Health & Wellbeing Board

January 2021

Mike Barker, Chief Operating Officer

Jan-Mar 2021

Managing the remainder of 2020/21

Given the second wave and the new more transmissible variant of the virus, it is clear that this winter will be another challenging time for the NHS

Our task is now five-fold:

1. Responding to Covid-19 demand
2. Pulling out all the stops to implement the Covid-19 vaccination programme
3. Maximising capacity in all settings to treat non-Covid-19 patients
4. Responding to other emergency demand and managing winter pressures
5. Supporting the health and wellbeing of our workforce

- In addition, we are now following a single operational response model for winter pressures, including Covid-19 and the end of the EU transition period. Our SRO to lead the EU/UK transition work is the Chief Operating Officer

What this means…

Responding to emergency demand and managing winter pressures

Lead: Nicola Hepburn, Director of Commissioning Operations

We are asking systems to take the following steps to support the management of urgent care:

- Ensure those who do not meet the 'reasons to reside' criteria are discharged promptly. We are asking all systems to improve performance on timely and safe discharge, as well as taking further steps that will improve the position on 14+ and 21+ day length of stay, aided by 100% completion of discharge and reasons to reside data
- Complete the flu vaccination programme, including vaccinating our staff against flu and submitting vaccination uptake data to the National Immunisation and Vaccination system (NIVS)
- Minimise the effects of emergency department crowding, continue to develop NHS 111 as the first point of triage for urgent care services, with the ability to book patients into the full range of local urgent care services, including urgent treatment centres, same day emergency care and speciality clinics as well as urgent community and mental health services.
- Maximise community pathways of care for ambulance services referral, as a safe alternative to conveyance to emergency departments. Systems should also ensure sufficient arrangements are in place to avoid unnecessary conveyance to hospital, such as the provision of specialist advice, including from emergency departments, to paramedics as they are on scene.

Responding to ongoing Covid-19 demand

Lead/s: Mike Barker, Nicola Hepburn & Claire Smith

- With Covid-19 inpatient numbers rising in almost all parts of the country, and the new risk presented by the variant strain of the virus, you should continue to plan on the basis that we will remain in a level 4 incident for at least the rest of this financial year and NHS trusts should continue to safely mobilise all of their available surge capacity over the coming weeks. This should include maximising use of the independent sector, providing mutual aid, making use of specialist hospitals and hubs to protect urgent cancer and elective activity and planning for use of funded additional facilities such as the Nightingale hospitals, Seacole services and other community capacity. Timely and safe discharge should be prioritised, including making full use of hospices. Support for staff over this period will need to remain at the heart of our response, particularly as flexible redeployment may again be required.
- Maintaining rigorous infection prevention and control procedures continues to be essential. This includes separation of blue/green patient pathways, asymptomatic testing for all patient-facing NHS staff and implementing the ten key actions on infection prevention and control, which includes testing inpatients on day three of their admission.
- All systems are now expected to provide timely and equitable access to post-Covid assessment services, in line with the commissioning guidance.

Implementing the Covid-19 vaccination programme

Lead: Mike Barker, Chief Operating Officer

- The Joint Committee for Vaccination and Immunisation (JCVI) priorities for roll out of the vaccine have been accepted by Government, which is why the priority for the first phase of the vaccination is for individuals 80 years of age and over, and care home workers, with roll out to care home residents now underway. It is critical that vaccinations take place in line with JCVI guidance to ensure those with the highest mortality risk receive the vaccine first. To minimise wastage, vaccination sites have been ensuring unfilled appointments are used to vaccinate healthcare workers who have been identified at highest risk of serious illness from Covid-19. Healthcare providers have been undertaking staff risk assessments throughout the pandemic to identify these individuals and it remains important that this is organised across the local healthcare system to ensure equitable access.
- If further vaccines are approved by the independent regulator, the NHS needs to be prepared and ready to mobilise additional vaccination sites as quickly as possible. In particular, Covid-19 vaccination is the highest priority task for primary care networks including offering the vaccination to all care home residents and workers. All NHS trusts should be ready to vaccinate their local health and social care workforce very early in the new year, as soon as we get authorisation and delivery of further vaccine

