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TRAFFORD COUNCIL

AGENDA PAPERS FOR

EXECUTIVE MEETING

Date: Monday, 19 December 2016

Time: 6.30 p.m.

Place: Committee Rooms 2 and 3, Trafford Town Hall, Talbot Road, Stretford M32 0TH

A G E N D A **PART I** **Pages**

1. **ATTENDANCES**

   To note attendances, including officers, and any apologies for absence.

2. **DECLARATIONS OF INTEREST**

   Members to give notice of any interest and the nature of that interest relating to any item on the agenda in accordance with the adopted Code of Conduct.

3. **MINUTES**

   To receive and, if so determined, to approve as a correct record the Minutes of the following meetings:

   (a) Executive, 31/10/16 1 - 4

   (b) Special Executive, 15/11/16 5 - 8

4. **MATTERS FROM COUNCIL OR OVERVIEW AND SCRUTINY COMMITTEES (IF ANY)**

   To consider any matters referred by the Council or by the Overview and Scrutiny Committees.

5. **REVISED COMMUNITY INFRASTRUCTURE LEVY (CIL) REGULATION 123 LIST 2016** 9 - 26

   To consider a report of the Executive Member for Economic Growth, Environment and Infrastructure.

6. **PROPOSED CORNBROOK HUB COMPULSORY PURCHASE ORDER** 27 - 38

To consider a report of the Executive Member for Economic Growth, Environment and Infrastructure.

7. **SUBSTANCE MISUSE SERVICES** 39 - 258

To consider a report of the Executive Member for Adult Social Services and Community Wellbeing.
PLEASE NOTE: The appendices to this report are very extensive, and so will not be reproduced in hard copy. They are all available with the rest of this agenda on the Council's website.

8. **COUNCIL TAX SUPPORT SCHEME FOR 2017/18 - PROPOSED CHANGES TO ALIGN WITH NATIONAL BENEFITS** 259 - 274

To consider a report of the Executive Member for Finance and Chief Finance Officer.

9. **TREASURY MANAGEMENT 2016/17 MID-YEAR PERFORMANCE REPORT** 275 - 290

To consider a report of the Executive Member for Finance and Chief Finance Officer.

10. **ANNUAL DELIVERY PLAN 2016/17 (SECOND QUARTER) PERFORMANCE REPORT** 291 - 326

To consider a report of the Executive Member for Transformation and Resources.

11. **UPDATE ON THE NEXT PHASE OF INTEGRATION BETWEEN TRAFFORD COUNCIL AND TRAFFORD NHS CCG** To Follow

To consider a report of the Executive Member for Adult Social Care and Community Wellbeing.

12. **TRAFFORD'S APPROACH TO INVESTMENT OPPORTUNITIES** To Follow

To consider a report of the Deputy Chief Executive.

13. **TRAFFORD'S PUBLIC SERVICE REFORM PROGRAMME - PROPOSED PLACE-BASED PROOF OF CONCEPT IN THE NORTH OF THE BOROUGH** 327 - 336

To consider a report of the Executive Member for Communities and Partnerships.

14. **AGMA COMBINED AUTHORITY / EXECUTIVE BOARD: FORWARD**

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PLANS AND DECISIONS

To receive and note the following:

(a)	GMCA Forward Plan November 2016	337 - 342
(b)	Joint GMCA / AGMA Forward Plan November 2016	343 - 346
(c)	GMCA Decisions 28/10/16	347 - 354
(d)	Joint GMCA / AGMA Decisions 28/10/16	355 - 360
(e)	GMCA Decisions 25/11/16	361 - 368

15. **URGENT BUSINESS (IF ANY)**

Any other item or items which by reason of:-

(a) Regulation 11 of the Local Authorities (Executive Arrangements) (Meetings and Access to Information) (England) Regulations 2012, the Chairman of the meeting, with the agreement of the relevant Overview and Scrutiny Committee Chairman, is of the opinion should be considered at this meeting as a matter of urgency as it relates to a key decision; or

(b) special circumstances (to be specified) the Chairman of the meeting is of the opinion should be considered at this meeting as a matter of urgency.

16. **EXCLUSION RESOLUTION**

Motion (Which may be amended as Members think fit):

That the public be excluded from this meeting during consideration of the remaining items on the agenda, because of the likelihood of disclosure of "exempt information" which falls within one or more descriptive category or categories of the Local Government Act 1972, Schedule 12A, as amended by The Local Government (Access to Information) (Variation) Order 2006, and specified on the agenda item or report relating to each such item respectively.

THERESA GRANT
Chief Executive

COUNCILLOR SEAN ANSTEE
Leader of the Council

Membership of the Committee

Councillors S.B. Anstee (Chairman), Mrs. L. Evans, M. Hyman, J. Lamb, P. Myers, J.R. Reilly and A. Williams (Vice-Chairman)

Further Information

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For help, advice and information about this meeting please contact:

Jo Maloney, 0161 912 4298
Email: joseph.maloney@trafford.gov.uk

This agenda was issued on Thursday 8th December 2016 by the Legal and Democratic Services Section, Trafford Council, Trafford Town Hall, Talbot Road, Stretford M32 0TH.

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EXECUTIVE

31 OCTOBER 2016

PRESENT

Leader of the Council (Councillor Sean Anstee) (in the Chair),
Executive Member for Children's Services (Councillor M. Hyman),
Executive Member for Communities and Partnerships (Councillor J. Lamb),
Executive Member for Economic Growth, Environment and Infrastructure (Councillor John Reilly),
Executive Member for Finance (Councillor P. Myers),
Executive Member for Transformation and Resources (Councillor Mrs. L. Evans).

Also present: Councillors Adshead, Stephen Anstee, Baugh, Bowker, Miss Blackburn, Brotherton, Butt, Cordingley, Duffield, Fishwick, Harding, Hynes, Procter, Shaw, A. Western and M. Young.

In attendance:

Chief Executive (Ms. T. Grant),
Deputy Chief Executive (Ms. H. Jones),
Corporate Director, Resources (Ms. J. Hyde),
Interim Corporate Director, Children, Families and Wellbeing (Ms. J. Colbert),
Director of Legal and Democratic Services (Ms. J. Le Fevre),
Chief Finance Officer (Ms. N. Bishop),
Democratic and Scrutiny Officer (Mr. J.M.J. Maloney).

APOLOGIES

Apologies for absence were received from Councillor A. Williams.

34. DECLARATIONS OF INTEREST

No declarations were made by Members of the Executive.

35. MINUTES

Members received for approval the draft Minutes of the Executive's meeting held on 19th September 2016. In discussion, the Leader of the Council advised that the meeting scheduled for 28th November 2016 would be cancelled.

RESOLVED – That the Minutes of the meeting held on 16th September 2016 be approved as a correct record.

36. MATTERS FROM COUNCIL OR OVERVIEW AND SCRUTINY COMMITTEES (IF ANY)

There were no matters to be reported to the current meeting.

37. CONSERVATION AREA APPRAISALS AND MANAGEMENT PLANS

The Executive Member for Economic Growth, Environment and Infrastructure submitted a report which provided a summary of the consultation responses received to the draft Conservation Area Appraisals (CAAs) and draft Management Plans (CAMPs) for Ashton upon Mersey, Brogden Grove, Dunham Town, Dunham Woodhouses, Empress, Flixton, Longford and Warburton; and which sought approval to the final documentation for adoption as Supplementary Planning Documents (SPD). An opportunity was provided for Members to raise queries on the report's content; and it was agreed that further information would be provided outside the meeting on the question of the preservation of structures within designated conservation areas.

RESOLVED -

(1) That the consultation responses and amendments made to the CAAs and CAMPs for Ashton upon Mersey, Brogden Grove, Dunham Town, Dunham Woodhouses, Empress, Flixton, Longford and Warburton as set out in Appendix 2 to the report be noted.

(2) That the following be approved for adoption and publication as Supplementary Planning Documents, as set out in Appendices 3-18 to the report:-

- Ashton upon Mersey Conservation Area Appraisal
- Ashton upon Mersey Conservation Area Management Plan
- Brogden Grove Conservation Area Appraisal
- Brogden Grove Conservation Area Management Plan
- Dunham Town Conservation Area Appraisal
- Dunham Town Conservation Area Management Plan
- Dunham Woodhouses Conservation Area Appraisal
- Dunham Woodhouses Conservation Area Management Plan
- Empress Conservation Area Appraisal
- Empress Conservation Area Management Plan
- Flixton Conservation Area Appraisal
- Flixton Conservation Area Management Plan
- Longford Conservation Area Appraisal
- Longford Conservation Area Management Plan
- Warburton Conservation Area Appraisal
- Warburton Conservation Area Management Plan

(3) That responsibility be delegated to the Director of Growth and Regulatory Services for approving any minor amendments to the wording of the documents, prior to their publication.

38. GREATER MANCHESTER ESTATES - MEMORANDA OF UNDERSTANDING

The Executive Member for Economic Growth, Environment and Infrastructure submitted a report which provided an update on the progress made with the Greater Manchester Estates workstream related to the Enabling Better Care priority of the Health and Social Care Strategic Plan. It also sought approval for the Council's participation in a Memorandum of Understanding with partners across the Greater Manchester local authority and health care sectors.

RESOLVED -

(1) That the content of the report be noted.

(2) That approval be given to the National Estates Memorandum of Understanding, attached as Appendix 1 to the report.

(3) That approval be given to the Greater Manchester Memorandum of Understanding, attached as Appendix 2 to the report.

(4) That authority be delegated to the Deputy Chief Executive to agree minor amendments to the wording of the two Memoranda.

39. OFFICE OF SURVEILLANCE COMMISSIONERS - OUTCOME OF INSPECTION 2016

The Executive Member for Transformation and Resources submitted a report which updated Members on the outcome of the inspection carried out by the Office of Surveillance Commissioners and set out the recommendations and the proposed action the Council would take in implementing those recommendations. In response to Members' queries, the Executive was advised that legislation provided that surveillance would only be used in limited, prescribed circumstances, and that the action points set out in the report had already been implemented.

RESOLVED – That it be noted that the Commissioner's recommendations have been accepted and that the following steps have been taken to implement the recommendations / learning points:-

a) an officer debrief of the lessons learned as a consequence of the inspection has taken place
b) amendments made to the main policy document *Guidance on the Use of Surveillance* as set out.
c) process now agreed with external agencies (GMP) in relation to authorisations for directed surveillance. Follow up checks to be carried out from time to time
d) periodic refresher training for authorising officers, applicants and enforcement officers will be arranged.

40. REPORT ON COMPLAINTS DETERMINED BY THE LOCAL GOVERNMENT OMBUDSMAN 2015/16

The Executive Member for Transformation and Resources submitted a report, in line with the Council's statutory duty, advising Members on adverse outcomes of complaints formally investigated by the Local Government Ombudsman. The report also provided Members with a summary of complaints determined in 2015/16. In answer to a query, it was agreed that further information would be provided, insofar as was consistent with the law, on the issues identified in two complaints involving child protection, and what had been done to rectify them.

RESOLVED – That the content of the report be noted.

41. AGMA COMBINED AUTHORITY / EXECUTIVE BOARD: FORWARD PLANS AND DECISIONS

There were no plans or decisions to be reported to the current meeting.

The meeting commenced at 6.30 p.m. and finished at 6.56 p.m.

SPECIAL MEETING OF EXECUTIVE

15 NOVEMBER 2016

PRESENT

Leader of the Council (Councillor Sean Anstee) (in the Chair),
Executive Member for Adult Social Services and Community Wellbeing (Councillor A. Williams),
Executive Member for Children's Services (Councillor M. Hyman),
Executive Member for Communities and Partnerships (Councillor J. Lamb),
Executive Member for Economic Growth, Environment and Infrastructure (Councillor John Reilly),
Executive Member for Finance (Councillor P. Myers),
Executive Member for Transformation and Resources (Councillor Mrs. L. Evans).

Also present: Councillors Adshead, Stephen Anstee, Baugh, Miss Blackburn, Bowker, Brotherton, Butt, Cordingley, Cornes (part only), Coupe, Duffield, Fishwick, Freeman, Haddad, Hynes, Procter, Ross, Shaw, Taylor (part only), A. Western, Whetton and M. Young.

In attendance:

Deputy Chief Executive (Ms. H. Jones),
Corporate Director, Resources (Ms. J. Hyde),
Interim Corporate Director, Children, Families and Wellbeing (Ms. J. Colbert),
Director of Legal and Democratic Services (Ms. J. Le Fevre),
Chief Finance Officer (Ms. N. Bishop),
Programme Assurance Lead (Mr. P. Helsby),
Democratic and Scrutiny Officer (Mr. J.M.J. Maloney).

42. DECLARATIONS OF INTEREST

Councillor Myers declared a Personal Interest in respect of Trafford Housing Trust and its Limelight development at Shrewsbury Street, and Councillor Lamb declared a Personal Interest in respect of his Board Membership of the Trafford Leisure Company.

43. MATTERS FROM COUNCIL OR OVERVIEW AND SCRUTINY COMMITTEES (IF ANY)

There were no issues to be reported to this meeting.

44. EXECUTIVE'S DRAFT REVENUE BUDGET PROPOSALS 2017/18 AND MTFS 2018/19 AND 2019/20

The Executive Member for Finance and Chief Finance Officer submitted a report which set out the Executive's three year budget strategy proposals and detailed draft revenue budget proposals for 2017/18 and Medium Term Financial Strategy (MTFS) for the period 2018/19 – 2019/20. An opportunity was provided for Members to raise initial questions in relation to the report; and it was noted that the proposals were subject to further development, consultation and review by Scrutiny prior to the Council's determination of its budget in February 2017.

RESOLVED -

(1) That approval be given to the 2017/18 to 2019/20 proposed budget strategy, draft revenue budget and MTFS including the income and savings proposals for the purposes of consultation only; and to the referral of these proposals also to the Scrutiny Committee for their consideration.

(2) That the proposals be noted to increase Council Tax by 1.99% for the three years 2017/18 to 2019/20, and to levy the permitted 2% precept over the same period, which is only permitted to be allocated to adult social care.

(3) That the budget gap for the years 2017/18, 2018/19 and 2019/20 be noted.

(4) That it be noted that the draft proposals are subject to various consultation exercises and impact assessments, movements in core funding, specific grants, costing and robustness assessments.

(5) That it be agreed that the decision is to be deemed urgent for the reasons set out in the report, and thus not subject to call-in.

45. INCREASING PHYSICAL ACTIVITY ACROSS THE BOROUGH

The Executive Member for Communities and Partnerships submitted a report setting out the case for investing capital to improve and modernise the Council's leisure centres. Investment was predicated on increasing usage of leisure centres with some consolidation of facilities to generate income sufficient to meet the capital costs over a reasonable period of time. The proposals were set within the context of ever increasing cost pressures on the health and social care system and the absolute imperative to secure improved health and wellbeing outcomes through a strategy of increasing levels of physical activity. An opportunity was provided for Members to raise questions on the report's content. Further financial details relating to the proposals were set out in a report considered in Part II of this agenda. (Minute 48 refers.)

RESOLVED -

(1) That the Physical Activity Vision be adopted.

(2) That the recommendations of the Commercial Prospectus be noted and approved, in principle and subject to further consultation where required.

(3) That approval be given to the principle of the Council making a capital investment of £24.39m identified as necessary in the Commercial Prospectus for all three phases/lots of works and subject to the need for further Executive approval, of any investment, once detailed business cases are produced demonstrating sufficient income growth to fund the capital costs.

(4) That authority be delegated to the Corporate Director, Resources in consultation with the Deputy Chief Executive, to procure project

management support and develop detailed schemes for the first two phases and release £250,000 to fund this development work.

(5) That approval be given to consultation on proposals for the closure of George H Carnall Leisure Centre and the consolidation of leisure services in that area at an improved Urmston Leisure Centre.

(6) That the proposals for the consolidation of golf facilities in the Flixton area be noted and that authority be delegated to the Corporate Director, Resources to enter into negotiations with existing providers to bring forward a detailed proposal in this regard.

(7) That the appointment be approved of Trafford Leisure Community Interest Company Limited as the operator of leisure services at the Council's leisure facilities and that authority be delegated to the Corporate Director, Resources in consultation with the Director of Legal and Democratic Services to negotiate the terms of and enter into a new operating agreement to support the delivery the Physical Activity Vision.

46. BUDGET MONITORING 2016/17 PERIOD 6 (APRIL - SEPTEMBER 2016)

The Executive Member for Finance and Chief Finance Officer submitted a report which informed Members of the current 2016/17 forecast outturn figures relating to both Revenue and Capital budgets. It also summarised the latest forecast position for Council Tax and Business Rates within the Collection Fund. In response to a query, it was agreed that further information would be provided in relation to the profile of vacancies within the EGEI Directorate.

RESOLVED - That the content of the report and the changes to the Capital Programme as detailed in paragraph 19 of the report be noted.

47. EXCLUSION RESOLUTION

RESOLVED - That the public be excluded from this meeting during consideration of the remaining items on the agenda, because of the likelihood of disclosure of "exempt information" which falls within one or more descriptive category or categories of the Local Government Act 1972, Schedule 12A, as amended by The Local Government (Access to Information) (Variation) Order 2006, and specified on the agenda item or report relating to each such item respectively.

48. INCREASING PHYSICAL ACTIVITY ACROSS THE BOROUGH

Further to the report considered in Part I of this agenda (Minute 45 refers), the Executive Member for Communities and Partnerships submitted a report setting out financial details of the case for investing capital to improve and modernise the Council's leisure centres. More details of the proposals and resolutions made in relation to this item are set out at Minute 45.

The meeting commenced at 6.30 p.m. and finished at 7.45 p.m.

TRAFFORD COUNCIL

Report to: **Executive**
Date: **19 December 2016**
Report for: **Decision**
Report of: **Executive Member for Economic Growth, Environment and Infrastructure.**

Report Title

Revised Community Infrastructure Levy (CIL) Regulation 123 List 2016

Summary

This report provides a summary of the purpose and content of the Revised Community Infrastructure Levy (CIL) Regulation 123 List and highlights the amendments from the original CIL Regulation 123 List, adopted in 2014.

The report also provides a summary of the consultation responses received on the draft Revised CIL Regulation 123 List (June 2016).

The report seeks approval of the Revised CIL Regulation 123 List for adoption to replace the original Regulation 123 List.

Recommendation(s)

That the Executive:

1. Notes the consultation responses received through the consultation on the Draft Revised CIL Regulation 123 List (June 2016), as set out in Appendix

2. Approves the Revised CIL Regulation 123 List (2016) for adoption to replace the original Regulation 123 List, as presented in Appendix 1.

3. Delegates authority to approve and make any minor, non-consequential, amendments to the wording of the document to the Director of Growth and Regulatory Services, prior to its publication.

Contact person for access to background papers and further information:

Name: Richard Roe (Director of Growth and Regulatory Services)
Extension: 4265

Background Papers: None

Relationship to Policy Framework/Corporate Priorities	The CIL Regulation 123 List contributes to a number of Corporate Priorities, due to its function in securing and improving infrastructure provision. These include: 'Economic Growth and Development'; 'Safe place to live – fighting crime'; 'Services focussed on the most vulnerable people'; 'Excellence in Education'; and 'Reshaping Trafford Council'.
Financial	CIL provides the mechanism for the Council to secure funding towards the required essential infrastructure in the borough. The proposed amendments to the Regulation 123 list will clarify what infrastructure will be funded by CIL.
Legal Implications:	The minor amendments proposed to the CIL Regulation 123 List can be lawfully made within the Regulations and all the consultation responses have been properly addressed. Although there is a threat of a Judicial Review being submitted against the Executive Decision being proposed in this report, the risk of this being a successful challenge is considered to be minimal.
Equality/Diversity Implications	The draft CIL Charging Schedule was subject to an Equalities Impact Assessment (EIA) in September 2013 to ensure that equality issues have been considered as part of the preparation. The revisions to the Regulation 123 List relate to minor wording changes, there are no changes proposed to the Charging Schedule or to the infrastructure requirements identified in the Regulation 123 List. A further EIA is therefore not required.
Sustainability Implications	The CIL Charging Schedule has been subject to an independent viability appraisal. Most of the evidence supporting it has been subject to independent sustainability appraisal as part of the preparation of the Core Strategy. The amendment to the Regulation 123 List is minor and has no additional sustainability implications.
Resource Implications e.g. Staffing / ICT / Assets	The Revised CIL Regulation 123 List has been prepared by staff within the existing Strategic Planning and Growth Team. The document will be available to view electronically via the web.
Risk Management Implications	The Revised CIL Regulation 123 List supports the sustainable delivery of the Council's Core Strategy, the emerging Greater Manchester Spatial Framework and Development Management function. If the Revised CIL Regulation 123 List is not progressed it could undermine the delivery of infrastructure in Trafford which could in turn put the delivery of future development at risk.

Health & Wellbeing Implications	None
Health and Safety Implications	None

1.0 Background

1.1 The Community Infrastructure Levy (CIL) allows local authorities in England and Wales to set a financial levy on developments to fund essential infrastructure to support planned growth.

1.2 The Trafford CIL Charging Schedule was formally approved at Full Council on 26th March 2014, and came into effect on 7th July 2014. This document sets out the charges for different types of development and any geographical variations in these rates and was subject to independent Examination.

1.3 In accordance with the CIL Regulations 2010 (as amended), the Council is required to produce a list of infrastructure projects that could potentially benefit from CIL funding; this list is known as the CIL Regulation 123 List. The Council adopted the original CIL Regulation 123 List on 7th July 2014 (alongside the CIL Charging Schedule).

1.4 The main purpose of the list is to provide transparency around what the Council intends to fund through CIL and what site specific infrastructure Section 106 contributions will continue to be used for. The intention is to ensure that there is no duplication in the use of CIL and Section 106 for the same specific infrastructure.

1.5 The CIL Regulation 123 List for Trafford contains a broad range of project types that could be eligible for CIL funding in the period to 2026. During the examination of the CIL, it was noted that the CIL Regulation 123 List included quite broad infrastructure categories and that a more detailed list would be helpful.

1.6 The Council consulted on a draft Revised CIL Regulation 123 List for a six week period from the 27th June – 8th August 2016.

1.7 The main purpose of the proposed revisions to the CIL Regulation 123 List was to provide minor clarifications and was not the reconsideration of the Council's infrastructure priorities. Two minor points of clarification have therefore been proposed. Firstly, a new sentence has been added at the beginning of each of the Transport, Education and Sport/Recreational facilities sections. This new sentence clarifies, in line with the original intention, that the projects eligible for CIL funding are those listed in the CIL Regulation 123 List only. Any other infrastructure required as a result of a specific development will be secured by way of a Section 106 Agreement.

1.8 The second change relates to the two 'catch all' points in the Education section of the CIL 123 List. These changes are intended to make clearer the intention behind the existing CIL Regulation 123 List and to confirm that bullet points one and six relate to the expansion of existing schools only. Through these changes, it will be clear that CIL funds will not be used for any entirely new schools other than those specifically listed in the CIL Regulation 123 List. The Revised CIL Regulation 123 List can be found in Appendix 1 of this Report.

2.0 Public Consultation and the summary of responses received on the draft Revised CIL Regulation 123 List.

2.1 The CIL Regulation 123 List can be amended without going through a full CIL review and examination process. Executive Member approval was given on the 13th June 2016

for the Council to consult on the draft Revised CIL Regulation 123 List. In line with Planning Practice Guidance on amending a CIL Regulation 123 List, and the public consultation guidance set out in the Council's Statement of Community Involvement, the following methods were used:

- Email / letter to all Statutory Consultees, major landowners and known developers in Trafford;
- Making the consultation document available on the Strategic Planning webpages;
- Making a copy of the consultation document available at Trafford Town Hall, Sale Waterside Offices and Libraries across the Borough; and
- Placing a consultation notice in the Local Press.

2.2 Consultees were invited to submit their comments via email or letter for a six week period running from 27th June to 8th August 2016.

2.3 Responses were received from Network Rail, the Environment Agency, Peel Land and Property, Natural England and Historic England. A summary of the comments received is provided below, with more detail and the Council's responses to the comments set out in Appendix 2.

3.0 Summary of Responses Received

3.1 The main issues raised through the consultation can be summarised as follows:

i. A request has been made for the provision of a school within the Trafford Centre Strategic Location to be included on the CIL Regulation 123 List, to bring it in line with the other Strategic Locations and to ensure that there is funding available to assist with its delivery.

ii. Objection to the insertion of the word 'existing' into the Regulation 123 List so that it states 'Borough wide expansion of existing primary schools'. The existing wording of the Regulation 123 List is considered to allow for flexibility as it suggests that the list of schools identified is not exhaustive and that funding for other schools could be considered.

iii. A request for the "attractive direct pedestrian link across Trafford Boulevard", referred to in Core Strategy Policy SL4 'Trafford Centre Rectangle', to be included within the CIL Regulation 123 List because the provision of a bridge link at Trafford Waters would affect the viability of any proposed development of the location.

iv. Objection to the proposed amendment to the wording of the strategic transport infrastructure section of the Regulation 123 List to state 'The following strategic transport infrastructure projects...' as this would only direct CIL funds towards the list of projects provided in the CIL Regulation 123 List. The view is expressed that the existing wording of 'Strategic transport infrastructure including...' indicates that the list of transport projects is not exhaustive and that this could therefore allow for funding to be directed towards schemes such as the Trafford Waters bridge link.

v. The opportunity to bring the CIL Regulation 123 List up to date, to support the delivery of the Strategic Locations, has been missed through the amendments proposed and that the amendments will remove all flexibility of CIL.

vi. The proposed changes place the Trafford Centre Rectangle Strategic Location in an extremely disadvantageous position compared with the other Core Strategy Strategic Locations. The view is expressed that the changes have been proposed to deliberately do so and are, therefore, not considered to be in accordance with Regulations and national guidance and should the Council decide to adopt the changes, consideration will be given to the submission of a legal challenge against the decision.

3.2 As stated previously, the main purpose of the proposed revisions to the CIL Regulation 123 List was not to make major changes or to reconsider the Council's infrastructure priorities. To do this, would require the Council to reconsider infrastructure needs for all sites across the whole Borough.

3.3 All the suggestions summarised above would result in significantly more infrastructure being included on the CIL Regulation 123 List with no additional CIL receipts being available. Any such significant change would require the revisiting of the CIL Charging Schedule and the CIL Regulation 123 List.

3.4 If the approach suggested in the representations above was to be taken in isolation from any major review of the CIL, the allocation of major infrastructure would be dictated to by planning decisions rather than by the Local Plan Strategy. For example, the need for a new school at Trafford Waters arises from the developer's decision to seek approval for more dwellings [1]at this location than is identified in the Local Plan.

3.5 Therefore, for the reasons set out in Appendix 2 of this report, no changes are considered necessary as a result of the comments received through the consultation.

3.6 Approving the amended wording of the CIL Regulation 123 List puts the infrastructure eligible for CIL funding beyond doubt consistent with the original intent and ensures that it is clear that any other necessary infrastructure is to be secured through S106 contributions. The Revised CIL Regulation 123 List ensures that there is absolute clarity on what infrastructure will be eligible for CIL funds and will ensure there is no possible perceived duplication of CIL and Section 106 funds being used for the same project.

3.7 Guidance in respect of changes to CIL Regulation 123 Lists makes it clear that such lists can be amended without going through a full CIL review and examination process, providing that an appropriate level of consultation is undertaken and the changes are clearly explained. It is considered that this requirement was fulfilled appropriately, by the Council, when it consulted on the draft Revised CIL Regulation 123 List during June and August 2016. Therefore it is considered that the proposed revisions are both appropriate and in accordance with Regulations and guidance in respect of these matters and no further changes are proposed to the list.

4.0 Sustainability Appraisal

4.1 Sustainability Appraisal (SA) is a process used to assess how sustainable development is being addressed and included in plans and strategies prepared by

[1] Approval was granted for: 3,000 dwellings; 80,000 sqm office; 6,700 sqm commercial; hotels; a care-home and a primary school on land known as Trafford Waters within the Trafford Centre Rectangle Strategic Location on the 13th October 2016 by the Planning and Development Management Committee. This approval is subject to the terms of a S106 Agreement which is yet to be signed.

organisations. The CIL Charging Schedule relates to infrastructure required to deliver the Trafford Core Strategy which was the subject of a sustainability appraisal.

4.2 Because the proposed amendments to the CIL Regulation 123 List are minor and clarify the ambit of the existing list, there are not considered to be any additional sustainability implications and therefore no new appraisal has been deemed necessary.

5.0 Next Steps

5.1 Following approval of the Revised Regulation 123 List, the document will be made available on the Council's website and will then help to inform when infrastructure would be funded through CIL and when S106 Agreements should be used to provide necessary infrastructure provision as part of planning proposals. The Revised CIL Regulation 123 List will also inform the allocation and spending of the strategic infrastructure portion of CIL funds.

Other Options

The Council could choose not to adopt the Revised CIL Regulation 123 List and could instead continue to use the existing CIL Regulation 123 List.

However, it has been highlighted that the wording used in parts of the existing CIL Regulation 123 List could be open to possible misinterpretation. Amending the wording of part of the CIL Regulation 123 List through the adoption of the Revised CIL Regulation 123 List will put the infrastructure eligible for CIL funding beyond doubt. This will ensure that the Council is in the strongest position to secure the infrastructure required for any proposed developments.

Consultation

The draft Revised CIL Regulation 123 List was subject to a period of public consultation in line with both Planning Practice Guidance on amending a CIL Regulation 123 List and the Council's Statement of Community Involvement.

Reasons for Recommendation

Adopting the Revised CIL Regulation 123 List will put the infrastructure eligible for CIL funding beyond doubt and ensure the Council is in the strongest position to secure the infrastructure required for any proposed developments. The changes will ensure there is absolute clarity on what infrastructure will be eligible for CIL funds and will ensure there is no possible perceived duplication of CIL and Section 106 funds being used for the same project.

Key Decision – Yes
If Key Decision, has 28-day notice been given? Yes

Finance Officer Clearance: PC
Legal Officer Clearance: JLF

Helen Jones

CORPORATE DIRECTOR'S SIGNATURE

Appendix 1

Revised CIL Regulation 123 List December 2016

Regulation 123 of the Community Infrastructure Levy (CIL) Regulations 2010 as amended, restricts the use of planning obligations for infrastructure that will be funded in whole or in part by CIL, to ensure there is no duplication between the two types of developer contributions. Further detail regarding planning obligation requirements can be found in the revised SPD1 – Planning Obligations 2014.

A CIL charging authority is required to publish a list of infrastructure that it intends to fund through CIL on its website. Trafford Council (as the Charging Authority) can review this list at least once a year as part of its monitoring of CIL receipts and expenditure.

The inclusion of an infrastructure project or type of infrastructure in this list does not signify a commitment from the Council to fund (either in whole or in part) the listed project or type of infrastructure through CIL. Nor does the order of the table imply any order of preference for CIL funding.

The Trafford CIL Infrastructure Note (May 2013) that informs this Regulation 123 list was submitted to the CIL Examination in December 2013. It contains a broad range of projects and project types across Trafford that could be eligible for CIL funding in the period to 2026. The current indicative range of infrastructure projects, derived from the Infrastructure Note that may be funded in whole or part through CIL in the five year period between 2014 and 2019, are set out in the table below.

Infrastructure currently considered likely to benefit from the application of CIL funding:
The following strategic transport infrastructure projects: *Western Gateway Infrastructure Scheme (WGIS)* *Extension of Metrolink through Trafford Park* *New Link Road to and through the development site at Carrington* *Significant improvements to public transport in Carrington and Partington* *Transformational junction improvement scheme in Stretford*
Strategic flood risk and drainage projects *Including those identified in the Local Flood Risk Management Strategy*
The following education projects: *Borough-wide expansion of* existing *primary schools to provide additional intake places* *Provision of a 1-form entry primary school to serve Pomona Island, Trafford Wharfside, Old Trafford and Lancashire County Cricket Club Quarter* *Provision of a 2-form entry primary school in Carrington* *Provision of a 1-form entry primary school in Altrincham* *Provision of a 1-form entry primary school in Stretford* *Borough-wide expansion of* existing *secondary schools to provide additional intake places*
The following strategic sport and recreational facilities: *Provision of a major wet and dry facility at Stretford* *Provision of a major wet and dry facility at Sale/Altrincham*
Strategic green infrastructure *Apart from those projects delivered directly on-site (including those for residential developments of 300 units or more)*

Appendix 2 – Summary of Representations

Date Received	Organisation	Person ID	Comment ID	Document Name	Summary Of Response	Response type	Proposed Council Response
27-Jun-15	Historic England	1074	101	Draft Revised CIL Regulation 123 List	General comments regarding the role of CIL.	General comment	General comment noted.
27-Jun-16	Network Rail	1235	102	Draft Revised CIL Regulation 123 List	Network Rail has no comments.	No comments	Noted.
02-Aug-16	The Environment Agency	1430	103	Draft Revised CIL Regulation 123 List	The Environment Agency has no comments.	No comments	Noted.
03-Aug-16	Natural England	1037	104	Draft Revised CIL Regulation 123 List	Natural England has no comments.	No comment	Noted.
08-Aug-16	NJL Consulting on behalf of Peel Land and Property	1373	105	Draft Revised CIL Regulation 123 List	Objection to the proposed changes and requests for amendments to be made.	Objection	Objection noted. See proposed responses to detailed comments below.
08-Aug-16	NJL Consulting on behalf of Peel Land and Property	1373	106	Draft Revised CIL Regulation 123 List	General comment on the purpose of CIL and of the role of the Local Infrastructure Plan (LIP) and Infrastructure Note (2013) in identifying infrastructure requirements.	General comment	General comment noted.

08-Aug-16	NJL Consulting on behalf of Peel Land and Property	1373	107	Draft Revised CIL Regulation 123 List	General comment regarding the five Core Strategy Strategic Locations, the key infrastructure required to facilitate delivery of the locations identified in Core Strategy Policies SL1 - 5 and the role of the Infrastructure Note (2013) in further detailing the required infrastructure.	General comment	General comment noted
08-Aug-16	NJL Consulting on behalf of Peel Land and Property	1373	108	Draft Revised CIL Regulation 123 List	Note that Policy SL4 'Trafford Centre Rectangle' of the Core Strategy includes a requirement for a school as part of the development of the location but that the provision of a school is not included in 'Implementation' section of Policy SL4. This is considered to be an omission, as the provision of a school is identified in the 'Implementation' sections of the other 4 Strategic Location Policies. It is noted that the background to this position is set out in the Infrastructure Note (2013) which states that schools in Urmston would have the capacity to take demand arising from future development of the Trafford Centre Rectangle Strategic Location (including Trafford Waters). A school at the Trafford Centre Rectangle has not therefore been included as part of the CIL Regulation 123 List. This position is now considered out of date as proposals for Trafford Waters have increased beyond growth anticipated in the Core Strategy, a position which has been recognised by Trafford Council which has stated that due to the increased growth, there will no longer be capacity within nearby schools to accommodate the development. A request for a school at	Objection	Trafford's Core Strategy was adopted in January 2012. The Core Strategy envisages 1050 homes at the Trafford Centre Rectangle (Policy SL4). Under those circumstances there was not anticipated to be a need for a new school here in contrast to the position at other strategic locations. The Core Strategy remains Council policy and provides an appropriate policy framework for the level of infrastructure to be supported through CIL and therefore identified in the CIL Regulation 123 List. To include a school at Trafford Waters in the Revised CIL Regulation 123 List would result in a significant change to the List. This is not considered to be appropriate given that the Trafford CIL supports the delivery of the Trafford Core Strategy. The majority of Trafford Waters

					Trafford Waters to be specifically identified in the Regulation 123 List to bring it in line with other Strategic Locations and to ensure that there is funding available to assist with its delivery.		would amount to growth beyond that expected in the Local Plan. The suggested change would result in significantly more infrastructure being included on the CIL Regulation 123 List with no additional CIL receipts being available. Any such significant change would require the revisiting of the CIL Charging Schedule and the CIL Regulation 123 List. If the approach suggested in the representation was to be taken in isolation from any major review of the CIL, the allocation of major infrastructure would be dictated to by planning decisions rather than by the Local Plan Strategy. The Revised CIL Regulation 123 List will ensure that if additional school places are required as a result of levels of development, significantly above those anticipated in the Core Strategy, they can be secured by way of a Section 106 agreement for a specific site and will not be considered contrary to regulations. No change proposed.

08-Aug-16	NJL Consulting on behalf of Peel Land and Property	1373	109	Draft Revised CIL Regulation 123 List	Objection to the insertion of the word 'existing' into the Regulation 123 List so that it states 'Borough wide expansion of existing primary schools'. The existing wording of the Regulation 123 List could allow for flexibility for CIL funding for schools beyond those specifically identified. The current wording suggests that the list of schools identified is not exhaustive and funding for others schools could be considered. This allows for changes in circumstances, such as have occurred at Trafford Waters. The insertion of the word 'existing' removes necessary flexibility that would have allowed CIL funding to be directed to a school at Trafford Waters. This is considered to be contrary to the purposes of CIL.	Objection	The text in the Education section has been revised to make it clear that bullet points one and six relate to the expansion of existing schools only, in accordance with the original intent. CIL funds will not be used for any entirely new schools other than those listed in the Revised CIL Regulation 123 List. The text for the Education section of the Regulation 123 List has been amended to clarify that the projects eligible for CIL funding are those listed in the Regulation 123 List only. Any other infrastructure required as a result of a specific development will be secured by way of a Section 106 agreement. The previous use of the word 'including' could have been misinterpreted to imply that the infrastructure listed is not exhaustive; the amended wording will therefore clarify this. Please see the Council's proposed response to 'comments 108' for further

							details. No change proposed.
08-Aug-16	NJL Consulting on behalf of Peel Land and Property	1373	110	Draft Revised CIL Regulation 123 List	Policy SL4 'Trafford Centre Rectangle' of Trafford Council's Core Strategy states that Trafford Waters must include 'An attractive direct pedestrian link across Trafford Boulevard'. This is also identified in the implementation section of the Policy and in the Council's LIP and Infrastructure Note (2013). Despite this, Peel note that the bridge link is not identified in the Regulation 123 List and there is no evidence to confirm why this has occurred.	Objection	The Regulation 123 List is derived from projects and types set out in the Infrastructure Note (2013). The Infrastructure Note (2013) contains a broad range of infrastructure projects and project types that could be eligible for CIL funding in the period to 2026. Not all projects included on the Infrastructure Note can be included within the CIL Regulation 123 List; neither would it be appropriate to do so. Please see the Council's proposed response to 'comments 108' for further details. No change proposed

08-Aug-16	NJL Consulting on behalf of Peel Land and Property	1373	111	Draft Revised CIL Regulation 123 List	The position regarding the Trafford Centre rectangle has progressed since the Infrastructure Note (2013) was published with the scale of proposed development at Trafford Waters having increased. It is felt that the importance of the bridge link has also now increased. The Trafford Waters planning application indicates that the cost of the bridge is in the region of £15.5m, which is £5.5m greater than that anticipated by the Council. The provision of the bridge link is the main item that limits the viability of the Trafford Waters development and its ability to provide for affordable housing. Evidence shows that the provision of the bridge link affects the viability of the Trafford Waters development and a contribution from CIL funding would significantly improve the deliverability of the bridge and the viability of the whole scheme. This would then increase the number of affordable homes that Trafford Waters could include. Therefore a request is made for the bridge link across Trafford Boulevard to be identified as one of the strategic transport infrastructure projects in the Regulation 123 List.	Objection	Whilst it is accepted that the bridge is an item of infrastructure necessary to support the sustainable development at Trafford Waters, and this is reflected in both the Core Strategy and the Infrastructure Note (2013). As stated above, the Infrastructure Note is a broad range of infrastructure projects which could be eligible for CIL funding in the period to 2026 but it would not be possible or appropriate to include all items within the 123 List. It is not considered appropriate to include the bridge on the 123 List. Please see the Council's proposed response to 'comments 108' for further details. No change proposed
08-Aug-16	NJL Consulting on behalf of Peel Land and Property	1373	112	Draft Revised CIL Regulation 123 List	Objection to the proposed amendment to the wording of the strategic transport infrastructure section of the Regulation 123 List to state 'The following strategic transport infrastructure projects...' as this would only direct CIL funds towards to list	Objection	The text of the Transport section has been amended to clarify that the projects eligible for CIL funding are those listed in the Regulation 123 List only. Any other

					of projects provided in the Regulation 123 List. It is felt that the existing wording of 'Strategic transport infrastructure including...' indicates that the list of transport projects is not exhaustive and that this could therefore allow for funding to be directed towards schemes such as the Trafford Waters bridge link. The original wording better reflects the purpose of CIL in assisting with the delivery of the Strategic Locations. The proposed amended wording would not support the delivery of the Strategic Locations and in particular Trafford Waters, as part of the Trafford Centre Rectangle Strategic Location and therefore is contrary to the objectives of CIL.		infrastructure required as a result of a specific development will be secured by way of a Section 106 agreement. The previous use of the word 'including' could have been misinterpreted to imply that the infrastructure listed is not exhaustive; the amended wording will therefore clarify this. Please see the Council's proposed response to 'comments 108' for further details. No change proposed.
08-Aug-16	NJL Consulting on behalf of Peel Land and Property	1373	113	Draft Revised CIL Regulation 123 List	The opportunity to bring the CIL Regulation 123 List up to date, to support the delivery of the Strategic Locations, has been missed through the amendments proposed. The amendments will remove all flexibility and CIL will have a narrower and less effective remit. If these proposals are fully published, CIL will not be able to appropriately support the delivery of the Trafford Centre Rectangle Strategic Location, which is contrary to the purposes of CIL. As a result, objection is made to the proposed amendments.		The amendments made to the Regulation 123 List puts the infrastructure eligible for CIL funding beyond doubt and ensures the Council is in the strongest position to secure the infrastructure required for any proposed developments. The Revised CIL Regulation 123 List will ensure that there is absolute clarity on what infrastructure will be eligible for CIL funds and ensures there is no possible perceived duplication of CIL and Section 106 funds being used for the

							same project. Please see the Council's proposed response to 'comments 108' for further details. No change proposed
08-Aug-16	NJL Consulting on behalf of Peel Land and Property	1373	114	Draft Revised CIL Regulation 123 List	The proposed changes place the Trafford Centre Rectangle Strategic Location in an extremely disadvantageous position compared with the other Strategic Locations, and appear to be deliberately designed to do so. Therefore, should the Council decide to adopt the changes, serious consideration will be given to submitting a legal challenge against the decision.		Approving the amended wording of the CIL Regulation 123 List puts the infrastructure eligible for CIL funding beyond doubt and ensures that the Council is in the strongest position to secure the infrastructure required for any proposed developments. The Revised CIL Regulation 123 List ensures that there is absolute clarity on what infrastructure will be eligible for CIL funds and will ensure there is no possible perceived duplication of CIL and Section 106 funds being used for the same project. Guidance in respect of changes to CIL Regulation 123 Lists makes it clear that these lists can be amended without going through a full CIL review and examination process, providing that an appropriate

							level of consultation is undertaken and the changes are clearly explained. It is considered that this requirement was fulfilled appropriately, by the Council, when it consulted on the draft Revised CIL Regulation 123 List during June and August 2016. Therefore it is considered that the proposed revisions are both appropriate and in accordance with Regulations and guidance in respect of these matters. Please see the Council's proposed response to 'comments 108' for further details. No change proposed.

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TRAFFORD COUNCIL

Report to:	**Executive**
Date:	**19th December 2016**
Report for:	**Decision**
Report of:	**Executive Member for Economic Growth, Environment and Infrastructure**

Report Title

Proposed Cornbrook Hub Compulsory Purchase Order

Summary

This report seeks Executive approval to utilise Combined Authority powers and to delegate authority to the Chief Executive in consultation with the Leader to present a report to the Greater Manchester Combined Authority requesting that a Compulsory Purchase Order is made in respect of the Cornbrook neighbourhood.

Recommendation(s)

The Executive will be asked to:

1. Approve the alternative delivery strategy as detailed in section 2 below, utilising the Greater Manchester Combined Authority Compulsory Purchase powers.

2. Delegate authority to the Chief Executive, in consultation with the Leader, to present a report to the Combined Authority requesting that a Compulsory Purchase Order is promoted by the Combined Authority in respect of the Cornbrook neighbourhood, as detailed in appendix one. The report will ask the Combined Authority to appoint Manchester City Council to act on its behalf in taking all necessary steps to prepare the case for the CPO, including but not limited to securing an appropriate indemnity in respect of the Combined Authority's costs in promoting and making the CPO

Contact person for access to background papers and further information:

Name: Richard Roe
Extension: 4265

Background Papers: None

Implications:

Relationship to Policy Framework/Corporate Priorities	This report relates to the corporate priority for economic growth and development and will support the delivery of a strategic regeneration site. The Cornbrook Hub Strategic Regeneration Framework (SRF) sets the objectives of delivering a distinctive location which will support the continued growth of the Manchester and Trafford's economies. The SRF will see the creation of a residential and commercial destination around a major transport hub. The delivery of this will provide a range of new employment and residential opportunities.
Financial	All revenue costs including officer time will be reimbursed under the terms of the agreed indemnity agreement. All capital costs will be reimbursed under the terms of the agreed indemnity agreement
Legal Implications:	The relevant legal process will be pursuant to the Greater Manchester Combined Authority Compulsory Purchase powers and an indemnity agreement will be entered into as referred to in the report
Equality/Diversity Implications	The land subject to the SRF is included within one of the Strategic Locations in the Trafford Core Strategy. During its preparation, that document was subject to an Equalities Impact Assessment (EIA) to ensure that equality issues have been considered as part of the preparation.
Sustainability Implications	The Trafford Core Strategy was subject to an independent sustainability appraisal as part of its preparation.
Resource Implications e.g. Staffing / ICT / Assets	The preparation of the CPO will require staff resources from within the Strategic Growth Service; the Planning and Development Service and; Legal and Democratic Services, however all costs will be reimbursed under the terms of an indemnity agreement Manchester Ship Canal Developments.
Risk Management Implications	The project team will meet on a regular basis and review any issues, risks which may arise. A key objective of the SRF is to deliver one of the Strategic Locations in the Council's Core Strategy. If the proposed CPO is not progressed it could undermine the delivery of this key site, which could in turn put the delivery of the Council's overall strategy at risk.

Health & Wellbeing Implications	No direct implications
Health and Safety Implications	No direct implications

1.0 Introduction

1.1 The Executives of both Trafford Council and Manchester City Council have previously approved the basis for a Compulsory Purchase Order to drive forward the regeneration of the Cornbrook area in and around the Cornbrook Metrolink station using Town and Country Planning Act Powers. This report now seeks to amend that strategy by seeking to use Regeneration Compulsory Purchase powers newly acquired by the Greater Manchester Combined Authority. Such an approach will enable powers that are much broader in scope to be deployed and the CPO process should be more cost efficient and should deliver an outcome much faster than using the Town and Country Planning Act powers.

1.2 Background

1.3 The Cornbrook area is situated on the fringe of the city centre and is part of a ribbon of development around the Bridgewater Canal and railway lines that links the city centre with other parts of the regional centre within Salford and Trafford. This area is currently not playing its full role in the renaissance of the conurbation core both in terms of employment growth and new residential development. The Cornbrook area falls within the boundaries of both Manchester City Council and Trafford Council. Manchester Ship Canal Developments (MSCD) has a significant landholding in the Cornbrook area and the work they have undertaken indicates that significant employment growth (circa 1750 jobs) and several thousand new homes could be unlocked in the wider environs of Cornbrook if this key site is developed.

1.4 2.2Whilst the Cornbrook area has many attributes, including the presence of the Cornbrook Metrolink station, it is unlikely that significant and comprehensive change can or will take place here in the absence of a co-ordinated approach to its regeneration. The regeneration of the St Georges area of Manchester has progressed very significantly over the last fifteen years but extending this regeneration momentum westwards into Cornbrook and beyond into Pomona is being held up by the current land uses and ownership structures within Cornbrook. The area in and around the Cornbrook Metrolink Station is in fragmented ownership and has been the home to a range of end uses that has held back and, still does hold back, the regeneration of the Cornbrook area and the Pomona area in Trafford.

1.5 The Manchester Ship Canal Developments (MSCD) strategy for the Cornbrook Hub includes creating a new commercial, residential and leisure destination, recognising the importance of the site's location as a "Gateway" between Manchester and Trafford. The regeneration proposals for Cornbrook will include significant environmental improvements to the immediate area and a potential new entrance and improved car parking to the Cornbrook Metrolink Station. In respect of their wider land interests MSCD proposes to deliver residential led development schemes in the Pomona area in Trafford.

1.6 In order to support the regeneration of the Cornbrook Hub, Manchester City Council and Trafford Council have adopted a strategic regeneration framework (SRF) for Cornbrook. The Framework document identifies how the area could be

transformed to create a new commercial, and leisure destination, which supports significant new employment and business growth opportunities.

1.7 The area which is covered by the SRF is located on the city fringe of the Manchester and Trafford border and is bounded by Chester Road, the Bridgewater Canal and the Cornbrook Metrolink Station. The total site area includes around 2.3 hectares of land that is divided into two distinct parcels by an operational railway/ metrolink system. One parcel of the site is located within the boundary of Manchester, with the remaining parcel located in Trafford.

1.8 The Cornbrook Hub SRF aims to deliver high density commercially led, mixed use development of the land within Manchester and Trafford. It would create a new gateway to Manchester city centre from the West and would improve access to the Cornbrook Metrolink Station, a major transport hub. A broad range of uses are anticipated including office space, residential (circa 100 dwellings), retail and a hotel. The proposals could deliver it is estimated around 1750 new jobs during construction and upon occupation, including local employment opportunities.

1.9 The Cornbrook Hub SRF sets out that a regenerated site could deliver an area that is integrated and well connected with its surroundings; the replacement of incompatible land uses with high quality buildings within a much higher quality environment; and reuse of the railway arches. It could also deliver the Bridgwater Canal and Irwell City Park and associated pedestrian/cycling routes; the provision of local amenities for the community; and improved permeability through the site providing improved access to the Cornbrook Metrolink station;

1.10 The land located in Trafford, is bounded by the Bridgewater Canal and the viaduct and divided into two sections by Cornbrook Road. The northern part is 1.10 hectares and is occupied by heavy industrial uses and the southern site is around 0.21 hectares and is vacant.

1.11 The regeneration of the Cornbrook Hub requires comprehensive large scale development and land assembly to transform the area, and deliver the step change required to ensure that it becomes a recognised new commercial, retail and leisure venue. The regeneration of the Cornbrook Hub will also enable the full redevelopment potential of the Pomona Island area to be achieved, by not only providing a gateway to Manchester City Centre, but also forming a new gateway onto the Pomona Island area. This would enable the delivery of a minimum of 1,100 new residential dwellings (Ref: Trafford Local Plan, Land Allocations-draft consultation January 2014) on the adjacent Pomona Island site, with the potential to increase this by a further 1,000 properties, which in turn will provide the impetus for the delivery of a real transformational scheme across the whole of the area.

1.12 The Executive in July 2015 considered a report in respect of the lands within Trafford forming part of the Cornbrook Hub neighbourhood seeking in principle the use of Town and Country Planning Act Compulsory Purchase powers to deliver the comprehensive regeneration of the lands. A similar report was also submitted by Manchester colleagues to their Executive in July 2015 in respect of the remaining lands which fall within Manchester.

1.13 The above report requested the executives to endorse the approach to the delivery of the Cornbrook Hub site as set out within the report. The approach adopted was that both authorities would make their own Compulsory Purchase Orders (CPO), which would be promoted in parallel through the confirmation process and managed by a project team made up of officers from both authorities with Manchester taking the lead role.

1.0 Change of strategic delivery approach

1.1 Under the Greater Manchester Devolution Agreements, the Combined Authority (CA) will be given powers to purchase land compulsorily. For the reasons explained below, it is now considered appropriate to utilise these new powers to promote a CPO.

1.2 Secondary legislation containing the devolution powers was laid before Parliament in November 2016 and will come into effect in December 2016.

1.3 Under the secondary legislation the power to make a CPO will rest with the CA until such time the elected Mayor takes office. After that time the CPO powers will be exercisable by the elected Mayor with the consent of the Combined Authority members for the areas affected by the proposed CPO

1.4 The CPO powers provided under the secondary legalisation include powers which correspond to those CPO powers available to the Homes and Communities Agency (HCA). Therefore it is considered that the relevant section in respect of the HCA compulsory purchase powers taken from the Government's updated CPO guidance should be taken into account in respect of a CPO by the CA using those powers.

1.5 The following is an extract from the new government guidance:

"The Homes and Communities Agency has compulsory purchase powers to acquire land and new rights over land under subsections (2) and (3) of section 9 of the Housing and Regeneration Act 2008. The agency can only exercise compulsory purchase powers with the authorisation of the Secretary of State. The Homes and Communities Agency can use its compulsory purchase powers to make a compulsory purchase order to facilitate the achievement of its objects set out in section 2 of the Housing and Regeneration Act 2008 (as amended). These are:

- to improve the supply and quality of housing in England
- to secure the regeneration or development of land or infrastructure in England
- to support in other ways the creation, regeneration or development of communities in England or their continued wellbeing
- and to contribute to the achievement of sustainable development and good design in England

with a view to meeting the needs of people living in England.

1.6 Having regard to the above, the advantages of using the proposed Mayoral/CA CPO powers in respect of the Cornbrook Hub over the initial approach endorsed by the Executive would be:

- The proposed new powers are wider than the planning CPO powers held by MCC and TC and are, in some respects, easier to use for the following reasons:

    - Government guidance suggests that they are more flexible, and may therefore allow a Framework "approach" to CPOs more easily than powers currently available (e.g. proceeding without the need for planning permission to be in place)

    - The powers are not subject to the "well-being" requirements that attach to a planning CPO (i.e. the requirement to demonstrate that the proposed development will contribute to the promotion of the economic, social or environmental well-being of the Council area).

    - The wider geographical jurisdiction of the Mayor/CA should allow a CPO to be promoted across the local authority boundary, without the need for separate CPOs to be made in each authority.

    - The CPO would cover the area of the approved Cornbrook Regeneration Framework in Manchester and Trafford, thereby ensuring the full delivery of the SRF objectives and ensuring the future sustainability of the area.

    - More cost efficient and in some cases speedier to deliver the outcome

1.7 However, as with any CPO, the acquiring authority must demonstrate a compelling case in the public interest for the use of the CPO power. This would include demonstrating that there are no impediments to the proposed development/regeneration taking place, including any physical or legal impediments such as planning issues or funding issues.

1.8 Therefore, in relying on the existing regeneration framework as a basis for the CPO, it is likely that some of the elements of work required to submit a planning application and secure planning permission would have to be undertaken in order to provide reassurance to the Inspector, in the event of a Public Inquiry, and to the Secretary of State that no impediments to the proposed development exist.

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1.9 Next Steps

1.10 The Executive is asked to approve the alternative delivery strategy set out in this report and the Recommendations above. If such approval is given, then it is proposed that authority is delegated to the Chief Executive in consultation with the Leader to work with Manchester City Council to prepare a report for consideration by the Combined Authority requesting the promotion of a CPO by the Combined Authority in respect of the Cornbrook Hub.

Indicative Timeline for CPO process

Reports to Councils Executive Seeking authority to submit report to Combined Authority (CA)	Trafford 19 December 2016 Manchester 14 December 2016
Report to GMCA requesting the utilisation of Combined Authority powers and delegation to Chief	January 2017

Executives and Lead members for Trafford and Manchester to promote the CPO	
CPO report prepared along with statement of reasons	March 2017
Submit Compulsory Purchase Order	Early April 2017
Objection period ends	Early June 2017
Relevant letter received to hold Public Inquiry	Late June 2017
Statement of Case submitted	Early January 2017
Estimated date for Public Inquiry	February 2018
Secretary of State's decision received	May 2018
Confirmation Notices	Late May 2018
6 weeks judicial period ends	Mid July 2018
General Vesting Declaration order sealed	August 2018
Lands vest in Combined Authority ownership	December 2018

1.11 CPO Indemnity Agreement

1.12 As with the previous CPO strategy being pursued using Town and Country Planning Act powers subject to Agreement, MSCD will underwrite the total cost of the CPO process. Under the agreed CPO Indemnity Agreement MSCD initially agree to indemnify both Manchester City Council and Trafford Council for internal officer time commitments, and any external consultant time, incurred through the CPO process. They will also provide an indemnity for all compensation liabilities associated with the CPO. Subject to Executive approval of the recommendations in this report, an indemnity would also need to be provided by MSCD in respect of any costs incurred, and compensation payable, by the Combined Authority in promoting and making the CPO.

1.13 The CPO Indemnity Agreement envisages that a project team, comprising representatives from MSCD, Manchester City Council and Trafford Council will be established that will meet regularly to oversee the making and confirmation of any CPO. Given that the project team has been meeting to discuss the early stages of the CPO and Manchester City Council has been taking the lead role, it is proposed that the Combined Authority appoints Manchester City Council to act on its behalf, in consultation with Trafford Council, to take all steps necessary to prepare the case for making the CPO; to prepare a report to the CA setting out the justification for the CPO and seeking authority to make the Order, and; thereafter to take all necessary steps to secure the confirmation of the Order in compliance with applicable legislation and guidance.

1.14 The Indemnity Agreement also envisages that an account will be held by MSCD's solicitors into which MSCD will pay in advance a sum equivalent to both Councils' and, where appropriate, the CA's best estimates of the likely costs involved in each stage of the CPO process. The Authorities will then be able to draw funds down from this account to fund their internal and external costs incurred through the CPO process. The CA will not be obliged to exercise its CPO powers to acquire any remaining third party interests unless and until MSCD has paid into

the account a sum equivalent to the total outstanding CPO liabilities of the CA and/or Councils, as agreed between the Councils and MSCD.

1.15 Finally, the agreement includes a commitment from MSCD to proceed with the development once commenced, subject to market conditions and demands and in consultation with Trafford and Manchester Council's.

1.16 Progress to Date

1.17 Since July 2015 significant progress has been made through the negotiations in assembling the land required for the proposed development, all the former lease holders, holding over have now vacated, the formal closure of Westminster Street has been obtained, terms agreed with Clear Channel and the demolition of vacant properties and subsequent hoarding off of the sites has been completed.

1.18 Extensive negotiations have been held with, Hutchinson 3G UK limited Bennett recycling, Mancunian Springs and their appointed surveyors including extensive accompanied visits in respect of potential relocation sites across the region, these are ongoing and will continue as long as necessary

1.19 An application for the erection of an 11 storey building of 86 apartments and a 10 storey building of 78 apartments with ground floor link, provision of car parking, access from Hulme Hall Road, new landscaping and refurbishment of footpath alongside Manchester Ship Canal/River Irwell was approved by Trafford Council under ref 85822/FUL/15. Alongside the above application, planning approval for the creation of an access road and new car parking beneath existing arches to provide 71 parking spaces for new residential development of 164 apartments at Pomona Wharf was approved by Manchester City Council under application ref 9034/FO/2015/C14 on the 10 August 2015.

1.20 Proposed Indicative Redevelopment timetable

1.21 MSCD have worked with both local authorities to prepare a delivery strategy for the Cornbrook Hub site, which has been derived from the key principles set out in the Cornbrook Hub Regeneration Framework. A copy of the illustrative delivery plan for the Cornbrook Hub site is attached is at Appendix 1

1.22 It is proposed to utilise the approved and adopted Cornbrook Hub Regeneration Framework, plus additional supporting planning studies, to support the CPO process in order to ensure and demonstrate that there are no planning or other impediments in respect of the proposals for the Cornbrook Hub scheme as advised by counsel in order to promote a successful CPO. The existing approved and adopted Cornbrook Hub Regeneration Framework document, provides an agreed framework for the scale, mass and type of new development.

1.23 The draft delivery programme includes:-

Phase 1a (being the part of the Cornbrook Hub site falling within Manchester): Creation of a new hotel destination: Start on site proposed late 2019.

Phase 1b (being the part of the Cornbrook Hub site falling within Trafford): Site remediation and decontamination in readiness for a new commercial business hub: Works could commence late 2019

Phase 2: Development of the 1st residential apartments at Pomona Island: Commenced onsite April 2016 – completion expected September 2017

Phase 3 / 4: Delivery of future residential and commercial phases at Pomona Island will be over a period of 5 - 10 years following completion of the CPO process/securing vacant possession of the Cornbrook site

The above draft timescales assume that land assembly can be completed by the end of 2018.

1.24 Conclusion

1.25 The proposed change of strategic delivery will ensure that the full objectives of the Cornbrook Hub SRF adopted by Trafford and Manchester councils will be delivered holistically and in a controlled, phased approach in order to create a new commercial destination which supports significant employment and business opportunities.

1.26 Other Options

1.27 The Council could choose to continue to pursue a CPO alone or in conjunction with MCC, but not through the new GMCA powers. However there would be more risks associated with such an approach in terms of achieving a successful outcome. This could potentially delay development of the area significantly.

1.28 Consultation

1.29 Extensive consultation has taken place regarding the Cornbrook scheme and MSCD have commenced discussions with a large majority of the owners of the properties within the scheme footprint. However, given the number of interests required to assemble the site for redevelopment and improvement, acquisition by agreement is not a pre-determined prospect and the use of Compulsory Purchase powers may be necessary to ensure that the land will be acquired which will enable the full objectives, outputs and vision of this transformational scheme to be achieved.

1.30 Reasons for Recommendation

1.31 To enable the proposed new CPO powers of the GMCA to be used, if required, to bring forward the regeneration of a strategic site across Trafford and Manchester supporting housing and economic growth.

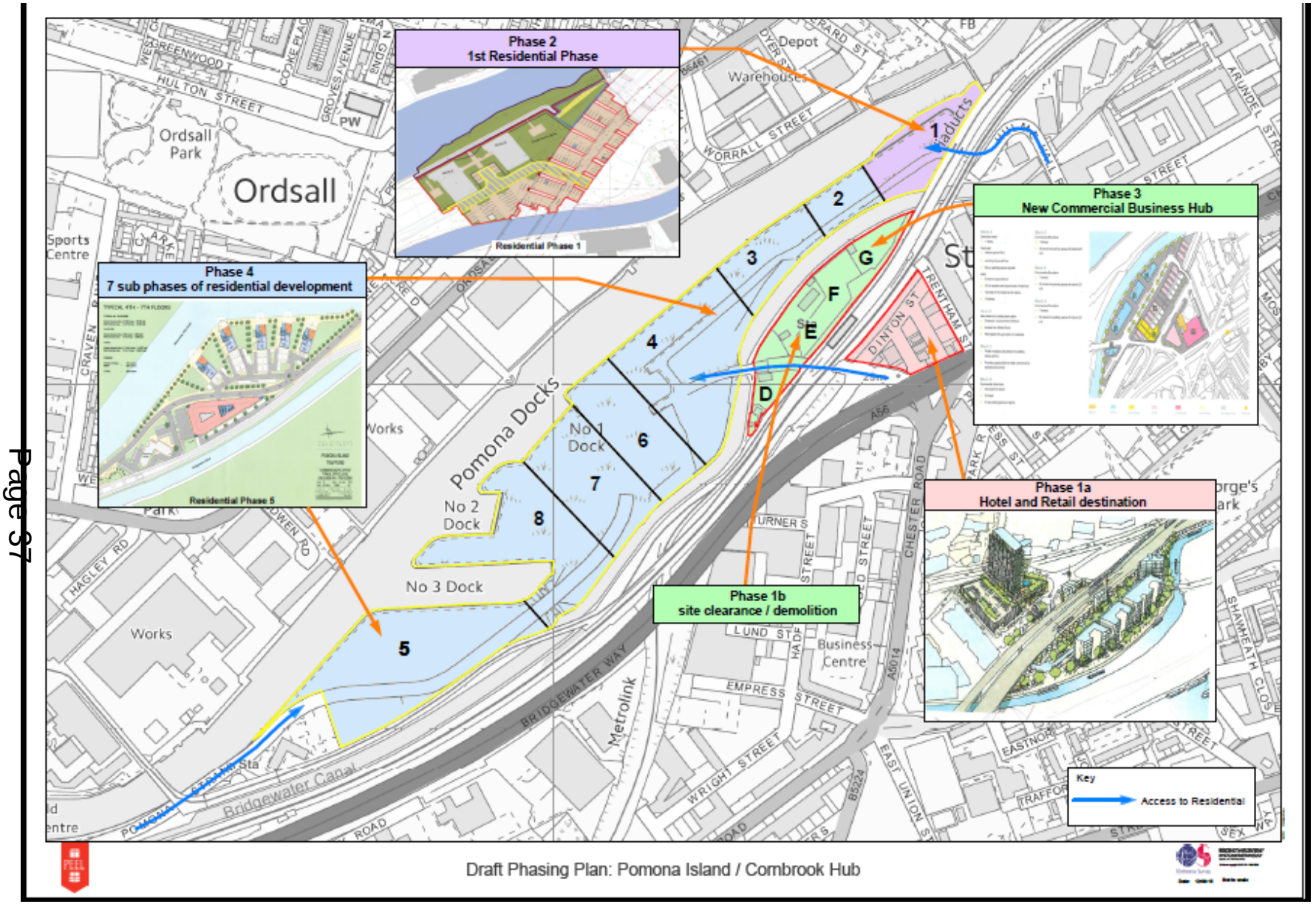
Key Decision): Yes
If Key Decision, has 28-day notice been given? Yes

Finance Officer Clearance *(type in initials)…….PC ……*
Legal Officer Clearance *(type in initials)…….mrj……*

Helen Jones

[CORPORATE] DIRECTOR'S SIGNATURE *(electronic)*
To confirm that the Financial and Legal Implications have been considered and the Executive Member has cleared the report.

Appendix 1
Illustrative Delivery Plan for the Cornbrook Hub Site



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TRAFFORD COUNCIL

Report to:	**Executive**
Date:	**19th December 2016**
Report for:	**Decision**
Report of:	**Executive Member for for Adult Social Services and Community Wellbeing**

Report Title

Substance Misuse Services

Summary

Executive to support the proposal which looks to provide a jointly commissioned Integrated Substance Misuse and Treatment Service.

The report provides an update on plans to implement a lead provider model with Bolton Council and Salford City Council.

Recommendation(s)

The Executive is asked to:

1) Agree the term of the new contract;
2) Approve the governance arrangements as detailed within the MOU;
3) Consider the Needs Assessment and draft Service Specification;
4) Agree to extend the current substance misuse contracts to align with commissioning partners;
5) Support the direction of travel for collaborative commissioning.

Contact person for access to background papers and further information:

Name: Deborah Gent
Extension: 4776

Background Papers: None

Implications:

Relationship to Policy Framework/Corporate Priorities	The provision of high quality and effective drug and alcohol services will contribute to the Health and Wellbeing Strategy
Financial	The intention is to offer the new contract for a period of 3 +1 +1 years from 1st October 2017
Legal Implications:	Trafford Council will extend contracts with the current service providers until 30th September 2017
Equality/Diversity Implications	An EIA Screening Form has been completed which confirms no major impacts identified and therefore no major changes required.
Sustainability Implications	None
Resource Implications e.g. Staffing / ICT / Assets	None
Risk Management Implications	Destabilisation of the substance misuse provider market
Health & Wellbeing Implications	The procurement process will aim to maintain and where necessary improve service quality and performance
Health and Safety Implications	None

Contents

1.Synopsis

1.1 This report provides an update to the Executive on the agreed procurement strategy for the joint commissioning of Trafford's substance misuse service with Bolton and Salford. The new service will provide support, delivered by a lead provider, to people with drug and alcohol problems in community settings. It will play a key role in promoting recovery and reducing the harm caused by alcohol and drug misuse, which are a significant cause of health inequalities in Trafford

1.2 On 16th August 2016, Jill Colbert, Interim Corporate Director, Children, Families and Well-being, agreed the substance misuse services could be recommissioned in conjunction with Bolton and Salford Councils, as part of a joint procurement model. Salford Council will take the procurement lead.

1.3 The commissioners have developed a service specification, a needs assessment and a Memorandum Of Understanding to implement this collaborative approach to service delivery. They have also completed a formal consultation process.

2. Background

2.1 Trafford Council became responsible for commissioning substance misuse treatment services when responsibilities for Public Health functions were transferred to the Council in April 2013.

2.2 Substance misuse is a cause of considerable harm to the health and wellbeing of Trafford residents. Trafford has a lower prevalence of drug and alcohol misuse than many other parts of the country but substance misuse remains a cause of considerable harm to the health and wellbeing of local residents and is an important cause of major health inequalities.

2.3 Trafford Council currently commissions a range of treatment and recovery services (detailed in appendix 1).

2.4 The current position

- The existing drug and alcohol service model is provided across four main contracts with three separate providers who work in partnership to deliver drug and alcohol services in Trafford. Local GP's and pharmacies are also contracted to deliver a range of substance misuse support services such as supervised consumption and needle exchange.

- Whilst there are no concerns regarding the quality of the service provided it is believed by commissioners that the number of people successfully completing treatment could be improved through the adoption of the Lead Provider Model.

- The current level of investment by Trafford is £2.3 million per year. It is estimated that savings of approximately £300k in the first year, will be secured for Trafford through the economies of scale gained from commissioning on a larger geographical footprint and also through having a single accountable lead provider model rather than several separate contracts.

- Commissioners from Bolton, Salford and Trafford have also extensively compared the

different elements of service provision that exist within their current individual treatment systems and discussed the service offers they would wish to specify for the future. The new specification will provide a more efficient service as it will be much more tightly defined than the existing specification, drawing on best practice from across the country (and wider)and will be outcomes focused.

2.5 The way forward

- Given the ongoing pressures on commissioning capacity across GM local authorities, it is proposed that Trafford collaboratively tenders Substance Misuse Services with Bolton and Salford. The Bolton, Salford and Trafford footprint is particularly logical given the authorities make up a joined up geographical area on the west of the conurbation.

- Moreover we already have a strong record of jointly commissioning and procuring services across GM and early work with Bolton and Salford has proved particularly fruitful in terms of sharing experience and knowledge of commissioning.

- It is proposed that Salford City Council act as the Lead Commissioner with necessary support from the Greater Manchester Procurement Hub. To this end, a procurement timeline has been produced. This timeline is necessarily tight in order to ensure that newly designed services are in place for October 2017 and in-year savings are made.

2.6 A competitive process will be initiated in December 2016, which will award a new contract from 1st October 2017.

3. Procurement Strategy

3.1 Both Trafford's legal team and STAR procurement have advised throughout the development of this proposal to ensure the process is undertaken within the appropriate legal frameworks.

4. Financial Implications

4.1 Trafford Council currently receives a ring-fenced Public Health grant from the Department of Health to fund the cost of its substance misuse services. As a consequence of Department of Health cuts to the grant allocations and projected further budget reductions the proposal is to make a reduction of £300,000 on the new contract.

4.2 It is suggested that £1,985,305 per year of the Public Health grant funding is committed to deliver this new three year contract that includes the option of an extension - subject to satisfactory performance - up to a further two years.

4.3 The joint procurement approach detailed in this report will help to deliver significant efficiencies through economies of scale. The total cost of the joint contract will be approximately £8m per year; Trafford will contribute almost £2m. This recommission contributes to approximately a 15% saving compared to 2016/17 in the cost of substance misuse services in Trafford.

4.4 The population in treatment to council spend ratio is detailed in the table below:

	Bolton	Salford	Trafford
Opiate	1271	797	384
Non-opiate	338	459	327
Alcohol	560	648	415
Total number of people in treatment	2169	1904	1126
% Number of People in Treatment	**42%**	**37%**	**22%**
Approximate spend	£3,000,000	£3,000,000	£2,000,000
% Spend	**38%**	**38%**	**25%**

5. Legal Implications

5.1 The procurement of the services will be undertaken in accordance with the EU Public Contract rules as well as in compliance with the Contract Procedure Rules of the council. The contract has a provision that gives each party the right to end the agreement early by giving proper notice.

5.2 The council will make all contract payments to Salford Council, in respect of the substance misuse service.

6. Risk Management

6.1 There are risks inherent in reducing the level of investment into substance misuse services and the level of savings required. These risks will be mitigated through the joint procurement strategy and the economies of scale gained through a reduction of fixed costs and overheads.

6.2 Work has been undertaken with a range of partners to inform the direction of travel and we are confident of our vision for improvement and delivering better outcomes for less through this new model.

6.3 The new provider will be expected to use every opportunity at their disposal to bring additional investment and capacity into substance misuse services using alternative sources of funding. A track record of securing investment and social value will be one of the criteria in the tendering process.

7. MOU

7.1 Procurement Colleagues at Salford Council have created a Memorandum of Understanding (MOU) for the joint commissioning of the Integrated Substance Misuse and Treatment Service (appendix 2). The Legal Team at Trafford have been consulted on this document and initiated a number of small amendments. This document delegates the decision to award the contract to Salford Council.

8. Needs Assessment

8.1 In support of the procurement process, New Economy (who work on behalf of the Greater Manchester Combined Authority and the Greater Manchester Local Enterprise Partnership have worked with Bolton, Salford and Trafford to develop the Needs Assessment (Appendix 3). This has informed the service offer in the contract specification.

9. Draft Service Specification

9.1 Representatives from the three local authorities have worked together to develop a draft Service Specification (Appendix 4).

9.2 The specification outlines our commissioning priorities, based on the needs assessment, stakeholder feedback, local and national policy and guidance, and evidence of what works.

10. Consultation

10.1 Work has been undertaken with current service users and a range of stakeholders, using the Working Together for Change (WTfC) model (an 8-step process to make sure that commissioners are taking into account the needs, wishes and aspirations of the people who need support and other stakeholders) to inform the direction of travel. Colleagues in Bolton and Salford, along with ourselves have held a series of consultation events with service recipients using this model to give the service user group a voice in the procurement process and during the development of the new specification.

10.2 Appendix 5 provides the feedback from the Trafford event:

11. Other Options Considered

1.1 Commissioners have considered the appropriate length of the contract. A shorter-term contract may deter many providers from 'pump-priming' or making other upfront investments in a new lead provider model, fearing their contract will not be renewed and they will not reap the benefits of investment. The 3+1+1 contract, presented here, allows for a longer term investment, it provides a 4-6 month lead in time and allows time to embed system change.

12. Reason for recommendations

12.1 Trafford requires a range of substance misuse services that meet the needs of residents in a flexible way. Alcohol and drug misuse causes significant harm to the health and wellbeing of individuals, families and communities. Levels of mortality and illness among people who are problem drug users are high.

12.2 The Executive is asked to:

1. Agree the term of the new contract. The proposal is to award a new contract for 3 years with an option to extend by 2 years, up to a maximum of 5 years.

   Extensions will be based on performance related quality measures and delivery of key outcomes. This is considered to be the option which will lead to the council obtaining best value for money and will provide a stable and supportive environment for service users.

2. Approve the governance arrangements detailed within the attached MOU;

3. Consider the Needs Assessment and draft Service Specification;

4. Agree to extend the current substance misuse contracts detailed in appendix 1, to align with commissioning partners; and

5. Support the direction of travel for collaborative commissioning.

Key Decision Yes

If Key Decision, has 28-day notice been given? Yes

Finance Officer Clearance *(type in initials)…HZ……*
Legal Officer Clearance *(type in initials)…MJ……*

CORPORATE DIRECTOR'S SIGNATURE *(electronic)*… 

To confirm that the Financial and Legal Implications have been considered and the Executive Member has cleared the report.

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Phoenix Futures Alcohol Recovery Navigation Service (Adults, 25+)

The Alcohol Recovery Navigation Service works with adults (over 25) and is the Single Point of Contact (SPOC) for the borough of Trafford. The service provides an integrated treatment pathway for anyone experiencing difficulties with alcohol. In order to navigate service users through the most appropriate and effective treatment pathway, Phoenix offer an initial appointment within one week of referral.

- Initial assessment and brief interventions.
- Confidential one-to-one structured and care-planned support.
- Capacity for evening appointments and home visits.
- Clinical assessment by the Detox Nurses.
- Optional group work.
- Referral to abstinence-focused 12 week programme and aftercare.
- Education, training, benefit, debt, and housing advice.
- A peer led support group.
- Complementary therapies and gym and swimming passes for all those participating in structured programmes.
- Self-referrals are welcome.

The Recovery and Abstinence service is for those who have become newly abstinent to access support among their peers.

GMW Community Detoxification Service (Adults, Alcohol, 25+)

The aim of this service is to ensure individuals who are experiencing problems with their alcohol use, undergo a detoxification with the intention of becoming abstinent. It deals with individuals who are assessed by clinical staff to determine their suitability for such treatment. They are then supported throughout this process and signposted to appropriate community agencies such as the Phoenix Futures Recovery and Abstinence service which will aim to sustain the gains made whilst in treatment among their peers.

There is also the option of inpatient detoxification which is done by the Smithfield Unit and takes 14-21 days. Individuals are assessed for this treatment by clinical

staff and this tends to be for those who are more dependent on alcohol than those undertaking Community detoxification, as outlined above. As funding is limited, all such applications need to be approved by the Commissioning and Service Development Manager.

Trafford AIM (Adults, 25+, Class A drug misuse)

Trafford AIM is a safe environment where you will be helped, encouraged and supported to deal with your substance misuse issues. It is for over 25s only.

Based in Old Trafford, this service is provided by Greater Manchester West.

This service is a clinician-led service, and, as such, they will help you to keep safe and support you with health difficulties from substance misuse. They deal primarily with users of heroin or crack cocaine (Class A), and offer both detoxifications from these substances, as well as substitute prescription to stabilise before you continue in your recovery.

This service has dedicated nurses for health checks and harm reduction advice, and offers clinics in Trafford. They also support a group for sufferers of Hepatitis C.

You can find Trafford Drug Services at:

454 Chester Road
Old Trafford
M16 9HD

Telephone 0161 877 0491

This is a short walk from Trafford Bar tram stop.

