The Oldham Locality Plan for Health & Social Care Transformation

April 2016-March 2021
## Contents

**Foreword** .................................................................................................................. 3

**How the plan works** .................................................................................................... 6

**Section 1: Strategic direction** ...................................................................................... 9

1.1 Our vision ..................................................................................................................... 9
1.2 The challenges we face in Oldham ............................................................................. 9
1.3 Creating a sustainable health and social care system ............................................. 11
1.4 Interface with GM programmes and how devolution can support us .................... 13
1.5 Principles underpinning the Plan .............................................................................. 15
1.6 Ways of working ......................................................................................................... 16
1.7 Recognising the contribution of other sectors ......................................................... 20
1.8 Implementation, governance and system leadership ................................................ 20
1.9 How we will recognise success .................................................................................. 22

**Section 2: Transformational programmes** .................................................................. 23

2.1 Establishing an Accountable Care Management Organisation .................................. 24
2.2 Mental health is central to good health .................................................................... 38
2.3 Starting Well: Early years, children & young people .............................................. 52
2.4 Living Well: Action to build resilient communities and provide early help .......... 60

**Section 3: Enabling strategies** ....................................................................................... 66

3.1 Workforce .................................................................................................................... 66
3.2 Data and IM&T ............................................................................................................ 69
3.3 Estates ........................................................................................................................ 71

**Appendix 1: The financial gap** .................................................................................... 72

**Appendix 2: GM-level devolution programmes** ......................................................... 77

**Appendix 3: Oldham CCG clinical programmes** .......................................................... 82
Foreword

The partners in Oldham share an ambition to see the greatest and fastest possible improvement in the health and wellbeing of our residents by 2020.

This improvement will be achieved by:

- Supporting people to be more in control of their lives;
- Having a health and social care system that is geared towards wellbeing and the prevention of ill health;
- Access to health services at home and in the community; and
- Social care that works with health and voluntary services to support people to look after themselves and each other.

Getting ready for devolution by April 2016 has accelerated planning for joint working between Oldham Council and NHS Oldham and prompted us to be more ambitious with our plans. In doing so, we are planning for health and social care operating in a system rather than within organisational boundaries.

We are also working with council and NHS partners across Greater Manchester to transform:

- The way we work as commissioners and providers of services;
- How the public engage with their own health;
- The public’s expectations of public services.

These changes will mean people in Oldham and Greater Manchester are less dependent on public services and will reduce demands on services to the point where a more efficient and effective health and social care system is able to provide the best treatment and care and stay in financial balance.

The ambition is to ensure that services are complementary, work with people’s own resources and are committed to achieving the best possible outcomes for people in Oldham. To achieve our ambition, we need to adopt ways of working and models of care that boost people’s sense of control, capability and independence so that we can break the links between socioeconomic factors, behaviours and ill-health, and equip people to manage existing health conditions themselves.

This Locality Plan outlines the key transformational programmes that will enable Oldham to deliver significant improvements in the health & wellbeing of our residents. It focuses in particular on how we transform prevention services and primary and social care. There are two other areas of work underway that the Locality Plan references. These are provider reform (including the Healthier Together initiative) and the pan-Greater Manchester transformation programmes. Together, these three areas will shape our health and social care system.

What difference will devolution make?

Devolution in Greater Manchester has provided us with the momentum and impetus to explore how much further and faster we can move towards realising a financially sustainable population health system that achieves our vision.
The successful delivery of this Locality Plan will mean that we have:

- Transformed the relationship between the population and the health and social care system, so that the public expects services to promote healthy behaviours, independence and self-care and we reduce dependency on high cost or institutionalised services;
- A primary care-led place-based health and social care system (an Accountable Care Management Organisation) that maximises the opportunity to pool budgets, integrate commissioning, and provides outcome-focused integrated care closer to home;
- A health and social care system that is built upon sustainable financial models;
- A workforce that has the skills and capacity to enable people to receive appropriate and timely help and support to address the root causes of health problems as well as the presenting symptoms;
- A health and social care system that recognises and supports a wider associated workforce including carers, other public sector areas such as the fire service, and social housing, voluntary and community organisations and volunteers;
- Improved quality and the public’s experience of health and social care, delivered greater efficiency, and improved population health outcomes;
- Developed an evidence base about the effectiveness of our resilience-focused programmes and have scaled these up across Oldham and fostered the widespread adoption of community development and asset-based approaches;
- A systematic approach to developing community-centred approaches (including social prescribing) to health and social care, working closely with Oldham’s voluntary and community sector.

**Engagement with stakeholders**

In October 2015 we held an engagement event on the second draft of the Plan to give services, voluntary organisations and others who have an interest in the health of people in Oldham an opportunity to input to the Plan. Around 125 delegates attended the event and voiced their support for the approach being taken. Their ideas and thoughts on the Plan’s four transformational programmes have been captured in this Plan.

**Financial planning**

Financial planning in Oldham is challenged by the complexity of the relationships between the two commissioning organisations (Oldham Council and Oldham Clinical Commissioning Group) and provider partners, including Pennine Acute Hospitals NHS Trust and Pennine Care NHS Foundation Trust, as well as the multi-borough footprint in which the providers operate. We describe the financial position of the commissioners in this Plan. The aim is to establish a better understanding of the providers’ financial position through the production of an Oldham specific finance statement.
Next steps

We are now focusing on the implementation of this Plan and will continue to complete the finance template for some of our major interventions, ensuring we understand their cost and effectiveness.

It is important to highlight that implementation and the financial planning required to achieve a sustainable health and social care system will be a continuous and iterative process that will extend past April 2016, as will the development of the new system leadership.

The Oldham Locality Plan also contributes to and takes account of the development of the Greater Manchester Strategic Plan that is progressing along a similar timetable.

______________________________  ________________________
Cllr Jean Stretton               Dr Ian Wilkinson
Deputy Leader and Cabinet Member Oldham Clinical Commissioning
for Health & Wellbeing            Group, Chief Clinical Officer
How The Plan Works

In Section 1 we describe the challenges that we face in Oldham, namely that too many of our citizens have poor health, there is a significant gap in health status between the least and most deprived communities, and too many of our families are in poverty. In addition, demand for health and social care services is outstripping the budget that we have available to provide them.

We are aligned to a number of Greater Manchester-level workstreams, including development of a mental health strategy and Public Sector Reform as well as those transformational programmes that arise from the Memorandum of Understanding with Public Health England. These workstreams will all contribute towards meeting our challenges.

To fundamentally improve health outcomes and reduce costs we need to change the relationship between different services to create a population health ‘system’, and between services and citizens to foster a culture of independence, resilience and self-care. We have identified six principles and a number of ways of working that, taken together, will create greater efficiency, promote resilience, and improve health outcomes.

We recognise that there is significant capacity and investment in our communities beyond the public sector. In particular, we outline the crucial contribution that voluntary, community and social housing organisations are making to the wellbeing and health of our population. We need to ensure that we continue to work with and support these organisations as part of the system. In addition, we need to recognise the role of carers in promoting health and reducing demand.

To achieve transformation will require a shift from organisational management to ‘system’ leadership, with greater collaboration, trust and the sharing of risk across organisations. In Section 1.8 we highlight the need for new forms of system leadership and new governance arrangements to reflect the emerging health and social care system.

We draw our success measures from a number of different national and local frameworks (see Section 1.9). We will adopt a mix of these measures, across process, financial and health outcomes, recognising that a small number of key indicators may also emerge from the planning that is underway at the Greater Manchester level.

In Sections 2.1-2.4 we describe four major transformational themes in health and social care in Oldham:

1. Establishing an Accountable Care Management Organisation;
2. Mental health is central to good health;
3. Starting Well: Early years, children & young people;
4. Living Well: Action to build resilient communities and provide early help.

Our plans follow the lifecourse approach adopted by Greater Manchester: Starting Well, Living Well, and Ageing Well.
Establishing an Accountable Care Management Organisation (ACMO) will see the setting up of an organisation in Oldham that will underpin a comprehensive health and social care ‘system’. It will be led by primary healthcare services and will seek to maximise the opportunities to pool budgets and integrate commissioning across the NHS and the Council. Through a single contracting arrangement with providers it will see the development of new and integrated models of care provided at home or in the community that improve efficiency and quality. It will transform how our workforce works with people, recognising their own strengths and promoting independence, and it will recognise and mobilise a wider associated workforce, including carers, social housing and voluntary and community organisations.

Our Mental health is central to good health programme recognises the centrality of good mental health to overall health and wellbeing and to functioning within a community and across the life course, and relates closely to our work on community resilience. The transformation will be in how we discuss and deal with mental illness, how we ensure effective services are available for swift recovery, and how we support Ageing Well by addressing dementia.

Our Starting Well: Early Years, children & young people programme will transform the way we support parents and families to give our children the best start in life. Early years was identified by Sir Michael Marmot as the highest priority area of action to reduce health and social inequalities. Much has been done to develop this area that we now want to take to a higher level of functioning.

Living Well: Action to build resilient communities and provide early help complements the ACMO by seeking to create a more empowered and independent population and thereby reduce demand on expensive and institutionalised health and social care services. The transformation will be the scaling up of the capacity of the council, NHS, housing and voluntary sectors to engage with communities to achieve social cohesion and empowerment, identified by Sir Michael Marmot as significant factors in reducing health inequalities. We will work with partners so they can develop new relationships that better connect the population to improve health outcomes and reduce dependency. Alongside our Early Years and Mental Health programmes, we also expect this approach to increase educational attainment and people’s readiness for work by promoting self-efficacy and aspiration.

It is important to recognise that there are many other initiatives, programmes and clinical models of care being delivered for and with people in Oldham on a day-to-day basis that influence wellbeing and health, both within and beyond the health and social care economy. It is not our intention to list all such programmes in this plan, but rather to focus on the major transformational programmes and establish a place-based whole system approach to commissioning and provision of services.

To achieve the desired outcomes from the above four transformation programmes, Oldham will require a number of enabling strategies to be developed, and these are outlined in Section 3 of the Plan:

- **Workforce**: how we align cultures, values and practice across all partner organisations and sectors, and how we support volunteers and carers. We recognise the pressure on staff from changing client needs and from requiring a different relationship between services and clients and will plan how we will support staff to adopt new ways of working.

- **Data and IMT**: how we collect, share and analyse data, e.g. to understand our at-risk population and to improve integration and quality of care, and how we use
technology to support resilience, self-care and a reduction in the dependency on face-to-face services;

- **Estates:** how we co-locate services to improve integration and customer focus and reassess our need for estates facilities in the light of new models of care provision.

These strategies are in development and will evolve as we identify the requirements of our transformational programmes.

And finally…

Devolution and the need to develop this Plan have accelerated the establishment of new ways of working across health and social care. In particular, we have been able to take a whole system approach to identify our shared drivers of demand on services e.g. changes to the population. The process has accelerated plans to widen the scope of pooled budgets and has enabled us to start to map all our programmes and interventions in a single place and to look at how we jointly plan programmes and share project management tools in the future. The process has also enabled us to look jointly at our system dependencies so that in future we can minimise the risk that changes to one part of the system inadvertently put pressure on another.

We will continue to adopt and develop this new approach.
Section 1: Strategic direction

1.1 Our Vision

Our vision is to achieve and sustain the greatest and fastest improvement in wellbeing and health for the 224,900 people of Oldham.

Through innovative programmes, new ways of working, and partnerships our population will be encouraged and empowered to:

- Take more control, improve their life chances, reduce risks to health and live well and adopt healthy lifestyles;
- Access care and support at an earlier stage;
- Manage their own conditions and live independently.

The key areas of focus described in this Plan are early years, mental health, community resilience, and the transformation of primary, community and social care services. We also describe the mobilisation of a workforce that includes other parts of the public sector, social housing, the voluntary and private sectors, and carers.

1.2 The challenges we face in Oldham

1.2.1 Poor health and health inequalities

Our population’s health is influenced by social inequality including poverty, worklessness, and disadvantage on the basis of race. The wider determinants of health such as education, employment, housing and transport are critical factors too.

Whilst we are seeing improvements in health, we are still nearer the bottom than the top of regional and national health and wellbeing indicators: life expectancy for both men and women remains lower than the England average and differs by 10.9 years for men, and 9.0 years for women between the most deprived and least deprived areas of Oldham. Unhealthy behaviour and the presence of multiple long-term conditions are both over-represented among our poorer, more disadvantaged communities, one fifth of households is in fuel poverty and one in four (12,700) of our children lives in poverty.

Currently, almost half of all five year olds in Oldham have experienced dental decay, with an average of 2.10 teeth decayed, extracted or filled per child. Not only does poor oral health constitute a health issue but it also impacts on a child’s life chances in terms of self-confidence and employability. In addition, Oldham has a higher than average number of children in Year 6 recorded as obese (19%).

Our adult population is less physically active, smokes more, and carries more excess weight than the England average and we have higher than average alcohol-related admissions to hospital. These unhealthy behaviours mean we have significantly higher
numbers of people with recorded diabetes, and deaths from smoking-related diseases, cardiovascular disease and cancer are significantly higher than the England average.

Poor mental wellbeing, a lack of self-esteem and low aspirations make choosing healthier behaviours and managing existing health conditions more difficult and so we need to ensure a balanced focus on people’s mental and physical health.

Among our 35,900 people aged over 65, one in ten is chronically socially isolated, which impacts on mental and physical health and is associated with increased visits to both primary care and A&E. Oldham has a significantly higher number of hip fractures among the over 75’s than the England average, which lead to hospital stays, increased social care costs, and loss of independence. There are estimated to be around 2,500 people living with dementia in Oldham, although only half of these are recorded on a GP register.

The key areas of focus in this Plan – early years, mental health, and community resilience - are recognised by Marmot\(^1\) as critical for reducing health inequalities. In addition, Marmot highlights the vital role that a transformed and integrated primary, community and social care sector can play in reducing health inequalities and promoting fair access, through initiatives such as patient empowerment, social prescribing, co-location and integration of services, risk segmentation, and the identification of people not currently accessing services.

1.2.2 Reducing demand to achieve financial stability

Across Greater Manchester there are significant financial pressures that pose a threat to the health and social care system as we know it today. The predicted financial gap in Oldham within the health and social care system (Section 1.3.1) presents a huge challenge and to bridge this gap requires a radical shift in the way services are shaped and operate. We have to commit and change the whole system so that it is entirely geared towards keeping people healthy and in control of their lives. We need to:

- Refocus our resources and make large scale improvements with regard to the social determinants of health, including access to good quality jobs, housing, leisure, transport and welfare;
- Improve the reach and effectiveness of prevention activities, including action to increase mental wellbeing, resilience and health aspiration;
- Shift our resources to early help, tackling high cost, complex issues, connecting people to job opportunities, and helping people to gain skills, confidence and self-esteem;
- Engage the wider health economy to nurture a health-promoting environment through local decision-making e.g. planning, leisure, parks, and housing;
- Invest in community and asset based approaches that promote positive behaviours and appropriate expectations of services;
- Expand efforts to engage individuals and communities across Oldham in civic life;
- Engage with public and private-sector employers to champion and support the introduction of health at work practices and charters;
- Use our investment in programmes to develop enterprises and local jobs;

• Ensure the availability of early intervention services for people at risk of losing employment through ill-health;

• Improve the detection and management of existing health conditions, promote self-care, and improve the integration of services so that people with limited resources can both access and navigate them effectively.

Only by promoting people’s involvement in services and releasing the assets of communities will we reduce demand on health and social care. This involves all the actions above and also recognising that Oldham has significant resources and assets beyond the formal health and social care system that can be marshalled to support population wellbeing and health.

1.3 Creating a sustainable health and social care system

1.3.1 Financial and planning assumptions/future projections

It is projected that, with current trends of increasing demand and less money for public sector services, the gap between the cost of delivering health and social care services and the budget available to pay for them will be around £2bn for the whole of Greater Manchester by 2020/21. That is the projection if nothing is done to reduce demand and to find more effective and cost effective ways of delivering services.

Each borough in Greater Manchester is also projecting what the financial state of its health and social care economy will be by 2020/21. The commissioner finance gap in Oldham as presented in Appendix 1 is the gap over the five year spending review period 2016/17 to 2020/21. This is forecast to be £123m, reducing to £26.9m if current interventions are implemented. These include:

• Protection of adult social care funding;
• Planned 2016/17 council budget reductions;
• Planned CCG savings;
• Additional NHS funding over the five years to 2020/21.

There will also be the opportunity to join up with Greater Manchester-wide interventions and access the pump-priming funds resulting from the Government’s 2015 autumn statement and the local government settlement.

How we maintain our financial sustainability beyond 2016/17 is still being discussed at a strategic level. We will ensure that the CCG meets its requirement to report an annual 1% cumulative surplus and that the Council reports a balanced annual budget. The four transformational programmes in this plan are the means through which we intend to close the gap between costs and available budget and as the details develop, the impact of these programmes on the financial gap, through reduced demand or more cost effective services, will be clarified.

In order to fully understand the financial sustainability of the health and social care economy in Oldham, we need to better understand the financial positions of our major NHS providers, Pennine Acute Hospitals NHS Trust and Pennine Care NHS Foundation Trust. Work is continuing to gather this information.
1.3.2 Existing financial pressures and the consequences of continued funding reductions

For several years Oldham has been working to transfer resources from higher end specialist services into preventative responses. However, social care demand has continued to put pressure on frontline services and in particular expenditure on Looked After Children (LAC) and Care Leavers.

Through investment in growing a strong and responsive in-house foster care service, alongside improving adoption performance and our investment in services such as the Adolescent Support Unit, we aim to maintain a low LAC population. This depends however on both the quality and effectiveness of ‘upstream’ services and also the effective operation of the social care front door with experienced and motivated staff. This is being tested out as some of our previous efficiency savings are having an impact on recruitment and retention (see Section 1.3.3).

We are witnessing some additional cost drivers in terms of legal costs, the implementation of Special Educational Needs and Disability (SEND) reforms (Section 2.3.5), and maintaining a strong Children’s Centre offer which underpins delivery of our integrated early years model.

Adult social care is already facing numerous existing pressures and the implications of further budget reductions would include:

- An inability for care at home providers to support people while operating within the local authority’s price framework, enhancing the pressure in acute environments.
- Providers withdrawing from the market on the basis of the local authority being unable to support an hourly rate deemed necessary for improved recruitment and retention of staff.
- The local authority being unable to fully implement its legal duties (within for example the Care Act and Mental Capacity Act) as a consequence of the need to prioritise a limited financial resource.
- The potential for a preventative approach to supporting community resilience to be diluted as systems becomes reactive as opposed to proactive.
- The potential for safeguarding thresholds to rise as local authorities have insufficient resources to address the issues of poor practice and limited capacity to drive up standards.

