Public Document Pack

HEALTH AND WELL BEING BOARD
Agenda

Date	Thursday 11 July 2024
Time	10.00 am
Venue	Lees Suite, Civic Centre, Oldham, West Street, Oldham, OL1 1NL

Notes

1. DECLARATIONS OF INTEREST- If a Member requires advice on any item involving a possible declaration of interest which could affect his/her ability to speak and/or vote he/she is advised to contact Paul Entwistle or Constitutional Services at least 24 hours in advance of the meeting.

2. CONTACT OFFICER for this agenda is Constitutional Services 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 Monday, 8 July 2024.

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

Please note that anyone using recording equipment both audio and visual will not be permitted to leave the equipment in the room where a private meeting is held.

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

Please also note the Public attendance Protocol on the Council's Website

https://www.oldham.gov.uk/homepage/1449/attending_council_meetings

MEMBERSHIP OF THE HEALTH AND WELL BEING BOARD
Councillors Brownridge, Davis (Chair), Mushtaq, Nasheen, Shuttleworth and Sykes

Item No

1 Apologies For Absence

2 Urgent Business

Urgent business, if any, introduced by the Chair

3 Declarations of Interest

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

4 Public Question Time

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

5 Minutes of Previous Meeting (Pages 3 - 8)

The Minutes of the meeting held on 7th March 2024 are attached for approval.

6 Review of Health and Well Being Board Membership (Pages 9 - 10)

To review the current membership of the Health and Well Being Board and to add and/or remove members with the approval of the Board.

7 Oldham Integrated Care Partnership (Pages 11 - 124)

Oldham Integrated Care Partnership's five-year strategy and one-year 2024/25 delivery plan.

8 Healthwatch Oldham's Work Programme 2024/25 (Pages 125 - 138)

An overview of Healthwatch Oldham's work programme for 2024/25

9 Better Care Fund End of Year Report and Plan (Pages 139 - 144)

Better Care Fund 2023-25; End of Year 2023-24 submission and Planning template for 2024-25

10 Public Health Annual Report 2023/24: Health and Housing in Oldham (Pages 145 - 180)

The Director of Public Health to provide an overview of the Public Health Annual Report.

HEALTH AND WELL BEING BOARD
07/03/2024 at 10.00 am

Present: Councillors Brownridge, J. Harrison (Chair) and Nasheen

Also in attendance: Rebecca Fletcher (Director of Public Health)
Dr. John Patterson (NHS)
Jayne Ratcliffe (Director of Adult Social Care)
Anna Tebay (Public Health Service)
Laura Windsor-Welsh (Action Together)
Rachel Dyson (Thriving Communities Lead)
Charlotte Stevenson (Public Health)
Sarah Hulston (Changing Futures)
Sheila Garara (Childrens Services)
Mike Barker (NHS)
Durga Paul (Constitutional Services)

1 **APOLOGIES FOR ABSENCE**

Apologies for Absence were received from Councillors Shuttleworth, Councillor Sykes, Councillor Mushtaq, Gerard Jones, Kelly Webb, Stuart Lockwood, Harry Catherall, Simon Blair, Davig Jago, Paul Clifford, Dr. Alistar Craig, Nasir Dad.

2 **URGENT BUSINESS**

There was no urgent business.

3 **DECLARATIONS OF INTEREST**

There were no declarations of interest received.

4 **PUBLIC QUESTION TIME**

There were no public questions to consider.

5 **MINUTES OF PREVIOUS MEETING**

RESOLVED that the minutes of the meeting held on 11th January 2024 be approved as a correct record.

6 **OLDHAM COUNCIL ENGAGEMENT TEAM - HEALTH AND WELLBEING INSIGHT**

The Thriving Communities Lead provided the board with a summary of insights from doorstep conversations with residents, where health and wellbeing issues were raised. The purpose of the report is to provide insights from the doorstep engagement work and consider how this might inform the priorities and work of the Board going forward.

The doorstep engagement team has operated in Oldham from August 2020, supporting engagement with residents around a range of issues including Covid19, the Don't Trash Oldham campaign and most recently the Cost of Living crisis.

The conversations were primarily focused on residents' wellbeing, bringing in specific focus areas as the conversation progressed. The Board were provided with a summary of the

insights around the theme of Health & Wellbeing during the period of July 2022 to August 2023.

During this time the focus of conversations was on the cost of living crisis, and a methodology was used to target those areas of the borough where residents were most likely to be impacted. The nature of the conversations will also be influenced by the time of day visits were made, the majority being during the day Monday – Friday. 28,399 conversations were held during this time and although finance and jobs was the largest topic of discussion, health and wellbeing was also a relatively common theme with 619 households raising related issues during that time.

Most common sub-themes within Health and Wellbeing were; Mental Health, General Health and Health Services. The pattern of issues raised was broadly similar across districts, although General Health was raised most often in West. The most common single issue was Long-term conditions, followed by loneliness and Mobility issues. Under the Health Services theme the most common issues was difficulty accessing GP services.

Members of the Health and Wellbeing Board commended the work done, specifically in relation to having in-person contact with residents.

The Board also noted that the insight gained from the Doorstep engagement work is not only useful in providing support where required in real time, but is useful to plan and strategise for the future in ensuring the needs of residents are met.

RESOLVED that, the Engagement Team Insight be noted by the Health and Wellbeing Board.

7 **POVERTY ACTION NETWORK OVERVIEW AND INSIGHT**

The Health and Wellbeing Board were provided with an update on the work of the Oldham Poverty Action Network over the last 12 months.

The Oldham Poverty Action Network launched in October 2022 bringing together the existing strands of anti-poverty work in the borough, with the recommendations and the Lived Experience members of the Poverty Truth Commission.

The Network is made up of VCFSE groups, public sector partners, Greater Manchester Poverty Action and people with Lived Experience of Poverty. The Network has been coming together monthly to co-design and develop ‘test and learn’ workstreams based on the recommendations from the Oldham Poverty Truth Commission under the headings of:

1. Building out from the cost-of-living response
2. Hope and Aspirations: Creating routes out of poverty
3. Building a joined-up approach to poverty alleviation & prevention

Task groups have been created for each of these 3 priorities.

The first task group (Building out from the cost-of-living response) are focused on Comms Campaigns that connect with people experiencing poverty and how they can get help and support. And the Oldham Community Advice Network – Digital Referral System, Connecting people seamlessly to the right support and advice.

The second task group (Hope and Aspirations: Creating routes out of poverty) are focused on Creating supported volunteering opportunities and developing the pathways into volunteering and employment.

The third task group (Building a joined-up approach to poverty alleviation & prevention) are focused on developing an Oldham Systems Conditions Forum and developing Community Leadership and Voice and Influence.

The Board discussed the Second Taskgroup in great details, focusing on developing the pathways into volunteering and employment. Members of the Board suggested there is often too much Jargon in Job Adverts and Person Specifications for Local Authority Roles which overcomplicates the recruitment process. Simplifying these would make roles more accessible, increase the candidate pool and subsequently address workforce shortage issues faced by the council. Cllr Brownridge offered her support in trying to address this issue.

Members of the Board commended the person-centred approach taken by the Poverty Action Network. Officers stated that they had established a blueprint for working with people with lived experiences that may be useful to other services and that they have an Oldham Framework for community engagement.

RESOLVED that, the Poverty Action Network Overview and Insight report be noted by the Health and Wellbeing Board.

8 **GM LIVE WELL - OLDHAM PLACE BASED PREVENTION BUDGETS**

The Thriving Communities Lead provided the board with an update on the progress of the GM Live Well programme and the Oldham accelerator proposal around place-based prevention budget.

The Board heard that ‘Live Well’ is a mayoral manifesto commitment and a key part of Greater Manchester’s response to tackling health and wellbeing inequalities. The GM ambition is that over the next two years and beyond, the ten localities across Greater Manchester, and the VCFSE sector, will work together to develop a sustainable Live Well ecosystem which

will help residents to maintain and improve their health, wellbeing, resilience and social connections.

In December 2022 GM localities were invited to put forward proposals for Live Well accelerator projects to be included in a solicited National Lottery Bid to draw in resource to support this work (a total of £1m over 2 years). Oldham put forward a proposal around the development of Place-based Prevention Budgets which was approved by the Health & Care System Leaders Group and Public Service Reform Board.

In the Autumn 2023, GM received the outcome of the National Lottery bid which supported the proposals. However, we are still awaiting the formal grant agreement with GMCA and funds to support the project.

The intention is to create the infrastructure to draw together existing funding from within the system, to be held by a local partnership and distributed by joint commissioning and funding decisions. The Council intend to involve community partners and residents in decision making, and where possible transfer decision making power to communities.

Members of the Board welcomed the report and approach set out, but stressed that a lot of work would need to be done in establishing new powers for Local Authorities to spend pooled funding.

RESOLVED that, the GM Live Well report be noted by the Health and Wellbeing Board.

9 **CHANGING FUTURES**

The Health and Wellbeing Board heard an update from Changing Futures on the work they are doing. Changing Futures are funded by The National Lottery and The Department of Levelling Up and have currently secured funding until March 2025.

The Officers that work with Changing Futures have lived experience of disadvantage and therefore are able to build up relationships with service users. The Case load is kept relatively low to allow for more time to be dedicated to individuals who need support.

The Board heard of some of the achievements of Changing Futures including successfully collaborating with partners and excellent feedback received from service users. They were also provided with some case studies to evidence the good work being done.

Members of the Board commended the work being done to help the most disadvantaged residents of Oldham.

Several Members of the Board also stressed the importance open communication between partners and service providers to ensure no duplication of work and that there are no gaps in services available.

RESOLVED that, the Changing Futures report be noted by the Health and Wellbeing Board.

10 **OLDHAM SAFEGUARDING ANNUAL REPORT 2022-23**

RESOLVED that the Oldham Safeguarding Annual Report be noted by the Health and Wellbeing Board.

The meeting started at 10.07am and ended at 12.13pm.

This page is intentionally left blank

HEALTH AND WELLBEING BOARD

Membership

Statutory

Oldham Council – minimum of one elected Member appointed by Leader of the Council - Six Councillors	Councillor Councillor Councillor Councillor Councillor Councillor Sykes
Director of Public Health	Katrina Stephens
Director of Children's Services	Gerard Jones
Director of Adult Social Care	Mark Warren
CCG – minimum of one representative from CCG covering Borough area - Five members	Mike Barker Dr John Patterson Majid Hussain Dr Keith Jeffery +1
Local Healthwatch Organisation	Tamoor Tariq

Discretionary membership Council or Board determined

Chief Executive	Harry Catherall
Deputy Chief Executive	Sayyed Osman
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
Voluntary Action (Oldham)	Laura Windsor-Welsh

Advisory/Non-voting

GM Fire and Rescue	Val Hussain
CCG Executive Nurse	Claire Smith

Invited Representative (Observer/participant by invitation)

Dr Kershaw's	Joanne Sloan

This page is intentionally left blank

Report to HEALTH AND WELLBEING BOARD

Oldham Integrated Care Partnership's five-year strategy and one-year 2024/25 delivery plan

Portfolio Holders:
Councillor Barbara Brownridge, Cabinet Member for Adults, Health & Wellbeing

Officer Contact: cllrb.brownridge@oldham.gov.uk

Report Author: Erin Portsmouth, Associate Director of Strategy, Planning and Development (Oldham), NHS Greater Manchester Integrated Care

Ext. n/a

Date: 11 July 2024

Purpose of the Report

This report is presented to the Health and Wellbeing Board to ensure members are fully up to date with the five-year health and care strategy and the one-year health and care delivery plan for Oldham Integrated Care Partnership.

Requirement from the Health and Wellbeing Board

The Health and Wellbeing Board is asked to receive, note and support the Oldham Integrated Care Partnership's five-year strategy and one-year 2024/25 delivery plan.

Oldham Integrated Care Partnership's (ICP) five5- year strategy and one-year 2024/25 delivery plan

1. Background

The Partnership's five-year strategy was agreed during 2023/24, following a full refresh of Oldham's Locality Plan, which was ratified in November 2019. It has had some minor updates but has not been extended in timeframe.

The Partnership's 2024/25 delivery plan covers our commitments in this current financial year, as well as the delivery of a range of objectives and priorities in relation to the national NHS Operational Guidance and NHS Greater Manchester Operational Plan.

This one-year delivery plan features the key priorities for the year ahead, as well as the detail of various action areas and milestones. At the heart of the plan is the implementation of our new Population Health Management model, build from extensive work to determine the drivers of demand for local services, as well as five workstreams making up our delivery and transformation programme for local health and care.

2. Current Position

All partners have committed to improving health and reducing health inequalities, and this strategy and delivery plan align with Oldham's Health and Wellbeing Strategy and Health Inequalities Action Plan.

3. Key Issues for Health and Wellbeing Board to Discuss

No key issues.

4. Recommendation

The Health and Wellbeing Board is asked to receive, note and support the Oldham Integrated Care Partnership's (ICP) five-5 year strategy and one-year 2024/25 delivery plan.

Oldham ICP Strategy
2023-27

Oldham
Integrated Care Partnership

Part of Greater Manchester
Integrated Care Partnership

Oldham
Integrated Care Partnership

CONTENTS

Oldham
Integrated Care Partnership

Introduction

Oldham Integrated Care Partnership brings together the borough's statutory health and care organisations, the local voluntary, community, faith and enterprise sector, Healthwatch Oldham, and clinical and care professional leads, with the aim of working together to improve local services for residents.

This strategy outlines the vision, principles, priorities and direction for the Partnership. It describes our strategic ambition for our local health and care system, how we will address challenges, and the outcomes we seek to achieve. The strategy is intended to act as a 'refresh' of the borough's 'Locality Plan for Health and Care Transformation', whilst providing a cohesive and up-to-date strategic context and framework that all partner organisations can collaboratively work to.

This strategy should be read in context with the existing Locality Plan, and this strategy aims to align with the following:

- NHS Greater Manchester ICP Strategy
- Oldham Health and Wellbeing Strategy
- The Oldham Plan
- NCA Vision 10 Strategy
- Pennine Care This is Us Strategy
- NHS Greater Manchester ICP Strategy
- Oldham Prevention Framework
- The Hewitt Review
- Public sector reform plans
- Strategic plans for children and young people
- Oldham Provider Collaborative development plan
- Oldham ICB Place Team / ICP operating model

Oldham
Integrated Care Partnership

Background

As per guidance from NHS England, health and care systems and providers have been asked to submit five-year joint forward plans before the end of March 2023.

The guidance also recommends that systems and providers:

- Review urgent and emergency care plans
- Review general practice access recovery plans
- Review the single maternity delivery plan
- Update their elective recovery plans
- Work through joint commissioning arrangements to develop delivery plans based on new arrangements for the delegation of budgets
- Develop robust plans that deliver efficiency savings

Whilst for us our 'system' is Greater Manchester, this strategy for Oldham takes the above into account.

The national context for health and care has changed over the past few, not only due to additional challenges brought about by Brexit, the pandemic and the cost of living crisis, but also in relation to wholescale statutory changes introduced by the Health and Social Care Act 2022.

However, the intentions to transform health and care in Oldham as set out in the 2019 Locality Plan remain.

Namely to:

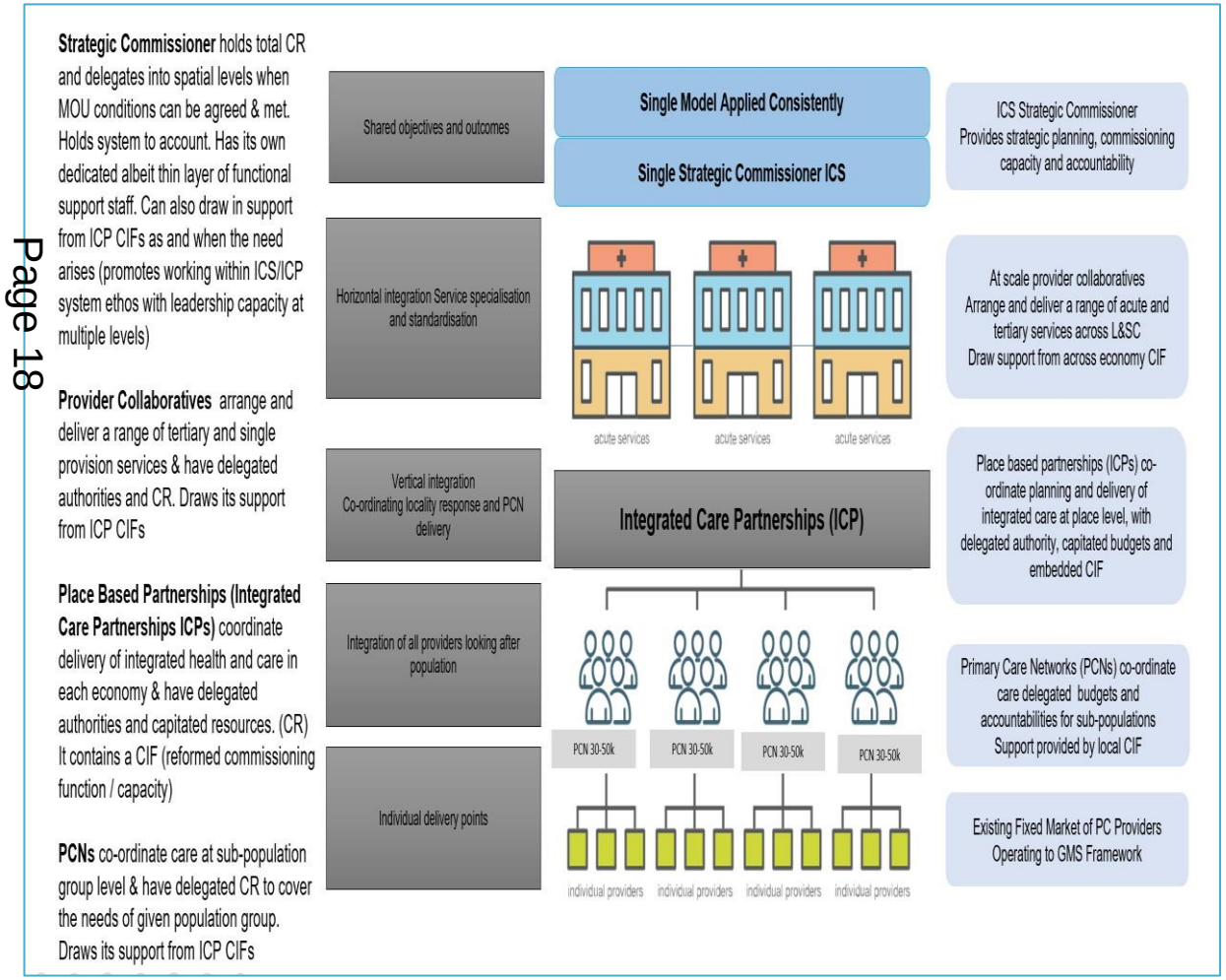
- Put patients, neighbourhoods and communities at the heart of local health and care
- Focus on prevention via population health management and 'early help and intervention' strategies
- Measure health and care service success in relation to real outcomes
- Deliver transformation and change via a partnership model
- Gain local benefit from the Greater Manchester public sector devolution model

Oldham
Integrated Care Partnership

The Greater Manchester context

Oldham
Integrated Care Partnership

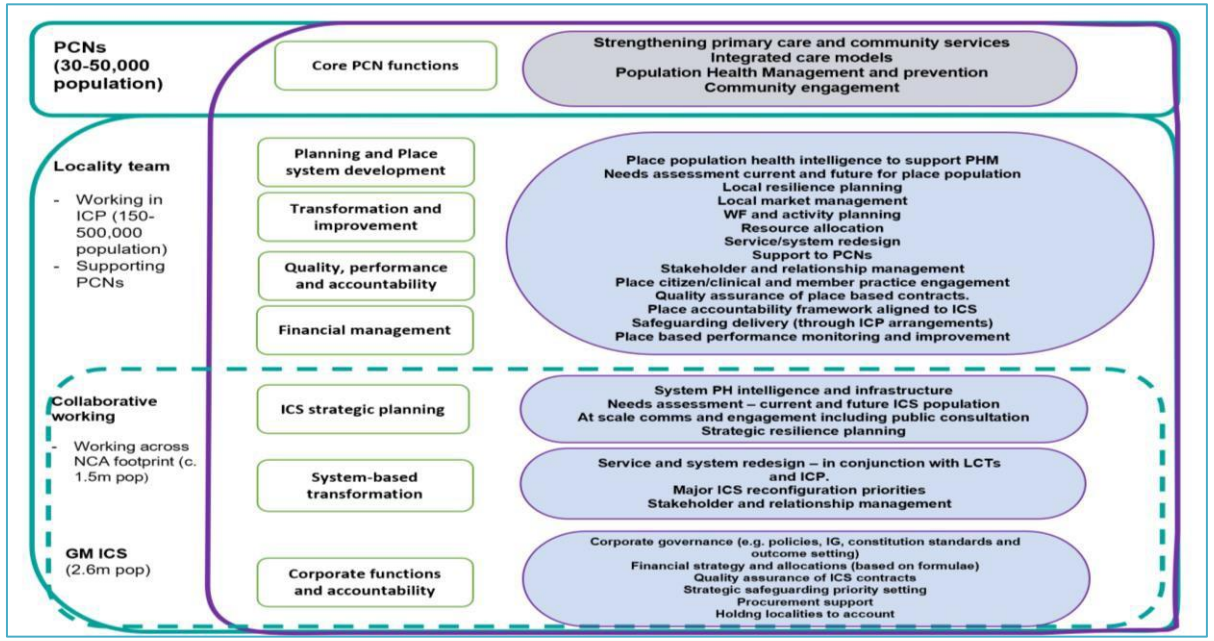
Greater Manchester Integrated Care System Operating Model



The new Integrated Care System model for Greater Manchester has been several years in the making. It was ahead of the national legislation in so many ways and is depicted opposite.

This will not be about eroding existing organisational statutory responsibilities and accountabilities, it will be about connecting the system together and committing to organise and deliver services close to our neighbourhoods.

It will mean reorganising the commissioning, delivery and transformation agenda at different spatial levels. Depicted below:



Oldham
Integrated Care Partnership

Greater Manchester strategic context

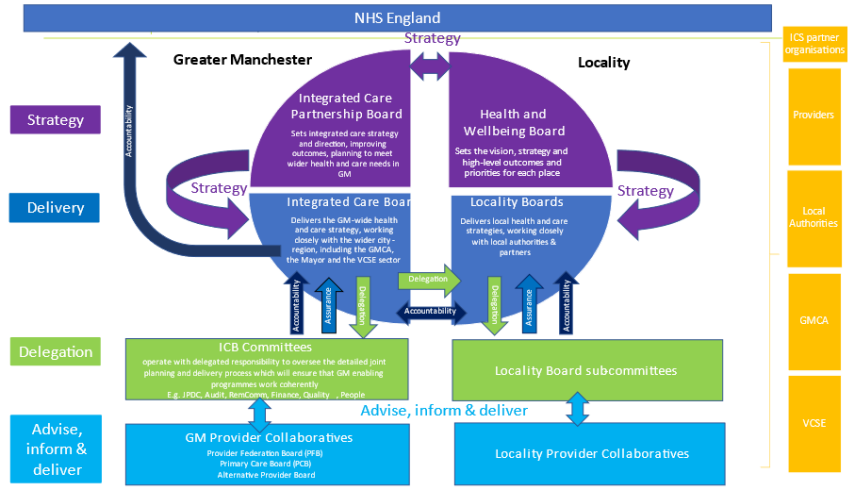
The **GM model for health and care**, developed to ensure that everyone can live a good life, is to:

- Rapidly increase the level of integrated place-based working, connecting partners and communities – collaborating to tackle health inequalities and respond to challenge
- Build on strong connections between the NHS, local authorities, VCFSE, and wider public services – to affect a wide range of the determinants of people's health, support proactive care, enabling people to live well at home
- Utilise provider collaboration to enable common development of pathways and make services sustainable – to drive access, outcome and experience improvements
- Utilise key assets and links with the education, academic, employment, housing and justice sectors – to tackle the root causes of poor health

- **GM Integrated Care Partnership Board** sits between NHS GM Integrated Care and local authorities, GM Combined Authority and the Mayor's office. The Board is responsible for delivering the national requirements of the NHS and allocate the county's annual £7bn health and care spending.

- **NHS Greater Manchester Integrated Care** allocates the NHS budget and commissions services for the population. It is directly accountable to NHS England for NHS spend and performance within the system. It delegates some functions and resources to locality boards, but remains formally accountable.

- **Locality Boards** operate in each of the ten districts of GM, bringing together political, clinical, and professional leaders of health and care.



Oldham
Integrated Care Partnership

GM's mission-based strategy

The Greater Manchester Integrated Care Partnership has set out its intent in a five year strategy and in doing so has set itself an ambition plan with four goals at its core, which will be delivered through six strategic missions. It intends to ensure that Greater Manchester is a place where everyone…

- … has a fair opportunity to live a good life
- … experiences high quality care and support where and when they need it
- … has improved health and wellbeing
- … works together to make a difference now and for the future

The six missions…

Stronger Communities	Helping people find & keep good work	Preventing illness and reducing risk and inequalities	Recovering core NHS and care services	Supporting our workforce and carers	Achieving financial sustainability
Help people, families and communities feel more confident in managing their own health	Support good work and employment	Helping people stay well and detecting illness earlier	Continuing to improve access to high quality services and reducing long waits	Ensure a sustainable workforce	Manage public money well to achieve our objectives

Oldham
Integrated Care Partnership

The Oldham context

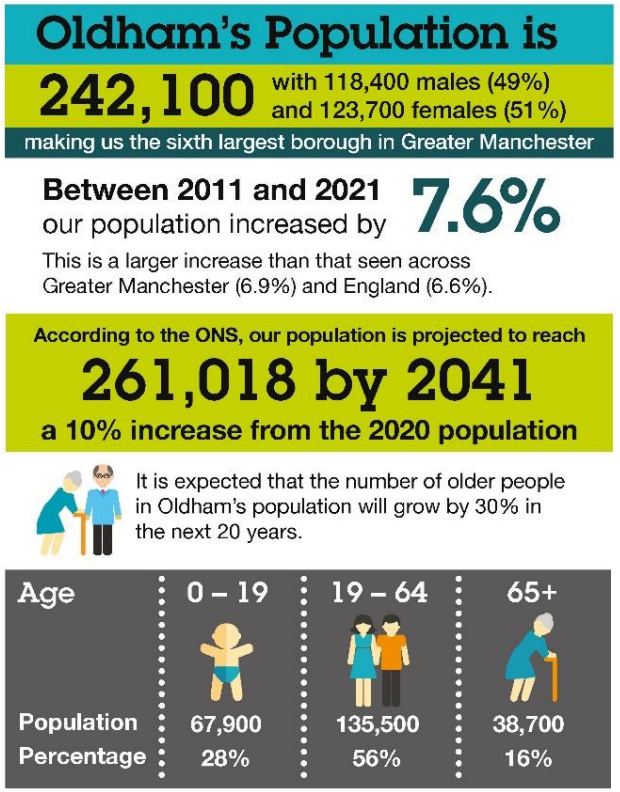
Oldham
Integrated Care Partnership

Oldham's challenges

Life expectancy in Oldham is two years shorter than life expectancy across England, and Oldham's residents have worse health than England's average. There are strong links between deprivation and poor health, and high levels of deprivation in the borough have a significant impact on health outcomes.

There are also significant social inequalities within Oldham with 40% of people living in Coldhurst belonging to an income-deprived household, whilst this is only around 5% in Saddleworth South. These social inequalities inevitably lead to health inequalities. The difference in life expectancy between the most and the least deprived wards in Oldham is over 9 years. As such, reducing social inequality within the borough is key to improving the health of our people.

Healthy life expectancy is a measure of the average number of years a person would expect to live in good health. This is based on contemporary mortality rates and the prevalence of self-reported good health. In Oldham, the number of years and proportion of life that males are spending in poor health is increasing.



Unemployment in Oldham is 7.3%

The highest in GM, and significantly higher than the England rate.

	March 22	March 21
Oldham	7.3%	9.9%
GM	5.6%	8.0%
England	4.3%	6.6%

Alexandra has the highest rate at **13.6%**

Saddleworth North has the lowest at **1.8%**

Youth unemployment in Oldham is 9.8%

The highest in GM, and significantly higher than the England rate.

	March 22	March 21
Oldham	9.8%	16.4%
GM	6.5%	10.8%
England	5.0%	9.2%

Hollinwood has the highest rate at **16.5%**

Saddleworth South has the lowest at **2.7%**

Annual Pay

The median annual gross pay for residents of Oldham is below that of GM and England.

Oldham	£27,594
Greater Manchester (GM)	£28,980
England	£31,490

Deprivation

Oldham currently has four areas within the borough which are among the top **1%** of the nation's most deprived areas.

However, **26.2%** of areas in Oldham are among the **10%** most deprived areas in England

Life expectancy 2018–20

	Oldham	England
Male	77.2	79.4
Female	80.5	83.1

Healthy life expectancy 2017–19

	Oldham	England
Male	58.3	63.2
Female	58.3	63.5

Oldham's life expectancy is significantly lower than England

Oldham
Integrated Care Partnership

The state of health and care in Oldham

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

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

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

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

Oldham
Integrated Care Partnership

Addressing the challenges

Following a lot of discussion there is little doubt that all partners in Oldham wish to ensure that "**Oldham is a vibrant place, which embraces diversity and is where people are thriving and communities are safe and sustainable – and that it is a place where improved health and wellbeing is experienced by all, and where the health and wellbeing gap is reducing**."

Indeed our assessment of the situation and challenges facing Oldham's health and care delivery system and the health of our population is that there remains a lot of opportunity to make substantial changes if we are to bring about these much needed improvements.

We believe that to tackle the challenges facing our system we need to improve and transform 18 core areas:

Population health and wellbeing outcomes	Wider determinants of health	Health inequalities	Quality, safety and safeguarding	The community and primary care offer	The quality and sustainability of specialist and hospital services	Place-based integration	Infant mortality	Smoking
Healthy weight	Physical activity	Oral health	Alcohol and substance misuse	Immunisations	Secondary prevention of long term conditions	Diabetes	Respiratory	Maternity

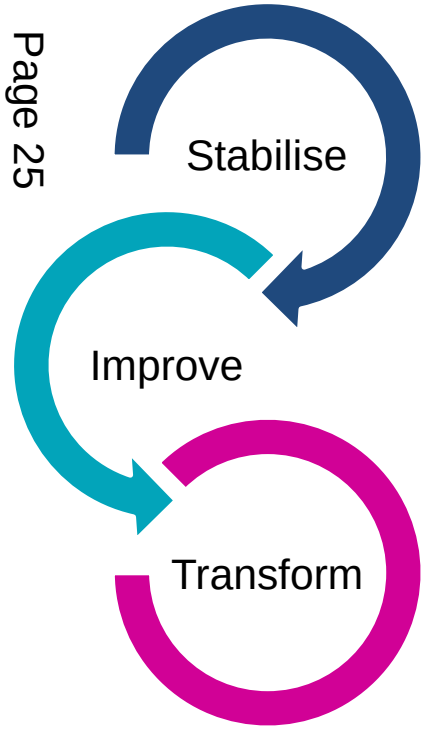
As a group of partners in Oldham we setting out a new strategic plan. Our Locality Plan describes our strategic ambition for Oldham's health and care system and how we will address the challenges presented. It describes, therefore, the outcomes we seek to achieve for residents of Oldham.

Oldham
Integrated Care Partnership

Addressing the challenges

Our assessment is that we face significant challenges without the added consequences of the pandemic. The pandemic has undoubtedly changed the environment, but it has added to not taken away from the challenges. That is why believe the challenge ahead is now both complicated as well as complex. In essence we face the pressure of delivering three linear issues in an overlapping fashion. We will need to stabilise those service de-stabilised because of the pandemic, improve some services that have been mandated nationally as needing improvement and also transforming our system and shifting it to a more preventative focus.

This is a five-year, non-linear journey…



Stabilise services in need of recovery, and stabilise organisations and teams currently undergoing change management processes

Improve services in line with local, regional and national targets, and in line with what our local population tells us they want and need

Transform whole system pathways to remove boundaries and make health and care a genuine patient-centred, seamless journey

This means our approach will need to be characterised by six core principles. So, to that end, we will…

Embrace the diversities, challenges and the opportunities that 'place' provides us with

Assess where the level of changes could best happen – Oldham-wide, neighbourhood-level or hyper- local

Ensure that the Oldham view is represented when changes are discussed, proposed and/or implemented at a GM-level

We will place expert advisory at the heart of change, be this from clinicians, care professionals, subject matter experts, or expert patients

Make integrated working a key component of everything we do, from day-to-day matrix team working through to the design and delivery of health and care pathways

Partnership systems at our disposal, both across Oldham collaboratives and as part of the '4 Locality Partnership' footprint with our neighbours in Bury, HMR and Salford

Oldham
Integrated Care Partnership

Oldham's model of care

Following significant work to gather the feedback health and care professionals, patients and the public, as well as the wider workforce, a Model of Care for Oldham has been developed.

