Report to COUNCIL – 6th November 2024

Oldham Council

Portfolio Report

Portfolio Holder: Councillor Barbara Brownridge
Cabinet Member for Adults, Health and Wellbeing

This report provides an update on the main activity since the last Council meeting relating to portfolio responsibilities.

Public Health

Social Prescribing Service

Oldham Council has recommissioned our Social Prescribing service for six more years from 1st November 2024. Action Together CIO will continue to lead a consortium of providers including Age UK Oldham, Tameside Oldham & Glossop Mind and Positive Steps in delivering the service.

The service connects residents with the local community activity and support offer to improve their physical and mental wellbeing. They also support people and communities to take control of their own health, become more resilient and improve their life chances. Social prescribing is a means of connecting people to a range of local activities, support, and services within the community, instead of offering only prescribed medical or care solutions. The service also has a key role in capacity building within the community, enabling voluntary and community groups and organisations to deliver activities and support which promotes the health and wellbeing of residents.

In the 23/24 financial year, Oldham's social prescribing service received more than 3,000 referrals, and made more than 1,700 connections to other support and activities. They are currently working with over 500 people, primarily people experiencing loneliness and isolation, as well as those with physical and mental wellbeing challenges. 80% of people supported by the service have seen a measurable improvement in their wellbeing following the intervention (using Short Warwick Edinburgh Mental Wellbeing Scale).

Adult Social Care (ASC)

Oldham Total Care

Oldham Total Care (OTC) continues to evidence a much-improved position with occupancy now at 96%, which is the highest since March 2019. The new registered manager is due to start on 4th November, which will be key to the continued successful development of the home as a centre of excellence for the people of Oldham.

Care Technology

With technological advancements in the field of Care Technology (or 'Assistive Technology') ASC is incorporating different forms of care and support which will compliment traditional packages of commissioned care. Our aim ensures residents are enabled to live safely and independently, whilst reducing the need for traditional forms of care. With this, we have commenced a roll out of mandatory training sessions for front line adult social care staff and are engaging with the market through a procurement approach.

Digital Switchover

MioCare as been leading a programme of work to ensure that Helpline and Response customers are not affected through the digital switchover, which means that by January 2027, all 'landlines' will be replaced with digital. This change does mean that MioCare are in the process of updating all Helpline and Response units to be compatible with the changes to digital. Through robust data

sharing agreements in place with Telecoms providers MioCare is ensuring a smooth transition and supporting Oldham residents through this process.

<u>Good Lives GM leadership collaborative - Transitional Safeguarding (including the potential to prevent homelessness)</u>
Six teams from across health and social care, local authorities, the VCSE sector and the Combined Authority are taking part in a new kind of leadership collaboration. Supported through 1-1 and group coaching, workshops, learning materials and webinars, teams conduct system-shifting experiments to rebuild structures and cultures that are barriers to their work to reduce inequalities.

ASC will be part of this fantastic opportunity in the GM Leadership collaborative, with a focus on Transitional Safeguarding. The collaborative is held in very high regard nationally. This sits with our priorities for complex safeguarding in ASC and links to community safety, Children's Social Care and public health priorities. The directorate has attended the first session and have been asked to share our training/guidance on 'making a section 42 referral' program as an example of good practice to be adopted regionally.

Oldham Integrated Care Partnership (ICP)
<u>Proactive Care and Prevention Activities - Focused Care</u>
A team of researchers based at the Universities of Glasgow, Oxford and Bath, are undertaking an NIHR-funded project exploring 'missingness' in healthcare, placing focus on the causes of missingness and interventions to address it. On 10 July 2024, two of the project team, Andrea Williamson and David Baruffati, visited Oldham to spend a day shadowing four Focused Care Workers (FCWs) to understand how the work undertaken by Focused Care (FC) can help to reduce missingness in healthcare. The full research paper for 'Missingness in Primary Care' is being written up over the coming months and this is a short summary that the research team are sharing of their thoughts on the Focused Care model. It is truly humbling to have such a positive summary of the model and work that the FCP's do on a daily basis in Oldham. The research has featured in the chief medical officer's report for the Scottish government and has the recommendation from the team that the model should be replicated nationally. It is great to think that Oldham are trailblazers in this model.

<u>Reducing Prevalence and Prevention Activities - Chronic Kidney Disease (CKD)</u>
Greater Manchester has one of the highest rates of cardiovascular disease and cardiovascular death in the UK. CKD is one of the largest modifiable risk factors for cardiovascular disease. Late presentation (within 3 months of starting dialysis) is very common in Manchester. Data states that of people who start dialysis every year 26% at Manchester Foundation Trust, 15% at Northern Care Alliance start dialysis having not been known to nephrology for more than 3 months. CKD affects around 7% of adult population, although coded CKD prevalence in Oldham is 3.8% and varies between 1.3% and 5.8% depending on primary care setting. Research suggests that there is a confidence gap in the management of CKD in primary care compared with other long-term conditions.

As part of our work on population health management and shifting our system to one focused prevention not just treatment, consultant Nephrologist, James Tollitt has launched the CKD Dream project working with primary care. All practices in Oldham will receive informative & collaborative advice and guidance via Electronic Referral System (ERS). All practices will be provided with their local data, a toolkit to help find uncoded patients who may not be receiving optimal medical therapy and PCN based CKD educational sessions. 10 practices will receive enhanced CKD support with a practice visit to run search tools to find patients in need of CKD optimisation/coding, 4 x 1 hour virtual MDTs with consultant nephrologists and investment of £4200 per practice to support medicine optimisation clinics/attendance at virtual MDT/engagement with practice visit(s). The Oldham CKD DREAM Project will aim to be complete by October 2025.

Recommendations: Council is requested to note the report.