Public Document Pack

HEALTH AND WELL BEING BOARD
Agenda

Date	Tuesday 25 January 2022
Time	2.00 pm
Venue	Lees Suite, Civic Centre, Oldham, West Street, Oldham, OL1 1NL
Notes	1. DECLARATIONS OF INTEREST- If a Member requires advice on any item involving a possible declaration of interest which could affect his/her ability to speak and/or vote he/she is advised to contact Paul Entwistle or Constitutional Services at least 24 hours in advance of the meeting. 2. CONTACT OFFICER for this agenda is Constitutional Services Tel. 0161 770 5151 or email constitutional.services@oldham.gov.uk 3. PUBLIC QUESTIONS - Any Member of the public wishing to ask a question at the above meeting can do so only if a written copy of the question is submitted to the contact officer by 12 noon on Thursday, 20 January 2022. 4. FILMING - The Council, members of the public and the press may record / film / photograph or broadcast this meeting when the public and the press are not lawfully excluded. Any member of the public who attends a meeting and objects to being filmed should advise the Constitutional Services Officer who will instruct that they are not included in the filming. Please note that anyone using recording equipment both audio and visual will not be permitted to leave the equipment in the room where a private meeting is held. Recording and reporting the Council's meetings is subject to the law including the law of defamation, the Human Rights Act, the Data Protection Act and the law on public order offences. MEMBERSHIP OF THE HEALTH AND WELL BEING BOARD Councillors M Bashforth (Chair), Birch, Chauhan, Leach, Moores and Sykes

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 - 6)

The Minutes of the meeting of the Health and Wellbeing Board held on 16th November 2021 are attached for approval.

6 Better Care Fund Plan 2021-22 (Pages 7 - 90)

7 Pharmaceutical Needs Assessment (Pages 91 - 94)

8 Time of Future Health and Wellbeing Board Meetings

Item for discussion.

9 Date of Next Meeting

The next meeting of the Health and Wellbeing Board will be on Tuesday 22nd March 2022 at 2.00pm.

HEALTH AND WELL BEING BOARD
16/11/2021 at 9.00 am

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

Also in Attendance:

Mike Barker	Strategic Director of Commissioning/Chief Operating Officer
Harry Catherall	Chief Executive
Dr Henri Giller	Independent Chair
Stuart Lockwood	OCLL
Kaidy McCann	Constitutional Services
Dr. John Patterson	Clinical Commissioning Group
Joanne Sloan	Dr Kershaw's
Katrina Stephens	Director of Public Health
Mark Warren	Director, Adult Social Care
Simon Watts	Public Health
Laura Windsor-Welsh	Action Together

1 **APOLOGIES FOR ABSENCE**

Apologies for absence were received from Councillor Birch, Councillor Leach, Dr Keith Jeffery, David Jago and Donna Cezair.

2 **DECLARATIONS OF INTEREST**

There were no declarations of interest received.

3 **URGENT BUSINESS**

There were no items of urgent business received.

4 **PUBLIC QUESTION TIME**

There were no public questions received.

5 **MINUTES OF PREVIOUS MEETING**

RESOLVED that the minutes of the meeting held on 14th September 2021 be approved as a correct record.

6 **OLDHAM SAFEGUARDING CHILDREN PARTNERSHIP ANNUAL REPORT**

Consideration was given to the Oldham Safeguarding Children Partnership Annual Report. The Board was informed that The Oldham Strategic Safeguarding Partnership had been developed by Oldham Council, Greater Manchester Police, and the Oldham Clinical Commissioning Group to ensure that all children and young people in the area get the safeguarding and protection they needed in order to help them to thrive.

The Board was advised that the business year 2020-21 had proven to be a challenging one for the Oldham Safeguarding Children Partnership, in particular, the challenge of Covid-19 which had tested the strength of Partnership bonds that had only been in their second year of reformulation. It was noted that the impact of Covid on children and families in Oldham had been disproportionate due to the levels of poverty and inequality that affect the Borough. The partnership had responded well to the challenge of the pandemic by:

- Identifying and responding to new levels of safeguarding demand – particularly with respect to harm to infants, increased levels of domestic abuse affecting children and meeting children's mental health and well-being needs.
- Enhancing the arrangements to enable reflection and learning of good safeguarding practice on a co-ordinated cross-agency basis.
- Examining current safeguarding processes and asking how they could better meet the needs of children and young people. Transitioning from children's services to adult services being a particular point of focus for this.
- Engaging with children and young people so to ensure that the Partnership identifies and responds to their priorities and concerns.

The Board was advised of the six strategic aims which were as followed:

- Excellent practice is the norm across all practitioners in Oldham
- Partner agencies hold one another to account effectively
- There is early identification of new safeguarding issues
- Learning is promoted and embedded
- Information is shared effectively
- The public feel confident that children are protected

The Board was informed that three areas of safeguarding risk had been identified as priority areas of focus which were as followed:

- Injuries to under 2-year-olds - During both periods of national lockdown Children's Services saw an increase in the number of children under the age of two years who were experiencing accidental and non-accidental injuries. Whilst the majority of these incidents were as a result of lack of supervision or sibling mishandling the circumstances highlighted the additional stresses and pressures that were being faced by parents of new and young children in the context of isolation and reduced support as a result of the pandemic.
- Significant increases in the number of high-risk domestic abuse incidents - Oldham saw a significant increase in high risk domestic abuse cases in Oldham during the Covid-19 pandemic, with a 92% rise in serious domestic abuse incidents affecting women and children. In the first week of February 2021 alone the Local Authority recorded 58 serious incidents of domestic abuse, compared to 43 in the whole month of February last year.

Many of the families had not previously been known the Children's Services but the severity of the incidents being reported were of significant concern.

- Increased concerns for children's mental health - Oldham Healthy Young Minds saw a large reduction in referrals in Q1 and Q2 of 2020-21 as the Country entered the first COVID-19 lockdown. Despite the reduction in routine referrals there was a notable increase in crisis referrals. Similar increases had been noted in the incidences of self-harm amongst young people which had risen each quarter since the start of the pandemic. Those areas were supported by a Partnership action and communications plans to ensure a coordinated response and awareness raising of the need and the available support for professionals and local communities.

RESOLVED that the report be noted.

7 **DEVELOPING A HEALTH INEQUALITIES PLAN FOR OLDHAM**

Consideration was given to a report which outlined a proposal for how a Health Inequalities Plan would be produced for Oldham with key timelines and the role of the Health and Wellbeing Board in overseeing the work.

The Board was advised that a development session themed around heath inequalities had been held in September 2021 following a discussion by the Director of Public Health on the two reports which made a series of recommendations for reducing health inequalities across Greater Manchester. The first report was from the GM Independent Health Inequalities Commission, titled The Next Level: Good Lives for All in Greater Manchester. The second report was from Michael Marmot's team at The Institute for Health Equity, titled Build Back Fairer in Greater Manchester: Health Equity and Dignified Lives.

The presentation and discussion highlighted the following:

- Health inequalities had existed and had been known about for a number of years, however Covid had exacerbated them, resulting in worse health and social outcomes for those who were already most disadvantaged.
- Oldham residents in particular were badly impacted by those inequalities given the low levels of income in the borough and the higher proportion of residents from minority ethnic groups.
- Recent reports from the GM Independent Health Inequalities Commission and the Institute for Health Equity were an opportunity for action in the borough. A document had been circulated which summarised system wide initiatives which were aligned with the recommendations made by Michael Marmot's team. This highlighted a number of areas where the Oldham system

was very much fulfilling the recommendations, as well as gaps where more work was needed.
- It was agreed that following the development session a plan would start to be developed for tackling health inequalities in Oldham, which would draw on the findings from those two reports.

The Board was advised that it had been proposed that a Health Inequalities Plan for Oldham would be developed by completing the following:

- Establishing a time limited task and finish group to steer the development of the plan.
- Producing an overview of evidence linked to health inequalities in Oldham, highlighting key areas of concerns. This would be drawn from the Joint Strategic Needs Assessment.
- Engaging with key system partners and residents to understand key issues. Summarise priorities raised linked to health inequalities from discussions.
- Meet with relevant system partners to understand existing programmes of work and governance and how they interact with the health inequalities agenda; summarise which priorities identified are already being progressed (e.g. by the Equality Plan, Anti-Poverty Plan).
- Develop a detailed action plan for the priorities which weren't already being progressed by other workstreams. Named individuals assigned to each action with timelines.
- Outline proposed governance to support implementation of the action plan above, emphasising the role of the Health and Wellbeing Board in driving delivery.

RESOLVED that:

1. The process and timeline outlined in the report be agreed.
2. The work be engaged with as appropriate as the plan is being developed.

8 **SUPPORTING PATIENTS WITH LONG COVID, CHRONIC PAIN AND FATIGUE**

Consideration was given to a report which advised the Board on the services available for patients with long Covid, and how those related to provisions for patients with chronic pain and fatigue.

The Board was advised that, according to research undertaken by the Office of National Statistics, around 1 in 10 people testing positive for Covid-19 exhibited symptoms for a period of 12 weeks or longer. 67% of GPs surveyed nationally reported that they were looking after patients with Covid-19 symptoms lasting longer than 12 weeks. A study by the Lancet published on 8th January 2021 which looked at the long-term health consequences of Covid-19 patients discharged from hospital, identified that at 6 months after acute infection, Covid-19 survivors were mainly troubled with fatigue or muscle weakness,

sleep difficulties, and anxiety or depression. Patients who were more severely ill during their hospital stay had more severely impaired pulmonary diffusion capacities and abnormal chest imaging manifestation and were the main target population for intervention of long-term recovery. The Lancet report added to the growing body of evidence that long Covid syndrome should be considered serious and is a long-term condition.

The Board noted that there was increased evidence that Covid-19 had a disproportionate impact on those in deprived populations and people in black and ethnic minority groups, exacerbating existing health inequalities. Of those people with persistent symptoms at 20 weeks, the current evidence suggested that the most common symptoms were fatigue (98%), breathlessness (87%), persistent cough (74%), headache (83%), fever (75%), chest pain (73%), muscle ache (88%) and joint pain (78%). However, a wide range of other symptoms were reported, affecting almost all body systems. It was noted that people with persistent symptoms often reported multiple different symptoms, which could relapse and remit over time.

The Board were advised that Long COVID Virtual assessment clinics covering Tier 3 assessment were set up at the end of January 2021. The Tier 4 service was in the process of being fully stood up across Greater Manchester. However, Oldham's Tier 3 services have been able to access this since the end of September 2021. Under the pathway development, Tier 1 would cover self-management. Patients would be directed to the Your Covid recovery website and the GP Peer Support Group. Tier 2 covered all GP practices that had signed up to deliver the NHS Direct Enhances Services for Long Covid which included guidance on identification, assessment and appropriate investigations prior to referral. Tier 3 would cover the development of a post-acute Covid assessment clinic.

RESOLVED that the report be noted.

9 **DATE OF NEXT MEETING**

RESOLVED that the date and time of the next meeting of the Health and Wellbeing Board be noted.

The meeting started at 9.00 am and ended at 10.34 am

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Report to HEALTH AND WELLBEING BOARD

TITLE: Better Care Fund Plan 2021-22

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

Officer Contact: Mark Warren, Director of Adult Social Care and Managing Director Community Health and Social Care

Report Author: David Garner, Head of Business Strategy and Performance Adult Social Care

Contact: 07866 185463 / david.garner@oldham.gov.uk

Date: 25 January 2021

Purpose of the Report

To provide the Health & Wellbeing Board with details of the Oldham Better Care Fund (BCF) Plan for 2021-22 and obtain sign off in line with the requirements of the national conditions of the BCF.

Requirement from the Health and Wellbeing Board

1. That the Health & Wellbeing Board discusses the content of the Oldham BCF Plan and make any suggested amendments.

2. Subject to any agreed amendments Health & Wellbeing Board agrees to sign off the plan in line with the requirements of the national conditions of the BCF.

Title

1. Background

1.1 The Better Care Fund (BCF) is one of the government's national vehicles for driving health and social care integration. It requires local clinical commissioning groups (CCGs) and local government to agree a joint plan, agreed and owned by the Health and Wellbeing Board. The joint plan supports integration using a pooled budget and is governed by an agreement under section 75 of the NHS Act (2006).

1.2 The details of the operation of the BCF are set out in two documents: *2021 to 2022 Better Care Fund policy framework* and *Better Care Fund planning requirements 2021-22*. These documents were only published in September and October 2021 and form the basis of the Oldham BCF plan for 2021-22.

1.3 In line with the requirements set out by government Oldham submitted its BCF Plan for 2021-22 on 16 November 2021. This was initially submitted to GM Health & Social Care Partnership as part of the agreement for regional ratification of BCF plans across Greater Manchester. The requirements allow for post-submission amendments and sign-off by HWBs in consideration of the late publication of the policy framework and planning requirements.

1.4 For 2021-22 the BCF plan is in two parts an overall template that provides information on income, expenditure, type of schemes funded, metrics and how the plan meets national conditions and a narrative plan outlining the key areas of focus in Oldham. This is based on the current Oldham Locality Plan.

2. Current Position

2.1 The BCF consists of three main funding contributions: NHS CCG contribution to the BCF; the Disabled Facilities Grant (DFG); and the Improved Better Care Fund (iBCF).

2.2 The total value of the BCF in Oldham in 2021-22 is £32,869,636. This is broken down as follows for 2021-22:

Funding Sources	Income
CCG Contribution	£19,667,669
Disabled Facilities Grant (DFG)	£2,343,287
Improved Better Care Fund (iBCF)	£10,858,680
Total	**£32,869,636**

2.3 Funding is dependent on meeting the following four national conditions:

National Condition 1: a jointly agreed plan between local health and social care commissioners signed off by the HWB

National Condition 2: NHS contribution to adult social care to be maintained in line with the uplift to CCG minimum contribution

National Condition 3: invest in NHS commissioned out of hospital services

National condition 4: plan for improving outcomes for people being discharged from hospital

2.3 In addition, a number of required metrics are in place to address the following:

- Avoidable admissions – this focuses on unplanned hospitalization for chronic ambulatory care sensitive conditions and replaces the previous measure for non-elective admissions
- Length of stay in hospital based on people staying in hospital for longer than 14 and 21 days
- Hospital discharge to normal place of residence
- Long-term support needs met by admittance to residential and nursing care homes
- Reablement based on the proportion of people over 65 still at home 91 days after discharge to reablement services

2.4 The Oldham Plan meets both of the national financial conditions and in both cases exceeds the minimum required spend. For NHS commissioned out of hospital services the investment exceeds the required spend by £1,734,423. The NHS contribution to Adult Social Care has been increased by the 5.3% CCG minimum contribution uplift.

2.5 The funding is utilised across health and social care to fund a wide range of provision for residents including funding:

- Residential enablement at Butler Green and Medlock Court
- A range of dementia services across the borough
- Community equipment and wheelchair provision
- Minor adaptations
- A range of Falls Services
- Warm Homes
- Alcohol liaison
- Carers support
- Healthwatch
- Respite Care
- Stroke support services
- A range of services to support hospital discharge

2.6 The narrative element of the plan focuses on how we will continue to deliver significant improvements in the health and wellbeing outcomes of our residents as we move towards place-based, person centred provision of care and services. It focuses on the wider determinants of health and addressing health inequalities in our footprint. It also emphasises how public services will work together to support everyone to take more responsibility for their own health. It should be noted that the Locality Plan is currently

2.7 There is also a focus, in the narrative plan, on both supporting discharge, on the implementation of the Disabled Facilities Grant and how we are working to address health inequalities in Oldham as specific requests were included as part of the planning process from government for details on these areas. More detailed information on the narrative plan is embedded at the end of this document.

2.8 Although there have been some changes to the BCF introduced this year, particularly in relation to the metrics, the government sees 2021-22 as a year of minimal change. However, following the review of the BCF in 2018 and the ongoing response to COVID-19, along with planned reform for health and social care the government has started to consider how future BCF arrangements take all of this in to account.

2.9 In view of this a review of the current BCF in Oldham will be undertaken throughout 2022-23 taking in to account the government's key areas of focus and the ongoing need in the borough.

2.10 As highlighted previously the Oldham Plan was submitted on 16 November 2021.It was not possible given the time limits to present the plan to the HWB prior to submission due to the dates involved. The initial plan submission was signed off on behalf of the CCG and local authority by:

Mark Warren	Director Adult Social Care and Managing Director of Community Health and Social Care
Kate Rigden	Chief Finance Officer Oldham NHS (CCG)
Anne Ryans	Director of Finance (Section 151 Officer) Oldham Council

2.11 We understand that the plan has been agreed both regionally and nationally and confirmation of this will be sent once we confirm that the HWB has signed off the plan in order to meet National Condition 1.

3. Key Issues for Health and Wellbeing Board to Discuss

3.1 For the Health and Wellbeing Board to consider the contents of the BCF Plan for 2021-22 and make any suggested amendments.

3.2 To agree whether the HWB is prepared to sign off the plan, subject to any amendments it proposes, in order to meet National Condition 1.

4. Recommendation

4.1 It is recommended that the Health and Wellbeing Board agree to sign off the Better Care Fund Plan for 2021-22.

Better Care Fund 2021-22 Template

1. Guidance

Overview

Note on entering information into this template

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a blue background, as below:

Data needs inputting in the cell

Pre-populated cells

Note on viewing the sheets optimally

For a more optimal view each of the sheets and in particular the drop down lists clearly on screen, please change the zoom level between 90% - 100%. Most drop downs are also available to view as lists within the relevant sheet or in the guidance sheet for readability if required.

The details of each sheet within the template are outlined below.

Checklist (click to go to Checklist, included in the Cover sheet)

1. This section helps identify the sheets that have not been completed. All fields that appear as incomplete should be completed before sending to the Better Care Fund Team.
2. The checker column, which can be found on the individual sheets, updates automatically as questions are completed. It will appear 'Red' and contain the word 'No' if the information has not been completed. Once completed the checker column will change to 'Green' and contain the word 'Yes'

3. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
4. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'.
5. Please ensure that all boxes on the checklist are green before submission.

2. Cover (click to go to sheet)

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off.
2. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to the Better Care Fund Team: england.bettercarefundteam@nhs.net
(please also copy in your respective Better Care Manager)

4. Income (click to go to sheet)

1. This sheet should be used to specify all funding contributions to the Health and Wellbeing Board's (HWB) Better Care Fund (BCF) plan and pooled budget for 2021-22. It will be pre-populated with the minimum CCG contributions to the BCF, Disabled Facilities Grant (DFG) and improved Better Care Fund (iBCF). These cannot be edited.
2. Please select whether any additional contributions to the BCF pool are being made from local authorities or the CCGs and as applicable enter the amounts in the fields highlighted in 'yellow'. These will appear as funding sources when planning expenditure. The fields for Additional contributions can be used to include any relevant carry-overs from the previous year.
3. Please use the comment boxes alongside to add any specific detail around this additional contribution including any relevant carry-overs assigned from previous years. All allocations are rounded to the nearest pound.
4. For any questions regarding the BCF funding allocations, please contact england.bettercarefundteam@nhs.net

5. Expenditure (click to go to sheet)

This sheet should be used to set out the schemes that constitute the BCF plan for the HWB including the planned expenditure and the attributes to describe the scheme. This information is then aggregated and used to analyse the BCF plans nationally and sets the basis for future reporting and to particularly demonstrate that National Conditions 2 and 3 are met.

The table is set out to capture a range of information about how schemes are being funded and the types of services they are providing. There may be scenarios when several lines need to be completed in order to fully describe a single scheme or where a scheme is funded by multiple funding streams (eg: iBCF and CCG minimum). In this case please use a consistent scheme ID for each line to ensure integrity of aggregating and analysing schemes.

On this sheet please enter the following information:

1. Scheme ID:

- This field only permits numbers. Please enter a number to represent the Scheme ID for the scheme being entered. Please enter the same Scheme ID in this column for any schemes that are described across multiple rows.

2. Scheme Name:

- This is a free text field to aid identification during the planning process. Please use the scheme name consistently if the scheme is described across multiple lines in line with the scheme ID described above.

3. Brief Description of Scheme

- This is a free text field to include a brief headline description of the scheme being planned.

4. Scheme Type and Sub Type:

- Please select the Scheme Type from the drop-down list that best represents the type of scheme being planned. A description of each scheme is available in tab 5b.
- Where the Scheme Types has further options to choose from, the Sub Type column alongside will be editable and turn "yellow". Please select the Sub Type from the drop down list that best describes the scheme being planned.
- Please note that the drop down list has a scroll bar to scroll through the list and all the options may not appear in one view.
- If the scheme is not adequately described by the available options, please choose ‘Other’ and add a free field description for the scheme type in the column alongside. Please try to use pre-populated scheme types and sub types where possible, as this data is important to our understanding of how BCF funding is being used and levels of investment against different priorities.
- The template includes a field that will inform you when more than 5% of mandatory spend is classed as other.

5. Area of Spend:

- Please select the area of spend from the drop-down list by considering the area of the health and social care system which is most supported by investing in the scheme.
- Please note that where ‘Social Care’ is selected and the source of funding is “CCG minimum” then the planned spend would count towards National Condition 2.
- If the scheme is not adequately described by the available options, please choose ‘Other’ and add a free field description for the scheme type in the column alongside.
- We encourage areas to try to use the standard scheme types where possible.

6. Commissioner:

- Identify the commissioning body for the scheme based on who is responsible for commissioning the scheme from the provider.
- Please note this field is utilised in the calculations for meeting National Condition 3.
- If the scheme is commissioned jointly, please select ‘Joint’. Please estimate the proportion of the scheme being commissioned by the local authority and CCG/NHS and enter the respective percentages on the two columns.

7. Provider:

- Please select the ‘Provider’ commissioned to provide the scheme from the drop-down list.
- If the scheme is being provided by multiple providers, please split the scheme across multiple lines.

8. Source of Funding:

- Based on the funding sources for the BCF pool for the HWB, please select the source of funding for the scheme from the drop down list. This includes additional, voluntarily pooled contributions from either the CCG or Local authority
- If the scheme is funding across multiple sources of funding, please split the scheme across multiple lines, reflecting the financial contribution from each.

9. Expenditure (£) 2021-22:

- Please enter the planned spend for the scheme (or the scheme line, if the scheme is expressed across multiple lines)

10. New/Existing Scheme
- Please indicate whether the planned scheme is a new scheme for this year or an existing scheme being carried forward.

This is the only detailed information on BCF schemes being collected centrally for 2021-22 and will inform the understanding of planned spend for the iBCF grant and spend from BCF sources on discharge.

