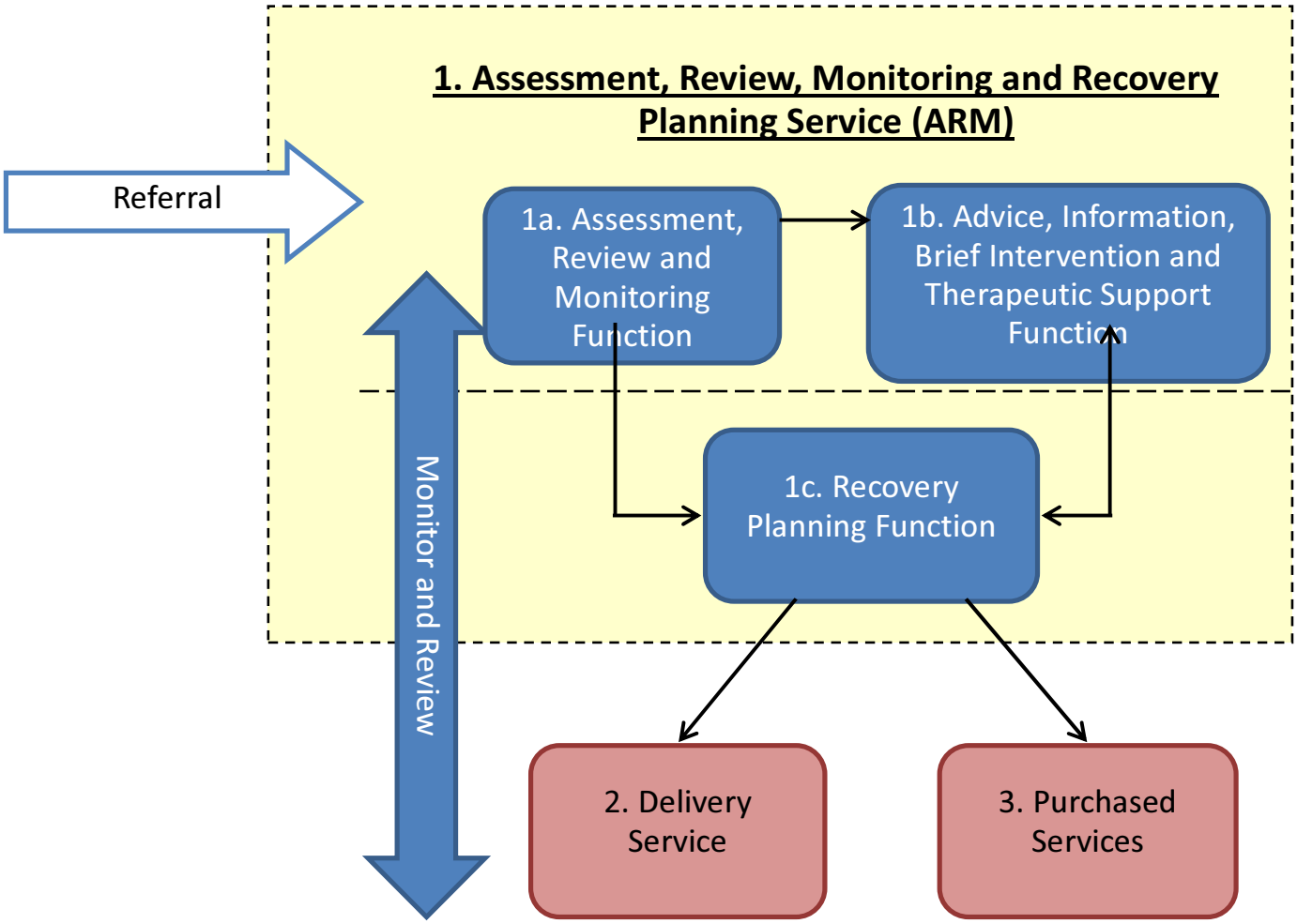
Referrals will access the Assessment, Review and Monitoring service (ARM or ESAPS) (see box 1), where they will be assessed for level of need.

Those requiring low level intervention will be provided with a brief intervention, advice and information.

Those with more complex substance misuse problems will have their full range of needs assessed. Where relevant, a *personal budget* may be agreed and allocated. Following assessment, individuals will access appropriate levels of support (commensurate with capability) in order to develop their Integrated Care Plan or Recovery Plan, which must be agreed and signed off by the assessor.

A range of services will be available to the service user through the commissioned treatment services (Box 2), with increasing flexibility to secure some services within a *Personal Budget (Box 3)*

The Integrated Care Plan/Recovery plan will be monitored and reviewed by the ESAP or ARM service throughout the individual's treatment journey with changes agreed as appropriate. The assessor will case manage the service user and will refer to treatment services as necessary.



The Service model

The diagram above shows where this service fits within the new model of substance misuse treatment services in Southampton.

This service will provide stage 1 of the treatment model above. Service users will either self refer or be referred to the ARM service by other professionals. The ARM service will provide a single point of entry in to treatment for substance misuse in Southampton. It will offer assessment and where appropriate, information, advice and brief interventions in order to provide early support to those seeking treatment for problems with substance misuse.

Following initial/full assessment, the ARM service will provide assistance with recovery and support planning (where this is required), case management and regular review of how the service user is progressing and whether the interventions provided are delivering the required outcomes.

Once the initial or full recovery/support plan has been prepared, the ARM service will refer the service user on to stages 2 and 3 of the treatment system as necessary, where the service user will be able to access a wide range of services and treatment opportunities.

The ARM service will be involved with the service user at every stage of the treatment system. It will therefore be the key to the effectiveness of the model.

The ARM assessors will have a significant role in being responsible for accessing drug and alcohol treatment packages from both commissioned services and from the private sector. The role will also provide advice, sign-posting and motivational and engagement work in order to keep the service users involved with services and engaged in effective treatment.

1. INTRODUCTION

This specification has been developed to set out Southampton City Council's requirements for services in line with a recovery focused drug and alcohol treatment system and details the system objectives and interventions to address identified drug and alcohol related needs. The commissioners wish to reshape the current adult drug and alcohol service provision into a whole-systems, integrated drug and alcohol treatment pathway, which increases the number of people able to achieve sustained recovery from dependence by providing individual support and treatment packages of care and which reduces the harm caused by addiction and dependence..

2. Background Information:

Southampton City Council is responsible for commissioning services in order to deliver the 2010 National Drug Strategy and the 2012 Alcohol Strategy in Southampton. For a significant number of people drug and alcohol consumption is a major cause of ill health. Drug and alcohol dependency is a complex health disorder with social causes and consequences. Drug use is linked to everything from heart and respiratory problems to psychosis and seizures, while heavy drinking is known as a causal factor in more than 60 medical conditions. Added to that is the increased likelihood of suffering violence and having unprotected sex that is seen among heavy drinkers and drug users.

Not all drinkers and drug users go on to develop addiction problems. There are just over 306,000 adult heroin and crack cocaine users in England with more than half receiving treatment in the community or prisons. Overall numbers in treatment have fallen gradually in recent years. Among young people, addiction problems are also decreasing. Just over 20,000 under 18s accessed substance misuse services last year – the overwhelming majority for cannabis or alcohol problems – a fall of six per cent in a year.

