Cabinet

Wednesday, 8 September 2021 at 5.30 p.m.

C1, 1st Floor, Town Hall, Mulberry Place, 5 Clove Crescent, London, E14 2BG

Agenda

Mayor John Biggs

Cabinet Members

Councillor Asma Begum	Deputy Mayor and Cabinet Member for Children, Youth Services, Education and Equalities (Statutory Deputy Mayor)
Councillor Rachel Blake	Deputy Mayor and Cabinet Member for Adults, Health and Wellbeing
Councillor Motin Uz-Zaman	Deputy Mayor and Cabinet Member for Work, Economic Growth and Faith
Councillor Danny Hassell	Cabinet Member for Housing
Councillor Sabina Akhtar	Cabinet Member for Culture, Arts and Sports
Councillor Sirajul Islam	Cabinet Member for Community Safety
Councillor Candida Ronald	Cabinet Member for Resources and the Voluntary Sector
Councillor Asma Islam	Cabinet Member for Environment and Planning
Councillor Mufeedah Bustin	Cabinet Member for Social Inclusion and Public Realm (job share)
Councillor Kahar Chowdhury*	Cabinet Member for Social Inclusion and Public Realm (job share)

*Not a formal cabinet member at this time

[The quorum for Cabinet is 3 Members]

Further Information

Reports for consideration, meeting contact details, public participation and more information on Cabinet decision-making is available on the following pages.

Public Information

Viewing or Participating in Cabinet Meetings

The public are welcome to attend meetings of the Cabinet. Procedures relating to Public Engagement are set out in the 'Guide to Cabinet' attached to this agenda. Except where any exempt/restricted documents are being discussed, the public are welcome to view this meeting through the Council's webcast system.

Only limited physical attendance at the Town Hall is possible at this time. If you wish to attend in person, please contact the clerk in advance of the meeting date (details set out below).

Meeting Webcast

The meeting is being webcast for viewing through the Council's webcast system.
http://towerhamlets.public-i.tv/core/portal/home

Contact for further enquiries:

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Web:http://www.towerhamlets.gov.uk

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A Guide to CABINET

Decision Making at Tower Hamlets

As Tower Hamlets operates the Directly Elected Mayor system, **Mayor John Biggs** holds Executive powers and takes decisions at Cabinet or through Individual Mayoral Decisions. The Mayor has appointed nine Councillors to advise and support him and they, with him, form the Cabinet. Their details are set out on the front of the agenda.

Which decisions are taken by Cabinet?

Executive decisions are all decisions that aren't specifically reserved for other bodies (such as Development or Licensing Committees). In particular, Executive Key Decisions are taken by the Mayor either at Cabinet or as Individual Mayoral Decisions.

The constitution describes Key Decisions as an executive decision which is likely

a) to result in the local authority incurring expenditure which is, or the making of savings which are, above £1million; or

b) to be significant in terms of its effects on communities living or working in an area comprising two or more wards in the borough.

Upcoming Key Decisions are published on the website on the 'Forthcoming Decisions' page through www.towerhamlets.gov.uk/committee

Published Decisions and Call-Ins

Once the meeting decisions have been published, any 5 Councillors may submit a Call-In to the Service Head, Democratic Services requesting that a decision be reviewed. This halts the decision until it has been reconsidered.

- The decisions will be published on: **Friday, 10 September 2021**
- The deadline for call-ins is: **Friday, 17 September 2021**

Any Call-Ins will be considered at the next meeting of the Overview and Scrutiny Committee. The Committee can reject the call-in or they can agree it and refer the decision back to the Mayor, with their recommendations, for his final consideration.

Public Engagement at Cabinet

The main focus of Cabinet is as a decision-making body. However there is an opportunity for the public to contribute through making submissions that specifically relate to the reports set out on the agenda.

Members of the public may make written submissions in any form (for example; Petitions, letters, written questions) to the Clerk to Cabinet (details on the previous page) by 5 pm the day before the meeting.

London Borough of Tower Hamlets

Cabinet

Wednesday, 8 September 2021

5.30 p.m.

Pages

1. APOLOGIES FOR ABSENCE

To receive any apologies for absence.

2. DECLARATIONS OF DISCLOSABLE PECUNIARY INTERESTS AND OTHER INTERESTS **9 - 10**

Members are reminded to consider the categories of interest, identified in the Code of Conduct for Members to determine; whether they have an interest in any agenda item and any action they should take. For further details, see the attached note from the Monitoring Officer.

Members are also reminded to declare the nature of the interest at the earliest opportunity and the agenda item it relates to. Please note that ultimately it is the Members' responsibility to identify any interests and also update their register of interests form as required by the Code.

If in doubt as to the nature of an interest, you are advised to seek advice prior to the meeting by contacting the Monitoring Officer or Democratic Services.

3. UNRESTRICTED MINUTES **11 - 24**

The unrestricted minutes of the Cabinet meeting held on 28 July 2021 are presented for approval.

4. ANNOUNCEMENTS (IF ANY) FROM THE MAYOR

5. OVERVIEW & SCRUTINY COMMITTEE

5 .1 Chair's Advice of Key Issues or Questions

Chair of Overview and Scrutiny Committee (OSC) to report on any issues raised by the OSC in relation to unrestricted business to be considered.

5 .2 Any Unrestricted Decisions "Called in" by the Overview & Scrutiny Committee

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(Under provisions of Section 30, Rule 59 of the Constitution).

6. UNRESTRICTED REPORTS FOR CONSIDERATION

6 .1	Reset Adult substance Misuse Service Contract Direct Award	25 - 150

Report Summary:
LBTH has recently received central government grants focused on adult substance misuse treatment and recover. This item requests permission to vary the current contracts relating to the adult treatment system (Reset), to directly award the current providers funds to increase activity related to Outreach, Treatment and Recovery.

Wards:	All Wards
Lead Member:	Cabinet Member for Community Safety
Corporate Priority:	A borough that our residents are proud of and love to live in

6 .2	Integrated housing and support Mental Health schemes: Direct Award of contract to Look Ahead Care and Support	To Follow

Report Summary:
New contract for in-borough supported living schemes for Mental Health. This item recommends the direct award of a single contract for an integrated housing and support offer for three accommodation schemes: Forensic Service Tabard Court; Commercial Road; and Coventry Road.

Wards:	All Wards
Lead Member:	Deputy Mayor and Cabinet Member for Adults, Health and Wellbeing
Corporate Priority:	A borough that our residents are proud of and love to live in

6 .3	Service Action Plan: Improving Air Quality in Tower Hamlets	151 - 180

Report Summary:
This item is the action plan in response to the overview and scrutiny challenge session on the council's air quality commitments and impacts on residents' health outcomes.

Wards:	All Wards
Lead Member:	Cabinet Member for Environment and Planning
Corporate Priority:	TH Plan 4: Better health and wellbeing.

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6 .4	Highways & Street Lighting Works Contract Tender	181 - 188

Report Summary:
This report sets out the planned re-procurement of the Council's Highways and Street Lighting Works Contracts as they are due to expire on the 31st March 2022. This contract also includes the procurement of a Professional Services Contract as a separate Lot as an integral part of the overall contract Tender.

Due to activity time dependencies within the procurement project plan timescales, this item, which would normally have been presented as part of the September Cabinet Contracts Forward Plan – Quarter Two (FY2021-2022) and is now rescheduled for presentation at November Cabinet, is being presented as a standalone item at September Cabinet.

Wards:	All Wards
Lead Member:	Cabinet Member for Social Inclusion and Public Realm
Corporate Priority:	A borough that our residents are proud of and love to live in

6 .5	3 – 11 Vallance Road - Disposal	189 - 200

Report Summary:
Freehold disposal of 3 -11 Vallance Road by way of Private Treaty.

Wards:	All Wards
Lead Member:	Cabinet Member for Social Inclusion and Public Realm
Corporate Priority:	A borough that our residents are proud of and love to live in

6 .6	122 Back Church Lane – Disposal	201 - 206

Report Summary:
Freehold disposal of 122 Back Church Lane by way of Private Treaty or Auction.

Wards:	All Wards
Lead Member:	Cabinet Member for Social Inclusion and Public Realm
Corporate Priority:	A dynamic outcomes-based Council using digital innovation and partnership working

6 .7	Town Hall IT Infrastructure	207 - 212

Report Summary:
The Council moves into the Town Hall in Whitechapel in 2022 and this report seeks Cabinet authority to procure the necessary hardware, software and services to ensure colleagues, partners and visitors can access the applications and data they need.

Wards:	All Wards
Lead Member:	Cabinet Member for Resources and the Voluntary Sector
Corporate Priority:	A dynamic outcomes-based Council using digital innovation and partnership working

6 .8	IT Recurring Contracts	213 - 222

Report Summary:
The Council holds a large number of contracts for IT applications and other services where the cost of change is likely to exceed any saving from re-procurement and needs to agree an appropriate way of managing these following the end of its strategic partnership which previously managed these arrangements.

Wards:	All Wards
Lead Member:	Cabinet Member for Resources and the Voluntary Sector
Corporate Priority:	A dynamic outcomes-based Council using digital innovation and partnership working

7. ANY OTHER UNRESTRICTED BUSINESS CONSIDERED TO BE URGENT

8. EXCLUSION OF THE PRESS AND PUBLIC

Should the Mayor in Cabinet consider it necessary, it is recommended that the following motion be adopted to allow consideration of any exempt/restricted documents.

"That, under the provisions of Section 100A of the Local Government Act, 1972 as amended by the Local Government (Access to Information) Act, 1985, the Press and Public be excluded from the remainder of the meeting for the consideration of the Section Two business on the grounds that it contains information defined as Exempt in Part 1 of Schedule 12A to the Local Government, Act 1972".

EXEMPT/CONFIDENTIAL SECTION (PINK)

The Exempt / Confidential (Pink) Committee papers in the Agenda will con
information, which is commercially, legally or personally sensitive and shou
divulged to third parties. If you do not wish to retain these papers after the
please hand them to the Committee Officer present.

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9. EXEMPT / CONFIDENTIAL MINUTES

Nil items

10. OVERVIEW & SCRUTINY COMMITTEE

10 .1 Chair's Advice of Key Issues or Questions in Relation to Exempt / Confidential Business

Chair of Overview and Scrutiny Committee (OSC) to report on any issues raised by the OSC in relation to exempt/confidential business to be considered.

10 .2 Any Exempt / Confidential Decisions "Called in" by the Overview & Scrutiny Committee

(Under provisions of Section 30, Rule 59 of the Constitution).

11. EXEMPT / CONFIDENTIAL REPORTS FOR CONSIDERATION

12. ANY OTHER EXEMPT/ CONFIDENTIAL BUSINESS CONSIDERED TO BE URGENT

Next Meeting of the Committee:
Wednesday, 22 September 2021 at 5.30 p.m. in C1, 1st Floor, Town Hall, Mulberry Place, 5 Clove Crescent, London, E14 2BG

Tower Hamlets Council
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DECLARATIONS OF INTERESTS AT MEETINGS– NOTE FROM THE MONITORING OFFICER

This note is for guidance only. For further details please consult the Code of Conduct for Members at Part C, Section 31 of the Council's Constitution

(i) Disclosable Pecuniary Interests (DPI)

You have a DPI in any item of business on the agenda where it relates to the categories listed in **Appendix A** to this guidance. Please note that a DPI includes: (i) Your own relevant interests; (ii)Those of your spouse or civil partner; (iii) A person with whom the Member is living as husband/wife/civil partners. Other individuals, e.g. Children, siblings and flatmates do not need to be considered. Failure to disclose or register a DPI (within 28 days) is a criminal offence.

Members with a DPI, (unless granted a dispensation) must not seek to improperly influence the decision, must declare the nature of the interest and leave the meeting room (including the public gallery) during the consideration and decision on the item – unless exercising their right to address the Committee.

DPI Dispensations and Sensitive Interests. In certain circumstances, Members may make a request to the Monitoring Officer for a dispensation or for an interest to be treated as sensitive.

(ii) Non - DPI Interests that the Council has decided should be registered – (Non - DPIs)

You will have 'Non DPI Interest' in any item on the agenda, where it relates to (i) the offer of gifts or hospitality, (with an estimated value of at least £25) (ii) Council Appointments or nominations to bodies (iii) Membership of any body exercising a function of a public nature, a charitable purpose or aimed at influencing public opinion.

Members must declare the nature of the interest, but may stay in the meeting room and participate in the consideration of the matter and vote on it **unless:**

- A reasonable person would think that your interest is so significant that it would be likely to impair your judgement of the public interest. **If so, you must withdraw and take no part in the consideration or discussion of the matter.**

(iii) Declarations of Interests not included in the Register of Members' Interest.

Occasions may arise where a matter under consideration would, or would be likely to, **affect the wellbeing of you, your family, or close associate(s) more than it would anyone else living in the local area** but which is not required to be included in the Register of Members' Interests. In such matters, Members must consider the information set out in paragraph (ii) above regarding Non DPI - interests and apply the test, set out in this paragraph.

Guidance on Predetermination and Bias

Member's attention is drawn to the guidance on predetermination and bias, particularly the need to consider the merits of the case with an open mind, as set out in the Planning and Licensing Codes of Conduct, (Part C, Section 34 and 35 of the Constitution). For further advice on the possibility of bias or predetermination, you are advised to seek advice prior to the meeting.

Section 106 of the Local Government Finance Act, 1992 - Declarations which restrict Members in Council Tax arrears, for at least a two months from voting

In such circumstances the member may not vote on any reports and motions with respect to the matter.

Further Advice contact: Janet Fasan, Director of Legal and Interim Monitoring Officer, Tel: 020 7364 4348.

APPENDIX A: Definition of a Disclosable Pecuniary Interest

(Relevant Authorities (Disclosable Pecuniary Interests) Regulations 2012, Reg 2 and Schedule)

Subject	Prescribed description
Employment, office, trade, profession or vacation	Any employment, office, trade, profession or vocation carried on for profit or gain.
Sponsorship	Any payment or provision of any other financial benefit (other than from the relevant authority) made or provided within the relevant period in respect of any expenses incurred by the Member in carrying out duties as a member, or towards the election expenses of the Member. This includes any payment or financial benefit from a trade union within the meaning of the Trade Union and Labour Relations (Consolidation) Act 1992.
Contracts	Any contract which is made between the relevant person (or a body in which the relevant person has a beneficial interest) and the relevant authority— (a) under which goods or services are to be provided or works are to be executed; and (b) which has not been fully discharged.
Land	Any beneficial interest in land which is within the area of the relevant authority.
Licences	Any licence (alone or jointly with others) to occupy land in the area of the relevant authority for a month or longer.
Corporate tenancies	Any tenancy where (to the Member's knowledge)— (a) the landlord is the relevant authority; and (b) the tenant is a body in which the relevant person has a beneficial interest.
Securities	Any beneficial interest in securities of a body where— (a) that body (to the Member's knowledge) has a place of business or land in the area of the relevant authority; and (b) either— (i) the total nominal value of the securities exceeds £25,000 or one hundredth of the total issued share capital of that body; or (ii) if the share capital of that body is of more than one class, the total nominal value of the shares of any one class in which the relevant person has a beneficial interest exceeds one hundredth of the total issued share capital of that class.

LONDON BOROUGH OF TOWER HAMLETS

MINUTES OF THE CABINET

HELD AT 5.33 P.M. ON WEDNESDAY, 28 JULY 2021

C1, 1ST FLOOR, TOWN HALL, MULBERRY PLACE, 5 CLOVE CRESCENT, LONDON, E14 2BG

Members Present in person:

Mayor John Biggs	
Councillor Sirajul Islam	(Statutory Deputy Mayor for Community Safety, Faith and Equalities)
Councillor Danny Hassell	(Cabinet Member for Housing)
Councillor Mufeedah Bustin	Cabinet Member for Planning and Social Inclusion (Job Share) - Lead on Social Inclusion
Councillor Eve McQuillan	Cabinet Member for Planning and Social Inclusion (Job Share) - Lead on Planning

Members Present remotely:

Councillor Rachel Blake	(Deputy Mayor and Cabinet Member for Adults, Health and Wellbeing)
Councillor Sabina Akhtar	(Cabinet Member for Culture, Arts and Brexit)
Councillor Asma Islam	(Cabinet Member for Environment and Public Realm (Job Share) – Lead on Public Realm)
Councillor Candida Ronald	(Cabinet Member for Resources and the Voluntary Sector)
Councillor Motin Uz-Zaman	(Cabinet Member for Work and Economic Growth)

Other Councillors Present in person:

Councillor Peter Golds	(Leader of the Conservative Group)

Other Councillors Present remotely:

Councillor Mohammed Pappu

Others Present remotely:

Fran Pearson	(Chair of the Safeguarding Adults Board)
Marcus Barnett	(Metropolitan Police)
Chetan Vyas	(Clinical Commissioning Group)
Keith Makin	(Independent Scrutineer, Children's Safeguarding)

Officers Present in person:

Janet Fasan	(Director of Legal & Monitoring Officer)
Denise Radley	(Corporate Director, Health, Adults & Community)
Will Tuckley	(Chief Executive)
Joel West	(Democratic Services Team Leader (Committee))

Officers Present remotely:

Zamil Ahmed	(Head of Procurement)
Kevin Bartle	(Interim Corporate Director, Resources and Section 151 Officer)
Claudia Brown	(Divisional Director of Adults Social Care)
Vicky Clark	(Divisional Director for Growth and Economic Development)
Sharon Godman	(Director, Strategy, Improvement and Transformation)
Patrick Harmsworth	(Senior Planning Officer, Planning Services, Place)
Fiona Heyland	(Head of Waste Strategy Policy and Procurement, Public Realm)
Adam Hussain	(Planning Officer, Development and Renewal)
Dan Jones	(Divisional Director, Public Realm)
Daniel Kerr	(Strategy and Policy Manager)
Ahsan Khan	(Chief Accountant)
Steve Nyakatawa	(Director of Education)
Marissa Ryan-Hernandez	(Plan Making Team Leader)
Mariana Schiller	(Central Area Design Guidance Project Manager, Planning and Building Control)
Ann Sutcliffe	(Corporate Director, Place)
James Thomas	(Corporate Director, Children and Culture)
Warwick Tomsett	Joint Director, Integrated Commissioning
Richard Williams	Business Manager Operational PR
Matthew Wong	Planning Officer
Matthew Mannion	(Head of Democratic Services, Governance)

1. APOLOGIES FOR ABSENCE

Apologies for absence were received on behalf of:

- Councillor Asma Begum (Deputy Mayor and Cabinet Member for Children, Youth Services and Education)
- Councillor Dan Tomlinson (Cabinet Member for Environment and Public Realm (Job Share) – Lead on Public Realm)
- Councillor Motin Uz-Zaman (Cabinet Member for Work and Economic Growth)

2. DECLARATIONS OF DISCLOSABLE PECUNIARY INTERESTS AND OTHER INTERESTS

There were no Declarations of Disclosable Pecuniary Interests.

3. UNRESTRICTED MINUTES

RESOLVED

1. That the unrestricted minutes of the Cabinet meeting held on Wednesday 30 June 2021 be approved and signed by the Chair as a correct record.

4. ANNOUNCEMENTS (IF ANY) FROM THE MAYOR

The Mayor made a number of announcements, including that:

- The Council's adult social care 'Local Account 2020-21' was complete and would be published.
- He was likely to be taking a number of Individual Mayoral Decisions over the next month including the academisation of a school, summer food schemes, an Article 4 Scheme proposal and one in relation to the Spitalfields Neighbourhood Plan.

5. OVERVIEW & SCRUTINY COMMITTEE

5.1 Chair's Advice of Key Issues or Questions

Pre-Decision Scrutiny Questions were received on the following Agenda Items:

- 6.1 Tower Hamlets Safeguarding Adults Board Annual Report 2020-21
- 6.4 Adoption of the South Poplar Masterplan SPD
- 6.6 Adoption of the Central Area Good Growth SPD
- 6.7 Adoption of the Reuse, Recycling and Waste SPD
- 6.11 Council Budget Monitoring Report – Provisional Outturn
- 6.12 Contracts Forward Plan 2021-22 Q1

All questions and responses were discussed during the debate on those items and written officer responses were also tabled on the questions for (6.1, 6.4, 6.6, 6.7, 6.12) with responses for (6.11) to be submitted to Overview and Scrutiny later in the week.

In addition, Councillor Mohammed Pappu, Chair of the Overview and Scrutiny Committee (OSC), provided an update to Cabinet of his Committee's recent work activities. He reported that they had held a meeting earlier in the week at which a number of issues had been discussed, including:

- Looking at the Council's Budget Outturn for 2020-21.
- Progress on the Safer Neighbourhood Action Plan
- Signed off the Committee's Empowering Communities report and its annual workplan.

The Mayor thanked Councillor Pappu for his update.

5.2 Any Unrestricted Decisions "Called in" by the Overview & Scrutiny Committee

Nil items.

6. UNRESTRICTED REPORTS FOR CONSIDERATION

6.1 Tower Hamlets Safeguarding Adults Board Annual Report 2020-21

Councillor Rachel Blake, Deputy Mayor and Cabinet Member for Adults, Health and Wellbeing, introduced the report. She began by thanking Christabel Shawcross for her work and support as the previous Chair of the Board before welcoming Fran Pearson to the meeting as the new Chair.

She welcomed the support the new Chair had already provided and looked forward to working with her in the future. She highlighted how impressed she was with the commitment of the Board and partners to continuous improvement to keep our communities safe. Safeguarding is about people, their wishes, aspirations and needs and it is everyone's responsibility.

Fran Pearson addressed the meeting and provided more detail about the report and how it set out the value and effectiveness on the partnership and its work. There had been clear evidence of effectiveness of the partnership working and she had been really impressed with many initiatives around community safety and also on how the Board linked into local strategic partnerships. She looked forward with working with the Cabinet on the many identified projects and work areas.

She also highlighted a number of her priorities as the new Chair including looking to work with all Councillors on supporting the work areas identified.

The Mayor welcomed the presentation. He thanked everyone for their hard work and dedication. He noted the Pre-Agenda Scrutiny Questions and officer responses. He proposed the recommendations as set out in the report and those Members present agreed the recommendations and it was:

RESOLVED

1. To note the Safeguarding Board Annual Report 2020-21 following its agreement at the July Safeguarding Board meeting.

6.2 Tower Hamlets Safeguarding Children Partnership Annual Report 2020-21

The Mayor introduced the annual report of the Tower Hamlets Safeguarding Children's Partnership. He invited representatives from the CCG and Police to speak as well as Keith Makin the independent scrutineer.

James Thomas, Corporate Director, Children and Culture, provided an initial introduction to the report and the work of the Partnership. He drew the

meeting's attention to the headline figures including around children in care and case numbers generally and how valuable early intervention and support with families was in keeping numbers down. The report also showed how the voice of young people was being significantly strengthened and three young scrutineers were soon to be recruited to work with Keith Makin.

The meeting then heard from Keith Makin, Marcus Barnett (Police) and Chetan Vyas (CCG). They highlighted key points from the report including reports on past cases, the more systematic approach to embedding learning, implementing lessons from child safety reviews, the passion and determination being shown by the partnership and finally the priorities for the coming years such as on domestic abuse and exploitation.

The partnership felt that there was already good progress being shown against priorities for the next year and these would be reported to Cabinet in the next Annual Report.

Keith Makin as the Independent Scrutineer reported that the borough was very well placed compared to many other boroughs and had shown good progress over recent months even despite the impact of the Covid pandemic.

The Mayor welcomed the presentation and the report. He highlighted that the work of all partners, in particular schools, were also really important in supporting the Partnership and he thanked them for their work.

He proposed the recommendations as set out in the report and those Members present agreed the recommendations and it was:

RESOLVED

1. To note the work that has been carried out by the Tower Hamlets Safeguarding Children Partnership over the year 2020-21 and the outcomes that members would like to see from the THSCP over the next year

2. To note the specific equalities considerations as set out in Paragraph 4.1 of the report.

6.3 SEND Improvement Board Annual Report 2020

The Mayor introduced the SEND Improvement Board Annual Report. He highlighted this was a really important role for the authority. In addition to the regular annual report content, the report had a particular look at the impact of the Covid-19 pandemic. He noted that the current local area inspection by OFSTED would be published soon. He brought the meeting's attention to the many strengths set out in the report and noted how important early diagnosis of problems was to support young people and increased capacity at local schools would be really important in providing this support.

James Thomas, Corporate Director, Children and Culture, took the committee through some of the key points in the report and in particular highlighted the

strong partnership work shown by this report. The Cabinet were also taken through many of the activities that took place to support the strategy and annual report including such as through children's centres and engagement from early years teams. There was also a big focus on the transitioning period to adult social care to ensure young people did not miss out on ongoing support.

The meeting heard from Councillor Rachel Blake, Deputy Mayor and Cabinet Member for Adults, Health and Wellbeing on the improvement work led by the Health and Wellbeing Board to support SEND services.

The Mayor welcomed the presentations and proposed the recommendations as set out. Members present agreed the recommendations and it was:

RESOLVED

1. To note the contents of the SEND Improvement Board Annual Report 2020.

6.4 Adoption of the South Poplar Masterplan SPD

Councillor Eve McQuillan, Cabinet Member for Planning and Social Inclusion (Job Share) – Lead on Planning, introduced the report. She thanked officers in the planning service for their work in creating this proposal knitting together three sites within the area. It would support local businesses and communities whilst also improving links to Canary Wharf over Aspen Way. New open spaces would also be created with a good public realm making it a pleasant place to live.

During discussion Councillor Peter Golds, Leader of the Opposition, thanked officers for the recent online public consultation that had taken place. He noted concerns about the difficulty of linking the South Poplar area to Canary Wharf given the different (north/south – east/west) focus of the areas.

The Mayor welcomed the report. He noted the Pre-Decision Scrutiny Questions and officer responses and proposed that the recommendations be approved. Members present in the meeting agreed the recommendations and it was:

RESOLVED

1. To approve the South Poplar Masterplan SPD (appendix 1 to the report) for adoption and authorise officers to prepare an adoption statement and publish the Regulation 18(4)(b) Statement and adoption statement so it can be considered a material planning consideration in the assessment of planning applications within the designated South Poplar Masterplan boundary.

2. To authorise the Corporate Director of Place to make any necessary factual or minor editing changes prior to publishing the final South Poplar Masterplan SPD.

3. To note the Representation schedule summarising representations received during the consultation and the responses to these representations as set out in appendix 2 to the report.

4. To note the Strategic Environmental Assessment and Habitats Regulation Assessment Screening Report and consultation responses attached in appendix 3 to the report.

5. To note the Equalities Impact Assessment Screening as set out in Appendix 4 to the report.

6.5 Adoption of the Queen Mary University London SPD

Councillor Eve McQuillan, Cabinet Member for Planning and Social Inclusion (Job Share) – Lead on Planning, introduced the report. She explained that the intention of the document was to support Queen Mary University in its development plans whilst at the same time looking to increase the accessibility of the site to local residents, improving its environmental impact and protecting existing heritage features. Finally, she thanked Patrick Harmsworth, Local Plan Place Growth Modelling and Monitoring Officer for his work in helping prepare the report.

The Mayor welcomed the report, thanked the officers involved in the project and proposed the recommendations as set out. The Members present agreed the recommendations and it was:

RESOLVED

1. To approve the QMUL Mile End Campus SPD (appendix 1 to the report) for adoption and authorise officers to prepare an adoption statement and publish the Regulation 18(4)(b) Statement and adoption statement so it can be considered a material planning consideration in the assessment of planning applications for planning decisions in the SPD study area.

2. To authorise the Corporate Director of Place to make any necessary factual or minor editing changes prior to publishing the final SPD.

3. To note the representation schedule summarising representations received during the consultation and the responses to these representations as set out in appendix 2 to the report.

4. To note the Strategic Environmental Assessment Screening as set out in Appendix 3 to the report.

5. To note the Equalities Impact Assessment as set out in appendix 4 to the report.

6.6 Adoption of the Central Area Good Growth Supplementary Planning Document

Councillor Eve McQuillan, Cabinet Member for Planning and Social Inclusion (Job Share) – Lead on Planning, introduced the report. The report was designed to support housing development across the central area of the borough. It was expected that over 7,500 homes would be built within that area over the next ten years. In particular, it was looking at supporting development on smaller sites with protection for heritage where required. She thanked officers in the planning service for their work in creating this document.

The Mayor welcomed the report. He noted the Pre-Decision Scrutiny Questions and officer responses and proposed the recommendations as set out. Members present agreed the recommendations and it was:

RESOLVED

1. To approve the Central Area Good Growth SPD (Appendix 1 to the report) for adoption and authorise officers to prepare an adoption statement and publish the Regulation 18(4)(b) Statement and adoption statement so it can be considered a material planning consideration in the assessment of planning applications for residential developments on small sites in the Central Area of Tower Hamlets.

2. To authorise the Corporate Director of Place to make any necessary factual or minor editing changes prior to publishing the final Central Area Good Growth SPD.

3. To note the representation schedule summarising representations received during the consultation and the responses to these representations as set out in the Consultation and Engagement Report in Appendix 2 to the report.

4. To note the Strategic Environmental Assessment Screening as set out in Appendix 3 to the report.

5. To note the Equalities Impact Assessment Screening as set out in Appendix 4 to the report.

6.7 Adoption of Reuse, Recycling and Waste SPD

Councillor Eve McQuillan, Cabinet Member for Planning and Social Inclusion (Job Share) – Lead on Planning, introduced the report. The intention of the report was to set out to developers and residents clearly the Council's expectations in terms of provision for waste, reuse and recycling. She thanked officers in the planning service for their work in creating this document.

The Mayor welcomed the report. He noted concerns expressed in discussion around recent collection problems but officers set out how that was being addressed. The Mayor noted the pre-decision scrutiny questions and officer responses and he then proposed the recommendations as set out. The Members present agreed the recommendations and it was:

RESOLVED

1. To approve the Reuse, Recycle and Waste SPD('the SPD') (appendix 1 to the report) for adoption and authorise officers to prepare an adoption statement and publish the Regulation 18(4)(b) Statement and adoption statement so that the SPD can be considered a material planning consideration in the assessment of planning applications for new residential and mixed-use buildings.

2. To authorise the Corporate Director of Place to make any necessary factual or minor editing changes prior to publishing the final Reuse, Recycle and waste SPD.

3. To note the representation schedule summarising representations received during the consultation and the responses to these representations as set out in Appendix 3.2 to the report.

4. To note the Strategic Environmental Assessment Screening as set out in Appendix 3.3 to the report.

5. To note the Equalities Impact Assessment as set out in Appendix 3.4 to the report.

6.8 Service Action Plan – Environment Scrutiny Challenge Session, Recycling Behaviour Change

Councillor Asma Islam, Cabinet Member for Environment and Public Realm (Job Share) – Lead on Environment, introduced the report. She explained that this was an action plan prepared in response to a Scrutiny Challenge Session. Many actions had already been completed including in the last item on the agenda (Item 6.7 – Adoption of Reuse, Recycling and Waste SPD). A number of actions were still in progress including on communications, improved information and encouraging behavioural change. The work of partners was really important in helping to meet these targets.

The Mayor welcomed the report as a good example of thoughtful scrutiny and the actions would help to improve the work of the Council. He proposed the recommendations set out in the report. The Members present agreed the recommendations and it was:

RESOLVED

1. To note the report of the Environment scrutiny challenge on resident behaviour change to boost recycling; and

2. To agree the service action plan in response to the report recommendations.

6.9 Authority to renew the lease at Sonali Gardens to provide continuity of care

Councillor Rachel Blake, Deputy Mayor and Cabinet Member for Adults, Health and Wellbeing, introduced the report. She explained that the specific contracts set out in the report supported the Council's overall vision for adult day support in the borough. The Council was confident it had the processes in place to ensure the services provided at the centres could be managed appropriately.

The Mayor welcomed the report and its key role in ensuring these services could continue to be provided. He noted the exempt appendices setting out confidential financial information. He thanked officers for their work on the report and proposed the recommendations as set out. The Members present agreed the recommendations and it was:

RESOLVED

1. To note the position with regard to the proposed new contracts for the provision of day care and community support hub and spoke activities service.

2. To note that premises at Sonali Gardens, which the Council holds on a lease from Clarion Housing, are required as an on-going location for the service and that the existing lease expires in March 2022.

3. To agree that the Council enters into a new lease for a term of up to 15 years, whilst seeking flexibility in the lease, and on the basis of the rent and other main commercial terms set out in Exempt Appendix 1 to the report.

4. To agree to delegate authority to the Corporate Director, Place Directorate to agree the remaining lease terms and any minor variations to the terms in the Appendices 1 to the report.

5. To Agree to issue a direct award to the Peabody Trust for the provision of day care at the maximum estimated value of £2,100,000 for up to 6 years (4+1+1 contract) at Sundial building and delegate authority to the Corporate Director, Health Adults and Communities Directorate, to agree the terms.

6. To agree that £135,000.00 funding (agreed by the Cabinet on 03/03/2021 to provide a community support hub service) will be added to the value of day care contracts in Sonali and Sundial to provide community support hub service. The proportion is yet to be determined.

7. To note that the contracts' value might increase in year 5 and 6 by a maximum of 3 % (based on forecasted inflation rate of the Retail Price Index in the United Kingdom from 2021 to 2025) of the contracts' value due to inflation.

6.10 Outcome of the public representations received in response, and decision in relation to, the statutory Notice on the proposal to establish an Autistic Spectrum Condition (ASC) provision at Hermitage Primary School

The Mayor introduced the report. He explained that this proposal was linked to the wider SEND strategy set out earlier on the agenda.

It was noted that this proposal came out of a previous review which highlighted a lack of school places at primary level for children with autism spectrum conditions. Up to this point many children had been having to look outside the borough for their school places.

The Mayor welcomed the report as providing an important bridge between specialist provision and mainstream schooling. He proposed the recommendation in the report. The Members present agreed the recommendations and it was:

RESOLVED

1. To approve the proposal to agree the prescribed alterations to Hermitage School as set out in the Statutory Notice at Appendix 2 to the report.

6.11 2020-21 Council Budget Monitoring Report – Provisional Outturn

Councillor Candida Ronald, Cabinet Member for Resources and the Voluntary Sector introduced the report providing the Council's Budget Outturn for 2020-21. She highlighted the massive uncertainty the Covid-19 pandemic had caused all councils but that government funding had helped to mitigate some of the impact but much of it had been last minute which made planning very difficult. Every forecast made had been wide of the mark for the year.

Despite this the Council was showing a small underspend overall compared to the expected small overspend. Departmental budgets varied significantly often impacted by the pandemic. Amongst other details of the report, she highlighted issues around business rates and council tax collection with a likely shortfall overall.

She noted concerns had been raised about loans to other local authorities but she reported that this was normal, low risk, activity.

During discussion officers provided an initial verbal response to the Pre-Decision Scrutiny Questions, detailed answers were to be provided later in the week. The significant government support during the pandemic was also noted.

The Mayor welcomed the report and proposed the recommendations set out in the report. The Members present agreed the recommendations set out and it was:

RESOLVED

1. To note the Council's 2020-21 provisional outturn position against General Fund, Dedicated Schools Budget, Housing Revenue Account and earmarked reserves for 2020-21;

2. To note that the reserves position of the Council remains somewhat uncertain pending the closure of the statement of accounts for the period 2016 – 2020;

3. To note the Council's provisional outturn position against General Fund and Housing Revenue Account capital programme approved budgets for 2020-21;

4. To note that there are no equalities implications directly resulting from this report, as set out in Section 4 of the report.

6.12 Contracts Forward Plan 2021/22 – Quarter One

Councillor Candida Ronald, Cabinet Member for Resources and the Voluntary Sector introduced the regular report listing planned tender processes for various contracts across the Council. The Pre-Decision Scrutiny Questions and officer responses were noted.

The Mayor and Cabinet confirmed that they were content for the contracts to be progressed as set out. The Mayor proposed the recommendations on that basis. The Members present agreed and it was:

RESOLVED

1. To note the contract summary at Appendix 1 to the report.

2. To agree that all listed contracts can proceed to contract award after tender by the appropriate Corporate Director for the service area.

3. To authorise the Director of Legal to execute all necessary contract documents in respect of the awards of contracts referred to at Recommendation 2 above.

4. To note the contracts listed in Appendix 2 to the report.

6.13 Nomination to Seahorse Homes Ltd

The Mayor introduced the report on nominations to outside bodies. It was noted that the report referred to appointments to London Housing Corporation as well as Seahorse Homes.

RESOLVED

1. To agree the nomination to outside bodies as shown in Paragraph 3.3 of the report.

7. ANY OTHER UNRESTRICTED BUSINESS CONSIDERED TO BE URGENT

Nil items.

8. EXCLUSION OF THE PRESS AND PUBLIC

Nil items.

9. EXEMPT / CONFIDENTIAL MINUTES

Nil items.

10. OVERVIEW & SCRUTINY COMMITTEE

10.1 Chair's Advice of Key Issues or Questions in Relation to Exempt / Confidential Business

Nil items.

10.2 Any Exempt / Confidential Decisions "Called in" by the Overview & Scrutiny Committee

Nil items.

11. EXEMPT / CONFIDENTIAL REPORTS FOR CONSIDERATION

Nil items.

12. ANY OTHER EXEMPT/ CONFIDENTIAL BUSINESS CONSIDERED TO BE URGENT

Nil items.

The meeting ended at 7.15 p.m.

MAYOR JOHN BIGGS

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Cabinet 8 September 2021	
Report of: Denise Radley – Corporate Director, Health, Adults & Community & Deputy Chief Executive	**Classification:** Unrestricted
Reset Adult substance Misuse Service Contract Direct Award	

Lead Member	**Cllr Sirajul Islam, Cabinet Member for Community Safety**
Originating Officer(s)	Keith Daley Interim Head of Service Substance Misuse
Wards affected	ALL
Key Decision?	No
Reason for Key Decision	N/a
Forward Plan Notice Published	N/a
Strategic Plan Priority / Outcome	1. A better deal for children and young people: aspiration, education and skills 2. Good jobs and employment 3. Strong, resilient, and safe communities Better health and wellbeing

Executive Summary

London Borough of Tower Hamlets' substance misuse service have recently been awarded Central Government Grant Funding to enhance pathways for 'rough sleepers' and those with substance misuse related offending.

The purpose of this report is to seek permission to allow the variation of the current contracts for Reset Adult Treatment Service following receipt of the grant funding.

Recommendations:

The Cabinet is recommended to:

1. Agree the variation of the: Reset Outreach and Referral Service delivered by Providence row (contract HAC5384 A) in line with the report.

2. Agree the variation of the: Reset Recovery Support Service delivered by Change, Grow, Live (CGL) (contract HAC5384 C) in line with the report.

3. Note that the Corporate Director will agree the variation of the Reset Treatment Service delivered by CGL (contract HAC5384 B) in line with the

report in accordance with the delegation under the constitution. This has been agreed at the Directorate Leadership Team on 26th July 2021

4. Note the contents of this report as an update on recent grants made to LB Tower Hamlets substance misuse service

1. REASONS FOR THE DECISIONS

1.1 The purpose of this report is to seek permission to allow the variation of the current contract for Reset Treatment Service following receipt of central government grant funding.

The increased funding from the grants for the Reset Treatment Service (contract HAC5384) amounts to £247,716 which is 7.75% of current contract value (£3,197,953) and therefore below the threshold for the need of Cabinet approval.

1.2 For Cabinet to agree a variation of contract of the Reset Recovery Support Service and Reset Outreach and Referral Service following receipt of central government grant funding.

The increased funding from the grants for the Reset Recovery Support Service (contract HAC5384) amounts to £253,000 (£113,000 + £140,901) which is 34% of the current contract value, and therefore needs Cabinet approval.

The increased funding from the grants for the Reset Outreach and Referral (contract HAC5384) Service amounts to £163,765 which is 100% of the contract value and therefore needs Cabinet Approval.

2. ALTERNATIVE OPTIONS

2.1 Option One - To implement a variation on each of the contracts as described within this document – Preferred option

2.2 Option Two - To implement a competitive tender process for single provider to deliver an ETE Support Service; Rough Sleeping Treatment Service; Rough Sleeper Outreach and Navigation Service

2.3 Option Three – To decline one or any of the central government grants.

2.4 See paragraph 5 for more details.

3. DETAILS OF THE REPORT

3.1 Since December 2020 London Borough of Tower Hamlets (LBTH) has received a number of central government grants focused on adult substance misuse treatment and recovery.

- **Rough Sleeping Drug and Alcohol Treatment Grant Scheme.** Total value £688,505 per annum funding for two years.

- **ADDER* Place-based Accelerator Funding.** Total Value £1,000,000 per annum funding for two years.

  *Addiction, Diversion, Disruption, Enforcement and Recovery

- **Individual Placement and Support.** Total value circa £140,000 (to be confirmed) per annum funding for two years.

3.2 **Rough Sleeping Drug and Alcohol Treatment Grant Scheme**

In December 2020 LBTH successfully bid for funding from the Ministry of Housing, Communities and Local Government (MHCLG) and Department of Health and Social Care (DHSC) Rough Sleeping Drug and Alcohol Treatment Grant Scheme. The grant is administered by Public Health England. The purpose of the funding was to:

a) ensure that the engagement that people have had with drug and alcohol treatment services whilst in emergency accommodation is maintained as they move into longer term accommodation (continuity of care).

b) support people to access, and engage in, drug and alcohol treatment who have not yet done so (access and engagement).

c) build resilience and capacity in local drug and alcohol treatment systems continue to meet the needs of this population in future years (resilient and sustainable models of care).

3.3 The successful LBTH bid focused on improving access and to, and retention in, treatment for the rough sleeping cohort. This will be achieved by allocating outreach 'Navigators' to work exclusively with this cohort supporting access into treatment, housing, and health/mental health services. The bid also included specific Navigator resource for Women rough sleeping and a Peer navigator.

In addition to the outreach to be delivered by our commissioned provider, additional resource will be in place to address the issues of Anti-Social behaviour (ASB) in the borough caused by those using drugs and/or alcohol. This activity will be undertaken by 2 x Assertive Engagement Workers Employed by the Council.

Treatment for this cohort will also be enhanced by the addition of 'ring fenced' clinical resource within Reset Treatment service including non-medical prescribing, clinical psychology, and recovery support.

3.4 Most of the roles identified will sit within our current commissioned providers Posts/Activity Funded:

Provider	Posts	Value
LBTH	2 x Assertive Engagement	£95,502

	Workers	
	1 x Rough Sleeping Pathway Manager	£58,336
	0.5 Data Intelligence Lead	£53,126
Providence Row Reset outreach & Referral	2 x Rough Sleeper Navigators	£81,046
	1 x Women's Rough Sleeping Navigator	£40,523.00
	1 x Peer Navigator	£42,196.00
Change, Grow, Live (CGL) Reset Treatment Service	0.5 FTE Clinical Psychologist	£46,281
	0.5 FTE Assistant Psychologist	£21,725
	1 FTE Non-Medical prescriber	£73,220
	0.5 FTE Dual Diagnosis Recovery Worker	£22,098
	1 FTE Homeless Recovery worker	£42,196

3.5 **ADDER Place-based Accelerator Funding** in April 2021, LBTH was identified as a possible ADDER Place-based Accelerator site. This attracts additional Central Government funding to enhance drug treatment, focused on reducing drug-related crime and the rise in drug-related deaths. To be achieved by building on existing work and looking to expand multi-agency partnership working in our areas to drive sustained health and crime related outcomes.

Project Aims/Outcomes

To deliver reductions in:

- the rate of drug-related deaths.
- drug-related offending.
- prevalence of drug use.

The funding was linked to the Central East Police Basic Command Unit (BCU) which includes LB Hackney. Working in partnership with Police and LB Hackney, we produced a delivery plan that was accepted by both Public Health England and the Home Office.

3.6 The LBTH elements of the Delivery Plan focuses on:

Improved continuation of care from prison to community by commissioning 2 x Prison Substance Misuse Workers who will work exclusively with Tower Hamlets residents in HMP Thameside to facilitate a successful discharge to community services.

A project that offers ongoing intensive support to identified children 10-14 who have been offered and refused or been part of the Breaking the Cycle project. This provides additionality in the form of an ongoing intensive support worker to divert young people at risk of criminality including criminal exploitation and drug supply.

A Women's Criminal Justice Pathway Coordinator to develop and deliver a Women's Criminal Justice Pathway in line with the London Blueprint for Women in the Criminal Justice System. The aim is to deliver a gender informed approach and improve outcomes for women in the criminal justice service.

Additional specialist substance misuse resource for the Integrated Offender Management Team and within the existing 'Through Care' Team.

The development of an 18 – 24-year-old 'Navigator' Team to work assertively with the 18 – 24 cohort to reduce drug related offending particularly drug dealing and divert this cohort away from entrenched substance misuse.