1.3.3 Workforce pressures

Greater Manchester health and social care economies, in common with others across the country, face numerous workforce challenges. Many councils find it difficult to recruit and retain skilled social care staff, such as social workers, and the difficulties experienced by the acute and community trusts in recruiting and retaining doctors, nurses and other staff are well evidenced at the national level.

In recent years, local authorities have commissioned most social care and support from external agencies rather than provide the services themselves. Private and third sector providers also struggle to recruit and retain staff, who may be better remunerated, or perceive that they will have greater career opportunities in other
sectors such as retail and hospitality. These and other sectors are recovering well following the recession, providing an increasing range of local employment opportunities for people across Greater Manchester whilst at the same time national investment in social care is reducing.

Another factor that benefits, but at times might also disadvantage organisations in Greater Manchester, is the mobility of labour. Greater Manchester operates as an economy in its own right, and transport links are rapidly improving thanks to substantial local investment. There is therefore a risk that health and social care recruitment in one part of Greater Manchester will attract staff who are required to maintain capacity in other parts of the conurbation, effectively moving the problem from one area to another. None of these issues is unique to Greater Manchester. They reflect the much wider challenges facing the health and social care system in England.

The Urgent Care Alliance (see Section 1.6.3) works across sectors to respond to these challenges. It is in the process of developing a longer-term strategy that will include planning to recruit, retain and deploy staff across the health and social care system as we move towards establishing the Accountable Care Management Organisation that will bring providers of health and social care together through a single contracting arrangement. This will provide opportunities to create new roles and career pathways as we work together with commissioners to develop new and integrated models of care provided at home or in the community to improve efficiency, quality and outcomes for local people.

1.4 Interface with Greater Manchester programmes and how devolution can support us

The cross-sectoral Oldham Partnership has already laid the foundations for the approach set out in this Plan through The Oldham Plan and Public Sector Reform.

We are closely aligning our key health and social care transformation programmes with Greater Manchester-wide agreements to ensure that we benefit from a joint approach and shared learning to address complex challenges. There are also clear economies of scale in terms of cost, collective negotiating power and sharing of best practice.

However, we recognise there can be diseconomies of scale if the appropriate level for services is not assessed sensitively, that can undermine the added social value and contribution of community-based solutions. We also want to ensure that there are consistent quality standards to enable cross-boundary working and fairness for our Greater Manchester residents. The Greater Manchester workstreams are:

- IM&T
- Workforce
- Capital and estates
- Communications and engagement
- Governance
- Contracting and procurement
- GM mental health strategy
- Learning disabilities
- Children and adolescent mental health services
1.4.1 Devolution: additional flexibility and abilities

Devolution in Greater Manchester has provided us with the momentum and impetus to explore how much further and faster we can move towards realising a financially sustainable population health system that achieves our vision. Key asks from devolution to enable this to happen are:

### Population based outcomes
Support to develop further population-level data sharing agreements across public sector organisations to understand need and enable us to track health outcomes and develop a place-based health and social care economy.

### Investment in the system
Investment to allow pump-priming of new services in primary care and the community to support the contraction of the acute sector. This will enable us to commission primary care on a population basis, improving access, proactively managing long term conditions, and eliminating variation across Oldham through the implementation of the standards.

### Integrated local system
The flexibility and support to develop a responsive local health and social care management system in Oldham through the Accountable Care Management Organisation (ACMO) model, that is able to support population health needs and to share and bring in learning and expertise from the Vanguard Programme.

### Responsive local workforce
Greater freedom from national arrangements, including the ability to contract for and price services in a different way. This will enable us to plan and develop the health and social care workforce in Oldham to respond effectively to local population health needs and to empower staff to work more freely across organisational and professional boundaries to provide comprehensive and seamless support to residents and patients.

### Delegation of accountability and scrutiny
The ability to delegate the relevant regulatory or supervisory powers from national bodies such as the Care Quality Commission, NHS England, Monitor and its successor, NHS Improvement to develop a provider regulation system more reflective of local needs.

### Community resilience and place-based solutions
To provide support to work with communities in Oldham to:
Achieve greater resilience and self-determination
Ensure a healthy start in life across Oldham
Support people earlier and on their own strengths
Change the model of health and social care provision to engage people in their own care.

**Finance and contracting**
- Capital investment and transitional funding
- Ability to plan capital and revenue spend across a CSR settlement period of five years
- More flexible financial rules and regulations in key areas, for example, council tax and business rates, or a reduced need to deliver annual surpluses
- Pooled budget flexibilities
- Greater freedom from national arrangements and flexibilities requiring changes to legislation – i.e. ability to contract for and price services in a different way and support for different models of contracting
- Significant flexibilities with possible changes to legislation / formal guidance needed (contracting and funding mechanisms) to move from commissioning on a tariff-based or block contracting approach to commissioning for outcomes
- Greater flexibility on payment schemes and support for different models of contracting

**Regulation**
- Influencing competition and choice regulations to enable Greater Manchester to take bold decisions on decommissioning services as demand is reduced or met in new ways.
- Development of local targets, responsive to local need.

**Capital and estate**
- Ability to own and transfer assets locally
- Capital flexibilities and bringing ownership of Estates back into the public sector

**Public Health**
Implementation of the Greater Manchester-wide framework for action and new leadership.

### 1.5 Principles underpinning the Plan

There are six principles that underpin the Locality Plan and will support the way we work with our key stakeholders across Oldham to deliver it:

- **The deployment of resources flexibly to enable professionals to do the right thing to achieve shared aims and objectives.** This will include integrating delivery and pooling NHS and local government resources where it makes sense to, and a closer relationship and different contracting arrangements between commissioners and providers;

- **A commitment to taking a whole system approach to health and social care in Oldham and across Greater Manchester, with a jointly owned model of inclusive governance and decision-making across commissioners, providers, patients, carers and the housing, voluntary, community and faith sectors;**
• A new relationship in Oldham between public services and citizens, communities and businesses that supports genuine co-production, the joint delivery of services, and a reduction in demand – “Do with, not to”;

• A focus on the lifecourse, prevention and the most disadvantaged, and a commitment to promote and use asset-based approaches that recognise and build on the strengths of individuals, families and our communities rather than focussing on the deficits;

• The Council and the CCG being responsible and striving to support innovation, reduce unwarranted interventions and admissions, reduce costs and improve productivity to get the best value possible and achieve financial sustainability without compromising the safety and quality of treatment and care;

• Partners across Oldham working with each other to ensure that all resources are used to the best effect to meet the needs of and to benefit the whole of Oldham’s civil society and financial economy. This will include taking account of the national and international evidence and best practice.

1.6 Ways of working

In Section 1.4 we outline ways of working at the Greater Manchester level and in Section 3.1 we identify a workforce and culture strategy as one of our enablers. Here we describe how we are working at the borough and district levels to facilitate the creation of a population health system.

1.6.1 Commissioners and providers

The main statutory bodies concerned with commissioning health and social care in Oldham are Oldham Council and Oldham CCG. The main providers are Pennine Acute Hospitals NHS Trust and Pennine Care NHS Foundation Trust, described below. Whilst these four organisations will remain at the core, we recognise the need to move to a place-based whole system approach to the commissioning and providing of services that involves partnerships at the district level (as outlined in Section 1.6.2) and partnerships with other sectors including housing and the voluntary sector, as outlined in Sections 2.4.1.2.

Pennine Acute Hospitals NHS Trust provides a range of hospital, specialist, integrated and community services to the localities of Oldham, Bury, Heywood, Middleton and Rochdale and North Manchester (population 820,000) in accordance with commissioner specifications. Services are delivered from four major sites: Royal Oldham Hospital, North Manchester General Hospital, Fairfield General Hospital in Bury and Rochdale Infirmary, together with the Floyd Unit.

Services are operated using a single service model that balances locally-based services close to the patient’s home with consolidated services e.g. stroke services for the north east locality consolidated at Fairfield General Hospital, gastroenterology at Royal Oldham, and maternity services at both North Manchester General and Oldham Hospitals. Consolidated services have higher volumes, standardised approaches and less variation, which in turn offers better outcomes for patients and economies of scale in terms of delivery.
The Royal Oldham has been designated as a specialist hospital under Healthier Together, supported by North Manchester and Fairfield General Hospital as local hospitals. The Healthier Together changes enhance the current single service model with acute surgery and acute medicine at the Royal Oldham.

Building on Healthier Together and working in partnership with commissioners the Trust has commenced a clinical service transformation programme that covers its full range of services to deliver clinical and financial sustainability by 2019/20.

**Pennine Care NHS Foundation Trust** provides community and mental health services across Bury, Oldham and the Rochdale boroughs, integrated community services in Trafford, and mental health services in Stockport and Tameside & Glossop.

Pennine Care has a long history of building and working within strategic community partnerships and developing and delivering integrated service models with a number of partners. Our strategy maximises system benefits, which in turn improve the quality of patient health and care. Pennine Care’s community foundation trust status provides robust governance within which to operate across the system and within partnerships.

Services are provided to people at all stages, from birth through to end of life and a significant proportion of patients have multiple long term and complex conditions. Services comprise multiple disciplines such as nursing, therapies, mental health, and social care, and includes the voluntary and community sector. Services operate at a neighbourhood or borough level according to local commissioning requirements and the bespoke needs of each borough.

Pennine Care’s community and mental health services are focused on caring for people at home or in the community, when it is safe to do so. This supports the wider system by deflecting activity from primary care and hospital, as well as reducing hospital length of stay. However, hospital/specialist mental health provision is also provided to ensure appropriate care is available to the most vulnerable groups that have varying and complex needs.

Improving community resilience is a key component of the community offer, ensuring patients, service users and carers have the skills and confidence needed to more effectively manage their own health and wellbeing.

Pennine Care operates a devolved business model, with flexible modes of delivery within the boroughs it services. Within Oldham, the Trust has formed a Community Provider Consortium including a range of health, care and voluntary partners and is working closely with strategic partners to further develop the primary medical care home offer in the context of system integration (see Section 2.1).

### 1.6.2 Integrated commissioning partnership

Oldham’s Integrated Commissioning Partnership (ICP) was created to support joint and aligned commissioning between health and social care. The ICP provides oversight and scrutiny of service integration and joint commissioning across the whole spectrum of Local Authority and CCG responsibilities, including adults’ and children’s services. It delivers the function of Oldham’s Health and Wellbeing Board in respect of promoting the integration of care around the needs of individuals by the use of pooled budgets, integrated provision and joint commissioning. The ICP operates to a Memorandum of Understanding. The functions of the Integrated Commissioning Partnership are:
• To make collective decisions on the review, planning, procurement, financial implications (budget, investments and savings) and performance monitoring of agreed areas which relate to the integrated commissioning of services;
• To oversee the budget for any services in scope who use any form of aligned or integrated budget;
• To promote improvement and innovation – review, monitor and drive up the quality and safety standards of commissioned services;
• To maintain links with sub-regional and regional drivers and policies, in particular those at a Greater Manchester level, and ensure a fit with the Oldham context.

Under the devolution agreement the governance system in Oldham will be reviewed to comply with that in Greater Manchester and to best support the development of the ACMO.

1.6.3 Provider collaboration: Urgent Care Alliance

Oldham has established an Urgent Care Alliance, which is a partnership arrangement between the CCG, Oldham Council, Pennine NHS Acute Hospital Trust, Pennine Care NHS Foundation Trust, local care and housing providers, Voluntary Action Oldham and Go-to-Doc (the out of hours GP service). All these organisations provide urgent care services in Oldham. The Alliance is changing the balance of care with increased community based solutions and has an outcome-based approach to commissioning and service delivery. The group has a Memorandum of Understanding that outlines shared strategic priorities, performance frameworks and investment models and is supported by a project team, funded by the CCG. The Alliance has established a range of schemes to deflect hospital admissions, supported by the Better Care Fund and contractual agreements. These schemes will, over time, help commissioners to shift resources from acute to community settings.

1.6.4 The Oldham Partnership, district partnerships and GP clusters

At the borough level we have established the Oldham Partnership which comprises leaders from across the public, voluntary and business sectors. Through this forum we are able to drive a collective response to Oldham’s economic and social challenges.

More locally we have established six district partnerships (groupings of around three council wards) and wherever possible we have devolved the Council’s decision-making and budgets to these partnerships. This has enabled greater democratic engagement in the Council’s business, led by our elected members, and a focus on locality working that recognises the assets and needs of different population groups.

In parallel with this, the six district partnerships are working closely with the eight GP clusters to co-locate, integrate and jointly commission services. We are currently reviewing the sub-borough level structures and their boundaries as we strengthen our focus on working in localities and integrating primary and community health services with social care at the neighbourhood level (Section 2.1).

1.6.5 Empowerment and co-production

Central to achieving a fully integrated population health system is the need to transform the relationship between services and citizens. Oldham is committed to achieving a cooperative future, where citizens, partners, the Clinical Commissioning
Group and the Council work together to ensure a productive borough with confident and resilient communities. The aim is that everyone ‘does their bit’ with everyone benefiting.

Engaging people in decisions about things that matter to them, and empowering them to take action and exert greater control improves mental wellbeing, self-esteem, and self-efficacy, creating the conditions for individuals to take greater interest in and responsibility for their health. Empowerment also builds resilience and resourcefulness, and reduces social isolation, all of which mitigate the negative impacts of financial and emotional set-backs.

Steps we are taking towards empowerment and co-production include:

- Creating a shared narrative about a positive future, raising aspirations that things can be different;
- Directly involving the public in the co-design of local services and in decisions about the future of health and care services and the local environment;
- Enabling people to exercise control over who they receive support from, where, when and how;
- Developing participatory budgeting opportunities to give people control over a proportion of the Council and NHS budgets;
- Using a systematic and partnership approach with the voluntary, community and faith sector, led by Voluntary Action Oldham, to develop and resource innovative projects and services, for example using a Dragon’s Den approach;
- Supporting GP practices to roll out Patient Online (appointments, repeat prescriptions and patient records) to give patients more control;
- Working to make personalisation central to the CCG’s commissioning plans through the Patient & Public Engagement (PPE) portfolio;
- Developing a social prescribing model, linking citizens to local activities and groups and reducing their reliance on treatments and medicines;
- Ensuring we are taking every opportunity to maximise social value across everything we do including service delivery, commissioning and procurement.

1.6.6 Making Every Contact Count

Making every contact count is an ethos and way of working that we need to adopt across our population health system and relates to workforce development as set out in Section 3.1. We need to adopt an approach that enables and empowers frontline staff everywhere to be our eyes and ears looking out for the vulnerable and at risk, able to spot care needs e.g. falls, frailty, isolation, deterioration, dementia, end of life, and offer advice and refer or signpost to the relevant services to reduce the likelihood of crises occurring.

Frontline services include the fire services (who are trusted in the community and already engaged in providing preventive services), community workers, and Housing Tenancy Support officers.

The One Estate workstream, outlined in Section 3.3, will facilitate the co-location of services which will in turn support these new ways of working.
1.7 Recognising the contribution of other sectors

We recognise that there is significant capacity and investment in our communities beyond the public sector, in particular from the voluntary, community and social housing sectors. These organisations fund and/or deliver community-based asset approaches, health promotion and health and social care services, and can access funding for initiatives that the public sector cannot. They also support a significant associated workforce of volunteers and contribute to the development of community cohesion and resilience (Section 2.4.1.2).

In order to connect the voluntary, community and faith sector and its work in communities into health systems we will develop:

- A shared strategic framework with the voluntary, community and faith sectors to enhance Oldham's whole health and wellbeing economy;
- A strategic investment mechanism to support and evaluate the work of voluntary, community and faith organisations to promote health and wellbeing.

1.8 Implementation, governance and system leadership

1.8.1 Implementation

The implementation and the financial planning required to achieve a sustainable health and social care system will be a continuous and iterative process that will extend past April 2016. We will adopt a culture of innovation and learning with our service providers and partners, adjusting our plans as we see what is working.

Our approach to implementation will also recognise that we are working within a system of commissioner, service provider and service user interaction and we will seek to use this to achieve greater impact.

1.8.2 Governance

The four transformational programmes each draw together initiatives from across the health and social care system. Therefore, in order to drive the effective implementation of the programmes, the following governance arrangements have been agreed:

1. Development of an Accountable Care Management Organisation
   The ACMO Board – responsible for driving the establishment of the ACMO.

2. Mental health is central to good health
   The Mental Health Strategic Group - made up of officers from the CCG, the local authority, and service providers.

3. Starting Well - Early years, children and young people
   The Best Start in Life Partnership – established by the Health and Wellbeing Board.

4. Living Well - Action to build resilient communities and provide early help
   A collaboration between the Health & Wellbeing Board and the Co-operatives and Neighbourhoods cluster.
The Health & Wellbeing Board will remain a statutory committee of the local authority and will continue to act as a strategic oversight board, with responsibility for monitoring the implementation and success of the Locality Plan. It will also ensure that Oldham plays a full and active role in shaping developments at the Greater Manchester level.

1.8.3 System leadership

In order to ensure the greatest and fastest possible improvement in the health and wellbeing of our residents by 2020, we need to equip and engage all our system leaders to collaborate to:

- Create the high quality places that attract and retain more productive people and businesses
- Reform the way that public services are designed to improve outcomes by working with rather than delivering services to people.

We recognise that different cultures exist across partners and agencies in Oldham. To work more effectively around a person and place we need common beliefs, behaviours and expectations. We need a new leadership approach that has its foundations in ‘place’ and is flexible enough to accommodate different spatial articulations of place such as city-region, district or neighbourhood. Figure 1 sets out our vision.

![GM Leadership Framework](image)  
**Figure 1: Our vision for place-based leadership**

It is about enabling our workforce to be ambassadors for Oldham and lead in a way that is about Oldham as a place not just their organisations. It is also about ensuring that we focus on innovation and people-based systems of change. Some of the key characteristics of Oldham leaders that we will develop include:

- Having an understanding of the Oldham ambition and the need for it be delivered in all corners of Oldham;
Having the ability to lead within, and on behalf of, their organisations, systems and places;

- Having an asset-based approach (focus on strengths, not deficits);
- Being adept at understanding and working with evidence, stories and data;
- Ensuring all decisions are informed by professional/clinical information and judgement together with consideration of the consequences for the people and places impacted by those decisions;
- Being democratically astute and champion accountability;
- Building strong connections and relationships;
- Acting with authenticity and integrity;
- Having a deeply-held sense of purpose to create the conditions where people can thrive;
- Connecting with and respect other people's stories and history;
- Resilience, curiosity and being relentless in pursuit of excellence.

### How we will recognise success

In the Foreword, we set out a number of high level outcomes that we expect to have achieved by 2020 following the successful implementation of the Locality Plan.

We currently monitor and measure health and wellbeing performance using outcomes from the following national and local outcomes frameworks and indicator sets:

- Public Health Outcomes Framework;
- NHS Outcomes Framework;
- Greater Manchester-wide health outcomes frameworks;
- The Oldham Health and Wellbeing Strategy;
- The Oldham Plan;
- Oldham CCG Health Inequalities Framework.

