Public Document Pack

HEALTH AND WELL BEING BOARD
Agenda

Date	Tuesday 26 June 2018
Time	2.00 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 Fabiola Fuschi at least 24 hours in advance of the meeting.

2. CONTACT OFFICER for this agenda is Fabiola Fuschi Tel. 0161 770 5151 or email Fabiola.fuschi@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, Thursday, 21 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.

Please note that anyone using recording equipment both audio and visual will not be permitted to leave the equipment in the room where a private meeting is held.

Recording and reporting the Council's meetings is subject to the law including the law of defamation, the Human Rights Act, the Data Protection Act and the law on public order offences.

MEMBERSHIP OF THE HEALTH AND WELL BEING BOARD
Councillors M Bashforth, Chadderton, Chauhan, Harrison (Chair), Jacques and Sykes
Independent Members: Dr Zubair Ahmad, Dr Zuber Ahmed, Jon Aspinall, Jill Beaumont, Julie Daines, Noreen Dowd, Neil Evans, Julie Farley, Nicola Firth, Majid Hussain, Dr Keith Jeffery, Merlin Joseph, Stuart Lockwood, Donna McLaughlin, Raj Patel, Dr. John Patterson, David Smith, Katrina Stephens, Charlotte Stevenson, Mark Warren, Carolyn Wilkins OBE and Liz Windsor-Welsh

Item No

10 Supplement - Urgent Primary Care Strategy (Pages 1 - 54)

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.

Table of contents

Table of Figures

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.

Page 4

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

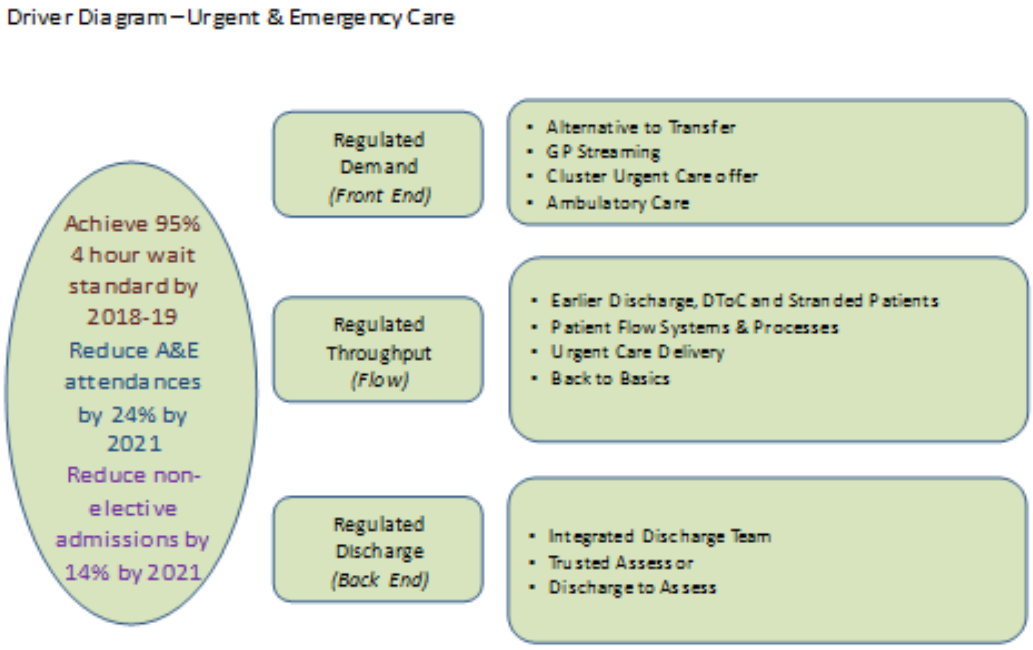
We have also included the following 'emergency' services, acknowledging that at present a number of patients will use these services to meet urgent rather than emergency care needs, and this has an impact on the way the services are able to operate.

- 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.*

Page 8

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)*

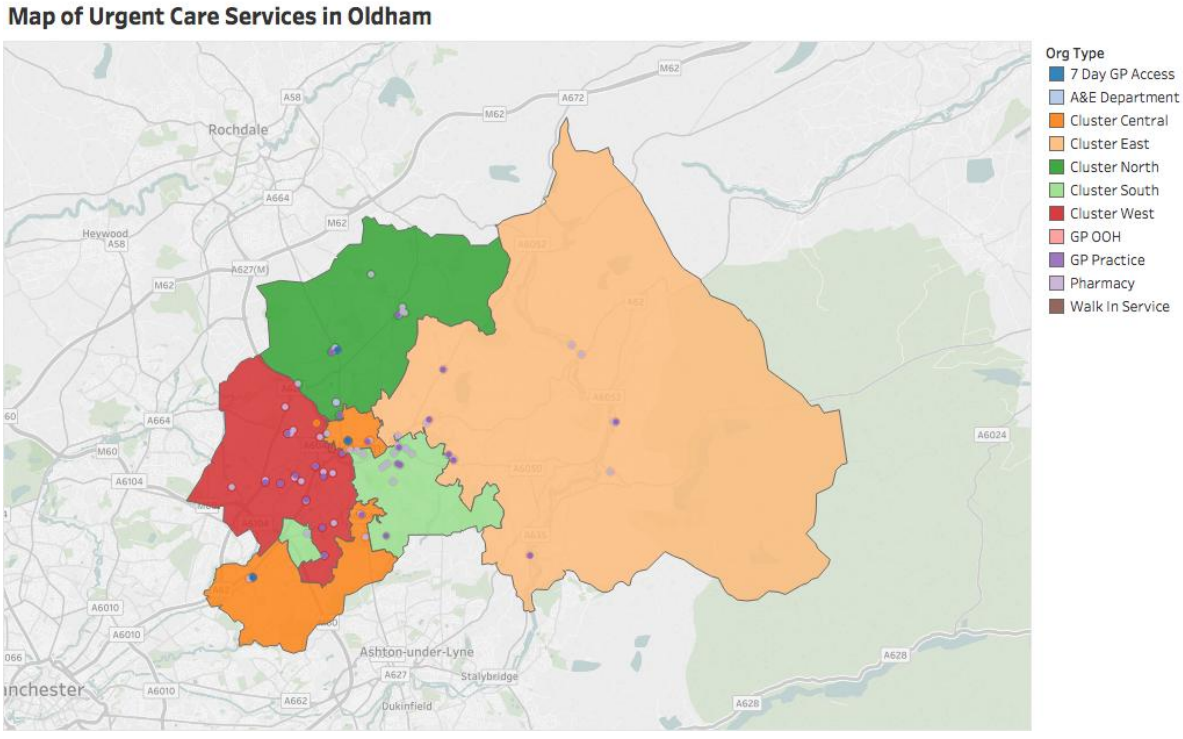
Better support for people to self-care can be achieved by providing better and more available information about self-treatment so that people can manage their situation with more confidence. A second component of support for self-care focuses on comprehensive and standardised care planning. The role 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)

