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Oldham Council

HEALTH SCRUTINY
Overview & Scrutiny Committee
Agenda

Date	Tuesday 7 January 2020
Time	6.00 pm
Venue	Crompton Suite, Civic Centre, Oldham, West Street, Oldham, OL1 1NL
Notes	1. DECLARATIONS OF INTEREST- If a Member requires advice on any item involving a possible declaration of interest which could affect his/her ability to speak and/or vote he/she is advised to contact Paul Entwistle or Mark Hardman at least 24 hours in advance of the meeting.

2. CONTACT OFFICER for this agenda is Mark Hardman Tel.0161 770 5151 or 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, 2 January 2020.

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

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MEMBERSHIP OF THE HEALTH SCRUTINY
Councillors Toor, McLaren (Vice-Chair), Alyas, Byrne, Davis, Hamblett, Ibrahim and Moores (Chair)

Item No

1 Apologies For Absence

2 Declarations of Interest

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

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3 Urgent Business

Urgent business, if any, introduced by the Chair

4 Public Question Time

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

5 Minutes of Previous Meeting (Pages 1 - 10)

The Minutes of the meeting of the Health Scrutiny Committee held on 3rd September 2019 are attached for approval.

6 Minutes of the Joint Scrutiny Panel for Pennine Care (Mental Health) Trust (Pages 11 - 16)

The Minutes of the meeting of the Joint Scrutiny Panel for Pennine Care (Mental Health) Trust held on 15th October 2019 are attached for noting.

7 Minutes of the Joint Scrutiny Panel for Pennine Acute Hospitals NHS Trust (Pages 17 - 22)

The Minutes of the meeting of the Joint Scrutiny Panel for Pennine Acute Hospitals NHS Trust held on 18th July 2019 are attached for noting.

8 Minutes of the Greater Manchester Joint Health Scrutiny Committee (Pages 23 - 38)

The minutes of the meetings of the Greater Manchester Joint Health Scrutiny Committee held on 10th July and 11th September 2019 are attached for noting.

9 Minutes of the Health and Wellbeing Board (Pages 39 - 46)

The minutes of the meeting of the Health and Wellbeing Board held on 24th September 2019 are attached for noting.

10 NHS Health Checks Programme - Update (Pages 47 - 52)

11 Integrating Community Health and Adult Social Care Services (Pages 53 - 78)

12 Review of Primary Care (Pages 79 - 90)

13 Council Motions (Pages 91 - 92)

14 Health Scrutiny Forward Plan (Pages 93 - 100)

15 Date and Time of Next Meeting

The next meeting of the Health Scrutiny Committee will take place on Tuesday, 28th January 2020 at 6.00 p.m. This meeting will be a Development Session.

HEALTH SCRUTINY
03/09/2019 at 6.00 pm

Present: Councillor Moores (Chair)
Councillors Toor, McLaren (Vice-Chair), Alyas, Byrne and Davis

Also in Attendance:

Andrea Entwistle	Principal Policy Officer - Health and Wellbeing
Lori Hughes	Constitutional Services
Mark Drury	Oldham CCG
Helen Ramsden	Interim Assistant Director, Joint Commissioning
Laura Windsor-Welsh	Action Together

1 **APOLOGIES FOR ABSENCE**

Apologies for absence were received from Councillor Ibrahim.

2 **DECLARATIONS OF INTEREST**

There were no declarations of interest received.

3 **URGENT BUSINESS**

There were no items of urgent business received.

4 **PUBLIC QUESTION TIME**

There were no public questions received.

5 **MINUTES OF PREVIOUS MEETING**

RESOLVED that the minutes of the Health Scrutiny Committee meeting held on 2nd July 2019 be approved as a correct record.

6 **MINUTES OF THE JOINT SCRUTINY PANEL FOR PENNINE CARE (MENTAL HEALTH) TRUST**

RESOLVED that the minutes of the Joint Scrutiny Panel for Pennine Care (Mental Health) Trust from the meetings held on 21st March 2019 and 23rd July 2019 be noted.

7 **MINUTES OF THE GREATER MANCHESTER JOINT HEALTH SCRUTINY COMMITTEE**

RESOLVED that the minutes of the GM Joint Health Scrutiny Committee held on 13th March 2019 be noted.

8 **RESOLUTION AND ACTION LOG**

RESOLVED that the Resolution and Action Log from the Health Scrutiny Committee held on 2nd July 2019 be noted.

9 **MEETING OVERVIEW**

RESOLVED that the Meeting Overview for this meeting be noted.

10 **NORTH WEST AMBULANCE SERVICE**

The Committee were provided with information which outlined the current performance, position and initiatives of the North West Ambulance Service with additional focus on the Oldham area.

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The presentation covered current performance against national targets, level of activity, number of hospital conveyances, hear and treat/see and treat numbers, new initiatives/projects and news from the trust. The sectors within the Ambulance Service were defined as well as the challenges for which there was a good and improving picture. The emphasis on the service was urgent care and improving the collaboration with other partners. Quarter 1 performances for 2018 and 2019 were compared and presented continued improvements. Measures had been brought in to reduce turn around times. The Committee were informed about working in a complex environment, changes to release ambulances quicker through changing the culture of staff and creating greater capacity. Members were informed about the extra demand and how this was being addressed. Emergency department attendances were outlined for each CCG and Oldham had shown a reduced attendance at A&E. Oldham was presented with high demand and the Ambulance Services was working with Oldham to look at ways to better manage patients to release ambulances within 30 mins.

Ambulance performance was improving and the targets for the response times were highlighted to the Committee. Members were informed about the response cars located in the communities and the improvements in response to cardiac arrest and stroke incidents. The number of conveyances had been reduced but a challenge remained with ambulance turnarounds.

Members sought and received clarification regarding the use of private ambulances. The use of private ambulances was being decreased by recruitment to the full potential to reduce dependence on private providers as well as the service being modernised. The Ambulance Service was also reducing time on scene through key messages being in place and work with the crews.

Members sought clarification on the performance indicators in reducing the turnaround time and getting to emergencies, did it affect the quality of care the patient needed, was the use of the car better and whether the emergency cars had the same equipment as the larger ambulance? Members were informed that in terms of care the car had the same equipment as the large van apart from lifting equipment. Assessment of a patient did not require the large ambulance. The cars provided a vital function and did not reduce the quality. With regard to the handover at the hospital, 30 minutes was enough to discuss the patient and relay what had happened. There was always triage with the clinician on the care of the patient.

Members sought clarification on what had improved performance and what steps could be taken to further improve performance not just within the ambulance service but also other members of the team and how sustainability could be ensured? Members were informed that sustainability was a concern, crews were dispatched following key questions being asked

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which had knocked 25 seconds off the cycle. There were things that could be addressed through technology. All crews now had i-tablets which could access patient records and were linked to location technology. Partnership with other services was key. Less life-threatening calls could be diverted to another provider. The Greater Manchester Health and Social Care Board was trialling links with a number of providers with funding to bring a pilot back and indicate a way forward for it to be brought in before the winter pressures.

RESOLVED that the information related to the North West Ambulance Service be noted.

11 **THRIVING COMMUNITIES**

The Committee received a report which provided an update on the Thriving Communities Programme and, in particular, the initial phase of the Social Prescribing Innovation Partnership.

The report outlined the Oldham Model whereby the Council and its partners were committed to a cooperative future and the Oldham Plan which set out the Oldham Model for delivering tangible and sustained change. The Thriving Communities element of the model would deliver the common objectives of the health and social care integration, Oldham Cares. The programme would deliver £9m plus of reduced demand in the health and care system as well as delivering wider benefits to Oldham residents around improvements to their general physical and mental health and wellbeing.

The Social Prescribing Network was highlighted which bridged the gap between medical care and the community. It was estimated that there were more than 700 community groups across Oldham delivering close to 1000 activities, events and positive interventions / support for residents. In Oldham West since January 2018 in excess of 250 people had been supported since January 2019. The network was helping people turn their lives around and work alongside existing services.

A three-year contract had been initiated in April 2019 which had been commissioned via an Innovation Partnership which was a new model of commissioning that allowed the approach to be iterated and evolved through co-production with residents and a higher emphasis on social value. A ‘Care Champion’ model was being tested in Cluster East which would see the development of peer networks for patients who have common illnesses attached to surgeries. Oldham residents could also directly refer themselves via the Oldham Cares website. Referrals and connections into community support had dramatically ramped up as the model was operating borough wide and three times the levels predicted in the business case.

Social Prescribing data was captured from interactions and trackers in the Social Prescribing network and work was ongoing to address obtaining timely health data. The report reflected referral sources.

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Fast Grants were outlined in the report which commenced in July 2019 and would deliver £60k each year into grassroots community groups. The next phase had been launched with over 40 applications received. Members were informed about the Social Action Fund which would commission five medium-sized projects and included the Oldham BAME Consortium, Wellbeing Leisure, Oldham Play Action Group & Wifi, Street Angels and Groundwork.

The Health Improvement Workstream and Thriving Communities had agreed to merge to give a stronger voice to earlier intervention and prevention to unpick system wide issues like obesity and oral health.

Members were informed about workforce development which would develop a common way for staff to work across organisational boundaries in a strength-based way. Workforce training would be made available to community groups who could benefit.

Members were informed on the stronger focus on evidence and evaluation with the Thriving Communities index which provided insight into where positive and negative norms lay within the borough. The index was available to members. Members engagement on the programme was also outlined in the report.

The Committee were informed that five clusters went live in July and the number of referrals had increased without having to access professional help. The number at present was almost 300 from across all clusters. The number 1 reason for referral was loneliness / social isolation and the second was mental wellbeing. Alongside advocating social care transformation was good community development work and it was important that organisations had the right amount of support and development. Work was being undertaken with Community Development Workers. Investment to the sector was important. Projects had now been awarded funding and started to deliver. The governance group had now merged with public health improvement group.

Members sought clarification on the primary care referral route and referrals from social care and how residents would find out about self-referrals. Members were informed that in the pilot phase there had been conversations with residents in places such as GP offices and handed out leaflets as well as using social media. Word of mouth was also key.

Members asked that as the voluntary sector was an integral part of the scheme, how would the sector be supported as well as investment. Many organisations involved residents who were retired who provided a degree of expertise. Members asked about the use of these resources and if a meeting / workshop would assist in pulling various groups together, identify most significant issues and develop a framework. Members were advised of ongoing community work and workforce

development. Members were also informed of work undertaken with the National Lottery.

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Members enquired how health and wellbeing outcomes were addressed. Members were informed data showed 157 connections and 90 different groups and organisations but needed to be careful not to overwhelm some organisations.

Members asked about support for hard to reach groups. Members were informed of link workers and work to ensure the workforce was representative of the communities and support provided by those who were bilingual, shared the same experiences as well as being approachable and accessible and how organisations worked with residents who had relationships on those communities such as key groups who supported women through a trusted relationship. A peer approach could be looked at.

RESOLVED that:

1. The progress on the Thriving Communities Programme be noted.
2. A discussion on the role of the voluntary sector with the Chair and Vice Chair be organised.

12 **CHOICE AND EQUITY POLICY**

The Committee gave consideration to a report which related to an updated Choice and Equity Policy and an outline consultation that would gather views of patients on the new policy.

NHS Continuing Healthcare (CHC) referred to packages of continuing care arranged and funded solely by the NHS where the individual had been found to have ‘primary health need’. Where a person qualified for CHC, the CCG had a duty to offer to provide a package of health and social care services which met the individual’s assessed health and associated social care needs.

The draft Choice and Equity Policy, which was appended to the report, set out how the CCG would implement CHC in accordance with the National Framework and took into account the legal requirement for the CCG to act efficiently, effectively and fairly. The policy would be applied to new patients (with exceptions) and, in a few cases, to existing patients whose care needs had changed considerably. The policy sought to balance the CCG’s duties to the individual and to all the other patients to ensure fairness and best value.

CCG staff would aim to work with patients to identify potential locations and care options. The CCG would generally use home care providers and care or nursing home providers that it had assessed as being able to meet procurement and contractual requirements. Under the policy, the CCG would generally not fund a care package in a person’s home if the cost of doing so was more than 10 percent higher than providing the same care in a care or nursing home. In addition, the CCG would generally

not fund a placement at a care or nursing home if its fees were more than 10 percent higher than those of a suitable preferred provider.

The CCG would take account of an individual's views and wishes regarding where their care package was provided, when determining whether their case was exceptional and justified a higher cost being incurred to provide care. This would include consideration of an individual's particular reasons and family circumstances, and whether there were compelling circumstances. However, in reaching the decision the CCG must be satisfied that the proposed overall cost of the care package was proportionate and a justifiable use of CCG funds in comparison to the cost of commissioning a package of care for the individual in another location.

The policy had been updated to ensure continued compliance with the National Framework, and Article 8 of the European Convention on Human Rights and had taken into account the implications for social care.

The CCG proposed a small scale, six-week consultation, as appended to the report, of the 232 Oldham patients who were currently in receipt of Continuing Healthcare beginning on 9 September 2019 and ending on 21 October 2019. It was aimed to finalise the policy at the CCG Governing Body meeting on 7 November 2019.

The Committee received information as to how resources were used efficiently and through a person centred approach and how the policy was applied. It was planned to put more joined up working in place. New arrangements were being implemented, quality assurance was being joined up. Consideration of services which would be funded was outlined and examples were provided. How the consultation would be undertaken and the timelines was outlined to the members.

Members sought clarification as to whom would be affected by the policy change and the ethnic background to those who were currently receiving funding. Members were informed that there could be changes to those who currently received CHC when a review was triggered and discussed through a best interest meeting. The ethnicity numbers were not available at the meeting.

Members sought clarification on the budget implications and the breakdown in conditions of those in Continuing Healthcare. Members needed a better understanding of the budget numbers and the way funding was deployed at the moment and more discussion with the advocates. Members raised the need for a degree of transition and how this was managed. Members asked about the outcome of the consultation and engagement with service users. Members requested a discussion on the outcome of the consultation and requested a workshop be arranged.

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Members asked if there was an adequate number of providers. Members were informed that there was a shortage of mental health nurses and that some providers were looking to expand the services and opportunities to work across localities. There were general issues around nursing provision. With regard to care at home, Oldham had several small organisations who were committed to Oldham and were sustainable and ethical. Members were also informed that services users when they reached the age of 18 fell under different legislative framework.

RESOLVED that:

1. The updated Draft Choice and Equity Policy and outline consultation be noted.
2. A workshop be scheduled to receive further information regarding Continuing Health Care (Adults) and the initial findings of the consultation prior to implementation of the Choice and Equity Policy.

13 **URGENT PRIMARY CARE**

The Committee gave consideration to a report which provided an update on the implementation of a new model of Urgent Primary Care for Oldham.

Aspects of the proposed model had been progressed which included the establishment of an A&E primary care stream and the sharing of medical records between GPs, hospital clinicians and other health and social care professionals. However, work to establish Urgent Care Hubs had proved to be complex with a considerable amount of work required which would ensure the service would be robust and both clinically and financially sustainable. The new model would not be implemented until the CCG was confident that the service would meet clinical needs, be safe and offered an improved patient experience. An Objective Review would be undertaken to take stock of progress and consider how best to implement the model going forward. Patient safety was important when services were changed within the NHS and not be brought in unless the change provided a better experience for patients.

It was anticipated that the review would take one month to complete. The outcome of the review would be discussed with the Health Scrutiny Committee at a future meeting.

Members sought clarification on the constraints which prevented the model from being introduced. Members were informed that the modal was based around primary care and a new way of working. The model needed to be worked out and robust. It was important to ensure that the best outcomes for residents.

RESOLVED that:

1. The update on Urgent Primary Care be updated.
2. The Health Scrutiny Committee received a further update on the outcome of the review when completed.

14 **COUNCIL MOTIONS**

The Committee were advised of a motion which had been referred to them by Full Council on 10 July 2019:

"Making a Commitment to the UN Sustainable Development Goals:

Council welcomes the UK Government's commitment to the delivery of the seventeen Sustainable Development Goals adopted by the world community at the United Nations in September 2015. The goals form part of the 2030 Agenda for Sustainable Development which seeks to eradicate extreme poverty, address inequality and injustice, and promote sustainable development and peace.
The goals are to:

- End poverty in all its forms everywhere
- End hunger, achieve food security and improved nutrition and promote sustainable agriculture
- Ensure healthy lives and promote well-being for all ages
- Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all
- Achieve gender equality and empower all women and girls
- Ensure availability and sustainable management of water and sanitation for all
- Ensure access to affordable, reliable and sustainable economic growth, full and productive employment and decent work for all
- Build resilient infrastructure, promote inclusive and sustainable industrialization and foster innovation
- Reduce inequality within and among countries
- Make cities and human settlements inclusive, safe, resilient and sustainable
- Ensure sustainable consumption and production patterns
- Take urgent action to combat climate change and its impacts
- Conserve and sustainably use the oceans, seas and marine resources for sustainable development
- Protect, restore and promote sustainable use of terrestrial ecosystems, sustainably manage forests, combat desertification, and halt and reverse land degradation and halt biodiversity loss
- Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels
- Strengthen the means of implementation and revitalise the Global Partnership for Sustainable Development

Wishing to replicate the UK Government's position on the goals, this Council resolves to make a similar commitment to their delivery, as far as is practicable and within its power and resources, and calls upon the Health and Overview and Scrutiny Boards to identify the work that is already being done by the Council and its partners and what more can be done, and to

present a report with its finding and recommendations to a future meeting of full Council.”

The Committee discussed the motion. Overview and Scrutiny Board would also be involved in the resolution of the motion. The issues would be raised with the relevant officers who had an understanding and information available to invite contributions. A deadline for the response would be given with information coordinated into a progress report. The information would then form one report to be reported back to the Overview and Scrutiny Board and Full Council.

RESOLVED that the approach agreed by the Overview and Scrutiny Board be endorsed by the Health Scrutiny Committee.

15 **MAYOR'S HEALTHY LIVING CAMPAIGN**

The Committee received a report which presented an overview of the Mayor’s Healthy Living Campaign for 2019/20.

The current Mayor would be focussing on the following health and wellbeing themes:

- Mental Health and Emotional Wellbeing;
- Healthy Eating; and
- Early Detection and Diagnosis of Health Conditions.

The Mayor had been using social media to promote her Healthy Living Campaign, shared information and advice on her chosen themes and details about a number of local services and organisations as part of her attendances at events. The Mayor had shared information about local and national organisations that supported mental health and also shared suggestions for the promotion and maintenance of good mental health. The Mayor had also shared advice regarding healthy nutrition and hydration to promote Healthy Eating. As part of her Early Detection and Diagnosis of Health Conditions Campaign theme, the Mayor had a health check and had shared advice regarding regular health checks and screening programmes.

Public Health officers were exploring opportunities for the Mayor to be involved in events which supported programmes which addressed Nutrition and Hydration for over 65s, Suicide Prevention and activity as part of the Whole School and College Approach to Mental Health and Emotional Wellbeing.

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

16 **HEALTH SCRUTINY FORWARD PLAN**

RESOLVED that the Health Scrutiny Work Programme for 2019/20 be noted.

17 **DATE AND TIME OF NEXT MEETING**

RESOLVED that the scheduled date and time of the next Health Scrutiny Committee meeting to be held on Tuesday, 15th

October 2019 at 6.00 p.m. This meeting will be a Development Session.

The meeting started at 6.00 pm and ended at 8.00 pm

JOINT SCRUTINY PANEL FOR PENNINE CARE (MENTAL HEALTH) TRUST

MINUTES OF MEETING
Tuesday, 15th October 2019

PRESENT: Councillor Sullivan (Rochdale BC) (Vice Chair in the Chair), Councillor Dale (Rochdale BC), Councillor Grimshaw (Bury MBC), Councillor Walker (Bury MBC), Councillor Holloway (Stockport MBC) and Councillor Wright (Stockport MBC).

