Public Document Pack

HEALTH AND WELL BEING BOARD

Date Tuesday 10 November 2020

Time 2.00 pm

Venue Virtual Meeting - https://www.oldham.gov.uk/info/200608/meetings/1940/live_council_meetings_online

Notes 1. DECLARATIONS OF INTEREST- If a Member requires any 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 Mark Hardman in advance of the meeting.

2. CONTACT OFFICER for this Agenda is Mark Hardman, email constitutional.services@oldham.gov.uk

3. PUBLIC QUESTIONS – Any member of the public wishing to ask a question at the above meeting can do so only if a written copy of the question is submitted to the Contact officer by 12 Noon on Thursday, 5 November 2020.

4. FILMING – This meeting will be recorded for live and/or subsequent broadcast on the Council's website. The whole of the meeting will be recorded, except where there are confidential or exempt items and the footage will be on our website. This activity promotes democratic engagement in accordance with section 100A(9) of the Local Government Act 1972.

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.

Item No

9 Impact on the Health and Care System (Pages 1 - 16)

Presentation slides attached.

11 Future developments in the NHS (Pages 17 - 40)

Presentation slides attached.

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CoVID19 and Oldham health and care system

Health and wellbeing board update

Introduction

- This presentation has been produced as a briefing to the health and wellbeing board regarding the impact of CoVID19 on the health and care system with a particular focus on the acute hospital
- Data has been taken from the point at submission of this report and will therefore be subject to further changes in the days after submission
- It will briefly look at the overall picture, the changes that have been made in the system and then the impact on various aspects of acute services firstly across the North East Sector of Greater Manchester and then specifically Oldham

The Oldham System adjustments

(7) Community Elective Care Services

Phase 1: Services to be continued in line with national guidance

Phase 2
Access to: Diagnostics/ Virtual Hospital/ Acute care provision where assessment and treatment cannot be deferred until post COVID.
Access via Supported Self Care, Advice and Guidance, Urgent Virtual Appointments, Urgent Face to Face.
Services : Cardiology (Lancaster House), Dermatology (Virgin Care), ENT (Inhealth), Gastroenterology (Inhealth), Gynaecology (Lancaster House), Orthopaedics (PMSK), Pain (PMSK), Rheumatology (PMSK) and Urology (Lancaster House).

(9) People at Home & in the Community

- Reablement service
- Self care with a well being call
- Home with support
- Additional support: carers/ equipment / night support– needs expansion
- **Community Place Based Hub** Pulls in named professionals when needed, helps people with wider needs (e.g. housing and pharmacy) and has one team supporting with food and mutual aid, volunteering and community intelligence

(6) Community Bed Based Offer – COVID/ Non COVID/ COVID query responses –

- Dr Kerhaws Hospice- inpatient closed see new End of Life offer- 4
- Butler Green and Medlock Court
- Bed base for LTC
- Alternative Care- Hotel 1 – Not COVID but can't return home because of COVID
- Alternative Care Hotel 2 – COVID X 7 Self contained rooms
- Nursing / residential homes (80 additional beds) commissioned via brokerage team OMBC, complex by IDT with bespoke pathways

(8) Mental Health – Hospital &Community

- Liaison MH A&E
- Safe Haven & 3rd Sector
- GM RRT support to all age liaison MH
- IAPT COVID 19
- Orchard Day Hospital
- **Mental Health Crisis** 24/7 Integrated All-Age MH/LDA/SM Open Access Crisis Lines & Clinical Assessment Service (CAS))
- Bereavement

(4) End of Life (also see 6)

- End of Life/ Palliative Care
- SPoA
- Home and residential/ Nc support. Children and Adults.

(10)Testing

(5) PPE coordination hub at the CIVIC Centre

(11) Safeguarding and quality

(3) Integrated Crisis Team (now includes ORCAT

- review discharge form, Assess person by visit if necessary or by telephone/video call if possible to establish need. Step up and down at present

(3) Discharge Coordination and Response Hub (Whitney Court) –out of hospital only

(Inc. IDT, Covid Assessment Centre, Enablement, Care Arrangers, Assistive Tech and Equipment). Step down from acute only
Clinical/ Social Care Discharge Hub - considers medical gases, oxygen, IV fluids and antibiotics supporting bed bases

3(a) Discharge transport preparation

Discharge Home

(2) Royal Oldham Hospital

COVID, Non COVID and COVID query responses

- Discharge lounges x 3)
- Assessment wards
- Admissions
- Speciality wards
- (2a)Paediatrics Advice and guidance from acute to PC observation and assessment – 2 pathways Under 3 months 3 months – 16 years

DRAFT Oldham COVID system capacity map

(1) Primary Care

- (1a) Primary Care Cold Pathway — Remains open to deliver immediate and necessary care. PC clinic and telephone support as usual out of hours and 7 day access.
- (1b) PC COVID HUB (ICC clinic mobilised. COVID Hot site)
- (1b) PC DIGITAL HUB to be supported by a visiting service (:face to face & digital consultations and proactive support to care homes
- Phase 3 Hub : Home Visits
- Phase 4 Digital Hub – Supporting Living and Care at Home

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What we changed - snapshot

- Define OCHS identity and place within the NCA Group and OCO
- Approach to service redesign
- Unhelpful performance and contract monitoring framework
- Clearly define ‘managed’ and ‘urgent care’ clinical pathways
- Address gaps in service provision – e.g. CE bed bases, overnight support
- Simplify complex referral and triage processes
- Improve links and communications with PCNs
- Therapy model – PCN links
- Move to geographical working model aligned with PCN’s
- Enhance support and focus on care homes
- DN OOHs move back to DN day service
- Re-focus on high risk residents in their own homes
- Community swabbing offer (with the exception of STICH), needs to be a system wide issue once services ‘return to normal’

