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HEALTH AND WELL BEING BOARD
Agenda

Date Tuesday 23 March 2021

Time 2.00 pm

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

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

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

3. PUBLIC QUESTIONS – Any member of the public wishing to ask a question at the above meeting can do so only if a written copy of the question is submitted to the Contact officer by 12 Noon on Thursday, 18 March 2021.

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

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

MEMBERSHIP OF THE HEALTH AND WELL BEING BOARD IS AS FOLLOWS: Councillors Ball, M Bashforth, Chauhan, Moores, Stretton (Chair) and Sykes, Chris Allsop, Mike Barker, Donna Cezair, Majid Hussain, David Jago, Dr Keith Jeffery, Gerard Jones, Stuart Lockwood, Dr. John Patterson, Claire Smith, Katrina Stephens, Rebekah Sutcliffe, Tamoor Tariq, Mark Warren, Carolyn Wilkins OBE and Liz Windsor-Welsh and by invitation Val Hussain, Joanne Sloan and Karen Worthington

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.

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 - 8)

The Minutes of the meeting of the Health and Wellbeing Board held on 26th January 2021 are attached for approval.

6 Health and Wellbeing Terms of Reference (Pages 9 - 12)

7 Refresh of the Local Outbreak Plan (Pages 13 - 44)

8 NHS White Paper - Integration and Innovation: Working Together to Improve Health and Social Care for All (Pages 45 - 52)

9 Date of Next Meeting

The Council has agreed dates for future meetings of the Board to be held on Tuesdays 22nd June, 27th July*, 14th September, 16th November, 14th December* 2021, 25th January and 22nd March 2022 at 2.00pm. (*dates identified as development sessions)

HEALTH AND WELL BEING BOARD
26/01/2021 at 2.00 pm

Present: Councillor Stretton (Chair)
Councillors Ball, M Bashforth, Chauhan, Moores and Sykes

Dr John Patterson	Oldham CCG
Majid Hussain	Oldham CCG
Mike Barker	Executive Director Commissioning and Chief Operating Officer (Oldham Council/Oldham CCG)
Mark Warren	Managing Director of Health and Adult Care Services
Gerard Jones	Managing Director of Children and Young People
Katrina Stephens	Director of Public Health
Tamoor Tariq	Oldham Healthwatch
Stuart Lockwood	Oldham Community Leisure
Donna Cezair	First Choice Homes

Also in Attendance:

Rebecca Fletcher	Consultant in Public Health and Chair of the Bury, Rochdale and Oldham Child Death Overview Panel
Annie Lowe	Public Health Registrar
Sian Walter-Browne	Constitutional Services
Mark Hardman	Constitutional Services

1 **APOLOGIES FOR ABSENCE**

Apologies for absence were received from Chief Supt Chris Allsop, Val Hussain, David Jago, Dr Keith Jeffrey, Joanne Sloan, Claire Smith, Rebekah Sutcliffe, Carolyn Wilkins, Liz Windsor-Welsh and Karen Worthington.

2 **DECLARATIONS OF INTEREST**

Tamoor Tariq declared a personal interest in agenda items 6 – 8 (Child Death Overview Panels and the National Child Mortality Database Annual Reports 2019/20) by virtue of being an elected member of Bury Council and a member of the Bury Health and Wellbeing Board.

3 **URGENT BUSINESS**

There were no items of urgent business.

4 **PUBLIC QUESTION TIME**

No public questions had been received.

5 **MINUTES OF PREVIOUS MEETING**

RESOLVED – that the minutes of the meeting of the Health and Wellbeing Board held on 10th November 2020 be approved as a correct record.

6 **BURY, ROCHDALE AND OLDHAM CHILD DEATH OVERVIEW PANEL 2019/2020 ANNUAL REPORT**

The Board received the 2019/20 Annual Report of the Bury, Rochdale and Oldham (BRO) Child Death Overview Panel (CDOP) presenting the annual review of CDOP data for BRO. The CDOP reviews all child deaths under 18 years, but not including still births, late foetal loss or termination of pregnancy. The Panel do not determine the cause of death but instead explores all the factors surrounding the death of the child. This learning enables required actions to be taken to protect the welfare of children and prevent future deaths.

Each CDOP collates information on the cases that have been closed in the last 12 months in order to review for themes. This enables each area to identify any lessons learnt and recognise where population level interventions are required to reduce future child deaths. The BRO CDOP report is supported by a Greater Manchester (GM) report which gives an overview of patterns across all four CDOPs in GM. In view of the relatively small numbers, and consequent difficulties with data analysis, this can be helpful when analysing for themes. The Annual Report presented an analysis of data gathered and presented recommendations and actions arising from considerations in the previous year.

The annual report was supported at the meeting by a presentation introduced by Rebecca Fletcher, Consultant in Public Health and Chair of the BRO CDOP 2019/20 and Annie Lowe, Public Health Registrar. The Report contained a review of the 29 closed cases in Oldham, Rochdale and Bury and Data collected between 1st April 2019 -31st March 2020. Highlighted report findings were that

- 66% of closed cases were expected deaths;
- 69% of closed cases occurred in a hospital setting;
- 34% of closed cases occurred in the neonatal period; and
- 58% of closed cases occurred in the first year of life,

with identified themes of prematurity, gender, deprivation and ethnicity being further considered. Modifiable risk factors associated with child deaths, such as maternal obesity and smoking were considered, along with interventions seeking to modify such behaviours and risk.

The Annual Report recommendations were summarised to the Board as

- giving consideration to other factors such as maternal age and breastfeeding;
- ensuring that data is recorded for unbooked pregnancy and concealed pregnancy;

- recognising that maternal obesity is a growing concern, and ensuring that is recorded in child deaths under 1 year;
- acknowledging and addressing that children living in deprived neighbourhoods or of BME ethnicity are over-represented in child deaths; and
- disseminating the report to the relevant departments within the health and wellbeing partnership to ensure shared learning.

In response to a query regarding actions that had been and were being undertaken to address key factors of ethnicity and deprivation, it was reported that advice was given through health visitors and midwifery services and that work was being undertaken to ensure services are appropriate and accessible, the aim being to make the wider sector aware of these issues. Further comment was made as to the impact of domestic violence which may lead to severe accidents and life threatening injuries and to the difficulties families are facing at this time. The Board was advised that work was currently going ahead to improve offers to families, with parenting advice and advice being given for people struggling with domestic violence.

Further matters raised regarding promotion of Healthy Start Vouchers in support of healthy diets and work with the Communications Team to develop the CDOP Annual Report in a more 'user friendly' format to aid dissemination would be pursued.

RESOLVED that the Oldham Rochdale and Bury Child Death Overview Panel Annual Report 2019/20 be received and noted, and the recommendations contained therein be supported.

7 **GREATER MANCHESTER CHILD DEATH OVERVIEW PANELS 2019/2020 ANNUAL REPORT**

The Board received the 2019/20 Annual Report of the Greater Manchester (GM) Child Death Overview Panels (CDOP) reviewing all infant and child deaths reported to the four GM CDOPs and including data from cases closed between 1st April 2019 and 31st March 2020. All deaths of children between 0-17 years of age are reported to a CDOP which analyses the social and medical circumstances surrounding these deaths, including risk factors which could potentially be avoided to prevent future child deaths. The aim of the Annual Report was to inform and guide local organisations on preventing further child deaths.

The Annual Report presented an analysis of data gathered and presented recommendations and actions arising from considerations in the previous year. The Report was supported at the meeting by a presentation introduced by Rebecca Fletcher, Consultant in Public Health and Chair of the ORB CDOP 2019/20 and Annie Lowe, Public Health Registrar. The Report contained a review of the 129 closed cases in GM and data collected between 1st April 2019 -31st March 2020.

Highlighted report findings were that a reduction in the number of cases reviewed across all CDOPs were mainly due to changes in the child death review process; and potentially modifiable factors were identified in 40% of all closed cases, with identified themes of age, causes, deprivation and ethnicity being further considered. Modifiable factors highlighted in the GM report included unsafe sleeping, maternal obesity in pregnancy, consanguinity, and smoking

The Annual Report recommendations were summarised to the Board as

- local areas should use the information on BAME communities being disproportionately represented, along with other local information, to inform work to address health inequalities;
- a continuing focus be given to smoking cessation in pregnant women;
- GM local authorities needing to reduce levels of obesity throughout the population, including women;
- GM CDOP Chairs to commission a 5-year GM CDOP analysis of cases;
- local areas to consider real time data on suicides to inform more timely responses; and
- implementation of an electronic CDOP reporting system to improve the process.

Further to a query as to whether future reports might include a trend analysis, it was suggested that as numbers were small these might be difficult to demonstrate. However, local figures were reviewed to see if trends were emerging and the proposed five year report may enable trends, particularly at the GM level, to be identified.

RESOLVED that the Greater Manchester Child Death Overview Panels Annual Report 2019/20 be received and noted, and the recommendations contained therein be supported.

8 **NATIONAL CHILD MORTALITY DATABASE ANNUAL REPORT 2019-2020**

The Board received the 2019/20 Annual Report of the National Child Mortality Database (NCMD). The NCMD collates data collected by all the Child Death Overview Panels (CDOPs) in England from their reviews of all children who die at any time after birth and before their 18th birthday. The Annual Report, the first prepared by the NCMD, covered the deaths of those children whose death was reviewed by a CDOP between 1st April 2019 and 31st March 2020, the purpose of the Report being to understand why children die and to put in place interventions to protect other children and reduce the risk of future deaths. A second NCMD annual report was to follow in Spring 2021 to include detailed analysis along with key messages and recommendations informed by the data and in consultation with the NCMD stakeholder professional and public representation groups.

The Annual Report was supported at the meeting by a presentation introduced by Rebecca Fletcher, Consultant in Public Health and Chair of the Bury, Rochdale and Oldham CDOP 2019/20 and Annie Lowe, Public Health Registrar. The presentation highlighted the following key points from the Annual Report -

- the NCMD received 3,347 child death notifications 1 April 2019 and 31 March 2020;
- there had been a decrease in the numbers of cases reviewed and closed nationally;
- "Perinatal/neonatal event", and "Chromosomal, genetic and congenital anomalies" combined represented over half (56%) of reviews completed. For 63% of deaths reviewed the child was aged under 1;
- 31% of the reviews identified one or more modifiable factors; and
- sudden, unexpected and unexplained deaths, deliberate injuries and trauma had the most modifiable factors identified

RESOLVED that the National Child Mortality Database Annual Report 2019/20 be received and noted.

9 **THE OLDHAM SIX-MONTH PLAN FOR COVID**

The Board received a presentation introduced by Katrina Stephens, Director of Public Health which set out what Oldham planned to do to contain Covid-19 over the next six months.

The presentation reflected on the efforts across Team Oldham and local communities to respond to the unprecedented challenge to life posed by Covid-19, with Oldham suffering some of the highest rates of infections and deaths in the country. A number of successes had been achieved by working together across Oldham and Greater Manchester, such as localised containment measures, improving Covid-safe practices across various settings and sectors, and supporting the most vulnerable. The impact of Covid and the measures to contain it in Oldham had already had far reaching impacts, and had exacerbated health, social and economic inequalities both within Oldham and between Oldham and the rest of the UK.

Looking ahead to the next six months, there were a number of challenges to overcome but through collective action and scientific developments it was hoped that a position could be reached where the virus no longer posed a significant risk. However, while Covid-19 continued to pose a very serious threat the Plan set out what Team Oldham will do to contain Covid-19 over the next six months. The Oldham Plan was based on the Greater Manchester Covid-19 Six-Month Plan, but contained specific detail about Oldham's response, setting out how an evidence-based approach would be taken through the assessment framework which had been developed, and how work would be undertaken within the Government's tiered

approach to contain Covid. Recognising the impacts that the containment measures have, the mitigations which will put in place over the next six months to support health, reduce social harms and protect the economy were also considered. The Plan also set out what will be done in terms of the rollout of a vaccine and testing to enable us to live with Covid in the longer term.

