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HEALTH AND WELL BEING BOARD
Agenda

Date	Thursday 2 November 2023
Time	10.00 am
Venue	Lees Suite, Civic Centre, Oldham, West Street, Oldham, OL1 1NL
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 in advance of the meeting. 2. CONTACT OFFICER for this Agenda is Tel. 0161 770 5151 or email constitutional.services@oldham.gov.uk

Item No

9 Winter Planning Update (Pages 1 - 8)

To consider a report presented by Maion Colohan, NHS, Manchester Integrated Care.

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Oldham
Integrated Care Partnership

Winter Planning Update

Health and Wellbeing Board

Date:	2 November 2023
Agenda Item No:	
Report Title:	Winter Planning Update
Portfolio Holder	Cllr Barbara Brownridge
Author:	Marion Colohan, Assistant Director of Communities and Partnership

Presented for: Approval/Information/Discussion (delete as applicable)
Information / Discussion
Previously presented at:
N/A

Purpose of the Report
To update the Heath and Wellbeing Board on: 1. Winter Planning 2023/24. 2. Winter Vaccination Programme 2023/24

Report Content

Winter Planning 2023/24

National approach

The national approach to 2023/24 winter planning outlines the key steps we must take together across all parts of the system to meet the challenges ahead and is comprised of four core elements:

- High-impact priority interventions drawn from the UEC recovery plan that all systems will be asked to deliver and provide assurance against.
- Clear roles and responsibilities for each part of the system so that both shared and individual organisational accountability is clear.
- Returns from systems on system-level resilience and surge planning, to avoid systems becoming overwhelmed at times of peak demand and a narrative return against key lines of enquiry.
- NHS England's winter operating model, including triggers for escalation. All of the interventions over winter should contribute towards the two key targets for UEC performance of:
  - 76% of patients being admitted, transferred or discharged within four hours by March 2024, with further improvement in 2024/25.
  - Ambulance response times for Category 2 incidents to 30 minutes on average over 2023/24

Link to Delivering Operational Resilience across the NHS this winter

GM ICB Tier 1 Allocation-May 2023

As part of the National UEC improvement, each system has been allocated into one of three tiers. GM ICB is one of two localities in the North-West that has been allocated to Tier 1 and as such will receive the highest level of support from NHS England (NHSE) to help achieve the UEC ambitions with a tailor-made approach, this includes.

- Self-assessment framework and maturity indices – To assess the services provided and identify opportunities for improvement. Led by GM ICB.
- Best practice standards, guidance, and case studies – Subject matter experts will provide guidance and peer support.
- Support and oversight from the national iUEC team – To provide advice and expertise on operational and clinical leadership. Self-assessment framework and maturity indices

In July an Integrated Urgent and Emergency Care Pathway Tier 1 maturity self-assessment assurance submission was requested by GM for NHSE which outlined a number of high impact priority interventions that all systems have been asked to deliver and provide assurance against:

	Actions
1	**Same Day Emergency Care**: Reducing variation in SDEC provision by providing guidance about operating a variety of SDEC services for at least 12 hours per day, 7 days per week.
2	**Frailty**: Reducing variation in acute frailty service provision. Improving recognition of cases that could benefit from specific frailty services and ensuring referrals to avoid admission.
3	**Inpatient flow and length of stay (acute)**: Reducing variation in inpatient care and length of stay for key iUEC pathways/conditions/cohorts by implementing in-hospital efficiencies and bringing forward discharge processes for pathway 0 patients **(see *Urgent and Emergency Care Recovery Plan* for Actions required)**.
4	**Community bed productivity and flow**: Reducing variation in inpatient care and length of stay by implementing in-hospital efficiencies and bringing forward discharge processes **(see *Urgent and Emergency Care Recovery Plan* for Actions required).**
5	**Care Transfer Hubs**: Implementing a standard operating procedure and minimum standards for care transfer hubs to reduce variation and maximise access to community rehabilitation and prevent re-admission to a hospital bed.
6	**Intermediate care demand and capacity**: Supporting the operationalisation of ongoing demand and capacity planning, including through improved use of data to improve access to and quality of intermediate care including community rehab.
7	**Virtual wards**: Standardising and improving care across all virtual ward services to improve the level of care to prevent admission to hospital and improve discharge.
8	**Urgent Community Response**: Increasing volume and consistency of referrals to improve patient care and ease pressure on ambulance services and avoid unnecessary admission.
9	**Single point of access**: Driving standardisation of urgent integrated care coordination which will facilitate whole system management of patients into the right care setting, with the right clinician or team, at the right time.
10	**Acute Respiratory Infection Hubs**: Support consistent roll out of services, prioritising acute respiratory infection, to provide same day urgent assessment with the benefit of releasing capacity in ED and general practice to support system pressures.