We want to assess the impact of the four transformational programmes and the Greater Manchester-wide priorities against the three main areas of:

- Health and wellbeing;
- Clinical sustainability;
- Financial sustainability.

Working through the Health and Wellbeing Board and the CCG, we will identify outcomes that both reflect these three areas and that people in Oldham find useful and fit with their priorities.
Section 2: Transformational programmes

In Section 1 we outlined our vision and described the principles, ways of working, system leadership and the contributions of other sectors that underpin how we do things in Oldham.

In this section we describe the four key programmes of work that are underway to transform health and wellbeing in Oldham and deliver our vision.

<table>
<thead>
<tr>
<th>Transformation 1</th>
<th>Transformation 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establishing an Accountable Care Management Organisation</td>
<td>Mental health is central to good health</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Transformation 3</th>
<th>Transformation 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting Well: Early years, children &amp; young people</td>
<td>Living Well: Action to build resilient communities and provide early help</td>
</tr>
</tbody>
</table>

These programmes fit together to provide action across the lifecourse, from pre-birth to end of life, and to provide action at both the individual and community levels, as shown in Figure 2 below.

![Figure 2: Oldham’s four transformational programmes](image)
2.1 Establishing an Accountable Care Management Organisation

2.1.1 Context

We face growing demographic pressures. Factors driving demand include projected increases in the older population (the 85 and over population in Oldham is projected to increase by 27% to approximately 5,300 by 2021) and an increasing complexity of need as greater proportions of younger and older adults live longer with complex and multiple conditions.

There are also particular local factors that serve to increase the volume and complexity of need for health and social care in the borough. Our Joint Strategic Needs Assessment highlighted:

- The number of people with long-term conditions is high and is expected to continue to increase. About a third of adults report that they have a long-term health condition or disability that limits everyday living. Nationally people with long-term conditions account for half of all GP appointments, seven out of every ten medical hospital beds and £7 of every £10 spent on health and care in England (NHS Forward View, 2014). Variation in relation to long-term condition management is a major contributory factor to the health inequality gap.

- On average in Oldham the number of years of life lived with a disability is 14.6 years for men, and 12.8 years for women, both higher than the national averages which are 10.9 years and 9.2 years, respectively.

In Oldham as elsewhere, cost pressures associated with an ageing population and an increase in the numbers of people with chronic illness, create a need for more accountable and integrated ways to deliver health services. People seeking care frequently require support from a range of different settings – hospitals, primary care, clinics, nursing homes and home care agencies.

Too often each organisational silo faces a different set of constraints and incentives, and consequently each part works to optimise its own performance with little, if any, consideration for other parts in the care delivery system. Duplication and gaps in information and communication result in variable quality of care and high costs. The integration of services across primary, community and social care is a major priority for partners in Oldham and is described below.

Alongside integration and the local transformation initiatives, the CCG is engaged in a programme of work to transform the hospital sector to deliver high quality services, improved health outcomes and the control of health and social care spend. Part of this...
programme is being undertaken at the Greater Manchester level (Healthier Together), and part is being undertaken at a North East Sector of Greater Manchester level, linked to the Pennine Acute Hospitals NHS Trust and Pennine Care NHS Foundation Trust clinical and financial stability programmes. Key challenges are outlined in Section 1.3 for both providers. Appropriate configuration of healthcare services to respond to commissioner intentions will impact on the level of risk associated with health and social care spend in the future.

2.1.2 Towards an Accountable Care Management Organisation

The NHS 5 Year Forward View\(^2\) (2014) strongly encourages localities to develop a shared vision of health and care for their populations and outlines a number of strategic choices. Becoming an ‘accountable care organisation’ has been the ambition of Oldham CCG since its inception\(^3\) and our strategic investments have aligned with this ambition. Within the new freedoms afforded by the NHS 5 Year Forward View, we are progressing our plans for an Accountable Care Management Organisation (ACMO) for Oldham.

The basic concept of an ACMO is a single managed entity with a single, outcome driven contractual framework. In this model, a group of providers come together to take responsibility for providing all care for a given population for a defined period of time under a contractual arrangement with a commissioner. The providers are held accountable for achieving a set of pre-agreed quality outcomes within a given budget or expenditure target. As care providers in England begin to work together to provide more integrated care, many models of accountable care organisations are emerging.

Our ambition is based on the premise that all members share risk and assume accountability for the resources spent caring for the population and the quality of that care. More recently, the CCG has engaged with partners in the Council, and the Health and Wellbeing Board to look at the potential to extend the scope of this ambition across the Borough, to include social care, the prevention agenda and mental health.

The development of the ACMO is a natural extension of the Oldham Primary Care Medical Home (PCMH) model. It will accelerate the pace at which we drive the shift away from a hospital-centred health system to one that is built around strong and efficient primary and community care provision and it will break down the barriers that currently exist between the various segmented parts of the system.

---

\(^2\)NHS Five Year Forward View

\(^3\)CCG in Oldham: A strategy for an Accountable Care Organisation, 2011
2.1.3 Why an ACMO?

The current health and social system is complex, with many competing organisations. The environment is calling for greater collaboration and more connected pathways of care. Commissioners managing providers through contracts has only ever been partially effective. Patients need a structured and effective care pathway that is consistent for all. Connecting the leadership of planning and service delivery into a single integrated organisation will have a much better chance of delivering truly integrated, quality care that is value driven.

The CCG set out how it would achieve its ambition to become an accountable care organisation during the CCG authorisation process (CCG in Oldham: A strategy for an Accountable Care Organisation, 2011). In order to make a difference to the health of our population, we will adopt a strategic approach that:

- Focuses on improving health outcomes and performance;
- Sets quality as the business strategy, and enables professionals to do the right thing within a managed systems framework;
- Is patient- and public-centred, with effective engagement mechanisms in place to enable people to live healthy lives, working closely with Healthwatch and patient voice organisations;
- Strengthens joint approaches with Oldham Council with a focus on prevention and the most disadvantaged;
- Enables patients to make informed choices (shared decision making);
- Is needs-led, with solutions developed by providers, patients and communities;
- Reduces unwarranted interventions (including admissions);
- Is developed using the national and international evidence base;
- Supports innovation.
2.1.4 What is an ACMO?

An ACMO is a new approach to care, which sees the planning of local health services connecting with the planning of social care. We then create a service delivery system that connects all the (mainly out of hospital) services together in order to ensure care is delivered in a seamless way. It is a single organisation that has care service planning, budget management and citizen engagement directly connected to the delivery of primary, community, mental health and social care.

It has a single leadership board that is responsible and accountable to the population of Oldham, to regulatory bodies such as NHS England and, in future, to the devolved Greater Manchester system. We are looking towards establishing a long-term payment system to enable integrated models of care, by defining capitated budget arrangements with specified outcomes, and putting appropriate risk and gainshare arrangements in place. It is not just commissioning and it isn’t just providing, it’s doing both, in a carefully organised way.

The ACMO has primary care as its central delivery focus and it is clinically-led. It may also include social care commissioning and provision, giving it health and social provider partners as part of its structure to ensure borough based delivery and assurance.

The organisation will have two components; the Managed Care Organiser (MCO) and the Multispecialty Community Provider (MCP).

The Managed Care Organiser will be responsible for:

- Planning programmes of care;
- Engineering contracts;
- Planning incentives;
- Regulating supply;

Figure 4: The components of the Accountable Care Management Organisation
• Managing system resilience & performance;
• Patient and consumer engagement;
• Integrated healthcare insight & analytics system.

The Managed Care Organiser will also need to establish contractual relationships with suppliers outside of the ACMO footprint, for acute and other services. If agreed, part of the AMHO budget will be managed through a pooled arrangement with Oldham Council. The extent of this arrangement, and the governance arrangements, are currently being negotiated.

The Multispecialty Community Provider will be:

• A single managed entity encompassing all NHS-funded out of acute hospital healthcare i.e. primary care including out of hours, community care, continuing care, urgent care, and the voluntary sector;
• Regulated through a single outcome-driven contractual framework with clearly defined levels of contribution and reward for providers within the MCP.

2.1.5 What difference will the ACMO make for Oldham patients?

The ACMO model proposed is based on an ethos of no unnecessary waiting, no unnecessary cost and no compromise on quality. Key outcomes will be:

• A minimum standard of access and long-term condition management being delivered in primary care;
• Reduction in the numbers of people admitted to hospital;
• Greater consultant input into the primary care based clinics supporting admission avoidance, particularly for those with specific conditions and the older population, where hospital admission may not be the best place for them to receive care;
• Improved clinical outcomes, performance, and the patient experience of care.

Figure 5 illustrates how the Oldham patient experience will change, providing an increased focus on primary care, technology, self-care and integration.
Figure 6 illustrates how care will be delivered in the ACMO.

Figure 6: Future care management

2.1.6 Managed Care Organiser

The clinical programmes that are currently prioritised are:

- Mental health
- Elective care
- Urgent care (non-elective)
- Primary care
- Cancer
- Children and young people
- End of life care
- Long-term conditions (vascular, respiratory and endocrine).

The mental health clinical programme is described in detail in Section 2.2, as mental health is one of our four transformational programmes. Aspects of the Children and Young People programme are captured in our Starting Well: Early Years transformational programme in Section 2.3. Summaries of the other clinical programmes are set out in Appendix 3.

Oldham CCG and Oldham Council are in discussion about the means by which certain commissioning budgets might be pooled and managed through an integrated commissioning team as part of the ACMO.
Managing our contracts collectively offers opportunities for the two main commissioners in Oldham to identify population needs and priorities and exercise joint influence over the total investment and resources available. It will also help ensure better citizen and service user experience through organisations working in a consistent way and acknowledging the whole system and interdependencies between organisations and services.

Integrated commissioning will focus on ‘productivity of place’ and ‘productive people’. It will balance the need to deliver services at a local/neighbourhood level whilst maximising opportunities for collaborative commissioning within North East Sector, Greater Manchester, regionally or nationally. Working in this way facilitates a ‘One Oldham’ approach to further developing and sharing commissioning skills and competencies.

We have already made progress through the integrated commissioning partnership across the CCG and the Council (see Section 1.6.2). Moving into the ACMO, the pooled arrangements will be focused on areas where we will have maximum impact in respect of outcomes, efficiencies and improved partnership working at all levels of commissioning.

For the Council, key areas that have a joint dimension include:

- Health and Wellbeing;
- Early intervention and prevention (family intervention, mental health, older people, neighbourhoods, carers);
- Community based budgets;
- Employment and skills.

For the CCG, areas that have a joint dimension include:

- Urgent care;
- Mental Health;
- Diagnostics (the prevention agenda).

In implementing a joined-up approach to commissioning there will be a focus on solutions and a commitment to encouraging innovation and creativity. It is important
that all stakeholders challenge traditional approaches and processes for their relevance. The tasks and principles required to apply an integrated commissioning approach to broader activities, including employment, education and housing, will also be considered.

2.1.7 Multi-specialty community provider

The proposed care delivery model to be provided through the MCP, is illustrated below.

Figure 8: Multi-speciality community provider

The integration of services across primary care, community care and social care has been a major priority for partners in Oldham. A significant amount of integration work has already commenced within the Urgent Care Alliance, and through the Better Care Fund. The vision for health and social care services in Oldham will see a radically new system which will combine improvements in people’s experiences, better health outcomes, and better use of the available resources.

Figure 9: Integrated care
The **Oldham Care Vortex** places primary care at the centre of patient care and describes a move away from institutional care towards a managed system of service transformation. This places greater emphasis (including investment) on managing an increasing caseload within communities, closer to the patient. The model (Figure 10) recognises international research and world-class managed care modelling and has guided the thinking, service modelling and service investment profiling in Oldham.

![The Oldham Care Vortex Model](image)

**Figure 10: The Oldham care vortex**

The continuous evolution of primary care in Oldham is the central mechanism for the pursuit of clinical excellence and clinical service delivery within our ‘out of hospital’ sector. Integration of service delivery and coordinated patient care management is central to our Integrated Care Strategy (the Oldham Care Vortex).

We believe that premium primary care is the fulcrum from which most clinical innovations will emerge and thereafter be delivered and regulated. The Oldham Primary Care (patient centred) Medical Home model is a preferred invest-able proposition. Our strategy for investment, development and regulation specifically correlates and complies with the expectations of national policy.

We have already invested £8.5m in primary care over the past 12 months, which gives us a strong platform on which to build our ACMO.

Continuous quality improvement applied to core primary care-based condition management will form the platform by which the bar is raised on service quality and patient experience, and by which health inequalities and secondary demand are reduced. Systematic and industrial scale quality improvement will, over time, contribute to delivering the ACMO strategy. An assurance framework has been established to manage and improve the performance of primary care teams across the borough.

We are transforming our primary care services so that out of hospital health care is seen as the norm, people’s health and social care needs are identified and managed collectively, not in silos, and so that prevention, self-care and independent living are
promoted in all pathways. Shared decision making will form the basis of all consultations to facilitate increased autonomy and behaviour change.

The PCMH places greater emphasis (including investment) on managing an increasing caseload within communities, closer to the patient. To support this, community services have been re-specified and re-tendered to wrap around the primary care medical home offer to ensure provision of joined up assessment and care management across all adult care areas. GP’s will also be given increased access to diagnostic facilities to support the prevention agenda. A particular focus will be given to cancer following the launch of the recent NICE guidelines.

Integrated health and social care core assessment teams, that include GP’s, district nurses, community matrons and social workers, will provide an holistic assessment of need and more seamless journeys for people in need of health and social care. The teams will play an important role in improving A&E performance by undertaking home visits upon referral of people who have been discharged from A&E to assess whether people require further health or social care support, or whether they can be referred to preventative services either at home or within the community.

Extending this integrated approach to include other professional groups will be necessary if we are to respond effectively to demographic change and projected increases in need and demand for treatment and care. Further expansion will include: re-ablement staff, dedicated physiotherapists, occupational therapists, independent prevention officers and trusted assessors.

The diagram below demonstrates the activities in primary care, which the ACMO will undertake.
2.1.8 Governance of the ACMO

The ACMO will have its own defined governance arrangements that are currently being worked through. There are a number of statutory duties and positions that the ACMO will need to take on in its establishment. These duties, responsibilities, roles and resource requirements will be mapped out as part of the programme plan.

2.1.9 Implementation

A significant amount of the strategic planning has already been completed associated with the establishment of the ACMO. The proposed timelines for establishment of the ACMO are:

<table>
<thead>
<tr>
<th>Jan- March 16</th>
<th>Collaborative approach agreed with Oldham Council and provider gear up commences</th>
</tr>
</thead>
<tbody>
<tr>
<td>April-June 16</td>
<td>Provider partner selection process</td>
</tr>
<tr>
<td>July-Sept 16</td>
<td>Delivery model gear up</td>
</tr>
<tr>
<td>Oct 16</td>
<td>Shadow form</td>
</tr>
<tr>
<td>April 17</td>
<td>Formal establishment</td>
</tr>
</tbody>
</table>

2.1.10 Transforming Adult Social Care

Negotiations are currently underway between Oldham CCG and Oldham Council about whether and how the ACMO outlined above will have responsibility for areas of work that the Council currently funds and leads on, and how governance arrangements would work. Areas for consideration include adult social care, Early Help services (Section 2.4) and improving health and wellbeing.

In the meantime, the Council is leading a significant programme of work to transform adult care and support that is aligned with the principles set out in this Locality Plan, focused on:

- Retaining a strong focus on protection and safeguarding;
- Maximising the opportunities within communities and the universal offer in respect of early intervention and prevention;
- Redesigning targeted services and investing in what is proven to work;
- Focusing on independence, re-ablement and recovery - less time ‘in the system’;
- Providing alternatives to a reliance on costly provision;
- Safe, good quality long-term care arrangements delivering the best feasible outcomes;
- Targeted integration of spend and services with NHS and other partners;
- Ongoing review of all activity to better focus on prevention and demand reduction.

Our vision is that adult social care services in Oldham, whether provided by the council, voluntary, community or private sector organisations will intervene early to
prevent, reduce and delay demand for intensive care and support whilst keeping people safe and helping them to live as independently in the community for as long as possible. This is represented in Figure 12 below.

![Figure 12: Vision for adult social care](image)

Key partners in developing and delivering the future model of adult care in Oldham include:

- Citizens
- Oldham Clinical Commissioning Group
- Housing providers
- Health and care providers
- Carers
- Voluntary sector
- Volunteers

In order to realise the vision for social care in Oldham, the Council and CCG are working together to develop and implement different approaches to commissioning and providing social care, taking account of resources, assets, and health and social care needs, all of which vary across localities and neighbourhoods. It is our intention that in future every contact with health and social care professionals will be targeted towards helping people to take control of their lives, be as independent as possible and improve their health and wellbeing.

Our challenge is to develop a whole system approach that will allow the flexible use of resources across Oldham’s health and social care and wider economy to invest in those things that will promote the greatest gains in our population’s health and wellbeing, and in the quality of services.

In line with our co-operative Council ambitions, we will work with service providers, patients, social care customers and their families and carers to develop new delivery
models and we will also collaborate with commissioners in surrounding local authorities to ensure that we have a stable, high quality and cost effective market of care and support providers in Oldham and surrounding boroughs. Elements of this work are underway and we are trialling a number of initiatives in 2015-16 including a Home from Hospital service and Discharge to Assess delivery model to inform future investment.

We will scale up new commissioning and delivery models in 2016. This will include setting the conditions for micro providers to develop and compete effectively for public sector contracts where that will contribute to the council’s and our partners’ strategic priorities, including generating sustainable economic growth and employment opportunities for local residents.

2.1.11 The Transforming Adult Services Programme

The Transforming Adult Services Programme is broken down into four themed areas that align to the vision, along with a fifth theme, core transformation.

The programme areas translate into a series of service-led and strategic projects which in many cases relate to and have interdependencies with the Better Care Fund submission. This was developed to make best use of resources across Oldham’s health and social care economy by protecting vital adult social care services and, perhaps even more importantly, paving the way for more strategic and coherent commissioning across health, social care and other sectors (such as social housing and universal provision).

2.1.11.1 Theme 1: Core Transformation

Within this theme are a number of key strategic projects which are fundamental to delivery of the vision of social care, including:

- the development (by April 2017) of a health and social care integrated locality model – multi-disciplinary teams working at a district level, building stronger links with communities and developing co-ordinated responses.
- the development of integrated services (including physical assets) during 2016 where this will improve outcomes for citizens and create more efficient and effective care pathways
- A strategic review during 2015/16 of the adult social care trading company and all activity to determine future model of delivery and growth opportunities, including review of use of estate and redevelopment/integration/disposal opportunities.