The development of an Employment, Training or Education (ETE) support offer for 18 – 24-year-olds accessing substance misuse treatment.

LBTH Roles

Provider	Posts	Value
LBTH	18-24 Navigators Team leader	£54,456
	4 x 18-24 Navigators	£141,540.00
	Lead Hospital Navigator	£54,456
	Hospital Case Manager	£47,772.00
	2 x IOM Substance Misuse Workers	£94,060.00
	Probation Substance Misuse Worker	£54,432.00
	2x DIP Case Managers	£103,708.00
	2x 10-14 Intensive Support Workers	£103,708.00
	Women's Criminal justice Pathway Coordinator	£58,636.00
	0.5 FTE x Intelligence & Performance Analyst	£31,988.00
Total		£744,756

3.7 Whilst the majority of these funded roles will be employed by, and based within the Council, the Employment, Training or Education (ETE) support offer for 18 – 24-year-olds will sit within Reset Recovery Support.

The ETE offer will be focused on Tower Hamlet residents who are prison leavers or have been in contact with the criminal justice system and have a substance misuse problem or are at risk of developing a substance misuse problem. The aim of the project will be to increase employment or prospect of employment for this cohort. It will reduce re-offending by diverting offenders into ETE opportunities by delivering holistic care and joined up support, ensuring continuity of care, and giving offenders their best chance at making sustained change.

Non LBTH Roles funded

Provider	Posts	Value
CGL	1 x Intervention Coach - Youth	£44,166
	1 x Case Manager	£48,821
	Specialist Training Budget	£20,105
Total		£113,092

3.8 **Individual Placement and Support (IPS).**
Alongside the funding for ADDER Place-based Accelerator, boroughs identified as ADDER Accelerator boroughs also attracted funding for IPS. Therefore, in

April 2021 LBTH were invited to be involved in the IPS programme. IPS is a Public Health England administered programme funded by the Department for Works and Pensions. It is currently funded for two years.

IPS is an evidenced based approach that aims for sustained employment through mainstream, competitive jobs. The distinguishing feature of IPS is that employment support is provided alongside clinical treatment. It works by integrating an employment specialist within treatment as an equal member of the multi-disciplinary team. This makes employment a key aim of recovery and integral to the aims of treatment. Whilst this resource will be open to all who access substance misuse services, it has clear synergies with the 18 – 24-year-old ETE offer identified within the ADDER Accelerator funded posts.

3.9 The IPS funded posts will sit within Reset Recovery Support Service

IPS Funded Roles/Activities:

Provider	Posts	Value
CGL Reset Recovery Support	Senior Employment Specialist	£42,638
	Case Management Specialist	£34,888
	Case Management Specialist	£34,888
	Case Manager Bursary	£15,000
	Local venue rental costs	£10,000
Total		£137,414

4. VARIATION - RESET CONTRACTS

4.1 Reset is the branding for the commissioned Adult Substance Misuse Service in Tower Hamlets. The service is contracted and delivered in three lots:

- Reset Outreach and Referral delivered by Providence row (contract HAC5384 A)
- Reset Treatment service delivered by Change, Grow, Live (CGL). (contract HAC5384 B)
- Reset Recovery Support delivered by Change, Grow, Live (CGL) (contract HAC5384 C)

Reset current providers have been delivering the service since October 2021 following a procurement exercise.

4.2 **Reset Outreach and Referral Service (RORS) delivered by Providence row (contract HAC5384 A)**
The need to vary the contract of RORS is as a result of increased central government funding for Rough Sleepers stemming from emergency measures introduced to deal with the coronavirus pandemic and the government ‘everyone in’ initiative. During this period Tower Hamlets was identified as one of the Local Authority areas with the highest numbers of people sleeping rough who had been moved into emergency accommodation during the COVID-19 pandemic. This attracted funding, and that funding was used to enhance the outreach resource within this contract.

4.3 Whilst the added funding for these roles are of significant monetary value (100% of current contract value), the variations to the contract, do not materially change the nature of the contract. Whilst the cohort is focused i.e., Rough Sleepers, the provider will continue to offer an outreach and referral service to Tower Hamlets residents engaged in substance misuse. This role will be undertaken by the Providence Row staff identified in table 3.4 for the rough sleeping cohort. Rough sleepers are identified specifically within the contract specification as a 'hard to reach' cohort that Providence Row are contracted to engage with.

4.4 The council given a relatively short amount of time to produce a workable bid for this funding. The funding available for the Rough Sleeping Drug and Alcohol Treatment Grant Scheme is time limited and runs from 01/04/2021 – 31/03/2023. There is no facility to 'carry over' funds into the following year. If a procurement exercise was required, this could not be achieved within a time frame that would maximise use of this funding opportunity. This is in part due to the limited commissioning capacity currently within the Substance Misuse Service, due to both vacancies within the team and the current Enabling Functions transformation project.

4.5 Procurement of an additional service to deliver outreach services to this cohort would cause significant duplication of both cost and operational delivery as the current provider was very recently (October 2019) commissioned to delivery outreach services for all 'hard to reach' groups.

4.6 **Reset Treatment Service (RTS) delivered by CGL (contract HAC5384 B)**

4.7 As with Reset Outreach and Recovery, the need to vary the contract of RTS is due to increased central government funding for Rough Sleepers stemming from emergency measures introduced to deal with the coronavirus pandemic and the government. There was deemed a need to increase clinical capacity within the treatment provision for Local authorities in receipt of the Rough Sleeping Drug and Alcohol Treatment Grant Scheme.

4.8 The variation proposed for this contract amounts to 7.75% of current contract value. Variations or modifications to a contract are permitted with Corporate Director approval for variations below 10% of the contract value.

4.9 CGL is commissioned to deliver the treatment element of the Reset contract, this included medical, psychological, and psychosocial interventions. The additional staff resource identified within table 3.4 will be 'ring fenced' to deliver these interventions to the rough sleeping cohort. These additional staff do not materially change the nature of the contract as they will offer the same level of service as generic service users currently access.

4.10 CGL have in place a robust clinical governance structure for the delivery of clinical interventions in Tower Hamlets. This governance structure is overseen locally by a consultant psychiatrist and nationally by CGL's governance Board. Within the funding there is no allocation for management and/or corporate overheads. Therefore, for effective delivery of the service, the staff identified within table 3.4 will need to be collocated within the current treatment service.

Governance arrangements for a second organisation will be complex and given the finite time available for delivery may prove arduous and not cost effective.

4.11 If a procurement exercise was required, this could not be achieved within a time frame that would maximise use of this funding opportunity. This is partly due to the limited commissioning capacity currently within the Substance Misuse Service, due to both vacancies within the team and the current Enabling Functions restructure.

4.12 **Reset Recovery Support Service (RRSS) delivered by CGL (contract HAC5384)**

4.13 The variation of contract for the RRSS is due to increase in staffing due to the funding from both ADDER Place-based Accelerator funding (table 3.7) and IPS funding (table 3.9).

4.14 The Reset Recovery Support Service is commissioned to deliver Recovery support to those within the adult treatment system. Recovery support includes, but is not limited to, ETE, Housing and Relapse Prevention. Recovery support is key service user achieving and maintaining their continued recovery from drugs and/or alcohol. This fact was recognised by central government who allocated extra funds to ADDER accelerator sites to focus on recovery support particularly employment.

4.15 The additional staff identified within tables 3.7 and 3.9 will offer practical employment support to both the 18 – 24-year-old cohort (ADDER), and to the general adult substance misuse caseload (IPS). Whilst this a significant increase in contract value (34%) the nature of the contract will remain unchanged. ETE support is specified with the current contract and is currently being delivered. The added resource (ADDER/IPS) would be in addition to the support currently available.

4.16 As stated, both the ADDER and IPS funding are time limited 01/04/2021 – 31/03/2023. There is currently no scope to extend the funding or to carry monies over to the following year. A timely implementation of both projects is needed to maximise the benefits for both service users and the Local Authority. Due to the current capacity issues within our commissioning resource, A procurement exercise would not be completed in a timely manner.

5. OPTIONS

5.1 Option One

To implement a variation on each of the contracts as described within this document – Preferred option

5.2 Option Two - To implement a competitive tender process for single provider to deliver an:

- ETE Support Service
- Rough Sleeping Treatment Service

- Rough Sleeper Outreach and Navigation Service

5.3 Option Three – To decline one or any of the central government grants.

6. COMMENTS OF THE CHIEF FINANCE OFFICER

6.1 The current contract with CGL to deliver the Treatment and Recovery service is for 5 years with a total cumulative value of £19.887m. The contract for Outreach is also for 5 years with a cumulative value of £820k. All three contract can be extended for further 2 years and is in Year 3 of the delivery. The contract is funded through Public Health grant.

Service break-down	Total Contract value £	Variation £	PerCentage
Treatment Services (CGL)	15,962,944	£247,716	2%
Recovery Services (CGL)	3,924,115	£253,000	6%
Outreach (Providence row)	820,000	£163,765	20%
Total	19,887,059	£664,481	

6.2 The variation to the contract will be funded from the additional grant and therefore will not affect existing funding arrangement or create additional pressure in the general fund.

6.3 The recommendation sought within the report and the financial implication is contained within the report. Should there be further financial implication, relevant approval will need to be obtained as part of the MTFS process.

7. COMMENTS OF LEGAL SERVICES

7.1 Under the Public Contracts Regulations 2015 the Council may increase the value of spend under a procured contract provided that the overall increase is not greater than 50% of the original contract value, the services need to connect with each other and that a new contractor cannot be used due to the excessive duplication of costs and inconvenience to the Council. The report shows compliance with this law and therefore the modification to the original procured contracts is lawful.

7.2 The Council will also alter the contracts to ensure that the requirements that the contractual requirements that relate to the extra spend are included in the contract. This will allow contract monitoring to ensure the increased expenditure achieves the aims for which it is intended and help demonstrate the Council's compliance with its Best Value Duty.

Linked Reports, Appendices and Background Documents

Linked Report

- NONE

Appendices

- LBTH Reset Outreach and Referral Service – Service Specification
- LBTH Drug and Alcohol Recovery Support Service – Service Specification

Officer contact details for documents:
N/A

London Borough of Tower Hamlets
Drugs and Alcohol Treatment Service
Service Specification

Contents

1 Introduction

1.1 Background

1.1.1 The misuse of drugs and alcohol presents a wide range of social and health issues. It can have serious consequences for individuals, their family members and whole communities including crime, domestic abuse, child abuse and neglect, family breakdown, homelessness and physical and mental health problems. Tower Hamlets has a high prevalence of drug and alcohol misuse, with around 48% of Opiate and Crack users and 20% of dependent drinkers currently engaging in treatment services.

1.1.2 Tower Hamlets has a committed partnership working hard to meet the objectives set out in our Substance Misuse Strategy (detailed below). Engaging those with substance misuse issues into treatment services is a key priority for our partnership with our collective aim being to improve the quality of life, health and wellbeing of substance misusing residents, enabling these individuals to become abstinent and sustain their recovery.

1.1.3 The Tower Hamlets Drug and Alcohol Action Team (DAAT) have commissioned drug and alcohol treatment services since the late 1980s. In 2014 a wholescale service review of the treatment system was undertaken to inform a transformation in the delivery of services.

1.1.4 The remodelled Treatment System was implemented in 2016 following extensive consultation, comprehensive review and significant redesign of substance misuse treatment services in Tower Hamlets, alongside a substance misuse specific needs assessment. The model adopted sets out three separate contracts: Drug & Alcohol Outreach and Referral Service, Drug & Alcohol Treatment Service and Drug & Alcohol Recovery Support Service.

1.1.5 Together these form Reset - the brand name for the system encompassing the three contracts. Reset is a recovery-oriented system supported by a number of services including the Reset Homeless Drug & Alcohol Service, Primary Care Drug & Alcohol Service, the Specialist Midwife based within Royal London Hospital and the Drug Intervention Programme.

1.1.6 In advance of this round of procurement a consultation with over 400 stakeholders was undertaken to assess stakeholder views of the current system. The findings from the consultation indicated support for retaining the current treatment model.

1.2 Re-procurement

1.2.1 The Council has a duty to comply with laws and regulations outlined by the European Union and the UK Government which inform how we award contracts. It is imperative that we are committed to ensuring quality service delivery and outcomes whilst achieving best value.

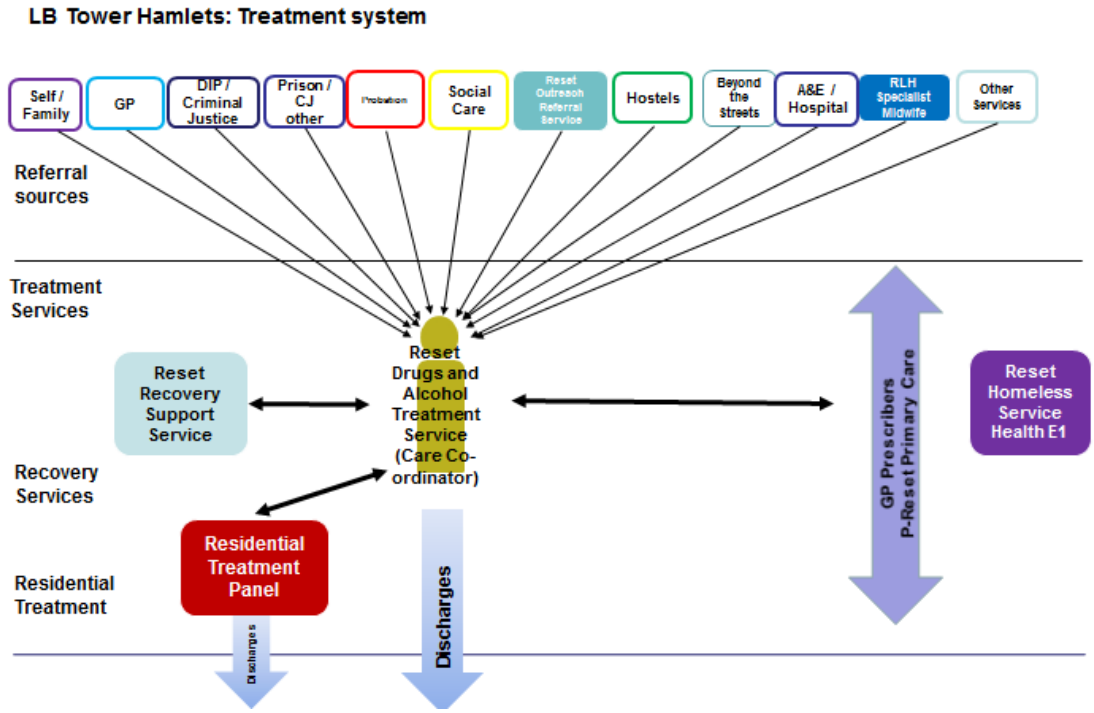
1.2.2 With existing contracts coming to an end in October 2019 and in line with Procurement and Legal procedures, the DAAT is now at the point of re-procuring the Reset contracts. As part of that, the DAAT conducted a comprehensive stakeholder consultation exercise which identified areas for improvement. These areas have been

evaluated and improvements incorporated into the contract specifications and Performance Framework.

1.3 Treatment Model

1.3.1 The current treatment model sets out three separate services operating together under the brand Reset; delivering the key components of outreach and referral, treatment and recovery support. The three services are supported by provisions sitting outside of this procurement, including Reset Homeless Service, Primary Care Drug & Alcohol Service and the Specialist Midwife. This model will underpin a drugs and alcohol treatment system that is recovery orientated. Treatment is based on a menu of complementary and associated interventions that are evidence based, service user focused and embedded in recovery.

1.3.2 This model is outlined below:



1.3.3 Consultation findings highlighted strengths in the treatment system model including the ease of navigation through the system with a single point of entry and dedicated care-coordination throughout the treatment journey. Outreach provisions were thought to have improved the engagement of hard to reach populations.

1.3.4 Areas for development were also identified: increased and tailored trauma informed offer for women, additional treatment locations/ hubs and increased support for service users with mental health conditions.

1.3.5 The DAAT is responding to the gaps identified through the revision of service specifications, review of key performance indications (KPIs), close monitoring of contract deliverables and oversight of the development of joint working pathway agreements.

2 National Context

There is a range of national and local cross-cutting policy themes that guides the work of Tower Hamlets and sets the backdrop to this procurement exercise:

2.1 Drug Strategy 2017

2.1.1 The Drug Strategy 20171 sets out the Government's approach to tackling drug use and the expectations for action from Government at both national and local levels alongside international partners, voluntary, third sector, health and community organisations adopting a partnership approach to respond to the challenges and harms caused by drug misuse and support individuals to live a drug-free life.

2.1.2 There are two overarching aims of the strategy regarding treatment:

- Reducing illicit and other harmful drug use,
- Increasing the numbers recovering from dependence

2.1.3 In order to deliver recovery orientated treatment, there is an acknowledgement that links with housing, employment and family services must be firmly established and integrated into overall treatment services and that supportive relationship with families, carers and social networks must be promoted.

2.1.4 It is also recognised that a joined-up approach to drugs and alcohol is vital and commissioning of drug and alcohol services should take place in an integrated way, whilst ensuring a focus on specific and appropriate interventions.

2.2 Medications into Recovery 2012

2.2.1 The Recovery Orientated Drug Treatment Expert Group led by Professor John Strang report Medications into Recovery 2012: Re-orientating drug dependence treatment2 provides a framework for meeting the ambition of the Drug Strategy to help more Heroin users to recover and break free of dependence.

2.2.2 The Expert Group's advice makes clear that:

- Care planning, with its on-going and planned reviews of specific goals and actions, should be part of a phased and layered treatment programme.
- A strategic review of the client's recovery pathway will normally be necessary within three months (and no later than six months) of treatment entry, and will then usually be repeated at six-monthly intervals.
- Strategic review should always revisit recovery goals and pathways (to support clients to move towards a drug-free lifestyle).
- Drug treatment should be reviewed based on an assessment of improvement (or preservation of benefit) across the core domains of successful recovery.

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[1] Drug Strategy 2017 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/628148/Drug_strategy_2017.PDF

[2] Medications in Recovery – http://www.nta.nhs.uk/uploads/medications-in-recovery-main-report3.pdf

2.3 Alcohol Strategy 2012 (update expected in 2019)

2.3.1 The Alcohol Strategy 2012 is built around four key objectives underpinned by a recovery orientated approach to treatment and a focus on those whose offending is alcohol related:

- End the availability of cheap alcohol and irresponsible promotions.
- Ensure that local areas are able to tackle local problems, reduce alcohol fuelled violent crime on our streets and tackle health inequalities by giving tools and powers to local agencies to challenge people that continue to act in an unacceptable way.
- Secure industry's support in changing individual drinking behaviour.
- Support individuals to make informed choices about healthier and responsible drinking, so it is no longer considered acceptable to drink excessively.

2.3.2 The Alcohol Strategy also highlighted provision of recovery orientated treatment in particular for dependent drinkers; whole family based approach within treatment services and continued support for effective health measures such as brief interventions.

2.4 Psychoactive Substances Act 2016

2.4.1 The Psychoactive Substances Act 20163 defines psychoactive substances and outlines offences and prohibited activities relating to such substances, also highlighting exceptions and substance exempt from the Act.

2.4.2 The Act provides enforcement powers and gives the Police and local authorities more powers to respond to the trade of psychoactive substances.

2.5 Dual Diagnosis

2.5.1 In 2017 Public Health England produced a guide for commissioners and service providers which sets out how services can be improved to "provide a range of coordinated services that address people's wider health and social care needs, as well as other issues such as employment and housing" (Better care for people with co-occurring mental health and alcohol/drug use conditions). It is estimated that around 40% of individuals diagnosed with a psychotic illness have misused drugs or alcohol (NICE 2016).

2.6 Good Practice

2.6.1 Dual Diagnosis is a 'whole system' multi-agency issue, affecting a broad cross-section of adults, with varying levels of severity and impact on the individual, their friends and family, as well as local communities. A population-based approach to commissioning and managing integrated dual diagnosis provision, which utilises existing resources to support the maximum number of people across a broad spectrum of need within local communities is required.

[3] The Psychoactive Substances Act 2016
http://www.legislation.gov.uk/ukpga/2016/2/pdfs/ukpga_20160002_en.pdf

2.6.2 NICE guidelines recommend:

- Rather than commissioning 'dual diagnosis specialist teams' wider services should adapt to and coordinate the care of this group
- Care should be led and coordinated through mental health services

2.6.3 Providers of Substance Misuse services should work with mental health services to ensure the following key principles are adhered to:

- Do not exclude adults and young people with psychosis and coexisting substance misuse from age-appropriate mental health care because of their substance misuse
- Do not exclude adults and young people with psychosis and coexisting substance misuse from age-appropriate substance misuse services because of a diagnosis of psychosis
- Consider seeking specialist advice and initiating joint working arrangements with specialist substance misuse services for adults and young people with psychosis being treated by community mental health teams, and know to be; severely dependent on alcohol or dependent on both alcohol and benzodiazepines or dependent on opioids and or cocaine or crack cocaine
- Adult community mental health services should continue to provide care coordination and treatment for the psychosis within joint working arrangements
- Do not exclude people from physical health care, social care, housing or support services because of their coexisting severe mental illness and substance misuse
- Adopt a person-centred approach to reduce stigma and address any inequity to access services people may face
- Undertake a comprehensive assessment of the person mental health and substance misuse needs.

2.6.4 The management of people with dual diagnosis remains an area of concern and one of high priority for mental health policy and in clinical practice. Individuals with coexisting mental health and substance misuse problems deserve high quality, patient focused and integrated care. This should be delivered within mental health services. This policy is referred to as "mainstreaming". Patients should not be shunted between different sets of services or put at risk of dropping out of care completely. 'Mainstreaming' will not reduce the role of drug and alcohol services which will continue to treat the majority of people with substance misuse problems and to advise on substance misuse issues. Unless people with a dual diagnosis are dealt with effectively by mental health and substance misuse services these services as a whole will fail to work effectively.

2.6.5 To support the principles of 'everyone's job' and 'no wrong door', set out in PHE's guidance, the following priorities in the delivery of care should be adhered to:

- Agree a pathway of care which will enable collaborative delivery of care by multiple agencies in response to individual need
- Appoint a named care coordinator for every person with co-occurring conditions to coordinate the multi-agency care plan

- Enable people to access the care they need when they need it and in the setting most suitable to their needs
- Make sure people are helped to access a range of recovery support interventions, while recognising that recovery may take place over a number of years and require long term support

2.6.6 The guide also recommends a framework for delivery of care based on the following factors:

- Strong therapeutic alliance
- Collaborative delivery of care
- Care that reflects the views, motivations and needs of the person
- Care that supports and involves carers (including young carers) and family members
- Therapeutic optimism
- Episodes of intoxication are safely managed

2.7 **Transforming Rehabilitation**

2.7.1 The Drug Strategy states "prison may not always be the best place for individuals to overcome their dependence and offending". The 'Transforming Rehabilitation' proposals have been introduced as part of the Government's overall response to crime, drugs and alcohol problems through the Offender Rehabilitation Act 2014 with lead responsibility for implementation resting with the Home Office. The Offender Rehabilitation Act 2014 sets out the following as priorities:

- Creation of a new public sector National Probation Service to work with the most high- risk offenders.
- Formation of 21 new Community Rehabilitation Companies (CRCs) to turn round the lives of medium and low-risk offenders.
- Giving statutory supervision and rehabilitation in the community to every offender released from custody, including those sentenced to less than 12 months in custody.
- Establishing a nationwide 'through the prison gate' resettlement service to give most offenders continuity of support from custody into the community; a network of resettlement prisons will ensure that offenders continue to be managed by the same provider as they move from custody into the community.
- Opening up the market to a diverse range of new rehabilitation providers to get the best out of the public, voluntary and private sectors and giving them the flexibility to do what works.
- Only paying providers in full for real reductions in reoffending.

2.7.2 Although offenders are not a homogeneous group, a range of problems or needs are more frequently observed in offender populations than in the general population. These include substance misuse problems, pro-criminal attitudes, difficult family backgrounds including experience of childhood abuse or time spent in care, unemployment and financial problems, homelessness and mental health problems. Many of these factors are interlinked and may vary from individual to individual and group to group.

2.7.3 A series of individual or social factors are understood to be associated with an increased risk of reoffending and these are routinely assessed as part of offender management practice. These factors or 'criminogenic needs' can be particularly associated with certain types of crime. Heroin and Crack use is particularly associated with some types of acquisitive offending such as shoplifting, and binge drinking of alcohol is particularly associated with violence.

2.7.4 The Ministry of Justice has announced further future reforms to the Probation service following the termination of the contracts with CRCs in 2020. The DAAT will expect Reset providers to work proactively with criminal justice agencies through the reforms as a significant proportion of referrals into the treatment system come via criminal justice pathways

2.8 Public Health Outcomes Framework 2016 - 2019

2.8.1 The Public Health Outcomes Framework (PHOF): Improving outcomes and supporting transparency4 sets out a vision for public health, desired outcomes and the indicators that will help to understand how well public health is being improved and protected.

2.8.2 Tower Hamlets DAAT has responsibility for delivering against four national public health indicators;

- Successful completion of drug and/or alcohol treatment (PHOF 2.15i, ii, iii)
- Deaths from drug misuse (PHOF 2.15 iv)
- Reducing alcohol related admissions to hospital (PHOF 2.18)
- Successfully engaging individuals with a substance misuse need in community-based structured treatment following release from prison (PHOF 2.16)

2.9 Metropolitan Police Service (MPS) Drugs Strategy 2017 – 2021

2.9.1 The MPS Drugs Strategy 2017-2021: Dealing with the impact of drugs on communities and confidence in Police aims to support local officers in their response to drug related matters with the aim of reducing the social and criminal impact of illicit drugs on communities in London.

2.9.2 The Strategy is based on 3 key principles:

- Reduce Demand
- Reduce Supply
- Reduce Harm

[4] Public Health Outcomes Framework 2016-19 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/545605/PHOF_Part_2.pdf 2013-2016 - http://www.phoutcomes.info/

3 Local Context

3.1 Tower Hamlets

3.1.1 Tower Hamlets has an estimated population of 308,000. This makes the borough a mid-sized local authority within London. The population is projected to reach 365,200 by 2027 – equivalent to around 15 additional residents per day for the next ten years. The population is expected to reach 400,000 by 2041.5

3.1.2 Tower Hamlets has a relatively young population compared with the rest of the country. Our median age in 2017 was 31.0 years which was the 4th youngest median age out of all local authorities in the UK.13 The median age was 35.1 in London (4.1 years older), 39.8 in England (8.8 years older) and 40.1 in the UK (9.1 years older). The borough's relatively young age profile reflects the fact that over the past ten years, the borough's working age population has increased much more quickly than the child population or older age groups.

3.1.3 Tower Hamlets ranks as the 16th most ethnically diverse local authority in England in terms of the mix of different ethnic group populations in the borough. More than two thirds (69 per cent) of the borough's population belong to minority ethnic groups (i.e. not White British), while just under one third (31 per cent) are White British the fifth lowest proportion in England & Wales.

3.1.4 Bangladeshi residents are the largest single ethnic group in Tower Hamlets, accounting for around one in three residents (32 per cent) at the time of the 2011 Census. This was the largest Bangladeshi population in the country, by far.

3.1.5 There are large differences in the ethnic profile of different age groups. The working age population (aged 16 to 64) is the most diverse age group, with no single ethnic group making up the majority of the population. On the other hand, 57 per cent of the borough's children (aged 0 to 15) are Bangladeshi and 57 per cent of the borough's older people (aged 65+) are White British.

3.1.6 Tower Hamlets has the highest proportion of Muslim residents in the country. In 2011, 38 per cent of borough residents were Muslim compared with 5 per cent in England and 13 per cent in London. Conversely, the borough had the lowest proportion of Christian residents nationally: 30 per cent of borough residents were Christian compared with 59 per cent in England & Wales. Around one in five (21 per cent) of residents had no religion and 7 per cent chose not to state their religion on the Census form.

3.1.7 On the average IMD score measure – which reflects the average level of deprivation across all LSOAs in an area - Tower Hamlets is the 10th most deprived area in England out of 326 local authority areas. This is a slight improvement since the 2010 IMD which ranked Tower Hamlets as 7th most deprived on this measure. Deprivation is widespread in Tower Hamlets and the borough remains one of the most deprived

[5] Borough Profile https://www.towerhamlets.gov.uk/Documents/Borough_statistics/Research-briefings/Population_2_BP2018.pdf

areas in the country. The borough fares worst on measures that relate to housing and income deprivation, especially income deprivation affecting children and older people[6].

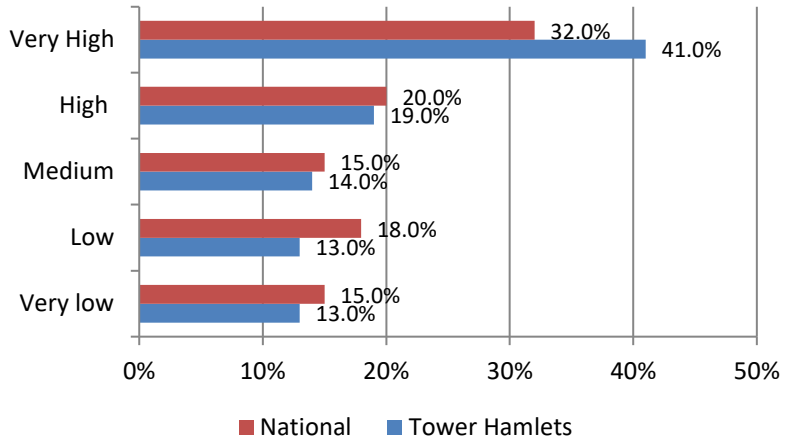
3.1.8 Tower Hamlets is estimated to have the third largest lesbian, gay and bisexual population in London with estimates from the 2015 GP survey placing the percentage of the adult population who identify as LGB at 8.7%[7].

3.1.9 Drug and alcohol treatment provision in Tower Hamlets will need to meet the specific needs of these diverse ethnic, LGBT and faith communities in particular the needs of the large Muslim, Bangladeshi & Somali communities.

3.2 Drug and Alcohol Treatment Population

3.2.1 Historically, complexity levels of the Tower Hamlets treatment population have been very high. Most recent data shows that complexity levels remain high, with around 41% of clients in treatment classified with very high complexity levels compared to a national average of 32%; therefore interventions need to reflect this complexity to effectively support service users.

Chart 1: Tower Hamlets client complexity compared to national average March 2018 (Source: Recovery Diagnostic Toolkit March 2018)



3.2.2 Treatment has a strong health focus and many service users have their Opiate substitution prescribed by local GPs under a 'Shared Care' arrangement between themselves and the local treatment providers. The substitute prescribing is designed to stabilise and maintain these service users. However, only a small proportion of those in treatment access wider recovery and cessation orientated psychosocial interventions. This needs to change particularly as the borough is being challenged to increase its successful completions from drug and alcohol treatment (a proxy outcome measure for recovery). Whilst it is clear that many in the treatment system are not ready to become drug and alcohol free, measures must be in place to support this aim and importantly the treatment system must work collaboratively with the

[6] The Indices of Deprivation 2015

[7] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/585349/PHE_Final_report_FINAL_DRAFT_14.12.2016NB230117v2.pdf

commissioned Primary Care Drug & Alcohol Service provider to enable this outcome orientation to become the central theme for treatment in the borough.

3.2.3 Therefore the priorities and dynamics of the treatment system in this context are to achieve;

- Improved focus on recovery with service users in Shared Care utilising interventions at the Recovery Support Service
- Improved performance management
- Coordination of resources and budgets to achieve strong value for money and service quality
- Improved broader health outcomes for service users including treatment and ongoing management of associated long term conditions
- Enhancing support offered to clients post-discharge

Drugs - Prevalence Estimates

3.2.4 Information about the number of people who use illicit drugs such as Heroin, other Opiates or Crack Cocaine is key to formulating effective policies for tackling drug-related harm as these drugs are associated with the highest levels of harm. It also helps inform service provision at the local level and provides a context in which to understand the population impact of interventions to reduce drug-related harm.

3.2.5 The latest 2014-15 estimates[8] for Tower Hamlets suggest there are:

- 2,798 opiate and/or crack users (OCU),
- 2,309 opiate only users,
- 2,543 crack only users,
- 773 intravenous drug users (2011/12 estimate)

3.2.6 The estimate refers to the period 2014/15 and suggests a total of 2,798 OCUs, representing a fall of around 20% from 3,561 in 2011/12.

3.2.7 Prevalence rates for OCUs, Opiate and Crack in Tower Hamlets are significantly above London and England rates. The LBTH Crack using estimate is nearly twice as high as the National and London rate.

3.2.8 The estimated unmet need was around 52% or 1,600 potential clients who would profit from treatment[9].

Alcohol – Prevalence Estimates

3.2.9 A large proportion of the Tower Hamlets population does not drink; this is reflective of the borough's diverse ethnic and faith population. It is estimated 48% of the adult population abstain from alcohol use. However amongst those people in Tower Hamlets who do drink there is evidence of higher rates of dependency and health harms associated with excess consumption

[8] PHE OCU estimate 2014/15 published 2017

[9] Unmet need is the number of individuals requiring treatment but not in contact with treatment services based on recent prevalence and 2017/18 treatment engagement.

3.2.10 The latest data estimates a total of 3,427 dependent drinkers in need of assessment and potential treatment in the borough. Based on this, around 82 per cent of those drinkers are currently not in treatment and their needs might be unmet.

3.2.11 The data shows that Tower Hamlets had the 7th highest rate of dependent drinkers in London. Around 20% of Tower Hamlets adults drink more than 14 units of alcohol as recommended by PHE.

Drug and Alcohol Treatment

3.2.12 The Tower Hamlets treatment system is the largest in London with more than 2,000 clients engaging in structured treatment per annum. This includes 1,232 Opiate clients, 146 non-Opiate clients and 691 alcohol clients (Alcohol only & Non-opiate & Alcohol) in 2017/18[10].

3.2.13 The treatment system has become more diverse over the last two years, attracting more women, students and young adults into treatment. Considerably more work needs to be undertaken to attract other groups, in particular the LGBTQ community where the prevalence of party drug use remains unknown locally.

3.2.14 Successful treatment outcomes have much improved since Reset started in Oct 2016. 411 clients left treatment successfully in 2017/18.

3.2.15 Re-presentations rate are comparably low and clients achieve very good rates of abstinence when attending structured treatment.

3.2.16 The introduction of short term treatment episodes has improved engagement with alcohol only and alcohol & non-Opiate clients.

3.3 Tower Hamlets Substance Misuse Strategy 2016-2019

3.3.1 The Substance Misuse Strategy is a joint strategy that was developed in partnership between London Borough of Tower Hamlets, NHS East London & the City, the Metropolitan Police and the London Probation Service. The Partnership Vision leading the strategy:

> "In Tower Hamlets, we will support children, young people, adults and their families to maximise their health and wellbeing whilst reducing the negative impact of drugs and alcohol. We will strengthen protective factors for those at risk, and empower those who are addicted or dependent to recover whilst reducing harm from continues use. We will bear down on the crime and anti-social behaviour associated with drug and alcohol misuse that impacts on our communities"

3.3.2 The strategy relies on a 'Three Strands' approach, addressing:

- **Prevention and Behaviour Change**: including information, education, support to parents, health messages and communications and safeguarding vulnerable young people and adults

[10] Source: NDTMS DOMES reports Q4 2017/18

- **Treatment**: through screening and identification, assessment and care planning, effective treatment, after care and reintegration
- **Enforcement and Regulation**: including dedicated and targeted operations, integrated offender management, licensing and regulatory enforcement and enforcement of controlled drinking zones.

3.3.3 The strategy sets out the broad framework for drug and alcohol interventions across the borough and identifies a range of priorities that address the themes listed above.

3.3.4 With reference to the Treatment strand of the Substance Misuse Strategy, the objectives for improving the outcomes of our service users are to:

- Take a person centred approach and deliver high quality services to meet the needs of individual service users,
- Provide a range of flexible, innovative and adaptable service approaches,
- Promote and deliver effective early intervention engagement,
- Empower those who are dependent on drugs and/or alcohol to recover,
- Deliver a service where recovery and associated interventions are integral to the design of the entire treatment journey; for example housing, volunteering, aftercare groups,
- Ensure services are delivered by a professional, competent and skilled workforce,
- Ensure services are underpinned by a robust clinical governance structure,
- Meet the needs of socially excluded communities (including BME, lesbian, gay, bisexual, transgender communities), ensuring effective engagement, and respond to the complexities of drug and alcohol users in Tower Hamlets,
- Continue to focus on the broader health and social issues and respond to the findings from the most recent Needs Assessment,
- Integrate the views of service users and significant others into account when designing service delivery by developing local partnerships and consulting service users regarding operational issues and changes,
- Support carers and concerned family/friends to receive support,
- Continue to review services to ensure they remain fit for purpose and locally focused.

3.3.5 The implementation of the Strategy is overseen by the DAAT Partnership Board and reports on progress are provided for other relevant boards such as the Community Safety Partnership and Health and Wellbeing Boards as appropriate.

3.3.6 With the current Strategy term coming to an end in 2019, the DAAT will be conducting a consultation to review current priorities and develop a new Strategy, the term yet to be decided.

3.4 Tower Hamlets Health & Wellbeing Strategy 2017 - 2020

3.4.1 Living a healthy life prevents illness and enhances wellbeing. The Health and Wellbeing Strategy 2017-2020 sets the ambition to make a positive impact on the physical and mental health and wellbeing of people living and working in Tower Hamlets.

3.4.2 The strategy states: "We know we face some big health challenges in Tower Hamlets but also that by working together across services - and with our local communities - we can make a positive difference to everyone's wellbeing in Tower Hamlets".

3.4.3 The strategy recognises that alcohol consumption and the use of illegal drugs are factors linked to poor health and one of the priority areas to address these issues is Employment and Health.

3.5 Joint Strategic Needs Assessment 2017 [11]

3.5.1 The Tower Hamlets Joint Strategic Needs Assessment (JSNA) is a living document overseen by the Tower Hamlets Health and Wellbeing Board. There is clear recognition that understanding health and wellbeing and debating priorities for action is a dynamic process that takes place within a context of continual change.

3.5.2 Life expectancy in Tower Hamlets remains lower than the rest of the country but continues to improve. Since 2000, life expectancy has increased in males and 5% in females.

- Male life expectancy is 78.1.3 years compared to 79.6 years nationally,
- Female life expectancy is 82.5 years compared to 83.2 years nationally in 2012-14

3.5.3 There are a number of demographic and socioeconomic factors that affect current and future health and social care needs in Tower Hamlets. These are:

- Rapid population growth
- High socioeconomic deprivation: Tower Hamlets is the 10th most deprived borough in the country. 58 of the population reside in the 20% most deprived areas in England; 24% live in the 10% most deprived
- High population churn - 19% move in or out of the borough per year
- Changes to the welfare system – particularly impacts on income, employment and housing.

3.6 Tower Hamlets Strategic Plan 2018-2021

3.6.1 The Strategic Plan sets out the council's key priorities and activities, including how the Council will deliver the strategic priorities of the new Mayoral administration and work in collaboration with partners to progress ambitions for the Borough.

3.6.2 The Strategy sets out three key priorities for 2018-2021

- Priority 1: People are aspirational, independent and have equal access to opportunities
- Priority 2: A borough that our residents are proud of and love to live in

[11] Latest JSNA documents can be found on the LBTH website https://www.towerhamlets.gov.uk/lgnl/health__social_care/joint_strategic_needs_assessme/joint_strategic_needs_assessme.aspx

- Priority 3: A dynamic outcomes-based council using digital innovation and partnership working to respond to the changing needs of the borough.

3.6.3 The strategy outlines actions to address a range of drug and alcohol related issues, including tackling crime and anti-social behaviour associated with the illegal supply of drugs and the misuse of alcohol, and providing to treatment to individuals.

3.7 Tower Hamlets Together

3.7.1 Tower Hamlets Together (THT) is a partnership including the Council and local health and social care organizations. THTs vision is; to work together improve the health and wellbeing of people living in Tower Hamlets. One of the primary aims of the THT programme is to deliver services in a more coordinated to both reduce duplication and improve the overall experience and outcomes for our residents who need them.

THT Mission and Values

3.7.2 To improve the health and wellbeing of people who live in Tower Hamlets and to improve the quality of the care services we provide, ensuring that we spend the money we have available, wisely. Our services will be person-centred, co-ordinated and will make a real and positive difference to people's lives. The values supporting THT's mission are: collaboration, compassion, inclusivity and accountability.

THT Priorities

3.7.3 The borough's approach to the development of integrated care sits within the overarching strategic framework of the Tower Hamlets Health and Wellbeing Strategy.

3.7.4 The current priorities are:

- Communities Driving Change – changes led by and involving communities
- Creating a Healthier Place – changes to our physical environment
- Employment and Health - changes helping people with poor working conditions or who are unemployed
- Children's Weight and Nutrition - changes helping children to have a healthy weight, encouraging healthy eating and promoting physical activity
- Developing an Integrated System – changes which will join-up services so they are easier to understand and access.

3.7.5 In order to deliver against the above priorities THT is organised around three workstreams to reflect Tower Hamlets population groups:

- Children – Born Well and Growing Well
- Healthy adults – Living Well
- Complex adults –Promoting Independence

3.7.6 Further information on the programme can be found here: https://www.towerhamletstogether.com/files/Our_Vanguard_Story_Tower_Hamlets_Together_Brochure.pdf

3.8 Tower Hamlets Community Safety Partnership Plan 2017-21[12]

3.8.1 The Partnership is statutorily responsible for community safety in the borough and is one of the Community Plan Delivery Groups.

3.8.2 The Community Safety Partnership is responsible for:

- Delivering Community Safety Partnership strategic priorities and any relevant targets arising from these priorities on behalf of the CSP Executive;
- Fulfil statutory responsibilities held by the CSP Executive under the legislation; and
- Respond to other issues relating to community safety, which may arise, from government policies or other developments.

3.8.3 The Partnership agreed that the following priorities for the period 1st April 2017 – 31st March 2021 (4 years).

- Priority A: Anti-Social Behaviour (ASB) including Drugs and Alcohol
- Priority B: Violence
- Priority C: Hate Crime, Community Cohesion and Extremism
- Priority D: Reducing Re-offending

3.8.4 Under the responsibility of the DAAT Board there are four indicators being monitored and reported to CSP, these are:

- Young People starting treatment
- Number of Adults in treatment who live with children
- Number of Adults in drug and alcohol treatment
- Number of individuals causing drug / alcohol related crime or ASB required to engage in structured treatment programmes via criminal or civil orders

3.9 Local Employment Strategy

3.9.1 The Local Employment Strategy has been developed in the context of the broad agreement of national, regional and local government, as outlined in the Strategic Regeneration Framework. In the context of this Strategy, convergence for Tower Hamlets means that the employment rate should be equal to the London average by 2020.

3.9.2 The structure adopted within this Strategy is:

- Context – summarises the history, geography and demographics of Tower Hamlets, particularly as they relate to its economic situation and the employment rate,
- Supply – describes and analyses the composition of working and non-working groups in Tower Hamlets,

12 https://www.towerhamlets.gov.uk/lgnl/community_and_living/community_safety__crime_preve/community_safety_partnership/community_safety_partnership.aspx

- Demand – details the types of businesses present in the borough, the changes (growth or contraction) of their relative importance to the labour market, and the skills they require,
- Delivery and funding – outlines current and forthcoming employment services provision at all levels that apply to the borough's residents,
- Analysis – sets out the key factors that this strategy needs to address,
- Aim and objectives – explains what strategic and intermediary objectives are proposed to increase the employment rate in Tower Hamlets.

3.9.3 The document moves from setting out the data to an analysis and discussion of its significance. This enables conclusions to be drawn from which the strategic objectives are set. It is worth noting that this takes place within the overall story of the profound and accelerating changes that have taken place in Tower Hamlets. The context makes it clear that the challenges to increasing the employment rate to the London average are substantial. However, the last three to four years have been a period of marked improvement, including progress in increasing the employment rate. Given this progress, the aim and objectives of this strategy, whilst stretching, are attainable.

3.9.4 There are five strategic objectives in the current strategy, these are:

- Objective 1: Making the Mainstream Services Work Better for Local Residents,
- Objective 2: Engaging Workless Residents Detached from the Labour Market and Complementing the Work of the Mainstream,
- Objective 3: Encourage Increased Aspirations to Engage with the Labour Market, Particularly for Inactive Groups,
- Objective 4: Ensure Investment is Co-ordinated and Focused,
- Objective 5: Capture Employment Opportunities for Tower Hamlets Residents within the borough and Wider London Labour Market.

