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

Contents

1 Introduction

1.1 Background

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

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

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

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

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

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

1.2 Re-procurement

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

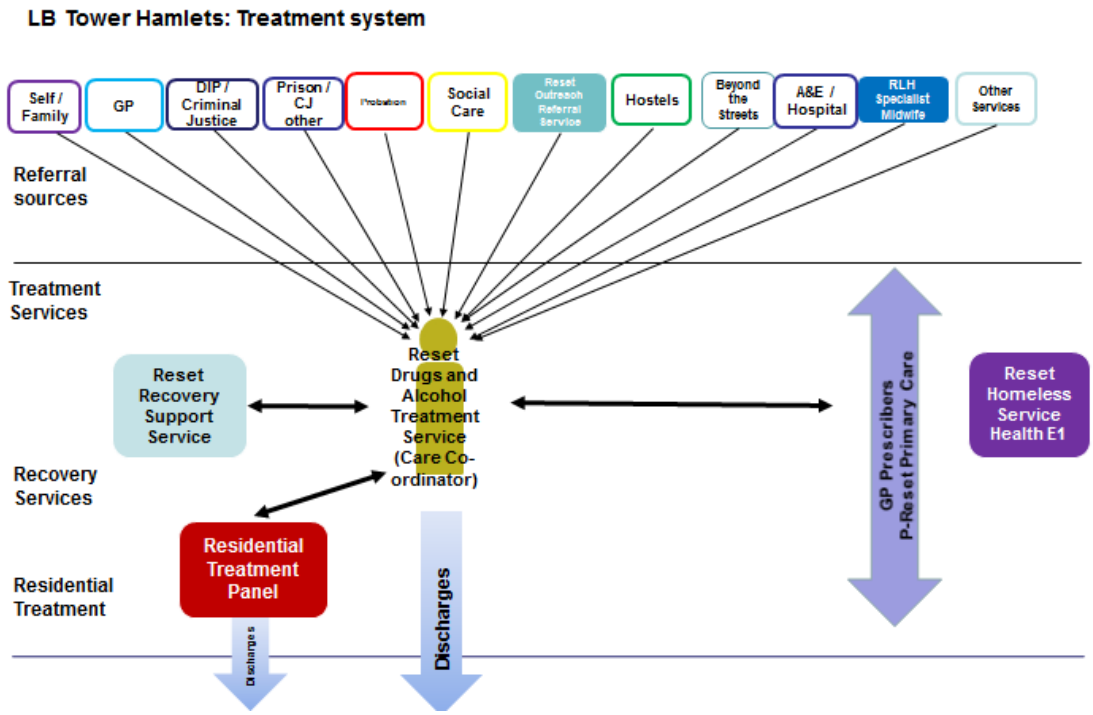
1.2.2 With existing contracts coming to an end in October 2019 and in line with Procurement and Legal procedures, the DAAT is now at the point of re-procuring the Reset contracts. As part of that, the DAAT conducted a comprehensive stakeholder consultation exercise which identified areas for improvement.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

improvements incorporated into the contract specifications and Performance Framework.

1.3 Treatment Model

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

1.3.2 This model is outlined below:



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

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

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

2 National Context

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

2.1 Drug Strategy 2017

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

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

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

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

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

2.2 Medications into Recovery 2012

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

2.2.2 The Expert Group's advice makes clear that:

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

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

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

2.3 Alcohol Strategy 2012 (update expected in 2019)

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

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

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

2.4 Psychoactive Substances Act 2016

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

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

2.5 Dual Diagnosis

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

2.6 Good Practice

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

2.6.2 NICE guidelines recommend:

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

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

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

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

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

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

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

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

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

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

2.7 **Transforming Rehabilitation**

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

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

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

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

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

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

2.8 Public Health Outcomes Framework 2016 - 2019

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

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

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

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

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

2.9.2 The Strategy is based on 3 key principles:

- Reduce Demand
- Reduce Supply
- Reduce Harm

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

3 Local Context

3.1 Tower Hamlets

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

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

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

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

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

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

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

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

[6] The Indices of Deprivation 2015

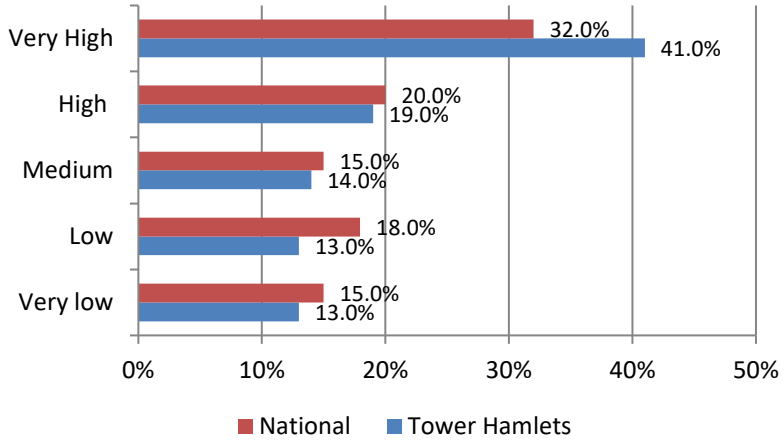
3.1.8 Tower Hamlets is estimated to have the third largest lesbian, gay and bisexual population in London with estimates from the 2015 GP survey placing the percentage of the adult population who identify as LGB at 8.7%[7].

