TOWER HAMLETS HEALTH AND WELLBEING BOARD

Tuesday, 21 June 2016 at 5.00 p.m. MP702, 7th Floor, Town Hall, Mulberry Place, 5 Clove Crescent, London E14 2BG.

This meeting is open to the public to attend.

Members:	**Representing**
Chair: Mayor John Biggs	(Executive Mayor)
Vice-Chair:	
Councillor Amy Whitelock Gibbs	(Cabinet Member for Health & Adult Services)
Councillor Rachael Saunders	(Cabinet Member for Education & Children's Services)
Councillor David Edgar	(Cabinet Member for Resources)
Dr Somen Banerjee	(Interim Director of Public Health, LBTH)
Dr Amjad Rahi	(Healthwatch Tower Hamlets Representative)
Dr Sam Everington	(Chair, NHS Tower Hamlets Clinical Commissioning Group)
Jane Milligan	(Chief Officer, Tower Hamlets Clinical Commissioning Group)
Councillor Abjol Miah	Young Mayor
Jane Ball	Tower Hamlets Housing Forum
Councillor Danny Hassell	(Non - Executive Group Councillor)
Co-opted Members	
Dr Ian Basnett	(Public Health Director, Barts Health NHS Trust)
DengYan San	(Young Mayor)
Dr Navina Evans,	(Deputy Chief Executive and Director of Operations)
Suzanne Firth	(Tower Hamlets Community Voluntary Sector)
Jackie Sullivan	Hospital Manager
Phil Langworthorthy	Acting Borough Commander

The quorum of the Board is a quarter of the membership including at least one Elected Member of the Council and one representative from the NHS Tower Hamlets Clinical Commissioning Group**.**

Questions
Before the formal business of the Board is considered, up to 15 minutes are available for public questions on any items of business on the agenda. Please send questions to the Officer below by **5pm the day before the meeting**.

Contact for further enquiries:
Farhana Zia, Democratic Services
1st Floor, Mulberry Place, Town Hall, 5 Clove Crescent, E14 2BG

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Tel: 02073644207
E:mail: elizabeth.dowuona@towerhamlets.gov.uk
Web: http://www.towerhamlets.gov.uk/committee

Role of the Tower Hamlets Health and Wellbeing Board.

- To encourage integrated working between persons who arrange for the provision of any health or social services in Tower Hamlets for the advancement of the health and wellbeing of the people in Tower Hamlets.
- To identify needs and priorities across Tower Hamlets and publish and refresh the Tower Hamlets Joint Strategic Needs Assessment (JSNA) so that future commissioning/policy decisions are based on evidence.
- To prepare the Joint Health and Wellbeing Strategy.
- To be involved in the development of any Clinical Commissioning Group (CCG) Commissioning Plan that applies to Tower Hamlets and to give its opinion to the CCG on any such proposed plan.
- To communicate and engage with local people on how they could achieve the best possible quality of life and be supported to exercise choice and control over their personal health and wellbeing. This will involve working with Local HealthWatch to make sure there's a continuous dialogue with the public to ensure services are meeting need.
- To carry out new functions as requested by the Secretary of State and as advised in guidance issued from time to time.

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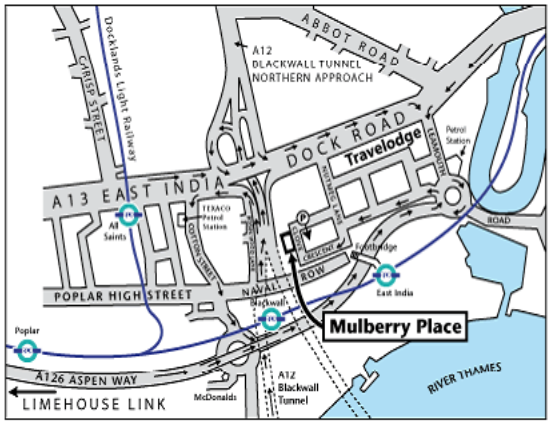

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PAGE NUMBER(S)

1. STANDING ITEMS OF BUSINESS

1 .1 Welcome, Introductions and Apologies for Absence

To receive apologies for absence and subsequently the Chair to welcome those present to the meeting and request introductions.

1 .2 Minutes of the Previous Meeting and Matters Arising

To confirm as a correct record the minutes of the meeting of the Tower Hamlets Health and Wellbeing Board held on. Also to consider matters arising.

1 .3 Declarations of Disclosable Pecuniary Interests **1 - 4**

To note any declarations of interest made by members of the Board. (See attached note of Monitoring Officer).

ITEMS FOR CONSIDERATION

2. TERMS OF REFERENCE **5 - 14**

3. TRANSFORMING CARE PARTNERSHIP PLAN **15 - 28**

4. SUSTAINABILITY AND TRANSFORMATION PLANS **29 - 34**

5. SUBSTANCE MISUSE STRATEGY 2016-19 **35 - 146**

6. HEALTH AND WELLBEING STRATEGY 2016-2020, DEVELOPING A STRATEGY THAT WILL MAKE A DIFFERENCE- NEXT STEPS **147 - 198**

7. AOB

8. DATE OF NEXT MEETING

Next Meeting Date: 9th August 2016

Date of Next Meeting:
Tuesday, 9 August 2016 at 5.00 p.m. in

DECLARATIONS OF INTERESTS - NOTE FROM THE MONITORING OFFICER

This note is for guidance only. For further details please consult the Members' Code of Conduct at Part 5.1 of the Council's Constitution.

Please note that the question of whether a Member has an interest in any matter, and whether or not that interest is a Disclosable Pecuniary Interest, is for that Member to decide. Advice is available from officers as listed below but they cannot make the decision for the Member. If in doubt as to the nature of an interest it is advisable to seek advice **prior** to attending a meeting.

Interests and Disclosable Pecuniary Interests (DPIs)

You have an interest in any business of the authority where that business relates to or is likely to affect any of the persons, bodies or matters listed in section 4.1 (a) of the Code of Conduct; and might reasonably be regarded as affecting the well-being or financial position of yourself, a member of your family or a person with whom you have a close association, to a greater extent than the majority of other council tax payers, ratepayers or inhabitants of the ward affected.

You must notify the Monitoring Officer in writing of any such interest, for inclusion in the Register of Members' Interests which is available for public inspection and on the Council's Website.

Once you have recorded an interest in the Register, you are not then required to declare that interest at each meeting where the business is discussed, unless the interest is a Disclosable Pecuniary Interest (DPI).

A DPI is defined in Regulations as a pecuniary interest of any of the descriptions listed at **Appendix A** overleaf. Please note that a Member's DPIs include his/her own relevant interests and also those of his/her spouse or civil partner; or a person with whom the Member is living as husband and wife; or a person with whom the Member is living as if they were civil partners; if the Member is aware that that other person has the interest.

Effect of a Disclosable Pecuniary Interest on participation at meetings

Where you have a DPI in any business of the Council you must, unless you have obtained a dispensation from the authority's Monitoring Officer following consideration by the Dispensations Sub-Committee of the Standards Advisory Committee:-

- not seek to improperly influence a decision about that business; and
- not exercise executive functions in relation to that business.

If you are present at a meeting where that business is discussed, you must:-

- Disclose to the meeting the existence and nature of the interest at the start of the meeting or when the interest becomes apparent, if later; and
- Leave the room (including any public viewing area) for the duration of consideration and decision on the item and not seek to influence the debate or decision

When declaring a DPI, Members should specify the nature of the interest and the agenda item to which the interest relates. This procedure is designed to assist the public's understanding of the meeting and to enable a full record to be made in the minutes of the meeting.

Where you have a DPI in any business of the authority which is not included in the Member's register of interests and you attend a meeting of the authority at which the business is considered, in addition to disclosing the interest to that meeting, you must also within 28 days notify the Monitoring Officer of the interest for inclusion in the Register.

Further advice

For further advice please contact:-

Melanie Clay, Corporate Director of Law, Probity & Governance & Monitoring Officer, Telephone Number: 020 7364 4801

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.

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Health and Wellbeing Board Tuesday 21 June 2016	Tower Hamlets Health and Wellbeing Board
Report of the London Borough of Tower Hamlets	**Classification:** Unrestricted
Tower Hamlets Health and Wellbeing Board Terms of Reference, Quorum, Membership and Dates of Meetings	

Lead Officer	Somen Banerjee, Director of Public Health
Contact Officers	Jamal Uddin, Strategy, Policy & Performance Officer
Executive Key Decision?	No

Summary

This report sets out the Terms of Reference, Quorum, Membership and Dates of meetings of the Tower Hamlets Health and Wellbeing Board for the Municipal Year 2016/17 for the information of members of the Board.

Following a peer review of the Board's effectiveness led by the Local Government Association, the report proposes some changes to the Terms of Reference to strengthen the leadership of the Board across the council, Clinical Commissioning Group and partners.

Recommendations:

The Health & Wellbeing Board is recommended to:

1. Note the Terms of Reference, Quorum, Membership and Dates of future meetings as set out in Appendix 1 and 2 of this report.
2. To discuss the following changes to the Health and Wellbeing Board members proposing to:

    a) Nominate the Cabinet Member for Health and Adult services as Chair of the HWBB

    b) Nominate a CCG representative as Vice Chair of the Board

    c) Request that the Mayor of Tower Hamlets and Chief Executive of LBTH to attend at least one meeting in the municipal year to review priorities and progress, and as required when key decisions are being considered.

    d) Nominate the Cabinet Member for Housing Management and Performance as a voting member of the Board

e) Nominate the Tower Hamlets Borough Commander of Met Police; Corporate Director of Communities, Localities and Culture (CLC); and Corporate Director of Development & Renewal, LBTH as co-opted members (non-voting members) of the Board

f) Nominate by the council a Councillor from the largest opposition group as a stakeholder (non-voting)

1. REASONS FOR THE DECISIONS

1.1 It is necessary for all Council committees including the Health and Wellbeing Board to note its Terms of Reference, Quorum, Membership and Dates of meetings for the forthcoming Municipal Year. It is timely to propose changes to strengthen the leadership of the Board following a recent review.

2. ALTERNATIVE OPTIONS

2.1 The Board could choose not to consider the Terms of Reference but it is not recommended as the Health and Wellbeing Board is expected to meet all the stated requirements in the Terms of Reference.

3. DETAILS OF REPORT

3.1 It is traditional that following the Annual General Meeting of the Council at the start of the Municipal Year, at which various committees are established, that those committees note their Terms of Reference, Quorum and Membership for the forthcoming Municipal Year. These are set out in Appendix 1 to this report.

3.2 The Board's meetings for the remainder of the year, as agreed at the meeting of the Council on 18 May 2016, are as set out in Appendix 2 to this report. In accordance with the agreed calendar, meetings of the Board are scheduled bi-monthly to take place on Tuesdays at 5.00pm. This means there are six meetings of the board held in a year. There are also two development sessions scheduled in a year.

3.3 It is clear from the Health and Social Care Act 2012 that health and wellbeing boards are different to other section 102 committees, in particular in relation to the appointment of Councillors. The regulations disapply the requirement for political proportionality and enables Directors of the Local Authority to become members of the board. In the 'HWBB a practical guide to governance and constitutional issues'[1] the following is the core membership that health and wellbeing boards must include:

- at least one councillor from the relevant council
- the director of adult social services
- the director of children's services
- the director of public health
- a representative of the local Healthwatch organisation
- a representative of each relevant clinical commissioning group (CCG)
- any other members considered appropriate by the council

[1] The source of 'HWBB a practical guide to governance and constitutional issues' is http://www.local.gov.uk/c/document_library/get_file?uuid=4503fcd2-4934-4962-8a58-f1b6ed38d5d2&groupId=10180

3.4 The membership of the Board in Tower Hamlets reflects the requirements of the Health and Social Care Act 2012 and allows other members that Tower Hamlets regard as important to the Health and Wellbeing of its residents.

3.5 This in effect means the board is able to review its membership and make necessary changes to appointments of the board to reflect health and wellbeing priorities in Tower Hamlets. There is more than one elected councillor on the board but there is no restriction on the total number of elected members that can be board members. The council is free to decide, in consultation with the health and wellbeing board, which members of the health and wellbeing board should be voting members.

3.6 In addition, the Health and Wellbeing Board took part in a peer review during April 2016 facilitated by the Local Government Association (LGA). The feedback was generally positive; with Board members noting that the Health and Wellbeing Board is ambitious in what can be achieved in Tower Hamlets and external feedback that our broad membership and active engagement from a range of partners was a strong base to build from.

3.7 The peer review highlighted the importance of effective and consistent leadership on the Health and Wellbeing Board to see through challenges faced by Tower Hamlets such as significant health inequalities and the collective response to austerity by local partners. The Board is ambitious about fully exploiting its system leadership role and playing a more active role in driving transformational change to tackle our most significant challenges. Best practice also recommends joint leadership between the council and CCG through the chairing arrangements. The Mayor and Chief Executive of Tower Hamlets are fully committed to the health and wellbeing agenda and as such will engage actively with the Board's work outside of formal meetings, to ensure engagement across the whole council, and formally attend the Board at least once a year to review priorities and contribute to key decisions.

3.8 In agreement with the current chair of the Board, the Mayor of Tower Hamlets, the report therefore proposes the following changes to the Board's membership and Terms of Reference:

- A new delegated chair person; Cabinet Member for Health and Adult Services to enhance strong, consistent leadership and trust;

- Nominate a CCG representative as Vice Chair of the Board to promote joint leadership across the main statutory partners;

- Formally require the Mayor of Tower Hamlets and Chief Executive of LBTH to attend at least one meeting in the municipal year as part of an annual review of health and wellbeing outcomes; They are not restricted to one meeting and are able to attend any Board meetings in an advisory capacity and/or to participate in key decisions;

- Introduce the Cabinet Member for Housing Management and Performance as an elected representative (voting member). This

means that more emphasis can be given to joint housing priorities across the Council, given the strong links between poor housing and ill health. This position will replace the Executive Advisor on Adult Social Care, which is a position that no longer exists in LBTH;

- The council to nominate a councillor from the largest opposition group as a stakeholder to the board. The stakeholder will be able to attend meetings regularly and take part in board discussions but is not a formal board member given the Board's executive role. A councillor from the majority group, who is not part of the executive, already attends the Board as a non-voting member.

- Additional senior officer appointments across the partnership to support the ongoing development and delivery of the Joint Health and Wellbeing Strategy 2016-2020;

    - The new Borough Commander of Met Police;
    - Corporate Director of CLC; and
    - Corporate Director of Development and Renewal

3.9 Other terms of reference would remain unchanged, such as the Chair of Health Scrutiny and Safeguarding Board Chairs for children's and adults being invited to attend as key stakeholders (non-voting).

4. COMMENTS OF THE CHIEF FINANCE OFFICER

4.1 There are no financial implications directly relating to this report.

5. LEGAL COMMENTS

5.1 I would advise that section 194 of the Health and Social Care Act 2012 requires the establishment of a HWB and sets out who the HWB must consist of. The existing Membership meets those requirements.

5.2 With regard to Councillor nominations, the Act requires that where the authority operates executive arrangements, as the Council does, then the Mayor must nominate these Councillors. If changes in the Councillor Membership of the Committee are proposed then a report has to go to the Mayor to nominate these Councillors.

5.3 Any changes to the Terms of Reference must be agreed by full Council pursuant to Article 4.02(d) of the Constitution.

6. ONE TOWER HAMLETS CONSIDERATIONS

6.1 When drawing up the schedule of dates, consideration was given to avoiding school holiday dates and known dates of religious holidays and other important dates where at all possible.

7. BEST VALUE (BV) IMPLICATIONS

7.1 There are no specific Best Value implications arising from this noting report.

8. SUSTAINABLE ACTION FOR A GREENER ENVIRONMENT

8.1 There are no specific sustainability implications arising from this noting report.

9. RISK MANAGEMENT IMPLICATIONS

9.1 There are no specific risk implications arising from this noting report.

10. CRIME AND DISORDER REDUCTION IMPLICATIONS

10.1 There are no specific crime and disorder implications arising from this noting report.

Linked Reports, Appendices and Background Documents

Linked Report

- NONE

Appendices

- Health and Wellbeing Board Terms of Reference
- Health and Wellbeing Board - Dates of Meetings 2016-17

Local Government Act, 1972 Section 100D (As amended)
List of "Background Papers" used in the preparation of this report
List any background documents not already in the public domain including officer contact information.

- NONE

Officer contact details for documents:

- N/A

APPENDIX 1

Tower Hamlets Health and Wellbeing Board – Terms of Reference, Quorum and Membership

The Health and Wellbeing Board will lead, steer and advise on strategies to improve the health and wellbeing of the population of Tower Hamlets. It will seek to do this through joint work across services in the Borough and the greater integration of health and social care as well as with those accessing services that can help to address the wider determinants of Health. The Board continues to support the ambitions of the Tower Hamlets Partnership outlined within the Tower Hamlets Community Plan.

The Health and Wellbeing Board has the following functions:

1. To have oversight of assurance systems in operation
2. To encourage integrated working between persons who arrange for the provision of any health or social services in Tower Hamlets for the advancement of the health and wellbeing of the people in Tower Hamlets.
3. To provide advice, assistance or other support in order to encourage partnership arrangements under Section 75 of the NHS Act 2006.
4. To encourage those who arrange for the provision of any health-related services in Tower Hamlets (e.g. services related to wider determinants of health, such as housing) to work closely with the HWB.
5. To encourage persons who arrange for the provision of any health or social care functions in Tower Hamlets and those who arrange for the provision of health-related services in Tower Hamlets to work closely together.
6. To identify needs and priorities across Tower Hamlets and publish and refresh the Tower Hamlets Joint Strategic Needs Assessment (JSNA) so that future commissioning/policy decisions are based on evidence.
7. To prepare the Joint Health and Wellbeing Strategy.
8. To develop, prepare, update and publish the local pharmaceutical needs assessments.
9. To be involved in the development of any CCG Commissioning Plan that applies to Tower Hamlets and to give its opinion to the CCG on any such proposed plan.
10. To communicate and engage with local people on how they could achieve the best possible quality of life and be supported to exercise choice and control over their personal health and wellbeing. This will involve working with Local HealthWatch to make sure there's a continuous dialogue with the public to ensure services are meeting need.
11. Consider and promote engagement from wider stakeholders.
12. To have oversight of the quality, safety, and performance mechanisms operated by member organisations of the Board, and the use of relevant public sector resources across a wide spectrum of services and interventions, with greater focus on integration across outcomes spanning health care, social care and public health. Areas of focus to be agreed from time to time by members of the Board as part of work planning for the Board.
13. Such other functions delegated to it by the Local Authority.
14. Such other functions as are conferred on Health and Wellbeing Boards by enactment

Quorum
The quorum of the Board in the Terms of Reference is a quarter of the membership including at least one Elected Member of the Council and one representative from the NHS Tower Hamlets Clinical Commissioning Group.

Membership The membership of the Board is as follows:

Chair

- Mayor of London Borough of Tower Hamlets (LBTH)

Vice Chair

- Cabinet Member for Health and Wellbeing

Elected Representatives of LBTH

- Cabinet Members for Health & Wellbeing and Children's Services (2)
- Cabinet Member for Resources
- Executive Advisor on Adult Social Care
- Non-executive majority group councillor nominated by Council

Local Authority Officers- LBTH

- Director of Public Health - LBTH
- Corporate Director of Children's Services – LBTH
- Corporate Director of Adult Services - LBTH

Local HealthWatch

- Chair of local Healthwatch

NHS (Commissioners)

- Chair - NHS Tower Hamlets Clinical Commissioning Group
- Chief Operating Officer – NHS Tower Hamlets Clinical Commissioning Group (CCG)

Co-opted Members (Non-Voting)

- Health Providers
- Chief Operating Officer - Barts Health
- Chair of Tower Hamlets - Council for Voluntary Services
- Deputy Chief Executive - East London and the Foundation Trust

- Representative from the Housing Forum.
- Chair of the Integrated Care Board
- The Young Mayor

Stakeholders that may attend the Board from time to time but are not members:

- Representative of NHS England
- Chairs of Tower Hamlets Safeguarding Boards (Adults and Childrens).
- Chair of the LBTH Health Scrutiny Panel
- Local Liaison Officer for National Commissioning Group.

APPENDIX 2

Tower Hamlets Health and Wellbeing Board
Meeting Dates 2016-17

Health and Wellbeing Board Meetings
(Board meetings are held bi-monthly normally on Tuesdays and will commence at 5.00pm – 7.30pm. The following board meetings will be held in Mulberry Place, 5 clove Crescent, E14 2BG)

- Tuesday 21 June 2016, 5 - 7.30pm in room MP702
- Tuesday 9 August 2016, 5 - 7.30pm in room MP702
- Tuesday 18 October 2016, 5 - 7.30pm in room MP702
- Tuesday 13 December 2016, 5 - 7.30pm in room MP702
- Tuesday 21 February 2017, 5 - 7.30pm in room MP702
- Tuesday 18 April 2017, 5 - 7.30pm in room MP702

Board Development sessions (2 in a year)

- Tuesday 12 April 2016, 1-5pm, Mulberry Place, Town Hall – MP702 (Supported by LGA)
- Date to be agreed

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Health and Wellbeing Board Tuesday 21st June 2016	Tower Hamlets Health and Wellbeing Board
Report of the London Borough of Tower Hamlets and Tower Hamlets CCG	**Classification:** Unrestricted
Transforming Care Partnership Plan	

Lead Officer	Denise Radley and Jane Milligan
Contact Officers	Carrie Kilpatrick Deputy Director Mental Health and Joint Commissioning
Executive Key Decision?	No

Summary

In October 2015, LGA, ADASS and NHS England published **Building the right support**, a national plan to reduce inpatient provision and enhance community services for people with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition. Building the right support sets out the ambition to mobilise commissioning collaborations of CCGs, NHS England specialised commissioners and local authorities across England to create Transforming Care Partnerships (or TCPs), tasked to deliver a specified national service model of good practice by March 2019.

This report sets out progress made to date in the formation of the Inner North East London Partnership Board and the development of the plan to date as well as the next steps.

Recommendations:

The Health & Wellbeing Board is recommended to:

1. Note the requirements of the Transforming Care Partnership Plan, progress made to date and the scheduled date for the final plan to be authorised by the Health and Well-being Board of August 2016

DETAILS OF REPORT

3. Introduction and Overview

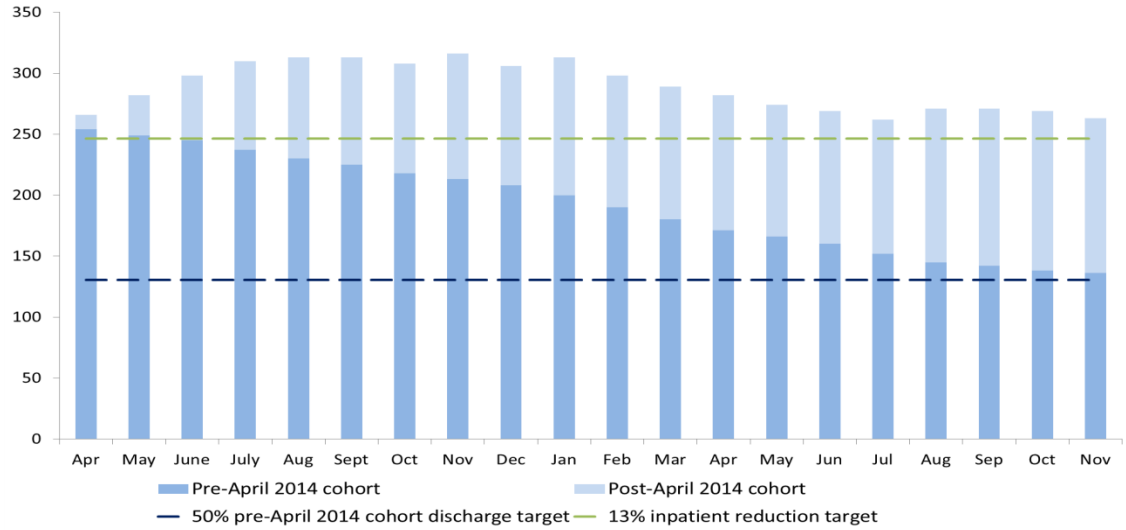
3.1 In October 2015, LGA, ADASS and NHS England published **Building the right support**, a national plan to reduce inpatient provision and enhance community services for people with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition. Building the right support sets out the ambition to mobilise commissioning collaborations of CCGs, NHS England specialised commissioners and local authorities across England to create Transforming Care Partnerships (or TCPs), tasked to deliver a specified national service model of good practice by March 2019.

3.2 Specifically the programme aims to achieve:

- A better community infrastructure resulting in a substantial reduction in the number of children, young people and adults with a learning disability and/or autism who display behaviour that challenges, placed in inpatient settings;
- Prevention of people living in inpatient services and a reduction in length of stay for those admitted to an inpatient facility;
- Better quality of care and support for children, young people and adults with a learning disability and/or autism who display behaviours that challenge;
- Better quality of life for children, young people and adults with a learning disability and/or autism who display behaviours that challenge.

3.3 There is a specific requirement for areas with large numbers of people in assessment and treatment units (ATUs) to reduce the use of inpatient beds; using national planning assumptions that each area should have inpatient capacity to cater for no more than 10-15 inpatients in CCG-commissioned beds and 20-25 inpatients in NHS England-commissioned beds (such as those in low- medium- or high-secure units) per million population. In a number of areas the plan will therefore focus on a significant remodeling, reduction or closure of this type of inpatient provision.

3.4 The programme builds on the Winterbourne View action plan and NHS England's commitment to reduce over reliance on inpatient care. In February 2015 NHSE commenced a programme to close inappropriate and outmoded inpatient care, establishing stronger support in the community; however progress nationally has been slow as admission rates during 2015/16 have not reduced significantly. In the period between April and November of 2015, when this programme was launched, 131 patients had been admitted to inpatient care, compared to 155 patients admitted in the same period last year. It was forecast that in 2015/16 there would be a total of 200 admissions, compared to 218 admissions in 2014/15.



Approximately a third of the people currently in hospital have been in inpatient settings for five years or longer.

3.5 To support local areas with transitional costs, NHS England has made available up to £30 million of transformation funding over three years, with national funding conditional on match-funding from local commissioners. In addition to this, £15 million capital funding will be made available over three years. The primary focus of this funding will be to facilitate the closure and re-provision of community based services for local areas where inpatient facilities are above the regional planning assumptions; INEL is not one of these areas.

In addition NHSE have made plan development funding available to each TCP and locally this has been used to employ a Programme Manager on an interim basis until the end of June 2016.

4. Overview of the National Service Model Requirements

4.1 The model which has been developed with people with learning disability and/or autism, as well as families/carers, and a group of independent expert's; sets out how services should support people with a learning disability and/or autism who display behaviour that challenges. Its foundation is that we all have a basic right to live in our own home and to develop and maintain an active role in society. The challenge is to mobilise innovative housing, care and support solutions in the community to enable this to happen for all, including those with the most complex support needs.

4.2 NHS England has outlined "what good looks like" for people with a learning disability and/or autism who display behaviour that challenges**.** The model is structured around 9 principles seen from the point of view of a person with a learning disability and/or autism:

I have a good and meaningful everyday life - access to activities, early year's services, education, employment, social and sports/leisure; and support to develop and maintain good relationships.
My care and support is person-centred, planned, proactive and coordinated – early intervention and preventative support based on risk stratification, person-centred care and support plans, and local care and support navigators/keyworkers to coordinate services set out in the care and support plan.
I have choice and control over how my health and care needs are met - with information about care and support in formats people can understand the expansion of personal budgets, personal health budgets and integrated personal budgets, and strong independent advocacy.
My family and paid support and care staff get the help they need to support me to live in the community - training for families/carers, support and respite for families/carers, alternative short term accommodation for people to use briefly in a time of crisis, and paid care and support staff trained in display behaviour that challenges.
I have a choice about where I live and who I live with – bespoke options, including small-scale supported living, and settled accommodation.
I get good care and support from mainstream health services. NICE guidelines and quality standards should be in place with annual health checks for all those over the age of 14; Health Action Plans, Hospital Passports, liaison workers in universal services, and schemes to ensure universal services are meeting the needs of people with a learning disability and/or autism (such as quality checker schemes and use of the Green Light Toolkit).
I can access specialist health and social care support in the community- Integrated specialist multi-disciplinary health and social care teams are available on an intensive 24/7 basis.
If I need it, I get support to stay out of trouble - with reasonable adjustments made to universal services aimed at reducing or preventing anti-social or 'offending' behaviour, liaison and diversion schemes in the criminal justice system, and a community forensic health and care function to support people who may pose a risk.
If I am admitted for assessment and treatment in a hospital setting because my health needs can't be met in the community, it is high-quality and I don't stay there longer than I need to. Staying no longer than needed, with pre-admission checks to ensure hospital care is the right solution and discharge planning starting from the point of admission or before.

4.3 In addressing the core principles the challenge is to ensure that services across the health and social care system, as well as other more mainstream services consider the needs of this very diverse group and have an appropriate and more importantly inclusive service offer.

5. The Inner North East London Transformation Care partnership

5.1 To meet the requirements, a Transformation Care Partnership (TCP) has been established for the Inner North East London region to lead and ensure the targets of this national agenda are realised. The Partnership will lead on the preparation of a local plan that sets out our vision, aims and anticipated outcomes; the outline plan to be submitted to NHSE with applications for funding (where required) by the end of June 2016.

5.2 This TC Partnership is made up of:

City & Hackney CCG	London Borough of Hackney
Newham CCG	London Borough of Newham
Tower Hamlets CCG	London Borough of Tower Hamlets
Waltham Forest CCG	London Borough of Waltham Forest
NHS Specialist Commissioning	City of London

Other key provider base and partners in the Programme will include:

- Barts Health NHS Trust
- East London NHS Foundation Trust
- Homerton University Hospital Foundation NHS
- North East London NHS Foundation Trust
- East London NHS Foundation Trust
- John Howard Centre (Medium Secure services including a Personality Disorder service commissioned by East London Foundation Trust)
- Cygnet (hospital for women with complex mental health needs, provisions including learning disability, personality disorder, psychiatric intensive care and low secure units)
- Venus Healthcare (forensic unit)

5.3 To ensure collaboration across the TCP area and across the relevant specialisms we have established a TCP Board comprising representation from each geographical area and a number of high level specialisms and a TCP Steering Group to deliver the plan. The Transforming Care Partnership Board has been set up to:

I. Oversee the development of the Transforming Care Plan
II. Gain and retain high level cooperation cross the Partnership
III. Provide steer, motivation, and challenge to the Implementation Team
IV. Drive the delivery and raise issues with NHSE where necessary
V. Monitor performance of the Transforming Care Implementation

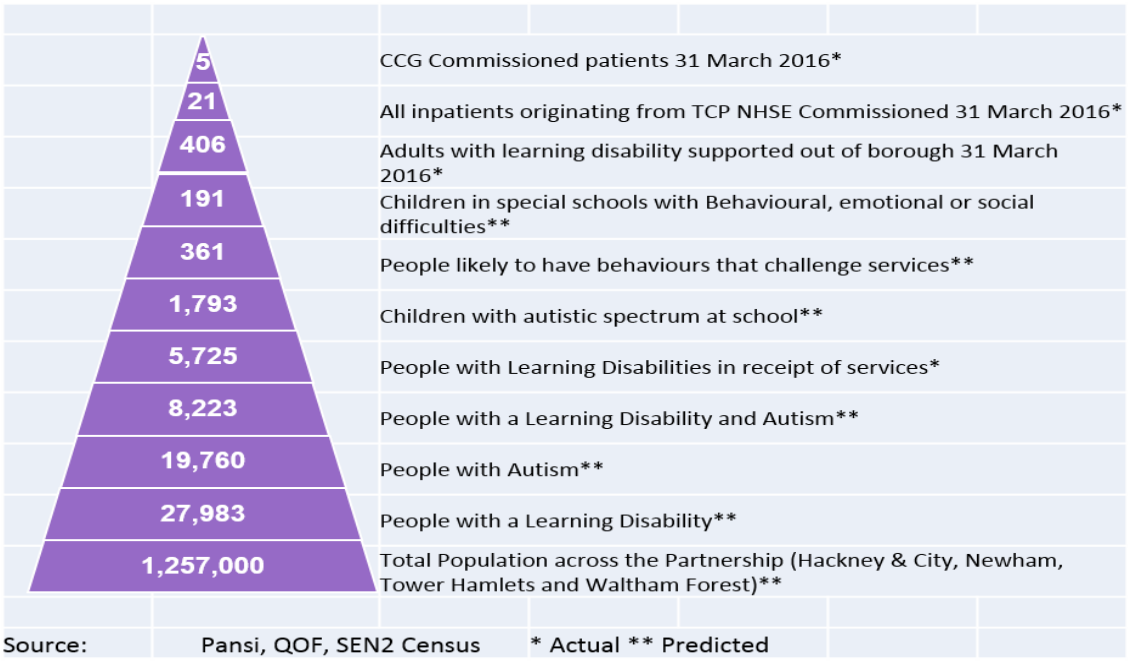
5.4 Tower Hamlets representatives on the board include Debbie Jones the Corporate Director of Children's Services, Carrie Kilpatrick the Commissioning

Manager for Mental Health Services (a joint Council CCG post) along with clinical representation from Dr Ian Hall the Consultant Psychiatrist with Tower Hamlets Community Learning Disabilities Service.

6. The Local Population in Need

6.1 Across the partnership our population of adults and children who fit within this defined cohort and are placed in inpatient settings is relatively low; we have very few people leaving Hospital who have lived in inpatient provision for over 5 years. At an INEL level, we currently have 6 people in CCG commissioned beds, plus 23 in NHSE commissioned beds, so we are one of those areas currently below the planning assumption targets.

In recognition of this, our planning target for 2019 is to reduce these numbers by 25%, which, while still a significant target, is lower than those TCP areas with high levels of in-patient bed usage.



INEL Regional picture of need

6.2 There is a variety of information available which informs our understanding of the local picture in Tower Hamlets. We have data about children with recognised Special Educational Needs or with a diagnosis of autism. We also know how many adults are known to the Community Leaning Disability Service. However, none of the data sources available to us currently categorise individuals by the Transforming Care criteria. In addition, we are also required to meet the needs of the individual categories within the cohort. Some of whom will not be known to services until crisis is reached. The cohort falls into the following categories of people:

- Who have a mental health condition such as severe anxiety, depression, or a psychotic illness, and those with personality disorders, which may result in them displaying behaviour that challenges.
- Who display self-injurious or aggressive behaviour, not related to severe mental ill health, some of whom will have a specific neuro-developmental syndrome.
- Who display risky behaviours which may put themselves or others at risk and which could lead to contact with the criminal justice system.
- Often with lower level support needs, not traditionally be known to health and social care services, from disadvantaged backgrounds who display behaviour that challenges, including behaviours which may lead to contact with the criminal justice system.
- Who have a mental health condition or display behaviour that challenges who have been in hospital settings for a very long period of time, having not been discharged when NHS campuses or long-stay hospitals were closed.

Profile of Adults for Tower Hamlets

6.3 Despite the difficulties in securing more sophisticated needs data on this very specific group we are able to say confidently that Tower Hamlets has a good record of adults using Assessment and Treatment Units (ATUs) as we have not made a placement into an ATU for the last 5 years. Currently people with learning disabilities and/or autism who have a mental health crisis access mainstream community psychiatric services or Mile End Mental Health Hospital where an inpatient admission is necessary. This is in line with national best practice in this area.

During 2015-16 there were 7 distinct psychiatric admissions for this group, with the average length of stay being 76 days. An audit of these cases indicates these individuals are nearly always in local community placements with low level care packages supported by carers in the family home or nearby.

6.4 Tower Hamlets currently has 3 adults placed by specialist commissioning in low to medium secure units for those who have come into contact with the criminal justice system. Currently these are placed in a medium secure unit in Norfolk, the John Howard centre and Belmarsh Prison. In addition Tower Hamlets also has one young person placed in CAMHS hospital placement.

Adults with LD in Tower Hamlets	**Numbers**
People with LD	4,848
People known to CLDS	850
Total number of People known to CLDS who have been categorised as within this cohort and at potential risk of a future hospital admission	143
Number of people categorised as a medium to high risk of admission	31
Number of out of borough LD placements	114

Number of out of borough LD placements considered to be within this cohort	45
Total number of People known to CLDS who have been categorised as within this cohort, and at potential risk of a future hospital admission, who have previously been admitted to Mile End Centre for Mental Health	43
Number of people with LD who have been admitted to Mile End Centre for Mental Health in 2015/16	7
Number of people with LD currently in secure units	3
Number of people in Assessment Treatment Units	0

6.5 There are thought to be around 1,910 adults with ASD in Tower Hamlets in 2011, approximately 765 of whom do not also have a learning disability.[1]

Profile of Children for Tower Hamlets

6.6 A data snapshot undertaken in Children's Services in 2014/15 tells us that there were 52 young people from Year 9 upwards who were identified by CWD as having Challenging Behaviours: 39 in mainstream education; 78 in special education and 21 in further education. It is worth noting that 22 of young people were in educational placements geographically outside of Tower Hamlets and of this number nearly half are outside of London.

6.7 Currently there are 794 children and young people with a diagnosis of autism.

6.8 Tower Hamlets Youth Offending Team includes a CAMHS worker to support this cohort and ease any internal transfers of the Young Person to the CAMHS Neuro-Developmental Team. It is estimated that there are less than 10 young people with autism/learning disability in touch with Youth Offending Team.

6.9 As part of the delivery phase of the TCP plan Children's and Adults Services will undertake a number of focused pieces of work to build a coherent picture of this group of individuals with detailed case audits to better understand the personal journey behind the numbers:

- Creation of a Risk Register within Children's/Transition to highlight those most at risk of a future hospital admission
- Close working with ELFT colleagues to identify relevant data within CAMHS
- In-depth financial analysis and modelling
- Understanding the numbers of out of borough placements who are hospitalised

[1] Tower Hamlets Joint Strategic Needs Assessment Autistic Spectrum Disorder: Factsheet 2010-2011

- Identification of information relating to the cohort who are not known to social care services
- Further analysis of the out of Borough residential care placements for adults, to establish scope for a more local option

For children's services this largely means utilising existing SEND / Transitions pathways and service offers to scope the resilience of existing services to establish the case for change. The focus will be to link in with existing pieces of work, for example the SEN review, to see if enhancements are required to ensure that behavioural based interventions can be strengthened in order to reduce the impact of these behaviours in adult life.

7. The Main Areas of Regional Focus

7.1 Local planning needs to be creative and ambitious, and based on a strong understanding of the needs and aspirations of people with a learning disability and/or autism, their families and carers, and on expert advice from clinicians, providers and others. In the INEL region and Tower Hamlets more specifically we are starting from a position of strength. We have a solid service model to build on, good local expertise within our services and a well-regarded local treatment offer. The intake teams and mental health and challenging behaviour long term team provide a pathway for this cohort which includes psychological, speech and language input at a minimum in addition to access to other service from the integrated team as appropriate to individual needs. The team also supports wider health access to mainstream health services, for example, through working with health colleagues to ensure reasonable adjustments.

We have relatively low numbers of people overall in inpatient provision; We are committed to providing personalised support and have been active in using mainstream mental health services, and building bespoke support for many people who challenge. The CCG is also currently implementing a pilot project to expand the use of Personal Health Budgets which will expand to comprehensively cover this whole cohort.

7.2 Because we are currently below the national planning assumptions for the use of ATU's, our regional plan will focus on identifying areas where there is a natural and evidenced based case for working sub-regionally to deliver change as well as developing and enhancing our local offer. We envisage that the regional plan will be complimented by a more local delivery plan in each Borough. This will enable us to build on the good practice within each locality to ensure that our use of more institutionalised hospital settings continues to stay low in the future.

7.3 Despite the solid foundation, we know that there is room for improvement and as a region we are identifying common areas where we wish to collaborate to improve, and others where we can use learning from one part of the TCP to inform and improve other parts so that we all fully meet the new Model by 2019. In particular we will design our approach around our new model of care which is built around three core components:

- Prevention and community support that minimises risk of inappropriate admission;
- Focused and high quality assessment, treatment and care while in hospital; and
- Effective and timely discharge supported by a plan that minimises the likelihood of readmission.

7.4 These three core components will each be underpinned by a life course approach in order to ensure that our pathways and service offers are appropriate and relevant to the different life stages and recognise that behaviour that challenges may have different antecedents / causations at those different stages.

7.4 Each of the borough / CCG areas will undertake their own gap analysis to determine the extent of change required at a local level to ensure that the local offer complies with the principles and requirements. We will do this work to a common timeline so that as a partnership we can then review the individual gap analyses together to identify commonalities that can be addressed by jointly commissioning across all or part of the patch (or in partnership with other TCPs if that makes sense). There are currently a number of key opportunities for collaborative working that we wish to further explore in developing a final plan:

- **Out-of-borough residential and specialist educational placements for adults, children and young people**: Although our inpatient numbers are low, as a partnership we have many people living outside our borough boundaries because we have not been able to support them locally, so our plan will explore options to develop a more regional solution with the overall aim of placing both adults and children, where possible, closer to home.