Experts agree it is hard to say exactly what has prompted the trend. It is likely to be a combination of factors from better access to treatment and health promotion campaigns to a wider cultural shift away from traditional drug use. However, as this has happened there has begun to be growing concern about the use of Novel Psychoactive Substances (NPS), sometimes referred to as legal highs – substances that mimic the effect of banned drugs, such as cathinones.

By comparison, alcohol-related problems among adults have been getting worse on many measures. Both hospital admissions and deaths linked to drinking have increased since the early 1990s. Overall it is estimated over 1m people in England have mild, moderate or severe alcohol dependence. About a third of these will face challenges that are similar to those people who are dependent on drugs.

While in the past the focus of drug treatment has been on reducing harm through schemes such as needle exchanges, current strategies favour an approach which places more emphasis on achieving recovery and abstinence. In addition to addressing

traditional drug use, dependency on prescription drugs and legal highs needs to be tackled.

Drug services in Southampton have been successful in targeting opiate and crack users for entry into treatment, some of whom are offenders, and there has been a year on year increase in the numbers entering and being retained in treatment.

The alcohol treatment system in Southampton has been subject to re-design over the last two years. This re-design has been successful in reducing waiting lists and times, as well as ensuring that treatment is available to an increased number of service users through a better defined treatment pathway. There had also been a reduction in alcohol-related hospital admissions. However, services experienced an increase in demand, with a high proportion of service users entering treatment at an increased level of complexity.

3. National and Local Drivers for Change:

The following documents have influenced the development of this specification (although not exclusively):

- Drug Strategy 2010 - "Reducing Demand, Restricting Supply, Building Recovery" http://www.homeoffice.gov.uk/drugs/drug-strategy-2010
- Alcohol Strategy 2012 – http://www.homeoffice.gov.uk/drugs/alcohol-strategy/
- All relevant NICE guidelines.
- Putting People First 2007
- Personalisation through Person Centred Planning 2010
- Improving services for substance misuse services – National Treatment Agency
- Systematically addressing health inequalities 2008. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_086570
- Health and Social Care Act 2000
- Gaining Healthy Lives in a Healthier City 2012. http://www.southampton.nhs.uk/aboutus/publichealth/hi/jsna2011
- Building Engagement, Building Futures 2011. http://www.education.gov.uk

- Health and Social Care Act 2012. http://www.dh.gov.uk/health/2012/06/act-explained/

- Tackling Drugs and Alcohol- Local Governments Public Health role. http://www.local.gov.uk/c/documentlibrary

4 Aims of the integrated treatment system (of which this service is one part):

The new drug and alcohol integrated treatment and recovery system in Southampton aims to provide a life changing, personalised substance misuse recovery pathway for the City, bespoke to the needs of individuals and communities. The Commissioners expect to build a strong and effective working relationship with the Provider, with shared values and vision regarding the delivery of the contract. The aim is to create an integrated treatment pathway that increases access to treatment and reduces the harm that problematic substance misuse causes to our communities, as well as helping people overcome dependence.

The new service model will have the following components:

- Assessment, planning and early support service (11 – 24 year olds)
- Assessment, review and monitoring service (24+ year olds)
- Commissioned Treatment Services
- Purchased Services

The commissioned treatment services will be delivered by a different provider than both the ESAP and ARMs. The ESAP and ARMs will be provided by one or two different providers

Those that aspire to making a full recovery from addiction will be enabled to do so, whilst a small number of others whose addiction may be long standing and complex, will be offered the opportunity to reduce the harms caused to their health and to the local community or to plan for the end of life in dignified and caring surroundings.

Recovery will be the primary goal of the integrated system and it is vital that the service as a whole and individual workers understand the principles of recovery. The UK Drug Policy Commission defines Recovery as:

"The process of Recovery from problematic substance misuse is characterised by voluntary sustained control over substance use which maximises health and well being and participation in the rights, roles and responsibilities of society".

5 The objectives of the new service model:

- To enable and support individual recovery from substance misuse and dependency and through appropriate treatment to live healthy, safe and crime free lives.

- To provide services that are easily accessible and which structure treatment around

the needs of the individual by providing personalised opportunities for sustained recovery and high levels of service user choice.

- To pro-actively work to re-engage individuals who have left the system prematurely.

- To improve the outcomes for children of service users by reducing the impact of drug and alcohol related harm on family life and to promote positive family involvement in treatment.

- To reduce the harms associated with substance misuse to the individual, the family and the community (including social exclusion, stigma, those related to offending, drug and alcohol related illnesses and accidents, unemployment, domestic violence, family breakdown and reduced ambition for children).

- To ensure that principles of harm minimisation underpin the delivery of all interventions in order to reduce the harm caused by drugs and alcohol on individuals, thereby contributing to a reduction in drug and alcohol related deaths and the transmission of blood borne viruses.

- To reduce the harm caused by drugs and alcohol to communities including contributing to a reduction in crime and anti social behaviour.

- To reduce the burden of drug and alcohol misuse on the wider public sector economy by promoting effective treatment and harm reduction responses in a range of settings including primary and community health care, mental health and criminal justice services.

- To improve the health and wellbeing of service users and their friends and family

- To safeguard adults, children and young people by developing effective practices and integrated approaches to safeguarding, in accordance with related national guidance, Southampton Safeguarding Children's Board (SSCB) and the Southampton Safeguarding Adults Board guidelines.

6. Scope of the new service model:

The new integrated treatment and recovery service will replace current drug and alcohol treatment services commissioned by Southampton City Council, with the exception of the tier 1 and 2 alcohol information/advice counselling service and the Alcohol Specialist Nurse Service.

7. Principles of Service Delivery:

Partnership working: approaches to treatment and recovery which are built around a multi agency partnership. The treatment system will engage with housing, health, education, employment, leisure, wider social care and family sectors in order to provide

an holistic service to service users.

All inclusive: Recovery means different things to different people. For some, abstinence will not be immediately attainable. Both abstinent and non-abstinent pathways will therefore be available and all interventions will be underpinned by a strong ethos of harm reduction.

Family oriented: Families play an important part in supporting recovery and the treatment system will therefore need to identify and respond to the needs of the service users' family.

Enabling: empowering and enabling service users to ensure that they feel fully involved in the treatment and recovery planning process and the planning, monitoring and delivery of the service as a whole.

Personalised: services will be delivered within the philosophy of personalisation (see section 7).

Active engagement: Recovery will be viewed as a process. Lapse and re-lapse is part of the learning process but pro-active systems within the treatment service will support re-engagement and long term support for service users leaving the treatment system.

Improving Health and Well being of service users, carers and families: reflecting the holistic needs of service users and their friends and family.

User led: service users, their family and friends must be central to the development, delivery and the evaluation of services.

Asset Based: reflecting the valuable and unique experience of service users and using that asset to develop peer approaches in order to build recovery capital which is sustainable.

