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

Contents

1 Introduction

1.1 Background

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

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

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

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

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

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

1.2 Re-procurement

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

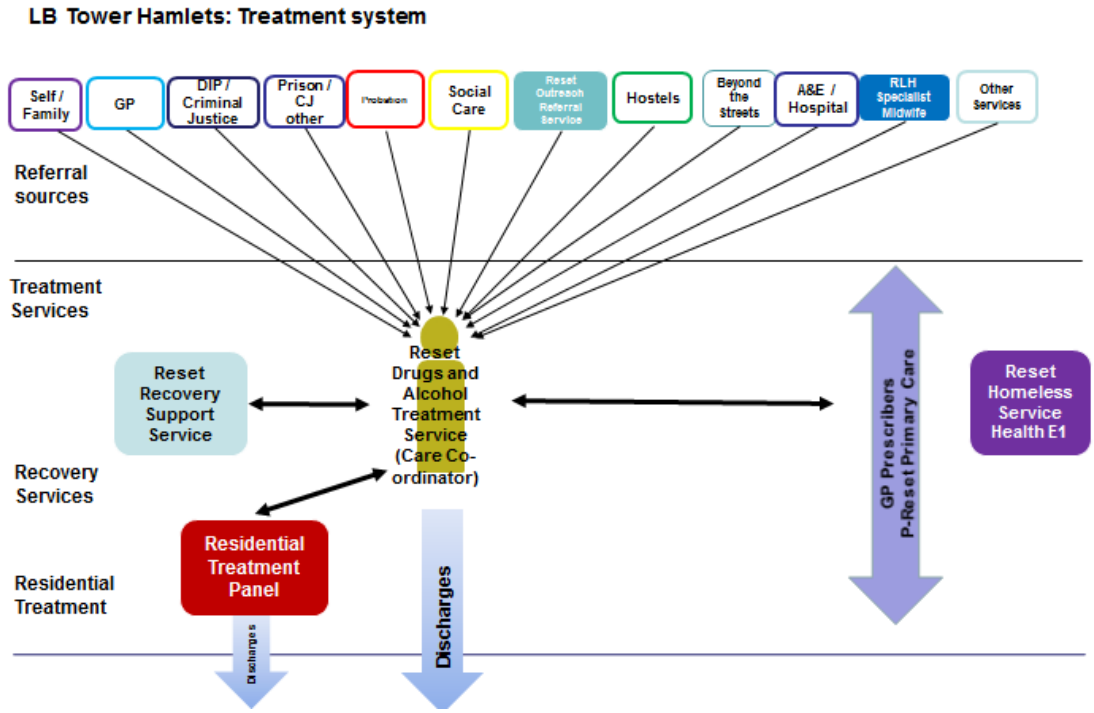
1.2.2 With existing contracts coming to an end in October 2019 and in line with Procurement and Legal procedures, the DAAT is now at the point of re-procuring the Reset contracts. As part of that, the DAAT conducted a comprehensive stakeholder consultation exercise which identified areas for improvement.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

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

1.3 Treatment Model

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

1.3.2 This model is outlined below:



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

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

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

2 National Context

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

2.1 Drug Strategy 2017

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

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

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

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

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

2.2 Medications into Recovery 2012

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

2.2.2 The Expert Group's advice makes clear that:

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

---

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

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

2.3 Alcohol Strategy 2012 (update expected in 2019)

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

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

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

2.4 Psychoactive Substances Act 2016

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

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

2.5 Dual Diagnosis

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

2.6 Good Practice

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

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

2.6.2 NICE guidelines recommend:

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

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

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

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

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

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

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

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

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

2.7 **Transforming Rehabilitation**

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

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

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

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

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

2.8 Public Health Outcomes Framework 2016 - 2019

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

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

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

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

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

2.9.2 The Strategy is based on 3 key principles:

- Reduce Demand
- Reduce Supply
- Reduce Harm

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

3 Local Context

3.1 Tower Hamlets

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

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

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

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

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

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

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

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

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

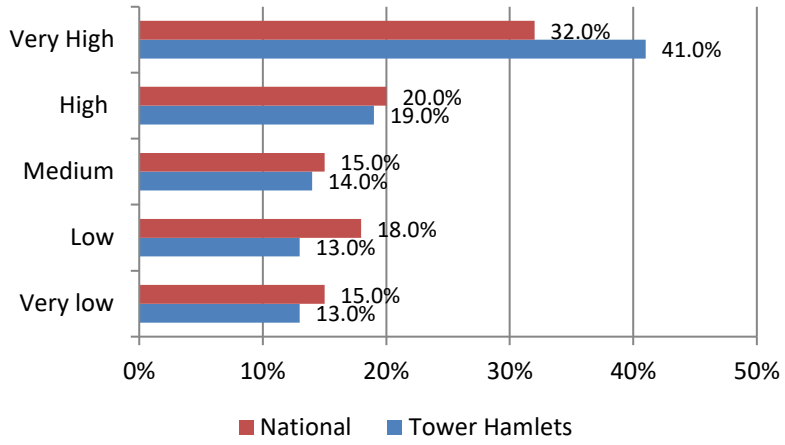
3.1.8 Tower Hamlets is estimated to have the third largest lesbian, gay and bisexual population in London with estimates from the 2015 GP survey placing the percentage of the adult population who identify as LGB at 8.7%[7].

