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HEALTH SCRUTINY
Overview & Scrutiny Committee
Agenda

Date	Tuesday 3 July 2018
Time	6.00 pm
Venue	Crompton Suite, Civic Centre, Oldham, West Street, Oldham, OL1 1NL

Notes

1. DECLARATIONS OF INTEREST- If a Member requires advice on any item involving a possible declaration of interest which could affect his/her ability to speak and/or vote he/she is advised to contact Paul Entwistle or Sian Walter-Browne at least 24 hours in advance of the meeting.

2. CONTACT OFFICER for this agenda is Sian Walter-Browne Tel.0161 770 5151 or email sian.walter-browne@oldham.gov.uk

3. PUBLIC QUESTIONS - Any Member of the public wishing to ask a question at the above meeting can do so only if a written copy of the question is submitted to the contact officer by 12 noon on Thursday, 28 June 2018.

4. FILMING - The Council, members of the public and the press may record / film / photograph or broadcast this meeting when the public and the press are not lawfully excluded. Any member of the public who attends a meeting and objects to being filmed should advise the Constitutional Services Officer who will instruct that they are not included in the filming.

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MEMBERSHIP OF THE HEALTH SCRUTINY
Councillors Ball, Leach, Taylor, Toor, Williamson and McLaren

Item No

1 Election of Chair

The Health Scrutiny Sub-Committee is asked to elect a Chair for the Municipal Year 2018/19.

2 Apologies For Absence

3 Declarations of Interest

To Receive Declarations of Interest in any Contract or matter to be discussed at the meeting.

4 Urgent Business

Urgent business, if any, introduced by the Chair

5 Public Question Time

To receive Questions from the Public, in accordance with the Council's Constitution.

6 Minutes of Previous Meeting (Pages 1 - 6)

The Minutes of the Health Scrutiny Sub-Committee held on 20th March 2018 are attached for approval.

7 Minutes of the Greater Manchester Health and Social Care Partnership (Pages 7 - 30)

The minutes of the GM Health and Social Care Partnership meetings held on 19th January and 16th March 2018. The minutes are attached for noting.

8 Minutes of the Greater Manchester Joint Health Scrutiny Meeting (Pages 31 - 38)

The minutes of the GM Joint Health Scrutiny meeting held on 10th January 2018 are attached for noting.

9 Minutes of the Joint Health Overview and Scrutiny for Pennine Care Foundation Trust (Pages 39 - 44)

The minutes of the Joint Health Overview and Scrutiny for Pennine Care Foundation Trust meeting held on 13th March 2018 are attached for noting.

10 Minutes of the Health and Wellbeing Board (Pages 45 - 50)

The Minutes of the Health and Wellbeing Board held on 23rd January 2018 are attached for approval.

11 Action Log (Pages 51 - 52)

12 Meeting Overview (Pages 53 - 54)

13 Mayor's Healthy Living Campaign (Pages 55 - 56)

14 Urgent Care Strategy (Pages 57 - 110)

15 Air Quality (Pages 111 - 122)

16 Pennine Acute CQC Inspection (Pages 123 - 126)

17 Council Motions (Pages 127 - 130)

18 Forward Plan (Pages 131 - 134)

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HEALTH SCRUTINY
20/03/2018 at 6.00 pm

Present: Councillor McLaren (Chair)
Councillors Goodwin, Toor and Williams

Also in Attendance:

Michelle Bradshaw	Bridgewater Trust
Oliver Collins	Principal Policy Officer
Mark Drury	NHS
Tracey Harrison	Joint Commissioning for People (Health & Social Care)
Lori Hughes	Constitutional Services
Mark Warren	Director, Adult Social Care

1 **APOLOGIES FOR ABSENCE**

Apologies for absence were received from Councillor Williamson.

2 **DECLARATIONS OF INTEREST**

There were no declarations of interest received.

3 **URGENT BUSINESS**

There were no items of urgent business received.

4 **PUBLIC QUESTION TIME**

There were no public questions received.

5 **MINUTES OF PREVIOUS MEETING**

RESOLVED that the minutes of the Health Scrutiny Sub-Committee meeting held on 30th January 2018 be approved as a correct record.

6 **MINUTES OF THE JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE FOR PENNINE CARE FOUNDATION TRUST**

RESOLVED that the minutes of the Joint Health Overview and Scrutiny Committee for Pennine Care Foundation meeting held on 30th November 2017 be noted.

7 **MINUTES OF THE JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE FOR PENNINE ACUTE HOSPITALS NHS TRUST**

RESOLVED that the minutes of the Joint Health Overview and Scrutiny Committee for Pennine Acute Hospitals NHS Trust meeting held on 3rd October 2017 be noted.

8 **GM HEALTH AND SOCIAL CARE PARTNERSHIP MINUTES**

RESOLVED that the minutes of the GM Joint Health and Social Care Partnership meeting held on 13th October 2017 be noted.

9 **GREATER MANCHESTER JOINT HEALTH SCRUTINY COMMITTEE**

RESOLVED that the minutes of the GM Joint Health Scrutiny meeting held 8th November 2017 be noted.

10 **MINUTES OF THE HEALTH AND WELLBEING BOARD**

RESOLVED that the minutes of the Health and Wellbeing Board held on 12th December 2017 be noted.

11 **MEETING OVERVIEW**

RESOLVED that the Meeting Overview for the meeting held on 20th March 2018 be noted.

12 **RESOLUTION AND ACTION LOG**

RESOLVED that the resolutions and actions from Health Scrutiny Sub-committee meeting held on 30th January 2018 be noted.

13 **URGENT PRIMARY CARE**

The Sub-Committee gave consideration to a report which provided an update on the outcome of the recent public consultation on the future model for urgent primary care in Oldham and subsequent decisions taken by the Clinical Commissioning Group (CCG) Governing Body on the implementation of the changes. An Equality Health Impact Assessment had been conducted which identified the most likely differential impact being upon people with disabilities or low incomes who may be adversely affected by the change of location of services.

The case for change was outlined in the report. Greater Manchester Devolution encouraged both innovation and financial support to bring about clinically led change across health and social care which included urgent primary care. This was reinforced by national NHS England guidance.

The options outlined considered were Option WI (Walk In) and Option HU (Urgent Care Hubs). Both options were set out in detail in the prospectus. It was noted that 58% of the 2,493 consultees had expressed a preference in the main survey for Urgent Care Hubs as opposed to 42% which wished to retain a Walk-In Service.

The CCG's Governing Body had agreed to proceed with the proposal for a number of Urgent Care Hubs located around Oldham which offered bookable urgent treatment appointments with core characteristics outlined in the report as well as additions to the original proposal.

Members sought and received clarification a definition of urgent care. Members also sought clarification ensuring the availability of phone lines, retention of walk-in alongside urgent care and how that was managed, the impact on accident and emergency and communications. Members were informed that phone lines would trip through and would not get lost in the system. The walk-in appointments would be addressed by the hubs. Communication was recognised as a key point. Members commented about the walk-in centre and limited times which

added pressure on Accident & Emergency. Members were informed that clusters would need to target times and were also informed that the out of hours GP services would still be available.

Members raised that the key to success was communications to the wider community. Members were informed when the time was appropriate, changes would be promoted and sustained. This was also recognised as a significant piece of work. An update would be provided to the governing body next month.

RESOLVED that:

1. The update on the future model on urgent primary care in Oldham be noted.
2. An update on the timeline for implementation be brought to the next meeting of the Health Scrutiny.

14 **INTEGRATED CARE ORGANISATION**

The Sub-Committee gave consideration to an update on the progress of the development of the Integrated Care Organisation and the work to develop the five integrated cluster teams. The integration of front-line services aimed to provide quality co-ordinated care within a community setting to residents as and when needed. It was hoped that this model would alleviate the extreme pressure which was seen at the Royal Oldham Hospital A&E Department.

Members were informed that the development was linked to the National and Greater Manchester picture. Members were informed about the integrated care model, consolidation of funding and local workforce plan. Financial challenges were also highlighted. Adult social care had been redesigned in Oldham which featured two elements in the new locality care: Commissioning and Provider. NHS and Council funding would be pooled under a S.75 agreement and services would be brought together through a phased approach over the next three years. Members were informed of the single line management and working arrangements across the five clusters Residents would be supported locally through coordinated care services. A key issue was a common IT infrastructure for staff to facilitate one care plans for residents.

Members asked how performance and services would be monitored. Members were informed that this was a key issue as the NHS had its own performance monitoring performance standards with a range of indicators as did social care. Divisional management teams would review performance and this would form part of the governance arrangements. Every management meeting would be summarised with key messages to staff.

Members asked about the challenge of recruiting qualified staff. Members were informed that keeping qualified staff was difficult, however, the service would continue to make Oldham an

attractive place work and provide options under the service delivery plans.

Members commented that the outcome would be a health service providing services to those who needed them, and were informed that this was linked to the Thriving Communities agenda which was aligning work with cluster models with residents through early help.

Members commented that there was an ongoing need to monitor progress and understand the direction of travel as well as the transition from Phase 1 to Phase 2. Members would be informed when team meetings would be held and be invited to attend.

RESOLVED that:

1. The update and progress made in the development of the Integrated Care Organisation be noted.
2. A further update be received by the Health Scrutiny Sub-Committee in the new Municipal Year.

15 **BRIDGEWATER NHS TRUST**

The Sub-Committee gave consideration to an update from the Bridgwater NHS Trust which included:

- The implementation of the Right Start Service;
- Performance Reporting and emerging outcomes; and
- The impact of the Trust's CQC inspection findings and subsequent action plan on the Right Start Service in Oldham.

The aim of the service was to tackle a number of key early childhood outcomes through the delivery of a number of statutory functions which were:

- Health visiting mandated visits
- Healthy child programmes 0-5 and 5 – 19
- Children's Centres

And outcomes:

- Child Development at 2 – 2.5 years
- Prevalence of breastfeeding at 6 – 8 weeks
- Improvement following a package of care delivered at universal/universal plus
- Take up of 2 year old entitlement.

Members were informed of the range of indicators on expected level of development which included: communication; gross motor; fine motor; problem solving and personal/social development. A case study was outlined to members and also informed that data was being refined that could track children who had problems before school. Oldham was leading across Greater Manchester which was a testament to the Council.

Members asked where referrals came from and were informed that this was through a range of places which included children's centres, audiology, nurseries and health services.

Members asked about the focus on parenting and were informed that every child had visits from health visitors which were critical. The assessment in using the Ages and Stages Questionnaire (ASQ) were parent led by educating parents on developmental milestones.

Members asked if percentage information was available for each ward and that the details could be shared with district teams. Members were informed that ward level information was shared at local advisory boards and members were encouraged to participate in the boards.

Members asked about work with parents who did not have English as a first language. Members were informed that bilingual workers in the service were used as well the interpreter's service and also followed best guidance. Children were started in their mother tongue and it was noted that this service was highlighted in the SEND report as an area of good practice. All assessments were carried out in the home language which was valued by the inspectors.

Members noted the quarterly percentages and were informed that percentages were approximate the same per quarter and the four quarters for the year equated to the birth rate. Members asked about patterns emerging across the wards. It was confirmed that patterns had emerged and an analysis would be completed and included in the end of year report.

Members asked about the implementation of the restructure and were informed that this was almost complete. The HR process was ongoing and staff had moved into the districts.

The Bridgewater Trust had also been subject of a trust wide CQC inspection and had developed an action plan which addressed the identified areas of concern. Members were informed that there was nothing specific to Oldham in terms of the action plan but another inspection was due.

RESOLVED that:

1. The update on the implementation of the Right Start Service, Performance reporting and the impact of the CQC inspection findings on the Right Start Service be noted.
2. The annual summary be reported to Health Scrutiny in June 2019.
3. A summary of figures for the 2018 be circulated as part of the Work Programme at the meeting in July 2018.

16 **CHILDREN'S SAFEGUARDING TASK GROUP**

The Sub-Committee gave consideration to an update on the Children's Safeguarding Task and Finish Group which looked

into the provision of child safeguarding provision in the borough. Two focus areas had been identified which were:

- Development of a more engaging and practical core safeguarding training package for elected members; and
- Continued development of the multi-agency offer.

Key actions were identified in the report.

The follow-up meeting was due to be re-arranged. Members agreed to receive a written update and that a further meeting be arranged in the new municipal year.

RESOLVED that:
1. The updated on the Children's Safeguarding Task Group be noted.
2. A written update be provided to the Task Group.
3. A further meeting be organised in the new Municipal Year.

17 **MAYOR'S HEALTHY LIVING CAMPAIGN**

The Sub-Committee gave consideration to an update on the Mayor's Health Living Campaign.

The Sub-Committee were informed that a meeting had been arranged with the incoming Mayor to discuss themes during his term of office.

RESOLVED that the update on the Mayor's Healthy Living Campaign be noted.

18 **COUNCIL MOTIONS**

There were no Council motions related to Health to be noted.

19 **2018/19 FORWARD PLAN**

The Sub-Committee gave consideration to the Oldham Health Scrutiny Sub-Committee Forward Plan for the 2018/19 Municipal Year.

Members referred to the future agenda item on Tobacco Control and asked that the use of shisha and e-cigarettes be included. The Annual Public Health Report would also be included on the work programme.

RESOLVED that:
1. The Health Scrutiny Sub-Committee Forward Plan for the 2018/19 Municipal Year be noted.
2. The suggestions made by the Health Scrutiny Sub-Committee members be included on the 2018/19 Work Programme.

The meeting started at 6.00 pm and ended at 7.51 pm

GM HEALTH AND SOCIAL CARE STRATEGIC PARTNERSHIP BOARD

MINUTES OF THE MEETING HELD ON 19 JANUARY 2018

Bolton CCG	Wirin Bhatiani
Bolton Council	Tony Oakman
Bury CCG	Kiran Patel
Christie NHS FT	Christine Outram
GM Mayor	Andy Burnham
GMCA	Eamonn Boylan Lindsay Dunn Jamie Fallon
GM ACCGs	Rob Bellingham
GM H&SC Partnership Team	Warren Heppolette Nicky O'Connor Jon Rouse Steve Wilson Zoe O'Neill Sarah Price Sarah Fletcher-Hogg Karishma Chandaria
GMCVO	Nathalie Long
Healthwatch	Jack Firth Mick Hodlin
Manchester Carers Forum	David Williams
Manchester CC	Councillor Bev Craig Geoff Little
Manchester Foundation Trust	Kathy Cowell
Manchester Health and Care Commissioning	Craig Harris
NW Boroughs Healthcare NHS FT	John Heritage
Oldham Council	Councillor Eddie Moores

Oldham CCG	Noreen Dowd
Primary Care Advisory Group (GP)	Tracey Vell
Primary Care Advisory Group (Pharmacy) Pennine Acute NHS Trust	Adam Irvine Jim Potter
Rochdale MBC	Steve Rumbelow Ross Jeffrey
Salford CC	Councillor Paula Boshell David Herne
Salford CCG	Tom Tasker Jim Potter
Salford Royal NHS Foundation Trust	Chris Brookes
Stockport CCG	Ranjit Gill
Stockport MBC	Councillor Wendy Wild Pam Smith
Tameside MBC	Councillor Brenda Warrington Gill Gibson
TfGM	Bob Morris
The Gaddum Centre	Lynne Stafford
Trafford CCG	Matt Colledge
Wigan Council	Councillor Peter Smith (in the Chair) Will Blandamer Donna Hall
Wigan, Wrightington & Leigh NHS FT	Carole Hudson Neil Turner
Wigan CCG	Tim Dalton Trish Anderson

SPB 01/18 WELCOME AND APOLOGIES

Apologies were received from;

Darren Banks, Simon Barber, Steve Barnard, Julie Connor, Paul Dennett, Alan Dow, Chris Duffy, Councillor Alex Ganotis, Pat Jones-Greenhalgh, Anthony Hassall, Beverley Hughes,

Bev Humphreys, Tony Hunter, Karen James, Kevin Lee, Claire Molloy, Steven Pleasant, Councillor Sara Rowbotham, Joanne Roney, Councillor Rishi Shori, Councillor Andrea Simpson, Mel Sirotkin, Jim Taylor, Liz Treacy, Alex Whinnom, Dorothy Whitaker, Ian Williamson, Carolyn Wilkins, Ian Wilkinson and Simon Wooton.

SPB 02/18 CHAIR'S ANNOUNCEMENTS AND URGENT BUSINESS

The Chair opened the meeting and wished members of the Board a Happy New Year. He highlighted that the NHS had received a considerable amount of publicity recently as it approached 70 years of establishment along with the challenges for health and social care systems nationally from winter pressures.

Tony Oakman, Chief Executive, Bolton Council was introduced and welcomed to the Board. Thanks were placed on record for the contribution of Anne Gibbs for her joint role as Director of Delivery and Improvement, NHSI for GM and Lancashire and within the GMHSCP and was wished success in her new role.

SPB 03/18 MINUTES OF THE MEETING HELD 13 OCTOBER 2017

The minutes of the meeting held 13 October 2017 were agreed as a true record.

RESOLVED/-

To approve the minutes of the meeting held on 13 October 2017.

SPB 04/18 CHIEF OFFICER'S UPDATE

Jon Rouse, Chief Officer, Greater Manchester Health and Social Care Partnership (GMHSCP), provided an update on key items of interest across the GMHSC Partnership.

The Board were asked to note and provide feedback on the content of the revised update report that included recommendations and decisions made at the GM Strategic Partnership Board Executive meetings.

The following items were highlighted;

- NHS England (NHSE) National Commissioning Committee have given GM the ability to make decisions around most specialised mental health services. In this context, GM has agreed a delegated specilaised commissioning portfolio which has been developed in collaboration with NHSE North West specialised commissioning team. Sarah Price, Sandy Bering, Tom Tasker and the team were thanked for the significant work undertaken to develop and agree the delegated portfolio. It was highlighted that the first area of focus would be CAMHS Tier 4 provision in order to address the barriers that existed between levels of intervention for children and young people.
- There had been significant coverage of the whistleblower case and letter from clinicians at Royal Manchester Children's Hospital expressing concern with regard to staffing levels in respect of critical care for children and young people. Manchester Foundation Trust (MFT) have issued a clear statement in terms of the seriousness with which they had taken the concerns and the appropriate steps taken. The Board were reassured that in light of the Francis Report, all parties had taken the concerns

seriously and were working to ensure that the provision of care in the unit was safe and of the highest quality possible;

- It was expected that the national planning guidance for the NHS 2018/19 which set out how extra resources announced in the November budget were to be allocated would be published imminently. It was anticipated that there would be some new requirements alongside the money which would need to be reflected in the devolution accountability agreement and may need some re adjustment to targets;
- It was reported that in light of national guidance issued in relation to the potential cancellation of elective procedures and outpatient appointments, GM had adopted a proportionate approach and had only cancelled procedures where necessary to ensure the safe running of UEC departments. It was recognised that cancellations were a huge inconvenience which could cause potential stress for patients. It was anticipated that just under 14% of procedures would be cancelled in January and partnership work had ensured this had been minimised. Plans for recovery and rebooking would be scheduled as a priority over the coming months. It was also advised that if the position was to change due to winter pressures for example, then the partnership and public would be kept informed;
- A succession of Ofsted and CQC SEND inspections has highlighted that there is work to do in GM to strengthen joint arrangements between Local Authorities and CCGs to focus on the assessment and planning of an individual education, health and care plan for each child with special educational needs;
- Salford locality were commended for their remarkable improvement in quality in care homes performance. The percentage of care homes rated good or outstanding compared to last year had seen a significant level of progress;
- Steve Wilson, Executive Lead, Finance and Investment provided a six month finance position update. It was advised that the financial position for 17/18 remained challenging especially for the provider sector. This was mainly due to Pennine Care FT not expecting to meet the agreed financial plan for the year and other trusts not meeting their UEC performance, thus not allowing for the maximum Sustainability and Transformation funding allocations from NHSI;
- Dr Tracey Vell provided the Board with feedback from the delegation of representatives that had visited 10 Downing Street earlier in the week to discuss support required to roll out primary care reform at scale. The meeting with representatives from Government, Treasury and the Department of Health had provided an opportunity to demonstrate the progression made in the development reviews of the LCO's as a collective part of the accountable care system. It also presented the opportunity to highlight some of the difficulties experienced in general practice, with contracts and estates. The group had requested support and a positive narrative towards general practice, primary care and community work.

Members of the Board welcomed the update provided and asked for clarification on the progress with government with regard to capital funding which had been held up due to control totals not being agreed. It was confirmed that the Partnership continued to make representations and the latest position was that resources could be released if GM could make a commitment across the system to meeting the aggregate of the individual control totals. However, as previously highlighted in the finance update, there could be no guarantee at this stage that such a position could be met due to the current deficit against planned position.

Assurance that transformation fund allocations were being used to make the intended improvements to services along with the required checks and balances was requested by the Board. It was recognised that there was a real and present risk with regard to funding and as such built into investment agreements were clauses which ensured that the transformation funding only be used for the purposes intended along with monitoring and tracking to provide assurance.

RESOLVED/-

To note the update report and provide feedback in relation to content or omissions for future updates.

SPB 05/18 TRANSFORMATION FUND UPDATE

Steve Wilson introduced a report providing an update on recent developments with the Transformation Fund.

This month had an expanded section on the findings and recommendations from the assessment team in their evaluation of the proposals from Salford and Wigan.

The key headlines were:

- The report provided a general update on the latest developments in relation to the £450m GM Transformation Fund and contained, in detail, the findings of the Transformation Fund Oversight Group (TFOG) on 23 November, 5 December and 13 December 2017, and the decisions of the Strategic Partnership Board Executive on 14 December, where the Mental Health, Salford and Wigan submissions were considered.
- The mental health proposals allocated funding to two key elements of the GM Mental Health Strategy which supported both the development of the Children and Young Peoples Crisis Care Pathway and the Liaison Mental Health Services within GM Acute Hospitals.
- The Salford proposals supported a plan to deliver a radical upgrade in population health through stratification and needs identification, engagement and prevention. It would support people to live healthy independent lives, managing their own conditions through a community asset based approach.
- Wigan's proposals build on their phase 1 transformation fund allocation and looked to deliver a new approach to out of hospital unplanned care, a reformed housing with care offer, a place based approach to specialist mental health services and a further acceleration of the Heart of Wigan programme.
- TFOG recommended a substantive investment of £27.68m in mental health services (this is out of the total transformation fund allocation of £42m agreed by SPBE in July 2017), £3.44m investment in Salford and £15.43m for Wigan. These funding recommendations were accompanied with material conditions for the funding. Funding for all proposals was approved by SPBE subject to those conditions.

RESOLVED/-

1. Note the Strategic Partnership Board Executive's decision to:

- Approve a substantive investment in the Mental Health business case for the Children and Young People's Crisis Care Pathway of £13.44m over four years, with phasing to be set out in the Investment Agreement and paid quarterly in advance:
  - 2017/18: £0.56m
  - 2018/19: £3.89m
  - 2019/20: £4.51m
  - 2020/21: £4.48m
  - Noting that there are material conditions with funding only to be released upon their satisfactory completion. These are set out at 2.4.3.

- Approve a substantive investment in the Mental Health business case for the Liaison Mental Health Services in Acute Hospitals of £14.24m over four years, with phasing to be set out in the Investment Agreement and paid quarterly in advance:
  - 2017/18: £0.37m
  - 2018/19: £2.96m
  - 2019/20: £4.73m
  - 2020/21: £6.18m
  - Noting that there are material conditions with funding only to be released upon their satisfactory completion. These are set out at 2.4.3.

- Approve a substantive investment in Salford of £3.44m over four years, with phasing to be set out in the Investment Agreement and paid quarterly in advance:
  - 2017/18: £0.28m
  - 2018/19: £1.51m
  - 2019/20: £1.37m
  - 2020/21: £0.28m
  - Noting that there are material conditions with funding only to be released upon their satisfactory completion. These are set out at 3.3.2.

- Approve a substantive investment in Wigan of £15.43m with phasing still to be determined, set out in the Investment Agreement and paid quarterly in advance:
  - Noting that there are material conditions with funding only to be released upon their satisfactory completion. These are set out at 4.3.2.

SPB 06/18 GM HEALTH AND SOCIAL CARE PARTNERSHIP GOVERNANCE REVIEW: PROPOSALS

Jon Rouse introduced a report which set out the review of the current governance arrangements for the GM HSC Partnership and proposed a number of changes to recognise and support the Partnership's move into its next phase of delivery of Taking Charge Together.

In drawing together the proposals in the report, all key stakeholders have been consulted. In addition the recommendations from a recent NHS England Internal Audit of governance have been incorporated. The proposals were supported by SPBE at their meeting in November 2017 and have been updated to reflect that discussion.

It was highlighted that the review provided the opportunity to ensure that GM health and social care governance was fit for purpose and proposed that the current Board became more public facing and focused on impacting the determinant's of health by working across public services and beyond, including the role of the VCSE. It would develop a strong relationship with local statutory Health and Wellbeing Boards in pursuing their local strategies along with the Mayor on public service reform priorities.

The Mayor of Greater Manchester, Andy Burnham supported the direction set out in the proposals and thanked the Board for the work done so far to integrate and engage with the public service reform agenda. He highlighted the work done regarding homelessness and in doing so extended his gratitude for the implementation of the proposal to help those of no fixed abode register with a GP along with the commitment not to discharge those from hospital onto the street and the ongoing efforts to address and improve mental health outreach. The broad GM person centred focus, which concentrated on place based interventions was welcomed and fully endorsed by the Mayor.

Members of the Board offered support for the report and discussed the importance of engaging the public and by doing so recognising the need to ensure that reports are public facing providing a clear understanding of the vision and ambitions. It was recognised that it may be challenging to implement citizen led agendas, however a balance would be required to become fully engaged with the public. Acknowledgment for the role of the VCSE in the report and the opportunities to become more innovative were welcomed. The importance of recognising the public as people that may access a myriad of services rather than a patient in just a health setting was highlighted.

It was confirmed that there had been an oversight in the terms of reference for the Health and Care Board and that the broader Primary Care Advisory Group should be represented as opposed to primary care through the Local Medical Committee.

RESOLVED/-

1. To note the issues with and limitations of the current governance approach;
2. To note the high level findings from the governance audit;
3. To agree the proposed changes;
4. To note the comments from the Board with regard to the broader public service reform agenda, public engagement and a person focused place based approach;
5. To amend the Terms of Reference for the Health and Care Board with regard to primary care representation.

SPB 07/18 GM HEALTH AND SOCIAL CARE PARTNERSHIP BUSINESS PLAN 2017/18 – SIX MONTH SUMMARY

Warren Heppolette, Executive Lead Strategy and System Development, introduced a report which summarised the Health & Social Care Partnership's progress in delivering its aims for the first six months of the financial year set out in the 2017/18 Business Plan.

It was advised that there had been a number of key achievements and relatively good performance against target, however there were inevitable challenges which would require addressing.

Key highlights included;

- The proportion of children who start school ready has steadily increased. Good progress had been made in improving the oral health of children along with the co-ordination in reducing the numbers of pregnant women and their partners who smoke in GM;
- The Lung Health Check pilot introduced and focused on deprived areas has led to a significant increase in early stage lung cancer being diagnosed;
- £134m investment for mental health was one of the number of momentous steps to deliver on the commitment to improve mental health and well-being of the residents in GM;
- The rate of progress with the mobilisation and progress to develop the Local Care Organisations (LCO's) was considered to be compellingly positive in helping to deliver new models of care and support in neighbourhoods;
- The support and activity of the community learning disability teams across GM had been recognised for the progress made in supporting people with learning disabilities to live in their communities;
- In line with Mayoral priorities, an innovative housing and health programme including the commitment to tackle homelessness had been set up in GM;
- Urgent and emergency care was one of the most challenging areas where there had been significant steps to introduce stability and consistency including the introduction of urgent primary care on a 24/7 basis;
- In order to improve hospital care, the first stage of the most significant hospital merger in the country, the Single Hospital Service was completed. Progress had been made in the development of the Northern Care Alliance along with secured national funding of £93m for capital investment for Healthier Together and the development to increase capacity for major trauma services;
- The work on genomics and cancer, being led by leading world experts and the GM Cancer Board would aim to dramatically advance precision medicine in the treatment of cancer;
- £10m of funds has been assigned to a range of digital projects across localities;
- The Workforce Transformation Strategy was agreed to help address the key workforce gaps and critical shortages;

The contribution of staff working seamlessly across the system to address the challenges and pressures faced by urgent and emergency care (UEC) systems to better support patients was recognised. A member welcomed that the rate of smoking had reduced in Greater Manchester but requested that consideration be given to a report which highlighted that

younger people were taking recreational drugs as opposed to smoking which may have a future impact on mental health.

The benefits of the Tameside integrated care digital health programme were highlighted to the Board and it was suggested that a presentation to demonstrate the cost effectiveness of this model be provided to the Board.

RESOLVED/-

1. To note the six month summary update on the progress this year;
2. To note the contribution of staff working across the system to address the challenges and pressures faced by admissions to UEC;
3. To receive a presentation from Tameside locality on the digital programme.

SPB 08/18 WINTER PREPAREDNESS

Jon Rouse introduced a report which provided an overview of the winter UEC performance to date and the work undertaken by the localities and the Partnership to continue to mitigate the demands of winter and provide safe, high quality care to patients. It also set out the current challenging position of the GM system and identified the ongoing risk in relation to service delivery over the winter.

The effort, dedication and commitment of staff across health and social care was recognised and the obligation to deliver a more sustainable framework at local and national level going forward was acknowledged.

The key headlines were:

- All local and national systems have reported a much greater number of higher acuity patients, which had resulted in increased hospital admission rates. This had resulted in much higher bed occupancy rates of 95% plus. This was despite running a GM-wide 'Home for Christmas' campaign and a significant effort by systems, leading up to the festive period, to achieve 85% bed occupancy. The validated performance against the 4 hour standard for Greater Manchester was 81.5% for December, down from 86.7% in November and 89.6% in October. Having sustained at or close to the recovery target level of 90% over summer and through to end of October it is disappointing that we have been unable to hold the position as winter has set in. On a more positive to note to date, partnership work across Greater Manchester has meant that OPEL4 major incidents have been avoided and delayed discharge numbers low.
- The Greater Manchester Health and Social Care Partnership with NHSI, had continued to work very closely with localities through regular site visits, system conference calls and workshops. Additional service improvement support has continued to be provided by NHSI, the Emergency Care Improvement Programme and Advancing Quality Alliance to three systems within GM (Bolton, Stockport and North East Sector).
- The Greater Manchester UEC Operational Hub had been operational for two months and had been working with the systems to help reduce ambulance handover delays, maintain

patient flow, support escalation processes and winter reporting to the regional and national winter rooms.

- GM had received approximately £21 million of additional winter monies from the national allocations for acute, primary care and mental health services. The additional monies have been predominantly used to increase; bed capacity, clinical workforce, primary care additional access and 24/7 mental health services.
- Following the publication of NHSI and NHSE guidance on the deferral of non-urgent elective activity until the 31st January, the GMHSCP had asked each locality UEC delivery Board to consider their response to the guidance and submit a plan for January and the remainder of the financial year. Work was currently underway to understand the implications of the guidance and any deferrals in the context of devolution and the formally adopted accountability agreement, particularly around the requirement to achieve constitutional standards such as Referral to Treatment.

The capacity of the estate and workforce were highlighted as constraints that would require immediate attention to manage the pressures and demand placed on the system.

Following his visits to the Emergency Care Hub, the Mayor reiterated the views of the Chief Officer and thanked all parts of the system for working in partnership and managing the situation under increased and unprecedented levels of demand. The one system and partnership approach to working, evident after the attack at the Arena had continued across the health and care system and was commended for continually improving.

Following the guidance issued by Government on the cancellation of elective procedures, the Mayor highlighted the proportionate and balanced approach adopted by GM which illustrated the benefits of a devolved health and care system. This had resulted in fewer procedures being unnecessarily cancelled which delivered a more favorable outcome for the residents of GM.

The record number of people arriving at UEC and the ultimate admissions demonstrated that the care at home model was no longer acceptable. The increasing impact of that would have an inevitable effect on the demand placed on the system, therefore a new model of care which optimises the patient journey, like Care 2020 was considered essential.

The Chair replicated the views expressed with regard to the efforts of the workforce across GM.

RESOLVED/-

1. To note the content of the paper in relation to winter preparedness;
2. To support the delivery against the identified priority areas;
3. To note the positive comments from the Board with regard to the efforts of the workforce across the system and;

4. To note a national and local solution is required to manage the pressures of winter in a sustainable framework.

SPB 09/18 BURY CCG MEDICINES STRATEGY

Dr Kiran Patel, NHS Bury CCG Clinical Chair, GMHSC Partnership introduced a presentation which provided an overview of the Medicines Optimisation project introduced ten years ago in Bury. Two areas of focus for the project were diabetes prescribing and the national call to reduce psychotropic medicines for people with learning difficulties (LD).

The driver for the diabetes medicine optimisation project was due to the fact that Bury's prescribing spend was 21% above the England average, higher than the North West average spend and the worst 10% of English Primary Care Trusts for cost-effective statin prescribing. The programme recommended a combination of incentive payment and support, the development of a trustworthy relationship and a cost effective model along with quality improvements. The data was analysed to challenge well established views and a programme of work was developed, the outcomes of which have reduced average practice spend on statin prescribing along with good outcomes.

Collaborative work was undertaken between Bury CCG and Pennine Care NHS FT to implement the call to action by reviewing all LD patients receiving antipsychotics. As a result all people where prescribing was considered inappropriate have had reduction plans in place, and where agreed, appropriate support was provided.

Members offered support for the optimisation strategy and welcomed the balance of cost with quality and engagement across the system involving patients with treatment plans. The work of the Medicines Strategy Board to reduce wastage and the implementation of electronic patient prescribing was highlighted as being a key area of focus.

The expansion of the primary care workforce to deliver front line medicine management care was recognised as allowing GP's more time to see and treat patients. It was suggested that in order to roll out the important piece of work across localities, collaboration would be required through the GP excellence programme. The emphasis on quality as a focus to develop involvement and understanding for patients would be paramount.

RESOLVED/-

1. To note the progress to date of Medicines Optimisation in Bury;
2. To consider programme roll out across localities using the GP excellence programme.

