Oldham Integrated Care Partnership (ICP) 2024/25 delivery plan

Oldham
Integrated Care Partnership

Part of Greater Manchester
Integrated Care Partnership

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Foreword

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This delivery plan covers the year one delivery of the Oldham Integrated Care Partnership's five-year strategy along with how we in Oldham will meet the obligations set out in the NHS planning guidance for 2024/25. It features the key priorities for the year ahead, as well as the detail of action areas and milestones. We have chosen to structure this plan around seven themed workstream areas, that incorporates the local recovery, improvement and transformation needed to deliver against Greater Manchester Integrated Care Joint Forward Plan, which in turn aims to deliver against the NHS's 'Long Term Plan' commitments.

Following detailed examination around the local 'drivers of demand' across Oldham health and care services, the recommended actions made because of this work are incorporated across the themed delivery areas.

If a priority action(s) in relation to the drivers and/or the Greater Manchester (GM) Operational Plan does not fit into a themed workstream area, the action(s) will be embedded into the relevant organisation's / team's 'business-as-usual' work.

Like with Oldham's 5-year Strategy, and as all partners have committed to improving health and reducing health inequalities, our local delivery and transformation activities for the year ahead will align with Oldham's Health and Wellbeing Strategy. In addition, plans for the prevention of ill health across all our communities will focus on the highest impact interventions, and:

- Take a quality improvement approach to addressing health inequalities and reflect the 'Core20PLUS5' approach in plans as detailed in our five-year strategy
- Consider the specific needs of children and young people
- Establish high intensity use services to support demand management in urgent and emergency care

Plans will also link to the five strategic priorities for tackling health inequalities:

1. Restoring NHS services inclusively
2. Mitigating against 'digital exclusion'
3. Ensuring datasets are complete and timely
4. Accelerating preventative programmes
5. Strengthening leadership and accountability

A collaborative partnership approach will be adopted for this area, with community involvement and 'lived experiences' utilised wherever possible, embedding various levels of engagement and equality, diversity and inclusion, from statutory impact assessments of change, through to full consultation and co-design and/or co-production. An inclusion health focus for local decisions will be utilised and Oldham's established Health and Care Senate, made up of clinical and care professional leaders will be a core point of direction and advisory in relation to operational improvements to local services, linking closely to patient and community groups to enable the outcomes of change to be as positive and effective as possible by considering the views of those impacted as our expert patients

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Context, challenges and overarching priorities

Our population

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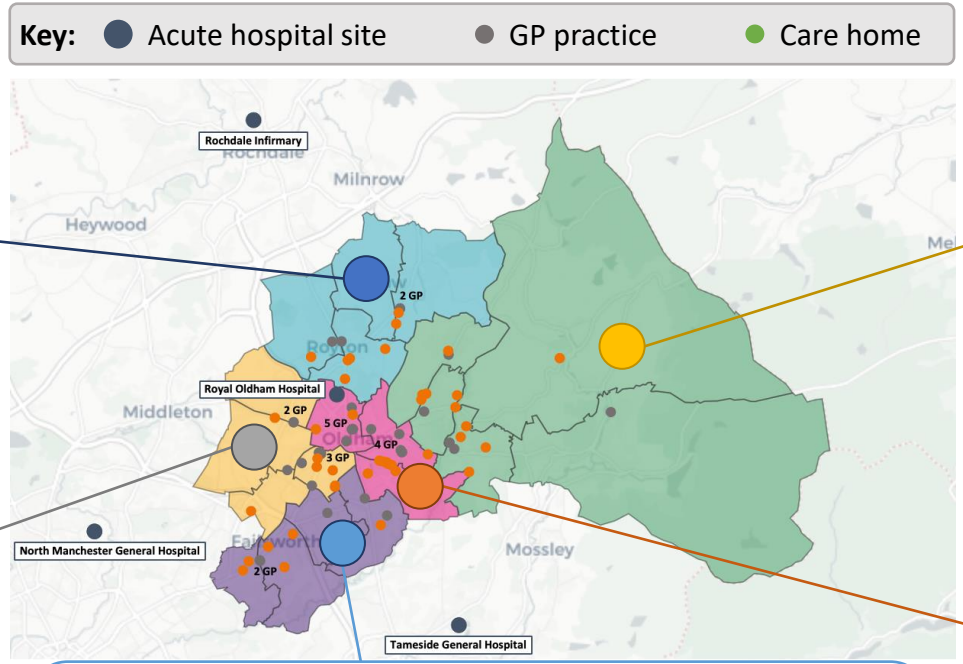
Across our five networked neighbourhoods, population demographics and health needs vary, with a young profile except in north, and deprivation concentrated in central, causing different resource needs.

North District

- **Oldest demographic** with large number of >65s (older than GM and England averages), and the **least ethnically diverse** of the Districts with a predominantly white population
- Some **pockets of deprivation**
- **Highest rates of obesity, respiratory disease, CVD and depression** in Oldham and above national rates, and high rates of diabetes
- **Highest rates of learning disabilities** with west



East District

- Age profile is slightly older than other districts apart from north, with **low ethnic diversity** and a predominantly white population
- East has the **lowest deprivation** of the Districts
- **Lowest rates of SMI** compared to other Districts
- **Lowest smoking rates in Oldham** but at **higher end of rates of respiratory disease**
- Relatively **lower rates of diabetes** although above the national average and **lowest frailty in 50-64**

West District

- **Young population** (similar to south) with **some high diversity** - a quarter of people are registered as Asian/Asian British
- Significant **pockets of deprivation**
- High rates of mental health conditions with **highest rates of SMI in Oldham**
- **Highest smoking rates** significantly above the national average and **relatively high rates of respiratory** disease and diabetes
- **Highest rates of learning disabilities** with north

South District

- **Younger population** profile (like west) but relatively **lower ethnic diversity**
- Significant **pockets of deprivation**
- **Lowest obesity rates** of Oldham but still above England, **lowest CVD rates** in Oldham (below England), and **relatively lower rates of diabetes** although still above England, but **high smoking rates**
- **High rates of mental health conditions** compared to nationally

Central District

- **Youngest population** profile(30% <16, 9% >65) and **highest degree of ethnic diversity** with nearly 50% of the population Asian and largest proportion of Black/Black British/Caribbean or African residents
- Significantly the **most deprived District**
- Relatively **high levels of smoking and obesity**
- **Highest levels of frailty** in 50-64 age group
- High needs for LTCs including **relatively high levels of mental health conditions, respiratory disease and highest rates of diabetes.**

Our core challenges

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Oldham is facing high levels of demand across the health and care system which are particularly visible at Royal Oldham Hospital.

This demand for public services is expected to be further influenced by a growing older population, with the over 65 population expected to grow by 30% by 2041, and high levels of deprivation.

The strain on service provision from this demand is reaching the point of being unsustainable despite the best endeavors to resolve the issues over several years.

Our focus for much of the years ahead will be about tackling the drivers of demand in our system. As part of this planning round we set about a whole system conversation to understand that question and collectively we have identified three primary drivers.

Our priorities as a whole system will focus on tackling and arresting this demand as much as we possibly can starting in 2024/25 but continuing into future years.

1. High health, care and social needs

- High deprivation and associated demographic factors
- Challenging living environment and/or home setting
- 'Risky' lifestyle and health behaviours, and high rates of risk factors
- High rates of physical and mental health conditions and disability

2. Insufficient focus on early intervention and prevention

- Limited self-management and/or overreliance on services
- Need for more early detection and prevention
- Challenges in access to and use of primary care and other upstream services
- Barriers to accessing non-urgent hospital care

3. Lack of service integration, communication and signposting

- Demand is sometimes directed to the 'wrong' place
- People don't know how to navigate the system or services
- Lack of integration across services and fragmentation of patient flows

Challenge 1: High health and social care needs

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In summary, there are a set of wider environmental factors and health needs in Oldham driving demand including deprivation, living circumstances and high rates of health conditions.

Drivers of health and care demand		Example evidence
Demographic factors closely tied to deprivation	• High levels of deprivation which are associated with lower GP/OP service use, and with higher CYP social care use • There is intersectionality between deprivation and ethnicity • High levels of crime and violence	• Strong links between child poverty and UEC use • Strong links between CYP mental health and deprivation
Challenging environment and/or home setting	• Poor parental mental health • High levels of domestic violence • High social isolation and loneliness • Need more familial support for new mothers (teen pregnancy)	• Social isolation is the top social prescribing referral • Adult and child mental health referrals are interrelated
Lifestyle, health behaviours and risk factors	• Poor housing stock (damp, poor insulation) • Low physical activity and/or poor diet • High obesity rates • High smoking rates, and high alcohol/drug use • High levels of stress (e.g. due to financial worries)	• High smoking and obesity rates, with obesity appearing to be a big driver of UEC use • Housing is the second highest social prescribing referral in central
High rates of health conditions and disability	• High rates of long-term conditions (diabetes, asthma, COPD) and high rates of learning disability needs • High rates of mental health conditions • High rates of some acute illness such as lung cancer	• LTCs and risk factors show strong links to UEC use • Growing mental health service use (CYP and adult)

Impact on demand	
	**High long-term health and care needs requiring primary, community, mental health and social care support** (and self-management) e.g. respiratory, mental health, social needs
	**High needs amongst CYP**, particularly mental health and earlier care support – there appears to be strong links between deprivation and CYP A&E use for mental health
	**High A&E use** for illness as health deteriorates or issues are undetected (e.g. high lung cancer rates, or for long-term conditions)

Challenge 2: Insufficient focus on early intervention and prevention

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In summary, there is a lack of focus on early intervention and prevention, and barriers to accessing upstream services and care, is creating additional 'failure' demand.

Drivers of health and care demand		Example evidence	Impact on demand
Limited self-management or overreliance on services	• **Low self-management** and **low health literacy** in some populations (accompanied by 'risk' behaviours like smoking) • **Service paternalism** or **'pathologising'** is creating dependency (e.g. low PIFU, potential use of A&E as front door)	• Lowest rates amongst peers of people with T2D meeting all 3 treatment targets • Relatively low PIFU	**High UEC demand** – either use as a front door, or presenting in A&E with deteriorating health
Need for more early detection	• There is variation in detection across services. **Low detection of cancer**, and **low reported prevalence of CVD**/hypertension potentially indicates need for more case-finding/detection • **Low uptake of health checks** and early prevention offers with a need to support better access in certain populations	• Second lowest detection of stage 1/2 cancer and highest A&E detection vs. peers • Lowest uptake of health checks (40-74) vs. peers	**Higher general community, mental health, social and primary care resource use** due to a rise in complexity from unmanaged health issues
Challenges in access and use of primary care services and other upstream services	• **Very long wait times** for some CYP services (e.g. SALT) • **Challenges in use of primary care**, appearing to be a mix of capacity issues and lack of engagement in some service users • **Capacity issues in community services** e.g. diabetes nursing • IAPT referral attrition and **gap in mental health service offer** • **Cultural barriers** such as language translation, mistrust	• Primary care appointments • per head are below nationally • High A&E attendances for LTCs, mental health, etc. • Links across deprivation, lower GP/OP and high A&E	**High CYP demand and complexity** including mental health needs – as issues go unaddressed
Barriers to non-urgent hospital care	• **Waits have risen** for elective and cancer services in acute care • There are some **gaps in current service provision**, such as a walk-in/minor ailments centre, CAMHS beds in Oldham	• EL waiting list size has grown 18% since August 2021	**More referrals and longer backlogs as** routine care is tagged as urgent to ensure patients are seen around long waits

Challenge 3: Not enough service integration and communication

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In summary, there is a need for more service integration such as issues in flows, signposting and communication across services drives referrals, duplication and care in the wrong setting. Community-led care navigation will be key.

