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Oldham Council

HEALTH AND WELL BEING BOARD
Agenda

Date	Tuesday 21 June 2022
Time	2.00 pm
Venue	Crompton Suite, Civic Centre, Oldham, West Street, Oldham, OL1 1NL
Notes	1. DECLARATIONS OF INTEREST- If a Member requires any advice on any item involving a possible declaration of interest which could affect his/her ability to speak and/or vote he/she is advised to contact Paul Entwistle or Mark Hardman in advance of the meeting.

2. CONTACT OFFICER for this Agenda is Mark Hardman Tel. 0161 770 5151 or email constitutional.services@oldham.gov.uk

3. PUBLIC QUESTIONS – Any member of the public wishing to ask a question at the above meeting can do so only if a written copy of the question is submitted to the Contact officer by 12 Noon on Thursday, 16 June 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 of defamation, the Human Rights Act, the Data Protection Act and the law on public order offences.

MEMBERSHIP OF THE HEALTH AND WELL BEING BOARD IS AS FOLLOWS:
Councillors M Bashforth (Chair), S Bashforth, Birch, Brownridge, Moores, Munroe and Sykes; Mike Barker, Chris Bowen, Harry Catherall, Majid Hussain, David Jago, Gerard Jones, Stuart Lockwood, Dr. John Patterson, Gaynor Mullins, Sayyed Osman, Katrina Stephens, Tamoor Tariq, Mark Warren, Laura Windsor-Welsh and by invitation Val Hussain, Joanne Sloan, Claire Smith.

Oldham Council

Item No

1 Appointment of Chair and Vice Chairs

To note the appointment of Councillor Marie Bashforth as Chair and to invite the appointments of Vice Chairs of the Health and Wellbeing Board for the 2022/23 Municipal Year.

2 Apologies for absence

3 Declarations of Interest

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

4 Urgent Business

Urgent business, if any, introduced by the Chair.

5 Public Question Time

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

6 Minutes of Previous Meeting (Pages 1 - 8)

The Minutes of the meeting of the Health and Wellbeing Board held on 22nd March 2022 are attached for approval.

7 Child Death Overview Panel - Oldham, Rochdale and Bury Annual Report 2020/21 (Pages 9 - 22)

8 A Health Inequalities Plan for Oldham (Pages 23 - 50)

9 Oldham Integrated Care Partnership Model Operating Model (Pages 51 - 82)

10 Health and Wellbeing Board Terms of Reference (Pages 83 - 90)

11 Date of Next Meeting

A Health and Wellbeing Board Development Session is scheduled to be held on Tuesday, 26th July 2022 at 2.00pm.

The Chair to propose that the next meeting of the Health and Wellbeing Board be now held on Tuesday, 20th September 2022 at 2.00pm.

HEALTH AND WELL BEING BOARD
22/03/2022 at 2.00 pm

Present: Councillor M Bashforth (in the Chair)
Councillors Birch and Moores

Also in Attendance:
Sayyed Osman (Deputy Chief Executive)
Katrina Stephens (Director of Public Health)
Stuart Lockwood – OCLL
Kirsty Rowlinson - OCLL
Laura Windsor-Welsh – Action Together
Dr John Patterson – Oldham CCG
Claire Smith - Executive Nurse (Oldham CCG)
Elaine Radcliffe – Oldham CCG
Julie Holt – Public Health Specialist
Simon Watts – Public Health Registrar
Peter Thompson – Constitutional Services
One member of the public

1 **APOLOGIES FOR ABSENCE**

Apologies for absence were received from Councillor Chauhan, Councillor Leach, Councillor Sykes, Tamoor Tariq, Majid Hussain, Dr Keith Jeffery, David Jago, Joanne Sloan, Donna Cezair, Harry Catherall, Gerard Jones and Mark Warren.

2 **URGENT BUSINESS**

There were no urgent items of business for this meeting of the Health and Wellbeing Board to consider.

3 **DECLARATIONS OF INTERESTS**

There were no declarations of interest received.

4 **PUBLIC QUESTION TIME**

There were no public questions received.

5 **MINUTES**

Resolved:
That the Minutes of the meeting of the Health and Wellbeing Board, held 25th January 2022, be approved as a correct record.

6 **PHARMACEUTICAL NEEDS ASSESSMENT**

The Health and Wellbeing Board considered a report of the Director of Public Health, which presented the draft Pharmaceutical Needs Assessment, 2022.

The meeting was informed that Oldham's Health and Wellbeing Board had a statutory responsibility to publish and keep up--to-date a Pharmaceutical Needs Assessment (PNA). The Department of Health and Social Care had determined that the publication of PNA's would be suspended during the Covid-19 pandemic with the deadline of October 2022 now being set for publication of the PNA.

The Public Health Service's Medicines Optimisation Team, acting on behalf of the Council, had undertaken the process of developing the PNA according to the guidance that had been issued by the Department of Health and Social Care.

It was planned that the draft Oldham PNA would be presented for review and approval, so that it could undergo a 60-day mandatory consultation period. This consultation period was planned to be held between 9th May – 10th July 2022. Following consultation, the final version, subject to any necessary amendments, would be presented at the Health and Wellbeing Board's scheduled meeting on 13th September 2022 for final approval, prior to publication on the Council's website by October 2022. The draft PNA referred to the possibility of new housing developments in the Borough of Oldham. Therefore, it was suggested that should any new housing development progress as expected and if one or more new village centre(s) were planned then the Board should support proposals that it would be beneficial to have a new pharmacy as part of any such development(s).

Resolved:

1. That the draft Pharmaceutical Needs Assessment, as detailed in the Board's report be approved for public consultation
2. That the Board recognises and acknowledges the timescale for the activity required to complete the Pharmaceutical Needs Assessment.
3. That should any housing development scheme progress as expected and if one or more new village centre(s) are planned then the Board supports a proposal that it would be beneficial to have a new pharmacy as part of any such development(s).

7 **PREHAB FOR CANCER**

The Board received a presentation from Oldham Community Leisure's Prehab4Cancer Programme Manager regarding their Prehabilitation Programme.

The meeting was advised that Prehabilitation enabled people with cancer to prepare for treatment through promoting healthy behaviours and through needs-based prescribing of exercise, nutrition and psychological interventions. Prehabilitation is part of a continuum to rehabilitation.

The programme operated by Oldham Community Leisure closely followed the programme that had been devised for Greater Manchester. The Greater Manchester model was the first 'prehab' system to be launched in the country, back in April 2019. It was described as a 'whole system, Multimodal approach' to Prehabilitation and Rehabilitation, which was clinically led and adhered to an evidence-based practice approach.

It followed a three Point programme – Exercise, Nutrition, Wellbeing. Patients were referred from multi-disciplinary teams

and they were assessed at set time points using validated measures. There then followed a tailored and progressive exercise programme; that followed specialised exercise guidelines, wellbeing intervention and dietic support. The programme was locally based and was accessible across Greater Manchester. There was an equity of access for patients across Greater Manchester. There were standard practices for raising concerns and feeding back to clinical teams, with steering groups to support and shape the service including Patient representatives.

The benefits in terms of surgery and treatment included: shortened and less complex recovery, potential reduction in length of stay, reduced treatment-related complications, improved adherence and completion of treatment, potential reductions in toxicity, improved cardiorespiratory function and a reduced impact of Sarcopenia.

The benefits in terms of longer-term rehabilitation included: improved functional capacity, improved strength and bone health, improved Mental wellbeing, improved confidence and self-esteem, improved aspects of Neuro-cognitive functions, a potential transition to lifelong habit of physical activity, a reduced risk of cancer specific mortality, a reduced risk of all-cause mortality and a reduced risk of recurrence.

The Board discussed the presentation in detail, noting the benefits for the community that can be gained through adherence to this programme and which can only be increased as the programme becomes more readily available and widely known about. The Board requested that an update report/presentation on this matter be brought to a future meeting for consideration.

Resolved:

1. That the presentation be noted and welcomed.
2. That a further presentation and/or a report on the Prehab for Cancer programme be considered at a future meeting of the Health and Wellbeing Board.

8 **LIFE EXPECTANCY UPDATE**

The Health and Wellbeing Board considered a report of the Director of Public Health that provided an update on the latest data on life expectancy in the Oldham borough, which has been produced for Oldham’s Joint Strategic Needs Assessment.

The report did not include information on the key contributors to the life expectancy gap between Oldham and England, as Officers were waiting for national data in this regard to be updated.

The report was closely related to the Health Inequalities Plan, as the focus of that plan was on reducing inequalities in life expectancy and health life expectancy.

It was reported that for the period 2018 - 2020 revealed that Oldham's life expectancy at birth was lower than the England, North West and Greater Manchester averages for both males and females. The most recent life expectancy at birth figure for Oldham males is 77.2 years and for Oldham females is 80.5 years. The latest life expectancy at birth figures represented a slight decrease for both males and females in Oldham compared with the figures for 2017 - 2019.

Life expectancy at age 65 years is lower in Oldham than for England, North West and Greater Manchester for both males and females. In addition, Oldham had the fifth lowest life expectancy at birth for males across Greater Manchester. Oldham females rank fourth lowest.

For males, the Borough's Alexandra, Werneth and Coldhurst Wards had the lowest life expectancy at birth, whilst Saddleworth South, Saddleworth North and Royton North Wards had the highest. There was an 11.8-year life expectancy gap between the Ward with the highest and lowest life expectancy.

For females, the Borough's Alexandra, Coldhurst and St. Mary's had the lowest life expectancy at birth, whilst Saddleworth North, Saddleworth South and Chadderton North had the highest. The gap in life expectancy for women between the wards with the lowest and highest life expectancy stood at 12.8 years.

The Latest figures (for the 2017 – 2019 period) revealed that the percentage of life spent in good health has increased slightly for Oldham males and decreased for females compared with the previous reporting period of 2016 - 2018.

The Board was informed that life expectancy at birth was a measure of the average number of years a person could expect to live based on contemporary mortality rates. For a particular area and time-period, it was an estimate of the average number of years a new-born baby would survive if he or she experienced the age-specific mortality rates for that area and time-period throughout his or her life.

Oldham's male life expectancy at birth for 2018 - 2020 was 77.2 years, 0.4 years lower than the figure for 2017 - 2019 of 77.6 years. This was in line with national and regional decreases. Most recent 2018 - 2020 figures showed that Oldham's male life expectancy at birth was falling short of the England average by 2.2 years, the North West's average by 0.8 years and the Greater Manchester average by 0.3 years. From 2001 - 2003 until the most recent reporting period of 2018/20, the overall increase in male life expectancy was similar between Oldham (4.7%), the North West (4.5%) and England (4.2%).

Oldham's female life expectancy at birth for the 2018 - 2020 period was 80.5 years, which was 0.5 years lower than the figure for 2017 - 2019 of 81.0 years. This was in line with national and regional decreases. The most recent 2018 - 2020 figures showed that Oldham's female life expectancy at birth

was falling short of the England average by 2.6 years, the North West average by 1.2 years and the Greater Manchester average by 0.8 years

Overall, from 2001 - 2003 until the most recent reporting period of 2018 - 2020, the overall increase in female life expectancy was similar between Oldham (2.4%), the North West (2.9%) and England (3.0%).

Across Greater Manchester there were considerable inequalities in life expectancy at birth for males. Oldham ranked 5th lowest across Greater Manchester at 77.2 years. Trafford ranked highest at 80.2 years and Manchester was lowest at 75.5 years. Only Stockport and Trafford had rates higher than the England average.

A similar pattern emerged with the female rates. Oldham ranked 4th lowest at 80.5 years. Trafford ranked highest at 83.8 years and Manchester was the lowest at 79.9 years. Stockport and Trafford were, again, the only Greater Manchester authorities to exceed the England average.

In considering the report the Board requested that further extracts and information, appertainng to the Joint Strategic Needs Assessment be included on future agendas for meetings of the Health and Wellbeing Board.

Resolved:

1. That the Health and Wellbeing Board notes the data presented in the submitted report and the implications for policy, planning and delivery across the Oldham borough's system.
2. The Board request that further extracts from the Joint Strategic Needs Assessment be included on the agenda for future meetings of the Health and Wellbeing Board.

9 **A HEALTH INEQUALITIES PLAN FOR OLDHAM**

The Health and Wellbeing Board considered a report of the Director of Public Health that provided an update on the development of the Health Inequalities Plan for the Oldham borough.

The meeting was reminded that in November 2021, Health and Wellbeing Board members had discussed the development of a Health Inequalities plan for Oldham and a process for development. Since then, a series of working group meetings have taken place, with a significant amount of work outside of the working group, reviewing key themes highlighted in the Greater Manchester Marmot Build Back Fairer report.

The working group's membership included: Oldham MBC Councillors, colleagues form the Public Health service, representatives from Employment Services, Children's Services, Organisational Development, Housing, Oldham CCG/Integrated Care Service, Action Together, First Choice Homes, Oldham

Community Leisure, Northern Care Alliance and Oldham HealthWatch.

As each theme was reviewed, recommendations from each session were drawn together to form the Health Inequalities Plan for the borough.

In terms of engagement and development of the plan there had been a retrospective review of various residential engagement exercises that had been carried out ahead of the working group sessions and the key themes from the engagement exercises were presented to inform the discussion and these included:

a. The work of the doorstep engagement team, which reviewed themes generated from extensive conversations that had been held ‘on the doorstep’ with residents between from the period August 2020 to November 2021.
b. Mental health, concerns about Anti-Social Behaviour, the environment and money issues were all key concerns that were raised.
c. The Insight Tracker had reviewed all insights that had been recorded in the insight tracker by professionals across Oldham up to November 2021, with a number of themes raised around learning disabilities and mental health.
d. The Community Champions Network had drawn on key themes that had emerged from several community champion network meetings during the pandemic.
e. The Poverty Truth Commission had examined emerging themes around the extent to which staff can associate and empathize with people in poverty informed elements of the plan.
f. The Early Years Strategy Consultation had observed a wide range of points raised by residents which informed the Children and Young People element of the plan.
g. The Authority’s Homelessness strategy was studied to determine if it could be used as part of the development of the health Inequalities Plan.
h. The Authority’s Covid-19 recovery plan included feedback from a wide range of residents who had offered their views on the impact of Covid-19 on their lives, which was particularly relevant to the employment related themes.
i. The ‘Let’s Talk Oldham’ programme had seen residents identify a number of priorities that were relevant to the health inequalities plan as part of this engagement around the corporate plan.

The members of the working group had offered their accounts of client/service user experiences in each individual working group discussion. Dedicated engagement had taken place in the form of a Poverty Truth Commission session focusing on residents’ experiences of using health services. Wider themes around issues relating to access, trust and relationships had emerged which were relevant to all aspects of the health inequalities plan. Further engagement was planned with residents to review it in draft form and to ‘sense check’ the priorities outlined therein. It was stressed that further conversations with residents would still

be needed to inform how actions were to be developed and delivered.

Resolved:

1. That the report be welcomed.
2. That the Health and Wellbeing Board notes the report and support further engagement with residents and wider stakeholders as the Borough's Health Inequalities Plan is further developed.
3. That after further consultation and engagement a finalised version of the Health Inequalities Plan be presented to the Board's next meeting on 21st June 2022, for approval.

10 **DATE OF NEXT MEETING**

Resolved:
That the next meeting of the Health and Wellbeing Board be held on Tuesday, 22nd June 2022, starting at 2.00pm, in the Civic Centre, Oldham.

The meeting started at 2.00pm and ended at 4.05pm

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Report to HEALTH AND WELLBEING BOARD

Child Death Overview Panel – Oldham, Rochdale and Bury Annual Report 20/21

Chair: Councillor M Bashforth

Officer Contact: Katrina Stephens, Director of Public Health

Report Author: Rebecca Fletcher, Consultant in Public Health

21st June 2022

Purpose of the Report

To provide Health and Wellbeing Board with the Oldham, Rochdale and Bury Child Death Overview Panel Report. The aim of this annual report is take data from the cases notified and reviewed by the local CDOP panel to make observations about causes and modifiable factors. This is to support the broader system to have a better informed discussion about how to promote child safety and reduce child deaths locally.