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

Performance Orientated - having robust performance management systems that will give timely information to commissioners in order to manage performance against agreed outcomes and targets and support service delivery and development. Continuous improvement must be part of the ethos of the service.

8. Service Specification - Assessment, Review, Monitoring and Recovery Planning service (ARMs):

Aims of the service

The service will:

- Provide easily accessible front door and a single assessment service for anyone seeking advice or help to address a substance misuse problem.
- Provide early help and brief interventions based on the service users need
- Plan and facilitate access to treatment services
- Monitor and review the treatment journey
- Provide a high quality, detailed and personalised assessment and Recovery Action Plan (RAP) for every service user entering the treatment system
- Place the needs of service users at the core of the service, promoting their health and well-being.
- Engage with service users and motivate them to remain in effective treatment. It will raise the aspirations of service users and promote their eventual independence.
- Provide opportunities for self development and the development of skills which will enable the service user to re-engage with their local communities.
- Encourage and enable service users to achieve their own stated goals within the treatment system, whether this is abstinence, maintenance on substitute medications or harm reduction.

Objectives of the service

- To enable the service user to address their treatment needs by ensuring access to personalised treatment and support services, whatever their drug of choice.

- To provide support and recovery planning processes that enable service users to identify their own needs, goals and outcomes.

- To work with other treatment providers and agencies (e.g. Probation, police, mental health services, SCC Peoples Directorate) and develop joint support and recovery plans with service users, where appropriate.

- To case manage the service users treatment journey.

- To enable access to appropriate wrap around services, volunteering, meaningful activities, peer support and families and carers support.

- To accurately and regularly (i.e. every 12 weeks) review the service users Recovery Action Plan (RAP), measure progress, record outcomes and update the plan, providing a blueprint for the service users journey to Recovery together with appropriate timescales for the achievement of the next segment of the journey.

- To record and monitor data in keeping with the appropriate local and national requirements.

9. Description of the service:

This Service is commissioned to provide advice, information treatment and support to anyone concerned by their drug or alcohol. When assessing the needs and planning the care of an individual **all** substance misuse will be considered, including opiates, alcohol, cannabis, benzodiazepines, stimulants and hallucinogens, novel psychoactive substances, prescribed and over the counter medicines.

The ARMs service will provide a city wide **single assessment, review, monitoring and recovery planning service** for service users entering the treatment system, (including those service users who are part of the criminal justice system.)

The provider will work with adults (aged 24 years and above) with substance misuse problems, who are likely to be chaotic and to have complex needs, as well as those with higher level of needs due to medical and other issues.

The service will provide a **single point of contact** for all service users apart from those wishing to directly access Harm Reduction.

The ARM and Recovery Planning process will follow these distinct steps:

1. Assessment (including the completion of a risk assessment addressing risk of harm to self and others)
2. Resource allocation where appropriate (i.e. where detoxification is part of the Recovery Action Plan)
3. Recovery/support Planning
4. Sign off & budget allocation **(including access via referral to the service delivery element)**
5. Review/ monitor

Initial assessment (triage) and Interim Recovery Action Plan:

An initial assessment will be completed in order to address the urgent and immediate needs of the service user on presentation to the service.

The initial assessment will deliver the following:

- Crisis interventions
- Brief interventions
- Reablement. (Reablement is an important tool in adult social care. It is often used in connection with elderly service users and means the provision of personal care, help with daily living activities and other practical tasks in the short term. Reablement encourages service users to develop the confidence and skills to care for themselves and develop the skills to live in the community. In the context of

substance misuse it will mean encouragement to take responsibility for planning their recovery and retain their independence within the community.

Comprehensive assessment:
Following the initial assessment, where a need for structured intervention has been identified an appointment will be made for a Comprehensive Assessment to be carried out. Whilst the service user's immediate needs are being addressed via the interim Recovery Plan, the **full assessment** will be completed and a full **Recovery Action Plan (RAP)** will be formulated, prior to commencing the most appropriate intervention(s) to address their drug and/or alcohol needs.

The key principles underpinning the assessment will be:

- Service users are offered a timely assessment of need and are informed about what to expect
- Service users experience a collaborative assessment and are fully informed and involved in all decisions about their care
- Comprehensive assessments are effectively co-ordinated to support the service users continuity of care and existing relationships with other professionals
- Assessments will be comprehensive, recovery & outcome focused and according to need

The service will ensure that the assessment process is user led and will, through a variety of approaches, promote self assessment and supported self assessment as a preferred method.

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

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

A full **risk assessment** shall be completed including their level of risk awareness to ensure that interventions to reduce risks are prioritised. . Where risks are identified, a risk management plan will be developed, implemented and linked to the service users' integrated care plan. This must be subject to regular review. Information relating to risk will be shared and acted upon according to the local risk assessment framework.

Risk assessment will take account of self-harm, risk from others, risk to others, housing, sexual exploitation, domestic violence and an appropriate action plan put in place to address these risks.

Assessment will be available in a range of settings to suit the needs of the service user, their family and the wider strategic priorities including specialist, primary and secondary care settings

The service will ensure that the assessment process is user led and will, through a variety of approaches, promote self assessment and supported self assessment as a preferred method.

Once the initial or full Recovery Action Plan has been completed, it will be the responsibility of the ARM assessor/lead practitioner to **refer** the service user to the appropriate commissioned services or provider of purchased services, in order for the service user to commence structured treatment.

Case Management, review and monitoring:
The ARMs has responsibility for the **case management** of all service users, ensuring their treatment journey is appropriate, progress is being made and that ultimately service users are working towards a planned exit from treatment.

The ARMs will have responsibility for the completion of any appropriate **review and/or monitoring tool** for the individual service user. For drug users, this will be at a minimum the Treatment Outcome Profile (TOPs). For alcohol users this could be the Alcohol Outcome Star. The ARM service will be responsible for the timely completion of all nationally required monitoring.

The ARMs service will be responsible for **monitoring and reviewing the Recovery Action Plan (RAP)** at regular 12 week intervals throughout the service user's treatment episode.

The ARMs must ensure that a variety of interventions are accessible to meet the service user's unique needs.

The ARMs must also meet the **needs of families and carers** of service users, giving the opportunity for families and carers to access the treatment system either as part of the service users' treatment or in their own right.

It will **motivate service users** to access and engage within structured forms of treatment to meet their recovery objectives.

Service users will be provided with clear, concise and consistent information about available services and interventions;

The service will actively plan for and manage service users **move on from structured treatment as part of the treatment plan**.

Direct payments:

The ARM service will have responsibility for managing a budget which will be used by service users to purchase certain services from providers outside of the treatment system. Once the Recovery Action Plan has been completed, the ARM assessor will need to establish the cost of any treatment packages or interventions that are not to be accessed from within the commissioned services.

Treatment options that fall within the criteria of the Care Management budget must be agreed with Adult Health and Social Care staff, who have the authority to agree funding. Protocols for working alongside AH&SC teams and for access to this budget will be finalised on appointment of the new service provider. Other specialist, personalised treatment options or activities may be funded via the Personalisation budget, to be held by the ARM service.

