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HEALTH AND WELL BEING BOARD
Agenda

Date	Thursday 10 September 2026
Time	10.00 am
Venue	J R Clynes Second Floor Room 2 - The JR Clynes Building
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 Alex Bougatef 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, 7 September 2026. 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. Membership of the HEALTH AND WELL BEING BOARD Councillors Al-Hamdani, Ghafoor, Hurley, Quigg, Shah and Woodvine

Item No

1 Election of Chair

To elect a Chair for the duration of the meeting.

2 Apologies for Absence

3 Urgent Business

Urgent business, if any, introduced by the Chair

4 Declarations of Interest

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

5 Public Question Time

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

6 Minutes of the Previous meeting (Pages 5 - 12)

To consider the minutes of the meeting of the Health and Wellbeing Board held 5th March 2026.

7 JSNA Update - Child Health Update

To receive a verbal update on the JSNA.

8 Local Outbreak Management Plan (Pages 13 - 82)

To receive and approve the Local Outbreak Management Plan.

9 Better Care Fund 2025-26 End of Year Report and Planning template for 2026-27 (Pages 83 - 92)

To note the content of the End of Year Report and provide retrospective approval for their submission to the Regional Better Care Fund panel

To note the content of the 2026-27 BCF Planning Template, and provide retrospective approval for its submission to the Regional Better Care Fund Panel

To 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).

10 Neighbourhood Plan (Pages 93 - 178)

The Health and Wellbeing Board is asked to:

1. Approve the Oldham Neighbourhood Health Plan as Oldham's strategic framework for neighbourhood health between 2026 and 2031.

2. Endorse the vision, priorities and outcomes set out within the plan.

3. Support partners to align existing transformation programmes and investment decisions with the delivery of the plan.

4. Receive annual progress reports on delivery, outcomes, risks and dependencies through established governance arrangements.

Approval of the Plan will provide formal place-based endorsement of Oldham's approach to neighbourhood health and enable the Plan to be recognised as Oldham's agreed response to Greater Manchester and national neighbourhood health requirements.

11 Update on NCA Situation (Pages 179 - 186)

To brief members of the Health and Wellbeing Board on the current situation at the Northern Care Alliance following various media reports.

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HEALTH AND WELL BEING BOARD
05/03/2026 at 10.00 am

Present: Councillor Davis (in the Chair)
Councillors Mushtaq, Nasheen and Sykes

Also in Attendance:
Dr Rebecca Fletcher – Director of Public Health
Andrea Edmondson – NHS ICB Oldham
Mark Gifford – Chief Executive (FCHO)
Steve Taylor – Northern Care Alliance
Dr John Patterson – NHS ICB Oldham
Jude Brown – Children's Services (OMBC)
Moneeza Iqbal – NHS ICB Oldham
Anna Howarth – OCLL
Sandy Mitchell - OACT
Reverend Jean Hurlston – Manchester Church of England Diocese
Claire Hooley – Assistant Director: Adult Social Care (OMBC)
Dr Charlotte Stephenson – Consultant in Public Health (OMBC)
Dr Lois Hall-Jones – Consultant in Public Health (OMBC)
Anna Tebay – Public Health Service (OMBC)
Rachel Dyson – Public Health Service (OMBC)
Jon Taylor – Intelligence and Data Services (OMBC)
Peter Thompson – Constitutional Services (OMBC)

1 **APOLOGIES FOR ABSENCE**

Apologies for absence were received from Councillor Brownridge, Councillor Sykes, Mike Barker, Lucy Lees, Stuart Lockwood, Jayne Ratcliffe and Mohammed Sarwar.

2 **URGENT BUSINESS**

There were no items of urgent business received.

3 **DECLARATIONS OF INTEREST**

There were no declarations of interest received.

4 **PUBLIC QUESTION TIME**

There were no public questions for this meeting of the Health and Wellbeing Board to consider.

5 **MINUTES**

Resolved:
That the minutes of the meeting of the Health and Wellbeing Board, held on 15th January 2026, be approved, as a correct record.

6 **JOINT STRATEGIC NEEDS ASSESSMENT UPDATE**

Jon Taylor gave the Board a detailed presentation which outlined the significant harms that were caused by alcohol consumption.

The data available was being used to improve the picture, for relevant and concerned agencies regarding alcohol harms. It was noted that the council used intelligence hubs which allowed for comparison and timelines of data. It was acknowledged that the scope of data needed to be widened. It was also noted that certain cultural changes regarding drinking alcohol had been noticed.

There existed the Greater Manchester Alcohol Strategy that aimed to be part of a wider conversation around the use of alcohol throughout life, and it was felt that a national prevention strategy, was required to address the prevalence of excessive alcohol consumption.

The rates of alcohol consumption were higher in affluent areas but that harms from alcohol were more prevalent in deprived areas. The impact on hospitals was discussed by the Board and it was noted that there were high levels of crossover with tobacco consumption, obesity and domestic violence.

The Greater Manchester Alcohol Strategy aimed to be a whole system approach, and that work had to be done in cooperation with partners. The priority areas of the strategy were discussed.

Members noted that community and prevention were at the heart of the strategy and that there was a need for a broader approach to alcohol. Members noted that alcohol is seen as 'socially acceptable' and that non-alcoholic option choices were weaker. This was noted in relation to changing drinking patterns.

The meeting was advised that the Borough of Oldham's overall actual rate of alcohol consumption was lower than would be first expected. However, the figures were distorted somewhat by the fact that up to 30% of the Borough's population professed to not drinking alcohol and there was in the Borough a large Moslem community.

There was though, high levels of hospital admissions and deaths caused, that were attributable to the consumption of high levels of alcohol. A disproportionate number of admissions and fatalities derived from people who lived in the Borough's most deprived communities.

It was noted that a spike in the levels of alcohol related incidents was expected over the summer months coinciding with the staging of the Football World Cup.

Resolved
That the presentation be noted and welcomed.

7 **CHILD DEATH OVERVIEW PANEL ANNUAL REPORT**

The Health and Wellbeing Board received a report from the Director of Public Health which advised that the Bury, Oldham and Rochdale Child Death Overview Panel (CDOP) reviewed deaths of children who were normally resident in the relevant local authority areas. The Panel was also able to review cases

of non-resident children who died within the local authority areas. A review of a case by this panel is one of many stages of a child death review process and is intended to find patterns in modifiable factors that have contributed to child deaths. This supports local and national learning and supported the prevention of future deaths.

The annual report for 2025 was produced by Dr Steven Senior, Consultant in Public Health and Chair of the Bury, Oldham, and Rochdale CDOP Panel at the time of writing. The report examined demographic data for the three areas, publicly available mortality statistics, and presented an analysis of cases reported to Bury, Oldham and Rochdale CDOP between 2022 and 2025.

The Health and Wellbeing Board was requested to consider the worsening measures of child poverty, in the Borough and look to work with local partners to ensure that local anti-poverty plans address the consequential increases in child poverty

The Health and Wellbeing Board, together with the Borough's partner agencies, should continue to work to reduce smoking, alcohol, and drug misuse in pregnancy by:

a. Ensuring smoking status and alcohol or substance misuse problems are identified early by ensuring that pregnant people are asked about smoking status, alcohol use, and substance use, that this information is recorded, and referrals to appropriate services are made; and
b. Continuing wider work to reduce the prevalence of smoking, alcohol misuse, and substance misuse across the population and ensuring provision of smoking cessation and drug and alcohol treatment services.

The board, with partners, was requested to promote safe sleeping practices, noting a possible relationship between unsafe sleeping arrangements and overcrowded or otherwise inappropriate housing and with alcohol use by parents. The Safeguarding Partnership were requested to ensure that children with additional vulnerabilities were captured in child protection or child in need plans.

The Health and Wellbeing Board was asked to work with partners and community organisations to raise awareness of the increased risk of death and illness faced by children born to parents who were close blood relatives and assure themselves that genetic counselling and testing services were being offered appropriately.

It was reported that reductions in high maternal body weight was likely best achieved by reducing high body weight in the population as a whole. This should include efforts to improve diet and exercise in childhood as well as adulthood and reduce inequalities. The board should assure itself of plans to reduce obesity in the population, as well as that support with nutrition and appropriate exercise is available to pregnant people and to people who were planning to become pregnant.

Resolved:
That the Annual report of the Child Death Overview Panel, be noted.

8 **LONELINESS AND SOCIAL ISOLATION UPDATE**

The Health and Wellbeing Board considered a report of the Director of Public Health which advised that loneliness and social isolation were causes of growing concern across the whole of the UK and in Oldham, which has serious implications for the health and wellbeing of the local population. Data showed that there were higher rates of loneliness in the Borough of Oldham, compared with regional and national averages.

Whilst the network of health and wellbeing services in Oldham had a positive impact on loneliness and social isolation, the Council was yet to take a borough-wide, targeted, and strategic approach to addressing these priority issues.

A recent development session had identified key themes around current assets, gaps and challenges, data and insights, and community engagement and participation.

Loneliness and social isolation were causes of growing concern, having serious implications for the health and wellbeing of the population. It was reported that anyone could experience loneliness and social isolation. Experiences of loneliness can be influenced by underlying factors such as identity, personality and situation. Triggers could include moving to a new area or becoming unemployed. Therefore, some people were particularly at risk of experiencing loneliness and social isolation.

An ONS Community Life Survey in 2023/24 had demonstrated that around one-four-adults feel lonely often or some of the time. However, a recent survey conducted by Ipsos on behalf of the Marmalade Trust (2025) found that 61% of UK adults who have experienced loneliness have never told anyone that they feel lonely. Internalised stigma was an identified barrier to opening up about their feelings. We therefore need to interpret data with caution and recognise that published statistics may underrepresent the true picture.

In Oldham, mental health and wellbeing (including reducing loneliness and supporting people to age well by reducing social isolation, are priorities identified in the Oldham health and wellbeing strategy 2022- 2030.

According to the Sport England Active Lives Survey, 8.5% of adults in Oldham feel 'lonely often' or 'always' (22/23- 23/24). Oldham had the 4th highest rate in Greater Manchester and higher rates of loneliness compared with the North-West and National average.

Resolved:

1. That the Health and Wellbeing Board supports the development of an Oldham Loneliness and Social Isolation Strategy based on the following principles:

a) Building on current assets
b) Improving access to existing offers
c) Proportionate universalism around identified target groups
d) Strengthening data and insights
e) Community engagement and resident-led approaches
f) Building confidence and reducing stigma
g) Reducing the risk of CVD in those experiencing loneliness and social isolation

2. That the Health and Wellbeing Board supports work focusing on the key role of primary care in addressing loneliness and social isolation

a) Education and awareness about the impact on health
b) Awareness of offers in Oldham
c) Referrals into the social prescribing service.

9 **OLDHAM LIVE WELL UPDATE**

The Health and Wellbeing Board considered a report that provided an overview of the Live Well model and its implementation in Oldham. It provided a summary of progress to date including governance, and investment priorities. It also highlighted the specific contributions of the programme to improving health and wellbeing across the borough.

The submitted report provided an overview of the Live Well model and its implementation in Oldham, summarising progress to date, governance, investment priorities and the specific contributions of the programme to improving health and wellbeing across the borough.

Live Well was a Greater Manchester's borough-wide approach to prevention and health creation, launched in February 2024. It aimed to tackle health, social and economic inequalities by growing community power, wealth and action. The model aligns strongly with Oldham's mission for Healthier, Happier Lives and is designed to be:

- Community-led – enabling residents and communities (including those most affected by inequalities, racism and injustice) to identify priorities and take direct action.
- System-enabled – reshaping public services to remove barriers, share accountability and support community leadership.

The Live Well approach was built around four components:

- Integrated neighbourhood working
- Strong, resilient VCFSE sector
- Community leadership and action
- Live Well spaces, centres and offers

The Oldham Live Well approach was an important programme of work that will have a significant impact on the health and

wellbeing of the Borough's residents. This could be realised in several domains:

a. Prevention & Early Intervention
    - Embedding prevention-first ways of working across the workforce
    - Strengthening pathways to local support
    - Providing consistent, sustainable prevention resources

b. Stronger Community Assets and Places
    - Creation of local Live Well centres
    - Support for sustainable and accessible community spaces
    - Investment in safe, welcoming environments where residents can connect, participate and stay well

c. Tackling Inequalities
    - Focus on communities most affected by structural inequalities
    - Integrated support for people experiencing economic inactivity, poor health or multiple disadvantages

d. Mental & Physical Wellbeing
    - "Get Oldham Healthy" supporting mental health therapy and physical activity
    - Community-led projects centred on nature, outdoor activity, safety and social connection
    - Volunteering as a route to improved wellbeing

e. Community Leadership and Voice
    - Participatory budgeting and resident decision-making
    - Expanded community organising and citizen leadership
    - Empowered communities shaping health, wellbeing and prevention priorities

The next steps for the project included: finalising the first Live Well Centres across districts; scaling participatory funding boroughwide; strengthening the Live Well Campus model; delivering the Live Well culture event and ongoing workforce development; and embedding evaluation and insight to shape future phases of delivery.

Resolved:

1. That the Health and Wellbeing Board notes the progress made across Live Well implementation.
2. That the Health and Wellbeing Board endorses the continued focus on prevention, community leadership and neighbourhood integration.
3. That the Health and Wellbeing Board supports alignment between Live Well priorities and Health & Wellbeing Board objectives.

4. That the Health and Wellbeing Board champion cross-system engagement, ensuring organisational commitment to the prevention-first culture.

10 **INTEGRATED CARE BOARD - TRANSFORMATION UPDATE**

The Director of Public Health reported that national changes to the composition and functionality of Integrated Care Boards were due to be implemented in the coming months. The Health and Wellbeing Board would be formally consulted on proposals. One of the aims of the exercise was, to reduce costs which, unfortunately, in some cases, could lead to compulsory redundancies.

Resolved:
That the Director of Public Health's verbal update on the future operations of Integrated Cre Boards be noted.

The meeting started at 10.00am and ended at 12.10pm

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Report to HEALTH AND WELLBEING BOARD

Local Outbreak Management Plan

Portfolio Holder:

Officer Contact: Rebecca Fletcher, Director of Public Health

Report Authors: Charlotte Stevenson, Consultant in Public Health.
Mandy Froggatt, Senior Health Protection Nurse.

Date: 10th September 2026

Purpose of the Report
For the board to consider Oldham's updated Local Outbreak Management Plan and approve the suggested changes.

Summary
The Local Outbreak Management Plan (LOMP) was developed to ensure clarity on operational roles and responsibilities for each responding organisation in the event of an outbreak of infectious disease in Oldham. It is intended to act as a companion to the GM Multi-Agency Outbreak Plan, providing operational detail and helping responders provide an effective and coordinated approach to outbreaks of communicable disease.

It is important for each organisation, having signed off this plan, to support staff to engage and to embed the multi-agency response to an outbreak of infectious disease and create familiarity with key tasks.

The plan is reviewed and updated every two years to be signed off by the Health and Wellbeing Board.

1. Background

1.1. The Local Outbreak Management Plan (LOMP) ensures that councils, health services, and communities can act quickly and efficiently to stop infectious diseases from spreading.

1.2. The LOMP outlines how to direct testing, contact tracing, and treatment to affected settings as well as clearly defining roles and responsibilities and identifying key contacts.

2. Things to consider

2.1 The review process includes:

- Looking for areas of duplication and opportunities for streamlining.
- Review of the key contacts list and updating as required.
- Consideration of additional topics for inclusion.

3. Review and update of plan

3.1 The plan was reviewed by the Local Authority Health Protection Team and has been presented and approved at the Health Protection subgroup of the Health and Wellbeing Board. A list of key changes is detailed below to assist the Health and Wellbeing board with reviewing and approving changes.

3.2 Acronyms have been updated to reflect organisational changes

3.3 Links to the most up to date national and local guidance have been added. This is also reflected in the examples in Sections 3 and 4.

3.4 Contents pages have been updated.

3.5 Further updates for a measles outbreak have been added to section 3 (3.10)

3.6 Contact numbers have been checked and updated in Section 5 with outdated telephone numbers removed. Job titles and organisation names have been used rather than named individuals.

3.7 All roles, responsibilities have been updated throughout the LOMP, within each section to ensure appropriate actions are performed by the relevant organization.

4. Issues for Health and Wellbeing board to consider

4.1. Health and Wellbeing Board is asked to consider the suggested changes to the LOMP and provide final sign off.

Local Outbreak Management Plan

Oldham

January 2026 (Version 4)

Document Control

Document title:	Operational Local Health Economy Outbreak Plan: Oldham
Document status:	Consultation draft
Document version:	Version 4
Document date:	January 2026
Document author(s):	Amanda Froggatt, Senior Health Protection Nurse
Document owner(s): *(Name/organisation)*	Template: GM Local Health Resilience Partnership / Greater Manchester Resilience Forum Borough Plan: Local Director of Public Health /NHS Greater Manchester Integrated Care (Oldham)

Change History

Version	Date	Status	Notes
0.01	20-02-17	Initial draft	Following 1st Planning Group meeting
0.02	15-03-17		Following 2nd Planning Group meeting
0.03	05-04-17		Following Health Protection Confederation discussion
1	15-01-17		Populated with Oldham information
2	28.09.21		In preparation of the winter, updated by Oldham
3	23.02.23	AE	Updated for the Greater Manchester Review
4	06.01.2026	Full overview	Full update, guidance, contacts and scenario tables

Approval

Approving group/body: FOR TEMPLATE	Approval date
Director of Public Health	
Health and Wellbeing Board	

Foreword

Protecting our communities from outbreaks of disease remains a cornerstone of public health. Rapid, coordinated action saves lives and prevents disruption, but it must go hand in hand with addressing the health inequalities that make some groups more vulnerable than others. By strengthening surveillance, improving access to care, and working collaboratively across sectors, we can reduce risks and build resilience. It is important that our arrangements are routinely reviewed in order to ensure that we can effectively respond as a system.

This plan has been developed to ensure clarity on operational roles and responsibilities for each responding organisation in the event of an outbreak. It is intended to act as a companion to the GM Multi-agency Outbreak Plan, providing operational detail helping responders quickly provide an effective and coordinated approach to outbreaks of communicable disease. It is important for each organisation, having signed off this plan, to support staff to engage in appropriate testing of the plan to embed the multi-agency response to an outbreak and create familiarity over key tasks.

This document aims to identify roles and responsibilities of those across the system to enable the prompt and efficient management of outbreaks in the locality. These include the NHS, Environmental Health, Public Health Department and the UK Health Security Agency (UKHSA).

Tackling health inequalities is a key principle to our response to outbreaks of diseases. We need to consider this in our communications and approach to managing outbreaks in different communities and settings. We will work together with our communities, valuing the role of community leaders and neighbourhood working in our health protection system.

Signed

……
Dr Rebecca Fletcher
Director of Public Health, Oldham

Signed

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Place Based Lead, (Oldham), NHS Greater Manchester

CONTENTS

Glossary of Terms

CPH	Consultant in Public Health
GMIC NHS	Greater Manchester Integrated Care NHS (Oldham)
HERG	Health Economy Resilient Group
DPH	Director of Public Health
NCA NHS	Northern Care Alliance NHS
PCFT	Pennine Care Foundation Trust
HCAIs	Health Care Associated Infections
HPT	Health Protection Team
SIT	Screening & Immunisation Team
GMIC NHS MO	GMIC NHS Medicines Optimisation
GTD	Go To Doc
LRF	Local Resilience Forum
OCT	Outbreak Control Team
PGD	Patient Group Directive
PSD	Patient Specific Directive
UKHSA	UK Health Security Agency
OMBC	Oldham Metropolitan Borough Council
BBV	Blood Borne Virus
TB	Tuberculosis
ILI	Influenza like Illness
ARI	Acute respiratory illness
MR(S)SA	Methicilin Resistant Staph Aureus (MRSA) Methicilin Sensitive Staph Aureus (MSSA)
CDI	Clostridioides (Previously Clostridium) difficile Infection
ESBL	Extended Spectrum Beta Lactamases
PVL-MRSA	Panton–Valentine leucocidin- MRSA
PCR	Polymerase chain reaction

GM IVIS (Intrahealth)	Greater Manchester Integrated Vaccination and Immunisation Service

PART 1: Aim, Objectives and Scope of the Plan

Aim of the Plan

This document has been developed to supplement the "Greater Manchester Outbreak Plan" at an Oldham level ensuring the right people are contacted at the right time to ensure that the borough is resilient and can respond appropriately to outbreaks.

It has been designed to ensure that an appropriate lead from each organisation is contacted as they will know which member of their service will need to be called and is therefore output/effect focused e.g., identifying clinical staff to provide antibiotics to many school children both in and out of normal working hours.

Objectives of the Plan

- To outline roles and responsibilities at a local operational level
- To outline the key tasks / activities involved in responding to outbreaks
- To give key considerations and outline some specific requirements needed for different outbreaks

Command & Control

- If UKHSA call an OCT, Oldham's DPH & members of Oldham's Health Protection Team (HPT) will participate in that group.

Declaration of an outbreak

- It is usual that locally confined smaller outbreaks (such as Norovirus, HCAIs, COVID19 & Influenza) will be recognised and declared by the Oldham HPT, with the response being led locally, however, rarely and for some very complex outbreaks the response may be led by UKHSA.
- The HPT may be contacted by a variety of sources to report an outbreak, typically these include UKHSA, nursing/care home staff, schools/nurseries, Adult Social Care, Northern Care Alliance NHS Trust Infection Prevention & Control (NCA NHS), Microbiology/virology or Environmental Health Officers.

Investigation and Control of Outbreaks

- Investigation and Control response will depend on the nature of the incident/outbreak and the outcome of the OCT discussion. It is expected that UKHSA will lead or support the provider in undertaking a risk assessment.
- Control measures should be documented with clear timescales for implementation and responsibility.
- A case definition should be agreed and reviewed as required during the investigation.
- Basic descriptive epidemiology is essential and should be reviewed at the OCT.
- Legal powers relating to the investigation of food poisoning outbreaks are vested in Local Authorities. If, during the investigation, it is determined that the outbreak is related to food then the management of this of would be handed over to the Environmental Health Team (EHO) and UKHSA.

Communications

- The communications response will depend on the nature of the incident/outbreak and the outcome of OCT discussions. It is expected that the OCT will identify & nominate which agency will lead the media response at the outset of the outbreak.

Complementary Guidance and Documentation

National

- NHS England » National infection prevention and control manual (NIPCM) for England
- https://www.gov.uk/government/publications/communicable-disease-outbreak-management-operational-guidance/communicable-disease-outbreak-management-operational-guidance
- https://www.gov.uk/government/publications/infection-prevention-and-control-in-adult-social-care-acute-respiratory-infection/infection-prevention-and-control-ipc-in-adult-social-care-acute-respiratory-infection-ari
- Investigation and management of outbreaks of suspected acute viral respiratory infection in schools: guidance for health protection teams - GOV.UK (www.gov.uk)
- Infectious diseases: education and childcare settings - GOV.UK (www.gov.uk)
- National measles guidelines version 8: July 2026
- Guidance on the prevention and management of Meningococcal meningitis and septicaemia in higher education institutions (publishing.service.gov.uk)
- https://www.gov.uk/government/publications/meningococcal-disease-guidance-on-public-health-management

- UK Guidelines for the Management of Contacts of Invasive Group A Streptococcus (IGAS) Infections in Community Settings (December 2022)
- https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/400105/code_of_practice_14_Jan_15.pdf
- https://assets.publishing.service.gov.uk/media/6426e4f1fbe620000c17da7e/guidelines-for-public-health-management-scarlet-fever-outbreaks-january-2023_.pdf
- https://assets.publishing.service.gov.uk/media/65ccdbbd1d93950012946677/Hepatitis-A-guidance-13-february-2024.pdf
- Complete routine immunisation schedule - GOV.UK
- https://www.gov.uk/government/publications/scabies-management-advice-for-health-professionals/ukhsa-guidance-on-the-management-of-scabies-cases-and-outbreaks-in-long-term-care-facilities-and-other-closed-settings
- https://www.gov.uk/government/publications/infection-prevention-and-control-in-adult-social-care-settings/infection-prevention-and-control-resource-for-adult-social-care
- https://www.gov.uk/government/publications/invasive-group-a-streptococcal-disease-managing-community-contacts
- https://assets.publishing.service.gov.uk/media/5a749fb7e5274a44083b82c1/Guidance_on_the_diagnosis_and_management_of_PVL_associated_SA_infections_in_England_2_Ed.pdf
- https://www.gov.uk/government/collections/clostridium-difficile-guidance-data-and-analysis
- https://www.gov.uk/government/publications/health-protection-in-schools-and-other-childcare-facilities/managing-outbreaks-and-incidents
- https://www.gov.uk/government/publications/health-protection-in-schools-and-other-childcare-facilities/managing-specific-infectious-diseases-a-to-z#e-colistecshiga-toxin-producing-e-coli
- https://www.gov.uk/government/publications/health-protection-in-schools-and-other-childcare-facilities/managing-specific-infectious-diseases-a-to-z
- https://www.gov.uk/government/publications/part-2a-orders
- https://www.turning-point.co.uk/services/rochdale-oldham
  https://www.bashh.org/_userfiles/pages/files/morrisetal2025britishassociationforsexualhealthandhivnationalguidelineonthemanagementofscabiesin_1.pdf

PART 2: KEY ASPECTS OF OUTBREAK MANAGEMENT

Investigations – Roles & Responsibilities

Prior to an Outbreak Control Team (OCT) being set up, UK Health Security Agency (UKHSA) will liaise directly with relevant partners to recommend and coordinate investigations.

Once an OCT is set up, the OCT will agree on coordination of investigations.
The types of investigation involved usually include:

- Epidemiological investigation: establishing links between cases/sources based on questioning of cases/next of kin and information on settings.
- Microbiological investigations: where a sample is taken and sent for analysis to a Laboratory.

NB. Any setting where staff affected have access to Occupational Health (OH), the investigation will be delivered through them.

Legal powers relating to the investigation of food poisoning outbreaks are vested in Local Authorities. If, during the investigation, it is determined that the outbreak is related to food then the management of this of would be handed over to the Environmental Health Team and UKHSA. Legal powers in relation to health and safety management of legionella at some workplaces is LA responsibility so could also apply in these situations.

Control measures

Control measures usually include:

- Identifying and controlling on-going sources. e.g. a cooling tower suspected of aerosolising Legionella, or a food premise with unsafe food preparation practice
- Preventing/limiting onwards spread, e.g. advising isolation of cases for infectious period, postponing admissions to a residential setting
- Reducing likelihood of severe illness in specific vulnerable groups: usually by prompt post-exposure prophylaxis (PEP)

Where compliance with recommendations around control measures is an issue, enforcement powers may be used. For the purposes of outbreaks and health protection incidents, the bulk of enforcement powers lie with OMBC:
https://assets.publishing.service.gov.uk/media/5a7a217ee5274a319e778131/Health_Protection_in_Local_Authorities_Final.pdf

2.2 Investigations Roles and Responsibilities - see contacts list for all contact details (pages 38-44)

Investigations:

Prior to an OCT being set up, UKHSA will liaise directly with relevant partners to recommend and coordinate investigations. Once an OCT is set up, the OCT will agree on coordination of investigations.

Response activity	Potential responder(s)		Considerations, comments or potential issues
	In hours (9-5, M-F)	Out of hours	
Questionnaires / Interviews/Consent	➢ UKHSA ➢ OMBC HPT	UKHSA	If notifiable (except sexual health clinics).
	➢ Hospital IPC team	Hospital IPC team	For Acute Trust incidents 0161 624 0420
	➢ UKHSA ➢ (Oldham EHO – Legionella only)	UKHSA	UKHSA undertake the patient questionnaires and sampling for Oldham (except in the case of Legionnaires Disease, where Oldham officers undertake the questionnaire).
	➢ Immunisations – school aged children - Intrahealth	UKHSA	Consent to immunisation forms: Schools/Children: Contact: Intrahealth.
Respiratory samples (e.g., swabbing) (see also managing outbreaks of respiratory illness in care homes below)	➢ Care home outbreaks: HPT/UKHSA risk assessment and Ilog, UKHSA Lab – wait and return ➢ Uni/over 18 referral to GP ➢ Nursery/Under 5 years – referral to GP ➢ Those not registered with GP e.g., Homeless/Rough sleepers Option 1: GP option 2: GTD (dependant on outbreak)	UKHSA Go to Doc	Care home staff responsible for taking swab, using the wait and return courier arranged via HPT/UKHSA Out of hours SPOC for UKHSA to access GMIC NHS Oldham Locality is via NWAS ROCC on 0345 113 0099, Option 1 for GM UEC Hub. Ask for the locality GMIC NHS Oldham Director On Call.

			There has been a change in guidance to enable the prescribing of antivirals for the management of flu outbreaks across any time of the year. This was implemented from October 2025 and will continue for the foreseeable future
Faecal (GI outbreak)	➢ OMBC Environmental health Officer ➢ Sampling via Ilog and UKHSA Lab as agreed in OCT ➢ If more than 2 cases unconnected – to see GP ➢ GP may be asked to obtain samples depending on organism. E.g., Clostridium difficile	UKHSA	UKHSA undertake the patient sampling for OMBC for environmental health related outbreaks UKHSA may notify EHO and HPT of outbreak, Samples posted back to UKHSA labs
Faecal (GI outbreak in a care home)	➢ Initial sampling taken by care home on GP instructions or with advice from OMBC HPT/UKHSA. ➢ OMBC HPT coordinate outbreak response and advise the home. ➢ OMBC HPT may contact UKHSA or EHO for advice. ➢ Care home staff take samples.	UKHSA UKHSA Lab	I Log to be generated – see full details and links to all request forms/processes, page 35 & Appendices
Oral fluid (e.g. Hep A outbreak)	➢ Identified in OCT by UKHSA ➢ Risk assessment and contact tracing undertaken by UKHSA ➢ Settings for children, outside of education, eg, children's home	UKHSA	Self-administered arranged by UKHSA. If wider community outbreak: e.g., School/nursery: option 1: School nursing team option 2: GTD Care Home: Care home nurses/NH team/GP University: Go to Doc Commercial Premises: UKHSA/HPT/EHO may support staff self-sampling GP- for rough sleepers with support from OMBC homelessness teams (see contacts) Looked after children nursing team

Urine Test		➢ GP/Care Home	N/A	If legionella: Care Home – Care Home Staff on request by UKHSA Primary care: GP
Environmental (e.g., food / water)		➢ Environmental Health Officers / HSE	UKHSA	e.g., Legionella/cryptosporidium Where EH are the enforcing authority then EHO undertakes or directs sampling For certain premises or complex sampling eg legionella linked to cooling towers EHO may need to discuss with HSE
Blood test		➢ NHS provider/GP	NHS Provider	e.g. Phlebotomy services for adults and children
TB – all investigations		➢ TB Nurses	N/A	e.g. Mantoux/IGRA testing, arrange X-ray
Scabies (clinical assessment)		➢ GP/Dermatologist ➢ Sexual Health Services	N/A	Most cases treated based on clinical assessment by GP or referral to dermatologist without testing. Advice from OMBC HPT for single cases and outbreaks. Follow UKHSA Scabies Guidance (see page 8/9) See link to BASHH .org in cases linked to sexual health services
Sexually Transmitted Infections		➢ NHS Trust Sexual Health Clinic/GP ➢ Sexual Health Services would respond to the outbreak.	N/A	Public Health Commissioning manager- Sexual Health commissioned services to be contacted in regard to response & communicate with partner services. HPT potentially for IPC advice
Transport to lab	Local lab transport system	➢ OMBC EHO	UKHSA	GP routine samples in-hours. EHO would liaise with Oldham Lab for posting of samples.
		➢ UKHSA Postal	N/A	e.g., measles on individual cases, Flu packs, UKHSA packs have paid return envelope.
		➢ Hand deliver		Care home flu swab samples Flu swabs – via UKHSA MRI lab process courier wait & return (see pages 32/33)

Control Measures:

Prior to an OCT being set up, UKHSA will liaise directly with relevant partners to recommend and coordinate control measures. Once an OCT is set up, the OCT will agree on coordination of control measures.

Response Activity	Potential Responder (S)		Considerations, comments or potential issues
	In Hours 9-5	Out of Hours	
Advice on infection, prevention & control measures	➢ OMBC Health Protection Team/UKHSA ➢ OMBC EHO	UKHSA	EHO for commercial food premises/preparation & GI Illness (eg, STEC)
Exclusion Advice	➢ OMBC /UKHSA/EHO	UKHSA	Using national UKHSA guidelines and advice. Would depend on the outbreak setting and type
Enforcement of control measures	➢ Local Authority with UKHSA support	Local Authority with UKHSA support	Proper Office EH for Part 2a Order (EHO team) see link above
Treatment and Prophylaxis (Including immunoglobulin, vaccines, antivirals, antibiotics and anti-toxins)	➢ GMIC NHS Oldham Medicines Optimisation – order vaccines/coordinate delivery. ➢ Identify local antiviral stockpile in key pharmacies. ➢ Antivirals available from general community pharmacies on prescription ➢ May use Immform or order direct from manufacturer for non- immunisation programme vaccines ➢ UKHSA may order direct in some circumstances/use own stocks- antivirals/vaccines at UKHSA discretion ➢ PGDs to be available from Trust for Immunisation Team/DNs ➢ From SIT for primary care/Use of PSD	UKHSA to order vaccines in specific cases Trust pharmacy/GMIC NHS Oldham Out of hours arrangements also to be confirmed by UKHSA. Other out of hour's work will be via Director on call and meds optimisation response use Go to Doc etc for antivirals – assessment of patients/contacts	There may be vaccine manufacturing shortages or ordering issues, ordering at short notice in some unusual outbreaks. – UKHSA to advise/support/identify roles if vaccination recommended by them Arrangements for Tamiflu embedded in pages 32/33 below, limited stock held by some pharmacies in Oldham, in addition to stock held by GtD NB – suspension form of Tamiflu in very limited stock at each holding pharmacy (2 bottles only) There has been a change in guidance to enable the prescribing of antivirals for the management of flu outbreaks across any time of the year. This was implemented from October 2025 and will continue for the foreseeable future Immunoglobulin via UKHSA risk assessment – specific arrangements will need to be agreed on a case-by-case basis (see appendix 6)

	➢ Flu antivirals prescribed via GtD using FP10 in and out of hours in event of care home outbreak		

Communications:

Response Activity		Potential Responders		Considerations, Comments or Potential Issues
		In Hours	Out of Hours	
To public	Advice letters which are specific to each setting (e.g., businesses, care homes)	OCT: OMBC/GM NHS Oldham/EHO/UKHSA	UKHSA	Dependent on topic and setting. Template letter provided by UKHSA for Infectious Diseases Template letter provided by UKHSA/EHO for food related or Environmental
	Update NHS 111	UKHSA	UKHSA	Script and algorithm provided by UKHSA for any LA comms via the Contact Centre. This would need to be pre-agreed.
	Helpline	OMBC/GMIC NHS Oldham	OMBC/GMIC NHS Oldham	Script and algorithm provided by UKHSA for any LA comms via the Contact Centre. This would need to be pre-agreed.
	Websites / social media	UKHSA/OMBC/GMIC NHS Oldham	UKHSA/OMBC/GMIC NHS Oldham	Comms Lead for UKHSA/OMBC/GMIC NHS Oldham
	Door to door	UKHSA/OMBC/GMIC NHS Oldham	UKHSA/OMBC/GMIC NHS Oldham	Need would have to be clearly identified and resourced.
To health partners	Briefings / sitreps from OCT	UKHSA/OMBC/GMIC NHS Oldham Comms & PCC	UKHSA/MHCC – Comms & PCC	see list of contacts for community cases in appendix

	Other relevant groups	Responsibility of each agency	Responsibility of each agency	
To the Media	Coordinated by UKHSA/OMBC/GMIC NHS Oldham via OCT	UKHSA/OMBC/GM NHS Oldham via OCT		Include all partner agencies in discussion of key comms messages
To Elected Members/Committees e.g. Health and Wellbeing Boards	DPH	DPH GMIC NHS Oldham on call director		Director of Public Health
Internal briefs	OMBC/GMIC NHS Oldham	OMBC/GMIC NHS Oldham		Oldham Communications (see contact list for info)

3: LOCAL OPERATIONAL ARRANGEMENTS FOR SPECIFIC TYPES OF OUTBREAKS REQUIRING AN OCT

NB:

"Responders" will depend on setting and situation – in each scenario there are a list of potential responders, not all responders will have a responsibility in every situation

In the event of a BBV incident/outbreak occurring in Oldham, OMBC Health Protection Team will act as a facilitator, providing the link between UKHSA and various parts of OMBC (these will vary according to location of outbreak and who is involved). The Health Protection Team will also act as a point of contact for individuals seeking advice.