Requirement from the Health and Wellbeing Board

Health and Wellbeing Board are asked to note the Child Death Overview Panel Annual Report. The Board is asked to agree the continuing work on infant mortality in Oldham.

Oldham Council

Annual Report of Child Deaths in Oldham, Bury and Rochdale

April 2020 – March 2021

1. Executive Summary

This is an annual review of the Child Death Overview Panel (CDOP) data for Oldham, Bury and Rochdale (ORB), which combine to make one of the four CDOPs in Greater Manchester (GM). The CDOP reviews all child deaths under 18 years, but not including still births, late foetal loss or termination of pregnancy. The panel do not determine the cause of death but instead explores all the factors surrounding the death of the child. This learning enables required actions to be taken to protect the welfare of children and prevent future deaths.

Every year, each CDOP collates information on the cases that have been closed in the last 12 months in order to review for themes. This enables each area to identify any lessons learnt and recognise where population level interventions are required to reduce future child deaths.

This year, we are producing a shortened version of the report which is based on the National Child Mortality Database extract for Oldham, Bury and Rochdale. The significant challenges from COVID, and the implementation of the e-CDOP system locally led to a smaller than usual number of cases being reviewed. A full report will be available next year.

1.1. Key Findings in Oldham, Bury and Rochdale (ORB)

In 2020/2021 there were 47 notified cases and 29 closed cases. It is pertinent to note that this report looks in detail at the closed cases, however these deaths did not necessarily occur in the last 12 months. Only once a case is closed is there the level of detail required to develop a narrative surrounding the death and therefore draw out themes. The duration of the review process can vary meaning that not all cases are closed in the same year that they are notified.

The 47 notified cases in 2020/2021 are children that have died in the last 12 months, however at the time of writing this report these cases have not yet been reviewed. It is important to hold this in mind when interpreting the results of this report. This year closed cases numbers have been low nationally, due to the impact of COVID and across GM due to the introduction of the new e-CDOP system.

55% of children were within a hospital setting when the fatal event occurred, with home setting being the second most common location. Males were overrepresented in closed cases at 59%, this is consistent with GM and national findings year on year, the reason for this is unclear.

Children are at the highest risk of death in the first year of life, and this is identified within the ORB data, 41% of cases were in the neonatal period and 55% in the first year of life. In relation to this, perinatal and neonatal events continue to be the most common cause of death, this is consistent with GM and national findings. Across ORB, the leading cause of child death was chromosomal/genetic/congenital abnormalities equating to 31% of the closed cases. The second most common cause of death was perinatal/neonatal event which was the category of 21% deaths.

Modifiable risk factors are areas which may contribute to an increased risk of child death, and if addressed at a population level can reduce the risk of future child deaths. 48% of closed cases had modifiable risk factors identified. Modifiable factors that were identified in ORB cases included hospital and clinical factors, domestic violence, consanguinity, and parental smoking.

2. Introduction

The aim of this report is to analyse the child deaths within Oldham, Bury and Rochdale (ORB), to make observations on the causes and modifiable factors, in order to identify recurring themes. This helps guide population level interventions to reduce childhood mortality within the area. This annual report is presented to the Health and Wellbeing board to inform on the findings, the current interventions in place and future recommendations.

When a child dies a review process occurs to enable learning and to identify where changes could be made to prevent similar child deaths in the future. The Child Death Overview Panel (CDOP) will review the child deaths of all children under 18-years, but not including still births, late foetal loss or termination of pregnancy. Oldham, Bury and Rochdale combine to make one of the four CDOPS in GM.

The four CDOPs in Greater Manchester are split as follows:

- Manchester North – Oldham, Bury, Rochdale, CDOP
- Manchester South -Tameside, Trafford, Stockport CDOP
- Manchester West -Bolton, Salford, Wigan CDOP
- Manchester City -Manchester CDOP

Every year, each CDOP collates information on the child death in the last 12 months to enable thematic learning to guide decision making on population level interventions. The report is supported by a GM report which gives an overview of patterns across all four CDOPs. In view of the relatively small numbers, and subsequent difficulties with data analysis, this can be helpful when analysing themes.

This report includes information for cases closed between 1st April 2020 and 31st March 2021. A case is defined as closed at the end of the CDOP review process.

2.1. Infant Mortality in the UK and comparisons with ORB

The crude rate of Infant mortality (2018-2020) across England is 3.9 per 1000 births; across the North West it is higher than nationally at 4.3 per 1000 births. Whilst Bury and Rochdale have a similar infant mortality rate to the rest of England, Oldham performs worse at 6.2 per 1000. In fact, as can be seen in Figure 1 below, Oldham has the highest infant mortality rate in the North West

Figure 1: Infant Mortality Rate, per 1000 births, by local authority, 2018-2020

Infant mortality rate 2018 - 20 — Crude rate - per 1,000

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	7,111	3.9	3.8	4.0
North West region	–	1,028	4.3	4.1	4.6
Oldham	–	58	6.2	4.7	8.0
Manchester	–	131	6.1	5.1	7.3
Bolton	–	61	5.6	4.3	7.2
Blackpool	–	25	5.4	3.5	7.9
Sefton	–	39	5.2	3.7	7.0
Rochdale	–	42	5.0	3.6	6.7
Knowsley	–	27	4.7	3.1	6.8
Salford	–	49	4.7	3.4	6.2
Liverpool	–	76	4.6	3.6	5.7
Stockport	–	41	4.3	3.1	5.9
Tameside	–	35	4.3	3.0	6.0
Warrington	–	26	4.2	2.7	6.1
Bury	–	27	4.1	2.7	6.0
Blackburn with Darwen	–	24	4.1	2.6	6.1
Wigan	–	40	4.0	2.8	5.4
Cumbria	–	49	3.8	2.8	5.1
Lancashire	–	137	3.8	3.2	4.5
Wirral	–	33	3.5	2.4	5.0
Cheshire East	–	36	3.3	2.3	4.6
St. Helens	–	18	3.2	1.9	5.1
Halton	–	12	2.9	1.5	5.1
Cheshire West and Chester	–	29	2.9	2.0	4.2
Trafford	–	13	1.7	0.9	3.0

Source: Office for National Statistics (ONS) *https://fingertips.phe.org.uk/profile/child-health-profiles/data#page/3/gid/1938133228/pat/6/par/E12000002/ati/302/are/E08000004/iid/92196/age/2/sex/4/cat/-1/ctp/-1/yrr/3/cid/4/tbm/1*

The child mortality rate, which is deaths of children aged 1-17 years (2018-2020), across England is 10.3 per 100,000, with the North West being higher at 11.5 per 100,000. Oldham and Rochdale both have rates higher than the England rate, and Bury's rate is similar. This can be seen in the figure below:

Figure 2: Child Mortality Rate, per 100,000 births, by local authority, 2018-2020

Child mortality rate (1-17 years) New data 2018 - 20 — Directly standardised rate - per 100,000

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	3,471	10.3	9.9	10.6
North West region	–	509	11.5	10.6	12.6
Oldham	–	28	16.5	10.9	23.8
Rochdale	–	24	16.1	10.3	23.9
Blackburn with Darwen	–	16	14.5	8.3	23.6
St. Helens	–	15	14.1	7.9	23.3
Liverpool	–	37	14.0	9.8	19.3
Tameside	–	19	13.8	8.3	21.6
Manchester	–	46	13.5	9.9	18.1
Lancashire	–	94	13.3	10.8	16.3
Bury	–	15	12.4	6.9	20.5
Wirral	–	23	12.0	7.6	17.9
Knowsley	–	11	11.6	5.8	20.9
Wigan	–	22	11.2	7.0	17.0
Trafford	–	17	10.8	6.3	17.3
Warrington	–	13	10.2	5.4	17.5
Cumbria	–	26	9.8	6.4	14.4
Bolton	–	19	9.6	5.8	15.0
Stockport	–	16	8.9	5.1	14.5
Salford	–	14	8.7	4.7	14.7
Cheshire East	–	19	8.6	5.2	13.5
Cheshire West and Chester	–	14	7.1	3.9	12.0
Blackpool	–	4	*	-	-
Halton	–	8	*	-	-
Sefton	–	9	*	-	-

2.2. Overview of Oldham, Bury and Rochdale Population aged under 18yrs

Across ORB there are approximately 153,288 children under the age of 18, equating to 24% of the total population of the area. One thing to note is that Oldham has a slightly higher percentage of under 18 years within its population at 25%, as seen in Table 1.

Table 1: Number of children aged under 18 in Oldham, Bury and Rochdale

Area	Under-18 Population size	Total Population	% population under -18
Bury	43,289	190,990	23%
Oldham	59,592	237,110	25%
Rochdale	50,407	222,412	23%
Bury, Oldham, Rochdale	153,288	650,512	24%
England	12,642,441	56,286,961	22%

Source: Mid-2019: April 2020 local authority district codes version of this datasethttps://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/populationestimatesforukenglandandwalesscotlandandnorthernireland

3. Reviews of child death cases 2020/2021

3.1. Notified cases 2020/2021

Between 1st April 2020 and 31st March 2021 there were 47 notified child deaths across ORB. This is lower than last year and the majority of the reduction is in notified deaths from Oldham.

Table 2: Number, percentage and rate per 10,000 of notified deaths across ORB, 2020/21				
Area	**Number of Notified Deaths**	**Percentage of overall ORB deaths**	**Total population 0-17 yrs**	**Rate of Notified cases per 10,000 population**
Bury	13	28%	43289	3.00
Oldham	14	30%	59592	2.35
Rochdale	20	43%	50,407	3.97
ORB	47	100%	153288	3.07

Source: GM CDOP Data 2019/2020

3.2. Closed Cases 2020/21

In 2020/21 there were 29 closed cases across the ORB CDOP. As seen in table 2, the closed cases in ORB account for 23% of GM closed cases. Oldham has the highest rate of closed cases, 2.35 per 10,000 of the population.

Table 3: Number and percentage of deaths (cases closed) across ORB 2020/21			
Area	**Total Deaths (Closed Cases)**	**Percentage of overall ORB deaths (Closed cases)**	**Rate of Closed cases per 10,000 population**
Bury	9	31%	2.08
Oldham	8	28%	1.34
Rochdale	12	41%	2.38
ORB	29	100%	1.89

Source: GM CDOP Data 2019/2020

It is important to note that whilst these cases were closed during this time, the deaths did not necessarily occur in the same 12-month time frame, due to the variable duration for a case to be closed. For the purpose of the CDOP annual report, the closed cases are discussed, as these offer the level of detail required to identify themes. It is important that this is kept in mind when interpreting the findings of this report.

3.3. Location of Death

The majority of deaths occurred in a hospital setting across all three localities. Deaths in hospital are more likely to do due to a perinatal or medical cause, rather than sudden unexpected death which would be more likely to occur in the home environment.

Table 4: Comparison of Location of Death 2020/21						
Area	**Hospital**		**Home**		**Other**	
	No	**%**	**No**	**%**	**No**	**%**
ORB	16	55%	10	35%	<5	

3.4. Causes/Category of Death

As part of the CDOP process each case is assigned a category of death from 10 defined options. The classification system is hierarchical therefore the category of death with the most relevance will be recorded as the primary category and cause of death, and others as secondary categories. The nationally defined categories of death as follows:

a. Deliberate inflicted injury, abuse or neglect
b. Suicide or deliberate self-harm
c. Trauma and other external factors
d. Malignancy
e. Acute medical or surgical condition
f. Chronic medical condition
g. Chromosomal genetic and congenital anomalies
h. Perinatal/neonatal event
i. Infection
j. Sudden unexpected, unexplained death

Figure 3: Category of Death - Cases reviewed 2020/2021

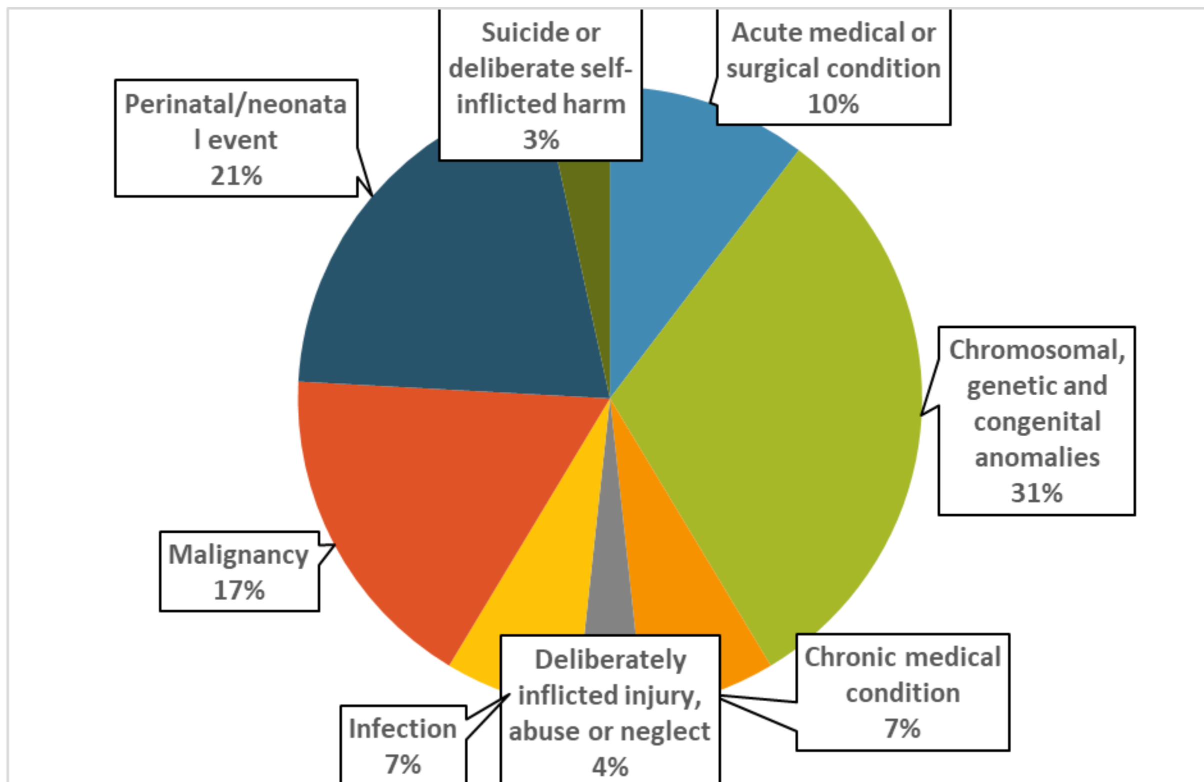


Figure 3 clearly demonstrates that chromosomal, genetic and congenital abnormalities were the most common cause of death, followed by perinatal and neonatal events. When combined, these two categories equate to half of the child deaths in ORB. This is consistent across GM, in line with national trends and the same as previous years.

3.5. Socio-demographics of cases closed in 2020/2021

3.5.1. Gender

When comparing deaths across the local authorities by gender, males appear to be over-represented at 59% when compared to females 41%, as seen in table 9. This is consistent with GM findings and national trends.

Table 5: Number of cases closed by Gender in ORB				
Area	Female		Male	
	No	%	No	%
ORB	12	41%	17	59%

3.5.2. Ethnicity

In all three areas, White British is the predominant ethnicity, with 68% of the child population across ORB classified as white and 32% as BAME. Of note, Oldham BAME child population is 40% compared to 28% GM.

Table 6: Child Population Ethnicity across Oldham, Bury and Rochdale, using mid 2019 population estimates.					
Area	Total under 18 population	White		BAME	
		No	%	No	%
Bury	43289	34631	80%	8658	20%
Oldham	59592	35755	60%	23837	40%
Rochdale	53299	36243	68%	17056	32%
ORB	156180	106629	68%	49551	32%

Source: Based on mid-2019 population estimates

In ORB, there is a higher rate of closed cases in the BAME population, suggesting that although numbers are small that BAME child deaths are over-represented. Clearly there is a health inequality associated with ethnicity.