6. Metrics (click to go to sheet)

This sheet should be used to set out the HWB's performance plans for each of the BCF metrics in 2021-22. The BCF requires trajectories and plans agreed for the fund's metrics. Systems should review current performance and set realistic, but stretching ambitions for the last two quarters of 2021-22.
The previous measure of Non Elective Admissions is being replaced with a measure of Unplanned Admissions for Chronic Ambulatory Care Sensitive Conditions. Performance data on this indicator up to 2019-20, by local authority can be found at:
https://digital.nhs.uk/data-and-information/publications/statistical/nhs-outcomes-framework/february-2021/domain-2-enhancing-quality-of-life-for-people-with-long-term-conditions-nof/2.3.i-unplanned-hospitalisation-for-chronic-ambulatory-care-sensitive-conditions

A data pack showing breakdowns of data for new metrics (discharge and avoidable admissions) is available on the Better Care Exchange.

For each metric, systems should include a narrative that describes:
- a rationale for the ambition set, based on current and recent data, planned activity and expected demand
- how BCF funded schemes and integrated care will support performance against this metric, including any new or amended services.
1. Unplanned admissions for chronic ambulatory sensitive conditions:
- This section requires the area to input a planned rate for these admissions, per hundred thousand people for the year. This is the current NHS Outcomes Framework indicator 2.3i.
- The numerator is calculated based on the expected number of unplanned admissions for ambulatory sensitive conditions during the year.
- The denominator is the local population based on Census mid year population estimates for the HWB.
- Technical definitions for the guidance can be found here:
https://files.digital.nhs.uk/A0/76B7F6/NHSOF_Domain_2_S.pdf
2. Length of Stay.
- Areas should agree ambitions for minimising the proportion of patients in acute hospital who have been an inpatient for 14 days or more and the number that have been an inpatient for 21 days or more. This metric should be expressed as a percentage of overall patients.
- The ambition should be set for the HWB area. The data for this metric is obtained from the Secondary Uses Service (SUS) database and is collected at hospital trust. A breakdown of data from SUS by local authority of residence has been made available on the Better Care Exchange to assist areas to set ambitions. Ambitions should be set as the average percentage of inpatient beds occupied by patients with a length of stay of 14 days and over and 21 days and over for Q3 2021-22 and for Q4 2021-22 for people resident in the HWB.

- Plans should be agreed between CCGs, Local Authorities and Hospital Trusts and areas should ensure that ambitions agreed for 21 days or more are consistent across Local Trusts and BCF plans.

- The narrative should set out the approach that has been taken to agreeing and aligning plans for this metric
3. Discharge to normal place of residence.
- Areas should agree ambitions for the percentage of people who are discharged to their normal place of residence following an inpatient stay.

- The ambition should be set for the healthand wellbeing board area. The data for this metric is obtained from the Secondary Uses Service database and is collected at hospital trust. A breakdown of data from SUS by local authority of residence has been made available on the Better Care Exchange to assist areas to set ambitions. Ambitions should be set as the percentage of all discharges where the destination of discharge is the person's usual place of residence.

4. Residential Admissions (RES) planning:
- This section requires inputting the information for the numerator of the measure.
- Please enter the planned number of council-supported older people (aged 65 and over) whose long-term support needs will be met by a change of setting to residential and nursing care during the year (excluding transfers between residential and nursing care) for the Residential Admissions numerator measure.
- The prepopulated denominator of the measure is the size of the older people population in the area (aged 65 and over) taken from Office for National Statistics (ONS) subnational population projections.
- The annual rate is then calculated and populated based on the entered information.
5. Reablement planning:
- This section requires inputting the information for the numerator and denominator of the measure.
- Please enter the planned denominator figure, which is the planned number of older people discharged from hospital to their own home for rehabilitation (or from hospital to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home).
- Please then enter the planned numerator figure, which is the planned number of older people discharged from hospital to their own home for rehabilitation (from within the denominator) that will still be at home 91 days after discharge.
- The annual proportion (%) Reablement measure will then be calculated and populated based on this information.

7. Planning Requirements (click to go to sheet)

This sheet requires the Health & Wellbeing Board to confirm whether the National Conditions and other Planning Requirements detailed in the BCF Policy Framework and the BCF Requirements document are met. Please refer to the BCF Policy Framework and BCF Planning Requirements documents for 2021-22 for further details.
The sheet also sets out where evidence for each Key Line of Enquiry (KLOE) will be taken from.
The KLOEs underpinning the Planning Requirements are also provided for reference as they will be utilised to assure plans by the regional assurance panel.
1. For each Planning Requirement please select 'Yes' or 'No' to confirm whether the requirement is met for the BCF Plan.
2. Where the confirmation selected is 'No', please use the comments boxes to include the actions in place towards meeting the requirement and the target timeframes.

Better Care Fund 2021-22 Template

2. Cover

Version 1.0

HM Government

NHS

Please Note:
- You are reminded that much of the data in this template, to which you have privileged access, is management information only and is not in the public domain. It is not to be shared more widely than is necessary to complete the return.
- Please prevent inappropriate use by treating this information as restricted, refrain from passing information on to others and use it only for the purposes for which it is provided. Any accidental or wrongful release should be reported immediately and may lead to an inquiry. Wrongful release includes indications of the content, including such descriptions as "favourable" or "unfavourable".
- Please note that national data for plans is intended for release in aggregate form once plans have been assured, agreed and baselined as per the due process outlined in the BCF Planning Requirements for 2021-22.
- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

Health and Wellbeing Board:	Oldham
Completed by:	David Garner / Karen Ratzeburg
E-mail:	david.garner@oldham.gov.uk / karen.ratzeburg@nhs.net
Contact number:	07866 185463 / 07812 651816

Please indicate who is signing off the plan for submission on behalf of the HWB (delegated authority is also accepted):

Job Title:	s151 Officer, OMBC / Oldham CCG CFO / DASS & Managing Direc
Name:	Anne Ryans / Kate Rigden / Mark Warren

Has this plan been signed off by the HWB at the time of submission?	Delegated authority pending full HWB meeting
If no, or if sign-off is under delegated authority, please indicate when the HWB is expected to sign off the plan:	Tue 14/12/2021

<< Please enter using the format, DD/MM/YYYY
Please note that plans cannot be formally approved and Section 75 agreements cannot be finalised until a plan, signed off by the HWB has been submitted.

	Role:	Professional Title (where applicable)	First-name:	Surname:	E-mail:
***Area Assurance Contact Details:**	Health and Wellbeing Board Chair	Cllr	Marie	Bashforth	marie.bashforth@oldham.gov.uk
	Clinical Commissioning Group Accountable Officer (Lead)		Mike	Barker	mike.barker3@nhs.net
	Additional Clinical Commissioning Group(s) Accountable Officers		Mike	Barker	mike.barker3@nhs.net
	Local Authority Chief Executive		Harry	Catherall	harry.catherall@oldham.gov.uk
	Local Authority Director of Adult Social Services (or equivalent)		Mark	Warren	mark.warren@oldham.gov.uk
	Better Care Fund Lead Official		Kate	Rigden	kate.rigden@nhs.net
	LA Section 151 Officer		Anne	Ryans	anne.ryans@oldham.gov.uk
Please add further area contacts that you would wish to be included					

in official correspondence -->					

**Only those identified will be addressed in official correspondence (such as approval letters). Please ensure all individuals are satisfied with the information entered above as this is exactly how they will appear in correspondence.*

Question Completion - When all questions have been answered and the validation boxes below have turned green, please send the template to the Better Care Fund Team england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'. Please also copy in your Better Care Manager.

Template Completed

	Complete:
2. Cover	Yes
4. Income	Yes
5a. Expenditure	Yes
6. Metrics	Yes
7. Planning Requirements	Yes

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2021-22 Template

3. Summary

Selected Health and Wellbeing Board: Oldham

Income & Expenditure

Income >>

Funding Sources	Income	Expenditure	Difference
DFG	£2,343,287	£2,343,287	£0
Minimum CCG Contribution	£19,662,703	£19,662,703	£0
iBCF	£10,858,680	£10,858,680	£0
Additional LA Contribution	£0	£0	£0
Additional CCG Contribution	£4,966	£4,966	£0
Total	**£32,869,636**	**£32,869,636**	**£0**

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum CCG allocation

Minimum required spend	£5,587,583
Planned spend	£7,322,006

Adult Social Care services spend from the minimum CCG allocations

Minimum required spend	£13,210,523
Planned spend	£13,217,885

Scheme Types

Assistive Technologies and Equipment	£2,664,371	(8.1%)
Care Act Implementation Related Duties	£2,824,324	(8.6%)
Carers Services	£1,484,238	(4.5%)
Community Based Schemes	£8,028,070	(24.4%)
DFG Related Schemes	£2,343,287	(7.1%)
Enablers for Integration	£0	(0.0%)
High Impact Change Model for Managing Transfer of	£1,041,098	(3.2%)
Home Care or Domiciliary Care	£2,814,670	(8.6%)
Housing Related Schemes	£110,000	(0.3%)
Integrated Care Planning and Navigation	£131,680	(0.4%)
Bed based intermediate Care Services	£4,118,436	(12.5%)
Reablement in a persons own home	£2,714,670	(8.3%)
Personalised Budgeting and Commissioning	£0	(0.0%)
Personalised Care at Home	£125,109	(0.4%)
Prevention / Early Intervention	£1,587,812	(4.8%)
Residential Placements	£2,714,670	(8.3%)
Other	£167,200	(0.5%)
Total	**£32,869,635**	

Metrics >>

Avoidable admissions

	20-21 Actual	21-22 Plan
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	900.1	1,198.0

Length of Stay

		21-22 Q3 Plan	21-22 Q4 Plan
Percentage of in patients, resident in the HWB, who have been an inpatient in an acute hospital for: i) 14 days or more	LOS 14+	10.1%	10.0%
ii) 21 days or more As a percentage of all inpatients	LOS 21+	5.2%	5.0%

Discharge to normal place of residence

	0	21-22 Plan
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence	0.0%	92.0%

Residential Admissions

		20-21 Actual	21-22 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	599	638

Reablement

		21-22 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	93.5%

Planning Requirements >>

Theme	Code	Response

NC1: Jointly agreed plan	**PR1**	Yes
	PR2	Yes
	PR3	Yes
NC2: Social Care Maintenance	**PR4**	Yes
NC3: NHS commissioned Out of Hospital Services	**PR5**	Yes
NC4: Plan for improving outcomes for people being discharged from hospital	**PR6**	Yes
Agreed expenditure plan for all elements of the BCF	**PR7**	Yes
Metrics	**PR8**	Yes

Better Care Fund 2021-22 Template

4. Income

Selected Health and Wellbeing Board: Oldham

Local Authority Contribution	
Disabled Facilities Grant (DFG)	Gross Contribution
Oldham	£2,343,287
DFG breakerdown for two-tier areas only (where applicable)	
Total Minimum LA Contribution (exc iBCF)	**£2,343,287**

iBCF Contribution	Contribution
Oldham	£10,858,680
Total iBCF Contribution	**£10,858,680**

Are any additional LA Contributions being made in 2021-22? If yes, please detail below	No

Local Authority Additional Contribution	Contribution	Comments - Please use this box clarify any specific uses or sources of funding
Total Additional Local Authority Contribution	**£0**	

CCG Minimum Contribution	Contribution
NHS Oldham CCG	£19,662,703
Total Minimum CCG Contribution	**£19,662,703**

Are any additional CCG Contributions being made in 2021-22? If yes, please detail below	Yes

Additional CCG Contribution	Contribution	Comments - Please use this box clarify any specific uses or sources of funding
NHS Oldham CCG	£4,966	To fund slight overspend on minimum
Total Additional CCG Contribution	**£4,966**	
Total CCG Contribution	**£19,667,669**	

	2021-22
Total BCF Pooled Budget	**£32,869,636**

Funding Contributions Comments
Optional for any useful detail e.g. Carry over

Better Care Fund 2021-22 Template

5. Expenditure

Selected Health and Wellbeing Board: Oldham

<< Link to summary sheet

Running Balances	Income
DFG	£2,343,287
Minimum CCG Contribution	£19,662,703
iBCF	£10,858,680
Additional LA Contribution	£0
Additional CCG Contribution	£4,966
Total	**£32,869,636**

Required Spend

This is in relation to National Conditions 2 and 3 only. It does NOT make up the t

	Minimun
NHS Commissioned Out of Hospital spend from the minimum CCG allocation	
Adult Social Care services spend from the minimum CCG allocations	

Checklist

Column complete:

Yes	Yes	Yes	Yes	Yes	Yes

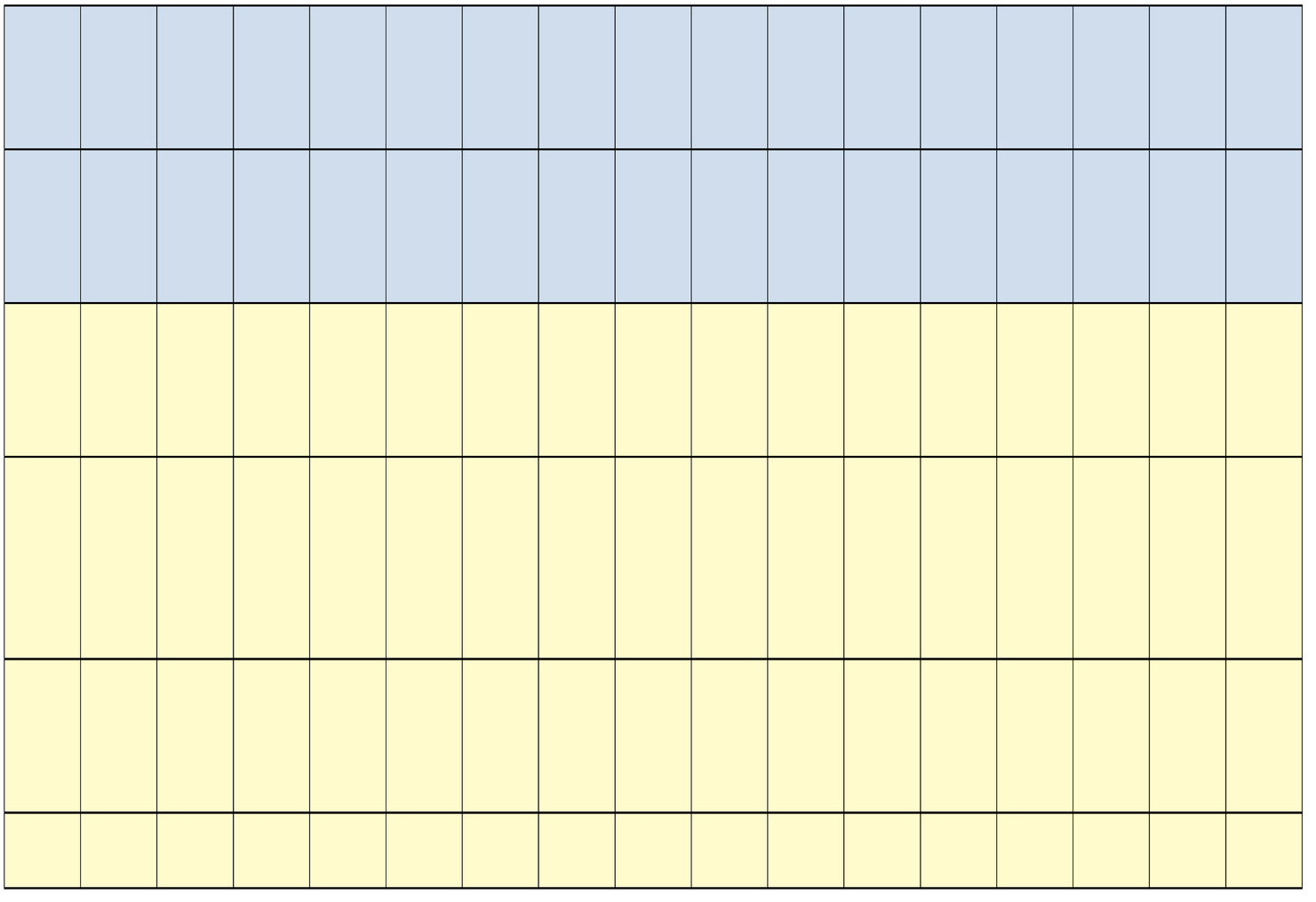
Sheet complete

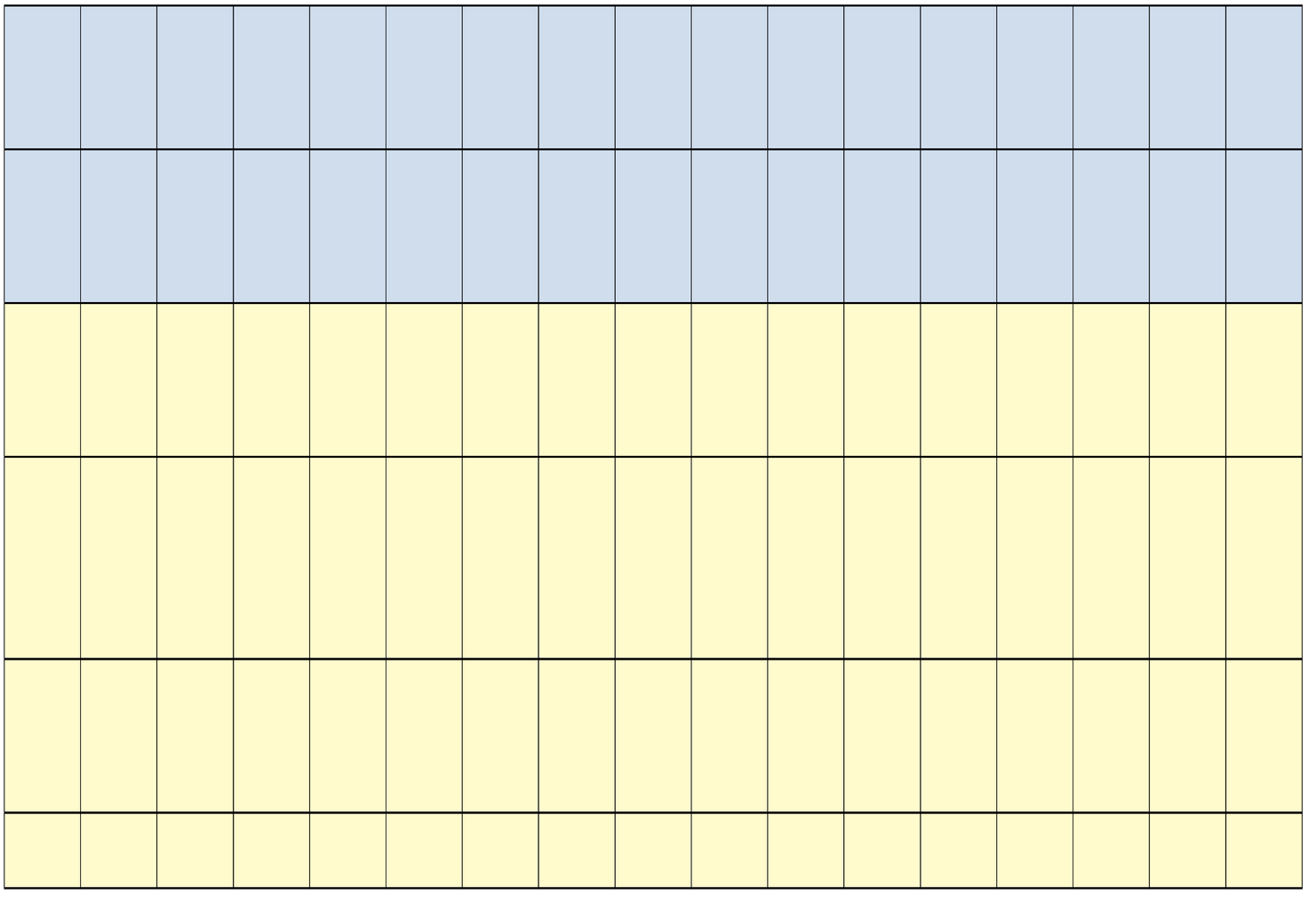
Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'
1	Reablement - Butler Green	Reablement - Butler Green	Bed based intermediate Care Services	Step down (discharge to assess pathway-2)	
2	Falls Investment	Falls Investment	Prevention / Early Intervention	Risk Stratification	
3	Falls Investment - Age UK	Falls Investment - Age UK	Prevention / Early Intervention	Risk Stratification	
4	Early Supported Discharge and Community	Early Supported Discharge and Community Stroke	Community Based Schemes	Multidisciplinary teams that are supporting	
5	Alternate to Transfer -GTD	Alternate to Transfer - GTD	Community Based Schemes	Multidisciplinary teams that are supporting	