What this means…

Maximising capacity in all settings to treat non-Covid-19 patients

Lead: Nicola Hepburn, Director of Commissioning Operations and Claire Smith, Chief Nurse

- Systems should continue to maximise their capacity in all settings. This includes making full use of the £150m funding for general practice capacity expansion and supporting PCNs to make maximum use of the Additional Roles Reimbursement Scheme, in order to help GP practices maintain pre-pandemic appointment levels. NHS trusts should continue to treat as many elective patients as possible, restoring services to as close to previous levels as possible and prioritising those who have been waiting the longest, whilst maintaining cancer and urgent treatments.
- To support you to maximise acute capacity, as set out in Julian Kelly and Pauline Phillip's letter of 17 December, we have also extended the national arrangement with the independent sector through to the end of March, to guarantee significant access to 14 of the major IS providers. NHS trusts have already been notified of the need for a Q4 activity plan for their local IS site by Christmas; this should be coordinated at system level. If you need it, we can also access further IS capacity within those providers subject to the agreement of the national team. However, we will need to return to local commissioning from the beginning of April and local systems, in partnership with their regional colleagues, will need to prepare for that.
- The publication of the Ockenden Review of maternity services is a critical reminder of the importance of safeguarding clinical quality and safety. As set out in our letter of 14 December there are twelve urgent clinical priorities that need to be implemented. All Trust Boards must consider the review at their next public meeting along with an assessment of their maternity services against all the review's immediate and essential actions. The assessment needs to be reported to and assured by local systems, who should refresh their local programmes to make maternity care safer, more personalised and more equitable.

Supporting the health and wellbeing of our workforce

Lead: Julia Veall, Joint Director of HR & OD

National direction: Our NHS people continue to be of the utmost importance, and systems should continue to deliver the actions in their local People Plans. Please remind all staff that wellbeing hubs have been funded and will mobilise in the new year in each system

Plan for 2021/22

National planning priorities

The Spending Review announced further funding for the NHS for 2021/22 but in the new year, once we know more about the progress of the pandemic and the impact of the vaccination programme, the Government will consider what additional funding will be required to reflect Covid-19 cost pressures.

1. Recover non-covid services

in a way that reduces variation in access and outcomes between different parts of the country. To maximise this recovery, we will set an aspiration that all systems aim for top quartile performance in productivity on those high-volume clinical pathways systems tell us have the greatest opportunity for improvements: ophthalmology, cardiac services and MSK/orthopaedics.

The Government has provided an additional £1bn of funding for elective recovery in 2021/22. In the new year we will set out more details of how we will target this funding, through the development of system-based recovery plans that focus on addressing treatment backlogs and long waits and delivering goals for productivity and outpatient transformation. In the meantime we are asking you to begin preparatory work for this important task now, through the appointment of a board-level executive lead per trust and per system for elective recovery.

2. Primary and community care

Prioritise investment in primary and community care, to deal with the backlog and likely increase in care required for people with ongoing health conditions, as well as support prevention through vaccinations and immunisations. Systems should continue to focus on improving patient experience of access to general practice, increasing use of online consultations, and supporting the expansion of capacity that will enable GP appointments to increase by 50 million by 2023/24.

3. Health Inequalities

Address the health inequalities that covid has exposed. This will continue to be a priority into 2021/22, and systems will be expected to make and audit progress against the eight urgent actions set out on 31 July as well as reduce variation in outcomes across the major clinical specialties and make progress on reducing inequalities for people with learning disabilities or serious mental illness, including ensuring access to high-quality health checks

4. People and workforce

Strengthen delivery of local People Plans, and make ongoing improvements on: equality, diversity and inclusion of the workforce; growing the workforce; designing new ways of working and delivering care; and ensuring staff are safe and can access support for their health and wellbeing.

5. Mental Health

Accelerate the planned expansion in mental health services through delivery of the Mental Health Investment Standard together with the additional funding provided in the SR for tackling the surge in mental health cases. This should include enhanced crisis response and continuing work to minimise out of area placements.

6. Integrating Care: Build on the development of effective partnership working at place and system level. Plans are set out in our Integrating Care document.