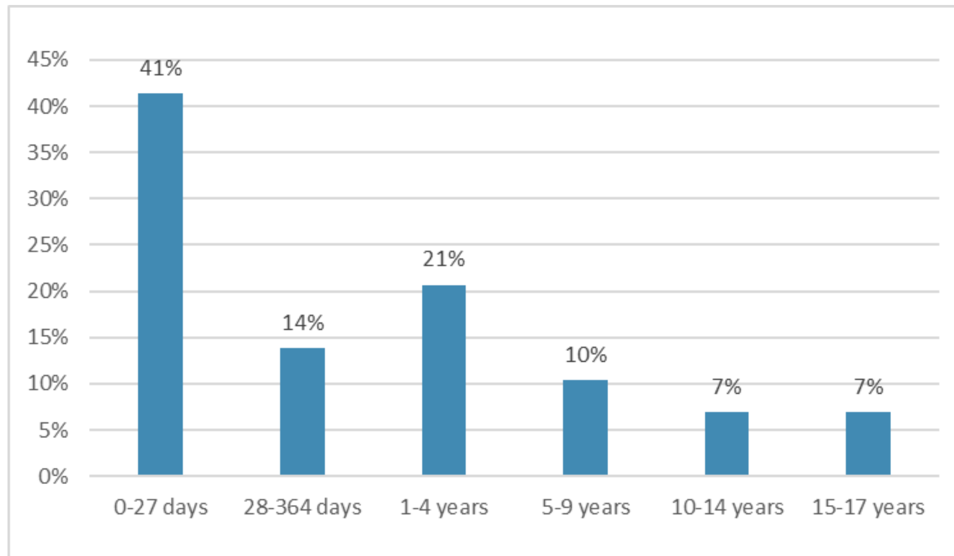
Table 7: Cases Closed by Ethnicity for Each Area						
Area	White			BAME		
	No	%	Rate/10,000	No	%	Rate/10,000
ORB	16	55%	1.50	13	45%	2.62

3.5.3. Age at death

Younger children have the highest risk of childhood mortality, and the highest risk of death is during the neonatal period[1]. Figure 5 demonstrates that as age increases the number of deaths falls. In ORB 41% of closed cases were in the neonatal period and 55% within the first year of life. This is consistent with GM and national trends.

[1] https://www.who.int/maternal_child_adolescent/documents/levels_trends_child_mortality_2019/en/

Figure 4: Age Group of Closed Cases 2020/2021



3.5.4. Low birth weight and Prematurity

Preterm delivery is defined as any birth before 37 weeks of pregnancy and can be subdivided depending upon gestational age[2]:

- Extremely preterm -less than 28 weeks
- Very preterm -28-32 weeks
- Moderate to late preterm -32-37 weeks.

Preterm delivery and the associated complications are the leading cause of infant mortality[5]. The earlier the gestation at which a baby is born, the higher the risk of infant death[3]. Preterm delivery is associated with risk factors such as poverty and maternal smoking [4]. 88% of all deaths in children under 1 year were born prematurely across ORB.

Low birth weight, defined as under 2500 grams, is often caused by a premature birth, and whilst some risk factors are unavoidable others include maternal smoking, drug and alcohol use, poor pregnancy health and nutrition, pregnancy related complications and mothers young age[5]. Birth weight for closed cases under the age of 1 have been compared across the localities in table 14. Across ORB 75% of closed cases under 1 year were associated with a low birth weight.

Table 8: Birth weight of closed cases for babies under 1 year only

Area	<2500g Low Birth Weight		>2500g Healthy Birth weight		Not recorded		Total
ORB	12	75%	<10		<5		16

[2] https://www.who.int/news-room/fact-sheets/detail/preterm-birth
[3] https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/childhoodinfantandperinatalmortalityinenglandandwales/2018#:~:text=1.-,Main%20points,of%203.6%20recorded%20in%202014
[4] https://www.rcpch.ac.uk/sites/default/files/2018-10/child_health_in_2030_in_england_-report_2018-10.pdf
[5] https://www.nuffieldtrust.org.uk/resource/low-birth-weight

4. Modifiable and other risk factors

4.1. Factors Identified that may have contributed to vulnerability, ill health or death

Form C, the child death review analysis form, is used by CDOP. All available information, gathered from different agencies, is reviewed in order to develop an understanding of the circumstances of the child's death and whether there were any associated modifiable factors. Through this process lessons can be learnt and shared, and local level action can be taken in order to reduce the risk of child death.

As part of the review, any factors that may have contributed to the child's death are identified.

These are split into four domains:

- Domain A: Factors Intrinsic to the Child
- Domain B: Factors in Social Environment including Family and Parenting Capacity
- Domain C: Factors in the Physical Environment
- Domain D: Factors in Service Provision

The level of influence is then determined, given one of the following:

- 0: Information not available
- 1: No factors identified, or factors identified but are unlikely to have contributed to the death
- 2: Factors identified that may have contributed to vulnerability, ill health or death

Factors identified in closed cases in ORB that may have contributed to vulnerability, ill health or death

Domain A: Factors Intrinsic to the Child
• Acute Sudden onset illness • Other Chronic long- term illness (excluding Asthma, epilepsy and diabetes) • Learning disability • Sensory Impairment • Other disability or impairment
Domain B: Factors in Social Environment including family and parenting Capacity
• Emotional/behavioural/mental/physical health condition in a parent or carer • Poor supervision • Child abuse and/or domestic abuse
Domain C: Factors in the Physical Environment
• Overcrowded home conditions
Domain D: Factors in Service Provision
• Prior medical Intervention • Access to services including translation services • Late booking of pregnancy

4.2. Modifiable Factors

Some factors associated with a child's death are modifiable, these are important as targeted interventions can be used to reduce risk where factors reoccur. A set standard of modifiable factors has been agreed by the GM CDOP Network to ensure consistency when categorising the preventability of child deaths. This is to reduce the subjectivity surrounding these matters.

The agreed definition of Modifiable Factors Identified is:

'The panel have identified one or more factors, in any domain, which may have contributed to the death of the child and which, by means of locally or nationally achievable interventions, could be modified to reduce the risk of future child deaths'

The Modifiable Factors are categorised and defined as:

Modifiable Factors in Perinatal / Neonatal Deaths
• Maternal smoking in pregnancy • Maternal Obesity (BMI 30 +) • Mothers who are Underweight (BMI < 18.5) • Unbooked pregnancies • Concealed pregnancies • Necrotizing Enterocolitis (NEC) where the baby was not fed expressed breast milk
Modifiable Factors in Sudden Unexpected, Unexplained Deaths
• Unsafe sleeping arrangements (co-sleeping bed/sofa) • Parental smoking
Modifiable Factors in Consanguineous Related Deaths
• Where there has been an older sibling who has died or is affected by the same genetic autosomal recessive disorder

Across ORB 48% of cases had modifiable factors identified. All cases across ORB had sufficient information to identify modifiable factors.

Modifiable Risk Factors identified by the ORB CDOP in the closed cases of 2020/21 included:

- Maternal Smoking in Pregnancy
- Parental Smoking
- Unsafe Sleeping arrangements
- Where there has been an older sibling who has dies or is affected by the same genetic autosomal recessive disorder

4.3. Other Identified Risk Factors

Other issues raised within the closed cases across ORB, that are not defined within the GM CDOP Network:

- Modifiable factors in sudden, unexpected, unexplained deaths such as drug and alcohol use and housing
- Factors in service provision including translation services, access to health care during COVID, and risks relating to domestic abuse and violence.

5. Recommendations

The following recommendations are based upon the findings of this report.

Recommendations

- Local areas should continue to work to reduce the key risk factors for deaths in children in ORB. These include:
  - Parental smoking including maternal smoking in pregnancy
  - Unsafe sleeping
  - Genetic conditions
  - Other risk factors for sudden, unexpected, and unexplained deaths including drug and alcohol use, poor housing and low rates of breastfeeding,
  - Barriers to healthcare access including translation services
- ORB CDOP to work with the other three GM CDOPs to identify and address rarer risk factors or causes of death
- Local areas to explore the potential reasons for the lower numbers of notified deaths in 2020/21. This reduction has not been sustained in 2021/22.

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Report to HEALTH AND WELLBEING BOARD

A Health Inequalities Plan for Oldham

Chair: Cllr M Bashforth

Officer Contact: Katrina Stephens, Director of Public Health

Report Author: Simon Watts, Registrar in Public Health

Date: 21/06/2022

Purpose of the Report

This report summarises progress on the development of the Health Inequalities Plan for Oldham for discussion with board members and agreement of a final version of the plan to take forward in the borough.

Requirement from the Health and Wellbeing Board

Board members are asked to:

- Offer any final feedback or comments on the plan.
- Agree and sign off on the final content of the plan.
- Discuss and agree Health and Wellbeing Board member lead sponsors for each of the themes within the plan.
- Discuss and agree governance arrangement for driving delivery of the plan's actions.
- Agree the timetable for reviewing themes in detail over the next 12 months.

A Health Inequalities Plan for Oldham

1. Background

In November 2021, Health and Wellbeing Board members discussed the development of a Health Inequalities plan for Oldham and the process for development. Since then, a series of working group meetings have taken place with system partners and a range of engagement has been drawn upon or carried out to form the basis of Health Inequalities Plan. The recommendations from the GM Marmot Build Back Fairer and GM Independent Health Inequalities Commission report were used as a starting point for discussions.

The actions within the plan sit within a number of key themes:
- Income, Poverty, Housing and Debt
- Housing, Transport and Environment
- Work and Unemployment
- Health in all Policies / Communities and Place
- Health and Wellbeing, and Health Services
- Children and young people

Some actions within the plan reflect and build upon existing work within the borough, others will lead to new work being initiated. The intention is to hold the key actions for reducing Health Inequalities in Oldham in one place, allowing progress to be tracked.
It is not intended for the plan to be a static document, with actions being removed when complete, or new ones added where appropriate as the plan develops.

2. The Draft Plan

See appendix 1 for the final draft of the Health Inequalities plan.

The HWB reviewed a draft of this plan on March 22nd 2022. Since then the following key changes have been made:

- Delivery leads and timeframes added where possible.
- Further actions added to Health in All Policies and Health Services themes.
- Wording has been updated slightly to give actions a more positive, asset based focus where appropriate.

3. Governance

It is proposed that for each of the key themes identified above, there is a HWB sponsor who will retain oversight of that aspect of the plan and liaise with delivery partners to help drive progress. The sponsor will offer an update on the actions at each HWB meeting.
Members should discuss who would sponsor each area at the HWB meeting on 21st June 2022, a start has been made in the table below:

Themes	HWB Sponsor
Income, Poverty, Housing and Debt	*For discussion*
Housing, Transport and Environment	Donna Cezair
Work and Unemployment	*For discussion*
Health in all Policies / Communities and Place	*For discussion*
Health and Wellbeing, and Health Services	Katrina Stephens/John Patterson
Children and young people	*For discussion*

At each HWB meeting there will be an agenda item to review progress on the Health Inequalities Plan as a whole, offering each sponsor a chance to offer brief updates and highlighting any concerns. At each HWB meeting one or two theme areas will be reviewed in more detail.

As the plan has been developed a series of relevant metrics/KPIs have been highlighted. The intention is that the metrics for each theme will be reviewed at the HWB meeting where that theme is reviewed in detail.

At an operational level, governance already exists in the system to drive the individual actions of the plan; it is not intended to develop separate governance to deliver the plan, but to drive delivery through these existing structures.

4. HWB Timelines for Reviewing Plan

For discussion, the table below proposes the order with which key themes within the Health Inequalities Plan will be discussed at HWB meetings:

HWB Meeting Date	Proposed Theme
21 Jun 2022	Review final draft of plan
13 Sep 2022	Health in All Policies / Communities and Place Income, Poverty, Debt
15 Nov 2022	Health and Wellbeing, and Health Services
24 Jan 2023	Housing, Transport and Environment Work and Unemployment
21 Mar 2023	Children and young people

5. Recommendations

Board members are asked to:

- Offer any final feedback or comments on the plan.
- Agree and sign off on the final content of the plan.
- Discuss and agree Health and Wellbeing Board member lead sponsors for each of the themes within the plan.
- Discuss and agree governance arrangement for driving delivery of the plan’s actions.
- Agree the timetable for reviewing themes in detail over the next 12 months.

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DRAFT Health Inequalities Plan for Oldham

June 2022

Context

What do we want to achieve?

- Improve the health of our residents with a focus on:
  - Reducing the gap in life and healthy life expectancy between Oldham and other boroughs.
  - Reducing the gap in life and healthy life expectancy within Oldham, particularly between low and high income group and by ethnicity.

Scope

- The intention is to keep this work action focused as opposed to writing a long strategy document. A lot of the pre-work has been done through the Marmot and Independent Inequalities Commission reviews of Health Inequalities in Greater Manchester.
- Actions should be deliverable in 2 years or less given the pace with which health inequalities need to be acted upon and the ever-changing environment within which the system operates.
- No services or organisations are out of scope for this work.

Context

Process and engagement for this work

- The GM Marmot report and Independent Inequalities Commission report for GM were used as starting points for understanding key actions we may want to take in the borough.
- A series of workshops took place every two weeks to discuss the key themes that came out of these reports and identify priorities for the borough. The key themes identified are below; data on each were explored through each workshop:
  - Income, poverty and debt
  - Work and unemployment
  - Children and young people
  - Housing, transport and environment
  - Health, Wellbeing and Health Services
  - Health in all Policies / Communities and Place

Context

Process and engagement for this work

- A retrospective review of the following pieces of resident engagement were carried out ahead of the working group sessions and the key themes from the engagement were presented to inform the discussion.
  - Door step engagement team
  - Insight Tracker
  - Community Champions Network
  - Poverty Truth Commission
  - Early Years Strategy Consultation
  - Homelessness strategy
  - Covid-19 recovery plan
  - Lets Talk Oldham
- Working group members offered their accounts of client/service user experiences to inform the working group discussion about priorities for the plan.
- Dedicated engagement took place in the form of a Poverty Truth Commission session around experiences of using health services, though wider themes about access, trust and relationships emerged are relevant to all aspects of the health inequalities plan.
- As the actions are developed and delivered, further conversations with residents will be needed to inform how actions are taken.

Role of the HWB in supporting delivery of this plan

- HWB sponsors for each area, supporting delivery leads where appropriate.
- Review progress on one theme at each HWB meetings over the course of the year.
- Plan to be iterative and not set in stone.

Measuring Progress

- Draw on GM Marmot dashboard to track against specific Marmot metrics.
- Development of specific indicators to track progress against actions developed as part of Oldham's health inequalities plan.
- Metrics relevant to each theme to be reported and reviewed at relevant HWB meeting.

Income, poverty, debt

What have people told us?

- Workshop:
  - Planned changes to UC may force residents into taking jobs earlier, potentially putting skilled workers into lower skilled, lower paid work.

- Poverty Truth Commission to date:
  - Precarious nature of system linked to skillset of staff in ability to respond to residents who are experiencing poverty.
  - Need to enhance understanding of poverty to help people with its impact and stigma.

- Financial concerns and debt a key issue flagged by residents to the door step engagement team.

- Dedicated PTC session on health:
  - The need for relationships and trust to be built rather than interactions centring around a transaction/specific issue.
  - Being careful in what services to co-locate in hub type settings – services with an enforcement role such as social care may deter residents from engaging.

