Healthier Oldham Plan

Oldham Neighbourhood Plan 2026 to 2031

Leaders of our key organisations are signed up to this neighbourhood plan

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Xxx
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Mark Gifford MBE
Chief Executive, First Choice Homes

Our Neighbourhood Plan

The content of our neighbourhood plan draws on the innovative work which has already begun in Oldham and our track record of delivery e.g. Population Health Management, our existing Neighbourhood Health Centres. Below is a summary of the high level content and themes it will encompass.

1. Introduction and vision

Describing our vision and ambitions for Oldham, the partners in Oldham delivering this plan

2. Drivers of demand

Describing the current population health outcomes and drivers of health and care demand in Oldham;

- **Oldham population and life expectancy by ward**
- **Our neighbourhood health needs**
- **Financial and activity picture**
- **Our operating model**
- **Our interventions**

3. Neighbourhood Health: Our approach

Describing the three key pillars of our neighbourhood approach;

- **Population Health Management**
- **Integrated Neighbourhood Teams**
- **Live Well in Oldham**

4. Support to Neighbourhoods

Describing the broader enablers which wrap around PHM and INTs to deliver effective neighbourhood health;

- **Transforming Primary Care**
- **Urgent Neighbourhood Services**
- **Intermediate Care & Home First**
- **Standardised Community Services**
- **Neighbourhood elective pathways**
- **Neighbourhood cancer prevention and reduction**

5. Neighbourhood Health: Enablers

Describing the key infrastructure, support and culture we are developing upon which neighbourhood health teams can be built;

- **Neighbourhood Health Centres**
- **Workforce and culture**
- **Estates**
- **Digital**
- **Information sharing**

6. Governance and next steps

Describing our system governance and arrangements which will enable our neighbourhood plan

Forward

This strategic plan represents our translation of the national strategic frameworks into the context of the health and care system in the borough of Oldham. As we plan the move away from our primary focus from 'delivering healthcare' and towards a system that understands citizens and patients as partners in the 'co-production of health', there are some core concepts that have guided our thinking.

The first and most important of these is that we must change the nature of the relationship between the NHS and the population that it serves. This plan describes how we intend to begin this process in three ways. First, by initiating a new, systematic and wide-ranging stakeholder engagement programme Second, by instituting a new annual strategic cycle that links the 'conversation' with our population with the 'contracting authority' that can enact the key requirements as they emerge. Third, by designing and consulting on a *personalised public health outreach function.* By proceeding in this way, we are seeking to simultaneously develop and empower the voices of patients, families and communities in a way that has the potential to transform the care system.

The second is that we must change the relationship between strategic management and care professionals. There are international examples of systems that have moved on from seeing professional leadership as an important *component* of the management system and instead have developed organisational models that place clinical and care professional leaders in direct positions of authority and strategic control.

This plan outlines how we are pursuing this idea in Oldham both by working closely with primary care leaders to develop the capability and governance arrangements for properly empowered placed based partnership and through our stated strategic goal of pursuing the concept of a new Integrated Healthcare Organisation

The third important insight is that the transformation of services must be supported by a transformation in the commissioning function itself. To deliver our new vision, commissioning must incorporate processes to translate stakeholder conversations into contracting requirements and understand that individual preferences need to be given a new importance alongside the traditional notion of need. It also needs to be led by a new, general practice-based partnership that harnesses the design insights of leading clinicians to the resource management and project planning of effective general management. It needs to look beyond traditional providers and develop new capabilities in the voluntary and independent sector. It must build new high frequency population health status and patient tracking information systems to consolidate the recent gains in access, introduce the new discipline of systematic management for quality and plan to deliver the new requirement to lift life expectancy. Finally, it needs to develop a new industry standard in areas such as social marketing and actuarial analysis to effectively manage individual and population risk.

Linking these three ideas together produces our mission of *professionally led, publicly accountable, individually responsive* health and care services.

Mike Barker, Deputy Place Lead & Deputy CEO Oldham Council

Our vision

The picture in Oldham is just as stark. Mortality is higher than average, and like elsewhere, the majority of deaths are driven by a small number of long-term conditions: cardiovascular disease, cancer and respiratory illness. But what stands out is the depth of need. People are living longer with poor health, often with multiple conditions, and mental health demand is both high and rising. This isn't just a case for incremental change. It points to a clear need to strengthen prevention and invest more decisively in mental health and early intervention.

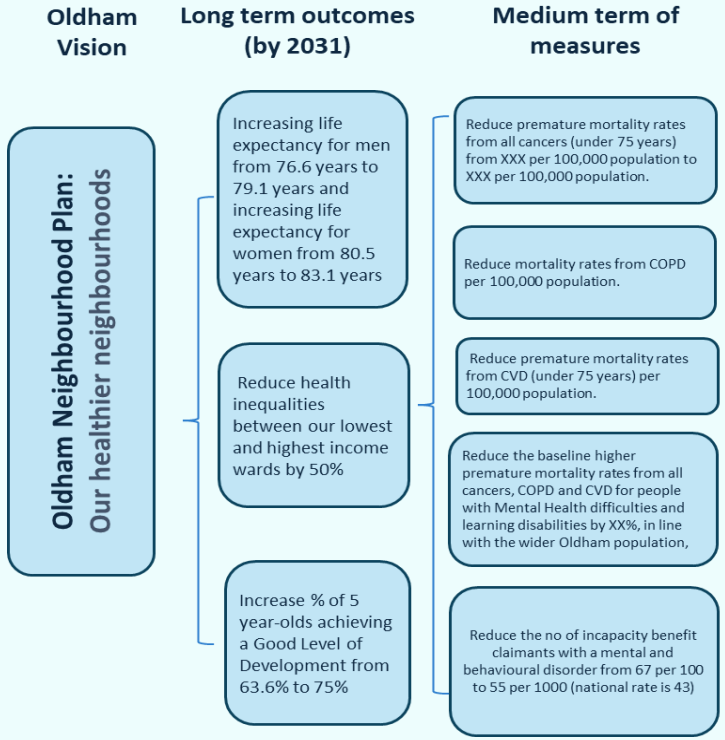
The logical argument of this strategic document is correspondingly simple, and lays out how we are going to respond to the health and well being challenges in the four areas of cardio-vascular disease (CVD), cancer, respiratory disease (with a focus on Chronic Obstructive Airways Disease) and mental health.

In practical terms, we are planning to ensure:

1. Better Care through more effective system management, the introduction of advanced quality monitoring and specific investments targeted at services in our key health need areas
2. Better Health through the development of a 'population health status monitor', based on the GP registered list. This will enable us to deliver thoroughly systematic health improvement programmes (our flagship being the CVD register programme). This will support the delivery of a highly targeted approach to social marketing of both self-care messages and invitations to participate in health and well-being services
3. Better Life through our programme to transform our mental health services and our partnerships with the local authority to enhance the quality of life of all citizens in Oldham

Whilst our ambitious plans will focus on preventing and reducing the devastating effects that cancers, cardiovascular disease, respiratory disease and poor mental health have on our community, we also intend to change our relationship with patients and our population through new channels of communication and the commissioning of far more personalised services.

To this end, by 2031 we aim to:



Our Plan

As we launch our Oldham Place Partnership , bringing together the organisations who support all age health, social care, housing, etc we set out our vision and plans for a whole-system approach to neighbourhood health and living well in Oldham.

Our plan is the culmination of the experience and learning from the individuals, communities and organisations who have come together in Oldham over recent years to improve the health outcomes and experience of Oldham residents. We find ourselves now at a critical moment where locally and nationally it is recognised that only through working at a neighbourhood level can we create true partnerships with residents which inform the delivery and design of services.

Much of what is described here in this plan is not new, however, a number of national and local drivers provide the right time to galvanise our collective ambitions. Our plan supports;

- NHSE's move to a neighbourhood health service
- Greater Manchester's Live Well ambition
- Oldham's wider place priorities

This plan has naturally emerged from the programmes of work commenced in Oldham which includes our Population Health Management programme led by our Primary Care Networks, our emergent Live Well programme, learning from the roll out of our Families First Partnerships and Mental Health Neighbourhood Teams (previously known as Living Well) .

No single organisation owns this plan – it is not an NHS plan, a council plan, or an organisational strategy. It outlines the combined ambitions of our partnership and the strengths each individual and organisation can bring when we would collectively towards a clear set of goals for our population.

To anchor our progress and ensure it continues, this plan describes our ambitions and visions but critically will be supported by a more detailed delivery plan and framework within an agreed partnership framework for Oldham.

Our Plan

Our PACE model provides the framework for our strategy.
For Oldham this means:

Personalised: We will establish a new relationship with our population where they are at the fulcrum for lifestyle healthcare choices and shaping health services for Oldham. For example, the GP practice-based register will be the core to ensuring individuals' well-being.

Advanced: We will ensure that our patients have access to the most effective leading-edge technologies. For example, we are planning a major investment in remote-monitoring technologies and the phased introduction of at least one world class option for our top 10 surgical procedures.

Care: will re-commission services to provide integrated health and social care and in so doing incentivise providers to respond with innovative models of provision

Environment: Oldham will not be bound by particular buildings in the future. Healthcare will be delivered in environments that are designed to fit with particular needs, expectations and lifestyle of patients and citizens.

In this context, we are planning to reconfigure the Better Care Fund to support the introduction of initiatives in each of our main health need areas. The implemented initiatives are expected to improve health and deliver savings. Any available investment must have been prioritised according to their anticipated impact and their value for money to deliver the outcomes outlined above.

We are also actively exploring the introduction of integrated services, and the next few months are critical for determining the extent to which this will play a part. If we retain our present structure, the impact of our programmes will be significantly beneficial for our population but will have a marginal impact on the overall pattern of investment. If we do fully move down the road of integration, we will retain a focus on our core strategies but will have a much greater impact on the profile of our contracts.

The collaborative supporting our plan

A range of providers across health, care, voluntary, community, faith and social enterprise sector, housing and other partners are already working together in Oldham to deliver integrated care. This collaborative effort is critical to the further expansion of neighbourhood health teams.

Oldham Council

- Adult social care
- Children's services (including Early Help)
- Drugs and alcohol services
- District and youth coordinators
- Public health
- Learning disabilities and mental health services

Healthcare

- Primary care (including PCNs)
- Mental health services (PCFT)
- GM ICB and Oldham locality
- Secondary care
- Community health services (NCA)
- Social prescribing and VCSE