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

3.2 Drug and Alcohol Treatment Population

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

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



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

[6] The Indices of Deprivation 2015

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

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

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

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

Drugs - Prevalence Estimates

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

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

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

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

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

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

Alcohol – Prevalence Estimates

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

[8] PHE OCU estimate 2014/15 published 2017

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

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

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

Drug and Alcohol Treatment

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

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

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

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

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

3.3 Tower Hamlets Substance Misuse Strategy 2016-2019

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

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

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

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

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

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

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

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

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

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

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

3.4 Tower Hamlets Health & Wellbeing Strategy 2017 - 2020

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

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

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

3.5 Joint Strategic Needs Assessment 2017 [11]

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

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

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

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

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

3.6 Tower Hamlets Strategic Plan 2018-2021

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

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

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

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

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

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

3.7 Tower Hamlets Together

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

THT Mission and Values

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

THT Priorities

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

3.7.4 The current priorities are:

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

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

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

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

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

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

3.8.2 The Community Safety Partnership is responsible for:

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

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

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

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

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

3.9 Local Employment Strategy

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

3.9.2 The structure adopted within this Strategy is:

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

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

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

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

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

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

3.10 DAAT Priorities 2018-19

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

3.10.2 Identified priority and areas for development include:

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

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

4 Drug & Alcohol Treatment Service (Reset Treatment Service)

4.1 Introduction

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

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

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

4.2 Purpose

Aims

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

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

Objectives

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

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

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

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

4.3 Scope

Service Users

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

Priority Groups

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

4.3.3 The following should be considered as priority groups:

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

Young Adults (18-24)

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

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

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

Service Integration

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

4.4 Exclusion Criteria

4.4.1 The following exclusion criteria apply:

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

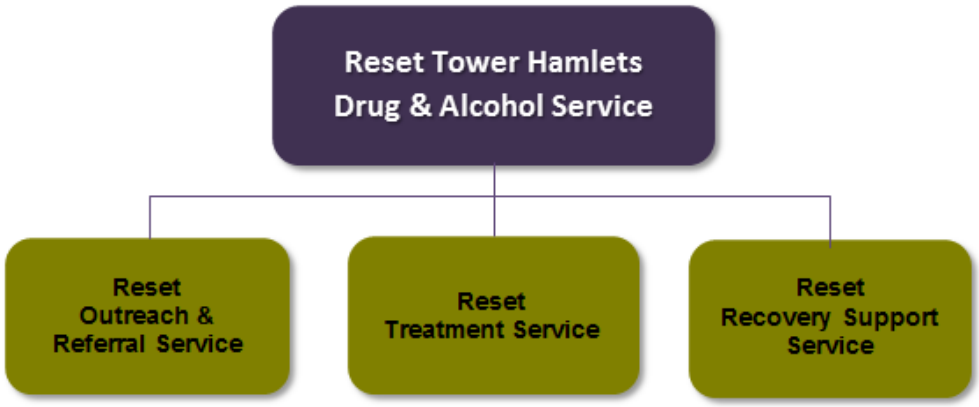
4.5 Communications and Marketing

The 'Brand'

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

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

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



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

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

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

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

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

Communications

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

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

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

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

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

Engaging Stakeholders

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

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

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

4.6 Treatment Interventions

Pharmacological interventions

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

4.6.2 Medical interventions for Opioid substitution should include:

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

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

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

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

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

- Methadone
- Buprenorphine

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

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

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

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

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

4.7 **Clinical Standards**

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

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

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

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

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

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

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

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

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

Access

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

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

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

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

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

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

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

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

Supporting Service Users in Primary Health Care Settings

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

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

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

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

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

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

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

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

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

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

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

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

4.8 Psychosocial Interventions

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

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

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

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

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

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

Relapse Prevention

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

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

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

Community Detoxification

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

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

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

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

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

Community Detoxification for Drug Use

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

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

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

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

Community Detoxification for Alcohol Use

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

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

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

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

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

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

Community GP Detoxification

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

Completion of Hospital Initiated Alcohol Detoxification

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

Inpatient Detoxification & Residential Rehabilitation

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

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

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

4.9 Dual Diagnosis

Definition

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

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

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

Tower Hamlets Service Model

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

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

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

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

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

4.10 Needle and Syringe Programme

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

4.10.2 The minimum expectation from the needle and syringe programme:

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

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

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

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

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

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

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

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

4.11 **Naloxone**

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

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

be replaced when they are used or expired.