Drivers of health and care demand		Example evidence	Impact on demand
Demand is sometimes directed to the 'wrong' place	• **Risk aversion** in the system may funnel people to secondary care, particularly for managing moderate mental health needs • Some Royal Oldham Hospital A&E use may be related to **proximity of A&E** and low awareness about alternatives, funneling demand to A&E	• GoToDoc pre-ED redirects many patients outside A&E • High numbers of low acuity A&E attendances	**High UEC demand** which could be triaged or managed in the community and/or primary care
People don't know how to navigate the system or services	• Service users, providers or care givers not always clear on the right care setting so people can **end up in the wrong place,** needing multiple re-referrals, re-assessments or getting 'lost' • Some populations **don't know how, why or when to access services** when they need (e.g. diabetes checks)	• Oldham has the largest proportion of adult social care referrals that go into universal/other services or require no further action	**Higher primary care demand** for things that could be managed elsewhere (e.g. OTC prescriptions, re-referrals from secondary care)
Lack of integration across services (both vertically and horizontally)	• Greater integration is needed across out-of-hospital services as well as in-hospital to more effectively manage people's needs across service boundaries and **reduce duplication**, with potential to strengthen and mature PCN roles • **Issues in horizontal patient flows across secondary care** specialities (inter-referral) creates duplication in demand, where patients are referred back to primary care to be referred back to acute care	• Very high A&E attends vs. peers for diabetes, respiratory, mental health • High rates of long-term conditions and social needs (e.g. deprivation, housing) require greater integration across all public services	**High referrals into multiple services, or that don't require care**, also driving up wait times (e.g. ASC referrals for advice and guidance, or onto other services)

Priorities

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This delivery plan features, in the delivery programme section, the transformation aims of Oldham Integrated Care Partnership, as well as the 'business as usual' plans for the year ahead for NHS Greater Manchester's locality Place Team, as linked to the national, regional and local NHS commissioning priorities.

For ease, the following slide describes Oldham Integrated Care Partnership's top four priorities, as these will enable direct delivery as linked to our five-year strategy and provide focus to help us to tackle local key performance issues and local drivers of demand in a collaborative way.

The delivery programme workstream action plans additionally feature the full work plans for health and care for the local Place Team.

Our four top priorities for 2024/25

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The scale of the challenge facing the NHS is unprecedented and whilst our operational plan for 2024/25 will describe the things we will do in Oldham to meet the things we have to do on behalf of the NHS we have set ourselves as an Integrated Care Partnership four top priorities for 2024/25. These are set out below. The detail of what we plan to do is set out in the delivery programme part of this plan.

1 Reduce 'late' service access, presenting in **high demand for UEC**– A&E and NEL *(closely linked to priority 4)*

- Improve **early detection, diagnosis, and prevention** by identifying patient cohorts to treat proactively
- **Improve self-management** of LTCs or risk factors (e.g. smoking)
- **Enhance the primary and community care model**, to improve capacity/availability, citizen engagement and case management

- UEC in **central, south, west**
- **CVD, respiratory** (smoking in west), **early frailty** (central) and **diabetes** (central, north, west)
- Proactive care for **BAME** groups

2 Proactive CYP intervention to **reduce downstream demand, including in social care**

- **Review current and previous service provision** (including early help triage), family support and early intervention model (0-5 years), and **referral criteria**
- **Improve access to key early CYP support** (e.g. MH, SALT services)
- Explore initiatives with **schools** on educational referrals and **police**

- High CSC in **central** and **south**
- Improve CYP MH support in **central**, review high SEN support
- CSC offer for **BAME** groups
- High CAMHS use in **north, east**

3 **Enhanced model for managing mental health** needs, including low- and mid-severity

- **Review service model and local provision** for 1) **Low/moderate MH needs** and 2) **Preventing people entering crisis**, including opportunities for social prescribing, crisis support and local MDTs
- Understand and **reduce attrition for IAPT and community MH**
- Address strained inpatient capacity (discharging, OOA placement)

- **Understand and address** CYP/ adult MH service use in central and west
- Support for **BAME** (IAPT use)
- Reducing delayed discharge

4 Supporting **better care navigation** and **coordination** *(tightly linked to priority 1)*

- Improve support and engagement on the **right care setting for different needs**, including effective **triage** processes
- Provide a clear, **single point of access**
- **Signposting and guidance on how to navigate services** for providers, service users and their families

- **ASC referrals with no further action/onto other services**
- Primary care access in **central** and **east** and low acuity A&E use in **central, south, east**

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Neighbourhoods at the heart of our delivery programme

Understanding our communities

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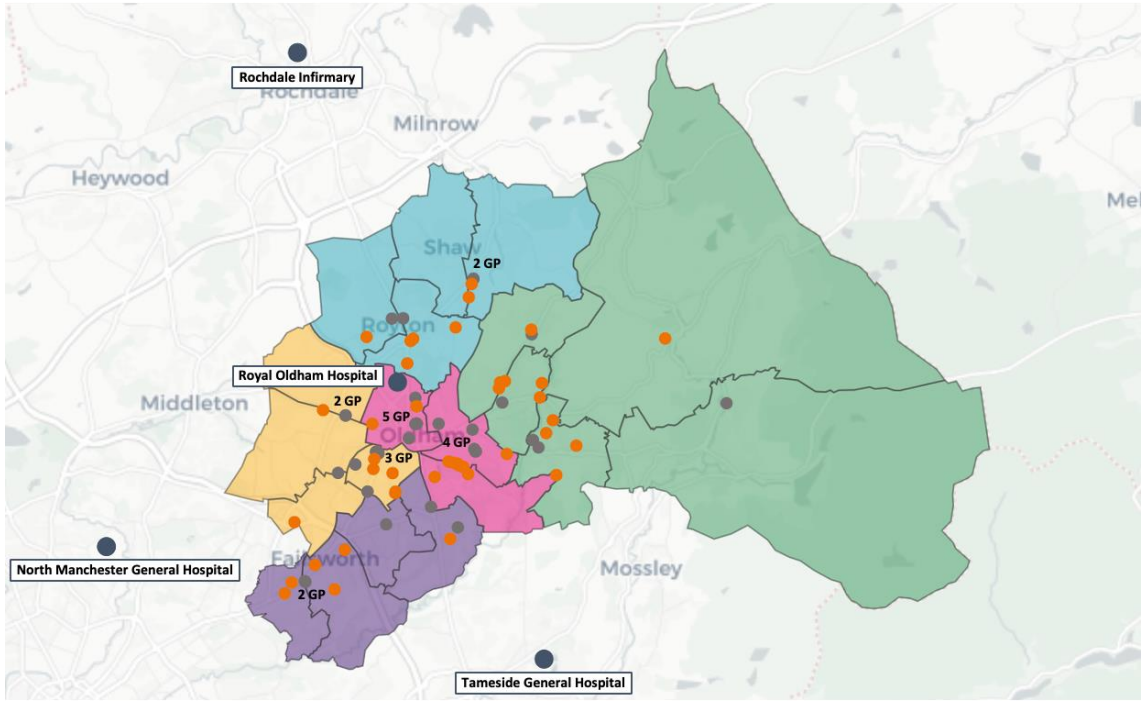
As well as being a key part of the population health management and place-based integration workstream within our delivery programme (as outlined in the section following this one), understanding our neighbourhoods and the communities within is at the heart of delivering real change during the year ahead.

Following the extensive collaborative listening and engagement that took place amongst all Oldham partners and communities to assess the key drivers of demand for health and care services and establish our overarching priorities (as outlined in the previous section), this same approach has been undertaken to plan how a preventative, early help and intervention, population health management approach will be taken.

This has resulted in an assessment of the overall opportunity, broken down to each of the five neighbourhoods as follows. (It should be noted that this is a summary, as an extensive range of more detailed data sit underneath for each neighbourhood.)

Taking this approach will also enable us to deliver against the key areas within the national NHS Planning guidance to improve health and join-up care, namely to:

- Expand evidenced-based approaches to population health, focusing on a healthy start to life, prevention, self-care and better management of long-term conditions
- Join up care closer to home including through integrated neighbourhood teams and place-based arrangements with local authorities and other system partners
- Integrate and streamline UEC pathways, with a particular focus on the management of older people with complex needs and frailty
- Continue to drive improvements in productivity and operational effectiveness



Population health management (PHM) models

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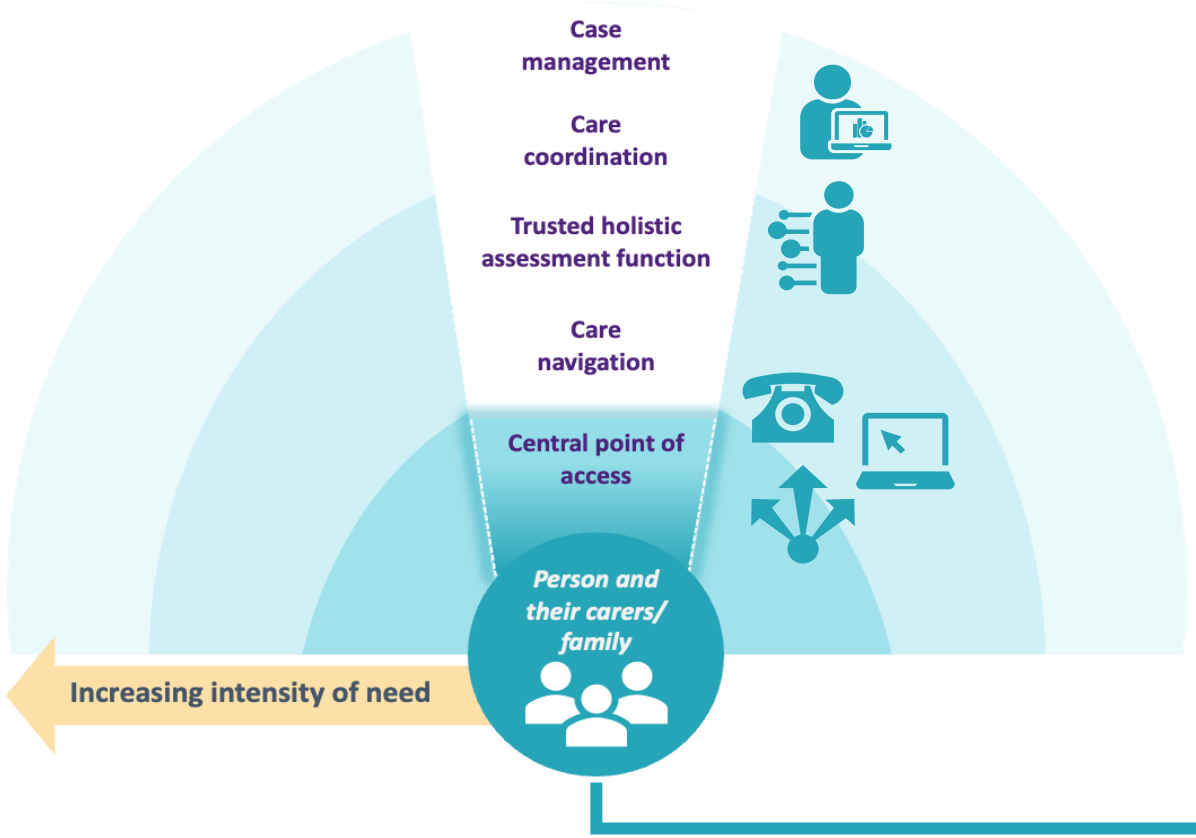
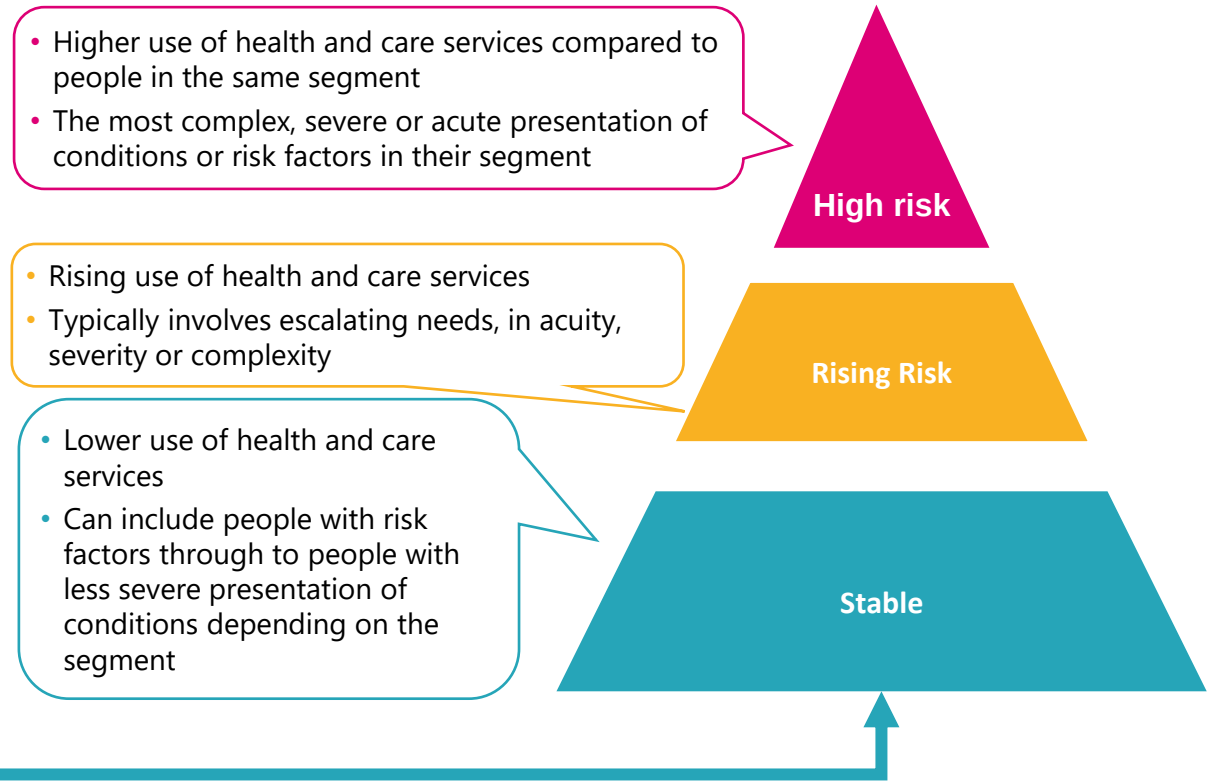
Underpinning the priorities are care coordination and navigation and population health management to proactively identify and manage people. **This will encompass community-led health approaches, self-care and self-navigation.**