SPB 10/18 WIGAN LOCALITY PRESENTATION

Will Blandamer, Programme Director of Health and Care Integration, Wigan Council introduced a presentation that provided an overview of the Wigan locality model which sought to improve outcomes and secure sustainable cost reduction in public service provision

through the large scale application of Wigan Deal principles across health and care and wider public services.

It was emphasised that large scale application of asset place based integrated place working for individuals and communities was core to the attainment of improving the population health and wellbeing, managing demand and reducing the cost base. It was advised that the focus of public services should be on the people who receive them and the communities in which they live and not the organisations that provide them.

In line with the GM framework, staff from different public services and agencies in the Healthier Wigan Partnership, work closely together to support residents with a shared common commitment and ambition.

Service delivery footprints built out of primary care clusters provided a focal point for new delivery models and the foundation for public service reform. This was gaining significant momentum and success as a single operating model for place based working has developed.

The best advocates to highlight the benefits already achieved of the single operating model and develop further are the staff who have expressed enthusiasm and confidence.

Members offered their support for the co-ordinated work being carried out and described it as the principle theme and aspect for the mobilisation of LCO development which was energising people at neighbourhood level. The model of public service delivery which has people at the centre was recognised as a tribute to reform. Will Blandamer was thanked for his contribution to the locality planning agenda and wished success in his new role.

RESOLVED/-

To note the progress provided and update on Wigan Locality Model.

SPB 11/18 GM COMMITMENT APPROACH TO CARERS: CARERS CHARTER AND COMMITMENT TO CARERS

Warren Heppolette, Executive Lead introduced a report which set out a commitment to carers, agreed by organisations across Greater Manchester to support the implementation of an integrated approach to the identification, assessment and meeting the health and wellbeing needs of unwaged carers; and the Carers Charter which has been developed by carers for carers and which articulates what carers across GM could expect.

The report also provided an overview of the programme of work and delivery plan being progressed to make real and embed the Commitment to Carers and Carers Charter into everyday support. It also detailed the potential ‘ask’ of partner organisations going forward to support the many carers in GM.

The background and emerging detail of the Support for Carers work programme, the key principles for supporting carers formalised through a Carers Charter and Commitment to Carers and how the offer for carers as a whole could be improved were highlighted to the Board.

Lynne Stafford, Chief Executive, The Gaddum Centre and the VCSE lead for carers provided an overview of the assistance provided by the voluntary and community sector to engage and consult with carers to feedback and design the charter through the forums that were already providing support.

David Williams, Chief Officer, Manchester Carers Forum and working carer provided a personal overview of the benefits of adopting the charter which he described as vital for the wellbeing of carers and maintenance of the essential workforce. He commended the Charter to the Board for endorsement which recognised the role of carers as partners in care provided.

The Mayor offered his support for the Charter and recognised that the development reflected the ethos of work of the Combined Authority where individuals and support organisations were involved in the development of policies. He suggested that ongoing core funding and financial support should be provided for carers organisations and the charter should be viewed as the start of the journey for carers. It was recognised that more could be done and the potential to provide carers with one point of contact to offer accountability and assurance was proposed.

The importance of the charter as new models of care are established and the potential implications and pressures on carers were highlighted. Reassurance was provided by the Chief Officer that a commitment would be made to all carers and that localities would be accountable for delivery of the charter and the commitment would be sought through the assurance framework. The challenge of funding for different cohorts was acknowledged.

RESOLVED/-

To approve and sign off the Commitment to Carers, the Carers Charter and delivery plan as appended within.

SPB 12/18 DATES OF FUTURE MEETINGS

Future meeting of the GM Health and Social Care Strategic Partnership Board are arranged as follows:

Friday 16 March 2018	10:00am – 11:30am	Council Chamber, Bury Town Hall

Friday 11 May 2018	10:00am – 11:30am	Council Chamber, Manchester Town Hall
Friday 13 July 2018	10:00am – 11:30am	TBC

GM HEALTH AND CARE BOARD

MINUTES OF THE MEETING HELD ON 16 MARCH 2018

Alzheimer's Society	Sue Clarke
Bury Council	Councillor Andrea Simpson Pat Jones-Greenhalgh
Bury CCG	Stuart North
Bolton CCG	Wirin Bhatiani
Carbon Literacy	Phil Korbel
Christie NHS FT	Tom Thorber
Dementia United	Rachel Volland
GM Mayor	Andy Burnham
GMCA	Lindsay Dunn Jamie Fallon
GM ACCGs	Rob Bellingham
GM H&SC Partnership Team	Karishma Chandaria Warren Heppolette Claire Norman Nicky O'Connor Dr Richard Preece Sarah Price Jon Rouse Vicky Sharrock Steve Wilson
GM Cancer Team	Claire O'Rourke David Shackley
GMCVO	Alex Whinnom
Healthwatch	Peter Denton
Manchester Foundation Trust	Kathy Cowell Darren Banks
Manchester Health and Care Commissioning	Ian Williamson

NW Boroughs Healthcare NHS FT	Simon Barber
Oldham Council	Councillor Eddie Moores
Oldham CCG	Julie Daines
Pennine NHS Trust	Karen Clough
Primary Care Advisory Group (Optometry)	Dharmesh Patel
Primary Care Advisory Group (Pharmacy)	Adam Irvine
Provider Federation Board	Ryan Donaghey
Rochdale MBC	Councillor Sara Rowbotham
Salford CC	Charlotte Ramsden
Salford CCG	Anthony Hassall
Salford Royal NHS Foundation Trust	Chris Brookes
SCN	Jeff Schryer
Stockport CCG	Gaynor Mullins
Stockport MBC	Councillor Wendy Wild
Tameside MBC	Councillor Brenda Warrington Steven Pleasant
Tameside NHS Foundation Trust	Karen James
Trafford Council	Gill Colbert
Trafford CCG	Cameron Ward
Wigan Council	Councillor Peter Smith (in the Chair) Stuart Cowley

Also present at the meeting was Alan Mills, to provide his experiences as a resident of GM living with dementia.

HCB 01/18 WELCOME AND APOLOGIES

Apologies were received from;

Councillor Allan Brett, Eamonn Boylan, Matt Colledge, Julie Connor, Mayor Paul Dennett, Alan Dow, Noreen Dowd, Theresa Grant, Ranjit Gill, GM Deputy Mayor Beverley Hughes,

Tony Hunter, Kevin Lee, Councillor Richard Leese, Claire Molloy, Bob Morris, Councillor John Murray, John Patterson, Jim Potter, Councillor Rishi Shori, Steve Rumbelow, Jim Taylor, Tracey Vell, Dorothy Whittaker and Carolyn Wilkins.

HCB 02/18 CHAIR'S ANNOUNCEMENTS AND URGENT BUSINESS

The Chair passed on his appreciation to the personnel mentioned in the report of the Chief Officer and thanked them for their contributions to the Health Partnership and the Board.

HCB 03/18 MINUTES OF THE MEETING HELD 19 JANUARY 2018

The minutes of the meeting held 19 January were agreed as a true record.

RESOLVED/-

To approve the minutes of the meeting held on 19 January 2018.

HCB 04/18 CHIEF OFFICER'S UPDATE

Jon Rouse, Chief Officer, Greater Manchester Health and Social Care Partnership (GMHSCP), provided an update on key items of interest across the GMHSC Partnership.

The following items were highlighted;

- It was reported that a 'devolution difference' communications and engagement campaign had been launched that week which aimed to demonstrate to staff, stakeholders and the public how health devolution was making a difference to the lives of the people of Greater Manchester. A devolution difference 'toolkit' would be available to assist staff and partners share the key messages and practical examples of successes;
- The World Health Organisation had announced that day that GM would be designated the UK's first Age Friendly City Region. Greater Manchester Combined Authority was working in partnership with the Centre for Ageing Better to develop and share innovative approaches to ageing across the city-region;
- GM had been successful in their bid to the Department for Digital, Culture Media and Sport for a significant grant to roll out fibre infrastructure. It was advised that this was fundamental for the ambition for digital interoperability and innovation within health and care. The Board were informed that this would be followed up by a bid to obtain status to become a digital care exemplar, which would attract additional resources to accelerate the interoperability of the digital system across GM;
- With regard to Urgent and Emergency Care performance, the Chief Officer paid tribute to the whole front line workforce in and out of hospital who had continued to deal with a level of unpresented demand for services which had put significant pressure on patient flow. The work at Fairfield Hospital and Rochdale Infirmary was highlighted as an example of how working together across the health and care system could produce an incredible level of performance of maintaining A and E four hour performance;
- The Care Quality Commission (CQC) report into Pennine Acute Trust (PAT) had rated them as 'requires improvement' with 'good' leadership. This had improved from the previous overall inadequate rating. Although ongoing work was still required, it was noted that all inadequate ratings had been eliminated and 70% of all services were rated as either good or outstanding which demonstrated great progress;

- The CQC report into Greater Manchester Mental Health Trust had found them 'good' overall with 'outstanding' leadership. Credit was extended to all the staff involved in the merger of Manchester Mental Health Trust with Greater Manchester West Mental Health, for recognising the opportunities and making improvements a year into the Trust acquisition;
- Steve Wilson, Executive Lead, Finance & Investment, GM Health and Social Care Partnership provided the Board with an update on the financial performance of health and social care. It was reported that the current position for 2017/18 indicated a surplus of £1.3m against a planned deficit of £17.6m. Credit was extended for all the hard work undertaken in the individual organisations across the system. It was advised that the surplus was likely to grow once CCGs released the risk reserves that had been set aside. However, the Board were reminded that significant one off items had fed into the performance and there would be challenges over the forthcoming financial years.

The Chair reiterated his credit on behalf of the Partnership to staff across the system who have worked during high levels of demand over the winter period. The emphasis of the Partnership to work together to divert patients to treatment in the community was considered fundamental to secure improvements across the system.

RESOLVED/-

To note the update report.

HCB 05/18 SCHOOL READINESS – THE HEALTH CONTRIBUTION TO EARLY YEARS

Sarah Price, Executive Lead, Population Health and Commissioning, GMHSCP introduced a report which outlined the health contribution to improving levels of school readiness in GM.

The Board were informed that good health in the earliest years of a child's life was vital to achieving the ambition of making the greatest and fastest improvement to the health, wealth and wellbeing of the 2.8 million people of Greater Manchester. There was a firm commitment to transform the system from expensive and reactive to prevention and early intervention and at no stage was this considered more important than the 1001 critical days from conception to age two years.

The report identified how health partners were working with wider partners to develop a shared co-ordinated work programme to ensure that school readiness was a key priority across Greater Manchester. It had been identified that pregnancy and birth provided a critical window of opportunity when parents were particularly receptive to advice, support and guidance.

Karen Clough, Specialist Midwife in Public Health Surveillance, Saving Babies Lives at Pennine Acute Hospitals NHS Trust supplemented this with an update on the work being done to help people to give up smoking during pregnancy.

It was reported that rates of smoking during pregnancy varied across Greater Manchester, with some of the highest rates in Pennine. For example, smoking at delivery rate in Rochdale reached 17.4 % in February, which was well above the national average of 10.8%.

An overview of the Greater Manchester smokefree pregnancy scheme called Baby Clear which would enable women to access specialist help for their smoking addiction was provided to the Board. It was advised that the Greater Manchester approach was on a larger scale than projects delivered before, was research backed and based on changing the culture around smoking in pregnancy. Throughout, the consistent message would be, that smoking in pregnancy would result in ill health for mother and baby.

It was believed that with the expertise of staff, enthusiastic leadership, funding and the commitment that the GM smokefree pregnancy scheme provided, a real difference to smoking rates in pregnancy could be achieved. This could ultimately improve the health of women and families and would have long term impacts on the health of future generations, giving children in Greater Manchester the very best start in life in a smoke free environment.

Members offered their support for the report and the Baby Clear programme but highlighted the constraints of resources and the financial sustainability across localities for the vital programme of work. It was agreed that cuts to local government budgets made the implementation of the programmes difficult. However, new monies allocated from the transformation fund allowed investment into such programmes often in the most deprived communities. The Board were provided with an update on the digital fund and it was reported that funding had allowed for the role out of mobile technology for health visitors which had enabled them to work more efficiently providing more time to support families. However, due to controls totals for both Tameside and Stockport not being agreed with NHS Improvement, access to capital funding for such investment was not available in those areas which was thus having a direct impact on families. Lobbying for access to discretionary capital, regardless of individual agreement on control totals would continue for those areas and be supported by the Partnership.

A member asked for clarification that the Baby Clear programme was only focused on tobacco smoking or included e cigarettes and vaping products. It was confirmed that at this stage tobacco related smoking was the primary focus.

The appetite for water fluoridation for the region in order to have the biggest impact on dental health inequalities was discussed and it was suggested that although it was a significant cost, it was a challenge that the Chair was keen to support and lead on.

The Chair offered support for the strategy but requested further information has to how the strategy would deliver the behaviour change required. It was suggested that the voluntary and community sector were utilised in order to influence behaviour change where possible. It was proposed that further information was requested from the GM School Readiness Board as to how the strategy would be implemented across the ten localities and in the service delivery areas where this would make a difference across the Partnership.

RESOLVED/-

1. To note the content of the report and commit ongoing support to the ambition to increase the number of children who are school ready in GM;
2. To continue to lobby NHSI and Central Government on the accessibility of discretionary capital for all localities;
3. To provide further consideration to fluoridation across the region;
4. To request further details from the GM Schools Readiness Board on the implementation of the health contribution to school readiness.

HCB 06/18 CHILDREN AND YOUNG PEOPLE MENTAL HEALTH PROGRAMME UPDATE

Simon Barber, Chief Executive, North West Borough Health Care and Chair of the Children and Young Peoples Mental Health Implementation Board provided an overview of the delivery to date of the Children and Young Peoples Mental Health Programme. It was reported that one in ten young people have a diagnosable mental health condition and 75% of adult mental illness begins before the age of 18. The Greater Manchester mental health ambitions, the achievements and the programme priorities for 2018-21 were outlined to the Board. Key reforms which included mental health leads in every school, new teams to support schools to meet mental health needs and shorter waiting times to get help and the deliverables were highlighted.

A video clip from a patient's story demonstrating the community eating disorder service was presented providing an insight into the collaborative work having an impact across GM. The service was developed on the core values of the thrive model which provided help, advice and the support required.

The Mayor of Greater Manchester welcomed the pace of the GM Mental Health Children and Young People Programme, but highlighted the importance of ensuring that consideration was provided to the voice of young people and their call for a curriculum for life. It was suggested that the Youth Combined Authority were invited to be involved in the development of the model outlined and highlighted that mental health was central for the wider life advice for children and young people. He further added that there should be specific connections to the wider life readiness agenda being developed and clear commitments to care leavers and young carers with regards to mental health.

In support of the programme, members reiterated the comments made by the Mayor with regard to children, young people and their parents being involved in the development of the pathways to ensure that a child friendly approach is adopted. It was highlighted that looked after children are often placed in boroughs where they have not originated from, it was recommended that this vulnerable group continue to receive the correct support and attention wherever they live. It was confirmed that the looked after children cohort were included within the whole programme and in particular with regard to the implementation of the crisis care model.

The Board welcomed the key reforms proposed with regard to support for schools and asked if there would be additional resources allocated alongside training. It was advised that training would be provided prior to any additional funding that maybe announced in the forthcoming Green Paper which would allow GM to be in a better placed position.

As localities faced increasing substantial financial challenges and new models of care were developed, innovative ways to engage the voluntary sector in the programme was emphasised as significant. Furthermore, the connection of models across the GM footprint and the sharing of best practice operating in districts was considered to be necessary. It was advised that the successful models implemented in localities would be developed to deliver single service specifications and consistency across GM.

The Board considered the role of technology and the growing body of research and evidence that suggested that social media impacted on the health and wellbeing of young people. It was proposed that further consideration and connections were made with the digital strategy

to ensure that the acceleration of the digital agenda did not have further bearing on the health and wellbeing of young people.

A member representing the voluntary sector provided the Board with reassurance that there had been a considerable level of engagement with young people, particularly with Children and Adolescent Mental Health Services commissioning and the work undertaken with young carers. There was a further offer of support from Healthwatch networks to help to develop the emerging agenda of mental health support for transition between Children's and Adult's services. The Board were informed that the voluntary sector and national charities had been engaged and were key partners in the delivery of all the identified workstreams.

It was confirmed that young people had assisted in the development of the programme and had provided consideration to the language used prior to implementation. Further engagement with the Children and Young People's Mental Health Implementation Board was being considered in order to provide an effective interface to monitor and provide an understanding as to whether programmes were beginning to make a difference to children and young people.

In welcoming the report, the Chair suggested the Children and Young People's Mental Health programme should be considered by the Youth Parliament. He reiterated the comments made by the Board with regard to the role of the voluntary and community sector.

RESOLVED/-

1. To note the progress update provided;
2. To note the comments from the Board with regard to continued children, young people, parental and carers involvement in service delivery and communication;
3. To provide the Children and Young People's Mental Health programme to the Youth Parliament for consideration and comment.

HCB 07/18 DEMENTIA UNITED

Anthony Hassall, Chief Operating Officer, Salford CCG provided the Board with an update on the Dementia United programme. It was highlighted that Dementia United continued to be a priority for Greater Manchester and the opportunities and developing work plan to mobilise a strategy and system response for people living with dementia and those who care for them aligned to the GM dementia standards was outlined in the report.

Anthony introduced Alan Mills, Sue Clarke and Dr Jeff Schryer to the Board and in doing so described them as being the important people to provide a view of the work being done to meet the strong commitment made to make GM the best place to live in the world with dementia. It was reiterated that there was a strong commitment to co design by involving those living with dementia, their carers, the voluntary sector and clinicians working in the field. Credit was extended to Sir David Dalton who had initiated the programme of work in GM.

An overview of the facts, aims of the programme, the journey so far and further work plan development was outlined to the Board. Alan Mills, who had been diagnosed with early on set dementia and Alzheimer's provided members with his experiences as a resident of GM living with dementia. He outlined the emotional and peer support that people with dementia required and described the variations offered at the specialist centres that perform further diagnosis and memory tests.

Sue Clarke from the Alzheimer's Society supplemented this by explaining that she had worked in the field of dementia over the last ten years across GM. She emphasised that people are more aware of the issues which those who have been diagnosed with dementia are living with and further encouraged members of the Board to provide support.

Dr Jeff Schryer, a GP in Bury provided an overview of the unique way in which Dementia United were working in partnership with people who suffer from dementia and their carers to help develop pathways. He provided an example of the work across the health and social care system and explained how it was making a difference to service delivery and provision.

The Chair thanked the individuals for the collective presentation which highlighted the exciting work underway to support people living with dementia. The Mayor of GM, reiterated his appreciation and acknowledged that support for people with dementia needed to be provided as well as the support delivered to people with cancer. He reflected that it had been confirmed that GM was the first UK's city region to be receive age friendly status by the World Health Organisation, which reaffirmed the strength of plans and vision. He suggested that the focus should be on age friendly rather than the dependency in order to achieve the full potential. It was confirmed that £1 million of funding had been announced by Sport England to promote physical activity for older people along with a GM Festival of Ageing on 2-15 July 2018, funded by the Heritage Lottery. It was emphasised that the language around contribution rather than dependency was important to the wider sense of maximising people's independence.

The Board were provided with an insight into the scheme introduced at Super League side Wigan Warriors reaching out to supporters with dementia and helping to tackle loneliness in the community. The club had set up a Rugby Memories group where fans of the team meet up once a week to watch an old game and reminisce about the glory days.

RESOLVED/-

1. To note the content of the report and proposed engagement with GM governing groups and localities;
2. To endorse the direction of travel;
3. To note the positive appreciation from the Board for the powerful presentation;
4. To note the announcement that GM was the first UK city region to receive Age Friendly status;
5. To note the announcement by Sport England that £1m of funding would be available to promote physical activity for older people;
6. To note the GM Festival of Ageing on 2-15 July 2018.

HCB 08/18 UPDATE ON CANCER WORK

Dr Richard Preece, Director of Quality, GMHSCP introduced a report which provided the Board with an update on cancer work across the Greater Manchester network. The report provided an overview, key data with associated commentary and outlined future priorities. The 2017 Report of the Greater Manchester Cancer Board, published in February 2018 which outlined many of the signature programmes in more depth was appended to the report.

It was reported that good progress was being made against the targets described in the 4-year GM Cancer Plan of Feb 2017 and also the cancer related aspects of the NHS planning guidance. The current highest priorities related to delivering accelerated pathways in lung,

colorectal, prostate and upper gastrointestinal cancer, alongside specific additional work in lung cancer, and delivery of the recovery package.

David Shackley, Medical Director and Claire O'Rouke, Lead Nurse, Greater Manchester Cancer supplemented the report with an overview of the highlights from the previous year and the forthcoming priorities from a professional perspective and progress for patients. Members were encouraged to attend the first GM Cancer Conference scheduled for 26 November 2018.

In welcoming the report the Chair acknowledged the work of the GM Cancer Board and the impressive achievements made in a short space of time.

RESOLVED/-

1. To note the progress made across the GM Cancer system;
2. To endorse the current approach and priorities;
3. To note the encouragement for members to attend the GM Cancer Conference on 26 November 2018.

HCB 09/18 HEALTHWATCH IN GREATER MANCHESTER – PROGRESS UPDATE

Peter Denton, Healthwatch Liaison Manager, Healthwatch in Greater Manchester introduced a report which provided an update of the first year of the GM Liaison function and identified development areas for Healthwatch for the coming year.

The report highlighted the statutory functions of local Healthwatch, particularly in terms of its role in assessing the quality of health and care services and in supporting community engagement.

It was reported that local Healthwatch priorities had been mapped against GM Health and Social Care plans. It was noted that Healthwatch priority activity with the Partnership was closely aligned with implementation of the Mental Health Strategy; Theme 3 Standardisation of Acute Hospital Services activity; and supporting effective engagement in the development and implementation of locality plans.

It was confirmed that Healthwatch had secured representation on a range of the Partnership's governance boards for both Mental Health and Theme 3 as well as at a strategic level. Healthwatch had also developed a process of aggregating patient, service user and carer feedback to inform its role on the GM Quality Board.

RESOLVED/-

1. To receive and note the contents of this report;
2. To reaffirm support for all members of the Partnership to work collaboratively with Healthwatch both at locality and Greater Manchester levels.

HCB 10/18 CARBON LITERATE HEALTH AND SOCIAL CARE – SALFORD LOCALITY PRESENTATION

Charlotte Ramsden, Strategic Director for Community, Health and Social Care, Salford City Council introduced a presentation on behalf of Councillor John Merry, Deputy City Mayor, Salford Council. The Board were provided with an overview of the impact of the Boxing Day

floods in 2016, with regards to adopting a commitment to become more carbon literate and responsible.

The Board were informed of the collective work to develop the opportunity across health and social care to become carbon literate and the ambition to make Greater Manchester one of the leading green cities in Europe. It was advised that to help realise these ambitions, a landmark Green Summit would be held on 21 March 2018.

Phil Korbel, Director Carbon Literacy Project described the added value in engaging people to participate in carbon literacy in order to prevent harm and promote well-being. The scale of the challenge in GM to obtain zero emissions by 2038 in response to the Paris Agreement was highlighted to the Board.

It was advised that Salford CCG would be the first carbon literate NHS organisation. Anthony Hassall informed members that Salford CCG would take forward the issue of carbon literacy and the impact of pollution across GM health and social care providers and CCG's.

The Mayor highlighted the opportunities from a health and economic perspective and encouraged organisations to make a pledge at the Green Summit. The individual benefits for organisations in terms of savings along with an overview of the GM plastics campaign to eliminate single use plastics was provided to the Board.

RESOLVED/-

1. To note the update provided;
2. To note the drive to eliminate single use plastics in GM;
3. To provide further consideration as individual organisations to making a pledge in advance of the Green Summit.

HCB 11/18 DATES OF FUTURE MEETINGS

Friday 11 May 2018	10:00am – 12:00 noon	Council Chamber, Manchester Town Hall
Friday 13 July 2018	10:00am – 12:00 noon	Council Chamber, Trafford Town Hall
Friday 14 September 2018	10:00am – 12:00 noon	Number One Riverside, Rochdale Council

Item 03

MINUTES OF THE GREATER MANCHESTER JOINT HEALTH SCRUTINY COMMITTEE HELD ON 10 JANUARY 2018 AT GMCA, CHURCHGATE HOUSE

Present:

Bolton Council	Councillor Shafaqat Shaikh
Bury MBC	Councillor Sarah Kerrison Councillor Annette McKay
Oldham Council	Councillor Colin McLaren
Stockport MBC	Councillor Laura Booth
Tameside MBC	Councillor Gillian Peet
Trafford MBC	Councillor Patricia Young
Wigan Council	Councillor John O'Brien (Chair)

Also in attendance:

Derbyshire County Council	Councillor Linda Grooby Jackie Wardle
GMCA, Governance Officer	Lindsay Dunn
GMCA, Scrutiny Officer	Susan Ford
GM H&SC Partnership	Stephen Dobson Warren Heppolette Janet Wilkinson
Wigan, Wrightington & Leigh NHS Trust	Andrew Foster

HSC/01/18 WELCOME AND APOLOGIES

It was noted that Councillor Sara Rowbotham (Rochdale BC) had been appointed as Rochdale's Cabinet Member for Health and Wellbeing and will no longer represent Rochdale on the GM Joint Health Scrutiny Committee. On behalf of the Committee, the Chair thanked Sara for her role and contribution to Health Scrutiny and wished her success in her new appointment. Furthermore, he requested that a letter be sent to Councillor Rowbotham by the Governance and Scrutiny Team, GMCA to that effect. It was noted that Rochdale Council are in the process of

reviewing their appointments to various Committees and would identify a Member for GM Joint Health Scrutiny imminently.

Apologies were received from Councillor Margaret Morris (Salford) and Steven Pleasant.

HSC/02/18 DECLARATIONS OF INTEREST

There were no declarations of interest made in relation to any item on the agenda.

HSC/03/18 MINUTES OF THE MEETING HELD 8 NOVEMBER 2017

The minutes of the meeting held 8 November 2017 were presented for consideration. It was noted that Councillor Linda Grooby (Derbyshire CC) and were also in attendance at the meeting.

RESOLVED/-

To amend the attendance to reflect the above and approve the minutes of the meeting held 8 November 2017.

HSC/04/18 HEALTH AND CARE WORKFORCE

Andrew Foster, Chief Executive, Wrightington, Wigan and Leigh NHS Foundation Trust provided Members with an overview of the workforce challenges facing health and social care.

He explained that the main reasons behind the 'workforce crisis' were due to the impact of austerity and the result of staff planning decisions made almost seven years ago. The Committee were informed that the impact of changing these decisions would take time to take effect.

As Chair of the GM Strategic Workforce Board, Andrew explained that staffing and recruitment decisions amongst NHS Trusts varied across GM and Members could raise specific concerns at their local health scrutiny committee.

Janet Wilkinson, Director of Workforce, Greater Manchester Health and Social Care Partnership (GMHSCP), introduced a presentation which provided the Committee with an update on health and care workforce in GM. Examples of the key national workforce shortages in health and social care were highlighted and it was noted that although GP vacancy rates had not been included, there was a shortage nationally and there had been an increase in vacancies.

It was noted that GM had similar workforce issues to the UK as a whole but had a clear view on where those challenges existed. However, a heat map which would highlight where the greatest problems existed across GM will be produced for consideration by the Committee.

Members were informed that forecasting suggested that the health and social care sector in GM needed approximately 17,000 people a year which was largely driven by replacement of staff rather than expansion of the sector. Manchester and Salford were predicted to need the highest numbers of workers over the next two decades, while requirement in Trafford and Rochdale would be smaller. The Committee were drawn attention to specific current and predicted future workforce shortages highlighted in the health and social care labour market intelligence report.

The key workforce risks and measures to address them were detailed in the presentation. It was noted that once data had been gathered by NHS Trusts, further analysis would be required to monitor the possible workforce implications of Brexit. However, Trusts had already reported that there were less applications from EU countries. It was reported that a primary care workforce lead would be recruited in early 2018 to assess if there are similar challenges for the primary care workforce.

Data obtained as a result of the urgent emergency care (UEC) workforce deep dive analysis exercise carried out in July 2017 across GM providers was presented. It highlighted that there was almost a 24% vacancy rate across middle grades and almost 18% of agency staff utilised, this was considered a significant issue at this grade. It was noted that this was the first time this data had been collected across GM and the key priorities to address UEC workforce challenges were detailed for the Committee. Members were informed that there were plans to include local urgent and emergency care performance data alongside this to correlate performance and against workforce analysis.

Andrew Foster provided an overview of the international recruitment programme Learn, Earn and Return, which would contribute to provide a solution to the middle grade gap. It was noted that the programme commenced fourteen years ago as a small project with an intake of 20 and it was anticipated that 125 trainees, mainly from India, would take place in 2018. The Committee were informed that the relationship benefited both the UK as it helps to fill vacancies quickly and the doctors themselves who would gain access to high quality training and a unique skills set. The doctors who access the scheme include those who have completed basic training but are still learning specialist skills and have yet to qualify as a consultant.

The importance of pastoral care both within the workplace and socially for the international trainees was described as being imperative to ensure low attrition rates. It was noted that GM is leading nationally with the recruitment programme which had received backing from Health Education England along with international support.

Members welcomed the update provided and asked if data would be available on how many non-British nurses were employed per NHS Trust across GM. Janet Wilkinson confirmed that the data for this would be collected for the Committee.

The Chair asked what positive action would be taking place to retain locally trained medical graduates. Andrew Foster highlighted the Greater Manchester Mayoral Manifesto's commitment to support graduates from a Greater Manchester university on a clinical course, by helping with student loan repayments for every year that they commit to working in Greater Manchester's NHS.

The Committee discussed the ongoing organisational challenge for the NHS of balancing the need for more staff (because of increased demand) within the context of financial austerity.

Members asked if the overseas recruitment could be expanded to include other countries in addition to India. Officers informed the Committee that whilst Indian nationals were the largest single group of overseas employees, nationals from other countries were also a valued part of the NHS workforce.

The Committee discussed the impact of the nursing bursary reforms and the inevitable reduction of mature applicants to the profession. It was confirmed that older applicants had decreased and a meeting later in the month had been arranged between the directors of nursing to discuss the issues which were having an impact which included childcare, housing and travel costs. It was also noted that male nurses were underrepresented in the NHS and a detailed action plan that would focus on the recruitment of male and mature nurses in GM would be developed.

A member of the Committee asked if those women affected by the change in the state pensions age had been identified in GM and were being considered as a potential area of focus for recruitment. Andrew Foster summarised the return to work scheme and it was confirmed that a focused piece of work was underway to recruit from different groups which were representative of all communities including black and minority ethnic (BME). The role of volunteers alongside the health and social care workforce was also described as being invaluable.

With regard to the pastoral care of overseas trainee doctors, a Member asked if there would be adequate resources available to provide the same level of mentoring and support given the increased intake. It was confirmed that other NHS Trusts across GM would be supporting the programme in order to offer assistance and provide continuity.

A Member raised issues with regard to the increasing cost and numbers of agency workers, the impact this had on staff morale and what was being done to attract them into permanent roles. Andrew Foster highlighted that resourcing the NHS nationally and locally with staff working overtime and from agencies in the short term was common place to meet routine demand. He confirmed that there were no on costs associated with agency workers, however standard agency costs were capped nationally at 55%. Furthermore, this was less of an issue in nursing, however agency doctors on the middle grade can cost double or triple the amount of staff who are permanently employed by an organisation.

A member raised the issue of the shift rota system which sometimes did not allow employees with families to adequately plan childcare arrangements. Janet Wilkinson, advised that good employers would ensure that an adequately in advanced rota system was planned well in advance to enable employees to put in place childcare arrangements.

Members asked how rigorously information was captured from those leaving the NHS. It was confirmed that this area required further development and highlighted the need to undertake leadership management investment in GM.
The impact of off-payroll working through an intermediary rule, known as IR35 was raised and it was advised that the effect for doctors and those employed in Information Management Technology were greater than for nursing.

The Committee highlighted that solutions to the address NHS workforce issues needed to be considered on a medium to long term basis. The requirement to work alongside Housing Associations and Local Authorities to alleviate housing problems was also raised. The Chair requested to receive further information on the workforce gaps at locality level along with an update on the impact of Brexit and incentives to attract underrepresented groups into for nursing.

RESOLVED/-

1. To note the content of the presentation;
2. To provide further information on the implications on staffing in the health and social care sector for Greater Manchester as Brexit negotiations develop and;
3. To agree that comparable data by locality be analysed and presented, including a heat map, to the Committee in March 2018;
4. To agree that data for primary care, once available, be incorporated and reported back to the Committee in due course;
5. To provide further analysis of the key recruitment gaps locally;
6. To provide details of the development framework to attract individuals and underrepresented groups into nursing.

HSC/05/18 DIGITAL PATIENT STRATEGY

Stephen Dobson, Chief Digital Officer, GM Health and Social Care Partnership provided the Committee with an overview of the GM Digital Patient Strategy. The broad outline of the types of cross organisational data sharing for direct care and for disclosing directly with patients was detailed in the presentation. Alongside this, examples of the benefits for information data sharing across organisational and regional boundaries were highlighted to the Committee.

Members were advised that the vision of a GM unified architecture was to create a single common platform for health, social care and local public services to securely share data to deliver seamless and integrated services for the benefit of citizens. GM digital collaborative had been working with GM Connect to develop a GM universal architecture for its Interoperability Hub that would include the ability to scale to the wider public sector.

The Committee were provided with detail of the GM Interoperability Hub which included the architecture required to share patient data along with a technical view of data services and current capabilities in GM.

It was reported that the Office for Life Sciences through its Life Science Industrial Strategy had introduced the concept of Innovation Hubs and that it was expected that there would be 3-5 innovation hubs across England which provided GM with the opportunity to apply for funding. An overview of the relationship between the Interoperability and Innovation Hubs was described. It was reported that Innovation Hubs would source much of their data from Interoperability Hubs and they would be important for research and partnership with academia and industry.