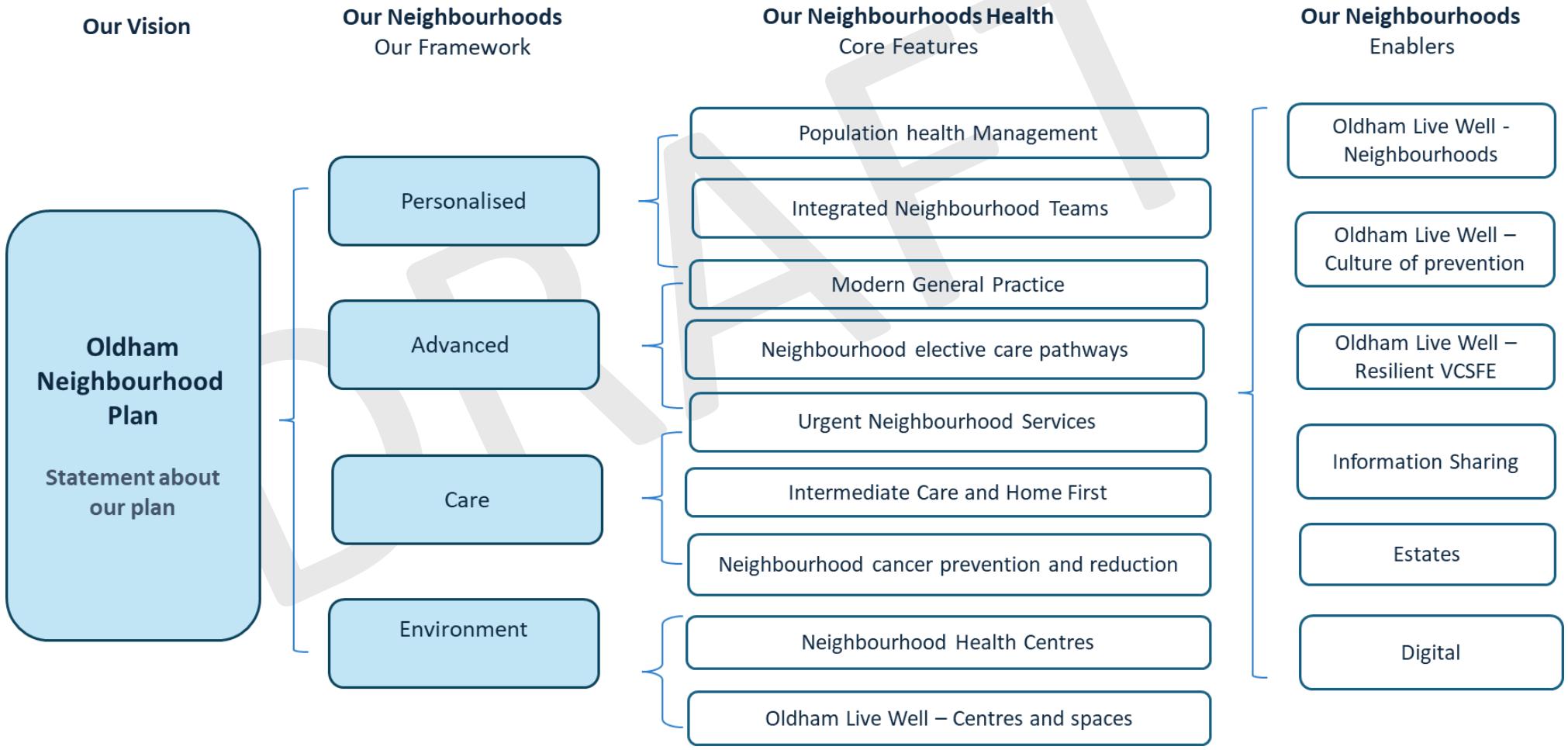
Voluntary sector*

**Examples of VCFSE engaged*

- TOGMind
- Age UK
- Action Together
- Positive Steps
- Home Start
- Oasis UK

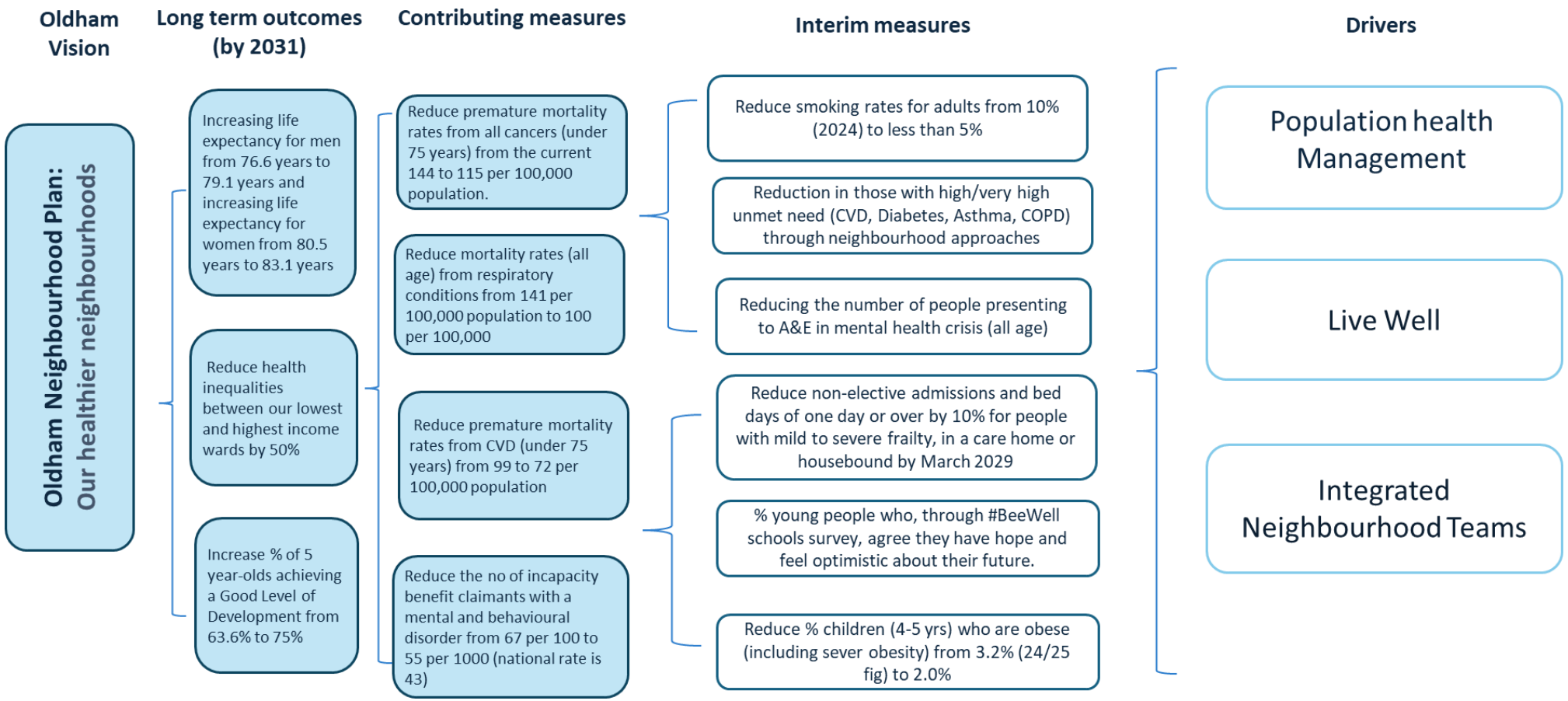
High level view of our plan

Our Neighbourhood Plan can be summarised through the key features of our framework, the core features of our neighbourhoods and the enablers which support this.



High level view of our plan - measurement

We have identified clear long-term outcomes for our population which this plan will deliver. To be able to monitor progress, medium term and interim measures have also been identified: these measures can be reported more frequently and drive long term outcomes



Policy context

Several national and local policies and drivers re-enforce the ways of working we have been developing in Oldham in recent years which prioritise strengthening communities and reducing health inequalities through a focus on neighbourhoods and multi-agency working.

The *10-year NHS Plan* outlined three key shifts required to modernise the NHS; hospital to community, analogue to digital, sickness to prevention, and the *NHS Neighbourhood Framework and National Neighbourhood Framework (2025)* set our clear expectations about creation of neighbourhood health approaches which our plan describes in detail.

Oldham is proudly part of the Greater Manchester city-region. The Greater Manchester Strategy 2025 to 2035 *'Together we are Greater Manchester'* sets out Live Well as a fundamental approach to reducing health inequalities and improving the everyday lives of residents which Oldham is at the forefront of delivering – detailed in our Oldham Live Well Strategic Case and referred to in this plan.

There is a lot of great work transforming residents' lives in Oldham. This plan describes health and care neighbourhood aspects of these priorities, whilst speaking to the relationship with other plans and priorities underway in the system.

Family Hubs have been created in Oldham transforming how families access support through providing universal (for everyone) one-stop shops, where you can access all the help and support you need to make sure your child is healthy, safe, and looked after (*Giving Every Child the Best Start in Life (2025)).*

Pride In Place Strategy is the government's plan to create safer, healthier neighbourhoods where communities can thrive, focussing on disadvantaged areas including parts of Oldham

Oldham's implementation of the *Families First Partnership Reform and Programme* launched 2025 is transforming the way families are supported through multi-agency working, improving child protection through family centred local approaches and introducing Family Help.

2. Drivers of demand

Describing the current population health outcomes and drivers of health and care demand in Oldham;

- Oldham population and life expectancy by ward
- Our neighbourhood health needs
- Financial and activity picture
- Our operating model
- Our interventions

About Oldham

In Oldham, we are united in our commitment to delivering public services where they are needed most. We welcome the ambition of the 10-Year Plan, which brings renewed energy and focus to our ongoing efforts to improve neighbourhood health.

Oldham has c243,000 residents, projected to increase by over 5% in the next 10 years. Whilst it has a young population profile with a high proportion of residents under 16, the number of people over 65 is set to grow by 30% by 2041, which will increase demand on the system. Furthermore, there is a much older population concentrated in the north district compared to the other geographies.

Population ethnic diversity also greatly differs by geography, with an ethnically diverse population in the central and west districts, but a predominantly white population in the north. Overlaid on this are clear differences in deprivation, particularly concentrated in central and then the west and south districts. Such high levels of deprivation and other wider determinants adversely impact Oldham residents' health outcomes and life expectancy, and lead to high health needs and later complex and/or acute demand.

The demographic differences and wider determinants of health, and variation in health behaviours, risk factors and prevalence across different geographies in Oldham, give rise to different patterns of health needs and health and care resource use across the neighbourhoods.

About Oldham – Our neighbourhood health needs

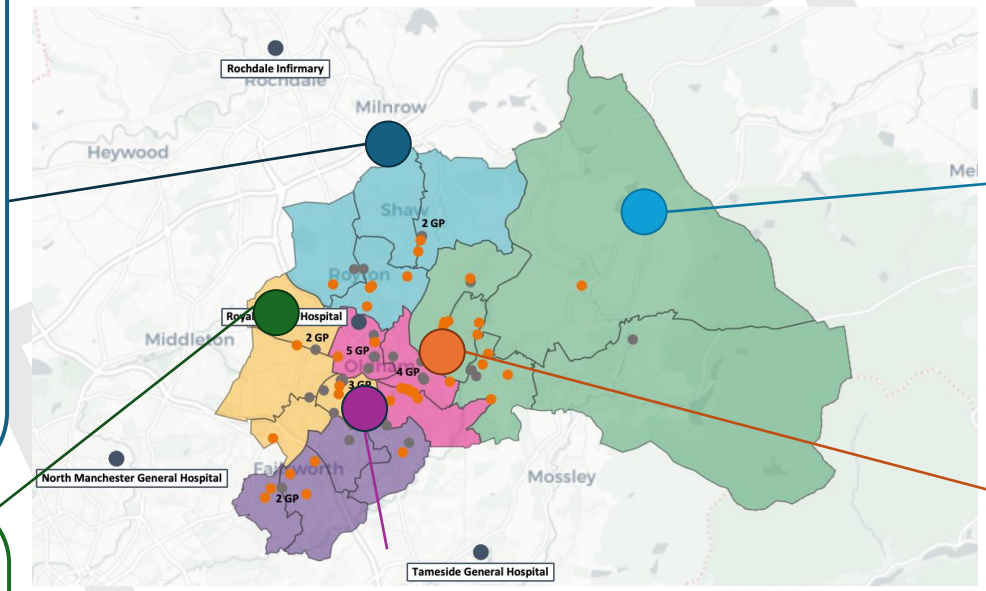
North District

- **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

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

Key: Acute hospital site | GP practice | Care home



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

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**

Central District

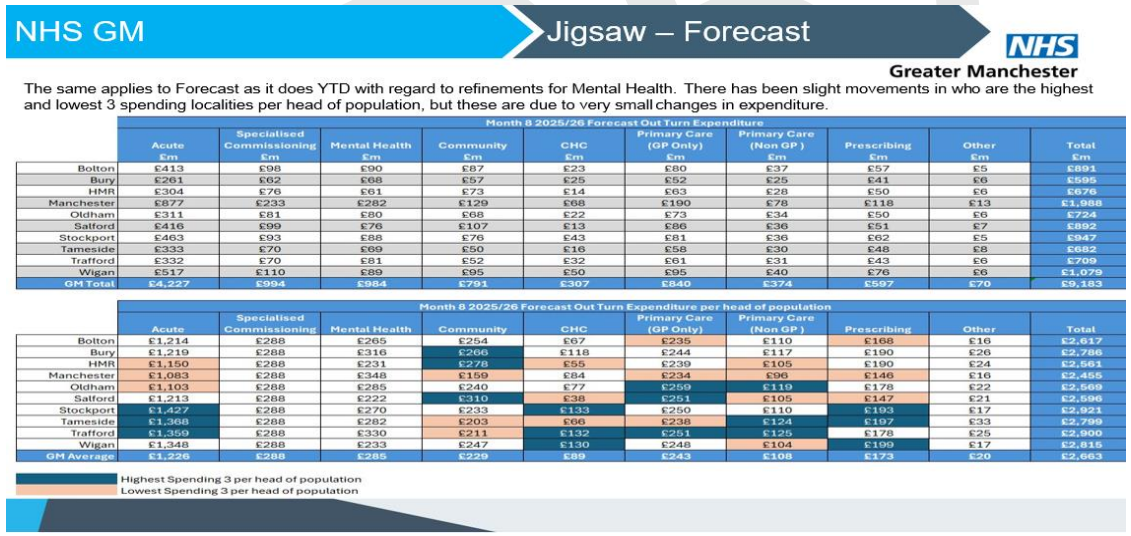
- **Youngest population** profile(30% <16, 9% >65) and **highest degree of ethnic diversity** with nearly 50% of the population Asian and largest proportion of Black/Black British/Caribbean or African residents
- Significantly the **most deprived District**
- Relatively **high levels of smoking and obesity**
- **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.**

About Oldham – health and care spend

Across health and care there is a total spend of c£832m for the population of Oldham. The way this spend is governed and organised is changing under NHS reforms, with a Place Fund the key mechanism for change in Oldham.

Our challenge is to get the best outcomes using this resource, deploying it in the most effective way to deliver our agreed outcomes. Fundamentally, the success of our neighbourhood plan relies on shifting resource from high-cost acute care to community-based setting and preventative activities.

GM ICB Jigsaw tool compares 10 localities spend per head of population



NHS GM — Jigsaw – Forecast

NHS Greater Manchester

The same applies to Forecast as it does YTD with regard to refinements for Mental Health. There has been slight movements in who are the highest and lowest 3 spending localities per head of population, but these are due to very small changes in expenditure.

Month 8 2025/26 Forecast Out Turn Expenditure

	Acute £m	Specialised Commissioning £m	Mental Health £m	Community £m	CHC £m	Primary Care (GP Only) £m	Primary Care (Non GP) £m	Prescribing £m	Other £m	Total £m
Bolton	£413	£98	£90	£87	£23	£80	£37	£57	£5	£891
Bury	£261	£62	£68	£57	£25	£52	£25	£41	£6	£595
HMR	£304	£76	£61	£73	£14	£63	£28	£50	£6	£676
Manchester	£877	£233	£282	£129	£68	£190	£78	£118	£13	£1,988
Oldham	£311	£81	£80	£68	£22	£73	£34	£50	£6	£724
Salford	£416	£99	£76	£107	£13	£86	£36	£51	£7	£892
Stockport	£463	£93	£88	£76	£43	£81	£36	£62	£5	£947
Tameside	£333	£70	£89	£50	£16	£58	£30	£48	£8	£682
Trafford	£332	£70	£81	£52	£32	£61	£31	£43	£6	£709
Wigan	£517	£110	£89	£95	£50	£95	£40	£76	£6	£1,079
GM Total	£4,227	£994	£984	£791	£307	£840	£374	£597	£70	£9,183

Month 8 2025/26 Forecast Out Turn Expenditure per head of population

	Acute	Specialised Commissioning	Mental Health	Community	CHC	Primary Care (GP Only)	Primary Care (Non GP)	Prescribing	Other	Total
Bolton	£1,214	£288	£265	£254	£67	£235	£110	£168	£16	£2,617
Bury	£1,219	£288	£316	£266	£118	£244	£117	£190	£26	£2,786
HMR	£1,150	£288	£231	£278	£55	£239	£105	£190	£24	£2,561
Manchester	£1,083	£288	£348	£159	£84	£234	£96	£146	£16	£2,455
Oldham	£1,103	£288	£285	£240	£77	£259	£110	£178	£22	£2,569
Salford	£1,213	£288	£222	£310	£38	£251	£105	£147	£21	£2,596
Stockport	£1,427	£288	£270	£233	£133	£250	£110	£193	£17	£2,921
Tameside	£1,368	£288	£282	£203	£66	£238	£124	£197	£33	£2,799
Trafford	£1,359	£288	£330	£211	£132	£251	£125	£178	£25	£2,900
Wigan	£1,348	£288	£233	£247	£130	£248	£104	£199	£17	£2,815
GM Average	£1,226	£288	£285	£229	£89	£243	£108	£173	£20	£2,663

Highest Spending 3 per head of population
Lowest Spending 3 per head of population

High level GM ICB and Oldham Council spend on health and social care for Oldham residents 25/26

Spend Type	Spend (m)
Acute & specialist NHS care	£311
Mental health	£80
Community health	£68
CHC	£22
Primary care	£101
Prescribing	£50
Public health	£20
Adult social care	£90
Children's social care	£90
Total	**£832**

Demand drivers based on finance, activity and system engagement

We undertook demand analysis, driver analysis, interviews and desktop research to identify three thematic areas which are driving health and care demand in Oldham, and which the interventions in our plan will address through our **operating model.**

