Oldham cares

Better Care Fund Narrative Plan 2021-22

Oldham Health & Wellbeing Board

November 2021

PART 1 Brief outline to embedding integration, person centred health, social care and housing services

1.1 The Oldham Better Care Fund Plan is based on the borough's Locality Plan for Health and Care Transformation that is currently subject to a refresh process. The Locality Plan was originally ratified by all health and care partners in November 2019 and forms the overarching strategy for local health and care transformation until March 2024. A full version of the Locality Plan is available on request.

1.2 The plan was finalised prior to the onset of the COVID-19 pandemic and prior to the announcements of the planned reforms to NHS commissioning and to wider national and regional reforms to the health and social care economy including the position of, and our involvement in, the devolved authority in Greater Manchester. While the existing strategy retains much of the original vision and direction and much of the planned implementation remains current, work is underway to extend where necessary and to refresh elements of the plan that require further development. A new comprehensive plan is expected to be in place before April 2022.

1.3 Our plan describes how we will continue to deliver significant improvements in the health and wellbeing outcomes of our residents as we move towards place-based, person centred provision of care and services. It focuses on the wider determinants of health and addressing health inequalities in our footprint. It also emphasises how public services will work together to support everyone to take more responsibility for their own health.

1.4 We want to design a health and care system that by 2024 helps people to start well, live well and age well, that improves the quality of care and services that our residents receive and ensures that the system is financially sustainable for the long-term so that we can continue to deliver the services that our residents need.

1.5 Our vision for health and wellbeing is set within the context of the Oldham Delivery Model. The model is built on three pillars;

- **Thriving Communities** – Enabling communities to make the right health and wellbeing choices and investing in community capacity.
- **Inclusive economy –** Building wealth for our communities and the right type of business opportunity that provide jobs and career paths linked into Education for the people of Oldham.
- **Co-operative services** – Integrating services around local resident need.

1.6 To support delivery of this change we have formed **Oldham Cares**. Oldham Cares is an alliance of health and social care commissioners and providers who are working together to achieve the following vision:

Oldham is a vibrant place, which embraces diversity and is where people are thriving and communities are safe and sustainable – it is a place where improved health and wellbeing is experienced by all, and where the health and wellbeing gap is reducing.

1.7 This improvement will be achieved by:

- Enabling people to be more in control of their lives and their care;
- A health and care system that is focused on wellbeing and the prevention of ill health;
- Addressing the wider determinants of health;
- Delivering support and care which is as close to, and connected with, home and community as possible;
- Consistent, reliable, good quality, person and community centred support and care that is available when necessary.

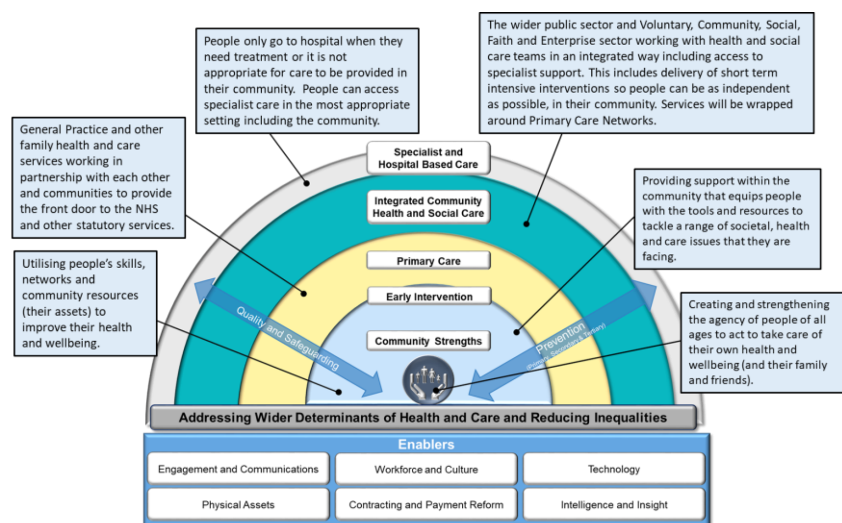
1.8 Plans are progressing for health and care to operate as an ICS to support the delivery of population health. Commissioners and providers are already implementing components of an ICS and are beginning to work seamlessly together to tackle the wider determinants of health and develop a consistent place based approach to planning and strategy rather than within organisational boundaries. Our priorities over next five years are to:

1. Focus on population health and wellbeing outcomes
2. Develop a strong community offer built on the foundation of Primary Care Networks
3. Deliver good quality, sustainable, specialist and hospital services
4. Undertake place based integration

1.9 To support the evolution of an ICS for Oldham a model of health and care has been developed. A model of care broadly describes how different health and care services, and partner organisations should work together in the future for a person, population group or patient cohort as they progress through the stages of a condition, injury or event. It aims to ensure people get the right care, in the right place at the right time, by the right team.