The Committee welcomed the update provided and discussed the funding requirements for the overall implementation of the strategy. Stephen Dobson reported that GM had received £10m of Digital Transformation Funding with an expectation of further announcements.

Whilst it was generally accepted that changes in IT systems would be challenging and costly, a Member pointed out that lessons needed to be learned from past failures of implementing the NHS patient record system. Members requested information on funding required and the timescales for implementation. It was noted that further information on funding would be obtained in July and an update on this and the progress made could be provided to the Committee in September.

RESOLVED/-

1. To note the update provided;
2. To note the feedback and comments from the Committee;
3. To agree to receive an update on funding and progress of the Digital Strategy in September 2018.

HSC/06/18 GM JOINT HEALTH SCRUTINY COMMITTEE WORK PROGRAMME 2017-18

Consideration was given to the GM Joint Health Scrutiny draft work programme for 2017-18. In addition to the items noted in the document, Warren Heppolette, Executive Lead Strategy and System Development, GMHSCP suggested the Committee may be interested in receiving updates on the implementation of the following transformational changes;

- The establishment of Local Care Organisations (LCO's);
- The creation of the new commissioning system including the integration of the single commissioning function;
- The future role of hospitals in GM with an update on the collaboration of acute trusts.

It was also suggested that the Committee received a copy of the six month update report on the GM Health and Social Care Partnership Business Plan to be presented to the Board in January.

Members were in agreement and suggested that an overview on the physical estate for co-located teams would be useful to share across localities. Warren recommended that an update on the GM Estates Strategy would provide the Committee with scope to review on a GM footprint and agreed to co-ordinate the report for consideration.

RESOLVED/-

1. That the work programme be updated to include a future update on the establishment of LCO's, the creation of the new commissioning system and the future of hospitals in GM;
2. To circulate a copy of the GM Health and Social Care Business Plan 2017/18 six month update to the Committee;
3. To receive an update report on the GM Estates Strategy at the March meeting.

HSC/07/18 DATES OF FUTURE MEETINGS

The GM Joint Health Scrutiny Committee will next meet on Wednesday 14 March 2018.

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Meeting of:

Joint Health Overview and Scrutiny Committee for Pennine Acute Hospitals NHS Trust

Date: 13th March 2018

Present:

Councillor Roy Walker (Bury Council)
Councillor Stella Smith (Bury Council)
Councillor Joan Davies (Manchester City Council)
Councillor Colin McLaren (Oldham Council)
Councillor Sarah Kerrison (Bury MBC)
Councillor John McCann (Oldham MBC)
Councillor Ann Stott (Rochdale MBC),
Councillor Linda Robinson (Rochdale MBC),
Councillor Norman Briggs (Oldham MBC)
Councillor Kathleen Nickson (Rochdale MBC)

Jack Sharp: Director of Strategy Salford Royal and Pennine Acute
Jo Purcell: Deputy Director North East Sector, Salford Royal and Pennine Acute
Dr Shona McCallum: Medical Director, Salford Royal Pennine Acute NHS Trust
Moneeza Iqbal: Clinical Service Strategy, Programme Director, Salford Royal and Pennine Acute NHS Trust
Dean Hambleton-Ayling: Associate Director of Workforce Salford Royal and Pennine Acute NHS Trust
Ms Julie Gallagher: Principal Democratic Services Officer

Apologies: Councillor John Farrell (Manchester City Council),
Councillor Shaukat Ali (Manchester City Council),

PAT. 17/18-18 APOLOGIES

Apologies were detailed above.

PAT.17/18-19 DECLARATIONS OF INTERST

There were no declarations of interest.

PAT.17/18-20 PUBLIC QUESTIONS

There were no public questions.

PAT.17/18-21 MINUTES AND MATTERS ARISING

It was agreed:

That the minutes of the meetings held on 3rd October 2017 be approved as a correct record.

PAT 17/18-22 NORTH EAST SECTOR ACUTE SERVICE STRATEGY

Jack Sharp: Director of Strategy and Moneeza Iqbal: Clinical Service Strategy, Programme Director, Salford Royal and Pennine Acute NHS Trust attended the meeting to provide members with a further update in respect of the North East Sector Acute Service Strategy. An accompanying report had been circulated to elected members in advance of the meeting which contained information in respect of the following areas:

- Drivers and objectives for the NES Acute Service Strategy
- Impact of the Locality Plans
- Where we are up to?
- National guidance and learning
- What should our evaluation criteria be?

The Programme Director reported that the primary focus will be to improve the quality of care as well as, continuing to address the CQC findings, whilst at the same time delivering on Healthier Together reconfiguration.

Questions were invited from those present and the following issues were raised:

In response to a Member's question, the Director of Strategy reported that recruitment continues to be a problem in the Trust. Vacancies exist across a range of disciplines and this is in part due to national shortages. The way staff work and how services are delivered will need to change.

The Programme Director reported that the strategy excludes North Manchester General Hospital, the Northern Care Alliance will continue to have responsibility for the hospital until the transaction is completed.
The Strategy will need to be consistent with the CCGs commissioning intentions in Bury, Rochdale and Oldham.

The Director of Strategy reported that work is underway in respect of communicating with the public with regards to the proposed changes, including the development of the northern care alliance, the disaggregation of NMGH as well as changes in each Borough in respect of the development of the Local Care Organisations.

Members discussed the evaluation criteria including which options are clinically sustainable; implementable; accessible; the right strategic fit and financially sustainable.

It was agreed:

1. Jack Sharp: Director of Strategy and Moneeza Iqbal: Clinical Service Strategy, Programme Director, Salford Royal and Pennine Acute be thanked for their attendance.
2. That members agreed that the evaluation measurable criteria for the North east sector strategy will be patient outcomes and access to care.

PAT 17/18-23 CARE QUALITY COMMISSION UPDATE

Jo Purcell, Deputy Director, North East Sector attended the meeting to provide Members with an update in respect of the recent re-inspection of the hospital and subsequent inspection report issued on the 1st March 2018.

The Deputy Director reported that significant improvements have been made across every hospital within the Trust since its last inspection in 2016 with 70% of the aspects of the services inspected now rated as either "Good" or "Outstanding".

There are now no longer any services across the Trust rated inadequate and the overall Trust rating is "requires improvement".

The CQC identified ten areas of notable outstanding practice and commended the Trust for the introduction and implementation of the nursing and accreditation system across all sites.

The ratings for each hospital and community service are as follows: NMGH, requires improvement; Royal Oldham, requires improvement; Fairfield General, Good; Rochdale Infirmary, Good; Community services, Good. The Trust was rated as Good for caring as well as being well lead.

Responding to a Member's question, the Medical Director reported that one of the biggest factors in improving the CQC Trust ratings was the transfer to a system of site management, with a Medical Director onsite.

PAT 17/18-24 WINTER PRESSURES UPDATE

Dr Shona McCallum, Medical Director, Bury and Rochdale attended the meeting to present an overview of the winter pressured faced at Fairfield General Hospital, Bury. The presentation contained

information in respect of the number of attendances, averaging over 200 a day and performance against the A&E four hour target.

Dr McCallum reported that a Bury System Leaders Forum has been established weekly, as well as 7 day working and speciality in-reach for Frail Elderly patients.

The Medical Director reported that the Trust had effectively prepared for potential pressures; all elective surgery for orthopaedics, Ear nose and throat had been cancelled thus enabled medical staff to provide additional support in A&E and on the wards.

Most services have been operational seven days a week in order to deal with the increase in patient traffic. The Medical Director reported that as a result of the effective planning put in place to tackle the winter pressures, NWAS diverted a greater number of ambulances to the Fairfield site.

In response to a Member's question, the Medical Director reported that the winter pressures experienced at the hospital were in part due to patients attending with long term and complex conditions coupled with a number of usually healthy, younger patients attending with severe flu symptoms.

The Medical Director reported that a number of patients required ventilation, additional beds were opened to accommodate this as well as an extra 52 ward beds.

It was agreed:

The Joint Committee's thanks be passed on to all the staff working across the Northern Care Alliance during this very difficult period.

PAT 17/18-25 STAFF UPDATE

Members of the Joint Committee considered an update report in respect of the ongoing staffing challenges within the Trust.

The report provide an overview of the numbers of staff in post, agency, sickness and staff turnover.

The Associate Director of Workforce reported that the current vacancy rates for Medical and dental staff and nursery and midwifery staff is 12.21% and 11.30% respectively. The Trust spent almost £38 million on agency staff in the last 12 months. The monthly staff sickness level is slightly above the national average.

In response to a Member's question, the Associate Director of Workforce reported that there is significant shortages in some specialisms including emergency medicine. This problem has been

exacerbated by work visa changes at the Home Office (Doctors and Nurses are classed as a non-shortage area). This has prevented some doctors obtaining a visa, this has affected 44 Doctors across the Northern Care Alliance.

The Associate Director of Workforce reported that a primary focus for the Trust is retention and recruitment. As the Northern Care Alliance expands and becomes a single Trust, including Salford Royal this will create a number of career development opportunities within the organisation.

Responding to a Member's question, the Associate Director of Workforce reported that the Trust is currently reviewing its staffing skills mix. Trainee nurse assistants and physican associates who take less time to train could be able to assist in areas where recruitment is problematic.

In response to a Member's question, the Associate Director reported that resilience training is being developed to assist staff.

It was agreed:

1. Further update reports in respect of staffing will be presented at future meetings of the Joint Committee.
2. The Associate Director of Workforce would provide updated information in respect of the percentage spend as part of the overall budget that is agency spend.
3. As well as clarification with regards to the high levels of management spend at North Manchester General Hospital

PAT 17/18-26 URGENT BUSINESS

There was no urgent business reported.

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HEALTH AND WELL BEING BOARD
23/01/2018 at 2.00 pm

Present: Councillor Moores (Chair)
Councillors Chauhan and Price

Carolyn Wilkins OBE	Chief Executive
Jon Rouse	Chief Officer, GM health and Social Care Partnership
Dr Zuber Ahmed	Oldham CCG
Jax Effiong	Manchester Fire
Michelle Bradshaw	Bridgewater Trust
Julie Daines	CCG
Neil Evans	Chief Superintendent, Greater Manchester Police
Kirsty Fisher	Healthwatch Oldham
Vinny Roche	FCHO
Maggie Kufeldt	Executive Director - Health and Wellbeing
Mark Warren	Director, Adult Social Care
Ben Gilchrist	Voluntary Action Oldham
Keith Jeffery	Oldham CCG
Majid Hussain	Lay Chair Clinical Commissioning Group (CCG)
Rebekah Sutcliffe	Place and Thriving Communities
Donna McLaughlin	The Pennine Acute Hospitals NHS Trust

Also in Attendance:

Katrina Stephens	Interim Director of Public Health
Charlotte Stevenson	Interim Director of Public Health
Oliver Collins	Principal Policy Officer
Sian Walter-Browne	Constitutional Services

1 **ELECTION OF CHAIR**

Councillor Moores was elected as Chair for the duration of the meeting.

2 **APOLOGIES FOR ABSENCE**

Apologies for absence were received from Councillor Dearden, Councillor Harrison, Councillor Heffernan, Jon Aspinall, Stuart Lockwood, Dr John Patterson, Liz Windsor-Welsh.

3 **URGENT BUSINESS**

There were no items of urgent business received.

4 **DECLARATIONS OF INTEREST**

There were no declarations of interest received.

5 **PUBLIC QUESTION TIME**

No public questions were received.

6 **MINUTES OF PREVIOUS MEETING**

RESOLVED that the minutes of the meeting of the Health and Wellbeing Board held on 12th December 2017 be approved as a correct record.

7 **MINUTES OF THE HEALTH SCRUTINY SUB-COMMITTEE**

RESOLVED that the minutes of the meeting of the Health Scrutiny Sub-Committee held on 19th December 2017 be approved as a correct record.

8 **ACTION LOG**

RESOLVED that the Action Log for the Health and Wellbeing Board meeting held in December 2017 be noted.

9 **MEETING OVERVIEW**

RESOLVED that the meeting overview be noted.

10 **GM DEVOLUTION UPDATE**

The Board gave consideration to a report and presentation for Jon Rouse, Chief Officer, GM Health and Social Care Partnership, that updated them on the progress made against the key outcomes outline in the Taking Charge Plan and discussed some of the key challenges both Greater Manchester and Oldham faced.

The Board was reminded that, in February 2015, the 37 NHS organisations and local authorities in Greater Manchester signed a landmark agreement with the government, to take charge of health and social care spending and decisions in our city region.

The Board were informed that Greater Manchester had the fastest-growing economy but not the healthiest population. The report set out the main goal - to see the greatest and fastest improvement to the health, wealth and wellbeing of the 2.8 million people in the towns and cities of Greater Manchester.

The Strategic Plan: Taking Charge of Health and Social Care in Greater Manchester (the Plan), set out the collective ambition for Greater Manchester over the next five years and complemented work done over the last ten years on reforming and growing the city region. The Plan was for five years and covered four major areas, as well as setting out key targets to be achieved by 2021.

Programmes and projects were being prioritised and there was reconciliation at local level through the Locality Plan. The Board acknowledged that there were major community contributions in

Oldham and there may need to be a focus on different ways of procuring services to enable voluntary organisations

RESOLVED that the update and the challenges and opportunities faced in Greater Manchester and in Oldham be NOTED.

11 **OLDHAM CARES - OUTCOMES FRAMEWORK**

The Board gave consideration to a report from the Joint Acting Directors of Public Health and a presentation from the Chief Executive which described the development of the Oldham Cares Outcomes Framework and set of supporting key indicators.

The outcomes framework and approach to developing a set of key indicators was presented for consultation and discussion, and the Board was asked to agree next steps in its development. It was explained that a clear focus on outcomes would dictate what was done and how it was done. If there was failure in a particular area, this would be identified quickly so that something else could be done.

The Board noted that an early draft of the outcomes framework had been presented at the Health and Wellbeing Board development session in June 2017.

The Board were informed that the Oldham Cares outcomes framework set out a range of high level outcomes based on the key changes desired in Oldham over the next decade. These would be the headline outcomes for Oldham Cares, which the whole system would work together to deliver, in order to improve the health of the population and the way the local health and social care system operated. These outcomes would inform commissioning priorities and performance management.

For each of these outcomes there would be a range of supporting indicators against which targets could be set, and achievement of the outcome demonstrated. The indicators would reflect the priorities and partners would be held to account if they were not meeting them.

Work by PWC to support the development of the approach suggested that the outcomes frameworks should be made up of:

- High level ‘outcomes’ which were the overarching results of impact on improving health and wellbeing and transforming the delivery of care. They reflected service user/patient outcomes as well as clinical and transformational objectives;
- Outcome indicators which were a range of specific measures that demonstrated the achievement (or not) of an outcome measure

Priority indicators would be identified for the Board to oversee and the other indicators would be subject to an assurance report, with regular reviews to ensure the current indicator set

was the correct one. The indicators considered by the Board would be subject to change as priorities changed.

The Board noted that decisions could be made in many different places and the process of decision-making may need to be mapped to show what decisions were made where.

RESOLVED that:-

1. The high level outcomes for Oldham Cares be agreed.
2. The proposed approach to developing the set of supporting indicators and associated targets be agreed.
3. The next Board meeting would receive a further report on the supporting indicators for the outcomes framework.

12 **STATE OF THE SECTOR IN OLDHAM**

The Board gave consideration to a report from the CEO and DCEO Action Together that provided information about the strengths, challenges, and development needs of Oldham's Voluntary, Community, Faith and Social Enterprise sector (VCFSE).

The Board were informed that the VCFSE played a critical part in reducing health inequalities and developing more prevention and self-care support across Oldham and its communities of geography and identity.

Action Together had commissioned Sheffield Hallum to undertake a review of the VCFSE in Oldham. The review highlighted ten key facts about the VCFSE sector in Oldham and demonstrated in monetary value the contribution it made and the strengths it had. It also highlighted the fragility of some parts of the sector and the need for strategic engagement and investment with the VCFSE sector.

The data showed there were approximately 1231 VCFSE organisations working across Oldham. 43% worked to improve health and wellbeing (including mental health) and 41% provided practical community development support to build and strengthen communities and reduce isolation. 87% of these organisations had an annual income of less than £10k and many were very tiny. Between them the organisations undertook 1.8 million interventions per year, which made a huge impact on the Oldham community.

The Board were informed that mapping work had begun to identify what was available from the voluntary sector and where the gaps were, to enable planning to take place to commission to sustainably fill the gaps. The sector would be involved in this asset mapping.

The Board acknowledged that the voluntary sector contributed a huge amount to the Oldham community in both the assistance it offered to the community and the opportunities offered to volunteers.

RESOLVED that:-

1. The contents of this work and significance to delivery implications and opportunities for the transformation of health and social care services in Oldham, in particular with regard to the Thriving Communities Programme be noted
2. The development of a strategic investment framework for the VCFSE be noted.

13 **OLDHAM'S STRATEGIC SELF-ASSESSMENT TO GM ON REFORM AND INTEGRATION**

The Board gave consideration to a report of the Assistant Chief Constable which informed them that Oldham had been asked to complete a Strategic Self-Assessment by Greater Manchester of where it believed it was in reforming and integrating services to deliver better outcomes for people and places. Oldham had taken the opportunity to internally assess and challenge its approach and was currently part way through this process.

The initial assessment had taken place and was presented along with a draft action plan. The views and action plan were in the process of being tested with partners before the final assessment and action plan were submitted to Greater Manchester by the 31 March 2018.

The Board were informed that the self-assessment process had considered mechanisms and processes. In Oldham there were other issues such as trust and relationships that were very important.

RESOLVED that Board members would send their comments to Rebekah Sutcliffe.

14 **MENTAL HEALTH OFFER IN OLDHAM**

The Board considered a report from the Senior Commissioning Business Partner, NHS Oldham CCG which provided them with an overview on the Mental Health work stream of the Local Care Organisation and the service offer in Oldham.

The Board were informed that 'Mental Health is Central to Good Health' was one of four transformation areas identified in the Oldham Locality Plan and it was hugely important that there was a coherent strategic and transformational approach. The Integrated Care Organisation would be responsible for the planning and provision of mental health services, ensuring treatment and prevention pathways were in place.

The Locality Plan highlighted the need to commission mental wellbeing programmes and interventions across shared budgets between the CCG, Council and other partner organisations, with a mutual interest and an incentive to make savings for reinvestment,

The report set out a series of improvement areas, against each of which were specific projects with timescales for delivery and recognised inter-dependencies with other ICO work streams. The Board were provided with updates on major projects and noted a series of measures that had been put in place to achieve improvement the available offer.

The Board noted that investment in mental health would have positive returns across other services and it was necessary to provide easy pathways to obtaining help.

RESOLVED that:-

1. The report be noted.
2. The Board would receive updates on the Improvement areas and associated projects in the future.

The meeting started at 2.00 pm and ended at 4.10 pm

Actions from the March meeting of the Health Scrutiny Subcommittee

	Agenda Item	Resolution / Action	Outcome of Action
March	**URGENT PRIMARY CARE**	RESOLVED that: 1. The update on the future model on urgent primary care in Oldham be noted. 2. An update on the timeline for implementation be brought to the next meeting of the Health Scrutiny.	
	INTEGRATED CARE ORGANISATION	RESOLVED that: 1. The update and progress made in the development of the Integrated Care Organisation be noted. 2. A further update be received by the Health Scrutiny Sub-Committee in the new Municipal Year.	An update on the Integrated Care Organisation is scheduled for the September meeting of Health Scrutiny
	BRIDGEWATER NHS TRUST	RESOLVED that: 1. The update on the implementation of the Right Start Service, Performance reporting and the impact of the CQC inspection findings on the Right Start Service be noted. 2. The annual summary be reported to Health Scrutiny in June 2019. 3. A summary of figures for the 2018 be circulated as part of the Work Programme at the meeting in July 2018.	The next update has been added to the sub-committee's long term forward plan The 2017/18 end of year report isn't yet available to be shared with the committee. As soon as this is produced it will be shared with the committee members for consideration

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Agenda

Oldham Health Scrutiny Subcommittee

3rd July 2018
6pm – 8pm
Crompton Suite, Civic Centre, Oldham

No	Item	Time
1-12	Appointment of Chair, Apologies, Declarations of Interest, Urgent Business, Public Question Time, Minutes of Previous Meeting, GM Health & Social Care Partnership Minutes, GM Joint Health Scrutiny Minutes, Joint Health Overview and Scrutiny Committee for Pennine Care Foundation Trust**,** Health and Wellbeing Board Minutes, Action Log, Meeting Overview	6.00pm
Items for Discussion		
13	**Mayor's Healthy Living Campaign** *Cllr Javid Iqbal, Mayor of Oldham* For the sub-committee to receive an update on the Mayor's Healthy Living Campaign.	6.05pm *15 mins*
14	**Urgent Care Strategy** *Donna McLaughlin* For the sub-committee to receive and discuss the Oldham Urgent Care Strategy	6.20pm *30 mins*
15	**Air Quality** *Rosie Barker, Service Development & Support Manager (Waste Management), Oldham Council* For the Board to discuss the progress made in both Oldham and at GM to address poor Air Quality.	6.50pm *30 mins*
16	**Pennine Acute CQC Inspection** *Nicola Firth, Interim Chief Officer / Director of Nursing of Oldham Care Organisation* For the Board to receive an update as to the progress of the Peninne Acute Trust following the recent re-inspection by the Care Quality Commission, and to discuss	7.20pm *30 mins*
17	**Council Motions** *Chair* For the sub-committee to receive an update on the progress of Health related Council motions.	7.50pm 10 mins
18	**Health Scrutiny Forward Plan 2018/19** *Chair*	8.00pm
	Close Chair	

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BRIEFING TO HEALTH SCRUTINY

Report Title: Mayors Healthy Living Campaign
Report Author: Oliver Collins
Date: 3rd July

Background:
Each year, the Mayor is approached to see whether they have any particular areas of health and wellbeing they would like to actively support and raise awareness of during their term in office.

For 2018/19, Cllr Javid Iqbal will be the Mayor of Oldham. The mayor has committed to supporting physical activity, with a particular focus on walking.

"Im a member of a walking group called the Kramblers [Kashmir Ramblers], we have over 400 members across the UK of all ages, gender and community. Come whatever the weather our Kramblers are out walking every Sunday, walking approximately 10-15 miles on each trip… 'If you are free on a Sunday, look out for the group's walks and let's get Oldham walking"

The Mayor is to be supported by Euey Madden, the Council's Principal Greenspace Manager, who currently manages and develops the walking offer within the borough.

The aim will be to raise the awareness of already existing, or establish new local community led walking groups, aimed at getting those who do no or very little physical exercise started in an easy and local community setting.

The Health Scrutiny committee will be kept updated through the year as to the activity the Mayor has been involved in to promote healthy living in the borough.

Recommendations to Health Scrutiny

Health Scrutiny sub-committee is asked to note the update and support the Mayor during his time in office

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Oldham Urgent Care Strategy: 2017/18–2020/21

LOGO & Pictures

Date	Version	Discussion/ Amendment
		Vision strategy agreed
2nd March	Draft	Task and finish group
8th March	Draft v2	Urgent Care Board for comments
9th March	Draft v3	Update with data requirements
	Draft v4	
	Draft v5	
26th March	Draft v6	Updated with data
9th April	Draft v7	Updated section 2.8 and 2.15/Submitted to UCDB
11th April	Draft v8	Updated data in section 2.2
2nd May	Draft v8.1	Updated whole document by DM
9th May	Draft v9	Updated Mental Health section, gtd input, table of contents and table of figures
29th May	Draft v9.1	Further general updates
	Draft v10	Amendments
12th June	Draft v11	Amendments

Acknowledgements

With thanks to Worcestershire and Croydon CCGs, South Devon & Torbay CCG, Sheffield City CCG on whose document/template this strategy is derived from.

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Executive Summary

Nationally, urgent or unplanned care leads to at least 100 million calls or visits each year, representing around a third of NHS activity, and accounts for more than half the costs (*NHS England, 2013*).

The purpose of the Urgent Care Strategy is to set out, in a single document, our future plans for commissioning and developing urgent care across Oldham to ensure it is effective, affordable and sustainable. Whatever the urgent need is, and in whatever location, our aim is to ensure that our population has access to the best care from the right person in the best place and at the right time.

The strategy document sets out and defines our vision and strategic aims for urgent care in Oldham. It includes a detailed description of current services including activity, quality and performance. The strategy finishes by describing commissioning principles, priorities for system change, defining 'what good looks like' to drive outcomes-based commissioning and suggested metrics for monitoring system change and development.

Strategic Aims:
1. To provide better support for self-care.
2. To help people with urgent care needs get the right advice in the right place, first time.
3. To provide highly responsive urgent care services outside of hospital, so people no longer choose to queue in A&E.
4. To ensure that those people with serious or life-threatening emergency care needs receive treatment in centres with the right facilities and expertise in order to maximise chances of survival and a good recovery.
5. To connect all urgent and emergency care services together around place (population of 30-50k) so the overall system becomes more than just the sum of its parts. (Integration and

The primary drivers are to:

- Achieve 91% towards the 95% 4 hour wait standard by March 2019
- Reduce A&E attendances by 24% by 2021
- Reduce non-elective admissions by 14% by 2021

A high level outcomes framework has been agreed to define 'what good looks like'. This is shown in the diagram below and will be developed further to encourage all providers to work together to meet shared aims.

High level outcomes

Oldham cares
Health and social care partnership

A. Healthy Population		B. Effective prevention, treatment and care		C. Service quality/health of the system	
A1.	Children have the best start in life	B1.	People dying early from preventable causes	C1.	Access to the right care at the right time.
A2.	Thriving communities which promote, support and enable good physical and mental health and wellbeing.	B2.	Find and treat people with undiagnosed conditions	C2.	Individuals and families have the best experience possible when using services.
A3.	Individuals and families are empowered to take control of their health.	B3.	Support people to self-manage and self-care where appropriate	C3.	Individuals and families have access to high quality treatment and care.
A4.	Everyone has the opportunity and support to improve their health and wellbeing, including the most disadvantaged.	B4.	Ensure mental health is central to good health and as important as physical health	C4.	Health and care system is financially sustainable.

Our priorities for change across the urgent care system over the next three years are:

- Move to a more proactive management of long term conditions and those at risk of hospitalisation by taking a population approach
- More actively promote self-care and make it much easier for patients to access high quality, reliable information and services
- Ensure primary care – in hours and out of hours services – is the service of choice for patients to meet their urgent care needs
- 111 direct booking into the 7 Day Service
- Develop options locally for patients to access an "urgent care hub" in each GP Cluster with enhanced skills to manage long term conditions and cases which currently present to hospital.
- Continue to reduce ambulance conveyance rates
- Develop community pharmacies into urgent care providers
- Reduce ED attendance rates and 999 calls for urgent conditions
- For urgent mental health care, achieve parity with physical health care
- Develop a paediatric urgent care pathway, at cluster level
- Develop a frail elderly urgent care pathway dovetailed with a population health approach to falls prevention at cluster level
- Consider prioritisation of services by need to tackle health inequalities
- Create a business intelligence platform to analyse and understand the impact of the wider determinants of health at a neighbourhood level.

This will be underpinned by our principles:

- *See individuals and their communities as assets and move to a more proactive, rather than reactive, urgent care system.*
- *Provide consistently high quality and safe care, across all seven days of the week.*
- *Be simple and guide good, informed choices by patients, their carers and clinicians.*
- *Provide access to the right care in the right place, by those with the right skills, the first time.*
- *Be efficient and effective in the delivery of care and services for patients.*
- *Ensure services are financially and clinically sustainable.*

1. Introduction

1.1 Purpose

The purpose of the urgent care strategy is to set out, in a single document, our future plans for commissioning and developing urgent care across Oldham. Whatever the urgent need is and in whatever location, our aim is to ensure that our population has access to the best care from the right person in the best place and at the right time.

The strategy document sets out and defines our vision, strategic principles and aims for urgent care in Oldham. It includes a detailed description of current services and including activity, quality and performance. The strategy finishes by describing commissioning principles, priorities for system change, defining "what good looks like" to drive outcomes based commissioning and, suggested metrics for monitoring system change and development.

The strategy links to the Oldham Locality Plan for Health and Social Care Transformation 2016-2021 approved by the CCG and Oldham Health and Wellbeing Board in August 2016. Oldham is a co-operative borough, with a strong history of working together, a place where everyone is encouraged to do their bit to create a confident, prosperous and ambitious place to live and work.

But deprivation, poor housing and the legacy of heavy industry have led to health that is generally poorer than England as whole, life expectancy which is shorter and stark health inequalities. We've already done a great deal to improve the situation and address health inequalities but it is recognised that we will need a step change to achieve even the national averages.

Greater Manchester Health Devolution has seen the region take charge of £6bn in health and social care spending at a time when services are facing growing financial and service pressures. To give impetus, Greater Manchester received an extra £450m transformation funding, and £21.4m of this has been secured by Oldham. Change is well underway across organisational boundaries to help ensure we make the greatest impact and make every penny count.

To deliver this change we have formed **Oldham Cares**. The Oldham Cares banner brings together everything that keeps local people healthier for longer and reduces health inequalities:

- A single commissioning function for health and social care in Oldham
- An alliance of providers of Oldham's health and social care services
- Oldham's voluntary, community and faith organisations
- The wider Oldham public as residents, patients and carers

The Oldham Cares ethos is that health and wellbeing are best produced co-operatively – with us all doing our bit to take better care of ourselves and those around us, and protect the health and care services we all hold dear.

Oldham Cares isn't another organisation – it's a whole system approach to improving health and quality of life; and delivering high quality, joined-up health and care services now and in the future. It's not just about organising and delivering services better; it's about the role we all have to play in looking after ourselves and those around us:

> **#ourbit** Working together to ensure you receive the health and social care you need, when and where you need it

#yourbit Leading a healthy and active lifestyle, looking after each other and using the right services responsibly

#result Sustainable health and social care, now and for the future

Oldham Cares will only succeed with the active participation of local people in caring for themselves and those around them.

In producing the strategy, we are mindful of the strategic direction set by the Urgent and Emergency Care Review, led by Professor Sir Bruce Keogh (NHS England, 2013). The review examined how the NHS organises and provides urgent and emergency care services in England, recognising that across the country, hospital services that support and sit behind A&E and ambulance services are under intense, growing and unsustainable pressure. The review set out proposals for a fundamental shift in how and where the NHS meets urgent and emergency care needs.

The Five Year Forward View (NHS England, 2014) identifies the importance of transforming urgent care over the next five years including much better support for self-care, breaking down barriers between services, new care delivery models, much better integration between urgent and emergency care services, and strengthening and investing in primary care. All these aspects of change feature in the strategy.

The 2018-19 planning guidance emphasised the need to refocus on the 4 hour standard with milestones of September 2018 for the achievement of 90% and for all providers to achieve 95% by end of March 2019. This strategy describes our approach to implementation of these national strategies within our local context.

1.2 What is urgent care?

'Urgent care' is largely without an agreed definition however we offer the following definition for the purpose of the strategy.

Urgent Care is the range of healthcare services available to people who need medical advice, diagnosis and/or treatment quickly and unexpectedly for needs that are not considered life threatening. (Immediate or life threatening conditions, or serious injuries or illnesses, would normally be deemed emergencies).

It is important in terms of patient contacts and resources; nationally, urgent or unplanned care leads to at least 100 million calls or visits each year, representing around a third of NHS activity, and accounts for more than half the costs (NHS England, 2013).

This strategy is predominantly focused on *urgent* care, using the definition above. Within scope is consideration of the following service areas:

- Self-care
- NHS 111
- Primary care – in and out of hours
- Walk in services /Urgent care centres
- Community pharmacy
- Mental health services
- Community services

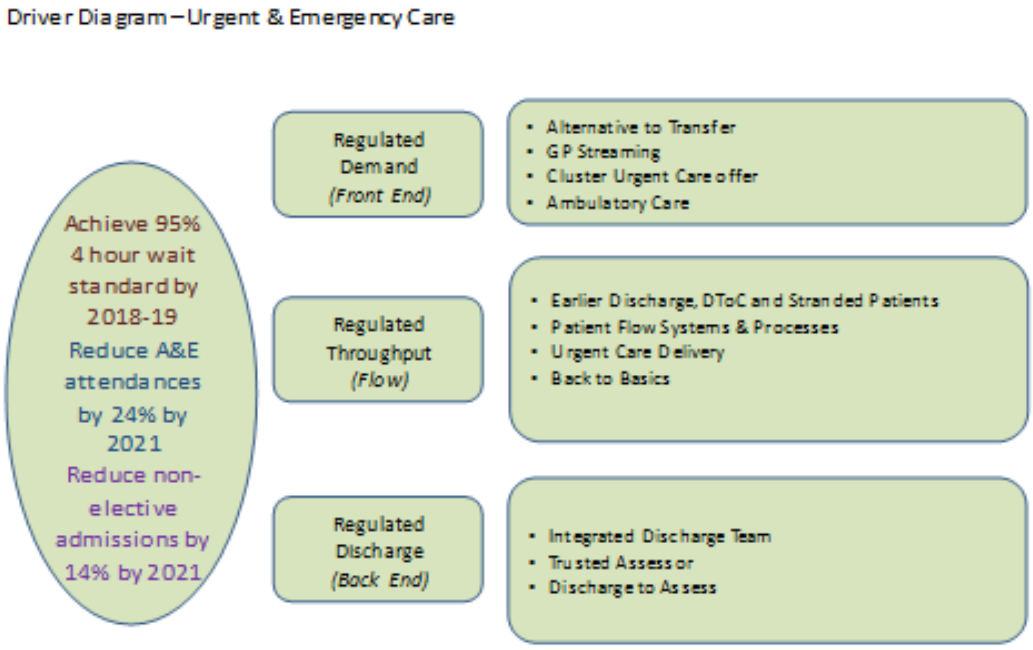
We have also included the following 'emergency' services, acknowledging that at present a number of patients will use these services to meet urgent rather than emergency care needs, and this has an impact on the way the services are able to operate.

- 999
- A&E

'Emergency services' not in the scope of the strategy are trauma and major trauma services and admitted patient care including surgery and intensive care.

Locally, the Oldham Urgent Care Delivery Board agreed a more detailed schematic of this vision, as described in the driver diagram shown in figure 1.