Page 10

- 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%

Page 13

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

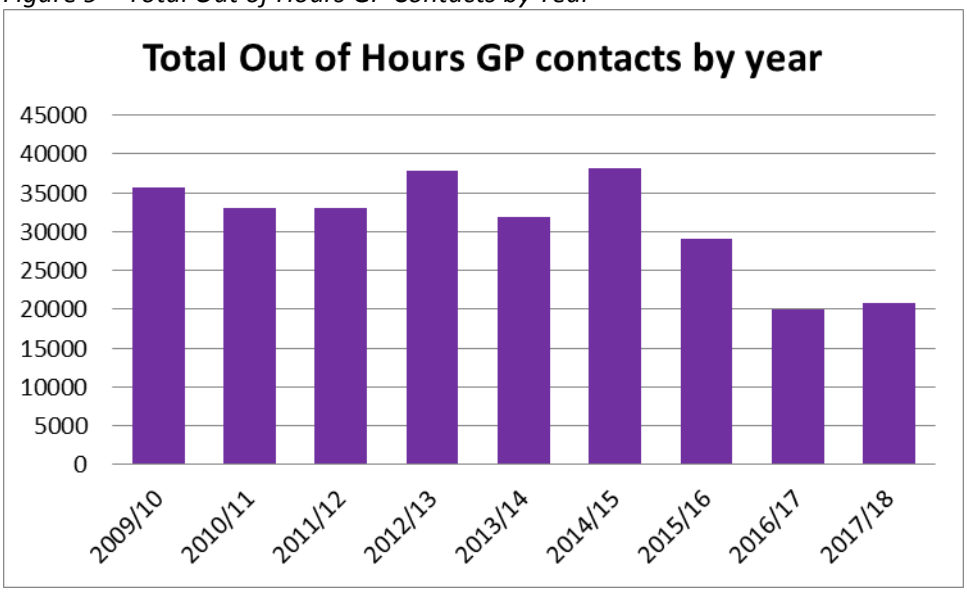
39.7% of people were dealt with by GP advice on the phone, 44.2% by attendance at a treatment centre and 16.1% received a home visit. Of the total seen, approximately 10% went 'towards hospital'. The times that most people access out of hours services are 7-9pm on weekdays and 8am to 1pm on weekends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