1.10 The model serves a high level visual that can be shared internally with staff to explain where services sit in the context of the wider health and care system. A blueprint from which more detailed models of care can be designed and delivered.

An All Age Model Built on Placed Based Integration with A Focus on Population Health



1.11 **A Population Health Management and Outcomes Focussed Approach -** Both the NHS and social care have a critical part to play in addressing the challenges in Oldham. However, these cannot be met by the health and care system alone. A much broader place based approach that pays more attention to the wider determinants of health and the role of a partnership of equals between the NHS, the local authority, public services and most importantly people and communities is required.

1.12 Population health principles and interventions can be applied at each tier within the Oldham health and care system; at an individual, neighbourhood, place and system level.

1.13 As an integral part of PHM, health and care commissioners and providers will be moving to a way of working that is focussed on population outcomes with an emphasis on prevention, wellbeing and encourages communities to flourish - the development of an outcomes focused system.

1.14 **Developing an Integrated Commissioning Function -** As the vehicle to commission for outcomes for the population, Oldham has developed an Integrated Commissioning Function (ICF). This has created the conditions and environment to deliver Oldham's vision, whilst continuing to develop and maintain a diverse and vibrant health and care economy that meets the needs and aspirations of local people, maximising social value, as well as delivering excellent health and social care services. It also ensures that the Care Act requirements for the Local Authority to develop a sustainable adult social care market is at the core of integrated decision making.

1.15 **An Increased Emphasis on Local Engagement -** As we enter into a new phase of commissioning development, we will create a framework within which a new conversation with our population about service change can take place in a way that is not tokenistic. In order to do this, we will ensure:

- that the nature of our discussion with the population will be genuinely *deliberative* and ask questions that are both strategically significant and genuinely 'open' in the sense that the answers from the process will affect what we do next.
- that we show the process by which the outcomes from such a conversation can be incorporated into our planning and delivery – or explain why certain aspirations are not possible.

PART 2 Supporting Discharge (national condition 4)

2.1 **Background -** From March 2020, in response to the pandemic, the Hospital Discharge Service requirements set out revised processes for hospital discharges, including a requirement that people should be discharged the same day that they no longer need to be in an acute hospital, with the implementation of a 'home first' approach.

2.2 The revised processes set out in the Hospital Discharge and Community Support: Policy and Operating Model, highlighted the need to implement a discharge to assess model and establish a 'transfer of care hub' to provide the appropriate care and support. This required NHS organisations to work closely with adult social care and housing colleagues, the care sector and the voluntary sector.

2.3 **Oldham's Discharge Response Offer** - Community Health & Adult Social Care (CHASC) discharge and enablement (D&E) offer in Oldham is an integrated Health and Social Care service with specialist community teams supporting our local population. These teams work together for the best outcomes to support discharges, with the four key aims to:

- *Support people to remain at home*
- *Help people to avoid going into hospital unnecessarily*
- *Help people return home from hospital as soon as they are medically safe to do so*
- *Prevent people from having to move into a residential home until they really need to*

2.4 The Integrated Discharge and Community Response Hub is at the centre of Oldham's community urgent care offer and has been developed to meet the operating model requirements. As the service also responds to the requirement for a 2-hour community health response, the hub will evolve, and work is underway to link more closely to the primary care digital hub and soon to be updated Urgent Care Hub. The other two critical components of the model are the Integrated Crisis Enablement Team (ICET) and Community Reablement. ICET provides support for up to five days for people discharged from hospital and referred from the community. Community Reablement provides rehabilitation packages of care for those who need it for up to six weeks. The Hub is the triage and coordination vehicle which ensures that people are directed to the most appropriate support as quickly as possible, with a focus on ensuring people return or remain at home where it is safe for them to do so.