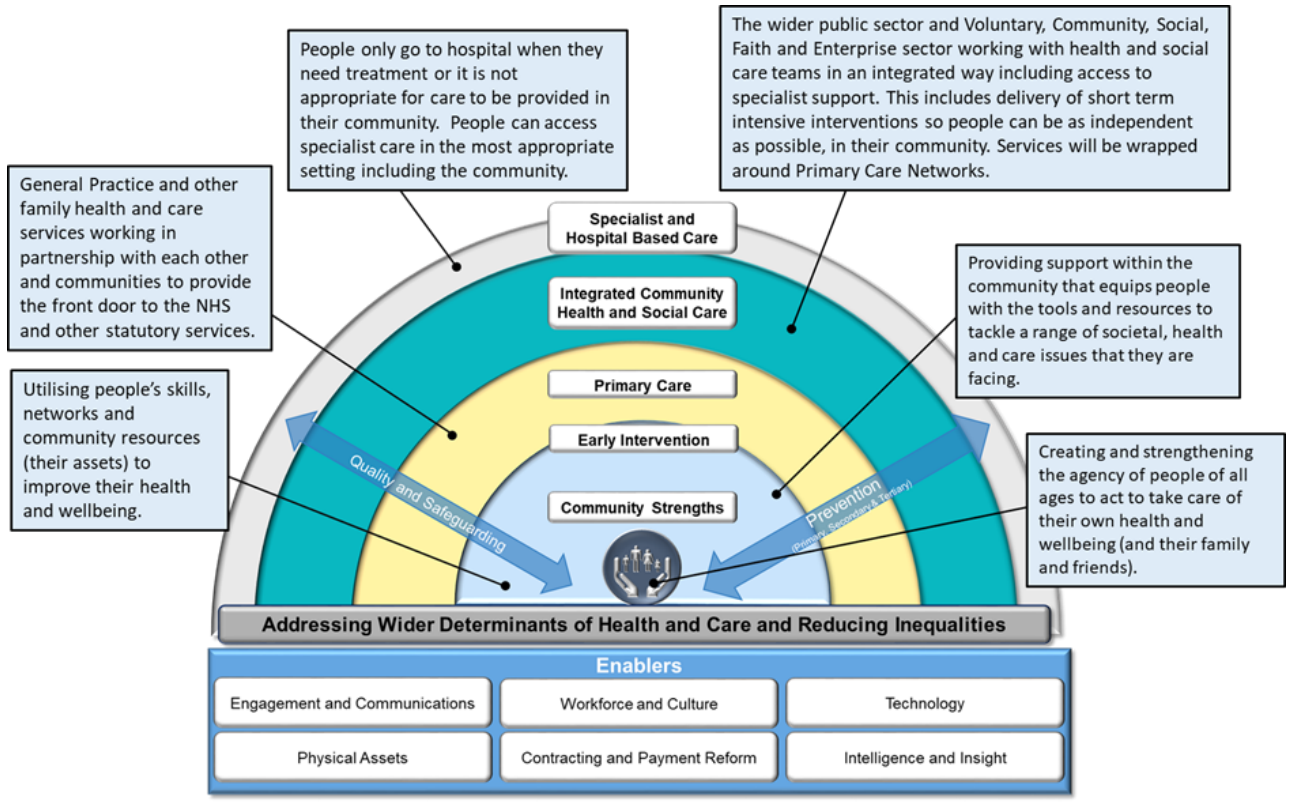
The model describes how different health and care services and partner organisations will work together for a person, population group or patient cohort as they progress through the stages of a condition, injury or event.

The model evolves local health and care into a truly integrated system, and aims to ensure people get the right care, in the right place at the right time, by the right team.

Our Model of Care describes a renewed focus for the planning and delivery of health and care services in our local system.

This model is one that is grounded firmly on a population health management and 'prevention' approach that reduces health inequity and enables people to live well at home.

The model places neighbourhoods and the general practice registered list as the cornerstone of our local health and care economy, with other services available, when needed and when care close to home is nor appropriate or possible, delivered to the highest quality.



Oldham
Integrated Care Partnership

Oldham's model of care

The design logic behind our model of care…

Is 'All age', but acknowledges that there may be transformational needs outside of this programme, such as in relation to children and young people

Places the person and their community at the centre

Builds on the requirements for all services to help address the wider determinants of health and address inequalities

Flows outwards recognising that people need to access different and more specialist care as their needs increase and become more complex

Is not linear, recognising that people can access services and support at all levels at a time

Provides an indication of the number of people accessing services by width of the arcs

Ensures that the core themes of addressing the wider determinants of health and care and reducing inequalities, prevention, safeguarding and quality permeate all arcs

Oldham
Integrated Care Partnership

Focusing on ten bold ambitions

As a group of partners working through the Oldham Integrated Care Partnership (ICP) we have agreed collectively to work to deliver 10 bold ambitions. To do so requires us to establish that ICP and ensure our place-based team convenes the partnership arrangements to deliver these 10 bold ambitions whilst also ensuring delivery of the delegated duties and functions from the ICB and that we have a detailed transformation programme in place to confirm the actions we will all take to bring about improvements.

Our 10 Bold Ambitions

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

Oldham
Integrated Care Partnership

Our overall strategy

In order to achieve our 10 bold ambitions we will launch a series of initiatives to address the root causes of ill health in our population. These initiatives will form the cornerstone of our investment over the next period and our performance management systems will be reworked to monitor both their implementation and their effectiveness.

Our initiatives will be designed to improve **prevention**, increase the **responsiveness** and **efficiency** of services and bring forward a new and more **personalised** approach to care delivery.

Preventative	We will proactively reach out to members of the population to reduce the prevalence of all diseases. This focus upon prevention will reduce mortality, improve quality of life and improve financial efficiency through a reduction in future healthcare requirement. The main way we will do this is through the use of our proposed public health outreach function – tailoring key health messages and interventions to population segments and individuals.
Responsive	Services will be delivered earlier in the disease cycle to maximise their effectiveness. We will target segments of our population to make people more aware of symptoms that should cause concern, leading to earlier presentations to primary care. Diagnostics will be carried out earlier and more expediently to reduce the overall wait to treatment. This shift will improve outcomes and reduce mortality in the period of the plan.
Individualised	We will track risk and disease prevalence on an individual rather than collective level. We will be able to predict the probability that individuals will experience CVD, for instance, and will design services to address these individual needs. We believe that this work will uncover important differences in reported prevalence in some of our deprived areas and where this is the case, a far improved service offering will be made available to individuals and support the reduction in health inequalities.
Tailored	Services will be tailored to be more effective to local populations. In some cases, services will be delivered entirely differently based upon locality, for example outreach spirometry testing.
Efficient	We shall strive to deliver more from our existing resources and these efficiencies will be re-invested to improve outcomes particularly in deprived areas. Efficiencies will be realised through pathway redesign, service reconfiguration and by shifting the focus from secondary to primary care.

Taken in the round delivering our strategy will mean establishing a new integrated health and care system for Oldham.

Oldham
Integrated Care Partnership

Delivering and organising our strategy

To achieve results we will need to fundamentally rethink:

- The way the public sector operate, and the relationship with communities
- How we work with individuals and families with problems
- How we connect with the community to both develop community connectedness, and build confidence
- How we have potentially challenging conversations that prompt a desire for change
- How we operate as a 'system' to unblock the barriers and system conditions that prevent people being able to make good choices and to live good lives
- How we intervene earlier, prevent failure demand and escalating levels of need leading to long term system-wide savings

We will work as an integrated care partnership in pursuit of financial and clinical sustainability rather than in organisational silos, developing aligned planning processes, investment decisions and risk management. At a high level we will close the forecast financial gap through a transformational programme focused on the following six core thematic areas…

Supporting people to be more control of their own lives, supporting people to look after themselves and each other	Focus on early intervention and prevention of ill health to mitigate growth in demand for services	Drive improvement in the system wide financial and performance position	Ensuring good quality, sustainable specialist and hospital services for the future	Redesign of community services so that people have access at home and in their locality	Transformation to create an Integrated Care System with a focus on population health management
• Adoption of a strength based approach to workforce reform • Linking people into 'more than medical' care through social prescribing • Investment in the support base around people e.g. community strengths in the Voluntary, Community Faith and Social Enterprise sector	• Development of a place based approach to promoting good health and wellbeing • Ensuring that a whole system approach is adopted to prevention and that it is hardwired into all service delivery • Implementation of new models of care that emphasise early intervention and prevention • Implementation of the Early Help offer and other whole system early intervention initiatives	• A continuous focus on quality improvement • Internal delivery of efficient and effective use of resources and better value • Striving for top quartile efficiency and productivity (including maximising the Carter Review and Rightcare analysis opportunities) • Delivery of system wide cost reduction • Development of a system estates strategy • Use of GIRFT reviews recommendations, Model Hospital and Pennine Acute Drivers of Deficit work	• Delivery of NCA-wide programmes consolidating services to improve reliability, outcomes and efficiency. • Development of new models, for the way elective care, specialist advice, diagnosis and treatment are delivery • Working in a different way to how we currently run specialist hospital services now • A focus on capacity remodeling, theatres and temporary staffing by the Oldham Care Organisation	• Proactive care management for people with long term conditions • Expansion of the enablement model • Enhanced primary care and the development of Primary care Networks • Integrating community health and social care • Increased investment in mental health • Reforming the Urgent and Emergency Care System to appropriately avoid costly admissions • Reducing delayed transfers of care, length of stay and unplanned admissions	• Adapting financial flows and exploring reforming contracting and payment mechanisms to align outcomes, metrics and financial incentives to support improved health and wellbeing outcomes, decision making and financial sustainability • Exploring provider models that have the potential to reduce management overheads and organisation • Development of new models of care focused on pathways and population cohorts • Integrating commissioning functions with a focus on strategic commissioning

Oldham
Integrated Care Partnership

Prioritising using the drivers of demand

Oldham is facing high levels of demand across its health and care system, exacerbated by a growing older population and high levels of deprivation, and we are reaching the point where services are unsustainable.

Demand is being driven by three thematic areas:

1. High health, care and social needs
2. Insufficient focus on early intervention and prevention
3. Lack of service integration, communication and signposting

In-depth analysis of the drivers of demand have identified four priority areas for intervention.

1. Reduce 'late' service access, presenting in **high demand for UEC**– A&E and NEL
2. Proactive CYP intervention to **reduce downstream demand, including in social care**
3. **Enhanced model for managing mental health** needs, including low- and mid-severity
4. Supporting **better care navigation** and **coordination**

Additional key areas of intervention are as follows:

- **Reducing OP** appointments
- Improving/seizing opportunities to **step down care**
- **Addressing wider determinants** around income, employment and housing

The drivers of demand inform this strategy, with interventions centred around care coordination, navigation and population health management, including segmentation and risk stratification – the detail behind these drivers will inform on-going prioritisation and yearly delivery against this five year plan.

Oldham
Integrated Care Partnership

Establishing a new health and care system in Oldham

Oldham
Integrated Care Partnership

A new infrastructure – the cornerstone of our strategy

Through our work on developing our strategic approach, several shortcomings in the traditional approach resulting from the commissioning/provider separation have become evident.

This section focuses on three of these: the link between the community conversation and the design of services, the delivery system for changing population health outcomes and the ability to deliver service integration across health and care and the NHS and local government, and the voluntary, community, faith and social enterprise sector.

1. **Developing an integrated care partnership and associated ways of working - place based integration**
2. **Population health outreach and management function**
3. **Community engagement**

In progressing in this way we will shift to a system characterised by:

- Its focus on population health and wellbeing outcomes
- A strong community offer built on the foundation of Primary Care Networks
- Good quality, sustainable specialist and hospital services
- Place-based integration and connection to community-led support and activity

1. An integrated care partnership and place-based integration

We have agreement from our system to establish an integrated care partnership to bring together all of our system into a **single organised function**. In doing so our design concept is to use general practice as the cornerstone of integration. This is for three reasons:

1. The GP registered list is the only place within the NHS where there is complete and confidential record of the present health status of individuals, and the continuous clinical relationship needed to interpret this.
2. General practice is the only location that contains a holistic record of the totality of healthcare interventions. This provides a unique point of reference for an integrated service and the only place where the impact of all providers on an individual's care can be found.
3. The registered list potentially provides an invaluable resource for tackling health inequalities, personalising care and transforming commissioning decisions. This is for two reasons. First, because we can identify those individuals who are either suffering from or most likely to be effected by our main killer diseases and ensure they are each receiving the best possible therapy. Second, if we can create a *consistent* view of the health status of individuals, then we can begin to respond more quickly and more personally as people's needs change.

This new integrated care partnership **will provide a new governance framework** that will enable GPs, consultants, nurses, AHPs and social care professionals to come together in integrated teams to deliver more efficient and effective pathways. During 2023/24 we will develop our detailed management programme and policy platform to embed the business and governance of integrated services for Oldham. This will include:

- A major programme of model of care development that will produce a comprehensive set of integrated pathways covering 'next step' care following attendance at general practice and for the management of long term conditions
- New work between primary care networks to enable them to participate in the new governance requirements of an integrated care partnership
- Discussions with HInM representatives on how the new ICS development programme could support integrated digital in Oldham
- The development of a major public and staff consultation exercise
- Work with the HEE to develop a new systematic education programme to support the new model of care

1. An integrated care partnership and place-based integration

Health and care will be integrated based on the principle that all and any services required for the 'next step care' after a GP consultation will be provided in community settings, unless by exception – supported by specialist opinion.

Our integration opportunities are, as a minimum, the following areas:

- Support and services that are presently delivered in outpatients
- Diagnostics
- Ambulatory and same day emergency care
- Day case work
- Community health services
- Adults' and children's care services
- Services provided from the voluntary, community, faith and social enterprise sector

Progressing in this way will enable us to support the whole system with the **introduction of a three-tiered population health system**, comprising:

- A collaborative that sets the framework for pursing a population health management approach in achieving the objectives outlined by a triple system aim.
- Development of Oldham place service networks, "creating teams without walls" that deliver services to our local communities with economies of scale benefits. These clinical service networks overlap and link in wider clinical networks that have either a North East Sector focus or a wider GM focus, such as mental health and cancer services.
- Integration of clinical and non-clinical services are that are built around the registered list and key public data lists in our five aligned PCNs and neighbourhood communities to help mobilise the local communities in the co-design of health and wellbeing solutions for hyper local populations and communities.

1. An integrated care partnership and place-based integration

A key component within our Oldham Integrated Care Partnership operating model is a **Delivery and Transformation Collaborative**. It is this Collaborative that will ensure the delivery of the transformation programme, as well as key areas of operational recovery and improvements. Its strategic direction will be set by Oldham Integrated Care Partnership Locality Board, and it will be operationally led, monitored and overseen by a Delivery and Transformation Board (as a sub-group of the Locality Board). This Delivery and Transformation Board will also oversee a range of themed cross-organisational / cross-sector groups that will undertake the design and implementation of the changes.

A programme management approach will be adopted, and the plans will be appendices to this strategy to ensure that there is an ability to flex and adapt delivery methods and undertake more detailed prioritisation as needed.

Our collaborative will work in such a way as to:

- Satisfy all statutory requirements for safe and effective practice
- Incorporate managerial, clinical and professional leadership across social care, primary, community and secondary care as a core component
- Increase satisfaction and improve the quality of care delivered and received
- Ensure financial sustainability

Local communities and neighbourhoods will be the basis for transformed integrated care delivery that is highly personalised and co-ordinated, where locally accessible care is the norm.

This is reliant on committing to a new arrangement for the deployment of health and care resources organised at community level rather than a hospital level, with all core teams coming together to form a geographically-focused resource to provide core support for local needs.

These will be “teams without walls” that deliver services to our local communities with economies of scale benefits, overlapping when needed with services delivered at a pan-Oldham or pan-GM level.

This integration will be built around the GP registered list and key public data lists in our five aligned neighbourhoods and Primary Care Networks, to help mobilise local communities in the co-design and/or co-production of health and wellbeing solutions.

Oldham
Integrated Care Partnership

2. Population health outreach

As detailed in The Hewitt Review, **"prevention, population health and tackling health inequalities are not a distraction from immediate priorities: indeed, they are the ley to sustainable solutions to those immediate performance challenges"**.

The focus of our transformation delivery programmes will be on creating and enabling this new prevention-focused system, with success marked against a range of experiential and performance outcome measures.

Through our transformation programme we will be pursuing a new coalition of clinical and non-clinical professionals, a neighbourhood-based 'core offer', and the development of a directory of services, linking into appointments and scheduling.

Population health management will be the core 'signalling function' for the system, driving integrated monitoring and support for people with long term conditions and those at risk, with services wrapped around them.

One of the key issues that has emerged from our development of this strategy has been the absence of an infrastructure whose purpose it is to maximise health gains. The most striking feature of this absence is the fact that there is at present no means by which we can secure a reliable view of population health at patient level.

For example, we do not know with any reliability exactly how many patients have cardio-vascular disease or to what extent, or which of our patients are likely to suffer from exacerbations from COPD. With respect to cancer, we do not know from diagnosis what the stage of disease is or which management protocols patients are being treated with. For mental health, it is impossible for us to know at population level how the available secondary care services are 'mapped' to our population need.

We can tackle this problem most effectively by re-focusing the registered list from GP practices to a single shared service. This has the unique benefit of providing a holistic view of each patient's overall healthcare interactions and also the place where definitive health status indicators exist for patients.

If we could develop the list so that it contained ***consistent and reliable*** health status indicators, and linked this information to a contact centre capable of proactive calling, we would have a powerful infrastructure that could both deliver highly targeted social marketing messages (e.g. concerning cancer symptoms to target age groups). This would also support the delivery of targets population health programmes (e.g. the call and recall system for future risk of CVD).

The development of such an infrastructure would require a careful negotiation with general practice, an absolute commitment to guaranteeing the confidentiality of information, thoroughly robust information governance protocols. We have started this discussion and will be taking it to the next level shortly after the clinical congress. We have also developed our preliminary high-level architecture for such a system and have started to explore the market for the availability of the components for a solution.

Oldham
Integrated Care Partnership

3. Citizen engagement and involvement

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

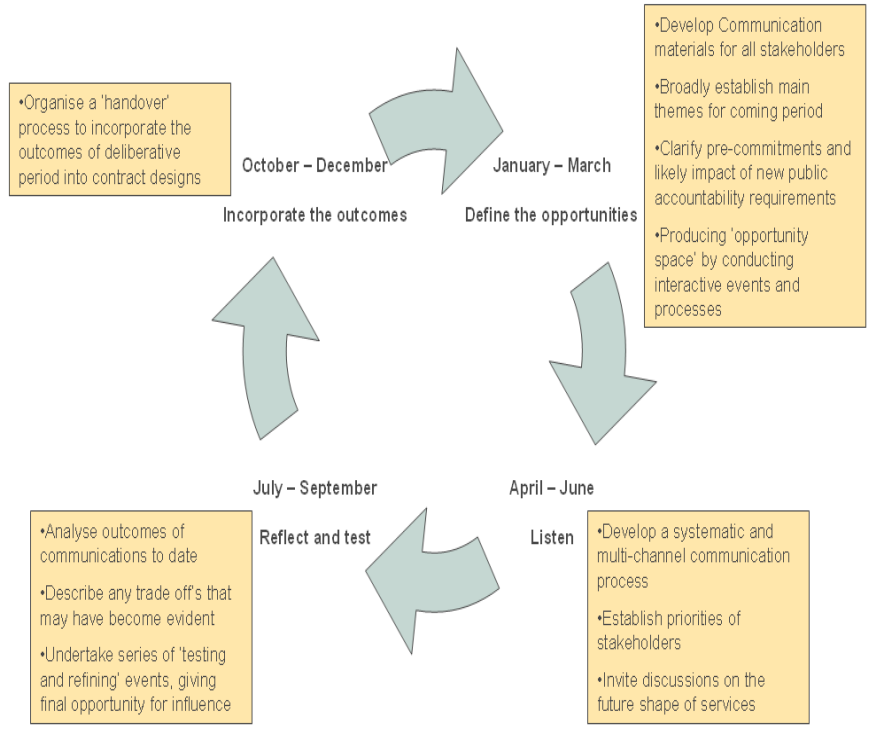
The key challenge is to create a framework within which the new conversation with our population about service change can take place in a way that is not tokenistic. In order to meet this challenge, we have to be able to meet two criteria. The first criterion is that the nature of our discussion with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

The way we will meet the first criterion is set out in detail during Q1. We will now briefly outline our proposal to meet the second criterion.

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

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

We would intend this process to have two effects over time – to both change the nature of our service design by placing a very high premium on the extent to which it is embedded in the wishes of our population and also to make the nature of our relationship with our stakeholders more meaningful by engaging in appropriate discussions at the right time to maximise the opportunities for joint working and explaining how best we can be influenced.



Oldham
Integrated Care Partnership

3. Citizen engagement and involvement

Citizen involvement will be at the heart of health and care, from the clinical and care professional support provided day-to-day, through to wholescale strategic change programmes. In Practical terms the partners will regularly agree priority communities to reach out to, either because it links to a specific project or programme, or because there is a need to provide more equity and health literacy to these groups.

Leaders from the Partnership will explore the use of 'citizen mentors' and will ensure that all involvement activities utilise an 'Art of Hosting' approach.
The Partnership has signed up to the Oldham Engagement Framework, which helps to connect public sector organisations to the voluntary, faith and social enterprise sector. This is complemented by a Partnership-wide citizen involvement strategy, which outlines the levels and methods of engagement that health and care partners will sign up to.

These levels will outline how the Partnership will ensure that the appropriate methods are adopted:

And within the area of engagement, the strategy will help the Partnership to explore the opportunities for the scope of change that local people can influence:

Oldham
Integrated Care Partnership

Support programmes

Oldham
Integrated Care Partnership

Equity and inclusion

The health of people in Oldham is generally worse than the England average, which is a stark statement of health inequality, and in some cases these are getting worse.

Inequality can be experienced in many ways, such as when it comes to:

- Accessing services
- Receiving care and support
- Life expectancy outcomes

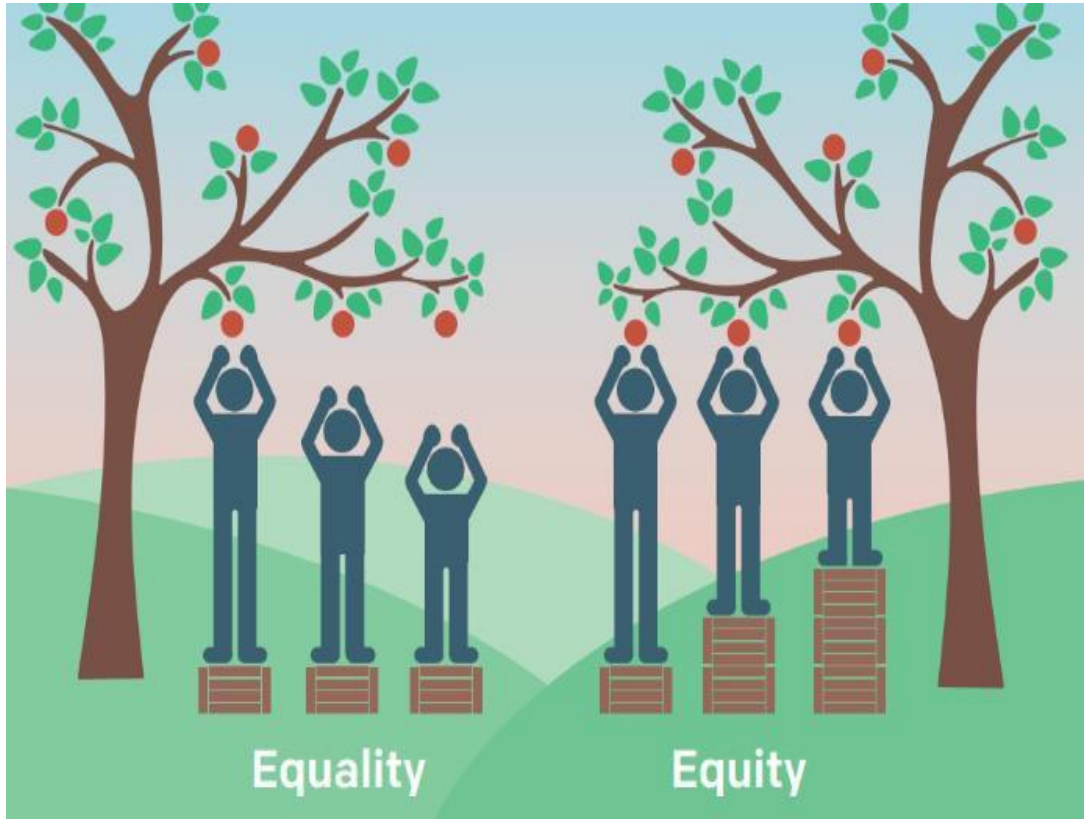
We know that system-wide and structural discrimination exists in Oldham, so as a Partnership we need to be brave and be committed to an approach where no one is excluded, and where we actively give people help to achieve real fairness and equality of access and outcomes for all.

We need to move from the broad aim of attempting to tackle health inequalities to ensuring that those underrepresented have a voice, can influence, and can be supported to a position of true equity in their day-to-day lives, as well as in the health and care environment.

There are some specific measures that will be embedded to help us do this.

This will include the collecting, analysing and utilising of protected characteristic data to drive improvements and reduce unwarranted variation for those in minority groups.

This will also include moving collective decision-making in relation to health and care beyond the statutory assessing of impacts, to a uniform 'inclusion health' checklist approach.



Oldham
Integrated Care Partnership

Social value

Oldham Integrated Care Partnership will undertake a social value approach to health planning and delivery, as linked to the Greater Manchester 'anchor actions' outlined.

This is, perhaps, even more important for our communities, which are some of the most diverse in the county in relation to age, income, ethnicity and culture. To achieve social value we must celebrate that diversity, develop the economies of our communities, and change cultural mindsets.

Strategies around 'health and wealth' will be undertaken, in particular when it comes to making active contributions to The Oldham Plan in relation to providing local communities employment opportunities and making the most of community assets. This will be part of a holistic approach to improving the life chances and feeling of belonging of everyone in the borough, supporting our five neighbourhoods to be community-designed, owned and led.

We will work together to reach out to, and strengthen connections with, our vital and thriving communities, as well as local volunteer, charity, faith and community-based organisations. We will do the same with other local organisations, such as local businesses.

We know that our local health and care leaders can be at the heart of this social value movement, and leading by example will support all of our teams to embody this approach.

Social value will also be embedded into any purchasing or procurement activities so that our supply chains can also make a positive contribution to our Place. We will utilise Oldham Council's Social Value Procurement Framework, as part of a broader cultural, longer term approach to this area so that it becomes 'second nature'.

Oldham
Integrated Care Partnership

Workforce

None of the ambitions outlined in this strategy can be delivered without the input and drive of our local health and care workforce.

Our workforce will need to be at the heart of co-producing change, helping health and care services in Oldham become places where people want to work because they are places where people's ideas, contributions and innovations are embraced, encouraged and rewarded.

We will ensure that our people are treated fairly and equally, ensuring that everyone, no matter what their background, has equal and fair access to career progression, training and development.

The Partnership has already signed up to a 'Team Oldham' workforce strategy, which not only guides services and organisations to a consistent approach to its workforce approaches, but supports a way of working that allows for a more flexible workforce delivery model. This is the for benefit of our staff as it will help to harness and manage talent across the whole Oldham footprint, but it will also benefit our service users by providing enhanced service effectiveness.

This Workforce Strategy aligns with the national NHS People Plan.

Opening jobs up to wider recruitment opportunities for local people (linking closely to the areas of social value and 'health and wealth'), retaining the staff that we do have, and opening the door to those wishing to return to health and care services in Oldham will be key to our workforce planning.

Where possible, when purchasing services Partners will aim to pay the Real Living Wage, as of course those delivering health, care and support for our communities are broader than only the NHS and local authority social care staff on other pay frameworks.

The Partnership will also have due regard to Oldham's Fair Employment Charter and Greater Manchester's Good Employment Charter.

Oldham
Integrated Care Partnership

Digital

There are many areas of our local health and care system that remain paper-based or operate on outdated systems that do not connect to each other. Our digital strategy locally would, therefore, be aligned to the GM Integrated Care digital ambitions outlined, delivered as a local Integrated Care Partnership.

The core of this will be to **DIGITISE**, **INTEGRATE** and **INNOVATE**, to ensure that digital can be a powerful driver for improving and transforming care, delivering productivity, and enhancing patient experiences. It will be co-designed with our workforce and citizens, and educating people on how to use the technologies will be key.

Local digital priorities that will be crucial for supporting our digital ambitions will include development of the Shared Care Record, joining up health and care records held with separate organisations based on the individual. We know this will improve patient experiences, and also improve the quality and safety of care and treatment delivered. We will also utilise the benefits of an enhanced integrated academic health, science and innovation system being developed by Health Innovation Manchester.

Utilising the power of our local Partnership will be vital, in order to influence and lobby for digital investment in Oldham. We will do this by having a better understanding of the digital needs of our population, and better insight of all of our local data assets. This will be collated into a digital roadmap to enhanced efficiency and integration.

Transforming areas of digital within health and care will not only benefit patients and staff in many ways, but it will also have important fiscal, economical and social benefits.

GM digital transformation ambitions:

- We deliver integrated, coordinated and safe care to citizens
- We enable staff and services to operate efficiently and productively
- We empower citizens to manage their health and care needs
- We understand population health needs and act upon insights
- We accelerate research and innovation into practice, as a globally leading centre

Sustainability and net zero

As already described, a core pillar of enabling work to truly transform local health and care services relates to sustainability.

When we talk about sustainability, we mean sustainability of resources, finances, estates and workforce. All of these areas are crucial to ensuring that health and care can improve and be present and high quality for future generations.

Oldham Integrated Care Partnership and its constituent members will work together in a collaborative way to ensure that through all strategic decision-making and operational leadership, we will get the best value possible for the Oldham health and care pound.

We want, and need to be a financially sustainable Partnership, which can only happen of all constituent parts of the Partnership are also financially sustainable.

Financial sustainability is essential to make sure we have the resources in Oldham to plan and deliver high quality health and care with excellent experiences for service users, which in turn is key to improving the health of our residents and communities.

The move of technical purchasing and contracting to a GM-level provides the environment where as partners locally we can thrive and resolve issues like these as a collective, and areas of all types of sustainability will be built into all projects and programmes.

Sustainability impacts, for example, will be addressed alongside other priority components such as quality and safety.

We will work as a Partnership towards 'net zero', participating in both local, regional and national 'Green Plans', implementing any relevant NHS wastage strategies.

As previously outlined, we will continually examine the local drivers for demand in health and care services, and use this insight to lead initiatives towards more high quality, effective, efficient and productive services. This is vital to ensure that we can maintain high quality and safe services that provide unparalleled patient experiences for generations to come.

Oldham
Integrated Care Partnership

Estates

We know that we need our health and care estates to be more efficient and more fit-for-purpose, so we will undertake an extensive review of the Oldham health and care estate footprint.

The aim of doing this review will be to ensure that our estates are appropriate for service delivery. We also need to understand what 'void' space we have and how we can reduce any void assets, as these are unsustainable. This may mean looking at solutions to repurpose estate spaces, which means that this work is also key to our transformation programme.

We will reform a local Strategic Estates Group, where we can also assess health and care assets alongside other community assets and other public sector buildings and services. Our overriding strategy, as well as ensuring estates usage is fit for purpose, is to connect the NHS with the wider public sector and community – the optimum strategy being wherever possible that estates are multi-purpose and public, health and care services are co-located – as 'one public sector' estate.

We will also use our estate in a creative way to support new ways of working within the Partnership – so that individuals and teams from across different organisations can work together in matrix or project teams as needed. Or even just come together to share ideas and undertake collaborative planning.

Oldham
Integrated Care Partnership

Effective working

Ways of working, planning and prioritisation

New ways of working will be embedded across Oldham Integrated Care Partnership and its constituent members. The aim will be to work in a much more 'boundary-less' way, with efficiencies and productivity created through sharing of resources, teams and expertise. Matrix working methods will be adopted to ensure that projects and programmes for transformation and recovery are designed, implemented and monitored in a multi-disciplinary and cross- organisational way, which will result in more effective and long-standing change.

A key appendix to this document will be a 1-year delivery plan, which will show the local drivers of demand, priority areas for delivery, national NHS constitutional responsibilities, as well as detailing how we will recover, improve and transform in these areas.

This delivery plan will sit outside of this strategy to ensure that work can be flexed to allow for changes in external environments (for example, regulatory, legal), and also changes to work prioritisation as needed (for example to support local, regional and national pressures). This will also mean the plan can be more easily adapted and approved each year.

A detailed governing handbook and risk management framework will also be appended to this strategy, and specific strategies and plans will also be put in place covering the following developmental areas for Oldham: **WORKFORCE**, **DIGITAL**, **ESTATES**, **CITIZEN INVOLVEMENT**, and **INFORMATION**, **INTELLIGENCE AND INSIGHT.**

Network groups will be utilised to undertake Partnership-wide planning, particularly in the areas of communications, stakeholder relations, research and insight, and workforce and organisational development. Oldham will also be an active participant in the work of the '4 Locality Partnership', utilising the benefit of a larger health and care footprint to help drive forward key innovations in relation to the areas of digital, business intelligence, data sharing and treatment pathways.

All plans, strategies and approaches will be agreed by the relevant Boards, and will involve all partners in their production to ensure buy-in.

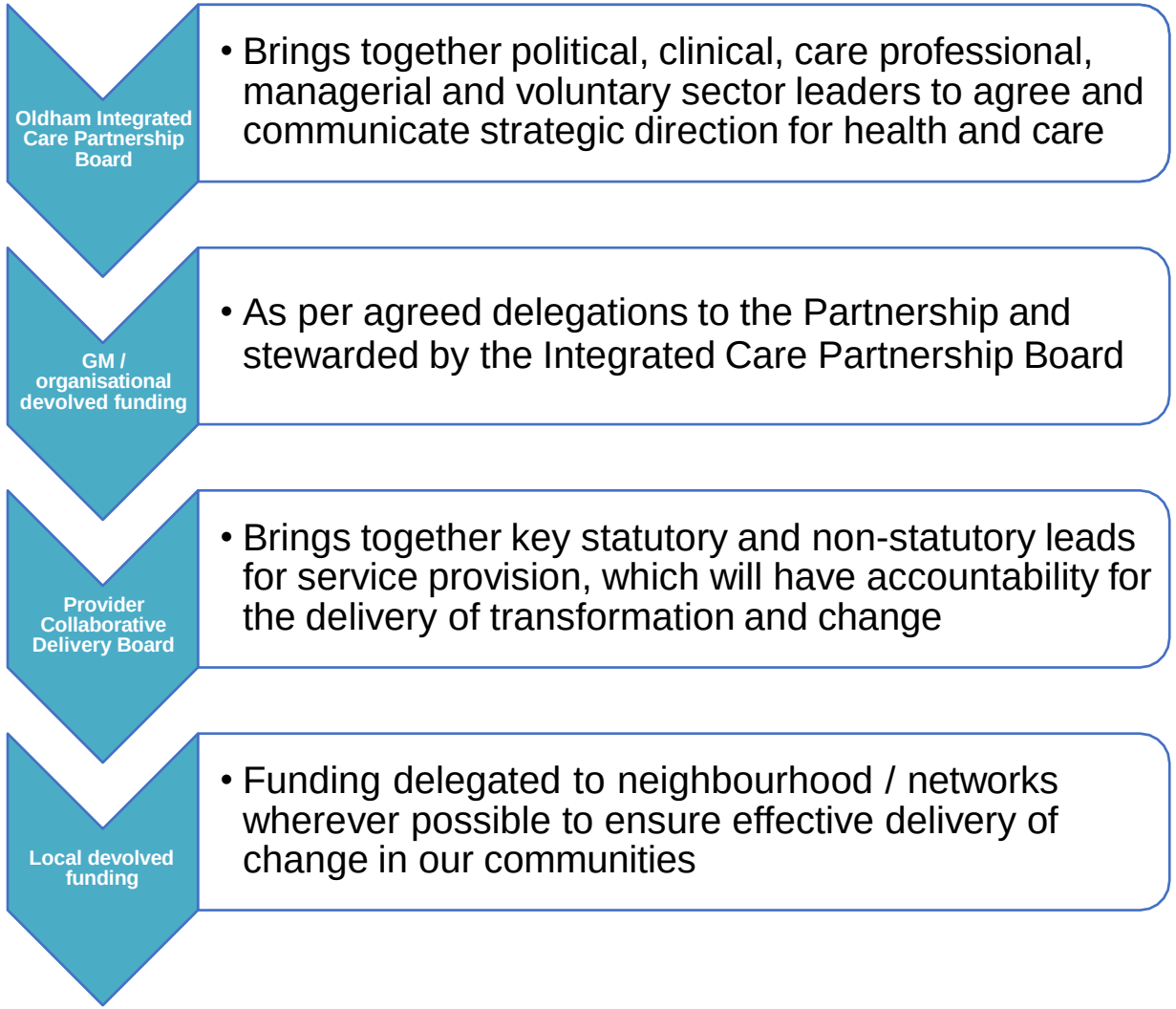
Oldham
Integrated Care Partnership

Governance

The Partnership will utilise governance as an enabling tool for change.