The ARM will thus have access to two distinct resources in order to facilitate service user access to personalised treatment options.

1. **Care Management budget:** for service users who meet the Adult Health and Social care criteria for access to the Care Management budget (i.e. their needs must be assessed as "critical and substantial"). This is likely to include service users who require detoxification or residential rehabilitation.

2. **Direct Payment Budget:** The ARM service will have responsibility for the management of the Direct payments budget. The service provider will be expected to produce a protocol detailing the criteria for access to the direct payment budget in agreement with commissioners. ARM assessors will cost any services to be purchased from this budget and present the Recovery Action Plan to the service manager(s) who will sign off the plan together with any proposed expenditure.

The amount of the direct payments budget will be notified at the time of the award of the contract.

It is expected that the direct payments budget will increase over the life of the contract as the market develops locally. The ARM service will therefore be expected to be aware of new service developments within the city and take an imaginative and innovative approach to encouraging the development of relevant and effective treatment and activity options for service users when developing Recovery Action Plans.

The service will also deliver the following:

- Provision of information and Brief Advice;
- Provision and support for service users to access a choice of detoxification programmes, including community detoxification where appropriate.
- Provision and support to access a range of residential rehabilitation models and

packages and post rehabilitation planning.

- Responsibility for working with the appropriate worker and agency regarding Criminal Justice requirements (e.g. court reports Drug Rehabilitation, people released from prison etc.);
- Assertive outreach – the provision of an assessment within a variety of settings, including custody suite/s and prisons;
- Proactive engagement and encouragement for those individuals who do not wish to engage with treatment at this stage or are unmotivated;
- Follow up on those who do not attend their arranged appointment;
- Encouragement and support for those complex service users who want to stabilise and "maintain";
- Liaison, referral and intervention with/alongside other agencies as appropriate and relevant to the recovery action plan (including Mental Health Services, Criminal Justice Agencies, other health services, housing, education, training and employment, families and Children's Services, Adult Safeguarding);
- A focus for all communication in relation to the recovery action plan within defined timescales, including progress reports, multi-agency decision making processes and other services' responses;
- The management of information capable of recording outcomes relating to the individual's engagement and recovery.
- The management of budgets relating to the purchase of services provided outside the treatment system.

The duration of service will differ between service users and depend upon their level of need for treatment and support. However, it is expected that the average length of support would be between 12 months and 2 years, although for many a much shorter period of time will be required. It is expected that some people may need short periods of more intensive treatment and support and others may need to retain a low level of contact for lengthy periods.

The provider will inform service users how they can access emergency and other services should they need help outside of the hours provided.

Brief Interventions, Therapeutic Work and Outreach to be provided

The provider will deliver the following interventions as appropriate. This will include:

- Targeted outreach work
- Provision of information and brief advice
- Brief interventions
- Solution focused work
- Problem solving techniques
- Follow-up work for service users disengaging from treatment
- Health Promotion and risk reduction including substance misuse, sexual health, awareness raising advice on safer drug use and needle exchange (where applicable) etc…
- Advocacy – where necessary acting as a contact point for individuals engaged in drug/alcohol recovery schemes, expressing their views or acting on their behalf

to help them secure the most appropriate services;

- Assertive outreach – the provision of an assessment within a variety of settings, including custody suite/s and prisons;
- Structured counselling
- Relapse prevention
- Partnership working with key partners, e.g. Police, Probation, Children and Families Services
- Assessment for needle exchange provision

Practical help and support

The Service will provide practical help and support either directly or through other services in line with the needs of each service user as identified in the assessment. This could cover a range of options such as support with accommodation, accessing other services, accessing transport, support via other professionals or volunteers, with benefits application, support with Court appearances and legal obligations, registering with health services, etc.

10. Recovery Planning

Recovery Planning is an integral part of the ARM service. It may be delivered as part of the assessment process by the ARM assessor or it may be delivered separately once the assessment has been completed.

This part of the service will empower individuals to develop their own plans, using appropriate methods such as web based tools and self help tools. The service provider will develop a range of measures to facilitate this which will be responsive to the capability of the individual.

Every service user must have an agreed Recovery Action Plan within a maximum of 2 weeks (i.e. 10 working days) of commencing the service.

The service user will write a Recovery Action Plan either independently or with assistance, in line with assessed level of support. Assistance may be in the form of help from others including family members or carers, peer mentors or by a member of the ARM service, where they will be offered guided self help to formulate the plan. The level of assistance will always be in line with the assessed level of support need for the service user:

Level 1: Minimal (i.e. self help) or no help required. Advice and information may be required to help service users complete the Recovery plan themselves.

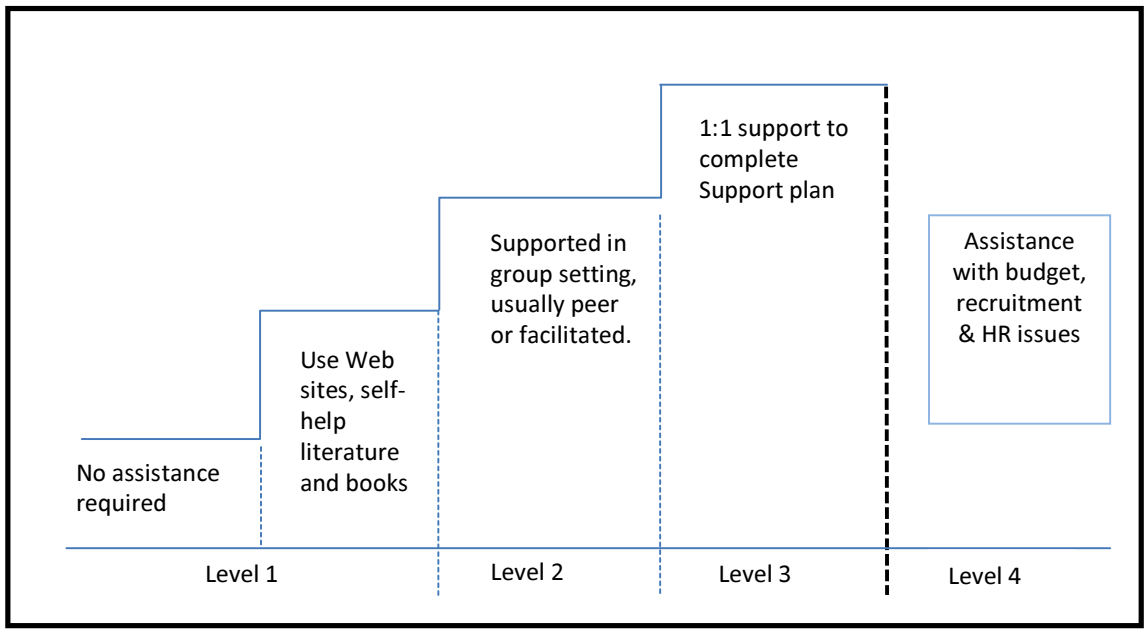
Level 2: Individuals need some assistance in completing their Recovery plan, likely to be in the style of peer support or group setting, with some assistance from a facilitator.