2.5 The services provide assessment and short-term interventions, including facilitated hospital discharge, crisis intervention, intermediate care and enablement services to patients.

2.6 These services consist of:

- ***Integrated Discharge Hub***
  The Integrated discharge hub is based at the Royal Oldham Hospital providing support and assessment seven-days a week. The team consists of Transfer of Care Nurses, Elderly Person Mental Health Nurse and Social Workers who are ward based, with the focus to support the most complex patients to be discharged to the appropriate place at the earliest opportunity.

  The team supports a person from an acute setting to the correct place to meet their needs. A Discharge to Access (D2A) referral form is completed by the most appropriate

person that knows the patient's needs for all pathways and it's then triaged by the integrated discharge hub clinician. A Home First (pathway 1) approach is always adopted and only where a person is unable to return home are pathways 2 (intermediate care) and 3 (short term placement) utilised. Community support for patients in their own home or care home setting can also be requested.

- ***Community Response Hub***
  The Community step up response hub receives referrals from the wider community teams including GPs, the Digital Hub, Matrons, District Nursing services, out of area referrals for Oldham residents, NWAS and social care when patients are in times of crisis. This is a direct route to prevent hospital admission and support people in their own homes. The service has seen a significant increase in the number of step-up referrals and has direct referrals requiring clinical triage and signposting. The triage will determine the level of assessment and support the person requires to keep them in their own environment.

- ***Intermediate Care – Butler Green (Nursing) & Medlock Court (Residential)***
  These are community, short-term rehabilitation beds which support the person to work with a multi-disciplinary team to gain as much independence as possible and help them return home, reducing unnecessary admissions to care homes and where possible preventing re-admission to hospital.

- ***Integrated Crisis Enablement Team (ICET)***
  ICET helps people get home from hospital quickly and safely and provides an admission avoidance rapid response service to people in urgent need of health and social care interventions at home within four-hours of referral. It also provides short-term interventions for up to five days before either withdrawing or making an agreed onward referral to other community services. The team carry out assessments for community follow up in the patient's own homes, this helps to prevent an acute hospital admission and /or reduce hospital bed days. The service aim is to provide a **SAFER** way of working, outlined below, to support hospital discharges into the community:

  S - Service provided in the patient's own home

  A - Assessment of individuals needs

  F - Fast and efficient service

  E - Effective results and better out comes for the patients

  R - Responsive and reactive teams providing community support

- ***Community Therapy Hub***
  The Community Therapy Hub provides support and rehabilitation for people in their own home following on from ICET or bed based Intermediate care. The team also support people at home to avoid an admission to hospital. The team take referrals from the community and will support people at home to avoid an admission to hospital.

- ***Community IV Team***
  The delivery of IV therapy in the community setting can reduce the requirements for hospitalisation and improve quality of life.

- ***District Nurse Liaison***
  The main aim of this role is to provide in-reach into The Royal Oldham Hospital to support the safe and effective discharges particularly for Oldham residents who will require District Nursing support in the community. The District Nurse Liaison post proactively identifies patients who can potentially be discharged to community via ward visits and assists hospital staff with referrals to ensure the right information is available to allow care to be provided.

- ***Single Point of Access (SPOA - District Nursing)***
  In the SPOA we have qualified nursing support to triage and manage referrals. For patients that need an urgent same day visit at the point of referral there is some capacity to provide a rapid response visit by the SPOA nurses to support discharge.

- ***Palliative Care Coordination Centre***
  The expansion of the Community Specialist Palliative Care team allowed the launch of the coordination centre in May 2021. This ability to manage more patients more efficiently in the community supports the Hospital and the preferred place of death as more patients are able to be managed in the community and kept at home. Support is also given with accessing care provision including fast track.

2.7 **Interdependencies -** The Integrated Discharge and Community Response Hub has several interdependencies: The Digital Hub, GPs across Oldham, MASH and social care and care providers.

2.8 The Digital Hub triages NWAS referrals and refer to the hub for follow up and home assessments. They offer a dedicated line for care homes and health and social care professionals. These route directly into the Digital Hub where the GPs and Nurse Practitioners are based and have access to the patient's GP record. They will then do a telephone or video assessment and either deal with the patient, refer on, or arrange a face to face/home visit if needed.