Phoenix Futures Community Recovery Service (Adults, 25+)

The Community Recovery Service is aimed at adults aged over 25 who would like to address a substance misuse issue, and live in Trafford.

The service offers a comprehensive programme consisting of:

- Workshops (life skills and relapse prevention).

- Peer support.
- Gym.
- Conservation Therapy Programme.
- IT skills.
- Smoking cessation sessions.
- Healthy lifestyle sessions.
- Access to employment/volunteering/education opportunities.
- Housing support.
- Budgeting support.

Community Recovery Service/ Recovery Abstinent Service
Bridgewater House
Bridgewater Street
Sale
M33 7EQ

Tel: 0161 905 8570

Fax: 0161 905 8579

Email: trafford.day@phoenix-futures.org.uk

Phoenix Futures Recovery Abstinence Service (Adults, 25+)

The Recovery Abstinence Service is for adults over the age of 25, living in Trafford (or that have a Trafford connection), who are abstinent from substances and require ongoing support. Our goal is to assist service users to maintain their abstinence and gain employment, training or education.

The service offers a comprehensive programme consisting of:

- Workshops (life skills and relapse prevention).
- Peer support.
- Gym.
- Conservation Therapy Programme.
- IT skills.
- Smoking cessation sessions.
- Healthy lifestyle sessions.
- Access to housing support.
- Budgeting support.

11-25 Service – Phoenix Futures Young People's Service (Young People, Alcohol and Drugs)

Phoenix Futures Young People's Service works throughout Trafford offering a specialist service for young people between the age of 11 and 25 with drug/alcohol misuse problems. The service provides a variety of interventions, including education, information, advice, support, structured treatment and acupuncture.

We provide:

- A care plan tailored to the needs of each individual.
- Advice and guidance on healthy living and sexual health.
- Holistic practical support to access other specialist agencies such as CAHMS, housing and healthcare.
- The help you needed to reduce substance use and to quit altogether.
- Group work and one-to-one support to tackle emotional difficulties likely to lead to risk-taking behaviour.
- School support around substance misuse issues, including awareness workshops.
- Evening and weekend appointments are available.

Eligibility criteria:

- Trafford residents between the ages of 11 and 25.
- Referrals are accepted from a wide range of services including self-referrals.

Phoenix Futures Young Persons Service
Bank House
177-179 Washway Road
Sale
M33 4AH

Tel: 0161 905 1013

Fax: 0161 973 4865

E-mail: traffordyps@phoenix-futures.org.uk

THIS MEMORANDUM OF AGREEMENT is made on

BETWEEN

(1) SALFORD CITY COUNCIL of the Civic Centre, Chorley Road, Swinton, Salford M27 5DA ("Lead Partner")

(2) THE BOROUGH COUNCIL OF BOLTON ("Bolton Council") of Town Hall. Bolton BL1 1RU

(3) TRAFFORD COUNCIL of Trafford Town Hall, Stretford M32 0TH

Collectively "the Parties"

BACKGROUND

This Memorandum of Agreement ("Memorandum") sets out the principles which shall govern the relationship between the Parties including their respective obligations and rights in respect of the Project.

IT IS AGREED as follows:

1. DEFINITIONS AND INTERPRETATION

In this Memorandum, unless the context otherwise requires, a reference to:

"**Confidential Information**" means any information which has been designated as confidential by any Party in writing or that ought to be considered as confidential (however it is conveyed or on whatever media it is stored) including information which relates to the business, affairs, properties, assets, trading practices, services, developments, trade secrets, intellectual property rights, know-how, personnel, customers and suppliers of any Party and all personal data and sensitive personal data within the meaning of the Data Protection Act 1998;

"Data Protection Legislation" means the Data Protection Act 1998 ("**DPA"**), the EU Data Protection Directive 95/46/EC, the Regulation of Investigatory Powers Act 2000, the Telecommunications (Lawful Business Practice) (Interception of Communications) Regulations 2000, the Electronic Communications Data Protection Directive 2002/58/EC, the Privacy and Electronic Communications (EC Directive) Regulations 2003 and all applicable laws and regulations relating to processing of personal data and privacy, including where applicable the guidance and codes of practice issued by the Information Commissioner

"**Memorandum**" means this document, including the Schedule which sets out the Project management and Party contributions hereto;

A "**Party**" means any party to this Memorandum individually and **"Parties"** refers to all of the parties to this Memorandum collectively. A Party shall include all permitted assigns of the Party in question;

"**Project**" means the procurement and management of a contract for Integrated Substance Misuse and Treatment Services on behalf of the Parties which this Memorandum is intended to deliver.

"Services Contract" means the contract to be entered into between the Lead Partner, Bolton Council, Trafford Council and the Provider on the terms attached to this Memorandum;

"Services Provider" means the provider appointed to deliver the Integrated Substance Misuse and Treatment Services under the Services Contract

"Services" means the integrated substance misuse and treatment services available to all people present in a local authority area and commissioned by a local authority pursuant to the Local Authorities (Public Health Functions) Regulations 2012, which Services will be delivered by the Services Provider in accordance with the Services Contract

"Staff" means employees, servants or agents

"Term" means three years from 1st October 2017 with the option to extend for two further periods of twelve months by agreement between the parties.

Comment [CH1]: Need to check if this is applicable for this service!

Comment [CH2]: Check the period of the contract!

2. PROJECT OUTLINE AND PRINCIPLES OF THE RELATIONSHIP

2.1 The Parties shall work together in delivering the Project and in particular shall perform their respective obligations under this Memorandum and the Services Contract.

2.2 The Lead Partner will:

a) Manage the procurement process of the Project in line with the Lead Partner's Contractual Standing Orders (CSOs), the Public Contracts Regulations 2015 (and any other relevant legislation) and best practice
b) Ensure delivery of the Project in accordance with this Memorandum and the Services Contract
c) Manage all financial, administrative and reporting aspects of the Project in accordance with this Memorandum and the Services Contract. This will include maintaining detailed project income and expenditure accounts and related documentation.
d) Manage the performance of the delivery of the Services by the Services Provider under the Services Contract through quarterly performance meetings and alert Bolton Council and Trafford Council to any problems identified as soon as reasonably possible.
e) Exercise all reasonable, care, attention and diligence in carrying out the Project in accordance with this Memorandum and the Services Contract
f) Procure the services of its Staff in carrying out the Project and ensure that deliverables relating to the Project are produced as may be agreed in writing by the Parties.
g) Ensure that each member of its Staff doing work on its behalf under this Memorandum:
   - is sufficiently qualified, trained, skilled and experienced in the type of work which he is to perform, exercises all due skill, care, attention and diligence in his work; and

- shall, promptly disclose to Bolton Council and Trafford Council all results and new intellectual property rights developed in the Project, and in any event by no later than the termination of this Memorandum (however effected)

h) Ensure that it has appropriate financial and auditing procedures in place to manage its commitments under this Memorandum and ensure that it has complied with all relevant tax implications and evidence this to Bolton Council and Trafford Council if reasonably required or requested
i) Keep project records (including but not limited to financial records, award letters, and management reports) for twelve (12) years after the Term ends.
j) Subject to clause 2.5 below, enforce the provisions of the Services Contract relating to the part of the Services being or to be delivered to the Lead Partner and be responsible for its own associated cost.

2.3 Bolton Council and Trafford Council will:

a) Provide any relevant data, information, technical specifications or other assistance reasonably required by the Lead Partner or other Party to the Project through its named representative subject always to Data Protection Legislation
b) Keep project records for twelve (12) years after the Term ends
c) Subject to the Lead Partner's role in the management of the Services Contract, manage the performance of the delivery of the Services by the Services Provider under the Services Contract through quarterly performance meetings and alert the Lead Partner to any problems identified.
d) Subject to clause 2.5 below, enforce the provisions of the Services Contract relating to the part of the Services being or to be delivered to Bolton Council and Trafford Council and be responsible for its own associated cost.

2.4 Together the parties will establish a Joint Commissioning Oversight Group (JCOG) to consider, discuss and review any service and service delivery contractual issues which may impact on any Party or Parties. The JCOG will meet on at least a quarterly basis or more frequently as agreed by the Parties. Any issues which cannot be resolved will be dealt with in accordance with clause 12.

2.5 The JCOG will consider and agree the admission of any additional Party to this agreement and any Service Contract.

2.6 In the event that one or any of the Parties is dissatisfied with the Services being or to be delivered by the Services Provider under the Services Contract, any proposed action discussed by the Parties against the Services Provider must be agreed by the JCOG including whether the Lead Partner shall take the lead in any enforcement action against the Services Provider.

2.7 Together the Parties will conduct a joint annual review with the Service Provider under the terms of the Services Contract, seeking continuous improvement and any options for potential savings.

2.8 Each Party warrants and agrees that in providing any services or in fulfilling any obligation or dealing with and administering funds under this Memorandum it will ensure it is fully compliant with EU and public sector procurement regulations and incorporate best practice principles.

3. DURATION

3.1 This Memorandum shall be effective from the date of its execution and shall continue until completion of the Project ("the Term") subject to earlier termination in accordance with clause 14 or extension by the Parties.

4. RESOURCES

4.1 The Parties shall provide such resources to enable them to comply with their respective obligations as they agree to so provide.

5. FURTHER ASSURANCE

5.1 The Parties shall promptly execute and deliver all such documents and do all such things as may, from time to time, be reasonably required for the purpose of giving full effect to the provisions of this Memorandum.

6. VARIATION AND WAIVER

6.1 No variation of this Memorandum shall be valid unless it is in writing and signed by or on behalf of each of the Parties.

6.2 No delay by a Party in exercising any provision of this Memorandum constitutes a waiver of such provision or shall prevent any future exercise in whole or in part.

7. SUCCESSORS AND ASSIGNS

7.1 The agreements reached between the Parties pursuant to this Memorandum shall continue for the benefit of their respective successors and assigns.

7.2 A Party cannot assign, sub-contract or in any other way dispose of this Memorandum or any part of it to any person, firm or company without the prior written consent of the other Party.

7.3 Any assignment or transfer or subcontract shall not relieve the Parties of any of their obligations or duties under this Memorandum.

8. NOTICES

8.1 Any notice or other communication required to be given under this Memorandum, shall be in writing and shall be delivered personally, or sent by pre-paid first-class post or recorded delivery or by commercial courier, to each Party required to receive the notice or communication as set out below:

SALFORD CITY COUNCIL: Director of Public Health

THE BOROUGH COUNCIL OF BOLTON: Director of Public Health

TRAFFORD COUNCIL: Director of Public Health

or as otherwise specified by the relevant Party by notice in writing to each other Party.

8.2 Any notice or other communication shall be deemed to have been duly received:

8.2.1 if delivered personally, when left at the address and for the attention of the contact referred to in clause 8.1; or

8.2.2 if sent by pre-paid first-class post or recorded delivery, at 11.00 am on the second business day after posting; or

8.2.3 if delivered by commercial courier, on the date and at the time that the courier's delivery receipt is signed.

8.3 A notice or other communication required to be given under this Memorandum shall not be validly given if sent by e-mail.

8.4 The provisions of this clause shall not apply to the service of any proceedings or other documents in any legal action.

9. CONFIDENTIALITY

9.1 Each Party acknowledges that pursuant to this Memorandum they will each disclose Confidential Information to the other Party. In consideration of the provision of such Confidential Information, each Party undertakes to the other Party:

9.1.1 to keep secret and confidential all Confidential Information disclosed to it, (including its employees, servants, agents or advisers) by or on behalf of the other in relation to the agreement or the business of the other Party which is of a confidential nature and not to use such Confidential Information for any purpose other than for the purposes of this Memorandum; and

9.1.2 not to disclose to any third party (other than its professional advisers or as required by law or any competent regulatory authority) any such Confidential Information other than that which comes into the public domain other than by breach of the undertakings contained in this clause 9.

9.2 These confidentiality undertakings shall subsist indefinitely so far as permissible by law.

9.3 The obligations of confidentiality set out in this clause 9 shall not apply to information already known to any Party (other than through a breach of a confidentiality undertaking), or derived independently of that received under or in connection with this Memorandum by any Party, information in the public domain or information required to be disclosed by law.

10. INFORMATION

10.1 Each Party acknowledges that the other Party is subject to the requirements of the Freedom of Information Act 2000 (”FOIA”) and the Environmental Information Regulations 2004 (“EIR”) and shall assist and co-operate with each other Party as necessary to comply with these requirements.

10.2 In responding to a request for information, including information in connection with the Project, each Party will use reasonable endeavours to consult with the other Party. Notwithstanding

this each Party acknowledges that the other Party may disclose information without consultation, or following consultation having taken their views into account.

10.3 Each Party shall ensure that all information produced in the course of the Project or relating to this Memorandum is retained for disclosure and shall provide all necessary assistance as reasonably requested to enable any other Party to respond to a request for information within the time for compliance and shall permit the other Party to inspect copies of such records as requested from time to time.

10.4 Each Party acknowledges that any statutory and other constraints on the exchange of information will be fully respected, including the requirements of the Data Protection Act 1998 and the Human Rights Act 1998.

11. LIMITATION OF LIABILITY

11.1 Each Party will be released from their respective obligations under this Memorandum in the event of any cause beyond the reasonable control of the Parties which renders the performance of this Memorandum impossible, including but not limited to, national emergency, war, prohibitive government regulation, industrial action, terrorism, the act or omission of any third party not being its agent or sub-contractor, any change in the law or in the interpretation of the law by the courts. Delay of less than six months shall not constitute such an event.

11.2 No Party excludes or limits liability to the other Party for death or personal injury caused by its negligence or that of its employees, servants or agents.

11.3 Subject to clause 11.2 no Party will be liable to any other Party for:

a) any indirect, special or consequential loss or damage; or

b) any loss of profits, turnover, business opportunities or damage to reputation or goodwill (whether direct or indirect).

11.4 If either Party incurs a loss arising out of or in connection with the Project and/or this Memorandum and/or the Services Contract as a consequence of any act or omission of the other Party which constitutes negligence, fraud or a breach of contract in relation to this Memorandum or the Services Contract then that Party shall be liable to the other Party for that loss and shall indemnify the other Party accordingly.

11.5 Clause 11.4 shall only apply to the extent that the acts or omissions of one Party contributed to the relevant loss. Furthermore, it shall not apply if such act or omission occurred as a consequence of that Party acting in accordance with the instructions or requests of the other Party.

11.6 If any third party makes a claim or intimates an intention to make a claim against any of the Parties which may reasonably be considered as likely to give rise to liability under this Memorandum the Party that may claim against the other Party will:

1.1.1 as soon as reasonably practicable give written notice of that matter to the other Party specifying in reasonable detail the nature of the relevant claim;

1.1.2 not make any admission of liability, agreement or compromise in relation to the relevant claim without the prior written consent of the other Party (such consent not to be unreasonably conditioned, withheld or delayed);

1.1.3 give the other Party and their professional advisers reasonable access to its premises and personnel and to any relevant assets, accounts, documents and records within its power or control so as to enable the other Party and their professional advisers to examine such premises, assets, accounts, documents and records and to take copies at their own expense for the purpose of assessing the merits of, and if necessary defending, the relevant claim.

1.2 Each Party shall ensure that they maintain policies of insurance in respect of all potential liabilities arising from this Memorandum.

1.3 Each Party shall at all times take all reasonable steps to minimise and mitigate any loss for which one party is entitled to bring a claim against the other pursuant to this Memorandum.

12. RECONCILIATION OF DISAGREEMENT

12.1 Any disagreements between the Parties will normally be resolved amicably at working level. In the event of failure to reach consensus between the Parties then such failure shall be handled in the following manner:

12.1.1 the dispute shall be referred to the Parties' Directors of Public Health for resolution at a meeting to be arranged as soon as practicable after the failure to reach consensus arises, but in any event within ten business days.

12.1.2 If the dispute is not resolved at that meeting, the Parties will attempt to settle it by mediation in accordance with the Centre for Effective Dispute Resolution (**"CEDR"**) Model Mediation Procedure. Unless otherwise agreed between the Parties, the mediator shall be nominated by CEDR and the Parties shall meet the costs of any such mediation in equal shares.

13. TERMINATION

13.1 Any Party may terminate its participation in the Project or this Memorandum by a minimum of six (6) months prior notice in writing to the other Party.

13.2 On termination of this Memorandum in accordance with this clause 13, each Party shall return the pre-existing information or materials to the Party that provided the information.

13.3 In the event of termination where liabilities on the Project are still outstanding, those liabilities will survive the termination of this Memorandum and will be discharged by the Parties in proportion to their respective liabilities under this Memorandum or under the Services Contract as determined by the JCOG or, in the event of dispute, in accordance with clause 12 above.

13.4 Should either party look to terminate the Services Contract, resolution will be sought initially through the JCOG to enable continued service delivery. Should resolution of any issues which may lead to termination not be possible the parties will agree a suitable exit plan.

14. ANNOUNCEMENTS

14.1 The Parties shall not make, or permit any person to make, any public announcement concerning the Project (whether before, at or after completion) except as required by law or with the prior written consent of the other Party.

15. CONTRACTS (RIGHTS OF THIRD PARTIES) ACT 1999

15.1 The Parties do not intend that any term of this Memorandum shall be enforceable by virtue of the Contracts (Rights of Third Parties) Act 1999 by any person that is not a party to it.

16. GOVERNING LAW

16.1 This Memorandum and all disputes or claims arising out of or in connection with the activities of the Parties in delivering the Project shall be governed by and construed in accordance with the laws of England.

17. PARTNERSHIP

17.1 Nothing in this Memorandum shall be construed as creating a partnership, a contract of employment or a relationship of principal and agent between any of the Parties to this Memorandum.

18. PRECEDENT

18.1 This Memorandum in no way creates a precedent for any further contracts between the Parties to this Memorandum.

19. WHOLE AGREEMENT & STATUS

19.1 This Memorandum contains the whole agreement between the Parties and supersedes all previous communications, representations, or arrangements whether written or oral.

19.2 Nothing in this Memorandum will prejudice, conflict with or affect the exercise by any Party of any of its statutory functions, duties, powers, rights, responsibilities and obligations arising or imposed under any legislative provision, enactment, byelaw or regulation whatsoever, nor will it fetter the exercise of any discretion. Nothing in this Memorandum will operate as a statutory approval, consent, licence or waiver by any Party.

20. SEVERABILITY AND SURVIVAL

20.1 If any part of this Memorandum is found by a court, tribunal or other competent body having jurisdiction to be invalid, unlawful or unenforceable, then that part will be severed from the remainder of this Memorandum, the remaining provisions of which will continue to be valid and enforceable to the fullest extent permitted by law. The Parties will negotiate in good faith to amend such provision so that it is valid, lawful and enforceable.

20.2 The provisions of clauses 6.2 (Waiver), 7 (Assignment), 9 (Confidentiality), 10 (IPR), 12 (Liability), 13 (Reconciliation), 14 (Termination), 16 (Third Parties), 20 (Whole Agreement) and 21 (Severability & Survival) shall survive termination of this Memorandum.

Each Party hereby confirms its agreement to the terms contained in this Memorandum.

The COMMON SEAL OF SALFORD CITY COUNCIL
was hereunto affixed in the presence of:

……
Authorised Signatory

……
Title

……
Date

EXECUTED AS A DEED by THE BOROUGH COUNCIL OF BOLTON
affixing its Common Seal in
the presence of:

……
Authorised Signatory

……
Title

……
Date

EXECUTED AS A DEED by TRAFFORD COUNCIL
affixing its Common Seal in
the presence of:

……
Authorised Signatory

……
Title

……
Date

The Schedule

Project Management and Party Contributions

1. The estimated annual value of the Services being procured by the Lead Partner on behalf of the Parties are as follows;

Salford City Council	£[ ]
The Borough Council Of Bolton	£[ ]
Trafford Council	£[ ]

2. The Parties shall enter into the Services Contract with the Services Provider and shall manage that contract in accordance with its terms and conditions to ensure that the Services are delivered by the Services Provider in accordance with each Party's respective service specifications.

3. Each Party shall be responsible for payment of any invoices submitted by the Services Provider and shall ensure that such invoices itemise the services provided to each of the Parties during the relevant invoiced period.

Substance Misuse Needs Assessment: Bolton Salford Trafford

Version: Full Draft for Critical Read

Date: 27/10/2016

Version	8
Author	Chloe Nelson
Creation date	27/10/2016
Data source (e.g. database)	Various – see referencing throughout the document
Parameters (e.g. timeframes)	April 2013 – March 2016 (in the main)
Key customer	Cluster Needs Assessment Steering Group

Company Confidential	Information which is restricted to specified MGC employees or that is disseminated to other parties as authorised by the Information Owner. Unauthorised access could cause an important financial and/or reputational loss to MGC; provide a significant competitor gain or a drop in customer confidence.	Internal post - clearly marked Company Confidential and addressed to specific recipient Externally – Include MGC return address on envelopes. Under 50 pages use a signatory delivery service, over 50 pages use approved courier service Fax should not be used. In person – 5 or fewer pages in a sealed envelope. 5 or more pages should be transported in a locked bag. Email - classification within the subject title	• Paper format - stored in a lockable filing cabinet in secure offices with no public access. Keys to filing cabinets must be stored in a Key Safe. • Not left unattended (e.g. table, desk or printer) as per MGC Clear Desk & Clear Screen Policy. • On systems – protected by login ID/password, and appropriate access restrictions. • Should not be saved directly to desktops, laptops or tablets where this can be avoided. Where this is unavoidable the information should only be stored on a company authorised and encrypted device and should be removed as soon as possible. • Critical data must be stored on a secure server that is frequently backed up. • USB devices - only held on encrypted devices. • Premises - must have appropriately controlled access (e.g. restricted access via code locks/reception desks)	Secure confidential waste bins or cross shredder.

Contents

Technical Notes

1.1 A number of technical notes apply to this needs assessment.

1.2 Where data is provided in this main report only for the Bolton, Salford and Trafford cluster, a breakdown is available by each area within the appendices.

1.3 Some data, when combined for the three areas, is not necessarily directly comparable. Where this is the case, this is stated in the footnotes (as well as reasons why).

1.4 Where presenting data relating to current treatment services, any numbers under 5 have been redacted.

1.5 Percentages vary. For example, some are calculated based on total numbers in treatment, and some on new presentations to treatment. Footnotes identify variations.

1.6 This report utilises the best available sources and amalgamates data to attempt to provide a comprehensive, but non-exhaustive, picture of need.

1.7 Data is benchmarked against GM and/or England, where provided. However, it is acknowledged that benchmarking against statistical neighbours is also useful. This report does not cover statistical neighbours due to the combination of three areas.

1.8 Readers should refer to footnotes for specific technical notes.

Glossary

BBVs	Blood Borne Viruses
BME	Black & Minority Ethnic
BST	Bolton, Salford & Trafford
CRC	Community Rehabilitation Company
CSEW	Crime Survey for England and Wales
DWP	Department for Work and Pensions
ESA	Employment Support Allowance
ETE	Education, Training & Employment
GM	Greater Manchester
GMCA	Greater Manchester Combined Authority
GMP	Greater Manchester Police
HIV	Human Immunodeficiency Virus
IB/SDA	Incapacity Benefit / Severe Disablement Allowance
ICO	Intensive Community Order
LAPE	Local Alcohol Profiles for England
LGBT	Lesbian, Gay, Bisexual & Transgender
MoJ	Ministry of Justice
MSM	Men who have Sex with Men
NDTMS	National Drug Treatment Monitoring System
NPS	New Psychoactive Substances OR National Probation Service[1]
OASys	Offender Assessment System
OCU	Opiate and Crack Use
PHE	Public Health England
PSR	Public Service Reform
UNODC	UN Office for Drugs and Crime

[1] Depending on context. See footnotes

Key Context: Introduction

a) The nature of substance misuse is complex, and it is changing. This expresses itself in various ways. We know that:

- increasing numbers of people are damaging their health through excessive drinking, and there has been an associated rise in the prevalence of alcohol-related conditions. Meanwhile, a move away from drinking in a public setting to drinking at home means that many individuals and families manage their problems without service support;
- new types of drug users are emerging; they are younger, likely to be poly-drug users, more diverse, more likely to buy drugs online and more willing to try unknown substances;
- specific behaviours and issues are arising – for example, the increase in prescription/over-the-counter drug misuse, and a surge in the use of new psychoactive substances in particular – are common and recognised challenges, and yet our system response is yet to fully evolve and respond; and
- there continues to be a presence of an ageing cohort of users, mostly OCU, who have been in treatment for a long time. These users are costly, complex and are likely to continue in treatment for some time.

Key Context: Progress to Date

b) In autumn 2015, New Economy and the Public Service Reform (PSR) team supported work between the 10 substance misuse commissioner leads in GM to facilitate the production of the report 'The Case for Change – Substance Misuse in Greater Manchester'.

c) The case for change document:

- traces through some of the key changes in patterns of substance misuse, reflecting on the latest developments and how the service offer in GM has evolved and responded;
- draws together our clearest GM evidence base on how substance misuse interconnects with other issues – from mental health and domestic abuse, to worklessness / productivity and child safeguarding challenges; and
- sets a level of ambition for future collaboration, by re-stating the case for working together on a set of common commissioning standards, and priming a practical discussion on how we can do more to collectively commissioning at the appropriate spatial level.


Appendix 1 Case for Change.docx

d) This paper was produced on behalf of the AGMA Wider Leadership Team to engage commissioning leads for substance misuse services in each of the ten GM authorities on future collaboration opportunities.

e) Since November 2015, the GM commissioners have been working collaboratively through a series of workshops. This work will develop a common set of standards for service provision in GM (across a range of topics, themes and priorities), and identify options for collaboration at a GM and cluster level. An early output from this work is the following shared vision for GM substance misuse commissioning:

GM Partners will work collaboratively to ensure that local systems of substance misuse intervention and treatment are commissioned and provided in accordance with common principles and standards, so that individuals and families affected by all forms of substance misuse, including alcohol, are supported to achieve recovery and live independently.

We will achieve more for less by:

- *Recognising that substance use is diverse and complex, and collectively responding to changing patterns of substance use and behaviour to provide the most effective route to recovery from all types of substance misuse.*
- *Rooting our approach in prevention and early intervention, anticipating future cost and escalating demand on services, and ensuring responses are appropriate to levels of need and health risk.*
- *Basing our approach to treatment and harm reduction on a growing evidence base, and a shared understanding of challenges, opportunities and changing circumstances - ensuring that we share learning, expertise and resources.*
- *Using asset-based approaches to enable long-term and sustained recovery from all types of substance misuse.*
- *Adopting a whole-person approach to working with complex families and individuals, and integrating provision with wider delivery models tackling Complex Dependency.*

f) The local authorities of Bolton, Salford and Trafford are working to action the vision statement and commitments made in the workshops by engaging in a joint commissioning exercise for their substance misuse treatment systems. It will act as a pilot in action for the collaborative work, and the service hopes to implement some of the 'common standards' developed through this process.

g) New Economy has worked with Bolton, Salford and Trafford to co-produce this needs assessment, which should inform the development of future Substance Misuse Services in the three areas.

h) This needs assessment is structured differently to many traditional substance misuse needs assessments. It is designed to reflect need based on key data and information sources. Where possible, breakdowns for the three areas are provided.

i) Data and information on need is mostly contained within chapters 3, 4 and 5. It is important to note that the information contained within these chapters should not be considered mutually exclusive. Many of the same topics and themes are discussed in these chapters, and are strongly correlated. Data that appears in different chapters, particularly when covering similar themes, should not be considered in isolation.

j) The structure provides a simple way of understanding and comparing need seen in the general population to the needs of current and previous service users in the treatment population.

1 Demographics Overview

1.1

2 Policy Context

2.1 POLICIES

2.2 Every £1 invested in drug treatment services saves £2.50 in costs to society (NTA, 2013). When modelled for Bolton, Salford and Trafford collectively, the figure is £3.32 for every £1 invested (NDTMS, 2015)[2]. However, this is only for costs and savings associated with OCU.

2.3 The number of alcohol-related hospital admissions in England is about one million per year and has been steadily rising (PHE, 2014a). Modelled for GM, this is a total cost of £167m per year (Alcohol Concern, 2014).[3]

2.4 As highlighted in the GMCA Alcohol Strategy, the combination of crime, health, worklessness and social care costs to Greater Manchester arising from alcohol are estimated at £1.2billion per year – around £436 per resident. Considering the combined costs arising in respect of Bolton, Salford and Trafford residents, the estimated cost of alcohol is calculated at around £300,000 per year, and £409 per person. The NHS and social care cost estimates for Salford are the highest of any of the GM districts, and the overall cost of alcohol per resident in Salford is second only to Manchester. Table 2.1 shows the differences across cluster area. Fuller details are supplied in the appendix to this report. (PHE, 2014)

Table 2.1: Cost of Alcohol Harm, Per Head of Population (2014 prices)

Area	NHS	Crime	Workplace	Social Services	Total*
Bolton	£77	£132	£152	£31	**£386**
Salford	£106	£140	£173	£46	**£459**
Trafford	£82	£89	£191	£25	**£384**
Cluster	£88	£121	£170	£34	**£409**
Greater Manchester	£89	£142	£175	£36	**£436**

*Total is slightly less than the sum of constituent theme costs, given a small element of double counting across categories.

2.5 The use of 'traditional' drugs, including opiates and crack, is declining. A new group of drug users is emerging; they are younger, likely to be poly-drug users, more diverse, more likely to buy drugs online and more willing to try unknown substances. The use of cocaine, ecstasy, LSD and ketamine is increasing, alongside New Psychoactive Substances (NPS) (Home Office, 2014). Significantly, these users are much less

[2] Figure is correct for June 2013 (the most up to date).
[3] Comprised of A&E attendances, inpatient admissions and outpatient attendances

likely to enter treatment for their drug use. Those particularly at risk of significant harm are younger adults who would formerly have been experimenting with traditional drugs, including young people involved with the criminal justice system and displaying early characteristics of complex dependency (see chapter 4).

3 General Population Needs Profile

3.1 This chapter is designed to provide a summary of need found in the general population. This will undoubtedly include both those who already access substance misuse treatment services, as well as those who are not currently accessing but display particular levels of need.

3.2 Topics covered in this section include:

- Drug use in the general (adult) population
- Alcohol use in the general (adult) population
- Young people's drug use
- Young people's alcohol and tobacco use
- New and emerging drug trends
- Marginalised and vulnerable communities' substance use

3.3 This section should not be read in isolation from subsequent chapters (4 and 5). Some information on general population use is also contained in Chapter 4 (Complex Dependency), and is grouped thematically. Many of the same topics and themes are discussed in these chapters.

3.4 Please see appendices for further data.

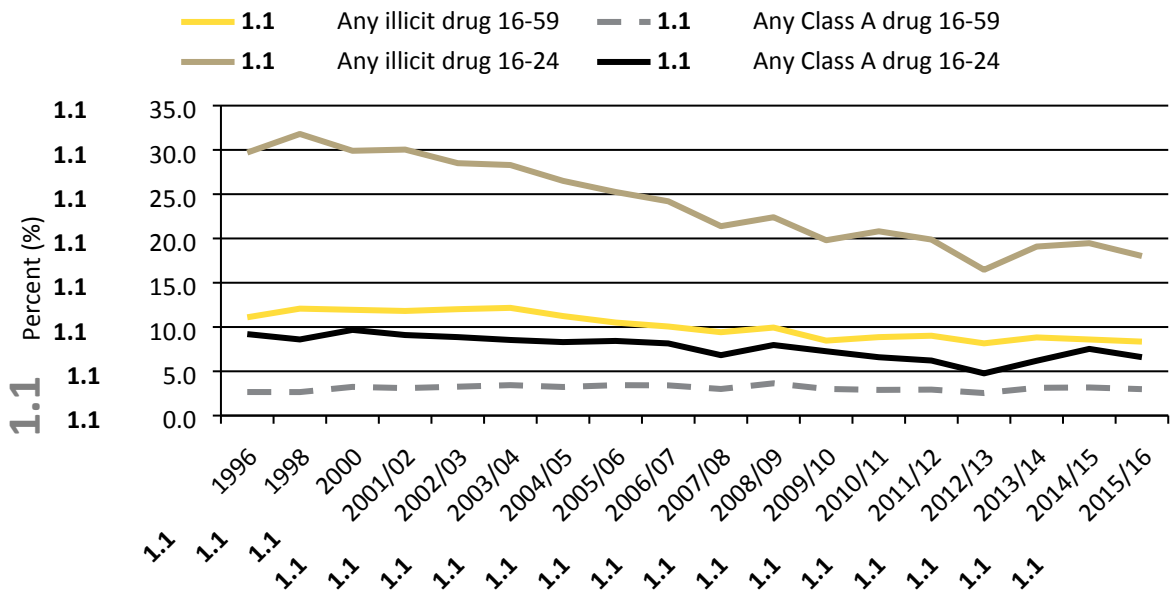
Drug Use

3.5 According to the 2015/16 CSEW[4], nationally, around 8.4% of adults aged 16-59 have taken an illicit drug in the last year. This equates to 37,314 people across the three areas (Bolton 13,487; Salford 12,631; Trafford 11,196). This is statistically significantly different from a decade ago, at 10.5% in 2005/6, but has been stable for the past seven years.

3.6 Illicit drug use is more common in younger adults, with 18.0% of those aged 16-24 having taken a drug in the last year. This proportion is more than double that of the wider age group, and equates to 15,124 younger adults across the three areas (Bolton 5,685; Salford 5,534; Trafford 3,905). This level of drug use is similar to 2014/15 (19.5%), but statistically significantly lower than a decade ago (25.2% in 2005/6). Graph 3.1 shows the use of illicit drugs over the past twenty years in England and Wales.

[4] The CSEW is recognised as a robust measure of recreational drug use for the drug types it covers. However, it may not provide as good a coverage of problematic drug users as they may not necessarily be a part of the household resident population, or they may be concentrated in specific and relatively small subgroups of the population.

1.1 **Graph 3.1: Use of illicit drugs in the last year in England and Wales**

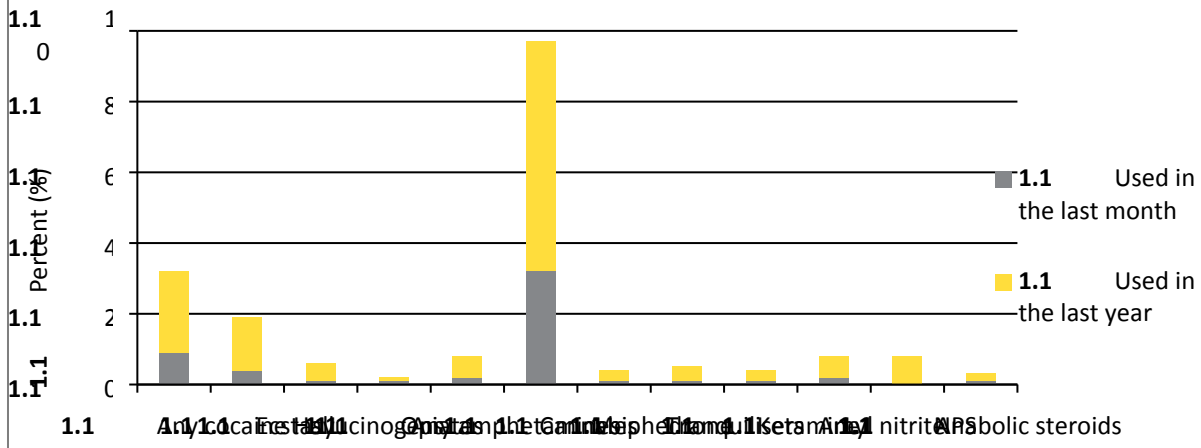


3.7 Estimates show that 3.3% of adults aged 16-59 are frequent drug users (having taken any illicit drug more than once a month on average in the last year). This equates to 14,659 people across the three areas (Bolton 5,298; Salford 4,962, Trafford 4,399). Younger adults are more likely to be frequent drug users, with a comparable proportion of 4.7% (3,949) 16-24 year olds across the three areas (Bolton 1,484; Salford 1,445; Trafford 1,020). 8.0% of all adults who had used drugs in the last year say that they have used drugs every day.

Drug Use by Type of Drug

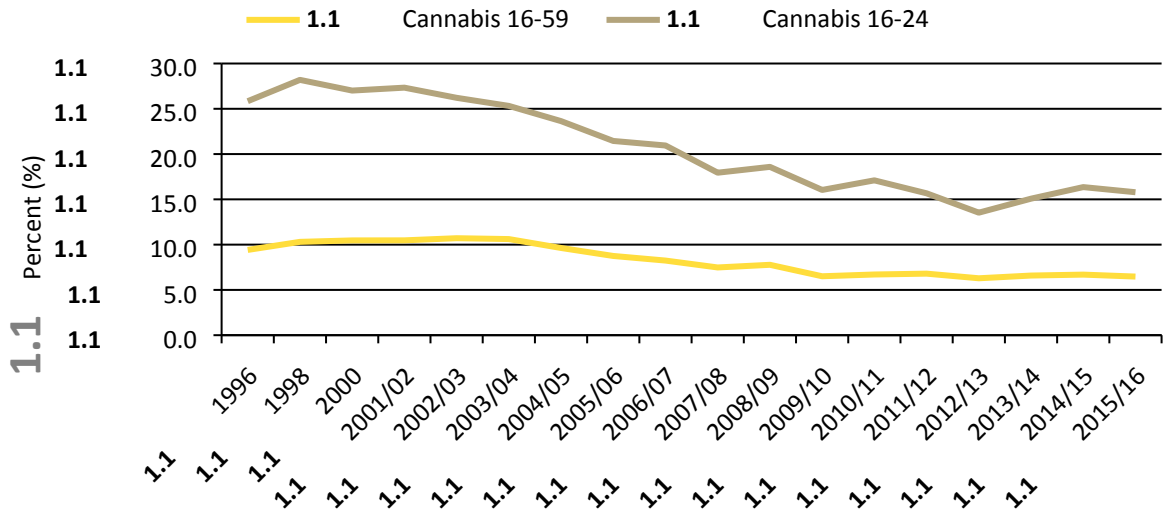
3.8 According to CSEW, cannabis is the most commonly used drug, with 6.5% of adults aged 16-59 having used it in the last year, equating to 28,874 people in Bolton (10,436), Salford (9,774) and Trafford (8,664). This is a similar proportion to the previous survey (2014/15) but has reduced significantly over the last ten years (from 8.7%, and from 9.4% in 1996). Graph 3.2 shows drug use by drug type in England and Wales.

1.1 **Graph 3.2: Drug use by drug typ in England and Wales**



3.9 Cannabis use is notably higher in younger adults, with 15.8% of those aged 16-24 having used the drug over the last year. This equates to 13,275 16-24 year olds in Bolton (4,990), Salford (4,857) and Trafford (3,428). This is similar to the 2014/15 estimate (16.4%), but represents a statistically significant reduction over the last decade (from 21.4%) and the 1996 survey year, when a quarter of younger adults used cannabis (25.8%). Graph 3.3 shows cannabis use trends over the last twenty years in England and Wales.

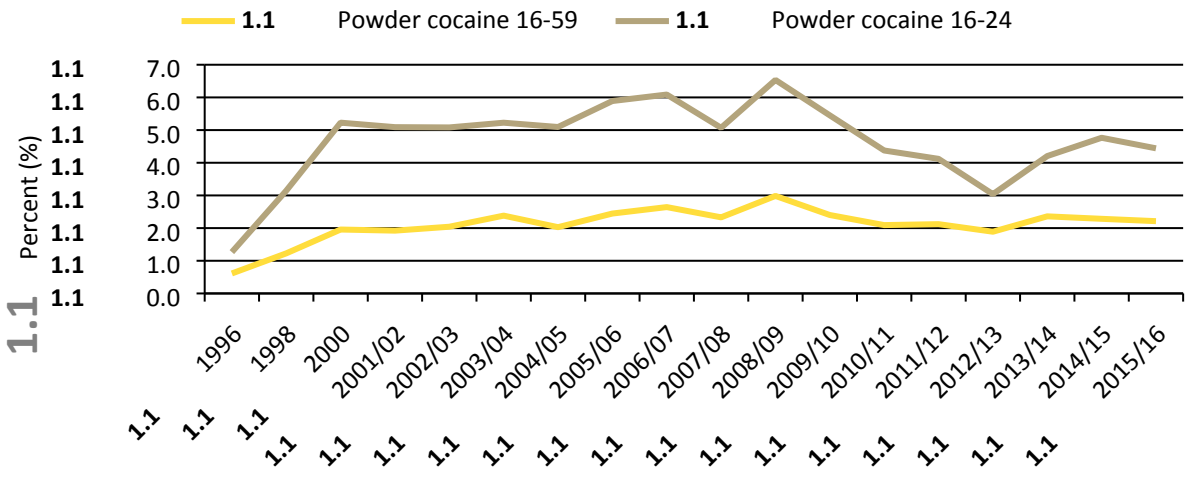
1.1 **Graph 3.3: Use of cannabis in the last year in England and Wales**



3.10 The next most commonly used drug (after cannabis) among 16-59 year olds is powder cocaine, at 2.2%, equating to 9,773 people in Bolton (3,532), Salford (3,308) and Trafford (2,932). In contrast, powder cocaine is the third most commonly used drug among young adults aged 16-24, at 4.4% after cannabis and ecstasy.

3.11 Graph 3.4 shows that among younger adults the trend for use of powder cocaine has fluctuated for a number of years in England and Wales, making it difficult to assess its overall direction. However, the overall trend for 16-24 year olds is likely to be flat over the last six years, and so similar to the trend for the wider age group.

1.1 **Graph 3.4: Use of powder cocaine in the last year in England and Wales**

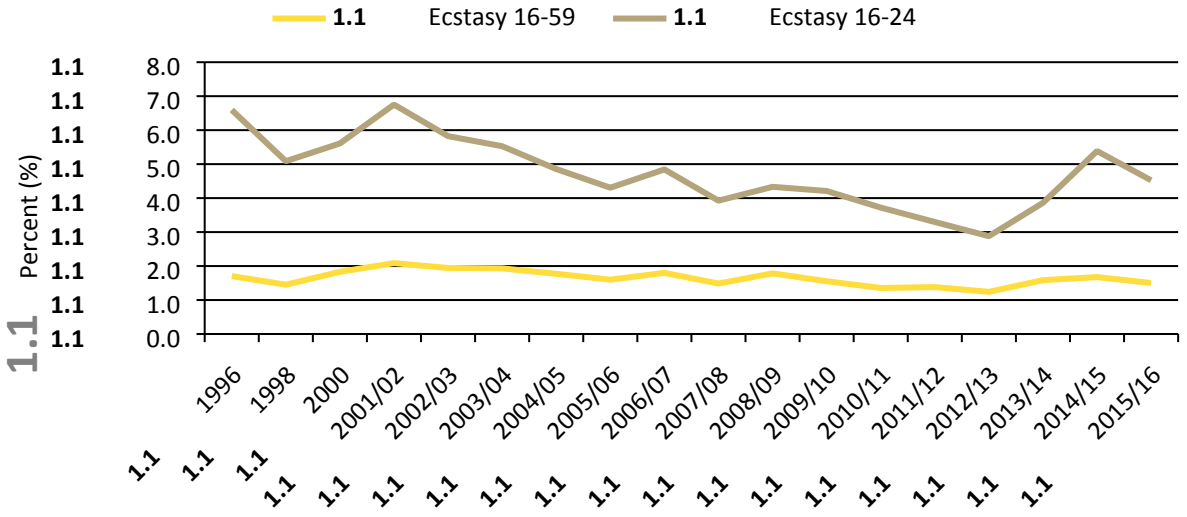


3.12 Levels of ecstasy use by adults aged 16-59 in the 2015/16 survey (1.5%, or 6,663 people across the three areas) is similar to the previous year (1.7%) and to that seen in the 1996 survey year (also 1.7%). Generally, the proportion of people using ecstasy has been relatively flat throughout the lifetime of the survey, fluctuating between 1-2% since measurement began in 1996.

3.13 Use is higher in younger adults with 4.5% of 16-24 year olds having taken ecstasy in the last year. This equates to 3,781 younger adults across the three areas. The trend in ecstasy use among young adults was generally downward until the 2012/13 survey year.[5] Estimates in the last three years have been higher than previously, with last year's ecstasy use reaching back to the level seen ten years ago (4.3%). As such, it appears that use is rising from its downward trend in England and Wales.

[5]Although estimates in this survey year appear to be out of line with recent results for many drug types and may be a result of sampling variation, but upward trends are not unique to this survey year.

1.1 **Graph 3.5: Use of ecstasy in the last year in England and Wales**



Alcohol Misuse

3.14 Alcohol misuse is England's second biggest cause of premature deaths, and the leading risk factor for deaths among men and women aged 35-44 years in the UK (Global Burden of Disease, 2010). 34% of men and 28% of women in the UK exceed current consumption guidelines on at least one day per week.

3.15 The NHS estimates that around 9% of men and 4% women show signs of alcohol dependence. According to Public Health England, 94% of dependent drinkers are not engaged with treatment at any one time.

3.16 A small sub-group within this cohort are both treatment resistant and placing a huge burden on public services; Alcohol Concern estimates these individuals cost at least £2.5 billion nationally each year (2015).

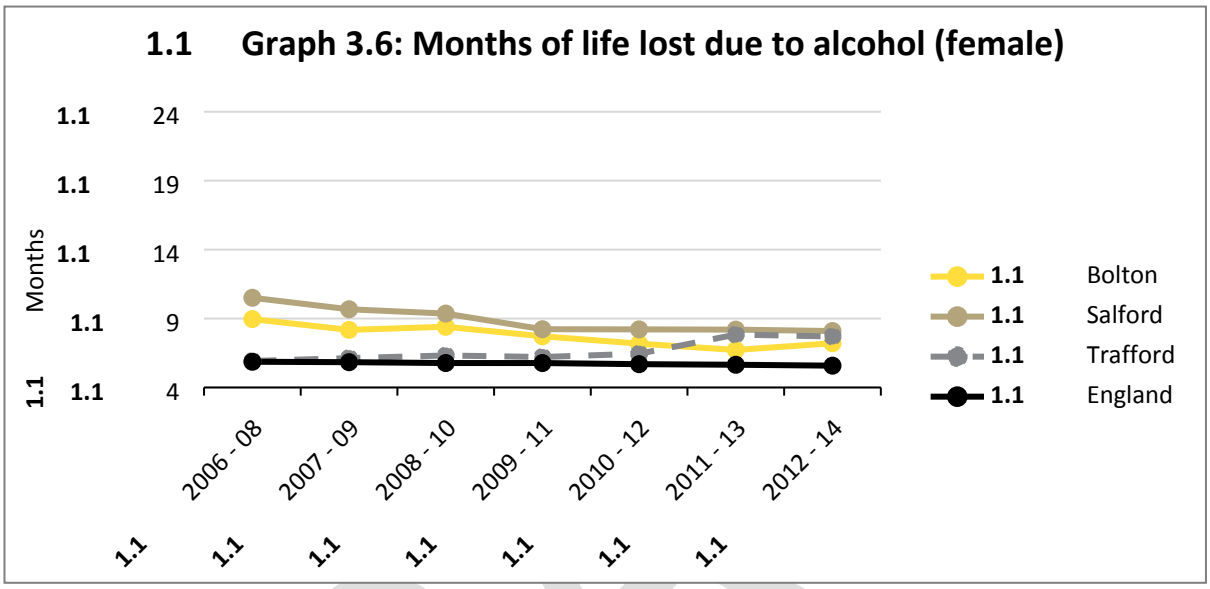
3.17 Data from the Local Alcohol Profiles for England (LAPE)[6] indicates that alcohol-related harm is increasing in all three areas.[7] However, the extent to which this is present and varies is dependent on measures used.

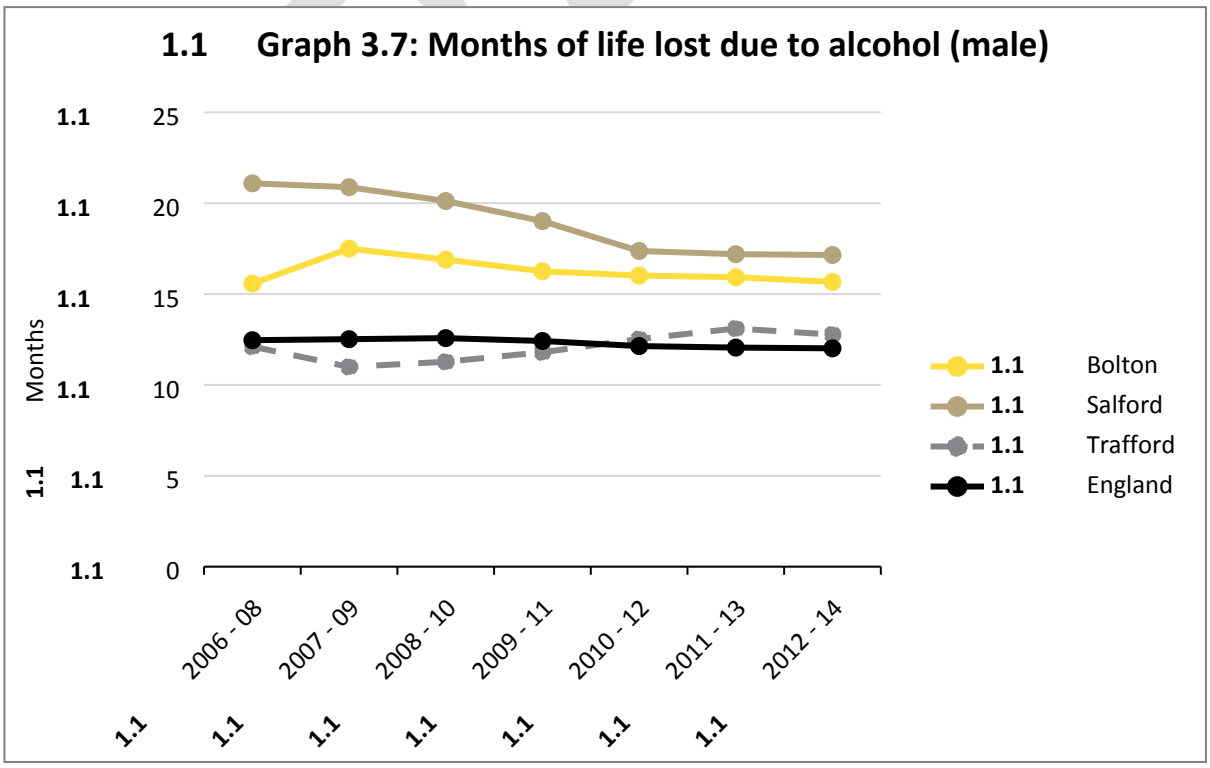
Mortality

[6] Unless otherwise stated, all LAPE data is taken from http://fingertips.phe.org.uk/local-alcohol-profiles

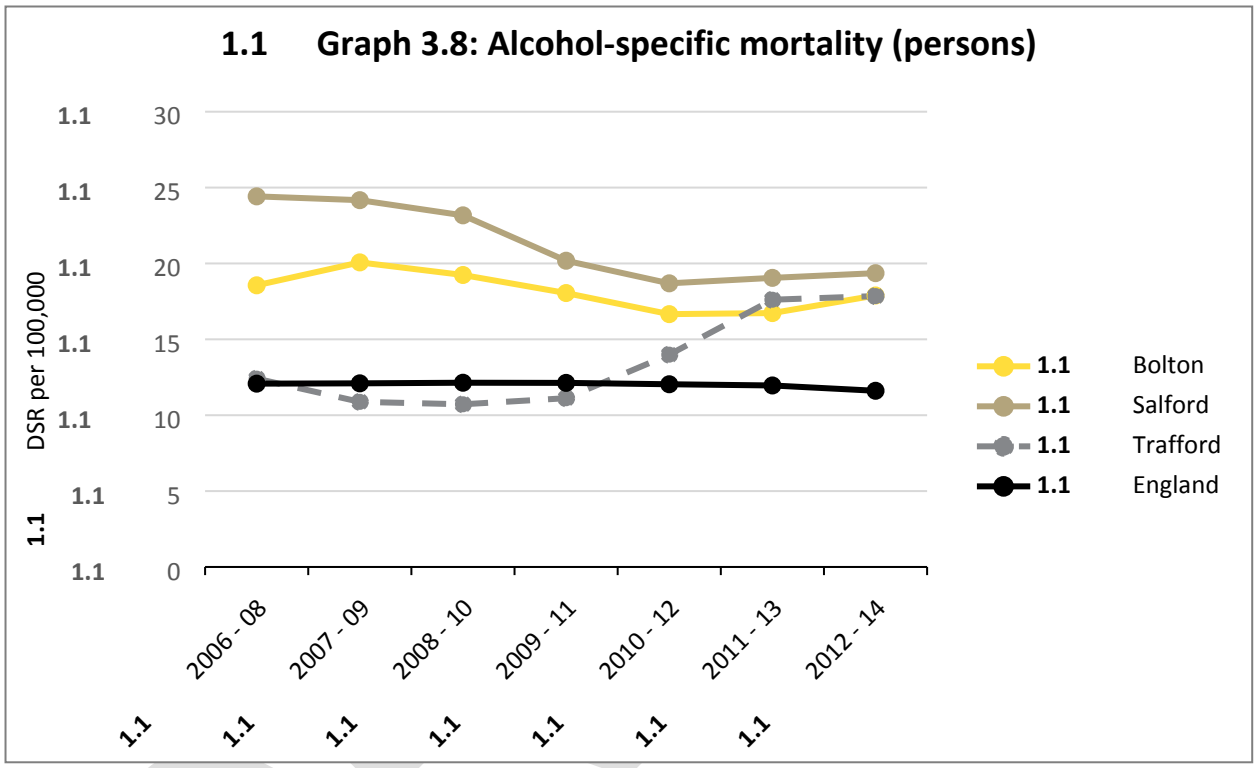
[7] Be aware that data from LAPE operates on a different timescale to other data used in this report. Some time points are two year periods as this is the way in which the data is provided. Where this occurs, the graphs are labelled as such. This means it is not necessarily directly comparable to data provided for financial years.

3.18 The number of months of life lost due to alcohol has decreased over the latest three time periods measured (2010-12 to 2012-14) in both Bolton and Salford, and increased in Trafford, for both males and females. However, as the graphs show, Bolton and Salford's starting points are higher. Months of life lost due to alcohol are considerably higher amongst men than women.



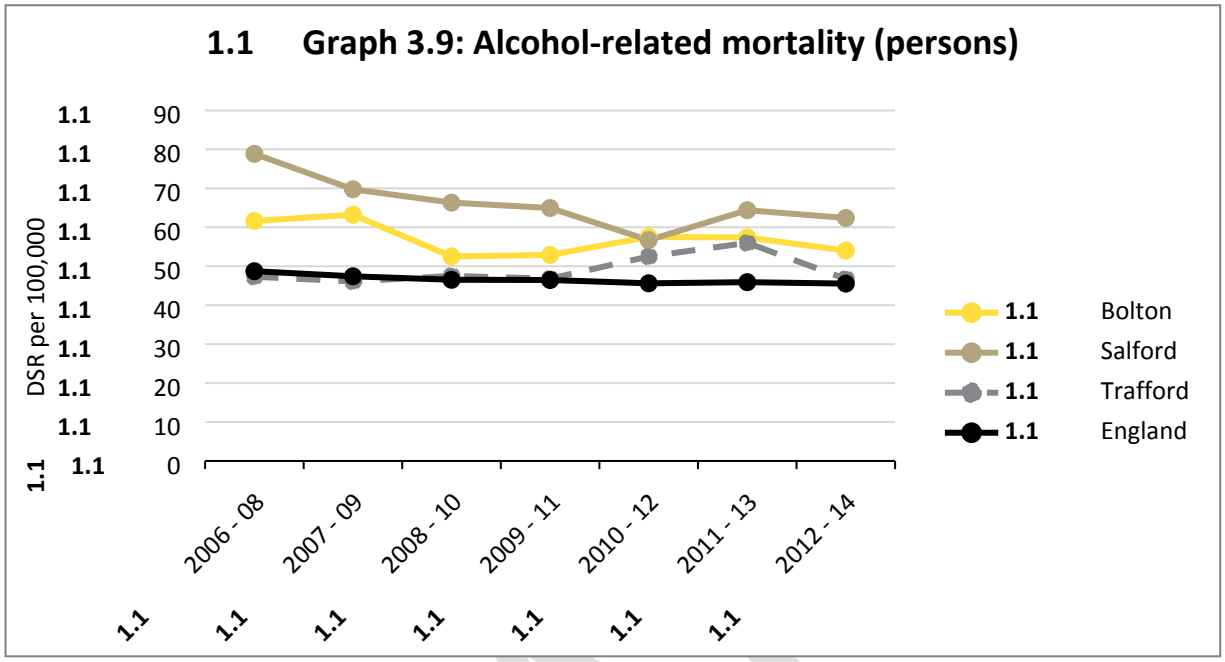


3.19 Alcohol-specific mortality[8] increased in all three areas over the latest three time periods (2010-12 to 2012-14). However, there are variations in these increases, ranging from 28% in Trafford to 7% and 4% in Bolton and Salford respectively. In addition, as can be seen from the graph, Trafford had a much lower starting point compared to the other two areas, with its increase simply bringing it in line with the other two areas. All three areas are significantly higher than the England average.

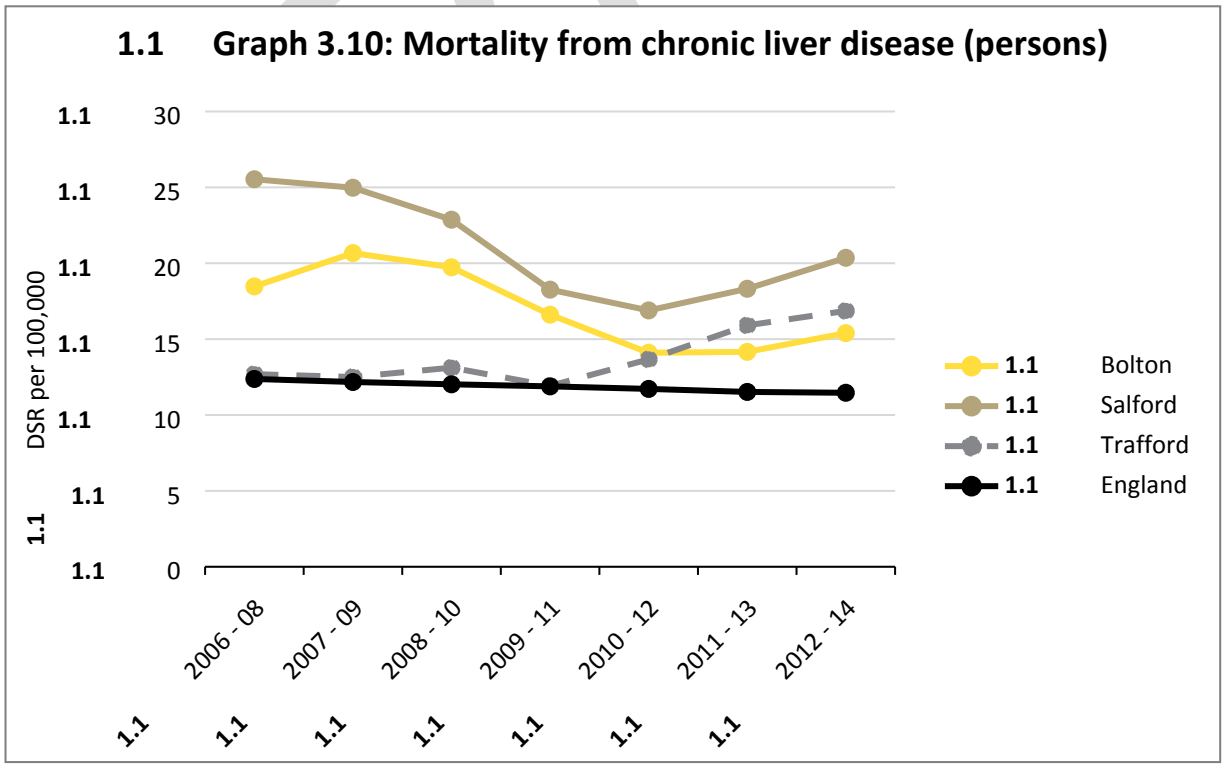


3.20 Alcohol-related[9] mortality increased in Salford (+10%), and decreased in Trafford (-11%) and Bolton (-4%) over the last three time periods (2010-12 to 2012-14). All three remain higher than the England average (though Trafford is only slightly so).

[8] Alcohol-specific conditions include those conditions where alcohol is causally implicated in all cases of the condition; for example, alcohol-induced behavioural disorders and alcohol-related liver cirrhosis.
[9] Alcohol-related conditions include all alcohol-specific conditions, plus those where alcohol is causally implicated in some but not all cases of the outcome, for example hypertensive diseases, various cancers and falls.



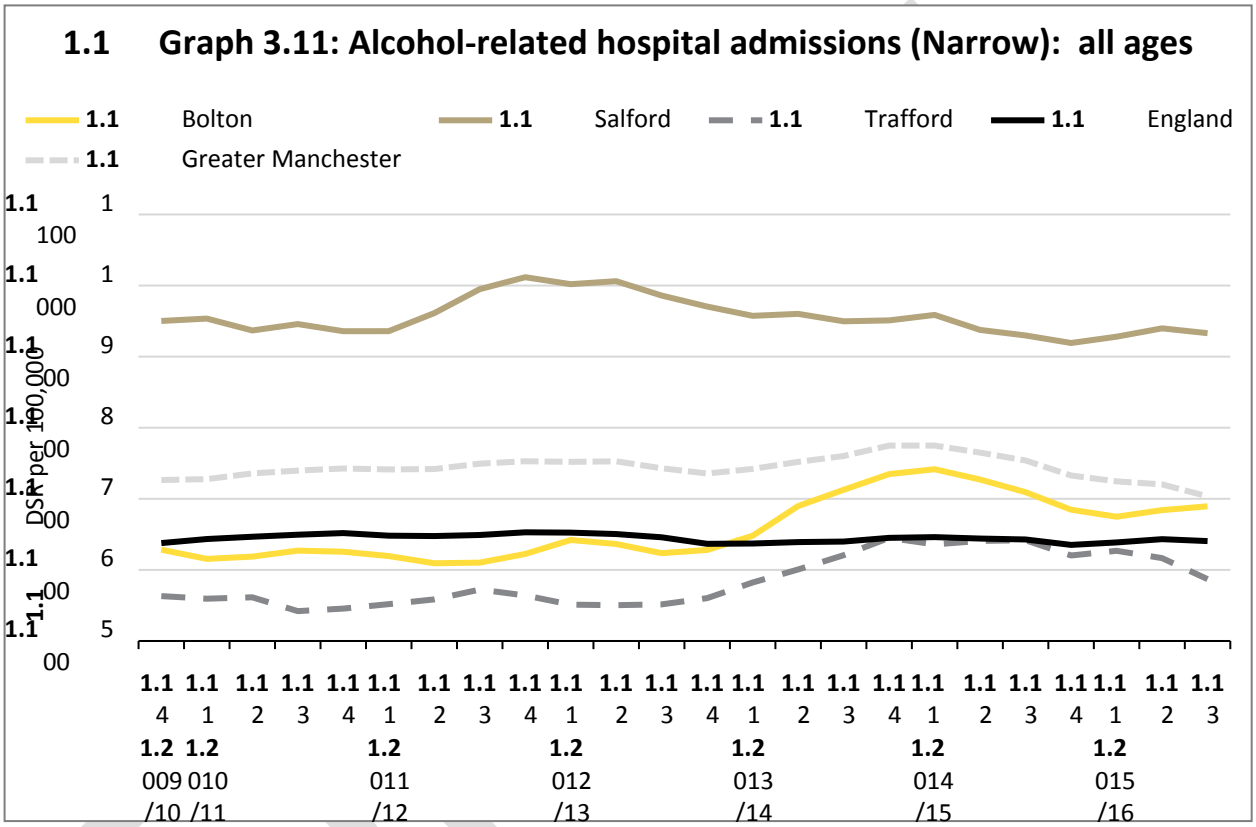
3.21 Both Trafford (23%) and Salford (21%) have seen sharp rises in chronic mortality liver disease over recent years (2010-12 to 2012-14). There has also been a rise in Bolton



(9%) over the same time periods, albeit smaller.

Hospital Admissions

3.22 During the three year time period from 2012/13 to 2014/15[10], hospital admissions for alcohol-related conditions (Narrow[11]) increased slightly in Bolton and Trafford, and decreased slightly in Salford. However, Salford's rate of admissions is significantly higher than Bolton's and Trafford's, and the England and GM averages. Generally, over a five year period admissions seem relatively stable, with some peaks.



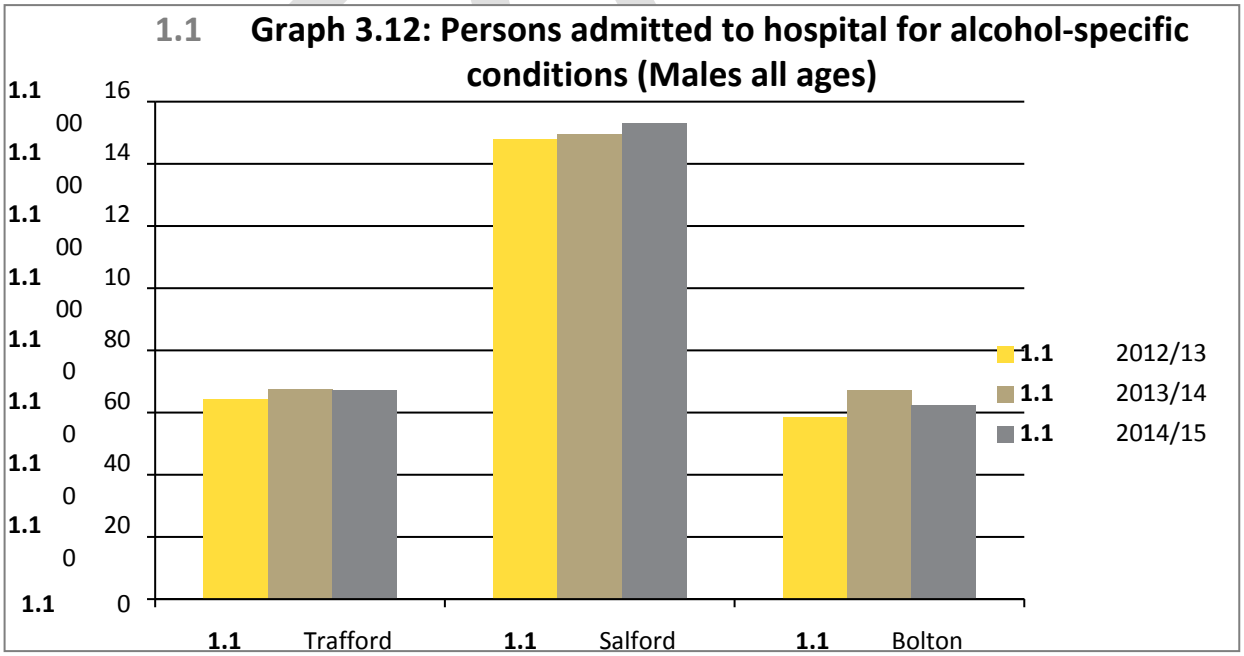
3.23 Table 3.1 provides some interesting breakdowns of percentage changes in the graph above. For example, we can see large increases in admissions for female over 65s in Trafford, and female under 40s in Bolton.

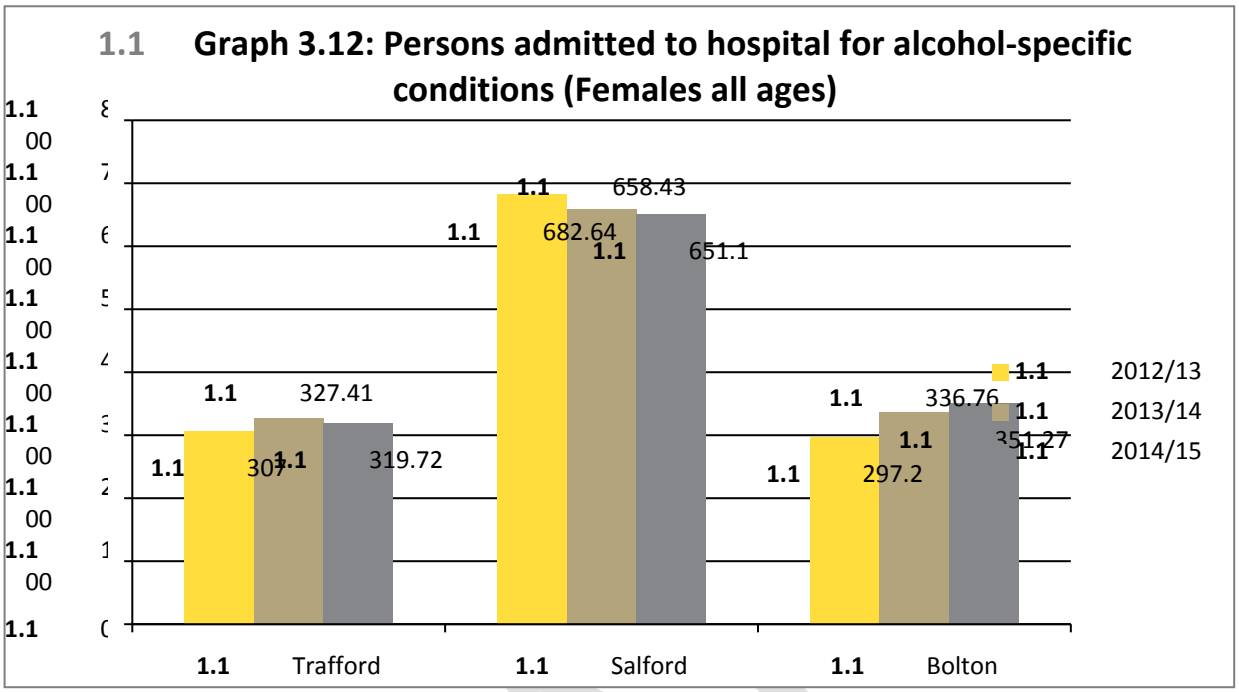
[10] Data for 2015/16 is estimated

[11] This needs assessment will only consider the Narrow measure alcohol-related hospital admissions. For further guidance on Narrow and Broad measures, please see LAPE guidance: http://www.lape.org.uk/downloads/LAPE%20User%20Guide_Final.pdf pp. 23/24

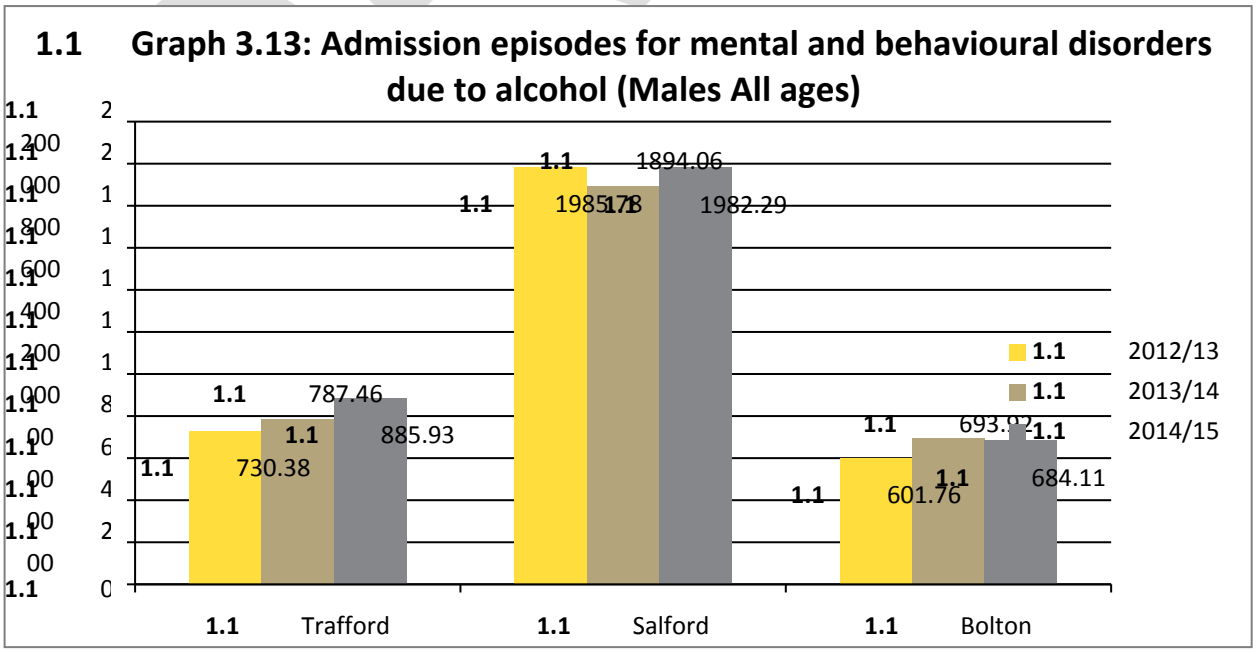
Table 3.1: Percentage changes in alcohol-specific hospital admission episodes (Narrow), 2012/13 to 2014/15 by age and gender		
	<40 years	
	Male	**Female**
Bolton	+16%	+32%
Salford	-10%	+6%
Trafford	-2%	-5%
	40-65 years	
	Male	**Female**
Bolton	+8%	+4%
Salford	-4%	+3%
Trafford	+18%	+13%
	65+ years	
	Male	**Female**
Bolton	+8%	+1%
Salford	-5%	-11%
Trafford	+12%	+25%

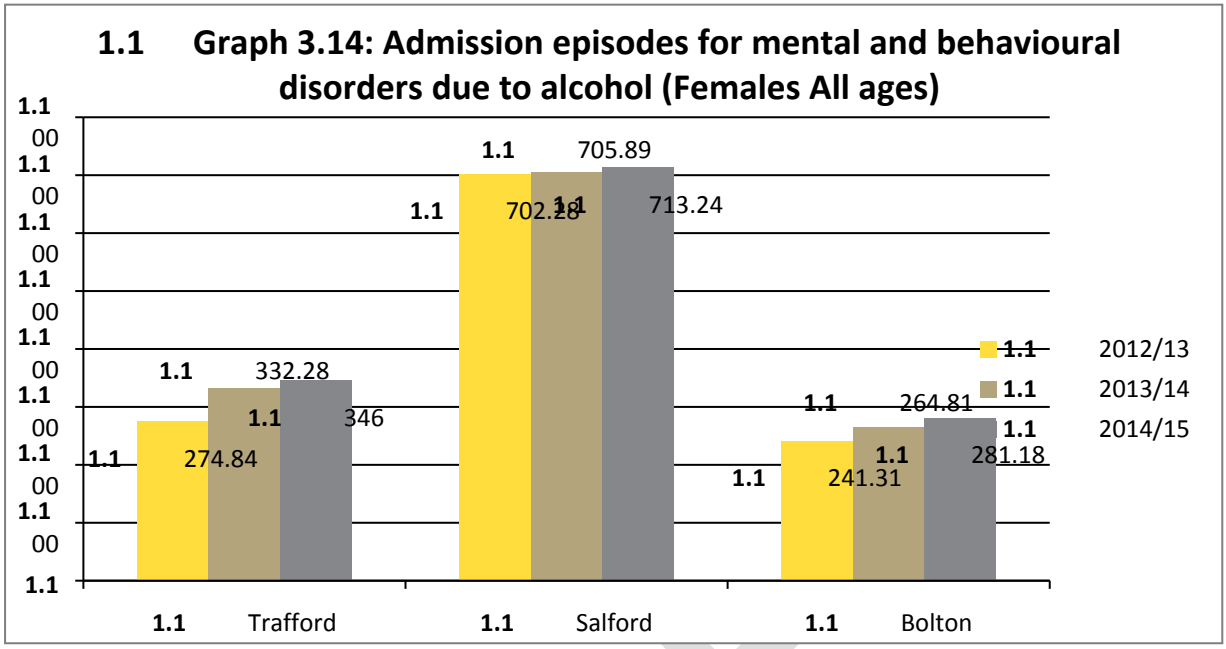
3.24 Across all three areas, alcohol-specific hospital admissions have been broadly consistent over the past three years. Alcohol-specific admissions remain much higher for men than for women. Salford's rates are significantly higher than other areas.





3.25 There have been fairly significant increases in admissions for mental and behavioural disorders due to alcohol in Bolton (15%) and Trafford (22%), with a steady rate in Salford. There is little gender variation in these trends, but men have much higher rates of admission for mental and behavioural disorders due to alcohol than women. Salford has much higher rates of admission than either Trafford or Bolton.





3.26 It is important to be aware that these statistics do not provide us with a complete or nuanced picture of how people are affected by alcohol harm. Evidence demonstrates that alcohol harm is a fundamental component of health inequalities, and a key driver of large gaps in (healthy) life expectancy in GM. For example, in 2013/14, those with an alcohol specific condition living in the most deprived areas had rates of admission to hospital more than twice those living in the least deprived areas (PHE, 2015).

Young People's Drug Use

3.27 Nationally, reported drug use amongst secondary school age children has halved since 2001. The latest data shows that the percentage of 11-15 year olds who say they have ever taken drugs has fallen from 29% in 2001 to 15% in 2014. 6% have used in the last month. Use increases with age, with 15 year olds four times more likely to have taken drugs than 11 year olds (24% compared to 6%). Use amongst boys (16%) is higher than girls (13%) (Fuller, 2015).

3.28 Amongst those young people who have used drugs in the last year the most commonly used drugs are cannabis (65%), solvents (28%), stimulants (20%) and psychedelics (13%). One in five of those who had used drugs in the last year used a Class A drug (cocaine accounted for half of Class A use).