Level 3: One to one support is needed to help the individual prepare their Recovery plan.

Level 4: Support needed with the execution and implementation of the treatment plan once agreed for example, the recruitment of Personal Assistants, setting up bank accounts and payment for services secured.

(See diagram 1 below)

Diagram 1 - Stepped approach to Recovery Planning:



Recovery Planning will empower individuals to mobilise their skills, assets and networks to best prepare the relevant plan for their treatment. There are three types of plans proposed, they are:

- Recovery Action Plan
- End of Life Plan (often referred to as using the Gold Standard Framework, and in the end stages of life, the Liverpool Care Plan)
- Risk/Harm reduction plan

Where possible, service users will be allocated the level of funding/ support available to them to meet their needs by the ARMs service. During the assessment process they will be informed about the methods by which their funding is available. For some elements the service will sit within a block contract, for other areas funding may be available as a direct payment, personal budget or indicative budget.

Budget allocations are usually provided as an indicative figure to inform the planning process. The final amount will be dependent on the formation of a plan, agreed by the

service user, their lead assessor and any other individual identified to be key to the decision making process (i.e. carer or professional). The Recovery Action Plan will need to be compliant with certain core requirements. This will include as a minimum:

- The plan will meet the relevant needs of the individual,
- The plan is deemed to be clinically safe (where medical interventions are being secured)
- The plan addresses areas of risk or concern highlighted in the assessment

Planning, monitoring and review will be a dynamic and empowering process involving the service user and where appropriate, professionals from partner agencies involved in the service users on-going treatment. This will include the service user's family and / or significant others with service user consent.

The provider will ensure that planning for treatment addresses the entire social and reintegration needs of the individual in order to sustain recovery, plan for end of life or reduce risks/harms.

The Recovery Action Plan will bring together information and where relevant the involvement of agencies and individuals to address issues such as housing, employment, finance, childcare and transport. In this way the Recovery Action Plan will support a sustained lifestyle change that will help to prevent relapse or best meet the service user immediate needs. This will also create a shared responsibility for, and ownership of, successful outcomes.

Types of plan:

Recovery planning (i.e. developing the Recovery Action Plan) will be the main and primary form of planning available, with the two others, End of Life and Risk Reduction being used in limited circumstances.

Recovery Action Plan:

Recovery planning will draw on the needs identified in the assessment, which will include recovery from problematic substance use and in doing so, will form the basis of the recovery plan and include:

- timescale for recovery
- wider needs that are key to achieving recovery
- management of risk during recovery
- services and support to be used to help address the individual needs and achieve recovery.
- The individuals own assets which will be important in achieving recovery

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

End of Life plan:

End of life care is support for people who are approaching death. It helps them to live as well as possible until they die, and to die with dignity. It also includes support for their family or carers.

The National Treatment Agency has noted that there are many older substance misusers who require treatment. For this reason it is vital that drug and alcohol treatment services are able to respond to the growing number of service users who may die while still involved with the treatment system.

For alcohol users there is evidence to suggest that increasing numbers may be affected by liver disease. There are a number of reasons why end of life care for people with liver disease is particularly challenging. Patients tend to be younger and often come from either isolated or ethnically diverse subcultures. They are more likely to have come to healthcare attention by circuitous routes of access. They may feel great stigma associated with their disease, the progress of which is punctuated by acute exacerbations. Most of all, perhaps, it is challenging because the cause of their death may have been preventable.

When a service user is assessed as being in the final 12 months of their life an End of Life plan will be drawn up. It may be recognised that the service user is unlikely to recover, but interventions may still be required in order to make the individuals life more comfortable and dignified.

End of life planning will follow the main components of the Gold Standard Framework and be available for those identified through an appropriate clinical team using the 'magic question' (those who are not expected to live more than 12 months).

EOL planning includes

- The patient's wishes, preferences or fears in relation to their future treatment and care.
- The feelings, beliefs or values that may be influencing the patient's preferences and decisions.
- The family members, others close to the patient or any legal proxies that the patient would like to be involved in decisions about their care.
- interventions which may be considered or undertaken in an emergency, such as cardiopulmonary resuscitation (CPR), when it may be helpful to make decisions in advance.
- The patient's preferred place of care (and how this may affect the treatment options available).
- The patient's needs for religious, spiritual or other personal support.
- Discussing and planning where the person would like to die.
- Funeral arrangements.
- Contact and involvement of Next of Kin and/or significant other.
- Burial arrangements.

Risk/ Harm reduction Plan

The inclusion of Risk /Harm reduction plans recognises that for some individuals recovery is not a realistic option or goal. It is envisaged that this planning approach will be pursued by a limited number of individuals. For most, reducing risk associated with levels of alcohol consumption or reducing harm from injecting behaviours (as well as other risk or harm behaviours) will be incorporated into their Recovery Plan as a first step towards recovery. The plan should be reviewed regularly with a view to moving to a Recovery Plan.

Risk/Harm reduction planning will include:

- Steps to be taken to reduce risk/harm
- Key support networks, family, carer and significant others available to assist
- Measures, flags or triggers that highlight risks/harms are increasing
- Services and support needed to reduce risk/harm.

For all types of planning the following will apply:

With consent, the assessor will refer service users to and support their engagement with other relevant services to meet those identified needs. The service will share plans and proactively foster partnership working with providers to develop appropriate services. It will jointly monitor progress with the assessor and assist in developing the plan.

All plans will be developed by the services user, with assistance where appropriate, and agreed with the assessment team/ lead professional. The service user will retain and sign a written copy.

Unmet treatment need shall be recorded on all recovery plans and the single information management system. Areas of unmet need should be collated and provided in summary report format to the commissioners to support needs assessment processes and planning.

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

The provider will undertake an annual audit of Recovery plans against recognised guidelines or commissioners expectations.

Key findings from the annual audit including action plans for improvement, shall be presented and discussed at contract monitoring meetings.

The service will recognise that the needs of individuals will be subject to change, often due to a range of circumstances. This will require changes in response, sometimes at short notice. Where this occurs the Recovery Action Plan will be updated to reflect the changes to approach within the delivery of services.

Transfer of care from Young Peoples services:

- The provider will be expected to develop robust protocols for the transfer of young adults from the Young Peoples Early Support, Assessment and Planning service (ESAP) in order to ensure that young people and young adults are offered continuity of care when they move on from the service.
- The service must produce a joint transition plan with ESAP.
- The Service and ESAP will develop protocols for transition work. These will be signed off by commissioners by end of quarter 1 of the contract
- The service must comply with the Southampton City Transition Policy
- The young person's Lead Professional should jointly work with the adult services, ARM to make this a seamless transition as possible

11. Eligibility criteria:

The Assessment, Monitoring, Review and Recovery Planning service will be for residents of Southampton City and/or who are registered with a Southampton GP.

The service will cater for service users from age 24 years onwards (with the exception of those service users aged over 24 years who qualify for a service from the tier 1 and 2 alcohol information/advice counselling service).