Care coordination, navigation and assessment approach according to complexity of need

Population health management approach using segmentation and risk stratification

Overall opportunity of implementing PHM models

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The opportunity of implementing the PHM models in the relevant neighbourhoods in Oldham could save £5.1m - £9.1m across the individual groups.

Neighbourhood	PHM priority group	Description of group used to calculate opportunity	Approach to quantify opportunity	Number of people who benefit	Minimum / low opportunity	Maximum / high opportunity
Central	0-17 CYP in good health with rising risk (e.g. in high-risk households)	CYP in good health segment but with 3 or more A&E attendances in a year (indicating potential rising risk)	Savings from delaying a proportion of CYP in good health with rising in risk moving into worse health*	500	£355k	£592k
West	0-17 CYP at risk of developing low to mid severity mental health	CYP with mild to moderate mental health disorder with or without single or multiple LTC (as an indication of case finding numbers)	Savings from delaying a proportion CYP at risk of mental health moving into low to mid severity mental health	400	£449k	£748k
North	65+ older people with frailty	Older frail people (65+) identified using the Lancet frailty index	Savings from avoidance of A&E visits and NEL admissions as well as a reduction in NEL occupied bed days (OBDs) for long lengths of stay for 65+ with frailty	1,921	£1.6m	£2.8m
South	65+ older people with frailty	Older frail people (65+) identified using the Lancet frailty index	Savings from avoidance of A&E visits and NEL admissions as well as a reduction in NEL occupied bed days (OBDs) for long lengths of stay for 65+ with frailty	1,240	£1.2m	£2.0m
East	50-64 working age adults at risk of frailty	Adults aged 50-64 with two or more physical LTCs, with or without a mental health condition	Savings from delaying a proportion of adults aged 50-54 who are at risk of frailty becoming frail	1,000	£1.5m	£3.0m
Sub total	-	-	-	**5,061**	**£5.1m**	**£9.1m**

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Quality, equality and equity

Assuring quality, safety and safeguarding

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The national priorities in relation to quality and safety is to:

- Implement the Patient Safety Incident Response Framework (PSIRF)
- Design a locality process for capturing and implementing the learning from the new Learn from Patient Safety Events (LFPSE) to maximise quality improvement across services
- Lead the locality on the understanding of the NHS patient safety syllabus

In addition, there are a range of GM-wide and local actions needed to ensure that health and care delivery is high quality, is safe, and that it safeguards the most vulnerable amongst our population.

These focus areas are outlined in the following slide and will be embedded into all improvement and transformation work.

In relation to local **safeguarding**, there are some specific locality priorities, namely to:

- Align locality safeguarding functions with GM expectation and statutory functions
- Design and implement a domestic abuse process across primary care.
- Design and implement a safeguarding supervision model across quality and CHC
- Promote the self-neglect themed national learning across the locality, to improve lives.

Link to GM missions:
Mission 2 – Helping people stay well and detecting illnesses earlier
Mission 5 – Supporting our workforce and carers

Assuring quality, safety and safeguarding

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In relation to local quality and complex healthcare, the following are priorities for 2024/25.

Link to GM missions:
Mission 2 – Helping people stay well and detecting illnesses earlier
Mission 5 – Supporting our workforce and carers

Quality:

- Embed quality across all governance and reporting frameworks to ensure transparency and equity of services.
- Continue to work with the Local Maternity and Neonatal System (LMNS) to implement the three-year maternity delivery plan and ensure women and families voices are heard.
- Improve the engagement of patients and families across locality services in relation to incident responses.

Complex healthcare:

- Ensure processes are effective and backlogs are kept to a minimum, in line with national targets
- Enhance partnership working in relation to complex care
- Design and implement a personal health budget (PHB) audit process, making improvements in relation to personal health budgets
- Review and implement an updated D2A process
- Design a CHC data profile which gives a weekly overview of CHC patient activity and demand.
- Raise the profile of jointly funded packages and empower commissioning nurses in decision making.

Reducing health inequalities

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As per the national NHS priorities, we will continue to address health inequalities and deliver on the Core20PLUS5 approach, for adults and children and young people.

As linked to The Oldham Plan and broader social value and anchor institutions work, wherever possible this plan, and its associated delivery programme, workstreams and enablers, will support opportunities around wealth building as centred around health and care employment opportunities.

The plan will also have due regard to, and alignment with, the 2024/25 health inequalities action plan, which is overseen by Oldham Health and Wellbeing Board. Those actions where there needs to be a direct oversight of delivery by Oldham Integrated Care Partnership will be built into the Board Assurance Framework, and the actions will also be embedded into the workstreams and all delivery actions. This will include building in an 'inclusion health' checklist to local health and care decision-making.

This plan and the delivery programme within has been designed to have due regard to the NHS Major Conditions Strategy. This strategy aims to be a comprehensive approach to addressing ill-health and early mortality, tackling health disparities to narrow the gaps between the highest and lowest rates of healthy life expectancy.

The major conditions covered under this framework, that are considered to contribute to more years for people in ill health, are:

- Mental health
- Cancer
- Dementia
- Cardio-vascular disease
- Chronic respiratory disease
- Musculoskeletal disorders

Link to GM missions:
Mission 2 – Helping people stay well and detecting illnesses earlier
Mission 5 – Supporting our workforce and carers

Reducing health inequalities

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The overall Health and Wellbeing Board health inequalities action plan features below, with the focus areas for Oldham Integrated Care Partnership in terms of oversight and delivery highlighted in green:

To develop an accountable structure where SMART action plans track weight, physical activity and oral health (0-5yrs) measures.	a) Establish a long-term vision for embedding the prevention framework across the Oldham system and b) Identify a medium to long term investment plan for social prescribing.	Have a consistent approach across the system that aids self-help and self-care, with joined up directories of services.	Further development of Oldham MH Living Well model, transforming of community MH services. Focus on 'no wrong front door' and MH teams working at a PCN level more focused on population need.	Increase capacity for, and equity of access to, addiction services, including developing dual diagnosis pathways.
Provide workforce education sessions to increase utilisation of the referral portal from EMIS/ elemental and capture the activity data for further interrogation.	Collect and report on primary care data on referrals into social and employment support to target improvements in uptake.	Maximise funds that residents are entitled to that will support all elements of preventive ill health through to acute or chronic health conditions	Implementation of the minor ailment scheme.	Agree a system wide approach to population health management that uses both data and intelligence to prioritise action and that fosters greater collaboration.
Work with GPs and patients to create a set of standards with regards to how virtual consultations are used in the borough and how patients' confidence in virtual consultations can be improved.	Work with Royal Oldham Hospital to review the DNA policy relating to children and young people, with specific focus on those that are in Care.	Reporting on waiting lists and length of wait by protected characteristics and income level and review the reasonable adjustments that are made for residents where appropriate.	a) To ensure robust data on vaccination programmes, with a particular focus on gaining intelligence on MMR vaccination rate by inclusion health groups e.g. Roma community. b) Collect robust data on cancer by stage and by cancer type, and uptake of screening through inclusion health cohorts.	Partners to support delivery of the LD strategy and action plan across the borough and ensure that when measuring health inequalities that outcomes for LD residents are reported as a group, drawing on the LD dashboard.

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Delivery programme

Organising our delivery programme

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This section outlines our overall delivery programme for the 2024/25 year, and the workstreams contained within.

The workstream areas within the delivery programme are:

1. **Children and young people health integration**
2. **Community services, out of hospital and elective care (scheduled care)**
3. **Mental health, learning disabilities and autism**
4. **Patient flow, urgent and emergency care (unscheduled care)**
5. **Population health management and place-based integration**

Each workstream section outlines the priorities and plans for the year ahead.

This plan shows how these areas, plus a range of other enabling and priority areas, align to the NHS Greater Manchester 'six missions', and have due regard to the overall national NHS 2024/25 planning priorities of:

- Maintaining a collective focus on the overall quality and safety of services, with a particular focus on maternity and neonatal and reducing health inequalities in line with the Core20PLUS5 approach (outlining fully in our five-year strategy)
- Improving ambulance response and A&E waiting times by supporting admission avoidance and hospital discharge and maintaining the increased acute bed and ambulance service capacity committed to across GM
- Reducing elective long waits and improving performance against the core cancer and diagnostics standards
- Making it easier for people to access community and primary care services, particularly general practice and dentistry
- Improving access to mental health services so that more people of all ages receive the treatment they need
- Improving staff experience, retention and attendance

Following this section key enabler areas are also highlighted, covering finance, estates, digital, workforce, engagement and communications.

1. Children and young people health integration

Link to GM missions:
Mission 1 – Strengthening our communities
Mission 4 - Recovering core NHS and care services

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Overview

This workstream oversees the improvement journey for the Children and Young People's services prioritised for change in Oldham as well as developing a successful and collaborative partnership. The purpose of this workstream is to provide oversight and direction to all aspects of children's transformation and improvement as well as supporting those programmes led by our partners.

The workstream has identified 4 programme areas for improvement:

- Joint Children's Commissioning and integration improvements
- Improvements to Speech, Language and Communication Needs
- Enhanced CYP Mental Health and Wellbeing Services
- Community Paediatrics Transformation *(supporting the Community Services workstream)*

The redesign work will be specified for and centred around the individual needs of the borough's five neighbourhoods. Population Health Management Principles form a key driver for change within each programme area and will inform any new delivery model through pilot-based approaches.

It is clear to both locality and provider colleagues that there are no extra funding mechanisms to improve services and that all redesign work will be within the financial envelope that each service sits. However, our approach will be to make best use of funds and where rebalance of funding can be achieved to enhance and improve outcomes then we will move forward at pace to implement this.

Following a Local Area inspection of Oldham's SEND Services in June 2023 that found systemic failings the local partnership has responded well and has begun the hard work of delivering improvements together. However, a key lesson from the post inspection response has been for the partnership to understand that responsibility never lies with one provider or one service. The SaLT provider is not solely responsible for the unacceptable waiting times for example, instead the lack of a balanced system of provision that either meets need in a school-based setting or better family support to prevent escalation of need plays its part too.