3.10 **DAAT Priorities 2018-19**

3.10.1 The DAAT is committed to delivering a comprehensive, recovery-orientated treatment system in Tower Hamlets, ensuring value for money, focus on harm reduction and preventative measures and improved recovery outcomes.

3.10.2 Identified priority and areas for development include:

- Improved engagement with women and improved offer for women
- Increasing the number and type of locations treatment interventions are delivered from, including outreach and in-reach interventions
- Improved support for clients with co-occurring mental health issues
- Increase the uptake of harm minimisation and treatment interventions for our LGBTQ community
- Increased uptake of recovery support interventions
- Improved links with housing services and providers
- Extended and flexible opening hours to meet client needs
- Continued and increased focus on whole-family interventions and support for affected others

- Increased identification of chronic disease such as COPD, liver disease with effective referral to primary or secondary care for treatment and management

4 Drug & Alcohol Treatment Service (Reset Treatment Service)

4.1 Introduction

4.1.1 This section sets out the expectations the council would want to place on the Provider(s). The specification seeks where possible to address local policy priorities and the priorities agreed by the DAAT Board.

4.1.2 This specification has been written in accordance with the principles and expectations outlined within the:

- National Drug Strategy 2017
- National Alcohol Strategy 2012 (updated strategy expected in early 2019)
- Drug Misuse and Dependence, UK Guidelines on Clinical Management (2017)
- Public Health England Commissioning for Recovery (2010)
- The Public Health Burden of Alcohol: Evidence Review (2018)
- Drug misuse treatment in England: Evidence Review of Outcomes (2017)
- Medications in Recovery: Re-orientating drug dependence treatment (2012)
- Other cited relevant guidance and local protocols

4.2 Purpose

Aims

4.2.1 The central aim of the Reset Treatment Service is to provide structured drug and alcohol treatment that will support and enable service users to become free from substance dependency and sustain long term recovery, whilst reducing the overall harm associated with drug and alcohol use. In particular it will seek to:

- Reduce risky behaviour(s) associated with drugs and alcohol (e.g. Injecting),
- Reduce exploitation (including sexual) associated with drugs and alcohol misuse,
- Reduce child safeguarding risks,
- Reduce adult safeguarding risks,
- Reduce alcohol/drug related crime and anti-social behaviour,
- Improve general health and wellbeing of service users,
- Improve mental health, wellbeing and quality of life.

Objectives

4.2.2 The Provider(s) will deliver a recovery focused service that fosters a culture of fair, equitable and flexible access to treatment that will:

- Prevent problematic drug and/or alcohol misuse and dependency,
- Actively support service users in cessation of illicit, non-prescribed drugs, alcohol and/or any other non-prescribed psychoactive substances,
- Empower service users to maximise opportunities and support reintegration into communities,
- Assist service users to improve their personal, social and family functioning,
- Reduce the risk(s) of prescribed drugs being diverted into the illegal drug market,

- Minimise the harms associated with substance misuse including the risks of Hepatitis A, Hepatitis B, Hepatitis C, Tuberculosis (TB), Human Immunodeficiency Virus (HIV) and other blood borne and sexually transmitted infections & alcohol related illnesses,
- Reduce the prevalence of drugs and/or alcohol related serious incidents including fatalities,
- Work in partnership with a range of local voluntary and community sector (third sector) organisations to achieve and deliver the specified outcomes,
- Promote drug and alcohol services and ensure suitable/appropriate access for those needing them (particularly vulnerable groups/individuals),
- Establish and maintain links with local primary care services/health and social care professionals to ensure that there are clearly identified and understood referral pathways between services,
- Establish and maintain procedures for the involvement of General Practitioners (GPs) to ensure all health related matters are addressed in an holistic manner,
- Proactively engage with and actively support carers and communities to improve services and outcomes for service users and their families,
- Actively work to enhance parenting practice and outcomes for families as an integral part of building and sustaining recovery,
- Implement effective practices and integrated approaches to safeguarding, and improving the welfare of the children of drugs and/or alcohol misusing parents,
- Develop, actively encourage and maintain positive and constructive working relationships with children and family services and contribute to the assessment and continued monitoring of families who are at risk or subject to child protection plans/actions,
- Implement effective practices and integrated approaches to safeguard vulnerable adults,
- Support and promote the use of peer recovery networks and recovery champions across all stages of service delivery and post discharge.

4.2.3 The provider will make harm reduction services available such as needle exchange, harm reduction advice and BBV services to anyone requiring such services on an open access basis.

4.3 Scope

Service Users

4.3.1 Reset Treatment Service is a service for residents of Tower Hamlets who are aged 18 years and over who are concerned about their own or someone else's drug taking and drinking behaviour. This includes legal and illegal drugs, novel psychoactive substances (known as "legal highs") and misuse of over the counter and prescribed medicine.

Priority Groups

4.3.2 The Provider(s) will ensure there is appropriate access to treatment for individuals that fall under priority groups for whom drugs and/or alcohol use is problematic.

4.3.3 The following should be considered as priority groups:

- Individuals from diverse BME and faith groups,
- Female substance misuse
- Pregnant women,
- Drug and/or alcohol using parents,
- Intravenous drug users,
- Individuals with co-morbid physical and/or mental health diagnosis where their drugs and/or alcohol use exacerbates this diagnosis,
- Individuals involved in prostitution,
- Individuals who are homeless or in unstable accommodation,
- Individuals recently discharged from prison,
- Individuals required by court orders to engage with treatment,
- Perpetrators and victims of domestic violence.
- Lesbian, Gay, Bi-sexual, Transgender and Questioning (LGBTQ) with a focus on Chemsex users

Young Adults (18-24)

4.3.4 The Provider(s) will recognise that young adult service users aged 18-24 years are particularly vulnerable and therefore provision within a predominately adult service or setting is not always ideal. Provision should be made to offer young adults the opportunity to receive treatment and support within younger-people friendly venues or settings. Adult-based provision is more focused on harm reduction and treatment approaches in relation to substance misuse, which may not be appropriate for those young people whose substance use is linked to a range of needs across mental health, education and employment, and who may have been in care or homeless at some point and care plans for young people should reflect this.

4.3.5 The Provider(s) will ensure there are transition plans in place for young people to move smoothly into structured adult treatment. The young person's service in Tower Hamlets has been commissioned to offer structured treatment interventions for young people until their 19th birthday therefore the Provider(s) will need to work closely with all appropriate teams to plan and manage the transition from young people's substance misuse services for as long as is determined necessary. The Provider(s) will ensure there is specific service provision tailored for this age group, supported through a service level agreement.

4.3.6 The Provider(s) will assess young adults on a case-by-case basis to determine if their needs would be better supported in an adult service or young person's service. For example: those 18 year olds that require a short-term intervention for non-opiate use could be seen and managed within the young person's service. Those aged 18-25 that are care leavers or have special educational needs or disabilities should be referred to and managed within the young person's service unless the assessment indicates that their needs would be better met within the adult service.

Service Integration

4.3.7 The service has been designed to meet the needs of a wide range of service users with respect to protected characteristics, substance (drug / alcohol) being misused and their stage of recovery. The provider will ensure interventions and locations are tailored to different cohorts to maximise the opportunity for recovery.

4.4 Exclusion Criteria

4.4.1 The following exclusion criteria apply:

- Service users who are not residents of Tower Hamlets; except where agreed between commissioners and service providers as part of a reciprocal agreement with another borough
- Serious acute psychiatric morbidity e.g. acute psychosis requiring acute psychiatric treatment
- Service users with serious physical morbidity e.g. life threatening physical illness
- Service users with chronic mental health conditions will be eligible to access interventions at Reset Treatment Service; however, a mental health assessment must be carried out by a commissioned mental health provider who will be responsible for leading on these clients' care plan
- All efforts are made by the Provider(s) to engage and retain service users within the service where appropriate, however from time to time it may be necessary to exclude a service user from the service because they have breached the rules (for example violent / threatening behaviour) or have failed to comply with the treatment programme. There is a reciprocal agreement in place with the London Borough of Hackney to facilitate ongoing treatment and the provider will adhere to this agreement.

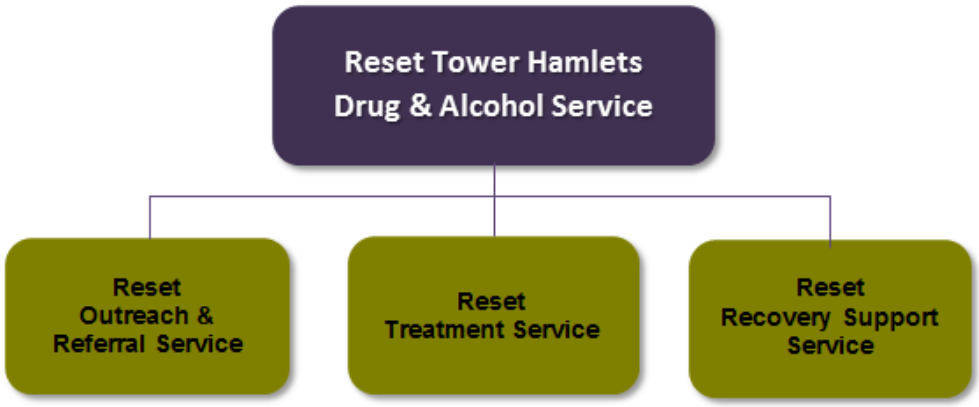
4.5 Communications and Marketing

The 'Brand'

4.5.1 The Provider(s) will operate under the Tower Hamlets drugs and alcohol system 'brand'.

4.5.2 The brand will be referred to as the Tower Hamlets Reset Drug and Alcohol Service. Each complementary component of this service being procured will be a subset of this overarching brand. This is set out in the chart below:

Chart 2: Reset Drugs and Alcohol Service Components 2019 - 2026



4.5.3 Compliant designed branding will be displayed on all correspondence provided by the DAAT. References within correspondence either to service users, the community and other partners will not be made by name of service Provider(s) but by the name given to the component part of the treatment services set out above.

4.5.4 Reset Brand Guidance will be made available to the Provider(s) and will outline the specifications of the Brand, the Logo, typography, design and communication requirements.

4.5.5 The Provider(s) must adhere to the DAAT Reset Brand Guidance (Appendix B), which informs Provider(s) of the appropriate way in which it operates its communication branding.

4.5.6 It is critical that this approach is adhered to and that all parties, even those who may be part of a consortium, reflect the design of this branding.

4.5.7 Where the Provider(s)'s own organisational logo(s) is displayed on any correspondence or publications (including but not limited to signage, leaflets and letterheads), the organisational logo(s) must not be more prominent than the agreed Reset logo.

Communications

4.5.8 The Provider(s) will ensure the services are well promoted throughout the borough, this should include:

- General public
- Service users
- Potential service users
- Key stakeholders and the wider DAAT partnership
- Key events including local and national campaigns

4.5.9 Information concerning the services on offer must be made available in a variety of forms and take account of the diverse needs of the residents of Tower Hamlets. This will include presentation of materials in different languages, to reflect local ethnic minority populations, as appropriate.

4.5.10 The Provider(s) shall make arrangements for all translation, telephone, one to one and British Sign Language interpretations. Signage for translation services should be clearly visible and accessible for service users.

4.5.11 The provider will support local and national drug and alcohol campaigns with a wide range of activities to raise awareness and encourage access to treatment. Currently, LBTH facilitates an annual programme of activities for Alcohol Awareness Week (November) and Recovery Month (September). The provider is required to support these as a minimum.

Engaging Stakeholders

4.5.12 In partnership with Reset Outreach and Referral Service and Reset Recovery Support Services, the service will provide specialist liaison, consultancy, training and support to generic services who may be working with people experiencing drugs and/or alcohol

problems: in particular but not limited to hospitals, adult social care, children's and family services, young peoples' services, hostels, mental health services, housing, employment and education services. The Provider(s) will support these services to screen all individuals for drugs and/or alcohol use and develop pathways into treatment services.

4.5.13 The Provider(s) will work with local communities, networks and service groups to forge strong relationships to increase the support available to facilitate treatment and recovery and encourage local ownership of services.

4.6 Treatment Interventions

Pharmacological interventions

4.6.1 Medication to support behaviour change and abstinence from drug and alcohol use is often a necessary component of treatment for many but medication alone is unlikely to be sufficient to support an individual achieving recovery. Medical interventions to accommodate withdrawal in a managed way must be delivered alongside discreet formal psychosocial interventions.

4.6.2 Medical interventions for Opioid substitution should include:

- Appropriate methods for initial confirmatory and ongoing drug/alcohol testing
- Medical and non-medical prescribing
- Opioid maintenance
- Opioid detoxification
- Medications for relapse prevention
- Benzodiazepines (for short term symptomatic relief of opioid withdrawal/detoxification)
- Medications to be used in cases of Opioid overdose (in conjunction with relevant training for service users/carers)

4.6.3 In delivering Opioid substitution therapy, the Provider(s) will employ protocols which assure a risk managed balance between appropriate maintenance and withdrawal from dependency.

4.6.4 Interventions for dependent drinkers will be delivered appropriate to individual need and in accordance with the National Institute for Health and Care Excellence (NICE) guidelines for individuals with a moderate or severe alcohol dependency. These interventions will include:

- Short term detoxification medication
- Induction onto anti-craving medication
- Relapse prevention medication
- Parenteral multivitamins
- Medication to support reduction of alcohol consumption

4.6.5 Drugs that are currently expected to be prescribed in accordance with the above are:

- Methadone
- Buprenorphine

- Buprenorphine - Naloxone
- Naltrexone
- Naloxone
- Diazepam
- Dihydrocodeine
- Lofexidine
- Chlordiazepoxide
- Disulfiram
- Acamprosate
- Nalmefene
- Thiamine
- Pabrinex

4.6.6 Organisational prescribing policies will be in place for all drugs listed in 4.6.5 and Provider(s) will ensure the commencement of detoxification is communicated to Primary Care partners. Prescribing costs for all drugs listed in 4.6.5 will be reimbursed on a monthly basis from the ring-fenced prescribing budget. Invoices must be accompanied by EPACT reports showing a breakdown of drug spend including all fees. Reimbursement is subject to an annual maximum value of £450,000.

4.6.7 The Provider(s) will ensure the service has a prescribing code which is used **only** for Reset treatment Service. Invoices for payment will be accompanied by a declaration that this code has been used only for Reset Treatment Service.

4.6.8 The Provider(s) will record all prescribing activity on Nebula.

4.6.9 The Provider(s) is required to comply with NHS guidance on the Security Of Prescription Forms and any incidents should be reported swiftly. Prescribing policies will be reviewed and updated under the Providers Clinical Governance processes for the approved list of medications outlined above and for new clinical technologies (as and when required).

4.7 **Clinical Standards**

4.7.1 All clinical interventions will be delivered in accordance with prevailing guidance including:

- NICE guidelines relevant to drugs, alcohol and dual diagnosis
- Drug Misuse and Dependence: UK Guidelines on Clinical Management (2017)
- Alcohol and drug treatment quality governance (2015)
- Medications into Recovery 2012
- British National Formulary
- Stop Smoking Nice Guidance NG92

4.7.2 Substitute prescribing regimes must be undertaken alongside structured psychosocial interventions and key working.

4.7.3 The Provider(s) will ensure that all practitioners involved in the delivery of clinical services are competent, appropriately qualified, and have access to mechanisms to maintain continuous professional development.

4.7.4 All clinical interventions will be based on comprehensive clinical assessment and on-going review and will be delivered as an integrated part of the wider commissioning for recovery focussed approach.

4.7.5 In consultation with all key stakeholders and in response to local needs, the Provider(s) will ensure that all clinical interventions offer comprehensive service user choice in available clinical treatment options.

4.7.6 All service users will be fully informed about the treatment options available to them, as well as the processes and any relevant risks associated with each. This information should be provided both verbally and in writing.

4.7.7 The Provider(s) will promote the development of GP, nurse, pharmacy and non-medical prescribing as seen as appropriate within the service

4.7.8 The provider will ensure Making Every Contact Count is integrated into clinical delivery with clear referral pathways to local services including smoking cessation.

Access

4.7.9 The Provider(s) will ensure there is prompt and accessible clinical assessment and prescribing to all those who need it within a maximum of 3 working days of receipt of referral. Where possible, low threshold fast track prescribing will be offered within 24 hours to those who demonstrate clinical need and/or are at significant risk of harm. This is imperative for those exiting prison and opening hours must reflect this need, taking into account peak time for prison discharges.

4.7.10 It is anticipated that prescribing and other clinical services will operate from a range of settings but primarily through the Reset Treatment Service.

4.7.11 The Provider(s) will ensure that clinical interventions operate to hours which reflect the needs of those who may require access to them including working adults, those recently released from prison and supporting GP extended hours.

4.7.12 The Provider(s) will develop clear criteria for the management of individuals in specialist substance misuse treatment and primary care settings across the borough to ensure service users are treated in a setting suited to their needs.

4.7.13 This criteria will be regularly reviewed with service users in the context of the wider recovery focussed approach and robust mechanisms will be implemented to ensure the effective transfer of appropriate service users into primary care.

4.7.14 In pursuance of a broader recovery focussed approach, Best Clinical Practice, NICE guidelines and good clinical governance arrangement, the Provider(s) will ensure, where it is safe and appropriate to do so, that a regime of substitute prescribing,

reduction and cessation within 12 weeks is undertaken. It is recognised that for some maintenance is a valid and realistic goal and where appropriate substitute prescribing may be undertaken to this end.

4.7.15 The service provider will utilise Patient Group Directions (PGDs) and Patient Specific Directions (PSDs) where appropriate.

Supporting Service Users in Primary Health Care Settings

4.7.16 The aim of supporting service users in primary health care settings is to provide on-going clinical intervention; support and treatment through the effective practice in other health care settings alongside ensuring service users have access to psychosocial interventions. The Provider(s) will contribute to the improvement and competencies of GPs and other practice staff involved in clinical management of substance misuse by delivering training and awareness raising.

4.7.17 There is a strong and long history of Opiate substitute therapy (OST) shared care in Tower Hamlets General Practices; with 28 practice sites (82% of practices) currently providing OST shared care in the network service for substance misuse and all 35 practice sites participating in the alcohol service, in addition to Health E1 Homeless Medical Practice which is contracted separately.

4.7.18 The provider will be a lead partner in shared care arrangements working in conjunction with the Primary Care Drug & Alcohol Service, and will deliver in accordance with the model developed including participation in joint governance processes. The provider will be expected to:

- Assist with the continual development and roll out of Care Coordinator support sessions within GP Practices.
- Provide accurate and timely lists to Primary Care practices of all their patients engaged in treatment and on NDTMS
- Assess all drug / alcohol patients at the beginning of their treatment journey.
- Prescribe for all OST clients for the first 8-12 weeks of their treatment, unless jointly agreed otherwise.
- Ensure Care Coordinators work closely with clients and general practices so that all clients engage with their GP at the earliest opportunity for healthcare and receive a comprehensive healthcare assessment from a physical and mental health perspective including risk arising from substance misuse. The provider will be expected to ensure clients continue to engage with their GP regularly for identified healthcare needs.
- Transfer prescribing for appropriate clients to their GP but continue to deliver intervention, care plan reviews and support for GP prescribers in a manner and location which is flexible and convenient for all.
- Monitor the progress of clients in shared care and ensure recovery support is maximised for all, ensuring signposting to recovery support interventions as appropriate.
- Actively participate in governance structures which will include the Drug and Alcohol Related Death and Harm Reduction Group and the Hidden Harm Steering Group.

4.7.19 The Provider(s) will closely collaborate with the Primary Care Drug & Alcohol Service and ensure processes are in place to ensure the safe and effective transfer of service

users and that these processes are reviewed on an annual basis or more regularly if required.

4.7.20 It is expected that the proportion of Reset Treatment Services' caseload (of Opiate users) managed in shared care will not exceed 30% of the total Opiate caseload in treatment, unless otherwise agreed by the DAAT.

4.7.21 The Provider(s) must ensure and report accurate records of the number of Opiate prescribed service users being managed in shared care settings.

4.7.22 The Provider(s) will work with individual GP practices to assist in the creation of a framework to improve the early identification and management of drugs and/or alcohol use in the primary care settings. This will include:

- Implementing a borough-wide programme of targeted screening for drug and/or alcohol use and, where appropriate, the delivery of brief interventions
- The provision of advice to GPs on the management of drugs and/or alcohol use issues that do not require substitute prescribing

4.7.23 The Provider(s) must work in close partnership with community pharmacists who provide dispensing and/or supervised consumption to ensure that their training needs are met.

4.7.24 The Provider(s) will develop working relationships with local community pharmacists. These include robust mechanisms for sharing information and safeguarding issues and an allocated single point of contact for all pharmacists' concerns.

4.8 Psychosocial Interventions

4.8.1 Psychosocial interventions form a core part of the service user's move towards recovery. The Provider(s) will provide access to a range of flexible one to one and group key-work sessions. Where a service user is receiving more than one intervention, all modalities will be integrated into a coordinated package of care (care-plan) by the Provider(s). All psychosocial interventions will be delivered in line with NICE guidelines and other best practice guidelines.

4.8.2 Psychosocial interventions will be available to all service users at all stages of their recovery journey including pre-contemplation, contemplation, active change and relapse prevention. The range of psychosocial interventions will be delivered according to the service user's treatment needs. These will include but not limited to:

- Motivational interviewing – cogitative behavioural approach to develop motivation to overcome addictions
- Solution focused brief therapy – focus on solution and goal orientated therapy
- Cognitive behavioural therapy – specialist psychological therapy to treat depression and anxiety, that underlie many addictions
- Relapse prevention techniques – to avoid relapses in the future and setbacks that occur as part of recovery
- The provider will ensure that all staff working with service users are trained to deliver one or more psychosocial interventions

4.8.3 Psychosocial interventions will support a range of needs including but not limited to:

- Drugs and/or alcohol use including poly use and cross use
- Motivation to change, aspirations for recovery and impediments to change
- Personal and life skills
- Positive support and relationships
- Dual diagnosis
- Anger management
- Positive parenting
- Relapse prevention with an emphasis on high risk situations and coping methods

4.8.4 A range of recovery support interventions including (but not limited to) structured group programmes, ETE support, benefits and housing support and counselling will be provided by Reset Recovery Support Service and clients should be supported to access these interventions as appropriate.

Relapse Prevention

4.8.5 Relapse Prevention, individual and group work will aim to include as core components:

- Assessment of life goals and commitment to change
- Identification of strengths and resources available
- Learning and understanding of strategies to anticipate drugs and/or alcohol use triggers and to develop alternative coping skills and methods
- Development of confidence by practising coping skills in real-life risk/high risk situations
- Identification of connections between drugs and/or alcohol use and other life situations and events
- Anticipating risk situations and pre-planning coping strategies

4.8.6 The specific needs associated with stimulant use are often different to those using other drugs, so the Provider(s) will ensure that interventions specific to these needs are available and incorporated into the recovery planning process.

Community Detoxification

4.8.7 In most cases community based detoxification will normally be offered. The exceptions will be individuals who, for the reasons below, will require in-patient detoxification or a combination of in-patient followed by community detox, in line with NICE guidance:

- Not benefited from previous formal community detoxification
- Significant co-morbid physical or mental health requiring medical/nursing care
- Complex poly detoxification requirements e.g. alcohol or benzodiazepines
- Significant social issues which will limit efficacy

4.8.8 The aim of this intervention is to provide community based medically assisted withdrawal from drugs and/or alcohol with pharmacological treatments that result in abstinence.

4.8.9 Prescribing will involve the provision of medically supervised withdrawal from Opiate and alcohol addiction. It is expected that prescribing will be in line with national and local guidance including the Department of Health's clinical guidelines, the British National Formulary and NICE; taking into account the recommendations for the reduction of drug and alcohol related deaths, identified in the report from the Advisory Council on the Misuse of Drugs and the government's response to that report and the subsequent action plan. Prescriptions must be written in accordance with the Misuse of Drugs Regulations 1985 (requirements set out in the British National Formulary and Annexe 4 of Drug Misuse and Dependence – UK guidelines on clinical management).

4.8.10 Guidelines state that for some patients, prescribers should arrange supervised consumption with an appropriate health professional, such as a community pharmacist. Prescriptions will normally be taken under daily supervision for the initial period of three months.

Community Detoxification for Drug Use

4.8.11 Eligible service users accessing recovery services should be allowed to undertake community detoxification, as appropriate. As part of a package of care if and/or where considered necessary community detoxification prescribing will include the following:

- A comprehensive prescribing assessment,
- A detoxification plan including clear aims and objectives agreed with the service user and including access to other interventions if appropriate,
- Regular review and monitoring using agreed protocols and good practice guidelines during the prescribing phase,
- Access to, or referral for, appropriate tests for Hepatitis B, Hepatitis C and HIV with informed consent and Hepatitis A and Hepatitis B prophylaxis where indicated,
- Opiate substitution therapy will be appropriately prescribed to minimise the likelihood of relapse.
- Naloxone will be appropriately prescribed or issued for use in case of an overdose as a result of relapse

4.8.12 Co-dependency of opioids and other substances including alcohol must be managed as part of the service user's care package.

4.8.13 Detoxification should not be undertaken in isolation, consideration must be given to the impact on an individual's general health and other medications to minimise the risks of adverse events (e.g. overdose, secondary to lowered tolerance, relapse into drug use, unexpected urgent admission to hospital, seizures etc.). The Provider(s) will ensure thorough communication with the service user's GP surgery, concerning all aspects of their medical treatment, informing the practice in writing at regular intervals.

Community Detoxification for Alcohol Use

4.8.14 The service user must express a clear wish to cease drinking or to stop drinking for at least a few weeks. An assessment including the Severity of Alcohol Dependence

Questionnaire (SADQ-C) should be undertaken, as the Alcohol Use Disorder Identification Test (AUDIT) screening tool only identifies a problem with dependence. The SADQ-C measures the severity of that dependence; scores of 15-30 normally require assisted alcohol withdrawal which can usually be managed in the community.

4.8.15 Consideration should be given to the potential risks arising from alcohol detoxification complications such as Delirium Tremens, Alcohol Withdrawal Seizure and Wernicke Encephalopathy. Vitamin supplementation is vital in any alcohol detoxification.

4.8.16 Alcohol detoxification with symptom-triggered medication may be considered if conducted in a safe comfortable environment following NICE clinical guidelines. The service user must be monitored on a regular basis and pharmacotherapy should only continue as long as the service user is showing withdrawal symptoms. This approach should include:

- Pharmacological relief,
- Clinical supervision,
- A safe and secure environment for the patient,
- Support and monitoring of the patient throughout.

4.8.17 The Provider(s) will ensure a service user's housing situation is given due regard when planning community detoxification and where individuals are in hostel or other supported housing accommodation, work with the housing provider to deliver a supportive package of care.

Community GP Detoxification

4.8.18 A service user may elect to continue to receive prescribing interventions from their GP, where the GP surgery agrees to work with the service user to undertake detoxification in the community. In this event the Provider(s) will ensure thorough communication with the individuals GP surgery, informing the practice in writing at regular intervals of an individual's treatment and progress against their care plan.

Completion of Hospital Initiated Alcohol Detoxification

4.8.19 The Provider(s) will provide treatment and management of withdrawal from alcohol in the home environment for those individuals whose medical treatment no longer requires hospitalisation. The Provider(s) will establish pathways and protocols with hospital liaison nurses and ensure a care plan detailing post-detoxification support is agreed prior to discharge.

Inpatient Detoxification & Residential Rehabilitation

4.8.20 Inpatient detoxification and residential rehabilitation will sit outside this contract. However the Provider(s) is required to manage the pathways for this modality of care. This will include:

- Undertaking assessments and supporting residential treatment applications for inpatient detoxification and residential rehabilitation,
- Preparing service users for residential treatment
- Liaison with residential treatment Provider(s) to ensure continuity of care to and from this treatment.

- Providing clinical and managerial representation on the Residential Treatment Panel as required by the DAAT
- Adhering to the Residential Treatment Panel Terms of Reference

4.9 Dual Diagnosis

Definition

4.9.1 The term **dual diagnosis** is a clinical category referring to people with mental health problems who also misuse alcohol or mind altering drugs, be it legal or illicit. It may, for example, include both someone with a psychotic condition who is also using street drugs, or someone who is depressed and also drinking heavily. There is, however, no formal definition of dual diagnosis. The dual diagnosis guidelines published by NICE in 2016 define it as:

"Coexisting severe mental illness and substance misuse" with severe mental illness indicating a clinical diagnosis of:

- Schizophrenia, schizotypal and delusional disorders
- Bipolar affective disorder and
- Severe depressive episodes with or without psychotic episodes

Tower Hamlets Service Model

4.9.2 The Tower Hamlets Dual Diagnosis service model will draw on previous good practice guidance and the Provider(s) will be expected to work in accordance with the Dual Diagnosis Good Practice Guide (2017), NICE guidance (2016) and East London Foundation Trusts Dual Diagnosis policy (2018) relating to co-existing psychosis and substance misuse. The Provider(s) will employ Agenda for Change Band 7 Nurses or equivalent specialist staff who will:

- Provide expert consultancy in the field of specialist dual diagnosis clinical practice to all partners within the health and social care system in Tower Hamlets.
- Work in close collaboration with the four Community Mental Health Teams (CMHTs) and provide satellite sessions at a frequency agreed with the CMHT team and Commissioner
- Be managed by the Reset Treatment Service and supervised by a Consultant Psychiatrist or equivalent Clinical Specialist/ Lead from within the Reset Treatment Service
- Ensure that a memorandum of understanding is in place prior to service commencement with THCCG commissioned mental health services which embeds safe interagency working: incorporating clear and formal arrangements for the management of dual diagnosis clients including clear referral, treatment and care pathways
- Establish a risk management protocol to be in place prior to service commencement which ensures that information sharing protocols have been agreed in advance of service commencement
- Develop (in collaboration with THCCG commissioned services) and deliver an annual dual diagnosis training and development package for mental health professionals within each CMHT, acute wards and the Primary Care Mental Health Services and

deliver accordingly. This training should be provided on a rolling basis to maximise engagement

- Deliver clinic and ward based interventions to provide joint assessment opportunities with mental health professionals where it is agreed joint assessment is necessitated because of complex substance misuse (i.e. poly substance misuse)
- Deliver support and training to staff within Reset Treatment Service on mental ill health and ensure the workforce are appropriately skilled to recognise mental ill health
- Deliver support and training to primary care health professionals (GPs, practice nurses, community nurses etc.) to support them in managing dual diagnosis patients being treated in primary care
- Interface with other relevant services to enhance collaborative working, i.e. A&E Liaison/RAID/Home Treatment/Criminal Justice agencies/hostel providers etc.
- To promote appropriate access to dual diagnosis support in relation to diversity and equalities in the borough
- Carry a smaller caseload (maximum of 25) of clients with a serious mental illness and substance misuse issues to ensure the needs of this client group are addressed effectively in collaboration with the mental health provider leading the clients care plan.

4.9.3 It is envisaged that Provider Multidisciplinary Team meetings will be utilised to manage and oversee the development and effectiveness of dual diagnosis interventions and pathways and the Reset Treatment Service will work collaboratively with THCCG commissioned mental health services to this end.

4.10 Needle and Syringe Programme

4.10.1 The Provider(s) will ensure intra-venous and intra- muscular drug users have access to sterile injecting equipment through the on-site needle and syringe programme and information to reduce the risks associated with high risk injecting behaviour. This will include information on access to specialist services for service users who may require more specific harm reduction initiatives or access to treatment relating to blood borne viruses (BBV) or wound care. The Provider(s) will also ensure the Needle and Syringe Programme is appropriately advertised displaying information regarding drop in times and availability across the Tower Hamlets drugs and alcohol services and pharmacies.

4.10.2 The minimum expectation from the needle and syringe programme:

- The service offered will be user friendly and non-judgemental
- The service will aim to reduce the transmission of BBVs associated with injecting drug use through the minimisation of sharing equipment between individuals and reducing the risks associated with the rates of other high risk injecting behaviours
- To offer advice and information relating to wound care, overdose prevention and basic life support
- To reduce the social and physical harms associated with injecting drug use including the promotion of safer injecting practices
- Identifiable and low dead space equipment to be provided

- Service must cater for and target all injecting drug users including those using image & performance enhancing drugs
- To increase and facilitate access to treatment services for clients not already engaged in structured treatment
- To reduce the potential for unsafe disposal of used injecting equipment and thus reducing the risks to public health
- To provide and reinforce a wide range of harm reduction messages including safe sex advice and advice relating to overdose prevention
- To offer advice relating to safe storage of all equipment
- Accurate records to be kept relating to service activity
- Distribution of Naloxone kits to Opiate using clients in accordance with Tower Hamlets Naloxone policy and in accordance with section 4.11 below.

4.10.3 The provider is expected to offer a full range of equipment including needles and syringes in various sizes, filters, spoons antibacterial swabs, waste bins, ascorbic/citric acid, foil and readily made needle exchange packs.

4.10.4 All needle and syringe and associated equipment will be in line with NICE Guidance and will be provided via the DAAT contracted provider from an agreed list. The Provider(s) will be responsible for ordering appropriate levels of equipment. Costs will be met by the DAAT outside of the core budget of this contract.

4.10.5 The Provider(s) will arrange for safe disposal of used equipment and costs of disposal will be met within the contract value.

4.10.6 The provider will ensure appropriate policies and procedures are in place for the safe return of used equipment to protect staff, service users and Tower Hamlets residents.

4.10.7 The Provider(s) will ensure that all staff engaged in needle exchange services receive the appropriate training required to enable them to deliver this role safely and appropriately.

4.10.8 The provider will keep detailed records of equipment issued and returned in a format agreed by the DAAT and will return quarterly reports.

4.11 **Naloxone**

4.11.1 The Provider(s) will identify any current or previous Opiate using clients at risk of overdose, including clients who are homeless, prison release clients, and those who have relapsed after a period of abstinence and ensure access to Naloxone.

4.11.2 The Provider(s) will supply Opiate users and clients at risk of overdose with Naloxone injection kits (or Naloxone nasal spray when licenced without prescription). Kits should

be replaced when they are used or expired.

4.11.3 The cost of Naloxone will be met by the Provider(s) and the Provider(s) will be responsible for ordering and managing stock and for the disposal of any expired stock.

4.11.4 The Provider(s) should maintain a record of clients supplied with Naloxone kits and submit quarterly records in a format agreed by the DAAT. Distribution will also be recorded on NDTMS for those individuals engaged in structured treatment.

4.11.5 The Provider(s) will ensure that staff engaged in supplying Naloxone receive the appropriate training, including overdose awareness.

4.11.6 The provider will report incidents of overdose and where Naloxone is administered by staff in the case of an emergency.

4.11.7 In cases of overdose where there is a suspicion of adulterated substances, the Provider(s) will submit a Local Drug Information System alert notice to the DAAT.

4.12 Blood Borne Viruses

Immunisation

4.12.1 All service users accessing the service will be pro-actively offered accelerated immunisation for Hepatitis A and Hepatitis B in accordance with the guidance in the Green Book[13]. All service users who have ever disclosed injecting practices should be immunised or have been identified as having had a full course of immunisations within the last 5 years. The Provider(s) will encourage all service users that refuse to be immunised to take up the vaccination. This will be done regularly as the service users come into contact with the service.

4.12.2 In order to maximise uptake of BBV interventions, the service will be made available across a number of sites. The number and location of sites will be discussed during mobilisation but will include the Providence Row Dellow Day Centre and other hostel locations identified as appropriate/ priority groups. Interventions will be offered to all drug/alcohol users considered appropriate, including those referred by the drug/alcohol referral service, regardless of whether they engage in structured treatment.

4.12.3 All costs relating to immunisation (including drug costs) will be met by the provider.

Testing and Treatment

4.12.4 Any service user with a history of injecting or who is at high risk of Hepatitis C should be provided with access to Hepatitis C testing. Clients should be offered a re-test every 6 months following a negative result and be given harm reduction advice and pre and post-test counselling.

4.12.5 For a number of years, users in Tower Hamlets have been able to access HCV treatment in a dedicated community clinic. The clinic is overseen by the

[13] https://www.gov.uk/government/collections/immunisation-against-infectious-disease-the-green-book

Gastroenterology Services department of Royal London Hospital but essentially run by the current BBV team. The provider will continue to deliver this clinic in conjunction with the Royal London Hospital and will need to employ nurses with the required competence and skills.

4.12.6 All costs related to HCV screening will be met by the provider.

4.12.7 All other costs relating to the HCV treatment clinic will be met by Barts Health (with the exception of Reset Treatment Service staffing costs).

4.13 **Sexual Health**

4.13.1 The Provider(s) will establish close working relationships and pathways to ensure that service users of both substance misuse services and sexual health services have their respective sexual health/ substance misuse health needs met within both services.

4.13.2 The provider will work provide weekly co-located Sexual Health/Substance Misuse clinics. This will include Chemsex clinics with the All East Sexual Health provided by Barts within Tower Hamlets.

4.13.3 In addition to testing for Hep B, C, and HIV, the provider will offer all clients attending substance misuse services testing for syphilis, chlamydia and gonorrhoea. Where the offer for testing is accepted and a positive test result has been identified, the provider will work in close partnership with All East to ensure positive result has been communicated, partner notification undertaken and treatment completed. The provider will also ensure clients attending substance misuse services are retested at the appropriate time interval for sexually transmitted disease and BBVs based upon frequency of partner change and risk behaviour as specified by the British Association of Sexual Health and HIV (BASHH) guidance.

4.13.4 For all female clients the provider will undertake an initial contraception assessments and regular review to ensure the most appropriate and effective method of contraception is provided. The substance misuse user provider will ensure condoms, commencement of combined hormonal pill, emergency hormonal contraception, Depo Provera injections and implants for long acting reversible contraception (LARC) are available at their service clinics to improve access to and uptake of contraception. For other forms of LARC the provider will work in partnership with All East to ensure substance misuse clients are easily able to access the full range of contraception provided at sexual health services.

4.13.5 Sexual health services provided i.e. chlamydia, syphilis, gonorrhoea and contraception as part of the substance misuse contract are chargeable under the prevailing London integrated sexual health tariff. The provider will need to be registered with the CQC for delivery of family planning and other relevant sexual health services and submit data to Pathway Analytics to enable payment verification. Sexual health surveillance data will be returned to Public Health England for prevailing surveillance systems for both STI monitoring and sexual health services. Reimbursement for the cost price of sexual health diagnostic and prescribing costs will be made upon the production of an invoice to Public Health in LBTH which

will be verified using the Pathways Analytics data information. (HIV, Hep B and testing and vaccination and treatment is included in the core delivery budget).

4.14 Drugs and Alcohol use in Pregnancy

4.14.1 The Provider(s) will work closely with the midwifery team in the Royal London Hospital to provide a specialist clinic for pregnant service users throughout their antenatal and postnatal care. The clinic will offer support and advice to pregnant women and their partners who are concerned about their drug or alcohol use. The Provider(s) will be responsible for coordinating a multi-disciplinary team of appropriate services to support the pregnant service user and ensuring all relevant services form part of the care planning process that will include care planning for post birth.

4.15 General Health

4.15.1 The Provider(s) will be expected to work in partnership with a range of health professionals to ensure that the general health needs of service users are addressed within the treatment and recovery plan, for example dentistry, occupational therapy and smoking cessation.

4.15.2 The Provider(s) will be required to offer healthy living advice, particularly in relation to healthy eating and smoking cessation and will support and encourage attendance at mainstream health services for example GP surgeries, breast screening, cervical screening etc. The Provider(s) will host satellites for LBTH commissioned smoking cessation services.

4.15.3 Whilst all service users will be encouraged to access their GP for general health needs, including wound management, the service will be expected to manage injecting site abscesses and ulcers where appropriate / beneficial to patient care. All costs associated with wound management are included within the contract value.

5 Key Policy Areas

5.1 Whole Family Interventions

5.1.1 The provider will address family issues for every service user as part of the assessment process. Focussed family interventions will be provided by the Reset Recovery Support Service and Reset Treatment Service must ensure service users are encouraged to engage with such interventions where there is a family need. To encourage collaborative working across Reset Services the provider will appoint a staff member to co-facilitate the Moving Parents and Children Together Programme (M-PACT) nine week programme (one evening per week), or equivalent evidence based programme agreed by Reset Recovery Support Service.

5.2 Hidden Harm

5.2.1 All professionals working with clients who live with or have access to children should understand their responsibilities, explicitly in order to achieve positive outcomes, keep children safe, and complement the support that other professionals may be providing. The welfare of the child will be the first consideration for the Provider(s) when working with substance misusing parents/carers. It is important that where parents are

receiving treatment and support, the needs of their children are fully considered to safeguard their welfare.

5.3 Safeguarding Children

5.3.1 The Provider(s) will make lockable safe storage boxes available to all service users who reside with children or young people or who may have access to the service users' medication while visiting. The safe storage boxes will be purchased and distributed by the provider, with appropriate verbal and written advice on the safe storage of medication and the disposal of medication/empty medication bottles.

5.3.2 The Provider(s) has a duty of care towards children as part of the Children Act 1989. Section 11 of the Children Act (2004) outlines a duty to cooperate amongst key personnel and bodies, to promote the welfare of children. The Provider(s) will ensure that standard operating procedures will require that the service actively seeks to identify service users with a parental responsibility and who are in frequent contact with children (under the age of 18), and to work with them to prevent any harm.

5.3.3 The Provider(s) will ensure that in providing the service it will utilise screening, risk assessment (and risk management) tools which effectively and comprehensively identify parental drugs and/or alcohol use and the potential impact(s) of such use on the child/children.

5.3.4 The Provider(s) must follow local protocols in all instances where there are concerns about a child's care/welfare or development to enable, and if necessary, facilitate accurate and appropriate assessment of the child's circumstances.

5.3.5 The Provider(s) must comply with the requirements of the Safeguarding of Vulnerable Groups Act 2006 associated regulations and guidance provided by the Independent Safeguarding Authority (ISA). The Provider(s) has a responsibility to ensure that referrals are made to the ISA whenever necessary and are in accordance with ISA guidance and stipulations. The Provider(s) will also be expected to attend relevant safeguarding meetings where service users are being discussed.

5.4 Multi-agency Early Help Assessment

5.4.1 In accordance with hidden harm and the whole family approach, the assessment will identify those service users who are parents and/or who come into regular contact with children. For these service users, a specific child needs assessment will be completed capturing at a minimum the following information:

- The name of the main carer/s for children
- The age of children
- The name of health visitor if applicable
- Has an early help assessment been completed? (children)
- Is there a child protection plan or has there been one open in the past?

5.4.2 Where children are identified, the Provider(s) will have mechanisms in place to be able to appropriately respond to the Early Help Assessment if applicable.

5.5 Safeguarding Vulnerable Adults

5.5.1 Adult safeguarding is important in preventing harm and exploitation of vulnerable adults who may be unable to safeguard themselves and to respond to it when it occurs. An adult at risk is defined as an adult "Aged 18 years or over; who may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation". (NHS England)[14]

5.5.2 Harm and exploitation may consist of:

- Physical harm, including hitting, slapping, pushing, kicking, misuse of medication, restraint, or inappropriate sanctions
- Sexual harm, including rape and sexual assault or sexual acts to which the adult has not consented, or could not consent to or was pressured into consenting to
- Psychological harm, including threats of physical hurt or abandonment, deprivation of contact, humiliation, blaming, over-controlling, intimidation, coercion, harassment, verbal abuse, and isolation
- Financial or material exploitation, including theft, fraud, pressure in connection with wills, property or inheritance or financial transactions, or the misuse or misappropriation of property, possessions, benefits, or direct payments
- Neglect and acts of omission, including ignoring medical or physical care needs; failure to provide access to appropriate health, social care or educational services; the withholding of the necessities of life, such as medication, adequate nutrition and heating
- Inappropriate discrimination, including racist, sexist, and that based on a person's disability, and any other forms of related harassment

5.5.3 Harm and exploitation can occur anywhere, for example:

- at home
- in care homes
- in day centres
- at work
- at college
- in hospitals or health centres/surgeries
- public places or in the community

5.5.4 The Provider(s) will ensure that their policies and procedures are linked with the Tower Hamlets Safeguarding Adults Multi-Agency Policy and Procedures: "Protecting adults at risk: London multi-agency policy and procedures to safeguard adults from abuse", produced by the Social Care Institute for Excellence with the Pan London Adult Safeguarding Editorial Board[15].

[14] https://www.england.nhs.uk/wp-content/uploads/2017/02/adult-pocket-guide.pdf
[15] http://www.towerhamlets.gov.uk/lgnl/health_and_social_care/safeguarding_adults.aspx

5.5.5 In emergency situations appropriate medical attention and contact with the police and any other relevant authority must be undertaken.