2.9 **Key successes -** The D&E programme in Oldham brings together NCA's acute and community urgent care services, MioCare Group's Enablement services and Oldham Councils Social Care Services to have a collective bigger impact. A programme of work is underway with all these partner organisations under the heading of *'big ticket items'* as follows:

- Embedding refined D2A and pathways
- Frailty model as part of admission avoidance
- IDT future model
- Sustainable hub and ICET
- Seven-day working
- Delivery model and management arrangements

2.10 One of the key successes of the programme to date is the shift from a range of separately commissioned services managed by different organisations with a separate Integrated Discharge Team to an Integrated Discharge Function working across organisations to bring the individual services together, it is widely accepted that this work has been one of the best examples of true health and social integration in the borough. This continues with a governance structure in place reporting to the D&E Design & Delivery Group.

2.11 Another key success is the recent digitalisation of the D2A form. Oldham is proud to be the forerunner in the development of a digitalised form. A clear benefit already being realised following implementation is improved decision making processes, enabling a quicker response and seamless care resulting in patients being discharged on the right pathway for them. Work is ongoing as we move into phase 2 of the journey which is looking at further interoperability between partner organisations to improve patient pathways.

2.12 There is some excellent joint working taking place between the Digital Hub, Integrated Discharge and Community Response Hub, and ICE-T. There is potential to integrate and streamline this work further so it is more effective and efficient.

2.13 **Challenges -** Oldham wishes to work together to deliver integrated place-based care – care that crosses the boundaries between primary, community, hospital, and social care, however this ambition is challenging working within the limited resources we have.

2.14 It has been recognised that the Community Response Hub has received an increase in community step up calls for patients who require a health or social care intervention to help keep them in their own homes. Many referrals into the hub are not in any receipt of health or social care input or known to services, this increase in care and support has an impact on services already at capacity.

2.15 In order to respond to the requirements of the Ageing Well 2-hour response there is also an additional request for response staffing within the ICET service to meet the ageing well requirements. The services will need further review to include reablement services for a faster response.

2.16 The D&E programme is in the process of recruiting to additional clinical roles to support the hub, however shortages of staff are widespread within the NHS and exist across all disciplines, this causes additional pressures on the current workforce and retention continues to be a growing problem.

2.17 **Areas for development -** A core component of the programme is the need for a 2-hour crisis response service. All localities are required to have a 2-hour response at home service operating 12 hours a day , seven days a week at a minimum using a model in line with national guidance. All services should be accepting referrals directly from key sources including 111, 999, GP, Social Care, Care Homes and Same Day Emergency Care (SDEC) services. Oldham does not currently have such a service.

2.18 There is also the additional need to implement the ageing well ambitions for 2021/22, the hubs are the single route into other services and provide clinical triage and signposting to the appropriate response services across Oldham. There are significant links with the frailty agenda and recognition of system wide change to assist in the delivery of services. Digitalisation of frailty is a key are for development following roll out of D2A.

2.19 The proposed future state model for Discharge to Assess and hospital avoidance through 2 Hour community response in Oldham needs to in place as soon as is practicable and by March 2022. It will bring together the various services that form the current approach and develop the pathways and ways of working with all agencies in the future state model. The relationship between the D&E with Primary Care Networks will be critical to the success of this model and caring for people with increasingly higher acuity in the community. This will help keep people at home where possible and help ensure a timely and safe discharge if

admitted. The vision being that all people in crisis receive an appropriate response and are tracked across the system and transition seamlessly.

2.20 Modelling is ongoing to establish optimum levels of activity and key stakeholders across the system will be mapping out the future state requirements at the D&E workshop in November, this will enable progression with key priorities aligned to action plans.

2.21 In addition the CHASC service is working with primary care to work through enhanced models to take a more proactive approach to supporting Oldham citizens to remain at home for as long as possible.

PART 3 Disabled Facilities Grant

3.1 Oldham supports people with disabilities to remain living in their own homes for as long as possible, and as independently as possible, by focusing on:

3.2 **Improved assessment and delivery -** Bringing together under a single line management structure assistive technology, community equipment and adaptations, and co-location of the Equipment and Adaptations team with Allied Health Professionals - including Community Occupational Therapists, who make over 99% of referrals for adaptations, within Oldham's Therapy Hub**.** This facilitates more effective joint working of health and technical staff, and person-centred solutions to complex cases.