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

3.2 Drug and Alcohol Treatment Population

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

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



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

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

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

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

Drugs - Prevalence Estimates

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

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

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

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

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

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

Alcohol – Prevalence Estimates

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

[8] PHE OCU estimate 2014/15 published 2017

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

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

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

Drug and Alcohol Treatment

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

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

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

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

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

3.3 Tower Hamlets Substance Misuse Strategy 2016-2019

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

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

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

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

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

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

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

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

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

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

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

3.4 Tower Hamlets Health & Wellbeing Strategy 2017 - 2020

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

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

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

3.5 Joint Strategic Needs Assessment 2017 [11]

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

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

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

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

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

3.6 Tower Hamlets Strategic Plan 2018-2021

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

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

- Priority 1: People are aspirational, independent and have equal access to opportunities
- Priority 2: A borough that our residents are proud of and love to live in
- Priority 3: A dynamic outcomes-based council using digital innovation and partnership working to respond to the changing needs of the borough.

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

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

3.7 Tower Hamlets Together

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

THT Mission and Values

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

THT Priorities

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

3.7.4 The current priorities are:

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

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

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

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

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

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

3.8.2 The Community Safety Partnership is responsible for:

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

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

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

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

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

3.9 Local Employment Strategy

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

3.9.2 The structure adopted within this Strategy is:

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

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

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

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

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

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

3.10 **DAAT Priorities 2018-19**

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

3.10.2 Identified priority and areas for development include:

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

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

4 Drug & Alcohol Outreach and Referral Service (Reset Outreach and Referral Service)

4.1 Introduction

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

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

- National Drug Strategy 2017
- National Alcohol Strategy 2012 (updated strategy expected in early 2019)
- Drug misuse and dependence, UK guidelines on clinical management (2017) Public Health England Commissioning for Recovery (2010)
- The public health burden of alcohol: evidence review (2018)
- Drug misuse treatment in England: evidence review of outcomes (2017)
- Medications in Recovery: Re-orientating drug dependence treatment (2012)
- Other cited relevant guidance and local protocols

4.2 Purpose

Aims

4.2.1 The central aim of the Drugs and Alcohol Outreach and Referral Service is to develop a proactive and targeted outreach service to identify and engage in structured treatment individuals with problematic drug and alcohol use that are not in contact with harm minimisation and /or treatment services.

4.2.2 The service will be dynamic and innovative in its approach to outreach and engagement and will support individuals to access structured treatment interventions and register on the National Drug Treatment Monitoring System (NDTMS).

Objectives

4.2.3 Reset Outreach and Referral Service has a key role to play in the development of an effective treatment system; providing targeted advice to both professionals and service users, harm reduction information and supporting referrals and access into treatment services for hard to reach groups.

4.2.4 The Provider(s) will provide outreach to 'hard to reach' and 'hidden' populations identified in the Tower Hamlets Drugs and Alcohol Needs Assessment.

4.2.5 The Provider(s) will inform those individuals about the risks associated with drugs/alcohol, to support them in reducing or eliminating such risks, and/or to help them improve their physical and psychosocial circumstances through individual or collective engagement.

4.2.6 The Provider(s) will deliver a street outreach service for those individuals with chaotic drug and/or alcohol use who are not willing or able to access structured treatment interventions. This will involve shifts outside of office hours in accordance with local need.

4.2.7 The Provider(s) will deliver in-reach into other health and social care settings including LBTH's commissioned hostel estate.

4.2.8 The Provider(s) will ensure there is appropriate signposting to other support services where an individual identified with problematic drug and/or alcohol use does not engage with the service.

4.3 Scope

Service Users

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

Priority Groups

4.3.2 The Provider(s) will target individuals that fall under priority groups for whom substance use is problematic but are not accessing harm minimisation and / or treatment services in Tower Hamlets.

4.3.3 The following should be considered as priority groups:

- Individuals with problematic opiate, non-opiate drugs and alcohol use
- Individuals from diverse BME and faith groups, particularly the Somali community
- Pregnant women
- Drug and alcohol using parents
- Intravenous drug users
- Individuals with co-morbid physical and/or mental health diagnosis where their drug or alcohol use exacerbates this diagnosis
- Individuals involved in prostitution
- Individuals who are homeless or in unstable accommodation
- Lesbian, gay, bi-sexual, transgender and questioning (LGBTQ) with a focus on Chemsex users
- Individuals recently discharged from prison
- Individuals required by court orders to engage with treatment
- Perpetrators and victims of domestic violence

Young Adults (18-24)

4.3.4 The Provider(s) will recognise that young adult service users aged 18-24 years are particularly vulnerable and therefore provision within a predominately adult service is not always ideal. Adult-based provision is more focused on harm reduction and treatment approaches in relation to substance misuse, which may not be appropriate for those young people whose substance use is linked to a range of needs across mental

health, education and employment, and who may have been in care or homeless at some point.