The outcomes of the self-assessment for Oldham were:

Same Day Emergency Care	Acute Frailty Services	Acute Hospital Flow	Community beds	Intermediate Care
Maturity score 5	Maturity score 4	Maturity score 6	Maturity score 5	Maturity score 6
7 days per week, 12hrs weekdays, 8hrs weekends	Month Frailty steering Group led by Oldham Care Org. Specialist	Daily ward rounds and huddles SAFER principles in place	General and Acute beds open in line with Operating Plan	Assessments and care plans in place for each individual
Consists of Multidisciplinary team led by consultant	Multi-disciplinary front door frailty team developed, additional senior clinical support recruited to.	Enhanced offer discharge lounge with increased capacity and manage IPC. Internal discharge transport being developed	Transfer of Care Hub operating alongside Discharge Hub 7 days per week to enable swift referral and effective discharge	Demand and Capacity review completed as part of BCF process
NWAS direct to SDEC pathway in place	Geriatric department is being established and a care Organisation approach to Frailty is being strengthened across the system.	Electronic D2A referral form in place and effective communication with families/carers takes place	Hospital Discharge Front Runner programme in place – strength-based training approach on wards to enable timely discharge.	Resource identified utilising BCF funds and Hospital Discharge Funds
SDEC review completed supported by ECIST	CFS routinely recorded at circa 97%	Discharge Frontrunner "Strength Based Approach" implemented Q2-Q4	Additional beds commissioned utilising Hospital Discharge Fund	Work to be done to submit comprehensive CSDS data
Scoping of surgical SDEC model to take place	Further work to be completed to achieve shared care records	Continuous Flow model to expand to Paeds & Surgery	Discharge Front Runner programme in place – project operating Q3 to improve early discharge for dementia cohort of patients	Consider Continuous Flow model for IMC beds
Ambition: Improve SDEC to over 40% of the take	CF model is contributing to an improvement in "80% of patients their stay in acute frailty is under 8 hours. "	Discharge Front runner communications documents to be developed for families/Carers	workforce planning in place over surge periods, staff flu vaccination programme to be in place	

Virtual Wards	Urgent Community Response	Single Point of Access	ARI Hubs	Transfer of Care Hub
Maturity score 3	Maturity score 5	Maturity score 2	Maturity score 6	Maturity score 6
VW available for respiratory, cancer and frailty Further development of step up pathways to take place	Operating within expected standards	More than one SPOA in Oldham – interdependencies within each, with direct referral for most	Urgent Care Hub operates 24/7, 7 days per week, with direct links to 2hr UCR, NHS 111, A&E, SDEC and Consultant Connect	SOP in place
Adult & Paediatric VW operating.	Comprehensive DoS profile with direct referral from NWAS	All UEC services profiled on the DOS and reviewed regularly	H&SC professionals direct phone line into ARI hub, which include primary care, 999, care homes, other health and social care professionals	Minimum standards achieved with 7 day per week operation
Additional workforce to support being recruited to	Falls Pick Up Service embedded within service	Multi-disciplinary workforce work across system	Work to be done on ECDS submission	Electronic D2A referral form in place to enable swift referrals and time discharge
Heart Failure ToC to take place over Q3	Work to take place in order to submit consistent CSDS data		Further work to increase PoC testing	Partnership working between VCSE in place, with AgeUK support and in-reach from Hospice provided via Hospital Discharge funds

In addition the 'High Impact Interventions' other work across the system is detailed below:

Primary Care

- Proactive work with Oldham GP practices on frailty via local enhanced service, focusing on prevention & intervention for people at risk of frailty, diabetes and respiratory conditions.

