Agenda

Locality Board – Meeting in Public

Date: 5th June 2023

Time: 4.00 pm – 6.00 pm

Venue: Council Chambers, Bury Town Hall Chair: Dr Cathy Fines

Item No.	Time	Duration	Subject	Paper/ Verbal	For Approval/ Discussion/ Information	By Whom
1.	4.00 – 4.05	5 mins	Welcome and apologies	Verbal	Information	Chair
2.			Declarations of Interest	Paper	Information	Chair
3.			Minutes of previous meeting held on 3rd April 2023	Paper	Approval	Chair
4.			Public Questions	Verbal	Discussion	Chair
Place Based Lead Update						
5.	4.05-4.15	10 mins	Key Issues in Bury	Paper	Discussion	Lynne Ridsdale
Integrated Delivery Collaborative Update						
6.	4.15-4.25	10 mins	Chief Officer's Update Report	Paper	Discussion	Kath Wynne-Jones
7.	4.25-4.40	15 mins	GM QIPP : Finance, Performance and Outcomes Standards 2023/24: Demand Management, Flow and QIPP	Paper	Discussion	Kath Wynne-Jones
8.	4.40-5.05	25 mins	Elective Care and Cancer Recovery and Reform	Presentation	Discussion	Karen Richardson
Updates & 'Quadruple Aims'						
9.	5.05-5.15	10 mins	Joint Forward Plan	Paper	Discussion	Warren Heppolette
10.	5.15-5.30	15 mins	System Finance Group Update • GM ICS position	Paper	Discussion	Sam Evans
11.	5.30-5.40	10 mins	System Assurance Committee update including; • NHS GM Quality Strategy	Paper	Information	Catherine Jackson

12.	5.40-5.50	10 mins	Strategic Workforce	Paper	Information	Kath Wynne-Jones
13.			Population Health & Wellbeing	Paper	Information	Jon Hobday
14.	5.50-5.55	5 mins (for all)	Performance Framework	Paper	Discussion	Will Blandamer
15.			PCCC Chair's Highlight Report	Paper	Information	Adrian Crook
16.			Clinical & Professional Senate	Verbal	Information	Dr Kiran Patel
17.			GP Leadership Collaborative • NHS GM Primary Care Blueprint • National Primary Care Recovery	Paper Verbal	Information	Mark Beesley / Chair
Closing Items						
18.	5.55-6.00	5 mins	Any Other Business	Verbal	Information	All

Date and time of next meeting
Monday, 3rd July 2023 at 4.00 pm via Microsoft Teams

If you wish to attend this meeting, please contact the Bury Corporate Team at; gmicb-bu.corporateoffice@nhs.net

If you would like to ask a question of the Bury Locality Board, please submit it by **email to** gmicb-bu.corporateoffice@nhs.net **no later than 31st May 2023 at 12 noon.** Questions received after this time will be taken to the following meeting.

Please note that due to the limited time we have, we cannot respond to public questions within the Locality Board meeting. We will acknowledge all the questions we receive and will respond to them formally in writing within 20 days.

Agenda Item 2

BURY INTEGRATED CARE PARTNERSHIP

Meeting: Locality Board			
Meeting Date	05 June 2023	**Action**	Consider
Item No.	2	**Confidential**	No
Title	Declarations of Interest		
Presented By	Dr Cathy Fines, Associate Medical Director and Chair of the Locality Board		
Author	Lindsay Johnson, Committee Secretary		
Clinical Lead			

Executive Summary

NHS GM has responsibilities in relation to declarations of interest as part of their governance arrangements (details of which can be found outlined in the NHS Greater Manchester Integrated Care Conflict of Interest Policy version 1.2).

NHS GM (Bury Locality) therefore, has a requirement to keep, maintain and make available a register of declarations of interest for all employees and for a number of boards and committees.

The Local Authority has statutory responsibilities detailed as part of Sections 29 to 31 of the Localism Act 2011 and the Relevant Authorities (Disclosable Pecuniary Interests) Regulations 2012. For other partners and providers, we understand that conflicts of interest are recorded locally and processed within their respective (employing) NHS and other organisations as part of their own governance and statutory arrangements too.

Taking into consideration the above, a register of Interests has been included detailing Declaration of Interests for the Locality Board.

In terms of agreed protocol, the Locality Board members should ensure that they declare any relevant interests as part of the Declaration of Interest Standing item on the meeting agenda or as soon as a potential conflict becomes apparent as part of meeting discussions.

The specific management action required as a result of a conflict of interest being declared will be determined by the Chair of the Locality Board with an accurate record of the action being taken captured as part of the meeting minutes.

There is a need for the Locality Board members to ensure that any changes to their existing conflicts of interest are notified to NHS GM (Bury Locality) Corporate Office within 28 days of a change occurring to ensure that the Declarations of Interest register can be updated.

Recommendations

It is recommended that the Locality Board:-

- Receive the latest Declarations of interest Register;
- Consider whether there are any interests that may impact on the business to be transacted at the meeting on 5th June 2023 and

BURY INTEGRATED CARE PARTNERSHIP

- Provide any further updates to existing Declarations of Interest within the Register.

OUTCOME REQUIRED *(Please Indicate)*	**Approval** ☐	**Assurance** ☐	**Discussion** ☐	**Information** ☒
APPROVAL ONLY; (please indicate) whether this is required from the pooled (S75) budget or non-pooled budget	**Pooled Budget** ☐	**Non-Pooled Budget** ☐		

Links to Strategic Objectives	
SO1 - To support the Borough through a robust emergency response to the Covid-19 pandemic.	☒
SO2 - To deliver our role in the Bury 2030 local industrial strategy priorities and recovery.	☒
SO3 - To deliver improved outcomes through a programme of transformation to establish the capabilities required to deliver the 2030 vision.	☒
SO4 - To secure financial sustainability through the delivery of the agreed budget strategy.	☒
Does this report seek to address any of the risks included on the NHS GM Assurance Framework?	☒

Implications						
Are there any quality, safeguarding or patient experience implications?	Yes	☐	No	☒	N/A	☐
Has any engagement (clinical, stakeholder or public/patient) been undertaken in relation to this report?	Yes	☐	No	☒	N/A	☐
Have any departments/organisations who will be affected been consulted ?	Yes	☐	No	☒	N/A	☐
Are there any conflicts of interest arising from the proposal or decision being requested?	Yes	☐	No	☒	N/A	☐
Are there any financial Implications?	Yes	☐	No	☒	N/A	☐
Is an Equality, Privacy or Quality Impact Assessment required?	Yes	☐	No	☒	N/A	☐
If yes, has an Equality, Privacy or Quality Impact Assessment been completed?	Yes	☐	No	☒	N/A	☐
If yes, please give details below:						
If no, please detail below the reason for not completing an Equality, Privacy or Quality Impact Assessment:						

Implications						
Are there any associated risks including Conflicts of Interest?	Yes	☒	No	☐	N/A	☐
Are the risks on the NHS GM risk register?	Yes	☐	No	☐	N/A	☒

Governance and Reporting		
Meeting	**Date**	**Outcome**
N/A		

Committees and Sub-Committees - Locality Board

Name	Current Position	Declared Interest- (Name of organisation and nature of business)	Type of Interest			Is the Interest direct or indirect?	Nature of Interest	Date of Interest		Comments	Consent to Publish Information
			Financial Interests	Non-Financial Professional Interests	Non-Financial Personal Interests			From	To		
Voting Members											
Cllr O'Brien	Leader of Bury Council & Joint Chair of the Locality Board	Bury Council - Councillor	X			Direct	Councillor			•Declaration of interest as per policy, •Declare in meetings where relevant, •Not to be sent papers where conflicted, •Not to be involved in any decision making where conflicted (which may then also involve the following action to be taken at a meeting); oRemaining present at the meeting but withdrawing from the discussion and voting capacity, oRemaining present at the meeting and participating in the discussion but not involved in any voting capacity. oBeing asked to leave the meeting	Y
		Young Christian Workers – Training & Development Team	X			Direct	Development Team				Y
		Labour Party		X		Direct	Member				Y
		Prestwich Arts College		X		Direct	Governor				Y
		Bury Corporate Parenting Board		X		Direct	Member				Y
		No Barriers Foundation		X		Direct	Trustee				Y
		CAFOD Salford		X		Direct	Member				Y
		Prestwich Methodist Youth Association		X		Direct	Trustee				Y
		Unite the Union		X		Direct	Member				Y
Cllr Tamoor Tariq	Executive Member of the Council Adult Care and Health	Bury Council - Councillor	X			Direct	Councillor	May-10	Present	•Declaration of interest as per policy, •Declare in meetings where relevant, •Not to be sent papers where conflicted, •Not to be involved in any decision making where conflicted (which may then also involve the following action to be taken at a meeting); oRemaining present at the meeting but withdrawing from the discussion and voting capacity, oRemaining present at the meeting and participating in the discussion but not involved in any voting capacity. oBeing asked to leave the meeting	Y
		Health Watch Oldham	X			Direct	Manager	Aug-20	Present		Y
		Pretty Little Thing				Indirect	Spouse		Present		Y
		Action Together CIC	X			Direct	Employed	Present			Y
		The Derby High School			X	Direct	Governor	Apr-18	Present		Y
		St Lukes Primary School		X		Direct	Member		Present		Y
		Unite the Union		X		Direct	Community Member	May-12	Present		Y
		Labour Party		X		Direct	Member	Jun-07	Present		Y
Cllr Lucy Smith	Executive Member of the Council for Children and Young People	Business in the Community	X			Direct		Jul-22	Present	•Declaration of interest as per policy, •Declare in meetings where relevant, •Not to be sent papers where conflicted, •Not to be involved in any decision making where conflicted (which may then also involve the following action to be taken at a meeting); oRemaining present at the meeting but withdrawing from the discussion and voting capacity, oRemaining present at the meeting and participating in the discussion but not involved in any voting capacity. oBeing asked to leave the meeting	Y
		The Christie NHS Foundation Trust				Indirect	Related to spouse	Jul-22	Present		Y
		Labour Party		X		Direct	Member	Oct-92	Present		Y
		Community the Union		X		Direct	Member	2016	present		Y
		Socialist Health Association		X		Direct	Member	2018	present		Y
		Catholics for Labour		X		Direct	Member	2018	present		Y
		GMB Union		X		Direct	Member	2016	present		Y
Warren Heppolette	Chief Officer for Strategy & Innovation	Greater Sport			X	Direct	Trustee	2018	Present	•Declaration of interest as per policy, •Declare in meetings where relevant, •Not to be sent papers where conflicted, •Not to be involved in any decision making where conflicted (which may then also involve the following action to be taken at a meeting); oRemaining present at the meeting but withdrawing from the discussion and voting capacity, oRemaining present at the meeting and participating in the discussion but not involved in any voting capacity. oBeing asked to leave the meeting	Y
		FC United			X	Direct	Director	2021	Present		Y
Dr Cathy Fines	Associate Medical Director & Joint Chair of the Locality Board	GP Federation	X			Direct	Practice is a member	2013	Present	•Declaration of interest as per policy, •Declare in meetings where relevant, •Not to be sent papers where conflicted, •Not to be involved in any decision making where conflicted (which may then also involve the following action to be taken at a meeting); oRemaining present at the meeting but withdrawing from the discussion and voting capacity, oRemaining present at the meeting and participating in the discussion but not involved in any voting capacity. oBeing asked to leave the meeting	Y
		Tower Family Health Care	X			Direct	Member practice is part of Tower Health Care	2017	Present		Y
		Horizon Clinical Network	X			Direct	Practice is a member	2019	Present		Y

		Greater Manchester Foundation Trust				Indirect	Husband is employed		Present		Y
Catherine Jackson	Associate Director for Nursing, Quality and Safeguarding (Bury)	NCA				Indirect	Partner is the Director of Patient Safety & Professional Standards at the NCA.	25.10.2021	Present	•Declaration of interest as per policy, •Declare in meetings where relevant, •Not to be sent papers where conflicted, •Not to be involved in any decision making where conflicted (which may then also involve the following action to be taken at a meeting); oRemaining present at the meeting but withdrawing from the discussion and voting capacity, oRemaining present at the meeting and participating in the discussion but not involved in any voting capacity. oBeing asked to leave the meeting	Y
Lynne Ridsdale	Chief Executive for Bury Council & Place Based Lead (GM ICS) Bury	CIPD		X		Direct	Fellow of the CIPD	2003	Present	•Declaration of interest as per policy, •Declare in meetings where relevant, •Not to be sent papers where conflicted, •Not to be involved in any decision making where conflicted (which may then also involve the following action to be taken at a meeting); oRemaining present at the meeting but withdrawing from the discussion and voting capacity, oRemaining present at the meeting and participating in the discussion but not involved in any voting capacity. oBeing asked to leave the meeting	Y
		NATS				Indirect	Husband employed by NATS, a contractor to Manchester Airport	2001	Present		Y
		National Trust			X	Direct	Member	2015	Present		Y
Sam Evans	Executive Director of Finance (Bury Council) and Strategic Finance Lead Bury Locality	Bury Council	X			Direct	Joint Role Held	5/5/2021	Present	Declaration of interest as per policy, declare in meetings where relevant. Actions required then to be agreed at the meeting by the Chair.	Y
Dr Vicki Howarth	Medical Director NCA (Bury)	Unilabs Ltd - Private Histopathology Service	x			Direct	Providing services as Consultant Histopathologist to the Alexandra Hospital, Cheadle.	2011	Present	•Declaration of interest as per policy, •Declare in meetings where relevant, •Not to be sent papers where conflicted, •Not to be involved in any decision making where conflicted (which may then also involve the following action to be taken at a meeting); oRemaining present at the meeting but withdrawing from the discussion and voting capacity, oRemaining present at the meeting and participating in the discussion but not involved in any voting capacity. oBeing asked to leave the meeting	Y
		Tameside and Glossop Integrated Care NHS Foundation Trust	x			Direct	Bank Consultant Histopathologist performing Coronial Post-Mortems for Manchester South Coroner	2015	Present		Y
Dr Kiran Patel	Medical Director (IDCB)	Tower Family Health Care	X			Direct	GP Partner	Jul-18	Present	•Declaration of interest as per policy, •Declare in meetings where relevant, •Not to be sent papers where conflicted, •Not to be involved in any decision making where conflicted (which may then also involve the following action to be taken at a meeting); oRemaining present at the meeting but withdrawing from the discussion and voting capacity, oRemaining present at the meeting and participating in the discussion but not involved in any voting capacity. oBeing asked to leave the meeting	Y
		Bury GP Federation - Enhanced Primary Care Services	X			Direct	Medical Director	Apr-18	Present		Y
		Laserase Bolton - Provider of a range of cosmetic laser and injectable treatments	X			Direct	Medical Director	1994	Present		Y
		Laserase Bolton - Provider of a range of cosmetic laser and injectable treatments				Indirect	Spouse is a Shareholder	2012	Present		Y
		Tower Family Health Care				Indirect	Spouse is a Director	Jul-18	Present		Y
Heather Caudle	Chief Nurse, NCA	Joint Royal College of Physicians Training Board					Member of the Specialist Advisory Committee in Palliative Medicine. – 4 days per year		Present	•Declaration of interest as per policy, •Declare in meetings where relevant, •Not to be sent papers where conflicted, •Not to be involved in any decision making where conflicted (which may then also involve the following action to be taken at a meeting); oRemaining present at the meeting but withdrawing from the discussion and voting capacity, oRemaining present at the meeting and participating in the discussion but not involved in any voting capacity. oBeing asked to leave the meeting	Y
		National Mental Health Nurse Directors Forum					Alumi – Attendance at the annual conference		Present		Y
		The Shuri Network					Steering Group Member – Monthly 2 hour meeting		Present		Y
		Kingston University, London					Visiting professor		Present		Y
		University of Surrey					Visiting professor		Present		Y
Donan Kelly	Chief Officer, Pennine Care Foundation Trust	Greater Manchester CYP Crisis Board		X		Direct	Chair	Jan-21	Present	•Declaration of interest as per policy, •Declare in meetings where relevant, •Not to be sent papers where conflicted, •Not to be involved in any decision making where conflicted (which may then also involve the following action to be taken at a meeting); oRemaining present at the meeting but withdrawing from the discussion and voting capacity, oRemaining present at the meeting and participating in the discussion but not involved in any voting capacity. oBeing asked to leave the meeting	Y
Sophie Hargreaves	Director, Manchester Foundation Trust	Manchester & Trafford LCO				Indirect	Spouse employed			•Declaration of interest as per policy, •Declare in meetings where relevant, •Not to be sent papers where conflicted, •Not to be involved in any decision making where conflicted (which may then also involve the following action to be taken at a meeting); oRemaining present at the meeting but withdrawing from the discussion and voting capacity, oRemaining present at the meeting and participating in the discussion but not involved in any voting capacity. oBeing asked to leave the meeting	Y
Helen Tomlinson	Chief Officer Bury VCFA	Bury One Commissioning Organisation			X	Indirect	Close family member is an employee at Bury One Commissioning Organisation	Nov-21	Present	•Declaration of interest as per policy, •Declare in meetings where relevant, •Not to be sent papers where conflicted, •Not to be involved in any decision making where conflicted (which may then also involve the following action to be taken at a meeting); oRemaining present at the meeting but withdrawing from the discussion and voting capacity, oRemaining present at the meeting and participating in the discussion but not involved in any voting capacity. oBeing asked to leave the meeting	Y
Will Blandamer	Deputy Place Based Lead & Executive Director Health and Adult Care	Ashton on Mersey Football Club Trafford			X	Direct	Chairman	2016	Present	•Declaration of interest as per policy, •Declare in meetings where relevant, •Not to be sent papers where conflicted, •Not to be involved in any decision making where conflicted (which may then also involve the following action to be taken at a meeting); oRemaining present at the meeting but withdrawing from the discussion and voting capacity, oRemaining present at the meeting and participating in the discussion but not involved in any voting capacity. oBeing asked to leave the meeting	Y
		Manchester Football Association			X	Direct	Non Executive Director & Board Champion for Safeguarding	2018	Present		
		Bury Council	X			Direct	Employed by Bury Council, and NHS GM reimburse a proportion of my salary	Oct-22	Present		
		Manchester Foundation Trust (Trafford Local Care Organisation)				Indirect	Spouse is a Community Nurse	Jan-23	Present		
Joanna Fawcus	Director of Operations, NCA	None Declared					Nil Interest			Declaration of interest as per policy	Y