OFFICERS: P. Thompson (Governance and Committee Services – Rochdale BC)

ALSO IN ATTENDANCE: Dr H. Ticehurst (Deputy Chief Executive – Pennine Care NHS Foundation Trust), N. Littler (Executive Director – Pennine Care NHS Foundation Trust), A. Osborne (Assistant Director – Pennine Care NHS Foundation Trust) and D. Wallace (Communications and Engagement Advisor – Pennine Care NHS Foundation Trust).

APOLOGIES
11. Apologies for absence were received from Councillors Hamblett, Moores, Surjan (Oldham MBC), Mobbs (Stockport MBC) and Susan Smith (Rochdale Borough Council).

DECLARATIONS OF INTEREST
12. There were no declarations of interests.

URGENT ITEMS OF BUSINESS
13. There were no urgent items of business for the Committee to consider.

MINUTES
14. The Committee considered the minutes of its most recent meeting held 23rd July 2019.

Resolved:
That the Minutes of the meeting of the Joint Health Overview and Scrutiny Committee for Pennine Care NHS Foundation Trust, held 23rd July 2019, be approved as a correct record.

INFORMAL MEETING
15. Resolved:
That the proceedings of the informal session of the Joint Health Overview and Scrutiny Committee for Pennine Care's membership held 10th September 2019, be noted.

FINANCIAL UPDATE
16. The Committee was updated on Pennine Care's current financial situation. Presently, based on information currently available, it was projected that there would be a budget deficit by the end of the 2019/20 financial year. However,

as reported to the last meeting, it was added that the figures in the report did not account for expected significant financial contributions to be forthcoming from the Department of Health and it was expected that the Trust would have a 'balanced budget' by the end of March 2020.

The Trust had recently introduced a savings programme to help reduce costs whilst the filling of some staffing vacancies was being delayed. It was noted and welcomed by Members of the Committee that by and large the savings proposals were not adversely affecting patient care.

Members sought clarification on the underlying reasons for the reported 25 week waiting list period for access to children's psychiatric services across the Trust's footprint.
Resolved:

1. The report be noted
2. The Chief Executive of Pennine Care NHS Trust be requested to submit a report to the Committee's next meeting regarding the underlying reasons for the reported 25 week waiting list period for access to children's psychiatric services across the Trust's footprint.

CQC INSPECTION AND ACTION PLAN
17. The Trust's Deputy Chief Executive reminded the meeting that the Care Quality Commission (CQC) had undertaken a 'Well Led' inspection of a selection of services provided by the Trust in the period August – October 2018. Some of the services inspected included dentistry, mental health hospital wards (for adults and for older people), PICU, home treatment teams and crisis services and walk-in centres across the Trust's footprint.

Regular reports on the implementation of the CQC's improvement plan were presented to the Trust's Board. The Committee was presented with information that detailed the Trust's responses to the CQC inspection and the only area of work that was shown as being 'red' (issue that were not on course to be successfully implemented) was the 'Review the patient experience structure and resource'. The Committee was advised of measures being put into place to improve this matter.

Resolved
That the report be noted.

ELECTRONIC PATIENT RECORDS
18. The Trust's Deputy Chief Executive reported upon the roll-out of electronic patient records across the trust's footprint. This programme has been ongoing for several years. Currently the programme was on 'Cohort 3' which covered all in-patients and all out-patients. This phase of the roll out was due to be completed in 2020, when approximately 2,000 staff would be 'on-line'.

Cohorts 4 and 5 of the programme were due to start in April 202 and lasting until July of that year. Cohorts 4 and 5 were due to cover MAS, Day Hospitals, the remainder of older people's Community Mental Health Team's and Psychology services.

The Committee was advised that the computerisation of patient records was a slow process but that steady progress was being made.

Resolved:
That the report be noted.

STAFF WELFARE STRATEGY
19. The Trust's Executive Director (Workforce) gave a presentation to the Committee updating on the Trust's Staffing and Workforce Development Strategy. Pennine Care employed in excess of 5,000 staff with additional (hundreds) of numbers on their temporary bank which provide ad-hoc cover to fill gaps created either by sickness or vacancies.

The workforce comprised staff that worked with Mental Health/Learning Disability and Community Services across the Trust's footprint. The current staff turnover rate for the Trust was approximately 11%, which was within the `average' range compared to other Mental Health/Learning Disability NHS Providers in the North of England. The Trust's vacancy rate was just over 10% and staff sickness rates were 5.3% which was above average, when compared to the Trust's 'peer group'.

The 'harder to fill' roles within Pennine Care mirrored the regional and national gaps in this regard, including: Medical Staff, newly qualified nursing roles (especially Band 5 level nurses in Mental Health services), walk-in centre staff and Health Visitors.

The Committee asked if further and more detailed information could be presented to the Committee regarding the Trust's staff sickness absence levels?

Resolved:
1. That the report be noted.
2. The Trust's Executive Director (Workforce) be requested to submit a report to the Committee's next meeting, on 20th January 2020, regarding staff sickness absence rates amongst the workforce of Pennine Care NHS Foundation Trust.

MIXED SEX ACCOMMODATION
20. The Committee was updated on progress towards the introduction of single sex wards at hospitals across the Trust's footprint. A full and detailed business case thereon was due to be submitted to the Trust's Board's meeting on 30th October 2019.

The Committee was updated on a proposed phased implementation:
a. Phase 1: Tameside Adults (following the introduction of this there would be a period of reflection to determine the effectiveness of the action.
b. Phase 2: Fairfield Hospital, Bury (Ramsbottom Ward) and Rochdale Infirmary (dormitory Ward)

c. Phase 3: Stockport Adults
d. Phase 4: older people's wards across Greater Manchester's North East Sector (Bury, Rochdale and Oldham)
e. Phase 5: Stockport and Tameside adults
f. Phase 6: Heywood, Middleton and Rochdale.

In considering the proposed implementation programme it was suggested that member of the Committee be invited to visit wards at different hospital sites across the Trust's footprint, beginning with the Aspden and Hope Ward at the Royal Oldham Hospital. It was agreed that visits by Members of the Committee would be held on Wednesday, 30th October with further visits to be held on specified dates in November 2019.

Resolved:
That the report be noted.

COMMISSIONING PSYCHIATRIC INTENSIVE (PICU) CARE BEDS ACROSS THE PENNINE CARE FOOTPRINT

21. The Trust's Deputy Chief Executive reported upon Psychiatric Intensive Care Units (PICU) that were a type of psychiatric in-patient ward. On these wards staffing levels are higher than on a normal acute admission ward. Many PICUs also have a seclusion room and most PICUs are single gender.

PICUs were designed to look after patients who could not be managed on open (unlocked) psychiatric wards due to the level of risk the patient posed to themselves or others. A patient's length of stay was normally short (a few weeks) rather than prolonged as the patient would be treated and returned to an open ward as soon as their mental state is stable.

PICU wards specialised in the assessment and comprehensive treatment of people with a broad spectrum of acute and enduring mental health needs. They provided care and treatment to inpatients who were experiencing the most acute phase of a mental illness. PICU services were designed and delivered in line with national guidance, including the physical environment, numbers of beds, staffing ratios and disciplines, and the interventions provided.

Pennine Care NHS Foundation Trust had submitted a bid to NHS Improvement for a £4.5 million capital development for the purposes of female PICU services. In order to make best use of estates it was proposed that the current PCFT vacant ward in the basement area of the Buckton Building at Tameside General Hospital be demolished and rebuilt as a 12 bedded male PICU service and the men are transferred from Stockport to Tameside.

The current male PICU unit (Cobden Unit at Stepping Hilll Hospital) would be redeveloped into a 10 bedded female PICU Unit. The rationale of developing the female unit in Stockport was to maintain the bed base at 10 beds (considered the largest number of beds for a female unit) and also moving the male provision to Tameside would link the PICU unit with the existing male Low Secure Unit (Tatton Unit) which is also based in the basement area of the

Buckton Building at Tameside General, which supports sharing of staff expertise and expert response teams.

The Trust was currently developing a full business case to be submitted to NHS Improvement to gain full commitment to the capital investment agreed in principle.

Resolved:
That the actions of the Trust, outlined above, with regard to the development of Psychiatric Intensive Care Units be fully supported and endorsed by the Committee.

DATES OF FUTURE MEETINGS

22. Resolved:

1. Formal meetings of the Joint Scrutiny Panel for Pennine Care (Mental Health) Trust be held on Tuesday, 21st January 2020 and on Tuesday, 17th March 2020; both meetings to be held in the Council Offices, Number One Riverside, Smith Street, Rochdale, commencing at 2.00pm.
2. Informal meetings of the Committee's membership be held with representatives of Pennine Care Foundation Trust's senior management, at the Trust's head office (225 Old Street, Ashton-under-Lyne) on: Tuesday, 19th November 2019, Tuesday, 18th February 2019 and Tuesday, 14th April 2020: all meetings commencing at 2.00pm.

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Meeting of:

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

Date: 18th July 2019

Present:

Councillor R Walker (Bury Council)
Councillor S Smith (Bury Council)
Councillor G McGill (Bury Council)
Councillor L Hamblett (Oldham Council)
Councillor R Surjan (Oldham MBC)
Councillor N Briggs (Oldham Council)
Councillor R Dutton (Rochdale Council)
Councillor L Robinson (Rochdale Council)
Councillor P Sullivan (Rochdale Council)

Jon Rouse Chief Officer, Greater Manchester Health and Social Care Partnership
O Khan, Programme Director Salford Royal Foundation Trust
S Gardner, Deputy Programme Director, Single Hospital Services Programme, Manchester Foundation Trust
V Morris, Programme Manager
K Southern, Assistant Director – Quality, Productivity and Improvement Department - Northern Care Alliance NHS Group
Nicky Tamanis, Deputy Chief Finance Officer, Salford Royal and Pennine Acute
Jo Purcell, Deputy Director North East Sector
J Patel, Deputy Chief Information Officer - Northern Care Alliance NHS Group
S Lockett, HR Business Partner - Northern Care Alliance NHS Group
J Gallagher, Democratic Services Officer

Apologies:

There were no apologies for absence.

PAT.19/20-01 APPOINTMENT OF CHAIR AND VICE CHAIR

1. That Councillor Linda Robinson (Rochdale Council) be appointed Chair of the Joint Health Overview and Scrutiny Committee for the Municipal year 2019/20.
2. That Councillor Stella Smith (Bury MBC) be appointed vice Chair of the Joint Health Overview and Scrutiny Committee for the Municipal year 2019/20.

PAT.19/20- 02 APOLOGIES

Apologies were detailed above.

PAT.19/20-03 DECLARATIONS OF INTEREST

There were no declarations of interest.

PAT.19/20-04 PUBLIC QUESTIONS

There were no public questions.

PAT.19/20-05 MINUTES AND MATTERS ARISING

It was agreed:

That the minutes of the meetings held on 23rd April 2019 be approved as a correct record.

PAT 19/20-06 PENNINE ACUTE NHS TRANSACTIONS UPDATE

Jon Rouse, Chief Officer, Greater Manchester Health and Social Care Partnership, Oz Khan, Programme Director Salford Royal Foundation Trust and Stephen Gardner, Deputy Programme Director, Single Hospital Services Programme, Manchester Foundation Trust, attended the meeting to update members on the work being undertaken to progress the Pennine Acute NHS Transaction. The presentation contained the following information:

- Details of the proposed plans for the PAT
- PAT Transaction Board
- Benefits for patients
- Next steps
- Stakeholder engagement

This Transaction is essential to support the future clinical, financial and workforce sustainability of acute hospital services in the North East sector and across Greater Manchester. The Deputy Programme Director reported that this transaction is about re-modelling health care across Greater Manchester and is an opportunity to strengthen how acute and community based services across these hospitals are delivered for patients, service users and staff.

The proposed plans will support and complement local integrated healthcare plans to meet the population health needs of local communities and wider local health plans to strengthen community support, deliver more care closer to home and maximise the use of the estate on the PAT footprint.

A PAT Transaction Board, independently chaired by GM HSCP, is overseeing the formal transactions and proposed changes in ownership. The PAT Transaction Board aims to complete the transactions and to formally split PAT by 31 March 2020, subject to rigorous due diligence, agreement of financial plans and approval of business cases.

Those present were given the opportunity to make comments and ask questions and the following points were raised:

Councillor Walker raised concerns that the name Salford Royal will be lost with the establishment of the new Northern Care Alliance.

Members sought assurances with regards to the transaction, the Chief Officer confirmed that any costs associated with the transaction would be met from transformation monies and not from existing health care budgets. Capital works will still need to be undertaken regardless of the transaction.

Responding to a member's question, the Chief Officer reported that Greater Manchester no longer has a Level 1 centre to provide specialist surgery and care for congenital heart disease patients. The Chief Officer reported that this is the only service to be lost from Greater Manchester following devolution. The Deputy Programme Director reported that if the tertiary centres had been consolidated earlier the Trusts providing the care may have been in a stronger position to retain these services.

The Chief Officer reported that this transaction will not impact the development of the locality commissioning organisations/integrated commissioning arrangements.

The transaction will provide the workforce with opportunities including greater certainty, career development and better facilities. It is hoped for the patents too, the proposals will alleviate the variations in services, support and outcomes across Greater Manchester.

It was agreed:

The officers be thanked for their attendance.

PAT 19/20-07 OPERATIONAL PLANS UPDATE ON THE YEAR 2018/19

Vee Morris Programme Manager and K Southern, Assistant Director – Quality, Productivity and Improvement Department attended the meeting to provide members with an update in respect of the Trust's Operational Plan. The presentation, circulated in advance of the meeting provided information in respect of the Trust's performance in the following areas:

- Attendance and four hour target within Urgent Care
- Reducing the Length of stay
- Elective care – referral to treatment
- Cancer Access

The presentation also included information with regards to the elective access and theatre transformation programmes and the single oversight framework.

K Southern, Assistant Director – Quality, Productivity and Improvement Department reported that over the last year Pennine, like the rest of the NHS has experienced increasing pressure and demand on services. In 2018-19 the Trust saw the highest ever number of patients attending its emergency departments - There were 394,473 patient attendances; an average of 1,081 per day or one patient every 80 seconds.

Members discussed the Cancer access target and in particular the failure of the Trust in 2018/19 to reach the initial two week target or the 62 day standard for

treatment. The Programme Manager reported the Trust improved performance for the 2 week wait pathway passing the 93% national standard every month since February 2019, and has gradually improved against the 62 day standard during 2018-19. A Cancer Improvement Board is now in place at the Trust.

It was agreed:

The Pennine Acute NHS Trust will provide members with comparative data from the previous year in relation to the trust performance against the Cancer Access target.

PAT 19/20-08 BUDGET REPORT

Nicola Tamanis Deputy Chief Finance Officer attended the meeting to provide members with an updated financial plan, the presentation contained the following information:

- The provider sector deficit was £571m at year end
- 3.6% in year savings achieved
- £3.9bn capital invested - £400m more than allocated
- A&E Performance improved marginally despite increases in attendances – 4.3% increase at quarter 4
- 5.4% increase in emergency admissions
- 96,348 vacancies, a reduction overall but increases in nursing vacancies

The Deputy Chief Finance Officer reported that the financial requirements will include returning to financial balance; achieving cash-releasing productivity growth of at least 1.1%; reducing growth in demand for care through integration and prevention; reducing variation; and making better use of capital investment.

The Trust has a number of planned investments these will include, virtual outpatient appointments, digital first primary care innovations as well as improving the volume of elective treatment year on year.

The Trust still produces a statement of accounts separate to that of the SRFT. The required savings target is less for SRFT than it is for Pennine, this is in part due to a larger budget spend on drugs within this Trust.

It was agreed:

In light of the ongoing required budget pressures at the Pennine Acute NHS Trust, a financial update will be a standing agenda item.

PAT 19/20-09 RECRUITMENT AND RETENTION WORKFORCE UPDATE

S Lockett, HR Business Partner attended the meeting to provide and update in respect of recruitment, retention, agency spend and sickness rates across the Pennine Acute NHS Trust. The HR Business Partner reported that the workforce headcount is steadily growing but vacancy rates still remain problematic in some areas in particular women's and children's services and the division of medicine.

Agency spend continues to be a priority for the Trust and although still high, mechanisms have been put in place to address this.

The Trust has engaged in an international recruitment drive which has included approaching refugee charities and partnering with other Trusts to recruit internationally; this work has led to the successful recruitment of 27 FTE doctors. A similar approach has been taken to the recruitment of nurses. The Trust, like other Trusts in the country, continues to struggle to recruit to posts in A&E.

It was agreed:

As this continues to be an area of concern for members of the Committee, a workforce update will remain a standing agenda item.

PAT 19/20-10 NORTHERN CARE ALLIANCE IT STRATEGY

J Patel, Deputy Chief Information Officer – provided members with an overview of work currently being undertaken to address IT infrastructure concerns within the Trust. The Deputy Chief Information Officer reported that a new infrastructure programme will focus on new servers, increasing data storage and back up capabilities; moving the GM radiology from the N3 network to the Health and Social Care Network and a wifi, full equipment refresh.

Work will be undertaken to replace cabling, switching and cabinets as well as the installation of a new telephony system. There will also be an upgrade of the computer operating systems to improve cyber security.

The Deputy Chief Information Officer Reported that this planned worked will allow for improved system performance and productivity with a faster and more reliable network to support remote working. As well as increased wireless capability. Recruitment to IT remains problematic, it is hoped that the changes to the Trust's IT infrastructure as well as much needed investment will help colleagues to work more collaboratively across the Northern Care Alliance and provide staff with more opportunities to digitise workflows.

Members expressed concerns in relation to the poor state of some of the IT infrastructure. The Deputy Chief Information Officer Reported that the Trust had undergone a number of staffing changes and acknowledged that there has been a lack of focus in relation to this matter in recent years. This has now been addressed, a ten year plan has been adopted as well as an increase in investment. The focus has changed within the organisation with an acknowledgment that digitalisation should be seen as an enabler and a means of retaining staff.

PAT 19/20-11 A BRIEFING ON THE PENNINE CARE COMMUNITY SERVICES TRANSFER

Jo Purcell, Director of Strategy reported that the Pennine Care community services staff had successfully transferred to the Northern Care Alliance on 1st July. A

comprehensive welcome pack was shared with staff and a helpline was provided for any issues that emerge during the first weeks.

Service level agreements are still in place with PCFT for IMT and procurement and estates health informatics and bank arrangements. Risk share agreement and governance arrangements have been signed off.

The Director of Strategy reported that the local care organisation development will be primarily concerned with ensuring that the local systems to determine the right community service model is in place. The focus going forward will be less on transfer and more on transformation and delivering the locality plans.

Members discussed the future arrangements with regards to tendering and procurement of community services; the Director of Strategy reported that the Northern Care Alliance has been awarded the contract for two years, what will follow will be a further procurement exercise, the procurement process will be determined by the Commissioners.

It was agreed:

The Director of Strategy be thanked for her update.