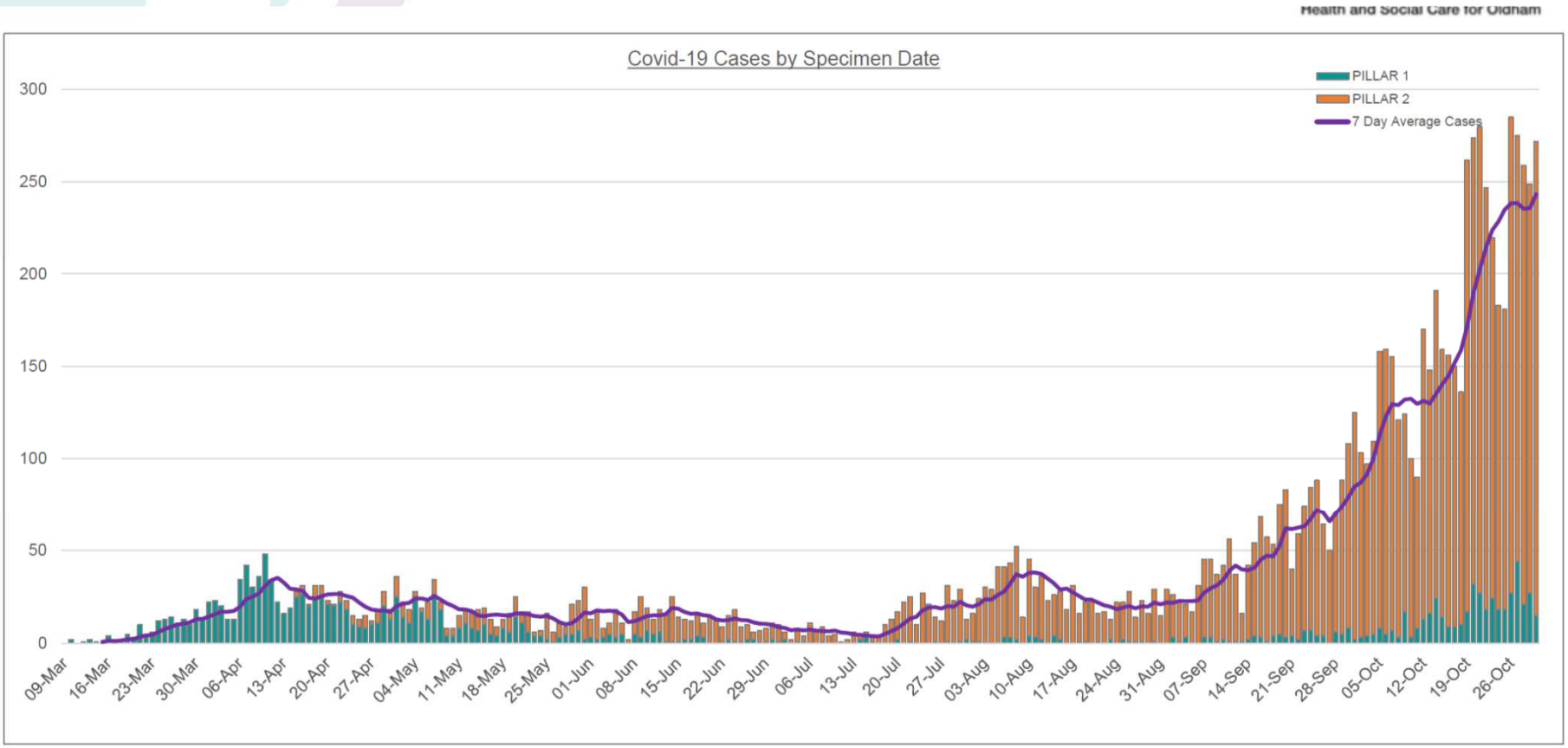
What we changed - snapshot

- Community swabbing offer (with the exception of STICH), needs to be a system wide issue once services 'return to normal'
- Integrated cluster teams to resume BAU
- Build leg ulcer model into treatment room offer
- Review 3:1 services
- Corporate support services centralised and disconnected from CS division
- Pathways to support COVID positive patients – step up/down
- COVID therapy / rehabilitation programme
- Link OOH nursing offer with GPs and day care teams more effectively
- Planned and managed care links with therapy teams
- Review how we work with PCNs – communications / MDTs, improved relationships and opportunities to talk

What we changed - snapshot

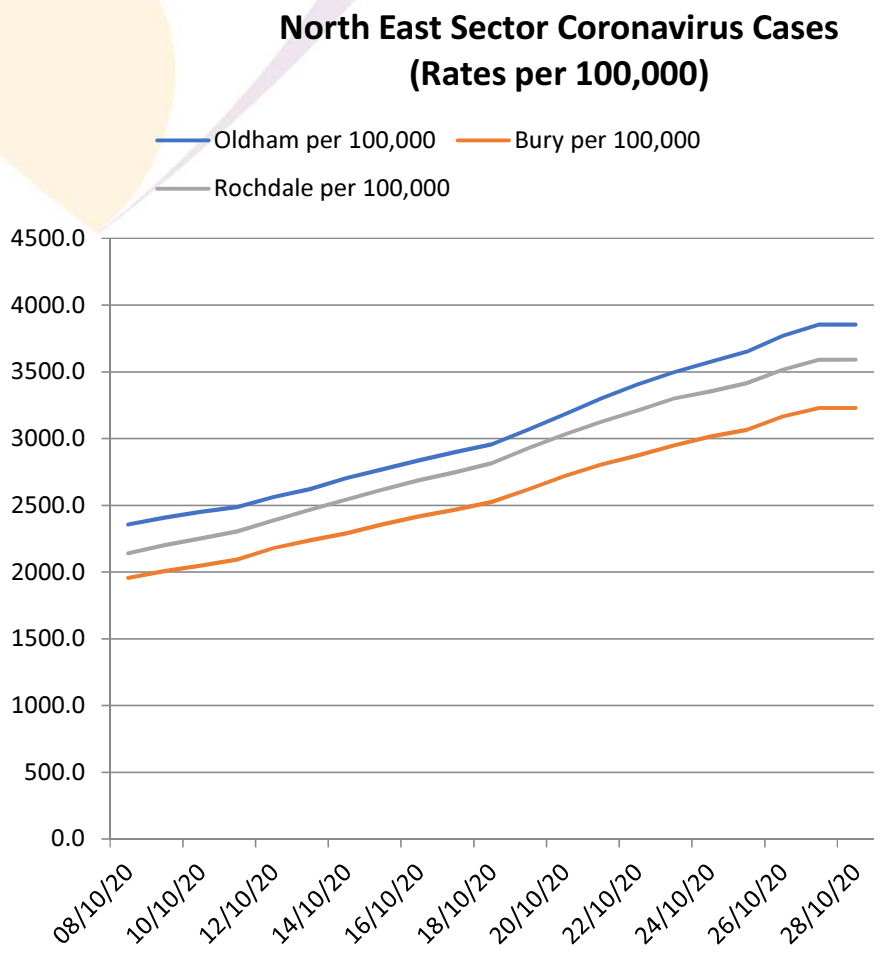
- Look at system ownership of risk management, link with performance
- Review strategic plan and shared understanding - expectation on management team
- Discharge hub
- STICH team
- System planning/system response, rather than working in isolation
- Vaccination planning and offer