It is imperative, therefore, that any transformation work undertaken in one part of the system is aligned to, understood and complemented by changes elsewhere. As such, this workstream has utilised the SEND and Inclusion Improvement Programme (S&IIP) for aspects if its own work. The SLCN and Joint Commissioning steering groups within the S&IIP will be the drivers for change within this workstream, limiting duplication of work and ensuring a partnership approach to change.

For those areas of transformation not able to be overseen elsewhere, then we have established a Children and Young People's Transformation Oversight Board as well as the creation of a CYP Mental Health Locality Board that reports through existing all age and Greater Manchester governance. The transformation work is underpinned by robust delivery plans and a programme tracker that can readily report into relevant partners and meetings as required.

1. Children and young people health integration

Link to GM missions:
Mission 1 – Strengthening our communities
Mission 4 - Recovering core NHS and care services

Oldham
Integrated Care Partnership

National priorities

- Reduce 52 week waits for access to children's community services.
- Ensure the plans for the recovery of core NHS services reflects the needs of children and young people.
- Increase the number of children and young people able to access mental health service (345,000 additional when compared to 2019) – *also reflected in mental health workstream.*
- Increase vaccination uptake for children and young people towards World Health Organisation recommended levels – *also reflected in the population health management and PBI workstream.*
- Continue to address health inequalities (Core20PLUS5) for children and young people .
- *It is acknowledged that all of the national priorities outlined in this plan are 'all age' and will ensure that children and young people are considered.*

Local priorities

- Introduce new governance arrangements for Children and Young People's Commissioning and for a SEND Local Inclusion Partnership.
- Reduce the number of Children and Young People on the waiting list for a Speech and Language service.
- Deliver a new model of delivery for Speech. Language and Communication Needs that delivers longest waiting time reductions and greater schools-based support.
- Co-production of an Oldham Children and Young People's Mental Health and Wellbeing Strategic Plan.
- Reduce the numbers of bespoke joint funded packages of care for Children and Young People.
- Deliver Oldham CAMHS provision up to the age of 18.
- Increase completion of ASD and ADHD assessments.
- Achieve >95% coverage with 2 doses of MMR vaccine in children and young people up to 19 years.

1. Children and young people health integration

Link to GM missions:
Mission 1 – Strengthening our communities
Mission 4 - Recovering core NHS and care services

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Solutions and actions

The Children and Young People's system needs to be a truly collaborative and partnership one, with various pressures and governance arrangements understood by all partners. Locality solutions also need to support the work being undertaken at GM level as part of the Children's Forward Plan programme.

The following actions need to be supported by either investment in or rebalance of funding towards the identified services and desired outcomes. We are currently funding too much at the higher complexity of need in all of our children's health services and so we need to work with finance and contracting colleagues to support transformation solutions.

Integration and Partnerships

- Appoint a dedicated Associate Director for Children's Transformation to work with partners and providers
- Appoint dedicated programme resource for CYP Mental Health and Wellbeing to work with partners and providers.
- Create a new Children's Transformation Oversight Board
- Ensure that the work delivered in locality is reported into the GM SEND Oversight Group as well as being informed by GM level programmes of change.
- Develop and embed an Oldham SEND Local Inclusion Partnership that works together on improvements and understands the co-dependencies and pressures of each partner.
- Develop and implement an integrated commissioning system through all levels from case panels, joint commissioning groups to ICP Board.

Children and Young People's Mental Health and Wellbeing

- Research and compile all Mental Health services in Oldham and produce this as an iTHRIVE directory.
- Ensure the iTHRIVE directory is in an accessible format to parent carers SENCoS and practitioners
- Commission new capacity to complete ASD and ADHD assessment for the16-18 age range.
- Commit new recurrent funding for CAMHS clinical capacity to increase the age range of support.
- Commission funding for a dedicated CAMHS practitioner to support young people within the Youth Justice System.
- Streamline the Neurodevelopment referral pathway

Speech, Language and Communication (SLC) Needs

- Produce and implement a SaLT recovery plan that is jointly funded by both the ICB and Local Authority.
- Deliver the Early Language Support for Every Child (ELSEC) programme
- Understand and embed the Balanced System programme within our own new delivery models.
- Introduction of Cluster working and Link Therapists within mainstream primary and secondary schools
- Deliver a Business Case for a new SLCN delivery model in Oldham by September 2024.

2. Community services, out of hospital and elective care

Link to GM missions:
Mission 1 – Strengthening our communities
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Overview

This workstream oversees the full redesign of community services as informed by all groups, partner organisations and data.

The purpose of this workstream is to provide oversight and direction, and support and leadership to progress the delivery of the commissioning and providing of high quality, all age, community health services for the Oldham locality.

The workstream works with the core purposes set for 'place', which are to:

- Improve outcomes in population health and healthcare.
- Tackle inequalities in outcomes, experience and access.
- Enhance productivity and value for money.
- Help the NHS support broader social and economic development.

The redesign work will be specified for and centred around the individual needs of the borough's five neighbourhoods.

The current community services are provided under a hosted arrangement by the Northern Care Alliance, however, requires a credible programme plan for service improvements. It is clear to both locality and provider colleagues that there are no extra funding mechanisms to improve services and that all redesign work will be within the financial envelope that community services sit.

The scale and breadth of the community service provision in Oldham is vast, and as such a working group was established who considered financial concerns, clinical issues, patient experience and relevant risks to establish a list of programme priorities. It became clear that an attempt to resolve all areas of concern at once would limit the success of the improvement programme, and as such the group identified key areas of focus.

2. Community services, out of hospital and elective care

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National priorities

Community services

- Improve community services waiting times, with a focus on reducing long waits.

Elective care

- Eliminate waits of over 65 weeks for elective care as soon as possible and by September 2024 at the latest (except where patients choose to wait longer or in specific specialties).
- Deliver (or exceed) the system specific activity targets, consistent with the national value weighted activity target of 107%.
- Increase the proportion of all outpatient attendances that are for first appointments or follow-up appointments attracting a procedure tariff to 46% across 2024/25.
- Improve patients' experience of choice at point of referral.

Diagnostics

- Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%.

Cancer

- Improve performance against the headline 62-day standard to 70% by March 2025.
- Improve performance against the 28-day Faster Diagnosis Standard to 77% by March 2025 towards the 80% ambition by March 2026.
- Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028.

Maternity, neonatal and women's health

- Continue to implement the Three-year delivery plan for maternity and neonatal services, including making progress towards the national safety ambition and increasing fill rates against funded establishment.
- Establish and develop at least one women's health hub in every ICB by December 2024, working in partnership with local authorities.

Primary Care

- Empowering patients by continuing to roll out tools that they can use to manage their own health and expanding community pharmacy services.
- Implementing Modern General Practice Access (MGPA) so patients know on the day they contact their practice how their request will be managed.
- Build capacity so general practice can offer more appointments from more staff than ever before.
- Cut bureaucracy to give general practice teams more time to focus on their patients' clinical needs.

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National priorities: Dermatology

Dermatology

There are more than 4,000 dermatological conditions and around half of people at any time consider they have a problem. Many disorders, such as psoriasis, eczema and acne, interfere with daily life, sleep and the ability to work. Skin cancer is the commonest UK cancer and is doubling every 14 to 15 years, meaning many people seek reassurance about changing moles. Skin infections, including scabies, MRSA, head lice and ringworm, cause outbreaks in hospitals, nursing homes and schools. Dermatology disorders can cause distress due to altered appearance, such as skin colour changes, scarring, altered facial appearance or hair loss, which can all have a profound effect on mental health and quality of life. Serious diseases usually managed by other specialties often first appear in the skin and so may present to dermatologists. The most severe skin disorders are life threatening.

Most of the national priorities for dermatology are the speciality level versions of the elective/cancer ones e.g.

- Eliminate waits of 65+weeks by Sept 24.
- Improve 62 day cancer performance to 70% by March 2025.
- 50% of suspected skin cancer referrals to be seen in a teledermatology clinic.

The Further Faster Dermatology Handbook (GIRFT/NHSE) November 2023 is based on best practice across a number of key metrics, in the ambition to eliminate 52 week waits.

The focus is on:

- Outpatients
- Pre-Appointments
- DNAs
- Activity and Capacity
- Remote Appointments
- PIFU

The focus of the Further Faster work is happening in our Provider Trusts.

We hope that the work being undertaken in GM Transformation will support this i.e:

- Dynamic Referral Templates
- Single Point of Access
- Teledermatology
- Appropriate pathways and care delivery settings/workforce etc

The key objectives for skin as outline (in draft) in the Cancer planning guidance are:

- 50% of SCR referrals to be managed through teledermatology (timeframe June2024 with teledermatology established as BAU by March 2025).
- Investigate, identify and implement recommendations for improvement within priority pathways (gynae, urology, breast and skin). It is the expectation that the pathway analyser will be used to support this process.
- More generally within the guidance is the need to work with providers on plans to manage capacity, factoring in usual seasonal changes eg skin services, bank holidays.

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National priorities: Palliative and End of Life Care (PEoLC)

Delivery of the national workstreams for PEoLC:

- Clinical Excellence – to support outstanding clinical care, based on the best available evidence, to ensure personalised PEoLC for people of all ages in all settings.
- Health Inequalities – reducing health inequalities in PEoLC as part of the national Core20PLUS5 approach.
- Workforce – working with partners to support and maintain a confident, capable and sustainable workforce.
- Commissioning– supporting Integrated Care Boards (ICBs) in their statutory duty to commission personalised, high quality PEoLC within integrated care systems, making optimal, sustainable use of funding.
- Data and Intelligence– establishing a clear pathway for the definition, development and implementation of information standards for PEoLC.

Continue to deliver against the '*Ambitions for PEoLC: A National Framework for Local Action 2021-2026*' which include:

- Ambition 1 – Each person is seen as an individual
- Ambition 2 – Each person gets fair access to care
- Ambition 3 – Maximising comfort and wellbeing
- Ambition 4 – Care is co-ordinated
- Ambition 5 – All staff are prepared to care
- Ambition 6 – Each community is prepared to help.

2. Community services, out of hospital and elective care

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Local priorities: Cancer

PCN based Early Diagnosis schemes – we have developed and are implementing a comprehensive strategy to meet the 75% early diagnosis ambition in the NHS Long Term Plan. The six pillars of this strategy seek to: drive earlier presentation; harness the reach of primary care; streamline referrals; expand case finding; improve screening uptake; and harness innovation.

Local initiatives and enablers – there will be an increasing emphasis on Alliances working with Oldham to produce a plan identifying priority local actions to increase early diagnosis in their populations. The focus should be on tumour sites with lower rates of early diagnosis. This work should align with wider cross cutting objectives to improve referral practice in primary care, support deprived populations and consider the role of local levers and incentives.

NHS-wide programmes – we continue to roll out evidence-based interventions that we are confident will improve early diagnosis. For Targeted Lung Health Checks and Liver, this will involve the expansion of existing plans to larger cohorts of the population. Work is underway to launch in Oldham in the Summer. We will begin to pilot interventions like the lowering of the FIT threshold in the NHS Bowel Cancer Screening programme. There are plans to see a new national workstream dedicated to driving up earlier diagnosis rates for pancreatic cancer, and we will initiate reviews of bladder and oesophageal cancer.

Tele-dermatology – working with the GM team this will be reviewed and relaunched if required. Oldham already have a robust tele-dermatology service through the wider skin provider and are working alongside other localities to ensure it is optimised and possible cancer diagnosis are recognised without delay.

Dermatology – work underway to review and improve the specification of clinical standards in the community to provide equity across all GM localities. Cancer pathways will be improved across all levels of care working with hospitals when referrals required.

Other key priorities:

- Key cancer health inequalities in Oldham will be identified engaging with people and communities to understand the key drivers causing inequalities and help design and develop approaches to overcome those barriers.
- Improve data monitoring to understand who is engaging with local services and who is not.
- Work with the lead for Health Inequalities to provide strategic oversight and support Participate in Health Inequalities forums to better enable sharing of resources and practical cross-Alliance support to tackling health inequalities.
- Work with the GM lead to establish the “Live Well with Cancer” programme in Oldham- Map and join up different forms of care and support already available or in development for people living with cancer in Oldham.