MINUTES OF THE MEETING OF THE GREATER MANCHESTER JOINT HEALTH SCRUTINY MEETING HELD ON WEDNESDAY, 10 JULY, 2019 AT BOARDROOM, GMCA OFFICES, CHURCHGATE HOUSE, OXFORD STREET, MANCHESTER M1 6EU

PRESENT:

Councillor John O'Brien (in the Chair)	Wigan Council
Councillor Linda Thomas	Bolton Council
Councillor Stella Smith	Bury Council
Councillor Eddie Moores	Oldham Council
Councillor Ray Dutton	Rochdale Borough Council
Councillor Margaret Morris	Salford City Council
Councillor Keith Holloway	Stockport MBC
Councillor Sophie Taylor	Trafford Council

OTHER MEMBERS IN ATTENDANCE:

Councillor Linda Grooby	Derbyshire County Council

OFFICERS IN ATTENDANCE:

Jackie Bene	Chief Executive Bolton NHS FT/Delivery Lead Improving Specialist Care Programme
Lindsay Dunn	GMCA
Anthony Hassall	Accountable Officer, Salford CCG/Lead Commissioner Improving Specialist Care Programme
Warren Heppolette	Executive Lead, Strategy and System Development, GMHSC Partnership
Joanne Heron	GMCA
Jackie Robinson	Communications and Engagement Lead, Improving Specialist Care Programme
Jon Rouse	Chief Officer, GMHSC Partnership

APOLOGIES: Councillor Eve Holt, Manchester CC
Councillor Stephen Homer, Tameside MBC

JHSC/16/19 APPOINTMENT OF CHAIR

A nomination for Councillor John O’Brien to be appointed as Chair for the Municipal Year 2019/20 was received and approved.

Resolved/-

That Councillor John O’Brien be appointed as Chair for the Municipal Year 2019/20.

JHSC/17/19 APPOINTMENT OF VICE-CHAIR FOR THE MUNICIPAL YEAR 2019/20

A nomination for Councillor Margaret Morris to be appointed as Vice-Chair for the Municipal Year 2019/20 was received and approved.

Resolved/-

That Councillor Margaret Morris be appointed as Vice-Chair for the Municipal Year 2019/20.

JHSC/18/19 MEMBERSHIP 2019/20

The Committee was asked to note its Membership for the 2019/20 Municipal Year:

Member	Substitute Member	Authority
Councillor Linda Thomas	Councillor Mudasir Dean	Bolton
Councillor Stella Smith	Vacancy	Bury
Councillor Eve Holt	Councillor Julie Reid	Manchester
Councillor Eddie Moores	Vacancy	Oldham
Councillor Ray Dutton	Councillor Patricia Sullivan	Rochdale
Councillor Margaret Morris	Councillor Samantha Bellamy	Salford
Councillor Keith Holloway	Councillor Wendy Wild	Stockport
Councillor Stephen Homer	Councillor Teresa Smith	Tameside
Councillor Sophie Taylor	Councillor Anne Duffield	Trafford
Councillor John O'Brien	Councillor Ron Conway	Wigan

Resolved/-

That the Membership for the 2019/20 Municipal Year be noted.

JHSC/19/19 MEMBER'S CODE OF CONDUCT AND ANNUAL DECLARATION FORM

Members were reminded of their obligations under the GMCA Members Code of Conduct and were requested to complete an annual declaration of interest form which will be published on the GMCA website.

Resolved/-

Members noted the report and the GMCA's Code of Conduct (Part 1 of the report) and agreed to complete an annual register of interest form (Part 2 of the report).

JHSC/20/19 TERMS OF REFERENCE

The Committee was asked to note its Terms of Reference.

Resolved/-

That the Terms of Reference for 2019/20 be noted.

JHSC/20/19 DECLARATIONS OF INTEREST

There were no declarations received in relation to any item on the agenda.

JHSC/21/19 MINUTES OF THE MEETING HELD ON 13 MARCH 2019

Members were asked to consider the approval of the minutes of the last meeting held on 13 March 2019.

Resolved/-

That the minutes of the last meeting held on 13 March 2019 be approved as a correct record.

JHSC/22/19 IMPROVING SPECIALIST CARE UPDATE

The Committee considered a presentation provided by Dr Jackie Bene, Chief Executive, Bolton NHS FT/Delivery Lead Improving Specialist Care Programme and Anthony Hassall, Accountable Officer, Salford CCG/Commissioning Lead Improving Specialist Care Programme.

Anthony Hassall advised Members that the Improving Specialist Care Programme is building on previous hospital transformation work across Greater Manchester and responding to the changing needs of the population. It aims to make best use of resources and compliments the shift in how care is delivered in the community and at a local level, removing variation and saving lives.

It was reported that Models of Care for eight services have been designed by clinicians and patients to ensure quality and reduce variation across GM. These services are;

- Benign Urology services
- Cardiology services
- Respiratory services
- MSK/Orthopaedics services
- Paediatric Surgery services
- Breast Services
- Vascular services
- Neuro-Rehabilitation services

The models have been assured through programme governance frameworks and undergone external clinical scrutiny. The recommended outcomes of the new Models of Care were outlined to the Committee.

Members were informed that feedback from the Patient and Public Reference Group was extensively supportive of the new Models of Care. Services moving sites to some degree, was supported by more than 80% of the group and only 4% of the group were not supportive of services moving.

Dr Jackie Bene provided the Committee with an overview of proposed site-specific options for detailed evaluation for each service.

The decision making process for the implementation of service change recommended by NHS England along with current status was highlighted. It was advised that the Greater

Manchester Joint Commissioning Board (JCB) is leading the appraisal of site options along with any decision to progress to a business case or consultation for any site and speciality. Further engagement with the Committee and a future update will be provided following assurance from NHSE England and JCB feedback.

On behalf of the Committee, the Chair thanked both Anthony and Jackie for the informative update. Councillor Keith Holloway advised that Stockport had received an update at their Local Health Scrutiny meeting which had promoted a helpful discussion on the impact of the changes. Any further opportunities of engagement with services in scope and the subsequent Models of Care were welcomed. It was considered crucial to be able to make a decision with regards to breast services swiftly due to the current fragility of the service.

A member questioned whether the role of the Committee at the next stage would be to receive the proposals for due noting or endorsement. It was clarified that the pre consultation business case for proposed site-specific options would require further NHSE Strategic Assurance. The options would then be presented to the GM Joint Health Scrutiny Committee to determine whether proposals are a significant variation which require further scrutiny and formal consultation.

Members discussed breast services and highlighted the requirement to provide diagnostics, screening and after care services locally to ensure that patients were able to access and receive care closer to home. It was confirmed that local public health access to mammography screening will continue and the proposal relates to a smaller subsection of patients who require further diagnostic screening.

In support of the models of care, the Committee highlighted the importance from the patient and carers perspective, of time and cost of travel along with availability and cost of car parking. A joined up approach to promote any financial assistance with travel and car parking charges was requested.

It was acknowledged that in relation to the Models of Care, the intention was to keep services as local as possible alongside the consolidation of services that are regarded to be more specialised. This movement of patients equates to approximately 6% of all activity in GM. However, in order to minimise the amount of movement, comprehensive travel time analysis is being undertaken by TfGM to assist in the evaluation.

A member questioned what the 80% Patient and Public Reference group represented. It was advised that the group that had received information on the Models of Care rather than the site specific options at this stage, reflected a collective geographical range across each locality in GM. It was acknowledged however that this did not reflect the views of the whole population and it was advised that each clinical commissioning group across Greater Manchester had the responsibility to ensure that further engagement was undertaken at the heart of communities.

It was further recommended that the starting point of the narrative provided to the public should focus on services which would be provided locally along with anticipated improved outcomes for patients.

Variation in Clostridium difficile**,** Methicillin-resistant Staphylococcus aureus (MRSA) infections and CQC ratings in hospitals were highlighted for consideration. Continuity of aftercare following surgery was recognised as paramount for patient safety.

Clarification was provided with regards to the scope of cardiology and vascular services. A member questioned the financial constraints to surgery and thresholds. It was confirmed that the decision to undertake surgery was based on clinical evidence rather than financial considerations.

The requirement to ensure that consistent patient information was available across sites was regarded as a key component of the programme. It was advised that technology had advanced in order to share images across hospitals and organisations. However, it was acknowledged that further work was required to share patient records in line with the appropriate information governance and security.

In support of the programme, the Committee welcomed the opportunity for further engagement and supplementary in depth discussion.

Resolved/-

- That the presentation be received and noted.
- That approval be provided to Greater Manchester Joint Commissioning Board (JCB) for the appraisal of site options.
- That any decision to progress to a business case or consultation for any site and speciality be delegated to the GM Joint Health Scrutiny Committee.
- That future updates be provided following assurance of NHS England and JCB feedback.
- That further engagement with the Committee on services in scope and the subsequent Models of Care, the options appraisal process and proposed service delivery at specific hospital sites be provided.

JHSC/23/19 WORK PROGRAMME

Consideration was given to the report of Joanne Heron, Statutory Scrutiny Officer, Governance and Scrutiny Team, GMCA.

It was explained that the Greater Manchester Joint Health Scrutiny's work programme had been included within the agenda for Members to develop, review, and agree. The work programme was a 'live' document which would be reviewed and, if necessary, updated at each meeting to ensure that the Committee's work programme remained current.

For information items taken previously to Greater Manchester Joint Health Scrutiny in 2018/19 were listed in appendix 1 of the report.

Items suggested included;

- Improving Specialist Care Programme Updates
- North West Ambulance Service performance and service delivery update
- IT/Digital Update
- Overview of homeless healthcare provision and 'A Bed Every Night' programme

- Children's Mental Health School's pilot
- Regular updates from the GM Health and Social Care Partnership

Resolved/-

That the suggested work programme items be included, updated and approved.

JHSC/24/19 DATES OF FUTURE MEETINGS

All meetings will take place between 10.00am – 12 noon in the Boardroom at GMCA Offices, Churchgate House, Oxford Street, Manchester, M1 6EU on the following dates:

- Wednesday 11 September 2019
- Wednesday 13 November 2019
- Wednesday 15 January 2020
- Wednesday 11 March 2020

MINUTES OF THE MEETING OF THE GREATER MANCHESTER JOINT HEALTH SCRUTINY MEETING HELD ON WEDNESDAY, 11 SEPTEMBER, 2019 AT BOARDROOM, GMCA OFFICES, CHURCHGATE HOUSE, OXFORD STREET, MANCHESTER M1 6EU

PRESENT:

Councillor John O'Brien (in the Chair)	Wigan Council
Councillor Keith Holloway	Stockport MBC
Councillor Eve Holt	Manchester City Council
Councillor Eddie Moores	Oldham Council
Councillor Margaret Morris	Salford City Council

OFFICERS IN ATTENDANCE:

Lindsay Dunn	GMCA
Lisa Fathers	Director of Teaching School & Partnerships, Bright Futures Educational Trust (BFET) Executive Team
Michael Forrest	Deputy Chief Executive, North West Ambulance Service (NWAS)
Warren Heppolette	Executive Lead, Strategy and System Development, Greater Manchester Health and Social Care Partnership (GMHSCP)
Joanne Heron	GMCA
Dr Sandeep Ranote	Medical Director, Northwest Boroughs Healthcare NHSFT & Children & Young People MH Lead, GMHSCP
Lee Teasdale	GMCA

APOLOGIES: Councillor Stella Smith (Bury Council)

JHSC/25/19 DECLARATIONS OF INTEREST

Councillor Holloway declared that his daughter was an employee of the Oldham Clinical Commissioning Group.

JHSC/26/19 MINUTES OF THE MEETING HELD ON 10 JULY 2019

Members were asked to consider the approval of the minutes of the last meeting held on 10 July 2019.

Resolved/-

That the minutes of the last meeting held on 10 July 2019 be approved as a correct record.

JHSC/27/19 GREATER MANCHESTER MENTAL HEALTH IN EDUCATION (MHIE) PROGRAMME

The Committee considered a report from Warren Heppolette (Executive Lead, Strategy & System Development, GMHSCP); Dr Sandeep Ranote (Medical Director, Northwest Boroughs Healthcare NHSFT & Children & Young People Mental Health Lead, GMHSCP) and Lisa Fathers (Director of Teaching School & Partnerships, BFET Executive Team), which provided an overview of the Mental Health in Education programme (MHiE) being delivered across Greater Manchester and provided details on each of the initiatives. The report also explored the scope of the future ambitions for the MHiE programme both locally and nationally and the governance structure by which the programme would be managed.

Warren Heppolette advised Members that in December 2017 the government had published the green paper 'Transforming Children and Young People's Mental Health Provision'. The paper had set out the ambition to go further in ensuring that children and young people showing early signs of distress were always able to access the right help in the right setting, when they needed it. As part of the next steps in the reforms the government had agreed to support the following three key elements:

- Mental Health Support Teams
- Four-week waiting times for access to specialist NHS children and young people's mental health services
- Designated senior leads for mental health

In addition to these, Greater Manchester (GM) had been working to deliver local projects designed to test the potential implementation model for the priorities within the green paper. These GM initiatives included:

- GM Mentally Healthy Schools and Colleges Pilot
- GM Mental Health in FE Colleges Project
- GM Universities MH Service Pilot
- GM Mental Health in Education Setting Standards

Dr Sandeep Ranote advised Members that the green paper had been informed in part by the 2015 paper 'Future in Mind'. This paper had brought together children and educational mental health experts from across the country to consider child psychiatric care and set an ambitious agenda for protecting and improving children and young people's mental health and wellbeing. It was emphasised that the programme was not just about putting money into services but also about ensuring parity in the support offer across all of GM and removing the stigma that was sometimes involved in seeking mental health support. Dr Ranote stated that the level of passion from all partners to make the programme a success was hugely positive – with the programme having allowed for joint working and collaboration on a level that had not been available previously.

Information around the development of mental health support teams was provided. Education Mental Health Practitioners (EMHPs) were linked to groups of schools and colleges, and would offer individual and group help to young people with mild to moderate mental health issues including anxiety; low moods and behavioural difficulties. The support teams would work with the school or college designated mental health lead to provide a link with more specialist mental health services. This would mean schools and colleges finding it much

easier to contact and work with mental health services. These teams would provide the link between the NHS and schools, and would work alongside others providing mental health support such as school nurses; educational psychologists; school counsellors; voluntary & community organisations and social workers.

It was emphasised that the support teams would be newly trained and would not take away from the existing specialist Child and Adolescent Mental Health Services (CAMHS) provision as this was about delivering a programme that supported and added to, rather than taking away from the existing structure.

Lisa Fathers spoke to the Committee from the perspective of Bright Futures Educational Trust (BFET). She advised that a positive side effect of the programme had been that it had also so far proved to have improve the wellbeing of the teachers involved as well as the students. Schools were being helped in a strategic way on how best to embed the ethos behind the programme. An example of this good practice had been in Gorton, where children knew exactly where they needed to turn to access first aid support and mental health support. 42nd Street as the Voluntary, Community and Social Enterprise (VCSE) lead had been very helpful, working hard to increase the number of mental health practitioners. Overall there was a strong package in place, with each individual school working in tandem with others across the piece. Young Mental Health Ambassadors had also been a great help in spreading knowledge around the work being done.

Dr Ranote advised that the Mentally Healthy Schools and Colleges Project was now about to move into Phase 4. At the conclusion of the project, it would have reached 125 schools and colleges, this equated to 10% of the 1200 schools and colleges across GM – whilst it was agreed that on paper this may not seem an impressive figure, in actuality it was considerably above the national average in its level of reach. The unfortunate reality was that there was not the funding or level of resource in place to directly reach all 1200 locations. The Project had helped the partners involved to develop a set of education setting standards that would act as the framework for schools and colleges across GM going forward.

It was noted that good work was taking place at local authority level as well, with Salford developing a strong programme for example. However, there was cognisance of the need to avoid 'postcode lotteries' and that all schools within GM should receive the same high level of support.

Committee Member Comments and Questions

Members expressed concerns about the number of children having to go straight from CAMHS into Adults mental health services – with many being 'failed by the system and falling through the gaps'. With this in mind, what level of work was taking place with mental health practitioners within schools and colleges?

It was advised that it was recommended to all schools and colleges that they sent their Special Education Needs Co-ordinators (SENCOs) on the training programme. Close work was also taking place with secondary education colleges as these often included cohorts that had behavioural and educational issues in their youth and had a differing set of needs from the mainstream with many having previously already had CAMHS support for mental health issues.

Members noted their concerns around only 125 of GM's 1200 schools and colleges being directly involved in the Mentally Health Schools and Colleges Project. How could local councillors help in getting the messages about the good work being done over to the remaining 90% of schools and colleges within GM? Members also asked about the process by which the 125 locations had been selected.

It was advised that following the conclusion of phase 3 of the project, officers were in a stronger position to review the governance aspects. A dedicated programme board needed to be formed to look at this, and it was suggested that a member of the Joint Health Scrutiny Committee could form part of the membership of this programme board. Further details about the programme board including the terms of reference would be provided to Members for further consideration. Any Members wishing to be nominated were asked to contact GMCA officers.

Regarding the 125 locations chosen - Phase 1 had involved a rapid 10 day turnaround with the initial cohort of schools being chosen very quickly but with an appropriate geographical spread across all localities in GM. Phase 2 saw closer working with the locality leads to identify schools that were most in need of assistance at present. Constant re-evaluation work had been taking place, and lessons were being learnt. It was also noted that the selection process had been overseen and agreed at the highest level.

Members expressed concern about parents who were unwilling to engage with the process – what was being done to communicate the work to them?

It was explained that a key part of the work involved in the pilot was seeking to reduce the taboos and stigmas around mental health, if these common concerns could be broached and dealt with, then parents would be less likely to refuse help for their child. There however remained many challenging situations to broach – and it was therefore important that the work continued beyond the school setting, with the whole system carrying these important messages – through parent champions, parent teacher associations, school governors etc. The messages often had more power when delivered by fellow parents instead of health professionals, and helped in developing an organic increase in understanding and empathy.

Members welcomed this approach and asked that they be informed of the schools within their localities involved in the programme – so that they could be involved in meetings helping to spread the importance of the work being undertaken.

It was also advised that schools themselves could choose to prioritise the importance of the issue, by paying to send more staff on training and arm them with the skills needed to approach mental health issues. National and international learning collaborations were also being formed – for example, GM was sharing intelligence with schools in Staten Island, New York – which had a similar makeup of demographics and wealth disparities to those seen in GM.

The Chair re-emphasised the importance of local links, stating that each of GM's local health scrutiny panels should also be looking to feed this information down through their own committees and receiving presentations on the good work being done.

It was commented that mental health issues often stopped many children from achieving at the level they should at school, and that if children could be made more resilient at the right age, then they would likely be more resilient as adults.

Officers agreed, stating the importance of pathway succession. The programme was one of a number of transformation programmes taking place in children's mental health and none of them worked in isolation, with 'the dots being joined' across schools; youth services; GPs; youth centres and other relevant partners. It was not expected at the present time that this work would lead to reductions in referrals to CAHMS, but instead it should see an increase in children being referred at the right time in the right setting. It was hoped that eventually, with good embedded working across the piece, that reductions in referrals would be seen, but this would inevitably take time.

Members sought more information on addressing the stigmas around mental health. Was fear and a lack of understanding at the root of the concerns? Was this lack of understanding being addressed in order to remove the element of fear?

Officers emphasised the importance of embedding the appropriate language and making services fully accessible. There was a need to influence the harder to reach parents who might not interact with the schools, like attending parent's evenings for example – there was often a need to go out to them. Sometimes these parents had been through bad educational experiences in their youth and could be distrusting initially – with trust having to be carefully built up over time.

Dr Ranote felt that the NHS needed to use its media partners in a more positive proactive way. It was found that often communications from the NHS were only being used to address negatives – and there was a need to look at a more proactive strategy, where the media could be used to help spread positive messages.

The Chair noted that the Greater Manchester Mental Health Network was due to hold a Greater Manchester Mental Health Strategy Review at the British Muslim Heritage Centre on 30 September and asked that all the relevant details be forwarded on to the Committee Members.