Income, poverty, debt

Potential metrics

- Marmot:
  - Indicator 9: Children in low income households (publicly available)
  - Indicator 10: Proportion of households with low income (publicly available)
  - Indicator 11: Debt data from Citizens Advice (GM Tableau)

Income, poverty, debt

Objective	Action	Delivery Lead(s)	Timeframe
Reduce structural barriers which perpetuate inequalities, particularly stigma and staff perception/understanding of those in poverty.	Develop and deliver front line staff training on the background and residents' experiences of poverty/debt/benefits, constituting workforce development around poverty. Include a focus on internal workforce wellbeing, particularly in light of cost of living crisis.	OMBC HR/OD / OD Networks	
	Increase use of the Money Advice Referral Tool across front line staff across the borough to improve signposting to support and impact wider determinants of health.	OMBC Policy / Public Health / Action Together	Q3 2022/23
Support those in most need as utility prices continue to rise.	Continue to support the delivery of, and funding for, Warm Homes Oldham and highlight the gap in support resulting from the cost of living crisis.	CCG / Public Health	Ongoing
Seek to prevent problematic debt levels in the borough.	Through development of new council tax collection policy, emphasise the impact on health of debt and the need to consider health impacts in collection strategies.	OMBC Revenue & Benefits	
	Develop wider programme of work aimed at preventing and reducing levels of problematic debt, including a focus on money management and rent arrears.	Poverty Working Group	

Housing, Transport and Environment

Potential metrics

- Marmot:
  - Indicator 12: Ratio of house price to earnings
  - Indicator 13: Households/persons/children in temporary accommodation
  - Indicator 14: Average public transport payments per mile travelled
  - Indicator 15: Air quality breaches

Housing, Transport and Environment

Objective	Action	Delivery Lead	Timeframe
Ensure every resident can access housing, while improving the health of our homeless population.	Continue to support the A Bed Every Night initiative and work to improve access to health and wider services for homeless population.	Senior leaders / CCG	
	Expand NHS Health Check eligibility criteria to all people who are homeless regardless of age.	OMBC Public Health	Q2 2022/23
	Continue development of substance misuse offer for people who are homeless.	Turning Point ROAR/ Homeless Service	
Strengthen housing support around minor repairs which can be unaffordable for some residents.	Developing a pilot funded by GM HSCP to improve minor repair provision, linking in participants into health service offers and measuring the impact of house repairs on resident health.	OMBC Public health / Housing	Q3 2022/23
Develop healthier housing provision in the borough.	Further develop the Healthy Homes element of the housing strategy in the next iteration of the housing strategy action plan, including strengthening links between health services and housing enforcement support.	OMBC Public health / Housing	
	Develop a forum for sharing good practice across providers and wider system in terms of making healthy improvements to homes	Housing providers	
Incorporate healthier design principles into all developments (resi and non-resi) in the borough.	Develop and include content on healthy planning and healthy green spaces in the new Local Plan	OMBC Public health /Planning	
	Strengthen the use of health impact assessments as part of the planning process.	OMBC Public health / Planning	

Work and Unemployment

- **What have people told us?**
- Workshop discussion:
  - Certain communities of higher need are poorly represented in Adult Education uptake.
  - Barriers to employment present through recruitment process, particularly for the long term unemployed who may lack confidence and self-esteem after multiple rejections.
  - We need to move away interviews then are not a good measure of a persons ability to do the job from our experience.
  - Unemployment rate is going down but the number of people not in work is going up
- Lets Talk Oldham – Engagement to support corporate plan:
  - 243 participants commented on the need to make Oldham a better place to work. For them securing more job opportunities and making it easy to get around on public transport were of highest priority.

Work and Unemployment

Potential metrics

- Marmot:
  - Indicator 5: NEETs at ages 18 to 24
  - Indicator 6: Unemployment rate *(report on both normal unemployed, and adjusted percentage for carers, ill health and those in education).*
    - *Also report on long term unemployed rate.*
  - Indicator 7: Low earning key workers
  - Indicator 8: Proportion of employed in non-permanent employment

Work and Unemployment

Objective	Action	Delivery Lead(s)	Timeframe
Ensure Oldham residents have equal access to employment opportunities.	Anchor organisations to work together to develop more equitable and accessible recruitment practices and use contracts and social value procurement to improve employment practices more broadly. Maximise benefit and learning from NCA work and how this can be shared more broadly across anchors.	Anchor Organisation HR/OD Teams	
Improve access to adult education provision across Oldham	Review adult education course uptake data and develop a plan for improving uptake in areas of highest socio-economic need, developing a targeted offer and engagement strategies and considering course time commitments and how they link to UC thresholds. .	OMBC Lifelong Learning Team	
Drive uptake in living wage and GM employment charter across Oldham	Develop a campaign to increase participation in the GM employment charter and Living Wage Foundation for Oldham, including enabling social care providers to pay the living wage.	Action Together	Sept 22-March 23
	Strengthen Social Value Procurement emphasis on the need to be a good and fair paying employer	Procurement teams in all anchor organisations	
Improve understanding of inequalities associated with employment across the borough	Collate data relating to employment practices and seek to share these data across the borough to inform understanding of need, the development of plans and monitor progress. Reported unemployment data to include those who are inactive due to illness or caring.	HR/OD Teams	
Maximise opportunities into employment in Oldham, particularly in the most underemployed areas	Work to connect pathways from life long learning into employment opportunities, maximising opportunities from leveraging pre-employment programmes (like the NCAs) and connecting into further learning opportunities (e.g. NCA's English language course for NHS roles.)	OMBC Lifelong Learning Team	

Health in all Policies / Communities and Place

What have people told us?

- Poverty Truth Commission session on health:
  - Poverty was highlighted as a barrier to accessing services (financially) and as a driver of poor health (e.g. poor diet, cold homes). Many residents experience challenges with the cost of bus fares and time to get to appointments. This point links to the need to equality impact assess all services so we can break down barrier issues (links to local plan as well and the need for a HIA)
  - The need to get women into the conversations earlier to inform how services develop and can be accessed.

- Consistent theme throughout all workshop sessions and through resident engagement about the importance of engraining resident voice into everything and every decision

Health in all Policies / Communities and Place

Potential metrics

- Marmot:
    - Indicator 16: Feelings of safety in local area
    - Indicator 17: People with different backgrounds get on well together
    - Indicator 18: Antisocial behaviour

Health in all Policies / Communities and Place

Objective	Action	Delivery Lead(s)	Timeframe
Health and Health Inequalities are considered in all policies	Embed Health and Health Inequalities into corporate reporting templates and embed into all new contracts that are commissioned.	OMBC Policy team	
	Review metrics which underpin Social Value Procurement as part of the annual review to ensure focus on Health Inequalities, including a focus on how we can add social value to places of particular need and how we support smaller, local providers to apply for competitive contracts which are open to wider tender.	OMBC Procurement/ Public Health	
	Review the Equality Impact Assessment processes and how the EIAs inform decision making.	OMBC Policy team	
	Expand public health/licencing work to consider how health impacts can be a consideration in the range of licencing decisions in Oldham (e.g. gambling).	OMBC Public health / licencing teams	
Residents views represented in all policies	Embed resident engagement and codesign in system culture and everything we do and supporting sustainable investment into it, including sustaining investment into door step engagement teams.	OMBC Communities/ Action Together/ All Anchor Orgs	May 22- March 23
	Develop infrastructure to draw together themes from multiple different resident engagements ensuring that intelligence is used to inform decision making at a corporate and a place based level.	OMBC Communities / Business Intelligence	May 22- March 23
	Involve people with lived experience in changing the way systems respond to, and support people, with multiple disadvantage, drawing on learning from Changing Future programme, Poverty Truth Commission and Elephant Trails.	OMBC ASC & Transformation/ Action Together/ All Anchor Orgs	
Enhance systems awareness of health inequalities and the role staff and organisations can play in reducing them	Provide workforce development sessions/training on Health Inequalities to improve awareness of the impact in Oldham and action required and make this a core part of the placed based workforce development offer.	HR/OD Teams	
Measure and track progress in reducing Health Inequalities	Work with GM and local BI teams to develop a fit for purpose dashboard for Oldham that reflects key data at Oldham level and aligns with the GM Marmot recommendations.	OMBC & NHS Business Intelligence	
Better coordinate local services in places that are convenient and trusted for residents	Place-based boards to be developed for each place to help drive this coordination of services and focus on prevention, early intervention and tackling inequalities	OMBC Communities	

Health, Wellbeing and Health Services

What have people told us?

- Poverty Truth Commission session on health:
  - Participants highlighted their issues with variation in primary care support and access. Waiting times were very variable, phones making it difficult to get through. Concern regarding virtual appointments and their suitability.
  - Lack of resident voice in GP closures.
  - Concern about DNA policies and that members had been discharged when they hadn't been able to make appointments for genuine reasons (or just because they were late).
  - Issues with geography and money to access services.
  - Issues with frequency of repeat prescriptions creating a burden.
  - How can we resource primary care to focus on HIs; how can we focus the workforce on HIs?
  - Multiple examples of poorly coordinate care with residents being passed between services without being supported: The need for services to be more relational than transactional; how can we align how we measure the performance of our services to this? Largely volume based targets currently.

Health, Wellbeing and Health Services

Potential metrics

- Marmot:
  - Indicator 19: Low self-reported health
  - Indicator 20: Low wellbeing in adults
  - Indicator 21: Numbers on NHS waiting list for 18 weeks
  - Indicator 22: Emergency readmissions for ambulatory sensitive conditions
  - Indicator 23: Adults/children obese
  - Indicator 24: Smoking prevalence

Health and Wellbeing, and Health Services

Objective	Action	Delivery Lead	Timeframe
Have a coordinated approach to prevention and early intervention, supported by a sustainable funding model.	Develop a coordinated whole system approach to delivering Healthy Weight across Oldham to include a focus on schools.	OMBC Public health	
	Reviewing existing provision, commissioning and grant investment arrangements including sustainability of investment, across whole early intervention and prevention system	OMBC Communities	
	Develop a directory of services for the system to clearly communicate what preventative and early intervention services are available for residents to access, carefully considering the capability and capacity of support available.	OMBC Communities / Action Together	
Strengthen mental health offer in the borough responding to increase in need during and post covid-19	Further development of Oldham MH Living Well model, transforming of community MH services. Focus on 'no wrong front door' and MH teams working at a PCN level more focused on population need.	NHS Oldham CCG	
	Increase capacity for, and equity of access to, addiction services, including developing dual diagnosis pathways.	OMBC Public Health / CCG	
	Include questions relating to MH in the NHS Health Check and link patients to appropriate support	OMBC Public Health/Primary Care	Q2 2022/23
	Evaluate and where appropriate identify funding to sustaining our existing prevention resources e.g. TogetherAll, aligning this to the wider early intervention and prevention review.	OMBC Public Health/System Board	Q4 2022/23
Improve social support around the health offer, particularly around debt and benefit advice and referral into employment support programmes.	Work to develop EMIS/elemental referral functionality to make it easier for GPs to refer for social support and behaviour change and showcase at GP training event.	GMSS, Primary care	
	Collect and report on primary care data on referrals into social and employment support to target improvements in uptake.	GMSS, primary care	
	Ensure pathways to wider support exist for those who have suffered a serious or unexpected illness which may impact their finances.	OMBC Public Health	Q1 2023/24

Health and Wellbeing, and Health Services

Objective	Action	Delivery Lead	Timeframe
Improve access to primary care for most vulnerable groups	Talk to residents (through 10GM funding and work) about barriers to accessing health services and seek to reduce these barriers e.g. exploring how travel costs can be subsidised/reimbursed through Healthcare Travel Costs Scheme.	Healthwatch Oldham	
	Foster greater collaborative working between public health, PCNs and place based teams in addressing health inequalities, aligned to Core20plus5, population health management and this plan.	Public health, PCNs, Place teams	Ongoing
	Work with GPs and patients to create a set of standards with regards to how virtual consultations are used in the borough and how patients' confidence in virtual consultations can be improved.	Primary care	
Improve policies which automatically discharging people who don't attend appointments, recognising their social and health impact.	Work with primary, secondary and community care to develop a DNA policy that makes allowances for DNAs due to social reasons and keeps people on care pathways. A specific focus on children non-attendances as part of this work.	Public Health / Primary Care	Q1 2023/24
	Reporting on waiting lists and length of wait by protected characteristics and income level and review the reasonable adjustments that are made for residents where appropriate.	CCG / NCA	
Improve data and intelligence on Health Inequalities to inform preventative work	Work with GM screening and immunisations team to improve Oldham dataset on screening and immunisations to a more granular level of detail so demographic variation in uptake can be understood and action taken.	OMBC Business Intelligence/Public Health	Q3 2022/23
Improve support and access to services for LD residents	Partners to support delivery of the LD strategy and action plan across the borough and ensure that when measuring health inequalities that outcomes for LD residents are reported as a group, drawing on the LD dashboard.	All/ Council & CCG BI	

Children and Young People

- **What have people told us?**

- Workshop discussion:
  - Research in the past that shows the importance of adult learning in enabling adults to better support their children's learning and development. In a nutshell "adults who read tend to have children who read“
  - OCL would be up for targeted work to reduced-cost swimming or daytime activity classes for early years/children and young mums. Feels like a follow-up meeting to scope options would be useful
  - Lack of confidence as adults -can stem all the way back to childhood - links to Early Years support is also key I think
- Early Years Strategy Consultation
  - Access to parent and child groups/activities a key issue.
  - Access to support for parents and carers also a problem, particularly lack of consistent health visitor support. Accessing breast feeding support also highlighted.
  - Lack of support for children’s speech and language issues - this was a common issue highlighted numerous times by different people; the S&L assessment process was also highlighted as challenging.
  - Availability and quality of SEND support for children in schools.
  - Parents don’t know what support is available and there is a lack of proactive communication to them. Existing communication needs to be in simple English.
  - Activities prohibitively expensive for low income families who aren't on benefits.

Children and Young People

Potential metrics

- Marmot:
  - Indicator 1: School readiness
  - Indicator 2: Low wellbeing in secondary school children (#Beewell)
  - Indicator 3: Pupil absences
  - Indicator 4: Educational attainment by FSM eligibility

Children and Young People

Objective	Action	Delivery Lead(s)	Timeframe
Strengthen mental support and preventative offer for young residents	Develop a pathway for 2-5 years olds for MH support.	Children's and mental health	
	Supporting more 18 and 19 year olds to get into employment, encouraging public sector employers to take on more vulnerable residents and use more equitable recruitment practices (linked to action in employment section).	All anchor organisations	
	Build and expand on the work the MH in education team are doing with parents around anxiety.	Education	
	Revisit outcomes from previous poverty proofing the school day audits and develop and develop further actions to ensure education is as responsive to poverty as it can be.	OMBC Policy /Education Teams	
Improve access to physical health support and preventative services for those in most need	Develop a targeted physical activity offer for low income families (driven by data which highlights who should be targeted).	Oldham Community Leisure	
	Work with schools and early years education providers on approaches to healthy weight, healthy eating and physical activity (linked to action under wellbeing on Healthy Weight).	Public health and education	
Identify food insecure residents at an earlier age (I.e. before FSM)	Develop systems and pathways that lead to the earlier identification of, and action on, early years and primary school age food insecurity.	OMBC Children's and education	
Improve Childhood Mortality in Oldham following latest data released	Act on infant mortality review being carried out to understand Oldham's highest rates of infant mortality in GM.	OMBC Public Health	Q4 2022/23
Address inequalities experienced by Looked After Children	Review CYP and health data and ensure that where possible it is being looked at through a LAC lens to help drive further action.	OMBC Public health	Q1 2023/24

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Report to HEALTH AND WELLBEING BOARD

Oldham Integrated Care Partnership Operating Model

Chair: Cllr M Bashforth

Officer Contact: Mike Barker

Report Author: Mike Barker

Ext. mike.barker3@nhs.net

Date: 21 June 2022

Purpose of the Report

This report has been prepared to enable the Health & Wellbeing Board to debate and discuss progress in relation to the establishment and readiness of the proposed Oldham Integrated Care Partnership as part of the establishment of the Greater Manchester Integrated Care System.

Requirement from the Health and Wellbeing Board

- To be engaged in the discussion process

Oldham Integrated Care Partnership Operating Model

Background

1. Integrated care systems (ICSs) are partnerships of health and care organisations that come together to plan and deliver joined-up services and to improve the health of people who live and work in their area.

2. They exist to achieve four aims:

   - **improve outcomes** in population health and healthcare
   - **tackle inequalities** in outcomes, experience and access
   - enhance **productivity and value for money**
   - help the NHS support broader **social and economic development**.

3. Following several years of locally-led development, and based on the recommendations of NHS England and NHS Improvement, the government has set out plans to put ICSs on a statutory footing.

4. To support this transition, NHS England and NHS Improvement has published guidance and resources, drawing on learning from all over the country. The aim is to enable local health and care leaders to build strong and effective ICSs in every part of England.

5. Collaborating as ICSs will help health and care organisations tackle complex challenges, including:

   - improving the health of children and young people
   - supporting people to stay well and independent
   - acting sooner to help those with preventable conditions
   - supporting those with long-term conditions or mental health issues
   - caring for those with multiple needs as populations age
   - getting the best from collective resources so people get care as quickly as possible.