- **Workforce Development:** Enabling providers to support those individuals and their families with the most complex needs builds resilience into community placements and enables people to benefit from skilled staff throughout the range of services they use, both specialist and mainstream. We will ensure a consistent level of expertise in key areas – communication, positive behaviour support and person centred planning and active support. Existing workforce partnerships and the footprint means this is an approach that could benefit from being delivered over a broader footprint.

- **Personal Health Budgets:** Tower Hamlets will take the lead in ensuring there is an aligned approach to the development of the TCP and Integrated personal commissioning objectives. As a national demonstrator site for Integrated Personal Commissioning our IPC cohort includes both adults and children with learning disabilities. We are actively developing integrated planning and budgeting models

building on existing Community Learning disability Teams' care planning processes for adults and the education healthcare planning process with children. The TCP cohort has been identified as an early point of focus for the IPC work (including identification of PHBs for these individuals). Tower Hamlets will be leading the way for our TCP and we will be seeking to learn from them to inform local plans in other boroughs.

8. Co-production, Engagement and finalising the Plan.

8.1 Within a restricted timescale we have been able to gain the input of people and their families through Interviews with families who have recently experienced an inpatient admission, to understand better what might have prevented crisis and admission to hospital and what would enable successful and sustainable support in the community. In developing our final plan we are planning an event for people within the cohort and their families to coincide with National Learning Disability Week in June.

8.2 We also intend to have Service User representation on our Board and are actively seeking someone to fill this position and identifying support needed for it so that it is not a tokenistic gesture, as well as identifying members for the Steering Group.

8.3 There are a number of established Partnership Boards and community groups across the WELC footprint and we are visiting these and other forums to explain the current arrangements and plans gain feedback and invest this feedback into our future planning.

8.4 Specifically in relation to this cohort, the Learning Disability Partnership Board (LDPB) provides a forum for local stakeholders to come together to share best practice and support and agree strategy and plans around learning disabilities in the borough. Adults with Learning Disabilities are represented on the board and attend the second half of the meeting with the above mentioned stakeholders.

8.5 Work is already underway to develop our more local delivery plan with consultation events being held with all key stakeholders including people with a learning disability and/or autism who display behaviour that challenges and their carers during the month of June. This will culminate in a stakeholder workshop to be held on the 1st of July.

Coproduction Events	Date	
TCP Provider Workshop	3rd June	✓
TCP Carer Workshop	24th June	
Tower Hamlets LD sports day	19th May	✓
Carers Forum	10th May	✓

Transforming Care in Tower Hamlets	1st June	
Learning Disability Partnership Board	21st March	✓
Challenging Behaviour Sub-group	25th April	✓
LD Health Sub-group	16th March	✓

8.6 The regional Transforming Care Plan will need to be taken through our governance structures in both the Council and CCG to inform development and co-design implementation. It is hoped to take the TCP programme to the Health and Wellbeing Board on 9th August 2016.

9. COMMENTS OF THE CHIEF FINANCE OFFICER

9.1 There are no financial implications arising directly from this report, which is for noting, however the work proposed is likely to impact on the financial provision of the council and its partners and in that context it needs to be fully aligned with the Outcomes Based Budgeting approach being adopted by the council. This report covers areas of significant expenditure and, given the financial challenges facing the Council and its partners, the opportunities for delivering services in the most effective way is a significant consideration.

10. LEGAL COMMENTS

10.1 The Health and Social Care Act 2012 ("the 2012 Act") makes it a requirement for the Council to establish a Health and Wellbeing Board ("HWB"). S.195 of the 2012 Act requires the HWB to encourage those who arrange for the provision of any health or social care services in their area to work in an integrated manner.

10.2 This duty is reflected in the Council's constitutional arrangements for the HWB which states it is a function of the HWB to have oversight of the quality, safety, and performance mechanisms operated by its member organisations, and the use of relevant public sector resources across a wide spectrum of services and interventions, with greater focus on integration across outcomes spanning health care, social care and public health.

10.3 Section 2B of the National Health Service Act 2006 (as amended by section12 of the Health and Social Care Act 2012) introduced a new duty for all local authorities in England to take appropriate steps to improve the health of the people who live in their areas. The Council is therefore responsible for improving the health of its local population and for public health services including services aimed at reducing reduce inpatient provision and enhance community services.

10.4 This is consistent with the Council's duties under Sections 1-7 of the Care Act 2014, including a duty to promote integration of care and support with health

services and a duty under section 6 to co-operate generally with those it considers appropriate who are engaged in the Council's area relating to adults with needs for care and support. Further, there is a general duty under to prevent needs for care and support from developing.

10.5 The Children Act 1989 provides the legislative framework relating to the Council's duty to promote the welfare of all children and young people in its area. Section 11 of the Children Act 2004 places duties on the Council to ensure its functions are discharged having regard to the need to safeguard and promote the welfare of children. Section 10 of 2004 Act and Section 27 of the 1989 Act refers to the requirement for local authorities to cooperate with other agencies to promote the well-being of children.

10.6 In respect of residential placements for children looked after by the Local Authority, there is a general duty under section 22G of the Children Act 1989 to secure, so far as reasonably practicable, sufficient accommodation within its area which is suitable to meet the needs of looked after children within the Local Authority's area. The aims of the Transforming Care Partnership Plan set out in the body of this report are consistent with these duties.

10.7 When considering the recommendation above, and during the review itself, regard must be given to the public sector equalities duty to eliminate unlawful conduct under the Equality Act 2010. The duty is set out at Section 149 of the 2010 Act. It requires the Council, when exercising its functions, to have 'due regard' to the need to eliminate discrimination (both direct and indirect discrimination), harassment and victimization and other conduct prohibited under the Act, and to advance equality of opportunity and foster good relations between those who share a 'protected characteristic' and those who do not share that protected characteristic.

Linked Reports, Appendices and Background Documents
Linked Report

- NONE

Appendices

- NONE

Local Government Act, 1972 Section 100D (As amended)
List of "Background Papers" used in the preparation of this report

- NONE

Officer contact details for documents:

- N/A

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Health and Wellbeing Board 21 June 2016	Tower Hamlets Health and Wellbeing Board
Report of: Jane Milligan, Chief Officer, Tower Hamlets CCG	**Classification:** Unrestricted
Update on North East London Sustainability and Transformation Plan (NEL STP)	

Contact for information	Helena Pugh, Local Authority Engagement Lead, NEL STP, Tower Hamlets, CCG

Executive Summary

This report provides an update to the Board on the development of the north east London Sustainability and Transformation Plan (known as the NEL STP). While the mandate for the STP development and sign off lies with health partners, local authorities are integral to its development, and have an important role to play in ensuring its success. Appendix A provides an update on the plan's development including the draft vision, priorities and enablers which have been identified to support the work of the STP. (This information has been circulated to the eight local authority areas in NEL.) As part of the STP development, several workshops are being held with key stakeholders to ensure their perspectives are reflected and woven into the STP. A draft 'checkpoint' STP will be submitted to NHS England on 30 June 2016, and further work will continue beyond this to develop the plan in more detail. Additional updates will be presented to the Board as they become available.

Recommendations:

The Health and Wellbeing Board is recommended to:

1. Discuss the approach set out in Appendix A covering the vision, draft priorities and enablers which have been identified to support the work
2. Provide feedback to the NEL STP Team

1. DETAILS OF REPORT

1.1 In December 2015 NHS England planning guidance required health and care systems across the country to work together to develop sustainability and transformation plans (STPs) for accelerating the implementation of the NHS Five Year Forward View (5YFV). England has been divided into 44 areas (known as footprints); Tower Hamlets is part of the north east London footprint. STPs are place-based, five year plans built around the needs of local populations. Further guidance was issued on 19 May which sets out details of the requirements for 30 June. **The guidance states that the draft STP will be seen as a 'checkpoint' and does not have to be formally signed off prior to submission**; it will form the basis of a local conversation

with NHS England in July. Further work will continue beyond this to develop the plan in more detail.

1.2 Based on the recent assessment of our health and wellbeing (Public Health Profile of NEL, March 2016), care and quality and the financial challenges we know that in order to create a better future for the NHS, and for local people to live long and healthy lives, we must make significant changes to how local people live, access care, and how care is delivered. Appendix A provides an update on the progress towards developing the NEL STP, covering the draft vision, priorities and enablers which have been identified to support the work.

2. FINANCE COMMENTS

2.1 The NEL STP will include activities to address current financial challenges.

3. LEGAL COMMENTS

3.1. The NEL STP Board is developing a plan as stipulated by the NHS England guidance.

6. IMPLICATIONS TO CONSIDER

6.1. The Board is asked to note and comment on the proposed content of the Sustainability and Transformation Plan for North East London.

Appendices

A. Briefing for Health and Wellbeing Boards

Delivering the NHS five year forward view: development of the north east London Sustainability and Transformation Plan

Closing the gaps: working together to deliver improved health and care for the people of north east London

Update for Health and Wellbeing Boards
2 June 2016

Background
Across north east London, the health and care system - clinical commissioning groups (CCGs), providers and local authorities are working together to produce a Sustainability and Transformation Plan (STP). This will set out how the NHS Five Year Forward View will be delivered: how local health and care services will transform and become sustainable, built around the needs of local people. The plan will describe how north east London (NEL) will:

- meet the health and wellbeing needs of its population
- improve and maintain the consistency and quality of care for our population
- close the financial gap.

The STP will act as an 'umbrella' plan for change: holding underneath it a number of different specific local plans, to address certain challenges. Crucially, the NEL STP will be the single application and approval process for transformation funding for 2017/18 onwards. It will build on existing local transformation programmes and support their implementation. These are:

- Barking and Dagenham, Havering and Redbridge: devolution pilot (accountable care organisation)
- City and Hackney: Hackney devolution in part
- Newham, Tower Hamlets and Waltham Forest: Transforming Services Together programme
- The STP is also supporting the improvement programmes of our local hospitals, which aim to supports Barts Health NHS Trust and Barking, Havering and Redbridge University Hospitals NHS Trust out of special measures

N.B. The NEL STP will not revisit any previously-made decisions, such as the closure of the A&E at King George Hospital in Ilford.

Additional guidance was issued on 19 May which sets out further details of the requirements for 30 June. **The guidance states that the draft STP will be seen as a 'checkpoint' and does not have to be formally signed off prior to submission**; it will form the basis of a local conversation with NHS England in July.

Developing the submission
A NEL STP Board and Partnership Steering Group meet regularly and are attended by both health and local authority colleagues. A meeting is scheduled for local authority chief executives and updates are being shared at each health and wellbeing board.

The involvement of patients, staff and communities is crucial to the development of the STP. We want it to be based on the needs of local patients and communities and command the support of clinicians, staff and wider partners. Where possible, we will build on existing relationships, particularly through health and wellbeing boards and patient panels and forums.

In addition, we are taking account of recent public engagement on the transformation programmes outlined above and where relevant the outputs are being fed into the STP

process; this will ensure that the views of residents from each local authority area are incorporated into the draft submission. In addition, a specific session was held for Healthwatch and patient engagement forum chairs to discuss the STP and how they would like to be engaged.

Tower Hamlets involvement in the development of the STP
Tower Hamlets health and social care colleagues are actively engaged in the development of the STP including: Jane Milligan (CCG Chief Officer), and Alwen Williams (Barts CE) are all core members of the STP leadership team and members of the STP Board.

- Jane Milligan is the overall lead for the NEL STP
- Alwen Williams is senior responsible officer overseeing the development of the infrastructure work portfolio
- There is Tower Hamlets LA, CCG and provider representation in portfolio workshops, system leadership events (held and planned)
- A session held with Healthwatch and Patient Engagement Forum Chairs, was attended by the Tower Hamlets Healthwatch Chair
- Face to face meetings have been held with the Director and Assistant Director of Adults Services; the Director of Public Health actively participated in the prevention workshop

Following Cheryl Coppell's retirement, Martin Esom (Chief Executive, LB Waltham Forest) is now the Local Authority executive lead supporting the development of the NEL STP.

Our draft vision and draft priorities
Throughout May the STP team has been holding a series of meetings and workshops with key stakeholders including providers, on a variety of topics including prevention, workforce, estates, technology and specialised commissioning. Key priorities raised will be included in the June submission.

Emerging priorities
Based on the recent assessment of our health and wellbeing (Public Health Profile of NEL, March 2016), care and quality and the financial challenges we know that in order to create a better future for the NHS, and for local people to live long and healthy lives, we must make significant changes to how local people live, access care, and how care is delivered. Some of our initiatives will be delivered at local level, some at borough level, some across boroughs and others at NEL level.

For NEL the key emerging areas of focus which we think will be key to addressing our health and wellbeing, care and quality and financial challenges are:

Transformation: focussing on prevention and better care to ensure local people can start well, live well and age well. This will include: whole system prevention and early help; urgent care and mental health. We also see community resilience as having an essential part to play: looking at wider determinants of health (e.g. work, housing, education), to make sure residents have an improved quality of life and confidence to embrace a model of self-care in managing their health and care needs.

Productivity: ensuring our providers and local authorities operate in the most effective efficient way possible to deliver value, considering shared opportunities for development.

Infrastructure: considering the best use of our estates across the system.

Specialised services: establishing sustainable specialised services for NEL, both for residents and those accessing services in NEL.

We have identified the following **enablers** to support our work:

- **Workforce**: recruitment and retention of a high calibre workforce, including making NEL a destination where people want to live and work, ensuring our workforce is effectively equipped to support delivery of new care models, caring for the workforce and reduction in use of bank/agency staff.
- **Communications and engagement:** ensuring stakeholders, including local people, understand and support the need to deliver the Five Year Forward View.
- **Technology:** considering the best use of technology to support and enable people to most effectively manage their own health, care and support, and to ensure a technology infrastructure which supports delivery of new care models.
- **Finance:** access and use of non-recurrent fund to support delivery of the plan, delivering financial sustainability across NEL.

These initial discussions have led us to produce a draft summary of what will be included in the submission (see attached). We welcome the HWBB's views on the following questions:

- Does the vision capture what we need to achieve?
- Have we identified the right priorities?
- How can we continue to work with you as we develop the STP?
- How can we make sure the STP will genuinely improve the lives of local people and care and the quality of health and care services?

Next steps
A meeting for local authority chief executives will take place in June.

The draft of the submission will be shared with NEL STP Board members for review and comment in the second week of June and the draft 'checkpoint' STP will be submitted to NHS England on 30 June. Further work will continue beyond this to develop the plan in more detail and engage with partners on it.

For more information: www.towerhamletsccg.nhs.uk/nelstp or nel.stp@towerhamletsccg.nhs.uk

DRAFT One Page Summary

Vision:

- To measurably improve health and wellbeing outcomes for the people of north east London and ensure sustainable health and social care services, built around the needs of local people.
- To develop new models of care to achieve better outcomes for all; focused on prevention and out of hospital care.
- To work in partnership to commission, contract and deliver services efficiently and safely.

	Prevent ill health and improve wellbeing	Better Care	Productivity	Specialised Services	Enablers for change
High level priorities	• **Reduce prevalence** • **Deliver wider health benefits** • **Support health & well being strategies of our boroughs**	• **Increase independence and deliver better outcomes** • **Reduce bed-base activity to enable growing population** • **Transform care pathways to reduce acute demand** • **Multi-disciplinary working in community hubs/localities**	• **Reduce unit cost** • **Implement new ways of delivery *within and between* providers** • **Ensure effective and efficient use for every pound of health & social care**	• **Optimise specialised services** • **Ensure effective whole pathway with patient at centre**	• **Enable transformation and change**
Content summary	**A. Starting well** to embed healthy lifestyles from birth onwards **B. Living well** to support prevention – obesity, alcohol, smoking, exercise, mental health **C. Ageing well** to keep older people healthier and independent for longer **D. Identify ill health & take early action** e.g. screening programmes, health checks, diabetes prevention **E. Nuturing a social movement for change** to encourage people to support each other **F. Wider changes** to improve the lives and prospects of the population – housing, employment **G. Personal responsibility**, all engaged and empowered to take control of their health	**A. Self-Care** to better manage health conditions and minor ailments **B. Transform primary care** – coordinated, proactive and accessible **C. Supporting children & young people** to live healthy lives **D. Coordinated and consistent urgent and emergency care** **E. Reduce admissions** to hospitals and care homes, and improve discharge, reablement and supporting independence to keep people at home **F. Strong sustainable hospitals** - optimising elective care, ambulatory care, maternity **G. Transform patient pathway** and outpatients, incl **cancer** **H. Mental health** strategy for NEL, delivering parity of esteem **I. Learning disability** care **J. End of life care** to support people to die in the way they wish	A. Standardise and consolidate business support services B. Consolidate clinical support services C. Hospital productivity - Length of stay - Theatre utilisation D. Pharmacy & medicines optimisation E. Workforce, tackling bank and agency challenge F. Capitalise on estates utilisation G. PFI affordability H. Capitalise on our collective buying power	**A. Realise benefits** of world class cancer and cardiac provision **B. Work collaboratively** to manage, commission and deliver specialised services **C. Transformation** programme for specialised services in North East London	**A. Infrastructure/estates optimisation** across NEL for future needs **B. Sustainable workforce** to deliver the strategy **C. Technology** to support full interoperability and move to paper-free services, shared digital health records, e-consultations and other digital services, advanced analytics to support population health **D. Finance** including payment methods to support delivery of system outcomes **E. New models of care delivery** / provider reform **F. Organisational development** to support new delivery models **G. Communications and engagement** **H. Equalities**

Health and Wellbeing Board Tuesday 21 June 2016	Tower Hamlets Health and Wellbeing Board
Report of the London Borough of Tower Hamlets	**Classification:** Unrestricted
Substance Misuse Strategy 2016-2019	

Lead Officer	Corporate Director Communities, Localities and Culture
Contact Officers	Rachael Sadegh, DAAT Co-ordinator
Executive Key Decision?	Yes

Summary

The Council has an obligation under section 6 of the Crime and Disorder Act 1998 to formulate and implement strategies in conjunction with other specified responsible authorities for –

- Reduction of crime and disorder
- Combating the misuse of drugs, alcohol and other substances
- Reduction of re-offending.

The current Substance Misuse Strategy adopted by LBTH and partners in 2012 expired in March 2016. Development of a new partnership strategy commenced in August 2015 and a draft strategy was agreed by MAB for consultation purposes in January 2016. Consultation has now completed and amendments made to the Strategy (Appendix 1).

The Strategy is a partnership strategy and requires agreement at Full Council.

Recommendations:

The Health & Wellbeing Board is recommended to:

1. Note that the Substance Misuse Strategy 2016-2019 is part of the Crime and Disorder Reduction Strategy in Tower Hamlets (the Community Safety Plan);
2. Note that the Substance Misuse Strategy 2016-2019 is part of the Crime and Disorder Reduction Strategy then pursuant to the Council's Budget and Policy Framework Procedure Rules, the Mayor as the Executive has responsibility for preparing the draft strategy for submission to the full Council to adopt;
3. Note that the Action Plan is due to go to the DAAT Board on 11th July 2016 to be further developed;
4. Note that the draft Substance Misuse Strategy 2016-2019 and Action Plan will be referred to the strategic partners for approval that the Strategy be adopted by their respective organisations;

5. Having given careful analysis to the consultation response, review and comment upon the draft Substance Misuse Strategy 2016-2019 as drafted; and
6. Note that if any further changes are made to the draft Substance Misuse Strategy 2016-2019 or if, for any reason, any of the strategic partners do not approve the Strategy then a further report must be submitted to Cabinet for the Mayor to consider and make a fresh recommendation to Full Council.

1. REASONS FOR THE DECISIONS

1.1 The Council has an obligation under section 6 of the Crime and Disorder Act 1998 to formulate and implement strategies in conjunction with other specified responsible authorities for combating the misuse of drugs, alcohol and other substances. This strategy will contribute towards the Crime and Disorder Reduction Strategy in Tower Hamlets (the Community Safety Plan).

1.2 There is wide Partnership support for the Strategy and partners have contributed to, and been consulted on the new strategy for 2016-19.

1.3 The strategy directly supports the achievement of objectives within two of the four Community Plan themes:

- A Safe and Cohesive Community
  - Reduce acquisitive crime and anti-social behaviour by tackling problem drinking and drug use
- A Healthy and Supportive Community
  - Empower people to live healthy lives together
  - Promote good mental health and wellbeing

2. ALTERNATIVE OPTIONS

2.1 The Council has an obligation to formulate and implement strategies in conjunction with other specified responsible authorities for combating the misuse of drugs, alcohol and other substances. Whilst the content may be subject to debate, failure to adopt a strategy is likely to place the Council at risk

3. DETAILS OF REPORT

3.1 Average rates of alcohol consumption across Tower Hamlets are relatively low as a large proportion of the population do not drink. This is estimated to be 29%. However, 26% of people who do drink have harmful or hazardous drinking patterns. Further levels of all recorded alcohol related crime, alcohol related violent crime and alcohol related sexual offences are significantly worse in Tower Hamlets compared to both the London and national averages. In addition, the borough sees higher admission rates of male alcohol related conditions (narrow & broad definitions) compared to London trends.

3.2 It is estimated there are around 3,560 opiate and ‘crack’ users in Tower Hamlets and 54% of residents who responded to the Annual Residents Survey (2014/15) said that drug misuse or drug dealing was a very or fairly big problem.

3.3 By working in partnership, we can seek to address the problems associated with drug and alcohol misuse. Via this strategy, the Council and its partners aim to help people who are affected by substance misuse or dependent upon drugs or alcohol.

3.4 The Substance Misuse Strategy 2016-19 builds upon the 2012-15 (extended to 2016) Substance Misuse Strategy. It is a 3 year partnership strategy and has been developed in conjunction with all partners and other significant stakeholders as well as residents, service providers and service users. It is supported by an evidence base document (see Appendix 2) which details recent needs assessment data as well as consultation undertaken in the development process.

3.5 The Strategy is structured around three 'pillars';

- prevention and behaviour change
- treatment
- enforcement and regulation

3.6 The three pillars are underpinned by a commitment to setting the foundations of achieving success via improved partnership working, governance processes and data intelligence. The approach remains the same as that for the 2012-15 strategy as there was significant support in the consultation for these three areas to remain the focus of the 2016-19 strategy.

3.7 Prevention and behaviour change commitments include: high quality and consistent information; targeted communication and education; multi-agency communications plan; expansion of screening and brief advice for alcohol problems; and access to good quality education in schools.

3.8 Treatment commitments include re-commissioning the drug / alcohol treatment system; recovery orientated treatment; improved response to children of drug / alcohol users; improved access to support around accommodation, employment, economic wellbeing and educational achievement; responding to dual diagnosis; equitable access to services; family based interventions; and specialist support for young people.

3.9 Enforcement and regulation commitments include maintenance and enforcement of the borough wide alcohol control zone; encouraging responsible alcohol sales; management of the night time economy; effective integrated offender management; implementation of conditional cautioning; work with young offenders; and effective communication with the public in relation to drug dealing.

3.10 An action plan has been developed for all three strands of the Strategy and will be overseen by the DAAT Board to ensure accountability and demonstrable improvement activity.

Strategy Development

3.11 A consultation exercise was conducted during November / December 2015 with stakeholders, residents and service users to evaluate the 2012-16 strategy and assess priorities for the new strategy. A total of 529 responses were received and analysed, including 301 resident surveys. A stakeholder workshop was held on 19/11/15 to discuss the findings and provide further

feedback in order to draft the new strategy. Findings from that consultation exercise are provided in the evidence base document (see Appendix 2).

3.12 A draft strategy incorporating the consultation responses and findings from the Needs Assessment was presented to DAAT Board in January and approved for consultation purposes. This draft was published online and a consultation launched on 17th March. The consultation was publicised via East End Life and the Council's website as well as being communicated to a wide range of stakeholders and also to members via the Members' briefing. Nine responses were received during the 4 week consultation period. In follow-up enquiries with stakeholders many felt that they had been consulted sufficiently whilst the draft strategy was in development and were satisfied that their views had been adequately reflected in the draft so saw little need to respond again. To this extent the exercise appeared to have generated a degree of consultation fatigue. The 9 responses received have been summarised in Appendix 2 and show that all respondents agreed or strongly agreed with the different aspects of the draft strategy. The responses do not call for any amendments, whilst comments made by DAAT Board members and MAB members have been used to amend the Strategy in places to clarify certain areas. The amended strategy is provided as Appendix 1.

3.13 Now that the consultation has closed, a draft action plan has been prepared by members of the DAAT Board and will be further developed and approved at the next meeting on 11th July (Appendix 3).

3.14 Strategic partners will be requested via the Community Safety Partnership Board to approve the strategy for adoption by their respective organisations.

3.15 In addition to the Strategy, the accompanying Action Plan will also be submitted to Full Council for sign off.

3.16 The Local Authorities (Functions and Responsibilities) (England) Regulations 2000 provide that the making of a crime and disorder reduction strategy pursuant to sections 5 and 6 of the Crime and Disorder Act 1998 is a function that is required not to be the sole responsibility of the Council's Executive. This prescription is reflected in Article 4 of the Council's Constitution, which includes a crime and disorder reduction strategy in the policy framework. The Substance Misuse Strategy forms a part of the Council's Crime and Disorder Reduction Strategy and it will need to be agreed by Full Council.

4. COMMENTS OF THE CHIEF FINANCE OFFICER

4.1 The report sets out for consideration and approval the Substance Misuse Strategy for 2016-19 following the recent consultation process. The budgeted resource available to the Council to contribute towards the Substance Misuse Strategy is £9m for 2016/17. This is made up of £8.286m from the Public Health Grant allocation which funds both the Drug and Alcohol Team and the Drug and Alcohol Intervention Team formerly the DIP. This is in addition to £0.715m of funding from the Mayor's Office for Policing and Crime (MOPAC)

for the current financial year. The future funding resources from MOPAC are yet to be determined by the new London Mayor.

4.2 The allocated budget for Drugs and Alcohol in 2015/16 included a £0.560m reduction, agreed as part of the savings challenge process for 2015/16. This saving was achieved in addition to a further underspend of £0.592m reported in the 2015/16 outturn. The 2015/16 underspend is a one off, related to the delayed retendering of its services.

4.3 In making the next steps in identifying £2.7 million of Public Health Grant savings, there are a number of options and it is likely the savings can be achieved through a combination of these. This includes the Drug & Alcohol service where further savings were not included in the Phase 1 savings currently out to consultation. An additional £39k of savings has been identified by the service for 2016/17 and further savings of £0.523m for 17/18.

5. LEGAL COMMENTS

5.1 This report relates to the draft Substance Misuse Strategy for 2016-19. There is a statutory requirement for such a strategy as the Council is one of the responsible authorities for Tower Hamlets, within the meaning of section 5 of the Crime and Disorder Act 1998 ('the 1998 Act'). Other responsible authorities for Tower Hamlets include: every provider of probation services in Tower Hamlets; the chief officer of police whose police area lies within Tower Hamlets; and the fire and rescue authority for Tower Hamlets. Together, the responsible authorities for Tower Hamlets are required to formulate and implement strategies for: the reduction of crime and disorder; combating the misuse of drugs, alcohol and other substances; and the reduction of reoffending pursuant to section 6 of the 1998 Act. When formulating and implementing these strategies, each authority is required to have regard to the police and crime objectives set out in the police and crime plan for Tower Hamlets.

5.2 Additionally, when considering this Strategy regard must be had to section 17 of 1998 Act and which places an obligation of the Council to exercise its various functions with due regard to the likely effect of the exercise of those functions on, and the need to do all that it reasonably can to prevent crime and disorder in its area.

5.3 The Crime and Disorder (Formulation and Implementation of Strategy) Regulations 2007 require that there be a strategy group whose functions are to prepare strategic assessments, following community engagement, and to prepare and implement a partnership plan and community safety agreement for Tower Hamlets. The partnership plan must set out a crime and disorder reduction strategy, amongst other matters. The strategy group must consider the strategic assessment and the community safety agreement in the formulation of the partnership plan. The Community Safety Partnership Board discharges these functions in Tower Hamlets.

5.4 With regard to consultation, regulations 12 to 14A of the Crime and Disorder (Formulation and Implementation of Strategy) Regulations 2007 provide for Community Engagement. Further, in consulting, the Council must comply with the common law principles set out in *R v Brent London Borough Council, ex p Gunning,* (1985) and recently approved by the Supreme Court in *R(Mosely) v LB Haringey 2014*. Those are *'First, that consultation must be at a time when proposals are still at a formative stage. Second, that the proposer must give sufficient reasons for any proposal to permit of intelligent consideration and response. Third that adequate time must be given for consideration and response. And finally, fourth, that the product of consultation must be conscientiously taken into account in finalising any statutory proposals."* There is no prescribed period for consultation, but principles of fairness apply such that there should be sufficient time for those being consulted to consider and respond to the matters arising, having regard to their complexity, impact etc. It is necessary to comply with the common law requirement to consider any feedback before making a decision.

5.5 Consultation has been carried out as referred to in paragraphs 3.11 and 3.12 of the report. The responses have been incorporated into the evidence base at Appendix 2 and the consultation responses must be conscientiously taken into account before the final adoption of the Substance Misuse Strategy for 2016-19.

5.6 The adopting of Substance Misuse Strategy for 2016-19 is for Full Council. The Local Authorities (Functions and Responsibilities) (England) Regulations 2000 (as amended) provide that the making of a crime and disorder reduction strategy pursuant to sections 5 and 6 of the 1998 Act is a function that is required not to be the sole responsibility of the Council's executive. In that regard, Part 2 Article 4 of the Council's Constitution includes the crime and disorder reduction strategy sections 5 and 6 of the 1998 Act in the policy framework. The Substance Misuse Strategy forms a part of the Council's crime and disorder reduction strategy and, on this basis, the final making of the strategy is for Full Council.

5.7 However, pursuant to the Council's Budget and Policy Framework Procedure Rules, the Mayor as the Executive has responsibility for preparing the draft plan or strategy for submission to the full Council. It will therefore be for the Mayor in Cabinet to recommend the draft strategy to Full Council. The final approval of the Draft Strategy is subject to the approval by by the respective strategic partners of the adoption of the draft Strategy. The Mayor as the Executive must also carefully analyse the consultation responses before making a decision to recommend to Full Council. Therefore, if any further amendments are made to the draft Strategy then it must go again to Cabinet for the Mayor as the Executive to recommend the amended Strategy to Full Council.

5.8 Before making a fresh Substance Misuse Strategy, 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 don't. Equalities considerations are set out in the One Tower Hamlets Section of the report and there is an Equalities Impact Checklist appended.

6. ONE TOWER HAMLETS CONSIDERATIONS

6.1 Individuals who misuse drugs and/ or alcohol are often marginalised members of the community, many of whom are in poverty. Implementation of this strategy therefore has implications for reducing inequalities and supporting community cohesion.

6.2 Substance misuse issues affect significant numbers of residents in Tower Hamlets directly or indirectly. Treatment and enforcement and regulation activities are provided directly to the public and are covered by the Strategy. All treatment services are monitored regularly to ensure equality of access and outcomes across all 9 protected characteristics. An EQIA (Appendix 4) has been conducted to establish the full impact of the Strategy and implement any measures necessary to mitigate against any differentials.

6.3 The Strategy commits to recommissioning treatment services and it is essential that the new services continue to offer equitable access to all client groups.

7. BEST VALUE (BV) IMPLICATIONS

7.1 It is estimated nationally that for every £1 spent on drug treatment, £2.50 is saved elsewhere. Treatment saves an estimated £960m costs to the public, businesses, criminal justice and the NHS.

7.2 The Strategy commits to a substantial redesign of the drug / alcohol treatment system. A reprocurement process started in July 2015 and has now concluded with new services expected to commence in October 2016. The redesign process is necessary to develop a lean, flexible and client centred treatment system which eliminates duplication, is cost efficient and delivers excellent value for money.

8. SUSTAINABLE ACTION FOR A GREENER ENVIRONMENT

8.1 There are no environmental implications associated with this strategy.

9. RISK MANAGEMENT IMPLICATIONS

9.1 The Partnership currently operates a well attended Drug and Alcohol Action Team (DAAT) Board as a subgroup of the Community Safety Partnership with representatives from all key stakeholders. The strategy action plan will be monitored through the DAAT Board to ensure Partnership involvement.

9.2 Drug and alcohol treatment services and drug / alcohol education in schools are currently funded via the Public Health Grant. Whilst partners

acknowledge the wider savings and benefits that are possible via investment in drug / alcohol services, there are pressures on the Public Health Grant and the future of the grant is uncertain.

9.3 There is a clear commitment within the Community Plan to reducing the impact of drug /alcohol misuse though budget pressures must be acknowledged.

10. CRIME AND DISORDER REDUCTION IMPLICATIONS

10.1 One of the three defining pillars of the strategy is Enforcement and Regulation. Key commitments outlined within this pillar include:

- Maintenance and enforcement of a borough wide alcohol control zone to reduce anti-social behaviour
- Creation of an environment where anybody under the legal drinking age is restricted from obtaining alcohol from licensed premises
- Improvements to the management and planning of the night time economy
- Disruption of the supply of drugs through effective enforcement
- Further development of the Integrated Offender Management Programme
- Work with young offenders to support them into drug / alcohol treatment
- On-going dialogue and effective communication with the public to address concerns about drug use and drug dealing.

10.2 We will measure success against these commitments via; residents' perceptions in the Annual Residents' Survey, Police data where made available and substance misuse related re-offending data.

11. SAFEGUARDING IMPLICATIONS

11.1 Safeguarding vulnerable adults and children is a core requirement when dealing with individuals misusing drugs and / or alcohol. The Strategy recognises this and commits to effective practices and integrated approaches to address the welfare of children of drug or alcohol misusing parents and vulnerable adults. From a prevention perspective, the Strategy commits to educating and building resilience to help those at risk make informed lifestyle choices whilst ensuring that programmes to further improve links and joint planning between support services continue to be progressed. These commitments are expanded in the accompanying action plan.

Linked Reports, Appendices and Background Documents

Linked Report

- NONE.

Appendices

- Appendix 1: Substance Misuse Strategy 2016-19

- Appendix 2: Substance Misuse Strategy Evidence Base
- Appendix 3: Substance Misuse Strategy 2016/17 action plan
- Appendix 4: Substance Misuse Strategy 2016-19 Equalities Impact Assessment

Local Government Act, 1972 Section 100D (As amended)
List of "Background Papers" used in the preparation of this report
List any background documents not already in the public domain including officer contact information.

- NONE

Officer contact details for documents:

- N/A

TOWER HAMLETS SUBSTANCE MISUSE STRATEGY

2016-2019

INTRODUCTION

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, physical and mental health problems.

In 2012 the first partnership substance misuse strategy for Tower Hamlets was published. Building on the successes and learning lessons from the previous strategy this new Partnership substance misuse strategy 2016-2019 has been developed by analysing local need, reviewing the evidence base for effective intervention, and by listening to local stakeholders, service users and residents of Tower Hamlets.

Considerable progress has been made in Tower Hamlets in reducing the harm caused by drug and alcohol misuse. Together across the Council, NHS, police, probation services and voluntary sector we have worked successfully to support people to improve their health and wellbeing, provided high quality treatment and support and effectively tackled antisocial behaviour and crime associated with drugs and alcohol. The commitment of our partners across health, education, youth services, police, probation services and voluntary and community sector is strong and we are resolved to reduce the negative impacts of drug and alcohol misuse in the borough.

Tower Hamlets' Health and Wellbeing Board and supporting strategy provides an excellent platform to strengthen the Partnership's joined up approach in addressing the wide ranging individual and societal harms caused by drug and alcohol misuse.

The strategic approach set out in this strategy supports the delivery of the borough's Community Plan. The Strategy will help deliver the Partnership's stated ambition to support a community which is both 'healthy and supportive' and 'safe and cohesive'.

This strategy outlines Tower Hamlets Partnership's approach to tackling the problems associated with drug and alcohol misuse in the borough. It presents the key commitments over the next three years from 2016 to 2019. The commitments and actions are a response to the identified needs of the borough in relation to substance misuse as well as a direct reflection of the priorities expressed by stakeholders, residents and service users via widespread consultation.

This strategy builds on the existing 'three pillars' approach to tackling drugs and alcohol in Tower Hamlets through; 'Prevention and behaviour change', 'Treatment', and 'Enforcement and regulation' as well as recognising the importance of the wider determinants of health such as education, employment and environmental factors essential as the foundations of health and wellbeing.

Some successes to date

During 2014/15, there were 2,274 adults, resident in Tower Hamlets, in specialist drug and alcohol treatment, the highest in London, with the people accessing our treatment services reflecting the borough's diverse communities.

Over the same period, around 49,995 adults (16+) were supported through Identification and Brief Advice for alcohol use.

In 2014/15 school year over 6,530 young people received substance misuse education.

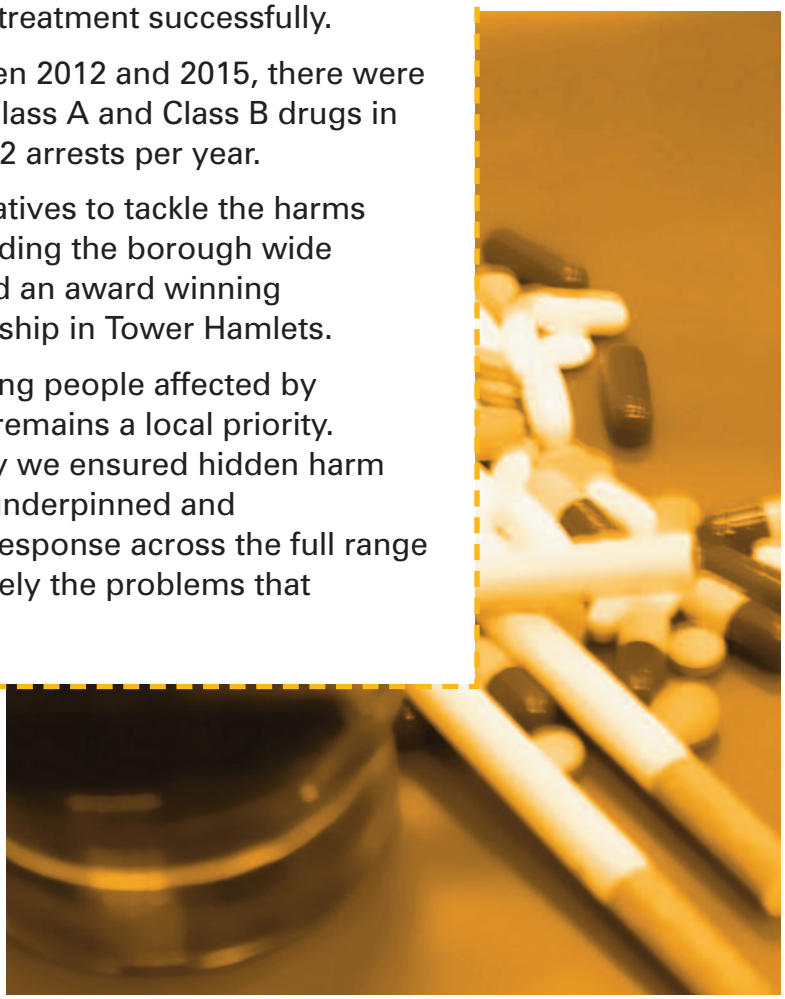
A rolling programme of targeted and whole population alcohol awareness campaigns has been implemented to educate, raise awareness and signpost support services.

More young people are accessing specialist treatment for drug and alcohol use. Last year there were 202 young people aged under 18 in treatment. Over this period 8 out of 10 young people left treatment successfully.

Over the three years between 2012 and 2015, there were 1,306 arrests of dealers of Class A and Class B drugs in the borough, on average 402 arrests per year.

There have been many initiatives to tackle the harms caused by alcohol use including the borough wide controlled drinking zone and an award winning Community Alcohol Partnership in Tower Hamlets.

Protecting children and young people affected by parental substance misuse remains a local priority. Throughout the last strategy we ensured hidden harm and safeguarding children underpinned and strengthened the strategic response across the full range of services to target effectively the problems that families face.



KEY FACTS ABOUT THE CURRENT POSITION ON DRUGS AND ALCOHOL IN TOWER HAMLETS

2

We have updated the information available regarding the nature and scale of drug and alcohol misuse in the borough, and the effects on individuals and the local community.