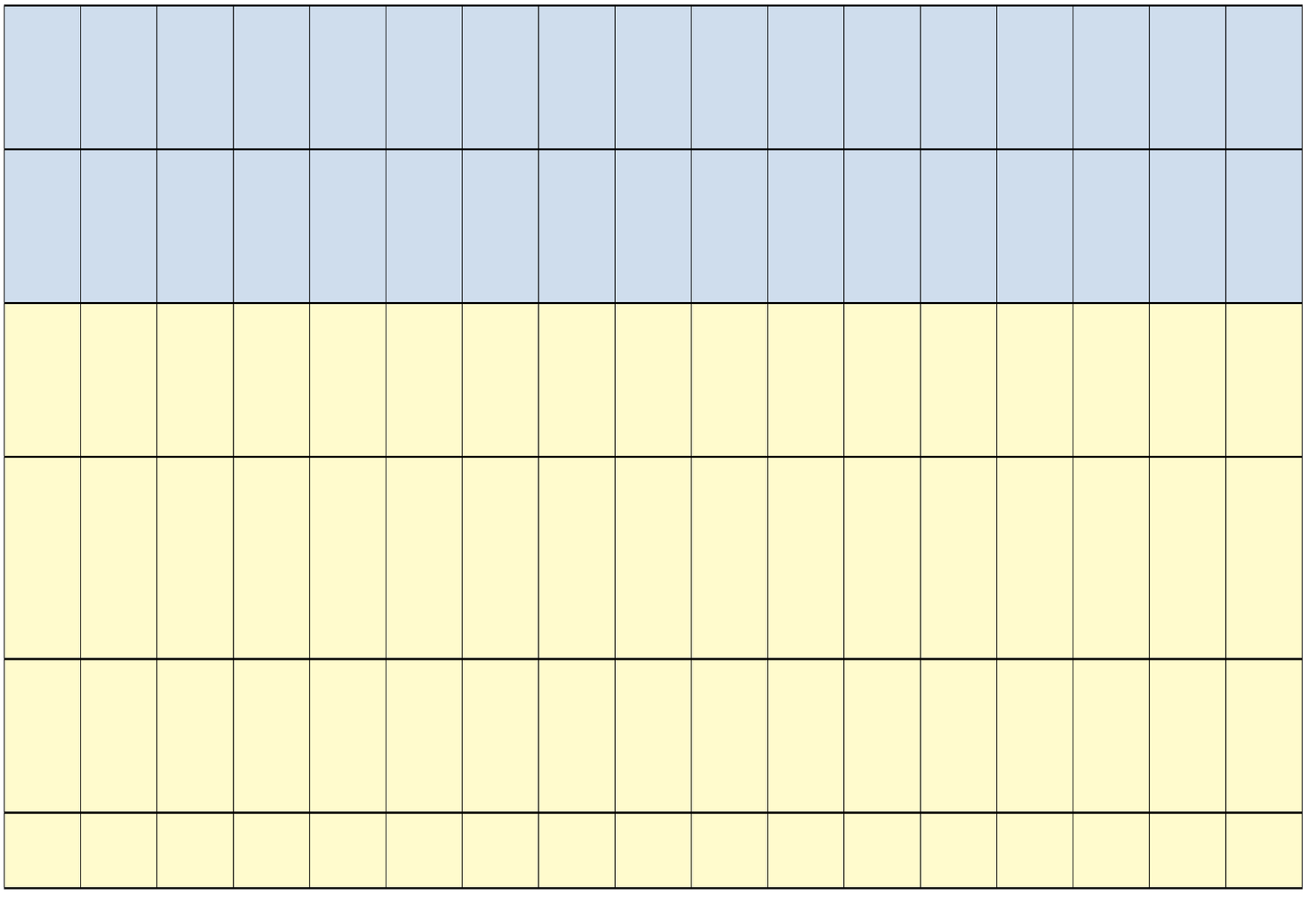
6	Community End of Life Consultant Service - Outreach	Community End of Life Consultant Service - Outreach	Personalised Care at Home	Physical health/wellbeing	
7	Wheelchair Service	Wheelchair Service	Assistive Technologies and Equipment	Community based equipment	
8	Community Equipment	Community Equipment	Assistive Technologies and Equipment	Community based equipment	
9	Carers - OMBC	Carers - OMBC	Carers Services	Respite services	
10	Action for Blind People	Action for Blind People	Integrated Care Planning and Navigation	Care navigation and planning	
11	Red Cross Assisted Discharge	Red Cross Assisted Discharge	High Impact Change Model for Managing	Home First/Discharge to Assess - process	
12	CHC Joint Working Agreement	CHC Joint Working Agreement	Community Based Schemes	Multidisciplinary teams that are supporting	
13	Alcohol Liaison - PAHT	Alcohol Liaison - PAHT	Integrated Care Planning and Navigation	Care navigation and planning	
14	Warm Homes	Warm Homes	Community Based Schemes	Integrated neighbourhood services	
15	Dementia Service - Age UK	Dementia Service - Age UK	Community Based Schemes	Multidisciplinary teams that are supporting	
16	Dementia Service - Making Space	Dementia Service - Making Space	Community Based Schemes	Multidisciplinary teams that are supporting	
17	Dementia Service - Pennine Care FT Memory Service	Dementia Service - Pennine Care FT Memory Service	Community Based Schemes	Multidisciplinary teams that are supporting	
18	Dementia Service - PCFT MH liaison service with care	Dementia Service - PCFT MH liaison service with care homes	Community Based Schemes	Multidisciplinary teams that are supporting	
19	Dementia Service - 0.6WTE Band 7	Dementia Service - 0.6WTE Band 7	Community Based Schemes	Multidisciplinary teams that are supporting	
20	Dementia Service - Senior Practitioner	Dementia Service - Senior Practitioner Dementia Training	Community Based Schemes	Multidisciplinary teams that are supporting	
21	Care Management - Maintaining	Care Management - Maintaining Eligibility	Care Act Implementation Related Duties	Carer advice and support	
22	Community Equipment - OCAS staffing costs	Community Equipment - OCAS staffing costs	Assistive Technologies and Equipment	Community based equipment	

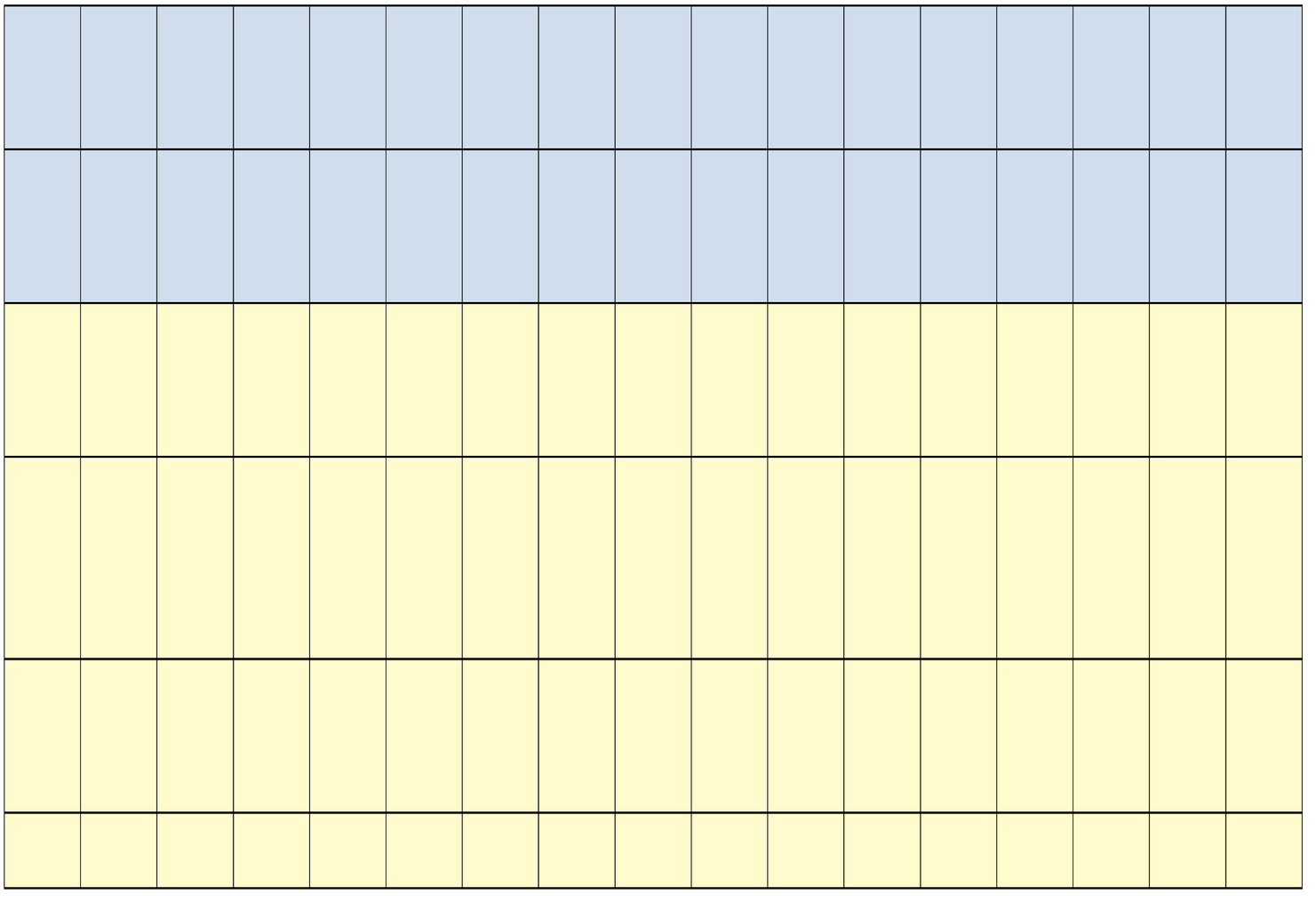
23	Helpline and Response (OCS)	Helpline and Response (OCS)	Prevention / Early Intervention	Choice Policy	
24	Reablement services (OCS)	Reablement services (OCS)	Community Based Schemes	Multidisciplinary teams that are supporting	
25	Hospital and Urgent Care Social Work Team	Hospital and Urgent Care Social Work Team	High Impact Change Model for Managing	Early Discharge Planning	
26	Healthwatch	Healthwatch	Other		oversight and signposting
27	Medlock court - Reablement residential	Medlock court - Reablement residential	Bed based intermediate Care Services	Step down (discharge to assess pathway-2)	
28	Residential Respite	Residential Respite	Residential Placements	Supported accommodation	
29	Community Equipment	Community Equipment	Assistive Technologies and Equipment	Community based equipment	
30	Council funded SRFT Services	Council Funded SRFT Services	Community Based Schemes	Multidisciplinary teams that are supporting	
31	Minor Adaptations	Minor Adaptations	Housing Related Schemes		
32	Strategic Partnerships	Strategic Partnerships	Carers Services	Respite services	
33	Minimum eligibility threshold	Minimum eligibility threshold	Home Care or Domiciliary Care	Domiciliary care packages	
34	Marie Curie	Cancer care at home	Personalised Care at Home	Physical health/wellbeing	
35	Clinical support to Medlock Court	Clinical support to Medlock Court	Community Based Schemes	Multidisciplinary teams that are supporting	
36	Stroke Association	Community stroke support - healthcare	Community Based Schemes	Multidisciplinary teams that are supporting	
37	Stroke Association	Community stroke support - navigating benefits and other	Community Based Schemes	Multidisciplinary teams that are supporting	
38	DFG	OMBC Disabled Facilities Grant (Capital Expenditure)	DFG Related Schemes	Adaptations, including statutory DFG	
39	iBCF	Improved Better Care Fund 2021-22	Community Based Schemes	Other	IBCF allocation used to support a range of

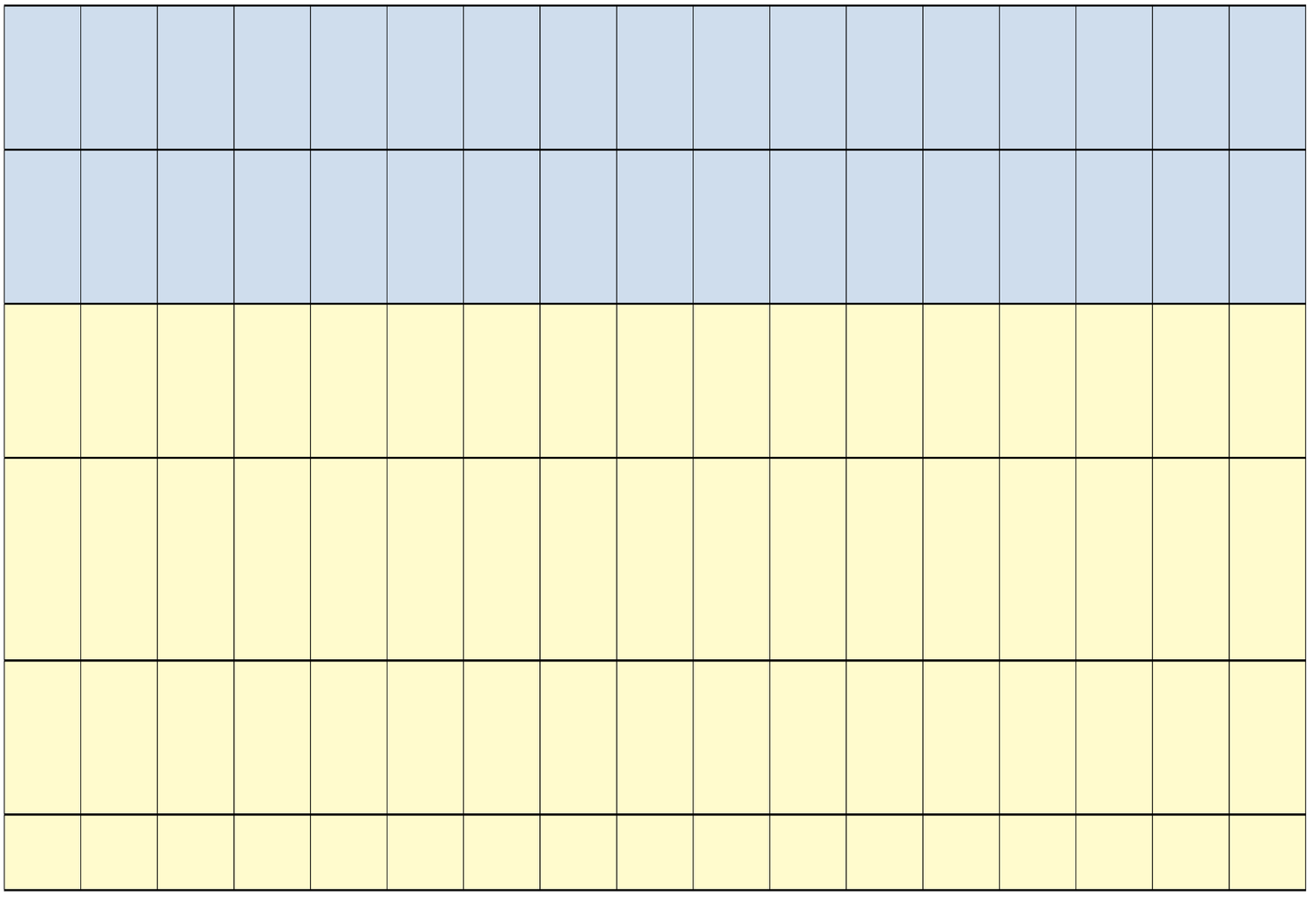
40	Respite Care	Respite Care (OCAS)	Carers Services	Respite services	
41	Home form Hospital	Home from Hospital	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge	
42	Shared Lives	Shared Lives (OCAS)	Community Based Schemes	Integrated neighbourhood services	
43	Mental Health Assesment and Rehabilitation	Mental Health Assesment and Rehabilitation (Miocare)	Community Based Schemes	Integrated neighbourhood services	
44	Oldham Community Leisure	Community physio / exercise classes	Prevention / Early Intervention	Social Prescribing	
45	Oldham Community Leisure	Community physio / exercise classes	Prevention / Early Intervention	Social Prescribing	
46	iBCF	Improved Better Care Fund 2021-22	Home Care or Domiciliary Care	Other	IBCF allocation used to support a range of
47	iBCF	Improved Better Care Fund 2021-22	Reablement in a persons own home	Other	IBCF allocation used to support a range of
48	iBCF	Improved Better Care Fund 2021-22	Residential Placements	Other	IBCF allocation used to support a range