A governance operating model handbook is a Schedule to this strategy, and describes how decisions are made and how the Partnership links with and interacts with other areas in the borough and with health and care across GM.

Partnership Integration Agreements are in place to bind the Partnership members together in relation to vision, principles, and strategic direction, supporting by a range of themed legal Schedules.



Oldham
Integrated Care Partnership

Risk management

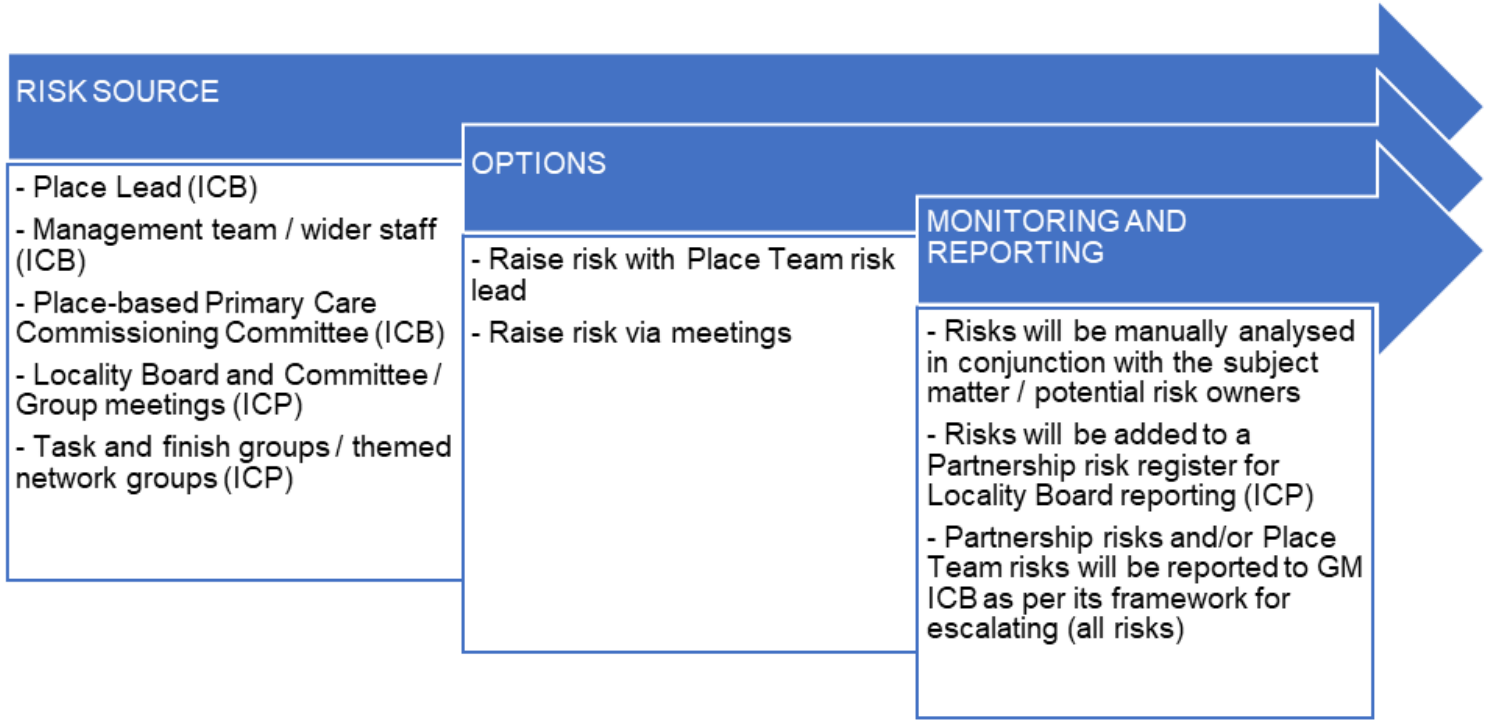
A strategic and operational risk management framework is embedded across the Partnership, to help track the risks to delivery of the Partnership's strategic aims, including all areas of transformation and recovery.

This process, which will focus on 'adding value' rather than repeating the risk processes of individual organisations, will also enable reporting and escalation to NHS Greater Manchester Integrated Care as needed.

BOARD ASSURANCE FRAMEWORK
- Risks to the delivery of the strategic aims

CORPORATE RISK REGISTER
- High level risks to the delivery of health and care transformation and recovery

OPERATIONAL RISK REGISTER
- Risks to the delivery of health and care transformation and recovery



Oldham
Integrated Care Partnership

Measuring our success

Oldham
Integrated Care Partnership

Outcomes and core measures

Whilst the overriding qualitative success for transformational change of local health and care over the duration of this strategy will be measured by the 'what will good like' experience and perception measures outlined, quantitative and qualitative, measurable outcomes will be written into every small operational project through to wholescale transformational programmes.

This is important to ensure that the potential impacts and any unintended consequences of change can be identified, tracked and measured, and will be the only way to make Partnership-led, integrated change that will benefit our communities for generations to come.

A number of core measures have been outlined as a guide to keeping our projects and programmes outcome focused.

Core measures:

- NHS Constitutional targets
- Care and treatment access – including service recovery indicators
- Patient reported outcome measures
- Patient experiences / journeys
- Improvements in population health
- Quality indicators and incidents
- Health inequalities
- Unwarranted variation
- Transitions between services
- Patient flow – with a focus on urgent and emergency care, length of stays and discharges
- Demand utilisation, use of resources and wastage
- Financial sustainability (locality budgets and affordability)

Oldham
Integrated Care Partnership

What will good look like?

- People will have responsibility over their own wellbeing and will have high levels of health literacy
- People's lived experiences will drive change and improvements in health and care
- People will have access to high quality, timely and personalised care in the most appropriate place
- People will genuinely experience integrated seamless care and support, no matter which organisation or individual is delivering the services
- People will feel reassured that future generations will be able to benefit from effective, efficient and sustainable health and care services

Oldham
Integrated Care Partnership

Oldham Integrated Care Partnership (ICP) 2024/25 delivery plan

Oldham
Integrated Care Partnership

Part of Greater Manchester
Integrated Care Partnership

Contents

Oldham
Integrated Care Partnership

Foreword

Oldham
Integrated Care Partnership

This delivery plan covers the year one delivery of the Oldham Integrated Care Partnership's five-year strategy along with how we in Oldham will meet the obligations set out in the NHS planning guidance for 2024/25. It features the key priorities for the year ahead, as well as the detail of action areas and milestones. We have chosen to structure this plan around seven themed workstream areas, that incorporates the local recovery, improvement and transformation needed to deliver against Greater Manchester Integrated Care Joint Forward Plan, which in turn aims to deliver against the NHS's 'Long Term Plan' commitments.

Following detailed examination around the local 'drivers of demand' across Oldham health and care services, the recommended actions made because of this work are incorporated across the themed delivery areas.

If a priority action(s) in relation to the drivers and/or the Greater Manchester (GM) Operational Plan does not fit into a themed workstream area, the action(s) will be embedded into the relevant organisation's / team's 'business-as-usual' work.

Like with Oldham's 5-year Strategy, and as all partners have committed to improving health and reducing health inequalities, our local delivery and transformation activities for the year ahead will align with Oldham's Health and Wellbeing Strategy. In addition, plans for the prevention of ill health across all our communities will focus on the highest impact interventions, and:

- Take a quality improvement approach to addressing health inequalities and reflect the 'Core20PLUS5' approach in plans as detailed in our five-year strategy
- Consider the specific needs of children and young people
- Establish high intensity use services to support demand management in urgent and emergency care

Plans will also link to the five strategic priorities for tackling health inequalities:

1. Restoring NHS services inclusively
2. Mitigating against 'digital exclusion'
3. Ensuring datasets are complete and timely
4. Accelerating preventative programmes
5. Strengthening leadership and accountability

A collaborative partnership approach will be adopted for this area, with community involvement and 'lived experiences' utilised wherever possible, embedding various levels of engagement and equality, diversity and inclusion, from statutory impact assessments of change, through to full consultation and co-design and/or co-production. An inclusion health focus for local decisions will be utilised and Oldham's established Health and Care Senate, made up of clinical and care professional leaders will be a core point of direction and advisory in relation to operational improvements to local services, linking closely to patient and community groups to enable the outcomes of change to be as positive and effective as possible by considering the views of those impacted as our expert patients

Oldham
Integrated Care Partnership

Context, challenges and overarching priorities

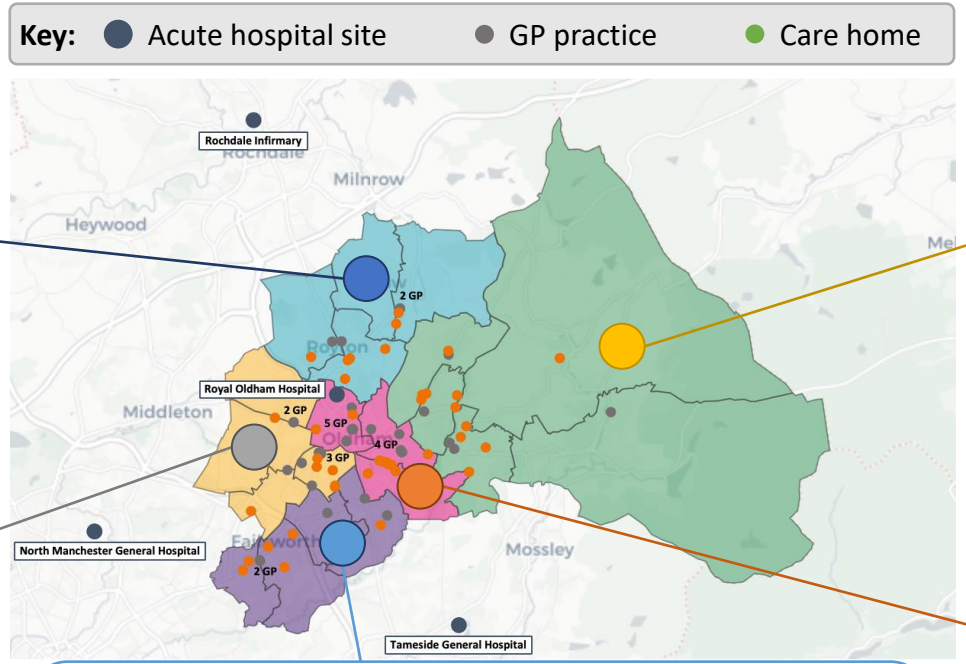
Our population

Oldham
Integrated Care Partnership

Across our five networked neighbourhoods, population demographics and health needs vary, with a young profile except in north, and deprivation concentrated in central, causing different resource needs.

North District

- **Oldest demographic** with large number of >65s (older than GM and England averages), and the **least ethnically diverse** of the Districts with a predominantly white population
- Some **pockets of deprivation**
- **Highest rates of obesity, respiratory disease, CVD and depression** in Oldham and above national rates, and high rates of diabetes
- **Highest rates of learning disabilities** with west



East District

- Age profile is slightly older than other districts apart from north, with **low ethnic diversity** and a predominantly white population
- East has the **lowest deprivation** of the Districts
- **Lowest rates of SMI** compared to other Districts
- **Lowest smoking rates in Oldham** but at **higher end of rates of respiratory disease**
- Relatively **lower rates of diabetes** although above the national average and **lowest frailty in 50-64**

West District

- **Young population** (similar to south) with **some high diversity** - a quarter of people are registered as Asian/Asian British
- Significant **pockets of deprivation**
- High rates of mental health conditions with **highest rates of SMI in Oldham**
- **Highest smoking rates** significantly above the national average and **relatively high rates of respiratory** disease and diabetes
- **Highest rates of learning disabilities** with north

South District

- **Younger population** profile (like west) but relatively **lower ethnic diversity**
- Significant **pockets of deprivation**
- **Lowest obesity rates** of Oldham but still above England, **lowest CVD rates** in Oldham (below England), and **relatively lower rates of diabetes** although still above England, but **high smoking rates**
- **High rates of mental health conditions** compared to nationally

Central District

- **Youngest population** profile(30% <16, 9% >65) and **highest degree of ethnic diversity** with nearly 50% of the population Asian and largest proportion of Black/Black British/Caribbean or African residents
- Significantly the **most deprived District**
- Relatively **high levels of smoking and obesity**
- **Highest levels of frailty** in 50-64 age group
- High needs for LTCs including **relatively high levels of mental health conditions, respiratory disease and highest rates of diabetes.**

Our core challenges

Oldham
Integrated Care Partnership

Oldham is facing high levels of demand across the health and care system which are particularly visible at Royal Oldham Hospital.

This demand for public services is expected to be further influenced by a growing older population, with the over 65 population expected to grow by 30% by 2041, and high levels of deprivation.

The strain on service provision from this demand is reaching the point of being unsustainable despite the best endeavors to resolve the issues over several years.

Our focus for much of the years ahead will be about tackling the drivers of demand in our system. As part of this planning round we set about a whole system conversation to understand that question and collectively we have identified three primary drivers.

Our priorities as a whole system will focus on tackling and arresting this demand as much as we possibly can starting in 2024/25 but continuing into future years.

1. High health, care and social needs

- High deprivation and associated demographic factors
- Challenging living environment and/or home setting
- 'Risky' lifestyle and health behaviours, and high rates of risk factors
- High rates of physical and mental health conditions and disability

2. Insufficient focus on early intervention and prevention

- Limited self-management and/or overreliance on services
- Need for more early detection and prevention
- Challenges in access to and use of primary care and other upstream services
- Barriers to accessing non-urgent hospital care

3. Lack of service integration, communication and signposting

- Demand is sometimes directed to the 'wrong' place
- People don't know how to navigate the system or services
- Lack of integration across services and fragmentation of patient flows

Challenge 1: High health and social care needs

Oldham
Integrated Care Partnership

In summary, there are a set of wider environmental factors and health needs in Oldham driving demand including deprivation, living circumstances and high rates of health conditions.

Drivers of health and care demand		Example evidence
Demographic factors closely tied to deprivation	• High levels of deprivation which are associated with lower GP/OP service use, and with higher CYP social care use • There is intersectionality between deprivation and ethnicity • High levels of crime and violence	• Strong links between child poverty and UEC use • Strong links between CYP mental health and deprivation
Challenging environment and/or home setting	• Poor parental mental health • High levels of domestic violence • High social isolation and loneliness • Need more familial support for new mothers (teen pregnancy)	• Social isolation is the top social prescribing referral • Adult and child mental health referrals are interrelated
Lifestyle, health behaviours and risk factors	• Poor housing stock (damp, poor insulation) • Low physical activity and/or poor diet • High obesity rates • High smoking rates, and high alcohol/drug use • High levels of stress (e.g. due to financial worries)	• High smoking and obesity rates, with obesity appearing to be a big driver of UEC use • Housing is the second highest social prescribing referral in central
High rates of health conditions and disability	• High rates of long-term conditions (diabetes, asthma, COPD) and high rates of learning disability needs • High rates of mental health conditions • High rates of some acute illness such as lung cancer	• LTCs and risk factors show strong links to UEC use • Growing mental health service use (CYP and adult)

Impact on demand

High long-term health and care needs requiring primary, community, mental health and social care support (and self-management) e.g. respiratory, mental health, social needs

High needs amongst CYP, particularly mental health and earlier care support – there appears to be strong links between deprivation and CYP A&E use for mental health

High A&E use for illness as health deteriorates or issues are undetected (e.g. high lung cancer rates, or for long-term conditions)

Challenge 2: Insufficient focus on early intervention and prevention

Oldham
Integrated Care Partnership

In summary, there is a lack of focus on early intervention and prevention, and barriers to accessing upstream services and care, is creating additional 'failure' demand.

Drivers of health and care demand		Example evidence	Impact on demand
Limited self-management or overreliance on services	• **Low self-management** and **low health literacy** in some populations (accompanied by 'risk' behaviours like smoking) • **Service paternalism** or **'pathologising'** is creating dependency (e.g. low PIFU, potential use of A&E as front door)	• Lowest rates amongst peers of people with T2D meeting all 3 treatment targets • Relatively low PIFU	**High UEC demand** – either use as a front door, or presenting in A&E with deteriorating health
Need for more early detection	• There is variation in detection across services. **Low detection of cancer**, and **low reported prevalence of CVD**/hypertension potentially indicates need for more case-finding/detection • **Low uptake of health checks** and early prevention offers with a need to support better access in certain populations	• Second lowest detection of stage 1/2 cancer and highest A&E detection vs. peers • Lowest uptake of health checks (40-74) vs. peers	**Higher general community, mental health, social and primary care resource use** due to a rise in complexity from unmanaged health issues
Challenges in access and use of primary care services and other upstream services	• **Very long wait times** for some CYP services (e.g. SALT) • **Challenges in use of primary care**, appearing to be a mix of capacity issues and lack of engagement in some service users • **Capacity issues in community services** e.g. diabetes nursing • IAPT referral attrition and **gap in mental health service offer** • **Cultural barriers** such as language translation, mistrust	• Primary care appointments • per head are below nationally • High A&E attendances for LTCs, mental health, etc. • Links across deprivation, lower GP/OP and high A&E	**High CYP demand and complexity** including mental health needs – as issues go unaddressed
Barriers to non-urgent hospital care	• **Waits have risen** for elective and cancer services in acute care • There are some **gaps in current service provision**, such as a walk-in/minor ailments centre, CAMHS beds in Oldham	• EL waiting list size has grown 18% since August 2021	**More referrals and longer backlogs as** routine care is tagged as urgent to ensure patients are seen around long waits

Challenge 3: Not enough service integration and communication

Oldham
Integrated Care Partnership

In summary, there is a need for more service integration such as issues in flows, signposting and communication across services drives referrals, duplication and care in the wrong setting. Community-led care navigation will be key.

Drivers of health and care demand		Example evidence	Impact on demand
Demand is sometimes directed to the 'wrong' place	• **Risk aversion** in the system may funnel people to secondary care, particularly for managing moderate mental health needs • Some Royal Oldham Hospital A&E use may be related to **proximity of A&E** and low awareness about alternatives, funneling demand to A&E	• GoToDoc pre-ED redirects many patients outside A&E • High numbers of low acuity A&E attendances	**High UEC demand** which could be triaged or managed in the community and/or primary care
People don't know how to navigate the system or services	• Service users, providers or care givers not always clear on the right care setting so people can **end up in the wrong place,** needing multiple re-referrals, re-assessments or getting 'lost' • Some populations **don't know how, why or when to access services** when they need (e.g. diabetes checks)	• Oldham has the largest proportion of adult social care referrals that go into universal/other services or require no further action	**Higher primary care demand** for things that could be managed elsewhere (e.g. OTC prescriptions, re-referrals from secondary care)
Lack of integration across services (both vertically and horizontally)	• Greater integration is needed across out-of-hospital services as well as in-hospital to more effectively manage people's needs across service boundaries and **reduce duplication**, with potential to strengthen and mature PCN roles • **Issues in horizontal patient flows across secondary care** specialities (inter-referral) creates duplication in demand, where patients are referred back to primary care to be referred back to acute care	• Very high A&E attends vs. peers for diabetes, respiratory, mental health • High rates of long-term conditions and social needs (e.g. deprivation, housing) require greater integration across all public services	**High referrals into multiple services, or that don't require care**, also driving up wait times (e.g. ASC referrals for advice and guidance, or onto other services)

Priorities

Oldham
Integrated Care Partnership

This delivery plan features, in the delivery programme section, the transformation aims of Oldham Integrated Care Partnership, as well as the 'business as usual' plans for the year ahead for NHS Greater Manchester's locality Place Team, as linked to the national, regional and local NHS commissioning priorities.

For ease, the following slide describes Oldham Integrated Care Partnership's top four priorities, as these will enable direct delivery as linked to our five-year strategy and provide focus to help us to tackle local key performance issues and local drivers of demand in a collaborative way.

The delivery programme workstream action plans additionally feature the full work plans for health and care for the local Place Team.

Our four top priorities for 2024/25

Oldham
Integrated Care Partnership

The scale of the challenge facing the NHS is unprecedented and whilst our operational plan for 2024/25 will describe the things we will do in Oldham to meet the things we have to do on behalf of the NHS we have set ourselves as an Integrated Care Partnership four top priorities for 2024/25. These are set out below. The detail of what we plan to do is set out in the delivery programme part of this plan.

1 Reduce 'late' service access, presenting in **high demand for UEC**– A&E and NEL *(closely linked to priority 4)*

- Improve **early detection, diagnosis, and prevention** by identifying patient cohorts to treat proactively
- **Improve self-management** of LTCs or risk factors (e.g. smoking)
- **Enhance the primary and community care model**, to improve capacity/availability, citizen engagement and case management

- UEC in **central, south, west**
- **CVD, respiratory** (smoking in west), **early frailty** (central) and **diabetes** (central, north, west)
- Proactive care for **BAME** groups

2 Proactive CYP intervention to **reduce downstream demand, including in social care**

- **Review current and previous service provision** (including early help triage), family support and early intervention model (0-5 years), and **referral criteria**
- **Improve access to key early CYP support** (e.g. MH, SALT services)
- Explore initiatives with **schools** on educational referrals and **police**

- High CSC in **central** and **south**
- Improve CYP MH support in **central**, review high SEN support
- CSC offer for **BAME** groups
- High CAMHS use in **north, east**

3 **Enhanced model for managing mental health** needs, including low- and mid-severity

- **Review service model and local provision** for 1) **Low/moderate MH needs** and 2) **Preventing people entering crisis**, including opportunities for social prescribing, crisis support and local MDTs
- Understand and **reduce attrition for IAPT and community MH**
- Address strained inpatient capacity (discharging, OOA placement)

- **Understand and address** CYP/ adult MH service use in central and west
- Support for **BAME** (IAPT use)
- Reducing delayed discharge

4 Supporting **better care navigation** and **coordination** *(tightly linked to priority 1)*

- Improve support and engagement on the **right care setting for different needs**, including effective **triage** processes
- Provide a clear, **single point of access**
- **Signposting and guidance on how to navigate services** for providers, service users and their families

- **ASC referrals with no further action/onto other services**
- Primary care access in **central** and **east** and low acuity A&E use in **central, south, east**

Oldham
Integrated Care Partnership

Neighbourhoods at the heart of our delivery programme

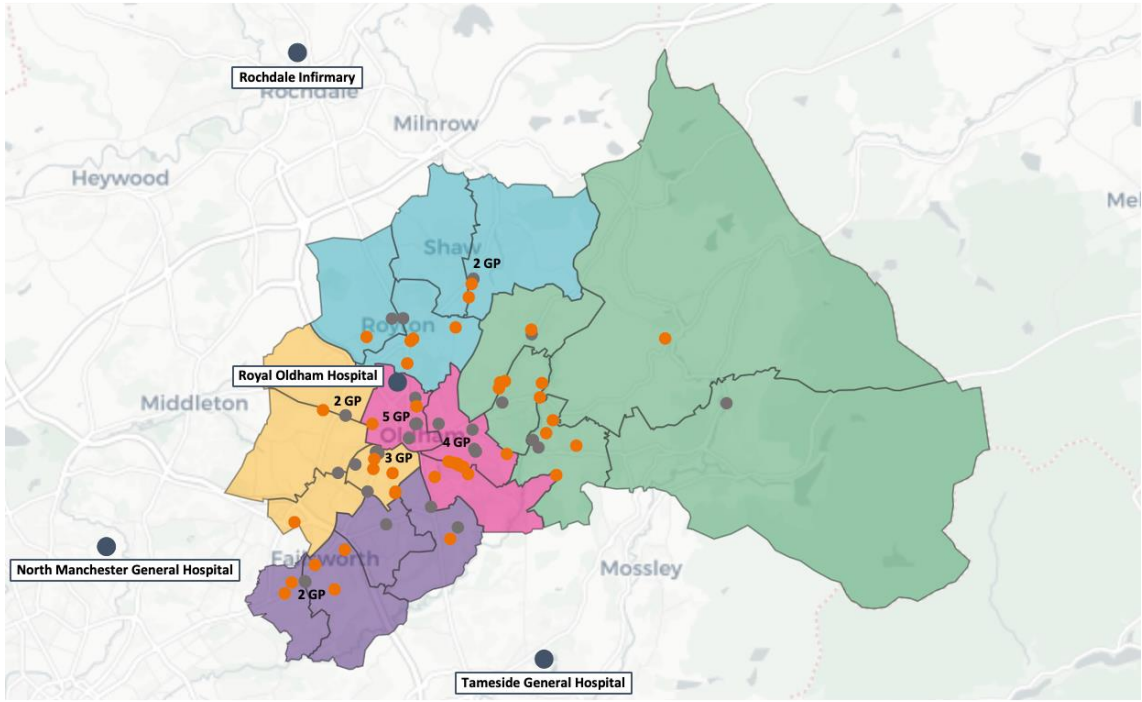
Understanding our communities

Oldham
Integrated Care Partnership

As well as being a key part of the population health management and place-based integration workstream within our delivery programme (as outlined in the section following this one), understanding our neighbourhoods and the communities within is at the heart of delivering real change during the year ahead.

Following the extensive collaborative listening and engagement that took place amongst all Oldham partners and communities to assess the key drivers of demand for health and care services and establish our overarching priorities (as outlined in the previous section), this same approach has been undertaken to plan how a preventative, early help and intervention, population health management approach will be taken.

This has resulted in an assessment of the overall opportunity, broken down to each of the five neighbourhoods as follows. (It should be noted that this is a summary, as an extensive range of more detailed data sit underneath for each neighbourhood.)



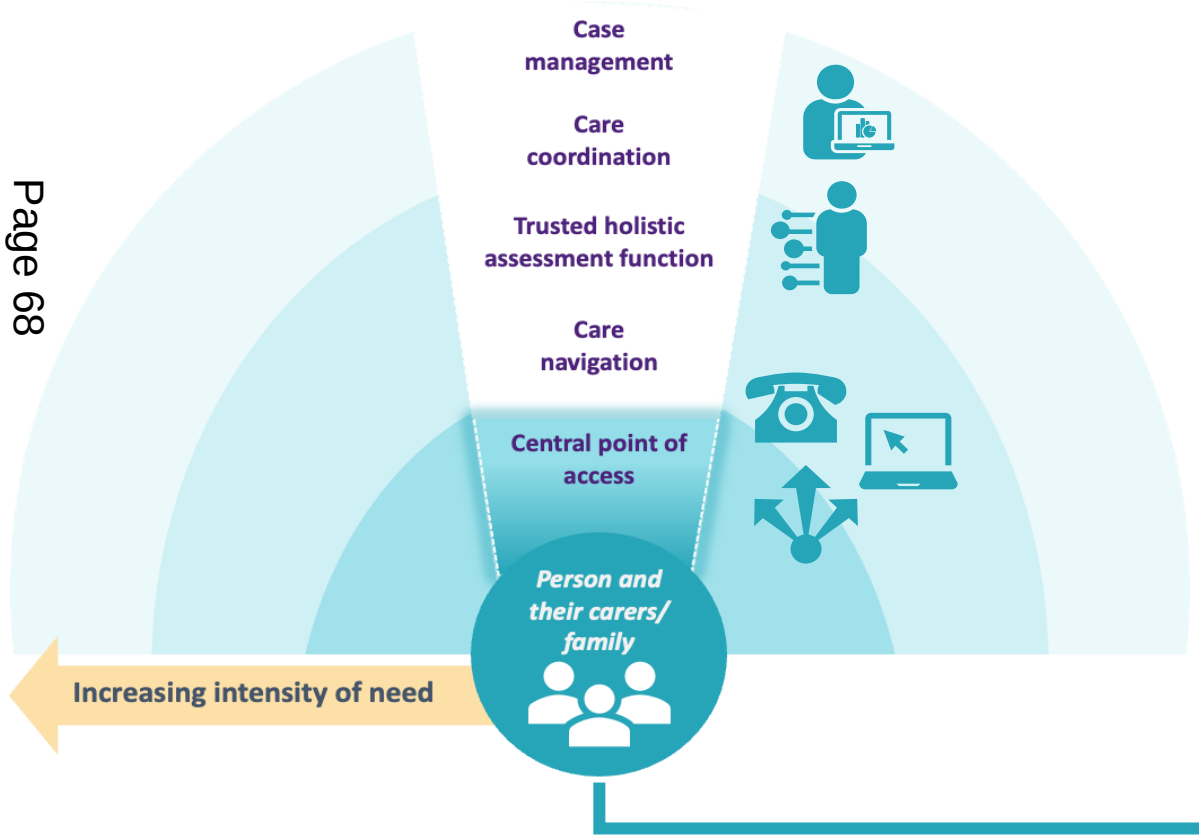
Taking this approach will also enable us to deliver against the key areas within the national NHS Planning guidance to improve health and join-up care, namely to:

- Expand evidenced-based approaches to population health, focusing on a healthy start to life, prevention, self-care and better management of long-term conditions
- Join up care closer to home including through integrated neighbourhood teams and place-based arrangements with local authorities and other system partners
- Integrate and streamline UEC pathways, with a particular focus on the management of older people with complex needs and frailty
- Continue to drive improvements in productivity and operational effectiveness

Population health management (PHM) models

Oldham
Integrated Care Partnership

Underpinning the priorities are care coordination and navigation and population health management to proactively identify and manage people. **This will encompass community-led health approaches, self-care and self-navigation.**



- Higher use of health and care services compared to people in the same segment
- The most complex, severe or acute presentation of conditions or risk factors in their segment

High risk

- Rising use of health and care services
- Typically involves escalating needs, in acuity, severity or complexity

Rising Risk

- Lower use of health and care services
- Can include people with risk factors through to people with less severe presentation of conditions depending on the segment

Stable

Care coordination, navigation and assessment approach according to complexity of need

Population health management approach using segmentation and risk stratification

Overall opportunity of implementing PHM models

Oldham
Integrated Care Partnership

The opportunity of implementing the PHM models in the relevant neighbourhoods in Oldham could save £5.1m - £9.1m across the individual groups.

Neighbourhood	PHM priority group	Description of group used to calculate opportunity	Approach to quantify opportunity	Number of people who benefit	Minimum / low opportunity	Maximum / high opportunity
Central	0-17 CYP in good health with rising risk (e.g. in high-risk households)	CYP in good health segment but with 3 or more A&E attendances in a year (indicating potential rising risk)	Savings from delaying a proportion of CYP in good health with rising in risk moving into worse health*	500	£355k	£592k
West	0-17 CYP at risk of developing low to mid severity mental health	CYP with mild to moderate mental health disorder with or without single or multiple LTC (as an indication of case finding numbers)	Savings from delaying a proportion CYP at risk of mental health moving into low to mid severity mental health	400	£449k	£748k
North	65+ older people with frailty	Older frail people (65+) identified using the Lancet frailty index	Savings from avoidance of A&E visits and NEL admissions as well as a reduction in NEL occupied bed days (OBDs) for long lengths of stay for 65+ with frailty	1,921	£1.6m	£2.8m
South	65+ older people with frailty	Older frail people (65+) identified using the Lancet frailty index	Savings from avoidance of A&E visits and NEL admissions as well as a reduction in NEL occupied bed days (OBDs) for long lengths of stay for 65+ with frailty	1,240	£1.2m	£2.0m
East	50-64 working age adults at risk of frailty	Adults aged 50-64 with two or more physical LTCs, with or without a mental health condition	Savings from delaying a proportion of adults aged 50-54 who are at risk of frailty becoming frail	1,000	£1.5m	£3.0m
Sub total	-	-	-	**5,061**	**£5.1m**	**£9.1m**

Oldham
Integrated Care Partnership

Quality, equality and equity

Assuring quality, safety and safeguarding

Oldham
Integrated Care Partnership

The national priorities in relation to quality and safety is to:

- Implement the Patient Safety Incident Response Framework (PSIRF)
- Design a locality process for capturing and implementing the learning from the new Learn from Patient Safety Events (LFPSE) to maximise quality improvement across services
- Lead the locality on the understanding of the NHS patient safety syllabus

In addition, there are a range of GM-wide and local actions needed to ensure that health and care delivery is high quality, is safe, and that it safeguards the most vulnerable amongst our population.

These focus areas are outlined in the following slide and will be embedded into all improvement and transformation work.

In relation to local **safeguarding**, there are some specific locality priorities, namely to:

- Align locality safeguarding functions with GM expectation and statutory functions
- Design and implement a domestic abuse process across primary care.
- Design and implement a safeguarding supervision model across quality and CHC
- Promote the self-neglect themed national learning across the locality, to improve lives.

Link to GM missions:
Mission 2 – Helping people stay well and detecting illnesses earlier
Mission 5 – Supporting our workforce and carers

Assuring quality, safety and safeguarding

Oldham
Integrated Care Partnership

In relation to local quality and complex healthcare, the following are priorities for 2024/25.