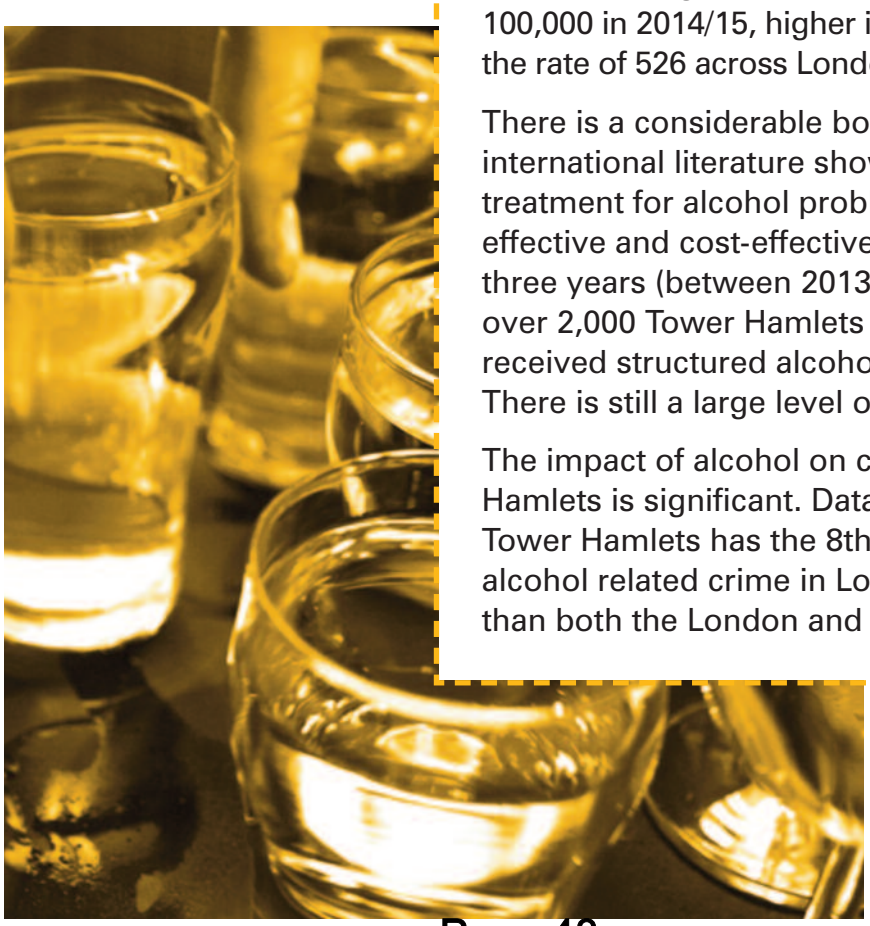
Key local facts: alcohol

There remain a large proportion of specific communities who do not drink due to cultural or religious reasons. Latest estimates (2012/13) suggest 29% of residents in Tower Hamlets do not drink, compared with 17% across England but of those who do drink 27% drink at levels likely to cause harm to their health.

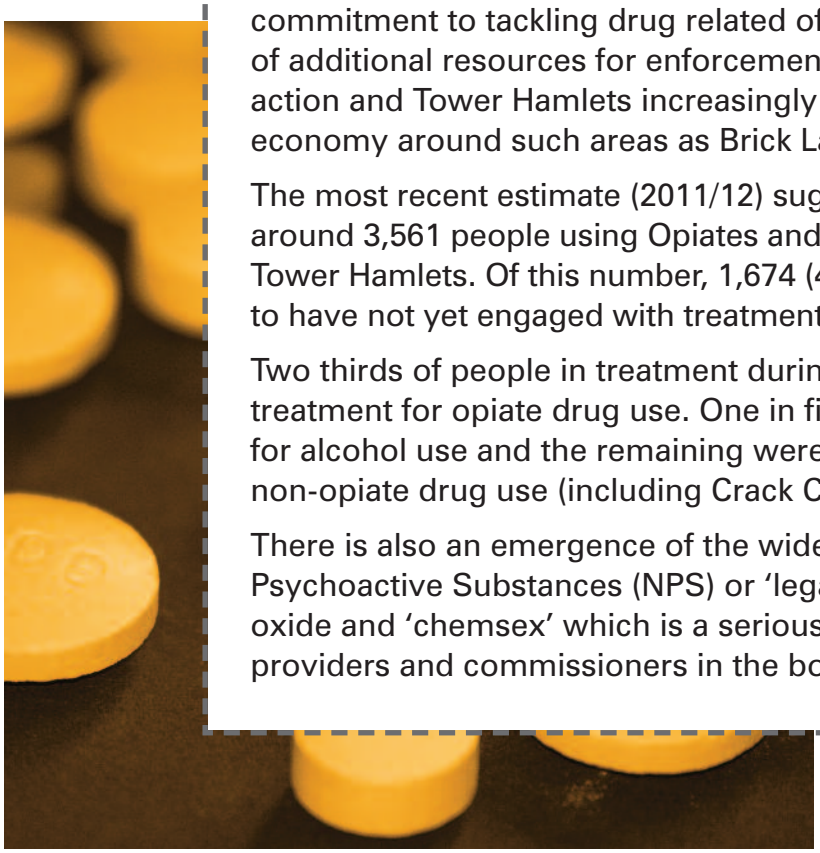
Since 2011 alcohol related hospital admissions in Tower Hamlets have been falling, however still remain above the London average, with a rate of 552 per 100,000 in 2014/15, higher in comparison to the rate of 526 across London.

There is a considerable body of international literature showing that treatment for alcohol problems is both effective and cost-effective. Over the past three years (between 2013 and 2015) just over 2,000 Tower Hamlets residents received structured alcohol treatment. There is still a large level of unmet need.

The impact of alcohol on crime in Tower Hamlets is significant. Data shows that Tower Hamlets has the 8th highest rate of alcohol related crime in London, higher than both the London and England average.



Key local facts: drugs



During 2014/15 there were 2,172 drug related offences (dealing and possession) in Tower Hamlets, an average of 181 offences per month. In comparison to other London boroughs Tower Hamlets has the fifth highest rate, a reflection of a combination of factors including the police commitment to tackling drug related offending, provision of additional resources for enforcement, targeted police action and Tower Hamlets increasingly popular night time economy around such areas as Brick Lane.

The most recent estimate (2011/12) suggests that there are around 3,561 people using Opiates and/or Crack Cocaine in Tower Hamlets. Of this number, 1,674 (47%) are estimated to have not yet engaged with treatment.

Two thirds of people in treatment during 2014/15 were in treatment for opiate drug use. One in five were in treatment for alcohol use and the remaining were in treatment for non-opiate drug use (including Crack Cocaine).

There is also an emergence of the wider use of New Psychoactive Substances (NPS) or 'legal highs' , nitrous oxide and 'chemsex' which is a serious concern for service providers and commissioners in the borough.

What local residents feel

Key findings from residents who responded to the Annual Residents Survey 2014/15:

- 54% felt people using or dealing drugs was a very, or fairly big problem
- 45% felt people being drunk or rowdy was a problem.

Key findings from residents who were consulted on the development of this strategy (General Population Survey, November 2015):

- 67% felt drug and alcohol misuse was a concern where they lived. The main concerns were around antisocial behaviour, drug dealing or drug taking in streets and empty bottles and cans littering the streets.
- 59% felt not enough was being done to address drug and alcohol concerns.

THE TOWER HAMLETS APPROACH

3

Our Partnership Vision

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 continued use. We will bear down on the crime and anti-social behaviour associated with drug and alcohol misuse that impacts on our communities.

The commitments contained in this strategy are the commitments of the local partnership, across health, education, youth services, police, probation services, fire service and the voluntary and community sector.

The Partnership aims to promote resilience, educate and raise awareness of the harms caused by drug and alcohol misuse by ensuring people have access to the right information and key health messages to support people to make more informed choices.

The Partnership aims to help people who are affected or dependent to recover, by enabling, empowering and supporting them to progress along a journey of sustainable improvement to their health, well-being and independence.

The Partnership is very aware of the serious social, psychological and physical complications of drug and alcohol misuse, as well as combined substance misuse and mental health problems (known as dual diagnosis). We will continue to develop our services so that they are attuned to the needs of our residents, some of whom have complex needs, and ensure that Tower Hamlets services continue to develop to effectively meet their needs against a backdrop of reduced funding provided by central government.

Carers and family members of substance misusers can become isolated and feel stigmatised. We will review the existing provision of mainstream support to carers of people with substance misuse issues and seek to better address their needs.

Alcohol, drug misuse and domestic violence are also strongly linked. The Partnership is committed to reducing domestic violence and places safeguarding of both children and vulnerable adults at the heart of its work to identify and address substance misuse in the family.

Through the consultation process of this strategy, partners agreed to continue in the approach and commitment to address the three crosscutting pillars of 'prevention and behaviour change', 'treatment', and 'enforcement and regulation'.

Tower Hamlets has been successful in meeting the needs of many communities, especially BME communities and there is still more work to be done to address the needs of groups underrepresented in treatment services e.g. people with disabilities and LGBT clients.

Prevention and Behaviour Change

Prevention and behaviour change includes the actions we will take to address the wider determinants of health and factors which we know increase vulnerability to drug and alcohol misuse.

We will ensure that accurate information is available on drugs and alcohol, to raise awareness of harms and to support people to make informed decisions to protect their health and wellbeing from substance misuse use.

Prevention and behaviour change also includes the advice and initial support that is available to people who might have early stage problems with drugs and alcohol.

Treatment

Treatment includes the actions we will take to improve the access to and uptake of effective treatment options for people who are dependent on, or who have problems with, drugs and alcohol. Treatment seeks to provide a recovery focused integrated drug and alcohol response to people's different needs whilst supporting harm reduction.

We will ensure our treatment services are available to the wide and diverse communities that make up our local residents throughout the lifecycle, for children and young people, adults and from prenatal to end of life care.

Enforcement and Regulation

Enforcement and regulation includes the actions we will take to enforce the law as it relates to drugs and alcohol, and tackle the anti-social behaviour and crime associated with drug and alcohol misuse.

We will ensure we make full use of the enforcement and regulatory powers available across the partnership targeting those people who profit from the harms associated with substance misuse.

A significant proportion of acquisitive crime is committed in order to provide funds to support drug use. We will continue to ensure that people arrested for serious acquisitive crime are tested for substance misuse and provided both robust enforcement interventions alongside effective treatment for their substance misuse issues.

THREE PILLARS APPROACH

Prevention and Behaviour Change

Including:

- Information and awareness
- Engagement
- Education
- Support for substance misusing population
- Prevention campaigns
- Health messages
- Communications
- Addressing hidden harm and safeguarding vulnerable young people and adults

Treatment

Including:

- Service engagement of those in need
- Accessible provision available to all
- Screening and identification
- Assessment and recovery planning
- Recovery orientated treatment
- Maintaining recovery support, aftercare and re-integration
- Support needs throughout the lifecycle
- Peer mentoring and self help

Enforcement and Regulation

Including:

- Integrated Offender Management (IOM)
- Licencing and regulatory enforcement
- Dedicated and targeted operations
- Enforcement of controlled drinking zone
- Make use of the full use of the range of enforcement and regulation powers available

Setting the Foundations for Effective Impact

- Build an innovative and creative partnership approach to tackling drugs and alcohol misuse
- Develop effective use of gathered and analysed data and intelligence
- Set the right governance mechanisms
- Safeguarding resources to sustain local provision
- Engage in national policy consultation

OUR COMMITMENTS

4

The alcohol-related element of our strategy seeks to improve the quality of life for both Tower Hamlets residents and visitors. We seek to encourage and promote a culture of responsible drinking coupled with responsible management of licensed premises.

The drugs element of our strategy seeks to reduce the demand for drugs through effective education and prevention, to increase the number of people entering services, reducing harm, engaging with and completing treatment in order to recover from drug misuse and to bear down on the crime associated with drugs.

This strategy sets out our priorities for addressing drug and alcohol misuse and how we intend to coordinate and deliver them, with key areas set out below.

ACTION: PREVENTION AND BEHAVIOUR CHANGE

- We will support people to maximise their health and wellbeing by providing targeted communication and community education about alcohol and substance misuse including information about the support services available alongside targeted support for those who are at risk.

- We will ensure that our drug and alcohol information and prevention activity is integrated within our broader health promotion and prevention programmes, to ensure that we offer helpful and accessible information consistently across agencies, and that front-line staff in all relevant settings have the right skills and knowledge to provide information and support, including mental health and wellbeing.

- We will develop a multi-agency communications plan for young people and adults with a focus on harm reduction, safer drinking levels whilst targeting communities with high level of alcohol related harm.

- We will continue to ensure identification and brief advice and, where appropriate, referral on to other agencies, is routinely undertaken on people attending key frontline services across health and social care.

[1] The Chief Medical Officer for England recommends that children should have an alcohol free childhood. If young people aged 15 to 17 years old drink alcohol, it should always be with the guidance of a parent or carer or in a supervised environment. http://www.dh.gov.uk/health/category/publications/

- We will work with universal services to ensure that the partnerships drugs and alcohol messages are consistent and supportive of our aim, to make people better informed and able to make healthier choices to access services.

- We will address hidden harm whilst safeguarding children and vulnerable adults through effective practices with integrated approaches to address the welfare of children of drug or alcohol misusing parents and vulnerable adults.

- We will work in partnership with schools to provide good quality drug and alcohol education, particularly around new psychoactive substances 'legal highs' and support schools to develop effective policies through a "whole schools approach".

- We will target universal prevention activity with young people at risk of drug misuse.

ACTION: TREATMENT SUMMARY

- We have redesigned our treatment services and in 2016/17 we will commission an integrated drug and alcohol treatment system that is recovery focused, helping adults who are addicted or dependent to recover, by enabling, empowering and supporting them to progress along a journey of sustainable improvement to their health, well-being and independence. The treatment system will have strong service user involvement and peer led recovery outcomes.

- The three main elements of this treatment system will deliver outreach and engagement, specialist structured treatment and the provision of the right support to ensure that recovery is lasting.

- We will support treatment that is recovery orientated and will work with established users to maintain their health and well-being and to reduce harm.

- We will support our adult and young people's treatment services to improve their response to the needs of children of drug and or alcohol misusers. We will embed good practice and develop a protocol between children's services (including safeguarding) and treatment providers, train workers and support staff to identify and respond to drug and/or alcohol using parents and their children.

- We will work across our partnership to develop services that address the wider social determinants of health and wellbeing, such as access to accommodation, employment support, economic wellbeing and educational achievement.

- We will strengthen our approach to actively encourage 'hard to reach' and difficult to engage people, such as homeless people, hostel residents, street drinkers and drug and or alcohol misusing offenders, in order to motivate them towards engaging in treatment and progress towards recovery.

- We will continue to increase access and uptake and improve outcomes from services across primary care, secondary care and specialist services.

- We will develop expertise within substance misuse treatment services to respond to the needs of drug and/or alcohol users with mental health needs and support the dual diagnosis pathways between substance misuse and mental health services.

- We will ensure our treatment services are available to people throughout the lifecycle, to support prenatal, postnatal, childhood, youth and the transition to adulthood and to end of life care.

- We will further ensure that access to our services is equitable for all of our local communities.

- We will ensure that family based interventions are integral to treatment provision.

- We will ensure that there is rapid access to intensive specialist support for those young people whose drug and alcohol misuse is already starting to cause harm and to support these young people in their transition to adult services where appropriate.

ACTION: ENFORCEMENT AND REGULATION

- We will maintain and enforce a borough wide alcohol control zone to reduce anti-social behaviour.

- We will actively enforce an environment where anybody under the legal drinking age is restricted from obtaining alcohol through working with licensed premises to ensure responsible alcohol sales, enforcement of any minimum alcohol pricing, and promotion of the available treatment services.

- We will continue to improve the management and planning of the night time economy through strengthening the role of local residents in regulating the environments where alcohol can be obtained through utilisation of licensing, planning and other regulatory powers.

- We will continue to disrupt the supply of drugs through effective enforcement.

- We will review and develop the Integrated Offender Management (IOM) programme to ensure drug misusing offenders receive a holistic support package aimed at stopping offending and drug dependence.

- We will implement conditional cautioning for people whose offending is related to substance misuse (not just class A drugs) actively encouraging and monitoring their engagement with treatment services.

- We will also work with young offenders, with a commitment to support them into treatment and to oversee them both as young people and through their transition to adulthood.

- We will address community concerns about drug use and drug dealing through on-going dialogue and effective communication with the general public.

SETTING THE FOUNDATIONS OF ACHIEVING SUCCESS

5

We believe it is critical to the effectiveness of this strategy to have firm foundations to underpin the three pillars. To this end, we wish to improve our understanding of the needs of our local population in the context of new emergent trends in drug and alcohol use, and to ensure that our responses to drugs and alcohol misuse lead to effective outcomes for the whole community. To this end:

- We will develop and build an innovative and creative partnership approach to tackling drug and alcohol misuse.
- We will ensure effective use of gathered and analysed data and intelligence across the partnership, to better understand and address the harms caused by drug and alcohol misuse. We will utilise national and local information on drugs and alcohol to create and monitor a performance dashboard that combines prevention, treatment and offending data.
- We will set the right governance mechanisms to ensure the priority actions are reported through the DAAT Board and to both the Health and Wellbeing Board and Community Safety Partnership Board.
- We will constantly review the impact of our services on underserved communities through a commitment to monitor uptake and access to treatments ensuring services are accessible.
- From an intelligence perspective we wish to continue to build an understanding of:
  - The impact on our population of the use of new drugs such as "legal highs", steroids, and over the counter and prescribed medicines, and will ensure that these areas are considered in future needs assessments.
  - Drug markets, distribution and trafficking, to inform our approach to enforcement and community development.
  - Treatment outcomes in other areas with similar treatment populations, to measure how effective our services are, and to help us to further improve them.
  - Drug and alcohol data and intelligence through developing a drug and alcohol related dashboard bringing together prevention, offending and treatment data.
  - Monitor and review cases of drug and alcohol related deaths and implement harm reduction strategies.
- We will work with partners in commissioning, primary and secondary care to prove the value of our drug and alcohol recovery services to safeguard the resources for this important work.

NEXT STEPS

6

The DAAT Board will oversee the implementation of the strategy.

We will develop an annual action plan which will provide the performance management framework against which we will measure our success. These action plans will be monitored and reviewed through the course of this strategy and we will drive delivery against set targets. We will be regularly communicating our achievements through our websites and newsletters.

As drug and alcohol misuse affects many of the partnership's strategic priority areas, reports on progress will also be provided for other relevant boards such as the 'Safe and Cohesive', 'Healthy Communities' and 'Health and Wellbeing' Boards as appropriate.

We intend to ensure that our analysis of need and demand is carried out in a structured and ongoing manner, informed by, and in the context of, a Joint Strategic Needs Assessment.

We will strengthen our cross partnership work by designating within each organisation a senior champion to own, and contribute to the effective delivery of this strategy and who will be responsible for tasks in our action plan.

We believe that service users and carers have a uniquely valuable contribution to make in the development, improvement and monitoring of services. We will, therefore, further develop mechanisms for effective service user engagement, including developing and implementing a Service User and Carer Charter and supporting the development of peer support/mentors and service user recovery champions. We will also ensure that support is available for carers or significant others who are affected by someone else's drug or alcohol misuse.

Operationally we will continue to ensure that our services and interventions are meeting the needs of the entire Tower Hamlets community, regardless of age, disability, gender assignment, marriage or civil partnership, pregnancy or maternity, race, religion and belief, sex, and sexual orientation, and will therefore work with our commissioned providers to monitor equity of access through audits.

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LONDON BOROUGH OF TOWER HAMLETS SUBSTANCE MISUSE STRATEGY EVIDENCE BASE

April 2016

Ottaway Strategic Management

www.ottawaystrategic.co.uk

London Borough of Tower Hamlets, Substance Misuse Strategy Evidence Base

Report by Ottaway Strategic Management ltd

April 2016

Contents

Tower Hamlets Substance Misuse Strategy 2016-19

Evidence Base

1 Summary

1.1 This document sets out the evidence base for the new Tower Hamlets Substance Misuse Strategy 2016-19. Extensive consultation took place with key stakeholders, service users, young people and residents of Tower Hamlets, through interviews, focus groups and surveys. Detailed findings from the programme of consultation are set out in the following sections.

1.2 The consultation process sought to review the outcomes and priorities of the current Substance Misuse Strategy 2012-16; to assess the three pillar approach – 'prevention and behaviour change', 'treatment', 'enforcement and regulation' and determine the borough's priorities over the next 3 years.

1.3 It has been estimated nationally that the total cost of problematic drug use to society is around £4 billion a year, and alcohol misuse is estimated at £21 billion a year. However, it is also a fact that treatment can be cost effective – for every £1 spent on alcohol treatment, £5 is saved elsewhere[1]. For drug misuse treatment, similar financial benefits are possible: for every £1 spent on drug treatment in Tower Hamlets, £2.82 is saved on health and crime costs[2].

1.4 This does not take account of the additional benefits derived from the impact of other prevention and early intervention initiatives that take place such as brief advice and information for alcohol use, programmes of awareness raising, education and campaigns promoting healthy lifestyle options.

1.5 In Tower Hamlets the prevalence rate of problematic drug use (Opiate and / or Crack Cocaine) is 18 per 1,000 population aged 18-64, 16 per 1,000 for Opiate users, 15 per 1,000 for Crack Cocaine users and 4 per 1,000 for injecting drug users. Rates in Tower Hamlets are significantly higher compared to the London and national averages.

1.6 There are estimated to be 3561 Opiate and / or Crack users (OCUs), 3047 Opiate drug users, 2955 Crack Cocaine users and 773 injecting drug users in the borough. Around 47% of Opiate and / or Crack users, 42% of Opiate and 53% of Crack users are not engaged with treatment services.

1.7 The average rate of alcohol consumption across Tower Hamlets is relatively low, due to a large proportion of the population who do not drink. Latest estimates suggest 29% of residents in Tower Hamlets do not drink, compared with 17% across England.

[1] https://www.alcoholconcern.org.uk/help-and-advice/statistics-on-alcohol/
[2] Based on spending review 2012-2015, NDMTS Value for Money

1.8 Since 2011 alcohol related hospital admissions in Tower Hamlets have been falling, however still remain above the London average, with a rate of 562 per 100,000, higher in comparison to the rate of 531 across London.

1.9 Fundamentally, the results of the consultation indicate a strong commitment among partners, service users and residents for the continuation of the 'three pillar' approach adopted in the current Substance Misuse Strategy, in tackling drugs and alcohol in Tower Hamlets. Focusing on 'prevention and behaviour change', 'treatment' and 'enforcement and regulation' as the key themes of each pillar.

1.10 Throughout the consultation process it was evident that drugs and alcohol was a particular concern among residents of Tower Hamlets. It was broadly agreed that the most priority actions to address drugs and alcohol were still relevant and should continue and be further developed over the next 3 years. In particular, there was a commitment to continue supporting people to make health lifestyle choices, early intervention and support for young people, addressing the needs of children of drug and alcohol using parents, supporting those that have never been in treatment, enforcing borough wide alcohol control and disrupting the supply of drugs. This came strongly through the findings from stakeholder interviews and survey, residents survey, service users and young people focus groups.

1.11 There was however a strong sense that in order to achieve these priority actions there must be ownership of, and commitment to, the strategy among partners. The strategy must be underpinned by a robust foundation and the delivery of an action plan to monitor and assess the impact the strategy will have on residents of Tower Hamlets.

1.12 The following sections outline the approach to this work and the key findings from the programme of consultation and evidence gathered in the development of this Strategy.

2 Executive Summary of the Tower Hamlets Substance Misuse Needs Assessment 2015

Overview

2.1 Conducting a Substance Misuse Needs Assessment is important to treatment planning and commissioning as it reviews service demand, offers comparison to relevant regional and national baselines and assesses local partnership performance over time.

2.2 The 2014/15 needs assessment reviewed the needs of the Tower Hamlets' substance misusing population to support the Drug and Alcohol Action Team (DAAT) and the wider partnership to respond to future treatment demand. The document was completed in Autumn 2015. Data included in the document represents information available at the time.

2.3 Before the completion of the 2014/15 needs assessment, the Partnership reviewed existing treatment services and completed another in-depth Substance Misuse Needs Assessment 2013/14 in March 2014. This initial work informed the process of re-procuring the drug and alcohol services in the borough.

2.4 In the context of the re-procurement exercise, the latest needs assessment 2014/15 provides an update of key data sets, reviews demand and discusses recent changes and new emerging trends in the borough. The needs assessment 2014/15 contains a wealth of data to contextualise and define services after the completion of the re-procurement process in 2016.

2.5 The needs assessment includes data based on the new Public Health England (PHE) / National Drug Treatment Monitoring System (NDTMS) drug categories which were introduced in 2014. The document includes the new PHE Needs Assessment data set and acts as the evidence base for the future Tower Hamlets Substance Misuse Strategy.

Context and Impact of commissioned substance misuse services

2.6 Contextual information

- There are estimated to be ***3,561 OCUs***, 3,047 opiate drug users, 2,955 Crack users and 773 IDUs in the borough. ***Prevalence estimates*** suggest that ***numbers are increasing*** compared to the last two years.
- Around 47% of OCUs, 42% of Opiate and 53% Crack users are not engaged with treatment services.
- ***OCUs*** in effective treatment make up a huge proportion of the ***treatment population*** in Tower Hamlets (nearly ***85%***).
- ***OCUs*** in treatment have ***fallen slightly*** by 1.6% over the past three years.
- ***Women are under-represented*** in treatment in the community (at 20%). The rate is below the London and national rates. Considerable numbers of female needle exchange users indicate unmet demand.

- Estimates indicate that a total ***of 9,878 residents are high risk drinkers***, and 17,652 consume alcohol at binge drinking level. The contrast between those estimated to have alcohol problems and those in treatment is great.
- Alcohol is an ongoing concern locally, reflected in alcohol related incidents, hospital admission and high numbers of Audit C positives across the partnership.
- ***Hospital admissions*** with alcohol related conditions (Narrow definition) are ***slightly decreasing*** in the bough. The decrease is based on lower numbers of male admissions.
- Alcohol related ***Ambulance callouts*** peaked in 2010/12 and have ***decreased*** over the last 4 years. However, high numbers of call outs originate from the Spitalfields & Banglatown, Bethnal Green, Whitechapel and Weavers areas.
- Tower Hamlets had the 8th highest rate of recorded crime attributable to alcohol, greater than London and England.
- ***Alcohol related Violent Crime rate*** in Tower Hamlets is higher than London and England and currently the ***4th highest in London***.
- High numbers of Audit C positive completions in local GPs indicate a high unmet alcohol related need in the borough.

2.7 There are a range of performance highlights and data trends which have emerged from the borough's treatment system. The key impacts of commissioned services are:

- In 2013/14 there were 732 new entries into drug treatment; 2,086 people in treatment and 611 people exiting the treatment system.
- ***More people were in treatment*** than the year before. Tower Hamlets has seen a downward trend in the number of ***clients in treatment***, from 2,763 in 2010/11 to 2,189 in 2012/13. However, this ***trend*** has been ***reversed with 2,212 clients in treatment in 2013/14***.
- The largest treatment providers with the highest volume of clients were CDT Lifeline (883), THCAT (620), Tower Hamlets Specialist Addictions Unit (338), Health E1 (264) and NAFAS (184).
- ***Both Public Health Outcomes Framework (PHOF) targets*** (2.15 a & b): Non-representation back into treatment of opiate & non opiate clients who successfully completed treatment ***are improving***.
- As a percentage of the numbers in treatment 6.8% opiate clients successfully completed treatment compared to 7.6% national average. However, ***successful completions are improving*** after very low rates back in September 2013 (5.1%).
- The number of clients citing opiate use fell by 9%, from 1,096 (2011/12) to 993 (2013/14). Those citing the use of ***crack dropped at a much faster rate*** (15.7%).
- ***Cocaine users*** in treatment ***increased*** by 29% between 2011/12 and 2013/14 while Cannabis users increase by 5%.
- ***Successful completion rate for alcohol*** users ***dropped to*** around 20% in 2013/14, around half of the national rate.

Key issues emerging from the assessment

- Successful completion of drug treatment is increasing but further improvement is needed.
- Alcohol successful completions need to improve and unplanned exits need to decrease.
- Treatment compliance remains a challenge across the treatment system. Important work is already going on to reduce the numbers of alcohol unplanned exits as some of the low rates are down to poor data recording by some providers.
- Re-presentations have improved but attention to re-presentation rates remains critical to maintain positive trends.
- There is further potential for additional treatment entries / new presentations as some services are not operating at full capacity.
- High levels of client complexity and diversity within the system remain a key characteristic and challenge.
- Relative low numbers of females and young adults in treatment remain a crucial challenge.
- Around 85% of the borough's drug treatment population were OCUs. In addition, an increase of Cannabis and Cocaine using clients accessing treatment represent need but also successful engagement work.
- Successful treatment of non-Opiate clients should remain a key focus and be advanced further.

The Full Substance misuse Needs Assessment 2014/15 can be accessed on the Tower Hamlets website following the link below.

http://www.towerhamlets.gov.uk/Documents/Adult-care-services/Social-issues/Substance-misuse/Substance_misuse_assessment.pdf

3 Strategy Design Engagement Process

3.1 Phase one of the consultation process involved obtaining the views of key stakeholders, drug and alcohol service users and general public perceptions:

- 21 face to face and telephone interviews with key stakeholders
- Substance Misuse Strategy Development – Stakeholder Workshop held at the Tower Hamlets Drug and Alcohol Network (DAN meeting) on 11th September 2015
- 5 service user focus groups with:
- opiate users (15 participants) 30th October 2015
- non-opiate users (10 participants) 27th October 2015
- alcohol users (14 participants) 12th October 2015
- targeted focus groups with women (3 participants) 21st October 2015
- homeless services users (2 participants) 12th November 2015
- 1 focus group with the Youth Council (10 participants) 12th November 2015
- 63 stakeholders participated in the Stakeholder Survey
- 301 residents participated in the Resident Telephone Survey
- 115 drug and alcohol service users participating in the Service User Survey
- Substance Misuse Strategy Development – Stakeholder Workshop held at the Shadwell Centre, partnership stakeholder engagement 19th November 2015

3.2 The consultation in phase one informed the key priorities and actions for the draft strategy.

3.3 The draft strategy was open for consultation on the 17th of March 2016 among the residents of Tower Hamlets and across the partnership via the council's website. In addition, the link was circulated to representatives across the partnership, including voluntary sectors services.

4 Substance Misuse Strategy Development 2016-19 Stakeholder Workshop (held at Drug and Alcohol Network (DAN) meeting)

4.1 20 stakeholders attended the DAN meeting, representation from a wide range of partner agencies including, CCG, treatment services (young people and adults), hostels, social care, and substance misuse commissioners.

Theme	Key Issues	Priorities going forward
Evaluating the Substance Misuse Strategy 2012-16	Outcomes relating to drugs	• All stakeholders felt the outcomes relating to increasing the number of drug users entering and engaging with and completing treatment had been met • There were mixed perceptions on the success of enforcement in relation to drugs, however there was acceptance that most stakeholders were not knowledgeable on enforcement • 50% perceived the enforcement action 'reducing the impact of drug related antisocial behaviour' was neither met nor unmet, and 50% perceived it was unmet • 25% perceived the dealer a day initiative succeeded in restricting the drugs trade, 25% perceived it was neither met nor unmet and 25% perceived it was unmet
	Outcomes relating to alcohol	• 25% perceived there had been a reduction in the ill health caused by alcohol, 25% perceived it was neither met nor unmet and 50% perceived it was unmet • 25% perceived there had been a reduction in alcohol related violence, antisocial behaviour and related domestic violence, 25% perceived it was neither met nor unmet and 50% perceived it was unmet • 75% perceived there had been a reduction in alcohol related antisocial behaviour as perceived by local communities, 25% perceived it was unmet • 50% perceived there had been a reduction in alcohol related harm to children and young people and 50% perceived it was unmet
Three Pillars Approach	Prevention and behaviour change, treatment, enforcement	• There was broad agreement within the workshop that the current three themes; prevention and behaviour change, treatment and enforcement and regulation were still

Theme	Key Issues	Priorities going forward
	and regulation	relevant.
Priorities going forward	Priority actions: prevention and behaviour change	In order of priority (top 4): • Multi-agency communications plan focussing on harm reduction • Working across partnership agencies to address wider determinants of health • Access for young people to good quality education • Supporting people to make health lifestyle choices
	Priority actions: treatment	In order of priority (top 4): • Rapid access to specialist treatment for young people • Family based interventions • Encouraging difficult to engage people to enter treatment • Increased uptake and improved outcomes across primary and secondary specialist services
	Priority actions: enforcement and regulation	In order of priority (top 4) • Disrupting the supply of drugs • The Integrated Offender Management (IOM) scheme • Effective communication of successful operations to reduce community concern • Working with licensed premises to combat under age sales

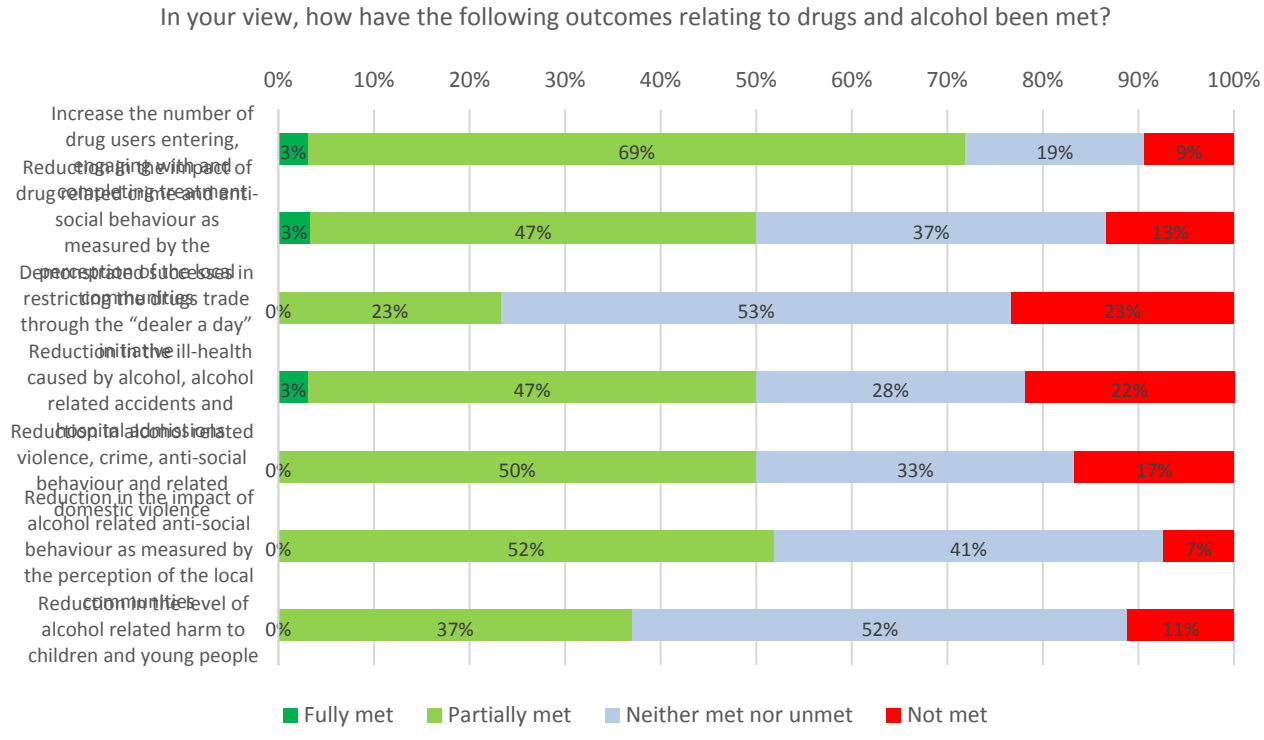
5 Stakeholder Survey

5.1 In total 63 participants responded to the stakeholder survey. Respondents were from a wide range of work areas, 33% were from general practice, a further 20% from pharmacies, 8% from the clinical commissioning group, 8% drug services, 6% public health commissioning. In addition, participants were members, acute trust services, criminal justice services (DIP, police, and the national probation service).

Evaluating Outcomes of the Substance Misuse Strategy 2012-15

5.2 Participants were invited to rate how well the outcomes of the current drug strategy 2012-15 had been met:

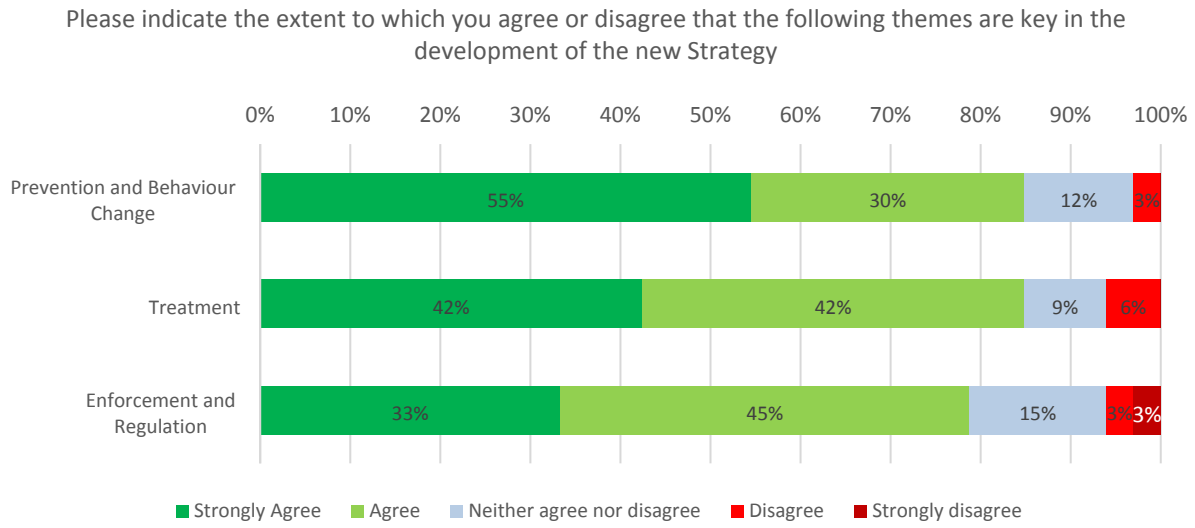
- 72% felt 'an increase in the number of drug users entering, engaging with and completing treatment' had been partially or fully met.
- 50% felt 'a reduction in the impact of drug related crime and anti-social behaviour as measured by the perception of the local communities' had been had been partially or fully met.
- 23% felt 'demonstrated successes in restricting the drugs trade through the "dealer a day" initiative' had been had been partially or fully met.
- 50% felt a 'reduction in the ill-health caused by alcohol, alcohol related accidents and hospital admissions' had been partially or fully met.
- 50% felt a 'reduction in alcohol related violence, crime, anti-social behaviour and related domestic violence' had been partially or fully met.
- 52% felt a 'reduction in the impact of alcohol related anti-social behaviour as measured by the perception of the local communities' had been partially or fully met.
- 37% felt a 'reduction in the level of alcohol related harm to children and young people' had been partially or fully met.



Support for the Existing 3 Pillars Approach and the Themes

5.3 Participants were invited to agree or disagree with the following themes as key in the development of the new strategy:

- 85% agreed or agreed strongly that 'Prevention and Behaviour Change' is a key theme.
- 84% agreed or agreed strongly that 'Treatment' is a key theme.
- 78% agreed or agreed strongly that 'Enforcement and Regulation' is a key theme.

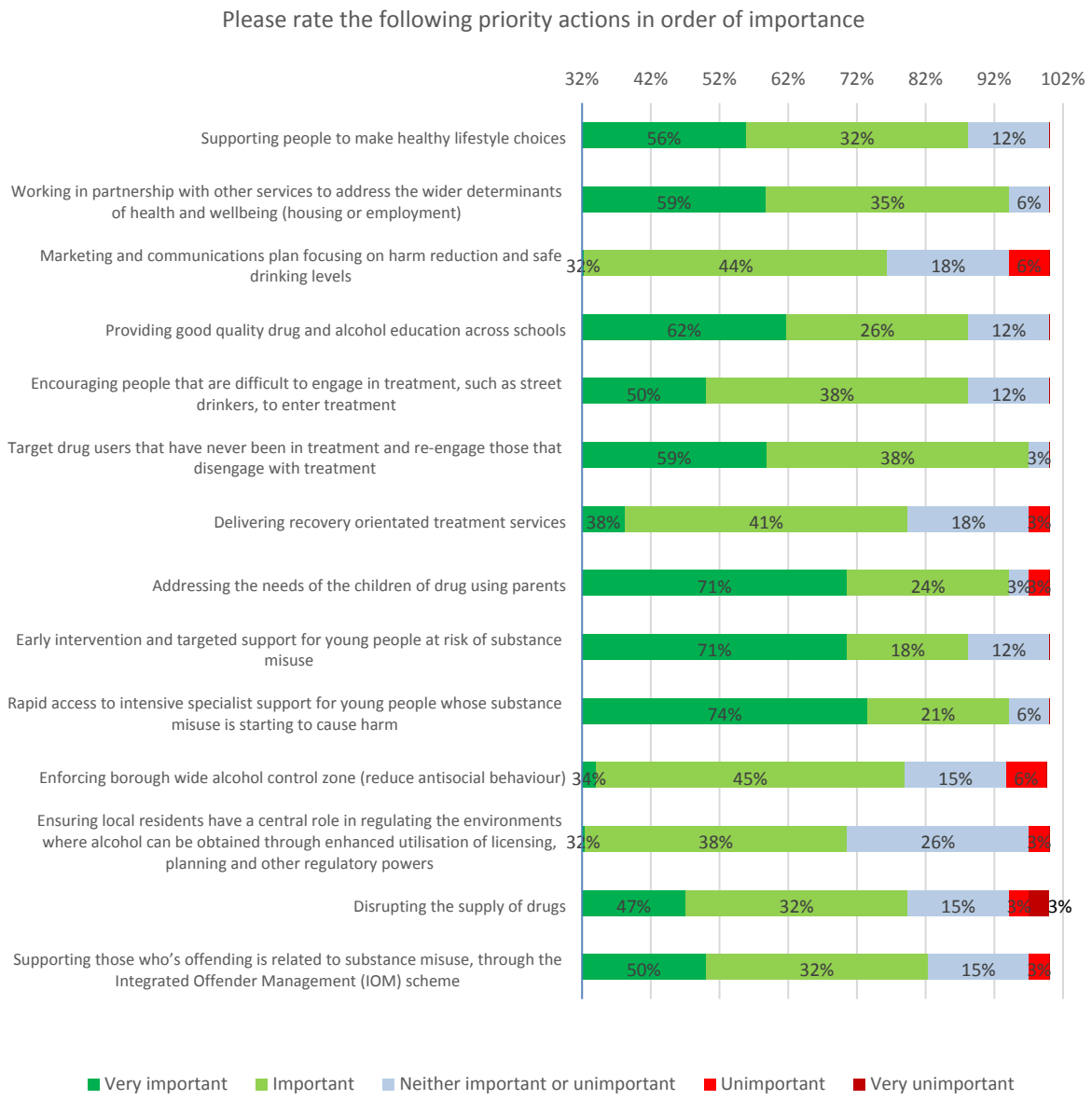


Priorities

5.4 Participants were invited to agree or disagree with the following priorities as key in the development of the new strategy:

- 88% felt 'supporting people to make healthy lifestyle choices' was either important or very important.
- 94% felt 'working in partnership with other services to address the wider determinants of health and wellbeing (housing or employment)' was either important or very important.
- 76% felt 'marketing and communications plan focusing on harm reduction and safe drinking levels' was either important or very important.
- 88% felt 'Providing good quality drug and alcohol education across schools' was either important or very important.
- 88% 'encouraging people that are difficult to engage in treatment, such as street drinkers, to enter treatment' felt was either important or very important.
- 97% felt 'Target drug users that have never been in treatment and re-engage those that disengage with treatment' was either important or very important.
- 79% felt 'delivering recovery orientated treatment services' was either important or very important.
- 94% felt 'addressing the needs of the children of drug using parents' was either important or very important.
- 88% felt 'early intervention and targeted support for young people at risk of substance misuse' was either important or very important.