The presentation gave detailed consideration to the impact of Covid-19 in Oldham; the containing of Covid-19; communicating, engaging and activating our communities; mitigating harms; and living with Covid-19, setting out priorities and planned actions for the coming six months in each case.

It was noted that action would be required from national Government over the coming months to support the Oldham and GM response to control the spread of the virus and to provide the support our individuals, communities and businesses need to survive the next six months. It was also recognised that the socioeconomic implications of Covid-19 may only just be starting to be seen and packages of further support would be required to ensure that GM is able to recover from the virus and we can continue to tackle the inequalities within Oldham, and between Oldham and the rest of the UK.

RESOLVED that the Oldham Six Month Plan for Covid be noted.

10 **UPDATE ON NHS DEVELOPMENTS AND IMPACTS ON AND IN GREATER MANCHESTER**

Mike Barker, Chief Operating Officer introduced a presentation advising the Board of NHS developments over the coming months.

Considering the final quarter of 2020/21, given the Covid second wave and the new, more transmissible, variant of the virus, it was clear that the winter period would be another challenging time for the NHS and presented five key tasks of responding to Covid-19 demand; implementing the Covid-19 vaccination programme; maximising capacity in all settings to treat non-Covid-19 patients; responding to other emergency demand and managing winter pressures; and supporting the health and wellbeing of the workforce. Activities and programmes supporting each of these key tasks were advised.

Looking to 2021/22, national priorities would be on recovering non-Covid services; primary and community care; health inequalities; people and workforce; mental health; and integrating care. While the Government had announced further funding for the NHS for 2021/22 within the Spending Review, the Government would consider what additional funding would be required to reflect Covid-19 cost pressures once impacts were clearer. Locally, Oldham's health and care phase 3 recovery assessment had been established and a six month plan with eight priorities of cancer; elective; workforce; mental

health and learning disabilities; health inequalities; primary care; winter; and integrated care determined. Actions underway and planned to further address these priorities were outlined in the presentation.

A process for the transition to an integrated system model for health and social care during 2021/22 was advised, with a view to shadow running from September 2021. The presentation considered the vision and principles behind this development and the issues being considered in the development of new systems and arrangements. Key areas for focus in the period to March 2021 relating to governance options, the financial framework, the clinical and professional leadership model and framework, the determination of appropriate geographies for specific services and commissioning responsibilities, a detailed CCG functional analysis and People/HR implications, were noted.

The opportunity that the proposals presented to have a system wide approach to issues such as deprivation and health inequalities was noted, it being further observed that while Oldham had recently faced a number of challenges, these had been responded to by Oldham organisations speaking with one voice and working together.

RESOLVED that the update on NHS developments be noted.

11 **DATE OF NEXT MEETING**

It was noted that the next meeting of the Board was scheduled to be held on Tuesday, 23rd March 2020 at 2.00pm.

The meeting started at 2.00 pm and ended at 3.30 pm

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Report to HEALTH AND WELLBEING BOARD

Health and Wellbeing Board – terms of reference

Chair: Councillor Stretton

Officer Contact: Katrina Stephens, Director of Public Health

Report Author: Mark Hardman, Constitutional Services

23 March 2020

Purpose of the Report
A review of the Council Constitution was largely completed in 2020 and final matters, including a refresh of the terms of reference of the Health and Wellbeing Board, are being submitted to the Council meeting on 24th March 2021.

Requirement from the Health and Wellbeing Board
1. That the draft revised terms of reference of the Health and Wellbeing Board be noted and supported;
2. The terms of reference be further reviewed by the Board in March 2022.

Health and Wellbeing Board – terms of reference

1. Background

1.1 A review of the Council Constitution was largely completed in 2020. A small number of residual matters are to be presented at the meeting of the Council on 24th March 2021, including the terms of reference of the Health and Wellbeing Board. While a report considering both the role of the Board and the terms of reference was drafted following a Board Development session held in January 2020 for consideration at the meeting of the Board scheduled in March 2020, that meeting was cancelled due to the Covid situation, with submission then being held back due to a combination of Covid and possible consideration of governance developments around health and social care generally. However, with the conclusion of the Constitution review and future arrangements still under consideration, it is now timely to present the review of the Board's terms of reference.

2. Current Position

2.1 The terms of reference of the Health and Wellbeing Board are contained at Part 3 (Responsibility for Functions) in the Council Constitution. A refresh exercise, focused on updating and refining content as opposed to presenting revised arrangements, has been undertaken across the Council's Constitution. The current terms of reference for the Health and Wellbeing Board are those as determined on formal establishment in 2012. This has meant that subsequent organisational and governance developments impacting on the Board have not been acknowledged and that the terms of reference are silent on certain reporting arrangements that have been introduced.

2.2 It should be noted the proposals in the refresh exercise are intended, and are considered to be, neutral in their effect. However, issues arising from the review for the Board to note are -

a) The statutory functions of developing the Joint Strategic Needs Assessment (JSNA) and the Health and Wellbeing Strategy and of the promotion of integration are key elements of the terms of reference;

b) There are what might be regarded as secondary functions of the Board provided for in the Health and Social Care Act 2021 (the Act) that need consideration.
   - While commissioning plans as envisaged in the Act are now not required of the CCG by the Secretary of State, some commissioning plans are available through, for example, the joint health and social care commissioning arrangements with the Council. Some reporting of these might be undertaken, not least on the basis of the commitment given alongside the terms of reference of the Commissioning Partnership Board (CPB) to provide a quarterly update to the Health and Wellbeing Board, providing information on key issues considered over the last quarter, and issues on the horizon.
   - How the CCG would consult with regard to performance assessments and the annual report might be considered against what is already to be reported in the context of integrated commissioning.

c) The function of ensuring that the Council complies with its duties to improve public health further to s2B and 111 of the National Health Act 2006 can remain referenced in the terms of reference, but it would be suggested that this be discussed with Scrutiny and might be an issue for consideration going forward.

d) Prior to the Covid pandemic, the Secretary of State had determined that the Better Care Fund (BCF) Plan be signed-off by the Health and Wellbeing Board. While this can be referenced in revised terms of reference, how the BCF might be

considered in practice beyond just a sign-off might be an issue for further consideration.

e) The 'allocation' or assumption of some degree of governance in relation to, for example, Safeguarding Boards, the Child Death Overview Panel and the CPB are not reflected in the Terms of Reference and should be referenced in revised terms of reference.

f) With reference to the CPB and the need to initiate the quarterly reporting regime as indicated alongside that body's terms of reference, this might include updates on the Locality Plan which directs improvement in the health and care services in the Borough and so links directly with the statutory purpose of the Board in addressing the local population's health and wellbeing needs.

2.3 The proposed revised Terms of Reference for the Health and Wellbeing Board, as they would be presented in the Council's Constitution and which have been the subject of consultation with the Board Chair and Vice Chairs, are attached at Appendix 1.

2.4 On the grounds of good governance, it is suggested that the Health and Wellbeing Board receive and, if considered appropriate, review the terms of reference in March 2021 and on an annual basis thereafter.

3. Consultation

3.1 The Chair and Vice Chairs of the Board and the Council's Members' Constitution Working Group have been consulted on the content of this report.

4. Recommendation

4.1 The Health and Wellbeing Board is asked to

- note and support the draft revised terms of reference of the Health and Wellbeing Board;
- agree that the terms of reference be further reviewed by the Board in March 2021.

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APPENDIX

Health and Wellbeing Board

Draft revised Terms of Reference

1. To lead and co-ordinate system-wide actions, including those of the Council, NHS Oldham CCG and partners in assessing the health needs of the local population and to prepare and publish the statutory Joint Strategic Needs Assessment (JSNA) in accordance with s196 of the Health and Social Care Act 2012.
2. To lead and co-ordinate system-wide actions, including those of the Council, NHS Oldham CCG and partners in support of the preparation and publication of the Board's Health and Wellbeing Strategy in accordance with s196 of the Health and Social Care Act 2012.
3. Subject to direction by the Secretary of State, to approve submission of the Better Care Fund Plan to NHS England.
4. To encourage those persons and organisations holding responsibility for the commissioning or provision of any health or social care services in the Borough to work together in an integrated and/or partnership manner for the benefit of the local population.
5. To consider reports from the Commissioning Partnership Board on key issues, including the joint commissioning intentions of the Council and the CCG and the Locality Plan;
6. To be advised of further joint health and social care commissioning arrangements agreed and implemented between the Council and/or the CCG and/or other partners and be kept updated as to key issues arising.
7. To be consulted in relation to the CCG annual report and performance assessment in connection with s14Z of the NHS Act 2006.
8. To ensure that the Council complies with its duties to improve public health as set put in Sections 2B and 111 of the National Health Act 2006 as amended.
9. To undertake such oversight of local safeguarding arrangements as the Board considers appropriate and necessary.
10. To undertake, jointly with the Bury and Rochdale Health and Wellbeing Boards, such oversight of the Bury, Oldham and Rochdale Child Death Oversight Panel as the Board considers appropriate and necessary.

Report to HEALTH AND WELLBEING BOARD

Local Outbreak Management Plan Refresh

Chair: Councillor Stretton

Officer Contact: Katrina Stephens, Director of Public Health

Report Author: Katrina Stephens, Director of Public Health

23rd March 2021

Purpose of the Report
To update the Board on Oldham's Local Outbreak Management Plan for Covid-19, and share the refreshed version of the plan for the Board's consideration and feedback.

Requirement from the Health and Wellbeing Board
1. To consider and endorse the refreshed Local Outbreak Management Plan

Local Outbreak Management Plan Refresh

1. Background

1.1 Local Authorities (LAs) have an ongoing statutory responsibility to have Local Outbreak Management Plans (LOMPs) for responding to emergencies in their areas as part of their existing duty for safeguarding and protecting the health of their population. They were tasked by Government to produce specific plans by end of June 2020 in response to the ongoing COVID-19 pandemic.

1.2 Publication of the Government's Roadmap for exiting national lockdown, the accompanying refresh of the Contain Framework and an increasing focus on Variants of Concern (VOC) highlight the importance of LAs urgently reviewing and updating their Local Outbreak Management Plans in order to ensure they remain fit for purpose as well as aid national understanding. Effective planning and deployment at local level is the first line of defence and critically underpins the achievability of the Roadmap.

1.3 The Contain Framework sets out guidance as to what these plans should cover. Plans were produced across all Upper Tier Local Authorities and demonstrated comprehensive epidemiology approaches, married to planning across their area. These plans were then assured by NHS Test & Trace's Contain Division in August 2020.

1.4 In March 2021 all LAs were asked to review and update their Local Outbreak Management Plan to incorporate the learnings of the past nine months; plan for the next phase of the response; account for the associated funding; and reflect potential changes in local roles, responsibilities and resources. The refresh also presents an opportunity to identify and share good practice and to reflect developments since the original plans were produced, such as local contact tracing partnerships, enhanced contact tracing and the need to respond to Variants of Concern (VOCs).

2. Current Position

2.1 Oldham's Local Outbreak Management Plan has been reviewed and an updated version produced to take into account learning and key developments since June 2020, and in line with guidance provided by NHS Test & Trace for the refresh of plans.

2.2 The updated plan was shared with the Contain Regional Partnership Team on 12th March. NHS Test & Trace have acknowledged that the timeframe given for the refresh may not have allowed local systems to seek the necessary sign off for their plans through the appropriate governance structures. As such, there is still an opportunity to amend and further develop the plan in response to any feedback provided by the Board.

