# Oldham ICP Strategy
2023-27

Oldham
Integrated Care Partnership

**Part of** Greater Manchester
Integrated Care Partnership

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# Introduction

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

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

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

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

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# Background

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

The guidance also recommends that systems and providers:

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

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

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

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

**Namely to:**

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

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# The Greater Manchester context

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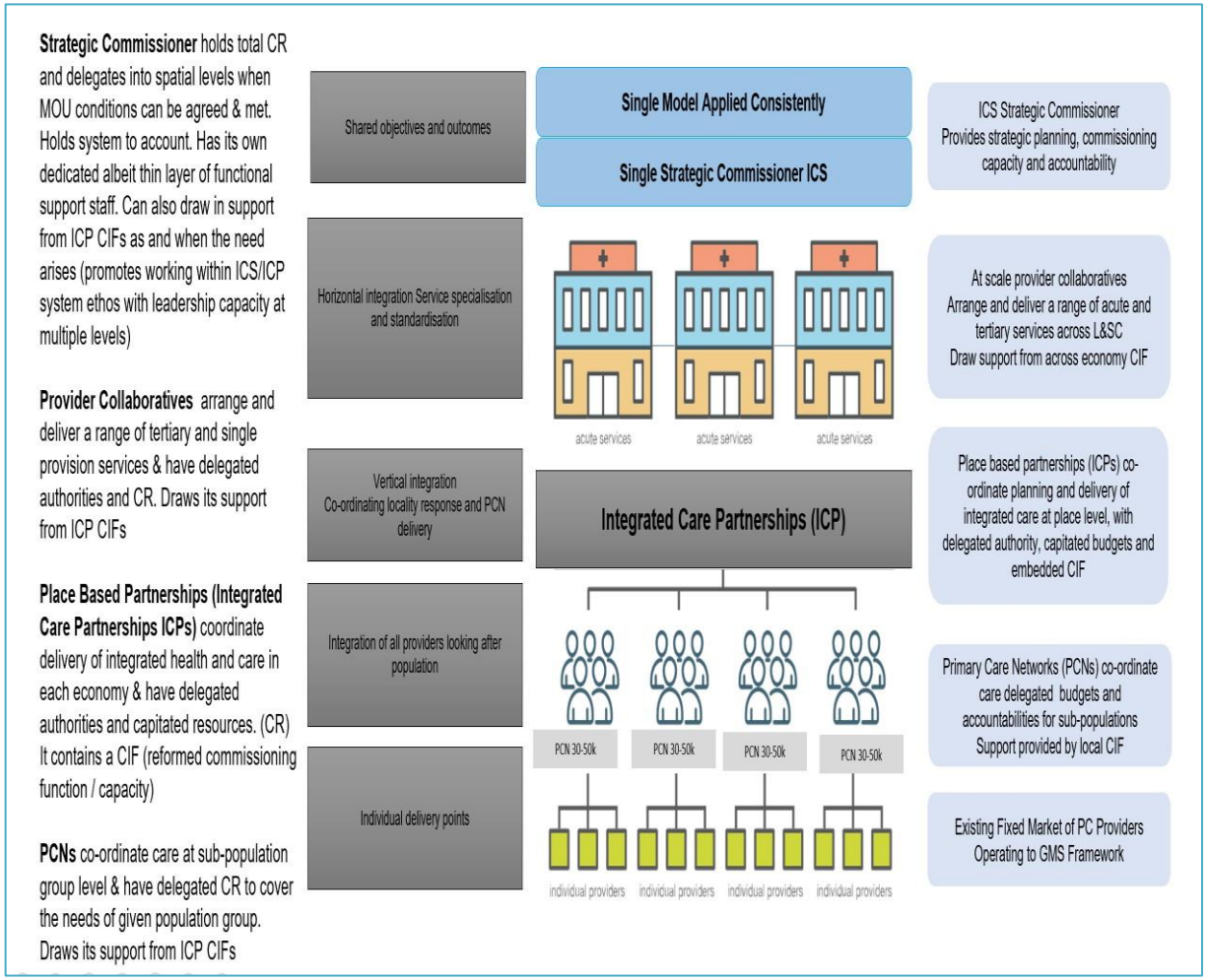
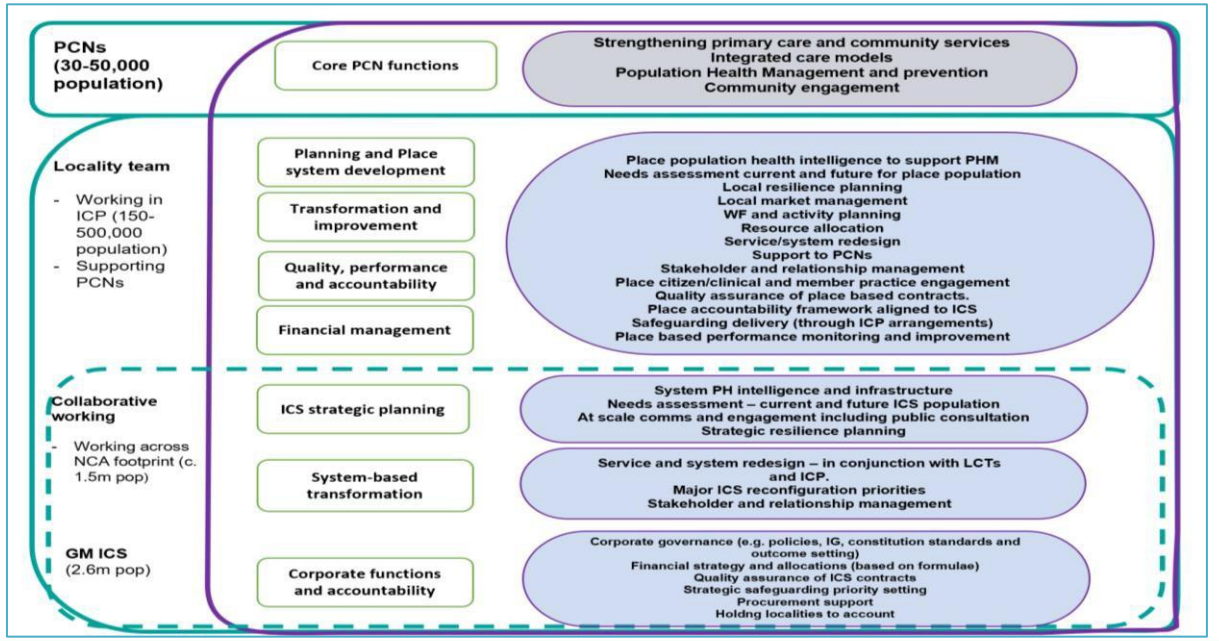
# Greater Manchester Integrated Care System Operating Model