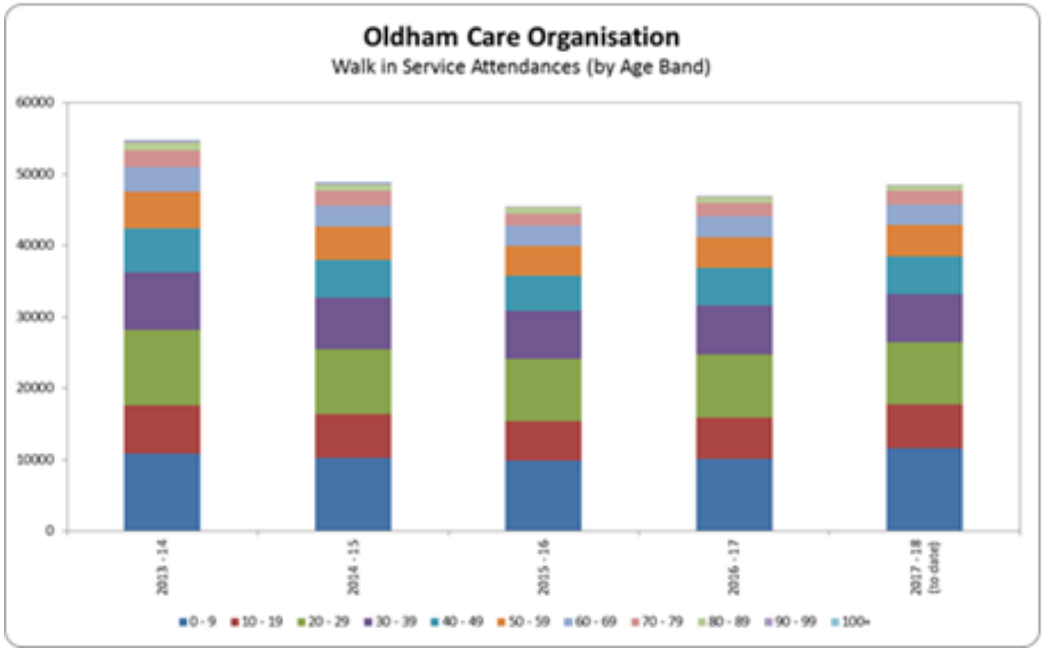
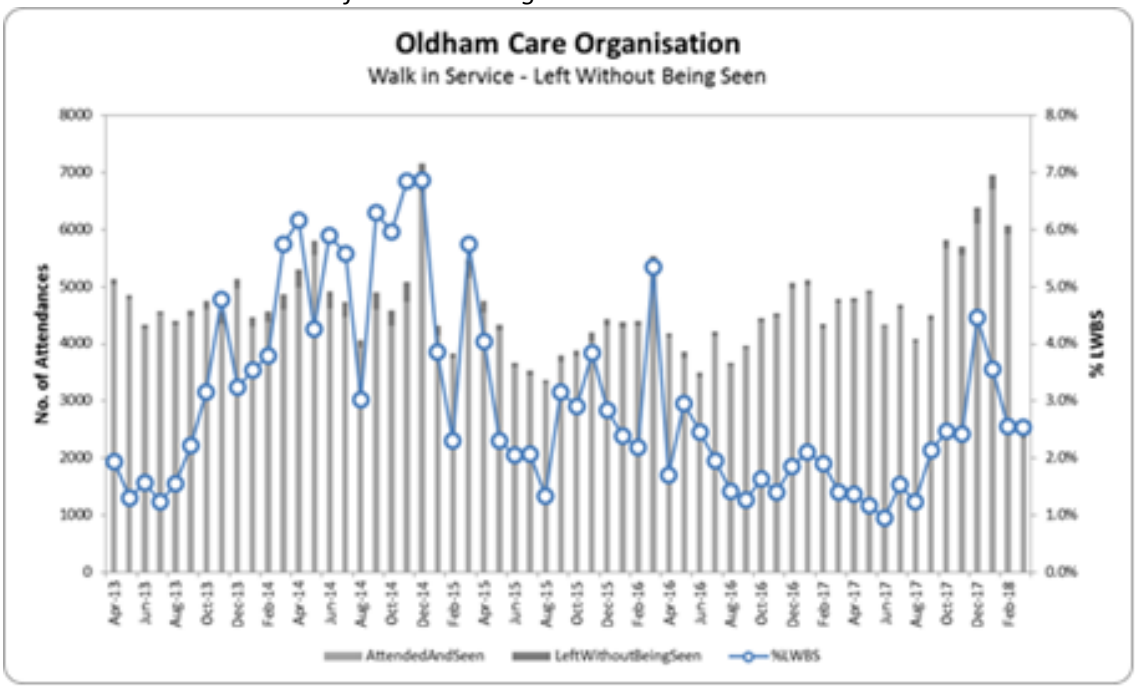
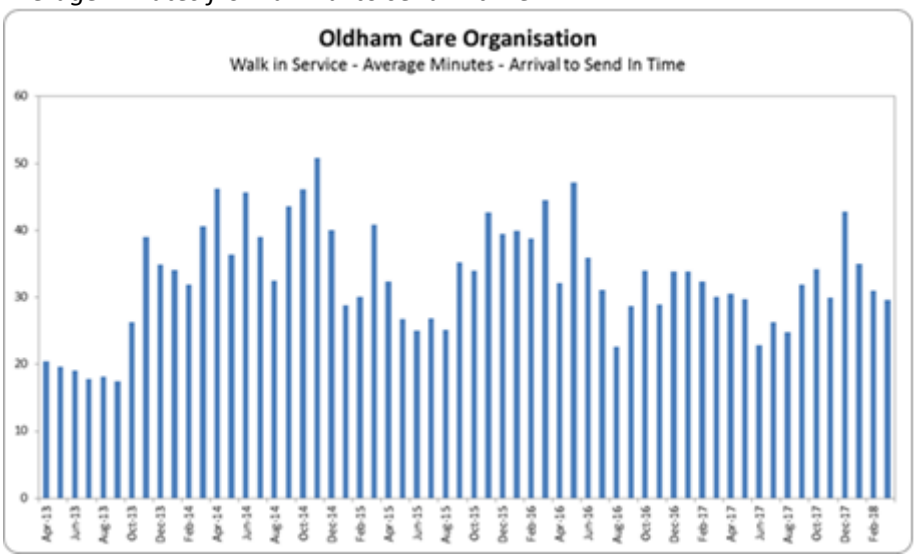