Non-Voting Members

Jeanette Richards	Executive Director of Children and Young People, Bury Council	None Declared					Nil Interest		Present	Declaration of interest as per policy	Y

Jon Hobday	Director of Public Health, Bury Council	None Declared					Nil Interest		present	Declaration of interest as per policy	Y
Adrian Crook	Director of Adult Social Care and Community Services	Bolton Hospice			X		Trustee	Jul-05	Present	•Declaration of interest as per policy, •Declare in meetings where relevant, •Not to be sent papers where conflicted, •Not to be involved in any decision making where conflicted (which may then also involve the following action to be taken at a meeting); oRemaining present at the meeting but withdrawing from the discussion and voting capacity, oRemaining present at the meeting and participating in the discussion but not involved in any voting capacity. oBeing asked to leave the meeting	Y
Kath Wynne-Jones	Chief Officer, Bury IDC	KWJ Coaching and Consulting	X			Direct	Owner	6/9/2021	Present	•Declaration of interest as per policy, •Declare in meetings where relevant, •Not to be sent papers where conflicted, •Not to be involved in any decision making where conflicted (which may then also involve the following action to be taken at a meeting); oRemaining present at the meeting but withdrawing from the discussion and voting capacity, oRemaining present at the meeting and participating in the discussion but not involved in any voting capacity. oBeing asked to leave the meeting	Y
Ruth Passman	Chair of Bury Healthwatch	None Declared					Nil Interest			Declaration of interest as per policy	Y
Catherine Wilkinson	Director of Finance, NCA	Age UK Lancs			X	Direct	Trustee and Treasurer for Age UK Lancs	May-18	Present	•Declaration of interest as per policy, •Declare in meetings where relevant, •Not to be sent papers where conflicted, •Not to be involved in any decision making where conflicted (which may then also involve the following action to be taken at a meeting); oRemaining present at the meeting but withdrawing from the discussion and voting capacity, oRemaining present at the meeting and participating in the discussion but not involved in any voting capacity. oBeing asked to leave the meeting	Y
TBC	Representative from the Primary Care Network (Lead)										

In attendance

Cllr Mike Smith	Leader of Radcliffe First	Angles and Arches	X			Direct	Director	2009	Present	•Declaration of interest as per policy, •Declare in meetings where relevant, •Not to be sent papers where conflicted, •Not to be involved in any decision making where conflicted (which may then also involve the following action to be taken at a meeting); oRemaining present at the meeting but withdrawing from the discussion and voting capacity, oRemaining present at the meeting and participating in the discussion but not involved in any voting capacity. oBeing asked to leave the meeting	Y
		Anodising Colour				Indirect	Spouse is a lab technician	Jul-05	Present		Y
		Radcliffe First		X		Direct	Leader	2019	Present		Y
		Radcliffe Litter Pickers		X		Direct	Member	2019	Present		Y
		Growing Older Together		X		Direct	Member	2019	Present		Y
Cllr Russell Bernstein	Cllr Bury Council, Conservative Leader	Bury Council	X			Direct	Councillor	May-21	Present	•Declaration of interest as per policy, •Declare in meetings where relevant, •Not to be sent papers where conflicted, •Not to be involved in any decision making where conflicted (which may then also involve the following action to be taken at a meeting); oRemaining present at the meeting but withdrawing from the discussion and voting capacity, oRemaining present at the meeting and participating in the discussion but not involved in any voting capacity. oBeing asked to leave the meeting	Y
		Philips High School			X	Direct		Sep-19	Present		Y
		Bury and Whitefield Jewish Primary			X	Direct		May-21	Present		Y
		Conservative Party		X		Direct	Councillor	Jul-19	Present		Y

Agenda Item 3

BURY INTEGRATED CARE PARTNERSHIP

Meeting: Locality Board			
Meeting Date	05 June 2023	**Action**	Approve
Item No.	3	**Confidential**	No
Title	Minutes of the Locality Board meeting held on 3rd April 2023		
Presented By	Dr Cathy Fines, Associate Medical Director and Chair of the Locality Board		
Author	Lindsay Johnson, Committee Secretary		
Clinical Lead			

Executive Summary

The minutes of the Locality Board meeting held on 3rd April 2023 are presented as an accurate reflection of the previous meeting, reflecting the discussion, decisions and actions agreed.

Recommendations

It is recommended that the Locality Board:-

- Approve the minutes of the previous meeting held on 3rd April 2023 as an accurate record;
- Review and receive an update on the actions captured.

OUTCOME REQUIRED *(Please Indicate)*	**Approval** ☒	**Assurance** ☐	**Discussion** ☐	**Information** ☐
APPROVAL ONLY; (please indicate) whether this is required from the pooled (S75) budget or non-pooled budget	**Pooled Budget** ☐	**Non-Pooled Budget** ☐	**N/A** ☒	

Links to Strategic Objectives	
SO1 - To support the Borough through a robust emergency response to the Covid-19 pandemic.	☒
SO2 - To deliver our role in the Bury 2030 local industrial strategy priorities and recovery.	☒
SO3 - To deliver improved outcomes through a programme of transformation to establish the capabilities required to deliver the 2030 vision.	☒
SO4 - To secure financial sustainability through the delivery of the agreed budget strategy.	☒
Does this report seek to address any of the risks included on the NHS GM Assurance Framework?	☒

Implications						
Are there any quality, safeguarding or patient experience implications?	Yes	☐	No	☐	N/A	☒
Has any engagement (clinical, stakeholder or public/patient) been undertaken in relation to this report?	Yes	☐	No	☐	N/A	☒
Have any departments/organisations who will be affected been consulted ?	Yes	☐	No	☐	N/A	☒
Are there any conflicts of interest arising from the proposal or decision being requested?	Yes	☐	No	☐	N/A	☒
Are there any financial Implications?	Yes	☐	No	☐	N/A	☒
Is an Equality, Privacy or Quality Impact Assessment required?	Yes	☐	No	☐	N/A	☒
If yes, has an Equality, Privacy or Quality Impact Assessment been completed?	Yes	☐	No	☐	N/A	☒
If yes, please give details below:						
If no, please detail below the reason for not completing an Equality, Privacy or Quality Impact Assessment:						
Are there any associated risks including Conflicts of Interest?	Yes	☐	No	☐	N/A	☒
Are the risks on the NHS GM risk register?	Yes	☐	No	☐	N/A	☒

Governance and Reporting		
Meeting	**Date**	**Outcome**
N/A		

Minutes

Date: Locality Board, 3rd April 2023

Time: 4.00 pm

Venue: Microsoft Teams

Title	**Minutes of the Locality Board**		
Author	Lindsay Johnson		
Version	1a		
Target Audience	Locality Board		
Date Created	April 2023		
Date of Issue			
To be Agreed	June 2023		
Document Status (Draft/Final)	Draft		
Description	Locality Board Minutes		
Document History:			
Date	**Version**	**Author**	**Notes**
5/4/2023	1	Lindsay Johnson	Draft Minutes produced
12/4/2023	1	Lindsay Johnson	Submitted to Mr Blandamer for review.
19/4/2023	1a	Will Blandamer	Minor amendments incorporated.
Approved:			
Signature:			---------- **Add name of Committee/Chair**

Locality Board

MINUTES OF MEETING
Locality Board Inaugural Meeting in Public 3rd April 2023 4.00 pm until 6.00 pm **Chair – Cllr O'Brien**

ATTENDANCE

Voting Members
Cllr Eamonn O'Brien, Leader of Bury Council **(Chair)** Dr Cathy Fines, Senior Clinical Leader in the Borough Cllr Tamoor Tariq, Executive Member of the Council for Adult Care and Health (joined at 4.30 pm) Cllr Lucy Smith, Executive Member of the Council for Children and Young People Mr Warren Heppolette, Chief Officer for Strategy and Innovation (GMIC) Ms Lynne Ridsdale, Place Based Lead Mr Simon O'Hare, Deputy Locality Finance Lead **(Deputising for Ms Sam Evans)** Ms Heather Caudle, Group Chief Nursing Officer, NCA Ms Joanna Fawcus, Director of Operations, NCA Mr Donan Kelly, Chief Officer, Pennine Care Foundation Trust Ms Catherine Jackson, Associate Director of Nursing, Quality and Safeguarding Ms Helen Tomlinson, Chief Officer, Bury VCFA (Voluntary, Community, Faith & Social Enterprise) Mr Will Blandamer, Deputy Place Based Lead, Executive Director of Health and Care
Non-Voting Members
Ms Jeanette Richards, Director of Children's Services Mr Adrian Crook, Director of Adult Social Services and Community Commissioning Ms Kath Wynne-Jones, Chief Operating Officer, IDCB
Invited Members
Cllr Mike Smith, Radcliffe Opposition Party Cllr Russell Bernstein, Conservative Opposition Party Mr Rob Bellingham, Director of Primary Care and Strategic Commissioning for Agenda item 9 Ms Philippa Braithwaite, Democratic Services, Bury Council Ms Jacqui Dennis, Head of Legal Services, Bury Council Mrs Lindsay Johnson, Committee Secretary **(Minutes)**

BURY INTEGRATED CARE PARTNERSHIP

MEETING NARRATIVE & OUTCOMES

1	Welcome, Apologies And Quoracy
1.1	The Chair welcomed all to the meeting.
1.2	Apologies were received from Dr Vicki Howarth, Ms Sophie Hargreaves, Mr Jon Hobday, Ms Catherine Wilkinson and Ms Sam Evans.
1.3	The meeting was declared quorate and commenced.

2	Declarations Of Interest
2.1	NHS GM has responsibilities in relation to declarations of interest as part of their governance arrangements (details of which can be found outlined in the NHS Greater Manchester Integrated Care Conflict of Interest Policy version 1.2).
2.2	NHS GM (Bury Locality) therefore, has a requirement to keep, maintain and make available a register of declarations of interest for all employees and for a number of boards and committees.
2.3	The Local Authority has statutory responsibilities detailed as part of Sections 29 to 31 of the Localism Act 2011 and the Relevant Authorities (Disclosable Pecuniary Interests) Regulations 2012. For other partners and providers, we understand that conflicts of interest are recorded locally and processed within their respective (employing) NHS and other organisations as part of their own governance and statutory arrangements too.
2.4	Taking into consideration the above, a register of Interests has been included detailing Declaration of Interests for the Locality Board.
2.5	In terms of agreed protocol, the Locality Board members should ensure that they declare any relevant interests as part of the Declaration of Interest Standing item on the meeting agenda or as soon as a potential conflict becomes apparent as part of meeting discussions.
2.6	The specific management action required as a result of a conflict of interest being declared will be determined by the Chair of the Locality Board with an accurate record of the action being taken captured as part of the meeting minutes.
2.7	There is a need for the Locality Board members to ensure that any changes to their existing conflicts of interest are notified to NHS GM (Bury Locality) Corporate Office within 28 days of a change occurring to ensure that the Declarations of Interest register can be updated.
2.8	**Declarations of interest from last meeting held on 6th February 2023** No declarations to note.
2.9	**Declarations of interest from today's meeting 3rd April 2023** None to declare other than what was detailed on the Declarations of Interest register submitted within the meeting pack.

ID	Type	The Locality Board	Owner
D/04/01	Decision	Received the declaration of interest register.	

3	Minutes Of The Last Meeting And Action Log
3.1	The minutes from the Locality Board meeting held on 6th February 2023 were considered as a true and accurate reflection of the meeting.
3.2	In regard to the outstanding action, this was confirmed as closed for the Locality Board as the action had been assigned to the Strategic Finance Group to take forward. The Locality Board was informed that discussions had taken place at the Strategic Finance Group meeting and that a number of partners were reviewing in order to try and build capacity within the voluntary sector.

ID	Type	The Locality Board	Owner
D/04/02	Decision	Accepted the minutes from the previous meeting as a true and accurate reflection of the meeting and agreed the outstanding action could be closed.	

4	Public Question
4.1	There were no public questions received or members of the public present at the meeting.

ID	Type	The Locality Board	Owner
D/04/03	Decision	Noted that there had been no public questions received and no members of the public were present at the meeting.	

5	Locality Board Formalisation
5.1	Mr Blandamer advised that at the Integrated Care Board meeting held on 15th March 2023, the Bury Locality Board was formally constituted as a decision making board from 1st April 2023. The Bury Locality Board would be a hybrid arrangement as outlined in the submitted documents and summarised as below:-
5.2	In respect of the Integrated Health and Care Fund (S75, Pooled Budget), the Locality Board will sit as a **joint committee** (of the ICB and Local Authority), established under Regulation 10(2) of the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000 ("the 2000 Regulations").
5.3	In respect of the NHS GM Aligned Budget (non-pooled) element of the Integrated Health and Care Fund (Aligned Budgets), the Locality Board will sit as a **Committee** of the Integrated Care Board (ICB) of NHS GM on which there is Council and wider partner representation. The Locality Board will fulfil the requirements as outlined in the NHS GM Scheme of Reservation and Delegation.
5.4	The Locality Board would hold one meeting with all members present in which both elements would be discussed and received in a collaborative way and the agenda/report coversheet would clearly define which remit a decision was to be made under. All voting arrangements are outlined in the Terms of Reference accordingly.

ID	Type	The Locality Board	Owner
D/04/04	Decision	Received the confirmation of the Locality Board being formally constituted as a decision board from 1st April 2023.	

6	Place Based Lead Update
6.1	Ms Ridsdale introduced her item and thanked colleagues for the warm welcome received as she commenced in her role as Place Based Lead for NHS GM (Bury) and also as Bury Council Chief Executive. Ms Ridsdale stated that since being in the role of (Place Based Lead) she had visited a number of health and care services in the borough and met with senior leaders and therefore thanked everyone for their time.

6.2	Ms Ridsdale made reference to the NHS GM 64 day staff consultation which had been launched on 29th March 2023 by the NHS GM Chief Executive, Mr Mark Fisher. Ms Ridsdale commented on the complexities involved in establishing structures and said that it was important for all to be mindful of the sensitivities surrounding this with NHS GM (Bury) colleagues.
6.3	In terms of Children's Services and SEND, Ms Ridsdale reiterated the need for a collective, concerted contribution from all partners in this in order to recognise and prioritise and build for the future services for children, young people and families for the whole system.
6.4	The Chair requested that formal thanks be recorded in the minutes for Mr O'Gorman on behalf of the Locality Board acknowledging that Mr O'Gorman had been a wise and inspirational leader in the system and as such we are grateful for all of his work.

ID	Type	The Locality Board	Owner
D/04/05	Decision	Received the update.	

7	Feedback from Development Session
7.1	Mr Blandamer presented the agenda item which gave an update from the Development Session held 6th March 2023, facilitated by external consultant, Mike Farrar.
7.2	Mr Blandamer gave thanks to colleagues for their contribution at the workshop and advised that there had been some key areas of focus/activity along with some priorities identified which had been detailed in the report.
7.3	Mr Blandamer proposed that as Locality Board members have the opportunity of working with Carnall Farrar (CF) (as part of the NHS GM wide review of governance and leadership) that the next steps/actions from the workshop be put on hold (for the time being) in order to reflect the work being carried out by CF. The Locality Board members agreed with this approach.
7.4	The Chair commented on the workshop facilitated by Mike Farrar, stating that he had found it useful.

ID	Type	The Locality Board	Owner
D/04/06	Decision	Noted the update provided following the development session and that actions and next steps would be placed on "hold" for the time being to reflect the work being carried out by CF.	

8	IDC Update
8.1	A verbal update was provided to the Locality Board with Ms Wynne-Jones explaining that the following had recently been considered in regard to the IDC; • IDC approved programme of work including board development, culture, programmes of care and financial strategy. • Aqua (advancing quality alliance) domains and where we need to get to. • Blueprint, full integration and workshops. • Governance around the Terms of Reference and expanding membership. • Clear reporting arrangements. • Patient engagement and strengthening of that. • Workforce strength based approaches and system leadership. • Realignment of SROs - 2/3 priorities and capacity aligned in the right places. • Key metrics and ensuring each programme has a metric of success that align to the quadruple aims and lets do it strategy. • Risk and performance management, along with building on GM performance dashboard.

