Appendix 4

EIAs for Approval at Council

Reference	Brief Detail	Responsible Officer
A008	Commissioning - Learning & Attainment	Steve Edwards
	SEN Transport	
B035	Redesigning services for Children, Young People and their Families (0-19 offer)	Jill Beaumont
	Proposal 1: Universal Youth Service	
	Proposal 2: Targeted Youth & Family Support Services	
	Proposal 3:Early Years 0-4 service redesign	
	Enabling EIA: All age early help offer	
B039	Review of Public Health Budget	Alan Higgins
	Proposal One (Re-tendering the Drug and Alcohol Treatment System for 2015-17)	
	Proposal Three (Review of Public Health Budget: Health Improvement Services)	
	Proposal Four (Review of Public Health Budget: School Nursing Service)	
	Proposal Four (Review of Public Health Budget: Healthy Schools Coordinator)	
D017	Customer and Business Support Redesign (includes D021 - Legal Services Redesign)	Suzanne Heywood
D020	Legal & Democratic - Registrar Service	Paul Entwistle

Equality Impact Assessment Tool

A008 Commissioning - Learning & Attainment: SEN Transport

Stage 1: Initial screening

Lead Officer:	Steve Edwards
People involved in completing EIA:	Steve Edwards
Is this the first time that this project, policy or proposal has had an EIA carried out on it? If no, please state date of original and append to this document for information.	Yes X No Date of original EIA: N/A

General Information

1a	Which service does this project, policy, or proposal relate to?	This savings proposal relates to the provision of home to school transport for pupils with Special Educational Needs and Disabilities, which comes under the Access Service within Learning and Attainment.
1b	What is the project, policy or proposal?	This proposal relates to a savings proposal within the wider Learning and Attainment proposal, **Budget template A008, entitled *SEN Transport*.** The current savings target against this project amounts to £64,000 for 2015/16 out of a total annual budget of £2.1 million. The savings specified for 15/16 will be achieved through procurement efficiencies, contract management and the transfer of transport costs for Our of Borough placements to the Dedicated Schools Grant. The re-procurement of contracts for routes has resulted in a reduced cost per day, but with no reduction in the level of service. Contract management involves the efficient scheduling and rescheduling where necessary of all current and future contracts. This will ensure that mileage is at a minimum. Where changes are made to contracts to reduce where pupils no longer require the service, contract prices are lowered in line with the terms and condition and the providers mileage rate. This does not affect service users. The transport costs for some Out of Borough placements will be transferred to the Dedicated Schools Grant (DSG) by incorporating them to the total cost of the placement. In these cases the school would arrange the transport and add the costs for this in to the overall charge for the placement. This would enable the Council to fund transport costs which are currently paid from its core grant from the High Needs Block of the DSG.

		A longer-term project has been initiated to look at how more substantial savings can be made from this budget in future years. This is being taken forward in consultation with Oldham's parent partnership organisation, POINT. Star Chamber endorsed this approach at its meeting on 20th October (please see Appendix 1) and has requested that further work should be undertaken to explore the following options: • Offering a personal budget as an alternative • Independent Travel Training • Designated Pick up and Drop off Points • Out of Borough Placements – transferring transport costs to the Dedicated Schools Grant. • Review the procurement strategy and current contract pricing structure • Review the current transport policy and eligibility of all those currently receiving support with transport • Passenger Assistants provided by contractors The timescale for agreeing changes to home-school transport arrangements is tied to Admissions legislation. Therefore, following consultation with parents through POINT a final decision for 2016/17 and subsequent years will be made by Cabinet in February 2015. Although a full EIA will not be needed for the 2015/16 saving of £64k, it is certain that a full EIA will be required once proposals for 2016/17 and beyond have been agreed.
1c	What are the main aims of the project, policy or proposal?	To achieve a reduction in Council spend on home to school transport whilst protecting the service to children and families
1d	Who, potentially, could this project, policy or proposal have a detrimental effect on, or benefit, and how?	There will be no impact on service users. The savings in 2015/16 can be achieved by driving through efficiencies in the delivery of contracts and by more effective procurement of transport on specified routes.

1e. Does the project, policy or proposal have the potential to <u>disproportionately</u> impact on any of the following groups? If so, is the impact positive or negative?				
	None	**Positive**	**Negative**	**Not sure**
Disabled people	☒	☐	☐	☐
Particular ethnic groups	☒	☐	☐	☐
Men or women (include impacts due to pregnancy / maternity)	☒	☐	☐	☐
People of particular sexual orientation/s	☒	☐	☐	☐
People who are proposing to undergo, are	☒	☐	☐	☐

undergoing or have undergone a process or part of a process of gender reassignment				
People on low incomes	☒	☐	☐	☐
People in particular age groups	☒	☐	☐	☐
Groups with particular faiths and beliefs	☒	☐	☐	☐
Are there any other groups that you think may be affected negatively or positively by this project, policy or proposal?				
E.g. vulnerable residents, individuals at risk of loneliness or carers.		☐	☐	

1f. What do you think that the overall NEGATIVE impact on groups and communities will be?	**None / Minimal**	**Significant**
	☒	☐

1g	Using the screening and information in questions 1e and 1f, should a full assessment be carried out on the project, policy or proposal?	Yes ☐ No ☒
1h	How have you come to this decision?	We have ensured that existing levels of provision will continue to be delivered in 2015/16 by achieving the savings target of £64k through contract management and procurement efficiencies.

Stage 5: Signature	
Lead Officer: Steve Edwards	**Date: 25.11.14**
Approver signature: Paul Cassidy	**Date: 25.11.14**
EIA review date: December 2015	

Equality Impact Assessment Tool

B035: Proposal One – Youth Service (0-19 offer for Children, Young People and Families) – Universal Youth Offer

Stage 1: Initial screening

Lead Officer:	Colette Kelly
People involved in completing EIA:	Neil Consterdine
Is this the first time that this project, policy or proposal has had an EIA carried out on it? If no, please state date of original and append to this document for information.	Yes x No Date of original EIA:

General Information

1a	Which service does this project, policy, or proposal relate to?	This proposal relates to **Budget Proposal B035 – 019 offer for Children, Young People and Families proposal one**. The proposal covers services offered by the Councils Integrated Youth Services which includes :- • District Youth and Sports Development Services • Central Youth Services – Empowerment & Participation • Detached Youth Services • School Swimming Service • Outdoor Education • School Sports Development Service • Study Support Services • Music Service.
1b	What is the project, policy or proposal?	The proposal is to reduce some of the services listed above, that the Council directly delivers to young people. In reducing its role as a direct provider of services, the Council will continue to support the voluntary, community and school sector to deliver a wider offer of activities for young people. This wider offer will include working closely with key providers, Oldham Community Leisure and Mahdlo.
1c	What are the main aims of the project, policy or proposal?	The main aims of the proposal are to :- • Reduce the Council's expenditure in the direct

		delivery of services and to release a saving of £600,000 towards the Councils overall target. • Support the sustainable development of a wider voluntary and community sector offer of services for young people. It is proposed that these aims will be achieved across each service area by :- **District Youth and Sports Development** • Disestablishing the District Youth and Sports Development Service. • Seconding the District Youth Development Officers to Mahdlo on a 12 month management pilot. • The District Youth Development Officers will continue to support and develop a wider local offer with the voluntary, community and school sectors in each District. **Central Youth Services – Empowerment and Participation**. • Reducing budgets and staffing levels • Continuing to provide support to the Youth Council and in addition staff will also support the Looked After Children Council. **Detached Youth Services** • Seconding the Detached Youth Team to Mahdlo for a 12 month management pilot. **School Swimming Service** • Transferring the service directly to OCL. Staff will be transferred under TUPE arrangements. **Outdoor Education, Schools Sport Development and Study Support Services** • Collectively these services currently form part of a business unit within the Council and trade directly with schools. The services raise income to cover staff salaries and back room support costs. • The staff in these services have expressed an interest in forming a staff mutual. The staff will be supported within the Council to develop a mutual that will work alongside OCL to deliver services in Oldham and beyond.

		Music Service • Retaining the service in the Council. The service is to be further considered for inclusion in the Borough's Cultural Trust which is under development with Oldham Coliseum and the Arts and Heritage Service (2017).
1d	Who, potentially, could this project, policy or proposal have a detrimental effect on, or benefit, and how?	Integrated Youth Services as listed in section 1a) is a range of universal services that are available to all young people living in Oldham aged 8 – 19 The proposal in its entirety as set out in 1c) is complex and multi-faceted, and presents elements that have the potential to impact on staff and young people and communities in both a detrimental and beneficial way. It also has the potential to indirectly impact both positively and negatively on the families and carers of young people and local sport and activity clubs. **District Youth and Sports Development Services** This aspect of the proposal appears to pose the greatest risk of having a detrimental effect on local young people in Districts through ceasing Council run youth and sport services. Local community based sports clubs who rely on the support of the District Sports Development officer, may struggle to comply with governing body requirements. This in turn may see grass root clubs close and reduce the level of funding brought in to communities through sporting bodies. Conversely, the proposal also has the potential to bring about universal benefits to young people in districts. This is to be achieved by enabling and supporting the voluntary, community and school sectors to grow and deliver a wider range of youth activities than the Council provides now and that those services are sustainable going forward. This is evidenced by the level of ongoing support and resources directed to the sector by local private investment, trusts and central government and governing bodies to support young people. **Central Youth Services – Empowerment and Participation.** This aspect of the proposal poses a limited detrimental impact on young people and staff. The potential detrimental impact relates to the reduction to some

		sessional activities and the staff support for the 60 Youth Councillors that form the Oldham Youth Council. The beneficial potential of this aspect is the alignment of the support offered to the Youth Council and the Looked After Children Council. The proposal brings both Councils under the same service so sharing resources, profile and provision within the wider democratic framework of the Council. **Detached Youth Service** This aspect of the proposal presents a potential risk that could impact detrimentally on young people and local communities. The proposal is to second the detached team on a twelve month pilot, to be managed by Mahdlo. The potential risk is that the team becomes dis connected from the wider community safety and cohesion arrangements within the Council. This could perhaps lead to delays in the team being deployed with partners to areas of tension or unrest and potentially leave young people and local communities exposed longer to anti-social behaviour and or community unrest. The proposed arrangements will be reviewed throughout the pilot period. The potential benefits associated with this element of the proposal are that staff within the Detached team could benefit from a direct connection and access to Mahdlo's services. Young people who come into contact with the Detached Team could also further benefit from a supported referral and introduction to Mahdlo's wider services. Mahdlo also have an outreach team and together the two teams will be compliment targeted work in the Districts. **School Swimming Services** The potential detrimental element in the proposed transfer to OCL is that young people and schools may lose the wider curriculum element currently delivered within the school swimming service – the difference in how they are taught to swim. The current staff are trained teachers whilst OCL staff are trained swimming instructors. On the other hand, the young people could also benefit from a wider community learning environment and the linkages to additional activity within the transfer proposal to OCL. A potential direct benefit to schools

		and parents is that this proposal should simplify the service delivery arrangements as it proposes to create a single provider in OCL, managing both the pools and the delivery of the swimming service across Oldham. **Outdoor Education , Schools Sport Development and Study Support Services** This element of the proposal is at its very early embryonic stages of development. There is potential that developing a staff mutual to run elements of services for young people will offer benefits to staff and young people. The proposal is out to consultation and as stated at its very early stages of development. Potentially a staff mutual could offer staff the benefits of having direct control over the shape, culture and structure of the organisation and their own employment terms and conditions and remuneration. In addition, a staff mutual has the potential to be more flexible in responding to young people and commissioners needs. This is because a staff mutual will not be as large or governed by a large democratic framework so decisions on service delivery have the potential to be made quicker in response to service and the needs of young people.

1e. Does the project, policy or proposal have the potential to disproportionately impact on any of the following groups? If so, is the impact positive or negative?				
	None	**Positive**	**Negative**	**Not sure**
Disabled people	☐	☐	☐	☒
Particular ethnic groups	☐	☐	☐	☒
Men or women (include impacts due to pregnancy / maternity)	☐	☐	☐	☒
People of particular sexual orientation/s	☐	☐	☐	☒
People who are proposing to undergo, are undergoing or have undergone a process or part of a process of gender reassignment	☐	☐	☐	☒
People on low incomes	☐	☐	☒	☐
People in particular age groups	☐	☐	☒	☐
Groups with particular faiths and beliefs	☐	☐	☐	☒

Are there any other groups that you think may be affected negatively or positively by this project, policy or proposal?				
Young people in Districts where there is not a strong offer already established from the voluntary and community sector		☐	☒	

1f. What do you think that the overall NEGATIVE impact on groups and communities will be?	**None / Minimal**	**Significant**
	☐	☒

1g	Using the screening and information in questions 1e and 1f, should a full assessment be carried out on the project, policy or proposal?	Yes ☒ No ☐
1h	How have you come to this decision?	The potential detrimental impact on disestablishing the District Youth and Sports offer could impact significantly in areas where there is not a strong voluntary and community or school sector offer.

Stage 2: What do you know?

What do you know already?

- Mapping of current activity and services delivered in each District has been carried out to show in the wider voluntary and community offer – see appendix 2.
- Consulted with VCF sector on local provision – including Mahdlo and OCL
- Taken into account the views of Youth Council and Young People in Districts on local provision
- Taken into account the views of the staff who work in each District on local provision .

What don't you know?

- Need ongoing analysis of the offer from the voluntary, community and school sector to grow and what additional support may be needed
- Need evaluation information on ability for groups to deliver across Districts to fill potential gaps in provision and for Young People to access provision elsewhere that better suits their needs

Further data collection

In order to try and fill these information gaps we will be undertaking:

- Further discussion has taken place with partners and local providers, groups schools and voluntary and community sector to assess potential growth areas and their capacity to work across districts
- Further work with local youth forums and groups to check opinions on local offer and any barriers to travel

Summary (to be completed following analysis of the evidence above)				
Does the project, policy or proposal have the potential to have a disproportionate impact on any of the following groups? If so, is the impact positive or negative?	**None**	**Positive**	**Negative**	**Not sure**
Disabled people	☐	☐	☐	☒
Particular ethnic groups	☐	☐	☐	☒
Men or women (include impacts due to pregnancy / maternity)	☐	☐	☐	☒
People of particular sexual orientation/s	☐	☐	☐	☒
People who are proposing to undergo, are undergoing or have undergone a process or part of a process of gender reassignment	☐	☐	☐	☒
People on low incomes	☐	☐	☒	☐
People in particular age groups	☐	☐	☒	☐
Groups with particular faiths and beliefs	☐	☐	☐	☒
Are there any other groups that you think that this proposal may affect negatively or positively?				
Young people in districts where there is a limited range of activities currently on offer the voluntary, community and school sector.		☐	☒	

Stage 3: What do we think the potential impact might be?

Consultation information	
3a. Who have you consulted with?	So far consultation has taken place both informal and formal with :- • Young People • Youth Council • Elected Members • Mahdlo • OCL • VAO • Police • Staff
3b. How did you consult? (inc meeting dates, activity undertaken & groups consulted)	Public consultation has been ongoing and completes on Friday 5 December 2014. There have been a range of scheduled and one off single purpose meetings to discuss the proposal as set out in section 1a). On completion of consultation details will be tabled at Appendix 3.

	Key stakeholders included :- • District Executives • Ward Councillors and Cabinet Members • Voluntary, Community Sector providers in Districts • Service users • Youth Council • Trade Unions • Youth Service Staff

3c. What do you know?
There remains a potential risk to the disestablishment of the District Youth and Sports services. This risk relates to the current level and range of provision in each District from the voluntary, community and school sector. In addition the risk of local community sports and grass root clubs not being able to satisfy the requirements of governing bodies and being forced to close or limit activity.
3d. What don't you know?
• The capacity for growth within the community and voluntary sector relates in part to Public Health outcomes around increasing wellbeing and physical activity with young people. Local commissions could help fill gaps and support local groups. • Further discussions will be held with local Young People beyond the Youth Council to assess the local views on what and from where young people would want to access activity.

3e. What might the potential impact on individuals or groups be?	
Generic (impact across all groups)	Young people may not be able to access particular activities within their local area. Young people may feel uncomfortable or insecure about accessing services outside of their neighbourhood.
Men or women (include impacts due to pregnancy / maternity)	No disproportionate adverse impacts identified.
People of particular sexual orientation/s	No disproportionate adverse impacts identified.
Disabled people	Disabled young people may have to travel further to access provision.
Particular ethnic groups	No disproportionate adverse impacts identified.
People who are proposing to undergo, are undergoing or have undergone a process or part of a process of gender reassignment	No disproportionate adverse impacts identified.
People on low incomes	Cost associated to alternative provision may be prohibitive for some low income families, including travel costs.
People in particular age groups	Younger age groups may be restricted from independently accessing provision if travel distances are significantly increased.

Groups with particular faiths and beliefs	No disproportionate adverse impacts identified.
Other excluded individuals and groups (e*.g. vulnerable residents, individuals at risk of loneliness, carers or serving and ex-serving members of the armed forces*)	Young people in some districts where there is a limited range of activities currently on offer by the voluntary , community and school sector

Stage 4: Reducing / mitigating the impact	
4a. Where you have identified an impact, what can be done to reduce or mitigate the impact?	
Impact 1: Limited existing range of provision from of voluntary, community and school sector provision in some districts	• Secondment of staff: Youth Development staff to Mahdlo for 12 months to continue to build the capacity and support the sector to expand. • Work with the sector including parents and schools to see what groups across Oldham can expand and deliver in different areas. • PH funding will target getting people active and could strengthen the business case of the mutual which has a Sports Development focus
Impact 2: Increase in travel costs and distances	• Mahdlo are providing a local session once a week in each District. • The Council has subsidised bus passes for young people to access Mahdlo. • Minibus pick up and drop up to and from at Mahdlo is being put in place supported by District Executives. • The new policy approach to Community use of Council Assets may also encourage local providers to put on more youth activity.
Impact 3: Young People unwilling to travel due to perceived risk/territory issues	• Taster sessions and advice in each District on what can be provided locally • GO! Oldham site is re launched and marketed showing details of range of activities available in each District • Continue to work with local youth forums to assess access and service needs

4b. Have you done, or will you do, anything differently as a result of the EIA?
Through the consultation process further issues have arisen regarding the impact of disestablishing the District Sport Development service. This relates to the impact on local sports and grass roots clubs based in the community, who form part of the wider Youth offer delivered by the voluntary and community sector in Districts. In disestablishing the District Sports Development team who support the local clubs, the level of activity the clubs and groups provide could reduce and some clubs fold. Connection into the national governing bodies of sport will be reduced at a time when Public Health England and Sport England are joining

forces to promote “Get Active” programmes and increase the level of physical activity - Oldham has low levels of activity post 16 and high levels of the obesity. Reducing capacity could also reduce the level of funding drawn into the Borough from sporting bodies to support local and borough wide activity in individual sports. We will now re-examine the Business Case of the proposed staff mutual to see if these functions could be delivered through the Mutual and or with OCL.

4c. How will the impact of the project, policy or proposal and any changes made to reduce the impact be monitored?

There is a project team around this proposal which will continue to monitor the implementation and identified risks will be regularly reviewed with local community and District networks of groups and key partners such as OCL and Mahdlo. Further reports to the Councils Overview and Scrutiny Board and Cabinet are also timetabled.

If the proposal is implemented there will be revised contractual arrangements with OCL and Mahdlo to manage performance and test and review the 12 month pilot management arrangements.

Conclusion

This is a complex proposal across a range of service areas within Integrated Youth Services and has the potential to impact on various groups who currently use and in the future may wish to access youth and sports provision. In examining risk and impact we have carried out extensive consultation with both young people, councillors, stakeholders and partners to ascertain the potential risk in each service area. Discussions with stakeholders will continue as we work through any implementation with partners and young people. There remains a risk that there will be a disproportionate impact in those areas where the voluntary and community sector offer is less developed. To mitigate this risk Mahdlo will continue to deliver and grow their District offer working with staff in Districts from the wider voluntary and community sector and from IYS to ensure that young people are supported through any transition periods Mahdlo are also providing mini buses to pick up and drop off young people who want to attend Mahdlo Town Centre Youth Zone . The Council is also subsidising travel costs with First Bus company so young people get a reduction in travel costs. The secondment of the 6 District Youth Development Officers to Mahdlo will also support the continuation of work with the local community and voluntary sector in each District to grow a sustainable youth offer, especially in those areas where the sector has limited provision at the moment.

We will continue to support the development of the staff mutual and in particular re-examine the emerging business case for the mutual with Public Health. We will also work with OCL to assess capacity to support local grass roots sports clubs and provide the connection to Governing Bodies to ensure sustainability within sport both at a corporate and local level

The transfer of the school swimming service to OCL does not initially pose any disproportionate impact as it’s a Borough wide transfer of the whole service from one organisation to another. Further work will need to be carried out with schools and OCL to agree a Service Level agreement .

Stage 5: Signature	
Lead Officer: Colette Kelly	**Date:** 08.12.14
Approver signature: Elaine McLean	**Date:** 08.12.14
EIA review date: December 2014	

APPENDIX 1: Action Plan and Risk Table

Action Plan

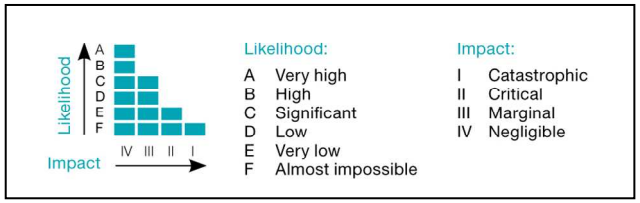
Once you have decided on the course of action to be taken in order to reduce or mitigate the impact, please complete the action plan below (An example is provided in order to help you)					
Number	Action	Required outcomes	By who?	By when?	Review date
Impact 1: Limited existing range of provision from of voluntary, community and school sector provision in some districts	• Mapping of district delivery is complete. Work needs to take place to highlight and fill any gaps in provision. • Secondment of staff: Youth Development staff to Mahdlo for 12 months to continue to build the capacity and support the sector to expand. • Work with the sector including parents and schools to see what groups across Oldham can expand and deliver in different areas. • Secure PH funding to get people more active • Support the business case of the mutual which has a Sports Development focus	• Wide provision of activities across all districts	• MAHDLO, OCL, Council	• Ongoing	• June 15
Impact 2: Increase in travel costs and distances	• Provision of a local session once a week in each District. (MAHDLO) • Provision of subsidised bus passes for young people to access Mahdlo.(Council) • Set up a minibus service to pick up and drop off from/ at Mahdlo is being put in place supported by District Executives. (Council) • Use new approach to Community use of Council Assets may also encourage local providers to put on more youth activity. (Council)	• Access for all young people regardless of location or cost of activity (inc. transport)	• MAHDLO, Council	• Ongoing	• June 15
Impact 3 Young People unwilling to travel due to	• Put on taster sessions and advice in each District on what can be provided locally • Relaunch of GO! Oldham site showing details of range of activities available in each District • Continue to work with local youth forums to assess access	• Access for all young people regardless of location or cost of activity	• MAHDLO, Council	• Ongoing	• June 15

perceived risk/territory issues	and young peoples' views of provision				

Risk table

Record any risks to the implementation of the project, policy or proposal and record any actions that you have put in place to reduce the likelihood of this happening.

Ref.	Risk	Impact	Actions in Place to mitigate the risk	Current Risk Score	Further Actions to be developed
1	Reduction in provision at a local level	Dissatisfaction with service user	See action plan above	CII	n/a
2	Range of activity may be unsuitable or limited to need	Dissatisfaction with service user	See action plan above	CII	n/a



Appendix 2- Summary of youth provision in districts

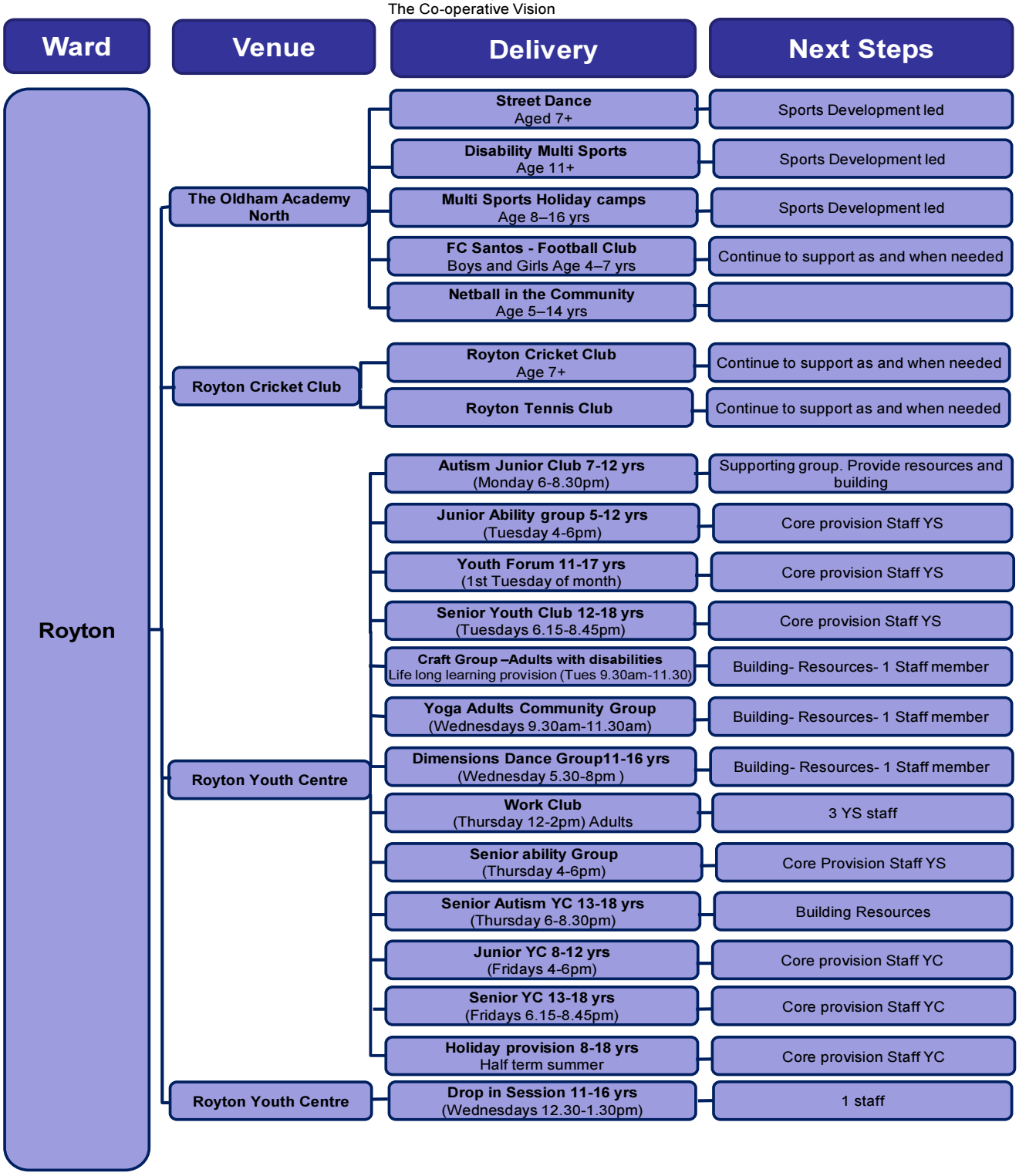
Youth & Sport – Shaw and Crompton (DRAFT)
The Co-operative Vision

Ward	Venue	Delivery	Next Steps
Shaw and Crompton	Crompton House	**Oldham Junior Badminton Club** Age 8 – 19 yrs	SDO supporting to become self-sustaining club
	Royton & Crompton School	**RSC Basketball Club** Age 9 +	SDO supporting to become self-sustaining club
		Friday night football league Age 14-19 yrs	Sports Development led
	Various	**Heyside Football Club** Boys and Girls Aged 5 +	Continue to support as and when needed
		Shaw Cricket Club Age 11-15 yrs	Continue to support as and when needed
	Heyside Cricket Club	**Heyside Cricket Club** Boys 8+ Girls 8-13 yrs	Continue to support as and when needed
	Shaw Youth Centre	**Snack and Chat Adults** (Mondays 1-3pm)	Core Provision YS Staff
		Senior Youth Club 13-19 yrs (Mondays 6.30-9pm)	Core Provision YS Staff
		Senior Youth Club 13-19 yrs (Tuesday6.30pm-9pm)	Core Provision YS Staff
		Inter Club 8-14 yrs (Wednesdays 3-5pm)	Core Provision YS Staff
		Chill Chat Snack 11-19 yrs (Thursdays 3-5.30pm)	Core provision staff YS Partnership with police funding
		Senior YC 13-19 yrs (Thursdays 6.30-9pm)	Core Provision YS Staff
		Holiday Provision 8 -18 yrs Half Term Summer	Core Provision YS Staff
	Crompton Library	**Library Support** 4-6pm(Mondays)	1 YS Staff
		Library Support 4-6pm (Tuesdays)	1 YS Staff
	Scout Explorer Unit – Hunger Hill, Kershaw St, Shaw	**Activities: Various from arts to camping** 14-26 yrs	Do not support these organisations
	Scouts Cubs & Beavers 1st Shaw Hunger Hill, Kershaw St	**Activities: Various from arts to camping** Beavers 6–8yrs Cubs 8–10.5yrs Scouts 10.5–14yrs	Do not support these organisations
	Scouts, Cubs & Beavers,3rd Shaw St Marys C.E. School, Rushcroft Rd, Shaw	**Activities: Various from arts to camping** Age: Beavers 6–8 yrs, Cubs 8–10.5 yrs, Scouts 10.5–14 yrs	Do not support these organisations
	Scouts, Cubs & Beavers,8th Shaw St Pauls Methodist Church, Rochdale Rd, Shaw	**Activities: Various from arts to camping** Age: Beavers 6–8 yrs, Cubs 8–10.5 yrs, Scouts 10.5–14 yrs	Do not support these organisations

Youth & Sport – Shaw and Crompton Continuation (DRAFT)
The Co-operative Vision

Ward	Venue	Delivery	Next Steps
Shaw and Crompton	East Crompton St James Shaw, Church Brigade	Y Team Girls 7–10 yrs (Tuesday 7.15 – 8.30) Y Team Lads 7-10 yrs (Friday 6.30 – 8.00) JTC Girls 10-13 yrs (Mon 7.15 – 8.30) JTC Lads (Fri 6.30 – 8.00pm)	Do not support these organisations
	St Pauls Methodist 63rd Shaw	**Activities: Various from arts to camping** Age:10–14 yrs Rainbow Unit – Tuesday Brownie Unit – Tuesday Guide Unit – Thursday	Do not support these organisations
	St Marys 14th Oldham Higher Crompton	**Activities: Various from arts to camping** Age:10-14 yrs Brownie Unit – Tuesday Guide Unit – Tuesday Rainbow Unit – Monday	Do not support these organisations
	Shore Edge,7th Oldham Shaw	**Activities: Various from arts to camping** Age:10-14 yrs Guides Thursday Brownie Monday Rainbow Tuesday	Do not support these organisations
	Shore Edge 72nd Oldham Shaw	Rainbow Unit –Wednesday Brownie Unit – Monday	Do not support these organisations
	Boys and Girls Brigade, Shaw Holy Trinity	**Activities: Outdoor skills** Age:11–17 yrs	Do not support these organisations
	St Josephs 44th Oldham Shaw	Brownie Unit – Thursday Guide Unit – Tuesday	Do not support these organisations
	St Annes 40th Oldham	Brownie Unit – Monday	Do not support these organisations
	St Aidans & Oswald 6th Oldham	Rainbow Unit – Thursday Brownie Unit – Tuesday Guide Unit – Monday	Do not support these organisations

Youth & Sport – Royton (DRAFT)
The Co-operative Vision

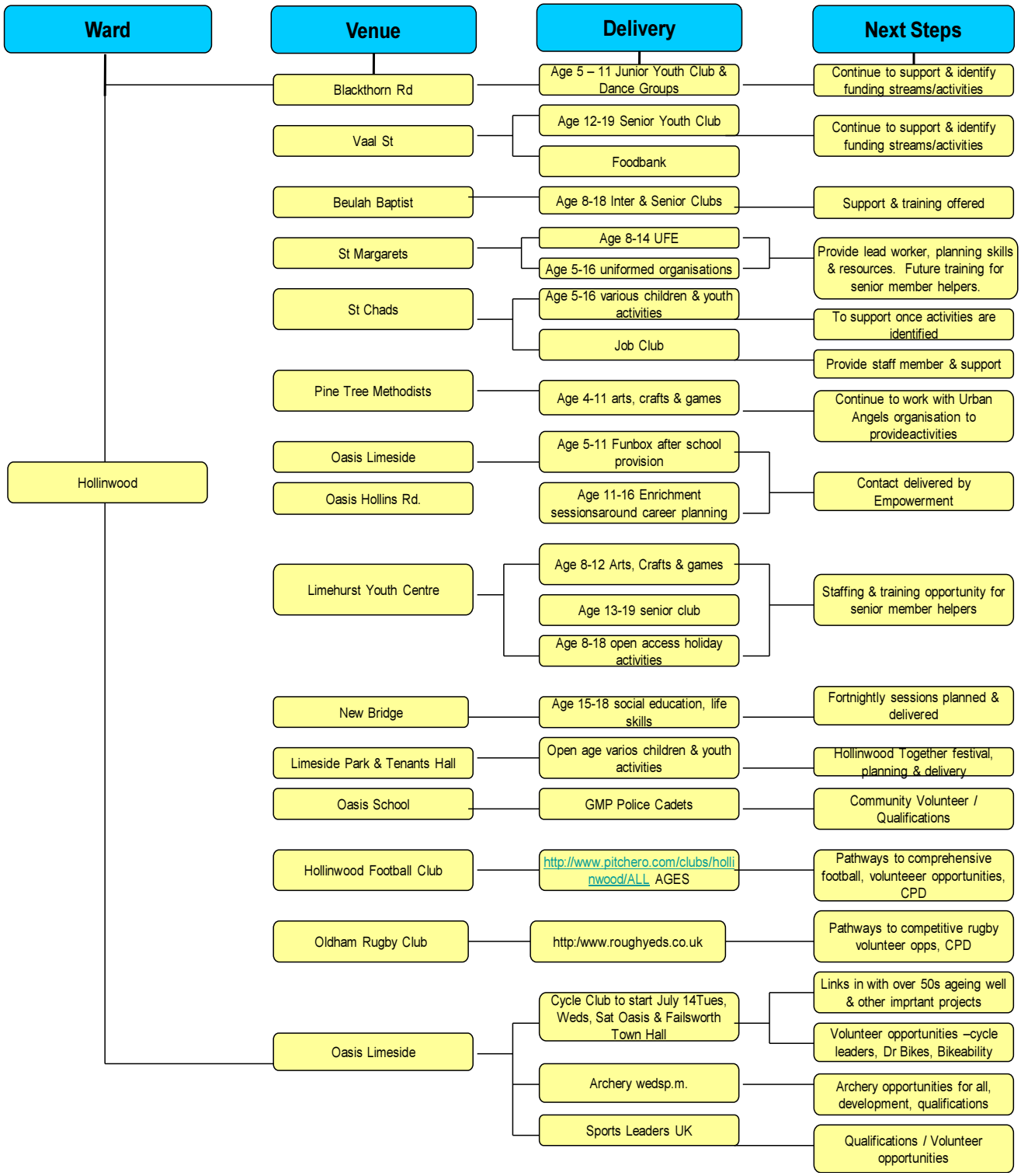


Youth & Sport – Royton Continuation (DRAFT)

The Co-operative Vision

Ward	Venue	Delivery	Next Steps
Royton	**Scouts, Cubs & Beavers - 1st Royton,Trinity Methodist, Radcliffe St, Royton**	**Activities: Various from arts to camping** Age:Beavers 6–8 yrs, Cubs 8–10.5 yrs, Scouts 10.5–14 yrs	Do not support these organisations
	Scouts, Cubs & Beavers - 2nd Royton Currently at Tandle Hill Park, Royton	**Activities: Various from arts to camping** Age:Beavers 6–8 yrs, Cubs 8–10.5 yrs, Scouts 10.5–14 yrs	Do not support these organisations
	Scouts, Cubs & Beavers - 3rd Royton Scout Hut, Old Edge Lane, Royton	**Activities: Various from arts to camping** Age:Beavers 6 –8 yrs, Cubs 8–10.5 yrs, Scouts 10.5–14 yrs	Do not support these organisations
	Scouts, Cubs & Beavers - 4th Royton,Thornham St James, Thornham Lane, Royton	**Activities: Various from arts to camping** Age:Beavers 6 –8 yrs, Cubs 8–10.5 yrs, Scouts 10.5–14 yrs	Do not support these organisations
	Scouts, Cubs & Beavers - 6th Royton,Scout hut by side of Downey House, Royton	**Activities: Various from arts to camping** Age:Beavers 6 –8 yrs, Cubs 8–10.5 yrs, Scouts 10.5–14 yrs	Do not support these organisations
	St Pauls Church, Royton, Brownies	**Activities: Arts, Crafts, dance & life skills** Age: 7-10 yrs	Do not support these organisations
	St Pauls Church 4th Oldham, Royton	**Activities: Arts Crafts dance & life skills** Age: 5-7 yrs Brownie Unit – Tuesday Rainbow Unit – Tuesday Guide Unit – Tuesday	Do not support these organisations
	St Pauls Church, 74th	**Activities: Arts, Crafts, dance & life skills** Age:10-14 yrs Brownie Unit – Tuesday	Do not support these organisations
	Beaver & Scouts, St Pauls Church, Royton	**Activities: Arts, Crafts, dance & life skills** Age:Beavers 6–8 yrs, Scouts 10.5-14 yrs	Do not support these organisations
	Air Cadets 1855 Royton Squadron, Park lane, Royton	**Activities: shooting training, flying , drill, music & adventure** Age:13–17 yrs	Do not support these organisations
	Scout Explorer Unit – Royton,Trinity Methodist, Radclyffe St, Royton	**Activities: Various from arts to camping** Age:14–26 yrs	Do not support these organisations
	Rainbows, Brownies and Beavers,Thornham St James, Royton	**Activities: Various from arts to camping** Age:5–7 yrs, 7–10 yrs	Do not support these organisations
	St Annes 46th Oldham - Royton	**Rainbow Unit** Brownie Unit – Tues Guide Unit – Mon	Do not support these organisations
	Trinity Methodist 11th Oldham, Royton	**Brownie Unit - Tuesday**	Do not support these organisations
	Trinity Methodist 24th Oldham, Royton	Rainbow Unit – Thursday Brownie Unit - Thursday Guide Unit – Thursday Royton District Senior section Unit Mondays	Do not support these organisations

Failsworth & Hollinwood Sport Offer 2014



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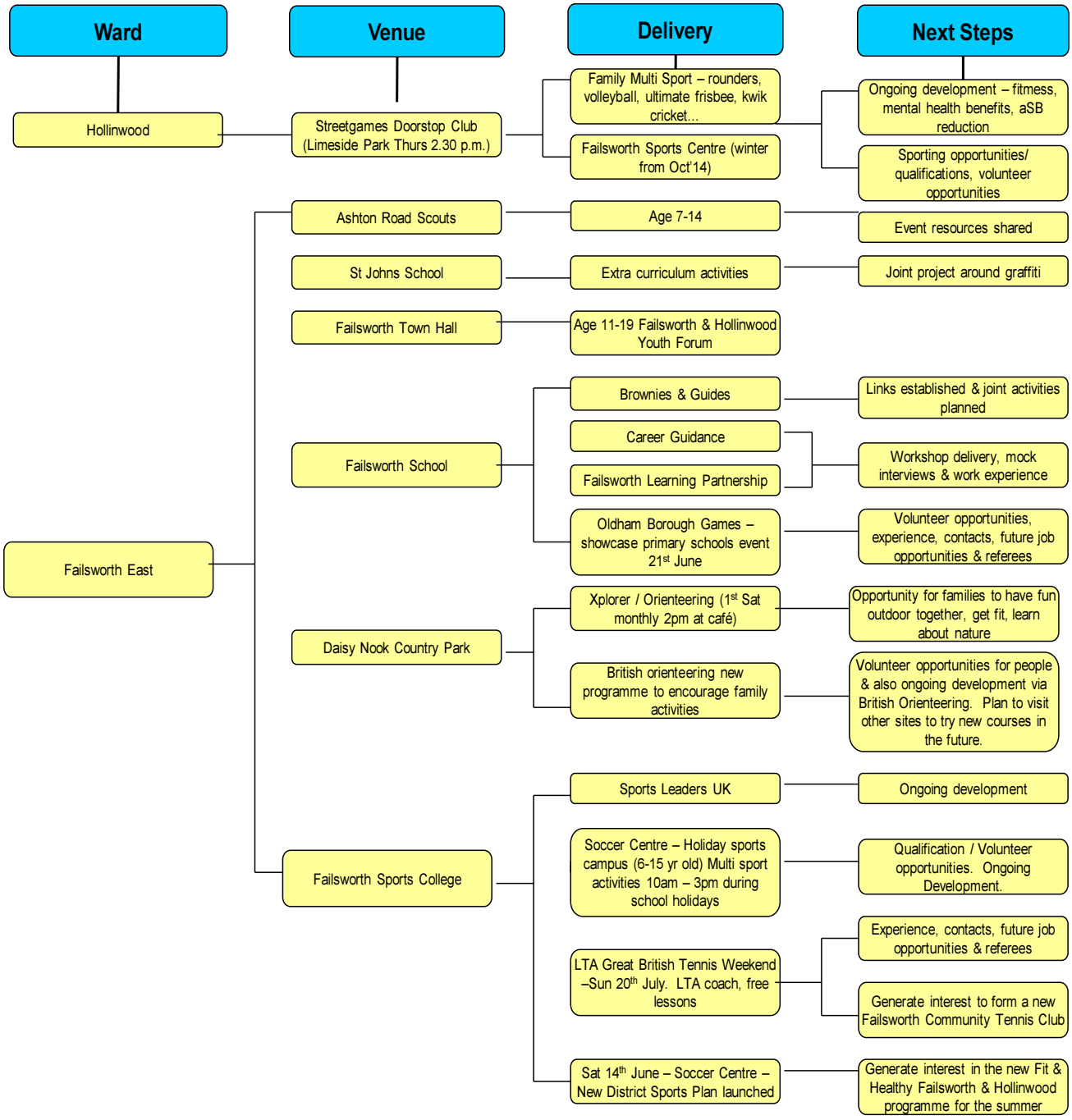

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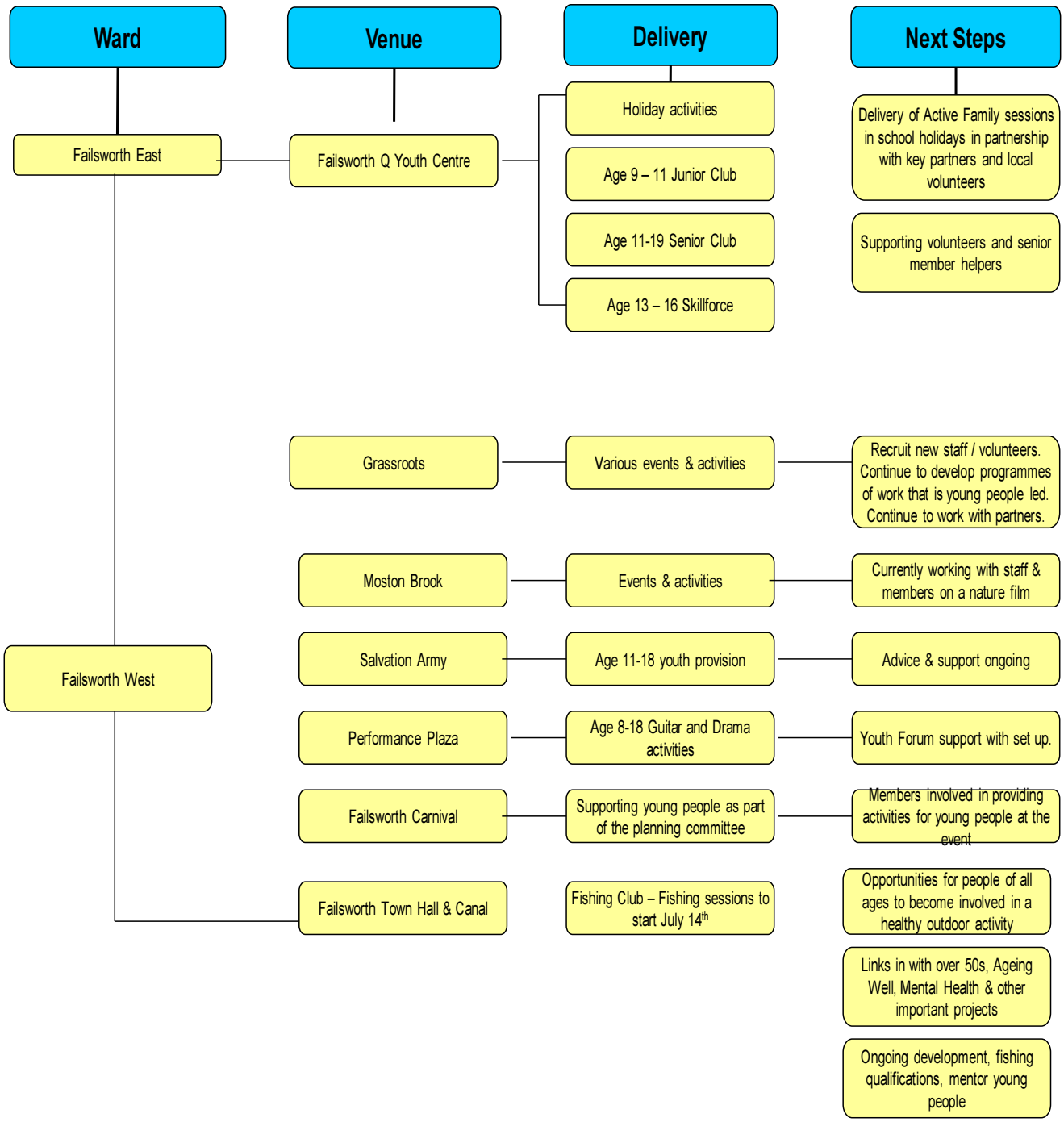
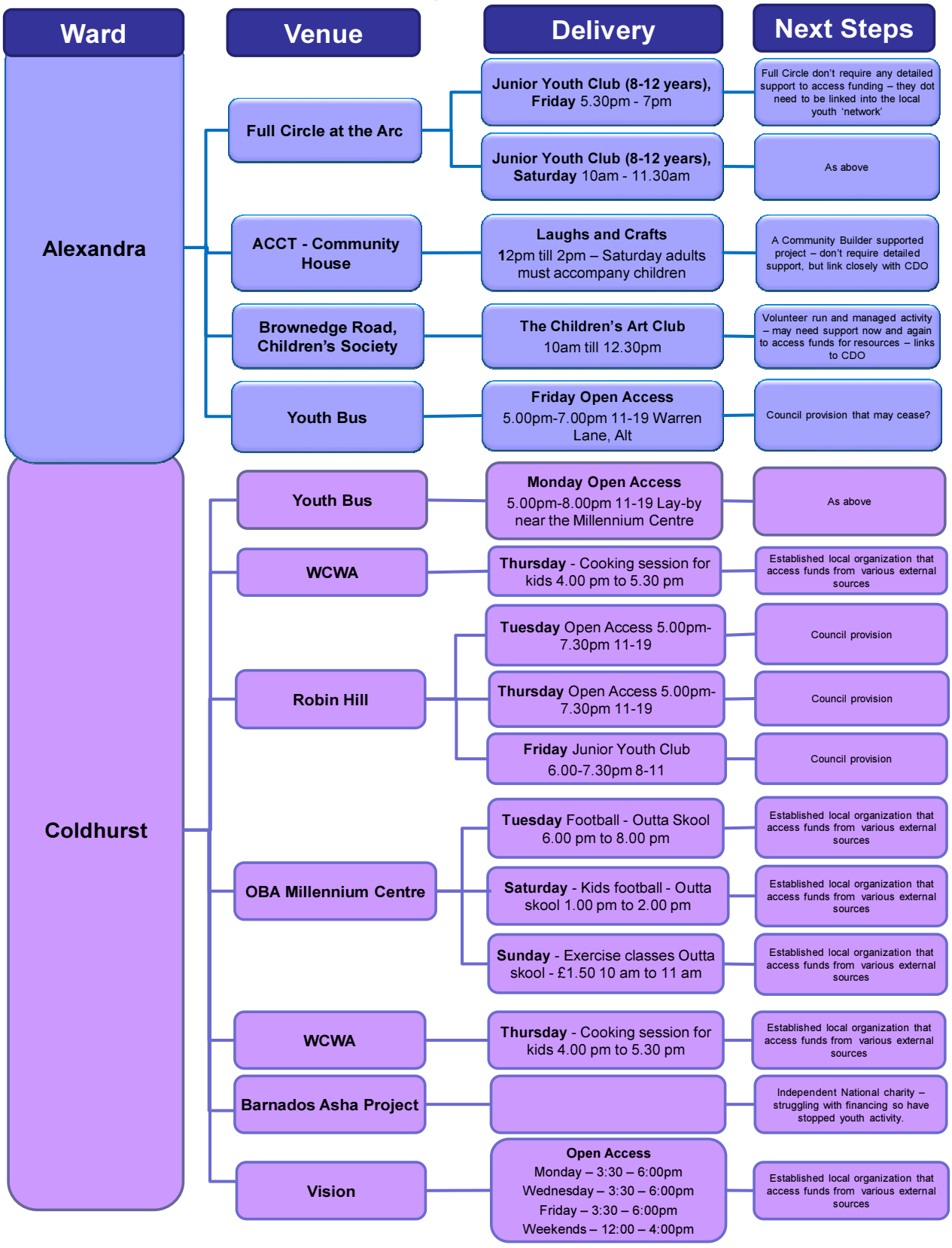
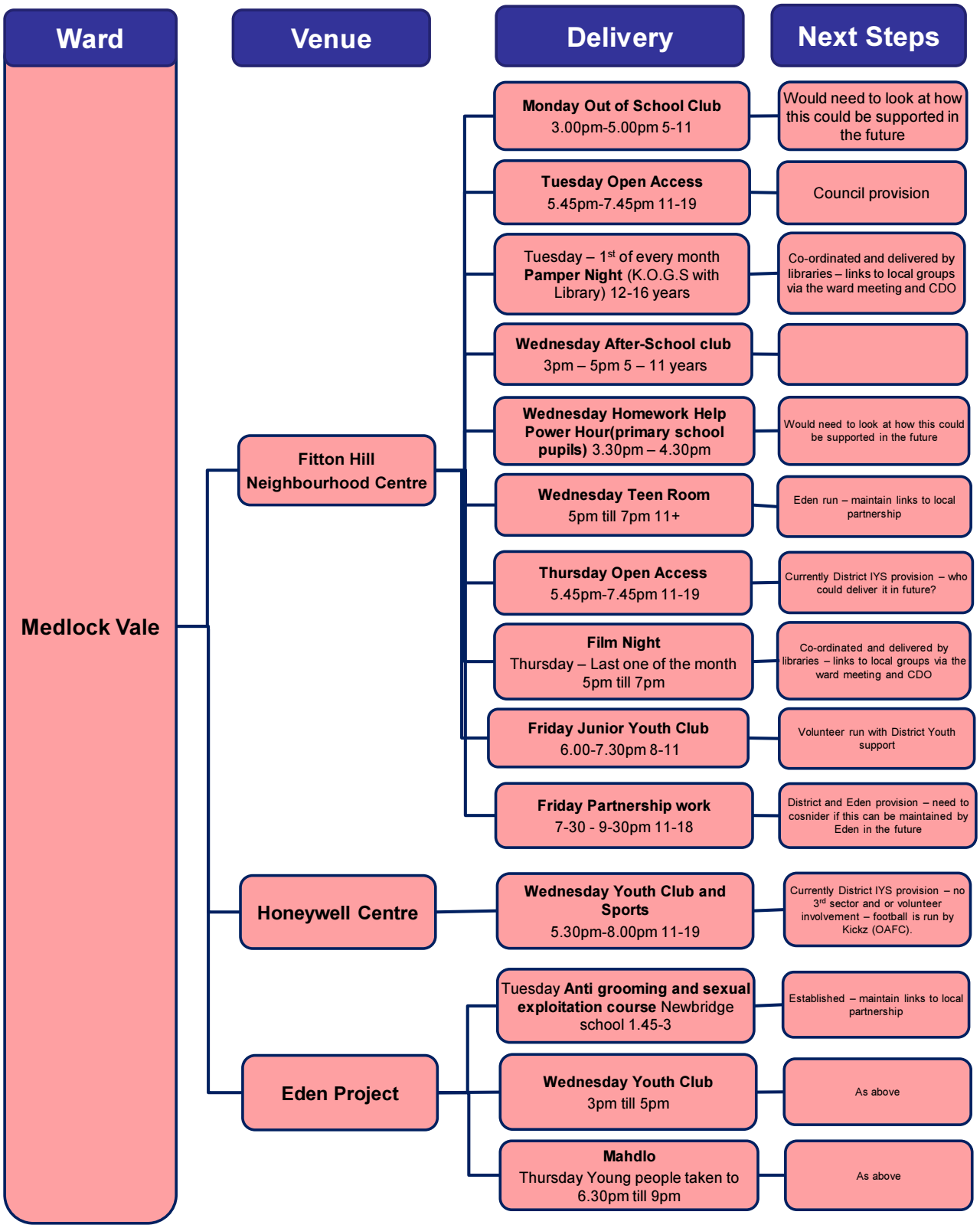


Youth & Sport Alexandra and Coldhurst (DRAFT)