- 94% felt 'rapid access to intensive specialist support for young people whose substance misuse is starting to cause harm' was either important or very important.
- 79% felt 'enforcing borough wide alcohol control zone (reduce antisocial behaviour)' was either important or very important.
- 71% felt 'ensuring local residents have a central role in regulating the environments where alcohol can be obtained through enhanced utilisation of licensing, planning and other regulatory powers' was either important or very important.
- 79% felt 'Disrupting the supply of drugs' was either important or very important.
- 82% felt 'Supporting those who's offending is related to substance misuse, through the Integrated Offender Management (IOM) scheme' was either important or very important.



Other Priorities

5.5 Participants were invited to add other priorities they considered were important to the development of the new substance misuse strategy:

- The priority consideration most frequently noted was the need to address new psychoactive substances (NPS) or legal highs, through more education, advice, information and awareness raising of the effects of using such substances.
- There was support of more harm minimisation and preventative work to become a priority consideration, particularly in light of NPS.
- It was also noted that a priority around increased emphasis on recovery from drug use and the continuity of support for drug and alcohol users to achieve sustained long term recovery.

6 Stakeholder Interviews

6.1 31 key stakeholders were interviewed about their thoughts on the 2012-16 strategy and their views on priorities for the 2016-19 strategy.

6.2 The majority of stakeholders interviewed indicated their support for the Pillar approach in the development of the new Substance Misuse Strategy, with themes being, **prevention and behaviour change**, **treatment** and **enforcement and regulation**.

Table 2: Themes, key issues and priorities going forward raised through the stakeholder interviews

Theme	Key Issues	Priorities going forward
Prevention (raising awareness)	Drug and alcohol awareness and education programmes	• Borough wide programme of drug awareness and training targeting local communities of Tower Hamlets, including the specific needs of the diverse groups such as the Somali and Bangladeshi communities.
	Harm minimisation	• Continue to develop policies and services that work to reduce the health, social and economic harms to individuals, communities and society that are associated with the use of drugs and alcohol
	Brief information and advice	• Accessible information, supporting brief information and advice • Utilisation of effective outreach to support brief information and advice
	Communications and marketing	• The perception of drug and alcohol treatment in Tower Hamlets is that it exists for the most chaotic and highly dependent drug and alcohol users. • Rebranding of treatment services to include all levels of need and all substances • Effective marketing of treatment options available among professionals and residents of Tower Hamlets
Treatment and Recovery Support	Adult drug and alcohol treatment services are currently being recommissioned. This has involved consolidating current treatment provision into three main integrated drug and alcohol services – outreach, treatment and recovery support. This has involved shifting the balance of commissioning towards prevention and outcome based services.	
	Meeting needs of women as drug and alcohol users	• Improve engagement of women into treatment services though access to child care, social care, midwifery, schools, health visitors, GPs

Theme	Key Issues	Priorities going forward
		Pregnant women • Pregnant women with the most complex needs are presenting with problematic drug and alcohol use and often homeless, engaging and then retaining these women in specialist substance misuse midwifery services is often difficult. • Support women at the prenatal and postnatal stages through improved pathways between community drug and alcohol treatment service and specialist substance misuse and midwifery services • Increased awareness and education about family planning and contraception is key, particularly around choices for long term contraception, through pathways into sexual health services. BME women • Anecdotally, there is a growing concern around the level of alcohol use among young Bangladeshi women who are not accessing treatment, due to stigma, shame and cultural barriers preventing them from seeking help.
	Available treatment options	• Clarity around what is available across Tower Hamlets treatment services for professionals in contact with drug and alcohol users • More abstinent based treatment options
	Recovery focus	• Increase emphasis and treatment focus on an individual's own motivation, priorities and the goals to want to recovery will increase their success in treatment. Holistic care planning is critical that takes into account an individual's wider support needs • Post treatment support for those successfully completing treatment is critical in sustaining long term recovery from substance misuse, this includes training programmes, learning basic skills such as literacy though conversation clubs, facilitating access to social networks etc.
	New Psychoactive Substances (legal highs)	• Anecdotally, there is a concern that people, in particular young people, are increasingly using new psychoactive substances (NPS). • Treatment services need to respond to new emerging drugs, particularly around advice, information, and awareness raising about the health risks and support into treatment

Theme	Key Issues	Priorities going forward
		• Advice, information, education and awareness raising need to be extended to communities across Tower Hamlets, as the use of NPS is largely reported in younger people
	Housing support and employment opportunities	• Access to suitable accommodation, maintaining tenancies and where necessary advocacy support. • Develop joint working protocols with Job Centre Plus (JCP)
	Welfare benefits and debt management	• Increase awareness and understanding of the changes introduced through the Welfare Reforms, in particular around sanctions imposed on benefits for non-attendance at treatment appointments. • Develop joint working protocols with housing departments.
	Workforce development	• Cultural shift in the way treatment services are delivered, and to whom they offer services. • Rebranding so that treatment services are not perceived as being only available to high complex needs (such as class A drug users) • Upskilling staff • Staff skills need to be developed regularly to ensure treatment services are delivering services that are evidence based.
	Mental Health Need	• Develop dual diagnosis provision within drug and alcohol treatment services • Develop pathways for drug and alcohol users to access mental health services
	Addressing wider physical health needs	• Recognising and addressing health needs must be the underlying factor in the treatment of people with substance misuse • Responding to increasingly challenging physical health needs in addition to substance use. • Addressing the physical health needs of people misusing drugs and in particular harmful alcohol use is critical • Improved links between treatment services and primary care
Young People	School and college based interventions	• Continue to implement whole schools approach across schools, colleges, pupil referrals units to support schools and colleges to deliver:

Theme	Key Issues	Priorities going forward
		• Drug and alcohol education training, lesson plans and resources to enable school staff to drug and alcohol education programmes. • School drug and alcohol education policies • Drug education delivered by specialist teams through Healthy Lives • Workshops aimed at increasing parental awareness of substance use among young people, the harms caused and health risks
	Referrals to treatment	• Improve referrals of children and young people into treatment services, through training across all services in contact with vulnerable young people to better identify substance misuse needs (including LAC, CAMHS, Child Protection teams)
	NSP and alcohol use	• There is a change in substances being used by young people with increasing use of spirits and NPS that will need to be addressed through education, awareness, health risks and treatment
	Hidden Harm	• Continue to address the needs of children of parents using drugs and alcohol
Reducing Offending	Governance Structure	• Develop the Re-Offending Board with overarching governance of IOM
	Drug Testing	• Review the effectiveness of targeted drug testing and assess the level of drug testing in Tower Hamlets against other London boroughs.
	Conditional Cautioning	• Implementing conditional cautioning for people who are offending and using substances, extending this to include all drugs (not just class A drugs) as well as alcohol. [inspector's authority] • Target conditional cautioning for young offenders • Police working with the Drug Interventions Programme (DIP) to develop treatment package that forms the condition of a police caution and consequences of breaches.

Theme	Key Issues	Priorities going forward
	Bail Conditions and Community Sentences	• Increase utilisation of court orders requiring offenders to engage with the DIP services, including Restrictions on Bail (ROB), Drug Rehabilitation Requirement Orders (DRR) and Alcohol Treatment Requirement Orders (ATR). • To promote the offender's rehabilitation through access to treatment, personal and behavioural change and the links between substance use, offending and effects on health. • Failure to attend treatment as part of a bail condition or community sentence constitute a breach of the bail condition or community sentence should result in breach proceedings. Robust follow-up to failed attendances at treatment services is necessary for this measure to be effective.
	Integrated Offender Management (IOM)	• Review and develop the IOM model that takes into account the recent changes to MPS policing model and creation of the National Probation Service and MTCnovo (London Community Rehabilitation Company) • Revisit the IOM cohort in terms of numbers, criteria for inclusion on IOM and the length of time an individual is on the IOM caseload • Develop protocols and working relations between all criminal justice agencies to ensure IOM becomes embedded within each organisation and driven by organisations rather 'person led'. • Information sharing agreements to enable the core IOM team (police, NPS, CRC and DIP leads) access to secure data and intelligence held on individuals on the IOM caseload through relevant vetting processes. • Develop robust performance indicators.
	CRC cohorts of offenders on license	• The CRC model will involve focusing on five specific cohorts; those with mental health needs, women, those aged 18-25, those aged 26-49 and those aged over 50. This will require partnership working with treatment services to address substance misuse need within these cohorts. • Develop clear pathways into treatment services for offenders on license with an identified substance misuse need and maximise opportunities to engage them with

Theme	Key Issues	Priorities going forward
		effective interventions.
Enforcement	Drug dealing	• Lack of perceived confidence in residents and communities of Tower Hamlets to report drug dealing due to fear of reprisal (often drug dealers, deal and live in the same area) • More needs to be done about drug dealing in Tower Hamlets, visible action against those who are dealing drugs • Anecdotally, young people will choose to deal drugs for around 5 years, this is sufficient time to make some money and stop. There is a confidence in young people and a perception that they will not get caught, there are no consequences and they will not get caught. • Increase in CCTV including mobile CCTV and anonymous reporting methods
	Underage sale of alcohol	• Underage drinking is a concern. It is perceived too easy for underage people to have someone else buy their alcohol. • Off Licensees need more information about and underage sales, effects on health. • Increase the number of test purchases
Cross cutting themes	Sharing intelligence	• There is a wealth of intelligence that can be shared between treatment and enforcement agencies. Develop multi-agency operational forums involving treatment services, police, licensing, trading standards where agencies can offer support and intelligence can be shared, as well as delivering some joint initiatives • Develop and implement a young person's network forum that allows professionals working with young people to discuss initiatives aimed at substance misusing young people across Tower Hamlets
	Gathering intelligence	• More intelligence needs to be gathered to assess current substance use in Tower Hamlets, particularly in light of NPS

7 Service User Focus Groups

Table 3: Focus group participant information:

Focus Group	Female	Males	Total Participants
CDT (opiate users)	2	12	14
NAFAS (non-opiate users)	0	10	10
THCAT (alcohol users)	7	7	14
ISIS (women drug and alcohol users)	3	n/a	3
Health E1 (homeless drug and alcohol users)	2		2
Total			43

7.1 The majority of service users participating in the focus groups indicated their support for the Pillar approach in the development of the Substance Misuse Strategy, with themes being, **prevention and behaviour change**, **treatment** and **enforcement and regulation**.

Table 4: Themes, key issues and priorities going forward raised through the all focus groups (opiate users, non-opiate users, alcohol users, women and homeless drug and alcohol users

Theme	Key Issues	Priorities going forward	Group
Prevention	Education and raising awareness	• There needs to be widespread communication within the different communities of Tower Hamlets. • Community groups need to be trained to then advocate about the harms of using drugs and alcohol • Drug awareness campaigns, social media (Facebook), local papers	Alcohol users Opiate Users Non-opiate Users Women Homeless
	Family support	• Parents need more information in relation to drugs and alcohol use among young people, particular around NPS, the signs of knowing when drugs or alcohol is being used, the health risks • Family support interventions where parents are using and or where children are using	Alcohol users Opiate Users Non-opiate Users Women Homeless
	Targeting young	• More information need to be provided to children and young people	Alcohol users

Theme	Key Issues	Priorities going forward	Group
	people	through schools, stronger messages of the impact of using drugs and alcohol	Opiate Users Non-opiate Users Women
Treatment	Lack of information about treatment options and offer	• Not enough information about what support is available, general consensus across the group was they "simply do not know what is available and what is not". Some felt quite strongly that not even their key workers knew what groups were available. • Some felt their treatment amounted to was "collect their script and go" but would like to be doing more. • There was agreement across all groups that there needs to be more information, leaflets and posters in treatment services, marketing material across tower hamlets (local papers, social media – particularly for the younger generations)	Alcohol users Opiate Users Non-opiate Users Women Homeless
	Out of hours' provision	• Weekend and evening provision is missing, participants feel there is no one to speak to and nowhere to go, and it is during the evenings and weekends that they feel most vulnerable. • Not all felt that Alcoholics Anonymous (AA) meetings were what they need • There was an appetite for more social groups where service users could share their experiences, in particular women considered treatment to be an isolated experience	Alcohol users Opiate Users Non-opiate Users Women Homeless
	Barrier to accessing treatment (women)	• Women drug and alcohol users are reluctant to come forward for treatment because they are afraid their children will be 'taken into care'. One participant had waited "over 2 years before thinking about getting help." • Women participants felt there is too much stigma that prevents them from seeking treatment	Women
	More than just treatment	• To improve the success of treatment more needs to be done to help people "sort out their lives", housing is a big issue and participants felt	Alcohol users Opiate Users Non-opiate Users

Theme	Key Issues	Priorities going forward	Group
		that there needs to be better access to training and gaining skills to help find employment. It was felt pointless recovering from drug or alcohol use if there is nothing to do at the end of it.	Women Homeless
	Peer mentors	• Participants felt they need more peer mentors, they felt key workers just don't understand and "so are not very helpful"	Alcohol Users Opiate Users
	Service user representation	• Service user representation, in the women's focus group there was support for more service user involvement and representation in the decision making process and running of services • Children of parents that use drugs or alcohol is a big concern, children "need support too" when their parents are using. There needs to be some provision where young people can be helped and supported through this.	Alcohol users Opiate Users Non-opiate Users Women
Enforcement	Policing drugs	• Across all groups it was felt there is not enough visible policing to stop people from dealing on the streets and in the neighbourhoods. It was perceived the police are not stopping drug dealing on streets • Fear among people in Tower Hamlets to report drug related crimes as they are fearful or reprisal	Alcohol users Opiate Users Non-opiate Users Women Homeless
	Regulating alcohol	• Alcohol was generally available and easily bought by underage people • Participants were aware of the controlled drinking zone but felt this was not being policed	Alcohol users Opiate Users Non-opiate Users Women Homeless

8 Young Person Focus Group

8.1 Participants were aged 16 and 17.

8.2 Focus group participant information:

Focus Group	Female	Males	Total Participants
Youth Council	5	5	10

Table 5: Themes, key issues and priorities going forward raised through the young person's focus group

Theme	Key Issues		Group
Drug and alcohol use	Perception of Cannabis use	• Cannabis is being used everywhere by people of all ages, 'you can smell it on the streets and in the parks.' • All participants agreed that generally, cannabis use is acceptable, 'it happens openly, it's normal'. All young people in the group had at some point seen others their age 'rolling up and smoking a joint.' • When asked why young people use Cannabis, responses including Cannabis use is seen as being 'cool and trendy' among young people. Other reasons included 'it's relaxing and relieves stress and boredom.' • It was felt that using Cannabis 'is normal' it's prevalent in their immediate environments and it was commonly used by older people they are around.	Young People
	Perception of alcohol use	• Young people that are drinking alcohol are drinking Vodka or the cheapest spirit with the highest alcohol content, such as 'Grey Goose'. • One of the reasons young people are drinking Vodka is because 'you cannot smell it' and therefore the parents don't find out. • In comparison to Cannabis use the group perceived alcohol more acceptable, and young people were using alcohol socially at the weekend	Young People
	Perception of NPS "legal highs"	• 'Legal highs' were perceived differently to Cannabis, it was felt these are bad for you, however among the group there was not a great deal of use of legal highs among their immediate peers.	Young People

Theme	Key Issues		Group
		• NSP referred to as 'legal cannabis' is commonly used, sold in the shops.	
Health risks	Key health messages	• Young people were not fully aware of the health risks associated with drug use or alcohol. At best they considered the effects of drug use would be in the longer term affecting the memory but generally it was not seen as being 'bad' for your health. • It was felt, however, the use of alcohol was less harmful but unable to explain what the impact on health would be.	Young People
Education (raising awareness)	Targeted education and awareness raising	• In terms of educating young people about drugs and alcohol, it was felt that the programmes of raising awareness and providing education should be aimed at those who are aged 16 or 17, as this is the time they are likely to be exposed to, and try using, drugs and alcohol • Drug and alcohol education during year 7, 8 and 9 was perceived as 'given too early, repetitive and not really parting with much information' • It was felt, messages about drug and alcohol use need to be more powerful, speaking to people that had used drugs and alcohol would be more helpful in deterring them from using drugs or alcohol, 'this makes it more real' for young people.	Young People
	Communication methods	• Key facts about using drugs and alcohol, communication should be 'short and snappy' using social media, such as hashtag and twitter, a short you-tube video etc.	Young People
	Targeting parents	• It was generally agreed amongst the group that parents did not know about the drugs being used, the signs of drug use or the effects.	Young People
Enforcement	Drugs (cannabis)	• The group agreed it was too easy to buy drugs (Cannabis) in Tower Hamlets, generally it happens in streets and neighbourhoods and mostly the people selling drugs are known. • It was felt 'police do nothing about Cannabis use, they walk past, and they have more important things to do.' • The same drug dealers that have been dealing for the past five years are	Young People

Theme	Key Issues		Group
		still dealing. • No one wants to report it to the police, they are afraid of come back on them.	
	Availability of alcohol	• The group agreed that it was too easy to buy alcohol at the local off licence, 'they're just businesses that don't really care who they're selling alcohol to.'	Young People

9 General Public Survey

9.1 In total 301 residents took part in the telephone survey.

Drug and alcohol misuse in Tower Hamlets

9.2 67% of respondents felt that where they live, drug and alcohol misuse was a concern. Of those who felt drug and alcohol misuse was a concern:

- 85% felt the concerns were around antisocial behaviour
- 84% felt the concerns were around drug dealing or drug taking on their streets or neighbourhoods
- 67% felt the concerns were around empty bottles or can littering the streets
- 67% felt the concerns were around rowdy behaviour from late night drinkers
- 55% felt the concerns were around violence/fear of violence
- 50% felt the concerns were around underage drinking
- 31% felt the concerns were around discarded needles or drug paraphernalia

9.3 59% of participants felt there was not enough being done to tackle these concerns about drug and alcohol misuse. Of those who felt not enough was being done to tackle the concerns:

- 43% felt there could be 'stronger police presence'
- 10% felt there could be 'more CCTV'

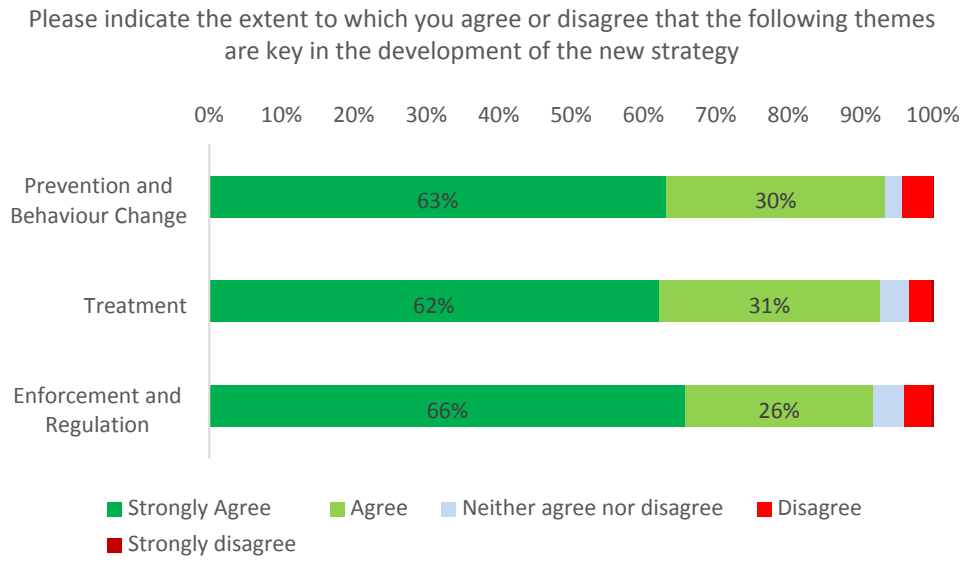
9.4 44% of respondents 'knew who to contact, if someone they know had had a drug or alcohol issue. Of those that knew who to contact;

- 34% would contact a GP
- 19% would contact A&E
- 45% would contact drug and alcohol services
- 30% would contact Alcoholics Anonymous
- 16% would contact Cocaine Anonymous
- 15% would contact Narcotics Anonymous
- 50% would contact the local authority
- 20% selected other as who they would contact, other included police, google search and yellow pages.

Support for the Existing 3 Pillars Approach and the Themes

9.5 Respondents were invited to agree or disagree with the following themes as key in the development of the new strategy:

- 93% agreed or agreed strongly that 'Prevention and Behaviour Change' is a key theme
- 93% agreed or agreed strongly that 'Treatment' is a key theme
- 92% agreed or agreed strongly that 'Enforcement and Regulation' is a key theme.

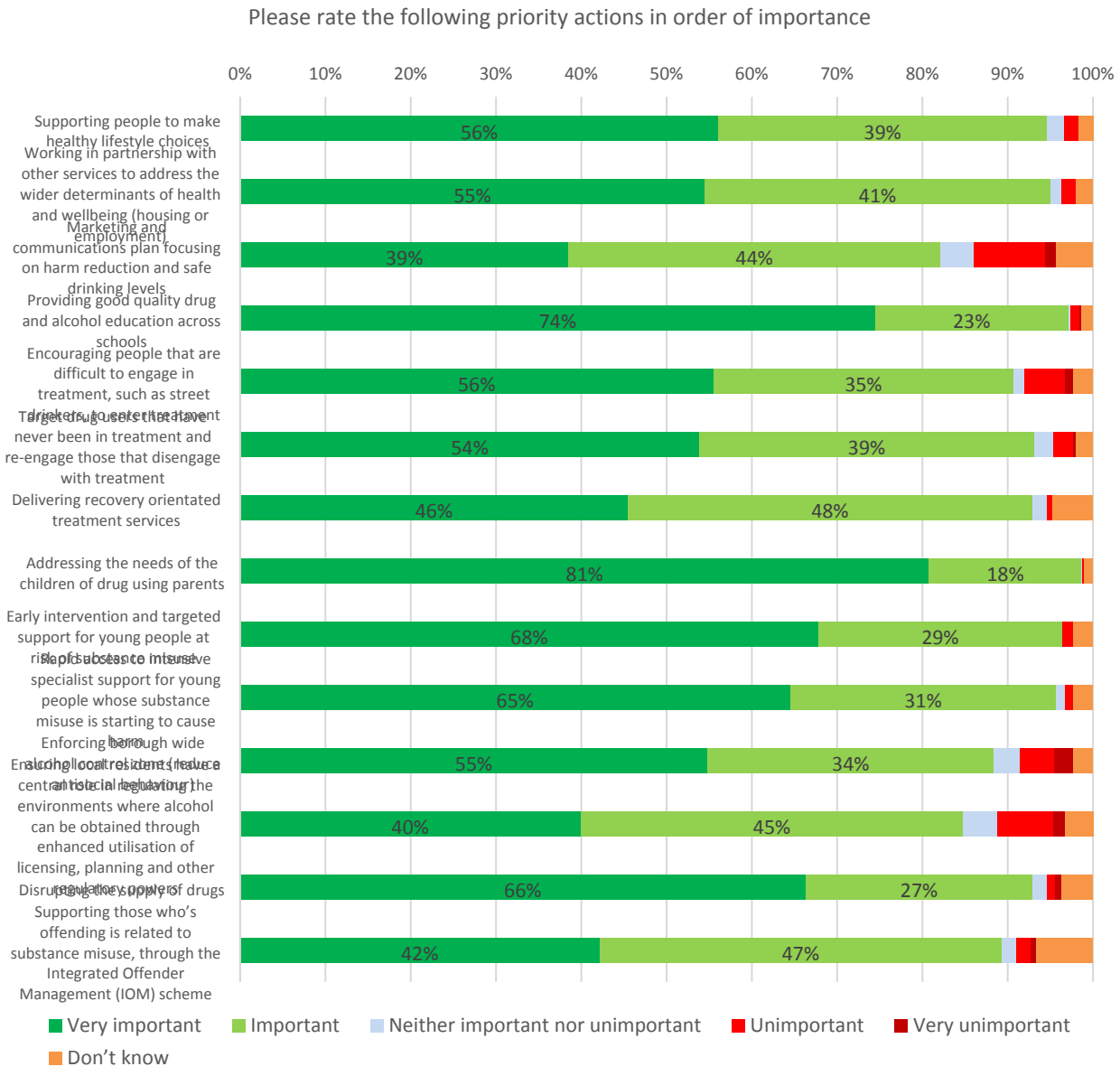


Priorities

9.6 Participants were invited to agree or disagree with the following priorities as key in the development of the new strategy:

- 95% felt 'supporting people to make healthy lifestyle choices' was either important or very important
- 95% felt 'working in partnership with other services to address the wider determinants of health and wellbeing (housing or employment)' was either important or very important
- 82% felt 'marketing and communications plan focusing on harm reduction and safe drinking levels' was either important or very important
- 97% felt 'Providing good quality drug and alcohol education across schools' was either important or very important
- 91% felt 'encouraging people that are difficult to engage in treatment, such as street drinkers, to enter treatment' was either important or very important
- 93% felt 'Target drug users that have never been in treatment and re-engage those that disengage with treatment' was either important or very important
- 93% felt 'delivering recovery orientated treatment services' was either important or very important
- 99% felt 'addressing the needs of the children of drug using parents' was either important or very important
- 96% felt 'early intervention and targeted support for young people at risk of substance misuse' was either important or very important
- 96% felt 'rapid access to intensive specialist support for young people whose substance misuse is starting to cause harm' was either important or very important
- 88% felt 'enforcing borough wide alcohol control zone (reduce antisocial behaviour)' was either important or very important

- 85% felt 'ensuring local residents have a central role in regulating the environments where alcohol can be obtained through enhanced utilisation of licensing, planning and other regulatory powers' was either important or very important
- 93% felt 'Disrupting the supply of drugs' was either important or very important
- 89% felt 'Supporting those whose offending is related to substance misuse, through the Integrated Offender Management (IOM) scheme' was either important or very important.



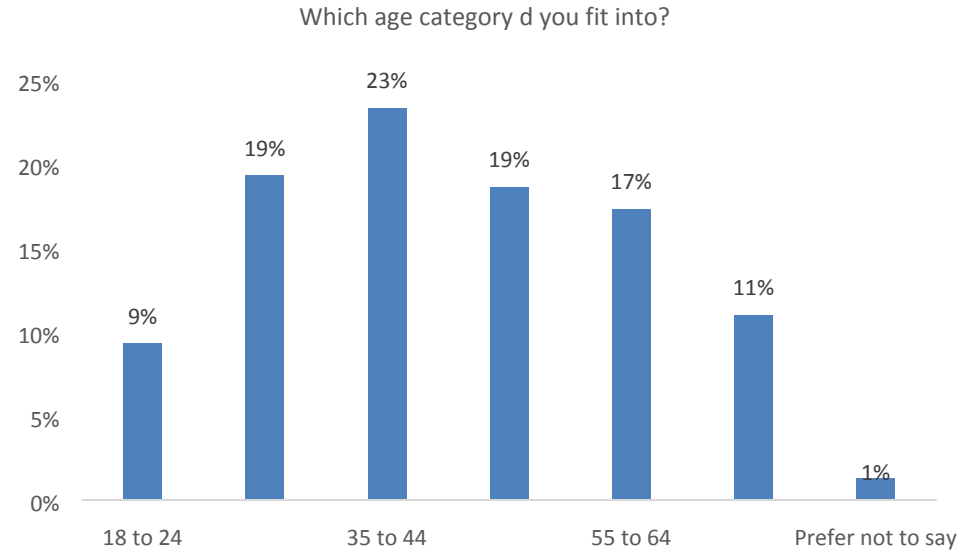
Other Priorities

9.7 Participants were invited to add other priorities they considered were important to the development of the new substance misuse strategy:

- The priority consideration most frequently noted were, need for a stronger police presence, more youth clubs and initiatives to keep young people busy and more drug and alcohol training in schools.

9.8 The following charts provide show the demographic profile of residents of Tower Hamlets who responded to this survey.

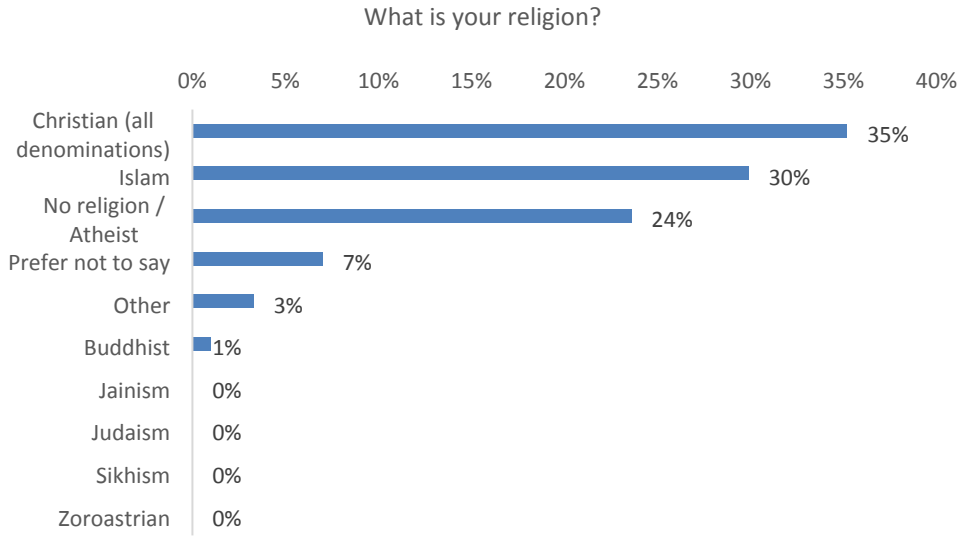
9.9 Profile of age:



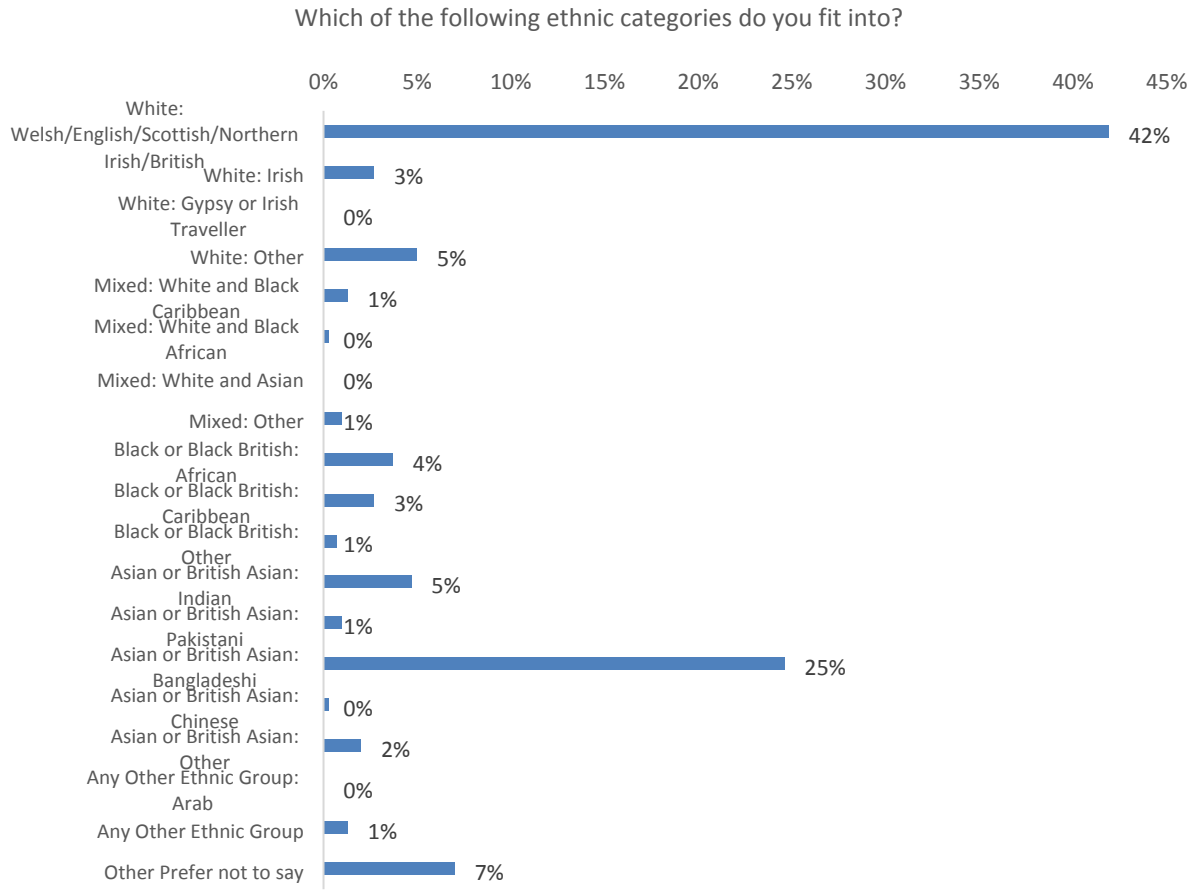
9.10 12% of respondents stated they had a disability

9.11 52% were female and the remaining 48% were male respondents

9.12 Profile of religious belief:

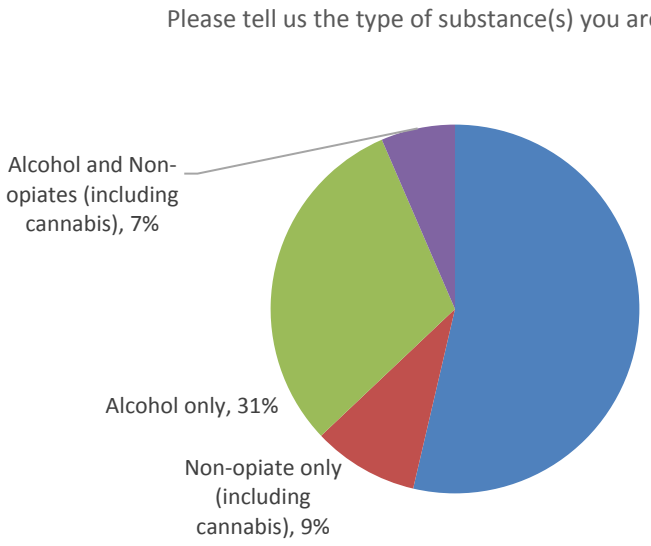


9.13 Profile of ethnicity:

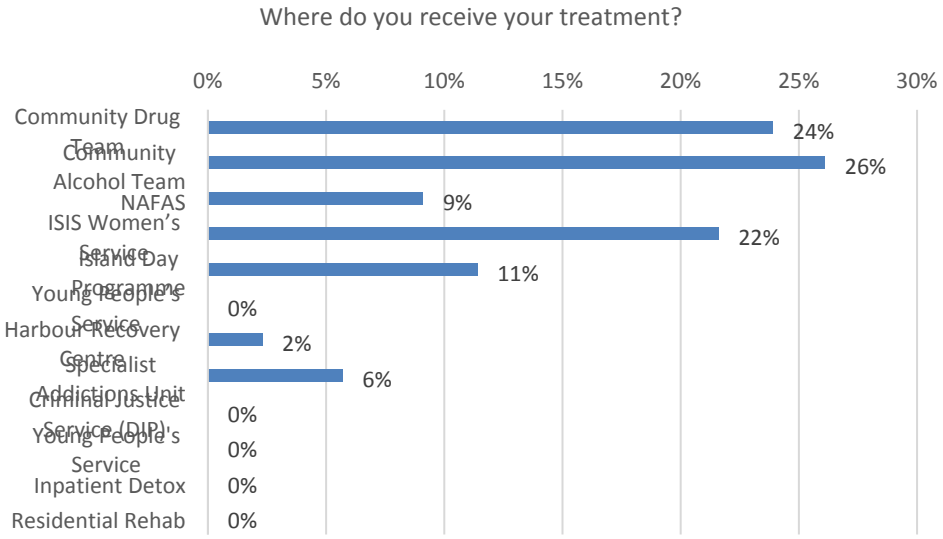


10 Service User Survey

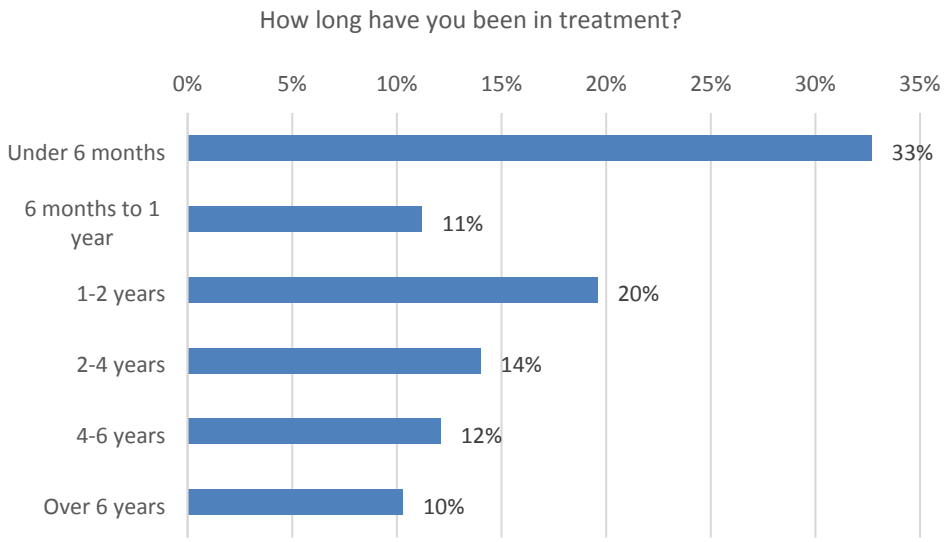
10.1 The Service User Survey was carried out through November 2015. In total there were 115 respondents to the survey, from a wide range of service users across the treatment system. The majority (54%) of respondents were in treatment for the use of opiate drugs (with any other drug or alcohol).