Overall aim is to reset the health and care system through eight priorities

Following the implementation of phase 2 recovery as part of the Covid-19 response, Oldham's health and care phase 3 recovery assessment and route to implementation has been established.

The overarching aim of this recovery work is to ensure that more, if not all, services are stepped back up safely, whilst operating within the context of enhanced infection, prevention and control (IPC) measures, which as well as impacting on care delivery, impacts on estate capacity also.

The data used for our planning is based on assumptions using existing and current capacity and demand modelling, and is aligned (for Oldham borough patients) with the Northern Care Alliance (incorporating Pennine Acute Hospitals – Royal Oldham) and Pennine Care.

We have devised a six month plan with 8 priorities:

1. Cancer
2. Elective
3. Workforce
4. Mental health and learning disabilities
5. Health inequalities
6. Primary care
7. Winter
8. Integrate care

National activity target expectations

Referrals:
- The national expectation is that this returns to **100%** of the previous year's activity – Oldham is realistically planning for this to be back to **80%**

Elective inpatients:
- That national ask is that this activity incrementally returns to **70%** of the previous year **rising to 90%** by March 2021 – Oldham is realistically planning for this to be back up to **73%**

Elective outpatients:
- The national ask is that this activity incrementally returns to **90%** of the previous year **rising to 100%** by March 2021 – Oldham is realistically planning for this to be back up to **91%**

Non-elective inpatients:
- Oldham is planning for this to be back up to **83%** of the previous year's activity

Emergency department attendances:
- The regional ask is that this activity returns to not less than **75%** of the previous year – Oldham is realistically planning for this to be back up to **89%**

Over the next six months we will…

1

Cancer

- Improve cancer referral data
- Work with NCA on a diagnostic hub business case to provide additional capacity
- Work with NCA to ensure that its cancer recovery plan is reviewed and approved
- Implement additional PET-CT scan machine
- Continue to promote the bowel, cervical and breast proactive screening programmes in primary care under 'Primary Care Plus'
- Implement local and national cancer campaigns: "We are here for you"
- Utilise existing Covid-19 community engagement to provide information on cancer symptoms and services

2

Elective care

- Work with providers to enact key demand management tools, such as 'advice and guidance' to support the reduction in outpatient need
- Work with NCA on the broader 'System Wide Outpatient Programme' to continue to implement different ways of delivering outpatient care, as well as implementing new initiatives to support reduction in volumes such as PIFU
- Work with providers to consider and consult on a more permanent arrangement to the use of medication for early medical abortions (up to 10 weeks) in conjunction with over the phone or virtual appointments
- Roll out of new referral template to improve quality of referral information and support improved triage with advice and guidance responses back where appropriate

What we are already doing

Cancer

- Northern Care Alliance (NCA) has recently launched the Rapid Diagnostic Centre at its Oldham and Salford sites, which has seen an increase in referrals and is running at an 8-10% cancer conversion rate
- Two week wait (2WW) cancer referrals now only 8% down on pre-lockdown levels
- Contracting of routine endoscopy diagnostics were transferred to the hospital trust to provide support for cancer work – supported by a GM-wide programme to increase mobile endoscopy capacity
- GM-wide surgical hubs for cancer in place at Rochdale Infirmary and The Christie as 'green' Covid-secure sites
- CCG-chaired Board in place to transform outpatients system-wide (SWOP), focusing on diagnostics and service recovery

What we are already doing…

Elective care

- GM-level management of independent sector hospital capacity in place across the system
- Independent sector community elective providers being engaged in relation to capacity availability, and will be supported by the CCG regarding estates needs due to IPC measures
- Virtual solutions are being used to increase outpatient activity (including assessments and reviews) to the required levels
- Pregnancy terminations continued to be provided throughout lockdown, with medications sent via post
- Supply of all community elective providers to NCA to look at potential for additional capacity that can be offered on an provider-to-provider basis
- Implementation of tele-dermatology to reduce face-to-face contacts required and increase the numbers of patients managed outside of specialist services