	• Financial strategy and a programme of potential opportunities and focus to drive efficiency as a system as well as budgets and opportunities for continued efficiency.
8.2	The reduction in the number of priorities was recognised which had been an ask of the Locality Board. It was advised that this would enable collective working when required along with the aim to stop duplication and repetition where possible.

		The Locality Board	
D/04/07	Decision	Received the update and noted the detailed work that had been undertaken.	

9	**Primary Care Blue Print Strategy**
9.1	Mr Bellingham, Director of Primary Care and Strategy at NHS GM was present for this agenda item in order to give the Locality Board some information regarding the Greater Manchester Primary Care Blueprint (Strategy).
9.2	It was advised that the GM Primary Care Blueprint was a collective plan for primary care in Greater Manchester which was first discussed in September 2022 at the Primary Care Summit that was attended by over 350 primary care colleagues. The session provided a rich source of ideas, issues and themes to take forward for the blueprint.
9.3	A number of key themes had also been agreed which were as follows:- • Capacity • Integrated working in neighbourhoods • Tackling and reducing inequalities • Prevention • Delivering a sustainable primary care system in GM
9.4	It was also advised that 'enabler' themes had been established for digital, workforce, estates, quality and standards.
9.5	Mr Bellingham advised the Locality Board that the aim was for the Blueprint to be completed by the end of June 2023.
9.6	A number of slides were provided to the Locality Board and Mr Bellingham made specific reference to the following:-
9.7	**Slide 6** This outlined the leadership approach and principles for the development of the Blueprint. It was noted that Ms Alderson, Head of Primary Care was the locality lead for Bury and had inputted into the Blueprint.
9.8	**Slide 9** This described how the Primary Care Strategy will be delivered as well as detailing aims for access, tackling health inequalities, prevention, early detection, managing long term conditions as well as standards.
9.9	The agenda item was opened up for discussion.
9.10	A comment was raised which enquired if a wider review/stock take on Primary Care as a whole should take place in order to understand the challenges and pressures and in particular those linkages around intervention, prevention, urgent care, demand and reduction, annual health checks and A&E attendances.

9.11	In order to address some elements of the above, the Locality Board was informed that the Bury locality Primary Care Strategy that was in development, described some of those measurable steps as well as identifying prioritisations, enabling work programmes and also asks of the wider system partners.
9.12	Mr Bellingham also advised that the Blueprint would set the standards and provide a model for Primary Care, however it would not promote uniformity across localities and that was where further detail should be sought from the locality primary care strategies.
9.13	It was advised that the aim of the Blueprint would be to consider capacity along with intent and the clustering of systematic challenges. In regard to capabilities it would be important to ensure that those were operating at the right scale and level.
9.14	Cllr Lucy Smith made specific reference to the engagement of the strategy and the importance of engaging with people and communities around their health and their choices. She said that it was essential engagement took place at a grass roots level.
9.15	Mr Bellingham agreed and advised that he was keen for the engagement to be sought through existing channels and mechanisms already in situ in Bury. He said he would welcome the locality's involvement in identifying those networks.
9.16	The Chair thanked Mr Bellingham for his presentation and suggested that the Locality Board members share the draft GM Primary Care Blueprint across wider system forums (where possible and appropriate) for feedback and comments.

ID	Type	The Locality Board	Owner
D/04/08	Decision	Received the Primary Care Blueprint Strategy and noted that once the draft was available that this should be shared across the system for feedback and comments.	
A/04/01	Action	To share the draft GM Primary Care Blueprint within their networks.	

10	Retrospective Approval of Urgent and Emergency Care Pressures Submission
10.1	Mr O'Hare advised that all localities would be receiving an allocation to provide additional support to support winter pressures, discharge to access and adult social care.
10.2	The Locality Board was informed that a submission would be provided by the locality and in order to achieve that submission a series of meetings with all system partners (including statutory and non-statutory partners along with those delivering the services) had taken place for that collective input. It was also confirmed that this had been shared in a number of other meetings including the Urgent Care Board.
10.3	The aim had been that this would be shared with the Locality Board at today's meeting, however due to a clarification matter, the paper would be issued to all members off line outside of the meeting.
10.4	The Locality Board would be asked the following;
10.5	1. To note process 2. To support overall provision 3. To support the elements as described in relation to the Better Care Fund.
10.6	Mr O'Hare advised that if any of the Locality Board members had any questions, they could contact him directly.

ID	Type	The Locality Board	Owner
D/04/09	Decision	Noted the verbal update and that a report would be issued offline outside of the meeting.	

11	SEND Graduated Approach Toolkit		
11.1	This item was deferred to the next meeting in June.		
ID	**Type**	**The Locality Board**	**Owner**
D/04/10	Decision	Noted that this agenda item would be presented at a future meeting.	

12	NHS Operating Planning Round for 23/23
12.1	The paper was introduced to the Locality Board which described to them the key priorities for 2023/24.
12.2	The paper submitted was a very comprehensive and detailed paper that pertained to the Bury Integrated Care Partnership with the intent of ensuring each programme in the partnership was very clear on the targets and priorities required. Mr Blandamer acknowledged the amount of work that had taken place in describing all the key planning and metrics and of the alignment to the programmes of work (as captured below) • Elective care, cancer and diagnostics; • Urgent Care; • Community Services; • Primary Care; • Maternity Services; • Mental Health (MH); • Learning Disabilities (LD); • Children and Young People; and • Health Inequalities and Population Health.
12.3	Mr Blandamer gave thanks to Susan Sawbridge for her tremendous work on this and confirmed also that all providers had made contributions in this submission too.
12.4	As detailed in the report the 2023/24 NHS Planning Guidance that can be found here: NHS Priorities and Planning Guidance 2023/24.

ID	Type	The Locality Board	Owner
D/04/11	Decision	Received the report and acknowledged the work of the programme areas to ensure alignment with the NHS operating plan for 2023-24.	

13	Strategic Finance Group
13.1	Mr O'Hare gave a brief update in relation to the budget setting describing the key points as follows:- • Challenging QIPP target • Bury Council have a balanced position and a testing savings target • Providers face difficult challenges • NHS GM and NHSE continue to have weekly meetings
13.2	Mr O'Hare informed the Locality Board that a report would be provided to them outlining the position.
13.3	Mr Blandamer commented on the role of the Strategic Finance Group and of the work that NHSE are carrying out in line with PWC in order to understand the drivers in relation to the financial challenges.

13.4	He said that it would be important to bring forward a report to the next meeting reflecting on scale, professional advice and the steps that we need to take in Bury. The Chair outlined the need to ensure that the Locality Board is continued to be sighted on those discussions around the financial planning.

ID	Type	The Locality Board	Owner
D/04/12	Decision	Noted the update provided.	
A/04/02	Action	Agreed for a report to be submitted to the next Locality Board meeting (if possible) reflecting on the work carried out PWC/financial challenges and the steps that are needed in Bury.	

14	Any Other Business
14.1	There was no other business to report and the Chair formally closed the meeting in public at 17.01.

ID	Type	The Locality Board	Owner
D/04/13	Decision	Noted that there was no other business to report and the meeting in public was closed at 17.01	

Locality Board Action Log

Status Rating - In Progress - Completed -

Title	Action	Lead	Status	Due Date	Update
A/04/01	To share the draft GM Primary Care Blueprint within their networks.	All			
A/04/02	Report to be submitted to the next Locality Board meeting (when available) reflecting on the work carried out PWC/financial challenges and the steps that are needed in Bury.	SOH			

Agenda Item 5

BURY INTEGRATED CARE PARTNERSHIP

Meeting: Locality Board			
Meeting Date	05 June 2023	Action	Receive
Item No.	4	Confidential	No
Title	Place Based Lead Update - Key Issues in Bury		
Presented By	Lynne Ridsdale, Place Based Lead		
Clinical Lead	Dr Cathy Fines		

Executive Summary
To provide an update on key issue of the Bury Integrated Care Partnership
Recommendations
The Locality Board is asked to note the update.

Links to Strategic Objectives	
SO1 - To support the Borough through a robust emergency response to the Covid-19 pandemic.	☒
SO2 - To deliver our role in the Bury 2030 local industrial strategy priorities and recovery.	☒
SO3 - To deliver improved outcomes through a programme of transformation to establish the capabilities required to deliver the 2030 vision.	☒
SO4 - To secure financial sustainability through the delivery of the agreed budget strategy.	☒
Does this report seek to address any of the risks included on the NHS GM Assurance Framework?	☒

Implications						
Are there any quality, safeguarding or patient experience implications?	Yes	☐	No	☐	N/A	☒
Has any engagement (clinical, stakeholder or public/patient) been undertaken in relation to this report?	Yes	☐	No	☐	N/A	☒
Have any departments/organisations who will be affected been consulted?	Yes	☐	No	☐	N/A	☒
Are there any conflicts of interest arising from the proposal or decision being requested?	Yes	☐	No	☐	N/A	☒
Are there any financial Implications?	Yes	☐	No	☐	N/A	☒
Is an Equality, Privacy or Quality Impact Assessment required?	Yes	☐	No	☐	N/A	☒
If yes, has an Equality, Privacy or Quality Impact Assessment been completed?	Yes	☐	No	☐	N/A	☒
If yes, please give details below:						

Implications						
If no, please detail below the reason for not completing an Equality, Privacy or Quality Impact Assessment:						
Are there any associated risks including Conflicts of Interest?	Yes	☐	No	☐	N/A	☒
Are the risks on the NHS GM risk register?	Yes	☐	No	☐	N/A	☒

Governance and Reporting		
Meeting	**Date**	**Outcome**
N/A		

1. **NHS GM Staff Consultation**

The formal consultation with NHS GM staff about staffing structures at both GM and locality level closed on 31st May. Following the end of consultation work will be undertaken to assess the outcome of the consultation, finalise the locality allocation, and finalise the process for pooling and filling posts by June. Filling of posts will commence in July and is intended to be largely complete by August. May I take this opportunity of thanking NHS GM (Bury) staff for their ongoing commitment and dedication to the work during this period of uncertainty.

2. Bury Integrated Delivery Collaborative

Kath Wynne Jones will provide an update on the work of the Integrated Delivery Board and wider Collaborative in her report later on the agenda. But may I thank colleagues across the system for getting us to the point where we have clarity on the SRO and Clinical leadership of each of the programmes overseen by the IDCB. A workshop was held on 16th May to step closer to clarity on not only leadership but 2 or 3 key priorities for each programme and the alignment of financial and activity information. A model of dispersed leadership across all partners for the work we do together is a positive place to be in. Further work is required to clarify the relationship to GM wide System Boards and programmes from each of our local programmes.

3. Palliative and End of Life Care Summit

Our palliative and End of Life Care programme is jointly let by Helen Lockwood – CEO Bury Hospice, and David Thorpe – Director of Nursing NCA Bury. Building on the outcomes of the preceding 5-year strategy a summit will be held on 28th June to frame the next steps in the transformational of palliative and end of life care services in the borough. Invites will be circulated in due course.

4. PWC Report

Colleagues will be aware that in the light of a very challenging financial position for the NHS in GM in this year 23/24, NHS GM has commissioned a report from PWC to identify opportunities for reducing costs. This report will be made available through the locality board when finalised. Key initial findings focus on issues around workforce, acuity and complexity, demand for services, the equity and utilisation of community-based services, and opportunities of back-office function alignment and aggregation.

A key element of the work will be to assess further opportunities to improve outcomes for residents, improve prevention and early intervention, and avoid unnecessary attendance at, or admission to hospital services, and to improve flow out of hospital. Colleagues across the Bury partnership have worked to identify some key lines of activity - on non-elective admission, elective admissions, ED attendances, delayed discharges and out of area placements, and this report is provided later on the agenda for retrospective approval. May I thank colleagues who have worked on this in a positive and system-based way.

5. Carnell Farrar Report

At the last Locality Board colleagues from CF attended to understand the way in which the locality board works in relation to the wider NHS GM ICB architecture. An Executive Summary of the CF report was circulated on 31/5/2023 and can be found on the Bury ICP website for reference on the Resources page: (Healthcare News & Resources | Bury Integrated Care Partnership). The report makes a series of observations on the themes of commitment, alignment, and direction. There are eight recommendations broadly focused on strengthening the clarity on decision making and accountability in the GM ICS – reflective of the work of Locality Boards, Provide Boards, System Boards, the GM ICB and the Joint Planning and Delivery Group. In circulating the report Mark Fisher recognised the review offered challenging findings which were nevertheless welcome as the ICS and ICB matures. Mark recognised 2 key priorities:

1. The development of an 'Integrated Strategic Delivery Plan' which will link the totality of our ICP strategy and our more immediate plans– Warren Heppolette is progressing this agenda through the work on the Joint Forward Plan (see below)
2. Clarification of the Operating Model - bringing greater precision to the roles of the ICB, localities, PFB and the system boards.

We will look to bring key themes from the report. both back to the Locality Board in due course and propose any amendments to the operation of the Bury Locality Board as required.

6. Joint Forward Plan

On 31st May Warren Heppolette – Chief Officer Strategy and Innovation, circulated an engagement draft of the Joint Forward Plan for the ICS. The papers have been circulated at short notice to locality board members and can also be seen on the Bury Integrated Care Partnership Website on the Resources page: (Healthcare News & Resources | Bury Integrated Care Partnership). The closing date for responses to the engagement draft is 26th June.

7. GP Services in Bury.

The meeting will recall a presentation at the last meeting on the GM primary care blueprint. A draft version of the final blueprint it available for consideration and has been discussed at the BICP GP Collaborative meeting on 17th May and the Clinical and Professional Senate on 31/5/23. The Locality Board should be assured that the blueprint provides context to, and aligns, with the outcome of the GP Workshop held in Bury in March and for which a key implementation plan has been agreed and developed.

An initial version of the PWC report referred to above has suggested a relative under staffing and under funding of GP services in Bury but further analysis is being undertaken to validate the figures used and the results are awaited. The draft PWC report did also provisionally indicate that the relative utilisation of some acute services (non-elective admissions, elective admissions, outpatients and A&E attendances) is relatively lower in Bury compared to other parrs of GM, which suggests GP services are both available and using secondary care services appropriately.

8. Intermediate Care Services

Through the urgent care board, a piece of work is being undertaken to ensure we have right sized and balanced across the spectrum of need the provision of intermediate care services, particularly bed-based

provision. We are pleased to welcome Ian Mello back to Bury on a temporary basis who will be leading this important piece of work reporting to the urgent care board.

9. **Statutory Meetings:** This report will routinely update the locality board on the work of the Health and Adult Care Scrutiny Committee and the Health and Well Being Board. Neither meeting has met since the last Locality Board but the Council at its first meeting of the municipal year held on 24th May has confirmed the leadership appointment for each function.

10. National Front Runner Discharge Programme

The locality board will be aware that the 4 localities partnership – describing the joint work of partners across Salford, Bury, Oldham and Rochdale and with NCA – was successful in becoming a national front runner testing new models of hospital discharge planning. Lindsey Darley leads this programme of work, which has two key themes – reviewing the discharge arrangements for those with complex dementia and focusing on a strengths-based approach to reduce deconditioning and promote independence in the hospital. Colleagues in Bury have embraced the opportunity of this focal point on discharge and evidence of improved outcomes is beginning to be evident in trial wards. A workshop held on 12/5/23 confirmed leadership and operational commitment to the programme in Bury.

11. Transforming Care Programme.

The Locality Board will be aware of this programme intended to significantly reduce the number of people with learning disabilities in long term institutional care and supported to be part of communities. It is very heartening to see Bury performs very highly compared to other GM localities on this indicator and i would like to thank colleagues in Bury and across GM for making such good progress.

12. Team Bury Partnership Arrangements.

The Locality Board, and the Health and Well Being Board (operating as a standing committee on health inequalities) sits as part of the Team Bury partnerships – driving forward our collective ambition for residents in the borough. Attached as Appendix 1 is confirmation of the other key partnership arrangements. Thankyou to all colleagues in the Bury health and care system for their commitment and support to many aspects of these arrangements.

13. GM Urgent Care System Tier 1 Support

NHS England have placed all integrated care systems in to one of three 'tiers', based on their urgent and emergency care performance, specifically A&E waits, and ambulance response times. GM along with approximately seven other systems, have been placed in Tier 1, which means we have been assessed as having the most challenges. Mark Fisher as Chief Executive of NHS GM has indicated that this is not surprising some key challenges to the GM system, and also it is not unwelcomed, as it now means we will be offered the highest level of support, advice, and guidance in addition to the resources we have already mobilised to help our system improve.

The locality board has previously been briefed on the relatively good performance of the urgent care system in Bury as determined by benchmarked performance on for example A&E waiting times, Ambulance turnaround times at FGH, and the numbers of 'days kept away from home patients. We would also recognise that pressures in the urgent care system are evident in other key sectors such as primary care, mental health services, and Community health services, and in social care provision.

Our position in Bury will be to recognise good progress, to note improvement opportunities (e.g via the

national discharge programme) but also benefit from the improvement and learning opportunities of the Tier 1 support at a GM level.