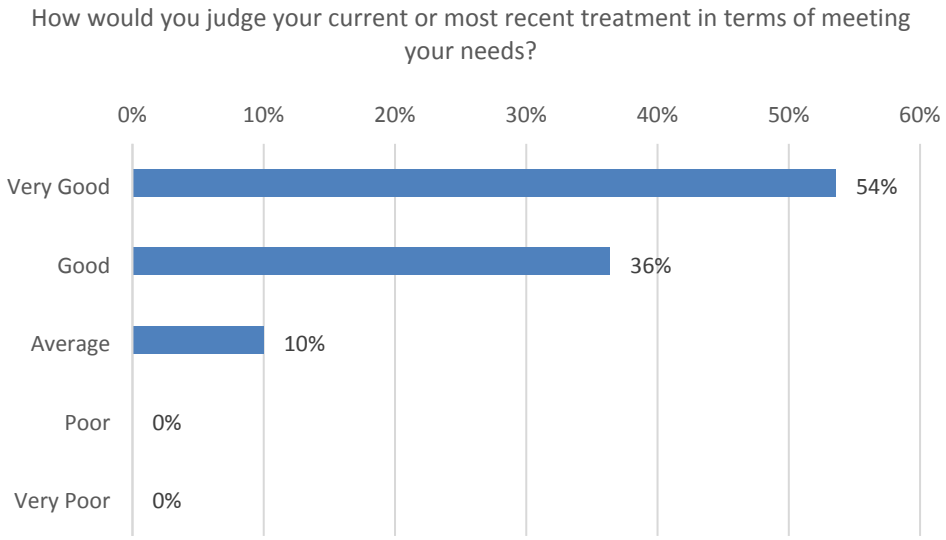
10.2 Respondents were in treatment with the following services:



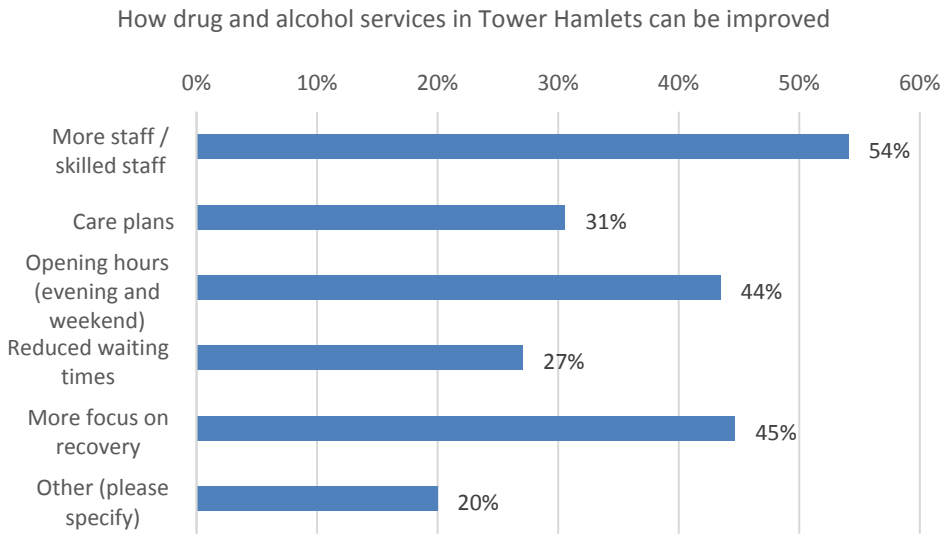
10.3 Respondents were in treatment for varying lengths of time, one third were in treatment for less than six months and 10% in treatment for over six years:



10.4 Overall respondents felt their treatment was meeting their needs. Over half (55%) of the respondents felt their current or most recent treatment was very good in meeting their needs, 36% felt it was good and 9% felt it was average.



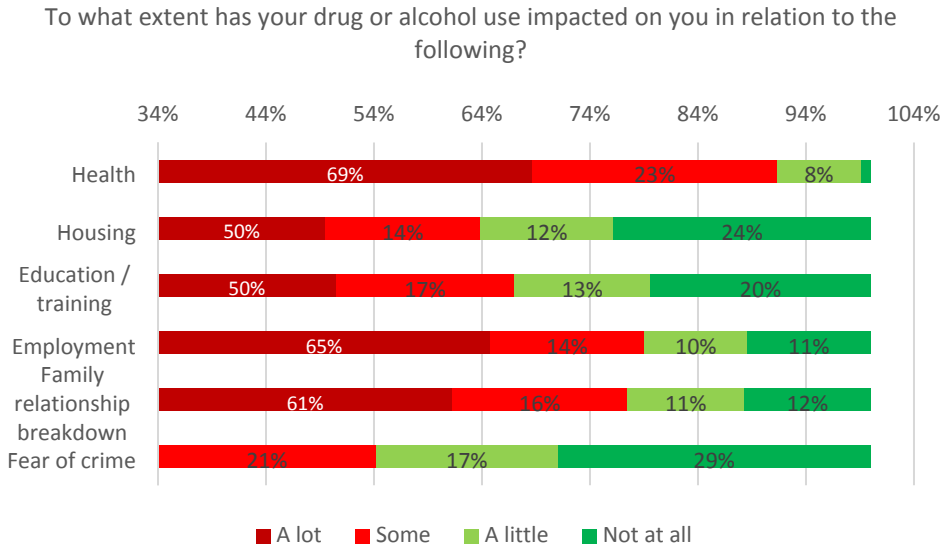
10.5 However, 74% also felt the treatment services in Tower Hamlets could be improved. Of those respondents, most felt improvements could be made by having more staff or skilled staff (54%), more focus on recovery (47%) and extended opening times (evening and weekend) (46%).



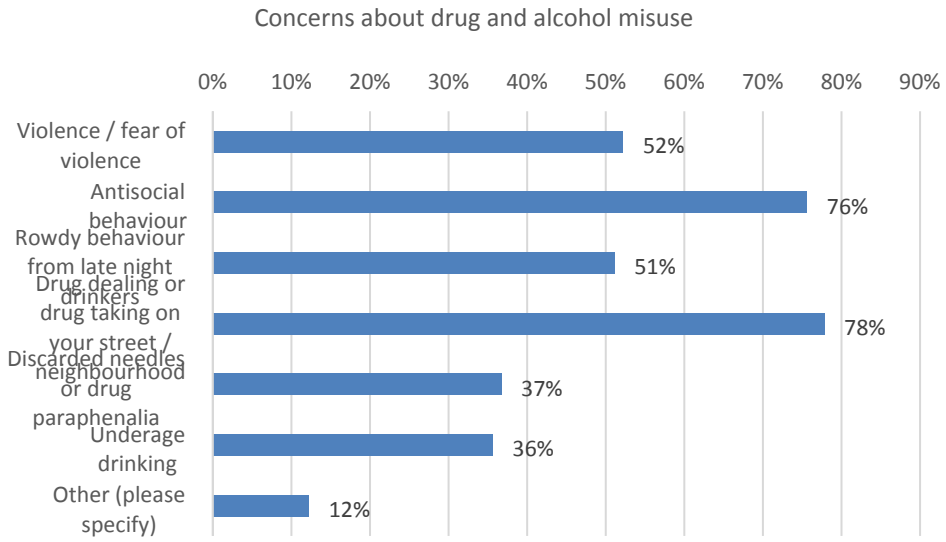
10.6 Specific comments in relation to improving drug and alcohol services included:

- Improved telephone contact at all hours
- Reverse any cuts and ensure this essential service remains funded.
- Shorter wait to get into recovery. More NA sessions in borough.
- Residential treatment for non UK residents
- More focus on training and education
- Alcohol should not be sold after 12am - it's making more people drink, means more mess, more antisocial behaviour
- More diversionary activities for drug users
- Length of treatment to be shortened.
- More activities in the borough
- Personal care
- More tailored approach to individual
- Give people who have been through the services the opportunity to be staff there afterwards.
- It's doing a great job.
- More day trips e.g. places of interest, museums, etc.
- LGBT service, psychotherapy more widely available.
- Longer opening hours.
- More days out/incentives for abstinence.

10.7 In terms of the impact of drugs and alcohol has had on the lives of respondents, the majority felt their health, housing, education or training, employment and family relationship breakdown had been impacted a lot.



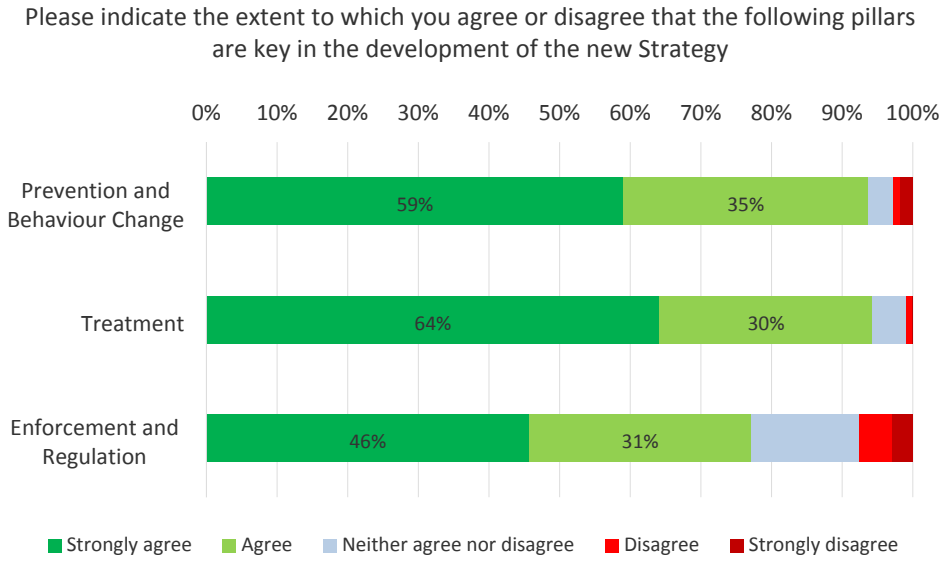
10.8 82% of respondents felt drugs and alcohol were a concern in the areas they lived. For the majority of respondents, the most common concerns were around drug dealing or taking on their street or neigbourhood (78%) and antisocial behaviour (76%).



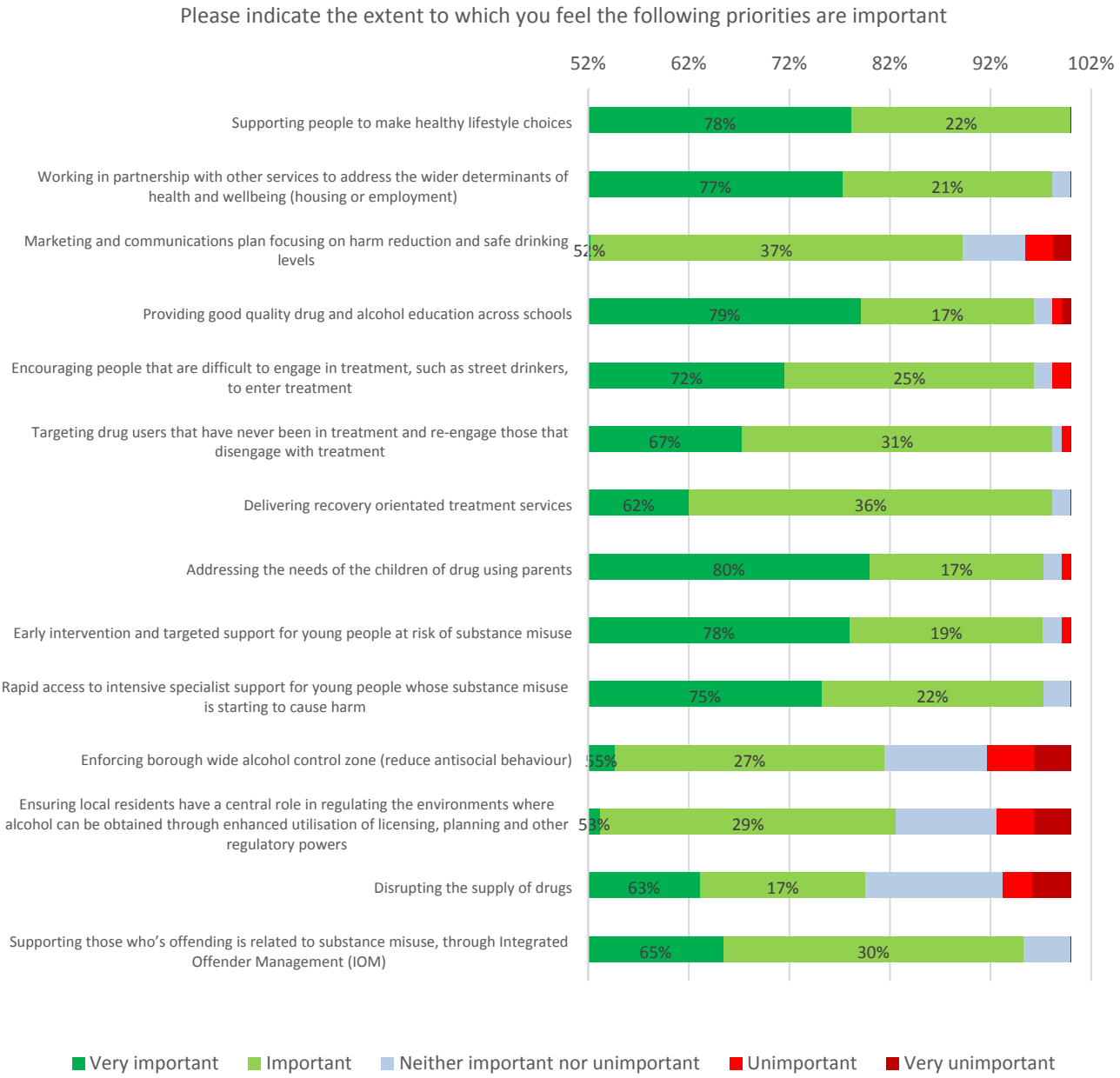
10.9 74% of respondents felt not enough was being done about these concerns.

10.10 The vast majority of respondents agreed with the three pillars of the current strategy being developed in the new strategy:

- 94% agreed with Prevention and Behaviour change
- 94% agreed with Treatment
- 77% agreed with Enforcement and Regulation



10.11 Service users felt the following issues were important:



10.12 Based on their experience, respondents were invited to set out other key priority actions for the strategy in relation to drugs and alcohol. The following priorities were highlighted:

- Educating GPs and more education in schools
- Fight to maintain the current level of services since treating people with addiction saves money - health, property etc - and reducing the service would be a false economy. N.B. maintaining a women's only service and one that is easily accessible to people of different ethnic backgrounds is essential.
- Employ more people who have been in recovery for a minimum of 2-years total abstinence.

- When people first start using they should be told what the risks are and what will happen to their lives should they continue.

- Get street drinkers off the street and protect women from intimidation by drunk and aggressive men.
- Better communication between alcohol and mental health services.
- Alcohol should be made more expensive and less widely available
- To have open days to tell clients their options about treatment
- Compulsory drug tests for service providers
- For people on the street or in some hostels, it's hard because drugs are in their face, even getting offered to them. When they are in this drug cycle, it is very difficult. Take them to rehab (if they are serious) - get drug free hostels and more dry ones.
- Quick access would be more helpful to leave Booth House because too much drugs in the place I don't want to stay there too long.
- Disrupt supply of drugs and tackling drug trading.
- Tackling crime and focusing on the dealers rather than the users.
- The 'new' user needs to understand 'addiction' is an illness and can be treated
- Policing - no enforcement will be useful without properly giving needed resources - issue for MP & councilors, general and local government.
- Help with housing so it will be better for us to stay safe and off it.

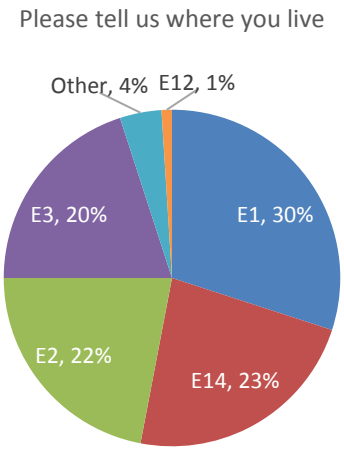
- Tighter control on individuals going in and out of rehab continuously by moving borough and using that council for funding for treatment.

- I think catching people while they are young and trying to prevent use in the beginning is the most important way forward. Prevention is paramount.

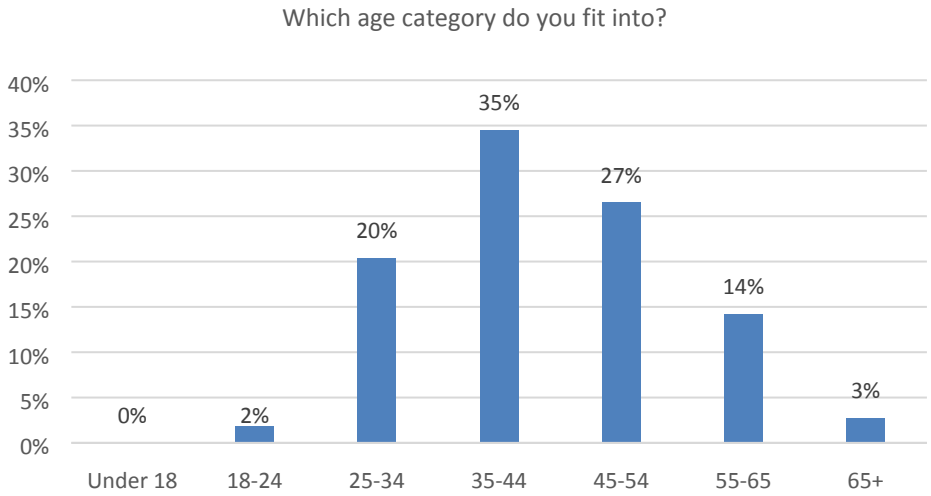
- More CCTV in known high risk areas, i.e. stairwell, car parks.
- More helplines available (24 hour) and posters to make potential client away in more public settings.
- Enforcing rehabilitation for people who are unable to work due to addiction
- Housing should be dealt with asap
- Don't disrupt the flow of drugs. This pushes prices up and makes the ringleaders recruit youngsters. I was once sold heroin by a 10 year-old, Yes a 10 year-old in Greenwich. Also it makes them cut the remainder of the drugs with a dirty alternative to make up the money.
- Make drugs legal
- Early intervention, better services for prevention of relapse. More education and support from GP's when looking for referral. However, by ensuring local residents have a central role in regulating the environments where alcohol can be purchased will encourage more harassment of drinkers.

10.13 The following charts provide the demographic profile of service users who responded to this survey.

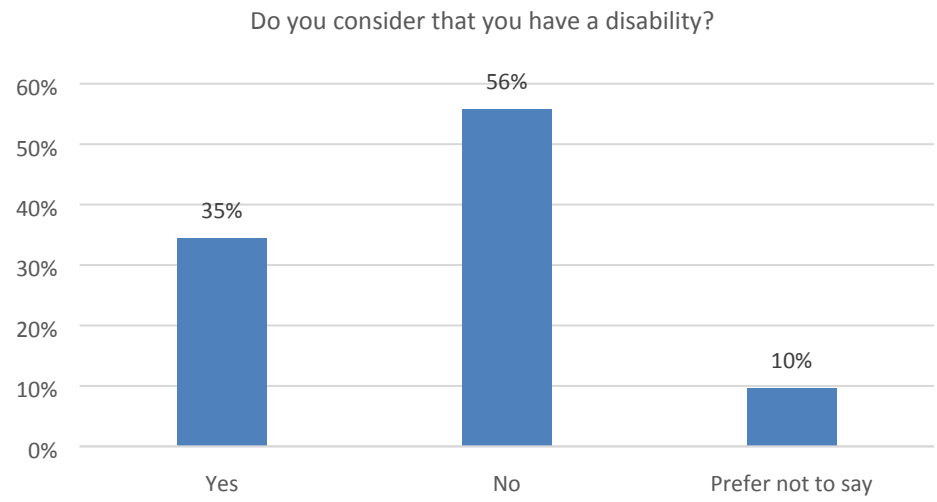
10.14 Profile of where respondents lived (within Tower Hamlets):



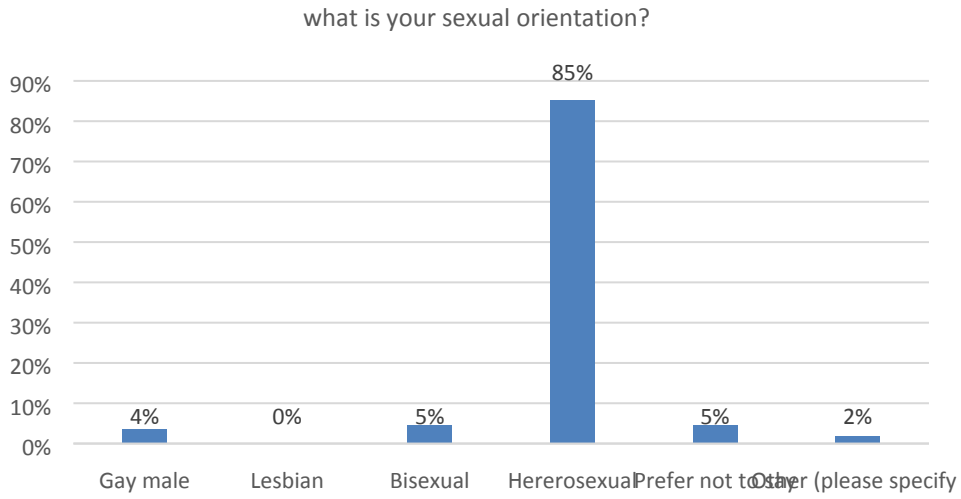
10.15 Profile of age:



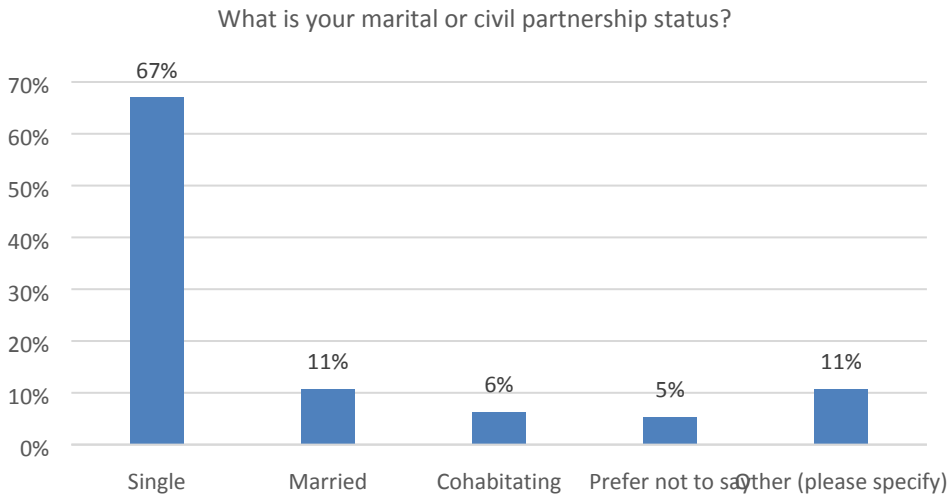
10.16 Profile of disability status:



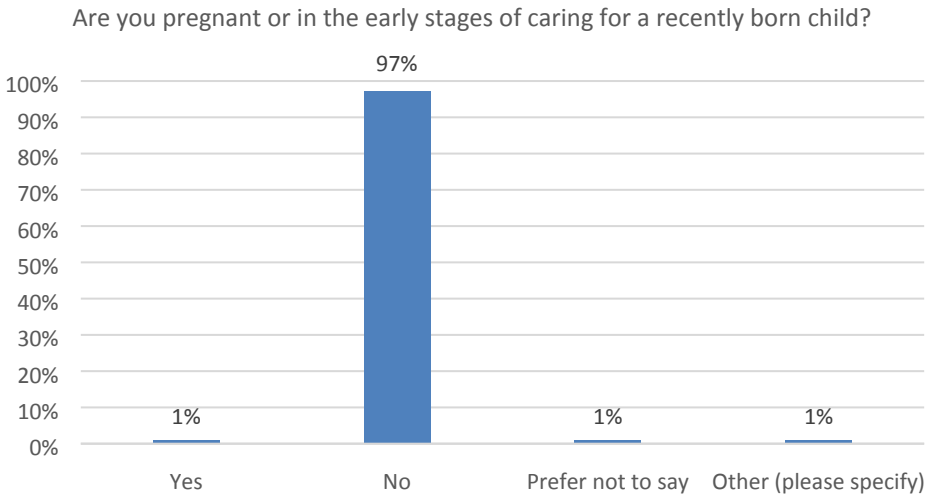
10.17 Profile of sexual orientation:



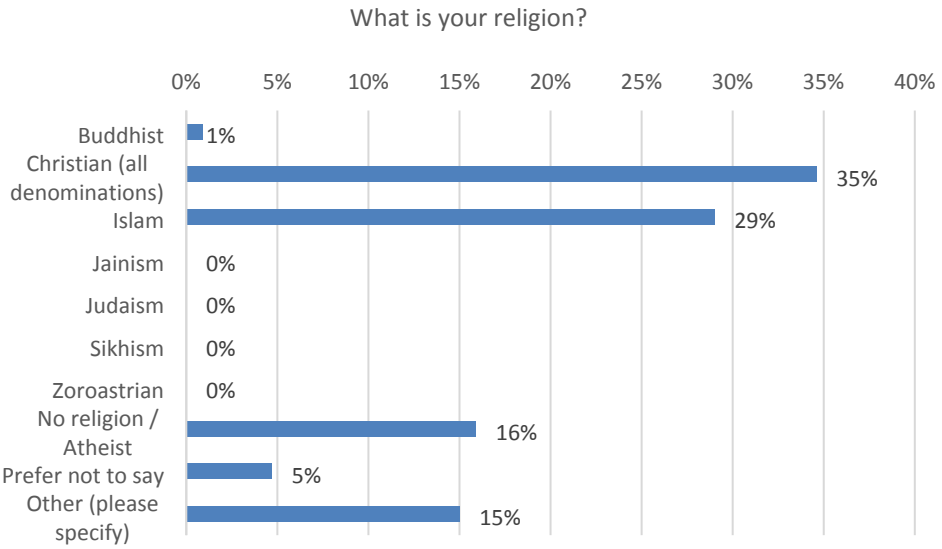
10.18 Profile of marital status:



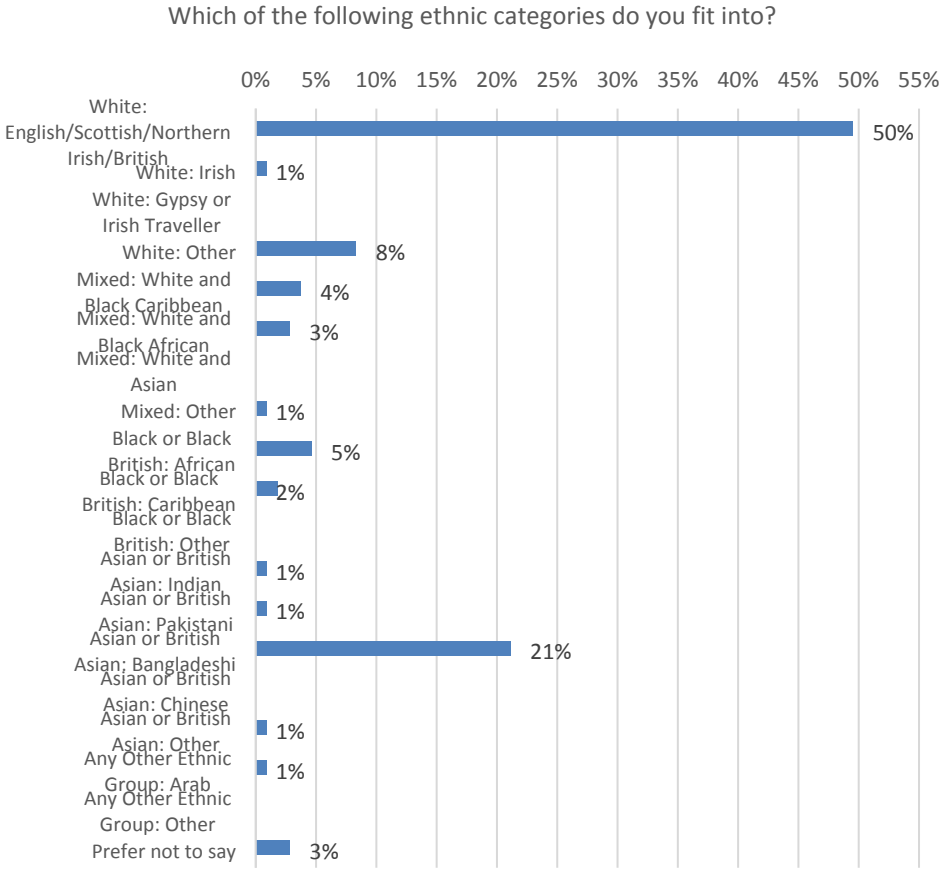
10.19 Profile of maternity/post maternity status:



10.20 Profile of religious belief:



10.21 Profile of Ethnicity:



11 Substance Misuse Strategy Development 2016-19 Stakeholder Workshop (held at Shadwell Centre)

11.1 34 stakeholders attended the workshop designed to evaluate the current strategy 2012-16, review the key findings from the programme of consultation to date and consider priorities going forward over the next 3 years. The majority of partners were represented at this meeting, including, treatment services, hostels, substance misuse commissioner (young people and adults), police, health, clinical commissioning group (mental health), pharmacists, social care, public health and service users.

11.2 The key findings are set out in the table below:

Theme	Key Issues	Priorities going forward
Evaluating the Substance Misuse Strategy 2012-15	What has worked well in the 2012-16 Strategy	**Prevention and behaviour change**: • Early identification and intervention • Engagement through tier 2 services and raising awareness of substance use among non-substance misuse services **Treatment:** • Better multi-agency working arrangements to address the needs of drug and alcohol users • Young person services are providing a holistic approach in meeting the needs of young people • Rapid access into treatment • Celebrating recovery events were successful and received positively **Enforcement and regulation**: • Controlled drinking zone has had a positive impact, with notable reduction in street drinking • Impact of the enforcement work of THEOs and police in general has worked well
	What has not worked well in the 2012-15 Strategy	**Prevention and behaviour change:** • Harm reduction, in relation to new psychoactive substances • Lack of understanding about young people and NPS drug use • Hidden problem of drinking – identification and engagement

Theme	Key Issues	Priorities going forward
		Treatment: • Pathways between primary health care and community treatment services, pathways from treatment into targeting recovery support • Communication about services on offer and available • Relationship between young person services, Mental Health, A&E needs better partnership approach **Enforcement and regulation:** • There are still hot spots where street drinking is a problem that needs to be addressed
	What could be learnt from the way the strategy was delivered	• Working more effectively to address the needs of people that misuse drugs and alcohol, between various agencies • Understanding of the changing drug and alcohol use among young people (spirits and NPS are most commonly used) • Improved links with partners to build cohesion between the different strands of the strategy • Clearly defined roles and responsibilities among partners so that actions are owned and monitored • Use 'golden thread' approach so that ownership of the strategy is from top to bottom • Regular review and monitoring of the strategy to 'keep the strategy live' • Raise profile of strategy
How to improve partnership working and collective response to tackling drugs and alcohol	Role partners have in preventing people from using drugs and drinking to harmful levels	• Increase involvement of voluntary sector in prevention work / utilise their relationships, networks • 'Prevention is everyone's business' – as drug and alcohol clients are often clients with other frontline services • Common themes in assessment tools/care plans among all front line services to identify and refer people with drug and alcohol issues • Increased effective communication of the risks associated with drugs and alcohol • Build resilient communities

Theme	Key Issues	Priorities going forward
		• Work with schools and education providers to take responsibilities (school, universities) • Build strong links with safeguarding to maximise reach • Utilise more the powers through licencing and trading standards
	How to better link treatment services to wider support services	• Information needs to flow between treatment and wider support services, including through formal routes for example through commissioning and contracts and though joint targets • Integrated services and colocation • Adopt a multidisciplinary approach and involvement in addressing the wider support needs (particularly in relation to housing, DWP) • Utilise strategy to secure buy-in at highest levels
	Enforcement and regulation efforts to reduce supply of drugs and better regulate alcohol	• Enforcement should be visible and empower communities • Make local authorities team visible • Controlled drinking zones need to be enforced, for them to be effective • The 'problems are in the borough' and effort should be focused there • Efforts should be targeted at the higher end of the supply chain and not target small dealers • A quicker police response, perception that THEO's are not as effective • Integrate treatment outreach services with enforcement • Limited licencing hours • Restrictions on sale of high strength alcohol
Priorities going forward	Specific areas of focus for the Substance Misuse Strategy 2016-19	**Prevention and behaviour change:** • Focus on community engagement • Focus on social media and internet to engage with drug users and residents, especially communities who buy drugs on the internet and meet to take drugs via the internet / social media (Chemsex) • Deliver holistic work with educational partners including schools • Utilise off licences and other alcohol sellers to inform about drugs and alcohol

Theme	Key Issues	Priorities going forward
		• Share knowledge about new research and developments in the profession, new drugs, methods of treatment etc. • Educate families and communities about drugs and alcohol • Clear strategy for drug/alcohol education - who does it, where, when **Treatment:** • Adopting a flexible and innovative approach to delivering treatment, respond to new emerging patterns and behaviour of substance use (NSP and Chemsex) • Ensure that treatment remains accessible for everyone who needs it • Treatment should be accessible on weekends and not just 9 to 5 / Monday to Friday • Clear pathways, client focused, increased choice and improved access • Develop proposal about drug consumption rooms • Foster partnership between young people and adult services • Develop integrated treatment programmes for families and make support available for families • Develop work focused on mothers and children, develop link further with Children centres • Workforce development **Enforcement and regulation:** • Joint tasking of THEOs, police and licensing teams • Conditional cautioning for alcohol / NPSs • Increase pre-enforcement planning • Mapping and understanding of the NPSs • Test purchases NPSs and alcohol • Address late night/early morning opening hours of off licenses • Continue to develop Integrated Offender Management (IOM) scheme • As part of the prevention key messages of the consequences of enforcement and regulation should be used
Barriers to achieving these		• The right information about what treatment is and what the options are

Theme	Key Issues	Priorities going forward
priorities		• Cuts and austerity – reduction in funding • Enforcement capacity is failing • Stigma remains as a barrier to treatment • National policy might not be in line with practice on the ground • Local red tape and paper work, outdated case management systems • Too many treatment providers in the borough making communication difficult and resource intensive • Confidentiality makes some work difficult and nearly impossible
Solutions to the barriers		• Substance misuse needs to be a shared responsibility • Communication between different partners and an understanding of what different partners are doing • Lobby national policy and contribute to PHE and other consultations • Focus on joined partnership working to mitigate cuts and austerity • Develop case management system, improve current Mi-case and free up time for keyworkers. • Create effective data sharing agreements between services (not just drug and alcohol services) • Promote positive impact of treatment for clients and the whole community

12 Common Strategy Priorities emerging (Based on the 3 Pillar Approach with modifications)

The consultations outlined culminated in generation of the broad priorities below and these were used to develop a draft strategy for consultation.

THREE PILLARS APPROACH		
Prevention and Behaviour Change	Treatment	Enforcement and Regulation
Including: • Information and Awareness • Engagement • Education • Support for Substance Misusing Population • Prevention campaigns • Health Messages • Communications • Addressing hidden harm and safeguarding vulnerably Young people and Adults	Including: • Service engagement of those in need • Accessible provision available to all • Screening and Identification • Assessment and recovery planning • Recovery orientated treatment • Maintaining recovery support, aftercare and re-integration • Peer mentoring and self help	Including: • Integrated Offender Management • Licencing and regulatory enforcement • Dedicated and targeted operations • Enforcement of controlled drinking zone.
Setting the Foundations for Effective Impact		
• Effective use of gathered and analysed Data and Intelligence	• Setting the right Governance mechanisms	• Safeguarding resources to sustain local provision

13 Consultation on Draft Strategy

13.1 The draft substance misuse strategy 2016-19 was published on the council's website for consultation among the general public and partnership services (statutory and voluntary). In addition, colleagues across the partnership were invited to participate in the consultation by the DAAT. The consultation closed on 14 April 2016.

13.2 Participants in the consultation were invited to complete a short survey asking them to indicate their level of support for the Partnership's vision for tackling drugs and alcohol, the clarity with which the priorities are set out and the level of support for the themes and priorities which make up the three pillars of the strategy.

13.3 In total there were 9 respondents to the survey, the majority were male (67%) and 33% female. Respondents were predominately from drug and alcohol services with some representation from GPs, social care and housing (including hostels). The findings are set out below:

- 100% agreed with partnerships vision to tackling drugs and alcohol
- 89% felt the priorities of the strategy were clear and easy to understand
- All respondents agreed and in some cases agreed strongly with the key themes under the three pillars of 'prevention and behaviour change', 'treatment' and 'enforcement and regulation'
- 56% agreed strongly with 'prevention and behaviour change' as a pillar of the strategy, 33% agreed, 11% did not respond
- 56% agreed strongly with 'treatment' as a pillar of the strategy, 33% agreed, 11% did not respond
- 67% agreed strongly with 'enforcement and regulation' as a pillar of the strategy, 11% agreed, 11% did not agree or disagree.

13.4 Respondents were invited to provide other suggestions or comments in relation to the strategy:

- "Embed the thinking of effective joint working as no organisation can meet the all the needs of our clients but working together should impact on higher successful outcomes."