Figure 12 – WIS Attendances who left without being seen



Page 20

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**

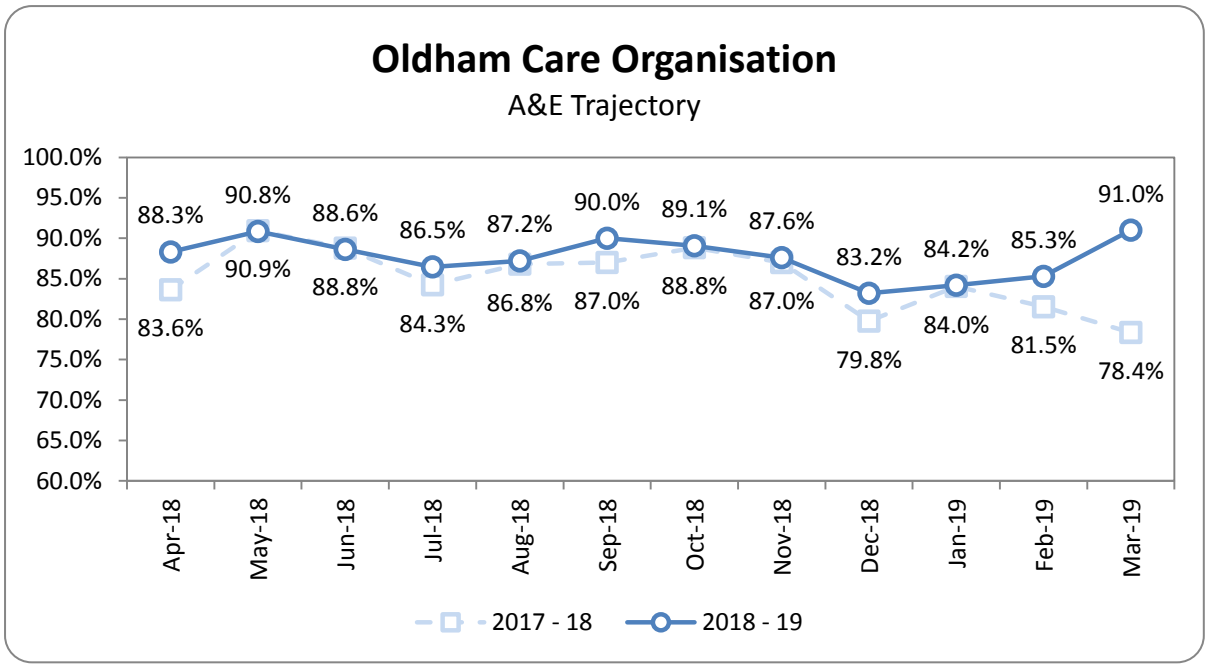
Figure 16 demonstrates the level of compliance against the national indicators but also demonstrates improvements made of the past 12 months, particularly in relation to '12 hour trolley waits'.

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

Page 24

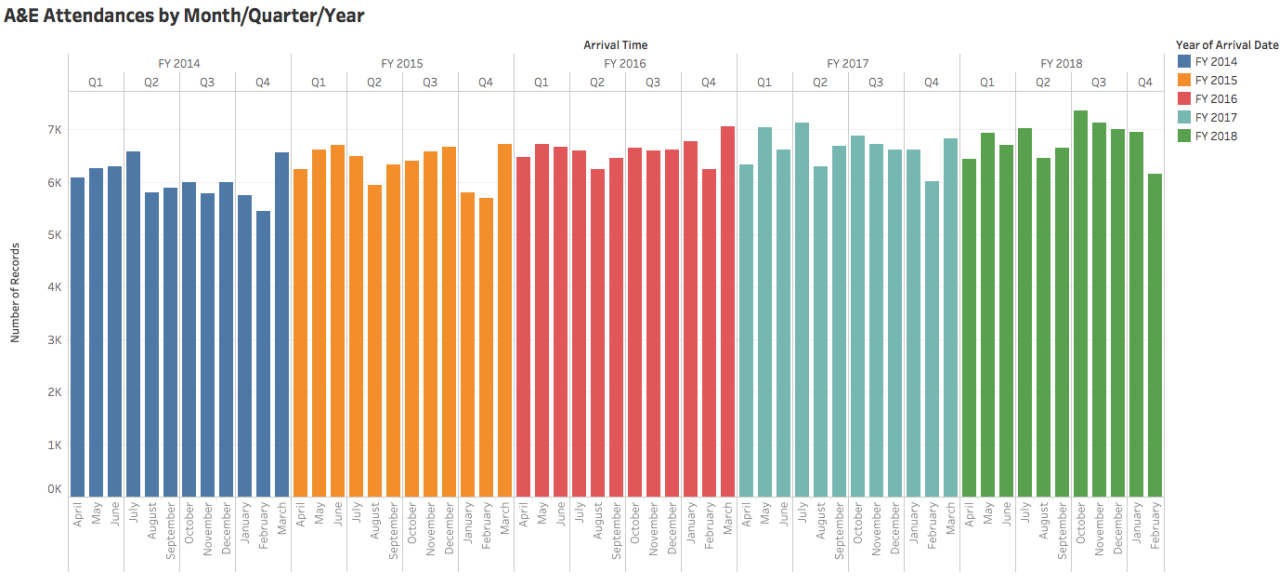


There has been a significant increase in ED attendances over the last five years, with the rate of attendances to Oldham being in excess of the national average (39,419 per 100,000 population locally, compared with 30,041 England).

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

Page 25

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)