5.5.6 The Provider(s) will adhere to the Tower Hamlets Adult Safeguarding guidance and protocols (including the sharing of relevant information) in all cases where an issue of safeguarding or suspected safeguarding has been identified.

5.5.7 The Provider(s) will have a policy on abuse with robust procedures on how to deal with alleged or suspected cases of abuse, regarding both the person experiencing the abuse and the perpetrator.

5.5.8 The Provider(s) will include in their Policy on Abuse that any incidence of alleged or suspected abuse must be reported to the Safeguarding Adults Team and commissioners.

5.6 Safeguarding Lead

5.6.1 The Provider(s) will have an identified adult and children safeguarding lead that will possess the appropriate knowledge and skills to fulfil the role. They will be a senior manager within the organisation and they will be single point of contact for all relevant matters.

5.6.2 Safeguarding leads will be expected to attend relevant meetings as necessary.

5.7 Working with Carers/Significant Others

5.7.1 In line with Supporting and Involving Carers (NTA 2008) the Provider(s) will ensure that throughout the assessment process, with the service user's consent, family members and significant others are involved in care plan development and throughout the treatment journey.

5.7.2 The Provider(s) will offer support and advice to all carers/significant others identified by service users and service users will be encouraged to identify people for the service to engage with.

5.8 Clinical Governance

5.8.1 The Department of Health in 1998 defined clinical governance as "a system through which organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish".

5.8.2 The key elements in this definition of clinical governance are:

- **Framework** – the various activities included in clinical governance need to be set within a framework that enables assurance for all aspects of clinical activity in a comprehensive and systematic way
- **Accountability** – public and independent sector health and social care organisations have a statutory duty to assure themselves on the quality of care they provide. Regulatory authorities ensure accountability for clinical governance. A structured accountability framework running right through the organisation ensures that everyone takes responsibility for clinical governance

- **Quality** – clinical governance should aim to ensure that treatment is safe, evidence based, effective, cost-effective, available, accessible and equitable, and that delivers the best possible service user experience
- **Environment** – a culture in which individuals and organisations can openly and honestly examine their own practice and take responsibility for change to achieve improvement. Requires a supportive no-blame ethos which focuses on systemic improvement

5.8.3 The Provider(s) will have clear and effective clinical governance in place and allow time for appropriate clinical governance operation and development to assure this.

5.8.4 The Provider(s) will demonstrate a robust clinical governance framework which includes:

- Demonstrable lines of clinical accountability including a named accountable officer
- Mechanisms to ensure treatment is safe, effective and evidence-based
- Mechanisms to ensure systematic and continual quality improvement
- Mechanisms to ensure continual staff development
- Mechanisms to monitor standards of care and quality of service in tower hamlets
- Mechanisms to identify good practice and any issues of concern including lessons learned, indicators will be monitored by:
- Patient experience – service user surveys, complaints, etc.
- Staff experience – evidence that time is made available for learning and reflection on practice and staff satisfaction surveys.
- Completed annual audit cycles and critical incident reviews, and changes made that demonstrate what has been learned

5.9 Service Delivery

Hours of Operation

5.9.1 The Provider(s) should not rely entirely on face to face contact to provide information, advice and structured treatment to service users. The Provider(s) must use a number of channels that are not limited to fixed office basis and face to face contact, for example through on-line and telephone facilities.

5.9.2 Where face to face contact is required this must be available at core times during the working week; core times are usually between 10am and 6pm, Monday to Friday. These times are to be agreed between the Provider(s) and commissioner and will depend on service user need.

5.9.3 The Provider(s) will ensure that they are flexible within and outside of core office hours to include access in the evenings and weekends at times that are suitable to service users. This will be at least two evening sessions per week and one weekend session. This will be agreed between the Provider(s) and commissioner and will depend on service user need but is expected to include a full suite of interventions unless otherwise indicated.

Location

5.9.4 The service will operate from a central location as well as from other locations across the borough to ensure service is accessible to all and engages a wide variety of services. This may include GP surgeries, hostels, day centres, community centres and service user's homes where health issues prohibit attendance at the treatment service.

5.9.5 All premises costs will be met by the provider within the contract value.

5.10 Business Continuity and Emergency Planning

5.10.1 The Provider(s) must have comprehensive and adequately tested business continuity plans in place in order to ensure continuation of critical services in the event of severe weather, adverse event or major service disruption.

5.11 Incident Reporting

5.11.1 The Provider(s) shall have clear protocols in place for reporting, recording and reviewing complaints and incidents and identify where lessons can be learnt to protect service users and staff and improve practice.

5.11.2 The Provider(s) will ensure that staff are aware of both the complaints procedure and incident reporting protocol and the organisations processes for dealing with concerns that arise about individuals including disclosures, behavioural difficulties, unacceptable risk or threat to staff or service users.

5.11.3 Service users must have access to the Provider(s)'s complaints procedure and made aware of their right to complain or make a compliment about the service they received without recrimination.

Local Drug Information System

5.11.4 The DAAT has implemented an agreed local drug information system (LDIS) that uses consistent and efficient processes for sharing and assessing information; issuing warnings where needed can help ensure high-quality, effective information that rapidly reaches the right people.

5.11.5 The LDIS model is intended for dangerous, new and/ or novel, potent, adulterated or contaminated substances regardless of their legal status.

5.11.6 Information and alerts received through this channel will be disseminated as appropriate, following an expedited assessment by the LDIS Coordinator (DAAT) and the LDIS Panel: a multi-disciplinary panel with suitable levels of expertise in relevant disciplines (e.g. medical, policing, pharmacology, drugs specialist etc.).

5.11.7 The Provider(s) will identify an appropriate representative to act as an LDIS Panel member and assist in the LDIS alert grading and dissemination process as per agreed local protocols.

5.12 Drug and Alcohol Related Deaths

5.12.1 The Provider(s) must have systems in place for reporting Serious Untoward Incidents (SUI) and Drug and Alcohol Related Deaths internally and it will be an expectation that

the DAAT is informed of such incidents at the earliest opportunity and within 2 working days (48 hours).

5.12.2 The DAAT's Drug and Alcohol Related Deaths Protocol requires all Provider(s) (where appropriate) to participate in the review of drug related deaths and embed any recommendations from the review in future practice and service delivery.

5.12.3 The Provider(s) will be expected to attend the quarterly Drug and Alcohol Related Death and Harm Reduction steering group and present anonymised cases for discussion amongst the partnership panel members.

5.13 Equalities

5.13.1 The Provider(s) will adopt a policy to comply with its statutory obligation under The Equality Act 2010 and will ensure that it does not treat one group of people less favourably than others because of their age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex or sexual orientation. The Provider(s) will need to demonstrate equality of access and outcomes across these protected characteristics within the Equality Act 2010.

5.13.2 Protected characteristics form part of assessment of need that will determine what, if any, additional support a person may need. The Provider(s) must assure the commissioner that they have the capability and robust mechanisms to routinely collect employee and service user level data regarding all the protected characteristics and to identify where extra needs arise due to protected characteristics.

5.13.3 The Provider(s) will analyse and understand where there is inequality of access and where there is inequality of outcomes across the protected characteristics. The Provider(s) will undertake an annual equality impact assessment which will be supplied to the commissioner to support Needs Assessment and Treatment Planning processes.

5.14 Information Governance

5.14.1 The Provider(s) will encourage all service users to sign the information sharing consent form at the earliest opportunity. The form gives options for the service user to decide who they wish to share their information with. This will include the whole Tower Hamlets drug and alcohol treatment system, the National Drug Treatment Monitoring System (NDTMS), external agencies and any future research projects. Where service users decline consent at the first meeting this must be approached

again sensitively and the importance of giving consent outlined. Service users must also be made aware of their rights to access any data which is held about them.

5.14.2 It should be stressed that consent is being given to sharing information whether they actively engaged in treatment or not. Guidance from the Data Protection Act 2018 suggests that consent should be sought every 6 months to ensure its validity.

5.14.3 The Provider(s) must respect the wishes of service users if consent is given and when requested to, share information accordingly and in line with the Data Protection Act 2018 which includes the safe handling, storage and confidentiality of personal data.

5.14.4 The Provider(s) will comply with all of the data protection obligations contained within the contract.

5.14.5 Information sharing is needed to assure continuity of care and treatment. It is important to ensure consistency in terms of what, when and how information is shared. The provider is required to sign the Substance Misuse Information Sharing Agreement between LB Tower Hamlets and the main agencies in the treatment system. The Provider(s) will collect special category personal data and personal data through the assessment process and subsequent recovery journey and share as stated in the Substance Misuse ISA.

5.14.6 In addition, the provider is required to sign key LB Tower Hamlets information sharing agreements / protocols including:

- LB Tower Hamlets Community Safety ISA
- Domestic Violence MARAC
- Tower Hamlets Prostitution Panel (THPP)
- High Impact Problematic Drinkers Panel (HIPD)

5.14.7 The Provider(s) is required to comply with information requests in response of domestic homicides and MASH (Multi Agency Safeguarding Hub) enquiries.

5.14.8 Wherever possible, the informed consent of the service user will be obtained before information is shared. 'Informed' means that the individual understands what information may be shared and the reason why.

5.14.9 The Provider(s) will submit accurate and true information to the NDTMS on a monthly basis as is required within the national submission schedule and nationally defined processes. This information will be 100% complete and of high quality (exceeding the DAMS 100% validation metrics) and it will reliably reflect the actual activity of the treatment system. For assurance purposes and where necessary the Provider(s) will provide a monthly data quality exceptions report and remedial action plan to the commissioner.

5.14.10 The Provider(s) will deploy a suitably robust system to capture comprehensive needle and syringe programme activity data. The Provider(s) will produce and supply the commissioner with quarterly needle and syringe programme activity report. The activity report will include at a minimum, basic demographic profile of clients, number

of visits, number of new contacts, drug of choice, injection sites used, amount and type of equipment distributed and the interventions delivered.

5.14.11 The Provider(s) will have an identified information governance lead that will possess the appropriate knowledge and skills to fulfil the role. They will be a senior manager within the organisation and they will be the single point of contact for all relevant matters.

6 Systems and Processes

6.1 Assessment

DAAT Common Assessment Framework

6.1.1 The Provider(s) will use the DAAT common assessment framework and single client management system (Nebula at time of writing) for drugs and/or alcohol users. This will minimise the duplication of assessments a service user may undergo and facilitates efficient access into structured treatment. A common assessment framework will further enable transparency, accountability and information sharing as the service user moves through the drug and alcohol treatment system.

6.1.2 The Provider(s) will use a variety of IT based methods when undertaking assessments to ensure they make efficient use of the time the assessment process takes, for example completing an assessment electronically whilst talking to the service user significantly reduces the time the process takes.

6.1.3 The Provider(s) will use an evidence based approach tailored to meet the individual needs of the service users, the International Treatment Effectiveness Project (ITEP) mapping tool will be used across the Tower Hamlets drug and alcohol treatment system. The Provider(s) will adopt a holistic approach to assessment and use the suite of assessment tools available, that include:

- Screening
- Initial Assessment
- Comprehensive Assessment
- Recovery/Care Plan
- Risk Assessment

6.1.4 The DAAT common assessment framework will also include the use of AUDIT. The DAAT recognises the value of using alternative assessment tools such as the SADQ for all individuals using alcohol. However to deploy a consistent approach it is expected that all services will use AUDIT-C across the Tower Hamlets drugs and alcohol treatment system as a minimum.

6.1.5 The Provider(s) will lead the periodic review of assessment systems and tools and continue to develop these assessment tools to adapt to changes in drug and alcohol use and local priorities.

6.1.6 Where an existing service user is referred to structured treatment from within the treatment system (i.e. through Reset Outreach and Referral Service), as a minimum the service user would have been screened for drug and/or alcohol use and assessed for risk. It will be the responsibility of the Provider(s) to ensure a comprehensive assessment is completed prior to the service user engaging in structured treatment.

6.1.7 Where individuals self-refer to structured treatment the Provider(s) will ensure an initial assessment is completed at the time a service user makes contact. Where the service user is ready to engage, a comprehensive assessment is made prior to the commencement of treatment and within one week.

6.1.8 Where individuals present with an immediate risk of harm the comprehensive assessment and a risk assessment will be completed within 72 hours to enable immediate access to treatment, inclusive of pharmacological interventions.

6.1.9 A risk assessment will be completed for every new service user and where risks are identified, a risk management plan will be developed and implemented and routinely updated.

6.2 Care and Discharge Planning

6.2.1 Following completion of a comprehensive assessment, all service users accessing structured treatment must have a written and structured care plan resulting from assessment. This will build on any existing care plans completed during the comprehensive assessment phase.

6.2.2 Care plans will focus on developing recovery outcomes, by ensuring that there are integrated recovery pathways for each service user that maps identified treatment and wider health and social care needs.

6.2.3 The care plan will be developed in conjunction with, and signed by, the service user to empower them to actively participate in their treatment. Service users will be given copies of their care plan.

6.2.4 The Provider(s) will review care plans on a regular and ongoing basis with the service users. The frequency of reviews will be determined by the individual service user's assessment of need. As a minimum all service users will have their care plans reviewed every six months.

6.2.5 Discharge planning will commence at the start of treatment and continue throughout treatment. All service users should be discharged from treatment in a care planned way, when other treatment options and onward referrals are made to relevant and appropriate treatment modalities.

Recovery Check-ups

6.2.6 Where service users successfully complete treatment a period of contact will be agreed between the Provider(s) and the service user. This contact will be structured check-up on recovery progress and maintenance, checks for signs of lapses, sign posting to any appropriate further recovery services, and in the case of relapse (or marked risk of relapse) facilitates a prompt return to treatment services.

6.3 Care Coordination

6.3.1 The Provider(s) will take the lead in the care coordination of service users and ensure that anyone entering structured treatment has one named care coordinator (key worker) that works with the service user throughout their structured care planned treatment.

6.3.2 The Provider(s) will be responsible for the coordination of additional services where this forms part of the service user's care plan, this will include access to services within the drugs and alcohol treatment system, namely Reset Recovery Support Service as well as wider health and social care services.

6.4 Case Management Systems

6.4.1 The Provider(s) will use any case management system that is commissioned by Tower Hamlets. Nebula provided by Orion PM is the current single case management and information system that is used by all drug and alcohol treatment services in Tower Hamlets. The Provider(s) will use Nebula to record drug and alcohol treatment activity. Nebula is an effective tool in facilitating information sharing between drug and alcohol treatment services and enables services to work more effectively across the treatment system.

6.4.2 Nebula supports the Core Data Set requirements for drug and alcohol monthly activity submissions for the purpose of providing information to the NDTMS.

6.4.3 The provider will work in partnership with all drug and alcohol treatment providers and TH DIP to develop the electronic case management further but will remain solely responsible for improvement work relevant to their own area of work. The funding of the case management system is included in the contract value.

6.4.4 Costs associated with the implementation of the case management system will be met by the Provider(s).

For further information on Nebula please refer to Appendix C.

6.5 Outcomes Reporting

6.5.1 The Treatment Outcomes Profile are designed to be completed collaboratively as an integral part of the service user's care plan and this will form the basis of regular and on-going care plan reviews.

Treatment Outcomes Profile

6.5.2 The Provider(s) will ensure care coordination supports the use of the TOP) tool to monitor an individual's progress. The Provider(s) will be required to complete TOP Starts (at start of treatment), TOP Reviews (6 month intervals) and Exit TOPs (at the end of treatment).

6.6 Drug Rehabilitation Requirements or Alcohol Treatment Requirements

6.6.1 The Provider(s) will ensure prompt access to treatment (within two working days) following a Community (or Suspended Sentence) Order with a Drug Rehabilitation Requirement (DRR) or Alcohol Treatment Requirement (ATR).

6.6.2 The Provider(s) will conduct comprehensive assessments of service users subject to a DRR or ATR. Together with the client and supervising probation officer a decision will made on what treatment appointments will be enforceable. The DRR or ATR nominal will sign an agreement that they understand that failure to attend as agreed might result in breach. Whilst there are no longer any probation standards on treatment attendance, a weekly appointment will be the minimum expectation for the first six weeks in treatment and any reviews of treatment attendance agreed with the service user and relayed to the Probation supervising officer.

6.6.3 The Provider(s) will drug test DRR clients regularly in accordance with requirements of the order and feedback appropriately to Probation. Costs associated with this testing are incorporated within the contract value. In collaboration with the DIP, the Provider(s) is also expected to provide Probation with information on attendance and progress in treatment and inform Probation promptly of non-attendance for enforceable appointments so breach action can be taken by the supervising officer. Where DRR treatment is complete at Reset Treatment Service but the service user is engaging with Reset Recovery Support Service, the testing costs will be met by the Recovery Support Service.

6.7 Re-engagement

6.7.1 The Provider(s) will ensure those service users that disengage with structured treatment prematurely or in an unplanned way are actively re-engaged with treatment services. Robust interventions will need to be in place at an early stage to address the needs of those service users that disengage. As part of all service user care planning a contingency plan will also be drawn up covering safety, risk, overdose prevention, harm reduction and support arrangements available to service users should they leave treatment in an unplanned way.

6.8 Referrals

6.8.1 The Provider(s) will promote open access provision to enable self-referral, referrals from within the Tower Hamlets drug and alcohol treatment system and referral from a wider spectrum of health and social care, criminal justice services and community and advocacy based organisations.

6.8.2 The Provider(s) will act as the central point of contact for all referrals for structured treatment and professionals though a dedicated phone line, secure email and website that will display information about treatment and basic advice about harm minimisation. This will include the single point of contact for Job Centre Plus.

6.8.3 The Provider(s) will be responsible for the onward referral of service users to other services including Reset Recovery Support Service. The Provider(s) will ensure there is a fast track referral process to the Recovery Support Service for service users requiring non-structured interventions such as legal advice, employment and benefits advice and drop in groups inclusive of music and drama.

7 Relationships and Partnerships

7.1 Collaborative Working

7.1.1 The Tower Hamlets drug and alcohol treatment system consists of a number of key commissioned services alongside Reset services. It is imperative that the Provider(s) adopts a collaborative approach and establishes strong links with the services outlined in the sections below.

Reset Outreach and Referral Service

7.1.2 The Provider(s) will establish strong links and clear pathways for individuals that come into contact with drug and alcohol treatment through the Reset Outreach and Referral Service. This will require collaborative working to ensure targeted/hard to reach individuals are seamlessly transferred into structured drug and alcohol treatment. The Provider(s) will offer surgeries/satellite provision at the Reset Outreach and Referral Service to facilitate this process.

Reset Recovery Support Service

7.1.3 Recovery support is integral to the service user's success and will begin at the time an individual enters treatment. All service users' immediate support needs will be determined at an early stage (through comprehensive assessment) and built into the care plan in conjunction with relevant Recovery Support Service specialisms, i.e. housing, welfare benefits, access to education, training and employment etc. Such recovery support should be available on site through a host of surgeries/satellites facilitated by Reset Recovery Support Service that will address the individual needs of the service user.

7.1.4 There will be a clear focus on enabling service users to access recovery support as soon as possible with the ultimate aim of enabling service users to move on to mainstream and wider community provision and support. There are certain measures that the Provider(s) should take to facilitate this process:

- Treatment should aim always to enable independence and be focused on supporting recovery capital/outcomes
- Planning for recovery and community re-integration should be a consideration right from the beginning of the recovery/treatment journey
- The transition from the system will be supported with opportunities to access peer, mutual aid and wider community support, this will require the provider(s) to match individual service user needs and interests to the available community resources e.g. Mental health, supporting people and sexual health services

Drug Intervention Programme (DIP)

7.1.5 The DIP is a tier two service responsible for engaging substance misusing criminal justice clients into treatment and consists of an arrest referral team, outreach team, court team, through care team, prison exit team and an IOM coordinator. The DIP team commission a prostitution support service whom the Provider(s) will be expected to work collaboratively with and make referrals to.

7.1.6 The Provider(s) will ensure there is capacity within the Treatment Service hub to accommodate the through care team, comprised of five members of staff.

7.1.7 The Provider(s) will work closely with DIP to ensure there is a robust pathway for criminal justice clients into and through tailored structured treatment interventions, and to minimise rates of unplanned exits amongst this cohort.

7.1.8 The Provider(s) will be expected to provide on-site interventions for this cohort.

Prostitution Support Service

7.1.9 The Prostitution Support Service operates a targeted street-outreach and case management of individuals involved in prostitution. The Provider will establish strong links with the service and in conjunction with the DIP to support individuals to access treatment and facilitate access to harm reduction interventions.

Royal London Hospital

7.1.10 The Provider(s) will provide regular satellite clinics (weekly as a minimum) at the Royal London Hospital to facilitate easy access into structured treatment. This will include teams such as the alcohol liaison and the Rapid Assessment, Interface and Discharge Team (RAID) teams.

7.1.11 The provider will agree a fast track pathway for individuals identified by the RLH service who have been initiated on Opiate Substitution Therapy whilst in hospital and were not in structured treatment prior to admission.

7.1.12 The provider will develop protocols to ensure continuity of alcohol detoxification treatment upon discharge from the Royal London Hospital.

Health E1 Homeless Medical Centre

7.1.13 Health E1 is a GP practice in Tower Hamlets for people who are street homeless or in temporary or hostel accommodation in the Borough of Tower Hamlets and E1. The practice register holds a number of clients with substance misuse needs. A proportion of these patients will be managed entirely within Health E1 but the Provider(s) will work with Health E1 to establish appropriate pathways and processes to meet the needs of Health E1 patients.

7.2 Whole System Relationship

7.2.1 In addition to the treatment system, the Provider(s) will be required to establish key partnerships and engage with local services to deliver joint outcomes. Local services within Tower Hamlets include but are not limited to:

- Local voluntary sector organisations that support, or provide a voice for customers and carers.
- GPs
- Community pharmacists
- Royal London Hospital
- NHS Primary and Secondary care services
- Local Community Mental Health Teams
- Child Protection Teams
- Children's Centres
- Probation
- DIP

- Integrated Offender Management Programmes
- Hostels and Housing Providers
- Job Centre Plus and Work Programme Providers
- TH Hate Crime, Violence Against Women and Girls and Domestic Abuse Team
- Specialist maternity services
- Other health and social care providers and services as required.

7.2.2 Joint assessments will be conducted collaboratively with other agencies where this is in the best interest of the service user and agreed by them to do so. This will include joint care plans and care plan reviews. This could include mental health service providers, social services, children and family services, probation and housing providers or other relevant agencies (as set out above).

7.3 Service User and Carer Engagement

Service Users, Carers and Significant Others

7.3.1 The Provider(s) will develop and deliver a service user engagement and involvement strategy, involving service users and their family and friends in the planning, developing and evaluation of services. This will require the Provider(s) to:

- Have a member of staff as the nominated/named service user/carer champion to co-ordinate and support service user engagement work
- Support and recruit service user and carer representatives within the service; these individuals will champion and support the work of the service and be proactive in working with their respective groups,
- Support the involvement of service users and carers within the planning of services to enable them to contribute at all levels of service development,
- Ensure service user representatives attend relevant service user and carer forums that are established within the service and/or jointly with other providers, provide support and opportunity for nominated service user reps to attend/participate in DAAT organised events/meetings/activities including those hosted by Public Health England and meetings with service user representatives across tower hamlets drug and alcohol services,
- Display within their premises a service users' Charter of Rights and Responsibilities, or equivalent.

7.3.2 The Provider(s) will ensure there are mechanisms which allow anonymous feedback from service users and carers and significant others. The Provider(s) will have a process to demonstrate that service user feedback has been heard and changes have been made where possible and appropriate or if it has not been possible, that decisions are explained.

7.3.3 The Provider(s) will evidence that the nature of the services provided has been strongly informed by service users and will undertake an annual service user satisfaction survey. Findings from the survey will be feedback to the commissioner

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

7.3.5 The London Borough of Tower Hamlets is keen to support user led activities/services and the Provider(s) will develop plans to work toward this.

Peer mentor/volunteer support

7.3.6 The Provider(s) will recruit, support and manage a cohort of peer mentors and volunteers to support service users and carers. Peer supporters will offer friendly, informal support and will:

- Provide a link between carers and families and services that can help them,
- Refer and encourage carers and families to engage with relevant services, where appropriate accompany carers and families to services when they need support to engage,
- Provide information to carers and families as a non-professional peer,
- Support service users to navigate through treatment and other support interventions.
- Accompany service users to meetings/appointments,
- Help to co-ordinate service user focussed activities/trips.

8 Workforce

8.1 Minimum Workforce Standards

8.1.1 Tower Hamlets is committed to developing a progressive and diverse workforce that is reflective of the local community. Locally employed staff will have an understanding of the diversity within Tower Hamlets to better respond to the needs of drug and/or alcohol users. The Provider(s) will ensure workforce opportunities take account of Tower Hamlets local employment priorities and positive local recruitment is promoted. In general, any service provider is required to undertake activities which see Tower Hamlets recognised nationally and locally as an inclusive employer that recruits, develops and supports staff from different backgrounds.

8.1.2 The Provider(s) will ensure that the workforce reflects the diverse populations it serves and structures are in place to attract and support those from diverse BME groups. The Provider(s) will also ensure that recruitment and retention policies demonstrate equality of opportunity and workforce data will be monitored quarterly to identify and address under-representation issues within the workforce.

8.1.3 The provider will ensure the workforce includes workers fluent in the common languages used amongst service users; this includes Bengali and Somali but other languages may be necessary.

8.1.4 All interventions will be provided by staff assessed by the provider as being appropriately trained, skilled and competent to provide them. Effective interventions require competent practitioners who must have basic occupational competencies;

front line staff must have competence in motivational approaches and brief interventions[16].

8.1.5 All job descriptions, person specifications and recruitment processes will be expressed in line with the Drug and Alcohol National Occupational Standards (DANOS) and other relevant national occupational standards. All drug and alcohol practitioner staff will be trained to at least Level 3 Diploma, NVQ Level 3 or equivalent, or will be in the process of working towards this.

8.1.6 The service will employ at least one full time equivalent consultant psychiatrist.

8.1.7 Addiction specialists, consultant psychiatrists (or other consultants) and GPs working in addiction should have training and competencies in line with both guidance from the Royal College of Psychiatrists (monitored through appraisal and professional revalidation procedures), Royal College of General Practitioners (RGCP Management of Substance Misuse Cert 1 and 2 at a minimum) and the DANOS.

8.1.8 All counsellors will be registered or accredited by The British Association for Counselling and Psychotherapy (BACP) or another appropriate body accredited by the Professional Standards Authority

8.1.9 The Provider(s) will ensure suitably qualified and trained non-medical prescribing staff are employed.

8.1.10 All drug and alcohol practitioners and volunteers will have appropriate clearance with the Disclosure and Barring Service in line with current legislation.

8.1.11 The Provider(s) will continually work towards achieving a workforce which is fully competent and able to demonstrate that all managers and staff have a recognised competency assessed or professional qualification appropriate to their role and are pursuing relevant continuous development.

8.2 Workforce Development

8.2.1 The Provider(s) will demonstrate that an appropriate level of funding is allocated to the regular training and development of staff at all grades, including managers. All staff will receive training in line with core DANOS competencies and in the following:

- Safeguarding Children
- Safeguarding Vulnerable Adults
- Risk Management
- Information Governance
- Harm Minimisation
- Suicide Prevention
- Making Every Contact Count
- Health And Safety
- Equality And Diversity
- DAAT Training Programmes

[16] https://tools.skillsforhealth.org.uk

- NDTMS Core Data Set Training
- Electronic Case Management System (Nebula)

8.2.2 It is expected the Provider(s) will achieve the above within the first 6 months with staff using a broad range of evidence based approaches to meet the needs of the services users. The Provider(s) will undertake an annual Training Needs Analysis and produce an action plan to ensure:

- All workers and their line-managers have, or are working towards, evidence of their basic competence in the field,
- All workers and their line-managers have completed, or are undertaking, a training course regarding safeguarding children and adults commensurate with role,
- All line managers have completed, or are undertaking, a training course in line-management,
- All workers and their line-managers have, or are working towards, evidence of basic IT literacy,
- All workers will be trained and demonstrate competent use of the Tower Hamlets case management systems and where relevant attend the NDTMS core data set training,
- Any new and emerging concerns/priorities specified by the DAAT are supported by learning and development programmes.

8.2.3 The Provider(s) will ensure there is a commitment to supporting current and ex-service users to become volunteers and will ensure volunteers receive training and supervision which is suited to their needs.

8.2.4 The Provider(s) will ensure they have a named workforce development lead.

9 Performance Management

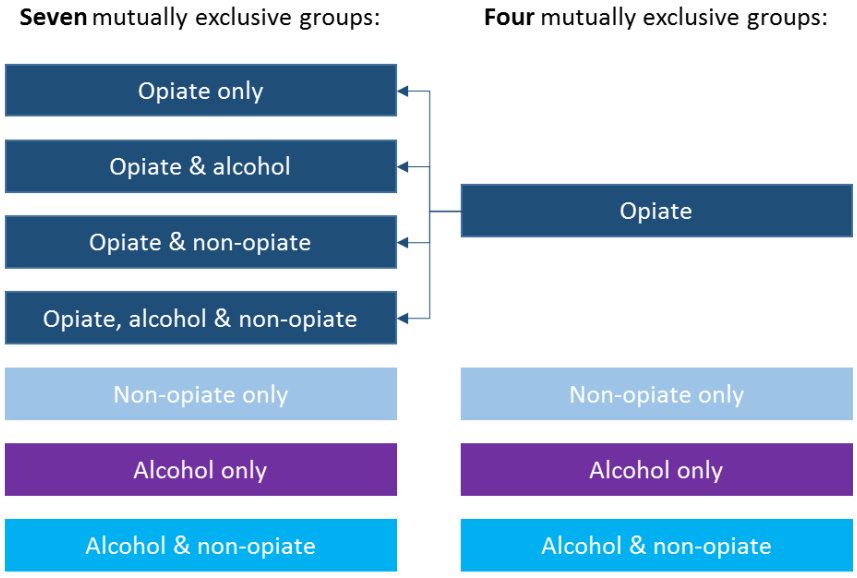
9.1 Performance Outcomes

9.1.1 The interventions delivered through this service will be expected to significantly support people through structured treatment. The Provider(s) will be performance managed on the number of service users engaged in treatment and the associated outcomes in relation to successful engagement in treatment.

9.2 National Drug Treatment Monitoring System

9.2.1 A change in the reporting methodology was introduce for 2014-15 that aligns the way treatment journeys are reported and also the way that service users are categorised by their problem substances. As of April 2014 the treatment journeys for services users in drug and alcohol treatment will be combined and reported as one pathway, with the outcomes and profile information for the services users being reported only once. The final outcomes, successful completions and re-presentations, will be reported at the end of the combined journey. From April 2014 substance misuse reporting will either consist of the seven or four substance groups as set out below, this supersedes the previous opiate, non-opiate and alcohol groupings.

Chart 3: New Categorisation of Substance Groups NDTMS April 2014



9.2.2 In order to group service users the presenting substances will be considered across all episodes in their latest treatment journeys, with a mutually exclusive grouping of substances used.

9.2.3 Which of the two mutually exclusive groupings will be used depends on the type of report, with the group of seven used mostly in activity reporting and the group of four used in higher level reports that are more outcome-focused.

9.2.4 The Provider(s) will use all relevant reports produced by NDTMS to monitor, assess and report activity and outcomes. These reports will include Provider(s) level drug and alcohol activity reports and Provider(s) level outcomes reports. The Provider(s) will apply this to all seven groupings of service users described above. The

Provider(s) will use the analysis of the Recovery Diagnostic Toolkit to understand the complexities of their service users and respond to identified needs that will result in better outcomes.

9.3 Local Outcome Comparators

9.3.1 A new reporting method was devised in 2014/15 to improve comparisons between local performance and that of other areas. This method supersedes the previous opiate and non-opiate clusters. In the new method, each local area will be compared to the 32 areas (called Local Outcome Comparators) that are most similar to them in terms of the complexity and treatment outcomes. There will be different groups of local outcome comparators for opiate, non-opiate and alcohol populations, in line with the new substance categories used in reporting for 2014/15. The same non-opiate comparators will be used for both the 'non-opiate only' and 'non-opiate and alcohol' substance groups.

9.3.2 The new method is similar to the 'nearest neighbour' method, however the term 'local outcome comparators' is used as the comparator areas are based specifically on the complexity of the populations in substance misuse treatment and not on broader similarity between the general populations of local authorities.

9.3.3 The local outcome comparators for Tower Hamlets will be used to benchmark successful completions and outcomes performance.

9.4 Key Performance Indicators

9.4.1 The Provider(s) will work within a performance management framework agreed by the commissioner. This framework will monitor service user treatment and outcomes data through NDTMS reports and local data reports. The key performance indicators set out below reflect the minimum levels of activity and can be subject to change.

9.4.2 These targets will be set at the start of the contract and subsequently reviewed and updated annually by the commissioner. Some activity will be monitored in the first six months to establish baseline data that will determine the desired level of outcomes. The targets may be subject to change throughout the contract and new indicators introduced as deemed necessary.

Quality Outcome Indicators / Reporting Requirements

	Indicator	Period	By Substance	Target	Method of Measurement	PBR Linked?
	In treatment					
1	Number of individuals starting a new treatment episode (YTD April to March)	YTD (Apr-Mar)	All Clients	Minimum of 1,300 new entrants per year	NDTMS Adult Activity provider report	N
1a	Number of individuals starting a new treatment episode (YTD April to March)	YTD (Apr-Mar)	All Opiate	No target		N
1b	Number of individuals starting a new treatment episode (YTD April to March)	YTD (Apr-Mar)	Non-opiate only	No target		N
1c	Number of individuals starting a new treatment episode (YTD April to March)	YTD (Apr-Mar)	Alcohol only	No target		N
1d	Number of individuals starting a new treatment episode (YTD April to March)	YTD (Apr-Mar)	Non-opiate & Alcohol only	No target		N
2a	Service users in effective treatment in %	Rolling 12 months	All Opiate	>/= 85%	NDTMS DOMES Partnership report	N
2b	Service users in effective treatment in %	Rolling 12 months	Non-Opiate only	>/= 85%		N
2c	Service users in effective treatment in %	Rolling 12 months	Alcohol and non-opiate only	>/= 85%		N
3	Numbers in treatment	YTD (Apr-Mar)	All clients	Minimum of 2,300 clients in treatment annually	NDTMS Adult Activity provider report	N
3a	Numbers in treatment	YTD (Apr-Mar)	All Opiate	No target		N

	Indicator	Period	By Substance	Target	Method of Measurement	PBR Linked?
3b	Numbers in treatment	YTD (Apr-Mar)	Non-opiate only	No target		N
3c	Numbers in treatment	YTD (Apr-Mar)	Alcohol only	No target		N
3d	Numbers in treatment	YTD (Apr-Mar)	Non-opiate & Alcohol only	No target		N
4	Number of individuals receiving a pharmacological alcohol withdrawal intervention	NDTMS specified 6 month review period	All service users	Minimum of 100 individuals a year	NDTMS Adult Activity provider report	N
5	Number of individuals receiving a pharmacological drug withdrawal intervention	NDTMS specified 6 month review period	All service users	Minimum of 320 individuals a year	NDTMS Adult Activity provider report	N
6	% service users with named care-coordinator	Rolling 12 mths	All service users	100%	Local data / ECMS	N
7	% service users with Health Care Assessment	Rolling 12 mths	All service users	98%	NDTMS Adult Activity provider report	N
8	% service users with Care Plans	Rolling 12 mths	All service users	100%	NDTMS Adult Activity provider report	N
9a	Female service users in treatment (YTD) in % - All Opiate	YTD (Apr-Mar)	All Opiate	22%	NDTMS Adult Activity	N

	Indicator	Period	By Substance	Target	Method of Measurement	PBR Linked?
9b	Female service users in treatment (YTD) in % - Non-opiate only	YTD (Apr-Mar)	Non-opiate only	20%	provider report	N
9c	Female service users in treatment (YTD) in % - Alcohol only	YTD (Apr-Mar)	Alcohol only	30%		N
9d	Female service users in treatment (YTD) in % Non-opiate & Alcohol	YTD (Apr-Mar)	Non-opiate & Alcohol only	25%		N
10	% service users from BME groups	YTD (Apr-Mar)	All service users	40% or more	NDTMS Adult Activity provider report	N
11	Client waiting times below 3 weeks (21 days) from referral to admission (Quarterly rate)	YTD (Apr-Mar)	All service users	100% of clients below 21 days	NDTMS Adult Activity provider report	N
	Completions and re-presentations					
12a	Service users successfully completing treatment and not re-presenting within 6 months of exit: Opiate users (Partnership PHOF)	Rolling 12 mths	All opiates	Achieve Top Quartile range for Comparator LAs	NDTMS PHOF Partnership	**Y**
12b	Service users successfully completing treatment and not re-presenting within 6 months of exit: Non-Opiate (Partnership PHOF)	Rolling 12 mths	Non opiates only	Achieve Top Quartile range for Comparator LAs	NDTMS PHOF Partnership	**Y**

	Indicator	Period	By Substance	Target	Method of Measurement	PBR Linked?
12c	Service users successfully completing treatment and not re-presenting within 6 months of exit: Alcohol only (Partnership PHOF)	Rolling 12 mths	Alcohol only	Achieve Top Quartile range for Comparator LAs	NDTMS PHOF Partnership	**Y**
13a	Re-presentations All opiate clients - Proportion who successfully completed treatment in the first 6 months of the latest 12 month period and re-presented within 6 months.	Rolling 12 mths	All opiates	Achieve Top Quartile range for Comparator LAs	NDTMS Adult Activity partnership report	N
13b	Re-presentations Non Opiate clients - Proportion who successfully completed treatment in the first 6 months of the latest 12 month period and re-presented within 6 months.	Rolling 12 mths	Non opiates only	Achieve Top Quartile range for Comparator LAs	NDTMS Adult Activity partnership report	N
13c	Re-presentations Alcohol only clients - Proportion who successfully completed treatment in the first 6 months of the latest 12 month period and re-presented within 6 months.	Rolling 12 mths	Alcohol only	Achieve Top Quartile range for Comparator LAs	NDTMS Adult Activity partnership report	N
13d	Re-presentations Non-Opiate & Alcohol only clients - Proportion who successfully completed treatment in the first 6 months of the latest 12 month period and re-presented within 6 months.	Rolling 12 mths	Non Opiate & Alcohol only	Achieve Top Quartile range for	NDTMS Adult Activity partnership report	N

	Indicator	Period	By Substance	Target	Method of Measurement	PBR Linked?
				Comparator LAs		
	Treatment exits					
14a	Service users discharged from treatment in an unplanned way, recorded as incomplete - dropped out, as a % of all discharges: All opiate clients	YTD (Apr-Mar)	All Opiate	</=40%	NDTMS Adult Activity provider report	**Y**
14b	Service users discharged from treatment in an unplanned way, recorded as incomplete - dropped out, as a % of all discharges: Non-opiate only clients		Non-opiate only	</=10%		**Y**
14c	Service users discharged from treatment in an unplanned way, recorded as incomplete - dropped out, as a % of all discharges: Alcohol only clients		Alcohol only	</=25%		**Y**
14d	Service users discharged from treatment in an unplanned way, recorded as incomplete - dropped out, as a % of all discharges: Non-opiate & Alcohol only clients		Non-opiate & Alcohol only	</=25%		**Y**
	Treatment Outcomes Profile					
15	TOP Starts completed (Quarterly compliance)	Quarterly	All clients	90% completion	NDTMS TOP Exceptions report - Provider	N
16	TOP Reviews completed (Quarterly compliance)	Quarterly	All clients	90% completion		N
17	TOP Exits completed (Quarterly compliance)	Quarterly	All clients	90% completion		N
18a	Opiate abstinence observed at 6 month TOP review	Rolling 12 mths	All drug users	Within expected range	NDTMS Adult 6 month Review	**Y**

	Indicator	Period	By Substance	Target	Method of Measurement	PBR Linked?
18b	Crack abstinence observed at 6 month TOP review	Rolling 12 mths	All drug users	Within expected range	outcomes provider report - All clients	**Y**
19	Clients stopped injecting within the expected reliable change at TOP Review stage	Rolling 12 mths	All drug users	Within expected range		**Y**
20	Alcohol use improved at 6 month TOP review - Alcohol clients only	Rolling 12 mths	Alcohol only	Achieve National average	NDTMS Adult 6 month Review provider report - Alcohol only	**Y**
21	Reset Treatment Service clients starting an intervention provided by Recovery Support Service (Tier 2 & Tier 3)	YTD (Apr – Mar)	All service users	A minimum of 900 RT clients a year	Provider report and local data	**Y**
	Hidden Harm report					
22a	Complete Hidden Harm monitoring form	Quarterly	All service users	Activity – Quarterly report	NDTMS provider report / Local data	N
22b	Family referrals of service users, parents and children to support agencies	Quarterly	All service user	Target to be agreed	Local data	N
	Blood Borne Viruses					
23	Hepatitis B intervention offered – New treatment Journey	YTD (Apr-Mar)	All service users	98%	NDTMS Adult Activity provider report	**Y**
24	Hepatitis B vaccination uptake (Clients offered & accepted)	YTD (Apr-Mar)	All service users	90%		**Y**
25	Hepatitis C intervention offered	YTD (Apr-Mar)	All service users	98%		**Y**

	Indicator	Period	By Substance	Target	Method of Measurement	PBR Linked?
26	Hepatitis C testing uptake (Clients offered & accepted)	YTD (Apr-Mar)	All service users	80%		**Y**
27	BBV testing & treatment report including number of tests undertaken and number of positive results	Quarterly	All service users	Activity – Quarterly report	Provider report / local data	N
	Drug/alcohol related deaths					
28	Number of drug or alcohol related deaths of people in treatment or who have been in treatment	To be reported as they occur and collated quarterly	All service users	No target	Provider report / local data	N
	Needle and Syringe Programme					
29	Needle and Syringe Programme Activity Report including naloxone distribution	Quarterly	All service users	Activity – Quarterly Report	Provider report / local data	N
	Workforce					
30	Workforce Diversity Data report	Quarterly	Staff	Activity	Provider report / local data	N
31	Annual Training Needs Analysis and Action Plan	Annual	Staff	Activity	Provider report / local data	N
32	Staff Caseload report	Quarterly	Staff	Activity	Provider report / local data	N
33	Complaints, compliments & incidents report	Quarterly	All service users / Staff	Activity	Provider report / local data	N
34	Annual Business Continuity report	Annual	Staff / All service users	Activity	Provider report	N
	Equalities data – protected characteristics					
34	Quarterly Report - Breakdown of all 9 protected characteristics (clients)	Quarterly	All service users	Activity	Local data / NDTMS	N

	Indicator	Period	By Substance	Target	Method of Measurement	PBR Linked?
	• Age • Disability • Race • Religion and belief • Gender reassignment • Marriage and civil partnership • Gender • Sexual orientation • Pregnancy and maternity					
35	Annual Equality Impact Assessment	Annual	All service users	Activity – Annual Report	NDTMS Provider report & Local data	N
	Service Users					
36	Annual Service Users Survey including findings and action plan	Annual	All service users	Activity	Provider Report	N

9.5 Payment by Results

9.5.1 Tower Hamlets will adopt an incentivised Payment by Results model where 90% of full contract value will be awarded in equal quarterly payments in arrears of each quarter. The remaining 10% of the quarterly payment will be paid on achievement of quarterly outcome targets agreed between the provider and commissioner.

9.5.2 The overall 10% PBR payment is depending on performance in selected KPIs. A proportion of the overall PBR payment has been allocated to each KPI or KPI group as shown below in the PBR schedule.

PBR schedule

KPI / KPI group	**Proportion of PBR payment allocated**	**When implemented**
KPIs 12a, b, c: Successful completions and non-re-presentations (Phof 2.15)	3%	Q3 2020/21
KPIs 14a, b, c, d: Treatment exits by substance group – drop out	2%	Q1 2020/21
KPIs 18a, 18b, 19, 20, 21: TOP Outcomes and Reset Treatment Service clients engaging with Recovery Support Service	2.5%	Q3 2020/21
KPIs 23, 24, 25, 26: Blood Borne Viruses	2.5%	Q1 2020/21

9.5.3 Payment will be made for all achieved and met PBR targets / target groups. Failure to achieve quarterly PBR outcomes will result in the PBR payment for the quarter being removed and reallocated by the DAAT. PBR will be applicable as stated above. Full details of the Payment by Results programme including appeals process will be provided at the point of contract agreement.

9.6 Contract Monitoring

9.6.1 The commissioner has a duty to monitor contract compliance and standard of the service provided to service users by the provider. This will be done by reviewing and monitoring the service as detailed in this specification through quarterly contract monitoring meetings between provider and commissioner.