Figure 1



NB: It should be noted that since this driver diagram was developed, a revised trajectory has been agreed for achieving the 95% 4 hour wait standard and Oldham is now aiming to reach 91% by March 2019.

1.3 Principles/objectives

The principles describe HOW we intend to work, whereas the strategic aims identify what we will be doing. The principles for good urgent and emergency have been described in the U&EC review and will be adopted locally.

Services should:

- *Provide consistently high quality and safe care, across all seven days of the week.*
- *Be simple and guide good, informed choices by patients, their carers and clinicians.*
- *Provide access to the right care in the right place, by those with the right skills, the first time.*
- *Be efficient and effective in the delivery of care and services for patients.*
- *Ensure services are financially and clinically sustainable.*

The national Urgent Care Review defined a number of patient focused objectives for system change, following a national patient engagement and consultation process. These will be incorporated into our priorities for change and tested out for during our consultation:

- *Services to be place-based and connected to people through and with the communities they live in.*
- *Make it clear how I or my family/carer access and navigate the urgent and emergency care system quickly, when needed.*
- *See our communities, patients their families/carers as assets*
- *Provide me or my family/carer with information on early detection and options for self-care, and enable me to manage my acute or long-term physical or mental condition.*
- *Increase my, or my family/carer's, awareness and publicise the benefits of 'phone first'.*
- *When my need is urgent, provide me with guaranteed same day access to a primary care team that is integrated with my GP practice and my hospital specialist team.*
- *Improve my care, experience and outcome by ensuring the early input of a senior clinician in the urgent and emergency care pathway.*
- *Wherever appropriate, care for and treat me where I present (including at home and over the telephone).*
- *If it's not appropriate to care for and treat me where I present, take or direct me to a place of definitive treatment within a safe amount of time; ensure I have rapid access to highly specialist care if needed.*
- *Ensure all urgent and emergency care facilities can transfer me urgently, and that the transport is capable, appropriate and approved.*
- *Real time information, essential to my care, is available to all those treating me.*
- *Where I need wider support for my mental, physical and social needs ensure it is co-ordinated and available.*
- *Each of my clinical experiences should be part of a programme to develop and train clinical staff and ensure development of their competence and the future quality of services.*
- *The quality and experience of my care should be measured and acted upon to ensure continuing improvement.*

1.4. Strategic aims

There are five strategic priorities for system change which are derived from the Urgent & Emergency Care Review and supported by the CCG through this strategy.

> *1. To provide better support for self-care.*
> *2. To help people with urgent care needs get the right advice in the right place, first time.*
> *3. To provide highly responsive urgent care services outside of hospital, so people no longer choose to queue in A&E.*
> *4. To ensure that those people with serious or life-threatening emergency care needs receive treatment in centres with the right facilities and expertise in order to maximise chances of survival and a good recovery.*
> *5. To connect all urgent and emergency care services together around place (population of 30-50k) so the overall system becomes more than just the sum of its parts. (Integration and transformation)*

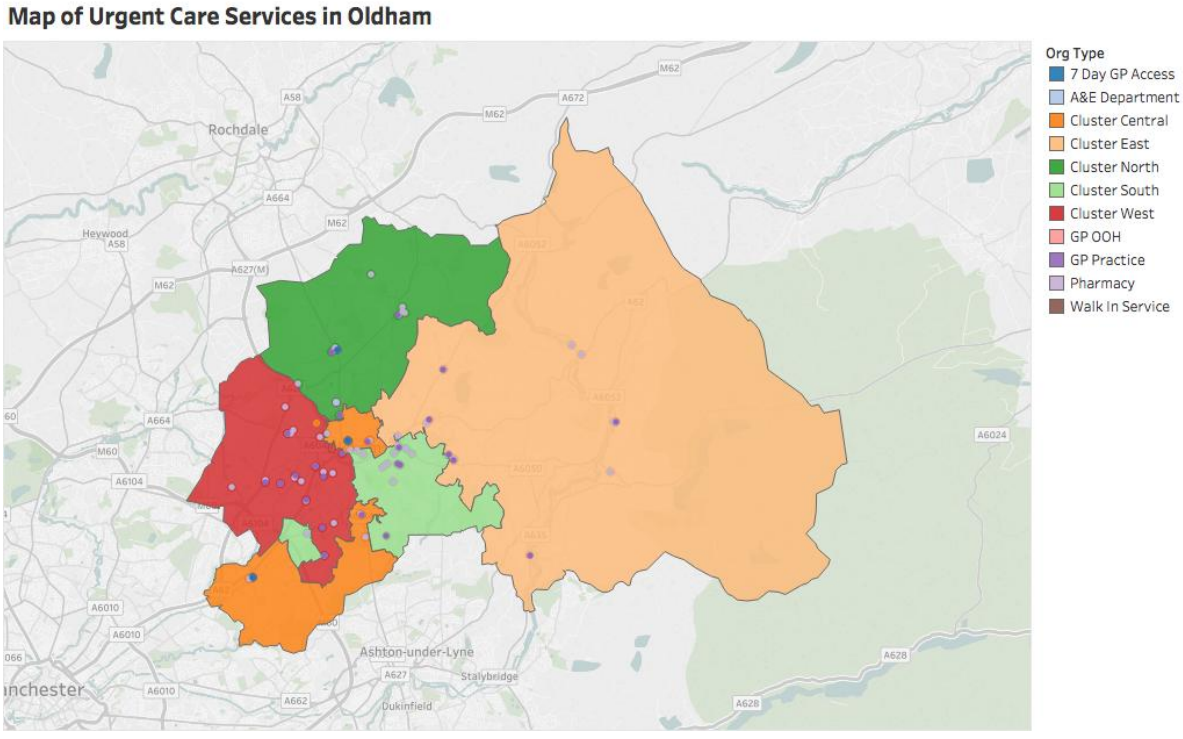
Better support for people to self-care can be achieved by providing better and more available information about self-treatment so that people can manage their situation with more confidence. A second component of support for self-care focuses on comprehensive and standardised care planning. The role of the voluntary sector is important and we will need to understand in more detail the nature and scope of these services.

It is important to help people with urgent needs get the right advice in the right place at the right time, *first time*. The NHS 111 service will develop further to ensure prompt access to high quality health advice and referral to appropriate services. Responsive urgent care services outside of hospital will ensure that people no longer need to choose to attend A&E. These services will incorporate pharmacy, primary care, new urgent care centres and mobile treatment maximising the role and contribution of each to reduce A&E attendance. The new 'urgent care centres' will provide access to walk-in minor illness and injury services and be part of wider primary care services including out-of–hours GP services and cluster offers. The Royal Oldham Hospital (ROH) under the newly introduced levels of hospital emergency department has been designated a high acuity site and a trauma unit. Although out of the remit of this strategy, it needs to be acknowledged that ROH will begin to see a shift in population who use this hospital as acute services are re-located from other North East Sector sites. Finally, all urgent and emergency care services will need to connect together to ensure the system is more than a sum of its parts. Ideally this will be through place based working with teams connected to local communities at 30-50k population size (cluster).

2. The current urgent care system

This section is intended to provide a 'service map' of the urgent care services currently in Oldham. It includes self-care, NHS 111, community pharmacy, primary care (in and out of hours), walk-in services, A&E, 999 ambulances, mental health and community services. Each service is described and relevant activity, quality and performance information shown where available. The current urgent care system in Oldham is complex, with a number of providers running different services. This does need to be simplified and this strategy aims to achieve this. The services are shown by location on the map in figure 2.

Figure 2 – Urgent Care Services in Oldham



- 51 pharmacies with 9 open 100 hours/week, plus 8 additional 'distance selling' pharmacies without a 'walk-in' option.
- 44 GP practices (reducing to 43 due to a merger)

- 7 day GP access – evening and weekend appointments at Failsworth, Royton and Integrated Care Centre (ICC)
- One GP out of hours service, (delivered by gtd healthcare) based at the Royal Oldham Hospital
- One NHS 111 urgent medical advice service
- One Walk in Service (WIS) based in the ICC
- One 999 ambulance service
- One Accident and Emergency (A&E) department

2.1 Self-care

NHS resources which support self-care include the NHS Choices website (www.nhs.uk), which has a wealth of information on conditions and treatments. It includes the 'symptom checker', which is also available in app form, and allows users to check symptoms if they are feeling unwell and to get an assessment and information about their illness and advice on what to do and where to go. NHS 111 can provide support and advice for self-care, as well as signposting patients to the most appropriate health service if applicable. In Oldham, working in partnership with a local GP practice and urgent care providers, the Urgent Care Alliance supported a self-care service (branded 'Stay Well'). Referrals from GP practices are managed in line with the Unplanned Admissions DOS.

As part of the Thriving Communities pilot in Holts and Lees, a community asset register has been developed which enables GPs and the wider primary care teams to proactively encourage self-care by accessing the voluntary sector.

2.2. NHS 111

North West Ambulance Service (NWAS) has been running Oldham NHS 111 since September 2013.
NHS 111 is a national initiative. It is a free to use telephone number that has been introduced to make it easier for patients to access local health services. The number should be used when there is an urgent medical need but the condition does not warrant a 999 call. It is available 24 hours a day, 365 days a year. In Oldham, those requiring a GP out of hours need to call 111.

When patients call 111 they are assessed by trained call handlers who are supported in their role by clinicians. The call handlers and clinicians will then provide healthcare advice and direct people to the relevant local service that best suits their needs. If an emergency ambulance is required then this will be arranged automatically during the call. The table below breaks down calls to the 111 service during 2017 by age and shows activity levels by 1,000 population. Rates are broadly similar to the rest of Greater Manchester.

Figure 3 – 111 calls by age

Calls by age and per 1000 population to the Oldham 111 service (Jan-Dec 2017)

Callers Triaged by Age	15 and Under	16 to 65	65 and Over	Total	Calls per 1,000 Population
January	1,256	1,986	790	4,032	17.92
February	1,136	1,558	622	3,316	14.74
March	1,188	1,678	583	3,449	15.33
April	1,149	1,848	787	3,784	16.82
May	1,046	1,739	617	3,402	15.12
June	859	1,584	612	3,055	13.58
July	1,006	1,737	713	3,456	15.36
August	814	1,699	685	3,198	14.21
September	930	1,690	677	3,297	14.65
October	1,342	1,831	629	3,802	16.90
November	1,223	1,704	645	3,572	15.88
December	1,548	2,057	848	4,453	19.79
2017 Total	**13,497**	**21,111**	**8,208**	**42,816**	190.29
% Breakdown	**32%**	**49%**	**19%**	**100%**	

Figure 4 – 111 calls by quality measure

Calls by Quality Measures and compared to Northwest region

Caller Treatment	Calls Triaged	Caller terminated call during triage	Callers who were identified as repeat callers	Triaged Patients Speaking to a clinician	Patients Warm Transferred to a Clinician Where Required	Patients Offered a Call Back Where Required	Call Backs in 10 Minutes
January	4,032	293	98	711	237	474	208
February	3,316	286	70	616	173	443	148
March	3,449	274	71	670	203	467	173
April	3,784	253	80	674	200	474	186
May	3,402	228	49	625	196	456	127
June	3,055	199	61	575	181	394	151
July	3,456	270	106	647	208	439	168
August	3,198	215	88	609	206	403	158
September	3,297	244	85	638	215	423	159
October	3,802	287	81	668	178	490	169
November	3,572	252	95	651	204	447	202
December	4,453	316	114	716	177	539	193
2017 Total	**42,816**	**3,117**	**998**	**7,800**	**2,378**	**5,449**	**2,042**
% Breakdown	**100%**	**7%**	**2%**	**18%**	**30%**	**70%**	**37%**
2017 Total for NW Region	**1,319,897**	**109,706**	**38,482**	**259,102**	**78,086**	**181,016**	**71,494**
% Breakdown	**100%**	**8%**	**3%**	**20%**	**30%**	**70%**	**39%**

Figure 5 – 111 calls by outcome

Calls by Outcome (Jan-Dec 2017)

Referrals Given	Calls Triaged	Ambulance Despatches	Attend A&E	Primary and community care	Recommended to Attend Other Service	Not Recommended to Attend Other Service
January	4,032	625	315	2,383	83	626
February	3,316	513	284	1,833	87	599
March	3,449	942	267	2,017	90	583
April	3,784	564	302	2,243	77	598
May	3,402	530	310	1,958	67	537
June	3,055	514	299	1,701	60	481
July	3,456	563	357	1,863	65	608
August	3,198	557	318	1,760	71	492
September	3,297	567	337	1,805	73	515
October	3,802	627	351	2,169	79	576
November	3,572	660	269	2,053	48	542
December	4,453	684	323	2,680	105	661
2017 Total Oldham	**42,816**	**7,346**	**3,732**	**24,465**	**905**	**6,818**
% Breakdown	**100%**	**17%**	**9%**	**57%**	**2%**	**15%**
2017 Total for NW Region	**1,415,897**	**209,870**	**119,815**	**811,476**	**34,178**	**240,558**
% Breakdown	**100%**	**15%**	**8%**	**57%**	**2%**	**17%**

Figure 6 – 111 calls by ethnicity

Oldham 111 Callers by Ethnicity (Jan-Dec 2017)

Callers Triaged by Ethnicity	White	Asian or Asian British	Black or Black British	Chinese	Mixed	Other	Not Collected	Total
January	2,758	889	35	4	114	48	184	4,032
February	2,357	658	21	1	91	30	158	3,316
March	2,420	707	17	1	74	53	177	3,449
April	2,643	794	29	3	110	35	170	3,784
May	2,317	750	27	1	70	36	201	3,402
June	2,194	567	31	3	76	30	154	3,055
July	2,364	763	35	4	93	39	158	3,456
August	2,287	622	18	4	82	26	159	3,198
September	2,282	723	26	2	67	36	161	3,297
October	2,570	894	20	2	100	43	173	3,802
November	2,447	833	26	3	78	38	147	3,572
December	3,026	1,049	45	7	127	44	155	4,453
2017 Total	**29,665**	**9,249**	**330**	**35**	**1,082**	**458**	**1,997**	**42,816**
% Breakdown	**69.3%**	**21.6%**	**0.8%**	**0.1%**	**2.5%**	**1.1%**	**4.7%**	**100%**
Oldham Ethnic breakdown (2011 census)	77.5%	18.1%	1.2%	0.3%	Mixed + other 2.9%			100%

A higher proportion of Asian/Asian British people registered with Oldham GPs use the 111 helpline than live in the borough (21.6% of total callers compared to 18.1% of the Oldham population). A lower proportion of White people contacted the 111 helpline in 2017 compared to the proportion who live in the borough (69.3% compared to 77.5%).

Key message
Self-care should be the first recourse for patients. It is difficult to assess how our community self-manage their care. Intuitively, there is the potential to empower our communities to make greater use of their own assets. This has been explored through the place-based pilots and thriving community workstream and will need to be built upon over the next year. Oldham's 111 usage is comparable to the North West. It is to be noted that our Asian/British Asian communities use 111 services to a greater degree.

2.3 Community pharmacy

There are 51 community pharmacies in Oldham situated in high-street locations, supermarkets and in residential neighbourhoods. A further 8 pharmacies provide an on-line/distance selling service. A map showing the location of community pharmacies in Oldham is included in figure 2.

Pharmacies open a minimum of 40 hours a week. Nine pharmacies in the area are open for 100 hours a week and a considerable number are open for extended hours including Saturdays. The majority have a private consultation room and patients can have access to a health care professional without the need for an appointment. Community pharmacies provide a convenient and less formal environment for those who cannot easily access or do not choose to access other kinds of health service.

Nationally, 99% of the population can get to a pharmacy within 20 minutes by car and 96% by walking or using public transport, even in the most deprived areas. Eighty-four per cent of adults visit a pharmacy at least once a year and on average an adult visits a pharmacy 16 times a year. Over 75% of adults use the same pharmacy all the time and the footfall into a community pharmacy is approximately three and a half times more than general practice.

Under their contractual arrangements with the NHS, community pharmacies provide a range of core services including dispensing medicines, repeat dispensing, disposal of unwanted medicines, healthy lifestyles advice, signposting and support for self-care. Community pharmacists, as experts in medicine, are also commissioned to provide medicines-adherence support through Medicines Use Reviews and the New Medicines Service. Both services support patients in getting the most benefit from their medicines.

Community pharmacy services can play an important role in enabling self-care particularly amongst patients with minor ailments and long term conditions.

In Oldham 47 pharmacies provide seasonal flu vaccinations, 52 provide Medicine Use Reviews, 42 provide a New Medicines Service and 2 provide stoma care. Thirty pharmacies provide emergency hormonal contraception and chlamydia screening and treatment; 3 provide NHS Health Checks; 5 provide needle exchange facilities and 1 provides supervised consumption. Two pharmacies support 111 requests out of hours with medication requests (a pilot scheme with plans to roll out across GM).

Key message

Oldham is well served by community pharmacies with extended opening times including evenings and weekends. There is potential to make much better use of their skills as part of the urgent care system including promotion of healthy lifestyles, signposting, support for self-care and medicines use reviews. There is also scope to consider their enhanced role in managing minor ailments and emergency supply of medicines out of hours.

2.4 GP Practices

Over 90% of all NHS patient contacts are thought to take place within primary care. There is a lack of available, up-to-date, data on general practice consultation activity, but levels have increased steadily over the last 10 years, with an estimated 340 million taking place nationally in 2012/13 (NHSE, 2013).

In Oldham there are approximately 4000 GP appointments available each weekday. There are 44 GP practices (soon to be 43 due to merger) within Oldham who provide services from 8am to 6:30pm. All practices provide essential services for people who are ill or believe themselves to be ill, immediately necessary treatment, additional services and a wide range of enhanced GP services. The GP Federation runs pre-bookable appointment slots in three locations between the hours of 6:30pm and 8pm weekdays and 10am to 2pm weekends and bank holidays (see section 2.5).

Contracting responsibilities for GP services have been devolved from NHS England to Oldham CCG to enable greater responsibility for primary care commissioning going forward.

All GP practices in Oldham offer daily urgent (with some offering non-urgent) telephone consultations with a GP. Depending on what clinical details the patient will disclose, patients are either transferred immediately to a GP, transferred in-between other consultations, transferred to the duty doctor or a GP calls the patient after surgery. Call back times do vary across the patch, ranging from 5-10 minutes to 4 hours in some practices. There appears to be no 'average' although the most common is 'within the hour' for an urgent request. Patients at some practices are also offered same day face to face consultations or, most commonly, 'as soon as possible'.

Since 2015, the CCG has commissioned all primary care to guarantee a same day appointment for all under 5s.

The National Urgent and Emergency Care Review highlights an issue with GP visiting times impacting on A&E attendance, with those requiring a home visit presenting at hospital later in the afternoon when A&E departments are at the busiest and staffing and support services are reduced. This is when GP visits are undertaken after morning surgery and before afternoon surgery, usually between the times of 11am and 2pm. There is some evidence locally that these visiting times do lead to higher rates of attendance from people GPs have visited later in the day. Earlier visiting times are being tested in Cluster West and will be evaluated.

Key message
GP practices are the most frequent provider of urgent care services and GP consultation rates are continuing to rise. All practices in Oldham encourage telephone consultation for urgent conditions, with most calling patients back within an hour (although this does vary). Arrangements for GP visits in the middle of the day has an impact on patients attending A&E later when the department is particularly busy and some support services are reduced.

2.5 GP 7 Day Access

The Oldham 7-Day Access service launched on 30th December 2015 and, following IT issues which could not be resolved during the holiday period, began to see patients on 5th January 2016. The service is provided by IGP Care Ltd (aka Oldham GP Federation), in conjunction with gtd healthcare, which provides some sub-contracted elements of the service.

The service is delivered on a hub basis, with locations at the Integrated Care Centre (ICC), Royton Health & Wellbeing Centre (RHWBC) and the Keppel Building in Failsworth. Appointments are offered

- at the ICC seven-days-a-week
- at Royton on Monday to Thursday, and Saturday
- at Failsworth on Wednesday and Saturday

- Evening appointments are available between 6:30pm and 8pm on weekdays and between 10am-2pm on weekend days.
- Appointments are available to book up to three weeks in advance, although the majority of appointments are made in the preceding twenty-four hours. Patients can access appointments on the same day via the single point of access, which is a telephone number that directs to a booking centre.
- Clinicians have access to the full patient record at each hub via EMIS. Data sharing is facilitated by an information governance (IG) sharing protocol and an IG agreement, which all 44 Oldham practices are signed up to.

2.6 GP Out of Hours services

GP Out of Hours services are provided across Oldham by gtd healthcare. The service runs from 6pm to 8am on weekdays, weekends and bank holidays when GP practices are closed. The service is for patients with urgent conditions that cannot wait until their GP practice is next open.

Access to the services is via NHS 111. If, following a series of questions, the caller is deemed to need primary care their details will be transferred to the GP Out of Hours service. At this point, a clinician will call the patient to take further details and offer advice as appropriate. Following the phone consultation with a clinician, the caller may also be advised to attend a treatment centre or a GP may undertake a home visit. A caller may also be referred to another service, depending on their needs.

The Out of Hours provider provides enhanced clinical assessment of calls received by 111 to ensure appropriate management of patients. They also receive all calls from 111 with an 'attend ED' disposition which are clinically assessed and deflected from ED where appropriate (approx. 60%) during the out of hours period.

Gtd also offer direct access to a GP in the out of hours period for all Nursing & Residential Homes and Health Care Professionals working in Oldham with a 1 hour response time.

Oldham GP Out of Hours Treatment Centre is based in the area known as Outpatients A, adjacent to the Emergency Department at the Royal Oldham Hospital.

Figure 7 – Out of Hours contacts by type

Oldham GP Out of Hours Service (Contacts by case type)					
		Apr 17 to Mar 18			
	Case type	Advice	Treatment Centre	Visit	Total
Oldham CCG	YTD	8254	9206	3351	20811

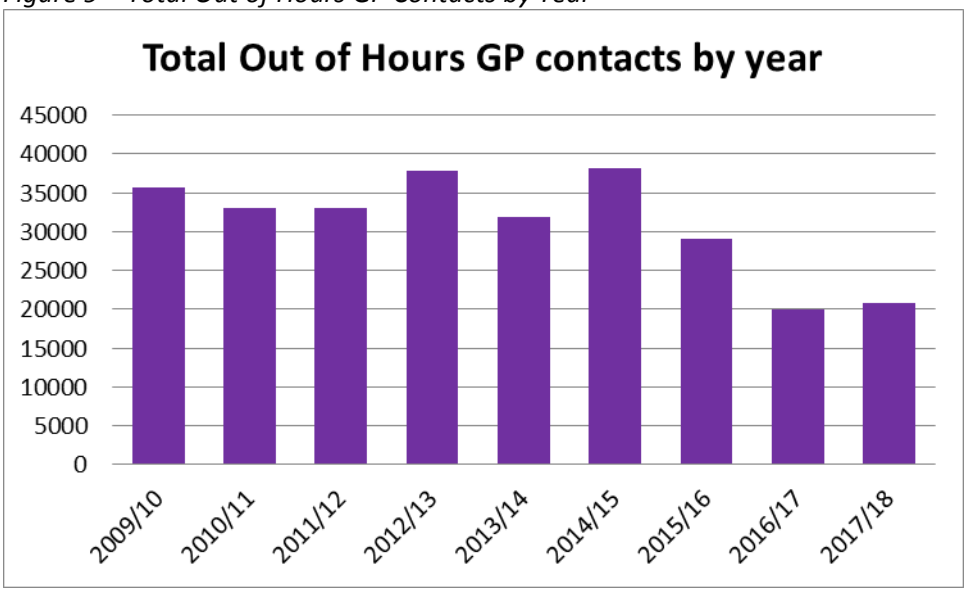
39.7% of people were dealt with by GP advice on the phone, 44.2% by attendance at a treatment centre and 16.1% received a home visit. Of the total seen, approximately 10% went 'towards hospital'. The times that most people access out of hours services are 7-9pm on weekdays and 8am to 1pm on weekends and bank holidays.

Figure 8 shows the number of Out of Hours service contacts by age range; as can be seen, a large proportion of those in contact with the service are aged 0-5 years, with the largest peak in very young children, aged 0-2 years.

Figure 8 – GP Out of Hours Contacts by Age Range

Oldham GP Out of Hours Service (Activity by Age Group)														
CCG	Age	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-17	Feb-17	Mar-17	YTD
Oldham CCG	0-16	598	452	358	434	310	440	679	588	810	530	466	503	6168
	16-18	25	21	9	19	22	28	28	17	21	26	16	18	250
	18-20	36	36	28	21	40	22	30	34	34	28	29	33	371
	20-24	118	112	98	101	95	92	95	106	120	128	104	113	1282
	25-29	139	100	115	105	98	106	113	108	144	116	94	89	1327
	30-34	115	89	87	96	97	76	101	98	109	116	83	108	1175
	35-39	88	68	82	62	83	74	80	77	114	86	67	71	952
	40-44	55	68	55	62	64	53	50	58	74	74	46	66	725
	45-49	74	53	41	54	52	54	45	47	80	63	57	75	695
	50-54	63	64	58	68	70	53	64	61	83	69	48	54	755
	55-59	63	71	51	56	76	46	59	54	75	79	43	63	736
	60-64	73	53	51	52	55	58	61	42	84	67	40	62	698
	65-69	78	66	45	58	44	62	59	50	75	74	49	56	716
	70-74	96	88	63	70	73	77	67	76	84	103	69	86	952
	75-79	92	74	77	61	87	74	72	78	114	82	73	77	961
	80+	294	259	201	236	254	238	212	251	340	265	237	261	3048
Oldham CCG Total		2007	1674	1419	1555	1520	1553	1815	1745	2361	1906	1521	1735	20811

Figure 9 – Total Out of Hours GP Contacts by Year



Nationally, the National Audit Office's report identified that the number of cases dealt with by the services had fallen in recent years, from 8.6 million in 2007-8 to 5.8 million in 2013-14. This has been partly attributed to the roll-out of NHS 111. This is being mirrored locally.

Achievement of the national quality requirements for out of hours by gtd is generally very good. Over 90% of urgent cases are clinically assessed on the phone in 20 minutes and routine cases within 60 minutes. For those requiring face to face assessment, over 90% of urgent cases are seen in two hours and nearly 100% of those assessed as routine are seen in six hours. The latest CQC report for this service was good. The 2017-18 cost per case for Oldham was £82.89. Comparing to the national average is difficult as there is no recent national data; however, when benchmarked in 2012 by the Primary Care Foundation (http://www.primarycarefoundation.co.uk/benchmark.html), Oldham's cost per case was £50.27 compared with a national average of £61.14.

Figure 10 – Out of Hours Patient Survey Results 2013-18

Patient Surveys

In order to obtain feedback on the Out of Hours Service we invite patients/carers to complete our patient satisfaction surveys. The table below shows the number of surveys received each year since 2013

2013/14	2014/15	2015/16	2016/17	2017/18	Total
49	96	84	76	67	372

The results of the surveys are summarised below;

- Of the 372 completed surveys, 89 patients received telephone advice, 237 were seen at the treatment centre, and 46 patients received a home visit.
- 92% of respondents felt that the staff they spoke to were polite and courteous
- 90% of the respondents were happy with the advice and treatment they were given by the clinician they saw/spoke to.
- 88% of the respondents stated that the felt reassured by the clinician they saw/spoke to.
- 94% of respondents attending the treatment centre stated that the environment was clean and tidy,
- 93% of the respondents that attended the treatment centre were happy with the distance they had to travel to the treatment centre.
- 46% of the respondents stated that they experienced a delay, and more than half of these stated that they had not been kept informed of the delays.
- 93% of the respondents felt they were treated with Dignity and Respect from gtd staff.
- 89% of respondents were happy with the overall care they received, 5% respondents stated they were only partially happy with the overall care and 6% stated they were unhappy with their overall care.

Since the launch of the Friends and Family Test (FFT) in 2015 gtd healthcare have received 3941 completed FFTs from patient/ carers attending the out of hours service. 92% of respondents stating that they were extremely likely or likely to recommend the service they received to their friends and family, this is consistent with results in other areas.

(The FFT figures for Lindley Medical Practice include both registered and walk in patients, therefore we are unable to separate the results between the walk in service and registered practice)

Key message

The GP Out of Hours service in Oldham performs well and is highly regarded by patients and professionals alike. It also provides good value for money. However, the number of cases seen by the service is falling, since the introduction of 111, a trend which has also been found nationally. The number of contacts for young children is high. A good proportion of cases are dealt with by telephone advice.

2.7 Walk In Service (WIS)

There is one Walk In Service based at the Integrated Care Centre in Oldham Town Centre. This opened in November 2009 and aims to provide additional urgent primary care access and stop patients going to A&E who could be better cared for outside hospital.

Figure 11 - WIS Attendance by Year and 10 year age band

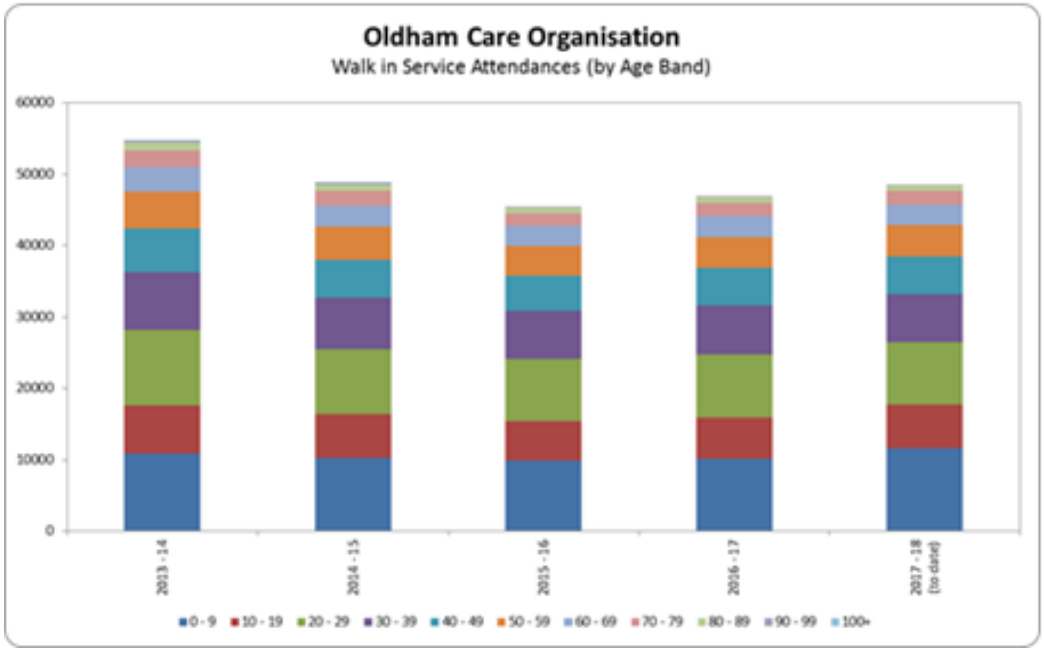


Figure 12 – WIS Attendances who left without being seen

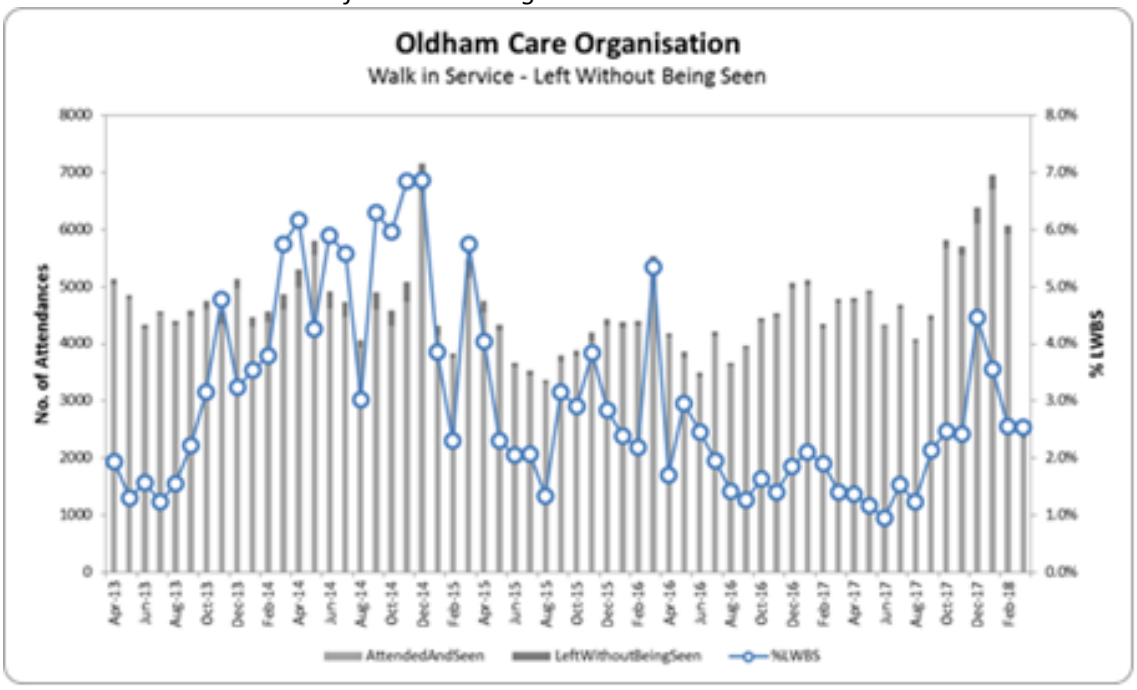
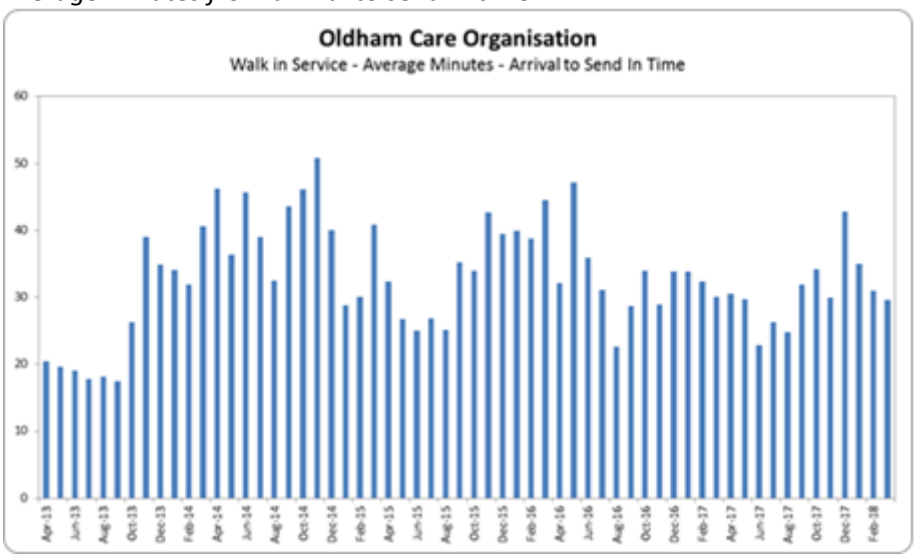


Figure 13 – WIS Average minutes from arrival to send in time



It has proven to be a popular and well-used service. However, the main downsides to this single centrally-located, turn-up-and-wait-to-be-seen service are:

- Patients who would otherwise have self-managed their minor ailments at home, seen their local pharmacist or waited to see their own GP have decided to go to the Walk In Service instead.
- It attracts a significant number of patients who live outside the borough of Oldham
- It is not equally accessible by all residents across the borough, due to location,
- A lack of bookable appointments and, at times, long waits to be seen.
- The WIS is not linked into the clinical systems of either patients' own GPs or the hospital, leading to fragmented care and the need to repeatedly take medical histories.
- A lack of access to diagnostic systems such as x-rays and blood tests, and additional support such as community services, mental health teams, the voluntary sector, housing etc.
- And perhaps most importantly it has not solved the issues it set out to fix – many patients still have difficulty seeing a GP urgently and A&E continues to be used by patients who could have been treated in primary care.