Link to GM missions:
Mission 2 – Helping people stay well and detecting illnesses earlier
Mission 5 – Supporting our workforce and carers

Quality:

- Embed quality across all governance and reporting frameworks to ensure transparency and equity of services.
- Continue to work with the Local Maternity and Neonatal System (LMNS) to implement the three-year maternity delivery plan and ensure women and families voices are heard.
- Improve the engagement of patients and families across locality services in relation to incident responses.

Complex healthcare:

- Ensure processes are effective and backlogs are kept to a minimum, in line with national targets
- Enhance partnership working in relation to complex care
- Design and implement a personal health budget (PHB) audit process, making improvements in relation to personal health budgets
- Review and implement an updated D2A process
- Design a CHC data profile which gives a weekly overview of CHC patient activity and demand.
- Raise the profile of jointly funded packages and empower commissioning nurses in decision making.

Reducing health inequalities

Oldham
Integrated Care Partnership

As per the national NHS priorities, we will continue to address health inequalities and deliver on the Core20PLUS5 approach, for adults and children and young people.

As linked to The Oldham Plan and broader social value and anchor institutions work, wherever possible this plan, and its associated delivery programme, workstreams and enablers, will support opportunities around wealth building as centred around health and care employment opportunities.

The plan will also have due regard to, and alignment with, the 2024/25 health inequalities action plan, which is overseen by Oldham Health and Wellbeing Board. Those actions where there needs to be a direct oversight of delivery by Oldham Integrated Care Partnership will be built into the Board Assurance Framework, and the actions will also be embedded into the workstreams and all delivery actions. This will include building in an 'inclusion health' checklist to local health and care decision-making.

This plan and the delivery programme within has been designed to have due regard to the NHS Major Conditions Strategy. This strategy aims to be a comprehensive approach to addressing ill-health and early mortality, tackling health disparities to narrow the gaps between the highest and lowest rates of healthy life expectancy.

The major conditions covered under this framework, that are considered to contribute to more years for people in ill health, are:

- Mental health
- Cancer
- Dementia
- Cardio-vascular disease
- Chronic respiratory disease
- Musculoskeletal disorders

Link to GM missions:
Mission 2 – Helping people stay well and detecting illnesses earlier
Mission 5 – Supporting our workforce and carers

Reducing health inequalities

Oldham
Integrated Care Partnership

The overall Health and Wellbeing Board health inequalities action plan features below, with the focus areas for Oldham Integrated Care Partnership in terms of oversight and delivery highlighted in green:

To develop an accountable structure where SMART action plans track weight, physical activity and oral health (0-5yrs) measures.	a) Establish a long-term vision for embedding the prevention framework across the Oldham system and b) Identify a medium to long term investment plan for social prescribing.	Have a consistent approach across the system that aids self-help and self-care, with joined up directories of services.	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.	Increase capacity for, and equity of access to, addiction services, including developing dual diagnosis pathways.
Provide workforce education sessions to increase utilisation of the referral portal from EMIS/ elemental and capture the activity data for further interrogation.	Collect and report on primary care data on referrals into social and employment support to target improvements in uptake.	Maximise funds that residents are entitled to that will support all elements of preventive ill health through to acute or chronic health conditions	Implementation of the minor ailment scheme.	Agree a system wide approach to population health management that uses both data and intelligence to prioritise action and that fosters greater collaboration.
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.	Work with Royal Oldham Hospital to review the DNA policy relating to children and young people, with specific focus on those that are in Care.	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.	a) To ensure robust data on vaccination programmes, with a particular focus on gaining intelligence on MMR vaccination rate by inclusion health groups e.g. Roma community. b) Collect robust data on cancer by stage and by cancer type, and uptake of screening through inclusion health cohorts.	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.

Oldham
Integrated Care Partnership

Delivery programme

Organising our delivery programme

Oldham
Integrated Care Partnership

This section outlines our overall delivery programme for the 2024/25 year, and the workstreams contained within.

The workstream areas within the delivery programme are:

1. **Children and young people health integration**
2. **Community services, out of hospital and elective care (scheduled care)**
3. **Mental health, learning disabilities and autism**
4. **Patient flow, urgent and emergency care (unscheduled care)**
5. **Population health management and place-based integration**

Each workstream section outlines the priorities and plans for the year ahead.

This plan shows how these areas, plus a range of other enabling and priority areas, align to the NHS Greater Manchester 'six missions', and have due regard to the overall national NHS 2024/25 planning priorities of:

- Maintaining a collective focus on the overall quality and safety of services, with a particular focus on maternity and neonatal and reducing health inequalities in line with the Core20PLUS5 approach (outlining fully in our five-year strategy)
- Improving ambulance response and A&E waiting times by supporting admission avoidance and hospital discharge and maintaining the increased acute bed and ambulance service capacity committed to across GM
- Reducing elective long waits and improving performance against the core cancer and diagnostics standards
- Making it easier for people to access community and primary care services, particularly general practice and dentistry
- Improving access to mental health services so that more people of all ages receive the treatment they need
- Improving staff experience, retention and attendance

Following this section key enabler areas are also highlighted, covering finance, estates, digital, workforce, engagement and communications.

1. Children and young people health integration

Link to GM missions:
Mission 1 – Strengthening our communities
Mission 4 - Recovering core NHS and care services

Oldham
Integrated Care Partnership

Overview

This workstream oversees the improvement journey for the Children and Young People's services prioritised for change in Oldham as well as developing a successful and collaborative partnership. The purpose of this workstream is to provide oversight and direction to all aspects of children's transformation and improvement as well as supporting those programmes led by our partners.

The workstream has identified 4 programme areas for improvement:

- Joint Children's Commissioning and integration improvements
- Improvements to Speech, Language and Communication Needs
- Enhanced CYP Mental Health and Wellbeing Services
- Community Paediatrics Transformation *(supporting the Community Services workstream)*

The redesign work will be specified for and centred around the individual needs of the borough's five neighbourhoods. Population Health Management Principles form a key driver for change within each programme area and will inform any new delivery model through pilot-based approaches.

It is clear to both locality and provider colleagues that there are no extra funding mechanisms to improve services and that all redesign work will be within the financial envelope that each service sits. However, our approach will be to make best use of funds and where rebalance of funding can be achieved to enhance and improve outcomes then we will move forward at pace to implement this.

Following a Local Area inspection of Oldham's SEND Services in June 2023 that found systemic failings the local partnership has responded well and has begun the hard work of delivering improvements together. However, a key lesson from the post inspection response has been for the partnership to understand that responsibility never lies with one provider or one service. The SaLT provider is not solely responsible for the unacceptable waiting times for example, instead the lack of a balanced system of provision that either meets need in a school-based setting or better family support to prevent escalation of need plays its part too.

It is imperative, therefore, that any transformation work undertaken in one part of the system is aligned to, understood and complemented by changes elsewhere. As such, this workstream has utilised the SEND and Inclusion Improvement Programme (S&IIP) for aspects if its own work. The SLCN and Joint Commissioning steering groups within the S&IIP will be the drivers for change within this workstream, limiting duplication of work and ensuring a partnership approach to change.

For those areas of transformation not able to be overseen elsewhere, then we have established a Children and Young People's Transformation Oversight Board as well as the creation of a CYP Mental Health Locality Board that reports through existing all age and Greater Manchester governance. The transformation work is underpinned by robust delivery plans and a programme tracker that can readily report into relevant partners and meetings as required.

1. Children and young people health integration

Link to GM missions:
Mission 1 – Strengthening our communities
Mission 4 - Recovering core NHS and care services

Oldham
Integrated Care Partnership

National priorities

- Reduce 52 week waits for access to children's community services.
- Ensure the plans for the recovery of core NHS services reflects the needs of children and young people.
- Increase the number of children and young people able to access mental health service (345,000 additional when compared to 2019) – *also reflected in mental health workstream.*
- Increase vaccination uptake for children and young people towards World Health Organisation recommended levels – *also reflected in the population health management and PBI workstream.*
- Continue to address health inequalities (Core20PLUS5) for children and young people .
- *It is acknowledged that all of the national priorities outlined in this plan are 'all age' and will ensure that children and young people are considered.*

Local priorities

- Introduce new governance arrangements for Children and Young People's Commissioning and for a SEND Local Inclusion Partnership.
- Reduce the number of Children and Young People on the waiting list for a Speech and Language service.
- Deliver a new model of delivery for Speech. Language and Communication Needs that delivers longest waiting time reductions and greater schools-based support.
- Co-production of an Oldham Children and Young People's Mental Health and Wellbeing Strategic Plan.
- Reduce the numbers of bespoke joint funded packages of care for Children and Young People.
- Deliver Oldham CAMHS provision up to the age of 18.
- Increase completion of ASD and ADHD assessments.
- Achieve >95% coverage with 2 doses of MMR vaccine in children and young people up to 19 years.

1. Children and young people health integration

Link to GM missions:
Mission 1 – Strengthening our communities
Mission 4 - Recovering core NHS and care services

Oldham
Integrated Care Partnership

Solutions and actions

The Children and Young People's system needs to be a truly collaborative and partnership one, with various pressures and governance arrangements understood by all partners. Locality solutions also need to support the work being undertaken at GM level as part of the Children's Forward Plan programme.

The following actions need to be supported by either investment in or rebalance of funding towards the identified services and desired outcomes. We are currently funding too much at the higher complexity of need in all of our children's health services and so we need to work with finance and contracting colleagues to support transformation solutions.

Integration and Partnerships

- Appoint a dedicated Associate Director for Children's Transformation to work with partners and providers
- Appoint dedicated programme resource for CYP Mental Health and Wellbeing to work with partners and providers.
- Create a new Children's Transformation Oversight Board
- Ensure that the work delivered in locality is reported into the GM SEND Oversight Group as well as being informed by GM level programmes of change.
- Develop and embed an Oldham SEND Local Inclusion Partnership that works together on improvements and understands the co-dependencies and pressures of each partner.
- Develop and implement an integrated commissioning system through all levels from case panels, joint commissioning groups to ICP Board.

Children and Young People's Mental Health and Wellbeing

- Research and compile all Mental Health services in Oldham and produce this as an iTHRIVE directory.
- Ensure the iTHRIVE directory is in an accessible format to parent carers SENCoS and practitioners
- Commission new capacity to complete ASD and ADHD assessment for the16-18 age range.
- Commit new recurrent funding for CAMHS clinical capacity to increase the age range of support.
- Commission funding for a dedicated CAMHS practitioner to support young people within the Youth Justice System.
- Streamline the Neurodevelopment referral pathway

Speech, Language and Communication (SLC) Needs

- Produce and implement a SaLT recovery plan that is jointly funded by both the ICB and Local Authority.
- Deliver the Early Language Support for Every Child (ELSEC) programme
- Understand and embed the Balanced System programme within our own new delivery models.
- Introduction of Cluster working and Link Therapists within mainstream primary and secondary schools
- Deliver a Business Case for a new SLCN delivery model in Oldham by September 2024.

2. Community services, out of hospital and elective care

Link to GM missions:
Mission 1 – Strengthening our communities
Mission 2 – Helping people stay well and detecting illnesses earlier
Mission 4 - Recovering core NHS and care services

Oldham
Integrated Care Partnership

Overview

This workstream oversees the full redesign of community services as informed by all groups, partner organisations and data.

The purpose of this workstream is to provide oversight and direction, and support and leadership to progress the delivery of the commissioning and providing of high quality, all age, community health services for the Oldham locality.

The workstream works with the core purposes set for 'place', which are to:

- 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.

The redesign work will be specified for and centred around the individual needs of the borough's five neighbourhoods.

The current community services are provided under a hosted arrangement by the Northern Care Alliance, however, requires a credible programme plan for service improvements. It is clear to both locality and provider colleagues that there are no extra funding mechanisms to improve services and that all redesign work will be within the financial envelope that community services sit.

The scale and breadth of the community service provision in Oldham is vast, and as such a working group was established who considered financial concerns, clinical issues, patient experience and relevant risks to establish a list of programme priorities. It became clear that an attempt to resolve all areas of concern at once would limit the success of the improvement programme, and as such the group identified key areas of focus.

2. Community services, out of hospital and elective care

Link to GM missions:
Mission 1 – Strengthening our communities
Mission 2 – Helping people stay well and detecting illnesses earlier
Mission 4 - Recovering core NHS and care services

Oldham
Integrated Care Partnership

National priorities

Community services

- Improve community services waiting times, with a focus on reducing long waits.

Elective care

- Eliminate waits of over 65 weeks for elective care as soon as possible and by September 2024 at the latest (except where patients choose to wait longer or in specific specialties).
- Deliver (or exceed) the system specific activity targets, consistent with the national value weighted activity target of 107%.
- Increase the proportion of all outpatient attendances that are for first appointments or follow-up appointments attracting a procedure tariff to 46% across 2024/25.
- Improve patients' experience of choice at point of referral.

Diagnostics

- Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%.

Cancer

- Improve performance against the headline 62-day standard to 70% by March 2025.
- Improve performance against the 28-day Faster Diagnosis Standard to 77% by March 2025 towards the 80% ambition by March 2026.
- Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028.

Maternity, neonatal and women's health

- Continue to implement the Three-year delivery plan for maternity and neonatal services, including making progress towards the national safety ambition and increasing fill rates against funded establishment.
- Establish and develop at least one women's health hub in every ICB by December 2024, working in partnership with local authorities.

Primary Care

- Empowering patients by continuing to roll out tools that they can use to manage their own health and expanding community pharmacy services.
- Implementing Modern General Practice Access (MGPA) so patients know on the day they contact their practice how their request will be managed.
- Build capacity so general practice can offer more appointments from more staff than ever before.
- Cut bureaucracy to give general practice teams more time to focus on their patients' clinical needs.

2. Community services, out of hospital and elective care

Link to GM missions:
Mission 1 – Strengthening our communities
Mission 2 – Helping people stay well and detecting illnesses earlier
Mission 4 - Recovering core NHS and care services

Oldham
Integrated Care Partnership

National priorities: Dermatology

Dermatology

There are more than 4,000 dermatological conditions and around half of people at any time consider they have a problem. Many disorders, such as psoriasis, eczema and acne, interfere with daily life, sleep and the ability to work. Skin cancer is the commonest UK cancer and is doubling every 14 to 15 years, meaning many people seek reassurance about changing moles. Skin infections, including scabies, MRSA, head lice and ringworm, cause outbreaks in hospitals, nursing homes and schools. Dermatology disorders can cause distress due to altered appearance, such as skin colour changes, scarring, altered facial appearance or hair loss, which can all have a profound effect on mental health and quality of life. Serious diseases usually managed by other specialties often first appear in the skin and so may present to dermatologists. The most severe skin disorders are life threatening.

Most of the national priorities for dermatology are the speciality level versions of the elective/cancer ones e.g.

- Eliminate waits of 65+weeks by Sept 24.
- Improve 62 day cancer performance to 70% by March 2025.
- 50% of suspected skin cancer referrals to be seen in a teledermatology clinic.

The Further Faster Dermatology Handbook (GIRFT/NHSE) November 2023 is based on best practice across a number of key metrics, in the ambition to eliminate 52 week waits.

The focus is on:

- Outpatients
- Pre-Appointments
- DNAs
- Activity and Capacity
- Remote Appointments
- PIFU

The focus of the Further Faster work is happening in our Provider Trusts.

We hope that the work being undertaken in GM Transformation will support this i.e:

- Dynamic Referral Templates
- Single Point of Access
- Teledermatology
- Appropriate pathways and care delivery settings/workforce etc

The key objectives for skin as outline (in draft) in the Cancer planning guidance are:

- 50% of SCR referrals to be managed through teledermatology (timeframe June2024 with teledermatology established as BAU by March 2025).
- Investigate, identify and implement recommendations for improvement within priority pathways (gynae, urology, breast and skin). It is the expectation that the pathway analyser will be used to support this process.
- More generally within the guidance is the need to work with providers on plans to manage capacity, factoring in usual seasonal changes eg skin services, bank holidays.

2. Community services, out of hospital and elective care

Link to GM missions:
Mission 1 – Strengthening our communities
Mission 2 – Helping people stay well and detecting illnesses earlier
Mission 4 - Recovering core NHS and care services -

Oldham
Integrated Care Partnership

National priorities: Palliative and End of Life Care (PEoLC)

Delivery of the national workstreams for PEoLC:

- Clinical Excellence – to support outstanding clinical care, based on the best available evidence, to ensure personalised PEoLC for people of all ages in all settings.
- Health Inequalities – reducing health inequalities in PEoLC as part of the national Core20PLUS5 approach.
- Workforce – working with partners to support and maintain a confident, capable and sustainable workforce.
- Commissioning– supporting Integrated Care Boards (ICBs) in their statutory duty to commission personalised, high quality PEoLC within integrated care systems, making optimal, sustainable use of funding.
- Data and Intelligence– establishing a clear pathway for the definition, development and implementation of information standards for PEoLC.

Continue to deliver against the '*Ambitions for PEoLC: A National Framework for Local Action 2021-2026*' which include:

- Ambition 1 – Each person is seen as an individual
- Ambition 2 – Each person gets fair access to care
- Ambition 3 – Maximising comfort and wellbeing
- Ambition 4 – Care is co-ordinated
- Ambition 5 – All staff are prepared to care
- Ambition 6 – Each community is prepared to help.

2. Community services, out of hospital and elective care

Link to GM missions:
Mission 1 – Strengthening our communities
Mission 2 – Helping people stay well and detecting illnesses earlier
Mission 4 - Recovering core NHS and care services -

Oldham
Integrated Care Partnership

Local priorities: Cancer

PCN based Early Diagnosis schemes – we have developed and are implementing a comprehensive strategy to meet the 75% early diagnosis ambition in the NHS Long Term Plan. The six pillars of this strategy seek to: drive earlier presentation; harness the reach of primary care; streamline referrals; expand case finding; improve screening uptake; and harness innovation.

Local initiatives and enablers – there will be an increasing emphasis on Alliances working with Oldham to produce a plan identifying priority local actions to increase early diagnosis in their populations. The focus should be on tumour sites with lower rates of early diagnosis. This work should align with wider cross cutting objectives to improve referral practice in primary care, support deprived populations and consider the role of local levers and incentives.

NHS-wide programmes – we continue to roll out evidence-based interventions that we are confident will improve early diagnosis. For Targeted Lung Health Checks and Liver, this will involve the expansion of existing plans to larger cohorts of the population. Work is underway to launch in Oldham in the Summer. We will begin to pilot interventions like the lowering of the FIT threshold in the NHS Bowel Cancer Screening programme. There are plans to see a new national workstream dedicated to driving up earlier diagnosis rates for pancreatic cancer, and we will initiate reviews of bladder and oesophageal cancer.

Tele-dermatology – working with the GM team this will be reviewed and relaunched if required. Oldham already have a robust tele-dermatology service through the wider skin provider and are working alongside other localities to ensure it is optimised and possible cancer diagnosis are recognised without delay.

Dermatology – work underway to review and improve the specification of clinical standards in the community to provide equity across all GM localities. Cancer pathways will be improved across all levels of care working with hospitals when referrals required.

Other key priorities:

- Key cancer health inequalities in Oldham will be identified engaging with people and communities to understand the key drivers causing inequalities and help design and develop approaches to overcome those barriers.
- Improve data monitoring to understand who is engaging with local services and who is not.
- Work with the lead for Health Inequalities to provide strategic oversight and support Participate in Health Inequalities forums to better enable sharing of resources and practical cross-Alliance support to tackling health inequalities.
- Work with the GM lead to establish the “Live Well with Cancer” programme in Oldham- Map and join up different forms of care and support already available or in development for people living with cancer in Oldham.

2. Community services, out of hospital and elective care

Link to GM missions:
Mission 1 – Strengthening our communities
Mission 2 – Helping people stay well and detecting illnesses earlier
Mission 4 - Recovering core NHS and care services

Oldham
Integrated Care Partnership

Local priorities: Elective care, diagnostics and long-term conditions

- Identify and screen at least 75% of people at risk of COPD by 31.03.2025.
- Identify and screen at least 75% of people at risk of diabetes by 31.03.2025.
- Target patients aged 40 years plus who have no record of BP, chol or BMI in the last 3 years for NHS Health Checks.
- Increase the proportion of people at risk of diabetes completing engaging with prevention programmes.
- Ensure same day urgent access to General Practice where clinically warranted.
- Agree an appropriate response at first contact for all non-urgent appointments, ensuring all patients are seen within 2 weeks.
- Develop and implement GM standards for Inclusion health and agree sustainable funding options (commissioning for Inclusion) and investment in prevention (for all adult and children CORE20PLUS5 pathways).
- Improve the early detection and management of risk factors for illness (focusing on CORE20+5 populations and conditions, and including the VCFSE sector as a delivery partner), for example, by increasing the uptake, reach, quality and impact of Learning Disability, Severe Mental Illness and NHS health checks across GM.
- Increase the proportion of people with diabetes receiving an annual review including 8 key care processes.
- Increase the proportion of children and young people receiving a full asthma review at least annually.
- Increase the proportion of people with COPD receiving a comprehensive review at least annually.
- Improve the management of long term health conditions (with a particular focus on CORE20+5 populations and conditions) including: • Improving the diagnosis of COPD and asthma by improving access to quality assured spirometry at a neighbourhood level.
- Work in collaboration with local authorities and clinical providers to tackle digital exclusion, collating and building on existing work done across localities and PCNs.
- Deliver a comprehensive plan to create a sustainable workforce for the long term including initiatives to grow our own workforce.
- Implement initiatives relating to the retention of our workforce.
- Deliver a comprehensive development, education and support offer.

2. Community services, out of hospital and elective care

Link to GM missions:
Mission 1 – Strengthening our communities
Mission 2 – Helping people stay well and detecting illnesses earlier
Mission 4 - Recovering core NHS and care services

Oldham
Integrated Care Partnership

Local priorities: Elective care, diagnostics and long-term conditions

CVD Diagnosis and Prevention – Quality Incentive schemes have delivered a +70% increase in NDPP Milestone 1 performance. We will continue to drive quality engagement with prevention and early intervention programmes. NHS Health checks have good uptake in Oldham and we will continue to drive quality completion and onward referral for patients who are eligible by working with practices. We are building on the quality agenda in primary care to optimise outcomes, applying the successes to all areas of CVD prevention and diagnosis.

Respiratory – Maintain the virtual ward model with increased deflection performance, aligned with the GM wider respiratory programme. A&G uptake to increase and paediatric response via clinic offer. Increased diagnosis rates to proactively intervene in respiratory illness management, especially focused on the winter pressure by early activation of symptom management.

Community Services – Collaborative working with community services will focus delivery on core deliverables of referral quality, system utilisation of advice & guidance, diagnostic capabilities and service retention. The way we work with community services needs to be reflective of the desired outcomes. Tackling referral culture by strengthening A&G to practices and developing education input to increase confidence. Social prescribing and increased patient activation to improve uptake of non-clinical services and prevention offers.

Eye / foot screening (diabetes) – Screening services are reduced in terms of estate/clinics, we are working with providers and estate to widen the offer and reduce the impact of condensed screening. Risks around sight loss and amputation have increased, need to be brought back down.

Diabetes – Ongoing work to transform the quality and efficacy of diabetes care and education in Oldham. Working with the GM taskforce and contributing to the development of wider education offers remains a priority as we seek to support our wider communities with meaningful access to diabetes education, including those with pre-diabetic levels to reduce the conversion. We remain dedicated to interventions including weight loss, education in alternative languages and reviewing the reach of our education services beyond newly diagnosed and 5 year.

Integration – Continue to work on closer alignment of services, pathways through primary care and the interface of A&G/onward referral and step down from specialist services. Focus on the education and shared care aspects of integration of services to reduce overall demand. This will be supported by greater utilisation of onward referral to third sector services at points such as NHS Health Check.

Other Key Priorities:

- Locality representation on all GM LTC/ community boards.
- Establish local CVD and Cardio groups to pick up the locality actions from the wider GM work.
- Re-invigorate VCSE interaction with the working group to support wider system development.
- Health inequalities/ Proactive service design to target reductions.

2. Community services, out of hospital and elective care

Link to GM missions:
Mission 1 – Strengthening our communities
Mission 2 – Helping people stay well and detecting illnesses earlier
Mission 4 - Recovering core NHS and care services -

Oldham
Integrated Care Partnership

Local priorities: Dermatology

The aim of the Greater Manchester Dermatology Transformation Programme is to develop a GM model of care to support current capacity and demand issues and deliver sustainable, modern high quality dermatology services. This included a gap analysis being undertaken to identify the capabilities within each locality in Greater Manchester to support a teledermatology pathway.

Drivers for Change:

- Sustainability
- Around 50% population affected by skin disease, +4000 conditions, 23-33% of the population at any time has a skin disease that would benefit from medical care
- Increasing demand
- Referral Variation
- Fragmented Service provision
- Workforce
- Getting it Right First Time (GIRFT)
- Variance in training/ education & knowledge
- GM financial deficit
- Operational Planning - priority

The front-end of the transformation work has been agreed/supported by the GM sustainability team and the work is aligned to the following core principles.

- Stage 1 of the Model of Care incorporates the following core principles:
  - ❖ Optimal management of the patient in primary care.
  - ❖ Centralised referral triage with specialist advice and where clinically indicated teledermatology.
  - ❖ Triage will stream the patient into the most appropriate setting for their disease severity – this may be onward referral to community, secondary or tertiary care, or back to the referrer with advice and a treatment plan.
  - ❖ Strengthen the current community offer where there is a gap in service provision.
- Work is underway to review and improve the specification of clinical standards in the community to provide equity across all localities. This will in turn improve cancer pathways across all levels of care working with hospitals when referrals are required.

Tele-dermatology – working with the GM team this will be reviewed and relaunched if required. Oldham already have a robust tele-dermatology service through the wider skin provider and are working alongside other localities to ensure it is optimised and possible cancer diagnosis are recognised without delay.

The provider for skin services in Oldham is challenged like other dermatology services across GM. Capacity is full for new patients with a long waiting list and there are a large number of patients waiting for allocation of a follow up appointment.

Oldham is the only GM service that provides an output for 2ww cancer referrals and at present is managing to sustain this, however this is at the cost of all other pathways. Utilising the help from the Sustainability team, the aim to reduce the number of patients waiting to be seen.

2. Community services, out of hospital and elective care

Link to GM missions:
Mission 1 – Strengthening our communities
Mission 2 – Helping people stay well and detecting illnesses earlier
Mission 4 - Recovering core NHS and care services -

Oldham
Integrated Care Partnership

Local priorities: Palliative and End of Life Care (PEoLC)

- To ensure commissioning arrangements to support PEoLC provision are in place to provide seamless provision of care and are influenced by local population-based needs assessment.
- Increase in the number of people identified with PEoLC need/in the last year of life.
- Increase the number of people with an EPaCCS (Electronic Palliative Care Co-ordination System) record - EPaCCS is a tool to electronically share information about patients in the final 12 months of life.
- Increase digital sharing of PEoLC information through the GM Care Record.
- Increase the number of people who die at their chosen location.
- Increase the opportunity for personalised care conversations and future care planning.
- Involving, supporting and caring for those caring for those important to the individual to see an increase in carers assessments and support plans; with every family having timely access to practical support, including social prescribing.
- Improve data and intelligence to support effective commissioning of PEoLC across the system.
- Increase in the knowledge, skills and confidence in staff in PEoLC.
- Address workforce planning to ensure an available workforce with the right skills to support the delivery of 24 hours 7-day services in PEoLC.
- Address unwarranted variation and inequalities in PEoLC provision.

2. Community services, out of hospital and elective care

Link to GM missions:
Mission 1 – Strengthening our communities
Mission 2 – Helping people stay well and detecting illnesses earlier
Mission 4 - Recovering core NHS and care services -

Oldham
Integrated Care Partnership

Local priorities: Maternity, neonatal and women's services

- Continue to deliver full range of maternity services.
- Continue to deliver Maternity Improvement Programme to provide high quality, safe maternity care. This incorporates the requirements of the national three year delivery plan for maternity and neonatal services.
- Support improvements in safety outcomes and the implementation of the Maternity Safety Package.
- Support delivery of the new Maternity & Neonatal Voices Partnership model.
- Implement one Women's Health hub in Oldham, starting with North PCN.

2. Community services, out of hospital and elective care

Link to GM missions:
Mission 1 – Strengthening our communities
Mission 2 – Helping people stay well and detecting illnesses earlier
Mission 4 - Recovering core NHS and care services

Oldham
Integrated Care Partnership

Solutions and actions: Cancer

- Support providers to investigate, identify and implement recommendations for improvement within priority pathways (gynaecology, urology, breast and skin), including specific pathway changes relating to; unexpected bleeding post HRT, risk stratification on the prostate pathway, and breast pain.
- Lower GI (at least 80% of referrals accompanied by a FIT result).
- Continue to see FIT fully implemented in line with clinical guidance across all Cancer Alliances, ensuring it is being used to inform use of colonoscopy (particularly in areas piloting reductions in the screening FIT threshold).
- Support the age extension of the NHS bowel cancer screening programme, working with ICBs, screening providers and commissioners to ensure sufficient colonoscopy capacity is available.
- Work with providers to put in place robust call and recall arrangements and the required scanning capacity to improve access to liver surveillance.
- Develop robust plans to review and improve referral practice in primary care.
- Skin (accelerate the adoption of tele-dermatology).
- Support the retention and onward referrals of patients in the NHS-Galleri Clinical trial. Put in place the processes required for the pilot programme and deliver the appropriate number of tests.
- Urological cancers (continued implementation of nurse-led biopsy and implementation of risk-stratification tools in prostate cancer).

Support the delivery of NHS-wide early diagnosis programmes:

- Targeted lung health checks (TLHC).
- Ensure sufficient CT-guided biopsy.
- Endobronchial ultrasound (EBUS) and treatment capacity to diagnose and treat people identified with cancer.
- Work with Cancer Alliances and providers to implement a regular demand and capacity assessment of systemic anti-cancer therapy services and ensure that, as part of provider multi-year capital plans, they have replacement plans for radiotherapy equipment.
- Develop and lead on local actions to improve early diagnosis, with a particular focus on tumour sites where the local system lags behind national averages, and among deprived communities with lower rates of early diagnosis.

Treatment and Care - providing the best possible treatment, patient experience of care and quality of life, both during and beyond treatment, and for those living with cancer:

- Implement national priority recommendations from clinical audit/GIRFT reports to reduce variation in treatment.
- Fully meet the commitments on personalised care interventions and Personalised Stratified Follow Up, as set out in the NHS Long Term Plan.

2. Community services, out of hospital and elective care

Link to GM missions:
Mission 1 – Strengthening our communities
Mission 2 – Helping people stay well and detecting illnesses earlier
Mission 4 - Recovering core NHS and care services

Oldham
Integrated Care Partnership

Solutions and actions: Cancer

- Improve productivity in priority pathways.
- Lower GI (at least 80% of referrals accompanied by a FIT result).
- Skin (accelerate the adoption of tele-dermatology).
- Urological cancers (continued implementation of nurse-led biopsy and implementation of risk-stratification tools in prostate cancer).
- Establish, where not already in place.
- Breast pain pathways.
- Unexpected bleeding pathways for women receiving HRT.
- Support the delivery of NHS-wide early diagnosis programmes.
- Targeted lung health checks (TLHC).
- Ensure sufficient CT-guided biopsy.
- Endobronchial ultrasound (EBUS) and treatment capacity to diagnose and treat people identified with cancer.
- Phlebotomy capacity to support implementation of the Multi-Cancer Blood Test Programme (Galleri) in participating areas.
- Work with Cancer Alliances and providers to implement a regular demand and capacity assessment of systemic anti-cancer therapy services and ensure that, as part of provider multi-year capital plans, they have replacement plans for radiotherapy equipment.

2. Community services, out of hospital and elective care

Link to GM missions:
Mission 1 – Strengthening our communities
Mission 2 – Helping people stay well and detecting illnesses earlier
Mission 4 - Recovering core NHS and care services

Oldham
Integrated Care Partnership

Solutions and actions: Elective care and diagnostics

The Elective Care System Board and Cancer Alliance are pivotal to the recovery and reform of elective care and cancer services across the ICB footprint, with the locality linking closely to ensure localised implementation to drive improvements in service provision for the population of Oldham.

Elective Care

Outpatient Excellence Programme (OEP) - Working to a single Four Locality Partnership Programme to implement the OEP including widening of PIFU, Remote Monitoring etc.

Referral Management and Patient Choice- Localised implementation of Patient Choice, Advice and Guidance, and Local Quality of referrals programme.

Non- NHS and Independent Sector Utilisation.

Speciality Specific:
Dermatology- recovery of Oldham Total Skin Service, with a view to procurement of service aligned to the GM Dermatology Programme if required.

Diagnostics

Continue to increase productivity and utilisation of the Oldham CDC.

Commission a significant expansion in GP direct access, ensuring GPs do not need to refer patients into secondary care because they cannot access core diagnostics directly, including the Vague Symptoms pathways.

Focus wider new capacity on specialties with significant waiting lists, seeking to implement one stop diagnostic testing ahead of first outpatient appointments.

Long-term conditions

Solutions in relation to improving lives and enhancing preventative approaches for those with long-term conditions will be delivered through the population health management / place-based integration workstream.

2. Community services, out of hospital and elective care

Link to GM missions:
Mission 1 – Strengthening our communities
Mission 2 – Helping people stay well and detecting illnesses earlier
Mission 4 - Recovering core NHS and care services

Oldham
Integrated Care Partnership

Solutions and actions: Dermatology

- To ensure teledermatology is working as efficiently as it should be.
- Provide administrative and clinical validation for all those on the waiting list.
- Discharge appropriate patients and give them a choice of PIFU.
- We need to ensure all data is made available both in locality and within GM to enable the reporting function to work correctly.
- Review clinic slots, patient ratio etc.
- Provide trajectories through the year.
- Review all pathways, working with GM's new specification and clinical map to ensure patients are seen in the right place.
- Ensure all performance reports are written with the input of performance leads within GM and the provider.
- Ensure all revised KPI's especially Cancer ones are recorded and delivering to standard.
- All cancer patients referred and transferred onto secondary care are done so in a timely manner without delay.
- Text messages to patients waiting to see if they would still like an appointment.
- Review of routine and follow up appointments.
- Provision of a new educational resource pack for GP's so appropriate referrals can be made.
- The service is to provide a full breakdown of activity for each dermatology pathway with further information on practice data.
- Potentially there will be a requirement to reduce the scope of the service in order to ensure best use of resources available.

These actions will support the improvement of the waiting list trajectory once they are profiled in which should give the locality the assurance that there is a continued reduction of patients who are overdue follow ups or waiting for a new appointment.