3.29 The percentage of secondary age children reporting the use of drugs within the last year is highest in the North West region. Reported prevalence was around 80% higher than other regions. This would give a rate somewhere in the range of 10% to 28% of 11-15 year olds, but likely to be closer to 17%, compared to 10% nationally.

3.30 Local data on drug use prevalence amongst children and young people has always been difficult to come by. It is often a hidden activity occurring outside the law with

negative consequences for users, making accurate prevalence estimates challenging to determine. The best current source is the WAY survey of young people (Ipsos MORI, 2015).

3.31 Taking a weighted average across the three areas, 9.5% of 15 year olds report using cannabis in the last year. Cannabis use was more common in Salford (10.2%) and Bolton (9.6%) with Trafford (8.9%) having a similar prevalence to the national average (8.9%).

3.32 Weighted across the three areas, only 3.0% of 15 year olds say they have ever tried drugs other than cannabis. Trafford has a higher prevalence for other drug use, at 4.3% which compares to 3.4% in Salford, 1.7% in Bolton and an England average of 2.5%.

3.33 There is little difference by gender for the three areas taken as a whole for other drug use (boys 2.8%; girls 3.2%) but girls in Salford (4.6%) and Trafford (4.1%) do differ notably from the prevalence seen in girls in Bolton (1.5%).

Young People's Alcohol and Tobacco Use

3.34 As well as posing a need themselves, smoking and drinking in young people are also good predictors of drug use. Young people who are regular smokers are at least eight times[12] as likely as non-smokers to report using drugs in the last year. Young people who drink (even infrequently) are at least three times[13] as likely as non-drinkers to report having used drugs in the last year.

3.35 Trading Standards North West conducts a biennial survey of 14-17 year old pupils on alcohol and tobacco use (Mustard/TSNW, 2015). The latest survey was conducted in 2015.[14]

3.36 The three areas have relatively similar proportions of children and young people reporting that they never drink (44% in Salford, 48% in Trafford, and 35% in Bolton[15]). Regular drinking (at least once a week) was also similar (9% in Salford, 10% in Trafford, and 18% in Bolton[16]). Slight variations in Bolton are to be expected given the different timelines (see footnotes).

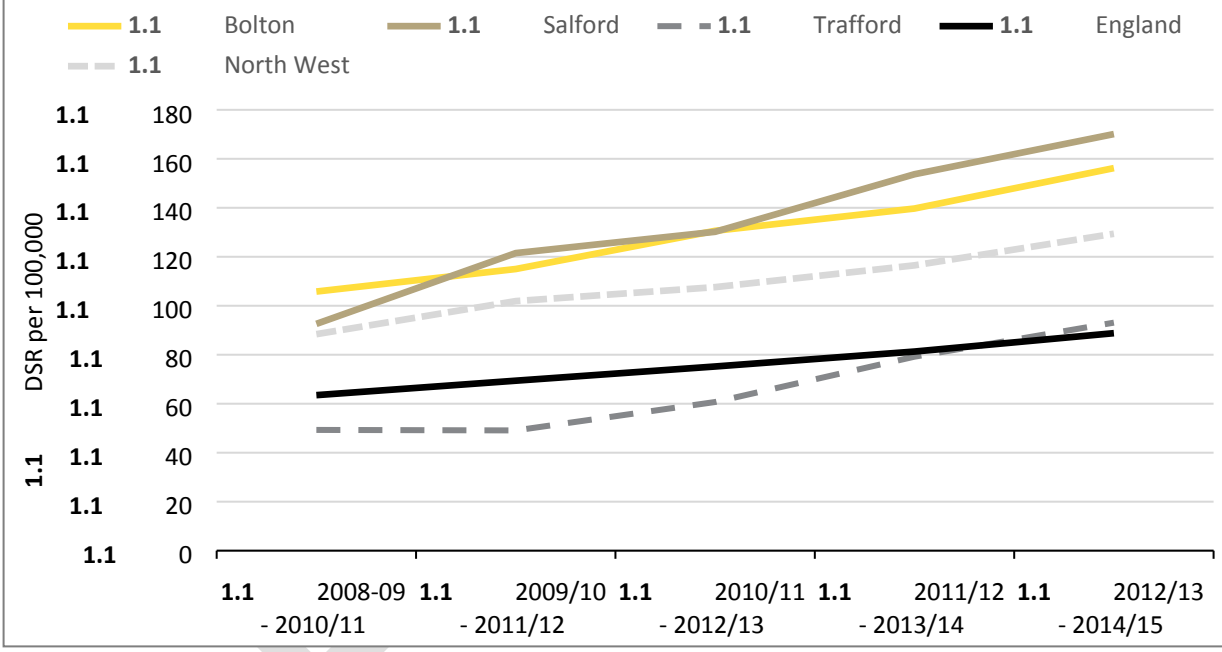
[12] The odds ratio (OR) for having taken drugs in the last year for regular smokers aged 11-15 compared to non-smokers is 13.69 (95% CI: 7.98 – 21.81)
[13] The OR for having taken drugs in the last year for 11-15 year olds who have drunk alcohol but not in the last week compared to those who have never drunk alcohol is 4.69 (95% CI: 3.29 – 6.69) for those who have drunk alcohol in the last week the OR is 8.73 (95%CI: 5.62 – 13.55)
[14] Bolton did not take part in the 2015 survey. As a result, data from 2013 are presented here for Bolton.
[15] However, the regional average was also lower in the 2013 survey
[16] However, the regional average was higher in the 2013 survey.

3.37 In all three areas and the region overall, smoking prevalence in children and young people has reduced in every survey since 2009. Currently, self-reported smoking rates are 10% in Salford, 7% in Trafford, and 9% in Bolton.

Young People's Hospital Admissions

3.38 Interestingly, graph 3.15 shows higher admission rates in Salford (170.1) and Bolton (156.2) compared to Trafford (93.1) but an increasing trend in all three areas, the North West region, and England as a whole. These figures equate to 58 admissions in Salford each year, 56 in Bolton each year, and 23 in Trafford each year. Across the three areas this means 2.6 children and/or young people can be expected to be admitted to hospital for substance misuse each week and looking at the direction of travel this number will likely increase over coming years.[17]

1.1 Graph 3.15: Young people hospital admissions due to substance misuse: DSR per 100,000 aged 15-24



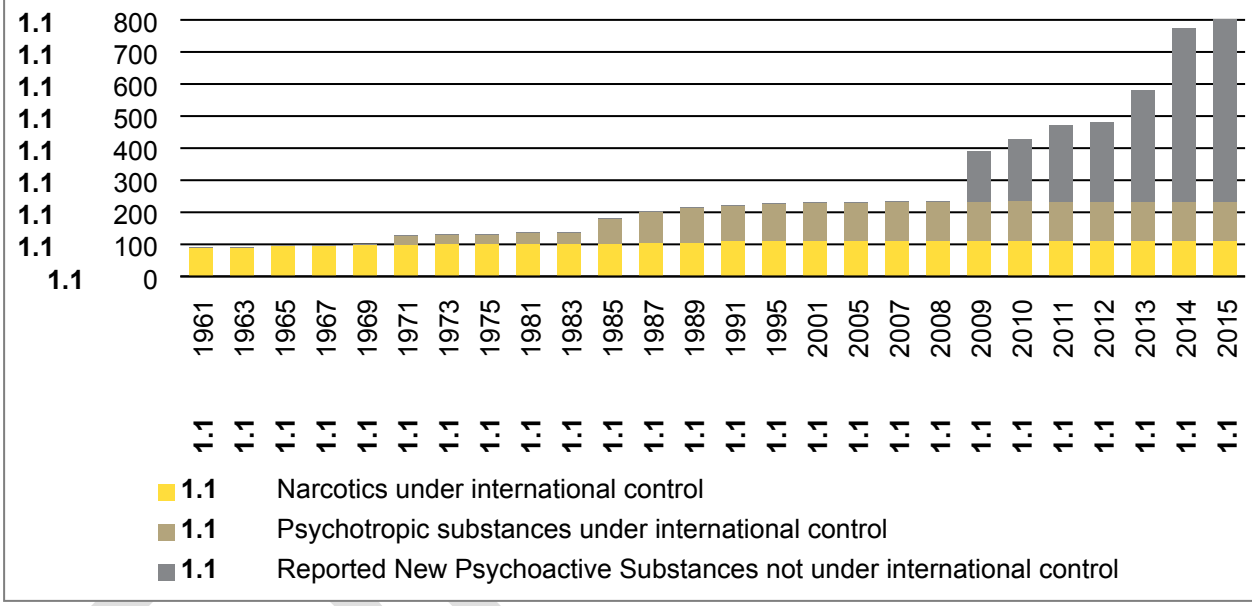
3.39 This is in contrast to evidence above that indicates that use of all substances is, across the general population of young people, declining. This confirms that the most high risk young people are still likely to present with high needs (see chapter 5).

[17] Data from Child Health Profiles, available: http://fingertips.phe.org.uk/profile/child-health-profiles

New and Emerging Drug Trends

3.40 The speed at which New Psychoactive Substances (NPS)[18] are being introduced to the market is unprecedented, and continues to rise. Towards the end of 2015, 75 new substances had been reported to the UN Office for Drugs and Crime (UNODC) for the first time. In 2014, the figure was 66. Towards the end of 2015[19], a total of 616 NPS not under international control had been reported to UNODC. In 2013, the figure was 348. None were reported before 2009 (UNODC, 2016).

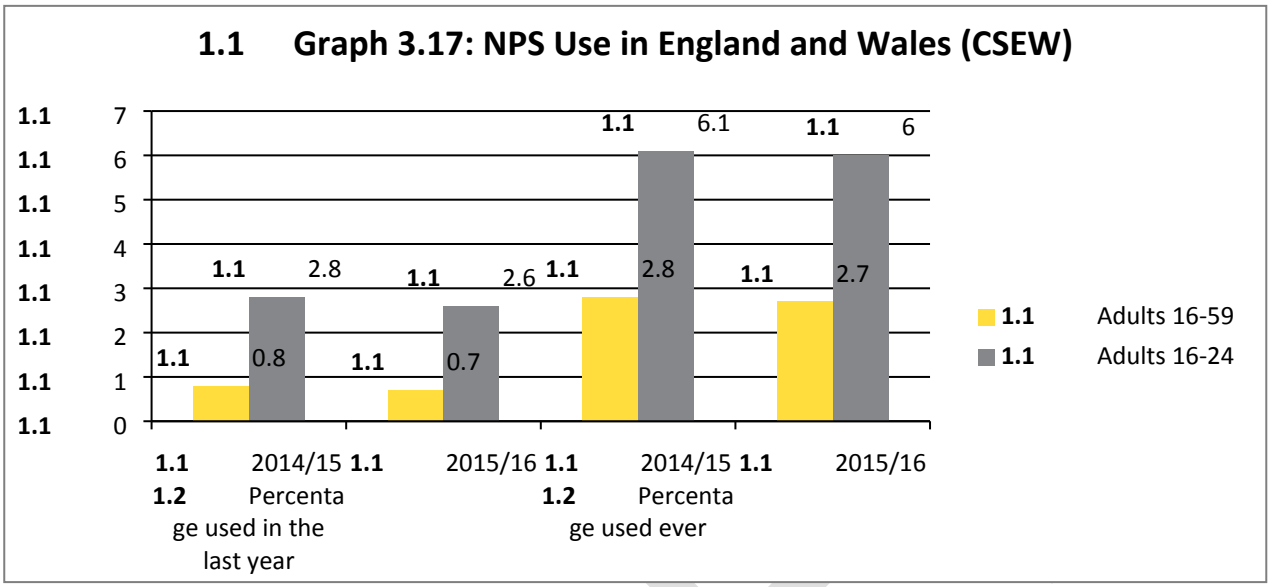
1.1 **Graph 3.16: Number of NPS not under international control, and substances controlled under the international drug conventions (1961-2013)**



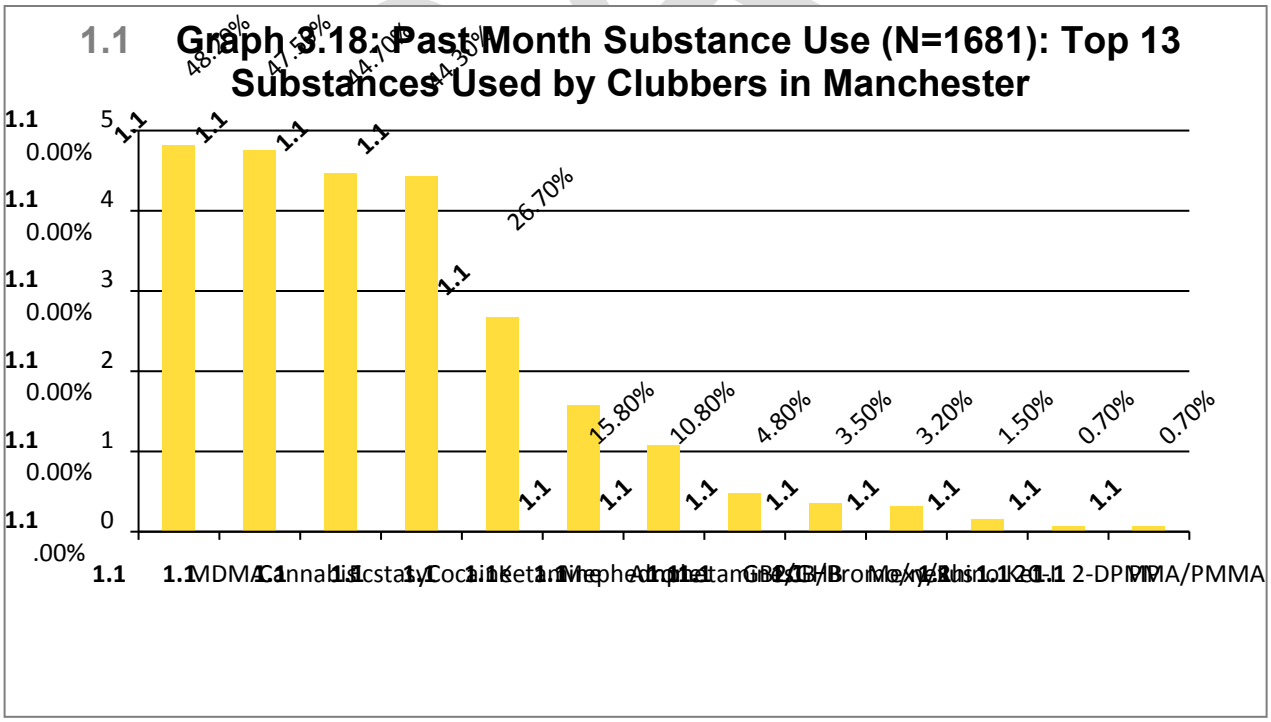
3.41 According to CSEW 2015/16, use of NPS is concentrated among young adults aged 16-24. Around 2.6% young adults took an NPS in the last year – a proportion more than three times higher than the general population. This equates to around 2,185 young people across the three areas. Use of NPS in the last year was concentrated among young men aged 16-24, of whom 3.6% had used a NPS in the last year compared to 1.6% of women.

[18] The UNODC defines a new psychoactive substance as "substances of abuse, either in a pure form or a preparation, that are not controlled by the 1961 Single Convention on Narcotic Drugs or the 1971 Convention on Psychotropic Substances, but which may pose a public health threat" (UNODC, 2015). This term encompasses those substances that have recently been banned under the Psychoactive Substances Act 2016 and that were often colloquially referred to as 'legal highs'. It should also be noted that some of these drugs are not actually 'new'. However, their availability and forms are.

[19] UNODC 2016 World Drug Report was released with this figure before the final number was available. This number may go up but will not go down.



3.42 Research from Manchester Metropolitan University analysing drug use in clubs in Manchester found that 79% (n=1,698) of people had 'ever used drugs'. 46% of these had used "legal highs" (Ralphs, 2013).



3.43 Whilst this research is based in the City of Manchester, patterns of night-time economy travel mean that the individuals within this study will not live only within Manchester, but across the boroughs.

3.44 26.9% of those surveyed reported bad experiences with "legal highs", ranging from confusion and memory loss to hallucinations, panic attacks and collapsing. Despite this, just 10% of the sample wanted more information and advice about drugs. This reflects wider evidence indicating that users of non-traditional drugs are reluctant to access treatment from services they view as for alcohol, heroin and crack users (RCPsych, 2014).

3.45 In 2015/16, 36 adults in treatment in Bolton, Salford and Trafford used NPS. In 2014/15, this figure was 6. In 2015/16, 24 young people in treatment in Bolton, Salford and Trafford used NPS. In 2014/15, this figure was 7.

3.46 These issues are not confined to GM. A 2014 Home Office report outlines barriers to treatment and intervention with people using NPS. These include a lack of knowledge on NPS and their harms, very little systematic recording of NPS prevalence and effects across health services, a limited evidence base relating to treatment, users being new and unknown to services, and challenges in sharing learning (Home Office, 2014). As the Royal College of Psychiatrists has summarised: there is a growing national recognition that "*our health services are not equipped to address the serious harms that NPS and club drug users are now reporting and were instead designed to deal with the drugs and dangers of the past decade*." (RCPsych, 2014)

3.47 In addition, there have been particular and growing problems in prisons and the custody suite relating to synthetic cannabinoids ('Spice'). These are outlined in Section 4.

Marginalised and Vulnerable Communities

3.48 People from marginalised and vulnerable groups (including but not limited to people with 'protected characteristics'[20]) often have particular needs relating to substance misuse. These groups are more likely to experience discrimination and marginalisation in their daily lives, making them more vulnerable to substance use, poor mental health and isolation.

3.49 Whilst not homogeneous, groups of people and communities who share certain characteristics can also often experience a range of barriers to engaging with substance misuse treatment services. These include, but are not limited to:

- BME and minority religious communities
- People with English as a second language (or no English)

[20] Protected characteristics are defined in the Equalities Act of 2010 as: age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex; sexual orientation.

- LGBT (lesbian, gay, bisexual and transgender) people and MSM (men who have sex with men, regardless of their identified sexual orientation)
- People with disabilities (including physical and sensory disabilities, such as deafness and/or blindness, learning difficulties and physical and/or mobility impairments)
- People with mental health problems (aside from dual diagnosis)
- People who have experienced (or are experiencing) domestic and/or sexual violence
- Older people
- Other minority communities, e.g. Travellers, Gypsies and Roma people
- People with non-traditional drug use (e.g. club drugs, NPS, over-the-counter and prescription drugs)

3.50 These groups experience particular, and sometimes high, needs relating to drug and alcohol use and accessing treatment. Intersectionality between these groups is also important, and they are not mutually exclusive (e.g. someone may identify as LGBT and have a physical disability). Intersectionality has further impacts on substance misuse and treatment.

3.51 Given the hidden nature of substance misuse in these communities, data and evidence are not always available. This means we often cannot provide robust evidence of need, but anecdotal information, patterns of behaviour and a history of discrimination mean that we can be reasonably sure that unmet need exists in these communities. An absence of data should not be taken as a sign of unimportance or low levels of need.

BME and minority religious communities

3.52 The evidence around BME drug and alcohol use is scarce and often local. It is an oft-neglected area that requires more research.

3.53 Substance misuse in BME communities, particularly South Asian, is regularly masked due to overall patterns of lower use amongst these communities and higher levels of associated stigma. However, this means that problematic use, when it occurs, is often hidden. *"Abstinence is high amongst South Asians, particularly those from Pakistani, Bangladeshi and Muslim backgrounds. But Pakistani and Muslim men who do drink do so more heavily than other non-white minority ethnic and religious groups."* (JRF, 2010). In particular, alcohol consumption amongst second-generation BME people has increased and is beginning to converge with overall consumption patterns. This is not just limited to young men but patterns of increasing use are being seen amongst younger women, too.

3.54 There are indications that use amongst Asian people is increasing. Data from CSEW indicates that from 2008/9 to 2015/16, the number of Asian people who had used drugs in the last year increased from 2.6% to 3.8%, a 46% rise. However, evidence

indicates that drug use in Asian communities is almost certainly under-reported in statistics. People of mixed heritage were the most likely to say that they had used drugs, at 15%.

Table 3.2: Respondents to CSEW 2015/16, by ethnicity (percentages)			
Ethnicity	**Any Class A drug**	**Any stimulant drug**	**Any drug**
White	3.3	3.6	8.9
Non-white	1.4	1.4	5.0
Mixed	6.4	6.4	15.2
Asian or Asian British	1.2	1.0	3.8
Black or Black British	0.4	0.6	4.6
Chinese or other	0.0	0.3	2.1

3.55 It is likely that this rise in drug use can be mainly attributed to cocaine and cannabis use. This is combined with a corresponding increase in alcohol consumption. For example, anecdotal information from Bolton indicates that young Asian males often test positive for alcohol and cocaine use (through Test on Arrest), reporting hazardous behaviour alongside these. Such patterns often escalate at key times such as Eid al-Fitr.

3.56 Substance misuse amongst Eastern European communities is less hidden, but more common. Bolton in particular has a growing Eastern European population. More? Bolton and Salford in particular have growing numbers of… LINK TO DEMOGRAPHICS SECTION when have it

3.57 Despite patterns of need, BME and minority religious communities have traditionally been under-represented in service provision. In 2015/16, 89.25% of adults in treatment across all three areas were White British. Adults in treatment from an Asian background represented 1.87%. Adults in treatment from an African, Caribbean or other Black background represented 1.09% and those of mixed heritage represented 2.15%.

3.58 Young people from an Asian background represented 1.22% of those in treatment. Young people in treatment from an African, Caribbean or other Black background represented 0.63% and young people of mixed heritage represented 5.60%. When compared to the evidence above, it appears that representation in services is not as ethnically representative as it could be.[21]

Table 3.3: Ethnicity of clients in treatment, 2015/16, across all three areas				
Ethnicity	**Adults**		**Young People**	
	Number	**Percentage**	**Number**	**Percentage**

[21] For example, compare the 15.2% prevalence in drug use amongst people of mixed heritage to their representation in services, at 2.15%.

White British	4640	89.25%	556	88.69%
White Irish	65	1.25%	6	0.96%
Other White	107	2.06%	6	0.95%
White & Black Caribbean	50	0.96%	14	2.18%
White & Black African	13	0.25%	5	0.80%
White & Asian	21	0.4%	10	1.64%
Other Mixed	28	0.54%	6	0.98%
Indian	30	0.58%	0	0%
Pakistani	22	0.42%	-	-
Bangladeshi	-	-	-	-
Other Asian	41	0.79%	-	-
Caribbean	26	0.5%	-	-
African	8	0.15%	0	0%
Other Black	23	0.44%	-	-
Chinese	0	0%	0	0%
Other	21	0.4%	-	-
Not stated	96	1.85%	7	1.15%
Missing	-	-	-	-

LGBT people and MSM

3.59 Estimates of the number of LGBT people in the population vary. The Gender Identity Research and Education Society (GIRES) estimates that around 1% of the UK population experiences some degree of gender variance. PHE estimate that gay, bisexual and other MSM make up 5.5% of the male population in the UK (PHE, 2014). The most reliable estimates indicate that LGB people represent between 5-7% of the population.

3.60 LGBT people are overwhelmingly more likely to use drugs compared to the general population (NEPTUNE, 2016). The LGBT foundation estimate that drug use amongst LGB people is 7 times higher than in the general population. Data from CSEW indicates that gay and bisexual men are more likely to have used drugs than heterosexual men. LGBT people are particularly more likely to use 'club drugs' than other groups. Binge drinking is twice as high amongst LGB people (of both sexes) than in the general population. However, the difference in alcohol use seems less apparent than the difference in drug use levels.

3.61 In a study by the LGBT Foundation in GM, *"over a fifth of the sample scored as dependent on a substance, and a further quarter showed at least one indicator of dependency. This included 16% of all alcohol users in the sample, and between 4 to 13% of users of the most commonly used drugs."* (LGBT Foundation, 2014, p.4) Poly

LGB drug users are more likely to display signs of dependency. This means that not only are LGB people more likely to use drugs and alcohol more frequently and more problematically, they are also more likely to show signs of dependency to these substances.

3.62 Whilst drug use is generally higher amongst LGBT people than heterosexual people, it is important to distinguish between and within this group when considering need. There are varying patterns of use between genders, but evidence is contradicting in terms of need pattern, though most evidence tends to indicate that gay and bisexual men have greater use than women. Studies generally indicate that patterns of drug use by people who identify as bisexual are higher than homosexual men and women.

3.63 This group often has worse broader health outcomes than their heterosexual counterparts. MSM in the UK are most affected by HIV and are at greater risk of other BBVs such as Hepatitis C.

3.64 Despite an indication towards higher patterns of need, LGBT people and MSM are less likely than the general population to seek treatment or support from mainstream services for health-related issues. Sexual orientation monitoring of those in treatment across the three areas appears to indicate that LGB people continue to be under-represented compared to their needs profile.[22]

Table 3.4: Sexual Orientation (adults in treatment), 1 Apr – 31 Mar 2016

	Bolton[23]		Salford[24]		Trafford[25]	
Identifying as:	**Number**	**Percentage[26]**	**Number**	**Percentage[27]**	**Number**	**Percentage[28]**
Bi-sexual	5	0.63%	16	1.06%	5	1.07%
Gay or Lesbian	25	3.17%	49	3.23%	20	4.30%
Heterosexual	759	96.2%	1450	95.71%	439	94.40%
Other	0	0%	0	0%	-	-
Not provided	138	-	221	-	8	-
Total	927	-	1736	-	473	-

3.65 Minority gender identity status is not currently monitored in treatment services.

[22] As this has only recently started being reported to NDTMS, data from the three areas is not necessarily comparable, as data may be for slightly different time periods and/or classifications (e.g. numbers in treatment vs. new presentations). This is why no overall average is provided. Footnotes indicate differences. However, the data can be taken as a reliable number for which it is labelled.
[23] Entrants to service
[24] Total numbers in treatment
[25] Starting structured treatment
[26] Percentages calculated out of the total number who disclosed (789) not total overall
[27] Percentages calculated out of the total number who disclosed (1515) not total overall
[28] Percentages calculated out of the total number who disclosed (465) not total overall

Older People

3.66 The Royal College of Psychiatrists estimates that 1 in 5 older men and 1 in 10 older women are drinking enough to harm themselves, figures that have increased by 40% in men and 100% in women over the past 20 years. This is likely to be a combination of those who only started drinking heavily as they aged, and those whose health problems from long-term drinking start to materialise as they become older. A number of risk factors for excess alcohol consumption materialise as people age, including bereavement, poor health and financial stress.

3.67 The cohort of people in treatment is also ageing. In England, nearly half (48%) of those in substance misuse treatment services are aged 40 or over, this figure reaches 68% among those being treated for alcohol alone. These figures are consistent with the pattern in GM and in Bolton, Salford and Trafford, with Trafford seeing slightly higher percentages.

Table 3.5: In treatment by age group, 1 Apr 2015 – 31 Mar 2016 (all drugs)

Age	Bolton	Salford	Trafford
40-44	423	370	150
45-49	320	302	196
50-54	161	187	137
55-59	95	98	60
60-64	44	43	39
65-74	20	32	31
75-84	-	-	-
Total over 50	322	364	269
Total all ages	2,169	1,904	1,126
Percentage over 40	49%	54%	55%
Percentage over 50	15%	19%	24%

Table 3.6: In treatment by age group, 1 Apr 2015 – 31 Mar 2016 (alcohol only)

Age	Bolton	Salford	Trafford
40-44	72	95	62
45-49	84	107	68
50-54	87	103	65
55-59	62	66	41
60-64	30	34	31
65-74	18	30	26
75-84	-	-	-
Total over 50	199	237	165
Total all ages	560	648	415
Percentage over 40	63%	68%	71%

Percentage over 50	36%	37%	40%

3.68 In 2014/15, there were 194 hospital admissions for alcohol related conditions (narrow) amongst over 65s for every 100,000 people in GM. This is worse than the England average of 190 (LAPE, 2016). This is an 11% increase from 2008/9, when there were an average 175 per 100,000 admissions amongst over 65s for every 100,000 people in GM, (and the England average was 174.8).

Table 3.7: Admission episodes for alcohol-related conditions (Narrow) over 65s per 100,000 people

Area	2012/13	2013/14	2014/15
Bolton	164.6	176.4	174.7
Salford	227.7	209.7	212.7
Trafford	152.4	172.8	177.8
England	185.7	184.5	190.5

3.69 It can often be difficult to engage certain types of older people in treatment, such as those in care homes and people with cognitive difficulties. Alcohol use in such cases exacerbates these cognitive and other health problems, but is often hidden.

3.70 There are a range of other people sharing common characteristics amongst whom substance use is highly prevalent. However, there are problems relating to reliable data for these people. For example, travellers, gypsies and Roma people often report high levels of drug and alcohol use. However, drug use still remains a taboo in many traveller communities and so high levels of use are hidden. An absence of data for these communities should not be viewed as an absence of need.

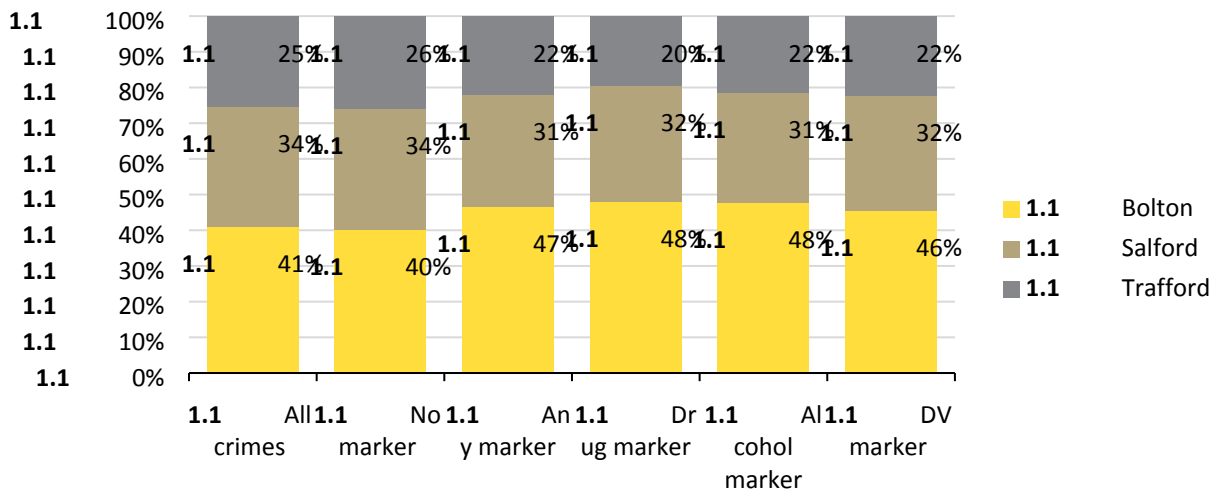
Offending

3.71 A wealth of data is available in relation to offending, domestic violence and substance use. Over the three year period from April 2013 to March 2016 there were 147,681 crimes recorded across Bolton, Salford and Trafford. When crimes are recorded, Greater Manchester Police (GMP) can flag whether the offence was influenced by drugs or alcohol or whether domestic violence was a factor through the use of 'markers'. Around one-in-seven of all crimes recorded in this period had a drugs, alcohol and/or domestic violence marker.[29]

3.72 The use of the markers has not changed significantly over the past three years and, whilst Bolton, Salford and Trafford vary in the number of offences, there is little difference across the three areas in the proportion of crimes using each marker, as shown below. For this reason data presented is for the three areas combined.

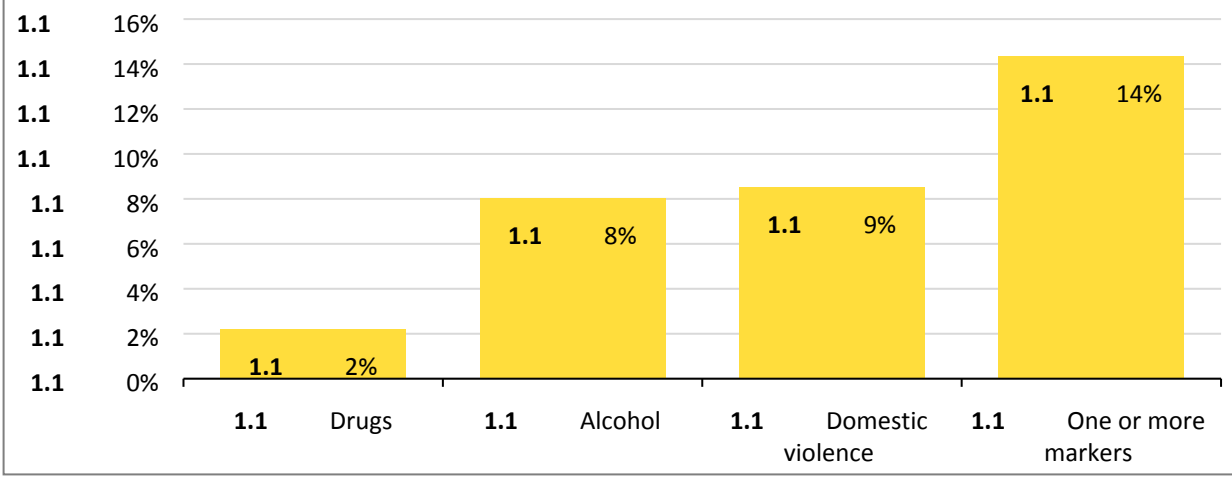
[29] Some crimes had more than one relevant marker attached. All had at least one out of alcohol, drugs or domestic violence.

1.1 Graph 3.19: Share of crimes by markers and District in Bolton, Salford and Trafford, 2013/14 - 2015/16



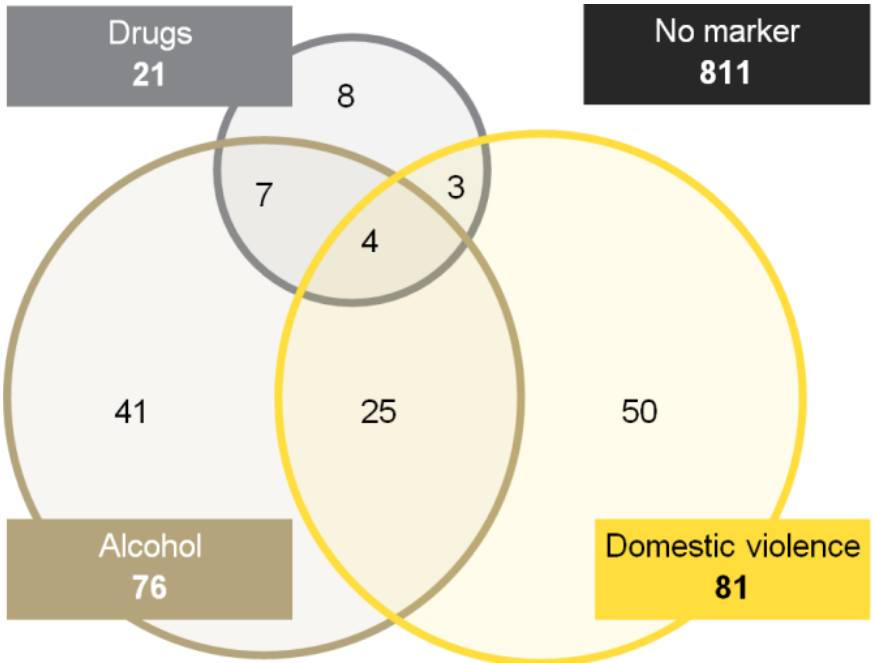
3.73 One-in-twelve crimes were flagged as involving alcohol, with a similar proportion involving domestic violence and far fewer, around one-in-fifty, involved drugs.[30] Some crimes have more than one of these markers. The chart below shows the frequency of use of the different markers.

1.1 Graph 3.20: Frequency of crime markers in Bolton, Salford and Trafford, 2013/14 - 2015/16



[30] This frequency is lower because these are where each crime had only one marker attached (i.e. only involving alcohol, only involving drugs or only involving domestic violence)

3.74 The crossover between the use of the markers is shown in the chart below. The figures shown relate to the number of offences using the markers within an average week across all three areas[31].



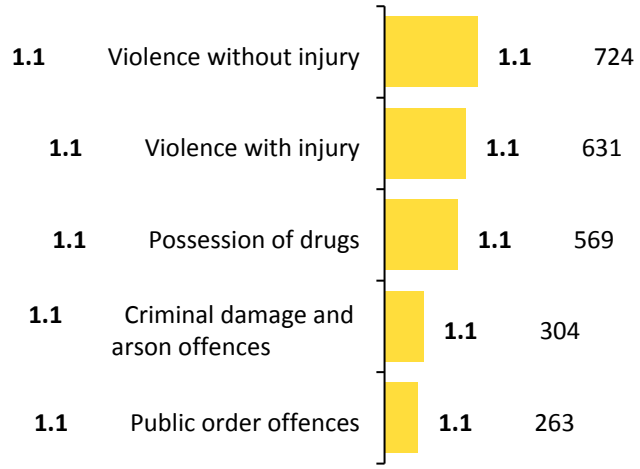
3.75 Crimes are grouped together using a 'crime tree', which has four levels. The first level has the broadest categories of crimes; these are then subdivided into narrower groupings at each subsequent level. Below are three charts showing the number and percentage of offences that use the three markers at this first level. Victim-based crimes have the highest number of crimes with each of the three markers. However, for crimes flagged as having drug or alcohol involvement the percentage was higher for non-victim based crimes.

3.76 Further sub-divisions give more detail on the types of offences that are most associated with drugs, alcohol or domestic violence. The charts below show the top five crime types for each marker in terms of number of offences and percentage of offences that have a marker.

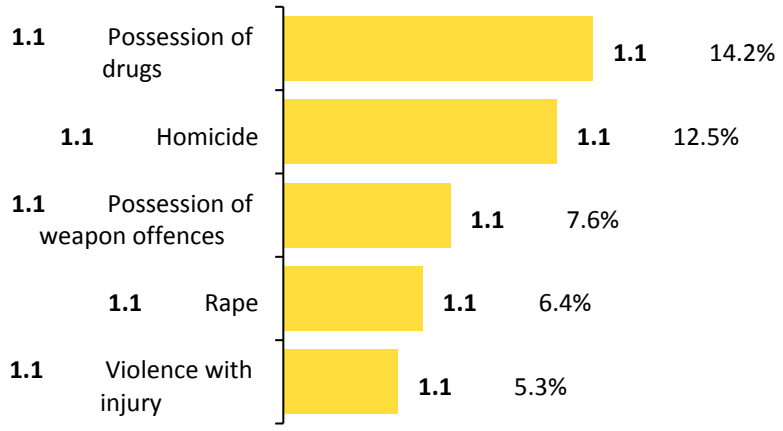
3.77 The drugs influence marker is used less than the other two. *Violent crimes* have the highest number of offences but, unsurprisingly, *Possession of drugs* has the highest proportion. *Homicide* is second highest but numbers are very low.

[31] Figures may not sum to totals due to rounding

1.1 Graph 3.21: Crimes with Drug Influence Marker Use in Bolton, Salford and Trafford (2013/14 - 2015/16)

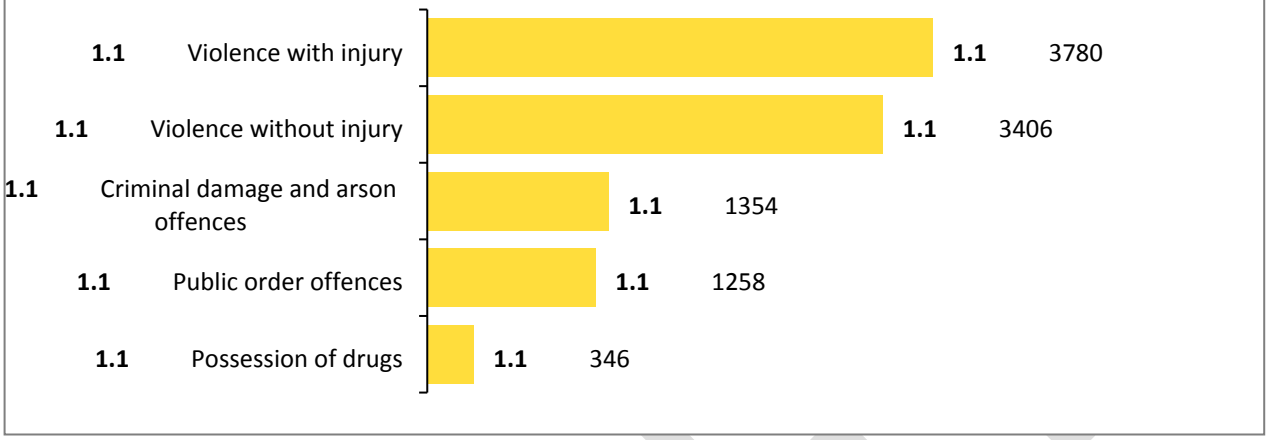


1.1 Graph 3.22: Crimes with Drug Influence Marker Use in Bolton, Salford and Trafford (2013/14 - 2015/16)

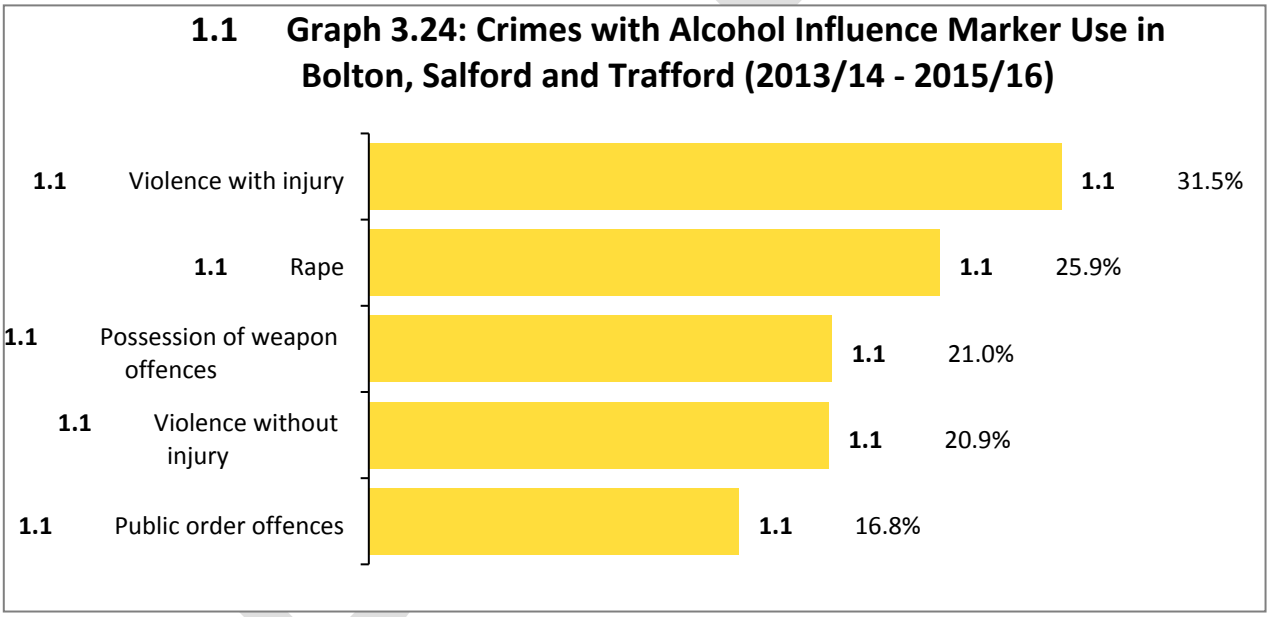


3.78 *Violent crime* also accounts for the highest number of alcohol influenced crimes; almost a third of all *Violence with injury* crimes have an alcohol influence. Around a quarter of *Rape* offences are influenced by alcohol.

1.1 Graph 3.23: Crimes with Alcohol Influence Marker Use in Bolton, Salford and Trafford (2013/14 - 2015/16)



1.1 Graph 3.24: Crimes with Alcohol Influence Marker Use in Bolton, Salford and Trafford (2013/14 - 2015/16)



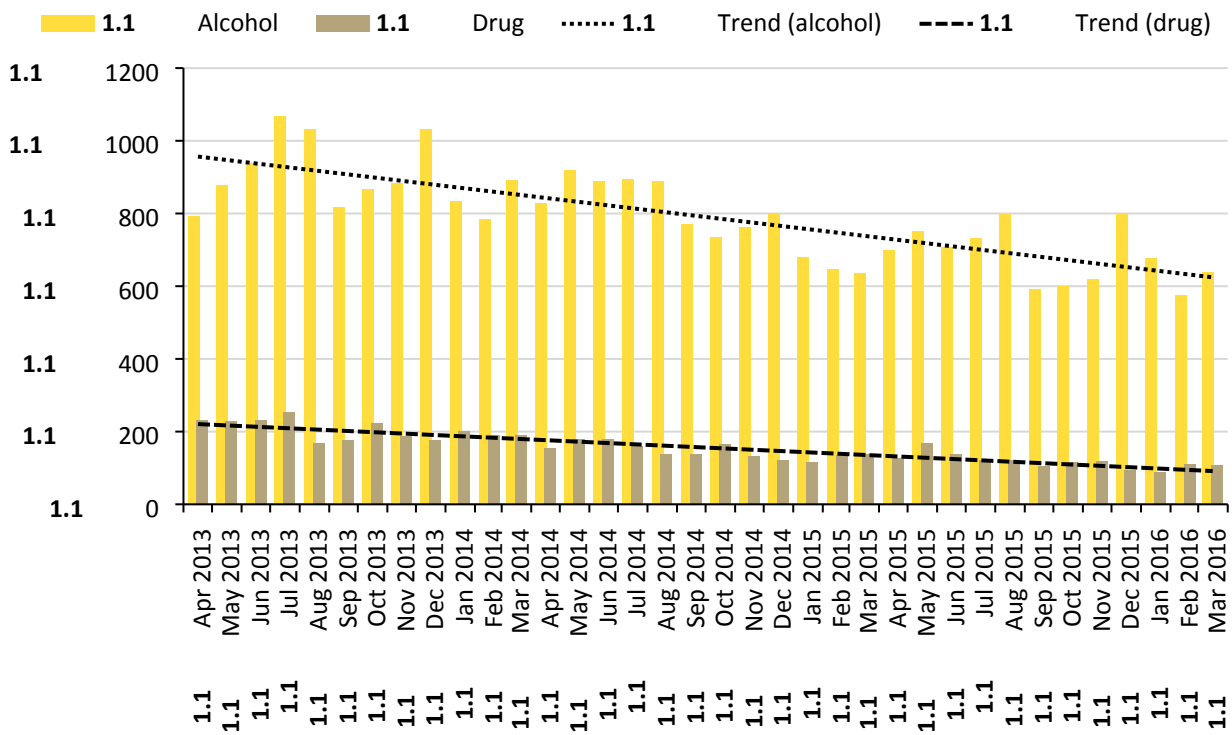
3.79 An alternative way of reviewing policing evidence is to consider the degree to which drugs and alcohol are mentioned in the GMP call handling system data – i.e. the records of the initial call from the public to the police. Not all incidents become recorded crimes, so this provides a wider breadth of policing activity that also covers antisocial behaviour, public safety & welfare related incidents, and other calls for service.

3.80 Data on incidents in Bolton, Trafford and Salford logged by GMP call handlers show a falling number of reports relating to drugs and alcohol between April 2013 and March 2016. There has been an annual fall of 24% in recorded drug related incidents over

three years and a smaller (13%) fall in recorded alcohol related incidents. During this period the overall number of incidents logged fell by 5% per year.

3.81 There is a discernible seasonal effect from the data on alcohol related incidents with peaks in the summer months and in December.

1.1 Graph 3.25: Drug and Alcohol Related Incidents, Bolton, Salford And Trafford (2013/14 - 2015/16)



4 Complex Dependency

4.1 Drug and alcohol misuse are often intertwined with a range of mental health and social problems, including: depression and anxiety; domestic abuse; loss; trauma; housing needs; unemployment; debt; offending; and severe mental disorders such as schizophrenia.

4.2 Tackling complex dependency is a key reform priority for GM. The evidence base that has been generated through the strands of our reform programme working with complex cohorts makes it clear that substance misuse can often be a root cause, or symptom, of other complex needs experience by families or individuals. People presenting to various different services will overlap, so providing an effective response to substance misuse as a part of an integrated, holistic intervention for a person or family in their context is a central element of our shared complex dependency challenge in GM.

4.3 This chapter discusses some of these complexities that are often seen alongside substance misuse. It is designed to place an emphasis on these complexities and highlight these patterns. The individuals with these needs can be found both in and out of treatment. This includes a focus on:

- (Un)employment
- Justice and Rehabilitation
- Families, Children and Safeguarding
- Housing and Homelessness
- Mental Health

4.4 This chapter should not be read in isolation from either the preceding (3) or subsequent (5) chapters. Many of the same topics and themes are discussed in these chapters, and are strongly correlated. Data that appears in different chapters, particularly when covering similar themes, should not be considered in isolation.

4.5 A report by Lankelly Chase (2015) found that the numbers of people with a substance misuse need alone, particularly OCUs, was decreasing. The numbers of people with a substance misuse need and a homelessness and/or offending need, is increasing. This suggests, particularly for those long-term opiate users still in treatment after long periods of time, that some clients are becoming more complex.

(Un)employment and Substance Misuse

4.6 Data from the GM Working Well programme indicates that in 2015, 17.5%[32] of clients stated that substance misuse is a barrier to work. When isolated for Bolton (14.4%) and Salford (18.4%) and Trafford (17.2%), the figure is 16.6%.

4.7 National DWP analysis on IB/SDA and ESA claimants has indicated that, across England, 1 in 15 working-age benefit claimants are dependent on drugs (primarily heroin and/or crack cocaine), and that 1 in 25 are suffering from alcohol dependency.

4.8 PHE benchmarking data on the number of claimants of IB/SDA and ESA with alcohol as the main disabling condition suggests that there are over 4,000 claimants across GM, and over 1,000 claimants across Bolton, Salford and Trafford. The crude claimant rate per 100,000 residents in GM is 77% higher than the England average (the Bolton, Salford and Trafford combined rate, similarly, is 70% higher). Viewed in a ranked list of 150 local authority areas, the claimant rate places Salford 7th and Bolton 17th on a national scale (Trafford is ranked 70th, close to the national average on this measure) (PHE, 2015.)

Table 4.1: Claimants of Incapacity Benefit/Severe Disablement Allowance or Employment and Support Allowance, whose main medical reason is alcoholism[33]

Area	2015 Rate per 100,000	2015 Count (Rounded)
Bolton	252	430
Salford	295	460
Trafford	141	200
BST Cluster	233	1,090
Greater Manchester	243	4,170
England	137	45,950

Justice and Rehabilitation

4.9 Criminal justice has been a central element of the Greater Manchester programme of public service reform for over five years, stemming back to GM's role as one of four original community budgets pilot, and a parallel designation as a Ministry of Justice 'Justice Re-investment' local pilot area. Work over recent years has culminated in a justice devolution deal that gives further freedom and flexibility to Greater Manchester

[32] Percentages calculated out of the total numbers who answered the question. A rating scale of 0-6, where 0 is no impact and 6 is severe impact, is used to rate substance misuse (and other issues) as a barrier to work. To arrive at this percentage we have assumed a cut off of 3 (all those who said 3, 4, 5 or 6 in the scale. If we change the figure to identify anyone who said substance misuse had some impact, then the percentage changes to 22% for GM, 17.9% for Bolton, 23.9% for Salford and 22.5% for Trafford (average 21.4%).

[33] Working age persons (males aged 16-64 years, females aged 16-61 years)

Combined Authority (GMCA) and the Mayor/Police and Crime Commissioner around criminal justice and offender management.

4.10 The Lankelly Chase Foundation estimates that for every 1,000 working age people in the cluster area, 4.3 people will have a history of offending and a substance misuse need (Bolton, 4.6; Salford, 6.0; and Trafford, 2.4).[34] The Salford figure is the highest in GM. This equates to an estimated population of 2,050 people across the three areas. An additional 1,000 people are estimated to have a combination of needs that also includes homelessness. There is evidence to suggest that this relates to persistent, low-level offenders serving short-term prison or community sentences, i.e. those people who constitute regular and costly individuals.

Table 4.2: Estimated numbers of people experiencing complex dependencies[35]

Area	Homelessness only	Offending only	Substance misuse only	Offending & substance misuse
Bolton	700	990	1,330	800
Salford	540	980	1,240	910
Trafford	190	390	660	340
BST cluster	1,430	2,360	3,230	2,050
GM	4,550	8,690	13,860	7,830

4.11 The development of priority themes and priority cohorts in respect of Justice and Rehabilitation means that there is now more evidence than ever before on the make-up and needs of GM offenders. A headline summary is provided here, and fuller details are available in the relevant Appendices.

In Police Custody

4.12 A recent dedicated health needs assessment considering GM custody suites found that nearly half of all detainees (44%) were identified during initial screening as requiring a further intervention from the custody healthcare provider. A physical health need was identified in 59% of cases, but only 15% of these were registered with a GP. Greater Manchester is currently in the process of awarding a contract that will put in place a new integrated service in police custody, covering custody healthcare services and wider liaison and diversion functions. This is the first integrated contract of its kind, and it will be vital for clear pathways to be established between custody suites and the local substance misuse treatment offer in Bolton, Salford and Trafford.

[34] This data is based only on the numbers of people accessing services for their requisite need. The scale of need in the population may be higher.
[35] Estimated for each area using prevalence rates above

4.13 The custody health needs assessment undertook bespoke analysis on the presenting needs of detainees, and found that 12% of sampled cases were alcohol dependent, 35% had a history of alcohol misuse, 23% had a history of illicit drug use, and 18% had recently used drugs (including prescription drugs) (Claire Cairns Associates, 2015). The evidence also suggests that alcohol is a stronger feature of the local GM profile of female detainees in custody than it is for males.

Offenders serving a community sentence or post-custody licence under CRC supervision

4.14 Some of the richest evidence available on the links between substance misuse and offending within Greater Manchester is available specifically in relation to individuals who have been convicted of an offence and are currently serving either a community sentence or period of post-licence supervision under the management of the Greater Manchester Community Rehabilitation Company. Sample data[36] has been provided that describes the criminogenic risk factors identified by CRC staff when undertaking Offender Assessment System (OASys) assessments on offenders resident in GM.

4.15 CRC assessments judge that, across the cluster as a whole, drug misuse is a criminogenic risk factor for 27.7% of offenders, whilst alcohol misuse is linked to offending behaviour in 41.1% of all cases. The association is recorded more frequently for Bolton offenders, particularly in relation to alcohol misuse.[37]

Table 4.3: Community Rehabilitation Company – Profile of Live Caseload (Aug 2016) Offender Assessment System (OASys) risk assessment ratings, % of offenders where drug / alcohol misuse is linked to the risk of reoffending

Area	Drug misuse (section 8 OASys)	Alcohol misuse (section 9 OASys)
Bolton[38]	28.7%	46.0%
Salford[39]	29.0%	38.0%
Trafford[40]	23.5%	38.1%
BST Cluster	27.7%	41.1%
GM[41]	28.2%	38.7%

[36] Data provides a snapshot picture relating to the total 'live' CRC caseload at the point of extraction (August 2016). Not every case under CRC management has a full OASys assessment (e.g. standalone risk assessment is made in some instances, for example in respect of offenders sentenced to 'standalone' unpaid work or curfew orders. In addition, some offenders on the 'live' caseload will not have hit their 'target' date for full OASys assessment at the point the dataset was compiled.
[37] CRC colleagues advise that – for reasons explained in ft 36 – this only relates to instances where an OASys is available and data has been captured. Around 30-35% of CRC cases are estimated to potentially have some kind of substance misuse issue that is not captured in OASys.
[38] N=466
[39] N=457
[40] N=247
[41] N=4,772

4.16 The appendices provide a full visualisation of assessed risk factors for the Bolton, Salford and Trafford cohorts, as compared to the overall GM profile for all criminogenic risk factors. This shows a range of complex needs, and highlights in particular:

- the markedly high numbers of offenders in Bolton for whom accommodation is judged to be directly associated with risk of reoffending;
- the relatively high levels of risk associated with financial / income issues for Salford offenders; and
- the general pattern of elevated risk for Bolton & Salford offenders as compared to Trafford offenders (also this is less notable for some risk areas than others).

Offenders serving a community sentence or post-custody licence under NPS supervision

4.17 Equivalent OASys data to that described above has also been supplied by the National Probation Service in relation to criminogenic risk factors. Somewhat unsurprisingly, given the remit of NPS to manage higher-risk offenders, the OASys profile suggests a higher prevalence of risk relating to substance misuse. NPS data suggests that drug misuse is a risk factor for 49.5%of all offenders in Bolton (52.2%), Salford (45.2%) and Trafford (52.2%). Alcohol misuse is judged as a risk factor linked to reoffending for 55.9% of cases in Bolton (60.1%), Salford (51.4%) and Trafford (55.1%). The association of alcohol misuse and reoffending for Bolton offenders is therefore marked both in the NPS and the CRC profile.

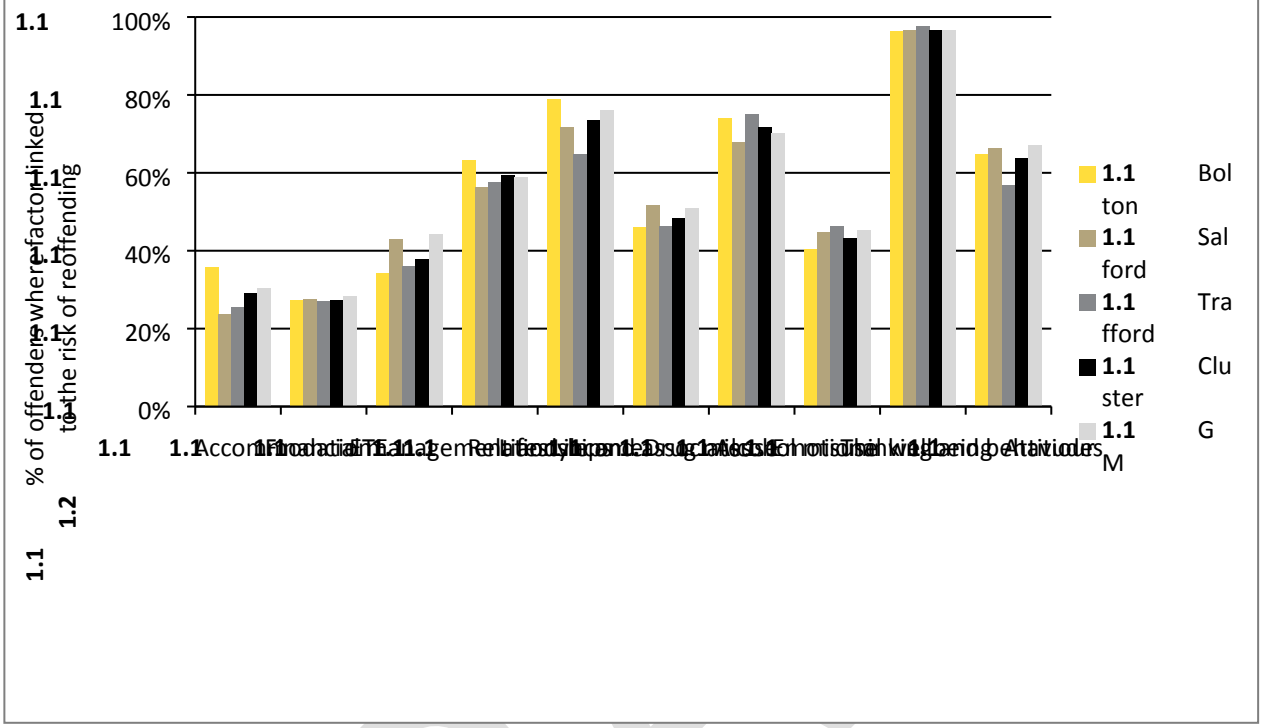
Community Sentences and Licences

4.18 A sub-set of caseload data (both in relation to NPS[42] and CRC caseloads) was analysed to look specifically and in isolation at offenders for whom the OASys has flagged a drug or alcohol misuse issue contributing to the risk of reoffending. The CRC data provided a sample of 2,631 offenders across GM, and 670 offenders in the Bolton/Salford/Trafford cluster). The NPS data provided a slightly larger sample of 3,233 offenders across GM, and 861 offenders in the Bolton/Salford/Trafford cluster).

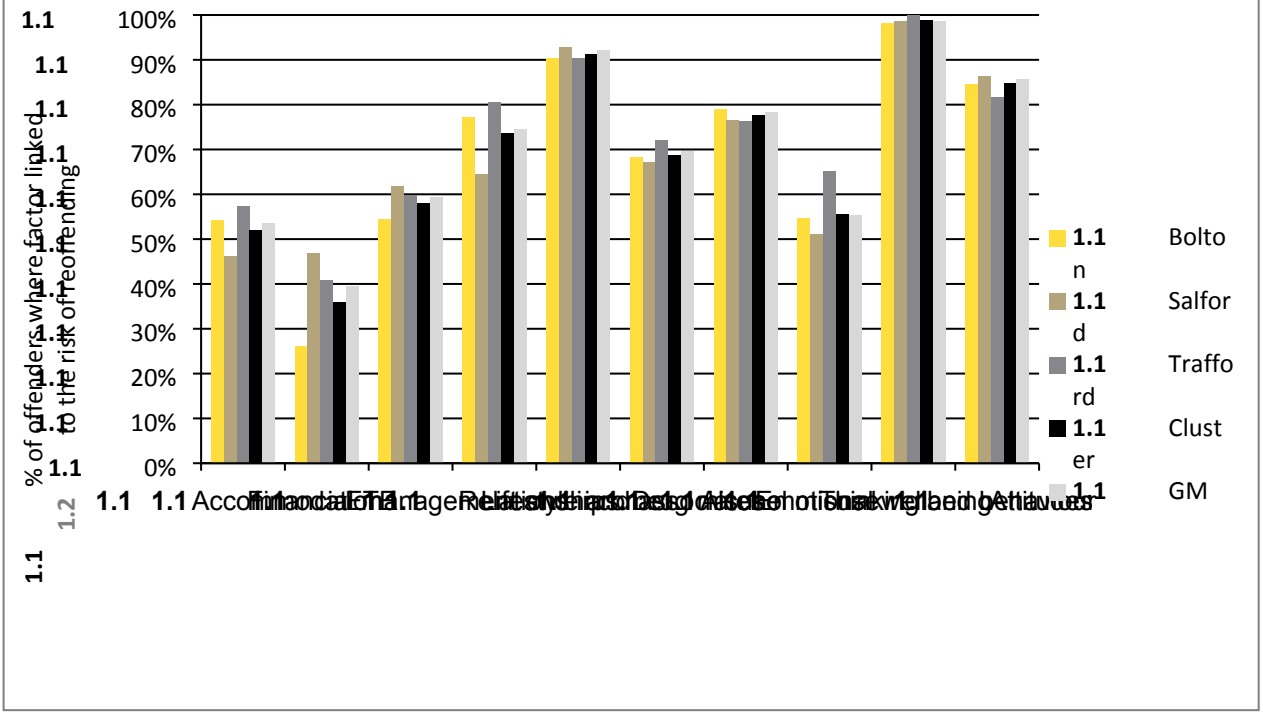
4.19 The picture of multiple complex needs is presented below:

[42] National Probation Service

1.1 Graph 4.1: Profile of CRC Live Caseload, August 2016 - Sample (Drug / Alcohol Issues = Yes) OASys risk assessment ratings



1.1 Graph 4.2: Profile of NPS NW Live Caseload (GM resident offenders) - Sample (Drug / Alcohol Issues = Yes) OASys risk assessment ratings



ICO: Young, adult males (18-25) at risk of short-term custody

4.20 One important sub-cohort under CRC supervision is cohort of young, adult males at risk of short-term custody who are made the subject of an "Intensive Community Order" (ICO) – a community order for GM resident offenders aged 18-25 who would otherwise have been sentenced to a prison sentence of less than twelve months. Snapshot data was provided by the CRC in respect of 214 GM-resident offenders with a 'live' ICO order, 41 of whom are residents of Bolton, Salford and Trafford. Taking into account the small sample sizes involved, the insight this provides relates to the seemingly disproportionate prevalence of drug misuse amongst offenders residents within the cluster area that are currently subject to ICO (nearly two thirds of the 41 cases).

Table 4.4: CRC Profile of ICO Caseload (Aug 2016): OASys risk assessment ratings, % of offenders where drug / alcohol misuse is linked to the risk of reoffending

Area	Drug misuse	Alcohol misuse
GM ICO[43]	46.7%	36.9%
BST Cluster[44]	63.4%	41.5%

Whole System Approach to Women Offenders

4.21 In 2014, a programme of work commenced to develop a consistent and common 'whole system approach' for women offenders across GM, building on the emergent 'women's centres' models in Bolton (Eve's Space project), Salford (Together Women project) and Manchester (Women Matta project). The whole system approach has developed a gender-specific common offer to support large numbers of vulnerable women across GM, and helping to reduce reoffending by tackling underlying needs, including substance misuse.

4.22 Bespoke data provided for this needs assessment helps to provide a clear profile of the varied needs of women who have accessed the local systems in Bolton, Salford and Trafford. [45] This is taken from a licensed Outcomes Star™ monitoring tool which measures presenting needs on a 1-10 scale across 12 pathways.[46]

4.23 The high proportions of Bolton women that are identified with support needs is notable, given comparisons to the other areas and to GM. 67.1% women offenders from Bolton are judged to have a substance misuse related need, compared to 41.5%

[43] N=214
[44] N=41
[45] Care should be taken when interpreting the results for Trafford women offenders, given the small sample that applies.
[46] Needs pertaining to substance misuse are screened. This is not separated into drug and alcohol misuse-related needs.

in Salford, 32.4% in Trafford and 48.2% across GM. Accommodation-related needs are also higher in Bolton.

1.1 Graph 4.3: Whole system approach to women offenders: Profile of women assessed to March 2016

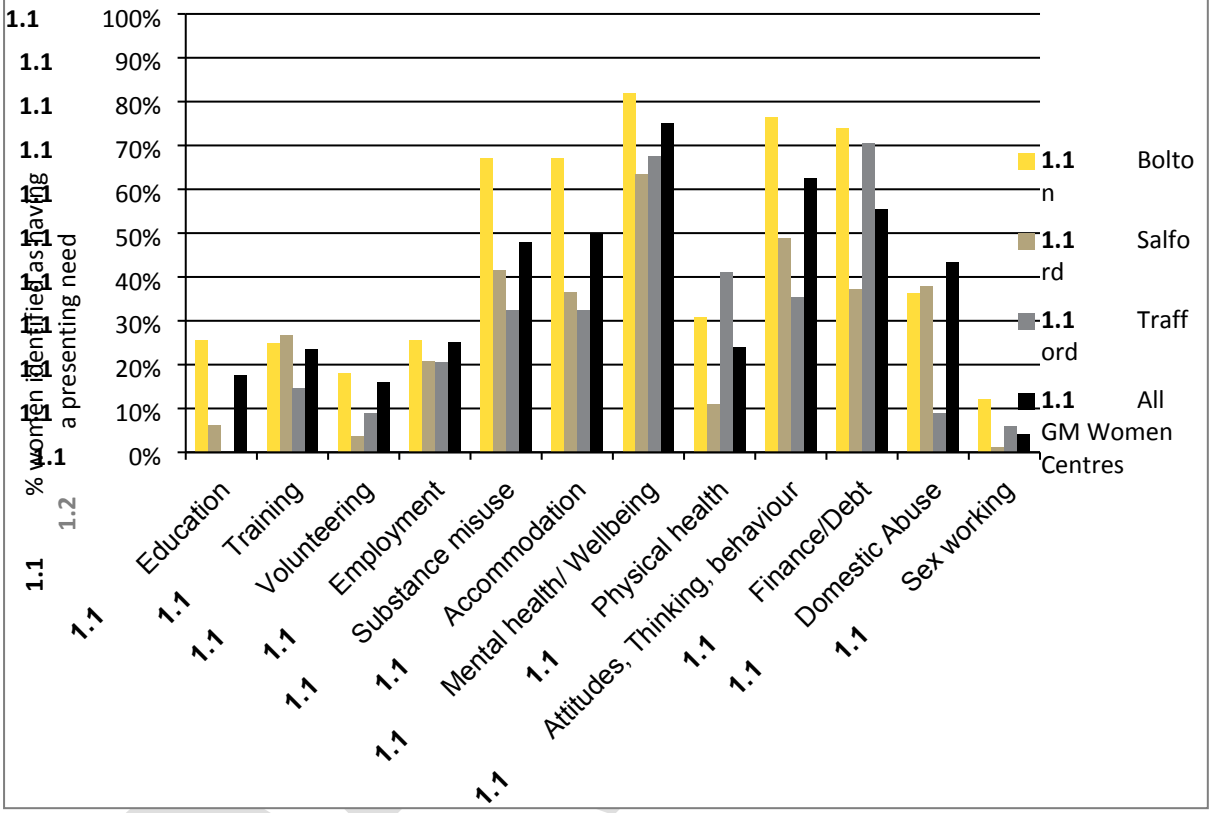


Table 4.5: Whole system approach to women offenders: Profile of women assessed to March 2016

Pathway	Bolton[47]	Salford[48]	Trafford[49]	All GM women centres[50]
Education	25.5%	6.1%	0.0%	**17.6%**
Training	24.8%	26.8%	14.7%	**23.4%**
Volunteering	18.1%	3.7%	8.8%	**16.1%**
Employment	25.5%	20.7%	20.6%	**25.0%**
Substance misuse	67.1%	41.5%	32.4%	**48.0%**
Accommodation	67.1%	36.6%	32.4%	**49.9%**
Mental health/ Wellbeing	81.9%	63.4%	67.6%	**75.1%**
Physical health	30.9%	11.0%	41.2%	**24.0%**

[47] N=149
[48] N=164
[49] N=34
[50] N=1,074

Attitudes, Thinking, behaviour	76.5%	48.8%	35.3%	**62.5%**
Finance/Debt	73.8%	37.2%	70.6%	**55.5%**
Domestic Abuse	36.2%	37.8%	8.8%	**43.3%**
Sex working	12.1%	1.2%	5.9%	**4.2%**

4.24 Data comparing the needs of women with and without substance misuse needs shows that substance misusing women offenders are twice as likely to have accommodation needs, a third more likely to have a mental health/wellbeing need, and a third more likely to have debt/finance issues.

Table 4.6: Whole system approach to women offenders: Profile of women assessed in 2015/16, all cluster, comparing needs of substance misusing women and non-substance misusing women

Pathway	Women Offenders with substance misuse need[51]	Women Offenders without substance misuse need[52]
Education	13.4%	9.7%
Training	23.5%	26.2%
Volunteering	11.2%	9.5%
Employment	22.9%	22.6%
Accommodation	62.0%	35.7%
Mental health/ Wellbeing	82.7%	60.1%
Physical health	31.3%	13.1%
Attitudes, Thinking, behaviour	74.9%	42.8%
Finance/Debt	64.8%	47.0%
Domestic Abuse	39.1%	29.2%
Sex working	12.3%	0.0%

Offenders in Prison

4.25 The majority, 38%, of adult males in treatment in GM prisons are in treatment for heroin use. For women, the rate is much higher, at 52%. Alcohol is the second highest treatment requirement for both groups, at 19% and 29% for men and women respectively (NDTMS, 2015e).

4.26 Seizures of synthetic cannabinoids (spice) in English and Welsh prisons increased from 15 in 2010 to 430 in 2014 (PRT, 2015). HMI Prisons states that synthetic cannabinoids were identified as a concern in 37% of men's prisons inspected in 2013/14, and 64% in 2014/15 (HMI Prisons, 2015). A report from HMP Buckley Hall in 2015 indicated that just over half of ambulance call outs were as a result of prisoners taking NPS (IMB, 2015).[53]

[51] N=179
[52] N=168
[53] The same period also witnessed a large increase in the number of ambulance call outs as a result of this. The report also stated that official statistics significantly under-report the prevalence of Spice in prisons.

Families, Children and Safeguarding

4.27 Tackling substance misuse is an integral element of the Troubled Families programme. Analysis of national profiling data in 2014 suggested that 14% of families within the national programme to date included an adult dependent on alcohol and 13% had an adult dependent on drugs[54] (DCLG, 2014).

4.28 Over time, the government's commitment to a five-year national study looking at the impact of the family key-work approach (the National Impact Study, NIS) will help to further develop the troubled families evidence base. This will provide benefit both for national insight and local decision making; a common set of Family Progress Data (FPN) will include standardised data at the Local Authority level specifically in relation to alcohol and drug dependence. However, at the time of writing this needs assessment, robust local data for the whole of GM is not yet available, and so excerpts from bespoke local data analysis have been compiled as follows:

- **Trafford** – Trafford Council have undertaken an analysis of substance use amongst their first and second Troubled Families Cohorts. The latest analysis, in September 2016, covered 448 families and 932 individuals. 28%[55] of families and 16%[56] of individuals were identified as having drug and/or alcohol problems for which they were receiving treatment. In 2015[57], these figures were 17%[58] and 10%[59] respectively. In the 15/16 financial year, 13% of individuals in treatment in Trafford were part of the Troubled Families cohort, rising to 44% of those in treatment for non-opiate substances only.
- **Salford** – In 2014/15, the national Troubled Families worked intensively with seven 'exemplar' areas to build up a detailed picture of the costs and fiscal benefits resulting from their local delivery of the programme. Salford, one of the seven exemplars, identified financial benefits from their local programme to health services in the order of £1,700 per family on average, attributed in significant part to *"a nearly 60% reduction in alcohol misuse and a 50% reduction in drug misuse in the 12 months following intervention."*[60]

4.29 Data from NDTMS indicates that 23.9% (667) of people starting on a new treatment journey in Bolton, Salford and Trafford in 2015/16 lived with children (with only limited differences in this percentage between areas). A further 39.2% are noted as having children but not living with them.

[54] Identified through a combination of clinical diagnosis and key worker assessment
[55] 125 families
[56] 147 individuals
[57] Troubled Families Cohort 1
[58] 72 families
[59] 83 individuals
[60] *The Benefits of the Troubled Families Programme to the Taxpayer* (DCLG, 2015)

4.30 Furthermore, 2.2% of women starting on a new treatment journey in Bolton (2.9%), Salford (2.0%) and Trafford (1.4%) in 2015/16 disclosed that they were pregnant.

4.31 There is strong evidence to suggest that many patterns of behaviour outlined above are formed in, or strongly affected by, childhood and young adulthood. For example, in the Troubled Families data, 23% of families with an adult drug user in this sample also had a child with a substance misuse problem, compared to 13% where there was no adult drug user. And 20% of families with an adult with an alcohol misuse problem had a child with a substance misuse problem, compared to 13% families where there was no adult misusing alcohol (DCLG, 2014).

4.32 In addition, 31.94% of young people in treatment in Bolton (28.47%), Salford (42.53) and Trafford (24.83%) are affected by other peoples' substance use.

4.33 It is highly likely that some of our most vulnerable young people using NPS and club, over-the-counter and prescription drugs will at some point require treatment, and this is most effective when provided before use has escalated. A blended approach that combines an 'early help' offer with a focus on complex dependency provides a means through which to prevent escalation, and to focus on high risk, high cost and high-need individuals and families.

Housing and Homelessness

4.34 Lankelly Chase estimates that in Bolton (1.9), Salford (1.8) and Trafford (0.9), for every 1,000 working age people, approximately 1.5 will be homeless and have a substance misuse problem. This equates to an estimated population of 750 individuals across Bolton, Salford and Trafford.[61]

Table 4.7: Estimated numbers of people experiencing complex dependencies[62]

Area	Homelessness only	Offending only	Substance misuse only	Homelessness & substance misuse
Bolton	700	990	1,330	340
Salford	540	980	1,240	280
Trafford	190	390	660	130
BST cluster	1,430	2,360	3,230	750
GM	4,550	8,690	13,860	3,080

Mental Health

4.35 20.2% of people starting on a new treatment journey in Bolton (21.5%), Salford (20.6%) and Trafford (16.9%) in 2015/16 had a dual diagnosis. However, poor mental

[61] See appendices for full tables
[62] Estimated for each area using prevalence rates above

health needs to be taken into consideration as a factor in its own right, aside from dual diagnosis.

4.36 There is a lack of robust data in this area. One of the best indicative measures of co-existing mental health problems in the drug/alcohol treatment population is captured within NDTMS and tracked in PHE's 'Co-existing substance misuse and mental health issues' Fingertips Tool.[63]

4.37 The latest 2014/15 data shows that in Bolton, Salford and Trafford 14.8% of people, when assessed for drug treatment, were receiving treatment from mental health services for reasons other than substance misuse. This is marginally lower than the 2013/14 figure. The cluster figure is lower than the GM equivalent proportion (21.9%), in part because the percentage figure for people in Trafford is markedly lower, and because of disproportionately higher figures for Manchester and Rochdale.[64]

4.38 The 2014/15 data shows that in Bolton, Salford and Trafford 13.1% of people were receiving treatment from mental health services at the time of their alcohol treatment assessment. This is an increase on the 2013/14 figure (11.7%). The GM equivalent figures are substantially higher (19.6% in 2014/15; 22.6% in the previous year). However, the GM percentage is skewed by disproportionately high figures for Manchester and Rochdale.

Table 4.8: Percentages receiving treatment for mental health alongside alcohol and/or drug treatment

	2013/14		2014/15	
Area	**Alcohol**	**Drugs**	**Alcohol**	**Drugs**
Bolton	16.7	16.1	17.2	17.0
Salford	12.6	16.9	16.0	18.7
Trafford	4.6	12.9	5.7	7.0
BST Cluster	11.7	15.5	13.1	14.8
GM	22.6	20.1	19.6	21.9

[63] The PHE guidance highlights: 'The measure is indicative of levels of co-existing mental health problems in the drug treatment population. However, it should not be regarded as a comprehensive measure of dual diagnosis as it only captures whether a person is receiving mental health treatment at a given point in time.'