4.3.5 The Provider(s) will ensure both outreach and service based interventions are specific and tailored for this age group and liaise as necessary with the Local Authority Public Health commissioned services for young people.

Exclusion Criteria

4.3.6 The following exclusion criteria apply:

- Individuals who are not residents of Tower Hamlets
- All efforts are made by the Provider(s) to engage and retain service user within the service where appropriate, however from time to time it may be necessary to exclude a service user from the service because they have breached the rules or have failed to comply with the treatment programme
- Serious acute psychiatric morbidity e.g. Acute psychosis requiring acute psychiatric treatment
- Service users who behave in a violent or threatening manner towards other service users or staff.

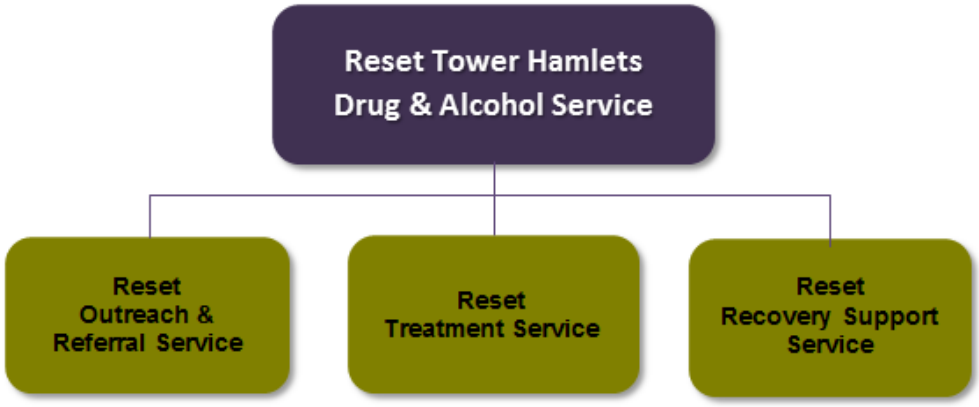
4.4 Communications and Marketing

The 'Brand'

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

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

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



4.4.3 Compliant designed branding will be displayed on all correspondence provided by the DAAT. References within correspondence either to service users, the community and

other partners will not be made by name of service Provider(s) but by the name given to the component part of the treatment services set out above.

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

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

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

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

Communications

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

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

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

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

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

Engaging Stakeholders

4.4.12 In partnership with Reset Treatment and Reset Recovery Support Services, the service will provide specialist liaison, consultancy, training and support to generic services who may be working with people experiencing drugs and/or alcohol problems. In particular but not limited to: hospitals, adult social care, children's and family services, young peoples' services, hostels, sexual health services, mental health, housing, employment

and education services. The Provider(s) will support these services to screen all individuals for drug and alcohol use and develop pathways into treatment services.

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

4.4.14 The Provider(s) will support Reset Treatment and Reset Recovery Support services in promoting the Reset offer alongside contributing to a detailed partnership annual training plan and support with ad hoc events including open days.

5 Outreach and Referral Interventions

5.1 Outreach Interventions

5.1.1 The Provider(s) will adopt evidence based dynamic and innovative approaches to enable the design and delivery of an outreach service thereby maximising the opportunities for referrals into treatment.

5.1.2 This service will provide low intensity interventions via outreach and open access to:

- Engage individuals who are not currently accessing the drugs and alcohol treatment services
- Motivate people to enter structured treatment in accordance with identified needs

5.1.3 Engagement will need to take place in a wide range of general services which include, but are not limited to, women only services, BME and faith groups, general hospitals and health centres, young adults and older people's services, sexual health services, hostels and day centres.

5.1.4 The service will engage a wide range of individuals who require, and would benefit from, drug and alcohol treatment and harm reduction interventions, and who are not currently accessing treatment services and will be able to apply new and innovative methods and initiatives to maximise opportunities for identification and engagement of residents with substance misuse support needs.

5.1.5 Target groups include 'hard to reach' cohorts, users with complex and non-complex needs; non-opiate users, those aged 18 – 24, Chemsex users, homeless populations, women, those with co-occurring substance misuse and mental health (dual diagnosis), and other priority groups as identified in the Substance Misuse Needs Assessment.

5.1.6 The Provider(s) will need to work with a wide range of other services to prevent individuals from developing problems, or to help prevent those who are currently misusing drugs and/or alcohol from developing more complex problems.