All contact details can be located in the contact section, from page 38

PART 3: LOCAL OPERATIONAL ARRANGEMENTS FOR SPECIFIC TYPES OF OUTBREAKS REQUIRING AN OCT

3.1 Arrangements for investigating complex TB incidents

	Response Activity		Responders		Considerations
			In hours	Out of hours	
Investigations	Detection/Alerting	➢ Notifiable disease ➢ UKHSA/OMBC Health Protection Team alerted about greater than usual cases/linked cases ➢ Alert TB services ➢ Identify contacts of infected individuals ➢ TB Team alert UKHSA/HPT of cluster/outbreak	UKHSA – call OCT TB services Oldham – take lead OMBC HPT – support as needed GMIC NHS Oldham – support as needed Microbiology laboratory - sampling etc	UKHSA	TB Team take the lead with UKHSA support OMBC HPT to support as requested Reduced capacity in TB Team
	Sampling – led by TB team/UKHSA and dependent upon outcome of any OCT	➢ Screen contacts/people in affected area (Oldham FT chest clinic) ➢ Large scale screening if needed ➢ Mantoux testing ➢ Interferon testing			

		➢ Mass x-ray (including mobile x-ray) ➢			
Control	Advice IPC	➢ Isolation ➢ Hygiene measures ➢ Provide advice/reassurance to worried individuals	TB Services – usually first contact and advice provided	UKHSA (if necessary)	Prescribing/sourcing availability of drugs Capacity of TB Team
	Treatment/Prophylaxis	➢ Mass vaccinations – BCG ➢ TB antimicrobial therapy –individual prescriptions from Consultant ➢ Latent infections	UKHSA – lead OCT OMBC HPT – support and IPC advice GMIC NHS Oldham District nursing General Practice		Individuals not complying with treatment due to complex social needs (e.g. homeless)
Comms – as agreed by OCT	To public	➢ Advice letters ➢ Update NHS 111, helpline, social media	UKHSA OMBC DPH/HPT	There is no out of hours Comms support. Silver Control will decide when Comms need to be involved	
	To health partners	➢ Outbreak email ➢ OCT minutes circulated ➢ Urgent Care ➢ Emergency Dept/NCA IPC teams	GMIC NHS OMBC Comms		
	To media	➢ Coordinate by UKHSA via OCT			

3.2 Investigating Hepatitis A in a school reception class or childcare setting (0-5 years old)

https://assets.publishing.service.gov.uk/media/65ccdbbd1d93950012946677/Hepatitis-A-guidance-13-february-2024.pdf

	Response Activity		Responders		Considerations
			In hours	Out of hours	
Investigations	Detection/Alerting	➢ Notifiable disease ➢ UKHSA/OMBC HPT notified of case(s) ➢ Identify close contacts ➢ Identify source	UKHSA – OCT and lead on actions including arrangements for oral fluid kits OMBC HPT/EHO - support and action as able	UKHSA Intrahealth	Intrahealth vaccination outside of S7A will need to be commissioned and funded by the ICB
	Sampling	➢ If identified by UKHSA in discussion with Colindale VRD, oral fluid testing of household may occur ➢ Ilog generated by UKHSA Lab			

		➢ Guidance does not recommend routine sampling (bloods etc)	Intrahealth – via IVIS for mass vaccinations		
Control	Advice IPC	➢ Increased hand hygiene, extra measures for close contacts ➢ Environmental Assessment of toilets and hand washing facilities ➢ Consideration of exclusion if risk assessment identifies concerns ➢ Exclusion of case until 7 days after onset of jaundice or 7 days after symptom onset if no history of jaundice	UKHSA – guide actions and risk assessment, including accessibility to HNIG if identified as a requirement (rare in this age group) OMBC HPT/EHO – IPC guidance and site visit	(unlikely to be required in child care setting) UKHSA Intrahealth	Availability of sufficient vaccine Ensure vaccinations are given in a timely manner via Intrahealth IVIS see appendices Identify/prescribe/source/administer HNIG
	Treatment/Prophylaxis	➢ HNIG (Human Immunoglobulin therapy) if within 7 days of exposure and upon risk assessment ➢ Vaccinate contacts ➢ Mass vaccination of childcare setting if risk assessment identifies need			
Comms – as agreed by OCT	To public	➢ Advice letters to schools/households ➢ Warn & Inform	UKHSA – co-ordinate GMIC NHS Oldham – support OMBC Comms - support OMBC DPH/HPT		
	To health partners	➢ Outbreak email ➢ OCT minutes circulated			
	To media	➢ Coordinate and led by UKHSA via OCT			

3.3 Investigating outbreaks in vulnerable groups (e.g measles at a traveller's site, IGAS, BBV in a homeless setting)

	Response Activity		Responders		Considerations
			In hours	**Out of hours**	
Investigations	**Detection/Alerting**	➢ Notifiable disease ➢ UKHSA/OMBC HPT notified of case(s) ➢ Identify close contacts ➢ Identify source	UKHSA – OCT UKHSA Lab – Ilog provision and results OMBC HPT – IPC advice, support	UKHSA UKHSA Lab GTD	UKHSA Lab capacity Consent to interventions from community
	Sampling	➢ UKHSA to provide kits if required ➢ Sampling kits?? ➢ Ilog generated	Serco if AS Hotel	Serco	

			District Partnership – support with access and communications		
Control	**Advice IPC**	➢ IPC advice provided appropriate to organism/outbreak	UKHSA	UKHSA	GP/GtD – residents with NFA
	Treatment/Prophylaxis	➢ Advice from UKHSA and OCT ➢ Mass vaccination onsite – Intrahealth ➢ Provision of PEP – OCT to decide if appropriate and how this will be administered/clinical assessments	OMBC HPT District partnership GPs/GtD Intrahealth	Intrahealth	Access to community Consent for interventions Intrahealth vaccination outside of S7A will need to be commissioned and funded by the ICB
Comms	**To public**	➢ Advice letters to community	UKHSA		
	To health partners	➢ Outbreak email (if appropriate) ➢ OCT minutes circulated ➢ Opportunities for improving uptake of immunisations	HPT OMBC Comms District partnership		
	To media	➢ Coordinate by UKHSA via OCT			

3.4 Arrangements for a GI outbreak linked to a food premise, swimming pool or petting farm

	Response Activity		**Responders**		**Considerations**
			In hours	**Out of hours**	
Investigations	Detection and Alert OCT with UKHSA, EHO Rapid Investigation of potential source in the setting	➢ UKHSA/OMBC EHO & HPT notified of case(s) ➢ Identify close contacts ➢ Identify source	UKHSA – convene OCT OMBC EHO – questionnaires and actions/sampling	UKHSA	Out of hours – identify appropriate route of support
	Sampling	➢ UKHSA to provide stool sampling kits if required via MFT Lab	OMBC HPT – actions and support as required		

	Environmental Faecal Sampling	➢ Ilog generated			
Control	**Advice IPC/EHO**	➢ Hand Hygiene ➢ Isolation Advice ➢ Recommended/enforcement case-based control measures	UKHSA – OCT identified actions EHO – control measures and guidance HPT – support as needed	UKHSA	
	Treatment/Prophylaxis	➢ Advice from UKHSA			
Comms	**To public**	➢ Communications as required as a result of the OCT	UKHSA EHO/DPH OMBC Comms	UKHSA OMBC Comms	
	To health partners	➢ Outbreak email if appropriate ➢ OCT minutes circulated			
	To media	➢ Coordinate by UKHSA via OCT			

3.5 Investigating meningococcal disease in a nursery, school or college

https://assets.publishing.service.gov.uk/media/673257250a2b4132b43d1448/UKHSA-meningo-disease-guidelines-november2024.pdf

https://www.gov.uk/government/publications/meningococcal-disease-guidance-on-public-health-management

	Response Activity		**Responders**		**Considerations**
			In hours	**Out of hours**	
Investigations	**Detection/Alerting**	➢ Meningococcal case notified to UKHSA (also OMBC HPT via email to DPH) ➢ Identify close contacts - UKHSA	UKHSA – convene OCT Consultant Microbiology – liaise	UKHSA Intrahealth	Prompt contact with setting and Warn and Inform as appropriate

	Sampling	➢ No screening needed, but highlight symptoms and importance of urgent medical attention ➢ Hospitalisation of anyone displaying symptoms	with UKHSA and OCT actions OMBC HPT - support actions NCA school nurses – 0-5 years Intrahealth – school aged children		Identify close contacts promptly
Control	**Advice IPC**	➢ Highlight symptoms and importance of urgent medical attention	UKHSA – W&I OMBC HPT - IPC advice to settings NCA school nurses 0-5 yrs Intrahealth for school aged	UKHSA Intrahealth – vaccinations only	Prescribing antibiotics Sourcing and administering antibiotics Intrahealth vaccination outside of S7A will need to be commissioned and funded by the ICB
	Treatment/Prophylaxis	➢ Prophylactic antibiotics for close contacts ➢ Check vaccination status of rest of school/college – offer vaccination for unimmunised			
Comms – as agreed by OCT	**To public**	➢ Advice letters – see link to guidance above for templates ➢ Update NHS 111, helpline, social media	UKHSA OMBC DPH/HPT		
	To health partners	➢ Outbreak email as appropriate ➢ OCT minutes circulated			
	To media	➢ Coordinate and led by UKHSA via OCT			

3.6 Investigating outbreaks of IGAS in a care home
https://assets.publishing.service.gov.uk/media/64071ec5d3bf7f25fa417a91/Management-of-contacts-of-invasive-group-a-streptococcus.pdf

	Response Activity		Responders		Considerations
			In hours	Out of hours	
Investigations	Detection and Alert	➢ Notifiable disease ➢ UKHSA/OMBC HPT notified of case(s)	UKHSA – convene OCT	UKHSA – lead actions	Instructions to setting staff – ensure labelling is accurate on both sample and label

	OCT with UKHSA Communication with care home information gathering Communication with outside professionals	➢ Identify close contacts – including health professionals, eg, District Nurse, Podiatry ➢ Identify source	OMBC HPT – liaise UKHSA and setting, actions from OCT identified MFT Lab – supply swabs and testing/results Comm IPC nurses (CICN) – follow up with NCA staff (DNs/podiatry etc)	MFT Lab – sampling, testing, results	
	Sampling	➢ UKHSA to provide screening kits if required via courier once agreed in OCT ➢ Screening group agreed by OCT ➢ Ilog generated ➢ Occupational Health for NCA staff			
Control	**Advice IPC**	➢ Environmental cleaning ➢ Equipment cleaning ➢ Exclusion and Isolation (including NCA staff identified by CICN team) ➢ Identify symptoms ➢ SICPs	UKHSA OMBC HPT – take lead for setting IPC guidance Adult Community Services – if appropriate for external contacts GP – individual cases Comm IPC team – take lead for identified close contacts, NCA staff and referrals to OH GtD – clinical assessments and prescribing for setting residents and staff	UKHSA GTD	Long term follow -up/screening for staff and residents who have tested positive Using one pharmacy to dispense preventative treatment for staff and residents
	Treatment/Prophylaxis	➢ OCT recommendations ➢ Co-ordinated by OMBC HPT in hours, Co-ordinated by UKHSA out of hours ➢ Clinical assessment and Prescription - GtD ➢ Provision via usual pharmacy ➢ Occupational Health for NCA staff			
	To public	➢ Communication to relatives ➢ Warn & Inform to staff	UKHSA OMBC DPH/HPT OMBC Comms	UKHSA	
	To health partners	➢ Outbreak email			

Comms – as agreed by OCT		➢ OCT minutes circulated ➢ Warn & Inform			
	To media	➢ Coordinate by UKHSA via OCT			

3.7 Arrangements for investigating and controlling blood-borne viruses (BBV)

	Response Activity	**Responders**		**Considerations**
		In hours	**Out of hours**	

Investigations	**Detection/Alerting**	➢ UKHSA/OMBC Health Protection Team notified when unusual numbers or cluster of cases	UKHSA OMBC HPT Turning Point (as appropriate) Oldham MRI Virology laboratory GPs	UKHSA	
	Sampling	➢ Blood samples for virology ➢ Screening of contacts ➢ Screen for multiple BBVs			
Control	**Advice IPC**	➢ Explain routes of transmission ➢ Hygiene measures ➢ Exclusion if health care worker	UKHSA OMBC HPT General Practice Consultant Microbiology	UKHSA	Prescribing, Sourcing of PEP
	Treatment/Prophylaxis	➢ PEP treatment for close contacts ➢ Vaccinations for close contacts and other contacts (dependant on virus)			
Comms	**To public**	➢ Advice letters ➢ Update NHS 111, helpline, social media	UKHSA GMIC NHS Oldham Comms OMBC HPT	UKHSA	
	To health partners	➢ Outbreak email ➢ OCT minutes circulated			
	To media	➢ Coordinate by UKHSA via OCT			

3.8 Arrangements for a Hepatitis A outbreak in a care home

	Response Activity	**Responders**		**Considerations**
		In hours	**Out of hours**	

Investigations	Detection and Alert OCT with UKHSA, HPT, EHO Rapid Investigation of potential source in the setting Complete questionnaires required if at local level Identification of food handlers affected	➢ UKHSA/OMBC HPT notified of case(s) ➢ Identify close contacts ➢ Identify source ➢ Identify food handlers	UKHSA OMBC HPT OMBC EHO GP	UKHSA GTD	Transportation for Samples Care staff to be reminded – complete full details on both sample and form Self sampling outside of care homes
	Sampling Obtain samples with support for residential homes if necessary	➢ UKHSA to provide kits if required (Oral Fluid test kits) ➢ Support to care home staff for testing if required – HPT			
Control	**Advice HPT/EHO**	➢ Hand Hygiene/ PPE ➢ Isolation Advice ➢ Recommended/enforcement case-based control measures	UKHSA OMBC HPT GPs/PNs for vaccines	UKHSA	Intrahealth will consider facilitating Immunoglobulin by individual arrangement depending on clinical indications
	Treatment/Prophylaxis	➢ Advice from UKHSA			
Comms	**To public**	➢ Communications as required, a result of the OCT/discussions	UKHSA OMBC HPT OMBC Comms	UKHSA OMBC Comms	
	To health partners	➢ Outbreak email ➢ OCT minutes circulated			
	To media	➢ Coordinate by UKHSA via OCT and also Oldham Communications			

3.9 Arrangements for a Measles Outbreak in a School or Early Years Setting

	Response Activity	Responders	Considerations

			In hours	Out of hours	
Investigations	GP/Clinical Review with Notification to UKHSA of possible, probable, or confirmed Case	➢ UKHSA/OMBC HPT notified of case(s) ➢ GP/UKHSA to Identify close contacts ➢ Identify source or is the case part of an ongoing outbreak	UKHSA OMBC HPT GP Walk in Centre/Emergency Departments	UKHSA GtD/111/ Emergency Department & Walk In Services	Transportation for Samples Not to send suspected cases to Emergency Departments or Walk In Centres without prior warning and isolation room prepared/available The returning of the surveillance kits
	Sampling Taken by reviewing clinician, Oral Fluid Testing Kits, Dry Swab (not to be put in charcoal – see important information poster embedded) Or Urine testing	➢ Surveillance kits to be sent out by UKHSA			
Control	**Advice IPC/UKSA**	➢ Hand Hygiene/Respiratory hygiene ➢ Isolation/Exclusion Advice ➢ Recommended/enforcement case-based control measures	UKHSA OMBC HPT Early Years Settings and Schools OMBC Education team Intrahealth (vaccinations) GPs	UKHSA	Support to settings nhsgm-measles-information-for-early-y nhsgm-measles-2025-important-informa
	Treatment/Prophylaxis	➢ Advice from UKHSA ➢ Opportunity to encourage uptake of immunisations			
Comms	**To public**	➢ Communications as required, a result of the OCT	UKHSA OMBC HPT GMIC NHS Oldham OMBC Comms	UKHSA OMBC Comms	
	To health partners	➢ Outbreak email ➢ OCT minutes circulated			
	To media	➢ Coordinate by UKHSA via OCT			

3.10 Arrangements for a Measles Outbreak in a Contingency Hotel

	Response Activity	Responders	Considerations

			In hours	Out of hours	
Investigations	GP/Clinical Review with Notification to UKHSA of possible, probable, or confirmed Case	➢ UKHSA/OMBC HPT notified of case(s) ➢ GP/UKHSA to Identify close contacts ➢ Identify source or is the case part of an ongoing outbreak	UKHSA OMBC HPT GP Walk in Centre/Emergency Departments	UKHSA /111/ Emergency Department& Walk In Services	Transportation for Samples **Not to send suspected cases to Emergency Departments or Walk In Centres without prior warning and isolation room prepared/available** The returning of the surveillance kits
	Sampling Taken by reviewing clinician, Oral Fluid Testing Kits, Dry Swab (not to be out in charcoal) Or Urine testing	➢ Surveillance kits to be sent out by UKHSA		Support can be given via Serco staff based in the hotel	
Control	**Advice IPC/UKSA**	➢ Hand Hygiene/Respiratory hygiene ➢ Isolation Advice ➢ Recommended/enforcement case-based control measures	UKHSA OMBC HPT GPs Serco	UKHSA Serco	Support to settings nhsgm-measles-2025-important-informa measles-easy-read-accessible.pdf
	Treatment/Prophylaxis	➢ Advice from UKHSA ➢ Opportunity to improve uptake of immunisations			
Comms	**To public**	➢ Communications as required, a result of the OCT	UKHSA OMBC HPT GMIC NHS Oldham OMBC Comms	UKHSA	
	To health partners	➢ Outbreak email ➢ OCT minutes circulated			
	To media	➢ Coordinate by UKHSA via OCT			

NB:
These types of outbreak responses are usually led by the HP team, locally within Oldham, providing outbreak emails three times per week to the wider system.

- **Influenza like illness (ILI)/ARI (including Covid19) in a care home**
- **Viral gastroenteritis in schools/nurseries**
- **Viral gastroenteritis in nursing/care homes**
- **An outbreak of an HCAI**
- **Outbreak of influenza in childcare settings (non-residential)**
- **Outbreak of scabies in nursing/care home**

Outbreak of Influenza like illness (ILI)/ARI (including Covid19) in a care home

	Response Activity	Responders	Considerations/Documents

			In hours	Out of hours	
Investigations	Detection/Alerting	➢ Two or more residents or staff suffering from ILI ➢ OMBC/UKHSA alerted by home ➢ Exclude Covid19 ➢ Information for affected staff/ residents taken ➢ Outbreak email sent to relevant groups ➢ Outbreak form sent daily to home to fill out and return to OMBC	OMBC HPT – risk assess/IPC advice Liaise UKHSA for screening of affected residents (Minimum data set) Complete iLog form and return to lab GP – clinical review MRI virology – courier wait and return, results GtD – clinical assessment and AVs via FP10 if agreed	UKHSA GTD	National guidance link: https://www.gov.uk/government/publications/acute-respiratory-disease-managing-outbreaks-in-care-homes Oldham Local process chart Flu%20process%20 20.12.24.docx UKHSA minimum data set to complete when reporting outbreak and request for sampling/consideration of AV UKHSA%20risk%20a ssessment%20data% Request Ilog and sampling (courier wait and return) iLOG%20request%2 0ARI%20.docx Ensure Care Home staff are aware to label accurately on both sample and form when screening
	Sampling	➢ Swabs to be obtained from symptomatic people (Max 5) on a wait and return - Ilog ➢ Swabs delivered to MRI Public health Laboratory for PCR ➢ Results to Oldham HPT in hours and GM UKHSA out of hours			
Control	Advice IPC	➢ Increased hand and respiratory hygiene measures advised	OMBC HPT	UKHSA	

		➢ PPE including FRSM/visors or goggles ➢ Home closed to admissions unless risk assessed with HPT ➢ Affected residents isolated until 5 days post symptoms ➢ Affected staff excluded following national guidance ➢ Deep clean before reopening ➢ Reopen after 5 full days with no new symptom onset in residents or staff			Access AVs process – **note, suspension form of Tamiflu is limited in stock at each pharmacy** Antiviral%20Arrangements%202025%20 Cohorting residents is key where residents may have dementia, consideration of isolation of all residents who are safe to do so for prevention of transmission. PPE for residents consideration.
	Treatment/Prophylaxis	➢ Antiviral treatment/PEP prescribed and administered dependant on lab results ➢ GP/GtD to use FP10 in season and PSD Out of Season.			
Comms	To care home	➢ Advice letters/emails/outbreak info pack ➢ Flu leaflet for staff	Oldham HPT	Staff letter via UKHSA	For staff – flu leaflet 2024%20flu%20info%20sheet.doc
	To wider systems	➢ Outbreak report via email			

Outbreak Situation	Detection/Alerting	Response	Control	Treatment/Prophylaxis	Documents
Viral gastroenteritis in schools/nurseries	OMBC HPT contacted by school/nursery/other source when 2+ cases are noted HPT to inform EHO and maintain contact with information as appropriate	Phone call between school & HPT to discuss symptoms and numbers of affected staff & students. HPT to inform UKHSA if risk assessment determines need for further action Infection Prevention & Control advice provided, verbally and via email Outbreak included in outbreak email and distributed Arrange for stool samples to be taken from affected residents and sent to laboratory if appropriate or identified by UKHSA	Affected pupils & staff to stay home for at least 48hours post last symptoms Extra hygiene measures advised: IPC advice including soap and water for hand washing only, no hand gel to be used Deep clean of school 48 hours after last symptoms Advice to change toothbrushes (including those used in the setting)	Unnecessary in most cases	https://www.gov.uk/government/publications/health-protection-in-schools-and-other-childcare-facilities/preventing-and-controlling-infections https://www.gov.uk/government/publications/health-protection-in-schools-and-other-childcare-facilities/children-and-young-people-settings-tools-and-resources

Outbreak Situation	Detection/Alerting	Response	Control	Treatment/Prophylaxis	Documents
Viral gastroenteritis in nursing/care homes	OMBC HPT contacted by home/other source when 2+ cases are noted	Phone call between home & HPT to discuss symptoms and numbers of affected staff & residents HPT to email resources and timeline template to home, to be filled out daily and emailed back to HP Team Included in outbreak email Arrange for stool samples to be taken from affected residents and sent to laboratory if indicated – see process chart for more information on when to consider sampling	Affected residents isolated for at least 48hours post symptoms Affected staff excluded for at least 48 hours post symptoms Closure to admissions and visitors (unless essential) until at least 48 hours post symptoms and whole home deep clean has been performed Extra hygiene measures advised: enhanced cleaning regimes, regular cleaning of high touch points. Infection prevention advice provided, including: soap and water only for hand washing; PPE stored outside resident rooms; changing of toothbrushes	Unnecessary in most cases	 D&V%20Outbreak%20process%20202  Gastro%20timeline%20template%20202  ILOG%20request%20ASC%20Gastro%20  Care%20Home%20guidance%20gastroin

Outbreak Situation	Detection/Alerting	Response	Control	Treatment/Prophylaxis	Documents
An outbreak of an HCAI	OMBC Health Protection Team contacted by processing laboratory or another source **NB** May need UKHSA involvement in certain situations	OMBC HPT to gather information as appropriate for risk assessment and liaise with UKHSA as needed Relevant partners informed: UKHSA/GP or ASC teams if care setting, education colleagues if school setting ILog number to be obtained if samples are to be obtained – usually guided by UKHSA	Dependent on causal organism ➢ MRSA ➢ PVL ➢ ESBL ➢ C.diff See relevant link above on page 8/9	Antibiotic treatment or decolonisation if needed. See relevant link to guidance on page 8/9	See links to guidance on page #

Outbreak Situation	Detection/Alerting	Response	Control	Treatment/Prophylaxis	Documents
An outbreak of influenza in childcare settings (non-residential)	OMBC Health Protection Team contacted by School/Nursery or another source when 2+ cases are noted	Phone call between school & HPT to discuss symptoms and numbers of affected staff & pupils/children HPT inform UKHSA for risk assessment HPT maintain contact between setting and UKHSA Outbreak form details added to outbreak spreadsheet daily Warn & inform letter to go to school/nursery for parents. (as indicated by UKHSA)	Affected students/staff to stay home for 5 days from onset of symptoms and until feeling well IPC guidance provided to setting: ➢ Hand hygiene ➢ Supervised hand washing where appropriate to setting ➢ Enhanced cleaning of surfaces and high touch points ➢ Deep clean of area at appropriate time	To be arranged with child's/staff's own GP	See links to guidance on page 8/9

Outbreak Situation	Detection/Alerting	Response	Control	Treatment/Prophylaxis	Documents
Outbreak of scabies in nursing/care home	HPT alerted in variety of ways: GP; care home staff; DNs; ASC staff NB/ 8 week incubation period – infectious to others during this period	Obtain information regarding cases from the care home manager or person in charge - confirm whether case/s have been seen and diagnosed in person by GP/ANP or another clinical person Confirmed cases to be treated immediately (2 treatments, 7 days apart) Contact tracing of individuals who may have had skin to skin contact with confirmed cases, without PPE, during the 8 weeks prior to diagnosis/symptoms – send W&I Whole home treatments to be co-ordinated; confirmed cases to receive treatment during whole home in addition to immediate treatment; whole home must be treated at same time (2 treatments, 7 days apart) Comms to be shared with visitors, families	PPE for staff at all times whilst awaiting whole home treatment to reduce risks of transmission Isolation of confirmed cases is not recommended Declutter and removal of soft furnishings prior to whole home treatment, supports deep cleaning and removal of dust Guides for application of cream and cleaning – see documents – distributed to all staff and residents as appropriate Transfers out/admissions in the setting must be risk assessed and discussed with HPT	Care Home to arrange with the GP for residents – noting UKHSA guidance in relation to the choice of topical and oral treatments Care Home to purchase creams for all staff	Applying%20ointment%20instructions. Care%20Home%20Comms%20Oct%2020 Scabies%20whole%20home%20treatmer Ivermectin%20instructions.docx Permethrin%20instructions.docx Would_you_know_if_you_had_scabies.p

Organisation	Name/comment	Contact details (telephone and email)
Oldham Local Authority		
First Response Team	To activate response from Gold/Silver/Bronze Officers, 24/7, 365 days	0161 770 2222
Director of Public Health	Dr Rebecca Fletcher	Rebecca.fletcher@oldham.gov.uk M; 07725652566 **PA:** Katie Carpenter: Katie.Carpenter@oldham.gov.uk
Consultant in Public Health (Health Protection Lead, Oldham)	Dr Charlotte Stevenson	Charlotte.stevenson@oldham.gov.uk
Assistant Director – Public Protection	Vacant position	
Health Protection Team	HPT (Mon – Fri, 9am – 5pm)	HealthProtection.Team@oldham.gov.uk
Public Health Commissioning Manager	M-F 9-5	Vicki.Gould@oldham.gov.uk public.health@oldham.gov.uk
Environmental Health	M-F 9-5	envhealth@oldham.gov.uk
	In event of outbreak requiring response M-F 9-5	lauren.wood@oldham.gov.uk envhealth@oldham.gov.uk
Communications/Media	Communications team	All media queries within office hours (9am to 5pm) should be sent to pressoffice@oldham.gov.uk;
	Out of hours support, visit intranet for details of on call contact	Review on call details via: https://www.oldham.gov.uk/info/200609/contact/938/media_queries
OMBC Control Room	Control Room	0161 770 4580
Civil Resilience/Emergency Planning	Darren McGrattan - 07540 649204	The contact number for emergencies is 0161 628 2000.

Educational settings	Andy Collinge Head of School Support Services	Andy.collinge@oldham.gov.uk
	Tony Shepherd Assistant Director of Education & Early Years	Tony.Shepherd@oldham.gov.uk
Safeguarding https://www.oldham.gov.uk/info/100010/health_and_social_care/1976/contact_social_services	Adult Multi Agency Safeguarding Hub	Adult.Mash@oldham.gov.uk
	Child Multi Agency Safeguarding Hub	Child.Mash@oldham.gov.uk
	Emergency Duty Team (Out of hours emergencies only)	edt@oldham.gov.uk

Organisation	Name/comment	Contact details (telephone and email)
UK Health Security Agency	Coordinate the outbreak response and provide scientific and technical advice	**0344 225 0562 (Option 2 for North West Team/Greater Manchester Health Protection Team)**
UKHSA Lab	clinical microbiology	0161 276 5686/5699, out of hours 0161 276 1234
	For Field Service North West	0344 225 0562 Option 6
	Dr Andrew Fox Consultant in Public Health Infection, Field Service (NW)	andrew.fox@ukhsa.gov.uk Mobile: 07736244920
	Faeces Sampling Kit – ordering stock	0161 253 6900 9am–5pm Mon-Fri Or 0161 276 6786 clare.ward@ukhsa.gov.uk; edward.cryer@ukhsa.gov.uk; donna.johnson@ukhsa.gov.uk;

UKHSA has the statutory responsibility for the protection of public health. This includes (but is not confined to) infectious disease, environmental hazards and contamination and extreme weather events – although some specific powers are delegated to the DPH who will lead the local authority response to any incident which poses a threat to public health. UKHSA will support an emergency response by:-

- - providing health protection services expertise and advice and co-ordinating responses to major incidents
- - assessing public health needs and gathering data to support emergency plans
- - carrying out risk assessments with the support of the organisation involved
- - providing scientific and technical advice
- - providing microbiology services

Organisation	Name/comment	Contact details (telephone and email)
Primary Care Lead	Head of Primary Care Operations (Oldham Locality) Tariq Sharf	tariqsharf@nhs.net 07964 909 143
ICB Associate Director Quality & Safety (Oldham)	Medicines Optimisation Team Andrea Edmondson	gmicb-old.medicinesoptimisationenquiries@nhs.net; andrea.edmondson@nhs.net; Tel: 07964113649
Urgent Care	Elizabeth Harper: Head of Urgent and Emergency Care (Oldham)	Elizabeth.harper10@nhs.net 07823 534 136
Go to Doc (GtD)	Responsible for Clinically assessing patient and prescribing relevant medication (outbreaks and PEP)	Health Care Professional Line: 0161 934 2828 gtd.businesscontinuity@nhs.net gtd.hubopsmanagers@nhs.net
	Senior Care Coordinator	07771578107 or 01619342820

Organisation	Name/comment	Contact details (telephone and email)
Oldham Royal Hospital (Northern Care Alliance, Oldham Care organisation)	Associate Director of Infection Prevention and Control	Linda Swanson 0161 2065036 07850939171 linda.swanson@nca.nhs.uk
	Senior manager on-call (for support or acute Trust incidents)	0161 624 0420
	Microbiology lab	0161 627 8360 – Main lab 0161 627 8359 – Managers office

	Adult Community Nursing Services Manager on Call	07970 002003
	Children's Nursing Services – Manager on Call	07970 002003

Organisation	Name/comment	Contact details (telephone and email)
School Nursing Team/School Nursing Lead (NCA)	Support with regards to outbreaks	0161 470 4346/ 07392280693
School aged Immunisations services	IntraHealth Ltd – support for outbreak situations requiring immunisation response	OldhamImms@intrahealth.co.uk 0333 358 3397
Looked After Children Nursing Team	Angela Jones Named Nurse - Oldham Children Looked After	oldhamlac@nca.nhs.uk 0161 627 8700

Organisation	Name/comment	Contact details (telephone and email)
Care Quality Commission	Emma Popay Operations Manager North Network Primary and Community Care	Emma.Popay@cqc.org.uk
	Jill Thornton Inspector North Network Primary Medical Services and Integrated Care	Jill.Thornton@cqc.org.uk
	Rajedha Yasmin Inspector - Network North	Rajedha.Yasmin@cqc.org.uk
Report concerns		https://www.cqc.org.uk/contact-us/report-unregistered-service

Organisation	Name/comment	Contact details (telephone and email)
Single point of Access for District Nurses	Can provide immunisation to Adults	0300 323 0464 0161 621 3435
District Nursing Services	Additional support and distribution of anti-viral by Patient Group Direction (PGD)	0161 357 5190

Organisation	Name/comment	Contact details (telephone and email)
TB Team	Stacey Farrow or Helen Ogden 07817 076531/ 07966 926 344	Tb.nursesnmgh@mft.nhs.uk; 0161 720 2394
	UKHSA – out of hours	0344 2255 0562
North Manchester General Hospital (Infectious diseases unit)	Infection Prevention and Control Team Matron Jainanna Chackachan	0161 720 2935 jainanna.chackachan@mft.nhs.uk

Organisation	Name/comment	Contact details (telephone and email)
Greater Manchester Integrated Care Partnership Oldham – commission services or extend services	NWAS Hold on call commissioner rota and numbers	0345 113 0099 gm.icp@nhs.net

Organisation	Name/comment	Contact details (telephone and email)
Community Health and Adult Social Care	Can provide support to residential care homes	0161 770 6936 (24hrs a day)

Organisation	Name/comment	Contact details (telephone and email)
Health & Safety Executive	HSE Enforcement Officer for GM	0300 003 1747 (8.30am-5pm) 0151 922 9235 OOH
NWAS	*The Control Room will be able to provide details of any incident to which NWAS has responded (including a log number). In the event that **non-urgent** medical assistance is required at RVP, reception centre or any other location to which MCC has responded to an incident, the Control Room can be contacted to request attendance (if available) from NWAS.*	*24/7 control room **0161 866 0661***

Organisation	Name/comment	Contact details (telephone and email)
Homelessness team OMBC	Moira Fields & Clare Ocansey	Moira.fields@oldham.gov.uk Clare.ocansey@oldham.gov.uk
Sexual health services	Melissa Hughes, HCRG, young people & adults melissa.hughes@hcrgcaregroup.com	0300 303 8565
Turning Point Oldham	Via online form on website (see links on page 9)	0300 555 0234 (Monday – Friday, 9am – 5pm

Organisation	Name/comment	Contact details (telephone and email)
OMBC District teams	North District	Place.TeamNorth@oldham.gov.uk
	East District	Place.teameast@oldham.gov.uk
	Central District	place.teamcentral@oldham.gov.uk
	West District	Place.teamwest@oldham.gov.uk
	South District	Place.teamsouth@oldham.gov.uk

Organisation	Name/comment	Contact details (telephone and email)
SERCO – Asylum accommodation and support services	SERCO Affy Rasheed (Partnership Manager)	AASC.victoriaoldham@serco.com affy.rasheed@serco.com

Part 6: Appendices

Appendix 1: Common and Other Outbreak Settings or Sources

These are examples of community settings sometimes associated with outbreaks

- Care homes: nursing, residential, intermediate, mixed etc.
- Schools / Colleges
- Nurseries / Child minders / Play centres
- University / student accommodation
- Food outlets and event caterers
- Petting farms
- Swimming pools / water activity parks
- Dental practices
- Community health care settings (GP practices, Integrated Care centres etc.)
- Prisons / Detention Centres
- Workplaces
- Ports / airports
- Hotels
- Leisure Centres
- Travellers Sites
- Private camp sites / holiday parks
- Community Hospitals
- Hostels
- Tattoo Parlours

Appendix 2: Common Pathogens

Below is a list of pathogens which can commonly cause outbreaks. This list is not exhaustive.