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

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

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



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# Greater Manchester strategic context

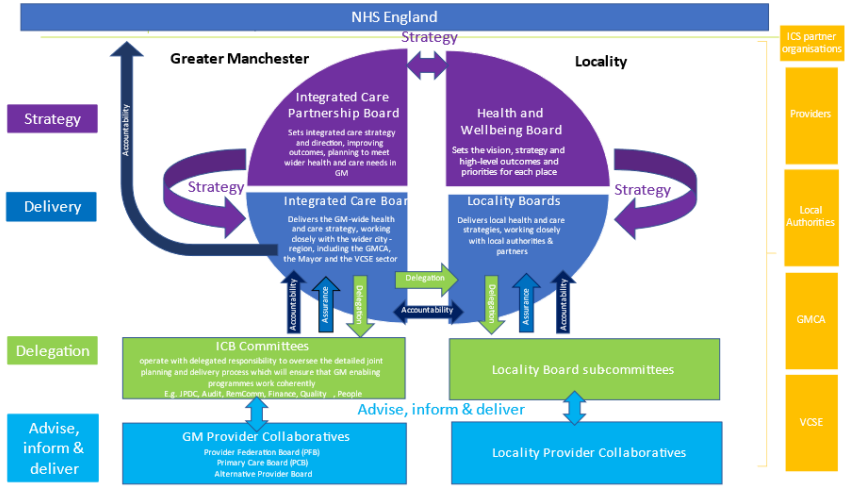
The **GM model for health and care**, developed to ensure that everyone can live a good life, is to:

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

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

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

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

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# GM's mission-based strategy

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

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

The six missions…

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

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# The Oldham context

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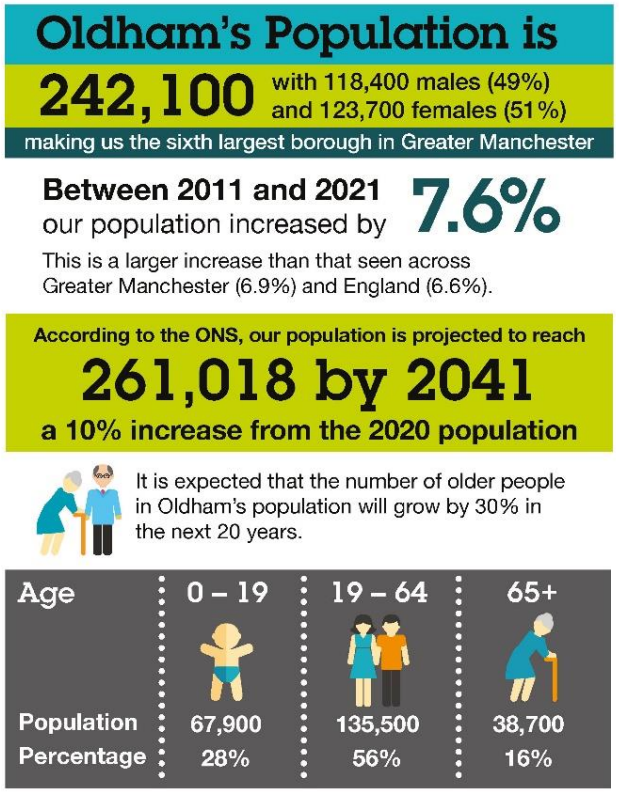
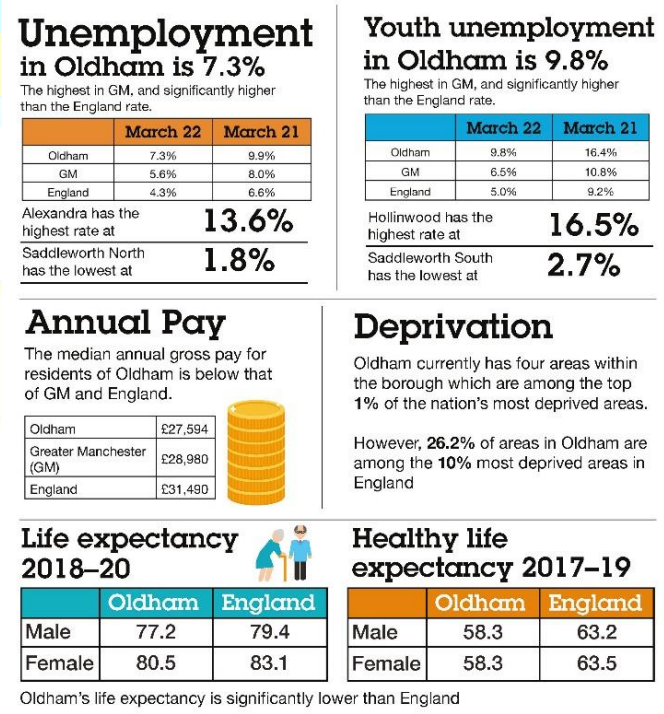
# Oldham's challenges

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

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

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



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# The state of health and care in Oldham