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

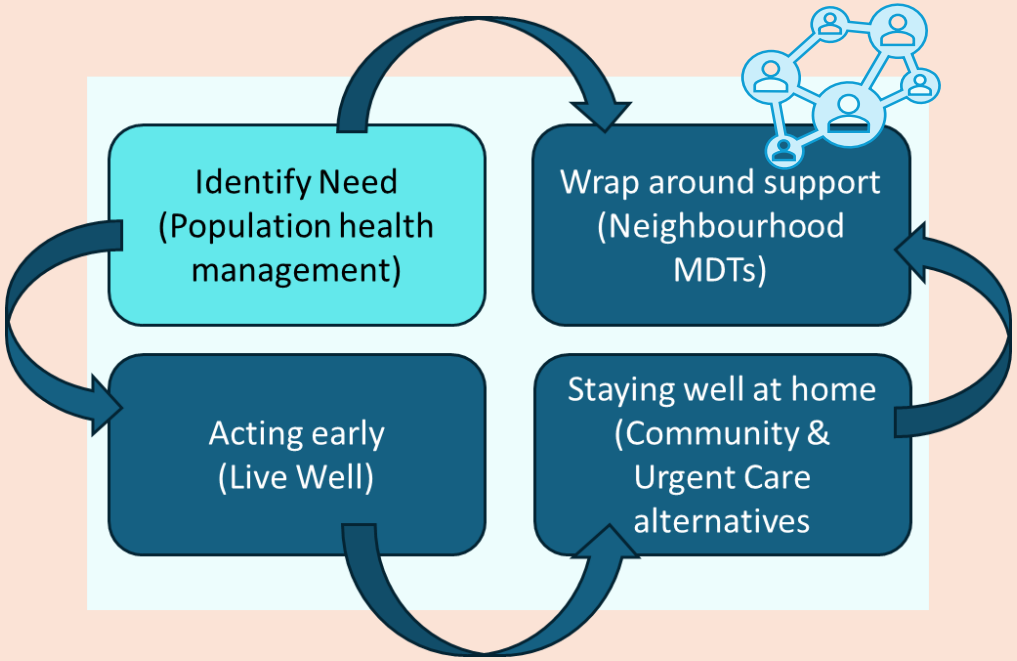
3. Lack of service integration, communication and signposting

- 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

Our operating model – responding to demand

Our operating model is simple but important, with **population health** at its core. By identifying and understanding need, we put in place interventions depending on the level of need, in line with our **prevention framework.**

Our health and care neighbourhood model is based on neighbourhood MDTs, alongside other neighbourhood health components (e.g. urgent neighbourhood services), providing wrap around support and support to stay well at home.



Our Oldham Prevention Framework is fundamental to this operating model by describing the type of response for the level of need at all levels.

Oldham Prevention Framework

Responding to demand drivers, themed interventions

As a result of our demand analysis, we have developed a plan which based upon key principles of PACE, but which addresses some key thematic areas as described;

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**

3. Neighbourhood Health: Our approach

Describing the three key pillars of our neighbourhood approach;

- **Population Health Management**
- **Integrated Neighbourhood teams**
- **Live Well in Oldham**

Neighbourhoods in Oldham

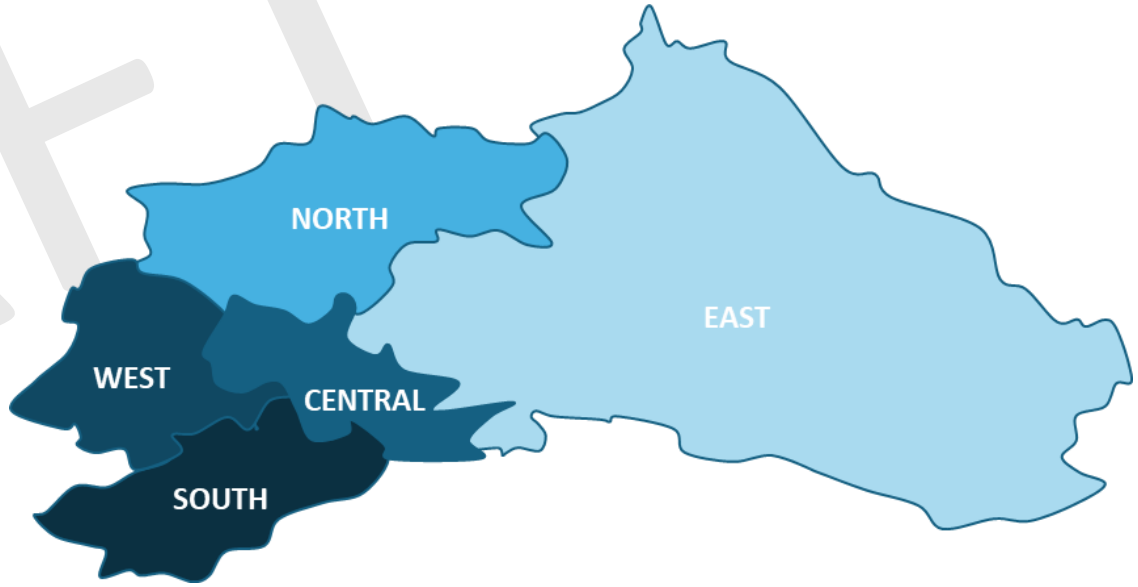
A number of policies describe the criticality of delivering public services on a neighbourhood footprint in order to bring them closer to residents, as well as the importance of strengthening neighbourhoods to reducing inequalities.

Oldham is unique in having achieved full geographical alignment across public services in 2020. This alignment was a bold and transformational step, taken to provide more responsive, joined-up services and to directly tackle entrenched inequalities. The realignment involved all major public services; including Social Care, Mental Health, Community and Primary Care, Policing, Housing and Homelessness Support, Environmental Health, Employment and Skills Services, the VCFSE sector, Community Safety, Substance Misuse, and Early Years services.

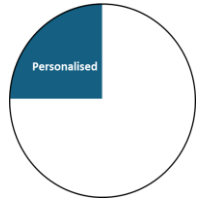
This system was designed around the existing Primary Care Networks (PCNs) wherever possible, resulting in the creation of five integrated neighbourhoods across Oldham. Now, five years on, these neighbourhoods and their associated services are well-established and form the foundation of our place-based approach to integrated care.

Oldham's neighbourhoods are split into five distinct neighbourhood or 'districts' which range in their geography and demographic and make up.

These neighbourhoods are aligned with our Primary Care Networks (PCNs) which will also be the footprint for our Neighbourhood Health delivery. These footprints fit within the 30 to 50k population recommended in national NHS guidance.



Anchoring our neighbourhoods around our PCNs, and consequently the GP practice-based register enables **personalised** care.



Neighbourhoods: Primary Care Networks (PCNs) and Population Health Management

Oldham has a well-established GP Board, which serves as the representative body for practices across the Oldham Locality through their membership in Primary Care Networks (PCNs). The GP Board holds a seat on the Partnership Committee, the Greater Manchester Integrated Care Board (GM ICB), and associated structures such as the GM GP Provider Board. Representation on these bodies is provided through nominated members, ensuring formal links to strategic planning and decision-making processes.

Each of the five PCNs, along with the GP Board itself, has established clinical, managerial, and administrative leadership structures.

Additionally, within each of the five Neighbourhoods, the Oldham **Population Health Management (PHM) Programme** has implemented a structured governance model known as the **'governance quad'.** This includes four key roles: a primary care clinical lead (typically a senior GP), a neighbourhood operational lead, a specialist care professional (such as a district nurse or occupational therapist in older adult models, or Early Help leads for children and young people), and a Council district coordinator.

The governance quad is responsible for oversight and decision-making related to PHM initiatives, including operational aspects such as caseload review and management. Quad meetings are also attended by other relevant professionals — such as secondary care consultants, care coordinators, assessors, and PCN Clinical Directors — particularly when their input is essential to the design or delivery of new care pathways.

Our population health management mode is based upon;

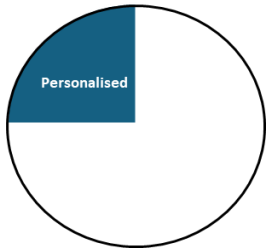
- Data-Driven Decision Making:
- Clinician-Led Design
- Strong Partnership with the VCFSE Sector
- Investment in Social Prescribing

PHM Governance quad

Neighbourhood Health in Oldham: Population health management

Consistently using quantitative and qualitative insights to identify cohorts (esp. those with complex needs), segment risk, and target intervention.

Where are we now?	• A data informed approach has been used to develop a population health management analysis and focus for each PCN • Target interventions developed for cohorts identified: over 65s with mild/moderate frailty, children at risk of developing low / mid-severity mental health conditions, children and their families in good health but at rising risk of developing poor health, 50-64s at risk of becoming frail through multi-morbidities • Population health management used by PCNs with multi-disciplinary teams formed for specific cohort, however dynamic use of PHM by broader system not established yet
What needs to happen next?	• Secure consistent and routine access to population health data to routinely monitor activity outcomes, with the support of GM ICB • Evaluate and build on PCN frailty models and children and young people approaches to devise consistent approach • Further development of approach alongside new Integrated Neighbourhood Teams (INTs) • Scale up approach to broaden population supported
What will be the impact	↑ Improved patient outcomes – manage existing conditions better, prevent / delay new conditions developing, keeping people healthier for longer ↑ Improved patient experience – personalised, holistic care plans ↓ Reduce unplanned demand –better co-ordination of services, reduced demand on acute services ↑ Strengthen integrated working – collaboration amongst staff across skillsets and organisations £ Value for money – reduce wider out-of-hospital and social care spend



Case study: North PCN Frailty pathway

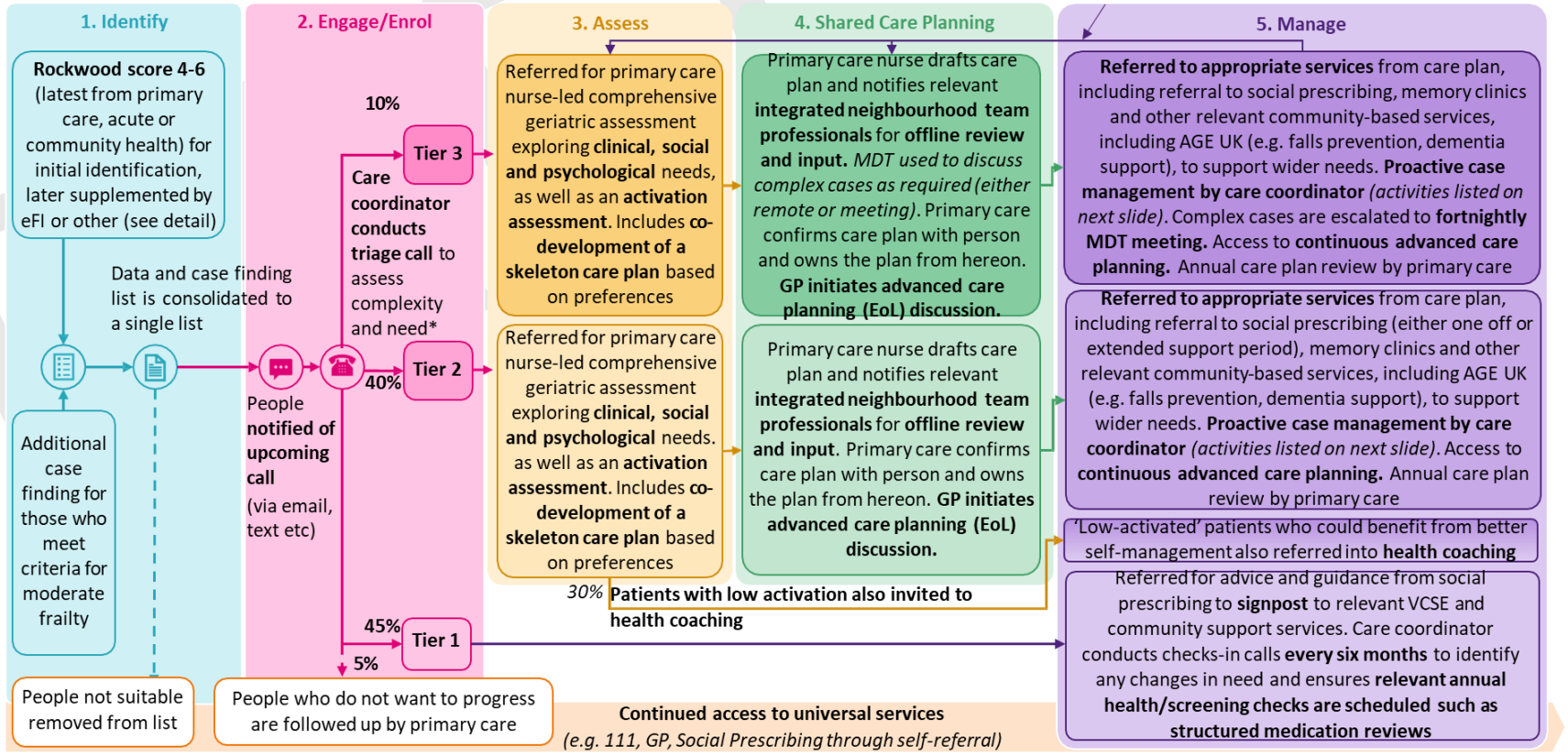
The PHM Frailty model was developed as a system-wide response to improve identification, coordination, and management of frailty.

At its core, the programme aims to:

- Standardise frailty identification and assessment
- Enable proactive, multidisciplinary care
- Improve communication and shared decision-making
- Reduce avoidable hospital utilisation
- Support patients to remain independent for longer
- On a system level, break down some organisational barriers, create better relationships as part of an integrated neighbourhood team.

The programme builds on existing Primary Care Network (PCN) structures, leveraging multidisciplinary teams (MDTs), shared care records, and enhanced roles.

North PCN Frailty Model – an example of the pathways developed for each Population Health approach



Case study: North PCN Frailty pathway

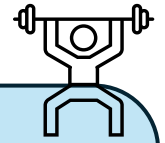
Supporting Social Connection and Independence Through Proactive Frailty Care

MR was identified for review through the proactive case-finding approach introduced at the beginning of 2026.

Rather than relying solely on a Rockwood Clinical Frailty Scale score, the service identified people with known **frailty risk factors** who may benefit from early intervention and preventative support.

During her assessment, MR explained that since retiring and giving up driving, she had become **increasingly isolated**. With no family available to provide support, she felt socially disconnected and identified **increasing social interaction as her main goal.** MR also reported experiencing pain in her hands and was advised to contact her GP for further assessment.

Following the assessment, MR was referred to Social Prescribing to help her access local community activities. The Social Prescribing team contacted her and provided information about opportunities available in her local area.
MR was also referred to the Strength & Stability programme. She has since started attending both the PCNs Strength & Stability classes and Chatty Café, both of which she reports enjoying immensely.