The full list of notifiable diseases is available here:

- Influenza
- Norovirus
- Scabies
- Tuberculosis
- Clostridium difficile
- PVL positive MR(S)SA
- Invasive Group A Streptococcal infection
- E Coli O157
- Hepatitis A
- Meningitis
- Pertussis
- Legionnaires Disease
- Measles
- Covid 19

Appendix 3: Suggested OCT Members

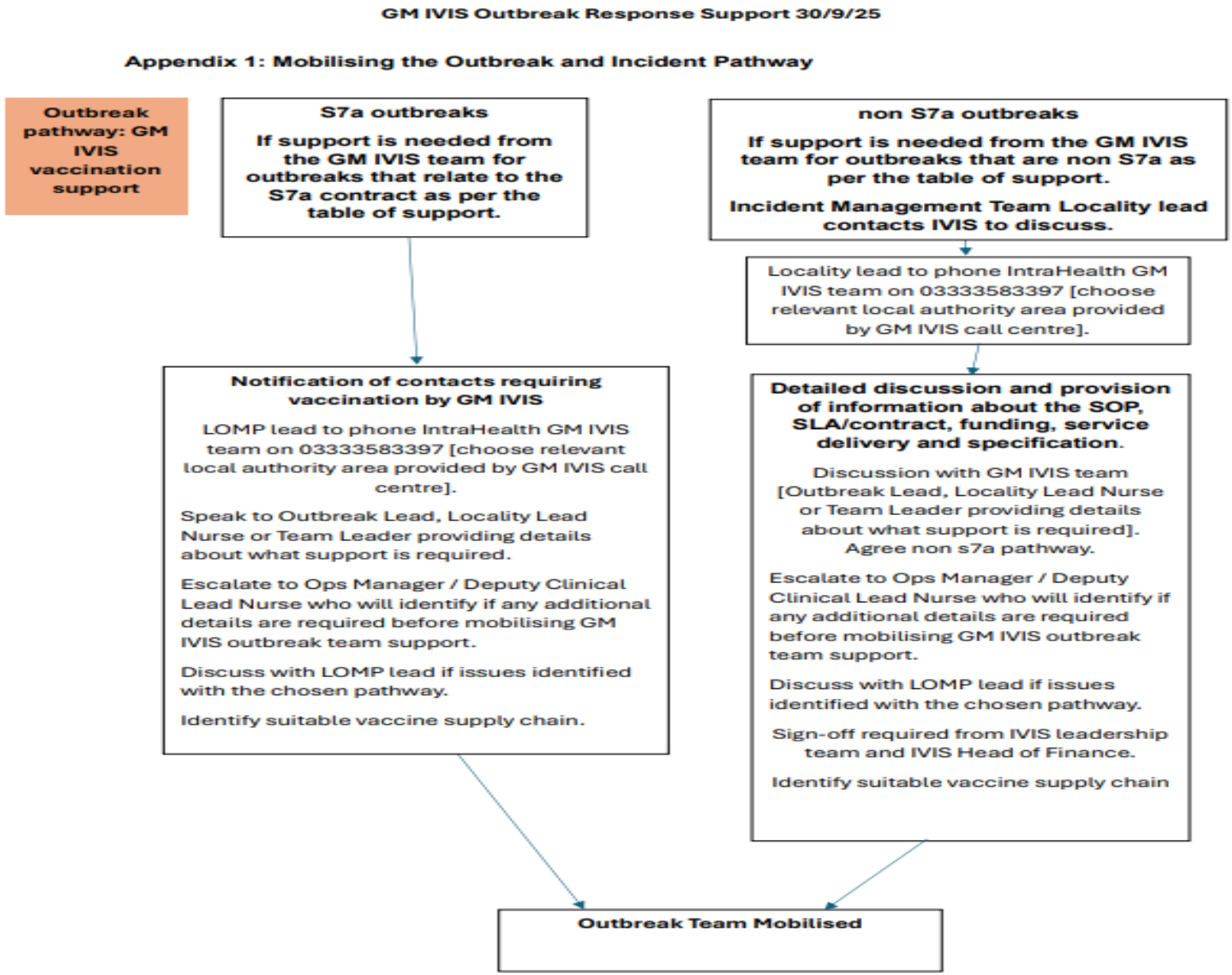
- Consultant in Communicable Disease Control
- Environmental Health Officer
- Consultant Microbiologist / Virologist
- Director of Public Health/ Local Health Protection Nurse
- NHS GM ICB Representative
- District Partnership Representative
- Representative from Comms and Marketing Team at Oldham Council
- Local NHS Provider Services (as required) [e.g. acute trust, GTD]

NB: This list is not exhaustive; depending on the nature of the outbreak representation from additional organisations may be required, for example, in the event of an outbreak in a school would be appropriate to include a representative from Education at OMBC.

Appendix 4: Outbreak or Incident Meeting Agenda Template

No	Agenda item
1	**Introductions and apologies**
2	**Summary of situation**
3	**CICN update**
4	**Microbiology**
5	**Risk assessment**
6	**Control measures**
7	**Communications**
8	**AOB**
9	**Date of next meeting**

APPENDIX 5: INTRAHEALTH RESPONSE SUPPORT



GM IVIS Outbreak Response Support 30/9/25

Appendix 2: List of potential vaccines that IntraHealth (GM IVIS) could deliver to support incidents and outbreak

Disease	Vaccine	Section 7A funding?	Other considerations
Influenza	Influenza	Nationally determined groups only (currently incl. primary and secondary school children)	Already part of IVIS for routine programme. Reactive
Covid-19	Covid-19	Nationally determined groups only (currently incl. individuals aged 6 months to 64 years in a clinical risk group).	Reactive
Hepatitis A	Hep A	No	Reactive or post-exposure
Hepatitis B	Hep B	Only Neonatal Hep B is included in S7A – no other Hep B provision	Likely to be small numbers/ household contacts only – post-exposure
Meningitis	MenACWY	Year 9 and above only	Already part of IVIS for routine programme Anything additional (e.g. if a MenACWY was recommended for a 9 year old) – not included in S7a? Reactive or post-exposure
Meningitis B		No	Reactive or post-exposure Vaccination only, not prophylactic antibiotic treatment
Pertussis	6-in-1vaccine 4-in-1vaccine	Up to age of 10 & unvaccinated, or pregnant included in S7A.	IVIS would only give Td/IPV as part of service, not pertussis containing vaccines Reactive or post-exposure

GM IVIS Outbreak Response Support 30/9/25

Measles	MMR	Pre exposure only to eligible cohorts	Already part of IVIS for routine programme Pre exposure only Post exposure to measles cases e.g vaccination if children in a nursery who have had close contact with measles would not be covered by S7A funding
Mpox	Mpox	No*	Need to work through mechanism/ pathway for getting vaccine to IntraHealth. IM/ID/SC route – training may be needed.
Rabies	Rabies	No	Very small numbers – rabies would be a post exposure (from an animal) rather than community transmission – normally given by GP
Varicella	Varicella	No	Reactive or post-exposure Vaccination only, not prophylactic antibiotic treatment

*Mpox pre-exposure vaccination for eligible cohorts is commissioned through GM sexual health services. Post exposure vaccination as part of outbreak response is not commissioned by NHS England S7a.

Appendix 6: Hep A Flowchart/Algorithm

https://assets.publishing.service.gov.uk/media/65ccdbbd1d93950012946677/Hepatitis-A-guidance-13-february-2024.pdf

Public health control and management of hepatitis A

Table 1 defines different risk groups who have an increased risk of spreading hepatitis A because of personal hygiene or occupation.

Table 1. People that pose an increased risk of spreading hepatitis A (source: Guidance on gastrointestinal infection)

Risk group	Description	Additional comments
A	Any person of doubtful personal hygiene or with unsatisfactory toilet, hand-washing or hand drying facilities at home, work or school	Risk assessment should consider, for example, hygiene facilities at the work or educational setting
B	All children aged 5 years old or under who attend school, pre-school, nursery or other similar childcare or child minding groups	Explore informal childcare arrangements
C	People whose work involves preparing or serving unwrapped food or drink to be served raw or not subjected to further heating	Consider informal food handlers, for example, someone who regularly helps to prepare buffets for a congregation
D	Clinical and social care staff who work with young children, the elderly, or other particularly vulnerable people, and whose activities increase the risk of transferring infection via the faeco-oral route. Such activities include helping with feeding or handling objects that could be transferred to the mouth	Someone may be an informal carer, for example, caring for a chronically sick relative or friends

Figure 1. Risk assessment for close contacts who are food handlers

This is a graphical version of Close contacts who are food handlers and have not received vaccine within 14 days of exposure, above.

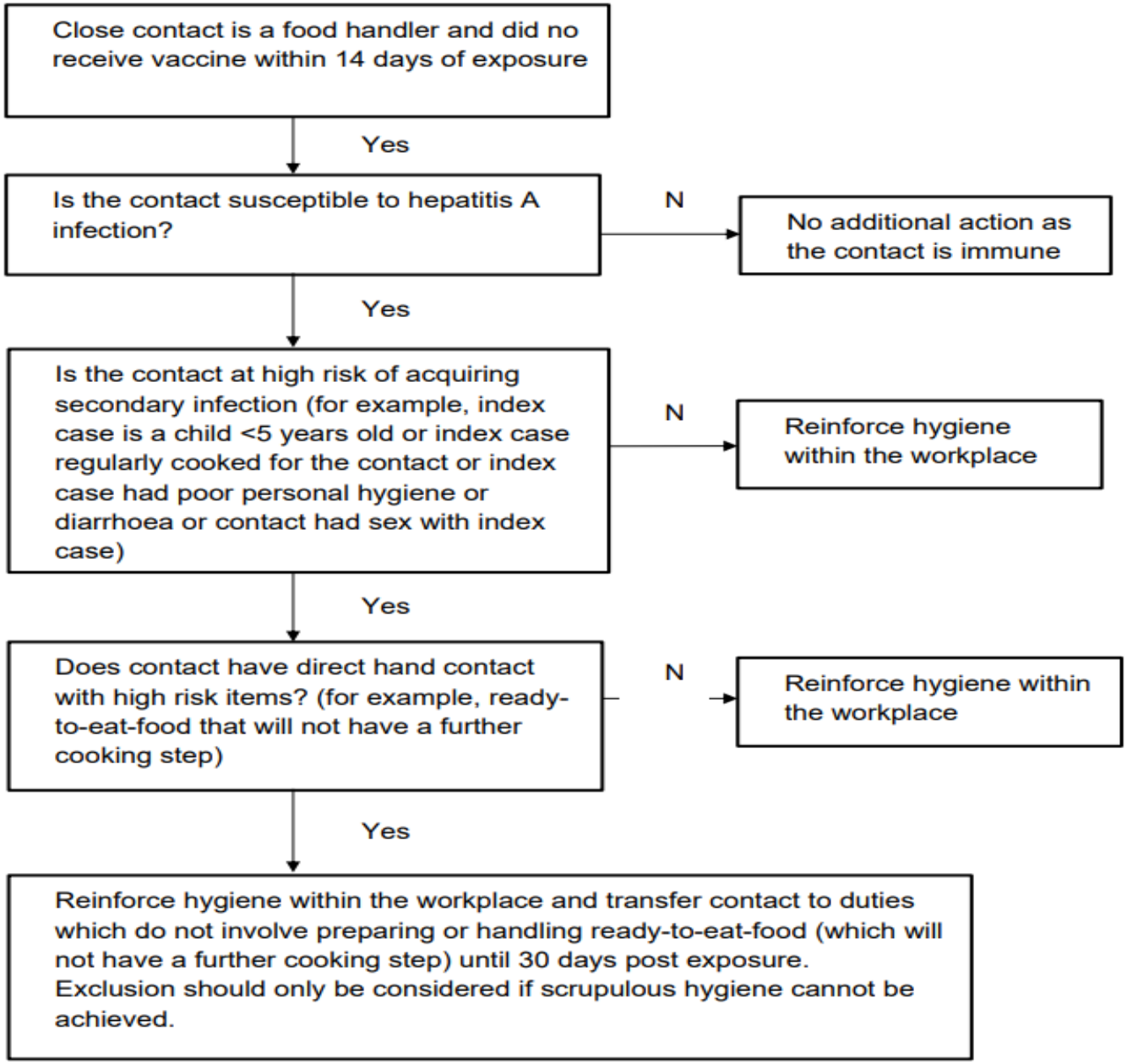
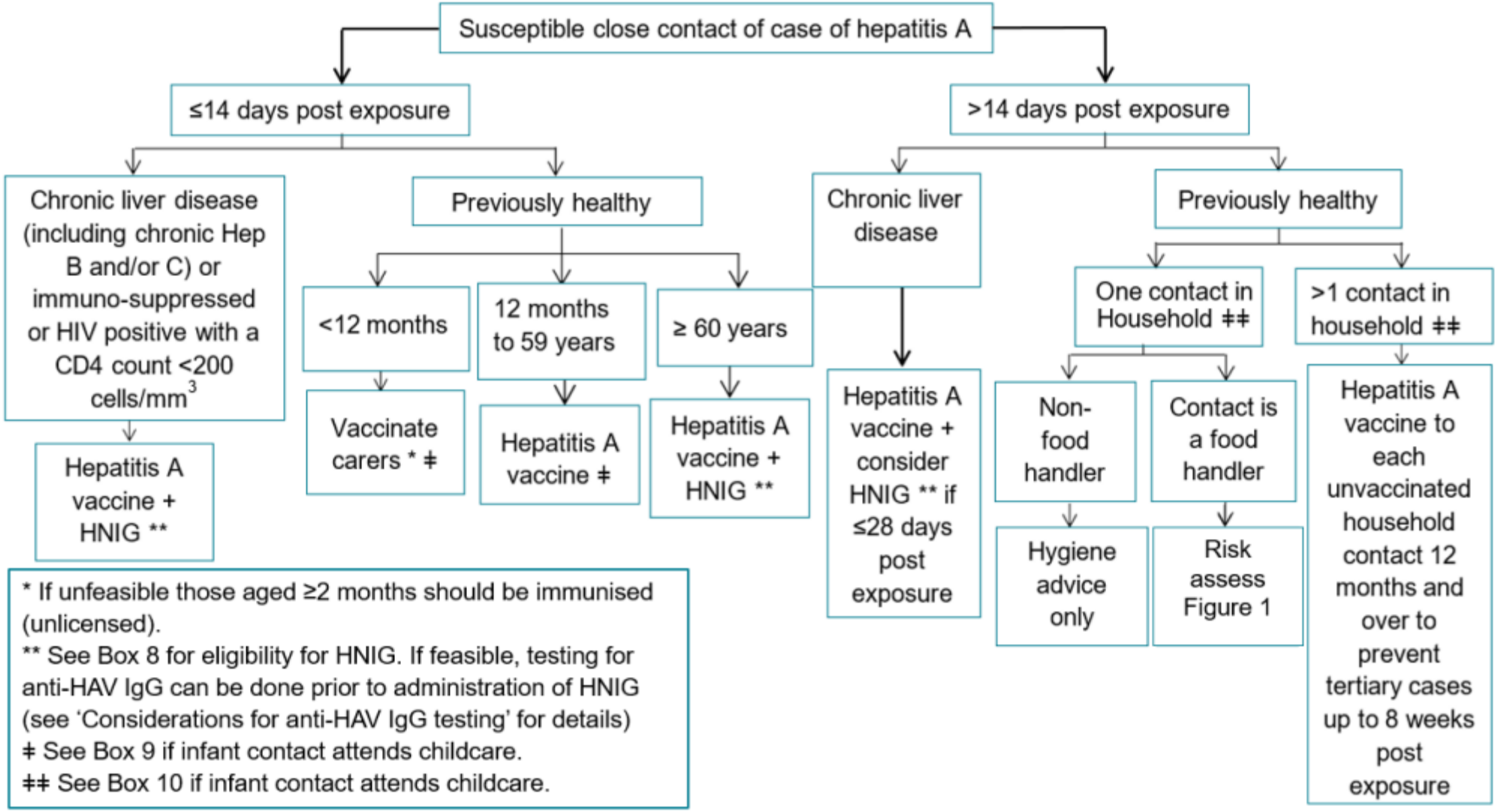


Figure 2. Algorithm for management of susceptible close contacts

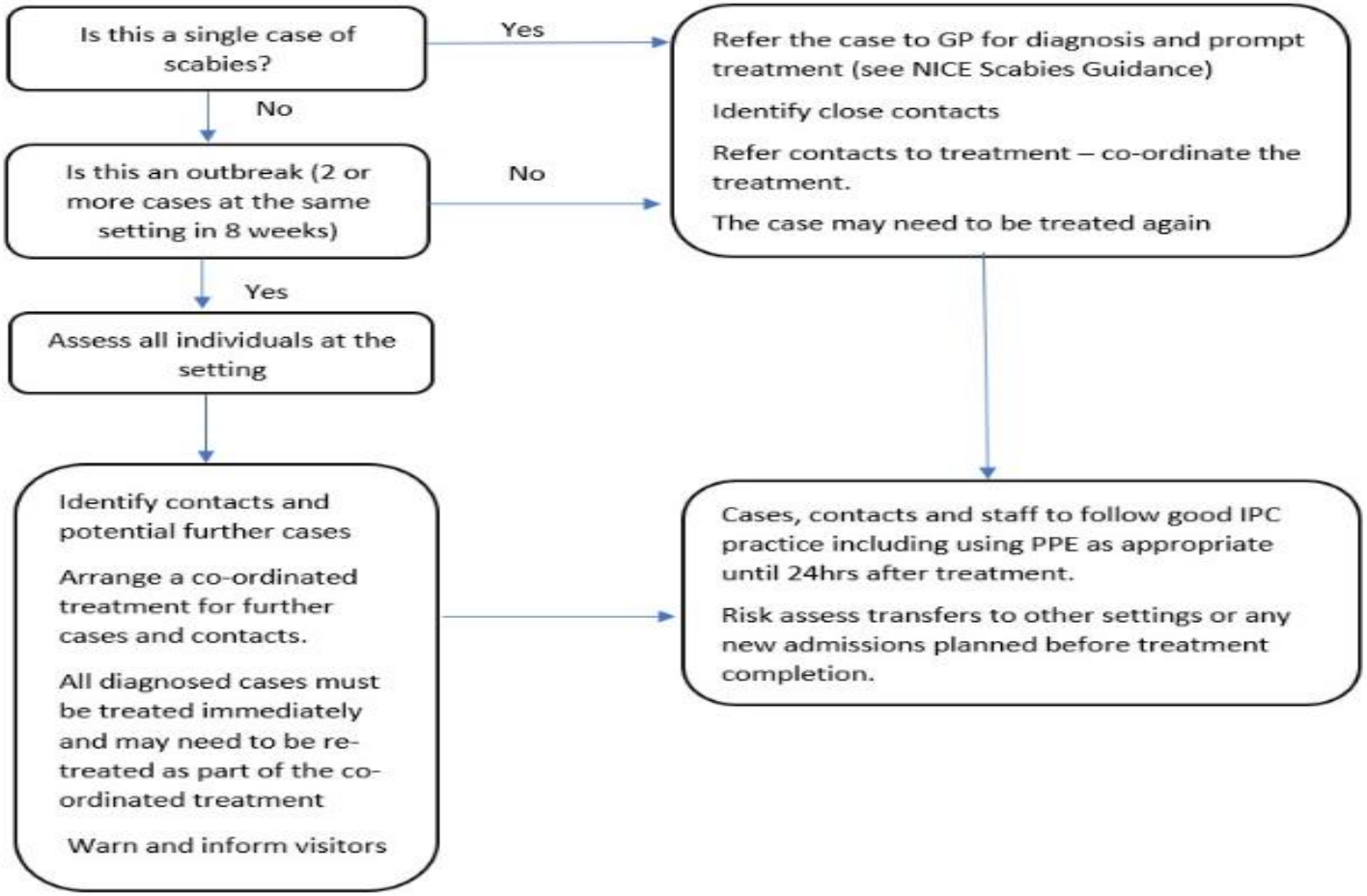
This is a graphic version of boxes 9 and 10.



Appendix 7: Scabies Algorithm

Algorithm summarising the public health management

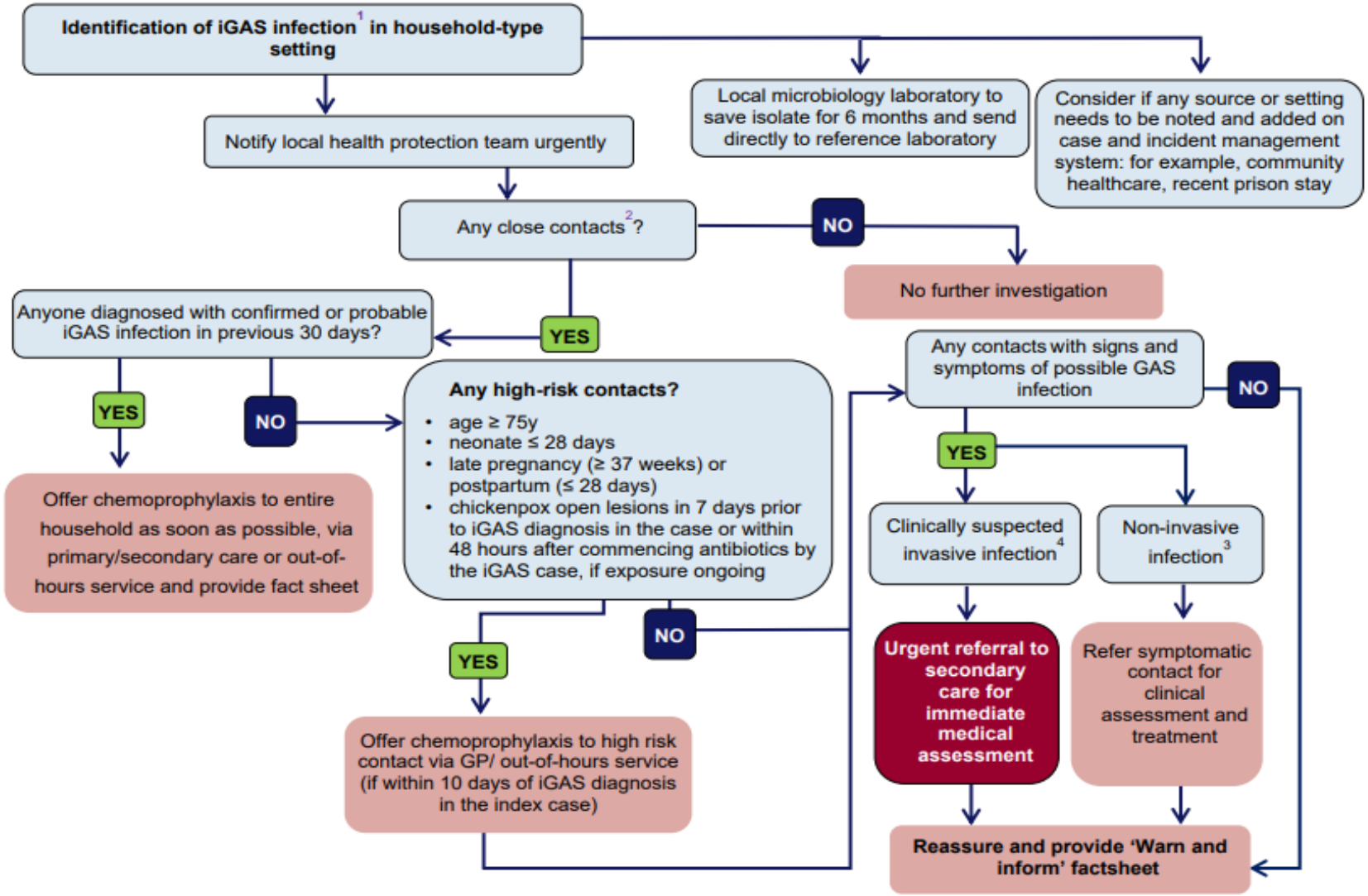
The algorithm consists of 2 questions which follow each other to help determine if the setting is dealing with an outbreak and to guide public health management.



Appendix 8: Management of iGAS (contacts/IPC measures/algorithm – various settings)

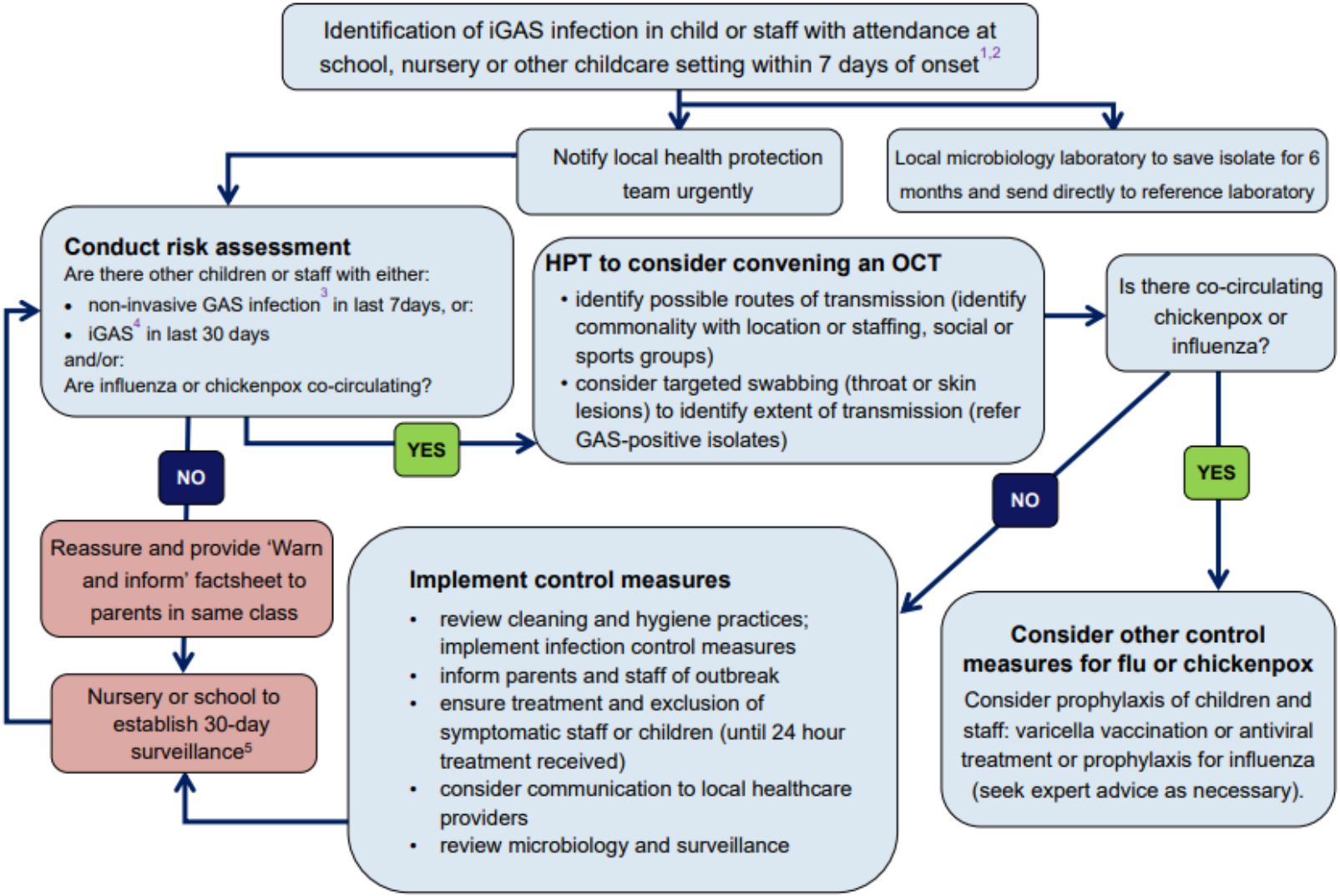
https://assets.publishing.service.gov.uk/media/64071ec5d3bf7f25fa417a91/Management-of-contacts-of-invasive-group-a-streptococcus.pdf

Algorithm 1. Management of contacts of a case of iGAS in a household-type setting (an accessible, text-only version is available)



1. Invasive GAS infection (iGAS) is defined through isolation of GAS from a normally sterile body site. GAS isolated from non-sterile site in combination with severe clinical presentation should be managed as per iGAS.
2. Close contact is defined as someone who has had prolonged close contact with the case in a household -type setting during the 7 days before diagnosis of iGAS infection. Examples include those living and/or sleeping in the same household, pupils in the same dormitory, intimate partners, or university students sharing a kitchen in a hall of residence. Consider contacts who provide nursing care (district nurses, health visitors).
3. Symptoms suggestive of non-invasive GAS infection include sore throat, fever, minor skin infections, scarlatiniform rash.
4. Symptoms suggestive of invasive disease include high fever, severe muscle aches or localised muscle tenderness +/- a high index of suspicion of invasive disease. In the absence of a more likely alternative diagnosis then emergency referral to A&E (contact A&E to advise of incoming patient).

Algorithm 2. Management of iGAS case linked to a nursery, school or other childcare setting (an accessible, text-only version is available)



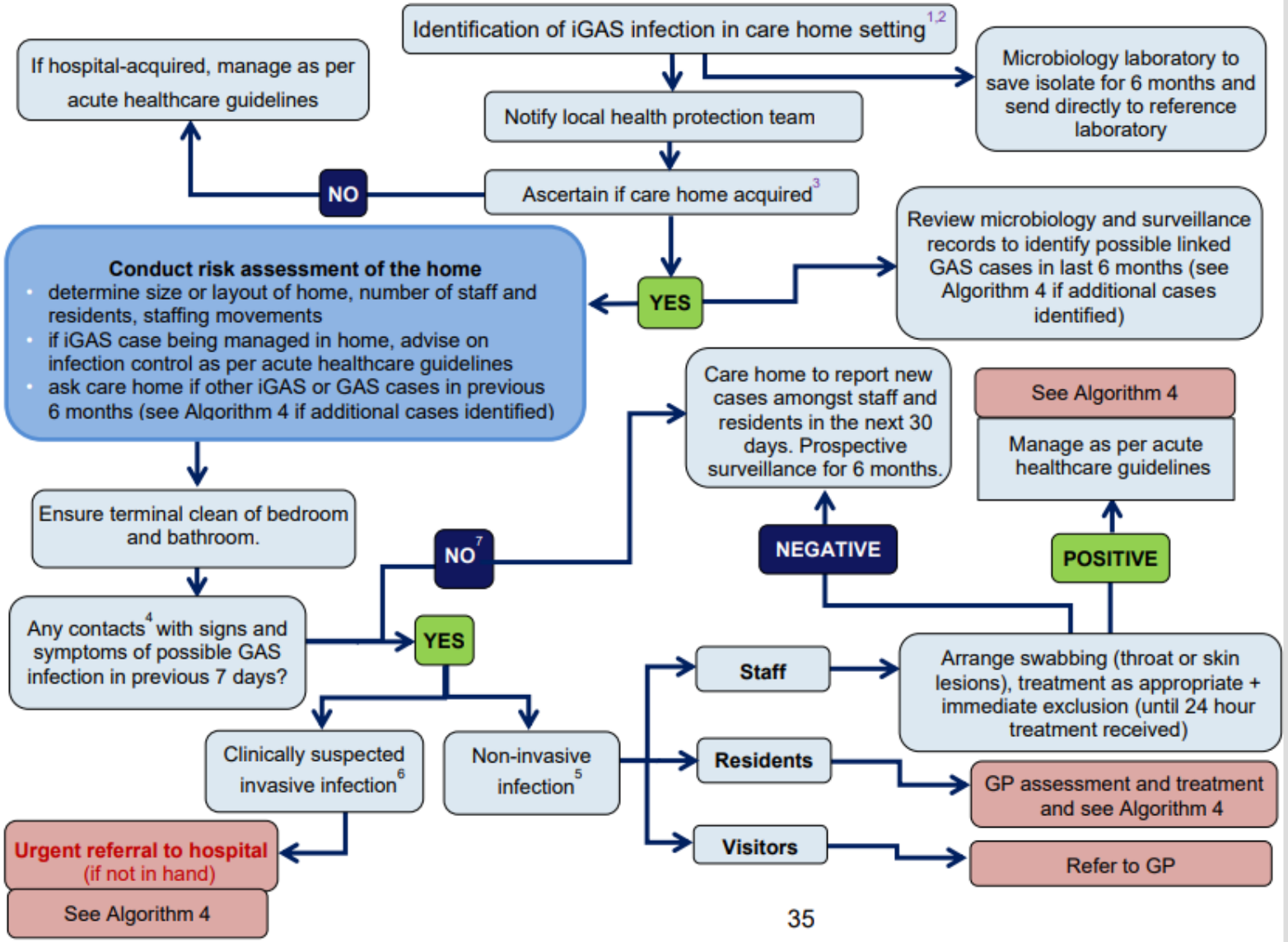
1. iGAS is defined through isolation of GAS from a normally sterile body site. GAS isolated from non-sterile site in combination with severe clinical presentation should be managed as per iGAS.
2. Where the case hasn't attended the setting in 7 days before onset, it may be necessary to inform the school, for example, if severe illness or death.
3. Symptoms suggestive of non-invasive GAS infection include sore throat, fever, minor skin infections, scarlatiniform rash
4. Symptoms suggestive of invasive disease include high fever, severe muscle aches or localised muscle tenderness +/- a high index of suspicion of invasive disease.
5. Prospective 30-day surveillance for GAS, iGAS, chickenpox and influenza.