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

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

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

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

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# Addressing the challenges

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

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

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

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

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

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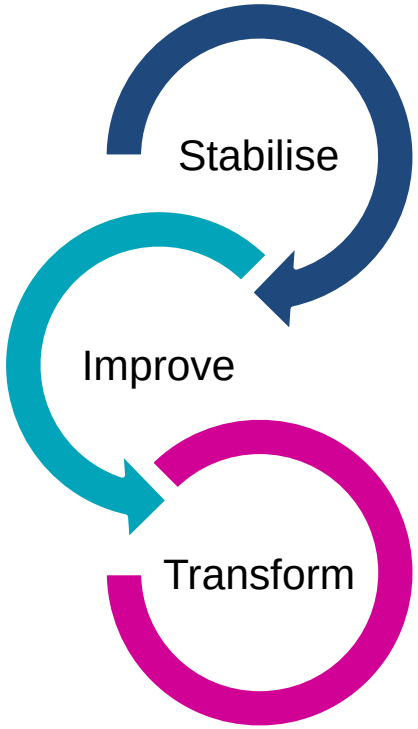
# Addressing the challenges

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

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




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

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

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

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

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

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

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

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

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

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

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# Oldham's model of care

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

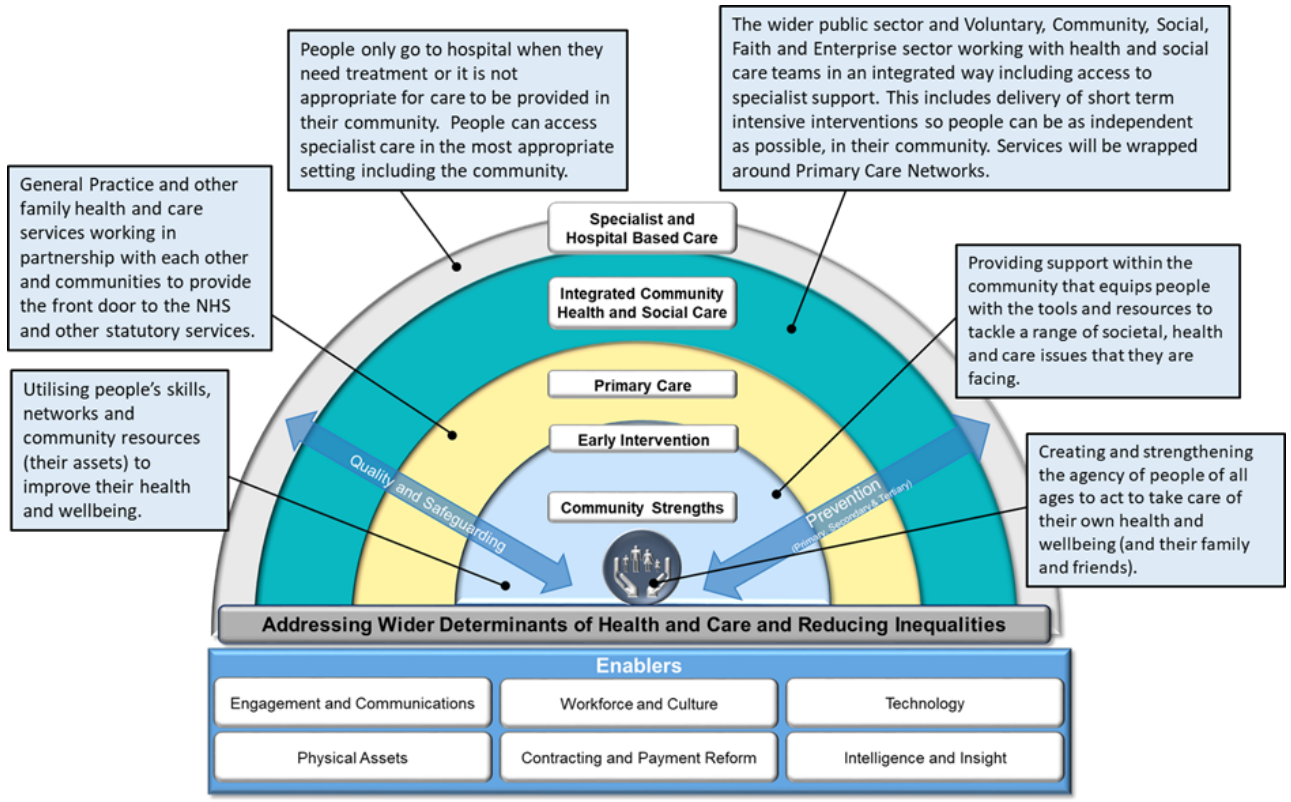
The model describes how different health and care services and partner organisations will work together for a person, population group or patient cohort as they progress through the stages of a condition, injury or event.