[64] See appendices for full data, including for other areas in GM

5 Treatment Population Needs Profile

5.1 This chapter provides an overview of the needs of service users in treatment in Bolton, Salford and Trafford.

5.2 This chapter should not be read in isolation from the preceding two (3 and 4) chapters. It is recommended that comparisons are made between the former and current chapters to consider the extent to which need in the general population is being met by the current treatment systems, where gaps arise, and where further work is required.

5.3 This chapter covers:

- Numbers in treatment;
- Substance use by substance type;
- New presentations to treatment;
- Other presenting needs, including housing and employment; and
- Young people in treatment (presenting needs and substance types)

Substance Use

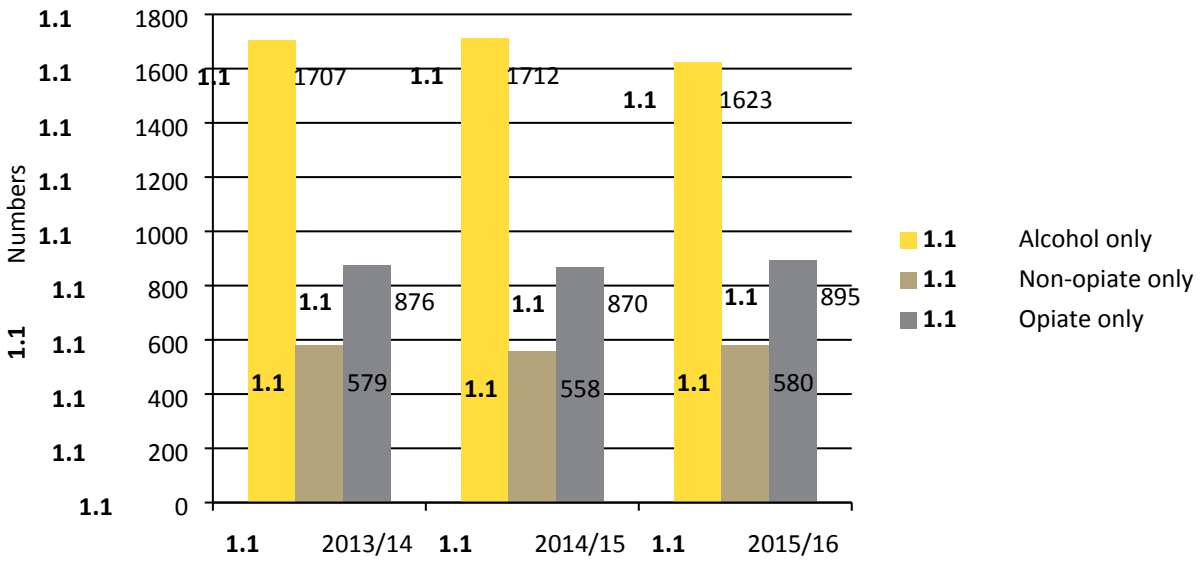
5.4 In 2015/16, there were 5,199 adults in treatment across the three areas. This is made up of 2,169 in Bolton, 1,904 in Salford and 1,126 in Trafford. There were 2,809 new presentations to treatment in this year: 1,014 in Bolton, 1,160 in Salford and 635 in Trafford.

5.5 In 2015/16, 17.2% of the treatment population used opiates only. However, this varied largely across the three areas, ranging from 21.3% (Bolton), 15.4% (Salford) and 12.3% (Trafford).

5.6 In 2015/16, 11.2% of the treatment population used non-opiate drugs (excluding alcohol) only. This is fairly consistent across the three areas, ranging from 7.9% (Bolton), 13% (Salford) and 14.2% (Trafford). This has increased from 10.8% in 2013/14 and 10.7% in 2014/15.

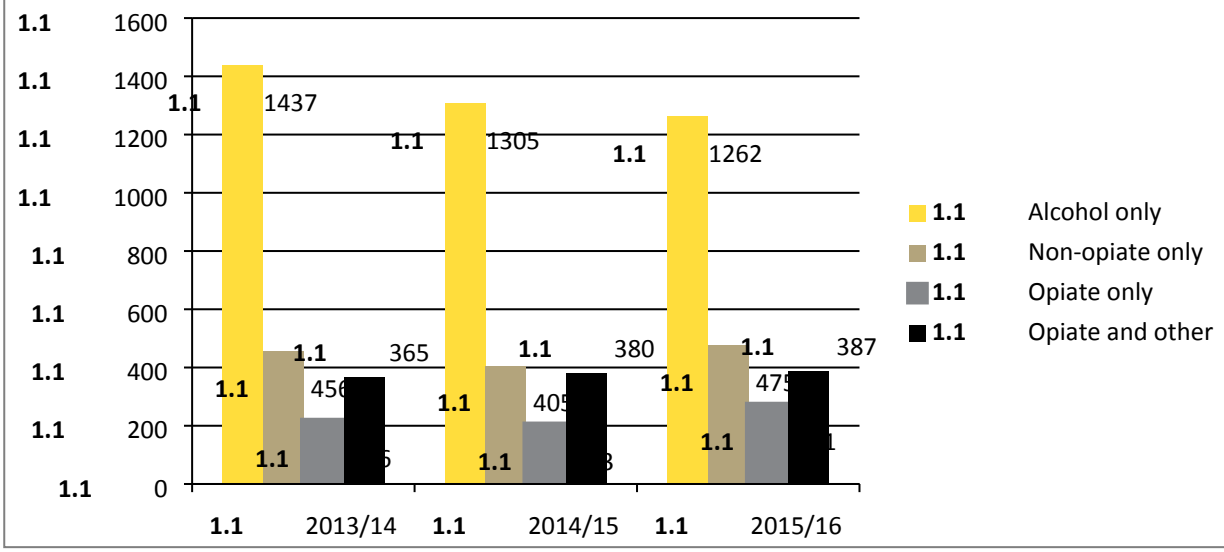
5.7 In 2015/16, 31.2% of the treatment population used alcohol only. This is fairly similar in Salford (34%) and Trafford (36.8%), but lower in Bolton at 25.8%.

1.1 **Graph 5.1:Numbers in treatment in across all areas, using:**



5.8 When considering new presentations to treatment, the picture is fairly similar.

1.1 **Graph 5.2: New presentations to treatment across all areas, using:**



5.9 Since 2006/7, there has been a 66% decrease in the numbers of people using Opiates and Crack in the treatment system across the three areas. There has been a 48% increase in people in treatment for non-opiate drug use in the same time period across the three areas.

Table 5.1: Substances used (in treatment) across all three areas[65]			
Substance	**2006/7**	**2015/16**	**Percentage change**
Opiates	2111	1713	-18.9%
Opiates and Crack	2157	739	-65.7%
Crack	532	43	-91.9%
Benzodiazepines	254	382	+50.4%
Amphetamines	212	350	+65.0%
Cocaine	181	529	+192.3%
Cannabis	431	977	+126.7%

5.10 Between 2013/14 and 2015/16 there was a significant increase in numbers in treatment using NPS across the three areas, from 1 to 36 (split fairly evenly over the three). However, they still represent a minority.

Table 5.2: Successful Completions (No Representations[66])				
	All drugs		**Opiates**	
Area	**13/14**	**14/15**	**13/14**	**14/15**
Bolton	12.7%	12.7%	4.8%	6.3%
Salford	20.4%	21.3%	10.2%	9.1%
Trafford	20.9%	20.8%	9.9%	6.5%
Cluster	18.0%	18.3%	8.3%	7.3%
GM	15.0%	15.2%	7.2%	7.2%

Other needs

5.11 In 2015/16, 15.76% of people starting on a new treatment journey across all three areas had some identified housing need on entry to treatment. Slightly higher proportions of people in Salford appear to have housing needs compared to the other two areas.

Table 5.3: Accommodation need at entry (new treatment journey/episode)					
	Bolton	**Salford**	**Trafford**	**All**	
				Number	Percentage[67]
NFA - urgent housing problem	23	54	13	90	3.46%
Housing problem	119	144	57	320	12.3%
No housing problem	870	869	453	2,192	84.24%

[65] Based on number of substances used not numbers of people; an individual may use more than one substance. Note some substances are excluded as they are not directly comparable as more detail on substances used is now collected (e.g. NPS and Prescription Drugs). Figures have been relatively stable between 2013/14-2015/16. See appendices for breakdown by area.
[66] Within six months
[67] Percentage is based on total number of people who answered the question (2,602), not total number overall.

Other/not answered	-	93	112	207	-
Total number of people	1,014	1,160	635	-	2,602

5.12 In Bolton, 21% of clients who did not report working at the start of treatment reported doing so at exit from treatment (2015/16). The figures are 7% in Salford and 17% in Trafford. This compares to a GM average of 23% and a national average of 27%.

Young People

5.13 In 2015/16, there were 627 young people[68] in substance misuse treatment services in Bolton (205), Salford (205) and Trafford (217). There were 452 new presentations to treatment in Bolton (129), Salford (174) and Trafford (149) in 2015/16.

5.14 191 (30.73%) were female and 436 (69.27%) were male.

5.15 The most commonly used substance by young people in treatment is overwhelmingly cannabis, followed by alcohol.[69] Cannabis is consistently in the majority, but ranges from being used 92.07% of times in Bolton, to 78.05% in Salford and 66.36% in Trafford. There appears to be a greater diversity in substances used in Trafford compared to the two other areas.

Table 5.4: Substances used, 2015/16[70]

Drug type	Bolton		Salford		Trafford	
	No.	%[71]	No.	%	No.	%
Cannabis	189	92.07%	160	78.05%	144	66.36%
Alcohol	114	56.30%	79	38.54%	94	43.32%
Amphetamines	4	2.03%	8	3.90%	5	2.30%
Cocaine	14	6.71%	55	26.83%	57	26.27%
Ecstasy	25	13.01%	18	8.78%	24	11.06%
Solvents	1	0.61%	3	1.46%	1	0.46%
Opiates	0	-	3	1.46%	8	3.69%
Crack	0	-	3	1.46%	2	0.92%
NPS	7	1.41%	2	0.98%	15	6.91%
Nicotine	20	9.35%	10	4.88%	1	0.46%

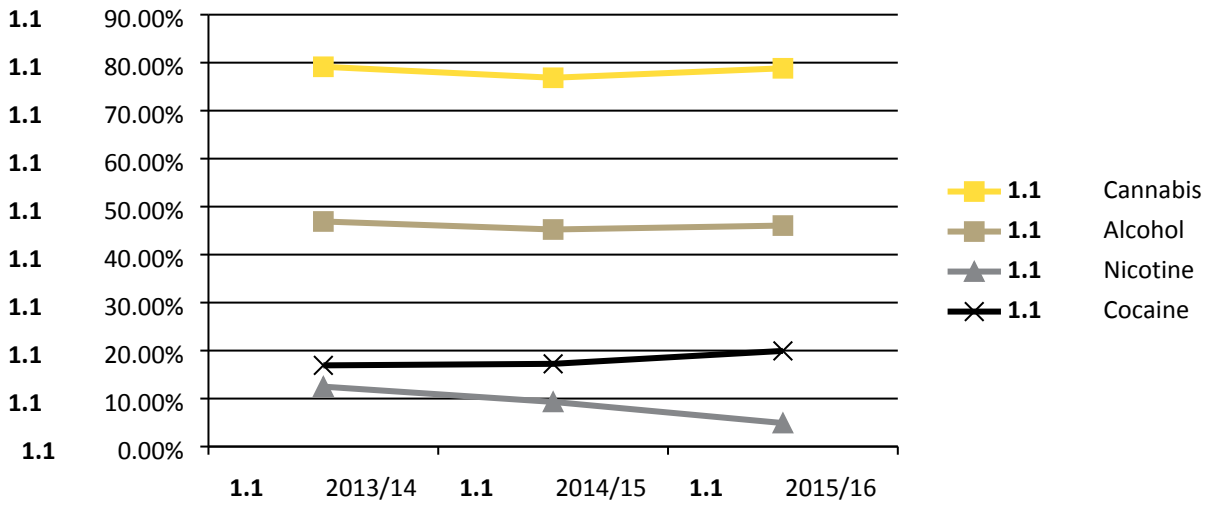
[68] For the purposes of this report, 'Young People' covers those aged up to 25, or all of those people who are or have been in treatment with Young People's Services, regardless of age.
[69] Note that Figures are of YP in specialist substance misuse community services year to date. Substances cited are from any episode for the young person in the year (any citation in drug 1, 2 or 3). Individuals may have cited more than one problematic substance so percentages may sum to more than 100%.
[70] Substances not individuals
[71] Percentages are calculated from total new presentations to treatment, not total number in treatment over the year

Other	2	1.02%	12	5.85%	21	9.68%

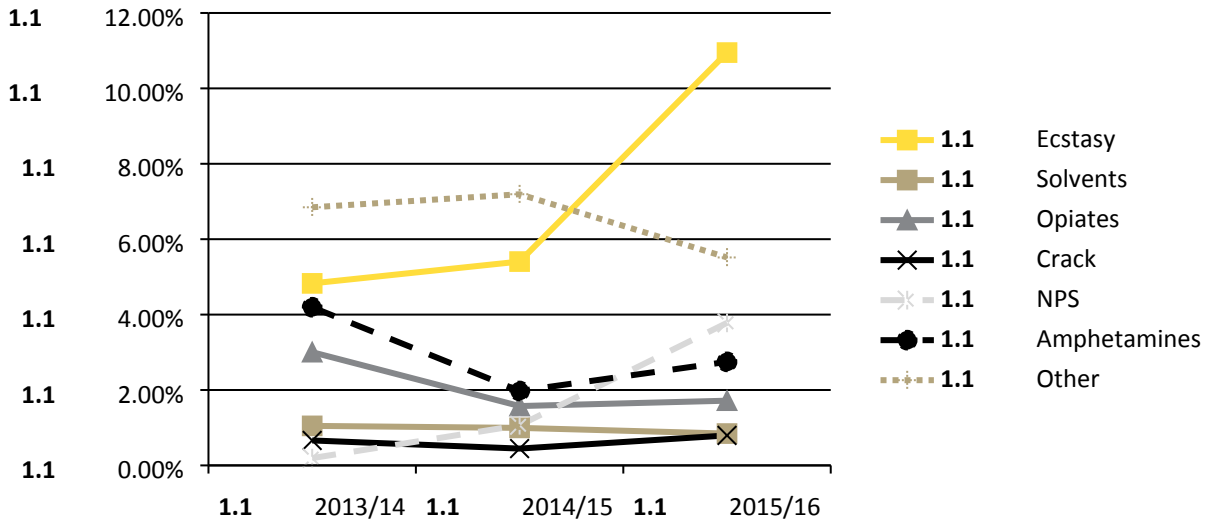
5.16 There are some notable trends when looking at substances used over a three year period.

5.17 The percentage of young people in treatment using Nicotine has reduced by 60.7% (From 12.5% to 4.9%). The percentage of young people in treatment using Ecstasy has more than doubled, from 4.8% to 11%.

1.1 **Graph 5.3: Percentages of young people in treatment using:**



1.1 **Graph 5.4: Percentages of young people in treatment using:**



5.18 Young people in treatment present with a number of substance-use related complexities.

Table 5.5: Substance use related vulnerabilities, 2015/16						
Characteristic	**Bolton**		**Salford**		**Trafford**	
	No.	**%[72] [73]**	**No.**	**%**	**No.**	**%**
Early onset	122	94.37%	174	100%	115	77.18%
Injecting	0	0%	6	3.45%	7	4.70%
High risk alcohol user	12	8.23%	28	16.09%	20	13.14%
Opiate or crack user	0	0%	5	2.87%	6	4.03%
Poly drug user	86	66.52%	101	58.05%	105	70.47%

5.19 The majority of young people in treatment in Bolton (59.61%), Salford (64.34%) and Trafford (50.59%) in 2015/16 had a planned exit.[74] However, this is compared to a national average of 77.34%.

5.20 In addition, young people in treatment present with a number of complex vulnerabilities and needs that are seen in combination with substance use.

Table 5.6: Presenting vulnerabilities at treatment start, 2015/16[75]						
Vulnerability	**Bolton**		**Salford**		**Trafford**	
	No.	**%[76]**	**No.**	**%**	**No.**	**%**
Looked after child	22	17.96%	23	13.22%	5	3.36%
Child in need	8	5.34%	8	4.60%	6	4.03%
Domestic abuse	28	22.52%	68	39.08%	19	12.75%
Mental health problem	33	25.57%	85	48.85%	72	48.32%
Sexual exploitation	19	14.31%	5	2.87%	-	-
Self-harm	37	28.92%	23	13.22%	18	12.08%
NEET[77]	9	6.85%	81	46.55%	51	34.23%
Housing problems[78]	-	-	5	2.87%	15	10.07%
Parent/pregnant	-	-	22	12.64%	22	14.77%
Child Protection Plan	10	7.92%	27	15.52%	-	-

[72] Percentages refer to percentage of people with that characteristic. Individuals may display more than one.
[73] Percentages are calculated from total new presentations to treatment, not total number in treatment over the year
[74] Treatment exits are calculated differently at partnership/centre level and at provider level so are not comparable.
[75] Percentages refer to percentage of people with that vulnerability. Individuals may have more than one.
[76] Percentages are calculated from total new presentations to treatment, not total number in treatment over the year
[77] For a further breakdown, see appendices
[78] For a further breakdown, see appendices

Anti-social behaviour/ criminal acts	23	25.57%	81	46.55%	36	24.16%
Affected by others' substance use	37	28.47%	74	42.53%	37	24.83%
Practicing unsafe sex	31	24.03%	28	16.09%	11	7.38%

5.21 Whilst there are some variations between local areas, this data gives us a good picture of the complex and intertwined needs that young people using substances have. Many of these will act as barriers to recovery, and are strongly linked to themes explored in the previous sections (relating to both young people and adults).

JOINT INTEGRATED SUBSTANCE MISUSE TREATMENT AND RECOVERY SERVICE FOR BOLTON, SALFORD AND TRAFFORD

SERVICE SPECIFICATION

DRAFT VERSION 6 (28/10/16)

Bolton Council

Salford City Council

TRAFFORD COUNCIL

TABLE OF CONTENTS

1. BACKGROUND

1.1 Introduction

a. Drug and alcohol misuse has a profound impact on individuals, families and communities across Bolton, Salford and Trafford (hereafter referred to as the BST cluster). This specification outlines an integrated drug and alcohol treatment and recovery service to be delivered across the BST cluster. The service is orientated around supporting service users to initiate and sustain meaningful and durable recovery. It will also improve public health and community safety through the early detection and treatment of drug and alcohol misuse.

b. The BST substance misuse service will ensure that people are actively supported throughout their treatment and recovery journey. A Case Management Team will ensure that the scope and pace of this support is tailored to the needs and complexity of individual service users. This will include users of alcohol and other drugs (legal and illegal, prescribed and non-prescribed).

c. Recovery is a complex phenomenon, and relapse is common. Granfield and Cloud[1] describe four main enablers of recovery:

   i. Human capital (e.g. health and wellbeing, skills, aspirations)
   ii. Social capital (e.g. family and community relationships)
   iii. Cultural capital (e.g. identity and values)
   iv. Physical and economic capital (e.g. education, employment, housing, money)

d. The total contribution of each attribute determines an individual's *recovery* capital. In order to develop recovery capital throughout a treatment and recovery journey, the service will integrate treatment and recovery services throughout, including housing, employment and education interventions. There will also be a focus on the development of a supportive recovery community, which can support service both during and after treatment.

e. It is proposed that a Lead Provider model be chosen because it allows for diversity of provision whilst avoiding the duplication of provision between competing providers. Since they are not in competition with each other, providers will have no interest in retaining service users unnecessarily but instead ensure that each individual moves seamlessly between services during the course of their recovery journey. The Lead Provider will hold the contract for the entire service and can choose to sub-contract areas of service delivery to other organisations as appropriate.

f. Bolton, Salford and Trafford are neighbouring Local Authorities with a combined population of over 760,000[2]. A unified substance misuse service can improve the quality of services provided across the three areas by maximising existing assets, sharing best practice and ensuring common standards of provision and governance. It also offers the potential to maximise economies of scale across the three areas.

[1] Granfield, R. and Cloud, W. (2001) Social Context and "Natural Recovery": The Role of Social Capital in the Resolution of Drug-Associated Problems. Substance Use and Misuse, Vol. 36, pp1543-1570

[2] ONS (2015) Mid-year population estimates

1.2 National guidance and standards

a. The principle of evidence-based treatment will underpin the delivery of services, which will be designed in accordance with existing national guidelines and strategies. The Lead Provider will be expected to have systems in place to audit existing services against national standards, and to ensure that new evidence can be rapidly identified and incorporated within its treatment model.

b. It is expected that the following list of resources (which should be considered indicative rather than exclusive) should directly influence the development and delivery of services.

- **Advisory Council on the Misuse of Drugs**
  - Recovery from drug and alcohol dependence: An overview of the evidence (2012) - link
  - What recovery outcomes does the evidence tell us we can expect? (2013) - link
  - How can opioid substitution therapy (and drug treatment and recovery systems) be optimised to maximise recovery outcomes for service users? (2015) - link
  - Prevention of drug and alcohol dependence (2015) - link
- **Department of Education**
  - The Munro review of child protection: final report. A child-centred system (2011) - link
  - Working together to safeguard children (2013) - link
- **Department of Health**
  - Drug misuse and dependence: UK guidelines on clinical management (2007) - link
  - Signs for improvement – Commissioning interventions to reduce alcohol related harm (2009) - link
  - Practical approaches to safeguarding and personalisation (2010)- link
  - You're welcome - Quality criteria for young people friendly health services (2011) - link
  - The Green Book: Immunisation against infectious diseases (2014) - link
  - Widening the availability of Naloxone (2016) - link
- **Home Office**
  - Drug strategy: Reducing demand, restricting supply, building recovery (2010) - link
  - The Government's alcohol strategy (2012) - link
  - New psychoactive substances review: Report of the expert panel (2014) - link
- **Local Government Association (LGA)**
  - A glass half-full: How an asset approach can improve community health and well-being (2010) – link
  - Guide to commissioning for maximum value (2012) - link

- **National Treatment Agency (NTA)**
  - NTA guidance for local partnerships on user and carer involvement (2006) - link
  - Models of care for alcohol misuses (2006) - link
  - Models of care for treatment of adult drug misusers: Update (2006) - link
  - Review of the effectiveness of treatment for alcohol problems (2006) - link
  - Supporting information for the development of joint local protocols between drug and alcohol partnerships, children and family services (2011) - link
  - Building recovery in communities: A summary of the responses to the consultation (2012) - link
  - Medications in recovery: Re-orientating drug dependence treatment (2012) - link
  - NDTMS data set J: Implementation guide for adult drug and alcohol treatment providers - link
  - Parents with drug problems: How treatment helps families (2012) - link
- **National Institute for Health and Care Excellence (NICE)**
  - CG51 Drug misuse in over 16s: Psychosocial interventions (2007) - link
  - CG52 Drug misuse in over 16s: Opioid detoxification (2007) - link
  - PH4 Substance misuse interventions for vulnerable under 25s (2007) - link
  - PH6 Behaviour change: General approaches (2007) - link
  - PH7 Alcohol: School-based interventions (2007) - link
  - TA114 Methadone and buprenorphine for the management of opioid dependence (2007) - link
  - TA115 Naltrexone for the management of opioid dependence (2007) - link
  - CG100 Alcohol-use disorders: Diagnosis and management of physical complications (2010) - link
  - NICE CG110 Pregnancy with complex social factors: a model for service provision for pregnant women with complex social factors (2010) - link
  - PH24 Alcohol-use disorders: Prevention (2010) - link
  - CG115 Alcohol-use disorders: Diagnosis, assessment and management of harmful drinking and alcohol dependence (2011) - link
  - CG120 Psychosis with substance misuse in over 14s: Assessment and management (2011) - link
  - QS11 Alcohol-use disorders (2011) - link
  - QS23 Drug use disorders in adults (2012) - link
  - PH50 Domestic violence and abuse: Multi-agency working (2014) - link
  - PH52 Needle and syringe programmes (2014) - link
  - QS83 Alcohol: Preventing harmful use in the community (2015) - link
  - NG33 Tuberculosis (2016) - link

- **NHS England**
  - Serious incident framework: Supporting learning to prevent recurrence (2015) - link

- **Novel Psychoactive Treatment UK Network**
  - Guidance on the clinical management of acute and chronic harms of club drugs and novel psychoactive substances (2015) - link
- **Public Health England (PHE)**
  - Medications in recovery: best practice in reviewing treatment (2013) - link
  - Supporting information for developing local joint protocols between drug and alcohol partnerships and children and family services (2013) - link
  - Advice for prescribers on the risk of the misuse of pregabalin and gabapentin (2014) - link
  - New psychoactive substances: A toolkit for substance misuse commissioners (2014) - link
  - Non-medical prescribing in the management of substance misuse (2014) - link
  - The role of addiction specialist doctors in recovery orientated treatment systems (2014) - link
  - Young people's hospital alcohol pathways: Support pack for A+E departments (2014) - link
  - Quality governance guidance for local authority commissioners of alcohol and drug services (2015) - link
  - Service user involvement: A guide for drug and alcohol commissioners, providers and service users (2015) - link
  - Take-home Naloxone for opioid overdose in people who use drugs (2015) - link
  - The international evidence on the prevention of drug and alcohol use: summary and examples of implementation in England (2015) - link
  - Supporting information for developing local joint protocols between drug and alcohol partnerships and children and family services (2013) - link
  - Substance misuse services for men who have sex with men involved in chemsex (2015) - link
  - Adults – drugs JSNA support pack 2017-18: commissioning prompts (2016) - link
  - Adults – alcohol JSNA support pack 2017-18: commissioning prompts (2016) - link
  - Mapping blood borne virus services across the NW community drug and alcohol services (2016)
  - Young people – Substance misuse JSNA support pack 2017-18: Commissioning prompts (2016) - link

- **Royal College of Psychiatrists**
  - Delivering quality care for drug and alcohol users: the roles and competencies of doctors (2012) - link
  - Substance misuse in older people: an information guide (2015) - link

1.3 Local guidance and standards

1.3.1 Local Authority

a. It is expected that this service will be designed with reference to the existing Locality Plans for each Local Authority area. These are documents created as part of the Greater Manchester devolution process and which outline the strategy for each area in relation to health and social care:
    - Bolton Locality Plan
    - Salford Locality Plan
    - Trafford Locality Plan

b. Each Local Authority will also have its own policies and procedures which the Lead Provider will need to observe including in relation to:
    - Equality and diversity
    - Safeguarding (child and adult)
    - Social value
    - Governance (see Section 4.7)

1.3.2 Greater Manchester

a. Bolton, Salford and Trafford Local Authorities are all situated within Greater Manchester (GM). Following the GM devolution agreement in 2014, a number of responsibilities have been transferred to GM, including in relation to health and social care, criminal justice, transport, planning and housing[3]. A directly elected mayor will oversee this work and will lead the Greater Manchester Combined Authority (GMCA).

b. The Public Sector Reform (PSR) agenda represents a GM-wide approach to review and restructure the delivery of public services in the region to maximise effectiveness and efficiency. There are six constituent themes:
    i. Health and social care integration
    ii. Employment and Skills
    iii. Complex Dependency / Troubled Families
    iv. Place Based Integration
    v. Justice and Rehabilitation
    vi. Housing and Homelessness

c. Each of these PSR themes can be linked to services which we expect to be delivered as part of the BST substance misuse service. As such, we would expect the Lead Provider to demonstrate a willingness to engage with, and support, developments at a GM level. Over the duration of this contract this may involve (in collaboration with Commissioners) redesigning aspects of service delivery to reflect changes at a GM level.

[3] GMCA (2016) Devolution - link

d. Further information about the devolution of health and social care in GM can be found in the strategic plan for GM Health and Social Care Devolution entitled '*Taking charge of our health and social care in Greater Manchester*[4]*'*

[4] GMCA (2015) Taking charge of our health and social care in Greater Manchester - link

1.4 Overview of Lead Provider Roles and Responsibilities

The Lead Provider will have responsibility for the whole BST substance misuse service. Overarching and strategic responsibilities are listed in this section, with additional responsibilities outlined throughout the sections of this service specification.

1.4.1 Responsibility for the system

The Lead Provider will:

i. Ensure the delivery of a recovery orientated system of treatment, support and care.

ii. Develop a system that offers individuals and families a choice of accessible and relevant services that enable them to recover from the damage caused by substance misuse.

iii. Ensure the delivery of high quality health and social care for both abstinence and non-abstinent routes to recovery.

iv. Oversee the whole supply chain of treatment and recovery provision, sub-contracting service delivery as appropriate

v. Develop pathways to identify and manage complex cases within the system including those with chronic health conditions

vi. Work with partner agencies to develop appropriate local housing infrastructure for service users including (but not limited to) the provision of recovery housing, stepdown housing and tenancy support according to local need

vii. Ensure that service users are encouraged to engage with education, training and employment opportunities as part of the recovery process

viii. Ensure the delivery of services that dovetail with pathways to and from Tier 4 services and HMP based provision.

ix. Manage access to residential detoxification and rehabilitation via a panel with representation from Bolton, Salford and Trafford Local Authorities, ensuring that arrangements align with the Greater Manchester Tier 4 framework

x. Establish a 'Recovery Fund' for the development of recovery and mutual aid at a system level and a 'Personalisation Fund' for individuals in all forms of recovery.

xi. Demonstrate a reduction in demand on costly acute services via cost benefit analysis

1.4.2 Responsibility for meeting need

The Lead Provider will:

i. Develop services based on the findings of the Needs Assessment

ii. Deliver appropriate interventions across the range of substances used in Bolton, Salford and Trafford; across the full spectrum of need.

iii. Ensure that emphasis is placed on case profiling, risk stratification and long term case management of the most severe, complex cases, with the lowest levels of motivation and assets

iv. Consider the needs of service users living at the boundary of the BST cluster who may frequently present to out-of-area hospitals and other services

v. Ensure the development of an assertive approach to seeking and finding new service users and reaching service users who are not engaging in treatment

vi. Understand emerging threats to the wellbeing and safety of the community through analysis of emerging drug trends including (but not limited to) Chemsex and the use of New Psychoactive Substances and performance-enhancing drugs.

vii. Ensure that services are designed to meet the health and social needs of an aging cohort of opiate users, including through close partnership working with General Practices and specialist services.

viii. Conduct surveillance of emerging local and national drug trends. This will include assuming responsibility for Salford's existing Early Warning System and expanding its scope to include Bolton and Trafford. The Lead Provider will also be expected to collaborate in the potential development of an Early Warning System for Greater Manchester.

1.4.3 Responsibility for budget

The Lead Provider will:

i. Ensure that the system is affordable, sustainable, represents value for money and is informed by the notion of 'invest to save' so that the effectiveness of the treatment system can be linked to savings elsewhere in local partnerships

ii. Provide economies of scale across Bolton, Salford and Trafford and ensure effective integration with services essential to promoting recovery (e.g. housing, employment, education and training)

iii. Ensure that the costs of designing and delivering substance misuse services in each Local Authority equate to the financial contribution of each Local Authority into the service.

iv. Avoid duplication and service blocking by ensuring that service users are referred as soon as is practicable for each individual recovery journey

1.4.4 Responsibility for recovery

The Lead Provider will:

i. Ensure that there is a rise in the volume of people achieving recovery alongside decreases in relapse rates and longer periods of remission.

ii. Improve and strengthen service users' parenting capacity and enable their recovery.

iii. Reduce the harm or neglect experienced by children and increase their life chances.

iv. Allow service users' families and/or significant others to support them in their recovery.

v. Reduce the long term impact of substance misuse for young people in Salford and Trafford.

vi. Develop an assessment and care planning process that includes measures of recovery potential and assets. Specifically, an account of each client's *complexity*, *motivation*, *severity* and *capital* (human, social, cultural and physical) will be incorporated into comprehensive assessments and treatment reviews and monitored over the course of each recovery journey

vii. Be the focal point of a system that will boost the human, social, cultural and physical capital of Bolton, Salford and Trafford for the benefit of those moving through the system from treatment to recovery to mutual aid.

viii. Ensure that all reasonable efforts are made to follow up all substance users who have completed specialist treatment in order to review their needs and risks for at least five years

ix. Draw people into mutual aid and recovery communities and engage with wider community recovery activities and assets.

1.4.5 Responsibility for people

The Lead Provider will:

i. Oversee the development of a balanced workforce with volunteers and paid staff in recovery supporting others on their recovery journeys

ii. Ensure the provision within the workforce of some trainee and apprentice posts to enable career progression from Peer Mentors into full time employment.

iii. Place emphasis on working with commissioners in developing Service User Representation and actively involving service users, their families and neighbours in the development and delivery of services in an equal and reciprocal relationship.

1.4.6 Responsibility for performance and governance

The Lead Provider will:

i. Deliver routine reports on the performance of the entire system and undertake longitudinal evaluation of its effectiveness.

ii. Report on the governance of the whole system for the whole contractual supply chain.

iii. Ensure that there is an effective governance system in place around the delivery of services so that providers comply with the requirements of the commissioners and stakeholders.

iv. Work closely with commissioners and other agencies to develop implement and monitor consistent, appropriate, effective and efficient processes in line with all relevant national frameworks and guidance.

v. Represent the substance misuse service at strategic board meetings (including, but not limited to Children's services) and to produce relevant strategic reports as requested by the Commissioners

1.5 Out of scope

1.5.1 General exclusions

The following services fall outside the scope of this tender in all three Local Authority areas:

i. **Tier 4 provision** (see Section 1.6.1)
   - With the exception of the local residential rehabilitation service detailed in Section 3.15
   - The Lead Provider will manage the budget for Tier 4 detoxification and residential rehabilitation services. This budget is separate to the contract value of this tender.

ii. **HMP based services**

iii. **Young People's Secure Estate**

iv. **Universal health and wellbeing services**

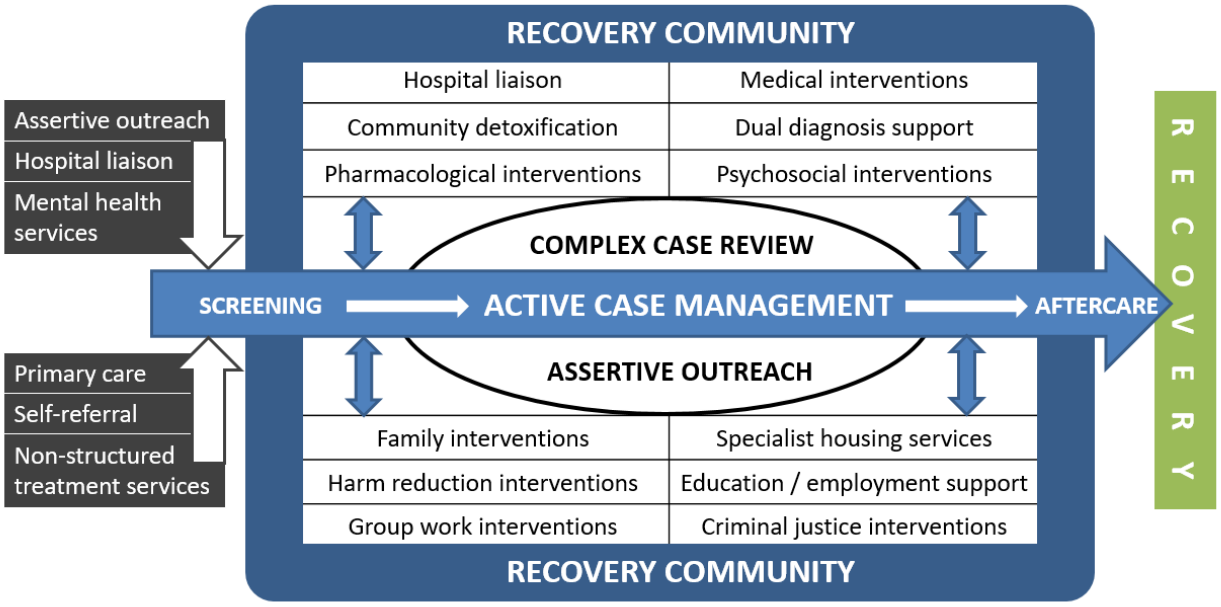
1.5.2 Specific exclusions

a. Due to existing arrangements, Bolton Council will not currently be commissioning a Young People's service (with the exception of Pharmacological interventions, as per Section 3.4) or a Hospital in-reach and liaison team.

1.6 System details

1.6.1 System diagram

a. The Lead Provider is expected to deliver a recovery orientated treatment system that addresses harm reduction at every level. The diagram below gives an indication of the intended structure of our model with similar, but separate, pathways existing for adults (all areas) and young people (Salford and Trafford only).



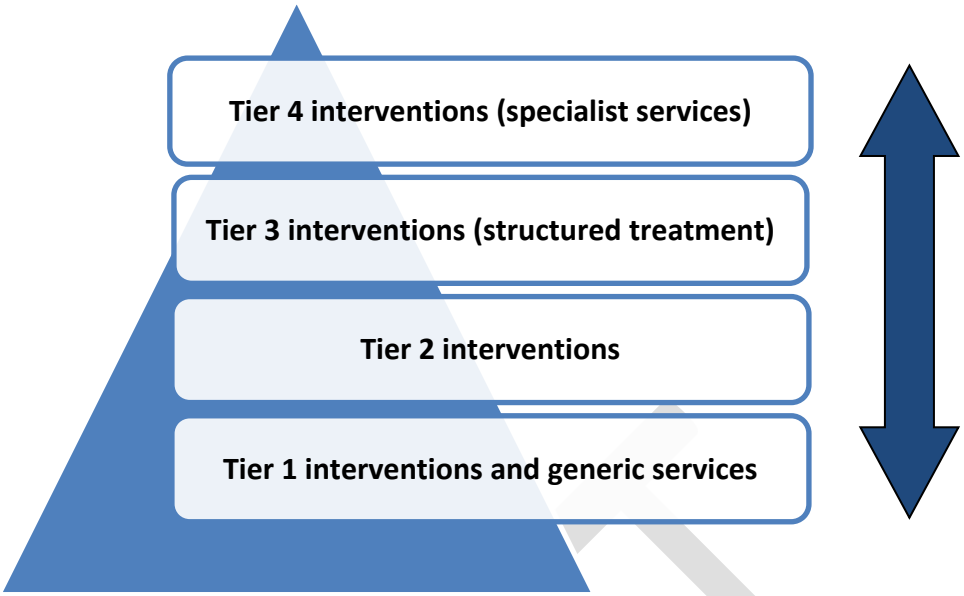
b. There will be several referral routes into the service in order to allow early identification of those at risk from drug and alcohol misuse. The Lead Provider will be expected to allow referrals from the following sources (as a minimum offer):

i. Assertive outreach teams (Section 2.2)
ii. Hospital liaison teams (Section 3.3)
iii. Mental health services (see Dual Diagnosis: Section 3.7)
iv. Primary care
v. Self-referral
vi. Non-structured treatment services (e.g. Aftercare services, Specialist housing services)

c.

d. Upon referral service users will be undergo screening, the structure and content of which will be agreed with Commissioners. It is expected that an appropriately skilled professional will conduct an holistic assessment of each service user to determine their level of need, level of risk and recovery capital. The person conducting the screening review will then determine which level of intervention the service user is likely to require initially. This will be based upon the four-tier model described by the National Treatment Agency[5]:

[5] National Treatment Agency. *Models of care for treatment of adult drug misusers: Update* (2006) - link



b. Higher tiers in the model correspond to increasing levels of need and complexity. The purpose of the treatment and recovery model is to allow service users to move between tiers (either up or down) dependent on a dynamic assessment of their needs and any associated risks. There is a degree of overlap between tiers but they can be broadly summarised as follows:

i. Tier 1

- Services supporting the drug and alcohol service provided by generic providers
- Examples may include:
  - Tier 1 screening and brief interventions (3.9.1)
  - Housing support (3.15)
  - Education, employment and training interventions (3.14)

ii. Tier 2

- Drug and alcohol interventions out-with structured treatment
- May require a lower degree of commitment from the client
- Examples may include:
  - Interventions to engage people into drug treatment
  - Interventions to support people prior to structured treatment
  - Interventions to help retain people in the treatment system
  - Harm reduction interventions (Section 3.7)
  - Tier 2 screening and brief interventions (Section 3.9.2)

iii. Tier 3

- Planned interventions that meet the threshold for structured treatment, which is defined according to the requirements of NDTMS reporting[6]
- Service users accessing Tier 3 services will accepted by the *Case Management Team* (Section 2.1) and have regular reviews of a personalised care plan
- Requires completion of NDTMS returns
- Examples include:

[6] NTA (2012) NDTMS data set J: Implementation guide for adult drug and alcohol treatment providers: Page 20 - link

- Pharmacological interventions (Section 3.4)
- Community detoxification (Section 3.2)

- Other interventions (e.g. Psychosocial interventions) may be considered a Tier 3 treatment if a specified treatment course is required and the level of need and/or risk requires service users to be subject to a Care Plan and regular reviews by a Case Manager

iv. Tier 4

- These are specialist drug and alcohol services, including:
  - Residential rehabilitation
  - Inpatient detoxification
- These services are not in the scope of this tender (with the exceptions outlined in Section 1.5.1
- The Lead Provider will be expected to offer support to service users entering and exiting Tier 4 services (Section 3.1)

c. Service users accepted into structured treatment will be allocated to a Case Manager who will co-ordinate their journey through BST substance misuse service. The Case Manager will work with the service users to develop a personalised care plan including referral for interventions available within the substance misuse service. Service users will be actively supported including regular reviews at a frequency dependent on the level of need and risk, to be agreed with the Commissioners.

d. Where appropriate, the Case Manager will ensure that service users who are not engaging with structured treatments are referred to the *Assertive Outreach Team* for support (Section **Error! Reference source not found.**).

e. Service users with high levels of complexity will be managed in collaboration with the Complex Case Review Team (Section 0). This will provide an enhanced level of support until service users can be stepped-down to the *Case Management Team*.

f. When appropriate, service users will be stepped-down from the *Case Management Team* and receive a package of aftercare as part of their ongoing recovery journey for a further five years (Section 2.5). Pathways to recovery are often not straightforward and the Case Manager and Aftercare services will ensure that service users experiencing difficulties, including relapse, are referred back in to the appropriate components of the service, depending on their needs.

g. It may be decided that some service users will not be eligible for structured treatment when they are initially screened. This will be documented in a Care Plan and the service user will still have access to other components of the delivery model, including the Recovery Community and Group Work interventions. The Lead Provider will work with Commissioners to develop a system whereby these cases will still undergo periodic review to identify any increasing risks or needs that may require users to access structured treatments or other aspects of the system. It is expected that the intensity and frequency of these reviews will be less than that for service users in structured treatment.

1.6.2 Eligibility

The following general eligibility criteria will be applied across the system:

a. **Residence**
   i. Service users will be resident in either Bolton, Salford or Trafford Council areas

b. **Age**
   i. In **Salford and Trafford:**
      - Service users aged under 21 will be considered young people
      - Service users aged 21 and over will be considered adults
      - In exceptional cases service users aged 21 to 24 may be considered eligible to remain in, or access, the Young People's service as determined by their Case Manager.

   ii. In **Bolton:**
      - Service users aged 19 and under will be managed by a separately commissioned service which is outside the scope of this contract (except for Pharmacological interventions)
      - Service users aged 20 and over will be considered adults

c. **Family**
   i. Family and extended family of service users are eligible for those parts of the treatment system specifically aimed at families

   ii. All family members will be strongly encouraged to access appropriate levels of treatment within the wider system where appropriate

1.6.3 Exclusion criteria

All relevant need and risk will be assessed and managed within the *Case Management Team* with support from the *Complex Case Review Team* where necessary. No one will be excluded from recovery entirely.

1.6.4 Operational details

The service will be delivered in accordance with the following overarching requirements:

a. Location

   i. Unless otherwise specified each element of the treatment and recovery system will be located at convenient points throughout Bolton, Salford and Trafford accessible by public transport

   ii. Access points will be determined by service user consultation and provider engagement with the Joint Strategic Needs Assessment.

   iii. Account must be taken of the mandated facilities (Section 4.6)

b. Hours of operation

i. Unless otherwise specified the Lead Provider and Commissioners will agree and confirm the hours of operation during the transition period.

ii. Any subsequent change to the hours of operation requires the agreement of Commissioners.

1.6.5 Admission criteria

a. Admission to each aspect of the BST substance misuse service will be based on need and suitability. Denial of access must be reasonable, proportionate and timely. All procedures governing exclusions must be available to view, easy to understand, fair, hear both sides, allow for representations and have a clear process of review and appeal, with a clearly described chain of governance.

b. Eligibility will be determined at an initial screening interview. Cases involving significant complexity will be referred to the Complex Case Review service which will work under existing NHS and Local Authority procedures (CPA, MDT, MAPPA, MARAC, and Safeguarding, Child Protection etc) to provide support to the service user and their Case Manager, as outlined in Section 0.

1.6.6 Discharge Process

a. Planned completions

i. The Lead Provider will agree a consistent discharge process with all partners contracted to deliver within the treatment system.

ii. Conditions of the discharge process include that:

- Case Managers will take responsibility for appropriately stepping service users down to lower threshold parts of the system
- Service users completing structured treatment will be referred on to Tier 2 Aftercare services (Section 2.5) and will have the opportunity to access personalised budgets for a period of up to 3 years (Section 0).
- Complete discharge from the system will occur after a five year period post-treatment during which time there will be ongoing contact from the telephone aftercare service (Section 2.5)
- National guidance regarding discharge from NDTMS must be followed.

b. Unplanned completions

i. These cases will be referred on to the *Assertive Outreach Team* (Section **Error! Reference source not found.**).

ii. Cases with high risk features will trigger a formal inter-disciplinary case management review, co-ordinated by the *Complex Case Review Team* (Section 0).

- This will determine risk and need in relation to set criteria including (but not limited to) child protection, safeguarding, prescribing, community safety (prison, police and probation), physical and mental health risks.

iii. Discharge of service users against professional advice will only occur following an appropriate risk and needs assessment by the *Complex Case Review Team*

1.7 Acronyms

AA	Alcoholics Anonymous
ACMD	Advisory Council on the Misuse of Drugs
AUDIT	Alcohol Use Disorders Identification Test
BBV	Blood Borne Virus
BME	Black and Minority Ethnic
BST	Bolton, Salford and Trafford
CAF	Common Assessment Framework
CAMHS	Child and Adolescent Mental Health Services
CDAO	Controlled Drugs Accountable Officer
CISS	Christo Inventory for Substance-misuse Services
CJS	Criminal Justice System
CPA	Care Programme Approach
DAAT	Drug and Alcohol Action Team
DAMS	Drug and Alcohol Monitoring System
DANOS	Drugs and National Occupational Standards
DBS	Disclosure and Barring Service
DIRDET	Drug Intervention Record Data Entry Tool
DRR	Drug Rehabilitation Requirements
EIP	Early Intervention and Prevention Service
ETE	Education, Training and Employment
FACS	Fair Access to Care Services
GMC	General Medical Council
GMCA	Greater Manchester Combined Authority
GP	General Practitioner
HIV	Human Immunodeficiency Virus
HMP	Her Majesty's Prison
IBA	Identification and Brief Advice
ITEP	International Treatment Effectiveness Project
JSNA	Joint Strategic Needs Analysis
LGBT	Lesbian, Gay, Bisexual and Transgender
LES	Local Enhanced Services
LIN	Local Intelligence Network
MAPPA	Multi Agency Public Protection Arrangements
MARAC	Multi-Agency Risk Assessment Conference
MASH	Multi Agency Safeguarding Hub
MDT	Multi-Disciplinary Team
MHRA	Medicines and Healthcare products Regulatory Agency
NA	Narcotics Anonymous
NDTMS	National Drug Treatment Monitoring System
NEXMS	Needle Exchange Monitoring System
NHS BSA	National Health Service Business Services Authority
NICE	National Institute for Health and Care Excellence
NTA	National Treatment Agency for Substance Misuse (PHE)

OCU	Opiate and/or Crack Cocaine User
PGD	Patient Group Direction
PHE	Public Health England
PHOF	Public Health Outcome Framework
PMF	Performance Management Framework
PPO	Prolific and Priority Offenders
PSR	Public Sector Reform
QuADS	Quality in Alcohol and Drug Services
RADAR	Rapid Alcohol Detox Acute hospital Referral
RAG	Red, Amber, Green rating system
RAID	Rapid, Assessment, Interface and Discharge
RCPsych	Royal College of Psychiatrists
RE-AIM	Reach Efficacy Adoption Implementation Maintenance
ROTL	Release on Temporary Licence
SAR	Specified activity requirements
SCH	Secure Children's Home
SOP	Standing Operating Procedure
STC	Secure Training Centre
TOP	Treatment Outcome Profile
YOI	Young Offenders Institute
YOS	Youth Offending Service
YPOR	Young Peoples Outcome Record

2. CASE MANAGEMENT

Active Case Management is fundamental to the BST substance misuse service. All service users accepted into structured treatment (see Section 1.6) will be assigned a Case Manager who will co-ordinate the interventions and support which they will receive while in structured treatment.

To ensure effective case management for young people and adults throughout the treatment system the Lead Provider is expected to create and develop the following teams:

i. Case Management Team (Section 2.1)
ii. Assertive Outreach Team (Section **Error! Reference source not found.**)
iii. Complex Case Review Team (Section 0)
iv. Young People's Team (Section 2.4)
v. Aftercare and Discharge Team (Section 2.5)

2.1 Case Management Team

a. The *Case Management Team* will offer consistent support to service users during their treatment and recovery journey, which may span multiple parts of the service. Its aim is to ensure that the right treatment is offered, at the right time, in the right place, for the right amount of time to the right person. It also provides a gate-keeping function for the treatment system.

b. The key functions of the *Case Management Team* are:

   i. Screening
   ii. Assessment of risk
   iii. Determination of need
   iv. Allocation of resources

2.1.1 New cases

a. New cases will undergo a screening interview which will determine their eligibility for the service based on an assessment of their needs and any risks identified. In order to be eligible for the *Case Management Team*, service users must be entering structured treatment (see Section 1.6 for definition). As outlined in Section 1.6.1, the Lead Provider is expected to work with Commissioners to agree a system whereby service users not in structured treatment can also benefit from periodic review of their needs.

b. Cases accepted by the *Case Management Team* will then be allocated a Case Manager within five working days, who will be the primary contact for the service user whilst they remain in the BST substance misuse service.

2.1.2 Existing cases

a. The Case Management Team will be involved with all elements of the treatment system across all Tiers. The Lead Provider should ensure that each component of the BST substance misuse service has access to the *Case Management Team* in order to refer new cases or discuss existing ones (for example, in the case of escalating risk).

b. The scope and frequency of support provided by Case Managers to their clients depends on a dynamic assessment of the levels of needs and risk of individual service users and should be based on national guidance, including from PHE. Functions of the Case Manager include:

i. **Needs assessment and risk assessment**
- All service users will be subject to regular assessment by their Case Manager (at a frequency to be agreed with the Commissioner)
- The provider will ensure close working relationships with partners to ensure that those with a mental health dual diagnosis receive appropriate interventions (see Section3.7)

ii. **Care Planning**
- All service users will have regular care-planning sessions (at a frequency to be agreed with the Commissioner)
- The provider will actively encourage the involvement of carers and families in the care plan
- Care plans will include the setting of appropriate goals and their content will include (but not be limited to):
  - Clinical and non-clinical interventions
  - Mental and physical health (see Section 3.6.1)
  - Finances
  - Housing
  - Family
  - Social relationships
  - Education, training and employment
  - Offending behaviour, where appropriate

iii. **Treatment reviews**
- For those in structured treatment
- This will include TOP and NDTMS sub-intervention updates.

iv. **Recovery support**
- Tailored support to improve recovery capital of service users
- This will include support relating to individual care and recovery (e.g. family and carer information, employment support, housing advice, physical and mental health advice, social care)

v. **Safeguarding**
- Case Managers will be trained to appropriately identify and act upon any Safeguarding concerns, including in relation to domestic violence

vi. **Care co-ordination**

- The *Case Management Team* will ensure effective communication with the wider clinical network, especially GPs and Pharmacists - including regular updates on reviews and/or significant changes to the care plan
- Case Managers will ensure that all service users have a named GP
- Significant updates will be provided in writing.
- All unsuccessful completions and unplanned discharges will be referred on to the *Assertive Outreach Team* (Section **Error! Reference source not found.**)

vii. **Aftercare**

- The Case Management service will oversee aftercare services including telephone aftercare (see Section 2.5)

2.2 Assertive Outreach Team (AOT)

a. The provision of an *Assertive Outreach Team* (AOT) is a fundamental requirement of the integrated treatment and recovery system. The Lead Provider is required to deliver a creative and flexible way of working with people who have problems relating to substance misuse who may be hard to engage or resistant to services.

b. The approach is characterised by work with clients in their own environment, wherever that may be. It will have two key, complementary functions:

   i. Identifying and engaging people not known to services with drug and alcohol problems in communities which may not engage with traditional services

   ii. Reaching and engaging with service users who drop out of treatment

c. It is expected that the AOT will contribute to a decrease in the numbers of high risk individuals that we lose contact with, reduce unplanned completions, and increase previously unknown entrants.

d. Many of these individuals and families will have very poor recovery assets but this is not necessarily their defining feature, as troubled individuals and families exist across the social and health gradient. . The AOT must reach and engage with service users in understandable language and behaviour.

e. The service must also work in close partnership with other aspects of the treatment and recovery system including (but not limited to):

   i. Harm reduction services

   ii. Medical intervention services

   iii. Dual diagnosis services

   iv. Hospital liaison services

   v. Pharmacological intervention services

   vi. Housing support

   vii. Criminal justice interventions

   viii. A+E

   ix. RAID

   x. Social Work teams

      - Currently in **Salford** there is an arrangement whereby the Drug and Alcohol service funds a social worker who is based within Salford Council's Social work department
        - This worker links both services and is able to use intelligence within the Social Work team to support outreach work targeting socially vulnerable and isolated individuals
        - It is recommended that the incoming Lead Provider continue this working arrangement

2.2.1 Identifying people not engaging with services

a. The AOT will work in a highly innovative way across Bolton, Salford and Trafford (in the home, on the street, in community venues) to implement approaches that proactively seek out drug and alcohol users unknown to services and provide persistent and intensive support. Priority will be given to specific at-risk populations including (but not limited to):

   i. Those within the Criminal Justice system (see Section 3.16)

   ii. Veterans

   iii. Homeless populations

   iv. BME communities and travellers

   v. Those with severe and enduring mental health problems (see Section **Error! Reference source not found.**)

   vi. Women and men suffering from domestic violence

   vii. Sex Workers

   viii. LGBT Groups

   ix. Disabled people – including mental, sensory, learning and physical

   x. Young people from the following groups:
      - Looked after children
      - Young offenders
      - Persistent absentees / excluded
      - Children of substance misusing parents
      - Young people with mental health issues

b. The Lead Provider will be expected to consider how best to meet the needs of these groups, involving collaborating with existing organisations including (but not limited to) community groups and housing providers where appropriate.

c. The aim of the service will be to bring people into structured treatment where appropriate and practical. However, it is recognised that there may be individuals (judged to have capacity to decide) who are in need of help but decline structured treatment despite exhibiting high-risk characteristics. The AOT will continue to engage with such individuals and provide appropriate support for as long as it is felt to be beneficial.

2.2.2 Engaging with service users who drop out of treatment

a. The service will look to re-engage those who have dropped out of treatment. Case managers will refer such cases into the AOT. Cases will be prioritised based upon perceived needs and levels of risks with particular priority given to those with:

   i. Complex needs

   ii. High levels of risk, including safeguarding concerns

   iii. Frequent drug and alcohol related admissions and attendances at Accident and Emergency departments

b. The Provider will be expected to develop information sharing agreements and pathways with A+E departments to allow frequent attendees with substance misuse problems (both drugs and alcohol) to be highlighted and referred into this service. An example of this approach can be seen in the current Salford Alcohol *Assertive Outreach Team* model[7]

c. It is expected that many of these service users will come from high-risk populations including those listed in Section 0, hence the development of relationships with these at-risk groups will be vital to the success of this service.

d. Allocation to the AOT will be decided by a Multi-disciplinary team (MDT), the members of whom are to be agreed with Commissioners. At the point of acceptance the MDT will determine the types of intervention felt most important for an individual service user. Examples may include (but are not limited to):

   i. Encouragement to engage with specialists (e.g. Psychologists, Psychiatrists, Forensic Services, Gastroenterologists, GPs, Police, Probation, Housing, Children Services, Adult Services, Third Sector Organisations)

   ii. Acting as bridge to recovery services and fellowship organisations

   iii. Building resilience and self reliance.

   iv. Brief interventions

   v. Specialist harm reduction support

   vi. Healthcare assessments

   vii. Support with paying bills etc.

e. Service users accepted by the AOT will be allocated a support worker who will work in collaboration with the Case Manager to provide appropriate interventions. The support worker will make regular contact with the service user. In cases of high need and risk this may require daily input initially. It is expected that the amount and frequency of support provided will gradually reduce over time as measurable risk and need reduce, until the service user no

[7] Hughes et al. (2013*) Salford alcohol assertive outreach team: a new model for reducing alcohol-related admissions*. Frontline Gastroenterology. 4(2):130-134

longer requires support from the AOT (but will continue to be supported by the *Case Management Team*).

2.2.3 Overarching service delivery requirements

a. Responsibilities of the Lead Provider

In respect to the AOT, the Lead Provider will be required to:

i. Conduct an asset-mapping exercise to identify existing support groups working with at-risk groups within Bolton, Salford and Trafford

ii. Conduct surveillance of the needs arising from highly complex and extreme forms of drug and alcohol use in Bolton, Salford and Trafford

iii. Assist Case Managers to manage the transition of service users between services

iv. Assist Case Managers to reach out to troubled families, considering the safeguarding of both adults and children (including those who become subject to formal child protection procedures).

v. Implement lone working policies to ensure that staff carrying out assertive outreach activities are not placed at risk

vi. Accurately record assertive outreach activity for service users known to the system within the Case Management IT system to ensure staff who may come into contact with the service user are fully aware of the current status of the case. Outreach work attempting to engage service users unknown to the substance misuse service will need to be recorded in alternative ways, to be agreed with Commissioners.

vii. Escalate concerns to appropriate authorities (for example, the Council, the probation service or the police) when service users have disengaged and increased risks are identified

b. Operational details

The service will be delivered in accordance with the following delivery requirements:

i. *Referrals*

The Lead Provider should ensure that the following referral routes are available:

- Routine referrals by the Case Manager (it is expected this will account for most referrals)
- Emergency referral from anywhere in the recovery system.
- Former AOT users may self-refer

ii. *Access*

- The Service will have a central base with access points determined by service user consultation and provider engagement with the Joint Strategic Needs Analysis.

- A range of techniques will be employed to contact and engage with Service Users including home visits, telephone calls, text messaging and liaison with other key partners (for example Police, Probation, Hospital, Housing, Jobcentre Plus).

iii. *Workforce*

- Consideration will be given to the role of employing former service users as peer mentors (see Section 3.14) within the workforce of the AOT in order to enhance outreach work, encourage the distribution of harm reduction advice and promote referrals into the service.

iv. *Discharge Process*

- Cases will typically be stepped down from the AOT by Case Managers.
- National guidance regarding discharge from NDTMS must be followed.
- The AOT will only discharge service users into Tier 2 and above services
- Unplanned completions in this service represent an immediate risk which will require mitigation, including the creation of risk management plans, via a multi-disciplinary process.
- In the case where a service user continues to be disengaged from treatment, the Provider will share all relevant information with Criminal Justice agencies, Children's Services or key stakeholders as appropriate within 24 hours.

2.3 Complex Case Review Team (CCRT)

a. The Lead Provider is expected to ensure that in Bolton, Salford and Trafford complex cases can be referred into a *Complex Case Review Team* (CCRT). Taking a co-ordinated approach to managing complex cases is a key aspect of the Public Sector Reform agenda. The CCRT will sit above the BST substance misuse service and accept referrals from the Case Management Team for service users with highly complex needs. They will then perform a strategic role in ensuring that all agencies involved in supporting complex service users are working collaboratively to meet shared objectives outlined within a personalised care plan.

b. Service design

i. This will be a highly specialist multi-disciplinary and multi-agency local service which manages complex and severe cases posing the greatest risk to themselves and others. A list of case characteristics necessitating referral to the *Complex Case Review Team* will be agreed with Commissioners. Examples of these may include (but are not limited to):

- Safeguarding concerns
- Domestic violence
- Severe and enduring mental illness
- High-risk medical co-morbidities

ii. The Lead Provider will ensure that there are clear protocols and training provided to Case Managers to enable them to identify and refer such cases on appropriately. Following referral, service users will remain under the *Case Management Team* while receiving input from the CCRT, but it is expected that their Case Manager will provide an increased degree and frequency of support and the *Assertive Outreach Team* will be expected to play a supportive role where necessary.

iii. The CCRT will be led by a Consultant or Specialist-Generalist and will be required to demonstrate specialist expertise from areas including (but not limited to):

- Substance misuse
- Clinical Medicine
- Psychiatry
- Social work (both adult and children's expertise)
- Any other appropriate partners

iv. The CCRT will meet regularly, at a frequency to be agreed with the Commissioners. The Case Manager of the service user will be expected to attend these meetings. At each MDT, the care plans and risk assessments of accepted service users will be reviewed and changes made as necessary. Cases will be stepped-down following an agreement at the MDT that the level of risk has improved. These cases will continue to get support from the *Case Management Team*.

v. In addition to this MDT input, service users managed under the CCRT will be eligible for referral to a clinical psychologist who should be based within the team.

c. **Responsibilities of the Lead Provider**

The Lead Provider will be expected to ensure that:

i. Specialist Governance procedures are created in liaison with the Responsible Consultant, local Safeguarding and Child Protection teams, Clinical Commissioning Groups. These should be in accordance with existing recommendations from PHE and NICE (Section 1.2)

ii. Necessary data sharing arrangements are in place to allow each access and sharing of clinical and risk information between Agencies, in accordance with Information Governance requirements

iii. A small number of high-risk cases (the critical few) will be managed under special measures dictated by clinical and community safety requirements Denial of access to such services must be reasonable, proportionate and timely, and be clearly described in the processes laid down by service governance

iv. Processes for the more complex cases, families and groups are fully integrated with existing NHS and Local Authority MDT arrangements (e.g. CPA, MDT, MAPPA, MARAC, Safeguarding, Child Protection etc).

v. The service works closely with the *Assertive Outreach Team* (Section **Error! Reference source not found.**) to ensure that high risk cases are supported up in the most appropriate location

d. **Operational details**

The service will be delivered in accordance with the following delivery requirements:

i. Referral process

- Referrals to the CCRT will normally be via the *Case Management Team*

ii. Waiting times

- The Lead Provider will ensure that waiting times for assessment, interventions and structured treatment are as short as possible

iii. Discharge

- Unplanned completions with high risk features will be referred directly to the AOT where a formal inter disciplinary case management review will take place and the risks and needs in the case are considered from a cross sectional viewpoint, to include child protection, safeguarding, prescribing, community safety (Prison, Police and Probation), physical and mental health risks (Severe and Enduring Mental Health cases).
- Planned completions will be stepped down to the *Case Management Team*
- The discharge processes for the more complex cases and families / groups will be best managed by a multi-disciplinary forum under existing NHS and Local Authority procedures (for example: CPA, MDT, MAPPA, MARAC, Safeguarding, and Child Protection).

2.4 Young Person's Service

DUE TO EXISTING ARRANGEMENTS THIS SERVICE IS NOT BEING COMMISSIONED FOR BOLTON LOCAL AUTHORITY AREA AS PART OF THIS TENDER PROCESS

The young person's substance misuse service will target vulnerable young people most at risk of developing serious and persistent substance misuse problems. The service for young people will function independently from the service for adults but the referral pathways and structure of provision will essentially be the same. Young people must be able to access high-quality, age-appropriate and evidence-based specialist substance misuse treatment interventions as a part of packages of care-planned support tailored to the individual, including social and health care interventions. In order to support a young person to change their pattern of substance misuse, it may also be important to involve parents, family and significant others with aspects of care and provide them with support.

2.4.1 Case Management

a. The young person's substance misuse service should have a *Case Management Team*, which is separate from the adult team. There will be specialist Case Managers who are trained to work with young people specifically. The functions of the Young Person's *Case Management Team* will otherwise be the same as the adult equivalent (outlined in Section 2.1)

b. Young people will also be able to access the *Assertive Outreach Team* (Section **Error! Reference source not found.**), which will be expected to provide dedicated support workers to engage young service users at risk of dropping out of treatment. These support workers will also be expected to attempt outreach activities at times and in places where there are likely to be young people (unknown to services) requiring support in respect of drug or alcohol problems

a. Young people will also be able to benefit from the **Complex Case Review team** (Section 0). Case Managers for the young person's service will be able to access the CCRT according to guidelines to be agreed with the Commissioners. The Lead Provider will ensure that the CCRT has specialist expertise in working with young people.

2.4.2 General interventions

a. Young people will have access to all interventions offered within the general substance misuse service. All interventions within the young person's service will be delivered separately from adult services.

b. The Lead Provider will be expected to ensure that all interventions provided to young people are specifically designed to meet the needs of this population. With regards to the substance misuse service this will require adaptions to services including (but not limited to):

i. *Hospital liaison* (Section 3.3). The Lead Provider should ensure that members of the hospital liaison team have received appropriate training to work with young people presenting acutely to hospital with drug and alcohol problems.

ii. *Pharmacological Interventions* (Section 3.4). These interventions should cover both alcohol and substance misuse and be delivered in accordance with relevant national guidelines.

iii. *Healthcare Assessments* (Section 3.6). All young people engaging with treatment should receive a regular comprehensive assessment including a healthcare assessment which is tailored to the needs of young people (Section 3.6.1), at a frequency to be agreed with Commissioners

iii. *Dual diagnosis support and psychosocial Interventions* (Sections 3.7 and 3.10). Young people within the service should be able to access Counselling, Cognitive behavioural therapy, Motivational interviewing, Relapse prevention and Family work. Depending on the age of the young person, this may involve collaborative working with local CAMHS providers.

iv. *Harm Reduction* (Section 3.8). Specialist advice and support targeted at young people will be provided, including in relation to injecting, overdose and accidental injury

v. *Group work interventions* (Section 3.12). The Lead Provider will develop specific groups for the young person's service

2.4.3 Youth Offending Service (YOS)

- The service will work with the YOS in developing substance misuse provision that meets both local needs and national standards, increases drug and alcohol awareness among young people involved in the criminal justice system, reduces levels of substance misuse amongst YOS clients, and identifies all YOS clients requiring specialist substance misuse support.

- The service will:

  i. Provide dedicated and specialist Tier 2 / 3 substance misuse resources to Youth Offending Services in all three boroughs.

  ii. Provide Specialist Tier 3 key work support to YOS clients with significant substance misuse issues.

  iii. Support group work sessions for clients.

  iv. Support diversionary activities with YOS clients.

  v. Support the development of service activity days.

  vi. Support parenting work and interventions where appropriate.

  vii. Offer specialist information, advice and training for YOS staff.

  viii. Offer training for staff of other services working with the YOS (e.g. Looked After Children and Pupil Referral Units).

2.4.4 Secure estate

a. Substance misuse within the Young People's Secure Estate is **not in scope** for this tender. The young people's specialist treatment service will work with the secure estate to ensure the smooth transition between custody and community for young people from Salford or Trafford with a substance misuse need.

b. This will involve attending case conferences and liaising with the YOI / SCH / STC following release and throughout the licence period as applicable.

2.4.5 Training requirements

a. The service will provide training to local authority and voluntary sector staff working with vulnerable young people from the priority groups. The training will cover:

   i. Age-appropriate screening of young people for substance misuse issues

   ii. Delivery of brief interventions

   iii. Referral process and pathways within the system.

b. The number of training sessions and individuals trained will be agreed with commissioners.

c. Training will be targeted at those services and staff most in need. It will be informed by regular reviews of referral numbers and pathways and by consultation with partners. It will ensure young people can quickly and easily access the full range of help and support they need from other agencies. It will increase the appropriateness of referrals and reduce the time between the identification of a substance misuse issue and the delivery of specialist interventions. Training provided by the service should be routinely evaluated.

d. Staff will be appropriately skilled and have the ability to successfully engage and maintain positive relationships with young people and their families/carers.

2.4.6 Overarching service delivery requirements

a. Responsibilities of the Lead Provider

In respect to the Young Person's service, the Lead Provider will be required to:

   i. Developing joint working protocols with Children's services in Bolton, Salford and Trafford Local Authorities

   ii. Encourage early identification in order to intervene early to avoid crisis and safeguarding risks and improve outcomes for vulnerable young people; including in relation to substance misuse, educational attainment, teenage pregnancy, offending and family support

   iii. Managing the smooth transition from young people's services to adult services.

   iv. Establish data sharing arrangements to determine the extent of crossover between substance misuse services and Child Protection, Child In Need, Early Intervention and Prevention and care proceedings

   v. Help young people to strengthen their resilience by developing the factors that promote it, such as educational achievement, training and employment, good health, positive relationships and meaningful activities.

   vi. Act responsively to changes in patterns of substance use amongst young people in Salford and Trafford.

   vii. Ensure that the voice of the child is central to the model and evidenced in reporting.

viii. Work in partnership with other agencies to address wider needs and optimise successful onward referrals, including (but not limited to):

- Leaving Care Services
- Youth Offending Service
- Alternative and mainstream education
- Hospital and other health services including school nursing
- Adult substance misuse services
- Connexions
- Helping families
- Safeguarding services
- Targeted youth services
- Relevant voluntary sector organisations
- Neighbourhood teams
- Housing services
- Sexual health services
- Children and Adolescent Mental Health Services (CAMHS)
- Emotional health services
- Early Help Hub 0-11 and 11-19
- Stronger Families

ix. Salford only:

- Work with the *Leaving Care* Service
  - This service employs a worker to provide substance misuse provision including routine screening to all young people within that service. This post is not in scope for this tender. The service will work closely with this worker
- Provide an appropriately trained worker to be based at *The Bridge* (a multi-agency hub which screens all contacts concerning the welfare or safety of a child. This will allow early detection of children and families requiring support and will also facilitate collaboration and appropriate data-sharing for complex and high-risk families

b. Operational details

The service will be delivered in accordance with the following delivery requirements:

i. Eligibility

- All service users aged under-21 will be considered young people. This will be reflected in the treatment and recovery offered. Young people in the structured treatment system will be reported on using the Young People's NDTMS core data set.
- In exceptional circumstances the service will work with clients resident in Salford and Trafford with alcohol and/or drug problems up to the age of 25, at the discretion of the *Case Management Team*.

ii. Priority groups

- The service will prioritise those young people most in need. This will take account of age, vulnerabilities and deprivation and also the following key groups:
    - Young people with mental health issues
    - Looked after children
    - Young offenders
    - Persistent absentees / excluded
    - Children of substance misusing parents

iii. Referrals

- The service will develop a clear threshold for access and ensure these are passed on to partners agencies. Referral pathways will be established with relevant agencies. Referrals should come with a CAF and / or Early Help Assessment (EHA).
- Key referral agencies include, but are not limited to:
    - Youth services
    - Children and families services
    - Looked After Children
    - Education, including alternative education
    - Youth Offending Service
    - Health and mental health services
    - Sexual health services

iv. Response and waiting times

- Responses will be rapid and proportionate to risk. No response time will exceed five days. Waiting times will not exceed three weeks.

v. Case management

- Case management and care coordination will sit outside the adult Case Management function whilst utilising common IT systems.
- The service will utilise the same Case Management IT system as the other parts of the treatment and recovery system. It will be fully compliant with the latest version of the Young People National Drug Treatment Monitoring System (NDTMS) core data set including the Young People's outcome record (YPOR) and will accommodate any changes to the core data set.

vi. Access

- Provision for young people must be available in a friendly environment that is acceptable, accessible and non-stigmatising for service users. It must also be delivered from locations that are separate from adult delivery.
- The hours of operation must be flexible and will include the provision of out-of-hours services to ensure that young people in education/employment can access treatment.

vii. Discharge

- All successful discharges will include an onward referral to a named service.

- Unplanned exits will be referred on to the *Assertive Outreach Team*. The referring source must be informed and consultation and support provided where appropriate.
- The Lead Provider will develop an agreed process for service users who need to transition between the Young Person's team and the Adult *Case Management Team*

c. Performance management

The service will work towards delivering PHOF and PHE outcomes for Salford and Trafford. The service will be required to:

i. Evidence the improvement of outcomes for young people in specialist treatment.

ii. Record additional locally agreed outcome data in addition to the NDTMS YPOR at treatment start, review and planned exit. This will be reported on quarterly.

iii. Design local performance indicators and targets to demonstrate effective delivery of the service outcomes, to be agreed with commissioners.

2.5 Aftercare and Discharge

a. Recovery from substance misuse is a lengthy process, particularly for those with comorbid health and social problems. The evidence suggests that it can take five years to determine whether a sustained recovery has been established after someone has overcome their dependence on drugs or alcohol[8].

b. The Aftercare and Discharge service will be light touch but perform a vital function in linking treatment and recovery for adults and young people. It will work alongside other elements of recovery provision in the system, acting as a contact point for other parts of the recovery community. Aftercare will be orientated around a telephone support service.

c. Service detail

i. Service users completing structured treatment will be referred on to Tier 2 Aftercare services where they will have the opportunity to access personalisation budget within the Recovery Fund for a period of up to 3 years. Complete discharge from the system will occur after a five year period post-treatment during which the telephone aftercare service will provide regular contact.

ii. The telephone aftercare service will ideally staffed by trained volunteers and peer mentors who will:

- Call members of the recovery community to see how their recovery is progressing.
- Make referrals back into the treatment service via the Case Management team where there are concerns about an individual, either directly or via the wider recovery community
- Engage people with the recovery community through invitations to recovery events or an invitation to a mutual aid event

iii. Level of contact will be determined by risk and complexity. Any cases requiring input from the CCRT during treatment will be managed as Complex during the Aftercare period. The table below shows the recommended frequency of contact for the five years following successful completion of structured treatment:

Time since discharge	Complex	Non-complex
0-12 weeks	Weekly	Weekly
12-52 weeks	Monthly	Quarterly
Year 2	Quarterly	Six monthly
Year 3	Six monthly	Six monthly
Year 4	Six monthly	Six monthly
Year 5	Six monthly	Six monthly

iv. We expect services to obtain consent from service users to be contacted throughout their recovery. This will include consent to pass details on to the AOT when genuine concerns are raised.

d. Responsibilities of the Lead Provider

[8] ACMD (2013) What recovery outcomes does the evidence tell us we can expect? - link

The Lead Provider will be required to:

i. Remain in contact with former service users in recovery for five years following discharge
ii. Support mutual aid opportunities in the recovery community and promote recovery events
iii. Signpost people in recovery to universal health and social care services.
iv. Re-engage those suffering from relapse as appropriate
v. Alert the AOT (Section **Error! Reference source not found.**) if further support is recommended
vi. Agree a consistent discharge process with all partners contracted to deliver within the treatment system

e. Performance management

Reporting will be minimal and will consist of the following:

i. Referrals received
ii. Call attempts and contacts made
iii. Numbers in recovery
iv. Numbers experiencing relapse
v. Referrals made

f. Operational details

The service will be delivered in accordance with the following overarching requirements:

i. Referral process

- Referrals will come from treatment services including recovery elements such as step-down care via the *Case Management Team*
- Both young people and adults can be referred

ii. Response times

- First contact should occur within the first week after successful completion of specialist treatment. Contact with individuals of concern should be attempted immediately in conjunction with the AOT.

iii. Waiting times

- There should be no waiting times for this service.

iv. Access

- The service will be telephone based.
- The hours of operation will be flexible based on need.

v. Priority groups

- Those previously managed by the CCRT
- Those who have left treatment most recently
- Parents

vi. Discharge

- Discharge will occur five years after the successful completion of treatment.

3. SERVICE COMPONENTS

This section will outline the key services which the Lead Provider will be expected to deliver within the integrated treatment and recovery system. The order in which they are presented approximates to the Tiered treatment model outlined in Section 1.6, starting with the highest intensity interventions.

3.1 Support for Tier 4 Detoxification and Residential Rehabilitation

a. Service design

i. The Provider will be expected to establish a panel to review applications for detoxification and residential rehabilitation in Bolton, Salford and Trafford. This will be done in collaboration with the Commissioners, who will hold the budget for these services.

ii. The Lead Provider will create and maintain positive relationships with Tier 4 providers to ensure smooth and effective transfer of treatment between Tier 4 and community services, including:

- Preparation pre-detoxification (working with families and carers wherever possible).
- Assessment and referral to Tier 4 services.
- Discharge and post-detoxification prescribing.
- Relapse prevention prescribing.
- Development of an exit plan for clients when discharged from Tier 4 services.

b. Responsibilities of the Lead Provider

In relation to Tier 4 services, the Lead Provider will be expected to:

i. Work closely with commissioners with regard to the Greater Manchester Framework arrangements for inpatient detoxification to ensure assessment and access procedures are in place.

ii. Work closely with Social Services to ensure assessment procedures are in place for access to inpatient rehabilitation and to provide access to young people's, families and adult social care, including specialist mental and physical health services.

iii. Monitor service user journeys following Tier 4 interventions, and report back to Commissioners

3.2 Community Detoxification

a. Community Detoxification is considered to be a Tier 3 intervention within this system. The Lead Provider is expected to ensure the offer of robust community detoxification for suitable cases (in relation to drug and alcohol misuse), in line with national and local guidance, policies and procedures. The nature of this service will be agreed with Commissioners.

b. Consistent with NICE guidance[9], community-based opioid detoxification should be offered to all eligible service users except those who:
   i. Have previously had an unsuccessful community-based detoxification
   ii. Require additional medical or nursing care due to physical or mental health comorbidities
   iii. Require polydrug detoxification
   iv. Have significant social problems which would restrict the benefit of community-based approaches

c. Before recommending detoxification, Case Managers will be expected to work with service users to identify their recovery capital and agree the most appropriate time to attempt detoxification. The Lead Provider will be required to demonstrate effective clinical governance arrangements to ensure that service users undergoing community detoxification are receiving appropriate levels of medical and psychosocial support.

d. Pathways will exist to facilitate timely referrals into inpatient detoxification where appropriate.