2.1.11.2 Theme 2: Universal

The key focus of projects within this theme is prevention, volunteering, and the provision of advice, information and signposting, and how we engage local communities and the resources within them. Through the stakeholder engagement event held in October 2015 (outlined in the Foreword) we have started a dialogue with local people and organisations about our approach and will continue this engagement as we develop and implement our delivery plans.
2.1.11.3 Theme 3: Early Intervention

We plan to design a targeted prevention model that has at its heart the principles and ethos of Local Area Coordination (LAC) but builds on and redefines existing asset-based activity in Oldham, in order to increase resilience and independence at community, family and individual levels.

There will be one main delivery vehicle for prevention and early intervention across the borough, using a family of asset-based approaches relevant to the specific needs of particular communities (of place, interest, identity, faith etc). This integrated model will bring together Early Help (Section 2.4), Promoting Independence in People (PIPs) and other social prescribing initiatives, with relevant health and adult social care prevention resources, to ensure we deliver good value for money as well as social value.

2.1.11.4 Theme 4: Personalisation and Enablement

The personalisation and enablement theme includes a number of projects including:

- **Extra Care Housing**
  
  A strategic project: Extra Care Housing is working through a number of phases to consider and implement the capital and service development opportunities around ECH, taking into account the needs of people with dementia and young people with autism.

- **Carers**
  
  A Strategic Project to improve our response to carers will include establishing the Co-operative Carers commission, improving information and signposting for carers and promoting the take-up of individual budgets.

- **Reviews of care packages**
  
  We have implemented a consistent, evidence based approach to reviews of current packages of care, with a focus on strengths and co-operative principles. This will be strengthened and extended to include learning disability and mental health services during 2016/17 as we develop more integrated services.

2.1.11.5 Theme 5: Protection

The protection theme is concerned with transforming those services at the acute end of the care pathway, including the implementation of an integrated approach to commissioning supported living for adults with learning disabilities, and the development of an incentivisation model for ongoing re-ablement by home care providers.
2.2 Mental health is central to good health

In this section we describe our approach to mental health. Physical and mental health are closely connected: there is "no health without mental health". Recognising deficiencies in mental health service provision, NHS England established the ‘Parity of esteem’ programme that aims to ensure that when citizens become unwell, they are able to use services that assess and treat mental health disorders or conditions on a par with physical illnesses.

Good mental health is also vital to achieving sustainable economic growth, improving educational attainment, productivity and employment rates, reducing dependency on welfare benefits, and reducing crime and antisocial behaviour.

The ACMO, described in Section 2.1, will be responsible for the planning and provision of mental health services, ensuring treatment and prevention pathways are in place.

We seek to outline a comprehensive, strategic approach to addressing mental health in Oldham that includes promoting good mental wellbeing, tackling stigma, preventing poor mental health, actions to promote recovery, and developing the workforce to support these.

Our approach must take into account:

- The wider factors that can lead people to become unwell;
- The full range of assets and resources available and how they might be deployed to help people to recover;
- Routes into meaningful activity such as volunteering, education, training and employment that contribute to sustainable recovery.

Access to quality data on the needs of the population through the Joint Strategic Needs Assessment (JSNA) is invaluable in supporting the CCG and Local Authority to design and plan our public mental health and wellbeing strategies. This will include a Mental Health Impact Assessment (MWIA) to measure the impact of current public services and activity on public mental wellbeing to inform future action.

The strategy will also depend on a good understanding of our local demographics and economy and in particular it will have to take account of the way Oldham is affected by socioeconomic inequalities in health.
The strategy will be aligned to other areas of strategic development work including: adults with learning disabilities; children, young people and adults with autism; special educational needs and disabilities (see Section 2.3.5); and dementia.

### 2.2.1 Developing a mental health strategy for Oldham

A local Mental Health Strategy Partnership Group, with membership of Oldham Council, Pennine Care NHS Foundation Trust (PCFT) and NHS Oldham CCG, has recently been refreshed with new terms of reference for developing local strategic partnership approaches to improving Mental Health outcomes in Oldham. It is proposed that this group will lead the development of a strategy for Oldham and will expand to include wider partners including housing, North West Ambulance Service (NWAS) and a number of voluntary and third sector organisations currently providing services in Oldham. The governance arrangements for this group are outlined in the diagram below:

![Figure 13: Governance arrangements for mental health in Oldham](image)

We will need to commission mental wellbeing programmes / interventions together and share budgets between the CCG, Council and other partner organisations with a mutual interest and an incentive to make savings for reinvestment, covering:

- Direct service provision for people currently experiencing or recovering from mental health problems or mental illness;
- Effective early intervention for people at high risk of such illnesses or in the early stages of them;
- Practical measures to prevent mental illness;
- Approaches to increase public understanding of mental health and mental illness and so combat stigma;
- Promotion of good health overall.
In light of the partnership approach that is required for improving mental health outcomes and the need to tackle the wider determinants of mental health, it is proposed that the strategy includes engagement with broader partners including housing, private and public sector employers, education, and voluntary, community and faith organisations. Coordinating and developing engagement mechanisms with these partners through the Health and Wellbeing Board will be essential for achieving our aims.

The strategy needs to capture and build on the best of the mental health services that have developed locally over the years. It will aim to join up the knowledge and experience of the professionals involved with the wealth of experience represented by people who have used mental health services over the years, and their families and friends.

The strategy is most likely to be effective if it is co-produced with people who have experienced mental ill health, their families and carers. Discussion with these groups will take place at an early stage and throughout the development of the Oldham strategy, possibly through the establishment of a reference group. A wider stakeholder engagement plan will also be developed.

The strategy will take an all-age approach covering the whole of the lifecourse from the very early years to old age. A strategy for Children and Young People has already been developed and is described in Section 2.2.3.5 below. Therefore, the main focus of development of the strategy will be on adults: Living Well and Aging Well. However, it is important to recognise commissioning and delivery issues that may arise at the transition from the children and young people’s strategy into the adult strategy.

It is proposed that a key focus of the strategy will be on the development of community capacity and peer support as part of the delivery of wider community resilience and support (see Section 2.4). This will support the achievement of the partnership’s co-operative aims by helping to prevent, reduce or delay demand for health, social care and other intensive interventions and helping people to maintain their recovery with a network of appropriate support in the community.

There is a strong relationship between mental ill-health and the misuse of drugs and alcohol and therefore our strategy will also be closely aligned to the action we are taking across Oldham to reduce substance misuse.

In addition, a key area of focus in the Greater Manchester mental health strategy that we will also take forward in Oldham is action to challenge stigma in communities and amongst professionals and employers. We will lead a public conversation to change the understanding of what mental illness is, how common it is and how to relate to people with mental illness. This will build on our successful work on a dementia-friendly Oldham.

2.2.2 Current and future programmes of work

Our approach to mental health covers three broad themes:

- Prevention and early intervention;
- Treatment and care;
- Recovery and relapse prevention.
Below we provide a brief outline of the current and future programmes of work, aligned with the above themes where possible. These will be developed for Oldham in line with regional and national priorities, and should be seen against a background of continuing efforts to maintain a routine high quality of care of people with common and more severe forms of mental illness.

It should be noted that the programmes of work do not necessarily fit in to one theme – for example, IAPT, early help offer and voluntary sector work would be representative across all three themes.

2.2.3 Prevention and early intervention

2.2.3.1 Early Help Offer

The Early Help Offer (see also Section 2.4) is an initiative of Oldham Council and is proposed as an important mechanism for reducing demand and supporting prevention and early intervention in mental health services. The cost of a future investment target of £600k from mental health budgets for the Early Help Offer has been funded by the council during 2015/16, whilst the impact of the Early Help Offer on demand for mental health services is assessed.

The investment works on the premise that by working with people at an early stage and with those who are already in secondary care who are able to stay in recovery, some clients will be diverted away from costlier specialist services. Referrals from secondary care are being made into the Early Help offer and a more thorough analysis of referral pathways is underway. A set of key performance indicators is also being developed to establish whether reductions are being achieved and mental health outcomes are improving following intervention from the service. The Mental Health Strategy Partnership Group will monitor the mental health outcomes achieved by the Early Help Offer.

2.2.3.2 Improved Access to Psychological Therapies (IAPT)

In October 2014, NHS England and the Department of Health jointly published ‘Improving access to mental health services by 2020’. This document outlines a first set of mental health access and waiting time standards for introduction during 2015/16 and sets out an ambition to introduce access and waiting time standards across all mental health services between 2016 and 2020. NHS England published in February 2015 the new ‘Guidance to support the introduction of access and waiting time standards for mental health services in 2015/16’ which outlines the required improvements towards meeting the first of these standards.

A service specification for improving access to psychological therapies (IAPT) in Oldham has been developed following a CCG-led review of existing elements of the IAPT service. The review has been undertaken within the context of the 2015/16 National Planning Guidance, and the mandatory targets on access, recovery and waiting time standards.

The CCG Governing Body agreed that the CCG would continue to commission Pennine Care NHS Foundation Trust for IAPT services in Oldham. However, through a redesign process that has effectively mirrored a procurement process, the Trust has made a proposal as to how the service will deliver against the new specification.
The new model is designed as a ‘Primary Care and Mental Wellbeing’ service, delivering ‘core IAPT’ (step 2-3) interventions as per the national model and local service specification, with a range of step 1 services offered to support clients at the sub-IAPT threshold as a ‘wrap-around’ to the core service. This provides wellbeing and social inclusion activities, pre- and post-therapy support to help sustained recovery, public awareness campaigns and community resilience.

The service will include partners agreed through an Integrated Pathway Hub (IPH) delivery model (see Section 2.2.3), the terms of which to be developed through an agreement prior to service commencement.

The new service model has been approved although sign-off is subject to further work to better understand how return on investment will be delivered through this additional investment in early intervention. There is further work on-going to determine a service level breakdown of the existing block contract funding with Pennine Care NHS Foundation Trust.

The CCG is awaiting confirmation of the 2016/17 allocations, tariff inflation and impact of Greater Manchester devolution, so whilst there is an overall intention to identify additional recurrent funding for service improvement, any investment at this stage would be made ‘at risk’.

The planned service commencement date is 1st April 2016.

2.2.3.3 Voluntary Sector Provision

Oldham Council commissions Tameside and Glossop Mind to provide an Independent Mental Health Act Advocacy Service and the council holds a contract with Keyring, a charitable organisation, to support vulnerable adults, including adults with mental health problems, in their own homes.

The voluntary and community sectors in Oldham will, in future, play an increasing role in enabling people who experience mental health-related difficulties to live as independently as possible in the community and reduce demand on more intensive mental health services. This may entail commissioning new services and will certainly include making sure that the wide range of voluntary services already available in Oldham are better able to engage with and support people who experience mental ill-health.

2.2.3.4 Public mental health approaches

Public Mental Health forms part of our comprehensive approach to mental health. This will be evidence based and will take a life course approach with the aim to improve mental health by tackling the wider determinants of mental health and thus lowering the personal and social costs of mental ill health through activities that target the causes of mental ill-health.

There is good evidence for interventions that reduce the burden of mental health disorders, enhance mental wellbeing and support the delivery of a broad range of outcomes relating to health, education and employment in Oldham.

Key to improving mental health is leadership and a skilled workforce to drive prevention, early intervention and recovery. Skilled and knowledgeable individuals within different statutory, private and voluntary sector organisations are essential to
shift the culture and improve mental wellbeing by working together. This can be strengthened by creating links between public health and wellbeing services across health and social care. As a consequence, both individual services and organisations will be able to use national policies, guidance and reports to drive mental wellbeing actions across Oldham.

Additionally, we will lead on a community asset-based approach to explore people's understanding of mental health and what needs to change. This will build on our successful work on dementia-friendly Oldham and will support actions across Greater Manchester to tackle stigma associated with mental health. This approach will develop our knowledge and identify the most appropriate interventions to support individuals and communities to access interventions and recover more quickly from mental illness.

We will deliver on a number of programme areas to support a public mental health approach. These include:

- Public health leadership and workforce development;
- Improving working lives, including supported employment and creating health environments for people with mental health problems;
- Improving quality of life through increasing opportunities for participation, personal development and problem solving that enhance control and prevent isolation;
- Interventions to prevent mental illness, including actions on suicide, violence and abuse;
- Tackling alcohol and substance abuse including direct measures with those abusing alcohol and screening programmes;
- Community empowerment and interventions that encourage improvements in physical and social environments, and strengthen social networks (see Section 2.4);
- Tackling stigma and discrimination against people with a mental illness;
- Technologies and innovation to support mental health promotion and prevention.

We propose to produce or refresh the Joint Strategic Needs Assessments for a number of areas relating to mental health including: adult mental health (including BME and veterans), drugs and alcohol; autism; learning disabilities; children’s mental health; and dementia.

### 2.2.3.5 Children and young people’s mental health

In Section 2.3 we outline our approach to Starting Well, ensuring children and young people get the best start in life.

The emotional wellbeing of children and young people is vital to Starting Well and we need to commission and deliver the most appropriate mental health services so that children and young people receive timely, integrated care and support, in the most appropriate setting, to ensure that they develop and grow into strong, resilient adults.

This recognises that:

- Early intervention can prevent ill-health and reduce mortality and morbidity for children and young people;
Healthy behaviours in childhood and the teenage years set patterns for later life;
Continued support for children and young people can mean that society as a whole can reap all the benefits of a resilient next generation, which is healthier and happier;
Adult mental illness may be preventable with appropriate interventions in childhood;
Research indicates that half of lifetime mental health problems start by the age of 14;
Social and emotional wellbeing creates the foundations for healthy behaviours and educational attainment. It also helps prevent behavioural problems (including substance misuse) and mental health problems;
Good mental health allows children and young people to develop the resilience to cope with whatever life throws at them and grow into well-rounded, healthy adults.

The Council and CCG jointly re-established the Emotional Wellbeing and Mental Health Partnership for children and young people across Oldham in January 2014. The Partnership has met regularly and has strong, consistent representation from partners across Oldham.

An Emotional Wellbeing and Mental Health (EWMH) Strategy has been developed. This is supported by a comprehensive three-year action plan with priorities grouped under five themes:

1 Commissioning budgets/resources: Ensure services that are commissioned and provided are child, young people and family focussed and meet their needs;

2 Access and pathways: Ensure timely, effective and accessible services that are cost effective; Encourage and increase liaison with service users to enable children and young people to directly shape and influence the provision they receive;

3 Improving service quality: measure outcomes and be evidence-based when commissioning/developing/redesigning services;

4 Prevention and early intervention;

5 Workforce development: Ensure properly structured care, delivered by professionals who care and are motivated to work to the highest standards; recognise that mental health is ‘everyone’s business’; strengthen relationships and support partnership working.

Progress and delivery of the plan will be monitored by the Emotional Wellbeing and Mental Health Partnership (EWMHP) and reported through the Council’s Best Start in Life Partnership.

Guidance has been issued to local CCGs for them to work together with local partners to enable the transformation of services to support children and young people’s mental health and wellbeing. Oldham CCG, jointly with the Council, has submitted a Children and Adolescent Mental Health Service (CAMHS) Transformational Plan to NHS England. This five-year plan will link strongly with the EWMH action plan detailed above, and will allow some of these actions to progress.
Implementation of the CAMHS Transformational Plan will focus on:

- Building resilience, promoting good mental health and wellbeing, prevention and early intervention;
- Addressing the needs of all children and young people including the most vulnerable (i.e. looked after children, care leavers, those within the youth justice system, those with learning disabilities), making it easier for them to access the support they need when and where they need it;
- Promoting equality and addressing health inequalities;
- A five-year vision;
- Delivering a clear joined-up approach, with clear pathways;
- Improving transparency and accountability.

The CCG will receive recurrent funding (once development and assurance of local transformation plans is attained) to the value of £138,184 specifically for delivery of an enhanced eating disorder service and £345,888 to improve perinatal care.

Additional investment for the Emotional Wellbeing and Mental Health of Oldham's young people has been identified from both the Council and the CCG:

- Council funding into early prevention and intervention of young people’s emotional wellbeing has been re-invested into the new Early Help Offer (EHO) (see Section 2.4) which seeks to intervene at the earliest possible point and prevent problems from escalating, as well as providing a ‘step down’ offer from specialist and crisis response services;
- The CCG has identified additional investment and has commissioned Tameside, Oldham and Glossop Mind to deliver a programme of activities across Oldham schools until March 2017. They have also identified significant additional investment in 2015/16 to re-specify the Tier 3 CAMHS specification.

Oldham is committed to ensuring that mental health promotion activities and interventions should be developed and directed at the most vulnerable groups, including reducing structural barriers to mental health, promoting social inclusion and improving resilience of the population. We are working towards implementing the mental health standards framework within schools including:

- Oldham Council identified preferred provider to deliver revised school health advisor’s service specification, with health needs assessments in schools being undertaken.
- Specialist mental health school advisor commenced in post acting as a conduit between schools and service providers.
- Named lead approach developed and mental health standard frameworks introduced into schools.

2.2.4 Treatment and Care

2.2.4.1 Dementia Diagnosis and Post-Diagnostic Support

Dementia is one of the key programmes of work at the Greater Manchester level ('Dementia United'). A central team made up of stakeholders from the ten localities is
developing a set of core components for localities to include in their dementia programmes, and is developing a five-year dementia programme for Greater Manchester.

In Oldham, the CCG and the Council’s public health team have worked closely to improve dementia diagnosis rates and improve the post-diagnostic support service provision in Oldham. The CCG and Council have jointly commissioned an ‘Enhanced Memory Service’ which includes several provider partners working together to deliver diagnosis and post-diagnostic support for people diagnosed with dementia and their families and carers. As the main provider of specialist clinical services for dementia, Pennine Care NHS Foundation Trust staff have worked closely with Public Health and the CCG to improve and expand the memory clinic service and address the range of secondary demands for service that it generates.

Further focused working is required to reduce the rates of anti-psychotic prescribing in people with dementia in Oldham. A work plan has been developed to take forward actions in both primary and secondary care to reduce the numbers of patients with dementia who are on antipsychotic agents.

It has been identified that more work needs to be undertaken to ensure that dementia services are provided equitably across the borough, i.e. to currently under-represented groups such as people of black and minority ethnic (BME) heritage. Further BME engagement and development of services to ensure an equitable standard is in place is required not just for dementia services, but across mental health service provision overall.

2.2.4.2 Early Intervention in Psychosis

Plans are in development between the CCG and Pennine Care NHS Foundation Trust to ensure new national targets are met in relation to Early Intervention in Psychosis in 2016/17. More than 50% of people experiencing a first episode of psychosis will be treated with a NICE-approved care package within two weeks of referral.

The CCG and PCFT will need to agree the delivery model for the Early Intervention Teams in order to:

- Meet the access and waiting time standards;
- Provide the full range of pharmacological, psychological, social, occupational and educational interventions for people with psychosis;
- Strengthen crisis contingency planning to reduce the need for access to unscheduled care.