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

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

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

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



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# Oldham's model of care

The design logic behind our model of care…

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

Places the person and their community at the centre

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

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

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

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

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

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# Focusing on ten bold ambitions

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

## Our 10 Bold Ambitions

1. We will seek to **influence the factors that improve population health** and wellbeing and reduce health inequalities and foster inclusion
2. We will **support residents to be well, independent, and connected** to their communities and to be in control of the circumstances of their lives
3. We will support **residents to be in control of their health and well being**
4. We will **support people to take charge of their health and care and the way it is organised around them, and to live well at home**, as independently as possible
5. We will **support children to 'start well'** and to arrive at school ready to learn and achieve
6. We will ensure all residents **have access to integrated out of hospital services,** that promote independence, prevention of poor health, and early intervention
7. We will work through **5 neighbourhood teams** to create opportunities for front line staff to know each and work effectively together
8. We will secure **timely access to hospital services where required**
9. We will work to **reduce dependence of people on institutional care** – hospitals and care homes.
10. We will work to ensure **high quality responsive services** where people describe a good experience of their treatment

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# Our overall strategy

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

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

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

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

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# Delivering and organising our strategy

To achieve results we will need to fundamentally rethink:

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

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

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

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# Prioritising using the drivers of demand

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

Demand is being driven by three thematic areas:

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

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

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

Additional key areas of intervention are as follows:

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

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

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# Establishing a new health and care system in Oldham

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# A new infrastructure – the cornerstone of our strategy

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

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

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

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

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

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# 1. An integrated care partnership and place-based integration

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

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

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

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

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# 1. An integrated care partnership and place-based integration

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

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

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

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

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

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# 1. An integrated care partnership and place-based integration

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

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

Our collaborative will work in such a way as to:

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

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

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

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

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

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# 2. Population health outreach

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

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

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

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

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

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

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

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

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

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# 3. Citizen engagement and involvement

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

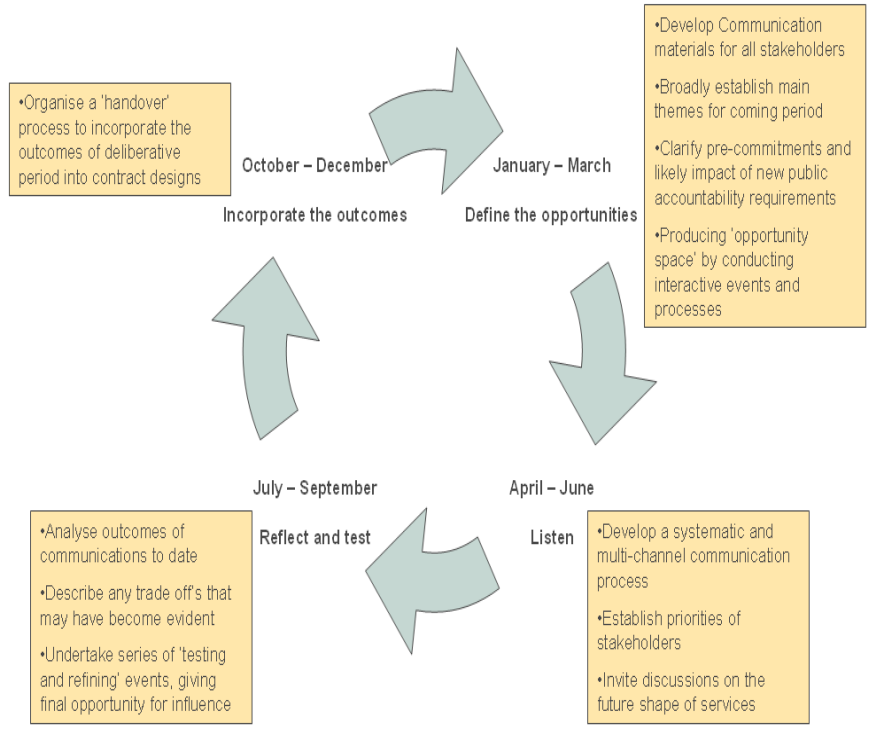
The key challenge is to create a framework within which the new conversation with our population about service change can take place in a way that is not tokenistic. In order to meet this challenge, we have to be able to meet two criteria. The first criterion is that the nature of our discussion with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