[9] NICE (2007) CG52 Drug misuse in over 16s: opioid detoxification - link

3.3 Hospital liaison service

VARIANCE – This service is not being commissioned in Bolton, due to existing arrangements

a. Alcohol and drug misuse is associated with increased rates of emergency presentations to hospital, often through Accident and Emergency departments. This is a group who often do not engage with other services. Furthermore, the point at which a person with drug or alcohol problems presents acutely to hospital represents a critical moment at which they may be more receptive to targeted support, including referral into treatment services where appropriate.

b. Having an effective hospital liaison service has three complementary functions:

   i. Identifying and engaging new service users, previously unknown to treatment
   ii. Working with established service users to reduce unplanned admissions

Supporting the medical care of service users following admission to hospital

c. Salford currently has a well-established hospital-based Alcohol Assertive Outreach Team which provides a liaison service, in addition to aspects of Complex Case Review and Assertive Outreach support[10].

d. ***Service details***

The Lead Provider will be expected to work in collaboration with NHS Clinical Commissioning Groups and NHS Trusts to develop a specialist service to provide the following functions:

i. Brief screening and interventions (see Section 3.9.2) through A+E and other appropriate settings (e.g. fracture clinics)

ii. Specialist drug and alcohol liaison support for services on inpatient wards

iii. Appropriate information sharing with hospital services regarding service users.

iv. Referral of new service users into the *Case Management Team* (Section 2.1)

v. Co-ordinated discharge planning for known service users in collaboration with the *Assertive Outreach Team* (Section **Error! Reference source not found.**) and Housing support services (Section 3.15)

vi. Ensure appropriate continuation of detoxification with psychosocial interventions following discharge from hospital, including transfer to inpatient detoxification units

vii. Developing a surveillance function to identify high-risk cases based on records of admissions relating to drug and alcohol problems

viii. Developing a service to engage and follow-up service users presenting out-with normal operating hours

ix. Ensuring that information on acute presentations through A+E suspected to be related to New Psychoactive Substances is reported on the local Early Warning System

[10] Hughes et al. (2013*) Salford alcohol assertive outreach team: a new model for reducing alcohol-related admissions*. Frontline Gastroenterology. 4(2):130-134

e. **Responsibilities of the Lead Provider**

In order to deliver the above service, the Lead Provider is expected to:

i. Ensure that patients presenting through A+E are appropriately screened for drug and alcohol problems in accordance with national guidance and standards
ii. Develop protocols to describe how service users should be managed when attending A+E or after being admitted to hospital, including where detoxification is required
iii. Ensure that all relevant hospital wards and departments have contact details for the BST substance misuse service,
iv. Develop information-sharing arrangements with hospital services to ensure the timely sharing of information when service users present to hospital services (e.g. in relation to needs, risks and medication dosages). Consideration will need to be given to how this will happen outwith the working hours of the liaison service.
v. Ensure that the named Case Manager of a service user is contacted following admission to hospital.
vi. Ensure that the BST substance misuse service is informed prior to the discharge of a known hospital patient, in order to contribute to safe and appropriate discharge planning.
vii. Ensure that alcohol liaison nurses are involved in delivering training in alcohol screening and brief interventions to hospital staff
viii. Ensure that the liaison service is equipped to support both adults and young people where necessary
ix. Work with the Specialist Housing and Support service (Section 3.15) to identify appropriate accommodation for homeless service users being discharged from hospital
x.

f. **Operational details**

The service will be delivered in accordance with the following delivery requirements:

i. *Location*
- The Lead Provider will be expected to deliver all of the above functions at Salford Royal NHS Trust
- Trafford does not have its own acute hospital. The Lead Provider will be expected to work with Commissioners to develop an appropriate model of support to Trafford residents being admitted through the University Hospital of South Manchester NHS Foundation Trust (Hospital)

ii. *Access*
- The service based at Salford Royal should provide a seven-day service led by alcohol nurse specialists according to set times agreed with Commissioners
- Access at other sites will be developed and agreed with Commissioners.

iii. *Workforce*
- The workforce of the hospital liaison service will vary depending on local need but it is expected to be led by alcohol nurse specialists.
- The liaison service will also have specialist medical and psychiatric support and oversight, provided by an appropriate specialist.

iv. *Discharge*

- Hospital liaison nurses will liaise with the Case Manager of known service users prior to discharge to ensure safe and co-ordinated discharge planning
- People presenting with drug or alcohol problems who are unknown to the service may be referred into the *Case Management Team* at discharge by the hospital liaison team
- GPs will be informed of each admission prior to discharge
- Based on the clinical scenario, liaison nurses will consider referring unplanned discharges to the Assertive Outreach Team (Section 2.2)

3.4 Pharmacological interventions

The Medical Intervention Service is expected to be able to provide specialist prescribing interventions for alcohol and substance misuse problems, as appropriate. Substitute prescribing will be offered where required but be provided as part of a broader recovery focused treatment package, since evidence suggests that the success rates of pharmacological interventions are dependent on treatments being delivered alongside psychosocial and recovery interventions.[11] Prescribing interventions will be reviewed at frequent intervals to ensure that they are contributing towards recovery goals.

3.4.1 Prescribing in substance misuse

a. The Service will be responsible for the following substance misuse pharmacological interventions:

i. Prescribing interventions (adults)

- Stabilisation prescribing
- Substitute prescribing
- Maintenance prescribing
- Detoxification prescribing (outwith Tier 4 settings)
- Overdose prevention prescribing (e.g. Naloxone)
- Relapse prevention prescribing (e.g. Disulfiram and Naltrexone)
- Prescribing to reduce or prevent withdrawal symptoms

ii. Prescribing interventions (young people)

- The service will need to consider local need for prescribing in young people across Bolton, Salford and Trafford
- A joint working arrangement will need to be agreed with the existing Young Person's service in Bolton (which is not being commissioned within this model)
- The Lead Provider will ensure there is sufficient expertise to deliver this service in accordance with national, evidence-based guidelines and safeguarding policies.
- Appropriate multi-agency pathways will be required to ensure that this activity is fully integrated with the activities of the Young Person's service.

iii. Supervised consumption

- Based on PHE guidance,[12] supervised consumption should be available to:
  - Service users starting opioid substitution treatment
  - Cases where it is felt service users will benefit either from continued supervision, or a return to supervision
- The service will work with service users to identify the most appropriate pharmacy

[11] ACMD (2015) How can opioid substitution therapy (and drug treatment and recovery systems) be optimised to maximise recovery outcomes for service users? - link

[12] PHE (2016) Adults – drugs JSNA support pack 2017-18: commissioning prompts - link

- The Lead Provider will develop strong partnership working and contract management arrangements with local pharmacies to ensure the effective utilisation of supervised self-administration.

iv. Support to Tier 4 services

- Preparation pre-detoxification
- Assessment and referral to Tier 4 Services
- Discharge and post detoxification prescribing
- Relapse prevention prescribing following discharge from Tier 4 services

b. In addition to managing opioid dependency, the Medical Intervention Service is also expected to provide specialist support to those suffering with other types of substance misuse, including (but not limited to) in relation to Benzodiazepines, New Psychoactive Substances and prescription medications (including Gabapentin and Pregabalin[13].

3.4.2 Prescribing in alcohol misuse

a. The Service will be responsible for the following alcohol misuse pharmacological interventions:

i. Prescribing in support of community based detoxification (including symptomatic needs)

ii. Nutritional supplements including vitamin supplements for dependant drinkers, in line with national guidance[14]

3.4.3 Overarching service delivery requirements

a. **Responsibilities of the Lead Provider**

The Lead Provider will be required to:

i. Work with Commissioners to developing arrangements to manage prescribing budgets on behalf of each member of the cluster, where appropriate

ii. Comply with relevant guidance from professional bodies including PHE and NICE, and adapt service provision in accordance with updates

iii. Register with the NHS Business Services Authority (NHS BSA) and inform the NHS BSA of all their prescriber details for ePACT, in order to obtain prescription pads. The Lead Provider will co-operate with the commissioners around access requirements to ePACT and prescribing data

iv. Have a clear evidence based and cost-effective prescribing policy and formulary

v. Ensure that significant changes to substitute prescribing interventions are presented to the commissioners before being implemented (unless of urgent medical need)

vi. Regularly review those receiving substitute medication in line with national guidance, including from PHE[15]

[13] PHE (2013) Advice for prescribers on the risk of the misuse of pregabalin and gabapentin - link

[14] NICE (2010) CG100 Alcohol-use disorders: Diagnosis and management of physical complications - link

[15] PHE (2013) Medications in recovery: best practice in reviewing treatment - link

vii. Ensure that testing is based on therapeutic requirements only and testing to support other interventions will only be delivered as appropriate - notably in line with Probation requirements for court led interventions.

viii. Communicate all instances of prescribing and changes to prescribed interventions with the service user's GP on the same day.

ix. Work with GPs to ensure that prescriptions being delivered by the BST substance misuse service are also coded on primary care record systems to reduce the risk of drug interactions

x. Take responsibility for the appropriate therapeutic monitoring of all service users being prescribed medication within the treatment system in accordance with national guidance including from the MHRA. This monitoring will include, but not be limited to, periodic ECG monitoring for those on specified doses of Methadone[16]. The Lead Provider will ensure there are clear protocols for acting upon abnormal results and sharing this information with necessary partners, including the GP of the affected service user.

xi. Ensure that comprehensive patient clinical records, including all prescribing, are maintained.

xii. Inform the Regional Accountable Officer for controlled drugs of all incidents where a controlled drug is involved even if the incident is later resolved. The reporting will be in the format required of the Accountable Officer. The Lead Provider will co-operate with the regional Accountable Officer as required around prescribing data and any investigations.

xiii. Ensure that service users who are carers for children or have contact with children, are provided with information about the risks to children from medications and the importance of safe storage. Home environments should be visited to assess risk and ensure suitable storage, including the provision of storage boxes.

b. **Operational details**

The service will be delivered in accordance with the following delivery requirements:

i. Referral Process

- Referrals to the service are normally via the *Case Management Team* although they may come from anywhere in the system where time, need or risk justify it.

ii. Response and waiting Times

- The Service is expected to adhere to Waiting Times set by PHE. The Commissioners must agree with any deviation from these priorities. All deviations must be documented so that public health and community safety concerns may be best managed in a safe manner.
- The Service will prioritise all referrals according to an assessment of need and risk

iii. Access

[16] Department of Health (2007) Drug misuse and dependence: UK guidelines on clinical management - link

- Substitute prescribing services will be delivered in a range of settings to maximise engagement which should be centrally located and accessible by public transport in Bolton, Salford and Trafford
- The Service will operate flexibly in line with clinical hours. Emergency services will be available at all hours.

3.5 Shared care

The Lead Provider will work closely with primary care providers and commissioners to provide an appropriate level of shared care interventions, within the primary care setting for alcohol and drug users (inclusive of those using drugs other than heroin). Shared care interventions will be recovery-orientated and in keeping with the principles of harm reduction.

a. **Service Design**

Key features of the Shared Care system include:

i. Delivery of Shared Care clinics

- The Lead Provider will provide dedicated Shared Care substance misuse practitioners to manage clinics within the primary care setting, and support GPs where there is clinical need
- Specialist clinical support for General Practitioners and other primary health care staff will be provided by secondary care service providers as required.
- All staff seeing service users within the Shared Care system should be trained to deliver brief and extended brief interventions
- Shared Care substance misuse practitioners should meet with GPs on a minimum 3-monthly basis to review their caseload
- The Lead Provider will conduct an independent review of Shared Care service users on a minimum 6-monthly basis. This will be done in order to ensure service users remain eligible for shared care and to determine whether they would benefit from any additional support or recovery interventions.

ii. Prescriptions

- GP primary care teams will be encouraged to generate prescriptions for their shared care clinics, however where this is particularly difficult or is not possible for any reason, the Lead Provider will generate shared care prescriptions on behalf of the practice.
- Shared Care teams should liaise regularly with community pharmacists.

iii. Testing

- The Provider will conduct regular drug and or alcohol testing of patients attending as appropriate to clinical need.

b. **Responsibilities of the Lead Provider**

In relation to Shared Care, the Lead Provider will be required to:

i. Contribute to the development and improvement of substance misuse Shared Care models in collaboration with commissioners, including the development of service specifications, service level agreements and performance indicators to meet local needs and in line with national and local guidance.

ii. Ensure appropriate therapeutic monitoring occurs where appropriate (see Section 3.4.1)

iii. Ensure that the Clinical Governance of Shared Care services is fully supported in liaison with the commissioners, assessing compliance against national quality standards including the National Drug Strategy, NICE and PHE guidance, National Service Frameworks and other relevant national and local policies and guidance.

iv. Alert the GP, related primary care services and others as appropriate to changes in the patient's healthcare or other emerging needs.

v. Facilitate collaborative working between primary and secondary care Substance Misuse Services to ensure the effective service delivery across the locality.

vi. Ensure those seen in Shared Care also have full access to services delivered by the Lead Provider including psycho-social interventions, specialist Tier 3 services and detoxification. It should also include screening and vaccination for communicable diseases as outlined in Section 3.6.2, which should be delivered in conjunction with the Shared Care GP

vii. Develop a Shared Care Substance Misuse Training Strategy, including content relating to client care, risk management and developments in substance misuse treatment. Bespoke training should also be delivered where required across the BST cluster, including to clinical staff, GPs and Pharmacists

viii. Lead on the promotion of Shared Care services, advising and contributing to the development of a range of marketing and communications materials to inform consistent development and delivery of Shared Care services.

ix. Develop and administer payment systems for primary care substance misuse treatment providers.

x. Provide Contract Management of GPs who provide Shared Care on behalf of the Lead Provider

c. **Performance management**

The Lead Provider will be expected to:

i. Work with commissioners to develop performance management systems, undertake analysis of data and use to inform long term strategic plans for performance and service improvement.

ii. Provide robust monitoring data to inform the commissioners and to satisfy NDTMS national requirements.

iii. Contribute to an annual review of the Shared Care service, in partnership with Commissioners in each area of the BST cluster.

iv. Liaise with Medicines Management representatives to provide clinical and prescribing data for relevant meetings as requested by commissioners.

v. Be accountable to the commissioners for the management of the Shared Care budgets; oversight of this will be maintained in the contract management function

d. **Operational details**

The service will be delivered in accordance with the following delivery requirements:

i. Eligibility Criteria

- All clients will initially be referred into the Integrated Treatment and Recovery system via the Case Management Team
- The Lead Provider will work with Commissioners to agree a set of eligibility criteria which Case Managers will then use to determine who is eligible for Shared Care
- These will consider patient preference and also include (but not be limited to) adults aged over 18 with stable mental health
- It is considered meeting these criteria with long-term health conditions will particularly benefit from Shared Care arrangements. Where this cannot be organised, Case Managers will be expected to ensure that service users receive regular clinical reviews for their long-term health conditions.

ii. Discharge

- The service will ensure immediate transfer back of service users to the *Case Management Team* where they become inappropriate for treatment within Shared Care as a result of clinical need or inappropriate behaviour or where the Shared Care provider becomes unwilling to continue to manage the service user for any other reason.

3.6 Medical intervention services

a. The Lead Provider will deliver a multi-disciplinary Medical Intervention Service which can be accessed by service users from the BST cluster.

b. The service will have the following objectives:

   i. To identify and manage the physical and mental health needs of service users, collaborating with GPs wherever possible and making referrals to specialist services when appropriate.
   ii. To ensure evidence-based screening and treatment of service users for blood-borne viruses and other infections.
   iii. To consider the needs of service users for smoking cessation interventions.
   iv. To work collaboratively with other clinical services including Pregnancy services and Gastroenterology departments to deliver services in accordance with the principles of harm reduction.

c. It is expected that all service users accessing structured treatment will be able to access the different components of the Medical Intervention service, at a frequency dependent on need and to be agreed with the Commissioners.

d. The Medical Intervention service will develop criteria to identify drug and alcohol users with high levels of medical need as part of routine healthcare assessments - these cases will be referred into the *Complex Case Review Team* (Section 0). The Lead Provider should ensure that there is joint working between the Medical Intervention Service and the *Complex Case Review Team* in order to best serve the needs of these individuals

e. The service should develop links with Specialist hospital-based colleagues where appropriate to provide specialist support for service users and direct referral pathways into specialist services. For example:

   i. The Gastroenterology team at Salford Royal Foundation Trust currently run joint clinics with the Alcohol Assertive Outreach Team and arrange Fibro-scanning for high-risk service users.
   ii. Bolton have developed a Hepatitis C support group which accompanies patients to fibro-scanning appointments at North Manchester General Hospital

3.6.1 Healthcare Assessments

a. In line with current NICE guidance[17] the Lead Provider should ensure that service users accessing structured alcohol or drug treatment services should receive a comprehensive health assessment. The content of this assessment will be based on levels of need and complexity but will reflect existing national guidance, including in relation to specific subgroups, such as older people.[18] The degree of support will depend on the age of the service user and their location within the Substance Misuse Service:

b. **Adults in structured treatment (Section 2.1)**

i. The Lead Provider will that service users in structured treatment (being managed by the *Case Management Team*)are provided with a regular health assessment within the treatment system as appropriate, arranged in liaison with specialist medical services

ii. This should include an assessment of physical and mental health, informed by national guidance. This should be conducted by an appropriate practitioner with content including (but not limited to):

- Diet and nutrition
- Cardio-vascular health (e.g. BP checks, BMI).
- Tobacco / cannabis use.
- Mental health
- Sexual health
- Dental health
- Wound care
- Immunisation status and need for additional vaccinations (see Section 3.6.2)
- Cervical screening eligibility (female service users)

iii. This may lead to onwards referral to primary, secondary or tertiary healthcare.

iv. Service users with concurrent mental health problems will be assessed for their suitability for psychosocial interventions (see Section 3.10) or referral into the specialist Dual Diagnosis service (see Section3.7).

c. **Adults not in structured treatment**

i. Service users not in structured treatment will be supported to access routine health checks via their GP, Pharmacy or Dentist, including a review of their vaccination status. This signposting will occur through:

- The Tier 2 brief interventions service (Section 3.9.2)
- Periodic reviews of service users not in structured treatment (as outlined in Section 1.6.1.g

ii. The following groups will be prioritised, where practical:

- No evidence of GP / Dentist / Pharmacist engagement within last 3 months.
- No evidence of an annual health screening and check-up in last 12 months.

[17] NICE (2011) QS11 Alcohol-use disorders (2011) - link
NICE (2012) QS23 Drug use disorders in adults (2012) - link

[18] DoH (2007) Drug misuse and dependence: UK guidelines on clinical management - link
RCPsych (2015) Substance misuse in order people: an information guide - link

- 3rd party risks as to physical and mental health (significant others, children).
- Frequent case management within Tier 3 and 4 services.
- Recent discharge from Tier 3 and 4 services.
- Prison releases.

d. **Young People's service (Section 2.4)**

   i. The Lead Provider will ensure the provision of a specialist healthcare assessment for all young people in receipt of specialist substance misuse provision. This will be delivered flexibly in age-appropriate settings

e. General Practice will play a pivotal role in managing the increasing medical comorbidities of an aging cohort of opiate users, and the Lead Provider will be expected to develop close relationships between General Practice surgeries and the BST substance misuse service. There must be clear pathways to ensure the timely sharing of information between services. The BST substance misuse service will be expected to provide a contact number which GPs can ring to request further information about any patients managed under the substance misuse service.

f. The service will also be expected to develop joint working arrangements with local sexual health services, including referral pathways, in order to address the needs of those presenting to the service with problems related to Chemsex[19] or any other issue requiring specialist input. This will include the provision of appropriate harm reduction advice and equipment within sexual health clinics, with consideration given to the co-location of needle exchange facilities.

3.6.2 Communicable Diseases: prevention and management

[19] PHE (2015) Substance misuse services for men who have sex with men involved in chemsex - link

a. Service details

The Medical Intervention Service will ensure the following interventions are available to service users, where appropriate:

i. *Screening*

- Service users entering structured treatment should be screened for:
  - Hepatitis B
  - Hepatitis C
  - HIV
- These tests should be repeated annually if initially negative for a service user who remains at risk
- In line with PHE guidance, the Lead Provider is expected to adopt on-site dried blood spot testing[20]
- The service should consider the need to provide screening for Tuberculosis as part of their treatment model on accordance with NICE guidance[21]

ii. *Vaccination*

- Based on Green Book guidance[22], service users should be considered for vaccination against:
  - Hepatitis A
  - Hepatitis B
  - Tetanus
  - Seasonal influenza.
- The need for the children of service users, family, carer and household contacts to receive vaccinations should also be considered

iii. *Treatment*

- The Lead Provider will ensure robust care pathways are in place to ensure service users with a positive test for Hepatitis B, Hepatitis C,HIV or TB are referred into effective treatment

b. Responsibilities of the Lead Provider

The Lead Provider should ensure that:

i. The service has a named lead for blood-borne viruses

ii. Staff involved in testing for blood-borne viruses (BBVs) receive appropriate training in delivering pre-test and post-test counselling to service users.

iii. There are clearly documented policies on the delivery of vaccinations, including the use of Patient Group Directions. These will be in accordance with local protocols and Green Book guidance.

iv. A proactive approach is taken when addressing the immunological health of vulnerable groups. This may involve assertive outreach and engagement with primary care services to ensure the maximum uptake of BBV services.

[20] PHE (2016) Mapping blood borne virus services across the NW community drug and alcohol services
[21] NICE (2016) NG33 Tuberculosis - link
[22] Department of Health (2014) The Green Book: Immunisation against infectious diseases - link

v. New screening and testing technology is identified as it develops and working practices are adapted accordingly, in conjunction with Commissioners and local clinical governance.

vi. All relevant staff have adequate and repeated training to provide BBV advice, support and testing to services users

vii. The service should establish BBV champions and peer support groups, working in close collaboration with local needle exchanges

viii. Joint working arrangements are developed with communicable disease treatment services, with consideration given to co-location of outreach treatment services within BST substance misuse service premises

3.6.3 Smoking Cessation Services

a. Rates of smoking among those who misuse drugs and alcohol are known to be high and evidence suggests that smoking cessation can contribute to improved drug treatment outcomes[23].

b. In line with national guidance[24], the Lead Provider will consider ways to offer smoking cessation support to service users, including:
   i. Nicotine-replacement therapy
   ii. Psychosocial interventions
   iii. Harm reduction advice
   iv. Referral to primary care or specialist services when necessary.

c. This support should be fully integrated within the treatment system. A recent pilot study supported by PHE gives an example of the type of integrated approach which the Lead Provider will be expected to deliver[25].

3.6.4 Maternity Services

a. Attracting and maintaining pregnant women who misuse substances in treatment programmes will enable better outcomes for pregnancy, childbirth and infant development.

b. The Lead Provider will be required to:

   i. Ensure that pregnant women have fast-track access to the BST Substance Misuse Service
   ii. Engage in close dialogue with substance misuse midwives where appropriate to ensure effective shared care arrangements throughout pregnancy and the postnatal period[26].
   iii. Involve workers from the Specialist Children and Family service (Section 3.11) with pregnant service users, where appropriate

[23] Department of Health (2007) Drug misuse and dependence: UK guidelines on clinical management - link

[24] PHE (2016) Adults – drugs JSNA support pack 2017-18: commissioning prompts - link

[25] PHE smoking cessation pilot evaluation report (2016) - link

[26] NICE (2010) Pregnancy with complex social factors: a model for service provision for pregnant women with complex social factors - link

iv. Ensure that all relevant information on needs and risks is communicated with Maternity services in the event that a service user becomes pregnant, based on agreed data sharing arrangements

v. Ensure that women being prescribed medication within the BST substance misuse service are rapidly reviewed by the Pharmacological Interventions service to ensure the ongoing safety, efficacy and appropriateness of their regime, in accordance with national guidance.[27]

3.6.5 Overarching service delivery requirements

a. **Operational details**

The service will be delivered in accordance with the following delivery requirements:

i. *Referral process*
- Referrals to the service are normally via the *Case Management Team*
- Referrals will be accepted from anywhere in the system, if justified by time pressures or risk status
- The Service will RAG rate all referrals to prioritise the order in which they are seen

ii. *Response and waiting times*
- The Service is expected to adhere to waiting times set by PHE.
- The Commissioners must agree with any deviation from these priorities.
- All deviations must be documented so that public health and community safety concerns may be best managed in a safe manner

iii. *Access*
- The Service will operate flexibly in line with clinical hours and the activities of the Assertive Outreach Team.

3.7 Dual diagnosis service

[27] Department of Health (2007) Drug misuse and dependence: UK guidelines on clinical management - link

a. Service users entering substance misuse services are at increased risk of experiencing mental health problems, especially anxiety and mood disorders. People with coexisting substance misuse and mental health problems are considered to have a 'dual diagnosis'. There is evidence that the treatment of mental problems during treatment improves recovery potential[28].

b. The Lead Provider will be expected to work in partnership with the wider integrated care system within the localities of Bolton, Salford and Trafford. This will involve actively and assertively working with acute, community, adult social care and mental health providers to ensure that when adults or young people need support, the experience will be as seamless, efficient and effective as possible, helping the individual to remain independent and self-managing as much as they can.

c. Owing to the co-morbidity of drug and alcohol misuse and mental ill health, the Lead Provider will be expected to work in close partnership with existing providers of specialist mental health services in the BST cluster, to share experience and expertise, and develop reciprocal arrangements enabling individuals presenting through mental health services to receive support and treatment for drug and alcohol problems and for those presenting through the drug and alcohol service to receive support for any mental health needs.

d. For those individuals open to both mental health services and drug and alcohol services, it is expected that the Lead Provider will facilitate an integrated dual diagnosis pathway, giving a single point of access for the individual, thus improving the patient experience and improving efficiency across both services.

e. The Lead Provider will be expected to deliver training to appropriate members of the treatment and recovery system (e.g. Case Managers and Care Co-ordinators) to help identify and support people presenting with mental health problems.

f. Consistent with NICE guidance, the Lead Provider will be expected to work closely with secondary care mental health services to develop local protocols for adults and young people with coexisting psychosis and substance misuse[29]

g. Details of this partnership arrangement, such as the provision of dedicated Dual Diagnosis clinics, will be agreed in collaboration with the Commissioners.

3.8 Harm reduction

[28] ACMD (2012) Recovery from drug and alcohol dependence: An overview of the evidence - link
[29] NICE (2011) CG120 Psychosis with substance misuse in over 14s: assessment and management - link

a. Harm Reduction will be part of the core philosophy of the integrated treatment and recovery system. The Lead Provider will work proactively and flexibly to reduce the harm caused by substance misuse and reduce the chances of substance misuse related death. The Lead Provider will work in partnership with other organisations as appropriate in order to work towards reductions in drug and alcohol related deaths, including in relation to medical comorbidities.

b. Harm reduction services must be available at all stages of the treatment journey in both the young person and adult services. Harm reduction should not be seen as a stand-alone service, but rather a range of interventions to be delivered as required.

c. The Lead Provider will ensure that all staff delivering harm reduction services receive adequate training and supervision. Consistent with national guidance[30], the Provider will ensure that all staff involved in needle exchanges are offered vaccination for Hepatitis B.

d. Specific consideration should be given to developing harm reduction advice should be available for the five main groups of New Psychoactive Substances:[31]

   i. Predominantly sedative drugs
   ii. Predominantly stimulant drugs
   iii. Hallucinogens and psychedelic drugs
   iv. Synthetic cannabinoids
   v. Dissociative drugs

3.8.1 Harm reduction advice

a. Harm reduction advice will be available to service users at every stage of their treatment and recovery journey. Case managers will review levels of need and risks at review appointments in order to ensure that service users are receiving appropriate harm reduction support.

b. Responsibilities of the Lead Provider

The Lead Provider will ensure that:

   i. Harm reduction advice is available from all aspects of the treatment systems (including through needle exchanges).
   Partnership arrangements with other services are developed where harm reduction messages are needed (e.g. in the context of people engaging in Chemsex presenting to sexual health services)
   ii. Harm reduction information is age-appropriate, with separate resources available for Young People

   iii. The following support is available to service users, when appropriate:

- Brief advice, interventions and extended interventions for alcohol and drug use.
- A full range of relevant information and advice covering related harms and risks.

[30] NICE (2014) PH52 Needle and syringe programmes - link

[31] PHE (2014) New psychoactive substances: A toolkit for substance misuse commissioners - link

- Needle exchanges
- Injection site assessment and management including basic wound care where required (and onward referral)
- Naloxone and Basic Life Support training
- Blood-borne virus services (see Section 3.6.2)
- Condoms
- Sexual health information, support and onward referral
- Smoking cessation advice and other health promotion advice
- Advice on how to access recovery groups and mutual aid
- Advice regarding the safe storage of medication

3.8.2 Needle exchanges

a. Needle exchanges will be delivered across the BST cluster in line with local and national policy and guidelines including NICE guidance[32]. Fixed Site, Outreach, and Community Pharmacy Needle Exchanges will be supplied and supported across the locality. Needle exchanges will include a range of equipment to meet the needs of the local population, in line with national evidence and local clinical governance guidance. This will include sharps bins and advice on the safe disposal of needles.

b. **Responsibilities of the Lead Provider**

The Lead Provider will:

i. Work towards full coverage of the injecting population inclusive of those injecting Performance and Image Enhancing Drugs and evidence this to commissioners.

ii. Ensure that needle exchange services are able to engage vulnerable groups (Section 3.8.2) such as those participating in Chemsex and those using a range of substances including (but not limited to) opiates, new psychoactive substances and performance-enhancing substances.

iii. Provide services at times and in places which meet the needs of service users.

iv. Consider outreach or detached services to meet the needs of the at-risk population who do not engage with traditional needle exchange programmes.

v. Ensure that the needle exchanges are fully integrated within the rest of the treatment system and providing other help including harm reduction advice and signposting to appropriate services.

vi. Perform Contract Management of Pharmacies delivering needle exchanges.

c. **Performance management**

i. The Lead Provider must ensure that activity is recorded at needle exchange sites. This will include client details, injecting drug use, treatment status, partial postcode and

[32] NICE (2014) PH52 Needle and syringe programmes - link

services received. Regular reports will be shared with Commissioners, including observations of trends in activity.

ii. This will be utilised by all needle exchanges whether fixed site, pharmacy based or peripatetic.

iii. They must also monitor the number and types of packs which they distribute.

3.8.3 Naloxone and Basic Life Support training

a. In line with national guidance[33], the provision of Naloxone will be considered for service users who are:

i. Currently using illicit opiates, such as heroin

ii. Receiving opioid substitution therapy

iii. Leaving prison with a history of drug use

iv. Who have previously used opiate drugs (to protect in the event of relapse)

b. Following discussion with the service user it will in some circumstances also be appropriate to train family members, friends and carers to administer Naloxone.

c. The Lead Provider will also consider supplying it to individuals based in settings where there is considered to be a high risk of overdose (e.g. hostel managers, outreach workers)

d. Responsibilities of the Lead Provider

The Lead Provider will:

i. Develop a system of Naloxone distribution across the BST cluster

ii. Develop a distribution strategy across the BST cluster to ensure the effective provision of Naloxone to both clients within the Substance Misuse Service and also those who are outside the treatment system but may be at risk, working with external partners where appropriate.

iii. Ensure the provision and training in the use of Naloxone to facilities and providers who regularly come into contact with the users of illegal substances such as homeless refuges, hostels, supported housing, relevant third sector charities.

iv. Monitor the usage of Naloxone kits and record the outcome of individual incidents.

v. Ensure this service is fully integrated with Harm Reduction advice to support service users to reduce and stop injecting drug use practices

vi. Provide the following training and support to service users (and family/friends/carers as appropriate):

- Training for Naloxone administration
- Overdose prevention training
- Basic life support training

[33] Department of Health (2016) Widening the availability of Naloxone - link
PHE (2015) Take-home naloxone for opioid overdose in people who use drugs - link

vii. Develop arrangements with HM Prisons to ensure that previously high risk opiate injectors are considered for Naloxone as part of their release plan

viii. Ensure appropriate clinical governance is in place to oversee the administration of Naloxone, including the use of Patient Group Directives where appropriate

3.9 Screening, brief advice and referrals

The Lead Provider will ensure the delivery of Tier 1 and Tier 2 alcohol screening and brief interventions consistent with current evidence and examples of best practice.[34] These should be available across the BST cluster.

3.9.1 Tier 1 services

a. The provider is required to ensure that universal patient screening, brief advice and onward referral is provided across the BST cluster.

b. The purposes of Tier 1 services are to:

   i. Screen members of the general population

   ii. Provide brief advice

   iii. Identify individuals in need of more in-depth treatment and refer them to the specialist services

c. Responsibilities of the Lead Provider:

   i. Develop referral pathways between the treatment and recovery system and universal services for the BST cluster.

   ii. Assist in the continued development of screening tools and interventions offered by universal services for Bolton Salford and Trafford.

   iii. Supply information on short training or e-learning (e.g. see www.alcohollearningcentre.org.uk) for Tier 1 (non-specialist) professionals to support the delivery of Identification and Brief Advice.

3.9.2 Tier 2 services

a. The aims of the treatments in Tier 2 are to:

   i. Engage drug and alcohol misusers into drug treatment

   ii. Make positive changes to drug and alcohol behaviour.

b. For many clients open access and Tier 2 services are the gateway into the wider treatment system providing an initial point of assessment and advice and, where required, referral into more structured interventions.

c. Tier 2 services provide open access to identification and brief advice for a wide range of drug and alcohol misusers referred from a variety of sources, including self-referrals. This tier is defined by its low threshold to access services, and limited requirements on drug and alcohol misusers to receive services. The Tier 2 services will increase people's levels of self-awareness,

[34] AERC Alcohol Academy (2013) Briefing Paper: Clarifying brief interventions - link
Drummond et al. (2012) Screening and Intervention Programme for Sensible Drinking' (SIPS) - link
Parkes T et al. (2011) An evaluation to assess the implementation of NHS delivered Alcohol Brief Interventions: Final Report – link

self-knowledge and self-efficacy to change. There will be congruence with the message from Tier 1 services.

d. **Service design**

i. The Tier 2 Brief Interventions Service will specifically target high risk populations and deliver bespoke messages of particular relevance to those individuals. Interventions will be targeted to those with the most chaotic patterns of drug and or alcohol misuse who have high levels of complex and unmet needs and poor levels of engagement with treatment services.

ii. Service delivery will focus on:

- General Practice sites
- Hospital sites
- Criminal Justice sites
- Community centres

iii. The above should list should be considered as indicative rather than exclusive.

iv. Tier 2 extended brief interventions differ from the IBAs or simple brief advice typically delivered by universal services outside the treatment and recovery system. Extended brief interventions are often described as brief motivational interviewing in order to clarify their purpose and the principles and skills required for their delivery.

v. These interventions will be offered by suitably trained non-specialists in general settings. Extended brief interventions can be substituted for simple brief advice where the professional has been suitably trained. This will also be dependent on the willingness of the client and the availability of sufficient time.

- Brief advice will be delivered by the provider, as appropriate to both drug and alcohol users, in a variety of settings to maximise engagement.
- All brief interventions will follow current national guidance and extended brief interventions will align to NDTMS descriptions and will be reportable to NDTMS
- Brief interventions will be followed up where possible to evaluate success.
- Motivational interviewing should be implemented for extended alcohol brief interventions, in line with Models of Care for Alcohol Misusers[35].

vi. The Lead Provider will ensure partnership working with other generic Tier 1 and Tier 2 health and wellbeing providers and align activity to the overall integrated drug and alcohol service specification (notably as to consistency of message and local feel of the offer made).

e. **Responsibilities of the Lead Provider:**

[35] NTA (2006) Models of care for alcohol misuses - link

i. Provide targeted identification and brief advice (IBA) services in public locations such as GP, Criminal Justice sites and other community locations.

ii. Focus on neighbourhoods where there is high prevalence of the most damaging kinds of drug and alcohol behaviour based on the Needs Assessment

iii. Work with service user groups to identify a range of "incentives" that will encourage service users to access the service. This could include washing facilities, hot meals, IT support, and access to complementary therapies.

iv. Provide a safe space for drug and alcohol users to access information, support and motivational interventions. The provider will signpost and refer individuals into related agencies and appropriate treatment depending on their needs including advice clinics on areas such as housing access and benefits.

v. Ensure that harm minimisation advice, information on treatment options and information around health and lifestyle for example nutrition, sexual health and smoking cessation are offered in a variety of methods and languages according to need

vi. Include identification and brief assessments and extended brief interventions for those individuals using alcohol and ongoing monitoring for those who are identified as having early signs of alcohol related harm to health

f. **Data collection**

i. The volume of brief intervention activity will be recorded and reported to commissioners. It is not expected that details of all those in receipt of brief interventions are recorded on the case management system. However, consideration should be given to the utility of recording individual details for follow-up purposes.

ii. Those individuals in need of more in-depth treatment or on-going support will be routinely entered on the case management system and NDTMS as appropriate.

iii. Recovery check-ups are recognised as a recovery support modality on NDTMS and should be recorded as such.

g. **Operational details**

The service will be delivered in accordance with the following delivery requirements:

i. Access

- Tier 2 services will be located at convenient points around the three localities covering key sites as outlined above
- Additional access points will be determined by service user consultation, provider engagement and the Joint Strategic Needs Analysis from each locality.
- Tier 2 services will be delivered in line with the operational hours of key sites

ii. Response and waiting times

- In the case of referrals for brief interventions, a quick response is required within the same hour, and as a minimum, the same day to maximise effectiveness.
- This will require flexibility and innovation to deliver, including the use of telephone technology.

3.10 Psychosocial interventions

a. The provision of psychosocial interventions should be seen as a key element of the treatment system. Psychosocial interventions will be available to all service users at all stages of their recovery journey including pre-contemplation, contemplation, active change and relapse prevention. Full consideration should be given to the family context of service users.

b. In line with NTA guidance[36], psychosocial interventions may be considered as structured treatments (requiring referral into the *Case Management Team*) dependent upon the type of assistance provided and level of need

c. **Service Design**

i. A range of psychosocial interventions will be offered that are person centred and recovery focused. They must be evidence-based, including in relation to guidance from the Department of Health[37] and NICE[38]. They will be delivered by appropriately trained and accredited staff to each service user according to need, progress and changing circumstances.

ii. Interventions will be provided to service users with a range of alcohol and drug problems (including in relation to New Psychoactive Substances[39])

iii. The offer will be regularly reviewed based on the changing needs of the client. This will include as a minimum:

- Motivational interviewing
- Cognitive behavioural therapy
- Coping skills training
- Relapse prevention therapy
- Contingency management
- Community reinforcement approaches
- Evidence-based psychological interventions for existing mental health problems
- Psychodynamic therapy (substance misuse focused)
- Counselling
- 12-step work

iv. Counselling will be provided or a referral made for specialist counselling requirements, where needed. The level and duration of counselling support provided will be based on a comprehensive assessment of need. It is anticipated that this will be reviewed after approximately six to eight sessions.

v. The Lead Provider will be expected to deliver specialist interventions addressing the issue of trauma within the treatment system.

[36] NTA (2012) NDTMS data set J: Implementation guide for adult drug and alcohol treatment providers - link

[37] Department of Health (2007) Drug misuse and dependence: UK guidelines on clinical management - link

[38] NICE (2007) CG51 Drug misuse in over 16s: psychosocial interventions - link
NICE (2012) QS23 Drug use disorders in adults - link

[39] New psychoactive substances: A toolkit for substance misuse commissioners (2014) - link

vi. The Lead Provider will be expected to ensure that service users with high levels of need are able to access clinical psychology services within the BST substance misuse service. Access to this resource will be via the *Complex Case Review Team* (Section 2.3)

vii. Where intensive psychological or counselling support is required, e.g. in relation to issues such as trauma, bereavement or post-traumatic stress disorder (PTSD), the Provider will identify and refer to alternative specialist services, where this support cannot be provided within the BST substance misuse service. The Provider should also ensure that staff appropriately signpost service users to local self-help groups, for example, Alcoholics Anonymous and Narcotics Anonymous and accompany them to meetings as appropriate.

viii. A full range of support programmes will be developed (1 to 1 and group where required) to build personal resilience and social capital, focusing on issues including:

- Substance misuse (including drug, alcohol and poly substance misuse).
- Relapse prevention.
- Pre detoxification / rehabilitation groups.
- Housing support.
- Relationships (including parenting).
- Education (including links with local educational providers).
- Employment (effective links with Job Centre Plus, pre-employment and voluntary work groups).
- Life skills (e.g. budgeting, basic cooking skills, nutrition, anger management, social skill development).
- Aftercare support for those successfully completing other treatment modalities.

d. All psychosocial interventions will be recovery-orientated, building on the recovery capital of each individual patient. Specifically the Provider will be responsible for delivering interventions designed to fully prepare clients for detoxification (community and inpatient) and residential rehabilitation in order to increase successful outcomes and reduce unplanned discharges.

e. **Responsibilities of the Lead Provider**

In relation to Psychosocial Interventions, the Lead Provider will be expected to:

i. Ensure that all psychological interventions offered are annually evaluated and updated in line with national guidance

ii. Employ or sub contract with staff who are accredited by the British Association of Counselling and Psychotherapy (BACP), and /or the United Kingdom Council for Psychotherapists (UKCP)

iii. Utilise both accredited and volunteer counsellors (who should be affiliate Members of an appropriate professional body and are working towards full accreditation) with the Provider ensuring that robust systems are in place for on-going training and supervision.

iv. Ensure staff receive regular supervision from individuals competent in both the intervention and supervision.

v. Ensure that staff use their professional bodies competence framework to quality assure their work.

f. **Performance management**

The Lead Provider will ensure that the Psychosocial Intervention service:

i. Monitors the number of sessions provided and develops appropriate outcome measures to evaluate the effectiveness of these sessions

ii. Ensures that service users are involved in reviewing the effectiveness of the interventions.

g. **Operational details**

The service will be delivered in accordance with the following delivery requirements:

i. Access

- The Provider will ensure that Psychosocial Interventions are offered in a range of locations including general practice and community facilities
- Home visits for initial assessment and/or interventions should be available within a clearly defined protocol, particularly for service users under the Assertive Outreach Team.

ii. Duration of treatment

- Psychosocial interventions will be provided for as long as is required to ensure successful treatment outcomes for individual service users.

3.11 Family interventions

a. The family will be central to BST's treatment and recovery system for both adults and children. Children of parents who are dependent on drugs or alcohol have an increased risk of emotional and physical neglect, and of having serious emotional and social problems in later life[40]. Engaging parents in treatment can lead to improved outcomes for both children and parents.

b. All aspects of the system must be designed, delivered and reviewed with the role of the family in mind. This will include a consideration of how the impact on each and every child of those in treatment is assessed. It will include the development of systems, pathways and interventions that minimise the negative impact that parental substance misuse can have on children. In short, the voice of the child must be central to our treatment system and evidenced in reporting.

c. It will also acknowledge the positive role families can play in successful treatment and recovery. It will capitalise on this in moving service users towards sustained recovery by involving families throughout. This will mean working not only with children, but other family members and significant others.

d. Seamless referral pathways should exist between Children's services and the treatment and recovery system. Referrals to the Family Intervention service can come via two different routes:

    i. **Children's services**: This will include those with drug and alcohol problems who are not known to the treatment and recovery system
    ii. **Treatment and recovery system**: Service users accessing structured treatment can be referred into the service by their Case Manager

3.11.1 Parental assessment and intervention

a. The parental status of all service users should be established upon commencement of structured treatment or entry into the *Assertive Outreach Team*. The needs of all children for whom service users have parental responsibility will be assessed and reviewed routinely. Where need is identified, appropriate action will be taken as a priority, in accordance with local policies and procedures, including those relating to child safeguarding.

b. Family interventions will be extended to service users within the wider system if significant risk has been identified. There will be a range of appropriate responses to the identified needs of the children of substance misusing parents within the treatment system.

c. All parents and carers of children and young people will be given harm reduction information and general advice including (but not limited to) the:

    i. Impact of substance misuse on children
    ii. Role of social services

[40] ACMD (2012) Recovery from drug and alcohol dependence: An overview of the evidence - link

iii. Positive parenting

iv. Safe storage of medication.

d. As suggested by PHE Good Practice, the Lead Provider will also work collaboratively and forge close links with local Stronger Families provision and Early Help services.

3.11.2 Family interventions

a. The Lead Provider will ensure that group work for service users with children at risk of poor outcomes due to parental substance misuse is delivered by workers from the Specialist Children and Family Service.

b. Group work with parents will explore general issues of drug and alcohol use as well as the effects this has on the lives of children and families. The sessions will support parents and carers to find new creative ways of communicating with their children with the aim of strengthening parenting capacity.

c. The Lead Provider will ensure that there is a Specialist Children and Family Service element of the treatment and recovery system. Parents in treatment who meet an agreed threshold will be referred on to this service for assessment and support. As part of agreed support plans, the service will work directly with children and their parents, provide activities for children and group work for parents and carers.

d. The service will provide additional support to families in their home. Family support will complement and be in addition to the 1:1 work with children and the group work with parent and carers.

e. The service will work directly with children to enable them to express their feelings, develop self-esteem and build resilience. It will also work in partnership with families in implementing a package of support.

f. The service will provide non-judgmental support, encouraging parents to work towards recovery and to be open about their substance use and other issues that affect them at home and in their parenting roles.

3.11.3 Overarching service delivery requirements

a. Responsibilities of the Lead Provider

In order to deliver the above service, the Lead Provider will be required to:

i. Identify the family arrangements of service users on entering the system through screening within the *Case Management Team*

ii. Assess the types and levels of needs in relation to the children and family of service users and conduct risk assessments specific to children and young people

iii. Tailor support around existing needs of the family and provide a care plan for the family.

iv. Work towards the prevention of family breakdown and children entering the looked after system.

v. Improve family's engagement with services relevant to the parents and child's needs.

vi. Promote recovery in parents and carers and/or to work towards managing their drug and alcohol use.

vii. Develop joint working protocols and data-sharing agreements with Children's services in Bolton, Salford and Trafford Local Authorities

viii. Help children to develop resilience and coping strategies in response to parental substance misuse and allow their voices to be heard by their parents and staff in the treatment service

ix. Raise awareness of family interventions throughout the treatment and recovery system

x. Highlight to the parent any significant harm caused by their drug or alcohol use
    - The service must follow BST specific Safeguarding Policy depending on the local authority the Lead Provider is working with, and refer into children's services if they feel a child is at risk of harm

xi. The Lead Provider must ensure that all services, including any sub-contracted services, have adequate training, including in relation to Safeguarding Policies

xii. Empower parents to make necessary changes that will improve the outcomes for their children and develop on the assets that already exist within families

xiii. Encourage parents to remain in treatment for their drug and alcohol use.

xiv. **Salford only:**
    - Work with the *Leaving Care* Service (Salford Local Authority only)
        - This service employs a worker to provide substance misuse provision including routine screening to all young people within that service. This post is not in scope for this tender. The service will work closely with this worker
    - Provide an appropriately trained worker to be based at *The Bridge* (a multi-agency hub which screens all contacts concerning the welfare or safety of a child. This will allow early detection of children and families requiring support and will also facilitate collaboration and appropriate data-sharing for complex and high-risk families

b. Operational details

The service will be delivered in accordance with the following delivery requirements:

i. Eligibility

- The service will work with parents and families with parental substance misuse issues resident in the BST cluster
- The Lead Provider will work with Commissioners to agree thresholds to each intervention based on need

ii. Access

- There should be a range of family-friendly, accessible and non-stigmatising venues across the BST cluster
- Home visits should be offered to those under the Specialist Children and Family Service and also for families being managed under the Assertive Outreach Team
- Evenings and weekend appointments should be available, in addition to routine times, to ensure that families in education/employment can access treatment.

iii. Priority groups

- Parents and carers with the highest threshold of need.
- Complex cases (such as those who have comorbidities and/or multiple presenting needs)

iv. Response and waiting times

- Families require access within reasonable timescales.
- A response and waiting list procedure will be agreed with commissioners.
- Baseline targets may be set after six months if deemed appropriate.

v. Discharge

- All successful discharges will include an onward referral to a named service.
- Unplanned exits will be referred on to the *Assertive Outreach Team* (Section 2.2)

c. Performance management

The service should be designed to address the following outcomes (in addition to those in Section 4.2):

i. Improve school attendance.

ii. Reduce the risk of children of service users becoming looked after.

iii. Improve the emotional well-being of children, young people and families.

iv. Improve parenting capacity.

v. Support adults on their recovery journeys.

vi. Reduce incidents of domestic abuse and anti-social behaviour

vii. 2010 Drug Strategy Outcomes relating to families:

- Improved relationships with family members, partners and friends
- The capacity to be an effective and caring parent.

The Lead Provider will also ensure that training and group work is routinely evaluated.

3.12 Group work interventions

a. Group Work Interventions are seen as critical to the successful journey of service users from treatment into recovery and it is expected that service users in the BST cluster are able to access these services.

b. Service design

The Lead Provider is expected to deliver a range of group work interventions with the following characteristics:

i. Groups will be available for both drug and alcohol users and developed in response to the needs of clients.

ii. Groups will be accessible (including by public transport) and delivered within walking distance for service users where possible.

iii. The range of groups offered will include SMART recovery and 12-Step recovery.

iv. It is desirable that over time the groups become peer led – however General Practice, Hospital and Criminal Justice targeted groups will need to be robustly designed, monitored and supported.

v. It is desirable that peer navigators and recovery champions take lead roles in delivering group work, within treatment and in recovery and mutual aid.

c. Responsibilities of the Lead Provider

In relation to Group Work Interventions, the Lead Provider will be expected to:

i. Provide different groups for different stages of recovery in a variety of settings.

ii. Allow service users greater choice in achieving their recovery objectives.

iii. Engage those who would not otherwise access treatment.

iv. Reduce isolation of service users and make others' recovery more visible.

v. Provide information about recovery events and encourage engagement.

vi. Promote and facilitate access to peer-led groups.

vii. Offer women's only sessions, where appropriate

d. Operational details

The service will be delivered in accordance with the following delivery requirements:

i. Location of service

- The service will be delivered from a range of community settings including, for example:
  - GP premises
  - Hospitals and Criminal Justice sites
  - Community Hubs & Gateways
  - Church halls

- The Lead Provider will focus on the neighbourhoods most affected by problematic drink and drug use.

ii. Days/Hours of operation

- The aim will be to provide groups during the day, in the evening and at weekends to ensure they are accessible.
- There will be service provision outside of regular office hours to encourage low complexity drinkers to practice moderated recovery and ensure the service is accessible for those in work.

iii. Referral Process

- There will be multiple referral routes to Group Work Interventions, including:
  - Referral from any component of the treatment and recovery service, including the *Case Management Team*
  - Self-referral (including via the treatment and recovery website – Section 0)
  - General Practice
  - Hospital and Criminal Justice delivery sites across the city
- Preferably there will be an opportunity to triage prior to attending group but that should not inhibit the attendance of newcomers who will otherwise be triaged once they have made themselves known.
- Where it is not possible to triage individuals in person prior to commencement, telephone triage is encouraged in order to not limit access.
- Most referrals will be low complexity / low severity but this is not a requirement – group entry will be determined on a case by case basis

iv. Response and waiting times

- The service will operate on a rolling basis – there will only ever be a waiting list if group capacity is exceeded and a new group is in formation.

v. Access

- The Groups should take place on at least a weekly rolling basis
- The aim will be to provide groups in a wide variety of locations, during the day, in the evening and at weekends.

vi. Aftercare

- The evidence-based Group-work Interventions will ideally be followed by life membership of the recovery community.
- This includes access to drink and drug free daily social activities, and recovery coaching.

vii. Discharge Process

- The intervention is a rolling group - members may join or leave at any stage.
- The *Case Management Team* may make onward referrals to Tier 3 or Tier 4 services.
- Decisions as to discharge e.g. breach of rules around sobriety or behaviour will be managed by permanent staff.
- When groups become self-managing arrangements as to arms-length support for group leaders will need to replicate these arrangements.

3.13 Development of a recovery community

a. The Provider will encourage and support the growth of an autonomous, local recovery community. The aim of the Recovery Community is to create a real community with a life of its own. The community will have a social life which features a developing range of drink and drug free activities that responds to the needs and ambitions of its Members. There will also be a focus on the development and delivery of drug and alcohol free social, leisure, sporting, arts and cultural activities every night of the week with a particular focus on weekends.

b. This work will be supported by a Recovery Fund. The Commissioners expect that 2% of the total budget envelope for each area will go to the Recovery Fund. The budget will be allocated in agreement with Commissioners locally and in agreement with service users.

c. It is expected that a proportion of the budget (to be agreed with Commissioners) will be apportioned to a 'Personalisation fund' which service users will be able to apply for to meet specific personal needs whilst in the treatment and recovery system (including Aftercare). This will be governed in accordance with requirements agreed with the Commissioners during transition to the new system.

d. Service design

i. The functions of a vibrant recovery community will include (but are not limited to):

- Fostering education, training and employment opportunities.
- Actively pursuing opportunities for the development of small businesses and social enterprise to provide further opportunities for the personal growth and development of Community Members.
- Offering a range of volunteering opportunities.
- Offering a pool of peer navigators and mentors right across the treatment and recovery system

ii. Recovery activities should be available for all; however it is critical to have some activities accessible only to those in abstinent recovery.

e. Responsibilities of the Lead Provider

In relation to the development of a recovery community, the Lead Provider will be expected to:

i. Identify and support existing networks of recovery including the advertisement of the contact details, availability and operating hours of mutual aid groups and recovery networks in Bolton Salford and Trafford.

ii. Provide opportunities to respond to the needs and ambitions of service users.

iii. Identify and support the development of Leaders within the Recovery community

iv. Support Community Leaders with the development of social enterprises to develop a sustainable income stream for the recovery community and provide additional opportunities for volunteering and employment for people in recovery.

v. Provide access to Advocacy for Service Users.

vi. Support the establishment of new 'self-sustaining' community support groups.

vii. Ensure that a live list of all support groups is kept and service users are signposted to these groups where appropriate.

viii. Provide support, training and where appropriate supervision for Recovery Community Leaders.

ix. Provide support to Recovery Community Leaders to identify and bid for other funding

f. Operational details

The service will be delivered in accordance with the following delivery requirements:

i. Referral Process

- Service users will be helped to engage with groups and activities within at all points within their recovery process. This will take account of the needs of the service user and requirements of the groups to ensure an appropriate match.

ii. Access

- The venues could be local service delivery points, gateway centres, church halls, people's houses, in the open air, in the countryside. A key consideration in planning services will be that people in recovery are unlikely to have significant disposable incomes to build personal social assets.
- The Lead Provider will ensure an activity is put on every night of the week with a particular focus on weekends.

3.14 Education, training and employment interventions

a. Research suggests that integrating education and training services within substance misuse services can improve employment outcomes and that undertaking voluntary work during treatment can help recovery[41]. A key part of the recovery system will be structured interventions to support education, training and employment (ETE) opportunities for service users all stages of the treatment and recovery system. It will act as a gateway to further formal learning and equip learners with the necessary skills to act as peer mentors/recovery workers or volunteers within services, if desired.

b. Service detail

i. The Lead Provider will organize interventions to allow service users to access education, training and employment interventions.

ii. The detail of these interventions will be agreed with Commissioners and the Recovery Community and should include the development of accredited training programmes according to the needs and aspirations of service users.

c. Responsibilities of the Lead Provider

In order to deliver the above services, the Lead Provider will be expected to:

i. Work with Commissioners to ensure that the ETE needs of service users are integrated within worklessness and employability strategies within each Local Authority.
ii. Work with Case Managers to ensure that service users are encouraged to consider ETE interventions from an early stage of their treatment and recovery journey
iii. Consult with commissioners and members of the recovery community to design and refine ETE interventions
x. Deliver training sessions in each area in collaboration with local Job Centres and Work Programmes and ensure that trainee and apprenticeship posts are made available to enable service users to make the step from Peer Mentor posts into full time employment within the drug and alcohol service.
iv. Develop the role of paid and voluntary positions (e.g. peer mentors) within the Substance Misuse Service
v. Consider establishing employment champions in each Local Authority area who can provide personalised support for service users looking to return to work[42]
vi. Develop and share case studies of successful ETE outcomes among service users
vii. Engage with local employers to address negative preconceptions and stigma about recruiting individuals with a history of substance misuse
viii. Ensure that all interventions delivered are consistent with the 'Working Well' theme of the GM PSR agenda[43]
ix. Ensure the development of ETE resources and programmes specifically focussed on service users in the Young Person's service (Section 2.4)

[41] ACMD (2012) Recovery from drug and alcohol dependence: An overview of the evidence - link
[42] PHE (2015) Alcohol JSNA support pack 2017-18: commissioning prompts - link
[43] GMCA (2016) Working Well annual report - link

x. Consider how to record successful ETE outcomes in service users in the recovery community who have left structured treatment

d. Operational details

The service will be delivered in accordance with the following delivery requirements:

i. **Referral process**

- Service users will be referred into this service by their Case Manager

ii. **Location**

- Where training courses are offered they should be delivered in a range of locations, including community facilities, according to identified need

3.15 Specialist housing and support services

Suitable, safe and secure accommodation is critical to supporting service users through treatment and into a sustained recovery.

a. In relation to this model the Commissioners have identified key groups of service users whose needs the Lead Provider will be expected to address:
    i. Dependent drinkers and drug users
    ii. Abstinent service users leaving inpatient detoxification units
    iii. Abstinent service users leaving residential rehabilitation units
    iv. Abstinent users moving towards independent living
    v. Street homeless (abstinent and non-abstinent)

b. Each of these groups has specific housing needs. In order to address the Lead Provider will be expected to provide an innovative housing offer which must include (but is not limited to):
    i. Tier 4 residential rehabilitation
    ii. Step-down housing
    iii. Floating support

c. It will be desirable to create a geographical sober living community of abstinent individuals in a discrete designated area. These people will likely have a fragile asset base, high problem severity, and need enhanced care.

3.15.1 Tier 4 Residential Rehabilitation

a. **Current provision:**

b.
- Salford - As part of the current Lead Provider model the THOMAS charity provide seven male and five female residential rehabilitation beds.

b. Residential rehabilitation is a Tier 4 service which provides accommodation and support to service users immediately following detoxification. The Lead Provider will ensure the continued presence of local Tier 4 Residential Treatment and Recovery provision to provide a focus for abstinent recovery and mutual aid.

c. It should be a highly specialized, entirely abstinent residential unit which features daily group work and 1:1 mentoring. This provision will operate from an explicit therapeutic community approach using validated methods clearly supported from the international evidence base. It will be supported by acute and specialist services as necessary.

3.15.2 Step-down housing

a. **Current provision**

- Salford - As part of the current Lead Provider model the THOMAS charity provide seven male and four female step-down housing beds.

b. Step-down housing acts as a bridge between rehabilitation and independent living. It should offer daily group work and support and will be expected to use and develop peer mentors. Provision of accommodation is expected to be for a minimum of 12 months.

3.15.3 Floating support

a. Floating support services can be effective at enabling those with drug and alcohol problems to sustain housing[44]. The Lead Provider will be expected to work with local partners to develop specialist housing support to service users who are living independently. The nature of this support will be agreed with Commissioners but may include:

i. Tenancy support

ii. Help with bills

iii. Home safety risk assessments

b. The support will be targeted based on level of need and complexity and will prioritise those coming from step-down housing. It will work closely with the *Assertive Outreach Team* (Section **Error! Reference source not found.**) and the Complex Case Review service (Section 0).

3.15.4 Overarching delivery requirements

a. **Responsibilities of the Lead Provider**

In order to deliver the above types of housing support, the Lead Provider will be expected to:

i. Name a social housing provider as a key partner to develop and jointly manage housing support services but also to develop flexible services e.g. pop up services in localities

ii. Understand the local housing market and supply of accommodation in the BST cluster, including access routes into all housing tenures

iii. Provide robust and reliable housing related information (both qualitative and quantitative) to help inform needs assessments and commissioning priorities.

iv. Liaise and engage in appropriate multi agency housing related forums e.g. homelessness and private landlord forums.

v. Liaise and work in partnership with Local Authority housing departments, registered social landlords and supported accommodation providers to ensure that the most appropriate housing solution is obtained for both abstinent and non-abstinent service users in housing need, homeless or in inappropriate housing.

[44] ACMD (2012) Recovery from drug and alcohol dependence: An overview of the evidence - link

vi. Build partnerships with the private rented sector in order to meet the housing needs of service users including linking into accreditation schemes and rent / bond guarantee schemes.

vii. Work in partnership with voluntary sector organisations and providers to complement existing services and maximise impacts, particularly with those that provide help and support to substance users with housing related problems.

viii. Ensure that appropriate support is offered for service users such as making arrangements on behalf of the service user, taking service users to appointments, providing substance misuse and other specialist counselling, ensuring medication is taken and medical appointments kept

ix. Align the housing support strategy with the 'Housing and Homelessness' stream of the GM Public Sector Reform Agenda (Section 1.3)

x. Work with the Hospital Liaison service (Section 3.3) to identify appropriate accommodation for homeless service users being discharged from hospital

b. **Operational details**

The service will be delivered in accordance with the following overarching requirements:

i. Eligibility
- Support will be provided to male and female service users and, where appropriate, families

ii. Referral process
- Referrals to Residential Rehabilitation and Step-down housing will come via the *Case Management Team*(Section 2.1)

iii. Response and waiting times
- Response times will be subject to a response and waiting list procedure agreed with commissioners

iv. Priority Groups
- The priority groups for the Tier 4 Recovery 'Dry' Residential Services and Tier 2 Abstinent Step Down Services are for service users with:
  - Low recovery capital
  - High problem severity
  - High complexity
  - Clear evidence of motivation for abstinence

3.16 Criminal justice interventions

a. The Lead Provider will ensure that all substance misusing offenders receive appropriate and co-ordinated interventions at every point of the Criminal Justice System (CJS). It is recognised that those within the Criminal Justice system often do not engage well with traditional treatment services. As such, it is expected that the Criminal Justice interventions will work closely with the *Assertive Outreach Team* (see Section **Error! Reference source not found.**) to deliver the services listed below.

3.16.1 Conditional Cautioning

a. Conditional cautions will be used as an opportunity to encourage substance misusing offenders to address their substance misuse problems. Joint working arrangements with the Police/CPS will be developed to ensure effective communication/referral pathways for Conditional Caution clients are established and maintained. Timely feedback will be provided to Greater Manchester Police on the outcome of the interview, (i.e. the offender has or has not taken up the offer of support).

3.16.2 Prison In-Reach

The Lead Provider will be expected to:

a. Provide sufficient prison link capacity to cover the engagement, release plan and reintegration requirements of clients due to and upon being released from prison (given available resources)

b. Identify and track all substance misusing offenders through custody until release.

c. Establish and maintain good and effective working links and relationships with HMP Substance Misuse teams at all HMPs - including identifying known points of contact within relevant HMPs and maintaining weekly liaison to track and update release dates.

d. Respond to and accept all HMP Substance Misuse Team referrals.

e. Secure notice of and respond effectively to any early releases.

f. Signpost all those offenders who are released on licence to the substance misuse service, either at the time of release or immediately prior to this.

g. Ensure engagement after release with other services that support re-integration back into the community.

3.16.3 Drug Rehabilitation Requirements (DRRs)

The Lead Provider will be expected to:

a. Conduct assessments of suitability for DRR.

b. Be responsible for the co-ordination of all delivery elements of the DRR including treatment appointments, lifestyle and health interventions.

c. Deploy a flexible approach in the delivery of the DRR, particularly with regards to an offender's treatment compliance and punctuality.

i. The decision to withdraw treatment services for clients must be undertaken in conjunction with the Offender Manager responsible for order enforcement.

d. Provide witness statements to support court proceedings where an offender has failed to attend an appointment.

e. Attend court if requested when breach proceedings take place.

f. Fully participate in sentence plan reviews.

g. Ensure, on successful completion of a DRR, that in conjunction with the offender manager a pathway into community treatment services is enabled.

3.16.4 Prolific and Priority Offenders (PPOs) or equivalent

The Lead Provider will be expected to:

a. Ensure that PPO and similarly risk-profiled / stratified offenders are provided rapid access to substance misuse treatment and interventions - such offenders must be given access to substance misuse treatment within 5 working days from referral.

b. Ensure that on release from custody; a PPO is drug tested, and as required during the duration of the licence.

c. Ensure that drug testing of clients including type of test and location is appropriate to the client's needs (e.g. offender in full time employment).

3.16.5 Alcohol Treatment Requirements (ATR)

The Lead Provider will be expected to:

a. Conduct assessments of suitability for ATR.

b. Co-ordinate and deliver the treatment element of ATR for the offender including treatment appointments, lifestyle and health interventions.

c. Provide treatment to offenders referred from the CRC who are assessed as alcohol dependent and who have committed offences.

d. Deliver a minimum of one treatment appointment per week.

e. Deploy a flexible approach in the delivery of the ATR, particularly with regards to an offender's treatment compliance and punctuality.

f. Provide witness statements to support court proceedings where an offender has failed to attend an appointment.

g. Attend court, if requested, when breach proceedings take place.

h. Fully participate in sentence plan reviews.

3.16.6 Integrated Offender Management (IOM/PPO)

a. Individuals who are the most prolific, causing harm and designated high risk will be referred for consideration to the IOM (Spotlight) team.

b. The purpose of this scheme is to provide additional support to this client group by monitoring engagement closely and providing an integrated, holistic support package to them to minimise chances of reoffending.

3.16.7 The DIP Team

a. This is based in Police Custody suites. Individuals who test positive for Class A drug misuse (Opiates and Cocaine) will receive an assessment by a designated member of the BST Substance Misuse Service whilst in police custody (Initial Assessment stage).

b. A further Follow-Up Assessment to attend in the community will then be made. These assessments are in accordance with the Drugs Act 2010. By providing intervention at arrest, it is hoped this will provide the motivation required to avoid longer-term contact with the criminal justice system. It is expected that drug-using offenders will have access to support with life skills, education, training and employment and housing.

3.16.8 Restriction on Bail

a. It is expected that individuals will benefit from operation of Restriction on Bail (or RoB) which is the name given to a specific bail condition which can be imposed on individuals by Criminal Justice Courts. The RoB condition legally compels those on Court bail to attend all appointments as directed by drug treatment agencies.

b. To be eligible for the bail condition, an individual must be:

   i. 18 or over

   ii. Have tested positive for Class A drugs upon arrest

   iii. Be appearing for an offence which the Court feels is drug use related.

c. The RoB Coordinator is based at Court premises and acts as an advisor to Judges and Magistrates on drug treatment, drug use and related offending. The RoB Coordinator will be expected to liaise with treatment services during bail periods to monitor the engagement of those subject to the condition. Treatment progress, whether good or bad, will be relayed to the Court by the Coordinator at any future hearings. Failure to attend RoB treatment appointments whilst on Court bail, may lead to an individual being arrested and having their bail revoked, leaving them remanded in prison custody.

3.16.9 Overarching service delivery requirements

a. In respect to Criminal Justice interventions, the Lead Provider will be required to:

i. Ensure that within the available budget the full range of services within the specification are available to Criminal Justice clients.

ii. Ensure that services are developed for the use of Criminal Justice clients, in consultation with the Probation and Police Services and the Commissioners

iii. Ensure that a pathway of end-to-end treatment is maintained (in partnership with other agencies and within available resources) through the Criminal Justice System into community services (HMP based services are out of scope in this tender).

iv. Ensure services for *high risk* offenders are delivered within appropriate venues including Probation Trust and related provider premises

v. Have a retention strategy in place to increase and maintain offender compliance

vi. Ensure that all users referred have offending identified through screening assessment or care planning, or have on-going community sentences i.e. DRR , ATR and cautions, and be coordinated through the Criminal Justice System

vii. Ensure effective partnership working with Criminal Justice agencies:

- Greater Manchester Police
- HM Courts
- CRC and NPS
- HM Prisons; specifically Prison Health Care and Substance Misuse teams to support users at point of release from custody
- Young People's Secure Estate

viii. Participate in the relevant multi-agency case meetings and case management arrangements in the wider partnership setting, including local Community Safety Partnerships / PPO schemes

ix. Within available resources, cover custody suites and courts to maximise opportunities for identifying, assessing, and approaching and engaging appropriate clients within services

x. Ensure staff are specifically trained to address re-offending

xi. Form and adhere to local agreements to communicate important information such as the appointment attendance / non-attendance of clients and provide feedback to link to enforcement / public protection to ensure consistency

xii. Seek to identify best practice and constantly strive to provide the highest level of service. However, any service processes for CJS services should not be changed without prior agreement.

xiii. Ensure that individuals subjected to an Alcohol Treatment Requirement or a Drug Rehabilitation Requirement receive treatment from the incoming provider in respect of their substance misuse needs.

xiv. Work in partnership with the new GM Liaison and Diversion Service to ensure a seamless pathway between both and that clients' needs are met

4. SYSTEM DELIVERY REQUIREMENTS

4.1 Universal IT system

a. The Lead Provider will have a single IT system able to deliver the required performance data expected across the whole integrated service in the BST cluster. This will require a process of data migration from the existing IT systems used in each area (see Appendix x) which will need to be factored into any transition period.

b. Responsibilities of the Lead Provider

The new system must incorporate the following functions and characteristics:

i. Clinical Management system

- All relevant information for service users in structured treatment should be recorded in a universal case management IT system. This will include (but not limited to): care planning, , health care assessments, BBV information and referrals
- The Lead Provider should work with Commissioners to develop appropriate mechanisms to report activity occurring outside of structured treatment (e.g. Tier 2 interventions, screening information)

ii. Needle exchange database

- There must be capability in place to record activity at needle exchange sites.
- This will include client attributer information (initials, DOB, gender), injecting drug use, treatment status, partial postcode and services received.
- This will be utilised by all needle exchanges whether fixed site, pharmacy based or peripatetic.
- There must also be a fully functioning reporting facility for the purposes of on-going monitoring and needs assessment.

iii. NDTMS systems compliance

- All NDTMS guidance must be adhered to in full.
- The system will be capable of recording, storing and reporting all NDTMS data for the treatment system
- Providers must have procedures in place to validate monthly NDTMS extracts prior to submission. This should ensure an accurate client count.
- This system must:
    - Have been validated and gained approval of PHE.
    - Be compatible with both the adult and young people's core data sets.
    - Be capable of managing multiple NDTMS agency codes whilst recording each treatment journey continuously.
    - Be accessible to all parts of the treatment system based on need to ensure continuity of care as client move through the treatment system.
    - Allow closer understanding of performance across the treatment system

iv. Performance reporting

- The system must also be capable of reporting on performance against local priorities (outline in Section 4.2)
- The system should also allow extraction of strategic data, and cohort data to be used for ad hoc studies and longitudinal research into effectiveness.

v. Accessibility and usage

- The Case Management IT System must be accessible to all parts of the system irrespective of location or specialism based on need - this will include any sub-contracted provision
- The Lead Provider must determine data responsibility roles and have agreements in place prior to the commencement of the contract.
- The treatment and recovery system must have sufficient licences for the number of users. Licence periods must be appropriate to ensure the continuity of service is not disrupted.
- Significant changes to clinical management systems must not take place without providing Commissioners with prior notification. Any changes, including upgrades, must be planned in order to avoid significant disruption to service delivery.
- The Lead Provider needs to ensure policies and protocols of all component parts of the system are aligned. This will include data flow across the treatment system.
- The Case Management IT system must be able to transfer records easily to a new system when required with minimum disruption to service delivery.
- The IT system must be able to assist with child protection and safeguarding needs

vi. Information governance

- IT procedures must be fully compliant with the Data Protection Act 1998, Caldicott Guidance and Practice and Information Commission Guidance and Practice
- Data sharing for the purposes of Community Safety must also comply with the overarching powers of the Information Commission.
- Development of information sharing agreements need to be factored into the implementation plan

4.2 Performance management

Please note the final set of outcomes (including target ranges) will be agreed with the provider following the award of the contract. A set of core indicators to measure service delivery will also be agreed with the provider.

a. Services need to show how the money they spend delivers sustainable outcomes by evidencing what they do, how they do it, and how well they do it. Specifically the service needs to evidence that *their* service/interventions have made a difference to the physical health, mental health and the overall wellbeing of the clients, families and communities they serve. The treatment and recovery system will work towards meeting the outcomes set out in the National Drugs Strategy 2010:

   i. Reduce illicit and other harmful drug use; and
   ii. Increase the numbers recovering from their dependence

b. The performance management of this contract will be done using a number of methods including:

   i. National and local data sets
   ii. Qualitative reporting
   iii. Financial and workforce reporting
   iv. Service user, family, and carer satisfaction surveys,

c. This will ensure that both hard and soft measures are utilised to monitor the delivery of the contract. The Lead Provider will be accountable for performance across all parts of the treatment system cover by this specification.

4.2.1 PHOF indicators

a. The following PHOF indicators are substance misuse specific and will be monitored by the Commissioners.

   i. PHOF 2.15i - *Proportion of all in treatment, who successfully completed and did not re-present within 6 months – opiate clients*
   ii. PHOF 2.15ii - *Proportion of all in treatment, who successfully completed and did not re-present within 6 months – non-opiate clients*
   iii. PHOF 2.16 - *People entering prison with a substance misuse dependence issue who are previously not known to community treatment*
   iv. PHOF 2.18 - *Alcohol admissions to hospital*
   v. PHOF 1.13i - *Re-offending levels - percentage of drug misusing offenders who re-offend*
   vi. PHOF 1.13ii - *Re-offending levels - average number of re-offences per drug misusing offender*

4.2.2 Service user outcomes

a. The Lead Provider will be expected to work with Commissioners and service users to develop an approach to monitoring treatment and recovery outcomes for individual service users. The chosen method will be designed to be completed in collaboration with service users with an emphasis on recovery outcomes.

b. An approach recommended by Commissioners is the use of the 'Outcome Star[45]', which is a measure that can be used to gather information from service users on a range of outcomes at different time points. These can be plotted and used to graphically compare progress through treatment and recovery.

c. The Lead Provider will ensure that service user outcome data is recorded systematically and submitted to Commissioners at regular intervals.

d. The Lead Provider will also be expected to produce case studies from different aspects of the BST substance misuse service, at a frequency to be agreed with Commissioners

4.2.3 Performance Management Framework

a. The Drugs and Alcohol Performance Management Framework will consistent of a number of national and local measures, including drug and alcohol specific indicators from the Public Health Outcomes Framework (PHOF). The local indicators will be based on what the commissioners and Lead Provider agree to be the best measures of performance, stretch and developmental work in a long term dialogue during the life of a contract. These will be developed and finalised during the transition phase.

b. The required outcomes are listed in the below, grouped by theme:

i. Motivation and Taking Responsibility
ii. Self-Care & living skills
iii. Managing Money & Personal Administration
iv. Social Networks & Relationships
v. Drug and alcohol Misuse
vi. Physical Health
vii. Emotional and Mental Health
viii. Meaningful Use of Time
ix. Tenancy and Accommodation

[45] 'Outcomes star' home page (2015) - link

4.2.4 Compliance

a. The performance data required under this specification and contract are subject to change by the commissioners; such changes will be discussed in advance and managed by the commissioners. During the post award pre commencement phase the following data extraction will be agreed in detail between the Lead Provider and Commissioner:

   i. Performance Management Framework (PMF).
   ii. Data derived from NDTMS and Local Data.
   iii. Range of Outcomes: process, clinical, & longitudinal evaluation.

b. A final agreement will be reached during the transition phase as to the precise monthly, quarterly and annual data returns and quality reporting required by the Commissioner.

c. The reporting of locally collected performance data will take place within an agreed timeframe. This will include some geographical reporting for headline indicators at sub-Local Authority level and TOP outcome data for the whole treatment population (e.g. local reporting of TOPS data will be more extensive than currently distributed nationally). Failure to comply with any targets will result in an exception report to include an action plan detailing how the Lead Provider identifies the problem and plans to resolve the problem.

d. In relation to overall compliance, the Lead Provider will be expected to:

   i. Comply with the performance management frameworks that support this specification. The Lead Provider will ensure that all parts of the system keep within any national and locally set targets.

   ii. Provide financial, performance and governance (inc. safeguarding) functions. An important element of this will be the collection, collation and reporting of whole supply chain:

      - Monthly and Quarterly and Annual data for Performance Management
      - Quality Data and Quality Standards compliance (upon request)
      - Information Governance Reporting (Quarterly and Ad Hoc)
      - Clinical Governance Reporting (in line with DoH and CCG requirements)
      - Financial Reporting (Quarterly)
      - Workforce Reporting (Quarterly)
      - Recovery and Personalisation Reporting (Quarterly)
      - Social Value Reporting (Quarterly)

   iii. Make full use of performance information as part of continuous service development.

   iv. Assist Commissioners in servicing strategic commissioning functions.

e. In relation to NDTMS compliance, the Lead Provider will be expected to:

i. Comply with all requirements of PHE and the Authority in maintaining accurate Patient records and uploading all monthly data and reports to meet in full the NDTMS Reporting requirements.

ii. Have internal processes to ensure data is validated prior to monthly NDTMS DAMS submission. This will include ensuring an accurate client count is submitted and discharge details are up-to-date. Sub intervention Reviews, including recovery support, and TOP forms must be completed at relevant points within the treatment system and input onto the data system in a timely manner.

iii. Have processes in place to update NDTMS data fields as appropriate. Relevant fields include Hepatitis C details, Hepatitis B details, Postcode and TOP care co-ordinator

iv. Ensure that discharges from NDTMS are linked to the service's discharge policy to ensure data is captured and reported in a timely manner.

v. Have a robust internal process for reviewing and utilising the full array of NDTMS reports, including the Recovery Diagnostic Toolkit and Reliable Change Index. Workers must have a full understanding of the requirements of NDTMS including why the data is collected and how the reports demonstrate activity.

vi. Have processes in place to ensure the timely and accurate submission of all relevant national datasets (including any new datasets that come into existence during the period of contract).

vii. Be accountable for timely and accurate data submissions across all parts of the treatment system cover by this specification. The minimum expected compliance rates are as follows:

- NDTMS core data set 100% data compliance
- TOPs 90% data compliance minimum
- YP outcome record 90% data compliance minimum
- NEXMS 100% data compliance
- DIRDET 100% data compliance

viii. Identify and agree a specific map of data collection events on NDTMS and any other agreed outcome tools across the supply chain. This will state which service elements collect data, when, and for what purpose. The map will inform audits and long term evaluation of performance and value for money and social return on investment by Bolton, Salford and Trafford Local Authorities and other funding partners.

ix. Complete full TOP data for all drug and alcohol clients within adult structured treatment.