5.1.7 The Provider(s) through one to one and group sessions will deliver low intensity interventions to meet identified needs including but not limited to:

- Advice and information – up to date accurate advice and information on drug and alcohol related harms, risk of drug and alcohol related deaths, blood borne viruses (BBV), how to reduce drug and/or alcohol use and available treatment options
- Motivational interviewing – a cognitive behavioural approach to help develop individual motivation
- Brief psychological interventions including identification and brief advice (IBA)
- Brief interventions for alcohol including use of Alcohol Disorder Use Identification Test (AUDIT-C and Full Audit) screening tool
- Distribute harm minimisation including naloxone distribution, health promotion, treatment and other information to those with whom contact is made

5.1.8 The Provider(s) will prepare service users to enter structured treatment and offer, where appropriate an escorting service to facilitate this.

5.1.9 Service users will be supported to access wider health and social care services. This will include GP registrations.

5.1.10 The Provider(s) will work in partnership with other local and centrally commissioned outreach teams, Drug Intervention Programme (DIP) , mental health teams, homelessness teams, police (safer neighbourhood teams) and other agencies to ensure that outreach is coordinated across the borough and targets particular areas identified as 'hotspots' where problematic drug and/or alcohol use may be perceived as anti-social.

5.1.11 The Provider(s) will ensure there are appropriate levels of in-reach into hostels and day centres as well as homelessness services. The Provider(s) will ensure that those at risk of homelessness or who are homeless and have drugs and/or alcohol issues have access to brief interventions and structured treatment where necessary. Focus should be given to those people who as a result of their drug and/or alcohol consumption may be at threat of eviction.

5.1.12 The Provider(s) will proactively seek to deliver outreach and in-reach into a range of settings where priority groups may be targeted and identified; for example universities, sexual health services, hospitals, community centres, mental health services.

5.1.13 The Provider(s) will be expected to deliver street based brief assessments and interventions that will include the distribution of harm reduction and health promotion materials (according to local needs), motivational engagement and information on local treatment options.

5.1.14 The Provider(s) will ensure that policies on risk assessment, escorting service users and lone working, if appropriate, govern the delivery of street outreach sessions.

5.2 Needle and Syringe Programme

5.2.1 The Provider(s) will ensure intra-venous drug users have access to sterile injecting equipment through the distribution of safe injecting equipment during outreach / in-reach and information to reduce the risks associated with injecting behaviour. This will include information on access to specialist services for service users who may require more specific harm reduction initiatives or access to treatment relating to BBVs or wound care. The Provider(s) will also ensure the Needle and Syringe Programme is appropriately advertised displaying information regarding drop in times and availability across the Tower Hamlets drugs and alcohol services and pharmacies.

5.2.2 The main aim of needle and syringe programmes is to reduce the transmission of BBVs and other infections caused by sharing injecting equipment, such as Human Immunodeficiency Virus (HIV), Hepatitis B and Hepatitis C. In turn, this will reduce the prevalence of BBVs and bacterial infections, so benefiting wider society[13].

[13] http://www.nice.org.uk/ph52

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

5.2.4 The minimum expectation from the needle and syringe programme:

- The service offered will be user friendly and non-judgemental
- The service will aim to reduce the spread of BBVs associated with injecting drug use through the minimisation of sharing equipment between individuals and reducing the risks associated with the rates of other high risk injecting behaviours
- To offer advice and information relating to wound care, overdose prevention and basic life support
- To reduce the social and physical harms associated with injecting drug use including the promotion of safer injecting practices
- Identifiable and low dead space equipment to be provided
- Service must cater for and target all injecting drug users including those using image & performance enhancing drugs
- To increase and facilitate access to treatment services for clients not already engaged in structured treatment
- To reduce the potential for unsafe disposal of used injecting equipment and thus reducing the risks to public health
- To provide and reinforce a wide range of harm reduction messages including safe sex advice and advice relating to overdose prevention
- To offer advice relating to safe storage of all equipment
- Distribution of Naloxone kits to service users in accordance with Tower Hamlets Naloxone policy.

5.2.5 The provider will encourage safe return of used equipment to reduce the quantity of discarded needles across the borough.

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

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

5.2.8 The Provider(s) will develop policies and procedures to ensure staff engaged in needle exchange services are appropriately protected against the risk of needle-stick injuries.

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

5.2.10 The Provider(s) will keep detailed records of equipment issued and returned in a format agreed by Tower Hamlets DAAT and will return quarterly reports.

5.3 Naloxone

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

5.3.2 The Provider(s) will supply Opiate users and clients at risk of overdose with Naloxone injection kits (or Naloxone nasal spray when licenced without prescription) through outreach and in-reach and as part of the needle and syringe programme. Kits should be replaced when they are used or expired.

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

5.3.4 The Provider(s) will maintain a record of clients supplied with Naloxone kits and submit quarterly records in a format agreed by the DAAT.