Therefore, Oldham CCG formally consulted with the public to change to a new Urgent Care Treatment Service delivered by locally tailored Urgent Care Hubs in each local cluster area, offering bookable urgent GP appointments, a single point of entry via patients' own GP practice, a single care plan and medical records shared between GPs, hospital clinicians and other health and social care professionals. A&E will also triage patients on arrival into either emergency or GP-led primary care streams based on their medical needs.

Key message
There is one Walk In Service within Oldham which, although popular, is being changed into Urgent Care Hubs as part of the development of GP clusters. Over the next three years there will be a change in the offer to the public. This will be included in the work plan which is being developed.

2.8 Emergency Department

There is one Emergency Department in the CCG footprint, this being the Emergency Department at Royal Oldham Hospital (part of the Northern Care Alliance) The department is open 365 days per year, 24 hours per day, providing care for all acute and emergency care patients. It is a designated trauma unit, supporting Salford Royal Hospital NHS Foundation Trust as the collaborative Trauma Centre as part of the wider Greater Manchester Trauma Network. A number of other services are linked to and/or provided from the department as described in figure 14.

Figure 14 – Services connected to A&E

Services connected to the Royal Oldham Hospital Emergency Department

- Minor injuries service
- Primary care streaming
- GP out of hours treatment centre
- Follow-up clinic
- Dressings clinic
- Rapid access clinic (nurse-led)
- Speciality nurses
- Rapid Access Chest Pain Clinic
- Dementia team
- Paediatrics Observation and Assessment Unit (O&A)
- ED Observation Ward - adults – 12 beds
- Mental Health Liaison (RAID)
- Ambulatory Care Unit (ACU) – 8 trollies; 3 treatment rooms
- Acute Medical Unit (AMU) – 48 beds
- SPRINT (Senior Persons' Resilience and Independence Team)
- A&E Therapy Team
- Urgent Care Social Work Team
- RAID Team
- A&E2Home Housing Officer

The department includes a paediatric area with child friendly facilities including a dedicated waiting area, child friendly treatment area and paediatric resuscitation bay.

Patients referred by GPs with medical conditions do not go through the normal Emergency Department system, unless they are clinically unstable, and are referred directly to the Ambulatory Care Unit (ACU). The ACU opening hours will ultimately be 8am until 10pm 7 days per week. This is being introduced in a phased approach in line with recruitment plans, with the unit currently closing at 8pm weekdays and limited opening at weekends. The National Urgent and Emergency Care Review identifies that '*staffing is probably the single most important factor in providing a high quality, timely and clinically effective service to patients.'* (pp. 49).

Nationally, there is concern regarding the number of doctors wanting to train in emergency medicine as well as widely-acknowledged recruitment and retention issues with senior doctors. The review suggests that 24 hour consultant delivered care is likely to be the most long-term workforce strategy, and also raises concern regarding variation in the number of hours that consultants are physically present in Emergency Departments, with significant variation between weekdays and weekends.

In December 2017, the Royal Oldham Emergency Department comprised 7.25 whole time equivalent (wte) consultants with a further 2 wte within the recruitment process. Following successful approval of a workforce business case, funding has been secured to increase the consultant establishment to 16.2 wte consultants. This will ensure 12 hours of consultant presence "on the shop floor" per day, with the remaining covered by on call. Despite this significant investment in consultant establishment, the department will remain non-compliant with the standards set down within Healthier Together.

Figure 15 - Safe Nurse Staffing Levels for ED

Total	Early	Late	Night
Band 7	1	2 (1 x 11:00 - 23:00)	1
Band 6	4	4	4
Band 5	10	11 (1 x 17:30 - 01:30)	10
Band 3	6	6	6

The Safe Nurse staffing levels above include the numbers required to meet the recommendations made in the Paediatric review that was undertaken by Julie Flaherty in Autumn 2017, that the Paediatric area of the Department is staffed by 2 Registered Nurses and 1 Healthcare Assistant at all times. The numbers also include the rostering of a 3rd Registered Nurse on a twilight shift.

In addition to this, the numbers include the provision of a Band 7 streaming Nurse from 11:00hrs-23:00hrs, and a Registered Nurse at all times to support the provision of timely Ambulance handover and initial assessment and treatment.

On the Acute Medical Unit (AMU), safe staffing levels every day 24/7 should be 9 registered Nurses and 8 Healthcare Assistants.

In March 2018, the Care Quality Commission (CQC) rated the Urgent and Emergency Services at Royal Oldham Hospital as 'Good'.

Accident and Emergency Quality Indicators (QIs) are published nationally by the Health and Social Care Information Centre. Reports are published quarterly from the Hospital Episode Statistics (HES) A&E data for the following five indictors:

- Left department before being seen
- Re-attendance rate
- Time to initial assessment
- Time to treatment
- Total time in A&E

The NHS Constitution stipulates that patients accessing Emergency Departments have a right to be seen, assessed, treated and admitted or discharged within 4 hours, with no patient waiting longer than 12 hours (from decision to admit) for provision of an appropriate specialty bed.

Nationally, the significant increase in pressures within the NHS, particularly operational activity and performance against the 4 hour access standard remains extremely challenging, particularly for patients requiring admission to hospital. The Oldham locality is no exception to this, and national and locally agreed thresholds have consistently not been met.

Figure 16 - Quality Indicators for A&E: Royal Oldham Hospital

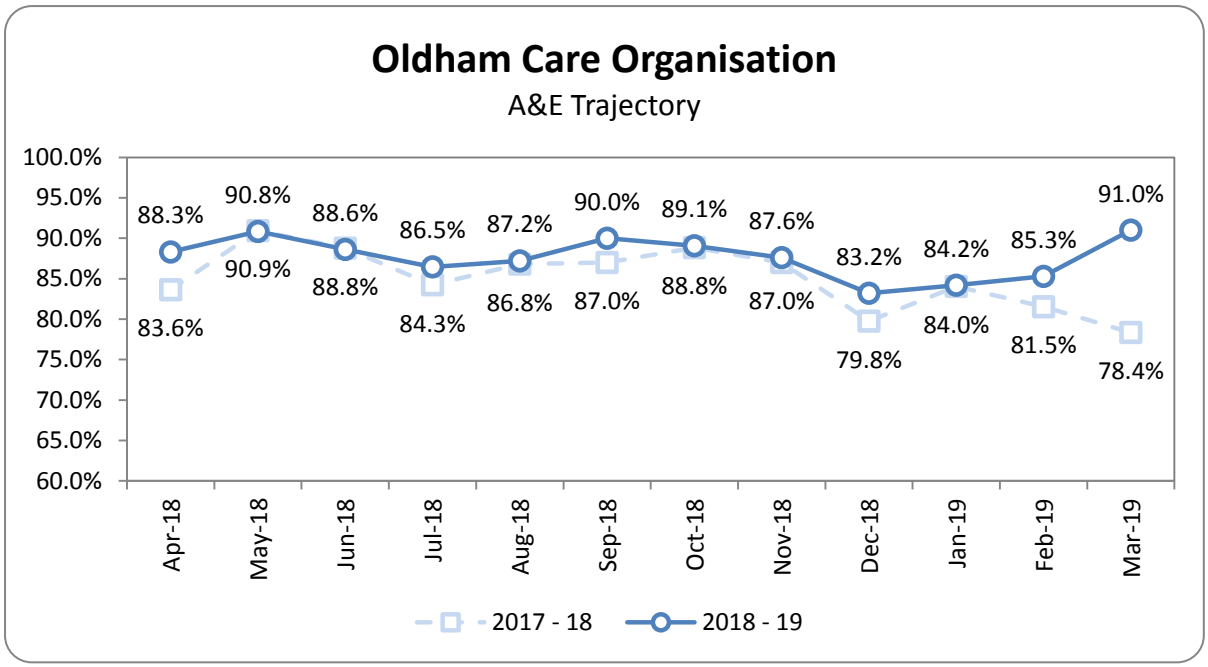
Month	Attendance	Non-Breach	% Achieved	Admitted	% Conversion	4-12 Hour Trolley Wait	12 Hour Trolley Wait
Apr-17	8384	6328	75.48%	2037	24.30%	370	4
May-17	8965	7768	86.65%	2284	25.48%	153	0
Jun-17	8646	7242	83.76%	2120	24.52%	227	1
Jul-17	9272	7171	77.34%	2182	23.53%	333	20
Aug-17	8459	6848	80.96%	2141	25.31%	235	1
Sep-17	8769	7133	81.34%	2296	26.18%	327	6
Oct-17	9455	7882	83.36%	2660	28.13%	183	1
Nov-17	9236	7452	80.68%	2659	28.79%	306	6
Dec-17	9154	6470	70.68%	2471	26.99%	262	7
Jan-18	9064	6867	75.76%	2574	28.40%	249	4
Feb-18	7846	5640	71.88%	2221	28.31%	377	4
Mar-18	8968	6109	68.12%	2483	27.69%	260	0
Apr-18	8531	6934	81.28%	2507	29.39%	148	1
Grand Total	**114749**	**89844**	**78.30%**	**30635**	**26.70%**	**3430**	**55**

Figure 16 demonstrates the level of compliance against the national indicators but also demonstrates improvements made of the past 12 months, particularly in relation to '12 hour trolley waits'.

Locally, numerous system-wide action plans have been agreed with local stakeholders and partner agencies in order to address the sub-optimal performance against the 4 hour access standard. Additional support has been provided by the Emergency Care Intensive Support Team (ECIST), a national team focussed on supporting challenged organisations with their emergency care improvement plans.

Oldham Care Organisations A&E Trajectory is shown below:

Figure 17 – Trajectory for 4 hour performance in A&E 2018-19

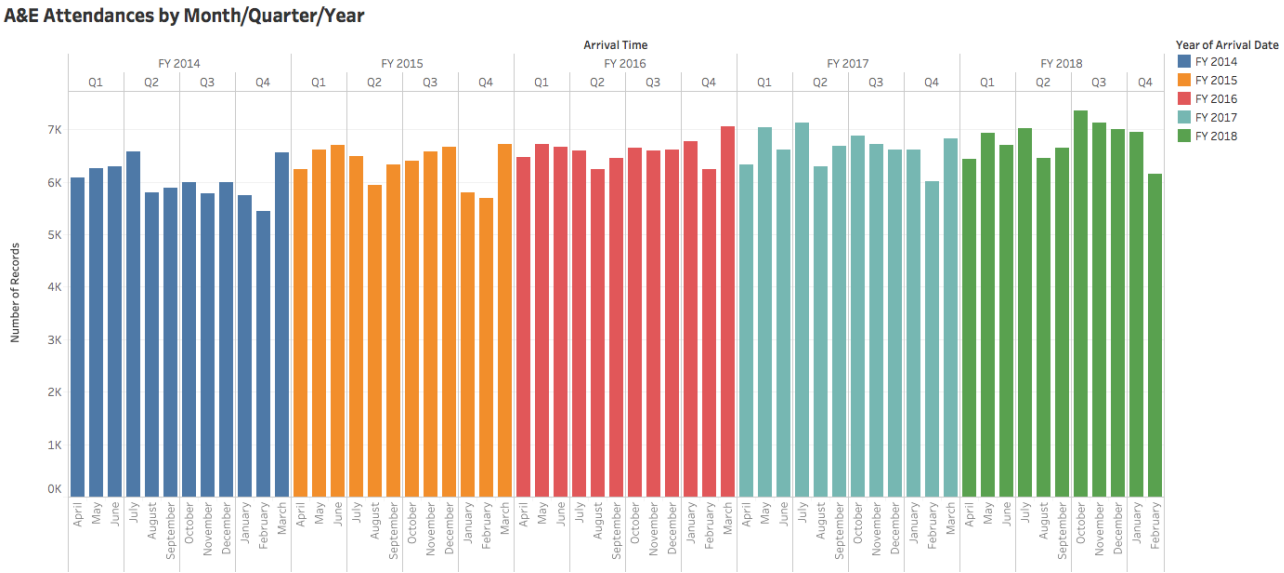


There has been a significant increase in ED attendances over the last five years, with the rate of attendances to Oldham being in excess of the national average (39,419 per 100,000 population locally, compared with 30,041 England).

Figure 18 - Number of ED attendances by month over last 5 years

A&E Attendances by Month/Quarter/Year

	Arrival Time											
	Q1			Q2			Q3			Q4		
Year of Arrival Date	April	May	June	July	August	Septem..	October	Novem..	Decemb..	January	February	March
FY 2014	6,087	6,256	6,291	6,580	5,796	5,889	5,986	5,781	6,002	5,745	5,437	6,565
FY 2015	6,236	6,607	6,708	6,494	5,939	6,335	6,396	6,571	6,675	5,807	5,689	6,729
FY 2016	6,477	6,716	6,675	6,595	6,248	6,455	6,642	6,590	6,609	6,773	6,241	7,052
FY 2017	6,333	7,036	6,618	7,121	6,294	6,677	6,880	6,715	6,621	6,608	6,005	6,819
FY 2018	6,436	6,938	6,709	7,026	6,461	6,654	7,363	7,134	7,007	6,957	6,146	



Please note data for Q4 2018 is not complete

Figure 19 – Quarterly percentage change in A&E attendances by age 2014-2018

Quarterly % change in A&E Attendances by Age Banding

		Age at Start of Episode (group)													
		Null		0-4		5-15		16-18		19-64		65-84		85+	
Year of Arrival Date	Quarter of Arrival Date	Number of Reco..	% Difference in ..	Number of Reco..	% Difference in ..	Number of Reco..	% Difference in ..	Number of Reco..	% Difference in ..	Number of Reco..	% Difference in ..	Number of Reco..	% Difference in ..	Number of Reco..	% Difference in ..
FY 2014	Q1	113		1,858		2,481		758		9,868		2,709		847	
	Q2	174	53.98%	1,648	-11.30%	2,166	-12.70%	695	-8.31%	10,268	4.05%	2,512	-7.27%	802	-5.31%
	Q3	181	4.02%	1,880	14.08%	2,045	-5.59%	642	-7.63%	9,628	-6.23%	2,606	3.74%	787	-1.87%
	Q4	152	-16.02%	1,822	-3.09%	2,356	15.21%	752	17.13%	9,471	-1.63%	2,430	-6.75%	764	-2.92%
FY 2015	Q1	124	-18.42%	1,961	7.63%	2,814	19.44%	818	8.78%	10,409	9.90%	2,648	8.97%	777	1.70%
	Q2	119	-4.03%	1,822	-7.09%	2,391	-15.03%	709	-13.33%	10,220	-1.82%	2,689	1.55%	818	5.28%
	Q3	154	29.41%	2,449	34.41%	2,324	-2.80%	732	3.24%	10,186	-0.33%	2,908	8.14%	889	8.68%
	Q4	138	-10.39%	1,968	-19.64%	2,232	-3.96%	773	5.60%	9,461	-7.12%	2,711	-6.77%	942	5.96%
FY 2016	Q1	146	5.80%	2,091	6.25%	2,875	28.81%	714	-7.63%	10,346	9.35%	2,881	6.27%	815	-13.48%
	Q2	176	20.55%	1,943	-7.08%	2,406	-16.31%	673	-5.74%	10,343	-0.03%	2,922	1.42%	835	2.45%
	Q3	187	6.25%	2,564	31.96%	2,337	-2.87%	732	8.77%	10,136	-2.00%	2,955	1.13%	930	11.38%
	Q4	265	41.71%	2,449	-4.49%	2,572	10.06%	765	4.51%	10,155	0.19%	2,939	-0.54%	921	-0.97%
FY 2017	Q1	238	-10.19%	2,141	-12.58%	2,912	13.22%	715	-6.54%	10,099	-0.55%	2,984	1.53%	898	-2.50%
	Q2	168	-29.41%	2,067	-3.46%	2,566	-11.88%	684	-4.34%	10,699	5.94%	2,998	0.47%	910	1.34%
	Q3	137	-18.45%	2,617	26.61%	2,440	-4.91%	764	11.70%	10,164	-5.00%	3,132	4.47%	962	5.71%
	Q4	182	32.85%	2,306	-11.88%	2,546	4.34%	708	-7.33%	9,823	-3.35%	2,872	-8.30%	995	3.43%
FY 2018	Q1	240	31.87%	2,094	-9.19%	2,768	8.72%	711	0.42%	10,279	4.64%	3,029	5.47%	962	-3.32%
	Q2	220	-8.33%	2,154	2.87%	2,462	-11.05%	693	-2.53%	10,568	2.81%	3,132	3.40%	912	-5.20%
	Q3	239	8.64%	3,096	43.73%	2,550	3.57%	723	4.33%	10,564	-0.04%	3,254	3.90%	1,078	18.20%
	Q4	129	-46.03%	1,240	-59.95%	1,282	-49.73%	362	-49.93%	5,537	-47.59%	1,692	-48.00%	579	-46.29%

Figure 20 – A&E attendances by cluster and age banding (table)

A&E Attendances by Cluster and by Age Banding

Financial Year	Age at Start of Episode (group)	Cluster					
		Null	Central Cluster	East Cluster	North Cluster	South Cluster	West Cluster
13/14	Null	489	47	12	14	27	31
	0-4	218	1,432	1,082	1,176	1,585	1,715
	5-15	289	1,617	1,522	1,548	1,863	2,209
	16-18	132	578	487	550	527	573
	19-64	1,288	7,906	6,549	7,291	7,451	8,750
	65-84	227	1,952	2,159	2,660	1,329	1,930
	85+	73	547	756	772	388	664
14/15	Null	449	24	7	13	25	17
	0-4	127	1,723	1,172	1,178	2,096	1,904
	5-15	153	1,749	1,635	1,606	2,272	2,346
	16-18	70	586	505	520	671	680
	19-64	656	7,951	6,604	7,457	8,831	8,777
	65-84	116	2,133	2,267	2,626	1,654	2,160
	85+	54	574	794	926	466	612
15/16	Null	534	62	28	12	84	54
	0-4	67	1,780	1,321	1,307	2,449	2,123
	5-15	84	1,846	1,606	1,608	2,524	2,522
	16-18	31	567	458	478	586	764
	19-64	466	8,263	6,768	7,171	9,312	9,000
	65-84	64	2,217	2,501	3,021	1,678	2,216
	85+	9	656	774	962	462	638
16/17	Null	494	60	25	11	84	51
	0-4	18	1,707	1,383	1,373	2,472	2,178
	5-15	12	1,850	1,738	1,682	2,644	2,538
	16-18	11	503	417	492	733	715
	19-64	230	8,258	6,532	6,997	9,610	9,158
	65-84	14	2,263	2,408	2,961	1,993	2,347
	85+	4	655	892	962	564	688
17/18	Null	452	102	38	42	143	78
	0-4	13	1,650	1,319	1,333	2,371	2,128
	5-15	16	1,662	1,521	1,456	2,452	2,221
	16-18	8	420	393	422	697	619
	19-64	243	7,392	6,180	6,430	9,256	8,626
	65-84	19	2,114	2,439	2,854	1,730	2,354
	85+		666	862	903	561	646

Figure 21 – A&E Attendances by Cluster and by Age Banding

A&E Attendances by Cluster and by Age Banding

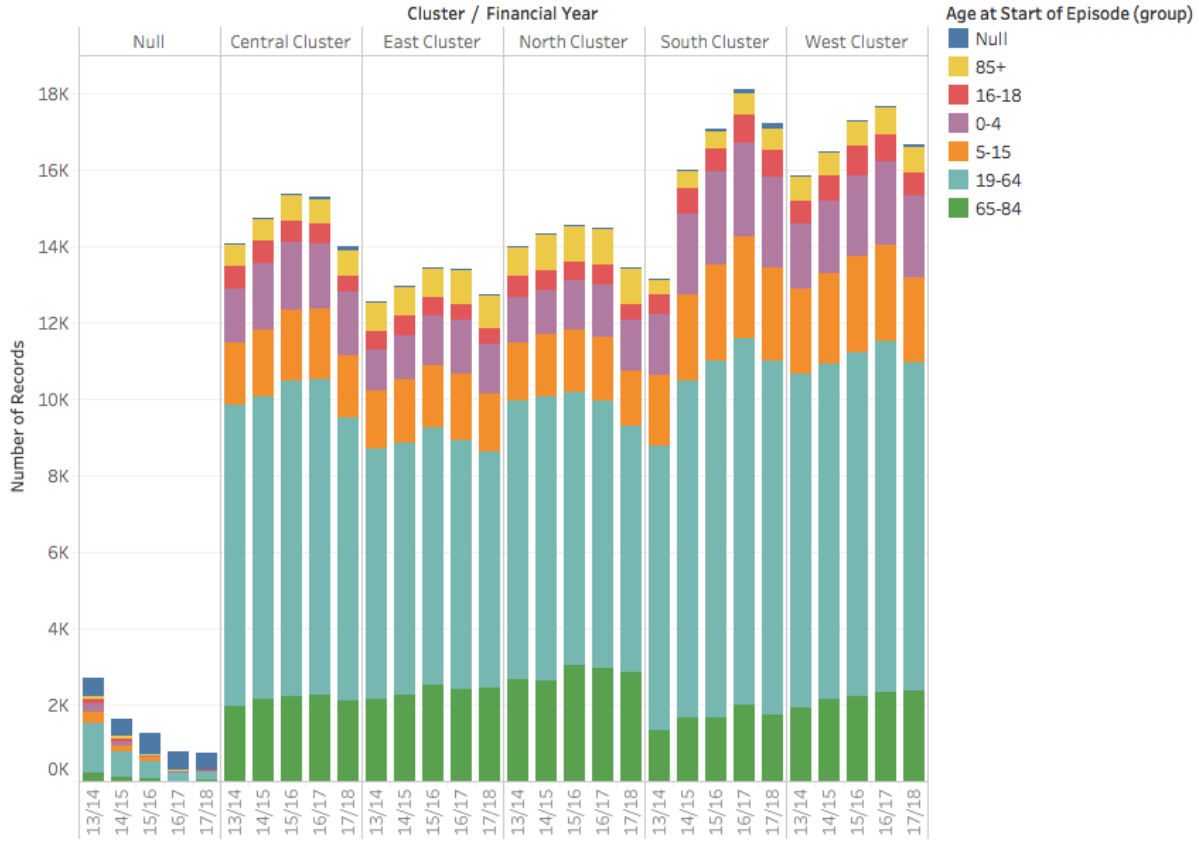
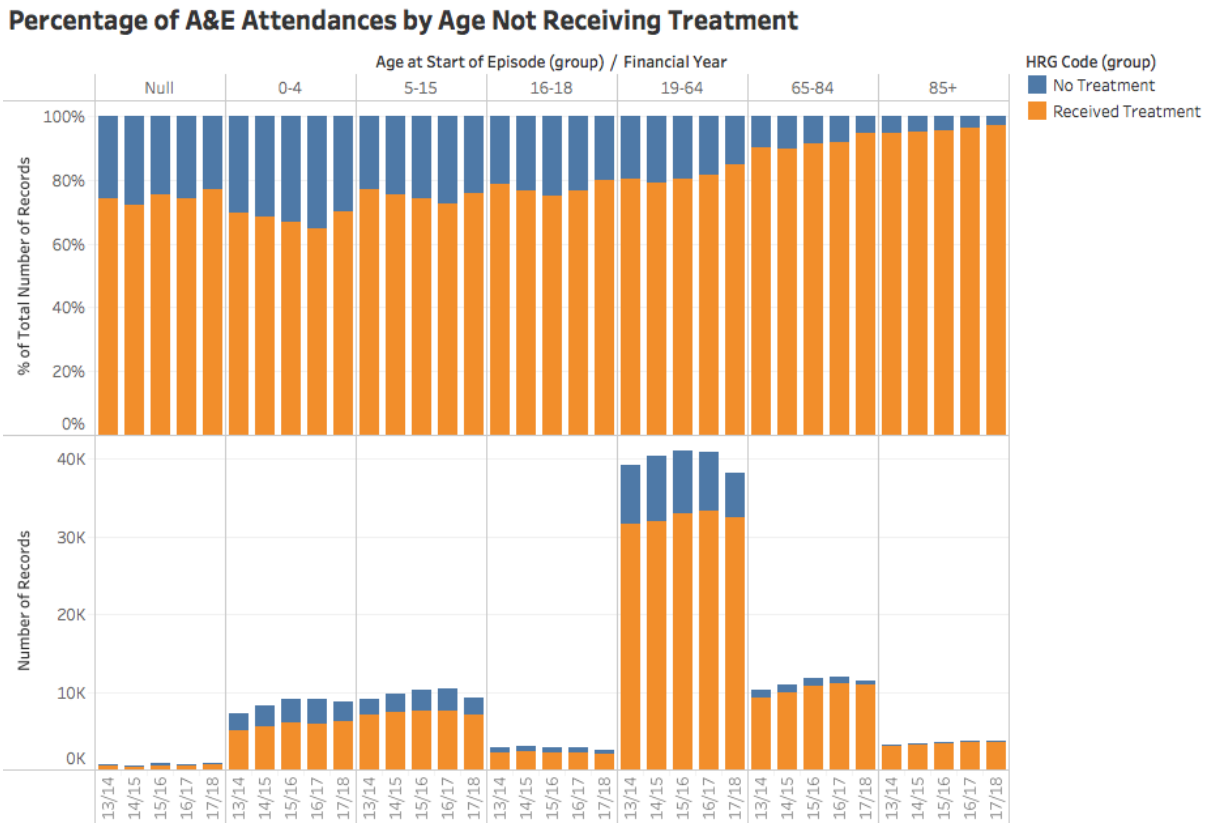


Figure 22 - Percentage of ED attendances by age not receiving treatment

Percentage of A&E Attendances by Age Not Receiving Treatment

Age at Start of Episode (group)		Financial Year / HRG Code (group) 13/14 No Treatment	13/14 Received Treatment	13/14 Unknown	14/15 No Treatment	14/15 Received Treatment	14/15 Unknown	15/16 No Treatment	15/16 Received Treatment	15/16 Unknown	16/17 No Treatment	16/17 Received Treatment	16/17 Unknown	17/18 No Treatment	17/18 Received Treatment	17/18 Unknown
Null	Number of ..	413	833	10	351	769	7	327	1,087	14	335	842	14	286	902	12
	% of Total ..	32.88%	66.32%	0.80%	31.14%	68.23%	0.62%	22.90%	76.12%	0.98%	28.13%	70.70%	1.18%	23.83%	75.17%	1.00%
0-4	Number of ..	2,529	6,105	3	2,893	6,820	2	3,328	7,157	5	3,581	7,100		3,169	7,378	1
	% of Total ..	29.28%	70.68%	0.03%	29.78%	70.20%	0.02%	31.73%	68.23%	0.05%	33.53%	66.47%		30.04%	69.95%	0.01%
5-15	Number of ..	2,327	8,268	2	2,643	8,844	3	2,866	8,983	1	3,203	8,996		2,659	8,342	
	% of Total ..	21.96%	78.02%	0.02%	23.00%	76.97%	0.03%	24.19%	75.81%	0.01%	26.26%	73.74%		24.17%	75.83%	
16-18	Number of ..	706	2,630	2	800	2,780		819	2,570		785	2,608	1	635	2,474	
	% of Total ..	21.15%	78.79%	0.06%	22.35%	77.65%		24.17%	75.83%		23.13%	76.84%	0.03%	20.42%	79.58%	
19-64	Number of ..	9,653	37,986	22	10,454	39,156	21	9,906	40,409	9	9,677	40,928	5	7,914	40,348	2
	% of Total ..	20.25%	79.70%	0.05%	21.06%	78.89%	0.04%	19.68%	80.30%	0.02%	19.12%	80.87%	0.01%	16.40%	83.60%	0.00%
65-84	Number of ..	1,187	10,575	2	1,305	11,256		1,182	12,307		1,252	12,572	5	908	12,584	
	% of Total ..	10.09%	89.89%	0.02%	10.39%	89.61%		8.76%	91.24%		9.05%	90.91%	0.04%	6.73%	93.27%	
85+	Number of ..	198	3,361		193	3,627		187	3,737		175	4,037	1	132	3,934	
	% of Total ..	5.56%	94.44%		5.05%	94.95%		4.77%	95.23%		4.15%	95.82%	0.02%	3.25%	96.75%	

Figure 23 – Percentage of A&E Attendances by age not receiving treatment



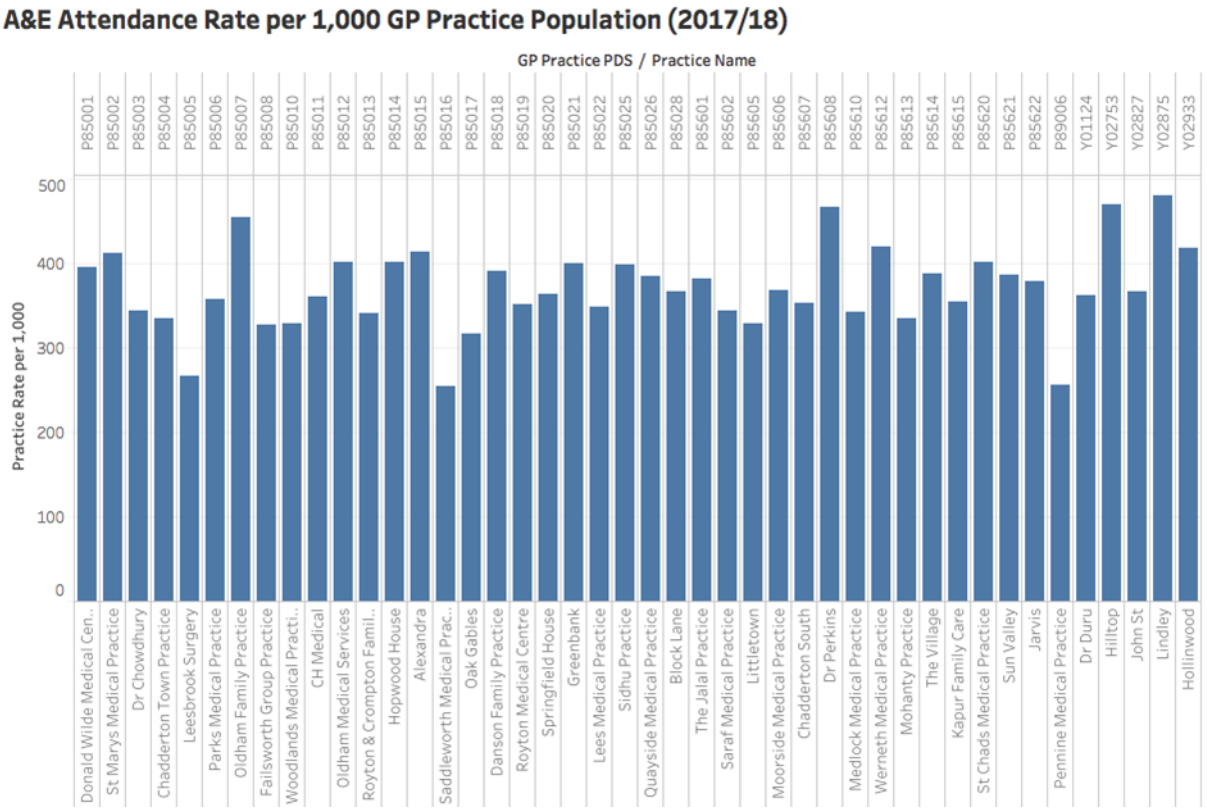
In 2017-18 15,703 people attended the Accident & Emergency Department at the Royal Oldham Hospital and received no treatment. The tariff for each attendance is £66.08, meaning that the cost of A&E attendances with no treatment in 2017-18 was £ 1,037,654.24.