Page 27

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

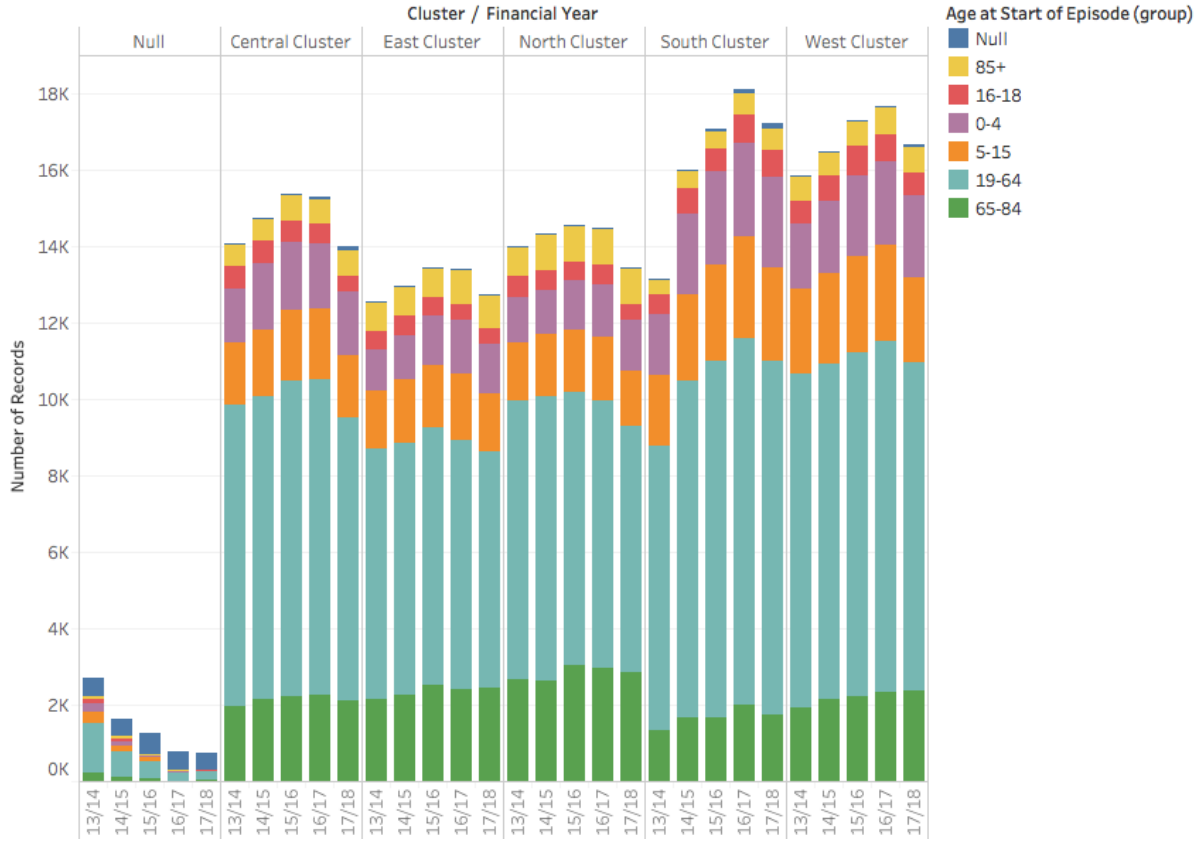


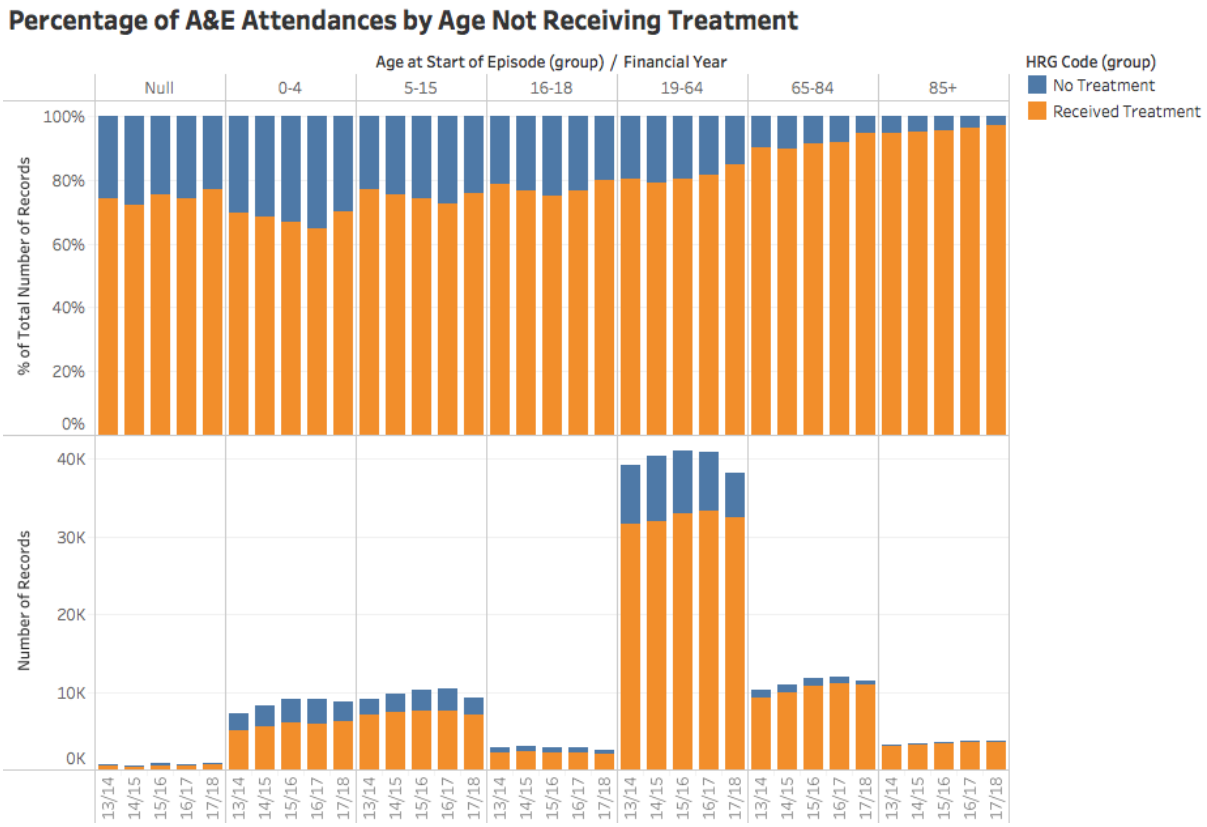
Figure 22 - Percentage of ED attendances by age not receiving treatment

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

Page 29



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)