Lisa Fathers advised that she could arrange a mental health workshop for members and that this could be arranged outside of the meeting.

Resolved/-

- That the progress made to date across a number of key education settings be noted by the Committee.
- That the proposals put forward be endorsed by the Committee.
- That details of the 125 schools and colleges involved in the GM Mentally Healthy Schools and Colleges Project be fed back to Committee Members.
- That details on the arrangements for the Greater Manchester Mental Health Strategy Review due to take place on 30 September 2019 be fed back to Committee Members.
- That officers be asked to confer further with Bright Futures Educational Trust around arrangements for a mental health workshop.
- That further details on the proposed dedicated governance board, including any terms of reference be fed back to Committee Members for consideration.

JHSC/28/19 NORTH WEST AMBULANCE SERVICE (NWAS) PERFORMANCE ACROSS GREATER MANCHESTER (GM)

The Committee considered a presentation from Michael Forrest on the performance of NWAS across Greater Manchester.

It was advised that following the development and implementation of a North West wide Performance Improvement Plan (PIP) in May 2018, the Trust had made significant improvements in performance throughout the 2018/19 operational year. Response performance had stabilised, leading to considerable improvements in patient safety and there was a commitment to achieving continued improvements – with 2019/20 having seen the devising of a Service Delivery Improvement Plan (SDIP) with the purpose of achieving and maintaining certain standards.

Across GM, the Trust had achieved some notable successes. During 2018/19 the Trust had conveyed over 15,500 fewer patients to emergency departments by both doubling its telephone triage capability, and increasing the number of patients managed on scene. This made a significant difference and allowed ambulances more freedom to deal with the most acute calls.

Timely access to response pathways of care was crucial to managing patients without the need for conveyance to emergency department. The NWAS referral pathway into the Wigan Community Response Team (CRT) had been developed in August 2018, with the main objective being to reduce conveyance to hospital for frail/elderly patients who could be supported within a community setting with additional support to best meet their individual need. The CRT was an existing service, however it was felt that if NWAS could access and utilise the multidisciplinary team and the wider range of services, then patient care would benefit. The Wigan CRT provided a strong example of how NWAS could work with providers across the wider health system, and it was intended that similar models of care would be pursued to ensure that patients avoided unnecessary conveyance when clinically appropriate to do so.

The level of demand for services was detailed to the Committee. Over 270,000 calls had been received but many of these were duplicate calls. For example, a significant traffic accident may result in 10+ calls to 999, and sometimes calls were made multiple times to check on the progress of an ambulance en-route. 10% of calls were now dealt with over the telephone, but this was only where appropriate and always with mindfulness of managed risk. 25% were now able to be dealt with on the scene. Good mechanisms were also in place which meant further growth could be absorbed without overburdening the department – the activity levels were continuing to increase so these appropriate mechanisms were increasingly important.

The Trust had developed a number of key strategies over the previous twelve months in order to support its ambition to be in the top three ambulance services by 2021, and to be the best in England by 2023. Urgent and Emergency Care and Quality Strategies would ensure that the right care was delivered at the right time, in the right place, every time. These were complimented by a number of key enabling strategies such as digital, workforce, fleet and estates.

It was also noted that the 111 Service contract was due for renewal in the next year. There was still some lack of understanding around what the 111 Service could do for people and this had helped to foster an undeserved poor reputation.

Warren Heppolette was invited to comment. He stated that systems working together to ensure the best level of integrated care was absolutely key. In the past the work of the NWAS would have been heard about in isolation, but that was not the case anymore, with services no longer being considered as a silo'd independent system, and instead being considered and understood within the context of the bigger picture of care models.

Committee Member Comments and Questions

Members agreed about the increasing importance and value of partnership working. When people did not have to face the trauma of entering a hospital setting and instead had an issue that could be managed on scene – it often added to the quality of life for that person.

Members asked, given the stressful and demanding nature of the job, how NWAS was coping when it came to levels of recruitment and retention.

It was advised that until recently paramedics had been on the staff shortage list, with a 14% gap. However, following a rigorous recruitment exercise – there was now a full establishment of paramedics in place. It was of course a job with challenges, it being noted that around 1300 assaults on NWAS staff were reported each year which was unacceptable – and it was found that the job had a higher than average turnover of staff. The staff could also often suffer burnout when working in the inner cities as there tended to be no breaks between call-outs. With that in mind, a transfer system had been implemented where paramedics could elect to spend some time working in a more town based/rural setting for a period, as taking care of the wellbeing of staff was vital

Reference was made to the installation of defibrillators in public spaces/businesses. It was important that these were registered so a record could be kept of their locations. The Chair recommended that members go back to their councils and work with other councillors/officers to establish the locations of defibrillators and help to build up a picture of all the locations.

Members suggested that a breakdown of the NWAS figures by district would be welcome to help them be in a position to ask the best related questions. It was advised that this information would be sourced for Members. It was advised that NWAS also made use of the 'Tableau' software system which could be signed up to for access to the catalogue of NWAS statistics.

Members expressed concern around the reliability of patient transport services, particularly in areas of low car ownership. It was advised that after being outsourced for some time, the transport patient service had now been brought back in-house, talks were taking place on how best to commission the service.

Members sought to see some of the NWAS sites on context, asking if a meeting could be held at the Parkway Centre on Princess Parkway, to look at the dispatch process in action, and also to pay a site visit to the new Wigan Fire and Ambulance Service hub. It was agreed that this

could be arranged and officers would take up the arrangement of suitable dates outside of the meeting.

The Chair drew the item towards a close – stating that three years previously he had been involved in a meeting where he had expressed serious reservations around repeated incidents of ambulance stacking, and was pleased to see that this service had been changing radically since then. He stated that statistics and data meant little to the patient at ground level – and all that mattered to them was their personal experience of being cared for appropriately and seeing a doctor or paramedic as soon as possible to assuage their fears. It was clear that NWAS had worked hard to achieve this, and examples of dealing with patients on site where appropriate so that they did not have to face the trauma of entering a hospital setting was a good example of this. The report was very welcome, and the results achieved were deserving of congratulation.

Michael Forrest thanked the Chair and the Members for their comments, stating that it was important that NWAS continued to receive an equal measure of support and challenge. He also advised that as part of looking to provide the best possible service to patients – 3000+ staff had now been trained in dementia awareness as NWAS sought a rollout of a dementia friendly ambulance service.

Resolved/-

- That the performance figures of North West Ambulance Service in GM and the opportunities to improve the service provided to Greater Manchester patients be noted by the Committee.
- That a breakdown of North West Ambulance Service figures by district be fed back to Committee Members.
- That arrangements be made for a site visit to, and meeting to be held, at the Parkway Centre.
- That arrangements be made for a site visit to the Wigan Fire and Ambulance Service Hub.

JHSC/29/19 WORK PROGRAMME

Consideration was given to the report of Joanne Heron, Statutory Scrutiny Officer, Governance and Scrutiny Team, GMCA.

The planned programme of work up to the March 2020 meeting was detailed to the Committee – the Statutory Scrutiny Officer asked that Members contact her if they would like to make any additions to the programme.

Resolved/-

That the work programme items be approved.

JHSC/30/19 DATES OF FUTURE MEETINGS

All meetings will take place between 10.00am – 12 noon in the Boardroom at GMCA Offices, Churchgate House, Oxford Street, Manchester, M1 6EU on the following dates:

- Wednesday 13 November 2019
- Wednesday 15 January 2020
- Wednesday 11 March 2020

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HEALTH AND WELL BEING BOARD
24/09/2019 at 2.00 pm

Present: Councillor Harrison (Chair)
Councillors M Bashforth and Sykes

Dr Bal Duper	IGP Federation
Chief Supt. Neil Evans	Greater Manchester Police
Donna McLaughlin	Alliance Director, Oldham Cares
Dr John Patterson	Clinical Commissioning Group
Katrina Stephens	Director of Public Health
Julie Farley	Healthwatch
Nicola Firth	Royal Oldham Hospital
Sarah Maxwell (substitute)	Oldham Community Leisure
Jayne Ratcliffe (substitute)	Community Services and Adult's Social Care

Also in Attendance:

Andrea Entwistle	Principal Policy Officer - Health and Wellbeing
Mark Hardman	Constitutional Services Officer
Kaidy McCann	Constitutional Services
Julie Winterbottom (item 9)	Oldham Royal Hospital
David Garner (item 12)	Head of Special Projects – Adult's Social Care
Angela Barnes (item 13)	Strategic Partnership Manager - Community Services and Adult Social Care
Andrew Sutherland (item 14)	Director of Education – Skills and Early Years

1 **APOLOGIES FOR ABSENCE**

Apologies for absence were received from Mike Barker, Majid Hussain, Val Hussain, Dr Keith Jeffery, Merlin Joseph, Stuart Lockwood, Vince Roche, Claire Smith, Mark Warren, Liz Windsor-Welsh and Councillor Ball.

2 **URGENT BUSINESS**

There were no items of urgent business received.

3 **DECLARATIONS OF INTEREST**

There were no declarations of interest received.

4 **PUBLIC QUESTION TIME**

There were no public questions received.

5 **MINUTES OF PREVIOUS MEETING**

The minutes of the meeting of the Health and Wellbeing Board held on 25th June 2019 were received.

Further to Minute 7 (Minutes of the Health Scrutiny Sub-Committee), it was commented that while the requested information had been received, this did not indicate a final position or the current status of IVF provision in Oldham. On being advised that the current provision was for one round of treatment, a request was made for details of the decision making on this issue.

Oldham Council

Further to Minute 12 (Updates from Sub-Committees), it was commented that reference to the 'Older People's Alliance' should refer to the 'Oldham Cares Alliance'.

RESOLVED that:

1. Subject to the amendment within Minute 12 of the words 'Older People's Alliance' to read 'Oldham Cares Alliance', the minutes of the meeting of the Health and Wellbeing Board held on 25th June 2019 be approved as a correct record.
2. Details of the decision making in respect of IVF provision in Oldham be circulated to Members of the Board.

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

RESOLVED that the minutes of the meeting of the Health Scrutiny Committee held on 2nd July 2019 be noted.

7 **RESOLUTION AND ACTION LOG**

RESOLVED that Resolution and Action Log from the meeting held on 25th June 2019 be noted.

8 **MEETING OVERVIEW**

RESOLVED that the Meeting Overview be noted.

9 **ROYAL OLDHAM HOSPITAL SCAPE ACCREDITATION**

The Board received a report presenting the journey the Emergency Department at the Royal Oldham Hospital had undergone in achieving three consecutive green NAAS (Nursing Assessment Accreditation System) assessments and reaching SCAPE (Safe, Clean and Personal Care) status.

Julie Winterbottom, Lead Nurse of the Emergency Department, introduced a presentation to the Board which outlined the NAAS process and the 13 Nursing Core Standards, which were scored against the elements of Environment, Care and Leadership with an overall RAG rating being given based on the outcome of each standard. The SCAPE Accreditation was established at Salford Royal Hospital in 2008 and was introduced at Oldham in 2016, with the first assessment undertaken in March 2017. The decision to award SCAPE status to the Emergency Department was approved by the Trust Board on 29th July 2019.

The Board noted that Oldham was the first Accident and Emergency Department to receive a green rating and

consistently improving results and that the Department, originally built for 230 visits per day, was the busiest in Greater Manchester regularly receiving around 315-415 patients a day. Consequently the accreditation would be set as a benchmark for the rest of Greater Manchester.

Members queried what additional processes had been put in place to help achieve Accreditation. The Board was informed that a Senior Sister was on duty on every shift, a safety checklist was required for each patient which ensured the patients safety, and that all forms and information were now being provided in one clear format creating consistency. Members of the Board commented that the Department was the 'Frontline of the Frontline' and it was queried whether the Police would be able to work like the Department and improve on the services they provided. An invitation was given to the Police to visit the Department. The Board requested that a letter of thanks and praise be sent to the Accident and Emergency Department on behalf of the Board.

RESOLVED that:

1. The update in relation to the Royal Oldham Hospital's Emergency Department achieving SCAPE Accreditation be noted.
2. A letter of thanks and praise be sent to the Accident and Emergency Department on behalf of the Board.

10 **CHILD DEATH OVERVIEW PANEL – STATUTORY RESPONSIBILITIES AND REVISED GOVERNANCE ARRANGEMENTS**

The Board received a report providing an overview of the statutory responsibilities of the Bury, Rochdale and Oldham Child Death Overview Panel (CDOP), including revised governance arrangements and an outline of the Child Death Arrangements Implementation Plan.

The Bury, Rochdale and Oldham CDOP had been set up by Child Death Review Partners, the Bury, Oldham and Heywood, Middleton, Rochdale CCG's and Bury, Oldham and Rochdale Councils, to review the deaths of children under the requirement of the Children Act 2004 and Working Together to Safeguard Children 2018 statutory guidance. The purpose of the CDOP is to undertake a review of all child deaths up to the age of 18 living within the covered areas, irrespective of the place of death.

The Board was informed that the CDOP was accountable to the Health and Wellbeing Boards in Rochdale, Oldham and Bury and that the function was no longer under the Department for Education. The Annual Report of the CDOP was due to be considered at the next meeting of the Health and Wellbeing Board at which further detail could also be considered. It was noted that the Panel was chaired by a Consultant in Public Health with the position rotating between the three Public Health Teams every two years, with Oldham next to Chair the Panel.

Oldham Council

Further to a particular issue that Healthwatch were to discuss with Public Health outside the meeting and in response to a query, the Board was informed that all child deaths, including suicides fell under the remit of the CDOP, though babies who were stillborn and lawful planned terminations of pregnancy were excepted.

RESOLVED that the statutory responsibilities of the Child Death Overview Panel, the changes to governance and the transfer of accountability for the Panel to the Health and Wellbeing Boards in Bury, Rochdale and Oldham be noted.

11 **GM COMMON STANDARDS FOR POPULATION HEALTH - UPDATE**

Further to Minute 10 of the meeting held on 25th June 2019, the Board received a report providing an update on the local work being undertaken on the Greater Manchester (GM) Common Standards for Population Health to develop ways to use them locally in line with existing standards and measures and consider how they linked to local outcomes and services.

In addition to the standards for seven population health themes provided in the first publication of GM Common Standards for Population Health, there was an overarching standard covering prescribed and non-prescribed public health functions. It was identified after a review, summarised in an appendix to the submitted report, that Oldham met or partially met all aspects of the standard with the exception of the weight management offer for children and families. The Board was informed that it would be addressed through a new healthy weight strategy and a review of weight management commissioning.

Members queried the overarching role of the standards with regards to the Oldham Locality. It was specified to the Board that the standards were primarily a tool used to assess the aspiration of the Borough and how Oldham compared to peers across the rest of GM. While the standards were not compulsory they could be used to drive outcomes to support localities achieve the best health gain. The standards created a reduced variance and enhanced consistency in the recording of health data and so would improve the measurement of population health across GM.

RESOLVED that the update on the local work on the Greater Manchester Common Standards for Population Health be noted.

12 **BETTER CARE FUND**

The Board received a report seeking agreement for the Oldham Better Care Fund (BCF) Plan 2019-20 from the Health and Wellbeing Board prior to submission to NHS England for approval.

The BCF, administered by NHS England, the Department of Health and Social Care and the Ministry of Housing, Communities and Local Government, provides a mechanism for joint health, housing and social care planning and commissioning whilst bringing together ring-fenced budgets from CCG allocations and funding paid directly to local government. For 2019-20 in Oldham, the total value of the BCF was £30,772,550 which included Disabled Facilities Grant and winter pressures funding.

Oldham Council

Access to the Fund was based on four national conditions being satisfied:

- an agreed plan signed off by the relevant Health and Wellbeing Board and the constituent local authorities and CCGs;
- a demonstration that the area will maintain the level of spending on social care services from the CCG minimum contribution in line with the agreed uplift;
- that a specific proportion of the area's allocation is invested in NHS-commissioned out of hospital services, which may include seven-day services and adult social care; and
- a clear plan on managing transfers of care including implementation of the High Impact Change Model for Managing Transfers of Care which includes adoption of the centrally set expectations for reducing Delayed Transfers of Care (DTOC).

There were an additional four national metrics required to be collected and submitted as part of the designated reporting mechanism:

- Non-elective admissions;
- Admissions to residential and care homes;
- Effectiveness of reablement; and
- Delayed Transfer of Care

The Board noted that Oldham continued to perform well on reducing DTOC and ranked the second lowest for DTOC within Greater Manchester. Oldham also ranked third lowest for Social Care attributed to DTOC but performed less well on the number of long-term residential placements.

Looking ahead, it was queried how the BCF would reflect the changing landscape of provision going forward. Members were advised that advance guidance for 2010/21 did reference Primary Care Networks and, for the first time, housing. In light of developments and the guidance it was necessary to review the Locality Plan to ensure it reflected the current and developing landscape.

RESOLVED that the Oldham Better Care Fund Plan be agreed and submitted to NHS England for approval.

13 GM CARERS CHARTER AND COMMITMENT TO CARERS

The Board received a report advising on the Greater Manchester (GM) Carers' Charter and Commitment to Carers and sought the formal commitment of the Board to delivering on the ambition of support to Carers locally.

The GM Social Care Partnership had charged the Adult Social Care Transformation Programme in February 2017 with delivery of four transformation priorities, one of which was to re-shape the current offer and support available to unpaid carers across GM. The Commitment to Carers (attached as an appendix to the report) was developed to encourage the commitment of organisations to improve the experience of unpaid carers across GM, the Commitment outlining a vision for carers and setting out how, through collaborative working, the offer to carers would be improved across the region.

The GM Carers Charter (attached as an appendix to the report) was designed by carers, voluntary, community and social enterprise groups, Councils, NHS England and NHS organisations in Greater Manchester, building on the aims of the Care Act 2014 and agreeing to acknowledge, respect and provide support and opportunities for carers. All partners were tasked to bring together best practice from local and national reviews into a comprehensive resource that all localities could use to inform their local delivery models and a GM Exemplar Model for Carer Support had been developed which focused on the following six critical priorities for support -

- early identification of carers;
- improving health and wellbeing;
- carers as real and expert partners;
- getting the right help at the right time;
- young carers and young adult carers; and
- carers in employment

These six priorities had been adopted as the basis for the Oldham Carers Strategy 2018 – 2021 which had been approved by the Board in September 2018. The inclusion of all GM information within the Oldham Strategy was noted, along with the work undertaken by the Oldham Partnership which included the acknowledgement of carers' voices and the reflection of the breadth and diversity of caring roles. In discussion, the Board noted that the Carers Partnership could not operate in isolation as certain outcomes required evaluation or delivery by others such as the Learning Disability or Dementia Partnerships. This was acknowledged and appropriate action plans were to be developed.

A consideration was given to the identification of and support to Carers given by GP surgeries, a matter which had been subject of CQC inspection considerations also. While GPs would hold a Carers' register, the data held could not be shared and so appropriate linkages to the Partnership and the Strategy were under consideration. A safeguarding consideration by Adult

Care had noted an issue concerning carers and bereavement where a vulnerable person might be left alone and even more vulnerable. It was noted that carers were targeted by the unscrupulous, for example when a partner died, and this was something that needed further consideration.

Oldham Council

RESOLVED - That the Greater Manchester Carers Charter and the Commitment to Carers be approved and adopted.

14 **SEND STRATEGY**

The Board received a report advising of the development and key highlights of Oldham's new Special Educational Needs and Disability (SEND) Strategy. The Strategy, which among other matters was seeking to address the five issues highlighted within a SEND Inspection undertaken two years previously, was in the final round of consultation. Inspectors were currently attending at the Council and were being presented with the evidence of improvements and the time that had been taken to build the vision and collaborative approach between the partners with an interest and input into SEND matters.