2.2.4.3 Rapid Access Interface and Discharge (RAID)/Psychiatric Liaison

The CCG has committed to commissioning a RAID service made up of three elements to build upon the existing limited provision from the Access and Liaison teams already in place:

- A&E liaison practitioners providing 24/7 cover to Royal Oldham Hospital A&E department, conducting mental health assessments within two hours of a patient being admitted;
• Alcohol liaison practitioners working within Royal Oldham Hospital A&E department and on hospital wards to assess people with alcohol misuse problems to provide effective interventions;

• Older people’s liaison practitioners working in Royal Oldham Hospital wards to provide mental health assessments to people aged 65 and over to ensure their needs are being met.

The CCG is working with both Pennine Care NHS Foundation Trust and Pennine Acute Hospitals NHS Trust to gather evidence of the intended outcomes from the service, including reductions in the number of admissions and re-admissions, reduced lengths of stay associated with co-morbid mental and physical disorder, and reductions in the need for residential care.

2.2.4.4 Crisis Care Concordat & Working with Police to Reduce Demand

The CCG has commissioned a Street Triage service in Oldham that supports people that have suspected mental health problems who come into contact with police, by providing advice and support to police officers who are working with them. This consists of one additional nurse practitioner working with the A&E RAID team at any given time.

A Crisis Care Concordat action plan has been drafted and is being managed through the monthly Police Partnership Board. The actions are divided into the following broad themes:

• Commissioning to allow earlier intervention and responsive crisis services;
• Access to support before crisis point;
• Urgent and emergency access to crisis care;
• Improved quality of response when people are detained under Section 135 and 136 of the Mental Health Act;
• Quality of treatment and care when in crisis;
• Recovery and staying well/prevention of future crisis.

The CCG is looking to strengthen its crisis care service provision in Oldham by working with third sector providers to develop a 24/7 helpline for people who may be experiencing a crisis and need help and advice at any time of the day or night.

Furthermore, the CCG is looking to develop the provision of a sanctuary-type, non-bed based facility with a view to offering support during the night for the vulnerable person in a crisis that does not require medical intervention. The plan is for this development to be included in the CCG’s Commissioning Intentions for 2016/17.

2.2.4.5 Psychological Medicine/Liaison Psychiatry

Services for people with a combination of mental and physical health problems have been developed in Oldham over the past 15 years and are now delivered in a number of ways, including inpatient and outpatient settings within the Royal Oldham Hospital and the community based Pennine Musculoskeletal service. Recent investment from NHS Oldham CCG has supported a modernisation of the service for people with chronic pain, and an initiative to improve the care of people with similar problems in general practice settings. Discussions on improvements in perinatal mental health
services in Oldham are also progressing well, following a successful pilot project. Our liaison psychiatry services are now recognised as setting a national standard.

### 2.2.4.6 Adults with Learning Disabilities

Oldham has a well-established Learning Disability Partnership Board that is currently overseeing the development of the Oldham Learning Disability Strategy. The document, which is at an early stage in its development, will be co-produced with learning disabled people, their families, carers and groups that represent their interests and will set out our collective strategic aims, aspirations and commissioning intentions.

Whilst we have some high quality local health and social care provision for people with learning disabilities and we are making good progress in developing supported living options we must improve our performance in terms of smooth transition from children’s to adult services, creating viable employment opportunities and bringing people with learning disabilities back into the borough from external placements.

It will also be important to work with neighbouring councils to develop high quality cost-effective local provision for people who have complex and multiple support needs, including individuals who exhibit challenging behaviour.

The joint commissioning strategy for people with learning disabilities in Oldham will need to ensure that it aligns with the Greater Manchester principles of reform, developed through the Greater Manchester Transforming Care Fast Track Plan. Oldham, along with the nine other boroughs in Greater Manchester, will be responsible for the implementation of change for people with severe learning disabilities and/or autism who have complex support needs (including mental health) – to reshape services away from institutional models of care, closing some inpatient provision and strengthening support available in the community. Additional national funding has been provided as part of the Fast Track implementation fund, and Oldham CCG and Council will contribute to the plan through commissioning and case management support, mapping existing provision and helping provide extra support options for service users, families and carers.

### 2.2.4.7 Adults with Autism

The Oldham ‘Autism Way Forward’ partnership board has recently revised its terms of reference and membership and is guiding the development of our updated Autism Strategy. The group, which comprises representatives of the council, CCG and voluntary sector agencies, as well as people with autism and family members/carers, is taking a whole system approach to raising public awareness and developing service responses to people who are on the autistic spectrum.

We are taking account of national policy developments and the council’s powers and duties under the Care Act 2014 as we develop local approaches to ensure that people with autism get the information, advice and support they need to have equal life chances and achieve better outcomes.
2.2.5  Recovery and Relapse Prevention

2.2.5.1 Adult Mental Health Social Work

For many years the council’s mental health social workers have been co-located with Pennine Care NHS Foundation Trust staff and whilst they remain employed by the council they report to managers employed by the Trust who allocate and oversee their work and provide line management support.

The Trust reformed its operating model (for the delivery of mental health services to adults under 65 years of age) earlier this year following consultation with stakeholders (including the Council) and staff. The Trust now operates the following services:

- Assessment and short term intervention;
- Active care coordination, complex case work;
- Clinical & treatment service, pharmaceutical administration, monitoring, physical health and GP liaison and support;
- Care management, short-term intervention, and commissioning of services;
- Borough-wide services: recovery, employment, education, occupation therapy service.

A reduction in the handover of cases between teams will improve patient/customer experience and outcomes, which in turn should, over time, generate further efficiencies.

The council is working with Pennine Care NHS Foundation Trust to review and consolidate the current arrangements to improve performance in the short- to medium-term. Longer-term, it is likely that the Council will establish a Section 75 agreement with the CCG, with one agency taking the lead for commissioning mental health services in Oldham. This approach will pave the way for the introduction of the Accountable Care Management Organisation outlined in Section 2.1.

2.2.6 Joint commissioning plans

We have a number of activities in place to support joint commissioning and these are outlined below.

2.2.6.1 Integrated Pathway Hub (IPH) Model

The IPH model is a proposed arrangement whereby, with appropriate safeguards, a mental health programme budget will be devolved to Pennine Care NHS Foundation Trust (PCFT) by NHS Oldham CCG. A work plan is in development to agree joint and shared objectives with regards mental health programme budgeting. The aim is to provide a full complement of integrated mental health services, enabling appropriate utilisation of commissioned services and the prospect of making savings that can be invested elsewhere in the mental health care pathway. The IPH will be developed in the form of a ‘Prime Provider’ contract model, with PCFT responsible for contracting, performance and quality monitoring arrangements with other providers of mental health services in Oldham.

The framework for the IPH and working relationship between NHS Oldham CCG and PCFT acting as the IPH is to be developed over the coming months with anticipated
commencement in April 2016. This may take the form of a phased implementation. The framework will set out to:

- Capture the vision and way forward;
- Set out aims and intended outcomes;
- Outline roles and responsibilities;
- Identify mutual concerns and establish processes to address these;
- Outline how the project relates to other partnerships;
- Establish the guiding rules and processes;
- Establish commitment and contribution from all key partners.

2.2.6.2 Section 75

In May 2015 ICP members were provided with several options to develop a revised partnership agreement between the Council and CCG for provision of mental health social work services in Oldham.

The recommended proposal was for the Council and CCG to enter into a Section 75 Agreement that would see one organisation (most likely the CCG) taking on the role of lead commissioner for mental health services in Oldham. Further meetings between health and social care commissioners are underway to discuss the detail of the Section 75 and plan for taking this forward.

2.2.6.3 Better Care Fund

The CCG and Council have a Section 75 agreement in place already to manage the Better Care Fund programme. Any further agreement reached in terms of mental health partnership working could be formalised as a schedule to this existing arrangement.

2.2.6.4 Bilateral Standard Contract

Oldham CCG has entered into a bilateral standard contract arrangement with PCFT in 2015/16 for mental health services. This agreement has been reached to enable a greater focus on the mental health needs of the Oldham population. The bilateral contract arrangement allows for greater control with respect to contract variation and allows for greater flexibility in terms of contracting arrangements with PCFT than previously through the multilateral arrangement.

2.2.6.5 Development of Greater Manchester Access and Quality Standards for 2016/17

In order to ensure ‘parity of esteem’ remains central to the integrated care model, an initial Mental Health KPI focus group drawn from the Greater Manchester Joint Mental Health Commissioners and Providers Forum was facilitated by NHS England on 13th April 2015 with a subsequent workshop on 25th June 2015. The events were attended by mental health commissioners, the Greater Manchester Commissioning Support Unit, and leads from Pennine Care NHS Foundation Trust, Manchester Mental Health and Social Care Trust and 5 Boroughs.
The task of the group was to review the current Greater Manchester-wide KPIs and revise these to form the basis for a new set of Greater Manchester Mental Health standards. A consensus position has been reached on a common understanding of core Mental Health Access and Quality Standards in line with national priorities.

### 2.2.6.6 Assessment of commissioning/market map/patient flows

As part of the developing Mental Health strategy a market mapping exercise needs to be undertaken, to fully identify what the CCG and Council are commissioning separately and what is being commissioned jointly. This will identify duplications and gaps in service and inform the strategy accordingly.

### 2.2.7 Conclusion

The local Mental Health strategy in Oldham will need to adopt the key principles that are coming out of the Greater Manchester discussions, namely:

- Increasing pace and scale of public sector reform;
- Maximising local solutions within a Greater Manchester vision and framework;
- Collaborative and aligned commissioning.

The adoption of these principles will ensure that mental health services in Oldham are equipped to:

- Strengthen individual and community resilience;
- Respond to increasing demands;
- Respond to changing demands;
- Tackle unmet needs;
- Provide the right care, at the right time, in the right place;
- Provide value for money.

Oldham’s strategic approach to Mental Health will work on the current developments as outlined in this plan, strengthening partnership arrangements to ensure an on-going focus on mental health and wellbeing as central to good health, on par with physical health, and looking beyond mental health services into wider public services and our society as a whole.
Starting well was given the highest priority among the six policy objectives identified by Sir Michael Marmot in his review of health inequalities (*Fair Society, Healthy Lives* 2010):

"Disadvantage starts before birth and accumulates throughout life. Action to reduce health inequalities must start before birth and be followed through the life of the child. Only then can the close links between early disadvantage and poor outcomes throughout life be broken".

Children and young people under the age of 20 make up 27.6% of the population of Oldham and 39.7% of school children are from a minority ethnic group.

As highlighted in Section 1.2.1, we have a number of health and wellbeing challenges among our children, in particular poor oral health and high rates of obesity. We also have wide variations in early education outcomes between groups of children and across the borough: in 2015, 43% of children in Oldham were assessed as not reaching the expected ‘good level of development’ measure at the end of the reception class year. This makes them less likely to succeed in Year 1 and beyond.

### 2.3.1 Right Start Core Service (0-5)

In order to tackle inequality and create opportunity, Oldham has committed to move from fragmented services and multiple separate assessments that can miss the wider factors influencing a child’s development, to a **Right Start Core Service** that will provide:

- A ‘whole child’ and ‘whole family’ approach for families with young children from conception to five years;
- An integrated and progressive series of eight assessments timed around crucial child development milestones, supported by specialists and the use of technology to increase face time with children, young people and families;
- Universal and additional evidence-based targeted services proven to be effective and good value for money.

---

4 Targeted services are usually put in place where there are concerns about a child’s progress in learning and development; health and wellbeing; behaviour and attendance; or when parents and carers are experiencing difficulties that are impacting on their parenting.
The aim is that ‘children are developing well and ready for school’. To achieve this, Right Start will work closely with schools and other early years providers at a leadership and operational level to plan and deliver services for parents and children, particularly at points of transition, to sustain children’s progress and improve overall achievement.

There will be a direct link with the Early Help Offer (Oldham’s ‘troubled families’ programme) (Section 2.4), the purpose of which is to improve households’ physical, social and emotional wellbeing so that they do not need ongoing support from crisis and specialist services. This will ensure early identification of need and appropriate preventative work, which in the longer term should reduce the demand for high cost services.

The Right Start team will deliver:

- The Healthy Child Programme (0-5);
- The Children’s Centre core purpose;
- Family Nurse Partnership;
- Oral health plan;
- Speech, language and communication needs.

### 2.3.1.1 Family Nurse Partnership

The Family Nurse Partnership (FNP) is a preventative programme for young first time mothers under the age of 20 years. It offers intensive and structured home visiting, delivered by specially trained nurses, from early in pregnancy until the child is two years old. At the heart of the programme is the relationship between the nurse and mother which enables the most at risk families to make changes to their health, behaviour and emotional development and form a positive relationship with their baby. The FNP also includes parenting groups to support young parents to promote their child’s development and to achieve effective behaviour management.

In Oldham there are currently four family nurses plus a supervisor enabling a case load of 100 families. FNP in Oldham started in 2014 and has so far recruited 78 families.

### 2.3.1.2 Oral Health Plan for under 5’s

Oral health in children under the age of five has been identified as a priority by the Oldham Health and Wellbeing Board. The latest oral health survey of five-year old children (published September 2013) found that approximately 48% of five year olds in Oldham had experienced dental decay. This was the second worst in England with the average of 2.1 decayed teeth per child. The causes of dental decay are linked to low levels of breast feeding, poor weaning practices and poor family nutrition, which are all underlying causes of obesity.

A challenging target has been set to reduce the prevalence of children with any dental decay from 48% to 38%, which would bring the oral health of children in Oldham in line with the North West average.

A three-year action plan has been developed that identifies the following priorities:

- Establishing an Oldham-wide culture that supports and values oral health;
• Increasing the number of under 5’s in Oldham who attend a dentist;
• Increasing the number of children under five who have a fluoride varnish applied to their teeth;
• Reducing the numbers of children under five who are subject to prolonged bottle feeding / use;
• Reducing the number of children who are drinking sugary drinks, particularly from a bottle;
• Increasing the numbers of children who are brushing their teeth twice a day, and particularly before bed;
• Increasing exposure to fluoride;
• Supporting the infant feeding strategy;
• Robust commissioning of oral health improvement resources with a focus on children under five.

A task and finish group has been established to coordinate the actions, and a project implementation group has been set up with representation from the oral health promotion team, health visitors, children centres, and the Council’s communications and policy teams.

2.3.1.3 Speech, language and communication need (SLCN)

There is clear evidence that without robust speech, language and communication skills children will struggle to learn, achieve, make friends, access the curriculum and develop the skills for work and life. Speech, language and communication need (SLCN) is one of the most common childhood disabilities. Depending on the criteria adopted, estimates indicate that as many as 10% of all children have SLCN and in areas of social deprivation more than half of the children starting nursery school have communication and language skills that are poorly developed.

It is Oldham’s aspiration that all children will enter primary school with age-appropriate speech, language and communication skills. Therefore, we are committed to ensuring that SLC needs are assessed through the Right Start framework and that children are encouraged to access appropriate support and intervention, including taking up a place in an early years setting.

We recognise the need for strategic planning and for a continuum of commissioned universal, targeted and specialist services to achieve our aspiration. The ten Greater Manchester authorities have worked in partnership to develop an Early Years New Delivery Model (EYNDM) to ensure all our children in Greater Manchester have the opportunity to achieve their full potential. This will be achieved through a preventative and early intervention approach to supporting SLCN that focuses on the ‘whole family’.

2.3.2 Other early years’ services

There are a number of services that sit outside the Right Start programme that influence child health and development.
2.3.2.1 Antenatal care and antenatal & new-born screening

In Oldham, we know that women within the St Mary’s, Coldhurst, Werneth, Chadderton South, Saddleworth North, West and Lees wards are booking late (beyond 12 weeks of pregnancy) into antenatal care programmes and work is underway to promote early booking, focusing on care delivery touch points, including Children’s Centres. Research has found that in Oldham, women from black and minority ethnic groups are more likely to present late and as a result community midwives are proactively encouraging women in those communities to come forward.

Pennine Acute Hospitals NHS Trust is planning an in-depth process review of antenatal booking pathways across all sites in order to identify bottlenecks and learn from what is working well.

There are six antenatal and newborn screening programmes:

- Fetal Anomaly and Down Screening programmes;
- Infectious Disease in Pregnancy;
- Sickle Cell and Thalassemia;
- Newborn blood spot;
- Newborn hearing;
- Newborn and Infant Physical Examination Screening.

These programmes are delivered by maternity services and for most Oldham women this will be at Royal Oldham Hospital. Performance is good across all programmes.

2.3.2.2 Smoking at time of delivery

The prevalence of women smoking during pregnancy in Oldham is 14%, slightly below the national target of 15%. Actions to reduce the prevalence further include:

- Participation in the Greater Manchester-wide Supporting a Smokefree Pregnancy Scheme (SaSFPS). The scheme provides enhanced support to those women who have set a quit date and achieved a 4-week quit. The aim for the pregnant woman is to remain smokefree throughout the pregnancy and for 12-weeks post-partum using carbon monoxide (CO) screening at each 4-weekly contact meeting as a motivational tool. A Love2Shop gift card is given as a reward for each 4-week period that the woman remains smokefree, validated by CO screening;
- The Early Help programme (see Section 2.4) delivers stop smoking support and has specific KPIs relating to smoking in pregnancy. Numbers are low but Early Help is still in its infancy and is being monitored quarterly;
- Early Help is supporting the delivery of stop smoking training to staff working in the Maternity service;
- Pennine Acute Hospitals NHS Trust has set up a Young Parents team. It is aimed at females under 20 with referrals made from community midwives and as part of their offer they will be addressing smoking and family planning.
2.3.2.3 Infant mortality

Infant mortality provides an important measure of the wellbeing of infants, children and pregnant women. It is also of interest to service planners, as it is seen as an important measure of the overall health of a population.

Every year in Oldham there are on average 17 infant deaths. This measure refers solely to deaths which occur to babies born alive, but who die within the first year of life. Over recent years the trend in Oldham has been downwards.

Detailed analysis covering the period 2004-2009 found that the highest infant mortality rates in Oldham were within the 20% most deprived wards. Action to reduce infant mortality will be a priority for the Better Start in Life Partnership, including reducing the number of babies with low birth weight.

2.3.2.4 Consanguinity (blood relatives)

The mortality and morbidity rates in Oldham in relation to autosomal recessive disorders linked to consanguineous relationships (relationships between people who are blood relatives) are higher than the national rates.

A specialist genetic counselling and training & workforce development programme has been commissioned by Oldham Council. The programme will undertake community-based information and intervention work with target communities and support the training of professionals in order to increase the uptake of universal services.

The programme will employ a community development worker and a genetics counsellor with the appropriate language skills to discuss genetic risk with families and provide training and information for professionals. This pilot programme runs for three years from 1st January 2016 and will be funded via the Better Care Fund. The programme will report to the Integrated Partnership Board.