5.3.5 The Provider(s) will maintain a record of any naloxone kits supplied to partner agencies (e.g. hostels) for the use in case of an emergency and in-line with DAAT guidance, and submit quarterly records in a formal agreed by the DAAT.

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

5.3.7 The provider will report incidents of overdose and where Naloxone is administered by staff in the case of an emergency as part of quarterly monitoring reporting.

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

5.4 Blood Borne Viruses

Immunisation

5.4.1 All individuals who engage with Reset Outreach and Referral Service will be offered access to immunisation against Hepatitis A and Hepatitis B via Reset Treatment Service. The Provider(s) should have a comprehensive range of protocols to raise awareness of risks from BBVs which promote testing and immunisation against Hepatitis A and B as well as testing and treatment for Hepatitis B, C and HIV.

5.4.2 The Provider(s) will ensure there are pathways for service users to access the BBV interventions through Reset Treatment Service, ideally co-located with any regular in-reach sessions, particularly where needle exchange services are provided.

5.5 Sexual Health

5.5.1 The Provider(s) will establish pathways for service users where sexual health risks have been identified with the community sexual health and GUM clinics for testing and treatment.

5.6 **General Health**

5.6.1 The Provider(s) will be required to offer healthy living advice, particularly in relation to healthy eating and smoking cessation and will support and encourage attendance at mainstream health services e.g. GP surgeries, breast screening, cervical screening etc.

6 Key Policies

6.1 Whole Family Interventions

Hidden Harm

6.1.1 All professionals working with adults living with, or having access to children should understand their responsibilities explicitly in order to achieve positive outcomes, keep children safe, and complement the support that other professionals may be providing. The welfare of the child will be the first consideration for the Provider(s) when working with substance misusing parents/carers. It is important that where parents are receiving treatment and support, the needs of their children are fully considered, in order for their welfare to be safeguarded.

Safeguarding Children

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

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

6.1.4 The Provider(s) must follow local protocols in all instances where there are concerns about a child's care/welfare or development to enable, and if necessary facilitate, accurate and appropriate assessment of the child's circumstances. The Provider(s) must comply with the requirements of the Safeguarding of Vulnerable Groups Act 2006 associated regulations and guidance provided by the Independent Safeguarding Authority (ISA). The Provider(s) has a responsibility to ensure that referrals are made to the ISA where necessary and are in accordance with ISA guidance and stipulations. The Provider(s) will also be expected to attend relevant safeguarding meetings where service users are being discussed.

Multi-agency Early Help Assessment

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

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

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

Safeguarding Vulnerable Adults

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

6.1.8 Harm and exploitation may consist of:

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

6.1.9 Harm and exploitation can occur anywhere, for example:

- At home
- In care homes
- In day centres
- At work
- At college
- In hospitals or health centres/surgeries
- Public places or in the community

[14] https://www.england.nhs.uk/wp-content/uploads/2017/02/adult-pocket-guide.pdf

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

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

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

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

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

Safeguarding Lead

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

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

6.2 Service Delivery

Hours of Operation

6.2.1 Tower Hamlets has a 24 hour drug and alcohol economy. The Provider(s) will ensure there is flexibility in the times of outreach to include early mornings, evenings and weekends. The hours of outreach will be agreed between the Provider(s) and commissioner and will depend on service user need.

6.2.2 The Provider(s) will operate an open access service for potential service users at core times during the working week; core times are usually between 10am and 6pm, Monday to Friday. These times are to be agreed between the Provider(s) and commissioner and will depend on service user need.

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

[15] http://www.towerhamlets.gov.uk/lgnl/health_and_social_care/safeguarding_adults.aspx

Business Continuity and Emergency Planning

6.2.4 The Provider(s) must have comprehensive and adequately tested business continuity plans in place in order to ensure continuation of critical services in the event of severe weather, adverse event or major service disruption. These will be made available to the commissioner and updated on an annual basis. .

6.3 Incident Reporting

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

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

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

Local Drug Information System

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

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

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

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

6.4 Drug and Alcohol Related Deaths

6.4.1 The Provider(s) must have systems in place for reporting Serious Untoward Incidents (SUI) and Drug and Alcohol Related Deaths internally and it will be an expectation that the DAAT is informed of such incidents at the earliest opportunity and within 2 working days (48 hours).

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

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

6.5 Equalities

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

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

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

6.6 Information Governance

6.6.1 The Provider(s) will encourage all service users to sign the information sharing consent form at the earliest opportunity. The form gives options for the service user to decide who they wish to share their information with. This will include the whole Tower Hamlets drug and alcohol treatment system, the National Drug Treatment Monitoring System (NDMTS), external agencies and any future research projects. Where service users decline consent at the first meeting this must be approached again sensitively and the importance of giving consent outlined. Service users must also be made aware of their rights to access any data which is held about them.