4.2.5 Performance meetings

a. Performance meetings will be formal meetings with Terms of Reference drafted and agreed by both parties. They will take place on a quarterly basis. Prior to the performance meetings commissioners will inform the Lead Provider of any areas of underperformance or concern. The Lead Provider will provide exception reports to address these issues.

4.3 Service user involvement

a. Service user involvement has been shown to have a beneficial impact on treatment and recovery outcomes. The Lead Provider will ensure that services are flexible and responsive to the needs of service users. Services will actively involve the individual and significant others in the treatment journey, allowing them to make informed choices based on the range of interventions available to them. All interventions will be fully explained and choices will be offered where appropriate. All users of the services offered will be treated with respect at all times.

b. According to the National Treatment Agency[46], successful service user involvement should result in:

   i. Strengthened accountability to all stakeholders
   ii. Services that genuinely respond to the needs of users and carers
   iii. A sense of ownership and trust

c. In collaboration with Commissioners, the Lead Provider is expected to systems which facilitate service user involvement in the BST cluster which reflect the latest guidance from agencies including PHE[47] and the Care Quality Commission. This describes four levels of a substance misuse system at which service users can become involved:

   i. In their own care or treatment plan
   ii. In strategic development and commissioning
   iii. Developing and delivering peer mentoring and support
   iv. Developing and delivering user-led, recovery-focused enterprises

d. The Lead Provider will be expected to demonstrate ways in which service users are being encouraged to participate at each level and evidence of how service user feedback has been incorporated into service planning and delivery. In this regard there will be an overlap with some of the interventions being developed by the Recovery Community (Section 0). Particular efforts will be made to engage and receive feedback from young people, carers and other priority groups.

4.4 Social marketing and communication

[46] NTA (2006) *Guidance for local partnerships on user and carer involvement* - link

[47] PHE (2015*) Service user involvement: A guide for drug and alcohol commissioners, providers and service users* - link

a. The Lead Provider will develop an integrated Social Marketing and Communication programme across the BST cluster. It is intended that this will:

   i. Raise awareness of the treatment and recovery service and increase numbers of 'unknown to treatment' referrals into the case management system

   ii. Encourage self-treatment, primarily by raising self-knowledge, self-efficacy and self-help, by accessing facilities such as 1:1 support, groups, fellowships, along with web and text based resources.

   iii. To enable and equip people to engage in their own care both individually and collectively via formal groups, informal groups, associations and fellowships – ideally at both a Greater Manchester wide level and neighbourhood level

4.4.1 Communications Strategy

a. The Lead Provider will ensure the design and implementation of a communications strategy detailing how they will respond to the full range of communication requirements including:

   i. Responding to general enquiries

   ii. Complaints

   iii. On-going care management issues

   iv. The handling of crisis and emergency situations.

b. The strategy will be reviewed on an annual basis and will cover communications with

   i. Service users
      - The Provider will implement innovative communication systems to effectively engage with service users.
      - The Provider will also ensure that patients are aware of how to make a complaint, if necessary.
      - The provider will ensure the provision of a text messaging reminder function for all appointments.

   ii. Staff

   iii. Partner agencies
      - The Provider will ensure that all necessary data sharing agreements are in place between appropriate service providers
      - This will ensure that staff are in possession of all the relevant information and facts about a client prior to their first appointment.

   iv. The public

   v. Media (see Section 4.4.6)

   vi. Commissioners

4.4.2 Marketing Plan

a. The Lead Provider must explore and develop pathways with all partner organisations and agencies so they are aware of what is available, from whom, and how referrals can be made. They must develop a marketing plan to promote the services and increase engagement. The Provider will work with the commissioners to develop a brand for the treatment and recovery system.

b. The techniques used will include:

   i. Distributing leaflets, posters and flyers.
   ii. Consulting with key stakeholders.
   iii. Launching new tools, interventions and services.
   iv. Developing age-appropriate catchphrases, slogans or straplines to help engage local people.

4.4.3 Patient Information

a. The Lead Provider will employ innovative channels of communication, including the internet, mobile telephones and applications. This will include a website for the integrated substance misuse service. The website should incorporate content on treatment and recovery services including locations and opening times. It should also contain accessible and attractive health promotion advice regarding substance misuse, including harm reduction messages. The Provider should also include an online 'self-referral' function within the website.

b. A wide range of information on alcohol, drugs, harm reduction and related issues will be provided to service users, family members and carers, and concerned others at all sites used for service delivery. The Provider will give service users and their families/ carers with information about where to go for support outside of regular office hours and which services to access in the event of a crisis. This will be available in leaflets and in electronic formats as appropriate and reviewed annually. The Provider will ensure high quality information is directed at parents and children on the effects of problem drinking and drug use in families.

4.4.4 Social Marketing

a. The Lead Provider must ensure the development, implementation and continuous evaluation of a comprehensive marketing plan. It will utilise the full range of media available including all relevant social media (as a minimum this will include Facebook and Twitter).

b. The provider will embed targeted communications and an overarching and effective communications process into the heart of service design and delivery. This will involve the active promotion of all services under the contract, featuring high quality and accessible information, to the following audiences:

   i. The immediate service user group.
   ii. The families, carers and concerned others of service users.
   iii. The wider population of substance misusers including those who are considered treatment naïve.
   iv. Other Tier 2, 3 and 4 providers.

4.4.5 Promotional Activities

a. The Provider will develop a range of evidence based and locally relevant social marketing campaigns (3 per year) which will be delivered via multiple communication channels.

b. The campaigns will be based on regularly updated and reviewed social marketing insight analysis and public consultation exercises – including at a neighbourhood level as service coverage improves. Campaigns must be targeted at an appropriate audience, credible and realistic in their aims.

c. The Provider will work with the commissioners to support related public health initiatives in each locality.

4.4.6 Media

a. The provider will identify and develop effective and productive relationships with all media in Bolton, Salford, Trafford and the wider Greater Manchester conurbation. The Commissioners expect the Provider to be proactive and innovative in their approach to communications. The Provider will respond promptly to media enquiries and work with Commissioners and other partner organisations to generate a flow of positive, good news press releases (the target will be a minimum of 12 articles per year) and/or other media related issues.

b. The Lead Provider will also work with the Commissioners and the Council Press Offices, to where appropriate, jointly respond to media related issues. Press releases and responses to media enquiries will be approved by the relevant local Commissioner.

4.5 Finance

a. It is intended that the new integrated system will see reductions over time of established opiate and crack cocaine users and increases in those entering long term recovery. The system will remain open to any new problematic drug users but it is expected that the declining prevalence of opiate and crack cocaine users will free resources for recovery from treatment year on year. Accordingly, The Lead Provider will establish a Recovery Fund for the development of recovery and mutual aid at a system level. This recognises movement from treatment to recovery, which is the key claim the successful Lead Provider must deliver on.

b. Contributions to the treatment and recovery system vary by Local Authority depending on local factors.

	Budget per annum
Bolton	£2.5m
Salford	£3.5m
Trafford	£2.0m

c. The Commissioners expect the Lead Provider to ensure that the budget contributed by each Local Authority is spent within that area, and be able to demonstrate this to Commissioners.

d. It is expected that there are economies of scale which can be realised for shared functions of the service. The Lead Provider will work with Commissioners to agree a system whereby a proportionate contribution from each area is shared and used to deliver these functions

e. Mechanisms for the assessment of funding bids will be established by Commissioners and Lead Provider.

f. The final allocations will be subject to negotiations between the Lead Provider and the Commissioner and approval by the Commissioners.

g. The overall outcomes delivered by the Lead Provider will represent a social return on investment over the life of the contract. This will be evidenced in a wide range of social, public health and community safety outcomes for the BST cluster. Any efficiency savings will be redistributed to the Recovery Fund (Section 3.13) according to criteria agreed with the Commissioners.

h. **Contract value**

i. The contract value is £8m per annum.

ii. The amounts may be subject to change in the event that:

- Local Authority budgets are reduced. In such circumstances the Commissioners would work with the Lead Provider to manage the cuts.
- Additional Local Authorities wish to join the cluster in order to deliver drug and alcohol services in their area. Bury Local Authority may join the cluster during the term of the contract. Arrangements governing any such eventuality will be agreed with Commissioners during the transition period.

4.6 Mandated facilities and other costs

a. The Lead Provider is expected to provide and operate all required premises within the contract value. As a minimum, treatment venues will be available across the BST cluster in accordance with the picture of need described in the Drug and Alcohol Health Needs Analysis, either from a permanent or shared site to NHS clinical standards. Mobile provision from a centrally located site is another option.

b. It is anticipated that the delivery of services will be remodelled in Year 1 from this stable baseline position. The commissioners will be informed of premises to be used and of any changes to premises being used. The use of joint premises with other providers is encouraged.

c. The Lead Provider will ensure that all premises used for service delivery are of a high standard and meet all legislative requirements. The unavailability of appropriate accommodation shall not be a reason for service non-provision. The Lead Provider will conduct regular risk assessments on all premises utilised.

d. The Commissioners have mandated a number of premises as detailed below to ensure a stock of buildings. The costs for rent, rates and running costs are shown in the table below. The running costs are an estimate based on the last 2 years. All costs are to be paid from the total contract value.

4.6.1 Bolton Council

4.6.2 Salford Council

Building	Function	Costs
Opportunities Centre	Family Young People's Service	Rent / rates **£18,000** per annum plus running costs Due to the forthcoming relocation of a range of services operating from council owned premises, this venue is likely to change prior to contract award. As such the values are indicative only.
Acton Square (SCC Building)	Specialist Drug and Alcohol Treatment Centre	155 m^2 / 1668 sq ft. Estimated commercial rental value £13,500 p.a. based on full repairing and insuring terms i.e. repairs and insurance extra. Running costs responsibility of the tenant (circa £26,000), Non Domestic rates (circa £6,000). **Estimated total £45,500**
Eccles Town Hall Basement	Administrative	Estimated commercial rental value £8,428 p.a. based on internal repairing terms with service charge (circa £4,830 p.a.). Running costs approximately £22,000. **Estimated total £35,258**
Gloucester House	Recovery Centre	Rent of £18,070 p.a. plus running costs and repairs of approximately £30,000. **Estimated total £48,070**
King Street	Specialist Drug and Alcohol Treatment Centre	£12,500 p.a. actual rent plus running costs and repairs of approximately £22,000. **Estimated total £34,500**

a. An additional privately owned building, the Haysbrook Centre, located in Little Hulton is currently used to deliver specialist drug and alcohol services for adults. The landlord has agreed that the lease will run until the end of September 2014. Once the contract has been awarded there may be an option to lease the property to the Lead Provider. The current rent is £19,200 pa and running costs approximately £32,500 p.a.

b. There are other mandatory items which must be provided and paid for from the total value of the contract.

c. These are:

   i. Observed methadone consumption - This is currently in the region of £30,000 per annum. It has never exceeded this figure in the last 4 years.

   ii. Shared Care – Shared Care is currently under developed in Salford with costs not exceeding £10,000 per annum. The commissioners will want work with the Lead Provider to progress Shared Care in the future.

   iii. IT infrastructure and equipment. This will include the Case Management System and wider means of communications as set out within this specification.

4.6.3 Trafford Council

4.7 Governance

a. Strong governance arrangements are vital for the effective delivery of services within the treatment and recovery system. When developing policies and procedures, the Lead Provider will be expected to review, and ensure compliance with, relevant national guidance including from PHE (*Quality governance guidance for local authority commissioners of alcohol and drug services* - link).

4.7.1 Partnership Working and Interdependencies

a. The Lead Provider will ensure that service design and delivery is transparent and informed by service user and community priorities. Services must be demonstrably accountable to commissioning partners and to the clients and communities they serve. The Lead Provider will ensure that services are outward looking and will engage with all relevant partners in order to achieve better lives for Bolton, Salford and Trafford residents. In doing so the Lead provider will take account of the following interdependencies:

i. Acute Trusts
ii. Clinical Commissioning Groups
iii. Community Safety Partnership
iv. Department of Work and Pensions / Job Centre plus – Work Programme
v. Education providers
vi. Facilitated self-help e.g. Drink Watchers
vii. General Practitioners
viii. Greater Manchester Fire and Rescue
ix. Greater Manchester Probation Trust
x. Greater Manchester Police
xi. Greater Manchester Police and Crime Commissioner
xii. Health and wellbeing boards
xiii. HM Prison Service
xiv. Housing departments, private agencies and social landlords
xv. Integrated Commissioning Board
xvi. Local Authorities
xvii. Local neighbourhoods
xviii. Mental Health Services
xix. Mutual Aid Groups
xx. National Commissioning Board
xxi. National Probation Service
xxii. Non-facilitated self-help groups
xxiii. Pharmacies
xxiv. Prison Health Care
xxv. Recovery communities
xxvi. Working Together with Families
xxvii. 360 children and young person's drug and alcohol service in Bolton (Part of the 5-19 integrated service)

b. In relation to Partnership working, the Lead Provider will be expected to:

i. Adopt a partnership approach to the delivery of the new contract so that partnership targets, expectations, and statutory requirements are met within the resulting system.
   - In particular, relationships with GP practices and pharmacy staff and other primary care staff groups are well maintained in order to achieve the maximum benefits of service users being seen in primary care settings.

ii. Work with Commissioners to align work:
   - Between Primary, Secondary, Acute and Specialist Care for the benefit of patient pathways and to enhance the prospects of successful treatment completions and the transition to recovery.
   - Across the key points of the system where the most vulnerable, high risk and high need patients will be identified – in General Practice, in Hospital, in children and young people and family services, and in the Criminal Justice System.
   - In neighbourhoods and directorates, notably adult social care and children's services, as well as health and wellbeing services and mutual aid.

iii. Develop flexible, localised, and mobile support for the whole range of drink and drug users in the BST cluster fostering relationships with Council Housing Departments, Social Landlords and the private sector landlords, as well as a range of social enterprises. It envisaged that the Lead Provider will make creative use of flats and neighbourhood offices in partnership with a local social care and housing providers.

iv. Contribute to the development of shared protocols with other health and social care organisations that are appropriate for the clients of the services. The Lead Provider will ensure all policies and procedures have clearly stated objectives and stipulate who is responsible for implementation and monitoring arrangements.

v. Work closely with any community organisation or group that shares the aims of this contract to ensure the service is fully embedded within the local economies and neighbourhood communities of the BST cluster.

4.7.2 Working with Children's Services

The Lead Provider will be expected to:

i. Establish a *Joint Protocol* with Children's Services in Bolton, Salford and Trafford Local Authorities, informed by PHE guidance[48] which will:

   - Promote effective communication between drug and alcohol services and children's services
   - Include a statement of purpose
   - Reference national policy and guidance
   - Set out clear information sharing arrangements and referral pathways
   - Ensure services identify need as early as possible and work collaboratively to help families and reduce risk.

[48] PHE (2013) Supporting information for developing local joint protocols between drug and alcohol partnerships and children and family services - link

- Be supported by an implementation plan and steering group to manage implementation of the protocol and monitor its progress. The protocol will state explicitly the questions to be asked at assessment to inform safeguarding and promote the welfare of children so that the need for action to protect children from harm is reduced, in accordance with national guidance[49]
- Establish data sharing arrangements to determine the extent of crossover between substance misuse services and Child Protection, Child In Need, Early Intervention and Prevention and care proceedings.

ii. Family services and the wider treatment system will also establish arrangements between family services, the wider treatment system and local Multi Agency Safeguarding Hub (MASH).

iii. Prepare reports as required for reviews, core groups, case conferences and courts.

iv. Facilitate a regular (initially six monthly) data matching exercise with Children's Services. This exercise will initially produce a summary of overlap between services

v. Establish reciprocal training arrangements with social workers in Children's Services to cover thresholds, services available to parents and referral processes.

vi. Deliver training to practitioners in the BST cluster to raise the awareness of the impact of parental substance misuse on children and enable staff to deliver appropriate brief interventions. The service will develop an initial screening tool for practitioners when working with children and families. The tool will be subject to evaluation and updating as required.

vii. Align Case Management functions with existing arrangements within Bolton, Salford and Trafford Local Authorities to promote joint working in order to achieve joint outcomes whilst avoiding duplication of function and resource allocation, ensure services are delivered as appropriate in family homes or in accessible community venues such as children's centres and schools.

viii. Work with Children's Services to monitor that training opportunities are fully utilised with an emphasis on training all staff in direct contact with high risk families.

4.7.3 Legal Compliance

a. The Lead Provider shall ensure that its employees, agents and sub-contractors comply with all relevant legislation, regulations and statutory circulars insofar as they are applicable to the service. These include, but are not limited to:

i. AIDS (Control) Act 1987
ii. Care Act (2015)
iii. Carers (Equal Opportunities) Act 2004
iv. Carers (Recognition and Services) Act 1995
v. Carers and Disabled Children Act 2000
vi. Children Act 2004
vii. Data Protection Act 1998
viii. Employment Act 2002

[49] Department of Education. *Working Together to Safeguard Children* (2013) - link

ix. Environmental Protection Act 1990
x. Equality Act 2010
xi. Food Hygiene Regulations 2006
xii. Food Safety Act 1980
xiii. Freedom of Information Act 2000
xiv. Health and Safety at Work Act 1974 (and subsequent regulations)
xv. Health and Social Care Act 2012
xvi. Human Rights Act 1998
xvii. Mental Health Act 2007
xviii. NHS and Community Care Act 1990
xix. Psychoactive Substances Act 2016
xx. Rehabilitation of Offenders Act 1974 (and subsequent reforms)
xxi. Work and Families Act 2006

b. The Lead Provider must demonstrate that it is compliant with appropriate legal requirements and must demonstrate that it has an adequate range of evidence based policies, protocols and strategies in place. Where they are absent the Lead Provider must demonstrate steps are being taken towards their development and evidence a timetable for delivery.

c. The Lead Provider will share all policies and updates with the commissioners.

4.7.4 Assurance framework

a. The Lead Provider is expected to:

i. Develop and maintain an Assurance Framework in consultation with the commissioners. This framework will allow all partners in the contract to share and manage risk effectively, thereby ensuring a high quality service is provided at all times. Any relevant investigations (internally, locally or nationally) will be incorporated into the Assurance Framework.

ii. Ensure that quarterly and annual compliance report are produced for the whole treatment and recovery system in respect of NICE Quality Standards 11 (Alcohol Dependence and Harmful Alcohol Use) and 23 (Drug Use Disorders).

iii. Work towards compliance with the Quality in Alcohol and Drug Services (QuADS) and any additional standards as developed by Public Health England.

b. The commissioner reserves the right to conduct audits on the Lead Provider or to bring in external auditors to monitor elements of service provision; the commissioners reserve the right to conduct such audits without prior notice to the provider.

4.7.5 Information Governance

a. Information Governance provides assurance to Commissioners as well as the provider. It is therefore essential that the Lead Provider has recognised assurance in the field by way of a current annual approved Department of Health Information Governance Toolkit with Satisfactory rating. This includes providing staff training in this field. This submission can be audited or inspected at any time by the commissioning organisation. In addition the Lead Provider must have a current Information Commissioners Registration Certificate. Information Governance must be supported by relevant and up to date Information Governance Policies. All significant breaches of information or confidentiality (e.g. DoH Level Two or above) must be reported to the commissioner.

b. All services should have a clear confidentiality and data handling policy that is understood by all members of staff and complies with:

   i. Data Protection Act 1998
   ii. Confidentiality: NHS Code of Practice
   iii. NDTMS Confidentiality Toolkit

c. All services should give consideration to the potential for a client to dispute whether they have given consent to share their data with NDTMS. The Lead Provider will ensure that services are able to evidence consent.

d. The Lead Provider will also ensure that appropriate consent policies are in place should Personal Identifiable Data be shared with external organisations. The sharing of Personal Identifiable Data must occur via secure methods of data transfer.

4.7.6 Internal Governance

a. The Lead Provider is expected to have a strong internal governance structure and organisational governance plan. This should cover issues including: communication between service users/carers/families and staff (including managers and clinicians), communication between staff across the service, effective reporting mechanisms, client records, service data, incident reporting and health and safety. Such governance arrangements will take into account all current or any future legislation that applies, for example the Data Protection Act 1998.

b. The Lead Provider will ensure all policies and other relevant documentation (e.g. assessment forms, care plans) are Equality Impact Assessed prior to use.

4.7.7 External Governance

a. The Lead Provider is expected to build and maintain high quality governance arrangements with partner agencies including the commissioners, and other providers/agencies and the community. A strong partnership of all related agencies and stakeholders will lead to better outcomes for all. The provider will have a clearly identified and accessible complaints and compliments procedure, and will act on all complaints in a timely manner. All complaints will be shared with the commissioners at contract management meetings, or earlier if the complaint impacts upon the Assurance Framework.

4.7.8 Clinical Governance

a. Appropriate Clinical Governance is of paramount importance to the commissioners and it is intended that Clinical Governance matters will be overseen by the commissioners as appropriate.

b. The Lead Provider is expected to:

i. Obtain and maintain accreditation with the Care Quality Commission (CQC). The Provider must meet the requirements of the CQC as well as all other statutory obligations, including in relation to any relevant sub-contracted services.

ii. Have robust mechanisms and processes in place to manage all aspects of clinical governance including the management of medicines.
- These governance arrangements will cover (but not be limited to):
  - Safeguarding
  - Untoward incidents
  - Risk reduction and prevention
  - Dissemination of alerts
  - Training
  - Monitoring of services.
- Processes will include escalation and notification of events to commissioners as required.

iii. Ensure that all clinical interventions will be delivered in line with national guidance such as NICE and or local guidance, where applicable. The provider has a responsibility to keep up to date with changes in guidelines.

iv. Comply with all legislation around the use of controlled drugs and adhere to guidance from the GMC and NMC as appropriate. Legislation includes:
- The Misuse of Drugs Act 1971
- Misuse of Drugs Regulations 2001
- The Health Act 2006
- The Controlled Drugs (Supervision of Management and Use) Regulation 2013
- Psychoactive Substances Act 2016

v. Ensure that those services stocking controlled drugs on the premises have, and comply with, an approved Standing Operating Procedure (SOP). The SOPs must be made available to the local lead Accountable Officer for controlled drugs.

vi. Ensure that there are clear quality governance structures supporting any Patient Group Directions within the treatment and recovery system in line with guidance from national bodies including PHE[50]

vii. Ensure there is a Home Office licence to hold stocks of controlled drugs. Arrangements need to be in place around delegated possession of the stock of controlled drugs if doctors or pharmacists are not involved in processes, as only doctors and pharmacists are legally able to possess controlled drugs unless under arrangements.

[50] PHE (2015) *Quality governance guidance for local authority commissioners of alcohol and drug services* - link

viii. Submit a periodic declaration and self-assessment to the local lead Accountable Officer for Controlled Drugs (CDAO); as requested by the CDAO.

ix. Actively support the work of the Greater Manchester Local Intelligence Network (LIN) for Controlled Drugs and adhere to the relevant legislation and guidance on the safe use and management of controlled drugs.

x. Accept unwanted medicines from service users in the community (known as patient returns) if requested and the person is covered to possess the medication under legislation (only doctors and pharmacists are legally able to possess controlled drugs). The Lead Provider will ensure that such returns are disposed of safely and comply with legislation and the environment agency. Best practice is to return the medication to the community pharmacy where it was dispensed. The Lead Provider is responsible for the collection of clinical waste from pharmacy needle exchanges.

xi. Ensure there is a policy and procedures regarding Infection Control for the whole treatment system.

xii. Deliver a Serious Untoward Incident Policy which is consistent with the guidance issued by the National Patients Safety Agency in April 2002. The Lead Provider (and all sub contracted agencies) will refer to Council led safeguarding arrangements for children and adults.

xiii. Have clear procedures for investigating and acting upon any Serious and Untoward Incidents findings.

xiv. Notify its partner within 24 hours of critical incidents (this must be the trigger to investigate the incident), and further provide quarterly reports to the commissioner.

xv. Produce reports on Serious Untoward Incidents, Adverse Health Care Incidents, and Near Misses, based on appropriate national guidance, including from NHS England[51]

4.7.9 Independent Case File Audit

a. The commissioners reserve the right to request an independent case file audit. The Lead Provider will facilitate access to the full case file on an agreed sample basis at critical parts of the system so that the commissioning aims and objectives and interests of the service users, funders and people of Bolton, Salford and Trafford are fully realised.

b. This will be undertaken in a sensitive manner, in the spirit of learning and improvement. Key findings and recommendations will be acted upon to increase quality and improve performance and service user experience.

c. Service users will have a role in designing case audit questions which the Lead Provider will then deliver on in a timely manner, in accordance with good data governance, but also public sector finance.

d. The Lead Provider will ensure the necessary permissions (to include permission of the Lead Provider organisation and all sub-contractors) are in place prior to the commencement of the contract.

[51] NHS England (2015) Serious incident framework: Supporting learning to prevent recurrence - link

4.7.10 Working with Children's Services

a. The Lead Provider will ensure that all staff employed across the system are fully aware of the service specification and performance managed as to the performance and quality requirements of this service.

b. The Lead Provider will be expected to:

i. Evidence workforce development in an annual workforce analysis report.

ii. Provide and maintain a detailed description of staffing structures across the treatment system inclusive of managerial relationships.

iii. Ensure that all services have and adhere to a recruitment policy.

iv. Ensure the workforce contains both generic substance misuse workers and more specialised drug and alcohol specific workers to deal with the range and complexity of interventions required, and medical professionals with relevant training.

v. Ensure staff competence and professional development in line with DANOS and any nationally accredited occupational standards recommended by Public Health England. The workforce will be competent in dealing with issues concerning the children of service users and their families and carers.

vi. Create opportunities for volunteers, as well as making use of the existing volunteer workforce and provide placements for students and trainees from a variety of professions and work settings (e.g. nursing, social work and care, counselling).

vii. Ensure that increasing numbers of people moving from treatment to recovery become peer mentors and navigators (e.g. greeting and reassuring new service users) and community volunteers (e.g. recovery events and activities and wider community initiatives).

viii. Be proactive in engaging volunteers in the delivery of the contract, and ensure that they receive the same support as paid members of the workforce.

ix. Ensure that all services provide all staff an induction and basic training programme appropriate for the needs of service users within a reasonable period of taking up appointment.

x. Ensure that all services are sufficiently staffed to ensure continuity of service, taking into account sickness, holidays and other absences.

xi. Ensure that all staff have access to appropriate supervision and training to develop and maintain their professional competence and that staff qualifications are up to date, including those for whom periodic registration is required

xii. Ensure that staff fulfilling a managerial role have appropriate management competencies and that specialists have training and competencies in line with guidance from the relevant professional bodies / royal college. The competence of practitioners with regard to prescribing interventions is paramount.

xiii. Ensure that all services fully comply with statutory requirements (e.g. protection of vulnerable adults, safeguarding children, rehabilitation of offenders), conduct

Disclosure and Baring Service checks for all applicants and monitor the existing workforce in this respect.

4.8 Workforce

The Lead Provider will be required to:

i. Ensure that all staff employed across the system are fully aware of the service specification and performance managed according to the performance management requirements of this specification (see Section 4.2)

ii. Evidence workforce development in an annual workforce analysis report.

iii. Provide and maintain a detailed description of staffing structures across the treatment system inclusive of managerial relationships.

iv. Ensure that all services have and adhere to a recruitment policy.

v. Ensure the workforce contains both generic substance misuse workers and more specialised drug and alcohol specific workers to deal with the range and complexity of interventions required, and medical professionals with relevant training.

vi. Ensure staff competence and professional development in line with DANOS and any nationally accredited occupational standards recommended by Public Health England.

vii. Ensure that the workforce is competent in dealing with issues concerning the children of service users and their families and carers.

viii. Ensure that substance misuse workers receive domestic violence training, in accordance with NICE guidance[52]

ix. Create opportunities for volunteers, as well as making use of the existing volunteer workforce and provide placements for students and trainees from a variety of professions and work settings (e.g. nursing, social work and care, counselling). Volunteers should receive the same support as paid members of the workforce.

x. Ensure that increasing numbers of people moving from treatment to recovery become peer mentors and navigators (e.g. greeting and reassuring new service users) and community volunteers (e.g. recovery events and activities and wider community initiatives).

xi. Ensure that all services provide all staff an induction and basic training programme appropriate for the needs of service users within a reasonable period of taking up appointment.

xii. Ensure that all services are sufficiently staffed to ensure continuity of service, taking into account sickness, holidays and other absences.

xiii. Ensure that all staff have access to appropriate supervision and training to develop and maintain their professional competence and that staff qualifications are up to date, including those for whom periodic registration is required

xiv. Ensure that staff fulfilling a managerial role have appropriate management competencies and that specialists have training and competencies in line with guidance from the relevant professional bodies / royal college. The competence of practitioners with regard to prescribing interventions is paramount.

[52] NICE (2014) PH50 Domestic violence and abuse: multiagency working - link

xv. Ensure that all services fully comply with statutory requirements (e.g. protection of vulnerable adults, safeguarding children, rehabilitation of offenders), conduct Disclosure and Baring Service checks for all applicants and monitor the existing workforce in this respect.

4.9 Social value

a. Social Value is a process whereby organisations meet their needs for goods, services, works and utilities in a way that achieves value for money on a whole life basis in terms of generating benefits not only to the organisation, but also to society and economy, whilst minimising damage to the environment.

b. Social Value is imbedded in both commissioning and Procurement policies across Bolton, Salford and Trafford and stipulates that providers are to:

   i. Promote employment and economic sustainability
   ii. Raise the Living Standards
   iii. Promote Participation
   iv. Build the capacity and sustainability of the voluntary and community Sector
   v. Promote equity and fairness
   vi. Promote Environmental Sustainability

c. The Provider is expected to meet the following social value outcomes for all three boroughs:

   i. More Local People in Work
   ii. Thriving Local Businesses
   iii. Responsible Businesses that do their bit for the local community
   iv. A local workforce that is fairly paid and well supported.
   v. Communities supported to help themselves
   vi. An effective and resilient 3rd Sector
   vii. A reduction in poverty, health and education inequalities
   viii. Reduction in costs by investing in prevention
   ix. Protecting our environment and reducing climate change

d. The Provider will evidence how they have met the above outcomes in relation to substance misuse for Bolton, Salford and Trafford. Evidence will be submitted on a quarterly basis and will be discussed as part of the scheduled quarterly contract meetings between the Provider and Commissioner.
e. The outcomes to be reported on each quarter will be agreed with the Commissioners upon contract award.
f. Social value policies for the BST substance misuse service should be developed with reference to the Greater Manchester Social Value policy[53]

[53] GMCA (2014) Social value policy - link

4.10 Contract

4.10.1 Compliance

a. The Lead Provider is expected to meet the identified targets within the budget set for this contract. Failure to meet targets will result in the commissioners requesting an action plan to redress the unmet target. The commissioners reserve the right to issue a default notice in line with contractual requirements for failure to address performance issues following the implementation of an action plan.

b. The commissioners expect to build a strong and effective working relationship with the Lead Provider, with shared values and vision regarding the delivery of this contract; a cultural alignment between commissioner and provider.

4.10.2 Contract management

a. The commissioners will manage this contract via quarterly contract management meetings which will be open to all relevant commissioners and service users and recovery advocates as appropriate. The Lead Provider will be invited and expected to attend, produce relevant reports including finance and evidence of delivery and outcomes as required by the contract and the associated Performance Management Framework and other monitoring documents. It is the commissioners aim to ensure that the governance arrangements applied to this specification are outward as well as inward looking and therefore views and experiences of stakeholder organisations in terms of the delivery of this service specification will be sought as part of contract management.

b. The provider will keep a risk register for all risk factors relating to this contract, which will be shared openly with the commissioners.

c. The provider is expected to be transparent in all areas of contract delivery and provide early warnings with an accompanying action plan for any areas of underperformance, detailed in an assurance framework.

d. On the expiry or termination of this Contract or termination of any Service the Provider must co-operate fully with the Authority to migrate the Services in an orderly manner to the successor provider, which shall include the transfer of all relevant case files and clinical data as appropriate to individual cases to inform continuity of care, and the Provider will maintain its own copies of any such information.

e. Payments quarterly in advance with the retention element to be determined on award of contract.

4.10.3 Charges and Payment

a. Payment Options:

   i. The Authority shall pay within 30 days of receipt of invoice
   ii. The Authority shall pay via Purchasing Card

b. The Lead Provider shall invoice the Authority for payment of the Charges in advance at the beginning of each quarter

c. The Authority will retain 2.5% of the Charges each quarter; such sum will be paid over to the Lead Provider on satisfactory performance of its obligations in this Contract.

4.10.4 Review of the service specification

a. The commissioners may review and/or vary this Service Specification from time to time in the interests of service users. The service provider will be closely involved in this process to identify any implications (financial and human resources) for service delivery.

b. The commissioners will engage in a variety of change management processes with the Lead Provider in the light of performance and evaluation of outcomes.

c. The commissioners reserve the right to review the content and detail of this service specification on an annual basis to take account of changes in national policy, funding and local substance misuse trends. This may also include the inclusion or exclusion of specific elements of services.

4.11 Developing the specification post-procurement

a. Between x and x 2017 there will be a transitional period; during which the ideal service specification will be finalised to the satisfaction of both Commissioners and Lead Provider.

b. Post procurement, there will be a process of co-design of final treatment pathways between the Commissioners and Lead Provider. The commissioners hold the view that recovery is a broad concept requiring many pathways and that recovery is a journey not an end state.

c. As this service will commence during significant change and transition within the local and national public sector, elements of this service specification are subject to change. Commissioners will fully engage with the provider during the lifetime of this service to ensure the specification remains relevant to both those who use the service and the partnership it links into.

4.12 TUPE statement

The Lead Provider will ensure that:
'…Where TUPE applies to the existing employees within the service(s) the provider will comply with all of its obligations under the TUPE regulations…'

5. APPENDICES

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Trafford Working Together For Change.

July 2016

Trafford – 16th July 2016

What's Working

Cards	IStatement	Votes
• To have good family support. • My son- regular contact. • Kid's wife. • To rebuild my family relationship (wife children) • My daughter. • Building back trust/relationships. • Time with my kids. • Warm attitude+ family friendly/ supporting parents.	**I am doing it because**	**3**
• Nothing needs to change. • Everyone is helpful when you arrive. • Nothing really enjoyed Phoenix futures. • Personally never come across anything that isn't working for me at Phoenix futures.	**I am happy.**	**4**
• Drug use reduction. • Both working well. • Continued amazing support from Phoenix. • Reducing my alcohol intake. • Drug and alcohol support with Phoenix- working towards deification. • Phoenix futures up service. • I feel listened to and know I can always call if I need to. • Cutting down on drug/alcohol use. • Helping me sort myself out, I am not on my own. • Coming Phoenix, keeping safe. • Being on time and picking up my script. • To gain my self-confidence. • Sorting my money out (Phoenix) • Calling welfare team.	**I am working through it.**	**1**

• To get better. • I enjoyed talking about triggers and learning ways to deal with them. • Reducing to a stage where I can detox. • Reduction and detox plan.		
• Peer support. • Great peer support meetings. • Attending peer support meetings. • 1 to 1 Wendy. • To continue to towards building a recovery. • Community and maintain partner agency recovery.		**4**
• Phoenix has essentially not just put me on the road to recovery, but opened up a new path that is enabling me to return to normality, somewhere I couldn't see myself re visiting. • All of Phoenix programme is working. • All information given. • Services are good at talking to each other. • Having support for my addiction that is ongoing with the help from Phoenix futures. The advice and guidance that Phoenix help me in so many ways. • The time and effort you put in to seeing young people. • Open minded. • Excellent keep it up. • The workers are really good and very supportive. • Phoenix futures is committed to help those who suffer from addiction. • Recovery is ultimately down to the individual without Phoenix futures it would not be possible. • Come to Phoenix.		11

• The support off staff and other service users has been crucial through my recovery without them I wouldn't have reached the stage where I am now. • The support you get from Phoenix. • Phoenix futures does not need changing, it is working. • More than helpful.		
• Getting back into work. • Remaining alcohol free with Phoenix help. • Staying sober. • Continued employment and independence. • To give up alcohol for good. • Get my life back on track with help from Phoenix. • I have stayed of the cannabis plus enjoyed having someone to talk to about my problem. • To stay abstinent. • Not drinking. • Finding work/accommodation. • Work going well • Education- Phoenix futures and skill to education. • Educating myself with different things, • My job structure. • Courses. • Stability (Housing and becoming clean) by attending all and every Phoenix futures guidance.	**I am moving forward**	**6**
• Relapse prevention groups at Phoenix futures. • Key work sessions, accupientence chilled me out. • Group work keeping busy going to Phoenix for groups and my key work. • Groups- peer support. • Sessions with key workers. • Coming to groups at Phoenix.	**I am part of something.**	5

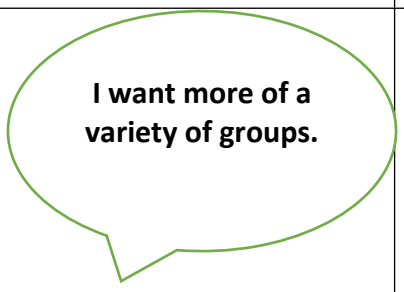
• Love the groups at Phoenix. • Attending group sessions at Phoenix. • Groups and one to one support. • Groups are working great.		
• Phoenix futures/ rise group. • Key works meetings with Wendy. • Health. • Key work one on one. • Peer support groups. • Health- mental + physical Phoenix Futures. • Drug sessions. • Care planning, peer support, relapse prevention, 3 way meetings. • Coming to recovery. • Coming to 1-1 sessions at Phoenix. • Attending Phoenix group meetings. • Attending Phoenix and having one to one with my key worker. • Phoenix support from key worker. • Having my key worker at Phoenix tell me how I can go about telling my days better. • Great key worker. • Support from worker and peers. • Key work appointment at Phoenix. • Support, structure. • Having a constant person to work with. • Flexible worker that does home visits. • Can come to home. • Association on key works and meetings. • Counselling.		8

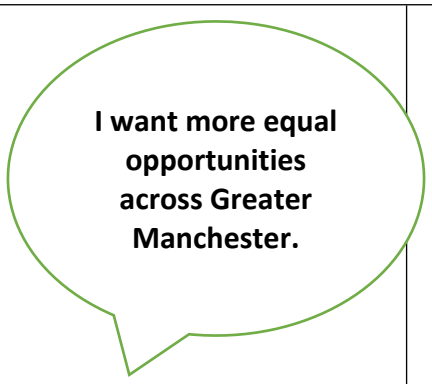
• Love RTN. • RTN. • Outdoor activity.	**I am giving something back.**	8

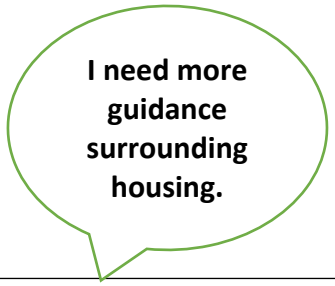
Trafford- 16th July 2016

What's Not Working

Cards	IStatement	Votes
• Some support over the weekend for people in early recovery. • Organising time. • Set appointment- days and times (Phoenix) • Evening appointments at Phoenix. • Due to work commitment I can't access more sessions. • Getting to work- need to nearer. • Aim is too far away- practically in Manchester not Trafford. • Times of groups. • Relapse/living alone. • Relapse prevention. • Not enough help available at the weekend when I am bored or fed up. • Opening hours.	**I need to access services when I need them.**	12
• Some people don't listen. • Communication could be better.	**I need communication better.**	2
• Some people+ place I am going. • Additional support with intuitive. • Money management. • Self-discipline. • More positive attitude and	**I want more help with personal development.**	5

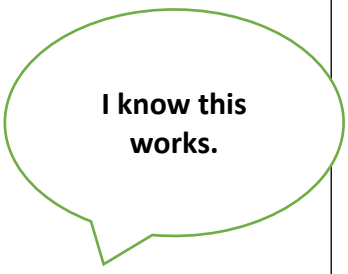
believe in my own strength • The way I think about it. • My self-esteem that Phoenix is building for me. • My mind-set. • My belief within myself to build my confidence up. • My habit. • My self-confidence and belief. • My way of thinking choices available. • My time management. • Getting more confidence. • Believing in myself and lack of confidence. • Regular relapses. • Has to stop immediately. • Trying to stop the gear. • Need to change my lifestyle.		
• More time.		
• Want a recovery. • More focused addiction group. • More outdoor activities. • More peer groups.		3
• A lot of questions in the first appointment.		

• Consistency across Greater Manchester (equal ops).		1
• Attitude of employers of people in recovery. • Working too much. • Work.		2
• Partner not stopping the drink. • Kids need to understand.		3
• Change wise it would be a good idea to see more support from outside the service with regard to the security and future development of Phoenix.		2

• Amount of staff. • More funding.		2
• Losing a lot of houses or flats in Trafford. • Housing. • Housing support- there isn't enough provision for housing help when you need it.		3
• Every little help from mental health services. • Mental health services working better with individuals what have substance misuse issues. • Long waiting lists from medical health counselling.		**15**

Trafford -16th July 2016

Important for the Future

Cards	IStatement	Votes
• Keep Phoenix futures groups and set ups. • Building and maintaining Trafford recovery community. • Phoenix futures staying open. • The Support helps. • Phoenix futures up service. • Getting out to young people		6

at an early age and telling them about the risks of drugs+ alcohol. • For Phoenix futures to carry on. • Having the support with Phoenix futures after detox. • Carry on the support from Phoenix. • Nice staff. • Excellent service and fantastic staff.		
• They help me get involved with other services in Trafford. • No cuts! • Do not cut funds go Phoenix futures. Their success is a long term money saver. • Keeping the service open. • Keeping Phoenix in Trafford. • To make sure help is still available for people like me who have fell on hard time's services like Phoenix. • Partner working. • Providing appropriate services closer to home. • To have easy access to groups and professional support. • Keep PEER mentors/volunteers involved. • Helping other. • Group in the evenings for continued support.	**I want to be positive.**	4
• Focusing on my future and dealing with my problems sober and drug free. • Getting self-confidence to start relationships again. • Getting surgery to scar tissue. • Healthy happy life. • To stay focused and extend further on the foundations		

that I have acquired from Phoenix. To have the ability to move towards retuning to the work place. To challenge my emotions and remain strong in control. • Working in a positive way. • Changing the way I think towards choices available. • Stop drinking with help from Phoenix. • Regaining trust and belief in myself and others. • Peer mentor helping other people in the service. • To build on my confidence, knowledge and self-worth that Phoenix has given me to progress positively. • To carry on and keep up with I have gained. • Keeping people interested changing their lives. • Phoenix futures has not just saved my life it has helped so many people change theirs. Very caring ad empathetic staff. • Get my life back to how it was with help from Phoenix. • Getting of the methadone.		

• Getting back in to work. • To get a job or re-train. • Working towards getting back into work. • To find full time work. • To get of my benefits. • Work towards gaining employment and securing stable accommodation for myself and my daughter. • Full time employment. • Working towards my goals/collage. • Volunteering job. • Get a job.		8
• To be around for my children and grandchildren. • My son. • To maintain abstinence at a good level i.e. government guidelines. • To get my daughter back in my care • To return to my family home. Improve family unit and gain stability. • Family. • Building a better future for all the family. • Drug use reduction • Support family.		5

Issue	Reasons W	Success
• Housing. • Get a flat. • Security.	I want a house.	3
• Working. • Stop drinking for good. Positive job. • Keeping my job. • Not to drink hold down my job at Asda. • My job.	I want a job.	4
• Health. • Me. • Health to sort out (Phoenix) • To have more ongoing support for my mental health.	I want a healthy future.	5
• To remain off alcohol. • Staying sober. • Saying NO! Remaining abstinent. • To remain abstinent. • Staying sober. • To stay well clear of alcohol. • To remain alcohol and drug free- working with Phoenix futures with aftercare team who can also support me with mental health. • Abstinent- Hope to work in an area of Phoenix. • Staying off alcohol. • To stay well clear of cannabis. • To stay drug free.	I want to remain abstinent.	5

I want more variety of group.	• Not having the confidence to explore the community groups. • Social anxiety self-esteem. • We don't know what is available.	**People & Families** I know when were and what is available to me. **Professionals** I have the confidence in providing a resourceful pathway.
What is already in place?	Women matter, peer support, alternative therapy, Mutual aid, Smart recovery, Holistic therapies, Breaking free (online), Recovery voices, Recovery through nature, flames, Women's peer support, relapse prevention, community café, welcome packs, dry umbrella, service directory, website, social media, target, intuitive recovery, emergency futures, GMRF, blue sci, Hope centre, gym access, one to one support, young people support, family support, princes trust, skills- reading and writing.	

		Votes
Radical	• GPS/Smartphone App that records, plans recovery pathway • Tailored to individual- checked in at recovery groups (like pedometer) • On- hold advertisement surrounding groups • Buddy system for new group attendance • L2 recovery academy • Life skills groups- to help get back into work • Service groups promote others into work groups • Online groups • Bus story advertising • Mobile advertising • Commercial advertising • Community skype groups • Advocacy/campaign/rights groups	**6** **8** **3**
Traditional	• Time/smart specific group/1-1 support • Recovery directory with all services • Facebook group • Dedicated group workers- outstanding someone to come and run focused groups • Community groups	**1** **2**
Different	• Recovery/peer led groups in non-clinical environment • Different times of day for groups • More peer led groups • Introduction to different groups doing treatment	**1**

Trafford- 16th July 2016

Solutions

Other Reasons Why!

Reasons why:

I want quicker access to mental health services.

Why is this the case? What's the reason why?

- People don't realise until it's too late they think it's going to get better on their own.
- Waiting list for CBT is too long.
- GP's attitude- Gate keeper's services.
- GP's understanding of mental health issues.
- Accessing the wrong services.
- Barriers- 1. Using alcohol and drugs- not allow you to work with services for mental health.
  2. Gate keepers assuming you're not right for treatment.
- Discharging people too early.
- Time limits.
- Help needed earlier- funding.

Solutions

Issue	Reasons Why	Success
I need to access services when I need them.	• More support/education for concerned others to enable them to better support the individual. • Some people aren't confident in groups, don't have access 1-1s and people don't know how to access other support network in the community. • People work and have children therefore can't attend 9-5. Addiction is not 9-5. Its 7 days a week.	**People & Families** We are happy to have more help when we want it. **Professionals** We are happy to provide more help when you want it.
What is already in place?	Phoenix futures (wide menu), AA,NA,AIM- Large menu, Intuitive recovery, Ramp, target- support groups- café, recovery voices, Smithfield peer support, skills to employment, smart- online groups, blue sci, various websites, women matter, BTG, Samaritans, recovery academy, intuitive skills tu employment, detox, rehab.	
		Votes
Radical	• 24/7 services • Bespoke services • Open door policy • Online keyworker • Online appointments • Community controlled services • No scripts • Is a worker to encourage the use of social media(Instagram, Facebook) • Satellite drinks in hotspots at danger times eg fri/sat nights or Monday mornings. Getting rid of boundaries location connections etc.	**3** **3** **1** **10**
Traditional	• Consulting but doing nothing • C.D.T • Peer leg recovery	
Different	• Ex-service users take full control • Only community detox • Community rehab • Evening and weekend opening hours • Partnership between services • Support café 24/7 • Aftercare after aftercare (for life)	**4**

Other Reasons Why!

Reasons why:

- People work.
- Can't attend 9-5.
- Addiction is not 9-5 its 7 days a week.
- Children.
- Service cant fund 24hr
- Don't have enough support network.
- Don't have enough access 1-1's.
- Some people aren't confident in groups.
- People don't know how to access other support networks i.e. Peer led community groups.
- More bespoke packages for service users.
- Having more support for concerned others enable them to better support the individual.
- People should be more encouraged to set up their own peer led groups/support network.

Solutions

Issue	Reasons Why	Success	
I want quicker access to mental health services	• Accessing the wrong service i.e. GP'S, receptionists, gate keepers, reaching braking point • Time- waiting list is too long. Time limits. Not getting help earlier • Barriers- using alcohol and drugs, not allowing you to work with services for mental health. Gate keepers assuming you're not right for treatment	**People & Families** Service user, mental health- Be more ion control of their recovery. Be more focused and confident. Worker-jobs satisfaction- seeing the person improving and seeing positive results.	
What is already in place?	IAPT, Physiological services, Blue Sky, Life centre, Family counselling- Stamford port Altringham, Moorside, Self-help, GP (Good/bad), Breaking free online, C.B.T, fear fighter, beating the blues, Phoenix, film/ intuitive leads (Specific needs), Samaritans, Sanctuary, FRANK, Stronger families, Relate, online services- mind, NHS choices mental health foundation, 42nd street.		
			Votes
Radical	• No medication • Patient lead services • Self-diagnosis • Alternative therapies e.g.- Reiki • One shop- integrated service • No hospital • Shamanism • Hearing voices • Peer counselling • Hypnosis • App to determine your state of mental health • Dietician (changing, reviewing someone's diet exercise plan mood food exercise) • Online mental health advice/ 1-1 counselling. • Mental health walk in centre • 24/7 telephone support • Peer support group • Run by volunteers • Skype		**7** **1** **10**
Traditional	• Moorside • C.D.T • GP • Phone help lines • Psychological service • Camhs • NHS- tradition • Faith based services • 5 ways to well being • Only accessing support when abstinent • 6 ways to well being		**1** **2**

	• Counselling for families around MH	
Different	• IAPS high intensity therapy • All online programmes • Alternative therapies e.g. Reiki • Family based intervention • Community wellbeing centres • Drama therapy • Music • Art therapy • Media • Creative visualisation • Creative writing • Mindfulness • A week without your phone • Self help	**1** **1** **1**

Issue	Reasons Why	Success
I want more help	• Missed Opportunities	**People & Families**

Other Reasons Why!

Reasons why:

I want more help with personal development:

- Changing culture.
- Definition of ''personal development'' means different things to different people.
- Signposting to other services, services that can support once closed to SMS.
- Encouragement, support and motivation.
- Not knowing about support outside of SMS and after SMS support finishes.
- Not being able to relate to professionals.
- Relationships not being former with external agencies, unaware of opportunities available.
- Consistency with workers, not feeling understood.
- Having the confidence to say this is not working.

with personal development	• Encouragement and leadership of staffing teams (Influence) • Changing Culture (services unable to keep up with recovery community)	Confidence to obtain and sustain recovery. **Professionals** Fulfilled, inspired and motivated.
What is already in place?	Recovery academy, RTN- Conservations award, skills to employment, BTG, Employability worker, ITS, Breaking free online, Access to wellbeing, Services such as 42nd street and IAPT, Blue Sci, Duke of Edinburgh, John Muri award, Voyage to recovery, Manchester voices, Forever Manchester, Princes Trust, Thrive, Mutual aid, Collages, Skills solutions, Connexions, Talk shop, Children's centre, Hope centre.	

		Votes
Radical	• Wellbeing workers within service- to support with emotions, confidence, mental health etc. • Collage/qualifications offered within services. • '' one stop shop'' website- all senses listed- ''matched'' with interests and skills and offered solutions/ideas. • Motivational texts. • Paid self-esteem mentors. • Interpersonal skill shops. • Community personal development leader. • Pay a nosey partner. • More education at younger age. • Create job role who is Member of Parliament for personal development. •	**17** **3** **2** **1**
Traditional	• Increased links with educational providers. Specific link workers within each of services. • Get counselling- life coaching book onto/attend training etc.	
Different	• Support development of service users and their learning to enable them to support each other e.g. they can deliver courses etc. • Self-sufficient neighbourhoods. • Online counselling/ treatment online.	

Trafford– 16th July 2016

Solutions

Other Reasons Why!

Reasons why:

I need more guidance surrounding housing:

- Belief/perception e.g. 'no housing in Trafford'.
- Private landlords and your rights clearly explained.
- Appropriate, simplified version for those who need it– Specific trained support workers for example.
- Easy transitions for people in difficulty.

- What plans are for the future: Updated websites, better understanding of those in charge- e.g drug/alcohol, learning at housing difficulties, service user involvement, different to normal housing market?
- Why?- change in circumstance, housing access- waiting lists etc., do people know how to access the computer?, system not explained very well, obstructions on age lifted, advice isn't readily available, increase in homeless.

Solutions

Issue	Reasons Why	Success
I need more guidance supporting my housing	• Discriminatory practice • Huge increase in demand due to homelessness. • The system is too complicated.	**People & Families** I understand the system and can get access to housing without complications my recovery has progressed. **Professionals.** As a worker it would my job easier and more fulfilling- allowing the client to focus on other important aspects of their recovery.
What is already in place?	Host- Trafford, Host- Salford, Trafford accommodation pathway (supported houses), 16x Housing association, Private landlords, Manchester move (online), Pinpoint, Pinpoint express, Sale- Waterside, Housing offices, Citizen advice bureau, Great places (Meadow Lodge, Pomona), Irwell Valley (Greenbank), Cold weather provision- shelter in church in Altringham, Narrowgate Hostel, Children and family services for under 18's.	

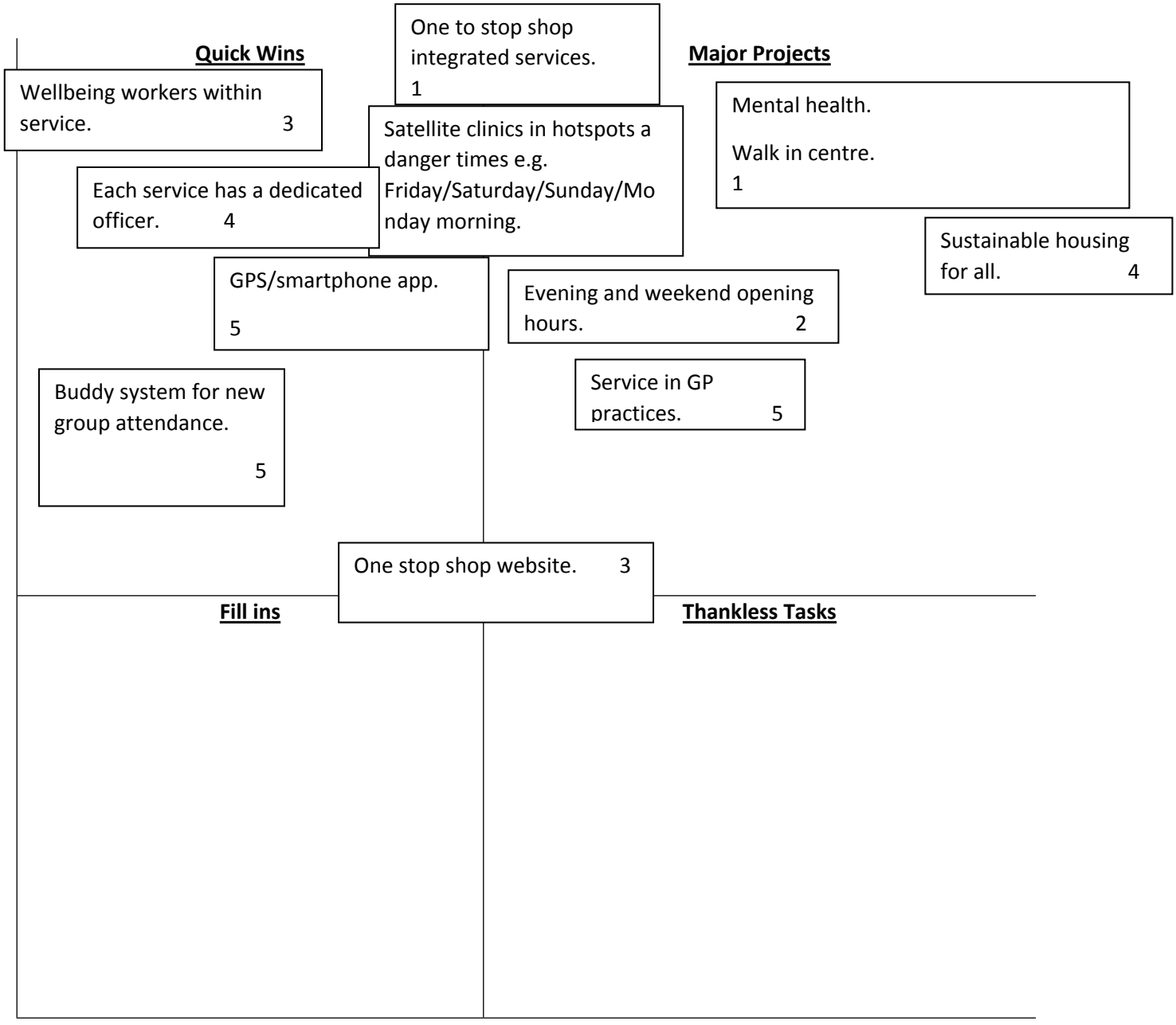
		Votes
Radical	• One application for ALL properties- more emergency accommodation. • Sustainable housing for all. • Scrap point scoring. • Nosey parker. • Earning money based housing band system. • Easier access to professional advice. • Community fostering system for any age of someone in crisis. • Online housing office. • One contact who manages your housing problem. • Self-build. • Remove hurdles to find housing. • Simplify housing process. • Life coaching. • Funding to help buy/build social housing. • Good neighbour street.	**1** **7** **1** **1** **2** **1**
Traditional	• Wider availability of housing offices. • More power to tenants. • Simplify housing benefit application. • Help with property deposits. • More located housing options. • More housing offices. • Independent skills booklet/support.	
Different	• Support housing always used following hospitalisation or detox, etc, i.e. Hostel. • Each service have dedicated housing officer. • Community control. • More changing lives courses. • Build more houses on land. • Cap rent for private landlords.	**2** **6**

Other Reasons Why!

Reasons why

- Why don’t we know of availability?
- Some people being uncomfortable.
- Social anxiety/self-esteem.
- Not having the confidence to ask! (For specific therapy/groups)
- Not having the confidence to explore the community for groups/mutual aid/alternative therapy.
- A reluctance to ask what’s out there.
- Communication concerns.

Success, Cost and Effort Chart



TRAFFORD COUNCIL

Report to: **Executive**
Date: **19 December 2016**
Report for: **Decision**
Report of: **Executive Member for Finance and Chief Finance Officer**

Report Title

Council Tax Support Scheme for 2017/18 – Proposed Changes to align with national benefits

Summary

This report summarises the current Council Tax Support Scheme and the proposed changes which will align the assessment criteria of scheme to those of the national benefits and then to maintain this alignment for any further national welfare reform changes in the future.

This report also summarises the feedback from the consultation which has been undertaken on these changes.

Recommendation(s)

That the Executive recommend to Council the proposed changes to the Council Tax Support scheme which will align the Council Tax Support scheme assessment criteria with those of the national benefits.

Contact person for access to background papers and further information:

Name: Louise Shaw
Extension: 3120

Background Papers: None

Relationship to Policy Framework/Corporate Priorities	Low Council Tax, Value for Money and services focused on the most vulnerable people
Financial	The existing Council Tax Support scheme is already funded by the Council and the changes proposed will not increase the funding required.
Legal Implications:	The Council has to formally set its local CTS scheme before 31 January 2017, in order for the scheme to be formally adopted for 2017/18. This is in accordance with the Local Government Act 2012.
Equality/Diversity Implications	An equalities impact assessment has been completed and there are no groups negatively impacted from the changes.
Sustainability Implications	None
Resource Implications e.g. Staffing / ICT / Assets	Resources required to implement the proposed changes to the scheme can be absorbed within current staffing levels.
Risk Management Implications	None
Health & Wellbeing Implications	A public consultation including presence at partnership meetings has taken place to gather the views of individuals and organisations that support vulnerable groups. Protected groups remain within the scheme as does the maximum award of 100% (subject to a band D charge and non-dependant deductions)
Health and Safety Implications	None

1.0 Background

1.1 In April 2013, following the abolition of Council Tax Benefit (CTB) which was a national scheme funded by a central government grant, the Council implemented its new local Council Tax Support (CTS) Scheme. The funding for the scheme was 10% less than the cost of the national CTB scheme.

1.2 Pensioners were, and still are, protected by legislation in that although local authorities could make changes, pensioners could be no worse off than they were under the previous CTB scheme. Therefore the only local discretion regarding reductions in CTS is to working age claimants.

1.3 There are 13.7k Trafford residents in receipt of CTS and spend is £10.1m per annum. 48% of CTS claimants are pensioners and therefore are protected from any changes introduced that would make them worse off when compared to the CTB scheme. The CTS pensioner spend is £5.1m per annum and the CTS scheme for pensioners already aligns with national pensioner schemes.

1.4 Each year, the Council has to formally approve its CTS scheme for the following financial year before the 31 January. Any changes to the CTS scheme require public consultation. Trafford has made no changes to its CTS scheme (other than to increase amounts in line with national uprates) since its introduction in 2013.

1.5 In September 2016 the Executive approved a proposal to consult with the public on changes to the current CTS scheme, to bring it in line with national benefits now and in the future. The consultation ended on 7 November.

2.0 Trafford's CTS Scheme

2.1 When compared to the schemes within GM, Trafford is amongst the few to award 100% CTS to out of work claimants (subject to Band D cap and less any non-dependant deductions).

2.2 The main differences between Trafford's CTS scheme and the previous CTB scheme are that under the new scheme:

- The maximum award payable is equivalent to a band D property charge.
- Child Benefit (for children aged 5 years or older) is treated as income.
- No backdating of awards.
- The rate at which benefit is withdrawn (known as the income taper) has increased from 20% to 30%.
- Deductions relating to adults in the property (non-dependents) increased by 20% and a new deduction was introduced for adults who receive benefit.
- The minimum level of award is set at £5 per week.
- No Second Adult Rebate provision

2.3 Protection was identified and implemented for the following groups:

- Protect claimants of pension age in line with the legislation
- Protect claimants and/or their partners who receive the middle or high rate of Disability Living Allowance for Care or Mobility from all the above changes except for abolishing Second Adult Rebate and abolishing discretionary backdating rules.
- Protect households who have a dependent child under 5 years old from including Child Benefit as income.
- Continue to apply our local discretion to disregard War Pensions and War Widows Pensions as income, when calculating awards of Council Tax Support.

2.4 Additions to the scheme to help those starting work were introduced:

- Eight week 'run on' of previous entitlement for the long term unemployed starting work. This is double the four week entitlement in the previous CTB scheme
- Child care disregard costs increased by 10% where parents are working and children are in approved childcare

2.5 To help with the transition from CTB to CTS, the Council agreed that a discretionary fund should be set up to help residents on a case by case basis. This supports and aligns to the discretionary fund in place for help towards housing costs, namely the Discretionary Housing Payments fund.

3.0 Drivers for change

3.1 Although the CTS scheme has worked as originally intended, it is no longer in line with other working age national benefits, including Housing Benefit (HB) which is administered alongside CTS on the same software system.

3.2 A variety of working age welfare reform changes have been implemented since April 2013 and this trend is intended to continue, in particular with increasing numbers of claimants now receiving Universal Credit (UC).

3.3 Currently, working age Trafford residents increasingly find themselves applying for support and getting their personal circumstances and income assessed differently, quite often this can be by the same Council officer. Explaining this to claimants, quite a high proportion of who are vulnerable is difficult and often leads to confusion.

3.4 Similarly, it adds an administrative burden to the Council to operate differing schemes.

3.5 Fundamentally, it is proposed that the current CTS scheme remains largely the same, with out of work claimants receiving maximum support (up to a band D) and protection still in place for the most vulnerable groups as described in 2.2 above. In addition, the Council intends to retain the extra support it put in place for workers as detailed in 2.3.

3.6 The changes the Council do propose is to align the scheme to bring it up to date with the changes that have occurred with national working age benefits already and then keep it in line with future changes as and when national legislation is implemented, subject to any scheme consultation requirements. Examples of the changes to date include those listed below:

- The introduction of UC in Trafford. The treatment of UC income is not explicitly defined in the CTS scheme;
- Capping the support available for new claimants with families, and for existing claimants with new children, to a maximum of 2 children;
- Removing the family premium allowance for new claimants with families;
- Applying a national minimum wage assumption to self-employed claimants who have been trading for more than 12 months and continue to declare no or little profit;

- Ensure residents who have no right to claim national benefits cannot claim CTS;

3.7 As most of the changes relate to new CTS claims, the Council is unable to accurately identify the number of affected claimants. However, based on expected numbers, looking at historical data, it is anticipated that approximately 10% of working age claimants (1100) will be affected in the first year of the scheme and this will rise over a 5 year period to approximately 13% (1700).

3.8 As national working age welfare reform changes tend to tighten the assessment criteria this will naturally mean that less CTS will be paid. The financial change is estimated to be a reduction of £160k (1.6% of total spend) in the first year, rising over a 5 year period to £320k (3.2% of total spend) - although that does not take into account any further unknown national benefit changes.

3.9 A copy of the wording of the intended changes is attached as Appendix B. A copy of the current scheme can be accessed from the council's website at http://www.trafford.gov.uk/residents/benefits-and-council-tax/benefits/docs/council-tax-support-final-regs-2014-15.pdf

4.0 Public Consultation

4.1 Although the proposed changes are minor, public consultation has taken place as required by law. A small proportion of existing claimants and new claimants will be worse off under the new scheme.

4.2 The consultation lasted for 6 weeks between 26 September and 7 November 2016. An online survey was created which enabled all information and views to be collated. A press release was issued advising the public of the proposed changes and how they could respond. The information has also been made available to all staff via the intranet.

4.3 In addition, Exchequer Services staff also attended partnership meetings and spoke to over 25 partnership groups across the borough. External partners were sent direct emails inviting them to respond. Partners included Citizens Advice Trafford, Age UK Trafford, Housing Associations, Trafford Centre for Independent Living and others.

4.4 The response to the survey was low, with only 59 responses recorded. 94% completed it on their own behalf with the remaining 6% completing it on behalf of an organisation or group. When asked about the individual proposed changes, with the exception of the family premium, the majority answered in favour of each of the changes proposed. It was an equal spilt in relation to the family premium. A summary of the responses can be found in Appendix A.

4.5 At the partnership meetings, the feedback tended to relate to individual circumstances rather than the scheme as a whole.

4.6 Throughout the consultation the main point of disagreement with the new scheme was the protection afforded to pensioners. However, changes in this area are largely prevented by national legislation

Other Options

The Council could decide not to change the scheme for 17/18. However, this would mean the continuation of a local scheme that is no longer fit for purpose and is increasingly difficult to understand and administer.

Reasons for Recommendation

The Council must adopt a local CTS scheme no later than 31 January before the start of the financial year to which the scheme applies in accordance with the Local Government Finance Act 2012. The proposed changes are to modify the existing scheme by adopting changes that align the local scheme with national benefit regulations whilst still retaining a more favourable approach within the scheme to those who are out of work when compared to the schemes within GM (subject to a Band D cap and less any non-dependant deductions)

Key Decision: Yes
If Key Decision, has 28-day notice been given? Yes

Finance Officer Clearance NB
Legal Officer Clearance mrj

CORPORATE DIRECTOR'S SIGNATURE 

To confirm that the Financial and Legal Implications have been considered and the Executive Member has cleared the report.

Appendix A – Public Consultation Survey Results

Q1 Are you responding on your own behalf or on behalf of an organisation or group?

Answer Choices	Responses	
Own behalf	94.92%	56
Behalf of an organisation or group	5.08%	3
Total		59

Q2 What is your name, your position in the organisation/group, and the name and address of the organisation/group on whose behalf you are submitting this response? The name and details of your organisation or group may appear in the final report.

Answered: 2 Skipped: 57

Q3 Removal of family premium the family premium is part of how we assess the 'needs' of any applicant. Family premium is normally awarded in addition to other premiums when there is at least one dependent child residing in the house. Removing the family premium will mean a family would have less premiums. From May 2016 Central Government removed the family premium for new claims for HB. Do you agree with this change to the scheme?

Answer Choices	Responses	
Yes	43.40%	23
No	43.40%	23
Unsure	13.21%	7
Total		53

Q4 Limit the number of dependent children within the calculation for CTS to a maximum of two. Within the current scheme, customers who have children are awarded a dependant's addition per child within their applicable amount and there is no limit to the dependant additions that can be awarded. From April 2017 Central Government will be limiting dependant's additions to some other benefits, including HB, to a maximum of two. Do you agree with this proposed change to the scheme?

Answer Choices	Responses	
Yes	56.60%	30
No	39.62%	21
Unsure	3.77%	2
Total		53

Q5 The Council proposes that where UC is the only income then maximum CTS is awarded subject to existing reductions within the present scheme. Do you agree with this proposed change to the scheme?

Answer Choices	Responses	
Yes	71.74%	33
No	8.70%	4
Unsure	19.57%	9
Total		46

Q6 The Council proposes that where those in receipt of UC and other income, such as wages etc., then the award of CTS is calculated using the total income. Do you agree with this proposed change to the scheme?

Answer Choices	Responses	
Yes	80.43%	37
No	10.87%	5
Unsure	8.70%	4
Total		46

Q7 The Council proposes that where those in receipt of UC receive either the Housing and/or Child care element of UC then these elements are disregarded when calculating CTS. Do you agree with this proposed change to the scheme?

Answer Choices	Responses	
Yes	71.74%	33
No	15.22%	7
Unsure	13.04%	6
Total		46

Q8 In order to align CTS with UC, the Council is considering an option to use a minimum level of income for those who are self- employed. This would be in line with the National Living Wage (or National Minimum wage if you are under 25) for the hours worked per week. Any income above this amount would be based on the actual amount earned. This would not apply until after one year from the start of the business. Do you agree with the proposal to set income for self-employed earners with a minimum earned income for their claim?

Answer Choices	Responses	
Yes	67.39%	31
No	15.22%	7
Unsure	17.39%	8
Total		46

Q9 The period for which a person can be temporarily absent from home and still receive CTS is currently 13 weeks. To align with HB it is proposed to reduce this time limit to 4 weeks. Do you agree with this change to the temporary absence rule?

Answer Choices	Responses	
Yes	73.91%	34
No	15.22%	7
Unsure	10.87%	5
Total		46

Q10 The Council proposes that those who are not entitled to claim other national welfare benefits including HB should not be able to claim CTS. Do you agree with this change?

Answer Choices	Responses	
Yes	54.35%	25
No	26.09%	12
Unsure	19.57%	9
Total		46

Q11 The Council proposes that the CTS scheme is aligned to and updated as and when required to keep in line with national welfare reform changes For example the Council proposes to be able to amend the CTS scheme to take into account changes like those relating to the family premium and limiting dependents allowance to two children as detailed above without further public consultation. Do you agree with this change?

Answer Choices	Responses	
Yes	52.17%	24
No	34.78%	16
Unsure	13.04%	6
Total		46

Q12 The scheme presently allows an eight week "run on" of previous entitlement for the long term unemployed starting work, double the entitlement awarded within the HB scheme, and higher child care costs are also disregarded. Do you agree the extra support for new workers should remain?

Answer Choices	Responses	
Yes	73.81%	31
No	21.43%	9
Unsure	4.76%	2
Total		42

Q13 Do you agree protection from reductions in CTS should remain in place for those where the claimant or partner receive the middle or higher rate of Disability Living Allowance for Care or Mobility (or Personal Independence Payments equivalent)?

Answer Choices	Responses	
Yes	73.81%	31
No	19.05%	8
Unsure	7.14%	3
Total		42

Q14 Do you understand how the proposed changes may affect how your CTS is calculated?

Answer Choices	Responses	
Yes	64.29%	27
No	11.90%	5
Unsure	23.81%	10
Total		42

Q15 Do you believe the proposed changes would simplify the application process when applying for support and understanding your entitlement?

Answer Choices	Responses	
Yes	57.14%	24
No	33.33%	14
Unsure	9.52%	4
Total		42

Q16 Do you agree with all the proposed changes to the scheme?

Answer Choices	Responses	
Yes	33.33%	14
No	52.38%	22
Unsure	14.29%	6
Total		42

Q17 Please use this space to make any other comments on this scheme.

- The changes to the scheme clearly target the vulnerable, low income earners and those in receipt of state benefits.
- anyone in receipt of a sickness benefit e.g. ESA,PIP should automatically get a reduction in CT
- I think that the vast majority of the proposed changes disadvantage those who struggle the most in our society who should be supported the most.
- I receive a discount because I am a FT student- would this cease? I know it is a Central Gov rule I think the Pensioner Projected for "richer" pensioners needs to end. We should take a hit of Welfare Reform fairly. The Welfare Reforms have hit the same groups again and again, single parents and low income families who do work.
- Maximum number of children should be raised to 3 instead of 2. CTS run on should be reduced to around 6 weeks to ensure first wage slip is received before entitlement reduces
- I believe that some of the changes, such as the reduction in family premium and restriction on number of child premiums should be time restricted. e.g. enforced only after the claimant has been claiming more than 12 months as this will then not penalise those people who find themselves requiring to claim for only short periods

Q18 Please use the space below if you would like the Council to consider any other options (please state).

- Increasing the council tax of those in larger, more expensive homes.
- Anyone in receipt of a benefit for illness e.g. ESA, PIP, should automatically get a reduction or exemption from Council Tax.
- Students get discount, also can't see anything about sole adults discount being retained.

- i only think that the claimant or partner on DLA should be included. not other household members
- include reductions from pensioners CTS

Q19 If you have any further comments or questions to make regarding the Council Tax Support scheme that you haven't had the opportunity to raise elsewhere please use the space below.

No comments

Q20 Are you, or someone in your household, getting Council Tax Support at this time?

Answer Choices	Responses	
Yes	9.52%	4
No	85.71%	36
Unsure	4.76%	2
Total		42

Q21 what is your sex?

Answer Choices	Responses	
Male	28.57%	12
Female	57.14%	24
Prefer not to say	14.29%	6
Total		42

Q22 what is your age?

Answer Choices	Responses	
16-18	0.00%	0
19-24	2.38%	1
25-39	23.81%	10
40-60	57.14%	24
Over 60	7.14%	3
Prefer not to say	9.52%	4
Total		42

Q23 Do you consider yourself to be disabled?

Answer Choices	Responses	
Yes	9.52%	4
No	73.81%	31
Prefer not to say	16.67%	7
Total		42

Q24 what is you ethnic group

Answer Choices	Responses	
White British	78.57%	33
White Irish	0.00%	0
Other white background	0.00%	0
White & black Caribbean	0.00%	0
White & black African	0.00%	0
White & Asian	0.00%	0
White and other background	0.00%	0
Asian or Asian British Indian	0.00%	0
Asian or Asian British Pakistani	0.00%	0
Asian or Asian British Bangladeshi	0.00%	0
Other Asian background	0.00%	0
Black or black British Caribbean	0.00%	0
Black or black British African	0.00%	0
Other Black background	0.00%	0
Chinese	0.00%	0
Any other background	0.00%	0
Gypsy Traveller	0.00%	0
Arab	0.00%	0
Prefer not to say	21.43%	9
Total		**42**

Appendix B – Proposed CTS Wording Changes

The paragraphs proposed for change are listed below, the wording changes are underlined:

Clarification of protected persons
protected categories means applicants or partners of applicants, or their family of the applicant or partner of the applicant within the meaning of regulation 6 of this scheme who receive the middle or high rate of disability living allowance for care or mobility or its subsequent equivalent personal independence payment

Temporary absence rule
For those absences where the person is absent outside Great Britain then the allowable period of temporary absence shall generally be limited to 4 weeks and will be calculated in accordance with the same criteria within the Housing Benefit and State Pension Credit (Temporary Absence) (Amendment) Regulations 2016 (S.I. 2016/624). Where those regulations extend the allowable period of temporary absence beyond 4 weeks the extended period will apply.

Classes of person excluded from this scheme
The classes of person described in paragraphs 21 to 23 are not entitled to a reduction under this scheme. In addition any person who is not entitled to claim other national welfare benefit nationally available in the United Kingdom shall not be entitled to a reduction under this scheme.