The big picture

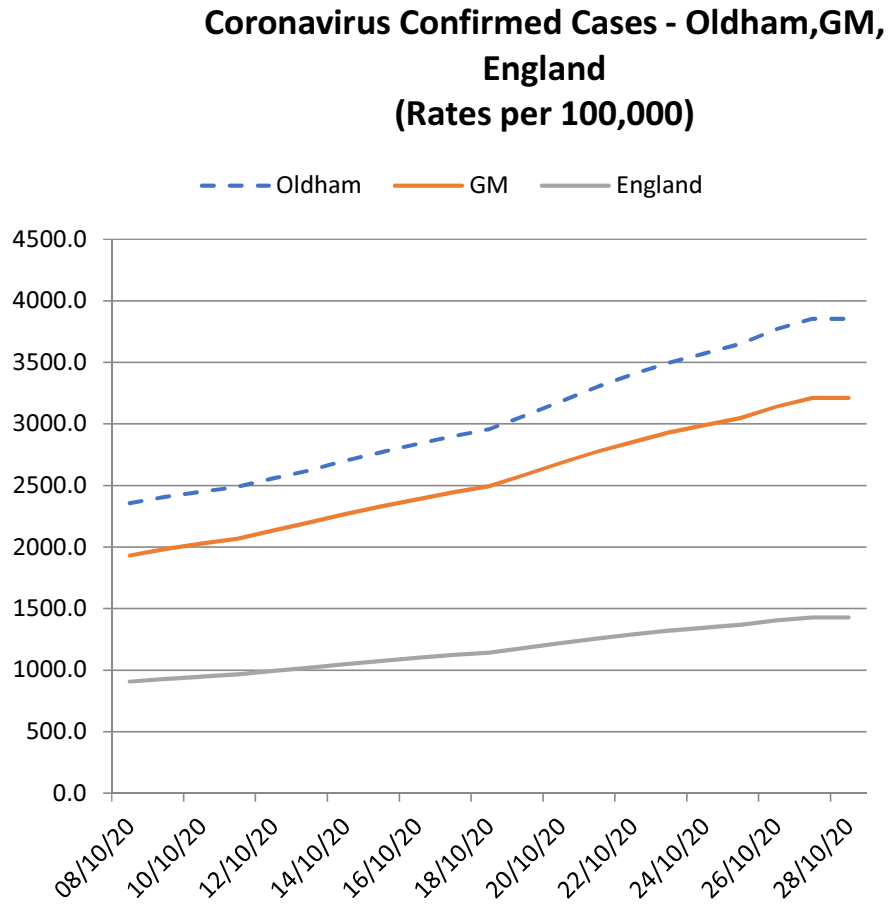


Context – North East Sector

The chart below shows the rates of confirmed coronavirus cases per 100,000 of population for each of the North East Sector local authorities



The chart below shows the rate per 100,000 of population of confirmed cases for Oldham compared to GM and England overall. Oldham has a higher rate than both GM and England as a whole.



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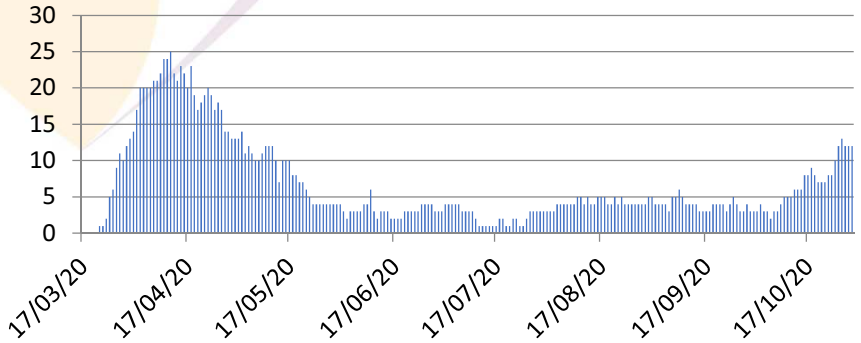
Summary of ROH impact

The figures below show the situation at Royal Oldham Hospital as at 08:00 on Monday 2 November 2020

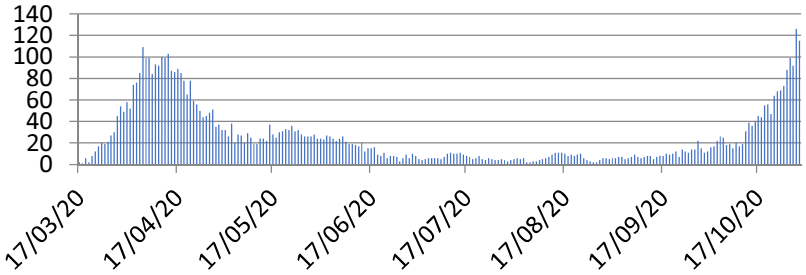
- No. of confirmed COVID patients in ITU/HDU Beds: 12
- No. of suspected COVID patients in ITU/HDU Beds: 0
- No. of non-COVID patients in ITU/HDU Beds: 10
- No. of unoccupied ITU/HDU Beds: 0
- No. of confirmed COVID patients with mechanical ventilation: 12
- No. of confirmed COVID patients with non-invasive ventilation: 10
- No. of confirmed COVID patients with oxygen support: 43
- No. of confirmed COVID patients in any other beds: 115

Impact on ITU

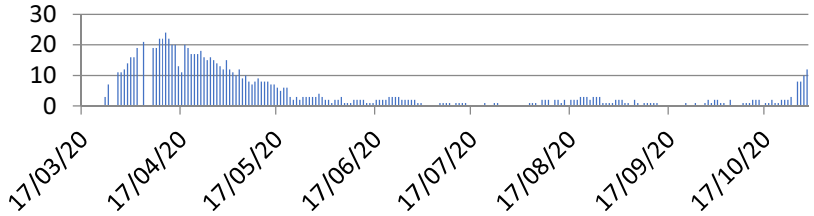
Royal Oldham Hospital Situation Report
Number of Confirmed COVID-19 Patients in ITU Beds



Royal Oldham Hospital Situation Report
Number of Confirmed COVID-19 Patients in Any Other Beds



Royal Oldham Hospital Situation Report
Number of Confirmed COVID-19 Patients on Mechanical…



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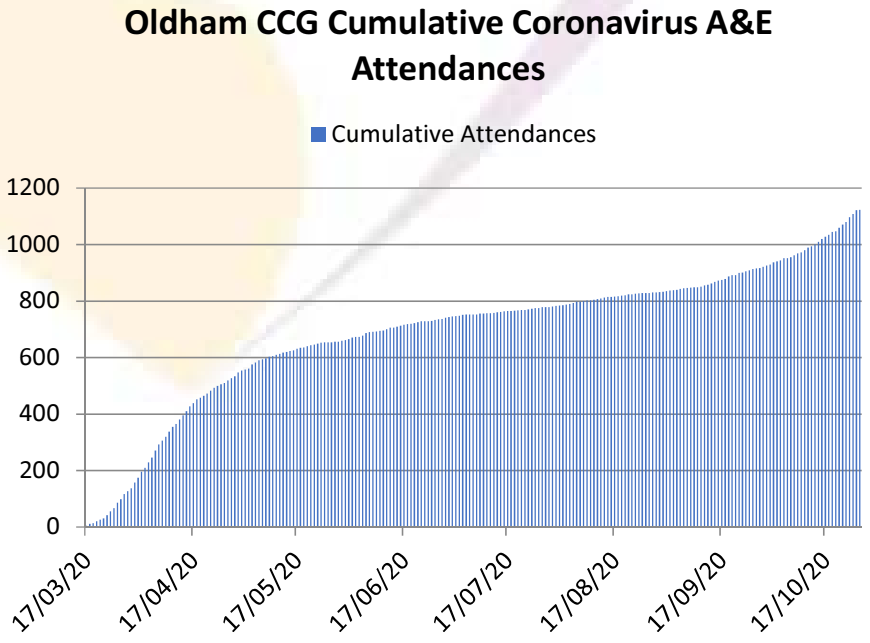
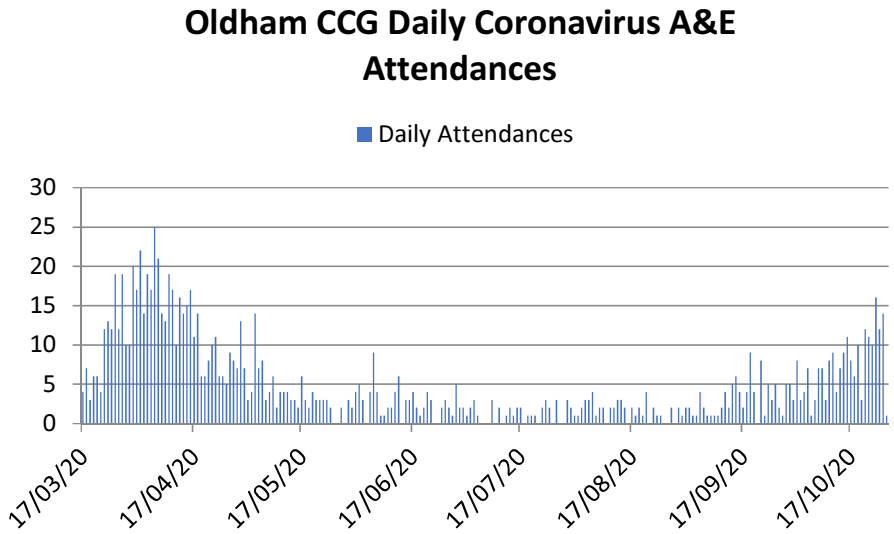
Impact on the emergency department