If the service are unable to offer robust assurances in the clearance of the current backlog then we will progress discussions to halt elements of routine service until there is a time in which we have a more stable backlog position.

We will continue to work with GM Sustainability Services to ensure there continues to be a dermatology service provided for Oldham patients.

2. Community services, out of hospital and elective care

Link to GM missions:
Mission 1 – Strengthening our communities
Mission 2 – Helping people stay well and detecting illnesses earlier
Mission 4 - Recovering core NHS and care services

Oldham
Integrated Care Partnership

Solutions and actions: Palliative and End of Life Care (PEoLC)

- Support GM in the delivery of its PEoLC ICB Statutory responsibilities.
- Development of a locality PEoLC Strategy.
- Completion of the *Commissioning and Investment Framework and Service Specification Assessment Tool* (in relation to PEoLC provision).
- Implement action plan identified through the *'Self-Assessment Tool: Ambitions for PEoLC'*.
- Support full roll-out in the locality of the Statutory Medical Examiner (ME) system which sees MEs providing independent scrutiny of all deaths in the community (not requiring a coroner review).
- Review of the night-sitting service for EoLC patients to ensure the service is fully integrated across the locality and those most in need are accessing the service.
- Contribute to the hospice review being undertaken across GM and implement the subsequent action plan.
- Reinvigorate the Electronic Palliative Care Co-ordination System (EPaCCS) Working Group and continue to embed the use of EPaCCS across the locality to ensure all care settings are utilising EPaCCS.
- Continue to utilise technology to embed the advancements in care that support PEoLC patients, i.e. virtual wards/consultation, remote monitoring equipment etc.
- Support GM/locality in exploring the availability of workforce to support 24/7 specialist palliative care (SPC).
- Identification and Proactive Care and Support Planning (PCSP): Support locality to establish and maintain a register of all patients in need of palliative care/support to ensure an increase is seen in the number of people identified with PEoLC. Adoption of the EARLY toolkit will support primary care to help identify patients more reliably. Once identified, Advance Care Planning (ACP) discussions can commence with salient information shared with all services, using EPaCCS.
- Support GM/locality in the work to adopt the use of the Carers Support Needs Assessment Tool (CSNAT) to assist in carers being supported for people at EoL.
- Stocktake required on utilisation and data captured via IPOS (Integrated Palliative Care Outcome Scale) Community of Practice - its use across all providers will assist in analysing person-centred outcome measures to ensure fair access to care.
- In conjunction with GM, identify requirement across the locality for professionals providing care for individuals with life-limiting illnesses to receive specific training and education in PEoLC and in communication skills.
- Support partners to continue to develop and deliver education in Care Homes relating to PEoLC and increase the prevalence of Advance Care Planning (ACP).
- Analyse the data dashboards captured on the GM hub and ensure locality is routinely collecting and reporting on PEoLC activity to inform ongoing quality improvement work, including that of equal access and meeting the needs of diverse groups.

2. Community services, out of hospital and elective care

Link to GM missions:
Mission 1 – Strengthening our communities
Mission 2 – Helping people stay well and detecting illnesses earlier
Mission 4 - Recovering core NHS and care services

Oldham
Integrated Care Partnership

Solutions and actions: Maternity, neonatal and women's health

- Continue to work with the LMNS, providers and wider partners to implement NCA's Maternity Improvement Programme.
- Work with providers and wider partners to implement Maternity Safety Package.
- North PCN to deliver the first Women's Health Hub with the initial focus on Long Acting Reversible Contraception for 2024/25. Further developments to be considered once funding has been confirmed.

3. Mental health, learning disabilities and autism

Link to GM missions:
Mission 1 – Strengthening our communities
Mission 4 - Recovering core NHS and care services

Oldham
Integrated Care Partnership

Overview

Place-based transformation in community mental health is a key priority for the Oldham locality.

- Shifting to genuine partnership working and a 'no wrong front door' approach.
- Removal of thresholds for referral, acceptance and discharge to seamless, continuous responsive care.
- Dissolving of barriers between:
    - Mental health and physical health.
    - Health, social care, VCSE organisations and local communities.
    - Primary and secondary care, to deliver integrated, personalised, place-based and well-coordinated care.
- Integrated approach to assessment with reduced need to 'keep telling your story' to different members and teams within community mental health.
- Person-centred approach according to the needs and complexity of the individual – ranging from brief initial contact/intervention to more comprehensive, multidisciplinary care that is centred around an individual's needs.
- Ensuring that people who use services are active participants when it comes to design, delivery, improvement and governance.
- Retain and strengthen the specialist support offer.

3. Mental health, learning disabilities and autism

Link to GM missions:
Mission 1 – Strengthening our communities
Mission 4 - Recovering core NHS and care services

Oldham
Integrated Care Partnership

National priorities

Mental health

- Improve patient flow and work towards eliminating inappropriate out of area placements.
- Increase the number of people accessing transformed models of adult community mental health (to 400,000), perinatal mental health (to 66,000) and children and young people services (345,000 additional CYP aged 0–25 compared to 2019).
- Increase the number of adults and older adults completing a course of treatment for anxiety and depression via NHS Talking Therapies to 700,000, with at least 67% achieving reliable improvement and 48% reliable recovery.
- Reduce inequalities by working towards 75% of people with severe mental illness receiving a full annual physical health check, with at least 60% receiving one by March 2025.
- Improve quality of life, effectiveness of treatment, and care for people with dementia by increasing the dementia diagnosis rate to 66.7% by March 2025.

People with a learning disability and autistic people

- Ensure 75% of people aged 14 and over on GP learning disability registers receive an annual health check in the year to 31 March 2025.
- Reduce reliance on mental health inpatient care for people with a learning disability and autistic people, to the target of no more than 30 adults or 12–15 under 18s for every 1 million population.

Local priorities

Mental health

- Improve patient flow and work towards eliminating inappropriate out of area placements through stronger place-based community teams, crisis alternatives, and discharge models of care.
- Increase the number of people accessing transformed models of adult community mental health through a fully redesigned community offer, built around neighbourhoods, and integrated with planned place-based hubs.
- Deliver a review of the whole psychological offer in Oldham in line with Trust priorities, across primary and secondary care psychology provision, to improve pathways for people who would benefit from this support.
- Continue to work with primary care on improving SMI physical health checks.
- Deliver the Oldham dementia strategy including a review of the post-diagnosis dementia support offer.
- Commission a service for ASD and ADHD diagnosis and treatment in line with GM and support the move to a GM model to ensure people with co-morbid mental health and/or complex needs are supported.

People with a learning disability and autistic people

- Deliver the LD strategy for ‘good health’.
- Continue to ensure people with LA and/or autism are supported to live locally and in the community, outside of inpatient settings, where appropriate.

3. Mental health, learning disabilities and autism

Link to GM missions:
Mission 1 – Strengthening our communities
Mission 4 - Recovering core NHS and care services

Oldham
Integrated Care Partnership

Actions / solutions

- Delivery against the key priorities with oversight of the Oldham Mental Health Locality Board.
- Review Oldham performance metrics for 24/25 and develop improvement plans where achievable.
- Deliver system efficiencies in mental health – high-cost placements, treatment packages and non-commissioned activity.
- Support recommendations of the population health programme of work as part of community mental health transformation.
- Deliver 2024/25 priorities as set out in the LD and Dementia strategies for Oldham.

4. Patient flow, urgent and emergency care

Link to GM missions:
Mission 4 – Recovering core NHS and care services

Oldham
Integrated Care Partnership

Overview

Oldham locality place will continue to deliver our urgent and emergency care offer, improve patient experience and further develop pathways to ensure efficient and effective delivery of services.

The main priority for Oldham will be to ensure effective services and quality patient care is in place to maintain patient flow in and out of the UEC system.

In order to deliver achievements, we will continue system oversight and transformation via the Oldham Urgent Care Delivery Group, and the Patient Flow work programme.

Our objectives to achieve will be:

- Improved performance in A&E wait times
- Improved patient handover times
- Reduction in admissions and LoS
- Reduction in 12hr waits
- Increase in 2hr rapid response provision
- Increase in “step up” activity and virtual ward beds
- Submission of all data sets (CSDS & ECDS)
- Improved data collection and intelligence
- Increase discharges before 5pm
- Increase discharges on pathway 0 & 1
- NRTR target 35 per day
- Increase SDEC activity

4. Patient flow, urgent and emergency care

Link to GM missions:
Mission 4 – Recovering core NHS and care services

Oldham
Integrated Care Partnership

National priorities

• Improve A&E waiting times, compared to 2023/24, with a minimum of 78% of patients seen within 4 hours in March 2025.

• Improve Category 2 ambulance response times to an average of 30 minutes across 2024/25.

Areas to focus from NHSE Operating Plan:

- Maintaining the capacity expansion delivered through 2023/24.

- Increasing the productivity of acute and non-acute services across bedded and non-bedded capacity, improving flow and length of stay, and clinical outcomes.

- Continuing to develop services that shift activity from acute hospital settings to settings outside an acute hospital for patients with unplanned urgent needs, supporting proactive care, admissions avoidance and hospital discharge.

Local priorities

Continue to implement initiatives and guidance outlined in:

- 10 UEC High Impact Initiatives.
- Delivery Plan for Recovering UEC Services.

Continue to contribute towards core population health management capabilities including risk stratification and using joined-up data between primary and secondary care.

Integrate and streamline UEC pathways with a focus on the management of older people with complex needs and frailty.

Provide system-wide overview and support during peak pressure times and support the GM SCC.

4. Patient flow, urgent and emergency care

Link to GM missions:
Mission 4 – Recovering core NHS and care services

Oldham
Integrated Care Partnership

Actions / solutions

- Continued development of front door frailty team.
- Continued refinement of Pre-ED service to maximise UTC provision, including minor injuries and re-direction of patients to more appropriate services.
- Increase utilisation of Consultant Connect and expand to enable paramedics and community services to be able to access.
- Enable direct booking from NHS 111 into primary and community care.
- Develop comprehensive ECDS stream from all urgent care services and support CSDS submission from community services.
- Continue attendance and admission avoidance schemes.
- Lead the system-wide Intermediate Care Services review.
- Work alongside NWAS and acute colleagues in order to increase direct pathways for crews and alternative pathways to conveyance.
- Utilise and manage UEC Recovery funding for both additional capacity and discharge support efficiently and effectively.
- Support secondary-Primary Care Interface development.
- Work towards a single point of access for all community urgent care services.
- Increase discharges and maintain low NRTR utilising the Discharge Hub and Integrated discharge team.
- Further enhance integrated working between NHS, LA and voluntary sector to support vulnerable patients being discharged to own homes.
- Participate and contribute to 4 pan-locality priorities across NCA footprint to provide more effective services for patients.
- Work with LA to ensure appropriate capacity available in community beds in order to maintain flow.
- Successfully procure 2025 Urgent Care Hub and Pre-ED service.

5. Population health management and place-based integration

Link to GM missions:
Mission 1 – Strengthening our communities
Mission 2 – Helping people stay well and detecting illnesses earlier

Oldham
Integrated Care Partnership

National priorities

- Continue to improve the experience of access to primary care, including by supporting general practice to ensure that everyone who needs an appointment with their GP practice gets one within 2 weeks and those who contact their practice urgently are assessed the same or next day according to clinical need.
- Increase dental activity by implementing the plan to recover and reform NHS dentistry, improving units of dental activity (UDAs) towards pre-pandemic levels.
- Increase the % of patients with hypertension treated according to NICE guidance to 80% by March 2025.
- Increase the percentage of patients aged 25–84 years with a CVD risk score greater than 20% on lipid lowering therapies to 65% by March 2025.
- Increase vaccination uptake for children and young people year on year towards WHO recommended levels.
- Expand evidenced-based approaches to prevention, self-care and the effective management of long-term conditions.
- Join up care closer to home through integrated neighbourhood teams and place-based arrangements.
- Update plans for the prevention of ill-health and incorporate them in JFPs, with focus on Core20PLUS5 populations and NHSE's high impact interventions for secondary prevention.
- By the end of June 2024, publish joined-up action plans to address health inequalities and implement the Core20PLUS5 approach.
- Develop core population health management capabilities and use joined-up data between primary and secondary care to support the implementation of the proactive care framework.
- Develop local system architecture to support the delivery of JFPs including to support primary care and community organisations to shape integrated neighbourhood teams.

5. Population health management and place-based integration

Link to GM missions:
Mission 1 – Strengthening our communities
Mission 2 – Helping people stay well and detecting illnesses earlier

Oldham
Integrated Care Partnership

Local priorities

- Collaborative approach to the prevention, screening and early identification of CVD, diabetes and COPD.
- Working with system partners to improve the uptake of MMR vaccinations through community engagement in areas of low coverage and with seldom-heard groups.
- Harness existing work across the system to provide personalised care, improve outcomes and promote independence for people living in a care home.
- Each Primary Care Network, (PCN) to identify those patients who do not engage in mainstream health and care or those who are high intensity users of services, often as a result of wider social determinants and produce a multiagency support plan, designed to meet their clinical and broader needs.
- Ensure outreach/ neighbourhood-based activities are in place.
- Implementation of a model designed to find and support those most in need which includes targeted approach to improve outcomes.
- Focus on community-led approaches to health, with a focus on self-care and self-navigation, supported by strong local care coordination.

5. Population health management and place-based integration

Link to GM missions:
Mission 1 – Strengthening our communities
Mission 2 – Helping people stay well and detecting illnesses earlier

Oldham
Integrated Care Partnership

Actions / solutions

We have:

- Co-developed PHM care model, outlining each activity, workforce, settings and additional detail, such as existing material / teams / services that can be leveraged, for each neighbourhood.
- Proposed governance quad for each PHM model, with roles and responsibilities outlined against each lead.
- Identified workforce roles and skills / capabilities identified by neighbourhood teams to deliver PHM model.
- Developed a resource model identifying roles, banding, expected WTE and costs for each PHM model.
- Produced population segmentation based on ADSP.
- Conducted a literature review on why this population group has been chosen in Oldham and can deliver return on investment.
- Calculated total opportunity in healthcare spend reduction over a year (and five years where relevant).
- Calculated total opportunity if model is applied in all neighbourhoods of Oldham.
- Developed an action plan setting out detailed next steps and timelines to successfully implement PHM models, to be reviewed with owners of each action to be identified.
- Co-designed lagging and leading KPI measures to track and monitor outcomes of each PHM model.
- Co-developed principles of working to guide implementation.

We will:

- Establish overall programme governance, with regular scheduled meetings of overall programme leads to discuss progress and raise and mitigate risks.
- Review and refine each neighbourhood's PHM care model alongside resourcing model, and share in relevant fora and boards across locality.
- Develop case for stepped implementation and resources required.
- Identify leads against activities described in delivery plans, detailing next level activities against each domain, with timeframes and risks.
- Set up governance quads and PMO team for each neighbourhood, with identified leads and regular scheduled meetings.
- Identify BI support for Oldham to support data-driven identification of population group, and consider utilising Graphnet which already has patient-level identification and care planning capabilities.
- Confirm KPIs to be tracked and monitor and track outcomes of the programme, considering incentivisation required.
- Continue neighbourhood forum to progress model and its vision, reviewing principles of ways of working to refine into a plan for collaboration.
- Create synthesis on incentivising providers to deliver PHM models.

Oldham
Integrated Care Partnership

Multi-place collaboration

Four Localities Partnership Work Programme 2024/25

Oldham
Integrated Care Partnership

As part of the planning process for 2024/25 we have been sharing priority areas to identify further areas where the FLP can support collaboration across localities and with the NCA We have secured commitment to progress the following areas:

Theme	Status	Scope of work	Delivery / enabler programme alignment
Discharge Integration	Commenced. Bringing forward 'case for change' and supporting business cases in Q4 2023/24	Improving Dementia pathways (admission avoidance, IP care, discharge) and strengths-based approach to IP care and discharge of all older people across the four localities/hospital sites.	Patient flow, urgent and emergency care
Community Estates	Commenced. Scoping opportunities for 2024/25 onwards.	Maximise use of community estate, address high-cost premises, strengthening collective negotiating position with partners, supporting shift of care out of hospital, aligning to locality estates strategies including 'health in the high street'	Community services and out of hospital care
Prescribing	Commenced, Scoping opportunities for 2024/25 onwards.	Identifying opportunities to effectively address prescribing costs across primary and secondary care, focused on prescribing 'waste', 'do not prescribe'/ 'limited clinical value' drugs and switch to cheaper generic drugs	Finance and estates
People	Commenced	Broaden entry routes across the four localities partnership into H&SC to: increase local employment; increase the diversity of our people; reduce vacancy rates; reduce health inequality by purposefully working with communities who face structural inequality	Workforce
Planned Care	New 2024/25	Bringing together locality plans for elective care and developing a single work programme for those that can be most effectively addressed across the footprint, including OP transformation and pathway standardisation	Elective care
Admission Avoidance	New 2024/25	Exploring opportunities to work with NWAS to reduce avoidable ambulance conveyances to hospital sites, focused on improving clinical decision making and availability and utilisation of community alternatives	Patient flow, urgent and emergency care
Community Services	New 2024/25	Address current variation and fragility within NHS community services, focusing on sharing good practice, standardisation of service specifications/pathways and improving quality of data and ability to demonstrate value for money.	Community services and out of hospital care

Oldham
Integrated Care Partnership

Data, insight and intelligence

Data, insight and intelligence overview

Oldham
Integrated Care Partnership

Whilst a wide range of performance indicators will be monitored and made visible to the Partnership on a regular basis, there are some specific and key focus areas for Oldham Integrated Care Partnership to track, both overall and as linked to the delivery workstreams.

These are the indicators that link directly to NHS Greater Manchester's **Mission 4** of 'recovering core NHS and care services', with a potential indirect impact on **Mission 6** of 'achieving financial sustainability'. Some also link to a specific national recovery target, as outlined in the 2024/25 national NHS Planning Guidance.

The indicators are broken down by **oversight**, where there is locality delivery responsibility and/or significant locality contribution needed, and **sight**, where the wider GM-system is responsible for delivering against the indicator, but awareness is important as there will be impacts on our communities and residents.

The indicators are also linked to the relevant delivery workstream(s).

Link to GM missions:
Mission 4 - Recovering core NHS and care services
Mission 6 – Achieving financial stability

Key performance monitoring areas

Oldham
Integrated Care Partnership

OVERSIGHT

Patient flow, urgent and emergency care	• A&E 4-hour performance (78% by March 2025)
Community services, out of hospital and elective care	• Cancers diagnosed at early stage using full registration data – stages 1 and 2 (75% by 2028)
Community services, out of hospital and elective care	• % of hypertension patients who are treated to target as per NICE guidance (80% by March 2025)
Community services, out of hospital and elective care	• % of patients identified as having 20% or greater 10-year risk of CVD are treated with statins (65% by March 2025)
Mental health, learning disabilities and autism	• % of patients aged 14+ with a completed LD health check (75% by March 2025)
Mental health, learning disabilities and autism	• Dementia diagnosis rate aged 65+ (66.7% by March 2025)

SIGHT

Community services, out of hospital and elective care	• Referral to Treatment Time incomplete – 65+week waits (eliminate by September 2024)
Community services, out of hospital and elective care	• Diagnostics - % waiting 6 weeks+ (95% within 6 weeks with maximum 5-week breach wait by March 2025)
Community services, out of hospital and elective care	• Cancer – 28-day wait from referral to faster diagnosis for all patients (77% by March 2025 and 80% by March 2026)
Community services, out of hospital and elective care	• Cancer patient treated within 62 days (70% by March 2025)
Population health management and place-based integration / Children and young people health integration	• MMR2 uptake at 5 years old (95%)

Oldham
Integrated Care Partnership

Finances and estates

Locality 2024/25 finance plan

Oldham
Integrated Care Partnership

We will manage a robust programme of financial savings, as well as projects to improve effectiveness and efficiency, via the primary delivery and transformation workstreams.

Our draft financial plan of £123.7m (see chart) is based on:

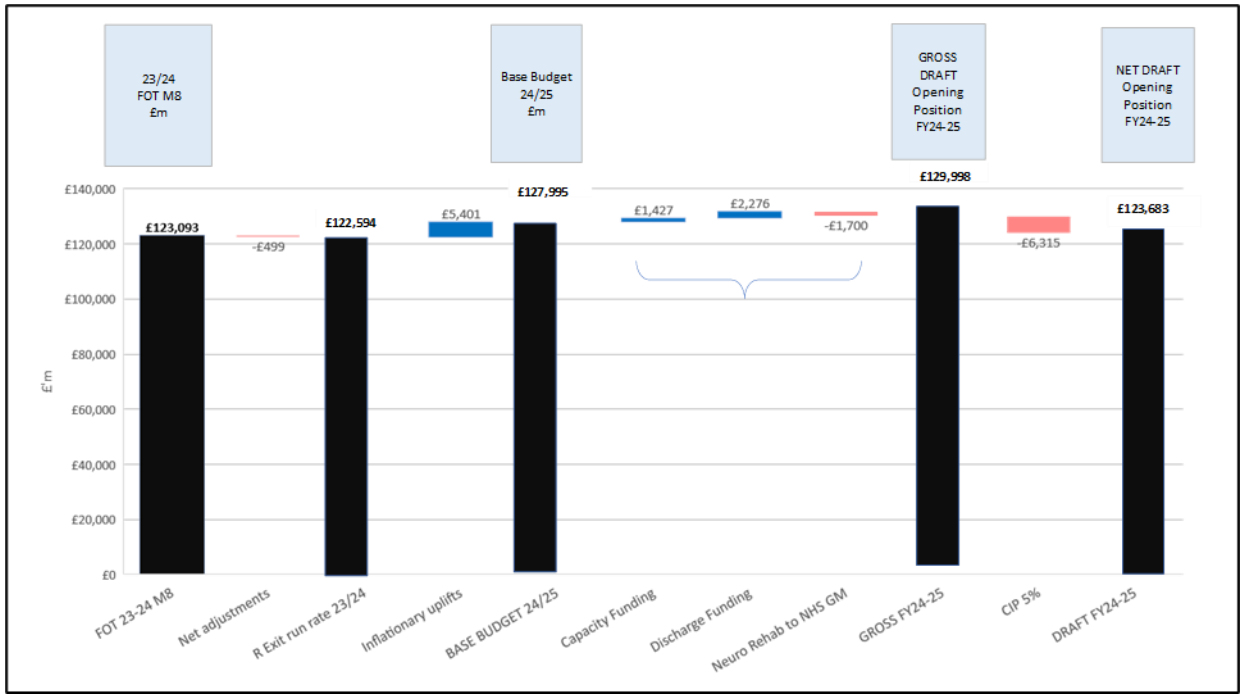
- Exit run rate from 2023/24 less non-recurrent items
- Inflation uplifts at planning guidance set rates
- Cost Improvement saving target of £6.3m. (see waterfall chart)
- Capacity and discharge allocations for 2024/25.

Link to GM missions:
Mission 6 – Achieving financial stability

Use of resources

- **NATIONAL PRIORITIES:**
  - Deliver a balanced net system financial position for 2024/25
  - Reduce agency spending across the NHS, to a maximum of 3.2% of the total pay bill across 2024/25

Financial Plan Bridge from 2023/24 outturn to 2024/25 draft Financial Plan



Service Development Fund and Better Care Fund

Oldham
Integrated Care Partnership

- Service Development Funding allocations support the delivery of the national objectives set out in the guidance confirmed.
- We will continue meet our minimum contribution to the Oldham Better Care Fund as per the policy framework planning requirements for 2023-2025, including growth at 5.66% for 2024/25.
- The minimum allocation requirement for Oldham locality in 2024/25 is £23.194m as set out by NHS England.
- The Better Care fund and capacity and discharge allocations will continue to be included into a Section 75 agreement between Oldham Council and NHS Greater Manchester Integrated Care, alongside grants paid to local government.
- The capacity and discharge allocations for Oldham Integrated Care Partnership for 2024/25 have increased by £2.1m from 2023/24, reflecting the commitments in the Government's Autumn Statement 2022.

Funding type	OMBC £m	ICB £m	Total £m
Discharge Funding	1.568	1.420	**2.988**
Capacity Funding		1.199	**1.199**
Total 2023/24	**1.568**	**2.619**	**4.187**
Discharge Funding	2.614	2.276	**4.890**
Capacity Funding		1.427	**1.427**
Total 2024/25	**2.614**	**3.703**	**6.317**
Increase from 23/24 to 2024/25	**1.046**	**1.084**	**2.130**

Link to GM missions:
Mission 6 – Achieving financial stability

Cost Improvement Programme for 2024/25

Oldham
Integrated Care Partnership

The local Cost Improvement Programme of £6.3m, or 5%, is based on the following:

- An allocation of Cost Improvement Programme targets based on locality influenceable spend; includes mental health and prescribing.
- A focus on recurrent delivery as a priority and wherever possible.
- The targeted management of Any Qualified Provider services based on exit run rates.
- The targeted cost reduction towards Continuing Healthcare and high-cost mental health and learning disability packages.
- A focus on budgetary control and accountability.
- A risk-based approach to the management and delivery of the cost Improvement Programme through regular monitoring and tracking.

Link to GM missions:
Mission 6 – Achieving financial stability

High level 2024-25 Cost Improvement Programme schemes

Oldham
Integrated Care Partnership

CIP scheme detail	Total 24/25
Prescribing	**£2,270,847**
CHC reviews	**£1,000,000**
Referral Gateway cessation	**£168,000**
PCIS	**£400,000**
Contract reductions	**£111,498**
CYP High cost case reviews	**£286,362**
LD reviews	**£210,000**
AQP	**£60,000**
ADHD RTC demand management	**£56,000**
Primary Care training	**£30,000**
IMC support	**£48,000**
PHB reviews	**£70,000**
BCF	**£424,500**
New funding opportunites	**£300,000**
OAPS	**£500,000**
Unidentifed	**£360,000**
Total	**£6,295,207**

Profile of CIP 2024/25			
Qtr 1	Qtr 2	Qtr 3	Qtr 4
£1,082,252	£1,366,328	£1,855,229	£1,991,399

- We have a £6.2m CIP target or 5%.
- There is a gap of c**£0.4m** to be identified.
- There is red rated risk of **£2.1m** in the plan.
- There are full detailed plans and associated impact assessments behind each scheme.
- The profile of CIP reflects the timing of delivery.
- The programme will be managed internally by Oldham Locality Place Team, overseen by NHS GM ICB.

Specific priorities for prescribing and medicines optimisation:

- Improve use of medicines via medicines use reviews and programmes to reduce wastage
- Ensure regular effectiveness and savings are established through prescribing programmes

Link to GM missions:
Mission 6 – Achieving financial stability

Estates plan for 2024/25

Oldham
Integrated Care Partnership

We will maximise the use of community estate, address high-cost premises, supporting shift of care out of hospital.

A key priority for the financial year is to maximise the use of clinical space – this be resolved by relocating services from acute settings to into community spaces to reduce the amount of 'void' estate areas.

Estates work will be undertaken collaboratively with partners across the borough via the five primary care networks and a local Strategic Estates Group.

Work will also be undertaken as part of the Four Localities Partnership, with a focus on dealing with any cross-boundary issues, and the sharing of good practice.

NHS voids / Best use of space

- Maximising use of Oldham Primary Care estate
- Reduction in cost of voids c£1m for Oldham
- Utilisation review
- Maximising use of bookable space

Maximising investment

- Access to national levelling up funds
- Access to NHS Capital / LA prudential borrowing
- Enabling economic regeneration

Local estates

- Core, flex and tail analysis
- New developments & disposals
- Sharing of NHS Trust estates strategy
- Oldham estates lead recruited

NHS PCN toolkit

- Capital prioritisation
- Digitalisation of records

Link to GM missions:
Mission 6 – Achieving financial stability

Oldham
Integrated Care Partnership

Involvement, engagement, communications, workforce and digital

Involvement, engagement and communications

Oldham
Integrated Care Partnership

Our local involvement, engagement and communications activity will be driven by the work and needs of the delivery programme and its workstreams. This will encompass engagement at its heart, and whenever possible a co-production or co-design approach with communities will be undertaken.

We will utilise our local involvement and engagement infrastructure, which includes an Engagement and Insight Group, which is our Local Participation Group, and has been developed in line with NHS Greater Manchester's People and Communities Participation Strategy and Action Together's Engagement Framework.

Our five Population Health Management footprints will be utilised for community engagement activities, and we will also utilise our local Health and Care Senate, with the aim of bringing clinicians and care professionals together with expert patients, families and carers to support pathway improvements and re-design work.

Within the locality we will support NHS Greater Manchester's 'Fit for the Future' programme, where we will work with individuals, families and communities in Oldham on the core challenges, so we can collectively make the best use of health and care funding to develop sustainable services. **We will also support the development of community-led health, care and engagement approaches, in line with the 'capacity development' mission of the voluntary, community, faith and social enterprise sector.**

A new local communications leads network for health and care will also be established to aid better proactive and reactive collaborative working to support the delivery programme and work around health improvement and system pressures.

Link to GM missions:
Mission 1 – Strengthening our communities
Mission 5 – Helping people stay well and detecting illnesses earlier

FIT FOR THE FUTURE

Core challenges:

- Improve people's health, so that they live long, healthy lives
- Improve performance, making sure we are meeting key targets on GP access and hospital waiting times
- Bring the local NHS finances back into balance

Workforce

Oldham
Integrated Care Partnership

We will establish a local workforce action plan focused on social value, partnership development and leadership initiatives, and new ways of working for our local NHS Greater Manchester Place Team.

The key local overarching workforce priority themes will be as follows:

- Support workforce actions that are outlined via the delivery workstreams within the transformation programme
- Support delivery of social value, 'health and wealth' and digital education for staff, as detailed in the health inequalities action plan
- Implement partnership-wide matrix working approaches wherever possible
- Develop a partnership-wide leadership plan and development schedule
- Develop an organisational development plan for Oldham's NHS Locality Place Team to ensure stabilisation moves to innovation

Work will link into the community-led work with the voluntary, community, faith and social enterprise sector, particularly in relation to delivering workforce to health and care services and enhancing the skills and employment of local people.

Workforce activities will also be embedded as needed into our delivery workstreams, as linked to service improvements and pathway changes, with a particular focus on the development of our new population health management approach for districts / neighbourhoods / Primary Care Networks.

Workforce

- **NATIONAL PRIORITIES:**
  - Improve the working lives of all staff and increase staff retention and attendance through systematic implementation of all elements of the People Promise retention interventions
  - Improve the working lives of doctors in training by increasing choice and flexibility in rotas, and reducing duplicative inductions and payroll errors
  - Provide sufficient clinical placements and apprenticeship pathways to meet the requirements of the NHS Long Term Workforce Plan

Link to GM missions:
Mission 5 – Supporting our workforce and carers

Digital

Oldham
Integrated Care Partnership

As linked to both the GM digital strategy and our Oldham Integrated Care Partnership 5-year strategy, priorities for improving the areas of digital within health and care services will focus on both infrastructure and capabilities of use (staff and patients).

There will be a priority, linking to both the health inequalities action plan and the engagement and involvement plans, in relation to digital education for staff, patients and communities, to help enhance access to services and health literacy.

Other digital work will link to the GM Primary Care Blueprint, including the plans for shared care records and care plans.

Additional locality digital projects will be scoped through 2024/25 as linked to the delivery programme and workstreams and overall performance priorities.

As staffing and budgetary resource for digital, workforce, engagement and communications is limited, we will utilise a partnership approach for delivery within Oldham, and across the Four Localities Partnership, wherever possible.

Digital

- **NATIONAL PRIORITIES:**
  - Ensure our infrastructure is modern and sustainable
  - Level up digital provider maturity
  - Deploy and upgrade electronic patient record systems
  - Connect services via, and champion the use of the NHS App
  - Align planned digital investments with the Federated Digital Platform

Link to GM missions:
Mission 2 – Helping people stay well and detecting illnesses earlier
Mission 4 – Recovering core NHS and care services
Mission 6 – Achieving financial stability

Oldham
Integrated Care Partnership

Glossary of terms

Glossary of terms

Oldham
Integrated Care Partnership

2ww	2 Week Wait
A&E	Accident and Emergency
A&G	Advice and Guidance
ADHD	Attention Deficit Hyperactivity Disorder
AQP	Any Qualified Provider
ASC	Adult Social Care
ASD	Autism Spectrum Disorder
BAME	Black, Asian, and minority ethnic
BAU	Business As Usual
BMI	Body Mass Index
BP	Blood Pressure
CAMHS	Child and Adolescent Mental Health Services
CDC	Community Diagnostic Centre
CHC	Continuing Health Care
Chol	Cholesterol
CIP	Cost Improvement Plan
COPD	Chronic Obstructive Pulmonary Disease
CSC	Childrens Social Care
CSDS	Community Service Data Set
CT	Computerised tomography
CVD	Cardio Vascular Disease
CYP	Children and Young People
D2A	Discharge to Access
DNA	Did Not Attend
ECDS	Emergency Care Data Set
ED	Emergency Department
EL	Elective
FIT	Faecal Immunochemical Test
FLP	Four Localities Partnership
GI	Gastrointestinal Tract
GIRFT	Getting It Right First Time
GM SCC	Greater Manchester System Control Centre
GM	Greater Manchester
GP	General Practice

Glossary of terms

Oldham
Integrated Care Partnership

H&SC	Health and Social Care
HRT	Hormone Replacement Therapy
IAPT	Improving Access to Psychological Therapy
ICB	Integrated Care Board
ICP	Integrated Care Partnership
IMC	Intermediate Care
IP	In Patient
JFP	Join Forward Plan
KPI	Key Performance Indicators
LA	Local Authority
LD	Learning Disabilities
LMNS	Local Maternity & Neonatal System
LoS	Length of Stay
LTCs	Long Term Conditions
MH	Mental Health
MMR	Measles, Mumps and Rubella
MRSA	Methicillin-resistant Staphylococcus aureus
NCA	North Care Alliance
NDPP	National Diabetes Prevention Programme
NEL	Non Elective
NHSE	NHS England
NICE	National Institute of Clinical Excellence
NRTR	No Reason to Reside
NWAS	North West Ambulance Service
OAPS	Out of Area Placements
OBD	Occupied Bed Days
OEP	Outpatient Excellent Programme
OP	Out Patient
OTC	Over The Counter
PCIS	Primary Care Incentive Scheme
PCN	Primary Care Network
PHB	Personal Health Budgets
PHM	Population Health Management
PIFU	Patient Initiative Follow Up

Glossary of terms

Oldham
Integrated Care Partnership

RTC	Right to Chose
SALT	Speech and Language Therapy
SCR	Skin Care Referrals
SDEC	Same Day Emergency Care
SEN	Special Educational Needs
SENCOs	Special Educational Needs Co-ordinators
SEND	Special Educational Needs and Disabilities
SLCN	Speech, Language and Communication Needs
SMART	Specific, Measurable, Agreed Upon, Reasonable, and Time-Bound
SMI	Severe Mental Illness
T2D	Type 2 Diabetes
UEC	Urgent Emergency Care
UTC	Urgent Treatment Centre
VCFSE	Voluntary, Community, Faith and Social Enterprise Sector
WHO	World Health Organisation

This page is intentionally left blank

Report to HEALTH AND WELLBEING BOARD

Healthwatch Oldham's work programme 2024-25

Portfolio Holders:
Councillor Barbara Brownridge, Cabinet Member for Health and Social Care

Officer Contact: Claire Hooley, Assistant Director for Commissioning and Market Management (ASC)

Report Author: Claire Hooley, Assistant Director for Commissioning and Market Management (ASC)

Ext. 4292 / Claire.Hooley@oldham.gov.uk

Date: 11th July 2024

Purpose of the Report

To provide the Health and Wellbeing Board with an overview of Healthwatch Oldham's work programme for 2024/25, and an opportunity to suggest areas to consider prioritisation going forward.