MR describes the Strength & Stability sessions as both enjoyable and empowering. She feels more confident, has learnt practical techniques that she believes she would not otherwise have known, and feels better equipped to maintain her independence.
She also highlights the social interaction the classes provide as one of the greatest benefits, saying it has been wonderful to meet new people and feel part of a community again.

By identifying MR early through recognised frailty risk factors and providing timely access to community-based support, the Proactive Frailty Service has helped reduce social isolation, improve confidence, increase community engagement and support her to remain independent.

This case demonstrates the value of proactive identification and early intervention in improving outcomes before a crisis occurs.

Case study:

OLDHAM SOUTH PCN FRAILTY PROGRAMME

Keeping people with mild-to-moderate frailty healthier, independent and at home for longer through proactive neighbourhood-based care.

FOCUS OF THE PCN

- Proactive identification and management of mild-to-moderate frailty in people aged 65+
- Support residents to remain independent, healthier and at home for longer
- Deliver holistic, person-centred care through population health management
- Reduce care fragmentation and improve coordination across neighbourhood services

HOW THE QUAD WORKED TOGETHER

Integrated neighbourhood working for our residents

INNOVATIONS & IMPROVEMENTS IDENTIFIED

Standardised frailty identification
Using risk stratification tools and Clinical Frailty Scores.

Multidisciplinary team (MDT) approach
Bringing together GPs, ACPs, care coordinators, pharmacists and community partners.

Holistic assessments & care planning
Addressing physical, cognitive, functional and social needs with personalised care plans.

Strength & Stability and prevention
Exercise classes, falls prevention, education and social prescribing to build resilience.

Stronger neighbourhood partnerships
Joint pathway design, shared ownership of care and regular communication across the Quad.

Improved coordination & information
Better information sharing and integrated care planning to reduce duplication and improve continuity.

BENEFITS TO RESIDENTS & PATIENTS

Remain independent longer
Support to live well at home and stay connected to their community.

Earlier intervention & prevention
Identifying needs and risks early to prevent crisis and reduce avoidable hospital admissions.

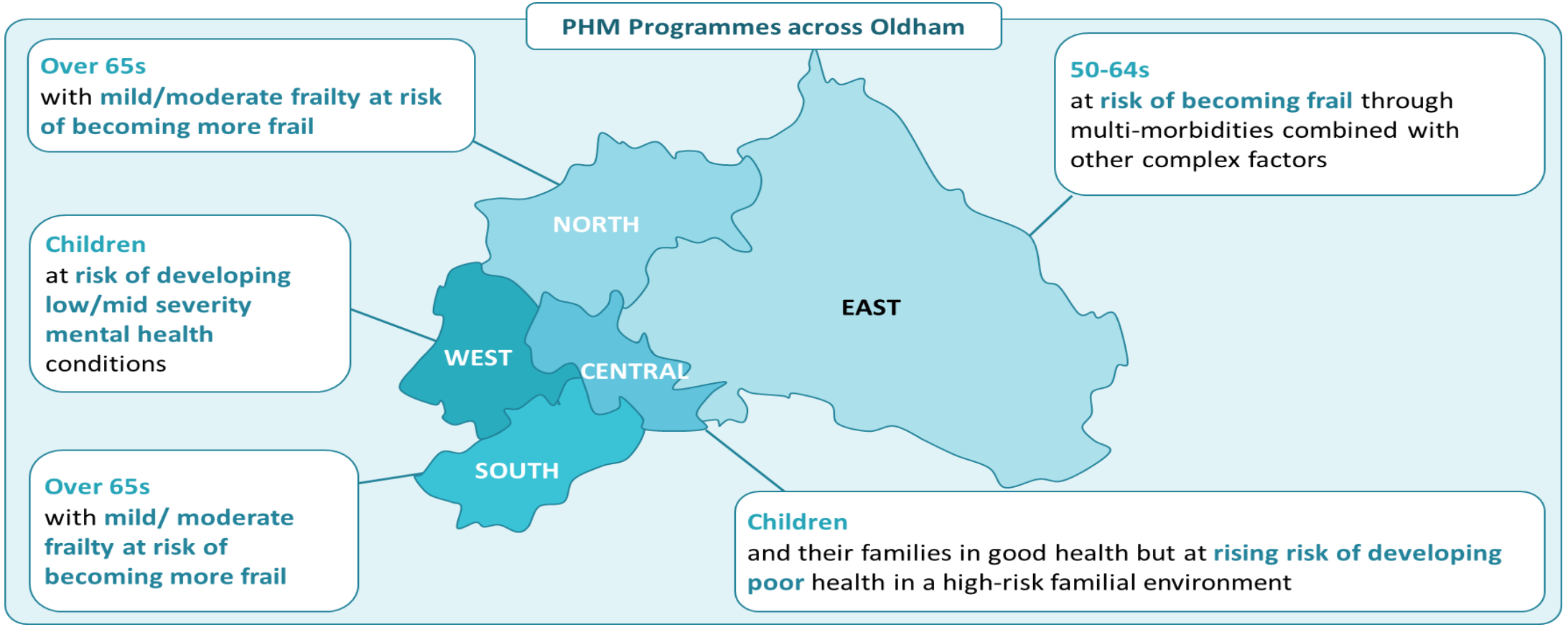
Better patient experience
Patients report feeling listened to, reassured, respected and supported.

More coordinated care
Joined-up services, less duplication and proactive management of complex needs.

> *"I feel listened to and more confident about managing my health. The support I get helps me stay independent."*
> – Resident feedback

Population Health Management in each PCN Neighbourhood

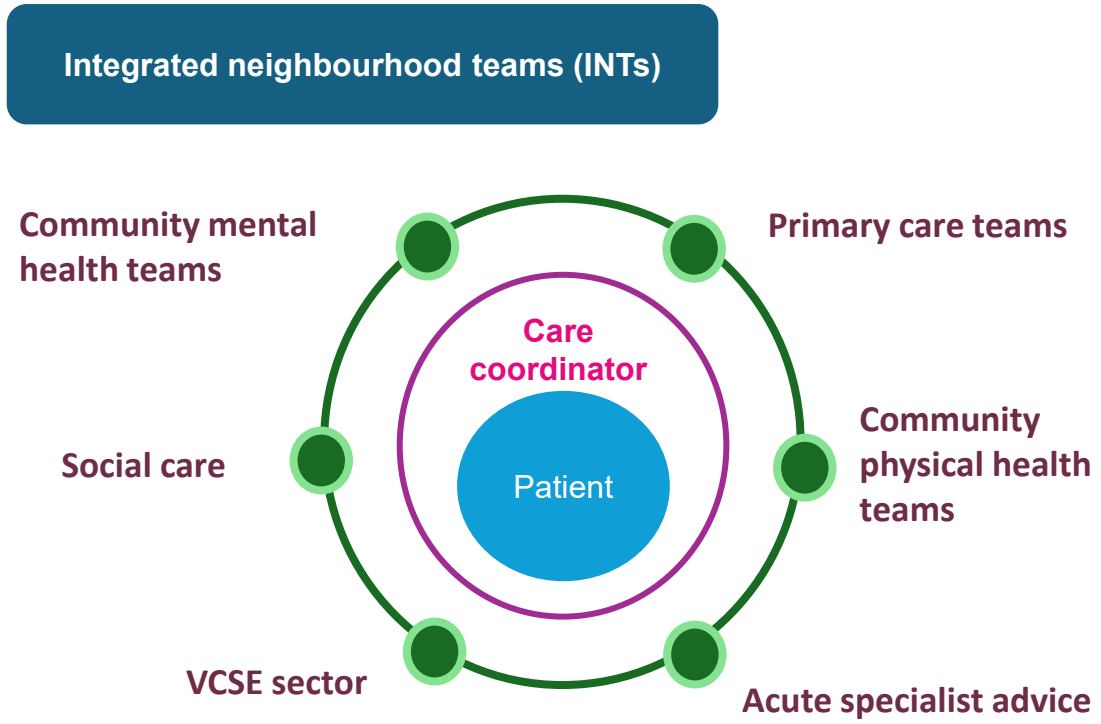
The diagram below describes the current focus of each PCN, based on our analysis of need, with interventions designed by the PCN quad



Neighbourhood Health in Oldham: Integrated Neighbourhoods Teams (INTs)

Integrated Neighbourhood Teams (INTs) or Neighbourhood Multi-disciplinary teams are fundamental to neighbourhood health, and to enacting our Population Health approach.

- Multiple sectors and care settings collaborating across a neighbourhood to provide a holistic, joined up approach that addresses all of a person's needs.
- Responsible for delivering the PHM pathway and creating shared ownership across sectors for proactively managing their population.
- The integrated neighbourhood team is empowered to make day-to-day decisions about the PHM pathway.



Neighbourhood Health in Oldham: Neighbourhood INTS

Integrated, primary-care-led MDTs with community, mental health, social care, VCFSE, and appropriate specialist input

Where are we now?	• Family Hubs established across all Oldham neighbourhoods, delivering integrated 0–19 (0–25 SEND) support including health visiting, early help, and children's services • Primary Care Networks (PCNs) provide a strong foundation for neighbourhood working, with additional Roles (ARRS) workforce (pharmacists, social prescribing link workers, care coordinators) and Population Health model • High-risk / frailty huddles established in some areas (e.g. district nursing + social care), but not consistently embedded across all neighbourhoods or across all age groups • Mental health neighbourhood teams operating in parts of Oldham but not funded by all PCNs
What needs to happen next?	• Develop INTs for integrated co-ordinated health and care delivery, ensuring processes focus on target cohorts - frailty, multi-morbidity, as well as children and young peoples mental health and asthma management. • Ensure all health and care integrated neighbourhoods teams are part of broader Live Well neighbourhoods in Oldham, with a team of teams approach (Mental health neighbourhoods, Family Hubs etc) • Implement a single point of access (SPA) for each neighbourhood and embed routine MDT working and governance • Ensure health and care pathways support neighbourhood links to skills, work and employment
What will be the impact	↑ Increase in patients supported through MDT care coordination↑ Increase in proactive reviews of high-risk cohorts (all age groups) ↓ Reduced ED attendances and non-elective admissions (particularly frailty, CYP crises and mental health) ↓ Reduced hospital length of stay through improved community coordination ↑ Improved patient and family experience: Joined-up, seamless care. Single point of contact and clearer navigation

INTs Case study: Neighbourhood Mental Health Service (NMHS)

NMHS is made up of: Living Well team, SPOE, Community Liaison, Access team, CMHT including psychiatric nurses, MH Wellbeing Practitioners, Psychology, Social Workers, VCSFE partners and 0.5 of the invested PCN practitioners (currently from 2 PCNS).

The service:

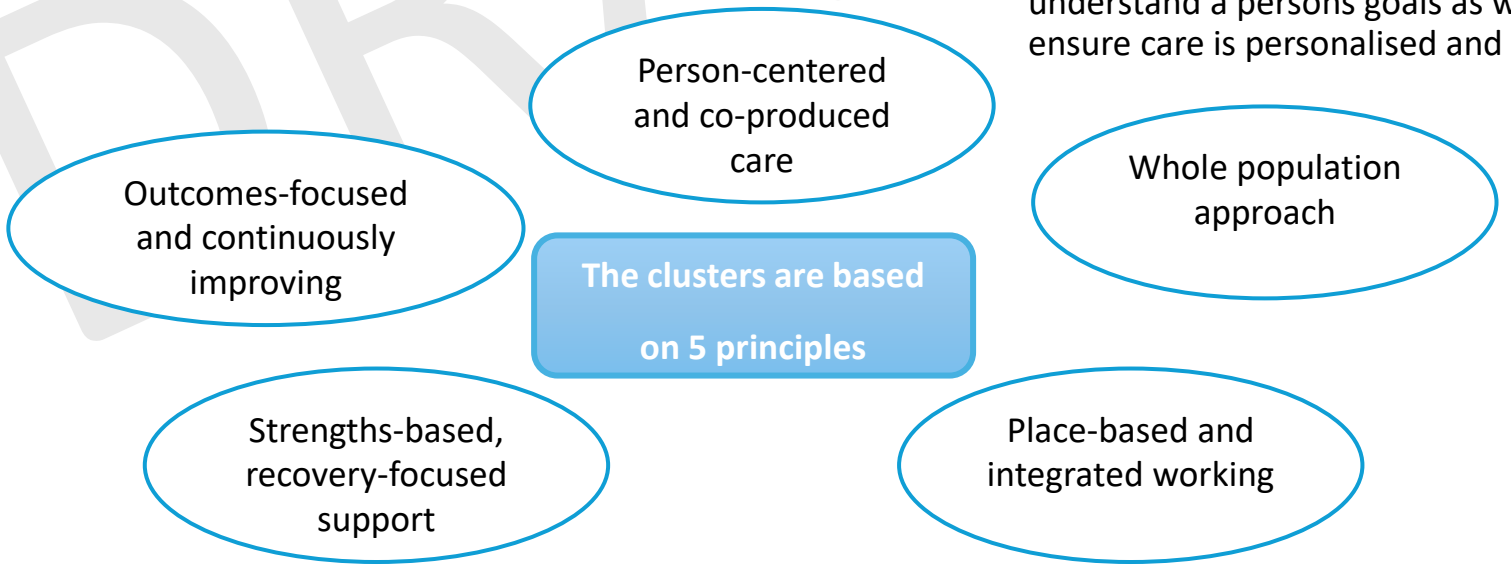
- opens an all age adult access point to secondary care services
- provides local, accessible MH support aligned to PCNs
- delivers ongoing care, treatment and recovery focused interventions
- works proactively with primary care, voluntary sector and community partners to prevent escalation and reduce reliance on specialist inpatient services

Referral Pathways

- All referrals will come via one central NMHS mailbox and will be triaged / assessed then directed to the appropriate service
- Complex cases requiring specialist intervention will be discussed in the weekly MDT (attended by specialist and NMHS practitioners)

Caseload Management – Key Worker Approach

- Each person has a named key worker who will co-ordinate care and ensure continuity and joined up support as well as ensuring engagement in appropriate intervention
- This approach builds a trusted therapeutic relationship and helps understand a persons goals as well as working across the MDT to ensure care is personalised and consistent



Our neighbourhoods: Live Well in Oldham

Neighbourhood health and integrated neighbourhood teams are a critical part of the broader Live Well approach in Oldham.

Oldham Live Well is an opportunity to drive a more preventative approach to public services and grow capacity and capability in our communities to take the lead on designing and delivering solutions.