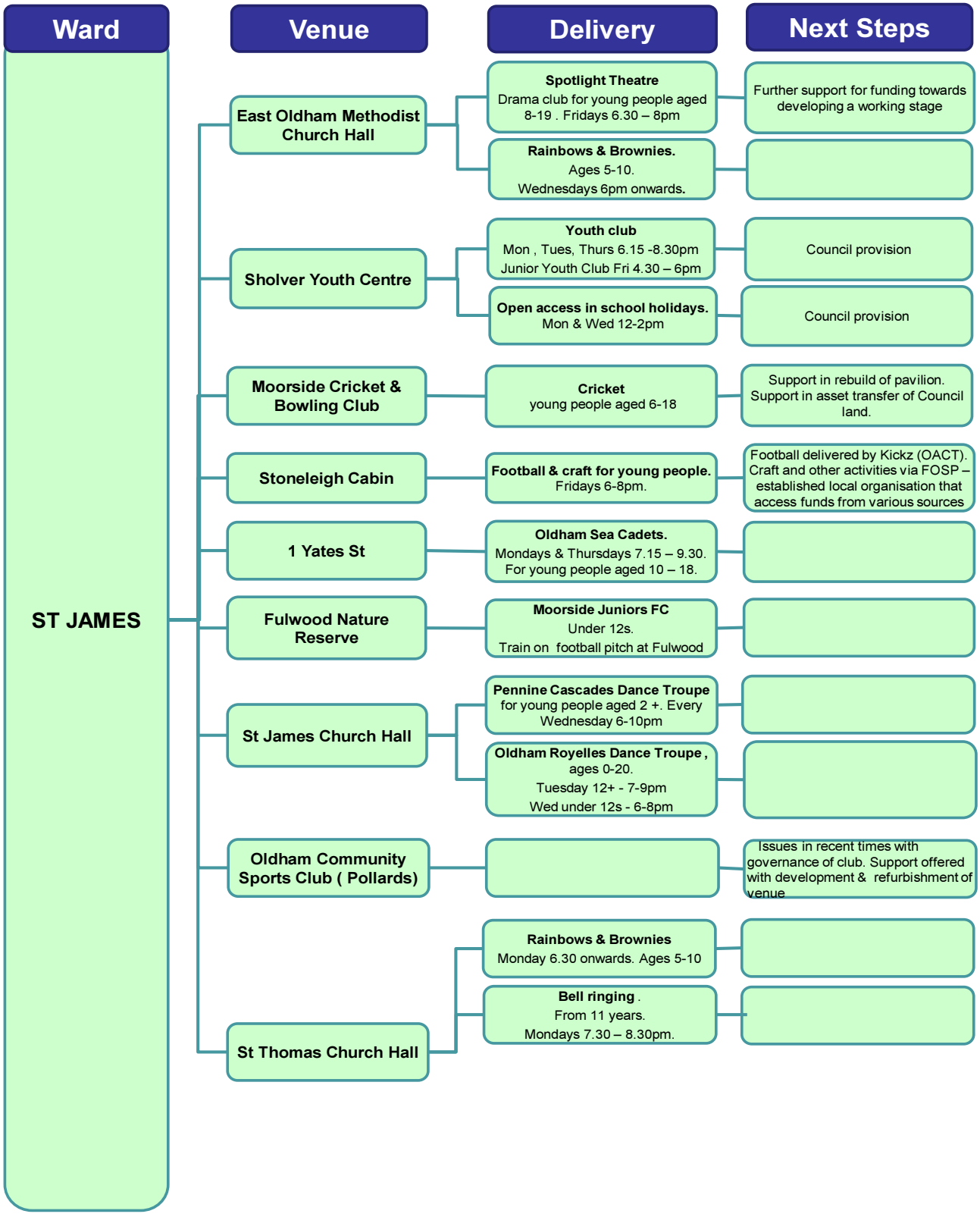
The Co-operative Vision



Youth & Sport – Medlock Vale (DRAFT)
The Co-operative Vision

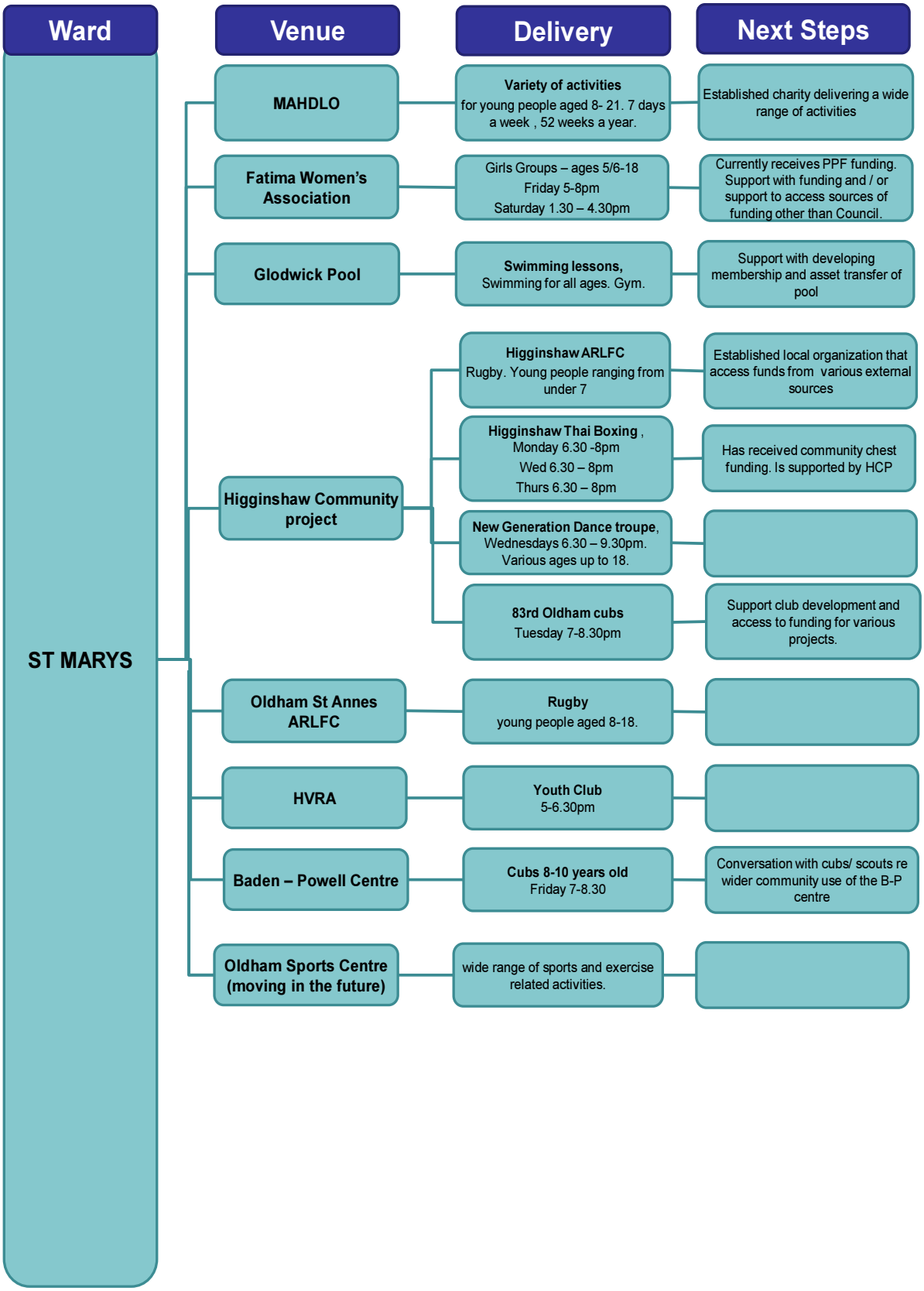


Youth & Sport – St James (DRAFT)
The Co-operative Vision



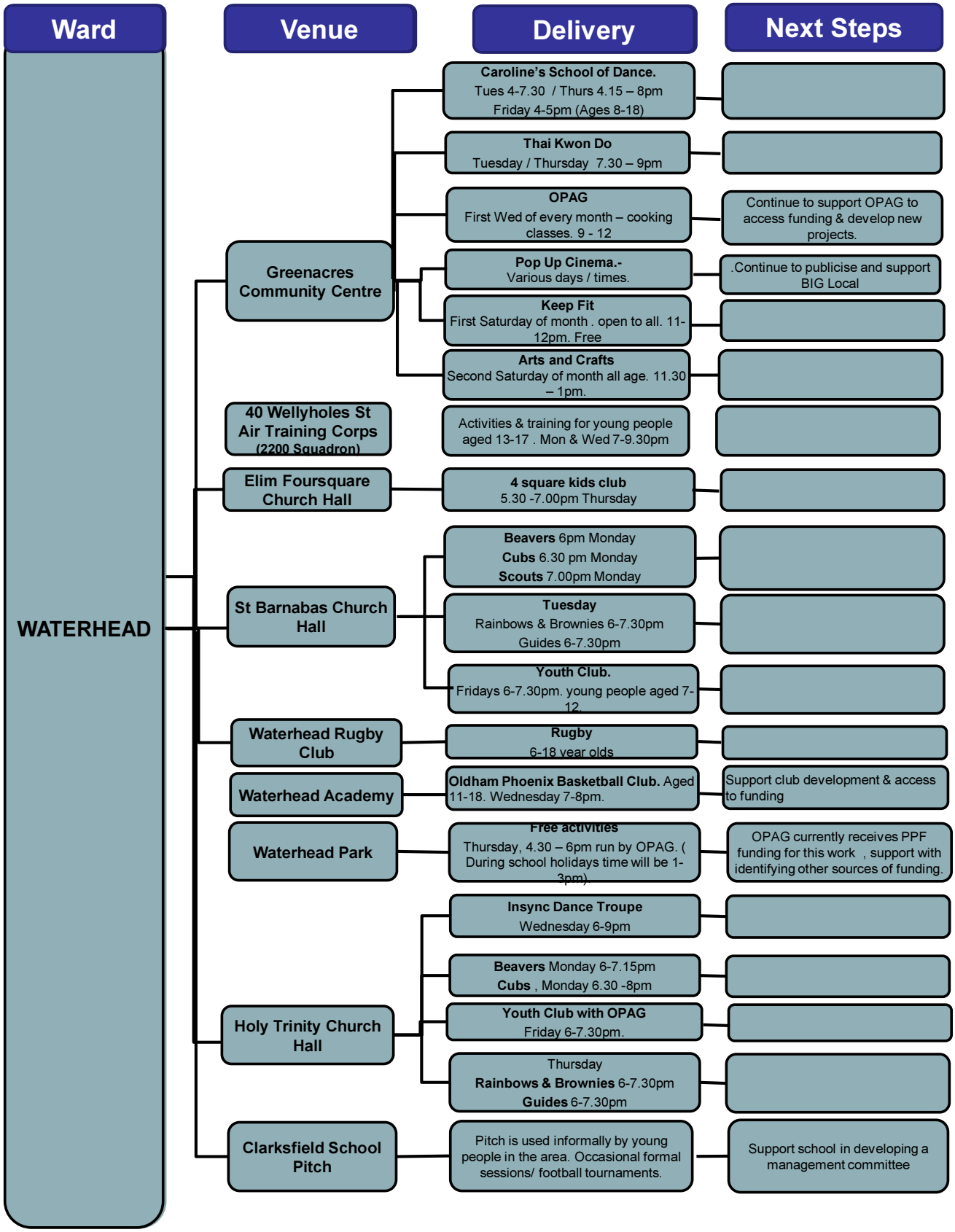
Youth & Sport St Marys(DRAFT)

The Co-operative Vision

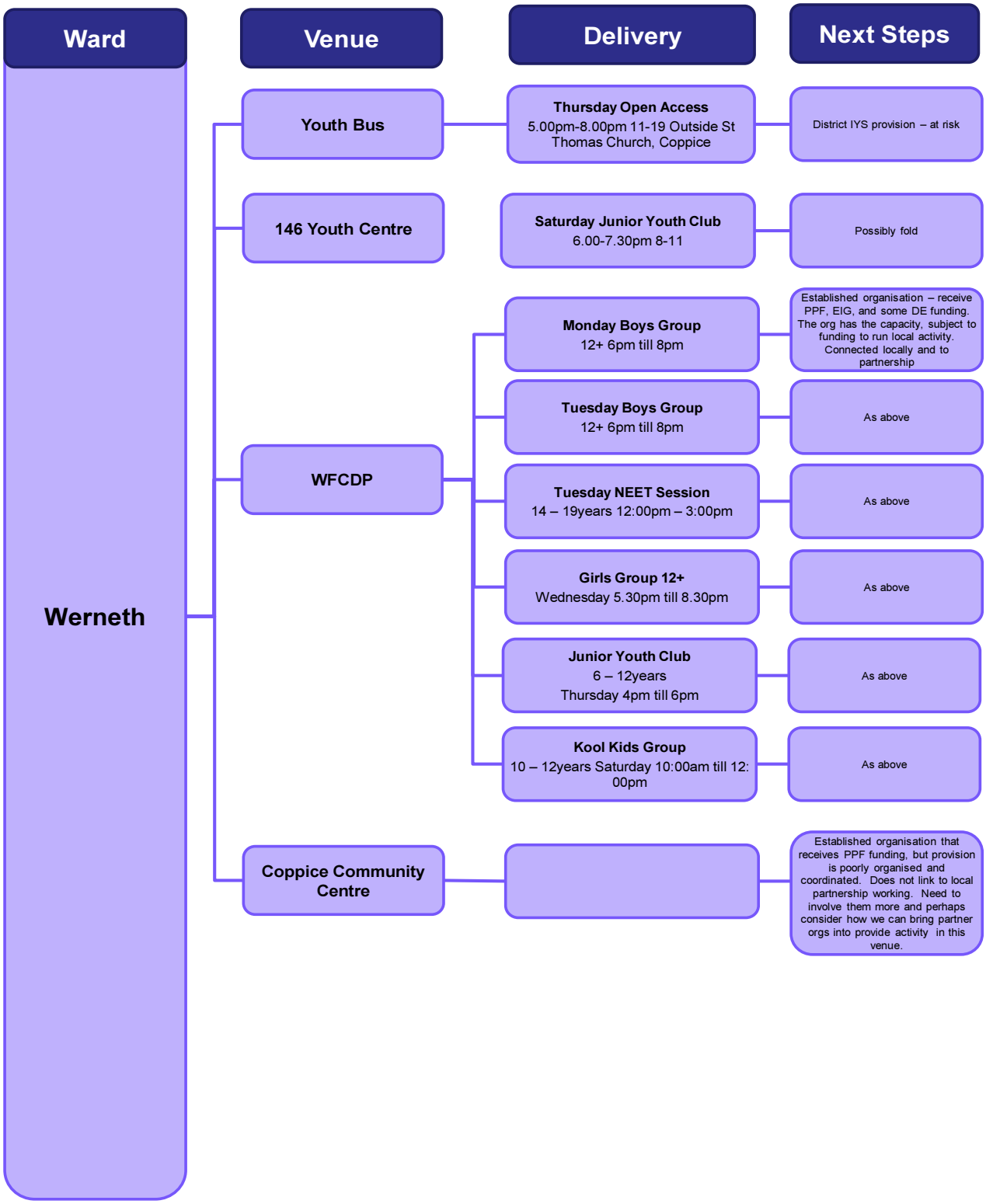


Youth & Sport Waterhead (DRAFT)

The Co-operative Vision

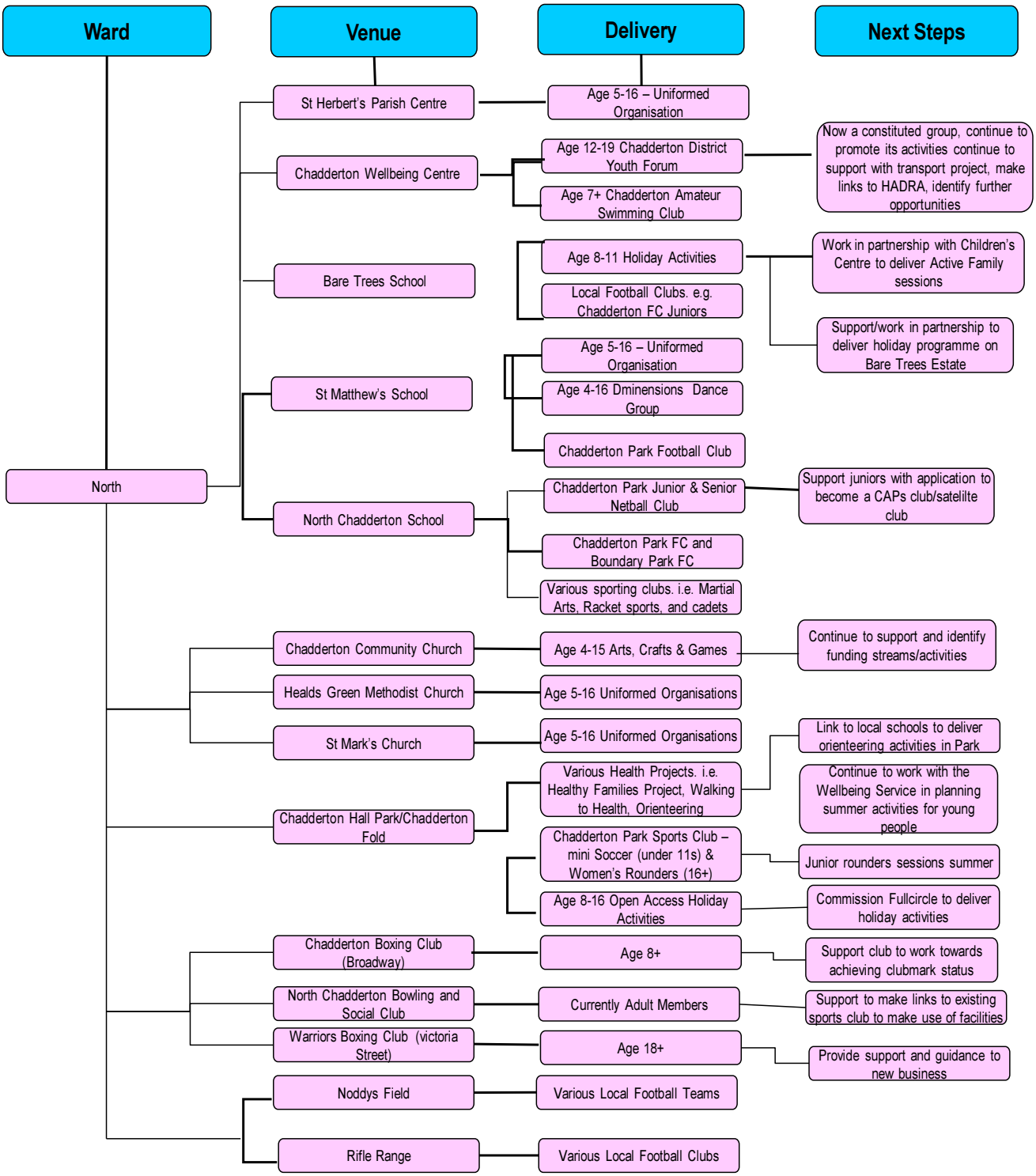


Youth & Sport Werneth (DRAFT)
The Co-operative Vision



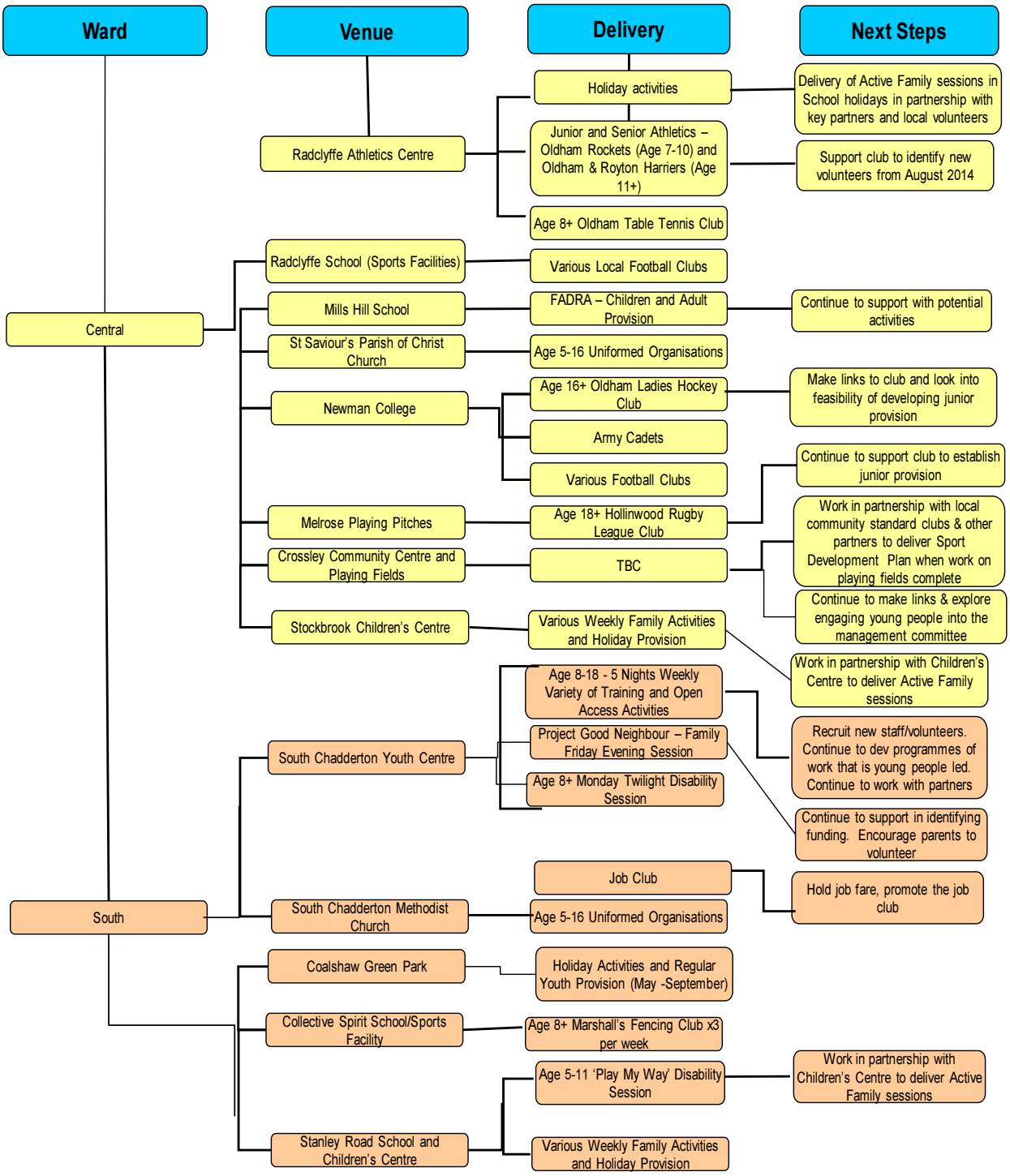
Youth & Sport North Ward

The Co-operative Vision

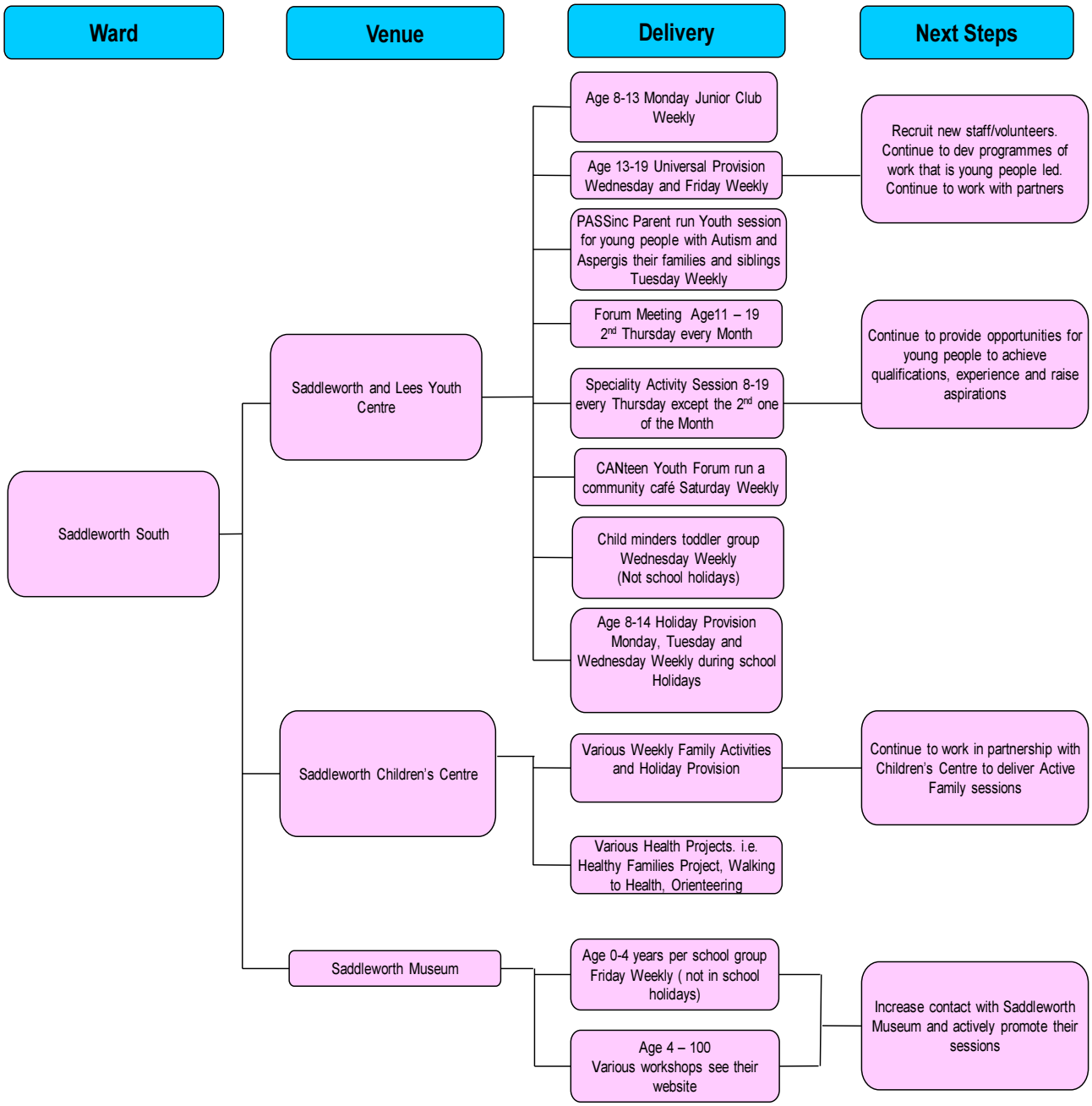


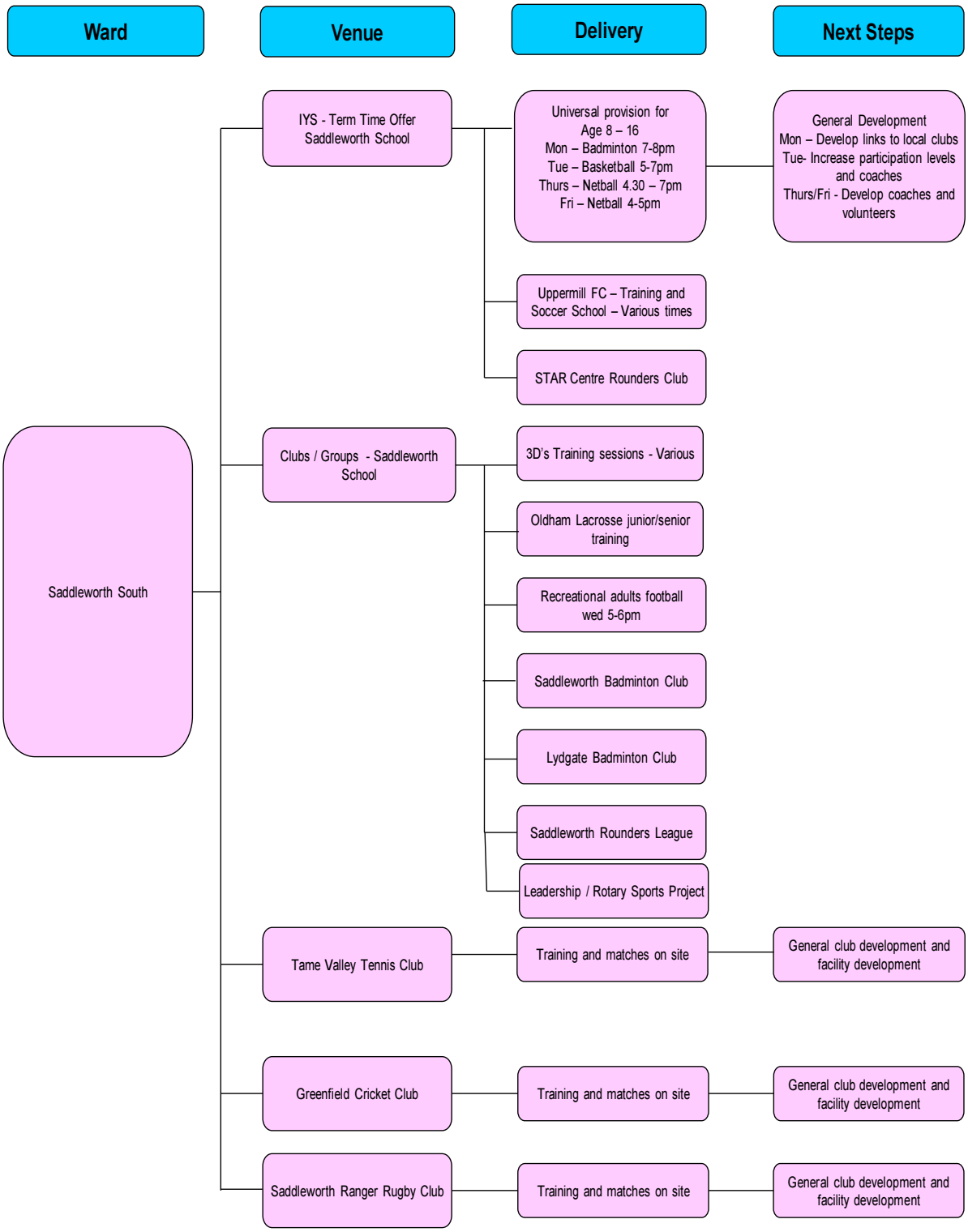
Youth & Sport – Central and South Wards

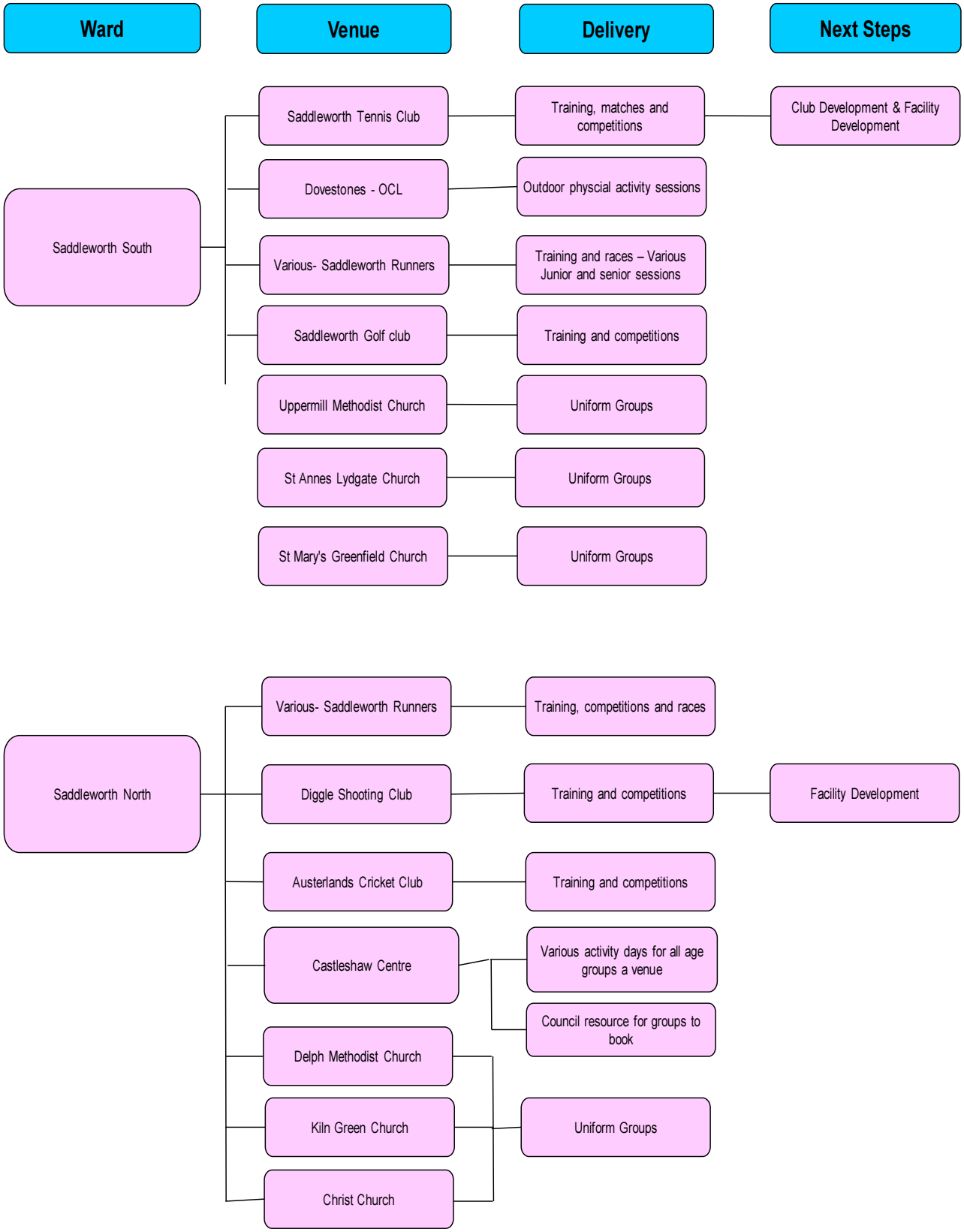
The Co-operative Vision

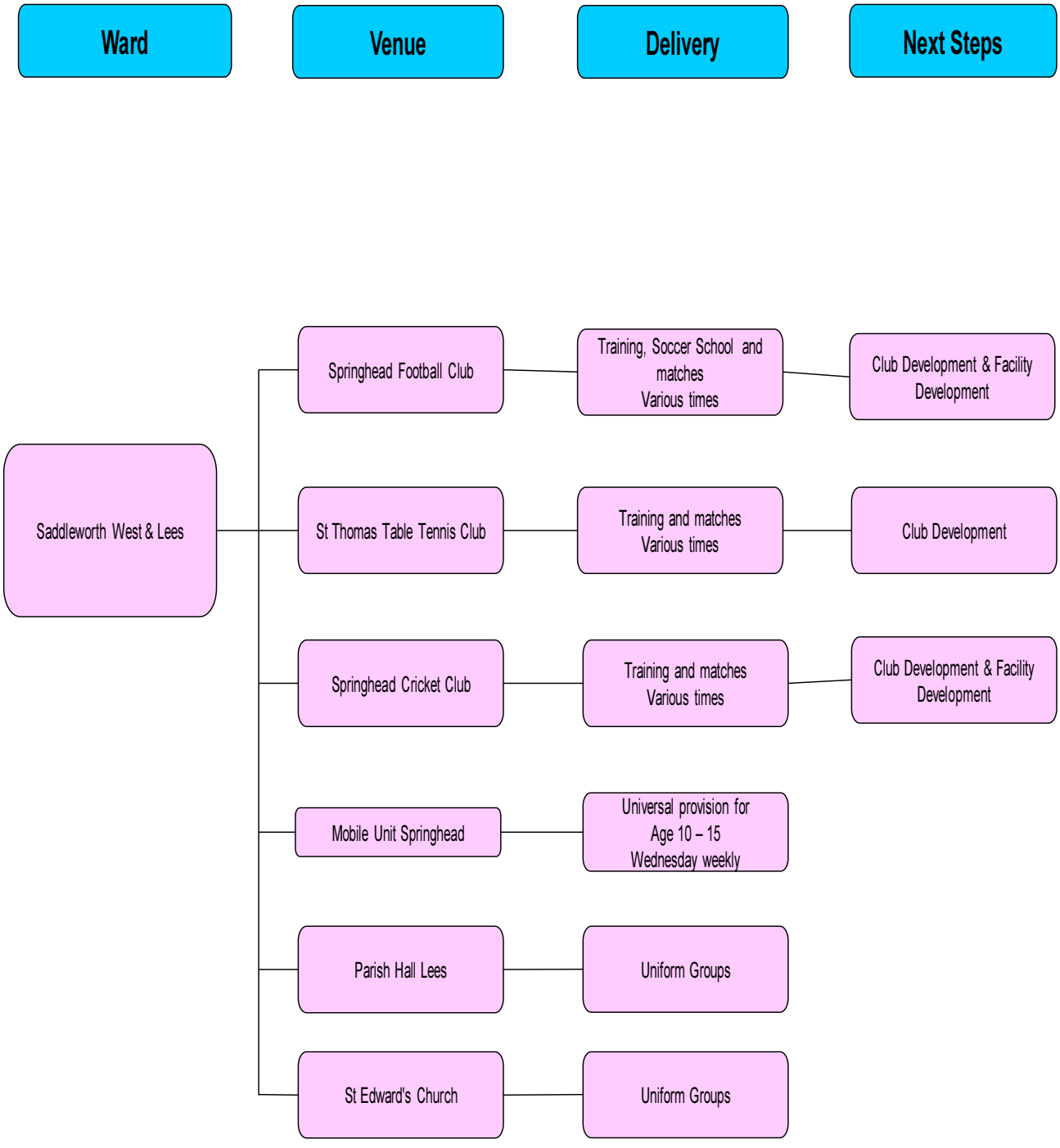


Youth & Sport Provision
Saddleworth and Lees
The Co-operative Vision




Ward
Venue
Delivery
Next Steps
Saddleworth South
IYS - Term Time Offer Saddleworth School
Universal provision for Age 8 – 16 Mon – Badminton 7-8pm Tue – Basketball 5-7pm Thurs – Netball 4.30 – 7pm Fri – Netball 4-5pm
General Development Mon – Develop links to local clubs Tue- Increase participation levels and coaches Thurs/Fri - Develop coaches and volunteers
Uppermill FC – Training and Soccer School – Various times
STAR Centre Rounders Club
Clubs / Groups - Saddleworth School
3D's Training sessions - Various
Oldham Lacrosse junior/senior training
Recreational adults football wed 5-6pm
Saddleworth Badminton Club
Lydgate Badminton Club
Saddleworth Rounders League
Leadership / Rotary Sports Project
Tame Valley Tennis Club
Training and matches on site
General club development and facility development
Greenfield Cricket Club
Training and matches on site
General club development and facility development
Saddleworth Ranger Rugby Club
Training and matches on site
General club development and facility development


Ward
Venue
Delivery
Next Steps
Saddleworth South
Saddleworth Tennis Club
Training, matches and competitions
Club Development & Facility Development
Dovestones - OCL
Outdoor physcial activity sessions
Various- Saddleworth Runners
Training and races – Various Junior and senior sessions
Saddleworth Golf club
Training and competitions
Uppermill Methodist Church
Uniform Groups
St Annes Lydgate Church
Uniform Groups
St Mary's Greenfield Church
Uniform Groups
Saddleworth North
Various- Saddleworth Runners
Training, competitions and races
Diggle Shooting Club
Training and competitions
Facility Development
Austerlands Cricket Club
Training and competitions
Castleshaw Centre
Various activity days for all age groups a venue
Council resource for groups to book
Delph Methodist Church
Kiln Green Church
Uniform Groups
Christ Church


Ward
Venue
Delivery
Next Steps
Saddleworth West & Lees
Springhead Football Club
Training, Soccer School and matches
Various times
Club Development & Facility Development
St Thomas Table Tennis Club
Training and matches
Various times
Club Development
Springhead Cricket Club
Training and matches
Various times
Club Development & Facility Development
Mobile Unit Springhead
Universal provision for
Age 10 – 15
Wednesday weekly
Parish Hall Lees
Uniform Groups
St Edward's Church
Uniform Groups

Appendix 3 Summary of Consultation

- Consultation on this option has been ongoing since June 2013 the key stake holders below have been engaged in developing the options.
- Ongoing dialogue will continue with young people and stakeholders following any implementation of the proposal. This will be carried out to ensure that the impact is assessed and mitigating measures are reviewed on an ongoing basis.

Young People and wider public	**When**	**How**
Youth Council	September 2013 – December 2014	Attended Youth Council sessions to talk through the proposals
Young People in District settings including Youth Forums	October 2014 – December 2014	Discussion with young people in District youth Centres and local settings
Petitioners Parents and Young People	26th November 2014 -	Meetings and correspondence with parents , users and petitioners
Local User Groups	14th October – 1st December 2014	Meetings with user groups in Districts in discussing the wider offer and local provision .
Overview and Scrutiny	2nd December 2014	Public Meeting and papers published - publically available
Cabinet Report	29th September 2014	Public Meeting and papers available published - publically available
Stake holder	**When**	**How**
Staff and TUs	September 2013- On Going	Meetings with staff groups and TUs
Police	September 2013 - October 2014	Meetings with partnership Chief Inspector .Community Safety and Cohesion partners
OCL		Meetings with OCL Chief Exec
MAHDLO	September 2013 - December	Meetings with Mahdlo Chief Exec , discussions at Mahdlo Board meetings
Positive Steps Oldham	October 2013 - 6th October 2014	Discussion with Chief Executive of PSO
Housing Providers	3rd October 2014	Meeting with FCHO and Regenda as key providers . discussion at OHIP
District Executives and local stakeholders including schools	September 2013 - December	Meetings with members and stakeholders from each District to consider the District Youth offer and wider provision within the Districts
Children's Safe Guarding Board	4th December 2014	Meeting of Children's Safeguarding board .Discussion on 0-19 delivery and savings options

Equality Impact Assessment Tool

B035: (0-19 offer for Children,Young People and Families) Proposal 2 – Targeted Youth & Family Support Service

Lead Officer:	Clare Bamforth
People involved in completing EIA:	Ed Francis Clare Bamforth
Is this the first time that this project, policy or proposal has had an EIA carried out on it? If no, please state date of original and append to this document for information.	Yes X No Date of original EIA:

General Information

1a	Which service does this project, policy, or proposal relate to?	This proposal relates to: • Budget template **B035: Redesigning Services for Children, Young people and their Families (0-19 Offer))** and specifically relates to **Project 2: Redesign of Oldham's Targeted Youth and Family Support Services.** • There are a range of services currently provided to support Oldham's vulnerable young people under the overarching banner of Targeted Youth Services. The services are currently being delivered by Positive Steps, Brook Advisory Service and The Children's Society; these contracts are due to end 31st March 2015. The total spend on targeted youth services in 2014/15 is £3,390,976. The current savings target against this project amounts to £450,000 for 2015/16. There is an additional savings target of £34,000 relating to Sexual Health services which links to budget template B039a. These proposed budget savings equate to 14% of current spend. The essence of this proposal is to: 1. Remove £450,000 from the career information, advice and guidance element of Theme 3 2. Remove £34,000 from the young people's sexual health element of Theme 1.

1b	What is the project, policy or proposal?	We are doing this as part of a project to review current service delivery specifications in line with changing priorities, ensure they are accurate and reflect required activities and meet the needs of vulnerable young people in the Borough. The services have been grouped into 3 themes focussing on the following service objectives: **THEME 1 - SEXUAL HEALTH AND SUBSTANCE MISUSE** Key service objectives: • A reduction in the number of Teenage Pregnancies • A reduction in Sexually Transmitted Infections • A reduction in hospital admissions due to substance misuse including alcohol **Service elements within this theme:** • Young people's Sexual Health Services • Teenage Pregnancy Partnership • Young people substance misuse (including alcohol) **THEME 2 – PREVENTION AND REDUCTION OF YOUTH OFFENDING** Key service objectives: • To reduce the number of first time entrants to the criminal justice system • Reduce re-offending by Young People • Young offenders engagement in positive activities and education, employment or training **Service elements within this theme:** • Youth Justice Services – prevention and restorative justice **THEME 3 – SUPPORT FOR VULNERABLE YOUNG PEOPLE** Key service objectives: • Ensure vulnerable young people have access to appropriate information, advice and guidance to succeed in education, work and life • Support for young people who go missing from home • Reduction in young people's risk taking behaviour. **Service elements within this theme:** • Careers Information, Advice and Guidance • Support for Young Carers • Independent interview process for children and

		young people who go missing from home By grouping the services in this way, we hope to provide opportunity for ensuring cohesive support to young people, a joined up approach for service delivery and maximum support for vulnerable young people across the areas, whilst also allowing us to consider streamlining service costs and functions to achieve the funding efficiencies required.
1c	What are the main aims of the project, policy or proposal?	• To redesign the targeted youth (11+) offer and re-commission the required services under the 3 themes to maximise quality of provision, improved outcomes and performance. • To reduce Council spend whilst still maintaining the outcome led vision for all Oldham's children and young people which will see them 'Ready to Learn, Ready for Life and Ready for Work and Parenthood'.
1d	Who, potentially, could this project, policy or proposal have a detrimental effect on, or benefit, and how?	This proposal will affect current providers of targeted youth provision whose existing contracts will end regardless on 31st March 2015. They will, however, have opportunity to submit proposals for the new delivery model required, or to work with the preferred provider in a similar way. **The impact on service users should be minimal.** Services are not ending; they are being aligned to ensure the maximum and most effective support is provided to Oldham's most vulnerable young people. Specific services will still be offered and delivered but the future delivery model may be different to what is currently in place for example a closer integration between sexual health and substance misuse services. The majority of the budget saving required will be taken from Theme 3 – Support for vulnerable young people – in particular from the IAG (Information, Advice and Guidance) service. This represents a 43% reduction against current funded activity in IAG provision. However, Oldham has historically funded this area of support at a higher level than some other neighbouring authorities and in the last few years schools have the responsibility for providing universal IAG (information advice and guidance). By tendering the service

		alongside other services for vulnerable young people we anticipate that the impact of the funding reduction will be mitigated. Initiatives such as Get Oldham Working mean that the offer to young people is not entirely dependent on this particular service. All Council's are measured on young people who are Not in Education, Employment or Training (NEET). Oldham's performance is consistently high when compared to statistical neighbours. The second area of budget efficiency attached to this relates to young people's sexual health services, which are currently delivered by Brook. This has a savings target of £34,000 against the current contract price £334,000 and which relates to the Public Health proposal detailed in section 1b. These services have been combined into Theme 1 – Young People's Integrated Sexual Health and Substance Misuse Services. Again, by combining this area of support with other health related services it aims to offer an integrated approach to supporting young people to lead healthy and positive lifestyles.

1e. Does the project, policy or proposal have the potential to <u>disproportionately</u> impact on any of the following groups? If so, is the impact positive or negative?

	None	**Positive**	**Negative**	**Not sure**
Disabled people	☐	☐	☒	☐
Particular ethnic groups	☒	☐	☐	☐
Men or women (include impacts due to pregnancy / maternity)	☒	☐	☐	☐
People of particular sexual orientation/s	☒	☐	☐	☐
People who are proposing to undergo, are undergoing or have undergone a process or part of a process of gender reassignment	☒	☐	☐	☐
People on low incomes	☐	☐	☐	☒
People in particular age groups	☐	☐	☒	☐
Groups with particular faiths and beliefs	☒	☐	☐	☐
Are there any other groups that you think may be affected negatively or positively by this project, policy or proposal?				
E.g. vulnerable residents, individuals at risk of loneliness or carers.		☐	☐	

If the answer is "negative" or "not sure" consider doing a full EIA

1f. What do you think that the overall NEGATIVE impact on groups and communities will be? Please note that an example of none / minimal impact would be where there is no negative impact identified, or there will be no change to the service for any groups. Wherever a negative impact has been identified you should consider completing the rest of the form.	**None / Minimal**	**Significant**
	☐	☒
		The services currently being delivered will be re-designed to improve their function, and then re-commissioned and there will still be an offer of support and provision available for current or future service users. The impact of reduced investment in some elements of the model are unknown at this stage and will be partly mitigated by the planned integrated service. This will be kept under review, as detailed below in box 3b.

1g	Using the screening and information in questions 1e and 1f, should a full assessment be carried out on the project, policy or proposal?	Yes ☒ No ☐
1h	How have you come to this decision?	We have ensured that existing services are still represented within the new delivery model, and have still been able to meet the financial efficiency against this budget. We have maintained significant investment in each of the areas of integrated support to minimise impact on service delivery, maintained provision to ensure improved outcomes for young people and to continue achieving high levels of performance. Existing service users will still be able to access and receive appropriate support, albeit through a potentially different model of delivery and provider. The focus remains to ensure that young people are 'Ready to Learn, Ready for Life and Ready for Work and

		Parenthood'. By combining service areas into the 3 themes, we aim to commission a more streamlined range of services which will ultimately offer wider support to young people. Although we are confident that the risk has been mitigated by the commissioning process we have undertaken, the potential risk that young people will not get an adequate service means it is appropriate for a full EIA. The contract award decision will be presented at Cabinet on December 15th. The findings of a full EIA will be considered as part of this process.

Stage 2: What do you know?

An EIA should be based upon robust evidence. This stage will guide you through potential sources of information and how to interpret it. Understanding the current context is a key stage in all policy making and planning.

What do you know already?

The following provides further information about the elements of the Integrated Support Services for Young People, in particular to those services within theme 3, where the majority of the funding reduction is directed, as detailed below**:**

THEME 3 – SUPPORT SERVICE FOR VULNERABLE YOUNG PEOPLE – NEET (not in education, employment or training) Prevention; Support for Young Carers, Independent interview process for children and young people who go missing from home.

NEET PREVENTION

Local Authorities have a statutory duty to encourage, enable and assist vulnerable young people to participate in education and training, with a particular focus on young people who are not in education, employment or training (NEET).

The Education and Skills Act 2008 legislated to raise the age of compulsory participation in education or training until at least 18 by 2015 and until the end of the year in which young people turn 17 in 2013 – this is known as Raising the Participation Age (RPA). Local authorities are responsible for ensuring that young people in their area participate and that there is support for young people to overcome barriers to engagement.

Oldham's current career, information advice and guidance service is commissioned to an external provider – Positive Steps - who deliver a range of services for vulnerable young people. This contract has been in place since 2009 – it was initially a 3 year contract with an option to extend for a further 2 years which was exercised in April 2013. The current contract is to end 31st March 2015.

Oldham's NEET performance over the lifetime of the contract has been consistently higher than

comparative local authorities, in line with local and national trends. We know that the local NEET population has decreased and that our targeted young people are positively engaged and progressing as detailed below:

NEET as % of 16-19 cohort (Year 12-14) – data as at July 2014	
Target as % of cohort	5.7%
Actual as % of cohort	**5.4%**
Actual Numbers	475
Cohort Size	9,000
Performance as % 12 months ago	5.9%
Numbers 12 months ago	499

Statistical Comparisons

Statistical neighbour Average	6.9%
England Average	5.9%

The data reported above demonstrates that Oldham is able to evidence a sustained decrease in the NEET rate over the last 12 months which is better than the statistical and England average.

What don't you know?

Until the new provider is in place and is delivering the new model, there are certain things that we won't know or be able to measure at this stage. Therefore:

1. We don't know what the impact will be of reducing the financial allocation within Lot 3.
2. We don't know if there will be any impact on the vulnerable groups identified below, and what this might be, if any.
3. We need to find out what our statistical neighbours have done with regard to their commissions of this service area.

Further data collection

We will include further data collection about one of our statistical neighbours in order to inform point 3 above.

Summary (to be completed following analysis of the evidence above)

Does the project, policy or proposal have the potential to have a disproportionate impact on any of the following groups? If so, is the impact positive or negative?	**None**	**Positive**	**Negative**	**Not sure**
Disabled people	☐	☐	☒	☐
Particular ethnic groups	☒	☐	☐	☐

Men or women (include impacts due to pregnancy / maternity)	☒	☐	☐	☐
People of particular sexual orientation/s	☒	☐	☐	☐
People who are proposing to undergo, are undergoing or have undergone a process or part of a process of gender reassignment	☒	☐	☐	☐
People on low incomes	☐	☐	☐	☒
People in particular age groups	☐	☐	☒	☐
Groups with particular faiths and beliefs	☒	☐	☐	☐
Are there any other groups that you think that this proposal may affect negatively or positively?				
E.g. vulnerable residents, individuals at risk of loneliness or carers.		☐	☐	

Stage 3: What do we think the potential impact might be?

Consultation information	
3a. Who have you consulted with?	In planning for the Procurement of the service model from 1st April 2015, we have consulted with members of the following forums representing the young people of Oldham: **Oldham Youth Council** – the democratically elected representative body for young people in Oldham. **Children in Care Council** – a group of young people currently within the care system. They are brought together to share their experience of the care system, to have their views heard and responded to, in order to make individual and larger improvements to a specific aspect of the service. **Barrier Breakers** – this group is made up of, and provides a voice for, young people with additional and/or complex needs. They are consulted with about changes to legislation in order to advise and influence decision makers around areas affecting young people with additional needs. Young people told us that the range of services was appropriate but raised issues in relation to the link to mental health support which is not being reduced as a part of the budget savings but is being re considered as part of the work around the 'all age early help offer'.

	A separate EIA is being completed in relation to the All Age Early Help Offer (AAEHO) which aims to improve household' physical, social and emotional well-being, so that they do not need ongoing support from crisis and specialist services. Young people were in the main complimentary about current arrangements and were concerned if the range of services included in the offer were to reduce. Discussions have taken place with current providers of the services under consideration. A particular note of concern for one provider was whether including the Independent Interview Process for Children and Young People who go Missing from Home service in Theme 3 would lead to a dilution of what they saw as a specialist service area. We have ensured in the service specification that delivery of what is now a statutory function will not be compromised and should be enhanced.
3b. How did you consult? (inc meeting dates, activity undertaken & groups consulted)	We met with members of the young people groups listed above on 6th, 11th and 12th August as part of a combined consultation. Representation from each group was received as detailed below: • Youth Council – 22 young people • Barrier Breakers – 7 young people • Children in Care Council – 6 young people We presented information to each of the groups detailing the services currently delivered under the over-arching Targeted Youth Services, including how much money the Council currently spends on these services. We outlined the changes to services under the new model and had detailed and interesting discussion with the young people around their experience of these services and whether they thought there were any services which we were not including and which they felt we should be doing. We received very positive and encouraging feedback about services currently commissioned. Some of the services currently commissioned as Targeted Youth are being developed in line with the All Age Early Help Offer. As part of wider consultation around this, we met again with members of all 3 representative groups on 27th August. We asked young people present to respond to key questions, following a presentation about the new model and services included in it. This prompted a lively and interesting sessions with the young people and created some useful and informative feedback

3c. What do you know?

1. **Impact**
2. **Mitigations**

1. IMPACT

1.1 DISABLED YOUNG PEOPLE – Young people with a disability are a vulnerable group when considering young people who are NEET. We would want to ensure that their needs continue to be met.

YOUNG PEOPLE WITH LEARNING AND OTHER DISABILITIES 16-19 IN EET			
Period	**%**	**Actual Number**	**Cohort**
September 2013	91.4	227	248
September 2014	87.4	235	269

Young People with LLDD (learners with learning difficulties or disabilities) could be affected as a result of reduced funding as there may be less support and resources available for them. However, we have mitigated this by ensuring that the new model of service delivery will provide a wider, holistic approach to supporting this cohort of vulnerable young people. We have time and the opportunity to work with the commissioned provider prior to the commencement of the new contract to make sure that this cohort remains a priority for their service delivery and planning.

Oldham is in a fortunate position of having a single provider of Universal CIAG and this provides a strengthened network of support and contact for other young people in mainstream school who may have additional requirements. It also contributes to the successful tracking of young people which is a statutory duty of the local authority.

We are not ceasing delivery of any services for young people in fact, by integrating services we hope to strengthen the offer and provision.

As part of the contract monitoring process, we will ensure promotion of national engagement programmes to evidence impartiality and maximise the opportunities for Oldham's young people to access alternative provision and maintain current performance. We will also strengthen our contractual monitoring process with the provider and will have clear expectations of what is required in terms of service delivery. We will involve service professionals in the monitoring of the contract to ensure we have their input into the process. We will ensure the provider promotes positive participation and promote CIAG to all young people including vulnerable groups.

From current performance monitoring (November 2014) we know that of the 111 cohort of young people with learning difficulties and disabilities who left mainstream education this year:

- 7 were NEET and actively seeking opportunities
- 43 went on to further education college
- 48 stayed at School 6th form college

- 4 went to Oldham Sixth Form College
- 9 went onto non employed training opportunities

1.2 PEOPLE IN PARTICULAR AGE GROUPS – because we are reducing the funding within the IAG theme, there could be an impact on young people aged 16-19 years old.

We know that there may be an impact on young people within this group who are seeking career information, advice and guidance (CIAG) as the funding within this area has been reduced.

Following the tender process, and if approved by Cabinet, the preferred provider for the new delivery model will be the current commissioned provider for targeted CIAG. They have held the contract for 5 years in total and are therefore experienced and proven in delivering CIAG to the young people in Oldham. In addition, during financial challenges over recent years, they have continued to do so with a reducing budget and have managed to maintain and improve performance in key areas, including the NEET rate.

2. MITIGATIONS

2.1 YOUNG PEOPLE'S SEXUAL HEALTH

It is anticipated that a £34,000 reduction in funding can be met by efficiencies released by delivering an integrated model, which will review back office and premise costs as opposed to impacting o front line delivery.