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

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

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

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



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# 3. Citizen engagement and involvement

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

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

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


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

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# Support programmes

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# Equity and inclusion

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

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

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

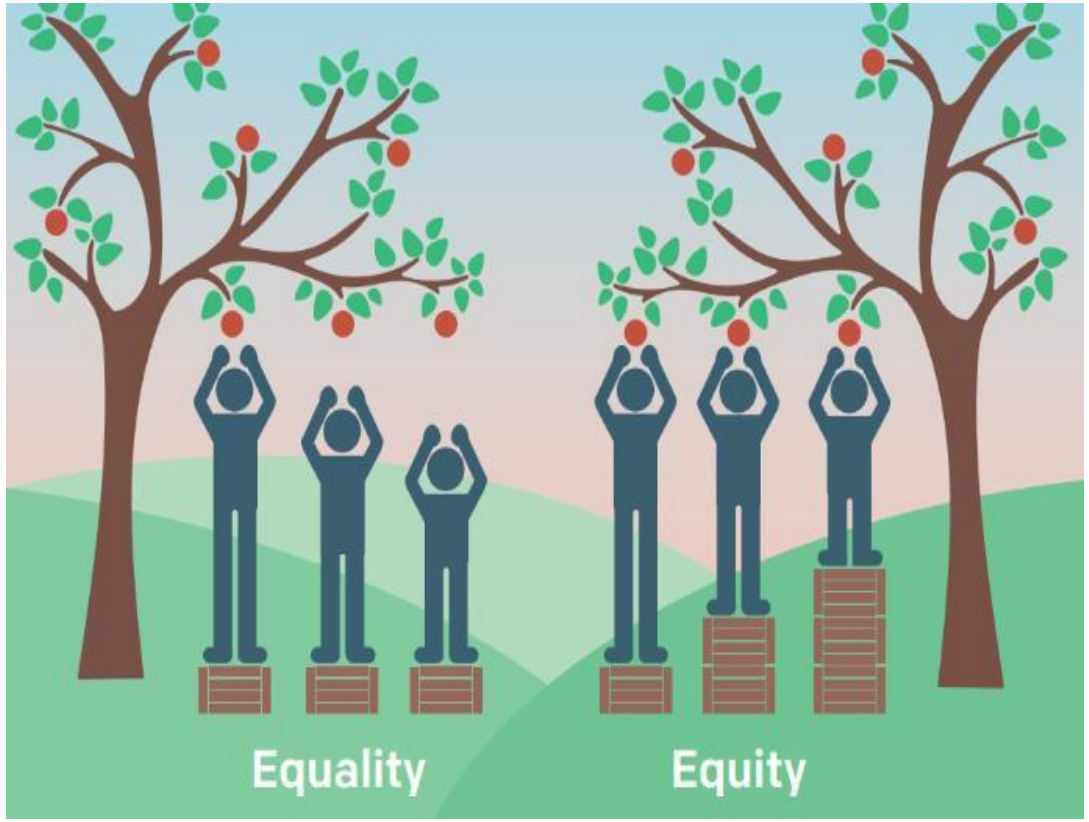
We know that system-wide and structural discrimination exists in Oldham, so as a Partnership we need to be brave and be committed to an approach where no one is excluded, and where we actively give people help to achieve real fairness and equality of access and outcomes for all.

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

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

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

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



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# Social value

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

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

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

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

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

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

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# Workforce

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

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

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

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

This Workforce Strategy aligns with the national NHS People Plan.