2.3.2.5 Routine childhood immunisations 0-5 years

Oldham has an excellent uptake of this programme. Data is collected quarterly from the Child Health Immunisation System (CHIS). We are exceeding all targets.

2.3.3 School Nursing Service

The overarching aim of the school nursing service is to ‘improve the health and wellbeing of children and young people and reduce health inequalities’.

The service will provide a universal programme of preventative health care with additional care based on need. It will operate 52 weeks a year and be represented by qualified Specialist Community Public Health Nurses (SCPHN), qualified nurses and support staff.

The service will have the following functions:

- Delivery of the Healthy Child Programme (5-19);
- Delivery of the National Child Measurement Programme across Oldham;
- Delivery of the universal school-age vaccination programme;
• Development of a health plan for each school.

The commissioning and implementation of this model have been aligned to the Early Years offer outlined in Section 2.3.1 and awarded to the same provider to enable a streamlined service 0-19. The contract period will be initially for three years for the period from 1st April 2016 to 31st March 2019, with an option to extend for a period of up to two more years.

2.3.3.1 National Child Measurement Programme

In Oldham, the target for excess weight (overweight and obesity combined) in reception year was set at 23%. In 2014-15, 3,158 children were measured - a participation rate of 92% - and a prevalence of 22.6% was reported.

Among children in year 6, 2,965 children were measured - a participation rate of 94% - and a prevalence of 35% was reported for excess weight.

Nationally, a Framework for addressing obesity is soon to be launched. In Oldham a Stakeholder Event in 2015 was attended by a wide range of partners from community and voluntary organisations, in addition to Council and NHS colleagues. The event identified current activity to prevent and manage overweight and obesity, and participants identified priorities for further activity across the system. Many of the actions identified as central to a system-wide approach to obesity link to other public health priorities including oral health improvement and Type 2 diabetes prevention. Oldham will align future childhood obesity reduction plans to the National Framework.

2.3.3.2 Universal school-age vaccination programme

The universal school-age vaccination programme consists of:

• HPV among 12-13 year-old girls. The target is 90% uptake. Oldham achieved 93.3% uptake in 2013/14;
• Men ACWY (previously Men C) among 13-15 year olds. The target is 95% - no formal data has been reported yet;
• 3-in-1 teenage booster among 13-18 year olds. The target is 95% - no formal data has been reported yet.

2.3.4 Integrated Services for Young People

We have a comprehensive Targeted Youth Service in place, delivered by Positive Steps, that provides an integrated model of delivery for vulnerable young people who can access a range of health services from their town centre base and other delivery points including schools and colleges. The new service allows officers to signpost young people to other services internally without having to make new referrals, which ultimately ensures a better and easier service for users. Staff are multi-trained in various areas to offer wider access to services – for example, staff have been trained in chlamydia screening and can offer this discreetly to young people accessing the centre.

Positive Steps has sub contracted the delivery of young people’s sexual health services and substance misuse services to Brook Oldham. In 2014, Oldham’s under-
18 conception rate was 23.9%, lower than the North West and Greater Manchester averages.

The Targeted Youth Service also provides:

- Careers information advice and guidance for vulnerable young people;
- The Youth Offending Team and crime prevention activity;
- Support to young carers.

The newly integrated model of service delivery is working well with the majority of targets being achieved. There are some areas of service delivery where performance dipped between July and September 2015. However, this is expected due to the summer months and the changes to young people’s situations at this time. Monitoring meetings are held regularly with the provider, where performance and service delivery are discussed and plans are identified to address any required areas of improvement.

We have also established a partnership (including seconding two staff teams) with Mahdlo, Oldham’s Youth Zone, harnessing the capacity generated by external funding streams not directly available to the Council. This will see development and delivery of high quality detached youth work in communities across Oldham. The work will typically involve delivering responsive youth work in non-traditional youth work settings (including local parks and streets), as well as supporting groups through more traditional youth work projects which challenge, develop and educate young people. The team supports delivery of youth work on high profile operations and events in Oldham.

### Special Education Needs and Disability

The Council and CCG, with key partners such as health providers, schools and colleges, are working together to improve experiences and life chances for children and young people and their families/carers. We aim to do this in partnership with those who use our services and those organisations such as Parents of Oldham in Touch (POINT) who represent their interests.

Our vision for children and young people with Special Educational Needs and Disabilities (SEND) is that they will have a range of support and opportunities available to enable them to become confident individuals, effective communicators, successful learners and responsible citizens, to remain healthy and to achieve the life outcomes to which they and their families aspire.

Oldham has a school population of 41,300, of whom around 2.6% (more than 1,070) are children and young people subject to a statement of Special Educational Needs. This number has risen steadily over the last five years. Whilst the number identified with Autistic Spectrum Disorder has significantly increased, it has been offset by a reduction in the proportion identified with Moderate Learning Difficulties (MLD) and Specific Learning Difficulties (SpLD). More than half (around 600) of Oldham’s children and young people with statements attend a mainstream school or setting, close to the national average.

There is a strong commitment between the local authority and CCG as lead commissioners for SEND services to move towards an integrated commissioning approach at strategic, operational and individual level. We have commissioned a joint
strategic needs assessment in relation to SEND to give us a better understanding of education, health and social care needs.

By 2017 children and young people with SEND and their families in Oldham will see:

- Increased opportunities, via the Parent/Carer Forum, to work closely with services to plan how to best meet the needs of their children through widespread adoption of ‘person-centred’ approaches;
- A broader and more diverse provision for Autistic Spectrum Disorder;
- The full implementation of Education, Health and Care (EHC) plans for those with complex needs thus promoting local integration and co-ordination of services, particularly at key transitions;
- Access to personal budgets across social care, education and health for those that want them, providing increased levels of choice and control;
- A diverse offering of information, support and SEND provision that is easy to find through Oldham’s ‘local offer’ directory of services;
- An integrated Early Years Offer for families with children under five (Section 2.3.1).

Anticipated outcomes for children are:

- A reduction in school exclusions;
- An increase in educational attainment;
- A reduction in delays in diagnosis and/or statementing.

### 2.3.6 Children and young people's mental health

This is described under Section 2.2.6.5.

### 2.3.7 Oversight of the Transformational programme

Oldham’s Best Start in Life Partnership is the children’s sub-group of the Health and Wellbeing Board and it will be responsible for strategic oversight of this section of the Locality Plan. Regular reporting to the Health and Wellbeing Board will ensure fitness for purpose and progress towards improving key outcomes.
2.4 Living Well: Action to build resilient communities and provide early help

2.4.1 Our current approach

In Section 2.1 we described how we are transforming our health and social care system so that we provide integrated care at home or in the community, improve the quality of care, increase efficiency and reduce spend on institutionalised care. In this section we describe how we will reduce demand on the new health and social care system by increasing the resilience and sense of control that people in Oldham feel they have over their lives.

Our ultimate objective is for people to be healthy and well, and not to become ill. This is about supporting social change. By working with individuals and communities to promote people’s participation, build social networks, and give people more control over their lives, we will promote mental wellbeing and develop the social support mechanisms that in turn create independence, empower positive change and create resilience to current or future setbacks.

Active citizenship is about being involved in your community, having your say and taking part in decisions that affect you. Above all, it is about people making things happen and taking the opportunity to be actively involved in tackling the things that need to change. Active citizenship can be achieved by taking part in voluntary work, involvement in community organisations and engagement with politics.

Active engaged citizens are the bedrock for empowered communities and social cohesion which in turn are core to reducing inequalities in health. The fundamental cause of inequalities in health is the relative lack of control and powerlessness of disadvantaged groups. Activity that can support disadvantaged groups to affect the use of public resources (e.g. participatory budgeting) will lead to improved health and wellbeing. The process of getting involved, together with others, builds social capital that leads to health benefits: feeling able to influence and control the living environment has psychological benefits and reduces the adverse health effects of stress.

This programme will build upon existing good practice in community development, participatory budgeting and others to generate engagement and creativity and support existing instances of active citizenship to promote a population that is active, involved and in control.

It is recognised that the effects of social networks and the results of intervening to strengthen them are locally specific, unpredictable and non-linear. Overly idealistic or
one-size-fits-all approaches will achieve little but deliberative, intelligent and participatory engagement with communities can generate significant advantages in:

- Increasing wellbeing;
- Positive effects on personal empowerment, higher levels of active citizenship and individual and collective agency;
- A beneficial multiplier effect across a community;
- Improved employability, improved health and savings in health and welfare expenditure.

Figure 14 shows the relationship between barriers to wellbeing and health, risk behaviours and health conditions and the central role that wellbeing and resilience play in reducing each of these and breaking the cycle. By focusing on resilience, we will improve people’s health status and life chances and empower them to manage existing conditions better and this will result in fewer A&E attendances, fewer hospital admissions, reduced lengths of stay and fewer admissions to adult social care.

Oldham is a Co-operative Borough. This means that ‘everyone does their bit and everyone benefits’. This has provided us with the drive to make a fundamental change in our approach – away from public services doing ‘to’ and ‘for’ people and towards people and communities developing the skills to be happy, confident and in control of their own lives.

Over the past few years, we have collectively across Oldham developed a number of programmes that have moved us in the direction of developing resilient individuals and resilient communities. Examples are:
2.4.1.1 Nurturing resilient individuals

A key focus has been on supporting individuals to build the skills and confidence they need to take control of their own lives. To this end, we have collectively undertaken a number of projects such as:

- Family Focus (a pilot to support families across the whole range of issues they face);
- Project Solution (to support households who are placing high demand on the Police);
- Early Help (which brings together a number of Council services to create a single offer that provides support across a wide range of issues);
- Focused Care (to support patients within a GP practice to address the social and environmental aspects of their health and wellbeing instead of relying on medical interventions).

2.4.1.2 Building resilient communities

Communities are crucial to achieving shared social outcomes, and better lives and connectedness is better for communities. We have therefore developed significant activity to engage, develop and build connectedness in our communities. This includes:

- Get Oldham Growing (which encourages people to get involved in growing, cooking and selling local food);
- BGreen (which is using an opportunity of installing energy efficiency improvements in 1400 homes to also address wider social issues in the area);
- Warm Homes Oldham. This is the first ‘payment by results’ scheme of its type in the country, with initial funding from the CCG, Council and housing providers. In its first two years we have already lifted 2,200 people out of fuel poverty;
- Well Oldham (which is understanding how we change norms and behaviours in a community to improve health and wellbeing).

This work has developed well in Oldham because we have worked closely with partners like Voluntary Action Oldham (VAO), the faith sector and social landlords who are connected with the wider community and are well placed to maximise their community asset base for engaging with communities to improve health and wellbeing. Over the years this has insured that individuals and communities can connect with each other to learn from previous experience in voluntary activity and find new opportunities.

Oldham Council has a strong network of district executives that also support community connectedness through community development workers and other staff. A training programme working at three levels, introduction to community development through to an action learning set, is also commissioned by Oldham Council for anyone from the general public, front line staff and councillors to attend.
2.4.2 Next steps

2.4.2.1 Building our capability for resilience and demand management

The learning from these programmes, and a review of the evidence available, suggests a clear rationale for an approach that manages long-term demand through building individual and community resilience and emerging consensus about its necessity.

We want to develop a shared approach to building resilience in our communities that is informed by evidence on how to build community connectedness and insight into what actually drives demand and shapes behaviour in communities. This is summarised in the following diagram:

![Diagram showing the approach to building resilient communities]

**Building wider approaches to community resilience and social norms:**
- Get Oldham Growing;
- Well Oldham;
- Learning from existing activity e.g. work led by social housing providers;
- Wider links to GM work, social movements;
- Building a systematic, Oldham-wide approach to community engagement, development and behaviour change;
- Review of place-based working.

**Nurturing individual resilience:**
- Early Help and learning from implementation to date;
- Focused Care and learning from implementation to date;
- Adults prevention (including PIPs, IPOs, Link Centre).

**Building good opportunities for resilient individuals and communities:**
- Get Oldham Working (including embedding a focus on employment and employability skills into everything we do).

**Workforce reform:**
- Supporting staff to develop the skills to work in the new ways required to support individuals and communities to be resilient as part of building a Co-operative Borough:
  - ABCD training
  - Engagement training
  - Emotional management training.

**Figure 15: Oldham’s approach to building resilient communities**

We want to develop an approach for Oldham that builds upon what we currently have – volunteering infrastructure, innovative initiatives across several partnerships – into a way of thinking about the involvement of communities that goes beyond isolated initiatives. This will include reshaping the role of front line staff to work with clients and to include a greater emphasis on being enablers of social networks to support inclusion and wellbeing.

A six step approach to building community capital has been developed by the Royal Society for the encouragement of Arts, Manufactures and Commerce. This is not necessarily a template for us to implement in Oldham but is a starting point that we will use to clarify a partnership and place based approach to community resilience. The six steps include:
1. Training **community researchers** to have the skills to gather information in the community in which they live;

2. Carrying out **survey work** in the communities to better understand the community and how people are connected to each other;

3. Undertaking **social network analysis** and wellbeing analysis to create a network map of the social relationships reported to identify key people, places and institutions;

4. **Sharing the information** gathered with the community to prompt discussion on how to respond and the importance of social relationships. The process of change is itself important;

5. **Designing interventions with the people** in the community to respond to the issues that have been highlighted with a focus on enhancing social connections;

6. **Learning** from what has been done by evaluating the process and the outcomes.

In addition to this necessary work to continue to build community capital we will also test, through the **Well Oldham** programme, how we can work with a community to unpick the relationship between a limited number of outcomes and independent variables with a view to generating a picture of how behaviours and social norms in a place can influence the health outcomes and therefore clinical and non-clinical spend.

This modelling work, coupled with on-the-ground knowledge of operational staff, will identify the types of outcomes and demands experienced in different places in Oldham, and we will use this to pin-point questions that would be useful to explore further – e.g. if we build a profile of what ‘normal’ demand would look like based on the characteristics of an area, then we can then understand whether an area is doing particularly well/better that would be expected given its characteristics, and explore what the norms are in this area that make this the case.

Having pinpointed the research questions, we will undertake social/community insight work to develop our understanding of norms and behaviours in communities; what motivates these; and how they drive outcomes and demand. This will include exploring prevalent behaviours in an area at a very detailed level – much more detailed than previously. For example, it might involve unpicking the drivers of demand for issues such as alcohol consumption, approaches to parenting, attitudes to work, attitudes to relationships at home, attitudes to own health, etc.

This will, over the medium term, give us a bottom-up, evidence-based dataset that will help us to better understand how to positively influence social norms and behaviours and deploy the wider range of place-based services to influence health and care outcomes in Oldham.

We will also begin to model the potential network effects on improving health and wellbeing of a preventative service that could influence social norms and behaviours at a community level. This is a core element of both the co-operative approach to care provision in Oldham, and of the Greater Manchester ambition around social movement/public health.

### 2.4.2.2 Understanding and working with communities

In summary it is our intention to achieve a transformation in the resilience and connectedness of communities in Oldham that will have positive outcomes in wellbeing, personal empowerment and active citizenship and savings in health, social
care and welfare costs. We will do this by building on the bedrock of voluntary activity and infrastructure in Oldham and innovative programmes to develop an approach based upon the importance of social relationships to community resilience and on a stronger understanding of how to shape social norms and behaviours.

In addition, a significant focus of the transformation of health and social care described in Section 2.1 is about empowering people to manage their own health conditions and about developing networks of community providers that people can be signposted to for help and support.
Section 3: Enabling strategies

We have identified three enablers that will be central to the realisation of our vision: workforce, data and IM&T, and estates. These strategies are in development and will evolve as we identify the requirements of our transformational programmes.

3.1  **Enabler 1 - Workforce**

In order to enable the realisation of our vision we need to ensure that we have the right workforce in place and that it is equipped with the skills, knowledge, experience and sufficient autonomy to enable and support new ways of working across existing organisational boundaries to support the health and wellbeing of Oldham residents.

We recognise that employment itself is a wider determinant of health and wellbeing and that health and social care providers make a significant contribution to the employment of local people. There are many opportunities within our workforce redesign to explore how we utilise some of these opportunities to assist young people to develop skills and employment (apprenticeships, cadet schemes, internships, graduate schemes), explore how we contribute to reducing long term worklessness (voluntary working, vocational training) and support people with disabilities to participate in employment opportunities.

3.1.1  **Changing Culture**

We need to foster shared behaviours, values and ethos at the leadership level and in the frontline workforce, to make the reform happen in practice. We need a culture that demands positivity, personal responsibility, openness and transparency. This is true for our entire workforce from the GP to the social worker, from the police officer to the accountant and from the librarian to the refuse collector. For our frontline workers this means the freedom to focus on what is important to an individual and family, and having a different conversation to identify assets unconstrained by tick box assessments. For our administrative functions it means moving to a role of enabler, breaking down bureaucracy and working with the community.

Our workforce (although employed in different organisations) does not work in isolation and there are many opportunities for daily discussion in the care of Oldham people. For example, our social workers and care workers are in everyday contact with our community nurses and General Practitioners and also with acute and voluntary services staff where Oldham people access urgent care, secondary care, outpatient services and continued long-term community support.

The new models of care outlined in Section 2, including Early Help, Local Area Coordination, and the Primary Care Medical Home, are necessitating new multidisciplinary teams to be formed.

We recognise that we need to build on these existing relationships, and in some cases develop new ones to map this care provision and develop integrated care. We believe that this change must engage the current workforce as they will have ideas and
experiences that will enable us to explore how we can best provide services in the future. We will explore how we develop a shared workforce and support staff to experience and understand each other’s areas. We plan to work with our existing workforce to involve them in future service design/redesign, to determine how care can best be structured and to shape the culture in which these services will be delivered.

We also wish to provide our staff with reassurance and support throughout this development. Our staff have been part of many organisational changes in the last five years and we recognise that any such developments may cause anxiety and stress. It is therefore important that we are open and honest with all our staff, keeping them informed and involved with the proposed changes and their impacts. This is also important if we are to retain the skills, knowledge and organisational memory that we need for the future. Each organisation should therefore ensure that existing staff support mechanisms and employee assistance programmes are communicated and reinforced to staff.

3.1.2 Determining the workforce (workforce planning)

How we employ and deploy our workforce will be critical to our future success. We envisage the workforce of the future looking significantly different to that of today. We have made a start on this work and our system leaders have begun to work together to identify the key facets of shared leadership and how we can enact this together.

There is an immediate pressure to ensure that existing workforce numbers are sufficient to meet current demand (see Section 1.3.3). In particular, we need to explore some of the reported underlying trends regarding the scarcity of registered health care professionals and an aging workforce. However, there also has to be a longer-term consideration of whether the current composition of the workforce can achieve the ambitions of future care models.