The charts below show the cumulative and daily Oldham registered patient A&E attendances at the Pennine Acute Hospital Trust for coronavirus related symptoms





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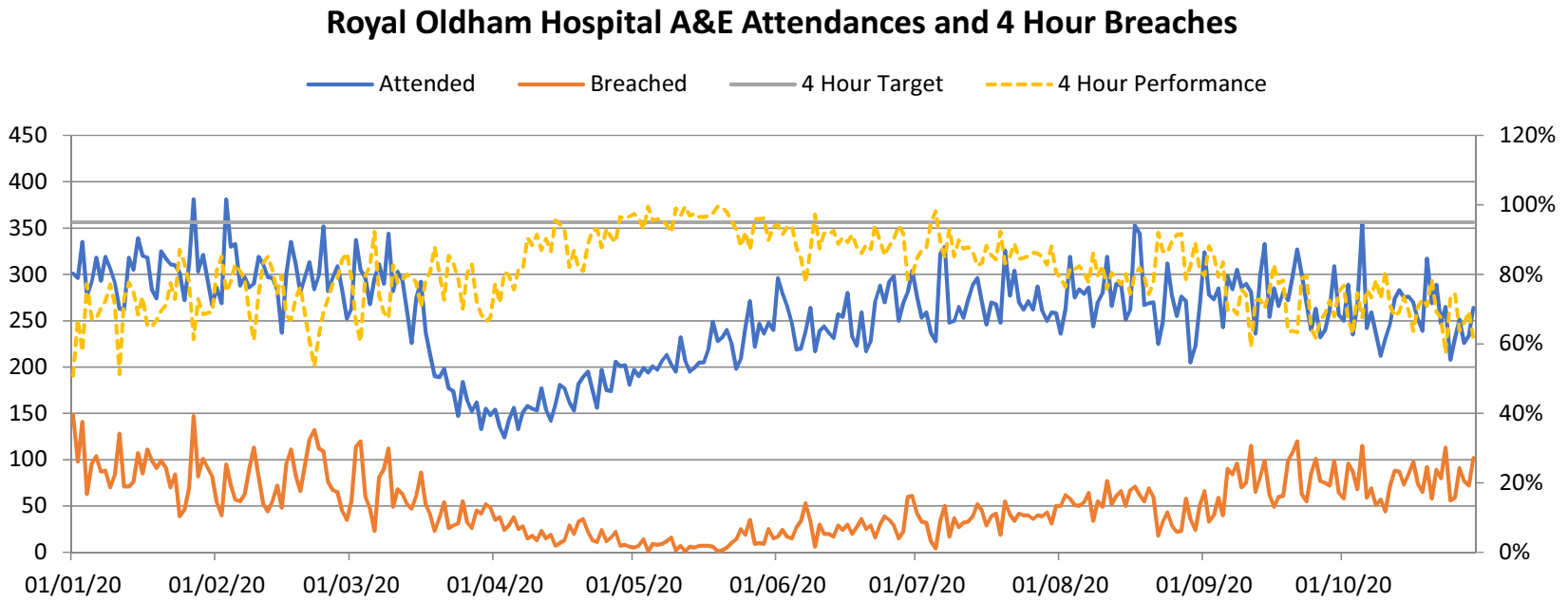
Impact on the emergency department

- The chart below shows the A&E attendances and 4 hour breaches at Royal Oldham Hospital along with the performance against target
- Attendances started to drop significantly in early March
- On 1 November the A&E performance was 61.4% and was below target
- Compared with the average of all ROH A&E attendances between January 1st 2020 and March 10th 2020:
  - The percentage change in the latest ROH total A&E attendances is (-14%)
  - The percentage change in the latest ROH A&E breaches is (+19%)
  - The percentage change in the latest ROH A&E performance is (-19%)



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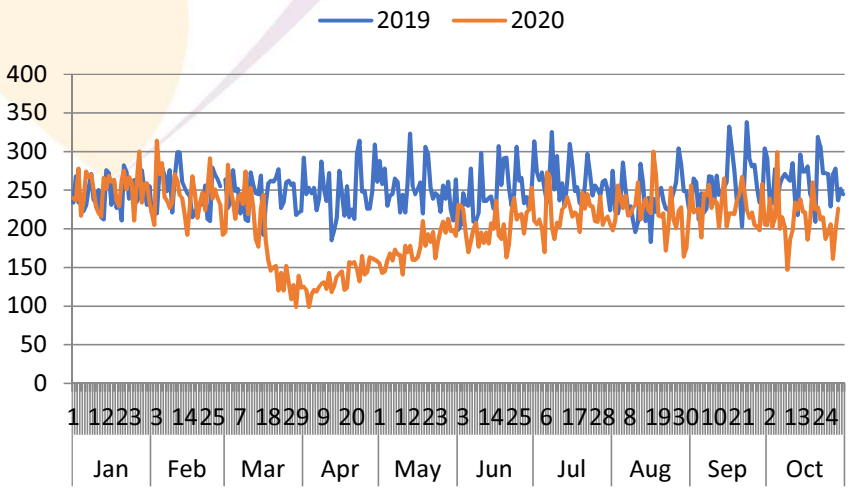
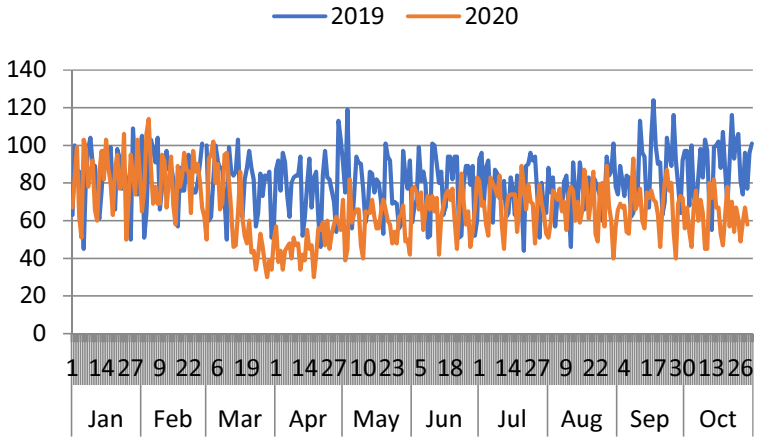
Impact on the emergency department

The charts below show the year on year activity for Oldham CCG's activity at Pennine Acute

Oldham CCG A&E Attendances at PAHT (Year on Year)



Oldham CCG Emergency Admissions at PAHT (Year on Year)



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Looking ahead

Each system within the region has submitted their plans outlining how they propose to manage and mitigate the impact of a rise in COVID cases

Outline of the request and scenario modelling undertaken

With increasing daily confirmed COVID cases in the community and hospitals reporting an increase in admissions related to patients with COVID, each system has been asked to submit:

1. **Actions planned** to take to **manage** and **mitigate** the impact of a rise in COVID cases
2. How taking these planned mitigations into account would **impact on the restoration of non-COVID health services** the phase three submissions

To estimate the impact on the phase three planning submissions a number of illustrative scenarios have been modelled.