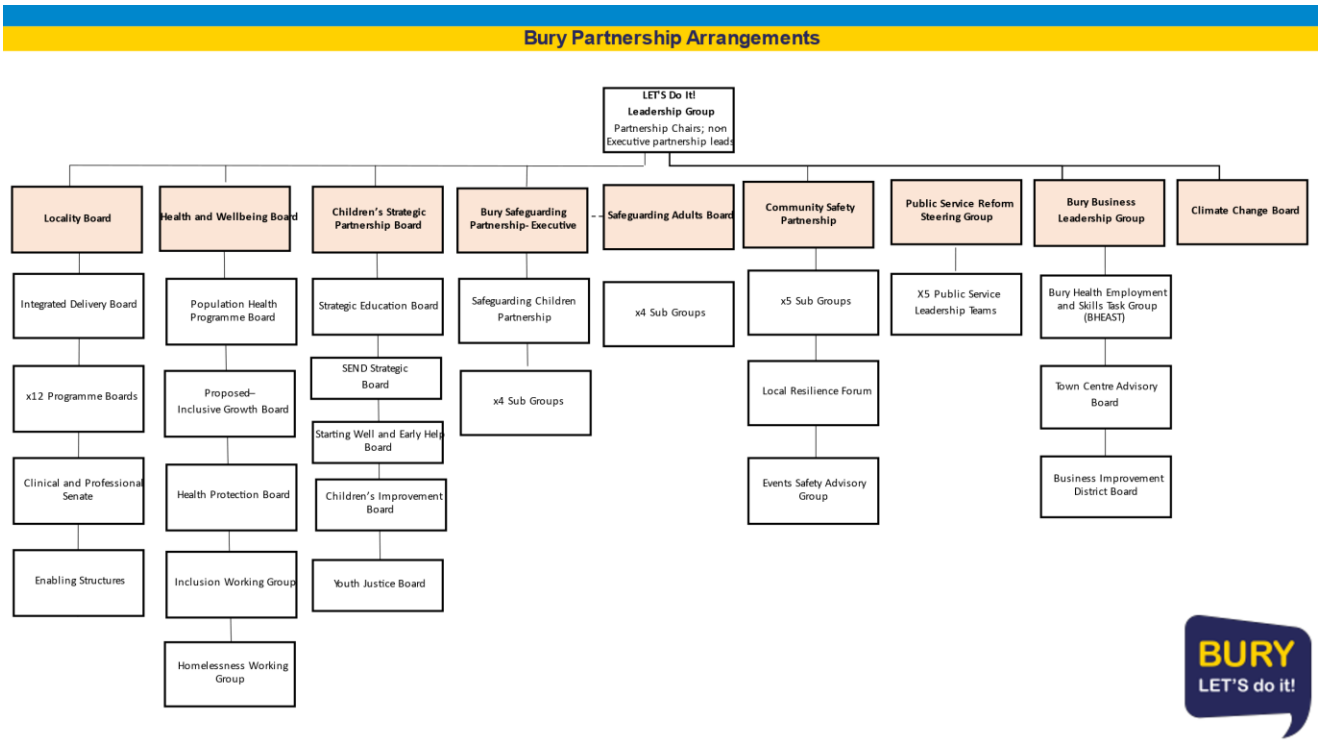
14. Jo Fawcus

Finally, may I offer my congratulations to Jo on her appointment to the substantive role of Chief Operating Officer of Bury Care Organisation in the NCA following an excellent interim period of work. Jo has been a great asset to the Bury system and along with other colleagues brings a resilient and talented team together and with a mindset of partnership and engagement that is most welcome as we drive our transformation programmes forward together.

Lynne Ridsdale
Place Based Lead
June 2022

BURY INTEGRATED CARE PARTNERSHIP

Appendix 1 – Team Bury Partnership Arrangements.



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Joint Forward Plan – Summary

Greater Manchester Integrated Care Partnership

1

Joint Forward Plan

Greater Manchester Integrated Care Partnership

- National guidance states that each ICB must publish a five-year Joint Forward Plan setting out how they propose to exercise their functions, which must be shared with NHSE by 30th June 2023.
- Whilst legal responsibility for the JFP lies with the ICB for the elements under their remit, systems have also been encouraged to use the JFP to develop a shared delivery plan for the integrated care partnership strategy. This is the approach we are taking in Greater Manchester
- Guidance from NHSE describes that the plans should be:
  - Fully aligned with the ambitions of the wider partnership
  - Build on local strategies and plans and reflect universal NHS commitments
  - Delivery-focused
- Whilst the JFP will cover 5 years, it will necessarily be more detailed in terms of the first two years.

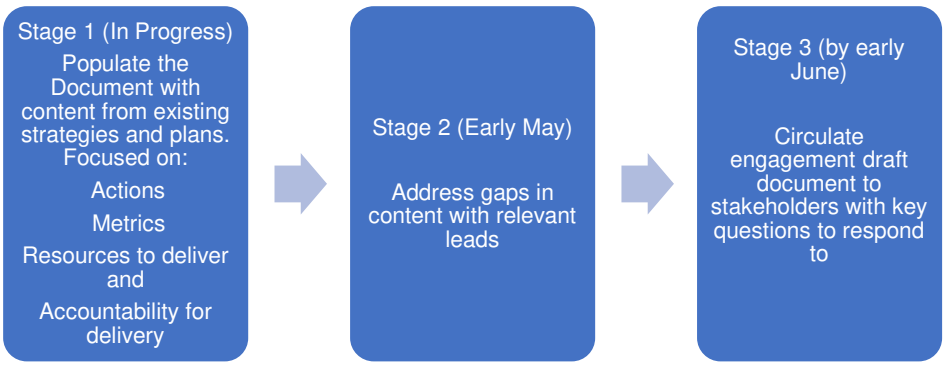
2

Update on Process

- The engagement draft is built from:
  - ICP Strategy
  - 23/24 Operational Plan
  - PWC and Carnall Farrar reports
  - Range of current system plans – including Locality Plans
  - Input from System Leads and Workshops
- As such, the plan reflects work in train within the system and being overseen by the governance. This is strengthened by detail on how we will measure delivery and accountability arrangements.
- The JFP is structured on the key actions to deliver the six ICP Strategy missions. We have set out proposed delivery and system leadership for each of the missions
- It is recognised that we need to keep developing the plan – particularly in respect of system financial sustainability. The plan sets out next steps and these are summarised in these slides.

3

Developing the Content



4

JFP Structure

Chapter	Content
Introduction and Context	• Short intro to GM system • Our strategic challenges • Our Opportunities and Assets
Our Strategy	• Summary of the ICP Strategy – vision, outcomes, missions, GM model for health
What we Will Do – Our Missions - Strengthening our communities - Helping people stay well and detecting illness earlier - Helping people get into, and stay in, good work - Recovering Core NHS and Care Services - Supporting our Workforce and Carers - Achieving Financial Sustainability	• The Actions to Deliver the 6 Missions • Measuring our delivery • Accountability
How we Will Deliver	• Performance Framework • Assurance and governance arrangements • Ways of Working • Next Steps in Implementing the Plan • Locality Plans (Links)

5

Our Missions – Overview

6

Proposed Accountability Arrangements

- Delivery Leadership – the board/organisation accountable for driving change and improvement in the relevant part of the system. This recognises that the key responsibility for bringing together and driving delivery will sit with Locality Boards, providers and provider collaboratives

- System Leadership – This recognises the board/group accountable for creating the system-wide conditions, frameworks, and standards to enable delivery

7

Our missions to meet the challenges

Strengthening our communities

Delivery Leadership: Locality Boards

System Leadership: Population Health Board

Areas of focus	Actions
Scale up and accelerate delivery of person-centred neighbourhood model	Continue to develop Live Well and Social Prescribing
	Coordinate our response to poverty
	Expand community-based mental health provision
	Living Well at Home
	Take an inclusive approach to digital transformation
Develop collaborative and integrated working	Embed the VCSE Accord
	Deliver a GM-wide consolidated programme for those experiencing multiple disadvantage
	Embed the GM Tripartite Housing Agreement
	Giving every child the best start in life
	Ageing Well
	Increase identification and support for victims of violence
Develop a sustainable environment for all	Delivering our Green Plan

8

Our missions to meet the challenges

Helping people stay well and detecting illness earlier
Delivery Leadership: Locality Boards

System Leadership: Clinical Effectiveness and Governance Committee (CEG); Population Health Board

Areas of Focus	Actions
Tackling inequalities	Reducing health inequalities through CORE20PLUS5 (adults)
	Equity in access to care and improved experience and outcomes for all children and young people (CORE20PLUS5 clinical priorities)
	Implementing a GM Fairer Health for All Framework
Supporting people to live healthier lives	A renewed Making Smoking History Framework
	Alcohol
	Enabling an Active Population
	Promoting Mental Wellbeing
	Food and Healthy Weight
	Eliminating New Cases of HIV and Hepatitis C
	Increasing the uptake of vaccination and immunisation
Upscaling secondary prevention	Early Cancer Diagnosis
	Early detection and prevention of Cardiovascular Disease
	Earlier diagnosis of Respiratory Conditions through Quality Assured Spirometry
	Early detection of unmet health needs for those living with Learning Disability and those with Severe Mental Illness
Living well with long-term conditions	Managing Multimorbidity and Complexity
	Optimising Treatment of long-term conditions
	Expansion of the Manchester Amputation Reduction Strategy (MARS) across NHS GM
	The GM Dementia and Brain Health Delivery Plan
	Taking an evidenced based approach to responding to frailty and preventing falls
	Anticipatory Care and Management for people with life limiting illness

9

Our missions to meet the challenges

Helping people get into, and stay in, good work

Delivery Leadership: Locality Boards

System Leadership: Population Health Board; GM Good Employment Charter Board, GM Employment and Skills Advisory Board

Areas of Focus	Actions
Enhance Scale of Work and Health Programmes	Expansion of our Working Well System
Develop Good Work	Working with employers on employee wellbeing through the GM Good Employment Charter
Increase the contribution of the NHS to the economy	Developing the NHS as an anchor system
	Implementing the Greater Manchester Social Value Framework

10

Our missions to meet the challenges

Greater Manchester Integrated Care Partnership

Recovering Core NHS and Care Services

Delivery Leadership: Locality Boards and PFB

System Leadership: System Boards; Finance and Performance Recovery Board

Areas of Focus	Actions
Improving urgent and emergency care and flow	Access to urgent care in the community
	Admission/Attendance Avoidance
	Improving discharge
	Increasing ambulance capacity
	Improving emergency department processes
Reducing elective long waits and cancer backlogs, and improving performance against the core diagnostic standard	Integrated Elective Care
	Improving productivity and efficiency
	Improving utilisation of the Independent Sector
	Improving how we manage our wait list
	Recovering children and young people's elective services
	Reducing waiting times in cancer
	Diagnostics
Improving service provision and access	Making it easier for people to access primary care services, particularly general practice
	Digital transformation of primary care
	Ensuring universal and equitable coverage of core mental health services
	Digital transformation of mental health care
Improving quality through reducing unwarranted variation in service provision	Improving quality
	NHS at Home – including Virtual Wards
Using digital and innovation to drive transformation	Implementation of Health and Social Care Digital Strategy
	Driving transformation through research and innovation

11

Our missions to meet the challenges

Greater Manchester Integrated Care Partnership

Supporting our workforce and our carers at home

Delivery Leadership: NHS GM People & Culture Function, NHS GM, NHS Trusts, Primary Care providers, Local Authorities, Social Care Providers, VCSE Organisations

System Leadership: GM People Board

Areas of Focus	Actions
Workforce Integration	Enable leaders and staff to work across traditional boundaries to support service integration
	Share best practice and develop tools to support a dynamic system culture
Good Employment	Increase in Good Employment Charter Membership and payment of Real Living Wage
	Improve access to staff benefits and flexible working
	Share best practice and resources to support managers
Workforce Wellbeing	Take action on the cause of staff sickness and improve wellbeing support
Addressing Inequalities	Building a leadership culture committed to addressing health inequalities
	Adapt the recruitment process to provide alternative entry routes for diverse talent
Growing and Developing	Develop our Greater Manchester careers approach to attract and support career development
	Develop and deliver the Greater Manchester retention plan
	Embrace digital innovation to improve the way we work – starting with HR digitisation
Supporting Carers	Provide more consistent and reliable identification and support for Greater Manchester's unwaged carers

12

Our missions to meet the challenges

Achieving financial sustainability

Delivery Leadership: Locality Boards; PFB

System Leadership: Finance and Performance Recovery Board

Areas of focus	Actions
Finance and Performance Recovery Programme	System recovery programme based on drivers of operational and financial performance
Developing Medium Term Financial Sustainability Plan	Development of three-year financial plan

13

Next Steps in Implementing the Plan

- Whilst the 30th June NHS England deadline is an important milestone, our work on delivery planning cannot stop there
- We will need to keep the momentum on our system conversations to make those choices that secure our long-term sustainability. NHS England's guidance describes that the plan should be continually reviewed and formally updated on at least an annual basis
- This means that we will continue to develop the JFP up to and beyond 30th June
- The steps we will focus on confirming our approach to long-term financial sustainability. These are:
  - Setting out in detail the phasing of all the programmes set out in this plan – across years 1,2 and 3 of the plan and prioritising those initiatives that will have the greatest impact
  - Ensure that all elements of the plan are costed in line with our medium-term financial plans and ensure we are maximising efficiency across the range of our activity
  - Continue to strengthen the delivery metrics and accountability arrangements
  - Quantify the population health potential of a fundamental shift in demand and a greater emphasis on early intervention and prevention. This will include modelling across all care settings. This needs to extend across all points of delivery
  - Drawing on this, confirm the process to undertake the population level segmentation and analysis for the longer-term transformation
  - Informed by this, position the key choices the GM system will need to make to deliver on long-term financial sustainability and continue to improve health outcomes

14

Your Feedback on the Draft Plan

- What are your views on the proposed accountability arrangements for the missions – in particular, the distinction between delivery and system leadership
- What are your thoughts on the key actions? Are there any areas of work that are missing or that we need to place greater emphasis on?
- Are the metrics selected for the actions the right ones? Are there any that you would change or add?
- Any other views on the document?

Greater Manchester Integrated Care Partnership

Joint Forward Plan – Engagement Draft

2023-2028

Greater Manchester Integrated Care Partnership

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1 Introduction

The way in which health and care services are organised in every part of England changed on 1st July 2022, as new national legislation came into force. Greater Manchester (GM) is now an Integrated Care System (ICS) – a partnership of organisations that come together to plan and deliver joined up health and care services, and to improve the lives of people who live and work in GM.

There is a requirement for all ICSs to develop a strategy. NHS organisations and local authorities must then have regard to this strategy when making decisions about the use of health and care resources. The five-year Strategy for the GM Integrated Care Partnership (ICP) was approved in March 2023 and can be found here.

National guidance states that each Integrated Care Board (ICB) must publish a five-year Joint Forward Plan setting out how they propose to exercise their functions. This should include the delivery of universal NHS commitments address ICSs' four core purposes and meet legal requirements.

JFP Principles

Principle 1: Fully aligned with the wider system partnership's ambitions

Principle 2: Supporting subsidiarity by building on existing local strategies and plans as well as reflecting the universal NHS commitments

Principle 3: Delivery focused, including specific objectives

This plan describes how GM will achieve the outcomes described in the ICP strategy. Achieving these outcomes involves *not only* integrated health and care services, *but also* action on the things that determine good lives. The strategy and plan describe a *complex system* which includes, but is not limited to, the activities under the direct influence (and resourcing) of NHS GM i.e., the 'health system'. Our ICP strategy describes our GM model for health and wellbeing which is a 'social model', including the wider determinants of health, and builds on the strong partnerships already in place with wider public services, the VCSE and our people and communities.

The Strategy was developed through extensive engagement with communities, partner agencies, practitioners and staff, across all ten localities. Its development was iterative, developing and adapting to the feedback received and ensuring it is reflective of the needs and expectations of our communities. This Joint Forward Plan is built from the results of that engagement.

2 Context

2.1 The GM Context

Greater Manchester is home to more than 2.8 million people with an economy bigger than that of Wales or Northern Ireland. Our population in the 2021 Census was estimated to be 2,867,800. This is an increase of 185,272 on the 2011 Census and represents a growth of 6.9% in ten years, higher than the growth across England and Wales (6.3%) over the same period.

There are ten councils in Greater Manchester: Bolton, Bury, Manchester, Oldham, Rochdale, Salford, Stockport, Tameside, Trafford and Wigan. All are unitary authorities, eight are metropolitan borough councils and two, Salford and Manchester are city councils.

The Greater Manchester Combined Authority (GMCA) is made up of the ten Greater Manchester councils and the Mayor, who work with other local services, businesses, communities and other partners to improve the city-region as described in the Greater Manchester Strategy (GMS)[1].

2.2 The composition of our Partnership

The **Greater Manchester Integrated Care Partnership** (this is the name of our integrated care system) connects NHS Greater Manchester Integrated Care, the Greater Manchester NHS Trusts and NHS providers across the whole of primary care with the GMCA, councils and partners across the VCSE, Healthwatch and the trades unions.