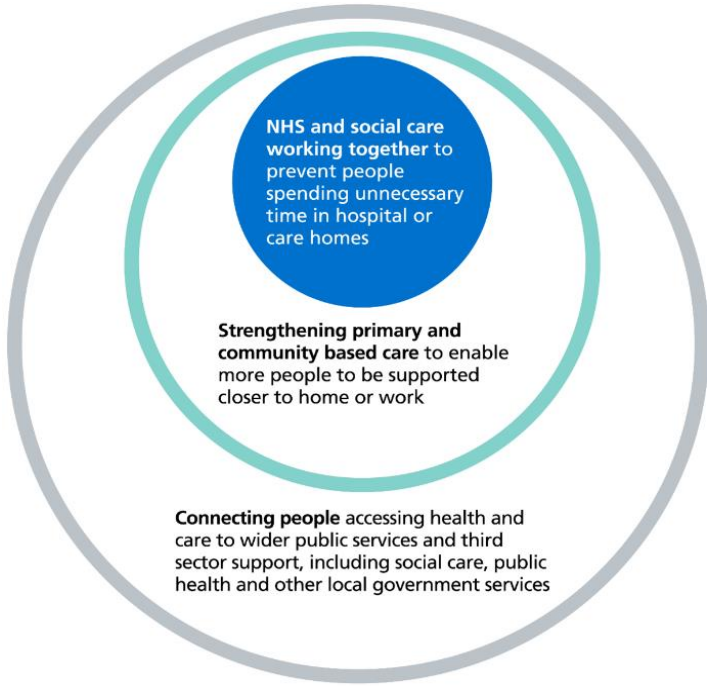
To achieve this, we will focus on a whole-system approach that prioritises prevention, collaboration, and our vibrant VCFSE sector. By building on our strong partnerships, and harnessing our local assets, we will create a sustainable model of health creation, that reduces health inequalities, enhances social connections, and ensuring every resident has the opportunity to flourish.

The rationale behind the Live Well approach is one which is familiar in Oldham – that integrated support, built around residents' needs, delivered at the right time and in the right place is critical to improving outcomes for all. This means bringing together the very best of formal and informal support across the system.

Live Well provides a shared framework for delivery across Council, NHS, VCFSE and partners building on Oldham's established place-based model and approach to building and supporting a strong Voluntary, Community, Faith & Social Enterprise (VCFSE) sector.

The key outcomes for this are:

- We will see improved wellbeing, independence, economic participation for our residents. Building on our community strength and pride of place.
- Decisions about services, neighbourhood delivery, regeneration, town centres, housing growth and capital investment are expected to demonstrate how they contribute to these outcomes.
- Prevention, asset-based working and neighbourhood delivery are the cornerstones of the Oldham approach.



Our neighbourhoods: Live Well in Oldham

The Live Well Approach in Oldham

Live Well is not a standalone programme or time-limited initiative.

It is the operating model for how Oldham works with residents, communities and across public services.

At its core, Live Well sets out a clear expectation:

- For residents: support is local, joined-up and focused on strengths
- For services: prevention and early help are the starting point, not the exception
- For partners: delivery is organised around districts and communities, not organisational boundaries

This is a deliberate shift in how the system operates. It will continue to move Oldham away from a model built around organisational silos and reactive intervention, towards one that is place-based, preventative and centred on the lived reality of residents' lives. Live Well will strengthen consistency, depth and impact of public service integration and partnership with the VCFSE.

It also creates a shared organising framework across the partnership — one that aligns the Council, NHS, VCFSE and other partners around a common way of working, rather than a collection of aligned but separate strategies.

What success looks like

When embedded, Live Well will mean:

- Residents experience a simpler, more coherent system of support
- More people get help earlier, in their own communities
- Services operate in a more coordinated and efficient way
- Communities play a stronger role in shaping and delivering solutions
- The system is better able to manage demand and reduce avoidable escalation

This is not a marginal change. It is a fundamental reorientation of how public services in Oldham work together.

An optimised integrated neighbourhood model. This will see multi-agency teams working on common geographical footprints of 30-50k population towards shared outcomes and purpose alongside local people and communities.

A resilient VCFSE Eco-system. Ensuring a resilient and connected local VCFSE offer from a sector resourced to respond to what matters to people, with community-led approaches at the heart.

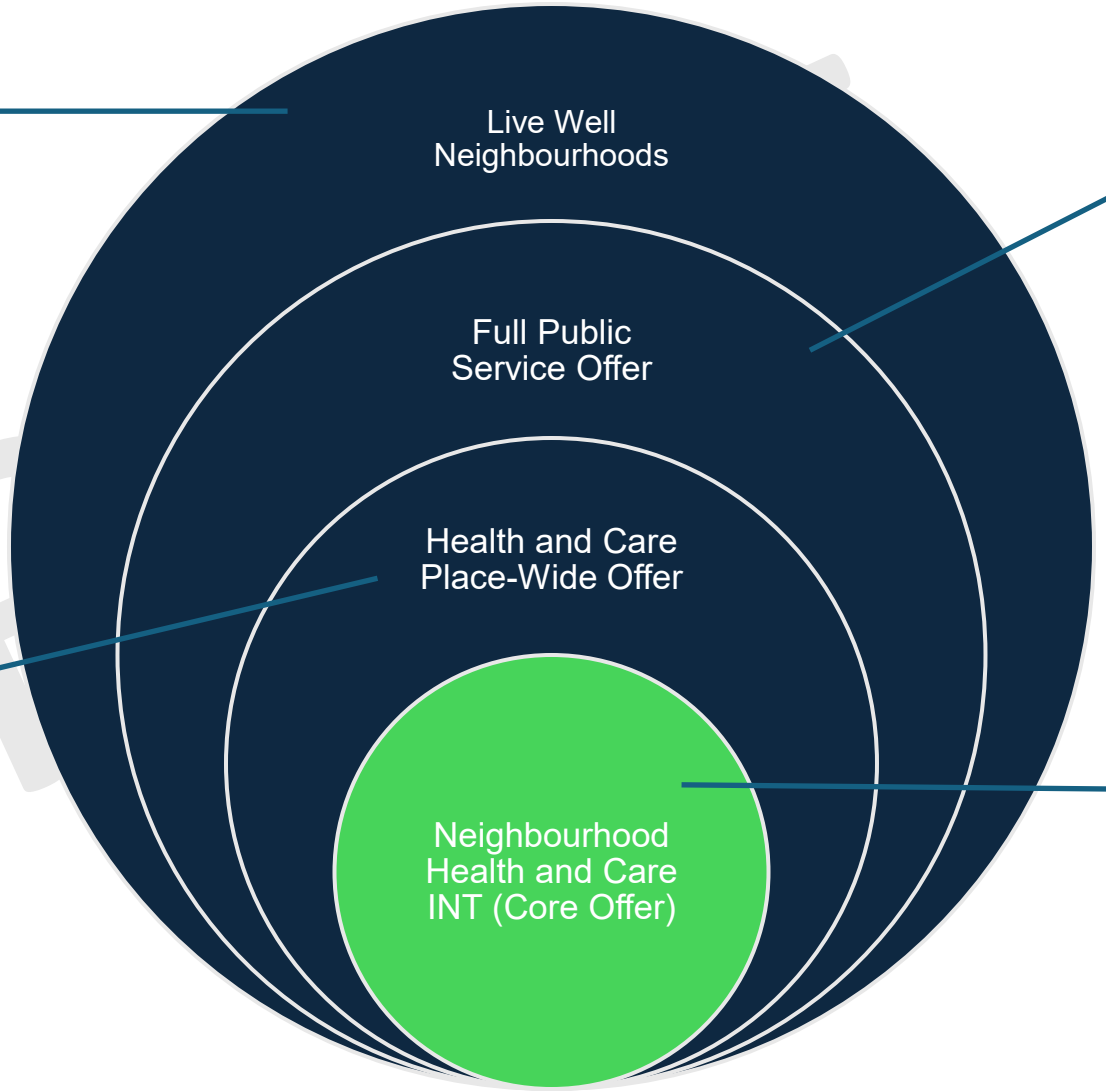
A culture of prevention. Where the workforce and organisational development is geared towards prevention, with an emphasis on person-centred and relational ways of working across all systems of support.

A network of Live Well centres, spaces and offers. These will see public services and community-based support working together to provide a consistent everyday support offer from recognisable places in the community.

Neighbourhood Health as part of Live Well – Our Delivery Model

#Bringing together:
- All neighbourhood level public services,
- VCFSE organisations,
- Live Well Centres and Spaces
- employment providers,
- multidisciplinary teams and
- community connectors

…shifting from siloed delivery to integrated support



- Place Public Service Leadership Teams:
  - Housing
  - Employment
  - Connection to Schools and Education
  - Community Safety
  - Police
  - DWP
  - Family First Hubs
  - Including VCFSE providers

- Hospital at Home
- Outpatient Transformation
- Intermediate Care
- Public Health Offer
- Reablement
- Urgent Community Response

- Primary Care (All Disciplines)
- Community Services
- Community Mental Health Teams
- Adult Social Care
- MDT for Children and Young People
- Agreed model for Primary/Secondary Care Interface – including role of Hospital Consultants
- Social Prescribing
- Agreed model for UEC, Elective, Dementia and Cancer care

4. Neighbourhood Enablers

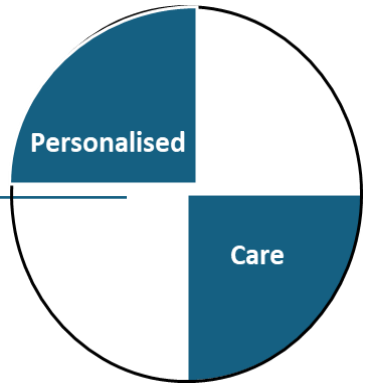
Describing the broader enablers which wrap around PHM and INTs to deliver effective neighbourhood health;

- Transforming Primary care
- Urgent Neighbourhood Services
- Intermediate care & home first
- Standardised Community Services
- Neighbourhood elective pathways
- Neighbourhood cancer prevention & reduction

Neighbourhood Health in Oldham: Transforming Primary Care

Modern general practice model which delivers improvements in access, continuity and overall experience for people and their carers

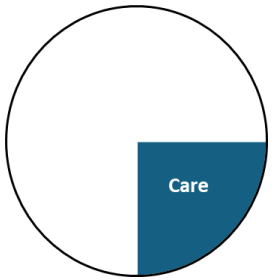
Where are we now?	• Access to online consultation systems throughout core hours • Access to online registration • Opening times for all modes of access available within core hours to be displayed on practice websites • Dataset available (e.g. GPAD) to monitor access and some, but not all, capacity and not demand
What needs to happen next?	• Increased GP capacity, utilising funding available through GP Reimbursement Scheme • Improvements to cloud-based telephony data collection • Same-day response for clinically urgent patient requests • Practices to ensure tools used to refer patients into community pharmacy services offer a full choice of pharmacy providers • Embedding Advice & Guidance in core practice • Embedding risk stratification and continuity of care in core PCN activity • Full use of practice, PCN and neighbourhood teams in unplanned and planned care
What will be the impact	↓ Reduced call waiting time, particularly between 8am and 10am ↑ Increase in % of clinically urgent patients seen on the same day ↑ Increase in % of 'non-clinically urgent' patients seen within one week and two weeks ↑ Improved patient choice in accessing community pharmacy services ↑ Improved patient experience of access



Neighbourhood Health in Oldham: Standardised Community Services

Community health and social care services playing a key role in delivering neighbourhood health and care

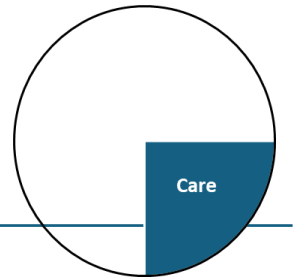
Where are we now?	• A range of community services exist across Oldham (district nursing, UCR, therapy, PCNs, mental health, social care and VCSE), but delivery is fragmented across providers • Variation between neighbourhoods in access, service offer, and MDT maturity • Core components of Integrated Neighbourhood Teams are in place, but not consistently embedded • Inconsistent referral routes, thresholds, and operating models (including limited 7-day coverage)Growing demand driven by frailty, multi-morbidity, and health inequalities • Data sharing and population health management are developing but not yet fully operationalised across the system
What needs to happen next?	• Consistent standardised neighbourhood service model for all relevant services including multi-neighbourhood provision • Ongoing work to reduce waiting times for core community services. E.g. falls management, care act reviews • Need to development of clear clinical leadership across all-age physical and mental health services linked with MDT approaches • Improve and expand out-of-hospital models for key pathways e.g. paediatric asthma management, adult diabetes, and frailty
What will be the impact	↑ Improved patient outcomes – better management of long-term conditions and prevention of deterioration ↑ Improved patient experience – more personalised, coordinated, and closer-to-home care ↓ Reduced unplanned demand – fewer ED attendances, admissions, and ambulance conveyances ↑ More integrated working – stronger collaboration across primary care, community, mental health, and social care ↓ Variation and inequalities – more consistent access and outcomes across neighbourhoods £ Better value for money – reduced duplication, lower acute spend, and shift to community-based care



Neighbourhood Health in Oldham: Intermediate care and home first

Rapid response, reablement, hospital-at-home, and enhanced care in care homes to prevent admissions, reduce LoS, and support independence.