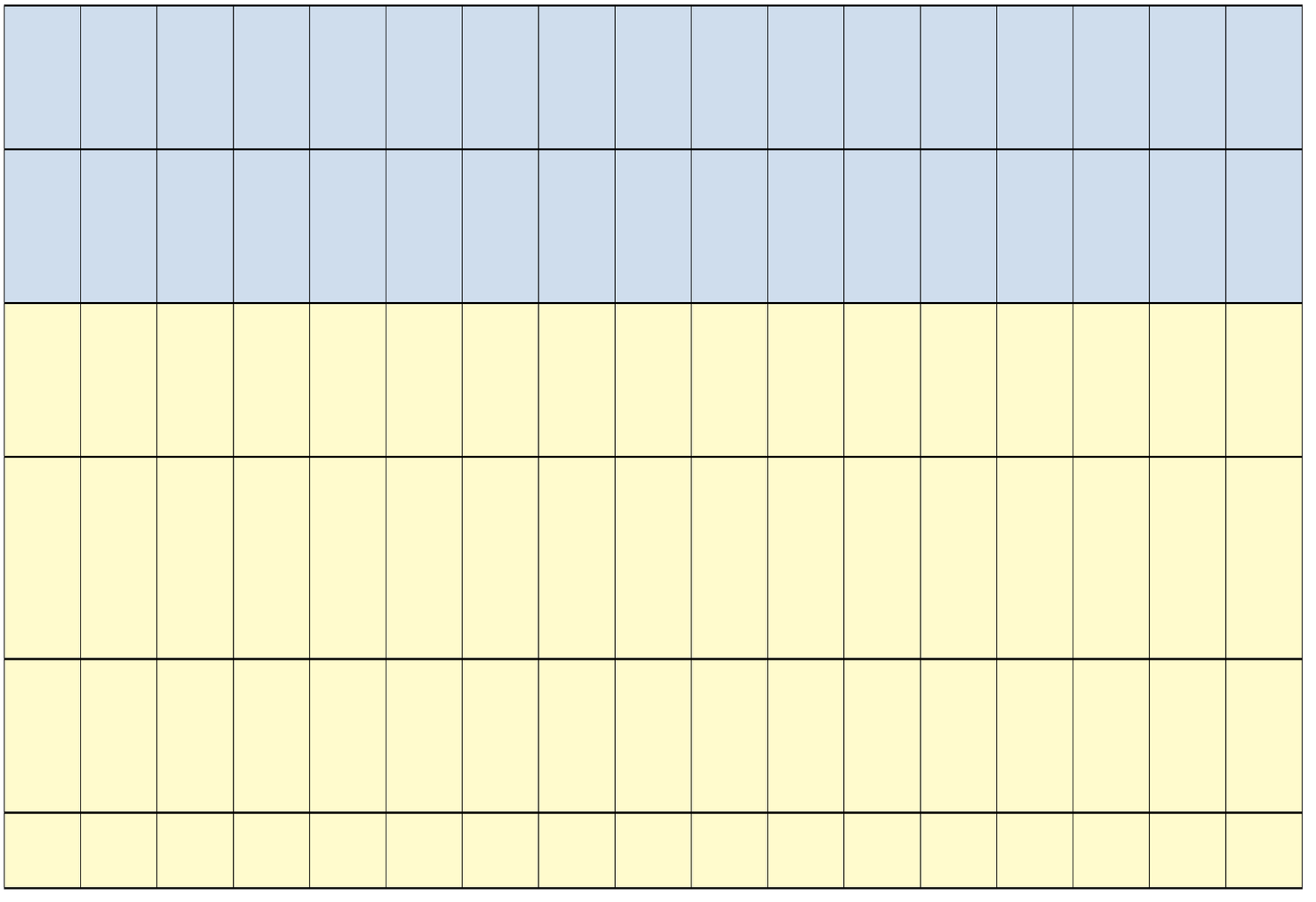


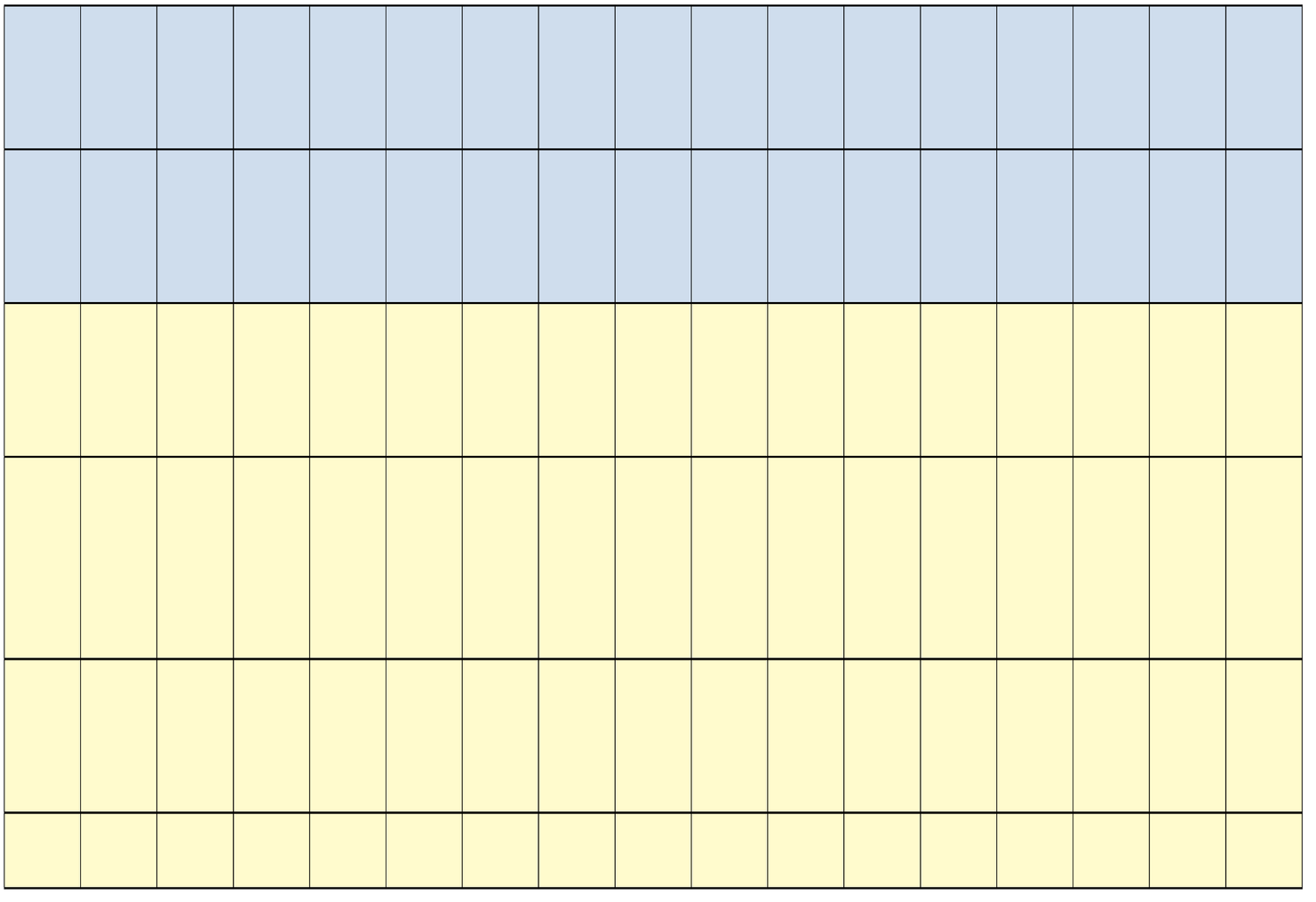


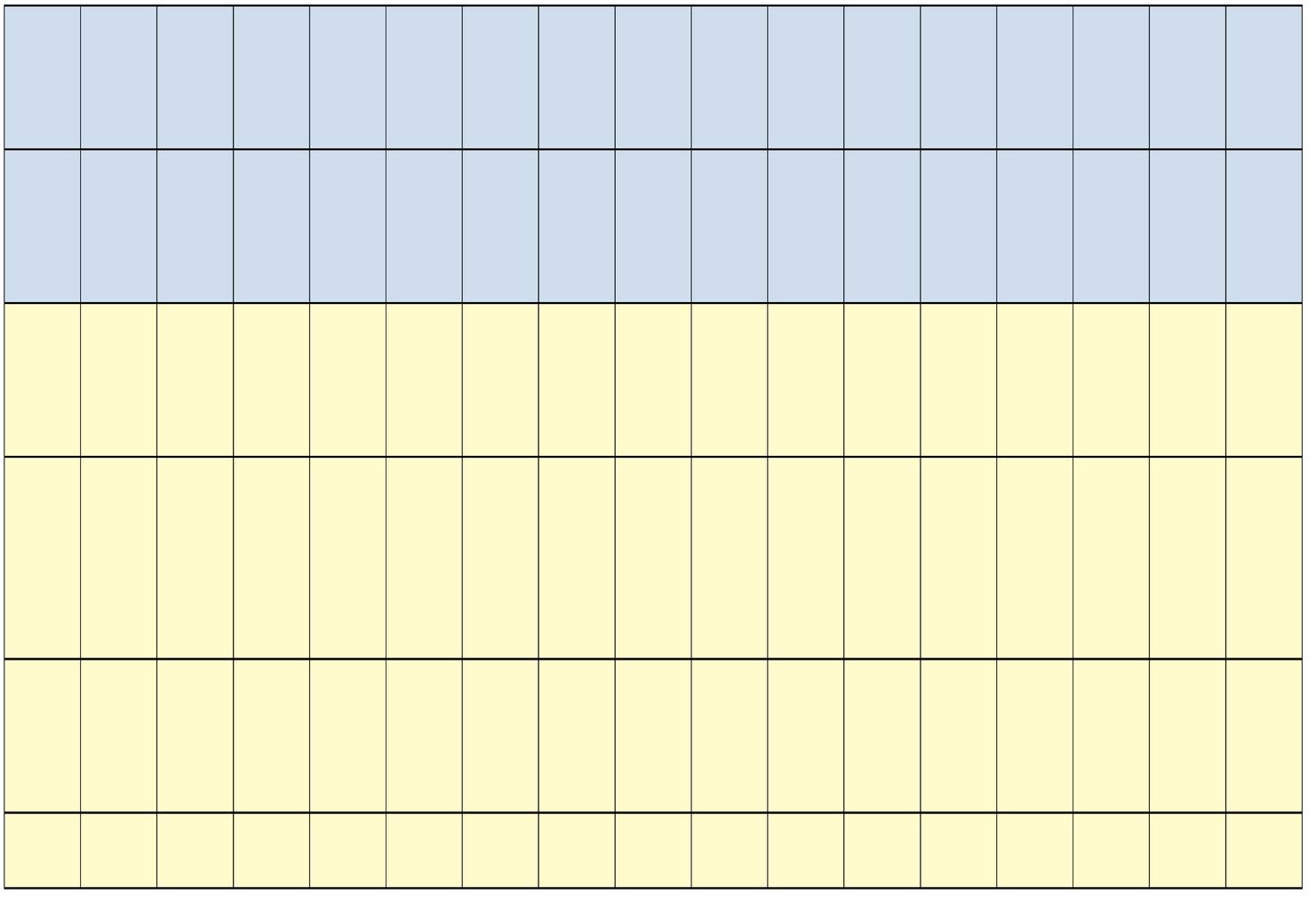


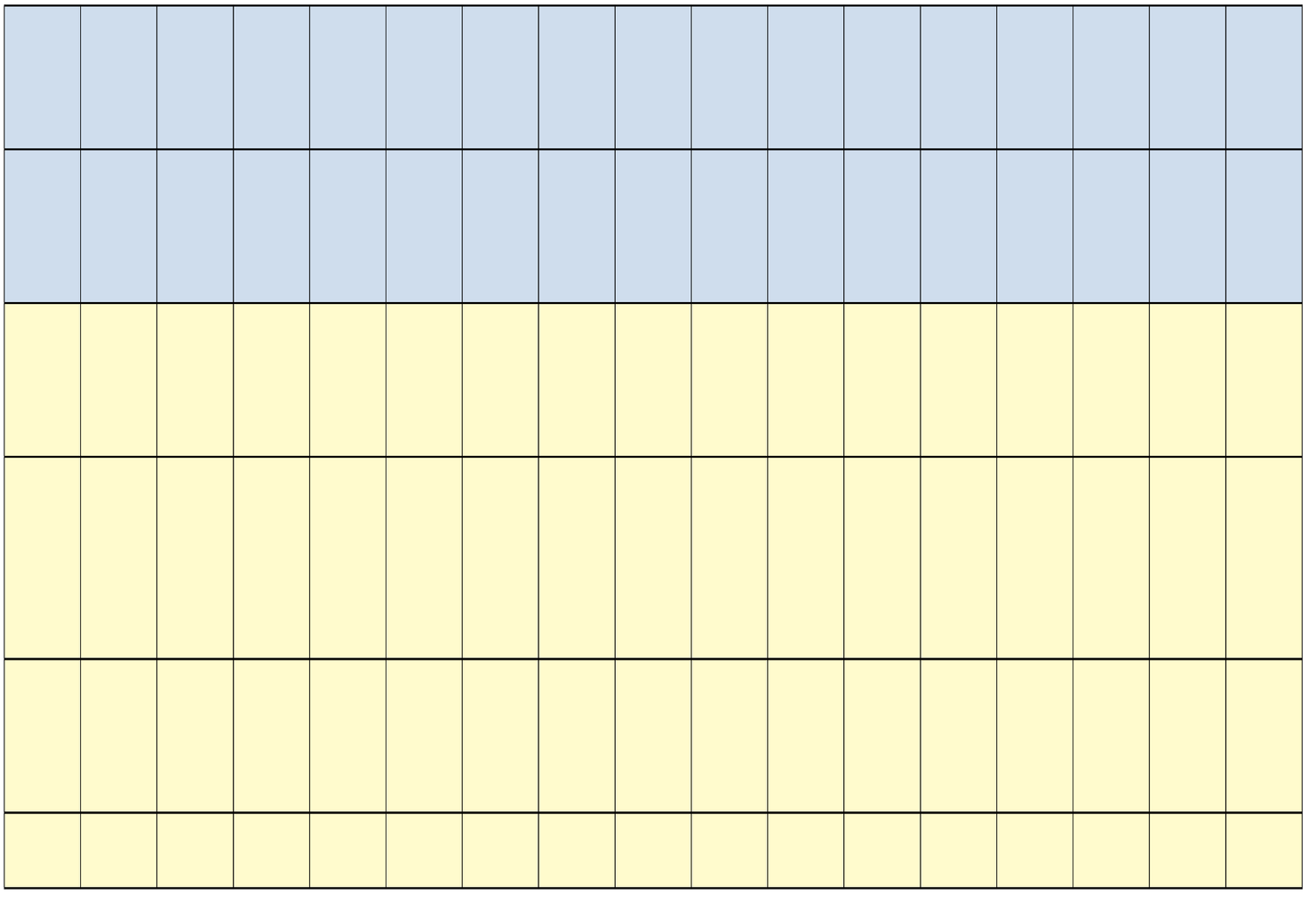


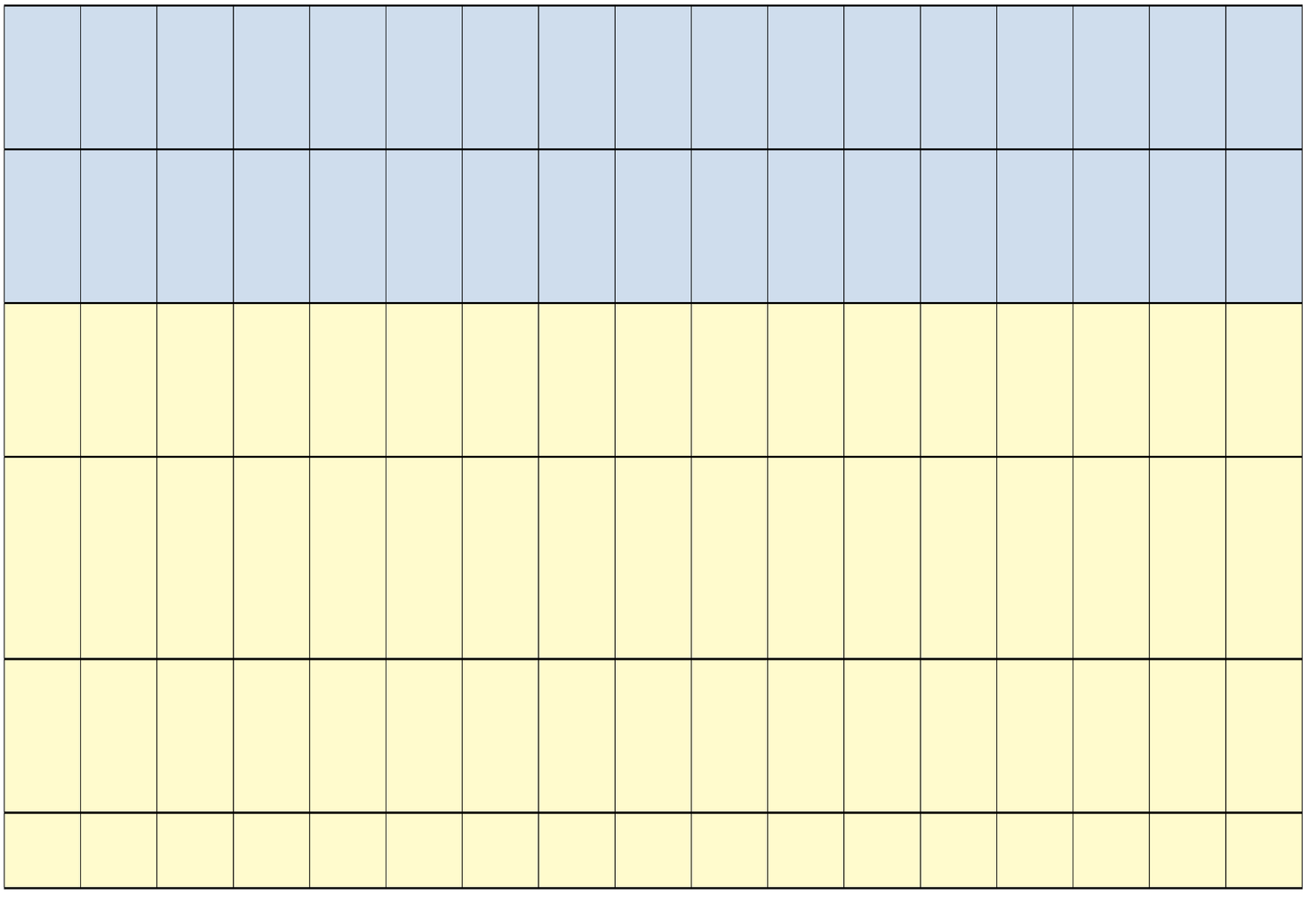


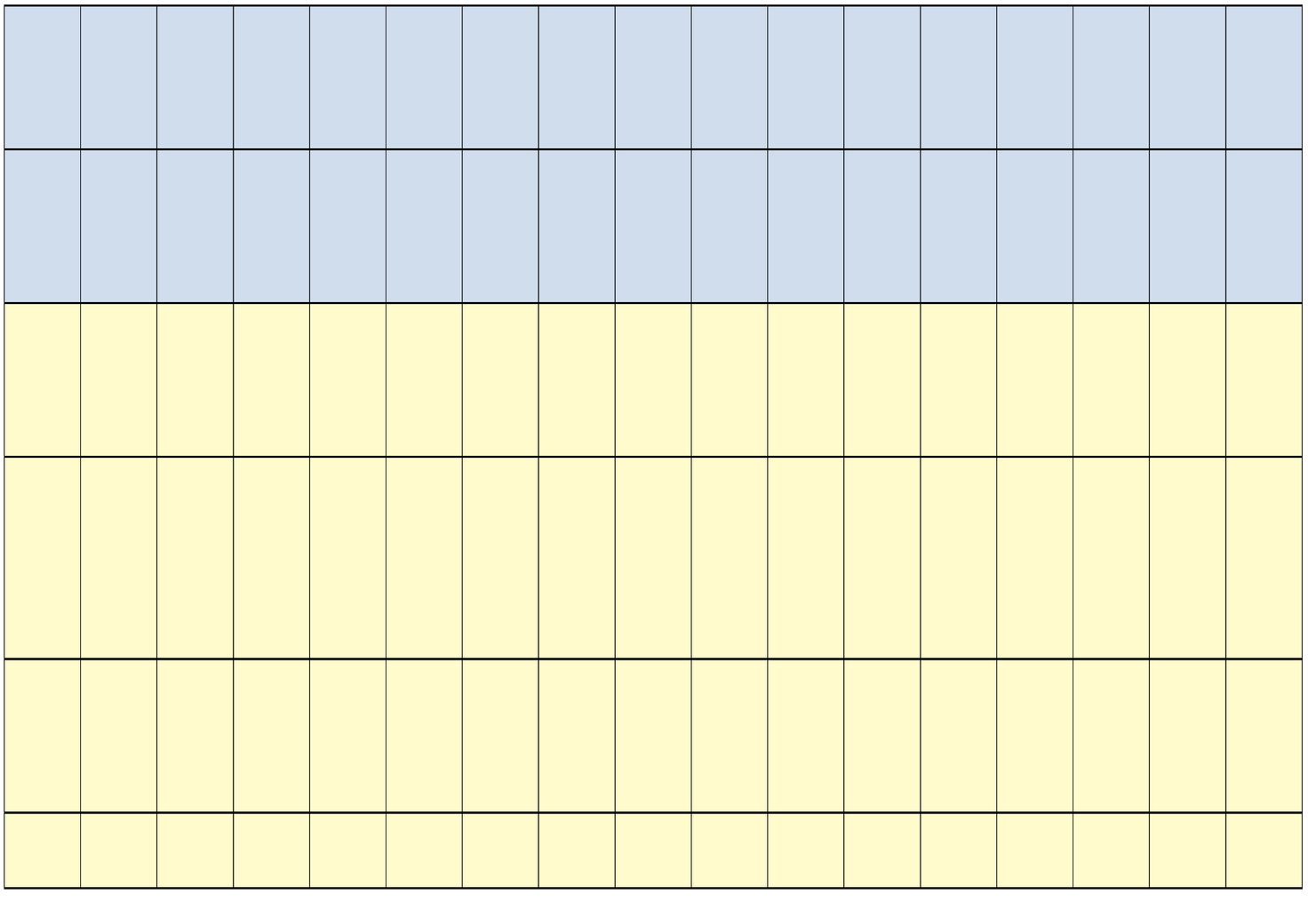


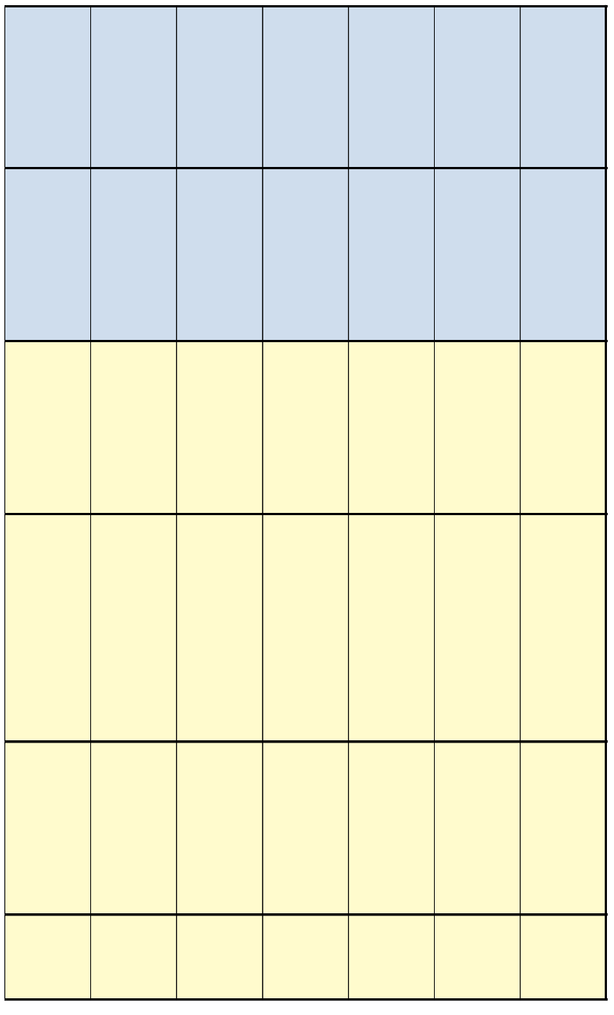












Expenditure	Balance
£2,343,287	£0
£19,662,703	£0
£10,858,680	£0
£0	£0
£4,966	£0
£32,869,636	**£0**

total Minimum CCG Contribution (on row 31 above).

n Required Spend	Planned Spend	Under Spend
£5,587,583	£7,322,006	£0
£13,210,523	£13,217,885	£0

Yes	Yes	Yes	Yes		Yes	Yes	Yes	Yes

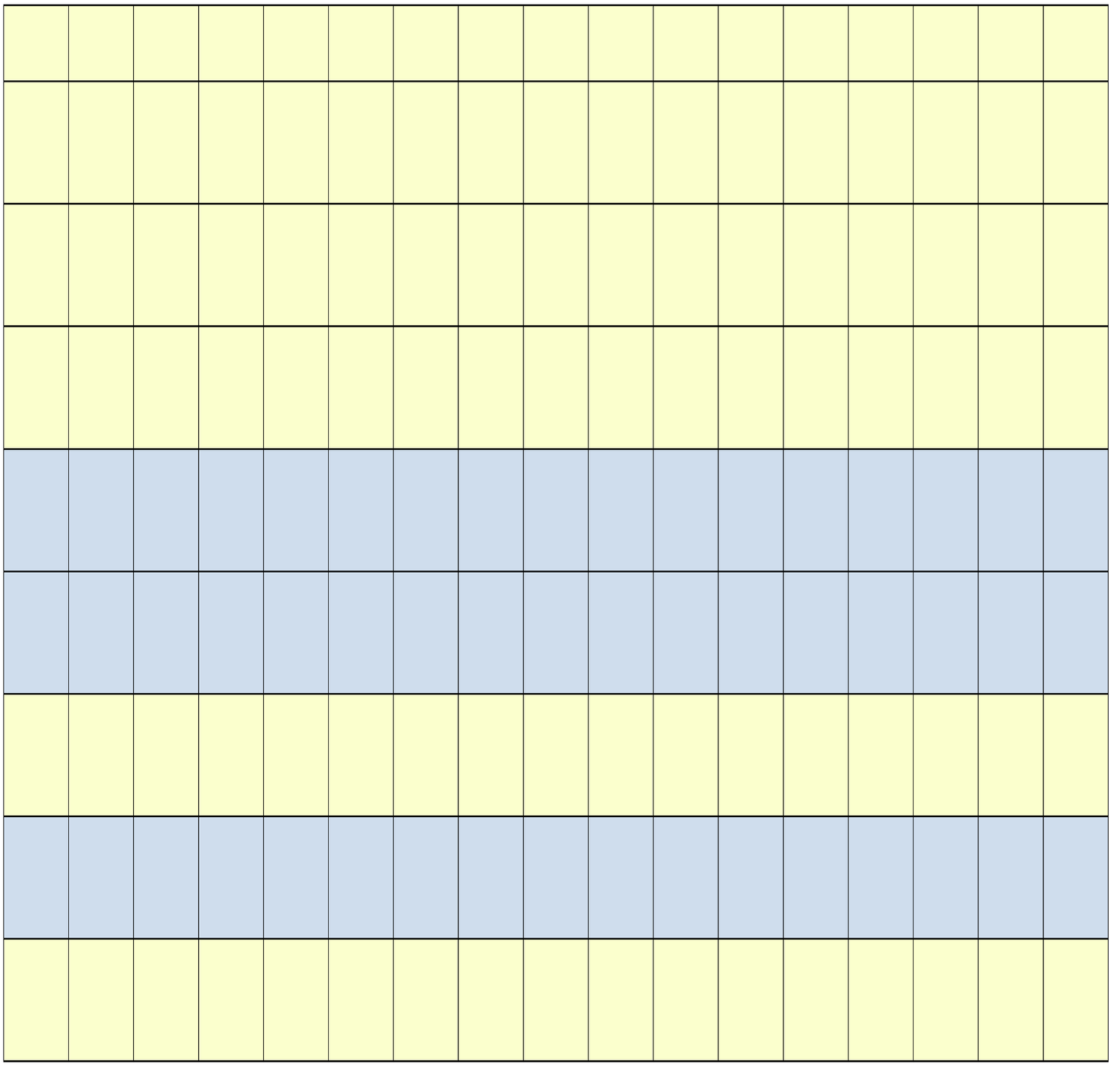
Planned Expenditure

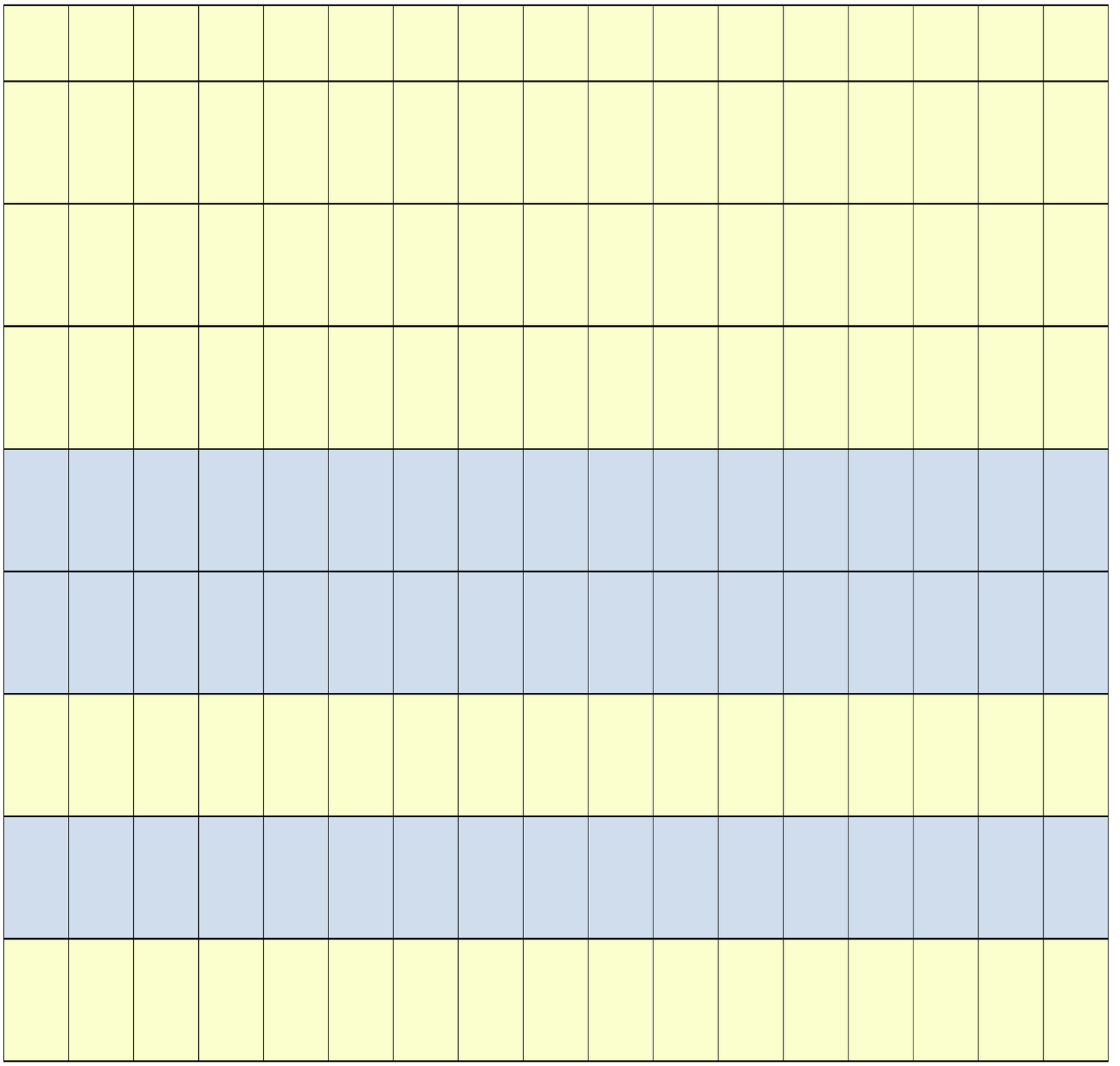
Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	Expenditure (£)	New/ Existing Scheme
Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£2,365,346	Existing
Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£233,269	Existing
Social Care		CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£78,628	Existing
Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£940,716	Existing
Community Health		CCG			Private Sector	Minimum CCG Contribution	£266,890	Existing