2.3 The Regional Partnership Team will now review our local plan in order to gather information about good practice, issues, risks and opportunities to inform discussions with central Government.

3. Recommendation

3.1 The Health and Wellbeing Board is asked to consider and endorse the refreshed Local Outbreak Management Plan.

Oldham COVID-19 Local Outbreak Management Plan:

March 2021

Table of Contents (complete at the end)

1. Glossary of Terms

Acronym	Full meaning
ADPH	Association of Directors of Public Health
CTAS	Contact Tracing and Advisory Service
DHSC	Department of Health and Social Care (DHSC)
DPH	Director of Public Health
GMICTH	Greater Manchester Integrated Contact Tracing Hub
JBC	Joint Biosecurity Centre
LFD	Lateral Flow Device
OMBC	Oldham Borough Council
PCR	Polymerase Chain Reaction
SCG	Strategic Co-ordination Group
SPOC	Single Point of Contact

2. Introduction

On 31 December 2019, the World Health Organization (WHO) was informed of a cluster of cases of pneumonia of unknown cause detected in Wuhan City, Hubei Province, China. The UK has been responding to a COVID-19 outbreak since 31st January 2020 when it was confirmed that a Level 4 National Incident has been declared for NHS England and NHS Improvement. On 11th March 2020 the World Health Organisation declared COVID-19 a pandemic.

The Oldham COVID-19 Outbreak Management Plan has been developed to meet national requirements for Local Outbreak Management Plans, as set out in the national COVID-19 Contain Framework. The Contain Framework sets out how national and local partners will work with the public at a local level to prevent, contain and manage outbreaks. Successful management of local outbreaks is a core element of NHS Test and Trace's ambition to break the chains of COVID-19 transmission to enable people to return to and maintain a more normal way of life.

This Local Outbreak Management Plan provides local direction and guidance to collectively manage and prevent the spread of COVID-19 across our communities, ensuring that preventative action is taken at an early stage and that local and national systems can work effectively in partnership to manage COVID-19. The plan supplements the existing Oldham Health Economy Outbreak Plan (2018) by providing specific management arrangements to effectively respond to the unique threats posed by the COVID-19 pandemic.

The GM Combined Authority and GM Health & Social Care Partnership have developed a COVID-19 Management Plan which follows the same principles as the local outbreak management plans in each of the 10 GM local authorities. The GM plan supports our local plans with clear approaches to collaboration, joint working and mutual aid through the Local Resilience Forum.

This document will continue to be reviewed and revised in response to changes in national requirements and advice, and to incorporate learning from implementation.

3. Aims, objectives, scope and principles

3.1 Aims

Our aim is to reduce the spread of COVID-19 through prevention, containment and suppression of outbreaks, and mitigate the impact of COVID-19 and the associated control measures on the local population.

3.2. Objectives of the Plan

- To provide an overview of the key control measures in place to contain and manage COVID-19, including testing, contact tracing and support for self-isolation
- Describe our approach to managing settings-based outbreaks, including those in vulnerable and high-risk settings and communities
- Describe our approach to managing enduring transmission and the structural inequalities which increase risk
- Outline the approach to surveillance using COVID-related data and other sources of information to monitor the extent and impact of COVID-19 infection across Oldham
- Outline measures to increase COVID vaccination uptake and reduce inequalities
- To provide an overview of local, regional and national responsibilities and how these teams will work together to deliver the plan
- Define governance, roles and responsibilities and command & control arrangements relating to COVID-19 management
- Set out communications and engagement arrangements with residents and partner organisations

3.3 Scope

The plan is to read in conjunction with the existing Oldham Health Economy Outbreak Plan (2018); it is not intended to duplicate or replace the existing plan.

The plan focuses on the key COVID-19 prevention and control arrangements, including vaccination and testing, in Oldham and the interface with the Greater Manchester COVID-19 Outbreak Control Plan and the national Contain Framework.

3.4 Principles of COVID-19 Management

The Association of Directors of Public Health (ADPH) has set out four principles for the design and operationalisation of local Outbreak Control Plans and arrangements, including local plans for contact tracing. These are stated below.

The prevention and management of the transmission of COVID-19 should:

- Be rooted in public health systems and leadership
- Adopt a whole system approach
- Be delivered through an efficient and locally effective and responsive system including being informed by timely access to data and intelligence
- Be sufficiently resourced

We will adopt and adhere to these principles throughout this plan and in its implementation.

4. Oldham approach to preventing and transmission of Covid-19

4.1 Community Testing

The DHSC have stated in their community testing guidance that up to a third of individuals who test positive for coronavirus have no symptoms at all and can therefore spread the virus unknowingly. As such Oldham have widened out the testing offer for those with no symptoms. This utilises lateral flow devices with rapid results in approximately 30 minutes ensuring that positive cases are identified at the earliest opportunity. This is connected into the national contact tracing system providing an opportunity for positive cases and their contacts to isolate and break the chain of transmission at the earliest point.

On the 18th January 2021, Oldham commenced targeted testing at scale for those that could not work from home, setting up 4 large tests sites for twice weekly routine testing. This programme of work has now been extended until the end of June 2021, and Oldham are moving towards a different model to significantly increase the number of testing sites at smaller venues that are better suited to meet the needs of residents. By having more sites spread across the borough, residents and those visiting Oldham for work, education or to see a loved one in a Care Home, will have greater choice, less travel and in many sites there will be bilingual staff supporting the self-swab model.

In addition to testing sites, we have an outreach testing and training provision to ensure that testing can be offered at large settings such as workplaces or community venues. We carry out the testing process on site whilst training the champions of those settings for a seamless handover. This is building a network of settings that can provide a sustainable model going forward. The settings are trained to be competent in basic infection, prevention and control, registering as a test site, registration for those attending, talking people through a self-swab, undertaking the analysis, interpreting the results and uploading of results to the national portal.

4.1.2 Symptomatic testing

Local Test Sites (LTS)

Oldham have established the locations of local test sites commissioned by DHSC to ensure that we minimising travel time for residents as much as is feasibly possible. Three LTS are currently in operation and plans underway to place a 4th site in Failsworth. The 3 static sites are situated in;

- Southgate Street Car Park, Centre of Oldham OL1 1DN
- Peel Street in Chadderton, OL9 9JX
- Honeywell Centre, Hadfield Street. Hathershaw, OL8 3BP

Although the national booking portal is in use, Oldham continues to work with DHSC to remove this process for those residents that find digital access a challenge and ensure that testing is available for those that have not been able to book via the portal.

4.1.3 Mobile Testing Units (MTU)

In addition to the static sites, mobile testing units are routinely used around the borough to ensure that wards with greatest travel distance or barriers in accessing a LTS have access to the MTU. Where data identifies areas of high transmission or low testing uptake, MTUs are strategically placed in these areas. Where larger outbreaks are identified, the MTUs move to the setting for proactive case finding.

4.1.4 Locally commissioned PCR testing

From the beginning of July 2020, Oldham commissioned a dedicated testing service to provide local testing from a clinical provider, ensuring that our local model meets the needs of the residents and core service, and flexible to changes in demand.

A key role of this service has been to offer door to door testing, alongside our community engagement teams, in areas of the borough where we have seen high case numbers/enduring transmission.

The commissioned service has also been providing routine asymptomatic PCR testing for health and social care staff, symptomatic testing for those working for Oldham Cares and staff providing system resilience at points of surge capacity. In addition to this, the commissioned service has provided pre-surgery testing and domiciliary support to a small number of residents that are unable to attend a test site or unable to undertake a self-swab though a home test/ postal kit.

Although new national testing programmes are replacing some of this local offer, we are retaining this local service to ensure we have flexible capacity to respond to outbreaks, and to support door to door testing.

4.1.5 Outbreak Management

Where high number of positive cases are identified within a setting, proactive testing/case finding is part of our outbreak response. Depending on the size and location of the setting we can deploy testing via our LTS sites, MTUs or via our locally commissioned service.

The locally commissioned service gives us flexibility to adapt our approach to meet local needs. For example, in a large workplace outbreak where language barriers existed and made it difficult for people to understand the instruction of how-to self-swab, our commissioned service were utilised for their clinical swabbing support. Likewise, in settings where self-swab became a challenge, such as early years settings, primary or special schools or in older more vulnerable adults the commissioned service were utilised.

4.2 Contract Tracing

4.2.1 Local Tracing Partnership (tier2)

When an individual tests positive for COVID-19 they were first notified by text or email from NHS Test and Trace instructing them to isolate. The national contact tracing tier 2 team receive information about all positive cases and attempt to contact to ensure that isolation requirements are understood and to acquire a list of contacts that the positive case has been in contact with 2 days prior to symptom onset (or test date if there were no symptoms). If after 48hours, the national team have failed to make contact or been unable to acquire the

contacts, the cases are securely passed to the Local Authority. Oldham Council only receives details of cases who are Oldham residents.
Trained contact tracers have made significant progress in making contact with residents that the national team have been unable to contact. Where required bilingual contact tracers are available. The phone call includes instruction to isolate and asks for information of contacts, but in addition to this Oldham staff use this call as an opportunity to check if individuals have any support needs such as food deliveries or prescription collections for those without a local support network. In addition to this the team are also able to connect individuals into isolation payments for those that are eligible.

The team prioritises contact tracing for any cases that has been identified as a variant of concern and will escalate these cases immediately to the director of public health.

The GM Integrated Contact Tracing Hub (GM ITCH) serves as a resilience hub to support surges in demand that exceed local capacity utilising expertise and capacity from the Greater Manchester Fire and rescue service.

4.2.2 Tier 1

As part of the national test and trace service, contact tracing which involves complex settings, groups or individuals requiring local knowledge will be automatically passed to the GM Integrated Contact Tracing Hub (GM ICTH). This complex contact tracing is referred to as tier 1 and is locally lead. Cases that relate to an Oldham setting are passed to the Local Authority daily for contact tracing that can commence without delay. The notifications are received through the Single Point of Contact (established within the Oldham Public Health team). The team have developed a standard operating procedure that details escalation routes and key officers for each of the specific settings identified. This function of a SPOC also serves to escalate notifications to GM, particularly those that are across geographical boundaries within Greater Manchester.

4.2.3 Local Resilience

Oldham tier 1 and tier 2 serve different functions, with tier 2 supporting cases and tier 1 supporting complex settings, but both come together under the contact tracing steering group to share local intelligence and build local resilience. Over the coming months both teams will be trained to a high standard of contact tracing for both tier 2b and tier 1 to offer additional resilience to the local system.

4.3 Support for Self-isolation

Oldham Council has produced a range of materials for the public informing them about the self-isolation rules and regulations, and highlighting that self-isolation, after testing positive is required by law to prevent the transmission of Covid-19. Communication materials also raise awareness of how individuals and families can continue to shop online, receive food, household items and medical prescriptions to their doors as well as apply for financial support.

A self-isolation toolkit has been published on Oldham Councils website which includes a detailed guide on ‘how to’ self-isolate, comprehensive information about the available testing centres and the range of financial support available to self-isolating residents.

Since the onset of the pandemic, increased financial support has been made available to those in financial crisis (including as a result of COVID, fleeing domestic violence, loss of employment) via additional funding by the Local Welfare Provision Scheme, This provides essential items such as carpets/beds and bedding/white goods and furniture and now includes a COVID protection pack (face mask/anti-bacterial gel and spray) for all adults in households eligible for support

As poverty is a real concern in Oldham, we have prioritised supporting our residents to access food and fuel throughout the pandemic. Food vouchers and welfare support has been routinely offered to families over the school holidays for low income families with children and young people. Individuals and families were also offered support with fuel via the Warm Homes team direct including crediting of pre-payment meters and provision of boiler repair/replacement service

The Council has adapted and widened its Discretionary Test and Trace Support Payment eligibility criteria from 1 February 2021 to overcome barriers to self- isolation

Over the next 6 months we will work with the Welfare Rights and financial inclusion team to support those claiming Test and Trace Support Payments with comprehensive support about maximising benefits and budgeting support

4.4 High-risk settings, communities and locations

4.4.1 High-risk places, locations and vulnerable communities have been identified and considered in the development of this plan and in local standard operating procedures. Our approach to prevention and management involves close collaboration between the Single Point of Contact (Public Health Team), Environmental Services, our Helpline and five place-based teams and specialist services working in some of these high-risk locations. This ensures that our approach is rooted in our communities, and that we can mobilise support and resources across the borough in response to outbreaks.