Greater Manchester Integrated Care Partnership Board is a statutory joint committee made up of NHS Greater Manchester Integrated Care and councils within Greater Manchester. It brings together a broad set of system partners to support partnership working and it is the responsibility of this Board to develop this Integrated Care Strategy - a plan to address the wider health, and care needs of the population.

NHS Greater Manchester Integrated Care, or NHS Greater Manchester (our integrated care board) is a statutory NHS organisation leading integration across the NHS, managing the NHS budget and arranging for the provision of health services in

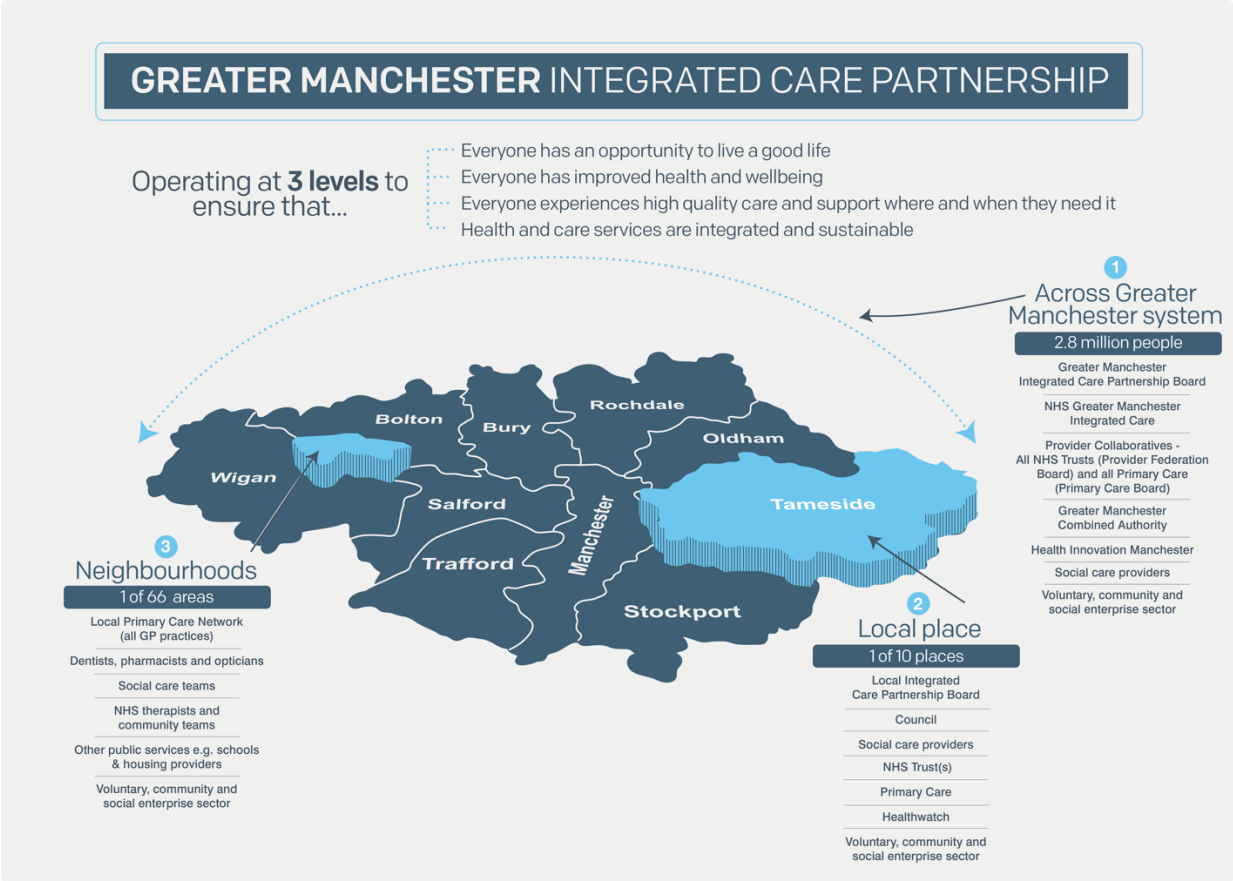
[1] https://aboutgreatermanchester.com/

a geographical area. It supports ten place-based integrated care partnerships in Greater Manchester as part of a well-established way of working to meet the diverse needs of our citizens and communities.

Greater Manchester Integrated Care Partnership is one of 42 integrated care systems across England. It is one of the largest and one of only two which covers the same geographical area as a Mayoral Combined Authority.

Figure 1 highlights how partners across health and care, wider public services and the VCSE work together as part of integrated neighbourhood teams across our ten localities in place-based partnerships and, where appropriate, across the whole of Greater Manchester to ensure consistency of access and experience and pursue improvements at scale.

Figure 1



Within Greater Manchester we have arrangements for providers to work together effectively at scale, including:

- The Greater Manchester Provider Federation Board (PFB): a membership organisation made up of the eleven NHS trusts and foundation trusts who provide NHS funded services across Greater Manchester and East Cheshire. It includes the NHS providers of 111, 999, patient transport services (PTS), community mental health and physical health services and hospital mental health and physical health services.
- The Greater Manchester Primary Care Board (PCB) has been supporting collaboration and integration since 2015 and will continue to support the delivery of outcomes at all levels of, and across, the system, through its various programmes and its work with all 67 Primary Care Networks[2] (PCNs) in Greater Manchester.
- Greater Manchester Directors of Adults' and Children's Social Care collaborating to support transformation of social care at scale. For adult social care this also includes joint working with the Greater Manchester Independent Care Sector Network.
- Voluntary, Community and Social Enterprise (VCSE) sector providers are part of a three-way agreement (the VCSE Accord) between the GMCA, NHS Greater Manchester and the VCSE Sector represented by the Greater Manchester VCSE Leadership Group, based on a relationship of mutual trust, working together, and sharing responsibility, and providing a framework for collaboration. The VCSE sector has also established an Alternative Provider Federation as a partnership of social enterprise and charitable organisations operating at scale across Greater Manchester. It provides an infrastructure for alternative providers to engage with NHS Greater Manchester on a Greater Manchester footprint.

2.3 What the Data is Telling Us

The Greater Manchester Integrated Care Partnership Strategy gives a comprehensive picture of the key data about our system. This includes:

- Demographic information
- Information on inequalities
- Demand on health and care services
- The financial picture
- Workforce pressures.

[2]Primary Care Networks involve GP practices working together with community, mental health, social care, pharmacy, hospital and voluntary services in their local areas in groups of practices

.

We have also drawn on our locality plans and local Health and Wellbeing Strategies which together identify the needs of our population and the plans in each locality to address these, aligned with our strategy and this plan (see section 11.4)

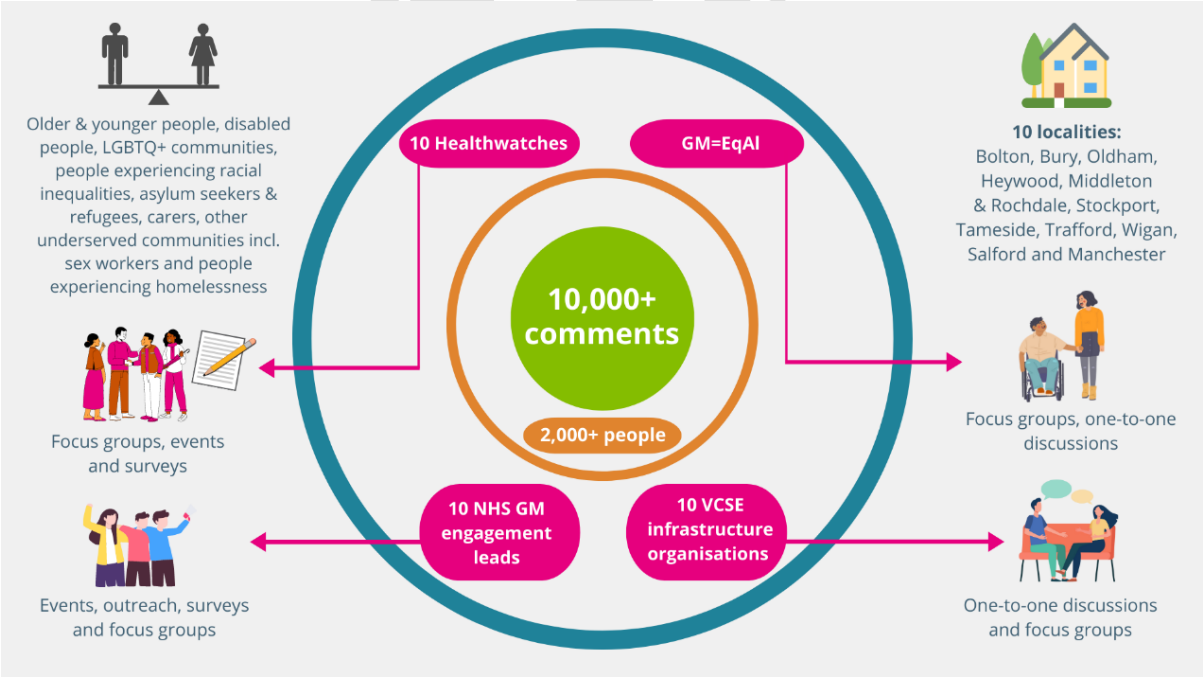
2.4 What residents are telling us

We carried out a major engagement exercise 'The Big Conversation' to inform the development of our ICP Strategy and this plan.

The Big Conversation had two phases. Phase one ran between March and May 2022 with the aim of consulting on the proposed vision and aims that had been suggested by the ICP leaders following a stakeholder engagement event they took part in. 1,332 people gave their views and consensus was most respondents agreed with the proposed aims and visions.

Phase two ran in October 2022 with the aim of ensuring the GM ICP had the insight it needed to be able to understand what matters most to communities across all ten localities - to help shape the priorities and actions for the strategy. A summary of the 'Big Conversation' is set out in Figure 2 .

Figure 2



3 Our Strategy

3.1 Overview

The Integrated Care Partnership Strategy outlined the most significant challenges facing the Greater Manchester health and care system:

- How to continue the improvements already made in GM's approach to integrated care and population health improvement
- The wider influences on health and good lives
- Economic inclusion
- Access to services, operational pressures and increasing demand
- Health outcomes and heath inequalities
- The challenge of financial sustainability

The Strategy is clear that we must both meet these immediate pressures and continue to address their underlying causes through improving the health of our population. The missions in the strategy were developed to ensure a recognition of this range of challenges.

This Joint Forward Plan will describe how we will realise these aims over the next five years – with a greater emphasis on years one to three. We will revise and update this plan each year.

3.2 Our vision and outcomes

As partners in Greater Manchester, we share the Greater Manchester Strategy (GMS) vision of wanting Greater Manchester to be a place where everyone can live a good life, growing up, getting on and growing old in a greener, fairer more prosperous city region.

For the Greater Manchester Integrated Care Partnership, this means we want to see a Greater Manchester where:

Everyone has an opportunity to live a good life
Everyone experiences high quality care and support where and when they need it
Everyone has improved health and wellbeing
Health and care services are integrated and sustainable

3.3 The Greater Manchester Model for Health and Wellbeing

Underpinning all our work is the Greater Manchester Model for Health and Wellbeing. This shows how we work with communities to prevent poor health and ensure support is available before crises occur to reduce demands on formal NHS and social care services. It is a social model for health and wellbeing (rather than predominantly a medical one), with people and communities at its heart.

Figure 3

Our challenge is that this Model is not universally realised across Greater Manchester. Our aim through the strategy and this supporting plan, is to confirm the actions and approaches necessary to achieve this and maximise the effectiveness of how we work together to improve our outcomes.

4 What we will do - our missions

4.1 Our missions

Our strategy sets out the following missions in response to the current challenges, within the context of our vision and outcomes

- **Strengthening our communities**

  We will help people, families and communities feel more confident in managing their own health and wellbeing. We will act on this with a range of programmes, including working across Greater Manchester to support communities through social prescribing, closer working with the VCSE and co-ordinated approaches for those experiencing multiple disadvantages.

- **Helping people stay well and detecting illness earlier**

  We will collaborate to reduce smoking rates, increase physical activity, tackle obesity and alcohol dependency. We also want to do more to identify and treat high blood pressure, high cholesterol, diabetes, and other conditions which are risk factors for poor health. Working in partnership and with targeted interventions, we will embed a comprehensive approach to reducing health inequalities.

- **Helping people get into, and stay in, good work**

  One of the purposes of Integrated Care Systems is to support wider social and economic benefits from NHS investment. We will act on this by expanding our Work and Health programmes, working with employers on employee wellbeing, through the Greater Manchester Good Employment Charter[3] and developing social value through a network of anchor institutions[4].

- **Recovering core NHS and care services**

  We will work to improve ambulance response and A&E waiting times, reduce elective long waits and cancer backlogs, improve access to primary care services and core mental health services, improve quality and reduce unwarranted variation for adults and children alike.

[3] https://www.gmgoodemploymentcharter.co.uk/
[4] https://www.health.org.uk/publications/reports/building-healthier-communities-role-of-nhs-as-anchor-institution

- **Supporting our workforce and our carers**

  We will promote integration, better partnership working and good employment practices, as well as supporting our workforce to be well and addressing inequalities faced in the workplace. We want more people choosing health and care as a career and feeling supported to develop and stay in the sector. We will consistently identify and support Greater Manchester's unwaged carers.

- **Achieving financial sustainability**

  Financial sustainability - 'living within our means' - requires an initial focus on financial recovery of the health system, to achieve a balanced position. We will identify the main reasons for financial challenges in the Greater Manchester health system, and implement a system wide programme of cost improvement, productivity, demand reduction and service transformation.

For each of the missions, we have set out the key areas of focus and the actions to deliver our vision and outcomes. These are described in greater detail in the next six chapters of this document. We have set out the accountability for the delivery of the missions. We describe this as:

- **Delivery Leadership** – the board/organisation accountable for driving change and improvement in the relevant part of the system. This recognises that the key responsibility for bringing together and driving delivery will sit with Locality Boards, providers and provider collaboratives
- **System Leadership** – This recognises the board/group accountable for creating the system-wide conditions, frameworks, and standards to enable delivery

4.2 Our ways of working

The way that we work together will play an important part in achieving our vision through our missions. To transform public services and integrate care we need to change the way we work with communities and fundamentally challenge our approaches to delivery. These ways of working run through all of our missions, as shown in this plan. Our outcomes cannot be achieved without us all working together.

Behaviours	We will …
Understand and tackle inequalities	✓ Take action at individual, team, organisation, and system levels, informed by data, to understand and tackle inequalities.

Share risk and resources	✓ Set out our expectations of each other, share data effectively, support joint working with shared resource and create a culture of collaboration. This must happen at every level and in every place.
Involve communities and share power	✓ Consistently take a strengths-based approach with co-design, co-production and lived experience as fundamental ingredients.
Spread, adopt, adapt	✓ Share best practice effectively, test and learn, and celebrate success, with supportive governance and resources. Adapt and implement best practice locally, in organisations and across systems.
Be open, invite challenge, take action	✓ Be open, honest, consistent and respectful in working with each other. Work on the boundaries and differences that we have in a constructive way, to support effective change.
Names not numbers	✓ Ensure we all listen to people, putting them at the centre, and personalising their care.

5 Strengthening our communities

We will help people, families and communities feel more confident in managing their own health. Our approach recognises that the organisation of the delivery of health and care services is only one of a range of contributors to the health and well-being of residents. The quality of housing, the availability of quality work, the extent to which residents are connected to their communities, and whether people feel safe also make a significant contribution.

Being deprived of these helps create and exacerbate the persistent health inequalities we see in many communities in Greater Manchester. Tackling these issues will play a key part in securing long term stability for our system – principally through keeping people well and independent in their homes and communities and reducing demand on expensive, acute services.

Our approach to this mission is underpinned by the Greater Manchester People and Communities Framework which defines our strategic approach to public engagement and involvement including key principles and commitments that support our ways of working.

Strengthening our communities Delivery Leadership: Locality Boards System Leadership: Population Health Board	
Areas of focus	**Actions**
Scale up and accelerate delivery of person-centred neighbourhood model	Continue to develop Live Well and Social Prescribing
	Coordinate our response to poverty
	Expand community-based mental health provision
	Living Well at Home
	Take an inclusive approach to digital transformation
Develop collaborative and integrated working	Embed the VCSE Accord
	Deliver a GM-wide consolidated programme for those experiencing multiple disadvantage
	Embed the GM Tripartite Housing Agreement
	Giving every child the best start in life
	Ageing Well
	Increase identification and support for victims of violence
Develop a sustainable environment for all	Delivering our Green Plan

5.1 Area of Focus: Scale up and accelerate delivery of person-centred neighbourhood model

Neighbourhood and place-based working provides the closest connection to the broadest range of factors affecting people's health and wellbeing. Most people will receive most of their day-to-day care for most of their lives in the neighbourhood or locality. The only place where local authority spend and planning, not only on care services, but also on the wider determinants of health comes together with NHS spend is at the locality level.