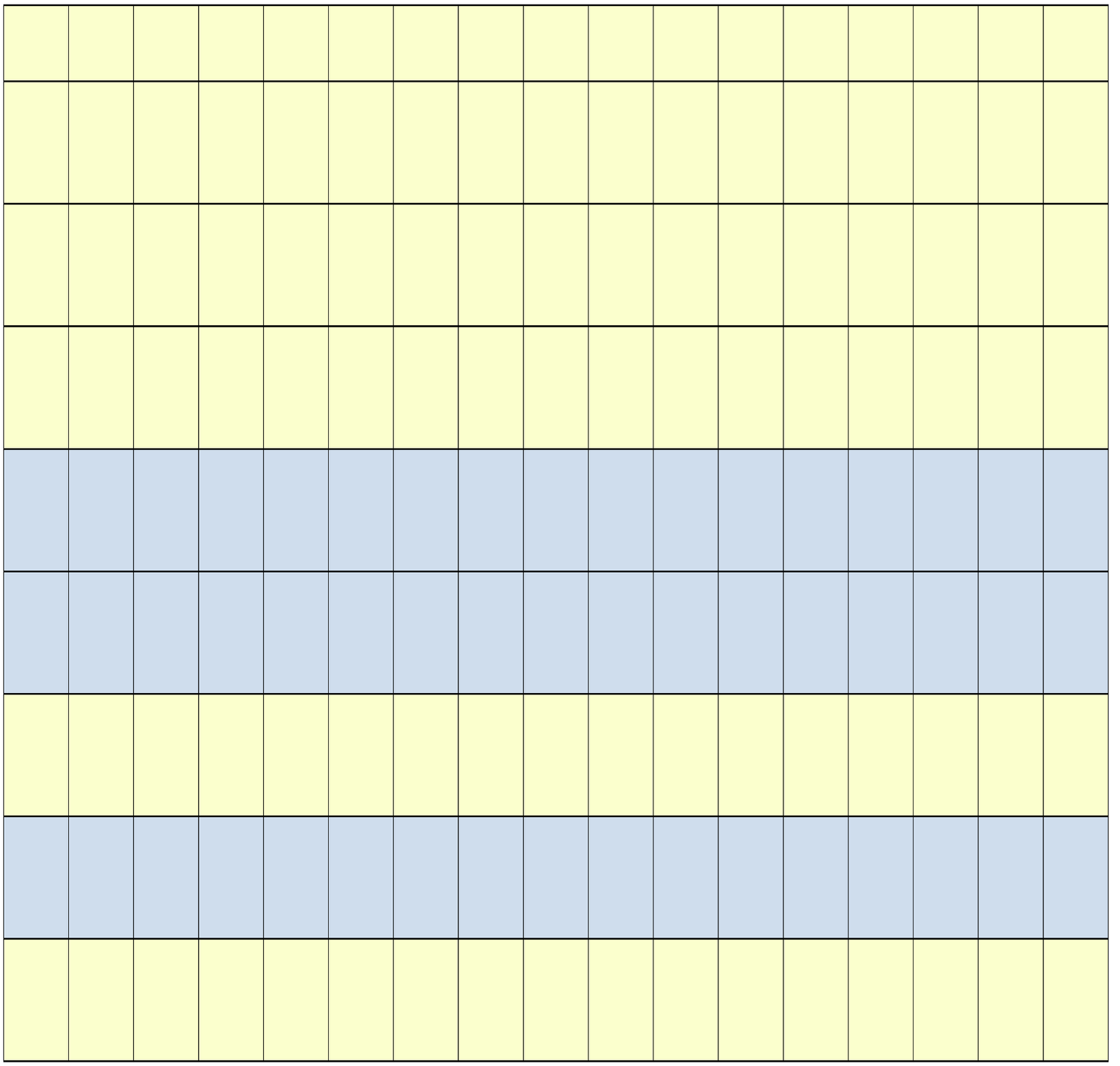
Community Health		CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£79,579	Existing
Community Health		CCG			Private Sector	Minimum CCG Contribution	£587,459	Existing
Community Health		CCG			Local Authority	Minimum CCG Contribution	£928,652	Existing
Social Care		CCG			Local Authority	Minimum CCG Contribution	£455,218	Existing
Social Care		CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£18,437	Existing
Social Care		CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£104,318	Existing
Social Care		CCG			Private Sector	Minimum CCG Contribution	£0	Existing
Acute		CCG			NHS Acute Provider	Minimum CCG Contribution	£113,243	Existing
Social Care		CCG			Local Authority	Minimum CCG Contribution	£125,000	Existing
Mental Health		CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£74,406	Existing
Mental Health		CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£35,523	Existing
Mental Health		CCG			NHS Mental Health Provider	Minimum CCG Contribution	£425,658	Existing
Mental Health		CCG			NHS Mental Health Provider	Minimum CCG Contribution	£147,388	Existing
Mental Health		CCG			CCG	Minimum CCG Contribution	£34,728	Existing
Mental Health		CCG			Private Sector	Minimum CCG Contribution	£21,956	Existing
Social Care		LA			Private Sector	Minimum CCG Contribution	£2,824,324	Existing
Social Care		LA			Local Authority	Minimum CCG Contribution	£308,260	Existing

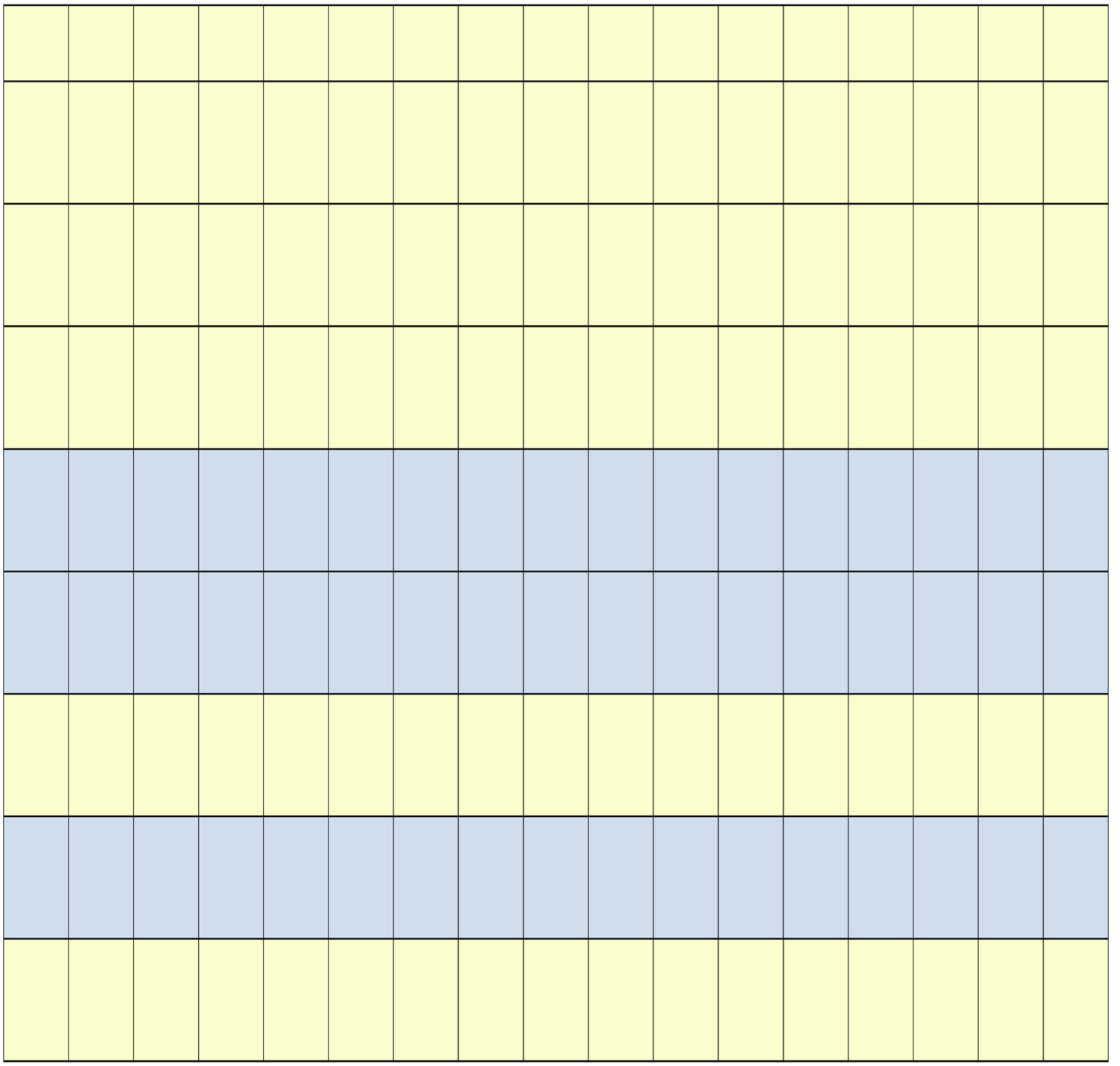
Social Care		LA			Local Authority	Minimum CCG Contribution	£1,230,420	Existing
Social Care		LA			Local Authority	Minimum CCG Contribution	£2,015,860	Existing
Social Care		LA			Local Authority	Minimum CCG Contribution	£936,780	Existing
Social Care		LA			Private Sector	Minimum CCG Contribution	£167,200	Existing
Social Care		LA			Local Authority	Minimum CCG Contribution	£1,753,090	Existing
Social Care		LA			Private Sector	Minimum CCG Contribution	£0	Existing
Social Care		LA			Private Sector	Minimum CCG Contribution	£840,000	Existing
Social Care		LA			NHS Community Provider	Minimum CCG Contribution	£408,930	Existing
Social Care		LA			Private Sector	Minimum CCG Contribution	£110,000	Existing
Social Care		LA			Local Authority	Minimum CCG Contribution	£469,160	Existing
Social Care		LA			Private Sector	Minimum CCG Contribution	£0	Existing
Community Health		CCG			CCG	Minimum CCG Contribution	£45,530	New
Social Care		CCG			CCG	Minimum CCG Contribution	£164,283	New
Community Health		CCG			CCG	Minimum CCG Contribution	£103,944	New
Social Care		CCG			CCG	Minimum CCG Contribution	£44,548	New
Social Care		LA			Local Authority	DFG	£2,343,287	Existing
Social Care		LA			Local Authority	iBCF	£2,714,670	Existing

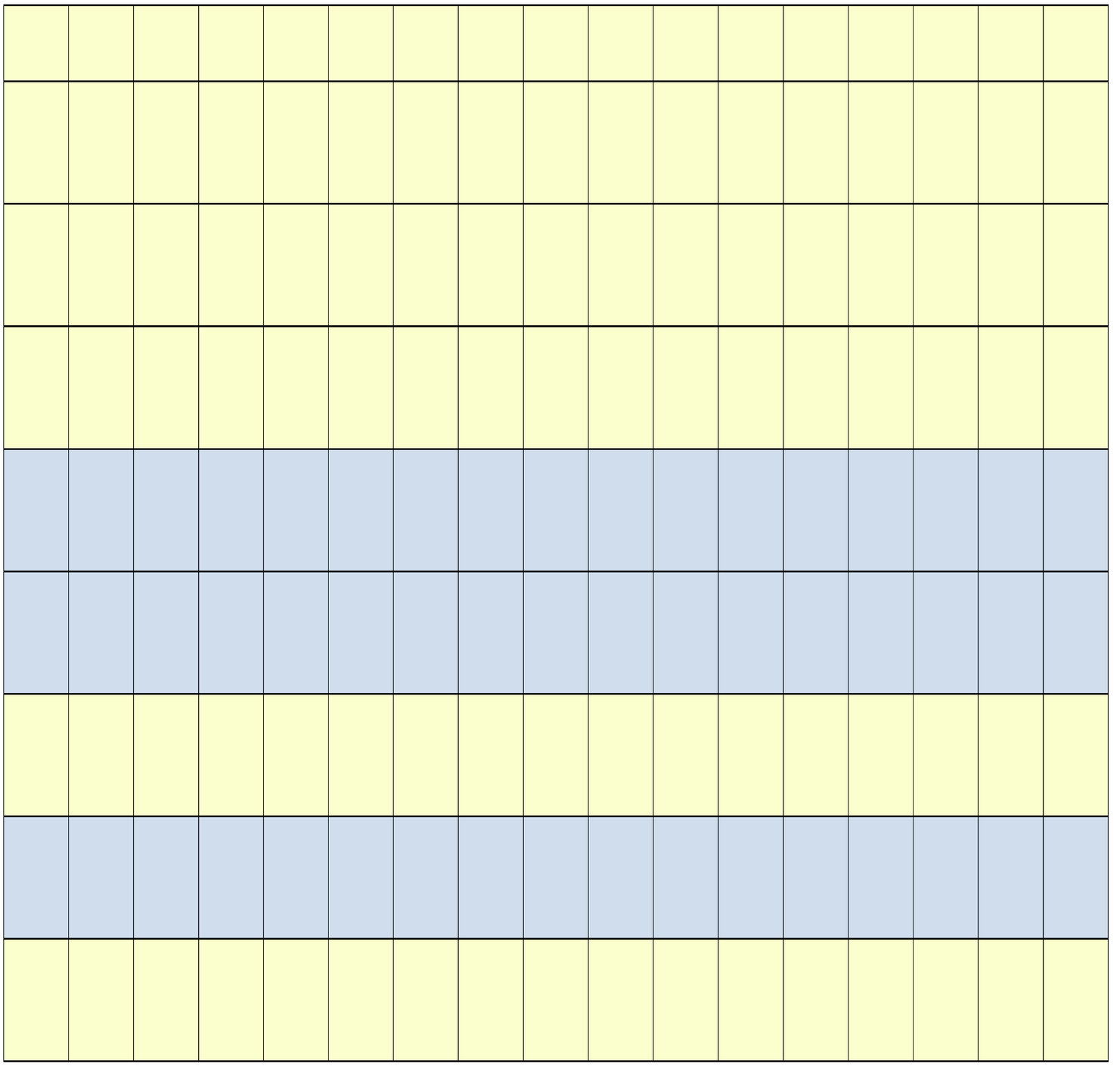
Social Care		LA			Local Authority	Minimum CCG Contribution	£559,860	New
Social Care		LA			Private Sector	Minimum CCG Contribution	£100,000	New
Social Care		LA			Local Authority	Minimum CCG Contribution	£283,770	New
Social Care		LA			Local Authority	Minimum CCG Contribution	£219,800	New
Community Health		CCG			CCG	Minimum CCG Contribution	£40,529	New
Community Health		CCG			CCG	Additional CCG Contribution	£4,966	New
Social Care		LA			Local Authority	iBCF	£2,714,670	Existing
Social Care		LA			Local Authority	iBCF	£2,714,670	Existing
Social Care		LA			Local Authority	iBCF	£2,714,670	Existing