Figures provided by the Office for National Statistics (ONS) published on 25 February 2014 have confirmed that Oldham has achieved a very significant reduction in teenage pregnancy rates for under-18 year olds. The conception rate (per 1,000 women in the age range 15-17) has decreased from 66.1 in 1998 to 33.1 at the end of 2012, a reduction of 49.9%. This means that Oldham has seen the largest reduction in teenage conceptions amongst similar local authorities and is also larger than the reduction, nationally, which is 40% over this period. ONS statistics are 12 months behind for reporting purposes.

The Education Funding Agency (EFA) produces information on the number of teenage parents who access learning via the Care to Learn grant scheme. The percentage is based on ONS estimates of the number of teenage parents under the age of 20 years who have accessed C2L. Oldham has been consistently well ahead of both statistical neighbours and England averages for take up during the reporting period. Most recent data received shows Oldham has the second highest take up rate in the country for January 2014 at 27.3%.

Teenage Parents Academic Age 16-18 in EET as % - Statistical Neighbour Comparison December 2013	
Oldham	**40%**
Statistical Neighbour Average	35.7%
England Average	28.8%

2.2 CAREER INFORMATION, ADVICE AND GUIDANCE

We are confident that we can take £450,000 out of the CIAG area of the offer, with minimal impact to front line service delivery. We have tested the market and more than one organisation

indicated that they could deliver the service as specified within the reduced finding envelope and in fact offered additional savings.

2.3 STATISTICAL NEIGHBOURS

We know that Tameside, one of our statistical neighbours commissions delivery of their CIAG to an external provider. This contract has been in place for just over 12 months, with a significantly reduced funding allocation similar to what we are proposing. They have reported that despite this, the provider has managed to reduce their NEET rate by 30% since the commencement of their contract. They have recently retendered the opportunity for a further 3 years (with the option to extend for a further 3 years) on a similar funding basis and have successfully offered the contract to the existing provider.

2.4 OTHER OPPORTUNITIES

In addition to the targeted IAG support offered through the new Integrated Support Services for young people there are also alternative employment and training programmes in place which offer support and opportunities through either support or activity based initiatives:

SUPPORT:

The **Youth Contract** has 3 strands to it which covers the following specific areas:

16/17 Year Old NEETS – for young people who have low GCSE qualifications and /or are young offenders. The programme offers key worker support in developing an individual plan of support for the young person.

Youth Contract Programme – a generic programme of support for 16-24 year olds through mainstream education providers offering study programmes and work experience opportunities.

Nu Traxx – for young people aged 18-24 who have been unemployed for 6 months. This provides a personal budget of £670 for young people to address barriers to employment such as having appropriate workwear.

ACTIVITY

Get Oldham Working provides employment support opportunities to Oldham residents, including a Youth Guarantee for every 18 year old young person leaving mainstream education of the chance to gain work experience, a paid traineeship, apprenticeship or an appropriate job offer.

Work Choice offers young people aged 18-24 who have a disability opportunities and support in gaining employment experience

Working Well offers support and opportunities to young people who have ill health problems and have been unemployed for 2/3 years. There is also a new initiative under this scheme extending the offer to young people who have been unemployed for 12 months.

The **Enterprise Trust Fund** offers support to residents in setting up their own business through either a grant or a loan scheme, with wraparound business support.

All Age Early Help Offer

At a wider level, Oldham Council is developing the All Age Early Help Offer. The purpose of this is to improve households' physical, social and emotional well-being, so that they do not need

ongoing support from crisis and specialist services and are able to do more for themselves. This offer will be open to all young people within Oldham and should reduce the demand on targeted services.

3d. What don't you know?

Until the new contract is awarded late December 2014/January 2015, we will not know the impact of any of the risks highlighted. We will closely monitor the contract and use our existing links with the preferred provider in order to raise any concerns with them at the earliest opportunity.

We will also be able to access the young people previously consulted to seek their views and opinions of the new service and any gaps or negative changes they are aware of.

We propose a full review of the new contract by October 2015 which will have allowed time for the changes to be implemented and for any significant areas of concern to be identified.

3e. What might the potential impact on individuals or groups be?	
Generic (impact across all groups)	N/A.
Men or women (include impacts due to pregnancy / maternity)	N/A
People of particular sexual orientation/s	N/A
Disabled people	Young people with a disability are a vulnerable group when considering young people who are NEET. We would want to ensure that their needs continue to be met.
Particular ethnic groups	N/A
People who are proposing to undergo, are undergoing or have undergone a process or part of a process of gender reassignment	N/A
People on low incomes	N/A
People in particular age groups	Because we are reducing the funding within the IAG theme, there could be an impact on young people aged 16-19 years old.
Groups with particular faiths and beliefs	N/A
Other excluded individuals and	

groups (*e.g. vulnerable residents, individuals at risk of loneliness or carers*)	N/A

Stage 4: Reducing / mitigating the impact	
4a. Where you have identified an impact, what can be done to reduce or mitigate the impact?	
Disabled Young people	• The new model of service delivery will provide a wider, holistic approach to supporting this cohort of vulnerable young people. • The preferred provider is also commissioned by schools to deliver Universal CIAG and this provides a strengthened network of support and contact for other young people in mainstream school who may have additional requirements • It also contributes to the tracking of young people which is a statutory duty of the local authority. Having one provider and therefore a single approach to this makes it easier and more cost effective and will ensure more robust data is reported • As part of the contract monitoring process, we will ensure promotion of national engagement programmes to evidence impartiality and maximise the opportunities for Oldham's young people to access alternative provision and maintain current performance • We will involve service professionals in the monitoring of the contract to ensure we have their input into the process
People in particular age groups	• By securing a single provider method of delivery across the 3 lots, the contract will be delivered and will provide a wider, holistic approach to supporting this cohort of vulnerable young people. • By combining service areas into 3 lots, there will be increased opportunity for young people to access wider support across a number of areas as they require.

4b. Have you done, or will you do, anything differently as a result of the EIA?
We will strengthen our contractual monitoring process and ensure dedicated involvement of service professionals to monitor the impact and risks to the young people identified. We are confident however, that the preferred provider is able to delivery this required service and will continue to do so.

4c. How will the impact of the project, policy or proposal and any changes made to reduce the impact be monitored?

- The contract will be monitored through internal quarterly monitoring systems, led by the Planning and Commissioning Manager with dedicated input from service managers, over the lifetime of the contract.

- The provider will submit detailed monitoring reports to the Planning and Commissioning Manager as agreed. Management information reports will also be circulated by the provider to wider colleagues such as Councillors, Head of Integrated Commissioning, Assistant Executive Director – Early Intervention and Families, Director of Children's and Adults Services and Assistant Associate Director Learning and Attainment for their information and reference.

- The provider will report to the relevant management boards such as the Teenage Pregnancy Strategy Board and the Youth Justice Board.as required and will provide information for these accordingly.

Conclusion
This section should record the overall impact, who will be impacted upon and the steps being taken to reduce / mitigate the impact

We believe that over all, the impact on the young people identified above will be minimal and have plans in place to monitor this accordingly. Indeed, we are confident that the new integrated offer to young people will be enhanced by the single provider approach and delivery from one centre providing a wider integrated programme of support to Oldham's vulnerable young people.

We believe that we have identified the risks and mitigated these accordingly and are confident that we will be able to work with a new provider to address any areas of concern which may arise during the first few months of the contract so that young people are not adversely affected.

However, we are also mindful that this is a new way of working and that there are elements within the new model which have not been linked before. We therefore acknowledge that the contract will need careful and effective monitoring over the first 2 quarters particularly to ensure there are no significant delivery issues and that none of the vulnerable groups identified are adversely affected.

Once you have considered the options for reducing the impacts, please complete the Action Plan and Risk Table at Appendix 1.

When the EIA is complete, please ensure that it is signed off by the lead officer and the appropriate senior officer.

Stage 5: Signature	
Lead Officer: **C Bamforth**	**Date: 18.11.14**
Approver signature: **J Beaumont**	**Date: 03.12.14**
EIA review date:	

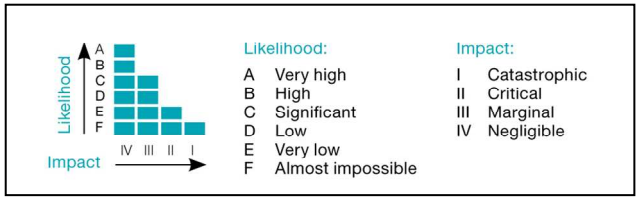
APPENDIX 1: Action Plan and Risk Table

Action Plan

Once you have decided on the course of action to be taken in order to reduce or mitigate the impact, please complete the action plan below (An example is provided in order to help you)					
Number	Action	Required outcomes	By who?	By when?	Review date
1.	Agree final service specifications and contract	• Agreed specifications will be in place with definitive outputs and outcomes, in line with requirements from the Council and with input from service professionals to ensure the new service model is as required from 1st April 2015.	CMB and colleagues	April 1st 2015	Annually?
2.	Transition	• We will work with the new provider following contract award and prior to commencement of the new model to ensure they are aware of the potential risks identified and have plans in place to address these if necessary. • We will ensure that service delivery is maintained during this transition period considering the existing and new provider, and any transfer of relevant data/information etc. to reduce any potential impact on service users.			
3.	Contractual Monitoring	• We will strengthen monitoring of the overall contract, ensuring dedicated involvement of service professionals from the LA and feedback from service users for the lifetime of the contract, but with particular focus during the first two quarters of the new contract in order to identify and address any significant concerns as soon as possible.	CMB	Q1 Q2	October 2015

Risk table

Record any risks to the implementation of the project, policy or proposal and record any actions that you have put in place to reduce the likelihood of this happening.					
Ref.	Risk	Impact	Actions in Place to mitigate the risk	Current Risk Score	Further Actions to be developed
R1	Significant gap in service identified following commencement of the new contract April 2015	The vulnerable groups identified above will be disadvantaged and will potentially receive a poor service	Contract Monitoring Robust service specifications in place	D2	Contract monitoring process to be maintained and reviewed



Equality Impact Assessment Tool

BO35:(0-19 offer for Children, Young People and their Families) Proposal 3 – Early Years 0-4 service offer

Stage 1: Initial screening

Lead Officer:	Tracey Harrison
People involved in completing EIA:	Tracey Harrison, Ed Francis
Is this the first time that this project, policy or proposal has had an EIA carried out on it? If no, please state date of original and append to this document for information.	Yes x No Date of original EIA: n/a

General Information

1a	Which service does this project, policy, or proposal relate to?	This proposal relates to: • Budget template **B035: 0-19 offer for Children, Young People and their Families** and specifically relates to **Proposal 3: 0-4 services for children and families redesign** The redesign of the 0-4 year old offer focuses on two areas, the infrastructure support services and the integrated delivery model at a District level. The Early Intervention and Prevention (EIP) service delivers the statutory elements of the 0-4 core offer by administering the Policy, Strategy and statutory compliance functions. The total budget for EIP services is approx. £12 million made up of Grants directly passported to settings, commissioned services and directly delivered services. The team have responsibility for delivering the following programmes and functions: The 2 year old offer Childcare Sufficiency Free Entitlement for 3 and4 year olds 3 x daycare services Early Years: Schools and Learning Settings Performance

		The Early Intervention and Prevention Service commissions and provides some of the services to meet the 0-4 District delivery model The service currently commissions the Children's Centres core offer and assets within all 6 districts (0-4) through voluntary sector organisations, Children's Society and Action for Children The EIP Service directly provides the following services at a District level: Early Years Additional Educational Needs services (0-5) Early Years Specialists Early Years Lead Practitioners The District services through the Children's Centres work in partnership with social care and health services such as Health visiting, oral health and the family nurse partnership
1b	What is the project, policy or proposal?	The proposal is to revise the current infrastructure and delivery model to ensure that it can deliver the statutory functions of the 0-4 offer in the future whilst achieving significant savings over the next two year period. The project will deliver £3million over the next two years, 2015/16 - £1.075 million and 2016/17 - £1.925 million. The infrastructure (back office) will be redesigned to deliver the early years function and provide the quality assurance and monitoring role for childcare settings in line with changing national requirements. There will be a reduction in the number of posts delivering this function. The District provision will be redesigned to establish an integrated delivery model bringing together the Children's Centres offer and Health Visiting Service (for implementation 2016/17). The project aims to integrate the current Children's Centre and Health Visiting services. Following the transfer of commissioning responsibility for Health Visiting (HV) from National Health Service England (NHSE) to the LA it is the intention to establish a single contract to create a single service for families with children under 5.
1c	What are the main aims of the project, policy or proposal?	
The Local Authority currently has a statutory duty to make arrangements to ensure that early		

childhood services are provided in an integrated manner, and secure a sufficient number of children's centres, in order to facilitate access and maximise the benefits of those services to young children and their parents.

Early childhood services are defined as early years provision (early education and childcare); social services functions of the local authority relating to young children, parents and prospective parents; health services relating to young children (e.g. Midwifery & Health Visiting), parents and prospective parents; training and employment services to assist parents or prospective parents; and information and advice services for parents and prospective parents.

Children's Centres must ensure access to the above services either by providing them directly or by providing advice and assistance on gaining access to services elsewhere); and Provide activities for young children are provided.

The current children's centre contract requires services to be delivered on a district basis and a 'group' structure made up of a number of children's centres, working in partnership with key partners such as, but not limited to, Health and Social Care.

The transfer of Public Health and their commissioning responsibilities to the Local Authority has provided the opportunity to fully integrate the Health Visiting and Children's Centres services to create a single service for under 5's, within the current construct of a district delivery model.

The main aims of this project/proposal is to reduce the total spend on 0-4 services whilst retaining a high quality service. We can achieve this by:

1. Redesigning the back office infrastructure and therefore reducing costs
2. Redesigning and implementing a new delivery model which integrates services across health, education and childcare into a single service. A key element of this redesign is the transfer of Health Visiting commissioning responsibilities to the Council

What would be different:

1. Improved information sharing
2. Improved assessment pathway, more responsive to meeting need at the earliest stage (Appendix 1)
3. Focus on evidence based interventions (Appendix 2 & 3)
4. Rationalised management structures across disciplines (Appendix 4)
5. Optimum use of buildings and facilities

The service entitles families with young children from conception to 5 years to a set of universal and additional evidence based services, through the 8 stage integrated assessment model and corresponding pathway of intervention.

The proposed model includes specialist functions such as clinical psychology; speech & language assistants; Additional Educational Needs (AEN) workers, to deliver on the Special Educational Needs and Disability (SEND) reforms for early years; and district strategic leads to ensure LA strategies/priorities are reflected in local plans

Given the nature of the health visiting service it is proposed that we will establish a single contract for the borough to give consistency of access for the population. There will be a single performance framework aimed at improving child development and public health priorities. The core delivery of the 8 stage assessment and intervention pathways (Appendix 1 & 2) is currently being piloted with an implementation date of March 2015. The redesign project builds on these elements providing the construct to enable Integrated delivery. Other information about the project is attached as an appendix. **Appendices:** Appendix 1: 8 Stage assessment model Appendix 2: Oldham's Pathway of Interventions. Appendix 3: Visualising the scale of the offer Appendix 4: Core function for the model		
1d.	Who, potentially, could this project, policy or proposal have a detrimental effect on, or benefit, and how?	This is a universal service for families with children under 5 and will secure an 'entitlement' to regular assessment/contact points along with a range of corresponding support/interventions. These services currently exist as individual services. They are described in section 1a - 0-4 Delivery model. The public should see an enhanced integrated service, continuing to be delivered on a district basis both in the community and from key delivery hubs. The benefits of the transformed service are introduction of a clear assessment framework (8 stage assessment) with specified intervention pathways, supported by specialists, There will be a direct link with the All Age Early Help Offer (The purpose of which is to improve household's physical social and emotional wellbeing so that they do not need ongoing support from crisis and specialist services). This will ensure early identification of need and appropriate preventative work, which in the longer term should reduce the demand for high cost services. The integrated delivery model will be monitored on a quarterly and annual basis. A robust performance and contract cycle is under development. This builds on the current children's centre performance requirements and the mandated Health Visitor performance framework. It is intended to align these to become a single outcomes framework in the future.

		The performance framework consists of service delivery outputs, and direct evaluation of interventions plus contract management monitoring of key elements required by the specification. In addition, children's centre provision is currently subject to an Ofsted inspection regime. The Local Authority is also accountable to ensure quality of provision as part of the inspection. The performance of the contract will continue to be reported, by the provider and commissioner, through the Early Years Programme Board on a bi-monthly basis.

1e. Does the project, policy or proposal have the potential to disproportionately impact on any of the following groups? If so, is the impact positive or negative?				
	None	**Positive**	**Negative**	**Not sure**
Disabled people	☐	☒	☐	☐
Particular ethnic groups	☐	☒	☐	☐
Men or women (include impacts due to pregnancy / maternity)	☐	☒	☐	☐
People of particular sexual orientation/s	☒	☐	☐	☐
People who are proposing to undergo, are undergoing or have undergone a process or part of a process of gender reassignment	☒	☐	☐	☐
People on low incomes	☐	☒	☐	☐
People in particular age groups	☐	☒	☐	☐
Groups with particular faiths and beliefs	☒	☐	☐	☐
Are there any other groups that you think may be affected negatively or positively by this project, policy or proposal?				
E.g. vulnerable residents, individuals at risk of loneliness, carers or serving and ex-serving members of the armed forces		☐	☐	

1f. What do you think that the overall NEGATIVE impact on groups and communities will be?	**None / Minimal**	**Significant**
	☒	☐

1g	Using the screening and	

	information in questions 1e and 1f, should a full assessment be carried out on the project, policy or proposal?	Yes ☐ No ☒
1h	How have you come to this decision?	The proposals ensure the essential maintenance of statutory duties for early years, health and children's centres along with provisions in the Health and Social Care Act 2012, such as transfer of public health to local authorities, providing for a closer link with social care and children's services. Although there are some job reductions proposed as part of the Year 1 savings requirement, the majority of these relate to vacant posts that have not been filled in advance of the new ways of working. We aim to finalise the performance and contract monitoring cycle in readiness for procurement to begin summer 2015. The EIA will be reviewed in 6 months' time prior to procurement process.

Stage 5: Signature	
Lead Officer: Tracey Harrison	**Date: 21.11.14**
Approver signature: Jill Beaumont	**Date: 21. 11.14**
EIA review date: December 2015	

EIA Appendices
BO35 – 0-19 – 0-4 PROJECT

Appendix 1: 8 Stage assessment model
Appendix 2: Oldham's Pathway of Interventions.
Appendix 3: Visualising the scale of the offer
Appendix 4: Core functions for the model

Oldham Council

The 8 Stage Assessment (11 July 2013)

GMCA GREATER MANCHESTER COMBINED AUTHORITY

AGMA ASSOCIATION OF GREATER MANCHESTER AUTHORITIES

Appendix 1

Stage 1 Pre Birth
Before 12 weeks, 6 days or on presentation
Midwife
Midwifery Health & Social Assessment
***early help Indicator**

Stage 2 New Birth Visit
10 – 14 days
Health Visitor
***early help indicator. CC registration.**

Stage 3 2 months
(1 mth to 2m 30d)
Health Visitor
***early help indicator**
(ASQ3)

Stage 4 9 months
(9m to 9m 30d)
Health Visitor
***Predict and plan for 2 year old offer**
(ASQ3)

Stage 4b Targeted 18 months
(17m to 18m 30d)
Targeted Twos pathway
***agree 2 year old offer and targets for child and parent/s**
(*ASQ3*)

Stage 5 24 months
(23-28 ½ months)
HV & EY provider
(ASQ3 and EYFS)

Stage 6
On entry to Nursery (universal 3/4 year old provision)
(ASQ3 as per age)
EY Provider
(ASQ3 and EYFS)

Stage 7 On entry to Reception in school
(ASQ3 as per age)
EY Provider and receiving school
(ASQ3 and EYFS)

Stage 8
Early Years Foundation Stage Profile and ASQ3
Undertaken by school within the last term
before the child's 5th birthday (by30/6)
***EYFS profile results derive from this assessment**

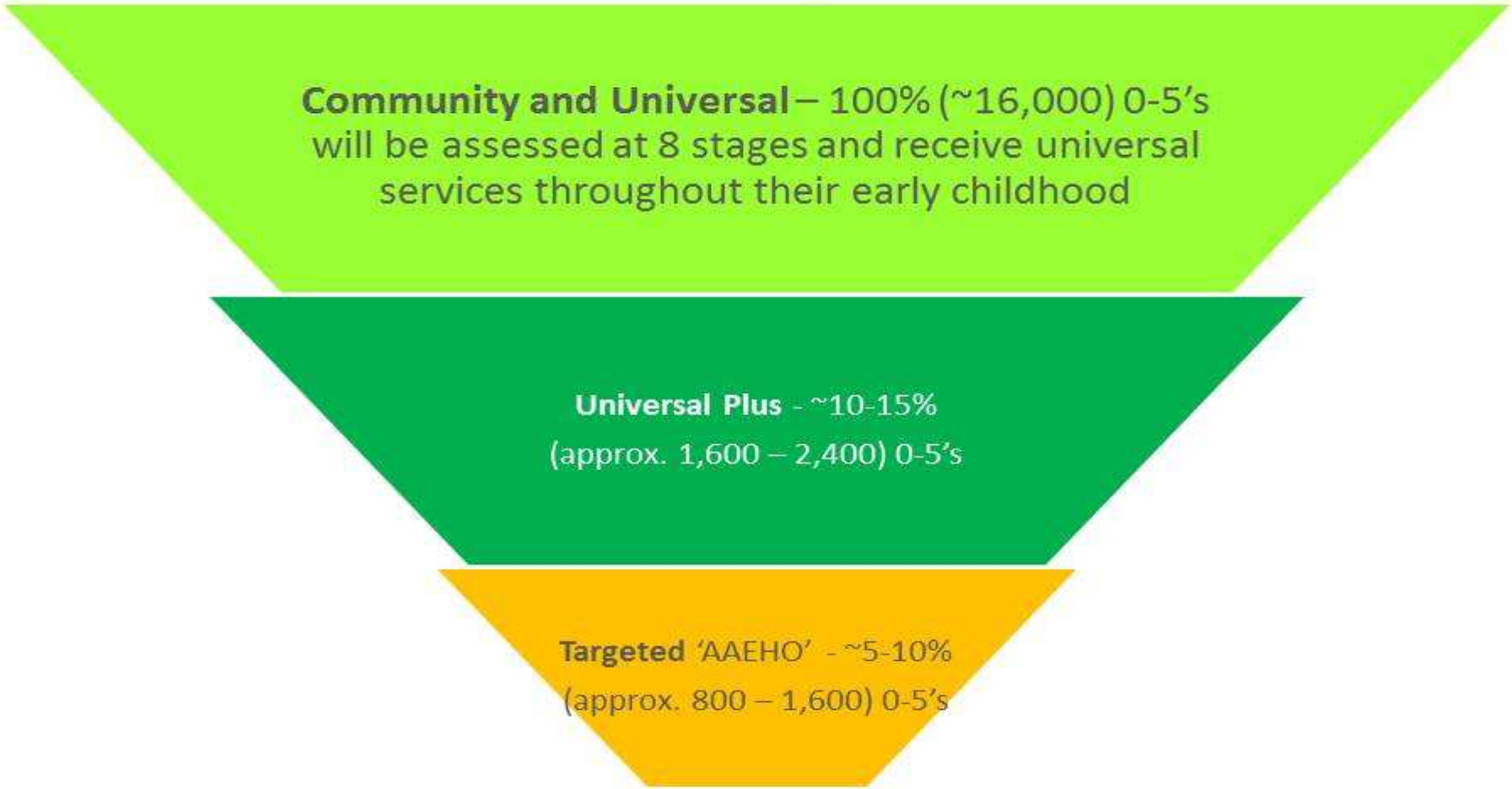
- All points are already part of Healthy Child Programme or Early Years Foundation Stage apart from Stage 4b, which is for all children identified with needs at stages 2 to 4 and key to ensuring appropriate access to Targeted Twos Daycare.
- Assessments at Stages 2, 3 and 4 to be undertaken within the family home wherever possible
- The engagement points will be expected to be undertaken in line with the ASQ3 timeframe. At every stage parent/s will be asked about their plans for work/education
- ASQ3 is parent led, standardised, retest reliable, and likely to be used as National measure of childhood development at 2/2 ½. EYSF is used throughout within daycare to measure progress.

Review April 2014

2

Appendix 2 - The pathway of intervention (linked to 8 stage assessment)

Appendix 3 - Visualising the scale of the offer



Appendix 4 - Core Functions 0-4 model

Based on statutory requirements for Healthy Child Programme and Children's Centre core purpose

Oldham Council

Core Team - Purpose

Core Team	Function	Posts required	Qualification/Professional competencies required
District Child & Family Service Manager	Takes a strategic lead for the service and ensures LA strategies/priorities are reflected in local plans. Supervision of Practice leads– Clinical & professional District Implementation of developments & initiatives Safeguarding lead and accountable person for the service Is accountable for work across boundaries and agencies. Has leadership responsibility and autonomy to act. Sets strategic direction in own area of work. Need to ensure the leadership of the 0-4 offer continues to focus on early education to accelerate improvement in EYs outcomes.	3 (0.5 per district)	Relevant degree and/or above in Health, social care or education Advanced diploma/post graduate qualification in relevant area and/or leadership Has a high level of expertise in a specific area of work or across a substantial breadth of service delivery and/or programmes.
Practice Lead Health Visiting & Parenting	Part of Leadership team. Supervision of HV s Case holder. Have the lead responsibility for the planning, coordination, quality assurance and evaluation of districts health and parenting priorities. Provide an expert practice lead, support developments and maintain practice standards. Have a strong focus on prevention, health promotion, early identification of needs and clear packages of support	6 (1 per district)	**Essential** - Registered Nurse (RGN) Diploma / Degree Specialist Community Public Health Nurse – Health Visiting Non Medical prescribing Qualified in motivational interviewing; Solihull approach; NBO; NBAS **Desirable**- Certificate/Diploma in Management Studies Specialist Community Practice Teacher Advanced knowledge of current clinical issues
Practice Lead Education & Learning	Practice lead for education and learning will be expected to develop with primary schools, individually or through primary collaborative, effective joint working to have an impact on early years outcomes for the most vulnerable children in an identified district. Provide an expert practice lead, support developments and maintain practice standards. Leadership of Stage 5/6/7/8 of the 8 stage model - engaging with all EYs providers work collaboratively with the 0-25 all age disability service to ensure that all requirements for early years in the 0-25 SEND Code of Practice are met. direct line management of the Area SENco	3 (0.5 per district)	Early Years or Education Graduate; SLC Specialism

Core Team - Purpose

Core Team	Function	Posts required	Qualification/Professional competencies required
Specialist Child & Family Worker – Health Visitor	Deliver the Health Child Programme Have a strong focus on prevention, health promotion, early identification of needs and clear packages of support To undertake and record Child Health Surveillance and Screening programmes Assess health needs of individuals, families and populations (8 Stage) Assigns targeted intervention activity regarding parenting skills and aspirations, attachment, bonding and social/emotional functioning; and speech language and communication to specific members of staff Monitors and evaluates targeted intervention activity	73.5 - 6 Practice Leads(call to action)	Registered Nurse (RGN) Diploma / Degree Specialist Community Public Health Nurse – Health Visiting Non Medical prescribing Qualified in motivational interviewing; Solihull approach; NBO; NBAS
Child & Family Worker	Matrix managed by : HV for targeted Intervention family cases work; Practice lead Education & learning for delivery of universal & Universal plus group activity i.e. play & stay, parent & child communication groups Work as part of an integrated team to deliver Oldham's 0-4 universal and targeted intervention programmes where it has been identified that a package of support is required to enable the child to meet developmental milestones. Carry a family caseload – under the supervision of a health visitor Identify child and family needs by undertaking agreed screening and assessment - under the supervision of a health visitor	38 (0.6 per HV minus 9 FTE FP = 0.52)	Minimum L3 qualified in Health, social Care or Education to include child development module. Communication and language knowledge and understanding or EYFS planning for Young Children Outreach worker with EYs background CAF & safeguarding experience Qualified in motivational interviewing and Solihull approach; knowledge and experience of delivering parenting programmes such as Solihull Group, Webster Stratton, Triple p

Core Team - purpose

Core Team	Function	Posts required	Qualification/Professional competencies required
Specialist Child & Family worker - AEN	Working with Oldham Council Workforce and Organisational Development Service to ensure there sufficient expertise and experience within the early years providers to support children with special educational needs. Provide advice, guidance (not practical support or fulfilling the role of the early years SENco) and dissemination of good practice around the development of inclusive learning environments to early years providers, including childminder agencies through SENco networks, drop ins etc Support links between the home, education, social care and transition to formal school Deliver locally agreed home based interventions/support i.e. Early Support to aid children's development at home.	6	Degree Early Childhood to include an element of SEN Studies Identifying and assessing individual needs Impact of specific difficulties on early childhood development Specific impact associated with social communion difficulties and autism spectrum conditions Level C or above English and Mathematics
Speech & Language Assistant	Support the planning, carry out the delivery and monitoring of parent and child communication groups.	3 (0.5 per district)	A Foundation degree in Health and Social Care and an NVQ3 in Working with Children and Families or equivalent
Clinical Psychologist	Clinical supervision for case holder/workers; build capacity in the team Delivery and oversight of parenting programmes 1-1 case work;	Minimum 1 across the borough	Post-graduate doctoral level training in applied psychology [or its equivalent for those trained prior to 1996 or outside the UK], including specifically models of psychopathology, clinical psychometrics, two or more distinct psychological therapies and lifespan developmental psychology as approved by the HPC. Professionally registered as a Practitioner Psychologist with the Health Professions Council (HPC)
Business Support- Back Office & Reception for Hub	Facilities management Administration function for Health & Education functions, Data input & analysis Reception duties, administration duties Administration & brokerage of 2YO	Minimum(1 per hub)	**Essential** Sufficient literacy and numeracy to undertake the tasks and duties of the role **Desirable** NVQ 2 in Business Administration or equivalent European Computer Driving Licence (ECDL)
Volunteer Co-ordinator	Create opportunities for volunteering Train and co-ordinate volunteers Support volunteers back to employment	1 for the borough	

Equality Impact Assessment Tool

Enabling EIA: Early Age Help offer

Stage 1: Initial screening

Lead Officer:	Jill Beaumont
People involved in completing EIA:	Liz Hume, Gerard Gudgion, Jill Beaumont
Is this the first time that this project, policy or proposal has had an EIA carried out on it? If no, please state date of original and append to this document for information.	Yes X No Date of original EIA:

General Information

1a	Which service does this project, policy, or proposal relate to?	All Age Early Help Offer – this will cover a number of service areas as outlined below. This is an enabler for the following budget proposals: • **B035: 0-19 offer for children and families** • **B039: Review of the Public Health Budget** • **C046 (elements of): Adult Social Services Redesign**
1b	What is the project, policy or proposal?	

The All Age Early Help Offer fundamentally re-designs mainstream services so that they are focused on helping people to help themselves; giving them the skills to problem solve and enabling them to manage their own lives. The key change to current delivery is that a single new offer will be created for all people with complex dependencies, replacing multiple overlapping services currently in place.

We estimate that the service will support around 3500 service users 1:1, with a range of needs, particularly:

- Mental health issues
- Drug and alcohol issues
- Housing issues
- Behaviour-related physical health issues
- Domestic violence/relationship issues
- Parenting issues
- General family support needs
- People out of work with complex barriers to employment
- Involvement in crime (current or historic)

In addition, it will support around 4000 people in community settings via group-work and one-off 1:1 appointments.
The new service will be targeted at:

- People with emerging problems in these areas, but who do not yet meet the criteria for statutory support (e.g. specialist mental health, social care). The service's aim will be to ensure they receive support to prevent them needing specialist services. People who can, with support be 'stepped down' from specialist services, as a route to them regaining full independence

1c	What are the main aims of the project, policy or proposal?

Target population

The service is expected to work with:

- Around 3500 households on a 1:1 level (including support provided through volunteer peer mentors and advocates – see below);
- Around 4000 additional individuals through group-work and initial contact/advice.

These households and individuals will have a combination of the following characteristics:

- Emerging mental health issues;
- Historic mental health issues that can now be managed outside specialist services;
- Emerging drug and alcohol issues;
- Historic drug and alcohol issues that can now be managed outside specialist services;
- Housing issues – particularly people at risk of homelessness;
- Behaviour-related physical health issues/behaviours that may lead to physical health issues (e.g. smoking, obesity, poor diet, low levels of physical activity);
- Identified by their GP as eligible for a 'health check';
- Experiencing emerging domestic violence/relationship issues;
- Having difficulty with parenting;
- General family support needs, including children poorly attending school or misbehaving in school;
- Out of work with complex barriers to employment;
- Involved in crime and anti-social behaviour.

High level outcomes

The following summarise the high level outcomes from the service:

- Improve mental health and well-being of individuals within households;
- Reduce reliance on drugs and alcohol of service users;
- Support service users to access and sustain stable housing;
- Improve physical health e.g. reducing smoking, reducing obesity, encouraging healthy eating;
- Reduce levels of domestic violence and relationship issues;
- Improve parenting;
- Reduce levels of involvement in crime and anti-social behaviour;
- Increase numbers of service users in employment;
- Increase numbers of people who feel confident to manage their own lives;
- Children's school attendance and behaviour;
- Increase numbers of households who feel confident in managing their finances.

1d	Who, potentially, could this project, policy or proposal have a detrimental effect on, or benefit, and how?

All service users identified above – they will all receive a different service in future to the one they would receive now. The majority will be new customers and will therefore not have an 'old' and 'new' to compare, but some will transition from one system to the other.

The intention is that the change will be a positive one:

Current situation	**How the requirements in this specification seek to change this**
There has been a tendency to separate out behaviour change relating to physical health from behaviour change relating to social and emotional well-being – this has resulted in a fragmented approach that fails to see an individual or their household as a whole person	The new service will cover physical health issues (e.g. smoking, obesity, unhealthy lifestyles, lack of physical exercise); and social/emotional issues (e.g. relationship issues, housing issues, finance/debt issues, poor mental well-being, drug & alcohol dependence, poor parenting).
There has been a 'silo' approach to commissioning and provision of services based on single issues or	The new service design explicitly requires providers to work with people and households as

tightly defined cohorts (e.g. smoking, obesity, mental health, drugs & alcohol, housing)	a 'whole person' in their context, and to provide a single offer to address all the issues an individual or household has, rather than passing them around the system to different providers for different issues
The plethora of silo'd services has meant that it is difficult to navigate and access services – meaning that those who do so are often either 'worried well' and the more empowered members of the community who can navigate their way around the system, or are people who have learnt to expertly 'play the system' to obtain everything they can from every service. This increase costs and contributes to ongoing inequalities as many who need the services do not access them at all or access them too late	The new service design requires use of a single point of access, for both self-referrers and referrals from other organisations. This makes it easy for both self-referrers and referring organisations to go to a single point. It also makes it easy to determine whether the same household is 'turning up' repeatedly, with different presenting issues. So that we are not reliant on people navigating the system, people who need support will also be identified through using data we hold on the Oldham population.
The current system is not financially sustainable – it is less efficient and effective to work with people and households on a single issue basis than for a single service to be able to work with them on all of their issues	The new service design is funded by collapsing multiple different existing services into a single delivery framework.
Greater emphasis needs to be placed on developing an individual's and household's skills and abilities to be resilient and self-manage – previous lack of emphasis on this has tended to result in long-term dependence on public services	The new service design explicitly requires the provider to have an absolute focus on developing an individual's and household's skills and abilities to be resilient and self-manage, and requires bidders to demonstrate how they intend to skill staff up to deliver in this way.

However, this is the first time that this scale of change to these types of services has been implemented nationally, so there is not a blueprint to follow. We have mitigated this risk by piloting the key elements of the programme (the intensive case workers and the engagement workers) first.

The other key risk is during the transition period, when some services are ending and the new one starting. During this period, we will need to ensure that robust plans are in place to continue supporting people who need services as they transition from one service to another. This is highlighted further in the risk log below.

1e. Does the project, policy or proposal have the potential to disproportionately impact on any of the following groups? If so, is the impact positive or negative?

	None	Positive	Negative	Not sure
Disabled people	☐	☐	☐	X
Particular ethnic groups	X	☐	☐	☐
Men or women (include impacts due to pregnancy / maternity)	X	☐	☐	☐
People of particular sexual orientation/s	X	☐	☐	☐
People who are proposing to undergo, are undergoing or have undergone a process or part of a process of gender reassignment	X	☐	☐	☐

People on low incomes	☐	☐	☐	X
People in particular age groups	X	☐	☐	☐
Groups with particular faiths and beliefs	X	☐	☐	☐
Are there any other groups that you think may be affected negatively or positively by this project, policy or proposal?				
Residents with complex dependencies (e.g. drugs & alcohol reliance, mental health & wellbeing problems)		☐	☐	X

1f. What do you think that the overall NEGATIVE impact on groups and communities will be?	**None / Minimal**	**Significant**
	☒	☐
	Note comment above – the intention is for there to be a positive impact across all service users. There should not therefore be a disproportionate impact for any service users. The exception to this is people with disabilities (particularly mental health problems), people on low incomes and residents with complex dependencies, who we would expect to see disproportionately represented in the client group for this service. However, this will depend on the model being set up effectively – hence indication of 'not sure' pending service user consultation	

1g	Using the screening and information in questions 1e and 1f, should a full assessment be carried out on the project, policy or proposal?	Yes X No ☐
1h	How have you come to this decision?	The reason for indicating 'not sure' above is that people on low incomes and residents with complex dependencies will be disproportionately represented in the client groups of the service. The novel nature of the change means we feel we should conduct further impact assessment to confirm the likely impacts.

Stage 2: What do you know?

What do you know already?

See Appendix 1 for a summary of the background research. In addition to this, we have completed recent pilot activities to test the impact of potential new ways of working that address the problems identified in this research.

In particular:

- Our Family Focus Teams have piloted (with around 100 families) a new approach to working with families to understand the root causes of their problems, and supporting families to develop the skills and resilience to address these problems for themselves. This has focused more heavily on direct intervention and work with families than previous 'key worker' approaches, which have focused more on co-ordination. This approach has had very positive reports from the families who have been supported.
- We have been working jointly with Greater Manchester Police to test an 'engagement worker' approach to working with people who persistently call the police. This works on the same principle as the Family Focus Teams, but is intended to be less intensive intervention over a shorter period of time. Again, early reports of the impact are positive, with people supported calling the police considerably fewer times after the intervention than before it.

What don't you know?

Although we have made every effort to test the impact of the new ways of working that we are proposing through the pilots noted above, we cannot fully know the impact of scaling this up and making it our mainstream way of working, replacing existing services.

We have a better chance of fully understanding this impact by consulting widely with key stakeholders and members of the public to identify their views on the potential impact of the changes we are making – although, it is not expected that anyone will have the 'magic bullet' of the definitive answer.

In addition, to date we have primarily anecdotal (although very consistent and very positive anecdotal) feedback on the impact of the Family Focus teams. We have therefore commissioned Business Intelligence to complete an early evaluation of the impact of the teams. It should be noted that we would only expect to see major change in the data items coming through in the longer term as new behaviours become embedded and entrenched, but it is now timely to consider whether there are early indicators of success.

Further data collection

In order to fill the gaps in our knowledge we have:

- Commissioned an evaluation report from Business Intelligence to identify the impact of our pilot activity to date. The full report is included at Appendix 2. Key findings are summarised below.
- Undertaken detailed consultation with stakeholders and service users. This included running 22 service user focus groups, attended by more than 150 service users. The detailed feedback is included at Appendix 3 and is summarised below.

Summary (to be completed following analysis of the evidence above)				
Does the project, policy or proposal have the potential to have a disproportionate impact on any of the following groups? If so, is the impact positive or negative?	**None**	**Positive**	**Negative**	**Not sure**
Disabled people	☐	**X**	☐	☐
Particular ethnic groups	**X**	☐	☐	☐
Men or women (include impacts due to pregnancy / maternity)	**X**	☐	☐	☐
People of particular sexual orientation/s	**X**	☐	☐	☐
People who are proposing to undergo, are undergoing or have undergone a process or part of a process of gender reassignment	**X**	☐	☐	☐
People on low incomes	☐	**X**	☐	

People in particular age groups	X	☐	☐	☐
Groups with particular faiths and beliefs	X	☐	☐	☐
Are there any other groups that you think that this proposal may affect negatively or positively?				
Residents with complex dependencies (e.g. reliance on drugs & alcohol, mental health & wellbeing problems)		X	☐	

Stage 3: What do we think the potential impact might be?

Consultation information	
3a. Who have you consulted with?	See Appendix 3.
3b. How did you consult? (inc meeting dates, activity undertaken & groups consulted)	See Appendix 3.

3c. What do you know?

Key messages from the evaluation report produced by Business Intelligence are:

- Overall, the impact from the pilots is positive.
- There is a significant anomaly in relation to school attendance – we had expected that the pilot activity would improve people's school attendance. However, the data suggests that this is not the case. We have therefore explored the reasons for this in more detail. It appears that there are two key reasons: (1) A core focus of the All Age Early Help Offer is on supporting people to develop the skills and resilience to be independent. The emphasis is therefore on supporting parents to take their children to school and manage their own relationships with the school. This contrasts to the approach from existing services who simply take the child to school. In the short-term, the latter approach will get more children to school, but it is not sustainable as the public sector cannot transport a whole cohort of children from their front doors to school. Longer term, the All Age Early Help Offer approach is therefore more sustainable, but is likely to result in a longer lead-in time before improvements are seen. (2) Buy-in from schools in crucial: a significant barrier that the pilots have found is that schools will often not engage in making overtures to parents and children to help them feel comfortable coming to school. In response to this, we have built specific capacity into the All Age Early Help Offer to liaise with schools to develop this engagement.
- There are some instances where training and workforce development has not fully impacted on practice – for example, there are still examples of practitioners in the pilots doing things 'to and for' rather than 'with' people. There are also still examples of them referring on to other agencies rather than providing the support themselves.

Key messages from the consultation and stakeholders and service users, and the ways that we are responding to the comments raised, are summarised below:

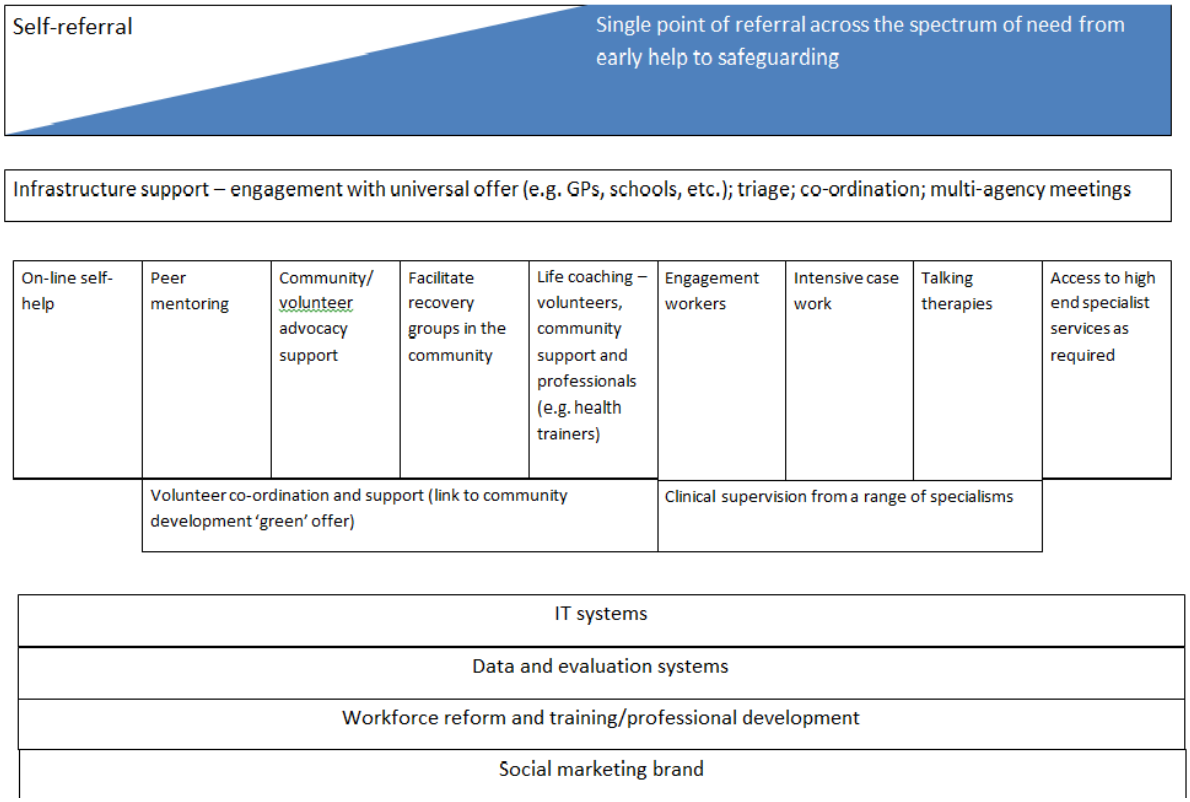
Feedback received	Response/change
Experience of service users	
Accessibility: 'phone and internet don't work for everyone; need to have a wide range of	Re-designed model to reflect much greater emphasis on outreach activity, and a presence in

different potential access routes; also need to consider different language requirements, ability to read.	community settings (see below). Ability to respond to differing language requirements will be incorporated into specification for contract and Service Level Agreement for in-house service.
A single point of access via the Council may put people off from self-referring or from engaging with an agency referral.	Re-designed model to reflect much greater emphasis on outreach activity, and a presence in community settings (see below).
Importance of developing skills for workers in the model, and recognition that it is a significant change in the way staff work, to shift to providing holistic support rather than focusing on specific topic areas.	Skills development programme already underway for in-house staff. Staff trained have given positive feedback; we have also had positive feedback from service users supported by the staff following the training. Learning from this will be shared with the successful bidder to aid in their staff development.
Are there confidentiality issues? What if a young person wants support but doesn't want their family to know? Or a person experiencing domestic abuse?	Added a requirement that people can be supported as individuals in these types of circumstances – although we would still expect the worker to understand and talk to them about the whole context and work across the range of issues the person they are supporting is facing.
Processes need to be flexible – e.g. if someone needs to come back into the service, they shouldn't need to repeat referral processes; for single appointments for one-off issues, these should be responded to immediately.	To be built into Service Level Agreement for the infrastructure aspect of the service.
What about those who have emerging issues but aren't ready to acknowledge them or engage in a formal service?	Re-designed model to reflect much greater emphasis on outreach activity, and a presence in community settings (see below).
Response times: how quickly will the 'phone be answered? When will appointments be made for one-off or initial appointments e.g. health checks? For more complex cases, how quickly will decisions about the support people will receive be made?	Service standards with short response times to be built into Service Level Agreement for the infrastructure aspect of the service.
Ensuring that the risks are not dis-proportionately felt amongst Oldham's poorest and minority ethnic communities and that there is meaningful ability to reach these communities.	This has been included explicitly in the specification for tender for the service: The provider must also ensure that the service is fully accessible to people from all backgrounds and communities represented in Oldham. This must take account of: o Particular language and cultural requirements; o Gender o Sexual orientation; o Religion; o Cultural background; o Ethnicity; o Disability
Transition arrangements	
Request that continuity of support for existing service users is planned into the transition	Being discussed with individual current providers – any cases expected to continue beyond April 2014

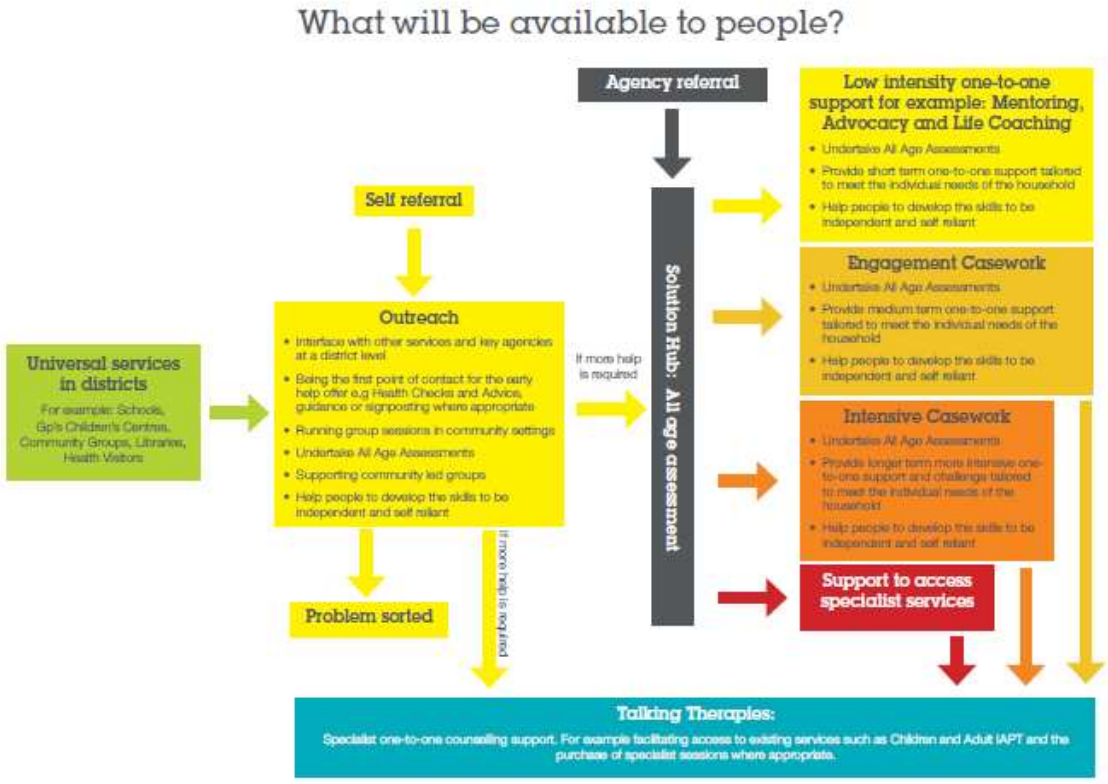
arrangements	will be identified and individual arrangements made to provide ongoing support wherever appropriate beyond April.
Links between agencies	
Need to ensure the offer links in with other services across the public sector to make sure it complements rather than duplicates or confuses	Current member of staff has been given responsibility for mapping referral routes in and out of the All Age Early Help Offer to prepare in advance of the approach going live in April.
Needs to be clear routes into specialist/tier 3-4 support	Current member of staff has been given responsibility for mapping referral routes in and out of the All Age Early Help Offer to prepare in advance of the approach going live in April.
Procurement arrangements	
Procurement timescales: 5 weeks is tight for developing innovative proposals or allowing local organisations to set up partnerships	Draft specification published 16th September to provide more time up-front. Procurement timescales extended to allow an additional two weeks for response times once the formal Invitation to Tender has been published.
Requirements: some of the requirements are too specific e.g. peer mentoring rather than just mentoring – could stifle innovation or restrict organisations' ability to bid	Requirements made more general, inviting tender responses to propose the detailed delivery arrangements.
Data and information	
Evaluation and monitoring will be critical – we need good systems in place, and we need to be prepared to change things if they're not working	Detailed evaluation and monitoring requirements drafted into the draft specification and comments invited. Approach to evaluation has been tested with the current pilots of the Family Focus and engagement work – see below.
IT systems will be critical to success	IT systems being developed in advance, and will be ready for user testing in October. This should give us a running start in April.

The single biggest change as a result of the feedback has been re-designing the model. The original model placed a high emphasis on formal and structured 1:1 work as below:

An outline model



In response to the consultation feedback, we have recognised the need for a much stronger 'informal' element to the model, focused much more on outreach, group-work and low intensity 1:1 work. This is represented in the new summary diagram of the All Age Early Help delivery model as (see below):



This serves two functions of providing an earlier intervention option, and also of raising awareness both amongst potential service users and services of the range of issues people might be experiencing, and working with people to give them the skills to manage these issues before they escalate to the point of needing intensive 1:1 support. It also provides a much more informal route into the service for people self-referring, as there will be many community-based access points, rather than requiring people to 'phone or use the internet.

3d. What don't you know?

We feel we now have a full picture of the impacts and therefore do not plan to collect further data before making a decision on implementing the All Age Early Help Offer. However, we will put in place a robust evaluation process to ensure that we regularly test the impact of the All Age Early Help Offer and are in a position to identify and address any emerging issues as soon as they arise.

This is summed up by a service user comment that 'I don't think you've forgotten anything, but we won't know until you try'.

3e. What might the potential impact on individuals or groups be?

Generic (impact across all groups)	Positive – our findings suggest that there will be a positive impact across all users of the service. We would not expect men/women; people of particular sexual orientations; particular ethnic groups; people who are proposing to undergo, are undergoing or have undergone a process or part of a process of gender reassignment; people in particular age groups; or groups with particular faiths and beliefs to be over-represented in the cohort for the service. There should not therefore be a disproportionate impact for any of these groups. The exception to this is people on low incomes and residents with complex dependencies, who we would expect to see disproportionately represented in the client group for this service, and who should

	therefore see a disproportionately positive impact compared to the general population. It is accepted that despite having reasons to expect positive outcomes there are risks that problems could result. Those reading this EIA should read and consider the risks identified in the risk table at Appendix 1. None of the risks identified directly relate to people with protected characteristics but for the same reasons that people on low incomes and residents with complex dependencies will experience positive impacts from the proposal (because they disproportionately use the services) it follows that they could experience a disproportionately negative impact, depending on the nature and extent of problems encountered under any new arrangements. However, none of the risks are considered to call upon further contingencies at this stage as the actions currently planned are considered appropriate.
Men or women (include impacts due to pregnancy / maternity)	No disproportionate impact – see above
People of particular sexual orientation/s	No disproportionate impact – see above
Disabled people	Positive impact - It is considered that people who need to access this Offer are likelier to involve a higher proportion of people who have disabilities, although not all such people are disabled. However, it is for this reason that it is considered that disabled people are likely to experience a positive impact.
Particular ethnic groups	No disproportionate impact – see above
People who are proposing to undergo, are undergoing or have undergone a process or part of a process of gender reassignment	No disproportionate impact – see above
People on low incomes	Positive impact – please note that the reason for the change from 'don't know' in section one is that we have now completed the further consultation, engagement and evaluation necessary to be clear on the impact, and have a good expectation that this will be a positive impact.
People in particular age groups	No disproportionate impact – see above
Groups with particular faiths and beliefs	No disproportionate impact – see above
Other excluded individuals and groups (e*.g. vulnerable residents, individuals at risk of loneliness, carers or serving and ex-serving members of the armed forces*)	Residents with complex dependencies: positive impact – please note that the reason for the change from 'don't know' in section one is that we have now completed the further consultation, engagement and evaluation necessary to be clear on the impact, and have a good expectation that this will be a positive impact.