We have a locality model in place in Greater Manchester, comprising:

- A Locality Board to ensure the priorities are decided together in the locality and support the effective joint stewardship of public resources benefiting health
- A Place Based Integrated Care Lead with dual accountability to the local authority and to NHS GM
- A place-based provider collaborative or alliance providing comprehensive integrated care at neighbourhood and place levels
- A means of ensuring clinical and care professional input and leadership to place based working

Our localities are made up of neighbourhoods of 30,000 to 50,000 population – with Primary Care Networks at their heart. The neighbourhood model ensures that support is available before crises occur, to reduce demands on formal NHS and social care services. This is pivotal to our social model for health.

5.1.1 Action: Continue to develop Live Well and Social Prescribing

Only by working alongside people and communities to create healthier happier lives will we see sustainable improvements in the health of our population. Live Well is our programme to support this across Greater Manchester.

Every day, people help each other, and take part in activities that keep them moving, creative, and sociable – improving their physical health and mental wellbeing. Many people, particularly those experiencing inequalities, do not have the same chances to access these opportunities - this is where Social Prescribing can help.

Social Prescribing is a way for local organisations, services and professionals to refer people to a worker who acts as a 'link' between the health and care system or wider public services and the community. There are now over 220 Social Prescribing Link Workers in Greater Manchester working alongside GPs and other community

organisations. Over 30,000 people a year directly access this. Through Live Well, we are committed to expanding this offer, and to ensuring it makes a targeted difference to people who experience inequalities.

We will work with, and build, on the community-led work in all of our localities to expand the 'Live Well' offer so that all residents, particularly those experiencing inequalities, are offered the chance to maintain and improve their health, wellbeing, resilience and social connections through access to information, activities, volunteering and support. This will include:

- Expanding the offer for key groups of people, including children and young people, and people with cancer.
- Making it easier for people to get social prescribing support, through improving connections and pathways between different parts of the system. In our developing Primary Care Blueprint, we set out our intention to improve interdisciplinary referral pathways for Primary Care and enable wider Primary Care teams to refer directly into social prescribing initiatives, behaviour change services, and wider welfare support.
- Help grow more sustainable opportunities in the community, such as for green social prescribing, and creative health
- For those who need more support to live well, we will work to develop person-centred care by equipping people with skills and confidence through development of a framework, tools, and training, as well as improving expansion and quality of personal health budgets. This supports our delivery of the comprehensive model of personalised care.
- Implementing the Greater Manchester Creative Health Strategy, helping spread the use of creative health approaches as tools to address health inequalities by growing and sharing the evidence base, supporting skills and knowledge development of the creative health workforce and helping health and care professionals to understand and access creative health approaches for the people they support.

Measuring our delivery

- Increase in social prescribing activity
- Increase in Social Prescribing Link Workers and other community connectors
- Proportionate investment in social prescribing and allied activity compared to deprivation index
  Improvements in wellbeing as measured through the ONS survey
- Community wellbeing measured through GM resident survey

Accountability

- Locality Boards
- Live Well Steering Group
- Primary Care System Board
- Population Health Board

5.1.2 Action: Coordinate our response to poverty

Poverty is the single biggest determinant of health outcomes and health inequalities. Building upon a 'deep dive' into poverty and health that was undertaken by the GM Population Health Board, the GM Integrated Care Partnership approved a range of actions aimed at addressing this issue.

A key feature of this response has been the development of a strategic partnership with Greater Manchester Poverty Action and tapping into their nationally recognised expertise to support NHS GM to establish and approach which can serve as an exemplar to other ICBs.

Our focus is on completing the ongoing strategic review of the role of NHS GM in tackling poverty, including:

- Reviewing the current NHS GM response to poverty against existing examples of good practice and the recommendations made by the Kings Fund in their publication – 'The NHS's Role in Tackling Poverty'
- Assessing the feasibility of NHS GM developing an anti-poverty strategy and adopting and implementing the socio-economic duty, a tool by which public bodies can ensure decisions they consider the needs of people experiencing poverty.
- Complete the ongoing test and learn activity around health and care workforce training and development around Poverty Awareness and Poverty Literacy and use the findings from this to implement a scaled-up programme of training and development across the GM health and care workforce.
- Complete the ongoing proof of concept activity exploring the application of 'poverty proofing' methodology in health and care (with an initial focus on pregnant women during pregnancy and 12 weeks post-partum) in the 20% most deprived areas of GM) and use the learning from this to develop a GM approach

Measuring our Delivery

In the long term, the impact of our activity will be measured by:

- A reduction in the gap in life expectancy and healthy life expectancy between the most deprived and least deprived areas of Greater Manchester.

In the shorter term, the impact of our activity will be measured by:

- 500 NHS GM or provider staff completing poverty awareness training by the end of 2023/24 and at least 50% of all NHS GM staff completing poverty awareness training by the end of 2028/29.
- % of GM residents worried about the impact of cost of living on their lives (GM Residents Survey)
- Excess deaths associated with fuel poverty / cold homes

Accountability

- Locality Boards
- Population Health Board
- Reform Board

5.1.3 Action: Expand Community-Based Mental Health Provision

As part of our neighbourhood model, we will expand provision of multi-disciplinary, strengths-based teams for mental health connecting to community-based care. We will aim to build resilience in people and communities and intervene earlier before people reach a point of crisis.

We need to have a shared language around how to address the mental health challenges we face as a city-region. Our approach is based on addressing historic under-investment in mental health, learning disability and autism (see section 8.3.3)

Our Mental Health and Well Being Strategy sets out our aim to provide clear, accessible care pathways for people, integrating mental wellbeing, social care and physical health. We will further integrate mental health offers into Early Help, family support, housing and schools.

In GM and in line with the Community Mental Health Transformation Framework, we are working across all ten localities to develop new and integrated models of primary and community mental health care which will support adults and older adults with severe mental illnesses and reach over 20,000 more people. A key area of work is scaling up the Living Well model across all GM localities which had been successfully piloted in Salford and Tameside between 2018-2021.

Over the next five years, we will:

- Continue to develop, embed and enhance Living Well models and integrated specialist community pathways in each of the ten localities
- Engage in meaningful co-production and co-design with people with lived experience and wider stakeholders
- Improve the quality of person-centred care by developing our multi-agency teams
- Working with a shared practice model that is strengths based, trauma-informed and solutions focused
- Providing increased access to evidence based psychological therapies, social support and community connections

Measuring our Delivery

- Achieve a 5% year on year increase in the number of adults and older adults supported by community mental health services
- Number of women accessing specialist community perinatal mental health services
- NHS Talking Therapies access: number of adults entering NHS funded treatment
- Access and waiting times for Children and Young People (CYP)
- Improving access (CORE 20 PLUS 5 groups) for CYP with long-term conditions to MH services including Child and Adolescent Mental Health Services (CAMHS), Eating Disorders and talking therapies.
- Better support offer for CYP with mental illness/ emotional/behavioural needs presenting in acute settings – including growing the number of mental health champions in acute settings

Accountability

- Locality Boards
- GM Mental Health System Board

5.1.4 Action: Living Well at Home

Adult Social care in Greater Manchester is rooted in the power of co-production with people, carers and families to enable better outcomes for people. The primary focus is on supporting people to live well at home, as independently as possible, making sure that the care and support people experience is built on their own strengths and those within the community, and is of the best quality.

The key elements of the programme are:

Workforce

- RECRUIT-implementation of the GM Care academy, delivery of the GM Social Care Workforce strategy, the GM International Recruitment Programme implementation, and the recruitment strategy for social workers and nurses
- RETAIN - expand blended roles to enhanced care workers, expand the person-centred care and support Trailblazer
- GROW – continual professional development training for nurses and Occupational Therapists (OTs), succession planning, leadership development and mentoring

Market Development and Sustainability

- A diverse and sustainable market with great quality and supports better outcomes and better lives
- Continuous improvement of the quality of social work
- Better commissioning models that support better outcomes and attract the best providers to the market

Digital

- Explore more collaboration, focussing where we can pool funding to deliver shared outcomes
- Improve number of providers using digital social care records as set out in our digital strategy (see section 8.5.1)
- Better utilisation of technology enabled care solutions

Safeguarding

- Working in partnership across all aspects of safeguarding to enable the best outcomes for people, especially in relation to complexity, prevention and sharing learning

Learning Disability

- Development of 3-year LeDeR (Learning Disabilities Mortality Review) strategy
- Develop apprenticeships programmes
- Continue roll out of the Keyworker workstream
- Roll out PACT and Riding the Rapids training
- Continue to implement the GM justice plan
- Continue to the roll out of the CYP Keyworker workstream
- Review advocacy – GM exemplar model

Measuring Delivery

- Workforce – increase in recruitment and retention of individuals successfully employed through the developing GM care academy
- Market shaping – more people living well at home (reduction in long term residential care)
- Quality – either a maintenance of existing or improvement of Care Quality Commission (CQC) ratings for providers, LAs and GM ICS (new single assurance framework)

Accountability

- Locality Boards
- GM Directors of Adult Social Care

5.1.5 Action: Take an inclusive approach to digital transformation to ensure equity for all

GM has significantly advanced the use of digital approaches across health and care, but there are still many people who cannot easily access or benefit from digitally enabled services and tools. In an increasingly digital world, people who are digitally excluded are at risk of worse access to services and poorer health outcomes, deepening inequalities.

People who are most likely to experience digital exclusion are:

- People living in deprived areas
- Inclusion health groups including people who are homeless, rough sleepers, asylum seekers and the travelling community.
- Protected groups according to age, disability and ethnicity.

A lack of digital access and skills can have a huge negative impact on a person's life. As many as 1.2m residents in Greater Manchester could be excluded in some way to access the benefits digital brings.

The GM Digital Inclusion Action Network (DIAN) has been established by the Greater Manchester Combined Authority to ensure digital inclusion is built into the transformation of public services, place-making and economic growth. It is focused primarily on getting all under-25s, over-75s and people with disabilities online.

NHS GM will continue to work in partnership with the DIAN and Health Innovation Manchester to build inclusion into the design and development of digitally enabled services and pathways, develop targeted approaches for key communities and boosting digital capabilities and awareness of inclusion barriers.

Measuring our Delivery

- Develop and deliver a series of pan-GM projects to address digital exclusion in key service areas including virtual wards, digital GP practices and the use of remote monitoring technologies
- Monitor uptake and access to digitally enabled services according to key demographics, including over-75s, under-25s and people with disabilities
- Develop and deliver a programme to improve health and care staff awareness of digital inclusion and build skills needed to spot and support people who may be impacted – number of staff participated, % increase in awareness and competence

Accountability

- GM Digital Inclusion Action Network
- GM Health and Care Digital Transformation Board

5.2 Area of Focus: Develop collaborative and integrated working

5.2.1 Action: Embed the VCSE Accord

Voluntary, Community and Social Enterprise (VCSE) sector providers are part of a three-way agreement (the VCSE Accord) between the GMCA, NHS Greater Manchester and the VCSE sector.

The VCSE Accord delivery plan for 2023 to 2026 sets out the future of the Accord over the next three years. The central themes of delivery are:

- Scaling up the VCSE role in addressing inequality, population health delivery models, and in creating a more inclusive economy
- Supporting the effective Commissioning and Investment of GM VCSE action
- Helping to develop a resilient 'VCSE Ecosystem' in the face of current challenges
- Ensuring powerful VCSE representation and voice, and
- Finding ways to support Greater Manchester's 75,000-strong VCSE workforce, 500,000 volunteers and 300,000 informal carers

Measuring our Delivery

- Three VCSE data targets met: contributing to system, access to collective data and VCSE intelligence built into decision-making
- Propositions for VCSE role in addressing wider determinants of health built into GM programmes and asks and VCSE at the heart of social and economic action in all ten localities and at GM-level
- Co-design and Co-production via VCSE sector defined and resourced
- VCSE accessing funding and investment across GM and across VCSE sector (equalities, providers, grassroots)
- All employees in the VCSE sector receive at least the Real Living Wage
- VCSE workforce at all levels (including leadership and management) is reflective of the diversity of the communities of Greater Manchester

Accountability

- VCSE Leadership group

5.2.2 Action: Deliver a GM-wide consolidated programme for those experiencing multiple disadvantage

Through the Devolution Trailblazer Deal in early 2023, the Government confirmed its support for GM's ambition to develop a city region-wide approach to supporting people and families experiencing multiple – social, economic and health –disadvantages. To support this work, the Government has agreed to review the secondary legislation that underpins pooled and aligned budgets (section 75 of the National Health Service Act 2006), with a view to amending the scope and simplifying the regulations where needed.

Demand on public services, including health and care, is often driven by cohorts of residents who are in contact with multiple agencies – for instance, people with drug and alcohol problems; people who are homeless; people with a range of complex long-term conditions who frequently present to acute services through A&E and other routes.

They are among the most vulnerable in our communities, and often experience entrenched disadvantage, long term unemployment, trauma and health inequalities. The most at-risk adults and children and young people in this situation are estimated to cost the public purse five times more than the average citizen per year.

These plans will support our aim to move from a system characterised by responses to cycles of chronic illness and exacerbation to one focused on a model that keeps people well at home and in their communities. They build on learning and effective approaches from the Supporting Families (Troubled Families) programme, Rough Sleeper Initiative, Housing First, Changing Futures and Working Well.

Measuring our Delivery

For the identified cohort:

- Reduction in A&E attendances
- Reduction in Non-Elective Admissions
- Reduction in Mental Health Crisis Presentations

Accountability

- Locality Boards
- Reform Board

5.2.3 Action: Embed the GM Tripartite Housing Agreement

The home is a driver of health inequalities. Inadequate housing causes or contributes to many preventable diseases and injuries. Direct effects of an inadequate home on a person's health can include heart attacks, stroke, respiratory disease, flu, falls and injuries, hypothermia and poor mental health. Poor housing is estimated to cost the NHS at least £1.4 billion per year in first year treatment costs alone.

The GM Tripartite Agreement 'Better Homes, Better Neighbourhoods, Better Health', is a collaboration between Greater Manchester Housing Providers, Greater Manchester Combined Authority and NHS Greater Manchester Integrated Care to deliver positive change across the city region. The Agreement sets out a collective vision to work alongside local people, neighbourhoods and stakeholder organisations to create lasting solutions to complex issues and challenges centred on housing and health.

Measuring our Delivery

- Increase supply of supported and specialist homes to support delivery of health and care system priorities
- Integrating housing pathways and models of joint working into place-based delivery via PCNs

- Delivery of the action plan on Damp, Mould and Condensation
- Delivery of the GM Good Landlord Charter to drive up standards in rented homes
- Activity to make our homes warmer and reduce fuel poverty, including domestic retrofit measures, delivery of Truly Affordable Net Zero homes, NHS GM Warm Homes pilots
- Action against the GM Healthy Homes framework to deliver consistent Home Improvement Agency services and policies
- Private rented sector interventions, including Good Landlord Scheme
- Responding to homelessness and rough sleeping - including embedding Inclusion Health principles in commissioning and delivery and ongoing health system investment

Accountability

- Locality Boards
- Population Health Board
- Tripartite Agreement Core Group

5.2.4 Action: Giving every child the best start in life

Greater Manchester is passionate about ensuring that all our children and young people get the best start in life and are cared for, nurtured and supported to grow up well and achieve their ambitions in life.

The specific health case for investment in children is extremely strong. The life course costs of late intervention have been estimated at £17bn across England and Wales (including nearly £4bn borne by the NHS).

GM partners (health education, voluntary, criminal justice sectors, GMCA and local authorities) have adopted a system-wide approach, delivered through a combined Children and Young People Plan. Further information on our work with children and young people can be found in the mission for helping people stay well and detecting illness earlier (section 6).

In the next five years, we will:

- Address inequalities within maternity services through delivery of the Greater Manchester and Eastern Cheshire Maternity Equity and Equality Plan 2022-2027 (see section 6.1.1).

- Fully embed the Smoke Free Pregnancy (SFP) programme into the mainstream maternity journey to achieve the high-level performance seen pre-pandemic (see section 6.2.1)
- Standardise pathways to prevent alcohol harm in pregnancy across all the GM maternity providers
- Continue rolling out the 'As Soon as You're Pregnant' campaign to encourage early booking and to increase timely uptake of screening tests, including those for sickle cell and thalassaemia
- During 2023/24, establish a GM advisory group to lead on the co-design of a framework for food and healthy weight that outlines priorities and sustainable investment for city-region action to build and scale good practice in maternity and early years (year 1) and for school aged children (years 2-5) through a whole family, whole-system approach
- Co–design with partners a plan to consolidate and roll out further a comprehensive approach to oral health improvement incorporating dental services and community based approaches
- Ensure effective health contribution to the implementation of the GM Children and Young People Plan, including working towards a shared vision of family help where families can get the help they need from the right places and people in their communities including health professionals.