The NHS Test and Trace service notifies the GM Contract Tracing Hub to undertake contract tracing which involves high risk settings or individuals requiring additional support.

We have established relationships with local high-risk settings which has ensured that they are aware of local arrangements and we encourage them to contact the Oldham Single Point of Contact as soon as they become aware of a case in their settings. This is to ensure that a swift response can be mobilised ahead of any notifications being communicated from the national team to Greater Manchester.

These measures are supplemented by weekly review of the common exposure data to identify COVID-19 hotspots and proactively deploy prevention measures.

4.4.1 Schools

All schools in Oldham have been provided with advice and guidance via written materials and online briefings/webinars. A resource pack has been developed including flow charts for notifications, actions to take in school if a child or staff member test positive for COVID-19 including sample letters for parents and carers. Training and advice have been provided in the correct use of personal protective equipment (PPE) and infection control measures by local Infection Prevention and Control Nurses.

To safeguard the health of the teaching workforce and keep as many staff, pupils and students in school and college as possible, rapid lateral flow COVID-19 tests are available to

schools and colleges. The use of rapid lateral flow tests will identify individuals with COVID-19 who do not have symptoms, which make up around a third of all cases. These are available to all staff, secondary school pupils and FE students.

If a child or staff member in an educational setting tests positive for COVID-19, and diagnosis has been confirmed, then the school informs Oldham Council public health team by completing an online notification form. The Council's Education and Public Health teams are working closely together to support schools to respond to cases and outbreaks. All schools have been recommended to complete the form as soon as they become aware of a case in their setting. This is to ensure that a swift response can be mobilised ahead of any notifications being communicated from the national team to Greater Manchester. They have also been recommended to contact the Oldham Single Point of Contact directly if there are any queries or concerns. The online form directly feeds into a school COVID-19 log which enables us to monitor local cases and identity sibling links between schools to support the identification of outbreaks and highlight priority areas for support and advice on prevention and management.

4.4.2 Care Homes

A dedicated support team for care homes (STICH) is in place to provide support to care homes in the prevention and management of COVID-19, including the provision of testing. This team works in collaboration with local infection prevention and control nurses/Health Protection Team to deliver regular training and advice on infection prevention, and to respond to any cases of COVID-19 in care home staff or residents. Care homes are able to access PPE supplies through the local hub. Daily calls are made to care homes to discuss support needs and deploy resources accordingly.

Figure 1 and Figure 2 show the national testing arrangements for care home at the time of this update.

Figure 1: Care home regular testing policy

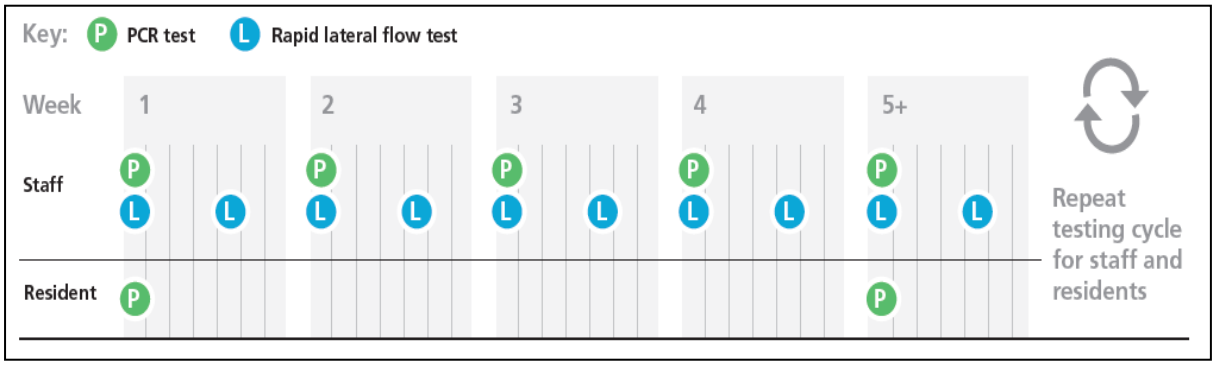
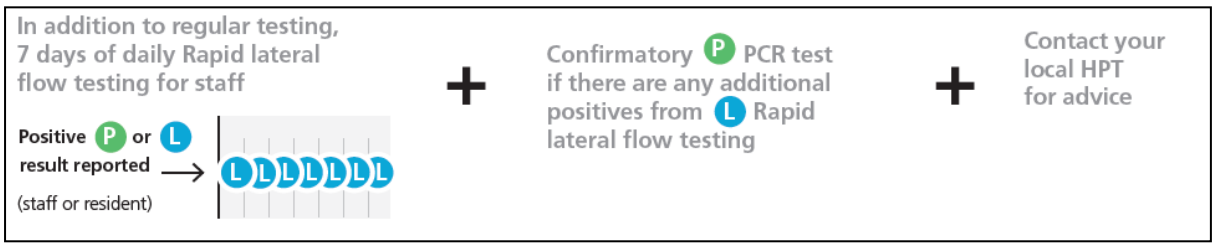


Figure 2: Care home rapid testing policy in an outbreak



The prevention, control and management of outbreaks in care homes is through the pre-existing Health Protection Team, plans and existing communication channels. These were already tried and tested for care home outbreaks for other infectious diseases (such as influenza), but have been scaled up and further developed to meet the increased demands of COVID-19 (for example recruitment of additional infection prevention and control nurses).

4.4.3 Section 6 and Appendix 7.4 provide more detailed guidance on the local arrangements for the management and control of outbreaks in specific settings such as schools, care homes and hospitals.

4.5 Compliance and enforcement (COVID secure)

4.5.1 In April 2020 the GM Covid-19 Compliance Group was created to establish a consistent approach to compliance across GM. Oldham representatives (Council and Police partnership) attend the GM Group and report to the local TCG with a focus on:

- Communicating and engaging with the community and local businesses to educate them on the restrictions in place and undertaking compliance visits to premises.
- Regularly meeting with partners, educational settings and local businesses to ensure the wider population is aware of, and engaged in, complying with
- Working closely with communications and engagement teams to secure insights from across our population are in place to inspire and change behaviours
- Carrying out multi-agency enforcement across the Borough using the Engage, Explain, Encourage and Enforce approach

4.5.2 Additional funding has been allocated to spend on compliance and enforcement of regulations. In Oldham we are continuing to focus on:

- Checking COVID-19 secure arrangements are in place in premises and engaging businesses about what more they can do, or ensuring premises are closed.
- Providing bespoke advice to businesses each time the restrictions are changed.
- Working closely with the police to communicate and engaging with the community and local businesses to educate them on the restrictions in place, and undertaking compliance visits to premises.
- Regularly meeting with partners, educational settings and local businesses to ensure the wider population is aware of, and engaged in, complying with restrictions.
- Working closely with communications and engagement teams to secure insights from across our population are in place to inspire and change behaviours. To include a focus on promotion of handwashing, face coverings and maintaining space
- Carrying out multi-agency enforcement across the Borough using the Engage, Explain, Encourage and Enforce approach.
- Promotion of NPIs like handwashing, face coverings and maintaining space

4.6 Surveillance, data integration and information sharing

Data to inform COVID-related surveillance and intelligence are crucial to identifying COVID-19 hot spots and outbreaks and monitoring impact of local response.

A local dashboard has been developed to regularly share data and intelligence through our COVID-19 governance structure and inform decision making. The dashboard includes latest data on cases, testing, outbreaks, hospitalisations, deaths, vaccinations and wastewater

testing. Variation by age, ethnicity, gender and area of residence is considered to shape our approach to reducing inequalities.

Officers from public health, environmental health, business intelligence and district teams meet weekly to review latest data on cases, clusters and outbreaks and share formal and informal intelligence on the current situation. Data used includes:

- Positive case employment data
- Contact tracing employment data
- PHE Common exposures analysis
- Local intelligence from our engagement and place-based teams

This ensures that any increase in cases is identified quickly and an appropriate response mobilised for example testing, engagement or enforcement.

The legislative framework supporting data sharing relating the management of the COVID-19 pandemic is the notice under regulation 3(4) of the Health Service Control of Patient Information Regulations 2002 which allows healthcare organisations, GPs, local authorities and arm's length bodies to share information to support efforts against coronavirus (COVID-19).[1]

Intelligence teams across Council, NHS, and other public sector organisations such as the Police, regularly share data to support the COVID-19 response (in line with the legislative framework).

4.7 Communication and engagement, including community resilience and promotion of key messages

A multi-channel communications and engagement plan has been developed to support the prevention and control of COVID-19. This plan includes providing information and advice on how to prevent the spread of COVID; action to take in response to symptoms and cases; how to access testing; how to access the vaccine and the importance of getting vaccinated; and how to access support during self-isolation and/or shielding.

Critical to our local plans is ensuring that we work alongside local communities to listen to and understand their needs and concerns and develop our approach accordingly. An approach to developing a network of community champions is underway with the Department of Health and Social Care, while the engagement and communications approach is also informed by and delivered in conjunction with Oldham's Equalities Advisory Group for COVID-19, in order to help inform and shape our work.

4.8 Governance

4.8.1 As the pandemic has evolved, we have refined local governance arrangements to meet the ever-changing requirements of COVID-19 to adequately meet the needs of the local population and align local arrangements with regional and national ones.

Our Strategic Coordination Group fulfils the role of the Health Protection Board, and meets twice weekly to oversee the local response to COVID-19. The Health and Care System Group coordinates the response to COVID from the Health and Care system, as well as being the co-ordinating vehicle for the development of a new integrated care system. Both these groups

[1] Coronavirus (COVID-19): notification to organisations to share information.

are supported by a range of thematic groups which lead the day to day delivery of the Local Outbreak Management Plan and wider system response.

Both the Strategic Coordination Group and the Health and Care System Coordination Group report to the Strategic Response and Recovery Board which is Elected Member led and fulfils the role of the Local Outbreak Control Board for public engagement and community leadership, as well as providing assurance and input from across the local system to guide and shape the design and delivery of local plans.

4.8.2 Oldham System Response & Recovery Board

- Responsible for overseeing the overall strategic response covering the breadth and depth of those issues needed to respond as a whole borough to the pandemic, including transition, recovery and transformation.
- This group will be jointly chaired by the Deputy Leader of the Council and Portfolio Lead for COVID-19 and the Cabinet member for Health and Social Care.
- Professional support to the board will be provided by the Council Strategic Director of Reform.
- Specialist advice and expertise related to the Contain Framework and Local Outbreak Management Plan will be provided to the Board by the Director of Public Health.
- Membership includes Leader of the Opposition, Chair of Health and Wellbeing Board, Council Deputy Chief Executive, Strategic Director of Health and Resources, DASS, DCS and senior representatives from across the partnership including GMP, GMFRS, Northern Care Alliance, Schools and colleges, VCSFE and Housing providers. Briefings will continue to Cabinet in support of the work of this Board.