9.6.2 As part of the monitoring arrangements the provider will be required to meet agreed performance indicators (as indicated above) based on evidencing progress on meeting the outcomes identified in the specification.

9.6.3 The commissioners will usually carry out quarterly monitoring visits throughout the contractual period. The monitoring visit will include policies, procedures, written plans and strategies within the service, staff files and service user files, complaints log, adverse incident reports, clinical audits, staff training records, and other relevant matters as specified by the commissioner. The monitoring visit may include informal talks with service users and/or staff. The commissioner retains the right to visit the provider as set out in the Contract terms and conditions.

Appendix A – Table of Abbreviations

AOR	Alcohol Outcomes Reporting
ATR	Alcohol Treatment Requirement
AUDIT	Alcohol Use Disorder Identification Test
BACP	British Association for Counselling and Psychotherapy
BME	Black and Minority Ethnic
CQC	Care Quality Commission
CRC	Community Rehabilitation Companies
DAAT	Drug and Alcohol Action Team
DANOS	Drug and Alcohol National Occupational Standards
DBS	Disclosure and Barring Service
DIP	Drug Interventions Programme
DOMES	Diagnostic Outcomes Monitoring Executive Summary
DRR	Drug Rehabilitation Requirement
ECAF	Electronic Common Assessment Framework
ECMS	Electronic Case Management System
ELFT	East London Foundation Trust
GP	General Practitioner
HIV	Human Immunodeficiency Virus
ISA	Independent Safeguarding Authority
ITEP	International Treatment Effectiveness Project
JCP	Job Centre Plus
JSNA	Joint Strategic Needs Assessment
M-PACT	Moving Parents and Children Together
NDTMS	National Drug Treatment Monitoring System
NICE	National Institute for Health and Care Excellence
OCU	Opiate and/or Crack User
PCT	Primary Care Trust
PHOF	Public Health Outcome Framework
RCGP	Royal College of General Practitioners
RCN	Royal College of Nursing
SADQ-C	Severity of Alcohol Dependence Questionnaire
SMART	Specific, Measureable, Achievable, Realistic and Timely
SUI	Serious Untoward Incident
TB	Tuberculosis
TOP	Treatment Outcomes Profile
VfM	Value for Money
YTD	Year to date

London Borough of Tower Hamlets
Reset Outreach and Referral Service
Service Specification

Contents

1 Introduction

1.1 Background

1.1.1 The misuse of drugs and alcohol presents a wide range of social and health issues. It can have serious consequences for individuals, their family members and whole communities including crime, domestic abuse, child abuse and neglect, family breakdown, homelessness and physical and mental health problems. Tower Hamlets has a high prevalence of drug and alcohol misuse, with around 48% of Opiate and Crack users and 20% of dependent drinkers currently engaging in treatment services.

1.1.2 Tower Hamlets has a committed partnership working hard to meet the objectives set out in our Substance Misuse Strategy (detailed below). Engaging those with substance misuse issues into treatment services is a key priority for our partnership with our collective aim being to improve the quality of life, health and wellbeing of substance misusing residents, enabling these individuals to become abstinent and sustain their recovery.

1.1.3 The Tower Hamlets Drug and Alcohol Action Team (DAAT) have commissioned drugs and alcohol treatment services since the late 1980s. In 2014 a wholescale service review of the treatment system was undertaken to inform a transformation in the delivery of services.

1.1.4 The remodelled Treatment System was implemented in 2016 following extensive consultation, comprehensive review and significant redesign of substance misuse treatment services in Tower Hamlets, alongside a substance misuse specific needs assessment. The model adopted sets out three separate contracts: Drug & Alcohol Outreach and Referral Service, Drug & Alcohol Treatment Service and Drug & Alcohol Recovery Support Service.

1.1.5 Together these form Reset - the brand name for the system encompassing the three contracts. Reset is a recovery-oriented system supported by a number of services including the Reset Homeless Drug & Alcohol Service, Primary Care Drug & Alcohol Service, the Specialist Midwife based within Royal London Hospital and the Drug Intervention Programme.

1.1.6 In advance of this round of procurement a consultation with over 400 stakeholders was undertaken to assess stakeholder views of the current system. The findings from the consultation indicated support for retaining the current treatment model.

1.2 Re-procurement

1.2.1 The Council has a duty to comply with laws and regulations outlined by the European Union and the UK Government which inform how we award contracts. It is imperative that we are committed to ensuring quality service delivery and outcomes whilst achieving best value.

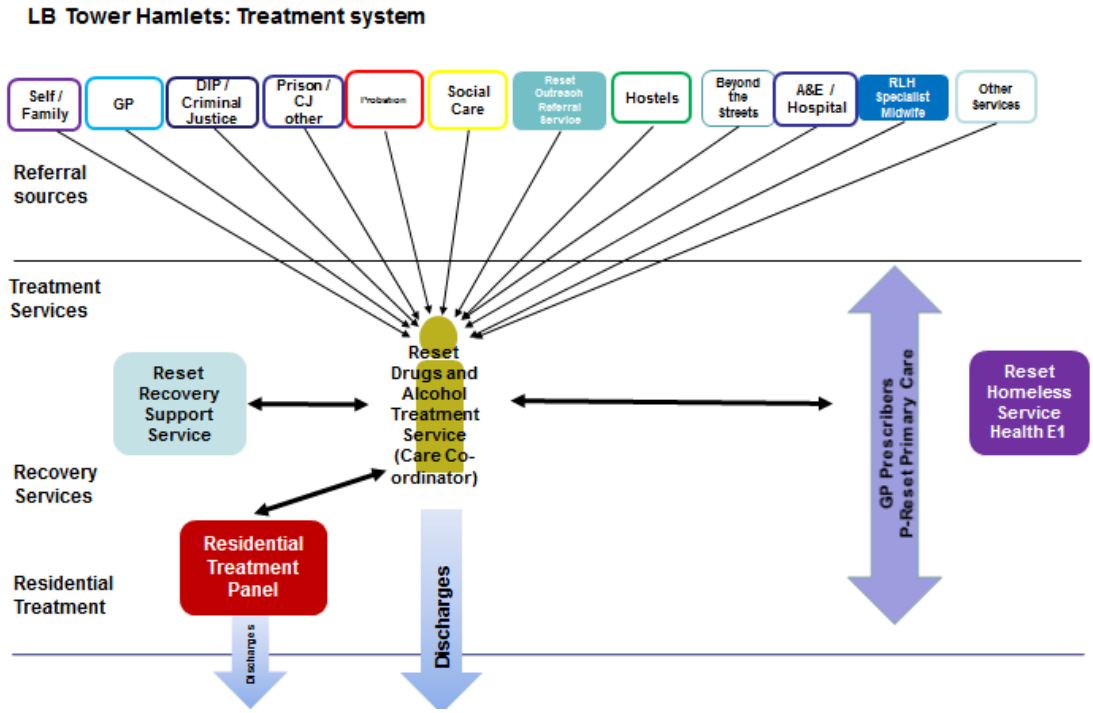
1.2.2 With existing contracts coming to an end in October 2019 and in line with Procurement and Legal procedures, the DAAT is now at the point of re-procuring the Reset contracts. As part of that, the DAAT conducted a comprehensive stakeholder consultation exercise which identified areas for improvement. These areas have been evaluated and

improvements incorporated into the contract specifications and Performance Framework.

1.3 Treatment Model

1.3.1 The current treatment model sets out three separate services operating together under the brand Reset; delivering the key components of outreach and referral, treatment and recovery support. The three services are supported by provisions sitting outside of this procurement, including Reset Homeless Service, Primary Care Drug & Alcohol Service and the Specialist Midwife. This model will underpin a drugs and alcohol treatment system that is recovery orientated. Treatment is based on a menu of complementary and associated interventions that are evidence based, service user focused and embedded in recovery.

1.3.2 This model is outlined below:



1.3.3 Consultation findings highlighted strengths in the treatment system model including the ease of navigation through the system with a single point of entry and dedicated care-coordination throughout the treatment journey. Outreach provisions were thought to have improved the engagement of hard to reach populations.

1.3.4 Areas for development were also identified: increased and tailored trauma informed offer for women, additional treatment locations/ hubs and increased support for service users with mental health conditions.

1.3.5 The DAAT is responding to the gaps identified through the revision of service specifications, review of key performance indications (KPIs), close monitoring of contract deliverables and oversight of the development of joint working pathway agreements.

2 National Context

There is a range of national and local cross-cutting policy themes that guides the work of Tower Hamlets and sets the backdrop to this procurement exercise:

2.1 Drug Strategy 2017

2.1.1 The Drug Strategy 20171 sets out the Government's approach to tackling drug use and the expectations for action from Government at both national and local levels alongside international partners, voluntary, third sector, health and community organisations adopting a partnership approach to respond to the challenges and harms caused by drug misuse and support individuals to live a drug-free life.

2.1.2 There are two overarching aims of the strategy regarding treatment:

- Reducing illicit and other harmful drug use,
- Increasing the numbers recovering from dependence

2.1.3 In order to deliver recovery orientated treatment, there is an acknowledgement that links with housing, employment and family services must be firmly established and integrated into overall treatment services and that supportive relationship with families, carers and social networks must be promoted.

2.1.4 It is also recognised that a joined-up approach to drugs and alcohol is vital and commissioning of drug and alcohol services should take place in an integrated way, whilst ensuring a focus on specific and appropriate interventions.

2.2 Medications into Recovery 2012

2.2.1 The Recovery Orientated Drug Treatment Expert Group led by Professor John Strang report Medications into Recovery 2012: Re-orientating drug dependence treatment2 provides a framework for meeting the ambition of the Drug Strategy to help more Heroin users to recover and break free of dependence.

2.2.2 The Expert Group's advice makes clear that:

- Care planning, with its on-going and planned reviews of specific goals and actions, should be part of a phased and layered treatment programme.
- A strategic review of the client's recovery pathway will normally be necessary within three months (and no later than six months) of treatment entry, and will then usually be repeated at six-monthly intervals.
- Strategic review should always revisit recovery goals and pathways (to support clients to move towards a drug-free lifestyle).
- Drug treatment should be reviewed based on an assessment of improvement (or preservation of benefit) across the core domains of successful recovery.

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[1] Drug Strategy 2017 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/628148/Drug_strategy_2017.PDF

[2] Medications in Recovery – http://www.nta.nhs.uk/uploads/medications-in-recovery-main-report3.pdf

2.3 **Alcohol Strategy 2012 (update expected in 2019)**

2.3.1 The Alcohol Strategy 2012 is built around four key objectives underpinned by a recovery orientated approach to treatment and a focus on those whose offending is alcohol related:

- End the availability of cheap alcohol and irresponsible promotions.
- Ensure that local areas are able to tackle local problems, reduce alcohol fuelled violent crime on our streets and tackle health inequalities by giving tools and powers to local agencies to challenge people that continue to act in an unacceptable way.
- Secure industry's support in changing individual drinking behaviour.
- Support individuals to make informed choices about healthier and responsible drinking, so it is no longer considered acceptable to drink excessively.

2.3.2 The Alcohol Strategy also highlighted provision of recovery orientated treatment in particular for dependent drinkers; whole family based approach within treatment services and continued support for effective health measures such as brief interventions.

2.4 **Psychoactive Substances Act 2016**

2.4.1 The Psychoactive Substances Act 20163 defines psychoactive substances and outlines offences and prohibited activities relating to such substances, also highlighting exceptions and substance exempt from the Act.

2.4.2 The Act provides enforcement powers and gives the Police and local authorities more powers to respond to the trade of psychoactive substances.

2.5 **Dual Diagnosis**

2.5.1 In 2017 Public Health England produced a guide for commissioners and service providers which sets out how services can be improved to "provide a range of coordinated services that address people's wider health and social care needs, as well as other issues such as employment and housing" (Better care for people with co-occurring mental health and alcohol/drug use conditions). It is estimated that around 40% of individuals diagnosed with a psychotic illness have misused drugs or alcohol (NICE 2016).

2.6 **Good Practice**

2.6.1 Dual Diagnosis is a 'whole system' multi-agency issue, affecting a broad cross-section of adults, with varying levels of severity and impact on the individual, their friends and family, as well as local communities. A population-based approach to commissioning and managing integrated dual diagnosis provision, which utilises existing resources to support the maximum number of people across a broad spectrum of need within local communities is required.

2.6.2 NICE guidelines recommend:

[3] The Psychoactive Substances Act 2016
http://www.legislation.gov.uk/ukpga/2016/2/pdfs/ukpga_20160002_en.pdf

- Rather than commissioning 'dual diagnosis specialist teams' wider services should adapt to and coordinate the care of this group
- Care should be led and coordinated through mental health services

2.6.3 Providers of Substance Misuse services should work with mental health services to ensure the following key principles are adhered to:

- Do not exclude adults and young people with psychosis and coexisting substance misuse from age-appropriate mental health care because of their substance misuse
- Do not exclude adults and young people with psychosis and coexisting substance misuse from age-appropriate substance misuse services because of a diagnosis of psychosis
- Consider seeking specialist advice and initiating joint working arrangements with specialist substance misuse services for adults and young people with psychosis being treated by community mental health teams, and know to be; severely dependent on alcohol or dependent on both alcohol and benzodiazepines or dependent on opioids and or cocaine or crack cocaine
- Adult community mental health services should continue to provide care coordination and treatment for the psychosis within joint working arrangements
- Do not exclude people from physical health care, social care, housing or support services because of their coexisting severe mental illness and substance misuse
- Adopt a person-centred approach to reduce stigma and address any inequity to access services people may face
- Undertake a comprehensive assessment of the person mental health and substance misuse needs.

2.6.4 The management of people with dual diagnosis remains an area of concern and one of high priority for mental health policy and in clinical practice. Individuals with coexisting mental health and substance misuse problems deserve high quality, patient focused and integrated care. This should be delivered within mental health services. This policy is referred to as "mainstreaming". Patients should not be shunted between different sets of services or put at risk of dropping out of care completely. 'Mainstreaming' will not reduce the role of drug and alcohol services which will continue to treat the majority of people with substance misuse problems and to advise on substance misuse issues. Unless people with a dual diagnosis are dealt with effectively by mental health and substance misuse services these services as a whole will fail to work effectively.

2.6.5 To support the principles of 'everyone's job' and 'no wrong door', set out in PHE's guidance, the following priorities in the delivery of care should be adhered to:

- Agree a pathway of care which will enable collaborative delivery of care by multiple agencies in response to individual need
- Appoint a named care coordinator for every person with co-occurring conditions to coordinate the multi-agency care plan
- Enable people to access the care they need when they need it and in the setting most suitable to their needs

- Make sure people are helped to access a range of recovery support interventions, while recognising that recovery may take place over a number of years and require long term support

2.6.6 The guide also recommends a framework for delivery of care based on the following factors:

- Strong therapeutic alliance
- Collaborative delivery of care
- Care that reflects the views, motivations and needs of the person
- Care that supports and involves carers (including young carers) and family members
- Therapeutic optimism
- Episodes of intoxication are safely managed

2.7 **Transforming Rehabilitation**

2.7.1 The Drug Strategy states "prison may not always be the best place for individuals to overcome their dependence and offending". The 'Transforming Rehabilitation' proposals have been introduced as part of the Government's overall response to crime, drugs and alcohol problems through the Offender Rehabilitation Act 2014 with lead responsibility for implementation resting with the Home Office. The Offender Rehabilitation Act 2014 sets out the following as priorities:

- Creation of a new public sector National Probation Service to work with the most high-risk offenders.
- Formation of 21 new Community Rehabilitation Companies (CRCs) to turn round the lives of medium and low-risk offenders.
- Giving statutory supervision and rehabilitation in the community to every offender released from custody, including those sentenced to less than 12 months in custody.
- Establishing a nationwide 'through the prison gate' resettlement service to give most offenders continuity of support from custody into the community; a network of resettlement prisons will ensure that offenders continue to be managed by the same provider as they move from custody into the community.
- Opening up the market to a diverse range of new rehabilitation providers to get the best out of the public, voluntary and private sectors and giving them the flexibility to do what works.
- Only paying providers in full for real reductions in reoffending.

2.7.2 Although offenders are not a homogeneous group, a range of problems or needs are more frequently observed in offender populations than in the general population. These include substance misuse problems, pro-criminal attitudes, difficult family backgrounds including experience of childhood abuse or time spent in care, unemployment and financial problems, homelessness and mental health problems. Many of these factors are interlinked and may vary from individual to individual and group to group.

2.7.3 A series of individual or social factors are understood to be associated with an increased risk of reoffending and these are routinely assessed as part of offender management practice. These factors or 'criminogenic needs' can be particularly associated with

certain types of crime. Heroin and Crack use is particularly associated with some types of acquisitive offending such as shoplifting, and binge drinking of alcohol is particularly associated with violence.

2.7.4 The Ministry of Justice has announced further future reforms to the Probation service following the termination of the contracts with CRCs in 2020. The DAAT will expect Reset providers to work proactively with criminal justice agencies through the reforms as a significant proportion of referrals into the treatment system come via criminal justice pathways

2.8 Public Health Outcomes Framework 2016 - 2019

2.8.1 The Public Health Outcomes Framework (PHOF): Improving outcomes and supporting transparency4 sets out a vision for public health, desired outcomes and the indicators that will help to understand how well public health is being improved and protected.

2.8.2 Tower Hamlets DAAT has responsibility for delivering against four national public health indicators;

- Successful completion of drug and/or alcohol treatment (PHOF 2.15i, ii, iii)
- Deaths from drug misuse (PHOF 2.15 iv)
- Reducing alcohol related admissions to hospital (PHOF 2.18)
- Successfully engaging individuals with a substance misuse need in community-based structured treatment following release from prison (PHOF 2.16)

2.9 Metropolitan Police Service (MPS) Drugs Strategy 2017 – 2021

2.9.1 The MPS Drugs Strategy 2017-2021: Dealing with the impact of drugs on communities and confidence in Police aims to support local officers in their response to drug related matters with the aim of reducing the social and criminal impact of illicit drugs on communities in London.

2.9.2 The Strategy is based on 3 key principles:

- Reduce Demand
- Reduce Supply
- Reduce Harm

[4] Public Health Outcomes Framework 2016-19 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/545605/PHOF_Part_2.pdf 2013-2016 - http://www.phoutcomes.info/

3 Local Context

3.1 Tower Hamlets

3.1.1 Tower Hamlets has an estimated population of 308,000. This makes the borough a mid-sized local authority within London. The population is projected to reach 365,200 by 2027 – equivalent to around 15 additional residents per day for the next ten years. The population is expected to reach 400,000 by 2041.5

3.1.2 Tower Hamlets has a relatively young population compared with the rest of the country. Our median age in 2017 was 31.0 years which was the 4th youngest median age out of all local authorities in the UK.13 The median age was 35.1 in London (4.1 years older), 39.8 in England (8.8 years older) and 40.1 in the UK (9.1 years older). The borough's relatively young age profile reflects the fact that over the past ten years, the borough's working age population has increased much more quickly than the child population or older age groups.

3.1.3 Tower Hamlets ranks as the 16th most ethnically diverse local authority in England in terms of the mix of different ethnic group populations in the borough. More than two thirds (69 per cent) of the borough's population belong to minority ethnic groups (i.e. not White British), while just under one third (31 per cent) are White British the fifth lowest proportion in England & Wales.

3.1.4 Bangladeshi residents are the largest single ethnic group in Tower Hamlets, accounting for around one in three residents (32 per cent) at the time of the 2011 Census. This was the largest Bangladeshi population in the country, by far.

3.1.5 There are large differences in the ethnic profile of different age groups. The working age population (aged 16 to 64) is the most diverse age group, with no single ethnic group making up the majority of the population. On the other hand, 57 per cent of the borough's children (aged 0 to 15) are Bangladeshi and 57 per cent of the borough's older people (aged 65+) are White British.

3.1.6 Tower Hamlets has the highest proportion of Muslim residents in the country. In 2011, 38 per cent of borough residents were Muslim compared with 5 per cent in England and 13 per cent in London. Conversely, the borough had the lowest proportion of Christian residents nationally: 30 per cent of borough residents were Christian compared with 59 per cent in England & Wales. Around one in five (21 per cent) of residents had no religion and 7 per cent chose not to state their religion on the Census form.

3.1.7 On the average IMD score measure – which reflects the average level of deprivation across all LSOAs in an area - Tower Hamlets is the 10th most deprived area in England out of 326 local authority areas. This is a slight improvement since the 2010 IMD which ranked Tower Hamlets as 7th most deprived on this measure. Deprivation is widespread in Tower Hamlets and the borough remains one of the most deprived areas in the country. The borough fares worst on measures that relate to housing and income deprivation, especially income deprivation affecting children and older people.[6]

[5] Borough Profile https://www.towerhamlets.gov.uk/Documents/Borough_statistics/Research-briefings/Population_2_BP2018.pdf

[6] The Indices of Deprivation 2015

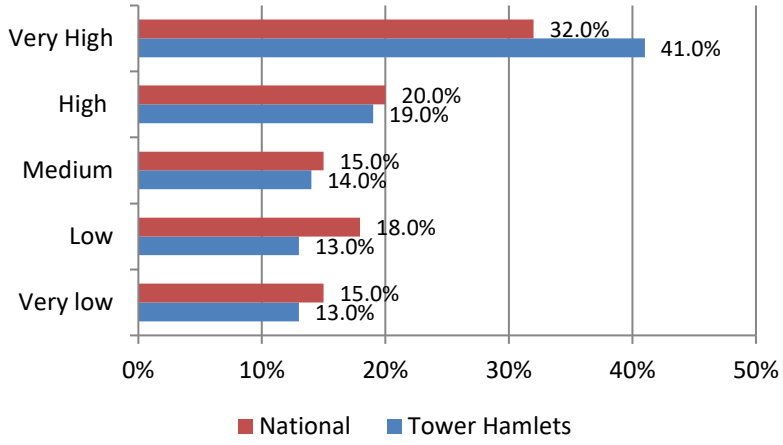
3.1.8 Tower Hamlets is estimated to have the third largest lesbian, gay and bisexual population in London with estimates from the 2015 GP survey placing the percentage of the adult population who identify as LGB at 8.7%[7].

3.1.9 Drug and alcohol treatment provision in Tower Hamlets will need to meet the specific needs of these diverse ethnic, LGBT and faith communities in particular the needs of the large Muslim, Bangladeshi & Somali communities.

3.2 Drug and Alcohol Treatment Population

3.2.1 Historically, complexity levels of the Tower Hamlets treatment population have been very high. Most recent data shows that complexity levels remain high, with around 41% of clients in treatment classified with very high complexity levels compared to a national average of 32%; therefore interventions need to reflect this complexity to effectively support service users.

Chart 1: Tower Hamlets client complexity compared to national average March 2018 (Source: Recovery Diagnostic Toolkit March 2018)



3.2.2 Treatment has a strong health focus and many service users have their Opiate substitution prescribed by local GPs under a 'Shared Care' arrangement between themselves and the local treatment providers. The substitute prescribing is designed to stabilise and maintain these service users. However, only a small proportion of those in treatment access wider recovery and cessation orientated psychosocial interventions. This needs to change particularly as the borough is being challenged to increase its successful completions from drug and alcohol treatment (a proxy outcome measure for recovery). Whilst it is clear that many in the treatment system are not ready to become drug and alcohol free, measures must be in place to support this aim and importantly the treatment system must work collaboratively with the commissioned Primary Care Drug & Alcohol Service provider to enable this outcome orientation to become the central theme for treatment in the borough.

7 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/585349/PHE_Final_report_FINAL_DRAFT_14.12.2016NB230117v2.pdf

3.2.3 Therefore the priorities and dynamics of the treatment system in this context are to achieve;

- Improved focus on recovery with service users in Shared Care utilising interventions at the Recovery Support Service
- Improved performance management
- Coordination of resources and budgets to achieve strong value for money and service quality
- Improved broader health outcomes for service users including treatment and ongoing management of associated long term conditions
- Enhancing support offered to clients post-discharge

Drugs - Prevalence Estimates

3.2.4 Information about the number of people who use illicit drugs such as Heroin, other Opiates or Crack Cocaine is key to formulating effective policies for tackling drug-related harm as these drugs are associated with the highest levels of harm. It also helps inform service provision at the local level and provides a context in which to understand the population impact of interventions to reduce drug-related harm.

3.2.5 The latest 2014-15 estimates[8] for Tower Hamlets suggest there are:

- 2,798 opiate and/or crack users (OCU),
- 2,309 opiate only users,
- 2,543 crack only users,
- 773 intravenous drug users (2011/12 estimate)

3.2.6 The estimate refers to the period 2014/15 and suggests a total of 2,798 OCUs, representing a fall of around 20% from 3,561 in 2011/12.

3.2.7 Prevalence rates for OCUs, Opiate and Crack in Tower Hamlets are significantly above London and England rates. The LBTH Crack using estimate is nearly twice as high as the National and London rate.

3.2.8 The estimated unmet need was around 52% or 1,600 potential clients who would profit from treatment[9].

Alcohol – Prevalence Estimates

3.2.9 A large proportion of the Tower Hamlets population does not drink; this is reflective of the borough's diverse ethnic and faith population. It is estimated 48% of the adult population abstain from alcohol use. However amongst those people in Tower Hamlets who do drink there is evidence of higher rates of dependency and health harms associated with excess consumption

[8] PHE OCU estimate 2014/15 published 2017

[9] Unmet need is the number of individuals requiring treatment but not in contact with treatment services based on recent prevalence and 2017/18 treatment engagement.

3.2.10 The latest data estimates a total of 3,427 dependent drinkers in need of assessment and potential treatment in the borough. Based on this, around 82 per cent of those drinkers are currently not in treatment and their needs might be unmet.

3.2.11 The data shows that Tower Hamlets had the 7th highest rate of dependent drinkers in London. Around 20% of Tower Hamlets adults drink more than 14 units of alcohol as recommended by PHE.

Drug and Alcohol Treatment

3.2.12 The Tower Hamlets treatment system is the largest in London with more than 2,000 clients engaging in structured treatment per annum. This includes 1,232 Opiate clients, 146 non-Opiate clients and 691 alcohol clients (Alcohol only & Non-opiate & Alcohol) in 2017/18.[10]

3.2.13 The treatment system has become more diverse over the last two years, attracting more women, students and young adults into treatment. Considerably more work needs to be undertaken to attract other groups, in particular the LGBTQ community where the prevalence of party drug use remains unknown locally.

3.2.14 Successful treatment outcomes have much improved since Reset started in Oct 2016. 411 clients left treatment successfully in 2017/18.

3.2.15 Re-presentations rate are comparably low and clients achieve very good rates of abstinence when attending structured treatment.

3.2.16 The introduction of short term treatment episodes has improved engagement with alcohol only and alcohol & non-Opiate clients.

3.3 Tower Hamlets Substance Misuse Strategy 2016-2019

3.3.1 The Substance Misuse Strategy is a joint strategy that was developed in partnership between London Borough of Tower Hamlets, NHS East London & the City, the Metropolitan Police and the London Probation Service. The Partnership Vision leading the strategy:

> "In Tower Hamlets, we will support children, young people, adults and their families to maximise their health and wellbeing whilst reducing the negative impact of drugs and alcohol. We will strengthen protective factors for those at risk, and empower those who are addicted or dependent to recover whilst reducing harm from continues use. We will bear down on the crime and anti-social behaviour associated with drug and alcohol misuse that impacts on our communities"

3.3.2 The strategy relies on a 'Three Strands' approach, addressing:

- **Prevention and Behaviour Change**: including information, education, support to parents, health messages and communications and safeguarding vulnerable young people and adults

[10] Source: NDTMS DOMES reports Q4 2017/18

- **Treatment**: through screening and identification, assessment and care planning, effective treatment, after care and reintegration
- **Enforcement and Regulation**: including dedicated and targeted operations, integrated offender management, licensing and regulatory enforcement and enforcement of controlled drinking zones.

3.3.3 The strategy sets out the broad framework for drug and alcohol interventions across the borough and identifies a range of priorities that address the themes listed above.

3.3.4 With reference to the Treatment strand of the Substance Misuse Strategy, the objectives for improving the outcomes of our service users are to:

- Take a person centred approach and deliver high quality services to meet the needs of individual service users,
- Provide a range of flexible, innovative and adaptable service approaches,
- Promote and deliver effective early intervention engagement,
- Empower those who are dependent on drugs and/or alcohol to recover,
- Deliver a service where recovery and associated interventions are integral to the design of the entire treatment journey; for example housing, volunteering, aftercare groups,
- Ensure services are delivered by a professional, competent and skilled workforce,
- Ensure services are underpinned by a robust clinical governance structure,
- Meet the needs of socially excluded communities (including BME, lesbian, gay, bisexual, transgender communities), ensuring effective engagement, and respond to the complexities of drug and alcohol users in Tower Hamlets,
- Continue to focus on the broader health and social issues and respond to the findings from the most recent Needs Assessment,
- Integrate the views of service users and significant others into account when designing service delivery by developing local partnerships and consulting service users regarding operational issues and changes,
- Support carers and concerned family/friends to receive support,
- Continue to review services to ensure they remain fit for purpose and locally focused.

3.3.5 The implementation of the Strategy is overseen by the DAAT Partnership Board and reports on progress are provided for other relevant boards such as the Community Safety Partnership and Health and Wellbeing Boards as appropriate.

3.3.6 With the current Strategy term coming to an end in 2019, the DAAT will be conducting a consultation to review current priorities and develop a new Strategy, the term yet to be decided.

3.4 Tower Hamlets Health & Wellbeing Strategy 2017 - 2020

3.4.1 Living a healthy life prevents illness and enhances wellbeing. The Health and Wellbeing Strategy 2017-2020 sets the ambition to make a positive impact on the physical and mental health and wellbeing of people living and working in Tower Hamlets.

3.4.2 The strategy states: "We know we face some big health challenges in Tower Hamlets but also that by working together across services - and with our local communities - we can make a positive difference to everyone's wellbeing in Tower Hamlets".

3.4.3 The strategy recognises that alcohol consumption and the use of illegal drugs are factors linked to poor health and one of the priority areas to address these issues is Employment and Health.

3.5 Joint Strategic Needs Assessment 2017 [11]

3.5.1 The Tower Hamlets Joint Strategic Needs Assessment (JSNA) is a living document overseen by the Tower Hamlets Health and Wellbeing Board. There is clear recognition that understanding health and wellbeing and debating priorities for action is a dynamic process that takes place within a context of continual change.

3.5.2 Life expectancy in Tower Hamlets remains lower than the rest of the country but continues to improve. Since 2000, life expectancy has increased in males and 5% in females.

- Male life expectancy is 78.1.3 years compared to 79.6 years nationally,
- Female life expectancy is 82.5 years compared to 83.2 years nationally in 2012-14

3.5.3 There are a number of demographic and socioeconomic factors that affect current and future health and social care needs in Tower Hamlets. These are:

- Rapid population growth
- High socioeconomic deprivation: Tower Hamlets is the 10th most deprived borough in the country. 58 of the population reside in the 20% most deprived areas in England; 24% live in the 10% most deprived
- High population churn - 19% move in or out of the borough per year
- Changes to the welfare system – particularly impacts on income, employment and housing.

3.6 Tower Hamlets Strategic Plan 2018-2021

3.6.1 The Strategic Plan sets out the council's key priorities and activities, including how the Council will deliver the strategic priorities of the new Mayoral administration and work in collaboration with partners to progress ambitions for the Borough.

3.6.2 The Strategy sets out three key priorities for 2018-2021

- Priority 1: People are aspirational, independent and have equal access to opportunities
- Priority 2: A borough that our residents are proud of and love to live in
- Priority 3: A dynamic outcomes-based council using digital innovation and partnership working to respond to the changing needs of the borough.

[11] Latest JSNA documents can be found on the LBTH website https://www.towerhamlets.gov.uk/lgnl/health__social_care/joint_strategic_needs_assessme/joint_strategic_needs_assessme.aspx

3.6.3 The strategy outlines actions to address a range of drug and alcohol related issues, including tackling crime and anti-social behaviour associated with the illegal supply of drugs and the misuse of alcohol, and providing to treatment to individuals.

3.7 Tower Hamlets Together

3.7.1 Tower Hamlets Together (THT) is a partnership including the Council and local health and social care organizations. THTs vision is; to work together improve the health and wellbeing of people living in Tower Hamlets. One of the primary aims of the THT programme is to deliver services in a more coordinated to both reduce duplication and improve the overall experience and outcomes for our residents who need them.

THT Mission and Values

3.7.2 To improve the health and wellbeing of people who live in Tower Hamlets and to improve the quality of the care services we provide, ensuring that we spend the money we have available, wisely. Our services will be person-centred, co-ordinated and will make a real and positive difference to people's lives. The values supporting THT's mission are: collaboration, compassion, inclusivity and accountability.

THT Priorities

3.7.3 The borough's approach to the development of integrated care sits within the overarching strategic framework of the Tower Hamlets Health and Wellbeing Strategy.

3.7.4 The current priorities are:

- Communities Driving Change – changes led by and involving communities
- Creating a Healthier Place – changes to our physical environment
- Employment and Health - changes helping people with poor working conditions or who are unemployed
- Children's Weight and Nutrition - changes helping children to have a healthy weight, encouraging healthy eating and promoting physical activity
- Developing an Integrated System – changes which will join-up services so they are easier to understand and access.

3.7.5 In order to deliver against the above priorities THT is organised around three workstreams to reflect Tower Hamlets population groups:

- Children – Born Well and Growing Well
- Healthy adults – Living Well
- Complex adults –Promoting Independence

3.7.6 Further information on the programme can be found here: https://www.towerhamletstogether.com/files/Our_Vanguard_Story_Tower_Hamlets_Together_Brochure.pdf

3.8 Tower Hamlets Community Safety Partnership Plan 2017-21[12]

3.8.1 The Partnership is statutorily responsible for community safety in the borough and is one of the Community Plan Delivery Groups.

3.8.2 The Community Safety Partnership is responsible for:

- Delivering Community Safety Partnership strategic priorities and any relevant targets arising from these priorities on behalf of the CSP Executive;
- Fulfil statutory responsibilities held by the CSP Executive under the legislation; and
- Respond to other issues relating to community safety, which may arise, from government policies or other developments.

3.8.3 The Partnership agreed that the following priorities for the period 1st April 2017 – 31st March 2021 (4 years).

- Priority A: Anti-Social Behaviour (ASB) including Drugs and Alcohol
- Priority B: Violence
- Priority C: Hate Crime, Community Cohesion and Extremism
- Priority D: Reducing Re-offending

3.8.4 Under the responsibility of the DAAT Board there are four indicators being monitored and reported to CSP, these are:

- Young People starting treatment
- Number of Adults in treatment who live with children
- Number of Adults in drug and alcohol treatment
- Number of individuals causing drug / alcohol related crime or ASB required to engage in structured treatment programmes via criminal or civil orders

3.9 Local Employment Strategy

3.9.1 The Local Employment Strategy has been developed in the context of the broad agreement of national, regional and local government, as outlined in the Strategic Regeneration Framework. In the context of this Strategy, convergence for Tower Hamlets means that the employment rate should be equal to the London average by 2020.

3.9.2 The structure adopted within this Strategy is:

- Context – summarises the history, geography and demographics of Tower Hamlets, particularly as they relate to its economic situation and the employment rate,
- Supply – describes and analyses the composition of working and non-working groups in Tower Hamlets,

12 https://www.towerhamlets.gov.uk/lgnl/community_and_living/community_safety__crime_preve/community_safety_partnership/community_safety_partnership.aspx

- Demand – details the types of businesses present in the borough, the changes (growth or contraction) of their relative importance to the labour market, and the skills they require,
- Delivery and funding – outlines current and forthcoming employment services provision at all levels that apply to the borough's residents,
- Analysis – sets out the key factors that this strategy needs to address,
- Aim and objectives – explains what strategic and intermediary objectives are proposed to increase the employment rate in Tower Hamlets.

3.9.3 The document moves from setting out the data to an analysis and discussion of its significance. This enables conclusions to be drawn from which the strategic objectives are set. It is worth noting that this takes place within the overall story of the profound and accelerating changes that have taken place in Tower Hamlets. The context makes it clear that the challenges to increasing the employment rate to the London average are substantial. However, the last three to four years have been a period of marked improvement, including progress in increasing the employment rate. Given this progress, the aim and objectives of this strategy, whilst stretching, are attainable.

3.9.4 There are five strategic objectives in the current strategy, these are:

- Objective 1: Making the Mainstream Services Work Better for Local Residents,
- Objective 2: Engaging Workless Residents Detached from the Labour Market and Complementing the Work of the Mainstream,
- Objective 3: Encourage Increased Aspirations to Engage with the Labour Market, Particularly for Inactive Groups,
- Objective 4: Ensure Investment is Co-ordinated and Focused,
- Objective 5: Capture Employment Opportunities for Tower Hamlets Residents within the borough and Wider London Labour Market.

3.10 **DAAT Priorities 2018-19**

3.10.1 The DAAT is committed to delivering a comprehensive, recovery-orientated treatment system in Tower Hamlets, ensuring value for money, focus on harm reduction and preventative measures and improved recovery outcomes.

3.10.2 Identified priority and areas for development include:

- Improved engagement with women and improved offer for women
- Increasing the number and type of locations treatment interventions are delivered from, including outreach and in-reach interventions
- Improved support for clients with co-occurring mental health issues
- Increase the uptake of harm minimisation and treatment interventions for our LGBTQ community
- Increased uptake of recovery support interventions
- Improved links with housing services and providers
- Extended and flexible opening hours to meet client needs
- Continued and increased focus on whole-family interventions and support for affected others

- Increased identification of chronic disease such as COPD, liver disease with effective referral to primary or secondary care for treatment and management

4 Drug & Alcohol Outreach and Referral Service (Reset Outreach and Referral Service)

4.1 Introduction

4.1.1 This section sets out the expectations Tower Hamlets would want to place on the Provider(s). The specification seeks where possible to address local policy priorities and the priorities agreed by the DAAT Board.

4.1.2 This specification has been written in accordance with the principles and expectations outlined within the:

- National Drug Strategy 2017
- National Alcohol Strategy 2012 (updated strategy expected in early 2019)
- Drug misuse and dependence, UK guidelines on clinical management (2017) Public Health England Commissioning for Recovery (2010)
- The public health burden of alcohol: evidence review (2018)
- Drug misuse treatment in England: evidence review of outcomes (2017)
- Medications in Recovery: Re-orientating drug dependence treatment (2012)
- Other cited relevant guidance and local protocols

4.2 Purpose

Aims

4.2.1 The central aim of the Drugs and Alcohol Outreach and Referral Service is to develop a proactive and targeted outreach service to identify and engage in structured treatment individuals with problematic drug and alcohol use that are not in contact with harm minimisation and /or treatment services.

4.2.2 The service will be dynamic and innovative in its approach to outreach and engagement and will support individuals to access structured treatment interventions and register on the National Drug Treatment Monitoring System (NDTMS).

Objectives

4.2.3 Reset Outreach and Referral Service has a key role to play in the development of an effective treatment system; providing targeted advice to both professionals and service users, harm reduction information and supporting referrals and access into treatment services for hard to reach groups.

4.2.4 The Provider(s) will provide outreach to 'hard to reach' and 'hidden' populations identified in the Tower Hamlets Drugs and Alcohol Needs Assessment.

4.2.5 The Provider(s) will inform those individuals about the risks associated with drugs/alcohol, to support them in reducing or eliminating such risks, and/or to help them improve their physical and psychosocial circumstances through individual or collective engagement.

4.2.6 The Provider(s) will deliver a street outreach service for those individuals with chaotic drug and/or alcohol use who are not willing or able to access structured treatment interventions. This will involve shifts outside of office hours in accordance with local need.

4.2.7 The Provider(s) will deliver in-reach into other health and social care settings including LBTH's commissioned hostel estate.

4.2.8 The Provider(s) will ensure there is appropriate signposting to other support services where an individual identified with problematic drug and/or alcohol use does not engage with the service.

4.3 Scope

Service Users

4.3.1 The Outreach and Referral Service is a service for residents of Tower Hamlets who are aged 18 years and over who are concerned about their own or someone else's drug taking and drinking behaviour. This includes alcohol, legal and illegal drugs, novel psychoactive substances (known as "legal highs") and misuse of over the counter and prescribed medicine.

Priority Groups

4.3.2 The Provider(s) will target individuals that fall under priority groups for whom substance use is problematic but are not accessing harm minimisation and / or treatment services in Tower Hamlets.

4.3.3 The following should be considered as priority groups:

- Individuals with problematic opiate, non-opiate drugs and alcohol use
- Individuals from diverse BME and faith groups, particularly the Somali community
- Pregnant women
- Drug and alcohol using parents
- Intravenous drug users
- Individuals with co-morbid physical and/or mental health diagnosis where their drug or alcohol use exacerbates this diagnosis
- Individuals involved in prostitution
- Individuals who are homeless or in unstable accommodation
- Lesbian, gay, bi-sexual, transgender and questioning (LGBTQ) with a focus on Chemsex users
- Individuals recently discharged from prison
- Individuals required by court orders to engage with treatment
- Perpetrators and victims of domestic violence

Young Adults (18-24)

4.3.4 The Provider(s) will recognise that young adult service users aged 18-24 years are particularly vulnerable and therefore provision within a predominately adult service is not always ideal. Adult-based provision is more focused on harm reduction and treatment approaches in relation to substance misuse, which may not be appropriate for those young people whose substance use is linked to a range of needs across mental

health, education and employment, and who may have been in care or homeless at some point.

4.3.5 The Provider(s) will ensure both outreach and service based interventions are specific and tailored for this age group and liaise as necessary with the Local Authority Public Health commissioned services for young people.

Exclusion Criteria

4.3.6 The following exclusion criteria apply:

- Individuals who are not residents of Tower Hamlets
- All efforts are made by the Provider(s) to engage and retain service user within the service where appropriate, however from time to time it may be necessary to exclude a service user from the service because they have breached the rules or have failed to comply with the treatment programme
- Serious acute psychiatric morbidity e.g. Acute psychosis requiring acute psychiatric treatment
- Service users who behave in a violent or threatening manner towards other service users or staff.

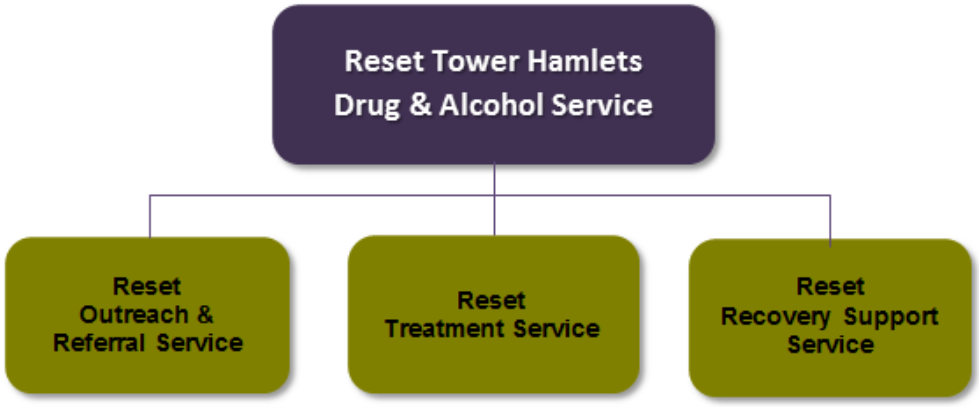
4.4 Communications and Marketing

The 'Brand'

4.4.1 The Provider(s) will operate under the Tower Hamlets drugs and alcohol system 'brand'.

4.4.2 The brand will be referred to as the Tower Hamlets Reset Drug and Alcohol Service. Each complementary component of this service being procured will be a subset of this overarching brand. This is set out in the chart below:

Chart 2: Reset Drugs and Alcohol Service Components 2019 - 2026



4.4.3 Compliant designed branding will be displayed on all correspondence provided by the DAAT. References within correspondence either to service users, the community and

other partners will not be made by name of service Provider(s) but by the name given to the component part of the treatment services set out above.

4.4.4 Reset Brand Guidance will be made available to the Provider(s) and will outline the specifications of the Brand, the Logo, typography, and design and communication requirements.

4.4.5 The Provider(s) must adhere to the DAAT Reset Brand Guidance (Appendix B), which informs Provider(s) of the appropriate way in which it operates its communication branding.

4.4.6 It is critical that this approach is adhered to and that all parties, even those who may be part of a consortium, reflect the design of this branding.

4.4.7 Where the Provider(s)'s own organisational logo(s) is displayed on any correspondence or publications (including but not limited to signage, leaflets and letterheads), the organisational logo(s) must not be more prominent than the agreed Reset logo.