Requirement from the Health and Wellbeing Board

1. That the Board notes the content of Healthwatch Oldham's work programme for 2024/25

2. That the Board considers areas for Healthwatch Oldham to consider going forward.

Healthwatch Oldham's work programme for 2024/25

1. Background

1.1 Under the Health and Social Care Act 2021 local authorities are statutorily obliged to provide local Healthwatch.

1.2 The contract was tendered in 2022 with Action Together being the successful bidder, and the new contract in place from April 2022.

1.3 Established, following the Health and Social Care Act 2012, local Healthwatch organsations are the local consumer champion for patients, service users and the public, covering both health and social care.

1.4 Local authorities have a statutory duty to commission a local Healthwatch organization which in turn has a set of statutory activities to undertake, such as gathering local views and making these known to providers and commissioners, monitoring and scrutinizing the quality of provision of local services, and a seat on the local Health and Wellbeing Board.

1.5 Local Healthwatch services are required to:

- **Listen:** be proactive to gather the views of people about their needs and experiences of local health and care services in Oldham.
- **Involve and Engage:** involve and engage communities from across the borough including by connecting with trusted networks to understand and learn what is important to local people.
- **Provider Data and Insight:** share the data and insight that has been gathered and produce reports which include recommendations about what local people have said about ways health and care services can be improved.
- **Share Information:** provide information and advice to the public about the local health and care services available to them and share information and support to access this.

1.6 Action Together has delivered the Healthwatch Oldham service since 2014. Competitive tendering has taken place with Action Together being the successful bidder through these tenders.

2. Current Position

2.1 Healthwatch Oldham has reviewed the prioritisation process of work areas and this is presented on slide 3 in the powerpoint. It includes receiving feedback from Oldham residents, in reviewing local and national health and care plans, and how this is presented to the Healthwatch Advisory Board. The workplan for 2024/25 is focused on three areas of focus:

1. Improving services (projects)
2. Influencing plans (strategic)
3. Involving the public (engagement)

2.2 Following approval from the Healthwatch Advisory Board, the Projects for this year are:

- Secondary/Metastatic Cancer Services – in progress
- Greater Manchester Children and Adolescent Mental Health Services (CAMHS) – being finalised
- Greater Manchester Menopause and Mental Health – late summer 2024
- People with learning disabilities experiences of diabetes services – December 2024

2.3 The areas of Engagement activities that have been approved by the Healthwatch Advisory Board are:

- Youth Watch 100
- Forums in August and December
- Hospital Services – working with Royal Oldham Hospital to understand experiences in different hospital departments
- Social care and older people – understanding experience of day services, care homes and supported accommodation.

2.4 The Strategic areas for Healthwatch Oldham that have been approved are:

- Child vaccination uptake: reviewing data and current activity regarding this to understand issues with health inequality focus and identify potential for future project work.
- Damp in housing and impact on health – understand the system response in place already to address damp in housing, monitor progress against improvement plans and promote to the public what progress is being made.

2.5 Other areas of focus which have been discussed and agreed with the lead Commissioner are:

- Follow up on previously reported recommendations: have they been achieved? If not, why not? Healthwatch Oldham will use an Impact Tracker to monitor progress against recommendations.
- Oldham's Health and Wellbeing Board: ensure that Healthwatch Oldham is a proactive member of the statutory board.
- Adult Social Care and Health Scrutiny Board: ensure strong partnership working.
- Signposting and support to Oldham residents.

2.6 The approach Oldham's Healthwatch service will take is:

- Alongside Commissioners and the contract monitoring approach in place, the Healthwatch Advisory Board will monitor progress on the workplan
- Horizon scanning for potential / new urgent priorities.
- Being flexible so there is the ability to adjust and reprioritise issues if needed.
- Strengthen data and insight capabilities to help the team give the board the information needed for each potential priorities
- Prioritise the resources ensuring maximum possible impact.

3. Key Issues for Health and Wellbeing Board to Discuss

3.1 Consider the presentation and comment on current priorities.

3.2 Make any suggestions for forthcoming areas of work.

4. Recommendation

4.1 It is recommended that the Health and Wellbeing Board note the contents of this report and presentation delivered at the Board meeting taking place 11th July, and comment on and make suggestions on current priorities and future.

5. Appendices

5.1 Presentation delivered 12th July:

HW Oldham Workplan HWBB July

Workplan 2024/25

Healthwatch Oldham

What Healthwatch does

1. Listen	We proactively gather the views of people about their needs and experiences of local health and care services in Oldham. We try to help resolve queries or concerns people may be having and connect them to the local provider.
2. Involve and Engage	We work with volunteers and with the voluntary and community sector to ensure we can gather experiences from all the different communities in Oldham and can tap into the trusted networks that exist to learn more about what is important to local people.
3. Provide Data and Insight	We share the data and insight that we gather and produce reports with recommendations about what local people have said about ways health and care services can be improved.
4. Share Information	We provide information and advice to the public about the local health and care services available to them and share information and support to access this.

- Small team (3fte), based within Action Together as the 'host'
- Support an Independent Advisory Board for Healthwatch Oldham

Prioritisation process

Healthwatch Oldham's workplan

- Identify priorities where we can achieve meaningful outcomes
- Focus on health inequality
- Build in timeframe for effective engagement and diversity of experience
- Robust project planning and project management
- SMART Recommendations
- Resource to follow up on recommendations

Framework of the plan

- Split into projects - two local projects and three projects with GM counterparts
- Identify where we should target our engagement
- Share with partners where there is an intent to work strategically with others on issues that may not be solely delivered by a health or care provider.

Workplan - Projects

- Secondary/Metastatic Cancer Services – in progress
- GM CAMHS – being finalised
- GM Menopause and Mental Health – late summer 2024
- People with learning disabilities experiences of diabetes services - December 2024

Workplan - Engagement

- Youth Watch 100
- Forums in August & December
- Hospital Services – working with Oldham Hospital to understand experiences in different hospital departments
- Social care and older people – understanding experiences of day services, care homes and supported accommodation

Workplan - Strategic

- Child Vaccination Uptake – reviewing data and current activity re this to understand issues, with health inequality focus and identify potential for future project work.

- Damp in housing and impact on health – understand the system response in place already to address damp in housing, monitor progress against improvement plans and promote to the public what progress is being made.

Workplan - Other

- Follow up on previous recommendations – use Impact Tracker to monitor progress against recommendations
- Health & Wellbeing Board – ensure we are proactive members
- Adult Social Care and Health Scrutiny Board – ensure strong partnership working
- Signposting and support to the public

Our approach

- Advisory Board will monitor progress on the workplan
- Horizon scanning for potential / new urgent priorities
- Flexible so can adjust /re-prioritise urgent issues if needed
- Strengthen data and insight capabilities to help the team give the board the information needed for each potential priority
- Prioritise our resources for impact

Report to HEALTH AND WELLBEING BOARD

Better Care Fund 2023-25; End of Year 2023-24 submission and Planning template for 2024-25

Portfolio Holder:
Councillor Barbara Brownridge, Cabinet Member Health & Social Care

Officer Contact: Jayne Ratcliffe, Director of Adult Social Care (DASS)

Report Author: Claire Hooley, Assistant Director for Commissioning and Market Management (ASC)

Contact: 4292 / Claire.Hooley@Oldham.gov.uk

Date: 11th July 2024

Purpose of the Report

In order to meet the national funding conditions of the Better Care Fund, this report seeks the Health and Wellbeing Board's approval on the submission of Oldham's:

- 2023-24 End of Year report
- 2024-25 Planning template

The Board should note, that in order to meet the deadlines set for the above, the templates have been submitted.

It also seeks the Board's approval to delegate the decision to submit quarterly reports to the Better Care Fund team, with the understanding that the reports will be noted at the next available Health and Wellbeing Board meeting.

Requirement from Oldham's Health and Wellbeing Board

1. a) Note the content of the 2023-24 End of Year report, and
   b) Provide retrospective approval for its submission to the Regional Better Care Fund panel

2. a) Note the content of the 2024-25 BCF Planning Template, and

b) Provide retrospective approval for its submission to the Regional Better Care Fund Panel

3. Agree to delegate the decision to submit quarterly reporting templates to the Place-Based Lead and Oldham Council's Chief Executive, in consultation with the Director of Adult Social Care (DASS).

1. Background

The Better Care Fund

1.1 The Better Care Fund's vision has been to support people to live healthy, independent and dignified lives, through joining up health, social care and housing services seamlessly around the person. The BCF Policy Framework centres of these objectives and now sets separate National Condition for each:

- enable people to stay well, safe and independent at home for longer
- provide people with the right care, at the right place at the right time.

1.2 As well as supporting delivery of the *Next Steps to put People at the Heart of Care*, the BCF programme underpins key priorities in the NHS Long Term Plan by joining up services in the community and the government's plan for recovering urgent and emergency care (UEC) services.

1.3 Differing from previous years, the current BCF plan spans two years for the period 2023-25, with the delivery of the BCF supporting two key priorities for the health and care system that align with the two existing BCF objectives of:

- improving overall quality of life for people, and reducing pressure on UEC, acute and social care services through investing in preventative services
- tackling delayed discharge and bringing about sustained improvements in discharge outcomes and wider system flow.

Better Care Fund Plan 2023-25 Planning template

1.4 The details of the operation of the BCF are set out in two documents: *Better Care Fund policy framework 2023 to 2025* and *Better Care Fund planning requirements 2023-25*. These documents form the basis of the Oldham BCF plan for 2023-25. The two year plan was submitted by the deadline of 28th June 2023.

1.5 Throughout 2023-24, colleagues across the Integrated Care Partnership (Oldham Locality) and Oldham's Adult Social Care service have worked together to submit quarterly reports, with all deadlines having been met. The timeline provided by the Better Care Fund national team is presented in the table below. From this we understand that the plan has been agreed both regionally and will be agreed nationally once we confirm that the plan has been agreed by the Health & Wellbeing Board as required under National Condition 1.

2023-24 End of Year Report

1.6 The Better Care Fund requires an End of Year report to be completed. For 2023-24 the deadline for this was 22nd May 2024, with reports to be approved by the locality's Health and Wellbeing Board. The approval process allows for submission of the plan prior to approval of the Health and Wellbeing Board.

1.7 It should be noted, that since the 22nd May, feedback has been received from the Regional Better Care Fund Panel, advising that the end of year report has been recommended for approval.

Better Care Fund 2024-25 planning template

1.8 The Better Care Fund also has a requirement for localities to submit a planning template. Whilst it is not envisaged there to be a great change from the two-year planning template, it gives localities the opportunity to review the initiatives in place in the first year of delivery compared to service capacity and demand, and therefore flex service delivery.

1.9 Changes that were made as a result of the second-year review were as a result of not being able to mobilise, for instance, due to some staffing challenges in the Mental Health arena, has resulted in this funding being directed elsewhere to an area where we have seen higher than anticipated demand and to support timely hospital discharge into a community setting or home.

1.10 The deadline to submit the Better Care Fund Planning template for 2024-25 was 10th June 2024. This deadline was met, and has been subsequently reviewed by the Regional BCF team and recommended for approval.

2. Current Position

2.1 The BCF continues to consist of three main funding contributions: NHS Greater Manchester Integrated Care Board (NHS GM ICB) contribution to the BCF; the Disabled Facilities Grant (DFG); and the Improved Better Care Fund (iBCF).

2.2 Due to increases being received for the Disabled Facilities Grant and Discharge Funding, the total value of the BCF in Oldham for 2023-25 period is £81,584,498. This is broken down as follows for 2023-25:

Funding Sources	**Income Year 1 (2023/24)**	**Income Year 2 (2024/25)**
DFG	£2,343,287	£2,555,942
Minimum NHS Contribution	£21,951,512	£23,193,968
iBCF	£11,187,623	£11,187,623
Additional LA Contribution	£0	£0
Additional ICB Contribution	£822,739	£462,916
Local Authority Discharge Funding	£1,568,487	£2,614,146
ICB Discharge Funding	£1,420,360	£2,275,895
Total	**£39,294,008**	**£42,290,490**

2.3 The use of the funding is dependent on meeting the following four national conditions:

National Condition 1: Plans to be jointly agreed
Plans must be agreed by the ICB and the local council chief executive prior to being signed off by the Health and Wellbeing Board.

National Condition 2: Enabling people to stay well, safe and independent at home for longer
Localities agree on how the services they commission will support people to remain independent for longer, and where possible support them to remining their own home.

National Condition 3: Provider the right care in the right place at the right time
Localities agree on how the services they commission will support people to receive the right care in the right place at the right time.

National Condition 4: NHS minimum contribution to adult social care and investment in NHS commissioned out of hospital services
The NHS minimum contributions for social care and NHS commissioned out of hospital spend for all HWB areas in both 2023-24 and 2024-25 has been uplifted by 5.66%. ICBs and Councils may agree a higher level of spend, where this will deliver value to the system and is affordable.

2.4 The BCF funding received may only be used for the purposes of:

- meeting adult social care needs
- reducing pressures on the NHS, including seasonal winter pressures
- supporting more people to be discharged from hospital when they are ready
- ensuring that the social care provider market is supported.

2.5 Working collaboratively across health and social care, the funding is utilised for Oldham residents to support the following initiatives and services:

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

2.6 Both the End of Year (2023-24) and Planning Template (2024-25) requires data to be submitted on capacity and demand of the locality. For instance, how many units of a service are available compared to the number of individuals anticipated to require a service. This has been a useful exercise in reviewing what services are available across the borough and to further understand the gaps in provision, therefore directing the funding to where is required to support people the most.

2.8 Work is taking place to review the section 75 agreement for it to be in place as soon as possible as per the national BCF deadline.

3. Key Issues for the Health and Wellbeing Board to Discuss

3.1 a) Note the content of the 2023-24 End of Year report, and
b) Provide retrospective approval for its submission to the Regional Better Care Fund panel

3.2 a) Note the content of the 2024-25 BCF Planning Template, and
b) Provide retrospective approval for its submission to the Regional Better Care Fund Panel

3.3 Agree to delegate the decision to submit quarterly reporting templates to the Place-Based Lead and Oldham Council's Chief Executive, in consultation with the Director of Adult Social Care (DASS).

4. Recommendation

4.1 It is recommended that the Health and Wellbeing Board agree to sign off:

a) the Better Care Fund End of Year Report 2023-24
b) the Better Care Fund Planning Template 2024-25
c) approve to delegate the decision to submit quarterly reporting templates to the Place-Based Lead and Oldham Council's Chief Executive in consultation with the Director of Adult Social Services (DASS).

5. Appendices

1. 2023-24 End of Year report

HWB OLDHAM
23-24 EOY Final repoı

2. 2024-25 Planning template

Oldham HWB
2024-25 Planning Ter

Report to Health and Wellbeing Board

Public Health Annual Report

Portfolio Holder:
Barbara Brownridge, Cabinet Member for Adults, Health and Wellbeing

Officer Contact: Rebecca Fletcher, Director of Public Health

Report Author: Rebecca Fletcher, Director of Public Health, and Anna Tebay, Head of Service, Public Health

2nd July 2024

Reason for Decision
The Health and Wellbeing Board is asked to note the content and recommendation of the Public Health Annual Report.

Executive Summary
The Public Health Annual Report is the report of the Director of Public Health. The 2023/34 report has taken a date led approach to examine the relationship between housing, health, and health inequalities. There is a particular focus and consideration on the cumulative effect of poor-quality housing on those most at risk of experiencing health inequalities and sets out a set of key recommendations in response to the findings. The report acknowledges the many examples of how Oldham is seeking to respond to the challenges.

Recommendations
The Health and Wellbeing Board is asked to note the content and recommendation of the Public Health Annual Report.
Member of the board are asked to consider the implications of the report for their own organisations.

1. **Financial Implications**

   1.1. None

2. **Legal Implications**

   2.1. None

3. **Oldham Equality Impact Assessment, including implications for Children and Young People**

   3.1. No

4. **Key Decision**

   4.1. No

DELETE THE SIGNATURE BOX IF THE REPORT IS A CABINET DECISION

Signed _____ Cabinet Member (specify whom)	Dated _____
Signed _____ Executive Director/Deputy Chief Executive	Dated _____

Health and Housing in Oldham

Public Health Annual Report 2023/24

Oldham Council

Contents

"A good life starts with a good home. It's so important"

Simon Carrigan
Poverty Truth Commissioner

Forewords

Foreword by Cabinet Member for Health and Social Care
Councillor Barbara Brownridge

The annual report of the Director of Public Health is an independent view on matters related to health and wellbeing in Oldham, and what needs to be done to improve it.

This report has a focus on health and housing. We know that Oldham, like many other places in the country, needs more good–quality housing. If we want our residents to live happy and healthy lives, then they must be able to live in a safe and secure environment that does not negatively impact on their wellbeing. Overcrowded homes of poor quality contribute to inequalities that must be addressed, and so I am pleased that this report is examining this area and look forward to seeing the future partnership working to combat the issue.

As Council Cabinet Lead for Health and Social Care I am happy to support publication of the 2023 Annual Report of the Director of Public Health and to encourage councillors, partners and communities in Oldham to do their bit by engaging in discussion and action about health, wellbeing and health inequalities in Oldham so that we could build toward a healthier future.

Councillor Barbara Brownridge

Councillor Barbara Brownridge

"If we want our residents to live happy and healthy lives, then they must be able to live in a safe and secure environment that does not negatively impact on their wellbeing."

Forewords

Foreword by the Director of Public Health
Rebecca Fletcher

Welcome to my first Public Health Annual Report as the Director of Public Health. I am pleased to be able to consider various aspects of housing, health and the unequal impact across particular groups within our population. For context, this report reflects on housing past, present and future, with the greatest degree of focus on the data and evidence base that links different aspects of poor–quality housing with physical and mental health.

There is a strong link between good–quality and secure housing and positive health outcomes, but of course the reverse of this is true, with poor housing causing or exacerbating physical and mental health conditions. Oldham has stark inequalities, between the borough and other areas of the country, and also within the borough between our least and most deprived areas. Housing is well recognised as one of the many contributing factors that affect our communities unequally.

This report identifies that for some communities, we can draw associations between poor health and an accumulative effect of multiple aspects of poor housing standards. For example, overcrowding is more likely to exist in deprived areas, where families are also experiencing fuel poverty with little/ no disposable income to spend on heating; this is then compounded by the fact that they are more likely to live in poorly insulated properties, where heat is easily lost through walls and the roof.

Tackling multiple aspects of housing standards is complex, and accountability does not sit with any single organisation or department, which is why it is essential that all partners continue to play their part during this time of need, but also in the consideration of future demand/ need. I close by thanking all colleagues who have contributed to this report from across the system.

Rebecca Fletcher

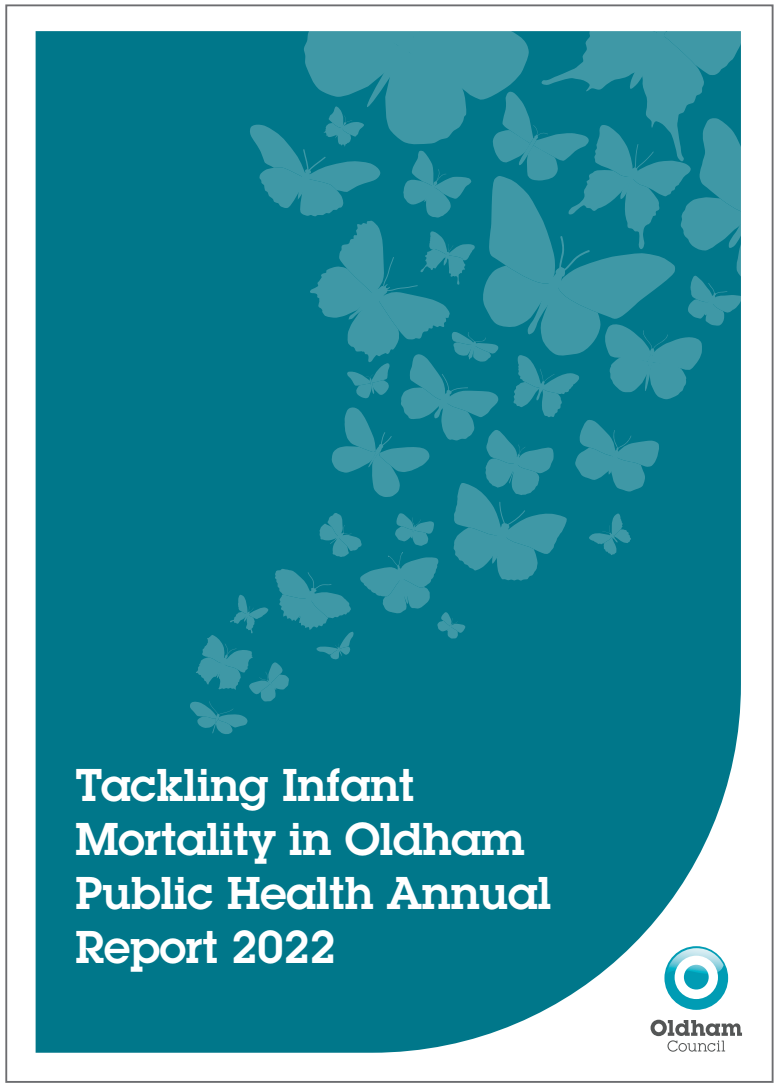
"Oldham has stark inequalities, between the borough and other areas of the country, and also within the borough between our least and most deprived areas. Housing is well recognised as one of the many contributing factors that affect our communities unequally."

Rebecca Fletcher

Reflections

Reflections on the recommendations from the 2022/23 Public Health Annual Report 'Tackling Infant Mortality in Oldham'

For the reflection on the recommendations made in last year's report 'Tackling Infant Mortality in Oldham', please see Appendix 1.



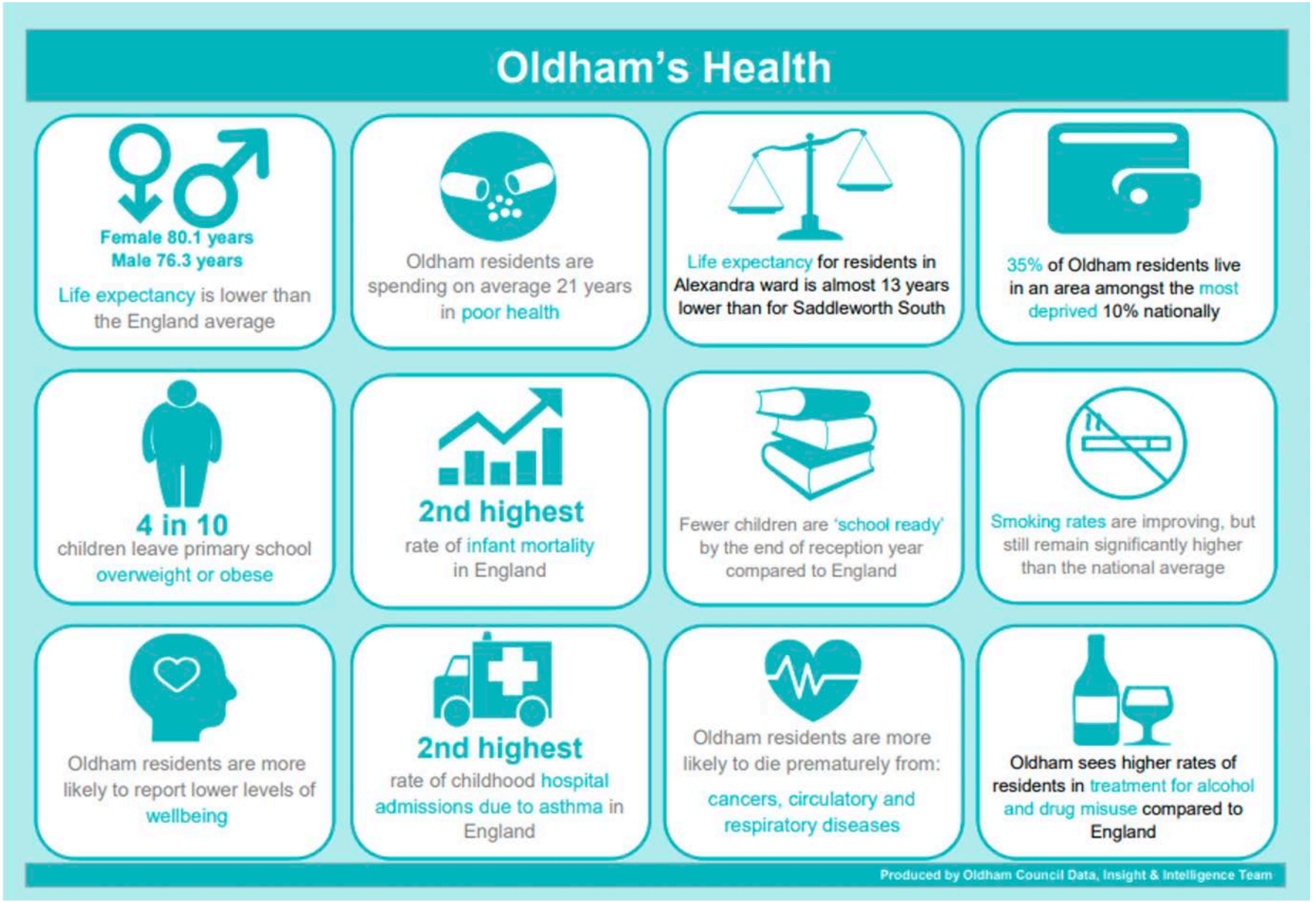
Introduction

Oldham's previous public health annual reports focused on specific health topics – COVID–19 and infant mortality, and poor–quality and overcrowded housing were highlighted as risk factors for both. This report therefore seeks to explore in more depth how housing contributes to health and health inequalities.

In Oldham, life expectancy and healthy life expectancy are shorter than the national average and there is a stark difference of nearly 13 years in life expectancy between the least and most deprived parts of the borough (JSNA Oldham). The 2021 Census shows us that in Oldham, fewer people self–report having 'very good health' (47%) compared to the England and Wales average (48%), and residents start to experience 'bad or very bad health' at an earlier age. Poor health and limited life expectancy are not new to Oldham, and to provide context for the relationship between health and housing in the borough, this report describes key historical aspects that have been integral to housing design. It describes Oldham's current housing stock while exploring the health of residents across different types and tenures, and it explains different issues faced by residents. This report also provides information on how Oldham Council is supporting residents, and what can be expected in the future.

Within this report, 'housing quality' refers to the physical conditions of a person's home. The World Health Organisation (WHO) defines good housing, or 'healthy housing', as a "shelter that supports a state of complete physical, mental and social well–being. ...Healthy housing also refers to the physical structure of the dwelling and the extent to which it enables physical health, including structurally sound, by providing shelter from the elements and from excess moisture, and by facilitating comfortable temperatures, adequate sanitation and illumination, sufficient space, safe fuel or connection to electricity, and protection from pollutants, injury hazards, mould and pests."

The terms 'poor–quality housing' and 'inadequate housing conditions' relate to the physical state that can negatively contribute to health including chronic disease or injury. Where the level of deprivation of an area is described, this is per the English Indices of Deprivation 2019 (IMD). Multiple sources of information have been used throughout, and detailed references are available on request.


Oldham's Health
Female 80.1 years
Male 76.3 years
Life expectancy is lower than the England average
Oldham residents are spending on average 21 years in poor health
Life expectancy for residents in Alexandra ward is almost 13 years lower than for Saddleworth South
35% of Oldham residents live in an area amongst the most deprived 10% nationally
4 in 10
children leave primary school overweight or obese
2nd highest
rate of infant mortality in England
Fewer children are 'school ready' by the end of reception year compared to England
Smoking rates are improving, but still remain significantly higher than the national average
Oldham residents are more likely to report lower levels of wellbeing
2nd highest
rate of childhood hospital admissions due to asthma in England
Oldham residents are more likely to die prematurely from:
cancers, circulatory and respiratory diseases
Oldham sees higher rates of residents in treatment for alcohol and drug misuse compared to England
Produced by Oldham Council Data, Insight & Intelligence Team

Key determinants of health

Problems with people's homes can influence their health. This idea is underpinned by Maslow's hierarchy of need (1943) and the Dahlgren and Whitehead (1991) model of the main determinants of health, the 'rainbow model'. In 1943, Abraham Maslow introduced the theory that people have basic needs which must be met before they can satisfy their psychological needs or reach self–fulfilment (Figure 1).

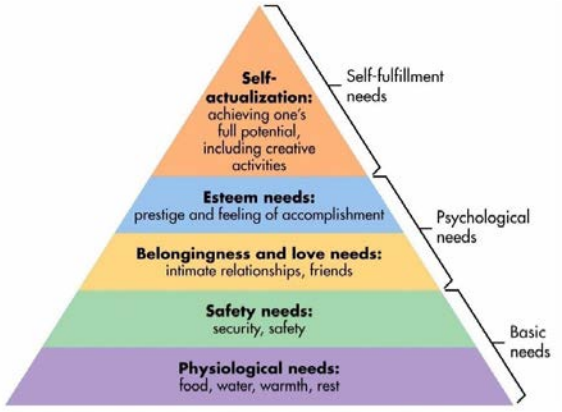


Figure 1: Maslow's hierarchy of needs (1943)

Good housing is fundamental for ensuring that basic needs can be met, with the ability to provide a place to shelter, a place to prepare food and eat, a place of safety and warmth, and somewhere to rest. The 'rainbow model' shows how a person's health is influenced by multiple factors, described as the wider determinants. These include an individuals' economic, social, cultural, and environmental conditions (Figure 2).

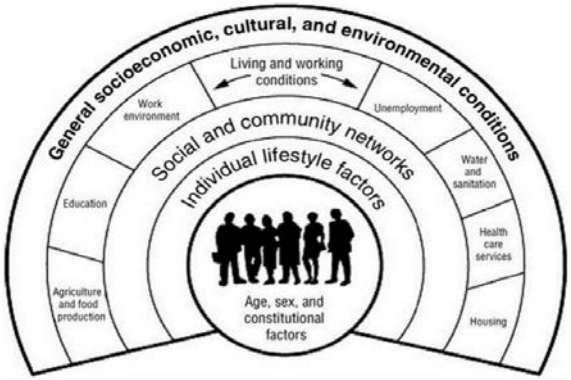


Figure 2: Dahlgren and Whitehead (1991) model of the main determinants of health

The wider determinants of health are increasingly thought to be the root cause of inequalities, and housing is arguably one of the most critical components. Housing comes in many different forms, and poor–quality, overcrowded and unaffordable housing contributes to poverty, instability, social exclusion, and direct health problems, including but not limited to respiratory infections, asthma, and poor mental health.

There are wide reaching impacts of housing, including on a person's ability to:

- Live independently and without risk of injury or illness
- Access healthcare services, education and training opportunities, and employment easily
- Manage own health and care needs
- Become part of a community, contribute, and feel safe

Furthermore, the WHO identified that poor physical and structural housing conditions disproportionately impact young children, older adults, individuals with disabilities and those with low income. This is because these groups are more likely to spend prolonged periods of time in the home and are therefore more exposed to the associated health risks. This means that poor–quality housing has the potential to widen health inequalities in Oldham.

The relationship between housing, health and health inequalities will be explored across tenure, type, and quality within three themes: 1) unsafe or unhealthy homes; 2) unsuitable homes, including overcrowding or inaccessibility; 3) unstable homes, including temporary accommodation or homelessness. Across the life course, the risks associated with each theme can vary. For example, while unhealthy homes increase the risk of respiratory illness and poor mental health in children, working age adults and older people, the risk of physical injury is greater for children and older people. Unhealthy homes are also associated with poor infant weight gain and poor diet in children. Unsuitable, overcrowded homes are associated with increased harms from tobacco and higher rates of tuberculosis in children and working age adults, while inaccessibility brings greater risks for older people, with higher chances of social isolation and injuries from falls. Adults with unstable homes experience increased risk of physical and mental health problems, suicide, alcohol and drug misuse, tobacco harm and tuberculosis, while children and young people may miss important health checks and immunisations.

The past

Oldham saw a transition from farming as the dominant industry to textiles. Small communities of weavers grew around established historic towns and by the mid–1700s, weavers' cottages were being built.

Industry declined owing to general economic depression. This led to bankruptcy and massive unemployment, and mill building ceased by the 1920s. Building of social housing began after the First World War. Large estates of semi–detached houses were erected to accommodate commuters from Manchester and terraced houses were built for industrial workers. Terraced houses are a significant part of Oldham's history, however this legacy leaves residents with poorly insulated properties.

The Housing Market Renewal (2004 – 2011) scheme intended to improve neighbourhoods that had low housing demand. Alt, Hathershaw, Fitton Hill, Werneth, Sholver and Derker were due to benefit. The scheme planned the demolition, refurbishment and erection of new homes. The scheme was intended to be carried out over 15 years, however funding was withdrawn in April 2011. Demolitions had already happened with no new housing built. Oldham Council committed to deliver an ongoing development in Derker.

Oldham comprised little more than a scattering of small settlements. From 1854 to 1910, urban Oldham roughly doubled in size, and Shaw, Royton, Hollinwood and Greenacres grew. By the late 19th century, Oldham was one of the foremost cotton towns in the world, and the population increased from around 12,000 to 137,000 by 1900.