Within this there are certain priority groups which reflect the strategic objectives of the Drug Action Team Partnership, the Tackling Alcohol Partnership and the Community Safety Partnership:

- Pregnant women
- Individuals whose children are categorised as in need under the Children's Act 2004 or have been subject to a Common Assessment Framework (CAF) or Family Assessment under the Families Matter programme.
- Individuals who have been recently discharged from prison
- Those subject to Multi Agency Public Protection Arrangements (MAPPA)
- Perpetrators and victims of domestic violence
- Drug and alcohol users required to engage with treatment as part of a court order.
- Drug and alcohol users identified through Integrated Offender Management processes.
- Drug and alcohol users at immediate risk of homelessness.
- Drug users and dependant drinkers with a co-morbid physical and/or mental health diagnosis where their drug or alcohol use exacerbates this issue.
- Drug and/or alcohol users who are new to the treatment system (known as "treatment naïve").
- Carers

12. Access to Services:

The Provider(s) will work with service users, carers, family members and the Commissioners to reduce any barriers to access and will work towards a culture of proactive engagement.

The Provider(s) will demonstrate innovation in developing a range of delivery options that recognises the changing methods of communication, including written, verbal, audio-visual, assertive outreach and detached work.

The Provider(s) will ensure equity of access for all groups, to deliver a non-judgemental and inclusive service, respecting age, colour, race, nationality, ethnic or national origin, marital status, mental or physical disability, religion or religious belief or philosophical belief, sex, sexuality (including sexual orientation), culture and social background.

The Provider will ensure that contact details and referral routes into the service are widely publicised in a range of contexts and formats. From the first point of contact individuals will be made welcome, well informed and responsible for their own recovery.

The Provider will be proactive in working with partners to utilise community venues that can be accessed by Service Users, thereby reducing stigma and encouraging access to services.

The service will give priority, subject to clinical need, to Military Veterans, in line with national guidelines where the drug or alcohol problem is linked to a period of service in the British Armed Forces.

Service Access Standards and Response Times:

The Service will provide promotional information, in appropriate formats and locations in order to raise awareness of the Service.

The Services will provide a first contact by telephone or in person within three (3) Working Days of the initial referral.

The Service shall ensure that service users commence structured treatment within fourteen (14) Working Days from the date of the first contact/appointment.

Where possible all Service Users will be offered a choice of working with either a female or male worker as appropriate.

Service Time and Location:

We are seeking to increase the number of people receiving information, advice and structured treatment about their drinking and drug taking behavior. This can be delivered through a number of channels which should not be limited to fixed office

bases and face to face contact. It could, for example be delivered through on-line and telephone facilities.

Where face to face contact is required this should include access at core times during the working week (core times are usually 9.00am to 5.00pm, Monday to Friday though this is subject to discussion and agreement) and include some access in the evening and on weekends, at times which are convenient and suitable to Service Users. This should be at least one evening and one weekend session per week and cover at least 8 hours per week. These times will be subject to future discussion and negotiation and subject to monitoring information on take up of service at various times.

Services will be able to flexibly respond to changes in need regarding access times by, for example, shifting the balance of access time from daytime to evening opening. Changes will be by prior agreement with the commissioners.

The Services will be delivered from accessible locations based in Southampton and arranged by the service provider.

13. Personalisation

Personalisation is the process by which services provided by the local authority are adapted to suit the personal needs of the service user. This means that all service users retain choice and control over the services they receive, along with greater emphasis on prevention and early intervention where possible.

Service users will be supported to develop their own Recovery Action Plan (RAP). The RAP once completed, will have sequenced interventions and activities as agreed with the service user and providers as necessary. The ARMs service will "sign off" the RAP following completion and will take responsibility for agreeing with the service user the most appropriate way for the RAP to be managed throughout treatment.

Service users will be supported to access generic services to help them develop their own RAP, including peer support networks.

The service will need to be able to adapt to changes arising as a result of the implementation of Personal Budgets and Personal Health Budgets. This includes enabling people to take a Direct Payment if they meet the eligibility for Local authority funding and linking people into other services which support and encourage people to take a direct payment.

Purchased Services

The Assessment Monitoring and Review service will have responsibility for holding a budget to be used in the purchase of services outside of the commissioned treatment system. The provider for delivery of services will be expected to develop a range of services which can be purchased separately from the commissioned services over the course of the contract, building flexibility and greater choice for service users. This will

mean that eventually a greater proportion of the budget will incrementally be spent on purchased services and less on block purchased commissioned services over the life of the contract.

For example:

Service	Year 1	Year 2	Year 3
ARM	£X	£X	£X
Delivery Service	90%	85%	80%
Purchased services	10%	15%	20%

NB: ***The investment in the block contracted services is expected to reduce over the course of the contract alongside an increase in people accessing services through Direct Payments or Personal Health Budgets. The investment in the ARM contract will remain constant, subject to any agreed variations.***

Purchased services may be delivered by the Delivery of services provider or by other providers, depending on service user choice.

14. System Outcomes:

The provider will work in partnership with Southampton City Council and the Commissioners to contribute towards the delivery of the following national Drug Strategy 2010 and Alcohol Strategy 2012 outcomes:

- Recovery from dependence on drugs or alcohol;
- Prevention of drug and alcohol related deaths;
- Prevention of infection by Blood Borne Viruses;
- Reduction in crime and re-offending;
- Sustained employment;
- The ability to access and sustain suitable accommodation;
- Improvement in mental and physical well being;
- Improved relationships with family members, partners and friends;

The Service will contribute to the strategic objectives of the Council in relation to alcohol and drug use:

- "Health and Wellbeing Strategic Plan 2009-12 (http://intranet.southampton.gov.uk/Images/Health%20and%20Wellbeing%20Strategic%20Plan%202009-12_tcm59-290057.pdf
- Joint Strategic Needs Assessment 2011 (http://www.southamptonhealth.nhs.uk/aboutus/publichealth/hi/jsna2011)

Addressing alcohol use underpins a number of priorities in Southampton's Health and Wellbeing Strategic Plan (2009-12), in particular:

- Achieving a healthy start in life – a reduction in the number of young people involved in substance misuse, particularly alcohol.

- Ensuring better health for all – reducing cardio vascular disease rates, reducing alcohol related violence in the night time economy and alcohol related hospital attendances and admissions, improving drug and alcohol care pathways, reducing worklessness and promoting health at work.
- Promoting independence and choice – enabling more people to live healthily for as long as possible in their own homes.

Tackling drug and alcohol related issues is one of the priorities in the Community Safety Strategy and underpins the intention to reduce crime and anti-social behaviour and improve quality of life and the city environment.