Communications

4.4.8 The Provider(s) will ensure the services are well promoted throughout the borough, this should include:

- General public
- Service users
- Potential service users
- Key stakeholders and the wider DAAT partnership
- Key events including local and national campaigns

4.4.9 Information concerning the services on offer must be made available in a variety of forms and take account of the diverse needs of the residents of Tower Hamlets. This will include presentation of materials in different languages, to reflect local ethnic minority populations, as appropriate.

4.4.10 The Provider(s) shall make arrangements for all translation, telephone, one to one and British Sign Language interpretations. Signage for translation services should be clearly visible and accessible for service users.

4.4.11 The provider will support local and national drug and alcohol campaigns with a wide range of activities to raise awareness and encourage access to treatment. Currently, LBTH facilitates an annual programme of activities for Alcohol Awareness Week (November) and Recovery Month (September). The provider is required to support these as a minimum.

Engaging Stakeholders

4.4.12 In partnership with Reset Treatment and Reset Recovery Support Services, the service will provide specialist liaison, consultancy, training and support to generic services who may be working with people experiencing drugs and/or alcohol problems. In particular but not limited to: hospitals, adult social care, children's and family services, young peoples' services, hostels, sexual health services, mental health, housing, employment

and education services. The Provider(s) will support these services to screen all individuals for drug and alcohol use and develop pathways into treatment services.

4.4.13 The Provider(s) will work with local communities, networks and service groups to forge strong relationships to increase the support available to facilitate treatment and recovery and encourage local ownership of services.

4.4.14 The Provider(s) will support Reset Treatment and Reset Recovery Support services in promoting the Reset offer alongside contributing to a detailed partnership annual training plan and support with ad hoc events including open days.

5 Outreach and Referral Interventions

5.1 Outreach Interventions

5.1.1 The Provider(s) will adopt evidence based dynamic and innovative approaches to enable the design and delivery of an outreach service thereby maximising the opportunities for referrals into treatment.

5.1.2 This service will provide low intensity interventions via outreach and open access to:

- Engage individuals who are not currently accessing the drugs and alcohol treatment services
- Motivate people to enter structured treatment in accordance with identified needs

5.1.3 Engagement will need to take place in a wide range of general services which include, but are not limited to, women only services, BME and faith groups, general hospitals and health centres, young adults and older people's services, sexual health services, hostels and day centres.

5.1.4 The service will engage a wide range of individuals who require, and would benefit from, drug and alcohol treatment and harm reduction interventions, and who are not currently accessing treatment services and will be able to apply new and innovative methods and initiatives to maximise opportunities for identification and engagement of residents with substance misuse support needs.

5.1.5 Target groups include 'hard to reach' cohorts, users with complex and non-complex needs; non-opiate users, those aged 18 – 24, Chemsex users, homeless populations, women, those with co-occurring substance misuse and mental health (dual diagnosis), and other priority groups as identified in the Substance Misuse Needs Assessment.

5.1.6 The Provider(s) will need to work with a wide range of other services to prevent individuals from developing problems, or to help prevent those who are currently misusing drugs and/or alcohol from developing more complex problems.

5.1.7 The Provider(s) through one to one and group sessions will deliver low intensity interventions to meet identified needs including but not limited to:

- Advice and information – up to date accurate advice and information on drug and alcohol related harms, risk of drug and alcohol related deaths, blood borne viruses (BBV), how to reduce drug and/or alcohol use and available treatment options
- Motivational interviewing – a cognitive behavioural approach to help develop individual motivation
- Brief psychological interventions including identification and brief advice (IBA)
- Brief interventions for alcohol including use of Alcohol Disorder Use Identification Test (AUDIT-C and Full Audit) screening tool
- Distribute harm minimisation including naloxone distribution, health promotion, treatment and other information to those with whom contact is made

5.1.8 The Provider(s) will prepare service users to enter structured treatment and offer, where appropriate an escorting service to facilitate this.

5.1.9 Service users will be supported to access wider health and social care services. This will include GP registrations.

5.1.10 The Provider(s) will work in partnership with other local and centrally commissioned outreach teams, Drug Intervention Programme (DIP) , mental health teams, homelessness teams, police (safer neighbourhood teams) and other agencies to ensure that outreach is coordinated across the borough and targets particular areas identified as 'hotspots' where problematic drug and/or alcohol use may be perceived as anti-social.

5.1.11 The Provider(s) will ensure there are appropriate levels of in-reach into hostels and day centres as well as homelessness services. The Provider(s) will ensure that those at risk of homelessness or who are homeless and have drugs and/or alcohol issues have access to brief interventions and structured treatment where necessary. Focus should be given to those people who as a result of their drug and/or alcohol consumption may be at threat of eviction.

5.1.12 The Provider(s) will proactively seek to deliver outreach and in-reach into a range of settings where priority groups may be targeted and identified; for example universities, sexual health services, hospitals, community centres, mental health services.

5.1.13 The Provider(s) will be expected to deliver street based brief assessments and interventions that will include the distribution of harm reduction and health promotion materials (according to local needs), motivational engagement and information on local treatment options.

5.1.14 The Provider(s) will ensure that policies on risk assessment, escorting service users and lone working, if appropriate, govern the delivery of street outreach sessions.

5.2 Needle and Syringe Programme

5.2.1 The Provider(s) will ensure intra-venous drug users have access to sterile injecting equipment through the distribution of safe injecting equipment during outreach / in-reach and information to reduce the risks associated with injecting behaviour. This will include information on access to specialist services for service users who may require more specific harm reduction initiatives or access to treatment relating to BBVs or wound care. The Provider(s) will also ensure the Needle and Syringe Programme is appropriately advertised displaying information regarding drop in times and availability across the Tower Hamlets drugs and alcohol services and pharmacies.

5.2.2 The main aim of needle and syringe programmes is to reduce the transmission of BBVs and other infections caused by sharing injecting equipment, such as Human Immunodeficiency Virus (HIV), Hepatitis B and Hepatitis C. In turn, this will reduce the prevalence of BBVs and bacterial infections, so benefiting wider society[13].

[13] http://www.nice.org.uk/ph52

5.2.3 The provider is expected to offer a full range of equipment including needles and syringes in various sizes, filters, spoons antibacterial swabs, waste bins, ascorbic/citric acid and foil and readily made needle exchange packs.

5.2.4 The minimum expectation from the needle and syringe programme:

- The service offered will be user friendly and non-judgemental
- The service will aim to reduce the spread of BBVs associated with injecting drug use through the minimisation of sharing equipment between individuals and reducing the risks associated with the rates of other high risk injecting behaviours
- To offer advice and information relating to wound care, overdose prevention and basic life support
- To reduce the social and physical harms associated with injecting drug use including the promotion of safer injecting practices
- Identifiable and low dead space equipment to be provided
- Service must cater for and target all injecting drug users including those using image & performance enhancing drugs
- To increase and facilitate access to treatment services for clients not already engaged in structured treatment
- To reduce the potential for unsafe disposal of used injecting equipment and thus reducing the risks to public health
- To provide and reinforce a wide range of harm reduction messages including safe sex advice and advice relating to overdose prevention
- To offer advice relating to safe storage of all equipment
- Distribution of Naloxone kits to service users in accordance with Tower Hamlets Naloxone policy.

5.2.5 The provider will encourage safe return of used equipment to reduce the quantity of discarded needles across the borough.

5.2.6 All needle and syringe and associated equipment will be in line with NICE Guidance and will be provided via the DAAT contracted provider from an agreed list. The Provider(s) will be responsible for ordering appropriate levels of equipment. Costs will be met by the DAAT outside of the core budget of this contract.

5.2.7 The Provider(s) will arrange for safe disposal of used equipment and costs of disposal will be met within the contract value.

5.2.8 The Provider(s) will develop policies and procedures to ensure staff engaged in needle exchange services are appropriately protected against the risk of needle-stick injuries.

5.2.9 The Provider(s) will ensure that all staff engaged in needle exchange services receive the appropriate training required to enable them to deliver this role safely and appropriately.

5.2.10 The Provider(s) will keep detailed records of equipment issued and returned in a format agreed by Tower Hamlets DAAT and will return quarterly reports.

5.3 Naloxone

5.3.1 The Provider(s) will identify any current or previous Opiate using clients at risk of overdose, including clients who are homeless, prison release clients, and clients who have relapsed after a period of abstinence and ensure access to Naloxone

5.3.2 The Provider(s) will supply Opiate users and clients at risk of overdose with Naloxone injection kits (or Naloxone nasal spray when licenced without prescription) through outreach and in-reach and as part of the needle and syringe programme. Kits should be replaced when they are used or expired.

5.3.3 The cost of Naloxone will be met by LBTH but the Provider(s) will be responsible for ordering and managing stock and for the safe disposal of any expired stock.

5.3.4 The Provider(s) will maintain a record of clients supplied with Naloxone kits and submit quarterly records in a format agreed by the DAAT.

5.3.5 The Provider(s) will maintain a record of any naloxone kits supplied to partner agencies (e.g. hostels) for the use in case of an emergency and in-line with DAAT guidance, and submit quarterly records in a formal agreed by the DAAT.

5.3.6 The Provider(s) will ensure that staff engaged in supplying Naloxone receive the appropriate training, including overdose awareness.

5.3.7 The provider will report incidents of overdose and where Naloxone is administered by staff in the case of an emergency as part of quarterly monitoring reporting.

5.3.8 In cases of overdose where there is a suspicion of adulterated substances, the Provider(s) will submit a Local Drug Information System alert notice to the DAAT.

5.4 Blood Borne Viruses

Immunisation

5.4.1 All individuals who engage with Reset Outreach and Referral Service will be offered access to immunisation against Hepatitis A and Hepatitis B via Reset Treatment Service. The Provider(s) should have a comprehensive range of protocols to raise awareness of risks from BBVs which promote testing and immunisation against Hepatitis A and B as well as testing and treatment for Hepatitis B, C and HIV.

5.4.2 The Provider(s) will ensure there are pathways for service users to access the BBV interventions through Reset Treatment Service, ideally co-located with any regular in-reach sessions, particularly where needle exchange services are provided.

5.5 Sexual Health

5.5.1 The Provider(s) will establish pathways for service users where sexual health risks have been identified with the community sexual health and GUM clinics for testing and treatment.

5.6 **General Health**

5.6.1 The Provider(s) will be required to offer healthy living advice, particularly in relation to healthy eating and smoking cessation and will support and encourage attendance at mainstream health services e.g. GP surgeries, breast screening, cervical screening etc.

6 Key Policies

6.1 Whole Family Interventions

Hidden Harm

6.1.1 All professionals working with adults living with, or having access to children should understand their responsibilities explicitly in order to achieve positive outcomes, keep children safe, and complement the support that other professionals may be providing. The welfare of the child will be the first consideration for the Provider(s) when working with substance misusing parents/carers. It is important that where parents are receiving treatment and support, the needs of their children are fully considered, in order for their welfare to be safeguarded.

Safeguarding Children

6.1.2 The Provider(s) has a duty of care towards children as part of the Children Act 1989. Section 11 of the Children Act (2004) outlines a duty to cooperate amongst key personnel and bodies, to promote the welfare of children. The Provider(s) will ensure that standard operating procedures will require that the service actively seeks to identify service users with a parental responsibility and who are in frequent contact with children (under the age of 18), and to work with them to prevent any harm.

6.1.3 The Provider(s) will ensure that in providing the service it will utilise screening, risk assessment (and risk management) tools which effectively and comprehensively identify parental drugs and/or alcohol use and the potential impact(s) of such use on the child/children.

6.1.4 The Provider(s) must follow local protocols in all instances where there are concerns about a child's care/welfare or development to enable, and if necessary facilitate, accurate and appropriate assessment of the child's circumstances. The Provider(s) must comply with the requirements of the Safeguarding of Vulnerable Groups Act 2006 associated regulations and guidance provided by the Independent Safeguarding Authority (ISA). The Provider(s) has a responsibility to ensure that referrals are made to the ISA where necessary and are in accordance with ISA guidance and stipulations. The Provider(s) will also be expected to attend relevant safeguarding meetings where service users are being discussed.

Multi-agency Early Help Assessment

6.1.5 In accordance with hidden harm and the whole family approach, the assessment will identify those service users who are parents and/or who come into regular contact with children. For these service users, a specific child needs assessment will be completed capturing at a minimum the following information:

- The name of the main carer/s for children
- The age of children
- The name of health visitor if applicable
- Has an Early Help Assessment been completed? (children)
- Is there a child protection plan or has there been one open in the past?

6.1.6 Where children are identified, the Provider(s) will have mechanisms in place to be able to appropriately respond to the Early Help Assessment if applicable.

Safeguarding Vulnerable Adults

6.1.7 Adult safeguarding is important in preventing harm and exploitation of vulnerable adults who may be unable to safeguard themselves and to respond to it when it occurs. An adult at risk is defined as an adult "Aged 18 years or over; who may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation". (NHS England)[14] .

6.1.8 Harm and exploitation may consist of:

- Physical harm, including hitting, slapping, pushing, kicking, misuse of medication, restraint, or inappropriate sanctions
- Sexual harm, including rape and sexual assault or sexual acts to which the adult has not consented, or could not consent to or was pressured into consenting to
- Psychological harm, including threats of physical hurt or abandonment, deprivation of contact, humiliation, blaming, over-controlling, intimidation, coercion, harassment, verbal abuse, and isolation
- Financial or material exploitation, including theft, fraud, pressure in connection with wills, property or inheritance or financial transactions, or the misuse or misappropriation of property, possessions, benefits, or direct payments
- Neglect and acts of omission, including ignoring medical or physical care needs; failure to provide access to appropriate health, social care or educational services; the withholding of the necessities of life, such as medication, adequate nutrition and heating;
- Inappropriate discrimination, including racist, sexist, and that based on a person's disability, and any other forms of related harassment.

6.1.9 Harm and exploitation can occur anywhere, for example:

- At home
- In care homes
- In day centres
- At work
- At college
- In hospitals or health centres/surgeries
- Public places or in the community

[14] https://www.england.nhs.uk/wp-content/uploads/2017/02/adult-pocket-guide.pdf

6.1.10 The Provider(s) will ensure that their policies and procedures are linked with the Tower Hamlets Safeguarding Adults Multi-Agency Policy and Procedures: "Protecting adults at risk: London multi-agency policy and procedures to safeguard adults from abuse", produced by the Social Care Institute for Excellence with the Pan London Adult Safeguarding Editorial Board[15].

6.1.11 In emergency situations appropriate medical attention and contact with the police and any other relevant authority must be undertaken.

6.1.12 The Provider(s) will adhere to the Tower Hamlets Adult Safeguarding guidance and protocols (including the sharing of relevant information) in all cases where an issue of safeguarding or suspected safeguarding has been identified.

6.1.13 The Provider(s) will have a policy on abuse with robust procedures on how to deal with alleged or suspected cases of abuse, regarding both the person experiencing the abuse and the perpetrator.

6.1.14 The Provider(s) will include in their Policy on Abuse that any incidence of alleged or suspected abuse must be reported to the Safeguarding Adults Team and commissioners.

Safeguarding Lead

6.1.15 The Provider(s) will have an identified adult and children safeguarding lead that will possess the appropriate knowledge and skills to fulfil the role. They will be a senior manager within the organisation and they will be single point of contact for all relevant matters.

6.1.16 Safeguarding leads will be expected to attend relevant meetings as necessary.

6.2 Service Delivery

Hours of Operation

6.2.1 Tower Hamlets has a 24 hour drug and alcohol economy. The Provider(s) will ensure there is flexibility in the times of outreach to include early mornings, evenings and weekends. The hours of outreach will be agreed between the Provider(s) and commissioner and will depend on service user need.

6.2.2 The Provider(s) will operate an open access service for potential service users at core times during the working week; core times are usually between 10am and 6pm, Monday to Friday. These times are to be agreed between the Provider(s) and commissioner and will depend on service user need.

6.2.3 The Provider(s) should not rely entirely on face to face contact to provide information, advice and brief interventions to service users. The Provider(s) should use a number of channels that are not limited to fixed office basis and face to face contact, for example through on-line and telephone facilities.

[15] http://www.towerhamlets.gov.uk/lgnl/health_and_social_care/safeguarding_adults.aspx

Business Continuity and Emergency Planning

6.2.4 The Provider(s) must have comprehensive and adequately tested business continuity plans in place in order to ensure continuation of critical services in the event of severe weather, adverse event or major service disruption. These will be made available to the commissioner and updated on an annual basis. .

6.3 Incident Reporting

6.3.1 The Provider(s) shall have clear protocols in place for reporting, recording and reviewing complaints and incidents and identify where lessons can be learnt to protect service users and staff and improve practice.

6.3.2 The Provider(s) will ensure that staff are aware of both the complaints procedure and incident reporting protocol and the organisations processes for dealing with concerns that arise about individuals including disclosures, behavioural difficulties, unacceptable risk or threat to staff or service users.

6.3.3 Service users must have access to the Provider(s)'s complaints procedure and made aware of their right to complain or make a compliment about the service they received without recrimination.

Local Drug Information System

6.3.4 The DAAT has implemented an agreed local drug information system (LDIS) that uses consistent and efficient processes for sharing and assessing information; issuing warnings where needed can help ensure high-quality, effective information that rapidly reaches the right people.

6.3.5 The LDIS model is intended for dangerous, new and/ or novel, potent, adulterated or contaminated substances regardless of their legal status.

6.3.6 Information and alerts received through this channel will be disseminated as appropriate, following an expedited assessment by the LDIS Coordinator (DAAT) and the LDIS Panel: a multi-disciplinary panel with suitable levels of expertise in relevant disciplines (e.g. medical, policing, pharmacology, drugs specialist etc.).

6.3.7 The Provider(s) will identify an appropriate representative to act as an LDIS Panel member and assist in the LDIS alert grading and dissemination process as per agreed local protocols.

6.4 Drug and Alcohol Related Deaths

6.4.1 The Provider(s) must have systems in place for reporting Serious Untoward Incidents (SUI) and Drug and Alcohol Related Deaths internally and it will be an expectation that the DAAT is informed of such incidents at the earliest opportunity and within 2 working days (48 hours).

6.4.2 The DAAT's Drug and Alcohol Related Deaths Protocol requires all Provider(s) (where appropriate) to participate in the review of drug related deaths and embed any recommendations from the review in future practice and service delivery.

6.4.3 The Provider(s) will be expected to attend the quarterly Drug and Alcohol Related Death and Harm Reduction steering group and present anonymised cases for discussion amongst the partnership panel members.

6.5 Equalities

6.5.1 The Provider(s) will adopt a policy to comply with its statutory obligation under The Equality Act 2010 and will ensure that it does not treat one group of people less favourably than others because of their age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex or sexual orientation. The Provider(s) will need to demonstrate equality of access and outcomes across these protected characteristics within the Equality Act 2010.

6.5.2 Protected characteristics form part of assessment of need that will determine what, if any, additional support a person may need. The Provider(s) must assure the commissioner that they have the capability and robust mechanisms to routinely collect employee and service user level data regarding all the protected characteristics and to identify where extra needs arise due to protected characteristics.

6.5.3 The Provider(s) will analyse and understand where there is inequality of access and where there is inequality of outcomes across the protected characteristics. The Provider(s) will undertake an annual equality impact assessment which will be supplied to the commissioner to support Needs Assessment and Treatment Planning processes.

6.6 Information Governance

6.6.1 The Provider(s) will encourage all service users to sign the information sharing consent form at the earliest opportunity. The form gives options for the service user to decide who they wish to share their information with. This will include the whole Tower Hamlets drug and alcohol treatment system, the National Drug Treatment Monitoring System (NDMTS), external agencies and any future research projects. Where service users decline consent at the first meeting this must be approached again sensitively and the importance of giving consent outlined. Service users must also be made aware of their rights to access any data which is held about them.

6.6.2 It should be stressed that consent is being given to sharing information whether they actively engaged in treatment or not. Guidance from the Data Protection Act 2018 suggests that consent should be sought every 6 months to ensure its validity.

6.6.3 The Provider(s) must respect the wishes of service users if consent is given and when requested to, share information accordingly and in line with the Data Protection Act 2018 which includes the safe handling, storage and confidentiality of personal data.

6.6.4 The Provider(s) will comply with all of the data protection obligations contained within the contract.

6.6.5 Information sharing is needed to assure continuity of care and treatment. It is important to ensure consistency in terms of what, when and how information is shared. The provider is required to sign the Substance Misuse Information Sharing Agreement between LB Tower Hamlets and the main agencies in the treatment system. The Provider(s) will collect special category personal data and personal data through the assessment process and share as stated in the Substance Misuse ISA.

6.6.6 In addition, the provider is required to sign key LB Tower Hamlets information sharing agreements / protocols including:

- LB Tower Hamlets Community Safety ISA
- Domestic Violence MARAC
- Tower Hamlets Prostitution Panel (THPP)
- High Impact Problematic Drinkers Panel (HIPD)

6.6.7 The provider is required to comply with information requests in response of domestic homicides and MASH (Multi Agency Safeguarding Hub) enquiries.

6.6.8 Wherever possible, the informed consent of the service user will be obtained before information is shared. 'Informed' means that the individual understands what information may be shared and the reason why.

7 Systems and Processes

7.1 Assessment

DAAT Common Assessment Framework

7.1.1 All Reset partners will use the DAAT common assessment framework and single client management system (Nebula at time of writing) for drugs and/ or alcohol users. This will minimise the duplication of assessments a service user will undergo and facilitate efficient access into specialist treatment and recovery. A common assessment framework will further enable transparency, accountability and information sharing as the service user moves through the Tower Hamlets drug and alcohol treatment system.

7.1.2 The Provider(s) will make contact with individuals through outreach and where relevant the Provider(s) will complete the screening and/or initial assessment to facilitate access to structured treatment. A risk assessment will be completed for every new service user and where risks are identified, a risk management plan will be developed.

7.1.3 The Provider(s) will be innovative in the use of Information Technology (IT) based methods when undertaking assessments to ensure they make efficient use of the time the assessment process takes, for example completing an assessment electronically whilst talking to the service user significantly reduces the time the process takes.

Care Coordination

7.1.4 The Provider(s) will be responsible for the initial care coordination of individuals who they make contact with and subsequently engage in their service. The provider will be responsible for handing over the care coordination once a service user engages in structured treatment.

Case Management Systems

7.1.5 The Provider(s) will use an electronic case management system to manage their client cohort and store client data securely.

7.1.6 The Provider(s) will record all contacts made through outreach whether or not the individual engages with the service. At the very minimum the Provider(s) will record:

- Name and contact details
- Time and location of contact
- Age/date of birth or, where unknown, the perceived age
- Ethnicity
- Gender
- Substance dependency
- Housing status
- Known to treatment/previously engaged with treatment

7.1.7 Nebula, provided by Orion PM is the current single case management and information system that is used by Reset Recovery Support Service and Reset Treatment Service. Read only access will be available to the Outreach & Referral service. Nebula is an effective tool in facilitating information sharing between drugs and alcohol services and enables services to work more effectively across the treatment system.

7.1.8 It is critical in developing a comprehensive outreach service the reasons for individuals not wanting to engage are asked and recorded. Contact information is essential in planning the approach to outreach and critical in identifying the level of unmet need in Tower Hamlets. This information will create an evidence base to inform needs assessments and future planning.

For further information on Nebula please refer to Appendix C.

7.2 Referrals

7.2.1 The Provider(s) will promote Reset services with external local services and forge links with various agencies and services in Tower Hamlets to attract vulnerable and hard to reach groups into treatment.

7.2.2 The Provider(s) will act as the key point of contact for referrals from local organisations and services that are in contact with individuals known to have problematic drug and/or alcohol use but are not willing or able to access treatment. For example, GPs and other health care services.

7.2.3 The Provider(s) will be responsible for the onward referral of service users that are ready and willing to engage with Reset Treatment Service. Where appropriate the Provider(s) will ensure onward referrals are made to local health and social care services or any other services identified who will be able to support the service user. For example, the Recovery Support Service provides a number of non-structured interventions including a legal advice clinic, housing advice and ETE support. Direct referrals can be made where agreed and details must be recorded in accordance with the requirements outlined above.

7.3 Relationships and Partnerships

Collaborative Working

7.3.1 The Tower Hamlets drug and alcohol treatment system consists of a number of key commissioned services alongside Reset services. It is imperative that the Provider(s) adopts a collaborative approach and establishes strong links with the services outlined in the sections below.

Reset Treatment Service

7.3.2 The Provider(s) will establish strong links with Reset Treatment Service. In collaboration with Reset Treatment Service, the Provider(s) will develop clear pathways for individuals that are ready and willing to engage with structured treatment. This will require collaborative working to ensure targeted/hard to reach individuals are seamlessly transferred into structured drugs and alcohol treatment. The Provider(s) will host surgeries/satellite for Reset Treatment Service to facilitate access to treatment and harm minimisation advice and information as well as BBV testing and vaccinations.

Royal London Hospital

7.3.3 The Provider(s) will work with the Royal London Hospital teams to support patients to access community services upon discharge, escorting patients where necessary.

Drug Intervention Programme (DIP)

7.3.4 The DIP is a tier two service responsible for engaging into treatment individuals involved in anti-social behaviour or criminal activity linked to their substance misuse.

7.3.5 The Provider(s) will work closely with DIP and local authority anti-social behaviour teams to facilitate collaboration where beneficial and support the engagement and re-engagement of individuals referred through criminal justice system pathways.

Prostitution Support Service

7.3.6 The Prostitution Support Service operates a targeted street-outreach and case management of individuals involved in prostitution. The Provider will establish strong links with the service and in conjunction with the DIP to support individuals to access treatment and facilitate access to harm reduction interventions. Referrals will be made to the Tower Hamlets Prostitution Partnership (THPP) where individuals are considered to be at increased risk.

7.4 Whole System Relationship

7.4.1 The Provider(s) will be required to make referrals to appropriate local support services for those individuals that choose not to engage with treatment. This may include referrals to social services, homeless persons unit, Health E1 (homeless medical practice) etc. Relevant local services within Tower Hamlets include, but are not limited to:

- Local voluntary sector organisations that support, or provide a voice for customers and carers
- Drugs and Alcohol Liaison services at the Royal London Hospital
- NHS Primary and Secondary care services, including GPs
- Local Community Mental Health Teams
- Children's Social Care
- Adults Social Care
- Children's Centres
- Probation
- Drug Interventions Programme (DIP)
- Integrated Offender Management Programmes
- Hostels and Housing Providers
- Community pharmacies
- Tower Hamlets Domestic Violence Team
- Specialist maternity services
- Beyond the Streets
- Other health and social care providers and services as required.

7.5 Service User and Carer Engagement

Service Users, Carers and Significant Others

7.5.1 The Provider(s) will develop and deliver a service user engagement and involvement strategy, involving service users and their family and friends in the planning, developing and evaluation of services. This will require the Provider(s) to:

- Support and recruit service user and carer representatives within the service, these individuals will champion and support the work of the service and be proactive in working with their respective groups
- Support the involvement of service users and carers within the planning of services to enable them to contribute at all levels of service development
- Ensure service user representatives attend relevant service user and carer forums, including those hosted by Public Health England and meetings with service user representatives across Tower Hamlets drug and alcohol services
- Display within their premises an agreed service users' Charter of Rights and Responsibilities or equivalent

7.5.2 The Provider(s) will ensure there are mechanisms which allow anonymous feedback from service users and carers and significant others. The Provider(s) will have a process to demonstrate that service user feedback has been heard and changes have been made where possible and appropriate or if it has not been possible, that decisions are explained.

7.5.3 The Provider(s) will evidence that the nature of the services provided has been strongly informed by service users and will undertake an annual service user satisfaction survey. Findings from the survey will be fed back to the commissioner.

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

Peer Mentor/Volunteer Support

7.5.5 The Provider(s) will recruit, support and manage a cohort of peer mentors and volunteers to support service users and carers. Peer supporters will also offer friendly, informal but confidential support to carers of individuals with drugs and alcohol issues and will:

- Support service users to access treatment and other support interventions
- Accompany service users to meetings/appointments.

8 Workforce

8.1 Minimum Workforce Standards

8.1.1 Tower Hamlets is committed to developing a progressive and diverse workforce that is reflective of the local community. Locally employed staff will have an understanding of the diversity within Tower Hamlets to better respond to the needs of drug and/or alcohol users. The Provider(s) will ensure workforce opportunities take account of Tower Hamlets local employment priorities and positive local recruitment is promoted. In general, any service provider is required to undertake activities which see Tower Hamlets recognised nationally and locally as an inclusive employer that recruits, develops and supports staff from different backgrounds.

8.1.2 The Provider(s) will ensure that the workforce reflects the diverse populations it serves and structures are in place to attract and support those from diverse BME groups. The Provider(s) will also ensure that recruitment and retention policies demonstrate equality of opportunity and workforce data will be monitored quarterly to identify and address under-representation issues within the workforce.

8.1.3 The provider will ensure the workforce includes workers fluent in the common languages used amongst service users; this includes Bengali and Somali but other languages may be necessary.

8.1.4 All interventions will be provided by staff assessed by the provider as being appropriately trained, skilled and competent to provide them. Effective interventions require competent practitioners who must have basic occupational competencies; front line staff must have competence in motivational approaches and brief interventions16.

8.1.5 All job descriptions, person specifications and recruitment processes will be expressed in line with the Drug and Alcohol National Occupational Standards (DANOS) and other relevant national occupational standards. All drug and alcohol practitioner staff will be trained to at least Level 3 Diploma, NVQ Level 3 or equivalent, or will be in the process of working towards this.

8.1.6 In addition the Provider(s) will ensure there are suitably qualified specialisms within the workforce to adequately respond to service user recovery and support needs, for example housing and welfare benefits.

8.1.7 All drug and alcohol practitioners and volunteers will have appropriate clearance with the Disclosure and Barring Service (DBS) in line with current legislation.

8.1.8 The Provider(s) will continually work towards achieving a workforce which is fully competent and able to demonstrate that all managers and staff have a recognised competency assessed or professional qualification appropriate to their role and are pursuing relevant continuous development.

[16] https://tools.skillsforhealth.org.uk

8.2 **Workforce Development**

8.2.1 The Provider(s) will demonstrate that an appropriate level of funding is allocated to the regular training and development of staff at all grades, including managers. All staff will receive training in line with core DANOS competencies and in the following:

- Safeguarding children
- Safeguarding vulnerable adults
- Risk management
- Information governance
- Harm minimisation
- Health and safety
- Equality and diversity
- DAAT training programmes

8.2.2 It is expected the Provider(s) will achieve the above requirements within the first 6 months with staff using a broad range of evidence based approaches to meet the needs of the services users. The Provider(s) will undertake an annual Training Needs Analysis and produce an action plan to ensure:

- All workers and their line-managers have, or are working towards, evidence of their basic competence in the field,
- All workers and their line-managers have completed, or are undertaking, a training course regarding Safeguarding Children and Adults commensurate with role,
- All line managers have completed, or are undertaking, a training course in line-management,
- All workers and their line-managers have, or are working towards, evidence of basic IT literacy,
- Any new and emerging concerns/priorities specified by the DAAT are supported by learning and development programmes.

8.2.3 The Provider(s) will ensure there is a commitment to supporting current and ex-service users to become volunteers and will ensure volunteers receive training and supervision which is suited to their needs.

8.2.4 The Provider(s) will ensure they have a named workforce development lead.

9 Performance Management

9.1 Performance Outcomes

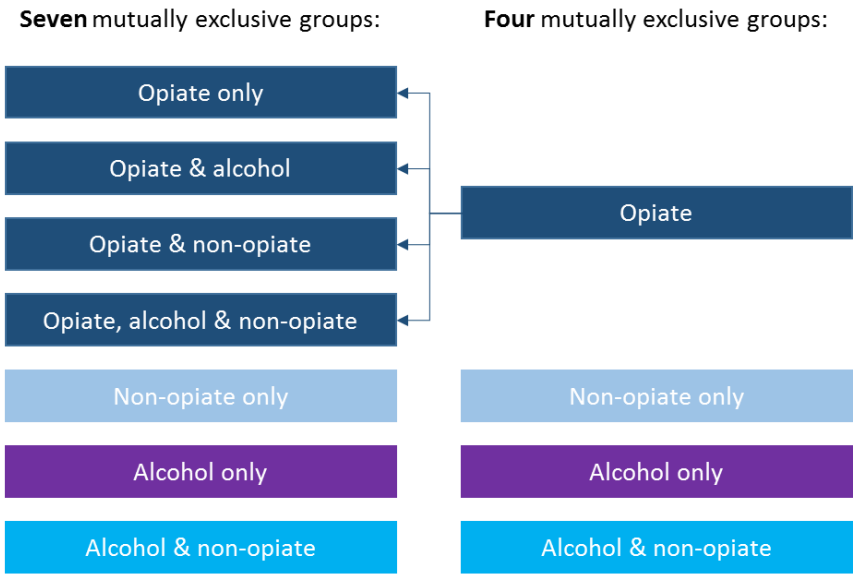
9.1.1 The interventions delivered through this service will be expected to significantly support people accessing structured treatment. The Provider(s) will be performance managed on the number of referrals to structured treatment and the level of engagement in structured treatment.

9.1.2 Whist the Provider(s) will not be responsible for entering and submitting service user information for the purposes of NDTMS, the Provider(s) will be required to have an understanding of the NDTMS reporting process as the Reset Provider(s) will be monitored against NDTMS outcomes reports.

9.2 National Drug Treatment Monitoring System

9.2.1 A change in the reporting methodology was introduced for 2014-15 that aligns the way treatment journeys are reported and also the way that service users are categorised by their problem substances. As of April 2014 the treatment journeys for service users in drug and alcohol treatment will be combined and reported as one pathway, with the outcomes and profile information for the services users being reported only once. The final outcomes, successful completions and re-presentations, will be reported at the end of the combined journey. From April 2014 substance misuse reporting will either consist of the seven or four substance groups as set out below, this supersedes the previous opiate, non-opiate and alcohol groupings.

Chart 3: New Categorisations of Substance Groups, NDTMS April 2014



9.3 Local Outcome Comparators

9.3.1 A new reporting method was devised in 2014/15 to improve comparisons between local performance and that of other areas. This method supersedes the previous opiate and non-opiate clusters. In the new method, each local area will be compared to the 32 areas (called Local Outcome Comparators) that are most similar to them in terms of the complexity and treatment outcomes. There will be different groups of local outcome

comparators for opiate, non-opiate and alcohol populations, in line with the new substance categories used in reporting for 2014/15. The same non-opiate comparators will be used for both the 'non-opiate only' and 'non-opiate and alcohol' substance groups.

9.3.2 The new method is similar to the 'nearest neighbour' method, however the term 'local outcome comparators' is used as the comparator areas are based specifically on the complexity of the populations in substance misuse treatment and not on broader similarity between the general populations of local authorities.

9.3.3 The local outcome comparators for Tower Hamlets will be used to benchmark successful completions and outcomes performance.

9.4 Key Performance Indicators

9.4.1 The Provider(s) will work within a performance management framework agreed by the commissioner. The performance management framework will monitor service user data through local data reports and NDTMS treatment activity reports. The key performance indicators set out below reflect the minimum levels of activity and can be subject to change.

9.4.2 These targets will be set at the start of the contract and subsequently reviewed and updated annually by the commissioner. Some activity will be monitored in the first six months to establish baseline data that will determine the desired level of outcomes. The targets may be subject to change throughout the contract and new indicators introduced as deemed necessary.

Quality Outcomes Indicators / Reporting Requirements

	Indicator	Period	By Substance	Target	Method of Measurement	PBR Linked?
	Outreach					
1	Hours of outreach per week (but does not include regular scheduled sessions / clinics)	Quarterly	All service users	>/=30 hours a week	Provider report / Local data	N
2a	Number of contacts (sign posting & harm reduction) A new contact is defined as no contact with the service in the previous 6 months or longer.	Quarterly	All clients	Minimum of 1,000 individuals a year	Provider report / Local data	N
2b			All Opiate	No target		
2c			Non-opiate only	No target		
2d			Alcohol only	No target		
2e			Non-opiate & Alcohol only	No target		
3	Provide quarterly report with breakdown of all individual contacts. Profile contacts using the following categories: Profile of users • Time • Location • Substance dependency • Housing status • Known to treatment/previously engaged with treatment • Age • Gender • Disability • Race	Quarterly	All service users	Provider report	Provider report / Local data	N

	• Religion and belief • Gender reassignment • Marriage and civil partnership • Sexual orientation • Pregnancy and maternity • Referral made (Y/N) • Engaged in treatment (Y/N)					
	Engagement					
4a	Referrals to Drugs and Alcohol Treatment Service (formally documented referrals)	Quarterly	All service users	Minimum of **200** referrals a year	Provider report / Local data	**Y**
4b	Referrals to Drugs and Alcohol Treatment Service – Specific need group identified by Substance Misuse Needs Assessment / DAAT (referrals formally documented)	Quarterly	All service users	Target to be specified in contract implementation period. Target group can change (annually) depending on identified need.	Provider report / Local data	**Y**
5a	Conversion to structured treatment (Confirmed engagement in structured treatment with treatment start date on NDTMS and confirmed case management system ID) – All clients	Quarterly	All service users	Minimum of **140** treatment starts a year	Provider report / Local data	**Y**
5b	Opiate clients			No target		N
5c	Non-Opiate only clients			No target		N
5d	Alcohol only clients			No target		N
5e	Non-Opiate & Alcohol only			No target		N
	Needle and Syringe Programme & Naloxone					

6	Needle and Syringe Programme Activity Report	Quarterly	All service users	Activity	Provider report / Local data	N
7	Naloxone distribution Activity Template	Quarterly	All service users	Activity	Provider report / Local data	N
	Workforce					
8	Workforce Diversity Data Report	Quarterly	Staff	Activity	Provider records	N
9	Annual Training Needs Analysis and Action Plan	Annual	Staff	Activity	Provider report	N
10	Provide complaints, incidents & compliments Report	Quarterly	All service users / Staff	Activity	Provider records	N
11	Annual Business Continuity report	Annual	All service users / Staff	Activity	Provider records	N
	Equalities					
12	Annual Equality Impact Assessment	Annual	All service users	Activity	Provider report	N
	Service Users					
13	Annual Service Users Survey including findings and action plan	Annual	All service users	Activity	Provider Report	N

9.5 Payment by Results

9.5.1 Tower Hamlets will adopt an incentivised Payment by Results model where 90% of full contract value will be awarded in equal quarterly payments in arrears of each quarter. The remaining 10% of the quarterly payment will be paid on achievement of quarterly outcome targets agreed between the provider and commissioner.

9.5.2 The overall 10% PBR payment is depending on performance in selected KPIs. A proportion of the overall PBR payment has been allocated to each Outcome target or Outcome target group as shown below in the PBR schedule.

PBR schedule

KPI / KPI group	Proportion of PBR payment allocated	When implemented
KPI 4a: Referrals to the Drugs and Alcohol Treatment service KPI 4b: Referrals to Drugs and Alcohol Treatment Service – Specific need group identified by Substance Misuse Needs Assessment / DAAT (formally documented referrals)	5%	Q1 2020/21
KPI 5: Conversion to structured treatment	5%	Q1 2020/21

9.5.3 PBR payment will be made for all achieved and met PBR targets / target groups. Failure to achieve quarterly PBR outcomes will result in the PBR payment for the quarter being removed and reallocated by the DAAT. PBR will be applicable from Q1 2020/21. Full details of the Payment by Results programme including appeals process will be provided at the point of contract agreement.

9.6 Contract Monitoring

9.6.1 The commissioner has a duty to monitor contract compliance and standard of the service provided to service users by the provider. This will be done by reviewing and monitoring the service as detailed in this specification through quarterly contract monitoring meetings between provider and commissioner.

9.6.2 As part of the monitoring arrangements the provider will be required to meet agreed performance indicators (as indicated above) based on evidencing progress on meeting the outcomes identified in the specification.

9.6.3 The commissioners will usually carry out monitoring visits quarterly throughout the contractual period. The monitoring visit will include policies, procedures, written plans and strategies within the service, staff files and service user files, complaints log, adverse incident reports, clinical audits, staff training records, and other relevant matters as specified by the commissioner. The monitoring visit may include informal talks with service users and/or staff. The commissioner retains the right to visit the Provider(s) as set out in the Contract terms and conditions.

Appendix A – Table of Abbreviations

AUDIT-C	Alcohol Disorder Use Identification Test – Consumption
BBV	Blood Borne Viruses
BME	Black and Minority Ethnic
CRC	Community Rehabilitation Companies
DAAT	Drug and Alcohol Action Team
DANOS	Drug and Alcohol National Occupational Standards
DBS	Disclosure and Barring Service
DIP	Drug Interventions Programme
DOMES	Diagnostic Outcomes Monitoring Executive Summary
ECAF	Electronic Common Assessment Framework
ECMS	Electronic Case Management System
ELFT	East London Foundation Trust
GP	General Practitioner
HIV	Human Immunodeficiency Virus
IBA	Identification and brief advice
ISA	Independent Safeguarding Authority
JSNA	Joint Strategic Needs Assessment
NDTMS	National Drug Treatment Monitoring System
OCU	Opiate and/or Crack User
PCT	Primary Care Trust
PHOF	Public Health Outcome Framework
SUI	Serious Untoward Incident
VfM	Value for Money
YTD	Year to date

Cabinet 8 September 2021	
Report of: Ann Sutcliffe, Corporate Director of Place	**Classification:** Unrestricted
Service Action Plan: Improving Air Quality in Tower Hamlets	

Lead Member	**Cllr Asma Islam, Cabinet Member for Environment**
Originating Officer(s)	Dan Jones, Divisional Director of Public Realm David Tolley, Head of EHTS
Wards affected	All wards
Key Decision?	Yes
Reason for Key Decision	Significant impact on wards
Forward Plan Notice Published	14 July 2021
Strategic Plan Priority / Outcome	A borough that our residents are proud of and love to live in

Executive Summary

This report submits the Service Action Plan response to the Environment scrutiny challenge session report and recommendations on "examining the Council's Air Quality Commitments and impacts on residents' health outcomes".

Recommendations:

The Cabinet is recommended to:

1. Consider the report of the Environment scrutiny challenge on "examining the Council's Air Quality Commitments and impacts on residents' health outcomes" and agree the service action plan in response to the report recommendations.

1 REASONS FOR THE DECISIONS

1.1 The Council's constitution requires the Executive to respond to the recommendations from the OSC.

1.2 The attached report is the Executive's response to the scrutiny recommendations arising from the Environment scrutiny challenge session's "examination the Council's Air Quality Commitments and impacts on

residents' health outcomes".

1.3 Improving air quality within the Borough remains one of the key priorities for the council.

1.4 As part of the 2020/21 Overview and Scrutiny Committees (OSC) work programme, the committee held an Environment Scrutiny Challenge Session on 30 March 2021, focussing on: "examining the Council's Air Quality Commitments and impacts on residents' health outcomes".

1.5 The committee noted that air pollution is one of the top concerns raised by residents in the Annual Residents Survey.

1.6 40 per cent of residents in Tower Hamlets live in areas that breach EU and government air pollution guidance.[1]

1.7 Tower Hamlets children living in some of our most polluted areas may have 5 to 10 per cent less lung capacity they may never get that back due to being exposed to high levels of air pollution.[2]

1.8 Tower Hamlets is London's third highest emitter of CO2.[3]

1.9 77 per cent of our residents are exposed to unsafe pollution levels; and long term exposure to air pollution reduces life expectancy mainly due to cardiovascular and respiratory illnesses; with studies also suggesting links with dementia, low birth weight and diabetes. Short-term exposure can also cause a range of effects including exacerbation of asthma, effects on lung function, and increases in respiratory and cardiovascular hospital admissions.[4]

1.10 The implementation of the service action plan will look to target and address the issues identified in the scrutiny challenge session.

2 ALTERNATIVE OPTIONS

2.1 To take no action. This is not recommended as the Environment scrutiny challenge session provides an evidence base to demonstrate that the council has drawn on and has applied best practice to the activities that have been undertaken to improve air quality in the Borough.

[1] London Atmospheric Emissions Inventory 2013 https://data.london.gov.uk/dataset/london atmosphericemissions-inventory-2013

[2] Research by Kings College London University investigated the link between traffic derived air pollutants and lung function in 8–9 year old children living in London's Low Emission Zone in east London.

[3] Climate Emergency Declaration: Tower Hamlets Net Zero Carbon Plan

[4] Tower Hamlets Transport Strategy

3 DETAILS OF THE REPORT

3.1 Air pollution has long been an issue for the borough with poor air quality formally recognised in Tower Hamlets in 2003, when the whole borough was declared an Air Quality Management Area due to not meeting national objectives. The 2017 Air Quality Action Plan demonstrates the borough still has poor air quality. It is one of the top concerns raised by residents in the Annual Residents Survey.