6. The continued development of Integrated Care Systems remains a priority for the NHS, to support joint working arrangements in managing the pandemic and accelerate local health and care service transformation to improve outcomes an reduce inequalities.

7. The Health and Care Bill, intends to put ICSs on a statutory footing and create Integrated Care Boards (ICBs) as new NHS bodies from 1 July 2022.

8. Up until 1 July 2022:

   i. CCGs will remain in place as statutory organisations. They will retain all existing duties and functions and will conduct their business (collaboratively

in cases where there are multiple CCGs within an ICS footprint), through existing governing bodies.

ii. CCG leaders will work closely with designate ICB leaders in key decisions which will affect the future ICB, notably commissioning and contracting.

iii. NHSEI will retain all direct commissioning responsibilities not already delegated to CCGs.

Current Position

9. Under the Health & Care Bill, a statutory ICS would be led by two related entities operating at system level – an 'ICS NHS body' and an 'ICS health and care partnership' – together, these will be referred to as the ICS.

10. However, the national implementation framework also states that all systems should establish and support place-based partnerships, with configuration and catchment areas reflecting meaningful communities and geographies that local people recognise. The ICS NHS body will remain accountable and therefore the governance and leadership arrangements put in place should support safe and effective delivery of the body's functions and responsibilities alongside wider functions of the partnership.

11. There are two important points that have been used to drive our designs locally in Oldham.

    i. Firstly, local partners will agree the form of governance that place-based partnerships adopt, having regard to existing local configurations and arrangements. Depending on the context and functions to be carried out at place level, governance arrangements may include the following, possibly in combination: consultative forum; (joint) committee of the NHS ICS body; individual directors of the NHS ICS body; lead provider and so on.

    ii. Secondly, the roles of place-based leaders will include convening the place-based partnership, representing the partnership in the wider structures and governance of the ICS and (potentially) taking on executive responsibility for functions delegated by the ICS NHS body chief executive or relevant local authority.

12. To that end, we have been working on the development of an operating model for Oldham's Integrated Care Partnership. That is appended to this report for further information.

13. The shadow NHS GM ICS set out a series of core characteristics that every locality operating model will be required to meet. These are as follows:

    i. A place-based lead for integrated health and care
    ii. A Locality Board
    iii. A place-based provider collaborative/alliance or local care organization and neighbourhood working arrangements

iv. Agreed arrangements for the joint management of the pooled budget
v. A clear accountable relationship with the NHS GM ICS
vi. A clinical and professional model that supports decision making
vii. A population health management system

14. We have undertaken a self-assessment of our proposed model against these criteria along with our progress to date. A summary of the key findings of our self-assessment are presented the following statements.

Neighbourhood Model:
- The emergence of five multi-agency district place boards are in place
- Multi-agency district operational leads groups in place
- Connectivity between district place boards and key networks (e.g. Youth Alliance)
- Developing community engagement methods embedding at neighbourhood level
- Positive evaluation of Thriving Communities and the approach to social prescribing
- Districts / neighbourhoods are coterminous footprints that are the right size

Local Provider Collaborative/Alliance:
- Long running Alliance of providers and commissioners
- Integrated Delivery Board established in May 2021
- Integration Agreement in place since July 2021
- Response-led multi-agency working
- Intensive programme of development engagement underway
- Integrated transformation programme –need to agree priorities & timeline
- Formalise a new arrangement –this could, for example, be decision-making in the first instance followed by additional pooling of provider budgets
- Agree the form of the Collaborative –'Provider Leadership Board Model'

Locality Board:
Form & Composition
- Oldham Health and Care System Board becomes: "Oldham Integrated Care Partnership Board"•A Joint partnership Committee underpinned by a Strategic Partnership Agreement
- Meets with a Section 75 Committee –evolved from the existing Commissioning Partnership Board with separate Terms of Reference and restricted decision-making
- Expanded S75 for 1 July onwards
- Oldham Health and Care System Board in place since September 2021
- Integration Agreement in place since July 2021
- Sub-groups established

Role
- Locality Plan in place
- Social value work established with a focus on workforce and employment
- Multi-agency quality assurance, surveillance and improvement groups established
- Finance and Sustainability Group established
- Financial flows discussed at Board

- Various Partner strategies and themed plans discussed at Board, including social children and young people
- Review all health and care strategies and plans –how do we ensure they are cohesive and connected?
- Consider regular checks that Board business addresses wealth business, social value and health inequalities –for example, via standardised paper cover templates
- Consider how oversight of unwarranted variation in performance and outcomes can be achieved
- Work with Health and Wellbeing Board to establish plans to tackle health inequalities

Place-based Lead:
- Oldham CCG AO put forward and appointed
- Accountable for ICB decisions into the 'Place'
- Leader of the 'Place' ICB team
- Part of GM Management Board
- Leader of the Partnership's development
- Dual reporting line

Population health system:
- Governance reviewed to ensure clear definition in role of Locality Board and Health and Wellbeing Board
- Health and Wellbeing Board will focus on wider determinants and overseeing delivery of the health inequalities plan
- System-wide health inequalities plan developed based on GM Marmot recommendations
- Self assessment against Population Health Characteristics Framework undertaken in November 21 and is informing development of plans and priorities
- Provider strategies have strong focus on population health and inequalities (incl. NCA, Pennine Care)
- DPH is a member of Locality Board and Provider Collaborative Board, and is the recognised system lead for population health
- Social prescribing well established and opportunities identified to further develop approach in line with place based working
- Door-to-door engagement teams and community champions work continuing beyond COVID to focus on wider determinants and other key health issues
- Strong VCSFE infrastructure and presence on partnership boards
- Covid testing and vaccination programmes co-designed with communities, and learning is being taken into other programmes
- PCN Population Health Management Plans in place
- Continued NHS investment in improving health/wider determinants e.g. warm homes
- Examples of joint commissioning across Council and CCG in response to local need e.g. health improvement and weight management, and genetic outreach services
- NCA work on social value also well developed with a particular focus on workforce and employment
- Public health input into licensing process and working with planning on development of Local Plan to ensure improving health is embedded in policy

- Some contracts with health inequalities performance measures in place

Clinical and professional leadershjip model

- A clinical and care professional leadership model established that aligns with best practice and the latest research
- Health and Care Senate established
- Initial priority pathway change areas established
- Transfer planned of existing CCG clinical lead posts into the new organisation place team
- Agreement of additional and time-limited roles
- Clinical and care professional leads embedded into Boards and working groups

Recommendation

15. The Health & Wellbeing Board is asked to note and discuss the contents of the report.

Appendices

1. Oldham ICP Operating Model

Oldham Integrated Care Partnership

Operating Model

Purpose of Document

In advance of the establishment of the GM ICS from 1/7/22, the Oldham Health and Care System has moved to establish the new partnership arrangements in transition form. This document consolidates the progress to date and describes as far as possible how the system will operate in practice.

It is recognised that the arrangements may continue to develop and refine up until 1/7/22 in the light of national guidance and the GM wide operating model.

We will also use the transition period September 2021 to July 2022 to test the arrangements described here with a series of scenarios – understanding how the system would work to address particular issues. This document will be updated as required.

It is also recognised that the arrangements may change and develop after 1/7/22 and again this document will be updated as required.

Presentation

We are presenting this operating model in a way that meets three objectives.

- to provide confidence and assurance to key stakeholders, including the GM ICB and Oldham Council – that we can effectively discharge the obligations of the Oldham Locality Board in relation to delegated authority.

- To describe to all partners in Oldham the way the system will work in as clear and simple way as possible.

- To provide as much clarity as possible to staff affected by the changes, notably CCG staff.

Version: Draft Version 1.2
Owner: Mike Barker
Date: 28/04/22
Target Date: 01/07/22 – Oldham Locality Board

Contents

A Background and Context

B Locality Plan for Health and Care

C Oldham Integrated Care Partnership - System Partnership Arrangements

D Oldham Integrated Care Partnership - System Partnership Leadership

E Oldham Integrated Care Partnership - Running Costs

F Financial Flows and Funding

G Greater Manchester Integrated Care System

H. Values and Behaviours of the Oldham Integrated Care Partnership

A. Background and Context

1) From the 1/7/22 – subject to legislation – the NHS is being reconfigured to work as part of Integrated Care Systems. The practical impact of this for Oldham is the abolition of the CCG with its functions adopted by a single Integrated Care Board for Greater Manchester, and the creation of a number of other GM wide partnerships.

2) This is a high-level operating model for the **Oldham Integrated Care Partnership** to be effective from 1/7/22. The term "Oldham Integrated Care Partnership" describes the joint work of all partners in the health and care system to deliver the Oldham Locality Plan – our strategy for health, care and wellbeing. The locality plan can be seen here.

3) The Locality Plan for Health and Care in Oldham sits as one part of the Strategy for the Borough – 'The Oldham Plan' - seeking to improve life outcomes for all residents in the borough. The Oldham Plan can be seen here

4) This document is an operating model for the way in which partners work together as a Oldham Integrated Care Partnership, and refers to the partnership meeting arrangements, and the roles capacity and governance and running costs required to support the system.

5) The Oldham Integrated Care Partnership is part of the wider Greater Manchester Integrated Care System, and we work closely with colleagues across Greater Manchester – including the GM Integrated Care Board, the GM Provider Federation Board, and the GM Primary Care Board – to both contribute to and benefit from the conurbation wide perspective.

6) In developing this locality operating model, we assume.

   - All CCG staff will TUPE to the GM ICS, and the bulk of staff will be redeployed in Oldham. The expectation is that the number of posts that will not be locally redeployed back to Oldham will be small.

   - We recognise that some CCG staff will be deployed at a GM level either directly in the GM ICB or via the GM Provider Federation Board. The particular posts in scope are yet to be determined.

   - We also recognise that many staff will continue to be deployed locally but the connections to GM wide working may be strengthened – connecting expertise across all parts of GM and the GM core.

   - We are further developing our integrated working arrangements in Oldham e.g in terms of the work we have done in the last year to blend the expertise across commissioning, and the local care alliance, and in the way we have integrated some business support functions between council and NHS – for example in HR, OD, Comms, and IM&T.

B. Locality Plan for Health and Care

7) Regardless of organisational change, the partners in Oldham have recently adopted a refreshed Locality Plan. The Oldham Locality plan describes our strategic ambition for the health and care system in Oldham. It remains our 'north star' – to retain a focus on the outcomes we seek to achieve for residents of Oldham during a period of transition.

   In summary the agreed objectives are as follows

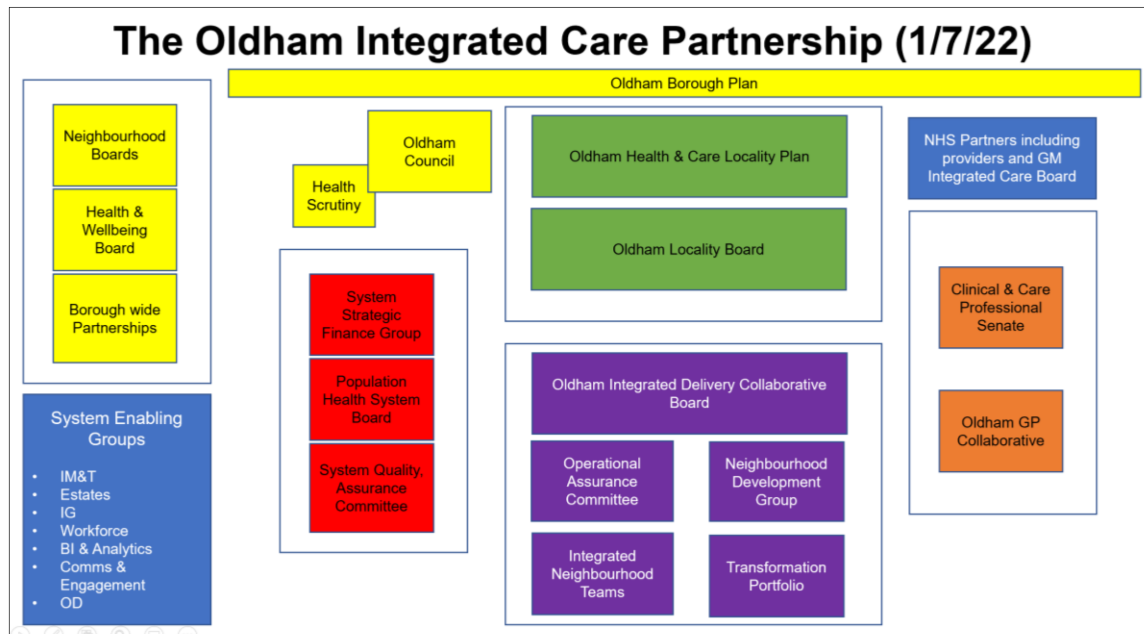
1) We will seek to **influence the factors that improve population health** and wellbeing and reduce health inequalities and foster inclusion 2) We will **support residents to be well, independent, and connected** to their communities and to be in control of the circumstances of their lives 3) We will support **residents to be in control of their health and well being** 4) We will **support people to take charge of their health and care and the way it is organised around them, and to live well at home**, as independently as possible 5) We will **support children to 'start well'** and to arrive at school ready to learn and achieve 6) We will ensure all residents **have access to integrated out of hospital services,** that promote independence, prevention of poor health, and early intervention 7) We will work through **5 neighbourhood teams** to create opportunities for front line staff to know each and work effectively together 8) We will secure **timely access to hospital services where required** 9) We will work to **reduce dependence of people on institutional care** – hospitals and care homes. 10) We will work to ensure **high quality responsive services** where people describe a good experience of their treatment

8) The Oldham Borough Strategy

   The Oldham Borough Strategy is for everyone who has a stake in our Borough's future: local people, community groups, organisations of every sort, whether public, private or voluntary. The strategy is a call to action for everyone in our Borough to get behind the change we all want to see and do all we can to make it happen. It is a commitment to a decade of reform; a bold ambition to tackle deprivation and improve growth through a programme of work that covers people; places; ideas; infrastructure and the business environment.

C. Partnership System

9) Partners in Oldham have already established in transitional form the partnership arrangements we will have fully operational from 1/7/22. The diagram below describes this.



10) The component parts of our partnership model are as follows

- **Locality Board**

  The partnership leadership of the Oldham Integrated Care Partnership is through the Locality Board, made up of senior representatives from all relevant statutory organisations and other key partners. It will bring together political, clinical, managerial and professional leaders to help shape the strategy, priorities and focus on integrated health and care for the Place.

  The Locality Board will include the Council, Clinical & Care Leadership, Northern Care Alliance, GP Federation on behalf of PCNs, the Greater Manchester ICB, the Oldham VCSE, and Healthwatch.

  The Locality Board sets the shared strategy for the partnership and ensures triple aim objectives of oversees the budget for health and care in the borough (some of which may be formally pooled), ensures the system focuses on outcomes and inequalities, and secures the transformation of the way services are delivered as described in the Locality Plan.

  The terms of reference for the Locality Board can be seen at…

  To discharge its functions effectively the Locality Board will operate as a partnership committee of the statutory partners – that is a formal joint

committee with the GM ICB, as a committee with delegated authority from the Council, and as a committee with delegated and pooled resources from the NHS partners.

Operating as a formal joint committee will not only support delegated decision making in relation to any financial pooled budget, but will allow more nimble decisions of policy, strategy, and operational decisions. For the Locality Board to operate in this way, each board of the members will need to agree the necessary delegations from its own board to the Oldham Locality Board.

The Locality Board will have an accountability to all of its partners. In particular the Locality Board will together own the delivery of the anticipated INTEGRATION AGREEMENT between the GM ICB and the Oldham Integrated Care Partnership for the delivery of GM ICB priorities and commitments.

- **Integrated Delivery Collaborative, and Board**

The 'engine room' of the Oldham Health, Care and Well Being system is the Integrated Delivery Collaborative. This describes the way we are building relationships between all the partners to deliver services and interventions, and to work together to transform the overall Oldham health and care system.

This includes all partners to the Locality Board but a number of other key services – e.g MioCare (the Council owned social care delivery organisation), the Hospice, First Choice Homes, and others.

Integrated Delivery Collaborative working takes place at borough wide level, in neighbourhoods, and in very local communities.