15. Performance Indicators

Local outcomes required:

(From a benchmark established between 1st April 2014 – 30th September 2014)

No	Performance Indicator	Target	Reporting frequency
1. Outreach and Brief Interventions			
1a	The number of service users receiving alcohol and/or drug brief intervention	To be agreed	Quarterly
1b	The number of service users contacted through targeted outreach	To be agreed	Quarterly
2. Entry to Services			
2a	95% of referrals are offered a triage/initial assessment within 2 working days	95%	Quarterly
2b	95% of new referrals receive a comprehensive assessment within 5 working days (after triage/initial assessment)	95%	Quarterly
2c	95% of first Interventions have a waiting time of less than 3 weeks from date of referral (based on modality start date and date of referral)	95% 100% < 4 wks	Quarterly
2d	A 10% increase in the numbers of service users entering treatment following assessment	To be agreed	Quarterly
2e	A 5% increase in the number of new presentations who go on to accept HBV vaccination	To be agreed	Quarterly
3. Numbers in Specialist Substance Misuse Services			
3a	An increase in the number of people abstinent from all presenting substances at two reviews within a 12 month period	To be agreed	Quarterly
3b	An increase in the number of people reporting a significant improvement in drug and/or alcohol use for all presenting substances at any two reviews within a 12 month period	To be agreed	Quarterly

3c	A 10% increase in the numbers of service users who are in effective treatment.	To be agreed	Quarterly
	A 5% decrease in the average length of time in treatment.	To be agreed	Quarterly
4. In Services			
4a	95% of Recovery Action plans are in place within 3 weeks of the service users treatment start date.	95%	Quarterly
4b	95% of Recovery Action Plans are reviewed after the comprehensive assessment within 12 weeks	95%	Quarterly
4c	95% of new referrals joint worked with other services	95%	Quarterly
4d	95% of new referrals have a key worker assigned	95%	Quarterly
4e	An increase in those who were injecting at the start of treatment who report no injecting on any two TOP reviews within a 12 month period.	To be agreed	Quarterly
4f	An increase in people in sustainable and secure housing.	To be agreed	Quarterly
4g	An increase in the number of people entering employment, education or training.	To be agreed	Quarterly
4h	More people achieving an improved outcome against an agreed outcome tool (i.e. TOP's, Alcohol star or Audit)	To be agreed	Quarterly
4i	A reduction in the number of drug and alcohol related deaths.	To be agreed	Quarterly
4j	A reduction in the number of alcohol related admissions to hospital	To be agreed	Quarterly
4k	A 5% increase in the percentage of service users who receive an HCV test. An increase in the number of service users engaging with HCV treatment	To be agreed	Quarterly
4l	Improved efficiency – reduction in DNA's, increased volume accessing the service, to be agreed and defined within contract discussions with the provider and based on benchmarking data established within the first 2 quarters of the contract.	To be agreed	Quarterly
5.Criminal Justice			
5a	A reduction in the average offending of the cohort compared to a baseline established in the first two quarters.	To be agreed	Quarterly

6. Exiting services			
6a	Service users should leave treatment in an agreed and planned way. Alcohol – 65% Drugs – 55%	65% 55% Threshold – above national avg	Quarterly
6b	A 10% increase in the number of planned discharges from the treatment system.	To be agreed	Quarterly
6c	A 10% decrease in the proportion of people who represent to treatment services within 6 months, having successfully completed treatment in the previous 6 months.	To be agreed	Quarterly
7. Treatment Outcome Profiles			
7a	90% TOPs recorded at - Start - Review - Exit (of planned exits)	90%	Quarterly
7b	Implementation of data capture systems which demonstrate service and individual outcomes by the second quarter of the contract.	To be agreed	Quarterly

Other Performance Indicators to be developed in discussion with the provider as required.

The provider will undertake regular service user feedback and satisfaction surveys which will be reported to the commissioners. The results must be used to inform service quality improvements.

16. Monitoring

The Council and the Service Provider shall meet once every Quarter during the Contract Period to monitor the performance and delivery of the Services in accordance with this Service Specification.

The Council's Representative or his or her deputy may undertake periodic monitoring visits and will meet the Service Provider's Representative. The Service Provider shall provide additional monitoring information on these occasions if required by the Council.

The Service User's Representative and Council's Representative or his or her deputy shall participate and contribute to Council surveys and consultation exercises where relevant or requested.

The Service Provider will allow reasonable access to authorised representatives of the Care Quality Commission and/or Southampton's Local Involvement Network in the

exercise of powers conferred on it to enter and view specified premises providing publicly funded health and social care services.

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17. Management information

In order to assess service performance and aid future planning the provider will be required to be able to collect and collate information to demonstrate contract requirements, agreed outcomes for the service and service users, compliance with performance indicators, service take-up against agreed contracted volumes and financial information. This includes, but is not limited to:

Management information number	Management information	Reporting frequency
Referrals and Service Activity		
1.	Number of new referrals	Quarterly
2.	Number of new referrals who received comprehensive assessment	Quarterly
3.	Number new referrals accessing treatment service	Quarterly
4.	Number of service users currently in treatment	Quarterly
5.	Referral source of referrals	Quarterly
6.	Quality of electronic data completion	Quarterly
7.	Number of people who successfully complete treatment	Quarterly
8.	Number of people who have maintained a reduced level of consumption at the 6 and 12 month stage of treatment.	
9.	Breakdown by age (of referrals and attending service)	Quarterly
10.	Gender breakdown of service users (of referrals and attending service)	Quarterly
11.	Ethnicity breakdown of service users (of referrals and attending service)	Quarterly
12.	Number of service users by vulnerability: unemployed, offenders, homeless, sexually exploited, service users with mental health problems,	Quarterly
13.	Drugs used, route of use, and risk behaviour (primary, secondary, poly-drug, method of administration, stimulant use, prevalence of IV users sharing)	Quarterly
14.	Number of new referrals who received comprehensive assessment	Quarterly
15.	Waiting times for treatment services (minimum, maximum and average)	Quarterly
16.	Number with Recovery Action plans drawn up	Quarterly
17.	Number on substitute prescribing	Quarterly
18.	Numbers and types of outcomes (planned exits, disciplinary exits, self exits, number remanded to custody, referrals to inpatient care, referral to more appropriate services etc.	Quarterly
19.	Number of people referred to other services (and speed of referral)	Quarterly
20.	Number of people using needle exchange service	Quarterly

21.	Numbers referred for vaccination programmes	Quarterly
22.	Service user feedback	Quarterly
23.	Health and social outcomes – using an accredited tool such as TOPs, Outcome Star, Outcome Web etc.	Quarterly
24.	Average length of treatment episode per service user	Quarterly
Outreach		
25.	Number of service users received outreach on drugs and alcohol issues in generic settings - Number of service users seen through targeted outreach - Number of service users contacted by targeted outreach Including information on referring agency, demographic profile and risk factors (i.e. age, gender, ethnicity, GP practice etc.)	Quarterly
26.	Brief Interventions on drugs and alcohol issues to individuals - Service users offered Tier 2 support - Service users receiving Brief Interventions on alcohol - Service users receiving Brief Interventions on drugs Including information on referring agency, demographic profile and risk factors	Quarterly

The Service Provider shall produce a Quarterly report in a format agreed between the Council and the Service Provider containing the above key performance indicator information which will be presented to the Council at least two weeks prior to the next Quarterly monitoring meeting and discussed with the Council at that meeting.