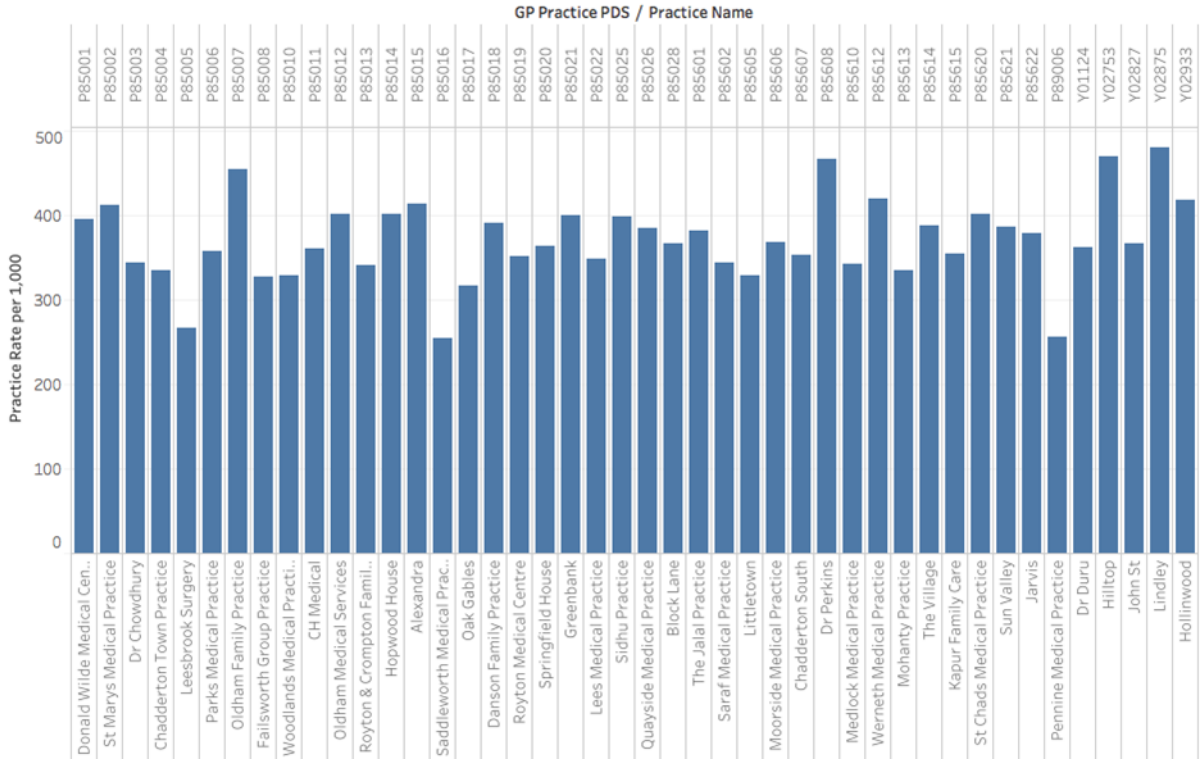
Page 30

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)

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



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

Page 32

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.

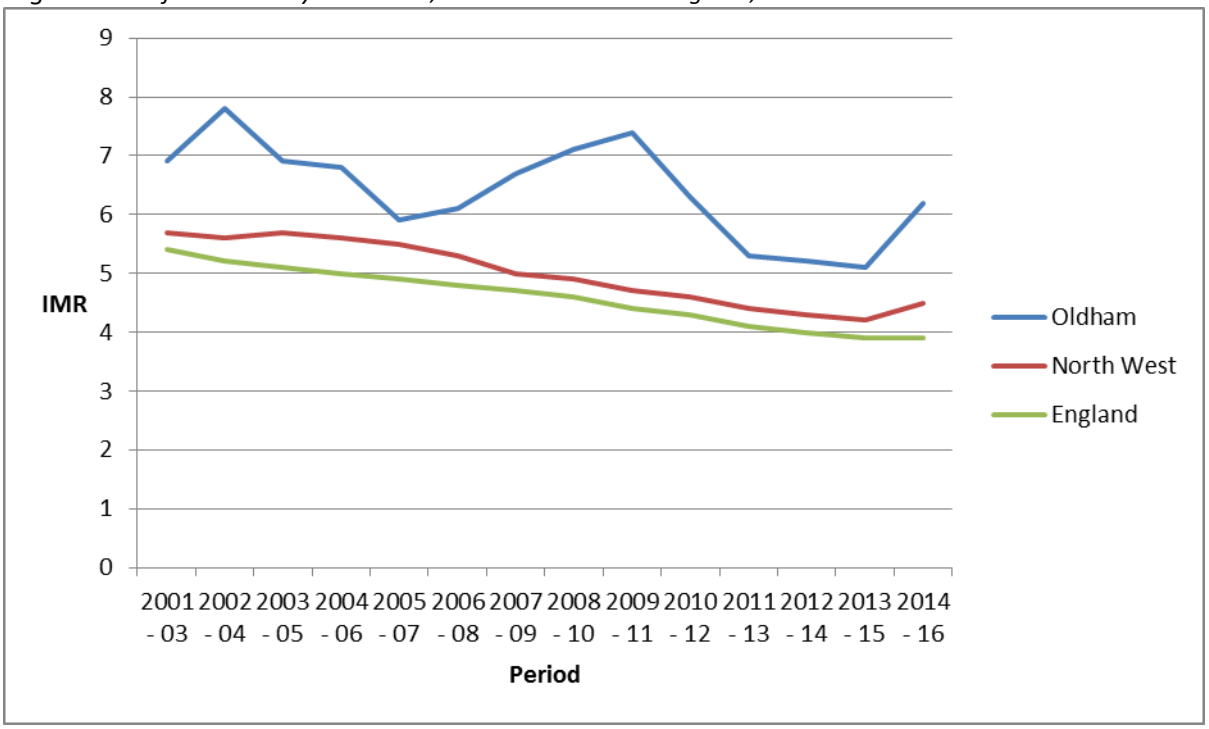
In response to the CQC inspection, a short stay paediatric assessment unit opened in November 2016. The unit is based on the Children's Ward and is consultant paediatrician led. The aim is to improve the urgent and emergency care pathway for children and young people. There is direct access for GP referrals (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