3.3 Ensuring optimum service delivery by jointly commissioning provision where possible. Three key Disabled Facilities Grant (DFG) delivery contracts are procured jointly with Tameside council. Procuring over a larger footprint is a more efficient use of commissioner resources and delivers better value for money, enabling more people to be supported. The Integrated Community Equipment Service (ICES) is a joint contract with our neighbouring borough of Tameside and includes the local authority and CCG from each borough. This contract includes provision of minor adaptations, enabling '*one set of feet through the door*' for many residents.

3.4 Utilising the funding flexibilities afforded by the Regulatory Reform Order (RRO). Oldham's RRO was refreshed in 2019 and several discretionary offers were introduced to extend the options available to residents, and reduce the bureaucracy involved in the DFG application process. Like most services, COVID-19 has impacted on this provision, with demand and activity patterns skewed in 2020/21 as a result of the pandemic. However, data from 2019/20 demonstrates that the application process is quicker, and the numbers of adaptation completions increased from the previous year as a result of adopting this approach.

3.5 **Promoting joined-up approaches to meeting residents' needs -** Oldham has structural barriers to provision of suitable, safe housing for some households. Parts of the borough are dominated by poor quality, small, terraced housing, which intersect with health inequalities experienced within these areas, and requires solutions at scale. As a consequence, meeting needs in some cases is a considerable challenge and are currently unable to be met.

3.6 Oldham's Strategic Housing Partnership includes Senior management representation from Joint Commissioning. This ensures that:

- the borough's main social housing providers remain engaged with a long-standing joint protocol to contribute to adaptations within their stock, undertaking minor adaptations from their own resources and contributing to the costs of major adaptations; and

- the needs of Adult Social Care and Health are recognised and included in partnership opportunities - such as within the development pipeline plans of key Registered Providers. These plans are informed by the Market Position Statement, plus data from the Disabled Housing Register and Community Occupational Therapy Team (COTT) information about households' needs.

PART 4 Equality and health inequalities

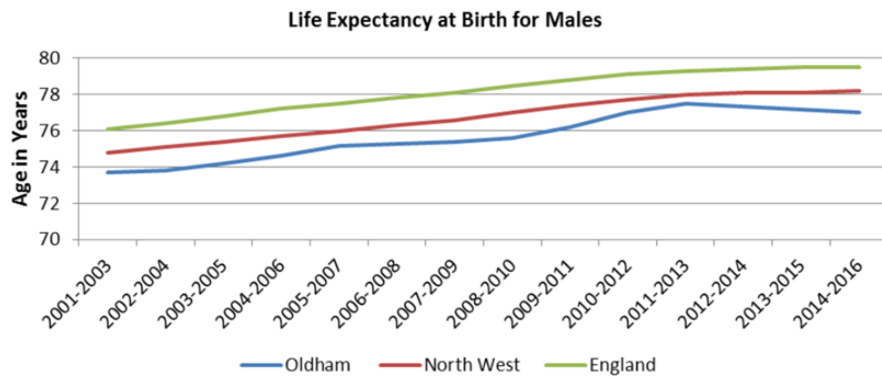
4.1 Our population's health and wellbeing is heavily influenced by social inequality including poverty, worklessness, and disadvantage on the basis of race. Oldham has a higher proportion (22.5%) of non-white Black and Minority Ethnic (BME) residents than England (14.6%).

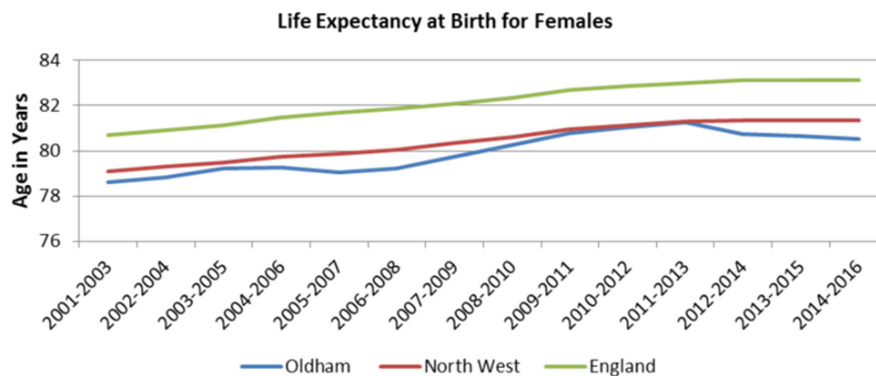
4.2 The wider determinants of health such as education, employment, housing and transport are also critical factors that play a significant role. For example, the employment rate in Oldham (68.4%) has fluctuated over time but still remains significantly lower than the GM (70.1%) and national averages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