3.2 The scope of the scrutiny challenge session was:

- To examine air pollution issues in the borough, and the Council's progress towards it's air quality commitments including the Anti-idling Policy, Open Space Strategy, Air Quality Action Plan, Net Zero Carbon Plan (commitments relating to air quality), Transport Strategy, Parking Policy, and the Liveable Streets Programme).
- To assess if there are any outstanding issues that haven't been addressed.
- To assess the impact on health implications for residents such as asthma and other health conditions linked to air pollution.
- To assess the Council's long-term plans for air quality improvement, including funding/budget proposals.

3.3 Desired outcome for the challenge session was to establish the extent to which the Council has been effective in meeting its plans to improve air quality and corresponding health outcomes of residents in the borough.

3.4 Following the challenge session on 30 March 2021, the service has developed action plan based on the recommendation which came out of the session.

3.5 The committee heard evidence from external experts and officers from within Public Realm, Corporate Communications and Strategy and the Performance Team.

3.6 The challenge session report outlines out scope and methodology used for the session. The report also presents key findings from the evidence gathered from the challenge session.

3.7 The report acknowledged that along with preparing the Air Quality Action Plan, the council has developed policies and strategies aimed at improving air quality in the borough - these include the Anti-idling , Transport Strategy, Liveable Streets Programme, Open Space Strategy, Parking Policy, and Net Zero Carbon Plan.

3.8 The report makes a number of recommendations for the council and its partners to consider and put into action to improve the air quality in the Borough.

3.9 The recommendations are grouped under four key themes which can found in the full challenge session report attached at Appendix 2.

4 EQUALITIES IMPLICATIONS

4.1 The recommendations within the report and proposals in the service action plan will make positive impact on the environment of the Borough, which will be beneficial for all regardless of their background.

5 OTHER STATUTORY IMPLICATIONS

5.1 Tower Hamlets Air Quality Action Plan (2017-2022) sets out actions the council is taking to improve air quality in the borough. This is a statutory document, which is required to be reviewed and updated every 5 years. The action plan is published as part of our duty to London Local Air Quality Management. Delivery of the actions are monitored by the Air Quality and Net Zero Strategic officer group.

6 COMMENTS OF THE CHIEF FINANCE OFFICER

6.1 This report has sought the cabinet to consider the report of the Environment scrutiny challenge on “examining the Council’s Air Quality Commitments and impacts on residents’ health outcomes” and agree the service action plan in response to the report recommendations.

6.2 Improving air quality within the Borough remains one of the key priorities for the council and action plan is needed considering the fact that Tower Hamlets is London’s third highest emitter of CO2.

6.3 Any financial implications arising from the implementation of any actions from the Action Plan will need to be contained within approved budgets..

7 COMMENTS OF LEGAL SERVICES

7.1 The Council is required by section 9F of the Local Government Act 2000 to have an Overview and Scrutiny Committee and to have executive arrangements that ensure the committee has specified powers. Consistent with this obligation, Part B, Section 19 of the Council’s Constitution provides that the Overview and Scrutiny Committee may consider any matter affecting the area or its inhabitants. This includes making recommendations to the authority or executive following from scrutiny challenge sessions.

7.2 Section 82 of the Environment Act 1995 requires local authorities to review air quality in their area and assess whether air quality standards specified in the National Air Quality Standards are being achieved. As Tower Hamlets has been designated an air quality management area , Section 84 of the Act imposes a duty to develop an Action Plan seeking to achieve the relevant air quality standards in the air quality management area. The recommendations in the report sets out how the service action plan will address the issues identified in the scrutiny challenge session.

7.3 When considering its approach to improving air quality, the Council must have due regard to the need to eliminate unlawful conduct under the Equality Act 2010, the need to advance equality of opportunity and the need to foster good relations between persons who share a protected characteristic and those who do not. A proportionate level of equality analysis is required to discharge the duty and information relevant to this is contained in the One Tower Hamlets section of the report.

Linked Reports, Appendices and Background Documents

Appendices

- Appendix 1: Service Action Plan: Improving Air Quality in Tower Hamlets
- Appendix 2: Air Quality Challenge Session Report

Officer contact details for documents:
Dan Jones, Divisional Director, Public Realm
David Tolley, Head of Environmental Health and Trading Standards

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Action	Responsibility	Date
Recommendation 1:		
The council to set up more air quality monitoring stations in key areas including around construction sites, such as by prioritising funding of air quality monitoring in future capital programmes so that it is proactive in collecting long-term accurate live air quality data from all parts of the borough not just certain sites; and to make monitoring data more accessible so residents are better informed to make decisions and promote behavioural change.		
Set up an air quality monitoring station for the Council's Blackwall Depot due to Euro 6 Vehicle emission standards in the area. This to take the form of an additional NOx tubes to be included near the depot site.	EHTS	31/8/21
<u>Highway monitor</u> (i)Background checks on site suitability, planning requirement, agreement from relevant stakeholders and power arrangements.	EHTS	31/08/2021
(ii)Obtain quotations via RFQ process/award contract	EHTS	30/09/2021
(iii)Highway (A1203) new monitoring station installation and live data link to Tower Hamlets AQ monitoring webpage.	EHTS	31/03/2022
<u>Making monitoring data more accessible</u> (i)Making monitoring data available on plasma screens at Mulberry Place	EHTS	30/09/2021
(ii) Undertake a review of how monitoring data is displayed on webpage and make it more accessible to residents including air quality on LYN app	EHTS/Digital Team	30/09/2021
<u>Construction site monitoring</u> • EHTS review planning applications for major development and recommend condition for PM10 monitoring for all major developments. Construction sites to undertake monitoring and submit monthly monitoring report to Pollution Team • Sites may not become live for up to 3 years from gaining planning consent. First monitoring report may not be due until around 12-18 months time	EHTS EHTS	Started February 2021 and going forward First monitoring report expected 12-18 months

		from February 2021
Recommendation 2:		
The council to develop a partnership plan with TfL to take a more proactive approach to manage and reduce traffic on the TfL roads in the borough, as these to have been identified to be high drivers of road-based pollution in Tower Hamlets.		
Produce Transport Strategy Delivery Plan incorporating traffic reduction measures in consultation with TfL		01/2022
Support introduction of the ULEZ expansion		10/2021
Carry out feasibility study into borough Workplace Parking Levy		01/2022
Recommendation 3:		
The council to develop evaluation methods of the Air Quality Action Plan to ensure the initiative's goals and objectives are being achieved, as well as identify any components of the initiative that are not effective.		
Develop air quality needs assessment to inform the air quality action plan for 2022	Public Health	September 2021
Update of the AQAP for 2022 to include • clear deliverables/outputs and targets. • Quantification of impacts of proposed measures • Clear Milestones • Defined roles and responsibilities	EHTS/Stakeholders	31/03/2022 And quarterly steering group meetings to develop/agree action measures
Subject to securing funding, commission a research study to quantify expected NO2 and PM10 emission/concentration reductions of the proposed measures	EHTS	31/03/2022
Ongoing assessment and reporting of progress annually to GLA – Annual Status Report (ASR).	EHTS	31/05/2022

Recommendation 4:		
The council to include air quality priorities into the remit of the Climate Emergency Partnership Board to ensure that it is included as an important part of partnership discussion.		
Establish the Climate Emergency taskforce to develop a partnership climate emergency action plan on behalf of the Partnership Executive Group (PEG)	SP Place, Sustainability	By 31 July 2021
Complete the taskforce's activities and input into a partnership climate emergency action plan	SP Place, Sustainability	By 30 Sep 2021
A draft partnership climate emergency action plan informed by the taskforce signed off by PEG	SP Place, Sustainability	By 30 Nov 2021
Recommendation 5:		
The council to identify existing air quality measures in the current capital programme and prioritise them for delivery, such as EV charging points.		
Develop and Adopt EV Delivery Plan by September 2021	Highways and Transport	September 2021
Install EV charging points at locations where the Council's fleet is parked including Commercial Road, Victoria Park and Blackwall Depot.	Operational Services	March/April 2022
Recommendation 6:		
The council to develop plan to install green walls and green spaces in schools that currently have none, to purify the air our children breathe and protect them from the surrounding air pollution.		
Secure s106 funding to undertake air quality audits at 3 primary schools • Cannon Barnet • Kobi Nazrul	EHTS	6/4/2021

• English Martyrs		
Shortlist 3 or 4 schools in areas above UK legal limit for NO2 (≥40µg/m³) (in the west of the borough) for audits & living walls	EHTS	6/4/2021
Undertake audits at each school	EHTS	July-September 2021
Write up audit findings and produce report	EHTS	September 2021
Procure services of landscape contractor via procurement portal to install green walls, 1 school per quarter	EHTS	July-Sept 2021- Canon Barnet Oct-Dec 2021- Kobi Nazrul
Recommendation 7:		
The council to develop plan to convert unused open spaces in the borough to green spaces to make these spaces greener and thus further reduce residents' exposure to air pollutants.		
Focus tree planting near to play areas, schools and commuter/school runs	Clean and Green	On Going
Focus on planting large canopy trees species, in location where they can reach their intended proportions without regular, cyclical pruning.	Clean and Green	On Going
Focus on planting 'green walls', to create barriers between vehicles and people.	Clean and Green	On Going
Recommendation 8:		
The council to promptly display anti-idling signs all over Tower Hamlets to discourage idling which will ultimately reduce emissions and help drivers save fuel.		
Identify schools (nursery/primary) exceeding UK legal limit for NO2 (≥40µg/m³)	EHTS	17/08/2020
Install 1 or more signs per quarter at schools exceeding legal limit for NO2 subject to	EHTS	01/06/2021 and

consent from schools- Q1 Malmesbury, Q2 Hermitage, Q3 Old Montague and Q4 Thomas Buxton		then ongoing per quarter
Install signs monthly at idling hotspot locations around the borough	EHTS	17/01/2019 ongoing
Recommendation 9:		
The council to investigate a new approach for stricter enforcement of anti-idling FPNs to better tackle idling and make this strategy more fit for purpose.		
Publicity/engagement of idling issues around the borough	EHTS/Comms	31/07/2021
Continue with weekly visits to idling hotspots locations and issue FPNs to non-compliant drivers	EHTS/Parking	31/03/2022
2018 Anti idling cabinet report recommended delegated authority to be given to CEOs and THEOs but these were never taken up. Parking Service and Community Safety Service should investigate taking on these powers. This will increase the number of resource available to enforce the FPN legislation.	Parking/Community Safety Service	31/12/2021 subject to agreement by relevant services
Parking Service to investigate creating a Traffic Management Order under the Road Traffic Regulations Act 1984 so that CEOs can issue a PCN	Parking Service	31/12/2021 subject to agreement by relevant services

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Environment and Community Safety Scrutiny

Challenge Session

Examining the Council's Air Quality Commitments and impacts on residents' health outcomes

16/04/2021

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Chair's Foreword

Air quality is vital to the health of Tower Hamlets' residents and the communities. Air pollution has been linked to short term health effects such as exacerbation of asthma, cough, wheezing and shortness of breath, as well as long term health effects such as lung cancer, respiratory conditions, stroke, and cardiovascular diseases. Ultimately these lead to increased respiratory and cardiovascular hospital admissions and mortality, and reduced life expectancy of our residents.

The Coroner's ruling about pollution being a factor in the tragic death of young Ella Kissi-Debrah of Lewisham in December 2020 surely must not be forgotten.

Air pollution has long been an issue for the borough with poor air quality formally recognised in Tower Hamlets in 2003, when the whole borough was declared an Air Quality Management Area due to not meeting national objectives. The 2017 Air Quality Action Plan demonstrates the borough still has poor air quality.

My role, as Scrutiny Lead for Environment and Community Safety, is to shine a light onto issues, query and examine, and make recommendations that will add value to the council's work. I am pleased to present this report that summarises the findings of the challenge session examining the council's air quality commitments and impacts on residents' health outcomes. The report makes several recommendations for the council to consider undertaking.

I'd like to thank following people who contributed to this challenge session:

- Councillor Asma Islam, Cabinet Member for Environment and Public Realm, and team of council officers who provided an overview of the council's commitments and approach to air quality in the borough and responded to scrutiny questions
- Natalie Curd from Idling Action London who provided a regional perspective on the performance of the borough
- James Wheale from Sustrans Tower Hamlets who provided an account of the voluntary sector perspective, particularly on clean routes to schools, the need for more engagement with residents via the voluntary sector's networks, and the need for more behaviour change programmes to encourage substantial, long-term changes to our air quality
- My scrutiny colleagues who supported the discussion and helped to form some of the recommendations being put forward

Councillor Faroque Ahmed

Scrutiny Lead for Environment and Community Safety

Summary of Recommendations

Causes of air pollution and correlating health impacts

Recommendation 1	The council to set up more air quality monitoring stations in key areas including around construction sites, such as by prioritising funding of air quality monitoring in future capital programmes so that it is proactive in collecting long-term accurate live air quality data from all parts of the borough not just certain sites; and to make monitoring data more accessible so residents are better informed to make decisions and promote behavioural change.
Recommendation 2	The council to develop a partnership plan with TfL to take a more proactive approach to manage and reduce TfL traffic on the TfL roads in the borough, as these to have been identified to be high drivers of road-based pollution in Tower Hamlets.

Council's commitments to improving air quality and their effectiveness

Recommendation 3	The council to develop evaluation methods of the Air Quality Action Plan to ensure the initiative's goals and objectives are being achieved, as well as identify any components of the initiative that are not effective.
Recommendation 4	The council to include air quality priorities into the remit of the Climate Emergency Partnership Board to ensure that it is included as an important part of partnership discussion.
Recommendation 5	The council to identify existing air quality measures in the current capital programme and prioritise them for delivery, such as EV charging points.

Targeted responses: open spaces/green spaces

Recommendation 6	The council to develop plan to install green walls and green spaces in schools that currently have none, to purify the air our children breathe and protect them from the surrounding air pollution.
Recommendation 7	The council to develop plan to covert unused open spaces in the borough to green spaces to make these spaces greener and thus further reduce residents' exposure to air pollutants.

Targeted responses: road-based emissions

Recommendation 8	The council to promptly display anti-idling signs all over Tower Hamlets to discourage idling which will ultimately reduce emissions and also help drivers save fuel.
Recommendation 9	The council to investigate a new approach for stricter enforcement of anti-idling FPNs to better tackle idling and make this strategy more fit for purpose.

Introduction

1.1 Air quality is an important public health issue – in London, 9,400 premature deaths are attributed to poor air quality and a cost of between £1.4 and £3.7 billion a year to the health service[1].

1.2 Air pollution contributes to shortening the life expectancy of Tower Hamlets residents, disproportionately impacting on the most vulnerable in our society, such as the poor, the old, the very young, and those with respiratory illnesses. Exposure to air pollution has also been linked to lung cancer, asthma, other respiratory conditions, Alzheimer's, stroke, cardiovascular diseases, and a number of other illnesses. Unsurprisingly, air pollution ranks as one of the top personal concerns of residents in the council's Annual Residents Survey[2].

1.3 Seventy-seven per cent of Tower Hamlets residents live in areas that breach EU and Government air pollution guidance[3], as a result, the lung development of children in Tower Hamlets is affected, causing them to have up to five per cent less lung capacity than the national average[4]. This capacity never grows back once it is lost.

1.4 The Environment Act 1995 required a national air quality strategy to be produced, and set national air quality standards and objectives for the first time. It also placed a statutory duty on local authorities to carry out a review and assessment of current levels of local air pollution, and to predict whether the national objectives would be met. Where non-compliance is likely, the local authority must declare an Air Quality Management Area, and produce an Action Plan detailing how it proposes to work towards meeting the objectives.

1.5 Tower Hamlets council completed its first review and assessment in January 2000 and determined that national air quality objectives would not be met. As a result, the entire borough was declared an Air Quality Management Area in 2003, and the council was under statutory obligation to produce an Air Quality Action Plan. This is still the case today, with the last Air Quality Action Plan prepared in 2017[5].

1.6 Along with preparing the Air Quality Action Plan, the council has developed policies and strategies aimed at improving air quality in the borough - these include the Anti-idling Policy, Transport Strategy, Liveable Streets Programme, Open Space Strategy, Parking Policy, and Net Zero Carbon Plan.

[1] https://www.londoncouncils.gov.uk/node/33224#:~:text=In%20London%20alone%2C%20air%20pollution,of%20pollutants%20into%20acid%20rain.

[2] https://www.towerhamlets.gov.uk/Documents/Borough_statistics/2019_ARS_Briefing_Paper.pdf

[3] https://data.london.gov.uk/dataset/london-atmospheric-emissions-inventory--laei--2016

[4] Research conducted through a major study (the EXHALE - Exploration of Health and Lungs in the Environment - project by King's College London) found that the lung capacity of 8 and 9-year-old children in Tower Hamlets is 5% lower than the national average

[5] https://www.towerhamlets.gov.uk/Documents/Planning-and-building-control/Strategic-Planning/Local-Plan/Submission_2018/Air_Quality_Action_Plan_2017.pdf

Methodology

2.1 The reasons for the scrutiny challenge session included:

- To examine air pollution issues in the borough, and the Council's progress towards its air quality commitments including the Anti-idling Policy, Open Space Strategy, Air Quality Action Plan, Net Zero Carbon Plan (commitments relating to air quality), Transport Strategy, Parking Policy, and the Liveable Streets Programme)
- To assess if there are any outstanding issues that haven't been addressed
- To assess the impact on health implications for residents such as asthma and other health conditions linked to air pollution
- To assess the Council's long-term plans for air quality improvement, including funding/budget proposals

2.2 A more detailed scope for the challenge session can be found at Appendix 1.

2.3 In light of the ongoing COVID-19 pandemic, the challenge session was held virtually via Microsoft Teams in order to comply with the government's requirements for social distancing.

2.4 The session, chaired by Councillor Faroque Ahmed, Scrutiny Lead for Environment and Community Safety, took place on Tuesday 30 March 2021 from 6pm to 8pm. The session followed a structure that included:

- Chair's overview, including focus of the session and intended outcome
- Presentation from the service led by the Cabinet Member for Environment and Public Realm, and supported by the Divisional Director of Public Realm
- Presentation from Public Health led by the Associate Director of Public Health
- Committee discussion and lines of enquiry
- Voluntary Sector user feedback, and input from Idling Action London Campaign
- Scrutiny Committee discussion and recommendations
- Chair's closing comments and next steps

2.5 Members in attendance:

- Councillor Faroque Ahmed - Scrutiny Lead for Environment and Community Safety (Session Chair)
- Councillor James King - Overview and Scrutiny Committee Chair
- Councillor Bex White - Scrutiny Lead and Chair for Children and Education Sub-Committee
- Councillor Gabriela Salva-Macallan - Scrutiny Lead and Chair for Health and Adults Scrutiny Sub-Committee
- Councillor Leema Qureshi - Scrutiny Lead for Finance and Resources
- Councillor Ehtasham Haque - Scrutiny Lead and Chair for Housing and Regeneration Scrutiny Sub-Committee
- Councillor Andrew Wood - OSC Member
- Councillor Denise Jones - OSC Member
- Halima Islam - OSC Member (co-optee)
- James Wilson - OSC Member (co-optee)
- Councillor Shad Chowdhury - non-executive councillor
- Councillor Victoria Obaze - non-executive councillor
- Councillor Val Whitehead - non-executive councillor

Evidence received from officers, experts, and users:

- Councillor Asma Islam - Cabinet Member for Environment and Public Realm
- Dan Jones - Divisional Director Public Realm, LBTH
- Katy Scammell - Associate Director Public Health, LBTH
- Natalie Curd - Idling Action London Project Lead
- James Wheale - Sustrans Tower Hamlets Project Officer (Voluntary Sector)
- David Tolley - Head of Environmental Health and Trading Standards, LBTH
- Muhammad Islam - Pollution Team Leader, LBTH
- Jack Ettinger - Strategic Transport Team, LBTH

The challenge session was supported by LBTH officers:

- Onyekachi Ajisafe - Strategy and Policy Officer, Corporate
- Adam Boey - Senior Strategy and Policy Manager, Corporate

Findings and Recommendations

Causes of air pollution and correlating health impacts

3.1. The primary pollutants of concern for Tower Hamlets are particulate matter (PM_{10} and $PM_{2.5}$) and nitrogen dioxide (NO_2). Scrutiny members in the challenge session heard that Tower Hamlets continues to show high levels of NO_2 (Blackwell exceeded National Air Quality Objective standards and WHO guideline values) and particulate matter ($PM_{2.5}$ exceeded WHO guideline values at all sites).

3.2. Pollution mapping across the borough showed consistently high levels of these pollutants along arterial roads (A11, A12, A13, and the Highway and Cambridge Heath Road/Mare Street)

3.3. Scrutiny members heard that the main causes of elevated air pollution is road transport.

3.4. However, our detailed information on pollution levels across the borough is limited and patchy. Upon reviewing the air monitoring stations set up in the borough, Members raised queries as to the insufficient amount of air monitoring stations in the borough - there is a big gap in the west of the borough where we seem to have the worst air quality, yet there are no live monitoring stations set up there.

3.5. The service confirmed that there were only a few monitoring stations in the borough and they have plans to only set up one more next year on the Highway. Council officers agreed that more monitoring stations are needed to get a more accurate picture of air pollution levels in the borough.

3.6. Scrutiny members were told that air pollution has been on a downward trend with the exception of $PM_{2.5}$. However, Scrutiny members raised issues with the air quality data presented by the council being outdated. Without accurate up-to date data, we cannot understand the full picture – where there are impacts, and their severity. This limits our informed and targeted response, with decisions not made on full information.

3.7. Having looked at the website and downloaded the air quality data, Scrutiny members highlighted that the council needs to share data collected from its air quality monitoring stations in even more accessible ways than that on its website, so there is more clarity as to what the latest information means to the public, and increase awareness and understanding about the situation in Tower Hamlets. Council officers conceded that other information could be used besides the GLA data that are updated every five years, and further thought needs to be put into how they are sharing and presenting the data, which they plan to look into.

Recommendation 1
The council to set up more air quality monitoring stations in key areas including around construction sites, such as by prioritising funding of air quality monitoring in future capital programmes so that it is proactive in collecting long-term accurate live air quality data from all parts of the borough not just certain sites; and to make monitoring data more accessible so residents are better informed to make decisions and promote behavioural change.

3.8. Council officers highlighted that that the poor air quality from NO_2 results from road traffic and roads over which the Council has no direct control. Lobbying with TfL continues - to work with

them to switch people away from driving and onto other transport methods such as train, walking and cycling. The Ultra-Low Emission Zone (ULEZ) expanding to Tower Hamlets on 31 October 2021 is forecast to help reduce this.

3.9. Scrutiny members enquired as to what standing communications the council has with TfL to engage with them on mitigating/monitoring the road-based pollution, as TfL roads such as for example the A13 seem to be main drivers of road-based pollution. Council officers commented that further information on this will be followed up on after the meeting.

3.10. Scrutiny members raised questions regarding what to expect as a result of the ULEZ extending to Tower Hamlets, as well as what would happen to residents with old cars not compliant with ULEZ. Council officers commented that there is a forecast reduction of a third of pollution based on TfL's modelling of the impact of ULEZ, they further added that if residents with vehicles that don't meet ULEZ requirements drive into the ULEZ zones they will have to pay a daily charge as is presently the case with the Central London ULEZ.

Recommendation 2
The council to develop a partnership plan with TfL to take a more proactive approach to manage and reduce TfL traffic on the TfL roads in the borough, as these to have been identified to be high drivers of road-based pollution in Tower Hamlets.

3.11. Scrutiny members heard from Public health about health implications of air pollution:

- short-term effects – exacerbation of asthma, coughing, wheezing and breathing difficulties; and
- long-term effects – stroke; lung cancer; respiratory conditions, cardiovascular disease.

3.12. Members were also told that no-one is safe but there are certain groups more at risk such as pregnant women (and their unborn children), children, adults with existing conditions, the elderly.

3.13. Public Health also revealed that health outcomes haven't changed (improved or declined) over the last five years, but such results are difficult to interpret regarding effectiveness of improvement efforts. We do not have enough detailed data to understand the complications. However, the Air Quality Action Plan needs to continue and we need to be ambitious about our efforts in order to improve. There are gaps: we should use community champions to enhance community mobilisation on air quality issues; we need to encourage and promote behaviour change.

Council's commitments to improving air quality and their effectiveness

3.14. Scrutiny members heard that the council has its Air Quality Action Plan (AQAP) that it has to produce as a statutory requirement, it's a is five-year plan which they report progress on an annual basis to the GLA. The council is due to review the AQAP in 2022, so work is currently underway to assess how successful it's been with actions and determine what actions may need to be included in the next iteration of the AQAP. There is a working group set up within the council that comprises of officers across the council's services including Public Health, to meet the actions of the AQAP.

3.15. Scrutiny members felt that in terms of monitoring the AQAP projects, evaluation methods need to be put in place to ensure the objectives of the Plan are being successfully achieved.

3.16. Members also raised that the Council is in the final year of its current AQAP, and of the 76 actions within the Plan, there are 22 without updates. And of the actions in the Plan that do have updates there are some with concerning issues regarding progress on the actions.

> **Recommendation 3**
> The council to develop evaluation methods of the Air Quality Action Plan to ensure the initiative's goals and objectives are being achieved, as well as identify any components of the initiative that are not effective.

3.17. The Scrutiny Members were concerned that the Air Quality Board was subsumed into the Health and Wellbeing Board (HWB). When Members queried the Public Health Team (who sit on the HWB) as to how often Air Quality is brought up in the HWB's agenda, it was identified that in the two years the Associate Director of Public Health had been in the council air quality had not yet been discussed in the HWB. In the first year, it hadn't been put on the agenda as the board has a massive agenda and only meets quarterly, and in the second year the focus had been on COVID-19.

3.18. Scrutiny members followed up with enquiring if there were any future plans to provide a separate partnership board where people will practice strategies to improve air quality, and they can come together with the council. Scrutiny members understands that officers within the council meet on air quality, which is good, but the intention is about extending that partnership opportunity. Council officers commented that they are looking into setting up a Climate Emergency Partnership Board and it may be that air quality can be discussed as a section of this Board, which is something they are willing to look into seeing as CO_2 emissions which is within the climate emergency remit, does have an impact on air quality as well.

3.19. Members queried that air quality certainly needs a board that it can be brought to for partnership work. Scrutiny members were of the opinion that it was a mistake for the Air Quality Board to have been subsumed into the HWB, especially as evidence heard in the meeting indicates that a lot of the air quality actions live within the Place Directorate.

3.20. Scrutiny members heard from the Idling Action London Campaign that one of the things that most councils will have to reflect on is the case of the Ella Kissi-Debrah inquest, and the findings that are coming out of that. One of these findings is on local authorities' partnership working together with other local authorities, the polluters, and other organisations. So, the Idling Action Project really encourages that partnership working.

3.21. Scrutiny members also heard from Sustrans that the council further working with voluntary organisations like themselves would be encouraged, especially in relation to behaviour change. Since they have a local understanding of the different cultural and social values, and therefore the barriers to change. Partnership working with organisations such as themselves during the design and engagement stages of air quality programmes, such as for example the Liveable Streets Programme would utilise their expertise and networks with schools and communities and would ensure that councils provide meaningful engagement in the planning and consultation stages of such big developments. As this is really when behaviour change programmes start to work, when collaborative design helps the planning, as well as the implementation and accessibility of the infrastructure to ensure we achieve the changes we need to make.

Recommendation 4
The council to include air quality priorities into the remit of the Climate Emergency Partnership Board to ensure that it is included as an important part of partnership discussion.

3.22. Scrutiny members heard that as part of the council's ambition to move towards the World Health Organisation recommended level for $PM_{2.5}$, which is 10 micrograms particles per cubic metre by 2030, more work needs to be done to reduce the amount of pollution that's caused from road traffic. The borough's current $PM_{2.5}$ level is currently higher than the UK average, so they hope to move people away from the usage of cars with combustion engines towards electronic vehicles (EV) as it would be interesting to monitor the effect that will have on the borough's PM levels.

3.23. Scrutiny members were concerned that funding has been available for electronic vehicle (EV) charging points, but there has still been a lag in delivery which is difficult to explain to residents. The Cabinet Member commented that the Council plans to install 300 EV charging points by 2022, however, of this target, they currently have installed about 159 EV charging points.

Recommendation 5
The council to identify existing air quality measures in the current capital programme and prioritise them for delivery, such as EV charging points.

3.24. Scrutiny members questioned what the Mayor of London's £200,000 Air Quality Fund had been spent on. Committee Members were also concerned about long-term data measuring of air quality, especially around schools. They highlighted that £5 million funding has been announced to local authorities to deliver projects to improve air quality and queried if this funding can be used to update and increase the capturing of this air quality long-term data.

3.25. The council officers commentated that in terms of monitoring of the Liveable Streets Programme and other similar schemes, the council are doing traffic counts that will help indicate whether traffic has moved. However, council officers conceded that the council needs to do more monitoring of air quality, they plan to put install one more monitoring station, as they are quite costly. The cost is approximately £50,000 per monitoring station, so funding permitted they are currently only committing to putting up just one monitoring station, with the hopes to put up more in the future.

Targeted responses: open spaces/green spaces

3.26. The Cabinet member acknowledged that parks, open spaces and trees help address the air pollution issues in the borough. Council officers added that the council monitors and reviews the loss and gain of open space areas annually which is published in the Local Plan's annual monitoring report. However, Scrutiny members were concerned that there were schools in the borough that had no open spaces within their premises at all.

3.27. Scrutiny members noted that green screens are in essence living screens which when installed in schools puts a barrier between the pollution and the school, as the leaves capture the pollutants. Scrutiny members enquired as to what efforts the Council has made to increase the number of green walls installed in schools to further protect children from the surrounding air pollution, and purify the air they breathe in. Council officers commented that there are green screens installed in 4 primary schools in Tower Hamlets.

3.28. Scrutiny members queried that there were a lot of schools along the TfL roads with high pollution, and enquired as to the location of the 4 primary schools where these green screens have been installed, how effective they are, and if there are plans to roll these out further if they are effective. Council officers commented that research undergone by King's College on a school in Enfield found that from the roadside to the school playground, there was approximately 18 micrograms reduction in NO_2, which is a significant reduction, so the green screens can be quite effective when used correctly.

3.29. Members further queried why more green screens had not been installed around more schools in the borough, especially those with no playgrounds.

3.30. Scrutiny members were also concerned about the increased use of wood burners in private homes and canal boats which create air quality issues, and highlighted that the council has no policy yet on this emerging issue. Council officers commented that residents should not be using unauthorised fuels and burners based on the Department for Environment, Food and Rural Affairs (Defra) legislation, and these are banned in the mock control zones. They added that the council doesn't get many complaints from residents regarding domestic wood burners. However, the Council does get more complaints about canal boats, and are trying to engage with boat owners via an awareness raising campaign which started in February, to educate boat owners on what they should be doing to reduce the burning. The Cabinet Member added that this has been raised to the Mayor's attention as well , and a meeting has been scheduled with Canal and River Trust to promote partnership working with them, with the aim to adjust their terms and conditions to ensure change, and discuss how the council can support those using wood burners to make that switch

Recommendation 6
The council to develop plan to install green walls and green spaces in schools that currently have none, to purify the air our children breathe and protect them from the surrounding air pollution. [NB. Action 54 in AQAP 2017]

3.31. The Chair commented that there are also a number of unused open spaces in the borough, which should be dealt with and made better use of by converting them into green spaces as soon as possible, as these will further help reduce residents health impacts from air pollution.

3.32. Scrutiny members also raised that there is an ongoing erosion of open spaces, and it is unclear what provision is being made regarding this, and whether as part of the Open Space Strategy there will be some form of reprovision of these in some of the ongoing construction in the borough, and how this is being monitored. Scrutiny members believe that replacements of these eroding open spaces need to be delivered, and they need to meet the kind of biodiversity level that's needed as a replacement.

Recommendation 7
The council to develop plan to covert unused open spaces in the borough to green spaces to make these spaces greener and thus further reduce residents' exposure to air pollutants.

Targeted responses: road-based emissions

3.33. Scrutiny Members raised the issue that more behavioural change work also needs to be done to change residents' mindsets and behaviours towards using vehicles and idling. The Cabinet Member conceded that there has been a lot of requests from residents regarding further action against idling, and for example in the Whitechapel area they have put up anti-idling signs around the East London Mosque and around 2 schools. She acknowledged that more signs need to be put up in idling spots around the borough and they are taking it seriously and working towards it as part of behaviour change.

3.34. Further in relation to idling, a co-optee member enquired if the work the council is doing is being fed through to companies like Uber, because in residential areas such as hers, Uber drivers consistently park outside residents' properties, while keeping their engines running, and many residents are placed in an uncomfortable position and mostly don't have the confidence to step out of their houses to tell the Uber drivers to switch off their engines, and this is happening quite a lot in certain areas of the borough. Council officers commented that they have approached corporate organisations to take control over what their drivers are doing.

3.35. Scrutiny members heard that anti-idling signs had been erected in some hotspots such as primary schools, however, the council is continuously trying to identify more hotpots, as they are aware that can further help reduce idling in the borough.

3.36. Scrutiny members felt that the increasing size of vehicles in the borough and their accompanying larger engines is demoralising in the fight against air pollution. Scrutiny Members believe that ideas on tackling this need to be considered by the council. Council officers commented that they have recognised the increase in size of vehicles and their pollution in terms of the changes they have made in their pricing charging in the Parking Policy. So that it levies a higher charge on those higher polluting vehicles and larger vehicles. They added that the council will continue to monitor whether this strategy has an impact or not on the size of vehicles we have in the borough, as it has done with some of the permits in the borough.

3.37. Scrutiny members were concerned about last mile deliveries and the recent increased use of delivery services and takeaway, they highlighted that this trend is likely to continue post-COVID-19. The Members questioned as to what plans the council have for last mile deliveries to de-incentivise the use of motor vehicles for these deliveries where it's not necessary. Council officers stated that there seems to be a certain amount of change that's happening

organically, there are more bicycle delivery companies operating in London, and it is anticipated that this will continue to grow based on what the council is doing. The council has a project called Blend Business Low Emission Network, which is part funded by the GLA. And as part of that programme, the council is looking to set up an e-cargo bike delivery service from crisp street market, which involves residents purchasing goods from crisp street market and then leaving their items with this delivery service for delivery to their homes. The Cabinet Lead also added that based on learning from the Climate Emergency partnership workshop on 17 March 2021, the council wants to look into encouraging resident behaviour change post-COVID-19 to educate residents in the same household to jointly purchase items together rather than separately, as this is more eco-friendly, and to also support businesses to deliver these goods to residents in an electric vehicle or any other means that is more environmentally friendly.

3.38. Scrutiny members had issues with the council's previous car scrappage schemes, as it only offers scrappage of old cars in exchange for new cars which will still cause pollution. The Scrutiny Members felt that a new innovative scheme similar to the new Coventry Council Scheme where residents are given mobility credits for scrapping their cars, needs to be developed by the council. As this scheme offers scrappage in exchange for money towards public transport, hire bikes, and similar less-polluting options.

Recommendation 8
The council to promptly display anti-idling signs all over Tower Hamlets to discourage idling which will ultimately reduce emissions and also help drivers save fuel.

3.39. Scrutiny members noted that the council had claimed powers to issue Fixed Penalty Notices (FPNs) for idling. However, when Scrutiny members raised questions over the future plans of the anti-idling programme, how effective this current system of enforcement has been on vehicle idling, and how many FPNs had been issued so far, council officers identified that no FPNs had been issued because the process involves enforcement officers in the first instance issuing a warning to drivers to turn the vehicle off when caught idling. Officers added that the council's focus is on educating drivers on the negative impact of idling and there is still a need for strong education to achieve behaviour change. The Cabinet Member also commented that the issue of continuous vehicle idling has also been brought to her attention by a number of residents and councillors, and that the team has put forward some ideas to further tackle idling and are more than happy to take some more ideas on board.

3.40. Scrutiny members acknowledged that during lockdown the anti-idling efforts had to be put on hold because of difficulties we all had to face. However, when things go back to normal there needs to be a more effective plan in place, because it is a serious issue in the borough, drivers are grossly idling every day. Scrutiny members felt that special measure needs to be taken to tackle this issue that isn't reducing, they reiterated that changes to the penalty system needs to be considered to make efforts more effective.

3.41. The Idling Action London project lead agreed that the current system of enforcement is a very ineffective tool, as it is very hard to enforce effectively because the legislation around enforcement is quite unworkable. The legislation is very old and vague, which means there is no clear guidelines for local authorities to follow. In terms of the possibility of enforcement fines being revised or improved, the City of London Corporation have submitted a bill to the House of Lords, which is due for its second reading, and as part of that bill increasing the fine for

fixed penalty notices, up to 80 pounds is included. So, if that bill goes through, it means that local authorities will then have that at their disposal.

Recommendation 9
The council to investigate a new approach for stricter enforcement of anti-idling FPNs to better tackle idling and make this strategy more fit for purpose.

Appendix 1. Challenge Session Scope

Environment Scrutiny Challenge Session Scope:

Examining the Council's Air Quality commitments and impact on residents' health outcomes

Title	Examining the Council's Air Quality commitments and impact on residents' health outcomes
Reason for enquiry	Air Pollution is one of the top concerns raised by residents in the Annual Residents Survey. Some key facts about air pollution highlighted by the council state: • 77 per cent of residents in Tower Hamlets live in areas that breach EU and government air pollution guidance. • Our children's lungs are up to 5 per cent smaller because of air pollution. • We are London's third highest emitter of CO2. • 77 per cent of our residents are exposed to unsafe pollution levels. • Air pollution is linked to asthma, heart disease, dementia, lung cancer and low birth weight. The reasons for this scrutiny challenge session are: • To examine air pollution issues in the borough, and the Council's progress towards it's air quality commitments including the Anti-idling Policy, Open Space Strategy, Air Quality Action Plan, Net Zero Carbon Plan (commitments relating to air quality), Transport Strategy, Parking Policy, and the Liveable Streets Programme). • To assess if there are any outstanding issues that haven't been addressed. • To assess the impact on health implications for residents such as asthma and other health conditions linked to air pollution. • To assess the Council's long-term plans for air quality improvement, including funding/budget proposals.
Core Questions	1. What are the main causes of air pollution in the borough, and what are the correlating health implications for residents? 2. Are there any specific resident groups that are especially impacted by air pollution in the borough? 3. What commitments have the Council made towards improving air quality in the borough (such as in relation to the Anti-idling Policy, Open Space Strategy, Air Quality Action Plan, Net Zero Carbon Plan (commitments relating to air quality), Transport Strategy, Parking Policy, and the Liveable Streets Programme)? And what progress has been made towards these? 4. To what extent do these air quality plans and commitments address the air quality issues in the borough? 5. Are there any issues/ gaps that haven't fully been addressed? 6. What efforts/plans has the Council made towards increasing the number of Green Walls and Roofs in the borough, especially in schools?

	7. How effective has the Council's air quality plans been on improving health outcomes of residents, especially children and young people? 8. What are the Council's air quality plans for the future and what are the funding/budget implications for this?
Proposed completion date	**30th March 2021 from 6pm-8pm**
Desired outcome	Establish the extent to which air quality issues have been addressed by the Council, and identify any issues/gaps not fully met.
What will not be included	There will be no focus on other areas relating to climate change besides air quality, specific to Tower Hamlets.
Risks (mitigation)	The session is dominated by untested opinions. It needs to be informed by robust evidence
Equality & Diversity considerations	Specific to demographics of Tower Hamlets. Air quality plans need to take into consideration the impacts on the different protected characteristics.
Key stakeholders/ consultees	Cllr Faroque Ahmed (Scrutiny Lead for Environment and Community Safety), Overview and Scrutiny Committee Members, Ward Councillors.
Cabinet member(s)	Cllr Asma Islam (Cabinet Lead for Environment and Public Realm)
Potential witnesses	Dan Jones (DD for Public Realm), Keiko Okawa, Katy Scammell (Public Health Consultant), Natalie Curd (Idling Action London), Tower Hamlets Project Officer (Sustrans)
Research/Evidence required	Desktop research, Internal (Council), and Annual Residents Survey
Timescales	Agree Scope pre-meeting & planning session: • Session 1: Scoping meeting with Scrutiny Lead for Environment 26 February 2021 • Session 2: Scoping `meeting with Council officer 4 March 2021 • Session 3: Scoping meeting with Scrutiny Lead for Environment and Council officers 8 March 2021 • Session 4: Challenge Session (virtual) 30 March 2021 6pm-8pm • Report first draft – April 2021 (scrutiny lead and officers for comments) • Scrutiny report for OSC sign off 26 April 2021 • Council response (action plan) for scrutiny recommendations June 2020 / July 2021 • Council response (action plan report) for CLT, MAB and Cabinet August 2021.
Publicity	Council Channels and email to members, once report has been completed and signed off by OSC, methods to publicise will be explored.
Links to Strategic/ Mayoral Priorities	**Priority 2:** A borough that our residents are proud of and love to live in **Outcome 1**: People live in a borough that is clean and green.

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Cabinet 8 September 2021	
Report of: Ann Sutcliffe – Corporate Director, Place	**Classification:** Unrestricted
Procurement of Highways & Street Lighting Works Contracts	

Lead Member	**Councillor Kahar Chowdhury, Cabinet Member for Highways and Public Realm**
Originating Officer(s)	Mehmet Mazhar – Head of Highways & Transportation
Wards affected	All wards
Key Decision?	Yes
Reason for Key Decision	Financial threshold (proposal to result in Council incurring Capital expenditure of above £5m)
Forward Plan Notice Published	27 July 2021
Strategic Plan Priority / Outcome	A borough that our residents are proud of and love to live in.

Executive Summary

This report sets out the planned re-procurement of the Council's Highways & Street Lighting Works Contracts as they are due to expire on the 31st March 2022.

Due to activity time dependencies within the procurement project plan timescales, this item, which would normally have been presented as part of the September Cabinet Contracts Forward Plan – Quarter Two (FY2021-2022) and is which now rescheduled for presentation at November Cabinet, is being presented as a standalone item at September Cabinet as procurement is scheduled to start in early October 2021.

Recommendations:

The Cabinet is recommended to:

1. Agree that contract set out in this report may proceed to procurement in October 2021
2. Confirm that contract set out in this report can proceed to contract award by the Corporate Director, Place, after Tender
3. Authorise the Divisional Director, Legal Services to execute all necessary contract documents in respect of the award of contract referred to in recommendation 2 above

1 REASONS FOR THE DECISIONS

1.1 It is a requirement of the Council's Constitution that "The contracting strategy and/or award of any contract for goods or services with an estimated value exceeding £250k, and any contract for capital works with an estimated value exceeding £5m shall be approved by the Cabinet in accordance with the Procurement Procedures".

2 ALTERNATIVE OPTIONS

2.1 The contract strategy, as outlined in this report, for the procurement of the Highways & Street Lighting Works Contract meets the requirements of the Constitution and provides full visibility of the planned contracting activity in this regard, therefore no alternative proposals are being made.

3 DETAILS OF THE REPORT

Scope of contract

3.1 This contract will replace the current highways and street lighting maintenance and improvement works contract (CLC 4371, structured in 4 Lots) that is due to expire on the 31st March 2022 following formally agreed contract extensions, which is essential for the effective delivery of the borough's Highways & Transportation Capital Programme of improvement works as well as the annual rolling programme of highways & street lighting maintenance works. The start date of new contracts on the 4th April 2022 will allow alignment of the contract start/end date with the beginning/end of the fiscal year, bringing about operational benefits for the delivery of programmes, schemes and projects.

3.2 As the Highway Authority, Tower Hamlets Council has responsibilities for the borough public highway network, which includes roads, footways, footpaths, highways structures and bridges, street lighting, highways drainage, road markings and signage, among its many highways assets. The Councils statutory obligations under this Authority include a duty under section 41 of the Highways Act 1980 to maintain the highway in a safe condition. This duty will be discharged via this Tendered works term service (suite of) contracts that cover maintenance and improvement of these highways assets.

3.3 The contracts require the provision by the contractor of plant, labour and materials in order to deliver the required works and services, in accordance with the Tendered contract terms, conditions and price list.

3.4 The current annual value of the existing contracts is £12.1m. The new contract will be structured into 3 individual contract Lots. The new annual value of these contracts Lots will be £15.8m per annum, made up as outlined, below:

- Lot 1 – Carriageway Machine Resurfacing (Contract Value £5m p.a.)
- Lot 2 – Highways Improvement & Maintenance (Contract Value £7.8m p.a.)

- Lot – 3 Street Lighting Improvement & Maintenance (Contract Value £3m p.a.)

3.5 Therefore, the total contract value over the maximum possible term duration of the contract (of 10 years) is potentially up to £158m.