Table 3. Infection control measures for care homes (adapted SIGN D) (113, 116)

Indication for use	Control measures	Strength of evidence
Single case of iGAS	• strengthen hand hygiene • review sick leave policy so staff not encouraged to work while ill • review IPC practices on site • check if any staff or residents have signs or symptoms of GAS (pharyngitis, skin conditions such as impetigo or erysipelas) or chronic skin conditions such as eczema or psoriasis which could increase GAS carriage on damaged skin • store isolates for further typing for at least 6 months and send isolates to Streptococcal Reference Service at UKHSA for typing • use appropriate personal protective equipment for staff and visitors in contact with the cases until after 24 hours antibiotics, as per prevention and control of group A streptococcal infection in acute healthcare and maternity settings in the UK (3) • implement enhanced surveillance for GAS infection • carry out hand hygiene audits and education • restrict staff movement where possible • educate patients, staff and visitors by distribution of GAS information leaflet • carry out full terminal clean of bedroom and bathroom to reduce possible environmental reservoir of GAS • provide education on transmission-based precautions	Common, well-accepted
Further cases of GAS/iGAS identified	• halt new admissions to home or defer routine clinic and radiology appointments where possible • consider screening all residents for GAS in throat and wounds • screen staff (throat swab and open skin lesions, for example, eczema) who are symptomatic or are epidemiologically linked to cases (for example, have had contact with cases) • isolate or cohort patients with GAS • trigger for further investigation (>=2 cases of iGAS/GAS) • consider targeted versus mass antibiotics	Unproven but unlikely to harm

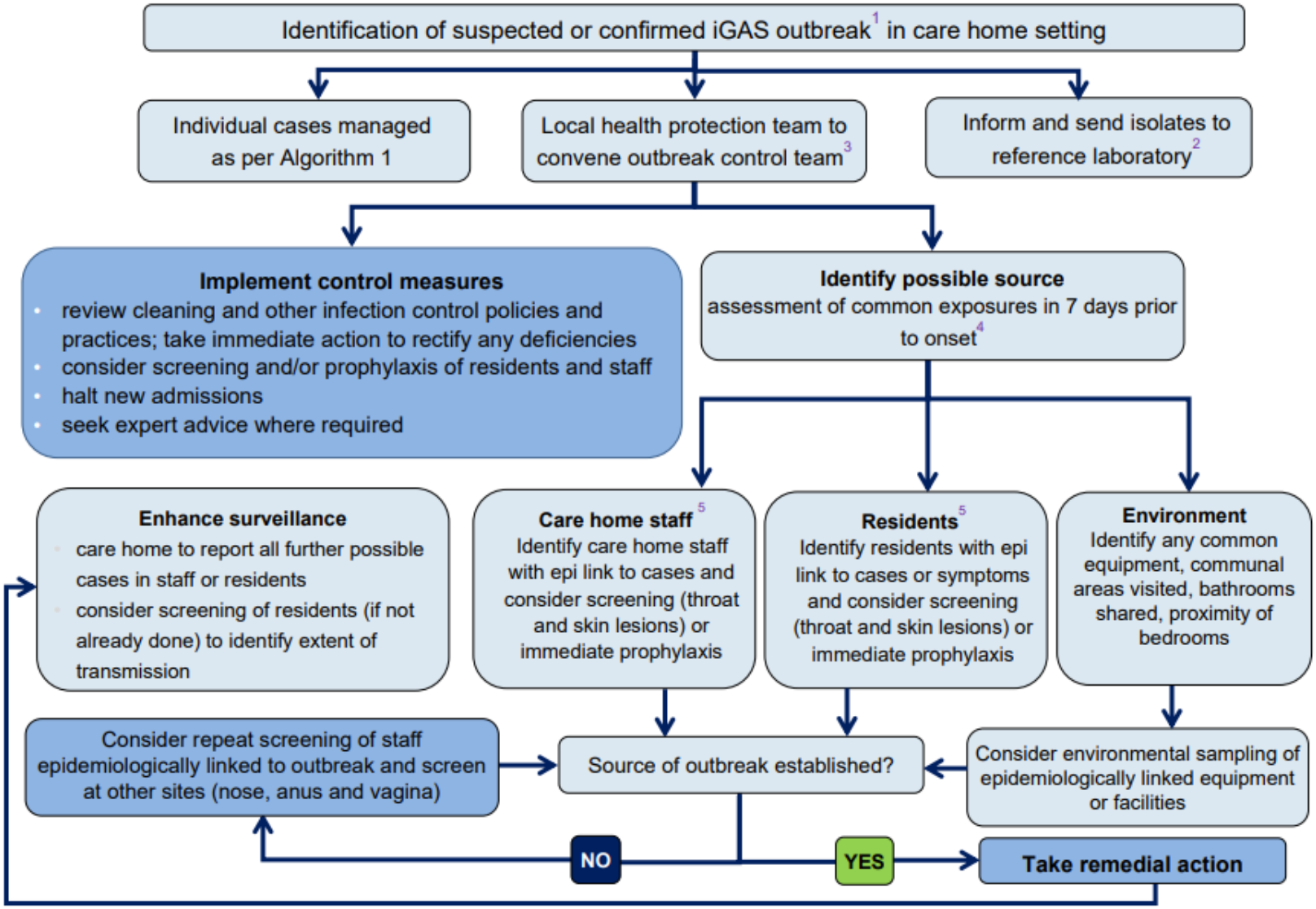
Indication for use	Control measures	Strength of evidence
Outbreak prolonged, consider further measures	• role of re-screening • consider further antibiotics • consider environmental involvement • optimum cleaning protocol	Needs further evidence

Algorithm 3. Management of a single case of iGAS infection in a care home setting (an accessible, text-only version is available)



1. Patient resided in a care home in 7 days prior to onset
2. Invasive GAS infection (iGAS) is defined through isolation of GAS from a normally sterile body site. GAS isolated from non-sterile site in combination with severe clinical presentation should be managed as per iGAS.
3. Consider care home acquired if symptoms or signs of infection not present on entry to care home and no other possible source of transmission identified, such as from recent hospital stay.
4. Carers, peripatetic staff, visitors, other residents with direct contact or close proximity to case.
5. Symptoms suggestive of non-invasive GAS infection include sore throat, fever, minor skin infections
6. Symptoms suggestive of invasive disease include high fever, severe muscle aches or localised muscle tenderness +/- a high index of suspicion of invasive disease. In the absence of a more likely alternative diagnosis then emergency referral to A&E (contact A&E to advise of incoming patient).
7. Consider whether asymptomatic staff contacts should be screened. Indications may include strong epidemiological link, absence of alternative potential source and/or where recent transmission of GAS within the home suspected.

Algorithm 4. Management of suspected or confirmed iGAS outbreak in care home (an accessible, text-only version is available)



1. Two or more cases of confirmed or probable iGAS infection related by person or place. These cases will usually be within a month of each other but the interval may extend to several months.
2. Clearly label isolates sent to the reference laboratory as being part of a suspected outbreak to prioritise processing. Epidemiological investigations and preventive measures should not await results of typing.
3. Outbreak control team may include care home manager, consultant microbiologist, occupational health adviser, local GP, local commissioning lead and communications adviser.
4. Assess possible sources according to case's movements or contacts in the home 7 days prior to onset. Carers, other residents, equipment and the environment are possible sources of outbreaks. Develop time lines and network analyses to identify common exposures (2 or more cases).
5. Carers, peripatetic staff (hairdressers, podiatrists, GPs, district nurses etc), visitors, other residents with direct contact or close proximity to case within 7 days prior to diagnosis. Consider kitchen staff.

Appendix 9: Process for respiratory screening and in event of ARI/Flu in care homes

Actions for respiratory outbreak and/or positive Flu case/s in care homes

An outbreak of Acute Respiratory Infection (ARI) is defined as 2 or more epidemiologically linked cases within 5 days.
See file path for all documents needed:
https://oldham365.sharepoint.com/sites/PublicHealth/Public%20Health%20Files/Forms/AllItems.aspx?id=%2Fsites%2FPublicHealth%2FPublic%20Health%20Files%2F2%2E%20Health%20Protection%2FOUTBREAKS%5FINCIDENTS%2FFlu%20%26%20Respiratory%20Illness%2F2024%2D2025%20season%20pathway%20documents&viewid=0c5ac442%2D2125%2D4c9d%2Da3ad%2Dac4e8c8f0117
Refer to Care Home Action Card for full guidance:
https://oldham365.sharepoint.com/:w:/r/sites/PublicHealth/_layouts/15/Doc.aspx?sourcedoc=%7BCA29EB21-2247-5A6D-9294-F28DF947800F%7D&file=ARI%20Care%20Home%20Action%20Card%2012.2024%20FINAL%20(1).docx&action=default&mobileredirect=true

1. **IPC Measures:**

Assess whether home needs to introduce outbreak measures, including closure for admissions/transfers etc.
Advise on IPC measures: enhanced PPE to include masks, eye protection; hand and respiratory hygiene; enhanced cleaning; ventilation; isolation of symptomatic residents and staff.
https://www.england.nhs.uk/national-infection-prevention-and-control-manual-nipcm-for-england/

2. **Testing:**

Exclude Covid 19:

- Test eligible residents with LFT – up to 5 residents. (most recent symptomatic)

If LFTs are negative, complete the “Template UKHSA minimum data set Feb 2025” and call UKHSA 0344 225 0562 to request risk assessment.
UKHSA HP practitioner will speak to a consultant and get back to you.
If screening is agreed, complete the “iLOG request 20.12.2024” and send it to the emails as directed on the form.
Let the care home staff know to expect a courier who will have up to 5 swabs - they should swab the most recently symptomatic residents (5) and give them back to the courier (wait and return).

** (Make sure the home staff know to write the full details of the resident on the swab and the form - name, DOB, NHS no)

Ask the care home staff to email to you the NHS no; DOB; initials of the 5 residents screened, so that you can obtain results. Health Protection Team have access to "e-lab" for results following respiratory screening and will check these during normal working hours. If screening is negative, all “outbreak” IPC measures should remain in place until there has been 5 days with no new symptoms reported.

3. **Care home staff actions following screening activity:**

If swabs are Flu positive - likely that antivirals will be recommended. UKHSA consultant will do this risk assessment and make the decision.
** Care home staff are responsible for completion of all resident information to support clinical assessments for antiviral medications. “Oldham care home resident info” document.

https://oldham365.sharepoint.com/:w:/r/sites/PublicHealth/_layouts/15/Doc.aspx?sourcedoc=%7B76C38C8F-B759-4188-A7DA-C1ADE48CB71D%7D&file=Oldham%20Care%20Home%20Resident%20Info%20winter%2024-25.docx&action=default&mobileredirect=true

4. **Once antivirals are recommended for care home residents**

Antiviral medications need to commence *within 48 hours* of exposure/diagnosis.
All actions need to be acted upon as a priority

Go to Doc are our provider of clinical assessments and for prescribing antivirals for care home residents.
0161 934 2828 Ops manager
0161 934 2820 ANP

- Email them on gtd.businesscontinuity@nhs.net; gtd.hubopsmanagers@nhs.net; "Please arrange for clinical assessment and prescriptions of antivirals as appropriate"

If no response after one hour, call Senior Care Coordinator 0n 07771578107 or 01619342820.

- Copy in the care home manager and all other email contacts we have in our list for the home (see link below) – also attach the list of pharmacies carrying stock

https://oldham365.sharepoint.com/:w:/r/sites/PublicHealth/_layouts/15/Doc.aspx?sourcedoc=%7BC87E97F1-F81B-47BB-B51D-4B9B35A197A8%7D&file=Care%20Homes%20Contacts%20from%20Jan%202023.docx&action=default&mobileredirect=true

(Antiviral meds can be prescribed in different doses, a treatment dose for those with symptoms/positive swab, and prophylactic dose for those without symptoms but who have been exposed to Flu.)

It is the responsibility of the home staff to identify a suitable pharmacy from the list ("antiviral arrangements for 2024-2025) and to collect the antiviral meds once prescribed and dispensed. It is beneficial for the care home staff to call the chosen pharmacy and inform them of the situation and how many prescriptions to expect (at this time, the pharmacy can inform the home staff if they do not have adequate stock).

** Important to note – pharmacies are only required to carry stock for 2 prescriptions of suspension form of Tamiflu. If more than 2 are needed, it may be beneficial to use more than one pharmacy.

5. **Additional actions:**

Give the home the flu leaflet for any staff who are concerned they may also need antivirals - they need to see their own GP.
Request the home to keep you updated. Ongoing risk assessment for measures and whether it is an outbreak or an individual case.
Ensure appropriate communication is ongoing and that all steps are being followed as a priority.
Request confirmation from the home staff once all residents have antiviral medications in place at the home and are either due to commence, or have already commenced.
Inform the home staff that they must inform our team if there are any discrepancies or concerns immediately.

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Report to HEALTH AND WELLBEING BOARD

Better Care Fund 2025-26 End of Year Report and Planning template for 2026-27

Portfolio Holder:
TBC

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

Report Author: Alison Berens, Head of Quality and Care Provisioning

Contact: 1792 / alison.berens@oldham.gov.uk

Date: 10th September 2026

Purpose of the Report

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

- 2025-26 End of Year Report
- 2026-27 Planning template

The Board should note, that in order to meet the deadlines set for the above by the national team, the templates have been submitted, delegation of this was previously provided for the End of Year Report in the 3rd April 2025 and covered the 2025-26 financial year. Deadlines for the Planning Template and the date of the local elections required the submission of planning documents to take place without full sign off via a Health and Wellbeing Board, not doing so would have risked incoming grant funding which has a significant impact for Health and Social care activity across the Oldham system. We now request retrospective approval.

It also seeks the Board's approval to continue to delegate the decision to submit quarterly reports during 2026-27 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 End of Year Report
   b) Provide retrospective approval for their submission to the Regional Better Care Fund panel

2. a) Note the content of the 2026-27 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 (BCF) is a national programme that brings together NHS and local authority funding to support joined-up health, care and housing services. It has been in place since 2015 though it has evolved throughout this time. Its purpose is to help councils, Integrated Care Boards (ICBs) and wider partners work together to improve outcomes for residents, particularly older people and those with complex health and care needs. By pooling budgets and agreeing shared plans, the BCF supports services that help people stay healthy, independent and living in their own homes for longer, reduces avoidable hospital admissions, enables timely discharge from hospital, and promotes more preventative, community-based care. Local BCF plans are agreed through Health and Wellbeing Boards and are a key mechanism for integrating health and social care at place level.

1.2 For 2026/27, the Better Care Fund framework sets out the following **national conditions**, which local authorities and Integrated Care Boards (ICBs) must meet when planning and deploying BCF funding:

- **Joint planning and agreement of BCF plans**
  BCF plans must be developed collaboratively between the local authority and ICB and approved through the Health and Wellbeing Board (HWB), demonstrating a shared approach to integrated health and care services.

- **Protecting and increasing investment in adult social care**
  The NHS minimum contribution to the BCF includes a mandated uplift, with funding continuing to support adult social care services and the integration agenda.

- **Supporting neighbourhood health and integrated care**
  Local areas must align BCF plans with the development of neighbourhood health services and integrated models of care, particularly for people with complex health and social care needs.

- **Delivering improved outcomes against national priorities**
  Local plans are expected to contribute to agreed goals around:
  - Reducing avoidable non-elective hospital admissions for people aged 65 and over.
  - Reducing delayed discharges from hospital.
  - Improving reablement outcomes.
  - Reducing demand for long-term residential and nursing home care through preventative and community-based support.

1.3 The national conditions require councils and NHS partners to pool funding, jointly plan services, invest in adult social care, and demonstrate how BCF-funded services will keep people independent, reduce pressure on hospitals, and improve the integration of health and social care in local communities.

1.3 The current BCF plan is only for one financial year for the period 2026-27, with the delivery of the BCF supporting the following priorities:

- **Supporting people to live independently at home for longer**, particularly older people and those with complex needs, through preventative and community-based services.

- **Reducing avoidable hospital admissions**, especially non-elective admissions for people aged 65 and over, by providing the right support in community settings.

- **Improving hospital discharge and reducing delays**, ensuring people can leave hospital as soon as they are clinically ready and receive appropriate support at home or in the community.

- **Strengthening reablement and rehabilitation services**, helping people regain independence following illness, injury or a hospital stay.

- **Reducing reliance on long-term residential and nursing care** through earlier intervention, prevention and effective community support.

- **Developing neighbourhood health services**, aligning local health and care provision around integrated, multidisciplinary teams that work closely with communities and voluntary sector partners.

- **Increasing investment in adult social care** while continuing to improve integration between NHS and local authority services.

Better Care Fund End of Year Report 2025-26

1.4 Throughout 2025-26, 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 to date.

1.5 At the end of the year (including Quarter 4 data) a full End of Year report is required. The deadline for submission of this report was the 5th June, as the documents were not available prior to the local elections on 7th May 2026, and there has not been a Health and Wellbeing Board since this time, this was submitted by the national deadline and now requires retrospective sign off from the Board. The document is attached at Appendix 1.

Better Care Fund Plan 2026-27 Planning template

1.6 The details of the operation of the BCF are set out in: Better Care Fund framework 2026 to 2027 - GOV.UK This document was used to prepare compliant Numerical and Narrative Plans for submission by the deadline date of the 19th May 2026. Due to when guidance was issued and the need to work through the documents with colleagues in the locality and at a Greater Manchester level, it was not possible to agree this prior to the local election on the 7th May, following which point there was not a Chair of the Health and Wellbeing Board in place to sign the report off in the absence of a Health and Wellbeing meeting, hence the requirement for retrospective approval. The planning document are attached as Appendices 2 and 3

2. Current Position

2.1 The total value of the BCF in Oldham for 2026-27 period is £51,919,685. This is broken down as follows:

	Income
DFG	£3,012,015
NHS Minimum Contribution	£27,008,093
Local Authority Better Care Grant	£13,801,769
Additional NHS Contribution	£8,097,808
Total	**£51,919,685**

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: implementing the objectives of the BCF
HWBs, through their joint plans, should deliver health and social care services that support improved outcomes against the fund's 2 principal policy objectives:

- to support the shift from sickness to prevention
- to support people living independently and the shift from hospital to home

National Condition 3: complying with grant conditions and BCF funding conditions - including maintaining the NHS minimum contribution to adult social care
The NHS minimum contribution to adult social care must be met and maintained by the ICB and will be required to increase by at least 3.9% in each HWB area.

Local authorities must comply with the grant conditions of the Local Authority Better Care Grant and of the Disabled Facilities Grant.

BCF plans will also be subject to a minimum expectation of spending on adult social care, which will be published alongside the BCF planning requirements. HWBs should review spending on social care, funded by the NHS minimum contribution to the BCF, to ensure the minimum expectations are met, in line with the national conditions.

National Condition 4: complying with oversight and support processes
Local areas and HWBs are required to engage with BCF oversight and support processes, which include:

- a regionally led oversight process
- enhanced oversight where there are performance concerns

Further detail regarding the BCF oversight and support processes are set out in the BCF planning requirements.

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 has been prioritised for Oldham to focus on residents to support the following initiatives and services:

Examples of Services funded	**Outcomes for people**	**Outcomes for the Oldham system**
Residential enablement at Butler Green and Medlock Court	• Supported to relearn or build daily living skills • Allows people to return home and live independently	• Reduces long-term care needs • Smooths the transition home from hospital (it can also be used to step up from the hospital to prevent further deterioration).
Falls prevention services	• Improved strength, mobility and stability • Less injuries • Increased confidence to cope safely at home	• Reducing the number of falls which in turn reduces the number of hospital admissions.
Dementia support services	• Improved quality of life and wellbeing for the person and their family,	• Reduced unplanned hospital admissions.
Community Occupational Therapy	• Increased independence and quality of life	• Prevention of crisis and delaying / preventing care home admissions • Avoiding hospital discharge delays
Community equipment and wheelchair services	• Providing people with the right equipment at the right time to maintain independence	• Avoids unnecessary hospital admissions • Facilitates timely hospital discharge • Reduces strain on informal or professional care givers
Disabled Facilities Grant services (including both minor	• Increased independence • Improved safety and accessibility	• Prevention of crisis by delaying or preventing the need for major structural home

Examples of Services funded	Outcomes for people	Outcomes for the Oldham system
and major home adaptations)	• Enhanced wellbeing by allowing people to stay in their own familiar local community	alterations, emergency hospital admissions or moving into a care setting
Alcohol liaison	• Improved physical and mental wellbeing	• Reduce emergency hospital admissions
Carers' support	• Improved physical and mental wellbeing, • Financial resilience	• Prevention of crisis caused by carer breakdown, in turn reducing emergency hospital admissions or long term care home admissions
Range of hospital discharge services	• People are supported home as quickly as possible • People feel confident and supported	• Improved hospital flow, freeing up hospital beds • Reduced hospital readmissions
Adult Referral Contact Centre	• Supported to maintain independence for as long as possible	• People are not pulled into long-term care before they need to be • Reduced care home admissions

2.6 For 2026-27 there has been a change to the reporting requirements, with no template in place for Quarterly reporting, the national team have confirmed there will be a template for Year End Reporting only.

2.7 Monitoring quarterly will be via the Regional BCF Team. For the North-West they have indicated that this will focus on providing information in the format which localities already report, so long as this provides sufficient information, with the focus on spend information in quarterly reporting and escalating any risks. Meetings are due to take place with the Regional team but have been delayed by summer leave. Dates have now been issued for reporting (to note there does not appear to be a requirement for a formal submission for Quater 1, this is consistent with previous years:

Quarter 2 – Submission deadline 30th October 2026
Quarter 3 – Submission deadline 29th January 2027
Quarter 4 – Submission deadline 30th April 2027

HWB will be updated as this progresses and provided with any reports submitted.

2.8 A BCF Collaborative Assurance and Development Group, attended by officers from the local authority and ICB Locality Teams (who have contract management

responsibility for services commissioned under BCF) meets regularly to review performance and spend information and will provide quarterly highlight and exception reporting into the Health and Wellbeing Board. It is anticipated that this will provide sufficient information for the Regional BCF Team's requirements and we will ensure that this is reported to HWB.

2.9 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 Areas for the Health and Wellbeing Board to Discuss

3.1 a) Note the content of the Year End Report
b) Provide retrospective approval for their submission to the Regional Better Care Fund panel

3.2 a) Note the content of the 2025-26 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 (including the year-end report) 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 2025-26 End of Year Submission
b) the Better Care Fund Planning Template 2026-27
c) approve to delegate the decision to submit quarterly reporting templates (including the year end report) to the Place-Based Lead and Oldham Council's Chief Executive in consultation with the Director of Adult Social Services (DASS).

5. Appendices

1. End of Year Report 2025-26

Oldham HWB BCF 2025-26 EOY Reportir

2. Numerical Plan 2026-27

Oldham BCF 2026-27 Numerical Template -

3. Narrative Plan 2026-27

Oldham HWB BCF 2026-27 Narrative Ret

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Report to HEALTH AND WELLBEING BOARD

Healthier Oldham Plan: Oldham Neighbourhood Plan

Portfolio Holders:
N/A

Officer Contact: Mike Barker, Deputy Chief Executive & Place Partnership Director

Report Author: Moneeza Iqbal, Director of Integration, Oldham Locality

Ext. moneeza.iqbal1@nhs.net

Date: 10th September 2026

Purpose of Report

This report seeks approval of the Oldham Neighbourhood Health Plan. The Plan sets out a five-year vision and delivery framework for neighbourhood health in Oldham, bringing together partners across health, social care, local government and the voluntary, community, faith and social enterprise (VCFSE) sector to improve outcomes, reduce inequalities and provide more integrated support closer to home.

Decision Required

The Health and Wellbeing Board is asked to:

1. Approve the Oldham Neighbourhood Health Plan as Oldham's strategic framework for neighbourhood health between 2026 and 2031.
2. Endorse the vision, priorities and outcomes set out within the plan.
3. Support partners to align existing transformation programmes and investment decisions with the delivery of the plan.

4. Receive annual progress reports on delivery, outcomes, risks and dependencies through established governance arrangements.

Approval of the Plan will provide formal place-based endorsement of Oldham's approach to neighbourhood health and enable the Plan to be recognised as Oldham's agreed response to Greater Manchester and national neighbourhood health requirements.

Executive Summary

The Oldham Neighbourhood Health Plan sets out how partners will work together over the next five years to improve health outcomes, reduce inequalities and support residents to live healthier and more independent lives.

Neighbourhood Health is not a separate programme. It is a key component of Oldham's wider approach to public service reform and Live Well, bringing together health services, social care, housing, employment support, family services, community organisations and local assets around the needs of residents and neighbourhoods. The Plan therefore represents a collective commitment by partners to shift from organisationally-led services towards a more integrated, preventative and community-centred model of support

Neighbourhood health provides an opportunity to organise services around local populations and communities, ensuring support is more coordinated, proactive and focused on prevention. The Plan establishes a phased implementation programme centred on population health management, integrated neighbourhood teams, Live Well neighbourhoods and stronger community partnerships.

The Plan recognises that successful delivery will depend on continued partnership commitment, effective governance arrangements, workforce capacity and the development of place-based investment approaches that support prevention and neighbourhood delivery.

Background: What is Neighbourhood Health?

Neighbourhood health focuses on organising care, support and wider public services around the needs of local communities, typically serving populations of between 30,000 and 50,000 residents. It brings together primary care, community services, mental health services, social care, housing providers, community organisations and local assets to provide more joined-up and person-centred support.

The benefits of a neighbourhood health approach include:

- Care delivered closer to home.
- Better coordinated support across organisations.
- Earlier intervention and prevention.
- Improved physical and mental health outcomes.
- Greater independence for residents.
- Reduced health inequalities.
- More sustainable use of public sector resources.

Neighbourhood health is central to national health and care policy and forms a key component of the NHS 10-Year Health Plan. In October 2025, Integrated Care Boards were asked to commence development of neighbourhood health plans for agreement through local Health and Wellbeing Boards. Greater Manchester has committed to developing plans for each locality by Autumn 2026.

Why Oldham Needs a Neighbourhood Health Approach

Oldham faces significant challenges relating to health outcomes, inequalities and increasing demand on public services.

Life expectancy remains below national averages, inequalities persist between communities, and many residents experience the combined impact of poor health, deprivation, social isolation, housing challenges and economic disadvantage. At the same time, demand for urgent care, hospital services, primary care, mental health support and social care continues to increase.

Traditional service models, often organised around individual organisations rather than residents and communities, are increasingly unable to meet the complexity of need experienced by many people.

A neighbourhood health approach provides an opportunity to move from reactive services towards prevention, early intervention and coordinated support. By bringing together public services, communities and local assets around neighbourhood populations, partners can improve outcomes, reduce duplication and ensure resources are used more effectively.

This approach aligns strongly with Oldham's ambitions for Live Well neighbourhoods and wider public service reform, supporting a shift towards community-led solutions and person-centred support.

The Oldham Neighbourhood Health Plan

The Oldham Neighbourhood Health Plan addresses national requirements whilst setting out a locally tailored vision for a healthier Oldham. The Plan establishes a long-term operating model based on three interconnected foundations:

- Population Health Management.
- Integrated Neighbourhood Teams.
- Live Well neighbourhoods.

The Plan sets out:

- The drivers of demand within Oldham and the case for change.
- A future operating model for neighbourhood health.

- Development of Integrated Neighbourhood Teams.
- Neighbourhood health enablers, including urgent neighbourhood services.
- Innovation and transformation programmes supporting neighbourhood working.
- The development of Neighbourhood Health Centres.
- Delivery milestones through to 2031.

The Plan complements and supports delivery of:

- The Oldham Plan.
- The Oldham Live Well Strategic Plan.
- Families First Partnership Programme.
- Best Start in Life.
- Other key place-based transformation priorities.

Partners already making significant contributions include:

- Primary Care Networks leading population health management approaches.
- Pennine Care NHS Foundation Trust and community partners delivering neighbourhood mental health services.
- TOG Mind and wider VCFSE partners supporting wellbeing and prevention.
- Northern Care Alliance, Adult Social Care and Miocare leading transformation of intermediate care and Home First services.
- Oldham Athletic, Sportstown and wider partners supporting the development of Neighbourhood Health Centres.

Residents, Communities and Live Well

A core principle of the Plan is that neighbourhood health should be designed with residents and communities rather than for them.

For residents, neighbourhood health should result in:

- Easier access to support closer to home.
- Better joined-up services and reduced duplication.
- Earlier help before needs escalate.
- Greater focus on prevention and wellbeing.
- Increased opportunities to influence local priorities and services.

The Plan will build upon the strengths of Oldham's communities, community assets and Live Well neighbourhoods. The voluntary, community, faith and social enterprise sector will play a key role in delivering prevention, social connection, wellbeing support and community development.

Community insight, lived experience and co-production will inform the ongoing development of neighbourhood services, integrated teams and local models of care throughout implementation.

Outcomes and Measures

The Plan sets out three long-term population outcomes:

1. Increase life expectancy for men from 76.6 years to 79.1 years.
2. Increase life expectancy for women from 80.5 years to 83.1 years.
3. Reduce the gap in outcomes between Oldham's most and least affluent communities by 50%.
4. Increase the proportion of five-year-olds achieving a Good Level of Development from 63.6% to 75%.

These outcomes represent long-term ambitions that will be influenced by a broad range of health, social and economic factors.

Progress will therefore be monitored through interim indicators and proxy measures which will be reported annually. These will include measures relating to:

- Prevention and early intervention.
- Access to primary and community care.
- Integrated Neighbourhood Team coverage.
- Resident experience.
- Hospital utilisation.
- Independence and supported living.
- Community wellbeing and participation.
- Reduction in health inequalities.

Delivery Timeline

The Plan will be implemented through a phased approach:

Year 1: Build on Our Foundations (2026/27)

- Evaluate existing population health management approaches.
- Identify sustainable pathways and neighbourhood models.
- Strengthen partnership arrangements.

Year 2: Early Implementation (2027/28)

- Establish integrated neighbourhood teams in priority areas.
- Deliver neighbourhood-based elective pathways.
- Expand prevention and community-based support.

Year 3: Integration and Scale (2028/29)

- Secure investment to scale successful models.

- Expand neighbourhood delivery.
- Implement home-based intermediate care approaches.

Year 4: Optimisation (2029/30)

- Integrated neighbourhood teams operating across all neighbourhoods.
- Broaden support to additional population groups.

Year 5: Maturity and Sustainability (2030/31)

- Full neighbourhood health model established.
- Sustainable funding and delivery arrangements embedded.
- Key neighbourhood enablers operating across the system.

Governance, Risks and Dependencies

Delivery of the Neighbourhood Health Plan will be overseen through established place-based governance arrangements.

The Health and Wellbeing Board will provide strategic oversight through annual review of progress, outcomes, risks and dependencies.

Operational delivery will be led through the Oldham Place Partnership and associated programme structures, supported by partner organisations across health, social care, local government and the VCFSE sector.

Key risks and dependencies include:

- Availability of sustainable investment to support neighbourhood delivery.
- Continued commitment and alignment from partner organisations.
- Workforce capacity across health, care and community services.
- Ability to evidence impact and demonstrate measurable outcomes.
- National policy, funding and system changes that may affect implementation.

These risks will be monitored through programme governance arrangements and escalated where required.

Financial and Resource Considerations

The delivery of neighbourhood health will require continued alignment of resources across partner organisations and a sustained focus on prevention and early intervention.

Partners recognise the importance of developing place-based investment approaches that support the shift of resources towards neighbourhood delivery and preventative services.

The Board is not being asked to approve a Place Fund through this report. However, members are asked to note that development of place-based investment mechanisms remains an important dependency for successful implementation of the Plan. Any future proposals relating to funding arrangements or place-based investment models will be considered through appropriate governance processes.

Recommendation

The Health and Wellbeing Board is recommended to:

1. Approve the Oldham Neighbourhood Health Plan as Oldham's strategic framework for neighbourhood health from 2026 to 2031.
2. Endorse the vision, priorities, outcomes and delivery approach contained within the Plan.
3. Support partners to align transformation priorities and investment decisions with delivery of the Plan.
4. Receive annual reports on progress, outcomes, risks and dependencies through established governance arrangements.

Approval of the Plan will provide formal place-based endorsement of Oldham's approach to neighbourhood health, support compliance with Greater Manchester and national expectations, and establish the framework for partnership delivery over the next five years.

Healthier Oldham Plan

Oldham Neighbourhood Plan 2026 to 2031

Leaders of our key organisations are signed up to this neighbourhood plan

Shelley Kipling
Chief Executive, Place Lead

Mike Barker
Director of Health & Care Integration (Oldham) NHS GM ICP / Deputy Chief Executive, Oldham Council

Laura Windsor-Welsh
Oldham Director, Action Together

Adrian McCourt
Managing Director (Interim)

Jenny Higson

Anthony Hassall
Chief Executive

XXXXXXX

Dr Brian Lewis
PCN Director (Central)

Dr Salim Mohammed
PCN (North)

XXXX
ONe Care

Dr Bal Duper
PCN Director (East)

Dr Simon Walton
PCN Director (South)

Dr Bilal Butt
PCN Director (Milltown Alliance /West PCN)

Adele Doherty
Dr Kershaw's

Julie Daniels
Director of Children's Social Care

Rebecca Fletcher
Director of Public Health

Jayne Ratcliffe
Director of Adult Social Care

Xxx
xxxx

Mark Gifford MBE
Chief Executive, First Choice Homes

Our Neighbourhood Plan

The content of our neighbourhood plan draws on the innovative work which has already begun in Oldham and our track record of delivery e.g. Population Health Management, our existing Neighbourhood Health Centres. Below is a summary of the high level content and themes it will encompass.

1. Introduction and vision

Describing our vision and ambitions for Oldham, the partners in Oldham delivering this plan

2. Drivers of demand

Describing the current population health outcomes and drivers of health and care demand in Oldham;

- **Oldham population and life expectancy by ward**
- **Our neighbourhood health needs**
- **Financial and activity picture**
- **Our operating model**
- **Our interventions**

3. Neighbourhood Health: Our approach

Describing the three key pillars of our neighbourhood approach;

- **Population Health Management**
- **Integrated Neighbourhood Teams**
- **Live Well in Oldham**

4. Support to Neighbourhoods

Describing the broader enablers which wrap around PHM and INTs to deliver effective neighbourhood health;

- **Transforming Primary Care**
- **Urgent Neighbourhood Services**
- **Intermediate Care & Home First**
- **Standardised Community Services**
- **Neighbourhood elective pathways**
- **Neighbourhood cancer prevention and reduction**

5. Neighbourhood Health: Enablers

Describing the key infrastructure, support and culture we are developing upon which neighbourhood health teams can be built;

- **Neighbourhood Health Centres**
- **Workforce and culture**
- **Estates**
- **Digital**
- **Information sharing**

6. Governance and next steps

Describing our system governance and arrangements which will enable our neighbourhood plan

Forward

This strategic plan represents our translation of the national strategic frameworks into the context of the health and care system in the borough of Oldham. As we plan the move away from our primary focus from 'delivering healthcare' and towards a system that understands citizens and patients as partners in the 'co-production of health', there are some core concepts that have guided our thinking.

The first and most important of these is that we must change the nature of the relationship between the NHS and the population that it serves. This plan describes how we intend to begin this process in three ways. First, by initiating a new, systematic and wide-ranging stakeholder engagement programme Second, by instituting a new annual strategic cycle that links the 'conversation' with our population with the 'contracting authority' that can enact the key requirements as they emerge. Third, by designing and consulting on a *personalised public health outreach function.* By proceeding in this way, we are seeking to simultaneously develop and empower the voices of patients, families and communities in a way that has the potential to transform the care system.