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

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

4.5 **Life Expectancy and Inequalities** Life expectancy (LE) in Oldham is currently lower than the national average for both men and women, 77.2 for men (79.6 nationally) and 80.9 for women (83.1 nationally). Healthy life expectancy in Oldham is significantly lower than the national average, particularly for women, 60.3 for men (63.4 nationally) and 58.6 for women (63.8 nationally). Inequalities in LE have been increasing slightly for men and significantly for women. The gap in LE between the most and the least deprived wards within Oldham is 8.4 years in males and 7.5 years in females. Rates of infant mortality (under 1 year old) are also higher than national levels (6.2 per 1,000 for Oldham, 3.9 per 1,000 for England).





4.6 In Oldham we are developing a system based on prevention and health equity that incorporates the following key facets based on the Institute of Health Equity's *Reducing Health Inequalities Through New Models of Care: A resource for New Care Models* (2018):

- **A focus on preventing ill health and supporting good health as well as treating ill health:** moving from reactive services to those that work to improve the conditions in which people live, which in turn will improve their health.

- **A focus on place:** which supports a focus on small areas and seeks to influence the environment and social and economic conditions of the place, especially for the most disadvantaged areas.

- **Cross-sector collaboration:** facilitating close collaborations between multiple organisations and sectors reaching beyond health and care, many of which have a significant influence on health e.g., housing, training and education.

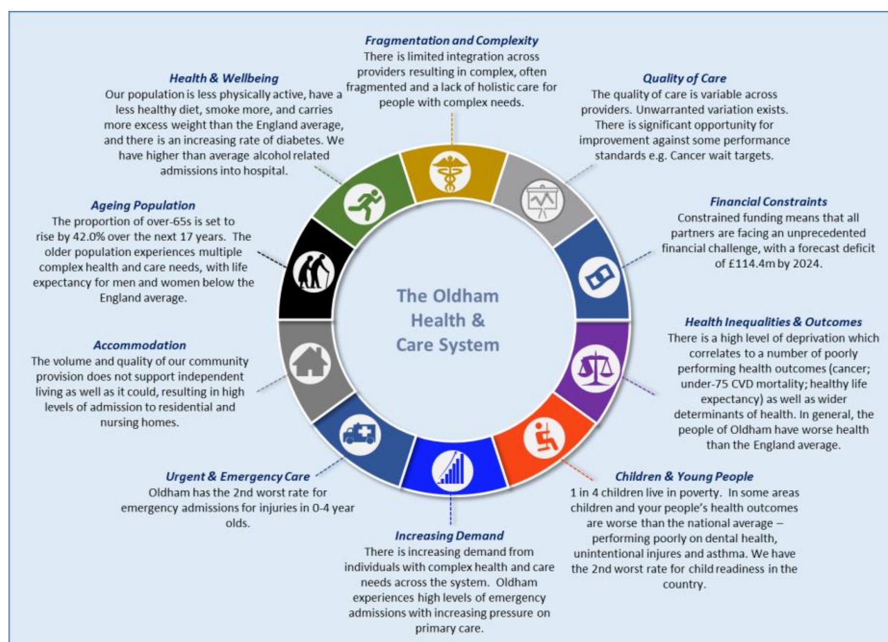
- **Focuses on population health:** Understanding the local population health and health risks for groups and areas. This includes the broader social and economic drivers of health as well as a focus on and inclusion of particular communities that are at risk of poor health.

- **Addressing wider determinants of health and reducing inequalities is the foundation of our model.** Through the model's implementation we will seek to maximise opportunities to address these determinants and reduce health inequalities.