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Local priorities: Elective care, diagnostics and long-term conditions

- Identify and screen at least 75% of people at risk of COPD by 31.03.2025.
- Identify and screen at least 75% of people at risk of diabetes by 31.03.2025.
- Target patients aged 40 years plus who have no record of BP, chol or BMI in the last 3 years for NHS Health Checks.
- Increase the proportion of people at risk of diabetes completing engaging with prevention programmes.
- Ensure same day urgent access to General Practice where clinically warranted.
- Agree an appropriate response at first contact for all non-urgent appointments, ensuring all patients are seen within 2 weeks.
- Develop and implement GM standards for Inclusion health and agree sustainable funding options (commissioning for Inclusion) and investment in prevention (for all adult and children CORE20PLUS5 pathways).
- Improve the early detection and management of risk factors for illness (focusing on CORE20+5 populations and conditions, and including the VCFSE sector as a delivery partner), for example, by increasing the uptake, reach, quality and impact of Learning Disability, Severe Mental Illness and NHS health checks across GM.
- Increase the proportion of people with diabetes receiving an annual review including 8 key care processes.
- Increase the proportion of children and young people receiving a full asthma review at least annually.
- Increase the proportion of people with COPD receiving a comprehensive review at least annually.
- Improve the management of long term health conditions (with a particular focus on CORE20+5 populations and conditions) including: • Improving the diagnosis of COPD and asthma by improving access to quality assured spirometry at a neighbourhood level.
- Work in collaboration with local authorities and clinical providers to tackle digital exclusion, collating and building on existing work done across localities and PCNs.
- Deliver a comprehensive plan to create a sustainable workforce for the long term including initiatives to grow our own workforce.
- Implement initiatives relating to the retention of our workforce.
- Deliver a comprehensive development, education and support offer.

2. Community services, out of hospital and elective care

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Local priorities: Elective care, diagnostics and long-term conditions

CVD Diagnosis and Prevention – Quality Incentive schemes have delivered a +70% increase in NDPP Milestone 1 performance. We will continue to drive quality engagement with prevention and early intervention programmes. NHS Health checks have good uptake in Oldham and we will continue to drive quality completion and onward referral for patients who are eligible by working with practices. We are building on the quality agenda in primary care to optimise outcomes, applying the successes to all areas of CVD prevention and diagnosis.

Respiratory – Maintain the virtual ward model with increased deflection performance, aligned with the GM wider respiratory programme. A&G uptake to increase and paediatric response via clinic offer. Increased diagnosis rates to proactively intervene in respiratory illness management, especially focused on the winter pressure by early activation of symptom management.

Community Services – Collaborative working with community services will focus delivery on core deliverables of referral quality, system utilisation of advice & guidance, diagnostic capabilities and service retention. The way we work with community services needs to be reflective of the desired outcomes. Tackling referral culture by strengthening A&G to practices and developing education input to increase confidence. Social prescribing and increased patient activation to improve uptake of non-clinical services and prevention offers.

Eye / foot screening (diabetes) – Screening services are reduced in terms of estate/clinics, we are working with providers and estate to widen the offer and reduce the impact of condensed screening. Risks around sight loss and amputation have increased, need to be brought back down.

Diabetes – Ongoing work to transform the quality and efficacy of diabetes care and education in Oldham. Working with the GM taskforce and contributing to the development of wider education offers remains a priority as we seek to support our wider communities with meaningful access to diabetes education, including those with pre-diabetic levels to reduce the conversion. We remain dedicated to interventions including weight loss, education in alternative languages and reviewing the reach of our education services beyond newly diagnosed and 5 year.

Integration – Continue to work on closer alignment of services, pathways through primary care and the interface of A&G/onward referral and step down from specialist services. Focus on the education and shared care aspects of integration of services to reduce overall demand. This will be supported by greater utilisation of onward referral to third sector services at points such as NHS Health Check.

Other Key Priorities:

- Locality representation on all GM LTC/ community boards.
- Establish local CVD and Cardio groups to pick up the locality actions from the wider GM work.
- Re-invigorate VCSE interaction with the working group to support wider system development.
- Health inequalities/ Proactive service design to target reductions.

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Local priorities: Dermatology

The aim of the Greater Manchester Dermatology Transformation Programme is to develop a GM model of care to support current capacity and demand issues and deliver sustainable, modern high quality dermatology services. This included a gap analysis being undertaken to identify the capabilities within each locality in Greater Manchester to support a teledermatology pathway.

Drivers for Change:

- Sustainability
- Around 50% population affected by skin disease, +4000 conditions, 23-33% of the population at any time has a skin disease that would benefit from medical care
- Increasing demand
- Referral Variation
- Fragmented Service provision
- Workforce
- Getting it Right First Time (GIRFT)
- Variance in training/ education & knowledge
- GM financial deficit
- Operational Planning - priority

The front-end of the transformation work has been agreed/supported by the GM sustainability team and the work is aligned to the following core principles.

- Stage 1 of the Model of Care incorporates the following core principles:
  - ❖ Optimal management of the patient in primary care.
  - ❖ Centralised referral triage with specialist advice and where clinically indicated teledermatology.
  - ❖ Triage will stream the patient into the most appropriate setting for their disease severity – this may be onward referral to community, secondary or tertiary care, or back to the referrer with advice and a treatment plan.
  - ❖ Strengthen the current community offer where there is a gap in service provision.
- Work is underway to review and improve the specification of clinical standards in the community to provide equity across all localities. This will in turn improve cancer pathways across all levels of care working with hospitals when referrals are required.

Tele-dermatology – working with the GM team this will be reviewed and relaunched if required. Oldham already have a robust tele-dermatology service through the wider skin provider and are working alongside other localities to ensure it is optimised and possible cancer diagnosis are recognised without delay.

The provider for skin services in Oldham is challenged like other dermatology services across GM. Capacity is full for new patients with a long waiting list and there are a large number of patients waiting for allocation of a follow up appointment.

Oldham is the only GM service that provides an output for 2ww cancer referrals and at present is managing to sustain this, however this is at the cost of all other pathways. Utilising the help from the Sustainability team, the aim to reduce the number of patients waiting to be seen.

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Local priorities: Palliative and End of Life Care (PEoLC)

- To ensure commissioning arrangements to support PEoLC provision are in place to provide seamless provision of care and are influenced by local population-based needs assessment.
- Increase in the number of people identified with PEoLC need/in the last year of life.
- Increase the number of people with an EPaCCS (Electronic Palliative Care Co-ordination System) record - EPaCCS is a tool to electronically share information about patients in the final 12 months of life.
- Increase digital sharing of PEoLC information through the GM Care Record.
- Increase the number of people who die at their chosen location.
- Increase the opportunity for personalised care conversations and future care planning.
- Involving, supporting and caring for those caring for those important to the individual to see an increase in carers assessments and support plans; with every family having timely access to practical support, including social prescribing.
- Improve data and intelligence to support effective commissioning of PEoLC across the system.
- Increase in the knowledge, skills and confidence in staff in PEoLC.
- Address workforce planning to ensure an available workforce with the right skills to support the delivery of 24 hours 7-day services in PEoLC.
- Address unwarranted variation and inequalities in PEoLC provision.

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Local priorities: Maternity, neonatal and women's services

- Continue to deliver full range of maternity services.
- Continue to deliver Maternity Improvement Programme to provide high quality, safe maternity care. This incorporates the requirements of the national three year delivery plan for maternity and neonatal services.
- Support improvements in safety outcomes and the implementation of the Maternity Safety Package.
- Support delivery of the new Maternity & Neonatal Voices Partnership model.
- Implement one Women's Health hub in Oldham, starting with North PCN.

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Solutions and actions: Cancer

- Support providers to investigate, identify and implement recommendations for improvement within priority pathways (gynaecology, urology, breast and skin), including specific pathway changes relating to; unexpected bleeding post HRT, risk stratification on the prostate pathway, and breast pain.
- Lower GI (at least 80% of referrals accompanied by a FIT result).
- Continue to see FIT fully implemented in line with clinical guidance across all Cancer Alliances, ensuring it is being used to inform use of colonoscopy (particularly in areas piloting reductions in the screening FIT threshold).
- Support the age extension of the NHS bowel cancer screening programme, working with ICBs, screening providers and commissioners to ensure sufficient colonoscopy capacity is available.
- Work with providers to put in place robust call and recall arrangements and the required scanning capacity to improve access to liver surveillance.
- Develop robust plans to review and improve referral practice in primary care.
- Skin (accelerate the adoption of tele-dermatology).
- Support the retention and onward referrals of patients in the NHS-Galleri Clinical trial. Put in place the processes required for the pilot programme and deliver the appropriate number of tests.
- Urological cancers (continued implementation of nurse-led biopsy and implementation of risk-stratification tools in prostate cancer).

Support the delivery of NHS-wide early diagnosis programmes:

- Targeted lung health checks (TLHC).
- Ensure sufficient CT-guided biopsy.
- Endobronchial ultrasound (EBUS) and treatment capacity to diagnose and treat people identified with cancer.
- Work with Cancer Alliances and providers to implement a regular demand and capacity assessment of systemic anti-cancer therapy services and ensure that, as part of provider multi-year capital plans, they have replacement plans for radiotherapy equipment.
- Develop and lead on local actions to improve early diagnosis, with a particular focus on tumour sites where the local system lags behind national averages, and among deprived communities with lower rates of early diagnosis.

Treatment and Care - providing the best possible treatment, patient experience of care and quality of life, both during and beyond treatment, and for those living with cancer:

- Implement national priority recommendations from clinical audit/GIRFT reports to reduce variation in treatment.
- Fully meet the commitments on personalised care interventions and Personalised Stratified Follow Up, as set out in the NHS Long Term Plan.

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Solutions and actions: Cancer

- Improve productivity in priority pathways.
- Lower GI (at least 80% of referrals accompanied by a FIT result).
- Skin (accelerate the adoption of tele-dermatology).
- Urological cancers (continued implementation of nurse-led biopsy and implementation of risk-stratification tools in prostate cancer).
- Establish, where not already in place.
- Breast pain pathways.
- Unexpected bleeding pathways for women receiving HRT.
- Support the delivery of NHS-wide early diagnosis programmes.
- Targeted lung health checks (TLHC).
- Ensure sufficient CT-guided biopsy.
- Endobronchial ultrasound (EBUS) and treatment capacity to diagnose and treat people identified with cancer.
- Phlebotomy capacity to support implementation of the Multi-Cancer Blood Test Programme (Galleri) in participating areas.
- Work with Cancer Alliances and providers to implement a regular demand and capacity assessment of systemic anti-cancer therapy services and ensure that, as part of provider multi-year capital plans, they have replacement plans for radiotherapy equipment.

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Solutions and actions: Elective care and diagnostics

The Elective Care System Board and Cancer Alliance are pivotal to the recovery and reform of elective care and cancer services across the ICB footprint, with the locality linking closely to ensure localised implementation to drive improvements in service provision for the population of Oldham.

Elective Care

Outpatient Excellence Programme (OEP) - Working to a single Four Locality Partnership Programme to implement the OEP including widening of PIFU, Remote Monitoring etc.

Referral Management and Patient Choice- Localised implementation of Patient Choice, Advice and Guidance, and Local Quality of referrals programme.

Non- NHS and Independent Sector Utilisation.

Speciality Specific:
Dermatology- recovery of Oldham Total Skin Service, with a view to procurement of service aligned to the GM Dermatology Programme if required.

Diagnostics

Continue to increase productivity and utilisation of the Oldham CDC.

Commission a significant expansion in GP direct access, ensuring GPs do not need to refer patients into secondary care because they cannot access core diagnostics directly, including the Vague Symptoms pathways.

Focus wider new capacity on specialties with significant waiting lists, seeking to implement one stop diagnostic testing ahead of first outpatient appointments.

Long-term conditions

Solutions in relation to improving lives and enhancing preventative approaches for those with long-term conditions will be delivered through the population health management / place-based integration workstream.