Appendix 1: Stakeholders Interviewed

Name	Organisation
Alex Verne	Specialist Addictions Unit (SAU)
Andy Bamber	Drug and Alcohol Action Team (DAAT), Tower Hamlets Council
Anna Livingstone	GP, Clinical Commissioning Grouo (CCG)
David Tolley	Licensing, Tower Hamlets Council
Dayo Agunbiade	Specialist Addictions Unit (SAU)
Elizabeth Hamer	Drug Interventions Programme (DIP)
Jill Goodard	Public Health
John Mzondo	Health E1
Karen Badgery	Children's Services, Tower Hamlets Council
Kate Smith	Public Health, Tower Hamlets Council
Kevin Kewin	Tower Hamlets Council
Linda Neimantas	Probation (CRC)
Madeleine Rudolph	Public Health England
Mark Hilton	CDT, Lifeline
Mike Hamer	Police
Paula McGranaghan	ISIS
Penny Louch	Health E1
Phil Greenwood	Providence Row Dellow Centre
Rachel Sadegh	Drug and Alcohol Action Team (DAAT), Tower Hamlets Council
Richard Stevenson	Island Day Programme
Sara Fox	CDT Young People, Lifeline
Shareen Hemmuth	Tower Hamlets Community Alcohol Team (THCAT)
Sharif Shaheen	Drug Interventions Programme (DIP)/ Integrated Offender Management (IOM)
Sharon Hawley	Specialist Addictions Unit (SAU)
Sibel Duru	NACRO
Somen Banerjee	Public Health
Sonia Carollo	Specialist Midwife
Tarlok Singh	Harbour Recovery Centre
Tohel Ahmed	NAFAS
Tony O'Ceallaigh	Tower Hamlets Clinical Commissioning Group (CCG)
Trevor Kennett	ASB Team, Tower Hamlets Council

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Substance Misuse Strategy Action Plan 2016/17 DRAFT

PLEASE NOTE THIS IS A WORKING DRAFT
A REVISED VERSION WILL BE DISCUSSED AT DAAT BOARD ON 11/07/16

Prevention and Behaviour Change

PBC1 We will support people to maximise their health and wellbeing by providing targeted communication and community education about alcohol and substance misuse including information about the support services available alongside targeted support for those who are at risk

Owner	Action	Deadline	Key Performance Indicator	Milestone	Progress update
LBTH PH	Health Champions?				
LBTH Childrens services	Action from youth service				
LBTH DAAT	Deliver visible launch of new treatment services with comprehensive messages regarding substance misuse and where to get help	30/11/16	Increase number of referrals into drug / alcohol treatment services by 5%	• Award contract to new services – June 2016 • Implement new services 01/10/16	

PBC2 We will ensure that our drug and alcohol information and prevention activity is integrated within our broader health promotion and prevention programmes, to ensure that we offer helpful and accessible information consistently across agencies, and that front-line staff in all relevant settings have the right skills and knowledge to provide information and support, including mental health and wellbeing

Owner	Action	Deadline	Key Performance Indicator	Milestone	Progress update
Public Health (LBTH)	Ensure the principles of Making Every Contact Count (MECC) are mainstreamed into frontline services.	End March 2017	xxxx	xxxx	xxxx

Public Health (LBTH)	Strengthen the inclusion of substance misuse in development of other relevant strategies / plans in 2016/17 including; • Health and Wellbeing Strategy • Children and Families Plan • Reprocurement of sexual health services across London • Hostels Commissioning Plans	End March 2017	• Substance misuse integrated in cross-cutting strategies of relevance. • Substance Misuse Strategy for 2016-19 aligned with new Health and Wellbeing Strategy	• Participation in scheduled consultations / workshops • Ensure new plans / consultations / strategies considered at DAAT Board	
PBC3 We will develop a multi-agency communications plan for young people and adults with a focus on harm reduction, safer drinking levels whilst targeting communities with high level of alcohol related harm					
Owner	**Action**	**Deadline**	**Key Performance Indicator**	**Milestone**	**Progress update**

Public Health	Develop and implement an annual multi-agency communications plan for service users (adults and young people) and professionals with a focus on: • harm reduction and safe drinking levels, targeting communities with high levels of alcohol related harm • drug related harm and treatment services available • Supporting parents to address drug and alcohol misuse with their children. • Harms associated with novel psychoactive substances / legal highs	Plan developed by 31/07/16 and delivered by 31/03/16	• A minimum of three high profile communications campaigns run during the course of the year. • A minimum of 300 direct contacts made via the communications campaign	• Communications plan to be presented to / agreed at July 2016 DAAT Board. • Communications activity to commence in August 2016.	
PBC4 We will continue to ensure identification and brief advice and, where appropriate, referral on to other agencies is routinely undertaken on people attending key frontline services across health and social care.					
Owner	**Action**	**Deadline**	**Key Performance Indicator**	**Milestone**	**Progress update**

TH DAAT	Ensure identification and brief advice interventions (IBAs) are routinely offered to adult clients across a range of frontline services including: • Hostels • Patients accessing hospital services • Sexual health services • Newly registered patients within GP practices • Probation services • Health trainers	March 2017	• Provision of IBAs written into service specifications of providers. • A minimum of 35,000 IBAs carried out across the borough • Increase number of individuals engaged in structured alcohol treatment by 10% compared to 2015/16 numbers.	• Review Barts Health contract and implement new model of service by January 2017 • Quarterly collection of data to be presented to DAATB • Agree incorporation of IBAs into sexual health service assessments by January 2017 • Agree recording of IBAs with Probation services by January 2017 • Deliver training sessions where required	
PBC5 We will work with universal services to ensure that the partnership's drugs and alcohol messages are consistent and supportive of our aim, to make people better informed and able to make healthier choices to access services.					
Owner	**Action**	**Deadline**	**Key Performance Indicator**	**Milestone**	**Progress update**
LBTH DAAT / LBTH Childrens services	Deliver quarterly fora to raise awareness of substance misuse issues for adults and Young People and enure pathways are embedded across frontline services	**March 2017**	• At least 8 meetings per year • Representation from key frontline services	• Quarterly young people substance misuse networks • Quarterly Drug and Alcohol Networks (adults)	

LBTH DAAT / LBTH Childrens services	Plan and deliver a course of training sessions to frontline professionals including: • Social care teams • Childrens centres • Probation services • Hostels • GPs • Pharmacists • Health visitors Training to incorporate Making Every Contact Count and amended Chief Medical Officers guidance on alcohol consumption Training in relation to YP services to embed a child rights based approach	**March 2017**	• A minimum of 12 training sessions to be delivered • A minimum of 120 staff to be trained directly	• Training plan to be developed by end August 2016 in conjunction with new treatment providers and Young Peoples service	

PBC6 We will address hidden harm whist safeguarding children and vulnerable adults through effective practices with integrated approaches to address the welfare of children of drug or alcohol misusing parents and vulnerable adults

Owner	Action	Deadline	Key Performance Indicator	Milestone	Progress update
LBTH DAAT	Ensure regular systemic programmes are provided to address the needs of groups of families where there is substance misuse.	Oct 17	A minimum of 2 programmes to be delivered post implementation of new services (Oct 16 – Mar 17)	• Agreement reached with new provider regarding the programme to be delivered (October 2016)	
LBTH DAAT	Ensure individual family support is available to address the impact of parental substance misuse	Mar 2017	A minimum of 20 family interventions recorded per year.	• Agreement reached with new provider regarding the interventions to be delivered (October 2016)	

LBTH DAAT	Continued Training around Opiate Substitute Therapy (OST) Medication with a focus on Children's Services to prevent children ingesting Methadone / Buprenorphine	**March 2017**	At least 3 training sessions delivered across children's services teams	• Agree for a and dates for training – September 2016	
LBTH DAAT	Establish a robust approach to carer involvement and support across services	Nov 16	Regular engagement with at least 10 known carers Substance misuse carer support needs recognised in new LBTH Carer Strategy	• Agreement reached with new providers regarding the offer to carers • New Carer strategy developed – end July 2016	
PBC7 We will work in partnership with schools to provide good quality drug and alcohol education, particularly around new psychoactive substances 'legal highs' and support schools to develop effective policies through a "whole schools approach".					
Owner	**Action**	**Deadline**	**Key Performance Indicator**	**Milestone**	**Progress update**
LBTH Childrens Services / PH	Healthy Lives actions				
PBC8 We will target universal prevention activity with young people at risk of drug misuse.					
Owner	**Action**	**Deadline**	**Key Performance Indicator**	**Milestone**	**Progress update**
LBTH Children's services	Provide effective early intervention for substance misusing individuals in the youth justice system within and beyond the youth offending team	Mar17	• 100% of young people in the criminal justice system screened for drug / alcohol issues	• Report ongoing performance via Young People Substance Misuse Operational Group	

Treatment					
T1 We have redesigned our treatment services and in 2016/17 we will commission an integrated drug and alcohol treatment system that is recovery focused, helping adults who are addicted or dependent to recover, by enabling, empowering and supporting them to progress along a journey of sustainable improvement to their health, well-being and independence. The treatment system will have strong service user involvement and peer led recovery outcomes. The three main elements of this treatment system will deliver outreach and engagement, specialist structured treatment and the provision of the right support to ensure that recovery is lasting.					
Owner	**Action**	**Deadline**	**Key Performance Indicator**	**Milestone**	**Progress update**
LBTH DAAT	Implement an integrated drug and alcohol treatment system that is recovery focussed	01/10/16	Improve percentage of successful completions of Opiate, Non-Opiate and alcohol treatment to ensure performance is always in the top quartile of performance amongst comparative boroughs	• Contracts awarded by end of June 2016	
TH DAAT	Appoint and utilize therapeutic, strategic and community recovery champions to support and drive recovery across the borough.	31/12/16	Respected and active champions in place. Clear remits established for champions	• Designate strategic recovery champion (s) • Implement robust communication / feedback activities with all champions to maximise impact on recovery. • Coordinate third Celebrating Recovery event in March 2017	
LBTH DAAT	Redevelop and relaunch service user involvement structures across the new treatment system	31/03/17	Regular attendance of service user representative at key meetings (DAATB, DAN, LUIC) Service user feedback incorporated into monitoring meetings and needs assessments	• Contracts awarded by end of June 2016 • New services implemented 01/10/16 • Service user involvement strategies / processes agreed with new provider by 31/12/16	

T2 We will support treatment that is recovery orientated and will work with established users to maintain their health and well-being and to reduce harm.					
Owner	**Action**	**Deadline**	**Key Performance Indicator**	**Milestone**	**Progress update**
LBTH DAAT	Implement a payment by results element to drug / alcohol treatment service contracts to ensure recovery and harm reduction outcomes are met	31/03/17	INSERT PBR outcomes	• Contracts awarded by end June 2016 • New services implemented 01/10/16 • Baseline data established during first 6 months of contract	
LBTH DAAT	Ensure widespread distribution of Naloxone injections to reduce the incidence of drug related deaths	31/03/17	Number of Naloxone injections distributed PHOF 2.15iv Deaths from Drug Misuse (New Indicator for 2016-19, data not yet available)	• New contracts awarded by end June 2016 • New services implemented 01/10/16 • Naloxone distribution routes established 01/11/16	
T3 We will support our adult treatment and young people's services to improve their response to the needs of children of drug and or alcohol misusers. We will embed good practice and develop a protocol between children's services (including safeguarding) and treatment providers, train workers and support staff to identify and respond to drug and or alcohol using parents and their children					
Owner	**Action**	**Deadline**	**Key Performance Indicator**	**Milestone**	**Progress update**
LBTH DAAT	Ensure MASH is responding proactively to risks associated with substance misuse with the support of the DAAT Hidden Harm advisor to advise on cases, and co-ordinate / facilitate joint assessments and workforce training	31/03/17	Twice weekly attendance of Hidden Harm advisor Increase the number of parents in treatment by 5%	Recruit permanent Hidden Harm Advisor by 31/08/16 Increase MASH attendance to twice weekly by 31/12/16	

LBTH DAAT	Implement a robust Drug Testing policy for children's social care to ensure that cases have a wider context for decision making	Aug 16	Policy developed and agreed	• Policy signed off at Hidden Harm Steering Group July 2016 • Policy implemented in children's services	
LBTH DAAT	Universal Audit C Alcohol Screening implemented in Children's Centre and Assessment Function in Children's Social Care	31/03/17	Xx screens undertaken in childrens centres / childrens social care	xxxxxx	
LBTH DAAT	Ensure that all workers have received CAF training and are able to contribute to ECAF to ensure children's workers have relevant information on families.	31/03/17	xx treatment staff CAF trained xx eCAFs submitted by treatment service staff	• New treatment service implemented 01/10/16 • Treatment service workforce established 31/12/16 • CAF training completed 28/02/16	
LBTH DAAT	Implement standardised Assessment Tool, consent and care plan questions around children/parenting for new treatment services.	Oct 16	Assessment tool used for 100% of clients engaged in treatment Consent gained for 90% of all new clients living with children engaging in treatment	• New treatment service implemented 01/10/16 • Assessment tool,	

T4 We will work across our Partnership to develop services that address the wider social determinants of health and wellbeing, such as access to accommodation, employment support, economic wellbeing and educational achievement					
Owner	**Action**	**Deadline**	**Key Performance Indicator**	**Milestone**	**Progress update**
TH DAS (recovery support)	Implement a variety of interventions accessible via the drug and alcohol recovery support service to help recovering drug /alcohol users to increase engagement in employment, training and education	31/03/17	Improve uptake of education / employment / volunteering opportunities by drug / alcohol users in treatment to ensure figures are above the regional average	• Implementation of new recovery support service Oct 2016 • Quarterly data obtained	
THDAS	Implement volunteer schemes across all new drug / alcohol services	31/03/17	Improve uptake of education / employment / volunteering opportunities by drug / alcohol users in treatment to ensure figures are above the regional average	• Implementation of new recovery support service Oct 2016 • Quarterly data obtained	
LBTH Adults services	Ensure the accommodation needs of substance misusers are addressed within LBTH Hostels Commissioning Plan to ensure hostel provision is appropriate within a reduced funding envelope	30/09/16	Ensure the number of individuals leaving treatment with an urgent accommodation need is below 5%	• Consultation during May 2016 • Hostels commissioning Plan presented to Cabinet xxx	

T5 We will strengthen our approach to actively encourage 'hard to reach' and difficult to engage people, such as homeless people, hostel residents, street drinkers and drug and or alcohol misusing offenders, in order to motivate them towards engaging in treatment and progress towards recovery					
Owner	**Action**	**Deadline**	**Key Performance Indicator**	**Milestone**	**Progress update**
LBTH DAAT	Improve the response to treatment resistant alcohol users to minimise the risk of harm to themselves and others	March 2017	Increase the number of alcohol users in treatment by 6%	• Blue light pilot implemented with xx clients across the borough by xxx • Evaluation of pilot and plans for roll out by end March 2017	
LBTH DAAT / Adults Services	Implement robust referral pathways between hostels and treatment services that maximise the skills and capacity of workers within both hostels and the treatment system.	Dec 2016	Increase number of substance misusing residents engaging in structured treatment by xxx	• Implementation of new treatment service Oct 2016 • Pathways and satellites established Oct 2016 • Quarterly data collection	
LBTH DAAT	Implement and develop a drug / alcohol outreach / referral service that motivates and engages treatment resistant individuals into structured treatment	March 2017	ENTER REFERRAL TARGETS	• Develop pathways and protocols with new service provider and partner agencies • Implementation of new service Oct 2016	
LBTH DAAT / CRC	Work with treatment services and CRC to maximise the utilisation and effectiveness of Drug Rehabilitation Requirements (DRRs) and Alcohol Treatment Requirements (ATRs) to reduce offending of those misusing substances	March 2017	70 DRR starts 34 DRR successful completions 32 ATR starts 17 ATR successful completions	• Review DRR / ATR pathways with new treatment service – Oct 2016 • Pilot rapid assessment to facilitate same day orders	
CRC	Through the gate package			•	

T6 We will continue to increase access and uptake and improve outcomes from services across primary care, secondary care and specialist services.					
Owner	**Action**	**Deadline**	**Key Performance Indicator**	**Milestone**	**Progress update**
LBTH DAAT	Review and recommission GP based drug / alcohol treatment services to ensure general health outcomes for drug / alcohol users in treatment are improved	31/12/16	TBC	• Tender process started by 31/07/16 • Contracts awarded by 31/12/16	
LBTH DAAT	Implement proactive outreach / referral service to increase numbers accessing treatment services		Number of outreach service referrals into treatment system ENTER TARGET	• Implement new outreach / referral service – Oct 2016	
LBTH DAAT, Barts Health	Improve the identification of, and response to, individuals with an alcohol problem when presenting to secondary care services including A&E. • Review drug / alcohol service commissioned from Barts Health • Confirm alcohol detoxification pathways between primary and secondary care	November 2015	INSERT TARGETS FROM SERVICE SPEC	• Develop new service specification in conjunction with Barts Health • Develop S75 agreement with THCCG	

T7 We will develop expertise within substance misuse treatment services to respond to the needs of drug and / or alcohol users with mental health needs and support the dual diagnosis pathways between substance misuse and mental health services.					
Owner	**Action**	**Deadline**	**Key Performance Indicator**	**Milestone**	**Progress update**
ELFT	Develop and implement renewed treatment pathways for clients with a dual diagnosis to ensure access to both mental health services and substance misuse treatment services in a timely and co-ordinated fashion	31/12/16	TBC	• Implement new treatment service – Oct 2016 • Robust referral pathways developed – Nov 2016	
TH YPSM and CAMHS	Improve services available to substance misusing young people who have a concurrent mental health issue	xxxx	Increase in referrals.	• Regular CAMHS satellite service to commence in the YP treatment service • Interagency meetings with CAMHS and Lifeline YP service to be scheduled to discuss cases using a signs of safety approach	
T8 We will ensure our treatment services are available to people throughout the lifecycle, to support prenatal, postnatal, childhood, youth and the transition to adulthood and to end of life care.					
Owner	**Action**	**Deadline**	**Key Performance Indicator**	**Milestone**	**Progress update**
LBTH DAAT	Develop further the Overland multi agency support group for substance misusing women with children under 5 (or during pregnancy)	Ongoing	A core cohort of 8 women regularly engaging	• Improve clarity on referral criteria and pathway to group by end Sep 2016	

TH YPSM	Develop robust guidance for the transition of young people moving from YP substance misuse services to adult treatment services Protocols put in place to increase the support during the transition stage from YPSM treatment service to DAAT service.	31/12/16	Improved uptake of treatment services.	• Implementation of new adult treatment service • Development of protocols between providers Dec 2016	
T9 We will ensure that access to our services is equitable for all of our local communities.					
Owner	**Action**	**Deadline**	**Key Performance Indicator**	**Milestone**	**Progress update**
LBTH DAAT	Complete annual substance misuse needs assessment which will include data and information relating to access and efficacy levels across all 9 protected characteristic groups	31/03/16	Needs assessment published Actions established for 2017/18 action plan to address inequitable access highlighted		
LBTH DAAT	Ensure all treatment services deliver services that are attractive to, and responsive to the needs of, substance misusing individuals across all 9 protected characteristics	31/03/16	xxx	• Agree collection of additional data with new treatment services – Oct 2016 • Quarterly collection of data • Service changes to be requested where presentation of certain groups is below required level	
T10 We will ensure that family based interventions are integral to treatment provision					
Owner	**Action**	**Deadline**	**Key Performance Indicator**	**Milestone**	**Progress update**
LBTH DAAT	Implement a variety of family based interventions within the new drug / alcohol recovery support service	31/12/16	Increase number of individuals accessing family support interventions by 10%	Implementation of new drug / alcohol recovery support service – Oct 2016	

T11 We will ensure that there is rapid access to intensive specialist support for those young people whose drug and alcohol misuse is already starting to cause harm and to support these young people in their transition to adult services where appropriate.					
Owner	**Action**	**Deadline**	**Key Performance Indicator**	**Milestone**	**Progress update**
LBTH Childrens services	Improve follow up response for young people presenting to A&E with substance misuse presentations • Implement specialist alcohol service to deal with young people presenting to A&E with an alcohol problem	March 2017	• Increased referrals into structured treatment. • Reduction in the number of young people presenting to A&E with alcohol and substance misuse presentations.	• Liaise with A&E leads within the Royal London Hospital to establish consistent referral processes. • Update and reinforce referral pathways and protocols from A&E to treatment services. • Agree service model for YP service • Procure YP service	
LBTH Childrens Services	Recommission Young People's substance misuse service to ensure timely and comprehensive intervention for young people experiencing problems with drugs / alcohol				

Enforcement and Regulation					
ER1 We will maintain and enforce a borough wide alcohol control zone to reduce anti-social behaviour					
Owner	**Action**	**Deadline**	**Key Performance Indicator**	**Milestone**	**Progress update**
	THEO action				
ER2 We will actively enforce an environment where anybody under the legal drinking age is restricted from obtaining alcohol through working with licensed premises to ensure responsible alcohol sales, enforcement of any minimum alcohol pricing, and promotion of the available treatment services					
Owner	**Action**	**Deadline**	**Key Performance Indicator**	**Milestone**	**Progress update**
Trading Standards, LBTH	**Develop and implement a Community Alcohol Partnership scheme in Mile End that targets the issues around underage drinking**		**To add numbers**	• **Activities implemented April – September 2016** • **Evaluation completed Feb 2016**	
Trading Standards, LBTH	**Increase coverage of the Best Bar None scheme across the borough to encourage responsible trading**		**20 premises to be registered in the scheme**	• **Launch Best Bar None 2016/17 – July 2016** • **Best Bar None awards ceremony – February 2016**	
ER3 We will continue to improve the management and planning of the night time economy through strengthening the role of local residents in regulating the environments where alcohol can be obtained through utilisation of licensing, planning and other regulatory powers					
Owner	**Action**	**Deadline**	**Key Performance Indicator**	**Milestone**	**Progress update**
LBTH Trading Standards	**Consult on the introduction of a late night levy to help fund the costs associated with the night time economy**	**xxx**	**xxx**	**xxx**	

ER4 We will continue to disrupt the supply of drugs through effective enforcement					
Owner	**Action**	**Deadline**	**Key Performance Indicator**	**Milestone**	**Progress update**
LBTH Trading Standards	**Enforce the new Psychoactive Substances Act**	**31/03/17**	**Rapid action taken in relation to any retail; supply of NPSs**	• **Remind service providers and licencees of the requirements of the Act via normal communication routes - June 2016**	
	POLICE ACTIONS				
ER5 We will review and develop the Integrated Offender Management (IOM) programme to ensure drug misusing offenders receive a holistic support package aimed at stopping offending and drug dependence					
Owner	**Action**	**Deadline**	**Key Performance Indicator**	**Milestone**	**Progress update**
LBTH DAAT / CRC / NPS	**Implement new communications protocol between treatment services and the IOM programme**	**31/12/16**	**100% of all substance misusing offenders in the IOM programme to be engaged in treatment services**	• **Implement new treatment service contracts – Oct 2016** • **Confirm IOM / treatment pathways – Oct 2016**	
NPS / CRC	**Implement the Gripping the Offender pilot (MOPAC funded) programme, providing additional support for identified offenders, many of whom have drug / alcohol issues**	**31/03/17**	**100% of GtO clients misusing substances to be engaged in a treatment programme** **Target for successful treatment completions?**		
NPS / CRC/ LBTH DAAT	**Review and develop a new MOU / SLA with local probation services to ensure offenders with substance misuse needs are identified within the system**	**31/12/16**	**New MOU / SLA in place** **Regular reporting on offenders' attendance for treatment appointments in place**		

ER6 We will implement conditional cautioning for people whose offending is related to substance misuse (not just class A drugs) actively encouraging and monitoring their engagement with treatment services					
Owner	**Action**	**Deadline**	**Key Performance Indicator**	**Milestone**	**Progress update**
POLICE					

ER7 We will work with young offenders, with a commitment to support them into treatment and to oversee them both as young people and through their transition to adulthood.					
Owner	**Action**	**Deadline**	**Key Performance Indicator**	**Milestone**	**Progress update**
YOS					

ER8 We will address community concerns about drug use and drug dealing through on-going dialogue and effective communication with the general public					
Owner	**Action**	**Deadline**	**Key Performance Indicator**	**Milestone**	**Progress update**
Safer Communities, LBTH	Effective communication of successful operations via promotion of positive stories in Our East End and via other channels	Ongoing	• Improved perceptions of drug / alcohol related anti-social behaviour and crime amongst residents		

Setting the Foundations of Achieving Success					
StF1 We will develop and build an innovative and creative partnership approach to tackling drug and alcohol misuse					
Owner	**Action**	**Deadline**	**Key Performance Indicator**	**Milestone**	**Progress update**
DAATB	**Review terms of reference and membership of the DAAT Board**	**31/07/16**			
StF2 We well ensure effective use of gathered and analysed data and intelligence across the partnership, to better understand and address the harms caused by drug and alcohol misuse. Utilising national and local information on drugs and alcohol through a dashboard that combines prevention, treatment and offending data.					
Owner	**Action**	**Deadline**	**Key Performance Indicator**	**Milestone**	**Progress update**
DAATB	**Review DAATB dashboard to ensure required prevention, treatment and offending data is reported quarterly**	**31/12/16**			
	•			•	
Safer Communities, LBTH	Produce regular hotspot analysis of key data (crime, drugs, alcohol, youth asb etc) to deliver targeted operations	Quarterly	• Quarterly analysis reports available • Inclusion within annual needs assessment report considered at November DAAT Board	•	
StF3 We will set the right governance mechanisms to ensure the priority actions are reported through the DAAT Board and to both the Health and Wellbeing Board and Community Safety Partnership Board.					
Owner	**Action**	**Deadline**	**Key Performance Indicator**	**Milestone**	**Progress update**

StF4 We will constantly review the impact of our services on underserved communities through a commitment to monitor uptake and access to treatments ensuring services are accessible.					
Owner	**Action**	**Deadline**	**Key Performance Indicator**	**Milestone**	**Progress update**
LBTH PH	**Rewrite Joint Strategic Needs Assessment for Substance Misuse (Adults and Young People)**	**31/07/16**			
StF5 From an intelligence perspective we wish to continue to build an understanding of: o the impact on our population of the use of new drugs such as "legal highs", steroids, and over the counter and prescribed medicines, and will ensure that these areas are considered in future needs assessments o drug markets, distribution and trafficking, to inform our approach to enforcement and community development o treatment outcomes in other areas with similar treatment populations, to measure how effective our services are, and to help us to further improve them o drug and alcohol data and intelligence through developing drug related dashboard bringing together prevention, offending and treatment data o monitor and review cases of drug and alcohol related deaths and implement harm reduction strategies					
Owner	**Action**	**Deadline**	**Key Performance Indicator**	**Milestone**	**Progress update**
StF6 We will work with partners in commissioning, primary and secondary care to prove the value of our drug and alcohol recovery services to safeguard the resources for this important work					
Owner	**Action**	**Deadline**	**Key Performance Indicator**	**Milestone**	**Progress update**
LBTH DAAT	Pilot the Family Tool Kit to establish the family and community cost savings achieved via drug / alcohol treatment	31/07/16	Report on findings generated	• Report presented to DAAT Board October 2016	

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Equality Analysis (EA)

Financial Year
2016/17

See Appendix A

Current decision rating

Section 1 – General Information (Aims and Objectives)

Name of the proposal including aims, objectives and purpose
(Please note – for the purpose of this doc, 'proposal' refers to a policy, function, strategy or project)

Tower Hamlets Substance Misuse Strategy 2016 to 2019

The new Partnership substance misuse strategy 2016-2019 has been developed by analysing local need, reviewing the evidence base for effective intervention, and by listening to local stakeholders, service users and residents of Tower Hamlets.

The approach set out in the strategy supports the delivery of the borough's Community Plan and supports the Partnership's stated ambition to support a community which is both 'healthy and supportive' and 'safe and cohesive'.

This strategy outlines Tower Hamlets Partnership's approach to tackling the problems associated with drug and alcohol misuse focusing on the three pillar approach of 1) Prevention & Behaviour Change 2) Treatment and 3) Enforcement & Regulation

The EA emphasises the extensive consultation work undertaken developing this strategy. This document summarises the treatment population by its 9 protected groups and the anticipated impact of the new Strategy on various groups.

As a result of performing the analysis, the policy does not have any known adverse effects on people who share Protected Characteristics.

Conclusion - To be completed at the end of the Equality Analysis process
(the exec summary will provide an update on the findings of the EA and what outcome there has been as a result. For example, based on the findings of the EA, the proposal was rejected as the impact on a particular group was unreasonable and did not give due regard. Or, based on the EA, the proposal was amended and alternative steps taken)

Name:
(signed off by)

Date signed off:
(approved)

Service area: Communities, Localities and Culture

Team name: Drug and Alcohol Action Team

Service manager: Rachael Sadegh

Name and role of the officer completing the EA: Matthias Schneppel, Information and Needs Analyst

Section 2 – Evidence (Consideration of Data and Information)

What initial evidence do we have which may help us think about the impacts or likely impacts on service users or staff?

- The DAAT had access to robust data and research about Tower Hamlets and its residents. This information is setting the scene and provides an understanding of the different communities in the borough.
- The Substance misuse needs assessment from 2014/15 represents a crucial part of the evidence base of the new strategy.
- DAAT has limited information about the local problematic drug user population and drug use in general. The majority of data comes from treatment sources, based on information about clients in the treatment system.
- The information is taken from local monitoring reports provided directly from service providers and Public Health England / National Drug Treatment Monitoring System data.
- Both quantitative and qualitative information contributed to the analysis and are represented in conclusions and recommended actions.
- Focus groups and stakeholder interviews played a crucial role in developing the new Substance Misuse Strategy and have informed strategic priorities.

Section 3 – Assessing the Impacts on the 9 Groups

Please refer to the guidance notes below and evidence how you're proposal impact upon the nine Protected Characteristics in the table on page 3?

For the nine protected characteristics detailed in the table below please consider:

What is the equality profile of service users or beneficiaries that will or are likely to be affected?
Use the Council's approved diversity monitoring categories and provide data by target group of users or beneficiaries to determine whether the service user profile reflects the local population or relevant target group or if there is over or under representation of these groups

Data shows that the profile of people in drug and alcohol treatment illustrates similarities but also differences when compared to the general adult population in Tower Hamlets.

The data discussed in the document shows that the female population is under-represented in the treatment system while White British, Bangladeshi and Christian residents were marginally over-represented in treatment. In comparison, the White-Other groups appears to be under-represented.

Age matters in drug and alcohol treatment data as many only access treatment after long periods of substance misuse. The treatment population in Tower Hamlets is dominated by those aged 30 to 44 / 49. Engagement of young adults in treatment remains a key priority. Some successes have been achieved by focusing engagement on party drugs and gay men. This will remain a priority in the new strategy.

Gender
In general, there were 2,274 adults in drug and alcohol treatment in 2014/15. Out of those, around 461 (20 per cent) were female and 1,813 (80 per cent) were male. The female treatment population is under-represented in Tower Hamlets when compared to the national average (30per cent). (Source: NDTMS 2014/15 Adult Activity Q4 National)

The overall gender split of the 18 plus population in the borough was 51.7per cent males and 48.3 per cent females. (Source: Census 2011)

Age
More than 55 per cent of Tower Hamlets residents in treatment during 2014/15 were aged 30-44, a strong over-representation compared to the proportion of residents in that age group according to the Census.

In Tower Hamlets, those aged 18 to 24 (6 per cent) were slightly under-represented compared and England (7.3 per cent). Clients in treatment aged 45 and older in Tower Hamlets resembles closely the proportion of clients in England aged 45 and older. The age structure of clients in treatment represents one of the key challenges of drug and alcohol treatment as clients will access treatment only after years of drug and alcohol misuse. See table below.

Age group	Tower Hamlets	Tower Hamlets	England
	All in treatment %	Census 2011 population 18 plus (%)	All in treatment (%)
18 – 24	6%	19%	7.3%
25 – 29	9%	20%	10.6%
30 – 34	20%	17%	16.6%
35 – 39	19%	11%	17.6%
40 – 44	17%	8%	16.6%
45 – 49	13%	6%	13.4%
50 – 54	8%	5%	8.7%
55 – 59	5%	4%	4.7%
60 – 64	2%	3%	2.5%
65 plus	1%	8%	1.8%

(Source: NDTMS 2014/15 Adult Activity Q 4 YTD)

Race / Ethnicity
The majority of clients in treatment were White British (43.2 per cent), higher than the total population aged 18 plus of 35.7 per cent. Around 23.3 per cent percent of those in treatment were Bangladeshi which was just below the proportion of British Bangladeshi in the 18 plus population in the borough (25 per cent).

In comparison, the Other White population was underrepresented in the treatment population. See table below. (Source: NDTMS 2014/15 All in treatment YTD / Census 2011)

Ethnicity	In treatment population Tower Hamlets %	Census 2011 – 18 plus population Tower Hamlets %
White British	43.2%	35.7%
White Irish	3.1%	1.9%
Other White	9.1%	14.9%
White & Black Caribbean	2.8%	0.8%
White & Black African	1%	0.5%

White & Asian	0.5%	0.9%
Other Mixed	1.3%	1.0%
Indian	1%	3.1%
Pakistani	0.4%	1.0%
Bangladeshi	23.3%	25.0%
Other Asian	1.2%	2.4%
Caribbean	3.2%	2.2%
African	2.5%	3.4%
Other Black	0.6%	1.1%
Chinese	0.3%	3.8%
Other	0.7%	2.4%
Not Stated	5.2%	N/A
Missing ethnicity code	0.7%	N/A

(Source: NDTMS 2014/15 Q4 Adult Activity YTD, Figures are rounded and Census 2011 18 plus population by ethnicity)

Religion or Belief

Tower Hamlets has the highest percentage of Muslim residents in England – 35 per cent compared with a national average of 5 per cent. Conversely, the borough has the lowest proportion of Christian residents in England: 27 per cent compared with a national average of 59 per cent. The third largest group was the group with no religion with 19 per cent.

Recent monitoring data from drug and alcohol service providers indicates that Christian residents (33.3 per cent) were slightly overrepresented in treatment while Muslim residents (33.1 per cent) were close to the general population. The proportion of residents with No religion including Atheists of 26.7 per cent was above the Census 2011 figure. See table below.

Religion	Religious belief of those in treatment	TH population (Census 2011)
Atheist	26.7%	19.1%
Buddhist	0.3%	1.1%
Christian	33.3%	27.1%
Hindu	0.3%	1.7%
Sikh	0.4%	0.3%
Jewish	0.2%	0.5%
Muslim	33.1%	34.5%
Any other religion	0.6%	0.3%
Not stated	5.3%	15.4%

(Source: Tower Hamlets Quarter 2 monitoring returns 2015/16 and Census data 2011)

Disability

Census 2011, respondents were asked whether their activities are limited by long-term health problems or disability. They were able to choose between 'limited a lot', 'limited a little' and 'no'. Of over 254,000 respondents in the borough, 7 per cent stated that their day-to-day activities were limited a lot, and another 7 per cent stated they were limited a little.

Service providers in Tower Hamlets monitor the take up of treatment by disability. Recent Q2 2015/16 monitoring returns indicate that nearly 30% of clients consider themselves to have a disability. This is twice the borough average of 14 per cent based on the Census 2011.

Gender Reassignment

The council does not hold information on gender reassignment in the borough. Service providers are monitoring the category but latest data from Q2 2015/16 did not show any clients in this category.

Sexual orientation
The council does not hold robust information about sexual orientation in Tower Hamlets. However, service providers monitor sexual orientation of those in treatment. Data indicates that around 93per cent were heterosexual, 4.4per cent homosexual and 1per cent Bi-sexual.

Sexual orientation	Percentage
Heterosexual	93.3%
Homosexual	4.4%
Bi-Sexual	1%
Other	0.4%
Not Recorded	1%

(Source: Tower Hamlets Quarter 2 monitoring returns 2015/16)

Anecdotal evidence shows that drug use by gay males is high but does not always show in the treatment data. However, the CDT's After Party project in 2015/16 has increased the engagement of gay men in treatment and work successfully with those clients.

Marriage or civil partnership
Service providers monitor the take up of treatment by marriage & civil partnership. Recent data shows that clients in treatment were most likely to be singe (45.4%), Married (14.1%), Co-habiting (6.3%). A large group of clients did not respond to this question (34%) in Q2 2015/16.

Pregnancy and Maternity
Service providers monitor the take up of treatment by pregnancy and maternity. Recent Q2 2015/16 data showed that a very small number of clients (below 10 clients) had given birth in the last 26 weeks or were pregnant.

What qualitative or quantitative data do we have?

List all examples of quantitative and qualitative data available (include information where appropriate from other directorates, Census 2011 etc) Data trends – how does current practice ensure equality

Quantitative data available for EA

- Statistics from NDTMS (National Drug Treatment Monitoring System) contains information about who is in treatment and for what. Data about drug & alcohol use and treatment data have been analysed extensively in the substance misuse needs assessment 2013/14 and 2014/15. The Substance Misuse needs Assessment 2014/15 is a crucial part of the Strategy evidence base. Analysis here is critical to assess service need, performance and support the understanding of treatment demand and inform substance misuse intervention priorities in Tower Hamlets.
- Data about the Tower Hamlets population has been accessed via Tower Hamlets Borough Profile web pages including information from the National Census 2011.
- 1 focus group with the Youth Council (10 participants) 12th November 2015
- 63 stakeholders participated in the Stakeholder Survey
- 301 residents participated in the Resident Telephone Survey
- 115 drug and alcohol service users participating in the Service User Survey
- Service user data from monitoring returns (latest data Q2 2015/16)

Qualitative information available for EA

- 21 face to face and telephone interviews with key stakeholders
- Substance Misuse Strategy Development – Stakeholder Workshop held at the Tower Hamlets Drug and Alcohol Network (DAN meeting) on 11th September 2015
- 5 service user focus groups with:
    - opiate users (15 participants) 30th October 2015
    - non-opiate users (10 participants) 27th October 2015
    - alcohol users (14 participants) 12th October 2015

    - targeted focus groups with women (3 participants) 21st October 2015
    - homeless services users (2 participants) 12th November 2015
- One focus group with the Youth Council (10 participants) 12th November 2015
- Substance Misuse Strategy Development – Stakeholder Workshop held at the Shadwell Centre, partnership stakeholder engagement 19th November 2015

Equalities profile of staff

Indicate profile by target groups and assess relevance to policy aims and objectives e.g. Workforce to Reflect the Community. Identify staff responsible for delivering the service including where they are not directly employed by the council.

The partnership is currently completing a re-procurement process of drug and alcohol services in the borough. This process might involve changes to service providers or existing staff structures, depending on service needs and existing service delivery capacity.

However, as part of the re-procurement exercise, DAAT will seek a commitment from service providers to employ local staff and subcontractors as part of the ambition to implement the Mayors *Workforce to reflect the community* policy.

- *Service provider staff*

The diversity of staff employed by service providers is a strong feature of local service delivery. Analysis indicates that the overall workforce is featuring the main cohorts of our diverse communities. However, some exceptions were noted in the data and there is scope to address this in the future.

The data shows that 49.4 per cent of the alcohol and drug service workforce were women, while men made up 50.6% of the workforce, indicating a relative gender balance.

The age data indicates that less than 2 per cent of staff was aged between 18 and 24 years. This might be caused by existing low levels of entry positions and lack of apprenticeships. There is potential to address this issue with the aim to create entry positions / apprenticeships in drug and alcohol services. The majority of staff were 25 to 44 years old (64.8%).

In terms of disability, it is noticeable that current service providers employed low levels of disabled staff (around 4 per cent). There is potentially scope to increase the accessibility of those jobs in the future.

In terms of ethnicity, staff of Bangladeshi origin (21 per cent) was under-represented in the workforce, when compared to the local adult population of 25.3 per cent. The White British (31 per cent) group was only slightly under represented compared to its overall size in Tower Hamlets.

In comparison, the Black African group (12.3 per cent) and the Black Caribbean group (8.5 per cent) were over-represented, while the White Other group was also slightly under-represented with 8.6 per cent. See table below.

Ethnicity	Residents Aged 18 to 64	STAFF Service providers Aged 18 to 64
White: Total	**51.5%**	**42.2%**
White: English/Welsh/Scottish/Northern Irish/British	33.9%	30.9%

White: Irish	1.7%	3.7%
White: Gypsy or Irish Traveller	0.1%	N/A
White: Other White	15.8%	8.6%
Mixed/multiple ethnic group: Total	**3.3%**	**6.1%**
Mixed/multiple ethnic group: White and Black Caribbean	0.8%	3.7%
Mixed/multiple ethnic group: White and Black African	0.5%	1.2%
Mixed/multiple ethnic group: White and Asian	1.0%	0%
Mixed/multiple ethnic group: Other Mixed	1.1%	1.2%
Asian/Asian British: Total	**36.0%**	**24.7%**
Asian/Asian British: Indian	3.2%	1.2%
Asian/Asian British: Pakistani	1.0%	0.0%
Asian/Asian British: Bangladeshi	25.3%	21%
Asian/Asian British: Chinese	4.0%	0.0%
Asian/Asian British: Other Asian	2.5%	2.5%
Black/African/Caribbean/Black British: Total	**6.6%**	**23.4%**
Black/African/Caribbean/Black British: African	3.5%	12.3%
Black/African/Caribbean/Black British: Caribbean	2.0%	8.6%
Black/African/Caribbean/Black British: Somali	N/A	2.5%
Black/African/Caribbean/Black British: Other Black	1.1%	0.0%
Other ethnic group: Total	**2.5%**	**1.2%**
Other ethnic group: Arab	1.1%	0%
Other ethnic group: Any other ethnic group	1.4%	1.2%

(Source: Population Census 2011, Staff data service providers Q2 / Q3 2015/16)

In terms of religion and belief, staff of Christian faith (40.2 per cent) were over- represented compared to the Tower Hamlets population (27 per cent). The proportion of staff with no religion (20.7 per cent) was only slightly above the borough average of 19 per cent. In comparison, the proportion of Muslim staff (29.3 per cent) was lower than the Tower Hamlets average of 35 per cent.

In terms of sexual orientation, the current staff structure is close to the borough average.

The staff equalities data shows that while the workforce is very diverse, there is scope in some categories to develop a workforce even closer to the Tower Hamlets community.

However, the current workforce of some providers can have similar characteristics because the project might be working with specific clients, for example, the women only project would be employing female staff only. The staff structure of providers can be related to the communities this service is serving and / or is shaped by specific ethics and service delivery philosophies.

Barriers?

What are the potential or known barriers to participation for the different equality target groups? Eg- communication, access, locality etc.

- A potential barrier to treatment is user engagement, communication and ways to access treatment (entry route). These barriers have been identified and are a priority noted in the strategy. This barrier will also be expressed in new performance targets for treatment providers.

- Intervention by drug and alcohol services in the borough will remain focuses and target needs of specific client groups including BME groups, women, gay men, young adults, hostel residents, and people with mental health issues. The new Substance Misuse strategy emphasises that treatment will remain accessible for everyone who needs it. The strategy includes various actions to respond to specific needs in communities and any emerging trends including party drugs, NPS and others.

- Additional communication will ensure treatment and support will be available to high need groups including:

- BME groups
- Female drug users - ensuring access to treatment for women
- Sex workers
- Alcohol users who do not mix with drug users
- Drug users in the LGBT community
- Drug users with mental health problems
- Khat use in predominantly Somali community
- Hostel residents
- Homeless users / rough sleepers
- Domestic violence victims
- Young adults 18 to 24
- Families dealing with drug / alcohol using family members

Recent consultation exercises carried out?
Detail consultation with relevant interest groups, other public bodies, voluntary organisations, community groups, trade unions, focus groups and other groups, surveys and questionnaires undertaken etc. Focus in particular on the findings of views expressed by the equality target groups. Such consultation exercises should be appropriate and proportionate and may range from assembling focus groups to a one to one meeting.

Extensive consultation exercises including focus groups and surveys informed the development of the new Substance Misuse Strategy 2016-19. Those engaged with service users, service providers, stakeholders and the general public. The findings informed directly the actions plan and evidence base of the new strategy.

Phase one of the consultation process involved obtaining the views of key stakeholders, drug and alcohol service users and general public perceptions:

- 21 face to face and telephone interviews with key stakeholders
- Substance Misuse Strategy Development – Stakeholder Workshop held at the Tower Hamlets Drug and Alcohol Network (DAN meeting) on 11th September 2015
- 5 service user focus groups with:
  - opiate users (15 participants) 30th October 2015
  - non-opiate users (10 participants) 27th October 2015
  - alcohol users (14 participants) 12th October 2015
  - targeted focus groups with women (3 participants) 21st October 2015
  - homeless services users (2 participants) 12th November 2015
- One focus group with the Youth Council (10 participants) 12th November 2015
- 63 stakeholders participated in the Stakeholder Survey
- 301 residents participated in the Resident Telephone Survey
- 115 drug and alcohol service users participating in the Service User Survey
- Substance Misuse Strategy Development – Stakeholder Workshop held at the Shadwell Centre, partnership stakeholder engagement 19th November 2015

In addition, the draft substance misuse strategy 2016-19 was published on the council's website for consultation among the general public and partnership services (statutory and voluntary). In addition, colleagues across the partnership were invited to participate in the consultation by the DAAT. The consultation closed on 14 April 2016.

Additional factors which may influence disproportionate or adverse impact?
Management Arrangements - How is the Service managed, are there any management arrangements which may have a disproportionate impact on the equality target groups

- We have not identified any management arrangements which may have a disproportionate impact on the equality groups / 9 protected characteristics. DAAT is continuing to monitor any potential negative impact as part of our contractual monitoring.

The Process of Service Delivery?
In particular look at the arrangements for the service being provided including opening times, custom and practice, awareness of the service to local people, communication

- The new strategy prioritises
  a) Prevention & behaviour change,
  b) Treatment
  c) Enforcement & regulation

The alcohol-related element of the strategy seeks to improve the quality of life for both Tower Hamlets residents and visitors. The partnership seek to encourage and promote a culture of responsible drinking coupled with responsible management of licensed premises.

The drugs element of the strategy seeks to reduce the demand for drugs through effective education and prevention, to increase the number of people entering services, reducing harm, engaging with and completing treatment in order to recover from drug misuse and to bear down on the crime associated with drugs.