Stage 4: Reducing / mitigating the impact

4a. Where you have identified an impact, what can be done to reduce or mitigate the impact?	
Impact 1: There are no examples of such large scale transformational change in the public sector relating to these types of services and groups of people – previously it has been at a relatively small scale, in relation to specific cohorts. This degree of change is therefore new and it is possible that models that were successful at a small scale may not work with larger numbers of families. This could result in families receiving a less good quality service than they currently do.	1. Undertaking consultation with a wide range of service users and stakeholders to identify anything we may have missed. Changes made as a result are summarised above. 2. We will put in place a robust evaluation process to ensure that we regularly test the impact of the All Age Early Help Offer and are in a position to identify and address any emerging issues as soon as they arise. This is summed up by a service user comment that 'I don't think you've forgotten anything, but we won't know until you try'.
Impact 2: During the transition period, when some services are ending and the new one starting. During this period, we will need to ensure that robust plans are in place to continue supporting people who need services as they transition from one service to another.	We are contacting all current providers to identify service users that they are supporting and anticipate will continue to need support post-1st April. An individual plan for each service user will then be developed in full consultation with the old provider, new provider and service user.
Impact 3: This is a significant scale of change without a blueprint: it is possible that we will not have thought of everything when the service 'goes live' on 1st April	Staff are already being trained to work in the new way, so there will not be a sudden shift required on 1st April 2015. Many current staff will continue to be employed in the new model and will therefore continue to deploy the considerable skills they have developed. We are 'double running' services for the most vulnerable groups – people with mental health problems and people reliant on drugs & alcohol, so that current services will continue alongside the development of the All Age Early Help Offer. This provides a 'safety blanket' if the All Age Early Help Offer does not immediately begin operating at full capacity and impact.

4b. Have you done, or will you do, anything differently as a result of the EIA?
See changes noted above as a response to the consultation.

4c. How will the impact of the project, policy or proposal and any changes made to reduce the impact be monitored?
Appendix 3 sets out detailed monitoring and evaluation plans.

Conclusion *This section should record the overall impact, who will be impacted upon and the steps being taken to reduce / mitigate the impact*
The work we have done suggests that the overall impact of the All Age Early Help Offer should be

positive. We have made changes to the model in response to stakeholder and service user feedback, which have strengthened the model. We have also put in place a robust monitoring and evaluation plan, which will highlight rapidly any issues arising from implementation of the model so that they can be addressed.

Stage 5: Signature	
Lead Officer: Liz Hume	**Date: September 2014**
Approver signature: Jill Beaumont	**Date: September 2014**
EIA review date: December 2015	

APPENDIX 1: Action Plan and Risk Table

Action Plan

Once you have decided on the course of action to be taken in order to reduce or mitigate the impact, please complete the action plan below (An example is provided in order to help you)					
Number	Action	Required outcomes	By who?	By when?	Review date
1	Prior to transition to new service, ensure that face-to face briefings take place with service users, new provider and old provider to agree transition arrangements	➢ Service users and families feel reassured about what is going to happen next ➢ A list of potential risks associated with the transition to be drawn up following briefings and these risks managed	All Age Early Help Service Manager	31st January 2015	11th February 2015
2	Arrange double-running funding for drugs & alcohol and mental health service users	Current services will continue alongside the development of the All Age Early Help Offer. This provides a 'safety blanket' if the All Age Early Help Offer does not immediately begin operating at full capacity and impact.	AED – Public Service Reform; AED – Adults and Commissioning	1st October 2014	30th November 2014
3	Staff training and development plan in place and implemented to ensure as many in-house staff and staff in aligned contracts are trained before 1st April as possible	There will be a greater opportunity for the new service to hit the ground running if staff are already trained	Operational Change Manager – Public Service Reform	Plan by 1st October 2014 Implemented by 31st March 2015	31st October 2014
4	Monitoring and evaluation process	This will ensure that we regularly test the impact of the All Age Early Help Offer and are in a position to identify and address any emerging issues as soon as they arise.	Lead BIU officer for Public Service Reform/Service Manager, Information & Improvement, Preventative	Interim plan: 1st October 2014 Final plan: 23rd	30th November 2014

			Services	December 2014	

5	Amend specification and service	This will ensure that the feedback is	Strategic Change	1st October	30th
	design, in line with summary above	represented in the detailed design of	Manager – Public	2014	November
	following service user consultation	the new model	Service Reform/Operational Change Manager – Public Service Reform		2014

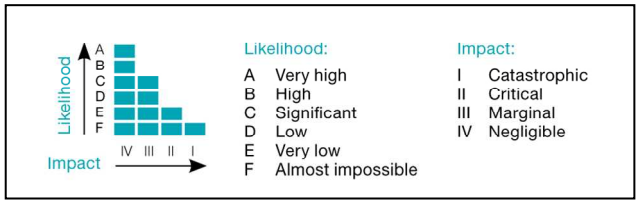
Risk table

Record any risks to the implementation of the project, policy or proposal and record any actions that you have put in place to reduce the likelihood of this happening.

Ref.	Risk	Impact	Actions in Place to mitigate the risk	Current Risk Score	Further Actions to be developed
R1.1	There are no examples of such large scale transformational change in the public sector relating to these types of services and groups of people – previously it has been at a relatively small scale, in relation to specific cohorts. This degree of change is therefore new and it is possible that models that were successful at a small scale may not work with larger	**High**	1. Undertaking consultation with a wide range of service users and stakeholders to identify anything we may have missed. Changes made as a result are summarised above. 2. We will put in place a robust evaluation process to ensure that we regularly test the impact of the All Age Early Help Offer and are in a position to identify and address any emerging issues as	**CII**	Currently planned actions are thought to be sufficient

	numbers of families. This could result in families receiving a less good quality service than they currently do.		soon as they arise. This is summed up by a service user comment that 'I don't think you've forgotten anything, but we won't know until you try'.		
	During the transition period, when some services are ending and the new one starting. During this period, we will need to ensure that robust plans are in place to continue supporting people who need services as they transition from one service to another.	**Medium**	We are contacting all current providers to identify service users that they are supporting and anticipate will continue to need support post-1st April. An individual plan for each service user will then be developed in full consultation with the old provider, new provider and service user.	**DII**	Currently planned actions are thought to be sufficient
	This is a significant scale of change without a blueprint: it is possible that we will not have thought of everything when the service 'goes live' on 1st April	**Medium**	Staff are already being trained to work in the new way, so there will not be a sudden shift required on 1st April 2015. Many current staff will continue to be employed in the new model and will therefore continue to deploy the considerable skills they have developed. We are 'double running' services for the most vulnerable groups – people	**AIII**	Currently planned actions are thought to be sufficient

			with mental health problems and people reliant on drugs & alcohol, so that current services will continue alongside the development of the All Age Early Help Offer. This provides a 'safety blanket' if the All Age Early Help Offer does not immediately begin operating at full capacity and impact.		



Appendix 1: Summary of evidence

The design of the new delivery model is based on the observation that:

- People's behaviours and expectations drive their use of public services – and at the moment, these behaviours and expectations are placing unnecessary demands (and therefore unnecessary costs) on public services.
- People's behaviours are heavily influenced by their social networks, and the social norms within those networks. For some, these networks are non-place-based – for example, communities of interest and friends and family living a long way away. However, for many people, place-based social networks and social norms are important – customer insight work suggests that this is particularly the case in Oldham.
- People's behaviours are also heavily influenced by the way the public sector interacts with them – by our structures, processes, and staff behaviours.

In order to fully understand this picture, we have conducted analysis from a range of different perspectives to help us understand both what needs to change, and the strengths we already have in our communities and services that can be built upon.

This analysis is not yet complete, but the following summarises the key messages to date. In order to break into this analysis, we focused initially on cohorts and geographies that professionals working in Oldham highlighted as being likely to cause high demand. These were:

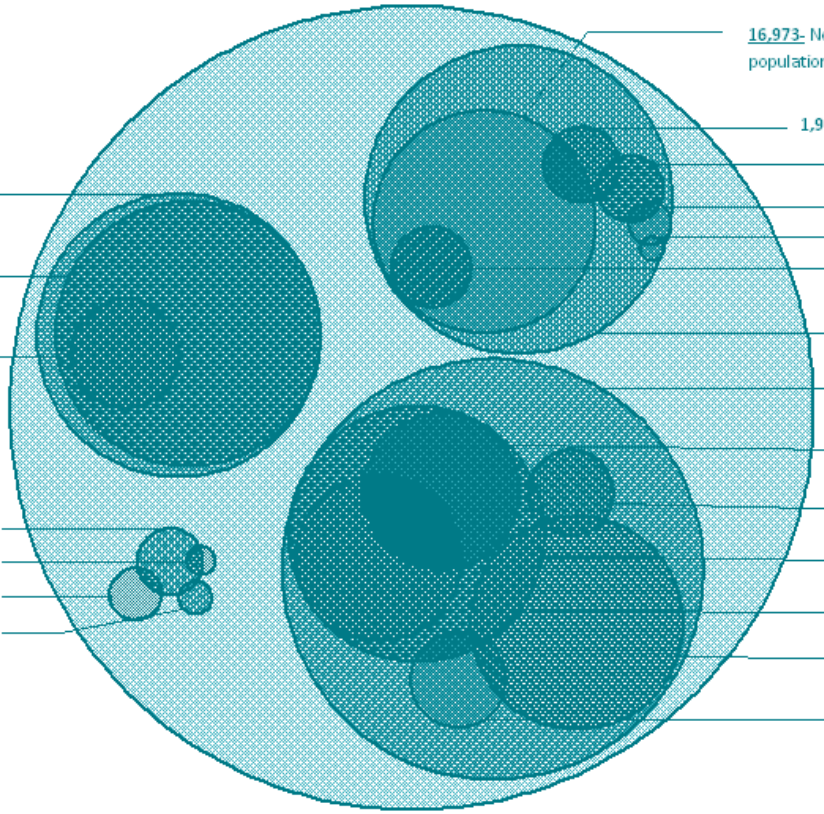
- Population-wide summary of groups placing demand on the public sector
- St Mary's and Coldhurst – two of our most deprived wards;
- Families with complex dependencies;
- People who were out of work;
- People dependent on drugs and alcohol;
- Older people using adult social care services and community and acute health care services;
- Families with 0-19 year olds;
- People regularly calling the Police.

The following draws on key findings from this analysis:

<u>Population-wide summary of groups placing demand on the public sector</u>

The following diagrams summarise the cohorts of people within Oldham who are placing demand on our systems. This is shown as two diagrams simply for ease of presentation.

Total Population: 224,897



Carers

28,422- Total Known Carers

24,312- Total Unpaid Carers

4,110- Total Registered Carers

Social Care

945- Children in Need

272- Child Protection

1,580- Children in Social Care

363- LAC

Older People

16,973- No of A&E attendances (aged65+ pro-rated on population basis i.e. 15% and uplifted by 5% due to cohort)

1,910- Community Based Service

1,430- Home Care Service Users

670- Number Accessing Reablement Services

190- Extra Care Housing

2,249- Ambulance call outs for falls (treated at the scene)

32,953- Total 65+

Younger People

62,300- Total 0-19 Population

23,000- 0-19 A&E Attendances

2,640- Children receiving Speech and Language Therapy

8,549- 0-5 A&E Attendances

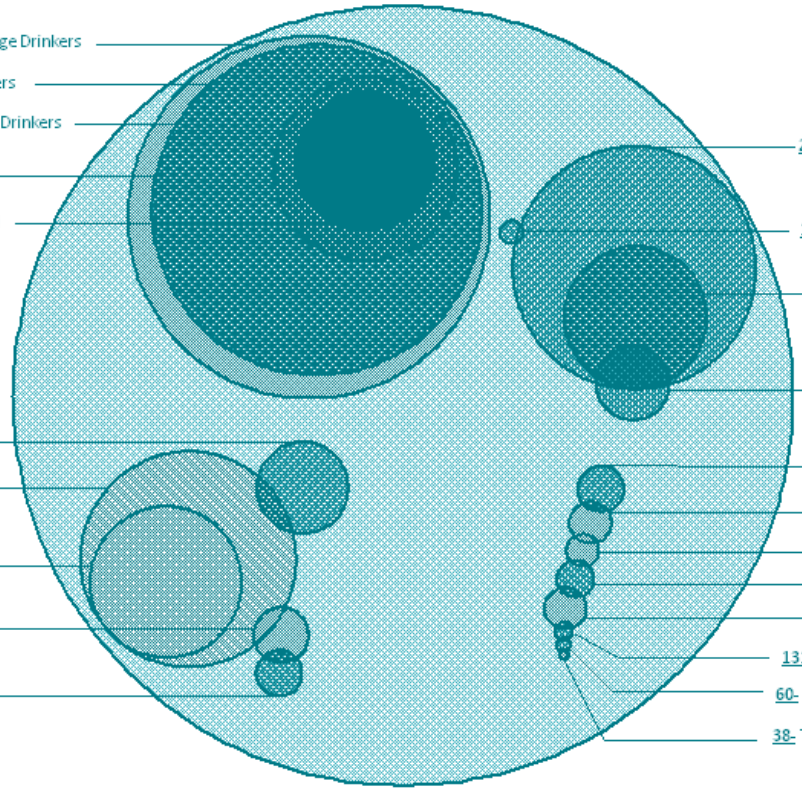
9,400- 19 Emergency Admissions

15,865- Dependent Children (0-19) Living In Poverty

3,236- Police Call Outs in Last 12 Months Associated with Children and Young People

TOTAL POPULATION: 224,897

Drugs and Alcohol



48,000- Binge Drinkers
40,000- Increasing Risk Drinkers
12,500- Higher Risk Drinkers
7,000- Dependant Drinkers
1,913- Individuals in Drug/Alcohol Treatment (ESTIMATE)

Benefits

22,164- Out of Work Benefits
168- Households affected by Benefit Cap
7,480- JSA Claimants
2,035- Youth JSA Claimants

Health

3,000- Adults registering with the Stop Smoking Service
17,000- Number of Visits to the integrated sexual health service (all ages) Per Year
8,300- Number of Visits to Brook young people's sexual health service (under 21) Per year
1,166- Adult Average of accessing community physical activity sessions
820- Numbers accessing healthy weight programmes within the Health Improvement service per year

Troubled Families

746- Total Number of Troubled Families
586- Number of Troubled Families Being Worked With
437- Troubled Families with DWP Benefits
544- Troubled Families with Crime Issues
649- Troubled Families with Education and Attendance Issues
131- Troubled Families Associated with Social Care
60- Troubled Families with Common Assessment Framework
38- Troubled Families in Youth Offending Service

Demands placed on public services by people's behaviours and expectations

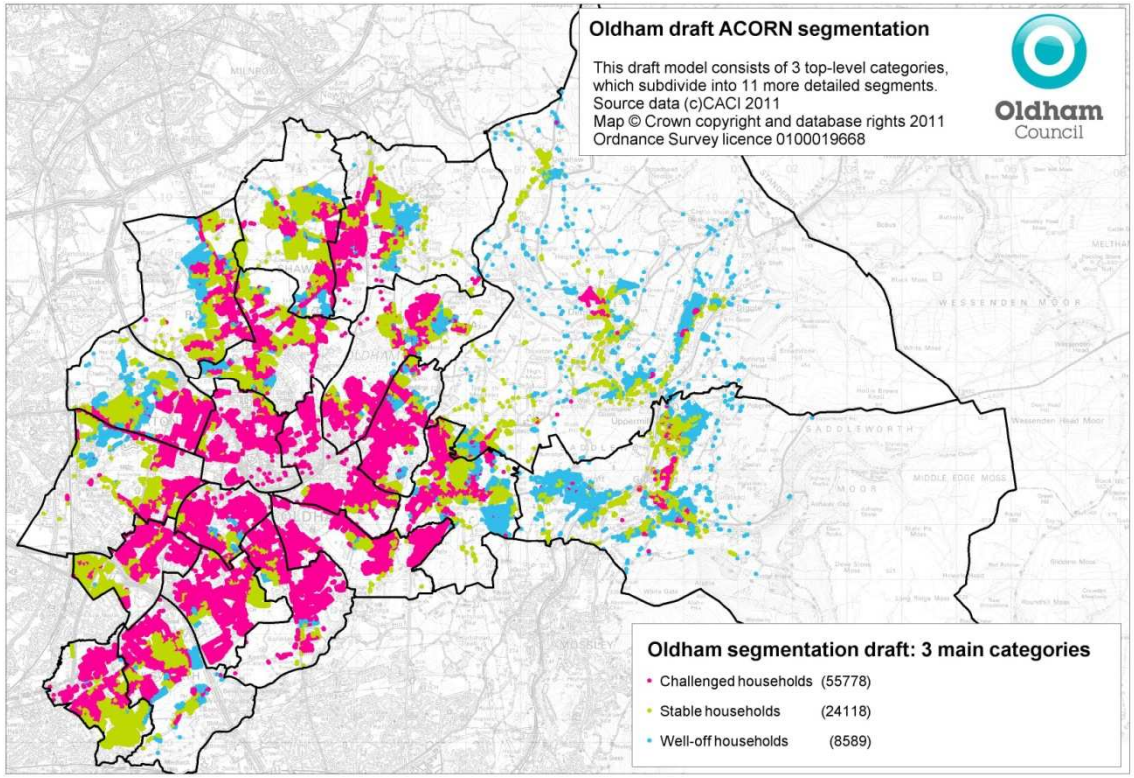
The analysis in St Mary's and Coldhurst has highlighted that people living in these areas exhibit numerous behaviours that are likely to be leading to a high demand on services:

Behaviour Evidenced	**Impact on outcomes**	**Likely Service demand**
Financial difficulties	Higher numbers reach a crisis point where they feel unable to cope; Higher levels of relationship problems, sometimes escalating to domestic violence; Higher levels of mental health problems Higher levels of drug & alcohol problems	Extra collection costs for council tax and social housing rents as people who struggle to manage their finances are less likely to pay in a timely way, or at all; More pressure on emergency support e.g. Crisis loans, food banks; More pressures on social care, family support; More pressures on specialist services e.g. Mental health, drugs & alcohol treatment
High smoking rates	Poor physical health; Often indicates low levels of mental wellbeing	High hospital admissions More need for primary health care More need for support in changing behaviours to stop smoking
High self harm/mental health issues	Lower likelihood of being in work Often indicates low levels of self confidence, self esteem and resilience	Higher levels of benefit payments High demand on mental health services More need for wellbeing services to support people in developing life skills to have stronger mental wellbeing
Low qualifications and in some areas low engagement in lifelong learning	Higher levels of unemployment Poorer language skills Poor mental and physical health Greater likelihood of involvement in crime and ASB	High numbers of benefit claimants More translation costs Greater demand on primary and secondary health care and social care Greater demand on police
Low Early Years Foundation Stage results	Poor child development, often symptomatic of poor parenting Greater likelihood of poor physical and mental health for both children and adults	Higher likelihood of referrals to and support from social care Greater demand on primary and secondary health care
Fly tipping	Poor quality physical environment Often has impact on people's aspirations, motivations etc, potentially supporting a cycle of long term unemployment etc.	Clean up requirement for environmental services Potential knock-on impact to demand on all other services identified above

Equally, the findings highlighted that these high demands tie in closely with the social norms and attitudes that are prevalent in those areas:

Issue identified by professionals working in St Mary's and Coldhurst	% of front line staff identifying as a big or very big problem	Comment
Drug and Alcohol misuse in the household is an issue	76	Evidence shows that this is a huge issue in some parts of St M & C in terms of hospital admission.
Financial attitudes changing- younger people borrowing beyond their means	73	This is supported by and supports the acorn data on pattern of debt and unmanaged debt. Leads to higher debt levels.
Alcohol abuse and violence at home	70	Causal factors often the sense of a lack of choice and control - financial problems, poor housing, low self-esteem. Feeling that the system works against you.
School readiness: children start at a lower level at school	70	Matches foundation stage evidence. School outcomes will be poorer in these wards, leading to poorer employment outcomes.
De-flated-no aspirations and lack of belief that things will or can get better	70	Matches Acorn evidence. Impossible to link to service demand specifically, but would make people less likely to engage in universal services (and therefore use higher end services when at crisis point). Supports need to build confidence and capacity in communities.
Overcrowded housing. Older and young people hanging around outside with nowhere to go	67	RSL work has identified reactive issue with young people clustering around tower blocks and other locations, public drinking etc.
Distrust of childrens centres and social services - 'take our kids'	63	May mean early opportunities for less expensive intervention are missed.
Lure of making quick money to then do something legitimate in longer term	62	Likely that for every young person who successfully manages this, multiple young people end up involved in crime for the long term.
Communities only request support when they are at crisis point	60	May mean early opportunities for less expensive intervention are missed.
Poor standard of housing impacts on behaviours and sense of ownership and community	59	Possibly also impacts on aspirations. Means people are less likely to be involved in community action. Supports case for alignment with capital investment.
Older generation feel they can control younger generation but younger generation don't respect them	57	Intergenerational changes=social issues=reactive costs. More older people costs, more financial support, more crime, etc
Seeking Instant gratification- looking for immediate service response	56	Increased dependency. Less forward planning could again mean it is less likely that early interventions will be sought out / engaged with
Perception of own mental health precluding from engagement in work/ activities etc	55	Unaddressed issues likely to compound problem, and result in poorer outcomes, and draw on higher-end services in the longer-term.
People making money legally in the area tend to move out. Many people with nowhere to go	55	Exacerbates the scale of the problem over time. In turn, this re-enforces entrenched social norms, as role models of positive norms become less frequent.
Low level crime doesn't get reported	55	May mean early opportunities for less expensive intervention are missed.

Only by changing these social norms and attitudes are we likely to significantly impact upon the demand placed on services in this area. The following maps summarise the findings from ACORN analysis across Oldham, showing a high proportion of households that have a high likelihood of experiencing complex dependencies based on the ACORN classification. This suggests that the types of issues highlighted in our analysis of St Mary's and Coldhurst are likely to be widespread across much of Oldham. It therefore emphasises the need to understand further the range of issues and behaviours that are driving poor outcomes for residents and high demand on services across other neighbourhoods in Oldham, not just in St Mary's and Coldhurst:



Social and community networks as influencers of people's behaviour

Our work to date has demonstrated the significant impact that a person's friends, family and neighbours have on their attitudes and behaviours – if the influences from these trusted people who they see regularly are at odds with the messages being received from public sector workers, there is little likelihood that the public sector messages will be heard, remembered and acted on.

Social Networks Analysis undertaken in St Mary's and Coldhurst has highlighted that there are strong geographically based social networks within our communities. There are relatively high levels of connectedness within relatively small geographic communities – and relatively few links outside these communities. This is partly because the people living in the area are less likely to go away to university, or travel far for jobs. This can result in relatively insular communities; but it also provides a strong mechanism for community support, resilience and change. This has been reinforced by recent work to map community assets and voluntary and community groups operating in communities across Oldham – this has demonstrated that there is a wealth of community activity, and that many people in Oldham are prepared to commit a lot of time and effort to contributing to their local area.

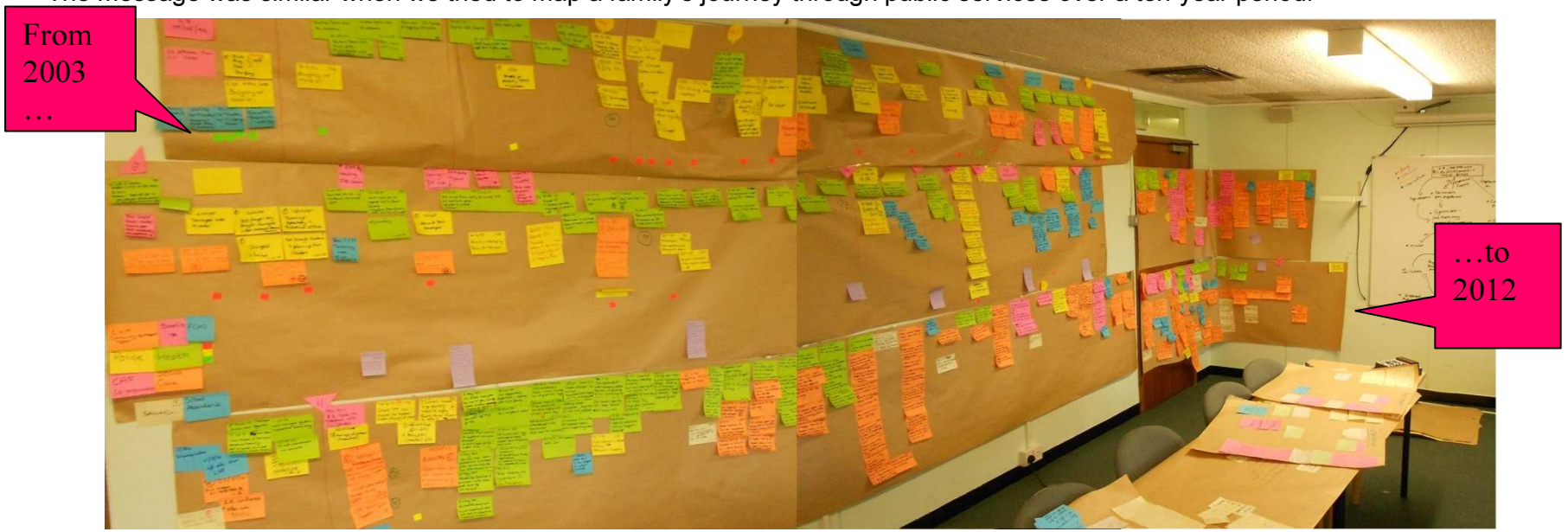
Values Modes analysis has also highlighted a critical point: in terms of the ways that people in our communities think and are motivated, people living in St Mary's and Coldhurst are incredibly homogenous, with very high levels of people (44%) being socially conservative 'Golden Dreamers'. This is particularly interesting in light of the fact that the public sector workers working with these families are predominantly 'transcenders' – or open to social change. They therefore view the world very differently, and hold different values to, the people they are delivering services for. This highlights the need to work with the community – building on the significant strengths and networks in the community, and recognising that our priorities are rarely the same as our communities' priorities. If we continue a paternalistic approach where 'the public sector knows best' and designs services accordingly, we will never succeed in influencing behaviour change.

<u>Public sector structures, processes and staff behaviours influencing the behaviour of individuals and communities</u>
There are three key messages that we have taken from our analysis of public sector systems, processes and staff behaviours:

1. Our systems are overly complicated and do not encourage or enable people to self-serve:
The following picture shows a snap-shot of some of the public services operating in Oldham, across the public sector:

Each post-it note in the picture represents a service. We attempted to pull together all the information to work out the pathways and structures sitting behind and linking all the services on offer - but we failed. It appears that there are no consistent pathways linking our services. We were unable to understand the links, so it seems unreasonable to expect the public to effectively navigate the services for themselves.

The message was similar when we tried to map a family's journey through public services over a ten-year period:



A post-it = a contact or intervention

Police/ Community Safety

Health

Barnados

Social Care

Housing

Community Outreach

Attendance Service

Housing Benefit

Family Intervention Project

CAF Co-ordination

2. We do not always recognise when people have small problems, which can mean that people reach crisis point before we recognise that there is a problem and provide support – and then it is often too late.

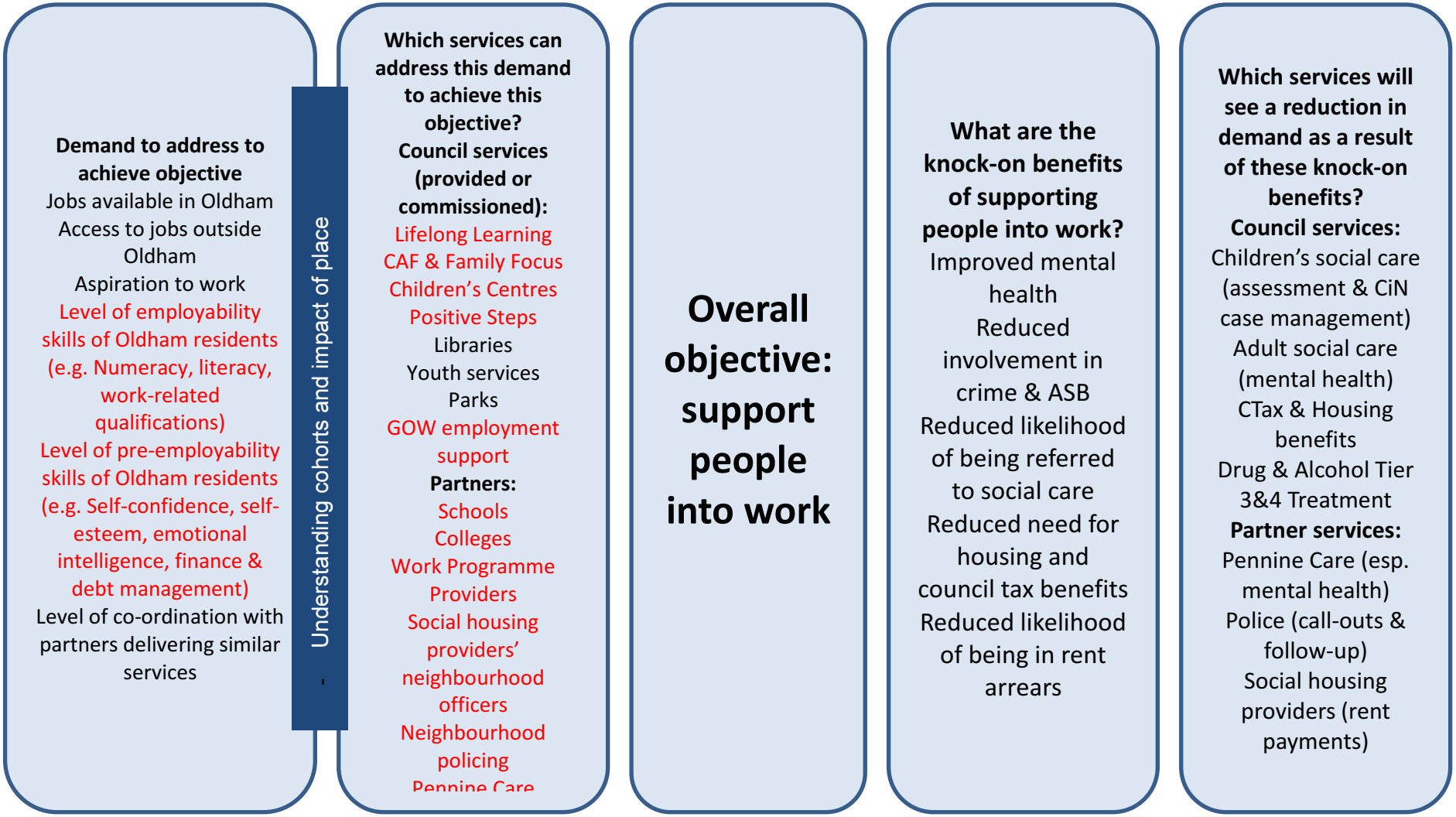
The (Oldham-wide) cohort-based analysis has already made it clear that there are huge groups of people that are placing high demand on our systems, who we are providing little or no support for – until they reach crisis point. For example, when analysing police demand, it soon became clear that around 10% of calls were generated in relation to just 57 households. Our initial assumption was that these would be 'frequent fliers' in other services as well, and were initially surprised when this proved not to be the case. However, on further analysis, it became clear that the reason for this was that the repeat callers were people who – although experiencing multiple and complex problems – did not hit the thresholds of any service for support. The same seems to be true anecdotally in relation to A&E and the Registered Housing Providers.

Equally, the majority (60%) of people with drug and alcohol problems who are known to the Police have only come into contact with the Police once – so will not have met thresholds for drug and alcohol treatment And, because the majority of people re-enter work after three to six months, there is currently little or no effort made to identify at an early point the handful of people with complex barriers to work

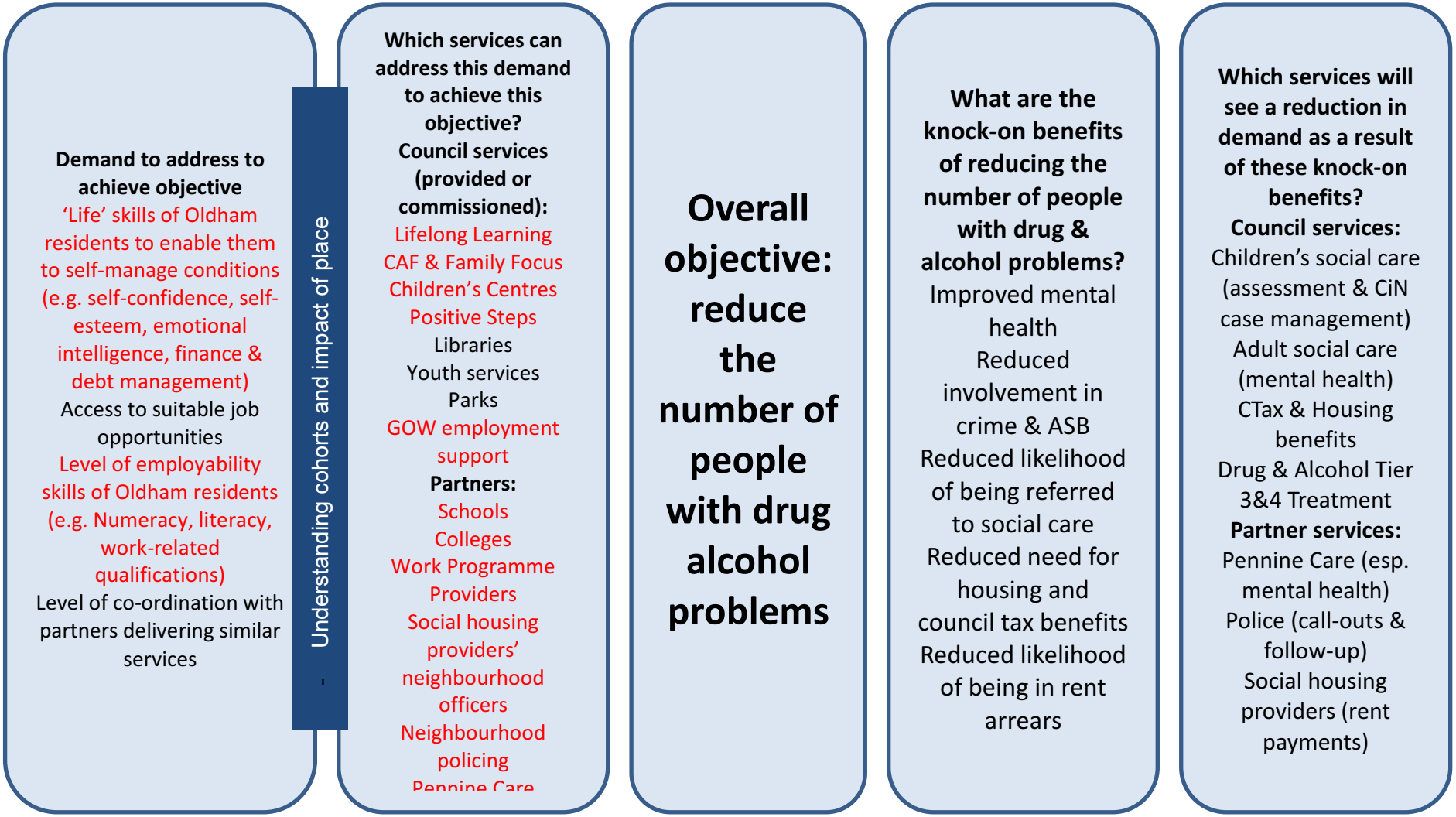
3. These issues are embedded in the way we work – from our processes, structures and staff behaviours. Changing it requires a wholesale change in the public sector offer, not just tinkering around the edges.

As our work has progressed, it has become apparent that we are much better at identifying and focussing onthe differences in what we do rather than the commonalities we have. The following examples show how we have focused on different groups of people being 'different' and having 'different needs' when, in fact, the needs are very similar:

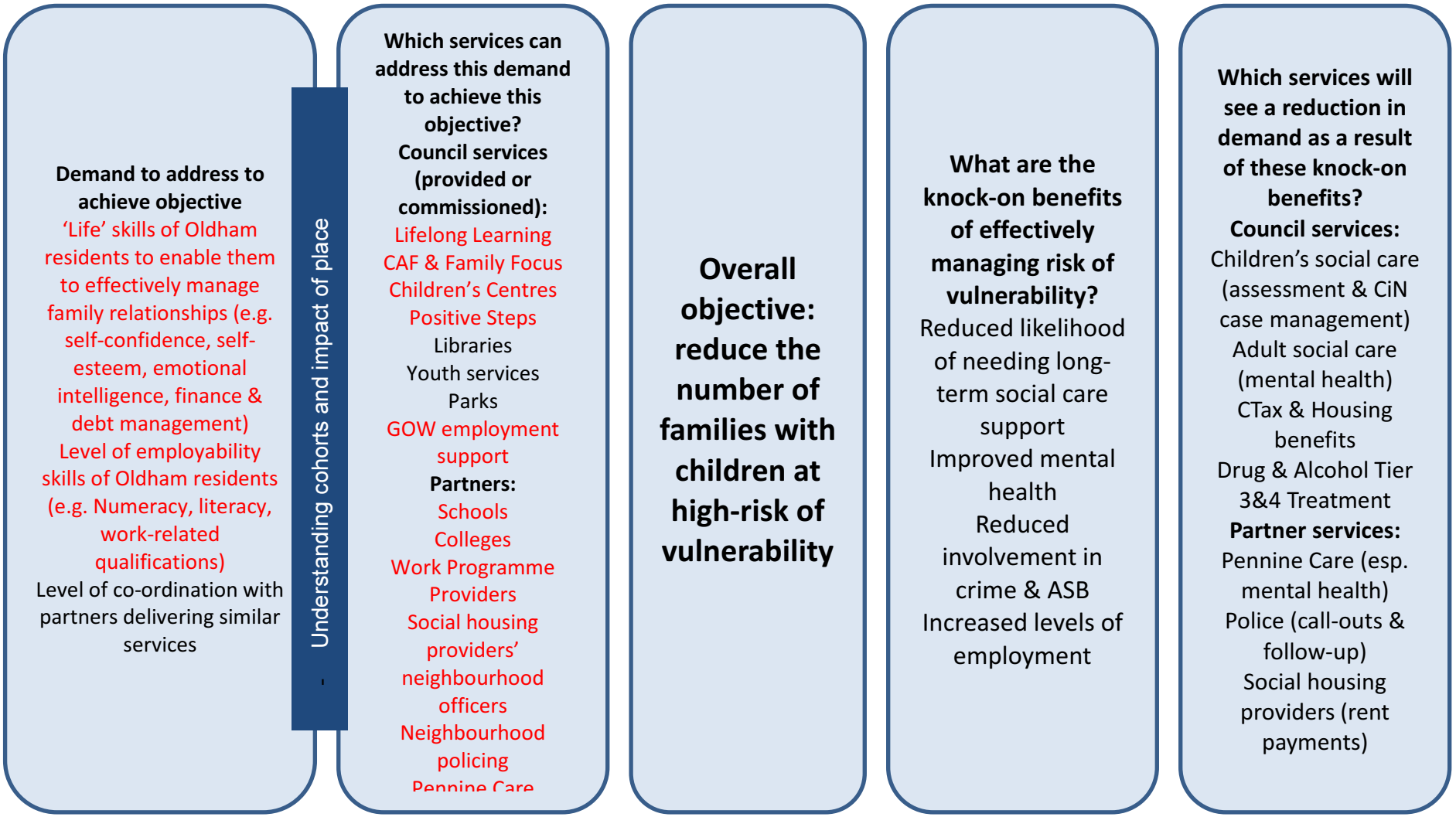
Supporting people into work



Understanding the demand chain: reducing the number of people with drug and alcohol problems



Understanding the demand chain: reducing the number of families with children at high risk of vulnerability



Appendix 2: Evaluation report: please see separate attachment

Appendix 3: Consultation and engagement

Log of partner and stakeholder feedback

Log of Engagement and consultation undertaken on All Age Early Help Offer

Date	Group engaged/consulted	Person delivering message	Key messages delivered	Key feedback/comments made	Proposed changes to All Age Early Help Offer in response to feedback/comments
21 May	Society Works event	Ed Francis, Gerard Gudgion & Liz Hume	Overall model shared – RAG rationale, plus A3 draft overarching model. Explained in context of cuts and therefore that no new money, so re-focusing existing funding.	Could we work with VCS to add value to our contract by recognising their potential for attracting in additional funding? Query raised re how we will ensure that good work by small organisations isn't lost in a bigger commission	Build into specification a request for track record of attracting additional match-funding, and commitment to using it to deliver on this offer. DONE Ensure specification allows for a range of smaller providers to

					work together. DONE
11 June	Society Works meeting	Gerard Gudgion	Briefed on emerging proposals and plans for further development over the summer	Positive but wanting to see more detail	None
26 June	Dr Patterson	Gerard Gudgion, Liz Hume	Shared emerging delivery model (A3 summary).	Promising and exciting Key opportunities to work together as Dr Patterson is developing something at a slightly lower level managed within the GP surgery, so could work together on patients who need more support than he can offer.	Agreed to develop a joint consent form Offer engagement training for staff from the surgery Use engagement workers when they start to work alongside Dr Patterson on some cases to see how we can work most effectively together.
27 June	Hayley Summers, LINK Centre	Liz Hume	Shared emerging delivery model (A3 summary) and overall rationale, particularly focusing on	Felt was a positive move and the focus on prevention welcome. Opportunities for working together further to test potential for volunteers as life	Agreed to meet again to develop model further.

			opportunities for expanding volunteering	coaches.	
7th July	Dr Andrew Vance and Marlon West	Liz Hume	Shared emerging delivery model (A3 summary) and overall rationale	From their perspective, common underlying issues are boredom, and community perceptions of what is normal e.g. work. People getting into work is key. Would suggest asking A&E to refer from their frequent fliers list, or any one-off attendees that cause concern Communications links between everyone involved in delivery are key Passing people around and referring on has to stop	Explore with Jon Bloor and Gerard Gudgion how to put supporting people into work central in the model. Incorporated work clearly in spec. Arrange meeting with A&E to explore referral opportunities – include in Maxine work plan Key risk identified in relation to communication between in-house and externally commissioned portions of the service. Key focus of model is

					intervention, not simply assessment and co-ordination – ensured is clear in specification and service design.
				Decision on what to do and initial contact would need to be same day or as close to that as possible. Need to emphasise for staff that it is better to do 10 pretty well than one perfectly.	Key targets built into specification with tight turnaround and reporting requirements for this.
				In assessments, need tools and training to encourage people to be honest.	Covered in engagement training
				Need to be clear that stays a single referral and co-ordination point, whoever is delivering or many of the benefits of integrating will be lost.	This is still the case for referring agencies. We have had a lot of feedback that it needs to be more flexible for service users, so there are now more access points for self-referral.
				If a case needs re-opening, needs to not require another	Will build into

				GP referral. Need a really clear list of what is available outside the offer for anyone we cannot help within the offer. Needs to be clear contract with patient that they do things for themselves as well e.g. physical activity etc.	MASSH processes. Online directory being developed by the Commissioning team Clear contract built in at start of intervention stating this.
8 July	Trade Unions	Jill Beaumont, Stewart Hindley & Liz Hume	Overall model shared, including rationale. Focus on prevention not cure, understanding root causes of problems. Not a clinical offer. Clear that wasn't new money. Talked about bringing some services (e.g. FFT in-house) to	Comments and clarifications on the model: - Make sure we avoid duplication and routes into specialist services are clear. - Clear single assessment is key. - Need to clarify relationship to safeguarding element of MASH.	Specification being drafted as a joint spec, not copying and pasting all contributors together. There will be two telephone numbers – one for safeguarding, one for solutions; additional staff will be included in the MASSH to support

			develop detailed offer initially before putting out to tender. Clear would be implications for internal staff – changing role, changing management, changing salaries; potentially some current roles redundant. Discussed re not fully decommissioning all services in year one, but doing some double-running e.g. mental health.	- Advocated having a period when we are tightly monitoring impact and developing and changing if necessary. Queries re staff implications: - Clarified if Pennine Care staff would be eligible to TUPE – we thought not as not a clinical model, but will give them the opportunity to discuss this. - Need to ensure regular briefing sessions for internal staff. - Need to ensure implications for staff are clear and that it is clear what has and has not been decided.	the solutions element of the work. We absolutely agree – a detailed monitoring and evaluation framework is in draft and can be shared as required. TU reps to be invited to staff briefing 11th July
10th July	Mental Health Commissioners and Providers	Jill Beaumont & Maggie Kufeldt	Introduced All Age Early Help Offer high level model and outline	Overall support for the model. Key concern focused around (a) funding implications for Pennine Care; (b)	Further meetings scheduled over the summer to explore more detail

			of funding implications.	development of pathways to ensure synergy between the All Age Early Help Offer and the Pennine Care service provision. Agreed a further series of meetings over the summer to explore these in more detail – see below.	
11th July	Internal staff affected	Jill Beaumont & Gerard Gudgion	Briefing on early plans and arrangements for engagement over the summer	Interested to see more detail	Further meetings scheduled over the summer to explore more detail
24th July	Children's Safeguarding Board Early Help Monitoring sub-group	Gerard Gudgion	Detailed how the AAEHO would work and what impact that would have on monitoring capacity.	All were supportive of the approach	An action plan around early help monitoring included the planned new proposals. Raised issue around clarifying link to Safeguarding – meetings with Kim Scragg and Paul Cassidy have since taken place to do this
30th July	Community Safety	Jill	Jill Beaumont	All partners were happy with	None

	Partnership	Beaumont/Anna Berry	described the new early help model and described the purpose.	this process.	
23rd July	Oldham Leadership Board	Jill Beaumont & Liz Hume	Introduce offer, inform of consultation process and invite initial feedback	Overall support. Some specific queries raised: Richard Spearing question re working together on where fits with work doing with them, but overall makes sense Richard also asked question about how fits with CCG commissioning intentions Cllr McMahon, need to make what do human and tailored around people's real lives. Cath Green question about whether it is still about reducing demand on services.	Meeting arranged to discuss – see below Denis answer that this is logical, with clear inputs and outputs. That have also got learning from health re numbers of people going round helping the same person, so fits with that. Service designed around people, not presenting symptoms Answer (combination

					of Jill and Cllr McMahon) that will expect to see reductions in reactive services and this is the premise, but not waiting on this to get funding together as it's a good thing to do anyway if we can improve outcomes within existing resources.
24th July	VCFP	Liz Hume	Discuss initial proposals on the offer in detail and record feedback	Overall support. Some specific queries raised: - Is 'peer mentoring' too specific?	Now just refers to mentoring
July-September	Pennine Care: mental health providers follow-up conversations	July: Stan Boaler: Jill Beaumont July: Caroline McCann: Jill Beaumont, Liz Hume, Mark Noble	Discuss initial proposals; client numbers; potential pathways into other Pennine services; overall impact on Pennine	Stan feedback that it was not innovative to only look at 200 MH clients being included in the model.	Numbers of clients changed in response to feedback from Stan. Need to further look again at the numbers as we go forward. Also re impact on primary care if stepping

		11th August: Liz Hume, Maggie Kufeldt, Gwyneth Jones, Neil Fallon August: Jill Beaumont, Maggie Kufeldt, Keith Jeffries, Jacqui Matley 2nd September: Maggie Kufeldt, Jill Beaumont, Keith Jeffries, Gwyneth Jones, Neil Fallon, Caroline McCann		Questions around evidence base, share next week when qualitative and CBA elements included. Concerns around impact on services, especially with savings coming out as well.	people down. Agreed could use the double running next year as an opportunity to really test this in practice, and start working more closely in detail on what the opportunities are and how this would work in practice. In line with remodelled service in Pennine being up and running from April 2015. Need to work on how AAEHO can contribute. To be set up as soon as possible and link in with Colin Elliott from council care management review perspective. Ahare evaluation framework draft so can see if will capture info needed, and let us know if need to

				IAPT capacity links, agreed that if we can get people to the point where they are ready and willing to access help. Would be helpful to agree what we will do to get people willing and able to enter treatment.	add any more into it. Steps re transitional arrangements for CAMHS and Adults, and double running to mitigate risk to people currently in services. TCA bid and reserves identified for this. Across adult mental health, drugs and alcohol and CAMHS. Need to develop formal pathway for this
1st August	Internal staff affected	Jill Beaumont & Gerard Gudgion	Staff who couldn't make the first meeting briefed on the approach and engagement plans	Interested to see more detail	Further meetings scheduled over the summer to explore more detail
18th August	Workshop discussion for all providers and stakeholders	Jill Beaumont & Maggie Kufeldt	Launch the formal consultation and seek detailed	See separate feedback sheet	

			feedback from a wide range of stakeholders		
20th August	Liz Windsor-Welsh	Liz Hume	Initial feedback and reflections from 18th August event	Key questions, are disability and older people in scope? Why is it being put out as a single tender? Which elements are to be kept in house and which external delivery?	Confirmed no, not as specific cohort groups, although if people in those categories also have behaviour change needs, they could access the service. To drive behaviour change for organisations and workers, and discourage bids that are just bringing together a collection of what we already have. Probably solutions hub and intensive case work in house and rest external, although some in PSO and Threshold contracts
22nd August	Internal staff affected	Jill Beaumont & Gerard Gudgion	Further detail shared and	Positive about the overall approach.	

			feedback from staff having considered the proposals	Queries focused on where individual staff fitted into the model.	Agreed this couldn't be specific until the model was signed off and would be made clear in the formal consultation starting 3rd October.
28th August	Chair of LSCB (Henri Giller), Susan Harrison and Maria Greenwood	Jill Beaumont, Gerard Gudgion	Informal discussion to brief the new Chair of the Adult's and Children's Safeguarding boards on the proposals	Supportive of the approach. Wanted LSCB to have a closer oversight as we move to implementation, although did acknowledge that members of the Board are already all individually involved	Take to the Board as a regular item, which Maria Greenwood would take.
22nd August	Health Improvement Service managers	Gerard Gudgion	Informal discussion to explore the detail of the new offer and the links to the existing offer from the health trainers.	Wanted clarification on the day to day operations of the model.	Pennine Care agreed to send case studies to demonstrate their current activity.
4th September	Fauzia – Fatima Women's Association	Liz Hume	Informal discussion to enable Fauzia to ask more detailed	Wanted to emphasise importance of outreach and engagement activity - have a lot of experience of getting people to engage with events. Do get	Outreach and engagement activity built into model as a specific element

			questions and provide feedback	people to take up. Often there is a problem with people coming and going. Offer needs to provide stability and volunteers. Good at getting people who are hard to reach. Would say that most of the time people do not self refer for that type of support. Would really support the need to build up the outreach and engagement and community connections and being easily accessible. Needs to have ability to engage with a whole range of different communities. Need to have a base in the community.	
9th September	Health and Wellbeing Board	Liz Hume	Raise awareness of consultation	Welcomed and Chair encouraged people to attend the event on the 19th September	NA
11th September	Action 4 Children	Liz Hume	Opportunity to discuss in more detail and answer specific queries relating to the proposals	PbR concerns raised – wanted to check whether this was something we were considering Supportive of the overall approach and principles, and welcomed the emphasis on early intervention and prevention Supportive of having 'phased' boundary around cases being	Currently not, certainly not for the majority of the model, due to uncertainty setting up a new model

				open to both social care and the All Age Early Help Offer Outcomes stars, initial scores not representative as tend to make things look worse, so need to make sure we factor this into planning, decision-making and evaluation Consider retaining multi agency meetings? Or some other way of sharing informal information that is less onerous but still encourages people to talk Transition in step up and down needs to be very clearly managed, would need some support from the agency who is doing the step down in order to make this happen effectively. So do not repeat what has already been done. Also to give people the confidence to do it. Transition arrangements over 1st April and ensuring no families who are receiving ongoing support are lost will be key	Feedback to Martin to incorporate into evaluation framework Reviewing meeting arrangements relating to District Family Panels, Operation Solution, Operation Challenger etc. Build in as requirement for Solution Hub to develop these arrangements. Arranging meetings

				Need to clarify relationship to Early Help Panels. Community development and community capacity links are key Escalation policy to challenge if needed re decisions on referrals	with providers who are being decommissioned to agree best approach to this Early Help panels key referral route in and step-down out – but Solution Hub needs to agree formal arrangements around this. Continue to link with Bruce Penhale and Alan Higgins on this. Need to build into operating practices of the Solution Hub
11th September	Xenzone	Liz Hume	Opportunity to discuss in more detail and answer specific queries relating to the proposals	Really positive in principle Volunteer role and good that not reliant totally on this. CYP who want to access services off their own back. Will need confidentiality.	Need to ensure that this is clearly

				Risks if get bad worker or don't get on with each other or if caseload badly managed. Raised concerns about it all going out as one tender rather than as separate lots.	specified as an option in the model, albeit still working holistically with young person – equally re confidentiality with an adult where necessary Need to plan in methods to manage this in operational processes Explained rationale and mitigation of sharing draft early.
11th September	Keyring	Liz Hume	Opportunity to discuss in more detail and answer specific queries relating to the proposals	Positive in principle Wanted to understand relationship of the All Age Early Help Offer to their current contract Queried whether their overall	Clarified that their funding is not currently being wrapped into the model – currently focusing earlier than Adult Social Care thresholds Clarified it would and

				model of support and developing skills across a spectrum of areas would fit with our approach	pointed out that they can still bid for additional business even though their current contract is not incorporated into the model
16th September	Eric Noi	Anna Berry	Provided an overview of the early help model and the consultation / procurement process	Queried how the smaller voluntary/community groups would contribute to the model.	No proposed changes
12th September	Operation Solution Board	Anna Berry	Provided an overview of the early help model and the consultation / procurement process. Also highlighted the links to project solution pilot and how processes would merge from the 1st April 15	Health agencies were keen to see the list of providers / services that were being pooled as part of the early help model. How will it fit into the services that CCG commission that sit outside of the early help model	No proposed changes
17th	Housing 21	Gerard Gudgion	Provided an	Very positive about the overall	No proposed

September			overview of the early help model and the consultation / procurement process.	approach and interested in being involved further as the detailed implementation progresses	changes
19th September	Wrap-up consultation workshop: all who have attended a previous session invited	Liz Hume & Margaret Rostron	Feedback findings from consultation and our proposed responses to what we've heard	Overall positive feedback and people felt that the comments that had been received during the consultation were well reflected and responded to in the summary documents Further points raised were: - Use simple language to sell to service users - Outreach/engagement critical for engaging difficult to reach groups - Need to ensure it is accessible to all communities - How does this link to welfare reform?	Accessibility to all service users has been included as a specific requirement in the specification. Many of the people who need to access this service will be affected by welfare reform – as part of the design, we need to ensure these

				- Looked After Children early help offered via CAMHS but with funding removed, what will happen to this group? - Working with young people when they're in school is positive. - Need to be careful that a hub and step up/step down model doesn't rapidly develop an impenetrable reception desk. - 'Prevention' is clearly at the heart of this model, which is excellent. - Are workers more skilled	people are identified and supported in relation to the welfare reform changes in addition to their other needs. We are now double-running the support for LAC for one year whilst we test the model. We have incorporated a range of other options for accessing the service, particularly through outreach, community groups and community settings, which should guard against this.

				in crisis response than prevention? Model relies on skills of workers. With funding reductions in specialist services, is there a gap between early help and specialist services? - Integrated training and awareness of others' roles will be key. - Domestic abuse, CSE and self-harming need to be prioritised. - Where will the improving access to psychological therapies service for children come from? - Provision for autism – if SEND is only included in phase 2, is there a gap of	See FAQs in relation to skills development These will certainly be key issues we would expect to be addressed within the offer. We are working with Pennine Care to agree appropriate pathways into the Children's IAPT. We also have a spot purchase budget where there is a particular need

				a year where funding will be redirected from CAMHS and the Early Help Offer not pick this up? - What support re training/consultation would be required from CAMHS? - What are the referral routes into CAMHS? - How will you ensure that any therapeutic type interventions are evidence-based e.g. parenting? - Need a strategy and vision shared with Oldham College &	identified. Autism is not currently commissioned by the Council from CAMHS – the only portion of the CAMHS service affected is the Council commission for tier 2 provision. This would need to be negotiated with the successful bidder. The MASSH will pass on any cases where the mental health issues are tier 3 or 4. Equally, CAMHS can pass any tier 2 cases to the MASSH. We have included guidance in the specification of the types of models and

				University – Early Years, health and social care education, training and qualifications and scope for development so the courses they offer develop the skills we need? - What are the staff retention strategies? How do you retain currently skilled staff? - If staff move to AAEHO or leave, how will the 0-4 offer be integrated or is the whole 0-4 offer commissioned? Would a percentage of the in-house work in the AAEHO be ring-fenced in the transition period? - Need to plan for families in transition. - With focus on adults as	techniques we would expect workers to be familiar with. We will work with Alun Francis to develop these links and specify opportunities and how we will take them forward. Good skills and training development, and good staff engagement so they understand what is going on. The 0-4 offer is only being commissioned from April 2016 – this gives us time to understand how the AAEHO works on the ground and to work in detail on these

				well, will safeguarding role be less clearly defined – will children get lost? - How would you know if it's not working – in three months, six months etc. Who would respond? - Staff working 24/7 – how would this work re contract, job descriptions and workers having commitments outside work?	connections before the 0-4 offer goes out to tender. See FAQs response. No – children will have a better offer because their parents will be supported as well, and that has a huge impact on a child's outcomes. We are developing a detailed evaluation framework to map this. This will be discussed in the restructure consultation for in-house staff.
19th September	Written feedback from Oldham Community Children's Services	Received from Siobhan Ebden by Michelle Heywood	Response to consultation materials	See separate document – response to written feedback	See separate document – response to written feedback

	(Pennine Care)				
19th September	Written feedback from First Choice Homes Oldham	Received from David Smith by Michelle Heywood	Response to consultation materials	See separate document – response to written feedback	See separate document – response to written feedback
19th September	Written feedback from Voluntary Action Oldham	Received from Liz Windsor-Welsh by Liz Hume	Response to consultation materials	See separate document – response to written feedback	See separate document – response to written feedback

Summary of service user feedback

All Age Early Help Offer: a service user consultation on the proposed approach

Context - The proposal

Many people and residents face issues in their lives that they need help to deal with. This could be anything from losing weight or giving up smoking or drinking to housing issues, debt and financial problems, domestic violence or unemployment.