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Solutions and actions: Dermatology

- To ensure teledermatology is working as efficiently as it should be.
- Provide administrative and clinical validation for all those on the waiting list.
- Discharge appropriate patients and give them a choice of PIFU.
- We need to ensure all data is made available both in locality and within GM to enable the reporting function to work correctly.
- Review clinic slots, patient ratio etc.
- Provide trajectories through the year.
- Review all pathways, working with GM's new specification and clinical map to ensure patients are seen in the right place.
- Ensure all performance reports are written with the input of performance leads within GM and the provider.
- Ensure all revised KPI's especially Cancer ones are recorded and delivering to standard.
- All cancer patients referred and transferred onto secondary care are done so in a timely manner without delay.
- Text messages to patients waiting to see if they would still like an appointment.
- Review of routine and follow up appointments.
- Provision of a new educational resource pack for GP's so appropriate referrals can be made.
- The service is to provide a full breakdown of activity for each dermatology pathway with further information on practice data.
- Potentially there will be a requirement to reduce the scope of the service in order to ensure best use of resources available.

These actions will support the improvement of the waiting list trajectory once they are profiled in which should give the locality the assurance that there is a continued reduction of patients who are overdue follow ups or waiting for a new appointment.

If the service are unable to offer robust assurances in the clearance of the current backlog then we will progress discussions to halt elements of routine service until there is a time in which we have a more stable backlog position.

We will continue to work with GM Sustainability Services to ensure there continues to be a dermatology service provided for Oldham patients.

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Solutions and actions: Palliative and End of Life Care (PEoLC)

- Support GM in the delivery of its PEoLC ICB Statutory responsibilities.
- Development of a locality PEoLC Strategy.
- Completion of the *Commissioning and Investment Framework and Service Specification Assessment Tool* (in relation to PEoLC provision).
- Implement action plan identified through the *'Self-Assessment Tool: Ambitions for PEoLC'*.
- Support full roll-out in the locality of the Statutory Medical Examiner (ME) system which sees MEs providing independent scrutiny of all deaths in the community (not requiring a coroner review).
- Review of the night-sitting service for EoLC patients to ensure the service is fully integrated across the locality and those most in need are accessing the service.
- Contribute to the hospice review being undertaken across GM and implement the subsequent action plan.
- Reinvigorate the Electronic Palliative Care Co-ordination System (EPaCCS) Working Group and continue to embed the use of EPaCCS across the locality to ensure all care settings are utilising EPaCCS.
- Continue to utilise technology to embed the advancements in care that support PEoLC patients, i.e. virtual wards/consultation, remote monitoring equipment etc.
- Support GM/locality in exploring the availability of workforce to support 24/7 specialist palliative care (SPC).
- Identification and Proactive Care and Support Planning (PCSP): Support locality to establish and maintain a register of all patients in need of palliative care/support to ensure an increase is seen in the number of people identified with PEoLC. Adoption of the EARLY toolkit will support primary care to help identify patients more reliably. Once identified, Advance Care Planning (ACP) discussions can commence with salient information shared with all services, using EPaCCS.
- Support GM/locality in the work to adopt the use of the Carers Support Needs Assessment Tool (CSNAT) to assist in carers being supported for people at EoL.
- Stocktake required on utilisation and data captured via IPOS (Integrated Palliative Care Outcome Scale) Community of Practice - its use across all providers will assist in analysing person-centred outcome measures to ensure fair access to care.
- In conjunction with GM, identify requirement across the locality for professionals providing care for individuals with life-limiting illnesses to receive specific training and education in PEoLC and in communication skills.
- Support partners to continue to develop and deliver education in Care Homes relating to PEoLC and increase the prevalence of Advance Care Planning (ACP).
- Analyse the data dashboards captured on the GM hub and ensure locality is routinely collecting and reporting on PEoLC activity to inform ongoing quality improvement work, including that of equal access and meeting the needs of diverse groups.

2. Community services, out of hospital and elective care

Link to GM missions:
Mission 1 – Strengthening our communities
Mission 2 – Helping people stay well and detecting illnesses earlier
Mission 4 - Recovering core NHS and care services

Oldham
Integrated Care Partnership

Solutions and actions: Maternity, neonatal and women's health

- Continue to work with the LMNS, providers and wider partners to implement NCA's Maternity Improvement Programme.
- Work with providers and wider partners to implement Maternity Safety Package.
- North PCN to deliver the first Women's Health Hub with the initial focus on Long Acting Reversible Contraception for 2024/25. Further developments to be considered once funding has been confirmed.

3. Mental health, learning disabilities and autism

Link to GM missions:
Mission 1 – Strengthening our communities
Mission 4 - Recovering core NHS and care services

Oldham
Integrated Care Partnership

Overview

Place-based transformation in community mental health is a key priority for the Oldham locality.

- Shifting to genuine partnership working and a 'no wrong front door' approach.
- Removal of thresholds for referral, acceptance and discharge to seamless, continuous responsive care.
- Dissolving of barriers between:
    - Mental health and physical health.
    - Health, social care, VCSE organisations and local communities.
    - Primary and secondary care, to deliver integrated, personalised, place-based and well-coordinated care.
- Integrated approach to assessment with reduced need to 'keep telling your story' to different members and teams within community mental health.
- Person-centred approach according to the needs and complexity of the individual – ranging from brief initial contact/intervention to more comprehensive, multidisciplinary care that is centred around an individual's needs.
- Ensuring that people who use services are active participants when it comes to design, delivery, improvement and governance.
- Retain and strengthen the specialist support offer.

3. Mental health, learning disabilities and autism

Link to GM missions:
Mission 1 – Strengthening our communities
Mission 4 - Recovering core NHS and care services

Oldham
Integrated Care Partnership

National priorities

Mental health

- Improve patient flow and work towards eliminating inappropriate out of area placements.
- Increase the number of people accessing transformed models of adult community mental health (to 400,000), perinatal mental health (to 66,000) and children and young people services (345,000 additional CYP aged 0–25 compared to 2019).
- Increase the number of adults and older adults completing a course of treatment for anxiety and depression via NHS Talking Therapies to 700,000, with at least 67% achieving reliable improvement and 48% reliable recovery.
- Reduce inequalities by working towards 75% of people with severe mental illness receiving a full annual physical health check, with at least 60% receiving one by March 2025.
- Improve quality of life, effectiveness of treatment, and care for people with dementia by increasing the dementia diagnosis rate to 66.7% by March 2025.

People with a learning disability and autistic people

- Ensure 75% of people aged 14 and over on GP learning disability registers receive an annual health check in the year to 31 March 2025.
- Reduce reliance on mental health inpatient care for people with a learning disability and autistic people, to the target of no more than 30 adults or 12–15 under 18s for every 1 million population.

Local priorities

Mental health

- Improve patient flow and work towards eliminating inappropriate out of area placements through stronger place-based community teams, crisis alternatives, and discharge models of care.
- Increase the number of people accessing transformed models of adult community mental health through a fully redesigned community offer, built around neighbourhoods, and integrated with planned place-based hubs.
- Deliver a review of the whole psychological offer in Oldham in line with Trust priorities, across primary and secondary care psychology provision, to improve pathways for people who would benefit from this support.
- Continue to work with primary care on improving SMI physical health checks.
- Deliver the Oldham dementia strategy including a review of the post-diagnosis dementia support offer.
- Commission a service for ASD and ADHD diagnosis and treatment in line with GM and support the move to a GM model to ensure people with co-morbid mental health and/or complex needs are supported.

People with a learning disability and autistic people

- Deliver the LD strategy for ‘good health’.
- Continue to ensure people with LA and/or autism are supported to live locally and in the community, outside of inpatient settings, where appropriate.

3. Mental health, learning disabilities and autism

Link to GM missions:
Mission 1 – Strengthening our communities
Mission 4 - Recovering core NHS and care services

Oldham
Integrated Care Partnership

Actions / solutions

- Delivery against the key priorities with oversight of the Oldham Mental Health Locality Board.
- Review Oldham performance metrics for 24/25 and develop improvement plans where achievable.
- Deliver system efficiencies in mental health – high-cost placements, treatment packages and non-commissioned activity.
- Support recommendations of the population health programme of work as part of community mental health transformation.
- Deliver 2024/25 priorities as set out in the LD and Dementia strategies for Oldham.

4. Patient flow, urgent and emergency care

Link to GM missions:
Mission 4 – Recovering core NHS and care services

Oldham
Integrated Care Partnership

Overview

Oldham locality place will continue to deliver our urgent and emergency care offer, improve patient experience and further develop pathways to ensure efficient and effective delivery of services.

The main priority for Oldham will be to ensure effective services and quality patient care is in place to maintain patient flow in and out of the UEC system.

In order to deliver achievements, we will continue system oversight and transformation via the Oldham Urgent Care Delivery Group, and the Patient Flow work programme.

Our objectives to achieve will be:

- Improved performance in A&E wait times
- Improved patient handover times
- Reduction in admissions and LoS
- Reduction in 12hr waits
- Increase in 2hr rapid response provision
- Increase in “step up” activity and virtual ward beds
- Submission of all data sets (CSDS & ECDS)
- Improved data collection and intelligence
- Increase discharges before 5pm
- Increase discharges on pathway 0 & 1
- NRTR target 35 per day
- Increase SDEC activity

4. Patient flow, urgent and emergency care

Link to GM missions:
Mission 4 – Recovering core NHS and care services

Oldham
Integrated Care Partnership

National priorities

• Improve A&E waiting times, compared to 2023/24, with a minimum of 78% of patients seen within 4 hours in March 2025.

• Improve Category 2 ambulance response times to an average of 30 minutes across 2024/25.

Areas to focus from NHSE Operating Plan:

- Maintaining the capacity expansion delivered through 2023/24.

- Increasing the productivity of acute and non-acute services across bedded and non-bedded capacity, improving flow and length of stay, and clinical outcomes.

- Continuing to develop services that shift activity from acute hospital settings to settings outside an acute hospital for patients with unplanned urgent needs, supporting proactive care, admissions avoidance and hospital discharge.

Local priorities

Continue to implement initiatives and guidance outlined in:

- 10 UEC High Impact Initiatives.
- Delivery Plan for Recovering UEC Services.

Continue to contribute towards core population health management capabilities including risk stratification and using joined-up data between primary and secondary care.

Integrate and streamline UEC pathways with a focus on the management of older people with complex needs and frailty.

Provide system-wide overview and support during peak pressure times and support the GM SCC.

4. Patient flow, urgent and emergency care

Link to GM missions:
Mission 4 – Recovering core NHS and care services

Oldham
Integrated Care Partnership

Actions / solutions

- Continued development of front door frailty team.
- Continued refinement of Pre-ED service to maximise UTC provision, including minor injuries and re-direction of patients to more appropriate services.
- Increase utilisation of Consultant Connect and expand to enable paramedics and community services to be able to access.
- Enable direct booking from NHS 111 into primary and community care.
- Develop comprehensive ECDS stream from all urgent care services and support CSDS submission from community services.
- Continue attendance and admission avoidance schemes.
- Lead the system-wide Intermediate Care Services review.
- Work alongside NWAS and acute colleagues in order to increase direct pathways for crews and alternative pathways to conveyance.
- Utilise and manage UEC Recovery funding for both additional capacity and discharge support efficiently and effectively.
- Support secondary-Primary Care Interface development.
- Work towards a single point of access for all community urgent care services.
- Increase discharges and maintain low NRTR utilising the Discharge Hub and Integrated discharge team.
- Further enhance integrated working between NHS, LA and voluntary sector to support vulnerable patients being discharged to own homes.
- Participate and contribute to 4 pan-locality priorities across NCA footprint to provide more effective services for patients.
- Work with LA to ensure appropriate capacity available in community beds in order to maintain flow.
- Successfully procure 2025 Urgent Care Hub and Pre-ED service.