4.8.3 The Strategic Response & Recovery Board will be supported by three groups as follows:

- **The Strategic Coordination Group:**

This will fulfil the duties of the health protection board and strategic coordination group outlined within government guidance:

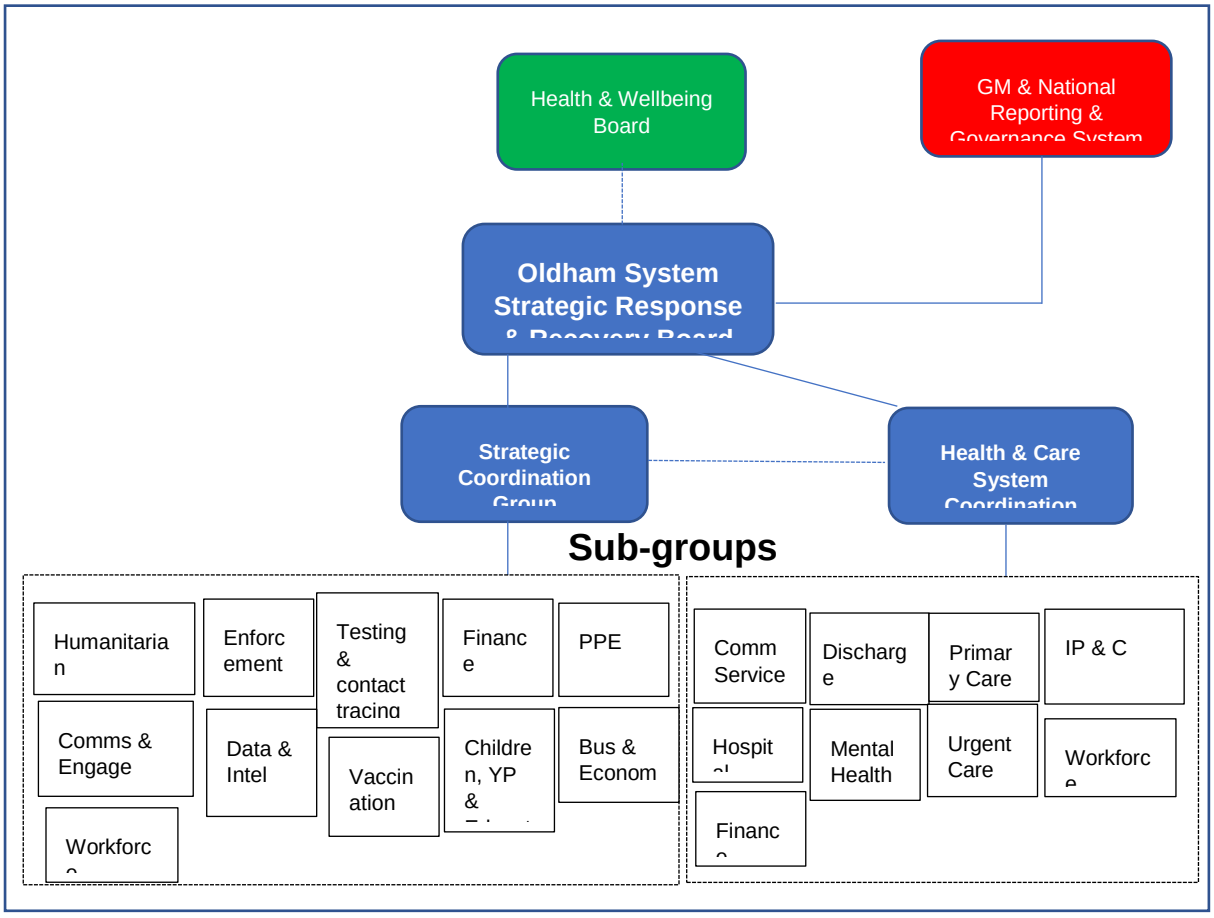
I. Accountable to the Oldham System Strategic Response & Recovery Board
II. Responsible for overseeing a number of Sector Response Groups (see **Error! Reference source not found.** above)
III. Managing the interdependencies between the Sector Groups
IV. Ensuring effective engagement with GM and national governance
V. Chaired by the Strategic Director of Reform on behalf of the Chief Executive with the Director of Public Health acting as Deputy
VI. Meeting twice weekly

- **The Health & Care System Co-ordination Group:**

I. Accountable to the Oldham System Strategic Response & Recovery Board
II. Responsible for overseeing a number of Sector Response Groups (see Figure 1 below)
III. Managing the interdependencies between the Sector Groups
IV. Ensuring timely reporting to the national bodies as required

V. Will also act as the co-ordinating vehicle for the development of a new integrated care system
VI. Jointly Chaired by the Strategic Director of Health & Resources and the Chief Clinical Officer
VII. Meeting twice weekly

Figure 1: Oldham COVID-19 Governance Arrangements (March 2021)



4.9 Resourcing

During the pandemic we have built additional capacity for testing, contact tracing and community engagement within the local system. We will use Contain Outbreak Management Funding to continue this work over the coming year. Where we have entered into new contracts for COVID-19 (for example community testing) we have done so in a way which gives the flexibility needed to adapt our approach over the coming months as the next phase of the pandemic evolves.

Our local approach has also required all members of #TeamOldham to be flexible and take on new roles. Balancing the ongoing demands of managing COVID-19 alongside business as usual activity will continue to present a challenge, particularly in an environment where significant savings also need to be achieved across the public sector and demand on services is rising. COVID-19 has also had some positive impacts in the forming of new partnerships and development of new ways of working which will continue to be of benefit into the future.

Our governance arrangements, and relationships between organisations and with local communities, enable us to work together collaboratively as a whole system to maximise our impact and achieve best use of resources.

4.10 Variants of concern

Our well-developed arrangements for hyperlocal testing and community engagement mean we are well placed to respond to variants of concern and variants of interest.

Our approach would be tailored to the situation and the communities affected, but would involve:

- Enhanced sequencing (with support from national system)
- Enhanced surveillance through wastewater testing
- Enhanced contact tracing, supported by the Greater Manchester Integrated Contact Tracing Hub and the regional PHE team, and ensuring good performance of test, trace & isolate systems.
- Community engagement through our door to door engagement teams, community champions, partnership working with voluntary, community and faith sectors, and with local community anchor organisations such as schools and housing providers
- Communications activity tailored to the target population using local channels such as private what's app and facebook groups, in addition to mainstream media and social media channels.
- Surge testing, through a combination of local testing sites, mobile testing units, door to door testing, and use of the national 'postcode push' system

4.11 Covid-19 Vaccination Programme

4.11.1 The Government plan for vaccines included a programme comprising 1) mass vaccination sites run by Regional NHS Teams and 2) local sites run by Primary Care Networks under nationally agreed Directly Enhanced Service contracts.

4.11.2 The national rollout plan was executed at rapid pace and the priority for rollout was set nationally by the JCVI, which advises that the first priorities for the COVID-19 vaccination programme should be the prevention of mortality and the maintenance of the health and social care systems. As the risk of mortality from COVID-19 increases with age, prioritisation is primarily based on age. The order of priority for each group in the population corresponds with data on the number of individuals who would need to be vaccinated to prevent one death, estimated from UK data obtained from March to June 2020.

- residents in a care home for older adults and their carers
- all those 80 years of age and over and frontline health and social care workers
- all those 75 years of age and over
- all those 70 years of age and over and clinically extremely vulnerable individuals
- all those 65 years of age and over
- all individuals aged 16 years to 64 years with underlying health conditions which put them at higher risk of serious disease and mortality
- all those 60 years of age and over
- all those 55 years of age and over
- all those 50 years of age and over

Achieving a high coverage across all population groups will contribute to reducing COVID-19 risks in the population and the associated inequalities.

In terms of mass vaccination centres, this is organized at Greater Manchester level and is located at the Etihad Stadium. Uptake by Oldham residents of the Etihad facility is only just starting to become known to the Oldham system as this is a nationally run programme and usage broken down by residents within each of Oldham's five Primary Care Networks is as follows:

- South Central: 4.39% of people from this area have had their vaccine at the Etihad facility
- North Central: 4.45%
- West: 9.04%
- South: 14.92%
- North: 9.06%
- East: 18.86%

4.11.3 The Oldham vaccination programme was set up as operational from 6 sites within the five Primary Care Networks. It was first launched on 14 December 2020 in Glodwick in South Central PCN followed later that week in North PCN (Royton Health & Wellbeing Centre) and West PCN (CH Medical), then between Christmas and New Year at South PCN (Failsworth) and then in January at North Central PCN (ICC Building) and then East PCN (Moorside Medical Centre). During the course of February and early March additional 'pop-up' clinics have also been held at Greengate Street Mosque, the EIC Centre and Millennium Centre all of which have been targeted at encouraging greater levels of update in our BAME communities.

In terms of uptake figures progress, the following table (Table 1) shows the key headlines. In summary, so far more than 76,000 vaccines have been administered – more than 90% taken up by those over 80 years old; more than 90% by those over 75 years of age; around 80% by those over 70 years of age and clinical extremely vulnerable; and around 85% of those over 65 years of age.

Table 1: Number of Vaccines by Cohort

Cohort ID	Cohort Description	Registered Po..	Oldham Regis..	% of 1st dose..	Oldham Regis..	% of 2nd dose..
1	Care Home Residents	1,371	1,218	88.84%	6	0.44%
2	80+	8,939	8,296	92.81%	2,050	22.93%
3	75+	7,644	7,145	93.47%	203	2.66%
4	70+ & CEV	21,793	17,280	79.29%	151	0.69%
5	65+	9,934	8,426	84.82%	69	0.69%
6	16-64 UHC	29,621	15,833	53.45%	261	0.88%
7	60+	6,846	3,020	44.11%	67	0.98%
8	55+	9,793	2,679	27.36%	119	1.22%
9	50+	11,316	2,433	21.50%	122	1.08%
10	16-49	94,367	9,713	10.29%	376	0.40%
Other	Non Eligible Population	58,805	242	0.41%	18	0.03%
Grand Total		260,429	76,285	29.29%	3,442	1.32%

Table 2 below shows a break down by Ward across Oldham which shows the lowest uptake for Cohorts 1-6 can be seen in Werneth, Coldhurst and St Mary's Wards with the highest uptake in Crompton, Saddleworth and Royton Wards.

Table 2: Breakdown by Ward for Cohorts 1-6

Vaccination Uptake By Ward - Cohort 1-6

Ward Name	Population	Vaccinated	% Vacc
Crompton Ward	4,024	3,498	86.90%
Saddleworth South Ward	3,814	3,313	86.90%
Royton North Ward	3,814	3,307	86.70%
Royton South Ward	3,888	3,307	85.10%
Saddleworth North Ward	3,610	3,051	84.50%
Shaw Ward	3,522	2,935	83.30%
Saddleworth West and Lees Ward	3,979	3,225	81.10%
Mossley Ward	2,275	1,793	78.80%
Chadderton Central Ward	3,340	2,462	73.70%
Failsworth East Ward	3,240	2,357	72.70%
Chadderton North Ward	3,373	2,412	71.50%
Failsworth West Ward	3,154	2,241	71.10%
Chadderton South Ward	3,177	2,233	70.30%
St. James' Ward	3,675	2,496	67.90%
Waterhead Ward	4,006	2,522	63.00%
Hollinwood Ward	4,020	2,494	62.00%
Alexandra Ward	4,065	2,395	58.90%
Medlock Vale Ward	4,213	2,360	56.00%
St. Mary's Ward	4,361	2,422	55.50%
Coldhurst Ward	3,787	2,082	55.00%
Werneth Ward	3,971	1,836	46.20%
Total	**77,308**	**54,741**	**70.81%**

4.11.4 Now we have vaccinated a significant number of our residents, we are starting to clearly see and understand the impact and correlation between deprivation and ethnicity and this is being looked at in detail by our Equalities Advisory Group. Table 3 below shows the correlation between ethnicity and the Index of Multiple Deprivation and it is clear that uptake rates are higher for every ethnic group in the most more affluent areas.