Scenario A: Restoration set out in the phase three plans.

Scenario B: Restoration of non-COVID services, with a consistent G&A bed occupancy of 5% for COVID patients across the phase three period. *The impact of this scenario has been shown on the following slides.*

Scenario C: Restoration of non-COVID services, with G&A bed occupancy reaching a maximum of 20% for COVID patients across the phase three period. *The impact of this scenario has been shown on the following slides.*

Scenario D: Restoration of non-COVID services, with G&A bed occupancy reaching a maximum of 35% for COVID patients across the phase three period. In the submitted templates, the activity impact of this scenario was not requested.

What's worked well - highlights

- **Governance**
- System governance structure and accountability
- CHASC governance
- Devolved decision making

- **Enablers**
- CHASC Culture
- Tech - video conferencing on TEAMs
- Home working - remote technology utilising efficiencies
- Video conferencing/consultation for patients - Diabetes, TVNs, AHPs
- System flexibility - increasing clinical/non clinical skills sets across services
- 7 day working and extended hours across services

What's worked well - highlights

Service Developments

- Remodelling of Butler Green to meet clinical need and system demand, D2A
- Enhanced CE medical provision
- Discharge Hub - ICET
- Therapy - virtual ward rehabilitation model post discharge - 7days
- MSK virtual consultations - video calls, online pre-recorded classes, self care programmes.
- Joint working with PCNs and District Nurses
- DN caseload cleansing - routine ear care, B12 inj, routine phlebotomy, dopplers on hold
- DN treatment room rationalisation
- STICH - joint working to support care homes incorporating community testing offer
- Developing pathways with Hospice at Home - single point of referral and access

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Developing a new Oldham health and care system

Strategic narrative

About this document

This document has been developed specifically to help support us in seeking to set one direction of travel for the Oldham health and care system. It assumes that we evolve into a new, more dynamic place based unified health and care system capable of operating within a CoVID-19 environment.

It also assumes that we move forward in such a way as to erode the old world descriptors of commissioning and provision, and is intended to provide the strategic narrative for that new system as it now develops within a CoVID19 environment.

A word of caution. This document refer to the word system in several different places and in several different ways. It should be taken to mean either the combined health and care system or the Oldham system. It never refers to just or simply the NHS in isolation – that would be to defeat the purpose.

This is a moment in which we can break a 72 year model of healthcare delivery and transform it in to a health and care model fit for the 21st Century

This is a discussion document.

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The National Picture

NHS Long Term Plan:

- **We will continue to develop ICSs, building on the progress the NHS has already made. By April 2021 ICSs will cover the whole country**. ICSs will have a key role in working with Local Authorities at 'place' level and through ICSs, commissioners will make shared decisions with providers on how to use resources, design services and improve population health. Every ICS will need streamlined commissioning arrangements to enable a single set of commissioning decisions at system level. This will typically involve a single CCG for each ICS area. CCGs will become leaner, more strategic organisations that support providers to partner with local government and other community organisations on population health, service redesign and Long Term Plan implementation.
- **We will continue to support local approaches to blending health and social care budgets where councils and CCGs agree this makes sense.** Consistent with emerging good practice across the country, there are four optional models that have been shown to work individually or in combination when supported by local partners:
  - voluntary budget pooling between a council and CCG for some or all of their responsibilities;
  - individual service user budget pooling through personal health and social care budgets;
  - the Salford model where the local authority has asked the NHS to oversee a pooled budget for all adult health and care services with a joint commissioning team; or
  - the model where the CCG and local authority ask the chief executive of NHS England to designate the council chief executive or director of adult social care as the CCG accountable officer.

The National Picture

- The NHS Long Term Plan set out a vision for integrated care built around the needs of local people. This reflects three important observations about modern healthcare:
  - decisions taken closer to the communities they affect are likely to give better outcomes;
  - collaboration in a place between health, care services, public health, and voluntary sector is likely to be more effective than competition in addressing health inequality, improving outcomes, and reducing waste from overlapping services; and
  - collaboration between acute providers (ambulance, hospital and MH) across larger geographic footprints is likely to be more effective than competition in sustaining high quality care, tackling inequality in access to services, and enhancing productivity
- These observations have been reinforced by the COVID experience so far:
  - Organisations in Oldham have had to cooperate to the maximum to support vulnerable people in care homes or who are shielding, and to communicate with and help protect "at risk" groups in the community; and
  - Furthermore, ROH has needed to work differently both to stand up the additional critical care capacity needed so urgently in the early phase of COVID, and now in restoring non COVID care to the greatest number in a safe way
- The Long Term Plan vision in the light of COVID sets out a new ambition for "System by Default" working that will frame the "engineering" work on revised financial flows, data and information, governance and accountability

Greater Manchester

- The GM system is now asking itself what is the future for commissioning and has instigated a strategic review. Initial indications suggest that this will open up a range of differences that are underlying in the system that will need to be resolved.
- The key early indications are as follows:
  - The 2017 Commissioning review retains a high level of support but there is concern over implementation – mixed progress on SCF (although significant local examples exists with stable pooled resources and governance); Slow to confirm the detail of a GM commissioning portfolio
  - Call for delineation of strategic and tactical commissioning between SCFs and LCOs; along with a clear and tangible delineation of resource and responsibility
  - Support and objection to a GM CCG with a shared appetite for both place based commissioning (and the concept of the "Locality £" etc) and scale and standardisation of aspects of commissioning at the GM level for acute and specialist services
  - If future financial allocations are nationally mandated to the ICS level there was a challenge and opportunity to use the ICS infrastructure to create breathing space with current CCG and Provider financial issues to develop a longer term approach and maintain support for place based commissioning (which could be through SCFs or LCOs)
  - The role and potential of the JCB is viewed positively as holding the breadth of ambition across both health services and population health
  - A will exists to soften the harder features of the commissioner provider split
- The locality level should be the core building block and locality-integration should happen around coterminous LA and CCG boundaries. This would incentivise public service reform on a locality basis. Elected members in LAs will also provide democratic accountability to the new commissioning landscape.
- Local Authority boundaries have been stable, enabling long-term planning. Spatial boundaries for acute services are subject to greater flux which would be challenging to appropriately plan on along-term basis.