Figure 24 – A&E attendance rate per 1,000 GP Practice Population (table)

A&E Attendance Rate per 1,000 GP Practice Population (2017/18)

GP Practice PDS	Practice Name	
P85001	Donald Wilde Medical Centre	395.3
P85002	St Marys Medical Practice	413.3
P85003	Dr Chowdhury	344.0
P85004	Chadderton Town Practice	335.6
P85005	Leesbrook Surgery	266.7
P85006	Parks Medical Practice	358.1
P85007	Oldham Family Practice	455.5
P85008	Failsworth Group Practice	327.2
P85010	Woodlands Medical Practice	328.6
P85011	CH Medical	361.4
P85012	Oldham Medical Services	402.8
P85013	Royton & Crompton Family Practice	342.2
P85014	Hopwood House	402.8
P85015	Alexandra	414.9
P85016	Saddleworth Medical Practice	254.5
P85017	Oak Gables	317.2
P85018	Danson Family Practice	391.1
P85019	Royton Medical Centre	352.5
P85020	Springfield House	364.8
P85021	Greenbank	400.9
P85022	Lees Medical Practice	348.5
P85025	Sidhu Practice	399.6
P85026	Quayside Medical Practice	385.0
P85028	Block Lane	367.3
P85601	The Jalal Practice	382.6
P85602	Saraf Medical Practice	344.1
P85605	Littletown	329.1
P85606	Moorside Medical Practice	369.5
P85607	Chadderton South	353.8
P85608	Dr Perkins	467.8
P85610	Medlock Medical Practice	342.5
P85612	Werneth Medical Practice	420.0
P85613	Mohanty Practice	334.7
P85614	The Village	388.5
P85615	Kapur Family Care	355.0
P85620	St Chads Medical Practice	402.0
P85621	Sun Valley	387.5
P85622	Jarvis	379.7
P89006	Pennine Medical Practice	255.9
Y01124	Dr Duru	362.9
Y02753	Hilltop	469.8
Y02827	John St	367.1
Y02875	Lindley	481.2
Y02933	Hollinwood	418.1

Figure 25 – A&E Attendance rate per 1,000 GP Practice Population (graph)



Whilst the total number of attendances has increased overall, significant material increases have been seen in the very young and very old age groups (figure 19). Locally, the population of Oldham is more likely to attend the ED than nationally. The link between deprivation and emergency presentation is well acknowledged.

2.9 Paediatric Services

The Start Well ICO workstream outlines the joint aspirations of OMBC and Oldham CCG in respect of improving life chances for children and young people in the borough. This section focuses on urgent care services for children attending ED, referred by a General Practitioner and those children who require hospital care. CQC 2016 deemed the paediatric service at the Royal Oldham Hospital to be inadequate and regulators recommended the closure of some inpatient beds in line with the available nursing workforce, therefore we have seen an increase in the number of children being transported out of area for secondary care treatment. The Acute Trust has an active recruitment campaign and has seen an increase in nursing workforce. The current nursing numbers provide safe access to 2 HDU and 20 beds, the improvements made over the past 18 months were recognised by the CQC and saw the rating improve from 'inadequate' to 'requires improvement'. The team are working hard to further improve the service with an ambition to move to 'good' before the next inspection.

A business case is being prepared to share with commissioners to repatriate children back to the Royal Oldham Hospital and increase the bed base in line with demand for winter 2018-19, this would see beds increasing to 4 HDU and 30 inpatient beds. This business case also outlines the need to increase the consultant resource to enable a consultant delivered service out of hours and at weekends to coincide with the spike in acute presentation. This medical resource is to be viewed as a borough asset with active conversations commencing with GP cluster leaders regarding the deployment of consultant resource during

the day into the clusters. This could help up-skill primary and community teams and support the shift of care into the community whilst maintaining the critical mass of consultant numbers to ensure a safe and sustainable acute out of hours workload.

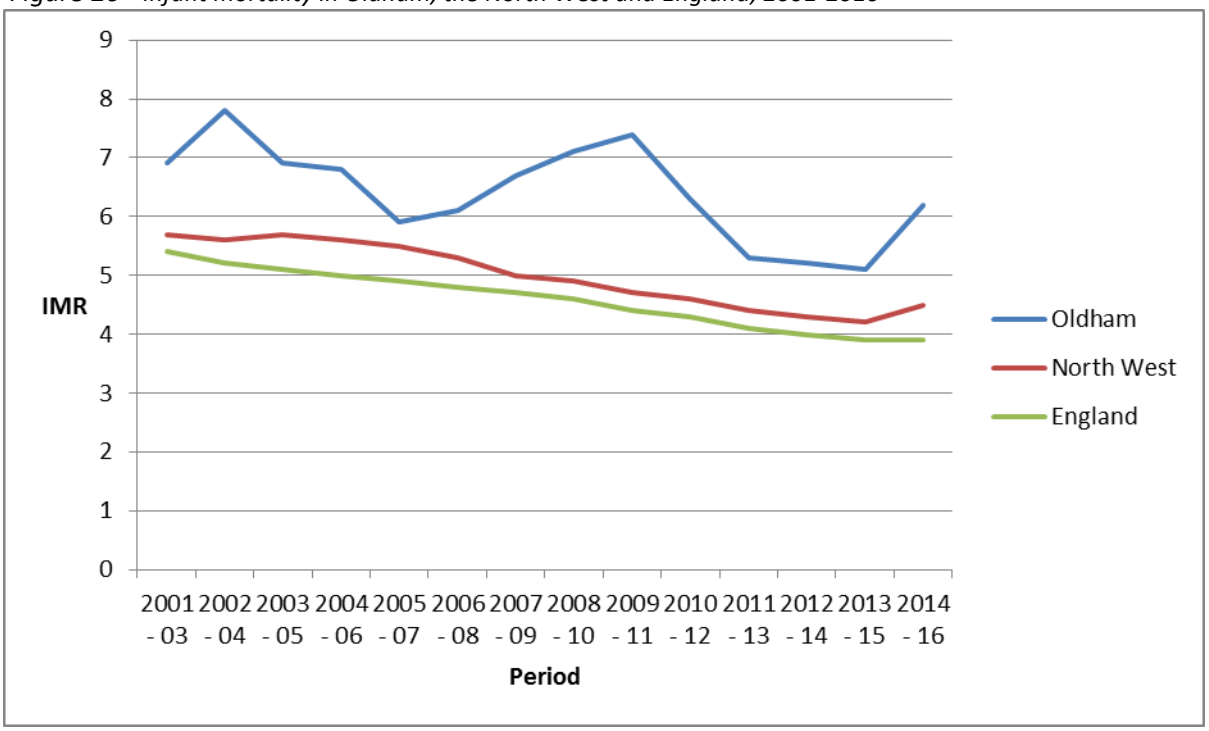
In response to the CQC inspection, a short stay paediatric assessment unit opened in November 2016. The unit is based on the Children's Ward and is consultant paediatrician led. The aim is to improve the urgent and emergency care pathway for children and young people. There is direct access for GP referrals (avoiding A&E), where children can be assessed in a more timely manner and in a child-friendly environment. The unit is open 24/7 and GPs contacting the hospital have direct access to a consultant paediatrician 9am-5pm, Monday to Friday, with an on call consultant service operating out of hours, and on site cover provided by a dedicated Specialty Trainee who can also provide direct advice and guidance. The Observation & Assessment area is busy seeing an average of 21 children per day, however there are peaks and troughs in activity and the unit can have as many as 45 children and their families in at peak times.

Over the past 2 years there has been a steady increase in the number of attendances which has peaked since August 17 when there was a sharp increase in non-elective activity which saw attendances rise from circa 900 per month to 1100, this has reduced slightly since February 2018 but remains higher than in previous years. In addition to higher numbers of children attending the hospital, acuity has also increased. In September 2016 our conversion rate of attendance to admit was 11.4%; this has steadily increased over a 12 month period reaching a high of 21.6% in the autumn of 2017.

Infant & Child Mortality

The infant mortality rate (IMR) is the number of deaths in infants aged under 1 year per 1,000 live births. Infant mortality data are collected by the Office for National Statistics (ONS) and reported through Public Health England's (PHE) Child and Maternal Health tool.

Figure 26 - Infant mortality in Oldham, the North West and England; 2001-2016



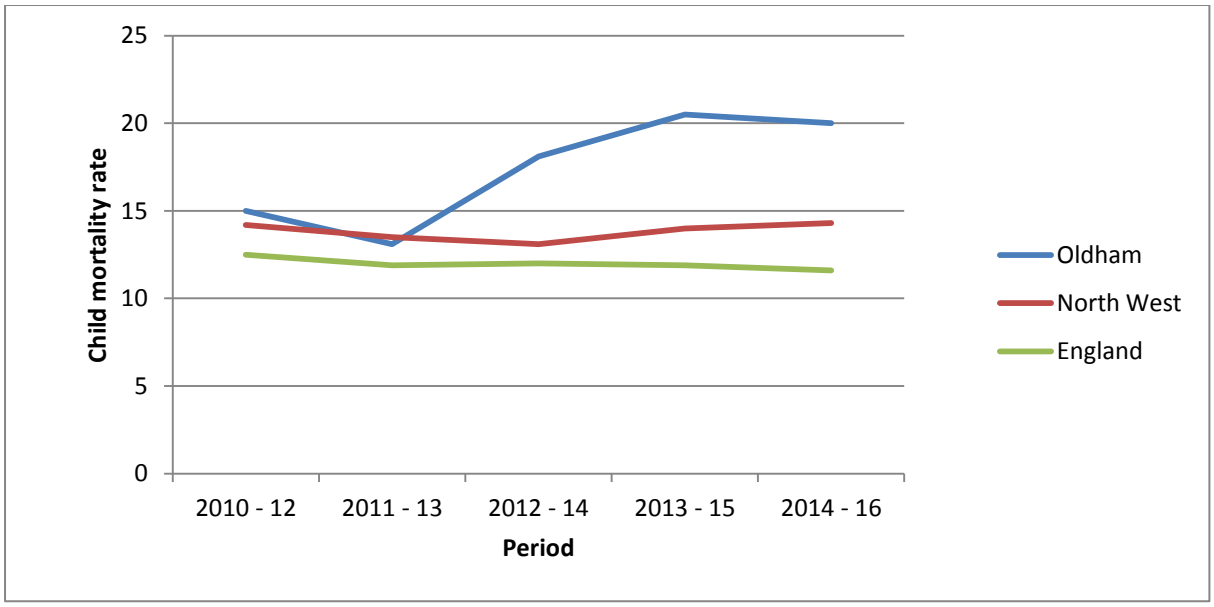
Source: Office for National Statistics

Infant mortality in Oldham is consistently higher than the rates for the North West and England. However, these differences are not statistically significant at every time point. Figure 26 shows fluctuations in the IMR for Oldham between 2001 and 2016 but this is probably due to small sample sizes (i.e. there are only a small number of infant deaths per local authority per year). Overall, there is a slight decreasing trend in Oldham's infant mortality.

Child mortality

Child mortality refers to deaths from all causes among children aged 1 to 17 years. It is expressed as a directly standardised rate per 100,000 population.

Figure 27 – Child mortality in Oldham, the North West and England; 2010-2016



Source: Office for National Statistics

Child mortality has increased in Oldham from 15 deaths per 100,000 in 2010-12 to 20 deaths per 100,000 in 2014-16. The child mortality rate in Oldham has been statistically significantly higher than the England average since 2012-14 onwards. Child mortality is also higher in Oldham than the North West average but this difference is not statistically significant.

2.10 Acute Medical Beds and Acute Take

The Royal Oldham Hospital has 380 acute beds, which benchmarks low in comparison to other organisations locally and nationally. The strategic direction of the health economy is to reduce the number of acute beds. However, it needs to be acknowledged that the baseline in Oldham is already at the lower end.

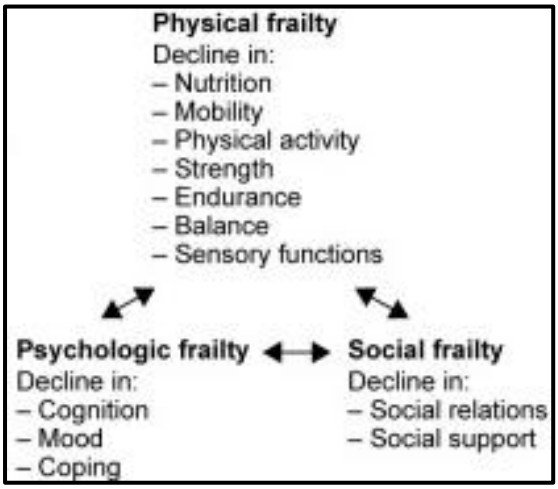
All new admissions into the hospital receive a consultant post-take review within 14 hours of admission as per the Royal College of Physicians' guidelines. Nationally, it is accepted that best practice ensures that in-patients will receive a senior medical review every day although current staffing levels within the hospital do not meet this requirement. However, following a successful workforce review and business case in 2017, the establishment is being expanded by a further four medical consultants.

Successful recruitment to these posts would enable a daily consultant review 5 days per week, but additional funding would be required to ensure this took place consistently across the 7 day period. A case for change will be developed with commissioner and GP cluster leaders to scope out the workforce implications for this transformation.

2.11 Older People and Frailty

The concept of frailty is multifactorial. It can describe a decline in physical and cognitive function as well as changes in social relations. There are various indices which aim to provide an overall measure of an individual's frailty; for example, the Tilburg Frailty Indicator (see Figure 28).

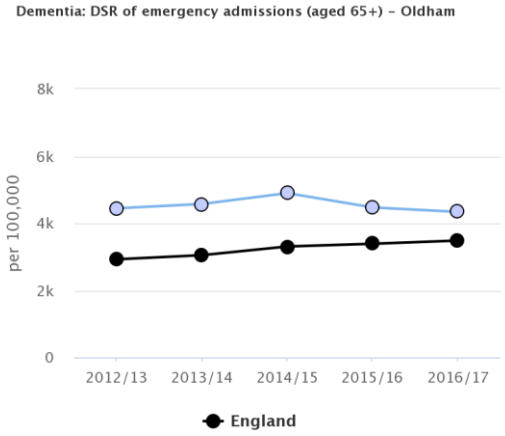
*Figure 28 – **A conceptual model of frailty***



Reproduced from Gobbens RJ, Luijkx KG, Wijnen-Sponselee MT, Schols JM. Towards an integral conceptual model of frailty. J Nutr Health Aging. 2010; 14(3); 175-181

There is currently no single frailty indicator available through routine data sources in the UK. However, there are data for individual outcomes which may contribute towards overall frailty and/or that are relevant when assessing urgent care utilisation. These include dementia prevalence and emergency hospital admission rate for people with dementia. The chart below shows that Oldham has a statistically significant higher rate of emergency admissions than England (and also higher when benchmarked against similar areas). This means that in 2016-17, 1,499 emergency admissions were for Oldham residents over 65 with a mention of dementia.

Figure 29 – Dementia – rate of emergency admissions (aged 65+)



It should be noted that many indicators (including the one illustrated above) are age-specific and will not capture frailty in younger adults. Other indicators may include smoking prevalence, physical inactivity, hypertension, obesity, diabetes, falls and social isolation. In areas of deprivation, such as Oldham, life expectancy and healthy life expectancy is lower than in more affluent areas.

The percentage of hospital beds being occupied by the frail and older population continues to rise. Oldham has a number of services which address the needs of this population including housing, community reablement, falls prevention etc.

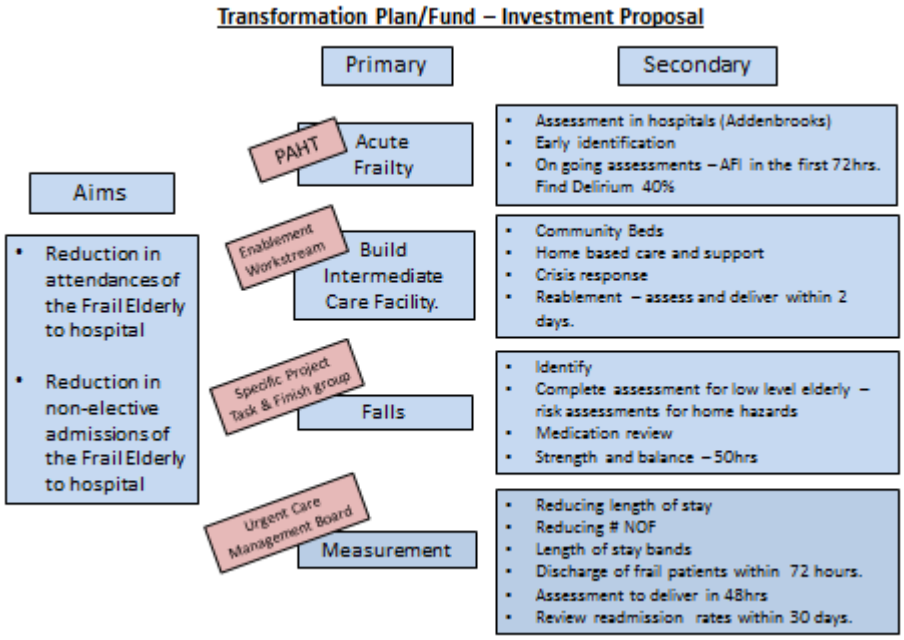
Since 2015, Oldham's Primary Care Quality Improvement scheme (EQALS Plus) has incentivised GP practices to invite, review and assess patients over the age of 75 for their risk of falls and any degree of frailty (the age range was reduced to over 65s in June 2017 in line with core contract requirements). Anyone found to have moderate or severe frailty should have a One Oldham Support Plan and appropriate intervention.

The scheme was not mandatory and uptake has been variable. Some practices have found the One Oldham Support Plan too time consuming to complete and that the payment attached to its completion was too small; others feel it is of limited value if it cannot be shared electronically. All of the above activity should be consistently coded but this has not always been the case.

The EQALS scheme will cease on 30th September this year and be replaced with an outcome focused scheme that will continue to include early identification and intervention with frailty.

As part of the Making Safety Visible Programme system leaders focused on frailty and recognised the need to take a population health approach to assertively managing those at risk of falls. The aspiration is to reduce the number of ED attendances and non-elective hospital admissions due to falls as outlined in the driver diagram below. A Frailty Steering Group has been set up to develop this further.

Figure 30 – Driver Diagram for Frailty



Key Message
There is one Accident and Emergency Department in Oldham offering a wide range of acute and emergency care services including trauma services, minor injuries, rapid access nurse led

clinics, speciality nurses and teams and a paediatric assessment unit. Connected to the department is an Ambulatory and Emergency Care Unit and Acute Medical Unit. Consultant establishment compared to the national position is good and the department has a good track record of attracting consultants despite the national shortage. There are plans to increase the workforce to enable greater consultant presence on the shop floor. The department has experienced some difficulties achieving the national quality requirements and four hour wait standard although in its recent CQC inspection received GOOD from INADEQUATE of the previous report. The rate of A&E attendance in Oldham is above the national average and increasing with particular increases in attendance from those living in South & West GP Clusters, very young children and those in the middle age ranges. Location and deprivation is also influencing attendance with higher rates of attendance from GP practices in deprived areas. The overall rate of attendance in A&E continues to be highest amongst young children and those aged 80+ years.

The situation for children within Oldham is worrying and unusual. One third of paediatric presentations to the ED are out of hours (between 6pm and 8am) which is higher than the other Pennine Acute hospital sites:

Hospital	Out of Hours Paediatric Presentations
Royal Oldham Hospital	33.34%
North Manchester General Hospital	30.60%
Fairfield General Hospital	26.81%
Rochdale Infirmary	22.99%

There has been a significant increase in the bed days occupied by older people which, in common with the national situation, will continue to grow. There is strong national and international evidence that this can be reduced by a population health approach and consistent interventions to a targeted group within the community.

2.12 999 Emergency Ambulance Service

North West Ambulance Service NHS Trust (NWAS) provides accident and emergency services throughout the North West region. The 999 telephone number and response is their main service. The 999 ambulance service is generally for use in emergencies, that is if a patient has a serious or life threatening emergency need.

Callers are connected to an ambulance 999 operator or call handler who asks a series of questions to establish what is wrong. Calls are categorised as Red 1, Red 2, Green 1, 2, 3 or 4 and response targets vary as outlined below:

Figure 31 – Current Response Targets for 999 calls

Current Response Targets

ARP 2.3 Response Standards

Category	Mean	90th Percentile
Life threatening Category 1	7 minutes	15 minutes
Emergency Category 2	18 minutes	40 minutes
Urgent Category 3	-	120 minutes
Less Urgent Category 4	-	180 minutes

Patients will always be taken to hospital when there is a medical need for this. However, ambulance crews increasingly carry out more diagnostic tests and do basic procedures at the scene. Crews also refer patients to social services, directly admit patients to specialist units and administer a wide range of drugs to deal with conditions such as diabetes, asthma, allergic reactions, overdoses and heart failure. Within Oldham, there is an Alternative To Transfer scheme for patients who have called an ambulance but who could be cared for safely in the community rather than having to be taken to the hospital, working with the patients' GP, out of hours service and community providers.

The GP OOH provider (gtd healthcare) is commissioned to provide a dedicated response to the Ambulance Service (NWAS) clinicians following application (by NWAS clinicians) of the Paramedic Pathfinder triage. This allows NWAS staff to refer safely to a responsive, medical service within the community, giving them an alternative to transferring to the Emergency Department, reducing the number of patients conveyed to the Emergency Department who can safely and appropriately be cared for within the community setting, and thereby reducing non-elective admissions. This service currently deflects approximately 6 patients per day, 2000 patients per year.

In addition, from 1st May 2018, during the out of hours period, gtd will receive referrals from the NWAS Clinical Hub for cat 3 & 4 ambulances for clinical assessment and appropriate management as an alternative to despatch.

The Ambulance Trust has one ambulance station in Oldham. Ambulance service demand has increased by about 6% year on year (NWAS Operational Information for staff, July 2017).

Under the rollout of the new ARP scheme, local and national data is not yet available but it is recognised that, although a large number of 999 calls are for immediately life threatening and life threatening conditions, there are still a number of calls for serious but not life threatening conditions and urgent conditions which could be managed in another way.

There is also some evidence nationally that there has been a steady rise in the number of ambulance calls per month, most notably health care professional calls, with a small *increase* for calls from patients. At this stage, we are unable to understand the trend locally or analyse ambulance conveyances by GP cluster.

> ***Key message***
> *The number of 999 calls from patients is understood to be rising locally, in line with national rises and the number of health care professional calls has increased. A number of calls are for immediately life threatening and life threatening conditions, although there are still a number for serious and urgent conditions which could be alternatively managed.*

2.13 Mental Health services

Core 24 Liaison Mental Health
The CCG has commissioned a RAID (Rapid Assessment, Interface and Discharge) service, which provides a psychiatric and alcohol liaison service in Royal Oldham Hospital. The service works within both the Emergency Department and older person inpatient wards, to provide psychiatric assessment and treatment for people presenting with urgent mental health needs.

There is a GM transformation scheme that has been developed in response to the national directive that by 20/21 no acute hospital should be without all age mental health liaison services in A&E departments and inpatient wards, and at least 50% of acute hospitals with a type 1 A&E should meet the Core 24 service standard as a minimum. In GM the target is more ambitious – to meet the Core 24 standard liaison MH service in all 10 GM acute hospitals with a type 1 A&E. The core-24 criteria are:

- The service should operate 24 hours a day, 7 days a week.
- The service should be a distinct specialty that is fully integrated with A&E department and general hospital pathways, and not provided as part of another service.
- The service should be based in the acute hospital, close to or in the A&E department.
- The service should have the skill mix and staffing level to operate a 24/7 rota effectively.

Transformation funding for this scheme has been approved to attain the staffing levels for a 500 bed acute hospital as a minimum in all 10 GM acute hospitals with a type 1 A&E. Royal Oldham Hospital will be staffed on a pro-rata basis according to the total number of beds. A Liaison Mental Health Steering Group is established to plan, develop and implement the staffing models – consists of provider Trusts, commissioners, clinical leads and SCN. CBA has been developed as part of the TFOG bid with modelling based on following outcomes (monetised in terms of fewer hospital bed days):

- Reduction in LOS in hospital for patients whose care is directly influenced by the MH liaison service.
- Fewer re-attendances at A&E by patients whose care is directly influenced by MH liaison service.

Recruitment in Oldham has commenced and the expanded service will be mobilised during 2018/19.

Integrated Crisis Safe Haven and Home Treatment Team
The CCG and Pennine Care NHS FT are working towards the development of a hub and spoke approach to an Integrated Crisis Safe Haven and Home Treatment Team, with the crisis café or safe haven providing a place away from the person's home, as well as away from A&E, for all people to access mental health crisis support, together with a 24/7 home treatment offer to work at home with those specifically at risk of admission. The Crisis Safe Haven will be based at the Evergreen Lounge at Forest House on the Royal Oldham site.
During working hours, the mental health service has a number of options for supporting people experiencing crisis or mental distress, these include Healthy Minds services for people with mild to moderate mental health needs or secondary care services such as the Access Team (which can provide short-term interventions), CHMT for those service users with severe and enduring mental health conditions who require longer term case management and Home Treatment services for people in acute mental health crisis who are at risk of an inpatient admission. However the majority of these services are commissioned to provide

support during the hours of 9-5pm, Monday to Friday; the exception being the Home Treatment which operates over a 7 day period until 9pm in the evening. Each borough has a home treatment team however none of these teams are currently resourced to operate over 24/7. There is a requirement in line with the 5YFV for all home treatment to be compliant with the core fidelity model, which includes 24/7 provision by 20/21.

As a consequence, between 9pm in the evening and 9am the following morning, the only option for people experiencing crisis or mental health distress is to present at the Emergency Department where they can receive a mental health assessment. For the clinician undertaking that assessment, there are only two options – either they discharge the person completely, with follow-up support either through the RAID service or the Access Team the following day, or they admit them to a mental health inpatient bed. For people presenting in crisis, frequently with co-morbid mental health, substance misuse issues and the associated risks, this is often a challenging clinical decision to make.

In this instance, the only option for immediate support and safety for that patient is admission, within that out of hours context. Some of these admissions, not all, will be short in length (5 days or less) whilst the immediate crisis is addressed and community support can be put in place.

The table below provides a summary of how this service will help alleviate the significant pressures CCGs and providers and facing across community, crisis and acute pathways.

Figure 32 – Mental Health System Pressures in Community, Crisis and Acute Pathways

System Pressure	Impact
Reducing no. of admissions to MH ward	Yes – directly support reduction for short-stay to everyone irrespective of known to services or not, who requires support overnight
Reducing no. of admissions out of area	Yes – indirectly as should lead to increased bed availability with the Trust
Reducing MH A&E attendances	Yes – directly where clinically appropriate
DTOCs from MH wards	Yes – directly as CRHTT provides early supported discharge and crisis safe haven as part of supported discharge
Readmission rates to MH wards	Yes – directly, as would be known to CRHTT and could form part of a supported discharge package
4 hour A&E breaches	Yes – as alternative to A&E for patients who do not need full RAID assessment
12 hour A&E breaches	Yes – indirectly with reduction in overall MH admissions creating capacity
Use of lounge on MH ward	Yes – indirectly with reduction in overall MH admissions creating capacity
Lack of out of hours provision – known to services	Yes – directly as no current provision outside ED setting for MH crisis support. The model would support wider spectrum of MH need
Lack of out of hours – not known to services	Yes – the model would support wider spectrum of MH need

2.14 Other Community Services

Figure 33 shows the availability of community services and those which are available seven days a week. As can be seen, there is a wide range of community and social care services provided locally, with varying five to seven day availability.

Figure 33 – Overview of community services provided in Oldham, availability and provider

Service	Provider	Provision (7 day)	Comments
Integrated Discharge Team (Discharge Co-ordinators/Transfer of Care Nurses/Social Workers/Patient Flow Trackers/A&E Therapists)	Multiple Lead: OMBC	7 day (reduced service at WE)	Not all partners provide 7 day service. Some posts not recurrently funded. Trusted Assessor pathways in place to IMC, reablement and some Care Homes.
Intermediate Care – Butler Green	Pennine Care Foundation Trust	Yes including admissions 7 days	28 beds including 8 Enhanced Intermediate Care
0ldham Rapid Community Assessment Team (ORCAT)	Pennine Care Foundation Trust	Yes	Step Down and Step Up short term support at home
Community IV Antibiotic Service	Pennine Care Foundation Trust	Yes	Domiciliary and ambulatory IV antibiotic service
Out of hours District Nurses	Pennine Care Foundation Trust	Yes	
Reablement Beds – Medlock Court	Miocare	Yes including admissions 7 days	32 reablement beds
Reablement at home services	Miocare	Yes	
Helpline	Miocare	Yes	
Transitional Beds – not all year	Private providers – currently Acorn Lodge and Werneth Lodge	Yes	Funded over winter periods to provide additional capacity
'Alternative' Beds	Various private providers	Yes	Accept patients with dementia. Alternative pathway to Limecroft Nursing Home.
Home from Hospital	Nightingales		Short term packages of care to fill gaps and assist discharges home
Stroke ESD	Rochdale	Yes	Are there clear discharge arrangements for Oldham residents who receive acute care on other sites e.g. Silver Heart Unit & Stroke

It makes for a complex picture of provision across Oldham, with some potential for confusion for patients involved with these services needing to access care urgently. Going forward, more of this information needs to be available through 111 to ensure patients can be signposted to the most appropriate services. Since

April 2017 there has been an integrated discharge team with single line management, based at the hospital to assist those patients who require support on discharge from hospital.

Community Enablement is the subject of a separate ICO workstream.

2.15 Summary of key factors facing the urgent care system and conclusions

Taken from the "key messages" through this section, the key issues relating to the urgent care system are as follows.

- We need to reduce public reliance on services and support self-care by greater use of community assets. Although there is a wide range of support tools and services available, uptake and usage locally is limited or unknown. Promotion of existing services and resources, including NHS Choices, should be a priority as should promotion of the NHS 111 number for advice.

- We are well served by community pharmacy, with extended opening times including evenings and weekends. They have a wide range of skills including support for self-care and sign-posting to other services (including 111) and potential to do more, including managing minor ailments and emergency supply.

- GP consultation rates are continuing to rise. Nearly all practices in Oldham encourage telephone consultation for urgent conditions, with most getting a call back within an hour (although this varies by practice). There is some evidence GP visits in the middle of the day has an impact on patients attending A&E later.

- The local GP out-of-hours service performs well and is highly regarded by patients and professionals. With the evening and weekend slots f or the GP Federation only available as booked appointments, although the WIS is also available. Therefore, there are 4 primary care providers with the urgent care space (patients' own registered GP, evening GP federation, gtd out of hours and Walk In Service). This could lead to a disjointed service. There is the opportunity with the development of clusters to refocus the urgent primary care offer at the 50,000 population level.

- NHS 111: Most patients are referred to primary care or ED, or receive an ambulance despatch. Referrals to other services including pharmacy and re-enablement / intermediate care are low as are the numbers of those receiving advice from the service. We need to increase the numbers of patients referred to services other than 999 and ED, particularly out of hours services and WIS/Urgent Care Hubs.

- There has been an increase in 999 calls from patients reported nationally, however the number of health care professional calls has also increased. Conveyance rates to emergency departments are high, with limited alternatives available as most community provision is step down not step up

- There have been some difficulties in waiting times in the A&E department, although CQC rating is 'Good'. Consultant cover is in the week is good, although drops at weekends. Our rate of A&E attendance is above the national average and increasing and we need to halt this rise. The overall rate of attendance in A&E continues to be highest amongst young children and those aged 80+ years, suggesting a need for clear pathways for these patients.

- The number of children presenting late and acutely unwell is a worrying trend. There needs to be both the investment in the community to prevent these children becoming unwell balanced with the need to respond to the regulatory requirement to improve and invest in the medical and nursing workforce at the hospital.

- There is an increasing number of elderly and frail patients being admitted to hospital. There is strong national and international evidence that this can be reduced by a population health approach and consistent interventions to a targeted group within the community. There are a number of services within Oldham who occupy this space, these need to be evaluated against this evidence and better co-ordinated.

- A wide range of community and social care services are provided locally, but not all are available six or seven days a week. Of those that are, there are often differences in provision. There are a number of services (Neurology, Stroke and Cardiology) where the acute centre is not at the Royal Oldham Hospital. Assurance is needed that there are clear discharge pathways into the Oldham community and re-enablement system.

- Further improvements need to be made to the multi-agency system of care and support so people in crisis because of a mental health condition and this is the subject of an ICO workstream.

2.16 Urgent care contracts and costs

The CCG also invests some of its allocation in additional local investment schemes (namely EQALS Plus, Boilerplate, Cluster Based Budget schemes and the 7 Day Access scheme). This amounts to a further investment of c£8.5m.

Table 33 show the urgent care services described in this strategy, the cost of each and the contract type. In some instances, it is not possible to separate out the cost of the "urgent" care services, particularly in primary care, but this provides an overview of the cost of services. The table shows the most expensive services are 999 and Accident and Emergency, with lower values attributable to the GP out of hours, MIU and 111 services. Where available, cost/case figures are included and more work will need to be done to assess the value for money offered by the various contracts.

Figure 34 – Urgent Care Contracts and Costs by Service

Service	**Cost, based on 2017-18 contract values**
Ambulance service (999)	Patient Emergency Services (NWAS) contract for 18/19 is circa £7,875k (including a CQUIN). The contract is a block contract. The cost per ambulance trip is £300.
Accident and Emergency	A&E attendances for Oldham patients at all Pennine Acute sites cost around £11m annually. A&E attendances for Oldham patients at all GM contracted trusts cost around £1.2m. The average cost of an A&E attendance for PAHT sites (Oldham patients) is £125 each. Simpler less complex attendances will be circa £85 each.
GP out of hours services	The cost of the GP out-of-hours contract in Oldham £1.725m. The contract is a block and the average cost per case is £54.
Walk In Centre	The estimated total cost of the WIS is £1.25m. This is an APMS contract for the Walk in Centre and a registered practice.
NHS 111	The cost of the 111 contract to Oldham is c£647k, based on a cost per call of £6.20. The contract is The contract is based on a risk

	share between NW CCGs.
Primary care (community pharmacy)	There are 59 Community Pharmacies in Oldham. The proportion of the budget that relates to pharmacies in Oldham cannot currently be extracted from GM data. is c£XX Pharmacies are paid against a contractual framework, based on a combination of block fees and fees linked to items dispensed.
Primary care (GP practices)	The 44 practices cost (including dispensing payments but excluding premises etc) is **c£23.3m**. Additional local investment schemes amounts to a further investment of c£8.5m. The contract is based on a fee per patient and specific fees & allowances.
These financial values require validation and are indicative to make the point.	