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

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

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

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

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

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

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

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

7 Systems and Processes

7.1 Assessment

DAAT Common Assessment Framework

7.1.1 All Reset partners will use the DAAT common assessment framework and single client management system (Nebula at time of writing) for drugs and/ or alcohol users. This will minimise the duplication of assessments a service user will undergo and facilitate efficient access into specialist treatment and recovery. A common assessment framework will further enable transparency, accountability and information sharing as the service user moves through the Tower Hamlets drug and alcohol treatment system.

7.1.2 The Provider(s) will make contact with individuals through outreach and where relevant the Provider(s) will complete the screening and/or initial assessment to facilitate access to structured treatment. A risk assessment will be completed for every new service user and where risks are identified, a risk management plan will be developed.

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

Care Coordination

7.1.4 The Provider(s) will be responsible for the initial care coordination of individuals who they make contact with and subsequently engage in their service. The provider will be responsible for handing over the care coordination once a service user engages in structured treatment.

Case Management Systems

7.1.5 The Provider(s) will use an electronic case management system to manage their client cohort and store client data securely.

7.1.6 The Provider(s) will record all contacts made through outreach whether or not the individual engages with the service. At the very minimum the Provider(s) will record:

- Name and contact details
- Time and location of contact
- Age/date of birth or, where unknown, the perceived age
- Ethnicity
- Gender
- Substance dependency
- Housing status
- Known to treatment/previously engaged with treatment

7.1.7 Nebula, provided by Orion PM is the current single case management and information system that is used by Reset Recovery Support Service and Reset Treatment Service. Read only access will be available to the Outreach & Referral service. Nebula is an effective tool in facilitating information sharing between drugs and alcohol services and enables services to work more effectively across the treatment system.

7.1.8 It is critical in developing a comprehensive outreach service the reasons for individuals not wanting to engage are asked and recorded. Contact information is essential in planning the approach to outreach and critical in identifying the level of unmet need in Tower Hamlets. This information will create an evidence base to inform needs assessments and future planning.

For further information on Nebula please refer to Appendix C.

7.2 Referrals

7.2.1 The Provider(s) will promote Reset services with external local services and forge links with various agencies and services in Tower Hamlets to attract vulnerable and hard to reach groups into treatment.

7.2.2 The Provider(s) will act as the key point of contact for referrals from local organisations and services that are in contact with individuals known to have problematic drug and/or alcohol use but are not willing or able to access treatment. For example, GPs and other health care services.

7.2.3 The Provider(s) will be responsible for the onward referral of service users that are ready and willing to engage with Reset Treatment Service. Where appropriate the Provider(s) will ensure onward referrals are made to local health and social care services or any other services identified who will be able to support the service user. For example, the Recovery Support Service provides a number of non-structured interventions including a legal advice clinic, housing advice and ETE support. Direct referrals can be made where agreed and details must be recorded in accordance with the requirements outlined above.

7.3 Relationships and Partnerships

Collaborative Working

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

Reset Treatment Service

7.3.2 The Provider(s) will establish strong links with Reset Treatment Service. In collaboration with Reset Treatment Service, the Provider(s) will develop clear pathways for individuals that are ready and willing to engage with structured treatment. This will require collaborative working to ensure targeted/hard to reach individuals are seamlessly transferred into structured drugs and alcohol treatment. The Provider(s) will host surgeries/satellite for Reset Treatment Service to facilitate access to treatment and harm minimisation advice and information as well as BBV testing and vaccinations.

Royal London Hospital

7.3.3 The Provider(s) will work with the Royal London Hospital teams to support patients to access community services upon discharge, escorting patients where necessary.

Drug Intervention Programme (DIP)

7.3.4 The DIP is a tier two service responsible for engaging into treatment individuals involved in anti-social behaviour or criminal activity linked to their substance misuse.

7.3.5 The Provider(s) will work closely with DIP and local authority anti-social behaviour teams to facilitate collaboration where beneficial and support the engagement and re-engagement of individuals referred through criminal justice system pathways.

Prostitution Support Service

7.3.6 The Prostitution Support Service operates a targeted street-outreach and case management of individuals involved in prostitution. The Provider will establish strong links with the service and in conjunction with the DIP to support individuals to access treatment and facilitate access to harm reduction interventions. Referrals will be made to the Tower Hamlets Prostitution Partnership (THPP) where individuals are considered to be at increased risk.

7.4 Whole System Relationship

7.4.1 The Provider(s) will be required to make referrals to appropriate local support services for those individuals that choose not to engage with treatment. This may include referrals to social services, homeless persons unit, Health E1 (homeless medical practice) etc. Relevant local services within Tower Hamlets include, but are not limited to:

- Local voluntary sector organisations that support, or provide a voice for customers and carers
- Drugs and Alcohol Liaison services at the Royal London Hospital
- NHS Primary and Secondary care services, including GPs
- Local Community Mental Health Teams
- Children's Social Care
- Adults Social Care
- Children's Centres
- Probation
- Drug Interventions Programme (DIP)
- Integrated Offender Management Programmes
- Hostels and Housing Providers
- Community pharmacies
- Tower Hamlets Domestic Violence Team
- Specialist maternity services
- Beyond the Streets
- Other health and social care providers and services as required.