Key tasks for the Integrated Delivery Collaborative are:

a. To create the conditions for the delivery of high-quality integrated health and care services in each of 5 neighbourhood teams,
b. To co-ordinate the delivery of the system wide transformation programmes – including for example urgent care, elective care, adult care transformation, learning disabilities
c. To create the frameworks and partnership arrangements to deliver the expectations of the Locality Board as described.

To provide a focal point for all that we have established an Integrated Delivery Collaborative Board (IDCB), with senior representatives from all partners. The IDCB is independently chaired.

The IDCB is a formal Partnership / Alliance of partners and is bound together by a 'mutually binding agreement' – a copy of which can be seen at ..

There will be an Integration Agreement that describes the relationship between the Locality Board and the IDCB. The Integration Agreement

describes particularly the adoption of the core objectives to improve effectiveness, efficiency, and population health gain. The Integration Agreement can be seen at:

The national ICS guidance identifies three models that NHS providers have typically used to form collaboratives under existing legislation. The models are not mutually exclusive; they can be combined or work in parallel, and one may evolve into another. The models are described below:

Model Type	Description
1. Provider leadership board model	Chief executives or other directors from participating organisations come together, with common delegated responsibilities from their respective boards (in line with their schemes of delegation), such that they can tackle areas of common concern and deliver a shared agenda on behalf of the collaborative and its system partners[1]. This model can make use of committees in common, where committees of each organisation meet at the same time in the same place and can take aligned decisions.
2. Lead provider model	A single NHS trust or foundation trust takes contractual responsibility for an agreed set of services, on behalf of the provider collaborative, and then subcontracts to other providers as required. Alongside the contract between the commissioner and NHS lead provider, the NHS lead provider enters into a partnership agreement with other collaborative members who contribute to the shared delivery of services.
3. Shared leadership model	Members share a defined leadership structure in which the same person or people lead each of the providers involved, with at least a joint chief executive. This model can be achieved by NHS trust or foundation trust boards appointing the same person or people to leadership posts. In the case of NHS trusts, this model can also be achieved by the board of one trust delegating certain responsibilities, consistent with the remit of the provider collaborative, to a committee which is made up of members of another trust's leadership team. Under either of the above approaches each provider's board remains separately accountable for the decisions it takes (even if aligned). Nevertheless, alignment of decision-making can be supported by using shared governance (such as committees in common).

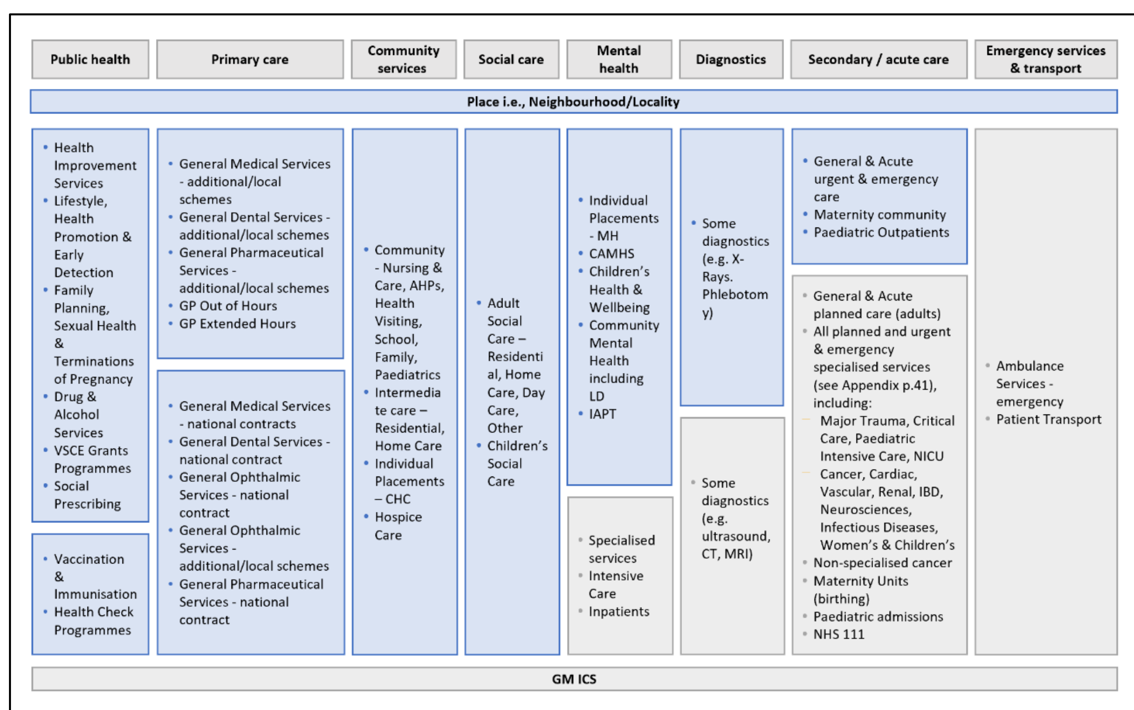
In Oldham our preferred model is Option 1 - In effect this would be described as a non-lead provider collaboration organised through a formal agreement and committee in common.

The scope of the Integrated Delivery Collaborative will include

- all and any services required for the 'next step care' after a GP consultation; and

- all care that can be provided in community settings, unless by exception – supported by specialists' opinion. Integration opportunities would therefore cover as a minimum:

    - the majority of support and services that are presently delivered in outpatients;
    - a significant array of diagnostics;
    - a range of ambulatory and same day emergency care (SDEC) pathways;
    - day case work;
    - the full range of community health services;
    - the full range of adults and children's care services; and
    - an extensive range of services provided from the voluntary sector.
    - The list above is a generic list, and our explicit working assumption is outlined in the following diagram that was undertaken earlier this year across the North East Sector supported by Carnall Farrar.



- **Neighbourhood Working**

A key task forThe default setting for integrated community health and care services in Oldham is though 5 integrated neighbourhood teams. These are:

- Oldham East
- Oldham West
- Oldham North
- Oldham South

- Oldham Central

We have a development plan for integrated neighbourhood working in health and care and this can be seen at..

The model of integrated neighbourhood team working in health and care operates at the same spatial levels as our community hubs - a focal point for community leadership and co-ordination in each of five neighbourhoods.

Increasingly wider public services are also working on the same spatial level - this includes GMP, Housing Providers, GMFRS, wide Council Services - with the understanding that prevention and early intervention across a range of public service can sustainably improve outcomes.

From a health and care perspective this work explicitiy recognises that the organisation of service delivery of health and care is a minority contributor to the health and well being of residents. More important is, for example, the quality of housing, the available of quality work, the extent to which residents are connected to their communities, and whether a life is led free from harm. This work is co-ordinated by the Oldham Public Service Reform Board.

Primary care is at the heart of our model of integrated care. We have 5 co-aligned Primary Care Networks and Council District neighbourhoods. The Primary Care Networks are supported in their development by the CCG and work continues to explore how best to support the maturity and system leadership of the primary care networks. The primary care team of the CCG/future ICB will work closely with the capacity of the PCNs to support Practices.

- **Triple Aim Programme Boards**

The triple aim approach is well understood in health and care systems. It is a framework that describes an approach to optimising system performance through the simultaneous pursuit of three dimensions: improving the quality of healthcare, improving the health of the population, and achieving value and financial sustainability.

Accordingly, the Oldham Integrated Care Partnership will have a System Groups with dedicated leadership and capacity reflective of whole system working, for each of the triple aim objective.

These groups will be:

- **System Wide Quality and Assurance Group.**
  The role is to co-ordinate quality assurance arrangements on behalf of the system – connecting to uni-organisaitonal assurance processes. The Terms of Reference for the group can be seen at.

- **Strategic Finance Group**

It will ensure oversight of the integrated fund in Oldham – made up of pooled, aligned, in view funding, and also the delivery of financial risk and 'gain share' from system wide initiatives. It will also be a role of the SFG to ensure that we can invest over the medium term into early intervention and prevention and move funding across agency boundaries at neighbourhood level. The terms of refence for the SFG is at

- **Population Health System Board**
  This strand is led by the statutory DPH and supported by the capacity of the Oldham Council Public Health team. The Health and Well Being Board operates as a standing commission on health inequalities, working with 'Team Oldham', and a specific and operational population health board comprised of operational leadership from health and care and wider partners. The terms of reference for the HWBB and the population health board are at.

- **Clinical and Care Professional Leadership**

Oldham has established a clinical and care professional senate with the intention of ensuring clinical and wider professional (e.g social worker) leadership is significantly influencing, leading, guiding, and challenging the work of the wider partnership arrangements. It is also intended to create opportunities for strengthened clinical and professional leadership across different sectors and interfaces e.g primary care/secondary care, mental/physical health, health/care.

A clinical senate board operates through mandated leadership and will coordinate the work of the wider clinical and care professional senate. The terms of reference for the clinical and professional senate are at..

Oldham will also seek to establish a GP Collaborative. This is a joint initiative between GP practices in Oldham, the 5 Primary Care Networks, and the Local Medical Committee. It is intended to support the voice of GP leadership particularly in the partnership arrangements, recognising the potential risk of the loss of the CCG as a GP membership organisation and as a key statutory authority in the borough.

As part of this change process, Oldham will create a GP Collaborative. This is an umbrella organisation creating an opportunity for the GP community to speak with one voice and influence the decision making in the wider partnership. Its membership will include the PCNs, GP Practices, and the LMC. A draft terms of reference is at

- **Enabling Groups**

Oldham Council and Oldham CCG have in the last few years established a number of joint and integrated teams – a shared comms and engagement function, a shared HR & OD function, and joined up working in IM&T development. These functions will continue to build relationships with key

partners to create and further mature system wide approaches where required.

The Oldham Health and Care System already has some existing system wide working groups – connected expertise from across council, NHS and other partners and these will be further developed.

The Oldham Integrated Care Partnership Groups are therefore the following:

- Oldham ICP Workforce Group
- Oldham ICP Strategic Estates Group
- Oldham ICP Business Intelligence Group
- Oldham ICP Comms and Engagement Group
- Oldham ICP IM&T Group

D. Leadership System

11) Having described the role and function of the partnership arrangements to deliver our Oldham Integrated Care Partnership, we need to consider the leadership architecture we need to manage and operate the system.

12) This is not about 'management structures' – because the system is complex with very many different organisations working together with their own management arrangements. This is about the leadership arrangements of the partnership system.

13) The leadership architecture described below is indicative and is subject to wider consultation with all staff affected. It is intended to represent a further step forward in the way all partners have worked together in the last 36 months – worrying less about who they work for, and rather focusing on bringing the talents of all to the priorities of the system.

14) In particular, the draft system leadership architecture draws heavily on the roles of current CCG staff who will transfer into the employment of the GM ICB, and of teams working across the Council and CCG as part of the commissioning function, and of capacity and leadership of what is currently described at Oldham Cares Alliance (LCO). However, this is not about 'recreating' a CCG; it is about bringing the capacity and expertise of CCG staff, LCO staff, Council staff and colleagues from across provider organisations to support the whole partnership system be as effective as possible.

15) The following describes the pillars of work required to support the system partnership described.

16) We envisage there are 6 teams/pillars supporting the work of the place-based lead and the wider Oldham Integrated Care Partnership.

17) The responsibilities of each pillar are described below.

Pillars	Functions
Strategy Planning and System Development	• Strategy Development • Business Planning • Business Intelligence • Organisational development • Policy & Partnerships • Ensuring enabling functions support system delivery • Benchmarking
Transformation	• Managing the Business of the Oldham Integrated Delivery Board • System Reform – interventions to improve performance through system and process redesign. • System Redesign – continuing pathway redesign development • Creating conditions for neighbourhood team working
Financial Planning	• Financial Management – Financial Planning, Operational and Strategic Decision/Investment Support, Financial Monitoring • Financial Accounting – Financial Reporting, Financial Control & Governance
Assurance and Monitoring	• Patient Experience • Provider Quality Management • Escalation and Resolution • Clinical Quality Assurance • Compliance Monitoring • System Safeguarding (connected to Oldham Integrated Care Partnership)
Clinical and Professional Leadership	• Convening Clinical and Professional Senate • Clinical Development and Networks • Connections to clinical networks on sub regional and GM footprint • PCN Development • Medicines Management – ongoing medicines management and prescribing support
Population Health System Pillar	• Ensuring a focus on health inequalities in all we do • Reporting to Health and Well Being Board operating as a standing commission on health inequalities.

18) The following are key considerations of leadership of each of the elements described above. It will be noted that the proposal remains subject to consultation.

- **The Place Based Lead**

Each of the 10 Places in GM will also identify a 'place-based lead'. The role of the place-based lead is to ensure the effective operation of the Oldham Integrated Care Partnership with an accountability to both the GM ICB and the Council for the effective operation of the partnership.

In Oldham the partners have agreed that the place-based lead should be vested in the role of the individual currently the Accountable Officer of the CCG and Strategic Director of the Council. We would expect that from 1/7/22 this person would have a formal role/accountability to the GM ICB as well as a continuation of the role within the Council.

- **Clinical and Professional Lead**

  It is expected that the clinical and care professional lead for the system leadership arrangements will be determined by the work of the Clinical and Care Professional Senate Board, and will in transition and beyond be the current Chief Clinical Officer of Oldham CCG until such time that the current term of office is ready to be renewed and then it will be reviewed.

- **Strategy Planning and System Development Pillar**

  It is expected that this role is filled by the current Oldham CCG Director responsible for this and that this individuals connects in to the GM Strategy and Planning function also.

- **The financial planning pillar**

  It is considered that the financial planning pillar lead is assumed to be the individual currently operating as the CCG Deputy Chief Finance Officer with a dotted line to the Council and Provider Directors of Finance. It is further expected that the postholder will be accountable to the Place Based Lead and the Locality Strategic Financial Planning Pillar.

- **Population Health Pillar**

  It is expected that the population health pillar is led by the Director of Public Health and supported by the Council Public Health team.

- **Assurance and Quality Pillar**

  It is expected that this role is filled by the current Oldham CCG Director of Nursing and Quality and that the staff in the current QA team and the CCG Safeguarding and CHC staff will report to the lead of the Assurance and Quality Pillar. It is envisaged that this individual will also bridge into the Council

- **Transformation and Delivery**

It is expected this pillar lead role is filled by the current CCG Director of Commissioning Operations.

19) There are three key statutory functions in the borough accountable to the Council that connect to all parts of the partnership arrangements described.

a. The Director of Adult Services. There are no changes planned to the management scope of this role from 1/7/22. As now the role will work closely with all pillars described.

b. The Director of Children's Services. Children's services in health and care are in scope of the arrangements described above, and the Oldham Children's Strategic Partnership will work to ensure the connection between the NHS service and the wider Children's partnership arrangements in the borough.

c. The Director of Public Health will, as previously described, manage a team influencing across the borough from a population health system perspective, and particularly the work of the Health and Well Being Board.

20) This structure also recognises where there are already integrated functions existing between the Council and the CCG, that we wish to build on and further develop. For Example

a. The System Strategy pillar may have responsibility for Organisational Development, the leadership would be provided from the existing person who leads the integrated NHS/Council OD function providing expertise and oversight to the team. The key task is ensuring the alignment of OD activities to the system partnership arrangements, and ensuring outcomes inform transformation priorities. There will be "a dotted line" to the Strategic Planning and System Development Pillar.

b. The integrated Council/CCG Comms team will continue with the current management arrangements provided by the Council but will describe a "dotted line" to the Strategic Planning and System Development pillar.

21) That we recognise we are seeking to operate as a whole system – and that in addition to the formality of attendance at the locality board and the IDCB, there is a need for a relatively informal **system leadership group,** to be chaired by the Place Based Lead. This brings in to the 'system leadership' sphere key senior leaders from a range of providers to work alongside the Place Based Lead.

22) There is further work to be done to map the wider system governance of Oldham, GM and the North East Sector to avoid duplication. This has been partly described by work commissioned by the Northern Care Alliance and the

4 localities it serves – Oldham, Bury, Salford, and Rochdale – from Carnall Farrar and this is available at…

A named "North East Sector Alliance Lead" has been appointed working across all 5 organisations.