We also know that many people are facing a number of these issues at the same time and, as a result, people are getting lots of individual advice and support for each issue from different organisations and services.

This can be very confusing and means that many people struggle to deal with the issues they are facing – leading to further problems and, as a result, more services being provided.

We think that introducing a single ‘all age early help’ offer could help.

This would mean that each person or family would have one contact who would work with them to tackle the issues they are facing. They would then work together to determine what support was required and what that support looked like. This could be anything from providing information to coaching and mentoring to 1:1 focused support for the household or referral onto specific services.

We think that this approach where we work with residents and across organisations would lead to better results for local people. It could also make huge savings for public services.

The consultation

The consultation took place across Oldham between the 18th August and 19th September attending and facilitating focus groups in community venues, targeting people who had experienced or were experiencing the following issues:

- Mental health issues
- Drug and alcohol issues
- Housing issues
- Behaviour-related physical health issues
- Domestic violence/relationship issues
- Parenting issues
- General family support needs
- People out of work with complex barriers to employment
- Involvement in crime (current or historic)

We had ideas about how we think the 'all age early help' offer should work. However, there is a lot of scope to change it and develop it.

To examine the proposed model we asked consistent questions, using the same themes and similar terminology:

- Do you think this model will help residents support themselves?
- What do you like about the model?
- What are the risks with the model? How could these be solved?
- What are the opportunities?

- Do you think it will be easy to access the service?
- What else would you like to know about the proposed delivery model?

We met and spoke to approximately 200 people within 29 groups. Overall the proposed model was very well received by the service users. During the focus groups participants consistently engaged in the group discussion and shared their views.

Five broad themes emerged based on the answers to the questions asked:

'**Things people liked & making a difference'** – there were 123 comments on what people liked and how they positively thought this way of working could make a difference:

- *41 people thought the whole approach was a 'good idea' although 12 of them had some reservations and concerns; 2 people felt we had thought of everything; 2 thought the model was easy to understand.*
- *8 liked the 'one stop shop'; another 13 liked the access, availability and flexibility of services; 2 thought 'self-referral' was good; whilst 2 thought the 'signposting and advice' helpful.*
- *7 talked positively about 'getting in early' another 3 suggested it was good to treat causes rather than problems and professionals and agencies having a wider view.*
- *11 people could see how this way of working could benefit them and another 6 could see the benefits for their family and friends; 1 said it might capture people who may be missed;3 thought it would help to build people's confidence; whilst another 3 said they would appreciate somebody to 'listen' and 'talk to'.*
- *Some people talked about service advantages; 1 said it would 'save time', another 1 thought people would be 'more aware'; 3 thought there would be less duplication of services; whilst 3 others thought it would save money.*
- *2 people could see the advantages of agencies and organisations communicating together; whilst 1 commented positively on them working together.*
- *4 people valued the consultation process, finding out what is 'important to people' and another said they appreciated the honesty about the 'cuts'.*

'The Hub' – The 'hub' was very important to people as they made 143 separate comments and questions:

- *1 person suggested that we drop the 'solution' from the title of the 'hub' as it gives the wrong impression*

- *13 people said they could access this service; 3 said they would not. 13 asked how they would access the service and what the referral process would be; whilst 5 wanted to know how long the service would be available for and another 2 asked how many times the service could accessed; 4 people had confidentiality concerns if accessing the 'hub'*
- *11 people wanted to know where the 'hub' would be; whilst another 30 suggested that it needed to be accessible for all; 4 commenting on the different community languages and specific accessibility needs; 2 asked whether this was a 24/7 service.*
- *26 asked how people would know about the 'hub'; 24 suggesting we needed good advertising and information that would engage people.*
- *8 showed concern about how long they thought they would wait for an appointment; 2 thought they may be kept waiting on the phone and 1 did not want an automated service*

'The workers' - were important to people as they recorded 52 overall responses:

- *9 asked who the 'Early Help' workers were; 17 questioned how they would be trained and what qualifications they would need; whilst another 8 wanted to know how much resources and how many workers there would be; 1 suggested that we needed good structures in place to support the staff.*
- *4 people asked how much time workers would have to give to people; 3 wanted to know whether it would be the same worker throughout.*
- *3 suggested independent support; whilst 2 wanted face to face meetings and another would like home visits.*
- *2 wanted to know how the workers would keep up to date on services and developments; whilst 2 stated it would be difficult to engage other services and partners.*

'**Service & delivery'** - *it was useful to see and hear the 137 responses people gave relating to the 'service and delivery':*

- *12 people wanted to know what would happen to existing services; whilst 5 felt services were being cut before new services had been put in place; another 6 asked who and how we would maintain the quality of the services.*
- *4 inquired about the 'implementation plan' and another 3 asked when it would happen; 5 questioned the process for disagreements and appeals; whist a further 2 asked what would be different.*
- *8 wanted to know how services would be funded, with another asking who would hold the 'purse strings'.*
- *13 suggested we needed good partnership working; another 10 suggested good communication; 4 wanted to know what the input from the voluntary sector would be; whilst 2 commented that we needed more 'conversations' with current frontline staff.*
- *9 people wanted service/agencies to respond when they say they will; another 4 suggested services/agencies do not always notice the 'triggers'; 1 thought that agencies would be reluctant to do the assessment and 1 asked whether the assessment would help with 'dual diagnosis'.*

- *9 people commented on the difficulties of families who 'don't engage'; 2 asked whether people could refuse and another 1 wanted to know what happens to those already in 'crisis'; 2 asked whether they would be turned away without the involvement of their whole family and 1 asked whether we would involve social care.*
- *3 people stated that all people need services not just those in 'crisis'; whilst 7 felt that some people would still not get services.*
- *4 people asked what support was available; 2 said they would be expecting 'solutions' to issues not 'advise'; 2 suggested whatever support services were available we ensure they 'work' whilst another had suggested there could be a 'back up' plan if things fail.*
- *9 commented on services that they felt had or would support them such as Children's Centres, Youth Services, DV counselling for children and 'drug' awareness in schools and colleges.*

'Community' – *There were a total of 18 responses involving the 'community':*

- *5 people suggested that it would be difficult to mobilise the community into doing things for themselves, whilst 3 commented on the input into community development needed.*
- *6 noted positively on changing community responsibilities, attitudes and behaviours.*
- *Another 2 wanted to know how we support community projects both existing and new.*
- *1 suggested that 'parents supporting parents' works and how we needed to recognise the diversity of the community.*

People also identified 'Cautions' and made 'general comments'

Cautions – There were 25 cautions and concerns:

- *3 people thought the idea and model was too idealistic; 1 thought the model would work in the early days but not in the long term; 2 felt they had not been consulted as much as they had wanted to be; whilst another 2 felt the decision had already been made; 2 stated that 'something was missing' but they did not know what.*
- *5 were concerned that it would be a 'temporary fix' or suggested it could something that never happens; another suggested difficulties in tackling ongoing service duplication.*
- *5 stated that people lose hope, as they never get help even when they ask for it; 4 people were concerned that those most vulnerable needed the maximum support even throughout the cuts.*

General comments – there were 52 individual comments following a wide range of subject areas and general statements. People talked about their own personal experiences with services and some of their perceptions of them. Others discussed their thoughts on why people faced difficulties and issues.

Detailed service user feedback

Consultation Feedback

Service: Children's Centre Coldhurst/Medlock/ Action for Children Spring meadows Children's Centres	**Date: 3rd September 2014 & 4th September 2014**	**Numbers attending: 6 parents 3 parents 17 parents**				
What I like?	**What need to be changed/or could make it better?**	**Have we forgotten anything?**	**Can you access this service?**	**What difference do you think it could make?**	**What else do you want to know?**	**General comments and ideas?**
It is good to find out what is important to people	I would like this to be in the children's centre	Be careful about making it too idealistic	Yes I think I can go to this service		How will people know about this service	Children need to have a bright future
This would be a good idea	We need more services e.g. 'stay and play's'	Communities are not ready for supporting each other	School is a great place to start for the hub to be	This could help me now, my house is overcrowded and my children are sleeping in the same room	Who /What are the Early Help people where will they come from	There is no disadvantage to finding out the problems and solutions

This will be good for me	Practical help for people with children to enable them to do other things such as volunteering, work, courses and have their children looked after – respite – child-care – babysitting service	I think it will be hard to get people to do things for themselves e.g. community things	Needs to be accessible in schools and doctors etc.	I need to move house but I don't want to leave the area, as my children are in school here	If I phone up how long will I be waiting - will I be put on hold	The Children's Centre did this for me
I'm glad about the honesty regarding the budget cuts	Professionals using wider view of supporting problems rather than just what they do e.g. stop smoking etc.	I don't want an automated service	How do people know about services?		Would midwives and health visitors use this? - Probably	I don't know where to go now
Good at cutting out the duplication Like the idea I am glad that you are taking the time	Problems with families who don't engage. Health Visitors should do	Cost of activities is prohibitive for some parents	There are things out there [particularly in the 'Big Local' area] for people – how do we		Does the offer of help depend on someone reaching out to help them?	People have been reliant on services doing it for us I would be

to hear our views THe consultation is good	more drop-in and check on families		get those messages out to them – people/communities for themselves			really upset if the baby classes disappeared All people need services not just those in crisis
In principle it seems an ideal 'holistic' approach. An agency would look at people's problems as a whole	People need to be more involved in their communities	Range of activities/services some of which are voluntary and there is a difference in the quality of those across the board – people doing for themselves	Information needs to be designed in a way that engages people. Often it's too wordy – needs to sell the idea better e.g. pictorial etc.		Is it just a change of responsibility? – giving it back to individuals	I think some children/parents will still not get services
Good but I'm not sure how realistic it is	Finding other ways to engage the most vulnerable and most needy and also with the simplest information	Time that the professionals like GP's can give as they have particularly only a limited time like 5 – 10 minutes for each person			Why would services reluctant to do CAF's now, want to do a general assessment in the future? E.g. housing	I think it is unrealistic to have a theme of a 'chest infection' possibly from a damp house
	There is a fear for some	I think a key factor is where			Will this process be	

	people to come forward as they think it will have negative results. Such as bringing in social services e.g. parent using drugs and alcohol and feels that their child may be taken away as a result - stigma	the 'hub' will be and what training will be given to those doing the very important 'assessments' of people's situations. I hope the training will be very thorough			phased in? When will it happen?	
	Community development – to develop community to provide services				Will there be a time limit on how long you would get a service for?	
	Families that need to go don't always use the services – how can we build on this?				Will you have the same person throughout?	

	It's not helping those it intended to					
	Approach to getting people into services is wrong as some people lack confidence to make the first move – parents supporting parents works				What will happen to the CAF as it is currently? What would be different for a family?	
					Where is the hub? Will there be 1 or 1 in each area?	
					Who will carry out the assessment?	
					Needs a lot of time from the professional. Will additional time in appointments be given to	

					them to implement it?	

Coldhurst -6 parents attended and 2 young children, 5 have English as an additional language however the group were able to support each other. The proposal was extremely well received and thought it was a good idea. As they chatted they could think of examples where they would benefit from unpicking their difficulties.
Medlock - 2 parents and 2 young children attended. This enabled us to have a really thorough discussion - again the proposal was received well and it was generally thought to be a good idea, they also discussed and reflected on things they thought may go wrong or have a disadvantage.
Action for Children – 17 parents attended Spring meadows children's centre from across the Action for Children Centre areas. A crèche was provided. The consultation lasted approx. 2 ½ hours. The model was generally well received although there were many questions the group had a thorough discussion about services and sometimes their difficulties accessing them – they also expressed the difficulties on parents on young children often not knowing where or when to access services. They also discussed children and families who needed services but often did not access them.

Service: MIND	**Date: 2nd September 2014**	**Numbers attending: 18**				
What I like?	**What need to be changed/or could make it better?**	**Have we forgotten anything?**	**Can you access this service?**	**What difference do you think it could make?**	**What else do you want to know?**	**General comments and ideas?**
I like the idea that there will be 1 number for all services, so I can just call that number for any issues	It will need a lot of staff	The nature of community development	I will be expecting the workers to offer advice not 'me'		Revolving Door - how many times can somebody access help?	I feel people are going to be failed especially

I'm having			looking for my own solutions			that need services but won't be recognised
			People may need some help		I want to access services but don't want my family involved will I be turned away?	
			Early days - yes Long term - no		How are services checked? Quality of services maintained? Where will the hub be? Will it be accessible to all?	
			Yes, if people know about it		What is the referral criteria?	
Giving the responsibility back to the local people/communities etc.	Not seen as a temporary fix and it will change again	Are the waiting/response times achievable	Yes, the access sounds ideal - but I'm not sure of the reality		The 'hub' could potentially be inundated - who is going to man this? How will they be able to keep up with services?	
It sounds great but not sure how it will be done	Communication Partnership working	Keeping up to date with new services - issue of?	Will people trust the triage or be concerned about anonymity?		Will there be enough resources available to meet all the needs?	

A triage/signposting service will be valuable	Tackling ongoing duplication/ CCG & public health	Have you taken into account the make-up of the diverse community and language needs			Will I get a quality service that will address all my needs?	
Early intervention and prevention makes economic sense	Lack of public education	Central services - people do not know what is on offer			How will I be maintained whilst I'm waiting for a referral?	
	Further conversation with organisations and front line workers	People are not ready though - social change			How will lower level services be funded?	
	Implementation plan?	Massive difficulties in delivering this - apathy, lack of education, people not knowing they have issues until it's too late			How will you change community attitudes?	
	How and who?	Implementation is key and a solid and slow development			Who maps and maintains the service providers?	

		and advice to public				
	Have a magic wand to rid Oldham of apathy	Reality			Who holds the purse strings?	
	Let more people know	True social change comes through public education not forced			I haven't got a problem what can you do for me?	
					Is this a 24/7 service model?	
					I'm not very confident will it work?	
					Are you going to be selective on services you are going to refer clients to?	
					Will there be enough triage workers?	
					How will staff be trained? Signposting	
					How many frontline staff?	
					What happen if I think I need counselling - do I just get it or does somebody make that decision?	
					How long would the	

					help/support be on offer for?	
Turning Point	**Date: 3rd September 2014**	**4 people**				
What I like?	**What need to be changed/or could make it better?**	**Have we forgotten anything?**	**Can you access this service?**	**What difference do you think it could make?**	**What else do you want to know?**	**General comments and ideas?**
More competitive services	Discussing self-esteem in schools Change leaflets to booklets on what services are on offer for people and families	A worry will be the quality and knowledge of the person at the 'hub'			Will there need to be a new building for the 'hub'?	Emphasis on lack of self esteem as a major source of problems empty houses - change - recycle
Council services to be proactive rather than reactive	Safeguarding money for vulnerable adults i.e. mental health, substance misuse,	Lack of support for homelessness - no ownership from any borough			How will people know about the services needed?	

	learning disabilities					
	Training people up for the work that's needed including peer support				If the 'hub' is in the community where will they be? Confidential?	
CCG Equality Group	**8th Sept**	**8 people**				
What I like?	**What need to be changed/or could make it better?**	**Have we forgotten anything?**	**Can you access this service?**	**What difference do you think it could make?**	**What else do you want to know?**	**General comments and ideas?**
Gets services organisations working/communicating	Build on the CAB model to ensure building a good practice		Will the early help offer be accessible to asylum seekers who have mental health, homelessness, self abuse, self confidence, financial etc. etc. issues		How will services ensure a behviour change model? In terms of support services - the funding is held by them and not the council.	Until we sort out the criminals we'll struggle

	Training for staff				How can we get [e.g. health] professionals accept expertise of VCF staff?	Strategic partners need to work together
					What will the VCF sectors input be?	People with the same issues benefit from being with other people like them
					Can voluntary / community groups refer people? E.g. Age UK, Victim Support, CAB, Refugee Action.	
					Can people will particular access needs, access the services? If so, how? e.g. I don't speak English, I don't use the phone because I am deaf / I'm afraid people are listening	
					What do services feel about the model?	
					How will early help workers encourage behaviour	

					change consistently?	
					What will the thresholds be for interventions?	
					With ascertaining respond times - any appeal process for this? If demand is high, how could you manage respond times?	
					How are people going to know they need help in the 1st place?	
					How will service and access be published, so individuals/groups/agencies know what is available?	
					Even if services say they will work together, if they don't what time limits are in place to remove that provider if they fail to work to their agreement?	
					How will you get 'professionals' to accept the voluntary sector with respect and work with them?	
					Have Oldham looked at good practice Nationally?	
					Who are the advisors?	

					Jack of all trades or biased towards children and families?	
					If you are expecting communities to input about what they need, how do you plan to engage with these communities?	
					What about people who need help but don't read or write so don't know how to refer for help?	
					How will the service deal with the thresholds to service delivery?	
					How will interagency be acceptable to staff e.g. special educational needs, child protection	
					What is the role of the voluntary sector? Can they refer in? Have they been consulted?	
					How do people find out about it?	
					Which services refer?	
					How is the offer accessed?	
					What is the role of the voluntary sector and how	

					will you fund them as does not happen for free?	
					Where will the money come from to hit the route of most problems?	
					Are there going to be champions in each service to keep to the time frames?	
					What happens when the service disappears and the money runs out?	
					How will money to help people receive new services or get support when returning after mind it?? help?	

Service: Madhlo	**Date: 1st Sept 2014**	**Numbers: 8 people**				
What I like?	**What need to be changed/or could make it better?**	**Have we forgotten anything?**	**Can you access this service?**	**What difference do you think it could make?**	**What else do you want to know?**	**General comments and ideas?**
Giving me advice	I think it would be a good idea if we have one number for all such as	The council should advertise it	As long as I know where it is	It would save more money and would improve relationships	How will people know where it is?	Traffic management – traffic problems

	hospitals – mental health and public services			and families would spend more time together		
Easy to understand	Free phone number Free post	Recession – no money	How will you know where it is if you don't have a computer	To prevent things getting out of hand	Where is the web-site?	
	Put it on a site in case people don't have a phone				What if you haven't got a phone?	
	Good advertising					
	Lots of advertising i.e. posters					

Service: Groundwork	**Date: 29th August 2014**	**Numbers attending: 10 people**				
What I like?	**What need to be changed/or could make it better?**	**Have we forgotten anything?**	**Can you access this service?**	**What difference do you think it could make?**	**What else do you want to know?**	**General comments and ideas?**
It's a good idea but …….	Provide numbers where certain individuals can	People lose hope with this as they never had help before	Yes, I feel it could help. Especially people with	Having someone to talk to	How long will you have to wait for a response?	All this can already be done by people. The problems are

	as in terms of someone who is in need of great – where others with least problems can call a different number.	even when they asked for help	serious problems			the laws that the Gov. dictate onto people. If they want to help, change laws help people instead of wasting money convicting them.
It think it's a good idea	I think people in charge need to look at priorities				Just how long will it take to help an individual? Or will they just pass you on to someone else?	Will the council be advertising this and not the way they do it normally. Last thing I knew they advertised was the Metro link
If it saves money but offers a good service then it may be good					Will it be a better service than trying to pay your council tax as they lose everything?	
					How much will they spend on buffets? Since that money	

					could be saved.	
					Would they actually help or just palm you off from one person to another?	
					Are these services offered by independent services though?	
					Is the 'solution hub' somewhere accessible?	
					Will it be 24 hour service?	

Service: Youth Council/Breaking Barriers/Children in Care	**Date: 27th August 2014**	**Numbers attending: 17 people**				
What I like?	**What need to be changed/or could make it better?**	**Have we forgotten anything?**	**Can you access this service?**	**What difference do you think it could make?**	**What else do you want to know?**	**General comments and ideas?**
More support for people to access services they need	Services are being cut before things are in place to cope	Involving everyone else's decision and opinion, also we		Yes, as it gives yourself a lot of options narrowed into	Services that are being cut and how that will affect people?	The decision has been made no matter what young people

	with the fall out	feel the decision has already been made		smaller groups		say! We know that nothing will change as the council has already decided that they will go ahead with this plan anyway
Less duplication	People awareness	No		Yes – because we will have less services and less opportunities	If there is a problem when the problem is dealt with will help then step in?	The fact is that we haven't been involved as much as we would have liked
More support groups	Putting too much funding into services that don't need it and getting rid of services completely which benefit some people	I don't know because I don't know what's supposed to be in it		Yes - Because I can easily direct someone who needs help	Why are universal and early help being reduced when we need these 2 categories to reduce high level/cost services [red]? We agree	Don't like – getting rid of professionals to give the jobs to unskilled, unqualified people e.g. community groups
The availability of services	Yes, by reducing the amount of cuts on universal and	Because the concept covers all areas that need to be		Yes – because a lot of people need services	Cutting youth services will have a detrimental	Don't like – cutting beneficial services and

	early help	targeted			effect on all services	preventing opportunities some people need
Trying to make thing more sustainable	Breakdown of services to see what they do	No		Possibly depending on the services being cut	Real case study of what will actually happen because of the cuts	It could have been presented better – it just flew over my head
Building confidence in people	Make people aware of services that won't exist and alternative ones	It's cool		Yes, because by cutting services such as Youth services. Oldham's youth is being affected because the youth services play a major part in their lives!	The first half hour which I missed?	Don't like - Too many wards
Less duplicate services	Make sentences smaller	Not sure what I'm missing! I just know something isn't complete				We do not understand about this situation, please rephrase better ☺
	Make people aware of what cuts are going to					Make it more simple and more pictures

	be made and how young people can prevent this. Help					
	Provide people with the necessary information to make the most of the service					Full report back to the Youth Council
	Combine effort to raise money					Youth services shouldn't be effected as I would class them as 'Early Help'
	Focus on who will do the and make the most of the funding					Any fundraising/ profit schemes involved?
	Make sure people get the maximum support even with funding cuts					I hope you listen, there is no point doing consultation with us if you aren't going to listen to what we say! We don't want

						tokenism we want a valued voice! [Article 12 UNCRC]

Service: Bridging the gap	**Date: 1st September 2014**	**Numbers attending: 14**				
What I like?	**What need to be changed/or could make it better?**	**Have we forgotten anything?**	**Can you access this service?**	**What difference do you think it could make?**	**What else do you want to know?**	**General comments and ideas?**
Gate to change 'first stop' 'the next steps'	Clear, client reference/location numbers Clear sharp communication		How are people going to access the service i.e. the hub?	About treating causes rather than symptoms	How long will you have to wait for an appointment?	Solution Hub? The end point – mane sounds like it is but if it isn't?
	Provide appointments that a person can text – reduce cost and accessible service		Freephone for the hub appointments and/or book appointment online		Is the action plan limited to the number of times seen? Is there always a follow up? [By a health worker?]	The hub needs very experienced trained staff or it will/could fail the users
					Would you have the same worker?	
					Would you have	

					the same worker?	
					Will there be enough staff to meet demand? It could be a long waiting list?	
					Catchment Areas Will there be clear, constructive borders set and clearly given correct contact name, dept., number, address for follow on service if outside your living area i.e. catchment area	
					How will community groups be supported to support themselves?	
					Hub – those	

					doing the 'actions plans' [initial assessment] what qualifications?	
					What is the difference between this model and what it is replacing?	
					Who will be at the 'hub'? Experience, background? Once the action plan – is there follow up? 2nd appointment ongoing	

Service: Intuative recovery	**Date: 9th September 2014**	**Numbers attending: 4**				
What I like?	**What need to be changed/or could make it**	**Have we forgotten anything?**	**Can you access this service?**	**What difference do you think it**	**What else do you want to know?**	**General comments and ideas?**

	better?			**could make?**		
It might capture people who would otherwise be under the radar From an agency perspective - it will be good to have one place that will access all					How long would this take to come into effect?	How will you ensure you have the best specialist services as the best won't always stay if the money/custom isn't there? The 'best' not the cheapest
					Would the staff be qualified?	Can this money not be ploughed into services already available to work better in communicating with each other
					How long will support/assistance be provided?	
					What happens to existing services?	
					Who decides the importance of relevant issues,	

					approached clients present with?	
					Who will be running the hub and how specialised are they across all areas?	
					Will people with genuine needs be discouraged from accessing specialist services?	
					If you want to access help for the family - will there be social service involvement?	
					Can you refer a family as a whole?	
					Do people have to give consent to be referred? Can people refuse?	
					Will this help with dual diagnosis? [Mental health/drugs etc.]	
					How will you ensure	

					safeguarding within a family unit?	
					How confidential will it be? What if one family member goes in and discloses/discusses another family member?	
					Where will the service be, will they just point you in the right direction?	
					How confidential will it be if everything is on a computer about your life?	
					Can they access all services?	
					Would it be confidential?	
					How will one person have all the answers?	
					Will they be specially trained?	

Service:	**Date: 27th**	**Numbers**	**Lees Suite**			

Threshold Floating Support Service	**August & 29th August 2014**	**attending: 10 people 4 people**	**Civic Centre Earl Mill**			
What I like?	**What need to be changed/or could make it better?**	**Have we forgotten anything?**	**Can you access this service?**	**What difference do you think it could make?**	**What else do you want to know?**	**General comments and ideas?**
People communicating	People knowing what's available	If you are isolated - money and health issues	Needs advertising to make people aware	Drug awareness in colleges for young people	What support is available for perpetrators? domestic violence	I think there is much more planning to be done for this to work and meet everyone's needs
This makes a lot of sense	Ensure face to face meetings	Will staff be able to cope?	I wouldn't have asked for help	This could have helped me e.g. if the service contacted before rent arrears got too bad	Why do agencies not notice where the triggers are?	Can feel like I'm being ignored - not important
I like the one stop shop	Initial home visits would be good	There is no help for people what have been through - keep getting to, if no	Everybody needs to know about it	May help in future	What about people already in crisis?	When issues are at a lower level - some contact from services is given
Good idea but it needs to works	Make sure services and	Training for all staff	Not sure I would have accessed	Other people because I have	Will services communicate	Negative effect of benefits

	agencies get back to you when they say		this - until in complete crisis	accessed 'floating support' and will direct friends there	with each other?	changes
I'd recommend to friends and family	Could this be another thing that doesn't happen?	Structures to support staff	Not everybody is comfortable with online services		When I phone up who understand my language?	Too much on venue not enough money on 'post it' notes
Very helpful and encouraging staff	Can we have interpreters	Will schools have time?	Make sure everybody knows		How do we consider community language + people not reading and writing	The council have forgot what people want
In theory an excellent idea - if groundwork is done	Advertising openly what services are available	Training	Advertise and make sure everyone understands		How will all the services know about it?	It is difficult to keep explaining myself to different services
I think it's a good idea, if they plan it right	Use of simple language and clear ideas	Training - all possible referral sources need to be aware - top to bottom	Accessibility is important		What if the caseloads get too much?	Have different community numbers
Like it if it works	Complain process should be resolve - if with housing -	Public services such as police, fire brigade, ambulance	Motivated by colleges - in schools - teenage help		Where is it going to be?	Women only day

	how to report your housing officer	services Housing Social Services	and support - awareness drug misuse - help if they are homeless			
Listening to each other	Make sure agencies share information	Too much responsibility - need a break - organised breaks for older people	SALMA		Provision for travel expenses?	Coffee and cakes at the feedback day
People putting their points across	If people were made aware of accessing				Will there be job cuts?	Advertise in free paper - on buses
	Male sure that it's local for people				How will people know about it?	Job centres not listening to public about their benefits
Service: Positive Steps ESF Youth Justice	**Date: 21st August 2014**	**Numbers attending: 11 people 8 people**				
What I like?	**What need to be changed/or could make it better?**	**Have we forgotten anything? Difficulties**	**Can you access this service?**	**What difference do you think it could make?**	**What else do you want to know?**	**General comments and ideas?**
Think a family approach is a	Kids start school at 5 years,	If things don't happen quick	Young adults/teenagers	Trying to get help for my son,	What if you get an assessment	In theory looks a good plan but

really good idea	schools need to know all services that are available to the families. As parents, child and teacher all communicate, school needs to help parents into the right organisation for help	enough families suffer	to be aware of service and how to get referral	uses so much stress. Involved with the police, council no help, spending so much money to use drugs	and you don't agree with this, you think you need more?	will need good systems in place and communication between agencies
To get to the problem early enough and not drag the problem out for a long time and things get worse so in the mean time you need more services to help you with the problem. That if dealt with early we would not need the services.	CAHMS need to listen to a parent if they ring for a self-referral, as parents know best when things are not right with their child. Not pass the book to doctor or school	Funding this x 2	Needs to be advertised so people are aware of service.	To help young people before they reach crisis point	The idea is fine but how long will it take to put into practice?	Think GP's will be difficult to link into scheme and think will struggle to get them on board and refer in

People being responsible	Services need to be delivered quickly	Meeting time constraints	More information where to seek help and more information on how to get funding for courses.	To help families more before it gets out of hand	Who is doing the assessment - what background or agency?	Majority of kids have prince and princess syndrome, if they think they should have everything that everyone has. If they don't they 'tant' and kick off
Talking about the issues	Promise but must deliver	Getting all families members to engage	the service will need to be widely advertised		If you are making cuts, what services are going to be left to refer to & implementation of services?	Town needs to open their eyes
Access to services - make it easier and are understandable	Opportunities for parents to continue with their education without being put under pressure to go to work	Things need to be dealt with straight away so they don't exclude	could be a lot easier if there was more advertisement			Community - Police don't listen - Council is no good wasting money
Asking for help when you need it	-Better advertisement -easy access -good	Families				Save money from cutting higher paid workers

	communication will be needed -independent support -friendly 1 to 1 support throughout, even when things seem fine at the moment, because everything could change again a month later -I think it's better to support families					
hopefully will be easy as going to the docs, centres etc.	advice and guidance - free phone number	Not knowing about the service				issues around sanctions from the job centre
	Advertise volunteers to give leaflets about service in Oldham	difficulties in communication between different services				massive issues from benefit changes
	Independent	people may be				Issues around

	support	too embarrassed to ask for help				sanctioning
	more communication with services	People feel they have nowhere to turn, thinking you're alone				Issues lead to illness, nervous breakdowns etc.
	free phone 0800 from mobile - not holding the line for ages	Single mum being left with departments to deal with				could use volunteers
	Keep it simple, independent support	the vulnerable and things changing				
	Easy access to a service phone number					
	Other help if something fails e.g. backup plan					
Service: Job Clubs Limehurst Royton	**Date: 19th August & 21st August 2014**	**Numbers attending: 7 people 4 people**				
What I like?	**What need to be changed/or could make it better?**	**Have we forgotten anything? Difficulties**	**Can you access this service?**	**What difference do you think it could make?**	**What else do you want to know?**	**General comments and ideas?**
It will be good		The broad	If people know	Forums for	Are you able to	I think you've

		spectrum of the worker	about and understand it	people with similar problems	follow this through?	thought of everything
Good idea but I think it's too big		People will just expect early help to do it	Yes, either a phone call or where you go	Just somebody to talk to	Can you pull it off?	
Good idea			If people know about it x 2	Being helped by others in the community		
I like this idea				I've had help now and I'm feeling confident		
We don't know if we don't try				More understanding about self/family		

Response to written feedback 19th September

Feedback received	Response
Early Help Comments from Oldham Community Childrens Services In principle we agree we need to work together to provide a service for families that is easier to understand for them, and also more cost effective for service providers.: - A key worker for families, less confusion easier access and contact arrangements - Opportunity for money saving if pooled resources between agencies. - Shared training budget - Less overlap and duplication of services - Agree web based tool for assessment would be more efficient. EG: It is not cost effective to complete a CAF, a referral to engagement workers, a referral to FFT Some queries are: - Long term sustainability? investment needs to be long term, otherwise both staff and clients will become disillusioned. - Where would CAF fit? - Objectives sound to have very high expectations, how will outcomes be measured? - Staff may struggle to adapt and change and worry how it will affect existing services. - Role responsibilities need to be very clear and a huge debate around skills and competencies. - Skill set of lead professional? - The key to this model will lie in the skills of the 'solution Hub' ie the first port of call. Who will sit on this panel? It needs to be populated by a	We are setting the service up for three years – this is as long as we have any degree of funding certainty, but we would expect it to continue beyond this if successful. See FAQs See draft specification published on the Chest 16th September Yes, we agree – for our internal staff, we have been developing a training plan and engaging staff as fully as possible throughout the process. We have also tried to be as open as possible so staff in external organisations affected can also take part in the discussion. As part of the tender, we have asked for a credible staff training and development plan to enable staff to adapt and change.

range of experienced practitioners who are open-minded and flexible. - Do we also need to include SEND; LD; literacy problems - When will common thresholds be defined and circulated? - Evidence of overlap in roles and consideration of the role of specialist practitioners? - Assuming that community will deliver services in this way? How many families don't have extended support? - Who has the cost benefit analysis of this? - Who has engaged with service users re their identified needs - Have BME demographics re lifestyle and culture been considered? This group may not actively seek help, but there are good examples of extended family support networks. However, this can be of detriment to wider family dynamics eg: other family members - Has the governance around sharing of assessments across agencies been considered? - Do vulnerable groups have ability to access group sessions? - What models of delivery have been considered to elicit sustained change	It will build on the current MASSH, so will have multi-agency input. The additional capacity we are putting in to support the extension to the Solution element is current Council staff – we are currently restructuring so cannot confirm precisely who this will be, but they are all experienced practitioners. We are exploring how to include this in phase 2. We are deliberately keeping the criteria as open as possible – we don't propose to narrow them down any further than those already circulated as we would rather have too many referrals than people feeling they have to wait until a problem escalates. Specialist services still have a clear place – this offer tries to stop issues escalating to the point they need specialist intervention, but we know that people will continue to need these services. We will work with specialist services to agree clear referral pathways. We are hoping that the community, community groups and community networks will have a role, but they're certainly not all of the solution, and need a lot of support from professionals. An evaluation report has just been finalised – we are very happy to share it with anyone who is interested. Service user consultation exercise carried out by an independent advisor, reaching 29 service user groups and around 200 service users. Accessibility to these groups has been specifically required in the specification.

in this timeframe?	
	Yes – we are working on the draft protocols at the moment.
○ Talking therapies: trained workers providing therapies e.g. Cognitive Behavioural Therapy, mindfulness promoting emotional health and wellbeing for families/individuals in order to stop them escalating to crisis point and requiring support from specialist services: who will be developing the pathways around these approaches	Some will and some will not – we've tried to specify the model to make it flexible enough to respond in different ways to different needs.
○ The case studies appear aimed at a slightly higher level of intervention that what is current being put out to tender.	The in-house elements will focus on the model we have tested through Troubled Families. For the portion to be delivered externally, we are inviting innovative responses to achieve specified outcomes rather than specifying delivery structures.
○ Fred with the alcohol issues will need to want to change his behaviour and if he doesn't then where is the authority to make him reflect on whether his drinking is impacting upon the behaviour of his family.	We have had conversations with Pennine Care and have agreed to establish pathways in relation to the Children's and Adult's IAPTs.
○ The plan to offer mediation within a family where domestic violence is an issue is not one that is recognisable as an evidence based intervention, and does give rise to concern that in such a situation, meaningful change may not be achieved and the victims situation may be perceived as being condoned by this type of response. Again this would appear to be higher up the scale of intervention than the elements of early help that are being commissioned.	Yes, they were demonstrating the 'engagement case worker' and 'intensive case worker' – at the time they were written, we hadn't decided which portions to keep in-house and which to put out to tender.
○ Involving perpetrators in domestic violence support is a risk	

	There are some cases where it works well and others where it increases risk – we have specified the service to be flexible enough to both work with both victim and perpetrator, or just work with one if this is more appropriate.
Barnardos feedback • Do you think this model will help residents support themselves? There appears to be little evidence of consideration of the need for differentiation to serve the needs of different communities. As an example, there are expectations on residents to access web self-help which could act as a barrier for some communities where there is a "digital divide" as a result of poverty, culture or ethnicity. Volunteering is not a "free" resource and it takes considerable capacity to support volunteers and groups. Within our organisation, as in many others, we have noted changes to the profile of volunteers. Increasingly, volunteering is undertaken by people who see it as a step on a pathway to personal and professional development. This has the impact of creating increased turnover and makes sustaining capacity potentially more expensive because of the need to renew the pool of volunteers. It is not clear that a reliance on self-sustaining groups has taken into account these types of change. • What do you like about the model?	We have broadened the range of options for accessing the service in the new model, including building in a strong outreach and engagement element, which we would expect to be delivered through community settings, enabling face-to-face access. We have also put a specific requirement in for the service to be designed and delivered in a way that is accessible to all potential service users. We have included support for volunteers e.g. supervision, training, expenses in our costing assumptions to develop our cost envelope for the service. We have also included active support for voluntary groups and networks (working with VAO), so the onus is not on volunteers to provide the sustainability.

There are potential benefits with a one-stop shop approach to early help, and it is accepted that this has the potential to reduce overlap of service provision, and provide a clear, holistic offer for families. Minimum operating standards should allow for timely and appropriate service responses. • What are the risks with the model? How could these be solved? A single service at this scale is likely to take the form of a "special purpose vehicle" comprised of a number of partnerships. The nature of procurement, with its emphasis on a single defined process is likely to mitigate against the development of a single effective partnership. The tendering process is likely to throw up partnerships which are patchy, with strengths in some areas and weaknesses in others. The proposed timeline is likely to contribute to that weakness as it is too short to allow organisations the period required to undertake due diligence and negotiate a potential delivery model.	We fully acknowledge that this is a risk. We have tried to mitigate it by sharing a draft specification as early as possible and extending the deadline for the return of bids so it is as late as possible whilst still allowing a decision by Christmas, allowing the successful provider 3 months to set up to start on 1st April.
There are potential serious operational risks, as staff carrying out initial assessments will need to be highly skilled to identify the underlying issues correctly and to avoid the risk of professionals and families focussing on the presenting issue rather than the underlying cause.	We agree that staff skills are critical – we have been testing training packages for our in-house staff, and we have included a requirement for a credible training plan as part of the evaluation criteria for the bids.
There is a view that the case studies provided within the consultation showed some naivety in the way in which underlying issues were assumed to just "emerge" a soon as the team engage at any level. This overlooks some of the messages from Serious Case Reviews about understanding "disguised compliance". Another issue is that there is mention of referral on to specialist services and/or therapeutic services, but this seems not to	Yes, we agree – the case studies were intended to give people a feel for how the model would work in terms of processes rather than the detail of the interventions undertaken with a household. We are not going to use them further because they raise the types of issues you describe. Many specialist services are still in place – e.g. social care, drug & alcohol treatment

recognise that specialist and therapeutic services are being decommissioned as part of the change process. It was felt that there is a need for more clarity as to whether these specialists will be employed as part of the new service, or if not where they will exist. It is not clear of the underlying methodology that has led to 3,500 being a proposed number, or of the balance of work that indicates the working case loads or allocation mechanisms. It would be helpful for potential providers to understand the overall demographic picture that has informed this rationale. Understanding these numbers is essential. Capacity will be a major concern as a provider may be squeezed by existing referrers who are be unable to refer to decommissioned specialist provision, and by generic social care services where many referrals do not meet the threshold but where there are limited exit strategies. • What are the opportunities? In the long-term the potential benefits of a single model of early help could help to reduce costs downstream, enable families to better understand the support they are being offered and build community capacity. However, the size and scale of the organisational and cultural shift required to put this in place is enormous and it is important that sufficient time is allowed to create the conditions for success. A rush to change because of the financial constraints could result in poorly implemented delivery, which may not be cost effective in the short or medium-term	(new commission), mental health services. The specific reference to talking therapies is the IAPTs – which we understand from Pennine Care need more referrals of people who are ready to engage. We have agreed with Pennine that we will ensure this offer only refers people ready to engage. We will share the methodology as a background document with the ITT.
Comments from Voluntary Action Oldham The AAEH model recognises the importance of prevention, person-centred, holistic services. We are wholly supportive of this	

approach and the fundamental concepts within the model. Community based services that can be tailored to the needs of the individual and delivered to empower and develop independence and confidence amongst Oldham's residents can only be a positive step forward. It would be helpful to know how the provider(s) will ensure the design and development of the service delivery model will be 'co-produced' with Oldham residents / service users and what part local people will play in monitoring and shaping this as the model evolves. Unfortunately this exciting preventative model is being introduced alongside significant budget cuts to key services and therefore we will not only be testing the impact of the new model but have to manage the cuts to services and changes to threshold levels which may have a significant negative impact on some of Oldham's most vulnerable people. It is reassuring to hear that you are parallel running this model for DAA and Mental health services to try to mitigate the risks. We would also like to ensure the risks are not dis-proportionately felt amongst Oldham's poorest and minority ethnic communities and would want there to be reassurance by the provider(s) that there is meaningful ability to reach these communities. It would be important to monitor this as part of the overall scrutiny of this new model and the contract itself. Throughout the dialogue with Society Works and the VCFP there have been many references to the fact that commissioners would like local voluntary organisations to play a role in the delivery of this work. Given the scale of the contract £1.5m and the relatively short timescales VAO feels this is highly unlikely. We will be working with potential lead contractors to establish partnerships where this is feasible but our experience of this size of contract suggests that meaningful partnerships cannot be created with small organisations pre-award and post award of the contract there is little	We have put a specific requirement into the specification relating to this. We very much appreciate all of Voluntary Action Oldham's efforts in supporting the development of partnerships. To mitigate the risk, we have: - shared a draft specification as early as possible; - extended the deadline for the return of bids so it is as late as possible whilst still allowing a decision by Christmas, allowing the successful provider 3 months to set up to start on 1st April; - included social value questions weighting at 25% in the evaluation criteria for the specification.

scope/ necessity on behalf of the lead provider for significant sub-contracting. Adding meaningful social value questions and rigorous questions throughout the ITT on how the provider will deliver locally appropriate service, that can be tailored to individual needs and ensure meaningful reach to local / diverse communities would help to encourage providers to find local providers who may more naturally have this to offer. Understanding how this will be manage within any sub-contracting arrangement would also be critical to ensure voluntary services and community based support is not seen as 'free' to the providers and an assumption made that this is being funded elsewhere.	
The draft specification information references 'support to community led groups' – we would like to see this clarified to describe what kind of support you would expect a provider of this nature would offer and reference the infrastructure contract we currently provide on behalf of Oldham Council.	We have clarified the type of support in more detail in the revised specification. We have also specifically required the successful provider to work with VAO on this element of the service.
There is still some confusion for us about who is included in the 'All Age' service – for example what is the offer for children with disabilities, older people with complex needs such as dementia etc.	See answers to FAQs

Combined feedback: notes from PSR workshop - 18th August 2014

Question 1 – Do you think this model will help residents to help themselves?	**Response**
Direction & model right, may 'possibly' help residents to support themselves – concerns around resources especially for the Hub	Maximum resources possible allocated – have largely protected from impact of savings
Need to describe the Early Help model better i.e. narrative needed about intervention at the earliest	Draft specification to be circulated 16th September includes a lot more detail

point possible for that household – badging as Early Help is confusing for some providers	
Not enough information to know how the system will work, therefore couldn't answer this.	Draft specification to be circulated 16th September includes a lot more detail
Depend on the appropriateness of interventions – are they the right ones at the right time for people? Are people ready to engage at that time in those interventions?	Decision-making process to identify the most appropriate interventions for a person or household from the suite available in the AAEHO – or facilitate a referral out if something else entirely is needed
Skills of staff within the MASSH; capacity & skills of workers to enable people to help themselves; Complexity/range of issues in households & can staff deal with this? Key: skills/supervision/training of staff	Workforce training and development plan being worked up – tested with Family Focus and Engagement workers, and Operation Solution
Important to use the right language within households and ensure it is used consistently and from an early point	Workforce training and development plan being worked up – tested with Family Focus and Engagement workers, and Operation Solution
Need to manage risks of the model and its effectiveness	See below comments in relation to risks identified
Trust – households will not go down the same route if they have had a previous bad experience.	Core to the model. Workforce training and development plan being worked up – tested with Family Focus and Engagement workers, and Operation Solution
Model needs a person centred approach – the staff dealing with households must be able to do this. It is key that this is the right people at point of engagement. Families need to 'feel' that the person they are dealing with is on board with them and totally on their side – they need to believe that this person will help them with whatever problem they have contacted them with.	Core to the model. Workforce training and development plan being worked up – tested with Family Focus and Engagement workers, and Operation Solution
Ultimately, the people supported want jobs or volunteering opportunities – people with LD still want jobs or meaningful activity.	Employment emphasised as a key outcome, and links to GOW team established to support this.
Case studies in presentation didn't reflect entrenched/complex issues in households	More detail added to written version of case study highlighting complexity of case. Note, though, that not all cases within the AAEHO will be complex – it is a graduated

	scale.
Evaluation: how will we know the model works /what will be the measures of success?	Evaluation framework being drafted; key elements shared within draft spec.
Have you considered a Neighbourhood MASSH approach – promote localism; ensure a community presence; more likely to get people engaged; although locations not co-terminus with Health (4 districts as opposed to 6 wards); place more responsibility with local people.	Reviewing District Family Panel approach to see how this connection can be strengthened; place-based approach also likely to form a key focus of continuous improvement and development.
Staff will have to learn new skills – this is not purely health/social care focus	Workforce training and development plan being worked up – tested with Family Focus and Engagement workers, and Operation Solution
Huge complexity of issues – again, underestimated	Workforce training and development plan being worked up – tested with Family Focus and Engagement workers, and Operation Solution
Question 2 – What do you like about the model?	
It is hopeful	
Model will work well with the third sector as they already operate like this.	
Like the way it offers help and support without the strict criteria.	
Central access point is good.	
Central access point would need to be able to refer into Council services and external services. There is a good example of this in housing-related support, with a common referral form and process, where there is a central access point.	Key to pick up as part of development of the Solution Hub will be referral pathways in and out.
With a positive attitude and approach you should get a better response	
Key worker role is absolutely crucial	
The model needs to be aligned with other organisations models	
Interfaces between organisations/services need to	

be mapped	
Duplication will only be reduced if everyone is on board	
Are conversations ongoing with other organisations such as JC+ to ensure they are on board and that their own policies/procedures/statutory duties etc, have been considered in order to ensure the model can work?	Yes informally; formal discussions will form part of the next phase of development.
Ensure consistent definition of community	
Question 3 – What are the risks with the model? How could these be solved?	
Risks relating to delivery	
RISK – As soon as the offer becomes formal, people can back off (particularly older and younger people).	
Mitigation – Solution hub in the long term would fit better outside the Council.	Intent is long-term to commission the model out, but taking a phased approach to implementation to reduce risk of change.
The process for referrals needs to be clear or there is a risk that the two pathways will be confused, or issues will be missed.	Key to pick up as part of development of the Solution Hub will be referral pathways in and out.
Need to be clear who the model is aimed at	Detail included in draft specification
Waves of need – the model will create an initial wave of need and then there will be others that surface and create further demand. Group felt that the numbers requiring help now, in 3 and then 5 years may have been underestimated	New model has greater flexibility to respond to fluctuations in demand because it works across all issues. If all areas of demand rise at once, this would have been no more or less of a problem in the old model.
Model will work well in the longer term but shorter term it was felt that families would not engage or move	Outreach element built into model; workforce training and development has a core focus on engaging households.
IT and information sharing are huge risks	MOSAIC (development of Frameworki) being developed and tested in advance of 'go live'. 30+ data sharing agreements in place for pilots that can be built on for roll-out.

Need organisational buy in at a strategic level	Cllrs, Chief Executive, EMT, Key AEDS, all fully engaged and on board
The model is currently cost focussed and not quality	Emphasis on costs is purely to ensure we don't over-spend. Key focus is on achieving improved outcomes for residents, which will be reflected in evaluation and monitoring.
The model won't work in isolation	Operational: Key to pick up as part of development of the Solution Hub will be referral pathways in and out. Strategic: next phase of development to work with partners on broadening the model out across partnership.
It needs to dovetail with other organisations and structural priorities	As above
People get 'lost' in the system and will need help not only accessing initially but progressing either up or down the system.	1:1 support emphasis should address this.
Key worker skills – risk that if these are not right the model will fail	Workforce training and development plan being worked up – tested with Family Focus and Engagement workers, and Operation Solution
Amount of specialist skills required for these key staff has been under estimated	Workforce training and development plan being worked up to fully reflect whole range of skills needed – tested with Family Focus and Engagement workers, and Operation Solution
High risk service demand is rising	New model has greater flexibility to respond to fluctuations in demand because it works across all issues. If all areas of demand rise at once, this would have been no more or less of a problem in the old model.
Sustainability of the model is a high risk	New model has greater flexibility to respond to fluctuations in demand because it works across all issues. If all areas of demand rise at once, this would have been no more or less of a problem in

	the old model.
Brief interventions create revolving door scenario and do not fully solve problems	Range of intervention durations available across the model, depending on level of need. Core principle of the model is that there does need to be a focus on working with households to give them the skills to help themselves so they do not become long-term dependent.
Increase in demand may overload some services which will then impact on the effectiveness of the model	Evaluation shows that pilots have consistently reduced demand on services as AAEHO workers do more intervention themselves.
There needs to be lateral entry points, so that people don't have to go through the whole system again once they've exited it.	Key to pick up as part of development of the Solution Hub will be referral pathways in and out.
Statutory duties/responsibilities for partner organisations needs further consideration	This model shouldn't reduce anyone's impact to meet their statutory duties – would need specific examples to comment more fully.
Need to manage the expectation – don't create gaps within the system which households expect someone will fill when the belief is they will do it for themselves, as this will create disappointment and negativity.	Workforce training and development plan being worked up to include being clear on this and manage expectations with households – tested with Family Focus and Engagement workers, and Operation Solution
Risks relating to procurement	
Risk that big agencies get all the work as smaller organisations can't compete with them.	Sharing draft spec early; extending timescales for return of ITT Offer to VAO to support workshops to enable partners to come together
Risk that consortium approach will not work in the short timeframe so will lose smaller companies.	Sharing draft spec early; extending timescales for return of ITT Offer to VAO to support workshops to enable partners to come together
Risk that during further rounds of savings, value based commissioning will be lost.	Maximum resources possible allocated – have largely protected from impact of savings
RISK – Timescales may not be realistic because not enough information to have a consultation on at the moment	Much more detailed information circulated on 19th August

	Sharing draft spec early; extending timescales for return of ITT Offer to VAO to support workshops to enable partners to come together
Timeframe: very fast e.g. for Consortia arrangements to be developed	Sharing draft spec early; extending timescales for return of ITT Offer to VAO to support workshops to enable partners to come together
Timescales for what services being asked to do : very risky	Sharing draft spec early; extending timescales for return of ITT Offer to VAO to support workshops to enable partners to come together
Governance of different organisations who may be involved	Sharing draft spec early; extending timescales for return of ITT Offer to VAO to support workshops to enable partners to come together
How are services supposed to get a consortium together to bid?	Sharing draft spec early; extending timescales for return of ITT Offer to VAO to support workshops to enable partners to come together
Can there be an event to enable networking to help us work together to support joint bids?	Sharing draft spec early; extending timescales for return of ITT Offer to VAO to support workshops to enable partners to come together
Timeline is quick	Sharing draft spec early; extending timescales for return of ITT
If you are looking for a consortia approach then the timescale rules out any smaller organisations as they will not have time to get it through their Governance structures at this stage.	Sharing draft spec early; extending timescales for return of ITT Offer to VAO to support workshops to enable partners to come together
The service specification and any Lots this may be put in	Sharing draft spec early
Question 4 – What are the opportunities?	