The second is that we must change the relationship between strategic management and care professionals. There are international examples of systems that have moved on from seeing professional leadership as an important *component* of the management system and instead have developed organisational models that place clinical and care professional leaders in direct positions of authority and strategic control.

This plan outlines how we are pursuing this idea in Oldham both by working closely with primary care leaders to develop the capability and governance arrangements for properly empowered placed based partnership and through our stated strategic goal of pursuing the concept of a new Integrated Healthcare Organisation

The third important insight is that the transformation of services must be supported by a transformation in the commissioning function itself. To deliver our new vision, commissioning must incorporate processes to translate stakeholder conversations into contracting requirements and understand that individual preferences need to be given a new importance alongside the traditional notion of need. It also needs to be led by a new, general practice-based partnership that harnesses the design insights of leading clinicians to the resource management and project planning of effective general management. It needs to look beyond traditional providers and develop new capabilities in the voluntary and independent sector. It must build new high frequency population health status and patient tracking information systems to consolidate the recent gains in access, introduce the new discipline of systematic management for quality and plan to deliver the new requirement to lift life expectancy. Finally, it needs to develop a new industry standard in areas such as social marketing and actuarial analysis to effectively manage individual and population risk.

Linking these three ideas together produces our mission of *professionally led, publicly accountable, individually responsive* health and care services.

Mike Barker, Deputy Place Lead & Deputy CEO Oldham Council

Our vision

The picture in Oldham is just as stark. Mortality is higher than average, and like elsewhere, the majority of deaths are driven by a small number of long-term conditions: cardiovascular disease, cancer and respiratory illness. But what stands out is the depth of need. People are living longer with poor health, often with multiple conditions, and mental health demand is both high and rising. This isn't just a case for incremental change. It points to a clear need to strengthen prevention and invest more decisively in mental health and early intervention.

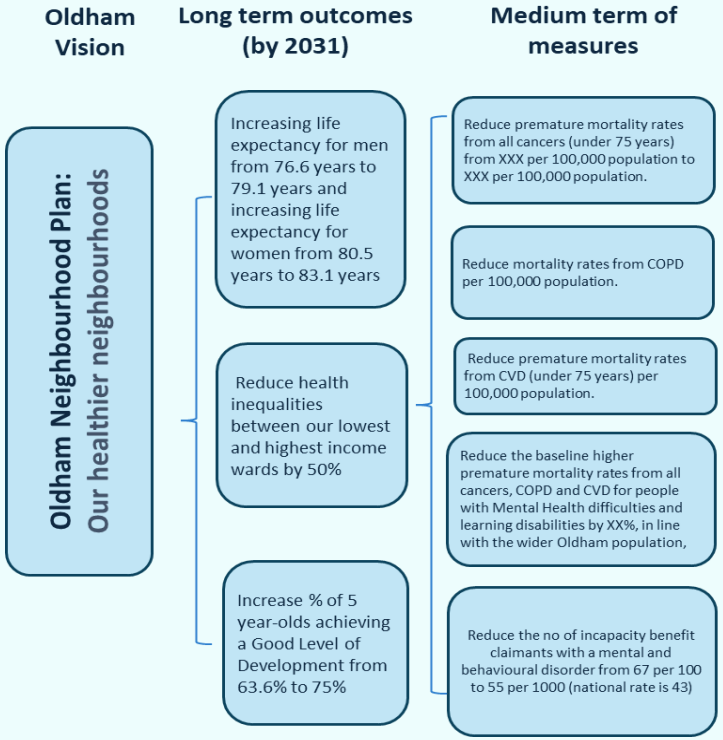
The logical argument of this strategic document is correspondingly simple, and lays out how we are going to respond to the health and well being challenges in the four areas of cardio-vascular disease (CVD), cancer, respiratory disease (with a focus on Chronic Obstructive Airways Disease) and mental health.

In practical terms, we are planning to ensure:

1. Better Care through more effective system management, the introduction of advanced quality monitoring and specific investments targeted at services in our key health need areas
2. Better Health through the development of a 'population health status monitor', based on the GP registered list. This will enable us to deliver thoroughly systematic health improvement programmes (our flagship being the CVD register programme). This will support the delivery of a highly targeted approach to social marketing of both self-care messages and invitations to participate in health and well-being services
3. Better Life through our programme to transform our mental health services and our partnerships with the local authority to enhance the quality of life of all citizens in Oldham

Whilst our ambitious plans will focus on preventing and reducing the devastating effects that cancers, cardiovascular disease, respiratory disease and poor mental health have on our community, we also intend to change our relationship with patients and our population through new channels of communication and the commissioning of far more personalised services.

To this end, by 2031 we aim to:



Our Plan

As we launch our Oldham Place Partnership , bringing together the organisations who support all age health, social care, housing, etc we set out our vision and plans for a whole-system approach to neighbourhood health and living well in Oldham.

Our plan is the culmination of the experience and learning from the individuals, communities and organisations who have come together in Oldham over recent years to improve the health outcomes and experience of Oldham residents. We find ourselves now at a critical moment where locally and nationally it is recognised that only through working at a neighbourhood level can we create true partnerships with residents which inform the delivery and design of services.

Much of what is described here in this plan is not new, however, a number of national and local drivers provide the right time to galvanise our collective ambitions. Our plan supports;

- NHSE's move to a neighbourhood health service
- Greater Manchester's Live Well ambition
- Oldham's wider place priorities

This plan has naturally emerged from the programmes of work commenced in Oldham which includes our Population Health Management programme led by our Primary Care Networks, our emergent Live Well programme, learning from the roll out of our Families First Partnerships and Mental Health Neighbourhood Teams (previously known as Living Well) .

No single organisation owns this plan – it is not an NHS plan, a council plan, or an organisational strategy. It outlines the combined ambitions of our partnership and the strengths each individual and organisation can bring when we would collectively towards a clear set of goals for our population.

To anchor our progress and ensure it continues, this plan describes our ambitions and visions but critically will be supported by a more detailed delivery plan and framework within an agreed partnership framework for Oldham.

Our Plan

Our PACE model provides the framework for our strategy.
For Oldham this means:

Personalised: We will establish a new relationship with our population where they are at the fulcrum for lifestyle healthcare choices and shaping health services for Oldham. For example, the GP practice-based register will be the core to ensuring individuals' well-being.

Advanced: We will ensure that our patients have access to the most effective leading-edge technologies. For example, we are planning a major investment in remote-monitoring technologies and the phased introduction of at least one world class option for our top 10 surgical procedures.

Care: will re-commission services to provide integrated health and social care and in so doing incentivise providers to respond with innovative models of provision

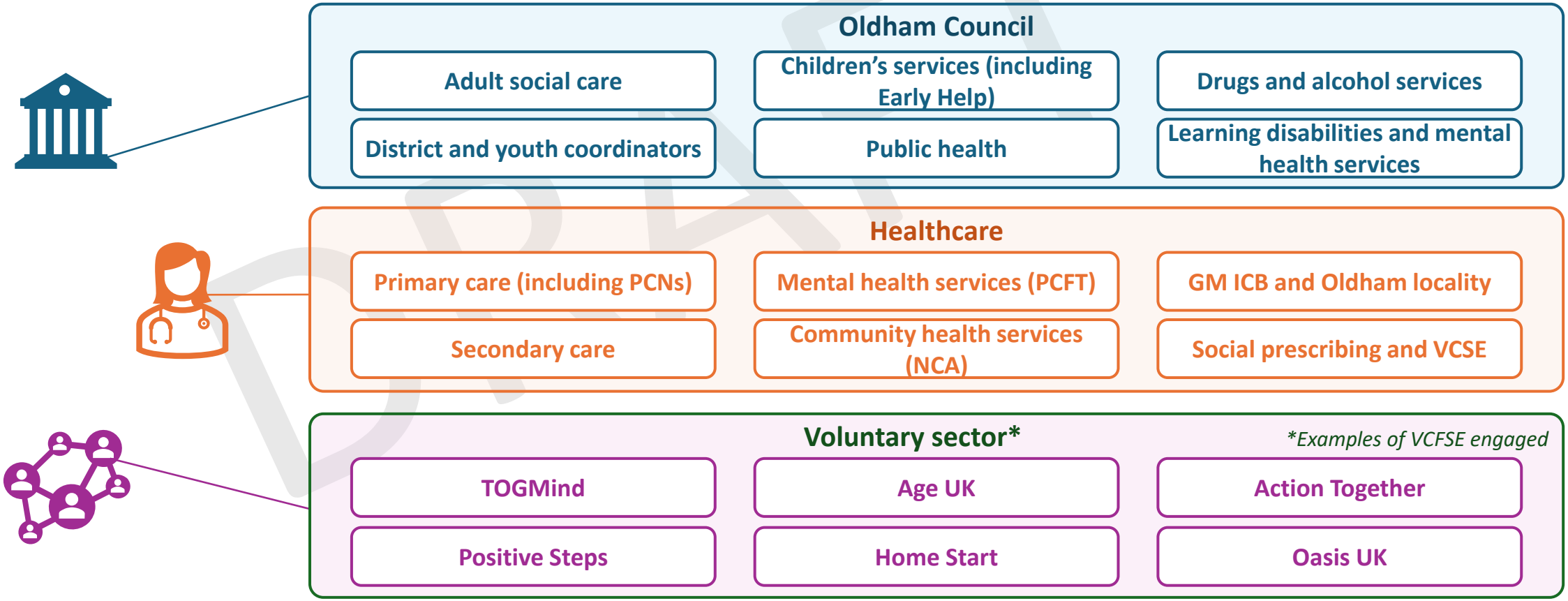
Environment: Oldham will not be bound by particular buildings in the future. Healthcare will be delivered in environments that are designed to fit with particular needs, expectations and lifestyle of patients and citizens.

In this context, we are planning to reconfigure the Better Care Fund to support the introduction of initiatives in each of our main health need areas. The implemented initiatives are expected to improve health and deliver savings. Any available investment must have been prioritised according to their anticipated impact and their value for money to deliver the outcomes outlined above.

We are also actively exploring the introduction of integrated services, and the next few months are critical for determining the extent to which this will play a part. If we retain our present structure, the impact of our programmes will be significantly beneficial for our population but will have a marginal impact on the overall pattern of investment. If we do fully move down the road of integration, we will retain a focus on our core strategies but will have a much greater impact on the profile of our contracts.

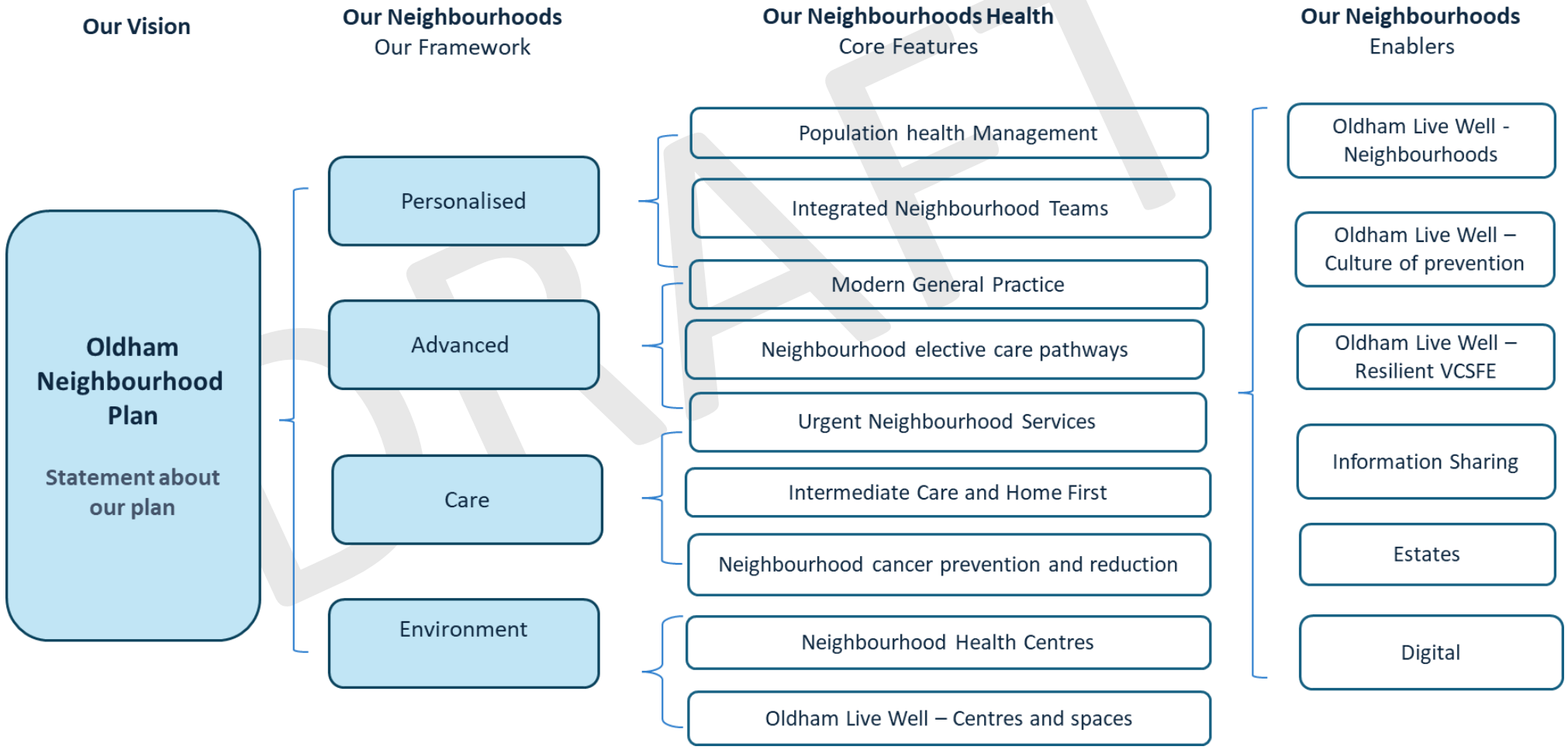
The collaborative supporting our plan

A range of providers across health, care, voluntary, community, faith and social enterprise sector, housing and other partners are already working together in Oldham to deliver integrated care. This collaborative effort is critical to the further expansion of neighbourhood health teams.



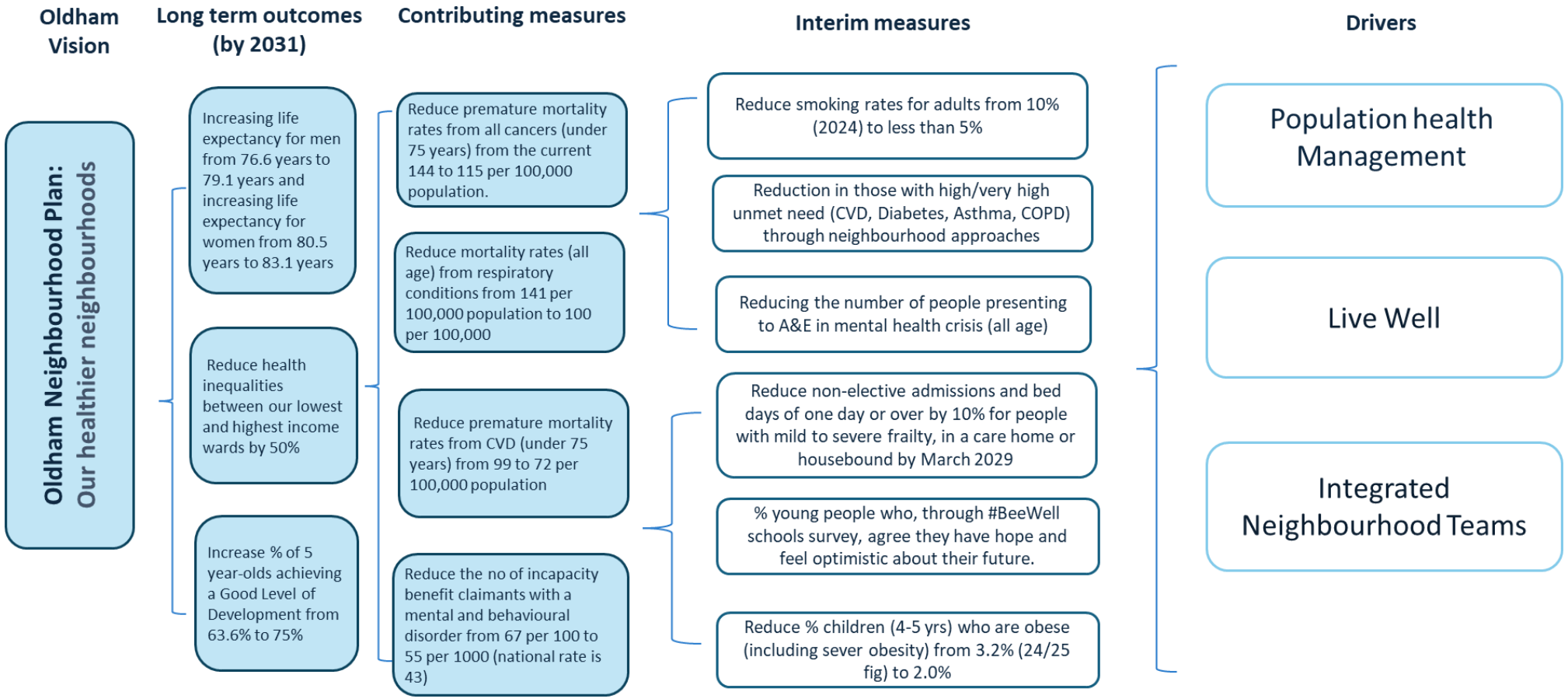
High level view of our plan

Our Neighbourhood Plan can be summarised through the key features of our framework, the core features of our neighbourhoods and the enablers which support this.



High level view of our plan - measurement

We have identified clear long-term outcomes for our population which this plan will deliver. To be able to monitor progress, medium term and interim measures have also been identified: these measures can be reported more frequently and drive long term outcomes



Policy context

Several national and local policies and drivers re-enforce the ways of working we have been developing in Oldham in recent years which prioritise strengthening communities and reducing health inequalities through a focus on neighbourhoods and multi-agency working.

The *10-year NHS Plan* outlined three key shifts required to modernise the NHS; hospital to community, analogue to digital, sickness to prevention, and the *NHS Neighbourhood Framework and National Neighbourhood Framework (2025)* set our clear expectations about creation of neighbourhood health approaches which our plan describes in detail.

Oldham is proudly part of the Greater Manchester city-region. The Greater Manchester Strategy 2025 to 2035 *'Together we are Greater Manchester'* sets out Live Well as a fundamental approach to reducing health inequalities and improving the everyday lives of residents which Oldham is at the forefront of delivering – detailed in our Oldham Live Well Strategic Case and referred to in this plan.

There is a lot of great work transforming residents' lives in Oldham. This plan describes health and care neighbourhood aspects of these priorities, whilst speaking to the relationship with other plans and priorities underway in the system.

Family Hubs have been created in Oldham transforming how families access support through providing universal (for everyone) one-stop shops, where you can access all the help and support you need to make sure your child is healthy, safe, and looked after (*Giving Every Child the Best Start in Life (2025)).*

Pride In Place Strategy is the government's plan to create safer, healthier neighbourhoods where communities can thrive, focussing on disadvantaged areas including parts of Oldham

Oldham's implementation of the *Families First Partnership Reform and Programme* launched 2025 is transforming the way families are supported through multi-agency working, improving child protection through family centred local approaches and introducing Family Help.

2. Drivers of demand

Describing the current population health outcomes and drivers of health and care demand in Oldham;

- Oldham population and life expectancy by ward
- Our neighbourhood health needs
- Financial and activity picture
- Our operating model
- Our interventions

About Oldham

In Oldham, we are united in our commitment to delivering public services where they are needed most. We welcome the ambition of the 10-Year Plan, which brings renewed energy and focus to our ongoing efforts to improve neighbourhood health.

Oldham has c243,000 residents, projected to increase by over 5% in the next 10 years. Whilst it has a young population profile with a high proportion of residents under 16, the number of people over 65 is set to grow by 30% by 2041, which will increase demand on the system. Furthermore, there is a much older population concentrated in the north district compared to the other geographies.

Population ethnic diversity also greatly differs by geography, with an ethnically diverse population in the central and west districts, but a predominantly white population in the north. Overlaid on this are clear differences in deprivation, particularly concentrated in central and then the west and south districts. Such high levels of deprivation and other wider determinants adversely impact Oldham residents' health outcomes and life expectancy, and lead to high health needs and later complex and/or acute demand.

The demographic differences and wider determinants of health, and variation in health behaviours, risk factors and prevalence across different geographies in Oldham, give rise to different patterns of health needs and health and care resource use across the neighbourhoods.

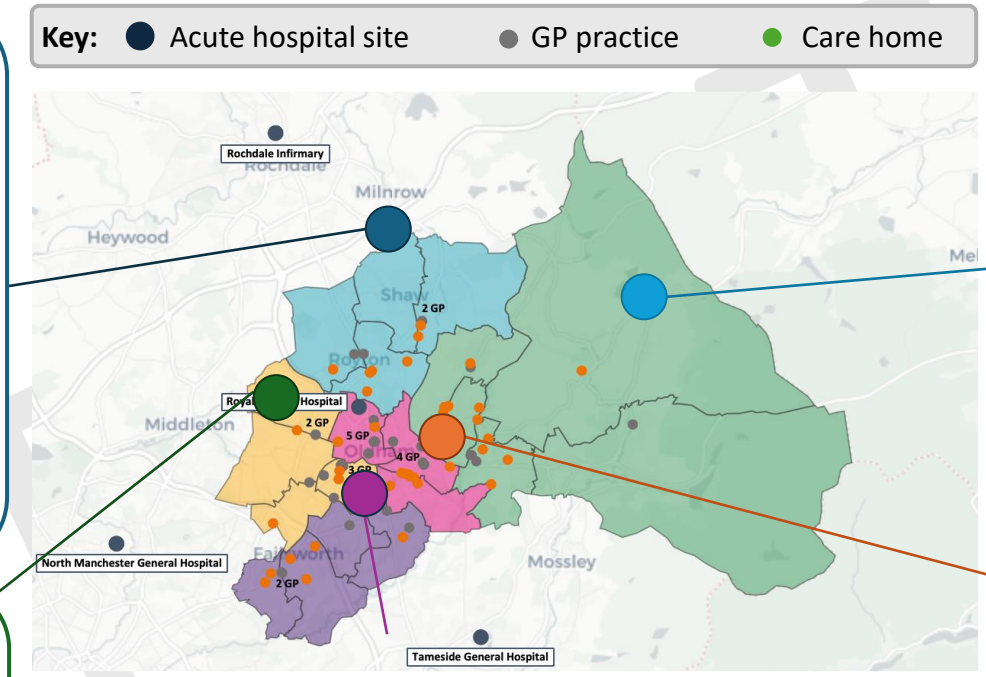
About Oldham – Our neighbourhood health needs

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

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

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**

Central District

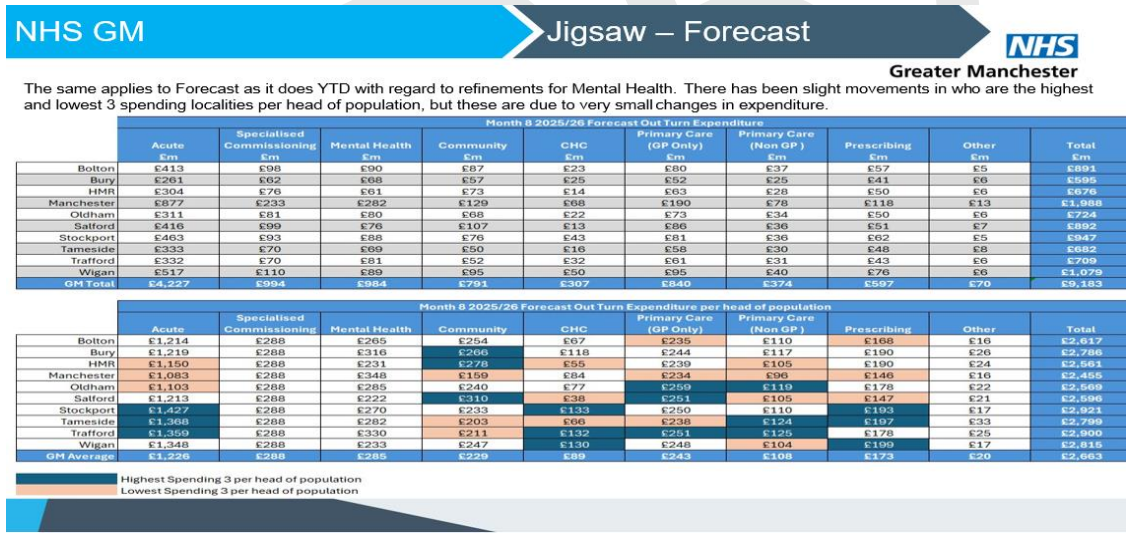
- **Youngest population** profile(30% <16, 9% >65) and **highest degree of ethnic diversity** with nearly 50% of the population Asian and largest proportion of Black/Black British/Caribbean or African residents
- Significantly the **most deprived District**
- Relatively **high levels of smoking and obesity**
- **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.**

About Oldham – health and care spend

Across health and care there is a total spend of c£832m for the population of Oldham. The way this spend is governed and organised is changing under NHS reforms, with a Place Fund the key mechanism for change in Oldham.

Our challenge is to get the best outcomes using this resource, deploying it in the most effective way to deliver our agreed outcomes. Fundamentally, the success of our neighbourhood plan relies on shifting resource from high-cost acute care to community-based setting and preventative activities.

GM ICB Jigsaw tool compares 10 localities spend per head of population



NHS GM | Jigsaw – Forecast

NHS Greater Manchester

The same applies to Forecast as it does YTD with regard to refinements for Mental Health. There has been slight movements in who are the highest and lowest 3 spending localities per head of population, but these are due to very small changes in expenditure.

Month 8 2025/26 Forecast Out Turn Expenditure

	Acute £m	Specialised Commissioning £m	Mental Health £m	Community £m	CHC £m	Primary Care (GP Only) £m	Primary Care (Non GP) £m	Prescribing £m	Other £m	Total £m
Bolton	£413	£98	£90	£87	£23	£80	£37	£57	£5	£891
Bury	£261	£62	£68	£57	£25	£52	£25	£41	£6	£595
HMR	£304	£76	£61	£73	£14	£63	£28	£50	£6	£676
Manchester	£877	£233	£282	£129	£68	£190	£78	£118	£13	£1,988
Oldham	£311	£81	£80	£68	£22	£73	£34	£50	£6	£724
Salford	£416	£99	£76	£107	£13	£86	£36	£51	£7	£892
Stockport	£463	£93	£88	£76	£43	£81	£36	£62	£5	£947
Tameside	£333	£70	£89	£50	£16	£58	£30	£48	£8	£682
Trafford	£332	£70	£81	£52	£32	£61	£31	£43	£6	£709
Wigan	£517	£110	£89	£95	£50	£95	£40	£76	£6	£1,079
GM Total	£4,227	£994	£984	£791	£307	£840	£374	£597	£70	£9,183

Month 8 2025/26 Forecast Out Turn Expenditure per head of population

	Acute	Specialised Commissioning	Mental Health	Community	CHC	Primary Care (GP Only)	Primary Care (Non GP)	Prescribing	Other	Total
Bolton	£1,214	£288	£265	£254	£67	£235	£110	£168	£16	£2,617
Bury	£1,219	£288	£316	£266	£118	£244	£117	£190	£26	£2,786
HMR	£1,150	£288	£231	£278	£55	£239	£105	£190	£24	£2,561
Manchester	£1,083	£288	£348	£159	£84	£234	£96	£146	£16	£2,455
Oldham	£1,103	£288	£285	£240	£77	£259	£110	£178	£22	£2,569
Salford	£1,213	£288	£222	£310	£38	£251	£105	£147	£21	£2,596
Stockport	£1,427	£288	£270	£233	£133	£250	£110	£193	£17	£2,921
Tameside	£1,368	£288	£282	£203	£66	£238	£124	£197	£33	£2,799
Trafford	£1,359	£288	£330	£211	£132	£251	£125	£178	£25	£2,900
Wigan	£1,348	£288	£233	£247	£130	£248	£104	£199	£17	£2,815
GM Average	£1,226	£288	£285	£229	£89	£243	£108	£173	£20	£2,663

Highest Spending 3 per head of population
Lowest Spending 3 per head of population

High level GM ICB and Oldham Council spend on health and social care for Oldham residents 25/26

Spend Type	Spend (m)
Acute & specialist NHS care	£311
Mental health	£80
Community health	£68
CHC	£22
Primary care	£101
Prescribing	£50
Public health	£20
Adult social care	£90
Children's social care	£90
Total	**£832**

Demand drivers based on finance, activity and system engagement

We undertook demand analysis, driver analysis, interviews and desktop research to identify three thematic areas which are driving health and care demand in Oldham, and which the interventions in our plan will address through our **operating model.**

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

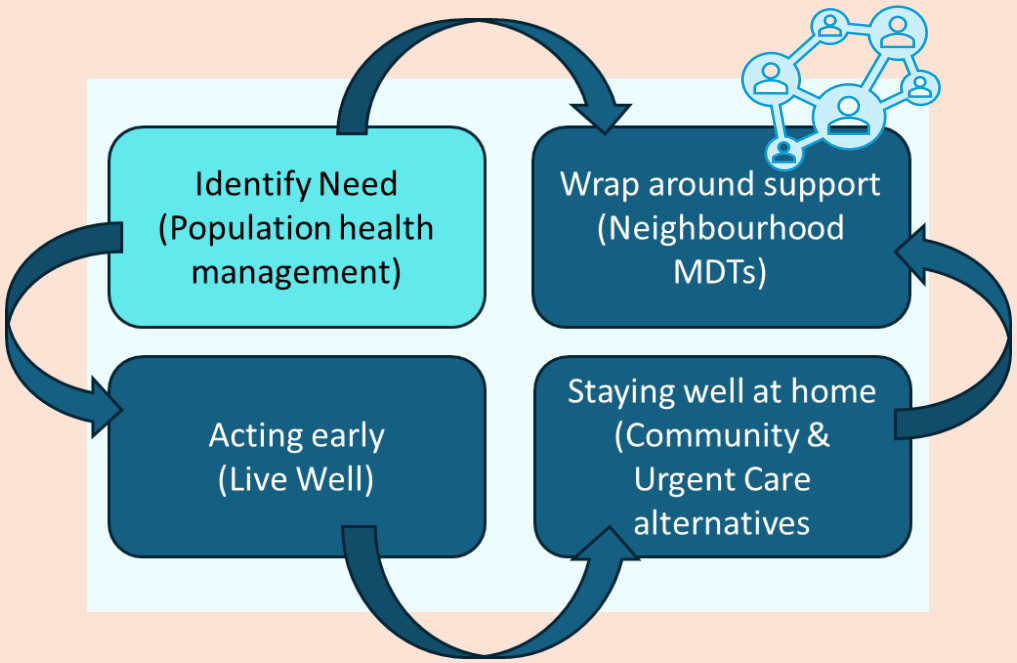
3. Lack of service integration, communication and signposting

- 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

Our operating model – responding to demand

Our operating model is simple but important, with **population health** at its core. By identifying and understanding need, we put in place interventions depending on the level of need, in line with our **prevention framework.**

Our health and care neighbourhood model is based on neighbourhood MDTs, alongside other neighbourhood health components (e.g. urgent neighbourhood services), providing wrap around support and support to stay well at home.



Our Oldham Prevention Framework is fundamental to this operating model by describing the type of response for the level of need at all levels.

Oldham Prevention Framework

Responding to demand drivers, themed interventions

As a result of our demand analysis, we have developed a plan which based upon key principles of PACE, but which addresses some key thematic areas as described;

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**

3. Neighbourhood Health: Our approach

Describing the three key pillars of our neighbourhood approach;

- **Population Health Management**
- **Integrated Neighbourhood teams**
- **Live Well in Oldham**

Neighbourhoods in Oldham

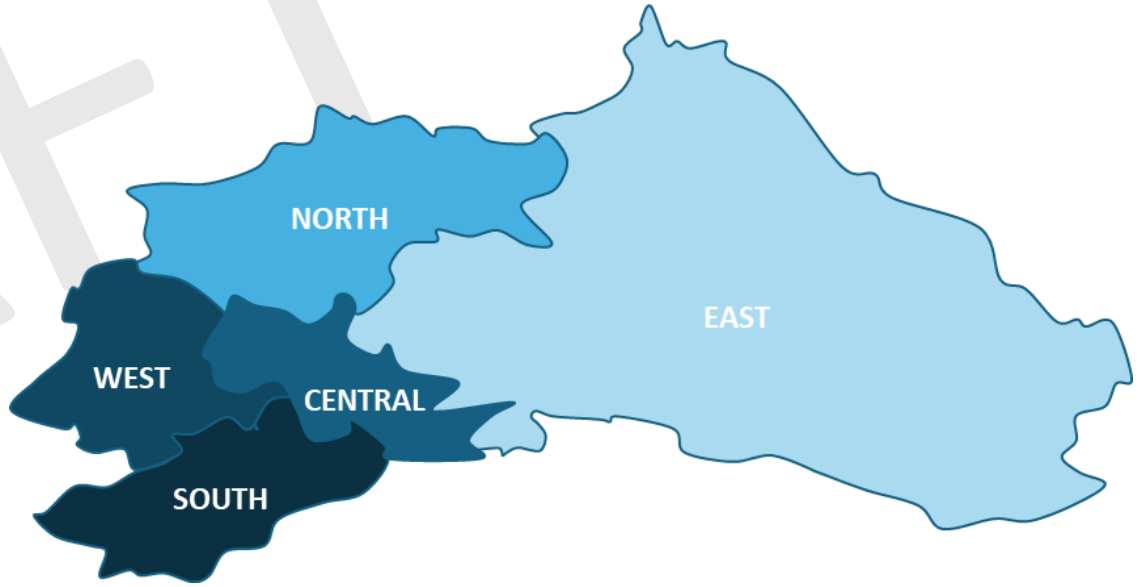
A number of policies describe the criticality of delivering public services on a neighbourhood footprint in order to bring them closer to residents, as well as the importance of strengthening neighbourhoods to reducing inequalities.

Oldham is unique in having achieved full geographical alignment across public services in 2020. This alignment was a bold and transformational step, taken to provide more responsive, joined-up services and to directly tackle entrenched inequalities. The realignment involved all major public services; including Social Care, Mental Health, Community and Primary Care, Policing, Housing and Homelessness Support, Environmental Health, Employment and Skills Services, the VCFSE sector, Community Safety, Substance Misuse, and Early Years services.

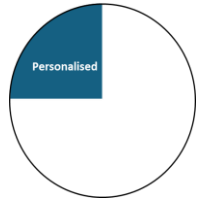
This system was designed around the existing Primary Care Networks (PCNs) wherever possible, resulting in the creation of five integrated neighbourhoods across Oldham. Now, five years on, these neighbourhoods and their associated services are well-established and form the foundation of our place-based approach to integrated care.

Oldham's neighbourhoods are split into five distinct neighbourhood or 'districts' which range in their geography and demographic and make up.