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

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

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

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# Digital

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

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

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

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

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

**GM digital transformation ambitions:**

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

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# Sustainability and net zero

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

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

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

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

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

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

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

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

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

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# Estates

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

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

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

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

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# Effective working

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# Ways of working, planning and prioritisation

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

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

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

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

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

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

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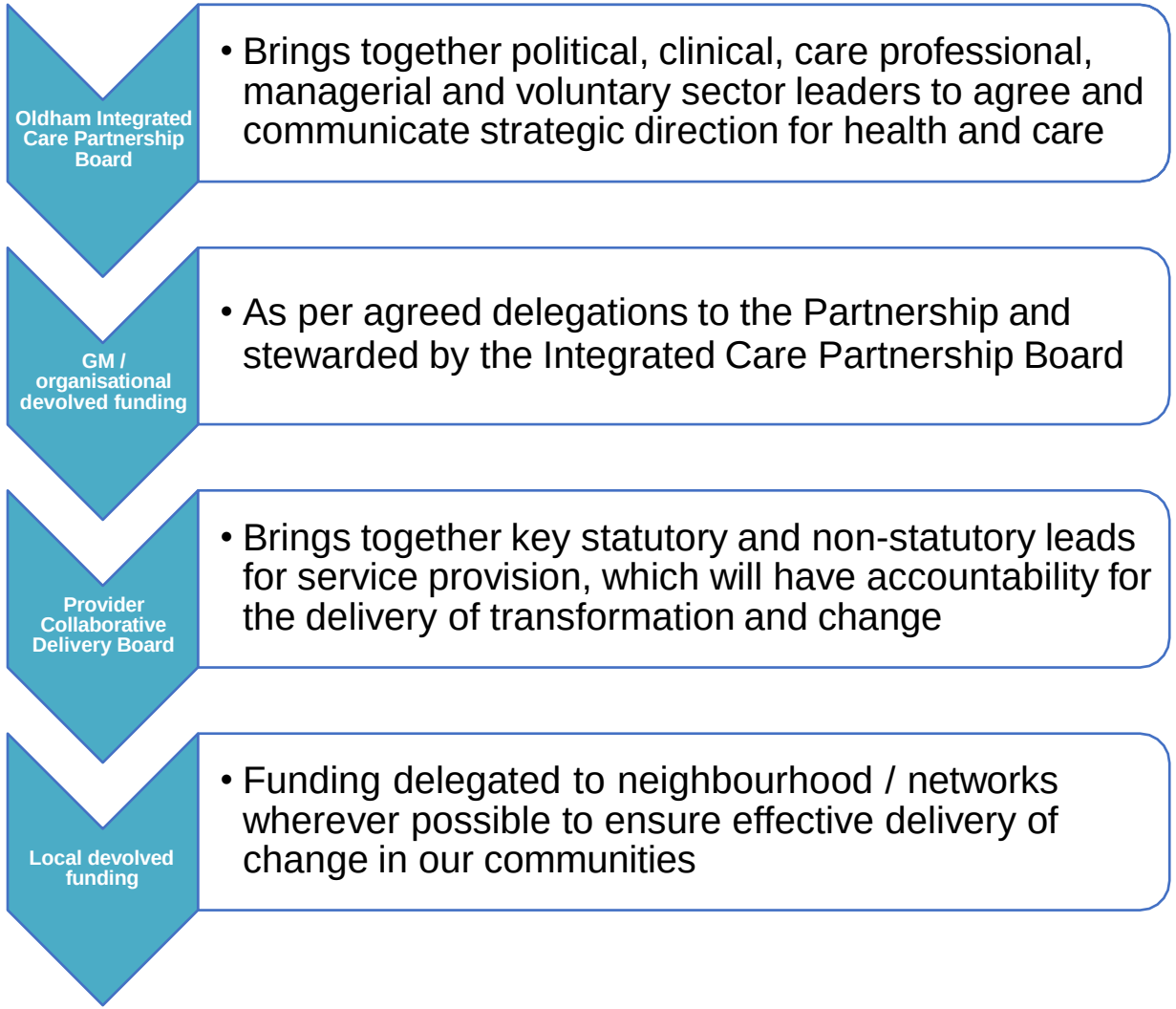
# Governance