Table 3: Vaccine Uptake across Ethnicity & IMD

		IMD Decile									
	Ethnicity	10	9	8	7	6	5	4	3	2	1
Highest Population	British	89%	87%	85%	83%	79%	76%	76%	72%	69%	68%
	Pakistani	64%	60%	55%	48%	46%	39%	50%	39%	47%	40%
	Any other white backgrou..	92%	85%	86%	76%	69%	57%	60%	50%	49%	44%
	Bangladeshi	46%	69%	45%	47%	48%	51%	49%	50%	48%	47%
	Not stated	87%	83%	86%	68%	61%	52%	61%	55%	45%	60%
	Any other ethnic group	89%	81%	81%	80%	65%	63%	58%	58%	55%	46%
	Null	73%	66%	66%	59%	42%	37%	34%	39%	27%	35%
	Irish	89%	85%	88%	83%	84%	77%	75%	68%	61%	68%
	Indian	84%	67%	79%	81%	84%	76%	84%	68%	71%	75%
	African	75%	64%	86%	40%	53%	51%	41%	42%	44%	38%
	Any other Asian backgrou..	100%	42%	57%	61%	46%	46%	46%	64%	40%	38%
	Caribbean	81%	100%	53%	67%	73%	59%	59%	55%	67%	59%
	White and Black Caribbean	78%	33%	77%	75%	61%	55%	64%	36%	58%	60%
	White and Black African	100%	86%	71%	43%	32%	44%	22%	37%	26%	40%
	Chinese	69%	77%	71%	56%	73%	40%	59%	50%	75%	75%
	Any other mixed backgrou..	100%	73%	43%	50%	31%	50%	45%	43%	35%	33%
Smallest Population	Any other Black backgrou..	88%	64%	71%	33%	43%	19%	60%	24%	24%	32%
	White and Asian	100%	100%	56%	60%	67%	50%	57%	38%	40%	42%
		Least Deprived									Most Deprived

4.11.5 Measures to improve vaccine uptake locally

The next phase of rollout will continue to move down the Cohort list but will focus on supplementing the existing PCN clinics through a number of tactics as follows:

- Additional clinics run in hyper-local community facilities such as Mosques with community activists supporting and advocating for members of their own community
- A consistently applied methodology for call and recall and call back for those not reached in the first contact call for vaccination with an escalation process that results in a call from your doctor for patients who have not taken up the offer
- A sustained community engagement programme encompassing community engagement teams doing door to door myth busting, interpreting where there are language barriers and organising community transport where there are needs
- A highly targeted communications campaign that focuses on continued myth busting with specific parts of the community but also promotes and nudges behaviour for uptake

4.12 Enduring transmission

Oldham has experienced relatively high rates of COVID-19 throughout the pandemic, driven by structural inequalities such as deprivation, housing, and employment patterns. COVID-19 has exacerbated inequalities and disadvantage which already existed in the population related to gender, race, age and income, and has meant that the local population has been particularly adversely affected by COVID-19 and the measures to control it. Specifically, we know that challenges for our population have included:

- Impact of self-isolation on income and job security
- Digital and language barriers to accessing national test and trace systems
- In large multi-generational households a higher number of people are potentially exposed as a consequence of a case within the household
- Higher proportion of working age population in public facing roles, jobs where working from home is not possible or working in higher risk settings, where potential for transmission is greater
- Implementing COVID secure measures in small – medium sized businesses where space and resources are more limited

These structural inequalities and enduring risks for transmission remain, and as such the challenge for Oldham in managing COVID will continue to be significant. In this context our focus on COVID-19 and level of activity across all the themes identified in this plan, will continue to be greater than in areas which do not have these risks.

Ensuring all elements of our COVID-19 response has an explicit focus on reducing inequalities and providing additional support to communities which have been most significantly impacted will be central to our approach, including:

- Community champions programme
- Door to door community engagement
- Outreach testing in areas of lower uptake including door to door testing, and testing in faith settings
- Community vaccination clinics in trusted venues supported by community groups and organisations
- Support for high risk businesses to prevent and manage outbreaks and implement COVID-secure measures, for example through discretionary business grants (e.g. support for the taxi trade to fit screens)

- Targeted communications activity supported by community members and using private channels/groups such as Whatsapp.
- Our 'We are Oldham' campaign focuses specifically on the additional risk that Oldham faces in controlling COVID-19 as lockdown eases and the part that everyone in the borough can plan in reducing transmission.
- Support for self-isolation including widening of criteria for discretionary self-isolation payments. We will be reviewing update of at home testing among secondary school and college students to identify where additional targeted support is needed to increase uptake and putting plans in place accordingly

5. Response to cases and management of outbreaks

5.1 Covid19 symptoms

The most common symptoms of coronavirus (COVID-19) are recent onset of a new continuous cough or a high temperature or a loss of, or change in, normal sense of taste or smell (anosmia).

Other symptoms include:

- aches and pains.
- sore throat.
- diarrhoea.
- conjunctivitis.
- headache.
- difficulty breathing or shortness of breath.
- chest pain or pressure.

However, evidence shows that approximately 40% to 45% of infected individuals do not show any symptoms.[2]

- **Incubation period**: Range 4 to 6 days, with the shortest recorded incubation of 1 day, and longest of 11 days.
- **Infectious period**: 48 hours before onset of symptoms until 7 days from onset of symptoms.

5.2 Case definitions

5.2.1 Possible case

Patients who are well enough to remain in the community with:

- New continuous cough, **OR**
- High temperature, **OR**
- Loss of, or change in, normal sense of taste or smell (anosmia)

Inpatient case definition

[2] Oran D.P and Topol R.J. Prevalence of Asymptomatic SARS-CoV-2 Infection - A Narrative Review. Ann Intern Med. 2020 Jun 3 : M20-3012. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7281624/

- Patient requiring admission to hospital (a hospital practitioner has decided that admission to hospital is required with an expectation that the patient will need to stay at least one night), and have either clinical or radiological evidence of pneumonia, **OR**
- Acute respiratory distress syndrome, **OR**
- Influenza like illness (fever ≥37.8°C and at least one of the following respiratory symptoms, which must be of acute onset: persistent cough (with or without sputum), hoarseness, nasal discharge or congestion, shortness of breath, sore throat, wheezing, sneezing, **OR**
- Loss of, or change in, normal sense of taste or smell (anosmia) in isolation or in combination with any other symptoms

5.2.2 Confirmed case

A positive test from a PCR (polymerase chain reaction) test. A positive test from a LFD (lateral flow device) test conducted under the supervision of an ATS site or registered site. A positive LFD test result from a home test kit is not confirmation of a positive case and a PCR test must be taken.

5.2.3 Contacts

A contact is a person who has been in a close proximity to a confirmed case from **48 hours** before onset of symptoms (or test if asymptomatic) to **10 days** after onset of symptoms (or date of testing).

A person who has been trained in wearing PPE and wears appropriate PPE or maintains appropriate social distancing (over 2 meters) would not be classed as a contact.

- **Household contact:** A person who lives with or spends significant time in the same household as a possible or confirmed case of coronavirus (COVID-19). This includes living and sleeping in the same home, anyone sharing kitchen or bathroom facilities, or sexual partners.
- **Direct contact without PPE:** Face to face contact with a case for any length of time, within 1m, including being coughed on, a face to face conversation, unprotected physical contact (skin to skin) or travel in a small vehicle with a case. This includes exposure within 1 metre for 1 minute or longer
- **Proximity contact without PPE:** Extended close contact (between 1 and 2 metres for more than 15 minutes) with a case.

5.2.4 COVID-19 outbreak definitions and declarations (residential and none-residential)

Table 1 provides the definition of an outbreak in non-residential settings and includes the criteria to assess recovery and declare the end of an outbreak. This definition is consistent with the WHO outbreak definition.

A cluster definition is also provided to capture situations where there is less epidemiological evidence for transmission within the setting itself and there may be alternative sources of infection; however, these clusters would trigger further investigation.

Table 1: Declaring and ending an outbreak and cluster in a non-residential setting

Type	Criteria to declare	Criteria to end
Cluster	Two or more confirmed cases of COVID-19 among individuals associated with a specific setting with onset dates within 14 days (In the absence of available information about exposure between the index case and other cases)	No confirmed cases with onset dates in the last 14 days
Outbreak	Two or more confirmed cases of COVID-19 among individuals associated with a specific setting with onset dates within 14 days AND ONE OF: Identified direct exposure between at least two of the confirmed cases in that setting (e.g. within 2 metres for >15 minutes) during the infectious period of the putative index case **OR** Absence of alternative source of infection outside the setting for initially identified cases when there is no sustained community transmission or equivalent Joint Bio-Security Centre (JBC) risk level	No confirmed cases with onset dates in the last 28 days in that setting (higher threshold for outbreaks compared to clusters)

5.2.5 Outbreak definition for residential settings

Table 2 provides a broader definition of an outbreak in residential settings. This definition differs from the definition for non-residential settings because COVID-19 is known to spread more rapidly in residential settings, such as care homes and places of detention, therefore a cluster definition is not required.

Table 2: Declaring and ending an outbreak and cluster in an institutional or residential setting, such as a care home or place of detention

Type	Criteria to declare	Criteria to end
Outbreak	Two or more confirmed cases of COVID-19 OR clinically suspected cases of COVID-19 among individuals associated with a specific setting with onset dates within 14 days	No confirmed cases with onset dates in the last 28 days in that setting

	NB. If there is a single laboratory confirmed case, this would initiate further investigation and risk assessment.	

5.2.6 Table 3 provides a broader definition of outbreaks in either in-patient and out-patient settings.

Table 3: Declaring and ending an outbreak in an inpatient setting such as a hospital ward or ambulatory healthcare services, including primary care

Type	Criteria to declare	Criteria to end
Outbreak in an inpatient setting	Two or more confirmed cases of COVID-19 OR clinically suspected cases of COVID-19 among individuals associated with a specific setting with onset dates 8-14 days after admissions within the same ward or wing of a hospital. NB. If there is a single laboratory confirmed case, this would initiate further investigation and risk assessment.	No confirmed cases with onset dates in the last 28 days in that setting (higher threshold for outbreaks compared to clusters
Outbreak in an outpatient setting	Two or more confirmed cases of COVID-19 among individuals associated with a specific setting with onset dates within 14 days AND ONE OF: Identified direct exposure between at least two of the confirmed cases in that setting (e.g. within 2 metres for >15 minutes) during the infectious period of the putative index case OR Absence of alternative source of infection outside the setting for initially identified cases when there is no sustained community transmission or equivalent Joint Bio-Security Centre (JBC) risk level	No confirmed cases with onset dates in the last 28 days in that setting

5.3 Outbreak Management: Actions, Roles and Responsibilities

The Director of Public Health will have the responsibility for declaring and managing local outbreaks in consultation with PHE North West and GM Integrated Contact Tracing Hub, and in line with the definitions above.

Notifications of cases and/or outbreaks will come either via local reporting direct to the Oldham Single Point of Contact, or via the GM ICTH to the Oldham SPOC.

The Director of Public Health (or designated deputy) will convene the Outbreak Control Team (OCT) including members of the local Strategic Coordination Group (Health Protection Board), plus representatives related to the particular setting and/or community where the outbreak has occurred.

5.4 Outbreak Control Team

There are occasions when an OCT may be formed at a local level to bring together key services to manage an outbreak and to minimise or prevent transmission of COVID-19. The following section sets out some scenarios where this approach may be considered.