These neighbourhoods are aligned with our Primary Care Networks (PCNs) which will also be the footprint for our Neighbourhood Health delivery. These footprints fit within the 30 to 50k population recommended in national NHS guidance.



Anchoring our neighbourhoods around our PCNs, and consequently the GP practice-based register enables **personalised** care.



Neighbourhoods: Primary Care Networks (PCNs) and Population Health Management

Oldham has a well-established GP Board, which serves as the representative body for practices across the Oldham Locality through their membership in Primary Care Networks (PCNs). The GP Board holds a seat on the Partnership Committee, the Greater Manchester Integrated Care Board (GM ICB), and associated structures such as the GM GP Provider Board. Representation on these bodies is provided through nominated members, ensuring formal links to strategic planning and decision-making processes.

Each of the five PCNs, along with the GP Board itself, has established clinical, managerial, and administrative leadership structures.

Additionally, within each of the five Neighbourhoods, the Oldham **Population Health Management (PHM) Programme** has implemented a structured governance model known as the **'governance quad'.** This includes four key roles: a primary care clinical lead (typically a senior GP), a neighbourhood operational lead, a specialist care professional (such as a district nurse or occupational therapist in older adult models, or Early Help leads for children and young people), and a Council district coordinator.

The governance quad is responsible for oversight and decision-making related to PHM initiatives, including operational aspects such as caseload review and management. Quad meetings are also attended by other relevant professionals — such as secondary care consultants, care coordinators, assessors, and PCN Clinical Directors — particularly when their input is essential to the design or delivery of new care pathways.

Our population health management mode is based upon;

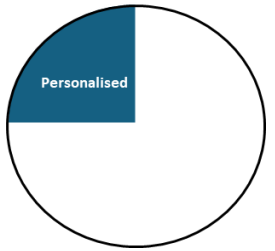
- Data-Driven Decision Making:
- Clinician-Led Design
- Strong Partnership with the VCFSE Sector
- Investment in Social Prescribing

PHM Governance quad

Neighbourhood Health in Oldham: Population health management

Consistently using quantitative and qualitative insights to identify cohorts (esp. those with complex needs), segment risk, and target intervention.

Where are we now?	• A data informed approach has been used to develop a population health management analysis and focus for each PCN • Target interventions developed for cohorts identified: over 65s with mild/moderate frailty, children at risk of developing low / mid-severity mental health conditions, children and their families in good health but at rising risk of developing poor health, 50-64s at risk of becoming frail through multi-morbidities • Population health management used by PCNs with multi-disciplinary teams formed for specific cohort, however dynamic use of PHM by broader system not established yet
What needs to happen next?	• Secure consistent and routine access to population health data to routinely monitor activity outcomes, with the support of GM ICB • Evaluate and build on PCN frailty models and children and young people approaches to devise consistent approach • Further development of approach alongside new Integrated Neighbourhood Teams (INTs) • Scale up approach to broaden population supported
What will be the impact	↑ Improved patient outcomes – manage existing conditions better, prevent / delay new conditions developing, keeping people healthier for longer ↑ Improved patient experience – personalised, holistic care plans ↓ Reduce unplanned demand –better co-ordination of services, reduced demand on acute services ↑ Strengthen integrated working – collaboration amongst staff across skillsets and organisations £ Value for money – reduce wider out-of-hospital and social care spend



Case study: North PCN Frailty pathway

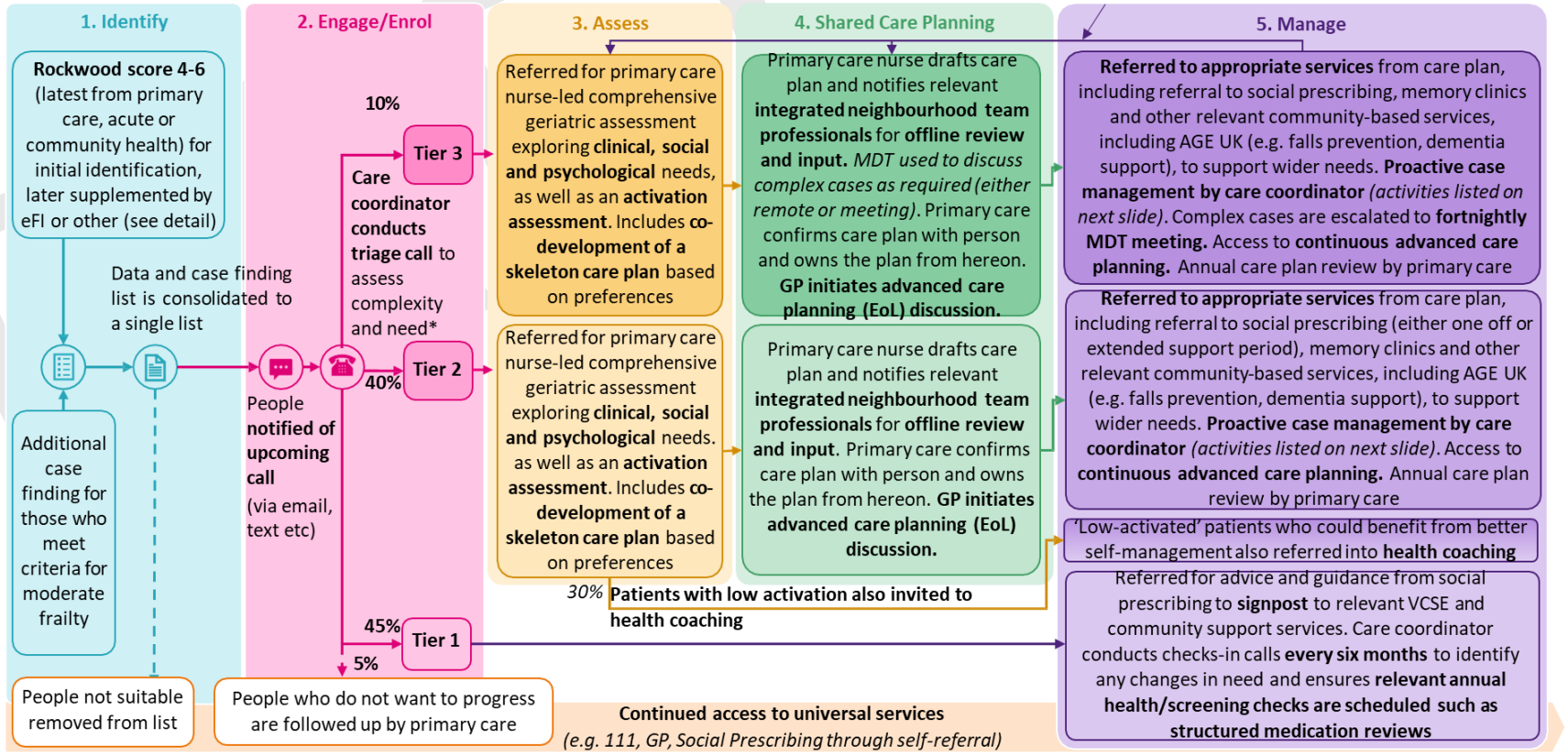
The PHM Frailty model was developed as a system-wide response to improve identification, coordination, and management of frailty.

At its core, the programme aims to:

- Standardise frailty identification and assessment
- Enable proactive, multidisciplinary care
- Improve communication and shared decision-making
- Reduce avoidable hospital utilisation
- Support patients to remain independent for longer
- On a system level, break down some organisational barriers, create better relationships as part of an integrated neighbourhood team.

The programme builds on existing Primary Care Network (PCN) structures, leveraging multidisciplinary teams (MDTs), shared care records, and enhanced roles.

North PCN Frailty Model – an example of the pathways developed for each Population Health approach



Case study: North PCN Frailty pathway

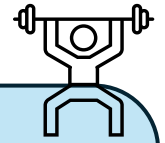
Supporting Social Connection and Independence Through Proactive Frailty Care

MR was identified for review through the proactive case-finding approach introduced at the beginning of 2026.

Rather than relying solely on a Rockwood Clinical Frailty Scale score, the service identified people with known **frailty risk factors** who may benefit from early intervention and preventative support.

During her assessment, MR explained that since retiring and giving up driving, she had become **increasingly isolated**. With no family available to provide support, she felt socially disconnected and identified **increasing social interaction as her main goal.** MR also reported experiencing pain in her hands and was advised to contact her GP for further assessment.

Following the assessment, MR was referred to Social Prescribing to help her access local community activities. The Social Prescribing team contacted her and provided information about opportunities available in her local area.
MR was also referred to the Strength & Stability programme. She has since started attending both the PCNs Strength & Stability classes and Chatty Café, both of which she reports enjoying immensely.



MR describes the Strength & Stability sessions as both enjoyable and empowering. She feels more confident, has learnt practical techniques that she believes she would not otherwise have known, and feels better equipped to maintain her independence.
She also highlights the social interaction the classes provide as one of the greatest benefits, saying it has been wonderful to meet new people and feel part of a community again.

By identifying MR early through recognised frailty risk factors and providing timely access to community-based support, the Proactive Frailty Service has helped reduce social isolation, improve confidence, increase community engagement and support her to remain independent.

This case demonstrates the value of proactive identification and early intervention in improving outcomes before a crisis occurs.

Case study:

OLDHAM SOUTH PCN FRAILTY PROGRAMME

Keeping people with mild-to-moderate frailty healthier, independent and at home for longer through proactive neighbourhood-based care.

FOCUS OF THE PCN

- Proactive identification and management of mild-to-moderate frailty in people aged 65+
- Support residents to remain independent, healthier and at home for longer
- Deliver holistic, person-centred care through population health management
- Reduce care fragmentation and improve coordination across neighbourhood services

HOW THE QUAD WORKED TOGETHER

Integrated neighbourhood working for our residents

INNOVATIONS & IMPROVEMENTS IDENTIFIED

Standardised frailty identification
Using risk stratification tools and Clinical Frailty Scores.

Multidisciplinary team (MDT) approach
Bringing together GPs, ACPs, care coordinators, pharmacists and community partners.

Holistic assessments & care planning
Addressing physical, cognitive, functional and social needs with personalised care plans.

Strength & Stability and prevention
Exercise classes, falls prevention, education and social prescribing to build resilience.

Stronger neighbourhood partnerships
Joint pathway design, shared ownership of care and regular communication across the Quad.

Improved coordination & information
Better information sharing and integrated care planning to reduce duplication and improve continuity.

BENEFITS TO RESIDENTS & PATIENTS

Remain independent longer
Support to live well at home and stay connected to their community.

Earlier intervention & prevention
Identifying needs and risks early to prevent crisis and reduce avoidable hospital admissions.

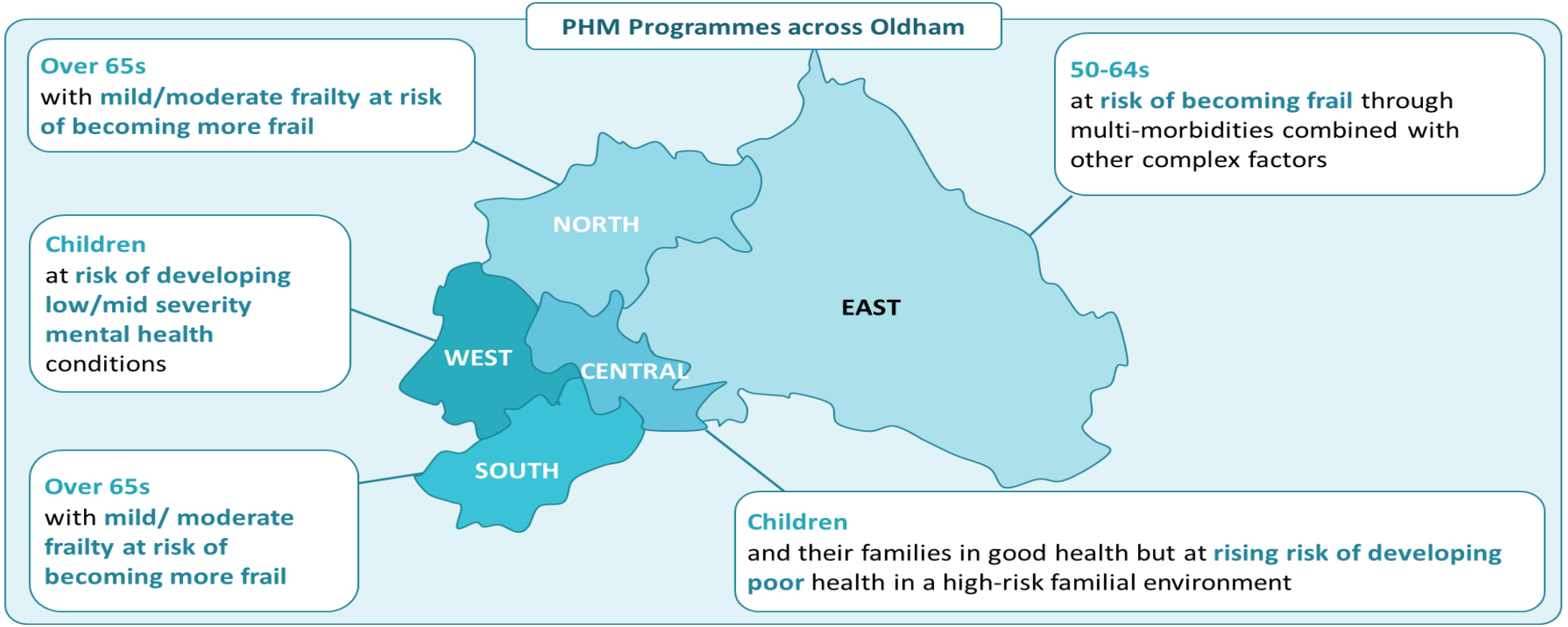
Better patient experience
Patients report feeling listened to, reassured, respected and supported.

More coordinated care
Joined-up services, less duplication and proactive management of complex needs.

> *"I feel listened to and more confident about managing my health. The support I get helps me stay independent."*
> – Resident feedback

Population Health Management in each PCN Neighbourhood

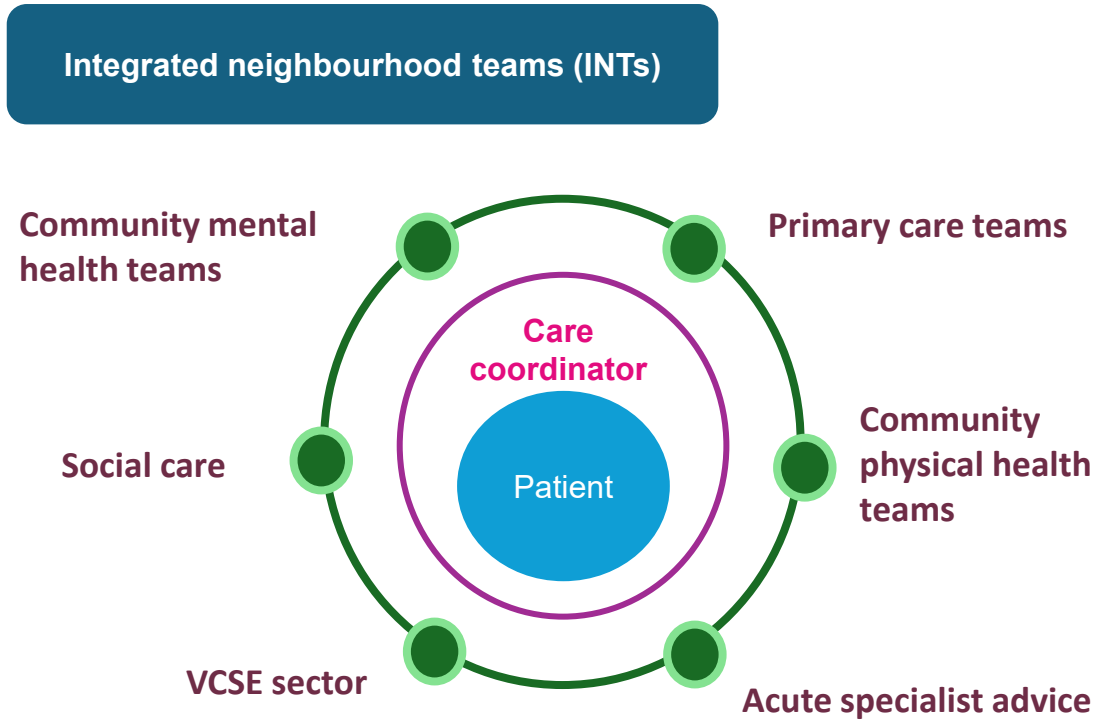
The diagram below describes the current focus of each PCN, based on our analysis of need, with interventions designed by the PCN quad



Neighbourhood Health in Oldham: Integrated Neighbourhoods Teams (INTs)

Integrated Neighbourhood Teams (INTs) or Neighbourhood Multi-disciplinary teams are fundamental to neighbourhood health, and to enacting our Population Health approach.

- Multiple sectors and care settings collaborating across a neighbourhood to provide a holistic, joined up approach that addresses all of a person's needs.
- Responsible for delivering the PHM pathway and creating shared ownership across sectors for proactively managing their population.
- The integrated neighbourhood team is empowered to make day-to-day decisions about the PHM pathway.



Neighbourhood Health in Oldham: Neighbourhood INTS

Integrated, primary-care-led MDTs with community, mental health, social care, VCFSE, and appropriate specialist input

Where are we now?	• Family Hubs established across all Oldham neighbourhoods, delivering integrated 0–19 (0–25 SEND) support including health visiting, early help, and children's services • Primary Care Networks (PCNs) provide a strong foundation for neighbourhood working, with additional Roles (ARRS) workforce (pharmacists, social prescribing link workers, care coordinators) and Population Health model • High-risk / frailty huddles established in some areas (e.g. district nursing + social care), but not consistently embedded across all neighbourhoods or across all age groups • Mental health neighbourhood teams operating in parts of Oldham but not funded by all PCNs
What needs to happen next?	• Develop INTs for integrated co-ordinated health and care delivery, ensuring processes focus on target cohorts - frailty, multi-morbidity, as well as children and young peoples mental health and asthma management. • Ensure all health and care integrated neighbourhoods teams are part of broader Live Well neighbourhoods in Oldham, with a team of teams approach (Mental health neighbourhoods, Family Hubs etc) • Implement a single point of access (SPA) for each neighbourhood and embed routine MDT working and governance • Ensure health and care pathways support neighbourhood links to skills, work and employment
What will be the impact	↑ Increase in patients supported through MDT care coordination↑ Increase in proactive reviews of high-risk cohorts (all age groups) ↓ Reduced ED attendances and non-elective admissions (particularly frailty, CYP crises and mental health) ↓ Reduced hospital length of stay through improved community coordination ↑ Improved patient and family experience: Joined-up, seamless care. Single point of contact and clearer navigation

INTs Case study: Neighbourhood Mental Health Service (NMHS)

NMHS is made up of: Living Well team, SPOE, Community Liaison, Access team, CMHT including psychiatric nurses, MH Wellbeing Practitioners, Psychology, Social Workers, VCSFE partners and 0.5 of the invested PCN practitioners (currently from 2 PCNS).

The service:

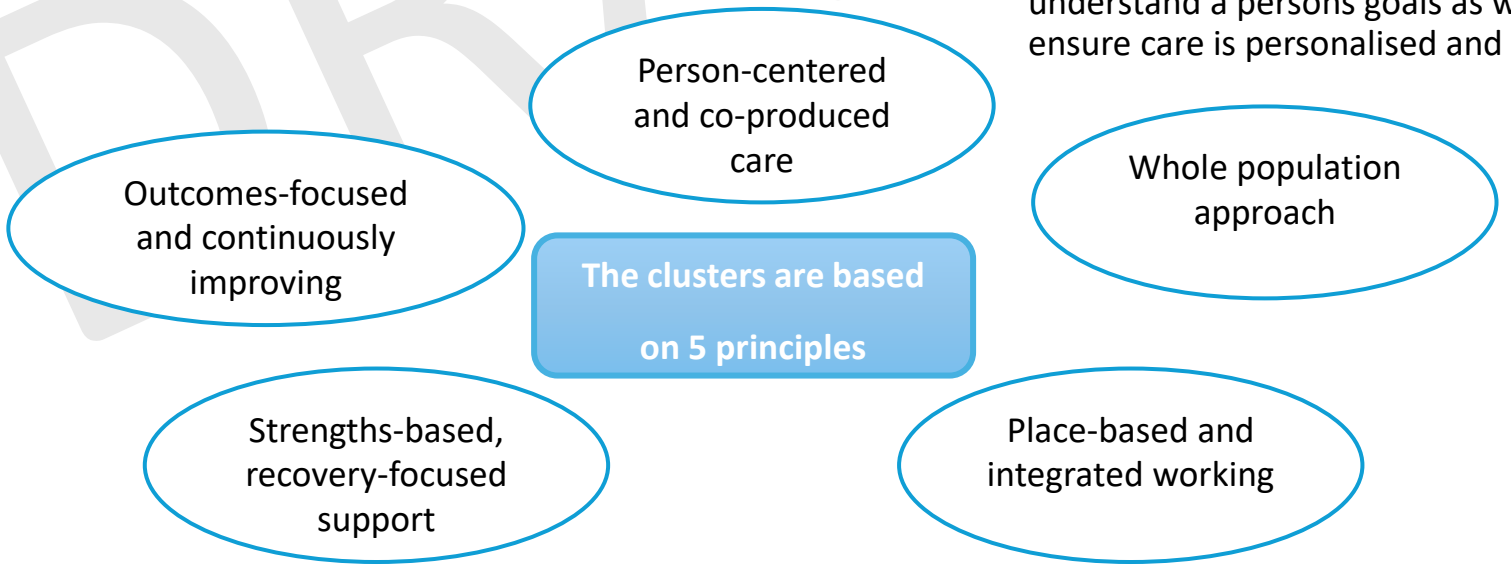
- opens an all age adult access point to secondary care services
- provides local, accessible MH support aligned to PCNs
- delivers ongoing care, treatment and recovery focused interventions
- works proactively with primary care, voluntary sector and community partners to prevent escalation and reduce reliance on specialist inpatient services

Referral Pathways

- All referrals will come via one central NMHS mailbox and will be triaged / assessed then directed to the appropriate service
- Complex cases requiring specialist intervention will be discussed in the weekly MDT (attended by specialist and NMHS practitioners)

Caseload Management – Key Worker Approach

- Each person has a named key worker who will co-ordinate care and ensure continuity and joined up support as well as ensuring engagement in appropriate intervention
- This approach builds a trusted therapeutic relationship and helps understand a persons goals as well as working across the MDT to ensure care is personalised and consistent



Our neighbourhoods: Live Well in Oldham

Neighbourhood health and integrated neighbourhood teams are a critical part of the broader Live Well approach in Oldham.

Oldham Live Well is an opportunity to drive a more preventative approach to public services and grow capacity and capability in our communities to take the lead on designing and delivering solutions.

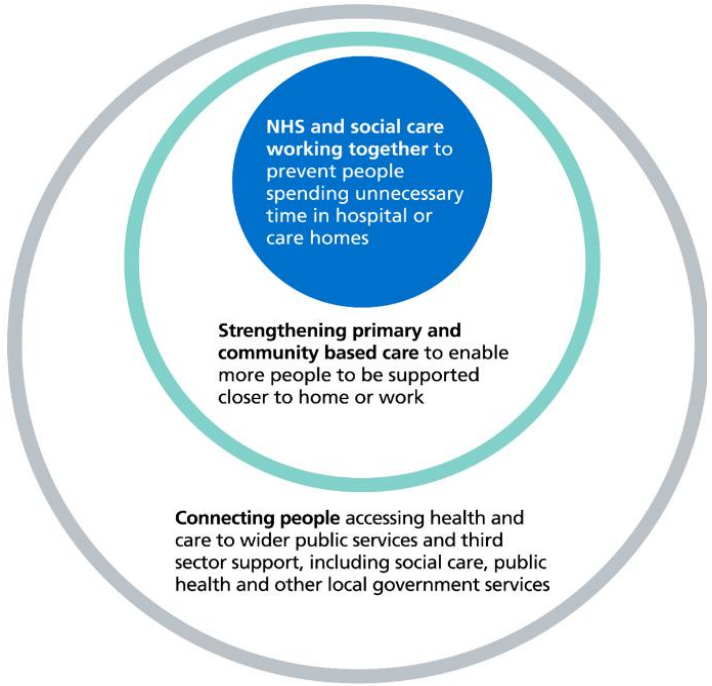
To achieve this, we will focus on a whole-system approach that prioritises prevention, collaboration, and our vibrant VCFSE sector. By building on our strong partnerships, and harnessing our local assets, we will create a sustainable model of health creation, that reduces health inequalities, enhances social connections, and ensuring every resident has the opportunity to flourish.

The rationale behind the Live Well approach is one which is familiar in Oldham – that integrated support, built around residents' needs, delivered at the right time and in the right place is critical to improving outcomes for all. This means bringing together the very best of formal and informal support across the system.

Live Well provides a shared framework for delivery across Council, NHS, VCFSE and partners building on Oldham's established place-based model and approach to building and supporting a strong Voluntary, Community, Faith & Social Enterprise (VCFSE) sector.

The key outcomes for this are:

- We will see improved wellbeing, independence, economic participation for our residents. Building on our community strength and pride of place.
- Decisions about services, neighbourhood delivery, regeneration, town centres, housing growth and capital investment are expected to demonstrate how they contribute to these outcomes.
- Prevention, asset-based working and neighbourhood delivery are the cornerstones of the Oldham approach.



Our neighbourhoods: Live Well in Oldham

The Live Well Approach in Oldham

Live Well is not a standalone programme or time-limited initiative.

It is the operating model for how Oldham works with residents, communities and across public services.

At its core, Live Well sets out a clear expectation:

- For residents: support is local, joined-up and focused on strengths
- For services: prevention and early help are the starting point, not the exception
- For partners: delivery is organised around districts and communities, not organisational boundaries

This is a deliberate shift in how the system operates. It will continue to move Oldham away from a model built around organisational silos and reactive intervention, towards one that is place-based, preventative and centred on the lived reality of residents' lives. Live Well will strengthen consistency, depth and impact of public service integration and partnership with the VCFSE.

It also creates a shared organising framework across the partnership — one that aligns the Council, NHS, VCFSE and other partners around a common way of working, rather than a collection of aligned but separate strategies.

What success looks like

When embedded, Live Well will mean:

- Residents experience a simpler, more coherent system of support
- More people get help earlier, in their own communities
- Services operate in a more coordinated and efficient way
- Communities play a stronger role in shaping and delivering solutions
- The system is better able to manage demand and reduce avoidable escalation

This is not a marginal change. It is a fundamental reorientation of how public services in Oldham work together.

An optimised integrated neighbourhood model. This will see multi-agency teams working on common geographical footprints of 30-50k population towards shared outcomes and purpose alongside local people and communities.

A resilient VCFSE Eco-system. Ensuring a resilient and connected local VCFSE offer from a sector resourced to respond to what matters to people, with community-led approaches at the heart.

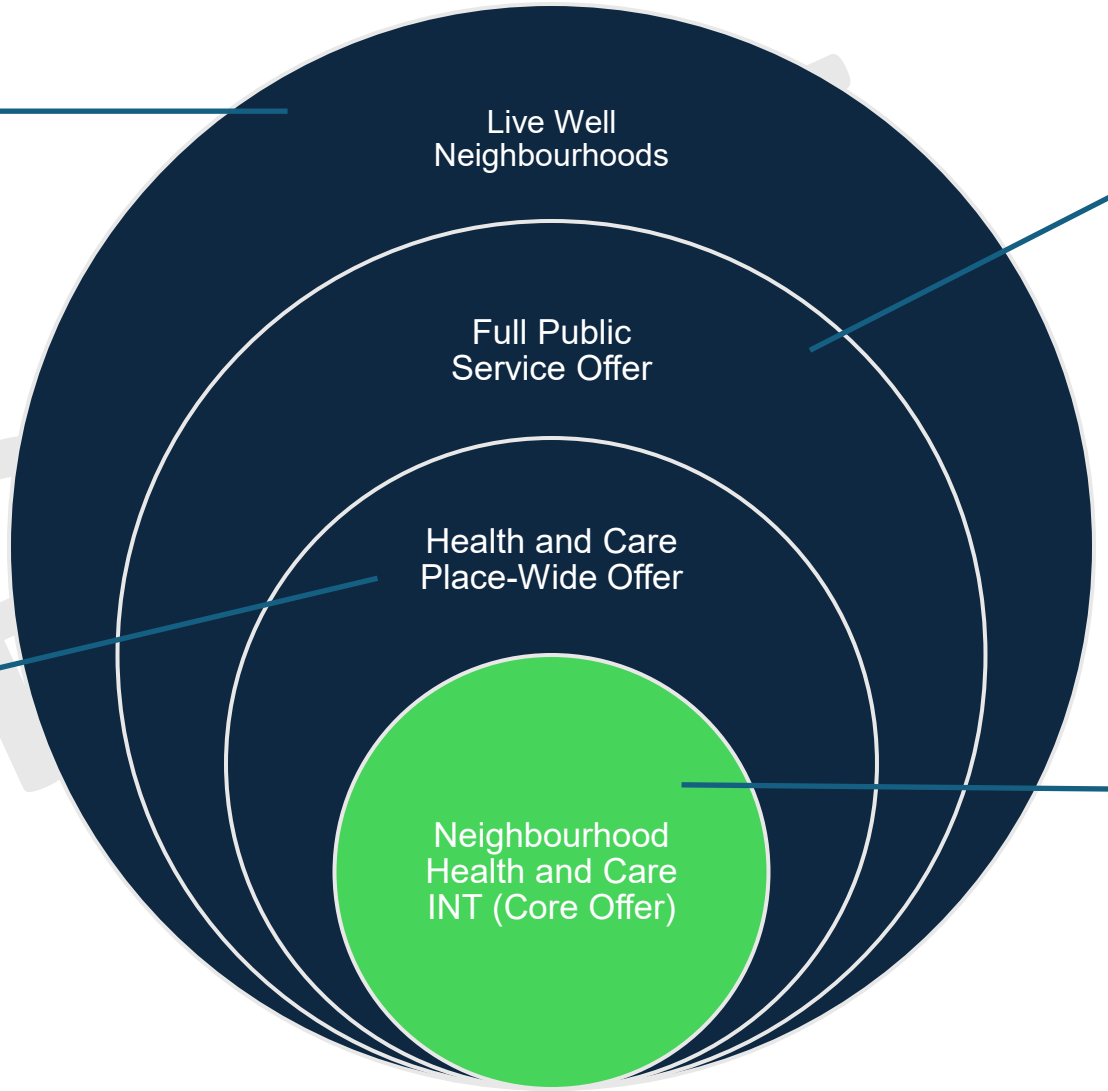
A culture of prevention. Where the workforce and organisational development is geared towards prevention, with an emphasis on person-centred and relational ways of working across all systems of support.

A network of Live Well centres, spaces and offers. These will see public services and community-based support working together to provide a consistent everyday support offer from recognisable places in the community.

Neighbourhood Health as part of Live Well – Our Delivery Model

#Bringing together:
- All neighbourhood level public services,
- VCFSE organisations,
- Live Well Centres and Spaces
- employment providers,
- multidisciplinary teams and
- community connectors

…shifting from siloed delivery to integrated support



- Place Public Service Leadership Teams:
  - Housing
  - Employment
  - Connection to Schools and Education
  - Community Safety
  - Police
  - DWP
  - Family First Hubs
  - Including VCFSE providers

- Hospital at Home
- Outpatient Transformation
- Intermediate Care
- Public Health Offer
- Reablement
- Urgent Community Response

- Primary Care (All Disciplines)
- Community Services
- Community Mental Health Teams
- Adult Social Care
- MDT for Children and Young People
- Agreed model for Primary/Secondary Care Interface – including role of Hospital Consultants
- Social Prescribing
- Agreed model for UEC, Elective, Dementia and Cancer care

4. Neighbourhood Enablers

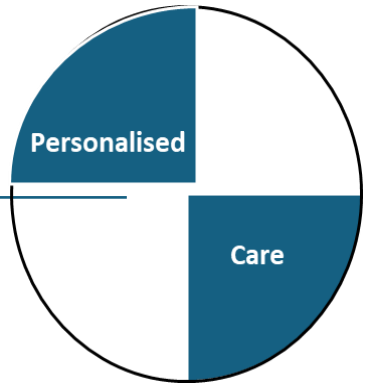
Describing the broader enablers which wrap around PHM and INTs to deliver effective neighbourhood health;

- **Transforming Primary care**
- **Urgent Neighbourhood Services**
- **Intermediate care & home first**
- **Standardised Community Services**
- **Neighbourhood elective pathways**
- **Neighbourhood cancer prevention & reduction**

Neighbourhood Health in Oldham: Transforming Primary Care

Modern general practice model which delivers improvements in access, continuity and overall experience for people and their carers

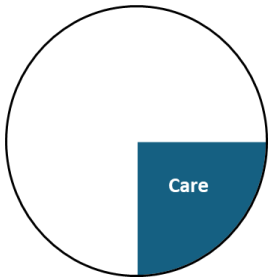
Where are we now?	• Access to online consultation systems throughout core hours • Access to online registration • Opening times for all modes of access available within core hours to be displayed on practice websites • Dataset available (e.g. GPAD) to monitor access and some, but not all, capacity and not demand
What needs to happen next?	• Increased GP capacity, utilising funding available through GP Reimbursement Scheme • Improvements to cloud-based telephony data collection • Same-day response for clinically urgent patient requests • Practices to ensure tools used to refer patients into community pharmacy services offer a full choice of pharmacy providers • Embedding Advice & Guidance in core practice • Embedding risk stratification and continuity of care in core PCN activity • Full use of practice, PCN and neighbourhood teams in unplanned and planned care
What will be the impact	↓ Reduced call waiting time, particularly between 8am and 10am ↑ Increase in % of clinically urgent patients seen on the same day ↑ Increase in % of 'non-clinically urgent' patients seen within one week and two weeks ↑ Improved patient choice in accessing community pharmacy services ↑ Improved patient experience of access



Neighbourhood Health in Oldham: Standardised Community Services

Community health and social care services playing a key role in delivering neighbourhood health and care

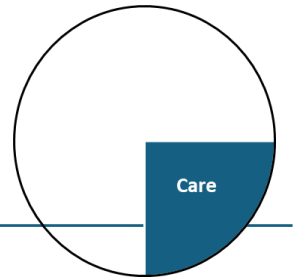
Where are we now?	• A range of community services exist across Oldham (district nursing, UCR, therapy, PCNs, mental health, social care and VCSE), but delivery is fragmented across providers • Variation between neighbourhoods in access, service offer, and MDT maturity • Core components of Integrated Neighbourhood Teams are in place, but not consistently embedded • Inconsistent referral routes, thresholds, and operating models (including limited 7-day coverage)Growing demand driven by frailty, multi-morbidity, and health inequalities • Data sharing and population health management are developing but not yet fully operationalised across the system
What needs to happen next?	• Consistent standardised neighbourhood service model for all relevant services including multi-neighbourhood provision • Ongoing work to reduce waiting times for core community services. E.g. falls management, care act reviews • Need to development of clear clinical leadership across all-age physical and mental health services linked with MDT approaches • Improve and expand out-of-hospital models for key pathways e.g. paediatric asthma management, adult diabetes, and frailty
What will be the impact	↑ Improved patient outcomes – better management of long-term conditions and prevention of deterioration ↑ Improved patient experience – more personalised, coordinated, and closer-to-home care ↓ Reduced unplanned demand – fewer ED attendances, admissions, and ambulance conveyances ↑ More integrated working – stronger collaboration across primary care, community, mental health, and social care ↓ Variation and inequalities – more consistent access and outcomes across neighbourhoods £ Better value for money – reduced duplication, lower acute spend, and shift to community-based care



Neighbourhood Health in Oldham: Intermediate care and home first

Rapid response, reablement, hospital-at-home, and enhanced care in care homes to prevent admissions, reduce LoS, and support independence.

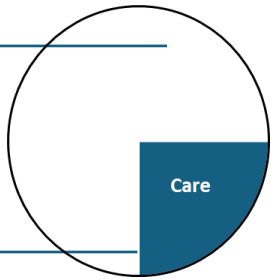
Where are we now?	• System largely focussed on discharge with limited focus on admission avoidance and step up due to acute pressures • Two intermediate care units operated from Butler Green (Operated by NCA) and Medlock Court (Operated by Miocare) offering support transition from hospital to home, boost independence and prevent hospital admissions • Re-ablement services (Miocare) providing short-term support to regain independence but capacity limited • Virtual ward model established but not integrated with other urgent community services and capacity under-utilised • High performing Urgent Community Response service but requires recurrent funding and expansion of hours
What needs to happen next?	• Deliver a fully standardised "Home First" model across all neighbourhoods aligned to NHS guidance • Default to discharge to assess (D2A) pathways • Maximise care at home before using bed-based care; Increase access to home-based reablement (Pathway 1) • Increasing and optimising the capacity of step-up and step-down intermediate care will help avoid admissions and attendances, improve discharge and support better recovery. • Transform end of life and palliative care to support more residents to die in their preferred place of care
What will be the impact	↑ Improved outcomes and independence; More people recover at home (maintaining a good level of independence and reducing the need for long term care and regain function ↓ Reduced unplanned demand; Fewer ED attendances, non-elective admissions, reduced ambulance conveyances ↓ Reduced length of stay (LoS) and delays to people returning to their usual home; ↑ Stronger integrated working; Improved coordination across acute, community, primary care, and social care £ Better value for money; shift from high-cost acute care to community-based provision



Neighbourhood Health in Oldham: Urgent neighbourhood services

Responsive services at neighbourhood level for people with an escalating or acute health need

Where are we now?	• Urgent Community Response (UCR) service in place in Oldham, providing rapid assessment and intervention in the community • Call Before Convey pathway bringing A&E advice and UCR intervention together to avoid ambulance conveyances but requires consistent utilisation • Crisis mental health services in place (including urgent MH helplines), but; not consistently aligned with neighbourhood MDTs, and limited integration with physical health crisis response • Rising demand across all age groups; Children and young people (CYP); increasing urgent MH and minor illness demand, adults: long-term conditions crises; older people: frailty crises and falls
What needs to happen next?	• Strengthen urgent care SPOA for Oldham • Integrate mental health crisis response into neighbourhood urgent pathways; including opening of 24hr mental health A&E • Maximise and integrate virtual wards / hospital at home for urgent deterioration: Same-day admission avoidance from community or ED front door. All-age cohort expansion where clinically appropriate • Strengthen urgent support for care homes and vulnerable groups; Direct access to clinical advice and rapid response. avoidance of unnecessary conveyance/admission • Develop an Enhanced Live Well model for Oldham pro-actively supporting those face multiple disadvantage requiring tailored intensive support
What will be the impact	↑ Increased same-day community-based urgent care episodes ↑ Increased virtual ward admissions from community and ED front door ↓ Reduced ED attendances (all-age), particularly category 3–5 ↑ Improved patient and family experience; Faster response times and care delivered at home or closer to home



Neighbourhood Health in Oldham: Elective pathways and diagnostics

We are determined to improve Oldham residents' access and support for planned care pathways, bringing as much as possible to their neighbourhoods and reducing the need for multiple unnecessary appointments.

The traditional hospital model is outdated, capacity often short falling against demand, and does not present a sustainable future for our health system.

Oldham is a at the forefront of left-shift, having long standing community-based outpatient and diagnostic services already in place, including being home to one of the first national Community Diagnostic Centres.

Technology is a key enabler to the delivery of 'out of hospital' planned care, with digital developments driving the ability to successfully embed new ways of working. Electronic referrals, virtual triage, remote consultations, and remote monitoring of long-term conditions will support the wider roll out of the new outpatient models of care.

The Northern Care Alliance Foundation Trust is a key place partner, and as the local acute trust which provides the majority of planned care for Oldham residents, colleagues at NCA will take a key leadership role in transforming existing outpatient and planned approaches. Independent sector and primary care led providers of planned pathways will work closely with secondary care colleagues to implement neighbourhood planned care pathways.

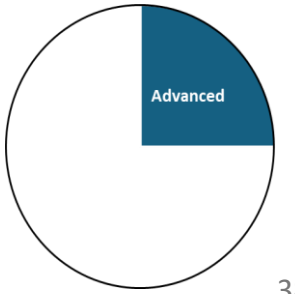
Advice and Guidance (A&G)

Advice and Guidance allows GPs, and wider primary care teams, to seek specialist advice to support the management of patients in the community, without the need for a specialist referral or lengthy hospital waits. The locality will continue to embed the use of both electronic A&G and the expansion of the telephone advice model available via Consultant Connect.

Single Point of Access (SPoA)

A SPoA simplifies access to services by offering an advice first model to support onward referrals, ensuring that patients get the right care for their needs quickly and safely.
Oldham system partners will work closely with Greater Manchester to optimise models across 10 high volume specialties in secondary and tertiary care ensuring that Oldham Neighbourhood teams utilise these SPoAs when launched. This will ensure that Oldham residents receive the right care, first time, every time.

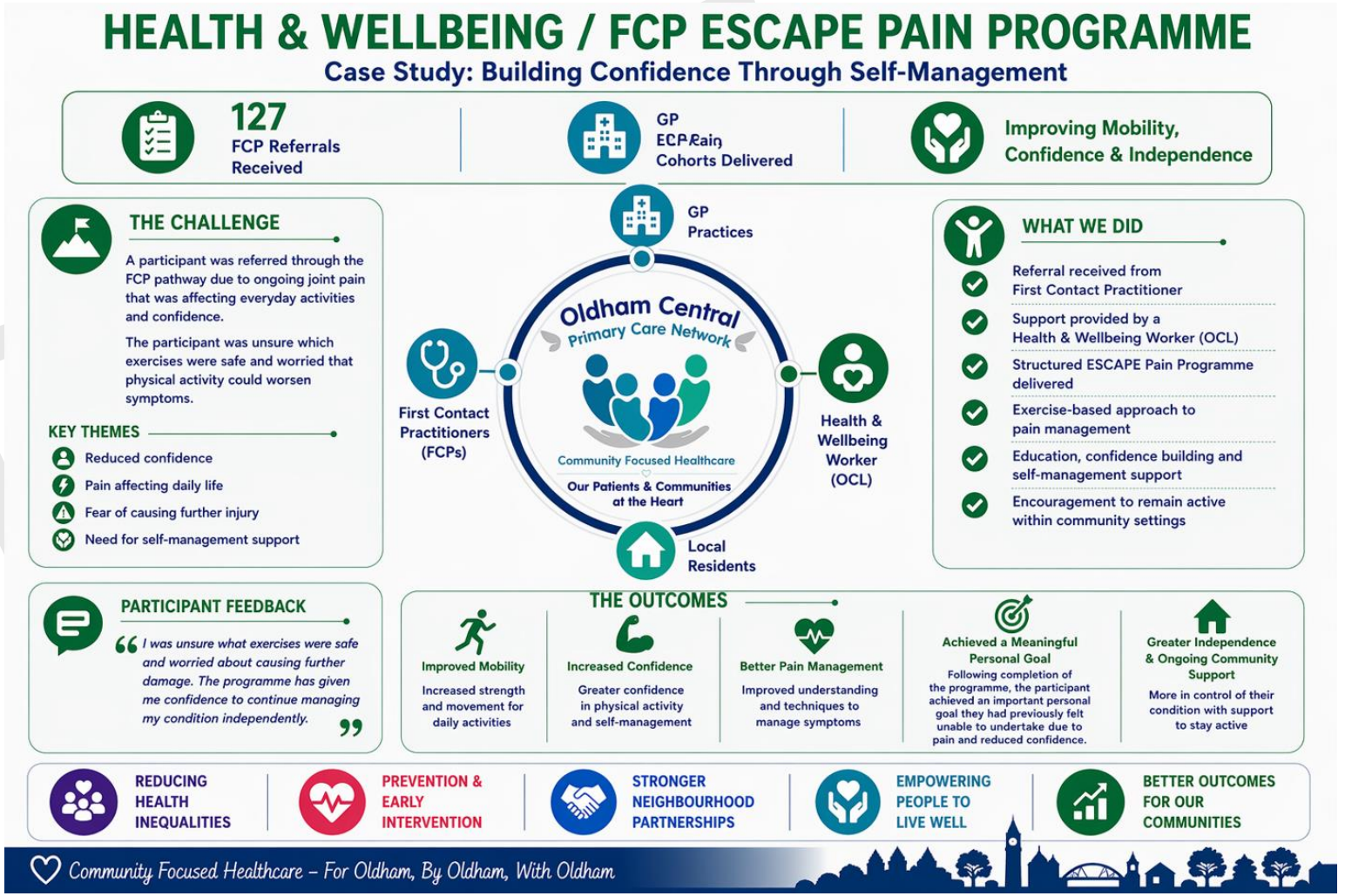
NHS Northern Care Alliance NHS Foundation Trust



Planned Care Case study: Oldham Central PCN 'escape pain programme'

Oldham Central PCN identified a cohort of patients who would benefit from a different approach to their pain management.

Working with the **First Contact Practitioner** and **Health & Wellbeing Worker**, a pathway was developed which would support patients to undertaken physical activity despite their pain, build confidence and engage with wider community activities and opportunities



Neighbourhood Health in Oldham: Cancer prevention and reduction

Our Vision

The NHS Long Term Plan ambitions for early cancer diagnosis are by 2028, 75% of people with cancer will be diagnosed at an early stage (stage 1 or 2) and 55,000 more people each year will survive their cancer for five years.

Our vision for the people of Oldham, is a future where everyone with cancer receives equitable and prompt early diagnosis

By raising public awareness, reducing health inequalities, and fostering collaboration and innovation, we aim for continuous improvement in the proportion of cancers diagnosed at an early stage.

Our Neighbourhood Teams in Oldham provide an ideal partnership vehicle to promote early cancer diagnosis and to identify new ways in which we can do so, to support the delivery of this strategy and national priority.

Symptom Awareness

- Build and optimise communication channels across the partners and communities to ensure we reach those in greatest need
- Systematically improve, share and promote campaigns to build symptom awareness and myth bust
- Identify specific areas and communities that could benefit from targeted campaigns
- Continuation of 'This Van Can' Roadshow, and other related GM Cancer Awareness Campaigns

Reduction Variation

- Use data and qualitative analysis to identify at risk characteristics
- Focus on solutions for our communities who have higher barriers to accessing traditional health routes
- PCN based action plans in place aimed at tackling health inequalities and reducing variation, with a strong focus on community outreach
- Work in partnership with VCFSE organisations and community groups to maximise reach into our communities

Collaborate with Primary Care

- Each neighbourhood has a named 'cancer lead' leading work on early diagnosis
- Primary Care Early Diagnosis Facilitators in place across Oldham
- Oldham Cancer Delivery Group brings together system wide partners to strengthen communication and collaboration across primary and secondary care
- Ongoing education for primary care and partners

Cancer Screening

- Encourage uptake in screening by raising awareness in eligibility criteria and the importance of early diagnosis
- Myth bust where there are misconceptions or barriers to accessing screening
- Continue to work with GPs to increase uptake in national Breast, Cervical and Bowel screening programmes
- Continuation of Targeted Lung Health Checks
- Ensure targeted approach and outreach into communities with lower screening uptake

5. Support to Neighbourhoods

Describing the key infrastructure, support and culture we are developing upon which neighbourhood health teams can be built;

- Neighbourhood Health Centres
- Workforce and culture
- Estates
- Digital
- Information sharing

Neighbourhood health – Neighbourhood Health Centres in Oldham

Our neighbourhood health centre approach brings together health, social care, and community services within accessible local hubs to deliver coordinated, person-centred care.

These centres act as anchors for multidisciplinary teams, supporting prevention, early intervention, and management of complex needs close to home. They integrate primary care, mental health, social care, and voluntary sector support, alongside community wellbeing services.

Designed to be flexible and inclusive, neighbourhood health centres;

- Improve access for residents
- Reduce fragmentation of services
- Enable proactive population health management
- Helping tackle inequalities while
- Strengthen community resilience
- Supporting residents to live healthier, more independent lives.

Key Neighbourhood health centres in Oldham

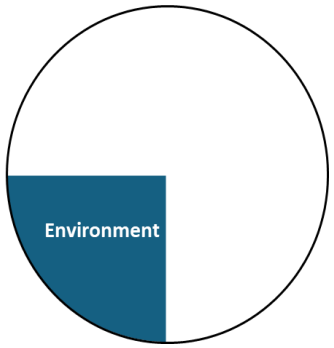
The following locations which are strategically situated across our geography to improve access for residents will be Neighbourhood Health Centres;

- Oldham Integrated Care Centre
- Moorside Health Centre
- Sportstown (Oldham Athletic Football Club)
- Chadderton Town
- Shaw & Crompton Health Centre

Oldham town centre development: The Oldham Town Centre development and the Neighbourhood Health and Care approach are designed to improve residents' quality of life by combining regeneration, housing, health services, and community support.

The benefits of Oldham Town Centre development and Neighbourhood Health and Care include:

- Easier access to health and care services
- New and improved housing
- Healthier public spaces and greener environments
- Reduced health inequalities
- More jobs and economic growth
- Stronger community networks
- A safer, more vibrant town centre



Neighbourhood Health Centres - Sportstown

Sportstown is a key pillar of our neighbourhood health and Live Well approach.

Based around the Oldham Athletic stadium, the initiative will look to develop sports facilities in the borough, along with creating education opportunities to help people gain qualifications while on a sports pathway.

Critically, it will offer an innovative neighbourhood location for the delivery of services for Oldham, as well as creating education and training opportunities for our local health and social care workforce.

Alongside this it will build on existing health promotion activities led in partnership by Oldham Athletic Sports Trust and VCFSE partners.

Workforce and culture for neighbourhood health

Delivering effective neighbourhood health in Oldham depends on a workforce that is integrated, community-rooted, and prevention-focused. At its core are multidisciplinary teams operating at neighbourhood level, anchored in primary care but extending across health, social care, and the voluntary sector. These teams require flexible role design and shared accountability to respond to complex population needs, particularly in areas of deprivation. Our colleauges will be equipped with population health skills, digital tools, and cultural competence to address inequalities and tailor care effectively. Strong local leadership, continuous professional development, and robust retention strategies are essential to sustain workforce capacity. Ultimately, enabling neighbourhood health in Oldham requires a coordinated, place-based workforce model that blends clinical expertise with community insight and a focus on prevention and wellbeing.

Key areas for development

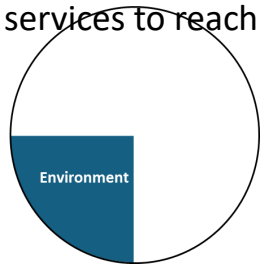
Workforce integration and flexibility: Roles designed to work across organisational boundaries (NHS, local authority, VCSE) with shared objectives and flexible job plans.
Strong primary care foundation: Well-resourced GP practices working at Primary Care Network (PCN) level as anchors for neighbourhood delivery.
Community and peer workforce expansion: Recruitment and development of community health champions, social prescribing link workers, and peer supporters with strong local ties.
Population health and data capabilities: Staff skilled in using shared data systems, risk stratification tools, and proactive care planning.
Cultural competence and local insight: Workforce reflecting Oldham's diverse communities, with language skills and understanding of local socio-economic challenges.
Prevention-focused skills and mindset: Training in early intervention, health coaching, behaviour change, and tackling wider determinants of health.
Leadership at neighbourhood level: Visible, empowered clinical and operational leaders who can coordinate across partners and drive local priorities.
Workforce development and retention strategies: Ongoing training, career pathways, and wellbeing support to retain staff in high-demand neighbourhood roles.
Digital and mobile working capability: Access to interoperable IT systems, remote working tools, and digital engagement platforms.
Partnership with voluntary, community and social enterprise (VCSE) sector: Sustainable funding and collaboration models to embed VCSE workers within care teams.
Safeguarding and Complex case management expertise: Skills to manage high-need individuals with multiple long-term conditions and social vulnerabilities.

Estates for neighbourhood health

Delivering neighbourhood health in Oldham requires a modern, flexible estate aligned with NHS neighbourhood health centre guidance, centred on accessible local hubs that bring services together around communities. These estates should enable co-location of multidisciplinary teams and provide adaptable spaces that support both clinical care and prevention-focused activities. Prioritising locations within communities—especially those with greatest need—helps improve access and reduce inequalities, while integration with existing community assets enhances efficiency and local engagement. Digital infrastructure must be embedded to support joined-up working, alongside inclusive design that reflects the borough's diversity. Overall, the estate should move away from fragmented, building-centric models towards a network of neighbourhood-based, multi-use spaces that support integrated, person-centred care close to home.

Key areas for development:

Neighbourhood health hubs aligned to NHS guidance; Accessible, multi-purpose centres acting as local anchors for integrated health, care, and community services.
Co-location of multidisciplinary teams; Space designed to bring together primary care, community health, mental health, social care, and VCSE partners.
Flexible and adaptable estate design; Modular, multi-use spaces that can support clinics, group activities, prevention services, and community use.
Community-based, accessible locations; Sites situated within neighbourhoods, particularly in areas of highest need, with good transport links and walkability.
Integration with community assets; Use of existing buildings (e.g. libraries, leisure centres, community centres) to maximise reach and sustainability.
Digital infrastructure embedded in estates; Reliable connectivity and facilities to support digital consultations, shared records access, and mobile working.
Prevention and wellbeing-focused spaces; Areas for health promotion, social prescribing, education, and voluntary sector activities.
Inclusive and culturally appropriate environments; Estates designed to be welcoming, safe, and reflective of Oldham's diverse communities.
Efficient utilisation of existing estate; Rationalisation and shared use of buildings across organisations to reduce duplication and costs.
Sustainability and net-zero alignment; Environmentally sustainable buildings aligned with NHS net-zero targets.
Outreach and satellite provision; Smaller, flexible spaces enabling services to reach underserved populations closer to home.



Enablers: Digital needs for neighbourhood health

Delivering neighbourhood health in Oldham requires a digitally enabled infrastructure that connects organisations, supports proactive care, and improves access for residents. Central to this is interoperable data systems that allow professionals across health, social care, and the voluntary sector to share information and coordinate care effectively.

Population health analytics and care coordination platforms help teams identify need early and manage complex cases, while mobile technologies enable staff to work seamlessly in community settings.

Equally important is ensuring digital inclusion so that all residents can benefit from new access channels and self-management tools. Alongside strong data governance, investment in workforce digital skills is essential to fully realise the potential of digital in supporting integrated, neighbourhood-based care.

Key areas for development

Shared care records and interoperability; Integrated data systems allowing real-time information sharing across NHS, social care, and VCSE partners.
Population health analytics; Tools to identify risk, segment populations, and support proactive, neighbourhood-level care planning.
Digital access and inclusion; Solutions to reduce digital exclusion, including support for residents with low digital literacy or limited access.
Mobile and remote working capability; Secure devices and applications enabling staff to work flexibly in community settings.
Digital triage and access channels; Online consultation platforms, telehealth, and multi-channel access to improve responsiveness and convenience.
Care coordination platforms; Systems that support multidisciplinary team working, shared care plans, and case management.
Data governance and information security; Clear protocols to ensure safe, lawful, and trusted use of patient data.
Workforce digital skills; Training to ensure staff can confidently use digital tools and interpret data.
Citizen-facing tools and self-management apps; Platforms that empower residents to manage their health and connect to local services.

Information sharing for neighbourhood health

Effective neighbourhood health delivery in Oldham relies on seamless, secure, and trusted information sharing across all partners involved in care. Central to this is the ability to access shared care records in real time, enabling multidisciplinary teams to coordinate care around the individual and respond proactively to need.

Strong information governance frameworks and clear data-sharing agreements are essential to ensure compliance while maintaining public confidence, supported by transparent consent processes. Standardised data and secure communication systems help professionals work efficiently across organisational boundaries, while access to both individual and population-level data supports better decision-making and targeting of resources. Overall, robust information sharing underpins integrated, person-centred care and is critical to improving outcomes at neighbourhood level.

Key areas for development

Shared care records across organisations; A single, interoperable record accessible by NHS, local authority, and VCSE partners.
Real-time data access; timely sharing of patient information to support responsive decision-making and coordinated care.
Clear information governance frameworks; Agreed policies, protocols, and legal agreements (e.g. data sharing agreements) to ensure safe and lawful data use.
Consent and transparency with residents; Clear communication on how data is used, with appropriate consent models that build public trust.
Standardised data and coding; Consistent formats and definitions to ensure information can be accurately shared and interpreted across systems.
Multidisciplinary team visibility; Shared care plans, risk registers, and case notes accessible to all relevant professionals.
Population-level data sharing; Aggregated data to support population health management, planning, and tackling inequalities.
Secure communication channels; Use of approved platforms for sharing sensitive information between professionals.
Integration with safeguarding systems; Effective information flow for vulnerable individuals across health, social care, and safeguarding services.

6. Commissioning for neighbourhood health

Commissioning for neighbourhood health involves aligning funding, contracts, and outcomes across health, social care, and community services to support integrated, place-based delivery.

It prioritises prevention, reduces fragmentation, and enables multidisciplinary teams to meet local needs, improve equity, and deliver coordinated, person-centred care within neighbourhoods.

Commissioning for Neighbourhood Health: Oldham Prevention Framework

In 2022, a system wide framework for prevention was developed and agreed by a range of partners including Oldham Council, VCFSE organisations, the NHS and others.
The aim of the work was to agree a shared framework for design, commissioning and delivery of services to ensure that Oldham residents are healthy, happy, resilient and independent.

This system wide approach supports our work to put prevention at the heart of what we do as an Oldham Partnership.

Single shared framework for Early Intervention & Prevention in Oldham

Objectives of the prevention framework

- To articulate shared objectives and outcomes
- To ensure prevention is central to everything we do
- To review and make sense of our current early intervention and prevention offer across the system
- To identify gaps
- To avoid duplication and maximise effective use of resources - building on work already done
- To support investment and commissioning decisions
- To support a collective approach to deliver enablers, such as workforce development
- To ensure resident focus and alignment to place-based delivery

Oldham Prevention Framework

Our prevention framework describes what should be offered at level of need

Oldham's prevention framework is structured as a whole-system, stepped approach that supports residents across four levels of need—ranging from "living well" to experiencing crisis—ensuring people receive the right support at the right time. At its foundation, the model focuses on creating strong social, economic, and environmental conditions that enable everyone to stay well and thrive, with universal services and community-based support widely accessible. As needs increase, targeted early help and preventative interventions are provided to those at risk, aiming to reduce inequalities and stop issues from escalating. For people experiencing more defined challenges, coordinated and often specialist support is offered to manage needs and prevent deterioration. At the highest level, intensive, multi-agency crisis support is delivered to keep people safe and stabilise complex situations. Overall, the framework emphasises prevention, early intervention, and integrated working to improve outcomes and reduce demand on acute services.

What's going on? (for residents)	What do we offer? (place & services)	How do we define that? (who & why)	What does it look like? (key characteristics)
Experiencing crisis or complex problems or challenges	Crisis or intensive support services	Intensive support for people with complex needs or in crisis. Keeping them safe, managing problems and re ducing impacts.	Acute crisis intervention or planned support. Likely to be multi-agency, may be specialist / statutory.
Experiencing problems or challenges	Support services	Bespoke support for people with identified needs. Reducing impacts or stop issues getting worse.	Planned support. May be single-agency / specialist or key worker coordinating a range of support services.
Staying well (despite some risks or concerns)	Some extra help and support; Help to access services for everyone	Targeted offer for people seeking help or at risk. Preventing issues escalating or reducing impact of inequalities.	Self-help. Community based activities and support. Low level support services available for those who need it. No barrier to access.
Living well	A good place to live; Services for everyone	Available to everyone. Creating conditions within places and communities for people to be well and thrive.	Social, economic and environmental conditions. Accessible services widely advertised. Empowering people and enabling self-help.

Oldham Prevention Framework

What's going on? (for residents)	Objectives (what is needed to achieve the aim)	Outcomes (what should we see if successful)	
		For residents	For services
Experiencing crisis or complex problems or challenges	People are safe and the impact of problems and challenges on their life is minimised so that the level of support can be reduced Services work together to provide the right support at the right time to keep people safe and tackle the root causes of problems	Improved individual wellbeing Reduction in risk and complexity	Coordinated and integrated services Fewer people need intensive support
Experiencing problems or challenges	People have the support they need to reduce the impact and/or tackle problems when they occur and live as well as possible Services work together to provide the right support at the right time and tackle the root causes of problems	Improved individual wellbeing People do not reach crisis or complexity	Coordinated and integrated services Fewer people need intensive support
Staying well (despite some risks or concerns)	Individuals and communities have the capacity to develop, implement and sustain their own solutions to problems and improve their own health, wellbeing & resilience Identify and provide additional targeted activity for populations/groups identified as having the highest risks of poorer outcomes	Reduced health & wellbeing inequalities People are doing more for themselves	Fewer people need support services People are accessing services earlier to manage risks
Living well	High quality services for everyone that are open and accessible The environment and community in which people live supports health, wellbeing, resilience and independence	Improved population health & wellbeing People are doing more for themselves	Fewer people need support services More people are accessing services for everyone

Our prevention framework describes what should be offered at level of need

Oldham's prevention framework supports neighbourhood health by providing a clear, place-based model that aligns services around the varying needs of local populations, enabling early intervention and coordinated care at community level. By prioritising prevention, self-help, and accessible community support, the framework helps neighbourhood teams focus on keeping people well and addressing risks early, reducing escalation into more complex needs. As individuals require more support, the framework enables integrated, multidisciplinary responses within neighbourhoods, ensuring care is joined-up, targeted, and proportionate. This structured approach strengthens neighbourhood health by improving outcomes, reducing inequalities, and ensuring resources are used effectively across the whole system.

Commissioning for Neighbourhood Health: Oldham Prevention Framework

Framework Principles

- Shared aim for people and places to be as **happy, healthy, resilient and independent** as possible
- **Strengths-based** - built around people not services
- Provide the **right support at the right time** – boundaries between levels are blurred
- **People may be at any level** or more than one level, at any time, and move between levels
- **Work to purpose and outcome** – not time or target driven
- Built on a **shared system wide understanding of support** available

Investment Principles

- Holistic **investment in outcomes** to achieve value – not the cheapest services
- **Commission less, design more** – working with communities
- **Focus investment on prevention** and demand reduction
- Seek to **remove barriers** to effective delivery

Residents First Principles

- Enable people to **help themselves**
- **Residents know how to access support**
- Provide holistic support to **tackle the root causes** of issues
- **Trauma informed**
- **Whole family** focus
- **Coordinated support** – not assessments and hand offs
- **Proactive and curious** professionals

7. Governance and next steps

Governance for neighbourhood health in Oldham requires shared leadership across NHS, council, and VCSE partners, with clear accountability at neighbourhood level.

Next steps include confirming delivery structures, embedding integrated teams, aligning commissioning, strengthening data sharing, and scaling pilots into a consistent, borough-wide model focused on prevention and outcomes.

Oldham Neighbourhood Health: High level milestones

We have strong foundations for the delivery of neighbourhood health in Oldham, but we plan ambitious expansion of this approach based on our learning and case studies.

Key milestones for the delivery of neighbourhood health in Oldham below.

Year 1 – Build on our foundations 26/27
- Review PCN Population Health Management approaches to understand good practice and sustainability
- Map population need and existing services
- Establish leadership and core multidisciplinary teams
- Develop workforce skills in prevention and population health
- Pilot neighbourhood working in priority areas

Year 2 – Early Implementation 27/28
- Expand multidisciplinary teams across all neighbourhoods
- Strengthen primary care networks as delivery hubs
- Roll out shared care records and digital tools
- Embed VCSE partners and social prescribing

Year 3 – Integration and Scale 28/29
- Fully integrate health, social care, and community services.
- Operational neighbourhood hubs (estate strategy in place)
- Implement population health management at scale.
- Standardise care coordination and case management
- Reduce duplication and streamline pathways

Year 4 – Optimisation 29/30
- Refine services based on outcomes and feedback
- Strengthen prevention and early intervention pathways
- Improve access and reduce inequalities across neighbourhoods
- Embed digital innovation and self-management tools
- Enhance workforce retention and career pathways

Year 5 – Maturity and Sustainability 30/31
- Fully embedded neighbourhood model across Oldham
- Demonstrable improvements in population health outcomes
- Sustainable, integrated commissioning model in place
- Strong community ownership and co-production
- Continuous improvement framework driving long-term impact

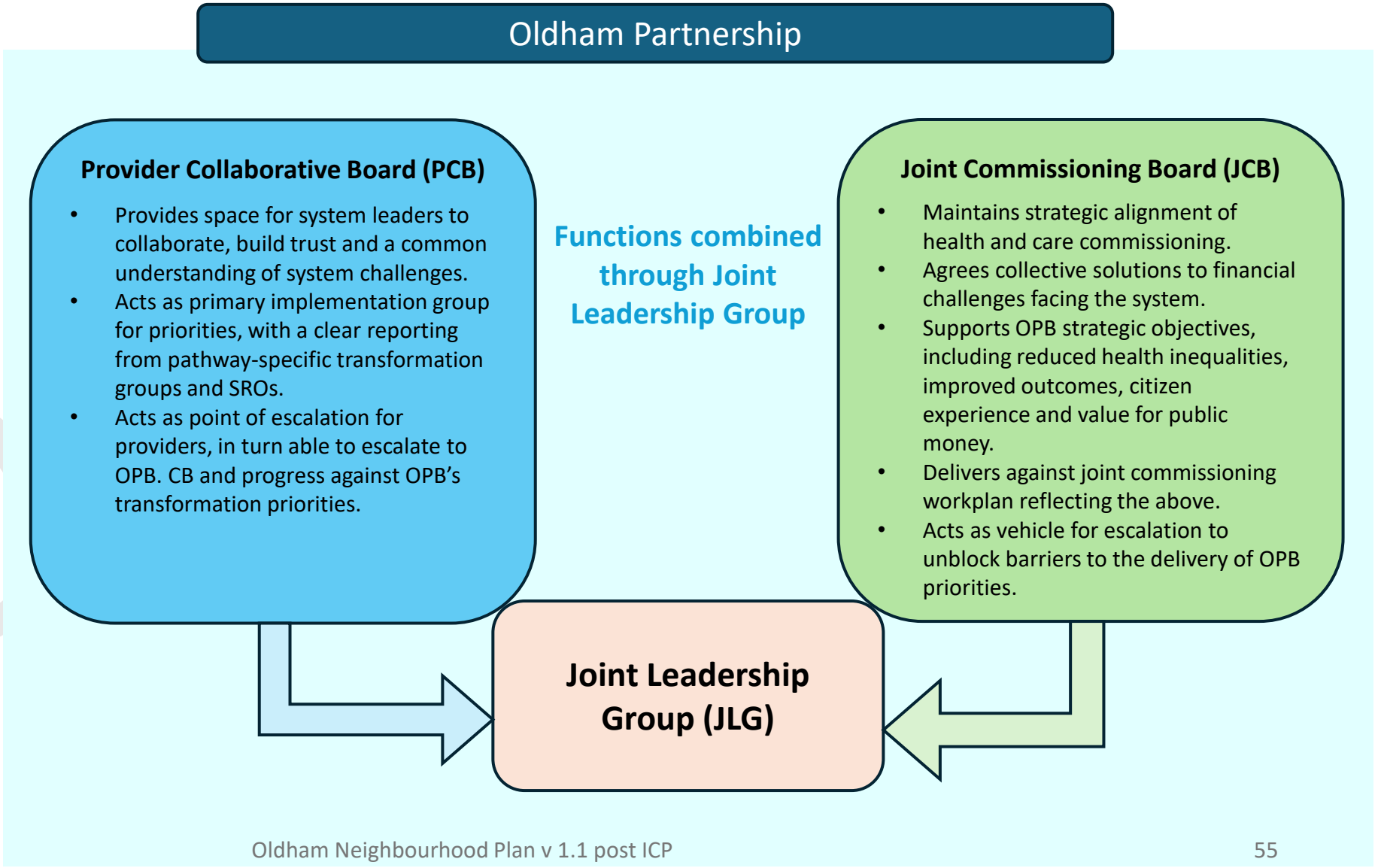
Neighbourhood Health: Our Governance

We will simplify our system governance to ensure that decisions can be streamlined.

Our existing provider collaborative board will become the main vehicle for delivery in Oldham.

The Joint Commissioning Board (JCB) will drive our needs based approach using the prevention framework principles.

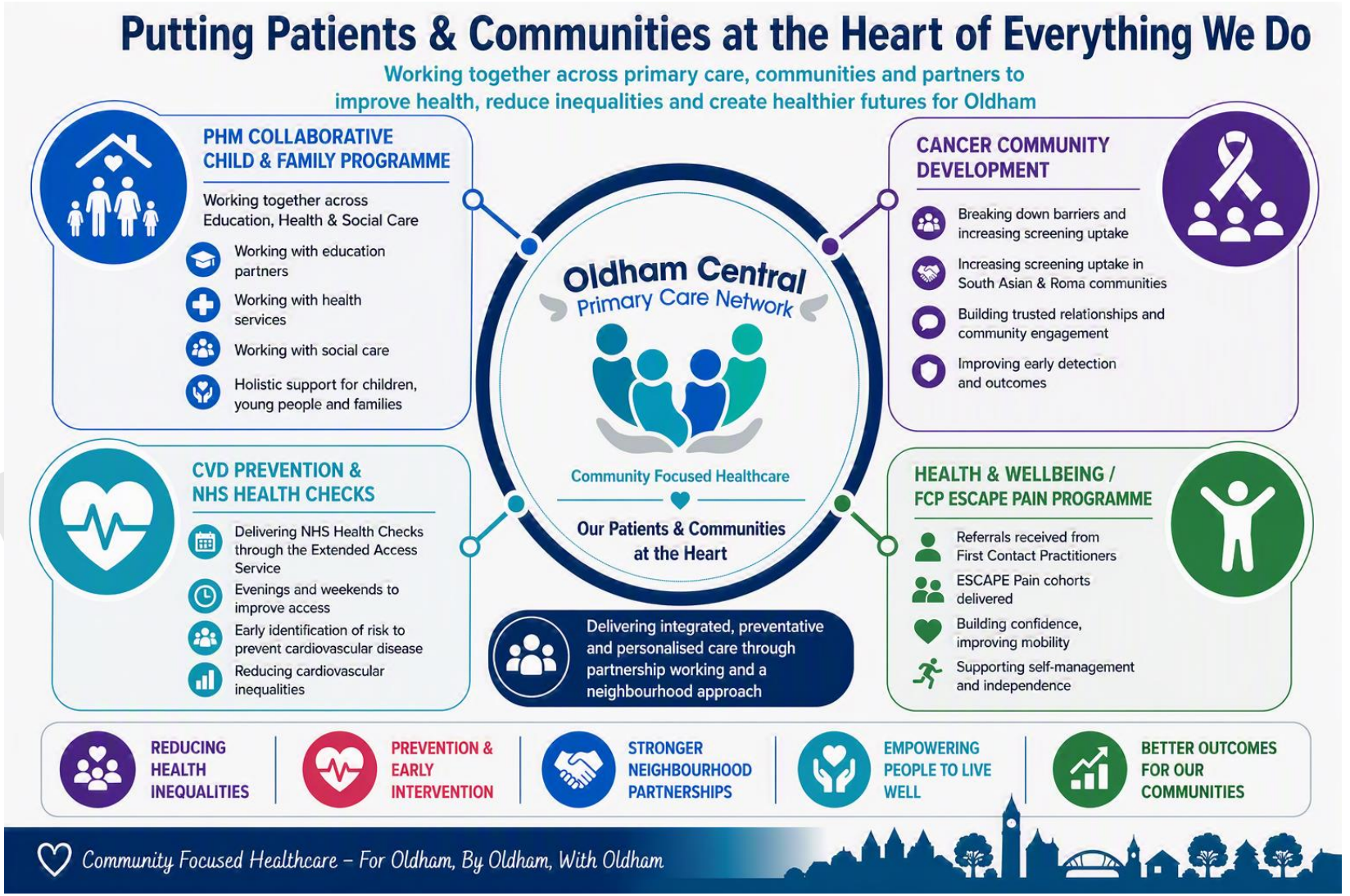
Our Joint Leadership Group brings together key provider and commissioner leads to work collaboratively on behalf of the Oldham Partnership



Glossary

A&G	Advice and Guidance
ABEN	Slide 19
ACP	Advanced Clinical /Practitioner
ADHD	Attention Deficit Disorder
ASC	Autistic Spectrum Condition
ASD	Autism Spectrum Disorder
CAMHS	Children and young People's Mental Health Service
CB	Commissioning Board
CORS	Child Outcome Rating Scale
CYP	Children and Young People
DAS	Director of Adult Social Services
DCS	Director of Children's Social Services
DPL	Delegated Place Lead
ELSEC	Early Language Support for Every Child
FGDM	Family Group Decision Making
GM	Greater Manchester
GM ICB	Greater Manchester Integrated Care Board
GMMH	Greater Manchester Mental Health
GP	General Practitioner/Practice
GTD	Go To Doc
HWBB	Health and Well Being Board
INTs	Integrated Neighbourhood Teams
JCB	Joint Commissioning Board
JCB	Joint Commissioning Board
JLG	Joint Leadership Group
LA	Local Authority
LAC	Looked After Children
LoS	Length of Stay
LTCs	Long Term Conditions
MACPT	Multi-agency Child Protection Teams
MASH	Multi Agency Safeguarding Hub
MDTs	Multidisciplinary Teams
MRI	Magnetic Resonance Imaging
MSK	Musculoskeletal
NCA	Northern Care Alliance
ND	Neuro Diverse
NEET	Not in education, employment or training
NHS	National Health Service
NHSE	NHS England
OPB	Oldham Partnership Board
PCB	Provider Collaborative Board
PCN	Primary Care Networks
PHM	Population Health Management
ROTH	Risk Outside the Home
RTT	Referral to Treatment
SEND	Special Educational Needs and Disability
SLCN	Speech, language, and communication needs
SPoA	Single Point of Access
SROs	Senior Responsible Owner
TEH	Targeted Early Help
TOG	Tameside and Oldham
VCFSE	Voluntary, Community, Faith and Social Enterprise

Case study: Oldham Central PCN



Case study: Oldham Family Hubs

Best Start Family Hubs

Building on the previous Family Hub offer, Oldham has made substantial, system-wide progress in implementing Best Start Family Hubs, moving from early rollout to a fully embedded borough-wide model They are now a core part of Oldham's Early Years and family support system, with seven hubs operating across all districts and further expansion and service integration underway. The hub network is aligned to national guidance and responding to local need.

These hubs act as one-stop access points for maternity, early-years, health visiting, and family-support services.

Key features already in place:

- Universal, one-stop-shop access for families providing access to health, education, parenting and early years support. Families can access support from pregnancy through to age 19 (or 25 for SEND):
  - Health visiting
  - Infant feeding support
  - Maternity information
  - Parenting support
  - SEND support
  - Speech and language support
  - Perinatal & child mental health

Key features already in place cont'd:

- Strengthening the delivery of the Healthy Babies programme within Family Hubs, ensuring closer alignment with public health priorities and improving coordinated access to health visiting, early years support and early intervention services
- Place based model which means families can access multiple services and support in one place that's closer to home.

Parent carer panels which ensure feedback from families with lived experience can support service improvements

Benefits of the hubs are designed to:

- Improve access to services by consolidating support in one place
- Enhance early intervention, helping families identify needs and access support before issues escalate
- Support child development, building on the legacy of Sure Start centres, which showed improved educational and health outcomes for children
- Strengthen family relationships by integrating services and putting family experiences at the centre of support

Future Plans

Oldham's future plans for Best Start Family Hubs focus on expanding services, strengthening integration, and modernising access. These plans include digital transformation and an expansion of the outreach offer which will strengthen community based engagement and enable service delivery to the wider community, particularly for families who don't normally engage with services.

Case study: Spinal Community Assessment Day

Tuesday 25 November 2025 @ Oldham Athletic Football Club

63 patients allocated appointments on the day who were on the spinal surgery waiting list, facing lengthy waits for a specialist opinion.

Alternative Concept: First of its kind event - an alternative to traditional ways of working in the NHS; a collaborative initiative between Northern Care Alliance NHS Foundation Trust and local community services aimed at improving person-centred care for individuals on the spinal surgery waiting list. This model has the potential to serve as a blueprint for future community-based "*super clinics*". The concept offered a range of resources tailored to the specific needs of the local population, including: assessments, advice, health promotion, social prescribing, rehabilitation and community & voluntary sector support (ie: MSK physiotherapy/pain management, weight management, mental health, smoking cessation and health checks). In addition, support for those whose condition was impacting their employment.

Holistic person-centred care: A patient passport was provided which they and/or the professionals populated with a treatment plan, advice, contacts for further support or anything else which was important for that person's spinal recovery. This ensured an understanding of individual needs, rather than a "*one-size-fits-all*" approach.

Critically, each patient's appointment commenced with a '*What matters to you*' conversation to ensure advice and treatment was supported by an in-depth understanding of each patients' priorities/wishes.

Reduced waiting times - Patients would ordinarily have waited much longer to be seen with usually multiple separate appointments over months. Despite being on a surgical waiting list, surgery is frequently not considered to be the long-term solution for many spinal conditions, yet patients wait months to be told this. Almost half of attendees were discharged, reducing the waiting list burden.

Different environment - Provided in a non-medicalised environment (described as calm and friendly) with same-day access to services.

Reduction in travel - Travelling far can be a barrier for patients accessing services outside of Oldham and to reduce this inequality, the specialist services were brought into the community - negating the travel to Salford Royal Hospital (to be assessed by the spinal team for only a single consultation).

Translators: The service utilised translators on the day to meet the needs of the people using the service.

Case study: Early Language Support for Every Child (ELSEC)

Since 2024, along with 9 other sites nationally, Oldham has been working to deliver the Early Language Support for Every Child (ELSEC) project to test out new ways of working to improve outcomes for children with speech, language, and communication needs (SLCN). The programme has been funded jointly by NHS England and the Department for Education.

Through the establishment of a dedicated ELSEC team, we have been able to pilot our new service within 15 schools through an 'Intensive offer,' and by providing “link” ELSEC assistants. These assistants provide training and support to school staff, to improve the early identification and support for children with SLCN. In total, 2406 school staff have been trained to date.

Last autumn, one of our participating schools, Beal Vale Primary School, hosted a celebration event to showcase the success of the programme and demonstrate the positive impact that the programme is having on our children and families. Feedback from families and staff from the school has been positive, with approximately 98% of the children making progress from their initial communication clinic session to the review at the end of the academic year.

In April 2025 (year 2) we launched a wider SLCN offer to enable all primary schools and nurseries access to support via ELSEC surgeries where staff can bring or listen to cases. These surgeries have been anonymous and advice is shared amongst those in attendance. In addition, we've also rolled out the WellComm training to all maintained primary settings.

This pilot has helped ensure children receive help at the earliest opportunity, often reducing the need for referrals into specialist services by addressing difficulties for children early in their education. It has also helped shape the national SEND Reforms and the new Experts at Hand offer which will be implemented nationally over the coming months.

Children and Young People's Neighbourhood System and Programmes

The Children and Young People's System is undertaking a number of system wide changes that are seismic in how we change delivery of our services. Oldham is leading the way in the delivery on these programmes, but it is imperative that they don't become disparate and disjointed programmes of change but complimentary and impactful to all partner delivery models.

Our vision for our Oldham Children and Young People's system is for a thriving and resilient support system where the needs of children and young people are met as early as possible and in the community in which they live, learn and play.

To achieve this, we will focus on a whole-system approach that brings together wide ranging programmes (Families First Partnership, SEND Reforms, Best Start in Life) into a neighbourhood model of support with single coherent and clear models to deliver needs led and preventative services.

To achieve this we need all partners to understand the ambitions and to embrace neighbourhood models of delivery, whether that be NHS providers and trusts, VCSFE organisations, Schools and Settings or Multi Disciplinary Teams around Primary Care. This will need a cultural shift as much as any programme change and as a partnership we will help support this approach.

The SEND Reforms will be the driver for much of this work as we build, and Oldham's local area partnership is committed to delivering **a fair, sustainable and inclusive system that identifies and supports needs early, equips partners and leads to better outcomes for our children and young people**. Families have confidence in support, and resources are used effectively to secure value for money. Our vision is grounded in a clear principle: support should be needs-led, accessed early and delivered through an integrated system, rather than driven by diagnosis or service boundaries. This means shifting from fragmented and reactive practice to a predictable, inclusive system where needs are identified and met earlier, within local mainstream provision wherever possible. We will develop our neighbourhood and district based system on these principles.

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Healthier Oldham Plan

Oldham Neighbourhood Plan 2026 to 2031

Health and Well-being Board

September 2026

Headlines

- The Oldham Neighbourhood Health Plan sets out how partners will work together over the next five years to improve health outcomes, reduce inequalities and support residents to live healthier and more independent lives.
- Neighbourhood Health is not a separate programme. It is a key component of Oldham's wider approach to public service reform and Live Well, bringing together health services, social care, housing, employment support, family services, community organisations and local assets around the needs of residents and neighbourhoods. The Plan therefore represents a collective commitment by partners to shift from organisationally-led services towards a more integrated, preventative and community-centred model of support
- The Plan recognises that successful delivery will depend on continued partnership commitment, effective governance arrangements, workforce capacity and the development of place-based investment approaches that support prevention and neighbourhood delivery.

What is Neighbourhood Health?

Neighbourhood health focuses on organising care, support and wider public services around the needs of local communities, typically serving populations of between 30,000 and 50,000 residents.

It brings together primary care, community services, mental health services, social care, housing providers, community organisations and local assets to provide more joined-up and person-centred support.

- The benefits of a neighbourhood health approach include:
- Care delivered closer to home.
- Better coordinated support across organisations.
- Earlier intervention and prevention.
- Improved physical and mental health outcomes.
- Greater independence for residents.
- Reduced health inequalities.
- More sustainable use of public sector resources.

Why Oldham Needs This Approach

Oldham continues to face:

- Lower life expectancy than national averages
- Significant health inequalities
- Rising demand across NHS and social care services
- Growing complexity of need
- Impact of deprivation, housing, social isolation and poor health
- Current service models are not sufficient on their own.

Neighbourhood Health provides a shift towards:

- ✓ Prevention
- ✓ Early intervention
- ✓ Community-led support
- ✓ More joined-up care

Our Vision

A healthier Oldham where residents receive coordinated support closer to home, enabling people to live healthier, happier and more independent lives.

Built on three foundations:

- Population Health Management
- Understanding need and targeting interventions
- Integrated Neighbourhood Teams
- Multi-disciplinary teams working around residents
- Live Well Neighbourhoods

Harnessing community assets, prevention and local strengths

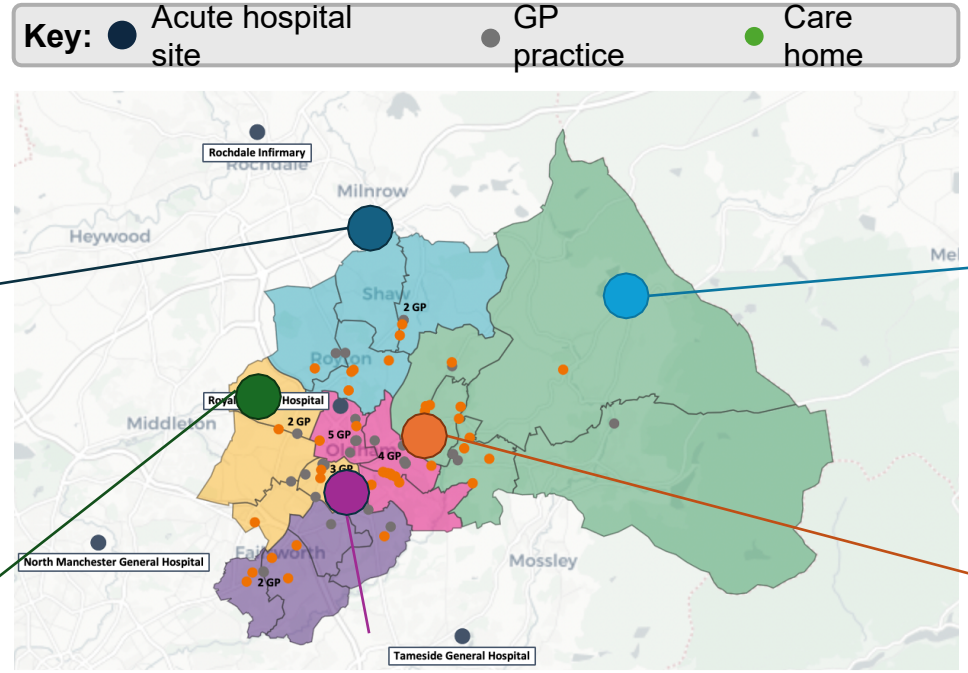
Our neighbourhood health needs

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

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

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**

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.**

What Will Change?

Residents should experience:

- Easier access to support
- Better joined-up services
- Less duplication
- Earlier help before needs escalate
- Greater focus on wellbeing and prevention
- More influence over local services

Designed with communities rather than for communities.

Key Partners

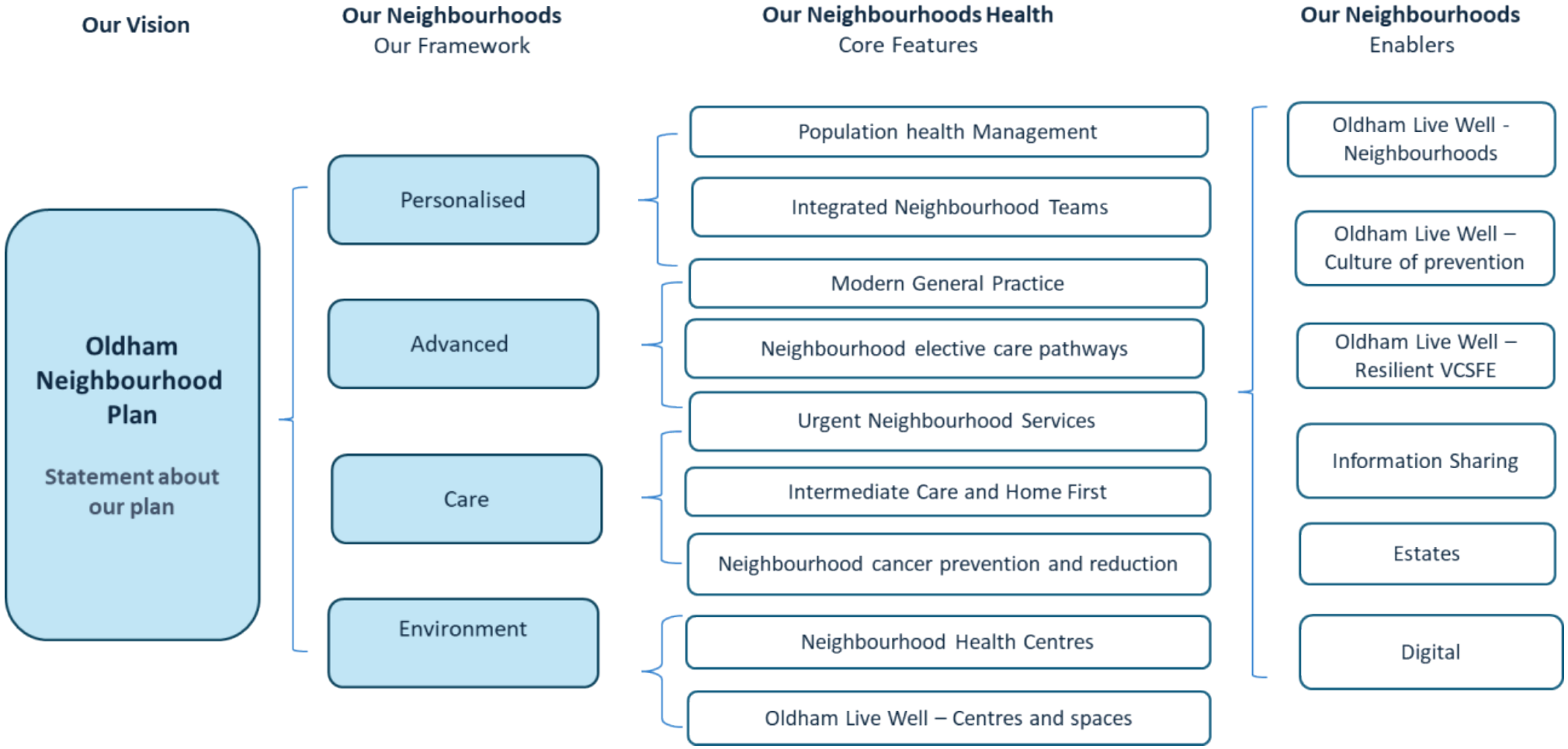
Building on existing strengths across:

- Primary Care Networks
- Pennine Care NHS Foundation Trust
- Northern Care Alliance NHS Foundation Trust
- Adult Social Care
- Miocare
- TOG Mind
- VCFSE sector
- Housing and community organisations
- Oldham Athletic and Sportstown

Working together as one place-based system

High level view of our plan

Our Neighbourhood Plan can be summarised through the key features of our framework, the core features of our neighbourhoods and the enablers which support this.



Our Neighbourhood Plan

Content of the Plan

2. Introduction and vision

Describing our vision and ambitions for Oldham, the partners in Oldham delivering this plan

2. Drivers of demand

Describing the current population health outcomes and drivers of health and care demand in Oldham;

- Oldham population and life expectancy by ward
- Our neighbourhood health needs
- Financial and activity picture
- Our operating model
- Our interventions

3. Neighbourhood Health: Our approach

Describing the three key pillars of our neighbourhood approach;

- Population Health Management
- Integrated Neighbourhood teams
- Live Well in Oldham

4. Neighbourhood Enablers

Describing the broader enablers which wrap around PHM and INTs to deliver effective neighbourhood health;

- Modern General Practice
- Urgent Neighbourhood Services
- Intermediate Care & Home First
- Standardised Community Services
- Neighbourhood elective pathways
- Neighbourhood cancer prevention and reduction

5. Support to Neighbourhoods

Describing the key infrastructure, support and culture we are developing upon which neighbourhood health teams can be built;

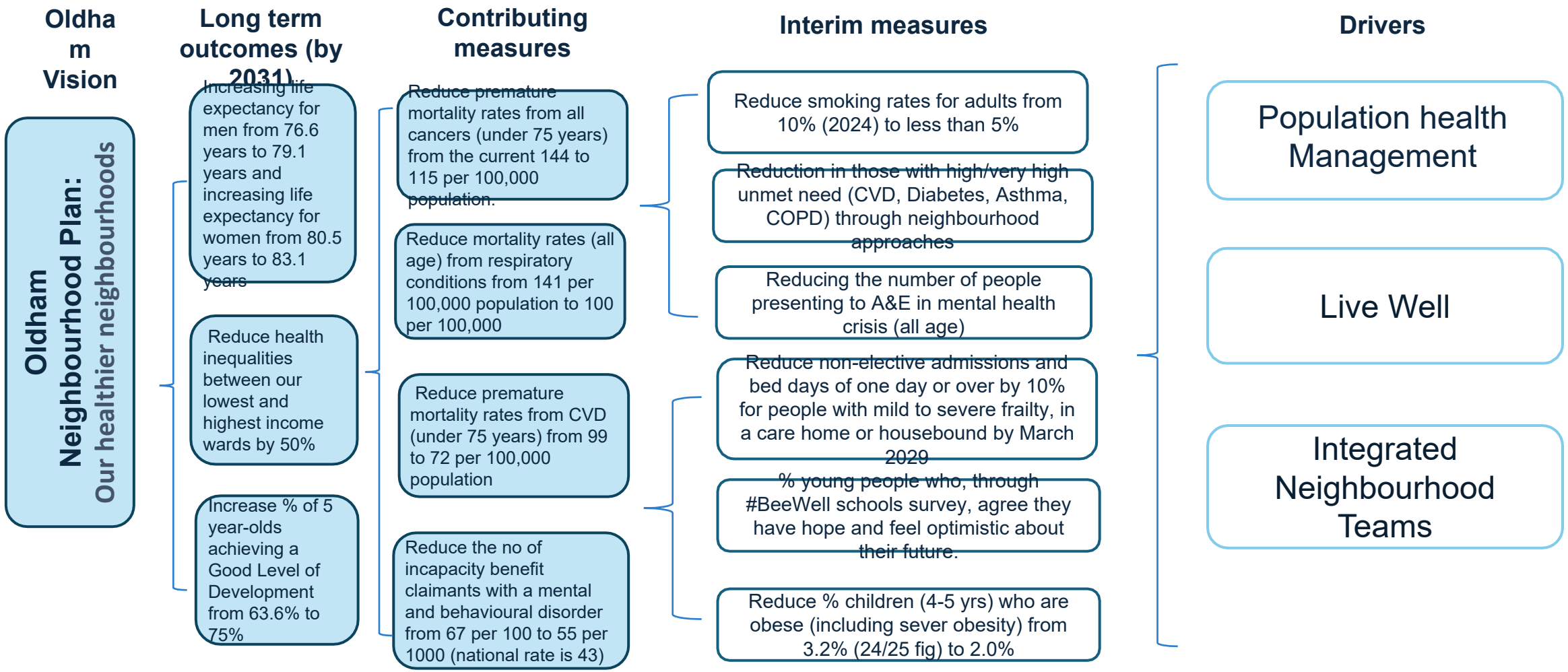
- Neighbourhood Health Centres
- Workforce and culture
- Estates
- Digital
- Information sharing

6. Governance and next steps

Describing our system governance and arrangements which will enable our neighbourhood plan

High level view of our plan - measurement

Our Neighbourhood Plan can be summarised through the key features of our framework, the core features of our neighbourhoods and the enablers which support this.



Delivery Roadmap

- Year 1 (2026/27)Build on foundations
- Year 2 (2027/28)Establish Integrated Neighbourhood Teams and expand prevention
- Year 3 (2028/29)Scale successful models across Oldham
- Year 4 (2029/30)Neighbourhood teams operating across all neighbourhoods
- Year 5 (2030/31)Mature and sustainable neighbourhood health model established

Key Risks and Dependencies

Success depends upon:

- Sustainable investment
- Continued partner commitment
- Workforce capacity
- Ability to demonstrate impact
- National policy and funding environment

Strong governance and partnership working will be essential.

Recommended HWBB Role

The Health and Wellbeing Board will:

- Provide strategic oversight
- Champion neighbourhood health across the system
- Ensure alignment with wider priorities
- Monitor progress annually
- Support delivery of shared outcomes
- This provides formal place-based endorsement of Oldham's response to Greater Manchester and national expectations

Questions for HWB

Does the Board believe the proposed vision and outcomes are sufficiently ambitious for Oldham?

Are there any population groups or communities that require greater focus within the plan?

What would success look like from a resident perspective in five years' time?

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Oldham Council

Report to Health & Wellbeing Board

Northern Care Alliance: Current Position, Improvement Activity and System Response

Portfolio Holder: All Group Leaders

Officer Contact: Mike Barker, Deputy Chief Exexutive (Health & Care)

Report Author: Mike Barker, Deputy Chief Executive (Health & Care)
Email: mike.barker@oldham.gov.uk

September 2026

Reason for Decision
This report is to brief members of the Health and Wellbeing Board on the current situation at the Northern Care Alliance following various media reports.

Executive Summary
This report provides the Health and Wellbeing Board with an overview of recent concerns relating to the Northern Care Alliance NHS Foundation Trust (NCA), the actions being taken by the Trust and the wider NHS system, and the implications for services used by Oldham residents.

The report has been prepared following significant national and local media coverage concerning patient safety, governance, organisational culture and the management of concerns within the Trust. It also reflects recent regulatory action taken by NHS England and the Care Quality Commission (CQC).

Recommendations
The Health and Wellbeing Board is asked to:

1. Note the contents of this report.
2. Note the actions being taken by the Northern Care Alliance, NHS Greater Manchester and NHS England North West.
3. Note that there are currently no proposed service changes affecting Oldham residents as a consequence of the improvement programme.
4. Request a further update once the Northern Care Alliance Integrated Improvement Plan has been finalised and agreed with regulators.

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Health & Wellbeing Board September 2026

Northern Care Alliance: Current Position, Improvement Activity and System Response

1 Background

1.1 The Northern Care Alliance NHS Foundation Trust was established in 2021 and provides hospital and community services across Oldham, Rochdale, Bury and Salford, including services delivered from The Royal Oldham Hospital.

1.2 Over recent months a number of concerns relating to patient safety, quality governance, organisational culture and leadership have received increased public attention through media reporting and regulatory scrutiny. These concerns have included:

- Historic failures in spinal surgery services that were examined through the independent Carlo Breen review.
- Concerns within gynaecology services relating to governance, administration and patient follow-up.
- Issues relating to incident management, complaints handling and organisational learning.
- Concerns regarding Freedom to Speak Up arrangements and whether staff consistently feel able to raise concerns.
- Ongoing challenges in urgent and emergency care, patient flow and workforce pressures.
- Wider concerns regarding organisational leadership, governance and improvement capacity.

1.3 Some of these issues relate to historic events and services, while others concern how effectively the organisation identifies, manages and learns from risks across the Trust. The cumulative effect has resulted in increased regulatory oversight and public concern.

1.4 Many of the issues now receiving public attention were already subject to varying degrees of regulatory oversight, review activity and improvement programmes before the recent media coverage. What has changed is the level of public visibility, the accumulation of concerns across multiple service areas and the subsequent decision by regulators to introduce enhanced improvement and assurance arrangements.

2 Public and Stakeholder Concerns

2.1 Recent media coverage has generated significant concern amongst patients, staff, residents, elected members and partner organisations across Greater Manchester. Concerns expressed publicly have focused on several key themes, including patient safety, delayed diagnosis and treatment, organisational culture, incident investigation, complaints handling, workforce pressures and whether staff feel able to raise concerns through Freedom to Speak Up arrangements.

2.2 For residents and patients, the primary concern is whether services remain safe and whether any historic or current failings may have affected patient care. There is also understandable concern regarding the pace of improvement and whether lessons from previous incidents and reviews have been embedded consistently across the organisation.

2.3 For staff, issues raised publicly have included organisational culture, leadership visibility, governance arrangements and confidence in internal processes for escalating concerns. These themes have featured in both regulatory findings and Freedom to Speak Up discussions over recent years.

2.4 For elected members and system partners, the principal concern is ensuring that residents continue to receive safe, high-quality care whilst maintaining confidence that identified issues are being addressed openly, transparently and at pace through robust improvement arrangements and independent oversight. This has led to requests for additional briefings, assurance and ongoing reporting from both the Northern Care Alliance and NHS Greater Manchester.

2.5 Whilst the concerns are serious, NHS Greater Manchester, NHS England and the Northern Care Alliance have all emphasised that patients should continue to attend appointments and seek healthcare services as normal unless contacted directly by the Trust. There are currently no planned service changes associated with the improvement programme

3 Regulatory and External Review Findings

3.1 Over the last two years the Northern Care Alliance has been subject to a range of reviews and oversight processes relating to quality, safety and governance. These have included:

- Independent review of spinal services.
- Rapid Quality Reviews relating to spinal and gynaecology services.
- NHS England quality oversight activity.
- Care Quality Commission inspections and warning notices.
- Wider governance and leadership reviews.

3.2 In summer 2026 NHS England issued formal enforcement undertakings to the Trust. These identified concerns relating to quality governance, management of risk and progress in addressing known issues within certain clinical services.

3.3 The Care Quality Commission has also issued a Section 29A Warning Notice following its Well Led assessment. The notice identified concerns relating to:

- Investigation and learning from patient safety incidents.
- Complaints management and organisational learning.
- Oversight of Freedom to Speak Up arrangements.
- Governance and risk management processes.
- Workforce wellbeing and equality-related workforce issues.

4 What the Northern Care Alliance is Doing

4.1 The Northern Care Alliance has acknowledged the seriousness of the issues raised and has stated publicly that patient safety remains its primary concern.

4.2 Key actions being undertaken by the Trust include:

Integrated Improvement Plan

4.2.1 The Trust is developing a single Integrated Improvement Plan which will bring together all actions arising from:

- NHS England undertakings.
- Care Quality Commission requirements.
- Independent reviews.
- Existing patient safety and governance improvement activity.

4.2.2 The intention is to replace multiple separate programmes with a single framework that can be monitored by regulators, partners and the Trust Board.

Changes to Clinical Leadership

4.2.3 In April 2026 the Trust introduced a new clinically-led operating model designed to place greater clinical leadership at the centre of decision-making and quality improvement activity.

Freedom to Speak Up and Culture

4.2.4 The Trust has appointed an independent senior nurse to strengthen arrangements for handling staff concerns and ensuring that any immediate patient safety issues are escalated appropriately.

External Review Activity

4.2.5 Further independent reviews of spinal and gynaecology services are planned, with findings expected to inform the next phase of improvement work.

Leadership Arrangements

4.2.6 The Trust is currently managing a period of leadership transition. Arrangements are being put in place to secure additional executive leadership support while improvement activity continues.

5 What NHS Greater Manchester is Doing

5.1 NHS Greater Manchester, as the Integrated Care Board, has significantly increased oversight arrangements relating to the Northern Care Alliance. This includes:

- Ongoing quality surveillance and assurance activity.
- Additional quality review meetings.
- Scrutiny of progress against improvement actions.
- Monitoring of patient safety risks.
- Monitoring of delivery against regulatory requirements.
- Regular reporting to NHS Greater Manchester governance structures.

5.2 NHS Greater Manchester has stated that its immediate focus is ensuring safe services for patients while supporting the longer-term programme of organisational improvement.

6 What NHS England North West is Doing

6.1 NHS England North West is providing formal regulatory oversight of the Trust's improvement programme. Key elements include:

- Formal enforcement undertakings.
- Establishment of enhanced oversight arrangements.
- Creation of a System Improvement Board.
- Monitoring progress against agreed actions and milestones.
- Oversight of external reviews.
- Ongoing assessment of clinical quality, governance and leadership improvements.

6.2 NHS England will therefore play the principal role in assessing whether the Trust delivers the required improvements and complies with regulatory requirements.

7 Governance and Accountability

7.1 It is important to recognise that the Northern Care Alliance is an NHS Foundation Trust with its own Board of Directors and statutory responsibilities for the quality and safety of services it provides. Oversight of provider quality, performance and regulatory compliance sits through established NHS governance arrangements involving the Trust Board, NHS Greater Manchester, NHS England and the Care Quality Commission.

7.2 Locality (Oldham) and place-based partnerships have an important role in understanding the implications for residents and local services but do not undertake the provider governance functions of the Trust or system regulators.

8 Implications for Oldham

8.1 The concerns outlined above have understandably generated significant interest amongst Oldham residents, elected members, Healthwatch and wider system partners. Given the importance of Northern Care Alliance services to the borough, local partners have sought ongoing assurance regarding patient safety, service continuity and delivery of the improvement programme.

8.2 The Royal Oldham Hospital remains open and continues to provide services to local residents. There are currently no planned service changes linked to the improvement programme. Patients are being advised to continue attending appointments unless contacted directly by the Trust.

8.3 Oldham Council, NHS Greater Manchester Oldham locality partners and elected members have sought assurances that:

- Services provided to Oldham residents remain safe.
- Any historic or current patient harm is identified and addressed appropriately.
- Improvement activity is robust and transparent.
- Local partners are kept informed of progress.
- Public confidence is maintained through clear communication.

8.4 Since the recent concerns entered the public domain, local partners have sought assurances from both the Northern Care Alliance and NHS Greater Manchester regarding the implications for Oldham residents and services. This has included requests for information relating to patient safety, service continuity, governance arrangements, regulatory oversight and delivery of the Trust's improvement programme. These matters will continue to be monitored through existing partnership, locality, Health and Wellbeing Board and health scrutiny arrangements

8.5 Given the importance of NCA services to Oldham residents, continued monitoring and engagement through local partnership and scrutiny arrangements will remain necessary as the improvement programme progresses.

9 Conclusion

9.1 The concerns identified within the Northern Care Alliance are serious and have resulted in significant regulatory intervention and heightened public scrutiny. However, a substantial programme of improvement, oversight and external assurance is now underway involving the Trust, NHS Greater Manchester, NHS England North West and the Care Quality Commission.

9.2 There is currently no evidence of any planned reduction in services for Oldham residents as a consequence of this work. The focus of all organisations involved is on maintaining safe services in the short term while delivering sustained improvements in quality, governance, leadership and organisational culture over the longer term.

10.0 Financial Implications

10.1 None for the Council.

11.0 Legal Implications

11.1 None for the Council at this stage as it is an NHS accountability.

12 Procurement Implications

12.1 At this stage none for the Council. However, the Council jointly procures/commissions some services from the NCA with the ICB. The Council will keep under review the situation and will bring forward nay proposed changes if that becomes necessary.

13.0 **Equality Impact, including implications for Children and Young People**

13.1 No

14 **Key Decision**

14.1 No

15 **Key Decision Reference**

15.1 N/A

16 **Background Papers**

16.1 N/A

17 **Appendices**

17.1 None

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

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