E) Running Costs

23) Partners in the Oldham Health and Care System are committed to the capacity required to operate the Oldham Integrated Care Partnership in way that secures the achievement of the objectives of the Locality Plan for residents of the borough.

24) Partners in Oldham also recognise the national commitment that the implementation of the Integrated Care System arrangements is not in itself intended to be a cost saving measure, nor is intended to denude 'places' like Oldham of the capacity to drive the scale of transformation required to deliver a clinically and financially sustainable system

25) Nevertheless, it is recognised that the Greater Manchester Integrated Care System is under significant financial pressure.

26) Our default setting is that the Oldham Integrated Care Partnership needs the running costs and in scope programme management costs currently attributable to the Oldham CCG. This is particularly true given the significant complexities that Oldham faces in terms of health inequalities and deprivation.

27) Our working assumptions are based on a running cost envelope that includes all cost locked in programme management funding

- Minus the savings of the non-executive directors
- Minus the vacancies of the clinical directors
- Minus 3% cost efficiency

28) Therefore we are assuming running costs (corporate) being in the region of at least £8.5m of current CCG staffing costs – the table below shows the overall GM calculations based on H2 planning for 2021/22 as developed by the GM Finance Leadership Group on behalf of the GM system.

Table 2: Indicative split of budgets based on H2 2021/22 Plans

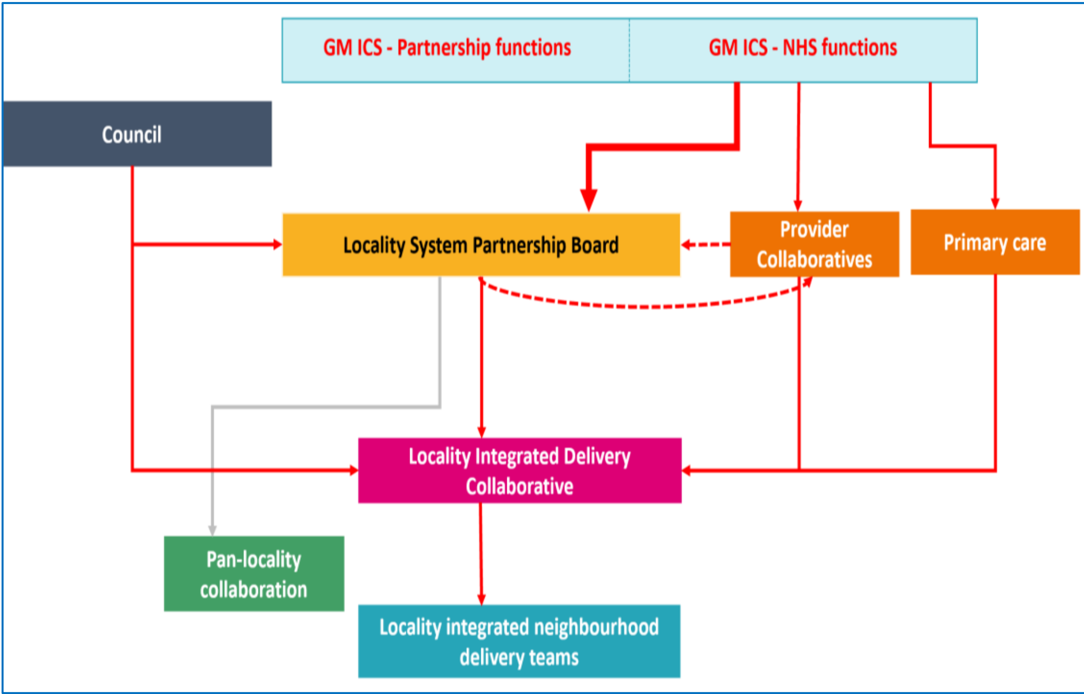
CCG	GM		Locality		Corporate		Total
	£000's	%age	£000's	%age	£000's	%age	£000's
Salford	391,280	75.8%	114,497	22.2%	10,449	2.0%	516,226
Manchester	815,997	76.3%	222,286	20.8%	31,091	2.9%	1,069,374
Oldham	364,806	78.4%	92,162	19.8%	8,329	1.8%	465,297
Bury	260,980	72.8%	90,520	25.3%	6,820	1.9%	358,320
HMR	311,828	74.7%	99,089	23.7%	6,771	1.6%	417,688
Wigan	438,050	73.3%	146,312	24.5%	13,282	2.2%	597,644
Bolton	399,460	74.0%	130,220	24.1%	9,960	1.8%	539,640
Stockport	409,042	74.8%	127,916	23.4%	10,132	1.9%	547,090
Trafford	311,560	71.9%	109,050	25.2%	12,718	2.9%	433,328
Tameside & Glossip	353,712	77.9%	93,408	20.6%	7,036	1.5%	454,156
Total Forecast	4,056,715	75.1%	1,225,460	22.7%	116,588	2.2%	5,398,763

F) Funding and Financial Flow

29) We have done an initial assessment of the financial flows within the new GM ICS in tandem with the work going on across GM. Our assessment of options is as follows:

Body	Financial flows
GM ICS - NHS and Partners	• Receives NHS budget allocation for the system • Delegates funds to localities – these should be commensurate to the scope of the Locality System Partnership Board • Provides some funding directly to provider collaboratives • Provides some funding directly to primary care
Council	• Councils fund the Locality Board directly, contributing to the integrated fund for the locality • Councils can fund the Locality Integrated Delivery Collaborative directly if they choose
Locality System Partnership Board	• Receives funding from the GM ICS Partnership Board / GM ICS NHS Board and the Council to create an integrated fund for the locality • The integrated fund is used to fund the Locality Integrated Delivery Collaborative • The Locality System Partnership Board can decide to 'passport' some of its funding to provider collaboratives • The Locality System Partnership Board can decide to spend some of its budget on pan-locality initiatives
Provider collaboratives	• Receive funding from the GM ICS Partnership Board / GM ICS NHS Board • The provider collaboratives have a responsibility to align budgets with localities and indeed will make up part of the relevant Locality System Partnership Board membership
Primary care	• Receives funding from the GM ICS Partnership Board / GM ICS NHS Board
Locality Integrated Delivery Collaborative	• Receives funding from the Locality System Partnership Board • Provides funding for the locality integrated neighbourhood delivery teams
Locality integrated neighbourhood delivery teams	• Receive funding from the Locality Integrated Delivery Collaborative • The ultimate aim is to work towards delegated funding at a neighbourhood level
Pan-locality collaboration	• May receive some funding from the Locality System Partnership Boards for pan-locality initiatives, but does not hold its own budget

30) Our view is that funding should be delegated from the GM ICS NHS Board to the Locality System Partnership Board, and we would see this funding flow as detailed on the chart that follows.

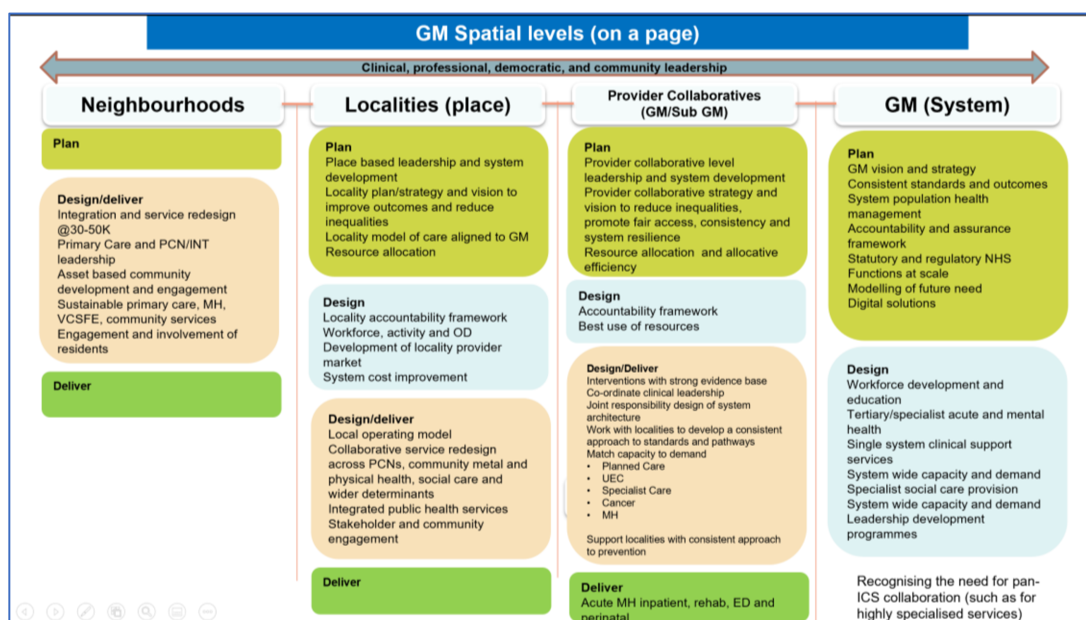

GM ICS - Partnership functions
GM ICS - NHS functions
Council
Locality System Partnership Board
Provider Collaboratives
Primary care
Locality Integrated Delivery Collaborative
Pan-locality collaboration
Locality integrated neighbourhood delivery teams

G) Greater Manchester Integrated Care System

NB – this section is consistently described in the Bury and also Rochdale Locality Plan – reflecting our ambition to share learning and develop a consistent approach to working within the GM ICS arrangements.

31) GM already has developed an architecture that set the pace for the national model of neighbourhoods, localities / places, provider collaboratives and an ICS (manifest in the Health & Social Care Partnership and governance structures). This is well understood, and leaders are clear that this architecture should remain the basis of the new operating model.

32) Equally there has been considerable work done on the spatial level at which service planning and delivery should be organised and undertaken.



33) In some specialities and conditions, such as mental health, these spatial levels have been taken to a more detailed and granular level with a clear explanation as to how services and programmes could address the challenge GM faces.

34) Provider Collaboratives that operate across GM with formal governance to plan and deliver diagnostic and acute care as defined in the spatial model. The governance arrangements must enable the constituent organisations to hold/manage a shared budget and to address the associated shared risks and benefits. These must also support the shared learning and development of their constituent organisations. They would require additional resources and strengthened governance to underpin the Collaboratives' work if they are to manage key programmes of activity.

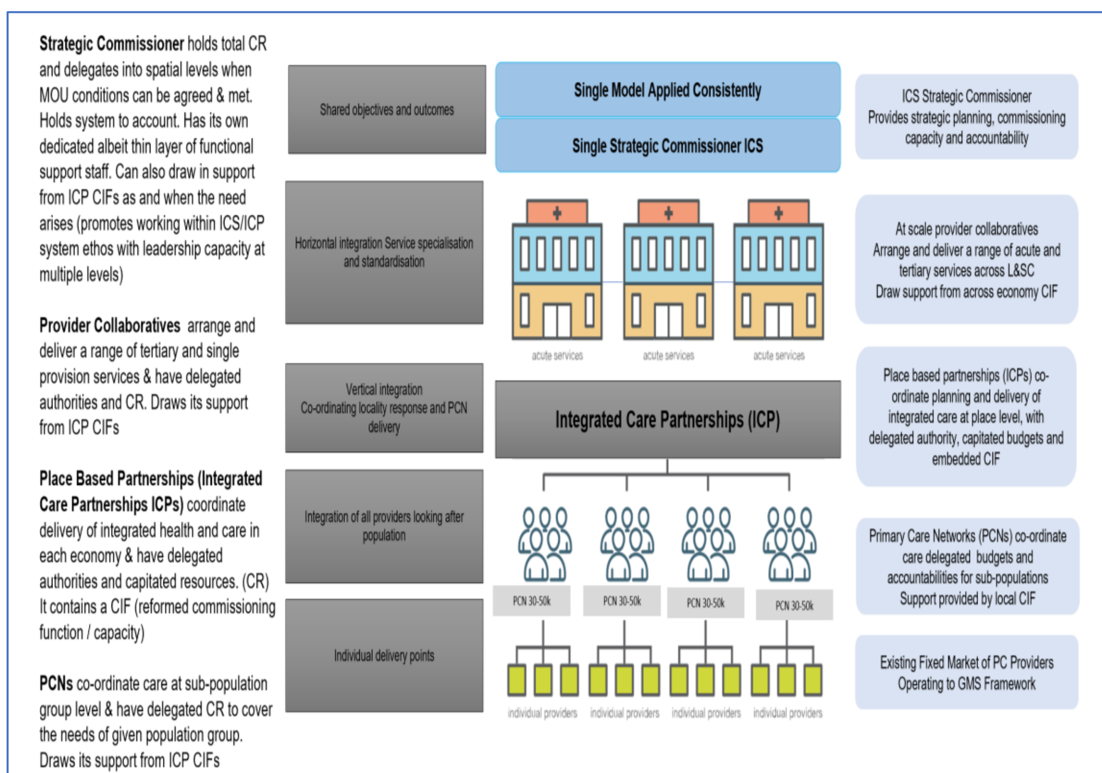
35) Capability at GM level to discharge the functions, governance and legal requirements of a statutory ICS (as constituted in the forthcoming legislation) whilst being consistent with the existing devolved GM structure and process.

The engagement process referenced the need to address and agree the new governance structure at GM level but focused more thinking onto the operating model beneath this level and further work will need to be done on this once a new operating model has been agreed.

36) There will be management capability at GM level to discharge the ICS statutory functions, convene the constituent partners within GM as appropriate and agreed, organise and deliver GMS wide enabling functions and deliver the 'upwards, outwards and downwards' accountability for the agreed GM priorities and expected outcomes

37) A system of joint planning convened at GM level but with constituent localities and collaboratives fully engaged to identify the synergies and connections between allocated resources. This would support the ICS with calibrating allocations and ensure a seamless coherent deliver of programmes (e.g connect the work on addressing both the stock and the flow of the planned care programme; join up cancer services delivery with cancer screening etc.).

38) The following diagram provides an overview of what this would likely look like.



39) The longer-term aim would be for other reform areas locally to be brought more closely into the Locality Board space, to help with the issues around the wider determinants of health and other local reforms. In essence the Locality Board would form the main part of our new 'Place-based Design Function' and our work with Carnall Farrar then revisited by the GM system in terms of spatial levels suggest that the System Board would take up responsibility for the design of the services 'in scope' in the diagrams that follow.

	Public health	Primary care	Community services	Social care	Mental health	Diagnostics	Secondary / acute care	Emergency services & transport
Place i.e., Neighbourhood/Locality	• Health Improvement Services • Lifestyle, Health Promotion & Early Detection • Family Planning, Sexual Health & Terminations of Pregnancy • Drug & Alcohol Services • VSCE Grants Programmes • Social Prescribing	• General Medical Services - additional/local schemes • General Dental Services - additional/local schemes • General Pharmaceutical Services - additional/local schemes • GP Out of Hours • GP Extended Hours	• Community - Nursing & Care, AHPs, Health Visiting, School, Family, Paediatrics • Intermediate care – Residential, Home Care • Individual Placements – CHC • Hospice Care	• Adult Social Care – Residential, Home Care, Day Care, Other • Children's Social Care	• Individual Placements - MH • CAMHS • Children's Health & Wellbeing • Community Mental Health including LD • IAPT	• Some diagnostics (e.g. X-Rays. Phlebotomy)	• General & Acute urgent & emergency care • Some General & Acute planned care (adults) (e.g. outpatients) • Maternity community • Paediatric outpatients	
GM ICS	• Vaccination & Immunisation • Health Check Programmes	• General Medical Services - national contracts • General Dental Services - national contract • General Ophthalmic Services - national contract • General Ophthalmic Services - additional/local schemes • General Pharmaceutical Services - national contract			• Specialised services • Intensive Care • Inpatients	• Some diagnostics (e.g. ultrasound, CT, MRI)	• Some General & Acute planned care (adults) • All planned and urgent & emergency specialised services (see Appendix p.41), including: – Major Trauma, Critical Care, Paediatric Intensive Care, NICU – Cancer, Cardiac, Vascular, Renal, IBD, Neurosciences, Infectious Diseases, Women's & Children's • Non-specialised cancer • Maternity Units (birthing) • Paediatric admissions • NHS 111	• Ambulance Services - emergency • Patient Transport

H. Values and Behaviours of the Oldham Integrated Care Partnership

40) The effective operation of the Oldham Integrated Care Partnership is a matter for all partners to positively commit and engage in accordance with an agreed set of values and principles. These have been developed through the Oldham Cares Alliance and will be adopted across the whole Health and Care System from Day whilst further OD work is undertaken to refine and enhance them.