Updating applicable amounts to limit to two children/young person and family premium
(b) an amount in respect of any child or young person who is a member of his family (determined in accordance with paragraph 2 of that Schedule) where he has been continuously entitled to a reduction under this scheme in respect of that child or young person on or before 31 March 2017 onwards; where he has not been or becomes not so entitled the total amount in respect of the children or young persons shall be limited to no more than two such amounts.
(c) if he is a member of a family of which at least one member is a child or young person, and he has been continually entitled to a reduction under this scheme on or before 31 March 2017 onwards, an amount determined in accordance with Part 2 of that Schedule (family premium);

Updating polygamous marriages applicable amounts to limit to two children/young person and family premium
(c) an amount determined in accordance with paragraph 2 of that Schedule (applicable amounts) in respect of any child or young person, where he has been continually entitled to a reduction under this scheme in respect of that child or young person on or before 31 March 2017 onwards, for whom he or a partner of his is responsible and who is a member of the same household; where he has not been or becomes not so entitled the total amount in respect of the children or young persons shall be limited to no more than two such amounts.
(d) if he or another partner of the polygamous marriage is responsible for a child or young person who is a member of the same household, and he has been continually entitled to a reduction under this scheme on or before 31 March 2017 onwards, the amount specified in Part 2 of that Schedule (family premium);

Non-dependant deductions: pensioners and persons who are not pensioners

(8) No deduction is to be made in respect of a non-dependant
(c) is not residing with the claimant because he is a member of the armed forces away on operations

(9) In the application of sub-paragraph (2) [(2) In the case of a non-dependant aged 18 or over to whom sub-paragraph (1)(a) applies, where it is shown to the appropriate authority that his normal gross weekly income is]
there is to be disregarded from the non-dependant's weekly gross income—
(a) any attendance allowance, disability living allowance, Armed Forces independence payment or personal independence payment received by him;

Updating self employed earnings minimum income
(3) Where an applicant's earnings have been calculated in accordance with sub paragraph (2) above and their earned income in respect of the period in question is less than the national living wage per hour worked then the national living wage will be assumed as income for that period for the number of hours worked.

Date on which change of circumstances is to take effect
105.—(1) Except in cases where paragraph 59 (disregard of changes in tax, contributions, etc.) applies and subject to the following provisions of this paragraph and paragraph 105(a) and (in the case of applicants who are pensioners) paragraph 106, a change of circumstances which affects entitlement to, or the amount of, a reduction under this scheme (change of circumstances), takes effect from the first day of the reduction week following the date on which the change actually occurs.

105 (A) Effective date of beneficial changes of circumstances notified late, persons who are not pensioners
105 (A) For the purposes of determining the date on which a superseding decision is to take effect, in a case where-
(a) the change of circumstances that is required by paragraph 113 of this scheme to be notified,
(b) that change of circumstances is notified more than one month after it occurs, or such longer period as may be allowed if there is good cause for late notification, up to a maximum of 13 months after the date the change occurred.
(c) the superseding decision is advantageous to the claimant
the date of notification of the change of circumstances shall be treated as the date on which the change of circumstances occurred.

Making an application
(8) For the avoidance of doubt where an applicant does not qualify for a reduction under this scheme on the entitlement date as defined in regulation 104 of this scheme, but a change of circumstances occurs which means that the applicant would now qualify for such a reduction, the applicant must make a new application to qualify for that reduction.

Information and evidence
111.—(1) Subject to sub-paragraph (3), a person who makes an application for a reduction under this scheme must satisfy sub-paragraph (2) in relation both to himself and to any other person in respect of whom he is making the application.
(4) Subject to sub-paragraph (5), a person who makes an application, or a person to whom a reduction under this scheme has been awarded, must furnish such certificates, documents, information and evidence in connection with the application or the award, or any question arising out of the application or the award, as may reasonably be required by the authority in order to determine that person's entitlement to, or continuing entitlement to

a reduction under this scheme and must do so within one calendar month of the authority requiring him to do so or such longer period as the authority may consider reasonable. Failure to comply with such a requirement will result in the termination of the entitlement to council tax reduction from:

(a) the date that the Authority requested the information.

(b) such earlier or later date as the authority considers appropriate having regard to the lack of information requested to satisfy itself of the person's continuing entitlement to a reduction under this scheme.

Decisions by authority

114 (1) The authority must make a decision on an application for a reduction under this scheme within 14 days of paragraphs 108 and 111 and Part 1 of Schedule 1 being satisfied, or as soon as reasonably practicable thereafter.

114 (2) An original decision may be revised or further revised by the authority which made the decision, at any time by that authority, where that decision–

(a) arose from an official error; or

(b) was made in ignorance of, or was based upon a mistake as to, some material fact and as a result of that ignorance of or mistake as to that fact, the decision was more advantageous to the person affected than it would otherwise have been but for that ignorance or mistake.

Amendments to the Scheme

19. The Authority may maintain this Scheme in line with changes to other national welfare benefits available in the United Kingdom subject to consultation requirements.

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TRAFFORD COUNCIL

Report to: **Accounts & Audit Committee 23 November 2016**
Executive 19 December 2016

Report for: **Discussion**
Report of: **The Executive Member for Finance and the Chief Finance Officer**

Report Title

Treasury Management 2016-17 Mid-Year Performance Report

Summary

This report has been prepared in accordance with the CIPFA Code of Practice and gives a summarised account of the Treasury Management activities and outturn for the first half of the year. The purpose of this report is to provide members with, an update of the world economic headlines for this period, the major debt & investment activities undertaken, revised interest rate and economic forecasts and a benchmarking update.

Debt Activity:-

- Net debt interest costs are forecasted to be £0.13m above budget as previously reported in the Revenue Budget Monitoring report,
- At 30 September the Council's external debt was £106.0m.

Investment Activity:-

- The annualised investment interest to be generated is forecasted to be in line with budget of £0.77m,
- Rate of Return achieved during the period April to September 2016 was;
  i. short term investments 0.72%, or 0.28% / £(155)k above the comparable performance indicator of the average 7-day **L**ondon **I**nterbank **BID** interest rate and
  ii. long term investments 5.25%,
- At 30 September the Council's level of investments was £102.1m.

Prudential Indicators:-

- During the first half of 2016/17 the Council complied with its legislative and regulatory requirements, including compliance with all treasury management prudential indicators.

Recommendations

That the Accounts & Audit Committee & Executive be requested to:

1. Note the Treasury Management activities undertaken in the first half of 2016/17.

Contact person for background papers and further information:

Name: Graham Perkins
Extension: 4017 Background papers: None

Relationship to Policy Framework/Corporate Priorities	Value for Money
Financial	The Council did not encounter any cash flow liquidity difficulties and all investment income was received on time. The projected level of investment income from investments for 2016/17 is £0.77m and this is in-line with budget. Net debt costs are £0.13m above budget due to increase costs on the Council's variable rate loan being incurred as reported in the Revenue Budget Monitoring report.
Legal Implications:	Actions being taken are in accordance with legislation, Department of Communities & Local Government (DCLG) Guidance, Chartered Institute of Public Finance & Accountancy (CIPFA) Prudential Code and Treasury Management Code of Practice.
Equality/Diversity Implications	Not applicable
Sustainability Implications	Not applicable
Staffing/E-Government/Asset Management Implications	Not applicable
Risk Management Implications	The monitoring and control of risk underpins all treasury management activities and these factors have been incorporated into the treasury management systems and procedures which are independently tested on a regular basis. The Council's in-house treasury management team continually monitor interest forecasts and actual market interest rate movements to ensure that any exposure to adverse fluctuations in interest rates are minimised and security of capital sums are maintained at all times.
Health and Safety Implications	Not applicable

1. BACKGROUND

1.1 Treasury management is defined as:

> The management of the local authority's investments and cash flows, its banking, money market and capital market transactions, the effective control of the risks associated with those activities and the pursuit of optimum performance consistent with those risks.

1.2 A main feature of this function is to ensure that the Council's day to day cash flow requirements are adequately planned and accounted for with any surplus monies being invested in low risk counterparties providing adequate liquidity initially before considering optimising investment return. An additional role is ensuring the Council's longer term funding requirements arising from its capital programme commitments are also considered which may involve arranging long or short term loans.

1.3 Each year in order to comply with the requirements of both the CIPFA Code of Practice on Treasury Management (the Code) and the CIPFA Prudential Code for Capital Finance in Local Authorities (the Prudential Code), the Accounts & Audit Committee together with the Executive will receive the following reports:

- annual treasury strategy for the year ahead (February)
- mid-year update report (November i.e. this report)
- annual report describing the activity undertaken compared to the strategy (June).

1.4 The Treasury Management Strategy for 2016/17 was approved by Council at its meeting on 17 February 2016 and the policies to be adopted for the year remain unchanged.

1.5 This mid-year report has been prepared in compliance with CIPFA's Code of Practice on Treasury Management, and covers the following:

- Economic Update (section 2)
- Treasury Position (section 3)
- Debt Activity (section 4)
- Investment Activity (section 5)
- Risk Benchmarking (section 6)
- Prudential and Performance Indicators (section 7)
- Recommendations (section 8)

2. ECONOMIC UPDATE

2.1 During the first half of 2016/17, the main economic headlines arising are outlined below with a forecast of the main indicators for 2017, highlighted at Appendix B for reference:

UK

- Gross Domestic Product (GDP) continues to remain positive with quarters 1 and 2 recording annualised growth of 2.0% y/y & 2.1% y/y respectively although this has slowed from the 2014 rate of 2.9% and 2015 of 1.8%.
- Economy continues to be of the world's strongest,

- Following the outcome of the Brexit referendum vote in June, businesses were reporting a downturn in confidence, however recent surveys are now reporting this not to be the case,
- Bank of England in response to the Monetary Policy Committee meeting on 4 August announced a rescue package to address the impact of the Brexit result which included reducing its bank rate from 0.50% to 0.25% and increasing quantitative easing from £375bn to £435bn,
- The monthly unemployment rate remains static at 4.9% period ending August 2016 compared to 5.0% for April 2016,
- Consumer Price Index (CPI) for the first half of 2016/17 has risen from 0.3% (April) to 1.0% (September) and this is in response to rising prices for clothing, overnight hotel stays and fuel. A further factor to this increase has been the fall in the value of sterling by 10% following the Brexit referendum and it is currently forecast that CPI could rise to 3% in the next 3 to 4 years, exceeding the Government's 2% target,

U.S.

- GDP continues to grow in 2016 with the recorded annualised movements for quarters 1 & 2 being 0.8% and 1.4% respectively, down from the 2015 position of 2.4%,
- Following the move in December 2015 by the Federal bank to move interest rates from 0.25% to 0.50% markets were expecting further increases in 2016 however these have been delayed due to weakness in the international markets with the next increase now expected in December 2016,
- The 3 month unemployment rate remained steady at 4.9% for the 3 months ending September 2016 which was the same level as that reported for the previous quarter,
- CPI was 0.2% for period ending August 2016,
- **Eurozone**
- In March 2015, the European Central Bank (ECB) commenced its massive euro quantitative easing (QE) programme purchasing high credit quality government and other Eurozone debt instruments at a rate of 60bn euro per month. This programme was expected to run until September 2016 however this date has now been extended to March 2017 with the monthly limit being increased from 60bn to 80bn euros,
- E.C.B. reduced its deposit facility rate to -0.4% and the main refinancing rate from 0.05% to 0% in March 2016,
- GDP grew by 0.6% in quarter 1 2016 (1.7% y/y) falling slightly to 0.3% (1.6% y/y) for quarter 2,
- The latest CPI figures show inflation currently remaining very sluggish at 0.29% for September 2016,

- The 3 month unemployment rate continues to remain static at 10.1% for the 3 months ending August with marginal change for the previous quarter;
- Italian constitutional referendum in December 2016, French Presidential election April / May 2017 & German Federal general election in August to October 2017 all of which could have a huge bearing on the future direction the Eurozone follows.

Other Countries

- Japan's economy appears to have stalled with weak growth being reported,
- China's economy continues to slow down with the outlook for its medium term growth prospects giving cause for concern.

2.2 The Council's treasury management advisors Capita, provide interest rate forecasts periodically through-out the year and the table below outlines the latest situation taking into consideration the above economic conditions:

	2016-17 Original Forecast %	2016-17 Revised Forecast %	2017-18 Revised Forecast %	2018-19 Revised Forecast %
Bank Rate	0.63	0.28	0.10	0.25
Investment Rates				
3 month	0.70	0.33	0.20	0.38
1 Year	1.15	0.66	0.65	0.78
PWLB Loan Rates				
5 Year	2.25	1.17	1.10	1.20
25 Year	3.55	2.51	2.40	2.50

2.3 It is widely expected the M.P.C. will cut the Bank of England's Bank Rate again to 0.10% before the year end and the above forecast reflects this with the first increase forecasted to occur in May 2018, back up to 0.25% with the further increase to 0.50% a year later. With regards to gilt yields and PWLB rates, these are only set to rise marginally from their current levels.

2.4 The Council's stance when undertaking or considering any money market transactions will continue to be as that adopted in previous years and to take a cautious approach in line with the current and forecasted economic position outlined above.

3. TREASURY POSITION

3.1 The Council's investment and debt position at the beginning and midway through the current financial year were as follows:

	31 March 2016		30 September 2016	
	Principal £m	Interest Rate %	Principal £m	Interest Rate %
DEBT				
Fixed rate:				
PWLB –fixed rate	47.2	6.11	47.0	6.06
PWLB – variable rate	0.0	0.00	0.0	0.00
Market – fixed rate (i)	6.0	3.68	24.0	4.19
Market – variable rate	51.0	5.73	35.0	6.44
Total debt	**104.2**	**5.79**	**106.0**	**5.78**
INVESTMENTS				
- Fixed rate	39.3	0.97	66.2	0.82
- Variable rate	37.7	0.52	31.3	0.38
- Other – CCLA	4.8	4.77	4.6	4.88
Total Investments	**81.8**	**0.98**	**102.1**	**0.87**
NET POSITION- DEBT / (INVESTMENT) (ii)	**22.4**		**3.9**	

Note: (i) Reflects Barclays market loans converting to fixed rate effective July 16 & includes £3m of interest free Salix loans
(ii) Net position = Total debt less Total Investments

3.2 When reviewing the above table, it is important to note that investment levels do fluctuate daily, reflecting timing issues arising from monies received ahead of spend which are available on a temporary basis.

4. DEBT ACTIVITY

4.1 The Council, as at 31 March 2016, was under borrowed by £30.6m, as a result of the total Capital Financing Requirement (CFR), the underlying need to borrow for capital purposes, of £134.8m being higher than its actual level of external debt of £104.2m.

4.2 During 2016/17 the Council's (CFR) position, is forecasted to increase by £7.9m from its closing position as at 31 March 2016 of £134.8m to £142.7m by 31 March 2017 reflecting the difference between the level of new capital expenditure financed by borrowing, £11.0m less the statutory Minimum Revenue Provision £(3.1)m (the amount set aside from revenue for the repayment of debt).

4.3 The Council's position of being under borrowed by £30.6m reflects decisions taken previously to apply its own funds (cash supporting reserves & balances) to fund its capital borrowing requirement rather than taking on any new debt due to the high "cost of carry" i.e. the difference between long-term debt interest rates and short-term investment interest rates.

4.4 This course of action continues to be widely adopted by Local Authorities and it is currently forecast to continue as both short (Investment) and long (debt) term interest rates have reduced to historically low levels, as highlighted in the table at paragraph 2.2, following the outcome of the June Brexit referendum

result and subsequent action in August by the Monetary Policy Committee to (a) reduce bank rate from 0.50% to 0.25% and (b) increase the level of support given to markets from £375bn to £435bn.,

4.5 This situation will continue to be monitored closely and any new borrowing opportunities which permit new loans to be taken to assist finance the Council's capital Investment programme without placing any additional financial burden on the revenue budget will be pursued.

4.6 The table at paragraph 3.1 highlights that the level of external debt has increased from £104.2m at 31 March 2016 to £106.0m at 30 September 2016, a net increase of £1.8m. This increase reflects a further £2m (£1m was received in 2015/16) of the £3.8m Salix loan which is to be used on the Council's Street Lighting Replacement Programme, being received at an interest rate of 0% with the remaining balance of £0.8m expected before the end of 2016/17. Maturing debt of £(0.2)m was repaid to the PWLB.

4.7 The majority of the Council's loans are held at fixed rates of interest however the Council has 1 loan which is subject to quarterly interest rate fixings using a recognised market indicator and as a consequence of the current economic climate this has resulted in a higher level of interest being paid during 2016/17; this is forecast to be £0.13m above budget and has been previously reported in the Revenue Budget Monitoring report.

4.8 Debt rescheduling opportunities have been limited due to the high breakage penalty (premium) costs which would need to be incurred and therefore during the first half of the year no debt restructuring has been undertaken however the situation will continue to be monitored for the remainder of the year.

4.9 The Council has 7 market loans totalling £59m, 2 of which are with Barclays bank at a value of £16m which were subject to interest rate reviews every 6 months by the bank. In July the Council received a letter from Barclays informing it that the bank had now waivered its right to review future interest rates and that the loans had been converted into fixed rate loans at the current interest rate levels at no cost to the Council. All other conditions of the loans remain the same. As a result of this action any sensitivity to market movements has been removed thereby enabling the Council to forecast with more certainty its ongoing debt costs.

4.10 During the first half of the year the Council had no liquidity difficulties as a result of proactive cash flow management thereby avoiding the need for any temporary borrowing to be undertaken.

5. INVESTMENT ACTIVITY

5.1 In accordance with the Code of Conduct, the Council's priorities when placing any temporary surplus funds with any approved institution remains as adopted in previous years which is security of capital, liquidity and then an appropriate level of return consistent with its risk appetite.

5.2 All investments placed with any of the Council's approved institutions and which matured during the first half of the financial year, were repaid on time without any difficulties and the list of institutions in which the Council invests continues to be kept under review. For reference during the first half of the year no institutions were added to or deleted from the Council's approved list.

5.3 The movement in the Council's temporary investments as at 31 March 2016 compared to 30 September 2016 is shown below for reference:

Sector	31 March 2016 £m	30 September 2016 £m
UK Banks	21.1	27.5
UK Building Societies	2.2	8.7
Money Market Funds	36.7	31.3
Non UK Banks	12.0	30.0
Local Authority	5.0	0.0
Other - CCLA	4.8	4.6
Total	**81.8**	**102.1**

The maturity structure of the investment portfolio was as follows:

Period	31 March 2016 £m	30 September 2016 £m
Instant Access	37.7	31.3
Up to 3 Months	5.5	13.8
3 to 6 Months	16.7	25.8
6 to 9 Months	9.5	2.5
9 to 12 months	7.6	24.1
Over 1 year	4.8	4.6
Total	**81.8**	**102.1**

5.4 Throughout the first half of the year, a total of 104 short term temporary investments were undertaken by the Council's in house treasury management team in an environment of historically low interest rates. The table below details the results of these activities, which clearly illustrates the Council outperforming the 7day LIBID benchmark, a recognised market performance indicator, by 0.28% on its short term investments whilst ensuring that all risk was kept to a minimum during this period.

Average level of short term Investments (ex CCLA) 1 April to 30 Sept £m	Average interest rate earned %	Average 7 day LIBID rate %	Additional interest earned against 7 day LIBID £k
104.0	0.72	0.28	155

5.5 In September 2015, the Council invested £5m in the Local Authority Property Investment fund, managed by the Church Commissioners Local Authority, (CCLA), enabling 1,643,872 units in the fund to be purchased. This fund is only available to Local Authorities and the objective of it is to generate long-term growth in the original amount invested whilst generating returns in the form of annual dividends by investing in commercial property throughout the UK.

5.6 This investment was undertaken in September 2015 on the understanding that funds would be placed with CCLA for a minimum period of 5 years enabling

capital growth to be generated following the deduction of entry costs totalling £0.3m has been taken into account and nothing has changed this position.

5.7 The Council's original investment placed with CCLA was £5m which as at 31 March 2016 was worth £4.8m however due to adverse market movements following the Brexit referendum result in June, the valuation of the Council's units had fallen to £4.6m as at 30 September. Market uncertainty regarding how the UK commercial property will react following both Brexit and the US presidential elections, makes it extremely difficult to forecast when the value of the Council units will reach its initial input value of £5m however the level of dividends received are currently forecasted to continue their strong levels as a result of high rental returns being achieved. For reference the annualised level of return generated for the first half of 2016/17 was 5.25% and it is expected to continue around this level for the forthcoming 12 months.

5.8 Due to a higher level of return achieved earlier in the first half of the year and higher temporary balances being available to be invested resulting from monies being received ahead of spend requirements, it is currently forecasted that the level of investment interest which will be generated from all of the Council's investments during 2016/17 will be in-line with that budgeted of £0.77m.

5.9 As highlighted in Section 2, it is currently a challenging market environment for earning a respectable level of interest as rates are very low and in line with the current 0.25% Bank Rate. With this in mind, together with the continuing potential for a re-emergence of a Eurozone sovereign debt crisis and other risks which could impact on the creditworthiness of banks, a low risk strategy will continue to be adopted. Given this risk environment, investment returns are likely to remain low.

5.10 A breakdown of the Council's investments, as at 30 September 2016 is provided at Appendix A for reference.

6. RISK BENCHMARKING

6.1 In accordance with the Code of Practice and CLG Investment Guidance, appropriate security and liquidity benchmarks are used by Officers to monitor the current and future potential risk conditions and undertake any corrective action to the operational strategy if required.

6.2 These benchmarks are simple guides to maximum risk (not limits) and so may be breached from time to time, depending on movements in interest rates and counterparty criteria.

6.3 During the first half of 2016/17 the Chief Finance Officer can confirm that no benchmarks, which were set in the Strategy report in February 2016, were breached as shown from the information below;

- **Security** – This table shows the benchmark for the Council's investment portfolio for each individual year and reflects the level of potential default when compared to the historic default rates.

	1 year	2 years	3 years
Original maximum default rate	**0.077%**	**0.056%**	**0.077%**
Position at 30.09.16	**0.016%**	**0.00%**	**0.00%**

- **Liquidity** – In respect of this the Council set liquidity facilities/benchmarks of:

  Liquid short term deposits of at least £15m available within 1 week notice and Weighted Average Life (WAL) benchmark expected to be 6 months, with a maximum of 3 years.

  For the first half of 2016/17 the above liquidity arrangements were complied with and at 30 September 2016 the WAL of its investments was 4.2 months.

- **Yield** - The local measure of the yield benchmark is to achieve a return above the 7 day LIBID rate.

  For the first half year of 2016/17 the investment interest return averaged 0.72%, against a 7 day LIBID rate of 0.28%.

- **Origin** – This stipulated that no more than 40% of the Council's total investments to be directly placed with non-UK counterparties at any time.

  For the first half of 2016/17 the maximum level was 32%.

7. PRUDENTIAL AND PERFORMANCE INDICATORS

7.1 In accordance with CLG Guidance, the CIPFA prudential Code and the CIPFA Code of Practice on Treasury Management, the Council has in place a number of prudential indicators ensuring that the Council's capital expenditure plans and borrowing remain robust, prudent and sustainable.

7.2 These indicators were originally set in February 2016 for the forthcoming year and are monitored on a monthly basis. During the first half of 2016/17 it can be reported that no breaches occurred.

7.3 To ensure that the in-house treasury management team are offering value for money in the activities undertaken, the Council joined the CIPFA benchmarking club. This facility enabled for comparisons to be undertaken of the treasury management function with 43 other local authorities of various sizes across England, Scotland and Wales and a representation of some of the 2015/16 findings are shown below;

Topic	Average	TBC
Capital Financing Requirement (non HRA) as at 31.03.2016	£323.2m	£134.8m
Level of investment (excluding CCLA property fund) at 31 March 2016	£113.0m	£77.0m
Level of borrowings at 31 March 2016	£258.7m	£104.2m
Average annual balance of temporary borrowing	£14.7m	£0.0m
Investment Rate of Return (excluding CCLA property fund) on investments	0.80%	0.81%
Average Consolidated Rate of Interest payable	4.35%	6.03%
Average rate of interest payable of temporary borrowing	0.52%	0.00%
Total operating costs of treasury management section per £'m	£0.66k	£0.43k

7.4 The main findings from the above table are summarised below;

- Level of investment return achieved was above the average whilst keeping any risk to a minimum,
- Consolidated Rate of Interest (average borrowing rate) reflects the level of historic debt taken at rates of interest higher than currently on offer and which are costly to settle early,
- No temporary borrowing undertaken in the year due to effective & proactive cash flow management,
- Operating costs well below the average levels reported reflecting an efficient and effective service provided by the Council's in house treasury team.

7.5 The Council's Audit & Assurance Service, as part of their 2016/17 audit plan, undertook a review of the treasury management process & activities undertaken in 2015/16. The objective of the review was to provide assurance on the operation of the key controls within the treasury management system. For the 10th year in succession a report was issued stating that the treasury management service offered a High Level of Assurance (very good) and there were no recommendations required to be implemented as a result of their audit.

8 RECOMMENDATIONS

8.1 That the Accounts & Audit Committee & Executive be requested to;

- Note the Treasury Management activities undertaken in the first half of 2016/17.

Other Options

This report has been produced in order to comply with Financial Regulations and relevant legislation and provides an overview of transactions undertaken during the first half of 2016/17.

Consultation

Information for the period 1 April 2016 to 30 September 2016 was obtained from Capita, the Council's external consultants.

Reasons for Recommendation

The report meets the requirements of both the CIPFA Code of Practice on Treasury Management and the CIPFA Prudential Code for Capital Finance in Local Authorities. The Council is required to comply with both Codes through Regulations issued under the Local Government Act 2003.

Finance Officer Clearance **…NB…….**

Legal Officer Clearance **…MJ……..**

Director's Signature

APPENDIX A

Breakdown of Investments as at 30 September 2016

Counterparty	Amount £k	Total £k
UK Institutions		
Banks		
Barclays	5,000	
Close Bros	2,500	
Goldman Sachs Investment Bank	5,000	
Lloyds	10,000	
Santander UK	5,000	27,500
Building Societies		
Coventry	1,200	
Leeds	2,500	
Nationwide	5,000	8,700
Money Market Funds		
Federated	8,530	
Invesco	3,100	
Legal & General	340	
Standard Life	19,330	31,300
Other		
Church Commissioners Local Authority	4,569	4,569
	Total UK Institutions	**72,069**
Non UK Institutions		
Commonwealth Bank of Australia	10,000	
National Bank of Abu Dhabi	10,000	
Qatar National Bank	10,000	30,000
	Total Non UK Institutions	**30,000**
	Grand Total	**102,069**

APPENDIX B

Major Economic Forecasts for Calendar Year 2017

Location	Gross Domestic Product	Unemployment Rate	Consumer Price Index	Bank Rate
UK	1.0%	5.2%	1.6%	0.10%
Euro Area	1.4%	9.8%	1.2%	0.05%
USA	2.1%	4.7%	2.0%	0.75%
China	6.2%	4.3%	3.0%	4.10%

Source of information OECD & Trading Economics

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TRAFFORD COUNCIL

Report to: **Executive**
Date: **19th December 2016**
Report for: **Information**
Report of: **Executive Member for Transformation and Resources**

Report Title

Annual Delivery Plan 2016/17 (Second Quarter) Performance Report

Summary

The attached report provides a summary of performance against the Council's Annual Delivery Plan, 2016/17. The report covers the period 1 July 2016 to 30 September 2016.

Recommendations

That Executive notes the contents of the Annual Delivery Plan Second Quarter Performance Report.

Contact person for access to background papers and further information:

Name: Peter Forrester
Extension: 1815

Background Papers: None

Relationship to Policy Framework/Corporate Priorities	The Annual Delivery Plan 2016/17 Quarter 2 Performance report summarises the Council's performance in relation to the Council's Corporate Priorities.
Financial	Not Applicable
Legal Implications:	None
Equality/Diversity Implications	None
Sustainability Implications	None
Staffing/E-Government/Asset Management Implications	None
Risk Management Implications	None
Health and Safety Implications	Not applicable

1.0 Background

1.1 The report provides a summary of performance against the Council's Annual Delivery Plan 2016/17 and supporting management information, for the period 1st July 2016 to 30th September 2016.

1.2 This covers the Council's six Corporate Priorities:

- Low Council Tax and Value For Money
- Economic Growth and Development
- Safe Place to Live – Fighting Crime
- Health and Wellbeing
- Supporting Young People
- Reshaping Trafford Council

2.0 Performance Update

2.1 The ADP has 36 indicators. To date, 25 of these have been reported in the second quarter. 11 are annual indicators which will be reported on later in the year.

2.2 Overall, performance in meeting targets remains good. There are 19 green indicators (on target), 2 amber indicators and 4 red (below target).

2.3 The following indicators are rated as green (on target):

- Improve the % of household waste arisings which have been sent by the Council for recycling/composting
- 10% increase in online transactions
- Percentage of Council Tax collected
- Percentage of Business Rates collected.
- Percentage of ground floor vacant units in town centres
- The number of housing units for full planning consents granted
- The number of housing units started on site
- Percentage of Trafford Residents in Employment
- The percentage of relevant land and highways assessed as Grade B or above (predominantly free of litter and detritus).
- Percentage of Highway safety inspections carried out in full compliance with the agreed programme
- Average achievement of Customer Care PIs (Amey)
- Maintain the position of Trafford compared to other GM areas in terms of Total Crime Rate.
- Permanent admissions of older people to Residential / Nursing care (ASCOF 2Aii)
- Percentage of Trafford pupils educated in a Good or Outstanding school.
- Number of young people accessing youth provision through Youth Trust model
- Reduction in the proportion of children made subject to a Child Protection Plan for a second or subsequent time
- Number of third sector organisations receiving intensive support
- No of Locality Networking Events held min 4 per locality per year

- Number of NHS Health Checks delivered to the eligible population aged 40-74.

2.4 The following are 10% below target (amber) and exception reports have been produced or will be produced:

- Percentage of major planning applications processed within timescales
- To improve the public perception of how the police and the Council are dealing with ASB and crime by 5% across Trafford as a whole

2.5 The following are below target (red) and exception reports have been produced or will be produced:

- Reduce the level of sickness absence (Council-wide, excluding schools) (days)
- The number of housing completions per year (gross) (Quarterly)
- Maintain the low level of 16-18 year olds who are not in education, employment or training (NEET) in Trafford
- Delayed Transfers of Care attributable to Adult Social Care per 100,000 pop 18+ (ASCOF 2Cii)

Finance Officer Clearance *NB*
Legal Officer Clearance *MJ*

CORPORATE] DIRECTOR'S SIGNATURE 

To confirm that the Financial and Legal Implications have been considered and the Executive Member has cleared the report.

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TRAFFORD
COUNCIL

ANNUAL DELIVERY PLAN 2016/17
Performance Report Quarter 2

1. Purpose and scope of the report

The report provides a summary of performance against the Council's Annual Delivery Plan (ADP) 2016/17 for quarter 2 and supporting management information.

This covers the Council's six Corporate Priorities

- Low Council Tax and Value For Money
- Economic Growth and Infrastructure
- Safe Place to Live – Fighting Crime
- Health and Wellbeing
- Supporting Young People
- Reshaping Trafford Council

Direction of travel is provided, where data is available.

All measures have a Red/Amber/Green assessment of current performance. This is based on actual data or a management assessment of performance (Section 4). The dashboard dials provides a clear picture of where current performance is relative to the RAG rating and more information is provided on subsequent pages.

For Corporate Priority indicators, where actual or expected performance is red or amber an Exception Report is included in the commentary (Section 5).

2. Performance Key

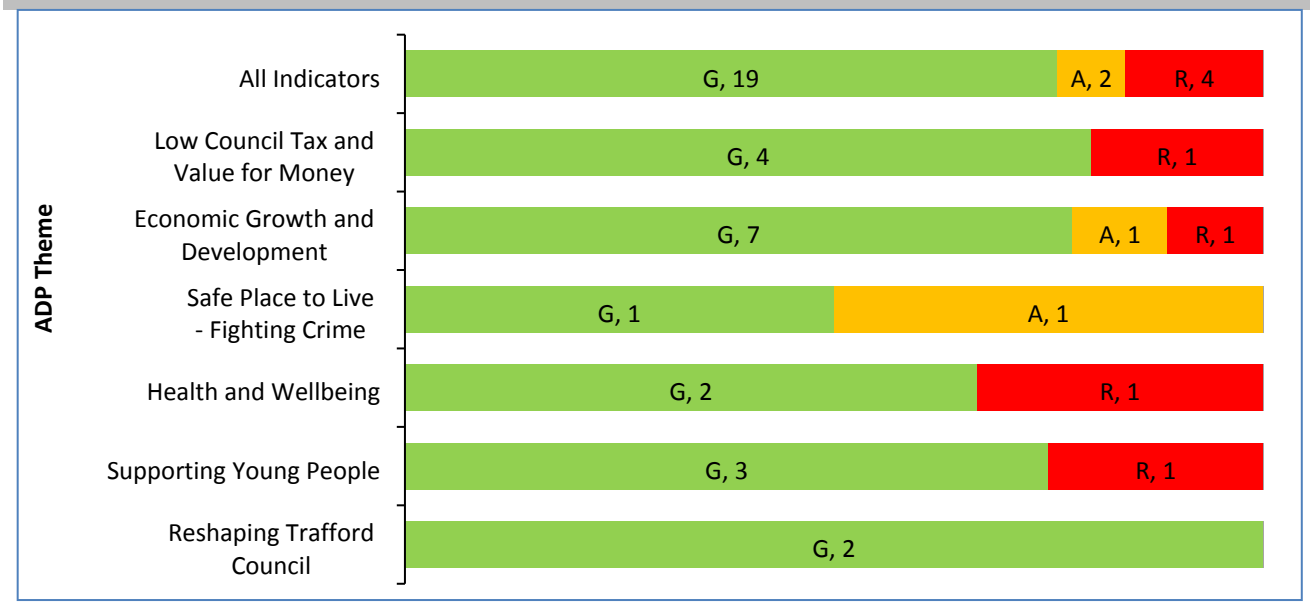
G Performance meets or exceeds the target	⬆	**Performance has improved compared with the previous period**
A Performance is within the agreed % of the target	⬌	**Performance is the same compared with the previous period**
R Performance is more than the agreed % of the target	⬇	**Performance has worsened compared with the previous period**

Where data is shaded, this indicates an estimated result and an assessment of performance by the Strategic Lead.

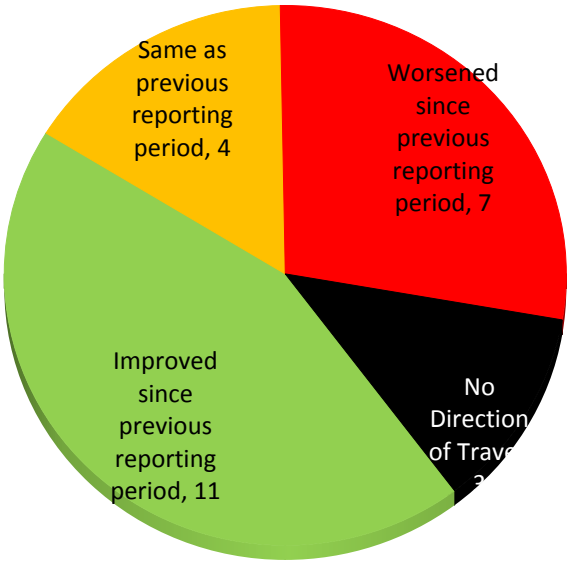
3. Performance Results

3.1 Performance Summary

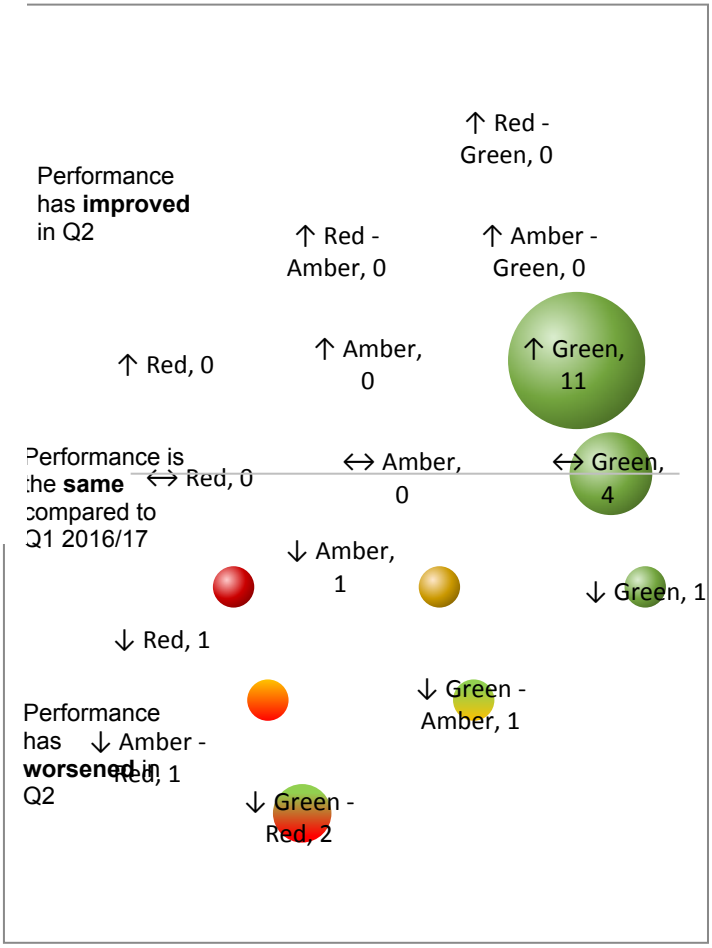
Performance Indicator RAG Status by Corporate Priority



Direction of Travel of all Performance Indicators



***Direction of Travel and RAG status** (Position in relation to central line indicates direction of travel in Q1; size of bubble represents the number of indicators)*



The ADP has 36 indicators 11 of these are annual indicators and 25 are Quarterly indicators.

There are 19 Green indicators (on target), 2 Amber and 4 Red. 11 have improved since last period, 4 have stayed the same 7 have worsened since the last period and 3 have no direction of travel.

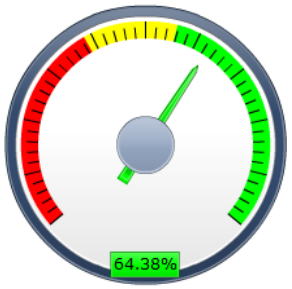
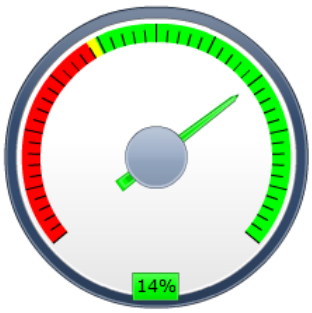
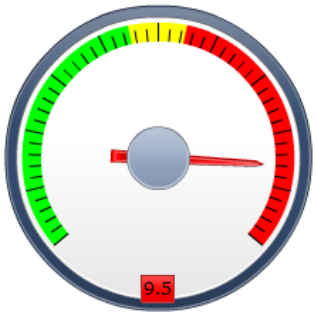
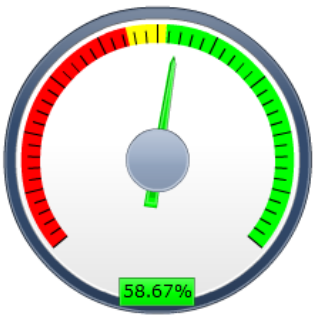
3.2 Performance Exceptions

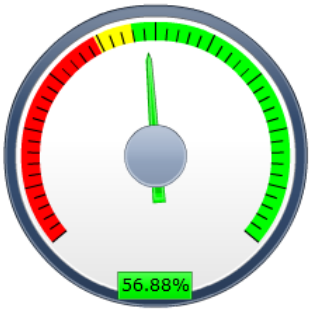
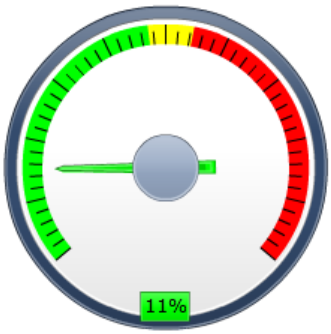
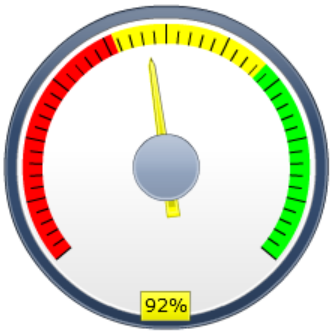
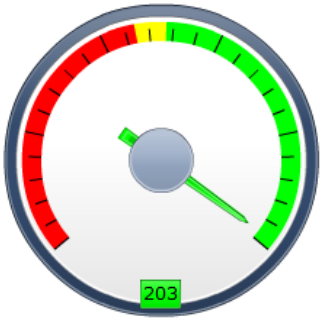
The following indicators have a RED performance status				Report Attached Y/N?
Corporate Priority	REF	DEFINITION	DOT Q1	
Low Council Tax And Value For Money		Reduce the level of sickness absence	↓	Y
Economic Growth And Infrastructure		"The number of housing completions per year (gross) (Quarterly)"	↓	Y
Supporting Young People		Maintain the low level of 16-18 year olds who are not in education, employment or training (NEET) in Trafford	↓	Y
Health And Wellbeing		Delayed Transfers of Care attributable to Adult Social Care per 100,000 pop 18+ (ASCOF 2Cii)	↓	Y

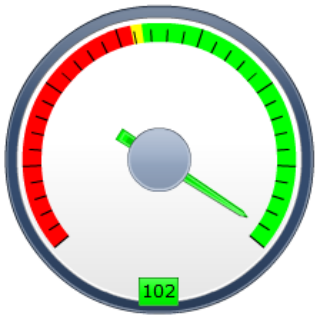
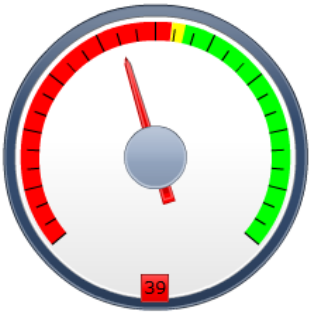
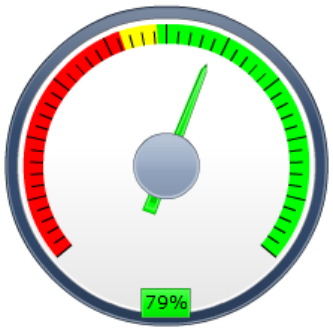
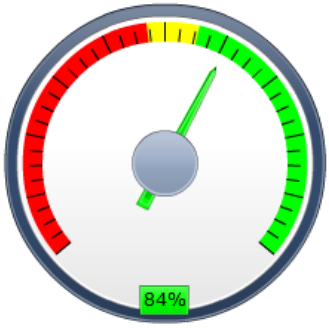
The following indicators have an AMBER performance status at the end.				Report Attached Y/N?
Corporate Priority	REF	DEFINITION	DOT Q2	
Economic Growth And Infrastructure		Percentage of major planning applications processed within timescales	↓	Y
Safe place to live – FIGHTING CRIME		To improve the public perception of how the police and the Council are dealing with ASB and crime by 5% across Trafford as a whole	↓	Y

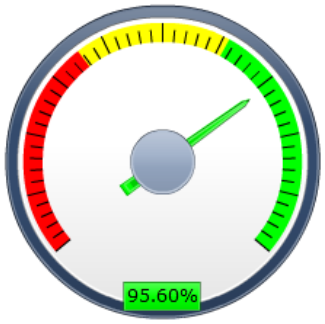
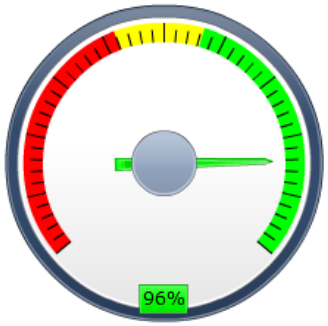
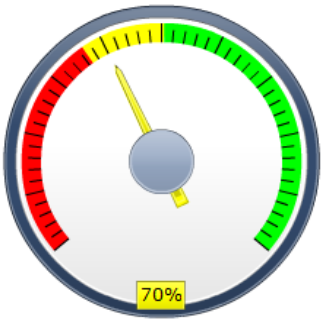
*Exception reports start on page 17

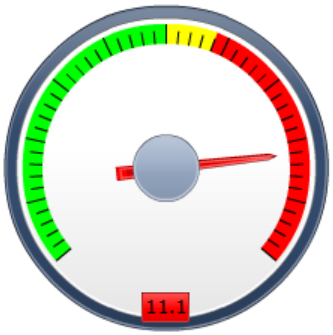
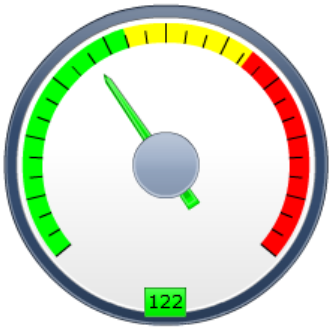
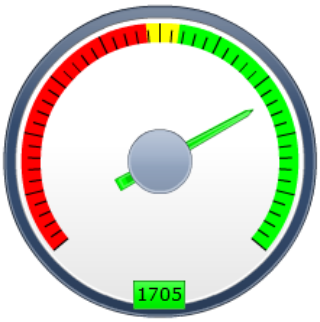
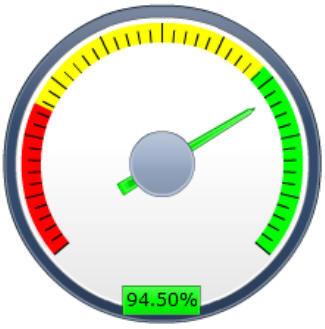
Section 4 – Performance Information

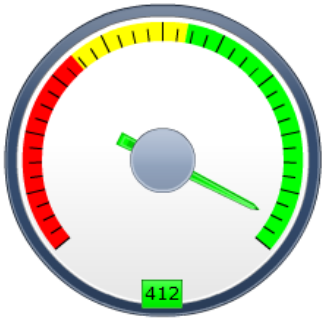
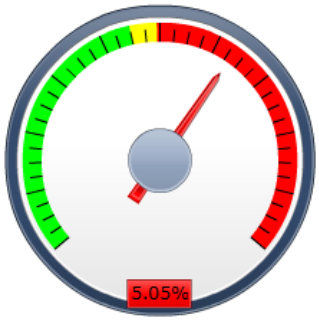
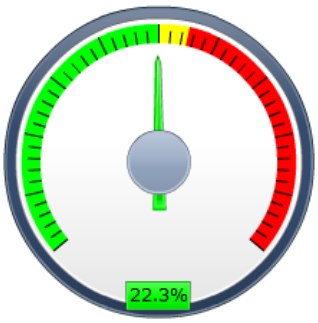
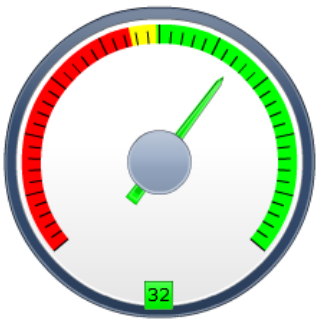
Metric Type	Dashboard Dial - Q1	DOT
One Trafford Partnership Improve the % of household waste arisings which have been sent by the Council for recycling/ composting Q2 Target - >=64% *Quarterly target changes to reflect seasonal variations. Higher targets set in summer and lower target set in winter to reflect reduction in garden waste collected.*		⬌
10% increase in online transactions Q2 Target – 8%		⬆
Reduce the level of sickness absence (Council-wide, excluding schools) (days) Q2 Target – 8.5 Days		⬇
Percentage of Council Tax collected Q2 Target – >=58.61%		⬆

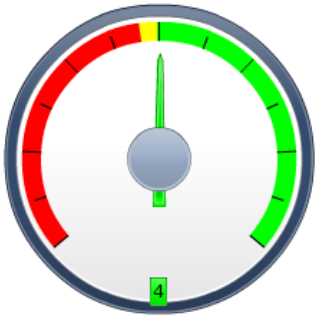
Percentage of Business Rates collected. Q2 Target – 56.62%		⬆
% of ground floor vacant units in town centres Q2 Target – <= 14.5%		⬆
Percentage of major planning applications processed within timescales Q2 Target – >= 96%		⬇
The number of housing units for full planning consents granted Q2 Target – 150		⬆

The number of housing units started on site Q2 Target – >=50		⬆
The number of housing completions per year (gross) (Quarterly) Q2 Target – >=50		⬇
Percentage of Trafford Residents in Employment Q2 Target – >=75%		⬌
One Trafford Partnership The percentage of relevant land and highways assessed as Grade B or above (predominantly free of litter and detritus). Q2 Target – >=83%		⬆

One Trafford Partnership Percentage of Highway safety inspections carried out in full compliance with the agreed programme Q2 Target – >=95.1%		↓
One Trafford Partnership Average achievement of Customer Care PIs (Amey) Q2 Target – >=90%		↑
Maintain the position of Trafford compared to other GM areas in terms of Total Crime Rate. Q1 Target – 1st		↔
To improve the public perception of how the police and the Council are dealing with ASB and crime by 5% across Trafford as a whole Q2 Target – >=76%		↓

Delayed Transfers of Care attributable to Adult Social Care per 100,000 pop 18+ (ASCOF 2Cii) Q2 Target – 10 per 100,000		⬇
Permanent admissions of older people to Residential / Nursing care (ASCOF 2Aii) Q2 Target – 125		⬆
Number of NHS Health Checks delivered to the eligible population aged 40-74. Q2 Target – >= 1500		⬆
Percentage of Trafford pupils educated in a Good or Outstanding school. Q2 Target – >= 94.5%		⬆

Number of young people accessing youth provision through Youth Trust model Q2 Target – >= 350		NEW
Maintain the low level of 16-18 year olds who are not in education, employment or training (NEET) in Trafford Q2 Target – <=4%		🡻
Reduction in the proportion of children made subject to a Child Protection Plan for a second or subsequent time Q2 Target – 22.70%		🡹
Number of third sector organisations receiving intensive support Q1 Target – >=25		🡹

No of Locality Networking Events held min 4 per locality per year Q2 Target – 4		⬅➡

LOW COUNCIL TAX AND VALUE FOR MONEY

Ensure that the Council can demonstrate that it provides efficient, effective and economical, value for money services to the people of Trafford.

For 2016/17 we will:

Make effective use of resources;

- Ensure the delivery of 2016/17budget savings
- Update the Council's financial forecasts in line with the forthcoming spending review and identify savings to meet the 2016/17 to 2018/19 budget gap
- Deliver a balanced budget in line with statutory responsibilities and Council priorities
- Continue to collaborate on efficiency projects with other local authorities and other partners
- Continue to work effectively with partners to improve service quality and value for money
- Ensure greater commercialisation of traded services to maximise best use of resources, improve customer service and to provide value for money.
- Actively investigate allegations of benefit fraud and ensure that this includes a focus on targeting more serious abuses
- Develop a Social Value Framework for Trafford which will enable us to maximise added value from our contracts, our spatial development and through Corporate Social Responsibility programmes by directing the resources we secure where they are most needed and in support of identified strategic and community priorities.
- Launch an innovative and collaborative HR Shared Service with Greater Manchester Police, the first of its kind in the North West.
- Implement the priorities outlined in the Digital Strategy to increase the number of transactions that are completed online. This will necessitate;
    - A digital workforce – challenging how we work, increasing the skills of the workforce, increasing the use of mobile technology, transform services to be paper-light.
    - An accessible Council – implement the new CRM system, maximising digital engagement with our customers, supporting customers to use digital technology.
    - Working with partners – raising awareness of Trafford's online offer, support economic growth through improved provision and usage of superfast broadband, learn from good practice
- Minimise increases in the Waste Disposal Levy through increased waste recycling and reuse of materials.

Key Policy or Delivery Programmes 2016/17

- Medium term Financial Plan
- GM Municipal Waste Management Strategy
- Trafford Social Value Framework

Ref.	Definition	Freq	15/16 Actual	16//17 Target	2016/17 Q2			
					Actual	Target	DOT	Status
CAG 08	Improve the % of household waste arisings which have been sent by the Council for recycling/ composting	M	60.36%	62.5%	64.38%	64%	⬅➡	G
One Trafford Partnership Indicator *Quarterly target changes to reflect seasonal variations. Higher targets set in summer and lower target set in winter to reflect reduction in garden waste collected.*								
New	10% increase in online transactions	Q	20%	30%	14%	8%	⬆	G
NI719	Delivery of efficiency and other savings and maximise income opportunities	A	£21.769 Million	£22.64 Million	Annual (Q4)			

Ref.	Definition	Freq	15/16 Actual	16//17 Target	2016/17 Q2			
					Actual	Target	DOT	Status
BV 12i	Reduce the level of sickness absence (Council wide excluding schools)	M	9	8.5 days	9.5 Days	8.5 Days	🡻	R
See exception report below								
BV9	Percentage of Council Tax collected	M	98.01% G	98%	58.67%	58.61%	🡹	G
	Percentage of Business Rates collected		97.41%	97.5%	56.88%	56.62%	🡹	G

ECONOMIC GROWTH AND INFRASTRUCTURE

To promote economic growth and increase levels of investment, housing and jobs in Trafford; to improve the local environment and infrastructure thereby enhancing the attractiveness of the borough as a place to live, work and invest in.

For 2016/17 we will:

- Deliver strategic development projects to facilitate housing and employment growth.
- Support our Town Centres to be vibrant and dynamic places to benefit residents, businesses and visitors.
- Deliver and enable investment and growth through effective planning processes and frameworks.
- Through the One Trafford Partnership, invest in the highway infrastructure, support the Metrolink expansion and improve sustainable travel choices to access jobs, services and facilities within and between communities.
- Support business growth and attract inward investment into the Borough.
- Maximise the potential of the Borough's assets, including international sporting facilities and visitor attractions, to lever in further investment.
- Encourage and support businesses, communities and individuals to take more ownership and responsibility for their environment in line with the Be Responsible campaign.
- Through effective regulation support businesses to thrive and protect the interests of consumers.
- Through the One Trafford Partnership, maximise the use of the Council's portfolio of assets to help support the delivery of Council objectives.
- Support housing growth and maximise investment in Trafford through the Greater Manchester Housing Investment Fund and other sources of funding.
- Through the One Trafford Partnership work pro-actively with stakeholders to maintain and improve the environment around our public spaces, highways and neighbourhoods.

Key Policy or Delivery Programmes 2016/17:

- Master Plans for: Old Trafford, Stretford (and Altrincham Strategy)
- Trafford Local Plan
- Community Infrastructure Levy
- Flood Risk Management Strategy (in partnership with Manchester and Salford)
- Economic and Housing Growth Framework and Prevention of Homelessness Strategy
- Land Sales Programme
- Transport Asset Management Plan
- GM Housing Investment Fund
- GM Minerals Plan
- GMSF (emerging)
- GM Transport Strategy 2040 (draft)
- Trafford Social Value Framework

Ref.	Definition	Freq	15/16 Actual	16/17 Target	2016/17 Q2			
					Actual	Target	DOT	Status
EG2	Percentage of ground floor vacant units in town centres	Q	12.80%	14.5%	11.2%	14.50%	⬆	G

Ref.	Definition	Freq	15/16 Actual	16/17 Target	2016/17 Q2			
					Actual	Target	DOT	Status
	Percentage of major planning applications processed within timescales	Q	95%	96%	92%	96%	↓	A
	The number of housing units for full planning consents granted	Q	1240	700	203	150	↑	G
Cumulative Q1 and Q2 actual is 268 over a target of 300								
	The number of housing units started on site	Q	270	300	102	50	↑	G
Cumulative Q1 and Q2 actual is 348 over a target of 200								
NI 154	The number of housing completions per year	Q	377	250	39	50	↓	R
See exception report below Cumulative Q1 and Q2 actual is 96 over a target of 100								
New (EG8)	Total Gross Value Added *(The total value of goods + services produced in the area)*	A	£6.6 billion	£6.95 billion	Annual Target			
	Value of major developments obtaining planning consent (based on Council tax and rateable value)	A	£1.7 million	£2.1 million	Annual Target			
	Value of major developments completed (based on Council tax and rateable value)	A	£509K	£1 million	Annual Target			
New (EG4.1)	Percentage of Trafford Residents in Employment	Q	78.8%	75%	79%	75%	↔	G
BRP02	Deliver the published 2015/16 Highway Maintenance Capital Programme	M	100% G	100%	Annual Target			
One Trafford Partnership Indicator								
	The percentage of relevant land and highways assessed as Grade B or above (predominantly free of litter and detritus).	Q	81%	83%	84%	83%	↑	G
One Trafford Partnership Indicator								
	Percentage of Highway safety inspections carried out in full compliance with the agreed	A	99.30%	100%	95.6%	100%	↓	G

Ref.	Definition	Freq	15/16 Actual	16/17 Target	2016/17 Q2			
					Actual	Target	DOT	Status
	programme							
One Trafford Partnership Indicator								
	Average achievement of Customer Care PIs (AMEY)	Q	91.23%	90%	96%	90%	⬆	G
One Trafford Partnership Indicator								
New	The percentage of food establishments within Trafford which are 'broadly compliant with food law.	A	89%	86%	Annual Target (Q4)			

SAFE PLACE TO LIVE – FIGHTING CRIME

Aim to be the safest place in Greater Manchester, and to have the highest level of public confidence and satisfaction in the action we take to tackle Crime and Anti-Social Behaviour.

For 2016/17 we will:

- Address the underlying causes of crime and anti-social behaviour by taking early action, empowering and working with local communities to prevent crime and improve public perception and confidence, and by working with partners to support and intervene at individual, family and community level, targeting resources where they are most needed.
- Improve public access to services offered by the Integrated Safer Communities team and through strong case management implement a collaborative and risk led approach to tackling Anti-Social Behaviour.
- Continue to develop and deliver innovative and effective interventions to address the behaviour of those involved in crime.
- Deliver responsive and visible justice by undertaking restorative approaches where appropriate and robust enforcement action which hold offenders accountable for their actions, and recover criminal assets where possible.
- Continue to work effectively with partners and our communities to implement the national Prevent Strategy and to raise awareness, reduce the risks of radicalisation and extremism and to promote and celebrate our diverse communities.
- We will, with our partners such as the police, identify the best methods for people to keep their property secure and continue to deliver the Safer Homes programme to target those properties vulnerable to burglary and support residents who experience or are at risk of domestic abuse.
- We will work with Greater Manchester Police to ensure that we recruit more Trafford citizens to the role of Special Constable to be active within Trafford.

Key Policy or Delivery Programmes 2016/17:

- Crime Strategy 2015-2018
- Building Stronger Communities Strategy

Ref.	Definition	Freq	15/16 Actual	16/17 Target	2015/16 Q2			
					Actual	Target	DOT	Status
STP1	Maintain the position of Trafford compared to other GM areas in terms of Total Crime Rate.	Q	1st G	1st	1ST	1ST	⬅➡	G
	Reduce the number of repeat demand incidents at addresses or locations by 20% that are linked to: • Domestic Abuse • Missing from Home (MFH) • Missing from Care (MFC) • Alcohol or Substance	A	Domestic Abuse		New	TBC	Annual Target	
			MFH		New	TBC		
			MFC		New	TBC		
			Alcohol or Substance Misuse		New	TBC		

Ref.	Definition	Freq	15/16 Actual	16/17 Target	2015/16 Q2			
					Actual	Target	DOT	Status
	Misuse							
	To improve the public perception of how the police and the Council are dealing with ASB and crime by 5% across Trafford as a whole	Q	74%	79%	70%	76%	↓	A
Awaiting exception report								
To increase the number of perpetrators of domestic abuse we work with through voluntary Behaviour Change programmes and to reduce the risk of those individuals repeating abusive behaviour.					40	Annual Target		

HEALTH AND WELLBEING

To commission and deliver quality services that encourage people to lead healthy and independent lives, enhancing wellbeing across Trafford with a particular focus on our vulnerable groups

For 2016/17 we will:

CFW Transformation Programme

- Transform the CFW delivery model with innovative approaches focused on the most vulnerable people in Trafford in line with Reshaping Trafford.

Health and Wellbeing

- Work with the CCG and local health providers to support delivery integrated commissioning and delivery of health and social care for Trafford
- Implementation of the GM Health and Social Care devolution in line with the Memorandum of Understanding
- Reduce health inequalities for our vulnerable groups and localities through the Health and Wellbeing Action plan
- Reduce alcohol and substance misuse and alcohol related harm
- Support people with long term health, mental health and disability needs to live healthier lives
- lives
- Promote healthy lifestyles and access to sport and leisure opportunities

Promoting resilience and independence

- Enable people to have more choice, control and flexibility to meet their needs
- Ensure that people in Trafford are able to live as independently as possible, for as long as possible
- Continue to implement the Care Act
- Support communities to promote their health and wellbeing by fostering enhanced social networks and by supporting an asset based approach to delivery community based solutions to improve health and wellbeing

Safeguarding vulnerable adults and children and young people

- Ensure that vulnerable children, young people and adults at risk of abuse are safeguarded through robust delivery and monitoring of commissioned and internally delivered services.
- Continue to focus on improving the quality of early help and social work practice, taking into account new legislation and government guidance.
- Be an active partner in the leadership and development of both the TSCB and Adult Safeguarding Board and ensure coordinated working across both Boards.
- Ensure clear visibility and appropriate responses to the risks of Child Sexual Exploitation, Missing, and radicalisation and other complex safeguarding issues to protect children and young people

Close the gap for vulnerable children, families and communities

- Embed early help and prevention across all aspects of work using learning from evidenced based models
- Continue to improve outcomes for children in care
- Improve support for families facing difficult times through locality working

Market management and quality assurance

- Ensure that services are available within Trafford to meet the needs of the population by helping to develop market capacity.
- Monitor service providers so any safeguarding issues or potential provider failure is identified at the earliest stage.

Key Policy or Delivery Programmes 2016/17

- CFW Transformation Programme
- GM Health and Social Care Devolution
- Better Care Fund programme
- Care Act Implementation
- Partnership Public Service Reform
- Governance and Implementation Programme
- Welfare Reform delivery
- Crime Strategy 2015-18
- Locality Plan
- Trafford Vision to reduce Physical Inactivity and Refreshed Sports and Leisure Strategy
- Building Stronger Communities Strategy

Ref.	Definition	Freq	15/16 Actual	16/17 Target	2016/17 Q1			
					Actual	Target	DOT	Status
	Delayed Transfers of Care attributable to Adult Social Care per 100,000 pop 18+ (ASCOF 2Cii)	Q	11.9	10.0	11.1	10.0	↓	R
See exception report below								
	Permanent admissions of older people to Residential / Nursing care (ASCOF 2Aii)	Q	284	250	122	125	↑	G
	Number of NHS Health Checks delivered to the eligible population aged 40-74	Q	5221	5500	1705	1500	↑	G

SUPPORTING YOUNG PEOPLE

Ensure that young people are well prepared to achieve in adulthood by creating an environment in which they can thrive.

For 2016/17 we will:
Improve the life chances of all children and young people

- Work with schools to maintain the 'Trafford family of schools' to support educational excellence
- Broker school to school support and quality assure interventions in line with national policy
- Provide effective system leadership across the Trafford Education system to support ongoing delivery of high quality education.
- Increase the promotion, number, range and take up of apprenticeships in our priority groups - Looked after Children, young people aged between 16-24, NEETS, and Trafford residents with a particular focus on areas of deprivation.
- Support vulnerable young people to secure employment through employment focused education and work experience initiatives and supported internship placement opportunities in partnership with our GM colleagues and partner agencies
- Provide monitoring, challenge and intervention for schools to ensure sustained high standards

- **Close the gap in educational outcomes across our vulnerable groups**
- Implement the outcomes of review of provision and support for children with special educational needs
- Implement the SEND reforms set out in the 2014 Children and Families Act
- Establish a 'Closing the Gap' Strategy for Education Standards
- Increase the percentage of care leavers in Education, Employment and Training
- Sustain the very high levels of two year olds in receipt of targeted nursery education
- Establish Partnership Operating Procedures to deal effectively with incidents of serious or high volume youth disorder
- Ensure there is targeted interventions available for young people at risk of becoming involved in criminal or Anti-Social Behaviour

- **Establish a Youth Trust**
- Support the transition of Council commissioning of youth provision to the new Trust Youth Trafford CIC, enabling and supporting the new Board to embed an independent and effective company at the earliest opportunity.

Key Policy or Delivery Programmes 2015 – 16

- CYP Strategy 2014-17
- Trafford Schools Causing Concern Protocol
- Trafford SEND Policy
- Trafford Closing the Gap Strategy (to be developed)
- Operating Procedures for tackling serious or high volume youth disorder

Ref.	Definition	Freq	15/16 Actual	16/17 Target	Quarter 2 2016/17			
					Actual	Target	DOT	Status
	% of pupils achieving 5 A*-C GSCE including English and Maths	A	70.70%	72%	Annual Target			
	% of disadvantaged pupils achieving 5 A*-C GSCE including English and Maths	A	38.6%	40%	Annual Target			

Ref.	Definition	Freq	15/16 Actual	16/17 Target	Quarter 2 2016/17			
					Actual	Target	DOT	Status
	Proportion of pupils at Key Stage 2 achieving excepted levels in Reading, Writing and Mathematics.	A	NEW	TBC	Annual Target			
LCA 2	Maintain the low level of 16-18 year olds who are not in education training or employment (NEET) in Trafford	M	4.2%	4%	5.05%	4.0%	🡻	R
See exception report below								
	Percentage of Trafford pupils educated in a Good or Outstanding school.	Q	93.90%	94.50%	95%	94.5%	🡹	G
	Reduction in the proportion of children made subject to a Child Protection Plan for a second or subsequent time	Q	25.30%	20%	22.3%	22.70%	🡹	G
	Number of young people accessing youth provision through Youth Trust model	Q	NEW	1050	412	350	**NEW**	G

RESHAPING TRAFFORD COUNCIL

Continue to develop relationships with residents, local businesses and partners to ensure that we all work together for the benefit of the Borough. Internally, to reshape the organisation to ensure the Council embrace is a fit for purpose and resilient organisation.

For 2016/17 we will:

- Continue to develop the organisational model to ensure sustainability of Council services with the Core Council comprising of strategy, commissioning, quality assurance and place shaping.
- Review services and progress implementation of alternative delivery models that can sit alongside the Core to enable the Council to manage the financial challenges and support the change required to deliver the Reshaping Trafford agenda
- Embrace the requirements of the GM devolution agendas, public service reform principles and refreshed GM Strategy in all Council transformation plans and Trafford Partnership activity, to ensure alignment and support of the overall ambitions
- Deliver our Locality Plan and work in partnership with the CCG and others to progress the implementation of the transformational developments therein
- Transform Children, Families and Wellbeing to sustainably manage demand and costs:
    - Establish an all-age integrated structure for community health and, social care services
    - Reshape social care provision
    - Create one multi agency front door for social care and complex support needs
- Develop arrangements to collocate, integrate and share services across agencies in Trafford and Greater Manchester, to secure greater efficiencies including shared use of buildings through a 'one Trafford estate' approach.
- Increase income generating opportunities in the Council
- Develop manager and staff skills to support the workforce through change and deliver the transformation required and with particular focus on key workers and asset based community development.
- Prepare residents and local businesses for the transition to the new organisation model taking into account our responsibilities under the Public Sector Equality Act.
- Ensure there are robust business continuity plans as we manage the transition programme
- Ensure that residents are consulted on and well informed about how the Council spends its budget and the standards of service that they can expect from us
- Build up the Info Trafford platform, and continue to develop the partnership Data and Intelligence lab to support service re-design.
- Through our new Partnership Governance arrangements lead, promote and adopt Public Service Reform principles across the Trafford Partnership through the identification of cross cutting challenges and implementation of new delivery models which support of all key elements of PSR.Continue to embed our locality working programme through locality networks, co-produced Locality Projects, Community Building and the Be Bold campaign in order to facilitate community engagement, empower and enable resident activity so as to continue to create stronger communities that are safer, cleaner, healthier and better informed.
- Develop an evaluation mechanism to track progress and outcomes of Locality Projects capturing different stakeholder perspectives
- Provide dedicated support to the Voluntary and Community Sector and facilitate mutually beneficial relationships between and across the sectors
- Relaunch the Customer Pledge to focus on key service standards, which customers will be able to expect, and which will be measurable. to ensure customers are at the centre of what we do.
- Utilise the Apprenticeship levy to maximise learning and development opportunities to existing staff in line with required targets.

Greater Manchester Strategy

- Engage fully in the devolution and integration of Health and Social Care
- Continue to support Public Service Reform through integrated governance and key workstreams i.e. Stronger Families; Working Well, Complex Dependency; Transforming Justice and Place

Based Integrated neighbourhood Delivery

Key Policy or Delivery Programmes 2016 – 17

- Customer Services Strategy
- Transformation Programme
- Reshaping Trafford Blueprint
- Collaboration Programmes (e.g. GMP, Strategic Procurement Unit)
- Building Stronger Communities Strategy
- Digital Strategy
- GM PSR and Complex Dependency framework
- Locality Plan
- Refreshed PSR delivery arrangements/implementation plan

Ref.	Definition	Freq	15/16 Actual	16/17 Target	2016/17			
					Actual	Target	DOT	Status
	Number of third sector organisations receiving intensive support	Q	461	100	32	25	⬆	G
	Number of Locality Networking Events held per locality per year	A	New	16	4	4	⬅➡	G

5. Exception Reports

5.1 Low Council Tax and Value for Money

Theme / Priority:	LOW COUNCIL TAX AND VALUE FOR MONEY		
Indicator / Measure detail:	Reduce the level of sickness absence (Council-wide, excluding schools) (days)		
Baseline:			
Target and timescale:	8.5 days	**Actual and timescale:**	9.5 days

Why is performance at the current level?

- Is any variance within expected limits?
- Why has the variance occurred?
- Is further information available to give a more complete picture of performance?
- What performance is predicted for future periods?

For a number of years, the Council set a target of 9 days absence, per employee per annum. At the end of 2015/16, this target was achieved. In order to drive further improvement in this area, a stretch target of 8.5 days was set for 2016/17. As at the end of Q1, there was a further improvement in sickness absence and levels decreased to 8.9 days. However, during Q2, there has been an increase in absence levels in general across the Council and they now stand at 9.5 days. This increase in levels is attributable to a small increase in long term absence cases, which have a significant impact on the overall performance figure. A Health & Wellbeing strategy has been developed for 2016/17, however, and it is anticipated that this will support the improvement of attendance throughout the remainder of the year.

What difference does this make – the implications of not meeting target?

- Impact on service users/public.
- Impact on corporate priorities and plans.
- Impact on service/partner priorities.
- Impact on equalities, sustainability or efficiency

Can we move resources to support this or other priorities?

If sickness absence levels are high, then this has a significant impact on service delivery and costs at a time when the Council has to manage with limited resources. High absence levels also carry the indirect cost of increased workload pressure on colleagues of absent staff.

How can we make sure things get better?

- What activities have been or will be put in place to address underperformance? Make specific reference to action plans.
- When performance will be brought back on track?
- Assess the need for additional resources/funding/training/investment.
- Identify the source of additional resources/funding/training/investment.
- Consult with other services, staff, managers, relevant Members and partners.

An action plan to improve attendance across the Council has been incorporated into the Health and Wellbeing Strategy which is being delivered across the Council. A Steering Group has been established to ensure the plan is focused and delivers tangible improvements. A pro-active approach is in place to improving a number of key areas to support attendance levels such as the prevention of illness and injury. moving and handling training, access to training and support for mental health conditions, access to staff benefits such as reduced rates for leisure activities. It also focuses on improving staff morale through reward and recognition initiatives e.g. Celebrating Success, Staff Awards, the implementation of a succession planning strategy; there is also a focus on continuing to drive forward improvements to our policies and processes e.g. refreshing the Improving Attendance Policy, improving management information on sickness absence, updating the approach to stress management.

In addition to the activities related to the action plan, we continue to monitor sickness absence at all levels throughout the organisation from an individual level via return to work interviews through to the involvement of Elected Members at Member Challenge sessions.

5.2 Economic Growth and Infrastructure

Theme / Priority:	**ECONOMIC GROWTH AND INFRASTRUCTURE**		
Indicator / Measure detail:	The number of housing completions per year (gross) (Quarterly)		
Baseline:			
Target and timescale:	Annual Target 250 Q2 Target 50	**Actual and timescale:**	Q2 Actual- 39

Why is performance at the current level?

- Is any variance within expected limits?
- Why has the variance occurred?
- Is further information available to give a more complete picture of performance?
- What performance is predicted for future periods?

This quarter the target of 50 housing completions has not been met. However, at quarter 1 the target was exceeded by 7 units and therefore at this time this slight underperformance is not expected to risk achieving the annual target.

Through our developer liaison it has been confirmed to the Council that an 80 unit apartment scheme is programmed to complete in November. The completion of these new homes will make a significant contribution to the Council's annual completion target. It will also mean that the quarter 3 target is also met via one development scheme.

What difference does this make – the implications of not meeting target?

- Impact on service users/public.
- Impact on corporate priorities and plans.
- Impact on service/partner priorities.
- Impact on equalities, sustainability or efficiency
- Can we move resources to support this or other priorities?

Housing growth is a corporate priority and new homes are needed to support growth ambitions at a local and regional level. New homes are also required to meet identified local housing needs across the Borough, ensuring that Trafford has the homes which residents need and aspire to and continues to be an attractive place to live.

The delivery of new homes provides the Council with income from additional Council Tax revenue and New Homes Bonus, paid direct by Central Government. This income plays an important part in the Council's future funding strategy and can be used to support the delivery of Council services to benefit the residents and businesses in the Borough.

How can we make sure things get better?

- What activities have been or will be put in place to address underperformance? Make specific reference to action plans.
- When performance will be brought back on track?
- Assess the need for additional resources/funding/training/investment.
- Identify the source of additional resources/funding/training/investment.
- Consult with other services, staff, managers, relevant Members and partners.

The Trafford Economic and Housing Growth Framework sets out clear strategic activities and interventions to support the Councils economic and housing growth ambitions. The Framework outlines interventions on ensuring an appropriate supply of sites with full planning consent and measures to support and facilitate these developments commencing and new homes physically being delivered.

Housing growth is now a primary focus of the Trafford Strategic Housing Partnership. Through the partnership, an action plan has been developed which includes themes around land supply and delivery, to ensure that Registered Housing Providers are better placed to maximise opportunities

for development and bring forward sites and develop a future pipeline.

The Council is also working closely with key strategic partners such as the Homes and Communities Agency, the Police and Crime Commissioner and Trafford Housing Trust, on key sites which present significant opportunities for residential development, for example Chester House, Sale Magistrate Courts and the Old Trafford Masterplan. The preparation of masterplans for these sites is a key step in taking them to the market for future delivery.

Opportunities for funding to support housing growth are continually sought. In June 2016 as part of a Greater Manchester bid and in conjunction with the Homes and Communities Agency, an expression of interest was submitted for the Starter Homes Land Fund. 11 sites were put forward with the capacity of c.350 new homes in the borough. The outcome of this expression of interest is expected to be made in the coming months. If successful it will provide equity funding which can be used to 'de-risk' sites, for example carrying out site investigations to determine ground conditions, obtaining outline planning consent, carrying out demolition of existing structures. This will make them more attractive to the market as it is these abnormal costs which affect viability, which is a predominant reason the market is failing to deliver them without intervention.

Government has also recently announced the Home Builders Fund, which consolidates £3bn of funding to support housing growth, including infrastructure funding, development finance and direct commissioning. This funding is targeted at unlocking new private house building and further information is expected on how local authorities can submit a bid is expected shortly. The Chancellors Autumn Statement also announced an additional £1.4bn for housing associations to deliver more affordable housing of every tenure. This is a significant change, not only have additional resources been allocated but it also gives Registered Providers the opportunity to deliver subsidised affordable rented homes again. This is likely to have an increase in the number of affordable homes delivered in the Borough in the future. The Council will ensure that it explores the opportunities created by this additional funding by linking up with Greater Manchester bids etc.

Following site visits by Officers to identify sites in receipt of planning which have not yet commenced contact has been made with a large number of land owners/agent/developers to establish if there are any known timescales for development commencing or any barriers which are preventing it. This exercise has enabled us to update information around ownership, where we have been informed that a site has been sold since the original planning application was made and update start and completions data. For those sites where it has been identified that barriers exist, next steps will be taken to establish what can be done to overcome these, what the Council's role may be in this and any resources required to support.

Theme / Priority:	**ECONOMIC GROWTH AND INFRASTRUCTURE**		
Indicator / Measure detail:	Percentage of major planning applications processed within timescales		
Baseline:			
Target and timescale:	96% 2016-17	**Actual and timescale:**	92% Q2 96% cumulative 2016-17

Why is performance at the current level?

- Is any variance within expected limits?
- Why has the variance occurred?
- Is further information available to give a more complete picture of performance?
- What performance is predicted for future periods?

The number of major applications submitted to and determined by the Council every quarter is a small number. There were 13 such applications determined in Q2. 12 of these were determined within timescales. Therefore the determination of a single planning application outside of timescales has led to performance dropping below target. However, the cumulative figure for 2016-17 remains on track as 100% of such

applications were determined within timescales in Q1.

The application that was not determined within timescales was for a variation of condition rather than a new, full application. It is apparent from the file that a longer period was required to deal with further amendments. However, positive discussions with the agent continued throughout the process and as planning permission had been previously granted for the substantive development, work was able to continue on site.

It is anticipated that as the number of applications determined increases, performance will remain on track as single applications have less impact on any variance in performance.

What difference does this make – the implications of not meeting target?

- Impact on service users/public.
- Impact on corporate priorities and plans.
- Impact on service/partner priorities.
- Impact on equalities, sustainability or efficiency

Can we move resources to support this or other priorities?

It is unlikely that the determination of a single planning application outside of timescales, where planning permission had already been granted for the main development, positive discussions were ongoing and work was progressing on site, would have any wider impact.

It is important, however, to maintain performance on major applications to ensure a continuing pipeline of schemes coming forward to support economic growth and investment in the Borough.

How can we make sure things get better?

- What activities have been or will be put in place to address underperformance? Make specific reference to action plans.
- When performance will be brought back on track?
- Assess the need for additional resources/funding/training/investment.
- Identify the source of additional resources/funding/training/investment.
- Consult with other services, staff, managers, relevant Members and partners.