3.6 Each contract Lot may be used on a “call-off” basis, meaning that there is no obligation to purchase services, or issue commissions, via these contracts. But, purchases can nonetheless be made by the Council, (as the Employer), on a “call-off” basis via each of the individual Lots, as required.

3.7 The contract Lots will also have integral provision of professional services via hourly rate prices submitted for a variety of graded professionals.

3.8 By procuring this contract, it will provide a mechanism by which the commitments within the Corporate (Strategic Plan), Transport Strategy and Mayoral Pledges may be delivered.

Contracting approach

3.9 Due to the value of the contract and in line with thresholds set out in the Public Contracts Regulations 2015 (as amended), the Tender will be openly advertised. The OJEU restricted procedure will be followed that enables short listing of a minimum of 5 bidders who have submitted an Expression of Interest and responded to Pre-Qualification Questionnaire that enables them to be shortlisted (or not) before an Invitation to Tender is issued. The scheduled procurement will commence in October and be advertised digitally via the London Tenders Portal.

3.10 The form of contract that will be used will be the New Engineering Contract 4 (NEC4), term service contract, with the partnering (collaboration) option linked to Key Performance Indicators (KPIs), which are referenced in paragraphs 3.12 and 3.13, below.

3.11 A contract duration (or term) of 10 years (made up of 7 core years plus 1+1+1 extension years linked to attainment of contract KPI’s and achievement of performance targets) allows a Tenderer to make a long term investment into the borough and hence provide more competitive prices to the benefit of the Council. The length of the term (potentially up to 10 years in total) will allow Tenderers to submit more competitive bids than if the contract term was shorter, as the greater amount of works purchased over a longer term could be offset against the contractor’sinitial capital investment costs, thus reducing their risk of making a reasonable profit thus resulting in the submission of keener pricesby them in order to win the contract/s.

3.12 The KPI’s will be linked to the contract term extensions. There will be quarterly and annual assessments that will determine this. Subject to satisfactory performance (in line with the agreed KPI targets), the term of the contract beyond the core 7 years may be extended by a further 3 years in single year increments, subject to the outcome of the overall annual assessment of performance on KPI’s. This could allow the full 10 year term to

be achievable. However, any additional single year term extension may be awarded once two successive years of good performance (measured via the KPI's) has been achieved, with effective credit being built up in 6 month increments. Therefore, subject to good performance it may be possible to award additional single year term extensions in years 2, 4 and 6 of the contract term. If the contractor's performance falls be the agreed set targets, then there may be a reduction in contract term in 6 month increments. This does not take away the Council's right (as the Employer) to terminate any of the contracts at any given time, if not satisfied with the overall performance of the contractor/s, and any remedial action fails to deliver improvement.

3.13 The KPI's will have annual targets that will incrementally increase year on year to ensure that there is continuous improvement throughout the term of the contract. There will be quarterly reviews culminating in annual reviews that determine whether the contract term is extended or reduced from the core 7 year term. It is proposed that the KPI's will address the following areas:

- Customer (local residents and businesses) satisfaction
- Resources & performance: Starting and completing works to agreed programme
- Timely submission of invoices
- Health and safety record
- Environmental performance (including recycling materials, waste reduction, site sustainability and carbon reduction)
- Social Value (including local employment, local apprenticeships that link with the Tower Hamlets Looked After Children Strategy)

3.14 The Tender submissions will be evaluated for each of the contract Lots on a 60:40 split, quality:price basis, (i.e. with 60% of the total available marks being awarded for quality and 40% of the marks being awarded for price). For each Lot, the quality evaluation will be based on an assessment of a combination of the Tenderers quality submission and a panel interview of select members of the team that they propose to resource the contract with.

3.15 As part of the Tender submission, the bidders will be required to submit a figure for the percentage discount they would offer if they were successful in being awarded more than one contract Lot

4 EQUALITIES IMPLICATIONS

4.1 Equalities and diversity implications, and the other One Tower Hamlets issues, are addressed through the tollgate process, and all contracting proposals are required to demonstrate that both financial and social considerations are adequately and proportionately addressed. The work of the Strategic Procurement Board and Corporate Procurement Service ensures a joined-up approach to the Council's procurement activities.

4.2 Additionally, as part of the Tender evaluation process, Tenderers will be asked to address equalities in their submitted Method Statements, which will be assessed as part of the non-financial criteria.

4.3 Pedestrians and users of public transport, particularly vulnerable users and people with mobility impairments are disproportionately affected by poorly maintained surfaces. Continuous investment in the maintenance of the highways infrastructure, delivered via this contract, will improve accessibility and ensure people can move around safely and easily throughout Tower Hamlets' public highways.

5 OTHER STATUTORY IMPLICATIONS

Best Value implications

5.1 As part of its commitment to best value, the Council is committed to ensuring that there is good governance and effective management of resources in terms of economy, efficiency and effectiveness with a focus on continual improvement, to deliver the best outcomes for the community. The procurement of this contract aims to deliver this via the KPI performance targets.

5.2 **Community benefits implications**

The Council's Social Value Matrix will be used to secure economic and community benefits for local residents. 5% of the evaluation weighting will be used to assess this element of the Tender responses. KPI's will include local employment and local apprenticeship targets.

Environmental implications, climate change and carbon reduction

5.3 The KPI's embedded into the contract includes performance targets on recycling materials, waste reduction, site sustainability and carbon reduction). Successful contractors will need to show evidence of achieving the performance targets in this regard (i.e. reduction, re-use and recycling, minimising the impact of construction works, environmental management systems, plant and vehicle standards). The environmental management systems requirements will include reduction in carbon emissions, innovative sustainable design and construction solutions that lower whole life carbon and whole life cost.

5.4 Any vehicles utilised by the successful contractor/s will need to deliver a reduction in exhaust pollutants and carbon dioxide emissions by increasing usage of zero and ultra low emission vehicles in their fleet where feasible.

6 COMMENTS OF THE CHIEF FINANCE OFFICER

6.1 This report is seeking approval to re-procure the Council's Highways & Street Lighting Works Contracts. The current contract is due to expire on the 31st March 2022.

6.2 The contract consists of a mix of revenue and capital expenditure with an estimated value over 10 years of £158m, an average of £15.8m per annum. This represents a significant increase in contract value from the existing contract of £12.1m per annum.

6.3 This is a call-off contract, with a ceiling set at £158m over ten years. Therefore this represents the maximum spend and not the guaranteed spend.

6.4 There are revenue budgets to the value of £4.1m per annum spread across a number of cost centres within Public Realm. Revenue spend will need to be contained within these budget levels in order not to generate a cost pressure. Any revenue expenditure above this will need to be funded within the overall Place budget.

6.5 There is a total approved capital budget of £13.6m relating to street lighting. This consists of street lighting replacement (£11.6m), remote monitoring of Street lighting (£0.8m), both included within the invest to save programme, and £1.2m for street lighting maintenance within the rolling programme. The current profile of the total capital budget is £9.2m in 2021/22, £4.0m in 2022/23 and £0.4m in 2023/24. Capital expenditure will need to be contained within these existing approved budgets.

7 COMMENTS OF LEGALSERVICES

7.1 The structure of this contract is a framework contract for the purposes of European law. Under the law a framework cannot be longer than 4 years except in exceptional circumstances and those circumstances must relate to the subject matter of the tendered opportunity. In this case the winning bidder will be required to invest in a significant amount of upfront capital in terms of plant and machinery; expenditure which the Contractor would expect to recoup over the lifetime of the contract. Restricting the contract to the 4-year period would mean that the Contractor would seek to reclaim the expenditure over only 4 years which would leave the resultant contract as being uneconomic. A 7 year contract (to 10 with extensions) is a proportionate length of contract to be both economic and justifiable given the expected economic lifespan of typical plant and machinery that will be used on the contract.

7.2 The proposed route to tender is compliant with the current procurement law. The law in this area is being reviewed. However, as with previous changes in the law over the last 20 years it is expected that any changes to the law will only apply to tenders advertised after the change has come into place regardless of when the contract is due to be awarded.

7.3 The tenders will be evaluated and awarded to those bidders who represent Best Value. This will be shown by using predetermined and prepublished evaluation criteria with the award going to the contractors who show themselves to be the most economically advantageous bidders on the blend of quality and price shown in the criteria.

7.4 Reference is made in the report to subsequent awards of contracts being called off. This may be without further competition but only in the exceptional circumstances that the firm on the lot who is to be used is clearly identified as

being the Best Value contractor without a further competitive pricing exercise being necessary.

Linked Reports, Appendices and Background Documents

Linked Report

- None

Appendices

- None

Background Documents – Local Authorities (Executive Arrangements)(Access to Information)(England) Regulations 2012

- None

Officer contact details for documents:
N/A

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Cabinet 8 September 2021	TOWER HAMLETS
Report of: Ann Sutcliffe Corporate Director of Place	**Classification:** Part exempt
Disposal of 3-11 Vallance Road, E1 5HS	

Lead Member	**Councillor Bustin, Cabinet Member for Planning and Social Inclusion**
Originating Officer(s)	Stephen Shapiro, Interim Head of Asset Management Thomas Parsonage, Interim Asset Manager
Wards affected	Spitalfields and Banglatown
Key Decision?	Yes
Reason for Key Decision	Financial threshold
Forward Plan Notice Published	11 August 2021
Strategic Plan Priority / Outcome	All

Executive Summary

3 -11 Vallance Road (edged red on plan) is a terrace of derelict retail shops with office and residential upper floors located within close proximity to Whitechapel Overground Station. The site is held within the HRA and has been derelict since 1968 when the council was first served with a Dangerous Structures Notice by the Building Control department. Various attempts have been made to redevelop in the intervening 50 years and several feasibility studies have been completed including the most recent feasibility study involving neighbouring owners Transport for London (TFL) and Longwood Properties Limited.

A decision has been made to dispose of 3 -11 Vallance Road by way of Private Treaty. An 8-week marketing period by commercial agents Gerald Eve in line with the Council's disposal policy commenced on 23rd May 2021. Neighbouring landowner Longwood Properties have shown interest in the site. London Newcastle who are a developer and previously assisted with a feasibility study have taken a particular interest in the site.

The first round of bids concluded and the Council received 8 bids. Bidder A and bidder B have produced the two highest offers, with the highest bid being £3m. A second round of bidding between the two parties has commenced in order to

establish the best and final offer from each party. Offers are likely to be in excess of £3M.

Due to the level of offer received it is above officer Delegated Authority level which is currently £1M and therefore Cabinet authority is therefore required.

Recommendations:

The Cabinet is recommended to:

1. Declare that 3-11 Valance Road is surplus to requirements

2. Note the bids received to date (Exempt Appendix A) and authorise the Corporate Director Place to accept the most advantageous offer for the disposal (freehold or long leasehold) for the site

3. Authorise the Divisional Director, Legal to enter into any legal agreements considered necessary to give effect to the recommendations in this report

4. To note the Equalities Impact Assessment.

1 REASONS FOR THE DECISIONS

1.1 The site has been derelict since 1968 when the Council was first served with a Dangerous Structures Notice by the Building Control department. Various attempts have been made to redevelop in the intervening 50 years and several feasibility studies have been completed including the most recent feasibility study involving neighbouring landowners TFL and Longwood Properties Limited.

1.2 Scaffolding inspections are currently carried out monthly to ensure the safety of the building and to flag any health and safety issues. The cost of managing and maintaining the scaffolding is draining resources as the building continues to deteriorate and become more of a health and safety concern.

1.3 When the site is disposed of it is envisaged that the buyer will re-develop the site into commercial, residential, or potentially mixed-use accommodation. This will provide the Council with a capital receipt and possibly provide new homes and/or employment space in the borough.

1.4 The site is currently being marketed for disposal. The council has received 8 offers and two offers have been received which are in excess of the other offers. Gerald Eve have reverted to both parties seeking best and final offers, however this may still require further clarification of the proposal. This is because the Council will require clarity on any overage provisions that are proposed, as well as resolving any outstanding title matters relating to Unit 11 Vallance Road which are summarised below.

1.4 a Unit 11 – The unit has a lease which has expired and tenant

benefits from 1954 Act rights to renew. The current occupation of the unit is not clear and therefore a S40 and hostile S25 Notice are due to be served. There are also reports of antisocial behaviour and loud music.

1.5 Reasons to declare the site surplus and market are due to the cost of maintaining a dilapidated building and the health and safety issues posed. High cost of scaffolding inspections and security. Limited funding for the individual or joint redevelopment of the site and planning constraints in the area.

2 ALTERNATIVE OPTIONS

2.1 Continue with further feasibility work and enter into another Cost Collaboration Agreement (CCA) with the neighbouring parties (TFL and Longwood Properties Limited). This will require more time and resources to reach the next stage of feasibility at a cost of approximately £300k.

2.2 Leave the site vacant and derelict which will continue to attract anti-social behaviour and represent a health a safety liability to the Council.

2.3 Re-develop 3-11 Vallance Road independently. This will require a large number of resources in order to re-develop the site independently and the result will be to only improve 1/3 of the overall area considering the adjacent landowners may leave their sites undeveloped.

3 DETAILS OF THE REPORT

3.1 The site has been widely marketed with strong levels of interest and bids received from a number of parties. Gerald Eve have reverted to the two highest bidders to seek best and final offers on an unconditional basis in order to establish the best returns for the Council. These offers may include an overage provision to top up the offer should certain planning achievements be met, but the proposal will not be solely based on this.

3.2 Due to the level of offers currently received this will comfortably exceed the Delegated Authority level, and approval is sought for the Corporate Director of Place to make the final decision on the sale level achieved depending on the total package of the offers.

3.3 Gerald Eve have confirmed that by marketing the property using private treaty this will ensure that the Council achieves best consideration as a result of the competitive bidding scenario.

3.4 Disposing of the site will remove the Council's liability of providing scaffolding checks and eliminate any health and safety liability for the building.

4 EQUALITIES IMPLICATIONS

4.1 There are no specific equalities implications arising from the decision to dispose of the site. The subsequent mixed-use development will result in the provision of new residential accommodation, including affordable units. This accommodation will therefore help to meet the demand in the borough from people on the housing waiting list in recognised housing priority need. The development will also include commercial space including retail and office accommodation which will create employment space in the borough.

5 OTHER STATUTORY IMPLICATIONS

5.1 This section of the report is used to highlight further specific statutory implications that are either not covered in the main body of the report or are required to be highlighted to ensure decision makers give them proper consideration. Examples of other implications may be:

- Best Value Implications,
- Consultations,
- Environmental (including air quality),
- Risk Management,
- Crime Reduction,
- Safeguarding.
- Data Protection / Privacy Impact Assessment.

5.2 No other statutory implications have been identified.

6 COMMENTS OF THE CHIEF FINANCE OFFICER

6.1 Disposal of the site at 3-11 Vallance Road will result in a revenue cost saving with the Council no longer required to provide scaffolding or security at the site. The asset sits within the Housing Revenue Account (HRA) and as a result the revenue saving will be for the HRA and not the General Fund.

6.2 This disposal will generate a HRA non-right to buy (RTB) capital receipts that can be used for any capital purpose.

6.3 However, if the non RTB capital receipts are used for any purpose other than affordable housing or regeneration, then the HRA Capital Financing Requirement must be reduced by the amount used, so that debt servicing costs are transferred from the HRA to the General Fund.

7 COMMENTS OF LEGAL SERVICES

7.1 The Council is a local housing authority under section 1 of the Housing Act 1985 (HA 85) and is proposing to dispose of the site. The site sits within the Housing Revenue Account (HRA). The Council has the power to dispose of properties held in the HRA under section 32(1), HA 85 provided that Secretary of State consent is obtained (s32(2), HA 85). The Council can apply to the Secretary of State for specific consent or can rely on one of the general consents if it can meet the required conditions. Under A.3.1.1 of The General

Housing Consents 2013 a local authority may (subject to restrictions that do not apply in this case) dispose of land for a consideration equal to its market value.

7.2 It should be noted that if the Council decides to dispose of the site for less than market value then a different consent regime is in place, and this would need to be complied with as a failure to do so will render a disposal void.

7.3 Section 1 of the Localism Act 2011 grants councils a general power of competence whereby a local authority has the power to do anything that individuals generally may. However, that power does not enable a local authority to do anything which it is unable to do by virtue of a pre-commencement limitation.

7.4 Section 123 of the Local Government Act 1972 is a pre-commencement statute that imposes limitations on the council's power to dispose of property. Section 123 of the Local Government Act 1972 provides that a council shall not (save where the consent of the Secretary of State has been obtained) dispose land for anything less than the best consideration that can reasonably be obtained. It is noted in this report that professional advice has been sought from Gerald Eve and that they are managing the bidding process. The report details that the competitive bidding process will ensure the Council receives best consideration and it is recommended at Gerald Eve endorse that the successful bid does represent best value for s123 purposes.

7.5 The Council also has an obligation under section 3 of the Local Government Act 1999 to secure continuous improvement in the way in which its functions are exercised, having regard to a combination of economy, efficiency and effectiveness (the best value duty). The report details that disposal of the site will provide the Council with a saving as it will no longer required to provide scaffolding or security at the site.

7.6 The Council has a Public Sector Equality Duty under the Equality Act (2010) to have due regard to the need to:

- Eliminate discrimination, harassment and victimisation and any other conduct prohibited under the Act
- Advance equality of opportunity between people who share those protected characteristics and those people who do not
- Foster good relations between people who share those characteristics and people who do not

7.7 As stated it in the report it is envisaged that the site will deliver new residential accommodation, including affordable units which will benefit the borough. It is also noted that it is expect that any development would include retail and office accommodation which will create employment space in the borough.

Linked Reports, Appendices and Background Documents

Linked Report

- None

Appendix 1

- Site Plan

Exempt Appendices

Two appendices are listed as exempt in accordance with paragraph 3 of Schedule 12a of the Local Government Act 1972 in that it involves the likely disclosure of exempt information in relation to the financial and business affairs of any particular person (including the authority holding that information).

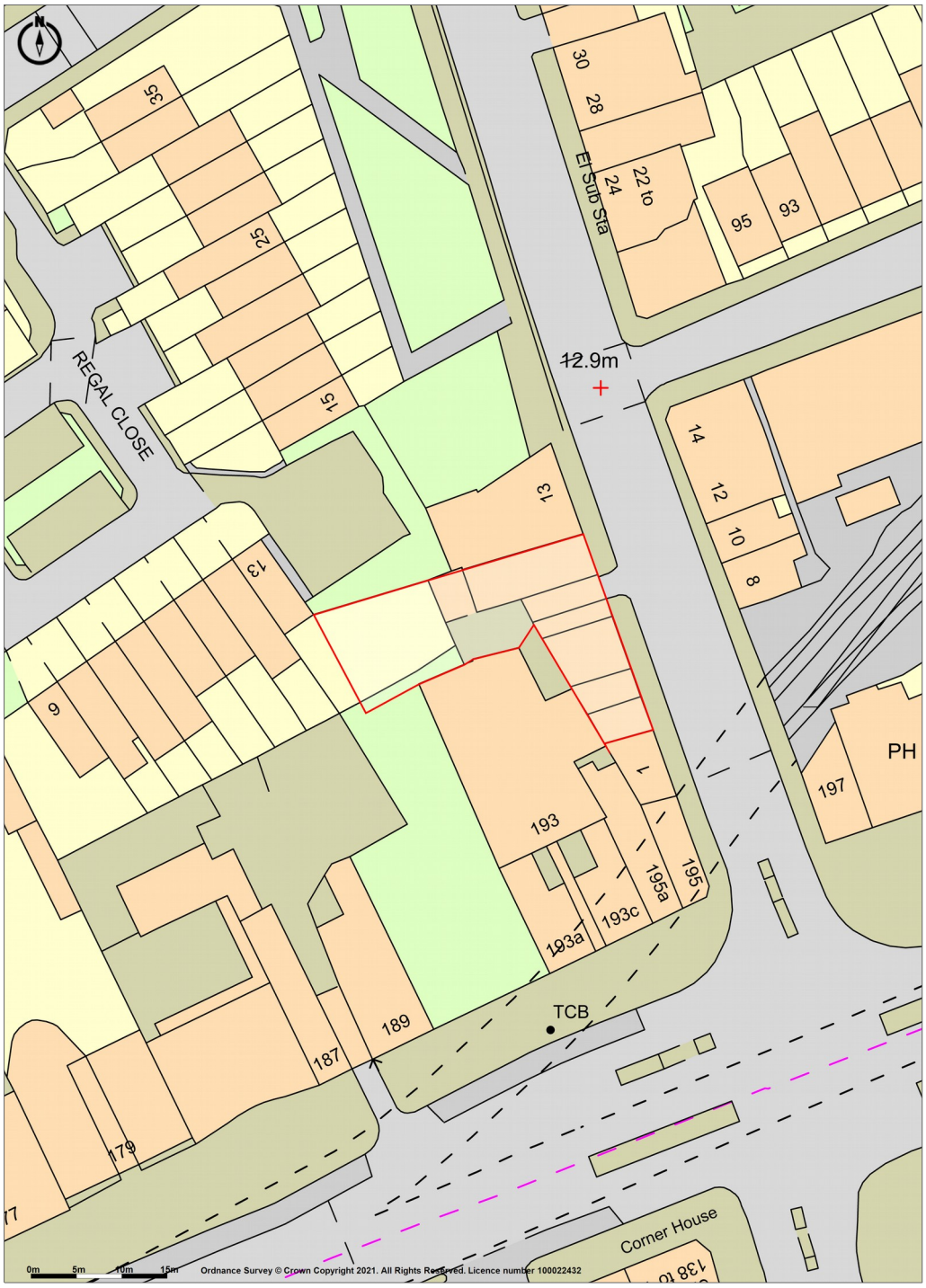
- First Round Bids

- Second Round Bids

Background Documents – Local Authorities (Executive Arrangements) (Access to Information) (England) Regulations 2012

- None

Officer contact details for documents:
N/A



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Cabinet 8 September 2021	
Report of: Ann Sutcliffe Corporate Director of Place	**Classification:** Unrestricted
Disposal of 122 Back Church Lane, E1 1NY	

Lead Member	**Councillor Bustin, Cabinet Member for Planning and Social Inclusion**
Originating Officer(s)	Stephen Shapiro – Interim Head of Asset Management Thomas Parsonage – Interim Asset Manager
Wards affected	Whitechapel
Key Decision?	Yes
Reason for Key Decision	Financial threshold
Forward Plan Notice Published	12 July 2021
Strategic Plan Priority / Outcome	A Borough that our residents are proud of and love to live in.

Executive Summary

122 Back Church Lane is a former school building which has been vacant for over 10 years. The site is on the eastern side of Back Church Lane towards the northern end of the road (edged red on the plan). A derelict school building currently occupies approximately half the site. The school to the south, with its main frontage onto Fairclough Street is Harry Gosling primary School. The school to the east of the site, with access onto Henriques Street is London East Alternative Provision - Tommy Flowers Centre (see Appendix 1).

A feasibility study has been undertaken in order to determine the potential development value of the property with the special assumption that planning permission has been achieved in each case.

The purpose of this report is to receive authority to dispose of 122 Back Church Lane, London, E1 1NY.

Recommendations:

The Cabinet is recommended to:

1. Provide authority to market and dispose of the vacant 122 Back Church Lane site on a freehold basis

2. Authorise the Corporate Director of Place to determine the best route to market.

3. To note the Equalities Impact Assessment.

1 REASONS FOR THE DECISIONS

1.1 The site has not been used for any purpose for over 10 years and therefore the site should be held surplus and disposed to benefit from a capital receipt.

1.2 External consultants Copping Joyce have reviewed the architect's feasibility study and provided 8 different development scenarios. It is anticipated that the sale price will exceed £1m and therefore the freehold disposal will require Cabinet approval at the relevant time.

1.3 A planning pre-application advice meeting was held on 19.03.2021 with mixed feedback regarding the two favoured options presented to the Planning Team. Whilst consideration was given to undertaking a further pre-application exercise, Copping Joyce have advised there is no merit in achieving planning permission before the disposal and therefore the early feasibility/drawings commissioned are sufficient in order to achieve a favourable sale price.

1.4 When the vacant building is disposed of the buyer will re-develop the site into commercial, residential, or potentially mixed-use accommodation. This may provide new homes for the Borough and/or employment space.

2 ALTERNATIVE OPTIONS

2.1 The existing building could be converted into residential accommodation. However the relatively low number of units achievable (4-6) and high cost of conversion means the project is unviable.

2.2 Leave the site vacant and unused for the foreseeable future. The vacant site results in expensive security provisions and is likely to attract anti-social behaviour.

3 DETAILS OF THE REPORT

3.1 This site has been identified as surplus land as at the Asset Maximisation board in June 2020, and instructions were subsequently issued to Copping Joyce to undertake a valuation.

3.2 As part of this Copping Joyce undertook 8 different scenarios which provided a broad price range of between £730k - £1.8M. The lower end was for refurbishment of the existing building and conversion into 3 two bed apartments. The higher end was for a larger development of 3 one bed plus 6 two bed apartments. Neither of the scenarios currently have planning permission.

3.3 By openly marketing this property buyers will compete through private treaty or auction and best consideration will be achieved. The final sale price will depend upon the assumptions and planning risk each bidder makes during the marketing process.

3.4 Both are considered suitable routes to market as auction opens it up to the pressure in the sale room however this is potentially hampered by way of a reduced marketing period.

3.5 Conversely Private Treaty will take considerably longer with multiple rounds being anticipated, and several offers are likely to be subject to planning which is something that will sought to be avoided by seeking unconditional offers only with an overage option, which is not possible at auction.

3.6 It is considered that both options will facilitate the Councils fiduciary obligation to secure best value for the site.

4 EQUALITIES IMPLICATIONS

4.1 There are no specific equalities implications arising from the decision to dispose of the site. The subsequent development will result in the provision of new residential accommodation and commercial employment space.

5 OTHER STATUTORY IMPLICATIONS

5.1 This section of the report is used to highlight further specific statutory implications that are either not covered in the main body of the report or are required to be highlighted to ensure decision makers give them proper consideration. Examples of other implications may be:

- Best Value Implications,
- Consultations,
- Environmental (including air quality),
- Risk Management,
- Crime Reduction,
- Safeguarding.
- Data Protection / Privacy Impact Assessment.

5.2 No other statutory implications have been identified.

6 COMMENTS OF THE CHIEF FINANCE OFFICER

6.1 Any marketing costs arising from the recommendation in this report will need to be contained within approved budgets within Place Directorate.

7 COMMENTS OF LEGAL SERVICES

7.1 The Council has an obligation under section 3 of the Local Government Act 1999 to secure continuous improvement in the way in which its functions are exercised, having regard to a combination of economy, efficiency and effectiveness (the best value duty). Land should only be disposed of by a local authority where it is considered to be surplus to the Council's requirements and this report details that the site has not been used for 10 years and that the council will benefit from a capital receipt on disposal.

7.2 Any marketing and consideration of offers made by potential purchasers must have regard to s123 Local Government Act 1972.

7.3 When disposing of land the Council has a statutory duty under section 123 of the Local Government Act 1972 to ensure that it obtains best consideration for the land and buildings disposed of. It is noted that approval for any disposal will require Cabinet approval at the relevant time.

Linked Reports, Appendices and Background Documents

Linked Report

- None

Appendices

- Site Plan

Background Documents – Local Authorities (Executive Arrangements)(Access to Information)(England) Regulations 2012

- None

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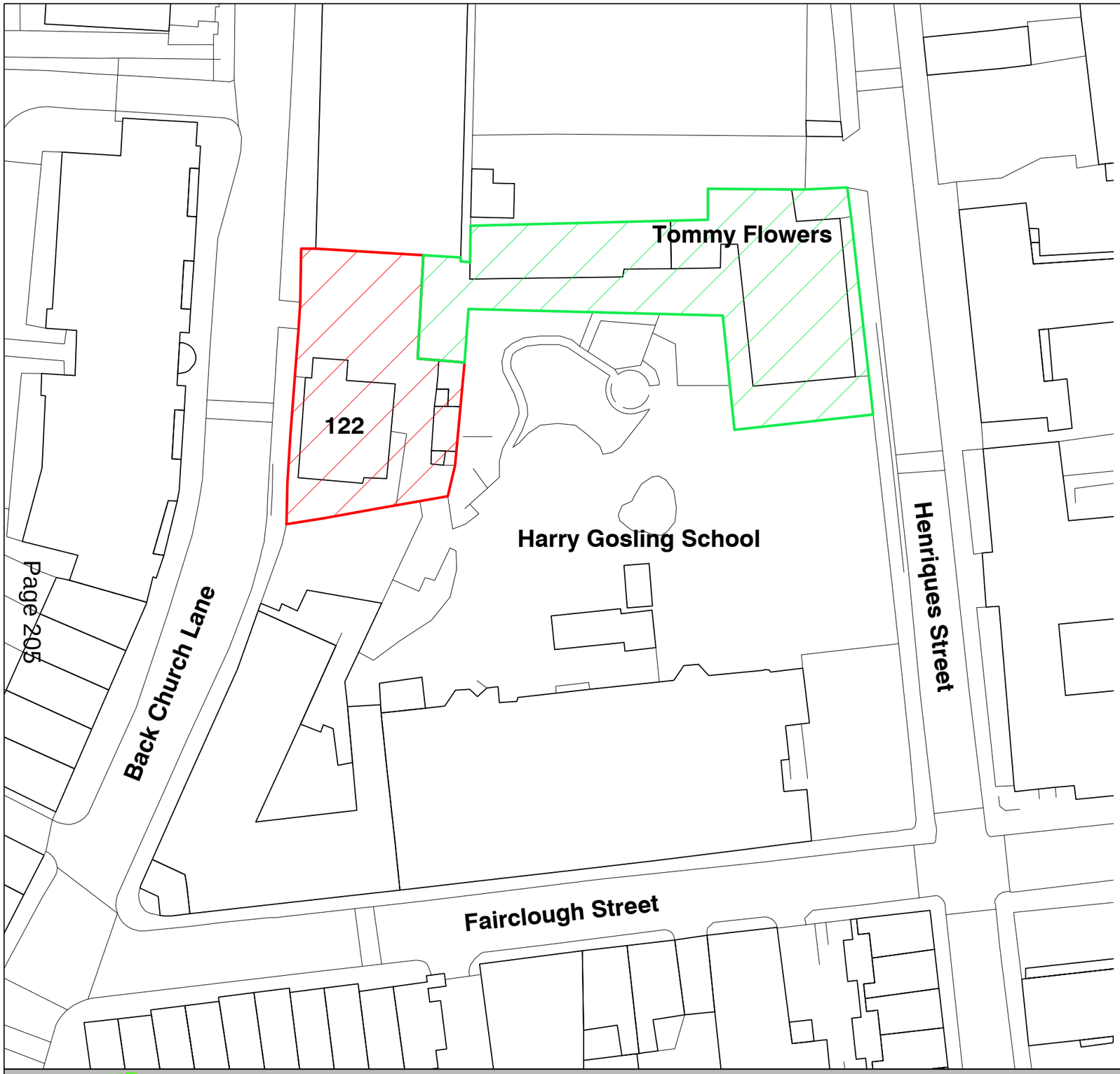

122 Back Church Lane

122 Back Church Lane

Tower Hamlets
Architectural Team - Capital Delivery
Mulberry Place
5 Clove Crescent
London E14 2BG
Telephone 0207364 7457

Feasibility Study

Back Church Lane
Tommy Flowers
London
E1 XXX

Site Plan Existing

Drawing No. - FE - 001

February 2018

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Cabinet 8 September 2021	
Report of Kevin Bartle, Interim Corporate Director - Resources (Section 151 Officer)	**Classification:** Part exempt (Appendix)
Town Hall IT Infrastructure	

Lead Member	Councillor Ronald, Cabinet Member for Resources and Voluntary Sector
Originating Officer(s)	Adrian Gorst
Wards affected	All wards
Key Decision?	No
Reason for Key Decision	N/A
Forward Plan Notice Published	29 July 2021
Strategic Plan Priority / Outcome	All

Executive Summary

The Council moves into the Town Hall in Whitechapel in 2022 and this report seeks Cabinet authority to procure the necessary IT hardware, software and services to ensure colleagues, partners and visitors can access the applications and data they need.

Recommendations:

The Cabinet is recommended to:

1. Approve the competitive procurement of IT hardware, software and services to enable the move to the Town Hall in 2022.

2. Authorise the Interim Corporate Director Resources to enter into such agreements as are necessary to give effect to the matters referred to in this report subject to the Council's Procurement Procedures.

1 REASONS FOR THE DECISIONS

1.1 The Town Hall IT infrastructure is an essential part of the new Town Hall and without it we will not be able to relocate staff or services.

1.2 Competitive procurement allows us to secure the best technology at the

most advantageous price.

1.3 Early approval mitigates against the risk of delays due to Brexit, the pandemic and shipping issues. It also allows suppliers to plan ahead and may secure lower pricing than would be available at shorter notice.

2 ALTERNATIVE OPTIONS

2.1 It may be possible to procure the necessary hardware, software and services through existing suppliers and contracts. This is not recommended as we may not secure the best technology at the most advantageous price without competition between suppliers.

2.2 If we do not start procurement in the early Autumn we may not have essential IT services in place and the move to the new Town Hall may be delayed and a “rush-job” nearer the time is likely to be more expensive.

3 DETAILS OF THE REPORT

3.1 The Council is relocating services and staff to the new Town Hall in Whitechapel in 2022 and requires wired and wireless network connectivity throughout the building to allow members, visitors, partners, and colleagues to connect to the internet and applications and data.

3.2 While the cabling within the building is included in the build contract, the switches and wireless access points that allow devices and users to connect to the internet, applications and data are not included in the build contract.

3.3 The IT service therefore needs to design a solution, procure switches and wireless access points and have these installed and tested in the new Town Hall before the Council relocates any staff or services.

3.4 These items will provide connectivity for all users of the new Town Hall.

3.5 There are ongoing discussions about additional requirements for specific areas including the Residents Hub, Council Chamber and areas occupied by partners however these will all operate on top of wired and wireless network and decisions on these additional services can be made later.

3.6 There is potential for a long lead time for the hardware, software and services as Brexit, the pandemic, and shipping issues have made it harder for suppliers to secure the components they need.

3.7 The IT service has secured funding for the necessary hardware, software, and services through the Digital Portfolio Board, Corporate Leadership Team and Capital Board.

3.8 Details of the anticipated cost is detailed in Appendix A.

4 EQUALITIES IMPLICATIONS

4.1 We have not identified any specific equalities implications.

5 OTHER STATUTORY IMPLICATIONS

5.1 This section of the report is used to highlight further specific statutory implications that are either not covered in the main body of the report or are required to be highlighted to ensure decision makers give them proper consideration. Examples of other implications may be:
Best Value Implications,
Consultations,
Environmental (including air quality),
Risk Management,
Crime Reduction,
Safeguarding.
Data Protection / Privacy Impact Assessment.

5.2 We have not identified any specific statutory implications.

6 COMMENTS OF THE CHIEF FINANCE OFFICER

The proposal is for a competitive process to be undertaken to secure providers for the supply and installation of an IT network in the New Town Hall toensure best value.available. All costs must be contained within approved budgets.

7 COMMENTS OF LEGAL SERVICES

7.1 The Council has the legal power to undertake the actions referred to in this report.

7.2 The Council has a legal duty to ensure its purchases are subject to competition under the Public Contracts Regulations and the Council's constitution. All purchases will be following a competitive exercise where the winning bidder has been determined as a result of the application of pre-advertised evaluation criteria in order to ascertain Best Value as well as to satisfy the procurement law.

7.3 The Council may also elect to use framework agreements to satisfy the competition duty.

7.4 The approval limits in terms of value should be restricted to the sums identified for such purchases detailed in the transformation reserve

7.5 The restricted appendix contains information which relates to the Council's budgeting for this project and financial affairs which if known by potential bidders may influence the bidders decisions on pricing and impair the Council's ability to obtain Best Value. This constitutes exempt information under the law. The fact that it is likely that the Council's commercial interests might be prejudiced as a result of the release of the information means that the public interest in maintaining the exemption outweighs the public interest in knowing the information.

Linked Reports, Appendices and Background Documents

Linked Report

- NONE

Appendices

Exempt Appendix – this appendix is listed as exempt in accordance with paragraph 3 of Schedule 12a of the Local Government Act 1972 in that it involves the likely disclosure of exempt information in relation to the financial and business affairs of any particular person (including the authority holding that information).

- EXEMPT: Appendix A - Anticipated Costs

Background Documents – Local Authorities (Executive Arrangements)(Access to Information)(England) Regulations 2012

- NONE

Officer contact details for documents:
Adrian Gorst, Director of IT

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Cabinet	
8 September 2021	
Report of Kevin Bartle, Corporate Director of Resources	**Classification:** Partially Restricted (Appendix 1)
Recurring IT Contracts Procurement Approval – Northgate and Bell Mitel/Wavenet	

Lead Member	Cllr Candida Ronald, Cabinet Member for Resources and the Voluntary Sector
Originating Officer(s)	Adrian Gorst
Wards affected	All wards
Key Decision?	Yes
Reason for Key Decision	Financial threshold
Forward Plan Notice Published	14 May 2021
Strategic Plan Priority / Outcome	All Priorities but mainly Priority 3 - A dynamic, outcomes-based council using digital innovation and partnership working to respond to the changing needs of our borough People say we continuously seek innovation and strive for excellence to embed a culture of sustainable improvement.

Executive Summary

The Council recommends entry new contract terms under a Crown Commercial Services (CCS) framework to continue support and maintenance for:

1) Northgate Housing Rents and Benefits applications pending the outcome of wider revenues and benefits project that is commencing now. Without these systems, the Council will not be able to collect rent or process housing benefits for the vulnerable.

2) Bell Mitel/Wavenet the telephony systems, pending the agreement of new ways of working and requirements for the planned town Hall move. Without this service, there will be no telephone system for Councils' staff, contact centre, residents, businesses, suppliers, and partners putting the Council's reputation at risk.

3) Eighteen applications and solutions with contract costs below £189K mostly for up to 3 years of extension using frameworks or renewals as advised by

procurement. Without new agreements, the Council is exposed to multiple system failures, with no software updates, fixes or enhancements being available.

Recommendations:

The cabinet is recommended to:

1. Approve the proposed procurement of:

    a. Northgate housing, rents and benefits application support and hosting, starting from 01 April 2022 for 3 years, through a direct award or via a Crown Commercial Service (CCS) framework, aligning this with the wider housing and revenues project that has recently been approved and is commencing now to gather requirements and will take a considerable time get to the tender stage, award, implementation, and transition.

    b. Bell Mitel/Wavenet telephony solution starting from 01 May 2022 for 3 years, through a direct award or via the Network Services 2 Framework.

    c. The renewal of 18 further recurring IT contracts each with a total contract spend below £189K for direct renewal routes or via a procurement framework as applicable.

2. Authorise the Divisional Director of IT Service to award the 20 new contracts referred to above. The total annual value of these contracts is £1.682M and their lifecycle value over next 3-5 years with extensions is £5.307M.

1 REASONS FOR THE DECISIONS

1.1 **Introduction** – This section will outline the imperatives to pursue the recommended routes.

1.2 **Funding** - For all contracts in the scope of this paper, funding has been approved by the Corporate Director of Resources as part of the IT revenue budget forward plan, including indexation.

1.3 **The Council's Bell Mitel/Wavenet telephony solution** - contract expires in April 2022. In the absence of capital funding or the resources to run a tender and project manage a transition from one supplier to another makes renewal of the current via a framework the least risky option. This service is a critical piece of infrastructure for communications externally and internally. With the transfer to the new Town Hall, there is a need to ensure continuity of provision for communications, both internally and externally.

1.4 **The Council's Northgate application support -** agreement expires in March 2022, whereas the Council's Northgate hosting agreement runs to 2024. Capital funding has just been approved to enable a programme of work to consolidate housing, rents, benefits, and revenues systems and processes. Renewal of the Northgate support agreement to 2025 is recommended as IT Service cannot project manage procurement and a transition any earlier than before 2025 without significant risks. Without the system, the Council would not be able to fulfil its statutory obligations.

1.5 **For the remaining 18 contracts -** individually the total recommended term value is below £189K, the proposed approach is to renew the agreements. The intent is to use the CCS frameworks or undertake a direct award, as advised by procurement, to renew with existing suppliers to maintain business continuity until such time that a strategic plan for the change or upgrade to these solutions is approved and funded.

2 ALTERNATIVE OPTIONS

2.1 **Do nothing –** If the Northgate application contract is allowed to expire, this would affect the collection of housing rent and the disbursement of Council housing benefit - the latter is a statutory responsibility for the Council. Similarly, if the Bell/Mitel service is allowed to expire, this risks the Council's ability to communicate both internally and externally. The Council would not be able to fulfil its core statutory responsibilities.

2.2 **Tendering through market competition –** this is not a feasible option, since capital funding for tendering has only been agreed for the housing revenues and benefits project over the next three years as detailed in point 1.4, hence the recommendation is that the Council renews the existing contract before they expire. With the telephony contract, new ways of working and Town Hall moves will inform new requirements for future tender.

2.3 A competitive exercise would likely be ineffective for both housing and telephony solutions, since for a 3-year tender typically only the existing bidders would bid, as there is huge investment needed upfront for both solutions.

3 DETAILS OF THE REPORT

3.1 Renewal of the Northgate support agreement for 3 years from April 2022 to March 2025 is recommended to allow requirements definition of housing and revenues, covering both Northgate and Civica applications, specification, tendering, evaluation and implementation and a transition by 2025.

3.2 The Bell/Mitel agreement needs renewal for 3 years from May 2022 April 2025 through framework before the move to Town Hall as new ways of working get established and the Council can define new telephony requirements.

3.3 The council is setting up and resourcing an in-sourced vendor management function that will develop a 5-year roadmap to enable us to maximise leverage from our strategic vendors through competition. It is not resourced to do this currently, having only taken full responsibility for the management of IT contracts since April 2021 after the end of the nine year contract with Agilisys through which Agilisys managed the portfolio of IT contracts for the council.

3.4 Appendix 1 - Table 1 (partially restricted) shows the current Bell Mitel/Wavenet, and Northgate contract spend (including sub-contractors) for which Cabinet approval is sought due to threshold levels. It also shows the proposed contract term. The potential value of these contracts exceeds £189K, which is the current minimum threshold (as set out in the Public Procurement Regulations) for public contracts to be tendered. The proposal is to use a CCS framework procurement route to purchase a support and maintenance agreement that is compliant with the regulations. Using this procurement route will ensure business continuity while programmes (housing, revenues, and benefits) and business change (Town Hall move) are in development.

3.5 Appendix 1 - Table 2 (partially restricted) shows the anticipated contract spend on the invocation of renewals or using frameworks that were available for cost-effectiveness.

4 EQUALITIES IMPLICATIONS

4.1 No equality implications are arising from the proposal as it is related to spending on IT applications and solutions support and maintenance.

5 OTHER STATUTORY IMPLICATIONS

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5.1 As detailed in previous sections, the loss of service would put at risk a range of services to Council inability to make or receive contact with citizens to provide services, collect rent or process benefits with a resulting failure in its statutory duty, putting most vulnerable in the community at risk and risking penalties and reputational damage.

6 COMMENTS OF THE CHIEF FINANCE OFFICER

6.1 The cost of these contracts will need to be contained within approved IT budgets.

7 COMMENTS OF LEGAL SERVICES

7.1 Appendix 1 includes information that relates to one or more businesses and this constitutes exempt information. The businesses commercial position would be significantly prejudiced by the release of such information. Therefore, following due consideration, the public interest in knowing the information contained in Appendix 1 is outweighed by the public interest in maintaining the exemption.

7.2 The Council has the legal power to undertake the actions referred to in this report.

7.3 The Council has just completed the exit of its previously procured external strategic partner model of ICT services delivery and is currently undergoing a transformation in the way it delivers the service. Part of the exit required the transfer of the partners subcontracts to the Council in order to allow the Council to directly manage the providers of the existing ICT infrastructure. Unfortunately, the Council needs to regularise these contracts to allow for a structured series of procurements over the next few years.

7.4 The position is further complicated by the Council's move to its new town hall which is currently under construction. Amongst other things this will significantly impact on the Council's future requirements and therefore necessitate short term continuations of existing contracts.

7.5 Also it is anticipated that any replacement for the telephony and revenues systems will require significant up-front investment by a contractor and therefore make any new contract uneconomic while ever the Council is only able to offer to the market such a short term contract. Therefore, regulation 32 is satisfied in respect of the proposed extension of the contracts referred to in this report on the grounds that competition is frustrated as a result of the subject matter of the contracts.

Linked Reports, Appendices and Background Documents

Linked Report

- NONE.

Appendices - Exempt

- Appendix. 1 IT Recurring Contracts includes information that relates to one or more businesses and this constitutes exempt information

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