5. Population health management and place-based integration

Link to GM missions:
Mission 1 – Strengthening our communities
Mission 2 – Helping people stay well and detecting illnesses earlier

Oldham
Integrated Care Partnership

National priorities

- Continue to improve the experience of access to primary care, including by supporting general practice to ensure that everyone who needs an appointment with their GP practice gets one within 2 weeks and those who contact their practice urgently are assessed the same or next day according to clinical need.
- Increase dental activity by implementing the plan to recover and reform NHS dentistry, improving units of dental activity (UDAs) towards pre-pandemic levels.
- Increase the % of patients with hypertension treated according to NICE guidance to 80% by March 2025.
- Increase the percentage of patients aged 25–84 years with a CVD risk score greater than 20% on lipid lowering therapies to 65% by March 2025.
- Increase vaccination uptake for children and young people year on year towards WHO recommended levels.
- Expand evidenced-based approaches to prevention, self-care and the effective management of long-term conditions.
- Join up care closer to home through integrated neighbourhood teams and place-based arrangements.
- Update plans for the prevention of ill-health and incorporate them in JFPs, with focus on Core20PLUS5 populations and NHSE's high impact interventions for secondary prevention.
- By the end of June 2024, publish joined-up action plans to address health inequalities and implement the Core20PLUS5 approach.
- Develop core population health management capabilities and use joined-up data between primary and secondary care to support the implementation of the proactive care framework.
- Develop local system architecture to support the delivery of JFPs including to support primary care and community organisations to shape integrated neighbourhood teams.

5. Population health management and place-based integration

Link to GM missions:
Mission 1 – Strengthening our communities
Mission 2 – Helping people stay well and detecting illnesses earlier

Oldham
Integrated Care Partnership

Local priorities

- Collaborative approach to the prevention, screening and early identification of CVD, diabetes and COPD.
- Working with system partners to improve the uptake of MMR vaccinations through community engagement in areas of low coverage and with seldom-heard groups.
- Harness existing work across the system to provide personalised care, improve outcomes and promote independence for people living in a care home.
- Each Primary Care Network, (PCN) to identify those patients who do not engage in mainstream health and care or those who are high intensity users of services, often as a result of wider social determinants and produce a multiagency support plan, designed to meet their clinical and broader needs.
- Ensure outreach/ neighbourhood-based activities are in place.
- Implementation of a model designed to find and support those most in need which includes targeted approach to improve outcomes.
- Focus on community-led approaches to health, with a focus on self-care and self-navigation, supported by strong local care coordination.

5. Population health management and place-based integration

Link to GM missions:
Mission 1 – Strengthening our communities
Mission 2 – Helping people stay well and detecting illnesses earlier

Oldham
Integrated Care Partnership

Actions / solutions

We have:

- Co-developed PHM care model, outlining each activity, workforce, settings and additional detail, such as existing material / teams / services that can be leveraged, for each neighbourhood.
- Proposed governance quad for each PHM model, with roles and responsibilities outlined against each lead.
- Identified workforce roles and skills / capabilities identified by neighbourhood teams to deliver PHM model.
- Developed a resource model identifying roles, banding, expected WTE and costs for each PHM model.
- Produced population segmentation based on ADSP.
- Conducted a literature review on why this population group has been chosen in Oldham and can deliver return on investment.
- Calculated total opportunity in healthcare spend reduction over a year (and five years where relevant).
- Calculated total opportunity if model is applied in all neighbourhoods of Oldham.
- Developed an action plan setting out detailed next steps and timelines to successfully implement PHM models, to be reviewed with owners of each action to be identified.
- Co-designed lagging and leading KPI measures to track and monitor outcomes of each PHM model.
- Co-developed principles of working to guide implementation.

We will:

- Establish overall programme governance, with regular scheduled meetings of overall programme leads to discuss progress and raise and mitigate risks.
- Review and refine each neighbourhood's PHM care model alongside resourcing model, and share in relevant fora and boards across locality.
- Develop case for stepped implementation and resources required.
- Identify leads against activities described in delivery plans, detailing next level activities against each domain, with timeframes and risks.
- Set up governance quads and PMO team for each neighbourhood, with identified leads and regular scheduled meetings.
- Identify BI support for Oldham to support data-driven identification of population group, and consider utilising Graphnet which already has patient-level identification and care planning capabilities.
- Confirm KPIs to be tracked and monitor and track outcomes of the programme, considering incentivisation required.
- Continue neighbourhood forum to progress model and its vision, reviewing principles of ways of working to refine into a plan for collaboration.
- Create synthesis on incentivising providers to deliver PHM models.

Oldham
Integrated Care Partnership

Multi-place collaboration

Four Localities Partnership Work Programme 2024/25

Oldham
Integrated Care Partnership

As part of the planning process for 2024/25 we have been sharing priority areas to identify further areas where the FLP can support collaboration across localities and with the NCA We have secured commitment to progress the following areas:

Theme	Status	Scope of work	Delivery / enabler programme alignment
Discharge Integration	Commenced. Bringing forward 'case for change' and supporting business cases in Q4 2023/24	Improving Dementia pathways (admission avoidance, IP care, discharge) and strengths-based approach to IP care and discharge of all older people across the four localities/hospital sites.	Patient flow, urgent and emergency care
Community Estates	Commenced. Scoping opportunities for 2024/25 onwards.	Maximise use of community estate, address high-cost premises, strengthening collective negotiating position with partners, supporting shift of care out of hospital, aligning to locality estates strategies including 'health in the high street'	Community services and out of hospital care
Prescribing	Commenced, Scoping opportunities for 2024/25 onwards.	Identifying opportunities to effectively address prescribing costs across primary and secondary care, focused on prescribing 'waste', 'do not prescribe'/ 'limited clinical value' drugs and switch to cheaper generic drugs	Finance and estates
People	Commenced	Broaden entry routes across the four localities partnership into H&SC to: increase local employment; increase the diversity of our people; reduce vacancy rates; reduce health inequality by purposefully working with communities who face structural inequality	Workforce
Planned Care	New 2024/25	Bringing together locality plans for elective care and developing a single work programme for those that can be most effectively addressed across the footprint, including OP transformation and pathway standardisation	Elective care
Admission Avoidance	New 2024/25	Exploring opportunities to work with NWAS to reduce avoidable ambulance conveyances to hospital sites, focused on improving clinical decision making and availability and utilisation of community alternatives	Patient flow, urgent and emergency care
Community Services	New 2024/25	Address current variation and fragility within NHS community services, focusing on sharing good practice, standardisation of service specifications/pathways and improving quality of data and ability to demonstrate value for money.	Community services and out of hospital care

Oldham
Integrated Care Partnership

Data, insight and intelligence

Data, insight and intelligence overview

Oldham
Integrated Care Partnership

Whilst a wide range of performance indicators will be monitored and made visible to the Partnership on a regular basis, there are some specific and key focus areas for Oldham Integrated Care Partnership to track, both overall and as linked to the delivery workstreams.

These are the indicators that link directly to NHS Greater Manchester's **Mission 4** of 'recovering core NHS and care services', with a potential indirect impact on **Mission 6** of 'achieving financial sustainability'. Some also link to a specific national recovery target, as outlined in the 2024/25 national NHS Planning Guidance.

The indicators are broken down by **oversight**, where there is locality delivery responsibility and/or significant locality contribution needed, and **sight**, where the wider GM-system is responsible for delivering against the indicator, but awareness is important as there will be impacts on our communities and residents.

The indicators are also linked to the relevant delivery workstream(s).

Link to GM missions:
Mission 4 - Recovering core NHS and care services
Mission 6 – Achieving financial stability

Key performance monitoring areas

Oldham
Integrated Care Partnership

OVERSIGHT

Patient flow, urgent and emergency care	• A&E 4-hour performance (78% by March 2025)
Community services, out of hospital and elective care	• Cancers diagnosed at early stage using full registration data – stages 1 and 2 (75% by 2028)
Community services, out of hospital and elective care	• % of hypertension patients who are treated to target as per NICE guidance (80% by March 2025)
Community services, out of hospital and elective care	• % of patients identified as having 20% or greater 10-year risk of CVD are treated with statins (65% by March 2025)
Mental health, learning disabilities and autism	• % of patients aged 14+ with a completed LD health check (75% by March 2025)
Mental health, learning disabilities and autism	• Dementia diagnosis rate aged 65+ (66.7% by March 2025)

SIGHT

Community services, out of hospital and elective care	• Referral to Treatment Time incomplete – 65+week waits (eliminate by September 2024)
Community services, out of hospital and elective care	• Diagnostics - % waiting 6 weeks+ (95% within 6 weeks with maximum 5-week breach wait by March 2025)
Community services, out of hospital and elective care	• Cancer – 28-day wait from referral to faster diagnosis for all patients (77% by March 2025 and 80% by March 2026)
Community services, out of hospital and elective care	• Cancer patient treated within 62 days (70% by March 2025)
Population health management and place-based integration / Children and young people health integration	• MMR2 uptake at 5 years old (95%)

Oldham
Integrated Care Partnership

Finances and estates

Locality 2024/25 finance plan

Oldham
Integrated Care Partnership

We will manage a robust programme of financial savings, as well as projects to improve effectiveness and efficiency, via the primary delivery and transformation workstreams.

Our draft financial plan of £123.7m (see chart) is based on:

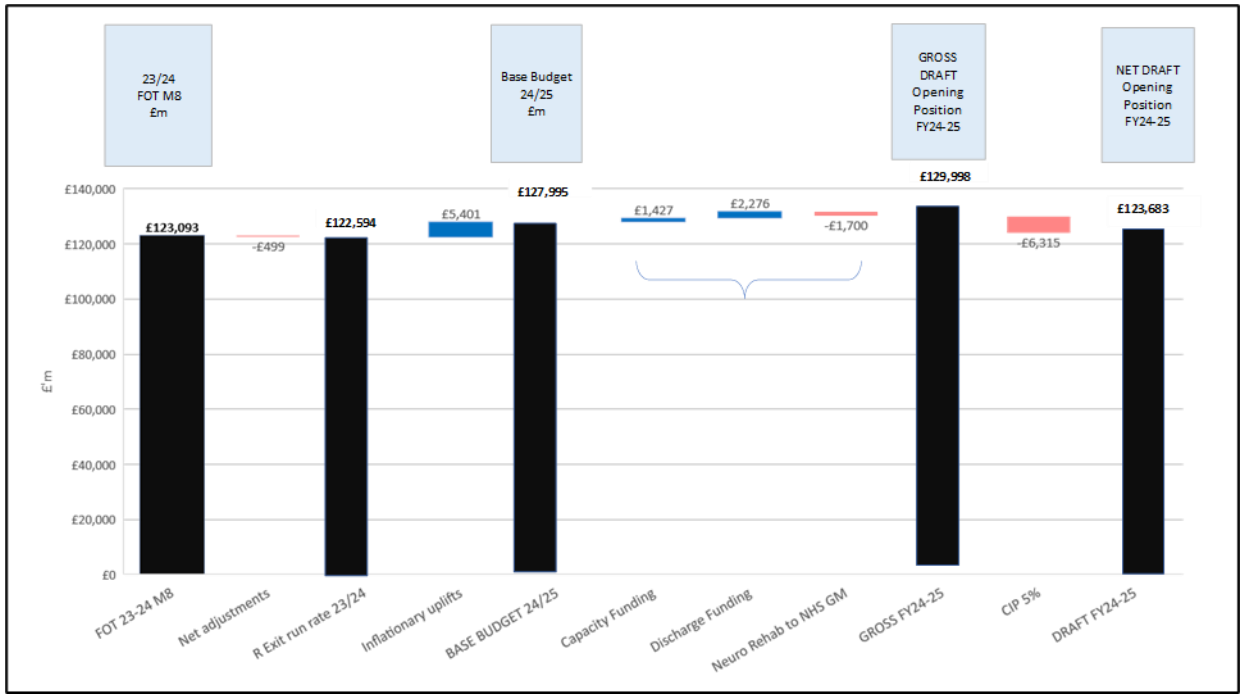
- Exit run rate from 2023/24 less non-recurrent items
- Inflation uplifts at planning guidance set rates
- Cost Improvement saving target of £6.3m. (see waterfall chart)
- Capacity and discharge allocations for 2024/25.