In principle, people agreed with the model	
Positive about the model – it fits well with the health model of people self helping – need to ensure households are on board and is it what the people of Oldham actually want?	
The model needs a shared understanding and accountability	
For those people who will engage – brilliant!	
To make a real difference	
Is more sustainable given funding issues – can't keep cutting contracts and expect services to carry on	
Workers gaining new sills	
Need to take a brave step (but don't throw the baby out with bathwater)	
Question 5 – Do you think it will be easy to access the service?	
Not unless people know it exists.	As part of Solution Hub development, need to develop clear approach to awareness raising and marketing.
1 hub doesn't work for most people	Evolved approach so now focuses on outreach and engagement more.
People like to see a face, not IT or phone	Above outreach means people will have a choice.
Mix of access required – range of opportunities and forms	As above
Model can't be all IT or phone based	As above
There is a barrier to the model if we expect people to access purely by themselves	As above – outreach, plus will actively encourage agency referrals so people do not have to self-refer
There are multiple SPOE's currently – health, extra care – need to be clear who does what and how people access?	As part of Solution Hub development, need to develop clear approach to awareness raising and marketing.
Hub needs NOT to be like a call centre- quality of	Needs to be included in development and

the workers here is key	training plans for Solution Hub workers
Is the Hub more about 'intelligence' and co-ordination than a single point of entry/access?	Yes, this is a strong part of its role; although it will continue to be a single point for picking up phone calls and e-mails (but see above re outreach opportunities for face-to-face contact)
How do we deal with the different levels of need etc without still duplicating: still need to have 'one conversation'	Yes, this is a core role for the Solution Hub
The model will need excellent multi skilled staff or else those who are very good at signposting – but that's if the service they are signposting too are still there….	To include in workforce development and training plan
People can't just be given a phone number or offered advice and be expected to follow it up. There needs to be support services available to support them to access help. Otherwise the likelihood is that they will just ignore it. Some people might not know/be aware of or be ready to accept that they need help: what is the hook to ensure these people engage? Need to ensure it is their choice to engage; these particular families/people are often not aware or interested in the wider community impact of their issues and don't feel this aspect is important or anything to do with them.	Outreach element of model strengthened considerably.
How will people with additional needs access the service – IT and Phone option is very difficult and limiting. What support is available for people with additional needs in order for them to be able to help themselves?	Outreach element of model strengthened considerably provides more options. Also flagged to consider in detailed design of and workforce planning for Solution Hub.
What about where people don't recognise they have a need or are not ready to engage?	Outreach element of model strengthened considerably provides more options. Also flagged to consider in detailed design of and workforce planning for Solution Hub.
Question 6 – What else would you like to know about the model?	
The presentation didn't mention families with a	Not specifically at present, although it is

child who has a SEND or PD. Are they included in this offer?	something we're looking at for the next phase of development.
How do referrals get fielded when they come in?	If straightforward single issue; appointment made. If more complex, Solution Hub uses risk matrix to determine priority; then collates information as appropriate to inform a decision – see diagrams included in materials circulated 19th August.
Who decides where the referral should go?	Solution Hub, but considering building in a challenge mechanism to this.
Step-up and step-down processes need to be mapped. How is this going to work?	Key to pick up as part of development of the Solution Hub will be referral pathways in and out.
If MASH is to be 'the hub' it needs to be expanded. Can't just be those people with FACS needs. What is the plan for this?	Additional staffing to focus on 'solution'/early help side to be built in as part of All Age Early Help Offer
If MASH to be used as central access point, where do the safeguarding issues go?	MASH safeguarding section
How is value-based commissioning being used?	See draft evaluation questions in spec
How will the solution hub keep track of the current services available and identify gaps in the current service provision?	On-line Service Directory being developed
How will referrals be managed and who will be doing the managing?	Solution Hub process – see above
Who will monitor outcomes?	Contract monitoring and evaluation within the Council, sitting outside the All Age Early Help Offer – all portions will be managed equally and held to the same standards
How will it be governed?	Oldham Leadership Board, Neighbourhood Commissioning Cluster, Early Help Board
Will there be access points in the community	Yes – outreach element now strengthened
Who else is buying into the model	Just Council at present – next phase is to work with partners on others also buying into the model
What is the mutual benefit?	Improved outcomes, more resilient residents = less long-term demand on services
How many workers involved?	Will depend on the model for the successful bidder.
Are staff available now and are they equipped	Internally, yes – we have been piloting and testing for a year. Externally, we believe so but it will require bidders to think laterally

	about the skills they need and have, rather than focusing on the presenting symptom they have typically worked with.
Key workforce development strategy crucial	Agreed – one is under development for internal staff, and will be required as part of a bid from the external provider.
Already some duplication within the model	Needs to be clearer what the duplication is?
Need to ensure preventative work with men is a focus – a lot of household problems are male related and the root cause of this needs addressing in order to solve wider problems.	The benefit of looking at the whole household and identifying root causes is that this should be picked up wherever it is an issue.
Under estimated some of the serious emotional disorders people have and how these are dealt with by staff who have specialist skills and qualifications – need to ensure the safety of staff working with these households as well. Staff cannot deal with this if they have simply generic and basic skills. Very detailed and specific training is required.	Agreed – will be fully incorporated into staff training and development
Consider withholding money for smaller local projects to support work within their locality – at a street/people level – to ensure community involvement	This should be picked up through a separate piece of work on community development
Make better use of community based assets – some local projects showing real potential to be involved – need to be seen as key partners not as an afterthought	Ability to engage and link with communities, build on networks and make use of existing assets will be emphasised in the tender spec and evaluation questions
Marketing and branding of the model is key	Agreed – we are putting additional resources into awareness raising for year 1.

Appendix 3: Monitoring and evaluation plans

Through working with people with the range of needs described above, we would expect to see benefits over time as summarised below:

Improved service delivery, including improved levels of engagement with households = 1-3 months	Improved 'soft' outcomes e.g. improved confidence, self-esteem, self-reported mental health and well-being = 1-3 months	Improved measurable outcomes, e.g. increased people in work, reduced involvement in crime etc. = 6-12 months	Reduced demand on high-cost, reactive services, e.g. reduced demand on social care, reduced need to access tier 4 DAAT services or tier 4 Mental Health services = 24 months	Of these, we would expect (to be quantified in the coming weeks): - £ savings to the police - £savings to social care - £ savings to DAAT - £ savings to mental health - £ savings to health 24-36 months

We are not expecting the provider to be held to account for achieving all of these outcomes as we recognise that some are a hypothesis relating to the benefits of early intervention and prevention. We do, however, expect the provider to facilitate access to all of this information to enable us to conduct a robust evaluation to highlight the impact of the early intervention and prevention work.

The following is therefore split into two sections:

- Core contract monitoring data, which the provider will be held responsible for (this data will also be used in the evaluation);
- Evaluation data, which the provider will not be held responsible for, but which the provider will be asked to take steps to ensure is available to support our evaluation.

Core contract monitoring

Purpose for monitoring	Indicator	Target	How measured
Improved service delivery	Number of people engaged through group sessions	6000	Quarterly returns – data gathering mode to be determined by provider and agreed with commissioner
Improved service delivery	Number of people engaged through group sessions with the following characteristics: o Smokers o Parenting issues (0-4 year olds) o Physical health issues o Other issues	 1500 1200 2100 1200	Quarterly returns – data gathering mode to be determined by provider and agreed with commissioner
Improved service delivery	Number of health checks complete	2100	Quarterly returns – data gathering mode to be determined by provider and agreed with commissioner
Improved service delivery	Of those identified as at high risk of health harm, percentage who take up an intervention from the All Age Early Help Service	25%	Quarterly returns – data gathering mode to be determined by provider and agreed with commissioner
Improved service delivery	Number of referrals from external agencies received	1500	Quarterly returns – data gathering mode to be determined by provider and agreed with commissioner
Improved service delivery	Number of referrals from other Council services received	1500	Quarterly returns – data gathering mode to be determined by provider and agreed with commissioner
Improved service delivery	Number of referrals that translate into 1:1 support being offered	50%	Quarterly returns generated through use of the MASSH system
Improved service delivery	Number of 1:1 support needs identified via group work	1000	Quarterly returns – data gathering mode to be determined by provider and agreed with commissioner
Improved service delivery	Number of people to support identified via data matching	1000	Quarterly returns – data gathering mode to be determined by provider and agreed with commissioner

Purpose for monitoring	Indicator	Target	How measured
Improved service delivery	An initial judgement is made within 48 hours of a potential case being identified (either by referral or data matching) as to how this case should be handled.	95%	Quarterly returns generated through use of the MASSH system
Improved service delivery	An in-depth assessment is undertaken on relevant cases within a week.	95%	Quarterly returns generated through use of the All Age Assessment system
Improved service delivery	All cases begin to receive support within a fortnight.	100%	Quarterly returns generated through use of the All Age Assessment system
Improved service delivery	Number of households receiving 1:1 support per year: peer mentoring, advocacy, life coaching	1500	Quarterly returns generated through use of the All Age Assessment system
Improved service delivery	Number of households receiving 1:1 support per year: engagement case workers	2100	Quarterly returns generated through use of the All Age Assessment system
Improved service delivery	Number of households receiving 1:1 support per year: intensive case workers	400	Quarterly returns generated through use of the All Age Assessment system
Improved service delivery	Break-down of people worked with to demonstrate the following range of issues: o have/be recovering from drug & alcohol issues; o recovering from adult mental health issues; o have emerging adult mental health issues; o have emerging child and adolescent mental health issues; o have domestic violence/relationship issues; o have problems parenting/family support issues relating to 0-4 year olds; o have housing issues; o have family support needs relating to 5-16 year olds; o need support to improve their physical health.	 500 250 350 600 100 750 500	Quarterly returns generated through use of the All Age Assessment system

Purpose for monitoring	Indicator	Target	How measured
	(NB this adds up to more than 3500 – this is because we expect each household to have at least one and probably more than one of these issues)	500 620	
Improved service delivery	Those supported 1:1 have an All Age Assessment	100%	Quarterly returns generated through use of the All Age Assessment system
Improved service delivery	Those supported 1:1 have at least three monthly follow-ups, including updates recorded to the All Age Assessment	100%	Quarterly returns generated through use of the All Age Assessment system
Improved service delivery	Those supported 1:1 have a final case closure All Age Assessment	100%	Quarterly returns generated through use of the All Age Assessment system
Improved service delivery	Those supported 1:1 have signed a consent form to enable sharing of data for operational and evaluation purposes	95%	Quarterly returns generated through use of the All Age Assessment system
Improved service delivery	Average time from case opening to case closure: engagement case workers	3 months	Quarterly returns generated through use of the All Age Assessment system
Improved service delivery	Average time from case opening to case closure: intensive case workers	9 months	Quarterly returns generated through use of the All Age Assessment system
Improved service delivery	Average time from case opening to case closure: peer mentoring, advocacy, life coaching	12 months	Quarterly returns generated through use of the All Age Assessment system
Improved service delivery	Percentage of people re-referred within 12 months	5%	Quarterly returns generated through use of the All Age Assessment system
Improved service delivery	Number of secondary schools visited to give up to date information about referral pathways for all areas covered by the All Age Early Help Offer	16	Quarterly returns – data gathering mode to be determined by provider and agreed with commissioner
Improved service delivery	Number of GPs visited to give up to date information about referral pathways for all areas covered by the All Age Early Help Offer	50	Quarterly returns – data gathering mode to be determined by provider and agreed with commissioner
Improved service delivery	Positive feedback from schools, GPs and other key stakeholders on the ease of the referral process,	75%	Quarterly returns – data gathering mode to be determined by provider and agreed with

Purpose for monitoring	Indicator	Target	How measured
	and the feedback mechanism.		commissioner
Basic demographic data	Number of adults in household	NA – for evaluation purposes only	Quarterly returns generated through use of the All Age Assessment system
Basic demographic data	Number of children in household	NA – for evaluation purposes only	Quarterly returns generated through use of the Al Age Assessment system
Basic demographic data	Dates of birth of all in household	NA – for evaluation purposes only	Quarterly returns generated through use of the All Age Assessment system
Basic demographic data	Number of adults with learning difficulties	NA – for evaluation purposes only	Quarterly returns generated through use of the All Age Assessment system
Basic demographic data	Number of adults with long-standing illness/disability	NA – for evaluation purposes only	Quarterly returns generated through use of the All Age Assessment system
Basic demographic data	Number of children with SEND	NA – for evaluation purposes only	Quarterly returns generated through use of the All Age Assessment system
Basic demographic data	Number of children with long-standing illness/disability	NA – for evaluation purposes only	Quarterly returns generated through use of the All Age Assessment system
Basic demographic	Housing tenure	NA – for	Quarterly returns generated through use of the

Purpose for monitoring	Indicator	Target	How measured
data		evaluation purposes only	All Age Assessment system
Basic demographic data	English spoken as a first language at home?	NA – for evaluation purposes only	Quarterly returns generated through use of the All Age Assessment system
Basic demographic data	Confirmation of address	NA – for evaluation purposes only	Quarterly returns generated through use of the All Age Assessment system
Basic demographic data	Ethnicity of primary carer	NA – for evaluation purposes only	Quarterly returns generated through use of the All Age Assessment system
Basic demographic data	Gender of each member of the household	NA – for evaluation purposes only	Quarterly returns generated through use of the All Age Assessment system
Basic demographic data	Compliance with providing the above data	90%	Quarterly returns generated through use of the All Age Assessment system
Self-reported and practitioner-reported outcomes	Measured using outcomes star at Appendix 1: ▪ Self-confidence; ▪ Self-esteem; ▪ Motivation; ▪ Mental well-being; ▪ Physical well-being; ▪ Substance misuse; ▪ Managing relationships in the household; ▪ Child behaviour;	All families show at least a three point improvement on all issues identified by the time the case is	Quarterly returns generated through use of the All Age Assessment system

Purpose for monitoring	Indicator	Target	How measured
	▪ Child attendance at school; ▪ Housing situation; ▪ Involvement in crime and ASB; ▪ Employment and skills.	closed???	
Self-reported and practitioner-reported outcomes	Number of 4 week smoking quits	2323	Quarterly returns – data gathering mode to be determined by provider and agreed with commissioner
Self-reported and practitioner-reported outcomes	Improved physical health: o Percentage of people identifying a need to improve their physical health who report an increase in their physical activity at three month follow-up o Percentage of people identifying a need to improve their diet reporting increasing fruit and veg intake to 5 a day o Percentage of people reporting a need to lose weight achieving a 5% total weight loss by case closure	60% 15% 25%	Quarterly returns – data gathering mode to be determined by provider and agreed with commissioner
Self-reported and practitioner-reported outcomes	Number of households prevented from becoming homeless who were at risk of becoming homeless when the intervention started Number of households prevented from accessing temporary accommodation	??	Quarterly returns – data gathering mode to be determined by provider and agreed with commissioner
Self-reported and practitioner-reported outcomes	Percentage of adults supported into employment who were unemployed at the start of the intervention	25%	Quarterly returns – data gathering mode to be determined by provider and agreed with commissioner
Self-reported and practitioner-reported outcomes	Households prevented from requiring escalation to a more expensive service, including: - Drug and alcohol treatment;	75%	Quarterly returns – data gathering mode to be determined by provider and agreed with commissioner

Purpose for monitoring	Indicator	Target	How measured
	- Specialist/secondary mental health services; - Specialist obesity services; - Children's Social Care; - Adult Social Care; - [any other services we would want to particularly reflect?]		

This is the information that the contract/success of in-house delivery will be monitored on, subject to a random sample of the self-reported and practitioner-reported measures being externally validated with the data collected from other data sources – see below – and working with the evaluation team to facilitate interviews and in-depth assessment of case files on a random sample of families.

5.2 Data requirements for evaluation purposes only

In order to enable a fuller assessment of the impact of the new All Age Early Help Offer, we will also access data from existing sources to enable us to assess measurable improvements in externally reported outcomes, and demand on services. The service provider will not have to collect this information. Their only responsibility is to ensure that consent forms are signed to enable us to access the data. As noted above, we will also choose a random sample of families to cross-check the self-reported and practitioner-reported improvements against the externally validated data – e.g. where self- and practitioner reporting suggests improvements in school attendance is this validated by the school attendance data?

Outcomes

Crime and ASB
Number of adults subject to ASB intervention
Number of young people (10-17) subject to ASB intervention
Number of ASB reports from housing providers
Number of adults convicted of criminal offence
Number of family members identified as being Prolific and Priority Offenders (PPO)
Family members with known criminal gang affiliations (nominal)
ASB first warning letter
ASB second warning letter
Warning interviews

Number of young people (10-17) convicted of criminal offence
Domestic Violence
Number of family members notified to MARAC as being a DA victim
Health and wellbeing
Family Registered with GP in area where they live
Family Registered with a Dentist in area where they live
Number of adults suffering mental health problems (Clinical diagnosis)
Number of children suffering mental health problems (Clinical diagnosis)
Number of children with ADHD (Clinical diagnosis only)
Number of adults dependent on alcohol (Clinical diagnosis)
Number of adults dependent on non-prescription drugs (Clinical diagnosis)
Number of adults and children who are overweight
Number of under 18 conceptions (15-17s) (Key worker assessment)
Housing situation
Family at risk of eviction – Eviction Order
Family at risk of eviction - Notice of Seeking Possession (NOSP)
Family at risk of eviction - Warning Letter for Breach of Tenancy
Family is in rent arrears
Employment
Young people who are NEET
Number of adults in employment
Education and attendance
Attendance by term
Number of children with school behavioural problems (BIP or equivalent intervention in place)
Number of children attending PRU or with some other form of alternative provision
Total number of managed moves
School Exclusions (permanent)
School Exclusions (temporary)
Headteacher concerns
Child development
Early Years Foundation Stage Profile score

Child care provision take-up (at 2 years of age)
Obesity (at reception class)
Oral health (at 5 year olds)

Demand on services (enabling us to calculate cost to services)

Number of social care contacts
Length and type of support received from social care
Number of children living in care/Looked After Children (LAC)
Number of children on Child Protection Plan
Number of children identified as Child In Need (CIN)
Number of social care contacts
Length and type of support received from social care
Number of adults receiving treatment for dependency on non-prescription drugs
Number of YP having substance misuse issues that reach threshold for structured treatment
Total cost of hospital treatments
Number of GP prescriptions
Cost of prescriptions
Number of impatient stays (number in total)
Number of G.P. appointments
Length of inpatient stays (in days)
Likelihood of being admitted to hospital (risk stratification)
Number of times attended A+E
Number of GP home visits to family members
Number of ambulance call-outs
Number of hospital outpatient appointments
Number of referrals to a MH treatment service
Number of adults receiving treatment for alcohol dependency
Number of referrals to a drug/alcohol service
Number of contacts with a drug/alcohol service
Prison sentences
Individuals in prison

Number of times accessed temporary accommodation, and length of stay
Number of ASB enforcement measures undertaken with tenant
CAF
Number of adults receiving out of work benefits
Number of police callouts to household
Arrests
DV incidents reported to police
Number of YJS referrals
Provision of services such as Special Educational Needs and Speech, Language Therapy
Subject to probation order (yes, no)
Order compliance

B039: Review of Public Health - Proposal One (Drugs and Alcohol treatment system)

Lead Officer:	Janet Sewart
People involved in completing EIA:	Janet Sewart, Roy Egginton (data).
Is this the first time that this project, policy or proposal has had an EIA carried out on it? If no, please state date of original and append to this document for information.	Yes Date of original EIA: n/a

General Information

1a	Which service does this project, policy, or proposal relate to?	Commissioning Public Health Relates to Savings Template BO39 – Proposal One (Drugs and Alcohol treatment system)
1b	What is the project, policy or proposal?	Re-tendering the Drug and Alcohol Treatment System for 2015-17 with a reduction in available budget of £980,000.
1c	What are the main aims of the project, policy or proposal?	- To have an effective integrated drug and alcohol treatment system consisting of two elements (a) structured treatment and (b) recovery and reintegration. The treatment system to cater for a reduced number of people as demand for these services reduces as a result of the new PSR model. - To transition the Recovery and Reintegration service into the PSR model from 1 April 2016. - Achieve better value for money by reducing the number of treatment providers to reflect the reduced amount of money available to commission drug and alcohol treatment in 2015-7. - Simplify access and routes into treatment. - Incorporate the new Early Help offer as part of Public Service Reform, to deliver prevention, early help and recovery support as part of a more holistic model. - Enable service users to have access to

		combined drug and alcohol services. - Widen the availability and the range of recovery services via the Early Help offer. These services to be focused on helping service users into employment, training, volunteering and peer mentoring. Also to prevent relapse, help with social re-integration and facilitate access to mutual aid/ support groups.
1d	Who, potentially, could this project, policy or proposal have a detrimental effect on, or benefit, and how?	This could potentially have a detrimental effect on Oldham residents in need of drug and alcohol treatment, particularly those more complex cases which require a longer period of treatment. The new model, with 40% reduced funding, is predicated on a reducing number of people requiring structured treatment and people having shorter 'treatment journeys'. It could potentially result in waiting lists for drug and alcohol treatment. It could potentially have a detrimental affect on people exiting treatment in need of recovery support if the new Early Help (PSR) offer cannot accommodate their needs. This could lead to relapse and re-entry into treatment and an additional burden on the treatment system. A potential benefit is that more people might be signposted into treatment at an earlier stage in their drug/alcohol taking, (as part of the new Early Help offer) and require shorter interventions, thus reducing the likelihood of escalation into high dependency/addiction. A potential benefit is that the treatment system is easier to access and all substances are dealt with by potentially one provider.

1e. Does the project, policy or proposal have the potential to <u>disproportionately</u> impact on any of the following groups? If so, is the impact positive or negative?				
	None	**Positive**	**Negative**	**Not sure**
Disabled people	☐	☐	☐	☑
Particular ethnic groups	☐	☐	☐	☑
Men or women (include impacts due to pregnancy / maternity)	☐	☐	☐	☑

People of particular sexual orientation/s	☑	☐	☐	
People who are proposing to undergo, are undergoing or have undergone a process or part of a process of gender reassignment	☑	☐	☐	☐
People on low incomes	☐	☐	☑	☐
People in particular age groups	☐	☐	☑	☐
Groups with particular faiths and beliefs	☐	☐	☐	☑
Are there any other groups that you think may be affected negatively or positively by this project, policy or proposal?				
Vulnerable people addicted to drugs and/or alcohol, some with mental health problems		☐	☑	
Offenders with addiction problems and some with additional mental health problems		☐	☑	

1f. What do you think that the overall NEGATIVE impact on groups and communities will be? Please note that an example of none / minimal impact would be where there is no negative impact identified, or there will be no change to the service for any groups. Wherever a negative impact has been identified you should consider completing the rest of the form.	**None / Minimal**	**Significant**
	☐	☑

1g	Using the screening and information in questions 1e and 1f, should a full assessment be carried out on the project, policy or proposal?	Yes ☑
1h	How have you come to this decision?	Based on the information above.

Stage 2: What do you know?

What do you know already?

Summary Profile of Adults (18+) in Drug Treatment in Oldham (2013/14)

Number in Tier 3 Drug Treatment = 1,028

Demographic Profile:
Gender: 22.7% female (n=233). 77.3% male (n=795)

Ethnicity:
1.2% Black/Black British (n=12)
10.0% Asian/Asian British (n= 103)
85.8% White/White British (n=882)
2.5% Mixed/Dual Heritage (n=24)
0.5% Other Ethnicities (n=5)
0.2% Not stated (n=2)

Age:
3.9% 18-19 year olds (n=40)
7.9% 20-24 year olds (n=81)
25.4% 25-34 year olds (n=261)
39.8% 35-44 year olds (n=409)
18.7% 45-54 year olds (n=192)
3.9% 55-64 year olds (n=40)
0.5% 65 years and older (n= 5)

Substance Use:
Heroin: 69.9% (n=719)
Crack cocaine: 27.3% (n=281)
Cannabis: 23.5% (n=242)
Cocaine: 10.7% (n=110)
Benzodiazepines: 9.0% (n=92)
Methadone: 8.6% (n=88)
Amphetamines: 5.2% (n=53)
Other opiates: 4.2% (n=43)
Prescription drugs: 2.7% (n=28)
Ecstasy/MDMA: 0.7% (n=7)
Other drugs: 1.6% (n=16)
Adjunctive alcohol use: 18.2% (n=187).

Adults in treatment who live with/have children:
In 2013/14 Oldham's rate for adults in drug treatment who live with/have children was 51.5% (204 from 396 new presentations). This is twice the regional (26.5%) and national (23.9%) averages.

Prevalence rate – the estimated number of opiate and/or crack users in Oldham per 1,000 of the 18-65 year old population is 10.9 significantly greater than the England average of 8.7.

Penetration rate – (i.e. proportion of estimated opiate and/or crack users in Tier 3 drug treatment is 52.0% - this is similar to the national rate of 52.3%.

Public Health Outcomes Framework (indicators 2.15i and 2.15ii).

The proportion of all in treatment who successfully completed treatment and did NOT re-present within 6 months:

- Opiates (2.15i): 8.13% (better than national and cluster averages).
- Non-opiates (2.15ii): 43.51% (better than national and cluster averages).

Alcohol

Number in alcohol treatment in 2013/14 = 843.

Gender: 34.6% Female [n=292] 65.4% Male [n=551]

Ethnicity:

0.4% Black/Black British [n=3]

1.5% Asian/Asian British [n=13] **v**
95.7% White/White British [n=807] **^**
1.5% Mixed/Dual Heritage [n=13]
0.4% Other ethnicities [n=3]
Not stated – 0.5% [n=4])

Age:

0.0% 18 to 19 years [n=0]
9.0% 20 to 24 years [n=76] **^**
22.3% 25 to 34 years [n=188] **^**
27.1% 35 to 44 years [n=228]

27.3% 45 to 54 years [n=230]

12.3% 55 to 64 years [n=104]
2.0% 65 years and older [n=17]

Adjunctive substance use:
Cannabis 10.9% (n=92)
Cocaine 5.3% (n=45)
Heroin: 3.4% (n=29)
Crack cocaine: 3.3% (n=28)
Amphetamines: 1.9% (n=16)
Methadone: 1.6% (n=14)
Benzodiazepines: 1.0% (n=8)
Prescription drugs: 0.8% (n=7)
Ecstasy/MDMA: 0.4% (n=3)
Other opiates: 0.2% (n=2)
Other drugs: 0.1% (n=1)

Synthetic Estimate: Existing drinkers

The Local Alcohol Profiles for England (LAPE) synthetic estimate for existing drinkers shows that amongst Oldham's population (age 16 years or more) of 174,700 19.3% [n=33,700] are abstainers (compared to 16.5% nationally) – the 42nd highest proportional rate out of 326 LAs in England. From the remaining 141,000 rates for lower risk drinking and 'increasing risk drinking' compare favourably to national averages. The estimate for 'Higher risk drinking' in Oldham is 6.24%, whilst low in the national context, still totals 9,700 individuals. The rate for binge drinking in Oldham is 23.4% [n=32,994] compared 20.1% nationally and represents the 57th highest rate out of 326 LAs in England.

Hospital admissions due to alcohol are amongst worst ranked in England:

Admissions for under 18s Oldham was 283rd out of 326 LAs
For alcohol related hospital admissions (broad definition) amongst adults Oldham was 253rd
For alcohol related hospital admissions (narrow definition) 211th out of 326 LAs in England

Successful completions and Re-presentations amongst Alcohol Clients (March 14):

- The proportion of all adult alcohol clients in Oldham who successfully completed treatment was 37.3% [314 from 842] – similar to regional (40.7%) and national (37.5%) averages.
- The proportion of adult alcohol clients who re-presented to alcohol treatment services within 6 months of a successful completion was 12.6% [26 from 207] – again similar to sub-regional (10.8%) and national (11.3%) averages.

Summary:

- The estimated increasing alcohol risk is 19.44% (n=32015) and 6.24% higher risk drinkers (n=9730).
- The synthetic estimate (Local Alcohol Profiles for England – LAPE) for existing drinkers (aged 16 years and over) in Oldham is 19.3% abstainers (n=33,700) compared to 16.5% in England.

- Of the remaining 141,000, 23.4% are binge drinkers (n=32,994) compared to 20.1% nationally.
- Alcohol specific hospital admissions for under 18s (crude rate 70.1) ranks Oldham 283 out of 326 LA admission episodes for alcohol related conditions (broad definition).
- Oldham is significantly worse than the England average but better than the regional average, ranked 253 out of 326 Local Authorities.
- Admission episodes for alcohol related conditions (narrow definition) is not significantly worse than the England average and is better than the regional average, ranked 211 out of 326.

Substance Misuse related Offending

- There were 1,331 Mandatory Drug Test episodes in 2013.
- A significant number of positive MDTs were for people known to treatment services.
- Oldham was 100th (best) out of 326 Local Authorities for alcohol related recorded crime.
- Oldham was 106th (best) out of 326 Local Authorities for alcohol related violent crime.

Young People (aged 18 years and below)

The new treatment service does not include a service for children and young people as this will be part of the new 0 – 19 year PSR Offer. In 2013-14 there were 142 children and young people in substance misuse treatment in Oldham.

Consultation Report (May 2014) Executive Summary:

Introduction

Oldham Metropolitan Borough Council commissioned the Centre for Public Innovation to undertake a consultation exercise to be used to support a subsequent comprehensive needs assessment. The needs assessment will be used to inform the modernisation of the current treatment system.

The consultation covered those in treatment and the treatment naïve, those in custody and engaged with probation services, families and carers, substance misuse professionals and volunteers and other key stakeholders. The consultation addressed both drug and alcohol use. In total, 103 service users and carers were interviewed as part of the consultation.

Conclusions

- **Recovery**: the majority of those consulted were attuned to the language of recovery, were comfortable with the concept, and saw it very much as something that treatment should be working towards.
  It is clear that service users are, on the whole, embracing the concept of recovery and so would no doubt welcome a more recovery-oriented treatment system. This consultation therefore endorses the decision to pursue a recovery-oriented treatment system.

- **Treatment journey**: service users described how the treatment journey should involve preparing them for life post-treatment from the outset. This would tend to suggest that setting ambitions and targets for clients from the point of engagement would be an important first step for many, along with an explanation of how treatment will work with them to prepare them for life post-treatment.
- **Psychological preparation**: those consulted communicated the importance of a psychologically-oriented approach to their treatment rather than a medically-oriented approach. That is, helping them prepare mentally for detox and a life after using, rather than focusing on the provision and use of a script. In shifting towards a recovery-oriented system, the role of psychological preparedness should be incorporated as much as possible to help people move to a contemplative phase in which they are more ready to move along their recovery journey.
- **Peer support**: those consulted noted the availability and importance of NA, AA and SMART recovery. It was widely recognised that different peer support models were appropriate for different people and therefore having a choice available locally was very important.

Next steps:

1. This consultation endorses the decision to explore a new recovery-oriented treatment system. Any such system will need to be designed in accordance with how service users perceive recovery. This would in turn tend to suggest a move away from a medically-oriented model of provision.

2. A shift to a recovery-oriented system is liable to involve a distinct change in mind-set for some currently delivering drug and alcohol services in Oldham. Work will need to be undertaken to support a culture change among staff and providers where work is currently being done in a more medically-oriented fashion in order that they support the new direction of travel.
3. The new treatment system should consider the role of a Single Point of Contact into both drug and alcohol services and the potential of co-locating this within a more generic service.
4. The new treatment system should consider emphasising the role of interventions to support psychological preparation for treatment.
5. The new treatment system should seek to expand the range of peer support services offered to create a grassroots, bottom-up recovery community who can support those going through treatment.
6. The new treatment system should consider separating out those clients who have been in treatment for an extended period and offering a distinct service recognising that for this cohort, dependency is a chronic condition.
7. The new treatment system should seek to renegotiate shared care services with GPs to align them more closely with the wider treatment system as well as enabling more clients to be treated in the community rather than in specialist services.
8. The new treatment system should maximise the role of volunteering for those coming through treatment to act both formally and informally as "recovery champions". Volunteering should in turn be linked into wider pathways to help volunteers move into further volunteering, training and employment opportunities.

There is an estimated 48% of drug users in Oldham who are not in treatment services and we do not know very much about this cohort.

We do not know very much about amphetamine users in treatment and amphetamine users in the criminal justice system as the Mandatory Drug Tests in the custody suite do not routinely record amphetamine use.

Further data collection

Summary (to be completed following analysis of the evidence above)				
Does the project, policy or proposal have the potential to have a disproportionate impact on any of the following groups? If so, is the impact positive or negative?	**None**	**Positive**	**Negative**	**Not sure**
Disabled people	☐	☐	☐	☑
Particular ethnic groups	☐	☐	☑	☐
Men or women (include impacts due to pregnancy / maternity)	☐	☐	☑	☐
People of particular sexual orientation/s	☑	☐	☐	☐
People who are proposing to undergo, are undergoing or have undergone a process or part of a process of gender reassignment	☑	☐	☐	☐
People on low incomes	☐	☐	☑	☐

People in particular age groups	☐	☐	☑	☐
Groups with particular faiths and beliefs	☑	☐	☐	☐
Are there any other groups that you think that this proposal may affect negatively or positively?				
People in the criminal justice system.		☐	☑	

Stage 3: What do we think the potential impact might be?

Consultation information	
3a. Who have you consulted with?	- A wide range of stakeholders - Service providers and potential service providers - Service users and potential service users
3b. How did you consult? (inc meeting dates, activity undertaken & groups consulted)	**Via meetings, briefings, and events (see below).** **Also commissioned a service user consultation from the Centre for Public Innovation.** **Alcohol and Drugs Strategic Forum Membership:** (Meetings: 5 March 2014, 13 May 2014, and every 6 weeks thereafter) **Drug and Alcohol Design Group (Task and Finish) Membership:** (Meetings: 10 December 2013; 10 January 2014; 5 February; 22 February 2014). **Drug and Alcohol Criminal Justice Design Group (Task and Finish) Membership:** (Meetings: 11 February 2014, 6 May 2014). **Community Safety and Cohesion Partnership (Board) Membership:** (Presentation on Re-designing the Drug and Alcohol Treatment System/PSR on 7 May 2014) **Provider Event (Drug and Alcohol Treatment System) – 8th April 2014** **Drug and Alcohol Scoping Workshop for PSR – 29 November 2013 attendees:** **Public Service Reform Programme Planning Group Membership:** (Meets every Tuesday. Also specific meetings on 24 September 2013; 24 January 2014). **PSR Drug and Alcohol Task and Finish Group attendees:** (Meetings: 7 November 2013). **Service Managers Meeting (drugs and alcohol) Membership:** (Meetings: every 6 weeks) **Consultation Report** The DAAT Strategic Manager, on behalf of Oldham Metropolitan Borough

	Council, commissioned the Centre for Public Innovation to undertake a consultation exercise in May 2014, to be used to support a comprehensive needs assessment to inform the modernisation of the current treatment system for 2015-16. The consultation covered those in treatment and the treatment naïve, those in custody and engaged with probation services, families and carers, substance misuse professionals and volunteers and other key stakeholders. The consultation addressed both drug and alcohol use. In total, 103 service users and carers were interviewed as part of the consultation. The final Consultation Report has been published and is attached at Appendix 1.

3c. What do you know?

Drug and alcohol use and misuse is a significant issue in Oldham.
The current treatment system is successfully commissioned to address the numbers of people in drug and alcohol treatment and to address the particular needs of:

(a) Alcohol only users.
(b) Opiate and/or crack users.
(c) 18-25 year olds who are not opiate and/or crack users.
(d) People in recovery.
(e) People dependent on benzodiazepines.
(f) Children and young people aged 18 years and younger.
(g) People in need of in-patient detoxification and/or community rehabilitation/ residential rehabilitation.

The current treatment system performs well (based on evidence) and in the top quartile for the PHE Cluster D (based on similar demography and treatment population). It also performs well in comparison to other Greater Manchester LAs and the North West.

The proposal is to reduce funding in alcohol and drug treatment by approximately 40% (£2million) for 2015 and beyond, in line with public service efficiency targets and specifically Public Health efficiencies.

With regard to current and future challenges, Black and Asian people are under-represented in treatment. Women are also under-represented. There will be an ageing treatment population as currently 63% of the treatment population are aged 35 – 65+. There are significant numbers of people dependent on benzodiazepines in Oldham.

Our commissioned Consultation told us that:

- The reasons why people misuse substances are complex and multi-faceted.
- It takes a number of years for people to access treatment services.
- The majority of people currently in treatment want to recover (i.e. become abstinent; or stabilised and able to work/socially function).
- Preparation for life post-treatment is essential, as is effective first contact (preferably via a Single Point of Access).
- Relatives, significant others and friends play an important role in the recovery of clients from addiction.
- Peer-group pressure is a significant factor in the on-set of substance use and misuse.
- Programmes that dig deep to explore the motivation to use and misuse substances are successful (RAMP and Intuitive Recovery currently commissioned).
- Counselling, peer support and volunteering are seen as important elements of the treatment

system.

- A change in mind-set and/or culture of some staff in currently commissioned treatment services is needed to effectively support recovery.
- A move away from a medically orientated model of provision is required.

3d. What don't you know?

It is very difficult to predict the impact on a completely new model of delivery, backed up by the Council's Early Help Offer (all age) which is a completely new way of delivering early help to vulnerable people, based on the co-operative Council work and PSR agenda.

3e. What might the potential impact on individuals or groups be?	
Generic (impact across all groups)	There might be insufficient capacity in treatment services for people requiring support and treatment, particularly those less 'problematic' substance users/misusers such as benzodiazepine dependents. There may be difficulties in transitioning from the existing model to the new model of treatment delivery. The new treatment service is predicated on the Council's new Early Help Offer (delivering the PSR agenda) supporting people with drug and alcohol problems and acting as a Single Point of Access. This might not work effectively because it has not been tried before and the complex needs of this cohort might not be able to be addressed in this way. Potential providers might not bid for the new treatment system because of the low value and TUPE costs.
Men or women (include impacts due to pregnancy / maternity)	Pregnant drug and alcohol users might not get effective support. Women are under-represented in treatment currently and a reduced service may exacerbate this.
People of particular sexual orientation/s	-
Disabled people	Some disabled people misuse substances so therefore some members of this group would be affected.
Particular ethnic groups	Black and Asian people are underrepresented in treatment services and a reduced service may exacerbate this.
People who are proposing to undergo, are undergoing or have undergone a process or part of a process of gender reassignment	-
People on low incomes	The majority of people in treatment services, or needing treatment, are on low incomes are unemployed. A reduced service would impact on this group more than more affluent people, because this group has less choice and is less able to access treatment services and support

People in particular age groups	The current treatment system is for all ages and includes children and young people. The new treatment system is for adults aged 18 years and over. The children and young people's element will be part of the 0-19 Early Help Offer. It is not yet clear how this will be delivered. (Note: There is a separate EIA being done for the Early Help Offer).
Groups with particular faiths and beliefs	-
Other excluded individuals and groups (*e.g. vulnerable residents, individuals at risk of loneliness or carers*)	People in the criminal justice system are particularly hard to engage and have complex dependencies. This group will require additional support. The reduction in the treatment system may impact on this group.

Stage 4: Reducing / mitigating the impact	
4a. Where you have identified an impact, what can be done to reduce or mitigate the impact?	
There might be insufficient capacity in treatment services for people requiring support and treatment, particularly those less 'problematic' substance users/misusers such as benzodiazepine dependents.	**Options/ what can be done to reduce the impact:** The intention is that the new model will reduce demand on this service. If not then there might have to be waiting lists for treatment. If this is the case, then this will need to be reviewed. The situation should be reviewed in 6 months. Additional funding might have to be identified to address this if it becomes a problem (to increase capacity). Support for people with benzodiazepine dependency has been written into the Specification. The Council's Early Help Offer is also offering talking therapies and support for people with mental health issues and drug and alcohol issues, so support could be offered to benzodiazepine dependents.
There may be difficulties in transitioning from the existing model to the new model of treatment delivery.	**Options/ what can be done to reduce the impact:** As the proposal is for a very different treatment model at a significantly reduced cost, then some elements should continue if possible to create a degree of continuation. In this respect, Acorn Community Rehabilitation should continue to be the default Tier 4 provider. They are part of the Tier 4 Framework and this is not part of the new commission. Existing providers should continue to be consulted on a regular basis to continue the good relationships between commissioner and providers to help with the transitional arrangements.
The new treatment service is predicated on the new PSR Early Help Offer supporting people with drug and alcohol problems and acting as a Single Point of Access. This might not work effectively because it has not been tried before and the complex needs of this cohort might not be able to be addressed in this way.	**Options/ what can be done to reduce the impact:** The complex dependencies for substance misusers must be taken into careful consideration by the PSR team when designing their model. Contingency plans should be put in place by the PSR team. It is recommended that a Transitional Coordinator is in place for a 12 month period to ensure one of the commissioned services targeting the most vulnerable people (criminal justice; BME residents; women) (Recovery and Reintegration) transitions into the Early Help model in 12 months time (or recommend an alternative model). Funding has not been identified for this post.
The procurement process has now been completed and there was only one bid for the new treatment system. This is likely because of	**Options/ what can be done to reduce the impact:** The one bid received is high quality and supported by a good interview. The recommendation is to award the contract to that bidder. The contract will be robustly monitored and report on, with a 6 month review of performance.

the low value and TUPE costs.	
Pregnant drug and alcohol users might not get effective support.	**Options/ what can be done to reduce the impact:** To include in the new Specification that the needs of pregnant substance misusers must be catered for.
Women are under-represented in treatment currently and a reduced service may exacerbate this.	**Options/ what can be done to reduce the impact:** Ensure the Women's Centre in Oldham support women with substance misuse problems/ victims of domestic violence. Ensure new provider(s) work with the Women's Centre.
Black and Asian people are underrepresented in treatment services and a reduced service may exacerbate this.	**Options/ what can be done to reduce the impact:** The Recovery and Reintegration Service will work with people from ethnic minority communities in a targeted way to ensure they are supported and appropriately represented. External funding will be sought to continue to support this priority throughout the year.
The majority of people in treatment services, or needing treatment, are on low incomes are unemployed. A reduced service would impact on this group more than more affluent people.	**Options/ what can be done to reduce the impact:** The Council's Early Help Offer will have to support this group towards and into employment.
The current treatment system is for all ages and includes children and young people. The new treatment system is for adults aged 18 years and over. The children and young people's element will be part of the 0-19 PSR Offer. It is not yet clear how this will be delivered.	**Options/ what can be done to reduce the impact:** The Early Help 0-19 Offer will have to ensure an effective substance misuse service for 18 years and under. The new treatment service will have an identified worker to link in with the young people's substance misuse service as part of the 0-19 PSR Offer. The specific needs of young adults will be addressed within the new treatment system.
People in the criminal justice system are particularly hard to engage and have complex dependencies. This group will require additional support. The reduction in the treatment system may impact on this group.	**Options/ what can be done to reduce the impact:** Continue to work with criminal justice agencies/colleagues to support this group and ensure a joined-up approach. Continue to lobby for Police and Crime Commissioner funding. Work with colleagues across Greater Manchester for collaborative commissioning to support this work. The Recovery and Reintegration Service to prioritise this group.

4b. Have you done, or will you do, anything differently as a result of the EIA?
Yes the Council/team/service will review the Service Specifications prior to the procurement process. I will ensure the continuation of joint work between the DAAT and PSR.

4c. How will the impact of the project, policy or proposal and any changes made to reduce the impact be monitored?
The Council/team/service will monitor the Action Plan from this EIA on a regular basis.

Conclusion

The overall (positive) impact of the proposal is that there is the opportunity for a transformational treatment system linked to the all age Early Help Offer (PSR agenda) which will help people move more quickly into recovery and support them in recovery. If this model works then that would have very positive outcomes and reduce the cost to the public purse. However it is an untested model.

The new treatment service, with reduced capacity, is relying on better through-put of people in and out of treatment; a new culture and ethos of people delivering support/treatment which is based on recovery and better wrap-around services as part of the Council's Early Help offer.

However, it is very difficult to predict what capacity is required. For example, if Oldham's rate for drug and alcohol treatment is more than double that in the region and nationally (based on averages), this could result in waiting lists for people requiring treatment and as this group of people are particularly complex, such a wait would probably result in further offending and/or other risky behaviours and in escalation towards the crisis end of addiction, thus requiring longer treatment from specialist treatment providers at an increased cost and for a longer time.

There could be secondary and consequential negative impacts on children whose parents cannot access treatment in a timely way and when they are motivated to change their behaviour. This tends to be a 'window of opportunity' and very much depends on the individual, where they are on their 'addiction journey' and a range of factors which affect their motivation to change/ seek help.

The information above on page 4 highlights the large number of middle-aged people in drug and alcohol treatment (aged 25 – 54) and there could be a disproportionate impact on this group of people.

Offenders with addiction problems tend to be the most difficult group to engage and support. They are also a very high demand group in terms of the cost to the public purse. There could also be a disproportionate impact on this group.

Overall, the people impacted are those already in treatment, people who will enter treatment and people using and misusing substances in the community who are not in treatment.

Steps to reduce/mitigate the impact:

- Governance: Alcohol and Drugs Strategic Forum chaired by the Director of Public Health, to oversee performance and delivery of the new treatment system and recommend any further developments.
- Governance: The Community Safety and Cohesion Partnership, chaired by the Chief Superintendent of Police, to oversee the criminal justice aspects of the new treatment system and the effective support of people in, and exiting from, the criminal justice system with drug and/or alcohol problems.
- Governance: Robust links between the new treatment system and PSR Early Help Offer: Via governance arrangements (meetings) and the appointment of a Transitional Coordinator to oversee the Recovery and Reintegration Service and PSR Early Help.
- The Recovery and Reintegration Service to be targeted at the most vulnerable groups – people in the criminal justice system and exiting from it; people in BME communities, women and veterans.
- Robust links between the Structured Treatment Service and the Recovery and

Reintegration Service and this to be written into both Specifications.

Stage 5: Signature	
Lead Officer: **Janet Sewart.**	**Date: 3.11.2014**
Approver signature: Alan Higgins	**Date: 3.11.2014**
EIA review date: December 2015	

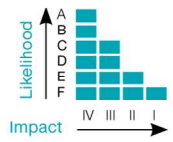
APPENDIX 1: Action Plan and Risk Table

Action Plan

Once you have decided on the course of action to be taken in order to reduce or mitigate the impact, please complete the action plan below (An example is provided in order to help you)					
Number	Action	Required outcomes	By who?	By when?	Review date
1	Review numbers of people using new treatment service on a quarterly basis and report via Governance arrangements, including people from BME communities, women and people in the criminal justice system.	➢ Sufficient capacity to meet demand	Data Management Officer	Quarterly	July 2015
2	Ensure effective governance arrangements to oversee performance and delivery reporting to the Alcohol and Drugs Strategic Forum, CSCP, PSR etc.	➢ Council and key partners to ensure the needs of this vulnerable cohort are being addressed effectively.	DAAT Strategic Manager; Chairs.	Quarterly	July 2015
3	Regular meetings with existing and then the new provider(s)	➢ Smooth transition from existing treatment system to new treatment system.	DAAT Strategic Manager. Provider managers.	Every other month.	May 2015
4	Consult service users (via focus groups etc.) to explore the service users experience of the new treatment system	➢ To ensure the new treatment system meets the needs of the people using the service.	New service provider(s).	September 2015	March 2016
5	Explore funding opportunities for a Transitional Coordinator to link the treatment system into PSR and support the transition for 2015 onwards.	➢ Someone who understands the issues for people with complex dependencies and also understands the PSR model to ensure a smooth transition from specialist provision into PSR for 2015.	DAAT Strategic Manager. PSR Manager.	August 2014.	March 2015.
6	Ensure people in the criminal justice system and exiting from the criminal justice system are engaged early and supported into and out of treatment/support/recovery and link into the new Community Rehabilitation Company (CRC)/ National Probation Service (NPS) model from April 2015.	➢ Early engagement, support, treatment and sustained recovery for people in and out of the criminal justice system.	DAAT Strategic Manager. CJ (DAAT) Coordinator.	September 2015	March 2016.

Risk table

Record any risks to the implementation of the project, policy or proposal and record any actions that you have put in place to reduce the likelihood of this happening.					
Ref.	Risk	Impact	Actions in Place to mitigate the risk	Current Risk Score	Further Actions to be developed
R1	Fragmentation	Ineffective pathways in place in and out of the 2 elements of the treatment system and PSR Early Help	Governance arrangements	C	Regular meetings with new provider(s) and PSR team
R2	PSR Early Help is not able to support the complex needs of substance misusers	Escalating dependency/addiction issues requiring high end support. Increase in demand and cost.	Governance arrangements	C	Appointment/identification of a Transitional Coordinator. Regular meetings with new provider(s) and PSR team.
R3	Low number/ low quality bids for the treatment system	Unable to appoint new provider(s)	Currently providers have been regularly consulted and are aware of the new Specifications and value.	D	Re-visit funding available for drug and alcohol treatment and support and potentially identify more funding.
R4	The complex needs of certain high risk groups are not able to be met as part of the reduced treatment system.	People potentially affected: BME communities. People in the criminal justice system. Young adults 18-25 years. Benzodiazepine users.	Additional funding has been identified to commission a recovery and reintegration service. This will focus on people in the criminal justice system, BME communities and women.	C	The Recovery and Reintegration Service is not a large commission. It will be necessary to review capacity issues and ensure these high risk groups are effectively supported.



Likelihood:
A Very high
B High
C Significant
D Low
E Very low
F Almost impossible

Impact:
I Catastrophic
II Critical
III Marginal
IV Negligible

OLDHAM METROPOLITAN BOROUGH COUNCIL

SUBSTANCE MISUSE CONSULTATION

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April 2014

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Table of Contents

The Centre for Public Innovation is a Community Interest Company that provides research, training, support and advice in the fields of health, social care, criminal justice and community development.

Our mission is to improve the outcomes of public services for their users, with a particular emphasis on the most disadvantaged.

CPI would like to thank everyone who has assisted with this consultation and gave of their time freely to share their views and help in organising aspects of the research.
Thanks to the hard work and persistence of the peer researchers who added invaluable insight that has added extra depth and quality to the findings.
Further thanks to service users who gave honest and heartfelt accounts of their individual journeys about the impact drugs and alcohol have had upon their lives.

Introduction

Oldham Metropolitan Borough Council commissioned the Centre for Public Innovation to undertake a consultation exercise to be used to support a subsequent comprehensive needs assessment. The needs assessment will be used to inform the modernisation of the current treatment system.

The consultation covered those in treatment and the treatment naïve, those in custody and engaged with probation services, families and carers, substance misuse professionals and volunteers and other key stakeholders. The consultation addressed both drug and alcohol use. In total, 103 service users and carers were interviewed as part of the consultation.

Factors contributing towards substance misuse

For the majority of individuals spoken to, much of their drug/alcohol use had started in their mid-teens. Regardless of the age cohort, using drink and drugs was described to be the norm amongst their peers. Social environment and acceptability amongst peer group was significant where drugs and alcohol was a common part of the social/working environment. It was common for individuals to use a range of psychoactive substances.
For those engaging with substance misuse services they found that their drinking or drug use did not remain at a 'safe' recreational level but had escalated to the point they were drinking and using drugs everyday, and the substance use had become a necessary physical and psychological fix.
Those who had gone through a therapeutic programme such as the RAMP programme and ADS group work spoke of a deeper understanding as to the reasons for their use and had begun to explore the links with motivation to use. Reasons these interviewees gave included:

- Family history of alcoholism and/or drug use
- Mental illness
- Childhood trauma
- Environmental factors
- Biological disposition
- Bereavement
- Response to life stresses

Contact with services

For the majority of individuals spoken to, it had taken a number of years before they had considered accessing services, with many speaking of several previous attempts having gone through detox and rehab.
In most cases interviewees said that they had entered treatment services because they had heard about them from other service users or were referred

by other agencies. Many said they had used the same service on more than one occasion.
Contact via letter was difficult for those living in chaotic circumstances where housing was an issue. Many did not have access to a mobile or frequently sold it on. Individuals recognised that when their life was chaotic this created challenges for services to maintain regular contact. None had come into contact with treatment via web-technologies (e.g. looking at websites and searching on the internet).
For a number of those interviewed, relatives had played a significant role in encouraging individuals to engage with treatment services.

Recovery

The consultation sought to explore what substance misusers understood recovery to be, and whether this was something that they wished to pursue through their treatment journey.
Most agreed that it was about abstinence and staying abstinent. A number of interviewees elaborated further, suggesting that recovery was about reflecting on, and understanding, the past and changing attitudes and behaviours. In a number of cases individuals equated recovery with re-building relationships with people who had been important to them.
While the majority thought that recovery was about being completely drug free, some interviewees considered themselves to be 'recovering' while still on a script, as long as they were stable.
The key factors which interviewees described as having helped achieve recovery included achieving stability, an increase in self-belief and feeling that there is a purpose to life. Keeping busy was essential to combating boredom which in turn was identified as a key contributing factor to relapse.

The role of different interventions

- **Counselling** was felt to be beneficial as it looked at an individual's wider context. This was not felt to be available or beneficial through one-to-one support. Some individuals were less happy with regards to the content of one-to-one, and felt sessions focused too much on the drinking or drug use. The majority of service users felt focusing purely on substance use related issues was not sufficient to produce enduring change and that practitioners needed to look at the wider context of their lives.
- **Peer support** were rated highly with some interviewees attending groups every day, however for others the philosophy did not feel comfortable. Nearly all of the interviewees interviewed cited peer support from others in recovery as an important element of recovery.
- **Volunteering** and peer mentoring work was seen as extremely positive and gave purpose, an increase in confidence, structure and opportunity to learn new skills. Across the services in Oldham many workers were ex-users were highly regarded by service users.

Discussion

A number of themes emerged of some note:

- **"Stuck" clients** is the label used by some to discuss those who have been in substance misuse treatment for extended periods of time. The

consultation highlighted the fact that many individuals had had multiple treatment episodes, or had continued to be in the treatment system for many years. The data from the stakeholder consultation tends to suggest that remaining in treatment for multiple years is not an aspiration for many clients, many of whom want to get “clean”.

- **First contact** was raised as those consulted talked about the importance of being ready to go into treatment and that, if this window of opportunity is missed, potentially disengaging again for a considerable time. The importance was stressed therefore of successful initial engagement to both encourage people to enter treatment and to start accessing services.
- **Volunteers** very highly regarded by those consulted. They were seen as exemplars, and proof that recovery was a real possibility. Their perspective as an ex-user was praised as they understood what treatment involved and what people had been through prior to engaging in treatment.
- **Shared care** was noted by its absence – that is none of the clients consulted referred to accessing GPs or receiving support via their GP.
- **Information technology** - none of the individuals spoken to used or had access to the internet, however a number did identify that they would like to learn how to use a computer but felt ‘stupid’.

Conclusions

- **Recovery**: the majority of those consulted were attuned to the language of recovery, were comfortable with the concept, and saw it very much as something that treatment should be working towards.
  It is clear that service users are, on the whole, embracing the concept of recovery and so would no doubt welcome a more recovery-oriented treatment system. This consultation therefore endorses the decision to pursue a recovery-oriented treatment system.
- **Treatment journey**: service users described how the treatment journey should involve preparing them for life post-treatment from the outset. This would tend to suggest that setting ambitions and targets for clients from the point of engagement would be an important first step for many, along with an explanation of how treatment will work with them to prepare them for life post-treatment.
- **Psychological preparation**: those consulted communicated the importance of a psychologically-oriented approach to their treatment rather than a medically-oriented approach. That is, helping them prepare mentally for detox and a life after using, rather than focusing on the provision and use of a script. In shifting towards a recovery-oriented system, the role of psychological

preparedness should be incorporated as much as possible to help people move to a contemplative phase in which they are more ready to move along their recovery journey.

- **Peer support**: those consulted noted the availability and importance of NA, AA and SMART recovery. It was widely recognised that different peer support models were appropriate for different people and therefore having a choice available locally was very important.

Next steps:

9. This consultation endorses the decision to explore a new recovery-oriented treatment system. Any such system will need to be designed in accordance with how service users perceive recovery. This would in turn tend to suggest a move away from a medically-oriented model of provision.
10. A shift to a recovery-oriented system is liable to involve a distinct change in mindset for some currently delivering drug and alcohol services in Oldham. Work will need to be undertaken to support a culture change among staff and providers where work is currently being done in a more medically-oriented fashion in order that they support the new direction of travel.
11. The new treatment system should consider the role of a Single Point of Contact into both drug and alcohol services and the potential of co-locating this within a more generic service.
12. The new treatment system should consider emphasising the role of interventions to support psychological preparation for treatment.
13. The new treatment system should seek to expand the range of peer support services offered to create a grassroots, bottom-up recovery community who can support those going through treatment.
14. The new treatment system should consider separating out those clients who have been in treatment for an extended period and offering a distinct service recognising that for this cohort, dependency is a chronic condition.
15. The new treatment system should seek to renegotiate shared care services with GPs to align them more closely with the wider treatment system as well as enabling more clients to be treated in the community rather than in specialist services.
16. The new treatment system should maximise the role of volunteering for those coming through treatment to act both formally and informally as “recovery champions”. Volunteering should in turn be linked into wider pathways to help volunteers move into further volunteering, training and employment opportunities.

Oldham Metropolitan Borough Council (hereafter Oldham) commissioned the Centre for Public Innovation (hereafter CPI) to undertake a consultation

exercise to be used to support a subsequent comprehensive needs assessment. The needs assessment will be used to inform the modernisation of the current treatment system in order to:

- Focus on prevention and early intervention
- Prevent relapse and re-presentations
- Put recovery at the heart of the treatment system.

The consultation undertaken was intended to be broad in its scope – both in terms of those to be consulted and the range of substances that fall within scope. The consultation covered those in treatment and the treatment naïve (that is, those with no previous experience of substance misuse); those in custody and engaged with probation services, families and carers, substance misuse professionals and volunteers and other key stakeholders. The consultation addressed both drug and alcohol use.

Note on terminology

For the sake of brevity, the term “substance misuse” is used throughout this report as a catch-all. This should be taken to refer to all substances, including alcohol.

The consultation adopted a qualitative approach – that is, all aspects of the consultation involved interviews and focus-groups.
The research comprised three elements:

- Service user consultation – undertaken by CPI researchers
- Peer research – undertaken by a group of trained service user
- Professional consultation – undertaken by CPI researchers

Each of the three consultation elements is described below.