7.5 Service User and Carer Engagement

Service Users, Carers and Significant Others

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

- Support and recruit service user and carer representatives within the service, these individuals will champion and support the work of the service and be proactive in working with their respective groups
- Support the involvement of service users and carers within the planning of services to enable them to contribute at all levels of service development
- Ensure service user representatives attend relevant service user and carer forums, including those hosted by Public Health England and meetings with service user representatives across Tower Hamlets drug and alcohol services
- Display within their premises an agreed service users' Charter of Rights and Responsibilities or equivalent

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

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

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

Peer Mentor/Volunteer Support

7.5.5 The Provider(s) will recruit, support and manage a cohort of peer mentors and volunteers to support service users and carers. Peer supporters will also offer friendly, informal but confidential support to carers of individuals with drugs and alcohol issues and will:

- Support service users to access treatment and other support interventions
- Accompany service users to meetings/appointments.

8 Workforce

8.1 Minimum Workforce Standards

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

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

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

8.1.4 All interventions will be provided by staff assessed by the provider as being appropriately trained, skilled and competent to provide them. Effective interventions require competent practitioners who must have basic occupational competencies; front line staff must have competence in motivational approaches and brief interventions16.

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

8.1.6 In addition the Provider(s) will ensure there are suitably qualified specialisms within the workforce to adequately respond to service user recovery and support needs, for example housing and welfare benefits.

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

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

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

8.2 **Workforce Development**

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

- Safeguarding children
- Safeguarding vulnerable adults
- Risk management
- Information governance
- Harm minimisation
- Health and safety
- Equality and diversity
- DAAT training programmes

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

- All workers and their line-managers have, or are working towards, evidence of their basic competence in the field,
- All workers and their line-managers have completed, or are undertaking, a training course regarding Safeguarding Children and Adults commensurate with role,
- All line managers have completed, or are undertaking, a training course in line-management,
- All workers and their line-managers have, or are working towards, evidence of basic IT literacy,
- Any new and emerging concerns/priorities specified by the DAAT are supported by learning and development programmes.

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

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

9 Performance Management

9.1 Performance Outcomes

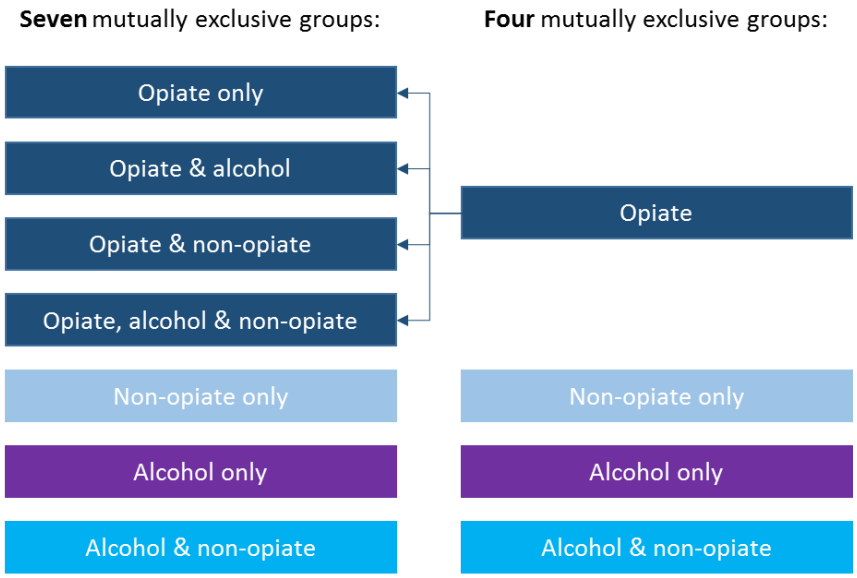
9.1.1 The interventions delivered through this service will be expected to significantly support people accessing structured treatment. The Provider(s) will be performance managed on the number of referrals to structured treatment and the level of engagement in structured treatment.

9.1.2 Whist the Provider(s) will not be responsible for entering and submitting service user information for the purposes of NDTMS, the Provider(s) will be required to have an understanding of the NDTMS reporting process as the Reset Provider(s) will be monitored against NDTMS outcomes reports.

9.2 National Drug Treatment Monitoring System

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

Chart 3: New Categorisations of Substance Groups, NDTMS April 2014



9.3 Local Outcome Comparators

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

comparators for opiate, non-opiate and alcohol populations, in line with the new substance categories used in reporting for 2014/15. The same non-opiate comparators will be used for both the 'non-opiate only' and 'non-opiate and alcohol' substance groups.