The ambition was for Oldham 'to be a place where children and young people thrive', the mission of the SEND Strategy being that 'We want all our children and young people with special educational needs and disabilities (SEND) to achieve well in their early years, at school and in further education, find employment, lead happy, healthy and fulfilled lives and have choice and control over their support'. The SEND Oldham Partnership believed that all children and young people, including those with SEND, should be:

- able to be educated in the borough where they live;
- able to access opportunities that prepare them to be successful in life, learning and work;
- able to access appropriate high-quality support to build their emotional resilience and improve their health and wellbeing;
- safe and happy when taking part in all experiences; and
- listened to and actively involved in decisions that affect their lives and communities

The key outcomes of the Strategy have shaped and directed a Development Plan which focused on the following key priorities for improvement:

- Every child and young person is a confident communicator;
- Every learning setting is inclusive;
- Every young person is ready for adulthood; and
- Every child and young person is a part of their community

The Board was advised that impacts in the community should become visible if significant improvement could be made in these areas over the coming three to five years. This gave

importance to the final consultations which would ensure that all partners were signed up.

The Board noted the benefits of keeping education, health and social care together as one and, with regard to the objective of inclusivity, the need to ensure the accessibility of schools. Noting issues of the physical accessibility of schools, the Board was advised that the issue was wider than just adaptions and included considerations such as waiting lists and school place planning. With regard to completion of Education, Health and Care Plans, it was confirmed that these were being dealt with in a more timely manner, with 90% now being completed within timescale. Improvements were also being seen in relation to health and social care inputs and to presentation.

RESOLVED – That the mission and outcomes of the Special Educational Needs and Disability (SEND) Strategy be endorsed, and the Board gives its support to the use of the approach undertaken to develop this Strategy being applied to other strategies in Oldham.

15 **CLOSING REMARKS**

The Chair noted that this would be the last meeting of the Board attended by Donna McLaughlin, Alliance Director, Oldham Cares and by Andrea Entwistle, supporting Policy Officer to the Board. Both were thanked for their services to the Board and wished well in their respective new roles.

16 **DATE AND TIME OF NEXT MEETING**

RESOLVED that the meeting of the Board be held on Tuesday 12th November 2019 at 2pm.

The meeting started at 2.00 pm and ended at 3.49 pm

Report to Health Scrutiny Committee

NHS Health Checks Programme – Update

Portfolio Holder:
Councillor Zahid Chauhan, Cabinet Member for Health and Social Care

Officer Contact:
Katrina Stephens, Director of Public Health

Report Author: Vicki Gould – Programme Manager Public Health, Oldham Council
Ext. 1951

7th January 2020

Purpose of the Report

The Health Scrutiny Committee has requested a report on the NHS Health Checks programme.

Summary of the issue:

This report provides an update on the NHS Health Checks programme in Oldham. This includes previous performance, an outline of our current performance and plans for the future of the programme in Oldham.

Oldham Council

1. Background to the NHS Health Check

1.1 NHS Health Checks is a national health risk assessment programme that aims to help prevent vascular disease including heart disease, stroke, diabetes and kidney disease. Patients between the ages of 40 and 74, who have not already been diagnosed with one of these conditions, are invited, once every five years to have a health check to assess their risk of developing one or more of the conditions above.

1.2 The 5-year programme was first introduced in 2013. In 2018, a decision was made to continue with a ‘second wave’ of the programme for a further five years; 2018-2023

1.3 In its first 5 years, the NHS Health Check is estimated to have prevented 2,500 heart attacks or strokes nationally. This is the result of people receiving intervention after their health check. The latest research suggests that:

- for every 27 people having an NHS Health Check, 1 person is diagnosed with high blood pressure
- for every 110 people having an NHS Health Check, 1 person is diagnosed with type 2 diabetes
- for every 265 people having an NHS Health Check, 1 person is diagnosed with kidney disease

1.4 The NHS Health Check gives a personalised risk of developing a heart or circulation problem in the next 10 years. Tailored advice and management plans are then put in place to lower the risk. This may include:

- Improving physical activity levels
- Diet advice
- Prescribed medicines for cholesterol or blood pressure
- Support to stop smoking

1.5 In Oldham, once the risk assessment has been completed, the individual receiving the health check is given feedback on their results and advice on achieving and maintaining healthy behaviours. If necessary, they are then directed to either a health improvement intervention (e.g. smoking cessation) or referred to their GP for clinical follow up including additional testing, diagnosis, or referral to secondary care.

1.6 Those patients identified as being at high risk of cardiovascular disease are placed on disease registers and clinically managed through their GP practice.

2. Performance to date

2.1 In Oldham we deliver NHS Health Checks using both a primary care and a community model. The community model has been developed through the Early Help service at Positive Steps. Early Help offer a mixed model of health checks and ‘Health MOTs’ and are targeting areas of the population with the greatest need. A

pharmacy model has also been implemented to support the health checks carried out in GP practices.

2.2 During the first 5-year wave, Oldham moved from one of the lowest performing local authorities nationally in 2013, to being an example of good practice. Between quarter 1 2014/15 and quarter 4 2018/19, 45.4% of Oldham's eligible population had taken up the offer of a health check. This is slightly below the England average of 48.1% but one of the top performances by a Greater Manchester authority.

2.3 The tables below summarise the performance of the programme 2013-2019

People invited for NHS Health Checks year on year

Period	Oldham			North West region	England
		Count	% of eligible population		
2013/14	● (red)	4,106	6.5%	16.6%*	18.4%
2014/15	● (red)	10,768	17.0%	18.1%*	19.7%
2015/16	● (green)	13,105	22.2%	18.0%*	18.8%
2016/17	● (green)	12,245	20.2%	19.0%*	17.0%
2017/18	● (green)	12,782	20.2%	22.3%*	17.3%
2018/19	● (red)	5,808	9.1%	22.1%*	17.6%

**Source:*
Local authorities collect information on the number of NHS Health Checks offered and the number of NHS Health Checks received each quarter and return this data to Public Health England

People receiving NHS Health Checks per year

Period	Oldham			North West region	England
		Count	% of eligible population		
2013/14	● (red)	2,780	4.4%	9.4%	9.0%
2014/15	● (red)	4,892	7.7%	9.6%	9.6%
2015/16	● (amber)	5,353	9.1%	9.1%	9.0%
2016/17	● (green)	5,761	9.5%	9.4%*	8.5%
2017/18	● (amber)	5,270	8.3%	9.9%*	8.3%
2018/19	● (red)	3,584	5.6%	9.7%*	8.1%

**Source:*
Local authorities collect information on the number of NHS Health Checks offered and the number of NHS Health Checks received each quarter and return this data to Public Health England

2.4 During 2018/19, reported performance dipped. However, when interpreting NHS Health Checks data for 2018/19, several factors surrounding the collection and reporting of the data need to be considered.

2.5 A change in data management provider occurred during this period, following the introduction of the GDPR and required compliance levels. As a result, GP practices in Oldham were unable to access reports advising them of patients eligible to receive an NHS Health Check during Q1 and Q2 2018/19.

2.6 This led to a dramatic decrease in the number of invites sent at the start of 2018/19 and also thus a reduction in the number of completed health checks. Once invite lists were made available to practices again (in Q3 2018/19) this led to a large

number of invites being sent to patients in this quarter and the following quarter, health checks being completed. Overall performance improved as a result for the final quarter of 2018/19.

2.7 During the first 2 quarters of 2019/20, invite lists have been fully accessible to GP practices and recorded performance for the full year when published in 2020 should be representative of NHS Health Check activity within Oldham.

2.8 As a result of the improvements seen in the reach and engagement of the programme in Oldham over the 5 years, the following patient findings were reported during last year: the number of patients who were entered onto a disease and/or condition monitoring register as a result of their NHS Health Check was 348. Of those 348:

- 44 patients were diagnosed with diabetes
- 11 patients were diagnosed with chronic kidney disease
- 103 patients were diagnosed with hypertension
- <5[1] patients were diagnosed with coronary heart disease or atrial fibrillation
- 197 patients were diagnosed as morbidly or super-morbidly obese

These numbers may not represent unique patients i.e. there may be some patients with more than one of these conditions found, however, these results demonstrate that a significant number of potentially life-threatening conditions have been uncovered through health checks, which can now be managed in primary care and/or through health improvement services.

2.9 Oldham is recognised in Greater Manchester as having some good practice examples in relation to delivery of the programme in Primary Care. These are:

- The length of appointment time in some Oldham practices for NHS Health Checks exceeds national recommendations of 20 minutes per appointment per patient
- The Q-Risk score[2] is given to the patient by a clinician at a point when the management pathway is already in place to support the patient.

3. Future development of the NHS Health Checks programme in Oldham

3.1 The ambition for the next wave of the programme in Oldham is an NHS Health Check that gives the best possible outcomes for local people. This means an increased focus on quality and outcomes and a more tailored, targeted approach to those who are most at risk.

3.2 Our key focus as we move into the second wave of 5 year roll out of the programme will be on improving the outcomes from the programme including:

- higher numbers of appropriate patients put onto care pathways for diagnosed conditions

[1] Numbers less than 5 have been suppressed for reasons of confidentiality.

[2] The Q-Risk score is found by entering in the patient data and test results, (i.e. family history, height/weight, and cholesterol score) and then using an algorithm to calculates a person's risk of developing a heart attack or stroke over the next 10 years. It presents the average risk of people with the same risk factors as those entered for that person. The algorithm was developed by doctors and academics and accepted by NICE.

- better and earlier condition management

3.3 We will also work to:

- Increase referrals to support services, including social prescribing
- Increase referrals to health improvement services such as smoking cessation, weight management and alcohol support
- Through the NHS Health Check identify common mental health conditions earlier i.e. stress, anxiety and depression and support timely referrals being made

3.4 In addition, Oldham have a community offer ensuring that those most at risk in the population are targeted for proactive invites to attend their health check, specifically: residents who are homeless or veterans.

3.5 We will also be looking to offer and deliver a higher number of Health Checks across the borough during the second five years.

3.6 To reflect our commitment to quality and outcomes for our population, NHS Health Check payments will be structured to reflect the various levels of intervention offered and linked to recorded individual patient outcome data and appropriate onward referrals.

3.7 Continuing Professional Development for clinicians delivering the checks will be ensured through ongoing CVD communications risk training and annual best practice training.

4. Wider public health work with primary care

4.1 The NHS Health Check programme is part of a broader range of public health work with primary care. Other work includes support and advice to each of the 5 primary care networks (PCN's), health literacy, GM working well programme called 'working well early help' and ongoing engagement within the respiratory collaborative.

4.2 A health literacy training programme is being piloted with practice nurses and healthcare assistants to communicate health information that is appropriate to residents understanding. Where residents better understand their health condition, they are better in control; and able to manage their condition and reduce the risk of hospital admissions.

4.3 Oldham have been the front runners embedding the GM programme 'working well early help' ensuring maximum referrals from GPs in the North PCN to a service that ensures people with health conditions who are off work with a fit note are supported back to work through timely and appropriate interventions.

4.4 The Public Health team are members of the Respiratory Collaborative in Oldham West PCN and have been involved in developing the priorities for the cluster to address the prevalence and impact of respiratory diseases, most recently presenting at the Oldham West PCN Respiratory Workshop. The Public Health team are leading the community response to reducing smoking rates as commissioners for stop smoking services, as reduced smoking rates will directly impact the prevalence of respiratory disease, in particular COPD, for which smoking is the biggest preventable risk factor. Work has also been undertaken to share best

practice on oral health for vulnerable older people and resources are being developed to be used in COPD patient education sessions, as poor oral hygiene increases the risk of respiratory infections.

5. **Recommendations**

5.1 The Health Scrutiny committee are asked to note the performance of the NHS Health Check programme and support the continued work to improve the quality of the programme and ensure it reaches those most at risk of long term conditions.

Report to Health Scrutiny Committee

Integrating Community Health and Adult Social Care Services

Portfolio Holder:
Councillor Chauhan

Officer Contact: Mark Warren, Managing Director & DASS, Community Health & Adult Social Care Service

Report Author: Debra Ward, Transformation Programme Manager
Ext. x4682

07 January 2019

1. Purpose of the Report

1.1 To provide an update on integrating community health and adult social care services.

2. Recommendations

2.1 Health Scrutiny Committee is invited to note the update provided and advise of dates for further updates.

3. Current position

3.1 The Community Health and Adult Social Care Service (Community Service) has two distinct elements of operation;

(i) The commissioning responsibilities for ensuring all statutory requirements of the Local Authority including safeguarding are enforced (as required by the statutory post of the Director of Adult Social Services – DASS) and

(ii) The leadership and operation of all the adult community health and statutory social care services operating in the borough. This is delivered through an alliance which includes employees from;
- Oldham Council
- Miocare
- Northern Care Alliance / Salford Royal Foundation Trust
- Pennine Care NHS Foundation Trust
- The social care commsioning element of the integrated commissioning function

3.2 The Community Service is a critical mechanism to realising this vision for the wider health and social care economy. It is therefore essential the service is focussed on

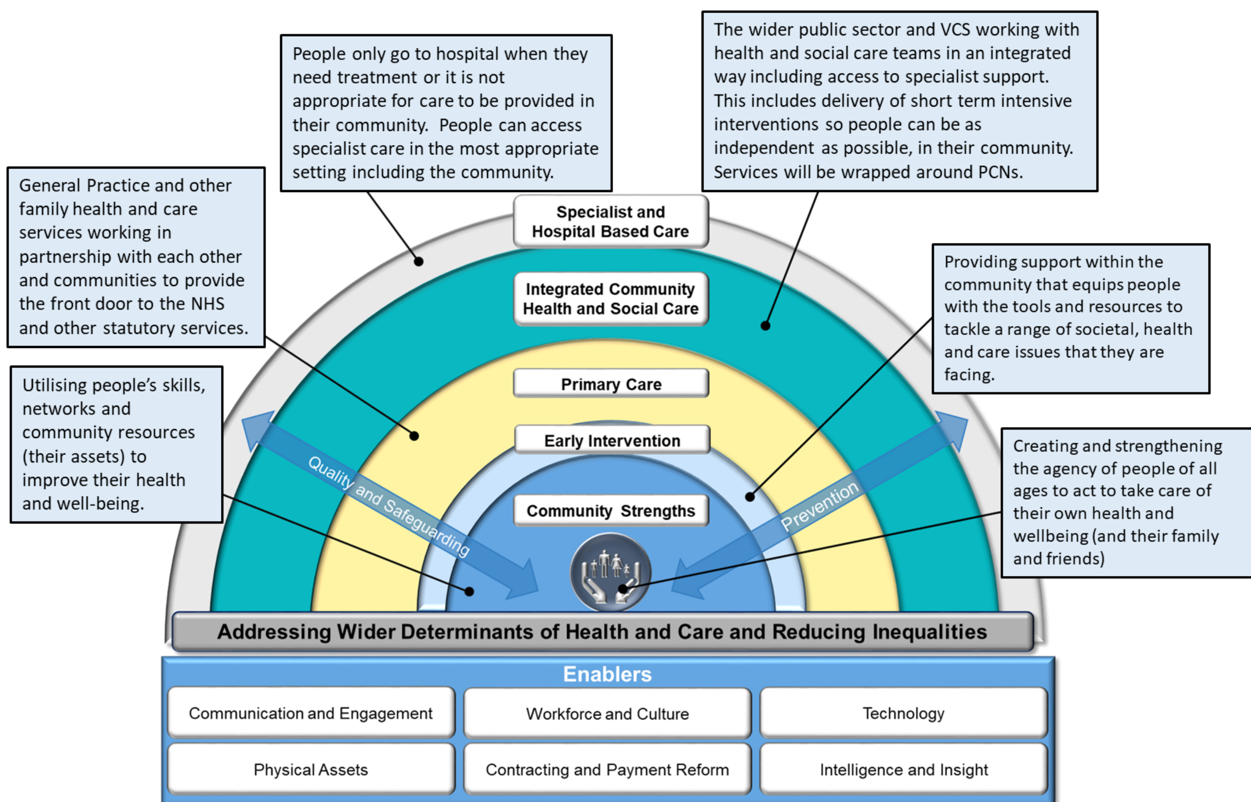
wellbeing and prevention, enabling people to regain independence, whilst targeting long-term support at those people with the most complex needs.

3.3 With a focus on strength and asset-based practice approaches at the forefront of how residents are supported, and a realisation that co-production grows thriving communities, it is essential for the service to consider a new future operating model, which places people at the centre of the care and support pathway. This will ensure they actively enable, inform and design services. It is anticipated that the health and social care economy will realise significant prevention-based improvements for the health and wellbeing of residents from a redefined integrated Community Service.

3.4 The model below, taken from the refreshed Locality Plan, emphasises a shift to self-care, preventative and place-based practice approaches to ensure that

- demand for services is prioritised
- people are triaged to receive the most appropriate support
- in the longer-term, people are enabled to self-care and take responsibility for their own wellbeing.

3.5 It is recognised that it is essential that the Community Service preventative approach complements the wider reform agenda and the early intervention review including Early Help, Thriving Communities and Social Prescribing.



3.6 The emphasis for phase 2 of integrating community services has therefore been refocused to design and implement an integrated community service that will

- enable practitioners to focus on supporting people in their communities
- avoiding acute interventions and long-term community service dependency
- reinforce a new culture of self-care, place and strength-based support

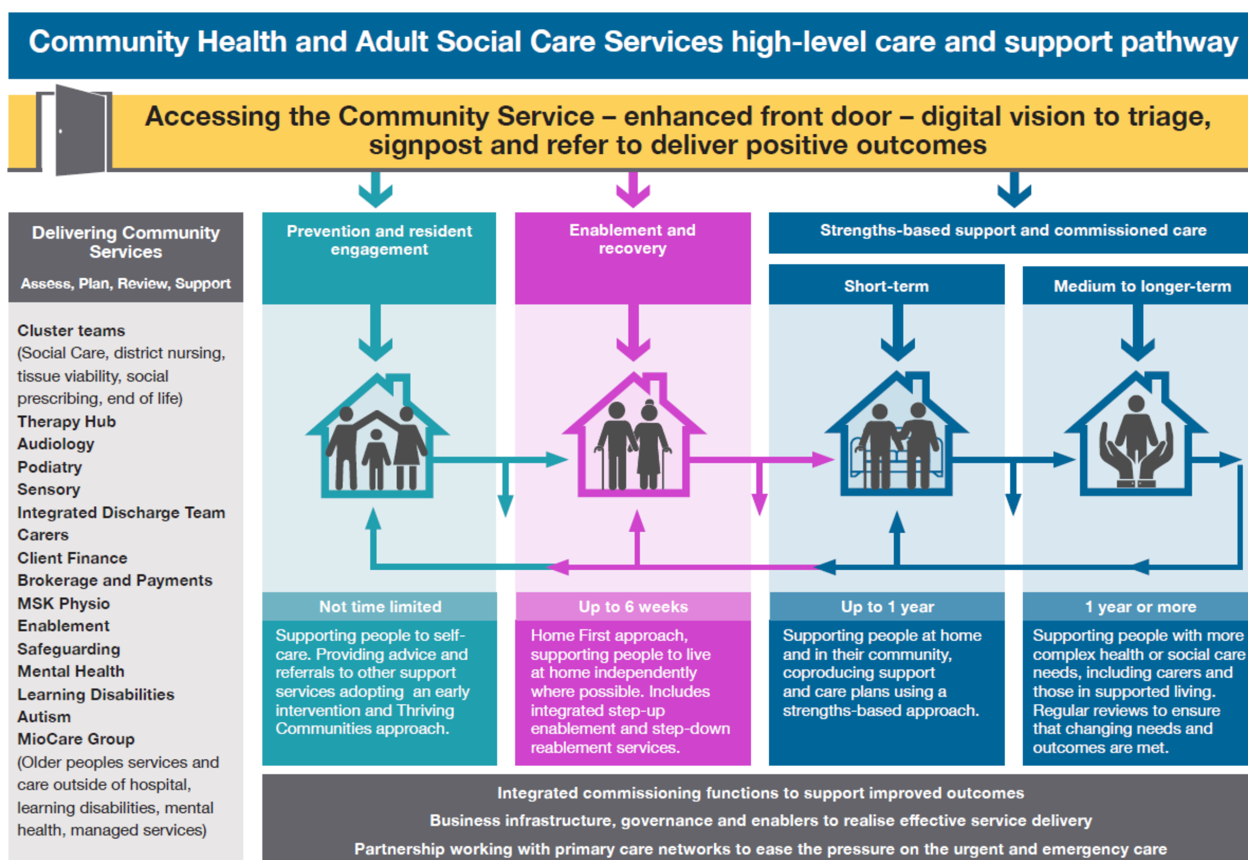
- drive financial, as well as demand efficiencies
- deliver better outcomes for residents and the economy as a whole.