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

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

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



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# Risk management

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

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

**BOARD ASSURANCE FRAMEWORK**

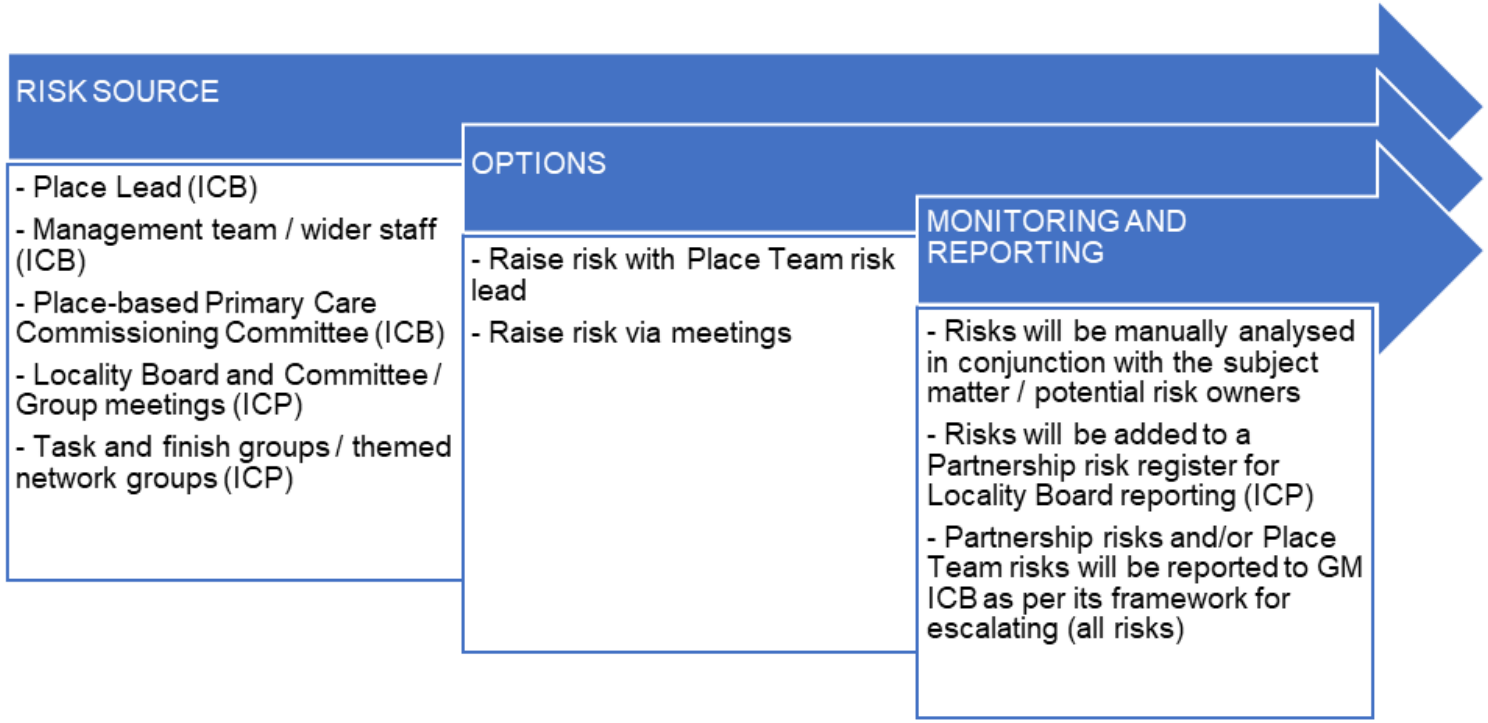
- Risks to the delivery of the strategic aims

**CORPORATE RISK REGISTER**

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

**OPERATIONAL RISK REGISTER**

- Risks to the delivery of health and care transformation and recovery



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# Measuring our success

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# Outcomes and core measures

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

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

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

**Core measures:**

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

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# What will good look like?

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

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