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

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

9.4 Key Performance Indicators

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

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

Quality Outcomes Indicators / Reporting Requirements

	Indicator	Period	By Substance	Target	Method of Measurement	PBR Linked?
	Outreach					
1	Hours of outreach per week (but does not include regular scheduled sessions / clinics)	Quarterly	All service users	>/=30 hours a week	Provider report / Local data	N
2a	Number of contacts (sign posting & harm reduction) A new contact is defined as no contact with the service in the previous 6 months or longer.	Quarterly	All clients	Minimum of 1,000 individuals a year	Provider report / Local data	N
2b			All Opiate	No target		
2c			Non-opiate only	No target		
2d			Alcohol only	No target		
2e			Non-opiate & Alcohol only	No target		
3	Provide quarterly report with breakdown of all individual contacts. Profile contacts using the following categories: Profile of users • Time • Location • Substance dependency • Housing status • Known to treatment/previously engaged with treatment • Age • Gender • Disability • Race	Quarterly	All service users	Provider report	Provider report / Local data	N

	• Religion and belief • Gender reassignment • Marriage and civil partnership • Sexual orientation • Pregnancy and maternity • Referral made (Y/N) • Engaged in treatment (Y/N)					
	Engagement					
4a	Referrals to Drugs and Alcohol Treatment Service (formally documented referrals)	Quarterly	All service users	Minimum of **200** referrals a year	Provider report / Local data	**Y**
4b	Referrals to Drugs and Alcohol Treatment Service – Specific need group identified by Substance Misuse Needs Assessment / DAAT (referrals formally documented)	Quarterly	All service users	Target to be specified in contract implementation period. Target group can change (annually) depending on identified need.	Provider report / Local data	**Y**
5a	Conversion to structured treatment (Confirmed engagement in structured treatment with treatment start date on NDTMS and confirmed case management system ID) – All clients	Quarterly	All service users	Minimum of **140** treatment starts a year	Provider report / Local data	**Y**
5b	Opiate clients			No target		N
5c	Non-Opiate only clients			No target		N
5d	Alcohol only clients			No target		N
5e	Non-Opiate & Alcohol only			No target		N
	Needle and Syringe Programme & Naloxone					

6	Needle and Syringe Programme Activity Report	Quarterly	All service users	Activity	Provider report / Local data	N
7	Naloxone distribution Activity Template	Quarterly	All service users	Activity	Provider report / Local data	N
	Workforce					
8	Workforce Diversity Data Report	Quarterly	Staff	Activity	Provider records	N
9	Annual Training Needs Analysis and Action Plan	Annual	Staff	Activity	Provider report	N
10	Provide complaints, incidents & compliments Report	Quarterly	All service users / Staff	Activity	Provider records	N
11	Annual Business Continuity report	Annual	All service users / Staff	Activity	Provider records	N
	Equalities					
12	Annual Equality Impact Assessment	Annual	All service users	Activity	Provider report	N
	Service Users					
13	Annual Service Users Survey including findings and action plan	Annual	All service users	Activity	Provider Report	N

9.5 Payment by Results

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

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

PBR schedule

KPI / KPI group	Proportion of PBR payment allocated	When implemented
KPI 4a: Referrals to the Drugs and Alcohol Treatment service KPI 4b: Referrals to Drugs and Alcohol Treatment Service – Specific need group identified by Substance Misuse Needs Assessment / DAAT (formally documented referrals)	5%	Q1 2020/21
KPI 5: Conversion to structured treatment	5%	Q1 2020/21

9.5.3 PBR payment will be made for all achieved and met PBR targets / target groups. Failure to achieve quarterly PBR outcomes will result in the PBR payment for the quarter being removed and reallocated by the DAAT. PBR will be applicable from Q1 2020/21. Full details of the Payment by Results programme including appeals process will be provided at the point of contract agreement.

9.6 Contract Monitoring

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

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

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

Appendix A – Table of Abbreviations

AUDIT-C	Alcohol Disorder Use Identification Test – Consumption
BBV	Blood Borne Viruses
BME	Black and Minority Ethnic
CRC	Community Rehabilitation Companies
DAAT	Drug and Alcohol Action Team
DANOS	Drug and Alcohol National Occupational Standards
DBS	Disclosure and Barring Service
DIP	Drug Interventions Programme
DOMES	Diagnostic Outcomes Monitoring Executive Summary
ECAF	Electronic Common Assessment Framework
ECMS	Electronic Case Management System
ELFT	East London Foundation Trust
GP	General Practitioner
HIV	Human Immunodeficiency Virus
IBA	Identification and brief advice
ISA	Independent Safeguarding Authority
JSNA	Joint Strategic Needs Assessment
NDTMS	National Drug Treatment Monitoring System
OCU	Opiate and/or Crack User
PCT	Primary Care Trust
PHOF	Public Health Outcome Framework
SUI	Serious Untoward Incident
VfM	Value for Money
YTD	Year to date