3.7 This approach will also seek to enhance the first phase of integration, which sought to co-locate frontline practitioners from health and social care into geographical cluster-based models of working, alongside a centralised Integrated Therapy Hub. With operational reform plans developed to realise safe, compliant and effective models of working, it would also provide opportunities to further clarify change requirements to enable cluster and specialist teams to work collectively, whilst complementing the planned GP Primary Care Networks (PCN) that are to be established by April 2020.

4. Realising a new integrated community service

4.1 The diagram below illustrates the high-level care and support pathway that we envisage will deliver our vision:

The Community Health and Adult Social Care Service combines a range of skills and knowledge, as part of an integrated place-based model, to enable people to maximise their independence and receive timely, safe, person-centred care as close to home as possible.



4.2 We are seeking independent expert input to produce a clear understanding of the gap between where we currently are, and where we need to be to deliver the vision. This will include developing a transition and implementation plan to realise the new operating model for the Community Service.

4.3 At the same time, the following are key areas of development, that are dependencies for delivering the vision:

4.3.1 Community enablement – whilst delivering the second phase of transformation funded projects, design and deliver an enablement model for Oldham. The model will build on the already partially integrated crisis enablement team and further improve the referral pathway and process into enablement services.

4.3.2 Embedding integration – developing and embedding standard operating procedures for integrated neighbourhood community teams. Approaches to integrated working have been trialed across teams, to differing levels of success. This area will take learning from the trials, and from other locality integrated teams across GM to develop best practice procedures for integrated teams.

4.3.3 Adults Targeted Model – designing and implementing a model for prevention and resident engagement to support people to self-care. The model will be aligned alongside the redesign and procurement of Oldham Family Connect, low-level early intervention and health improvement and weight management specifications/services.

4.3.4 Streamlining governance and decision-making – there's currently approximately 50 groups that make decisions affecting community services. These boards span across the Council, Oldham Clinical Commissioning Group, Oldham Care Organisation, Northern Care Alliance, Pennine Care Foundation Trust, and Oldham Cares. Groups have been formed within the Community Service to provide oversight and assurance. Once fully established early 2020, it is anticipated that these groups will take over some of the decision making currently covered by other groups, thus reducing the amount of duplication in reporting to and attending meetings. The evolving governance structure for decision making and assurance for CHASC is included at appendix 13.3. The structure seeks to enable five organisations to deliver through one vehicle (CHASC leadership forum), whilst recognizing that the Community Service is expected to adhere to the governance arrangements of each of the organisations, which does not support efficient decision making.

4.3.5 Operational reform – some of the existing services are operating with high risk concerns around delivering a safe and effective service. For the services areas most at risk (District Nursing and intermediate care) recovery plans are in operation in the interim to track improvements via risk mitigation plans. A plan is being developed to reform other operational areas that are known to require e.g. system resilience to continue to deliver efficiently and effectively. This work will ensure that we have strong and stable services in operation, ahead of transforming them to meet the refocused vision.

4.4 All of this activity is being managed under a transformation programme to ensure that the links and dependencies across all areas of activity are joined up and delivered appropriately across the system. Due to the need to test out the design and delivery approach Oldham Cares has signed up to, the activity listed above is underway whilst the refocused vision for the Community Service is in the design

stage. The design stage will conclude by end of March 2020 and it is envisaged that transitional arrangements will be in place by May 2020. The full solution will be implemented by July 2020, allowing for a 12-month period in which to deliver the solution within the agree hosting period with the Oldham Care Organisation.

5 Reviewing community health contracts

5.1 In July 2019 community health contracts transferred from PCFT to the Oldham Care Organisation (part of the Northern Care Alliance). At the point of transfer, it was recognised that the specifications for health contracts were out of date and needed updating. Previously, specifications have been sporadically reviewed and updated service by service. A project is underway to review the specifications, taking a system-wide approach to ensure that interdependencies across the system are taken into consideration.

5.2 Contracts will be reviewed under the following grouped activity areas (in the order noted below):

- Childrens services
- Community enablement
- Adult community nursing (including clinical elements of the Single Point of Access)
- Therapy/AHP
- Palliative and End of Life
- Appointment Centre (including non-clinical elements of the Single Point of Access)
- Pennine MSK

5.3 All health contracts will be reviewed as part of this project. The review will ensure input from enablers, service leads, contract managers, commissioners and other stakeholders as relevant. The services identified as the highest risk will be first and include District Nursing and Intermediate Care residential enablement delivered at Butler Green.

5.4 Recommendations from each activity area will be considered within their own right, and collectively to ensure a whole system approach to the review.

5.5 Patient and quality outcomes-based specifications will be produced by the end of March 2020.

6. Redesigned Safeguarding service and Social Care

6.1 A redesigned safeguarding adults system that has both strategic and operational elements is now in the process of being implemented. All reactive safeguarding going forward will be undertaken by the neighbourhood and specialist teams with the strategic service supporting the Safeguarding Adults Board

6.2 The social care services are also evolving and whilst facing demand pressures a single line leadership model across health and social care services is in place.

6.3 A Business Infrastructure service is being designed to take responsibility for the business and performance elements of managing the alliance of services and all undertaken within existing resources.

7. Integrated Commissioning Function

7.1 An update on commissioning was provided to the Health Scrutiny Committee 10 September 2019. See Appendix 13.1.

8. Key issues for Overview and Scrutiny to Discuss

8.1 For scrutiny to take note of the proposal for further integrating community services as part of phase 2 of the transformation change programme.

8.2 For Scrutiny to seek assurance that both the statutory duties of the Council and CCG are being undertaken.

8.3 The service has a combined operating budget in the region of £95 million. Adult Social Care is projecting a budget overspend.

9. Key Questions for Overview and Scrutiny to Consider

9.1 For scrutiny to consider the scope and scale of integration within Community Services.

9.2 For scrutiny to clarify date for further updates.

10. Links to Corporate Outcomes

10.1 Integration works proactively with residents and partners to promote health, independent lifestyle whilst providing the right level of care at the right time.

10.2 We aim to put social value and transformation outcomes at the heart of delivery of Community Services.

10.3 Through integration, we will reform out services which will in turn lead to better outcomes and delivery for residents.

11. Additional Supporting Information

11.1 None.

12. Consultation

12.1 All enablers are involved in the redesign and implementation of integration.

13. Appendices

13.1 Oldham Cares Commissioning Arrangements Update report

O&S report
020919.docx

13.2 Organisational structure chart for the Community Health and Social Care Service

191217 Updated
CHASC Senior Manag

13.3 Governance structure for the Community Health and Social Care

Governance for
CHASC from July 2019

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Report to OVERVIEW AND SCRUTINY BOARD

Oldham Council

Oldham Cares Commissioning Arrangements Update

Portfolio Holder:
Cllr Zahid Chauhan, Cabinet Member for Health and Social Care

Officer Contact:
Mike Barker – Chief Officer and Strategic Director of Commissioning, Oldham Clinical Commissioning Group (CCG)

Mark Warren – Director of Adult Social Services (DASS) and Managing Director, Community Health and Adult Social Care Service

Report Author:
Helen Ramsden – Assistant Director of Integrated Commissioning

Ext: 0161 622 6451

Purpose of the Report

To provide Overview and Scrutiny Board with an update on the integrated commissioning arrangements for health and social care in Oldham.

1. Background

1.1 As part of the Oldham Cares model to integrate health and social care services in the borough, both the Council's Adult Social Care function and CCG commissioning functions co-located in April 2018 and relocated to Ellen House.

1.2 This forms part of a wider Greater Manchester model of establishing a Strategic Commissioning Function and an Integrated Care System in each locality, with the purpose of aligning activity and ensuring an infrastructure is in place to design and deliver services going forward.

1.3 The Director of Adult Social Care (DASS) retains statutory responsibility for the Adult Social Care (ASC) commissioning requirements and works closely with the Strategic Director of Commissioning and Chief Officer of the Clinical Commissioning Group (CCG).

1.4 A Section 75 aligned budget has been arranged and the total health and care commissioning budget in Oldham is circa £430 million per annum of which ASC represents £60 million (net) and £89 million (gross).

1.5 This report aims to provide an update on progress on integrating our commissioning functions to date and also provide an overview of the future direction of travel.

2. Current Position

2.1 Joint Commissioning

2.1.1 Following co-location of the health and social care commissioning functions in April 2018, work has been ongoing in relation to the areas of activity identified in the section 75 arrangements:

- Learning Disability
- Mental health
- Care home and care at home commissioning
- Dementia
- Continuing Health care
- Safeguarding strategy and policy work

2.1.2 In addition to commissioning activity, teams have been realigned to ensure more joined up working and leadership:

- The Interim Assistant Director of Joint Commissioning (substantively Head of Commissioning for Adult Social Care) now has responsibility for ASC

Commissioning, CCG commissioning of Mental Health and Learning Disabilities and Complex Care including Continuing Health Care (CHC) which are the most significant areas of overlap in terms of spend / markets / users of services across health and social care.

- Redesign of the Complex Care Team structure and implementation of an improvement plan, which includes closer working with integrated community health and social care teams.
- Integration of the ASC and CCG Quality Teams under single line management arrangements.
- Review and redesign of Strategic Safeguarding led by the Managing Director of Community Health and Social Care and the CCG Executive Nurse (now in implementation stage).

2.1.3 A work plan of the strategic and tactical commissioning activity has been developed for the current year and beyond, aligned to GM priorities for Adult Social Care Transformation and the Living Well at Home Programme which is attached at Appendix 8.1.

2.1.4 Strategy Development

2.1.5 *Market Position Statement*

2.1.6 The Market Position Statement published in 2017 sets out the anticipated demand and current market position in relation to a range of needs and services. This is due to be refreshed and is included in the commissioning service plan for 2019/20. This also links to the development of a dynamic market development approach, referenced below. The supported housing market position statement developed in 2017, and the subsequent supported housing strategy (currently being finalized for learning disability services but recognized as required for other population cohorts) seeks to refine and specify further the amount and type of supported housing required to meet current and future need.

2.1.7 *Managing Provider Failure and Contingency Planning*

2.1.8 The Managing Provider Failure Policy and Procedure sets out The Care Act (2014) duties of the local authority in relation to provider failure and continuity of care, and processes and protocols in the event of failure. However, the policy and procedure go further and recognises the joint commissioning that takes place across the local authority and the CCG. This has been in place since 2017 and a refresh is included in the commissioning service plan for 2019/20. Whilst this covers some elements around contingency management, it is recognized that there is not a separate contingency plan that sets out arrangements in the event of provider failure, including the ability to access the services of Miocare. Work is under way with NW ADASS around contingency planning, and Oldham will be linking in with this work, to establish a separate contingency plan as part of the refresh of the Managing Provider Failure Policy and Procedures.

2.1.9 *Population Level and Service Specific Strategies*

2.1.10 A number of specific strategies are in place or in development, that identify current and future demand, and inform future commissioning plans, for example:

- Autism strategy
- Learning disability strategy
- Dementia strategy
- Assistive technology strategy
- Mental health strategy
- Supported housing strategy

Each of these areas has its own work plan/steering groups and priorities.

2.1.11 Commissioning Activity

2.1.12 *Dynamic Market Development*

2.1.13 Flowing from the Greater Manchester Health and Social Care Partnership (GMHSCP) Adult Social Care Commissioning Strategy, workstreams related to Living Well at Home, Supported Housing and Residential and Nursing Care and a new group, establishing a Dynamic Market Development Approach, have established. Oldham and Salford are the GM lead commissioners for this group, and membership will include health and social care commissioners, providers and user representatives. The scope and focus of this group are currently being agreed with the DASS lead Diane Eaton (Trafford), and GMHSCP.

2.1.14 *Cluster-Based Care at Home Commissioning*

2.1.15 The care at home commissioning model has been redesigned and re-procured to align to integrated clusters with a focus on outcomes, supporting market stability, whilst retaining a healthy market by reducing travel time and the operating costs of providers. There are four categories, across both health and social care, which will be managed in an integrated way:

- Category 1 – Care at home
- Category 2 – Extra Care Housing
- Category 3 – Childrens
- Category 4 – Specialist care

2.1.16 *Care Homes*

2.1.17 From April 2019, fees for care home placements have been aligned to CQC ratings across the local authority and the CCG, to further promote and encourage quality improvement. At the current time, over 80% of care home beds are rated good or above by CQC, however Oldham has no care homes in the outstanding category, and it is hoped that the CQC joint work described below will increase understanding in this area to better support the market to strive for outstanding.

2.1.18 Care home commissioning is on the work plan for 2019/20 with the aim of introducing a single contract, specification and outcomes framework for care homes across health and social care.

2.1.19 *Supported Living*

2.1.20 The contract for learning disability supported living services is due to expire in 2020. This is already a joint contract and outcomes framework across health and social care and will be reviewed prior to retender.

2.1.21 Holly Bank, the new purpose-built supported living scheme for adults with learning disabilities, autism and complex needs has been under development for some time, and the first tenants are due to move in later this year. The service will be provided by Miocare and will enable people currently living out of the Oldham area, in unsuitable accommodation in Oldham, or with family, to move into purpose-built apartments with care and support tailored to their individual needs.

2.1.22 *Living Wage Foundation (LWF)*

2.1.23 The Council, in common with other localities across Greater Manchester, has stated a political ambition to gain Living Wage Foundation (LWF) status, which then creates implications for the CCG. This means that not only will we commit to paying our own staff at least the LWF rate (currently £9/hr), but we must also ensure that all suppliers pay their staff at this rate as well. This is an ambition that is welcomed in terms of a recognition of the low pay within the care sector, but there are anticipated to be significant financial implications arising from this, and work is underway to initially complete soft market testing, gaining the views of providers of this impact and the consequential impact on contract prices.

2.1.24 <u>Quality Initiatives</u>

2.1.25 *Provider Assessment and Market Management Solution (PAMMS)*

2.1.26 The implementation of the Provider Assessment and Market Management Solution (PAMMS) in Oldham and three/four other GM localities, will provide a systematic way to gather, analyse and respond to quality and sustainability priorities across the adult social care market.

2.1.27 *Care Quality Commission (CQC) Joint Working*

2.1.28 Planning is under way with CQC to undertake some reciprocal shadowing arrangements, with the aim of better understanding the activities and responsibilities of the regulator and commissioners with regard to quality oversight, assurance and improvement.

2.1.29 *Provider Quality Improvement Programme (PQuIP)*

2.1.30 As part of the GM Improving Care Home Quality work, Oldham has implemented the Provider Quality Improvement Programme (PQuIP), initially with care homes. This is a detailed supportive audit process against a common set of requirements across all GM localities. As a result of this work, the quality newsletter, ongoing provider engagement through the provider forum and the investment in, and alignment of, Quality Monitoring Officers to clusters, the quality of care homes in Oldham, as judged by CQC ratings, has increased from 50% to over 80%.

2.2 Micro Commissioning / Community Health and Social Care

2.2.1 The Adult Social Care operational care teams have now integrated with NHS community health staff and are now configured to work across five geographical clusters servicing populations of 40,000 to 55,000 GP registered patients.

2.2.2 A single line management model is in operation and these teams commission services at an individual level once assessment have been carried out and eligibility criteria applied. The teams work closely with the SCF to ensure commissioning at all levels recognises the local frameworks in place. The governance structure for this element of the service is at Appendix 8.2.

2.2.3 OMBC ASC staff are still employed by the council and deployed on a cluster arrangement and specialist service arrangement. The community Health service transferred from the employment of Pennine care NHS Foundation Trust to the employment of the Northern care Alliance / Salford Royal NHS Trust on the 1st July. Again, the staff are deployed on a cluster and specialist service arrangement.

2.2.4 The council maintains its partnership with Pennine Care NHS Foundation Trust on the delivery of Learning Disability and mental health services.

2.2.5 The CCG, OMBC and NCA are working together to develop a newly designed service against revised service specification outcomes designed to incentivise services to work together and ensure maximum effectiveness and efficiency.

2.3 Public Health

2.3.1 The Council's public health function has a dual role in health and social care commissioning: as direct commissioners of public health services, as well as providing support to all commissioners to ensure that services are based on a detailed understanding of need and take an evidence-based approach to improving and protecting the health of the population, as well as reducing inequalities. This includes:

- Supporting health and social care commissioning:

- Identifying current, and predicting future, health needs
  - Ensuring cost-effective prevention activity is included and embedded within health and care services
  - Using evidence of effectiveness and cost-effectiveness to support the review and redesign of care pathways
  - Development of methods and indicators to support monitoring and evaluation and ensure that services deliver the expected health outcomes
  - Providing specialist healthcare public health advice in tendering processes and throughout the commissioning cycle

- Commissioning public health services:

  - Healthy Child Programme for 0-5- and 5-19-year olds
  - Sexual health services
  - NHS Health Checks
  - Substance misuse services
  - Oral health improvement services
  - Stop Smoking services
  - Services to support improvements in physical activity and diet
  - Services to promote and support good mental wellbeing

2.3.2 The commissioning of public health services and the public health budget are not currently included within the scope of the section 75 arrangement; however, the public health team aims to work collaboratively to support commissioning and service delivery across Council, CCG and Oldham Cares. In addition, some public health services have been commissioned through collaborative arrangements with other local authorities in Greater Manchester, for example the all age sexual health service is commissioned across Oldham, Bury and Rochdale, and the adult substance misuse service across Rochdale and Oldham. These collaborative arrangements have enabled substantial savings to be made with minimal impact on the scale and quality of service delivery.

2.4 Summary

2.4.1 Our work so far has been co-locating teams, developing service level commissioning strategies, testing our governance systems and processes and jointly delivering things across health and social care. We are about to enter the next phase of our journey and this is very briefly outlined below.

2.5 Next Stages of Development

2.5.1 Under the leadership of the strategic director of commissioning with significant input from the director of adult social services (DASS) a comprehensive blueprint for the future of integrated commissioning has now been developed and agreed within the system. As a high level this blueprint envisages a move beyond excellent service commissioning to Commissioning for Outcomes and Communities of Identity, with a focus on social value across three phases:

- **In the short run**, this will mean re-allocating commissioning responsibilities for certain individual service areas between Locality and GM level which may create **synergies and efficiencies;**
- **In the medium run**, and in parallel to maximising efficiencies from commissioning services at scale, commissioners need to **start building and piloting outcomes-based pathways** for specific populations; and
- **In the long run**, an integrated, patient-centred approach to care will have **services that 'wrap around' the needs of users**, with an emphasis on prevention. **Outcomes-based** commissioning will deliver **social value** across Oldham and in turn across GM.