Mental health and learning disabilities

- IAPT services activity is returning to pre-Covid levels – the service has continued to be in place throughout
- It is expected that the children and young people access target will be met
- Health checks for people with learning disabilities (LD) have continued throughout as part of the Direct Enhanced Service and Primary Care plus
- We are expecting the Transforming Care trajectories to be met for both secure and non-secure patient discharges by 31 March 2021
- The 'eliminating mixed sex accommodation' programme is now underway again following a pause in March 2020

Health inequalities

- Health inequalities are being addressed via Primary Care Plus in relation to key indicators such as by increasing prevalence and reducing exception reporting – those with severe and enduring mental health conditions are targeted, as well as those vulnerable to frailty
- Work is underway to address the issues that driver poor health outcomes, such as the recruitment of social prescribers who are deployed into PCNs
- GPs and the acute trust are reviewing all children and young people on the 'shielded' patient list and removing those from the list that are no longer deemed clinically 'extremely vulnerable' – all children and young people on the list are seen by services
- Increased testing is in place for all vulnerable people
- Regular 'sit-reps' are in place for care homes

Over the next six months we will…

3

Workforce

- Work across the Oldham Cares system to agree a collaborative approach and response to the NHS People Plan
- Produce a specific primary care response to the NHS People Plan, as a collaborative approach between the commissioners and Greater Manchester and Health Education England workforce leads
- implement the new primary care workforce programme to support the delivery of recruitment, retention and training objectives

4

Mental health and learning disabilities

- Increase investment in mental health services in line with the 'MHIS' plan
- Oversee the implementation of the IAPT 24/7 helpline to include full crisis resolution and home treatment services, and work with Pennine Care FT to ensure that the appropriate recruitment is in place and delivered to support the workforce action plan for the service
- Work with providers to ensure that access to these services is clearly promoted and advertised – this will include continued borough-wide campaigns to support mental health and wellbeing for all
- Following a review of LD prescribing of anti-psychotics, develop an action plan for this area to support practices and provide them with implementation plans
- Develop an action plan to support LeDeR reviews and lack of capacity

5

Health inequalities

- Examine the potential to utilise medicines optimisation pharmacists working within PCNs to identify and support at risk patients as part of structured medicines reviews and health checks
- Extend the teams to support the 'continuity of carer' agenda, with specific teams to be put in place for vulnerable patients, including those with learning disabilities
- Phase in a new 'visiting plan' for maternity units to ensure the necessary family support is in place, as safety measures allow

Workforce actions already underway

- Enhanced mental health initiatives, platforms and support for all staff across the Oldham system are in place
- Regular 'pulse' surveying is in place to track how staff in the Oldham Cares system are feeling
- New equality strategy for Oldham is being produced by all partners and the community, voluntary and faith sector
- Oldham CCG 'equity' plan for recruitment, retention and progression is in development

Over the next six months we will…

Primary care

- Ensure clinical pathways and standard operating procedure are signed off for the paediatric virtual ward
- As part of processes to deal with childhood immunisation issues, oversee (in collaboration with CHIS) the redesign of processes to improve the system going forward
- Assess the effectiveness and quality of the weekly pastoral care calls between primary care and care homes, as well as individual care plans and structured medicines reviews
- Development of a revised outcome-based district nursing offer to bridge the period up to March 2021, which will ensure caseload prioritisation and also areas of current commissioned activity that can be ceased/provided differently in the wider system
- Confirm next steps for STICH enhanced nursing support for care homes and end of life pathways
- Develop robust links between medicines optimisation team and the PCNs
- Commission the GM ‘minor ailments’ scheme as support to the ‘self-care’ policy work
- Work with secondary care to increase the amount of medicines provided at discharge to reduce pressure on primary care prescribing
- Ensure that clinical vulnerable children are prioritised in community service recovery plans
- Ensure oversight of children with complex health needs and who have been shielding who may not be able to return to school so that their care and educational needs are met
- Maximise and lock in the benefits and changes that have been realised during COVID-19
- The system deficit will need to be managed in the context of the impact of the pandemic and will focus on: Managing the backlog of patients; Safely resuming clinical activity; Preparing for winter; Surge planning; Supporting our existing workforce and securing a sustainable workforce; and Exacerbation of existing health inequalities.