New Deal for Communities (2000 – 2010) launched in 1998 to transform 39 deprived neighbourhoods in England. Hathershaw and Fitton Hill were beneficiaries of this programme.

The Single Regeneration Budget (1994 – 2002) was the UK government's main regeneration fund for deprived areas.

Post–medieval

Industrial

16th century | **17th century** | **18th century** | **19th century** | **20th century** | **21st century**

The present

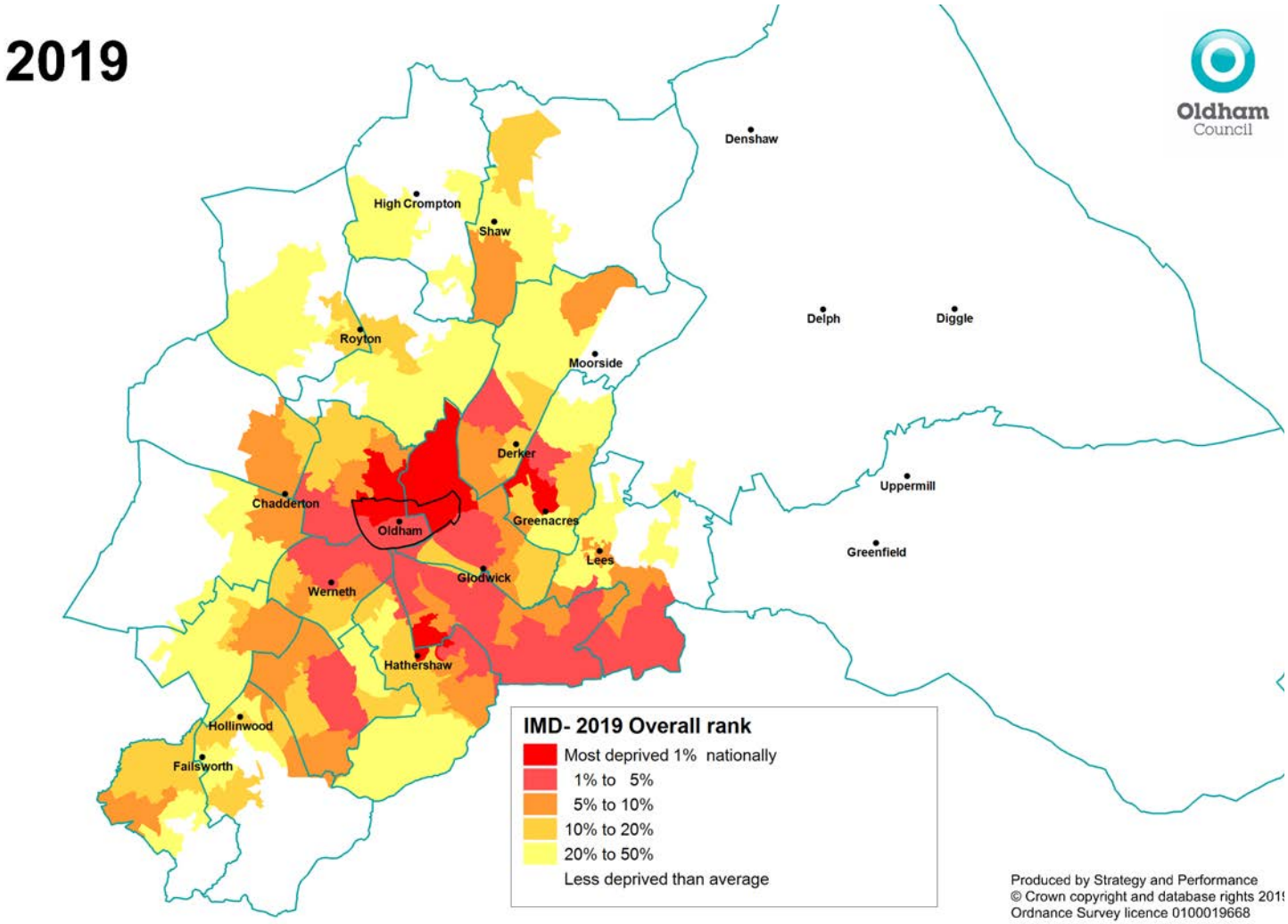


Figure 3: Level of deprivation in Oldham compared with the national average (IMD)

House prices

In 2023, the median house price in Oldham was £180,000 (ONS). For decades, median house prices in the borough have been consistently lower than those for the North West region and England as a whole. However, there has still been a marked increase in property prices since 2000 (Appendix 2). There are more than 93,100 homes in Oldham (ONS Census 2021), with an estimated vacancy rate of 1%. In Oldham, 7 of 20 wards are among the 10% most deprived areas in England (Figure 3), and more than one quarter of residents experience the highest level of income deprivation (English Indices of Deprivation 2019; IMD). This affects residents' ability to buy properties of their own and means that choice of property may be more limited. Residents' ability to maintain and repair a purchased property could also be restricted.

Health and tenure

Health varies by tenure, both in Oldham and nationally (Figure 4). The largest proportion of people with good health in Oldham are owner occupiers, while people with poor health most commonly live in social rented homes. The pattern of general health and tenure is similar in Oldham to the national picture; however, the proportion of people over the age of 65 with 'bad or very bad' health living in the private rented sector is larger in the borough (20% compared with 16%). This has implications for adult social services which may be limited in their ability to support people to stay at home with home adaptations in this sector. It is also expected that the older population of 10–15 years in the future may be more dependent on the private rented sector than currently.

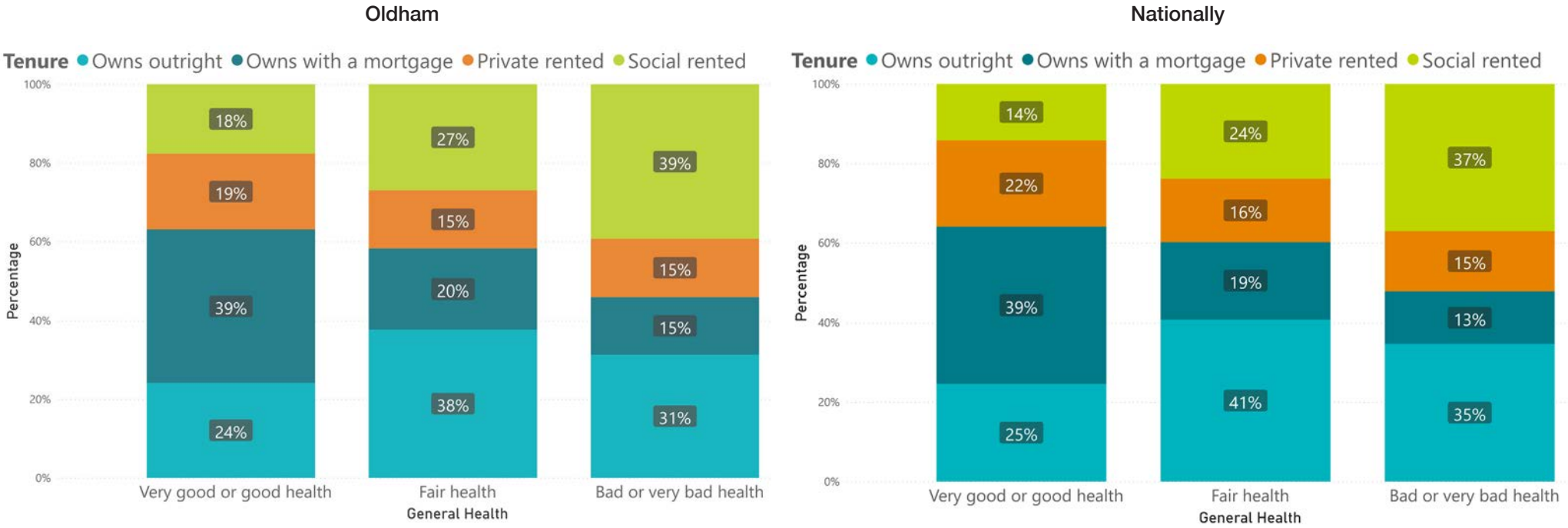


Figure 4: Percentage of people by general health status and tenure of accommodation.Oldham (top right) and nationally (bottom right). (ONS Census 2021)

Over the last 30 years only the private rented sector has seen consistent growth in Oldham (Figure 5), and while more properties have become rental properties, rent prices have also increased. Emerging research shows that the private rented sector in the UK on average fares worse for affordability, precariousness, security, and quality compared to other tenures. The Health Foundation recently found that 21% of homes in the private rented sector were non–decent, and more than half had serious hazards.

The private rented sector is largest in Oldham's more deprived wards. This means that the high costs and poor conditions most associated with the private rented sector disproportionately impact Oldham's deprived communities. People living in these communities are therefore likely to spend a higher proportion of their income on housing and have less remaining to spend on essentials such as heating or food. The 2021 Census shows that just over a quarter of children in Oldham are now living in the private rented sector, which is an increase of 15% from 2001. This means that more children in Oldham are now vulnerable to the associated impacts, and these may have additional repercussions for this age group. If accommodation is unstable, for example, this could impact on school attendance and attainment.

Compared with homeowners, the English Housing Survey 2021/22 identified that people living in rented accommodation (private rented sector or social renting), generally had lower scores for life satisfaction, thinking life is worthwhile, and happiness, and higher scores for anxiety. Social renters had the lowest wellbeing scores and the highest anxiety score (Appendix 3). Additional factors may influence the relationship between wellbeing and tenure; for example, social renters were most likely to be unemployed or 'other inactive' (this includes people with long-term sickness or full-time caring responsibilities') or earn the lowest income.

More information about health and housing tenure in Oldham is available on Oldham's Joint Strategic Needs Assessment website.

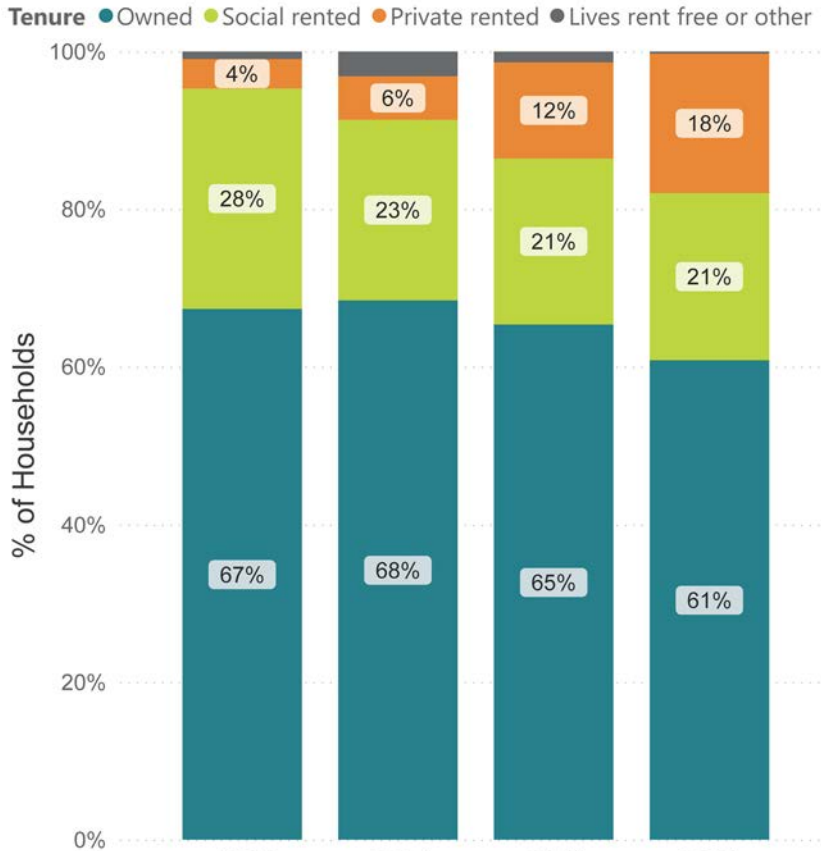


Figure 5: Percentage of households in Oldham by housing tenure type, from 1991–2021 (ONS Census)

Health and housing type

There are also different patterns of health across different types of housing. People who live in flats generally experience poorer health than people living in other types of housing in Oldham (Figure 6), and people who live in flats in other parts of England. Compared with other types of accommodation in Oldham, a larger percentage of flats are occupied by disabled people (Figure 7). Disabled people living in flats are therefore likely to have worse health than people who only live in a flat or only have a disability. If people with reduced mobility are without access to a lift or ground floor accommodation, there could be a knock–on effect to accessing outdoor green space, social activities, or affordable healthy food. This would in–turn affect their health and wellbeing.

Additionally, more Oldham residents aged 65 years and over live in terraced houses than the national average. The Office for National Statistics (ONS) shows that terraced houses generally have the lowest ratings of insulation; this means they are not energy efficient, and some may remain cold through the winter. Oldham has approximately 36,000 terraced houses and the distribution is not equal across the borough (ONS Census 2021; Appendix 4). Terraced houses are most commonly found in deprived wards such as St Mary's, Waterhead, Medlock Vale, and Werneth. This means that in Oldham, warmth may be less affordable for a more deprived, more vulnerable population (see 'Excess cold or heat' for more information about the impact of cold homes on health).

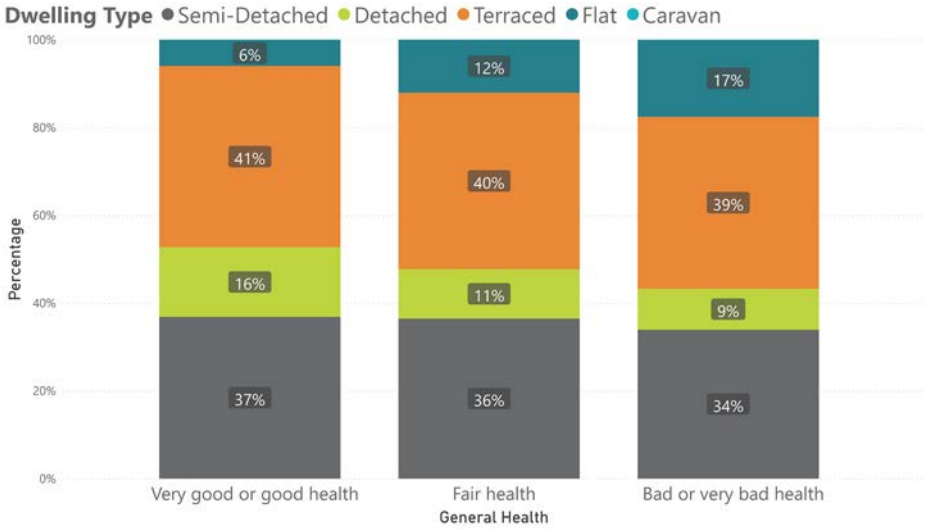


Figure 6: Percentage of people by general health status and type of housing; Oldham (ONS Census 2021)

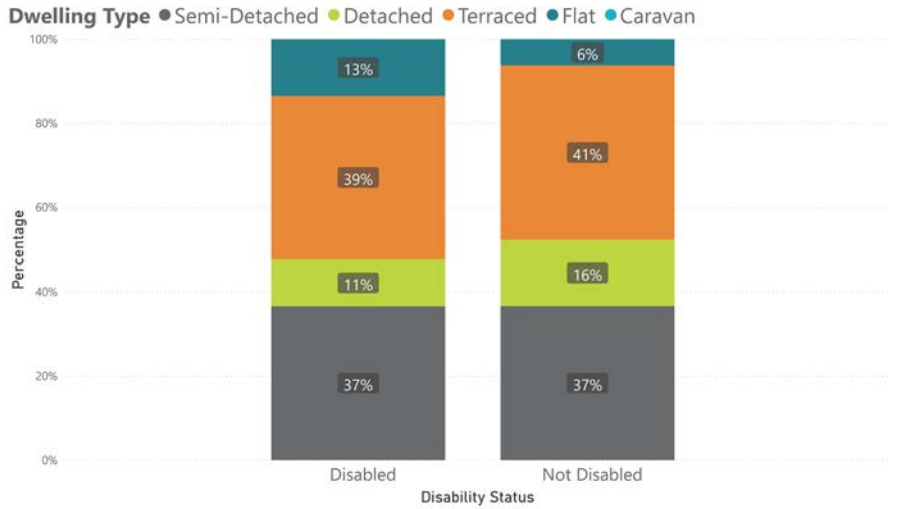


Figure 7: Percentage of people by disability status and type of housing; Oldham (ONS Census 2021)

Health and housing quality

In 2000, the Government introduced the Decent Homes Standard (DHS) to set a minimum standard for social housing in England and Northern Ireland. This aimed to improve housing stock and therefore quality of life, by ensuring that homes were free from serious hazards, in a reasonable state of repair, had reasonably modern facilities, and could provide reasonable thermal comfort. The DHS has been developed over time, to include the housing health and safety rating system (HHSRS) and to be extended to the private rented sector. According to The Health Foundation, in 2022, 3.7 million homes (15%) did not comply with the DHS. Although the percentage of non–decent homes in Oldham is similar to England as a whole, as of 2020, Oldham had a higher percentage of homes with Category 1 hazards, per the HHSRS (Oldham 12%, England 10%). This means that more homes in Oldham pose a risk of serious harm to occupants. According to the English Indices of Multiple Deprivation 2019, 10% of Oldham is represented by housing of the poorest quality, nationally.

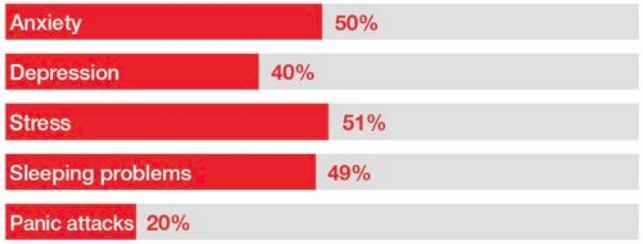


Figure 8: Percentage of all adults in the North West who have had a housing problem in their lifetime, who said that it contributed to mental health issues (Shelter 2017)

Shelter (2017) found that nationally, 1 in 5 adults had suffered mental health issues in the past 5 years due to housing problems. This figure was higher in the North West region, with almost half reporting anxiety, stress or sleeping problems (Figure 8).

Oldham's Local Housing Needs Assessment (2019) reviewed the extent to which households were satisfied with the state of repair of their home. Overall, almost 3 in 4 respondents were satisfied and more than 1 in 10 reported some dissatisfaction. Within the assessment, 46% of respondents indicated a home repair problem. Of those with a repair problem, the most common areas of concern in the borough were dampness/mould growth (39%), windows (31%), and the roof (29%).

As part of the Cost–of–Living response, a targeted programme of doorstep engagement took place. This focused on areas where data suggested people were most likely to be impacted. Conversations were open ended, asking residents about their general wellbeing. Between July 2022 and July 2023, 483 issues were raised by residents about housing, and this was the 5th most common issue discussed. Outstanding repairs, damp, and mould were the most common issues raised by tenants of both private and social landlords, followed by the need for aids or adaptations within the home. Ill health or disability and overcrowding were the most common reasons residents in social housing were seeking a house move.

Households expressing the highest levels of dissatisfaction were characterised by:

- households living in East Oldham
- renting privately
- living in affordable housing
- living in terraced houses
- flats or maisonettes
- living in pre–1919 dwellings
- having an income of less than £200 each week
- had a young Household Reference Person
- households containing someone with an illness/disability

Unsafe homes

Hazardous, unsafe housing is characterised by risk of fire, unsecured blind cords, dangerous windows and stairs, and presence of mould and damp, for example. Each year there are approximately 6,000 deaths in the UK as a result of home accidents (ROSPA), with the highest proportion represented by children under 5 years old and people in older age. In addition to this, 500,000 hospital admissions are attributed to accidents in the home each year. In Oldham, the rate of hospital admissions caused by unintentional and deliberate injuries in children aged 0–4 years is almost double that for England as a whole (Oldham: 204.5 per 10,000; England: 103.6 per 10,000). The rate of injury varies over the year, with more accidents occurring during the summer months when children spend more time in the home.

Damp and mould growth

One indicator of a poor–quality home is mould, which is a hazard to health. 1% of the Oldham private rented sector (approximately 165 properties) is considered to have serious mould and 20% (approximately 3,300 properties) have moderate mould. Damp and mould in the home could be caused by penetrating damp, rising damp, or condensation leading to mould growth. Penetrating damp is a structural issue that could be from a roof leak, leak from a water pipe or disrepair of a window. Rising damp usually relates to deterioration of the damp proof course of the building.

Condensation leading to mould growth is the most common cause of damp and is particularly evident during the winter months when there is less likely to be ventilation. Anecdotally, there has been an increase in condensation during the cost–of–living crisis owing to reduced usage of central heating during cold periods. Damp and mould in the home is associated with respiratory infections, allergies and asthma. Damp and mould can also affect the immune system.

Research by the National Institute of Health suggests that homes experiencing greater deprivation are more likely to experience greater severity of mould. This is particularly relevant for children living in deprivation, as they are more susceptible to hospital admissions linked to respiratory syncytial virus which is known to be exacerbated by damp and mould. 16% of children in Oldham experience the highest level of income deprivation nationally, which means that a substantial proportion are at risk. Minority ethnic households are also disproportionality impacted – “Mixed White and Black Caribbean (13%), Bangladeshi (10%), Black African (9%) and Pakistani (8%) households were more likely to have damp than White British households (3%)”.

The Oldham Offer

The Home Improve Loan scheme

The Home Improve Loan scheme is one of the tools available to help owner occupiers in Oldham who are on a low income to carry out essential repairs to their home, for example, to pay for a damp proof course, or replace a window. This is a loan facilitated through the release of equity in their home. Home Improve Loans play a crucial part in the sustainability of housing within Oldham, and by helping residents to remain in the area they also help to maintain communities. The scheme also enables the local authority to contribute to meeting the Decent Homes Standard for vulnerable households in the private sector, which means that more people live in homes that are in a decent condition. To date, Oldham Council has provided 191 equity loans to residents with a value of £3.75m and has made budget provisions for the next three years of more than £500,000.

Selective Licensing

Selective licensing is a license scheme which requires all private landlords with properties in a designated area to apply for a license and comply with certain conditions. Conditions include gas and electrical safety, installation and management of smoke alarms, and suitable provision for storage and collection of household waste. The scheme was introduced within the Housing Act 2004 as a tool to improve the management and quality of private rented properties.

It was recognised that poor management standards in the private rented sector contributed to several issues for Oldham residents. Oldham Council implemented Selective Licensing in the borough in 2015, and a new scheme came into operation in July 2022. This means that any privately rented properties in certain areas, such as in Hollinwood and Clarksfield, will require a licence to operate. A map of affected areas is available on the Oldham Council website.

Tenants Charter

Oldham Council also has a Tenants Charter so that residents know what to expect from their landlord, how to get help if they need it, and what to do if a landlord doesn't carry out repairs and maintenance properly. This is in line with the Council's Housing Strategy (2019), that committed to: provide access to information and accommodation, prioritise early intervention and prevention, and provide support to those most in need.

Pests

Pests are similarly found in houses of disrepair, or in low–income households that cannot afford pest control measures. Rats for example, are more commonly found in densely populated areas where they can access food and shelter easily. Pests are associated with increased risk of asthma, allergies and transmission of certain diseases, which are spread through urination, faecal droppings and shedding of skin/ fur. In addition to this, rodents can cause an increased fire risk by gnawing through electricity cables.

The Oldham Offer

Pest Control

For a 12–month trial period (April 2023 – March 2024), Oldham Council invested in free and universal pest treatment for all homeowners and private tenants in Oldham who were experiencing an infestation in their home. This helped to tackle infestations of rats, mice, cockroaches, bed bugs and fleas. The aim was to remove all 'public health related pests' with the aim of reducing the risks associated with poor health/ infectious diseases.

> "Homes that are cold can cause and worsen respiratory conditions, cardiovascular diseases, poor mental health, dementia, hypothermia, and problems with childhood development."
>
> Institute of Health Equity

Excess cold or heat

Homes that are cold can cause and worsen respiratory conditions, cardiovascular diseases, poor mental health, dementia, hypothermia, and problems with childhood development (Institute of Health Equity). Cold homes are associated with an increase in hospital admissions and excess winter deaths, particularly in vulnerable groups such as the elderly, the young, and those with pre–existing health conditions. The Building Research Establishment (2021) estimates the cost to the NHS of treating those affected by poor housing to be £1.4bn per year.

The recent rise in energy prices has driven more households into fuel poverty, which is associated with properties that are: poorly insulated, older, rented, end terrace or converted flats, or off the gas network. Age UK have estimated that 2.35 million households in England are fuel poor and struggle to heat their homes, and 6 million low–income homes in the UK have band D or lower energy efficiency. This likely means that low–income families not only struggle to afford to heat their homes, but when they do, they lose much of the heat due to poor insulation.

In 2021, 16% of households in Oldham experienced fuel poverty. This means that more households in Oldham were not able to meet their energy needs at a reasonable cost when compared with Greater Manchester (15%) and England (13%) as a whole. The percentage in Oldham also increased from 2020, where the regional and national percentages fell. The variation

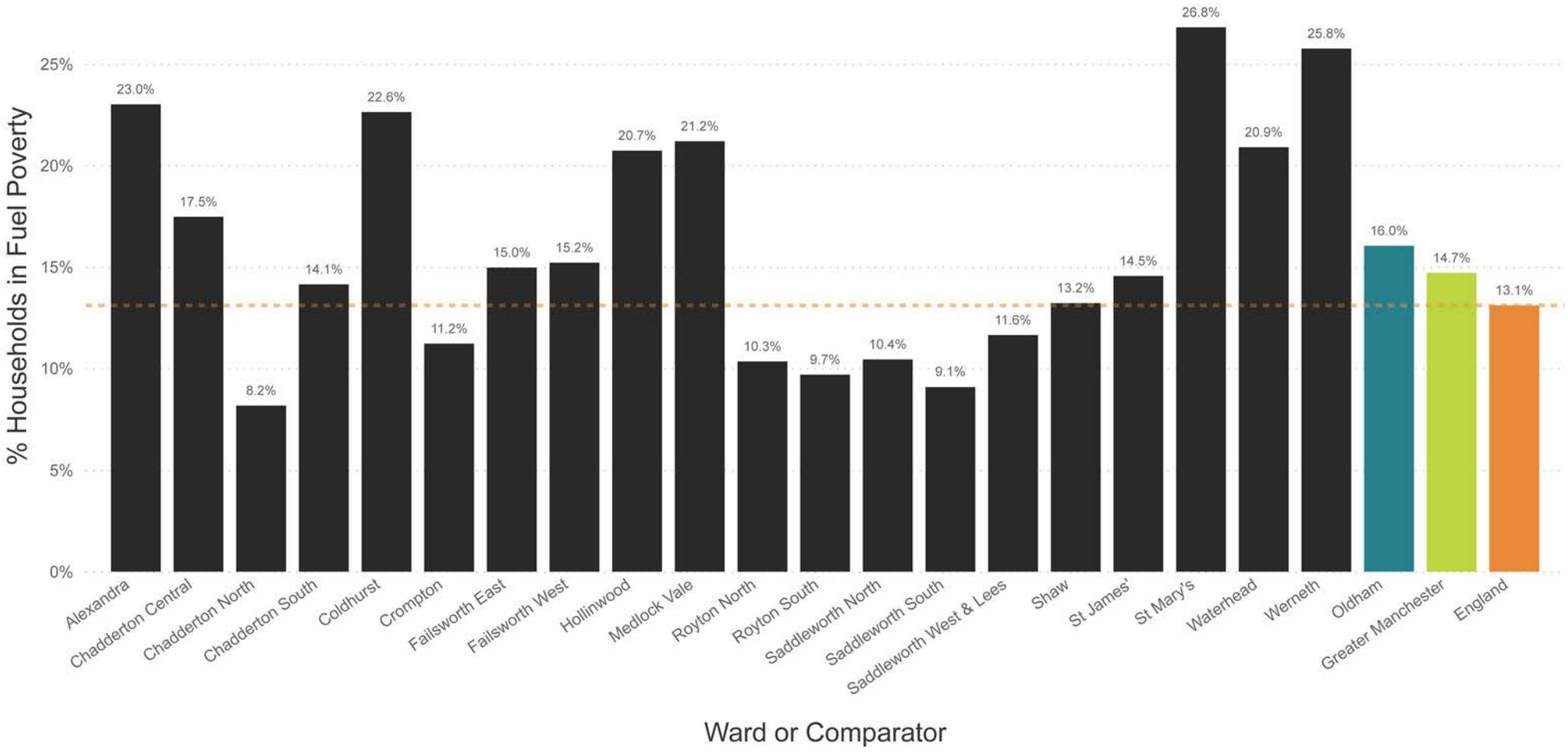


Figure 9: Percentage of households experiencing Fuel Poverty in Oldham by Ward, with reference to Greater Manchester and England (ONS Census 2021)

across wards in Oldham is highlighted in Figure 9. In St Mary's and Werneth, more than 1 in 4 households experienced fuel poverty in 2021.

The death rate also increases during heatwaves, with heat contributing to deaths from various causes such as heart disease and respiratory disease. In 2022, across all periods of high temperatures, the ONS estimated there were 2803 excess deaths in England, the highest number since the Heatwave Plan for England was introduced in 2004.

The Oldham Offer

Warm Homes Oldham

The Warm Homes Oldham scheme has been running since 2013 with the aim of tackling fuel poverty experienced by vulnerable residents, including older people, people with illnesses and disabilities, families with young children and pregnant women. The warm homes scheme provides a range of support including:

- Home visits
- Energy efficiency measures and advice
- Help with energy and water debt
- Application to trust funds
- Fuel and food vouchers
- Referrals to other partner services for further support

Between October 2022 and March 2023, the Warm Homes team received 5200 referrals. The increase and spikes in demand have at times out paced capacity, but the team are continuing to support residents who are struggling to pay energy bills and heat their home, particularly those most likely to be disproportionately affected.

Support and Inclusion team

The Oldham Council team works with residents who are struggling with money by helping them learn budgeting skills and maximise their income, this means they are more likely to be able to afford their bills, so they are more likely to stay warm. The team proactively identifies residents who struggle the most with their energy bills, seeking help from the Warm Homes team to offer a "Winter Warm" pack. This includes draft excluders, radiator foils, blankets, hot water bottles and energy efficient devices. This is a proactive step to ensuring that the cost of living doesn't further widen inequalities.

Cost of Living programme

The winter of 2022/23 saw substantial increases in inflation and in the costs of food, energy, and fuel. This widened the disadvantage gap between the less and more affluent households in the borough. The Cost of Living response allocated a total of £3m towards a programme of interventions to support residents who were likely to be significantly impacted by the rising cost of living. Interventions included the Warm Homes Scheme, the Support and Inclusion team (both above), and the provision of more advice and support via Citizens Advice and the doorstep engagement team. When residents raised issues with the doorstep engagement team, they were able to signpost to relevant support or in more complex cases, connect residents with services such as Tenancy Relations or the Social Landlord. The Cost of Living response also funded voluntary, community, faith, and social enterprise sector organisations to provide support for those residents either already in financial crisis and experiencing multiple disadvantages or likely to be disproportionately impacted, such as Age UK and homelessness charities. Support for the Cost of Living response remains in place throughout winter 2023/24 as inflation, although reduced from 2022/3 levels, remains high, and the energy price cap was raised by Ofgem.

Discretionary Housing Payments are also available and can prevent eviction for residents in arrears or unable to pay their rent.

Able–to–pay Area Based Retrofit programme "Homes for Health and Resilience"

In autumn 2023, Oldham Council secured a £140,000 grant from Connected Places Catapult to work together with the Catapult and local retrofit experts, Carbon Co–op, to develop an Area Based Retrofit offer in Oldham for the 'able to pay' sector. The scheme will address properties which do not qualify for national grant schemes and aims to deliver a programme of work which will improve housing in terms of energy and carbon performance, health and wellbeing and resilience to a changing climate. The programme will also design a study to look at all aspects of implementing a local area–based

retrofit scheme for improved energy efficiency and decarbonisation of the housing stock including supply chain, skills, financing options for home–owners and also delivery models for non–owner–occupier tenures including the private rented sector.

The project partners will also work closely with local registered providers of social housing to look at how they are addressing the retrofit challenge. They will also review the Council's private finance initiative housing stock and explore how the contract can move away from like–for–like gas boiler replacement programmes to lower carbon alternatives, to improve the fabric of the building while ensuring the needs of tenants are met.

It is expected that the scheme will select two areas of Oldham initially, with consideration of housing types and a range of socio–economic indicators. If the scheme is successful in these areas, it will be rolled out more widely across the borough.

Unsuitable homes

A house can be unsuitable for many reasons, whether it is too small, doesn't meet an individual's health or disability needs, or it is not affordable.

Overcrowding

The amount of space people have is an important aspect of housing quality. The ONS defines overcrowding as "to have an occupancy rating of negative 1 or less, which implies that a household has fewer bedrooms than required". Overcrowding can also be described as a mismatch between the type of dwelling and the needs of the household, depending not only on the number of people but their ages, their sex and their relationships. It indicates insufficient space not only for sleeping but for living, for household activities such as cooking, and for storage.

Damp and mould growth is a common side–effect of overcrowding due to the increase in humidity from having a large number of people in a small space. This means that people living in crowded conditions are also likely to experience the impacts of exposure to damp and mould, described previously.

Overcrowding can have a significant impact on health behaviours and is linked to food insecurity (see Facilities), increased risk of infection and poor mental health. There is evidence that overcrowding impacts on children's education through higher rates of sickness absence and difficulty in studying/ concentration at home.

Compared with England, approximately double the percentage of homes in Oldham are overcrowded (Oldham: 8%; England 4%). The percentage in Oldham has also increased slightly while there has been a reduction of almost 3% nationally. Overcrowding in Oldham is most common to terraced properties in the most deprived wards. Overcrowding, in the main, is not observed in Oldham's most affluent wards (Figure 10). More information relating to overcrowding in Oldham is provided on Oldham's Joint Strategic Needs Assessment website. Overcrowding is distinct from intergenerational living in this context, where the latter is associated with benefits such as decreased social isolation, and improved mental and physical health.