2.5.2 We have committed to a number of design features for our new Integrated Commissioning Function (ICF) to ensure there are improved outcomes for people in Oldham. The design will enable the ICF to work collaboratively with services and people to co-design and develop models of care that are rooted in the community, where people are at the centre of services and there is a shift in focus to early intervention and prevention as well as improving wellbeing. The design principles are as follows:

1. The Council and the CCG will come together to form a single, small and strong **Integrated Commissioning Function (ICF)** with a breadth of responsibilities. This will maximise economies of outcomes.
2. The ICF will support the local care delivery to strengthen its existing **Neighbourhood Leadership Systems** to include clinical and political leadership, personalised care, asset-based community development, and citizen and community engagement.
3. The ICF will manage a significant **combined fund across health, social care and wider public services**, enabled by a risk-sharing agreement.
4. The ICF will adopt an **investment-led approach to commissioning and decommissioning** and support the move away from hospital and residential care services to investment in prevention and early intervention.

2.5.3 In Oldham our model will also seek to re-engineer support services and our model will focus on delivering against several key objectives:

1. The ICF will develop **responsive Commissioning Support Services (CSS), integrated at a locality level**. The ICF will generate economies of outcomes through consolidation with broader place-based authorities and public services.
2. The ICF will transfer the **portfolio of CSS** where it aligns and supports the integration of care at a neighbourhood level.
3. The ICF will **aggregate specific CSS,** using existing shared service centres at a GM level where there is a case to generate savings and consolidate specialist expertise.
4. We will seek to **build, and/or expand** in a uniform way, innovative capabilities that support new place-based models.

2.5.4 The ICF will create the conditions for a high-quality partnership in the borough between the providers of health and social care services for the delivery of a set of agreed population outcomes.

2.5.5 The dynamic system will be built on a blended approach to commissioning and provision drawn from a common foundation of financial analysis, engagement of local people, system performance, and quality assurance. It will also draw on outcomes from the whole system enabling functionality already in place, such as integrated IM&T development, single estates strategic intent, integrated communications and engagement approach, and single workforce development strategies.

2.5.6 The ICF will develop competence in the key characteristics of the commissioning process:

- understanding need;
- clarifying outcomes and standards;
- maintaining a clear focus on system wide performance and quality assurance and improvement;
- clarifying the financial scope of services and;
- adherence to clinical frameworks and standards.

2.5.7 The focus of the ICF is at this stage is to build an effective approach to commissioning to support the Oldham Cares vision. It is being developed with reference to a broader ambition of creating an integrated approach to the commissioning for the wider public service system.

2.5.8 Oldham has committed to develop common geographical footprints at a population size 30,000 to 50,000. A framework for Integrated Place Based Working at this level is close to completion. This will enable the partnership in Oldham to work together to develop a joined up placed based approach to commissioning across a wider range of services.

2.5.9 The ICF is not an organisation it is instead made up of a number of different parts:

- The operation of a Joint Commissioning Committee (JCC) with an oversight of the combined budget for the place;
- The role of an ICF team supporting the work of the JCC;
- Clarification of the relationship between the JCC and the statutory function/s of the CCG and Council;
- The management arrangements for the ICF team and the accountability to a single accountable officer for both Oldham Clinical Commissioning Group (CCG) and Council;
- A combined fund - held by the JCC, supported by the ICF Team.

2.5.10 The CCG will host the JCC and in suggesting the hosting arrangements due regard was given to the legislation that currently restricts the CCG's capacity to delegate e.g. Primary Care, Surgery etc.

2.5.11 The ICF will seek to create the conditions for integrated provider arrangements in the place. In the first instance, by autumn 2019 the ICF will issue high level commissioning intentions to move towards an Integrated Care System (ICS).

2.5.12 The system is currently developing an alliance approach and this networking approach will evolve. A number of models are being explored, for example a single lead provider arrangement supported by formal alliance and other appropriate legal mechanisms to achieve integration e.g. Section 75 agreements. All potential approaches will need to be evaluated and a recommended approach agreed. The formal mechanisms of moving money from ICF to provider alliances will be underpinned by common assumptions and will be conditional on the way in which providers will deliver services being fully aligned to the principles behind the Locality Plan. The conditionality will reflect all the characteristics of reformed public services.

2.5.13 With a blended approach to commissioning and provision in the borough the ICF will have a single approach to quality improvement and assurance – dependent not on contract meetings and periodic performance management initiatives or penalties, but on an agreed integrated performance framework between ICF and providers where both have a contribution and sense of responsibility for the success of the programmes/ services being delivered.

2.5.14 The ICF arrangements will need to respond to the statutory obligations and reporting requirements of CCG and Council, but the mechanism by which those obligations are met will always be co-designed and co-owned.

2.6 Linking the Population Conversation with the Contract

2.6.1 We are entering a phase of commissioning development where there will be an ever greater need to increase the responsiveness of our services. This applies not only to the need to inculcate a culture of personalisation within the services we contract for – which we will begin to do by promoting patient reported outcome measures, incentivising the enhanced personalisation of services and establishing an approach to population health outreach – but also to the design of the contract requirements themselves.

2.6.2 The key challenge is to create a framework within which a new conversation with our population about service change can take place in a way that is not tokenistic. In order to meet this challenge, we have to be able to meet two criteria. The first criterion is that the nature of our discussion with the population should be genuinely *deliberative* and ask questions that are both strategically significant and genuinely ‘open’ in the sense that the answers from the process will affect what we do next. The second criterion is that we need to be able to show the process by which the outcomes from such a conversation can be incorporated into our planning and delivery – or explain why certain aspirations are not possible.

2.6.3 We will develop an annual business cycle that divides the planning year into two phases – a ‘deliberative phase’ and a ‘contracting phase’. This will link in with other work we are undertaking to ensure our contracting positions are developed much earlier in the year, enabling more clinical engagement with both commissioners and providers and more time to establish new requirements e.g. for quality indicators.

2.6.4 The ‘deliberative phase’ would focus our efforts on stakeholder engagement into the period from January to September within the cycle. This would in turn break down into three quarters of work.

2.7 A New Commissioning Framework

2.7.1 Our goal is to use the discipline of commissioning to develop the culture and ‘outward mindset’ of the Oldham system.

2.7.2 Our work will be guided by Oldham’s Integrated commissioning framework. That will mean embedding the following ten core principles in everything that we do operating as an integrated commissioning function:

1. Focused on improved outcomes for the people of Oldham
2. A consistent commissioning approach to planning, designing and evaluating services
3. The right people involved at the right stage of commissioning
4. Open-minded about how best to achieve outcomes
5. High-quality, robust evidence informing our decisions
6. Hold all services to account for the delivery of Oldham’s strategic outcomes
7. People at the heart of our commissioning approach
8. A commitment to building capacity
9. We will maximise social value
10. Our supply chains will be sustainable and effective

2.7.3 The purpose of the ten core principles is to ensure:

- We are commissioning all services to consistently high standards, making best use of the tools and resources available - in an era of ever reducing financial resources, fulfilling our statutory responsibilities will remain our first priority, and taking a commissioning approach to how we achieve this will help ensure that we deliver the best outcomes for the resources available.
- We are improving outcomes by commissioning tackling areas of high deprivation to reduce inequality and bring about sustainable behaviour changes.
- We are rebalancing our models of care to develop person centred services that are delivered close to home within local communities.
- We are creating the conditions within Oldham for the changes emerging from our transformation activity to be sustainably embedded.
- We are reflecting the public sector commitments; providers are supported to understand the process that Oldham uses to commission services and understand how they can be involved at each stage.
- We are compliant with relevant legislation including the Best Value Statutory Guidance 2012, the Care Act 2014, the Public Services (Social Value) Act 2012, the Health and Social Care Act (2012) and The Equality Act 2010, and also that we are in line with best practice such as the National Commissioning standards for Adult Social Care.

3 Key Issues for Overview and Scrutiny to Discuss

3.1 For Scrutiny to take note of the developing commissioning design model in Oldham Council.

3.2 For Scrutiny to seek assurance that both the statutory duties of the Council and CCG are being undertaken.

3.3 For Scrutiny to be aware of a challenging financial operating gap which will impact upon the way services are commissioned and delivered.

4 Key Questions for Overview and Scrutiny to Consider

4.1 For the Board to seek an assurance that the strategies across the Council and CCG are being joined up.

4.2 For Scrutiny to understand the impact of service integration at the front line.

4.3 For Scrutiny to clarify how the strategic commissioning objectives linked to the wider Greater Manchester Health and Social Care Partnership objectives.

5. Links to Corporate Outcomes

5.1 Integrated commissioning will lead to better outcomes for people with health and social care needs; realising positive public sector reform whilst proactively achieving improved wellbeing, lifestyles and provision of care, at the right place, right time.

6 Additional Supporting Information

6.1 None.

7 Consultation

7.1 Key partners from across the Oldham Cares Alliance have actively informed and engaged the integration landscape across health and social care services, including the evolution of our integrated commissioning elements.

8 Appendices

8.1 Strategic and Tactical Commissioning Activity Work Plan

ASC Work Programme_MASTER

8.2 Community Health and Adult Social Care Service Governance

190828 Governance
for CHASC from July

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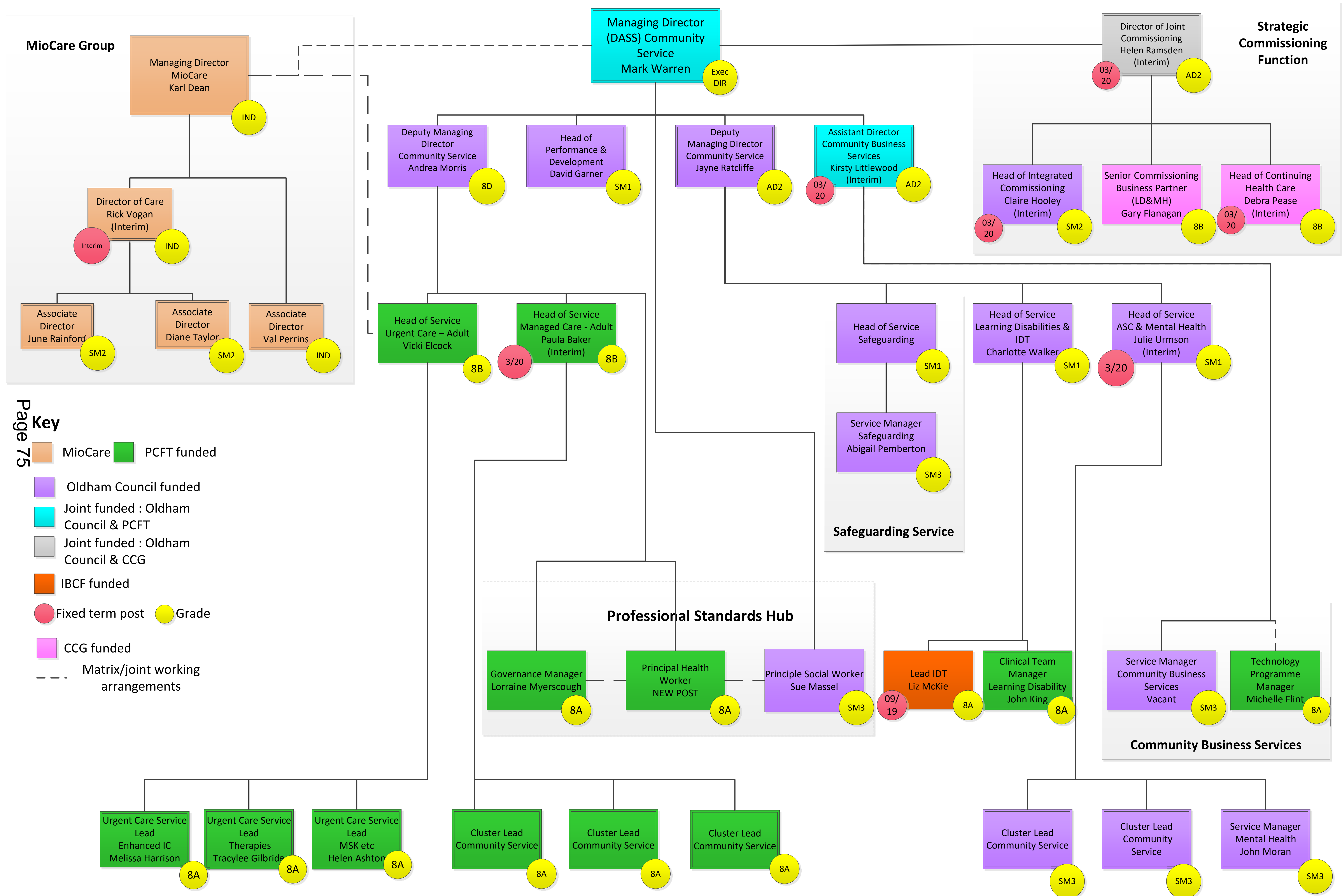
Interim Community Health & Adult Social Care Structure July 2019



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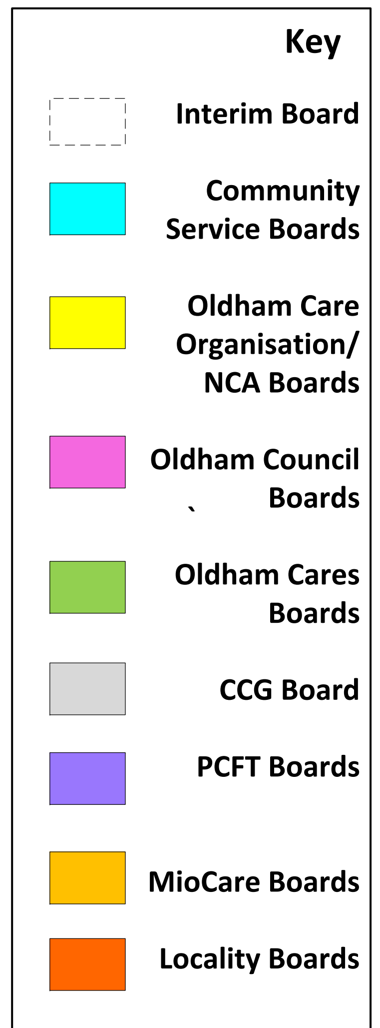
Draft Governance for Community Health and Adult Social Care Services from July 2019 v0.8



Cabinet, Council
C: Sean Fielding

Overview & Scrutiny Board (O&S), Council
C: Colin McLaren

Portfolio meetings
C: Cllr Chauhan

Leadership, Council
C: Sean Fielding

Senior Management Team (SMT), Council
C: Caroyln Wilkins

Strategic Design Authority (SDA)
C: Carolyn Wilkins
Dep: Rebekah Sutcliffe

Strategic Design Steering (SDS) Group
C: Rebekah Sutcliffe

Health and Well Being Board
C: Councillor Harrison

Oldham Safeguarding Adults Board & sub-groups
C: Henri Giller

Oldham Safeguarding Adults Intelligence Group (SAIG)
C: Helen Ramsden

Commissioning Partnership Board
C: Cllr Chauhan/Majid Hussain

Alliance Board
C: Sam Jones

Joint Leadership Team (JLT)
C: Carolyn Wilkins
Dep: John Patterson

Cluster Implementation Board
C: John Patterson
Dep: Mark Warren

Community Health and Adult Social Care (CHASC) leadership forum
C: Mark Warren

Alliance Leadership Team
C: Paul Wood
Dep: Mike Barker

Group Risk & Assurance Committee (GRAC)
C: Raj Jain

Care Organisation Assurance & Risk Committee (COARC)
C: Nic Firth

Management Board
C: Nic Firth

Oldham Care Organisation Leadership team meeting
C: Nic Firth

Corporate PCFT Board
C: TBC

Integrated Leadership Group (ILG)
C: Andrea Morris

Directorate Leadership Group (LD)
C: Jeremy Bentham

Directorate Leadership Group (MH)
C: TBC

Community Services review group
C: Mark Warren/ Nicola Hepburn

MioCare Board
C: Councillor Bashforth
Dep: Peter White

Adult Social Care (ASC) DMT
C: Mark Warren
Dep: Helen Ramsden

CCG Leadership Team (MET)
C: John Patterson
Dep: Mike Barker

Leadership, Systems and Governance Oversight
C: Jayne Ratcliffe & Andrea Morris

Finance
C: David garner & Gioia Morrison

Workforce & OD
C: Emma Gilmartin

Performance & Information
C: David Garner & Alyson Wadsworth

Quality, Practice & Clinical Governance
C: Andrea Morris

Business Assurance Group
C: Kirsty Littlewood

Change Programme Boards
C: Various

CHASC Vacancy Panel
C: Charlotte Walker

Mosaic Governance Group
C: Kirsty Littlewood

Combined ILG/ AMT - TBC

Remuneration
C: Cathy Butterworth

Operation
C: Peter White

Finance, Audit & Risk
C: Jeff Jones

Workforce, Learning & OD
C: Nic Firth

Operations & Performance
C: Dan Grimes

Finance & Information
C: David Jago

Clinical Effectiveness
C: Jawad Hussain

Quality & Patient Experience
C: Nic Firth

Sub-committees: Risk committee

Sub-committees: Medical productivity

Sub committees: Access & Performance, Cancer Improvement , Patient Flow Improvement

Sub-committees: Better Care, Lower Cost (BCLC), Improvement Board DMO

Sub-committees: Infection Prevention, Oldham Mortality Oversight Group (OMOG)

Sub-committees: Patient Experience Group, Health & Safety Committee Claims Group, Safeguarding

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BRIEFING TO HEATH SCRUTINY COMMITTEE

Report Title: Review of Primary Care

Report Author: Mark Hardman, Constitutional Services Officer

Date: 7th January 2020

1. Background

1.1 At the meeting of the Committee held on 3rd September 2019 Members received the latest of a number of reports advising of progress in implementing a new model of Urgent Primary Care for Oldham.

1.2 At that time the Committee was advised that a new model would not be implemented until the CCG was confident that the service would meet clinical needs, be safe and offered an improved patient experience. An Objective Review, anticipated to take one month to complete, was to be undertaken to take stock of progress and consider how best to implement the model going forward.

1.3 The Committee noted the update provided and resolved that a further update be submitted on the outcome of the review when completed.

1.4 The appended presentation provides the requested update and now more broadly addresses the future of all of General Practice in Oldham, rather than just Urgent Primary Care. Representatives from Oldham CCG will be in attendance at the meeting to deliver the presentation and receive questions from the Committee.

2 **Recommendations**

2.1 The Health Scrutiny Committee is recommended to receive the report and to raise and discuss issues arising with attending CCG representatives.

2.2 The Health Scrutiny Committee is recommended to consider whether it would wish to receive further reports on this issue and, if so, to identify a timescale or circumstances arising to determine submission of further report(s).

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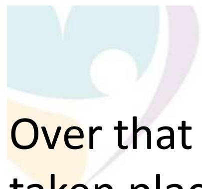
Oldham CCG



Oldham's Position

Over that last year, with a new leadership team, an objective review of Primary Care has taken place on the work that was commissioned historically with the support of CQC, MiAA, NHS England alongside other partners.

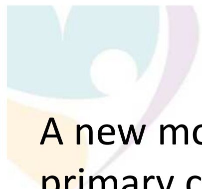
This has raised many issues resulting in focussed work taking place to ensure the safety of patients and support individuals in practice to deliver services.

Work remains ongoing to close down 2016/17, 2017/18 & 20118/19 work which is aimed to be completed by April 2020.