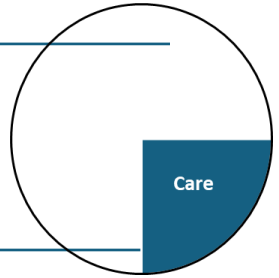
Where are we now?	• System largely focussed on discharge with limited focus on admission avoidance and step up due to acute pressures • Two intermediate care units operated from Butler Green (Operated by NCA) and Medlock Court (Operated by Miocare) offering support transition from hospital to home, boost independence and prevent hospital admissions • Re-ablement services (Miocare) providing short-term support to regain independence but capacity limited • Virtual ward model established but not integrated with other urgent community services and capacity under-utilised • High performing Urgent Community Response service but requires recurrent funding and expansion of hours
What needs to happen next?	• Deliver a fully standardised "Home First" model across all neighbourhoods aligned to NHS guidance • Default to discharge to assess (D2A) pathways • Maximise care at home before using bed-based care; Increase access to home-based reablement (Pathway 1) • Increasing and optimising the capacity of step-up and step-down intermediate care will help avoid admissions and attendances, improve discharge and support better recovery. • Transform end of life and palliative care to support more residents to die in their preferred place of care
What will be the impact	↑ Improved outcomes and independence; More people recover at home (maintaining a good level of independence and reducing the need for long term care and regain function ↓ Reduced unplanned demand; Fewer ED attendances, non-elective admissions, reduced ambulance conveyances ↓ Reduced length of stay (LoS) and delays to people returning to their usual home; ↑ Stronger integrated working; Improved coordination across acute, community, primary care, and social care £ Better value for money; shift from high-cost acute care to community-based provision



Neighbourhood Health in Oldham: Urgent neighbourhood services

Responsive services at neighbourhood level for people with an escalating or acute health need

Where are we now?	• Urgent Community Response (UCR) service in place in Oldham, providing rapid assessment and intervention in the community • Call Before Convey pathway bringing A&E advice and UCR intervention together to avoid ambulance conveyances but requires consistent utilisation • Crisis mental health services in place (including urgent MH helplines), but; not consistently aligned with neighbourhood MDTs, and limited integration with physical health crisis response • Rising demand across all age groups; Children and young people (CYP); increasing urgent MH and minor illness demand, adults: long-term conditions crises; older people: frailty crises and falls
What needs to happen next?	• Strengthen urgent care SPOA for Oldham • Integrate mental health crisis response into neighbourhood urgent pathways; including opening of 24hr mental health A&E • Maximise and integrate virtual wards / hospital at home for urgent deterioration: Same-day admission avoidance from community or ED front door. All-age cohort expansion where clinically appropriate • Strengthen urgent support for care homes and vulnerable groups; Direct access to clinical advice and rapid response. avoidance of unnecessary conveyance/admission • Develop an Enhanced Live Well model for Oldham pro-actively supporting those face multiple disadvantage requiring tailored intensive support
What will be the impact	↑ Increased same-day community-based urgent care episodes ↑ Increased virtual ward admissions from community and ED front door ↓ Reduced ED attendances (all-age), particularly category 3–5 ↑ Improved patient and family experience; Faster response times and care delivered at home or closer to home



Neighbourhood Health in Oldham: Elective pathways and diagnostics

We are determined to improve Oldham residents' access and support for planned care pathways, bringing as much as possible to their neighbourhoods and reducing the need for multiple unnecessary appointments.

The traditional hospital model is outdated, capacity often short falling against demand, and does not present a sustainable future for our health system.

Oldham is a at the forefront of left-shift, having long standing community-based outpatient and diagnostic services already in place, including being home to one of the first national Community Diagnostic Centres.

Technology is a key enabler to the delivery of 'out of hospital' planned care, with digital developments driving the ability to successfully embed new ways of working. Electronic referrals, virtual triage, remote consultations, and remote monitoring of long-term conditions will support the wider roll out of the new outpatient models of care.

The Northern Care Alliance Foundation Trust is a key place partner, and as the local acute trust which provides the majority of planned care for Oldham residents, colleagues at NCA will take a key leadership role in transforming existing outpatient and planned approaches. Independent sector and primary care led providers of planned pathways will work closely with secondary care colleagues to implement neighbourhood planned care pathways.

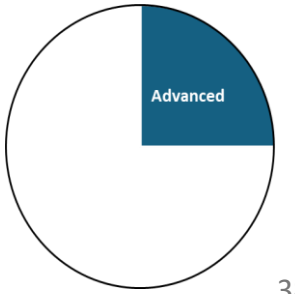
Advice and Guidance (A&G)

Advice and Guidance allows GPs, and wider primary care teams, to seek specialist advice to support the management of patients in the community, without the need for a specialist referral or lengthy hospital waits. The locality will continue to embed the use of both electronic A&G and the expansion of the telephone advice model available via Consultant Connect.

Single Point of Access (SPoA)

A SPoA simplifies access to services by offering an advice first model to support onward referrals, ensuring that patients get the right care for their needs quickly and safely.
Oldham system partners will work closely with Greater Manchester to optimise models across 10 high volume specialties in secondary and tertiary care ensuring that Oldham Neighbourhood teams utilise these SPoAs when launched. This will ensure that Oldham residents receive the right care, first time, every time.

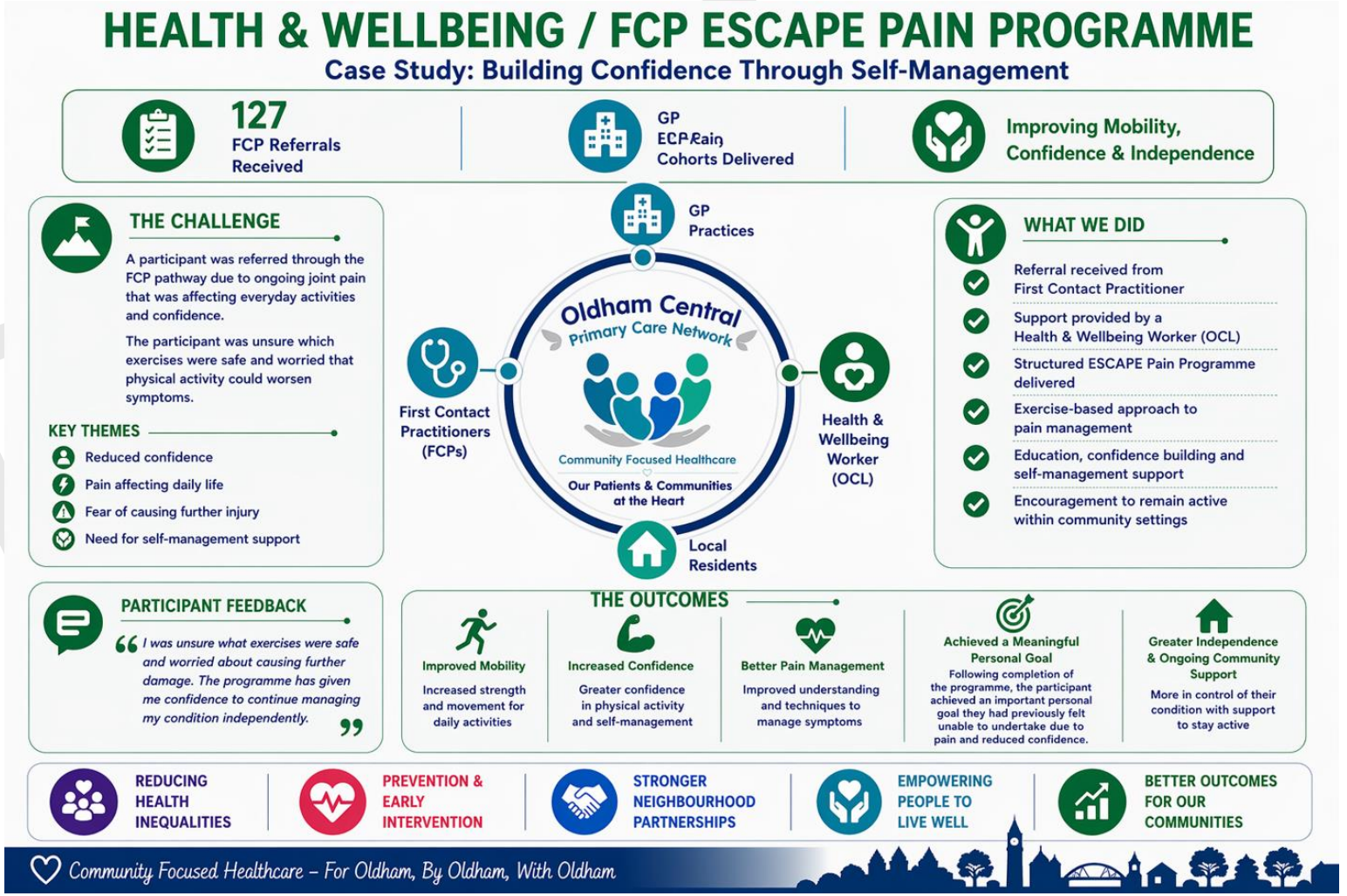
NHS Northern Care Alliance NHS Foundation Trust



Planned Care Case study: Oldham Central PCN 'escape pain programme'

Oldham Central PCN identified a cohort of patients who would benefit from a different approach to their pain management.

Working with the **First Contact Practitioner** and **Health & Wellbeing Worker**, a pathway was developed which would support patients to undertaken physical activity despite their pain, build confidence and engage with wider community activities and opportunities



Neighbourhood Health in Oldham: Cancer prevention and reduction

Our Vision

The NHS Long Term Plan ambitions for early cancer diagnosis are by 2028, 75% of people with cancer will be diagnosed at an early stage (stage 1 or 2) and 55,000 more people each year will survive their cancer for five years.

Our vision for the people of Oldham, is a future where everyone with cancer receives equitable and prompt early diagnosis

By raising public awareness, reducing health inequalities, and fostering collaboration and innovation, we aim for continuous improvement in the proportion of cancers diagnosed at an early stage.

Our Neighbourhood Teams in Oldham provide an ideal partnership vehicle to promote early cancer diagnosis and to identify new ways in which we can do so, to support the delivery of this strategy and national priority.

Symptom Awareness

- Build and optimise communication channels across the partners and communities to ensure we reach those in greatest need
- Systematically improve, share and promote campaigns to build symptom awareness and myth bust
- Identify specific areas and communities that could benefit from targeted campaigns
- Continuation of 'This Van Can' Roadshow, and other related GM Cancer Awareness Campaigns

Reduction Variation

- Use data and qualitative analysis to identify at risk characteristics
- Focus on solutions for our communities who have higher barriers to accessing traditional health routes
- PCN based action plans in place aimed at tackling health inequalities and reducing variation, with a strong focus on community outreach
- Work in partnership with VCFSE organisations and community groups to maximise reach into our communities

Collaborate with Primary Care

- Each neighbourhood has a named 'cancer lead' leading work on early diagnosis
- Primary Care Early Diagnosis Facilitators in place across Oldham
- Oldham Cancer Delivery Group brings together system wide partners to strengthen communication and collaboration across primary and secondary care
- Ongoing education for primary care and partners

Cancer Screening

- Encourage uptake in screening by raising awareness in eligibility criteria and the importance of early diagnosis
- Myth bust where there are misconceptions or barriers to accessing screening
- Continue to work with GPs to increase uptake in national Breast, Cervical and Bowel screening programmes
- Continuation of Targeted Lung Health Checks
- Ensure targeted approach and outreach into communities with lower screening uptake

5. Support to Neighbourhoods

Describing the key infrastructure, support and culture we are developing upon which neighbourhood health teams can be built;

- Neighbourhood Health Centres
- Workforce and culture
- Estates
- Digital
- Information sharing

Neighbourhood health – Neighbourhood Health Centres in Oldham

Our neighbourhood health centre approach brings together health, social care, and community services within accessible local hubs to deliver coordinated, person-centred care.

These centres act as anchors for multidisciplinary teams, supporting prevention, early intervention, and management of complex needs close to home. They integrate primary care, mental health, social care, and voluntary sector support, alongside community wellbeing services.

Designed to be flexible and inclusive, neighbourhood health centres;

- Improve access for residents
- Reduce fragmentation of services
- Enable proactive population health management
- Helping tackle inequalities while
- Strengthen community resilience
- Supporting residents to live healthier, more independent lives.

Key Neighbourhood health centres in Oldham

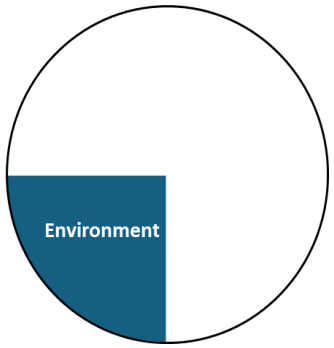
The following locations which are strategically situated across our geography to improve access for residents will be Neighbourhood Health Centres;

- Oldham Integrated Care Centre
- Moorside Health Centre
- Sportstown (Oldham Athletic Football Club)
- Chadderton Town
- Shaw & Crompton Health Centre

Oldham town centre development: The Oldham Town Centre development and the Neighbourhood Health and Care approach are designed to improve residents' quality of life by combining regeneration, housing, health services, and community support.

The benefits of Oldham Town Centre development and Neighbourhood Health and Care include:

- Easier access to health and care services
- New and improved housing
- Healthier public spaces and greener environments
- Reduced health inequalities
- More jobs and economic growth
- Stronger community networks
- A safer, more vibrant town centre



Neighbourhood Health Centres - Sportstown

Sportstown is a key pillar of our neighbourhood health and Live Well approach.

Based around the Oldham Athletic stadium, the initiative will look to develop sports facilities in the borough, along with creating education opportunities to help people gain qualifications while on a sports pathway.

Critically, it will offer an innovative neighbourhood location for the delivery of services for Oldham, as well as creating education and training opportunities for our local health and social care workforce.

Alongside this it will build on existing health promotion activities led in partnership by Oldham Athletic Sports Trust and VCFSE partners.

Workforce and culture for neighbourhood health

Delivering effective neighbourhood health in Oldham depends on a workforce that is integrated, community-rooted, and prevention-focused. At its core are multidisciplinary teams operating at neighbourhood level, anchored in primary care but extending across health, social care, and the voluntary sector. These teams require flexible role design and shared accountability to respond to complex population needs, particularly in areas of deprivation. Our colleauges will be equipped with population health skills, digital tools, and cultural competence to address inequalities and tailor care effectively. Strong local leadership, continuous professional development, and robust retention strategies are essential to sustain workforce capacity. Ultimately, enabling neighbourhood health in Oldham requires a coordinated, place-based workforce model that blends clinical expertise with community insight and a focus on prevention and wellbeing.

Key areas for development

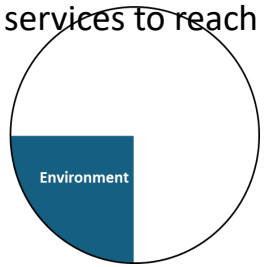
Workforce integration and flexibility: Roles designed to work across organisational boundaries (NHS, local authority, VCSE) with shared objectives and flexible job plans.
Strong primary care foundation: Well-resourced GP practices working at Primary Care Network (PCN) level as anchors for neighbourhood delivery.
Community and peer workforce expansion: Recruitment and development of community health champions, social prescribing link workers, and peer supporters with strong local ties.
Population health and data capabilities: Staff skilled in using shared data systems, risk stratification tools, and proactive care planning.
Cultural competence and local insight: Workforce reflecting Oldham's diverse communities, with language skills and understanding of local socio-economic challenges.
Prevention-focused skills and mindset: Training in early intervention, health coaching, behaviour change, and tackling wider determinants of health.
Leadership at neighbourhood level: Visible, empowered clinical and operational leaders who can coordinate across partners and drive local priorities.
Workforce development and retention strategies: Ongoing training, career pathways, and wellbeing support to retain staff in high-demand neighbourhood roles.
Digital and mobile working capability: Access to interoperable IT systems, remote working tools, and digital engagement platforms.
Partnership with voluntary, community and social enterprise (VCSE) sector: Sustainable funding and collaboration models to embed VCSE workers within care teams.
Safeguarding and Complex case management expertise: Skills to manage high-need individuals with multiple long-term conditions and social vulnerabilities.