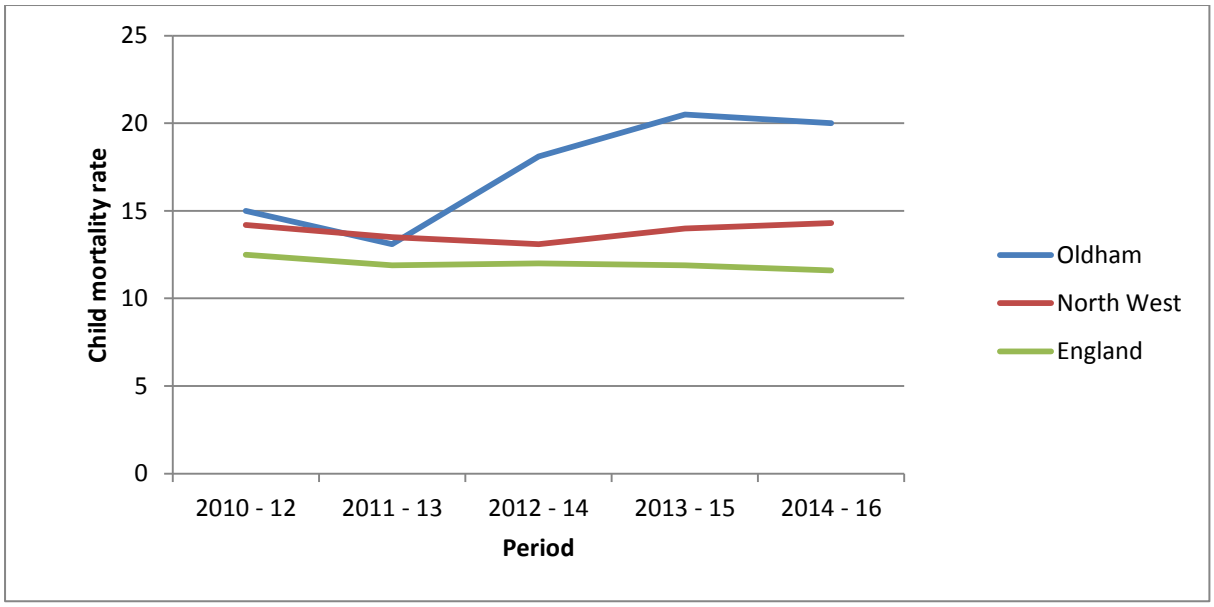
Source: Office for National Statistics

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.

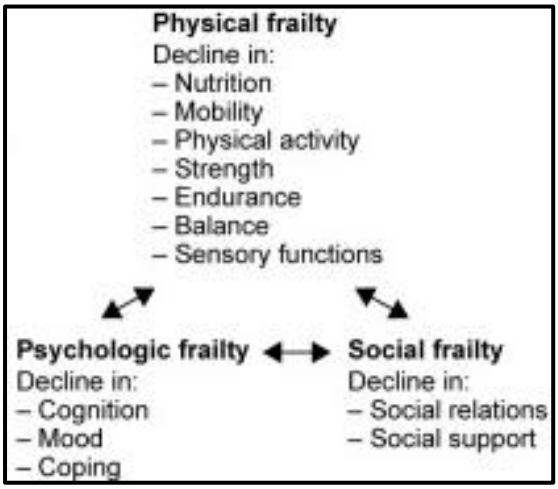
Page 34

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).

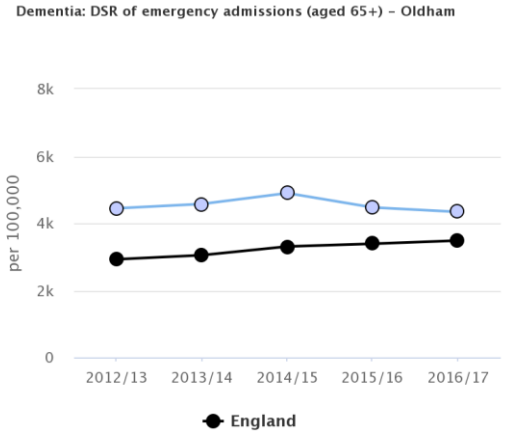
*Figure 28 – **A conceptual model of frailty***



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.

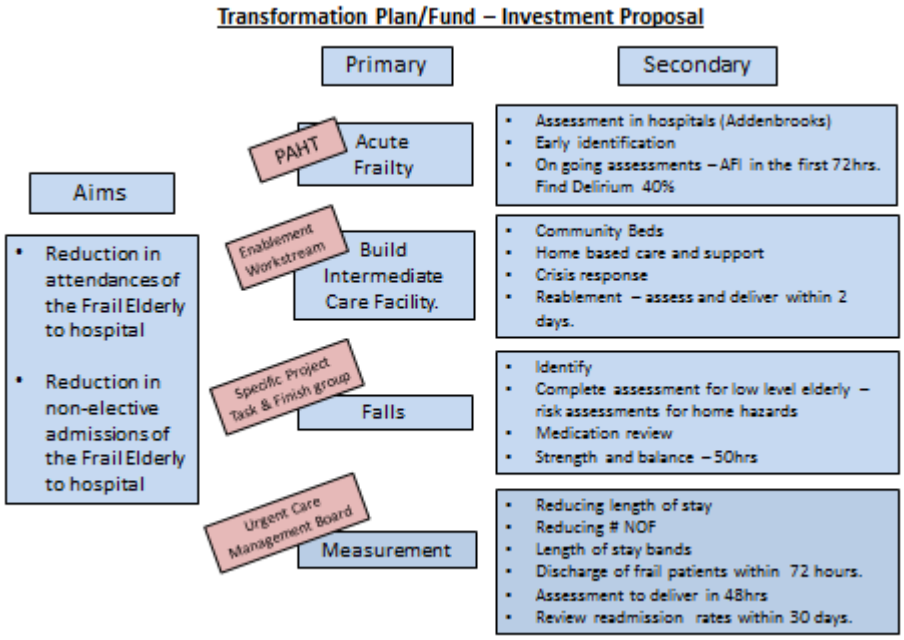
Since 2015, Oldham's Primary Care Quality Improvement scheme (EQALS Plus) has incentivised GP practices to invite, review and assess patients over the age of 75 for their risk of falls and any degree of frailty (the age range was reduced to over 65s in June 2017 in line with core contract requirements). 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