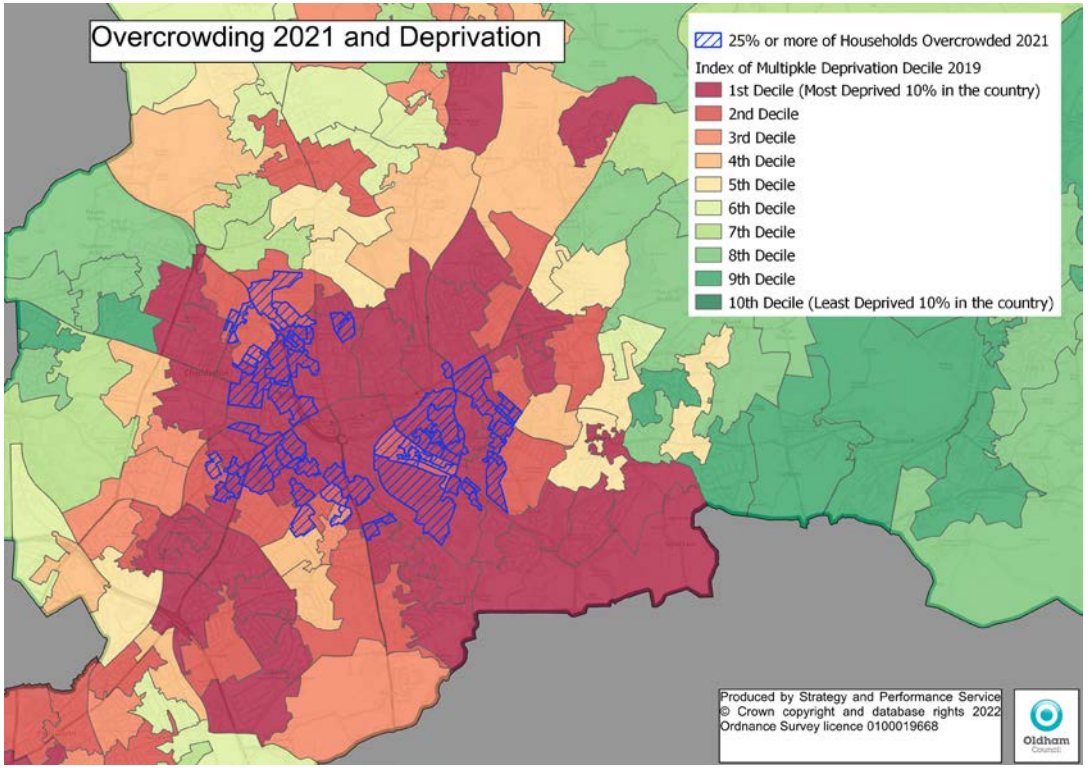


Figure 10: Areas in Oldham with overcrowding of 25% or more households overlaid with deprivation.

Facilities

There are many factors that positively or negatively affect diets and food choices, including the type of housing people live in and if this gives them access to basic kitchen and cooking facilities. When “people do not have adequate physical and economic access to sufficient, safe and nutritious foods that meet their dietary needs and preferences for an active and healthy life”, they experience food insecurity. Studies into food insecurity affecting young people in the UK found that lacking the sufficient storage space to store food e.g., fridge or a freezer (21%), not being able to afford energy costs to cook (17%) and not having access to a decent kitchen to prepare meals (11%) were significant contributors to poor diet.

Those who struggle with food insecurity are more likely to rely on cheaper, poor–quality options that are high in calories, fat, salt or sugar. Consistently having an unhealthy diet has a negative effect on health outcomes, and is associated with weight gain, obesity, and other chronic conditions such as diabetes, cancer, heart disease or stroke. Food insecurity has also been found to negatively impact on mental health, leading to feelings of stress, anxiety, and depression. The Food Foundation monitors the impact of household food insecurity in the UK; in 2022 they estimated that 7.3 million adults and over 2.6 million children in the UK experienced food insecurity.

Unsuitable for individual needs

The shortage of accessible/ adaptable properties has a significant and disproportionate impact on people with disabilities and or health conditions as it affects their ability to live independently.

Source: Public Health England

Food insecurity has been found to negatively impact on mental health, leading to feelings of stress, anxiety, and depression.

Unstable homes

Homelessness

Homelessness doesn't just refer to rough sleepers but includes those with unstable accommodation and those that are 'sofa surfing'. People who are homeless are more likely to have poor mental and physical health, and are more vulnerable to issues relating to alcohol and drug use, and exploitation. Some conditions might have been a catalyst to becoming homeless, and some conditions might result from rough sleeping.

The use of Section 21 eviction notices, which landlords can deliver without tenants doing anything wrong, increased nationally by 38% on the previous year and is thought to be driving the surge in homelessness and the need for temporary accommodation in England.

Temporary accommodation

Figures from the Department for Levelling Up, Housing and Communities (DLUHC) show that the number of households living in temporary accommodation in England was at a record high between January and March 2023. 104,510 households were living in temporary accommodation, which is a 10% increase from the previous year. This includes almost 65,000 families, and 131,370 dependent children. (Statutory Homelessness in England: January to March 2023). There are a number of direct and indirect health, social, and educational consequences for children and families experiencing homelessness or living in temporary or insecure accommodation. For example, children who move into temporary accommodation are 50% more likely to have lower wellbeing than those who don't (Children's Society). Shelter (2023) found that nationally, almost half (47%) of families with school–age children have been forced to move schools because of living in temporary accommodation, and this has a wider impact on pupil attainment. Children under 5 years old living in temporary accommodation also have more accidents and respiratory infections, and poor vaccination rates (Local Government Association). In addition to this, there is an identified risk to parental mental health, especially among single mothers, with an association between housing instability and an increased risk of depression in mothers.

People who are accommodated in houses of multiple occupation (HMO) are also more likely to be subject to the impacts of overcrowding on health directly, and indirectly through health behaviours. Health behaviours are actions taken by individuals that affect health outcomes, for example diet, alcohol consumption, drug taking, physical activity, smoking or sexual activity. The house in which an individual or family lives has a considerable influence on the choices, or lack of choices available to support healthy behaviours. For individuals who live in shared accommodation, the behaviours of other residents such as smoking, can remove all control within the environment that impacts on health outcomes. Exposure to second hand smoke is damaging to health for children and adults. It can lead to minor illnesses such as eye irritations, headaches, coughs, sore throat, dizziness or nausea, or significant impact to health for example onset of or exacerbation of respiratory conditions like asthma. Although some landlords may enforce smoke–free homes and spaces, there can be a lack of consistency and there may be no policy against tenants smoking in any shared living area.

People who are homeless or living in temporary accommodation are also disproportionately affected by food insecurity.

People who are homeless or living in temporary accommodation are also disproportionately affected by food insecurity (see Facilities), with more than two thirds (68%) of people living in temporary accommodation having inadequate access to basic facilities (Shelter).

The type of temporary accommodation provided by a local authority can vary widely dependant on housing stock and availability. Some households might be offered self–contained properties with access to a kitchen whereas others could be offered options where cooking facilities are either limited or shared with others, such as a hotel, bed and breakfast (B&B) or HMO. UK government guidance states that for families with children and pregnant women, local authorities should only use B&B accommodation as a last resort and for a maximum of 6 weeks. Despite the 6–week limit, due to a lack of housing stock and other available options, families will sometimes stay for much longer than this. There is no limit for single adults or couples on the length of time they might be accommodated with no access to cooking facilities. There are also inconsistencies across B&Bs and hotels, with some providers offering breakfast and evening meals, and some with no provision of food or cooking facilities. For people living without cooking or storage facilities, the quality and variety of food options available to them is limited, often relying on takeaways or food that doesn't require heating. This can further impact on the finances of a group already in financial hardship.

In line with the Housing Act 1996, Oldham has a legal duty to offer interim accommodation to households that are eligible. In the period between December 2020 and December 2023, the number of households in statutory Temporary Accommodation rose from 171 to 507, which is almost a three–fold increase. There are now consistently more than 7500 applicants on Oldham's Council Housing Need Register, and households requiring temporary accommodation have more complex needs than in previous years. More applicants have a history of mental health problems, a history of rough sleeping, have experience with the criminal justice system, or have experience of/are at risk of domestic abuse.

In a recent snapshot of the register (Appendix 5), half of the applications are for Council Tax band 2 properties, and the most common requirement is for 1 bed (41%).

Between December 2020 and December 2023, the number of households in statutory Temporary Accommodation rose from 171 to 507, which is almost a three–fold increase.

The Oldham Offer

Shared Health Foundation

Oldham Council is working with Shared Health Foundation to reduce the impact of poverty through practical support to families who live in temporary accommodation. It ensures that families have access to health services and are signposted to the support they require. It offers a drop–in service at local hotel provision so families can discuss any health–related concerns they may have with a qualified practitioner.

As a strategic priority, Shared Health Foundation work closely with Oldham Council to make sure the temporary accommodation provision is safe and secure for families. For example, facilitating safe sleeping arrangements by ensuring cots are provided, and ensuring properties are free from child hazards through the provision of baby gates and blind cord clips. Shared Health Foundation also lobbies and collaborates with policy bodies to ensure the voices of families are heard. The most recent project enabled fridges and washing machines to be installed in one of Oldham's most used temporary accommodation hotels for families.

The future

Housing is one of the political priorities for Oldham Council and in 2023, the Leader of the Council, Arooj Shah, agreed a motion declaring the borough is in the midst of a housing crisis as too many residents are considered to be living in substandard or overcrowded housing. In early 2024, the Council will seek to bring together key partners including social housing, private rented and owner–occupiers as well as members of the voluntary and social enterprise sector, council officers and cabinet members for an Oldham Housing Summit.

The most recent Local Housing Needs Assessment was conducted in 2019 to inform the Council's Housing Strategy and the Local Plan review, and there are plans in place to update the information.

The 2019 report shows the number of people across the borough aged 65 or over is projected to increase by more than 35% by 2037, from 37,800 in 2018 to 51,300. A major strategic challenge for the Council is to ensure that there is a range of appropriate housing provision which is accessible and adaptable to support for the borough's older population, and residents with disabilities and/or health conditions. Future builds will also need to respond to demands relating to climate change and more extreme weather patterns, for example with better insulation and the ability to cool down in high temperatures.

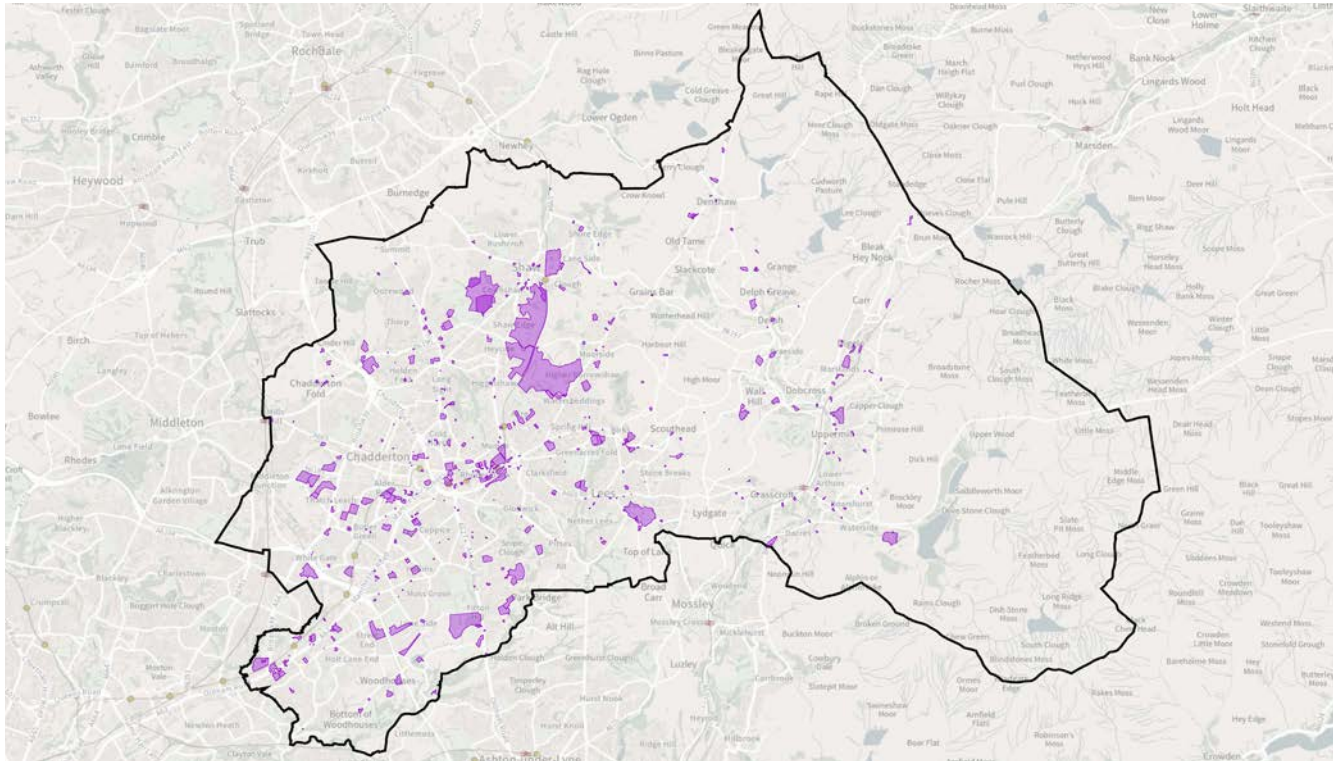


Figure 11: Oldham Housing Land Supply 2023 - purple highlighting indicates proposed development areas.

New build housing plays a vital role not only in the creation of more properties, but also in generating market churn. This creates opportunities for households to move into more suitable housing and may therefore release housing that is affordable to lower income groups. More information on population churn in Oldham is available on Oldham's Joint Strategic Needs Assessment website.

Oldham's Housing Land Supply indicates the number and location of homes expected to come forward in the borough in the short and long term to meet Oldham's housing need. As of 1st April 2023, 13,061 homes have been identified for the period of 2023 to 2049. This is split into:

- Short term (2023–2028) – 3,191 homes
- Medium term (2028–2033) – 5,202 homes
- Long term (2033–2049) – 4,668 homes

A large portion of the housing land supply is expected to come forward within the central wards of Coldhurst and St Mary's, particularly within Oldham Town Centre (over 2,000 homes) (Figure 11). Most of the housing supply within Oldham Town Centre will be made up of apartments.

The number of new homes needed in Oldham is set out in 'Places for Everyone' – a Greater Manchester long term plan for housing. Oldham is required to deliver 11,560 homes between 2022 and 2039, which equates to an average of 680 homes per year. The housing requirement is phased:

- 2022–2025 – 404 homes per year
- 2025–2030 – 680 homes per year
- 2030–2039 – 772 homes per year

Places for Everyone Strategic Allocations

Places for Everyone sets out several strategic allocations for around 2,650 homes within Oldham. The largest scale of development from these allocations will be in the north of the borough and most of the allocations are expected to come forward in the medium to long term. Some of the allocations, particularly the larger such as Beal Valley and Broadbent Moss, will require supporting transport, education, health and social infrastructure. As such, the timescales for delivery may differ.

In terms of the quality of the existing housing stock, especially in terms of energy performance, there will be a need to deliver a large–scale retrofit programme over the next few years to meet local Oldham and Greater Manchester carbon neutrality targets, improve health outcomes and tackle the 'cost of living crisis' by reducing residents' energy bills. Oldham's 2030 carbon neutrality target is for every Oldham household to have a comfortable property with affordable energy bills. The scale of investment required to achieve this is significant, and the Council continues to explore the potential to secure large–scale investment from commercial sector low carbon infrastructure providers. More information is available in the Oldham Green New Deal Delivery Partnership investment prospectus (2023), and on Oldham's Joint Strategic Needs Assessment website.

Recommendations

1. Oldham should continue to work as a system in response to crisis and the unprecedented housing demand, and also move towards a preventative and early intervention model.

2. Oldham should build upon the commitments made at the housing summit, led by the leader of the Council. This includes a pledge to build 500 new social homes over the next 5 years. Oldham Council should ensure healthy housing is a focus in the actions taken forward.

3. Health needs and potential impacts on health should be considered during temporary accommodation allocations, where properties have been assessed for suitability for families with young children and those with health conditions or disabilities. Housing leads and healthcare practitioners should further work together to explore shared solutions:

    a. To explore mitigations to barriers in accessing school, employment opportunities, or health centres

    b. To ensure that household complexities, including presence of drug or gambling addictions, alcohol dependency, disabilities, and physical and mental illness, are recognised and supported.

4. Through a no wrong front door approach, Oldham Council should ensure that staff from across the system are equipped to support vulnerable or at risk individuals with a range of housing needs.

5. Oldham Council should maximise opportunities to improve housing standards, for example through selective licensing, pest control and home improvement loans. A key focus should be on the private rented sector where residents are experiencing damp and mould.

6. Oldham Council should seek to systematically join and analyse data to understand how housing issues for residents are layered with non–housing complexities. Oldham's most vulnerable residents should be proactively identified and supported to prevent a point of crisis.

    a. Ensure that Oldham Council continues to use data and intelligence to monitor trends across a number of housing areas to prepare for future demand and implications to a wide range of services.

7. Ensure that strategic links are made and maintained to improve health outcomes and reduce inequalities through wider environmental and economic plans, such as housing development, climate change and decarbonisation.

Conclusion

This report has reflected on the links between health and housing, and identified the groups most likely to be disproportionately impacted. The report highlights several characteristics of poor–quality housing, and although the possible health impacts have been explored in isolation, it is more likely that homes have multiple issues at the same time, for example, overcrowding and mould. This brings a cumulative effect, where more issues lead to worse health and wellbeing. Young children, the elderly, and those with health conditions are more likely to be negatively impacted by the effects of poor–quality housing. People living in poor–quality homes are also more likely to live in deprived areas, which in Oldham, have a higher proportion of privately rented homes. This raises the scenario of a large family living in an insecure, privately rented home in a deprived area; the home is overcrowded and has poor insulation, and the family are experiencing fuel poverty. The lack of affordable warmth during cold periods can drive condensation and encourage mould growth. Evidence presented in this report demonstrates that this family could experience increased hospital admissions due to accidents and respiratory illness, poor mental health, poor diet and physical health, and poor educational attainment. Each of these possible consequences can have life–long impacts, which widen inequalities over generations. Over the last 30 years, Oldham has seen noticeable growth in the private rented sector, an increase in no fault evictions, and increased demand for temporary accommodation. These are driven by the cost–of–living crisis and are occurring nationally. However, the impact appears to be starker in deprived local authorities such as Oldham, and existing inequalities in life expectancy and healthy life expectancy will be exacerbated.

This report would not have been possible without input from staff working across multiple teams and service areas in Oldham Council. Special thanks must go to Anna Tebay, Head of Service – Public Health, who expertly curated and coordinated the content, and to Amber Podmore, Kathryn Willan, John Pritchard and Emily Baylis–Tunney for their invaluable contributions.

This report explores housing with restriction to the physical features of the property. Homes do not exist in isolation but are part of a social community which can, in itself, positively or negatively impact on wellbeing. This is similarly true of the location of the house in terms of safety, access to services, transport infrastructure, jobs, air quality and so much more. While housing plays a critical role in population health, it is not the only factor.

Appendix

1 Reflections on the recommendations from the 2022/23 Public Health Annual Report 'Tackling Infant Mortality in Oldham'

We should continue to take steps to improve the cultural competence of maternity services by ensuring the impact of parents' culture, ethnicity and language is discussed and considered during the antenatal risk assessment process, initial assessment and follow–up

- A Maternity Improvement Programme is underway at the Northern Care Alliance to improve quality & safety of maternity services.
- The Rochdale & Oldham Midwifery Enhanced Service (ROMES) continues to offer culturally sensitive enhanced maternity services to service users with specific needs.
- The Rochdale and Oldham Maternity Voices Partnership (ROMVP) provide the user perspective. ROMVP has been established for some time to inform service development and was commissioned locally. The service will be commissioned centrally from Greater Manchester from April 2024 with a significant financial uplift. The service will follow the new guidance and will include the 'neonatal' element to become an 'MNVP' from 1st April.
- Badgernet (digital healthcare notes) has recently been introduced for all women accessing maternity services, enabling them to take a more active role in their maternity care.
- There is increased capacity in the community midwifery service following recent recruitment of new midwives.

Professionals who work with families and pregnant women including GPs, midwives, maternity support workers, and neonatal staff, should undertake training on consanguinity and genetic conditions, for example the e–learning for health (eLfH) Close Relative Marriage module.

- The maternity services in Oldham undertake regular update training on all aspects of preconceptual and maternity care.
- In addition to the mainstream genetics service, the Community Genetics Service continues to provide additional support to at risk or concerned families. This service is to be promoted more.
- There is a requirement to improve the waiting time for the mainstream genetic screening as there is anecdotal evidence that some families are waiting up to 2 years for results and are left considering pregnancy whilst waiting, with the outcome of screening not known.
- Plans are in place to review Bradford's consanguinity model and success rate to share the learning from that programme.

We need to agree and roll out an Oldham approach to delivering personalised safe sleep messages for parents across the borough. This should be led by maternity and health visiting but include wider training for all staff across the wider children's workforce to understand the risks of SUDI.

- Oldham have continued with the Safer Sleeping Programme, with the intention to re–visit the communication campaign to ensure it dovetails with any national/regional campaigns for maximum impact.
- Sleeping arrangements are observed via targeted early help visits (from a variety of professionals) with a particular focus on safe sleep messaging in multi–occupancy homes.
- The handover from Midwifery to Health Visiting teams to be tightened up to ensure Safe Sleep (and other appropriate health messages) are consistently given.
- Oldham continues with Spoons Neonatal Family Support Programme, which helps parents to deal with these vulnerable infants on eventual discharge to home.
- New guidance for GPs has been published for post–natal maternal health checks. This has been circulated to all primary care services. However, prior to this, targeted and generic education & development sessions were completed within primary care following feedback from the MVP of poor experience.

As a borough, we need to commit to mitigating the impacts of poverty on the risks for infant mortality and make this a priority for the Health and Wellbeing Board and the wider Oldham system. This should include considering funding for safe places for babies to sleep and ensuring that housing for families with infants recognises that they need to sleep in a cot.

- There is a poverty alleviation programme in Oldham. This involves a number of partner agencies working together to address the wide–ranging risk factors for, and consequences of, poverty on all members of the community. Within that wider programme there are specific initiatives targeted at pregnant women and families with young infants. They include access to the 'Baby Bank' to provide recycled equipment for the care of an infant, the provision of 'Crib' to provide safe sleeping equipment for parents living in temporary accommodation, and the promotion of healthy start vouchers, vitamins and the uptake of child benefit. There are also local initiatives on the provision of services to ensure 'warm homes' that are of suitable quality.
- The maternity services have also been using the 'poverty proofing approach' to ensure that any financial barriers to service users accessing their services are reduced/removed.

Oldham should become fully accredited by UNICEF Baby Friendly Initiative and work towards the gold award. This will support Oldham to continue to be breastfeeding friendly over the coming years.

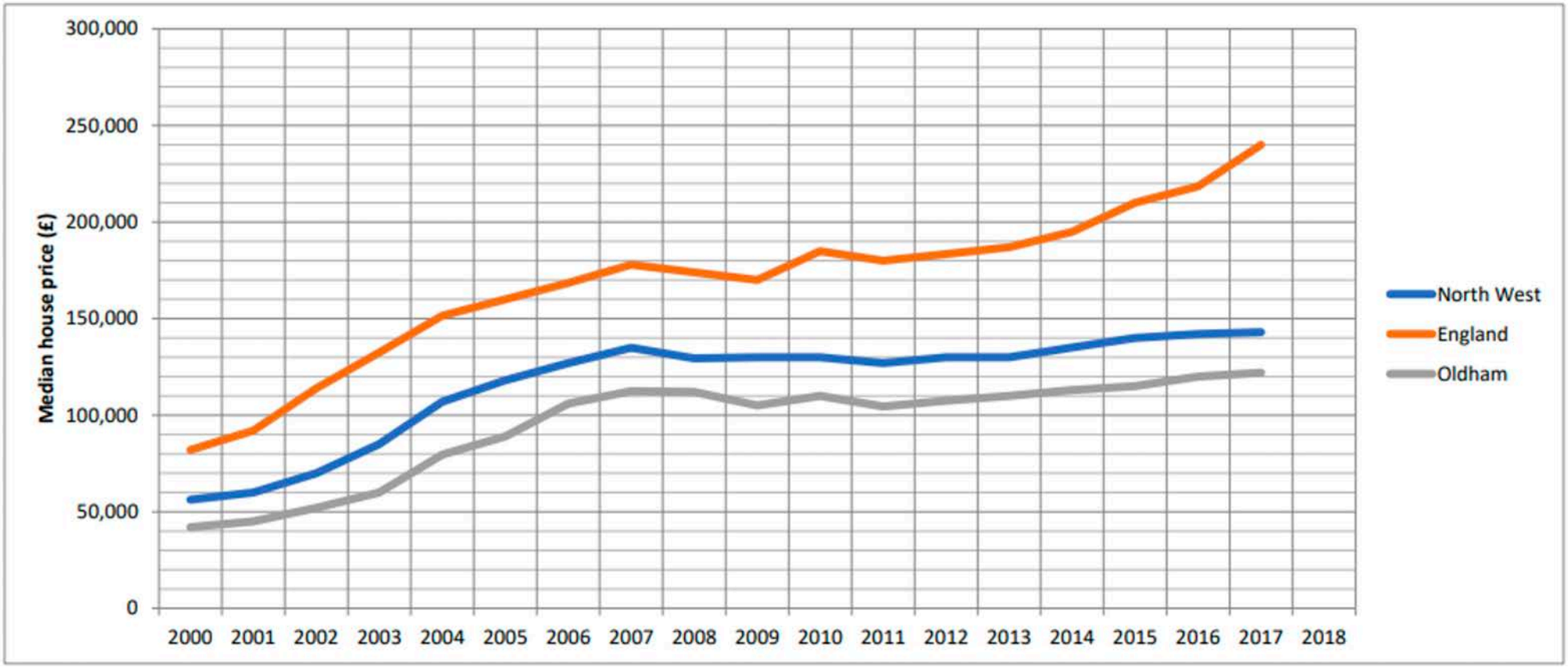
- Oldham Council and the Northern Care Alliance are working together towards gold accreditation from the UNICEF baby Friendly Initiative.
- There is also a number of other initiatives underway to promote breast feeding in Oldham, e.g., Home Start Oldham and Tameside (HOST) breastfeeding peer support service, continued access to the Breastfeeding Network's breastfeeding helpline, and the infant feeding support service.

The aim for Oldham should be for all pregnancies to be smoke–free. The Oldham Tobacco Alliance should work closely with maternity, Rochdale and Oldham Maternity Voices Partnership (ROMVP) and leaders across the borough to develop approaches to further reduce smoking in pregnancy.

- Oldham continues to provide the Smoking in Pregnancy Service and to promote smoke–free homes in Oldham, via the work of the Tobacco Alliance.
- Women with additional risks to their pregnancies, such as smoking, are placed on the 'Saving Babies' Lives' pathway of maternity care and given additional advice and support.

2 House Prices

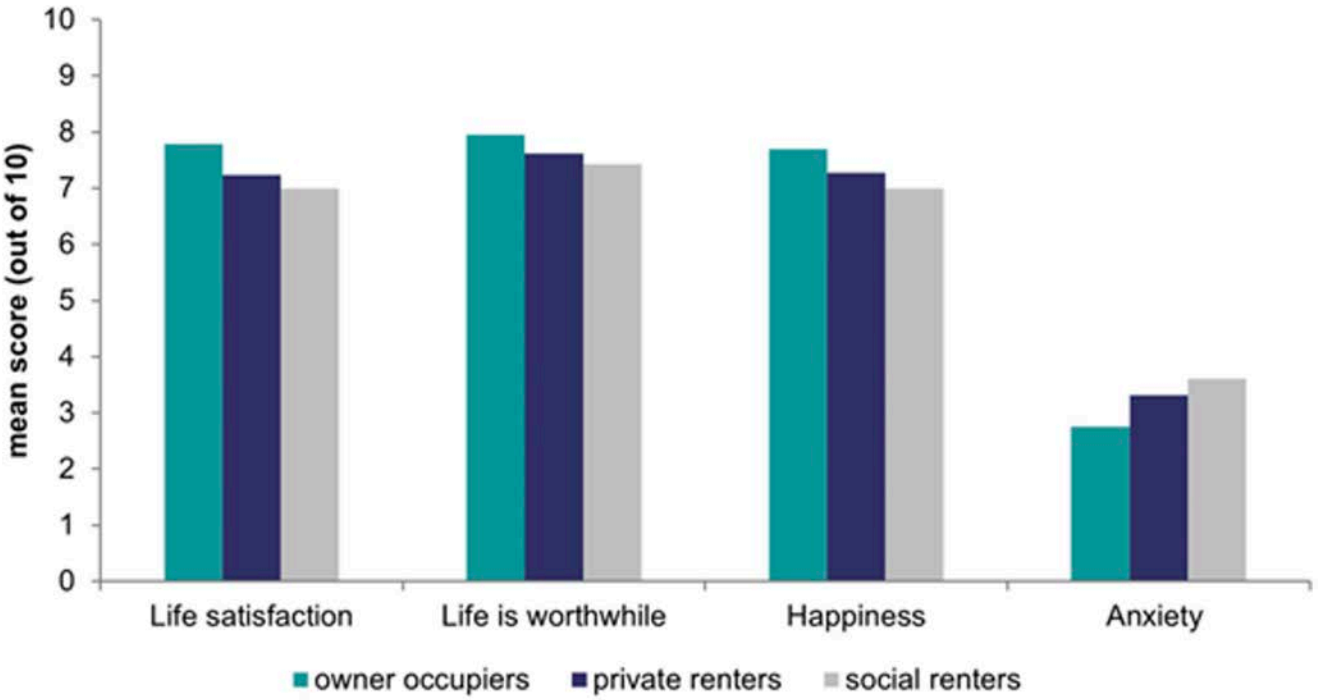
Median house price trends (2000 to 2017): Oldham borough, North West region and England



Source: Data produced by Land Registry © Crown copyright 2018

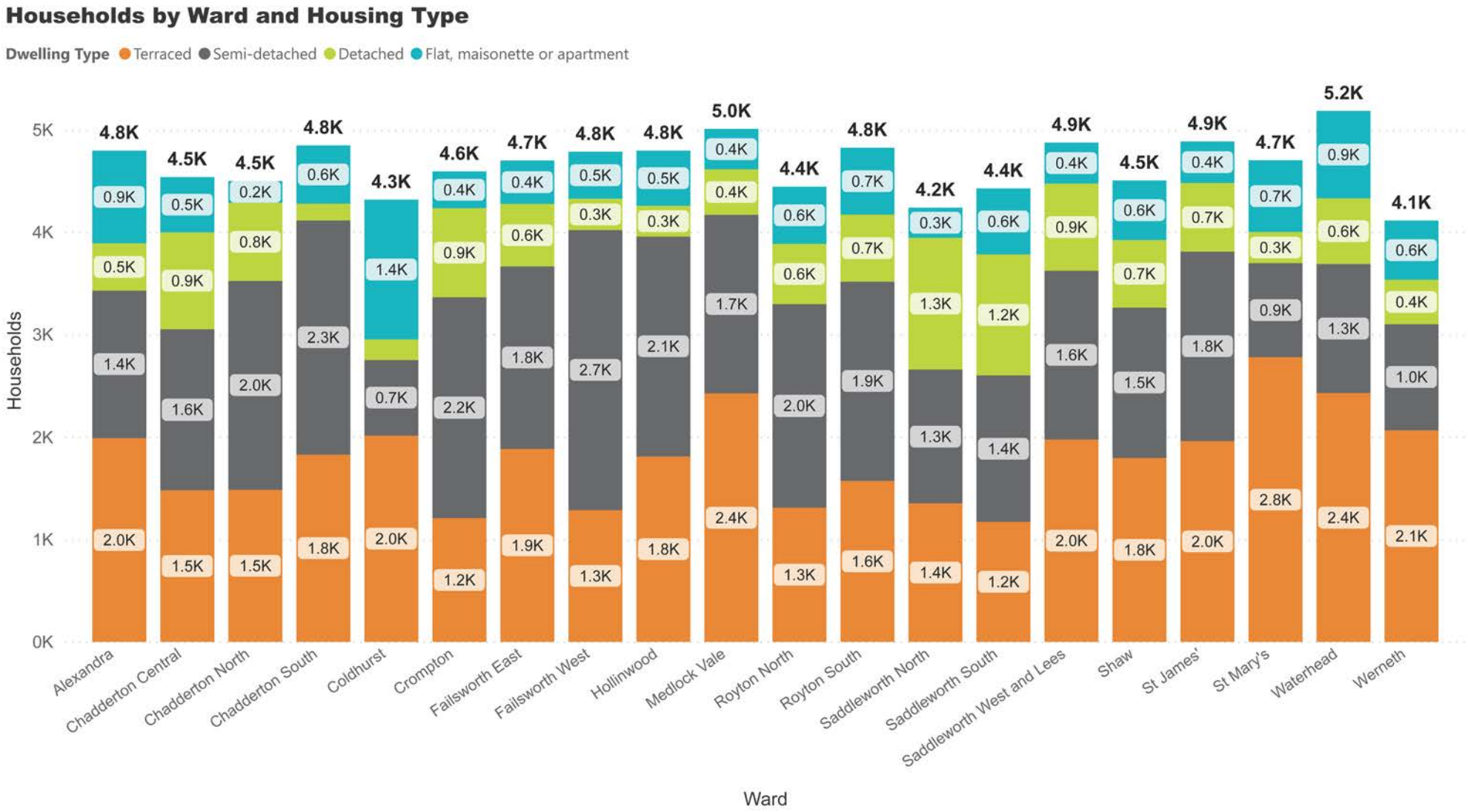
3 Housing Tenure

Housing tenure and wellbeing in England (English Housing Survey 2021/22)



4 Housing Type

Number of households by ward and housing type in Oldham (ONS Census 2021)



5 Temporary Accommodation

Snapshot of requirements per applications to Oldham's Housing Needs Register (2023)

Bed size	Band 1	Band 2	Band 3	Band 4	Total
1 bed	864	1349	725	194	3132
2 bed	507	971	358	90	1926
3 bed	342	1105	309	57	1813
4 bed	175	390	85	19	669
5 bed	48	50	7	2	107
6 bed	7	7	0	0	14
Total	1943	3872	1484	362	7663

This page is intentionally left blank