What we are already doing

- Locality-wide post-Covid rehab pathway implemented across acute, community and primary care and is working well, and additional capacity has provided for the lung service
- Community service recovery plans in place
- A community optometry service was commissioned in May 2020 to support the national ask for local urgent eye care services, which has continued and will be expanded to include routine care to help reduce the demand on acute trusts
- Care home ‘STICH’ enhanced community nursing support in place for care homes and end of life
- Work underway for PCNs to take a greater lead role in proactively reaching out to vulnerable patients as part of the MDT approach
- All 6-8 week checks for babies have been maintained throughout
- Paediatric ‘virtual’ ward due to go live, with an additional 20 beds to support early discharge
- Paediatric ‘rapid access clinics’ due to commence for primary care community care services to refer into specialisms, with the aim of avoiding hospital admissions
- The children’s community nursing team has maintained face-to-face contract throughout Covid-19 with children who have complex health needs and also children on the end-of-life pathway

Over the next six months we will…

7

Winter

- Consider the establishment of a ‘cold diagnostic site to reduce DNAs due to Covid-19 fears
- Consider a more joined-up approach with community pharmacy so that there is reduced competition for vaccine supply
- Work with community pharmacies to improve the signposting of key services and the best ways to access them during the winter, as well as promotion of the flu immunisation programme to encourage take-up
- Increase the number of paediatric multi-disciplinary teams across the neighbourhoods in the borough

What we are already doing

- A robust flu immunisation programme plan is now in place for Oldham, with specific interventions for target and at-risk groups, integrated with the national and local communications and engagement flu and winter campaign
- A multi-agency flu programme group is in place to ensure the delivery of the immunisation plan – this includes a dedicated individual from the CCG’s primary care team to coordinate work as needed with practices
- Community and primary care nurses are trained to administer flu vaccines
- Paediatric rapid access clinics are increasing in number, offering up to 30 appointments per week - GP ‘advice and guidance’ service in place, which will also coordinate with the rapid access clinic
- StartWell specialist nurses are back in the emergency department

Conclusion

The success of the next six month recovery plan will be reliant on:

- Robust partnership working
- Strong clinical leadership and engagement
- Effective engagement with our communities and with patients
- Clear programmes for service redesign and transformation
- Good governance

The core transformation programmes will centre around:

- A new model for managing long term conditions, utilising a ‘hub’ that includes non-elective, elective and primary / community care
- A new model for urgent care, as linked to the Greater Manchester model
- Redesign of local community services

Transition to an integrated system model

High level timeline

Jan – Mar '21

Planning Phase

Do as much work now to prepare for the future

April – Sept '21

Transitional Phase

Move into new arrangements where feasible

Sept – Mar '22

Shadow Running

Be ready to operate new systsem

Vision and principles

Vision

- Significantly raise healthy life expectancy through a place-based approach to better prosperity, health and wellbeing
- To enable place based approaches to tackling the social determinants of health, reduce inequalities, and provide high quality, proactive care within a population health approach
- Focus on the people we serve, the place where we live and work and the partnerships we create

Principles

- To be organised and act as accountable to the local population and to each other
- To provide strategic leadership for place- political, clinical and executive/ managerial focused on the needs of our population rather than organisations
- Priorities and objectives will be framed according to our service and offer to residents - advice on staying well; preventative services; simple and joined up services for care and treatment when they need it; simple, active support to those who are vulnerable and at risk to keep as well as possible
- The sector as a local economic contributor, delivering social value - through its employment, training, procurement and volunteering activities, to play a full part in social and economic development
- Deliver the best health and care services for the place based budget
- Continue to redress the balance of care to move it closer to home
- Make decisions about funding for the totality of the place based budget, criteria and design of services through co-production and co-design with service users
- Working with communities to empower change
- Removing (through integration) and disregarding (through governance) the commissioner/provider separation
- Decides upon and drives the changes we pursue collectively at the GM level