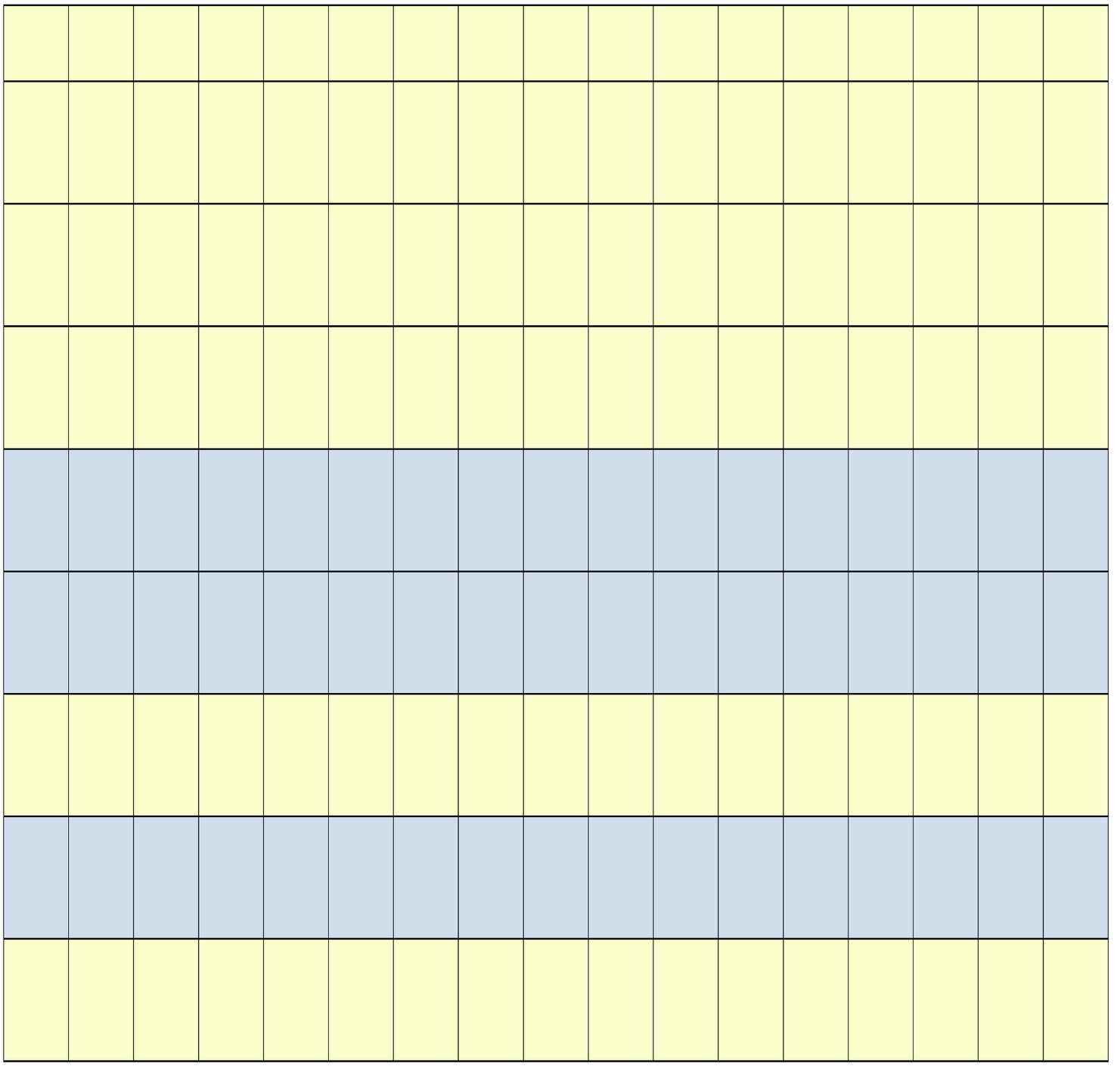


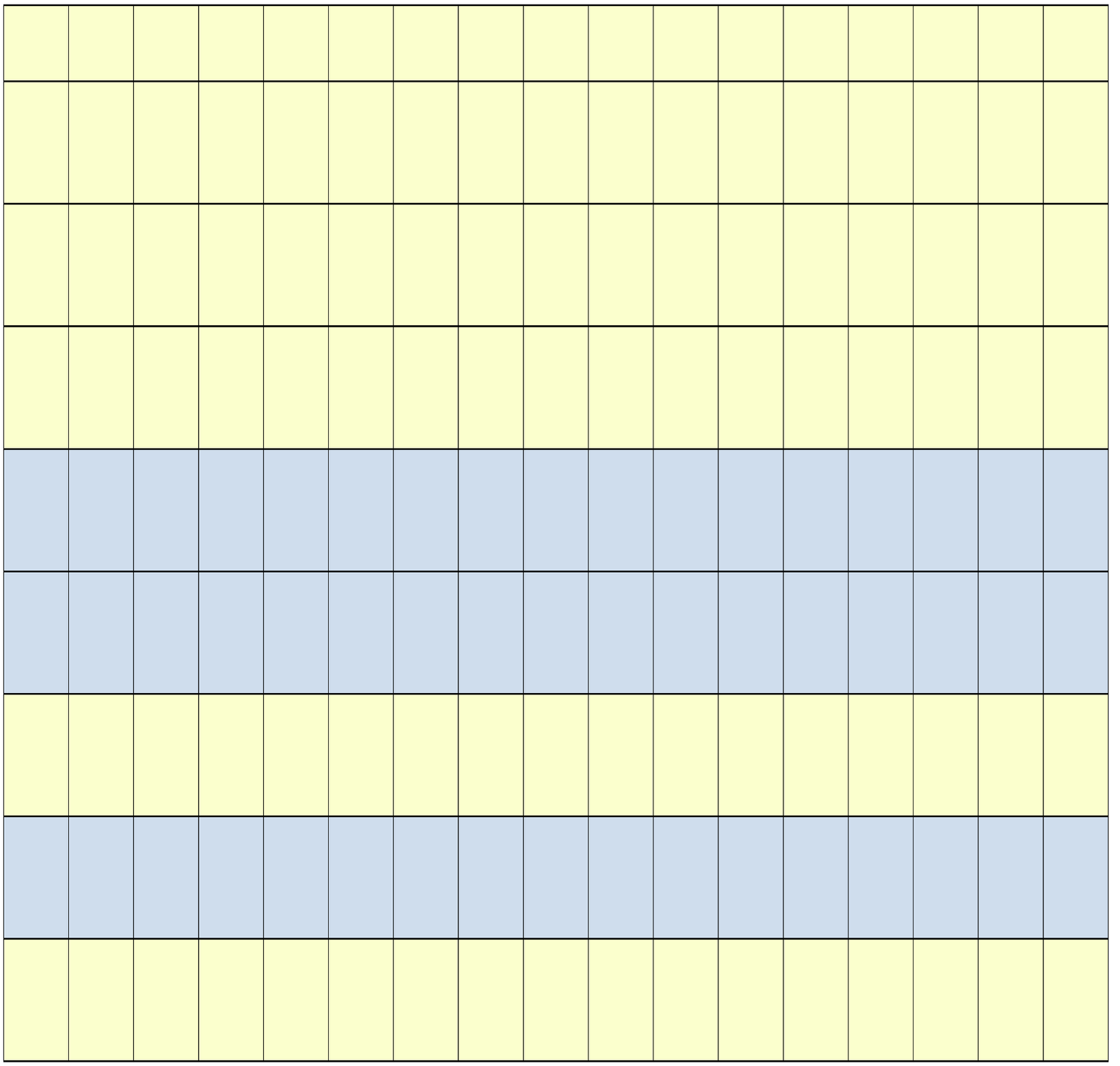


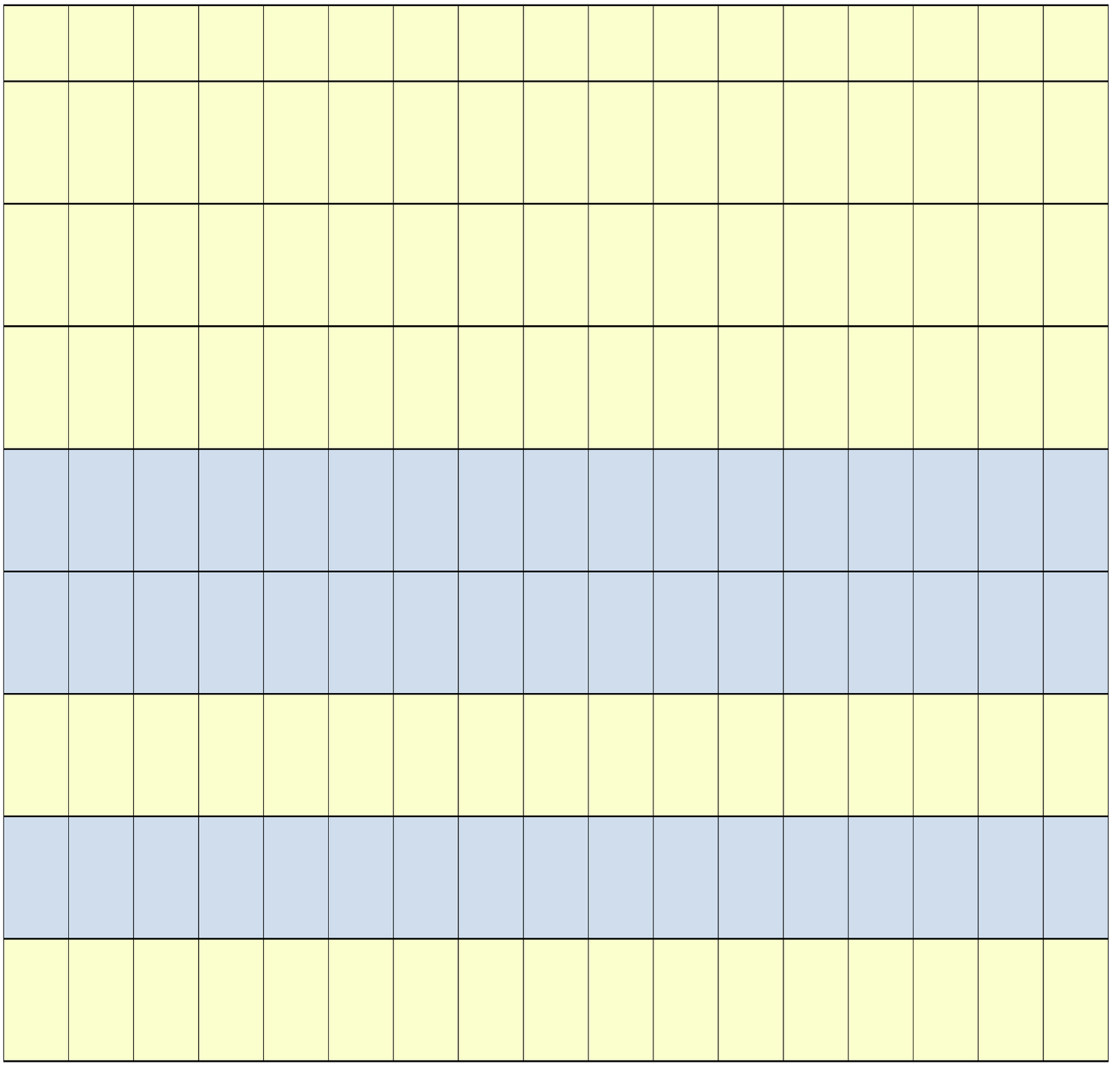


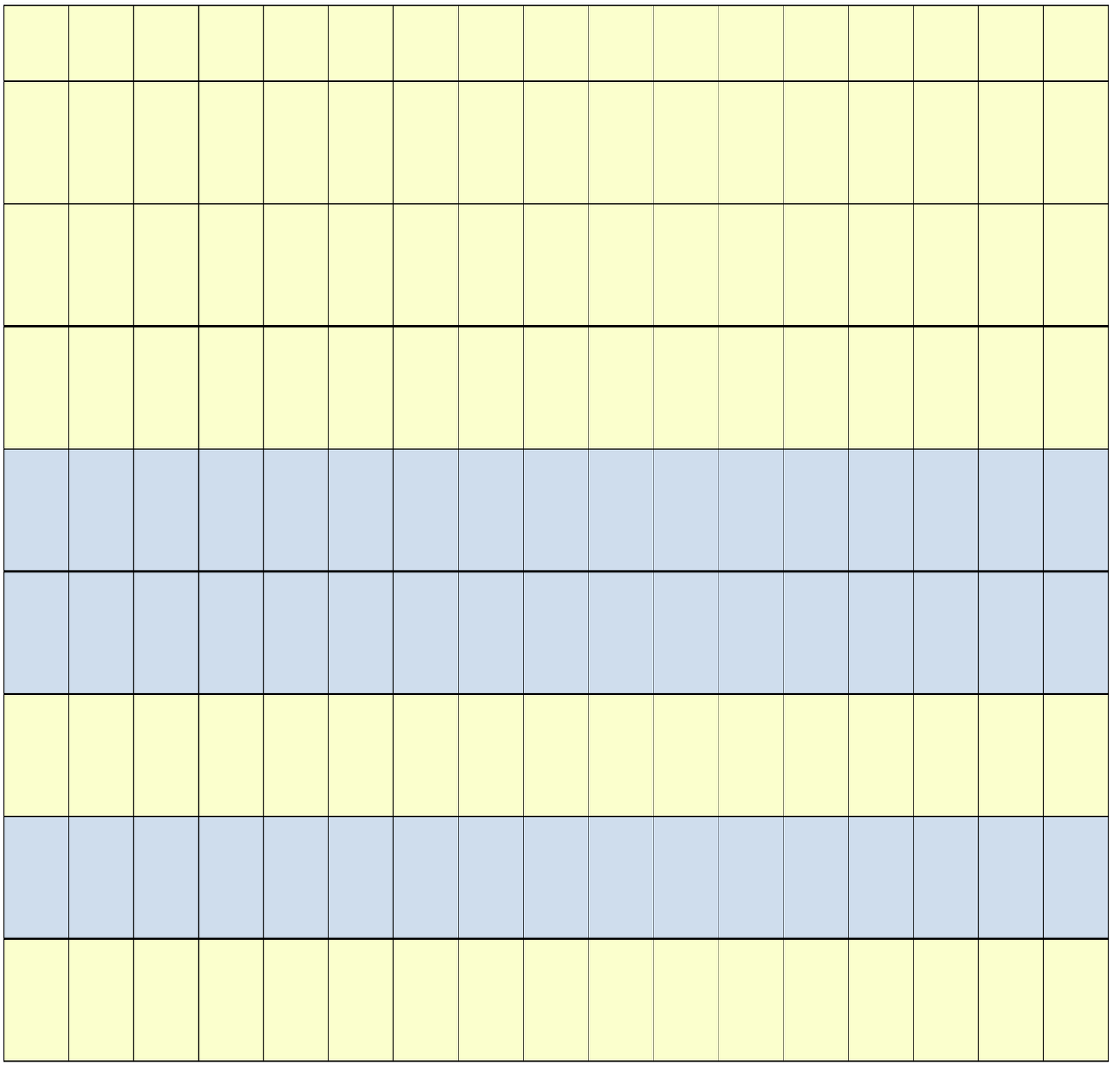


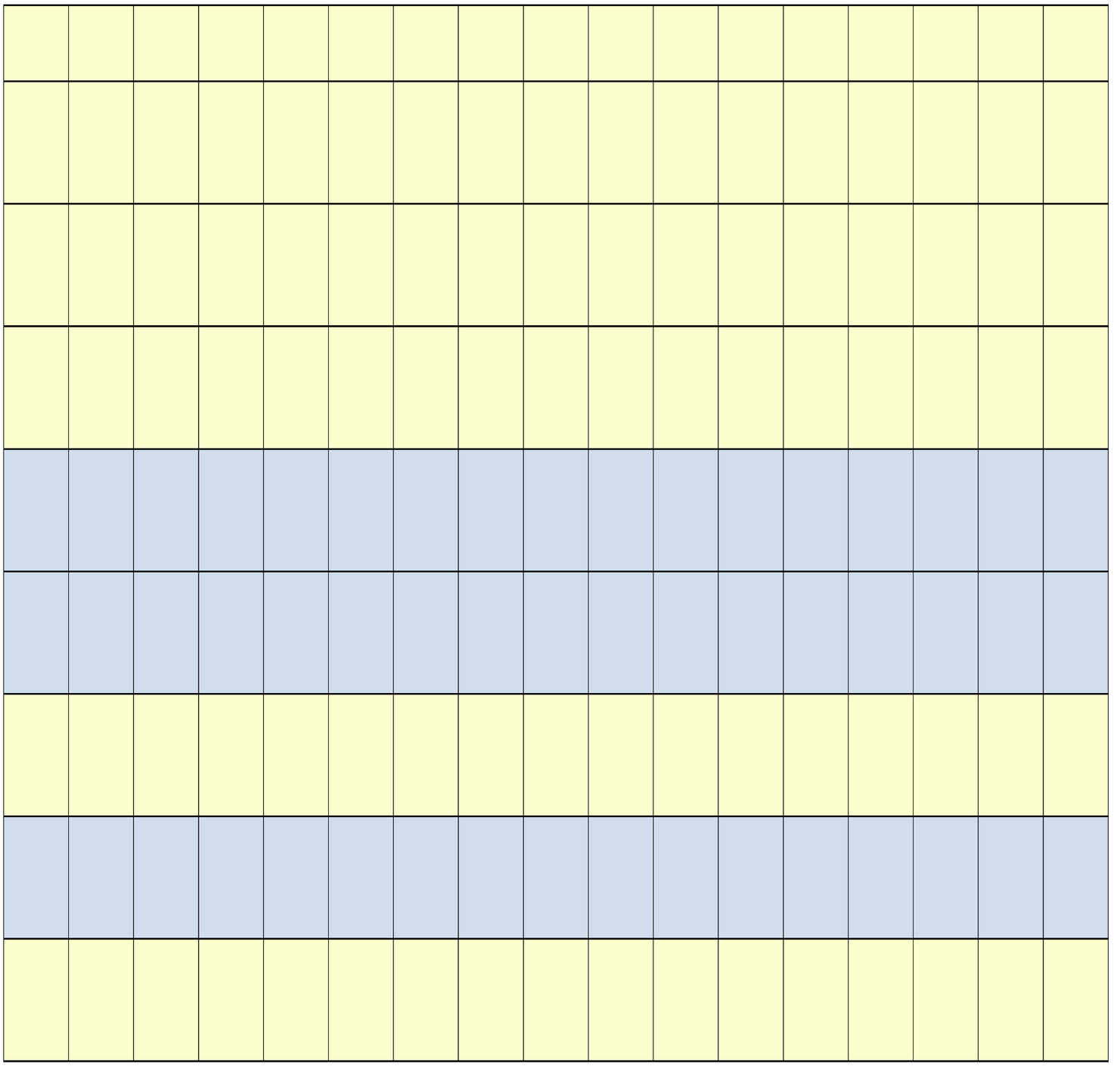


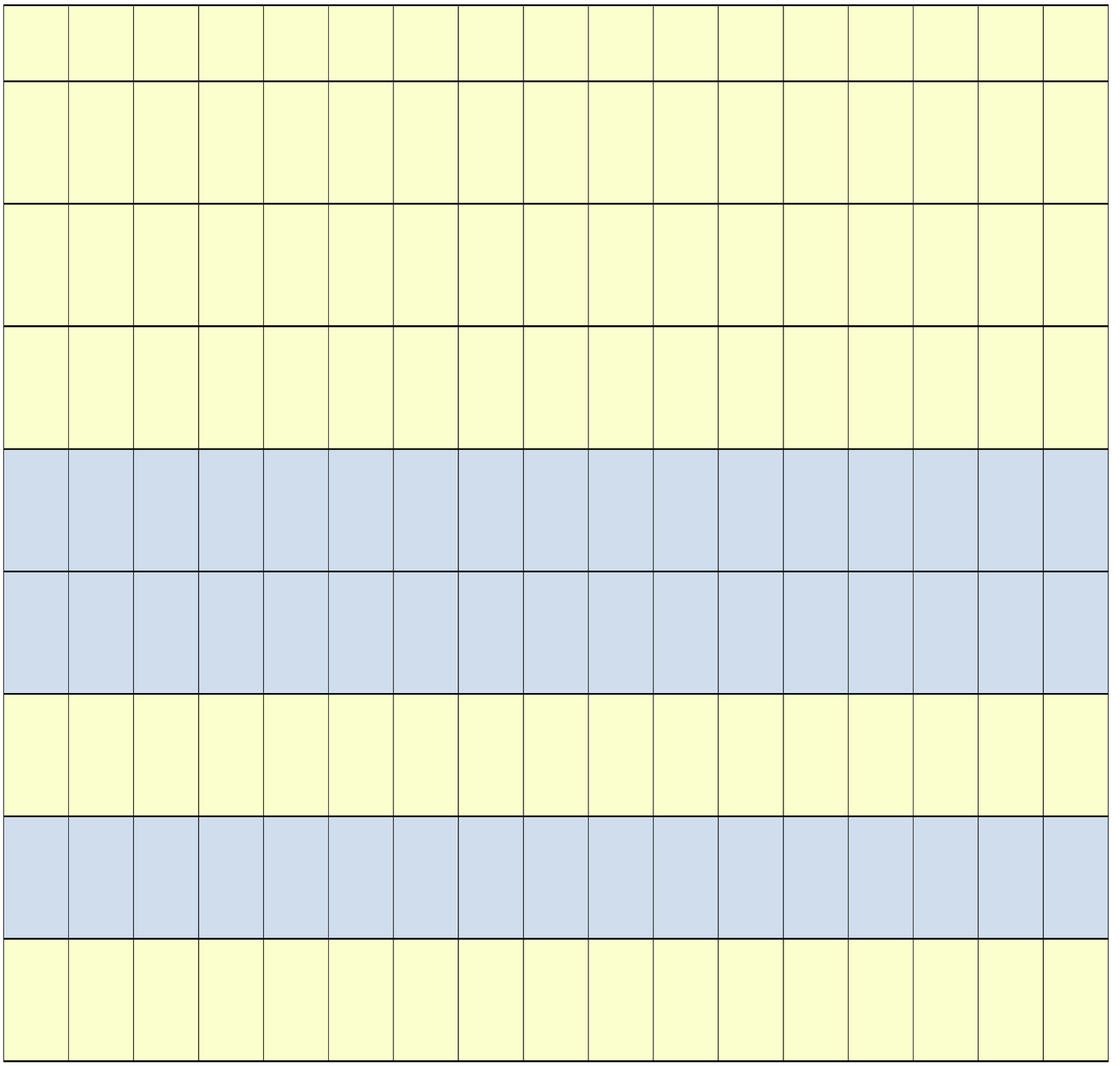












2021-22 Revised Scheme types

Number	Scheme type/ services	Sub type
1	Assistive Technologies and Equipment	1. Telecare 2. Wellness services 3. Digital participation services 4. Community based equipment 5. Other
2	Care Act Implementation Related Duties	1. Carer advice and support 2. Independent Mental Health Advocacy 3. Other
3	Carers Services	1. Respite services 2. Other
4	Community Based Schemes	1. Integrated neighbourhood services 2. Multidisciplinary teams that are supporting independence, such as anticipatory care 3. Low level support for simple hospital discharges (Discharge to Assess pathway 0) 4. Other
5	DFG Related Schemes	1. Adaptations, including statutory DFG grants 2. Discretionary use of DFG - including small adaptations 3. Handyperson services 4. Other
6	Enablers for Integration	1. Data Integration 2. System IT Interoperability 3. Programme management 4. Research and evaluation 5. Workforce development 6. Community asset mapping 7. New governance arrangements 8. Voluntary Sector Business Development 9. Employment services 10. Joint commissioning infrastructure 11. Integrated models of provision 12. Other

7	High Impact Change Model for Managing Transfer of Care	1. Early Discharge Planning 2. Monitoring and responding to system demand and capacity 3. Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge 4. Home First/Discharge to Assess - process support/core costs 5. Flexible working patterns (including 7 day working) 6. Trusted Assessment 7. Engagement and Choice 8. Improved discharge to Care Homes 9. Housing and related services 10. Red Bag scheme 11. Other
8	Home Care or Domiciliary Care	1. Domiciliary care packages 2. Domiciliary care to support hospital discharge (Discharge to Assess pathway 1) 3. Domiciliary care workforce development 4. Other
9	Housing Related Schemes	
10	Integrated Care Planning and Navigation	1. Care navigation and planning 2. Assessment teams/joint assessment 3. Support for implementation of anticipatory care 4. Other
11	Bed based intermediate Care Services	1. Step down (discharge to assess pathway-2) 2. Step up 3. Rapid/Crisis Response 4. Other

12	Reablement in a persons own home	1. Preventing admissions to acute setting 2. Reablement to support discharge -step down (Discharge to Assess pathway 1) 3. Rapid/Crisis Response - step up (2 hr response) 4. Reablement service accepting community and discharge referrals 5. Other
13	Personalised Budgeting and Commissioning	
14	Personalised Care at Home	1. Mental health /wellbeing 2. Physical health/wellbeing 3. Other
15	Prevention / Early Intervention	1. Social Prescribing 2. Risk Stratification 3. Choice Policy 4. Other
16	Residential Placements	1. Supported living 2. Supported accommodation 3. Learning disability 4. Extra care 5. Care home 6. Nursing home 7. Discharge from hospital (with reablement) to long term residential care (Discharge to Assess Pathway 3) 8. Other
17	Other	

Description
Using technology in care processes to supportive self-management, maintenance of independence and more efficient and effective delivery of care. (eg. Telecare, Wellness services, Community based equipment, Digital participation services).
Funding planned towards the implementation of Care Act related duties. The specific scheme sub types reflect specific duties that are funded via the CCG minimum contribution to the BCF.
Supporting people to sustain their role as carers and reduce the likelihood of crisis. This might include respite care/carers breaks, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence.
Schemes that are based in the community and constitute a range of cross sector practitioners delivering collaborative services in the community typically at a neighbourhood/PCN level (eg: Integrated Neighbourhood Teams) Reablement services shoukld be recorded under the specific scheme type 'Reablement in a person's own home'
The DFG is a means-tested capital grant to help meet the costs of adapting a property; supporting people to stay independent in their own homes. The grant can also be used to fund discretionary, capital spend to support people to remain independent in their own homes under a Regulatory Reform Order, if a published policy on doing so is in place. Schemes using this flexibility can be recorded under 'discretionary use of DFG' or 'handyperson services' as appropriate
Schemes that build and develop the enabling foundations of health, social care and housing integration, encompassing a wide range of potential areas including technology, workforce, market development (Voluntary Sector Business Development: Funding the business development and preparedness of local voluntary sector into provider Alliances/ Collaboratives) and programme management related schemes. Joint commissioning infrastructure includes any personnel or teams that enable joint commissioning. Schemes could be focused on Data Integration, System IT Interoperability, Programme management, Research and evaluation, Supporting the Care Market, Workforce development, Community asset mapping, New governance arrangements, Voluntary Sector Development, Employment services, Joint commissioning infrastructure amongst others.