5.4.1 For care home settings, the investigation will be led by the local health protection team unless there are particular issues such as:

1. High number of deaths
2. The outbreak has been ongoing despite usual control and infection control measures
3. There are concerns on the safe running of the setting or institution
4. There are other factors that require a wider range of partners to be involved or escalation to the GM SCG which would prompt the setting up of a multi-agency OCT

5.4.2 For schools, the initial investigation would be led by the Local Authority SPOC in which the workplace is located, and would be escalated to GMICTH where necessary. The below issues will influence whether an OCT is required and if a joint response needs to be mobilised:

1. There has been a death in the setting
2. There are a large number of vulnerable people (e.g. special educational needs unit)
3. There are a high number of cases
4. The outbreak has been ongoing despite usual control and infection control measures
5. There are concerns on the safe running of the setting or institution
6. There are other factors that require multi-agency coordination and decision-making requiring escalation to the GM SCG which would prompt the setting up of a multi-agency OCT

5.4.3 For hospitals, NHS NW is establishing a system of reporting outbreaks. Management of outbreaks in NHS trusts will be led by NHS trusts with input from PHE and other GM agencies as required.

5.4.4 For primary care, initial investigation of an outbreak will be led by the GMICTH on behalf of localities, working closely with the setting and relevant commissioners. Localities will be informed of all cases.

If there are concerns (such as those below) a multi-agency OCT will be established and escalation to the GM SCG considered will be made:

1. There are a large number of vulnerable people (e.g. special educational needs unit)
2. There are a high number of cases
3. The outbreak has been ongoing despite usual control and infection control measures
4. There are concerns on the safe running of the setting or institution
5. There are other factors that require multi-agency coordination and decision making

5.4.5 For outbreaks in other settings (such as workplaces), these will be initially managed by the Local Authority SPOC in liaison with Environmental Health. This can be escalated to GMICTH if necessary.

If there are concerns such as those below, the locality will lead in considering the need for escalation to the GM SCG and the establishment of a multi-agency OCT:

1. There are a large number of vulnerable people
2. There are a high number of cases
3. The outbreak has been ongoing despite usual control and infection control measures
4. There are concerns on the safe running of the setting or institution
5. There are other factors that require multi-agency coordination and decision making

5.4.6 For suspected community outbreaks, initial investigation will be by the local authority in partnership with GMICTH . If community transmission is ongoing, an OCT will be formed in line with district outbreak plans however, if the community transmission is thought to be escalating to a point which may overwhelm the district OCT, escalation of the situation to the GM SCG will be considered especially if:

- There are a large number of vulnerable people
- There are a high number of cases
- The outbreak has been ongoing despite usual control and infection control measures
- There are concerns about the safe running of key community infrastructure.

5.4.7 For suspected outbreaks in Greater Manchester Fire and Rescue (GMFRS) and Greater Manchester Police (GMP), initial investigation will sit with GMFRS and GMP who, supported as required by the GM Integrated Contact Tracing Hub (which includes staff from PHE NW), will begin managing the outbreak within their environment. A multi-agency OCT may be called if a suspected outbreak has the potential to impact on either GMFRS or GMP capacity to fulfil their statutory duties or if the impacts will require partnership support. Escalation to the GM SCG will be considered if wider impacts are significant.

5.5 Outbreak Management: Key actions

Following the declaration of an outbreak, The Director of Public Health (DPH) will lead the local response to an outbreak within Oldham.

Initial investigation: This will enable the OCT to understand the extent of the outbreak and inform outbreak control activities:

a. **Contacting an affected setting** (e.g. head of school; manager of care home) to get details of the situation, which would include numbers of possible and confirmed cases (and whether any are at high risk of severe COVID-19 disease), dates of onset of symptoms, numbers of people potentially affected (including numbers at high risk of severe COVID-19 disease), any wider risks, and potential impacts that would need support from the system.

b. **Contact tracing:** Much of the contact tracing will be done by the NHS Test and Trace service and GM Integrated Contact Tracing Hub. Local contact tracing will be carried out by the Council's Environmental Health Team following referral to the Single Point of Contact, and local settings/services leads appropriate to the outbreak.

c. **Providing initial infection prevention and control advice.** This may include signposting to existing guidance and sources of support, advice on isolation and exclusion and other infection prevention and control advice. This will be led by community infection prevention & control nurses/Health Protection Team.

d. **Ensuring that any symptomatic people who have not yet been tested are tested promptly.** This will ensure actions are based as much as possible on confirmed cases, as well as helping to rule out situations that are not linked to COVID-19. In care homes all residents and staff will be tested regardless of their symptom status. This will be coordinated by the Test and Trace Manager, in collaboration with the commissioned testing service.

e. **Identifying any urgent support needs.** This would include meeting health needs among cases and contacts to prevent detrimental effects on any underlying medical conditions (e.g. access to medication) as well as wider social impacts on individuals and communities and impact on services. The response to meet these needs will be coordinated through the Community Hubs.

f. **Notifying the wider system and communication.** Early notification to the lead(s) for the wider system for that setting will ensure timely support for consequence management is available as early as possible and impacts on the wider system can be managed. It will also allow wider information and intelligence about the situation to be included in the risk assessment. Early warning to the communications lead can make sure that proactive and reactive communications messages are in place early.

   At every stage in this process communications will be important both to make sure that all parties are operating on the same information, to ensure transparency of actions taken, and to build trust across the system and with the public. Accurate recording of actions and decisions will also be important, both for management of the situation and to provide an audit trail of situation management.

g. **Enforcement of control measures**: Oldham will rely mainly on proactive engagement with communities to facilitate adherence to control measures. Legal enforcement under schedule 21 of Coronavirus Act 2020 will be an act of last resort and would be approved through the local SCG/Gold structure. Schedule 21 confers powers relating to potentially infectious persons and makes related provision.

2. **Notification to GM Integrated Contact Tracing Hub (GM ICTH):** Where appropriate, locally identified cases and outbreaks will be escalated to the GM Integrated Contact Tracing Hub for support with contact tracing and outbreak management. Escalation criteria will remain flexible so that cases might be escalated

if they are particularly high risk or complex, and extra help is needed in managing them. This will be agreed between the Oldham SPOC lead and the GM ICTH.

3. **Identification and implementing control measures.** This will include both infection prevention and control and consequence management actions. Actions will be assigned as appropriate. Where risk assessment suggests that further investigation and control of the outbreak needed to assess and manage the risk to the public's health and ensure control measures are implemented as soon as possible an Outbreak Control Team (OCT) will be arranged. This team will agree and coordinate the activities of the agencies involved in this wider process.

4. **Monitoring of situation and actions.** The situation will be monitored, and any extra actions identified will be allocated to an appropriate owner. The risk assessment will be reviewed if information emerges that would affect it (such as an increase in the numbers of cases, or expansion of the outbreak so that a wider group may be affected).

5. **Closure**. Once all necessary infection prevention and control and consequence management actions are complete the situation will be closed for further actions. This should be communicated to everyone involved in managing the situation and whoever notified the situation in the first place.

5.6 Other Outbreak Management Considerations (communications, managing delivery, PPE management, consequence management) missing

5.6.1 Communication during a specific outbreak

The Oldham SPOC will work with communications leads across Oldham Council and other partners including PHE to determine any reactive and wider communications required in relation to a specific outbreak. Where required, Oldham SPOC will work with PHE to develop reactive press statements relating to outbreak situations as they arise

SPOC contact details will be shared with partners to help two-way communication and help support partners in preventing and managing cases.

5.6.2 Managing Media and Political Impact

Outbreaks in certain settings such as schools may result in wider media interest, which can cause public unrest and disruption. The COVID-19 Prevention and Control Board will support these settings with resources to provide clear advice and information and manage any wider media and political impacts in these situations as they arise.

5.6.3 Managing Delivery

A log of all actions arising from the various work streams supporting COVID-19 outbreak management will be held by the Oldham SPOC and can be reviewed through the governance to track progress and ensure actions and control measures are being followed up.

5.6.4 PPE

Effective management of PPE stock will be important to achieve effective infection prevention and control in settings. Oldham has a PPE Hub with the responsibility to achieve this aim.

5.6.5 Consequence management

Some individuals may either not be in a position to meet the requirements of self-isolation (e.g. homeless people, those with social or mental health issues), or may not feel able to comply with self-isolation due to the economic and social impact on them and their family.

In situations where consequence management issues are identified for individuals, the following actions will be taken:

1. Escalated to the Oldham SPOC via the GM ICTH or via local intelligence
2. The Oldham SPOC will identify the most appropriate method to provide support to the individual to enable them to comply with self-isolation (via referral into relevant support or specialist service e.g Self Isolation Payment Scheme) – this will include any other relevant partners
3. Key partners to support individuals include but not limited to:

   Oldham COVID-19 Help Line as the front door to triage support and needs including signposting to Place Hubs as well as the following services where relevant:

   - Citizen's Advice Bureau – supporting residents to access financial support during isolation e.g. payment holidays.
   - Welfare rights for more complex financial support and welfare assistance benefits.
   - NHS volunteer service and local third sector support in their community.
   - Action Together – as the main support agency and link into wider third sector organisations including volunteers across the borough

6. Appendices (confidential documents not included)

- 6.1 Key contacts
- 6.2 Associated Plans
- 6.3 Key contacts, protocols and guidance for high risk settings or complex settings and vulnerable cohorts

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Report to HEALTH AND WELLBEING BOARD

NHS WHITE PAPER BRIEFING: *INTEGRATION AND INNOVATION: WORKING TOGETHER TO IMPROVE HEALTH & SOCIAL CARE FOR ALL*

Portfolio Holders:
Councillor Zahid Chauhan, Cabinet Member for Health & Social Care

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Ext. N/a

Date: March 2021

Purpose of the Report

This report has been produced to provide a briefing for members of the Health & Wellbeing Board on the recently published NHS White Paper entitled Integration and Innovation: Working Together to Improve Health & Social Care for All.

Requirement from the Health and Wellbeing Board

The Board is asked to note the briefing.

NHS White Paper Briefing: *Integration and Innovation: Working Together to Improve Health & Social Care for All*

Introduction

1 The origins of the white paper were in 2019, when the Secretary of State for Health and Social Care Matt Hancock asked NHS England to identify and consult on what legislative changes were needed to fulfil the ambitions of the ten-year NHS long term plan. So, the white paper was expected at some stage.

2 The white paper does not cover broader social care reform – it gives a commitment that proposals for reform will be published this year – but it does give some direction of travel for adult social care and also for changes in public health.

3 The proposals in the white paper are considered in the following themes:

i. Working together to integrate care – statutory Integrated Care Systems (ICSs) with "dual structure" governance arrangements (the main focus of this policy briefing).

ii. Reducing bureaucracy – removing requirements on competition and procurement in the NHS.

iii. Improving accountability and enhancing public confidence – the formal merger of NHS England and NHS Improvement and new powers for the Secretary of State (SoS).

4 Additional proposals – many related to public health and adult social care. Proposals will be set out in a Health and Care Bill, with legislation in place for implementation in 2022.

Working together to integrate care

5 The white paper proposes that the forthcoming Health and Care Bill will support two forms of integration.

i. ***Removing barriers within the NHS and making "working together an organising principle".*** NHS bodies (NHSE, ICSs and providers) will have a "triple-aim" duty of better health and wellbeing for everyone, better quality of health services for all individuals, and sustainable use of NHS resources. The intention is to help align NHS bodies around a common set of objectives with strong engagement with local communities.

ii. ***Greater collaboration between the NHS and local government*** as well as wider delivery partners to improve health and wellbeing outcomes for local people. There will be a broad "duty to collaborate" across the healthcare, public health and social care system applied to NHS organisations (ICSs and providers) and local authorities. This aims to rebalance duties which focus on the role of individual organisations and their interests. Local authorities and NHS

bodies will be expected to work together in the ICS under one system umbrella. The Secretary of State will have powers to issue guidance on how the duty may work in practice.