The service provider should make use of an information sharing agreement which allows partner agencies to share information about the customer as appropriate and needed;

18. Information System and Data Collection Required

The successful provider will be required to purchase an appropriate IT system, which will be common across all treatment providers, for case recording and uploading data in order to facilitate multi-disciplinary working and provide accountability and information sharing within the wider context of service user confidentiality and clinical governance. The system must be agreed with commissioners.

The Service Provider will provide routine data and monitoring information. It will also include individual and Service outcomes obtained using an accredited monitoring tool.

Service Website
The Service Provider will provide an up to date website which includes information that

explains what the Service provides, how to access the service and signposting to other accredited services.

Self-Help Materials
The service will make available and develop self-help materials which can be given to individuals and to partner organisations to assist them in working with people with drug and alcohol problems. The overall aim is to maximise the interventions of other agencies and teams in working with people who may then not require referral to higher intensity services.

19. Workforce Requirements

The Service Provider will ensure that staff:

- are appropriately experienced, qualified and trained;
- have received appropriate induction, supervision (management and clinical)
- Receive annual appraisal;
- are CRB checked where appropriate;
- have received training in the use of processes and equipment;
- are trained in Child and Adult Safeguarding and Safe Issues and generic risk assessment

Workforce planning should address:
- capacity and flexibility to respond to the likely pattern of demand; and
- appropriate grade of staff to provide specified service, avoiding use of highly qualified staff for routine interventions.

20. Volume of Service

The current Southampton drug treatment service deals with between 750 and 800 adults (aged 18 +) and up to 70 young people (aged 11-17 years). Approximately 20% 0f these are within the 18-24 year age bracket.

In order to undertake costings, the Service Provider should therefore expect a potential service volume of between 640 and 700 drug dependant adult (24 +) service users per annum. In addition the commissioners would expect an annual increase of 10% in the number of service users being retained in effective treatment.

For alcohol users the National Treatment Agency JSNA Support pack for strategic partners indicates the following data for Southampton:

Number of dependent drinkers	3873
Numbers in treatment 2011-12	7%
National percentage of dependent population in treatment	13%

We would therefore wish to increase the numbers of dependant drinkers in treatment to at least the national average.

21. Safeguarding and Multi-Agency Safeguarding Hub developments (updated November 2013)

Multi Agency Safeguarding Hub:
Southampton City Council is currently in the process of implementing a Multi-Agency Safeguarding Hub (MASH). This will be a central and co-located team which brings together agencies (and their information) in order to identify risks to children at the earliest possible point and respond with the most effective interventions.

MASH allows the multi-agency safeguarding team to carry out a joint confidential screening, research and referral of vulnerable children. Agencies work together to ensure vulnerable children are identified and properly cared for and protected.

The purpose of the MASH:
The purpose of the MASH is to make the best decisions which will keep children safe. This will in turn ensure timely and necessary interventions, improving the outcomes for vulnerable children.

Agencies included in the MASH:

- Children's Social care
- Police
- Health (including substance misuse services)
- Education
- Probation
- Housing
- Youth Offending Service

How the MASH will work:
Concerns relating to the safeguarding or welfare of a child will be considered by the MASH screening team including self referrals, multi-agency referrals, and a referral from the Police, another local authority or an anonymous referral.

Information is collected from all the partner agencies within the timescales set by the Head of the MASH. The most urgent cases will be turned around within two hours.

All information is collated and the MASH reviews and analyses the information received from partner agencies and writes a summary of that information on a MASH record. The MASH recommends what further action should be taken.

Substance misuse services will be expected to input into the MASH and how this will take place is currently being discussed and developed. It is the intention of the commissioners that all substance misuse providers will need to work closely with Children's services and all other partners in order to provide information and a swift and comprehensive assessment whenever children are felt to be at risk of harm. The resource required for this work is already included in the price of this contract and there will be no additional funding available.

Appendix 1

Quality Outcomes Indicators

The provider shall report Quality Outcomes Indicators in the Contract Review meetings (monthly or quarterly as appropriate) clearly indicating any variance from the thresholds indicated below (for example by indicating the threshold number or percentage in the body of the report alongside reported performance).

If there is a difference between the Providers report and the data reported by NDTMS then for the purpose of assessing performance, the NDTMS report will be used.

Alcohol:

Quality Outcomes Indicator	**Threshold**	**Method of Measurement**
Compliance with the NATMS data set	100% load 99% data quality	Monthly review/DTMU report
***** Planned discharge (% of service users with a discharge reason of treatment complete: alcohol free or treatment complete: occasional user)	65%	Provider report. NATMS validation
* Number of alcohol users completing treatment alcohol free	Baseline in first 9 months, then review	NATMS
Proportion of service users with a **"Start"** Treatment Outcomes Profile completed	90%	Provider monthly report
Proportion of service users with a 6 month **"Review"** Treatment Outcomes Profile completed.	90%	Provider Quarterly report
* Number of service users with an outstanding sub intervention review	0	Reported monthly by DTMU via the drop box.
Number of service users leaving treatment in a planned way with an **EXIT** Treatment outcomes Profile completed	90%	Provider quarterly report

Drugs

Quality Outcomes Indicators	Threshold	Method of Measurement
Compliance with the NDTMS core data set	100% load 99% Data quality	Monthly review/DTMU report
* Planned discharge (% of service users with a discharge reason of treatment complete: drug free or treatment complete: occasional user)	55%	Provider report. NDTMS validation
*Number of drug users completing treatment drug free.	Baseline in first 6 months, then review	NDTMS
Proportion of service users with a **"Start"** Treatment Outcomes Profile completed	95%	Provider Monthly report. NDTMS TOP Exception report to validate.
Proportion of service users with a 6 month **"Review"** Treatment Outcomes Profile completed.	90%	Provider Quarterly report. NDTMS TOP Exception report to validate.
*Number of service users with an outstanding sub intervention review	0	Reported monthly by DTMU via the drop box.
Number of service users leaving treatment in a planned way with an **EXIT** Treatment outcomes Profile completed	90%	Provider quarterly report. NDTMS TOP Exception report to validate.
*Proportion of Criminal Justice service users who start treatment within 5 days of referral	90%	Provider monthly report.
*Proportion of waiting times (first intervention) within 21 calendar days of referral	95%	Provider quarterly report. NDTMS agency to validate.
*Number of waiting times (first intervention) that are 42 or more days	0	Provider monthly report
* Number of drug users completing drug free	Baseline in first 9 months, then review	NDTMS

*Number of service users completing as an occasional user of drugs other than opiates or crack cocaine	Baseline in first 9 months, then review	NDTMS
*Number of representations (service user type : opiates) who start a new treatment episode anywhere in England within 6 months of completing treatment.	0	NDTMS monthly "representations" report YTD (provider, client type: opiates)
*Number of representations (service user type: non-opiates) who start a new treatment episode anywhere in England within 6 months of completing treatment.	0	NDTMS monthly "representations" report YTD (provider, client type: non- opiates)
* Public Health Outcomes Framework – Indicator 2.15 – Successful completion of drug treatment	Upper quartile performance for cluster (opiates and non-opiates)	NDTMS and Public Health england

Quality Outcomes Indicators that are marked with an * are applied to both ARM and DDATRS services.