As described previously, the current urgent care system is complex and this can lead to patients having to access multiple services to find the 'right' one for them which can lead to unnecessary attendance and cost in the system. This does suggest that urgent care services may not be being used most efficiently or effectively, with some default to the more expensive services including A&E and 999. Our ambition is to drive a significant shift in the focus of resources on urgent care away from emergency ambulance and acute care towards care in the local community, where it is safe to do so. This will be by developing primary, community and adult social care into clusters of c. 50,000 population. Acute hospital care will only be used for the patients for whom it would not be possible to care for safely and appropriately in other environments. However, they need to be clinically and financially sustainable.

3. Principles and objectives

Having reviewed the current urgent care system and patient perspectives and priorities, it is timely to re-visit the vision, principles and objectives and, strategic aims described in section one to assess how closely our current services and system match what we are aiming for.

A gap analysis was undertaken by the Urgent Care Alliance Operational Group which took the known current service provision and explored the key gaps against their knowledge. Further work is required and many of these gaps are being addressed through transformational work streams.

Figure 35

Summary of Gap Analysis Outcomes		
Gap identified	**Details**	**Address by:**
Frailty/Falls/Dementia patients	Frailty screening, dementia screening, falls prevention, One Support Plan,	Urgent & Emergency Care work stream
GP urgent care offer	including GP Fed 7 day access 111 appointments	Core & Extended Primary Care work stream
IDT working 7 days	including IT access across site	Community Enablement work stream
Community IV Therapy	Review of core service	Review underway
Patient transport & ambulance handover times	Ambulance handover improvement plan has improved handover times significantly in April 2018; review of patient transport completed and proposal for procurement of future service.	Transport group meeting in Oldham and at NES level to progress

Clinical support for Care Homes	Trusted assessor pathway agreed with 10 Care Homes. Proposal for clinical support to reduce hospital attendances and admissions to be included in UEC work stream business case.	Community enablement and UEC work streams
Health support for homeless people	All GPs should accept patients with no fixed abode; in practice, they are likely to register at Lindley House which is co-located with the Walk in Service at the town-centre base at the ICO.	
Support for BME older people	Unclear how much of an issue this is; further investigation needed.	
Trust between organisations		All levels of ICO
GP Streaming in ED	Pilot scheme in place but future model not yet determined.	UEC work stream
Ambulatory Care expansion	Expansion to 7 days	UEC work stream
Fit to Sit preparation for discharge		Part of TROH QI plans
Discharge 2 Assess beds	including Medlock accepting over 18	Community Enablement work stream
Estates issues at TROH	Size of discharge lounge; configuration of ED, use of ACU, development of Urgent Treatment Service	UEC work stream and PAHT plans
Take home medications	Delays in ordering and dispensing can impact on flow; reduced service at weekends	TROH QI plans
Equipment/orthotics availability	Further investigation required	
Provision for larger bariatric patients	Further investigation required	

In developing services to achieve the vision, we need to ensure the **principles** guide our decisions to ensure a simple and straight forward network of high quality urgent services are routinely available. We will increasingly articulate 'what good looks like', including outcomes and quality standards for all our urgent care services, to ensure we are able to monitor and assess quality. These will be evidence-based, incorporate patient experience and draw on the expertise of local providers. Most, but not all, urgent care services are available seven days a week. The cornerstone services, which are available seven days a week, are NHS Choices, NHS 111, 999, some community pharmacies and urgent primary care services (a combination of in-hours GP practices and out-of-hours service) based at cluster level.

The proposed principles are:

- *See individual and their community as an asset and move to more proactive rather than reactive urgent care system.*
- *Provide consistently high quality and safe care, across all seven days of the week.*
- *Be simple and guide good, informed choices by patients, their carers and clinicians.*
- *Provide access to the right care in the right place, by those with the right skills, the first time.*

- *Be efficient and effective in the delivery of care and services for patients.*
- *Ensure services are financially and clinically sustainable*

4. Priorities for system change

Considering the map of current services and use of the same suggests we have more to do in the next five years to develop a clearer and more comprehensive range of urgent care services at a cluster level. To do this, we need to focus on our priorities for change described below, which incorporate the five strategic priorities for change described in the first chapter: support for self-care; right advice, right place, first time; highly responsive services available outside of hospital; those with life threatening emergency needs receive care in more specialist centres; and, urgent and emergency care services are connected.

Our **priorities for change** over the next three years are as follows; these priorities are intended to deliver an urgent care system across Oldham.

☑ **Move to a more proactive management of long term conditions and those at risk of hospitalisation by taking a population approach.** Oldham will introduce a risk stratification tool to identify those communities at greatest risk. The clusters will develop their urgent care offer to include the proactive management of these patients.

☑ **More actively promote self-care and make it much easier for patients to access high quality, reliable information and services**. This can include making best use of the web including NHS Choices, peer support and voluntary sector support. We also want all providers to provide consistent messages about self-care are given and sign-post to other appropriate services, including the third sector. We will explore social marketing to ensure messages are targeted accordingly and link to the Thriving Communities' agenda. Each cluster will develop a community asset register to access third and voluntary sector services in a consistent and reliable way.

☑ **Ensure primary care – in hours and out of hours services – is the service of choice for patients to meet their urgent care needs**. Most patients see primary care, particularly GP practices, as their main urgent care provider. We need to ensure that this continues to happen and that patients get prompt access to high quality services when they most need them. Consistent, same day access to primary care will become the norm. Many practices are already able to see patients the same day for an urgent issue however this is not always available. A more timely approach to requests for home visits is also important, so patients with urgent conditions are assessed and seen promptly and to avoid the mid-afternoon/late evening "bulge" of attendance at A&E. Earlier home visits are currently being piloted in one cluster and will be evaluated after 13 weeks. Primary care access will be developed at a cluster level.

☑ **111 direct booking into the 7 Day Service** – a pilot service being trialled across GM, due to start in Oldham in early summer. Patients will ring 111 and go through the usual assessment process. If the algorithms for matching the patient symptoms suggest that it would be appropriate for the patient to see a GP, 111 will see if there is an available appointment in the Oldham 7-Day Access service in one of the slots that will be reserved for these types of appointments. 111 will then book the patient into the service, rather than going through the standard process of having the patient ring the 7 day booking line, and the patient will go to the designed 7 day hub for their appointment.

☑ **Develop options locally for patients to access an "urgent care hub" in each GP Cluster with enhanced skills to manage long term conditions and cases which currently present to hospital.** The guide specifications for these services are still in development however it seems likely that they will need to include access to walk-in minor illness and injury services and be part of wider primary care services

including out-of–hours GP services. The urgent care cluster offer will need to contain a core offer which is consistent across Oldham. Our priority for reconfiguration will be to ensure a high quality, consistent and safe service can be provided and this is likely to mean economies of scale are necessary.

☑ **Continue to reduce ambulance conveyance rates.** We want to continue to work with the trust to provide care and treatment at the scene, wherever necessary, or convey patients to alternative services including urgent care centres as they develop.

To support this priority, we are working with NWAS and GtD to test a *proof of concept* to pilot an alternative to dispatch, working alongside the established Alternative to Transfer Service. Using a MDT approach, the workforce will respond to appropriate 999 calls across Oldham following a review of the case summary, pulling category 3 and 4 patients directly from the NWAS 'stack' thus reducing the need for an ambulance. This will primarily be through the 'hear and treat' model with the option of a visiting clinician to respond to 'see and treat', thus providing focused clinical assessment over the telephone or at the patients' location, followed by appropriate immediate treatment/referral to alternative services to A&E.

☑ **Develop community pharmacies into urgent care providers.** We have a wide network of community pharmacy services locally, with extended opening hours. They are well placed to offer more enhanced urgent care services and we will be exploring this in more detail including advice for minor ailments, medication, emergency supply of medicines and advice and support for long term conditions. They will increasingly become part of the urgent care network and there is scope for trialling roles for pharmacists in locations where urgent care is provided.

☑ **Reduce ED attendance rates and 999 calls for urgent conditions.** In delivering all the above, we need to halt the year on year rise in attendance at our A&E department so it is fully able to become an Emergency Centre dedicated to more serious and life threatening conditions. Reducing the number of 999 calls will also be important, and we need to include in this halting the rise in health care professional calls to 999.

☑ **For urgent mental health care, achieve parity with physical health care.** People in crisis because of a mental health condition are kept safe and helped to find the support they need, whatever the circumstances in which they first need help, and from whichever service they turn to first. No one in mental health crisis will be turned away or find themselves alone in their distress. Wherever possible, crisis will be prevented from happening through planned prevention work and early intervention.

☑ Thinking back to the needs assessment, a high proportion of those using urgent care services are children, particularly pre-school children. This suggests a need to ensure that there are **suitable urgent care services available for children and that all services are child friendly.** In some instances, there may be a need to ensure that speciality paediatric trained doctors and nurses are available out of hospital to upskill community and primary care. The GP out-of-hours service and A&E in particular both currently see large numbers of young children; it is likely that this picture is mirrored in in-hours general practice too, although we do not have figures for this. There is a need to publicise urgent care services to parents of young children, in particular the NHS 111 number and provide support for self-care and advice for common childhood illnesses. There is the potential to work with the Start Well work stream of ICO programme.

☑ Given the high proportion of young children using the services a priority recommendation would be to develop a **paediatric urgent care pathway**, at cluster level. This will need to reflect the community diversity, poverty and other indicators.

At the other end of the spectrum, the highest attendance *rate* per 1000 patients in A&E continues to be amongst older people. Very often, a busy A&E department is not an appropriate place for a frail older person to be.

☑ A priority recommendation therefore is to develop a **frail urgent care pathway**, with the emphasis on pre-hospital care, including developing support to care homes, avoiding the need in most instances for the

frail elderly to receive acute hospital care. Again, this needs to take place at cluster level to ensure the appropriate risk stratification and population health approach. This is to be dovetailed with a **population health approach to falls prevention** at cluster level.

☑ We recognise that Oldham has high level of **health inequalities** and therefore the priority is to consider prioritisation of services by need and not only a universal offer.

☑ It is widely researched that a number of other factors (housing, lifestyle, employment, isolation) impact on the wellbeing of an individual and our community**.** In order to move from a reactive to a reactive urgent care system, Oldham needs to explore these **wider determinants of health** and tackle these as well as improve service delivery. During the next year, the ICO will create a business intelligence platform to analyse wider public health and to a neighbourhood level (144 within the borough).

5. 'What good looks like' – quality and outcomes

Appropriate and timely access to urgent care influences outcomes. Oldham Cares is developing an outcomes framework which at high level has been agreed as;

Figure 36

High level outcomes

Oldham cares
Health and social care partnership

A. Healthy Population	B. Effective prevention, treatment and care	C. Service quality/health of the system
A1. Children have the best start in life	B1. People dying early from preventable causes	C1. Access to the right care at the right time.
A2. Thriving communities which promote, support and enable good physical and mental health and wellbeing.	B2. Find and treat people with undiagnosed conditions	C2. Individuals and families have the best experience possible when using services.
A3. Individuals and families are empowered to take control of their health.	B3. Support people to self-manage and self-care where appropriate	C3. Individuals and families have access to high quality treatment and care.
A4. Everyone has the opportunity and support to improve their health and wellbeing, including the most disadvantaged.	B4. Ensure mental health is central to good health and as important as physical health	C4. Health and care system is financially sustainable.

This will need to be adapted to include the outcomes where urgent care services can contribute, including support for self-care, avoidable admissions and improving patient experience. We will increasingly include these outcome standards in contracts with urgent care providers, ensuring that as far as possible the same standards apply across different contracts to encourage providers to work together to meet shared aims. These will be developed by the Urgent Care Transformation Work Programme.

Figure 36 begins to scope out local quality and outcomes standards that we will be looking for across the urgent care system. Broadly, these can be categorised as system design standards and those for service delivery, clinical governance and workforce, and commissioning arrangements. These are high level at this stage, and focus predominantly on the system and service delivery standards applicable to all urgent care

providers. A more detailed description for these standards will need to evolve as we continue on our transformation journey and in particular give attention to the wider social determinants of health.

Figure 37 – Quality and Outcome Standards

System Design:

· The citizens of Oldham are to be considered within their place – i.e. family, friends and wider community. The system will be designed in the context of place.

· Connections will be made to self-care at each point in the urgent care system, maximising the use of voluntary and community assets.

· The patients will be seen by the right person with the right skills to manage their needs, first time. · The patient knows how to access information and guidance in the event of needing urgent or emergency care · Prompt care is good care and the emphasis should be on access across the whole system.

· Delays and handoffs between urgent care providers should be minimised; all providers will work together to ensure that if a patient has been previously seen clinically assessed as needing another service, then can be "fast tracked" for treatment elsewhere.

· General practice is the bedrock of any urgent care system; all commissioning strategies for urgent care should start by addressing the key role of general practice. If all practices improved the speed and effectiveness in responding to same day urgent requests in a consistent manner at scale (through the clusters) there would be a substantive beneficial effect on the wider healthcare system.

· Best practice is adopted across urgent care services, including early senior review and "see and treat" for minor illness and injury.

· There is greater integration between services, to reduce confusion and duplication.

· Patients are involved in their care and treatment and in the design and delivery of services, with an emphasis across all providers on citizen engagement and patient experience, and adapting services to meet patient preferences. · Productivity should be measured in time the person is engaged with system, not just productivity as a measurement of health provider assets.

· Services are at a standard that people would recommend to them to family and friends. · Information is shared across urgent care providers to improve patient care and outcomes, with complementary and interoperable solutions. · Urgent care services are "networked" into an emergency department professional support, clinical supervision and advice on clinical standards.

· 'Out of hours' urgent care services are co-located as far as possible, with reciprocal arrangements for advice and support and to pick up each other's caseload when either team has no waiting patients.

· No closed door – if a service cannot meet your needs you will be seamlessly passed onto a more relevant service.

Service Delivery:

Physical environment; demand and capacity; clear information; initial clinical assessment; see and treat; health and wellbeing advice – every contact counts; care of children away from hospital and prompt initial visual assessment; initial mental health assessment; liaison psychiatry; services for pregnant women; rapid response for end of life; mental health care.

Clinical Governance & Workforce:

Named clinical governance lead; patient involvement and feedback; shared governance, safeguarding policies and procedures; dignity and respect; kindness; competencies to assess children, maternity and mental health needs and refer as appropriate; first responder skills in caring for the acutely ill.

Commissioning Arrangements:

Focus on outcomes not activities; incentives for innovation and collaboration.

Joint health and social care commissioners will be a highly effective commissioner of urgent care through good working relationships with providers, a sound understanding of services, observing services – including walking the floor; talking to patients, staff and clinicians; performance monitoring and early recognition of issues.

The commissioning arrangements will create the environment for front line staff innovation to thrive.

In addition to these, we need to do more work locally defining outcomes and quality standards for A&E, primary care and primary care front end of ED, cluster hubs. These will need to draw on existing quality

standards (where they exist) and other relevant standards including the ED quality indicators, GM Primary Care Medical Standards that include access and Healthier Together for example.

Figure 38 - Specific Quality Standards by service: ED, in hours primary care and cluster urgent care offer

A&E	Primary Care (in hours GP)	Cluster Urgent Care offer
❖ 'shop floor' consultant cover at least 12 hours per day, including bank holidays and weekends. ❖ Local achievement against ED quality indictors to be at least as good as the national average and move towards top 25%. ❖ Consistent achievement of the 4 hour wait standard. ❖ Improvements in patient satisfaction with ED services.	❖ Patients contacting their surgery with an urgent condition should receive a clinical assessment, which can be over the phone within one hour. ❖ Those needing to be seen for an urgent condition will be seen on the same day. ❖ Those requesting an urgent home visit are promptly clinically assessed , on the phone, and visited as quickly as possible after assessment (PCF recommend 20 mins for phone assessment and a visit within one hour of assessment) ❖ 7 day access into evenings and early mornings (before 9am) if local needs dictate.	❖ Available and operational for at least 12 hours per day (with 16 being the optimum) ❖ Clinical multi-disciplinary team available at all times ❖ Initial assessment within 15 minutes ❖ Overall waiting and treatment time should be no more than 3 hours (with the optimum being 2 hours). ❖ Proactive risk stratification of those at risk of requiring urgent treatment having a proactive management plan and key worker from the MDT.

6. Associated developments/ consideration

This strategy needs to be viewed within the context of the CCGs approach to financial management, which also applies to this strategy. Planned spending on the current main healthcare provider services will remain at the same level as planned except where organisations can demonstrate that by spending more than this, savings will be made elsewhere in the system and this can be agreed with those organisations. This means we are unlikely to see additional recurrent resources available for urgent care. However, the transformation funds are available for the next 3 years to test new ways of working (or for double running cost) to improve system efficiency and reducing the reliance of the population on the more expensive services: 999 and ED in particular.

The new integrated care organisation (Oldham Cares) brings together all providers of urgent care into an alliance agreement. This will be the vehicle by which we can see resources shifting from acute care to high-quality, value-for-money care provided closer to and in people's homes.

We will see a shift in the current workforce configuration to more community-based teams delivering seven-days-a- week services. This will include working at a cluster level to achieve this within primary care.

Alongside this Urgent Care Strategy is the Thriving Community programme which aims to create and sustain community assets to enable people to self-manage their own conditions in their place.

7. Outcomes

The outcomes are contained within the original ICO documentation. This detail was not signed up to at Service Component level but was aggregated up. In May 2018 the system re-submitted ICO deflections which will come into place during 2018-9 and the full year effect in 2019-20. Business cases are being submitted with detailed expenditure plans and impact on future years during quarter 1 2018.

Figure 39 – Transformation Benefits & Deflections

Transformation Benefits/ Deflections - Benefits Realisation Monitor

Name of Service Component	ALL	A&E			Total	NEL			Total	Stretch Targets A&E	Stretch Targets NEL
Transformation Lifecycle Profile Sign Off by Comm	Y/N	18/19	19/20	20/21		18/19	19/20	20/21		18/19	18/19
Deflection title and brief description of the transformation taking place in this deflection area. (Project list of applicable)	ALL										
ICO TF Profiling assumptions April 2018 (% split)	Thriving Communities	11%	31%	57%		11%	31%	57%		11%	11%
Deflection Targets As of April 2018 (%/ abstract)		292	777	1,452	2,546	35	93	174	306	292	35
ICO TF Profiling assumptions April 2018 (% split)	C&EPC	17%	41%	42%		18%	41%	41%		17%	18%
Deflection Targets As of April 2018 (%/ abstract)		517	1,245	1,266	3,028	318	705	717	1,740	1,267	318
ICO TF Profiling assumptions April 2018 (% split)	U&EC										
Deflection Targets As of April 2018 (%/ abstract)		-	-	-	-	-	-	-	-	-	-
ICO TF Profiling assumptions April 2018 (% split)	Start Well	33%	33%	34%		33%	33%	34%		33%	33%
Deflection Targets As of April 2018 (%/ abstract)		2,236	2,274	2,313	6,823	184	187	190	562	3,387	184
ICO TF Profiling assumptions April 2018 (% split)	MH	20%	40%	41%		20%	40%	41%		20%	20%
Deflection Targets As of April 2018 (%/ abstract)		237	482	490	1,209	19	38	38	94	237	19
ICO TF Profiling assumptions April 2018 (% split)	Community Enablement	9%	44%	48%		9%	44%	48%		33%	33%
Deflection Targets As of April 2018 (%/ abstract)		180	920	1,012	2,112	90	460	506	1,056	2,970	1,485
ICO TF Profiling assumptions April 2018 (% split)	Health Improvement										
Deflection Targets As of April 2018 (%/ abstract)					-				-	-	-
	Total %	22%	36%	42%		17%	39%	43%		27%	28%
	Total Planned Deflections	3,462	5,698	6,533	15,718	646	1,483	1,626	3,757	8,153	2,041
	IA Deflections (PwC) Carry Forward	4,062	6,248	11,509	21,819	1,092	1,511	2,773	5,376	4,062	1,092
	Variance	- 600	- 550	- 4,976	- 6,102	- 446	- 29	- 1,147	- 1,619	4,091	949
	%	85%	91%	57%	72%	59%	98%	59%	70%	201%	187%
				Reconcile to IA 4th Year	29,100			Reconcile to IA 4th Year	7,039		
				Variance	- 7,281			Variance	- 1,663		

I:\Information, Intelligence & IT\BI - Business Intelligence\Adhoc Requests\ICO Deflections re-work 03-04-18\[ICO Deflection Detail 19-04-18.xlsx]Front

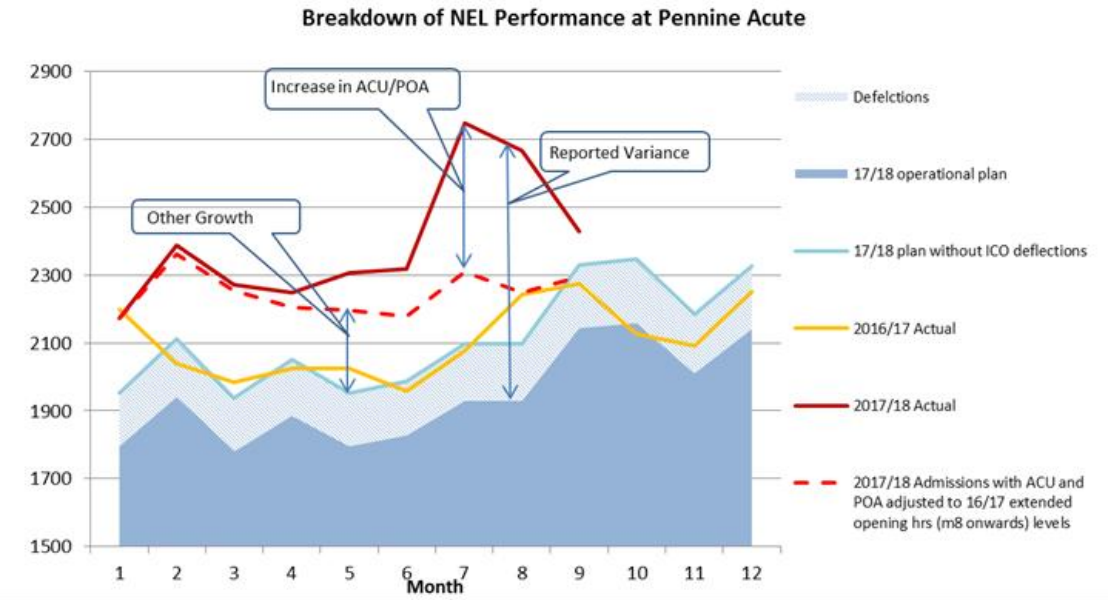
This does not take into account the fact that since the agreement of the high level ICO deflections there has been an underlying "growth" of 5.62% (1,086 emergency admissions to month 8 or 1,629 straight line forecast). This is detailed below:

Figure 40 – Growth in Emergency Admissions at TROH

	YTD M8 'Over performance'	%age of Total Over Performance	Over Performance %age Total	Comments
ACU	906	19%	12.49%	All admissions to ambulatory care ward HACU (includes transfers to other wards and >0 LOS)
POA	1,515	32%		All admissions to Paediatric O&A ward HPOA (includes transfers to other wards and >0 LOS)
ICO deflections not achieved (Operational plan)	1,175	25%	6.06%	Note:- Operational plan and contract plan with PAHT are not consistent due to last minute adjustments to the ICO deflection quantity.

Other NEL Over Performance	1,089	23%	5.62%	Increases are occurring across all other areas
Total PAHT Acute Non-Elective over-performance vs plan of 24.17%	**4,684**	**100%**	**24.17%**	

Figure 41 – Breakdown of Non Elective Performance at Pennine Acute



8. Key Strategic Milestones

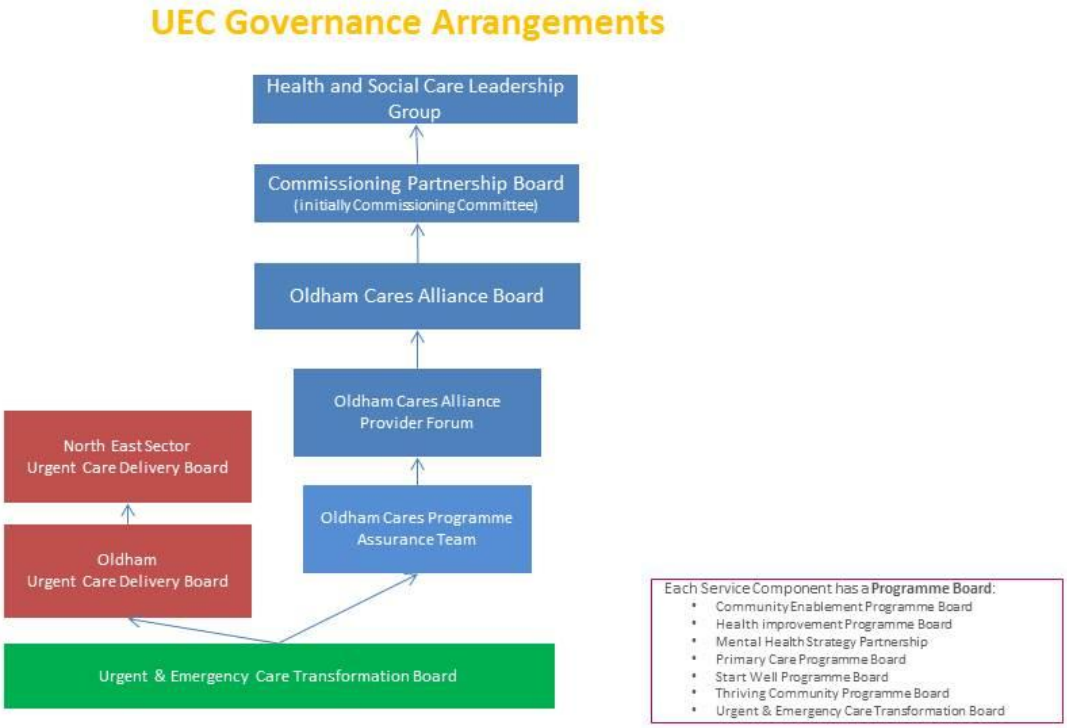
Figure 42 – Timeline of Key Strategic Milestones

Each workstream is developing a detailed action plan, this timeline illustrates the key strategic milestones for 2018-19.

Key Strategic Milestones	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19
Launch of 10 by 10 within Royal Oldham Hospital										
Agreement of 4 hour trajectory for 18-19										
Decision on Oldham risk stratification tool										
Transformation business cases agreed										
Consolidation of front end streaming (hours of working)-										
Relaunch SPRINT										
Colocation of community health and social care staff into clusters										
Primary care urgent care cluster offer basic offer (phase 1)										
Procurement process commences for front end of ED										
Launch of Integrated Crisis Safe Haven and Home Treatment Team										
Completed recruitment to deliver Core 24 RAID compliance										
Launch of Paeeadiatric Hub including revised paediatric urgent care pathways										
Launch of risk stratification tool across GP practices										
Primary care urgent care cluster offer basic offer (phase 2)										
Launch frailty pathway										

9. Governance

Figure 43 – Governance Arrangements



BRIEFING TO HEALTH SCRUTINY

Air quality: an update on recent developments to the policy and legislative context in Oldham and Greater Manchester

Report author: Rosie Barker

Date: Monday 3rd July 2018

Summary

In January 2018, a report was brought to Health Scrutiny setting out the public health impacts of air pollution in the UK and describing work being done at a Greater Manchester level, through the Greater Manchester Air Quality Action Plan, to address the issue across the conurbation.

The report also clarified that the government has mandated 29 local authorities, including 7 districts within Greater Manchester, to undertake comprehensive feasibility studies, assessing a wide range of options, to identify solutions to specific local exceedances as soon as possible.

Oldham was not one of the 7 districts in Greater Manchester required to undertake this study, but it was agreed that all 10 districts would be included as air pollution does not recognise administrative boundaries.

This work has been progressed accordingly, led by Transport for Greater Manchester (TfGM), however, in April 2018, Oldham was identified in a subsequent wave of local authorities at risk of not meeting the nitrogen dioxide pollution levels on specific road links by 2021 and a ruling was made that each authority must produce a plan to achieve compliance as soon as possible.

The following report therefore provides an update on the Oldham local feasibility study in as well as expanding on the link with the work being led by TfGM.

1.0 Background

1.1 Air quality has become an increasingly important and high profile topic over the last decade and local authorities have a range of statutory and public health responsibilities in this area.

1.2 Nitrogen dioxide and particulate matter are the emissions of most concern as their detrimental impacts on public health are now beginning to be fully understood and so - largely driven by court cases brought by the environmental lobbying group, Clientearth - in July 2017 the government published a plan for tackling roadside nitrogen dioxide in the UK, to bring concentrations within the statutory limits in the shortest possible time.

1.3 Based on air quality modelling data which predicts future non-compliance, the plan expanded the number of local authorities already required to take action to 28 in total (plus London), including 7 authorities in Greater Manchester - Manchester, Bolton, Bury, Stockport, Salford, Trafford and Tameside.

1.4 Oldham was not identified as being in scope in this 'first wave' however it was acknowledged that air pollution does not recognise administrative boundaries and so a regional approach including Oldham would be taken and led by Transport for Greater Manchester (TfGM) on behalf of the Greater Manchester Combined Authority (GMCA).

1.5 TfGM representing the 10 authorities have since been working on a wide package of measures to improve air quality across the conurbation.

1.6 However, in February 2018 the High Court found that a further 45 local authorities (a 'second wave') were at risk of not meeting the nitrogen dioxide pollution levels on specific road links within their administrative boundaries by 2021 and a ruling was made that each authority must produce a plan to achieve compliance as soon as possible.

1.7 Oldham was identified in this 'second wave' and as such, we received a ministerial directive in April to carry out a feasibility study to evidence which, if any, measures can be taken to bring for nitrogen dioxide compliance in the shortest time possible on the stretch of road that has been identified as being in exceedance.

1.8 In this respect, it should be noted that a recently published LGiU "Joint Parliamentary Report on Air Pollution" highlights the following:

> *"Local authorities have a choice – to take a similar approach to national government in introducing measures that target minimum legal compliance in specific geographies (specific roads for example), or, to enshrine air quality as a fundamental pillar of their urban planning, transport & health approach. Reaching minimum compliance will lower, but not eliminate, the figure of up to 40,000 deaths a year attributable to air pollution. The legal limits being exceeded are even less stringent than World Health Organisation (WHO) limits. Therefore a wider approach, that embeds air quality across policy domains, is one which will yield the greatest benefit for local citizens, for whom air population is an increasingly important topic."*

1.9 The stretch of road cited in the Oldham directive is the A62 by-pass which runs from King Street roundabout to the traffic lights at Mumps – see Appendix 1 & 2 for maps and details of levels of exceedance.

1.10 As such, Oldham is in the unique position now of working across AGMA to meet target levels for 2020 and a separate directive working on different data to meet target levels by 2021 and that the local study timeframe (submission by July 2018) actually precedes the regional study timeframe (submission by December 2018).

1.11 This presents a series of practical difficulties and therefore working closely with the Department for the Environment & Rural Affairs (DEFRA), it has been agreed that we will take a local approach focusing on the stretch of road identified by the government to respond to the individual directive placed against Oldham but recognizing that more detailed work is ongoing through TfGM to support the regional approach which has a greater likelihood of improving air quality across the region.

1.12 It is also important to highlight that early indications from TfGM's regional modelling work show that there may be higher emissions and/or additional links identified across the wider conurbation than originally anticipated. However, these figures are still being refined and are subject to change so in order to meet the timescales associated with 'second wave' authorities, the focus of Oldham's feasibility study will be restricted to the stretch of road identified in our directive.

2.0 Oldham's local feasibility study

2.1. The feasibility study requires Oldham to develop a list of measures which will bring about nitrogen dioxide compliance in the shortest possible time as well as setting out a preferred measure, as follows:

Part	Title	What is required	Deadline
Part 1	Understanding the problem	Information about the source of emissions and make-up & destination of traffic on the location in scope.	Monday 30th April (submitted)
Part 2	Developing a long list of measures for addressing the exceedances	A list of measures that could in theory be implemented to bring about compliance in the shortest possible time. The measures given in Oldham's submission were taken directly from TfGM's work to ensure alignment.	Monday 30th April (submitted)
Part 3	Assessing deliverability/feasibility and delivering a short list	Refining the long list based on whether the measures are practically feasible and deliverable to have impact within the required timeframe (e.g. it would not be practically feasible to introduce cycle lanes on a dual-carriage way.)	Thursday 31st May (submitted)

Part 4	Evidencing the short listed measures to identify options that could bring forward compliance	Modelling the shortlisted measures to establish whether they would actually have the necessary impact e.g. incentivizing the uptake of electric vehicles may be practically feasible, but if there is only a 1% take up, this will not reduce emissions sufficiently to achieve compliance. **It is possible that once modelled, no measures can be taken forward.**	Friday 29th June
Part 5	Setting out a preferred option	Measures that, once modelled, are shown to have impact, must then be assessed against further criteria (e.g. VfM). **Again, it is possible that once assessed, there will not be a preferred option.**	Tuesday 31st July

2.2 As at Thursday 21st June, Oldham have submitted Parts 1, 2, & 3 in line with the required deadlines and our submission sets out all of the measures already taken and/or planned in Oldham to improve air quality (see Appendix 3).

2.3 Aligned with TfGM's work, the shortlist of measures outlined at this stage are:

- Incentivise drivers of light goods vehicles and cars to switch to electric vehicles
- Incentivise Oldham Council and partner staff to switch to electric vehicles.
- Renewal, upgrading and further expansion of the electric vehicle charging point network in Oldham.
- Improve Local Authority fleet to electric and/or low emission through a procurement policy
- Congestion Deal traffic management (which includes a wide range of options from signal optimization to changes in speed limit).
- Incentivise private hire vehicles (taxis) to switch to electric vehicles
- Communications campaigns/awareness raising of health and cost benefits of different modes or around a particular community/schools and programmes to support.

2.4 A wide range of measures have been discounted on the basis that they are not deliverable locally and are more likely to bring about compliance if approached from a regional level e.g. any measures related to regulation of buses.

2.5 It is also important to clarify that where measures have been discounted, we may still pursue them as part of the wider local air quality objectives, but we are not able to take them forward as part of this study because of the specific technical outputs required i.e. we must be able to clearly evidence how any measures taken forward will bring about the required reduction in NOx concentrations by 2021 through detailed emissions and dispersal modelling as well as a sound evidence base for modal shift assumptions.