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

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

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

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

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

4.12 Blood Borne Viruses

Immunisation

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

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

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

Testing and Treatment

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

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

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

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

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

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

4.13 **Sexual Health**

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

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

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

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

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

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

4.14 Drugs and Alcohol use in Pregnancy

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

4.15 General Health

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

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

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

5 Key Policy Areas

5.1 Whole Family Interventions

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

5.2 Hidden Harm

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

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

5.3 Safeguarding Children

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

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

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

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

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

5.4 Multi-agency Early Help Assessment

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

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

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

5.5 Safeguarding Vulnerable Adults

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

5.5.2 Harm and exploitation may consist of:

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

5.5.3 Harm and exploitation can occur anywhere, for example:

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

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

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

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

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

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

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

5.6 Safeguarding Lead

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

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

5.7 Working with Carers/Significant Others

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

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

5.8 Clinical Governance

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

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

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

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

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

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

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

5.9 Service Delivery

Hours of Operation

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

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

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

Location

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

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

5.10 Business Continuity and Emergency Planning

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

5.11 Incident Reporting

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

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

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

Local Drug Information System

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

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

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

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

5.12 Drug and Alcohol Related Deaths

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

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

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

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

5.13 Equalities

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

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

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

5.14 Information Governance

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6 Systems and Processes

6.1 Assessment

DAAT Common Assessment Framework

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

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

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

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

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

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

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

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

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

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

6.2 Care and Discharge Planning

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

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

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

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

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

Recovery Check-ups

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

6.3 Care Coordination

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

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

6.4 Case Management Systems

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

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

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

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

For further information on Nebula please refer to Appendix C.

6.5 Outcomes Reporting

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

Treatment Outcomes Profile

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

6.6 Drug Rehabilitation Requirements or Alcohol Treatment Requirements

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

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

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

6.7 Re-engagement

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

6.8 Referrals

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

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

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

7 Relationships and Partnerships

7.1 Collaborative Working

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

Reset Outreach and Referral Service

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

Reset Recovery Support Service

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

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

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

Drug Intervention Programme (DIP)

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

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

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

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

Prostitution Support Service

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

Royal London Hospital

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

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

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

Health E1 Homeless Medical Centre

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

7.2 Whole System Relationship

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

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

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

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

7.3 Service User and Carer Engagement

Service Users, Carers and Significant Others

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

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

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

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

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

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

Peer mentor/volunteer support

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

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

8 Workforce

8.1 Minimum Workforce Standards

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

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

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

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

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

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

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

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

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

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

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

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

8.2 Workforce Development

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

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

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

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

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

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

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

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

9 Performance Management

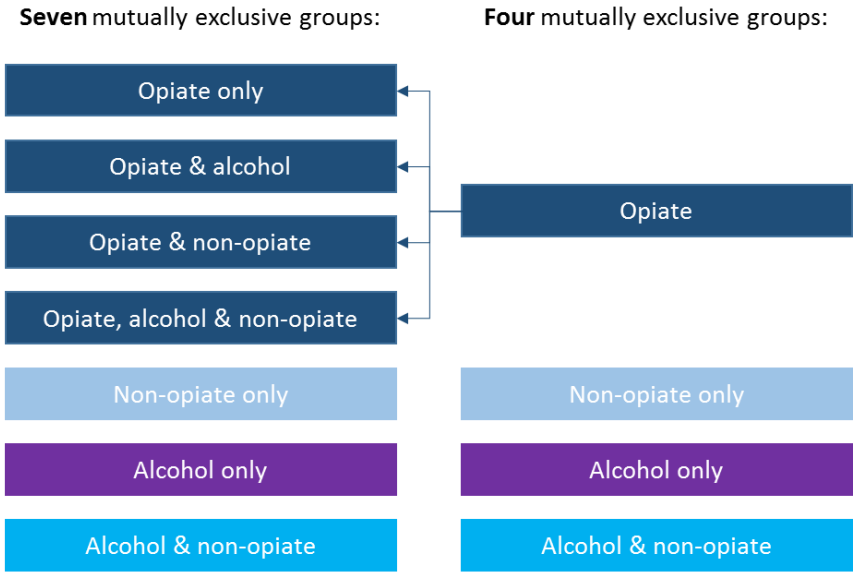
9.1 Performance Outcomes

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

9.2 National Drug Treatment Monitoring System

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

Chart 3: New Categorisation of Substance Groups NDTMS April 2014



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

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

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

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

9.3 Local Outcome Comparators

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

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

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

9.4 Key Performance Indicators

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

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

Quality Outcome Indicators / Reporting Requirements

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

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

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

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

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

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

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

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

9.5 Payment by Results

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

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

PBR schedule

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

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

9.6 Contract Monitoring

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

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

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

Appendix A – Table of Abbreviations

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