Link to GM missions:
Mission 6 – Achieving financial stability

Use of resources

- **NATIONAL PRIORITIES:**
  - Deliver a balanced net system financial position for 2024/25
  - Reduce agency spending across the NHS, to a maximum of 3.2% of the total pay bill across 2024/25

Financial Plan Bridge from 2023/24 outturn to 2024/25 draft Financial Plan



Service Development Fund and Better Care Fund

Oldham
Integrated Care Partnership

- Service Development Funding allocations support the delivery of the national objectives set out in the guidance confirmed.
- We will continue meet our minimum contribution to the Oldham Better Care Fund as per the policy framework planning requirements for 2023-2025, including growth at 5.66% for 2024/25.
- The minimum allocation requirement for Oldham locality in 2024/25 is £23.194m as set out by NHS England.
- The Better Care fund and capacity and discharge allocations will continue to be included into a Section 75 agreement between Oldham Council and NHS Greater Manchester Integrated Care, alongside grants paid to local government.
- The capacity and discharge allocations for Oldham Integrated Care Partnership for 2024/25 have increased by £2.1m from 2023/24, reflecting the commitments in the Government's Autumn Statement 2022.

Funding type	**OMBC £m**	**ICB £m**	**Total £m**
Discharge Funding	1.568	1.420	**2.988**
Capacity Funding		1.199	**1.199**
Total 2023/24	**1.568**	**2.619**	**4.187**
Discharge Funding	2.614	2.276	**4.890**
Capacity Funding		1.427	**1.427**
Total 2024/25	**2.614**	**3.703**	**6.317**
Increase from 23/24 to 2024/25	**1.046**	**1.084**	**2.130**

Link to GM missions:
Mission 6 – Achieving financial stability

Cost Improvement Programme for 2024/25

Oldham
Integrated Care Partnership

The local Cost Improvement Programme of £6.3m, or 5%, is based on the following:

- An allocation of Cost Improvement Programme targets based on locality influenceable spend; includes mental health and prescribing.
- A focus on recurrent delivery as a priority and wherever possible.
- The targeted management of Any Qualified Provider services based on exit run rates.
- The targeted cost reduction towards Continuing Healthcare and high-cost mental health and learning disability packages.
- A focus on budgetary control and accountability.
- A risk-based approach to the management and delivery of the cost Improvement Programme through regular monitoring and tracking.

Link to GM missions:
Mission 6 – Achieving financial stability

High level 2024-25 Cost Improvement Programme schemes

Oldham
Integrated Care Partnership

CIP scheme detail	Total 24/25
Prescribing	**£2,270,847**
CHC reviews	**£1,000,000**
Referral Gateway cessation	**£168,000**
PCIS	**£400,000**
Contract reductions	**£111,498**
CYP High cost case reviews	**£286,362**
LD reviews	**£210,000**
AQP	**£60,000**
ADHD RTC demand management	**£56,000**
Primary Care training	**£30,000**
IMC support	**£48,000**
PHB reviews	**£70,000**
BCF	**£424,500**
New funding opportunites	**£300,000**
OAPS	**£500,000**
Unidentifed	**£360,000**
Total	**£6,295,207**

Profile of CIP 2024/25			
Qtr 1	Qtr 2	Qtr 3	Qtr 4
£1,082,252	£1,366,328	£1,855,229	£1,991,399

- We have a £6.2m CIP target or 5%.
- There is a gap of c**£0.4m** to be identified.
- There is red rated risk of **£2.1m** in the plan.
- There are full detailed plans and associated impact assessments behind each scheme.
- The profile of CIP reflects the timing of delivery.
- The programme will be managed internally by Oldham Locality Place Team, overseen by NHS GM ICB.

Specific priorities for prescribing and medicines optimisation:

- Improve use of medicines via medicines use reviews and programmes to reduce wastage
- Ensure regular effectiveness and savings are established through prescribing programmes

Link to GM missions:
Mission 6 – Achieving financial stability

Estates plan for 2024/25

Oldham
Integrated Care Partnership

We will maximise the use of community estate, address high-cost premises, supporting shift of care out of hospital.

A key priority for the financial year is to maximise the use of clinical space – this be resolved by relocating services from acute settings to into community spaces to reduce the amount of 'void' estate areas.

Estates work will be undertaken collaboratively with partners across the borough via the five primary care networks and a local Strategic Estates Group.

Work will also be undertaken as part of the Four Localities Partnership, with a focus on dealing with any cross-boundary issues, and the sharing of good practice.

NHS voids / Best use of space

- Maximising use of Oldham Primary Care estate
- Reduction in cost of voids c£1m for Oldham
- Utilisation review
- Maximising use of bookable space

Maximising investment

- Access to national levelling up funds
- Access to NHS Capital / LA prudential borrowing
- Enabling economic regeneration

Local estates

- Core, flex and tail analysis
- New developments & disposals
- Sharing of NHS Trust estates strategy
- Oldham estates lead recruited

NHS PCN toolkit

- Capital prioritisation
- Digitalisation of records

Link to GM missions:
Mission 6 – Achieving financial stability

Oldham
Integrated Care Partnership

Involvement, engagement, communications, workforce and digital

Involvement, engagement and communications

Oldham
Integrated Care Partnership

Our local involvement, engagement and communications activity will be driven by the work and needs of the delivery programme and its workstreams. This will encompass engagement at its heart, and whenever possible a co-production or co-design approach with communities will be undertaken.

We will utilise our local involvement and engagement infrastructure, which includes an Engagement and Insight Group, which is our Local Participation Group, and has been developed in line with NHS Greater Manchester's People and Communities Participation Strategy and Action Together's Engagement Framework.

Our five Population Health Management footprints will be utilised for community engagement activities, and we will also utilise our local Health and Care Senate, with the aim of bringing clinicians and care professionals together with expert patients, families and carers to support pathway improvements and re-design work.

Within the locality we will support NHS Greater Manchester's 'Fit for the Future' programme, where we will work with individuals, families and communities in Oldham on the core challenges, so we can collectively make the best use of health and care funding to develop sustainable services. **We will also support the development of community-led health, care and engagement approaches, in line with the 'capacity development' mission of the voluntary, community, faith and social enterprise sector.**

A new local communications leads network for health and care will also be established to aid better proactive and reactive collaborative working to support the delivery programme and work around health improvement and system pressures.

Link to GM missions:
Mission 1 – Strengthening our communities
Mission 5 – Helping people stay well and detecting illnesses earlier

FIT FOR THE FUTURE

Core challenges:

- Improve people's health, so that they live long, healthy lives
- Improve performance, making sure we are meeting key targets on GP access and hospital waiting times
- Bring the local NHS finances back into balance

Workforce

Oldham
Integrated Care Partnership

We will establish a local workforce action plan focused on social value, partnership development and leadership initiatives, and new ways of working for our local NHS Greater Manchester Place Team.

The key local overarching workforce priority themes will be as follows:

- Support workforce actions that are outlined via the delivery workstreams within the transformation programme
- Support delivery of social value, 'health and wealth' and digital education for staff, as detailed in the health inequalities action plan
- Implement partnership-wide matrix working approaches wherever possible
- Develop a partnership-wide leadership plan and development schedule
- Develop an organisational development plan for Oldham's NHS Locality Place Team to ensure stabilisation moves to innovation

Work will link into the community-led work with the voluntary, community, faith and social enterprise sector, particularly in relation to delivering workforce to health and care services and enhancing the skills and employment of local people.

Workforce activities will also be embedded as needed into our delivery workstreams, as linked to service improvements and pathway changes, with a particular focus on the development of our new population health management approach for districts / neighbourhoods / Primary Care Networks.

Workforce

- **NATIONAL PRIORITIES:**
  - Improve the working lives of all staff and increase staff retention and attendance through systematic implementation of all elements of the People Promise retention interventions
  - Improve the working lives of doctors in training by increasing choice and flexibility in rotas, and reducing duplicative inductions and payroll errors
  - Provide sufficient clinical placements and apprenticeship pathways to meet the requirements of the NHS Long Term Workforce Plan

Link to GM missions:
Mission 5 – Supporting our workforce and carers

Digital

Oldham
Integrated Care Partnership

As linked to both the GM digital strategy and our Oldham Integrated Care Partnership 5-year strategy, priorities for improving the areas of digital within health and care services will focus on both infrastructure and capabilities of use (staff and patients).

There will be a priority, linking to both the health inequalities action plan and the engagement and involvement plans, in relation to digital education for staff, patients and communities, to help enhance access to services and health literacy.

Other digital work will link to the GM Primary Care Blueprint, including the plans for shared care records and care plans.

Additional locality digital projects will be scoped through 2024/25 as linked to the delivery programme and workstreams and overall performance priorities.

As staffing and budgetary resource for digital, workforce, engagement and communications is limited, we will utilise a partnership approach for delivery within Oldham, and across the Four Localities Partnership, wherever possible.

Digital

- **NATIONAL PRIORITIES:**
  - Ensure our infrastructure is modern and sustainable
  - Level up digital provider maturity
  - Deploy and upgrade electronic patient record systems
  - Connect services via, and champion the use of the NHS App
  - Align planned digital investments with the Federated Digital Platform

Link to GM missions:
Mission 2 – Helping people stay well and detecting illnesses earlier
Mission 4 – Recovering core NHS and care services
Mission 6 – Achieving financial stability

Oldham
Integrated Care Partnership

Glossary of terms

Glossary of terms

Oldham
Integrated Care Partnership

2ww	2 Week Wait
A&E	Accident and Emergency
A&G	Advice and Guidance
ADHD	Attention Deficit Hyperactivity Disorder
AQP	Any Qualified Provider
ASC	Adult Social Care
ASD	Autism Spectrum Disorder
BAME	Black, Asian, and minority ethnic
BAU	Business As Usual
BMI	Body Mass Index
BP	Blood Pressure
CAMHS	Child and Adolescent Mental Health Services
CDC	Community Diagnostic Centre
CHC	Continuing Health Care
Chol	Cholesterol
CIP	Cost Improvement Plan
COPD	Chronic Obstructive Pulmonary Disease
CSC	Childrens Social Care
CSDS	Community Service Data Set
CT	Computerised tomography
CVD	Cardio Vascular Disease
CYP	Children and Young People
D2A	Discharge to Access
DNA	Did Not Attend
ECDS	Emergency Care Data Set
ED	Emergency Department
EL	Elective
FIT	Faecal Immunochemical Test
FLP	Four Localities Partnership
GI	Gastrointestinal Tract
GIRFT	Getting It Right First Time
GM SCC	Greater Manchester System Control Centre
GM	Greater Manchester
GP	General Practice

Glossary of terms

Oldham
Integrated Care Partnership

H&SC	Health and Social Care
HRT	Hormone Replacement Therapy
IAPT	Improving Access to Psychological Therapy
ICB	Integrated Care Board
ICP	Integrated Care Partnership
IMC	Intermediate Care
IP	In Patient
JFP	Join Forward Plan
KPI	Key Performance Indicators
LA	Local Authority
LD	Learning Disabilities
LMNS	Local Maternity & Neonatal System
LoS	Length of Stay
LTCs	Long Term Conditions
MH	Mental Health
MMR	Measles, Mumps and Rubella
MRSA	Methicillin-resistant Staphylococcus aureus
NCA	North Care Alliance
NDPP	National Diabetes Prevention Programme
NEL	Non Elective
NHSE	NHS England
NICE	National Institute of Clinical Excellence
NRTR	No Reason to Reside
NWAS	North West Ambulance Service
OAPS	Out of Area Placements
OBD	Occupied Bed Days
OEP	Outpatient Excellent Programme
OP	Out Patient
OTC	Over The Counter
PCIS	Primary Care Incentive Scheme
PCN	Primary Care Network
PHB	Personal Health Budgets
PHM	Population Health Management
PIFU	Patient Initiative Follow Up

Glossary of terms

Oldham
Integrated Care Partnership

RTC	Right to Chose
SALT	Speech and Language Therapy
SCR	Skin Care Referrals
SDEC	Same Day Emergency Care
SEN	Special Educational Needs
SENCOs	Special Educational Needs Co-ordinators
SEND	Special Educational Needs and Disabilities
SLCN	Speech, Language and Communication Needs
SMART	Specific, Measurable, Agreed Upon, Reasonable, and Time-Bound
SMI	Severe Mental Illness
T2D	Type 2 Diabetes
UEC	Urgent Emergency Care
UTC	Urgent Treatment Centre
VCFSE	Voluntary, Community, Faith and Social Enterprise Sector
WHO	World Health Organisation