Page 44

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

Page 46

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

Page 47

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

Page 48

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

Page 49

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

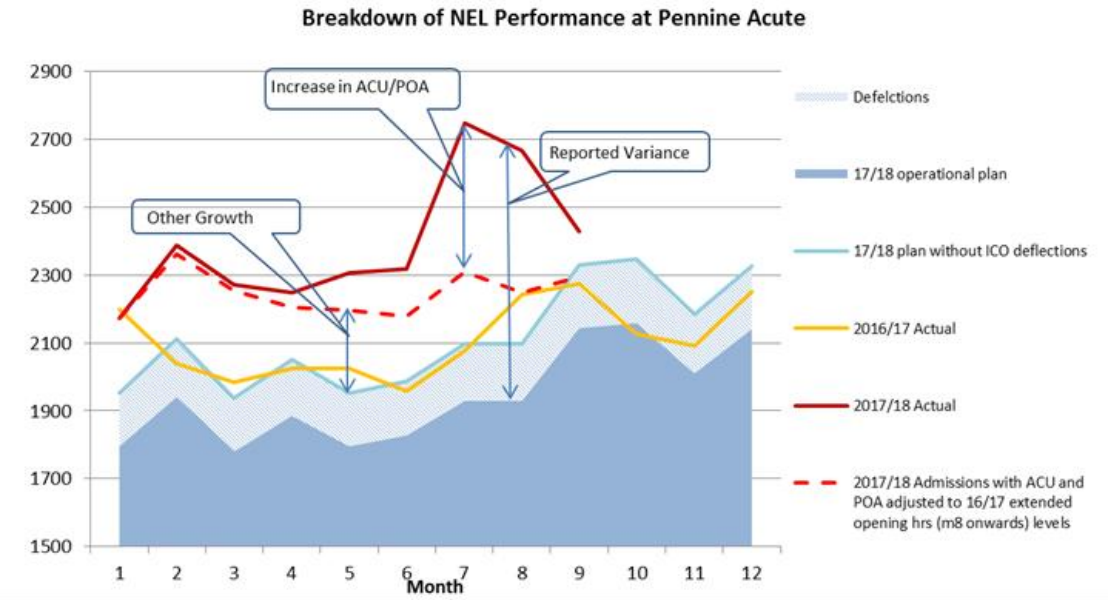
This does not take into account the fact that since the agreement of the high level ICO deflections there has been an underlying "growth" of 5.62% (1,086 emergency admissions to month 8 or 1,629 straight line forecast). This is detailed below:

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

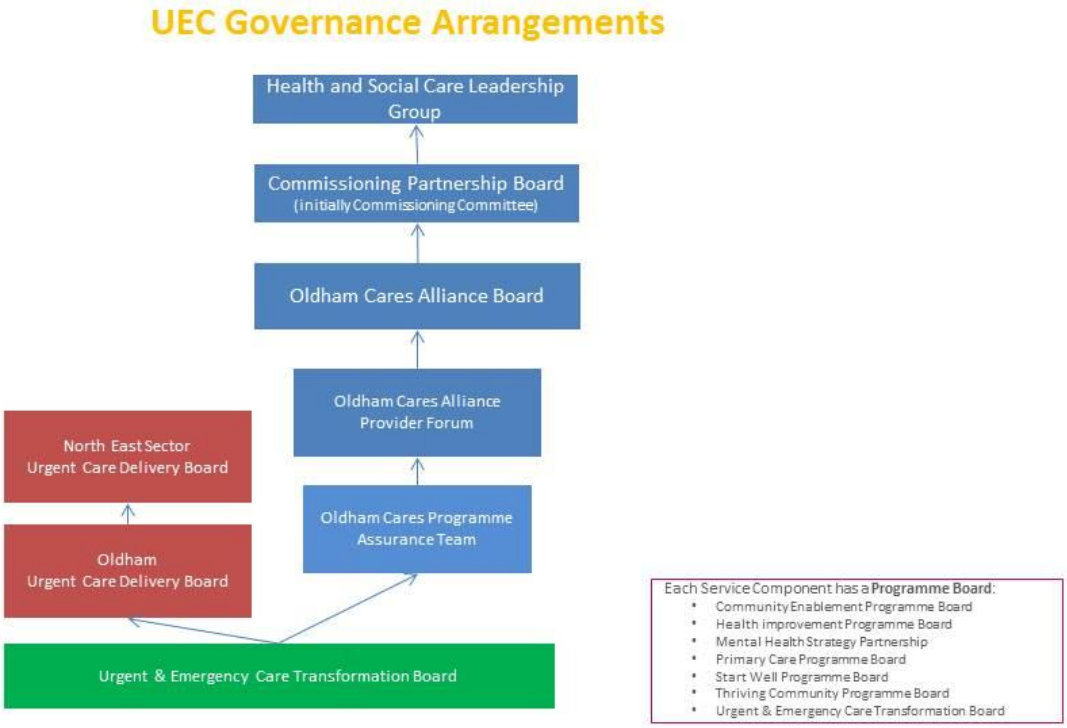
Figure 42 – Timeline of Key Strategic Milestones

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



Page 54