Estates for neighbourhood health

Delivering neighbourhood health in Oldham requires a modern, flexible estate aligned with NHS neighbourhood health centre guidance, centred on accessible local hubs that bring services together around communities. These estates should enable co-location of multidisciplinary teams and provide adaptable spaces that support both clinical care and prevention-focused activities. Prioritising locations within communities—especially those with greatest need—helps improve access and reduce inequalities, while integration with existing community assets enhances efficiency and local engagement. Digital infrastructure must be embedded to support joined-up working, alongside inclusive design that reflects the borough's diversity. Overall, the estate should move away from fragmented, building-centric models towards a network of neighbourhood-based, multi-use spaces that support integrated, person-centred care close to home.

Key areas for development:

Neighbourhood health hubs aligned to NHS guidance; Accessible, multi-purpose centres acting as local anchors for integrated health, care, and community services.
Co-location of multidisciplinary teams; Space designed to bring together primary care, community health, mental health, social care, and VCSE partners.
Flexible and adaptable estate design; Modular, multi-use spaces that can support clinics, group activities, prevention services, and community use.
Community-based, accessible locations; Sites situated within neighbourhoods, particularly in areas of highest need, with good transport links and walkability.
Integration with community assets; Use of existing buildings (e.g. libraries, leisure centres, community centres) to maximise reach and sustainability.
Digital infrastructure embedded in estates; Reliable connectivity and facilities to support digital consultations, shared records access, and mobile working.
Prevention and wellbeing-focused spaces; Areas for health promotion, social prescribing, education, and voluntary sector activities.
Inclusive and culturally appropriate environments; Estates designed to be welcoming, safe, and reflective of Oldham's diverse communities.
Efficient utilisation of existing estate; Rationalisation and shared use of buildings across organisations to reduce duplication and costs.
Sustainability and net-zero alignment; Environmentally sustainable buildings aligned with NHS net-zero targets.
Outreach and satellite provision; Smaller, flexible spaces enabling services to reach underserved populations closer to home.



Enablers: Digital needs for neighbourhood health

Delivering neighbourhood health in Oldham requires a digitally enabled infrastructure that connects organisations, supports proactive care, and improves access for residents. Central to this is interoperable data systems that allow professionals across health, social care, and the voluntary sector to share information and coordinate care effectively.

Population health analytics and care coordination platforms help teams identify need early and manage complex cases, while mobile technologies enable staff to work seamlessly in community settings.

Equally important is ensuring digital inclusion so that all residents can benefit from new access channels and self-management tools. Alongside strong data governance, investment in workforce digital skills is essential to fully realise the potential of digital in supporting integrated, neighbourhood-based care.

Key areas for development

Shared care records and interoperability; Integrated data systems allowing real-time information sharing across NHS, social care, and VCSE partners.
Population health analytics; Tools to identify risk, segment populations, and support proactive, neighbourhood-level care planning.
Digital access and inclusion; Solutions to reduce digital exclusion, including support for residents with low digital literacy or limited access.
Mobile and remote working capability; Secure devices and applications enabling staff to work flexibly in community settings.
Digital triage and access channels; Online consultation platforms, telehealth, and multi-channel access to improve responsiveness and convenience.
Care coordination platforms; Systems that support multidisciplinary team working, shared care plans, and case management.
Data governance and information security; Clear protocols to ensure safe, lawful, and trusted use of patient data.
Workforce digital skills; Training to ensure staff can confidently use digital tools and interpret data.
Citizen-facing tools and self-management apps; Platforms that empower residents to manage their health and connect to local services.

Information sharing for neighbourhood health

Effective neighbourhood health delivery in Oldham relies on seamless, secure, and trusted information sharing across all partners involved in care. Central to this is the ability to access shared care records in real time, enabling multidisciplinary teams to coordinate care around the individual and respond proactively to need.

Strong information governance frameworks and clear data-sharing agreements are essential to ensure compliance while maintaining public confidence, supported by transparent consent processes. Standardised data and secure communication systems help professionals work efficiently across organisational boundaries, while access to both individual and population-level data supports better decision-making and targeting of resources. Overall, robust information sharing underpins integrated, person-centred care and is critical to improving outcomes at neighbourhood level.

Key areas for development

Shared care records across organisations; A single, interoperable record accessible by NHS, local authority, and VCSE partners.
Real-time data access; timely sharing of patient information to support responsive decision-making and coordinated care.
Clear information governance frameworks; Agreed policies, protocols, and legal agreements (e.g. data sharing agreements) to ensure safe and lawful data use.
Consent and transparency with residents; Clear communication on how data is used, with appropriate consent models that build public trust.
Standardised data and coding; Consistent formats and definitions to ensure information can be accurately shared and interpreted across systems.
Multidisciplinary team visibility; Shared care plans, risk registers, and case notes accessible to all relevant professionals.
Population-level data sharing; Aggregated data to support population health management, planning, and tackling inequalities.
Secure communication channels; Use of approved platforms for sharing sensitive information between professionals.
Integration with safeguarding systems; Effective information flow for vulnerable individuals across health, social care, and safeguarding services.

6. Commissioning for neighbourhood health

Commissioning for neighbourhood health involves aligning funding, contracts, and outcomes across health, social care, and community services to support integrated, place-based delivery.

It prioritises prevention, reduces fragmentation, and enables multidisciplinary teams to meet local needs, improve equity, and deliver coordinated, person-centred care within neighbourhoods.

Commissioning for Neighbourhood Health: Oldham Prevention Framework

In 2022, a system wide framework for prevention was developed and agreed by a range of partners including Oldham Council, VCFSE organisations, the NHS and others.
The aim of the work was to agree a shared framework for design, commissioning and delivery of services to ensure that Oldham residents are healthy, happy, resilient and independent.

This system wide approach supports our work to put prevention at the heart of what we do as an Oldham Partnership.

Single shared framework for Early Intervention & Prevention in Oldham

Objectives of the prevention framework

- To articulate shared objectives and outcomes
- To ensure prevention is central to everything we do
- To review and make sense of our current early intervention and prevention offer across the system
- To identify gaps
- To avoid duplication and maximise effective use of resources - building on work already done
- To support investment and commissioning decisions
- To support a collective approach to deliver enablers, such as workforce development
- To ensure resident focus and alignment to place-based delivery

Oldham Prevention Framework

Our prevention framework describes what should be offered at level of need

Oldham's prevention framework is structured as a whole-system, stepped approach that supports residents across four levels of need—ranging from "living well" to experiencing crisis—ensuring people receive the right support at the right time. At its foundation, the model focuses on creating strong social, economic, and environmental conditions that enable everyone to stay well and thrive, with universal services and community-based support widely accessible. As needs increase, targeted early help and preventative interventions are provided to those at risk, aiming to reduce inequalities and stop issues from escalating. For people experiencing more defined challenges, coordinated and often specialist support is offered to manage needs and prevent deterioration. At the highest level, intensive, multi-agency crisis support is delivered to keep people safe and stabilise complex situations. Overall, the framework emphasises prevention, early intervention, and integrated working to improve outcomes and reduce demand on acute services.

What's going on? (for residents)	What do we offer? (place & services)	How do we define that? (who & why)	What does it look like? (key characteristics)
Experiencing crisis or complex problems or challenges	Crisis or intensive support services	Intensive support for people with complex needs or in crisis. Keeping them safe, managing problems and re ducing impacts.	Acute crisis intervention or planned support. Likely to be multi-agency, may be specialist / statutory.
Experiencing problems or challenges	Support services	Bespoke support for people with identified needs. Reducing impacts or stop issues getting worse.	Planned support. May be single-agency / specialist or key worker coordinating a range of support services.
Staying well (despite some risks or concerns)	Some extra help and support; Help to access services for everyone	Targeted offer for people seeking help or at risk. Preventing issues escalating or reducing impact of inequalities.	Self-help. Community based activities and support. Low level support services available for those who need it. No barrier to access.
Living well	A good place to live; Services for everyone	Available to everyone. Creating conditions within places and communities for people to be well and thrive.	Social, economic and environmental conditions. Accessible services widely advertised. Empowering people and enabling self-help.

Oldham Prevention Framework

What's going on? (for residents)	Objectives (what is needed to achieve the aim)	Outcomes (what should we see if successful)	
		For residents	For services
Experiencing crisis or complex problems or challenges	People are safe and the impact of problems and challenges on their life is minimised so that the level of support can be reduced Services work together to provide the right support at the right time to keep people safe and tackle the root causes of problems	Improved individual wellbeing Reduction in risk and complexity	Coordinated and integrated services Fewer people need intensive support
Experiencing problems or challenges	People have the support they need to reduce the impact and/or tackle problems when they occur and live as well as possible Services work together to provide the right support at the right time and tackle the root causes of problems	Improved individual wellbeing People do not reach crisis or complexity	Coordinated and integrated services Fewer people need intensive support
Staying well (despite some risks or concerns)	Individuals and communities have the capacity to develop, implement and sustain their own solutions to problems and improve their own health, wellbeing & resilience Identify and provide additional targeted activity for populations/groups identified as having the highest risks of poorer outcomes	Reduced health & wellbeing inequalities People are doing more for themselves	Fewer people need support services People are accessing services earlier to manage risks
Living well	High quality services for everyone that are open and accessible The environment and community in which people live supports health, wellbeing, resilience and independence	Improved population health & wellbeing People are doing more for themselves	Fewer people need support services More people are accessing services for everyone

Our prevention framework describes what should be offered at level of need

Oldham's prevention framework supports neighbourhood health by providing a clear, place-based model that aligns services around the varying needs of local populations, enabling early intervention and coordinated care at community level. By prioritising prevention, self-help, and accessible community support, the framework helps neighbourhood teams focus on keeping people well and addressing risks early, reducing escalation into more complex needs. As individuals require more support, the framework enables integrated, multidisciplinary responses within neighbourhoods, ensuring care is joined-up, targeted, and proportionate. This structured approach strengthens neighbourhood health by improving outcomes, reducing inequalities, and ensuring resources are used effectively across the whole system.

Commissioning for Neighbourhood Health: Oldham Prevention Framework

Framework Principles

- Shared aim for people and places to be as **happy, healthy, resilient and independent** as possible
- **Strengths-based** - built around people not services
- Provide the **right support at the right time** – boundaries between levels are blurred
- **People may be at any level** or more than one level, at any time, and move between levels
- **Work to purpose and outcome** – not time or target driven
- Built on a **shared system wide understanding of support** available

Investment Principles

- Holistic **investment in outcomes** to achieve value – not the cheapest services
- **Commission less, design more** – working with communities
- **Focus investment on prevention** and demand reduction
- Seek to **remove barriers** to effective delivery

Residents First Principles

- Enable people to **help themselves**
- **Residents know how to access support**
- Provide holistic support to **tackle the root causes** of issues
- **Trauma informed**
- **Whole family** focus
- **Coordinated support** – not assessments and hand offs
- **Proactive and curious** professionals

7. Governance and next steps

Governance for neighbourhood health in Oldham requires shared leadership across NHS, council, and VCSE partners, with clear accountability at neighbourhood level.

Next steps include confirming delivery structures, embedding integrated teams, aligning commissioning, strengthening data sharing, and scaling pilots into a consistent, borough-wide model focused on prevention and outcomes.

Oldham Neighbourhood Health: High level milestones

We have strong foundations for the delivery of neighbourhood health in Oldham, but we plan ambitious expansion of this approach based on our learning and case studies.

Key milestones for the delivery of neighbourhood health in Oldham below.

Year 1 – Build on our foundations 26/27
- Review PCN Population Health Management approaches to understand good practice and sustainability
- Map population need and existing services
- Establish leadership and core multidisciplinary teams
- Develop workforce skills in prevention and population health
- Pilot neighbourhood working in priority areas

Year 2 – Early Implementation 27/28
- Expand multidisciplinary teams across all neighbourhoods
- Strengthen primary care networks as delivery hubs
- Roll out shared care records and digital tools
- Embed VCSE partners and social prescribing

Year 3 – Integration and Scale 28/29
- Fully integrate health, social care, and community services.
- Operational neighbourhood hubs (estate strategy in place)
- Implement population health management at scale.
- Standardise care coordination and case management
- Reduce duplication and streamline pathways

Year 4 – Optimisation 29/30
- Refine services based on outcomes and feedback
- Strengthen prevention and early intervention pathways
- Improve access and reduce inequalities across neighbourhoods
- Embed digital innovation and self-management tools
- Enhance workforce retention and career pathways

Year 5 – Maturity and Sustainability 30/31
- Fully embedded neighbourhood model across Oldham
- Demonstrable improvements in population health outcomes
- Sustainable, integrated commissioning model in place
- Strong community ownership and co-production
- Continuous improvement framework driving long-term impact

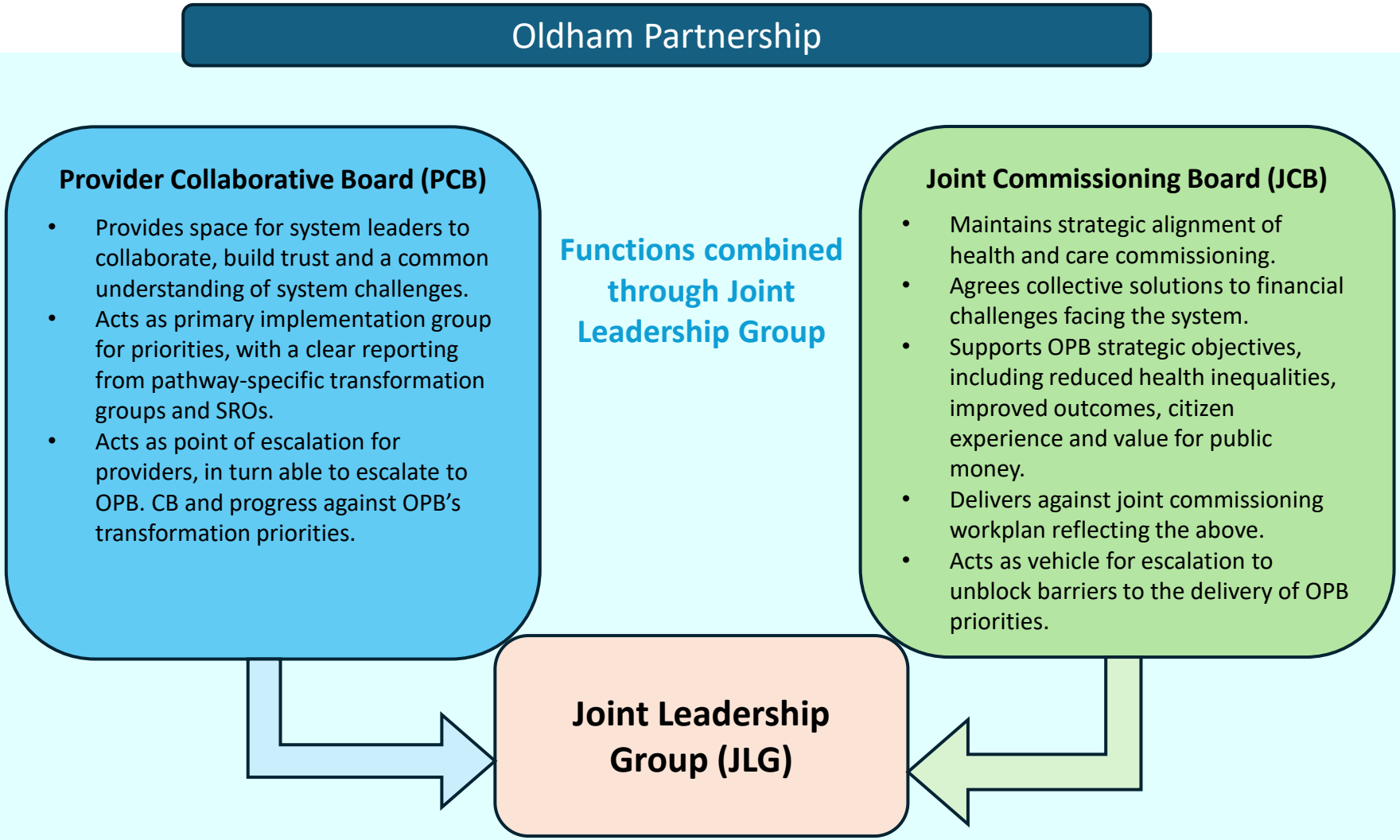
Neighbourhood Health: Our Governance

We will simplify our system governance to ensure that decisions can be streamlined.