The eight changes or approaches identified as having a high impact on supporting timely and effective discharge through joint working across the social and health system. The Hospital to Home Transfer Protocol or the 'Red Bag' scheme, while not in the HICM, is included in this section.
A range of services that aim to help people live in their own homes through the provision of domiciliary care including personal care, domestic tasks, shopping, home maintenance and social activities. Home care can link with other services in the community, such as supported housing, community health services and voluntary sector services.
This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.
Care navigation services help people find their way to appropriate services and support and consequently support self-management. Also, the assistance offered to people in navigating through the complex health and social care systems (across primary care, community and voluntary services and social care) to overcome barriers in accessing the most appropriate care and support. Multi-agency teams typically provide these services which can be online or face to face care navigators for frail elderly, or dementia navigators etc. This includes approaches such as Anticipatory Care, which aims to provide holistic, co-ordinated care for complex individuals. Integrated care planning constitutes a co-ordinated, person centred and proactive case management approach to conduct joint assessments of care needs and develop integrated care plans typically carried out by professionals as part of a multi-disciplinary, multi-agency teams. Note: For Multi-Disciplinary Discharge Teams related specifically to discharge, please select HICM as scheme type and the relevant sub-type. Where the planned unit of care delivery and funding is in the form of Integrated care packages and needs to be expressed in such a manner, please select the appropriate sub-type alongside.
Short-term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or avoidable admission to hospital or residential care. The care is person-centred and often delivered by a combination of professional groups. Four service models of intermediate care are: bed-based intermediate care, crisis or rapid response (including falls), home-based intermediate care, and reablement or rehabilitation. Home-based intermediate care is covered in Scheme-A and the other three models are available on the sub-types.

Provides support in your own home to improve your confidence and ability to live as independently as possible
Various person centred approaches to commissioning and budgeting, including direct payments.
Schemes specifically designed to ensure that a person can continue to live at home, through the provision of health related support at home often complemented with support for home care needs or mental health needs. This could include promoting self-management/expert patient, establishment of 'home ward' for intensive period or to deliver support over the longer term to maintain independence or offer end of life care for people. Intermediate care services provide shorter term support and care interventions as opposed to the ongoing support provided in this scheme type.
Services or schemes where the population or identified high-risk groups are empowered and activated to live well in the holistic sense thereby helping prevent people from entering the care system in the first place. These are essentially upstream prevention initiatives to promote independence and well being.
Residential placements provide accommodation for people with learning or physical disabilities, mental health difficulties or with sight or hearing loss, who need more intensive or specialised support than can be provided at home.
Where the scheme is not adequately represented by the above scheme types, please outline the objectives and services planned for the scheme in a short description in the comments column.

Better Care Fund 2021-22 Template

6. Metrics

Selected Health and Wellbeing Board: Oldham

8.1 Avoidable admissions

	19-20 Actual	20-21 Actual	21-22 Plan	Overview Narrative
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	Available from NHS Digital (link below) at local authority level. Please use as guideline only	900.1	1,198.0	2019/20 baseline was 1,261. The primary reason for the reduction in admissions since March 2020 was due to the necessity to close a number of beds at Royal Oldham Hospital in order to comply with Infection Prevention Control measures, and have designated Covid and non-covid beds. The reduction in bed base

>> link to NHS Digital webpage

8.2 Length of Stay

		21-22 Q3 Plan	21-22 Q4 Plan	Comments
Percentage of in patients, resident in the HWB, who have been an inpatient in an acute hospital for: i) 14 days or more ii) 21 days or more As a percentage of all inpatients (SUS data - available on the Better Care Exchange)	Proportion of inpatients resident for 14 days or more	10.1%	10.0%	Oldham has historically had low 14+ day LOS in comparison to other GM localities due to the small bed base. Recent activity has shown a small increase in LoS, which is the same across GM. A number of factors are contributing to the rise in LoS. Some patients admitted due to Covid have had very lengthy stays in ICU, and then onwards recovery in the bed base, which has contributed. There are also cases
	Proportion of inpatients resident for 21 days or more	5.2%	5.0%	

8.3 Discharge to normal place of residence

	21-22 Plan	Comments
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	92.0%	Oldham has historically been relatively successful in discharging patients to their usual place of residence. Due to the need to discharge some patients to designated settings throughout the pandemic in order to isolate, the number of people discharged to their usual place of residence decreased. During the last year,

8.4 Residential Admissions

19-20 Plan	19-20 Actual	20-21 Actual	21-22 Plan	Comments

Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	805	887	599	638	The projection for 2021/22 is based on both current and 2020/21 performance levels adjusted to consider the impacts of COVID-19. Current services are focused on residential and community-based enablement. Community health
	Numerator	308	340	230	250	
	Denominator	38,284	38,312	38,417	39,180	

Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population (aged 65+) popu
2018 based Sub-National Population Projections for Local Authorities in England:
https://www.ons.gov.uk/releases/subnationalpopulationprojectionsforengland2018based

8.5 Reablement

		19-20 Plan	19-20 Actual	21-22 Plan	Comments
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	90.4%	93.6%	93.5%	Ensuring people have access to to the reablement support they need is a key element of Oldham's Locality Plan. Both residential and home-based reablement are key components of our work in this area. It works across our community health and social care services to ensure that people receive the support they need. The current
	Numerator	113	88	87	
	Denominator	125	94	93	

Please note that due to the splitting of Northamptonshire, information from previous years will not reflect the present geographies. As such, all pre-populate
combined.

For North Northamptonshire HWB and West Northamptonshire HWB, please comment on individual HWBs rather than Northamptonshire as a whole.

Please set out the overall plan in the HWB area for reducing rates of unplanned hospitalisation for chronic ambulatory sensitive conditions, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.

Please set out the overall plan in the HWB area for reducing the percentage of hospital inpatients with a long length of stay (14 days or over and 21 days and over) including a rationale for the ambitions that sets out how these have been reached in partnership with local hospital trusts, and an assessment of how the schemes and enabling activity in the BCF are expected to impact on the metric. See the main planning requirements document for more information.

Please set out the overall plan in the HWB area for improving the percentage of people who return to their normal place of residence on discharge from acute hospital, including a rationale for how the ambition was reached and an assessment of how the schemes and enabling activity in the BCF are expected to impact on the metric. See the main planning requirements document for more information.

Please set out the overall plan in the HWB area for reducing rates of admission to residential and nursing homes for people over the age of 65, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.

ılation projections are based on a calendar year using the

Please set out the overall plan in the HWB area for increasing the proportion of older people who are still at home 91 days after discharge from hospital into reablement/rehabilitation, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.

d figures above for Northamptonshire have been

Better Care Fund 2021-22 Template

7. Confirmation of Planning Requirements

Selected Health and Wellbeing Board: Oldham

Theme	Code	Planning Requirement	Key considerations for meeting the planning requirement These are the Key Lines of Enquiry (KLOEs) underpinning the Planning Requirements (PR)	Confirmed through
NC1: Jointly agreed plan	**PR1**	**A jointly developed and agreed plan that all parties sign up to**	Has a plan; jointly developed and agreed between CCG(s) and LA; been submitted? Has the HWB approved the plan/delegated approval pending its next meeting? Have local partners, including providers, VCS representatives and local authority service leads (including housing and DFG leads) been involved in the development of the plan? Where the narrative section of the plan has been agreed across more than one HWB, have individual income, expenditure and metric sections of the plan been submitted for each HWB concerned?	Cover sheet Cover sheet Narrative plan Validation of submitted plans
	PR2	**A clear narrative for the integration of health and social care**	**Is there a narrative plan for the HWB that describes the approach to delivering integrated health and social care that describes:** • How the area will continue to implement a joined-up approach to integrated, person-centred services across health, care, housing and wider public services locally. • The approach to collaborative commissioning • The overarching approach to support people to remain independent at home, and how BCF funding will be used to support this. • How the plan will contribute to reducing health inequalities and inequalities for people with protected characteristics? This should include - How equality impacts of the local BCF plan have been considered, - Changes to local priorities related to health inequality and equality, including as a result of the COVID 19 pandemic, and how activities in the BCF plan will address these	Narrative plan assurance
	PR3	**A strategic, joined up plan for DFG spending**	**Is there confirmation that use of DFG has been agreed with housing authorities?** • Does the narrative set out a strategic approach to using housing support, including use of DFG funding that supports independence at home? • In two tier areas, has: - Agreement been reached on the amount of DFG funding to be passed to district councils to cover statutory Disabled Facilities Grants? or - The funding been passed in its entirety to district councils?	Narrative plan Confirmation sheet
NC2: Social Care Maintenance	**PR4**	**A demonstration of how the area will maintain the level of spending on social care services from the CCG minimum contribution to the fund in line with the uplift in the overall contribution**	Does the total spend from the CCG minimum contribution on social care match or exceed the minimum required contribution (auto-validated on the planning template)?	Auto-validated on the planning template

NC3: NHS commissioned Out of Hospital Services	**PR5**	**Has the area committed to spend at equal to or above the minimum allocation for NHS commissioned out of hospital services from the CCG minimum BCF contribution?**	Does the total spend from the CCG minimum contribution on non-acute, NHS commissioned care exceed the minimum ringfence (auto-validated on the planning template)?	Auto-validated on the planning template
NC4: Plan for improving outcomes for people being discharged from hospital	**PR6**	**Is there an agreed approach to support safe and timely discharge from hospital and continuing to embed a home first approach?**	• Does the BCF plan demonstrate an agreed approach to commissioning services to support discharge and home first including: - support for safe and timely discharge, and - implementation of home first? • Does the expenditure plan detail how expenditure from BCF funding sources supports this approach through the financial year? • Is there confirmation that plans for discharge have been developed and agreed with Hospital Trusts?	Narrative plan assurance Expenditure tab Narrative plan

Agreed expenditure plan for all elements of the BCF	**PR7**	**Is there a confirmation that the components of the Better Care Fund pool that are earmarked for a purpose are being planned to be used for that purpose?**	• Do expenditure plans for each element of the BCF pool match the funding inputs? (auto-validated) • Is there confirmation that the use of grant funding is in line with the relevant grant conditions? (see paragraphs 32 – 43 of Planning Requirements) (tick-box) • Has funding for the following from the CCG contribution been identified for the area: - Implementation of Care Act duties? - Funding dedicated to carer-specific support? - Reablement?	Expenditure tab Expenditure plans and confirmation sheet Narrative plans and confirmation sheet
Metrics	**PR8**	**Does the plan set stretching metrics and are there clear and ambitious plans for delivering these?**	• Have stretching metrics been agreed locally for all BCF metrics? • Is there a clear narrative for each metric describing the approach locally to meeting the ambition set for that metric, including how BCF expenditure will support performance against each metric? • Are ambitions across hospital trusts and HWBs for reducing the proportion of inpatients that have been in hospital for 21 days aligned, and is this set out in the rationale? • Have hospital trusts and HWBs developed and agreed plans jointly for reducing the proportion of inpatients that have been in hospital for 14 days or more and 21 days or more?	Metrics tab

Please confirm whether your BCF plan meets the Planning Requirement?	Please note any supporting documents referred to and relevant page numbers to assist the assurers	Where the Planning requirement is not met, please note the actions in place towards meeting the requirement	Where the Planning requirement is not met, please note the anticipated timeframe for meeting it
Yes	A draft submission was shared on 9/11/21 with David Jago, the Chief Officer of Oldham Care Organisation at the Northern Care Alliance FT. The final submission was shared with the Oldham Integrated Delivery Board on 24/11/21		
Yes			
Yes			
Yes			

Yes			
Yes			

Yes			
Yes			

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Better Care Fund Narrative Plan 2021-22

Oldham Health & Wellbeing Board

November 2021

PART 1 Brief outline to embedding integration, person centred health, social care and housing services

1.1 The Oldham Better Care Fund Plan is based on the borough's Locality Plan for Health and Care Transformation that is currently subject to a refresh process. The Locality Plan was originally ratified by all health and care partners in November 2019 and forms the overarching strategy for local health and care transformation until March 2024. A full version of the Locality Plan is available on request.

1.2 The plan was finalised prior to the onset of the COVID-19 pandemic and prior to the announcements of the planned reforms to NHS commissioning and to wider national and regional reforms to the health and social care economy including the position of, and our involvement in, the devolved authority in Greater Manchester. While the existing strategy retains much of the original vision and direction and much of the planned implementation remains current, work is underway to extend where necessary and to refresh elements of the plan that require further development. A new comprehensive plan is expected to be in place before April 2022.

1.3 Our plan describes how we will continue to deliver significant improvements in the health and wellbeing outcomes of our residents as we move towards place-based, person centred provision of care and services. It focuses on the wider determinants of health and addressing health inequalities in our footprint. It also emphasises how public services will work together to support everyone to take more responsibility for their own health.

1.4 We want to design a health and care system that by 2024 helps people to start well, live well and age well, that improves the quality of care and services that our residents receive and ensures that the system is financially sustainable for the long-term so that we can continue to deliver the services that our residents need.

1.5 Our vision for health and wellbeing is set within the context of the Oldham Delivery Model. The model is built on three pillars;

- **Thriving Communities** – Enabling communities to make the right health and wellbeing choices and investing in community capacity.
- **Inclusive economy –** Building wealth for our communities and the right type of business opportunity that provide jobs and career paths linked into Education for the people of Oldham.
- **Co-operative services** – Integrating services around local resident need.

1.6 To support delivery of this change we have formed **Oldham Cares**. Oldham Cares is an alliance of health and social care commissioners and providers who are working together to achieve the following vision:

Oldham is a vibrant place, which embraces diversity and is where people are thriving and communities are safe and sustainable – it is a place where improved health and wellbeing is experienced by all, and where the health and wellbeing gap is reducing.

1.7 This improvement will be achieved by:

- Enabling people to be more in control of their lives and their care;
- A health and care system that is focused on wellbeing and the prevention of ill health;
- Addressing the wider determinants of health;
- Delivering support and care which is as close to, and connected with, home and community as possible;
- Consistent, reliable, good quality, person and community centred support and care that is available when necessary.

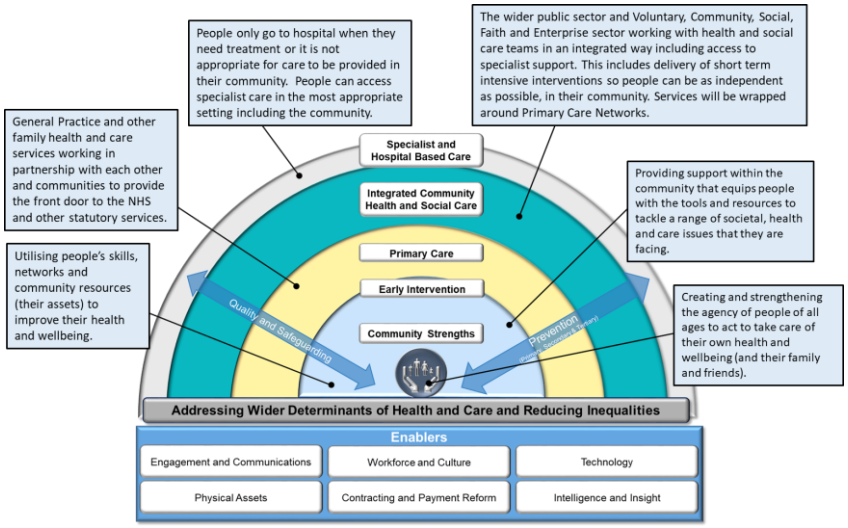
1.8 Plans are progressing for health and care to operate as an ICS to support the delivery of population health. Commissioners and providers are already implementing components of an ICS and are beginning to work seamlessly together to tackle the wider determinants of health and develop a consistent place based approach to planning and strategy rather than within organisational boundaries. Our priorities over next five years are to:

1. Focus on population health and wellbeing outcomes
2. Develop a strong community offer built on the foundation of Primary Care Networks
3. Deliver good quality, sustainable, specialist and hospital services
4. Undertake place based integration

1.9 To support the evolution of an ICS for Oldham a model of health and care has been developed. A model of care broadly describes how different health and care services, and partner organisations should work together in the future for a person, population group or patient cohort as they progress through the stages of a condition, injury or event. It aims to ensure people get the right care, in the right place at the right time, by the right team.

1.10 The model serves a high level visual that can be shared internally with staff to explain where services sit in the context of the wider health and care system. A blueprint from which more detailed models of care can be designed and delivered.

An All Age Model Built on Placed Based Integration with A Focus on Population Health



1.11 **A Population Health Management and Outcomes Focussed Approach -** Both the NHS and social care have a critical part to play in addressing the challenges in Oldham. However, these cannot be met by the health and care system alone. A much broader place based approach that pays more attention to the wider determinants of health and the role of a partnership of equals between the NHS, the local authority, public services and most importantly people and communities is required.

1.12 Population health principles and interventions can be applied at each tier within the Oldham health and care system; at an individual, neighbourhood, place and system level.

1.13 As an integral part of PHM, health and care commissioners and providers will be moving to a way of working that is focussed on population outcomes with an emphasis on prevention, wellbeing and encourages communities to flourish - the development of an outcomes focused system.

1.14 **Developing an Integrated Commissioning Function -** As the vehicle to commission for outcomes for the population, Oldham has developed an Integrated Commissioning Function (ICF). This has created the conditions and environment to deliver Oldham's vision, whilst continuing to develop and maintain a diverse and vibrant health and care economy that meets the needs and aspirations of local people, maximising social value, as well as delivering excellent health and social care services. It also ensures that the Care Act requirements for the Local Authority to develop a sustainable adult social care market is at the core of integrated decision making.

1.15 **An Increased Emphasis on Local Engagement -** As we enter into a new phase of commissioning development, we will create a framework within which a new conversation with our population about service change can take place in a way that is not tokenistic. In order to do this, we will ensure:

- that the nature of our discussion with the population will be genuinely *deliberative* and ask questions that are both strategically significant and genuinely 'open' in the sense that the answers from the process will affect what we do next.
- that we show the process by which the outcomes from such a conversation can be incorporated into our planning and delivery – or explain why certain aspirations are not possible.

PART 2 Supporting Discharge (national condition 4)

2.1 **Background -** From March 2020, in response to the pandemic, the Hospital Discharge Service requirements set out revised processes for hospital discharges, including a requirement that people should be discharged the same day that they no longer need to be in an acute hospital, with the implementation of a 'home first' approach.

2.2 The revised processes set out in the Hospital Discharge and Community Support: Policy and Operating Model, highlighted the need to implement a discharge to assess model and establish a 'transfer of care hub' to provide the appropriate care and support. This required NHS organisations to work closely with adult social care and housing colleagues, the care sector and the voluntary sector.

2.3 **Oldham's Discharge Response Offer** - Community Health & Adult Social Care (CHASC) discharge and enablement (D&E) offer in Oldham is an integrated Health and Social Care service with specialist community teams supporting our local population. These teams work together for the best outcomes to support discharges, with the four key aims to:

- *Support people to remain at home*
- *Help people to avoid going into hospital unnecessarily*
- *Help people return home from hospital as soon as they are medically safe to do so*
- *Prevent people from having to move into a residential home until they really need to*

2.4 The Integrated Discharge and Community Response Hub is at the centre of Oldham's community urgent care offer and has been developed to meet the operating model requirements. As the service also responds to the requirement for a 2-hour community health response, the hub will evolve, and work is underway to link more closely to the primary care digital hub and soon to be updated Urgent Care Hub. The other two critical components of the model are the Integrated Crisis Enablement Team (ICET) and Community Reablement. ICET provides support for up to five days for people discharged from hospital and referred from the community. Community Reablement provides rehabilitation packages of care for those who need it for up to six weeks. The Hub is the triage and coordination vehicle which ensures that people are directed to the most appropriate support as quickly as possible, with a focus on ensuring people return or remain at home where it is safe for them to do so.

2.5 The services provide assessment and short-term interventions, including facilitated hospital discharge, crisis intervention, intermediate care and enablement services to patients.

2.6 These services consist of:

- ***Integrated Discharge Hub***
  The Integrated discharge hub is based at the Royal Oldham Hospital providing support and assessment seven-days a week. The team consists of Transfer of Care Nurses, Elderly Person Mental Health Nurse and Social Workers who are ward based, with the focus to support the most complex patients to be discharged to the appropriate place at the earliest opportunity.

  The team supports a person from an acute setting to the correct place to meet their needs. A Discharge to Access (D2A) referral form is completed by the most appropriate

person that knows the patient's needs for all pathways and it's then triaged by the integrated discharge hub clinician. A Home First (pathway 1) approach is always adopted and only where a person is unable to return home are pathways 2 (intermediate care) and 3 (short term placement) utilised. Community support for patients in their own home or care home setting can also be requested.

- ***Community Response Hub***
  The Community step up response hub receives referrals from the wider community teams including GPs, the Digital Hub, Matrons, District Nursing services, out of area referrals for Oldham residents, NWAS and social care when patients are in times of crisis. This is a direct route to prevent hospital admission and support people in their own homes. The service has seen a significant increase in the number of step-up referrals and has direct referrals requiring clinical triage and signposting. The triage will determine the level of assessment and support the person requires to keep them in their own environment.

- ***Intermediate Care – Butler Green (Nursing) & Medlock Court (Residential)***
  These are community, short-term rehabilitation beds which support the person to work with a multi-disciplinary team to gain as much independence as possible and help them return home, reducing unnecessary admissions to care homes and where possible preventing re-admission to hospital.

- ***Integrated Crisis Enablement Team (ICET)***
  ICET helps people get home from hospital quickly and safely and provides an admission avoidance rapid response service to people in urgent need of health and social care interventions at home within four-hours of referral. It also provides short-term interventions for up to five days before either withdrawing or making an agreed onward referral to other community services. The team carry out assessments for community follow up in the patient's own homes, this helps to prevent an acute hospital admission and /or reduce hospital bed days. The service aim is to provide a **SAFER** way of working, outlined below, to support hospital discharges into the community:

  S - Service provided in the patient's own home

  A - Assessment of individuals needs

  F - Fast and efficient service

  E - Effective results and better out comes for the patients

  R - Responsive and reactive teams providing community support

- ***Community Therapy Hub***
  The Community Therapy Hub provides support and rehabilitation for people in their own home following on from ICET or bed based Intermediate care. The team also support people at home to avoid an admission to hospital. The team take referrals from the community and will support people at home to avoid an admission to hospital.

- ***Community IV Team***
  The delivery of IV therapy in the community setting can reduce the requirements for hospitalisation and improve quality of life.

- ***District Nurse Liaison***
  The main aim of this role is to provide in-reach into The Royal Oldham Hospital to support the safe and effective discharges particularly for Oldham residents who will require District Nursing support in the community. The District Nurse Liaison post proactively identifies patients who can potentially be discharged to community via ward visits and assists hospital staff with referrals to ensure the right information is available to allow care to be provided.

- ***Single Point of Access (SPOA - District Nursing)***
  In the SPOA we have qualified nursing support to triage and manage referrals. For patients that need an urgent same day visit at the point of referral there is some capacity to provide a rapid response visit by the SPOA nurses to support discharge.

- ***Palliative Care Coordination Centre***
  The expansion of the Community Specialist Palliative Care team allowed the launch of the coordination centre in May 2021. This ability to manage more patients more efficiently in the community supports the Hospital and the preferred place of death as more patients are able to be managed in the community and kept at home. Support is also given with accessing care provision including fast track.