Characteristics of a new GM system

There is likely to be a growing organisation of some functions at GM level as the pressure for it to act and behave like an integrated care system grows

However, ***Place*** *will be the key building block for health and care integration*

- For most people their day-to-day care and support needs will be expressed and met locally in the place (Oldham) where they live
- The key building block for the future health and care system will therefore be at 'place', which means at a local authority footprint (where there are joint strategic needs assessments and health and wellbeing strategies)
- At its core the principle is to create an offer to the local population in each place.
- This offer will include:
  - Everyone living in that place is entitled to access clear advice on staying well
  - Everyone living in that place is entitled to access a range of preventative services
  - Everyone living in that place is entitled to access simple and joined up services for care and treatment when they need it
  - Anyone who is vulnerable or at high risk is entitled to simple, active support to keep as well as possible
  - Everyone living in that place is entitled to expect the NHS, through its employment, training, procurement and volunteering activities, to play a full part in social and economic development

Aggregated functions to GM level

ICS core roles: *shared system-wide activities*

- At the ICS footprint, in respect of both the place and provider collaborative based functions and services, there will be the need to determine:
  - financial allocations across places and sectors;
  - improvement and transformation resource;
  - assurance and intervention;
  - workforce commissioning and development;
  - emergency planning and response;
  - strategic projects to run at scale across places/systems

Provider collaboration: *operating at scale in health and care integration*

- For some people at times in their lives when they have more severe, complex or acute needs they will look to access the right specialist expertise for their specific condition
- Some of these more specialist needs cannot be planned and organised effectively at the place level for a number of reasons and there may be significant economies of scale that support efficiency and better use of the public purse
- This means that some provision, for example hospitals, ambulance services, and specialist mental health needs to be organised through provider collaboratives that operate at ICS level on a larger footprint
- The offer to the population across the system at ICS level will include**:**
  - Everyone is entitled to access the full range of high-quality acute hospital and mental health services
  - Everyone is entitled to fair access to these services, with access according to need and not (for example) on geography, socio-economic or ethnic background

Aggregated functions to GM level

- Whilst the majority of delivery will happen at place, to create this joined up offer the NHS require provider collaboratives to have a number of roles and functions to act at system level:

  - There will be identified NHS leaders for the “hospital systems”, ambulance services and “acute mental health systems.”

  - At system level the provider collaboratives will have six main functions:
    - to plan, modernise and invest in the development of services including “at scale” transformation;
    - to ensure the quality and sustainability of services, making use of clinical networks;
    - to enact mutual aid arrangements between organisations to enhance resilience;
    - to ensure fair and equal access times across the footprint;
    - to hold individual hospitals and units to account for delivery of plans;
    - to ensure collaboration in the delivery of health, social and economic development plans in each place.

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So, Oldham needs to adapt and evolve

Proposition – a new Oldham model

- Firstly, our entire approach must and will be rooted in the Oldham model:
  - Thriving communities – it will take decision-making about services closer to communities
  - Inclusive economy – by pooling budgets and connecting health and care to wider public services
  - Co-operative services – integrating working will ensure this
- A wide range of strategic change and design work within health and care consistently points to three core concepts in relation to integrated health and care services:
  - the design and development of at scale models of care (design),
  - the delivery arrangements that would be needed to support them (delivery)
  - the governance that would be needed to ensure quality, safety and effectiveness (regulation and assurance).
- Our current system is weak at several points and through our locality plan we committed to develop a new integrated health and care system with three new functions at its core:
  - **Design** – delivered through a new approach to integrated commissioning
  - **Delivery** – delivered through a new integrated way of working that moves beyond our existing 'alliance'
  - **Assurance** – delivered through a new system wide quality assurance framework
- Our aim in moving towards this way of working is to create a new proactive 'population health' focused system rather than a reactive 'illness and care' system

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A new approach

- Oldham will need to be able to create a joined up offer so that:
  - Everyone living in that place is entitled to access clear advice on staying well and is entitled to access a range of preventative services
  - Everyone living in that place is entitled to access simple and joined up services for care and treatment when they need it
  - Anyone who is vulnerable or at high risk is entitled to simple, active support to keep as well as possible
  - Everyone living in that place is entitled to expect the NHS, through its employment, training, procurement and volunteering activities, to play a full part in social and economic development
- This will require an agreement to aggregate some decision-making and control of some things to GM level
- But several NHS roles and functions will need to exist at place level:
  - to support and develop PCNs;
  - to simplify, modernise (including technology) and join up health and care (this includes joining up primary and secondary care where appropriate);
  - to understand and identify – using population health management techniques and other intelligence – people and families at risk of getting left behind and to organise proactive support for them; and
  - coordinating the local contribution to health, social and economic development to prevent future risks to ill-health within different population groups.
- There will need to be a culture of working where behaviour are inclusive, involving local communities, collaborative with all local partners, rigorous and data driven, transparent and open in reporting to local people and Health & Wellbeing Boards

A new approach

- A new system will need to be orchestrated and this could be achieved through the creation of a new joint committee which has core membership as commissioners and providers, elected members and clinicians
- It will also need convenor of the resources – a ‘place’ leader - able to work in partnership with the other organisations at ‘place’ with responsibility to direct local NHS resources, either through their role or through the convening of the Oldham Population Health Board - should be the Council / CCG CEx as the natural existing leader of the overall place system
- This will require the management system to be led and convened and we have learned much from Covid19 in doing so which we should replicate.
- This could then be orchestrated through 5 neighbourhoods boards which bring together the elected members, PCN director and management team for the neighbourhood

Balance

- There is a risk we concern our energy with a focus on the NHS – this would be the wrong thing to do
- As we implement this new system our design must be guided also by the wellbeing principles enshrined in the Care Act as that introduced a general duty on local authorities to promote an individual's 'wellbeing'. This means that they should always have a person's wellbeing in mind and when making decisions about them or planning services
- Wellbeing can relate to:
  - personal dignity (including treatment of the individual with respect)
  - physical and mental health and emotional wellbeing
  - protection from abuse and neglect
  - control by the individual over day-to-day life (including over care and support)
  - participation in work, education, training or recreation
  - social and economic wellbeing
  - domestic, family and personal relationships
  - suitability of living accommodation
  - the individual's contribution to society
- The wellbeing principles are also part of the eligibility criteria. Local authorities have to consider the impact of the role of a carer on their own wellbeing. Similarly, they have to consider the impact of a disabled person's needs on their wellbeing. If the impact is significant then the eligibility criteria are likely to be met

Agreed model of care

People only go to hospital when they need treatment or it is not appropriate for care to be provided in their community