Our existing provider collaborative board will become the main vehicle for delivery in Oldham.

The Joint Commissioning Board (JCB) will drive our needs based approach using the prevention framework principles.

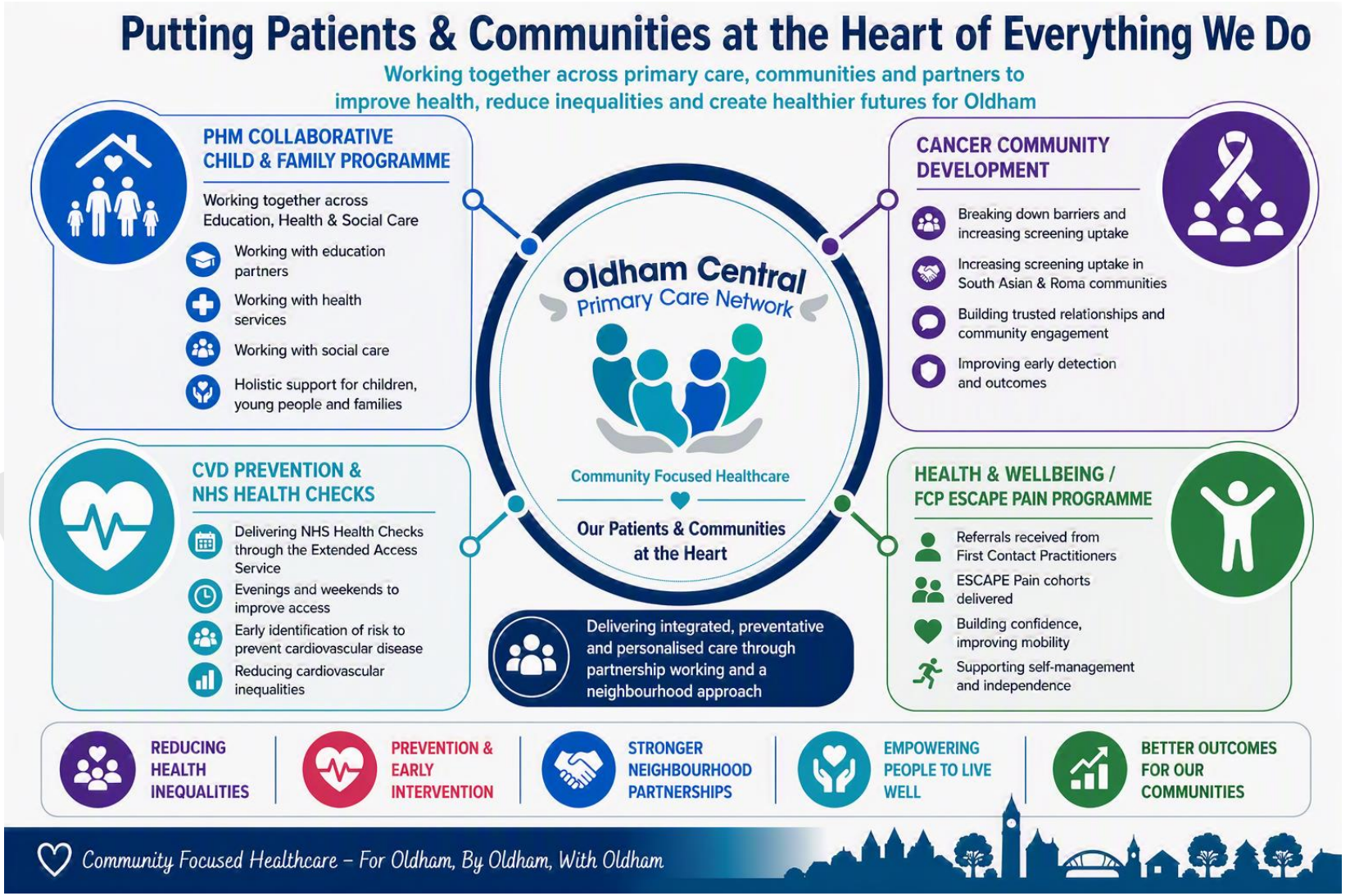
Our Joint Leadership Group brings together key provider and commissioner leads to work collaboratively on behalf of the Oldham Partnership



Glossary

A&G	Advice and Guidance
ABEN	Slide 19
ACP	Advanced Clinical /Practitioner
ADHD	Attention Deficit Disorder
ASC	Autistic Spectrum Condition
ASD	Autism Spectrum Disorder
CAMHS	Children and young People's Mental Health Service
CB	Commissioning Board
CORS	Child Outcome Rating Scale
CYP	Children and Young People
DAS	Director of Adult Social Services
DCS	Director of Children's Social Services
DPL	Delegated Place Lead
ELSEC	Early Language Support for Every Child
FGDM	Family Group Decision Making
GM	Greater Manchester
GM ICB	Greater Manchester Integrated Care Board
GMMH	Greater Manchester Mental Health
GP	General Practitioner/Practice
GTD	Go To Doc
HWBB	Health and Well Being Board
INTs	Integrated Neighbourhood Teams
JCB	Joint Commissioning Board
JCB	Joint Commissioning Board
JLG	Joint Leadership Group
LA	Local Authority
LAC	Looked After Children
LoS	Length of Stay
LTCs	Long Term Conditions
MACPT	Multi-agency Child Protection Teams
MASH	Multi Agency Safeguarding Hub
MDTs	Multidisciplinary Teams
MRI	Magnetic Resonance Imaging
MSK	Musculoskeletal
NCA	Northern Care Alliance
ND	Neuro Diverse
NEET	Not in education, employment or training
NHS	National Health Service
NHSE	NHS England
OPB	Oldham Partnership Board
PCB	Provider Collaborative Board
PCN	Primary Care Networks
PHM	Population Health Management
ROTH	Risk Outside the Home
RTT	Referral to Treatment
SEND	Special Educational Needs and Disability
SLCN	Speech, language, and communication needs
SPoA	Single Point of Access
SROs	Senior Responsible Owner
TEH	Targeted Early Help
TOG	Tameside and Oldham
VCFSE	Voluntary, Community, Faith and Social Enterprise

Case study: Oldham Central PCN



Case study: Oldham Family Hubs

Best Start Family Hubs

Building on the previous Family Hub offer, Oldham has made substantial, system-wide progress in implementing Best Start Family Hubs, moving from early rollout to a fully embedded borough-wide model They are now a core part of Oldham's Early Years and family support system, with seven hubs operating across all districts and further expansion and service integration underway. The hub network is aligned to national guidance and responding to local need.

These hubs act as one-stop access points for maternity, early-years, health visiting, and family-support services.

Key features already in place:

- Universal, one-stop-shop access for families providing access to health, education, parenting and early years support. Families can access support from pregnancy through to age 19 (or 25 for SEND):
  - Health visiting
  - Infant feeding support
  - Maternity information
  - Parenting support
  - SEND support
  - Speech and language support
  - Perinatal & child mental health

Key features already in place cont'd:

- Strengthening the delivery of the Healthy Babies programme within Family Hubs, ensuring closer alignment with public health priorities and improving coordinated access to health visiting, early years support and early intervention services
- Place based model which means families can access multiple services and support in one place that's closer to home.

Parent carer panels which ensure feedback from families with lived experience can support service improvements

Benefits of the hubs are designed to:

- Improve access to services by consolidating support in one place
- Enhance early intervention, helping families identify needs and access support before issues escalate
- Support child development, building on the legacy of Sure Start centres, which showed improved educational and health outcomes for children
- Strengthen family relationships by integrating services and putting family experiences at the centre of support

Future Plans

Oldham's future plans for Best Start Family Hubs focus on expanding services, strengthening integration, and modernising access. These plans include digital transformation and an expansion of the outreach offer which will strengthen community based engagement and enable service delivery to the wider community, particularly for families who don't normally engage with services.

Case study: Spinal Community Assessment Day

Tuesday 25 November 2025 @ Oldham Athletic Football Club

63 patients allocated appointments on the day who were on the spinal surgery waiting list, facing lengthy waits for a specialist opinion.

Alternative Concept: First of its kind event - an alternative to traditional ways of working in the NHS; a collaborative initiative between Northern Care Alliance NHS Foundation Trust and local community services aimed at improving person-centred care for individuals on the spinal surgery waiting list. This model has the potential to serve as a blueprint for future community-based "*super clinics*". The concept offered a range of resources tailored to the specific needs of the local population, including: assessments, advice, health promotion, social prescribing, rehabilitation and community & voluntary sector support (ie: MSK physiotherapy/pain management, weight management, mental health, smoking cessation and health checks). In addition, support for those whose condition was impacting their employment.

Holistic person-centred care: A patient passport was provided which they and/or the professionals populated with a treatment plan, advice, contacts for further support or anything else which was important for that person's spinal recovery. This ensured an understanding of individual needs, rather than a *"one-size-fits-all"* approach.

Critically, each patient's appointment commenced with a '*What matters to you*' conversation to ensure advice and treatment was supported by an in-depth understanding of each patients' priorities/wishes.

Reduced waiting times - Patients would ordinarily have waited much longer to be seen with usually multiple separate appointments over months. Despite being on a surgical waiting list, surgery is frequently not considered to be the long-term solution for many spinal conditions, yet patients wait months to be told this. Almost half of attendees were discharged, reducing the waiting list burden.

Different environment - Provided in a non-medicalised environment (described as calm and friendly) with same-day access to services.

Reduction in travel - Travelling far can be a barrier for patients accessing services outside of Oldham and to reduce this inequality, the specialist services were brought into the community - negating the travel to Salford Royal Hospital (to be assessed by the spinal team for only a single consultation).

Translators: The service utilised translators on the day to meet the needs of the people using the service.

Case study: Early Language Support for Every Child (ELSEC)

Since 2024, along with 9 other sites nationally, Oldham has been working to deliver the Early Language Support for Every Child (ELSEC) project to test out new ways of working to improve outcomes for children with speech, language, and communication needs (SLCN). The programme has been funded jointly by NHS England and the Department for Education.

Through the establishment of a dedicated ELSEC team, we have been able to pilot our new service within 15 schools through an 'Intensive offer,' and by providing “link” ELSEC assistants. These assistants provide training and support to school staff, to improve the early identification and support for children with SLCN. In total, 2406 school staff have been trained to date.

Last autumn, one of our participating schools, Beal Vale Primary School, hosted a celebration event to showcase the success of the programme and demonstrate the positive impact that the programme is having on our children and families. Feedback from families and staff from the school has been positive, with approximately 98% of the children making progress from their initial communication clinic session to the review at the end of the academic year.

In April 2025 (year 2) we launched a wider SLCN offer to enable all primary schools and nurseries access to support via ELSEC surgeries where staff can bring or listen to cases. These surgeries have been anonymous and advice is shared amongst those in attendance. In addition, we've also rolled out the WellComm training to all maintained primary settings.

This pilot has helped ensure children receive help at the earliest opportunity, often reducing the need for referrals into specialist services by addressing difficulties for children early in their education. It has also helped shape the national SEND Reforms and the new Experts at Hand offer which will be implemented nationally over the coming months.

Children and Young People's Neighbourhood System and Programmes

The Children and Young People's System is undertaking a number of system wide changes that are seismic in how we change delivery of our services. Oldham is leading the way in the delivery on these programmes, but it is imperative that they don't become disparate and disjointed programmes of change but complimentary and impactful to all partner delivery models.

Our vision for our Oldham Children and Young People's system is for a thriving and resilient support system where the needs of children and young people are met as early as possible and in the community in which they live, learn and play.

To achieve this, we will focus on a whole-system approach that brings together wide ranging programmes (Families First Partnership, SEND Reforms, Best Start in Life) into a neighbourhood model of support with single coherent and clear models to deliver needs led and preventative services.

To achieve this we need all partners to understand the ambitions and to embrace neighbourhood models of delivery, whether that be NHS providers and trusts, VCSFE organisations, Schools and Settings or Multi Disciplinary Teams around Primary Care. This will need a cultural shift as much as any programme change and as a partnership we will help support this approach.

The SEND Reforms will be the driver for much of this work as we build, and Oldham's local area partnership is committed to delivering **a fair, sustainable and inclusive system that identifies and supports needs early, equips partners and leads to better outcomes for our children and young people**. Families have confidence in support, and resources are used effectively to secure value for money. Our vision is grounded in a clear principle: support should be needs-led, accessed early and delivered through an integrated system, rather than driven by diagnosis or service boundaries. This means shifting from fragmented and reactive practice to a predictable, inclusive system where needs are identified and met earlier, within local mainstream provision wherever possible. We will develop our neighbourhood and district based system on these principles.