Before we are able to design our future workforce we recognise that we need more sophisticated knowledge regarding our current workforce across primary care and among voluntary and social care services. There is at present no shared understanding about how workforce information is profiled and the underlying trends and key issues. We know that we need to look beyond the numbers of directly employed and in what roles to determine the wealth of skills and knowledge that we have in place. All key partners will need to work together to scope the workforce information that is available and identify where there are any gaps in our knowledge.

3.1.3 Skills and Knowledge

We know that providing services in a new and integrated way will require our workforce to develop new skills and competencies.

We will be asking some of our staff to work in a different care arena as we explore how best to care for people with long-term conditions in their own homes and communities. There are challenges associated with working in different health care environments that will require staff support and development.

Some staff will also need to take on new roles and responsibilities to provide effective integrated care and there is an associated skills development need. For example, as we move our focus onto prevention of ill-health, supporting people to maximise their health and wellbeing, reducing risk and enabling effective self-care we recognise that our workforce will need the skills and knowledge to support this agenda.
Through the design of new care pathways and the services needed to enable these, we will determine the skills and knowledge that are needed. We can then align the workforce to these priorities and explore how to provide the learning and development needed to effectively deliver the services. Our work on dementia awareness and management in Oldham has identified the scale of the future challenge and we have begun to implement shared learning initiatives working across the health and social care sectors to increase the skills and knowledge of the existing workforce in caring for people with dementia.

We are also cogniscent that our colleagues working in other public sector organisations share some of our skills and priorities although these may have a different focus (for example there are a number of public agencies with responsibilities for safeguarding children and there are some excellent examples of shared learning and development via the Local Children’s Safeguarding Board).

### 3.1.4 New roles

As we explore care pathways and how best to deliver these in an integrated way we also envisage that we will identify innovative roles that work across existing organisational boundaries to enable improvements in health and wellbeing. In particular, we see that there is a need to work with and empower communities so that they are able to take up challenges associated with self-care and locality improvement.

Oldham has a long history of such initiatives that we can revisit and build upon. We have successfully commissioned and managed local health improvement programmes that utilise expert patient programmes, community development schemes, health improvement initiatives and health trainers. As part of this agenda we need to ensure that frontline staff understand the value of making every contact count and foster a culture of social prescribing to meet people’s wider needs.

We do not merely propose to implement past programmes but to revisit what is currently in place, evaluate what has worked and why and to use this best practice to work with volunteers from local communities to enable change.

We know that this will require some of our staff to work in different ways and also with different agencies. The social housing and voluntary and community sectors have a wealth of skills and experience that can be shared with our workforce. We wish to change the ethos of our workforce from being care providers to being care enablers.

### 3.1.5 Carers Strategy

According to the 2011 census there are 24,322 carers in Oldham, with just over 5,000 carers currently registered with the Oldham Carers Centre. It is estimated that this workforce saves the health and social care system billions of pounds.

We are transitioning to new carers’ services with the aspiration to have a fully adopted new model and resources to underpin it by April 2016. In particular, our approach will seek to ensure that carers’ own wellbeing and health is promoted, that peer support and networking opportunities are increased, and more opportunities are created for carers to become volunteers and befrienders. In addition, we are establishing a specialist dementia carers support service, recognising the particular challenges associated with caring for dementia patients.
3.2 **Enabler 2 - Data and IM&T**

IM&T reconfiguration and innovation are key enablers to achieving our vision of an integrated population health system.

The NHS 5 Year Forward View made a commitment that, by 2020, there would be “fully interoperable electronic health records so that patient’s records are paperless”. Technology enablers were set out including online services for family doctors, interoperable electronic health records, better data and intelligence and accredited apps for the population.

Personalised Health & Care 2020 builds on these themes. It proposes requirements for joined up, digital real-time records across health care, standards around data, apps & devices, intelligence and patient & the public access to view and add to records across all care settings. Information needs to flow more effectively across health and care to support the delivery of direct patient care.

In September 2015 guidance was released to CCGs to support them in the implementation of the National Information Board’s vision of economies to become ‘paper-free at the point of care’ (The Forward View into Action: Paper-free at the Point of Care - Preparing to Develop Local Digital Roadmaps). In April 2016, as part of the annual Clinical Commissioning Group (CCG) planning process, CCGs will be required to submit their plans - local digital roadmaps - for how their local health and care economies will achieve the ambition by 2020.

Primary care clinical leads in Oldham have agreed four overarching technology principles:

1. Connect
2. Integrate
3. Empower
4. Collaborate

Oldham uses the predominantly borough-wide EMIS Primary Care system. Being on a single clinical system has enabled practices or groups of practices to access clinical records and manage patients who are not registered with them directly, and will support our extended access pilot.

We are currently implementing plans to enable providers outside of primary care e.g. community nurses, out of hours doctors, social services and A&E consultants to gain access to the full and detailed primary care record for any patient that they are involved with. In the short term, Oldham is in the process of sharing a “viewer” of its primary care system with its community provider and adult social services. Other services are preparing a similar solution for their services back to primary care.

The medium- to long-term solution to integrated records being considered by Oldham is a portal solution. This project is a collaboration between North East Sector CCGs, Local Authorities, Pennine Acute Hospitals NHS Trust, Pennine Care NHS Foundation Trust and local Out of Hours services. Ultimately the goal is for all care providers to have read/write functionality to the portal for all of the clinical systems in use.

We are currently trialling new types of technology within the borough to support innovative working. These include video consultations and virtual clinics and waiting
rooms, “surgery pods” for diagnostics and fully functional mobile working solutions for clinicians. We have also implemented telehealth for a cohort of patients with chronic obstructive pulmonary disease.

Among those patients registered with a long term condition, the CCG has established an Extending Quality & Local Access Supply (EQALS) scheme in 2013/14 to improve their proactive management – this applied to 7.5% of the CCG’s registered population. Practices were provided with a risk stratification tool by the CCG, which assisted practices in identifying patients at risk of unplanned admission, for example for dementia or end of life care. The intention ultimately is that every patient with a long-term condition will have a ‘year of care’ plan in place.

In line with the ethos of a Co-operative Oldham and our vision for health and social care, one of our key areas of work under the IM&T strategy is empowerment. The Empower principles are:

- The public should be able to access services digitally by default
- We will integrate health & care record portals to provide one stop shops across health & social care
- Everyone in Greater Manchester will be able to access mobile apps with local service information and guides to pathways and self-care
- Subject to robust consent and screening standards, patients will be given full access to their GP records, including consultation notes and results to reduce practice demand and increase empowerment
- People will be given online access to their electronic care plans
- Public-facing digital projects for health & care will be coordinated and governed across organisational boundaries
- Self service will be ubiquitous across health & care settings
- People will interact with services and self-monitor by using person-held digital records linked to service-held records.

**Locally-Led Design**

At borough level within Oldham we will develop a local Informatics Board to design and oversee the delivery of the Digital Roadmap to realise the ACMO and 2020 vision, while ensuring that the high level principles are congruent with the overarching Greater Manchester principles.

The Board will be tasked with ascertaining the Oldham Care Delivery Partners’ digital maturity index to develop a baseline and set plans for investment to progress and develop Oldham’s maturity metrics and advancement against the digital roadmap.

The borough will measure its maturity against:

- **Readiness** – governance, leadership, resources, IG & strategic alignment.
- **Capabilities** – health records, medicines management, outcomes, decision support & remote care.
- **Infrastructure** – WiFi, business continuity, mobile working, system resilience, virtual desktops & single sign on.
3.3 **Enabler 3 - Estates**

Over the last few years, public sector organisations within Oldham have been working successfully to remodel and achieve efficiencies from their estates. However, it is recognised that a more collaborative and innovative approach is now required to be able to break down historic barriers and to pool resources more effectively to fully maximise opportunities to wider public benefit. This approach aligns fully with the Government’s One Public Estate initiative and Greater Manchester Combined Authority’s strategic direction.

Oldham public sector partners are committed to delivering improved public services for all our residents by directly delivering or commissioning the highest quality services available. As outlined in Section 2.1, we want to provide these high quality services as close to our residents’ communities and homes as we can, in a joined up way, giving them the best possible value for money and improved accessibility at a time and location convenient to them.

We recognise that property and the built environment are fundamental components to delivering high quality, accessible and efficient public services. Therefore, the partner organisations are working together through a newly formed Strategic Estates Group (SEG) to use property to deliver a more integrated, accessible, innovative and efficient range of public services and as an enabler to develop shared services and to support and enhance physical and economic regeneration.

To fully realise these opportunities together we are taking a more strategic approach to property management and investment and our Strategic Estates Plan sets out our intentions to improve management of this valuable and high-cost resource aligned with priority outcomes for Oldham residents.
APPENDIX 1: The financial gap

This appendix describes in summary the current picture for Oldham Council and the CCG, the local financial challenge and the financial assumptions and where possible the financial position over the next five years. We have not included information about the areas outlined below as this work is supported by analysis and modelling at the Greater Manchester level that is still in progress:

- Impact of locality & sector plans
- Impact of Greater Manchester transformation
- Capital & estate
- Workforce transformation
- Information, data sharing and innovation.

Combined Commissioner Gap

The information in Table 1 summarises the combined CCG and Council financial gap from the information outlined in further detail in the sections below.

<table>
<thead>
<tr>
<th></th>
<th>CCG</th>
<th>OMBC</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gap before savings</td>
<td>84.6</td>
<td>38.4</td>
<td>123.0</td>
</tr>
<tr>
<td>Savings identified - CCG over 5 years</td>
<td>(36.0)</td>
<td>(36.0)</td>
<td></td>
</tr>
<tr>
<td>Savings identified - Council 2016/17</td>
<td>(9.3)</td>
<td>(9.3)</td>
<td></td>
</tr>
<tr>
<td>Residual gap</td>
<td>48.6</td>
<td>29.1</td>
<td>77.7</td>
</tr>
<tr>
<td>Protection of Adult Social Care</td>
<td>(13.3)</td>
<td>(13.3)</td>
<td></td>
</tr>
<tr>
<td>Additional NHS funding (share £8bn)</td>
<td>(37.5)</td>
<td>(37.5)</td>
<td></td>
</tr>
<tr>
<td>Potential Residual gap</td>
<td>11.1</td>
<td>15.8</td>
<td>26.9</td>
</tr>
</tbody>
</table>

The savings identified are planned interventions which if successfully implemented will go some way towards closing the five-year gap.

Oldham Council

This section sets out the current financial planning assumptions for Oldham Council social care budgets.

In 2015/16 the Council is estimating it will spend £138.328m on Children’s and Adult social care. Of this, £66.125m is funded by external contributions from other organisations, including the NHS, and clients that have been assessed as being able to contribute to the costs of their care. The remaining £72.203m is funded from the Council’s own resources.

This baseline figure of £72.203m for social care provision in Oldham has been used to determine the size of the financial gap by 2020/21, given the expected cost pressures and council funding reductions in the intervening period.
Current assumptions derived from the Council’s Medium Term Financial Strategy (MTFS) have been applied to the 2015/16 baseline budget and modelled over the years 2016/17 to 2020/21.

The assumptions are subject to change and will be updated over the coming weeks following the Autumn Statement (25th November) and once the final local authority settlement is published in mid-December.

The current estimated cumulative five-year financial gap for the Council’s social care budget is £38.434m. The 2020/21 budget shortfall is presented in Table 2; the cost pressures and funding reductions are explained in more detail below.

Table 2: Oldham Council Financial Challenge 2020/21 (All values in £m)

<table>
<thead>
<tr>
<th>Baseline Position</th>
<th>Demographic changes</th>
<th>Staffing (Council employed)</th>
<th>Contracts including NLW impact</th>
<th>Public Health (pressure due to proposed cut in grant)</th>
<th>Total Pressure</th>
<th>Estimated Baseline Spend by 2020/21</th>
<th>Estimated Funding Reduction 2016/17 to 2020/21</th>
<th>Estimated Resource Baseline 2020/21</th>
<th>Financial Challenge</th>
</tr>
</thead>
<tbody>
<tr>
<td>72.203</td>
<td>2.752</td>
<td>1.059</td>
<td>10.718</td>
<td>1.065</td>
<td>15.594</td>
<td>87.797</td>
<td>(22.840)</td>
<td>49.363</td>
<td>38.434</td>
</tr>
</tbody>
</table>

**Cost Pressures**

The main assumptions which result in a £15.594m cost pressure by 2020/21 are set out below:

- Demographic growth at 0.7% per annum (as per Greater Manchester-wide assumption);
- Pay inflation – 1%
- Non-pay (General Inflation) – 0%
- Inflation relating to contracts – including the impact of the National Living Wage (NLW) using NW ADASS model:
  - 2016/17 – 6.7%
  - 2017/18 – 4.0%
  - 2018/19 – 3.9%
  - 2019/20 – 3.7%
  - 2020/21 – 3.6%
- Public Health Grant – 7.1% grant reduction (pending the outcome of current consultation) which will create a £1.065m cost pressure to be met from council funds.

**Funding reductions**

The baseline budget in 2015/16 is assumed to be balanced and any pressure will be met in-year.
The budget is shown as a “net” figure after taking into consideration use of client contributions, Public Health Grant, contributions from Health Partners (e.g. the Better Care Fund (BCF) and other third party contributions. This “net” baseline represents expenditure funded from the Council’s mainstream resources – namely Council Tax, Business Rates and Revenue Support Grant (RSG) plus some other small grants from Central Government.

Funding reduction assumptions are as follows:

- Council Tax – no change (to 2015/16 level);
- Business Rates – no change;
- Better Care Fund – no change;
- Client contributions and other external income – no change;
- RSG (reduction year on year):
  - 2016/17 – 34%
  - 2017/18 – 41%
  - 2018/19 – 50%
  - 2019/20 – 100% (Takes RSG to zero)
  - 2020/21 – 0%

**Budget savings**

As part of the Council’s annual budget setting process, social care budget savings have been identified of £9.3m to enable the Council to report a balanced budget position for 2016/17. If implemented they would reduce the Council’s financial gap to £29.1m over the four years 2017/18 to 2020/21.

**Protection of Social Care**

The Greater Manchester Health and Social Care Comprehensive Spending Review submission to Government included a request for protection of Adult Social Care for the five year spending review period. If this is successful, indicative figures from Greater Manchester suggest that Oldham would receive £13.3m to protect some of the estimated funding reductions that are included in our local financial plans.

The combined commissioner gap outlined in Table 1 has been adjusted under the assumption that £13.3m for the protection of Adult Social Care will be received.
Assumptions used

General:

- The Plan is for NHS Oldham CCG only - other plans will be overlaid on top of this as part of consolidation at local / Greater Manchester level. Consequently, no assumptions have been included in respect of the CCG’s share of Pennine Acute Hospitals NHS Trust’s deficit.
- It uses Month 6 (September 2015) forecast outturn as the starting point.
- The impact of GP Primary Care Co-commissioning is included, which has added £30.8m of allocation and costs.
- No further transfers of services to/from Specialised Commissioning included if not already anticipated in the Month 6 forecast outturn.
- Current NHS England business rules apply (0.5% contingency, 1% non-recurrent use of recurrent allocation, 1% cumulative surplus).

Revenue Resource:

- Target allocation per head achieved in 2016/17.
- Demographic growth in future years as for 2015/16.
- Programme Allocation per head remains constant from 2016/17.
- Running costs allocation remains constant in actual terms (i.e. no % increase).
- Better Care Fund (BCF) allocation remains constant in actual terms (i.e. no % increase in future years).
- GP Primary Care Co-commissioning allocation included and remains constant.
- Specialised commissioning allocation included and remains constant.
- £2m non-recurrent allocation (return of 2015/16 surplus) in 2016/17, but none thereafter.

Costs:

- NHS net deflator is -0.3% in 2016/17 and then -1.2% thereafter in line with Greater Manchester assumptions.
- 2.5% CQIN for all providers irrespective of whether currently ETO/ DTR.
- 1% activity growth on acute contracts (above demographic growth) in line with Greater Manchester assumptions.
- 6% prescribing inflation in line with Greater Manchester assumptions.
- 4.5% Continuing Healthcare / Mental Health cost per case inflation in line with Greater Manchester assumptions.
- 4.5% social care inflation.
- 2.5% pay inflation.
- 2.5% non-pay inflation.

**Investments:**

Recurrent: £36.25m over 5 years

Non-recurrent: 1% of programme allocation (approximately £3m each year).

**Gap between forecast allocations and costs before QIPP**

Under NHS Business Rules, the CCG is required to achieve a cumulative 1% surplus against its total annual allocation from NHS England. For 2020/21, this will be approximately £3.6m.

Based on the assumptions above, it is anticipated that there will be a gap of £84.6m against the cumulative surplus requirement by the end of 2020/21 before any Quality, Innovation, Productivity and Prevention (QIPP) schemes are applied.

**What are we going to do to bridge that gap?**

As a result of the CCG becoming an Accountable Health Management Organisation (ACMO) with a Multispecialty Community Provider operating within its umbrella, the CCG is anticipating making recurrent QIPP savings of £2.3m per annum. These savings will be from an expected reduction in emergency admissions to acute hospitals, attendances at Accident & Emergency departments and in GP prescribed drugs.

This would reduce the gap by £36m over 5 years, resulting in a shortfall of £48.6m against the required cumulative 1% surplus target of £3.6m.

The CCG is expecting to receive approximately £37.5m of the Greater Manchester share (£444m) of the £8bn extra funding for the NHS announced by the government in July 2015. This would leave a residual gap of £11.1m in the event that the funding was not received until 2020/21. If some (or all) of this amount is received in earlier years, then the gap could be considerably reduced, if not eliminated altogether, depending on the timing of the receipt of the funds.

In addition, the CCG and Oldham Metropolitan Borough Council are currently discussing ways in which services can be better integrated and premises utilized more efficiently across the borough. Whilst it is expected that savings will arise from this integration, none have been anticipated in the CCG’s figures above.

Furthermore, the CCG has been extremely prudent in its assumptions with regard to a non-recurrent return of previous years’ surpluses. Apart from a return of £2m from 2015/16 in 2016/17, no returns have been included.

**What will be the cost to address it e.g. double running, pump-priming etc**

The plans for establishing the ACMO are still being developed and therefore the costs are not yet finalised.
APPENDIX 2: Greater Manchester programmes

Across Greater Manchester, we are working together on the radical reform of public services through a series of challenging and ambitious programmes. The need to address the gap between public spending and income generated in Greater Manchester is a clear driver for change. The scale of financial challenge facing Greater Manchester public services will continue over the coming years and continues to be a driver for change. But we also have the ambition to improve outcomes for our residents, increasing independence and reducing the rising demand on public services.

Action at the Greater Manchester level on mental health, and in particular dementia and development of Access and Quality Standards for 2016/17 is described in Section 2.2.2.