- Capacity & Access Plans in place for PCNs to implement to improve access to general practice. Plans include increase to digital offer – more online triage, better signposting, improved websites.
- Modern general practice funding applications received from practices to improve access to general practice.
- Review of GP referral to NHS Community Pharmacist Consultation Service (GPCPCS) to take place to maximise utilisation.

Children and Young People Services:

- Virtual Ward and ARI hub operating 24/7 for children and young people including over bank holiday periods
- Continuous Flow Model in Paediatrics to commence September
- Paediatric mutual aid arrangements in place across GM if required, including critical care
- CCNT operating 7 days a week 8am to 10pm, pathways in place to support early discharge from hospital and GP referrals to CCNT in the Community
- Children's Advanced Clinical Practitioner Clinic is available 4 days per week for same day rapid assessment for children & young people aged 0-18 years with acute/short term illness (referrals need to be made by a health practitioner.)

Ambulance Trust:

- GM CAS in place to hear and treat Cat3 & 4 calls
- Electronic direct referral from 999 to falls pick up service, 2hr community UCR, UTC offer in place
- Comprehensive DoS profiling of all alternative services
- Mental Health Rapid Response vehicles operating to minimise 999 conveyances
- Direct phone line for H&SC professionals to Oldham's Urgent Care Hub which operates 24/7 and consists of multi-disciplinary workforce including GP's and ANP's.
- KPI is to respond to H&SC referrals within 30mins, and to NWAS calls within 20mins

Mental Health, Reducing ED presentations

- Joint Response Vehicles – operational 7 day 3pm – 1am
- Urgent and Emergency Care Appointments – bookable appts available within 72 hours
- Helpline – operational 24/7
- Children and Young People – development of Home Treatment offer and Rapid Response provision
- Strong links with VCSE Listening Lounge space
- Community Mental Health Transformation work continuing to strengthen community offer
- Development of GM wide Mental Health Urgent Triage model in NWAS Emergency Operations Centre
- Daily bed management meetings to review waiters across the system and prioritise admissions
- Weekly system meetings with PCFT/ICB/LA to review inpatients CRFD and delayed transfers across PCFT and Out of Area Placements to ensure reduced length of stay
- Recruiting to discharge co-ordinator posts to support patient flow across PCFT acute wards and OAPs
- GM Moving On Project operational - Step down flats available to support discharge for people with accommodation specific issues

Local authorities and social care:

- The transfer of care team is operating and is multi-agency including Health, Social Care and community colleagues.
- The team collate and report capacity across the system on a daily basis and identify capacity challenges.
- This is escalated to Commissioning services in partnership with Health and Social leads as part of the sitrep escalation process.
- The ASC Strategy includes a Vision for Adult Social Care in Oldham – Supporting you to be independent, healthy, safe and well. The Strategy is due to be formally signed off in Summer 2023 and launched in September with a public campaign.
- Oldham DASS and Deputy Place Based Lead meet regularly.
- BCF plans made in partnership between LA and NHS. They include increasing capacity for beds, and services designed to enable early discharge. Regular review of BCF plans and performance take place.
- The Care Homes provider forum in June 2023 was dedicated to 'Supporting Care Homes' and covered Falls Prevention initiatives (Data, Challenges/Solutions, Myth Busting, Oldham Offer, ISTUMBLE and KOKU initiatives) in readiness for winter. It provided support to the sector in respect of the 2 hr UCR service, Managing Deterioration, Restore 2 Mini and a re-cap around the benefits of Pulse Oximeters.
- Easy read Care Homes poster and pathway outlining what to do to help a resident and the steps a care home can take and available locally to avoid hospital admissions has been created and distributed
- Financial discharge incentives to the whole market payable on admissions from hospital across the holiday weekends at Christmas and New Year (This is an approach we implement across weekends throughout the year that coincide with public holiday periods). The approach acknowledges that staff expect to be renumerated accordingly to work over these key holiday periods.
- Discharge data analysed over previous winters and identified a number of 'surge weekends' where we expect discharge demand to peak. Participating homes required to ensure senior staff available throughout the 4 days around/including these weekends who could process discharges at pace, undertaking tasks such as reviewing D2A documentation submitted within 2 hrs, overseeing the admission end to end process.