Please Note -
Reports/stats/data can be added as Appendix

Target Groups	Impact – Positive or Adverse What impact will the proposal have on specific groups of service users or staff?	Reason(s) • Please add a narrative to justify your claims around impacts and, • Please describe the analysis and interpretation of evidence to support your conclusion as this will inform decision making Please also how the proposal with promote the three One Tower Hamlets objectives? -Reducing inequalities -Ensuring strong community cohesion -Strengthening community leadership
Race	Neutral - Positive	The majority of clients in treatment were White British (43.2 per cent), a rate higher than the total population aged 18 plus of 35.7 per cent. Also over-represented were Black Caribbean clients and client of mixed heritage. Around 23.3 per cent percent of those in treatment were Bangladeshi which was just below the proportion of British Bangladeshi in the 18 plus population in the borough (25 per cent). In comparison, the Other White population, African, Chinese and Indian were under-represented in the treatment population. While will have various reasons including age and gender, it remains paramount that the treatment system remains accessible to all groups. The strategy continues to target high need groups in the borough including the Somali and Bangladeshi communities. Existing local knowledge will need to be retained and utilised to target specific treatment needs or any barriers which might stop people entering treatment. The DAAT contract specifications and a robust monitoring process will ensure that service providers will deliver agreed performance targets for BME groups.
Disability	Neutral - Positive	It is know that many of the TH service users classify themselves as having a disability. The new treatment system will built upon existing positive work and we anticipate developing strong links with mental health services improving services for those clients. The strategy makes clear that mental health issues need to be addressed. DAAT contract specifications and a robust monitoring process will ensure that service providers will deliver agreed performance targets for disabled clients. This will include support for the Dual Diagnosis pathway between substance misuse and mental health.
Gender	Neutral - Positive	In general, there were 2,274 adults in drug and alcohol treatment in 2014/15. Out of those, around 461 (20 per cent) were female and 1,813 (80 per cent) were male. The female population is under-represented in treatment and lower than the national average (30per cent) in treatment. (Source: NDTMS 2014/15 Adult Activity Q4 National)

		We know that women are less likely to enter the treatment system, which remains a significant challenge for any treatment provider. The new strategy continues to focus on female users and build upon local expertise to improve on current treatment outcomes. DAAT contract specifications and a robust monitoring process will ensure that service providers will deliver agreed performance targets by gender.
Gender Reassignment	Neutral - Positive	Currently we don't have enough information to access the impact on the group. However, we anticipate that with general service improvements, a positive impact will be experienced in this group. The strategy commits to ensuring equitable access to services across all populations.
Sexual Orientation	Neutral - Positive	The council does not hold robust information about sexual orientation in Tower Hamlets. However, service providers monitor sexual orientation of those in treatment. Data indicates that around 93per cent were heterosexual, 4.4per cent homosexual and 1per cent Bi-sexual Anecdotal evidence shows that drug use of gay men is high. This group has been targeted as part of the CDT 'After Party' project. The strategy will build upon the positive experience of this pilot and continues to improve treatment engagement and treatment success for this group including "Chemsex". DAAT contract specifications and a robust monitoring process will ensure that service providers will deliver agreed performance targets for the LGBT community. The strategy commits to ensuring equitable access to services across all populations.
Religion or Belief	Neutral - Positive	Tower Hamlets has the highest percentage of Muslim residents in England – 35 per cent compared with a national average of 5 per cent. Conversely, the borough has the lowest proportion of Christian residents in England: 27 per cent compared with a national average of 59 per cent. The third largest group was the group with no religion with 19 per cent. Recent monitoring data from drug and alcohol service providers indicates that Christian residents (33.3 per cent) were slightly overrepresented in treatment while Muslim residents (33.1 per cent) were close to the general population. The proportion of residents with No religion including Atheists of 26.7 per cent was above the Census 2011 figure. Drug and alcohol use and addiction is a problem in most communities, no matter what faith or belief. However, the large Muslim community stands out with high abstinence levels. The substance misuse strategy makes it clear that treatment services will need to apply tailored approaches to work effectively with different communities in Tower Hamlets and achieve the best results. DAAT contract specifications and a robust monitoring process will ensure that service providers will deliver agreed performance targets for residents with or without a belief/religion.
Age	Neutral -	More than 55 per cent of Tower Hamlets residents in treatment during 2014/15 were aged 30-44, a strong over-

	Positive	representation compared to the proportion of residents in that age group according to the Census. In Tower Hamlets, those aged 18 to 24 (6 per cent) were slightly under-represented compared to England (7.3 per cent). The group of clients in treatment aged 45 and older in Tower Hamlets resembles closely the proportion of clients in England aged 45 and older. The age structure of clients in treatment represents one of the key challenges of drug and alcohol treatment as clients will access treatment often only after years of drug and alcohol misuse. It is know that age matters when accessing treatment and the close relationship between problematic drug use, age and treatment need. The aim of the strategy is to offer and provide successful treatment as early as possible in the life of a drug and alcohol user. We will ensure that our services are available to people throughout the lifecycle, to support prenatal, postnatal, childhood, youth and the transition to adulthood and to end of life care. DAAT contract specifications and a robust monitoring process will ensure that service providers will deliver agreed performance targets for residents of any age with an additional focus on young adults aged 18 to 24. The strategy includes commitments to improving services and outcomes for young people.
Marriage and Civil Partnerships.	Neutral - Positive	Currently we don't have enough information to access the impact on the group. However, we anticipate that with general service improvements, a positive impact will be experienced in this user group.
Pregnancy and Maternity	Neutral - Positive	Currently we understand that numbers in this particular group are low. However, each case in drug and alcohol treatment is a high priority and will be supported already. Clients in this group will continue to receive the service they need and we anticipate that with general service improvements clients should experience a positive impact
Other Socio-economic groups / Carers	Neutral - Positive	Currently we don't have enough information to access the impact on the group. However, we anticipate that with general service improvements, a positive impact will be experienced in this user group. However, we know that many of our services are accessed by hostel residents and homeless people and also offenders exiting the criminal justice system. DAAT contract specifications and a robust monitoring process will ensure that providers will work closely with those groups. The new strategy is also focusing on families making clear that support for families and 'significant others' are a priority.

Section 4 – Mitigating Impacts and Alternative Options

From the analysis and interpretation of evidence in section 2 and 3 - Is there any evidence or view that suggests that different equality or other protected groups (inc' staff) could be adversely and/or disproportionately impacted by the proposal?

Yes? No? x

If yes, please detail below how evidence influenced and formed the proposal? For example, why parts of the proposal were added / removed?

(Please note – a key part of the EA process is to show that we have made reasonable and informed attempts to mitigate any negative impacts. An EA is a service improvement tool and as such you may wish to consider a number of alternative options or mitigation in terms of the proposal.)

Where you believe the proposal discriminates but not unlawfully, you must set out below your objective justification for continuing with the proposal, without mitigating action.

Section 5 – Quality Assurance and Monitoring

Have monitoring systems been put in place to check the implementation of the proposal and recommendations?

Yes

How will the monitoring systems further assess the impact on the equality target groups?

- The implementation of the strategy will include an annual action plan which will provide the performance management framework against which DAAT will measure its success. The action plan will be monitored and reviewed through the course of the strategy and DAAT will drive delivery against set targets.
- Service providers are already monitoring clients in treatment using the nine protected characteristics categories. The data will be monitored as part of the contract monitoring and will inform the strategic direction of service delivery.
- The impact of treatment and drug and alcohol related work on different equality groups will be reviewed regularly at Project Team and DAAT Board meetings.

Does the policy/function comply with equalities legislation?
(Please consider the OTH objectives and Public Sector Equality Duty criteria)

Yes? x No?

If there are gaps in information or areas for further improvement, please list them below:

- The information for some of the protected characteristics categories is limited. Regular monitoring will ensure that service providers will respond to missing information as a business crucial matter.

How will the results of this Equality Analysis feed into the performance planning process?

- Results of the EA will inform the target setting process and the development of key performance indicators of drug and alcohol services.
- Actions from this EA will be included in the Action plan and Performance management Framework of the Substance Misuse Strategy 2016-19.
- Service providers are required to use equalities information to target outreach work and develop projects to respond to needs in our communities.

Section 6 - Action Plan

*As a result of these conclusions and recommendations what actions (if any) **will** be included in your business planning and wider review processes (team plan)? Please consider any gaps or areas needing further attention in the table below the example.*

Recommendation	Key activity	Progress milestones including target dates for either completion or progress	Officer responsible	Progress
Ensure that the Prevention and Behavioural Change message is targeted effectively to different communities in the borough.	- Provide targeted communication and community education for those who are at risk of alcohol and drug misuse.	- Communicate services to current service users - Focus on effective service user engagement - Develop education programs to educate wider population including young people	DAAT Commissioning Manager	
Ensure that access to treatment is open for all our local communities.	- Ensure that drug and alcohol services will respond to specific need groups including BME and women, - Ensure that the services are accessible geographically and opening times will cater for client needs. - Improve engagement with 'hard to reach' groups including homeless people, hostel residents, street drinkers and drug & alcohol misusing offenders.	- Service provider and partnership to achieve specific performance targets	DAAT Commissioning Manager	
Monitor New Substance misuse Strategy including action plan	- Monitor action plan and report about progress (Annually / Quarterly)	- Provide updates to DAAT Board	DAAT Information and Needs Analyst	
Produce annual needs assessment with particular regards to high need groups (groups identified in EA).	- Produce annual needs Assessment - Incorporate emerging needs and underrepresented groups in annual targets for providers.	- Completion and discussion of needs assessment at DAAT Board - Communicate results to service providers and staff.	DAAT Information and Needs Analyst	

Appendix A

(Sample) Equality Assessment Criteria

Decision	Action	Risk
As a result of performing the analysis, it is evident that a risk of discrimination exists (direct, indirect, unintentional or otherwise) to one or more of the nine groups of people who share *Protected Characteristics.* It is recommended that the use of the policy be suspended until further work or analysis is performed.	**Suspend – Further Work Required**	**Red** 
As a result of performing the analysis, it is evident that a risk of discrimination exists (direct, indirect, unintentional or otherwise) to one or more of the nine groups of people who share *Protected Characteristics.* However, a genuine determining reason may exist that could legitimise or justify the use of this policy.	**Further (specialist) advice should be taken**	**Red Amber** 
As a result of performing the analysis, it is evident that a risk of discrimination (as described above) exists and this risk may be removed or reduced by implementing the actions detailed within the *Action Planning s*ection of this document.	**Proceed pending agreement of mitigating action**	**Amber** 
As a result of performing the analysis, the policy, project or function does not appear to have any adverse effects on people who share *Protected Characteristics* and no further actions are recommended at this stage.	**Proceed with implementation**	**Green:** 

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Health and Wellbeing Board Tuesday 21st June 2016	Tower Hamlets Health and Wellbeing Board
Report of the London Borough of Tower Hamlets	**Classification:** Unrestricted
Tower Hamlets Health and Wellbeing Strategy 2016-2020: developing a strategy that will make a difference - next steps	

Lead Officer	Somen Banerjee, Director of Public Health
Contact Officers	Somen Banerjee, Director of Public Health
Executive Key Decision?	No

Summary

Based on the discussions at the Board meeting in March and previous workshops, there is consensus that the Tower Hamlets Health and Wellbeing Strategy should be 'a strategy with a small number of core, widely owned, accountable objectives, but that is adaptive and responds to feedback'.

The Board has identified five areas for transformation:

- Addressing the health impacts of deprivation
- Helping communities lead change around health
- Healthy place
- Tackling childhood obesity
- Developing a truly integrated system to support health.

At the meeting, Board members have been asked to present back a powerpoint presentation addressing the following seven questions around transformational area:

- Why is this important issue for health and wellbeing in Tower Hamlets?
- What is currently being done to improve outcomes?
- Where would we like to be in 3 years (vision statement)?
- Within this area, what does the Board need to focus on?
- What are the top areas of action the Board needs to focus on over the next 12 month to drive transformational change (max 2) and why?
- What is required to make this happen?
- What are the top indicators that the board needs to track (max 3)?

These presentations and subsequent discussion will provide the basis for the draft of the strategy that will come to the next Board meeting.

Recommendations:

The Health & Wellbeing Board is recommended to discuss the presentations focussing particularly on the areas of action and indicators.

1. REASONS FOR THE DECISIONS

1.1 The reasons for the decision are to identify a small number of widely owned, accountable objectives for the strategy

2. ALTERNATIVE OPTIONS

2.1 If the Board were not fully involved in key decisions around the shape and approach of the strategy it would fail

3. DETAILS OF REPORT

3.1 See attached report

4. COMMENTS OF THE CHIEF FINANCE OFFICER

4.1 This paper moves forward the discussion on the Tower Hamlets Health and Wellbeing Strategy 2016-2020. There are no direct financial implications indicated at this stage as a result of the recommendations in this report.

4.2 The Health and Wellbeing Strategy 2016 - 2020 would need to factor in the financial resources which are available during the period covered by the strategy in accordance with the Council's Medium Term Financial Plan.

5. LEGAL COMMENTS

5.1 The Health and Social Care Act 2012 ("the 2012 Act") makes it a requirement for the Council to establish a Health and Wellbeing Board ("HWB"). S.195 of the 2012 Act requires the HWB to encourage those who arrange for the provision of any health or social care services in their area to work in an integrated manner.

5.2 This duty is reflected in the Council's constitutional arrangements for the HWB which states it is a function of the HWB to have oversight of the quality, safety, and performance mechanisms operated by its member organisations, and the use of relevant public sector resources across a wide spectrum of services and interventions, with greater focus on integration across outcomes spanning health care, social care and public health.

5.3 Section 116A of the Local Government and Public Involvement in Health Act 2007 places a duty on the HWB to prepare and refresh a joint strategic health and wellbeing strategy in respect of the needs identified in the Joint Strategic Needs Assessment, so that future commissioning/policy decisions are based on evidence. The duty to prepare this plan falls on local authorities and the Clinical Commissioning Group, but must be discharged by the HWB.

5.4 In preparing this strategy, the HWB must have regard to whether these needs could better be met under s75 of the National Health Service Act 2006. Further, the Board must have regard to the Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies published on 26 March 2013, and can only depart from this with good reason.

5.5 The review of the strategy provides the opportunity to refresh and update the focus of the HWB to reflect current and future needs within the borough. This review programme provides the basis for the HWB to ensure the priorities identified are the right areas of focus for the strategy before agreeing any final strategy and plan.

5.6 When considering the recommendation above, and during the review itself, regard must be given to the public sector equalities duty to eliminate unlawful conduct under the Equality Act 2010. The duty is set out at Section 149 of the 2010 Act. It requires the Council, when exercising its functions, to have 'due regard' to the need to eliminate discrimination (both direct and indirect discrimination), harassment and victimization and other conduct prohibited under the Act, and to advance equality of opportunity and foster good relations between those who share a 'protected characteristic' and those who do not share that protected characteristic.

6. ONE TOWER HAMLETS CONSIDERATIONS

6.1 The strategy is about how health can be improved for the borough as a whole but with a particular priority on how those in greatest need can be targeted.

7. BEST VALUE (BV) IMPLICATIONS

7.1 One of the drivers shaping the strategy are the cost pressures on the health and care economy and this will need to be a consideration in the discussions

8. SUSTAINABLE ACTION FOR A GREENER ENVIRONMENT

8.1 Healthy planning is one of the transformation areas identified

9. RISK MANAGEMENT IMPLICATIONS

9.1 The proposals in the paper are draft currently and address a risk that the strategy focus does not engage the board and reflect the priorities and approach that will work for the board in years to come

10. CRIME AND DISORDER REDUCTION IMPLICATIONS

10.1 There may be interdependencies between strategies such as those relating to crime and disorder and the priorities emerging through health and wellbeing strategy

Linked Reports, Appendices and Background Documents

Linked Report

- NONE

Appendices

- Report on Health and Wellbeing Strategy workshop, January 2016
- Report on Kings Fund Strategy workshop, October 2015

Local Government Act, 1972 Section 100D (As amended)
List of "Background Papers" used in the preparation of this report
List any background documents not already in the public domain including officer contact information.

- State NONE if none.

Officer contact details for documents:

Somen Banerjee, Director of Public Health
Somen.banerjee@towerhamlets.gov.uk

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Tower Hamlets Health and Wellbeing Strategy - next steps

Background

Based on the discussions at the Board meeting in March, there is consensus that the Tower Hamlets Health and Wellbeing Strategy should be 'a strategy with a small number of core, widely owned, accountable objectives, but that is adaptive and responds to feedback'.

The Board also agreed five areas of focus for transformation based on the following criteria:

1. Transformation will have significant positive impact
    a. The area is considered to be an important health and wellbeing issue with regard to the size of the problem, inequalities issues and/or cost
    b. There is good evidence for intervention (or credible potential to build evidence)
2. The area matters to Tower Hamlets citizens
3. System change is feasible
4. There is collective will to achieve the change

Through previous workshops, the Board arrived at the transformational areas (as below) and the task is now to identify what aspects of these areas the Health and Wellbeing Board needs to focus on and where the Board can use its levers to make the difference.

In order to take this forward, Board members have been allocated to each transformational areas as follows:

- Addressing the health impacts of deprivation
    - Cllr Amy Whitelock Gibbs, Lead Member for Health and Adults Services
    - Will Tuckley, Chief Executive LBTH
    - Somen Banerjee, Director of Public Health LBTH
    - Ian Basnett, Public Health Director, Barts Health
    - Officer support:
        - Kevin Kewin (Strategy and Performance)

- Helping communities lead change around health

    - John Gillespie, THCVS
    - Dianne Barham, Healthwatch
    - Officer support:
        - Emily Fieran Reed (Strategy and Performance, LBTH)
        - Ellie Hobart (THCCG - Corporate Affairs)
        - Susie Chrome (Public Health - Localities, Adults, LBTH)
        - Sade Johnson (CLC - Localities)

- Healthy Place
    - Cllr David Edgar, Lead Member for Resources
    - Shazia Hussain, CLC
    - Somen Banerjee, Director of Public Health, LBTH
    - Officer support:
        - Owen Whalley (Planning and Building Control, D&R, LBTH)
        - Esther Trenchard-Mabere/Tim Madelin (Public Health, Adults Directorate, LBTH)

- Tackling Childhood Obesity
    - Cllr Rachael Saunders, Lead Member Education and Children's Services
    - Sam Everington, Tower Hamlets CCG Governing Body (Chair)
    - Debbie Jones, Corporate Director, Children's Services
    - Officer support:
        - Esther Trenchard-Mabere (Public Health, Adults Directorate, LBTH)

- Developing a truly integrated system to support health
    - Cllr Amy Whitelock Gibbs, Lead Member Health
    - Denise Radley, Corporate Director Adults, LBTH
    - Jane Milligan, Chief Officer, Tower Hamlets CCG
    - Officer support:
        - Chris Lovitt (Public Health, Adults Directorate, LBTH)
        - Karen Sugars (Commissioning and Health, Adults Directorate, LBTH)
        - Simon Hall (Commissioning, Tower Hamlets CCG)

At the meeting, Board members have been asked to present back a powerpoint presentation addressing the following seven questions around transformational area:

The seven questions for each transformational area are:

1. Why is this important issue for health and wellbeing in Tower Hamlets?
2. What is currently being done to improve outcomes?
3. Where would we like to be in 3 years (vision statement)?
4. Within this area, what does the Board need to focus on?
5. What are the top areas of action the Board needs to focus on over the next 12 month to drive transformational change (max 2) and why?
6. What is required to make this happen?

7. What are the top indicators that the board needs to track (max 3)

It has been for Board members to decide how they would best like to do this and who they would like to involve. Given the experience and knowledge of those involved detailed information or reading material was not provided but it was for Board members to request resources as needed from support officers as appropriate.

In addition, discussions at the workshops have identified the need to develop a shared understanding and framework for the terms 'health' and 'wellbeing' as applied to the strategy. This has been explored through an open workshop led by the Director of Public Health.

Board members will present at the meeting and there will be a discussion on whether the priorities identified are the right areas of focus for the strategy. This will provide the basis for the draft of the strategy that will come to the next Board meeting.

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Tower Hamlets Health and Wellbeing Strategy 2016-2020
Developing a strategy that will make a difference – next steps

1. Purpose of this paper

1.1 The purpose of this paper is to set out the key issues emerging out of the two Health and Wellbeing Strategy development workshops and discuss the implications for the strategy.

1.2 To recap:

- The Kings Fund session explored the purpose of the strategy, the role of the Health and Wellbeing board and the elements of an exemplar strategy (Appendix A)

- The Pinpoint session at the extended Health and Wellbeing Board in aimed to identify potential priorities for the strategy (Appendix B)

2. Why do we want a health and wellbeing strategy?

2.1 There was some discussion through the workshops that without a Health and Wellbeing strategy there is much that would happen in any case around improving health and wellbeing in the borough. This raised a challenge around added value of a strategy.

2.2 However, there was a strong consensus that the current environmental, political, economic, social, technological contexts provide a complex set of threats and opportunities and that the need for strong focussed system leadership is greater than ever.

2.3 Having a health and wellbeing strategy that is jointly owned by key partners, that clearly articulates a shared set of aspirations and is a focus for collective action on the most important health and wellbeing issues facing local people, will be vital in what will undoubtedly be challenging years ahead for all of us.

3. What do we mean by a health and wellbeing strategy and what is the scope?

What do we mean by health and wellbeing?

3.1 It was evident from the workshop discussions that there are differences in how the terms 'health' and 'wellbeing' are understood within and between organisations.

3.2 Whilst this is inevitable as 'health' and 'wellbeing' are terms that are used differently across society and cultures, it is important that there is some consensus around the meaning of the core concepts around which the strategy is based and that partners can refer back to.

3.3 Based on discussion at the Pinpoint session as well as reference to wider literature, it is clear that health and wellbeing are not interchangeable terms. People may be healthy but have low levels of wellbeing and vice versa.

3.4 For example, in the last years of life, an individual's health (ie level of mental and physical functioning) may be poor but that person's sense of wellbeing may be high (eg due to having a good living conditions, a sense of control and connection to loved ones).

3.5 However, whilst not interchangeable, health and wellbeing are self-evidently linked. One way of thinking about this is to see health as a resource for wellbeing. Two particularly helpful definitions that could inform the strategy in making this clear are the following:

3.6 **Health** is more than the absence of disease; it is a resource that allows people to realize their aspirations, satisfy their needs and to cope with the environment in order to live a long, productive, and fruitful life. In this sense, health enables social, economic and personal development fundamental to well-being[1].

3.7 **Wellbeing** is a subjective evaluation of how we feel and experience our lives[2].

3.8 This concept of 'health as resource' and 'wellbeing as the outcome' has potentially profound implications for how services should be shaped

How does this inform the scope and interdependencies of the strategy?

3.9 Based on the above discussion, the high level purpose of the strategy can be framed as a strategy that aims to develop health as a resource to improve people's wellbeing.

3.10 The following is a helpful expression of the factors that help develop this resource:

'A healthy community is one where all sectors contribute to create social and physical environments that foster health. In practice, such a community meets basic needs: access to affordable, healthy foods; affordable housing and transportation; and essential services such as medical care and education. It offers a sustainable, healthful environment with clean air and

[1] http://www.cdc.gov/hrqol/wellbeing.htm
[2] http://www.local.gov.uk/health/-/journal_content/56/10180/3510475/ARTICLE

water, open space and parks, low levels of toxic exposures and low emissions, and affordable, sustainable energy. Equally important, it has a constructive economic and social environment with adequate job opportunities, educational opportunities for advancement, and social equity. Last but not least, it offers robust civic and social engagement with safe, supportive families, relationships, homes, and neighbourhoods for all parts of society.'[3]

3.11 This framework of thinking about a 'healthy community' highlights the breadth of factors that impact on the extent to which health is a resource for wellbeing. It also highlights the importance of being clear about the interdependencies of the Health and Wellbeing Strategy with other strategies.

3.12 For example, an employment strategy would aim to improve wellbeing through employment. Employment, in itself a determinant of wellbeing, impacts on a range of other factors linked to wellbeing, one of which is health. However, for some people, building health as a resource enables them to benefit from employment as a driver of wellbeing.

3.13 The relationship between the Employment Strategy[4] and the Health and Wellbeing strategy relates to how health barriers can be addressed to help people find employment and also potentially how the strategy can promote employment of people in the health and care sector where there are shortfalls.

3.14 Similar linkages could apply to a range of other strategies eg housing, environmental health, housing, transport, education, crime.

3.14 Looking at it from the other way, if health and care services support developing health as a resource but are also focused on wellbeing as the outcome, they have a role in helping people access services that enable them to access other resources promoting wellbeing such as good employment, housing, income and education.

3.15 Identifying and developing the shared aspirations between other strategies and the health and wellbeing strategy will therefore need to be a critical element of the strategy.

4. What approach do we want to take to the strategy?

4.1 The conclusion of the King's Fund workshop was a consensus that the requirement is 'a strategy with a small number of core, widely owned, accountable objectives, but that is adaptive and responds to feedback'.

[3] *Public Health Reviews, Vol 32, No 1, 174-189*

[4] If there is a Health and Wellbeing Strategy would the Employment Strategy be better referred to as the Employment and Wellbeing Strategy?

4.2 The thinking behind this conclusion was that the purpose of the Health and Wellbeing Board, through its strategy is to provide collective systems leadership across the health and care economy. This is potentially a hugely powerful resource if it is focussed skilfully.

4.3 However, this power is dissipated if the strategy seeks to cover everything and the Board would set itself up to fail if it tried to track the breadth of activity impacting on health and wellbeing (much of which would continue without issue regardless of the Strategy or Board).

4.4 The approach to development of the strategy is therefore to identify those issues where collective systems leadership will significantly add value and unlock the potential for transformational change.

4.5 Another element of the thinking is the nature of this leadership. In the Kings Fund session it was recognised that the Strategy was about trying to drive change in a complex system. This means moving away from mechanistic action plans but recognising that trying to drive such change is iterative.

4.6 Whilst it is essential to have a clear end point, the journey there will require ongoing learning, evaluation, flexibility and adaptation rather than a rigid action plan. This will require a different and more dynamic way of framing the monitoring and oversight of the strategy.

5. What do we want the strategy to focus on?

5.1 One of the key themes of the King's Fund session was the importance of the Health and Wellbeing Board and stakeholders having a sense of ownership of the strategy and its priorities.

5.2 The purpose of the subsequent Pinpoint session was to surface those issues that the Board considers to be high priority in improving health as resource for wellbeing and to which it can add value through its systems leadership role.

5.3 The initial reflection was that whilst the Board functions well its added value remains unclear. However, the refresh of the strategy and the planned review of how the Board functions provides the opportunity to 'push the last 20%' and may require it to make controversial decisions.

5.4 This highlighted again the importance of the strategy focussing on a small number of transformational areas that are distinct from the wide range of 'business as usual' areas impacting on health as a resource for wellbeing across the council, NHS and non-statutory sectors.

5.5 In this context, participants identified and explored those areas that they thought would be important for the strategy to address having reflected on local health need and what they would like people to be saying about the achievement of the Board in 2020.

5.6 The areas were identified collectively and the following questions were explored further (pictures of the boards are in Appendix B):

How (by 2020) could the Board have an impact on…

- developing a shared understanding of health and wellbeing?
- improving outcomes through shared ways of working and shared goals?
- addressing the health consequences of deprivation?
- unlocking community capacity to improve health and wellbeing?
- reducing childhood obesity?
- improving health through housing?

Other areas identified but not explored were the health impacts of the environment (eg air quality, active travel) and mental health in early years.

5.7 Subsequent to the workshop, officers from public health, corporate strategy and policy and the CCG met to review the outputs of the meeting with an aim to assessing how these could inform identifying and articulating potential transformational areas for the Board. There was further discussion at the Health and Wellbeing Board Executive Officers Group.

5.8 Discussion around what constitutes a 'transformational area' identified the following criteria:

1. Transformation will have significant positive impact
    a. The area is considered to be an important health and wellbeing issue with regard to the size of the problem, inequalities issues and/or cost
    b. There is good evidence for intervention (or credible potential to build evidence)
2. The area matters to Tower Hamlets citizens
3. System change is feasible
4. There is collective will to achieve the change

5.9 The five transformational areas in the next session below are an interpretation of the outcomes of the workshops, discussion and reflection on the criteria and are set out for comment and discussion.

6. What could the transformational areas be?

6.1 To lead a transformation in how we address the health impacts of deprivation

What this might look like in 2020

- High level strategic commitment to levering all resources across the partnership to address the health impacts of poverty
- Step change in understanding and targeting of those with greatest health need linked to deprivation
- Joined up, targeted approaches involving integrated working between key partners eg health, housing, employment, welfare, education, community safety, voluntary sector and business

6.2 To lead a transformation in how communities lead change to improve health

What this might look like in 2020

- High level commitment to cultural change around the role of communities in shaping services
- Shared framework across the partnership around community engagement and mobilisation
- Supportive environment to encourage community led action around health and wellbeing

6.3 To lead a transformation in integrating health into planning

What this might look like in 2020

- High level strategic commitment to ensuring that considerations around health and wellbeing are built into planning
- Involvement of the Health and Wellbeing Board in planning decisions that will significantly impact on health and wellbeing
- Shared accountability of the Local Plan with the Health and Wellbeing Board

6.4 To lead a transformation in addressing childhood obesity in the borough

What this might look like in 2020

- High level strategic commitment across all key partners
- Willingness to make big, potentially sensitive decisions
- Strong engagement of communities and other partners to enable local solutions
- Dialogue across communities and other partners to ensure there is learning across the system
- High profile communications

6.5 To lead a transformation in developing a truly integrated health and care system

What this might look like in 2020

- High level strategic commitment to
    - Shared definition of health and wellbeing
    - Shared outcomes
    - Shared intelligence to inform planning
    - Shared, joined up commissioning plans
    - Shared workforce plans
    - Shared approaches to delivery across provider organisations

7. What are the next steps?

7.1 In summary, it is proposed that there are five areas for transformational change

- Addressing the health impacts of deprivation
- Helping communities lead change around health
- Integrating health into planning
- Tackling childhood obesity
- Developing a truly integrated system to support health

7.2 As discussed previously, the objective is 'a strategy with a small number of core, widely owned, accountable objectives, but that is adaptive and responds to feedback'

7.3 One way forward would be to assign a board member to each of these areas and (with the support of officers) to give them responsibility to:

- Understand what is currently going on in the area
- Identify 1 or 2 high level metrics linked to the area that would be important for the Board to track
- Identify 1 or 2 areas of system transformation that are already happening or need to happen where the oversight of the Board could add value
- Identify whether there are any potential risks around 'business as usual' where the Board could add value

7.4 This would complete by the end of April to enable drafting of the strategy by the Board meeting in June

8. Questions for the Board

1. **Do the definitions of 'health' and 'wellbeing' (and the concept of health as one of a numbers of resources for wellbeing) feel ok as working definitions for the strategy?**

2. **Does the 'health community' description feel like a good description of what we would like Tower Hamlets to look like if it is a place that supports health as a resource for wellbeing?**
3. **Does the description of the interdependencies of the Health and Wellbeing Strategy with other strategies sound right?**
4. **Does the approach to the strategy sound right?**
5. **Do the transformational areas feel about right? Is there anything important missing?**
6. **Do the next steps of involving Board members and getting them to identify a small number of metrics and actions for the strategy to track feel right?**
7. **Anything else?**

Tower Hamlets HWB strategy session

Key points of 26th October 2015 discussion at the King's Fund

The King's Fund Ideas that change health care

Agenda

1.	Introduction and context	13.30 – 13.45
2.	What changes are we facing over the next five to ten years? What are the implications for our strategy?	13.45 – 15.00
3.	What do we want our new strategy to achieve?	15.00 – 15.45
4.	Break	15.45 – 16.00
5.	What kind of strategy would help us achieve our aspirations?	16.00 – 16.50
6.	What are the next steps?	16.50 – 17.00

1. Introduction, our future strategy

Putting health and wellbeing at the heart of everything we do in Tower Hamlets

The new Tower Hamlets Health and Wellbeing Strategy

Workshop 1:

What is the aspiration? What kind of strategy do we need?

1. Discussion points

- Current strategy

  - Process of development as important as outcome
  - HWB strategy "a critical pillar", articulates story, connected to other strategies
  - Success not so much a story of the Board itself and its actions, but the relationships built around the table today
  - Hard pushed to find anyone who knows it "at the coalface"

- Future strategy

  - Move on from ticking boxes to impact. From processes delivered on time to actual outcomes delivered. Did it make a difference? Needs to be flexible and adaptive
  - A greater role for housing
  - Need to understand return on investment, together we have £250mn of resources

2. How should the strategy adapt to future trends?

- To change in the health and wider systems…
  - Supply side
    - Money
    - Workforce
    - Communities as assets
  - Demand side
    - Population ageing
    - Expectations
- To change in society…
  - Role of public services
    - Delivery? Enabling? Localism?
  - Medical and consumer technology
  - Networks
  - Housing and other wider determinants

- **Are these national trends that might affect how you revise your health and wellbeing strategy?**
- **If not, what is missing or not relevant to Tower Hamlets?**
- **What are the 3-5 key national factors that your strategy needs to reflect, or adapt to, locally?**

2. Discussion points

- National vs TH trends
  - Beware correlation ≠ causation e.g. evidence of intervention on housing vs housing problems association with poor health
  - TH, younger and more families, a potential strength
  - 1,700+ community organisations, are we making enough of this?
- What's missing?
  - Early years
  - Population churn and implications, very stable and very mobile populations require different approaches
  - Massive Lea Valley development, health in planning opportunity
  - Mental health
  - Radicalisation
  - But… "too many things, focus on narrow set and get them right"

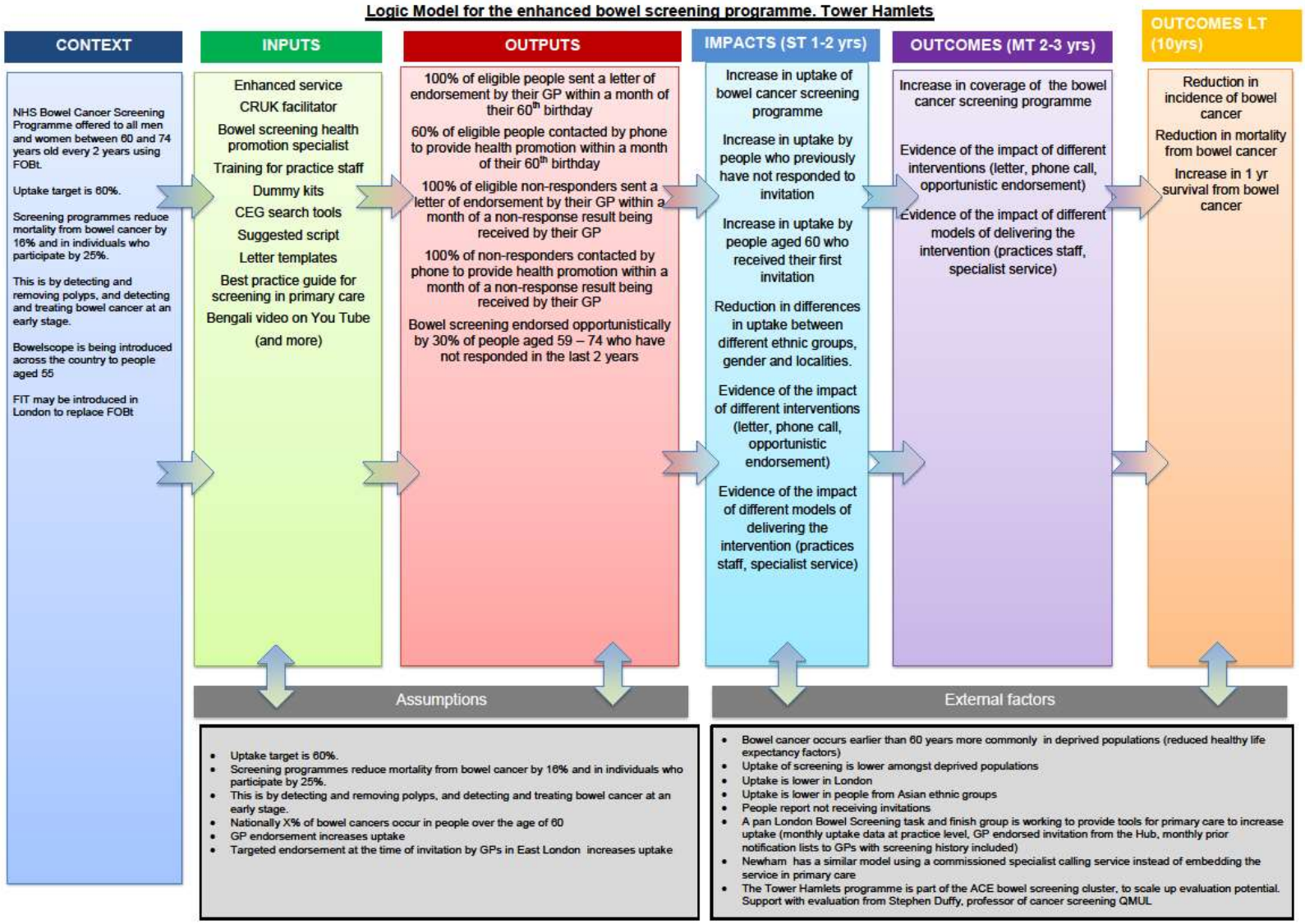
3. What do we want the new strategy to achieve?

Aspiration – expressed simply

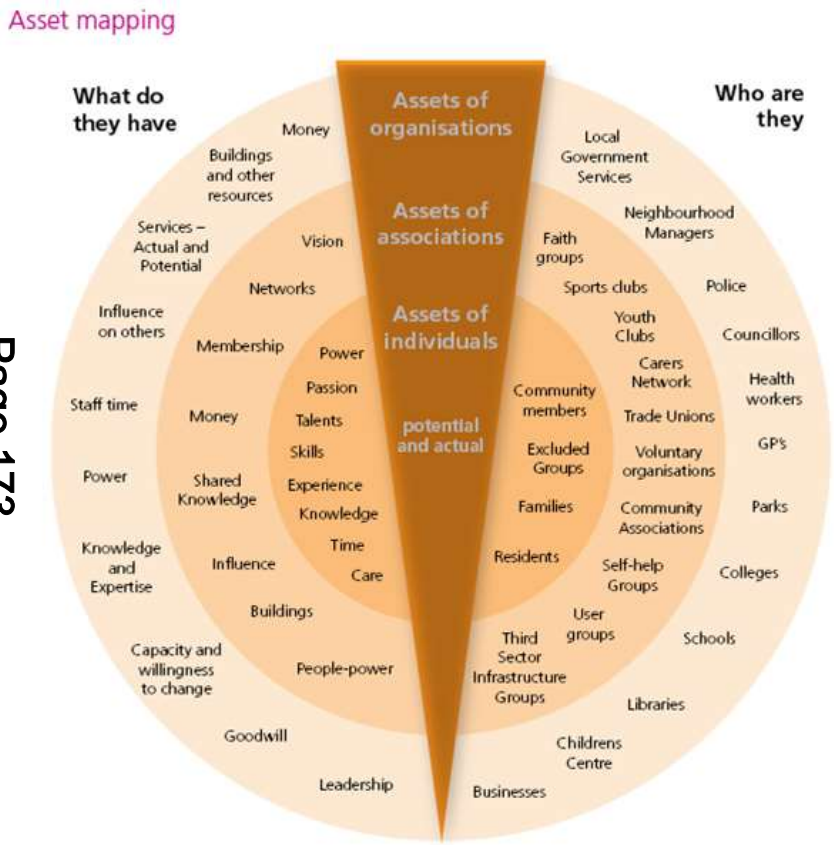
More people in the Borough leading healthier lives

- **A place that supports health**
  - **Healthy environments**
  - **Healthy communities**
  - **Health promoting services**
- **More people**
  - **Valuing health**
  - **With foundations for healthy lives**
  - **Protected from health harms**

Logic – relating inputs to outcomes



Assets that support health and wellbeing that we can influence



- Excellent joined up services
  - Statutory sector
  - Non statutory
- Wider determinants
  - Local economy
  - Employment
  - Income
  - Housing
  - Education
- Physical environment
  - Green spaces
  - Clean air
  - Active travel
  - Communal spaces
- Cohesion
  - Connecting people
  - Partnerships, enterprise

3. Key respondents

- Jane
  - A strong partnership that can deliver a focussed set of priorities (less rather than more)
  - Opportunity with new leadership at Bart's, the vanguard, through our staff and using our resources collectively
  - Need to manage demand through enabling health, and a social movement
- Luke
  - Need to improve outcomes for carers and on shared outcomes (e.g. housing and health)
  - The strategy needs to have a strong focus on prevention
- Diane
  - Move from a strategy between statutory sector to one between that sector and the public
  - An investment in improving health literacy, helping community plan for illness and response
  - Need to use schools and other settings for health
- Debbie
  - Need to avoid strategy losing its impact over time and as it cascades down; therefore needs to be bottom up
  - Innovation yes, but needs to be sustainable and breed resilience
  - Children and school readiness, vulnerable and complex needs

3. Discussion points

- Reach and focus
  - To spread aspiration (place and people) across the system at multiple levels (inc coalface and community)
  - Build and support assets and strengths, not conditions in isolation
  - Need to target long-term residents (IMD figures misleading)
  - A mixed approach. i) High impact, few objectives, ii) wider partnerships and accountability iii) be clear what can't do (don't overpromise)

- What's missing?
  - "Health heavy", need to focus on wellbeing to connect with community and key partners (otherwise "easy to step away")
  - Renewed map of community assets (not just physical)
  - Delivery needs to look very different in different parts of the borough
  - Staff have to be on board, or won't happen

- Has it worked?
  - "Can feel the benefits, even if we don't know what's written on the paper"
  - Build in feedback, "a boat on a stormy sea", clear on destination but flexible and adaptive on route to get there

5. What kind of strategy/board is required?

What do we want from our strategy?...