2.7 **Interdependencies -** The Integrated Discharge and Community Response Hub has several interdependencies: The Digital Hub, GPs across Oldham, MASH and social care and care providers.

2.8 The Digital Hub triages NWAS referrals and refer to the hub for follow up and home assessments. They offer a dedicated line for care homes and health and social care professionals. These route directly into the Digital Hub where the GPs and Nurse Practitioners are based and have access to the patient's GP record. They will then do a telephone or video assessment and either deal with the patient, refer on, or arrange a face to face/home visit if needed.

2.9 **Key successes -** The D&E programme in Oldham brings together NCA's acute and community urgent care services, MioCare Group's Enablement services and Oldham Councils Social Care Services to have a collective bigger impact. A programme of work is underway with all these partner organisations under the heading of *'big ticket items'* as follows:

- Embedding refined D2A and pathways
- Frailty model as part of admission avoidance
- IDT future model
- Sustainable hub and ICET
- Seven-day working
- Delivery model and management arrangements

2.10 One of the key successes of the programme to date is the shift from a range of separately commissioned services managed by different organisations with a separate Integrated Discharge Team to an Integrated Discharge Function working across organisations to bring the individual services together, it is widely accepted that this work has been one of the best examples of true health and social integration in the borough. This continues with a governance structure in place reporting to the D&E Design & Delivery Group.

2.11 Another key success is the recent digitalisation of the D2A form. Oldham is proud to be the forerunner in the development of a digitalised form. A clear benefit already being realised following implementation is improved decision making processes, enabling a quicker response and seamless care resulting in patients being discharged on the right pathway for them. Work is ongoing as we move into phase 2 of the journey which is looking at further interoperability between partner organisations to improve patient pathways.

2.12 There is some excellent joint working taking place between the Digital Hub, Integrated Discharge and Community Response Hub, and ICE-T. There is potential to integrate and streamline this work further so it is more effective and efficient.

2.13 **Challenges -** Oldham wishes to work together to deliver integrated place-based care – care that crosses the boundaries between primary, community, hospital, and social care, however this ambition is challenging working within the limited resources we have.

2.14 It has been recognised that the Community Response Hub has received an increase in community step up calls for patients who require a health or social care intervention to help keep them in their own homes. Many referrals into the hub are not in any receipt of health or social care input or known to services, this increase in care and support has an impact on services already at capacity.

2.15 In order to respond to the requirements of the Ageing Well 2-hour response there is also an additional request for response staffing within the ICET service to meet the ageing well requirements. The services will need further review to include reablement services for a faster response.

2.16 The D&E programme is in the process of recruiting to additional clinical roles to support the hub, however shortages of staff are widespread within the NHS and exist across all disciplines, this causes additional pressures on the current workforce and retention continues to be a growing problem.

2.17 **Areas for development -** A core component of the programme is the need for a 2-hour crisis response service. All localities are required to have a 2-hour response at home service operating 12 hours a day , seven days a week at a minimum using a model in line with national guidance. All services should be accepting referrals directly from key sources including 111, 999, GP, Social Care, Care Homes and Same Day Emergency Care (SDEC) services. Oldham does not currently have such a service.

2.18 There is also the additional need to implement the ageing well ambitions for 2021/22, the hubs are the single route into other services and provide clinical triage and signposting to the appropriate response services across Oldham. There are significant links with the frailty agenda and recognition of system wide change to assist in the delivery of services. Digitalisation of frailty is a key are for development following roll out of D2A.

2.19 The proposed future state model for Discharge to Assess and hospital avoidance through 2 Hour community response in Oldham needs to in place as soon as is practicable and by March 2022. It will bring together the various services that form the current approach and develop the pathways and ways of working with all agencies in the future state model. The relationship between the D&E with Primary Care Networks will be critical to the success of this model and caring for people with increasingly higher acuity in the community. This will help keep people at home where possible and help ensure a timely and safe discharge if

admitted. The vision being that all people in crisis receive an appropriate response and are tracked across the system and transition seamlessly.

2.20 Modelling is ongoing to establish optimum levels of activity and key stakeholders across the system will be mapping out the future state requirements at the D&E workshop in November, this will enable progression with key priorities aligned to action plans.

2.21 In addition the CHASC service is working with primary care to work through enhanced models to take a more proactive approach to supporting Oldham citizens to remain at home for as long as possible.

PART 3 Disabled Facilities Grant

3.1 Oldham supports people with disabilities to remain living in their own homes for as long as possible, and as independently as possible, by focusing on:

3.2 **Improved assessment and delivery -** Bringing together under a single line management structure assistive technology, community equipment and adaptations, and co-location of the Equipment and Adaptations team with Allied Health Professionals - including Community Occupational Therapists, who make over 99% of referrals for adaptations, within Oldham's Therapy Hub**.** This facilitates more effective joint working of health and technical staff, and person-centred solutions to complex cases.

3.3 Ensuring optimum service delivery by jointly commissioning provision where possible. Three key Disabled Facilities Grant (DFG) delivery contracts are procured jointly with Tameside council. Procuring over a larger footprint is a more efficient use of commissioner resources and delivers better value for money, enabling more people to be supported. The Integrated Community Equipment Service (ICES) is a joint contract with our neighbouring borough of Tameside and includes the local authority and CCG from each borough. This contract includes provision of minor adaptations, enabling '*one set of feet through the door*' for many residents.

3.4 Utilising the funding flexibilities afforded by the Regulatory Reform Order (RRO). Oldham's RRO was refreshed in 2019 and several discretionary offers were introduced to extend the options available to residents, and reduce the bureaucracy involved in the DFG application process. Like most services, COVID-19 has impacted on this provision, with demand and activity patterns skewed in 2020/21 as a result of the pandemic. However, data from 2019/20 demonstrates that the application process is quicker, and the numbers of adaptation completions increased from the previous year as a result of adopting this approach.

3.5 **Promoting joined-up approaches to meeting residents' needs -** Oldham has structural barriers to provision of suitable, safe housing for some households. Parts of the borough are dominated by poor quality, small, terraced housing, which intersect with health inequalities experienced within these areas, and requires solutions at scale. As a consequence, meeting needs in some cases is a considerable challenge and are currently unable to be met.

3.6 Oldham's Strategic Housing Partnership includes Senior management representation from Joint Commissioning. This ensures that:

- the borough's main social housing providers remain engaged with a long-standing joint protocol to contribute to adaptations within their stock, undertaking minor adaptations from their own resources and contributing to the costs of major adaptations; and

- the needs of Adult Social Care and Health are recognised and included in partnership opportunities - such as within the development pipeline plans of key Registered Providers. These plans are informed by the Market Position Statement, plus data from the Disabled Housing Register and Community Occupational Therapy Team (COTT) information about households' needs.

PART 4 Equality and health inequalities

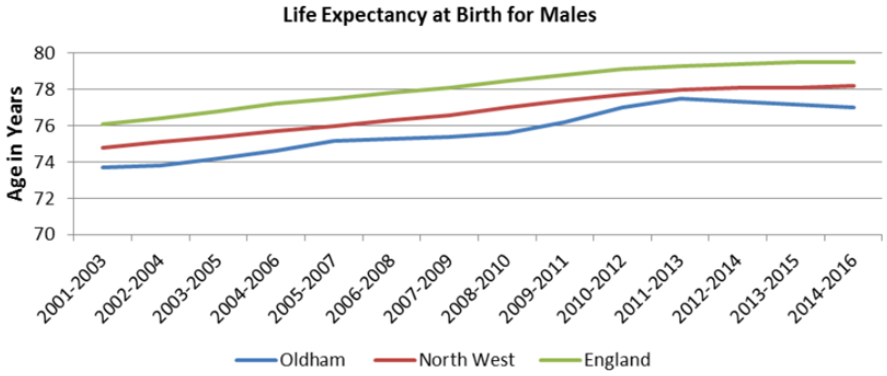
4.1 Our population's health and wellbeing is heavily influenced by social inequality including poverty, worklessness, and disadvantage on the basis of race. Oldham has a higher proportion (22.5%) of non-white Black and Minority Ethnic (BME) residents than England (14.6%).

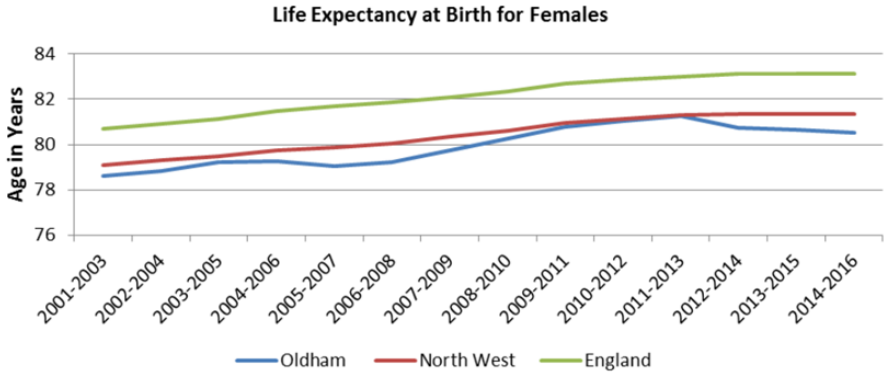
4.2 The wider determinants of health such as education, employment, housing and transport are also critical factors that play a significant role. For example, the employment rate in Oldham (68.4%) has fluctuated over time but still remains significantly lower than the GM (70.1%) and national averages (74.1%). This rate is negatively impacted by a high proportion of economically inactive residents. Oldham has high rates of residents with long term illness/disability and large numbers of inhabitants choosing not to work.

4.3 The latest Indices of Deprivation (2019) analysis has shown that Oldham's overall ranking has declined from 34th to 19th worst of 317 Local Authorities. This appears to be associated with a widening in the geographical extent of deprivation in the borough. This correlates to a number of poorly performing health outcomes (cancer; under-75 preventable mortality; healthy life expectancy) as well as wider determinants of health.

4.4 In general, the people of Oldham have worse health than the England average. Whilst we are seeing improvements in health (e.g., there has been encouraging ranking improvements in Health Deprivation), we continue to see large inequalities in health outcomes across the borough.

4.5 **Life Expectancy and Inequalities** Life expectancy (LE) in Oldham is currently lower than the national average for both men and women, 77.2 for men (79.6 nationally) and 80.9 for women (83.1 nationally). Healthy life expectancy in Oldham is significantly lower than the national average, particularly for women, 60.3 for men (63.4 nationally) and 58.6 for women (63.8 nationally). Inequalities in LE have been increasing slightly for men and significantly for women. The gap in LE between the most and the least deprived wards within Oldham is 8.4 years in males and 7.5 years in females. Rates of infant mortality (under 1 year old) are also higher than national levels (6.2 per 1,000 for Oldham, 3.9 per 1,000 for England).





4.6 In Oldham we are developing a system based on prevention and health equity that incorporates the following key facets based on the Institute of Health Equity's *Reducing Health Inequalities Through New Models of Care: A resource for New Care Models* (2018):

- **A focus on preventing ill health and supporting good health as well as treating ill health:** moving from reactive services to those that work to improve the conditions in which people live, which in turn will improve their health.

- **A focus on place:** which supports a focus on small areas and seeks to influence the environment and social and economic conditions of the place, especially for the most disadvantaged areas.

- **Cross-sector collaboration:** facilitating close collaborations between multiple organisations and sectors reaching beyond health and care, many of which have a significant influence on health e.g., housing, training and education.

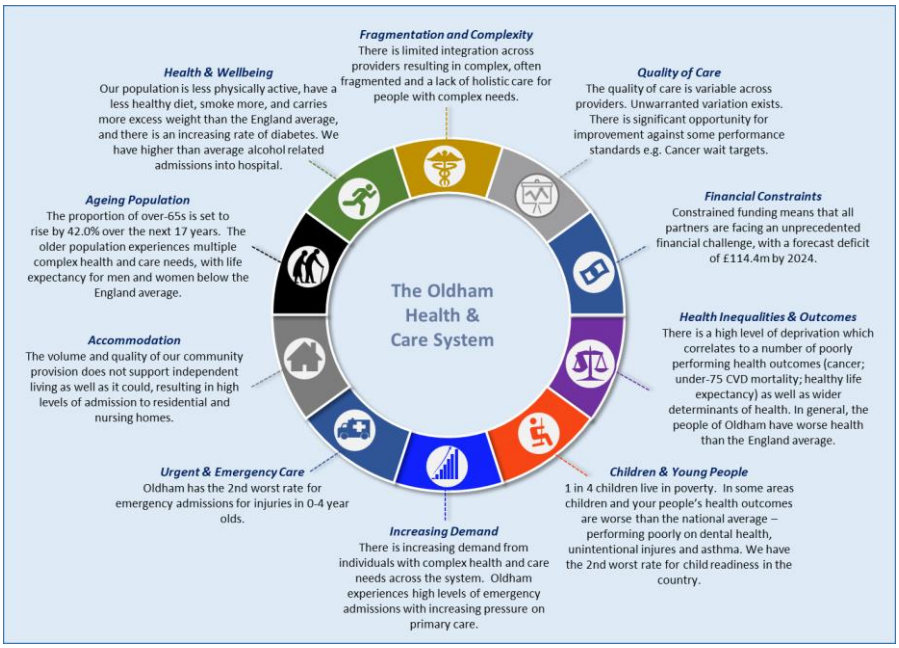
- **Focuses on population health:** Understanding the local population health and health risks for groups and areas. This includes the broader social and economic drivers of health as well as a focus on and inclusion of particular communities that are at risk of poor health.

- **Addressing wider determinants of health and reducing inequalities is the foundation of our model.** Through the model's implementation we will seek to maximise opportunities to address these determinants and reduce health inequalities.

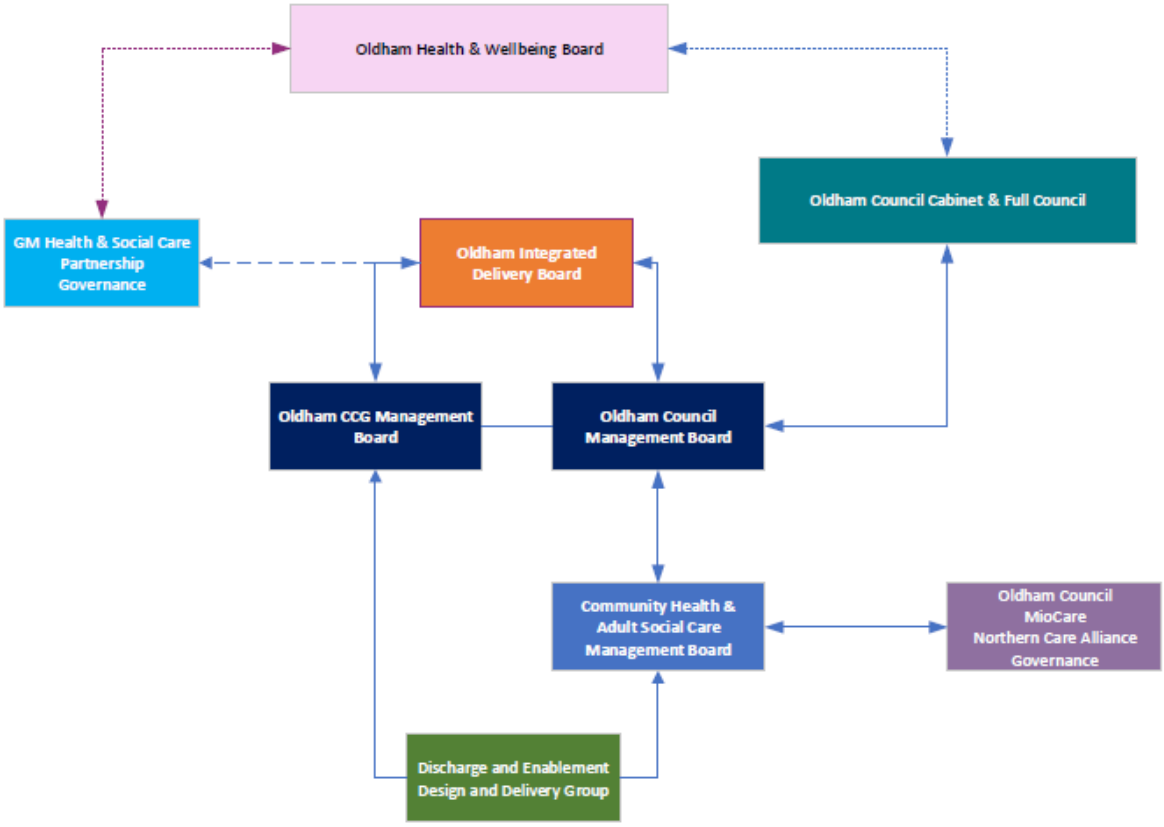
4.7 This recognises that while many of the levers to impact and improve health and reduce health inequalities often sit outside the remit of health and care organisations in Oldham, there are significant opportunities for our organisations to do more to address these ambitions.

4.8 As our model takes shape through the evolution of an ICS we will ensure that integration extends beyond health and care organisations and integrates with other sectors to form place-based population health systems that influence the wider community and the social and economic drivers of health. In addition, work is also underway to consider how the findings of the *Build Back Fairer the COVID-19 Marmot review* can be best utilised within Oldham.

The diagram below provides a summary of the key challenges facing Oldham's Health and Care System



APPENDIX 1 Governance



APPENDIX 2 Bodies involved in preparing the plan

Members from a range of different sectors across Oldham are involved in the development and ongoing monitoring of the activity relating to the Better Care Fund. These include members of the Health & Wellbeing Board and Integrated Delivery Board and include the following organisations:

Oldham Council

Oldham CCG

Northern Care Alliance

Pennine Care NHS Foundation Trust

Oldham Primary Care Networks

Action Together Community Interest Organisation

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Report to HEALTH AND WELLBEING BOARD

Pharmaceutical Needs Assessment

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

Officer Contact: Katrina Stephens, Director of Public Health

Report Author: Julie Holt, Public Health Specialist

25th January 2022

Purpose of the Report

The purpose of this report is to update the Health and Wellbeing Board on the progress of the production of the Pharmaceutical Needs Assessment.

Oldham Health and Wellbeing Board has a statutory responsibility to publish and keep up to date a Pharmaceutical Needs Assessment (PNA). Oldham's current PNA was due to be reviewed during 2020/21 and the renewed PNA to be published in April 2021.

The Department of Health and Social Care determined that the publication of PNAs be suspended for one year, until April 2022, in order to reduce unnecessary extra pressure on local authorities and Local Pharmaceutical Committees (LPCs) during the response to the Covid-19 pandemic. Further notification was received that the deadline for publishing the PNA has now been postponed until October 2022.

Guidance for production of the PNA was produced in October 2021, setting out the process to be followed.

The Medicines Optimisation team has been contracted to undertake the PNA for Oldham. The Team will concurrently undertake the PNAs for Bury and Rochdale.

Requirement from the Health and Wellbeing Board

The Health and Wellbeing Board is requested to:

1. Note that guidance for the production of the PNA has now been received.
2. Note the delay to the intended timescale due to the impact of the COVID pandemic and staff absence in the Medicines Optimisation Team undertaking the PNA.
3. Note the issues raised and the need for mitigating actions to limit the impact of any further delays on the production and publication of the Oldham PNA.

Guidance for production of the PNA

The guidance for the production of the PNA was published in October 2021. (https://www.gov.uk/government/publications/pharmaceutical-needs-assessments-information-pack).

Whilst this information pack has no statutory standing and does not constitute non-statutory guidance, it aims to support local authorities to interpret and implement their duties with regard to pharmaceutical needs assessments. and sets out the process to be followed

The information pack is set out as follows:

- chapter 1 introduces the requirements for pharmaceutical needs assessments,
- chapter 2 defines a number of the terms used in the regulations,
- chapter 3 provides an overview of the process of developing a pharmaceutical needs assessment,
- chapter 4 describes the engagement that should be undertaken whilst the document is being written,
- chapter 5 sets out the information that must be contained within the pharmaceutical needs assessment,
- chapter 6 provides advice on how to identify gaps in the provision of pharmaceutical services,
- chapter 7 sets out the requirement to consult on a draft of the document, and
- chapter 8 sets out the requirements on the health and wellbeing board once the document is published.

There are three appendices:

- appendix 1 contains a suggested timeline,
- appendix 2 contains a decision-making flowchart in relation to the requirements set out in chapter 8 and 6
- appendix 3 contains three supplementary statement templates

Oldham's PNA

The intention is for the Oldham PNA (and similarly for Bury and Rochdale) to follow the process set out in the guidance to produce the PNA and for it to be published on-line by the deadline.

Current position

Due to the impact of Covid and staff sickness in the Medicines Opimisation, the time frames for undertaking the PNAs in the three boroughs (Oldham, Bury and Rochdale) has slightly drifted. The Medicines Management team have identified some timing and capacity issues as follows:

1. There is concern that the survey on pharmacy services may generate a limited response due to the public focus currently being on COVID issues. Also, there may be a lack of healthcare staff able to promote the survey to increase uptake.
2. The Team, which is not at full capacity, is also engaged in delivering COVID measures which will stretch their ability to deliver the three PNAs concurrently.
3. The draft Oldham PNA will need to be approved for the mandatory 60 day consultation to take place in March to allow consultation over April and May so that

the final version after amendments are made can be delivered to a Health and Wellbeing Board in July or Aug for approval

4. Having a draft available by March requires the timely provision of accurate data sets on population, housing and services from LAs, CCGs and NHSE, which may be challenging to achieve because of staff shortages due to deployment and COVID-related absences.
5. The formation of the ICS has been delayed from April 1st 2022 to 1st July 2022. This means the documents will be written under current terminology i.e. they will refer to CCGs, but will be published once ICS are established, thus a 'bridging terminology' will be required to account for potential future changes.

6. Despite the delay to the date for establishment of the ICS, as yet there has been no mention by the Department of Health of any further delay of PNA publication date.

Medicines Optimisation has proposed a schedule which is slightly amended from the original and which will meet the publication deadline. Briefly this is:

a) To send out pharmacy surveys / questionnaire from 14th Jan 2022
b) collate local data and write a draft before 7th March 2022
c) gain approval in March for the draft to be sent out for 60 day stakeholder consultation undertake the required 60 day public consultation (April/ May 2022)
d) amend the draft in line with consultation responses in May/June 2022
e) seek final approval for publication from the Health and Wellbeing Board in June/July/or August (dependent on the Board's meeting dates)
f) upload the final document on-line by the deadline of October 2022.

The Medicines Optimisation Team have been asked to develop a contingency plan to mitigate the impact of limited staff capacity and any further delays which could result in the Oldham PNA not being completed by the deadline.

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