2.5 The above measures are now being modelled to establish which, if any, will bring this road link within compliance.

2.6 The legal deadline for final submission of this feasibility study is the end of July and further feedback will be provided to Health Scrutiny on the final measures (if any) submitted, as part of an update in September on the wider TfGM regional work.

3.0 Regional study led by TfGM and the Greater Manchester Air Quality Action Plan

3.1 The regional feasibility study being led by TfGM builds on the Greater Manchester Air Quality Action Plan, which aims to improve air quality by:

- **Reducing traffic:** for example, by encouraging travellers to switch from cars to use public transport, cycle and walk more;
- **Increasing efficiency:** improving traffic flow by reducing congestion and stop-start travel to decrease air pollution peaks and to lower emissions overall; and
- **Improving the vehicle fleet:** by encouraging the replacement of older, more polluting vehicles with newer, smaller, cleaner, lower-emission vehicles.

3.2 Actions in the Air Quality Action Plan have been divided into seven main areas:

- **Development management and planning regulation:** including standardisation of regulation and policy across Greater Manchester;
- **Freight and HGVs:** to reduce emissions associated with the movement of freight and goods by road;
- **Buses:** buses have a vital role to play in public transport. New legislation and the development of Greater Manchester's 2040 transport strategy will assist in growing bus usage and improving vehicle standards;
- **Cycling:** building on existing strategies and initiatives to encourage cycling as an attractive and convenient way to travel;
- **Travel Choices:** encouraging the public and businesses to make sustainable travel choices is essential in improving air quality;
- **Cars:** measures to reduce emissions from cars and reduce the number of vehicle trips can make real improvements; and
- **Information and resources:** education and providing information to the public, businesses and policy makers is vital in bringing air quality improvements.

3.3 The regional feasibility study is broadly structured in the same way to align with the GM Air Quality Plan, however all the measures and interventions in the feasibility study are being put through an extremely detailed modelling exercise

which reviews emissions and dispersal. Similarly to Oldham, only measures that show compliance can be taken forward however, early indications suggest that there will be a variety of measures which meet the relevant impact criteria.

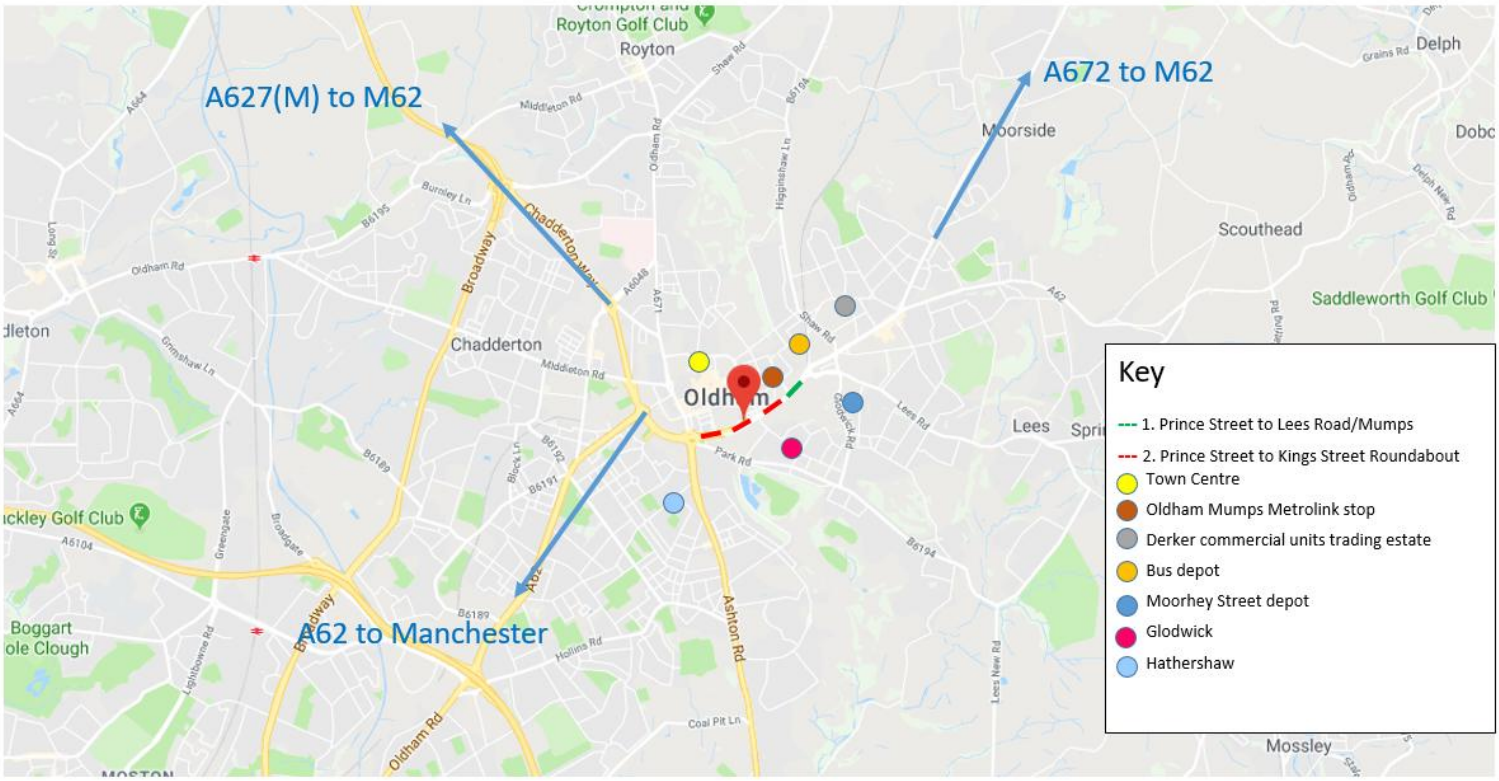
3.4 The legal deadline for submission of the regional feasibility study is December 2018 and as such, each of the individual GM authorities will be required to take the proposed measures through their respective governance processes in order to meet this deadline.

4.0 Link with Public Health

4.1 Updates on both the local and regional study will be brought back to Health Scrutiny in September 2018.

4.2 In the interim, endorsement and support is sought of both the local and regional work from public health colleagues, particularly in terms of communications and engagement with the public to continue to raise the profile of this major health issue

Appendix 1 – Map of location in scope



Appendix 2 – Emissions data

Oldham Council

Table of Projected Exceedances

Road(s) in exceedance	Census ID	Annual mean nitrogen dioxide concentration. All figures are provided in µg/m³ and 40 µg/m³ is the statutory annual mean limit value for NO_2.					Source apportionment for total NO_x 2015 (figures may not sum to 100% due to rounding)
		2017	2018	2019	2020	2021	
A62	36632	47	45	43	41	38	5% Regional background, 11% Urban background (non-traffic), 12% Urban background (traffic), 31% Diesel cars, 7% Petrol cars, 18% Diesel LGVs, 0% Petrol LGVs, 11% HGVr, 3% HGVa, 2% Buses
M60 (Highways England managed)	77006	46	44	42	40	38	5% Regional background, 10% Urban background (non-traffic), 19% Urban background (traffic), 27% Diesel cars, 3% Petrol cars, 25% Diesel LGVs, 0% Petrol LGVs, 6% HGVr, 5% HGVa, 0% Buses
M60 (Highways England managed)	77007	47	45	43	40	38	5% Regional background, 11% Urban background (non-traffic), 21% Urban background (traffic), 26% Diesel cars, 3% Petrol cars, 22% Diesel LGVs, 0% Petrol LGVs, 7% HGVr, 5% HGVa, 0% Buses

Appendix 3 – Measures taken already (B) and/or planned (C) in Oldham

B1. Direct link/impact on A62: The Oldham Cycle and Pedestrian-Friendly Town Centre scheme – we completed this scheme last year, which included improvements to the Union Street West pedestrian-cycle bridge and the Campus Oldham Highway Improvement Scheme. The Campus Oldham Scheme included the reallocation of road space to pedestrians and cyclists and new cycle and pedestrian crossings on King Street. King Street runs from north to south on the edge of the town's shopping area and connects Oldham College, Oldham Leisure Centre, the Oldham King Street Metrolink stop and Oldham Sixth Form College. The scheme was partially funded through the Cycle City Ambition Grant 2 Fund (CCAG2), which made a contribution of £1.2 million.
B2. Direct link/impact on A62: Supporting schools - On the back of our successful CCAG2 bid, we assisted both the Oldham Sixth Form College and the Oldham (FE) College to bid for CCAG2 funding. Both colleges were successful in securing around £80,000 each to prepare cycling action plans and deliver improvements such as cycle parking that will complement our physical changes and increase levels of cycling to the colleges. They have used their CCAG2 grants to provide more than 140 new cycle parking spaces at Oldham College and Oldham Sixth Form College with improvements to changing rooms and upgraded CCTV. They are now also part of TfGM's Cycle Schools and Colleges project and as a result they have been supplied with pool bikes and students are being offered free cycling taster sessions by TfGM.
B3. Direct link/impact on A62: Improvements to walking and public transport into the town centre - we have delivered pedestrian and bus infrastructure improvements with a £2 million Local Growth Deal contribution. Works included the creation of a new pedestrianised link, Parliament Square, as part of the redevelopment of the Old Town Hall into a restaurant and cinema complex, which connects the new development to the Oldham Central Metrolink stop and the town centre's retail core via Clegg Street and Parliament Square.
B4. Direct link/impact on A62: Further improvements to walking and public transport into the town centre Greater Manchester Local Growth Deal 2 - we have almost completed delivery of a £5 million programme of Growth Deal 2 funded improvements designed to improve the town centre and make it more attractive for cyclists, pedestrians and public transport users to access - these schemes have focused on the Prince Street/Oldham Mumps area adjacent to the A62 as well as the Yorkshire Street corridor and links including Retiro Street. The programme connects the town centre retail core, the Mumps/Prince's Gate development and the Oldham Heritage and Arts Centre proposed development.
B5. Direct link/impact on A62: Metrolink - the Oldham-Rochdale Metrolink line opened in 2012, and was extended to run through Oldham Town Centre from January 2014. Patronage on this line has been growing faster than on any other line since it opened. Tram frequencies were increased and some double units introduced on the line when the Exchange Square tram stop was opened in Manchester City Centre in December 2015 in advance of Manchester's full Second City Crossing being completed in early 2017. There are still capacity problems on the line, especially at peak times, which has been recognised recently and action taken to address the situation: the GM Mayor has allocated £83 million of the GM Transforming Cities

Fund for the purchase of 27 new trams, some of which will be deployed to further increase the number of double units operating on the Oldham line between Manchester and Shaw to provide additional capacity. An initial order for 24 vehicles will be placed before the end of June 2018.
B6. Direct link/impact on A62: Cycle Hub - In March 2018, a new cycle hub was opened right next to the Mumps Metrolink Stop which is adjacent to this stretch of the A62 Oldham Way. TfGM has installed the hub, which provides secure, attractive cycle parking for 40 bikes alongside a bicycle pump and repair stand. The hub, which is ideally located at the Metrolink park and ride on Regent Street and is close to the town centre, adds to hundreds of bike parking spaces available at a growing network of local cycle hubs across Greater Manchester aimed at encouraging more people to cycle as part of their journey. It is the second hub to open in Oldham this year: the Hollinwood Metrolink Cycle and Ride Stop hub opened in February 2018.
B7. Direct link/impact on A62: Partnerships to encourage cycling Oldham Council has also teamed up with Positive Cycles to create a community bike hub at a prominent location in the heart of Oldham Town Centre, which opened in February 2018. This charity recycles, services, and make bikes roadworthy before selling them back to the community at a discounted price. Bikes are also donated to students accessing the Positive Steps Career Guidance Service, so they can travel to and from college/training. Positive Cycles also works closely with Oldham Council service users and Transport for Greater Manchester (TfGM), providing 'wheels' to jobseekers as part of the "Bike Back to Work" scheme.
B8. General air quality improvement: Electric vehicles - we have continued to expand the network of GMEV electric vehicle charging points in Oldham, with new charging points being installed at the Mumps Metrolink car park in January 2018, with usage continuing to increase year on year since the first posts were installed in 2014.
B9. General air quality improvement: Bikeability with schools - We also work with schools to promote sustainable travel through our Road Safety Team, including providing cycle training to primary school children through the Bikeability programme having secured over £1/3 million from the Department for Transport to provide training until March 2020, including core Bikeability sessions and the Learn to Ride element of Bikeability Plus
B10. General air quality improvements: Walk to School Project We are also involved in delivering the GM Walk to School Project in partnership with TfGM and Living Streets, which aims to increase the number of children walking to school. There are currently 7 Oldham primary schools signed up to the project, which have been selected as they either lie within areas of the highest risk for child road casualties or lie within an Air Quality Management Zone.
B11. General air quality improvements: GM Travel Choices and Active Travel programmes We also work closely with TfGM to ensure that people living and working in Oldham have the opportunity to access the GM Travel Choices and Active Travel programmes as set out in the examples below. Our aim is to maximise take-up of the initiatives on offer in Oldham. The programme includes: – Travel Choices Business Engagement, which provides support to facilitate and encourage the use of sustainable transport for commuting and business trips to employers in the Business Travel

Network. The cycling and walking packages include events, Dr Bikes, pool/loan bikes, learn to ride training, cycle maintenance classes, cycle champions, grants for cycle parking, changing facilities and loan bikes, and walking programmes. In Oldham, 21 businesses are signed up to the network, 12 of which have developed Sustainable Travel Action Plans. Five businesses in Oldham have received grants for active travel infrastructure. JD Williams and Pennine Acute Trusts (Oldham Royal Hospital) have both received TfGM Travel Plan Accreditation (gold and silver standard respectively).

- Travel Choices Access to Employment, which supports jobseekers to overcome travel barriers to work, including through personalised travel advice, discounted public transport tickets or supply of a free refurbished bicycle and training (Bike Back to Work). A similar offer also exists for apprentices to support them accessing training. In 2016/17, 45 people benefited from Bike Back to Work in Oldham.

- Active Travel initiatives including: Business support for cycling and walking; Information, Events and Marketing; Cycle Parking and Infrastructure; and Cycle Training and Safety. Examples of our activity in this area include the Oldham Cycle Network Map, which we update regularly and is part of the GM cycle network series of maps, and our participation in the GM Walking Festival which takes place throughout the month of May.

C1. Direct link/impact on A62: Oldham Council staff travel As a major employer in Oldham Town Centre the Council is working pro-actively to reduce the impact of staff commuting and business travel on the environment. We have a number of arrangements in place with local public transport operators, including First Buses, and have recently reviewed and refreshed some of our existing facilities, including our showers, drying room and lockers at the Civic Centre. As part of a planned relaunch of the Plan, we will be carrying out a staff travel survey in May 2018 and will be using the results to inform further development of the Plan. We are a member of TfGM's Business Travel Network and will be seeking accreditation of our travel plan through TfGM's Travel Choices Accreditation Award Scheme later this year.

C2. Direct link/impact on A62: Oldham Council Partners staff travel - We are looking to lead by example with the work we are doing on our staff travel plan by working with our Oldham Plan partners in both the public and private sector through the Oldham Partnership Board over the course of the coming year to encourage and support them to reduce the impact of their commuting and business travel on the environment and become part of TfGM's Business Travel Network.

C3. Direct link/impact on A62: Third phase of improvements to walking, cycling and public transport into the town centre We are in the early stages of developing and delivering a £10 million programme of improvements in Oldham Town Centre which have been awarded £6 million from the third bidding round of Local Growth Deals. This programme includes schemes that will improve connectivity to and across the town centre for pedestrians and cyclists, such as high quality public realm and connectivity improvements to the King Street cycle/pedestrian bridge at the

western end of the A62 link that is the subject of this feasibility study as well as around the Civic Centre hub and Market Hall area. This programme is still under development and as such not all elements are indicated on the map of measures implemented and underway (Map 2). This programme however, does include the refurbishment of Middleton Road Bridge which is part of a DfT-funded Challenge Scheme and which is temporarily causing queuing and delays on this stretch of Oldham Way as a result of the extensive traffic management needed to deliver the scheme safely. The works are due to be completed by the end of 2018.
C4. General air quality improvements: Bikeabilty programme with schools We will continue to work with schools, including on the delivery of the Bikeability training programme for which we have funding up to March 2020.
C5. Direct link/impact on A62: Streets for All - We will be working with TfGM on developing the Streets for All corridor proposal for the Ashton-Oldham-Rochdale corridor and will ensure that air quality issues on the A62 Oldham Way, which lies within the corridor, are given a high priority.
C6. Direct link/impact on A62: Congestion Deal - We will work TfGM and our partners to deliver the Mayor's Congestion Deal proposals in Oldham.
C7. General air quality improvements with potential direct link/impact on A62: Oldham Council staff travel survey We will use the results from our staff travel survey to further develop our staff travel plan to encourage sustainable commuting and business travel.
C8. General air quality improvements with potential direct link/impact on A62: Rapid chargers for EVs - We will work with TfGM to identify suitable locations for a rapid charger(s) in Oldham following Greater Manchester's successful £3 million bid to the Clean Air Plan Early Measures Fund.
C9. General air quality improvements: Work with Mayor's Cycling and Walking team We will work with the Mayor's Cycling and Walking Team to develop our cycling and walking networks with a view to submitting a funding bid to the Mayor's Challenge Fund;
C10. General air quality improvements with potential direct link/impact on A62: GM Local Cycling and Walking Infrastructure Plan We will work with TfGM to develop the Oldham element of the GM Local Cycling and Walking Infrastructure Plan by December 2018.
C11. General air quality improvements with potential direct link/impact on A62: Town Centre surveys - TfGM will undertake a town centre perceptions survey this summer which will include questions to determine the attractiveness and feasibility of accessing Oldham Town Centre by sustainable modes and enable us to focus our efforts on the type of initiatives that are more likely to result in more people travelling sustainably.
C12. General air quality improvements: Travel Choices and Active Travel programme in Oldham. We will continue to work with TfGM to implement the Travel Choices and Active Travel programme in Oldham.
C13. General air quality improvements: GM Clean Air Day 2018 We will be supporting Greater Manchester's Clean Air Day in June.

Northern Care Alliance NHS Group
Salford Royal NHS Foundation Trust and The Pennine Acute Hospitals NHS Trust

Title of Report	**Care Quality Commission (CQC) Inspection Report and Response: Pennine Acute Hospitals NHS Trust**

Submitted to	Overview and Scrutiny Committee - Oldham
Date	June 2018

Executive Summary	The purpose of this paper is to provide the Committee with an update following the recent publication of the Pennine Acute NHS Trust CQC report in March 2018 including: • Development of an overarching action plan submitted to CQC by 11th April 2018 • Development of local action plans in each of the NE sector Care Organisations • Assurance and monitoring within Care Organisations and Committees in Common • Greater Manchester monitoring of the Trust-wide Improvement Plan

Name	Nicola Firth
Job Title	Director of Nursing/Acting Chief Officer, Oldham Care Organisation

1.0 Introduction

1.1 Between 17 October and 16 November 2017 the CQC inspected services across the Northern Care Alliance, North East Sector Care Organisations, North Manchester, The Royal Oldham and Fairfield Hospitals. This was because at the last inspection in 2016, Pennine Acute NHS Trust was rated as 'inadequate' overall. Rochdale Infirmary and the community services were not inspected at this time as these were rated 'good' overall at the last inspection.

1.2 The report was published on 1st March 2018 and the Trust rating had improved from 'inadequate' to 'requires improvement' with all three Care Organisations improving their individual ratings as seen below.

Care Organisation	Rating 2018	Rating 2016
North Manchester	Requires Improvement	Inadequate
The Royal Oldham	Requires Improvement	Inadequate
Fairfield	Good	Requires Improvement

All services across the 3 Care Organisations have either improved or stayed the same with no 'inadequate' ratings applied. A number of services had improved by two ratings including:

- Medical Care at Fairfield Hospital from 'requires improvement' to 'outstanding'
- Maternity Services at both North Manchester and The Royal Oldham from 'inadequate' to 'good'
- Urgent Care Services as North Manchester from 'inadequate' to 'good'

The table below demonstrates the improvements at the Royal Oldham Hospital:

2016

Ratings for Royal Oldham Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires Improvement Aug 2016	Good Aug 2016	Good Aug 2016	Requires Improvement Aug 2016	Requires Improvement Aug 2016	Requires Improvement Aug 2016
Medical care (including older people's care)	Requires Improvement Aug 2016	Requires Improvement Aug 2016	Good Aug 2016	Requires Improvement Aug 2016	Good Aug 2016	Requires Improvement Aug 2016
Surgery	Requires Improvement Aug 2016	Requires Improvement Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Requires Improvement Aug 2016
Critical care	Inadequate Aug 2016	Requires Improvement Aug 2016	Good Aug 2016	Requires Improvement Aug 2016	Inadequate Aug 2016	Inadequate Aug 2016
Maternity	Inadequate Aug 2016	Requires Improvement Aug 2016	Good Aug 2016	Requires Improvement Aug 2016	Inadequate Aug 2016	Inadequate Aug 2016
Services for children and young people	Inadequate Aug 2016	Requires Improvement Aug 2016	Requires Improvement Aug 2016	Requires Improvement Aug 2016	Inadequate Aug 2016	Inadequate Aug 2016
End of life care	Good Aug 2016	Requires Improvement Aug 2016	Good Aug 2016	Good Aug 2016	Requires Improvement Aug 2016	Requires Improvement Aug 2016
Outpatient and Diagnostic imaging	Requires Improvement Aug 2016	N/A	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016
Overall	Inadequate Aug 2016	Requires Improvement Aug 2016	Good Aug 2016	Requires Improvement Aug 2016	Inadequate Aug 2016	Inadequate Aug 2016

40% rated 'Good'

2017-18

Ratings for Royal Oldham Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good ↑ Feb 2018	Good → Feb 2018	Good → Feb 2018	Requires Improvement → Feb 2018	Good ↑ Feb 2018	Good ↑ Feb 2018
Medical care (including older people's care)	Requires Improvement → Feb 2018	Requires Improvement → Feb 2018	Good → Feb 2018	Requires Improvement → Feb 2018	Requires Improvement ↓ Feb 2018	Requires Improvement → Feb 2018
Surgery	Requires Improvement → Feb 2018	Requires Improvement → Feb 2018	Good → Feb 2018	Good → Feb 2018	Good → Feb 2018	Requires Improvement → Feb 2018
Critical care	Requires Improvement ↑ Feb 2018	Requires Improvement → Feb 2018	Good → Feb 2018	Requires Improvement → Feb 2018	Requires Improvement ↑ Feb 2018	Requires Improvement ↑ Feb 2018
Maternity	Requires Improvement Feb 2018	Good Feb 2018	Good Feb 2018	Good Feb 2018	Good Feb 2018	Good Feb 2018
Services for children and young people	Requires Improvement ↑ Feb 2018	Requires Improvement → Feb 2018	Good ↑ Feb 2018	Requires Improvement → Feb 2018	Requires Improvement ↑ Feb 2018	Requires Improvement ↑ Feb 2018
End of life care*	Good Aug 2016	Requires Improvement Aug 2016	Good Aug 2016	Good Aug 2016	Requires Improvement Aug 2016	Requires Improvement Aug 2016
Outpatient and Diagnostic imaging*	Requires Improvement Aug 2016	N/A	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016
Overall	Requires Improvement ↑ Feb 2018	Requires Improvement → Feb 2018	Good → Feb 2018	Requires Improvement → Feb 2018	Requires Improvement ↑ Feb 2018	Requires Improvement ↑ Feb 2018

*Not inspected

51% rated 'Good'

2.0 Next Steps

2.1 The report provides a summary of the findings following the inspection which includes:

- Action the Trust 'MUST' take that is necessary to comply with its obligations
- Action the trust 'SHOULD' take to comply with a minor breach

2.2 There are a total of 19 'MUST' actions and 71 'SHOULD' actions. However, there are a number of the actions which are repeated throughout the services. This is much less than was required following the 2016 inspection.

2.3 In order to support the development of a comprehensive action plan at Group and Care Organisation level, the actions have been themed in to the following headings:

- Infrastructure
- Workforce
- Risk and Safety
- Training
- Documentation and Standards
- Medicines Management

2.4 As the 'MUST' actions are necessary for the Trust to comply with its obligations, progress against these actions will be monitored by Group through the Group Risk and Assurance Committee (GRAC) and the Committees in Common (CiC). In addition, the Trust provided an overarching action plan to meet these legal requirements which were identified as not being met during the inspection. The action plan was shared with the CQC in April 2018. Once all of the actions have been completed the Trust will need to inform the CQC, who will then check via the regular relationship visits reporting back to the Trust on their judgements.

2.5 Each Care Organisation has developed an action plan to meet the requirements of all the 'Must and 'Should' actions as appropriate. The action plans will be monitored via the Care Organisation's assurance committees and risks reported to the Care Organisation Assurance and Risk Committee (COARC) and GRAC via an assurance statement and Board Assurance Framework as appropriate.

2.6 Corporate Services for example: Safeguarding, Patient Safety and End of Life teams will ensure their systems and processes including audit plans are developed and reflect the requirements identified within the actions required. Progress against the actions will be reported through the relevant Group-wide/ Trust-wide Committee and through the regular Care Organisation reporting mechanisms to ensure the requirements are being met and assurance provided

2.7 The development of the action plan to meet the legal requirements requested by the CQC is being coordinated by the Group Director of Governance and Corporate Nursing. The following regulations identified which link to the Must actions are:

Regulated Activity	Regulation
Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good Governance
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing

3.0 GM Improvement Board

3.1 The CiC action plan was presented to the final Improvement Board in April 2018 outlining the arrangements going forward

3.2 The action plans are incorporated in to the work plan for regular discussion and monitoring at the Clinical Quality Leads (CQL) meeting with the Clinical Commissioning Groups (CCG), and supported by the CCG program of scheduled walk rounds on each site

3.3 CQC and NHS Improvement (NHSI) will both continue with the regular relationship meetings and will incorporate planned visits to services as part of this process to monitor progress against the actions identified

4.0 Recommendations

4.1 The Committee is asked to consider the matters raised in this report and note the approach being taken.

BRIEFING TO HEALTH SCRUTINY

Report Title: Council Motions

Report Author: Oliver Collins

Date: 30th January

Background: There has been one Council meeting since the last time the Health Scrutiny Committee met. The following health related motions were discussed and agreed at that meeting.

Youth Council Motion

Vaping or the use of e-cigarettes is becoming a more and more common sight. More and more people can be seen using these products. I'm sure we all know someone who vapes, and I'm sure most of us saw someone vaping today.

Some people welcome vaping as a 'safer' alternative to smoking tobacco products but let's be honest the jury is out on that one. We do not know how safe these products are Cancer research UK have published reports calling for further research into the effects of vaping on health and to increase our knowledge on how 'safe'' these products are.

We at Oldham Youth council have concerns that vaping is becoming an attractive activity for young people. We know anecdotally of young people who began vaporing without ever having been a smoker. These are not just alternatives to tobacco but are becoming a nicotine addictive habit for non-smokers too.

We strongly believe this is in large part due to the advertising and promotion of e-cigarettes and vaping. We believe that E-cigarette companies and the tobacco industry are targeting young people;

- They present their marketing in such a way that it uses attractiveness, coolness, colours and innovative packaging – with a wide range of 'fun' flavours that is particularly aimed at a youth market. With flavours like candy apple and tutti fruity with bright packaging that looks like confectionary how can this not be aimed at the youth market?
- They use social media and celebrity inspired styling and endorsements
- They sponsor big sports events
- They portray their products as socially attractive

All this is particularly appealing to a younger audience and to non-smokers.

Over recent years we have seen the regulation of tobacco promotion with the introduction of smoke free public spaces, advertising bans, age restricted sales, a de-normalisation of smoking industries, plain packaging and point of sale restrictions. Vaping products however are not controlled in this way. And this great work at reducing the likelihood of young people (and older people) from smoking) is being undermined by this.

These control policies were introduced to prevent people from taking up smoking and rightly so. But if we don't want people to smoke and we certainly don't want young people to take up smoking would we want them to start vaping.

In November 2017 Committees for Advertising Practice have introduced some new rules that will prevent e cigarette advertising from targeting non-smokers including children and young people, these restrictions will also prevent TV advertising attempting to tap into youth culture. We are particularly pleased to see that an emphasis has been placed on protecting young people and we welcome these new rules but they don't go far enough.

A study by Moreon et all found that flavoured e cigarette liquids such as fruits and alcohol flavours are most frequently used by young people. And studies in the US have found that young people who vape are far more likely to smoke. Studies like these and the fact that the 'safety' of vaping is yet to be truly determined causes us great concern

We want to prevent young people from these potentially harmful practices and we feel more needs to be done to prevent vaping from being seen as fun, acceptable and a 'cool' thing to do. We would like to see the same controls on vaping as there are on tobacco products. We would like to see advertising banned, we would like to see plain packaging controls in place and we would like to point of sale restrictions. We believe that these restrictions on the promotion of vaping will further reduce the likelihood of people taking up vaping and in turn smoking.

The Youth Council ask Council to resolve:
That the Chief Executive writes to the minister of Health and asks for these restrictions to be put in place for vaping products.

Motion of Opposition Business

Councillor Williamson MOVED and Councillor Turner SECONDED the following motion:

This Council notes that:

- Childhood obesity has risen to epic proportions. In October 2017, the medical journal, The Lancet, reported one in every ten young people, aged 5 to 19, in the UK are classed as obese:
- In Oldham, sadly the situation is even worse. The Public Health England profile for the Borough, published July 2017, reported that 21.9% of children at Year 6 (660 in total) were classed as obese;

- Obese children are more likely to become obese adults, putting them at risk of developing serious health conditions (such as type 2 diabetes, heart disease, stroke and certain types of cancer);
- Takeaway food, where it is unhealthy, so called junk food, is undoubtedly a contributing factor in the increase;
- Although the Oldham School Meals Service is a Gold standard provider, regrettably some pupils chose to eat at or from takeaways;
- In June 2016, the Royal Society for Public Health called for a ban on the delivery of takeaway meals to school gates. A survey conducted by the RSPH amongst young people found half had ordered takeaways on their smart phones and a quarter had paid for fast food to be delivered to the school gates;
- At least 22 local authorities have adopted Supplementary Planning Document and Local Plans that include a prohibition on new fast food takeaways within 400 meters of local schools (a buffer zone);
- In July 2012, Oldham Council adopted a Supplementary Planning Document which placed restrictions on the density of hot food takeaways, but which did not include any restriction on new takeaways within a specified buffer zone.

Council resolves to ask the Planning Committee to investigate the desirability and practicality of:

- Introducing a prohibition on new takeaways within a 400 metre buffer zone as part of the Local Plan; Council shall also contact all schools within the Borough to seek reassurances they:
- Enforce a 'stay-on-site' policy at lunchtimes;
- Ban the delivery of takeaways to the school gates for collection by pupils; And ask them to do so; if they do not."

Councillor Moores MOVED and Councillor Jabbar SECONDED that under Council Procedure Rule 8.4(d) the motion be referred to the Overview and Scrutiny Board. On being put to the vote, that the MOTION be REFERRED to Overview and Scrutiny was CARRIED UNANIMOUSLY. RESOLVED that under Council Procedure 8.4(d) the motion be referred to the Overview and Scrutiny Board.

Response

Provided by Katrina Stephens, Interim Director of Public Health

Officers in Planning and Public Health are working together to compile relevant information to assist members in considering the desirability and practicality of limiting new takeaways near schools. This will include information on the current locations of takeaways and schools, alongside information about overweight and obesity in children. Information about the experience of other authorities which have introduced similar restrictions on takeaways is also being gathered. Discussions are underway with the Chair of Health Scrutiny about including a workshop on tackling overweight and obesity as part of the Health Scrutiny work programme within the next few months. With the Board's agreement, further discussion about the desirability and practicality of restricting new takeaways could form part of the agenda for such a workshop.

Most Oldham schools have a stay on site policy (all primary schools, most secondary) during breaks/ lunch times for safeguarding reasons, which is promoted as good school management practice from the DfE.

Whilst on site, many schools do offer a varied healthy option menu for snack and meal choices. The Education Catering Service provides high quality, high nutritional healthy options to 78 primary schools, which has been recognised nationally (Gold Food for Life Catering Mark and the prestigious Best OF Organic Market – BOOM award), which serves circa 13000 meals per day.
In addition, most schools do not allow the delivery of takeaways to the school gates, however this will be raised that the next primary and secondary head teacher meetings, to confirm that this is the case.

OLDHAM HEALTH SCRUTINY SUBCOMMITTEE

FORWARD PLAN 2018-19

Date of meeting	Topic to be addressed	What	For discussion, approval, information?	Lead Officer *Internal if no e-mail address given*
11th September	Oldham Cares	Progress report on the development and implementation of Oldham Cares	Discussion	Carolyn Wilkins
	Tobacco Control	Progress report on the development and implementation of the Council's approach to Tobacco control and how it links to the GM programme	Discussion	Lianne Davies
	Safeguarding Reports	Adult and Children's Safeguarding Board Reports	Discussion	Henri Giller
	Council Motions	Review of Health related motions at council and subsequent actions	Discussion	Chair
	Mayors Healthy Living Campaign		Discussion	Chair

23rd October	**Regional Adoption Agency**	**12 month progress report**	**Discussion**	**Jill Beaumont**
	Council Motions	**Review of Health related motions at council and subsequent actions**	**Discussion**	**Chair**
	Mayors Healthy Living Campaign		**Discussion**	**Chair**
11th December				
	Council Motions	**Review of Health related motions at council and subsequent actions**	**Discussion**	**Chair**
	Mayors Healthy Living Campaign		**Discussion**	**Chair**
29th January	**Pennine Care Foundation Trust – CQC Inspection**	**Progress update for 2018**	**Discussion**	**Stuart Richardson, Managing Director Mental Health** **stuart.richardson4@nhs.net**
	Council Motions	**Review of Health related motions at council and**	**Discussion**	**Chair**

		subsequent actions		
	Mayors Healthy Living Campaign		**Discussion**	**Chair**
26th March				
	Council Motions		**Discussion**	**Chair**
	Mayors Healthy Living Campaign		**Discussion**	**Chair**

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