- How well does the group believe it understand what the community wants to support their health and well-being?
- Are we able to formulate this in the most useful way – i.e. getting the underlying needs (and assets) rather than pointing to symptoms?

Do we have a clear sense of our role and our resources and capabilities, which might inform where we focus our effort?

Do we want a focused strategy aiming to drive forward a limited number of priorities or something more expansive?

What sort of board is realistic and best for our communities?...

Talking Shop

Very limited role

Information sharing

Substantive decisions made through other channels

Rubber stamper

Shares existing plans and strategies across organisations

A high level role in agreeing how different plans contribute to shared goals

Tightly focused

Agrees a limited number of shared priorities

Focuses collective effort on supporting delivery of those objectives

Careful monitoring of progress against small number of measures

System orchestrator

Board plays main decision-making role across health, care and public health systems

Oversees commissioning of broad range of services and their performance

5. Discussion points

- Strategy
  - We have a good sense of what the community needs
  - Or doe we? A focus on aspiration, wants, expectations, what the community can do for itself?
  - Should the focus be on key principles including ensuring feedback into systems, so that we can react and navigate to our destination?
  - Overall, focus on a few core objectives

- What's missing?
  - "Health heavy", need to focus on wellbeing to connect with community and key partners (otherwise "easy to step away")
  - Health literacy, better patient experience and sense of "respect"

- The Board
  - Needs to be held to account for using information it receives and making a real difference to outcomes
  - Continuous learning and improvement in strategy over time
  - Enabling and decision-making, an "unlocker" on tricky issues
  - Form follows function, ensure objectives first then governance through the Board

Conclusion – King's Fund reflections

- Goodwill and engagement
  - There is a lot of goodwill and understanding amongst your partners
  - Most people were highly engaged in the conversation
  - There was not full consensus (and not to be expected at this stage) but in fact a high degree of common ground on direction of travel
- Direction of travel
  - Has to make a real difference, not tick-boxes, "*We can feel the benefits, even if we don't know what's written on the paper*"
  - The strategy needs to have a small number of core objectives; these can be a combination of principles, and of specific deliverables
  - The strategy needs to move away from specific conditions and pathways of care towards a holistic focus, enabling and engaging communities and their assets, as well as providing services in response to needs
  - The strategy therefore should pay as much attention (if not more) to wellbeing as health to ensure wide understanding and ownership by partners to it, and communities they serve
  - The strategy needs collective ownership and call upon collective resources, including finance and staff commitment

…a strategy with a small number of core, commonly and widely owned, accountable objectives; but that is adaptive and responds to feedback…

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Tower Hamlets NHS

Health & Wellbeing Board Strategy Workshop

12 January 2016

Session Photographs & Digest

Tower Hamlets NHS

Health & Wellbeing Strategy 2020

Session Objectives:

to allow the board to reflect on its objectives and identify some high impact initiatives which all stakeholders can support.

Programme:

Focus exercise to identify progress to date

Future Search to highlight Board aspirations

Identify where the H & W B could have an impact

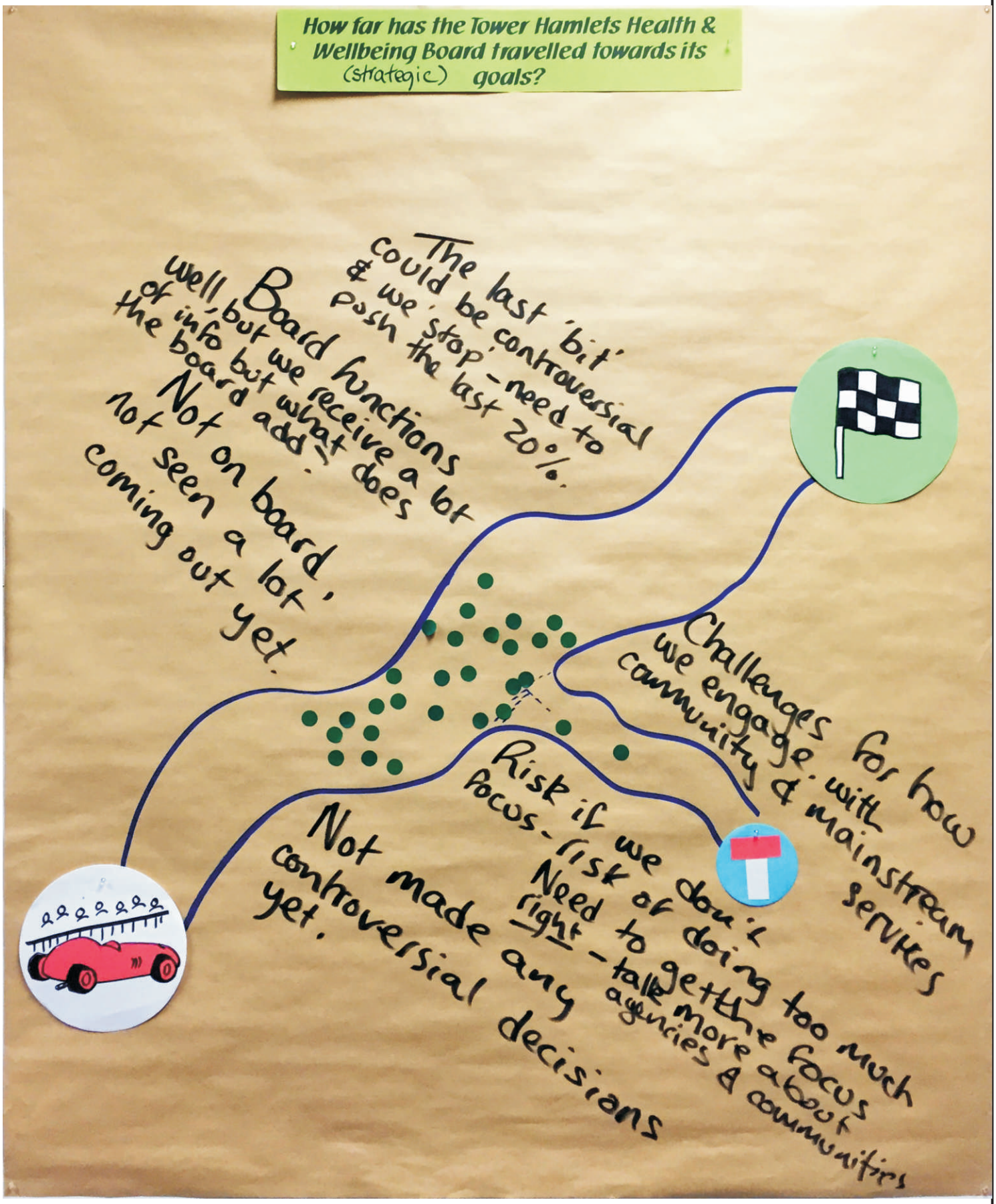
Contents:

Focus board ‘Where are we now?’

2020 Headlines!

Key themes from Future Search discussions

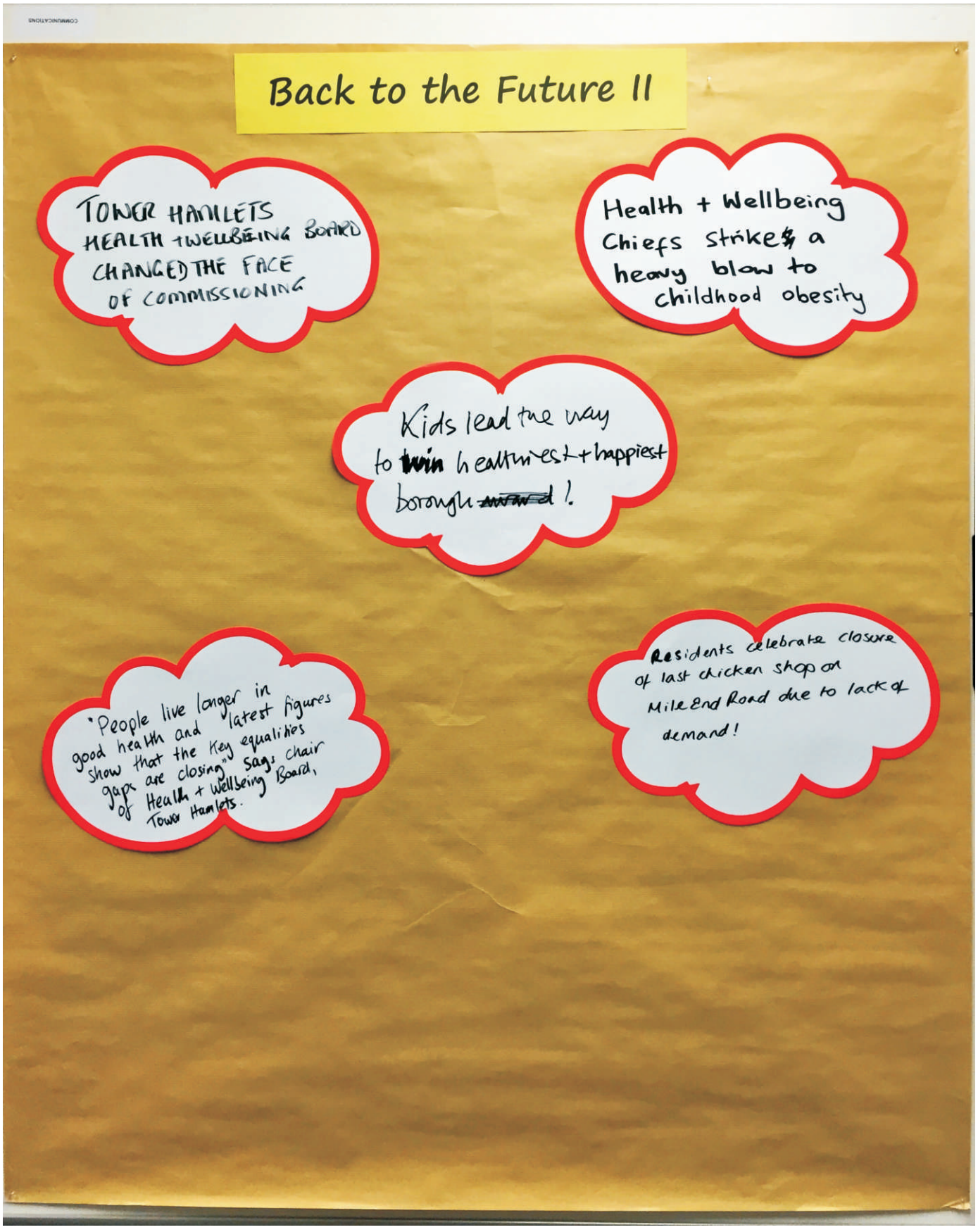
Board Impact syndicate discussions - 6 topics



How far Have We travelled?

A snapshot of how the Board feels it is doing. Many positive comments reflecting the ability of the Board members to work together, but a recognition that it has yet to take, and publicise, any controversial decisions.

A recognition that engagement and visible 'added value' are important.

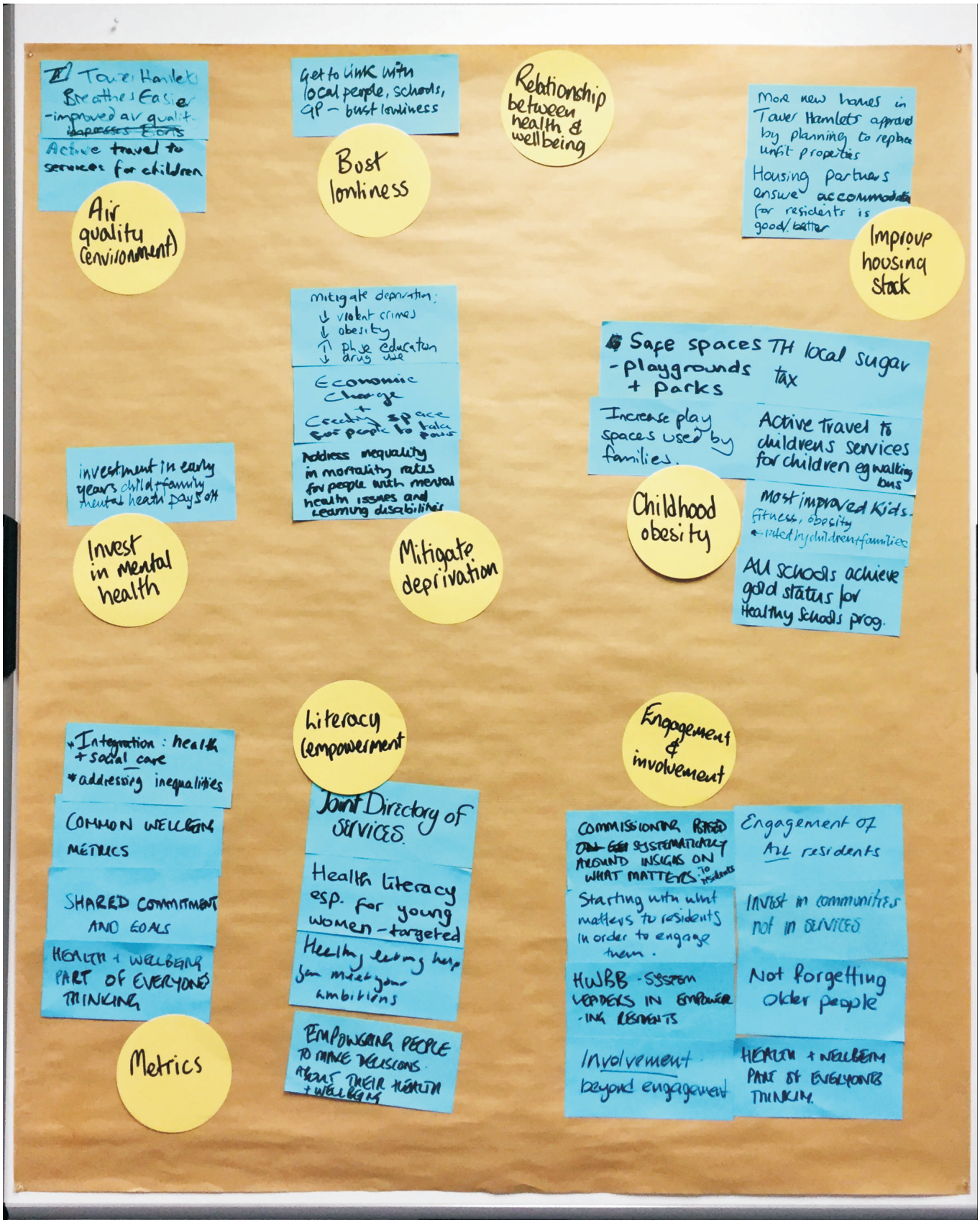


Future Search - What We'd Like to Hear in 2020

'changing the face of commissioning' 'tackling childhood obesity'

'the healthiest & happiest Borough'

'closing the equality gaps' 'closing the last chicken shop'



Key Themes from the Future Search Discussions

- air quality (the environment
- tackling lonliness
- articulating the link between health & wellbeing
- improving the housing stock
- investment in mental health
- mitigating deprivation
- addressing childhood obesity
- shared & common metrics
- literacy, especially health literacy
- engagement & involvement

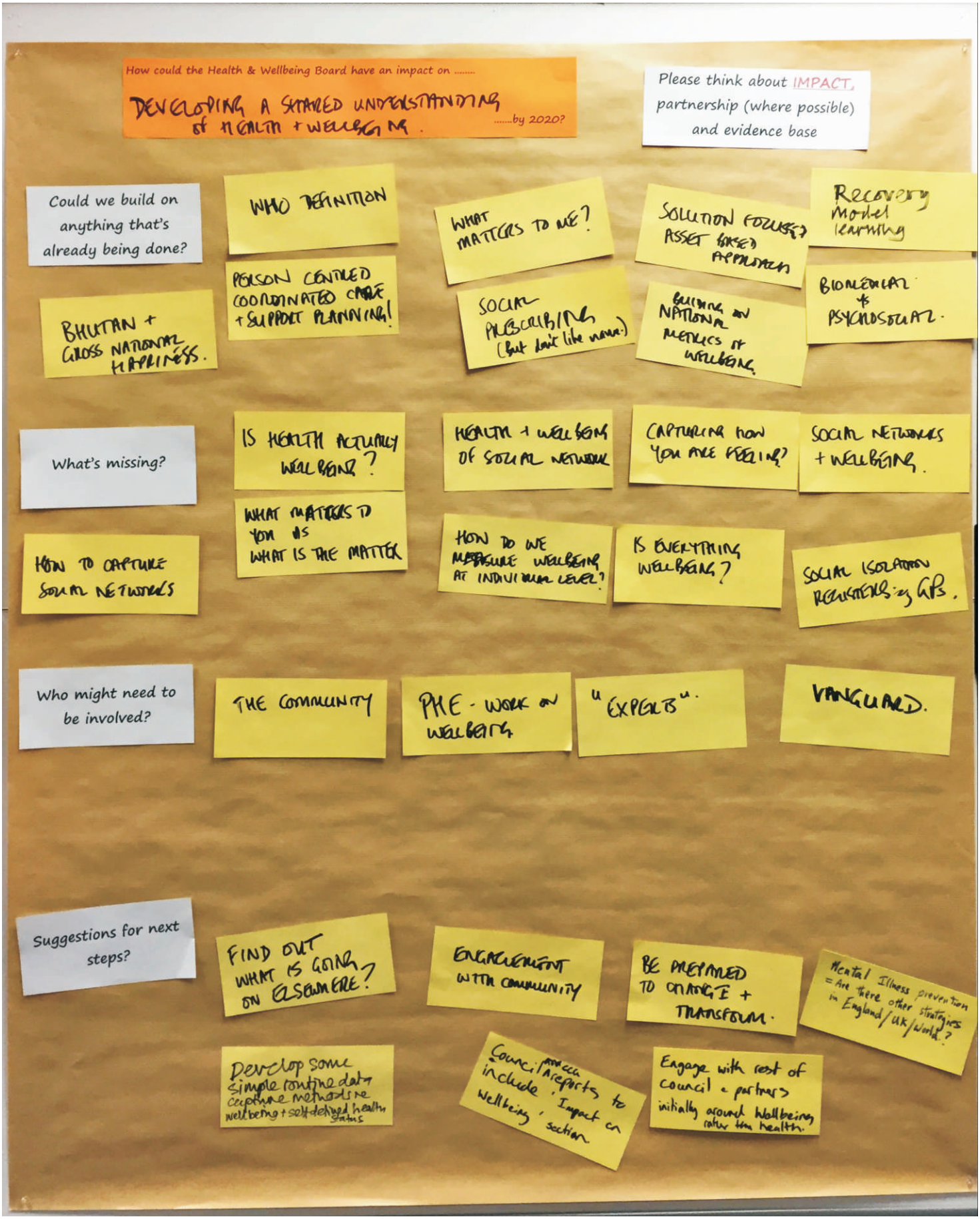
Syndicate Discussions

The following pages contain photographs of the boards prepared by sub groups who talked about the following themes:

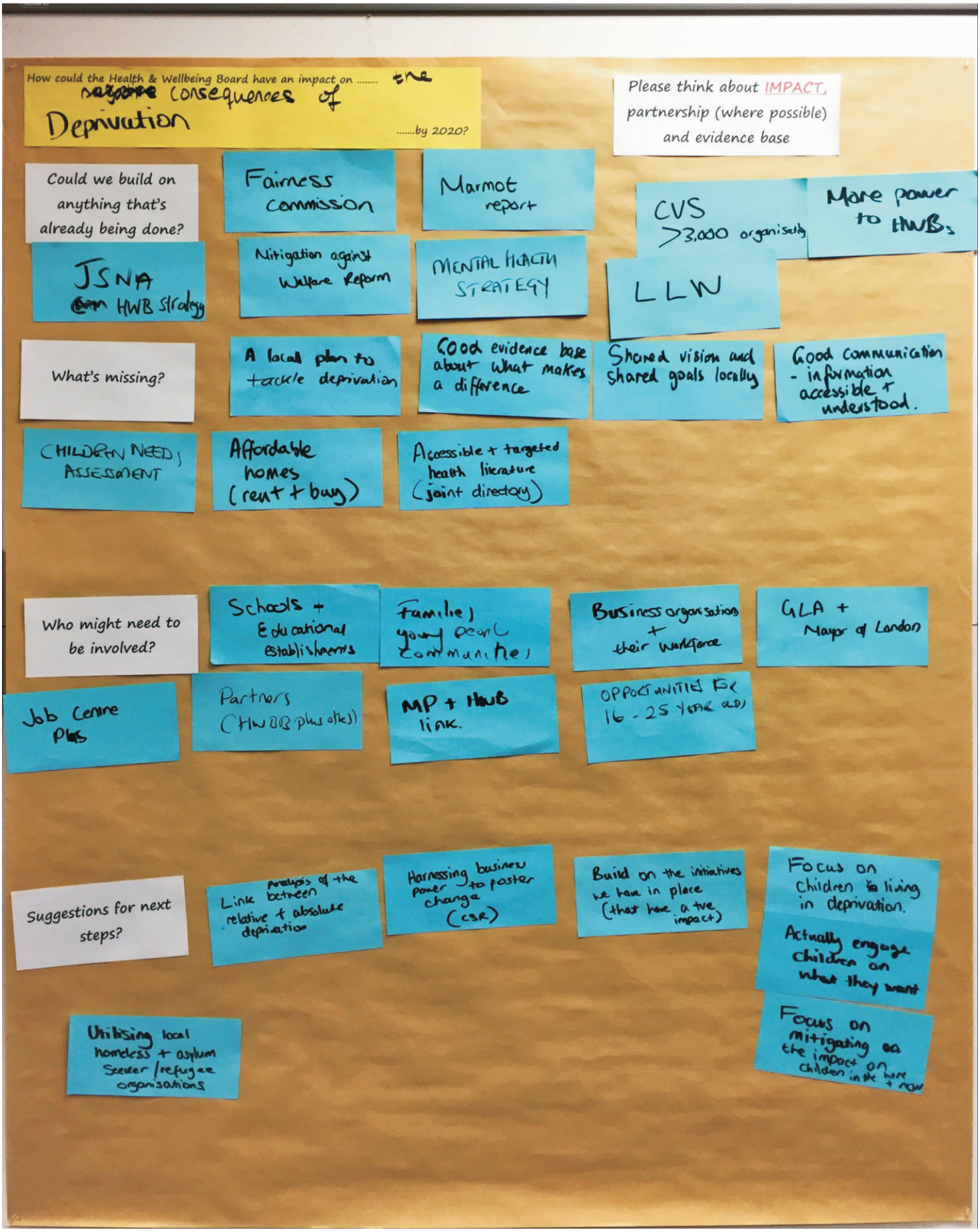
- ❑ developing a shared understanding of health & wellbeing
- ❑ the consequences of deprivation
- ❑ the quality of housing
- ❑ childhood obesity
- ❑ outcomes by agreeing shared ways of working and goals
- ❑ unlocking community capacity to improve HOW

Rather than simply re-type the comments, you are invited to explore these pages by looking at the cards and considering the comments in the original script.

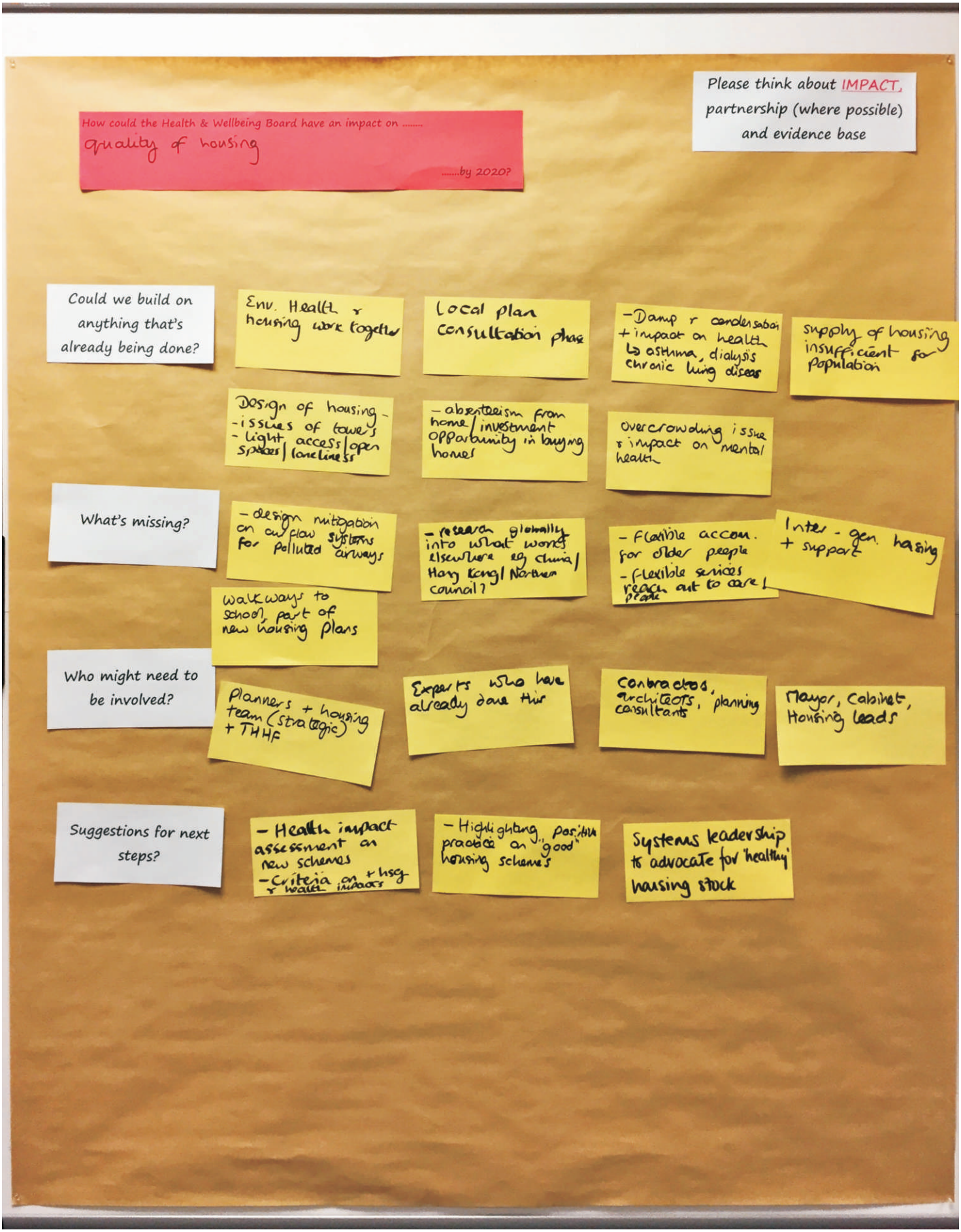
A blank page has been inserted after each photograph for your comments.


How could the Health & Wellbeing Board have an impact on .....
DEVELOPING A SHARED UNDERSTANDING OF HEALTH + WELLBEING.
.....by 2020?
Please think about IMPACT, partnership (where possible) and evidence base
Could we build on anything that's already being done?
WHO DEFINITION
WHAT MATTERS TO ME?
SOLUTION FOCUSED? ASSET BASED APPROACH
Recovery Model learning
PERSON CENTRED COORDINATED CARE + SUPPORT PLANNING!
BHUTAN + GROSS NATIONAL HAPPINESS.
SOCIAL PRESCRIBING (but don't like name:)
BUILDING ON NATIONAL METRICS OF WELLBEING.
BIOLOGICAL & PSYCHOSOCIAL.
What's missing?
IS HEALTH ACTUALLY WELLBEING?
HEALTH + WELLBEING OF SOCIAL NETWORK
CAPTURING HOW YOU ARE FEELING?
SOCIAL NETWORKS + WELLBEING.
WHAT MATTERS TO YOU VS WHAT IS THE MATTER
HOW TO CAPTURE SOCIAL NETWORKS
HOW DO WE MEASURE WELLBEING AT INDIVIDUAL LEVEL?
IS EVERYTHING WELLBEING?
SOCIAL ISOLATION REGISTERS eg GPs.
Who might need to be involved?
THE COMMUNITY
PRE - WORK ON WELLBEING
"EXPERTS".
VANGUARD.
Suggestions for next steps?
FIND OUT WHAT IS GOING ON ELSEWHERE?
ENGAGEMENT WITH COMMUNITY
BE PREPARED TO CHANGE + TRANSFORM.
Mental Illness prevention = Are there other strategies in England/UK/World?
Develop some simple routine data capture methods re wellbeing + self defined health status
Council/ area reports to include 'Impact on Wellbeing' section
Engage with rest of council + partners initially around Wellbeing rather than health.

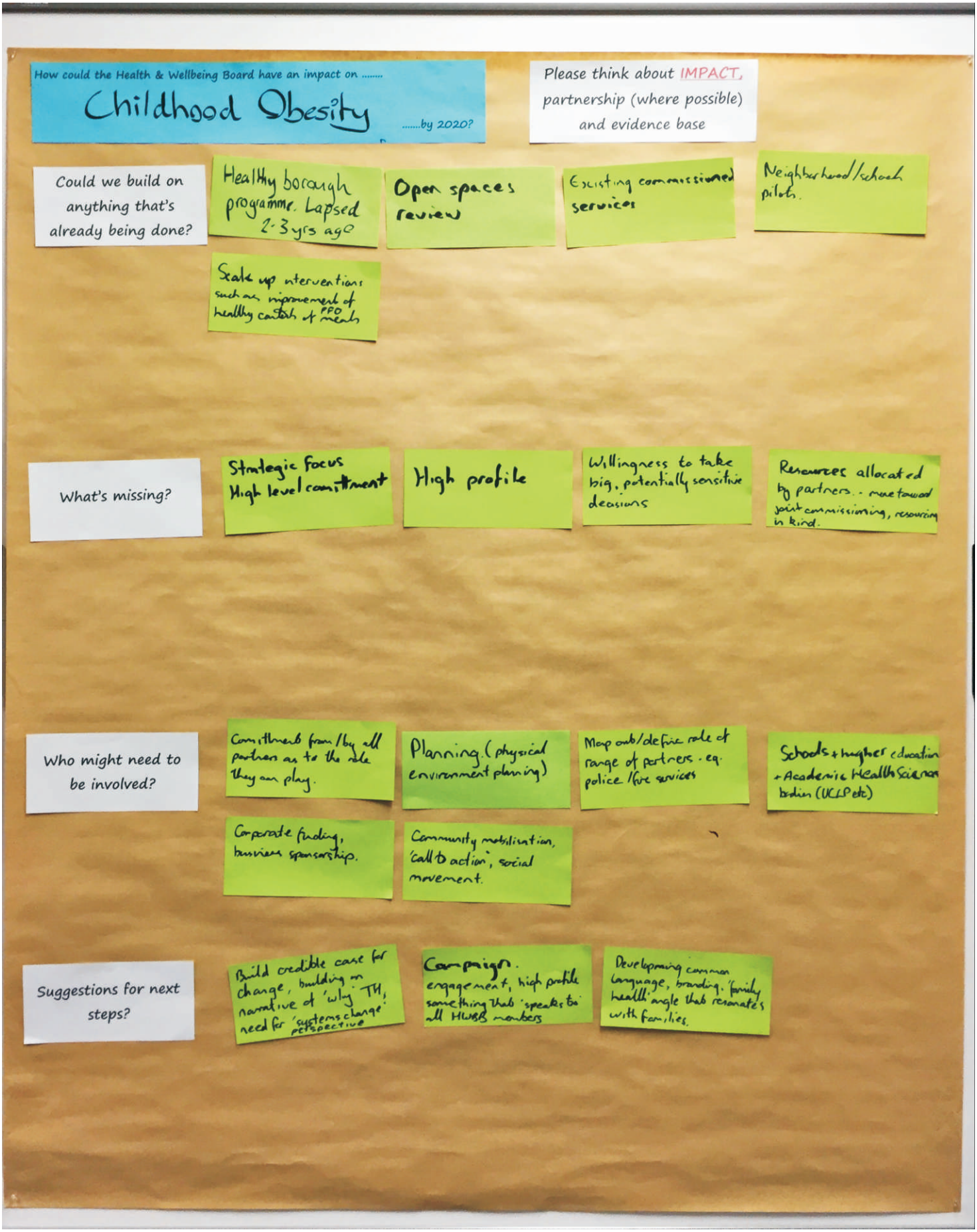
Notes:


How could the Health & Wellbeing Board have an impact on ..... the consequences of Deprivation .....by 2020?
Please think about IMPACT, partnership (where possible) and evidence base
Could we build on anything that's already being done?
Fairness commission
Marmot report
CVS >3,000 organisations
More power to HWBs
JSNA
Nitigation against Welfare Reform
MENTAL HEALTH STRATEGY
LLW
What's missing?
A local plan to tackle deprivation
Good evidence base about what makes a difference
Shared vision and shared goals locally
Good communication - information accessible + understood.
CHILDREN NEED ASSESSMENT
Affordable homes (rent + buy)
Accessible + targeted health literature (joint directory)
Who might need to be involved?
Schools + Educational Establishments
Families young people Communities
Business organisations + their workforce
GLA + Mayor of London
Job Centre Plus
Partners (HWBB plus others)
MP + HWB link.
OPPORTUNITIES for 16 - 25 YEAR OLDS
Suggestions for next steps?
Link analysis of the relative + absolute deprivation
Harnessing business power to foster change (CSR)
Build on the initiatives we have in place (that have a +ve impact)
Focus on Children living in deprivation.
Actually engage children on what they want
Focus on mitigating as the impact on children in the here + now
Utilising local homeless + asylum Seeker / refugee organisations

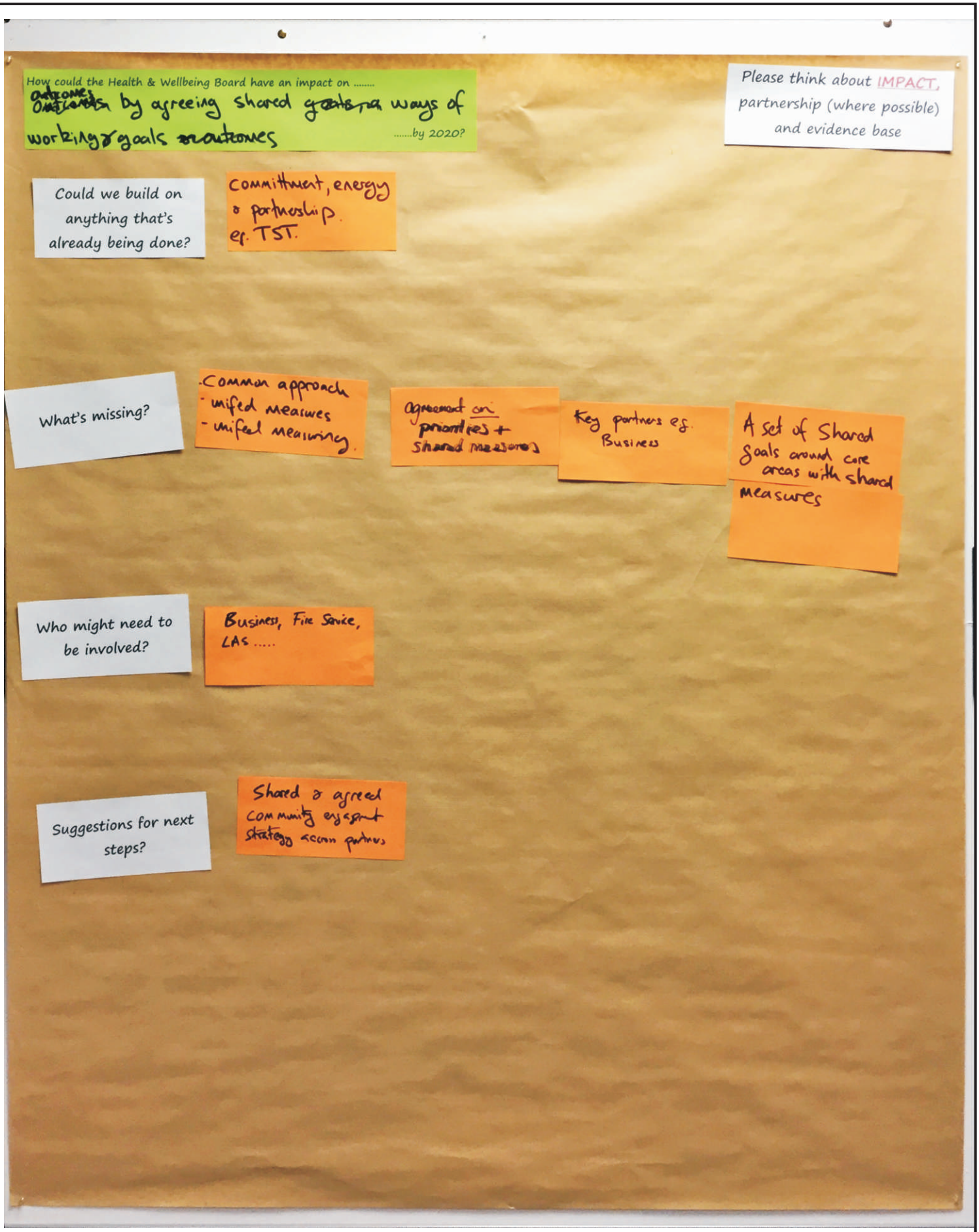
Notes:


How could the Health & Wellbeing Board have an impact on .....
quality of housing
.....by 2020?
Please think about IMPACT, partnership (where possible) and evidence base
Could we build on anything that's already being done?
Env. Health + housing work together
Local plan consultation phase
-Damp + condensation + impact on health eg asthma, dialysis chronic lung disease
supply of housing insufficient for population
Design of housing - issues of towers - light access/open spaces/loneliness
- absenteeism from home/investment opportunity in buying homes
overcrowding issue + impact on mental health
What's missing?
- design mitigation on ventilation systems for polluted airways
- research globally into what works elsewhere eg China/Hong Kong/Northern council?
- Flexible accom. for older people - flexible services reach out to care/ peace
Inter-gen. housing + support
walkways to school, part of new housing plans
Who might need to be involved?
Planners + housing team (strategic) + THHF
Experts who have already done this
Contractors, architects, planning consultants
Mayor, Cabinet, Housing leads
Suggestions for next steps?
- Health impact assessment on new schemes - Criteria on + use + health indoors
- Highlighting positive practice on "good" housing schemes
Systems leadership to advocate for "healthy" housing stock

Notes:


How could the Health & Wellbeing Board have an impact on .....
Childhood Obesity
.....by 2020?
Please think about IMPACT, partnership (where possible) and evidence base
Could we build on anything that's already being done?
Healthy borough programme. Lapsed 2-3 yrs ago
Open spaces review
Existing commissioned services
Neighbourhood/school pilots
Scale up interventions such as improvement of healthy content of FFO meals
What's missing?
Strategic focus High level commitment
High profile
Willingness to take big, potentially sensitive decisions
Resources allocated by partners - move toward joint commissioning, resourcing in kind.
Who might need to be involved?
Commitment from/by all partners as to the role they can play.
Planning (physical environment planning)
Map out/define role of range of partners - eg. police/fire services
Schools + higher education + Academic Health Science bodies (UCLP etc)
Corporate funding, business sponsorship.
Community mobilisation, 'call to action', social movement.
Suggestions for next steps?
Build credible case for change, building on narrative of 'why' TH, need for 'systems change' perspective
Campaign - engagement, high profile something that 'speaks to' all HWBB members
Developing common language, branding, 'family health' angle that resonates with families.

Notes:


How could the Health & Wellbeing Board have an impact on .....
outcomes by agreeing shared goals & ways of working & goals & outcomes
.....by 2020?
Please think about IMPACT, partnership (where possible) and evidence base
Could we build on anything that's already being done?
committment, energy & partnership eg. TST.
What's missing?
-Common approach
- unified measures
- unified measuring.
Agreement on priorities + shared measures
Key partners eg. Business
A set of Shared Goals around core areas with shared measures
Who might need to be involved?
Business, Fire Service, LAs .....
Suggestions for next steps?
Shared & agreed community engagement strategy across partners

Notes:

How could the Health & Wellbeing Board have an impact on .....

Unlocking community capacity to improve HoW .....by 2020?

Please think about IMPACT, partnership (where possible) and evidence base

Could we build on anything that's already being done?

Looking at pockets of G' practice. Specific "Place" → spreading
Learning from past → joining up lessons & building on them.
Has to be neighbourhood/network/place basis.
→ duplicate hours.

What's missing?

Change in partners culture to be able to support communities to lead change & improvement. ■ Trains staff as enablers.
Trust within senior stakeholders → letting go control See it through even when it's complicated
Coherence - Feeling that residents have control/responsibility - Empowering residents to feel they have a role in their neighbourhood.
Politics & patronage - corrupted view of rlop between citizens & the state.
Look outwards. Bolton, Birmingham etc. comparable
Good communication tools - more than 1 -

Who might need to be involved?

not just staff with health system being trained
Citizens & residents are the most important HWB workers
Equal partnership between professionals & community
Self fed its more sustainable.

Suggestions for next steps?

Review lessons from past & existing good projects & what made it work for each partner organisation. Then look at good external best practice thematically.
Being honest about budgets
Communities having trust
Culture change within organs ≠ with citizens.

Notes: