Appendix A: Detailed Project Information

Start Well: Avoidable Admissions

The Case for Change

There is increasing demand in the local health and care system which has resulted in significant attendances and admissions in an acute setting (i.e. hospitals) for children & young people (particularly under 5's). High volumes of low acuity activity is being seen at emergency departments.

What does our intelligence tell us?

At a GM Level:

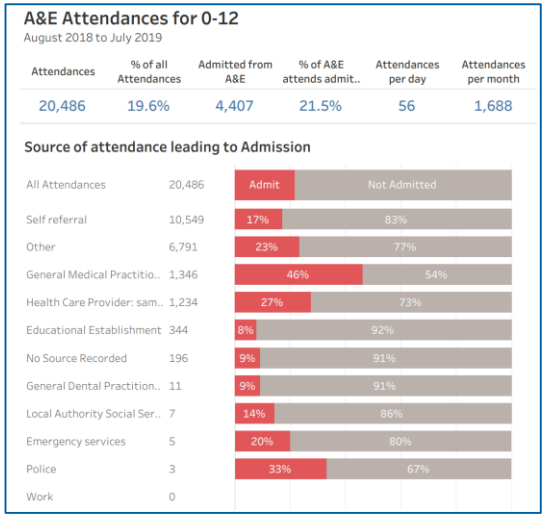
- Over 20% of Paediatric A&E attendances have no treatment and no investigation, with a further approximately 75% of attendances having low level investigation and low level treatment that could potentially be provided out of hospital;
- The Northwest has the 2nd highest rota gaps in England for Paediatrics. Greater Manchester has a 20.3% rota gap for Tier 2 (middle grade) compared to 13.7% nationally;
- There are inconsistencies in performance across a number of areas in paediatrics. E.g. on average 4% of paediatric attendances at A&E are waiting longer than 4 hours however in some places this is as low as 0.2%;
- Clinical outcomes across GM are variable with speciality level data illustrating inconsistent practice across organisations;
- 9 of the 12 GM CCGs have standardised rates of admission statistically significantly above the national average for child emergency admissions in Asthma;

At a Local Level:

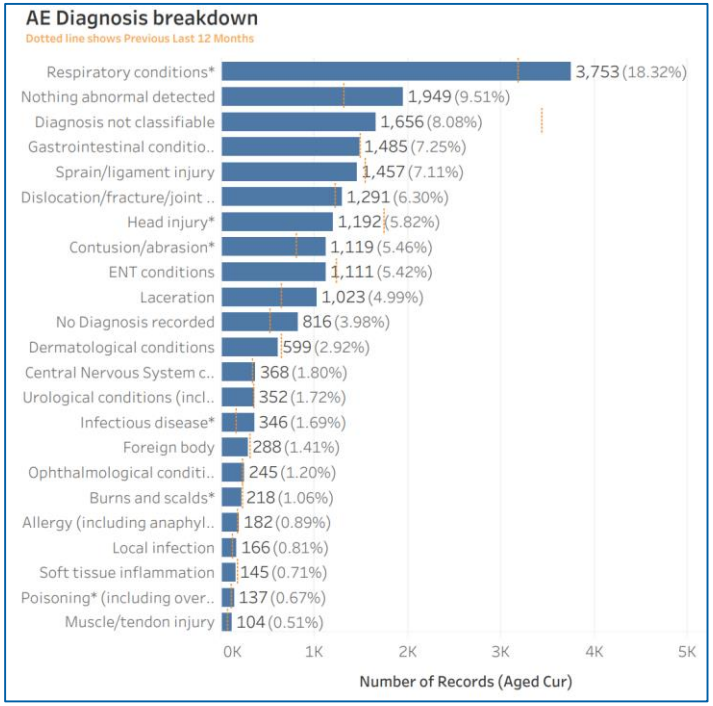
Attendance & Admissions (Period August 2018 – July 2019

Attendances

- A significant number of all attendances at A&E are for 0-12 year olds (19%, 20,486) and of these 21.5% are admitted.
- The greatest proportion of attendance are those that self refer with only 17% of those leading to admission.
- A significant proportion of children and young people attending A&E did not have an identifiable condition and did not receive any treatment (32.02%, 6559). 23.1%, (11549) were discharged with no follow-up treatment.



- The highest presentations are those with respiratory condition, 18% of the total presentations.
- The second highest diagnosis of 9.5% are those children with nothing abnormal detected suggesting that they need not be seen in an Emergency Dept.

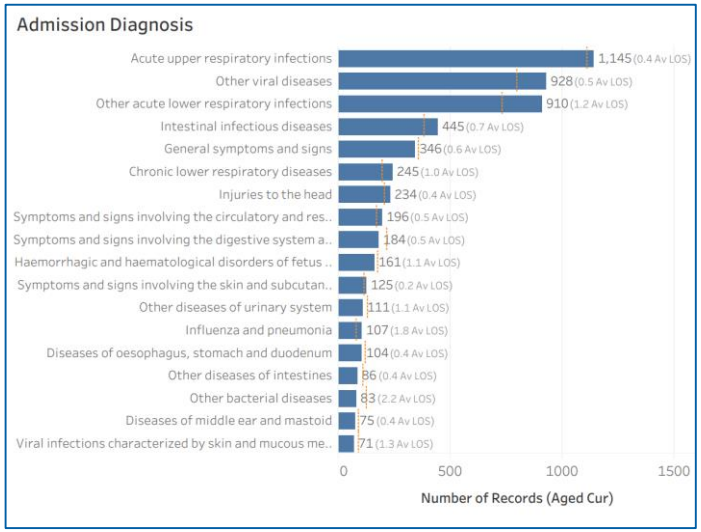


Admissions

- 65% (25,674) of admissions come from A&E Dept. and 25.63% (1781) direct from the GP with 59.94% (4,166) of those children having zero length of stay. These admissions cost the system approximately £3m. This raises the question as to whether those children needed admission. Further detail is required to fully understand this picture.
- Respiratory admission make up the highest percentage of admissions (16.48%, 1145), with an average LoS of 0.4,m costing the health system an estimated £825k.

Admissions by Length of Stay

LOS (group)	Admissions	% of Total	Avg. Tariff
0	4,165	59.94%	£720.66
1	1,711	24.62%	£852.20
2+	1,073	15.44%	£1,473.96
Grand Total	6,949	100.00%	£869.36



What our Patients and Communities Have to Say

The themes from recent surveys conducted in 2019 with patients attending A&E highlighted:

- Challenges in accessing services in a timely;
- A lack of health literacy for the population and professional (knowing where to go for what condition and what services are open and when);
- Flexibility of 111 to tailor their response (use of algorithms/key trigger words);
- Risk aversion/confidence of General Practice in treating young children.

Aim and Objectives

Aim: To reduce unnecessary hospital admissions for children and young people (age 0-12), particularly those with long term conditions This will be done through connecting care for children enabled by co-operative partnerships between acute and community care with an emphasis on condition-specific pathways of integrated care across the system. Specific targets:

- Reduce **A&E attendances** for 0-12 year olds at the ROH by **6,823 cases** over the next 3yrs.
- Reduce **Non-Elective admissions** for 0-5 year olds at the ROH by **562 cases** over the next 3yrs. 80% of this target (450) includes attendance at the O&A Unit at the ROH.
- Reduce **Outpatient Appointments** for 0-5 year olds at the ROH by **2,800** over the next 3yrs

Objectives:

- Develop a model for preventing avoidable admissions including GP / Paediatrician multi-disciplinary teams; Children's Community Nursing Teams (CCNTs); specialist nurses in the Emergency Department; peer support engagement in the community
- Implement consistent care pathway for **respiratory**, **gastrointestinal** and **allergy** conditions including prevention and transition.

High Level Outcomes (Oldham Cares Framework)

Service Quality/Health of the System:

- Access to the right care at the right time e.g. Parents will choose to access services locally when their child has an acute illness and have confidence in those services
- Individuals have the best experience possible when using system
- Individuals and families have access to high quality treatment and care e.g. CYP with LTC's or complex health problems will be managed effectively in Primary Care

Effective Prevention and Treatment:

- Support people to self-care and self manage where appropriate e.g. Increased patient/ family knowledge and confidence in managing minor illness and LTC

Healthy Population:

- Children have the best start in life
- individual and families are empowered to take control of their own health
- Everyone has the opportunity and support to improve their health and wellbeing, including the most disadvantaged

Links to LTP Commitments

- Reducing Pressure on Emergency Hospital Services
- Improving care for children with long-term conditions, such as asthma, epilepsy, diabetes and complex needs

Resources

Sponsor: Jill Beaumont

Clinical Lead: Einas Ben Hamieda (TBC)

Project Manager: Jill Beaumont

Project Contributors: Angela Welsh (Commissioner), Danine Townsend (CCNT Manager), Penny Martin (Divisional Manager Women's and Children's), Sarah Cooke (Homestart); Chloe Hardman (Business Partner South Cluster), Atta Hanfi (Business Partner Central), Zia Jalal (GP lead Central), Elizabeth Roscoe (GP Lead South), Lisa McGarty (PMO Admin)

Stakeholder Engagement Channels

- Homestart peer volunteering programme to engage with the local community
- One off survey completed by the CCG in A&E
- Utilisation Management Company survey in A&E
- Ongoing feedback through specialist nurse reporting in A&E

Interface with other Programmes

GM Health and Wellbeing Strategy: Children and Young People, Objectives 2 (Early years and school readiness) 3 (Mental health and resilience) & 6 (Preventing avoidable admissions, particularly

GM Plan Priorities: 1. School Readiness and 2. Healthy children and young people

Achievements to Date:

Enhanced specialist nurse provision; Volunteer Co-Ordinator ,Model with Peer Support; Draft Asthma Standards; Community Children's Nurse Team Referral model; Open GP access to a paediatrician advice

	2019/20		2020/21				2021/22				2022/23				2023/2024			
Deliverables/Milestones	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
Achievement To Date																		
Weekly paediatric MDT's in each pilot clusters																		
Offer MDT to all clusters																		
Targeted intervention to non-urgent under-5's who are 'frequent-flyers' to A&E.																		
Implementing a Rapid Access Clinic																		
Shared record of cases accessible in provider systems																		
Integrated seamless pathways for respiratory /allergy and gastro (model)																		
Pathway in place																		

Top Risks/ Issues

- Lack of clarity around funding envelope and profiling
- Project resources to deliver the outputs in the timeframe
- GM challenge on achievement of proposed plan and targets (Initial investment case outputs were revised during mobilisation)
- Funding post 2021 (e.g. rolling to MDT to all clusters)
- Buy-in and commitment to new ways of working
- Evidence/evaluation to demonstrate effectiveness

Thriving Communities: Insight Project

Context

Early intervention and prevention is beneficial but hard to quantify, target and measure and track. The lean operating model of the VCFSE hasn't always led itself to high levels of detail and rigour. The insight workstream introduces a number of key products which will enable us to give more grounding, rationale and an evidence based approach.

In Oldham we are trying to get a measure of how areas function as communities, and what the impacts of that are. This should help us target communities where community capacity needs to be improved.

The insight workstream identifies and describes existing community assets, builds good practice, captures evidence of impact and change, and conducts further research through innovative approaches. In doing so, it will establish a detailed, rich and dynamic intelligence resource for Oldham, with a much wider relevance for other programmes and work streams. The three key workstreams of this project are as follows:

The Thriving Communities Index: This helps us understand how the borough is progressing as a whole and how we are impacting residents in terms of the 3 main tranches of indicators:

- Place – the indicators of the area e.g. greenspace or community assets
- Residents – the indicators population e.g. education attainment or smoking prevalence
- Reactive demand – the impact of the above on services e.g. safeguarding referrals or police callouts.

Community Asset Mapping: Identifying and engaging community assets to understand the make-up of the community capacity across the borough. This will start with Oldham West and rolling out on a cluster by cluster basis.

Community Research: Developing an approach to assessing and surveying how Thriving Oldham is (in terms of the wellbeing of residents across the borough) and the impact the programme has upon that.

Aim and Objectives

Aim: To establish a detailed, rich and dynamic intelligence resource for Oldham programme with a much wider relevance for other programmes and work streams.

Objectives:

- To deliver direct improvement to the health and wellbeing of all people living in Oldham and in doing so help address health inequality.
- To adopt an asset based approach to commissioning that draws upon the strengths of individuals, families and communities and supports a thriving VCSFE across the borough.
- To work with the VCSFE to develop a sustainable approach to funding of the sector.
- To maintain and grow community capacity across the borough

High Level Outcomes (Oldham Cares Framework)

Healthy Population

- Thriving Communities which promote, support and enable good physical and mental health and well-being.
- Individuals and families are empowered to take control of their health.
- Everyone has the opportunity and support to improve their health and wellbeing, including the most disadvantaged.

Effective Prevention and Treatment and Care

- Mental health is central to good health and as important as physical health
- Support people to self manage and self care where appropriate

Service Quality/Health of the System

- Individuals and families have the best experience possible when using services
- Health and care system is financially sustainable.

Resources

Sponsor: Rebekah Sutcliffe

Clinical Lead: Dr Hollie Francis

Programme Manager: Peter Pawson

Project Contributors: VCSFE, Policy Lead, Finance, Communications, Health Improvement, Start Well Lead, MHIG Lead, Urgent Care PM, Core and Extended Primary Care PM, Managing Director Community Health and Adults Social Care, ICP and Alliance Forum.

Stakeholder Engagement Channels

A multi partner Thriving Communities and Health Improvement Delivery Group has been established with positive engagement from all members

Interface with other Programmes

GM Plan Priorities:

- Become an age-friendly city, tackle isolation and loneliness and encourage community connectiveness

Achievements to Date: Local Area Research and Intelligence Association (Laria) Awards 2019: for Best use of data. Over 80 colleagues from different organisations have access to the TC Index. Several presentations on the TC Index have been delivered in different forums.

	2019/20		2020/21				2021/22				2022/23	
Deliverables/Milestones	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**
You and Your Community Survey (community research)	Draft spec and sign off	Release to market and assess responses	Award contract and compose questions	Socialise questions and sign off								
Thriving Communities Index	Pre step tool survey and consultation	Analyse data sets and agree methodology	Process data, refine outcomes and phase 1 report									
Community Asset Mapping	TBC											

Top Risks/ Issues

- Funding streams available to community groups and residents are reduced, increasing the demand of more formal health and social care, e.g GP, A&E admission
- Insufficient stakeholder commitment from all Health Care system leaders, as well as non-health partners, is not gained
- Thriving Communities index may not deliver its ambition
- Socio-economic changes globally and nationally, e.g. Brexit, could change or increase the demand profile of need (e.g. rising levels of child poverty). This could skew the impact of the programme
- Health IG requirements prevent the level of accuracy needed (e.g. 6 digit postcode whereas health IG limits to 4).

Thriving Communities: Social Prescribing

The Case for Change

Social Prescribing is a practice that enables General Practitioners and other frontline healthcare professionals to encourage and empower residents to co-design solutions to remediate their health and well-being concerns. The practice uses both a holistic and Strength based approach by linking residents to existing support networks. In turn, this has the potential to alleviate the stress on health care system as increasing number of residents will be 'self-managing'.

What Our Intelligence Tells Us

Growing healthcare needs are putting a huge financial strain on NHS resource and budget. Health and well-being strains on the NHS include: increasing number of people living with mental health conditions, loneliness, isolation and obesity. Social Prescribing plays a vital part in supporting a sustainable NHS future by reducing pressure on the primary care sector and enabling it to deploy its resources where they are needed most.

GPs and health care professionals recognise that good health and well-being of individuals is determined by a range of social, economic and environmental factors. Emerging evidence suggests there is a correlation between practicing social prescription to the improved health and well-being outcomes for patients. Social prescribing connect individuals to their community for support.

Case Study: Social Prescribing (Rotherham)
A study of a scheme in Rotherham (a liaison service helping patients access support from more than 20 voluntary and community sector organisations), showed that for more than 8 in 10 patients referred to the scheme who were followed up three to four months later, there were reductions in NHS use in terms of accident and emergency (A&E) attendance, outpatient appointments and inpatient admissions.

Local Context

The Oldham Public Health Annual Report 2017 is an independent review on the state of health and well-being in Oldham. The research behind the report depicts a positive image of the health and well-being for the average person living in Oldham. However, It recognises that the statistics for health and well-being in Oldham are not improving as fast as other Local Authorities in the country.

The report recognises that health and well-being is not static and can be influenced and changed through positive policy initiation and implementation on all aspects of a person's life including employment policies, the distribution of income, policies that affect the quality of education, financial support for parents, air quality and food production.

The Oldham Social Prescribing Innovation Partnership is a pioneering three-year contract on behalf of Oldham Cares using a new commissioning model and procurement approach. This Partnership is thought to be one of the first for the public sector in England. The commissioning model draws power from the social value act and focuses on innovating and iterating the service model through coproduction with partners and residents to get the best service and offer possible to meet resident's needs.

A consortia of voluntary, community faith and social enterprise (VCFSE) partners works in partnership with the local health and care arena specifically - Oldham Cares, Oldham Council, Action Together (lead), Mind, Age UK, Positive Steps and Altogether Better. The Partnership focuses on developing social prescribing – specifically linking in residents/patients who have 'more than medical' needs e.g. social isolation, loneliness, low level mental health or physical health.

Aim and Objectives

Aim: To deliver direct improvement to the health and wellbeing of all people living in Oldham and in doing so help address health inequality.

Objectives:

- To adopt a strength based approach to commissioning that draws upon the strengths of individuals, families and communities and supports a thriving VCSFE across the borough.
- To work with the VCSFE to develop a sustainable approach to funding to the sector.
- To further connect and maximise the impact of the VCSFE and help align it to the needs of residents.
- To maintain and grow community capacity across the borough.
- To develop an approach to social prescribing that supports the whole of the Oldham Cares system and bridge dependencies with other elements of reform such as place based integration.
- To deliver deflections for primary care and A&E.

High Level Outcomes (Oldham Cares Framework)

Healthy Population

- Thriving Communities which promote, support and enable good physical and mental health and well-being.
- Individuals and families are empowered to take control of their health.
- Everyone has the opportunity and support to improve their health and wellbeing, including the most disadvantaged.

Effective Prevention and Treatment and Care

- Support people to self manage/self-care where appropriate

Service Quality/Health of the System:

- Access to the right care at the right time.
- Individuals and families have the best experience possible when using services.
- Health and care system is financially sustainable.

Links to LTP Commitments

- Supporting the development of Primary Care Networks
- Supports the ambition for 750,000 people to have a personalised care and support plan to manage their long term health conditions.
- Supports the ambition for social prescribing: Over 1,000 trained social prescribing link workers will be in place by 2020/21 rising further by 2023/24, with the aim that over 900,000 people are able to be referred to social prescribing schemes by then.
- Supports the ambition for social personal health budgets: 200K people will have a personal health budget so they can control their own care, improve their health experiences.
- Supports the ambition to develop the skills and behaviours of 75,000 clinicians and professionals through practical support to use personalised care approaches in their day-to-day practice.

Resources

Sponsor: Rebekah Sutcliffe

Clinical Lead: Dr Hollie Francis

Project Manager: Pete Pawson

Project Contributors: VCSFE, Policy Lead, Finance, Communications, Health Improvement, Start Well Lead, MHIG Lead, Urgent Care PM, Core and Extended Primary Care PM, Managing Director Community Health and Adults Social Care, ICP and the Alliance Forum.

Stakeholder Engagement Channels

- A multi partner Thriving Communities Delivery Group has been established and is now into its 9th month with positive engagement from all members.

Interface with other Programmes

GM Plan Priorities:

- To build a Greater Manchester framework and support capacity and capability building for person and community centred approaches.
- Increased work with VSCFE to build stronger communities

Successes to Date: This Innovation Partnership is thought to be one of the first for the public sector in England The partnership encompasses in excess of 12 team members. It has supported over 300 people to date with referral routes from across the system; primary care, social care, acute and self-referral, with a plan to support thousands over the course of the partnership. This is already delivering benefits to the health and care system. In the cohort of people being targeted and supported, early indications are that GP appointments are being reduced by 62.5% and reductions in accident and emergency are in excess of 90%.

	2019/20		2020/21				2021/22				2022/23				2023/2024			
Deliverables/Milestones	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
Deliver of service to Oldham people																		
Build connections with other care settings																		
Sustainability case, commissioning and transition to BAU																		

Top Risks/ Issues

- Funding streams available to community groups and residents are reduced, increasing the demand of more formal health and social care e.g. GP, A&E admission.
- Insufficient stakeholder commitment from all Health Care system leaders, as well as non-health partners, is not gained.
- Thriving Communities index may not deliver its ambition.
- Socio-economic changes globally and nationally, e.g. Brexit, could change or increase the demand profile of need (e.g. rising levels of child poverty) could skew the impact of the programme

Thriving Communities: Workforce & Strength Based Approaches

The Case for Change

Adoption of a strength based approach to care and support encourages individuals and communities to utilise people's skills, networks and community resources (their assets) to support residents to improve their health and well-being. Individuals and groups that are the most socially and economically disadvantaged largely benefit from asset based community approach.

What Our Intelligence Tells Us

Local authorities across the country have adopted an strength based approach to influence and improve the health and well-being of residents through a concept known as 'social prescription'. Voluntary, Community, Social, Faith and Enterprise organisations (VSCFE) are committed to adopting a strength based approach and workers in voluntary organisations are co-located in GP surgeries to offer non-medical support and connect residents to their assets, to alleviate the symptoms of present health conditions.

Community groups have utilised communal space to mobilise themselves, have a meeting space, discuss local complex and important issues and feedback to their local authority. The strength based approach then empowers communities to engage in 'self-care'.

Local Context

In Oldham we have agreed to develop a strength based approach delivery model. To enable this requirement to be fulfilled, it is recognised that staff will need to have different conversations at the front line than they currently do. For some this will be a significant shift as the dynamic will completely change from the traditional way of fixing people to support them to become more self-accountable.

Oldham Council, on behalf of Oldham Cares, is therefore seeking to engage a provider to work with us to codesign a development programme which will be used as part of a toolkit in order to equip our front-line staff to have those different conversations. We believe that working in this way will reduce demand on multiple professionals by minimising the duplication of assessments, provide better outcomes for individuals and enable a one system approach to changing the way we assess for and provide services, ensuring we are able to target services and resources more effectively.

We need to fully embed this as an approach, so it becomes the norm i.e. the way we do things around here. It is therefore also recognised that leadership including elected members will require support to develop this new way of working in order to provide environments which are conducive for this way of working to flourish. This tender process will start in October 2019.

Aim and Objectives

Aim:

The leadership and workforce workstream will help reshape the way leadership and workforce development is undertaken across the borough to enable our staff and leaders to more consistently adopt an asset and place based approach and operate in a system that supports that. This will complement the wider GM Leaders work and establishment of the co-operative workforce aspired to in the Oldham Plan.

Objectives:

- To adopt an strength based approach to commissioning that draws upon the strengths of individuals, families and communities and supports a thriving VCSFE across the borough.
- To further connect and maximise the impact of the VCSFE and help align it to the needs of residents.
- To develop an approach to social prescribing that supports the whole of the Oldham Cares system and bridge dependencies with other elements of reform such as place based integration.

Case Study: Strength Based Community Development (Oldham, Action Together)

Rani came to Oldham from India three years ago and became widowed. Rani has a one-year-old daughter. Her GP referred her for social prescribing due to mild depression. She contacted Action Together, the organisation supporting the Social Prescribing scheme in Oldham and was linked up to a knitting group at her local community centre. Her connector found a play and stay session for her daughter and Rani went on to start further education with Oldham Lifelong Learning Service and is now looking for employment

Links to LTP Commitments

- Supporting the development of Primary Care Networks
- Supports the ambition for 750,000 people to have a personalised care and support plan to manage their long term health conditions.
- Supports the ambition for social prescribing: Over 1,000 trained social prescribing link workers will be in place by 2020/21 rising further by 2023/24, with the aim that over 900,000 people are able to be referred to social prescribing schemes by then.
- Supports the ambition for social personal health budgets: 200K people will have a personal health budget so they can control their own care, improve their health experiences.
- Supports the ambition to develop the skills and behaviours of 75,000 clinicians and professionals through practical support to use personalised care approaches in their day-to-day practice.

High Level Outcomes (Oldham Cares Framework)

Healthy Population

- Thriving Communities which promote, support and enable good physical and mental health and well-being.
- Individuals and families are empowered to take control of their health.
- Everyone has the opportunity and support to improve their health and wellbeing, including the most disadvantaged.

Effective Prevention and Treatment and Care

- Support people to self manage/self-care where appropriate

Service Quality/Health of the System

- Access to the right care at the right time.
- Individuals and families have the best experience possible when using services.
- Health and care system is financially sustainable.

Resources

Sponsor: Rebekah Sutcliffe

Clinical Lead:

Programme Manager: Pete Pawson

Project Contributors: VCSFE, Policy Lead, Finance, Communications, Health Improvement, Start Well Lead, MHIG Lead, Urgent Care PM, Core and Extended Primary Care PM, Managing Director Community Health and Adults Social Care, ICP and Alliance Forum.

Stakeholder Engagement Channels

- A multi partner Thriving Communities and Health Improvement Delivery Group has been established with positive engagement from all members.

Interface with Other Programmes

GM Plan Priorities:

- To build a Greater Manchester framework and support capacity and capability building for person and community centred approaches.
- Increased work with VSCFE to build stronger communities

Achievements to Date: Approval to go out to tender to commission strength based training for Oldham Cares staff.

	2019/20		2020/21				2021/22				2022/23			
Deliverables/Milestones	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
To Commission Strength Based Training for all Oldham Cares Staff.	Writing of tender specification and Approval to go out to procurement	Go out to procurement for training provider	Co-design training	Train community staff	Train community staff	Train Primary Care staff	Train remaining staff	Train remaining staff	Evaluate outcomes and successes of training	Develop and implement long-term embedded approach for existing and future workforce (inc induction)	Lessons Learnt			

Top Risks/ Issues

- Funding streams available to community groups and residents are reduced, increasing the demand of more formal health and social care, e.g. GP, A&E admission
- Insufficient stakeholder commitment from all Health Care system leaders, as well as non-health partners, is not gained
- Thriving Communities index may not deliver its ambition.
- There is a risk that socio-economic changes globally and nationally, e.g. Brexit, could change or increase the demand profile of need (e.g. rising levels of child poverty). This could skew the impact of the programme
- There is a risk that Health IG requirements prevent the level of accuracy needed (e.g. 6 digit postcode whereas health IG limits to 4).

Thriving Communities: Social Action Fund and Fast Grants

The Case for Change

Social isolation and loneliness are becoming increasingly prominent, particularly amongst the elderly population. Data suggests the increase on GP appointments are in direct correlation to loneliness, increasing the burden and demand on the health and care system.

Grants support disadvantaged individuals and community organisations to create opportunities to help them improve their individual lives or build better communities they live in e.g. start a business or implement a community project initiative. Grants enable individuals and communities to develop and/or enhance skills e.g. employment related skills, social connection skills.

What Intelligence Tells Us

National Context

Social isolation and loneliness are on the rise, and many older residents are particularly vulnerable to feeling isolated and lonely and thus cut off from society. Isolation can have a detrimental impact on those with poor health conditions.

Loneliness Study

The Jo Cox Loneliness study (2017) highlighted the stress on our health and care services, particularly GP surgeries as a result of loneliness amongst the elderly population that can result in the exacerbation of health conditions which provide opportunities to frequently visit GPs. Symptoms of health conditions may be alleviated through early help and increased social connectiveness.

Case study: Impact of Social Action Fund (Salford CVS)

The Salford Third Sector Fund Grants Programme has provided grant funding to a range of voluntary and community sector organisations and schools in Salford to support activities around health and well-being. Investment in social action yielded was financially beneficial with a return of £7 to £1 invested.

Local Context

Oldham has a positive track record on delivering funding across Oldham to VCSFE organisations through the Action Oldham Fund. Oldham Action Fund has supported a range of project initiative that have driven real transformational change to take place locally and have increased social connection of local individuals.

The Fast Grants in Oldham supplement the Social Action Fund work in the way that communities are able to use their ideas for social and community connection to receive funding for community projects that will make a difference in their local area.

Since September 2018, more than 70 community organisations have already benefitted from these grants and there are now even more opportunities for 2019/20.

The guidance on ideas for applications will be:

- Supporting the community to be fit and healthy
- Developing skills of local people
- Changing the area for the better
- Encouraging community participation

Aim and Objectives

- To deliver direct improvement to the health and wellbeing of all people living in Oldham and in doing so help address health inequality.
- To adopt an asset based approach to commissioning that draws upon the strengths of individuals, families and communities and supports a thriving VCSFE across the borough.
- To work with the VCSFE to develop a sustainable approach to funding of the sector.
- To maintain and grow community capacity across the borough
- To ensure that the resources of the wider social care system are directed towards places and the people that need it most and enable positive demand management.

Links to LTP Commitments

- Use of funding to implement the six components of the NHS Comprehensive Model for Personalised Care including, social prescribing and community based support.

High Level Outcomes (Oldham Cares Framework)

Healthy Population

- Thriving Communities which promote, support and enable good physical and mental health and well-being.
- Individuals and families are empowered to take control of their health.
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Effective Prevention and Treatment and Care

- Mental health is central to good health and as important as physical health.
- Support people to self manage and self care where appropriate.

Service Quality/Health of the System

- Individuals and families have the best experience possible when using services.
- Health and care system is financially sustainable.

Example of a Success

Fullcircle runs a Junior Youth Club (ages 6-12), every Friday evening in the South Chadderton area of Oldham. The Youth Club attracts 30-50 young people weekly and has been running successfully for eight years. The Youth Club is open access and provides a safe environment for children to participate in a range of diversionary activities and make new friends. The team applied to fast grants to enable them to add an indoor sporting element to the club by purchasing a pool table and a table tennis table. With the Fast Grant they were able to purchase two pool tables (one of which was a smaller table for the younger children) and one table tennis table. The tables have made a great impact to the people attending sessions at the centre, and the group has been able to offer additional activities, which in turn have engaged more young people to participate in physical activities. The team have also been able to encourage more team games and enable young people to take the lead on things like mini pool tournaments. The team of youth workers have also noticed an increase in confidence amongst many young people whilst they are learning and playing new sports. Some young people have made new friends, as they have found a common interest.

The Junior youth club will continue for the next 12 months and beyond (dependant on funding). They are keen to provide more opportunities to the children young people and families that live in the South Chadderton area. The team continue to work with core groups to plan and create new opportunities for local people.

One dad who brings his 5 year old to the brunch club said: *"This table is great I want one at home".* Keira aged 8 said *"I like playing pool, I prefer this small table I can reach the balls better - I am getting good!!"*

Resources

Sponsor: Rebekah Sutcliffe

Clinical Lead: N/A

Programme Manager: Pete Pawson

Project Contributors: VCSFE, Policy Lead, Finance, Communications, Health Improvement, Start Well Lead, MHIG Lead, Urgent Care PM, Core and Extended Primary Care PM, Managing Director Community Health and Adults Social Care, ICP and Alliance Forum.

Stakeholder Engagement Channels

A multi partner Thriving Communities Delivery Group has been established and is now into its 9th month with positive engagement from all members.

Interface with other Programmes

GM Plan Priorities: Become an age-friendly city, tackle isolation and loneliness and encourage community connectiveness

Achievements to Date: Soft testing of the fund is underway with the VCSFE and Partners. The Innovation fund is entering the final stage of planning and socialisation, Fast Grants are now in action and have delivered initiatives including a BME sewing and language group and the Community Café.

	2019/20		2020/21				2021/22			
Deliverables/Milestones	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
Fast Grants	Launch of Fast Grants for 19/20	Bi weekly Panel meetings	Bi Weekly Panel meetings	Write up of Fast Grants 19/20	Launch of Fast Grants 20/21	Bi Weekly Panel meetings	Bi Weekly Panel Meetings	Write up of Fast Grants 21/22		
Social Action Fund (including quarterly monitoring and Community of Practice sessions)	Mobilisation of 5 SAF Projects	Ongoing work and Community of Practice	Delivery of Projects and outreach work	Community engagement and consolidation of Projects						

Top Risks/ Issues

- There is a risk that smaller grants don't lead to sustainability – we accept that smaller grants don't need to lead to sustainability but they are about addressing immediate community need with smaller results.
- There is a risk that the evaluation is not accepted by the system due to the traditional medicalised approach – we are sighting commissioners in advance of the tender so agreement is reached on the expectation around future community evaluation with an immediate focus on social prescribing.
- There is a risk that the social action fund doesn't leave a legacy behind all 5 projects. We accept this risk and that the funds purpose has been around providing medium term community capacity and also supporting the social prescribing network.

Thriving Communities: Thriving Communities Hub

The Case for Change

The Thriving Communities Hub is an opportunity to firmly establish our approach to delivering early intervention and prevention as well as social change built on evidence, practice and impact. This supports the ambition to transform the way that the Voluntary, Community, Social, Faith and Enterprise (VCSFE) sector and public services interact and commission. This builds on academic research and attracting funding to the borough with an emphasis on moving to earlier community support models.

What Our Intelligence Tells Us

The extent of people's participation in their communities, and the added control over their lives that this brings, has the potential to contribute to their psychosocial well-being and, as a result, to other wider population health outcomes.

In order to develop sustainable approaches to early intervention and prevention, which are embedded in the community and social action, there is a need to strengthen the relationship between the public and VCFSE sector as well as build the case for investment in communities.

Case Study: Salford Third Sector Fund

Salford third sector fund has provided grant funding to a range of voluntary and community sector organisations and schools in Salford to support activities around health and well-being. In 2014/15 and 2015/16, over £1.6million was awarded by NHS Salford CCG and Salford CVS in grants.

16 grants were chosen for undertaking full impact evaluation activities. In this, interviews were undertaken with grant recipients and beneficiaries with one metric of impact detailed, utilising a Cost Benefit Analysis (CBA) approach.

The method found that the impact of investing in social action produced a return on investment of £7 for every £1 spent.

Overview of the Initiative

The hub will shape the commissioning balance into Oldham for VCFSE early intervention and prevention initiatives whilst helping to attract money into the borough.

The Thriving Communities programme is predicated on the concept that improving outcomes for the people of Oldham will be enabled through simultaneous investment in public service reform and empowering communities. It focuses on creating the conditions for sustainable prevention, social action and change. This will achieved through developing and implementing a systemic approach to maintaining, building and growing community capacity across the borough through effective collaboration and ways of working with communities and the VCSFE sector.

The rationale for the creation of a specific Thriving Communities Hub project within the wider programme is in recognition that the sustainability of the approaches being implemented through the programme will be contingent on developing a longer-term strategy for investment in our communities, and community led activity. In order to achieve this, there is a need to strengthen the relationship between the public and VCFSE sector, to build the evidence case for investing in communities to transform our approach to commissioning and investing in the sector, and attract new funding to the borough.

Aim and Objectives

The Thriving Communities Hub project contributes to following Thriving Communities & Health Improvement Objectives:

- To adopt an asset based approach to commissioning that draws upon the strengths of individuals, families and communities and supports a thriving VCSFE across the borough.
- To work with the VCSFE to develop a sustainable approach to funding of the sector.
- To further connect and maximise the impact of the VCSFE and help align it to the needs of residents.
- To engage people and communities in the design and delivery of services.
- To support early intervention and prevention.
- To support the building of the Oldham brand and attract investment to the borough.
- To ensure that the resources of the wider social care system are directed towards places and the people that need it most and enable positive demand management.

High Level Outcomes (Oldham Cares Framework)

Healthy Population

- Thriving Communities which promote, support and enable good physical and mental health and well-being.
- Individuals and families are empowered to take control of their health.
- Everyone has the opportunity and support to improve their health and wellbeing, including the most disadvantaged.

Effective Prevention and Treatment and Care

- Support people to self manage/self-care where appropriate.
- Ensure mental health is central to good health and as important as physical health.

Service Quality/Health of the System

- Access to the right care at the right time.
- Individuals and families have the best experience possible when using services.
- Individuals and families have access to high quality treatment and care.
- Health and care system is financially sustainable.

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Resources

Sponsor: Rebekah Sutcliffe

Clinical Lead: Dr Hollie Francis

Programme Manager: Pete Pawson

Project Manager: Rachel Dyson

Project Contributors: Action Together, Thriving Communities team, Health Improvement team, Thriving Communities & Health Improvement Programme Board members, Council Policy Lead, District teams, Finance, BI, CCG Commissioners

Stakeholder Engagement Channels

- A multi partner Thriving Communities and Health Improvement Delivery Group has been established with positive engagement from all members.
- A Thriving Communities Funding Opportunities group has been established with cross partner membership.
- Voluntary Sector Leadership Group

Interface with other Programmes

Key interfaces;

- Wealth building project
- Poverty proofing strategy
- GMCVO funding initiatives

Achievements to Date

- A Thriving Communities Funding Opportunities group has been established and is meeting on a monthly basis.
- A long-term conditions VCFSE network has been convened by CCG, Thriving Communities and Action Together, with a view to widening the network over time.
- A proposal for the evaluation of Social Prescribing has been developed based on current best practice, this will be considered by CPB in October.
- An initial piece of work has been undertaken to establish an understanding and baseline of funding to the VCFSE sector.

	2019/20		2020/21				2021/22				2022/23			
Deliverables/Milestones	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
Attract additional funding & resources to VCFSE	Develop strategic relationships with key funders	Plan and progress identified projects												
Strategic approach to grant funding	Scoping, feasibility, options to be explored as partnership	Activity TBC dependant on scoping												
Asset based commissioning	Review research and explore best practice	Activity TBC dependant on scoping												

Top Risks/ Issues

- Commitment from senior stakeholders across the whole partnership is not gained
- There is not sufficient capacity within VCFSE infrastructure, and organisations to effectively contribute & codesign.
- There is a risk that socio-economic changes globally and nationally, e.g. Brexit, impact on availability of external funding sources for VCFSE sector.
- There is a risk that Health IG requirements prevent the level of accuracy needed (e.g. 6 digit postcode whereas health IG limits to 4).

Primary Care Plus: Reducing Variation & Improving Outcomes

The Case for Change

A patient's ease of access to their practice and continuity of care can affect their quality of care and health outcomes. One of the key issues for Oldham CCG is the wide variation in access and quality across primary medical service providers.

There are currently 15.4 million people in England with a long term health condition (LTC) . Treatment and care of people with LTCs accounts for 70% of the total health and social care spend in England and an ageing population means that by 2025 it is estimated that the number of people with at least one LTC will rise by 3 million to 18 million (DH, 2010).

We will focus on the early identification and proactive management of LTCs that have a significant contribution to morbidity and mortality in Oldham and most often have a negative impact on patient's quality of life.

Oldham CCG is the third highest prescriber of antibiotics per head of population in the whole of England. This situation is long-standing and despite falls in the prescribing levels, these have not kept pace with decreases elsewhere. Oldham is an outlier on this national indicator and reasons for it are myriad. The approach to reducing the items being prescribed is through changing a culture of demand and also of supply. This is a quality issue in terms of reducing antibiotic overuse and preventing the emergence of resistance that will reduce their effectiveness in the future.

In 2018 NHS England published a list of items of limited clinical value that should not be routinely prescribed on the NHS in primary care. In Oldham these medicines accounted for around £600K per annum. These drugs have limited evidence of efficacy, specific safety concerns or are not cost-effective and so they are a priority from both quality and financial perspectives.

Oldham has one of the highest prescribing levels of these medicines in GM per head of population. A focussed approach to the appropriate prescribing of antibiotics and drugs of limited clinical value will contribute to improved quality and reduced unnecessary waste in the system.

High Level Outcomes.

1. Access

- Improvement in the overall experience of patients with their GP practice and in making an appointment
- Access to pre-bookable, longer appointments for patients with complex needs
- Same day access for children aged 5 and under with an acute clinical need that is clinically appropriate to be managed in primary care
- Increase in the number of patients able to book appointments and order repeat prescriptions online
- Equitable access to a phlebotomy service for all patients at their registered practice site

2. Long Term Conditions and Complex Care

- Increase in the number of people attending screening for bowel, breast or cervical cancer
- Increase in the early identification of people with disease
- Enhancing the quality of life for people with long term conditions
- Reduction in morbidity and mortality associated with long term conditions
- Contribute to a reduction in A&E attendances and unplanned admission for people with long term conditions
- Increase in the early identification and intervention of frailty in people aged 65 and over
- Ensure parity of esteem in respect of physical health for people with learning disability

3. Prescribing

- Reduction in prescribing of antibiotics and drugs of limited clinical value
- Improve quality and reduce unnecessary waste in the system
- An overall reduction in costs
- Reduction in antibiotic overuse and the emergence of resistance that will reduce their effectiveness in the future

Resources

Sponsor: Nicola Hepburn

Clinical Lead: Dr J Patterson

Project Manager: Marion Colohan

Project Contributors:

Dr M Hohmann – Clinical Director (Cancer)

Dr K Jeffery – Clinical Director (Mental Health)

Rebecca Towns – Clinical Director (Respiratory)

Dr Nick Milne – Clinical Director (CVD)

Dr E. Ben Hamieda – Clinical Director (Maternity and Children)

Oldham CCG Meds Optimisation Team

Oldham CCG Primary Care Team

Stakeholder Engagement Channels

- Primary Care Programme Board
- Primary Care Plus Tracker Group
- Practice Manager Forum

Interface with Other Programmes

- Primary Care Access
- Primary Care Workforce
- Primary Care Quality

Achievement To Date

Primary Care Plus was launched on 1st April 2019 with all 43 practices committing to its delivery. Early results from Q1 (April to June 2019) suggest that practices have already made a positive impact on improving access, the identification and management of people with long term conditions and complex needs, and a reduction in the prescribing of antibiotics and drugs of limited clinical value.

Q2 data (July to September 2019) is currently being collated and is expected to demonstrate continued improvement across all areas.

Top Risks/ Issues

- Withdrawal or lack of engagement with the scheme by practices in year 1 and / or subsequent years
- Winter pressures impact on practices' capacity to maintain focus and progress to date
- Lack of identified recurrent funding beyond 2021/2022

Primary Care Workforce

Primary Care in Oldham, and particularly General Practice, faces a number of workforce challenges that must be addressed in order to ensure that our population continues to receive quality care. Rising vacancy rates, increasing locum usage and an ageing workforce present significant threats to sustainability. However, there are also opportunities, via additional funding and co-ordinated resources, that will allow us to find solutions to these problems by improving recruitment, improving retention and developing our current staff.

Work is required to ensure that practices are able to create time and space to attract and develop new roles in primary care, taking advantage of the opportunities that have arisen from initiatives such as primary care networks and from new sources of funding.

What Our Intelligence Tells Us

Oldham CCG faces significant primary care workforce challenges that have the potential to adversely impact on the quality and sustainability of care delivery if not addressed.

- According to June 2019 data* there are currently working in general practice in Oldham:
  - 144 GPs (109 WTE), excluding locums and registrars
  - 91 nurses (64 WTE)
  - 56 clinical professionals delivering direct patient care (36WTE), including 36 Health Care Assistants (HCAs)
- Around 11% of Oldham GPs are aged 55 or older
- Around 32% of Oldham nurses are aged 55 or older
- Oldham needs to attract a minimum of 23 GPs per year to the locality to maintain the status quo and may need more than twice that figure to deliver transformation objectives; the figures for nurses are similar and there is also a shortage of trained HCAs.

NHS Digital June 2019

Outcomes

- Increase number of salaried and partner GPs
- Decrease number of locums working in Oldham
- Increase number of practice nurses
- Increase number of GP trainers
- Improve over-55s GP retention rate
- Increase number of HCAs
- Increase number of medical students choosing to work in Oldham

Aim and Objectives

- Analyse and evaluate current workforce and future needs
- Attract and retain the best primary care staff
- Develop new roles
- Train and develop existing staff to drive quality improvement
- Implement new ways of working to reduce bureaucracy
- Improve the quality of primary care delivery
- Develop a primary care career pathway
- Create a sustainable and efficient workforce

Links to National Strategy

NHS England Long Term Plan

- Improving the working lives of staff
- Increase staff numbers, particularly in clinical roles such as GPs and nurses
- Supporting and developing staff
- Ensure our people have rewarding jobs, work in a positive culture, with opportunities to develop their skills
- Make training more accessible
- Grow wider apprenticeships in clinical and non-clinical jobs in the NHS
- Grow the medical workforce
- Increase the number of doctors working in general practice
- Attract and fund additional staff to form an integral part of an expanded multidisciplinary team
- Retain the staff we have
- Give staff the development and career progression that they need
- Enable staff to make the most of their skills and expertise

Area	Milestone	2019/20				2020/21			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Developing New Roles	PCNs ready to integrate five new roles into practice teams								
Recruitment	Oldham training package in place to train practice nurses locally								
	Relationships established with local & regional educational institutions to increase number of Oldham clinical staff directly employed								
	Implement lifecycle approach for recruiting & retaining GPs and nurses								
Retention	First wave of new GP trainers enrolled on BTC course								
	Focus group work with ST3s completed								
Workforce Data	Process in place for collecting accurate workforce data from practices on regular basis								
Training & Education	Primary Care training needs analysis undertaken								
	Support package in place to increase number of GP training practices								
	Co-ordinated training & education process in place								
Primary Care Careers	Pathway developed for increasing number of HCAs, nurses and APNs								
	System in place for utilising unused apprenticeship levy funding across Oldham Cares footprint								

Top Risks/Issues

- Inability to recruit and retain key staff impacts on service delivery
- Lack of co-ordination of training and education programmes increases likelihood of gaps in key skills area
- Failure to develop a career pathway will result in increased vacancies in key roles in primary care in Oldham
- Failure to understand the needs of the current workforce will result in a strategy and programme plan that is ineffective
- Lack of current workforce data could lead to incorrect assumptions being made that result in ineffective actions being taken that do not address actual issues in development, recruitment or retention of staff

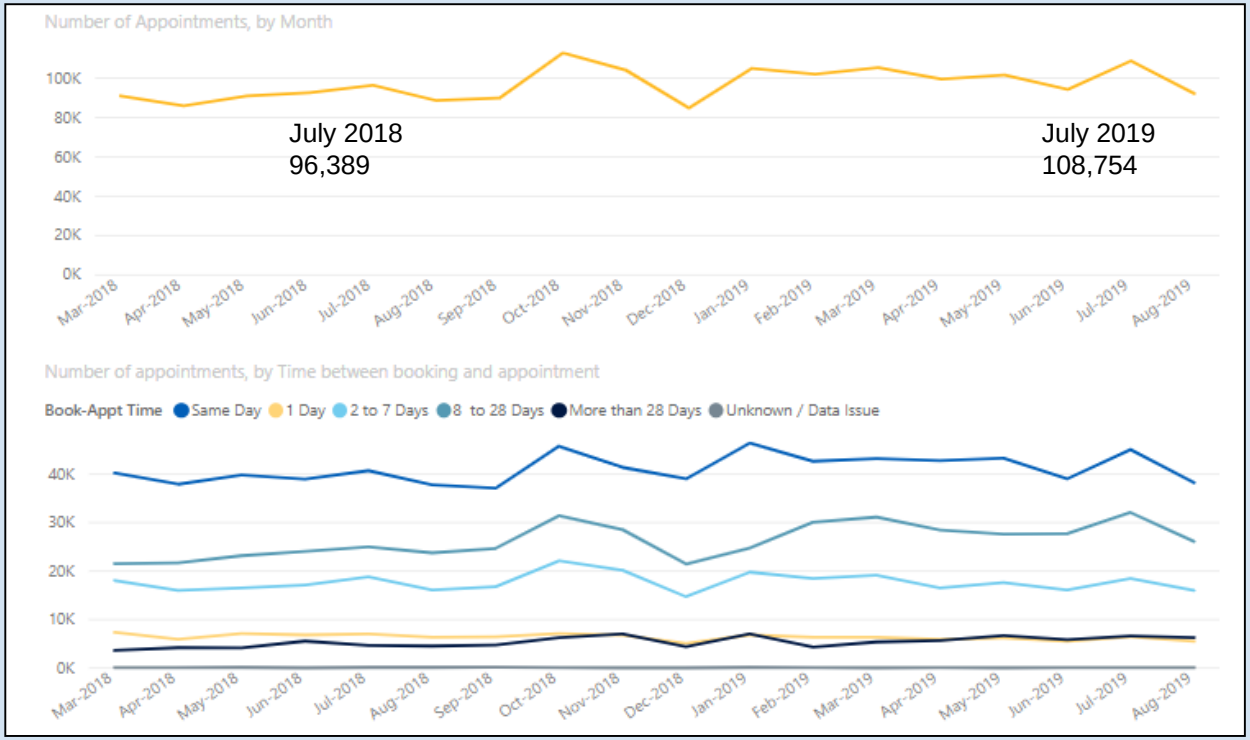
General Practice Access

The Case for Change

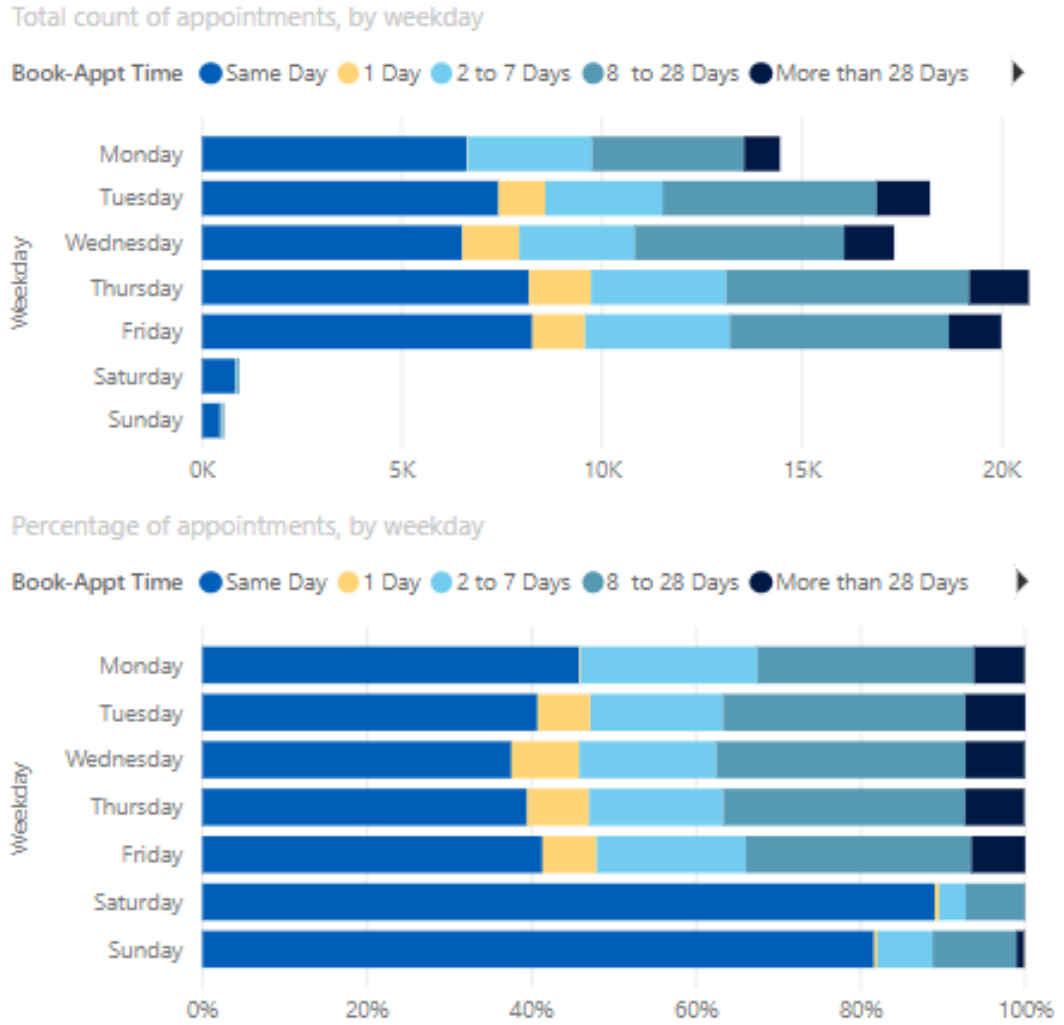
Patients are reporting more difficulty in accessing general practice, including a decline in overall experience of making an appointment.

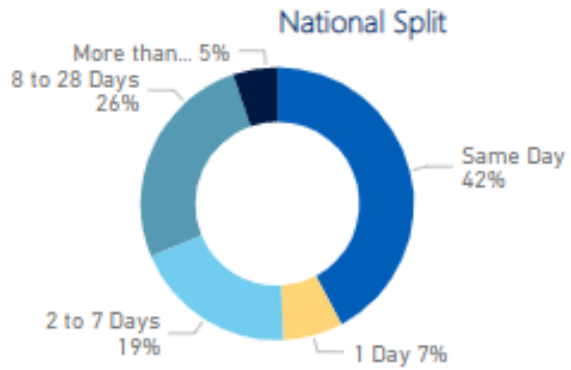
What Our Intelligence Tells Us?

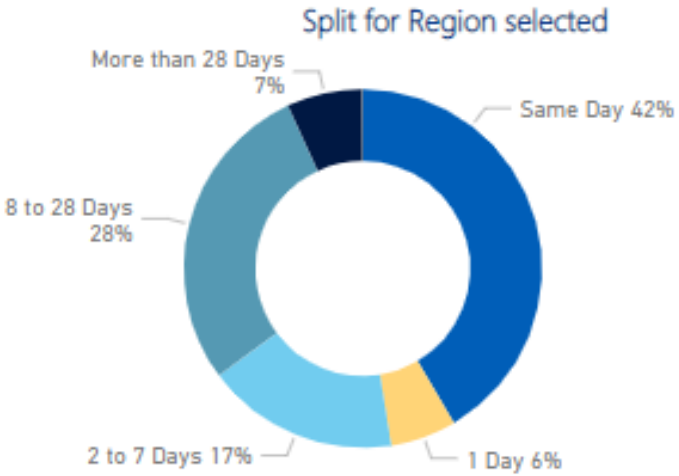
- UK general practice is facing intense resource and workforce pressures. Workload has risen at least 16% over the past seven years, but the share of the overall NHS budget is less than it was a decade ago. The number of GPs has not risen at pace with demand.
- Good access is not just about getting an appointment when patients need it. It is also about access to the right person, providing the right care, in the right place at the right time.
- There was a steady increase in the number of clinical appointments available in Oldham between April 2018 and March 2019
- Oldham practices now offer more than 400 appointments to every 1,000 patients.



Appointments in general practice – time between booking and appointment – Oldham and GM (August 2019)







The data can be found here: http://digital.nhs.uk/pubs/ApptsGP

What Our Patients Have To Say

Public satisfaction with general practice remains high, but in recent years patients have increasingly reported, through the GP Patient Survey, more difficulty in accessing services including a decline in overall experience of making an appointment in general practice.

In the July 2019 survey:

- Approximately two thirds (65.9%) rated their overall experience of making an appointment in Oldham as fairly or very good. This is below the GM (69.1%) and national (67.4%) figures. The Oldham figure is influenced a small number of very poor scores. The Oldham average between July 2014 and July 2018 (seven surveys) was 71.1%.
- Of patients who had tried, two thirds of Oldham patients (65.8%) said it was easy to get through to their GP practice on the phone. This is a decrease of three percent compared with 2018 (68.8%). This is lower than the GM figure (67.6%) but higher than national performance (65.3%).
- 64.5% of respondents registered with Oldham GP practices were satisfied with their practices opening hours. This has dropped by nearly 15% in two years – a trend also seen across GM and England.

Aim and Objectives

Aim: To ensure people in Oldham can access general practice in a timely way, and at a time that suits them. Specifically:

- To continue trajectory of increasing number of general practice appointments available each month.
- To improve CCG-level scores relating to access in the 2020 GP Patient Survey and beyond.

Objectives

- Ensure that practices deliver, under the PCN DES, 30 minutes of extended hours appointments with a primary care clinician per 1,000 population.
- Implement online consultations in all practices by March 2020. This will make it more convenient to contact services, will include advice to help people stay well and manage their own health.
- Develop new roles within networks, in accordance with the PCN DES, to improve access for patients by integrating physiotherapists, social prescribers and physician associates in to practice teams.
- Signposting training for staff and a connected, integrated system for health and social care to help facilitate the flow of people to the right services, freeing up more appointments for those that require time with a practice clinician.

High Level Outcomes (Oldham Cares Framework)

Effective prevention and treatment

- Support people to self-care and self manage where appropriate e.g. Increased patient/ family knowledge and confidence in managing minor illness and LTC

Service Quality / Health of the System:

- Access to the right care at the right time
- Individuals have the best experience possible when using system
- Individuals and families have access to high quality treatment and care

Links to Long Term Plan Commitments

- More healthcare staff working in and with GP practices
- These staff will make sure people get better access to a wider range of support for their needs
- Expansion in the number of services available in local GP practices
- “Digital” GP consultations

Resources

Sponsor: Nicola Hepburn

Clinical Lead: None

Project Manager: Marion Colohan

Project Contributors: Primary care team

Stakeholder Engagement Channels

- New general practice training scheme for Oldham – CCG-funded half day closing training sessions for General Practice
- The PM 500 Club – quarterly CCG-funded half day training event specifically for practice managers
- Driving improvement through local incentive scheme (Primary Care Plus) – includes measures of access

Interface With Other Programmes

- Workforce
- Primary care quality

Achievements to Date

- Oldham CCG was one of the first wave of localities to participate in the clinical pharmacist scheme, embedding pharmacists into practice teams to deliver patient-facing clinics.
- Offer of nearly 8,000 minutes of pre-bookable extended access appointments via the Oldham 7-Day Access service.
- Significant majority of practices achieving Primary Care Plus access indicators in first quarter of the scheme.

Top risks / issues	
	• Winter pressures has significant negative impact on general practice access • General practice workforce issues worsen • Primary care networks are unsuccessful in recruiting to new roles • Implementation of online consultations is not successful or does not deliver any improvements in access

General Practice Assurance Framework

Background

The Care Quality Commission have introduced a maximum inspection interval of five years for practices with an overall rating of Good or Outstanding. It is important local commissioners monitor the quality of services in these periods: annual assurance visits are an expectation of CCGs. To date, there has not been a consistent approach to monitoring of general practice performance in Oldham.

Whilst practices are accountable for the quality of services and are required to have their own quality monitoring processes in place, CCGs have a responsibility for quality assurance and improvement under delegated commissioning. Oldham CCG takes this responsibility seriously and continuously strives to improve the quality of general practice, reduce variation and support its member practices to enable this. A framework has been developed that sets out how the CCG will monitor, support and manage the performance of its member practices.

Quality Assurance Visits

Assurance visits to practices will take place on at least an annual basis. As well as a focus on clinical quality, the visits will include consideration of practice governance. We know from recent analysis of CQC inspection findings that the inability to effectively implement and review policies / procedures (e.g. recruitment, professional registration) are common failings for practices in Oldham.

Other aspects of the visit will be bespoke, based on consideration of the available data and information. At the time the visit is announced, the practice will be asked to specify any topics or issues they want to be included on the agenda.

Where the CCG highlights areas of relatively poor performance, it is important we can provide resources to help practices improve. Part of this will be the sharing of good practice between providers. This may include encouraging practices to “buddy” on specific issues where one has performed particularly well.

Information Dashboard

The CCG will compile and monitor national comparative data (including QOF, GP patient survey), local information (including safeguarding, infection control), and current CQC inspection ratings. The dashboard will help inform the discussions during the practice assurance visits. The dashboard will be routinely shared with networks to support them in their ongoing work. Data will be put into the context of the particular provider and used alongside other intelligence to gain an understanding of any potential risk to quality or patient safety.

Oldham Care Organisation Priorities

Oldham Care Organisation Priorities

1. Pursue quality improvement to ensure safe, reliable and compassionate care

This means
- Reductions in core patient /service user harms each year
- Improvements in mortality indices each year
- Achieving Care Quality Commission rating of Good or Outstanding

In order to achieve this we will:
- Deliver the Quality Improvement Strategy
- Develop reliable mortality review and reporting processes
- Achieve 20% reduction in Clostridium Difficile infections
- Achieve 20% reduction in grade 2 pressure ulcers and 0 grade 3 and 4 pressure ulcers
- Implement streamlined electronic Venous Thromboembolism (VTE) assessments to prevent and reduce the risk of VTE

2. Improve care and services through partnership, integration and collaboration

This means
- Our local populations will be kept healthy, safe and well in our communities, access our hospitals less and go home sooner
- We will be a valued partner to other organisations

In order to achieve this we will:
- Develop care pathways for adults and children, in association with key partners to reduce time spent in hospital
- Implement reliable systems to improve patient flow, including structured ward/board rounds and regular review of stranded patients
- Provide clear leadership to the Local Care Organisation (LCO) development group
- Participate in the integrated children's boards
- Lead the Northern Care Alliance (NCA) redesign programme for critical care services, in collaboration with Greater Manchester's Healthier Together to deliver safe, reliable and sustainable care

3. Deliver the financial plans to ensure stability

This means
- Improved financial performance year on year
- Operational efficiency and workforce productivity metrics are met each year

In order to achieve this we will:
- Deliver reliable and effective medical and nursing rotas, by re-designing roles, maximising rotas and reducing the need for agency/locums
- Implement robust booking and approval process for agency usage to reduce agency spend
- Develop financial opportunities from realisation of benefits from Get It Right First Time, model hospital and benchmarking
- Attract and grow sources of revenue and capital
- Deliver on theatre utilisation plans to improve productivity

4. Support our staff to deliver high performance and continuous improvement

This means
- More people will recommend us as a 'Place to work' and 'Place for care'
- We will deliver on training, coaching and talent development plans

In order to achieve this we will:
- Develop innovative models for recruitment and retention
- Implement the contribution framework to optimise staff performance
- Contribute, implement and deliver the NCA People Strategy
- Implement the NCA talent management programme to expand opportunities for role enhancement and to retain excellent staff
- Develop enhanced practitioner roles with a particular focus on A&E and intensive care to provide sustainability

5. Deliver operational excellence

This means
- Delivering urgent, planned and cancer care improvements to achieve our targets
- Developing and implementing Standard Operating Models to eliminate unwarranted variation

In order to achieve this we will:
- Deliver urgent care workstreams to achieve improvements in quality and access standards
- Fully embed the Gooroo® modelling tool to develop robust capacity and demand planning
- Deliver cancer two week wait performance in line with trajectories
- Deliver 62 day cancer performance in line with agreed trajectories
- Manage the waiting list size in line with agreed trajectories and national planning advice
- Participate in the development of standard operating models for theatre and elective access transformation

6. Develop and implement our Service Development Strategy and the Northern Care Alliance enabling strategies

This means
- Reliably delivering our plans so that benefits can be achieved in agreed timescales

In order to achieve this we will:
- Participate in the delivery of the Phase 1 priorities of the Service Development Strategy
- Implement agreed NCA strategies across Oldham, working with partners as required
- Improve visual management systems through business intelligence systems
- Improve information management and technology infrastructure
- Contribute to the development of a Royal Oldham Hospital Estates Strategy

7. Deliver excellence in research and education programmes

This means
- Through our research we will improve care and outcomes for our populations
- We will enable our staff to reach their potential

In order to achieve this we will:
- Participate in the development of NCA strategies with a specific focus upon :
  - Vascular medicine
  - Foetal medicine
  - Inflammatory bowel disease
  - Rheumatology

Our Alliance Priorities:

1. Pursue quality improvement to ensure safe, reliable and compassionate care
2. Improve care and services through partnership, integration and collaboration
3. Deliver the financial plans to ensure stability
4. Support our staff to deliver high performance and continuous improvement
5. Deliver operational excellence
6. Develop and implement our Service Development Strategy and the Northern Care Alliance enabling strategies
7. Deliver excellence in research and education programmes

Our services will be:

- **Evidence based** and of the **highest quality**
- **Highly reliable:** high quality whatever the day of the week or hour of the day
- **At scale:** creating benefits for people through standardisation of best practice
- **Trusted:** providing safe, effective and compassionate service
- **Connected:** seamlessly delivering what matters most to people and communities
- **Pioneering:** continuously innovating and improving services.

Oldham Care Organisation Programmes

Project	Overview	Outputs	Key Milestones
Theatres	**Aim:** To reduce the number of operations cancelled on the day by 50% by March 2020 There are patient, financial and reputational impacts as a result of cancelled operations. 22 of the 36 complaints that have Gynaecology have received over the last 12 months have been directly related to delays in being offered an operation date, or being cancelled on the day of the operation. Potential income lost from cancelled operations over 18 months is £822,447 for gynaecology and £412,872 for General Surgery. Plus the wasted costs (of the theatre, surgeon and anaesthetist) over 18 months which total £191,585 for gynaecology and £86,547 for General Surgery.	• Improve pre-operative systems and processes • Build a patient-centred and safety-focused culture in theatres • Ensure efficient ward processes	• 19th Sept - Project launch (complete) • 24th Oct - Learning session 1 12th Dec – Learning session 2 • 23rd Jan – Learning session 3 • 5th Mar 2020 - Summit
Capacity Re-Modelling	**Aims:** Re-modelling of bed capacity to inform decision-making and planning to support the delivery of timely care to patients. Key objectives: • Deliver the right care, in the right place, at the right time to the population served by the Royal Oldham Hospital • Ensure that services have the required accommodation and workforce to deliver a high quality service • Position the Oldham Care Organisation in the top 10% for comparisons of bed occupancy, length of stay and operational performance against peers • Ensure that pathways between primary care, community and secondary care meet the needs of the population served • Improve pathways within the Care Organisation to ensure that the patient receives the care required at the right time without delays • Enable the workforce to work within teams and across teams and to develop new roles to meet the needs of the patients Analysis by the British Medical Association (BMA) has shown that where beds numbers declined most quickly, performance also deteriorated at the fastest pace. This demonstrates the need for this transformation programme to ensure the proposed changes to beds are evidence based and ensure that services are sustainable to meet the demand. Oldham CO is also facing a reorganisation of local services through the Acute General Surgery Programme and will see increased activity for General surgery within the next eighteen months. There is growing national shortage of qualified clinical staff which has resulted in increased use of agency and other temporary workers to fill vacancies, leading to an increase in pay expenditure. Reconfiguration of the Oldham care organisation will explore sustainable workforce models including innovative workforce solutions.	• Optimised workforce model • Optimised accommodation configuration • Optimised pathways between primary care, community and secondary care • Improved pathways within Oldham Care Organisation • Improved workforce processes	• Nov ’19 (phase 1) • Final options appraisal • Financial evaluation undertaken • IM&T evaluation undertaken • Dec ‘19 – (phase 1) bed reconfiguration commences • March ‘20 – phase 2: commence implementation based on preferred option

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General Surgery	Then aims and objectives of the General Surgery Programme are to; • Create sector level single service models for the delivery of GS • Reduce unwarranted variation in the provision of GS across Greater Manchester • Make better use of limited GS resources • Deliver better patient outcomes and reduce mortality rates The case for change in GS was articulated within a GM level programme for Acute General Surgery, which identified: • Unwarranted variation in GS outcomes across GM • Inefficient use of workforce/upcoming workforce challenge • Potential to improve patient outcomes including prevention of up to 200 deaths a year	• Sector level MDTs • Transfer of in scope activity to hub site (ROH) • Improved patient outcomes • Compliance with NELA* standards • Sector wide care pathways • Reduction in non elective admissions • Compliance with HT clinical standards	• Jan 19 - Access allocated capital • Feb 19 – Begin capital programme • Apr 19 – First moves of high risk EL activity • Dec 20 – complete capital programme • Jan 21 – Transfer of NEL activity
Critical Care	Develop and implement a safe, reliable, high quality, clinically and financially sustainable adult critical care service. Objectives include: • Improvement in ICNARC standardised mortality ratio • Increased satisfaction with the service • Achieve a CQC 'good' rating Critical issues & opportunities include: • Unsustainable staffing situation for both medical and nursing staff • Availability of critical care capacity and patient flow • Opportunity to innovate and lead on the development of local standards, service specification and standard operating procedures	• Standard Operating Procedure • Consistent staffing • Policy alignment • GPICS compliant	• Nov '19 – First programme board Sep '20 – CC unit meeting national policy GPICS • Mar '20 – Develop shared vision for delivery of critical care • Mar '21 – LT workforce model developed & • Mar '20 – Completion of the interim CC expansion implementation of digital solution
Temporary Staffing	Aims to reduce the expenditure of temporary staffing whilst maintaining safe care	• Blended workforce model • Recruitment process • Business case for the recruitment of substantive HCA and activity co-ordinators	• Implement efficient sickness & absence management • Establish a clearly defined recruitment process • Recruitment of substantive HCA and activity co-ordinators

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Rapid Diagnostics Centre	Transform patient experience and outcomes across the NCA through pioneering the development of a new RDC service model, ensuring equitable, consistent and reliable access for patients and GPs to innovative pathways of care which enable the rapid diagnosis or exclusion of cancer. The implementation of an RDC will need to achieve the following benefits: • Significant contribution to sustainable delivery of cancer access targets across NCA • Improve patient experience – reduced delay and uncertainty, increased support and information • Improve speed of diagnosis • Reduce delays associated with multiple, uncoordinated referrals and tests • Reduce % of patients diagnosed via emergency presentation across the NCA • Reduce non attendance • Reduce duplicated activity and unnecessary appointments. Multidisciplinary Diagnostic Centres have been shown to improve outcomes for patients presenting with non-specific but concerning symptoms, specifically with regards to the new standard to confirm or exclude a diagnosis of cancer within 28 days of a patient visiting their GP. RDC builds on this evidence by providing an up scaled RDC service with increased scope covering all urgent suspected cancer referrals for specific tumour groups with common diagnostic approaches.	• Outline Business Case • Full Business Case • Model for sustainable diagnostics service to support the RDC. • Standard Operating Procedures for each phase • Workforce model for each phase • Target Operating Models for each phase	• End Nov '19 – Completion of OBC • End Jan '20 – Phase 1 go live • End Mar '20 – Completion of FBC • End Jul '21 - Phase 2 additional cohorts go live • End Oct '21 – Phase 3 additional cohorts go live
Urology	The term Single Shared Service describes the consolidation of similar services and capabilities which are currently fragmented and sometimes duplicated. A Single Shared Service is co-ordinated and cohesive; delivered across multiple sites within the organisation. The development of an NCA Urology Single Shared Service is driven by 4 factors: Outcomes – where, for example, we know that travelling further for a more specialist, larger service will improve care (e.g. for stroke). Workforce – fragmentation and separation can result in a lack of resilience, often highlighted in the provision of on-call services and pressures on senior clinical staff (medical, nursing and AHPs). Combining previously separated services can address these issues. Opportunities – to share best practice and reduce unwarranted variation, through Standard Operating Models, as explained below. Technology – for example the development of remote Intensive Care Units. Aims: • Ensure equity of access and provision, measured through a performance dashboard with markers for quality of care and service • Remove unwarranted variation across service delivery and care provision	• A single urology service across NCA with one vision • Single governance structure for urology across NCA • Standard, agreed policies and practice • Single set of performance metrics & dashboard for urology across NCA • Objectives for the single service	Still to be approved • Nov '19 - Establish Single Service Programme Board • Feb '20 - Agree clinical standards for Urology single service • June '20 - Scope options for Urology Investigation unit at ROH/ RI and inpatients surgical capacity (theatre and beds) at ROH • Sept '20 - Scope options for Urology Investigation unit at ROH/ RI and inpatients surgical capacity (theatre and beds) at ROH.