6 ICSs will be put on a statutory footing to allow stronger and streamlined decision making and accountability. ICSs will have "dual structure" arrangements which reflect the two forms of integration – an ICS NHS body (board) and an ICS Health and Care Partnership.

7 **The ICS NHS body** will be responsible for the daily running of the ICS. Responsibilities will include developing a plan to meet health needs of the population, setting out the strategic direction for the system, "explaining" the plans for capital and revenue spending of NHS providers in the system, securing the provision of health services to meet the needs of the system population, and achieving system financial balance. The ICS NHS body will take over the functions and funding of CCGs (Clinical Commissioning Groups) and will be able to delegate funding "significantly" to place level and to provider collaboratives. It will take over CCGs' responsibilities in relation to overview and scrutiny committees.

8 NHS trusts and foundation trusts will remain separate statutory bodies and the ICS NHS body will not have the power to direct providers. But there will be a new duty to have regard to the system financial objectives so both providers and ICS NHS bodies will have a mutual interest in financial control at the system level.

9 Each ICS NHS body will have a unitary board accountable for NHS spend and performance within the system. It will, as a minimum, have a chair and a CEO and will include representatives from NHS trusts, general practice, local authorities and others determined locally, such as mental health trusts, plus non-executive directors.

10 NHSE will publish guidance on how boards should be constituted. There will be a more clearly defined role for social care in the structure of ICS NHS boards to give adult social care a greater voice in NHS planning and allocation.

11 **The ICS Health and Care Partnership** will bring together the NHS, local government and wider partners, such as the voluntary and community sector and Healthwatch, to "develop a plan to address the system's health, public health and social care needs" and to promote partnership arrangements. The ICS NHS body and local authorities will have to have regard to that plan when making decisions.

12 The Health and Care Partnership cannot impose arrangements that are binding on local government and the NHS "given this would cut across existing local authority and NHS accountabilities". Membership and functions will be determined locally.

13 The white paper suggests that the Partnership could be used as a forum for agreeing on priorities, coordinated action and aligned funding on key issues, which may be particularly useful in the early stages of ICS formation. Guidance will be published to support ICS partnerships to align operating practices and culture to "deliver for the adult social care sector".

14 The white paper stresses that within the dual structure there will be local flexibility over how ICSs are arranged, and partners are encouraged to develop mature joint arrangements that deepen integration and improve outcomes.

15 There will be new legislation to make it easier for organisations to work closely together through setting up joint committees which could either be between ICSs and NHS providers or between NHS providers. Both types of joint committee could include representation from other bodies such as primary care networks, GP practices, community health providers, local authorities and the voluntary sector.

16 The white paper makes many references to the “primacy of place”. ICSs must “support place based joint working”, with place-based arrangements “at the core of integration”. Place-level commissioning will “frequently” align geographically to a local authority boundary, and the Better Care Fund (BCF) will be a tool for agreeing on priorities. ICSs will work closely with health and wellbeing boards (HWBs) as they have “the experience as place-based planners”. The ICS NHS body will be required to have regard to joint strategic needs assessments and joint health and wellbeing strategies produced at HWB level (and “vice versa”, presumably this means HWBs will need to have regard to the ICS partnership plan). ICSs will need to consider how they can align allocation and functions with places, such as using joint committees, but models will be for local determination. NHSE and other bodies will provide support and guidance based on insights from early wave ICSs.

17 The Department for Health Social Care (DHSC) will explore how to enhance the role of the Care Quality Commission (CQC) in reviewing system working. It wants to strengthen the patient voice at place and system levels to create “genuine coproduction”.

18 Other legislative proposals include:

i. A reserve power to set a capital spending limit on foundation trusts, if needed, to support the third aim of the Triple Aim duty in relation to the sustainable use of NHS resources.

ii. Collaborative commissioning – for instance, NHSE delegating commissioning to more than one ICS board, ICSs collaborating on delegated commissioning, groups of ICSs using joint and lead commissioner arrangements to make decisions and pool funds across all their functions, and a greater range of delegated options for NHS England public health responsibilities, such as national immunisation programmes.

iii. A specific power to issue guidance on joint appointments between NHS bodies, NHS bodies and local authorities, and NHS bodies and combined authorities.

iv. More effective data sharing to support integration and digital transformation of care pathways – to be set out in the forthcoming data strategy for health and care.

v. NHS decision-making bodies will be required to protect promote and facilitate patient choice with respect to services or treatment.

Reducing bureaucracy

19 The requirement for competition applied to the NHS through the Health and Social Care Act 2012 will be removed. The NHS will no longer be subject to the Competition and Markets Authority. Where there is no value in running a competitive procurement process, these can be arranged with the most appropriate provider.

20 NHSE will consult on a "bespoke health services provider selection regime" which will enable collaboration and collective decision making. The division between funding-decisions and provision of care will be maintained. The NHS will have greater discretion over procurement.

21 The SoS will have the power to create new trusts within an ICS where this would result in the best health outcomes. Subject to engagement and consultation, ICSs may apply to the SoS to set up a new trust.

Improving accountability and enhancing public confidence

22 The merger of NHS England and NHS Improvement will be put on a statutory footing, with the organisation called NHS England.

23 The government will have new powers over the NHS to support greater collaboration, information sharing, aligned responsibility, and future agility in responding to change. These include:

i. Reforms to make the government's mandate to the NHS more flexible (the current mandate sets annual priorities and expectations for NHSE).

ii. Power to transfer functions between arm's length bodies (no plans currently other than those already underway – the NHS England/Improvement merger and establishing the National Institute for Health Protection (NIHP) and related reforms to the public health system).

iii. Removal of time limits on special health authorities (such as NHS Blood and Transplant) which currently must be renewed every three years.

24 Also, since contested reconfigurations are often lengthy and ministers have to account for decisions in parliament without being meaningfully engaged in the process, the SoS will have the power to intervene at any point in the reconfiguration process. The SoS will have to seek appropriate advice to inform their decision and publish it transparently. Statutory guidance will be issued on the new process, including removing the current local authority referral process "to avoid creating any conflicts of interest". The Independent Reconfiguration Panel is expected to be replaced by new arrangements which will be based on learning from the work of the IRP.

25 Additional measures

i. Additional proposals have emerged from work on the pandemic and will support health and care system recovery. They are designed to address specific problems or barriers rather than providing comprehensive reform.

Social care

26 The government recognises the significant pressures faced by the sector and will bring forward proposals for reform this year, aimed at ensuring everyone can access affordable, high quality, joined-up and sustainable adult social care.

27 A new improved level of accountability will be introduced within social care, with an "enhanced assurance framework" allowing greater oversight over local authority delivery of care to raise standards and reduce variation in quality. The framework will involve improved data collection to allow for better understanding of capacity and risk, for example, better data on services provided to self-funders. The Health and Care Bill will introduce a new duty for the CQC to assess local authorities' delivery of adult social care duties, and the SoS will have a new power to intervene if it is considered a local authority is failing to meet their duties. The DHSC will work with the sector on the assurance framework which will be introduced over time. There will be a new standalone legal basis for the better care fund (BCF) separating it from the NHS mandate setting process – a technical change with no impact on the BCF policy.

28 The current requirement to assess people before hospital discharge will be replaced by a Discharge to Assess model in which an individual can receive NHS continuing health care (CHC) and NHS funded nursing care (FNC) assessments and Care Act assessments after they have been discharged. This will allow assessments in a familiar environment, enabling a more person-centred evaluation of care needs. The new model will not change eligibility thresholds for CHC or the Care Act; the white paper says it will not increase financial burdens on local authorities. The system of discharge notices and financial penalties will no longer be required.

29 The SoS will have a new legal power to make payments directly to social care providers in exceptional circumstances, such as in maintaining the stability of the market (correcting a limitation in existing legislation).

Public health

30 The experience of the pandemic has underlined the importance of a population health approach and robust health protection. The government will publish proposals for the future of the public health system – the new NIHP and the remaining functions from the closure of Public Health England "in due course".

31 The proposals in the white paper will address targeted issues that need primary legislation. There will be a public health power of direction through which the SoS can require NHSE to discharge public health functions and direct how the delegated functions are exercised – effectively strengthening existing powers.

32 Legislative changes will support the rollout of the national obesity strategy; specifically, introducing further restrictions on the advertising of high-fat salt and sugar foods before 9 pm and a new power for ministers to alter certain food and alcohol labelling requirements to make healthy choices easier.

33 The white paper says that water fluoridation is clinically proven to improve oral health. Currently, ten per cent of the population of England receives fluoridated water. Councils have the power to propose and consult on new fluoridation schemes and the SoS has responsibility for approving these. In light of difficulties identified by local authorities, the white paper proposes that the DHSC would take responsibility for proposing new schemes and the associated costs; schemes would continue to be subject to public consultation.

34 Other additional proposals relate to safety and quality, such as changes to regulatory bodies including a statutory NHS Health Services Safety Investigations body and Medical Examiners System and standards for hospital food.

Some Discussion Points

35 There is a lot of detail in the white paper, and, while some of its proposals are controversial, such as powers of the SoS to intervene earlier in reconfigurations and changes to overview and scrutiny and the Independent Reconfiguration Panel, it provides a coherent set of proposals. The DHSC has listened to concerns from local government and CCGs on the central importance of place, and on making sure that ICSs reflect a broad range of stakeholders, including local government. There is much to welcome in the document on that basis.

36 With measures in the Health and Care Act 2012 under review, it would have been possible for health and wellbeing boards to have been abolished but their value has been recognised and all HWBs now need to up their game to the level of the best. The proposals give a mainstream role for local government in ICSs – boards and partnerships. This needs to be maintained in the subsequent legislation and guidance.

37 How the ICS body/board and the partnership work together will be crucial and there is much to do to get the system level working effectively everywhere, as well as the vital issue of establishing place-based arrangements. Statutory joint committees with real control over resources, bringing together providers, primary care networks, local government and voluntary and community sector representatives should be a positive way forward. These would work alongside health and wellbeing boards to establish the broad vision and priorities, promote collaboration and focus on the social determinants of health. CCGs became a valued part of the health and care landscape in many areas and their important contribution needs to be maintained.

38 The white paper describes the “shift away from an adversarial and transactional system centred on contracting and activity payments to one that is far more collaborative and dedicated to tackling shared problems”. It will probably take some time for some partners to adjust to a collaborative culture.

39 There are also some unclear areas – this is a rolling back of competition rather than a whole scale dismantling of the commissioner/provider split in the NHS. The white paper says that funding decisions will be separate from provision, but it is not clear how this will happen with providers as board members.

40 A new assessment framework for adult social care is advocated. Hopefully, a system involving both sector-led improvements with light-touch national oversight will evolve. The ultimate aim must be for assessment of integration – the CQC local system reviews of 2019 proved very informative.

41 The document does not give many clues about the future of the remaining PHE functions and how NIHP will operate. On public health it says, “rather than containing health improvement expertise within a single organisation, driving change in future will mean we need many different organisations to have the capacity and responsibility for improving health and preventing ill health”. It would have been helpful to have more emphasis on the role of ICSs in prevention and, particularly, in tackling the social determinants of health.

Conclusions

42 The white paper has been influenced by the extensive collaboration and innovation that partners from all sectors have demonstrated in tackling the pandemic. It shows a good understanding of how health, social care and public health fit together, while stakeholders’ concerns, such as ICSs potentially undermining effective place-based arrangements, have been listened to.

43 Overall, this white paper is a positive development. The lack of information on social care reform remains a huge gap, and the proposals will need to be carefully worked on. It also doesn’t seem to address the huge issues around health inequalities. ICSs have changed a lot since they were set up as sustainability and transformation partnerships and it is doubtful that this will be the last word.