In total, 103 service users and carers were interviewed as part of the consultation.

4.a Service user consultation

This part of the consultation was led by trained researchers/consultants and engaged with a range of individuals in treatment (including offenders) from:

- HMP Forest Bank
- ADS
- Gateway
- Acorn Treatment (RAMP)
- Acorn Treatment (Secondary Care)
- Intuitive Recovery

The sample was chosen opportunistically from existing drop ins, group sessions and a local recovery event held at Gateway, in addition to seven offenders who were accessing drug services in HMP Forest Bank. Individuals interviewed span the whole recovery journey from the initial stages of coming into treatment and using substances of some kind, to those who had been abstinent for a period of time.
The consultation also engaged with existing carers' groups, and where appropriate service users were asked to invite family members who wished to participate and speak to the researcher about their experiences in confidence.
In total, 66 service users were consulted as well as 14 carers.
Data were collected using a semi-structured interview schedule developed specifically for the consultation.
Service users were asked a range of questions which reflected the objectives of the consultation; to understand the impact drugs and alcohol had upon their lives and the lives significant others' as well as understanding their experience of local services.
Key areas included consideration of:

- Understanding what led to an individual using drugs/ alcohol and continuing to do so.
- What had helped/was helping in recovery?
- What were the main challenges which impacted upon their recovery?

- Their experience of services and the contribution of different types of support and interventions including, peer support, group work, one-to-one
- Access and engagement with services including first contact with services and the value of the phone and internet
- Experience of support from volunteers as well as positive role models

The interview pro forma used is set out in the Appendix.

4.b Peer research consultation

To ensure that the consultation was as broad in scope and as inclusive as possible, a peer research approach was also adopted – that is, training individuals from within the substance misuse community to interview others within this population.
Peer research was adopted as a means to engage with people who might not wish to engage with a researcher. As such, it enabled the consultation to tap into a variety of voices and opinions of those who might not otherwise have been heard.
CPI's approach to undertaking the peer research is set out below.

Recruitment of peer interviewers

With the help of senior practitioners, CPI identified 10 service user volunteers who were appropriate to become peer interviewers. Criteria of "appropriateness" included being in recovery, being motivated to engage in training and ongoing research work, and having certain key aptitudes (such as confidence in talking to other people).

Peer Interviewer Training Workshop

Ten individuals were invited to a training day on 10th December 2013. Eight individuals attended (five men and three women.)
The training workshop included an introduction and general overview of the aims and objectives of the substance misuse consultation, why it was important for service users to be involved, an explanation of the proposed role of peer interviewers, the interview schedule and an introduction to interviewing techniques - especially listening skills. Peer researchers also received training on basic interviewing techniques. Information, guidance and support were given on health and safety, responsibilities, ethics, informed consent and lone working.

Peer researcher target group to be interviewed

CPI wanted the peer interviews to target a number of distinct cohorts, namely:

- People who had never been in treatment. This might include people in contact with the needle exchange but not long term clients of a treatment service.
- People who had recovered who might or might not be in contact with treatment services.

It was envisaged that potential interviewees would therefore be people who:

- Were users who were known to the peer interviewers but not in treatment
- Attended the needle exchange
- Attended the Oldham Recovery Base
- Attended the Wellbeing Centre
- Attended the Advocacy Project

All the peer interviewers agreed to undertake five interviews each, which were to be undertaken during the second and third week of January.
When the CPI consultant tried to contact them at the end of the second week of January, it was not possible to reach three of them, because of changed/unobtainable numbers. In addition:

- one now had a job
- one had been accepted on a training course, and
- one had relapsed after Christmas and was not fit to undertake interviews.

However, the two remaining peer researchers managed to undertake 11 and 12 interviews respectively, meaning that a total to 23 peer interviews were successfully completed.

4.c Professional stakeholder consultation

To ensure that a strategic perspective was included in the consultation, CPI undertook interviews with a number of professional stakeholders.

Professional stakeholders were consulted from the following organisations:

- Oldham Metropolitan Borough Council (officers and Elected Members)
- Police
- Probation
- Clinical Commissioning Group

In total, 12 stakeholders were interviewed. A copy of the interview pro forma is set out in the Appendix.

4.d Stakeholder event

Towards the end of the consultation period, a stakeholder event was held drawing key stakeholders and practitioners together from across Oldham. The purpose of the event was to explore a number of themes from the data to better understand and contextualise the data collected. In total 15 stakeholders attended the event including user representatives.

This section sets out the profile of the sample population consulted as part of this work. In total 103 service users and carers were interviewed.

5.a Service user consultation

Table 1 shows the breakdown of individuals consulted by the CPI researcher and sets out the profile according to gender, ethnicity and accommodation.

Table 1: Composition of service users consulted

	Number
Gender	
Male	43
Female	23
Total	**66**
Ethnicity	
White British	61
Bangladeshi	1
Irish	2
Traveller	1
South African	1
Total	**66**
Accommodation status	
Own home	12
Hostel/Supported	10
Renting	19
Acorn Secondary Care	9
NFA	2
With family	7
Total	**59**
Employment status	
Employed	6
Unemployed	39
Housewife/husband	1
College	1
Volunteering	12
Total	**59**

Parenting status	
No children	20
Have children and are in contact	22
Have children and have intermittent contact (includes children on child protection plan/in foster care)	13
No contact	11
Total	**66**

Note the seven individuals spoken to in prison do not feature in the accommodation/ employment statistics.
In terms of age, this ranged from 25 years to 61 years (for men) with a mean age of 42. For females, this was 24 years to 51 years with a mean age of 39 years.

Status of respondents (carers)

11 carers were female (10 mothers and one daughter) and three males (all fathers). All were White British.

5.b Peer researcher interviewees

The peer researchers trained (see Section 4 – above) undertook a total of 23 interviews. Of these:

- 15 were male and 8 were female
- 20 self-identified as White British
- one self-identified as Black British
- one self-identified as Asian
- one self-identified as Jewish.

The age range spanned from 32 to 56 years.

- Seven of those interviewed were in their thirties,
- 10 were in their forties
- five were in their fifties.

In terms of accommodation:

- 12 of the interviewees lived alone in privately rented bedsitters or one bed flats.
- seven lived in supported accommodation;
- two lived with parents and
- two were homeless (“sofa surfing” or sleeping on friends floors for short periods).

In relation to employment status, one interviewee was in employment, one was working as a volunteer with the NHS. The rest (21) were unemployed and all bar the interviewee in employment were in receipt of benefits.

5.c Note on sample

Whilst a broad cross-section of users was consulted, we note that certain groups are missing within the sample.
Local professional stakeholders talked of a growing population of steroid users. None of those consulted reported using steroids. At the stakeholder event, attendees noted that the general perception was that steroid users access needle exchange services but are as yet not accessing treatment *per se*.
We note that, among the sample population, no one was interviewed with a primary over-the-counter medicine dependency (such as benzos).
We note also that users of novel psychoactive substances did not feature in the sample population.

At the outset of each interview, CPI researchers explored the early history of people's substance misuse and their perceptions of what they thought had led them to engage in drug and alcohol use. These findings are set out below. Note – peer researchers were not asked to investigate contributory factors so this section is derived solely from CPI obtained data.
For the majority of individuals spoken to, much of their drug/alcohol use had started in their mid-teens (between 14 – 17 years). Regardless of the age cohort, using drink and drugs was described to be the norm amongst their peers. Social environment and acceptability amongst peer group was significant where drugs and alcohol was a common part of the social/working environment.
For those engaging with substance misuse services they found that their drinking or drug use did not remain at a 'safe' recreational level but had escalated to the point they were drinking and using drugs everyday, and the substance use had become a necessary physical and psychological fix.

- "I got to the point where I would wake up trembling, stomach cramps, feeling sick it was awful and [I] would have to drink before I even got out of bed...I was a wreck."
  (Female, 43 years, alcohol)
- "I was the one out of my friends who no longer just took drugs at the weekend I started to seek them out more regular. I wanted more and I didn't care at the time. It became my main purpose in life."
  (Male, 29 years, ecstasy, amphetamine and coke)
- "I ask myself 'Why do I have to use until I black out?' I can't use in moderation."
  (Male, 42 years, alcohol)
- "Even being on life support and nearly dying has not been a deterrent to stop using."
  (Male, 51 years, heroin, cocaine)
- "I was brought round from an overdose and went straight back out to score from hospital."
  (Male, 32 years, heroin, anti-depressants)

It was common for individuals to use a range of psychoactive substances. Poly-drug use included using more than two substances during a certain period where some individuals wished to experience the effects of both substances simultaneously, to improve the effects of a particular drug or to help manage negative effects.
When asked how their drinking or drug use had intensified to a level of dependency, internal reflectivity and insight varied depending upon where individuals were in their recovery. For those who were in the earlier stages, many were not clear why they had chosen to drink and use drugs to excess: some cited enjoyment while others mentioned not being able to know when to

stop when something was causing so much harm. Others felt they had a lack of disregard for the negative impact of substances and that these were outweighed by the 'buzz' and 'good feelings' and that addiction gave them positive reinforcement. For others, drugs and alcohol helped to disguise feelings of low self confidence and difficulties to lead a 'normal life'.
For those who had gone through a therapeutic programme such as the RAMP programme and ADS group work, individuals had and spoke of a deeper understanding as to the reasons for their use and had begun to explore the links with motivation to use, understanding this as part of their recovery, highlighting the 'multiple functions' the substance use had for the individual. This was considered useful in understanding how personality and environmental variables impacted on patterns of drug use and how the perceived functions predicted the likelihood of future consumption.
Reasons given included:

Family history of alcoholism and/or drug use

Their own parents had drunk. It was a tolerated activity amongst family. Some spoke of neglect and secret alcohol use.
A number of individuals had got involved and started a relationship with someone who used drugs which later became a joint activity.

Mental illness

Individuals spoke of struggling with an anxiety, depression and low mood since their teens which had gone un-noticed and un-treated.

- "I have been self harming since I was 14...with several attempts of overdose, I cut my wrists last time and ended up in the ICU for three days. The doctors couldn't understand how I survived."
  (Male, 32 years, cocaine and alcohol)
- "Looking back I was depressed. I was withdrawn, [I] started to disengage at school and home, stayed a lot in my room but no one questioned it [they] thought I was just being moody."
  (Male, 44 years, alcohol)

Childhood trauma

For some service users there was a suggestion of a link between early life experiences and substance misuse, suggesting that their drug/alcohol use was an attempt to self-medicate, and to try and disassociate from negative feelings and thoughts. The types of childhood trauma which were particularly prevalent amongst those with drinking problems was emotional abuse and neglect from their parents/significant others.

Environmental factors

Peer pressure was mentioned by several service users who felt this was not age specific. Individuals spoke of falling prey to peer pressure to fit into new social classes, new workplaces and new neighbourhoods.

- "I moved here [Oldham] from Bournemouth with me brother. Where we were housed was full of drug users and we knew no one. The only way not to stick out as the new people was to make friends. You had to use s'mthin' to survive if you wanted to carry on living here."

(Male, 29 years, heroin)

Biological Disposition

Those who had followed a 12 step model programme spoke of their biological vulnerability to addiction before they even began to use drugs or alcohol and this perspective was also echoed by some family members.

Bereavement

Some individuals had started to use drugs or alcohol to help self-medicate and escape emotions in response to a death of a family member.

- "When my partner died I started to take all sorts [drink and drugs] anything to block out the pain. I don't think I have ever grieved even after all these years because I would take anything to block out the pain. The pain would be so intense now cause I've never faced up to what happened".
  (Male, 45 years, heroin, alcohol)

Response to life stresses

For several individuals the dependency has been sourced from a significant relationship breakdown, redundancy, losing children through social service involvement and financial worries.

7.a Previous contact with treatment services

For the majority of individuals spoken to, it had taken a number of years before they had considered accessing services, with many speaking of several previous attempts having gone through detox and rehab. The main conflict was giving up even when knowing the levels of harm it was causing in their lives but committing to abstinence was a challenge in itself.

- “I was in denial for years. The drink was at the side of my bed, it was really bad.”
  (Female, 44 years, alcohol, cannabis)
- “I didn’t see anything wrong with my drug use, it wasn’t until it started to impact my work and I was losing jobs that I realized.”
  (Male, 42 years, heroin)

Sixteen of those that the peer researchers interviewed (out of 23) had previous contact with drug treatment services in Oldham and elsewhere in the country. Four of those interviewed were ‘treatment naive’, and three of these had gone straight into abstinence based recovery services.
In most cases interviewees said that they had entered treatment services because they had heard about them from other service users or were referred by other agencies. Many said they had used the same service on more than one occasion. For example:

- “I already knew about the service 'cos I had used it in the past. I needed help and knew where to go.”
- “I already knew I could trust the people there to help me.”
- ‘”he police referred me to a drug worker after I had been arrested.”
- “My GP knew I was in a mess and got me an appointment with the drug service at Gateway.”

7.b Engagement with treatment

First contact with services varied depended upon when the individual first came into services.
Contact via letter was difficult for those living in chaotic circumstances when housing was an issue and they were ‘sofa surfing’ as well as by phone as many did not have access to a mobile or frequently sold it on. Individuals recognised that when their life was chaotic this did create challenges for services to maintain regular contact. Suggestions were given to be able to access ‘information points’ to touch base where they could receive regular information and reminders of when their appointments were.

None had come into contact with treatment via web-technologies (e.g. looking at websites and searching on the internet).
Individuals spoke of varied levels of contact with services which appeared to depend upon specific workers.
Of those that the peer researchers interviewed, all who had had previous contact with treatment services were asked what had encouraged them to seek treatment. In the majority of cases, interviewees spoke about the desire to stabilise their lives. For example, two interviewees said:

- "I wanted better prospects and to build a better life for myself and hopefully gain employment in the future."
- "I just got sick of stealing to feed my habit - since being in treatment I haven't shop lifted at all."

In a number of cases the individuals told the interviewer that they had *"reached rock bottom".* Often their lives had deteriorated to a point where they were totally chaotic.

- "I had become street homeless and decided I had to try to make changes in my life."
- "Drugs were affecting everything in my life. I didn't realise how much 'til I hit rock bottom."

In some cases, individuals said that they had started to realise that either their physical or mental health was seriously deteriorating - in some cases both.
For example:

- "I was determined to live a happy healthy abstinent life... I had become aware of the possible damages to my health."
- "I was diagnosed with bi-polar - and I knew that I did not want to be addicted to drugs any more because it wasn't helping me."
- "I was suffering from depression and using drugs to self-medicate really. I contacted services to try and overcome my substance misuse and get a better quality of life."
- "I finally realised my health was suffering and I needed to change – I just couldn't remember the last time I woke up and felt healthy."
- "My doctor helped me to make an appointment with a drug service. I was unaware of the service until my doctor told me about it and helped me."

In a number of cases relatives had played a significant role in encouraging individuals to engage with treatment services. Several individuals said that they had started to realise how their substance misuse was affecting others, especially their families.

- "Rebuilding family relationships had encouraged the service user to engage with the CAT and wanting to work towards rehab and recovery."
- "My chaotic lifestyle finally meant that the children were suffering."

Most of those interviewed by the peer researchers were very positive about their experience of treatment services. In particular, they recognised the critical role that key workers had played in their treatment, helping the service user reduce use and maintain stability.

- “My worker has definitely encouraged me to maintain stability regarding my treatment.'
- “It's all about having a good worker.”
- “The workers at Gateway helped me a lot – they made me realise I needed to grow up and get off the Class A drugs.”

Within the small peer research sample, those who were not positive about treatment services were those who had found out about them when they had been in custody, although this appeared to be largely coincidental. In one case the individual lacked confidence in the worker and in the second case he blamed his treatment worker for not securing a rehab place before he was arrested and imprisoned

- “I worked with my care manager while I was in custody, but to be honest I felt alienated by the service, although I think this is probably because she (the worker) really didn't have a clue about me!”
- “I have been discouraged from going to treatment services because I was set up with a drugs raid by a group involved with cocaine. I was really annoyed because I had been asking my worker for months to put me in rehab. Now - while these charges are still on-going - I can't do anything and I know I am in a no-win situation.”

However in some cases interviewees described how their workers had helped them on ‘a journey towards recovery’:

- “I have been encouraged to address my drug use and work towards abstinence and maintaining it.”
- “I have a good relationship with my worker and he has encouraged me to work towards recovery - not using illicit drugs but first being stable on my prescription.”
- “Basically treatment involves getting help and support with my problem and maintaining being clean. My worker and I are working towards me being drug free now.”

The ‘journey’ often involved key workers helping individuals with practical issues such as accommodation and sorting out benefits:

- “I got the encouragement I needed in that I've now got my own place to live. I am still in services because I have a really good relationship with my worker.”
- “My key worker made me realise that I needed to gain some type of stability and control over my life - like somewhere to live.”

7.c Offenders

The experience (and responses given) by offenders tended to differ from that of clients in the community. The data collected from inmates at HMP Forest Bank is therefore set out separately in this section of the report.

Individuals spoken to in prison who were accessing drug and alcohol services were in the main sentenced for possession, including for personal use, violence, or acquisitive crime.

Prison was not viewed as a deterrent for any of the individuals spoken to in with regards to discouraging them from offending them again post-release. When using in excess, for most individuals crime was the only way to fund the habit and was viewed as a necessity. A number of individuals however spoke of periods of not being in prison and offending whilst stable on methadone. All spoken to had also experienced community drug services in Oldham.

Prison was viewed as an opportunity to get clean but those interviewed pointed out that the sentence needed to be of a reasonable length to be able to achieve change. Without a sufficiently long sentence it was felt more realistic to be maintained on a prescription.

- “Everyone around me was using, coming into prison can give some opportunity to get clean.”
  (Male, 42 years, heroin, crack)
- “Prison removed me from the chaos and I got clean”.
  (Male, 54 years, alcohol)
- “Living in the community sober is more difficult than staying clean in prison.”
  (Male, 34 years, heroin)

All the offenders who had experienced community DRRs did not find them to be helpful and felt the focus primarily was on their offending not on wider issues going on for the individual concerned such as debt management, relationships and finding work.

All the offenders had been in prison several times and felt the highest risk of relapse was at point of discharge if there was no safety net to go straight into within the community, as prison provided such a structured environment.

- “You end up spending your discharge grant on drugs before you even get home”.
  (Male, 26 years, heroin, crack)
- “I need to be picked up from prison and me into rehab. It’s what I need so that I don’t go and score”.
  (Male, 34 years, heroin)

All the prisoners spoke of a range of different programmes available and opportunities to get involved as recovery mentors and volunteering. The programmes were highly rated if you were motivated to want to change and including; medication, psychosocial interventions, behaviour change programmes, employment and training and mutual aid type groups.

7.d Families and Carers

In addition to interviews with drug and alcohol users, interviews were also conducted with 14 family members and carers. Again, given their very different perspective, their views are recounted here as a separate section. There were many personal stories which illustrated the challenging times gone through as a carer of a drug user.

Daughter's account of mother who used heroin and crack.

- "Mum was a heroin and crack user, I knew from 12 years, there are five of us, I hated her especially when she broke up with my step dad. I noticed more visitors, a funny smell, mum started to get agitated, her appearance changed, slowly deteriorated with no interaction with us kids. The youngest was two years, I brought up the kids. I was 15 waitressing, mum didn't give a xxxx, I remember the kids never getting presents so I did waitressing and the next year got the kids stuff.

  My step dad only had legal rights to the younger three, but I had enough and I ended up moving in with him. It took my mum three weeks before she even noticed we had gone. By then I had dropped out of school. But with my step dad's help I turned my life around and went to college.

  I am now 23 years old and we didn't speak for the last eight years, mum is now clean but I feel so angry, so many lost years why wasn't how she is now with us. I am proud of her don't get me wrong she's a drugs worker and she's won awards but in a way I can't be completely happy.

  I got back in touch with her because I now have a son, and I want him to know his grandma, she's allowed weekly supervised visits".

Mother's account of son who used crack:

- "I was trapped 'cause of my grandkids, I kept on getting advice from the drugs workers not to give him money. I left him one weekend without money for gas and electric, I know I was enabling him. 3 times we reported him to social services they said he's fine because the children were not at serious harm but they didn't see what I saw. He owed so much money to the suppliers, the police actually advised me to pay as the house could have got trashed. We have ended up over £10,000 in debt".

Father's account of daughter who is receiving support for alcohol:

- “We didn’t even know she was that bad until the social services once turned up at our door about our grandkids. The kids had been temporarily removed and they wanted to know if we would foster them. My first reaction was no as we had supported her so much, my wife was already ill, we are in our 60’s. But then neither I nor my wife wanted the kids put into foster care. So now we have guardianship orders, my daughter is allowed supervised visits. It’s up and down, she’s stubborn and manipulative we can’t see her getting the kids back for at least another year. My wife has had to go part-time because we can’t afford the childcare and she’s shattered working as well”.

Family members spoke of the difficulty of speaking to someone outside of their family due to shame and guilt, isolating themselves from their own friends and family because they didn’t want to lie.

- “You don’t want to be a burden, you feel no-one has problems like you. You become isolated from everyone”.
- “I didn’t want to ask for help. I didn’t give up on him, I was disgusted though and didn’t go out of my front door”.

However many now felt the benefits of speaking to others and the weight which had been lifted attending a carer’s support group.

- ‘It’s incredible coming here [Families and Carer Group] at first the shame and burden is too much but as new families attend you can see the different stages of grief and you can say I’ve been where you was two months ago and now I can talk without crying and I am getting on with the rest of my life’

The strength of the Families and Carers Group spoke volumes as individuals told of their relief and the different strategies they learnt from each other on how to handle their family member. They also spoke of feeling stronger understanding regarding what the recovery process entailed and what to expect, which they described to be empowering and enabling.

- “I now understand the treatment process. I can enable, support and challenge. Her recovery by default has changed suddenly recovery is your responsibility. We have now set the boundaries. Coming here stops me caving into her demands”.

For those who were looking after their grandchildren they spoke of the need to have services available for children who could provide early intervention, help to understand what was happening and provide an outlet for them.
Some of the carers who had opted not to attend formal groups found great solace in religion and their faith, attending church regularly and receiving support including practical advice from the church.

A central feature of this consultation was exploring the concept of “recovery”. The shift to a recovery focus is perhaps the most significant change in the substance misuse agenda in recent years. This represents a break from nearly 20 years of policy and practice in which the harm reduction agenda has been pre-eminent and which aimed to move people into treatment and retain them. Thus the 2010 Drug Strategy clearly states that “Our ultimate goal is to enable individuals to become free from their dependence”, going on to lead a drug-free life.
The consultation sought to explore what substance misusers understood recovery to be, and whether this was something that they wished to pursue through their treatment journey.

8.a Definitions of recovery

Those interviewed by the peer interviewers were asked what they understood by the term recovery.
Strikingly, most agreed that it was about abstinence and staying abstinent.

- “Getting off drugs - just living a normal life. I did get clean and stayed clean for 3 years - I'm aiming for that again.”
- “It means to be clean and not dependent on drugs. 14 years ago I didn't take drugs and I want that life back again. That's what it means to me.”
- “I think it's about living an abstinent life and being able to do every day things without having to take any medication to feel ok.”
- “It's definitely about getting to the point of abstinence and maintaining abstinence.”
- “Living without my script and being clean.”

A number of interviewees elaborated further, suggesting that recovery was about reflecting on, and understanding, the past and changing attitudes and behaviours:

- “Recovery is to stay away from drugs and learn to change my behaviours and thinking patterns.”
- “Recovery is moving away from the wreckage of the past - a chance to rebuild my life and relationships.”
- “I think recovery is about engaging back into society - which I wasn't a part of when I was addicted.”
- “To maintain total abstinence, and to understand my bad and sick behaviours when I was using.”
- “It would be about stopping using and changing my life - no longer dependent on a drug or a drink.”

In a number of cases individuals equated recovery with re-building relationships with people who had been important to them:

- "Recovery means living life free from all drugs – not being tied to a chemist or a dealer and enjoying life with my family again."
- "Re-building relationships with loved ones and my friends again."
- "Recovery means a better life and being a more pro-active person. It's about maintaining better relationships."
- "Building ties and relationships with children - I am going to be a grandfather soon!"

Interestingly, while the majority thought that recovery was about being completely drug free, three interviewees considered themselves to be 'recovering' while still on a script, as long as they were stable:

- "It means stability - I don't have to go out and steal. I'm not engaging with crime."
- "Obtaining stability on my medication and stop using illicit drugs."

There was a general awareness and acknowledgement that there was increasing focus on recovery in treatment and that this had resulted in a change in how services were delivered – for instance providing more choice and a range of different interventions throughout the recovery journey.

- "I hadn't heard about recovery back in 2008, [I] got a DRR or face five years in prison. I took drugs for really bad anxiety; lots of suicide attempts put ropes around my neck wanted it to stop".
  (Male, 49 years, heroin)
- "Previously [I] had a script from GP but no support from groups".
  (Female, 39 years, heroin, alcohol)
- "For several years I had a 'script now I'm given a choice to stop".
  (Male, 52 years, heroin)

Some individuals spoke of the vision for recovery as not being shared by all workers.

- "Some workers only want to keep you on methadone. Now [it's] more about recovery outcomes, but I know someone who has been on 3mls for ages. Some workers don't agree with recovery. They openly say it and think if we want methadone we should be on it for as long as we need".
  (Male, 38 years, heroin, amphetamines)
- "I have been at Gateway on and off for 11 years. 10 bags a day, 140 mls. Always done prostitution. Been asking for detox, but I am on and off titration 'cause of my epilepsy. Not spoken to anyone regarding sex work, don't feel I can".
  (Female, 36 years, heroin, alcohol)

The professional stakeholders interviewed echoed this view to a certain extent. Stakeholders tended to describe local treatment services as "starting" to embrace the recovery agenda, rather than being fully immersed in this way of thinking and working, and felt that there was still some way to go before recovery was internalised in how services were offered and delivered.

8.b Aids to recovery

The key factors which interviewees described as having helped achieve recovery included achieving stability, an increase in self-belief and feeling that there is a purpose to life. Keeping busy was essential to combating boredom which in turn was identified as a key contributing factor to relapse.

- "I attend meetings, do groups, voluntary work and have a toolbox. I've changed my playground and playmates – they were associates. I have real friends now a recovery community. I also have friends outside of recovery. NA is such a resource to everyone."
  (Male, 49 years, heroin)
- "You need a toolkit and mutual aid stuff for when you're on your own; you need tools for the low points."
  (Male, 49 years, heroin)
- "I feel like I have the skills now to deal with stuff going wrong. Don't hide away have to deal with it. Had major stuff going on and I now ring someone."
  (Female, 44 years, alcohol)
- "[I] kept on making plans and not able to keep them and would make excuses. I am now keeping busy, focusing on Christmas. Before I set milestones around years now I take each day as it comes."
  (Female, 36 years, heroin)
- "Aftercare is there if I am having a wobble."
  (Female, 33 years, alcohol, cannabis)

Specific groups which provided practical strategies and a support network were valued.

- "I can't function in real life, I have learnt strategies, [I'm] taking responsibilities, learning to live again."
  (Male, 36 years, heroin)
- "ADS do prep work pre detox and aftercare, they are really good groups."
  (Male, 46 years, alcohol)
- "I found parenting courses really useful, really enjoy it, you pick up tips from each other. You can be open and say when you are finding it really hard."
  (Female, 30 years, heroin, coke)
- "I have just signed up for the DV (domestic violence) group, trying to get my kids back and Straight Ahead course, Intuitive Care, Bridging the Gap.

Trying to get more stability back. Just completed 12 week RAMP found it very useful."
(Female, 27 years, alcohol, cannabis)

- "I feel self-worth now. I have taken personal responsibilities. I can articulate myself better now. I have better relationship with the children now, at first I didn't know how to respond with the kids."
(Female, 38 years, heroin)
- "Huge motivator to come here I know I won't drink until I've had my appointment. look I'm shaking."
(Male, 54 years, alcohol)
- "Family conferences really help. Helps families understand addiction, offers mediation."
(Male, 28 years, heroin)
- "My mum and dad attend the family group once a week they really enjoy going find it helps with the shame and stigma. Family is a huge motivator."
(Female, 33 years, alcohol)

For some, there was less satisfaction with the services. Some service users found the programmes too tough especially where contact was not encouraged with families whilst in secondary care.

- "In the DEAP programme there are four weeks where you are not allowed contact with family. It's really difficult, the first time I couldn't cope and left".
(Male, 42 years, heroin)

Others found some of the programmes too intense or were not ready to abstain and wanted to continue to drink/use drugs socially and did not feel the advice necessarily supported this nor could this be supported by a wider recovery community such as Narcotics Anonymous (hereafter NA) or Alcoholics Anonymous (hereafter AA).
Some service users felt access to services had been a struggle and were not happy with the minimum level of commitment needed.

- "[I've] had to jump through hoops to get [a] detox and attend all my appointments it does my head in."
(Male, 44 years, heroin, cocaine)

Environment was a key concern and for a significant number of people where they lived posed significant problems and did not support stability.

- "I am very vulnerable where I live, everyone is bang at it. I have been jumped three or four times,[they] know when my benefits come in and so have others. The police are not helping, I'm too sacred and I can't get moved".
(Male, 44 years, heroin)

Individuals who had ended up in hospital post overdose were not positive about the support received. The RAID team were felt not to be proactive and did not recognise that straight out of hospital you were likely to miss your appointments. None of the individuals who had ended up in hospital due to an overdose mentioned receiving any support from mental health services.

- "When you are in that frame of mind you need someone to be persistent, you will eventually accept help".
  (Male, 42 years, heroin, cocaine)

Although the numbers of individuals spoken to from a Black and ethnic minority community were very small, there was a striking difference in the resource capital already available in their lives such as family support, access to income and employment. Nearly all interviewed mentioned the interventions and practitioners not necessarily understanding or recognising cultural differences in how the drug use was viewed and the shame and guilt associated with addiction as well as how 'some things were done different because that's just the way in ours'.
For others who wished to leave substance misuse services and step out of a recovery community which only offered peer support, clearer exit strategies were suggested which were gave people the confidence to move on. Some felt there was an over emphasis on a peer support recovery community which did not prepare you for the 'real world'.

- "We try and separate ourselves from others which is not a good thing, need to get a balance in life".
  (Male, 47 years, heroin)
- "You need to get out of the recovery bubble and not become too dependent, develop wider interests".
  (Female, 42 years, alcohol)
- "You can get lost in the system just going round and round. I'm scared, can I lead a different life? I want to get away from drugs and alcohol. What's my place in society, I want to do normal stuff, but I'm so scared what if I can't".
  (Male, 47 years, alcohol)

The peer interviewers asked individuals what they thought were the key factors that had assisted their progress towards recovery. The factors described are set out below:

Readiness

All those interviewed by the peer researchers suggested that the single most important factor in achieving a successful recovery was what they termed "readiness":

- 'It's no good unless you are ready to do it and I think only you know when you are ready.'
- 'Being ready is really important. There are courses like RAMP which help you work towards being ready and these are really good in preparing you.'

It was clear from the data that “readiness” could take years to arrive at as well as more than one attempt.

- “I have been at the CDT for nearly 20 years. I went to Acorn for two years – also at ADS and Phoenix House over this time. I have tried different services at different times with a view to recovery.”

Information about the right service at the right time

The majority of those who described themselves as being in recovery said that it was essential to find information about the right services and what services offer.

- “I do think that more information and knowledge about services such as ACORN would assist greatly in getting people into recovery more quickly. I for one had little awareness about the services that were available while I was addicted. Maybe this was because my drug of choice was not illegal.”
- “I really needed more awareness of services and what was on offer in my area. I did find out eventually but more information is needed to help others.”
- “I thought that the hospital services were a great help in getting me information so I was referred to the right abstinence based services.”

Understanding recovery and preparing for it

Having an understanding of recovery, preparing for it and knowing what to expect was thought to be vital. It was thought that this was an area for improvement within most services.

- “I do feel that better awareness of the services and what is involved in 'recovery' and more about the different approaches would have helped me recover sooner.”
- “I think the only thing that could have been different and better would be if I had known more about rehab and its availability before I was actually offered services. I feel that my awareness could have been raised earlier.”
- “I was lucky because I had had prior knowledge and experience with ADS rehab and also counselling based treatment which prepared us for what to expect from detox and rehab.”

Some of the interviewees had been prepared through attendance on a RAMP (Recovery and Motivational Programme). All of these interviewees thought the programme was extremely helpful:

- “RAMP helped me a lot - I found the group really good.”

Post detox support from abstinence based services

Nearly all of those who were in recovery referred to the importance of post detox support from abstinence based services. One interviewee told the peer interviewer that he had:

- "…stumbled across a new group at the CDT for people who were aiming for total abstinence. I tried it and the penny just sort of dropped."

A number referred specifically to ACORN services and the stepped approach to recovery. Two individuals told the peer interviewer:

- "I don't think I was really aware of the context of recovery before engaging with ACORN. In order to stay clean and maintain abstinence it is important to stay in and around ACORN and to engage with outside fellowships such as NA and AA."
- "An understanding of being an addict is important before you can understand recovery. I think recovery means engaging with the right services available and outside fellowships to maintain abstinence and enjoy life without the use of substances."

For one person, recovery had involved attending a peer led SMART (Self Management and Recovery Training) programme which is based on the view that there is no single approach to recovery that is right for everyone, but that mutual self-help can help recovery and combined with treatment can be very helpful for many people. It is generally thought that it offers a viable alternative to 12 step programmes.

One-to-one key worker support

One-to-one key worker support was cited by the majority of individuals as a key factor in achieving successful recovery:

- "The workers at Gateway are the reason for my recovery - they have helped such a lot."

Key worker support often involved support with a range of practical issues. For example, help with accommodation was cited as being extremely important by a number of interviewees.

- "Getting my own property and stabilising my lifestyle definitely worked towards my recovery and enabled me to become a lot more stable in the decisions that I needed to make regarding recovery."

Financial stability was also mentioned by another interviewee who emphasised the valuable role played by his key worker in ensuring he had his full entitlement to benefits.

- "Being able to cope financially again undoubtedly assisted my recovery."

Family support

Those who had had support from their families through their recovery cited this as having made a huge difference.

- "My family and friends have been really important all along. Feel as if I couldn't have done it without them."
- "My brother's support with the recovery is really important to me - it will make a big difference to me knowing that he is there for me."

- "Unconditional love from my family and NA was really important to me."

On-going support

Most of the interviewees thought that the on-going support provided by abstinent based services was critical:

- "There is no way I could have done this on my own and I could not have gained recovery without the services/agencies that are available. I definitely needed help from ACORN and the fellowships as well as all those peers on the RAMP."
- "The thing is I am more aware of my triggers now, so I am able to prevent any type of relapse. The counselling I got was second to none. And being introduced to the fellowship and 12 step programme had a profound impact on me."

Only one individual had undertaken the ACORN House DEAP Programme which is designed to assist those who are in recovery following a community-based non-residential detox. The individual who mentioned the DEAP programme was still attending it and had not yet completed it. He commented that *"so far it was good".*

None of the interviewees who had engaged with ACORN had yet undertaken their STAR (The Skills Training and Reintegration) course which is specifically designed for those in recovery to help them overcome the practical and psychological barriers of gaining employment. (On completion of this course all graduates receive a Certificate in Recovery Coaching and a level 1 award in Mentoring. All participants are guaranteed a voluntary work placement with partner agencies 'so that they can put the training into practice and share their experience and knowledge to mentor/support others in recovery.)

8.c Sustaining recovery

Several individuals spoke of having made several attempts in the past including residential rehab, detox and attending several AA meetings in a week. Some also spoke of periods of abstinence and sobriety spanning from six months to several years.

One of the main challenges individuals spoke of, in particular those who had engaged in treatment more than once, was the level of complacency which came after they had left services and started to believe they did not need to use any kind of service including mutual aid support. It was felt to be essential to the recovery process to have the life skills to deal with life itself including both practical and emotional responsibilities.

- "With each hiccup in life it's so easy to go back to what you know will block all the crap out and then a few days later I find myself back at square one because I couldn't stop."

  (Male, 44 years, heroin, cocaine, alcohol)

Individuals challenged those in treatment who wished to continue to be recreational users of drugs or social drinkers and said openly it was impossible to do that.

- "Once an addict, always an addict."

(Male, 44 years, alcohol)

This statement resonated with people in 12-step recovery, where the problem was generally perceived and experienced as a chronic, relapsing disorder. Some of the service users had been sober for a period of time but described themselves as “a recovering addict.” They likened their addiction recovery to a chronic mental or physical illness, and that the nature of addiction required those living with it to constantly monitor mood changes, life events, and triggers that may cause relapse.

Some individuals felt that recovery was only possible once someone had reached a particularly pronounced low-point in their life or an unprecedented level of self-destruction. A staple of 12-step meeting is sharing, stories emphasizing “bottoming out” as the catalyst for quitting do in fact reflect the perception many people have of their experience. However this was not shared by everyone in particular those returning to treatment.

- “If I reach a low point, quit for several years and then relapse, I develop a “new” bottom when I return to recovery - cancelling out the prior story.”

  (Male, 51 years, heroin)

It was suggested that many people don’t actually quit when their problem is at its worst because intense stress itself is a strong predictor of ongoing addiction and relapse.

- “Workers need to understand why I don’t attend my appointment. Those are my low points to get me through those moments and not discharge me is crucial.”

  (Male, 47 years, alcohol and anti-depressants)

- “When I attend appointments that means I am doing well but an assessment is needed of my rock bottom – when I don’t want to engage with appointments.”

  (Male, 44 years, alcohol)

The differing view is further complicated by those service users whose personal recovery is based on a particular view and were resistant to other perspectives for fear that recognizing the complexity will lead to relapse. For example, acknowledging that some people recover by moderation, you might be tempted to try it.

Boredom and loneliness were two of the most frequent factors associated with relapse and trying to keep busy once out of treatment. This particularly resonated for those not wishing to join a mutual aid support network.

Individuals spoke of struggling with their emotions whilst in treatment. Some described it as 'emotional immaturity' – for instance having never let themselves deal with pain with a clear head. Accessing services when not under the influence of drugs and alcohol was difficult as there was 'nowhere to hide' and it was second nature to numb feelings with substances.
Interviewees were asked to explore how a range of interventions had helped and supported them at this point.

9.a Counselling/one-to-one support

Individuals spoke about how one of the most difficult aspects of treatment had been the counselling. A number stated that they had felt it was the most difficult thing they had ever had to do.

- "[Acorn] strip you until you have to face who you have become, all the nasty sides of the drunk and drugs. I hated it at first...I didn't want to hear what I had done to others, myself, and I didn't want to be told that I needed to take responsibility. It's the hardest thing I have ever done in my life and each session I vowed I wouldn't come back...but I did and now I know it's the best thing I ever did."

  (Male, 44 years, heroin, cannabis)

Counselling was felt to be beneficial as it looked at an individual's wider context. This was not felt to be available or beneficial through one-to-one support and highlighted the relevance of different approaches taken by local providers.
Some individuals were less happy with regards to the content of one-to-one, and felt the sessions focused too much on the drinking or drug use such as (for instance how well they were doing with their methadone) but did not address wider contextual issues and helping individuals to understand why there were where they were. There were also reports that one-to-one was not offered by all services and that there was an expectation that everyone was suitable or would like to participate in groups.

- "I am lucky if I get any one-to-one here it's only available if I ask for it all I can really access are the groups."

  (Male, 42 years, heroin, cannabis)
- "In the one-to-ones I have had it's all about my script they never ask me anything else...I feel really rushed and I'm lucky if they will see me for more than 15-20 minutes."

  (Male, 44 years, heroin)
- "I don't just want to do drinks diaries I want to talk about what's going on in my head; I don't just want to tell them about my drinking."

  (Male, 44 years, alcohol)

This highlights the difference in psychosocial interventions offered and the approach which is taken at both individual practitioner and organisation level.

The majority of service users felt focusing purely on substance use related issues was not sufficient to produce enduring change and that practitioners needed to look at the wider context of their lives.
Key areas individuals valued and found useful included:

- Goal Setting, which gave the interventions a direction, and provided a standard by which progress could be reviewed and gave clients concrete evidence of improvement.
- Motivational interviewing, which addressed clients' ambivalence about changing behaviour by encouraging them to consider the good and not so good aspects of drug use.
- Problem solving, which incorporated verbal instructions, written information and skill rehearsal.
- Relapse prevention and management interventions, encompassing cognitive behavioural strategies that provided clients with skills and the confidence to avoid and deal with any lapses. This often involved exploration of high risk situations, mood, thoughts, places, people, situations and events.
- Confrontational counselling

There was a recognition that less time was available now in one-to-ones and service users felt at times 'short changed' and 'rushed,' feeling that sessions focused too much on their drug/alcohol use but did not support wider issues in particular psychological pressure.

- "[I] can't just sit with myself, I take drugs to get rid of these feelings. I've got too much going on in my head I want it to stop."

  (Female, 36 years, heroin and cocaine)
- "I have been in treatment a long time. It's changing not a lot of time available now in one-to-ones. I'm fed up being on a script [it] ties you down. I don't know where the years have gone. I started using 12-13 years ago. There is less around [services] if you have been on methadone a long time, if you are new to services that's easier. There are always changes in the worker you get a different person each time."

  (Male, 42 years, heroin, cannabis)

9.b Peer support

There were several service users who rated NA and AA groups highly and some attended groups every day. They spoke of being around people who genuinely cared, having gone through similar experiences and who were available almost constantly. However for others the philosophy did not feel comfortable or the dynamics of some the groups attended were found to be not welcoming and over bearing.
The importance of mutual aid was individual to each person. It was a challenge for those who had gone through a 12 step recovery programme but

did not wish to attend the AA/ NA groups as a longer term option and felt there was little alternative on offer which offered frequency and choice.
Nearly all of the interviewees interviewed by the peer researchers cited peer support from others in recovery as an important element of recovery. For many peer support was available through attending regular peer group meetings at abstinence based service.

- "It is about seeing other people like me but in recovery who were now helping out at drug services and socialising normally."

AA and NA also played a vital role in providing peer support, often alongside abstinence based services however it should be noted that fellowships based on 12 steps approaches did not appeal to everyone. On the whole, assessment of fellowships was positive:

- "It is really important if you are in recovery to engage with outside fellowships like NA and AA."

Several interviewees spoke about the value of peer led SMART programmes and the individual who had attended one suggested that this was of great importance to him:

- "Accepting that I can no longer use drugs of any kind. Getting support from my peers through SMART meetings and looking at underlying issues that would possibly cause me to use drugs. Generally being able to live a healthy lifestyle again."

It was also evident that SMART programmes could offer an important alternative philosophy and approach to AA and NA, which was more acceptable for some individuals.
Two interviewees told the peer interviewers that they had definitely wanted more peer support than had been available. This was especially the case at the beginning of their time in recovery services.

- "'I needed a bigger support network. Looking back fellowships, meetings, sponsors would all have assisted greatly in my road to recovery. This wasn't really available to me until later on."

Professional stakeholders interviewed generally noted the presence of peer recovery but felt that more could be offered and that more work needed to be done to encourage and support this agenda.

9.c Volunteering

The opportunity to volunteer and go into peer mentoring work was seen as extremely positive and gave purpose, an increase in confidence, structure and opportunity to learn new skills.
Across the services in Oldham many workers were ex-users were highly regarded by service users who felt this contributed to the attributes and values of practitioners, who understood and could challenge appropriately.

- "It's difficult to pull the wool over his [key worker] eyes. In one look he knows you're lying, he knows where I'm coming from."

(Male, 42 years, heroin, cocaine)

- “It inspires me when I see others in recovery running the groups and sessions. There are a couple of them we used to score together.”

  (Female, 44 years, alcohol, cannabis)

This section addresses some themes that emerged or were identified by the researchers as being of some note:

10.a "Stuck" clients

"Stuck" clients is the (somewhat pejorative) label used by some to discuss those who have been in substance misuse treatment for extended periods of time – i.e. multiple years.
It was notable that many of the individuals consulted said that their involvement with drug and alcohol services was over very long periods of time. For example:

- "I've been coming to Gateway for five years now and on the same script for last six months."
- "I have been attending various CDTs all over the North West for 22 years. I was also in prison for six years."
- "It's been at least ten years now. My doctor arranged an appointment at the service and I've been attending ever since."
- "Been at Gateway on and off for about ten years."
- "I have been at the CDT for nearly 20 years."

One respondent told a peer interviewer: *'I have been in drug services as far back as I can remember!'*
The consultation therefore highlighted the fact that many individuals had had multiple treatment episodes, or had continued to be in the treatment system for many years.

This issue was also highlighted by some of the professional stakeholders interviewed. One stakeholder went as far as to describe the ongoing provision of a script as a "chemical cosh" to "manage" people rather than treat them and address what was driving their substance misusing.
The fact of numbers of people remaining in treatment for long periods of time is interesting when juxtaposed against perceptions of what recovery meant to those consulted. Whilst recognising a divergence of views among clients and that CPI only consulted with a sample population, it was striking that for many recovery was synonymous with abstinence. This would tend therefore to suggest that remaining in treatment for multiple years is not an aspiration for many clients, many of whom want to get "clean". Given that Oldham seeks to create a recovery-oriented system, the conclusion would appear to be that treatment should move away from prolonged engagement.
In terms of addressing "stuck" clients and enabling them to move on, stakeholders pointed to the importance of "visible recovery" – that is, role models volunteering or working within the treatment system who can offer hope and belief to others. As such, stakeholders identified the need for symbols of change within the system.

Building on this, stakeholders talked about creating a “treatment journey” for each client with a clear aspiration at the end. The journey should be ambitious and make clear from the outset that there is an expectation that treatment is for a defined period, and that clients will move on from specialist treatment and support rather than engagement being an ongoing state.
More practically, stakeholders noted that options need to be made available to clients. The more options that are available, the more likely that an individual will find a treatment package that best meet their needs.
Stakeholders discussed the possibility of “challenging” those who had been in treatment for four years or more and developing alternative pathways for these longer-term clients. The possibility was discussed of separating out longer-term clients and moving them into shared care or other intervention. This would keep the focus of the bulk of the treatment system on recovery and moving clients on, whilst recognising that for some clients, theirs is a long-term condition that needs a different approach more akin to harm minimisation.

10.b First contact with the treatment system

First point of contact was raised as an issue as those consulted talked about the importance of being ready to go into treatment and that, if this window of opportunity is missed, potentially disengaging again for a considerable time. The importance was stressed therefore of successful initial engagement to both encourage people to enter treatment and to start accessing services.

Stakeholders talked of the possibility of first engaging with clients in non-substance misuse settings and in situations that felt more “normative” - that is, environments or places not obviously associated with substance misuse treatment but where people might go to access a range of services. It was felt that this would help address issues for some around the stigma of going to a substance misuse treatment service. Some noted that this initial contact could potentially be delivered along with a brief intervention thereby enabling work with those who are using drug or alcohol problematically, but who are not yet dependent.
Other stakeholders explored the idea of creating a Single Point of Contact (SPOC) model – an identified service responsible for engaging clients, planning a treatment journey appropriate to their needs and aspirations, and then linking on to appropriate providers. It was noted by some that the SPOC service would not necessarily even have to be a specialist substance misuse service, but could be rolled into a more generalised service meeting multiple needs.
A number of stakeholders interviewed noted that Oldham is having to seek improved efficiencies across all services due to financial pressures. Some therefore felt that the provision of a generalist SPOC-like service would be a cost-effective approach that could reduce duplication whilst (potentially) improving accessibility. Parallels were drawn to the work in setting up the Multi-Agency Safeguarding Hub in 2013 which has been seen as having a positive impact on integration and coordination of work with young people and their families. Interviewees noted the potential through this approach to improve integration with mental health services and Safeguarding.

Stakeholders were most clear that, however first point of contact is delivered, the response must be rapid in order to respond to clients as soon as they are contemplating treatment, rather than letting the opportunity pass.

10.c Volunteers

As noted above at Section 9.c, volunteers were very highly regarded by those consulted. They were seen as exemplars, and proof that recovery was a real possibility. Their perspective as an ex-user was praised as they understood what treatment involved and what people had been through prior to engaging in treatment.

Stakeholders felt that volunteering should be built around a career path, or a chance to "move forward". This would enable those just through treatment to engage on a light-touch basis at first and, as their confidence grows, to seek further opportunities and to take on more responsibility, to move from informal volunteering to more formal roles.

The idea of a career path was felt to include encouraging – where appropriate – volunteers to move on from working in the drug and alcohol field and that they should be seeking opportunities in the community and elsewhere to help them manage a transition away from treatment. This would have the added benefit of releasing capacity within the system to take on new volunteers as older volunteers move on to other work and activities.

It was recognised that, while volunteers bring much added value, they cannot be seen as a free resource. Volunteering, properly done, requires the provision of support, training and co-ordination, for which there is a cost.

10.d Shared care

The issue of shared care was identified - perhaps paradoxically - due to its absence. Whilst shared care is delivered in Oldham, none of the clients consulted referred to accessing GPs or receiving support via their GP.

Stakeholders interviewed noted this issue, with one stating that:

- "We know there aren't enough GPs in shared care and those GPs that are getting older. There aren't enough younger GPs taking this up."

Another noted that:

- "My opinion is that shared care is being propped up by a very few interested GPs and, of course, ODAS."

Some stakeholders felt that the performance management of shared care should be shifted from its current guise in which payments are made per patient. (One stakeholder noting that this creates a perverse incentive to sign-up to shared care, but not to necessarily deliver the expected service). It was suggested that a better model would be contracted activity – that is, for a given spend, a GP would be expected to see a minimum number of clients over a given period (for instance, one quarter).

Some stakeholders explored the idea of operating and managing shared care by an independent provider - i.e. not by GPs. It was felt that this would lead to better coverage, better access for clients and more robust performance

management of shared care spending - that is, more accountability for how the money is spent and what outcomes are being achieved for the investment. Regardless of how shared care is re-modelled, there was a very clear sense that shared care was not as effective as it could be in its current form and that, in the move to a more recovery-oriented system, GPs should play a much greater role in managing and supporting clients.

10.e Information technology

The consultation sought to address the extent to which clients engaged in new technologies.

None of the individuals spoken to used or had access to the internet, however a number did identify that they would like to learn how to use a computer but felt ‘stupid’. Several felt being able to have support online or by phone at evenings and weekends was vital and that it would help in particular when bored or lonely and there was an increased temptation to use. The use of apps to self assess how well they were doing was welcomed. Although none of the individuals consulted with had used the Breaking Free programme they felt it would be a good idea and could see the benefits however others felt face to face contact was vital.

A number of broad conclusions can be derived from the consultation. These are explored below.

11.a Recovery

The majority of those consulted were attuned to the language of recovery, were comfortable with the concept, and saw it very much as something that treatment should be working towards. As noted elsewhere, it was striking the extent to which recovery and abstinence were used synonymously. It is important to note that, for some, recovery meant the ongoing use of a script and so there was not absolute consensus on this concept (as would be expected).

Nonetheless, it is clear that service users are, on the whole, embracing the concept of recovery and so would no doubt welcome a more recovery-oriented treatment system. Put another way, should commissioners seek to create a recovery-oriented system, they would be doing so working with the grain of service user opinion, rather than against it. This consultation therefore endorses the decision to pursue a recovery-oriented treatment system.

11.b Treatment journey

While oft repeated, the analogy of treatment being a journey was used very often among those consulted. Of some note, service users described how the journey should involve preparing them for life post-treatment from the outset. Many described the anxiety that the idea of a life without substances caused and it was this fear that created problems for them along the way. This would tend to suggest that setting ambitions and targets for clients from the point of engagement would be an important first step for many, along with an explanation of how treatment will work with them to prepare them for life post-treatment. That is, treatment should start with a defined end in mind.

11.c Psychological preparation

It was clear from those interviewed that many service users wanted to talk about the emotional and mental issues that they were dealing with as part of their treatment. Those consulted could be somewhat dismissive of one-to-one and key-work sessions where the focus was on titration and maintenance – as one put it: ”In the one-to-ones I have had it’s all about my script”.

Those consulted communicated the importance of a psychologically-oriented approach to their treatment rather than a medically-oriented approach. That is, helping them prepare mentally for detox and a life after using, rather than focusing on the provision and use of a script. To this extent a number of existing services are proving to be popular - for instance RAMP - which people valued for enabling them to prepare for detox.

In shifting towards a recovery-oriented system, the role of psychological preparedness should be incorporated as much as possible to help people move to a contemplative phase in which they are more ready to move along their recovery journey.

11.d Peer support

Peer support was highly valued by those consulted. Those consulted noted the availability and importance of NA, AA and SMART recovery. It was widely recognised that different peer support models were appropriate for different

people and therefore having a choice available locally was very important (rather than, for instance, expecting everyone to work effectively within a 12-step model).

We note that the aspiration is for the new recovery-oriented system to build on the strengths of the local community. To the extent that peer support is, in effect, community led, increasing capacity would appear to be an excellent way to improve treatment outcomes, reduce re-presentations and draw on the assets within the community.

CPI recognise that this consultation is a precursor to a wider needs assessment that is being planned.
We are mindful therefore not to close down options until other aspects of the needs assessment have been completed and a full picture is obtained.
Given that, it is still possible to outline some recommendations that might be used to inform and shape the future treatment landscape. These are set out below:

1. This consultation endorses the decision to explore a new recovery-oriented treatment system. Any such system will need to be designed in accordance with how service users perceive recovery. This would in turn tend to suggest a move away from a medically-oriented model of provision.
2. A shift to a recovery-oriented system is liable to involve a distinct change in mindset for some currently delivering drug and alcohol services in Oldham. Work will need to be undertaken to support a culture change among staff and providers where work is currently being done in a more medically-oriented fashion in order that they support the new direction of travel.
3. The new treatment system should consider the role of a Single Point of Contact into both drug and alcohol services and the potential of co-locating this within a more generic service – that is, not necessarily being provided by a specialist treatment organisation.
4. The new treatment system should consider emphasising the role of interventions to support psychological preparation for treatment.
5. The new treatment system should seek to expand the range of peer support services offered to create a grassroots, bottom-up recovery community who can support those going through treatment.
6. The new treatment system should consider separating out those clients who have been in treatment for an extended period (for instance four years or more) and offering a distinct service recognising that for this cohort, dependency is a chronic condition.
7. The new treatment system should seek to renegotiate shared care services with GPs to align them more closely with the wider treatment system as well as enabling more clients to be treated in the community rather than in specialist services.
8. The new treatment system should maximise the role of volunteering for those coming through treatment to act both formally and informally as “recovery champions”. Volunteering should in turn be linked into wider pathways to help volunteers move into further volunteering, training and employment opportunities.

14.a Service user consultation pro forma

Purpose of this consultation is to help inform what changes could be made to the current treatment system if any.
Key priorities – prevention/ early intervention, preventing relapse and re-presentations
Confidentiality/ consent

Individuals in treatment
Describe to me how you got here today? In terms of your drug/ alcohol use/ your current circumstances/ offending?
How long have you been using drugs/ alcohol?
What made you want to get help? How did you know where to go? Have you ever tried before? What happened (if disengaged)?
What happened when you first came into services? (Briefly outline what kind of support you have received/ tried? 1-2-1/ group work, mentors, volunteering). Have you used the phone/ internet to receive help?
What did you first want/ expecting when you came to the service? Has this changed?
What's your understanding of what recovery is? Do you feel the service is hoping to get you drug/ alcohol free?
What do you feel about the treatment? What's helped? Not helped? What about in your life outside anything – what's helped you stay focused?
Where else have you been besides here?
Do you feel that the services you have seen have similar/ different views?
What's the hardest thing about getting better?

What do you feel about others in treatment? Any suggestions?
Are you finding local drug use is changing? What are some of the key issues for people living in Oldham?
Anything not currently available but you think would make a big difference?
Would any of your friends/ family want to be spoken to?