2.0 Winter Vaccination Programme 2023/24

The Winter Vaccination programme for Covid 19 and Flu is underway across Oldham with clinical teams are offering coadministration where possible.

- The eligible cohorts for Covid and Flu vaccinations are aligned and available to;
- Residents in a care home for older adults
- All adults aged 65 years and over
- Persons aged 6 months to 64 years in a clinical risk group, as laid out in the Immunisation
- Green Book, COVID-19 Chapter (Green Book)
- Frontline health and social care workers
- Aged 16 to 64 years old and are a carer
- Persons aged 12 to 64 years who are household contacts (as defined in the Green Book) of people with immunosuppression

Those eligible can access a vaccine with their registered GP or via a Community Pharmacist. Local Vaccination Sites which can be found using the National Booking System (NBS) and there are some 'walk in' clinics available, the details of which can be found on the NHS website.

Covid Vaccine Performance Data

Performance at 10 October 2023

86,250	17,827	1,843	6,715	20.7%
Eligible for Autumn Booster (Received 1 dose)	AW23 Doses Delivered	Boosters Delivered This Week to Date Wk/C: 09-Oct-23	Boosters Delivered Last Week Wk/C: 02-Oct-23	AW23 % Uptake

		Eligible	AW23 Delivered	AW22 Boosters Delivered	% Uptake	AW22 Uptake
1: Care Home Residents & Residential Care Workers	Average	1,264	785	950	62.1%	75.2%
2: Healthcare Workers	Average	12,100	1,317	5,224	10.9%	43.2%
3: Social Care Workers	Average	2,646	301	1,129	11.4%	42.7%
4: 80+	Average	8,735	3,492	7,130	40.0%	81.6%
5: 75-79	Average	8,307	3,652	6,822	44.0%	82.1%
6: 70-74	Average	9,082	3,289	7,004	36.2%	77.1%
7: 65-69	Average	10,851	2,883	7,254	26.6%	66.9%
8: At Risk	Average	32,185	2,106	9,725	6.5%	30.2%
9: 12-15 At Risk	Average	471	1	68	0.2%	14.4%
10: 12-17 Household contacts of immunosuppressed	Average	424	1	23	0.2%	5.4%
11: 5-11 At Risk	Average	185	0	47	0.0%	25.4%
Grand Total		86,250	17,827	45,376	20.7%	52.6%

GM ICB
Covid-19
Planning

Sub ICB: All
PCN: All
GP Practice: All
JCVI Group: All
Patient Ethnicity: All
Patient Ethnicity Group: All
Patient Age Bracket: All
Patient Gender: All

1,026,219	214,306	36,187	76,844	20.9%
Eligible for Autumn Booster (Received 1 dose)	AW23 Doses Delivered	Boosters Delivered This Week to Date Wk/C: 09-Oct-23	Boosters Delivered Last Week Wk/C: 02-Oct-23	AW23 % Uptake