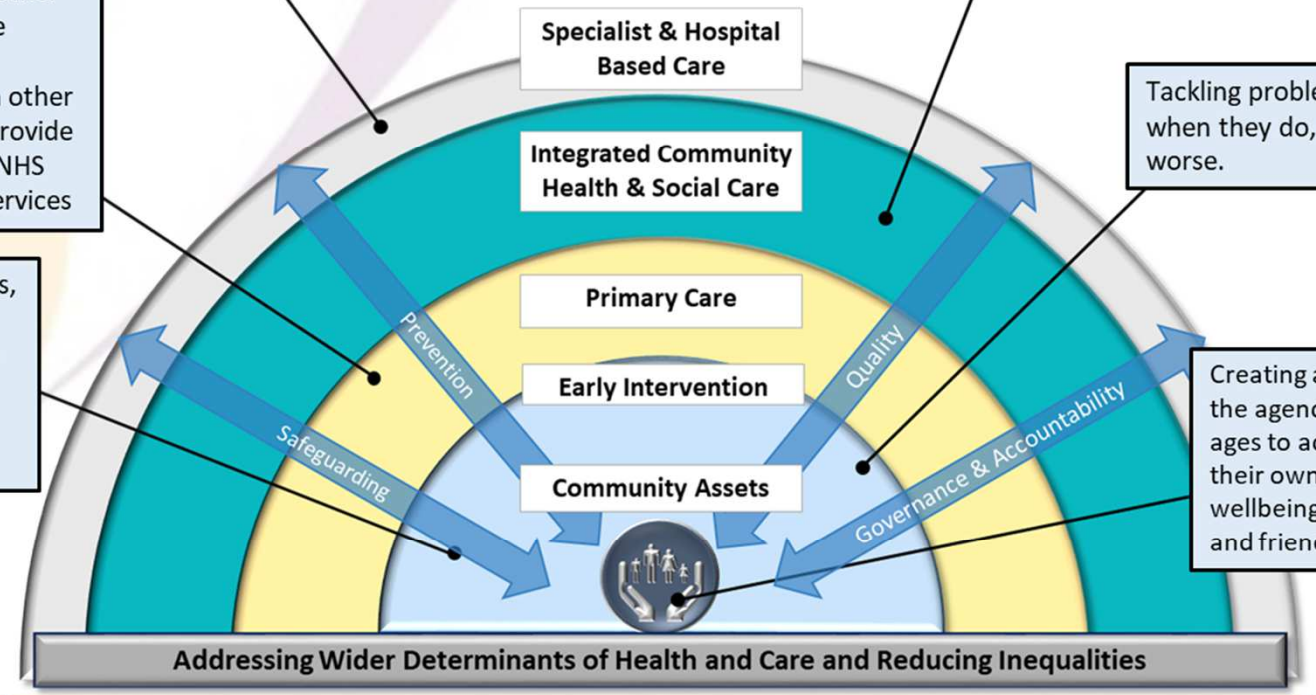
The wider public sector and VCS working with health and social care teams in an integrated way including access to specialist support. Delivery of short term intensive interventions so people can be as independent as possible, in their community

General Practice and other family health and care services working in partnership with each other and communities to provide the front door to the NHS and other statutory services

Tackling problems head-on when they do, before they get worse.

Utilising people's skills, networks and community resources (their assets) to improve their health and well-being

Creating and strengthening the agency of people of all ages to act to take care of their own health and wellbeing (and their family and friends)



Enablers

Technology	Workforce & Culture	Communication & Engagement
Physical Assets	Finance, Contracting & Payment Reform	Intelligence & Insight

NHS Oldham Clinical Commissioning Group

The vision, scope and definition of integration

- Our vision is for a renewed focus in our system – one firmly on population health management, a reduction in health inequalities and enabling people to live well at home.
- Our system will focus on neighbourhoods and the general practice list as the cornerstone of the health and care economy
- Our definition therefore of integration will be:
  - All and any services required for the 'next step care' after a GP consultation; and
  - All care provided in community settings, unless by exception – supported by specialists opinion
- Integration opportunities would therefore cover:
  - the majority of support and services that are presently delivered in outpatients;
  - a significant array of diagnostics;
  - a range of ambulatory and same day emergency care (SDEC) pathways;
  - day case work;
  - the full range of community health services;
  - the full range of adults and children's care services; and
  - an extensive range of services provided from the voluntary sector.
- Delivery will also encompass a digital first approach whenever and wherever possible

The scope of integration

- To achieve this there would need to be:
  - A new coalition of clinical and non-clinical professionals
  - A neighbourhood-based ‘core offer’
  - A directory of services would be developed, linking into appointments and scheduling
- Population health management would be at the core ‘signalling function’ for the system, driving the integrated monitoring and support for people with long term conditions and those at risk, and with services wrapped around them
- We would need to identify and agree the optimum contractual vehicle to enable this new way of working
- Our delivery approach would need to:
  - Satisfy all statutory requirements for safe and effective practice
  - Incorporate managerial, clinical and professional leadership across social care, primary, community and secondary care as a core component
  - Increase satisfaction and improve the quality of care delivered and received
  - Ensure financial sustainability

Core partners

- Oldham would move to an arrangement with a core set of members its new population health management system
- Members would either have the majority of control over the pathways, the majority of the staff or the majority of the funding or a combination of all or some of these three criteria
- Thus the core partners are:
  - **Oldham Council** – social care, children services and community health
  - **The Northern Care Alliance** – community health and medical specialties
  - **The 5 Primary Care Networks** – primary care and placed based leadership focus
  - **The Clinical Commissioning Group** – to enable 'tactical commissioning' devolution
  - **Pennine Care Foundation Trust** – for the co-ordination and delivery of mental health and learning disabilities services
- The core group would be supported by key partner organisations, and where appropriate, there will support for developing provider alliances to hep with the delivery of holistic pathways