Officers have been instructed to treat variation applications for major development in the same way that they would a new, full application. This will ensure that the particular circumstances whereby this application was not determined within timescales does not arise again.

The Planning and Development Service continues to focus resource in its Major Developments Team, seek opportunities for developer funding through Planning Performance Agreements to maintain this resource and review process and procedure. These measures assist in maintaining performance on major applications.

5.3 Safe Place to Live – Fighting Crime

Theme / Priority:	**SAFE PLACE TO LIVE – FIGHTING CRIME**		
Indicator / Measure detail:	To improve the public perception of how the police and the Council are dealing with ASB and crime by 5% across Trafford as a whole		
Baseline:	74% 2015-126 outturn		
Target and timescale:	79% annual	**Actual and timescale:**	Q2 70%

Why is performance at the current level?

- Is any variance within expected limits?
- Why has the variance occurred?
- Is further information available to give a more complete picture of performance?
- What performance is predicted for future periods?

There has been an overall increase in confidence of 2.2% that the police and GMP are dealing with ASB and Crime since quarter one.

The perception figures are highest in Hale Town centre with a confidence rate of 96% and lowest in Stretford at 23%. There are clearly great discrepancies in confidence levels across the Borough. However, when compared to the question regarding GMP only (not the Local Authority in conjunction with) tackling crime and

ASB there are major differences in confidence levels with the data ranging from 87%-100%.

There are significant lower perceptions of the police and Council dealing with issues in the following areas: Longford East, Stretford, Davyhulme East, Dunham, Timperley South, Sale Moor North and Saint Mary's East.

Altrincham East, Hale and Hale Town Centre have all seen significant increases in the perception that GMP and the Local Authority are dealing with ASB and Crime.

There are several influences that could have predicted these falls in perception including the lessening of patrols around town centres and publicity this has received. The numbers of respondents in the perception surveys is low making it difficult to understand how accurate and meaningful responses are.

What difference does this make – the implications of not meeting target?

- Impact on service users/public.
- Impact on corporate priorities and plans.
- Impact on service/partner priorities.
- Impact on equalities, sustainability or efficiency

Can we move resources to support this or other priorities?

The sample size remains small and therefore results for areas and communities are an indication only. However public confidence is a key issue for the Safer Trafford partnership, to ensure that as well as residents living in the safest borough in GM, they also feel safe and are aware of the work undertaken and opportunities available to contribute to improving community safety and confidence. The surveys are therefore monitored by the Safer Trafford Partnership on a quarterly basis so that remedial action can be taken as needed. The Safer Trafford Integrated Partnership Team (STIPT) will be scoping the surveys in the next quarter to ascertain how the sample size can be increased and also to try to ensure these are supported by the partnership and not just a GMP activity.

How can we make sure things get better?

- What activities have been or will be put in place to address underperformance? Make specific reference to action plans.
- When performance will be brought back on track?
- Assess the need for additional resources/funding/training/investment.
- Identify the source of additional resources/funding/training/investment.
- Consult with other services, staff, managers, relevant Members and partners.

The survey will be discussed at the next STP Managing Crime and Community Confidence sub-group in December and at the next STIPT managers meeting at Stretford police station to ascertain how we can engage with further community groups, involve wider partners and make the survey returns more meaningful. We are also making greater use of the TP website to promote good news stories

5.4 Health and Wellbeing

Theme / Priority:	**HEALTH AND WELLBEING**		
Indicator / Measure detail:	Delayed Transfers of Care attributable to Adult Social Care per 100,000 pop 18+ (ASCOF 2Cii) (Target is <7.9 anyone time)		
Baseline:			
Target and timescale:	10.0	**Actual and timescale:**	**11.1**

Why is performance at the current level?

- Is any variance within expected limits?
- Why has the variance occurred?
- Is further information available to give a more complete picture of performance?
- What performance is predicted for future periods?

There is a historical pattern of high delayed discharges from University Hospital South Manchester (UHSM) that is due to a range of complex factors. Data is currently outside of expected tolerance limits but it is not unusual or specific to Trafford as South Manchester are also experiencing

increased discharges with patients from other areas, including Manchester.

An upward trend in delayed discharges is being experienced nationally and Greater Manchester has also seen significant activity increases across acute hospitals this quarter, which adds to the pressure.

The performance is attributed to a number of factors as listed below:

- Some homecare providers have insufficient provision for business continuity to cover peak periods due to recruitment difficulties. This leaves them with poor staffing levels and a limited ability to take new packages, putting further stress on an already limited workforce. We are working with providers to resolve this and have been commissioning new providers.
- The Stabilise and Make Safe (SAMS) provision has been operational from early December 2015. We expect this new service to a have a positive impact in 2016/17 and more capacity will be created in SAMS to take more patients out of hospital quickly.
- A review has shown that the flow of Trafford patients from acute settings, and expectations of future service established by clinicians in hospitals are not always appropriate or sustainable. An action plan is now in place with UHSM to try and resolve this issue.
- There is an ongoing lack of intermediate care beds in Trafford which is putting additional pressure on other types of care packages thus increasing delayed discharge volumes. This is recognised by Trafford CCG and the bed capacity has been increased by 15 beds.
- There have been substantial challenges with recording in line with national definitions i.e. consistency of approach/interpretation being an issue across the hospitals.

Overall, the factors that result in a delayed discharge are complex and start almost at the point of admission. There is no one set of data that definitively indicates how/where the problem can be solved. Therefore there is no one definitive solution.

Finally, significant work is underway between the council, UHSM and Trafford CCG to review the processes in place from admission onwards, including requiring the acute providers to look at their own processes as well as medical bed capacity. A full action plan is in place with UHSM and Trafford CCG, and its impact will be monitored in 2016/17.

What difference does this make – the implications of not meeting target?

- Impact on service users/public.
- Impact on corporate priorities and plans.
- Impact on service/partner priorities.
- Impact on equalities, sustainability or efficiency

Can we move resources to support this or other priorities?

The implications of not meeting the target include:

- Patients remaining in hospital longer than necessary which may impact on their independence and recovery?
- The council will incur a financial cost for Social Services attributable delays.
- The reputation of the organisation is affected negatively
- The delays contribute to pressures on bed availability during this period although it should be noted that the hospital have also reduced the bed availability over the last 12 months.
- The acute providers' ability to maintain NHS targets may be compromised

Intervention measures have been put in place to improve flow and new Homecare providers have been awarded contracts to reduce the continuous demand.

Pennine Care continues to support and facilitate discharge for some patients via their Health Care support workers to expedite discharge, where possible.

How can we make sure things get better?
• What activities have been or will be put in place to address underperformance? Make specific reference to action plans. • When performance will be brought back on track? • Assess the need for additional resources/funding/training/investment. • Identify the source of additional resources/funding/training/investment. • Consult with other services, staff, managers, relevant Members and partners.
Activities aimed at addressing the underperformance include: • Additional capacity being brought to the Homecare market with 5 new providers being added to the framework from December 2015. This should result in an improvement in access in the medium term. Against the backdrop of a national shortage of home care provision, bringing new providers on board will be required if the situation is to improve. • Further procurement is being considered for additional capacity • A full agreed action plan is in place to address findings from an earlier review re. delays in the system: the impact of this is being monitored • There are 2 additional re-ablement staff based within the team at UHSM to improve and co-ordinate the appropriate flow of service users into the Stabilise and Make Safe service to reduce the burden on homecare. • A dedicated SEA has been appointed to carry out the 6-week out of hospital review. • A GM Social Care Work stream pilot involving Manchester and Stockport Social Care colleagues is working to develop an integrated cross-border model and greater peer review. • A review of intermediate care capacity has highlighted a capacity shortage. We are working closely with the CCG on a pilot to address this. • Education and awareness raising sessions for clinicians and other hospital staff have been undertaken with an information leaflet for discharged patients produced and posters re: team members and roles are now on display on the wards to ensure that an informed referral process to Social Care

5.5 Supporting Young People

Theme / Priority:	**Services for the most vulnerable people**		
Indicator / Measure:	NEET		
Indicator / Measure detail:	NEET – Proportion of 16-18 year old young people not in education, employment or training		
Baseline:	**4.25% 2015/16**		
Target and timescale:	4% at March 17	**Actual and timescale:**	5.05% at Q2 (Sept) 2016/17

Why is performance at the current level?
• Is any variance within expected limits? • Why has the variance occurred? • Is further information available to give a more complete picture of performance? • What performance is predicted for future periods?
Traditionally there is a high unknown figure in September and October as during this period we re-validate 20,000 destinations of young people aged 13-19 during this period. This affects the validity of September NEET rate and this cannot be used as a reliable indicator of the current NEET rate. This is the same issue for every local authority in Q2 and in previous years there have been higher targets at this time of the year to reflect this data anomaly. It is well into October before we have reliable enrolment data from across GM and once received this has a significant

impact on our NEETs who move into education at this time of year. At Q3 reliable data on NEET will be available.

There is a clear action plan to improve NEET performance over the following 3 month period with an expectation of bringing the NEET rate back on target within the next quarter through a combination of additional tracking and increase in NEET work via additional external funding bids.

What difference does this make – the implications of not meeting target?

- Impact on service users/public.
- Impact on corporate priorities and plans.
- Impact on service/partner priorities.
- Impact on equalities, sustainability or efficiency

Can we move resources to support this or other priorities?

NEET young people have poorer outcomes and cost the local and national economy over their lifetimes as such the service will target an improvement for these young people.

If NEET is on a rising trend, vulnerable young people are less likely to be receiving enhanced early help services. Young people who require home visits or weekly caseload support due to their specific needs including SEN & mental health issues will be more unlikely to move from NEET to EET (unless other support is being provided elsewhere e.g. care leavers). The service hopes to use external income streams including ESF and Talent Match to focus resources on vulnerable young people.
Please note that due to the September and October data collection issue no conclusions should be made about the level of NEET at the end of Q2.

How can we make sure things get better?

- What activities have been or will be put in place to address underperformance? Make specific reference to action plans.
- When performance will be brought back on track?
- Assess the need for additional resources/funding/training/investment.
- Identify the source of additional resources/funding/training/investment.
- Consult with other services, staff, managers, relevant Members and partners.

1. The service has an action plan to address tracking issues. The plan includes enhanced information sharing work and agreements with schools, colleges and other partners. The majority of schools have now signed updated data sharing agreements and the quality and range of data is much improved.
2. Trafford Connexions has been successful as the sub-contractor for the GM ESF NEET contract. This provides support and a programme of learning to Trafford young people who are NEET or at risk of NEET. This will have a direct influence on reducing the NEET rate in the borough. It is likely the effect of this work will be seen in figures from November 2016.
3. The Talent Match programme has been extended and will allow us to work with up to 20 NEET 18/19 year olds providing intensive support to the long term unemployed and thus impact positively on the NEET rate. On the 21st October 2016 an application was submitted for the continuation of funding of our 2 Talent Coaches for a further year to the end of January 2018.
4. The ESF CEIAG contract has been awarded pending the mandatory 10 day standstill period. When this period comes to an end an announcement on this programme and its potential impact on NEET intervention work can be made.
5. Additional tracking resources have been secured and it is hoped this will improve both unknown and NEET rates.

TRAFFORD COUNCIL

Report to: Council Executive
Date: 19th December 2016
Report for: Information
Report of: Executive Member Communities & Partnerships

Report Title

Trafford's Public Service Reform programme- our proposed place-based proof of concept in the north of the borough

Summary

This report explains how the work undertaken for the Typical Weekend and One Trafford Response programme has led to the proposal for the north place-based proof of concept.

Recommendation(s)

1. **The Executive notes the contents of this report**

Contact person for access to background papers and further information:

Name: Kerry Purnell
Extension: 0161 912 2115

Background papers: none

Implications:

Relationship to Corporate Priorities	The project is a key part of Trafford's integrated Public Service Reform Programme with overall aims to promote individual and community resilience and working together for Trafford. It is aligned to Intervention 5 of the Vision 2031 programme, co-designing and co-producing services that enable people, communities and businesses to do more for themselves and each other.
Financial	The main financial considerations are set out in the body of the report.
Legal Implications:	None

Equality/Diversity Implications	A key objective of the proof of concept is to reduce inequalities gaps wherever possible. One of the reasons the north of the borough was chosen is because of its diverse communities and the opportunity to test out new ways to ensure there is equality of access to support and services (where appropriate).
Sustainability Implications	The proof of concept will be used to test new ways of working, develop business propositions based on Cost Benefit Analysis techniques in order to inform a new operating model for service delivery which will be rolled out across Trafford
Resource Implications e.g. Staffing / ICT / Assets	There is strong Partnership commitment to the programme including nominated representatives to the Task Group and Project team and pooled financial commitment to support the costs of the Programme Manager role. The proof of concept may well involve new ways and hours of working for staff across Trafford. It will involve co-location of staff from across agencies, making effective use of buildings and other assets. The intention is to use the TCC to act as a data, information sharing and case co-ordination hub for the project which will involve testing improved ICT infrastructure and access.
Risk Management Implications	Information Governance and Data Security needs will be considered with the support of the GM Connect team.
Health & Wellbeing Implications	None
Health and Safety Implications	None

1.0 Background

1.1 As part of the GM programme for place based working Trafford has committed to developing a place-based pilot by January 2017 and developing a roll out plan by April 2017. At the outset of our integrated partnership Public Service Reform programme in February 2016 we agreed our vision for place based working as:

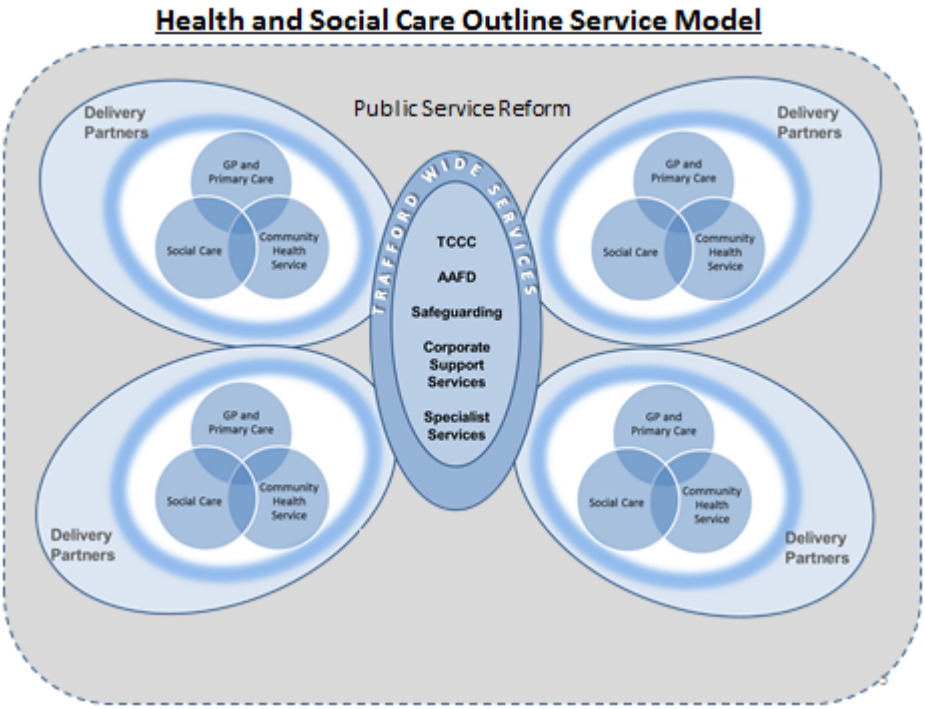
'Trafford will have 4 place based co-located multi-agency teams providing services in the area which cover the whole spectrum of need from early help to specialist services (as appropriate)'

1.2 Trafford's approach is ambitious as it covers a larger geography than the other boroughs, is the only one that has health and social care integration at its heart and is taking a whole system approach. We have never intended to create a new team of seconded staff in a small neighbourhood where the pilot happens 'over there' away from 'business as usual'. We are committed to designing and testing and redesigning and re-testing a whole new way of operating that will affect how we all work together; as well as how we commission services henceforth, across sectors, putting our service

users at the centre so as to improve outcomes for our residents and Trafford as a whole.

1.3 The Police and Crime Commissioner has allocated £1.5m funding to support the roll out of place-based working subject to boroughs submitting their roll out plans before end of March 2017. These timescales are tight for Trafford but we are aiming to have designed and started to implement a model for our proof of concept within the timeframe that will allow us to take advantage of this funding in 2017.

1.4 There is more opportunity to draw down funding for our roll out through the Health and Social Care Transformation Fund bid which is currently being worked up. We are in a good place to do this as there is a strategic commitment in Trafford to ensure the PSR and Health and Social Care transformation are integrated, as the desired outcomes are entirely synchronised. At the heart of the integration of health and social care provision and delivery is the butterfly model which will be informed and optimised by the place based model. The 'enablers/fundamental foundations' for the delivery of Trafford's Locality Plan equate to the 'enabling' work streams in our PSR programme, all of which will be tested in the proof of concept.



2.0 The One Trafford Response (Perfect Weekend exercise)

2.1 The One Trafford Response weekend confirmed thinking that the Trafford Co-ordination Centre has a future role as the Trafford hub to provide the single point of access to services and the place where live-time information sharing takes place to inform holistic case management and intelligent commissioning.

2.2 Following on from the findings of the Typical Weekend in July and the 12 months' worth of demand data analysis undertaken, the One Trafford Response exercise was

held over the weekend 23rd to 26th of September. A multi-agency hub was tested over 6 shifts covering 39 hours, largely out of hours. 9 agencies with access to their organisational databases, came together at the TCC. In addition a multi-agency intervention team with a range of skills and experience was on hand each shift to deliver creative live-time solutions to the cases presented. In total 181 staff from 21 different organisations were involved. 13 cases were taken through the hub during the weekend. All were complex and are now being monitored in terms of ongoing case co-ordination.

2.3 There was a huge amount of learning from the weekend. Staff completed reflective logs and questionnaires. A multi-agency debrief session which was attended by over 100 staff was held on Tuesday 3rd October where some of the learning from both the process and the cases was shared. This learning has shaped thinking about the place-based pilot and implementation of Trafford's Locality Plan.

2.4 A detailed slide story of our One Trafford Response journey has been drafted and will be ready to share in the coming weeks.

3.0 Transition to our place-based proof of concept in the north

3.1 At a special joint meeting of the PSR Board and Operations Group held on 3rd October, agreement was given to include place-based working in the Transformation Fund bid. This meeting discussed the potential design principles for our place-based pilot and how to take forward the One Trafford Response model. Attendees asked for an options appraisal of suggested places and client cohorts. This appraisal was drafted and discussed by the PSR Board on October 11th. Based on the level of demand across a range of themes, the opportunity to work with diverse communities and to test out cross border issues, the decision was made that the Trafford place-based pilot will take place in the north locality/neighbourhood covering the 4 wards in Old Trafford and Stretford.

3.2 It will be designed to have the maximum impact possible on the following outcomes:

- **Closing the inequalities gaps**
- **Deflecting inappropriate resources/demand**
- **Promoting community resilience and self-reliance**
- **Delivering a sustainable model that can be up-scaled across Trafford**

It will encompass the One Trafford Response model as appropriate.

3.3 The PSR Operations Group was tasked with deciding what exactly is in scope and identifying a multi-agency task group and other resources required. Following a workshop on 28th October the Operations Group made recommendations to, and a resource request of, the PSR Board and also emphasised the need for early engagement with the Voluntary, Community and Social Enterprise sector. This began at the VCSE Strategic Forum on 2nd November. On 8th November the PSR Board committed to resourcing the governance arrangements set out below and to empower a partnership task and finish group and project team to design the detailed model for the proof of concept.

4.0 Design Principles

4.1 The PSR Board have agreed the following design principles for the proof of concept:

- Harness the Trafford Pound
- Maximise asset based community solutions
- Promote community resilience, independence and behaviour change
- Design against real demand and context
- Citizen centric not service shaped (acting with humanity)
- Test workforce development initiatives
- Less management and more added value leadership - 'fix the way work is organised and led not the way it is done'
- Test our current H&SC transformation initiatives including joint commissioning and the new models for primary care.

5.0 Scaling up the One Trafford Response model

5.1 The proof of concept will encompass the One Trafford response model as appropriate:

- Co-location of staff from across partners
- Live-time information sharing
- Unlocking the potential of frontline staff
- Blurring of the professional boundaries
- Maximising the key worker and case-coordination approach as per the Stronger Families approach
- 7 day working including anti-social hours
- Accelerating the optimisation of the TCC which will act as the information sharing hub

5.2 The proof of concept will also provide an opportunity to test out Trafford Council's Rethinking Social Work, '3 conversations' approach. In its present form, the social care system is geared towards prescribing a service that, once in place, usually results in ever increasing levels of dependence for each person, which goes hand in hand with spiralling costs. As part of our overall objective to increase self-reliance and to maximise all our assets in our communities, we are now seeking a fundamental shift in focus where residents are expected to remain independent for as long as possible and are supported to reach their full potential.

5.3 Our most significant challenge is to unlock the potential of local communities, families and the individual. If we get it right this will mean not just reducing costs, but the ability of each resident of Trafford to live longer to lead healthier more fulfilling lives, independently within their own home, amongst their family, friends and the community they belong to.

5.4 Building on what we did over the One Trafford Response weekend, we want to liberate our workforce, by giving them permission to use their judgement to implement innovative and creative solutions in order to unlock the potential of each individual and that of their community so that more people live independently. To do this we are introducing a new approach to social care 'assessment'. One that's simple, one that's based on a different conversation and one that reforms and reclaims social work. These conversations do not necessarily need to be carried out by qualified people; knowledge of the local area and facilities is equally as important. A conversation that goes like this:

- **Conversation 1** - 'How can I connect you to those things that will help you get on with your life'? Those assets and strengths that already exist within your family and your neighbourhood.

- **Conversation 2** - If a person is at risk we ask 'what needs to change to make you safe'? 'How do I help you to make that happen' how do I use my knowledge of the community to support you'? And 'how do we pull this together in an emergency plan and stay with you to make sure it works'?

- **Conversation 3** - 'What does a good life look like for you'? 'Where do the sources of funding and other resources come from to support your chosen way of life'? And, 'who else do you want to be involved in your support planning'

5.4 It always starts with the assets and strengths of people, their families and their communities. It works chronologically, so we prove that we have exhausted conversation 1 and 2 before having conversation 3. It embeds place based and asset based principles because our staff need to know the communities and neighbourhoods well of those people they are listening to.

5.5 The proof of concept will provide opportunities not just for social care but for other frontline staff across agencies to test out the concept.

6.0 What is in scope?

6.1 The proof of concept will cover the wards of **Stretford, Longford, Clifford and Gorse Hill.** The following partners have thus far committed to be involved:

Trafford Council (including integrated all age social care)	**THT**
GMP	**Pennine**
CCG (including a lead GP, Practice Manager)	**DWP**
TCC	**The Work Company**
GMFRS	**New Charter Housing**
THRIVE Trafford	**VCSE reps**

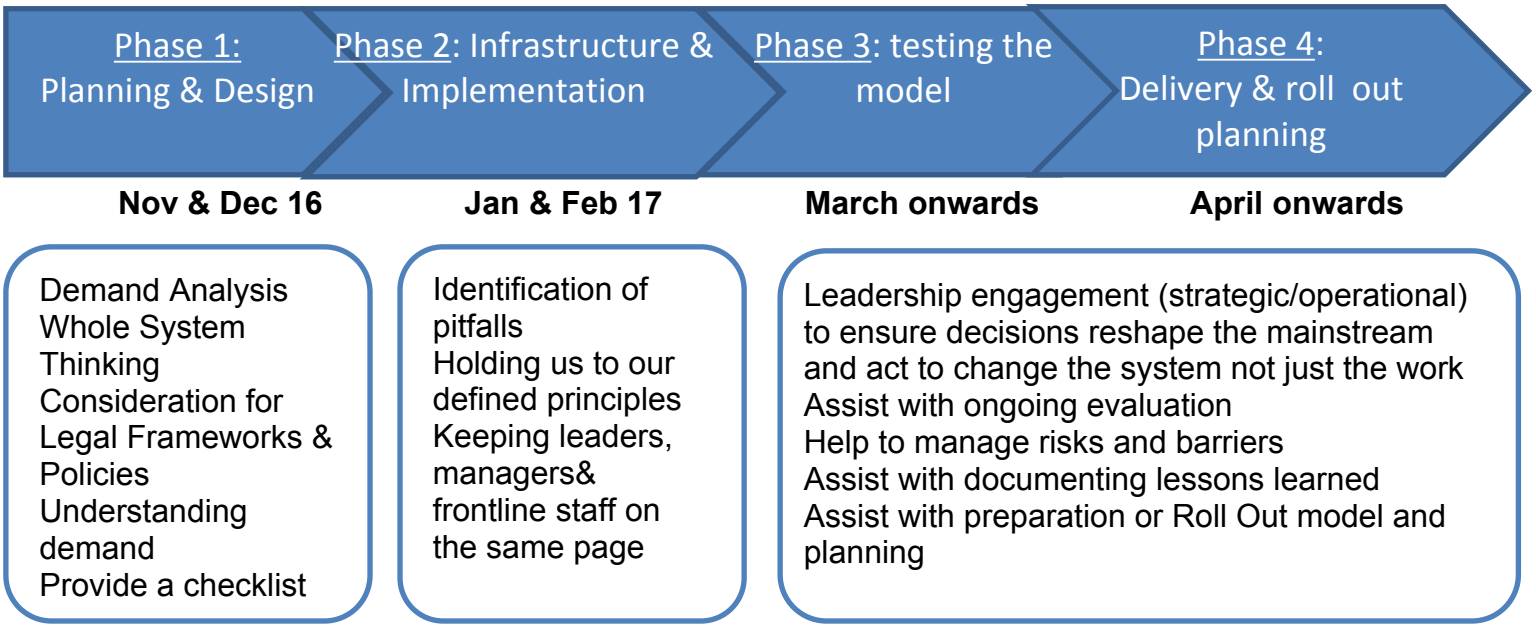
6.2 The Clinical Commissioning Group and Trafford Council will review the list of their commissioned providers to agree which ones should be approached to be involved.

6.3 The 'client groups' in focus will be those at the tipping point between needing early help support and complex needs services, in order to deflect demand by intervening earlier and promoting and utilising individual and community strengths . However the PSR Board accepts that flexibility and adaptability is needed at the design and early implementation phase so that all opportunities to impact on the 4 overarching priorities are maximised.

6.4 The programme is likely to be iterative, testing the new models with certain types of cases incrementally to maximise impact and learning and to provide every opportunity for success.

7.0 GM Support

The GM Public Service Reform Team have committed to providing the Place Based Project with 2 team members for up to 3 days a week for the duration of the project, initially assisting with the preparation stage of the project and continuing to provide support through the implementation, delivery and evaluation stages. One team member will come from the GM PSR team and one will be from a consultancy commissioned by the Office of the Police and Crime Commissioner.



8.0 Governance

9.0 Financial Considerations

9.1 Funding in principle has been secured from the GM Transformation Fund to support the costs of a Programme Manager for 6 months and to pay for some external evaluation. Both of these are Trafford Partnership resources.

9.2 During the proof of concept cost benefit analysis (CBA) techniques will be applied to demonstrate where the new delivery model may create efficiency savings or a the ability to invest more in prevention through deflecting inappropriate demand and de-escalating clients away from costly public services. The CBA results will be used to develop more detailed business propositions to help us draw down further GM Transformation Funds to deliver an effective roll-out of the integrated place-based model.

9.3 In addition we will be completing our place-based Roll-Out Plan for GM before March 2017 which will provide the opportunity to attract a further £150,000 worth of funding from the Police and Crime Commissioner.

10.0 Immediate Next Steps to end December 2016

- Identify and brief all Task and Finish (T&F) Group and Project team members
- T&F representatives start to share key messages within their own organisations at all levels
- Weekly T&F meetings until 21st December
- Provide a specific briefing to all ward Councillors for the 4 wards covered by the proof of concept
- VCSE taskforce held 25th November to engage as many VCSE organisations delivering in the north locality as possible
- Re-examine demand and needs data for the area
- Engage with GM Public Service Reform team to learn of best practice from other areas and to shape project plan, dependencies and milestones
- Draft options for workable model

10.1 A workshop will be held 21st December to finalise model and plan for phase two infrastructure and planning implementation Jan – March 2017.

11.0 Recommendations

11.1 **That the Executive note the contents of this report.**

Key Decision *(as defined in the Constitution)*: No
If Key Decision, has 28-day notice been given? No

Finance Officer Clearance *(type in initials)…NB……*
Legal Officer Clearance *(type in initials)……MJ……*

CORPORATE DIRECTOR'S SIGNATURE Joanne Hyde

To confirm that the Financial and Legal Implications have been considered and the Corporate Director has cleared the report prior to issuing to the Executive Member for decision.

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GMCA GREATER MANCHESTER COMBINED AUTHORITY

GREATER MANCHESTER COMBINED AUTHORITY

FORWARD PLAN OF STRATEGIC DECISIONS
1 December 2016 – 31 March 2017

The Plan contains details of Key Decisions currently planned to be taken by the Greater Manchester Combined Authority; or Chief Officers (as defined in the constitution of the GMCA) in the period between 1 November 2016 and 28 February 2017.

Please note: Dates shown are the earliest anticipated and decisions may be later if circumstances change.

If you wish to make representations in connection with any decisions please contact the contact officer shown; or the offices of the Greater Manchester Integrated Support Team (at Manchester City Council, P.O. Box 532, Town Hall, Manchester, M60 2LA, 0161-234 3124; info@agma.gov.uk) before the date of the decision.

Subject	Contact Officer	Description	Anticipated Date of Decision
Brexit Monitor	**Portfolio Lead:** Tony Lloyd, Cllr Richard Leese Portfolio Lead Officer: Simon Nokes Contact Officer: John Holden	Monthly Update	25 November 2016
Metrolink 2017	**Portfolio Lead:** Tony Lloyd Portfolio Lead Officer: Jon Lamonte Contact Officer: Jon Lamonte	To report on the procurement process for the operation and maintenance of the Metrolink system from July 2017.	25 November 2016

Subject	Contact Officer	Description	Anticipated Date of Decision
Rail Industry Funding Submissions for CP6 (2019 – 2024)	**Portfolio Lead:** Tony Lloyd Portfolio Lead Officer: Jon Lamonte Contact Officer: Jon Lamonte	To present the priority list of future rail schemes to be submitted into the industry control period mechanism with a view to securing funding.	25 November 2016
Strategic Road Studies Update	**Portfolio Lead:** Tony Lloyd Portfolio Lead Officer: Jon Lamonte Contact Officer: Peter Molyneux, Transport for the North	Update on three strategic road studies in the north to improve east west connectivity.	25 November 2016
Digital Infrastructure	**Portfolio Lead:** Cllr Richard Leese Portfolio Lead Officer: Simon Nokes Contact Officer: John Hodcroft	Update	25 November 2016
Apprenticeship programme	**Portfolio Lead:** Cllr Richard Leese Portfolio Lead Officer: Simon Nokes Contact Officer: John Hodcroft	GM Public Sector	25 November 2016

Subject	Contact Officer	Description	Anticipated Date of Decision
North West Construction Hub	**Portfolio Lead:** Tony Lloyd Portfolio Lead Officer: Theresa Grant Contact Officer:		25 November 2016
Brexit Monitor	**Portfolio Lead:** Tony Lloyd, Cllr Richard Leese Portfolio Lead Officer: Simon Nokes Contact Officer: John Holden	Monthly Update	16 December 2016
Stations Devolution	**Portfolio Lead:** Tony Lloyd Portfolio Lead Officer: Jon Lamonte Contact Officer: Jon Lamonte	Outline Business Case	16 Dec 16
Metrolink Trafford Park Line and Metrolink – Results of the Public Enquiry on Trafford	**Portfolio Lead:** Tony Lloyd Portfolio Lead Officer: Jon Lamonte Contact Officer: Steve Warrener	Outcome of the Procurement of the Works Contract and Results of the Public Enquiry on Trafford	16 Dec 16

Subject	Contact Officer	Description	Anticipated Date of Decision
Brexit Monitor	**Portfolio Lead:** Tony Lloyd, Cllr Richard Leese Portfolio Lead Officer: Simon Nokes Contact Officer: John Holden	Monthly Update	31 January 2017
Brexit Monitor	**Portfolio Lead:** Tony Lloyd, Cllr Richard Leese Portfolio Lead Officer: Simon Nokes Contact Officer: John Holden	Monthly Update	24 February 2017
To be confirmed			
100% Business Rates retention	**Portfolio Lead:** Cllr Kieran Quinn Portfolio Lead Officer: Richard Paver Contact Officer: Janice Gotts	Proposed utilisation of proceeds.	To be confirmed
Intermediary Body Status	**Portfolio Lead:** Cllr Kieran Quinn Portfolio Lead Officer: Simon Nokes Contact Officer: Alison Gordon	Update on progress of discussions with Government	To be confirmed

Subject	Contact Officer	Description	Anticipated Date of Decision
Stations Investment	**Portfolio Lead:** Tony Lloyd Portfolio Lead Officer: Jon Lamonte Contact Officer: Steve Warrener	Programme and Asset Management – Proposal for Transfer	March 2017
GM Growth Deal Transport Update	**Portfolio Lead:** Cillr Richard Leese Portfolio Lead Officer: Jon Lamonte Contact Officer: Steve Warrener	6 monthly Update	March 2017
Greater Manchester City Deal : Homes for Communities Agency Receipts	**Portfolio Lead:** Cllr Richard Farnell Portfolio Lead Officer: Eamonn Boylan Contact Officer: Bill Enevoldson	Proposed Strategy for equity investment	To be confirmed
Greater Manchester Housing Fund	**Portfolio Lead:** Cllr Richard Farnell Portfolio Lead Officer: Eamonn Boylan Contact Officer: Bill Enevoldson	Specific housing requirements and opportunities to bridge the funding gap	To be confirmed

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JOINT GREATER MANCHESTER COMBINED AUTHORITY
& AGMA EXECUTIVE BOARD AND AGMA EXECUTIVE BOARD

FORWARD PLAN OF STRATEGIC DECISIONS
1 December 2016 – 31 March 2017

The Plan contains details of Key Decisions currently planned to be taken by the Joint Meeting of the Greater Manchester Combined Authority and AGMA Executive Board; or Chief Officers (as defined in the GMCA and AGMA constitution) in the period between 1 December to 31 March 2017.

Please note: Dates shown are the earliest anticipated and decisions may be later if circumstances change.

If you wish to make representations in connection with any decisions please contact the contact officer shown; or the offices of the Greater Manchester Integrated Support Team (at Manchester City Council, P.O. Box 532, Town Hall, Manchester, M60 2LA, 0161-234 3124; info@agma.gov.uk) before the date of the decision.

JOINT GMCA AND AGMA EXECUTIVE BOARD

Subject	Contact Officer	Description	Anticipated Date of Decision
Work & Health Co-Commissioning	**Portfolio Lead:** Councillor Peter Smith & Councillor Sean Anstee Portfolio Lead Officer: Steven Pleasant Contact Officer: Matt Ainsworth	Update from discussions with Department of Works & Pensions	25 November 2016
North West Construction Hub	**Portfolio Lead:** Councillor Sean Anstee Portfolio Lead Officer: Theresa Grant	Annual Report	25 November 2016
Greater Manchester Metropolitan Debt Administration Fund	**Portfolio Lead:** Councillor Kieran Quinn	Estimated Rates of Interest and Borrowing Strategy 2015/16 Revised and	25 November 2016

Subject	Contact Officer	Description	Anticipated Date of Decision
	Portfolio Lead Officer: Steven Pleasant Contact Officer: Thomas Austin	2016/17 Original	
GM Housing Providers Update	**Portfolio Lead:** Councillor Richard Farenll Portfolio Lead Officer: Eamonn Boylan Contact Officer: Cath Green (GM Housing Providers)	Annual Update	25 November 2016
GM Spatial Framework	**Portfolio Lead:** Councillor Richard Farnell Portfolio Lead Officer: Eamonn Boylan Contact Officer: Chris Findley/Anne Morgan	Progress update on Consultation	27 January 2017
GM Spatial Framework	**Portfolio Lead:** Councillor Richard Farnell Portfolio Lead Officer: Eamonn Boylan Contact Officer: Chris Findley/Anne Morgan	Outcome of Consultation	24 February 2017
To be confirmed			

Subject	Contact Officer	Description	Anticipated Date of Decision
Greater Manchester Residential Growth Strategy	**Portfolio Lead:** Portfolio Lead Officer: Eamonn Boylan Contact Officer: Steve Fyfe	Response to the Spending Review to support the City Region's aspiration for growth	To be Confirmed
GMCA & AGMA Scrutiny Pool Review	**Portfolio Lead:** Tony Lloyd Portfolio Lead Officer: Liz Treacy Contact Officer: Susan Ford	Update on Implementation of the Scrutiny Pool Review	To be confirmed

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DECISIONS AGREED AT THE MEETING OF THE GREATER MANCHESTER COMBINED AUTHORITY, HELD ON FRIDAY 28 OCTOBER 2016 AT SALFORD CIVIC CENTRE

GM INTERIM MAYOR	Tony Lloyd (in the Chair)
BOLTON COUNCIL	Councillor Cliff Morris
BURY COUNCIL	Councillor Rishi Shori
MANCHESTER CC	Councillor Richard Leese
OLDHAM COUNCIL	Councillor Jean Stretton
ROCHDALE MBC	Councillor Richard Farnell
SALFORD CC	Councillor John Merry
STOCKPORT MBC	Councillor Alex Ganotis
TAMESIDE MBC	Councillor Kieran Quinn
TRAFFORD COUNCIL	Councillor Sean Anstee
WIGAN COUNCIL	Councillor Peter Smith

JOINT BOARDS AND OTHER MEMBERS IN ATTENDANCE

GMF&RS	Councillor David Acton
GMWDA	Councillor Nigel Murphy
TfGMC	Councillor Andrew Fender

DEPUPUTY PORTFOLIO HOLDERS IN ATTENDANCE

Councillor Brenda Warrington (Tameside)	Health and Social Care
Councillor Wendy Wild (Stockport)	Health and Social Care
Councillor Linda Thomas (Bolton)	Health and Social Care
Councillor Paula Boshell (Salford)	Planning and Housing
Councillor Aasim Rashid (Rochdale)	Low Carbon, Waste and Environment
Councillor Lynn Travis (Tameside)	Low Carbon, Waste and Environment
Councillor Jenny Bullen (Wigan)	Skills and Employment
Councillor Abdul Jabbar (Oldham)	Skills and Employment
Councillor Donna Martin (Rochdale)	Children's Services
Councillor Linda Blackburn (Trafford)	Children's Services
Councillor Dylan Butt (Trafford)	Economic Strategy
Councillor Ebrahim Adia (Bolton)	Economic Strategy
Councillor Sue Murphy (Manchester)	Reform

Councillor Jo Platt (Wigan)	Transport
Councillor Angeliki Stogia (Manchester)	Fairness, Equalities and Cohesion
Councillor Jane Black (Bury)	Fairness, Equalities and Cohesion

OFFICERS IN ATTENDANCE

Margaret Asquith	Bolton Council
Mike Owen	Bury Council
Howard Bernstein	Manchester CC
Maggie Kufeldt	Oldham Council
Pauline Kane	Rochdale MBC
Jim Taylor	Salford CC
Eamonn Boylan	Stockport MBC
Steven Pleasant	Tameside MBC
Theresa Grant	Trafford Council
Alison McKenzie Folan	Wigan Council
Ian Hopkins	GM Police
GM Fire & Rescue Service	Paul Argyle
Simon Warburton	Transport for Greater Manchester
Simon Nokes	New Economy
Adam Allen	Office of the Police & Crime Commissioner
Clare Monaghan	Interim Mayor's Office
Liz Treacy	GMCA Monitoring Officer
Andrew Lightfoot	Deputy Head of the Paid Service
Julie Connor	Head of GMIST
Rebecca Heron	GM Integrated Support Team
Sylvia Welsh	GM Integrated Support Team
Paul Harris	GM Integrated Support Team

183/16 APOLOGIES

Apologies for absence were received and noted from City Mayor Paul Dennett. Councillor John Merry deputised in the City Mayor's absence.

Donna Hall (Wigan), Steve Rumbelow, (Rochdale) Steven Pleasant, (Tameside), Jim Taylor (Salford), Carolyn Wilkins (Oldham), Jon Lamonte (TfGM) and Peter O'Reilly (GMF&RS).

184/16 DECLARATIONS OF INTEREST

Councillors Sean Anstee and Richard Leese each declared a personal interest in Item 9 Capital Expenditure Update 2016/17 and Item 10 GMCA Revenue Update 2016/17 as they are each Board Members of the Manchester Growth Company.

Councillor Leese also declared a disclosable pecuniary interest in relation to Item 14 Greater Manchester Housing Fund Requests and the Part B report at Item 18 as he is a Director of the Manchester Ship Canal Company. In declaring this interest, Councillor Leese wished to make it clear that he had no connection with the company indicated with in the reports that had applied for the grant.

185/16 MINUTES OF THE GMCA MEETING HELD ON 30 SEPTEMBER 2016

The minutes of the GMCA meeting held on 30 September 2016 were submitted for consideration.

RESOLVED/-

To approve the minutes of the GMCA meeting held on 30 September 2016 as a correct record.

186/16 FORWARD PLAN OF STRATEGIC DECISIONS OF GMCA

Consideration was given to a report advising members of those strategic decisions that were to be considered by the GMCA over the forthcoming months.

RESOLVED/-

To note the Forward Plan of Strategic Decisions, as set out in the report.

187/16 REFRESHING THE GREATER MANCHESTER STRATEGY – TIMETABLE AND ENGAGEMENT STRATEGY

Tony Lloyd, GM Interim Mayor introduced a report outlining the agreed approach for the engagement of GM residents, businesses and stakeholders in the refresh of the Greater Manchester Strategy, ensuring that all stakeholders have the opportunity to shape and influence the emerging strategy.

The paper also details the proposed timetable and provides a brief update of progress to date.

Members noted that both the Greater Manchester Strategy and Transport Strategy for Greater Manchester were key strategies for the Greater Manchester Strategy and as part of the refreshing process it was noted that there was a need to emphasise the work taking place to develop strong communities, such as working well and troubled families and a concept of a strong place.

RESOLVED/-

1. To note that further updates on progress will be provided as the conversation develops.
2. To note the timetable and that the approach set out in the report meet the objectives for the consultation.

188/16 GM-CONNECT FUNDING

Tony Lloyd, GM Interim Mayor introduced a report which provided a summary of the funding requests for Phase 2 of GM-Connect and sought Members' approval to draw down resources from within the overall GM-Connect budget.

Members noted that the Phase Two funding, which would commence mid November, will be used to continue the GM-Connect programme and add additional resources to the team, stand up an Architecture Design & Commissioning Function to help ensure transparency and consistency in information sharing across Greater Manchester (work that will be aligned with the requirements of the Health and Social Care IM&T strategy and place-based work across GM), the execution of co-designed information sharing activities with partners, and the development of resident and partner engagement activities as set out in the report.

Members noted that the Treasurer was to oversee the GM Connect funding process to ensure value for money and sustainability.

RESOLVED/-

To note and approve the GM-Connect Phase two draw down funding requests for the next twelve month period, as set out below:-

Area	FY 16/17 Cost	FY 17/18 Cost	Total Cost
Information Sharing Support capacity increase	£50,000	£100,000	£150,000
Architecture Design & Commissioning Function	£100,000	£150,000	£250,000
Use Case Progression and Delivery	£150,000	£100,000	£250,000
Resident and Partner Engagement	£50,000	£100,000	£150,000
Core GM-Connect staffing	£120,000	£480,000	£600,000
Total:	**£ 470,000**	**£930,000**	**£ 1,400,000**

189/16 GREATER MANCHESTER BREXIT MONITOR

Councillor Richard Leese, introduced a report which presented Members with an update on the progress with work to understand the full implications of Brexit on GM and develop an appropriate policy response. An analysis on the key issues identified for GM's key growth sectors and major employment sectors was provided and identified three principles which should underpin the UK's negotiation of the terms of the withdrawal from the EU to support continued growth and prosperity in GM.

In addition, Members noted that the latest edition of the monthly Greater Manchester Brexit Monitor was appended to the report and provided a real-time snap shot of the economic and policy impact of Brexit.

The Chair highlighted that Greater Manchester needed to be represented as part of the Brexit negotiations in order for the specific requirements for its economy to be addressed.

In response to an enquiry from a Member regarding the purported agreement between Government and Nissan, Councillor Leese noted that Greater Manchester's economy

needed to retain foreign owned companies and international trade in GM and would seek for any agreement with Nissan to be also applied to Greater Manchester should the need arise.

RESOLVED/-

1. To note the contents of the latest GM Brexit Monitor.
2. To note the updated review of risks and opportunities by sector as summarised in section 3 to the report.
3. To confirm the three principles for withdrawal from the EU which have been identified, as set out in section 4 to the report, and that these principles should form the basis of future discussions with Government.

190/16 CAPITAL EXPENDITURE UPDATE 2016/17

[note: Councillors Sean Anstee and Richard Leese each declared a personal interest in this item.]

Councillor Kieran Quinn, Portfolio Lead for Investment Strategy and Finance, introduced a report presenting an update in relation to the GMCA 2016/17 capital expenditure programme.

The report also sought approval from Members for the utilisation of £1million of the Growth Deal grant to support the Manchester Growth Company - Digital Capital project to enable the Business Growth Hub to implement new advanced technologies to enhance its service delivery to Small and Medium Enterprises across Greater Manchester. Members noted that it was anticipated that 1,000 companies would be engaged through this project.

RESOLVED/-

1. To note the current 2016/17 forecast compared to the previous 2016/17 capital forecast.
2. To approve the utilisation of the £1million of the Growth Deal grant to support the Digital Capital project as detailed in paragraph 8.10 to the report.

191/16 GMCA REVENUE UPDATE 2016/17

[note: Councillors Sean Anstee and Richard Leese each declared a personal interest in this item.]

Councillor Kieran Quinn, Portfolio Lead for Investment Strategy and Finance introduced a report informing members of the 2016/17 forecast revenue outturn position as at the end of September 2016.

RESOLVED/-

1. To note the Economic Development and Regeneration revenue outturn position for 2016/17 shows a surplus against budget of £0.14 million after transfers to ear-marked reserves.

2. To note the transport revenue outturn position for 2016/17 which is in line with budget after contributions to earmarked reserves of £0.744 million.

3. To approve the budget adjustments referred to in paragraphs 2.2 – 2.17 for Economic Development and Regeneration budgets.

4. To approve the re-designation of funds to Manchester Growth Company for the Business Growth Hub as detailed in paragraphs 2.7 – 2.9.

5. To note the TfGM outturn position for 2016/17 which is in line with budget.

192/16 GREATER MANCHESTER 2040 TRANSPORT STRATEGY CONSULTATION

Tony Lloyd, GM Interim Mayor introduced a report which provided Members with a summary of the feedback received during the 12-week consultation (July to September 2016) on the 'Greater Manchester Transport Strategy 2040: Consultation Draft' and highlighted the next steps in finalising the strategy.

Members noted that a further update on the detailed analysis from the consultation responses would be presented at the upcoming GMCA meeting in December.

The Chair reiterated the need for the Transport Strategy to serve the GM Spatial Framework aspirations.

RESOLVED/-

1. To note, and comment as appropriate, on the range and nature of responses received on the Greater Manchester Transport Strategy 2040 Consultation Draft.

2. To note the next steps in finalising the strategy by the end of 2016.

194/16 ENERGY COMPANY FOR GREATER MANCHESTER – WHITE LABELLING

Councillor John Merry introduced a report which provided Members with an update on the proposals for a GM Energy Company ('GMEC') to the GMCA. The report highlighted that given the increasing level of competition in the energy supply market and the significant associated set up costs and financial risks, the potential for the development of Energy Company for Greater Manchester was not considered a viable option and for these reasons, the process should be paused in order to understand how the current energy market will develop.

Members agreed to take the commercially sensitive Part B Energy Company For Greater Manchester – White Labelling report as read during consideration of this item.

In response to a comment from the Chair, it was noted work would continue in relation to social value and energy supply particularly in relation to pre-paid energy meters and fuel poverty issues.

Member also noted that work would continue to explore opportunities to develop non-renewable energy in Greater Manchester.

RESOLVED/-

1. To note the work undertaken to determine the appropriateness of a white label arrangement with prospective partner suppliers.

2. To agree that in an increasingly competitive energy supply market, the potential benefits of such an arrangement are outweighed by the risks. As such, a potential White Labelling arrangement should not be pursued at the present time.

3. To note that consideration is being given to alternative approaches which will enable GMCA to have a positive impact on fuel poverty in Greater Manchester and encourage investment in local generation assets.

195/16 GM INVESTMENT FRAMEWORK PROJECT UPDATES

Councillor Kieran Quinn, Portfolio Lead for Investment Strategy and Finance and Eamonn Boylan, Portfolio Lead Chief Executive for Investment Strategy and Finance seeking GMCA approval for a second loan to Fabrik Games.

Members agreed to take the commercially sensitive Part B GM Investment Framework Project Updates report as read during consideration of this item.

RESOLVED/-

1. To agree that the project funding application by Fabrik Games (loan of £300k) be given conditional approval and progress to due diligence.

2. To agree to delegate authority to the GMCA's Treasurer and Monitoring Officer to review the due diligence information and, subject to their satisfactory review and agreement of the due diligence information and the overall detailed commercial terms of the transaction, to sign off any outstanding conditions, issue final approvals and complete any necessary related documentation in respect of the loan at 1) above.

196/16 GREATER MANCHESTER HOUSING FUND REQUESTS

[note: Councillor Richard Leese declared a disclosable pecuniary interest in this item.]

Councillor Richard Farnell, Portfolio Lead for Planning and Housing introduced a report which sought the approval of Greater Manchester Combined Authority for a GM Housing Fund loan of £8.303m.

Members agreed to take the commercially sensitive Part B Greater Manchester Housing Fund Requests report as read whilst considering this report.

RESOLVED/-

1. To approve the loan as detailed in this and the accompanying Part B report.

2. To agree to recommend to Manchester City Council that it prepares and effects the necessary legal agreements in accordance with its approved internal processes.

197/16 EXCLUSION OF PRESS AND PUBLIC

Members noted that as the commercially sensitive information was taken as read during the consideration of Energy Company for Greater Manchester, Greater Manchester Investment Framework and Conditional Approval (Minute 195/16) and Greater Manchester Housing Fund Requests (Minute 196/16) the recommendation to exclude members of the press and public would not be moved.

198/17 ENERGY COMPANY FOR GREATER MANCHESTER

CLERK'S NOTE: This item was considered in support of the Part A Energy Company for Greater Manchester (Minute 194/16).

199/16 GM INVESTMENT FRAMEWORK

CLERK'S NOTE: This item was considered in support of the Part A Greater Manchester Investment Framework (Minute 195/16).

200/16 GREATER MANCHESTER HOUSING FUND REQUESTS

CLERK'S NOTE: This item was considered in support of the Part A Greater Manchester Housing Fund Requests (Minute 196/16).

DECISIONS AGREED AT THE MEETING OF THE JOINT GREATER MANCHESTER COMBINED AUTHORITY AND AGMA EXECUTIVE BOARD HELD ON FRIDAY 28 OCTOBER 2016 AT SALFORD CIVIC CENTRE

GM INTERIM MAYOR	Tony Lloyd (in the Chair)
BOLTON COUNCIL	Councillor Cliff Morris
BURY COUNCIL	Councillor Rishi Shori
MANCHESTER CC	Councillor Richard Leese
OLDHAM COUNCIL	Councillor Jean Stretton
ROCHDALE MBC	Councillor Richard Farnell
SALFORD CC	Councillor John Merry
STOCKPORT MBC	Councillor Alex Ganotis
TAMESIDE MBC	Councillor Kieran Quinn
TRAFFORD COUNCIL	Councillor Sean Anstee
WIGAN COUNCIL	Councillor Peter Smith

JOINT BOARDS AND OTHER MEMBERS IN ATTENDANCE

GMF&RS	Councillor David Acton
GMWDA	Councillor Nigel Murphy
TfGMC	Councillor Andrew Fender

DEPUPUTY PORTFOLIO HOLDERS IN ATTENDANCE

Councillor Brenda Warrington (Tameside)	Health and Social Care
Councillor Wendy Wild (Stockport)	Health and Social Care
Councillor Linda Thomas (Bolton)	Health and Social Care
Councillor Paula Boshell (Salford)	Planning and Housing
Councillor Aasim Rashid (Rochdale)	Low Carbon, Waste and Environment
Councillor Lynn Travis (Tameside)	Low Carbon, Waste and Environment
Councillor Jenny Bullen (Wigan)	Skills and Employment
Councillor Abdul Jabbar (Oldham)	Skills and Employment
Councillor Donna Martin (Rochdale)	Children's Services
Councillor Linda Blackburn (Trafford)	Children's Services
Councillor Dylan Butt (Trafford)	Economic Strategy
Councillor Ebrahim Adia (Bolton)	Economic Strategy
Councillor Sue Murphy (Manchester)	Reform
Councillor Jo Platt (Wigan)	Transport
Councillor Angeliki Stogia (Manchester)	Fairness, Equalities and Cohesion
Councillor Jane Black (Bury)	Fairness, Equalities and Cohesion

OFFICERS IN ATTENDANCE

Margaret Asquith	Bolton Council
Mike Owen	Bury Council
Howard Bernstein	Manchester CC
Mary Kufeldt	Oldham Council
Pauline Kane	Rochdale MBC
Charlotte Ramsden	Salford CC
Eamonn Boylan	Stockport MBC
Sandra Stewart	Tameside MBC
Theresa Grant	Trafford Council
Alison McKenzie Folan	Wigan Council
Ian Hopkins	GM Police
Paul Argyle	GM Fire & Rescue Service
Simon Warburton	Transport for Greater Manchester
Simon Nokes	New Economy
Adam Allen	Office of the Police & Crime Commissioner
Clare Monaghan	Interim Mayor's Office
Liz Treacy	GMCA Monitoring Officer
Andrew Lightfoot	Deputy Head of the Paid Service
Julie Connor	Head of GMIST
Rebecca Heron	GM Integrated Support Team
Sylvia Welsh	GM Integrated Support Team
Paul Harris	GM Integrated Support Team

77/16 APOLOGIES

Apologies for absence were received and noted from City Mayor Paul Dennett. Councillor John Merry deputised in the City Mayor's absence.

Donna Hall (Wigan), Steve Rumbelow, (Rochdale) Steven Pleasant, (Tameside), Jim Taylor (Salford), Carolyn Wilkins (Oldham), Jon Lamonte (TfGM) and Peter O'Reilly (GMF&RS).

78/16 DECLARATIONS OF INTERESTS

There were no declarations of interest made by any Member in respect of any item on the agenda.

79/16 STATUTORY FUNCTION COMMITTEE – APPOINTMENTS

a) Statutory Functions Committee

Members considered the nomination of Councillor Abid Chohan (Manchester) as a substitute to Councillor Bernard Stone (Manchester) on the Statutory Functions Committee for the remainder of 2016/17.

RESOLVED/-

To note the nomination of Councillor Abid Chohan (Manchester) as a substitute to Councillor. Bernard Stone (Manchester) on the Statutory Functions Committee for the remainder of 2016/17.

b) GMCA and AGMA Scrutiny Pool

Members considered the nominations of Councillors Zahra Alijah and James Wilson (both Manchester) as Members of the GMCA and AGMA Scrutiny Pool as direct replacements for Councillors Angeliki Stogia and Matt Strong (both Manchester) for the remainder of 2016/17.

RESOLVED/-

To note the nominations of of Councillors Zahra Alijah and James Wilson (both Manchester) as Members of the GMCA and AGMA Scrutiny Pool as direct replacements for Councillors Angeliki Stogia and Matt Strong (both Manchester) for the remainder of 2016/17.

80/16 MINUTES OF THE JOINT GMCA AND AGMA EXECUTIVE BOARD HELD ON 26 AUGUST 2016

The minutes of the meeting of the Joint GMCA and AGMA Executive Board held on 26 August 2016 were submitted for consideration.

RESOLVED/-

To approve the minutes of the meeting of the Joint GMCA and AGMA Executive Board held on 26 August 2016 as a correct record.

81/16 FORWARD PLAN OF STRATEGIC DECISIONS OF JOINT GMCA & AGMA

Consideration was given to a report advising members of those strategic decisions that were to be considered by the int GMCA and AGMA Executive Board over the forthcoming months.

RESOLVED/-

To note the Forward Plan of Strategic Decisions, as set out in the report.

82/16 MINUTES OF THE JOINT GMCA AND AGMA EXECUIVE BOARD AUDIT COMMITTEE HELD ON 23 SEPTEMBER 2016

The minutes of the proceedings of the Joint GMCA and AGMA Executive Board Audit Committee held on 23 September 2016 were considered.

RESOLVED/-

To note the proceedings of the Joint GMCA and AGMA Executive Board Audit Committee held on 23 September 2016, as a correct record.

83/16 JOINT GMCA AND AGMA SCRUTINY POOL MINUTES – 9 SEPTEMBER 2016 AND 14 OCTOBER 2016

The minutes of the proceedings of the Joint GMCA and AGMA Executive Board Scrutiny Pool held on 9 September 2016 and 14 October 2016 were submitted.

RESOLVED/-

To note the proceedings of the Joint GMCA and AGMA Executive Board Scrutiny Pool held on 9 September 2016 and 14 October 2016.

84/16 GREATER MANCHESTER SPATIAL FRAMEWORK – DRAFT CONSULTATION

Councillor Richard Farnell, Portfolio lead for Planning and Housing introduced a report which updated Members on the next stage of the Greater Manchester Spatial Framework (GMSF). The report also sought the approval from Members to commence a consultation process under regulation 18 of the Town and Country Planning (Local Planning) (England) Regulations 2012. Members noted that if agreed, it was proposed that the consultation process would commence on 31 October and would close on 23 December 2016 and will be undertaken in line with the Statement of Community Involvements of the 10 local planning authorities.

Councillor Farnell explained the basis of the GMSF was a strategy for greener, more sustainable growth and highlighted the importance of this framework for the future economy for Greater Manchester, including identifying land to develop 200,000 new jobs and a housing supply to meet the needs of a changing economy and a growing and ageing population. Members highlighted the importance that the GMSF was supported by improved transport infrastructure and an increase in the investment and provision of public service assets, such as schools, skills, training and health provision in order for Greater Manchester's aspirations to be met.

Initial proposals in the GMSF consultation documents identified the use of brown-field sites. Members noted that 70% of the sites identified were located within urban areas, however this would not meet all of Greater Manchester's needs and for this reason the Spatial Framework proposes the release of 8% of Greater Manchester's Green Belt. In addition, it was noted that 43% of the Green Belt would remain and that a robust spatial framework was required in order for such to be protected from speculative development.

Members noted that a number of consultation events would take place until the initial consultation process closed on 23 December 2016 and the proposals would be updated to capture the comments received during this consultation.

Eamonn Boylan, lead Chief Executive for Planning and Housing gave a presentation on the contents of the draft GMSF, which included an overview of potential new sites and the wider consultation process timescales.

Councillor Anstee sought clarification that the assurances given in the plan regarding transport infrastructure provision were credible. In addition, he enquired as to how this plan may inform housing investment funding and planning powers to enable deliverability and to inform future requests to Government. In response, it was noted that delivery of growth and infrastructure was fundamental and as planning authorities, Greater Manchester Local Authorities were unlikely to approve developments unless they were satisfied that the infrastructure was present to support the development. Members noted that the Autumn Statement submission to Government sought investment for transport infrastructure funding and also noted the importance of utility infrastructure from major providers.

With regard to housing and housing investment, Members noted that delivery mechanisms to deliver at scale and speed would need to be explored.

Councillor Merry highlighted that if there wasn't a plan in place it could potentially lead to developers identifying sites on an ad hoc basis. The draft plan brings together the

conurbation for planning for the future and would help to protect areas of green space. Support was given for the initial consultation process to commence.

Councillor Morris commented that transport infrastructure plans were needed to take the GMSF work forward.

Councillor Ganotis noted the GMSF provided a strategic approach for Greater Manchester for the next twenty years which will meet the economic and housing needs and minimises Green Belt incursion. He noted that the consultation processes went further than required and Councils were encouraged to engage with all stakeholders in relation to the consultation. It was noted that each district would need to formally endorse the GMSF.

Councillor Richard Leese noted that as yet, this was not a statutory framework, but would in future become a statutory Mayoral Spatial plan. He noted that some Local Authorities had put their statutory frameworks on hold whilst the GMSF is being developed so it is a very important document. With regard to Green and Blue infrastructure policies, opportunities to green urban areas may be presented. He highlighted that the absence of a plan would leave local planning authorities vulnerable for planning decisions to be overturned.

Councillor Quinn supported the comments made by Councillor Leese. The GMSF would allow for districts to challenge applications with regard to insufficient infrastructure provision. Clear advice and guidance was needed for the public in relation to the consultation engagement process.

Councillor Peter Smith commented that it was important to make it clear that the Spatial Framework and Transport Strategy sit below the Greater Manchester Strategy, forming a suite of strategic documents, which when taken together set out the vision and ambitions and how it is intended that they will be implements.

The Chair noted that the powers of local planning authorities would remain and reiterated that the investment in infrastructure was important. The use of existing brown field sites was important and that work was taking place with government to explore how brown field sites can be made more useable.

In summing up, Councillor Farnell thanked Members for their comments. He highlighted that with regard to Rochdale, there was an opportunity to grow its population in order to provide a sustainable and attractive location for developing business opportunities. Councils were each encouraged to take a lead with regard to the consultation process within their own localities. Councillor Farnell reiterated that this was a plan and that districts would maintain their individual decision making processes with regard to planning applications.

RESOLVED/-

1. To note the report and unanimously agree the approach set out in the report.

2. To unanimously approve the Draft GMSF (Appendix 1), approach to site prioritisation (outlined in Appendix 2) and Integrated Assessment (Appendix 3) for consultation.

3. To unanimously agree to delegate responsibility to make final amendments to the Draft GMSF and background documents (Appendix 4) to Eamonn Boylan, Lead Chief Executive, Planning & Housing in consultation with Councillor Farnell, Portfolio

Holder for Planning & Housing and agree publication of the documents for consultation.

86/16 AGMA PROCUREMENT STRATEGY

Tony Lloyd, GM Interim Mayor introduced a report providing an update on the Procurement Hub's operation.

Members noted the social value elements contained in section 4 of the Annual Report

RESOLVED/-

To note the Annual Report.

87/16 BUSINESS RATES UPDATE

Councillor Kieran Quinn, Portfolio Lead for Investment Strategy and Finance, introduced a report providing members with an update on the Business Rates Pool position in 2016/17. GM Districts will need to make an in principle decision on whether to retain the Pool for 2017/18 by the end of October 2016, though any district can decide to opt out of the pool at the time of the provisional RSG settlement.

The GMCA Treasurer confirmed that work was progressing with the 10 GM Districts and 2 Cheshire authorites regarding the risk assurances regarding pooling. An update from DCLG has indicated that they were supportive of the pooling initiative.

RESOLVED/-

1 To agree the principle of the continuation of the Business Rates Pool to include the GM districts plus Cheshire East and Cheshire West, with the final recommendation being agreed by the GMCA Treasurer and the Portfolio Holder for Investment Strategy and Finance once the provisional finance settlement has been announced. At that stage the decision will be subject to appropriate approvals by each of the participating authorities.

2 To note that progress continues to be made with Communities and Local Government with regard to participation in the 100% Business Rates Pilot and will be the subject of a future report.

88/16 AGMA REVENUE UPDATE 2016/17

Councillor Kieran Quinn, Portfolio Lead for Investment Strategy and Finance, introduced a report informing members of the 2016/17 forecast revenue outturn position as at end September 2016.

RESOLVED/-

1. To note the report and the current revenue outturn forecast for 2016/17 which is projecting a minor underspend of £14,000 against budget after transfers to ear-marked reserves.

2. To approve the revisions to the revenue budget plan 2016/17 as identified in the report and described in paragraphs 1.2-1.5 of the report.

DECISIONS AGREED AT THE MEETING OF THE GREATER MANCHESTER COMBINED AUTHORITY, HELD ON FRIDAY 25 NOVEMBER 2016 AT GMP HEADQUARTERS, CENTRAL PARK, MANCHESTER

GM INTERIM MAYOR	Tony Lloyd (in the Chair)
BOLTON COUNCIL	Councillor Cliff Morris
BURY COUNCIL	Councillor Rishi Shori
MANCHESTER CC	Councillor Richard Leese
OLDHAM COUNCIL	Councillor Jean Stretton
ROCHDALE MBC	Councillor Richard Farnell
SALFORD CC	Councillor John Merry
STOCKPORT MBC	Councillor Alex Ganotis
TAMESIDE MBC	Councillor Kieran Quinn
TRAFFORD COUNCIL	Councillor Sean Anstee
WIGAN COUNCIL	Councillor Peter Smith

JOINT BOARDS AND OTHER MEMBERS IN ATTENDANCE

GMF&RS	Councillor David Acton
GMWDA	Councillor Nigel Murphy
TfGMC	Councillor Andrew Fender

OFFICERS IN ATTENDANCE

Margaret Asquith	Bolton Council
Mike Owen	Bury Council
Howard Bernstein	Manchester CC
Carolyn Wilkins	Oldham Council
Steve Rumbelow	Rochdale MBC
Jim Taylor	Salford CC
Eamonn Boylan	Stockport MBC
Steven Pleasant	Tameside MBC
Theresa Grant	Trafford Council
Donna Hall	Wigan Council
Ian Pilling	GM Police
Paul Argyle	GM Fire & Rescue Service
Jon Lamoonte	Transport for Greater Manchester
Peter Cushing	Transport for Greater Manchester
Mark Hughes	Manchester Growth Hub

Adam Allen	Office of the Police & Crime Commissioner
Clare Monaghan	GM Interim Mayor's Office
Liz Treacy	GMCA Monitoring Officer
Rodney Lund	GMCA
Andrew Lightfoot	Deputy Head of the Paid Service
Julie Connor	Head of GMIST
Rebecca Heron	GM Integrated Support Team
Sylvia Welsh	GM Integrated Support Team
Paul Harris	GM Integrated Support Team

201/16 APOLOGIES

Apologies for absence were received and noted from City Mayor Paul Dennett. Councillor John Merry deputised in the City Mayor's absence.

Apologies were also received from Peter O'Reilly (GMF&RS) and Ian Hopkins (GMP).

202/16 CHAIR'S ANNOUNCEMENTS AND URGENT BUSINESS

a) White Ribbon Day

In welcoming Members to the meeting, the Chair noted that white ribbons were being worn to mark White Ribbon Day, a global campaign to end violence against women and was supported by all Greater Manchester public agencies.

203/16 DECLARATIONS OF INTEREST

There were no declarations of interest made by a Member in respect of any item on the agenda.

204/16 MINUTES OF THE GMCA MEETING HELD ON 28 OCTOBER 2016

The minutes of the GMCA meeting held on 28 October 2016 were submitted for consideration.

RESOLVED/-

To approve the minutes of the GMCA meeting held on 28 October 2016 as a correct record.

205/16 FORWARD PLAN OF STRATEGIC DECISIONS OF GMCA

Consideration was given to a report advising members of those strategic decisions that were to be considered by the GMCA over the forthcoming months.

RESOLVED/-

To note the Forward Plan of Strategic Decisions, as set out in the report.

206/16 MINUTES

a) Greater Manchester Local Enterprise Partnership – 10 November 2016

The Minutes of the Greater Manchester Local Enterprise Partnership held on 10 November 2016 were submitted for information.

RESOLVED/-

b) Transport For Greater Manchester Committee – 11 November 2016

The minutes of the Transport for Greater Manchester Committee (TfGMC) meeting held on 11 November 2016 were submitted for information.

With regard to minute reference TfGMC16/54, Metrolink Second City Crossing Service Patterns, Councillor Jean Stretton highlighted her disappointment that there was not a direct link to Piccadilly Station from Oldham and Rochdale included in the Metrolink service patterns which were agreed by TfGMC. She requested a meeting with the Chair of GMCA, Chair of TfGMC, representatives of Transport for Greater Manchester (TfGM) and Councillor Richard Farnell in relation to this matter. In supporting Councillor Stretton's comments, Councillor Richard Farnell commented that a direct link to Piccadilly Station, as a major transport hub was important for the future economic growth of Oldham and Rochdale.

RESOLVED/-

1) To note the minutes for the Transport for Greater Manchester Committee meeting held on 11 November 2016.
2) To note the comments of Councillors Jean Stretton and Richard Farnell in relation to minute TfGMC16/54, Metrolink Second City Crossing Service Patterns.
3) To agree that a meeting be convened with Councillors Stretton and Farnell, Chair of GMCA, Chair of TfGMC, representatives of TfGM at the earliest opportunity to discuss Metrolink Second City Crossing Service Patterns.

207/16 AUTUMN STATEMENT

Councillor Richard Leese, Portfolio Lead for Economic Strategy introduced a tabled report that highlighted the announcements within the recent Autumn Statement with particular reference to those which are of specific relevance to Greater Manchester.

Members noted that with regard to Social Care funding, a 4% increase was needed rather than the 2% increase proposed in Autumn Statement. This level of increase would not make any significant change and potentially would leave people in vulnerable conditions worse off. This was disappointing and GM should continue to push strongly for Social Care funding.

RESOLVED/-

1) To note the contents of the report.
2) To agree that a more detailed analysis of the announcements set out in the Autumn Statement be brought to the next meeting of the Combined Authority for further consideration.

208/16 GREATER MANCHESTER BREXIT MONITOR

Councillor Richard Leese, Portfolio Lead for Economic Strategy presented a report which updated Members on the progress with work to understand the full implications of Brexit on GM and develop an appropriate policy response. The latest edition of the monthly Greater Manchester Brexit Monitor was attached to the report which provided a real-time snap shot of the economic and policy impact of Brexit.

RESOLVED/-

1) To note the update report.
2) To agree that a further report be submitted to the January 2017 GMCA meeting, in consultation with relevant portfolio leads, which will outline the main issues that Greater Manchester will require the Government to respond to as part of the Brexit negotiations.

209/16 2014-20 ERDF PROGRAMME: FINANCIAL INSTRUMENT PROPOSALS UPDATE

Councillor Kieran Quinn, Portfolio Lead for Investment Strategy and Finance, introduced a report which provided an update to Members on the progress in respect of the establishment of the GM Fund of Funds ("FoF") and the Northern Powerhouse Investment Fund ("NPIF"), as part of the 2014-20 ERDF programme and sought their approval to the granting of £0.5m to the new structure to cover initial fund overheads.

RESOLVED/-

1) To note the updated proposals to establish the new funds as set out in the report.
2) To grant approval for GMCA to lend £0.5m to support the establishment of the GM FoF in its initial phase with a further review of its sustainability before the 2018-19 financial year and to note that this £0.5m will be funded from a corresponding sum distributed to the GMCA from the Evergreen Holding Fund.

210/16 TRANSPORT FOR THE NORTH STRATEGIC ROAD STUDIES

Councillor Richard Leese, Portfolio Lead for Economic Strategy, introduced a report which provided an update on the two strategic highways studies co-sponsored by the Department for Transport and Transport for the North which impact on the Greater Manchester road network, namely the M60 North West Quadrant and a Trans-Pennine Tunnel.

Members noted that the findings of the studies will be published during December 2016 and will feed in to the Autumn Statement. Further work was also to be undertaken to calculate the wider economic and resilience benefits to enable the completion of strategic outline businesses cases.

A Member supported the finding in relation to the M60 North West Quadrant scheme and highlighted how this would improve congested area, particularly in relation to Worsley, if this scheme was approved, the Highways Agency ought to be reminded to undertake any works in a way to minimise disruption, unlike their approach to the current M60 Smart Motorway works.

With regard to the Trans-Pennine Tunnel Members noted that it was anticipated that such works would improve journey times between Manchester and Sheffield by 30 minutes and welcomed the potential for the development of this scheme.

RESOLVED/-

To note the progress of the Strategic Road Studies in Greater Manchester.

211/16 GREATER MANCHESTER HOUSING FUND MID YEAR REPORT 2016/17

Councillor Richard Farnell, Portfolio Lead for Planning and Housing introduced a report which informed Members of the outturn and forecast positions of the GM Housing Fund for 2016/17. In addition, Members also noted the position in relation to the indemnity entered into by each of the Local Authorities in relation to the GM Housing Fund.

Members agreed to take the commercially sensitive Part B GM Housing Fund for 2016/17 report (Item 16) as read whilst considering this report

RESOLVED/-

1) To note the outturn and forecast position of the GM Housing Fund for 2016/17 and to note that there has been no requirement for the GM Local Authorities to account for any impairment as a result of the performance of the Fund.
2) To note the position in respect of the indemnity given for the GM Housing Fund by GM Local Authorities.

212/16 METROLINK 2017 PROJECT

Tony Lloyd, GM Interim Mayor introduced a report which provided an update in relation to the process to procure a service provider to operate and maintain the Metrolink system from July 2017.

RESOLVED/-

1) To note the current position in relation to the project.
2) To approve in principle the creation of a rolling three year Metrolink renewal and enhancement capital programme as part of the Greater Manchester Transport Fund and to request the TfGM Finance and Corporate Services Director and GMCA Treasurer submit a further report for approval in January 2017.

213/16 METROLINK TRAFFORD PARK LINE

Tony Lloyd GM Interim Mayor introduced a report which provided Members with an update on the granting of powers under the Transport and Works Act 1992 for the construction and operation of the Trafford Park Line extension to the Metrolink system and sought approval to release the funding and enter into the contracts to deliver the scheme.

In welcoming the scheme a Member thanked Transport for Greater Manchester for their efforts in developing this extension to the Metrolink network and securing the Transport and Works Act Order from Government. He also noted the contribution made by Trafford Council with the use of Earnback funding.

Members agreed to take the commercially sensitive Part B Metrolink Trafford Park Line report, (Item 18) as read whilst considering this report.

RESOLVED/-

1) To welcome the Secretary of State's decision to make the Order under the Transport and Works Act 1992 for the construction and operation of the Trafford Park Line.
2) To approve the release of the remaining funding to commit a total of £350 million for the scheme.
3) To approve that TfGM enter into the contracts with MPact Thales, various utilities and WSP Parsons Brinckerhoff for the delivery and management of the scheme to design and construct the line; and delegate authority to the TfGM Chief Executive, Chief Operating Officer and the Finance and Corporate Services Director, in conjunction with the GMCA Treasurer to finalise the terms and enter into the contracts.

214/16 GREATER MANCHESTER INVESTMENT FRAMEWORK APPROVAL

Councillor Kieran Quinn, Portfolio Lead for Investment Strategy and Finance introduced a report which sought approval for an investment into Clowdy Group Limited (T/A "Twine"). The investment will be made from recycled monies.

Members agreed to take the more detailed, commercially sensitive, Part B Greater Manchester Investment Framework Approval (Item 19) as read whilst considering this report.

RESOLVED/-

1) To agree that the project funding application by Twine, (investment of up to £300,000), as set out in the report, be given conditional approval.

2) To agree to delegate authority to the Combined Authority Treasurer and Combined Authority Monitoring Officer to review the due diligence information and, subject to their satisfactory review and agreement of the due diligence information and the overall detailed commercial terms of the transaction, to sign off any outstanding conditions, issue final approvals and complete any necessary related documentation in respect of the investment at a) above.

215/16 EXCLUSION OF PRESS AND PUBLIC

Members noted that as the commercially sensitive information was taken as read during the consideration of GM Housing Fund for 2016/17 (Minute 211/16), Metrolink 2017 Project (Minute 212/16) and Greater Manchester Investment Framework Approval (Minute 214/16) and for this reason were not considered in Part B of the Agenda.

Members considered the exclusion of the public from the meeting during consideration of the report at item 17.

Resolved/-

That, under section 100 (A)(4) of the Local Government Act 1972 the press and public should be excluded from the meeting for the following item of business on the grounds that this involves the likely disclosure of exempt information, as set out in paragraph 3, Part 1, Schedule 12A of the Local Government Act 1972 and that the public interest in maintaining the exemption outweighs the public interest in disclosing the information.

216/16 GREATER MANCHESTER HOUSING FUND MID YEAR REPORT 2016/17

CLERK'S NOTE: This item was considered in support of the Part A Greater Manchester Housing Fund Mid Year Report 2016/17 (Minute 211/16).

217/16 METROLINK 2017 PROJECT

Tony Lloyd, GM Interim Mayor and Portfolio Lead for Transport provided an update following the evaluation of bids submitted as part of the process to procure a service provider to operate and maintain the Metrolink system from July 2017. The report also sought the approval of Members to the appointment of the Confirmed Preferred Bidder for the project, as identified in the report.

RESOLVED/-

1) To approve the appointment of the Confirmed Preferred Bidder for the Metrolink 2017 project, as identified in the report, and to grant delegated authority to the TfGM Chief Executive, Chief Operating Officer and the Finance and Corporate Services Director, in conjunction with the GMCA Treasurer, to finalise the terms and enter into the contract.

2) To approve in principle the creation of a rolling three year Metrolink renewal and enhancement capital programme as part of the Greater Manchester Transport Fund and request the TfGM Finance and Corporate Services Director and GMCA Treasurer submit a further report for approval in January 2017.

218/16 METROLINK TRAFFORD PARK LINE

CLERK'S NOTE: This item was considered in support of the Part A Greater Manchester Housing Fund Mid Year Report 2016/17 (Minute 213/16).

219/16 GREATER MANCHESTER INVESTMENT FRAMEWORK APPROVAL

CLERK'S NOTE: This item was considered in support of the Part A Greater Manchester Investment Framework Approval (Minute 214/16).