Measuring our Delivery

- SATOD (Smoking at Time of Delivery) rate to be reduced to 4% or less by 2026
- School readiness: Increase in the percentage of children achieving a good level of development at the end of reception
- Reduction in the infant mortality rate
- 83% of children to reach the expected level of development by 2024
- Improved access to speech and language therapy services
- Increase the uptake of funded childcare and early education places for 2-year-olds by April 2024
- Decrease in proportion of children 0-5 years old with dental decay
- Increase in the prevalence of breast feeding

Accountability

- GM Children and Young People's Board
- Population Health Board
- Locality Boards
- GM Maternity Board

5.2.5 Action: Ageing Well

The pursuit of an age-friendly Greater Manchester is in line with the UN Decade of Ageing and the WHO (World Health Organisation) Age-friendly cities and communities programme. Our approach focuses on improving financial security, tackling inequalities and creating places for people to age well through healthy, active and connected lives. We do this by championing the voice of older people, challenging ageism, growing the GM age friendly movement and delivering changes across our city region to improve later life.

A unique cross-sector Ageing Hub partnership brings together the Greater Manchester system leadership at the Ageing Hub Executive Group and a range of task groups, to collectively deliver on the strategy, supported by the Ageing Hub team at GMCA. The Ageing Hub works alongside the 10 districts of Greater Manchester to integrate age-friendly approaches at a neighbourhood, district and Greater Manchester level.

The Greater Manchester Ageing in Place Pathfinder is a £4 million investment (2022-25) by partners, led by GMCA, in eight neighbourhoods to create strong and supportive neighbourhoods to improve connection, health and wellbeing of residents over 50 years of age.

Measuring our Delivery

- Number of neighbourhoods with identifiable Ageing Well Action Plans

Accountability

- Greater Manchester Reform Board
- Ageing Hub Executive Group

5.2.6 Action: Increase identification and support for victims of violence in all health care settings

We are working collaboratively with partners to develop community-led, whole system approaches to violence reduction, to strengthen early intervention programmes and to embed trauma-responsive health and well-being pathways for victims of violence in all health care settings and for people in contact with the criminal justice system.

Health services can provide a safe space for disclosure of domestic or sexual violence and abuse – and we must tackle the variation in provision that can lead to unidentified and unmet need. We will:

- Increase identification and support for victims of gender-based violence in health care settings, including development of primary care and sexual health services pathways
- Implementation of Sexual Assault Referral Centre pilot to develop integrated pathways for victims of sexual assault who have complex mental health problems
- Develop community-led solutions to violence reduction through culture and sport
- Develop trauma-responsive approaches for victim support in health care settings, including delivery of the Violence Reduction Community Navigator pilots
- Developing tailored health and well-being pathways for women in contact with police, custody, court and probation services and on release from prison.
- Develop trauma responsive care in line with GM system plans to become an Adverse Childhood Experience (ACE) and Trauma Responsive system. In 2023-2024, Localities will lead on implementation of the GM ACE and Trauma framework through co-design of community development plans in targeted neighbourhoods to improve community resilience and create a social movement for change
- In 2024/25, learning from these pilots will inform proposals to scale and spread these models and to establish clear referral pathways in all health and care settings for victims of violence in response to legal duties (Serious Violence Duty and Domestic Abuse Act) and to fulfil the NHS commitments in the GM Gender Based Violence Strategy[5].

Measuring our delivery

- Referral from health and care settings into domestic and sexual violence advocacy services
- Referrals from urgent and primary care into the Violence Reduction Community navigator programme
- Number of trauma leads and champion roles across third and public sector organisations
- Number of trauma/ACE recognised trainers and professionals working in the health and care system
- Trauma/ACE embedded within communities of practice at neighbourhood, Locality and GM level

[5] Gender Based Violence Strategy - Greater Manchester Combined Authority (greatermanchester-ca.gov.uk)

Accountability

- Population Health Board
- Locality Boards
- GMCA Gender based Violence Board and Violence Reduction Board

5.3 Area of Focus: Develop a sustainable environment for all

5.3.1 Action: Delivering the NHS Green Plan

Climate change is the greatest global health threat facing the world in the 21st century, but it is also the greatest opportunity to redefine the social and environmental determinants of health (Lancet Commission, 2009).

In May 2022, we published our Green Plan 2022-2025, aligning priorities and carbon budgets with the national NHS Delivering a 'Net Zero' National Health Service report and the GMCA 5 Year Environment Plan. Two overarching goals are outlined:

- To achieve a net zero NHS GM Integrated Care Carbon Footprint by 2038 – this target is the science-based approach outlined in the GMCA 5-Year Environment Plan. We will seek assurance that providers are delivering against their own plans, whilst focusing on priorities that we can deliver most effectively by working together.
- To achieve a net zero NHS GM Integrated Care Carbon Footprint Plus by 2045 – this is a national NHS target to eliminate the carbon impact of the goods and services we buy. We will work closely with national and regional partners to achieve this

Over the next five years we will focus on delivering and scaling up activities outlined in the Green Plan, refreshing this as necessary to ensure it remains current, and maximising the opportunities from collaboration.

We will:

- Ensure all Trusts have robust travel plans in place and work closely with Local Authorities and TfGM (Transport for Greater Manchester) to improve access to sites by active travel and public transport,
- Consider carbon emissions from procurement
- Harness the carbon reduction opportunities presented by digital transformation
- Engage the system-wide workforce with the net zero agenda by developing comprehensive training, awareness and behaviour change programmes

- Embed net zero into commissioning processes and across more clinical services
- Work closely within the NHS GM Anchors Network to drive a more strategic and aligned focus across trusts and localities
- Ensure appropriate prescribing by supporting social and low carbon options, with support for patients to reduce medicines waste

Measuring our delivery

- Total carbon footprint
- Fleet composition and emissions by organisation
- Inhalers carbon footprint
- % Virtual appointments across both primary and secondary care
- Increase in active and sustainable travel by staff and patients (as demonstrated through % modal shift in survey responses)

Accountability

- Population Health Board
- GM Net Zero Delivery Board

6 Helping people stay well and detecting illness earlier

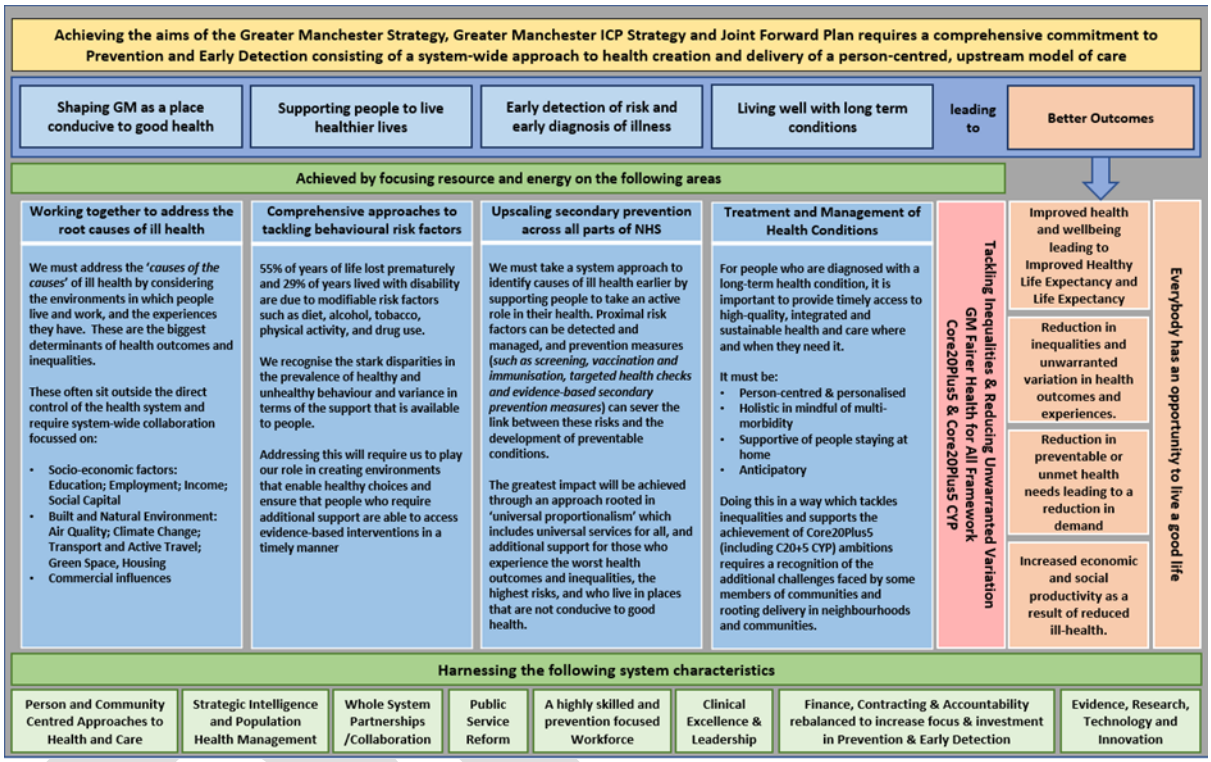
There is a strong rationale for the NHS to increase its focus on prevention and improving population health outcomes. For the past decade, improvements in life expectancy and healthy life expectancy have stalled, and inequalities in health have widened.

Life expectancy and healthy life expectancy for people born in GM is significantly lower than the England average. Importantly, much of this burden of poor health and early death (borne disproportionately by the most deprived and marginalised communities) can be attributed to conditions that are preventable through coordinated action across the health and care system.

Helping people stay well and detecting illness earlier Delivery Leadership: Locality Boards System Leadership: Clinical Effectiveness and Governance Committee (CEG); Population Health Board	
Areas of Focus	**Actions**
Tackling inequalities	Reducing health inequalities through CORE20PLUS5 (adults)
	Equity in access to care and improved experience and outcomes for all children and young people (CORE20PLUS5 clinical priorities)
	Implementing a GM Fairer Health for All Framework
Supporting people to live healthier lives	A renewed Making Smoking History Framework
	Alcohol
	Enabling an Active Population
	Promoting Mental Wellbeing
	Food and Healthy Weight
	Eliminating New Cases of HIV and Hepatitis C
	Increasing the uptake of vaccination and immunisation
Upscaling secondary prevention	Early Cancer Diagnosis
	Early detection and prevention of Cardiovascular Disease
	Earlier diagnosis of Respiratory Conditions through Quality Assured Spirometry
	Early detection of unmet health needs for those living with Learning Disability and those with Severe Mental Illness
Living well with long-term conditions	Managing Multimorbidity and Complexity
	Optimising Treatment of long-term conditions
	Expansion of the Manchester Amputation Reduction Strategy (MARS) across NHS GM
	The GM Dementia and Brain Health Delivery Plan
	Taking an evidenced based approach to responding to frailty and preventing falls
	Anticipatory Care and Management for people with life limiting illness

The complexity and breadth of activity that is required to drive change through prevention and early detection is set out in our GM Framework for Prevention (Figure 3):

Figure 3



For the purposes of the framework, we have used the broader definition of secondary prevention, used by the UK chief medical officers, to include "evidence based, preventive measures to help stop or delay disease, taken during an interaction between an individual patient and a clinician" [6].

Our framework has four distinct areas of focus:

1. Tackling inequalities and reducing unwarranted variation through Core20Plus5 and the GM Fairer Health for All Framework
2. Supporting people to live healthier lives by implementing comprehensive approaches to tackling behavioural risk factors for illness.

[6] Restoring and extending secondary prevention | The BMJ

3. Upscaling secondary prevention across the NHS (including the early identification of risk and diagnosis of illness, and the effective management to prevent progression).
4. Supporting people to live well with long term conditions through the equitable, effective, and efficient management of diagnosed health conditions

We need to put in place more upstream models of care and integrated neighbourhood models that better address the needs of those at higher risk of illness, and those not currently in contact with services. This will require increased population health management capability.

Secondary prevention must be an integral part of all patient care pathways. All medical and allied professionals have an opportunity to 'make every contact count'. Prevention activities also need to be extended to population groups with historically low uptake, and those not in contact with NHS services, to ensure delivery within communities and neighbourhoods.

As set out in the GM Prevention Framework, the NHS also has an important role to play in working across the system with partners to address the root causes of ill health (relating to factors such as poverty, education, work, and housing), and to shape GM as a place that is conducive to good mental and physical health.

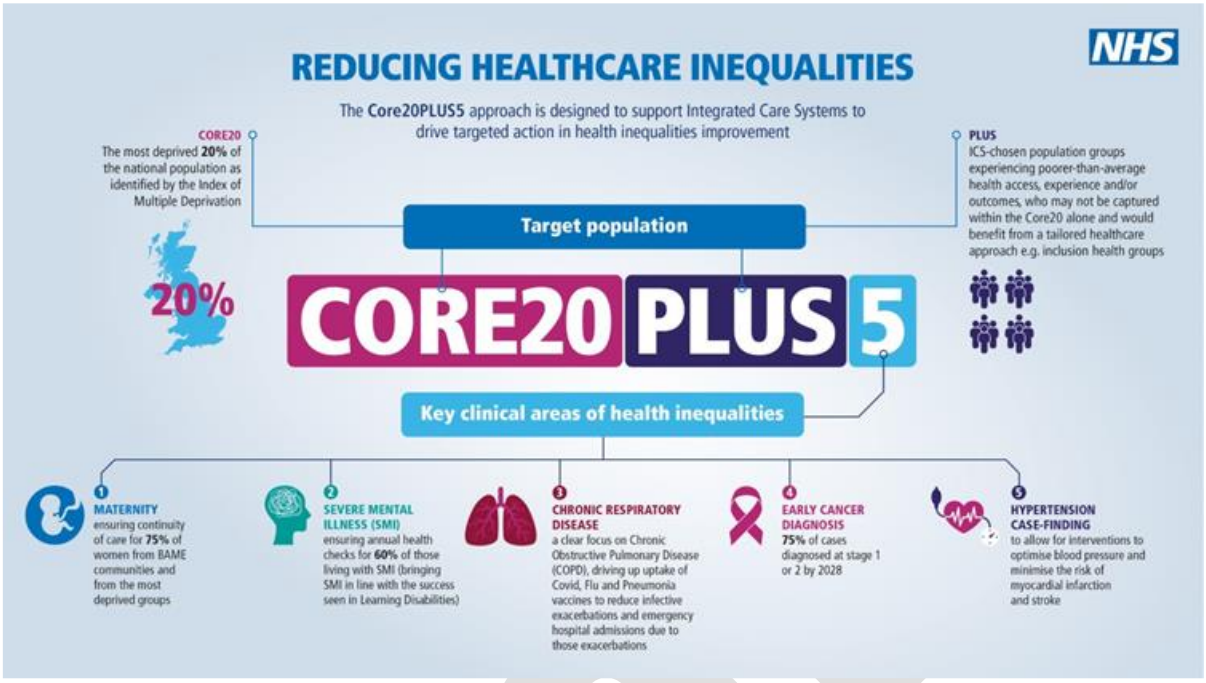
6.1 Area of Focus: Tackling health inequalities

6.1.1 Action: Delivery of CORE20PLUS5 (adults)

The CORE20+5 framework for adults (Figure 4) outlines the key clinical areas that should be targeted to reduce health inequalities.

Of the five clinical areas of health inequalities, severe mental illness annual health checks, chronic respiratory disease, early cancer diagnosis and hypertension case finding are covered in section 6.3

Figure 4



Maternity

We have developed a Maternity Equity and Equality Action Plan. The plan has been carefully co-designed and co-produced with the people we serve.

It is an ambitious and dynamic plan that contains 36 Interventions and 363 individual actions with particular focus on those areas that make the biggest impact:

- Preconception care
- Early access to antenatal services
- Enhanced Midwifery Continuity of Carer
- Personalised Care and Support Planning
- Black & Asian Maternity Equity Standards
- Universal & Targeted vitamin D supplementation
- Embedding of Saving Babies' Lives Care Bundle, including the Smokefree Pregnancy programme
- Addressing raised BMI
- Establishment of Family Hubs across GM

Our staff from ethnic minority background are representative of our local populations and will have the same opportunities and experience as others

In 2022 the GM Equity and Equality steering group was established which brings together clinical, VCSE, education colleagues to oversee and deliver the Maternity Equity and Equality Action Plan.

The group have already delivered on improvements identified in the plan including the development of Black and Asian Maternity Equity Standards, public facing information materials, working with Maternity Action to support pregnant women at work and the commencement of a student mentor scheme

Cancer

GM Cancer Alliance established a Cancer Health Inequalities Working group in 2021, and it leads on the health inequalities work programme for the cancer system in GM.

Examples of work that have taken place in or are underway include:

- A report commissioned by the Cancer Alliance and undertaken by GMCVO into the inequalities in cancer prevention, diagnosis and care
- A review of GM Cancer's User Involvement Programme assessing what a successful and effective programme looks like and how can it be more diverse and work for everyone

The strategy and implementation plan for 2023-24/5 was approved by the GM Cancer Board in May 2023.