A new relationship between public services and citizens

Much of the success of our ambitious agenda for growth and reform in Greater Manchester is predicated on a new relationship and 'deal' between citizen, state and society. Work to deliver the Greater Manchester Strategy: Stronger Together is posing significant questions about the role of the public in public services, as well as what it will mean to be a citizen in Greater Manchester in the future.

The way individuals, families and communities are interacting with services is changing, transforming the role of the state into one that delivers the appropriate services at the right time. We are seeking to create the conditions that enable people to become resilient and empowered, increasingly focusing on identifying where preventative services can achieve improved outcomes, greater efficiencies and reductions in overall demand on services.

We want to achieve a new relationship between public services and citizens, communities and businesses that enables shared decision making, democratic accountability and voice, genuine co-production and joint delivery of services. “Do with, not to”.

We will deliver the following actions and approaches:

- Asset based approaches that release the ambitions and talents and build on the strengths of individuals, families and our communities, recognising the independent contribution they make to health and wellbeing outcomes, rather than focussing on the deficits;
- Behaviour change programmes in our communities that build independence and support residents to be in control;
- Place-based approaches that redefine services and put individuals, families, communities at the heart;
- A stronger prioritisation of wellbeing, prevention and early intervention;
- An evidence-based understanding of risk and impact to ensure the right intervention at the right time;
- Approaches that support the development of new investment and resourcing models, enabling collaboration with a wide range of organisations;
- Programmes to support active engaged citizens.
**Early Implementation**

It is proposed to focus on two areas that are already in the Greater Manchester public health agreement; the Greater Manchester physical activity programme and the Greater Manchester Ageing Well programme.

**Greater Manchester Moving**

This is an exemplar opportunity to support a social movement across the life course to improve the health and wellbeing of Greater Manchester residents with a clear focus on tackling the causes of physical inactivity. It will facilitate the reduction in health inequalities, strengthen assets and enable greater connectivity of people to economic growth and prosperity.

We will establish Greater Manchester Moving as a unique public, private, voluntary partnership to underpin and support the Greater Manchester ambition to:

- Increase levels of participation in physical activity in our most inactive citizens;
- Increase active travel, and;
- Increase economic output of the sport and physical activity sector.

**Greater Manchester Ageing Well**

Greater Manchester has set the ambition to be the first Age Friendly City Region in the UK. A central strand of this work is to build a social movement that challenges negative perceptions of ageing and the demands placed upon public resources.

In alignment with the wider aims of the Greater Manchester devolution proposition we will establish a Greater Manchester Ageing Hub with the capacity to meet our overall ambition of becoming an age friendly city region.

In order to support a social movement for change we will bring together world-leading research institutes, policy expertise, public and private partners, alongside civic and community organisations to make a step change in how the city region thinks about ageing and how it acts to mobilise Greater Manchester assets – in partnership with external agencies. Early priorities include a focus on:

- A ‘midlife’ approach with Centre for Ageing Better;
- Economic opportunities of ageing populations;
- Age-friendly communities to reduce isolation (Ambition for Ageing);
- Age-friendly services, with a focus on culture and ageing; age-friendly hospitals;
- Age-friendly design, with a focus on public spaces and the built environment, spatial strategy;
- Links to a social movement approach and wider preventive agenda including dementia.

**Leadership**

This is part of the wider Greater Manchester workforce programme. The aims of this workstream are:
• To develop leaders across Greater Manchester who can lead not only within and behalf of their organisations and professions, but increasingly can work beyond this to lead within and on behalf of ‘place’. This new approach will be flexible enough to accommodate different spatial levels of place such as city region, district or neighbourhood;
• To develop a more coherent approach to leadership development that is not organised through professional disciplines (e.g. health, social work etc.), or is structured around organisations (e.g. local authorities, etc.);
• To develop an approach which will incorporate skills and behaviours identified by places and through Greater Manchester work streams as essential to the delivery of our ambitions for the region.

The leadership workstream is strategically managed through the Greater Manchester workforce transformation group.

**Progress and next Steps:**

A paper was received and supported by the Public Sector Reform leadership in June 2015, describing an approach and Greater Manchester leadership framework.

Three system wide workshops held.

Expression of Interest submitted to the IC Pioneer programme for funding to support a digital sharing platform.

Funding secured for 2x 12 month contracts for project support – to be advertised Oct/Nov 2015.

Developing the tender: a market place event for leadership providers planned for 12th Nov 2015, to explore the ‘core spine’ offer of the framework.

8 days’ facilitation provided by the NHS LA or leadership centre secured.

Aim to begin with a leadership offer in Jan/Feb 2016 starting with master classes and innovation exchanges.

**Transformation of primary care**

The aim of this workstream is the development and implementation of a new primary care strategy for Greater Manchester, ensuring it is aligned with the Greater Manchester Health and Social Care Devolution strategic plan and individual locality plans.

**Current progress**

• A ‘Thought leadership’ event set out some key principles for the next steps for primary care;
• The development of a ‘discussion document’ to be used as an engagement tool, feedback from which will inform the new primary care strategy for Greater Manchester. The document includes high level themes: innovation, consistently high quality care, provider and workforce development, people powered health and behaviour change and new models of care;
• Commenced engagement with key stakeholders to seek input into the primary care strategy, including the 5th Greater Manchester Primary Care Summit on 4th November.

Next steps
• Continued engagement with key stakeholders;
• Primary care chapter for Greater Manchester strategic plan - December 2015;
• Final version of the primary care strategy - January 2015;
• Development of implementation plan/transformation programme - January-March 2016;
• Commence implementation - April 2016.

Specialised services transformation
The aims of this workstream are:
• The development and implementation of a Specialised Services strategy for Greater Manchester, ensuring it is aligned with the Greater Manchester Health and Social Care Devolution strategic plan and individual locality plans;
• Oversight of on-going specialised services transformation programmes;
• Oversight of the day to day commissioning and performance of Greater Manchester Specialised Services.

Current progress
• Development of a proposed Urology and Obstetrics and Gynaecology (OG) Cancer Specialised services transformation process;
• Development of clinical and patient-experience standards for Urology and OG cancer which will lead to world-class patient outcomes;
• Commenced engagement with key stakeholders to co-design the Greater Manchester Specialised Services strategy and service transformation process.

Next steps
• Continued engagement with key stakeholders;
• Implementation of the Urology and OG Cancer Surgery transformation programme – October 2015 -April 2016;

Early intervention and prevention
This workstream will see the development of an Early Intervention and Prevention Strategy building on the themes of:
• Public health, reform and growth;
• Social movement and co-production (linked to asset based approaches);
• Starting well: early years;
• Living well: work and health;
• Ageing well.

Early implementation priorities include:

• **Best Start** – Improving school readiness across Greater Manchester through integrated service delivery for young children and their families;
• **Work and Health** – Increasing productivity by improving health in the workplace and building resilience and recovery in extended working well cohort and the Work Programme;
• **Ageing Well** – establish a Greater Manchester Ageing Hub to support Greater Manchester programmes of work;
• **Find and Treat Programmes** – scale up find and treat programmes across Greater Manchester.
APPENDIX 3: CCG Clinical programme summaries

Elective Care Programme

The vision of the elective care programme is to improve health and healthcare for the people of Oldham by ensuring patients have access to high-quality, integrated and responsive elective healthcare services. These services will be delivered when and where they are most needed; aligned to the expectations and needs of our local population.

The CCG takes a collaborative approach in working with patients, carers, health and social providers across primary, community and acute care, in order to improve community based provision, thus preventing avoidable admissions and improving patient convenience. Working with the Referral Gateway, there will be a continued clinically led programme that will drive the reduction in inappropriate referrals and ensure that patients are seen by the right person, in the right place, at the right time, first time.

In order to deliver the vision for elective care the CCG will employ the following strategies:

- **Demand Management** - the CCG has developed demand management initiatives to ensure patients receive the right care in the most appropriate setting, whilst ensuring the best use of resources across the health economy. Oldham CCG have a well-established referral gateway which assists in regulating the quality and appropriateness of referrals, adherence to best practice referral guidelines and most importantly ensuring that patients are directed into the most appropriate level of service at the right time. The CCG will continue on-going work with the gateway provider to drive continual improvements in demand management.

- **The Market Approach** - the CCG will utilise the market approach in the commissioning of elective healthcare services in order to encourage a competitive market and stimulate responsiveness of providers across both the NHS and the Independent sector. This approach will aid the CCG to commission high quality of services which are responsive to local population needs, whilst ensuring best value for money.

- **Integrated Pathway Hub (IPH) Model** - the CCG is employing the IPH model in a number of specialities within the elective care programme. This model allows for more effective pathway management which aids improved integration of care, cohesiveness of patient pathways and therefore an improved patient experience. This model has been adopted for Muscular skeletal services (MSK) and is also being adopted for Dermatology and Ophthalmology.

Urgent Care (non-elective) Programme

In order to deliver the vision for non-elective or urgent care the CCG is developing key areas of service delivery. This involves working and collaborating with several providers to optimise and redesign urgent care pathways and allow the commissioned resource to follow the patients through the care pathway. The CCG is working with an Alliance of the Urgent Care providers to deliver this transformation.

The key measures are:
• Reduced non elective admissions and readmissions
• Reduced A&E attendances
• Reduced Lengths of stay in hospital
• A reduction in occupancy rates in the hospital

In and Out of hospital work streams are in progress

• Developing clear urgent care pathways with the focus on patients with Frailty Syndrome for both in and out of hospital care – In hospital and out of hospital frailty pathways with a focus on delivering care to the patients in the most clinically appropriate place. The CCG is working to commission community urgent care pathways to support community, and primary care, which aligns with, and links to an acute hospital offer.

• Reducing clinically inappropriate lengths of stay in the acute hospital - this involves developing and implementing an integrated approach to transferring the patients care from hospital to the community. There will be standards developed across the borough that will support and monitor the quality of the transfer of care of patients. There will be a review and redesign of the community bed base and also domiciliary based services that will give intermediate, assessment and transitional options to patients as they move from hospital back to home.

• Reducing readmissions to the acute hospital - There will be a single point of contact developed for all urgent care services that is supported by a robust directory of services. This will allow patients and professional to have access to the most appropriate services at the right time. Patients that are known to services or are classified as at risk of an urgent care episode will have a single care plan that all agencies can access online reducing duplication and sharing patient care choices and baselines. There will be a review of the falls service to align the current services with work around EQALS (primary care) and frailty.

Primary care

The aim of the primary care programme is to systematically improve the access, quality and scope of primary care medical services delivered by GP practices in Oldham. Services will be delivered through the Oldham 3M model at a practice (1M), GP cluster (2M) or borough wide (3M) level.

Specific aspects of the programme designed to reduce health inequalities will focus on:

Improving access

There will be easy access to high quality, responsive, preventative primary care. Improved access will:

• Deliver minimum capacity levels in general practice with improved access to a prescribing clinician
• Improve patient convenience through extended telephone and reception opening times
• Improve patient convenience through advance booking of appointments
• Ensure same day access for children under five.
In line with the Greater Manchester Standards for Primary Care, access to primary medical services will be enhanced further with the introduction of seven day services at four sites across Oldham from December 2015.

**Improving Quality**

GP practices will deliver targeted evidence based interventions that improve patient quality of life and reduce demand pressures in secondary care with a focus on:

- **Cancer** - improve screening rates and increase the proportion of cancers diagnosed at an early stage.
- **Dementia** – every GP practice will have a ‘Dementia Champion’ responsible for improving systems of care for patients with dementia and support for their carers.
- **End of Life Care** - Improving the quality of care for patients nearing the end of life and increasing the proportion of deaths in the patients preferred place.
- **Proactive Care for the Frail Elderly** to increase the number of patients diagnosed with Dementia, reduce A&E attendance and unplanned admissions for people aged 75 and over.
- **A highly proactive & responsive approach** to avoiding unplanned admission to hospital through improved quality of long term condition management and continuity of care.
- **Paediatric asthma** - increasing the identification of children and young people with asthma and reducing the number of emergency admissions for those already diagnosed.
- **Developing learning organisation cultures** within primary care, which drive continuous quality improvement thorough sharing of good and best practice between primary care professionals and improved communication between primary care teams.
- **Improving the early diagnosis of alcohol related liver disease** by increasing the identification of people aged 16 to 39 who are drinking alcohol and are at increasing or higher risk of harm with primary care providing alcohol brief advice for those at increasing risk and referral to alcohol services for patients at higher risk.
- **Improved health and wellbeing of people living in care homes**
- **Increase in patient/ carer/ care home/practice satisfaction** with GP practice services

The primary care programme across Oldham will continue to be delivered in line with the Greater Manchester Standards for Primary Care with annual review of the programme to further enhance primary care services in Oldham.

**Cancer Programme**

The CCG vision is to support prevention and reduction of the incidence of cancer. Oldham is committed to detecting and diagnosing cancer early and to ensuring rapid access to the best available treatment and aftercare, aiming to improve cancer outcomes and survival, and ensuring those living with and beyond cancer receive the care and support they need to lead as healthy and active a life as possible, for as long as possible.
Programmes of work include:

**Early Detection**

Promoting early diagnosis of cancer to improve survival rates and reduce cancer mortality. The ambition for those who develop cancer is early presentation to the GP, timely referral of suspected cancer, and access to high quality and responsive diagnostic and treatment services – close to the patient (wherever possible). There is an intention to develop a pathway for patients with non-specific but concerning symptoms with the establishment of a multidisciplinary diagnostic centre (MDC).

**Living With and Beyond Cancer**

Developing and embedding a sustainable model for ‘Living with and beyond cancer’ across the north east sector of Greater Manchester, which aligns with the key work-streams identified in the national programme. This includes:

- Ensuring all cancer patients have access to holistic needs assessment, treatment summary, cancer care review and a patient education and support event – the ‘Recovery Package’;
- Developing and commissioning risk stratified pathways of post treatment management (the pathway of care for cancer survivors is based on a model of care for people with long term conditions. A stratification process will help to identify which care pathway is most suitable for each patient, based on the level of care needed for the disease, the treatment and the patient’s ability to manage, and therefore what level of professional involvement will be required).
- Promoting physical activity;
- Understanding and commissioning for improved management of the consequences of treatment.

**Children and Young People’s Programme**

The CCG vision of the children and young people’s programme is to improve access to joined-up and effective local services, ensuring that the right services are in place to meet the specific health needs and expectations of children and their families whereby:

- Parents/carers are provided with the information they need to help their children lead healthy lives, with information about what is available in their communities.
- Healthcare and other environments encourage children and young people to make healthy choices.
- Extra support is provided for those from the most disadvantaged backgrounds.

The Children and young people programmes include:

**Urgent and emergency care**

Develop and implement a new delivery model for paediatric emergency and urgent care through the Urgent Care Alliance, using a children’s programme budget approach.

With clear accountability and a budget for paediatric pathways, partners will be able to use clinical judgment and skills to improve and, where necessary, redesign services to achieve better quality, productivity and value. The integrated programme budget will
deliver better clinical outcomes from commissioning spend because providers are incentivised to reduce waste and deliver high quality care. A particular focus is on delivering improvements in the diagnosis and management of care for children and young people with asthma.

**Emotional Wellbeing and Mental Health**

Oldham’s child and adolescent mental health services (CAMHS) Transformational Plan aims to ensure that services commissioned are sustainable, efficient and grounded in the best available evidence that contributes to children and young people enjoying good emotional wellbeing and mental health. Key objectives that will drive the delivery of the transformation plan include:

- Promoting good mental health, building resilience and identifying and addressing emerging mental health problems early on;
- Providing children, young people and their families with simple and fast access to high quality support and treatment;
- Improving care and support for the most vulnerable and disadvantaged children in Oldham by closing critical service gaps, improving support at key transition points and tailoring services to meet their needs.

**Maternity Services**

The NHS Oldham Choice offer commits to ensuring that women are informed about their ‘local choice offers’ for using maternity services. This choice can depend on what services the CCG commissions, as well as on clinical judgment about what is best for women and their baby/babies. However, for the majority of women, the choice of where to go for their maternity care is personal to them and Oldham CCG recognises that it is essential that women have the information they need to make this choice. The CCG website gives details and links to the services commissioned within the offer from the following providers; Pennine Acute Hospitals NHS Trust (Royal Oldham & North Manchester General), Tameside Hospital, Stepping Hill Hospital, University Hospital South Manchester and St Mary’s Hospital. There is also an option for any choice outside local choice to be discussed with the CCG in exceptional circumstances.

The National Maternity Review, launched following the Kirkup Report, has prompted a Regional Maternity Review Group established by NHS England North. Oldham will work in partnership with North East Sector and Greater Manchester colleagues on a number of work programmes aimed at improving quality e.g. quality surveillance, saving babies lives, compassionate leadership and maternity experiences. It is essential to draw in both local and national learning to ensure the best possible offer for women and their families. The key objectives will include:

- Promoting stronger links between Primary Care, Maternity Services and Safeguarding to ensure information flow, safety and risk management are optimised.
- Reducing variation in commissioning of maternity services with a more effective standardised KPI Framework.
- Improved data flow across services including paediatrics and neonates to ensure that services are not viewed in isolation.
End of Life Care

The CCG Vision is to deliver effective End of Life care services to support people in dying in their preferred place of care.

This is being delivered through the following programmes of work:

- Development of the Integrated End of Life care service provider (this includes community, hospice, hospital based, social care and third sectors services working together). The aim is to develop a programme budget for End of Life care enabling all services to work under a single management structure.
- Implementation of EPACCS to support a single care record for End of Life care patients
- Development of the Hospice at Home model
- Continuation of the Six steps care home education programme
- Support for the DNA CPR (Do not resuscitate Cardio Pulmonary Resuscitation) documentation process.
- Delivery of Rapid Palliative Care discharge from hospital.

Long Term Conditions (Vascular, Respiratory and Endocrinology)

The CCG vision is to improve access and support for people with long term conditions, working in collaboration with our Urgent care, Elective care and Primary care programmes to put care plans in place for patients wherever possible to ensure they are supported in managing their own condition avoiding unnecessary hospital admissions. The CCG also aims to improve access and diagnostic support in community and primary care to ensure the relevant support is provided to people when it is required.

This is being delivered through the following programmes of work:

Re-procured community services

The CCG re-procured community services in 2013 this process was designed to ensure that care is delivered closer to home and to support the development of integrated health and social care teams. The CCG continues to work with community, social care and third sector providers to deliver integrated care for the population of Oldham.

Integrated community services

The CCG has in place contracts for integrated community services in the following areas, Ophthalmology, Diabetes, Respiratory and End of Life care. Each of these services along with the core community services is designed to assist in managing patients care closer to home with a focus on avoiding unnecessary emergency admissions. These services also have a focus on education in primary care.

Management and identification in primary care

In collaboration with the Primary care programme the CCG has developed risk stratification to support identification of the population defined as ‘at risk’ of requiring emergency care. Each of the Long term condition clinical programmes also has a focus on case finding and closing the gap between predicted prevalence and actual disease registers.