	Eligible	AW23 Delivered	% Uptake	Bolton	Bury	Manches..	Oldham	Rochdale	Salford	Stockport	Tameside	Trafford	Wigan
1: Care Home Residents & Residential Care Worke..	12,550	7,567	60.3%	68.6%	61.8%	66.6%	64.3%	69.8%	40.6%	70.6%	57.1%	60.5%	41.6%
2: Healthcare Workers	167,806	18,553	11.1%	9.5%	12.4%	9.3%	11.8%	10.6%	7.7%	16.8%	13.5%	13.4%	8.0%
3: Social Care Workers	36,201	4,160	11.5%	13.2%	14.1%	9.0%	12.2%	13.7%	9.0%	15.2%	12.3%	11.1%	9.4%
4: 80+	105,458	41,304	39.2%	41.3%	40.7%	30.3%	42.2%	43.9%	26.4%	50.9%	40.8%	39.9%	33.3%
5: 75-79	95,963	39,363	41.0%	42.7%	40.5%	31.9%	46.2%	46.2%	29.9%	52.3%	42.5%	43.8%	34.5%
6: 70-74	106,206	37,778	35.6%	34.9%	37.1%	28.2%	38.6%	38.6%	25.5%	47.4%	39.3%	36.9%	30.2%
7: 65-69	128,333	35,732	27.8%	27.2%	30.3%	21.5%	29.0%	29.6%	19.8%	39.3%	30.7%	30.0%	23.3%
8: At Risk	360,251	29,773	8.3%	8.0%	9.2%	6.7%	7.3%	8.0%	5.7%	14.3%	9.9%	9.0%	6.5%
9: 12-15 At Risk	5,696	57	1.0%	1.7%	2.1%	0.8%	0.4%	0.7%	0.3%	0.4%	1.1%	1.8%	1.2%
10: 12-17 Household contacts of immunosuppres..	5,035	17	0.3%	0.9%	0.5%	0.1%	0.2%	0.2%	0.0%	0.2%	0.0%	0.7%	0.4%
11: 5-11 At Risk	2,720	2	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%
Grand Total	1,026,219	214,306	20.9%	21.7%	23.2%	14.2%	22.1%	22.7%	14.1%	30.7%	23.3%	23.2%	18.3%

Weekly Doses Delivered
Autumn 2022 | Autumn 2023

Daily Doses Delivered

Site Breakdown

PILLAR	SITE NAME	TOTAL
CP	Ashton Road Pharmacy	265
CP	Butler Green Pharmacy	-
CP	Cathedral Pharmacy	666
CP	Focus Pharmacy	239
CP	Imaan Pharmacy Werneth	1,090
CP	St Chads Pharmacy	1,374
CP	Strachans Chemist	1,373
CP	Suburb Pharmacy	-
CP	Well Chadderton - Block Lane	253
CP	Well Greenfield - Chew Valley Road	215
CP	Well Oldham - Horsedge Street	175
CP	Well Shaw - High Street	252
	TOTAL	5,902

PILLAR	SITE NAME	TOTAL
PCN	Barley Clough Medical Centre	1,143
PCN	CH Medical	1,908
PCN	Hollinwood/Kepple	445
PCN	Lees Medical Practice	3,058
PCN	Royton Health and Well Being Centre	4,805
	TOTAL	11,359

Work is ongoing to address the variation in uptake across the PCN's. There are specific workstreams supporting communities to better understand the importance of vaccination, helping to breakdown language barriers and challenges to accessing services. Work is will commence with the Council of Mosques and targeted Men and Women's community groups in areas of low vaccination uptake. The locality will be supporting in-reach to supported living facilities to help vaccinate residents with Learning Difficulties and Autism. This will be progressed throughout 22/23 as a result of national funding from NHS E provided to GM ICB localities to address variation, increase uptake of C-19 vaccination and to tackle inequalities.

Flu data will be available mid-November

Schools Flu Programme

The School Nursing programme and Intra Health commenced their vaccination schedules in schools and to those educated at home from 25th September. The NHS communication and engagement team are supporting to promote uptake and are promoting additional community clinics in areas where uptake has been previously lower.

Recommendation/s

The Health and Wellbeing Board to: Note the Winter Planning progress for 2023/24 and offer advice and support to the work programme.