Functions and responsibilities

Governance and the role of the Local System Board/Partnership Board

- Setting strategic direction
- Aligning political, clinical and managerial leadership or the place including accountable public health leadership
- High level resource allocation including incorporation of the NHS allocation for the locality into the place based budget
- Agreeing transformation plans and overseeing system delivery and health & care transformation
- Agree Locality's strategic connection to GM, NW etc. according to agreed functional alignment and responsibility
- Responsible for relevant 'health' outcomes within the Single Outcomes Framework
- Overseeing the development of the new system (neighbourhood model and PCN support, integration of delivery and alignment of resources)

Delivery arrangement

- Confirmed scope of service and operating model for the 'next generation LCO' (this will confirm a common, minimum core – primary care, social care, community services, local acute care (eg acute medicine, elements of outpatients etc), community Mental Health & wellbeing) alongside the means to connect to Out Of Hours, VCSE, housing, education, criminal justice etc partners) and will be all age. It is understood that some will be organisationally integrated, some contractually and some aligned through partnership agreement and that this may change over time.
- Responsibility for driving the change -Tactical commissioning; risk stratification & case finding; lived experience and co-production; strengths based/asset based working; workforce development and blended roles
- Actionable connections to true prevention services (housing, employment, VCSE etc)
- Confirming what is out of scope and proposed to be enacted at the GM level (suggestions include - certain aspects of specialised commissioning, cancer, elective care, EPPR, Business Intelligence and Analytics, Clinical pathway development, market management of the Independent Sector, aspects of Urgent and Emergency Care?)

Developing the local model

Local system Board

- Aligned intentions around local System Board/Population Health Board (often collapsing 2-3 existing boards into the new construct)
- To establish and operate the Place Based Budget together. The budget may include resources pooled, aligned and ‘in view’
- Mechanism or clinical leadership will need specific attention and support
- Intention in some places for equivalent neighbourhood governance and deployment/delegation of budgets to neighbourhoods (localised subsidiarity)
- Creation of expanded Place Budget with system budget process and shared responsibility for financial sustainability
- system based quality and assurance approach

Evolution of commissioning

- Commissioning will be brought together into a single function, with a single leadership structure, significantly expanded pooled budget and the back office between the CCG, Council & LCO will be consolidated into a single support function with the efficiency benefits realised.
- Arrangement to ensure also the deployment of resources organised at community level and all core teams coming together to form a geographically-focused resource to provide core support to local population health needs
- New financial framework to accelerate LCO maturity and development – eg progress to a single, whole population health contract

Developing the local model

Integrating Provision

- Clarify options for the next stage of the locally integrated model - Primary Care, Social Care, Mental health and FT working together through a legally binding integrated contractual agreement; OR a lead provider model; OR intended development of an expanded care trust. Potential for provider side s75
- Need to understand implications for the development of the FT model
- It is understood that some will be organisationally integrated, some contractually and some aligned through partnership agreement and that this may change over time. Each locality will have their own route map guiding these changes – NB we have recognised the need to identify a balance between flexibility & consistency
- A means to enable the neighbourhood model, supporting the development of the integrated teams and confirming contracting, accountability and leadership arrangements with PCNs (PCN Maturity and Development)
- Expanding neighbourhood ambitions – mental health, housing, schools, drugs and alcohol, people with no recourse to public funds etc
- There will be an erosion of the commissioner /provider split and the local system will identify how it describes and organises those functions in future
- New quality assurance, quality monitoring, and improvement models spanning the scope of the LCO/Local Care Trust/Local Partnership
- Alignment of staff into the LCO/Local Care Trust/Local Partnership to create single place based functions eg's include: IT, BI, Finance, Communications, Contracting, IG, Choose and Book and CHC.
- Demonstrating readiness to undertake the relevant commissioner and provider functions- possibly through an authorisation process

Key areas of focus for Jan - Mar

1. Governance options (functions, membership & establishment of local system board; delegation framework)
2. Financial framework (funding flows, accountability, mechanisms for pooling)
3. Clinical/professional leadership model and framework
4. Determination of appropriate geographies for specific services/commissioning responsibilities
5. Detailed CCG functional analysis
6. People/HR implications

- Overseen by MET with updates to Governing Body as appropriate
- Models implied need to be signed off by Governing Body as well as other parts of the system