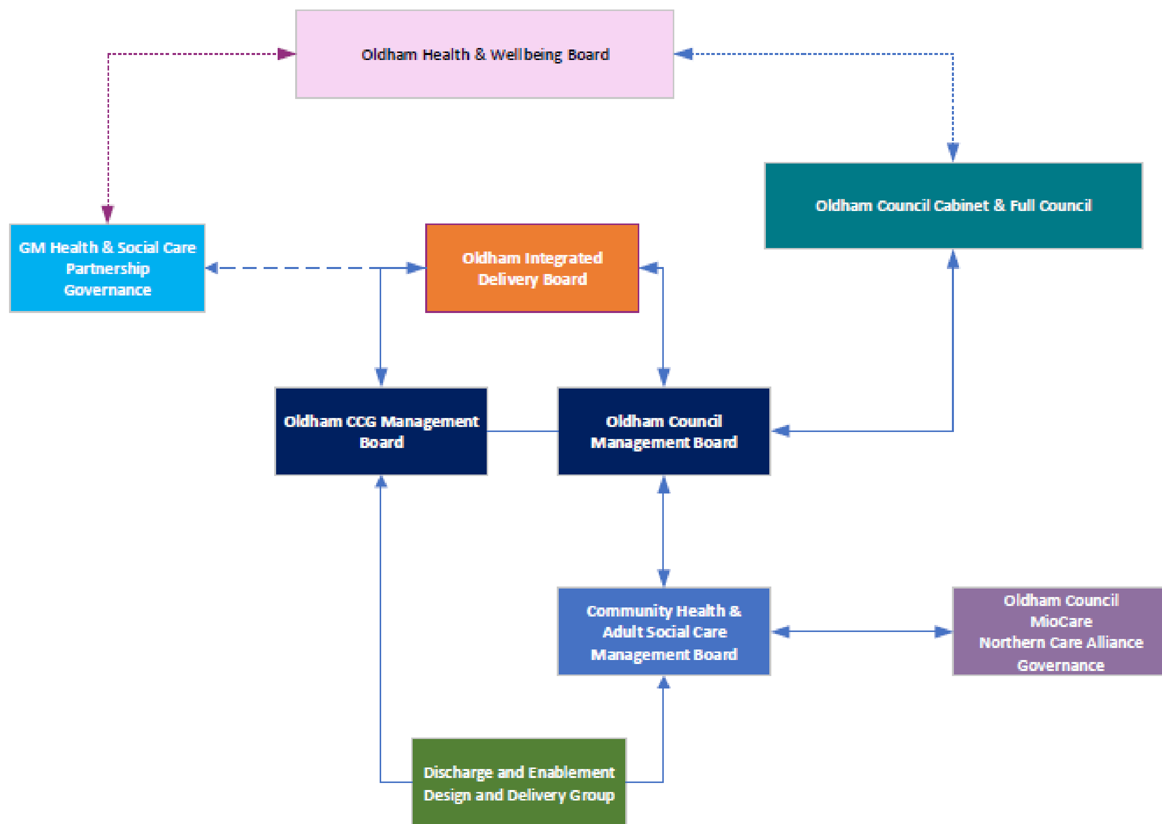
4.7 This recognises that while many of the levers to impact and improve health and reduce health inequalities often sit outside the remit of health and care organisations in Oldham, there are significant opportunities for our organisations to do more to address these ambitions.

4.8 As our model takes shape through the evolution of an ICS we will ensure that integration extends beyond health and care organisations and integrates with other sectors to form place-based population health systems that influence the wider community and the social and economic drivers of health. In addition, work is also underway to consider how the findings of the *Build Back Fairer the COVID-19 Marmot review* can be best utilised within Oldham.

The diagram below provides a summary of the key challenges facing Oldham's Health and Care System



APPENDIX 1 Governance



APPENDIX 2 Bodies involved in preparing the plan

Members from a range of different sectors across Oldham are involved in the development and ongoing monitoring of the activity relating to the Better Care Fund. These include members of the Health & Wellbeing Board and Integrated Delivery Board and include the following organisations:

Oldham Council

Oldham CCG

Northern Care Alliance

Pennine Care NHS Foundation Trust

Oldham Primary Care Networks

Action Together Community Interest Organisation