Performance across Primary Care continues to improve despite the challenges known to us all and from the data received from Primary Care Plus is indicating it is, in the main, working as planned by reducing inequalities and improving health outcomes.

Work has commenced to develop a Primary Care Strategy that identifies our priorities. The first draft is currently underway that will identify the CCG priorities as directed by the National and GM position.

Our Primary Care Networks will be part of the development of this and will be asked to support the design of the outcomes expected and the services delivered within each PCN. This will be launched on 1 April 2020 and will support us to deliver our overall commissioning intentions.



Primary Care Commissioning Intentions

A new model of Primary Care is required across Oldham so we can be assured we have a sustainable primary care offer, with a strong workforce who have a manageable and appropriate workload, that are able to meet the needs of our population's fluctuating demands across our health and social care economy.

We know across Oldham:

- The capacity, scale, resilience and quality of the current business model in primary care across Oldham is not fit to respond effectively to future challenges
- Whilst there are examples of good Primary Care in Oldham, we know that there is considerable variation in access to care and in health outcomes
- Infrastructure plans need to be forward looking and demonstrate how the asset base will be developed to be a key enabler for service transformation
- There is considerable interest amongst local GP's (and other providers) in examining the benefits that may arise from introducing new models of care and realising the benefits of working at scale

We will achieve…	How we plan to commission for this…
A reduction of unwarranted variation in clinical care to help ensure that the health community makes the most appropriate use of the scarce resources that are available	Encourage and support general practice to provide core practice first and foremost
Improve resilience and quality in Primary Care	Development of a primary care assurance framework that delivers 'Good' as standard and develops workforce
Ensure the active engagement of primary care in the improvement of population health management	Develop primary care networks (PCN) and build a local strategy that is based around meeting the needs of each PCN's population with the appropriate workforce to deliver the agreed outcomes

GP Assurance Framework

New Assurance Framework for General Practice in Oldham

- Visits to practices will take place on an annual basis as a minimum. This supportive process will form part of the ongoing dialogue between practices and the CCG
- As well as a focus on clinical quality performance, the visits will include consideration of practice governance
- The CCG will compile and monitor national comparative data (including QOF and GP patient survey), local information (including safeguarding and infection control), and current CQC inspection ratings. The dashboard will help inform the discussions during the practice assurance visits. The dashboard will be routinely shared with networks to support them in their ongoing work. Data will be put into the context of each provider and used alongside other intelligence to gain an understanding of any potential risk to quality or patient safety
- Where a potential or actual risk is identified, the CCG will take the necessary steps to assure itself that adequate and effective support is being provided to reduce the risk, identify any ongoing areas for improvement and be able to demonstrate and measure that improvement. The focus will be the same for all practices: support to improve, with market exit as a last resort.
- Visits will commence early 2020 following recruitment to the Primary Care Team

Care Quality Commission Inspections

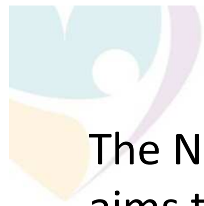
Date	Outstanding	Good	Requires Improvement	Inadequate	Not Inspected	Total
August 2019	4.65% (2)	74.42% (32)	14% (6)	4.65% (2)	2.33% (1)	100% (43)
October 2019	4.65% (2)	72.09% (31)	11.63% (5)	6.98% (3)	4.65% (2)	100% (43)

x5 RI Practices are:

- Jarvis
- St Chads
- Moorside
- Lees
- Kapur

X3 Inadequate Practices are:

- Littletown Family Medical Practice
- The Parks
- South Chadderton Health Centre



Case for Change

The NHS Five Year Forward View sets out the case for change in healthcare. Oldham CCG aims to enable general practice to play an even stronger role at the heart of more integrated out-of-hospital services. These will deliver better outcomes, more personalised care, excellent patient experience and the most efficient possible use of NHS resources.

Our vision for transformation in primary care is built upon a compelling case for change with a clear set of drivers for improvement. In developing the primary care strategy, key themes have been used to underpin our planning activities in the short to medium term and these build on the work already undertaken and the improvements achieved.

Demand and Variation

- Feedback shows there is still room for improvement when offering a service which is fully accessible to patients. The increasing level of demand both from an aging population and raised patient expectations means that primary care needs to find new ways of both managing activity, whilst at the same time delivering services in ways that meet patient needs. It is well known that there are limited numbers of GPs available within primary care and so assessing skill mix to make the best use of the skills and expertise available should be a focus. Because there are many different contractors providing services, variation is inevitable. However, primary care providers need to come together to make processes and pathways more efficient and consistent across the whole of the service.

Case for Change

Workforce challenges

- Challenges around sustaining a competent and motivated workforce are well documented through evidence from Health Education England's Workforce Audit Tool, and providers' feedback around the pressures of recruiting and retaining staff. Added to this, Oldham has a significant number of GPs, Nurses and Practice Managers approaching retirement age and continues to struggle as an under-doctored area compared to other CCGs. Staff development and succession planning need a joined up approach with other local partners to avoid the cycle of staff moving around the healthcare system.

Contracting and Funding

- Primary care contracting is complex and not always focussed on outcomes for patients. We recognise that implementing and monitoring contracts across so many providers offers challenges. With the shift of care into the community, effective and properly funded contracts are vital. Integrated approaches which are focused on the needs of the patient and improvements to the quality of care are needed to ensure that different groups of providers work better together.

Case for Change

Walk in Centre Review Findings

- High level of un-registered patients attending - approx. 15% of activity
- 15% of total antibiotic prescribing for whole of Oldham
- Current cost for the service is £1.5m with a prescribing budget of £40,265,414 spent to date. This makes up approx. 2% of total prescribing in Oldham.

Potential Future Service

- Alternative urgent care service to deliver ambulatory care services
- Alternative Long Term Conditions management service to support the reduction in out patient activity

PCN Deliverables

We need to update and understand where each Network is against the PCN Maturity Matrix. This matrix is not a binary checklist or a performance management tool. It is designed to support network leaders, working in collaboration with systems, places and other local leaders within neighbourhoods, to work together to understand the development journey both for individual networks, and how groups of networks can collaborate together across a place in the planning and delivery of care.

Using the matrix as a basis for these discussions will allow networks to:

- Come together around a shared sense of purpose, identify where PCNs are in their journey of development and consider
- Consider how they can build on existing improvements such as those that may have been enabled by the GP Forward View and other local integration initiatives.
- Make plans for further development that help networks to continue to expand integrated care and approaches to population health, and that can best meet the health and care needs of the population served by the network.
- Identify support needs using the PCN Development Support Prospectus as a guide for framing support plans

PCN Deliverables

Following the completion of the maturity matrix agreement on how the five reimbursable roles below are delivered:

- Clinical pharmacists (from 2019)
- Social prescribing link workers (from 2019)
- Physician associates (from 2020)
- First contact physiotherapists (from 2020)
- First contact community paramedics (from 2021)

BRIEFING TO HEATH SCRUTINY COMMITTEE

Report Title: Council Motions

Report Author: Mark Hardman, Constitutional Services Officer

Date: 7th January 2020

1. Ban on Fast Food and Energy Drinks Advertising

1.1 Background:

At the meeting of the Overview and Scrutiny Board held on 22nd October 2019, the following Motion, considered by the Council at the meeting held on 11th September 2019 and referred to the Board in the first instance, was referred onwards to the Health Scrutiny Committee:

"Council notes that:

- Fast food contains high level of fats, salt and sugar and energy drinks often contain high levels of caffeine and sugar.
- Excessive consumption of these products contributes to obesity, tooth decay, diabetes, gastro-intestinal problems, sleep deprivation and hyperactivity.
- The Royal College of Paediatrics and Child Health predicts half of all children in the UK will be overweight or obese by 2020.
- The Mayor of London banned all fast food advertising on publically-controlled advertising spaces across London's entire transport network.
- Sustain and Foodwatch recently published a report 'Taking Down Junk Food Adverts' which recommends that local authorities regulate adverts on public telephone boxes and that the Advertising Standards Authority should be able to regulate advertising outside nurseries, children's centres, parks, family attractions and leisure centres.

As a local authority with a statutory responsibility for public health, Council believes that it should do all that is possible to discourage the consumption of fast food and energy drinks.

Council therefore resolves to:

- Ask the Chief Executive to write to the Chief Executive of Transport for Greater Manchester asking TFGM to impose a ban on the advertising of fast food and energy drinks on publicly owned poster sites etc across the Greater Manchester transport network.

- Ensure that fast food or energy are not advertised on any hoarding or within any building owned by this Council including large advertisements on bus stops.
- Ensure that such products are not sold to children or young people on any of our premises.
- Ask our NHS, social housing, voluntary and private sector partners, including the Mayor of Greater Manchester, to make a similar undertaking.
- Ask the Chief Executive to write to the relevant minister requesting the recommendations of the ‘Taking Down Junk Food Adverts’ report be adopted as government policy as soon as possible; copying in our local members of Parliament to seek their support.

1.2 **Recommendations**

The Health Scrutiny Committee is requested to determine how to proceed with the resolution.

OLDHAM HEALTH SCRUTINY COMMITTEE

FORWARD PLAN 2019 - 20

Part A – Meeting Programme

Date of meeting	Topic	Summary	For discussion, approval, information?	Lead Officer
2 July 2019 **6pm – 8pm** **Lees Suite, Civic Centre**	Elected Member Safeguarding Training	Update as requested in November 2018	Discussion	Ed Francis, Assistant Director Safeguarding and Partnerships Ed.Francis@oldham.gov.uk
	Children and Young People's Mental Health and Emotional Wellbeing	For the committee to consider the current offer for Children and Young People's Mental Health and Emotional Wellbeing. To include consideration of: - CAMHS Transformation Plan Update - Findings of Healthwatch's review of CYP Mental Health Services	Discussion	Representatives from across the Health system to include: - Jill Beaumont, Director of Children's Health and Wellbeing jill.beaumont1@nhs.net - Dr Keith Jeffery, Clinical Director for Mental Health NHS Oldham CCG keith.jeffery@nhs.net - Mike Bridges, Public Health Specialist Mike.Bridges@oldham.gov.uk - Julie Farley, Healthwatch Oldham julie.farley@healthwatcholdham.co.uk
	Council Motions	Review of Health-related motions at council and subsequent actions	Discussion *(standing item)*	Chair
	Mayor's Healthy Living Campaign	To update the committee on recent activity	Discussion *(standing item)*	Chair

3 September 2019 6pm – 8pm Crompton Suite, Civic Centre	North West Ambulance Service	To engage with the committee regarding local health priorities and how NWAS can best meet the needs of Oldham's communities	Discussion	Pat McFadden, Head of Service for Greater Manchester (plus local manager) Officer contact: Madeline Edgar, Senior Communications Manager Madeline.Edgar@nwas.nhs.uk
	Social Prescribing	For the committee to consider the progress made in the initial phase of the Innovation Partnership	Discussion	Pete Pawson, Thriving Communities and Place Based Intervention Programme Manager Peter.Pawson@unitypartnership.com
	Choice and Equity Policy	For the committee to consider the development of the policy and any subsequent implications	Discussion	Mark Drury, Head of Public Affairs – Oldham Cares (mark.drury@nhs.net)
	Council Motions	Review of Health-related motions at council and subsequent actions	Discussion *(standing item)*	Chair
	Mayor's Healthy Living Campaign	To update the committee on recent activity	Discussion *(standing item)*	Chair
	Urgent Primary Care	Update to Health Scrutiny as requested in March 2019	Update – For noting only	Dr John Patterson, Chief Clinical Officer and Deputy Accountable Officer, Oldham Cares (john.patterson3@nhs.net)
15 October 2019 6pm – 8pm Crompton Suite, Civic Centre ***Development Session***	Primary Care	Including access to GPs	Discussion	Mark Drury, Head of Public Affairs – Oldham Cares (mark.drury@nhs.net Dr. John Patterson, GP
	Pennine Acute Hospitals NHS Trust Transaction Programme	Update to Health Scrutiny as requested in March 2019	Update – For noting only	Steve Wilson, Executive Lead (Finance & Investment) - Greater Manchester Health & Social Care Partnership (PA: karenwinterbottom@nhs.net)

7 January 2010 **6pm – 8pm** **Civic Centre**	Public Health in Primary Care/ Oldham Health Check	Combined item - Update as requested by the committee in December 2018/overview of progress made since the launch of the Oldham Health Check	Discussion	Consultant in Public Health (Healthcare) Katrina Stephens, Director of Public Health (Katrina.Stephens@oldham.gov.uk)
	Integration of the community and commissioning teams – Phase 2 implementation	To provide the committee with an overview of the second phase the Adults Social Care and Community Health integration	Discussion	Mark Warren, Managing Director Community Health and Adult Social Care (DASS) (Mark.Warren@oldham.gov.uk)
	Council Motions	Review of Health-related motions at council and subsequent actions	Discussion *(standing item)*	Chair
	Urgent Primary Care	Outcome of the Objective Review to take stock of progress and consider how best to implement the Urgent Primary Care model going forward (as resolved/stated in submitted report, September 2019).	Discussion	Mark Drury, Head of Public Affairs – Oldham Cares (mark.drury@nhs.net
28 January 2020 **Development Session** **6pm – 8pm** **Crompton Suite Civic Centre**	Joint Strategic Needs Assessment	To provide the Committee with an overview of the online Joint Strategic Needs Assessment		Katrina Stephens, Director of Public Health (Katrina.Stephens@oldham.gov.uk)
	TBC			
24 March 2020	End of Life Services	For the committee to receive an	Discussion	Julie Farley, Manager – Healthwatch Oldham

6pm – 8pm **Lees Suite, Civic Centre**	Review	overview of the outcome of the review of End of Life Services conducted by Healthwatch Oldham and NHS Oldham CCG.		(julie.farley@healthwatcholdham.co.uk) Mark Drury, Head of Public Affairs – Oldham Cares (mark.drury@nhs.net)
	Adult Safeguarding arrangements – Implementation of action plan	For the committee to receive an overview of Oldham's Safeguarding Adults Arrangements: - To include Healthwatch/OSAB review of Preventative Adult Safeguarding	Discussion	Mark Warren, Managing Director Community Health and Adult Social Care (DASS) (Mark.Warren@oldham.gov.uk) Henri Giller, Independent Chair of Oldham Safeguarding Adults Board Julie Farley, Manager – Healthwatch Oldham (julie.farley@healthwatcholdham.co.uk)
	Oldham Family Connect	To provide the committee with an overview of the impact of Oldham Family Connect and progress made to date	Discussion	Bruce Penhale, Assistant Director Communities and Early Intervention Bruce.Penhale@oldham.gov.uk
	Oldham Children and Young Person's Alliance	To provide the committee with an overview of the priorities of the Alliance and progress made since its establishment	Discussion	Gerard Jones, Managing Director Children Elaine Devaney, Director of Children's Social Care
	Council Motions	Review of Health related motions at council and subsequent actions	Discussion *(standing item)*	Chair
	Mayor's Healthy Living Campaign	To update the sub-committee on recent activity	Discussion *(standing item)*	Chair
	Thriving Communities Programme	Update to Board as requested in March 2019	Written update – For noting only	Peter Pawson, Thriving Communities Programme Manager (Peter.Pawson@unitypartnership.com)

	Oral Health	Progress report as requested by the committee in December 2018	Written update – For noting only	Katrina Stephens, Director of Public Health (Katrina.Stephens@oldham.gov.uk)
	NOTE – The Work Programme for the March 2020 meeting should be considered as 'indicative' at this stage pending review of Work Programmes across all three Overview and Scrutiny Committees.			

Part B - ONE OFF MEETINGS, WORKSHOPS AND TASK AND FINISH GROUPS

Date of meeting	Topic	Summary/Purpose	Notes/Outcome	Lead Officer
19 Sept 2019	Voluntary and Community Sector Development	One-off meeting: Discussion re the role and development of the community sector with Chair and Vice Chair as agreed at meeting on 3 September	Meeting completed – no further action needed	Laura Windsor-Welsh, Strategic Locality Lead, Action Together LauraWW@actiontogether.org.uk
~~3 Oct 2019~~ **To be rescheduled**	OTC Medicine Review	Task and Finish Group: Initial scoping meeting scheduled for 3 Oct with Chair, Vice Chair, Clinical Director for Medicines Optimisation and Advanced Prescribing Support Pharmacist		Mark Drury, Head of Public Affairs – Oldham Cares (mark.drury@nhs.net)
22 Oct 2019	Continuing Healthcare – Equality and Choice Policy	Workshop: To provide the committee with detailed information regarding complex cases (demographic profile, types of care being provided, budget information) and a summary of consultation findings	Meeting completed – further update required.	Helen Ramsden, Interim Assistant Director of Joint Commissioning Helen.Ramsden@oldham.gov.uk
Feb 2020 (indicative)	Continuing Healthcare – Equality and Choice Policy	As agreed at the Workshop held on 15th October 2019 – Workshop: To receive details of the results of the consultation and implementation of the newly		Helen Ramsden, Interim Assistant Director of Joint Commissioning Helen.Ramsden@oldham.gov.uk

		commissioned service (as agreed at Workshop held on 22 October 2019).		
tbc	Pennine Acute Hospital NHS Trust Transaction Programme Primary Care – Including access to GPs	As agreed at the Development Session held on 15th October 2019 – Workshop to consider both issues: To meet at key points in the Transaction Programme when required to consider progress, including discussions around bed spaces and issues of emergency flow; current financial position and 3-4 year budget; development of glossary of health and social care terms; receipt of action plan updates for the GP Getting to Good; funding available to GPs not accessed by Oldham and how parties can work together to secure the funding.		Steve Wilson, Executive Lead (Finance and Investment) GM Health and Social Care Partnership Mark Warren, Managing Director Community Health and Adult Social Care (DASS) (Mark.Warren@oldham.gov.uk) Mike Barker Strategic Director for Commissioning mike.barker3@nhs.net
tbc	Infant Mortality and Child Death	Task and Finish Group		

Part C – Outstanding issues/possible topics for consideration – dates to be determined

When discussed	**Topic**	**Summary/Purpose/Notes**	**Timescales**	**Lead Officer**
	Transfer of PCFT community services to NCA – Implications for OMBC	Transfer took place on 1 July 2019 – update on first 100 days		Mark Warren, Managing Director Community Health and Adults Social Care (DASS) Mark.Warren@oldham.gov.uk
	Implementation of the GM LD strategy in Oldham Council	Considered by Health and Wellbeing Board in November 2019		Mark Warren, Managing Director Community Health and Adults Social Care (DASS) Mark.Warren@oldham.gov.uk

	Smoking and Tobacco Control	To consider local provision and initiatives		Andrea Entwistle, Public Health Business and Strategy Manager Andrea.Entwistle@oldham.gov.uk
	Sexual Health Integrated Service	Tri-borough (Oldham, Rochdale and Bury) contract re-tender		Andrea Entwistle, Public Health Business and Strategy Manager Andrea.Entwistle@oldham.gov.uk
	Greater Manchester Fire and Rescue Service	To outline the current performance, position and initiatives of GMFRS with additional focus on the Oldham area		Val Hussain, Borough Manager: Bury, Oldham & Rochdale, GMFRS hussainv@manchesterfire.gov.uk
	Immunisations	Particular focus on Flu Programme 19/20 and MMR – to be considered at first meeting of municipal year 20/21 as figures released May/June 2020.	June 2020	Gloria Beckett, Infection Prevention & Control Nurse, Public Health Gloria.Beckett@oldham.gov.uk
	Public Health Annual Report	To provide the Committee with an overview of the Public Health Annual Report	To be re-scheduled from January 2020 Development Session)	Katrina Stephens, Director of Public Health (Katrina.Stephens@oldham.gov.uk)

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