14.b Interviewee profile data pro forma

Please complete for each service user who has participated in the consultation. No identifying data will be used and all information will be destroyed 3 months after the project ends.

PROFILE DATA			
Client ID: (for CPI use)	DOB:	Gender:	Ethnicity:
Housing status:	Employment Status:	Relationship Status:	Parental Status: All children live with client □ Some of the

			children live with client □ None of the children live with client □ Not a parent □ Social worker involved □ Has received parenting interventions □ Pregnant □
BACKGROUND			
What is their primary/ secondary drug of choice/ or was?		How long has the client been accessing your service/ did access the service?	
Any safeguarding involvement – adult/ children (previously/ current)?		Any mental health concerns (previous/ current)? Is there involvement from mental health services?	
Brief overview of current support/ interventions being received from your service – e.g. 1-2-1, group work, social support, physical needs/ had received.			
Are they in contact with any other services including non-drug/alcohol which is supporting their recovery?			

14.c Peer researcher consultation pro forma

Peer Interview schedule

Name of Peer Interviewer:	**Date of interview:**	
To be completed for all interviewees		
Name of interviewee (initials only)		
Gender (please tick)	Male	Female
Self identified ethnicity		
Age		
Current living circumstances	**Accommodation**	**Employment**
Are you currently in contact with any clinical substance misuse treatment services? If so which ones	Yes	No
To be completed by those who are not currently in contact with any clinical substance misuse treatment services?		
Have you had contact with clinical treatment services in the past?	Yes	No
If so which ones and for how long?		
If you have never been in contact with treatment services, is there a reason?		
Are there things that you think encouraged you, or might have encouraged you, to engage with treatment or work towards recovery?		

To be completed by those who are in 'recovery'			
What do you understand by 'recovery?' What does it mean to you?			
How did you come to be in recovery?			
Are there any other things that you think would (or have) assisted you towards recovery?			

Equality Impact Assessment Tool

B039: Proposal Three (Review of Public Health Budget: Health Improvement Services)

Stage 1: Initial screening

Lead Officer:	Andrea Fallon
People involved in completing EIA:	
Is this the first time that this project, policy or proposal has had an EIA carried out on it? If no, please state date of original and append to this document for information.	**Yes** Date of original EIA: NA

General Information

1a	Which service does this project, policy, or proposal relate to?	Public Health – Proposal Three: Health Improvement Services
1b	What is the project, policy or proposal?	To make changes to our investment portfolio relating to health improvement services (Stop smoking services, healthy weight services, food and nutrition and physical activity services). We propose to reduce those that are reliant upon delivery through discrete contracts with external providers, and increase those delivered via wider council services. Wider council services will move toward delivering specific public health interventions relating to health improvement and reporting against Service Level Agreements with specific Key Performance Indicators aligned to public health outcomes. In particular we wish to rapidly expand the delivery of the Making Every Contact Count approach.
1c	What are the main aims of the project, policy or proposal?	Make changes to investments in Health improvement Activity by reducing investment in externally commissioned health improvement services by £739,898, and using this to invest in replacement activity at greater scale via wider council services. a. Interventions/services where there is likely to be a temporary reduction or loss are: i. Weight management courses for children (MEND).

		ii. Weight management courses for Adults iii. Community Mental Health Development iv. Self-care courses v. Healthy Eating Courses vi. Reduction in Community Food Growing Skills activities vii. Pathways to Health course (training for unemployed people wishing to access health related jobs) viii. Making Every Contact Count and brief interventions Training ix. Low level physical activity interventions (eg walking and cycling schemes) This funding will be reinvested in wider council services who can demonstrate that they are able to deliver the activities above and more, alongside specific KPIs, at greater scale and value for money than previously commissioned.
1d	Who, potentially, could this project, policy or proposal have a detrimental effect on, or benefit, and how?	• Children who require access to a healthy weight management programme (who are overweight or obese) • It could disproportionately affect those who are unable to afford commercially available alternatives (such as Slimming World or Weight Watchers) • It could disproportionately affect BME communities as these communities have a higher need for these services.

1e. Does the project, policy or proposal have the potential to disproportionately impact on any of the following groups? If so, is the impact positive or negative?				
	None	**Positive**	**Negative**	**Not sure**
Disabled people	☒	☐	☐	☐
Particular ethnic groups	☒	☐	☐	☐
Men or women (include impacts due to pregnancy / maternity)	☒	☐	☐	☐
People of particular sexual orientation/s	☒	☐	☐	☐
People who are proposing to undergo, are undergoing or have undergone a process or part of a process of gender reassignment	☒	☐	☐	☐
People on low incomes	☐	☐	☒	☐
People in particular age groups	☐	☐	☒	☐
Groups with particular faiths and beliefs	☐	☐	☐	☒

Are there any other groups that you think may be affected negatively or positively by this project, policy or proposal?				
E.g. vulnerable residents, individuals at risk of loneliness or carers.		☐	☐	

1f. What do you think that the overall NEGATIVE impact on groups and communities will be?	**None / Minimal**	**Significant**
	☐	☒
		Most likely to be a gap in provision relating to healthy eating and physical activity work

1g	Using the screening and information in questions 1e and 1f, should a full assessment be carried out on the project, policy or proposal?	Yes ☒ No ☐
1h	How have you come to this decision?	Reductions in funding for commissioned health improvement activity will (in the short term) be noticeable for residents, and this is likely to disproportionately affect certain groups. However this is anticipated to be a transitional arrangement, as delivery will be sought from the full public health grant – completion of a full EIA will enable us to set this out fully and examine the risks and benefits more openly.

Stage 2: What do you know?

What do you know already?

Services that have been commissioned so far to improve health (ie reduce behaviour related risk factors such as smoking, excess weight, and inactivity) reach only a fraction of those at risk or who wish to make a change in lifestyle. Although of value to the individuals who access them, we know that alone they are insufficient to make the difference needed for a shift in population level health.

Evidence shows that we need to reach far more people, more often, and in particular those who do not identify that they may have an issue, or who feel excluded or marginalised from accessing health improvement services. Thus a systematic and scaled up approach to behaviour change and making every contact count, and a health in all policies approach is the priority for improving health in Oldham

This part of the EIA describes issues relating to lifestyle issues, in particular how we are

changing our investment in health improvement services.

i. Health in Oldham is relatively poor. The number of individuals who have conditions which are related to lifestyle behaviour is high, for example the number of people in Oldham who are diagnosed with Cancer and Cardiovascular diseases such as Diabetes is significantly higher than nationally, and cancer and cardiovascular disease are strongly related to whether people smoke, are physically inactive, are overweight or obese and or abuse alcohol.

ii. National and local data shows us that significantly more adults smoke than nationally.

iii. Although obesity levels in Oldham are 'amber' in relation to national data, the number of individuals who are physically inactive is particularly high in relation to national figures, suggesting that there is a real need to support residents to become more active, as inactivity in itself is a risk factor for disease in later life. Greater activity levels would of course have a positive impact in reducing the numbers of individuals who are overweight or obese and would also improve mental wellbeing throughout the borough.

iv. One of the proposals is to shift investment to support increased activity levels for Oldham residents, alongside some recent significant investments in leisure services and community development.

v. Poor diet, reduced activity levels and smoking contribute to a significant proportion of the health burden for the borough. We need to rapidly increase the scale and impact of all our services to support individuals to reduce behaviour related risk factors.

vi. We know that our borough is not equal, in that more residents in deprived neighbourhoods are likely to be overweight/obese or smoke and are less likely to be physically active or to eat five portions of fruit and vegetables per day.

vii. We are retaining specific services including health trainers and stop smoking services, and these will be embedded as part of a new broader Early Help Service.

What don't you know?

We do not have specific data on service use by district or ethnicity for the purposes of the EIA.

Further data collection

None for the purposes of this EIA – we have used data available Public Health England

Summary (to be completed following analysis of the evidence above)				
Does the project, policy or proposal have the potential to have a disproportionate impact on any of the following groups? If so, is the impact positive or negative?	**None**	**Positive**	**Negative**	**Not sure**
Disabled people	☒	☐	☐	☐

Particular ethnic groups	☒	☐	☐	☐
Men or women (include impacts due to pregnancy / maternity)	☒	☐	☐	☐
People of particular sexual orientation/s	☒	☐	☐	☐
People who are proposing to undergo, are undergoing or have undergone a process or part of a process of gender reassignment	☒	☐	☐	☐
People on low incomes	☐	☐	☒	☐
People in particular age groups	☐	☐	☒	☐
Groups with particular faiths and beliefs	☐	☐	☐	☒
Are there any other groups that you think that this proposal may affect negatively or positively?				
E.g. vulnerable residents, individuals at risk of loneliness or carers.		☐	☐	

Stage 3: What do we think the potential impact might be?

Consultation information	
3a. Who have you consulted with?	<u>What consultation have we been undertaking?</u> Consultation on the public health savings proposals have wherever possible, been included as part of larger consultation events and activities as services users were identified as overlapping with those for other services which were part of wider consultations taking place. Thus we were able to maximize our reach, and reduce the need for stakeholders to input into numerous different consultations. Since public health investment overall is not decreasing, we have also been working across the council to establish a Public Health Transformation Fund. This fund will support delivery against key public health outcomes from within wider council services. <u>Consultation undertaken so far with/via</u>: • Public Consultation via OMBC website. • Through open access public consultation meetings. • Consultation with NHS Oldham Clinical Commissioning Group. • Consultation relating to the establishment of an All Age Early Help Service, including Health trainers and stop smoking services(separate consultation) • Consultation relating to the review of all 0-19s services (see specific template) • Consultation in relation to Drugs and Alcohol Services (see

	separate template) Further consultation we may need to do. We have received a number of queries and suggestions relating to public health savings and have considered and amended plans where it is appropriate to do so. We do not foresee at this point that further consultation may be needed but will revisit this in future if it becomes evident that this would be appropriate.
3b. How did you consult? (inc meeting dates, activity undertaken & groups consulted)	N/A

3c. What do you know?

In the short term, ie until wider council services start to pick up the activity required, there will be a reduction, loss or change in some services as follows:

i. Access to council funded structured weight management programmes for children ('MEND) will stop, although support for reducing and managing overweight and obesity in childhood will be embedded as part of the new 0-4s integrated service when commissioned.
ii. Access to structured weight management programmes via the council will stop in the short term but we are commissioning an Early Help service which will support clients who are identified as intending to reach a healthy weight to do so (via support from a Health Trainer). In addition we are looking at alternative group support for those who intend to reach a healthy weight. On a strategic level we are commissioning services that seek to get people more active more often through community and district level initiatives and via wider council services.
iii. Public Health funded physical activity schemes will change, from being commissioned via a discrete health improvement service to being available via a variety of services throughout the council via the Transformation Fund including via the leisure services contract.
iv. Cookery courses and healthy eating courses for families will change, from being commissioned from a specific service to being embedded as part of wider council services, including schools.
v. The specific 'Pathways to Health' programme will stop (programme of supporting individuals from deprived and BME backgrounds to gain NVQs and work experience in health and social care), and instead a wider range of support into employment will be funded via the 'Get Oldham Working' scheme.

3d. What don't you know?

The scale at which wider council services will be able to deliver the full range of services which will replace those lost above. The process of identifying services has begun, and the full list of available services will be in place from April 2015.

Should wider council service snot be able to deliver public health initiatives and programmes, investment will be redirected and new services commissioned.

3e. What might the potential impact on individuals or groups be?	
Generic (impact across all groups)	Loss of specific health improvement activity for issues which are cross cutting.
Men or women (include impacts due to pregnancy / maternity)	NA – the service does not target either men or women and we are not aware that these groups would be disproportionately disadvantaged.
People of particular sexual	NA – the service does not target people of particular sexual orientation

orientation/s	and we are not aware that these groups would be disproportionately disadvantaged
Disabled people	NA – the service does not target Disabled clients and we are not aware that these groups would be disproportionately disadvantaged
Particular ethnic groups	NA – the service does not target BME groups and we are not aware that these groups would be disproportionately disadvantaged
People who are proposing to undergo, are undergoing or have undergone a process or part of a process of gender reassignment	No –the service does not target individuals proposing or undergoing gender reassignment and we are not aware that these groups would be disproportionately disadvantaged
People on low incomes	Structured weight management programmes and healthy eating courses are offered through the service for free – we are looking at alternative ways of offering group support for those on low incomes.
People in particular age groups	Children who are either overweight or obese will be affected in the short term as there will be no structured programmes available, however we intend to commission support for children identified as overweight or obese as part of our 0-19 service review.
Groups with particular faiths and beliefs	NA – the service does not target those with particular faiths and beliefs and we are not aware that these groups would be disproportionately disadvantaged
Other excluded individuals and groups (*e.g. vulnerable residents, individuals at risk of loneliness or carers*)	No – we are not aware if the activities lost may disproportionately affect these groups

Stage 4: Reducing / mitigating the impact	
4a. Where you have identified an impact, what can be done to reduce or mitigate the impact?	
1. Access to structured weight management programmes funded via the council will stop	In addition to commissioning wider council services to support people to achieve a healthy weight, the council is looking at at alternative Weight management methods (eg voucher schemes for other local groups) to ensure that individuals from disadvantaged backgrounds in particular are not disproportionately affected.
2. Access to low level physical activity schemes will stop	The council will be commissioning a range of community development initiatives over the coming months and will also look to wider council services to support individuals to take up more lower level physical activities through getting involved local activities
3. Access to council funded weight management programmes for children ('MEND) will stop.	The council will be including weight management programmes for children ('MEND') through the new 0-4 integrated services model, although this will not be in place until 2016/7. In the meantime we will look to develop some enhanced information and advice for parents using an appropriate media (eg through our website, or in an information pack)
4. Public Health funded Cookery courses and healthy eating courses for families will stop.	We will look to support communities who identify healthy cooking courses as a local priority and to this end we have devolved some of the public health budget to district level - district partnerships may seek to commission this type of activity should their community identify it as a priority. We are also commissioning Food for life (schools based scheme) and the school catering service has been commissioned to undertake a project in schools during 2015/6
5. Council funded Self-care	Council funded 'self-care' courses will stop although these were

courses will stop	limited in number, and we will work alongside wider council services to deliver support for those with a long-term health condition. We will work with Oldham NHS CCG to ascertain the impact of this going forward and the numbers affected.
6. The 'Pathways to Health' programme will stop	The pathways to health programme will stop but we will look to the Get Oldham Working programme to support those individuals who may have accessed this programme to seek support via the GOW larger programme.
7. Probation health trainer service will stop (2016/7)	We are developing an All age early help offer as part of our PSR work, and it is envisaged that a similar intervention will be available via this new service for this client group.

4b. Have you done, or will you do, anything differently as a result of the EIA?
We have considered in particular the loss of weight management programmes for adults as the Why Weight programme was one of the few free evidence based low level interventions available for all in the borough. This was offered to around 400 clients per year, however we have been looking at alternative and potentially better value schemes that can be offered to a larger number of clients and these will be determined in April 2015.

4c. How will the impact of the project, policy or proposal and any changes made to reduce the impact be monitored?
The Investment plan and programme are overseen by the Public Health Commissioning Board who collectively provide assurance that the Public Health grant is used to achieve the maximum public health benefit.

Conclusion
This EIA sets out a significant change in the portfolio of investment relating to health improvement activity commissioned by the council. It indicates a changing rather than reducing investment portfolio. This EIA has sought to offer transparency with regard to temporary or permanent losses in service. This has been undertaken during a process of transition – ie efficiencies which have been sought from externally commissioned services have or will be invested in wider council services as these can most likely offer better value and scale than previously commissioned. At any time should investment prove not to demonstrate outcomes and best value, these will be reviewed and changed.

Stage 5: Signature		
Lead Officer:	**Andrea Fallon**	**Date: 24.11.2014**
Approver signature:	**Alan Higgins**	**Date: 24.11.14**
EIA review date:	**December 2015**	

APPENDIX 1: Action Plan and Risk Table

Action Plan

Number	Action	Required outcomes	By who?	By when?	Review date
1	Costings and feasibility of a voucher scheme for weight management programmes, potential partnership approach	Wider council services deliver against this action. SLAs and KPIs set up to demonstrate delivery. Feasibility identified of meeting the demand for weight management programmes using this route.	A Fallon and J Holt	March 2015	March 2015
2	Wider council services will be tasked with increasing opportunities and activities which increase physical activity.	Service level agreements and staff workshops as part of the Public Health Transformation Fund implementation	A Fallon R Reid	Feb 2015	March 2015
3	Access to council funded weight management programmes for children ('MEND) to be included in 0-4s services redesign	0-4 new integrated service model includes access to support and or programmes for children identified through the NCMP programme as overweight or obese.	A Fallon, T Harrison	Oct 2015	March 2015
5	Council funded Cookery courses and healthy eating courses for families will stop and be replaced by activity across the council to increase knowledge of healthy eating for clients	Wider council services will deliver against this action. We will also look at how communities can develop these activities through providing investment in community development activities.	A Fallon R Reid	April 2015	April 2015
6	Assessment of the impact of stopping funding for self-care courses (ie are there alternatives in place)	Analysis of impact of loss of self- care courses funded by the council.	A Fallon	April 2015	April 2015
7	An equivalent intervention to the 'Pathways to Health' programme will be sought via wider council services and or the Get Oldham Working programme.	Wider council services deliver against this action. SLAs and KPIs set up to demonstrate delivery.	A Fallon	April 2015	April 2015
8	Probation health trainer service will stop (2016/7)	Ex-offenders will be able to access generic Health trainer service within the Early Help	A Fallon	April 2016	April 2016

		Service			

Risk table

Ref.	Risk	Impact	Actions in Place to mitigate the risk	Current Risk Score	Further Actions to be developed
R1.1	**Wider council services do not come forward to deliver against the required activity**	**Council may not be able to demonstrate that it meets all the Department of Health conditions of use for the Public Health Grant**	**Executive Directors to identify services which are able to deliver against desired outcomes**	**Likelihood C = significant Impact = II critical**	**Workshop with Executive directors Workshops with frontline staff SLA development and robust KPI development**

Equality Impact Assessment Tool

B039: Proposal Four (Review of Public Health Budget: School Nursing Service)

Stage 1: Initial screening

Lead Officer:	Mike Bridges, Public Health Specialist
People involved in completing EIA:	Andrea Fallon, Consultant in Public Health
Is this the first time that this project, policy or proposal has had an EIA carried out on it? If no, please state date of original and append to this document for information.	Yes

General Information

1a	Which service does this project, policy, or proposal relate to?	Public Health – B039a (Proposal Four) **Review of the School Nursing Contract** (one of six included in B039a A second EIA has been completed on the element of proposal four covering Healthy Schools funding and follows this EIA in the appendix.
1b	What is the project, policy or proposal?	To reduce the value of the School Nursing contract from £1.232M in 2015/16 to £1M in 2016/17. This is following GM benchmarking information around comparable SNS spend and in the context of reviewed 0-4 commissioning arrangements. The reduction in the value of the contract is part of the council saving target but will be **re-invested** into the Councils **'Public Health Investment Fund'** maintaining the integrity of the ring fenced use of the Public Health Grant to Local Authorities. The service will be expected to make savings from existing management and overheads in the first instance and we will look to set out a new service specification for 2016/7 that reflects the local priorities and context.. The provider also has responsibility for Health Visiting which is commissioned by NHS England. There is a service relationship between Health Visiting and School Nursing which includes clinical supervision, line management and safeguarding. The responsibility for Health Visiting commissioning will transfer to local authorities in October 2015.

		The saving from the reduction in the value of the contract will be reinvested into wider council services that can demonstrate their ability to deliver activities for children and young people which meet Key Performance Indicators and Public Health Outcomes.
1c	What are the main aims of the project, policy or proposal?	To reduce the value of School Nursing contract in 2016/17 from £1.232 to £1M.
1d	Who, potentially, could this project, policy or proposal have a detrimental effect on, or benefit, and how?	The School Nursing Service provides a progressive universal service for all children and young people aged between 5 and 19 years olds attending free schools and academies within Oldham Borough Council (including home taught children). The service delivers universal elements of the Healthy Child Programme which is under pinned by the Oldham Joint Strategic Needs Assessment (JSNA). The service intensifies its offer for children and young people who have more complex and long term needs (Universal Plus) e.g. vulnerable and at risk groups, including young carers, children in care, young offenders, those not in education, employment or training (NEET) and children with disabilities. School nurses are instrumental in co-ordinating services for children and young people with multiple needs (Universal Partnership Plus). The service aligns to the Health Visiting Services to provide continuity of service from 0 to 19 years of age. The school nursing service is central to the co-ordination of the Healthy Child Programme 5 to 19 (HCP). The reduction in the value of the School Nursing Service contract may disproportionately affect the physical and mental of children and adolescents by: • Limiting the range of evidence based early interventions to address physical and mental health as part of the Health Child Programme support 5 to 19 including families. There is an increased recognition of the importance of early intervention early intervention to prevent physical and mental health problems during childhood and adolescence which, if undetected, may subsequently have a lifelong impact throughout adulthood. • A schools lack of access to a school nurse is likely inhibits their ability to address health issues across the school, including the tackling of unhealthy life styles issues such as obesity and sexual health problems. The current emphasis on educational attainment further highlights the value of the School Nursing Service; a healthy child has an increased capacity to learn and achieve full potential. • The service may become over stretched with Education, Health and Care Plans (Children and Families Act 2014),

		Safeguarding and Child Protection Work. This may limit the time school health nurse have to undertake wider public health interventions to improve physical and mental health outcomes for children. • As such we intend to review the role of School Nurses in the context of their current roles, to ensure that the service is commissioned in such a way as to ensure that SNS efforts are focused upon activities for which there is sound evidence of positive outcomes.

1e. Does the project, policy or proposal have the potential to disproportionately impact on any of the following groups? If so, is the impact positive or negative?				
	None	**Positive**	**Negative**	**Not sure**
Disabled people	**x**	☐	☐	☐
Particular ethnic groups	**x**	☐	☐	☐
Men or women	**x**	☐	☐	☐
People of particular sexual orientation/s	**x**	☐	☐	☐
People who are proposing to undergo, are undergoing or have undergone a process or part of a process of gender reassignment	**x**	☐	☐	☐
People on low incomes	☐	☐	**x**	☐
People in particular age groups	☐	☐	**x**	☐
Groups with particular faiths and beliefs	**x**	☐	☐	☐
Are there any other groups that you think may be affected negatively or positively by this project, policy or proposal?				
		☐	☐	

1f. What do you think that the overall NEGATIVE impact on groups and communities will be?	**None / Minimal**	**Significant**
	☐	☒

1g	Using the screening and information in questions 1e and 1f, should a full assessment be carried out on the project, policy or proposal?	Yes **x** No ☐
1h	How have you come to this decision?	The decision to undertake a full EIA

Stage 2: What do you know?

What do you know already?

1. Health and Wellbeing of Children in Oldham

The health of children and young people is generally worse than the England average. The level of child poverty is worse than the England average with 26.8% of children aged under 16 years living in poverty. The rate of family homelessness is better than the England average. Children in Oldham have average levels of obesity: 10.1% of children aged 4-5 years and 19.4% of children aged 10-11 years are classified as obese. The MMR immunisation rate is better than the England average. The immunisation rate for diphtheria, tetanus, polio, pertussis and Hib in children aged two is better than the England average. In 2012, there were 907 acute sexually transmitted infection diagnoses in young people aged 15 to 24 years. This represents a rate of 30.7 diagnoses for every 1,000 people in this age range which is lower than the England average.

2. Population Profile Children and Young People

2.1:The 2011 Census estimated Oldham had 45,900 residents aged five to nineteen of whom:

- 34,000 were aged 5 to 15 years
- 18,300 were aged 14 to 19 years
- 11,800 were aged 16 to 19 years

2.2: The wards with the highest populations of 5 to 19 year olds were:

- St. Mary's (with 3,800 aged 5-19, of whom 2,850 were aged 5-15 and 950 were aged 16-19);
- Coldhurst (with 3,650 aged 5-19, of whom 2,770 were aged 5-15 and 880 were aged 16-19); and
- Werneth (with 3,110 aged 5-19, of whom 2,340 were aged 5-15 and 770 were aged 16-19).

2.3: Oldham's population aged 5-19 is projected to increase from 2016, reaching around 48,700 by 2021 – an increase of 2,800 (or around 6%) over the 2011 midyear population estimate. Within this group, the population aged 5-15 is projected to increase more rapidly, reaching around 34,400 by 2016 and 37,400 by 2021, an increase of around 10% and 3,400 over the 2011 estimate. The population aged 16-19 is projected to decrease, dropping to 11,200 by 2019 and recovering to 11,300 by 2021.

2.4: The ethnic group composition of Oldham's population aged 5-19 is more diverse than that of Oldham overall (as would be expected given the youthful age structures of Oldham's Bangladeshi, Pakistani and mixed populations). There are no new population projections with an ethnic group component currently available, yet based on the increasing diversity amongst 0-4 year olds, the ethnic group composition of Oldham's population aged 5-19 may be expected to change substantially over the next ten years.

3. National Context and Evidence

3.1: The importance of giving every child the best start in life and reducing health inequalities throughout life has been highlighted by Marmot and the Chief Medical Officer (CMO). The Healthy Child Programme (HCP) is available to all children and aims to ensure that every child gets the good start they need to lay the foundations of a healthy life. School Nursing Services are a key component of the Healthy Child Programme (5-19) and support school-aged children to achieve the best possible health outcomes.
3.2: Marmot and the CMO both recognised the importance of building on the support in the early years and sustaining this across the life course for school-aged children and young people to improve outcomes and reduce inequalities through targeted support. There will be challenges within a child's or young person's life and times when they need additional support. Universal and targeted public health

services provided by school nursing teams are crucial to improving health and wellbeing of school-aged children.

3.3: Department of Health, NHS England, Public Health England and Local Government association signed up to the pledge for better health outcomes for children and young people in February 2013. The pledge puts children, young people and families at the heart of decision making and improving every aspect of health services, and sets out shared ambitions to improve physical and mental health outcomes for all children and young people and reduce health inequalities.

4. Expected Outcomes of the School Nursing Service

4.1: The School Nursing Service leads and contributes to improving the outcomes for children and young people but **are not solely responsible** for achieving these as a partnership approach is required. The service will need to work with a number of partners including health and social care teams, teachers and youth workers to deliver the evidence based public health interventions as outlined in the Healthy Child Programme (5-19), and using the core principles of Making Every Contact Count for intelligent, opportunistic interventions.

4.2: The Public Health Outcomes Framework and NHS Outcomes Framework clearly define a range of outcome measures that are significant to the school aged population.

- Improving School readiness
- Reducing Pupil absence
- Reducing first time entrants to the youth justice system
- Reducing the number of 16-18 year olds not in education, employment or training
- Reducing under 18 conceptions
- Reducing excess weight in 4-5 and 10-11 year olds (all sub-indicators)
- Reducing hospital admissions caused by unintentional and deliberate injuries in children and young people aged 0-14 and 15-24 years
- Improving emotional wellbeing of looked-after children
- Reducing smoking prevalence – 15 year olds
- Reducing Self harm
- Chlamydia diagnoses (15-24 year olds)
- Improving population vaccination coverage (all sub-indicators)
- Reducing tooth decay in children aged 5

5. Description of the Current School Nursing Service

5.1: The service proactively works within, and provides an on-going commitment to an integrated model of service delivery that promotes health, prevents illness and enables children to reach their full potential within school, the family and the wider community.

5.2: The primary aims of the service are:

To achieve the best health and well-being outcomes for all children and young people through a programme of public health intervention and advice, health assessments, health screening, guidance and support;

- They work closely with partner agencies in Oldham to help individuals or groups to achieve optimum health;
- They deliver preventative services through information and education of children and young people;
- Where necessary they refer children and young people to specialised services, thus providing targeted services to those who are in most need;

- They develop in line with national and local priorities and guidelines effective and evidence-led approaches;
- They provide a high quality service that is accessible to children and young people in Oldham; and ensure quality improvements and as well as providing an appropriate "young people friendly" service by meeting the quality standards laid out in 'You're Welcome': quality criteria for young people friendly health services (2011).

5.3: In addition to the above the School Nursing Service has a crucial role in identifying 'at risk' children and young people becoming the most vulnerable adults in the future. The service will aims to reduce risk through early intervention and long term investment to support children, young people and their families to reach their full potential.

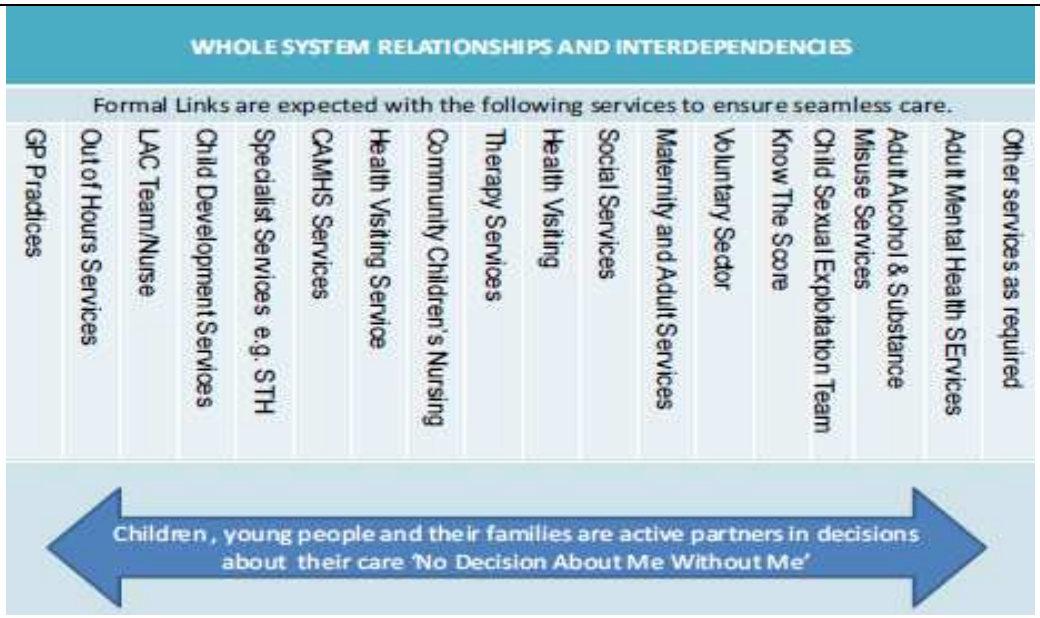
Early indicators (not exhaustive) of needs include:

- Truancy or school exclusion
- Behavioural Problems
- Poor emotional, social or coping skills
- Poor Mental Health
- Learning difficulties
- Low aspirations low self esteem
- Poor family support or problems in the family
- Domestic Abuse
- Friends or family members involved in risky, antisocial behaviour or criminal behaviour
- Deprivation or poverty
- Family instability
- Drug or Alcohol misuse
- Not being in education, employment or training (NEET)
- Homelessness
- Health protection (infectious disease, emergencies)

5.4: The service also provides health action plans for each young person in need (SEN), including children with long term conditions, looked after children, those on a child protection plan and any other child deemed appropriate.

5.5: The School Nursing service is a universally accessible service acceptable to all backgrounds and communities which has proven key to the delivery of the Government Public Health agenda. Drop-in sessions are available in all Secondary Schools across the Borough and there is a health team based in Positive Steps Oldham (PSO). This health team provides health advice on a drop-in basis.

Whole System Relationships



5.6 The Service has a range of skill mix with Bands 4-8 included in the staffing structure.

- Band 8a 1.0wte
- Band 7 3.64wte
- Band 6 15.84wte
- Band 5 1.39wte
- Band 4 1.77wte

6. Service Activity 2013/14

The GM School Nursing Commissioners are currently bench marking the school nursing services across Greater Manchester. However, this is proving slightly difficult as a number of local authorities include other services as part of their school nursing contract such as weight management, sexual health services and some mental health. It is anticipated that the benchmarking will be completed by October 2014.

Average Caseload size:

The average school nurse case load is 2429 children/young people compared to Health Visitors that have 250.

Key Stage (KS)	School years (Y)	Age	Population size
1	1–2	5–7	9676
2	3–6	7–11	12087
3	7–9	11–14	9051
4	10–11	14–16	6275
5	12–13	16–18	6110
Total			43199

There are also **(these figures change consistently):**

160 LAC living in Oldham
680 children on safeguarding monitor system.
200 missing education or educated at home

7. Special Educational Needs (SEN)

7.1: As part of the Children and Families Act 2014 Local Authorities will be required to consider new requests for an assessment of special educational needs and co-ordinate services around a child or young person. Under the new rules, SEN statements and learning difficulty assessments (LDAs) will be replaced with education, health and care (EHC) plans taking children and young people up to the age of 25. From September, new assessments of SEN will follow the new rules, and support will be provided through an EHC plan. Existing statements and LDAs will remain in force until all children and young people have completed the transition. Transfers from statements to EHC plans should be completed within three years, so for pupils who already receive support, you'll need to follow the old guidelines until September 2017.

7.2: This may place additional burdens on the School Nursing Service to support EHC's. At present there are 7,340 children and young people with an SEN. Table 2 shows the total number of children and young people in School Action, School Action Plus and with an SEN statement at primary, secondary and special school.

Table 2: SEN numbers in Oldham

SCHOOL CENSUS
January 2014
SEN - by LA (numbers)
First or only registrations

Phase	Total	No special provision	School Action	School Action Plus	Statements
Primary	25195	20634	2683	1565	313
Secondary	15445	13219	1396	583	247
Special	514	0	0	4	510
Total	**41201**	**33861**	**4083**	**2186**	**1071**

8. Summary

A reduction in the value of the school nursing contract is set against poor health outcomes for children and young people in Oldham, increases in the school aged population, high levels of child poverty and deprivation, increase in ethnic population and greater demands on the service from the Child and Family Bill (SEND Reform) and reduction other statutory services.

9. Key Points

There is likely to be a projected increase in the number of 5 to 19 year olds which could impact on the School Nursing Service and affect the services ability to deliver universal elements of the Healthy Child Programme 5 to 19 years.

Changes in Oldham's ethnic group composition are likely to affect patterns of residence by ethnic groups. There may be an increased need for work within the community, particularly within schools to work with families. At present 38.1% of school children are from a minority ethnic group in Oldham.

If the trend in Oldham's general fertility rate continues to be higher than the regional and national average, there may be increased demand in the future and future investment may be required.

The health and wellbeing of children in Oldham is generally worse than the England average, the

Healthy Child Programme is central to improving the health outcomes of children and young people 5 to 19.

The level of child poverty is worse than the England average with 26.8% of children aged under 16 years are living in poverty. Children living in deprived areas of Oldham are likely to have a higher prevalence of disease and chronic illnesses such as Asthma. The average level of obesity is 10.1% of children aged 4-5 years and 19.4% of children aged 10-11 years are classified as obese.

There is likely to be an increase in the number of children requiring time from a school health nurse for the education, health and care plans identified with SEN reforms. The outcome will be an increased caseload. The ability to deliver PHSE lessons such as sexual health and personal relationships is likely to be affected by the expected increase in the school population, SEN education reforms, as well as changes within the changing ethnic composition of Oldham.

The teenage pregnancy rate in Oldham has slowed down and there is a risk that teenage pregnancy rates may increase as School Nurses are unable to deliver PHSE including other preventive interventions.

Summary (to be completed following analysis of the evidence above)				
Does the project, policy or proposal have the potential to have a disproportionate impact on any of the following groups? If so, is the impact positive or negative?	**None**	**Positive**	**Negative**	**Not sure**
Disabled people	X	☐	☐	☐
Particular ethnic groups	X	☐	☐	☐
Men or women (include impacts due to pregnancy / maternity)	X	☐	☐	☐
People of particular sexual orientation/s	X	☐	☐	☐
People who are proposing to undergo, are undergoing or have undergone a process or part of a process of gender reassignment	X	☐	☐	☐
People on low incomes	☐	☐	X	☐
People in particular age groups	☐	☐	X	☐
Groups with particular faiths and beliefs	X	☐	☐	☐
Are there any other groups that you think that this proposal may affect negatively or positively?				
		☐	☐	

Stage 3: What do we think the potential impact might be?

Consultation information	
3a. Who have you consulted with?	What consultation have we been undertaking? Consultation on the public health savings proposals have wherever possible, been included as part of larger consultation events and activities as services users were identified as overlapping with those for other services which were part of wider consultations taking place. Thus we were able to maximize our reach, and reduce the need for stakeholders to input into numerous different consultations. Since public health investment overall is not decreasing, we have also been working across the council to establish a Public Health Transformation Fund. This fund will support delivery against key public health outcomes from within wider council services. Consultation undertaken so far with/via: • Public Consultation via OMBC website. • Through open access public consultation meetings. • Consultation with NHS Oldham Clinical Commissioning Group. • Consultation relating to the establishment of an All Age Early Help Service, including Health trainers and stop smoking services(separate consultation) • Consultation relating to the review of all 0-19s services (see specific template) • Consultation in relation to Drugs and Alcohol Services (see separate template) Further consultation we may need to do. We have received a small number of queries and suggestions relating to public health savings and have been considering and amending plans where it is appropriate to do so. We do not foresee at this point that further consultation may be needed but will revisit this on an ongoing basis where it becomes evident that this would be appropriate.
3b. How did you consult?	See above

3c. What do you know?
The reduction in the value of the School Nursing Contract may disproportionately affect children and young people, in particular those children living within more deprived wards of Oldham where there is a greater need for the scheduled delivery of the Healthy Child Programme to improve health outcomes, referral to health services, chronic disease management and early intervention and prevention.
3d. What don't you know?
The ability of wider council services to start to pick up public health activity to improve physical, Emotional and Mental Health of children and adolescents using the Public Health Investment Fund. • The impact of the Children and Families Act 2014 and SEND Reforms on the service. • The increase of Safeguarding and Child Protection workload on the role of School Nursing Service. • The increase in the school age population on the service and caseloads of school nurses. • The future increase in free schools in Oldham • The numbers of children being taught at home who do not access statutory services • The increase in the number of Looked After Children (LAC)

3e. What might the potential impact on individuals or groups be?	
Generic (impact across all groups)	There should be no adverse effects across disability, race, sexual orientation, faith or belief. The main areas of concern are children and young people and those living in low income areas.
Men or women (include impacts due to	N/A

pregnancy / maternity)	
People of particular sexual orientation/s	N/A
Disabled people	N/A These is a specialist service that is commissioned by Oldham Clinical Commissioning Group for disabled children and those with complex medical needs.
Particular ethnic groups	Children from particular BME groups may have a greater need for early interventions for physical and emotional health improvement as the prevalence of behaviour related risk factors are greater in adults amongst this proportion of the population
People proposing to undergo, are undergoing or have undergone a process or part of a process of gender reassignment	N/A
People on low incomes	Children and young people living low income households are more likely to suffer from physical, emotional and mental health issues. The service is universal but is required to provide a targeted service for the most at-risk children and families and to help parents give their children the best possible care. A reduction in the value of the school nursing contact is likely to affect the universal offer of the health child programme 5 – 19 in other more affluent areas of the Borough.
People in particular age groups	Children and young people aged between 5 to 19 may be affected with the reduction in the value of the contract and loss of school schools funding as the service may have to move towards a more targeted service. The delivery of the Healthy Child Programme 5 to 19 as a universal offer will be affected impacting on the health outcomes for some children and young people in some wards of Oldham.
Groups with particular faiths and beliefs	N/A
Other excluded individuals and groups (*e.g. vulnerable residents, individuals at risk of loneliness or carers*)	N/A

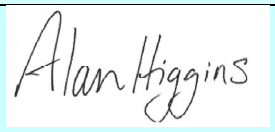
Stage 4: Reducing / mitigating the impact	
4a. Where you have identified an impact, what can be done to reduce or mitigate the impact?	
Impact 1: Low Income	Ensure the service weights individual school nursing caseloads by deprivation and other relevant factors such as ethnicity.
Impact 2: Children and Young people	
Impact 3: SEN	

4b. Have you done, or will you do, anything differently as a result of the EIA?
The reduction in the contract value has been identified as saving for the council to be reinvested into the Public Health Investment Fund. As a result of the EIA there is an urgency to engage with Schools to raise the profile of the School Nursing Service and opportunities to co-commission early prevention interventions based on evidence and the Health Child Programme 5 to 19 years of age. A new set of outcome measures has been developed through the Greater Manchester School Nursing Commissioner Group to improve health outcomes for children and young people and drive some

efficiency through co-commissioning.

4c. How will the impact of the project, policy or proposal and any changes made to reduce the impact be monitored?
The impact will be monitored through quarterly contract monitoring with the service. The Public Health Outcomes Framework and Child Health Profile (including readiness to learn and GCSE results and health and wellbeing impacts on school attainment).

Conclusion
The reduction in the value of the School Nursing Contract and Healthy Schools likely to disproportionately affect children and young people, in particular those children living within more deprived wards of Oldham where there is a greater need for the scheduled delivery of the Healthy Child Programme to improve health outcomes, through early intervention, referral to health services, chronic disease management and prevention initiatives. As a result of the EIA there is an urgency to engage with Schools to raise the profile of the School Nursing Service and opportunities to co-commission early prevention interventions based on evidence and the Health Child Programme 5 to 19 years of age. A new set of outcome measures has been developed through the Greater Manchester School Nursing Commissioner Group / alongside a new service specification to improve health outcomes for children and young people and drive some efficiency through co-commissioning with schools and other potential partners e.g. Oldham Clinical Commissioning Group.

Stage 5: Signature		
Lead Officer:		**Date: 24.11.14**
 **(Mike Bridges)**		
Approver signature:	 **(Alan Higgins)**	**Date: 24.11.14**
EIA review date: December 2015		

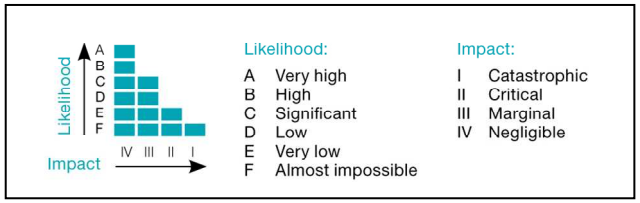
APPENDIX 1: Action Plan and Risk Table

Action Plan

Number	Action	Required outcomes	By who?	By when?	Review date
1	**New Service Outcomes**	**New service outcome measures to be implemented in October as part of contract variation.**	**Mike Bridges**	**Beginning Oct 2014**	**Oct 2014**

Risk table

Ref.	Risk	Impact	Actions in Place to mitigate the risk	Current Risk Score	Further Actions to be developed
R1.1	**Increase in Safeguarding and Child Protection Case**	**Capacity of the service to deliver universal elements of Healthy Child Programme**	**Asked service to undertake a review of safeguarding and child protection review**	**Likelihood C = significant Impact = II critical**	**Actions to be taken forward with school nursing steering group.**
R1.2	**Wider council services do not come forward to deliver against health, emotional and mental health for children and young people.**	**Possible breach of conditions of the Public Health Grant**	**Executive Directors to identify services which are able to deliver against children and young people public health outcomes**	**Likelihood C = significant Impact = II critical**	**Workshop with Executive directors Workshops with frontline staff SLA development and robust KPI development**
R1.3	**Increase in free schools and children taught at home**	**Capacity of the service to deliver universal elements of Healthy Child Programme**	**Monitoring the number of free schools and children being taught at home.**	**Likelihood C = significant Impact = II critical**	



Equality Impact Assessment Tool

B039: Proposal Four (Review of Public Health Budget: Healthy Schools Coordinator)

Stage 1: Initial screening

Lead Officer:	Mike Bridges Public Health Specialist
People involved in completing EIA:	Alan Higgins Director of Public Health
Is this the first time that this project, policy or proposal has had an EIA carried out on it? If no, please state date of original and append to this document for information.	Yes X No Date of original EIA:

General Information

1a	Which service does this project, policy, or proposal relate to?	Public Health – B039a (part of Proposal Four) Proposal Four: Healthy Schools Funding
1b	What is the project, policy or proposal?	To make changes to our investment portfolio relating to child and maternity (Healthy Schools £20,000) and deliver elements of Healthy Schools programme through wider council services
1c	What are the main aims of the project, policy or proposal?	The council has previously disinvested in the Health Schools programme prior to April 2013. However a limited amount of funding was continued through the contribution of £20k grant from Public Health, offered to Positive Steps Oldham each year. As part of the councils efficiencies programme it is proposed to end this grant, to coincide with the larger Positive Steps contract being re-procured, and the forthcoming review of the school nursing contract.
1d	Who, potentially, could this project, policy or proposal have a detrimental effect on, or benefit, and how?	Funding for the healthy schools programme was hitherto offered to Positive steps as provider in order to expand their existing work around health issues for young people. This funding was offered as a grant, and priorities were agreed annually, eg support for reducing teenage pregnancy, o preventing the uptake of smoking amongst young people. The focus of work changed each year depending on local priorities. It is expected that wider council services will be able to pick up some elements of the service, with others needing to stop. In addition, as part of the re-tender of the School Nursing Contract (from 2016/7) it is intended that the role of the School Nursing Services is clearly defined in relation to some

		of the current Healthy Schools programme as there is currently some overlap ie • Advice and guidance on PHSE lessons relation to physical health, sexual health, relationships and emotional wellbeing. • Advice on PHSE curriculum resources • Advice on healthy schools award and enhanced award. • Advice on healthy eating awards It is anticipated that wider council services are able to support schools and deliver activities to replace some of this lost activity through their existing funding arrangements.

1e. Does the project, policy or proposal have the potential to <u>disproportionately</u> impact on any of the following groups? If so, is the impact positive or negative?				
	None	**Positive**	**Negative**	**Not sure**
Disabled people	**X**	☐	☐	☐
Particular ethnic groups	**X**	☐	☐	☐
Men or women (include impacts due to pregnancy / maternity)	**X**	☐	☐	☐
People of particular sexual orientation/s	**X**	☐	☐	☐
People who are proposing to undergo, are undergoing or have undergone a process or part of a process of gender reassignment	**X**	☐	☐	☐
People on low incomes	**X**	☐	☐	☐
People in particular age groups	**X**	☐	☐	☐
Groups with particular faiths and beliefs	**X**	☐	☐	☐
Are there any other groups that you think may be affected negatively or positively by this project, policy or proposal?				
		☐	☐	

1f. What do you think that the overall NEGATIVE impact on groups and communities will be?	**None / Minimal**	**Significant**
	X	

1g	Using the screening and information in questions 1e and 1f, should a full assessment be carried out on the project, policy or proposal?	Yes ☐ No **X**

1h	How have you come to this decision?	The grant was given to the provider as an annual grant towards the healthy schools programme. Schools and Academies have a statutory obligation for the health, emotional and mental wellbeing of children within their schools. As part of the Pupil Premium schools are expected to the health and wellbeing issues in their schools as part of educational attainment. Going forward school nurses as part of the new school nursing service outcome measures will be expected to engage with their schools and develop a joint health assessment and action plan to improve health outcomes. This will also include advice on PHSE lessons relating to sexual health and relationships, tackling lifestyle issues and emotional and mental wellbeing.

Stage 5: Signature
Lead Officer: Mike Bridges Date: 21.11.2014
Approver signature: Alan Higgins Date: 21.11.2014
EIA review date: December 2015

D017: Customer and Business Support Redesign (including D021 Legal and Democratic – Legal Services Redesign)

Stage 1: Initial screening

Lead Officer:	Suzanne Heywood
People involved in completing EIA:	Suzanne Heywood Sarah Bell
Is this the first time that this project, policy or proposal has had an EIA carried out on it? If no, please state date of original and append to this document for information.	Yes Date of original EIA: Not applicable

General Information

1a	Which service does this project, policy, or proposal relate to?	Customer and Business Support Services Redesign (also relates to proposal D021 Legal and Democratic – Legal Services Redesign)
1b	What is the project, policy or proposal?	This EIA relates to budget proposal D017 (Customer and Business Support Redesign) this will deliver savings of £200k in 2015/16 and £350k in 2016/17. The total budget for the service is £8.602m (excluding recharges and benefits). Additionally, this EIA covers the budget proposal D021 Legal and Democratic – Legal Services Redesign. The vision for the Customer and Business Support Service is to support the organisation to deliver resident focussed services thorough effective people, processes and technology.
1c	What are the main aims of the project, policy or proposal?	The review will ensure that the service is able to support the changing needs of the Council and its services. It aims to improve the customer experience whilst reducing operational costs. The redesign programme will include a full review of the activities undertaken by the staff employed within the service. However, to be effective the review will need to consider end to end processes and as such will be

		undertaken in conjunction with the 52 services across the Council that we support.
		
		The full scope of the programme is currently in development and will include:
		
		• A full end to end review of service processes from the initial stages of customer contact through to task completion/job fulfilment. This will include:
		  ○ removal of duplication and waste (failure)
		  ○ determining significance of tasks and amending those deemed unnecessary i.e. more risk based approach
		  ○ working with other corporate services to minimise overlaps
		  ○ implementing/reviewing quality procedures to reduce waste
		  ○ maximising opportunities for automation and self- serve through the use of technology
		
		• Review of access channels available for customers (internal and external) the aim is to provide a choice of access channels, with a key focus on moving services online and moving telephone and email contact to the Contact Centre.
		
		• Review of business support requirements across the Council, moving to a more bespoke service rather than a generic model ensuring the support provided meets the needs of the service.
		
		• Reviewing management structures to ensure the service drives transformation.
		
		The redesign activity will take place over a two year period.

1d	Who, potentially, could this project, policy or proposal have a detrimental effect on, or benefit, and how?	The project will have a direct impact on all services supported by the Customer and Business Support Service and could have an indirect impact on the customers of those services. In some areas this could be a positive impact in that the service will receive support through Customer and Business Support which is more tailored to the individual needs of the service. i.e. they get the support they need (bespoke) rather than being offered staff who can undertake a standard range of tasks (generic). In some areas there could be a negative impact. For

		example if staffing within a service is reduced and then there is an unforeseen peak in workload the service may suffer and this could have a direct impact on residents. Any redesign of the service will be undertaken in conjunction with the services we support and actions. At the point of reviewing each service EIA screening will take place and where any potential disproportionate adverse impacts are identified, a full EIA will be carried out.

1e. Does the project, policy or proposal have the potential to disproportionately impact on any of the following groups? If so, is the impact positive or negative?				
	None	**Positive**	**Negative**	**Not sure**
Disabled people	☒	☐	☐	☐
Particular ethnic groups	☒	☐	☐	☐
Men or women (include impacts due to pregnancy / maternity)	☒	☐	☐	☐
People of particular sexual orientation/s	☒	☐	☐	☐
People who are proposing to undergo, are undergoing or have undergone a process or part of a process of gender reassignment	☒	☐	☐	☐
People on low incomes	☒	☐	☐	☐
People in particular age groups	☒	☐	☐	☐
Groups with particular faiths and beliefs	☒	☐	☐	☐
Are there any other groups that you think may be affected negatively or positively by this project, policy or proposal?				
None		☐	☐	

1f. What do you think that the overall NEGATIVE impact on groups and communities will be?	**None / Minimal**	**Significant**
	☒	☐

1g	Using the screening and information in questions 1e and 1f, should a full assessment be carried out on the project, policy or proposal?	Yes ☐ No ☒
1h	How have you come to this	Any redesign of the service will be undertaken in

	decision?	conjunction with the services we support. At the point of reviewing each service EIA screening will take place and where any potential disproportionate adverse impacts are identified, a full EIA will be carried out.

Stage 5: Signature		
Lead Officer:	**Suzanne Heywood**	**Date: 24.10.14**
Approver signature:	**Emma Alexander**	**Date: 24.10.14**
EIA review date:	**December 2015**	

Equality Impact Assessment Tool

D020: Legal and Democratic – Registrar Service

Stage 1: Initial screening

Lead Officer:	Paul Entwistle
People involved in completing EIA:	Paul Entwistle Jenni Barker
Is this the first time that this project, policy or proposal has had an EIA carried out on it? If no, please state date of original and append to this document for information.	Yes

General Information

1a	Which service does this project, policy, or proposal relate to?	This EIA relates to budget proposal D020: Legal and Democratic – Registrar Service.
1b	What is the project, policy or proposal?	The proposal is to amend the opening hours of the Registrar Service. The Registrar Service is primarily responsible for registering births, marriages and deaths within the borough, they also officiate at weddings and civil partnership ceremonies. Currently the service operates Monday to Friday between 8am and 6pm. On occasion, the service has taken appointments on a Saturday, but this is by exception and relies on availability of staff and other commitments such as weddings. The proposal is to close the Registrar Service for one day in the week and open on a Saturday instead.
1c	What are the main aims of the project, policy or proposal?	It is anticipated that £25,000 can be saved through amendments to the terms and conditions of the permanent staff in the Registrar Service. The change would see the service start to operate on a rota basis, which means that we would reduce overtime payments. The new opening times would also reduce the need for sessional staff.
1d	Who, potentially, could this project, policy or proposal have a	It is anticipated that the new opening times of the service would not have a disproportionate adverse

	detrimental effect on, or benefit, and how?	impact on any groups. We have considered the potential impact on people of particular faiths and beliefs, particularly where a culture requires that the deceased persons are buried within a certain time period. We have concluded however, that this is not the case. It will still operate for five days a week, so people will not be waiting to register a death (or a birth or marriage) for longer than they do currently, in fact we believe this is an improvement to the Service on two counts. Firstly, we anticipate that opening on Saturdays will increase the accessibility to, and convenience of, the service to those who find it harder to get an appointment in the week because of work or family commitments. Secondly, the Contact Centre will be able to make appointments for people whilst the Service is closed on the Monday, meaning that appointments can be secured even though the Registrar Service is closed.

1e. Does the project, policy or proposal have the potential to disproportionately impact on any of the following groups? If so, is the impact positive or negative?				
	None	**Positive**	**Negative**	**Not sure**
Disabled people	☒	☐	☐	☐
Particular ethnic groups	☒	☐	☐	☐
Men or women (include impacts due to pregnancy / maternity)	☒	☐	☐	☐
People of particular sexual orientation/s	☒	☐	☐	☐
People who are proposing to undergo, are undergoing or have undergone a process or part of a process of gender reassignment	☒	☐	☐	☐
People on low incomes	☒	☐	☐	☐
People in particular age groups	☒	☐	☐	☐
Groups with particular faiths and beliefs	☒	☐	☐	☐
Are there any other groups that you think may be affected negatively or positively by this project, policy or proposal?				
E.g. vulnerable residents, individuals at risk of loneliness, carers or serving and ex-serving members of the armed forces		☐	☐	

1f. What do you think that the overall NEGATIVE impact on groups and communities will be?	**None / Minimal**	**Significant**
	☒	☐

1g	Using the screening and information in questions 1e and 1f, should a full assessment be carried out on the project, policy or proposal?	Yes ☐ No ☒
1h	How have you come to this decision?	It is anticipated that the new opening times of the service would not have a disproportionate adverse impact on any groups. We have considered the potential impact on people of particular faiths and beliefs, particularly where a culture requires that the deceased persons are buried within a certain time period. We have concluded however, that this is not the case. It will still operate for five days a week, so people will not be waiting to register a death (or a birth or marriage) for longer than they do currently, in fact we believe this is an improvement to the Service on two counts. Firstly, we anticipate that opening on Saturdays will increase the accessibility to, and convenience of, the service to those who find it harder to get an appointment in the week because of work or family commitments. Secondly, the Contact Centre will be able to make appointments for people whilst the Service is closed on the Monday, meaning that appointments can be secured even though the Registrar Service is closed. We will monitor any issues with the new opening hours and resolve them as far as possible.

Stage 5: Signature	
Lead Officer: Paul Entwistle	**Date: 27.11.14**
Approver signature: Emma Alexander	**Date: 27.11.14**
EIA review date: December 2015	