41) In summary, all partners to the partnership arrangements committed to the following 7 Values and Behaviours

Collaboration
Working cooperatively to achieve a common purpose, sharing responsibility and accountability.

- I take responsibility for developing and maintaining good relationships with all partners
- I take accountability for delivering on our collective purpose, vision and staying aligned to our principles, values and behaviours
- I will share organisational perspectives/challenges etc but remain focussed on putting the people of Oldham first
- I will act with empathy to understand and appreciate the challenges and pressures that my colleagues are facing I keep others informed in a timely manner
- I will bring back the perspective of the IDC into my own organisation
- I will actively encourage participation/create the conditions that enable others to participate
- I will be proactive in participating
- I will role model the behaviours outside Board meetings as a system leader

Courage
Pushing past our comfort zone to take risks, challenge each other, have the hard conversations, and take the difficult decisions.

- I will contribute to difficult conversations/meetings and decisions
- I will choose courage over comfort by facing the difficult conversations/decisions
- I will stay aligned to our values when facing tough decisions
- I will take a risk even when the outcome isn't certain
- I surface concerns when I anticipate/experience conflict with a positive intent to seek resolution
- I will embrace challenge, fears, and feelings

Creativity
Trying new things together that we know will add value/improve outcomes.

- I look for the opportunities to try new things together
- I create a culture where people are given permission and psychological safety to fail and feel supported to learn from their experiences, free from blame.
- I am pragmatic in my approach to excellence

- I provide challenge or question the status quo/traditional way of doing things in a positive manner and am open to new ideas
- I will provide the space for new ideas, thinking, learning, discussion

Integrity
Consistently to do what we say we are going to do in accordance with our purpose, principles, values and behaviours.
- I act with honesty and truthfulness
- I keep my word
- I consistently practice and model the values rather than just professing them
- I will be honest about potential conflicts of intentions
- I act with the best of intentions
- I will act in the interest for the greater good

Inclusion
We will be inclusive in everything we do and address any potential barriers to this.
- I seek out and actively listen and involve others' views to develop ideas and solutions
- I will create a culture where everyone can feel safe, seen, heard, understood, and are respected
- I will create the conditions where everyone feels like they belong.
- I look for the strengths/talents in everyone and am inclusive in my daily practice
- I value and encourage diverse thinking and experiences and will be open in learning and understanding including what this means
- I will call out a lack of inclusion and discrimination where I see, hear, experience, or become aware of this
- I take decisions that will address the inequalities that exist within our population
- I will ensure we listen and coproduce with those who are seldom heard and most likely to experience discrimination and inequality.
- I actively seek to understand and remove barriers to inclusion
- I act with empathy, compassion, kindness to everyone

Making a difference
By doing together what no one partner can achieve on their own.
- I will look for the opportunities to work together that collectively add value
- I recognise what works already and build on that
- I will share information in an open transparent way in support of our collective goals
- I will share strengths/assets in the pursuit of our ambition, and I recognise that I may need to give something up for the benefit of the system.
- I will endeavour to bring my organisational colleagues along the journey with us to enable system working
- I will enable system working and remove organisational barriers/challenges to this

- I will adopt the methodology of co-production with partners, our staff and our communities
- I will strive for improvement

Trust

To be vulnerable with one another by being willing to admit our mistakes, share our struggles, or ask for help/support from others

- I am open and honest with my communication about what is going on in my organisation including when I don't know
- I communicate where there are any conflicting/competing priorities
- I consistently do what I say I am going to do
- I will not take action that could damage trust
- I will use curiosity to explore confusions
- I act with empathy and compassion to understand and appreciate everyone's individual pressures/challenges
- I am open and honest about any mistakes and own my mistakes
- I ask for support and clarify needs
- I will give and receive feedback in situations where it is felt trust has been damaged to restore trust
- I will not have conversations without the involvement/knowledge of our partners about actions that affect us
- I put my trust in my colleagues' abilities, knowledge and expertise

Report to HEALTH AND WELLBEING BOARD

Health and Wellbeing Board – terms of reference

Chair: Councillor M Bashforth

Officer Contact: Katrina Stephens, Director of Public Health

Report Author: Katrina Stephens, Director of Public Health

21 June 2022

Purpose of the Report
The Terms of Reference of the Health and Wellbeing Board (HWB) were last reviewed in March 2021, and at that time the Board agreed to undertake a further review in March 2022. The advent of Integrated Care Systems and the governance arrangements to support them have implications for the role and operation of the HWB, and the planned review is therefore timely to ensure these new arrangements can be considered and appropriate changes made.

Requirement from the Health and Wellbeing Board

1. Note and support the draft revised terms of reference of the Health and Wellbeing Board subject to any final amendments prior to submission to Council being determined by the DPH and Deputy Chief Executive in consultation with the Chair of the HWB;
2. Consider and make recommendations on the arrangements for development sessions for the Board;
3. The terms of reference be further reviewed by the Board in March 2023.

Health and Wellbeing Board – terms of reference

1. Background

1.1 The Health and Social Care Act 2012 required the establishment of a Health and Wellbeing Board (HWB) in every Upper Tier Local Authority in England, from April 2013. The intention of establishing HWBs was to build strong and effective partnerships which improve the commissioning and delivery of services across NHS and local government, leading to improved health and wellbeing for local people.

1.2 Health and wellbeing boards are a formal committee of the local authority charged with promoting greater integration and partnership between bodies from the NHS, public health and local government. Under the 2012 Act, they have a statutory duty, with clinical commissioning groups (CCGs), to produce a joint strategic needs assessment and a joint health and wellbeing strategy for their local population.

1.3 Joint Strategic Needs Assessment (JSNA) is a process by which the current and future health, care and wellbeing needs of the local community are assessed in order to inform local decision making.

1.4 The Joint Health and Wellbeing Strategy (JHWS) is intended to inform commissioning decisions across local services such that they are focused on the needs of service users and communities, and tackle the factors that impact upon health and wellbeing across service boundaries. The JHWS can also be used to influence the commissioning of local services beyond health and care to make a real impact upon the wider determinants of health[1].

1.5 A review of the Council Constitution including the terms of reference of the Health and Wellbeing Board was completed in early 2021. At the time of the review, the HWB agreed to undertake a further review of its terms of reference in March 2022.

2. Current Position

3.1 The current terms of reference of the Health and Wellbeing Board are contained at Part 3 (Responsibility for Functions) in the Council Constitution.

3.2 The advent of Integrated Care Systems (ICS) and the governance arrangements to support them have implications for the role and operation of the HWB. Whilst the ICS statutory guidance confirms the continued role of the HWB in JSNA and JHWS, 'Thriving Places: guidance on the development of place-based partnerships as part of statutory integrated care systems'2 suggests significant overlap in the role and membership of the Place-based ICS Board and the HWB.

3.3 This potential overlap is particularly apparent in Greater Manchester, where the population health ambitions of the GMICS mean that there is also a drive to include a range of wider partners on place-based boards in order to drive improvements in the wider determinants of health.

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[1] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/215261/dh_131733.pdf

[2] https://www.england.nhs.uk/wp-content/uploads/2021/06/B0660-ics-implementation-guidance-on-thriving-places.pdf

3.4 In this context there is a need to ensure there is a clearly defined role for the HWB which is distinct from the Health and Care System Board, with a clear articulation of the relationship between the two Boards and how they will work together.

3.5 Furthermore, the pandemic has placed a greater emphasis on the importance of population health and health inequalities, for which the Council and HWB hold statutory responsibilities, and the urgency with which action needs to be taken across all aspects of society to improve health and address health inequalities.

4. Proposed changes

4.1 Oldham's HWB has recently developed a health inequalities plan for the borough. This plan aims to reduce inequalities in life expectancy and healthy life expectancy within the borough, and between in Oldham and England. The actions proposed consider the broad range of determinants of health and health inequalities and includes action on education and employment, housing, transport, environment, income and poverty, as well as health and care services.

4.2 It is proposed that this Plan becomes the focus of the work of the HWB, effectively becoming the JHWS. With changes to the Board membership to ensure appropriate coverage of topics such as housing, environment and employment, the HWB could oversee and drive delivery of the Health Inequalities Plan. It is therefore proposed that the Council's Director of Economy and Director of Environment be invited to join the Board.

4.3 In addition, the HWB should continue to play a key role in the JSNA, ensuring that key findings are considered, and appropriate recommendations are produced and acted upon. The proposal to broaden the membership of the HWB would help extend understanding and awareness of the JSNA across the system.

4.4 The relationship between the HWB and Health and Care Locality Board must be clearly delineated to prevent duplication. The focus of HWB on the wider determinants of health will help to ensure that there is a clear distinction in the roles of the two Boards. The Health and Care Locality Board should be able to refer matters concerning the wider determinants of health to the HWB for consideration, and vice versa regarding the health and care system's role in improving population health and addressing health inequalities.

4.5 A strong relationship between the Oldham Partnership and the Health and Wellbeing Board will be important. The work of the HWB can support delivery of the Oldham Plan, and action across the full scope of the Oldham Plan and the work of the Oldham Partnership will be critical to improving population health and reducing health inequalities. There is overlap in the membership of the Oldham Partnership and the Health and Wellbeing Board which should support this approach.

4.6 The Terms of Reference for HWB include a requirement for the Board "To ensure that the Council complies with its duties to improve public health as set out in Sections 2B and 111 of the National Health Act 2006 as amended;". In order to fulfil this responsibility it is proposed that the Board receive regular reports on health improvement and health protection, to ensure the board is sighted on relevant work and has the opportunity to shape how the Council is working alongside other partners to meet its statutory responsibilities.

4.7 Revised Terms of Reference and membership of the board, reflecting the above proposals, are included in Appendix 1 and 2 respectively. Proposed changes to

membership also reflect new Integrated Care System arrangements, as CCGs will cease to exist in July 2022.

4.8 An outline agenda for future meetings has also been included at Appendix 3, which incorporates some of the proposals regarding regular reporting on JSNA, health inequalities plan, health improvement and health protection referenced in this report.

4.9 As in previous years, six Board meetings and two Development session (July and December) have been scheduled for the coming year (Appendix 4). As part of this review of Terms of Reference the Board are invited to consider the proposed timetabling of these planned Development Session and how they could be best utilised to support the Board in the coming year.

5. Approval of proposed changes

5.1 Terms of Reference require sign off by Council, and it is proposed that the revised Terms of Reference for the HWB be submitted to Council in July, subject to any final amendments being determined by the DPH and Deputy Chief Executive in consultation with the Chair of the HWB.

5.2 On the grounds of good governance, it is suggested that the Health and Wellbeing Board receive and, if considered appropriate, review the terms of reference in March 2023 and on an annual basis thereafter.

6. Recommendation

6.1 The Health and Wellbeing Board is asked to

- note and support the draft revised terms of reference of the Health and Wellbeing Board subject to any final amendments prior to submission to Council being determined by the DPH and Deputy Chief Executive in consultation with the Chair of the HWB;
- consider and make recommendations on the arrangements for development sessions for the Board
- agree that the terms of reference be further reviewed by the Board in March 2023.

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APPENDIX 1

Health and Wellbeing Board

1. To assess the health needs of the local population and to prepare and publish the statutory Joint Strategic Needs Assessment (JSNA) in accordance with s196 of the Health and Social Care Act 2012;
2. To prepare and publish the Borough's Health and Wellbeing Strategy [the Oldham Locality Plan] in accordance with s196 of the Health and Social Care Act 2012;
3. To approve submission of the Better Care Fund Plan to NHS England;
4. To highlight and oversee action to address the health inequalities existing in the Borough, encouraging those persons and organisations holding responsibility for the commissioning or provision of public services in the Borough to work together in an integrated and/or partnership manner for the benefit of the local population;
5. To ensure that the Council complies with its duties to improve public health as set out in Sections 2B and 111 of the National Health Act 2006 as amended;
6. To receive and oversee plans to protect and improve the health of the local population
7. To be consulted by the GM Integrated Commissioning Board and/or the Locality Board in respect of those documents and plans detailed at s14Z of the National Health Service Act 2006 (as amended)
8. To receive those documents and plans from the Integrated Commissioning Board and/or the Locality Board as detailed at s14Z of the National Health Service Act 2006 (as amended)
9. To assess the need for pharmaceutical services in the Borough area and publish a Pharmaceutical Needs Assessment and any revised Assessment, pursuant to s128A of the NHS Act 2006 (as amended).
10. To undertake such oversight of local safeguarding arrangements as the Board considers appropriate and necessary;
11. To undertake, jointly with the Bury and Rochdale Health and Wellbeing Boards, such oversight of the Bury, Oldham and Rochdale Child Death Oversight Panel as the Board considers appropriate and necessary.

APPENDIX 2

HEALTH AND WELLBEING BOARD

Proposed Membership from July 2022

Statutory

Oldham Council – minimum of one elected Member appointed by Leader of the Council - Six Councillors	Councillor Marie Bashforth (Chair) Councillor Steve Bashforth Councillor Barbara Brownridge Councillor Eddie Moores Councillor Leanne Munroe Councillor Howard Sykes
Director of Public Health	Katrina Stephens
Director of Children's Services	Gerard Jones
Director of Adult Social Care	Jayne Ratcliffe
Greater Manchester ICS – minimum of one representative of GM ICS + four locality representatives	Mike Barker, Place Lead Dr John Patterson +1 +1 +1
Local Healthwatch Organisation	Tamoor Tariq

Discretionary membership Council or Board determined

Chief Executive, Oldham Council	Harry Catherall
Deputy Chief Executive, Oldham Council	Sayyed Osman
Director of Economy, Oldham Council	TBC
Director of Environment, Oldham Council	TBC
Chief Officer (Oldham) – Northern Care Alliance	David Jago
Chief Officer (or rep) – Pennine Care	Gaynor Mullins
Greater Manchester Police	Ch Supt Chris Bowen
Oldham Community Leisure	Stuart Lockwood
Housing Partnership (First Choice Homes)	Donna Cezair
Action Together	Laura Windsor-Welsh

Advisory/Non-voting

GM Fire and Rescue	Val Hussain
CCG Executive Nurse[3]	Claire Smith
Consultant in Public Health	Dr Rebecca Fletcher
Consultant in Public Health	Dr Charlotte Stevenson

Invited Representative (Observer/participant by invitation)

Dr Kershaw's	Joanne Sloan

[3] TBC subject to confirmation of ICS representatives

APPENDIX 3

Health and Wellbeing Board

Meetings 2022-23

Tuesday, 21st June 2022 at 2.00pm.

Tuesday, 26th July 2022 at 2.00pm (Development Session)

Tuesday, 13th September 2022 at 2.00pm

Tuesday, 15th November 2022 at 2.00pm

Tuesday, 13th December 2022 at 2.00pm (Development Session)

Tuesday, 24th January 2023 at 2.00pm

Tuesday, 21st March 2023 at 2.00pm

APPENDIX 4

Health and Wellbeing Board

Template Agenda

1. Apologies for Absence

2. Urgent Business

Urgent business, if any, introduced by the Chair.

3. Declarations of Interests

To receive any Declarations of Interests in any contract on matter to be discussed at the meeting.

4. Public Question Time

To receive questions from members of the public, in accordance with the Council's Constitution.

5. Minutes

To consider the attached Minutes of the meeting of the Health and Wellbeing Board held 25th January 2022.

Standing items

6. Joint Strategic Needs Assessment

To consider new and updated information which has been included in the Joint Strategic Needs Assessment

7. Health Inequalities Plan Updates

To receive highlight reports detailing progress on the key themes of the health inequalities plan

8. Health Inequalities Plan: Thematic Review

To undertake a more detailed review of one thematic area from the health inequalities plan and consider progress, opportunities and challenges

9. Public Health Updates

To receive highlight reports detailing progress in delivering plans for:

   a. Health improvement
   b. Health protection

Business items

Items covering other areas for which the Board is responsible including Child Death Overview Panel, Better Care Fund, key ICS plans.