Integrated teams

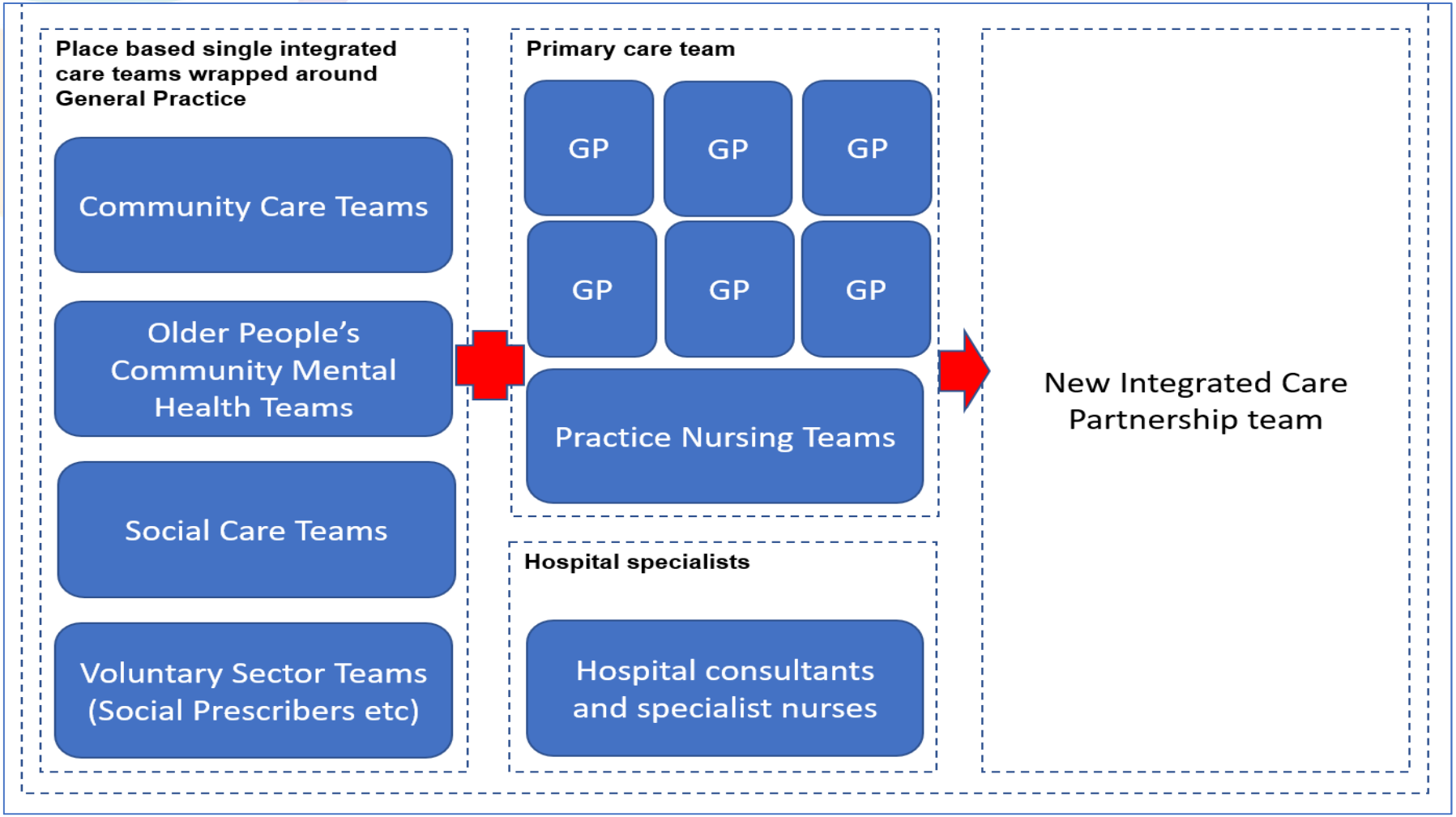
- Local communities would be the basis for integrated care delivery, so that highly personalised and co-ordinated, locally accessible care is available:
  - Consider the establishment of disease or speciality-specific centralised hubs to govern a range of de-centralised delivery services covering a population of c. 30k to 80k
  - Utilise existing sites as 'health campuses' where as many services as possible can be accessed
  - Seek new pathways to be delivered across health campuses and primary care centres
  - Utilise more mobile diagnostic technologies
  - Utilise 'digital first' in service delivery
- There would be a new arrangement for the deployment of resources organised at community level (not hospital level) and all core teams coming together to form a geographically-focused resource to provide core support to local population health needs.
- Progressing in this way will enable us to support the whole system with the introduction of a three tiered population health system, comprising:
  - A collaborative that sets the framework for pursing a population health management approach in achieving the objectives outlined by a triple system aim.
  - Development of Oldham place service networks, "creating teams without walls" that deliver services to our local communities with economies of scale benefits. These clinical service networks overlap and link in wider clinical networks that have either North East Sector focus or wider GM focus, such as mental health and cancer services.
  - Integration of clinical and non-clinical services are that are built around the registered list and key public data lists in our five aligned PCNs and neighbourhood communities to help mobilise the local communities in the co-design of health and wellbeing solutions for hyper local populations and communities.

Integrated teams

- The establishment of these integrated community hubs, offer exciting opportunities to connect with other aspects of our model and vision, with examples including:

  - Targeted early years interventions
  - Early help for children and families
  - Virtual teams supporting local schools
  - Support for vulnerable tenants in the private and social rented sectors
  - Interventions to prevent anti-social behaviour and criminality
  - The variants of the Working Well programme, linked to the roles of the DWP and Job Centre Plus

Integrated team-based working example



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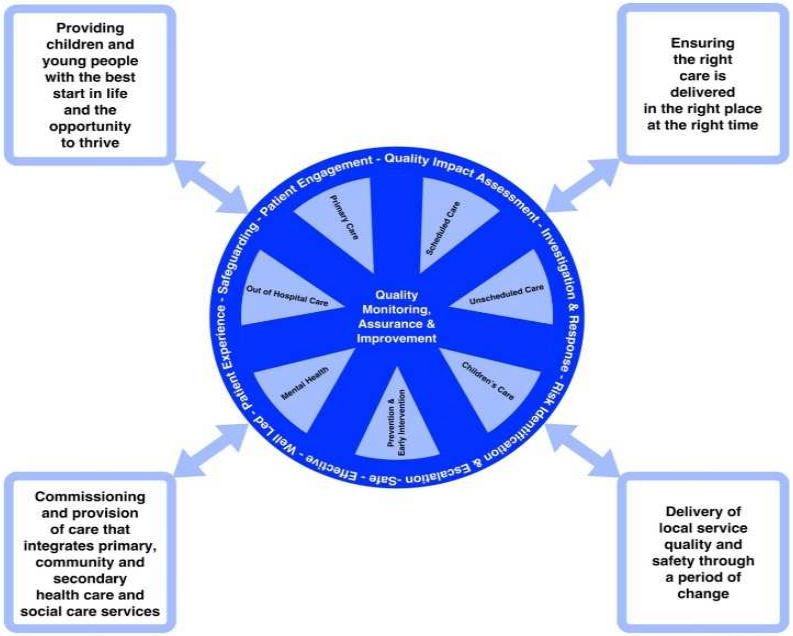
A new assurance function

- Quality monitoring, assurance and improvement across the health and social care system must be everyone's business
- We will develop:
  - Shared accountability for risk
  - Shared accountability for quality and
  - Shared accountability for improvement as a core embedded principle throughout our new system.
- This new assurance model will:
  - Focus on whole health and care quality monitoring, assurance and improvement
  - Be collaborative
  - Place quality and safety at the heart of decision-making
- This will need to be led and bring in safeguarding, quality and other significant aspects of health related quality measures
  - The ideal lead is the CCG Chief Nurse who will bring together medics, nurses, AHPS and other professionals to set standards of quality and the quality and standards framework



- This framework and approach will need satisfy the statutory roles of DASS, DCS, DPH etc and each will retain those statutory responsibilities

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Timelines

We have not got time on our side. They key proposed milestones are as follows:

1. Commissioning intentions: issued by end Oct 2020
2. Operating model designed: by end December 2020
3. New ‘delivery’ integration agreement: by end December 2020
4. Shadow operation of new integrated ‘delivery’ arrangements: Jan – March 2021
5. New pooled budget for commissioning: by 1 April 2021
6. Implementation of new design function: by 1 April 2021
7. New ‘design’ governance arrangements operational: by 1 April 2021

This is hugely ambitious!

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Summary and next steps

Summary and next steps

Top 15 Characteristics of a new system

1. Single placed based 'leader'(Council CEx)
2. Steamlined governance to orchestrate the system
3. Population health focused, connected to wider determinants
4. No boundaries between commissioning and provision – system planning and delivery orchestrated via population health board
5. Five main / core partners
6. Connected system from top to bottom – strategic borough level board supported by 5 neighbourhood boards
7. Placed based multi-disciplinary, integrated teams
8. Service offer for all but sensitive to neighbourhood needs
9. Pooled funds and single system budgeting process
10. Subsidiarity based system – do in Oldham what Oldham needs, do rest at GM or NES level
11. All statutory roles able to discharge their duties
12. Intelligence led and data driven
13. Rationalised back office where it makes sense
14. Professionally and clinically led
15. Regulatory and statutory responsibilities met by all organisations through system based quality and assurance approach

- We have a once in a generation opportunity to break an outdated 72-year model of healthcare delivery and transform into a 21st Century health and care delivery model connected to the wider public service system
- If we can agree this direction then work needs to progress at rapid pace on an operating model that is co-designed and owned by the key partners