Key priorities are:

- Make health inequalities everyone's business. For the cancer system to achieve its overall goals around early diagnosis, operational performance and personalised care and treatment, health inequalities must be addressed
- Better use of data, understanding health inequalities in the cancer system and the impact we are having
- Target all cancer innovation and improvement to tackle health inequality groups as set out in CORE20PLUS5
- Funding of two Health Inequalities pieces of research, one to look at how inclusive our cancer research population is and one to increase up take from our ethnic minority communities in cancer clinical trials

Measuring our Delivery

- Ensuring Continuity of Maternity Care for 75% of women from BAME communities and the most deprived groups
- Achieve 75% of cancers being diagnosed at stage 1 or 2 by 2028

Greater Manchester Integrated Care Partnership

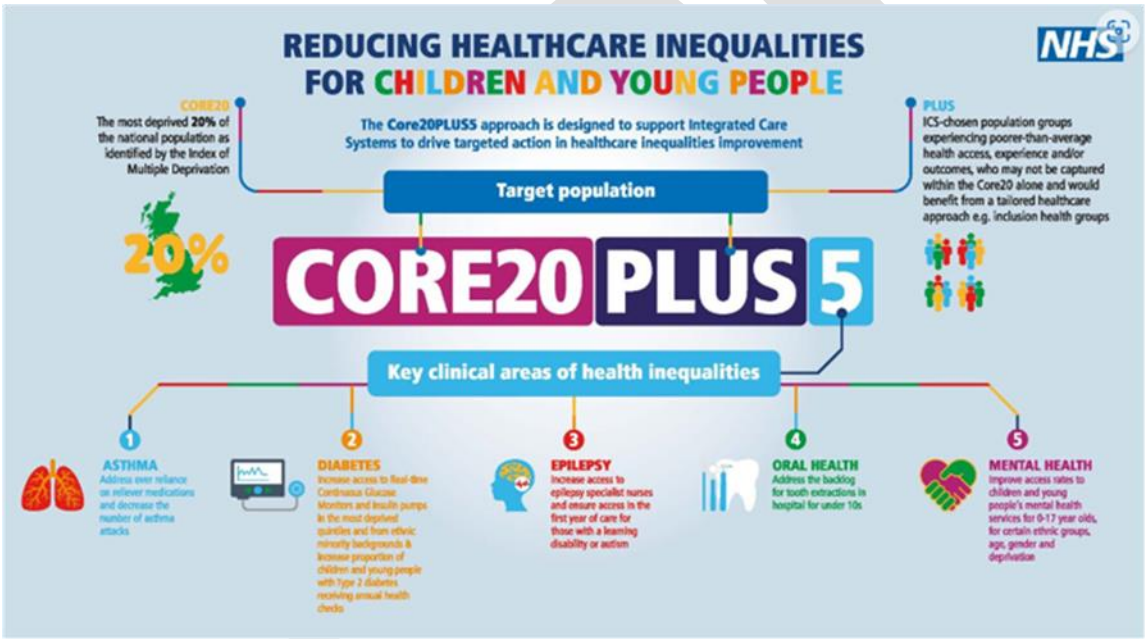
Accountability

- Locality Boards
- Clinical Effectiveness and Governance Committee (CEG)
- Population Health Board
- Quality and Performance Committee
- GM Cancer Board
- GM Maternity Board

6.1.2 Action: Equity in access to care and improved experience and outcomes for all children and young people (CORE20PLUS5 clinical priorities)

The national CORE20PLUS5 framework for children and young people (CYP) outlines the key clinical areas relating to secondary prevention that should be targeted to reduce health inequalities (Figure 5).

Figure 5



Over the next five years, we will:

- Build on the existing partnerships and cross-sectoral leadership in GM, through the newly established GM Childrens Board, to enable a social model of care for CYP so that equity, inclusion, and sustainability are at the heart of all care pathways.
- Asthma - Test out population health approaches to asthma prevention and management through asthma friendly schools' pilots, programmes to develop CYP

asthma peer mentors in primary and secondary schools and integrated care pathways

- Diabetes – Implement a whole system approach to enabling CYP and their families to eat well, move more and achieve a healthy weight
- Epilepsy – Review access to Epilepsy Specialist Nurses and epilepsy tertiary services
- Dental and Oral Health – Reduce tooth decay in children by delivering a GM Oral Health Improvement Programme to increase the number of children brushing their teeth every day in early years setting, in schools and at home; and increase the access to dental services for children by increasing the number of routine and urgent dental spaces available; increasing the dental practices that are in the Child Friendly Dental Practice (CFDP) Network; developing the dental care pathway for looked after children; and by increasing the number of sessions for children who need dental extraction(s) in a hospital setting.
- Mental Health – increase access to community and crisis services through support teams working with education settings and implement a core mental health offer for Cared For/Care Leavers including Speech and Language support and Trauma Informed Care

Measuring our Delivery

- A reduction in avoidable admissions and emergency attendances for relevant clinical conditions
    - Reduction in rate of emergency admissions for asthma for CYP aged 18 years and under from 180.1 per 100,000 population to 137.12 per 100,000 in line with the North West average by March 2024.
    - Reduction in rate of emergency attendances at hospital for asthma for CYP aged 18 years and under
    - Reduction in rate of emergency hospital admissions for diabetes for CYP aged 18 years
    - Reduction in rate of emergency attendances at hospital for diabetes for CYP aged 18 years and under
    - Decrease in rate of epilepsy-related emergency admissions for CYP aged 18 years and under from 31.98 per 100,000 population
    - Reduction in rate of emergency attendances at hospital for epilepsy for CYP aged 18 years and under from 163.4 per 100,000 population
- Digital inclusion plans implemented with routine monitoring.
- Increase in healthy weight prevalence for Y6 pupils across GM from 58.4% (latest GM data for 2021/22) to 60.8% (latest England average for 2021/22).

- Reduction in prevalence of overweight (including obesity) for Y6 pupils across GM from 40% (latest GM data for 2021/22) to 37.8% (latest England average for 2021/22).

CYP Asthma

- Year on year reduction in prescription of oral steroids

CYP Diabetes

- Increase access to CGM (Continuous Glucose Monitoring) from 10.9% to 20.9% in the most deprived quintile
- Increase access to insulin pumps from 23.5% to 27.7% in the most deprived quintile
- Minimum of 60% of CYP with diabetes received all 7 care processes.

CYP Epilepsy

- % of children and young people with epilepsy, with input by epilepsy specialist nurse within the first year of care (Minimum 85%)
- % of children and young people with epilepsy after 12 months where there is evidence of a comprehensive care plan that is agreed between the person, their family and/or carers and primary and secondary care providers, and the care plan has been updated where necessary. (Minimum 74%)
- % of children and young people meeting defined criteria for paediatric epilepsy surgery
- Referral criteria with evidence of epilepsy surgery referral (Minimum 50%)

CYP Oral Health

- Increase the number of settings recruited to the GM Oral Health Improvement Programme
- Reduce the waiting times for proportion of children waiting in excess of 18-weeks for dental extractions in a hospital setting
- Increase proportion of children and young people (aged 0-18-years) accessing routine and urgent NHS General Dental Service

CYP Mental Health

- Improved access to mental health support for children and young people in line with the national ambition for 345,000 additional individuals aged 0-25 accessing NHS funded services (compared to 2019)
- The Greater Manchester Assessment and In-reach Centre (GMAIC) available 7 days a week with a 24/7 consultation service to support the wider system with young people presenting in crisis to urgent and emergency settings.

- GM-wide, 24/7 single point of access for all CYP crisis services to improve accessibility and system navigation for referrers and specialist pathways to support looked after young people experiencing emotional distress

Accountability

- Children's System Board
- Population Health Board
- Mental Health and Wellbeing Board
- Quality and Performance Committee
- Clinical Effectiveness and Governance Committee (CEG)

6.1.3 Action: Implementing a GM Fairer Health for All Framework

Health inequalities mean that some groups have significantly worse health outcomes and experience than others. These inequalities are avoidable, unfair, and systematic. Reducing health inequalities is a priority for NHS GM and we continue to work in partnership across the NHS, local government, and voluntary sector to take comprehensive approaches to address the socio-economic causes of poor health.

We have been working with system partners and communities to codesign a Fairer Health for All Framework to ensure that health equity and equality and sustainability are embedded systematically at the heart of our decision making, system leadership and governance.

The Fairer Health for All Framework (Figure 6) outlines our priorities for coordinated action to reduce inequalities across the life course through a set of shared principles:

Figure 6

Our key delivery actions are:

- To complete the codesign and launch of the Fairer Health For all Academy to provide learning and development opportunities focusing on health equity and population health approaches. Priority learning and development programmes in 2023/24 include: a fellowship programme for people working in the VCFSE sector, primary and secondary care, and establishing at least three communities of practice supporting Live Well, Population Health Management and integrated neighbourhood working.
- To further develop VCSE-primary care partnerships to address the CORE20PLUS5 clinical priority areas. In 2023/4, as part of the implementation of the primary care blueprint we will synthesise the learning from the CORE20PLUS5 community connector pilot led by the Caribbean African Health Network and the VCSE-PCN partnership pilots into a series of practical guides and tools
- To continue to build and sustain our adaptive capability (analysis, people, and systems) within NHS GM for population health management and strategic intelligence (see section 6.1.4). In years 1 and 2, we will complete development of the GM health and care intelligence hub, capture best practice for population health management, establish a strategic intelligence business 'unit' and design and implement development programmes to enhance capability where we can have the greatest impact aligned to CORE20PLUS5 clinical areas and primary care blueprint priorities.

Measuring our Delivery

- Narrow the gap in healthy life expectancy between men and women living in GM and between all ten Localities and the England average
- Reduction in avoidable mortality
- Reductions in health inequality in the onset of multiple morbidities

Accountability

- Population Health Board

6.1.4 Action: Monitoring and targeting of unwarranted variation in outcomes

Pivotal to the whole system approach to reducing health inequalities is access to cross-sectional data through the GM Advanced Data Science Platform (ADSP) which is enabling a system level view on key priorities and inter-sectional understanding of protected characteristics, thus improving our accuracy and completeness of data sets on patient ethnicity, disability and other protected characteristics. The ADSP has been created to ensure that we have a wide range of interoperable and specialist capabilities to support the generation of actionable insight for clinicians and multidisciplinary teams and intelligence to support service optimisation and population health.

Cross-sectoral intelligence (data and insight from public and VCSE partners accessed via the GM Health and Care Intelligence Hub), facilitates a shift in how we understand health inequalities across the life course and for people with multiple conditions to inform allocation of resources according to need and the identification of segmented performance and quality targets for communities and neighbourhoods. This cross-sectoral approach is facilitated through a GM VCSE intelligence group, and investment in VCSE capacity and skills to collate and analyse data and insight.

The GM Health and Care intelligence hub is a web based portal that is being co-designed to bring together data, community insight, web-based tools, guidance, shared learning and workforce development resources to support people working in health and care to better understand health inequalities and variation in care in their areas and implement upstream models of care.

These technologies enable the development of a record-level longitudinal linked dataset which combines primary, secondary, mental health, social care and community data held in our GM shared care record with other health and care data that is available nationally and via local flows from providers, such as our live A&E or

daily hospital discharge data. Using this combined data, we can support clinicians to identify and enrol individuals onto acute and chronic disease remote monitoring programmes; mitigate risks of health deterioration; and support the identification of appropriate population level or prevention interventions. The insight from the advanced analytic capabilities of the ADSP can be written back into the health and care workflow through the shared care record.

Measuring our Delivery

- Continued development and application of the record-level longitudinal linked dataset across health and care

System Leadership

- Population Health Board

6.2 Area of Focus: Supporting People to Live Healthier Lives

We know that if Greater Manchester was a place that enabled people to smoke less, drink less alcohol, do more exercise, and eat better food, it would have a major impact on health and wellbeing. There are also stark disparities in the prevalence of healthy and unhealthy behaviour and variance in terms of the support that is available to people, which in turn drives unacceptable levels of health inequality. We also know that unhealthy behaviours are a symptom of the presence of deep-seated societal and commercial causes of poor health.

6.2.1 Action: A renewed Making Smoking History Framework to deliver our smokefree ambition

GM is committed to becoming the first global city region to be smokefree and since 2017 has been delivering the evidence-based Making Smoking History (MSH) Strategy.

Reducing smoking prevalence is integral to GM's approach to tackling inequalities. Becoming a smokefree city region by 2030 creates a unique opportunity to reduce health inequality and increase healthy working life expectancy with ONS estimating that overall healthy life expectancy would increase by just over 6 years for men and 7 years for women if GM becomes smokefree by 2030 (a prevalence of <5%).

An updated Making Smoking History (MSH) five-year framework will be published in Autumn 2023. The refreshed framework will further strengthen our reputation as national leaders in tobacco control through a strong commitment to innovation and

research and delivering behaviour change. Over the next five years we will deliver our **GMPOWER** approach:

- **G**rowing our social movement with communities to create change culture, denormalise smoking and turn off the tap of new young smokers. This includes working with housing providers and communities re smoke free homes
- **M**onitoring and evaluating prevalence through the national Smoking Toolkit Study and through increasing research collaboration with GM academia.
- **P**rotecting people from secondhand smoke. Work will continue through the WHO Bloomberg Partnership for Health Cities to deliver more outdoor smokefree spaces.
- **O**ffering every smoker support to quit, targeted at the most disadvantaged. This includes comprehensive programmes within acute and community services (CURE, Smoke Free pregnancy, SMI mental Health, Targeted Lung Health Checks), as part of a wider model of support delivered through pharmacy, community, and digital.
- **W**arning of the dangers of tobacco through insights driven, multi-media behaviour change
- **E**nforcing regulation across the full range of tobacco and nicotine regulation including action to protect young people from vaping products
- **R**aising the price of tobacco is achieved both through advocacy for national tax increases and GM coordination of a Tackling Illicit Tobacco programme.

Measuring our Delivery

- Reduced smoking prevalence in overall population – GM and locality targets
- Reduced smoking prevalence in Routine and Manual groups - GM and locality targets
- Reduced smoking at time of delivery/during pregnancy (see section 5.2.4) .
- SOF metrics for NHS LTP Treating Tobacco Dependency Programmes

Accountability

- Population Health Board

6.2.2 Action: Reducing Harms from Alcohol

Alcohol is a significant cause of health harms and Greater Manchester residents experience this disproportionately, which culminates in demand for health and care services.

Reducing alcohol harm at a pace which meets our ambitions will require a scaling up and acceleration of our current whole system efforts and extensive collaboration with a range of partners. Our approach will be anchored in the findings of the GM Big Alcohol Conversation.

Over the next five years we will:

- Develop the independent evaluation of an evidence-based and co-produced NHS GM plan to tackle the health harms associated with alcohol, as a constituent part of a refreshed overarching GM Drug and Alcohol Strategy
- The development of this plan will be underpinned by a strategic evidence and research partnership with the NIHR Applied Research Collaboration (Greater Manchester); comprehensive primary research into the alcohol consumption behaviours of children and young people in Greater Manchester; and focused engagement with high-risk cohorts
- Commission a community-led 'Ambition for Alcohol' aimed at accelerating a social movement for change in Greater Manchester
- Build on our activity to date on tackling the harms associated with alcohol consumption in pregnancy by fully implementing the NICE Quality Standards for Foetal Alcohol Spectrum Disorder (FASD)
- Continue to monitor and evaluate our existing Alcohol Care Teams (ACTs) and improve quality, and reduce variation through the development of a GM Community of Practice

Measuring our Delivery

The impact of our activity will be measured by closing the gap to the national average for:

- Alcohol specific mortality
- Admission episodes for alcohol specific conditions
- Admission episodes for alcohol specific conditions – Under 18s

Accountability

- Population Health Board
- Drug and Alcohol Programme Board

6.2.3 Action: Enabling an Active Population

Greater Manchester Moving is our social movement of people, communities, and organisations, from every sector and place across the city region, with a shared goal of enabling Active Lives for All, aligned behind the knowledge and belief that:

- Moving matters to us all
- We need to design movement back into our lives
- Everyone has a role to play

'GM Moving in Action 2021-31' sets out our collective strategy and whole system approach for achieving this mission, making it easier for people to move more and a natural part of how we all live, travel, work, and play.
Approximately 30% of the GM population are still not experiencing the health benefits of physical activity and the patterns in the data reflect the social determinants of health and point to a need for culture, systems, and behaviour change. We have identified where GM Moving can support the missions of the ICP strategy These are outlined below and will be the focus of our collective efforts in this area in the next three to five years.

- While You Wait – supporting people waiting for hospital treatment
- Deconditioning and Falls Prevention
- Mental Health and Wellbeing
- Health inequalities and SEND (Special Educational Needs and Disability)
- Live Well
- Health and Care Workforce Wellbeing
- Priority Clinical pathways (Respiratory, CVD and Cancer)
- Healthy Active Places
- Women's Health

We will:

- Embed GM Moving (movement, physical activity, and sport) across the health and care mode through a universal and targeted approach to tackle inequalities in inactivity
- Continue to connect with national and international networks such as the Active Partnership Network and the Global Community of Practice, to learn from, and share our understanding of whole system approaches to physical activity

Measuring our delivery

- Reduce inequalities by increasing physical activity rates amongst the groups most likely to be physically inactive, with a specific focus on lower socio-economic groups; culturally diverse communities; disabled people; people with long-term health conditions

- Reduce whole population inactivity rates as measured by the active lives survey and close the gap to the national average

Accountability

- Population Health Board

6.2.4 Action: Promoting Mental Wellbeing

It is our ambition to create a unified, integrated, and equitable system that will help to realise a mentally healthy city region in which every child, adult, and place matters. We aim to achieve this through our new GM Mental Health and Wellbeing Strategy.

The strategy recognises a need to focus on early intervention and prevention. Poor mental health and ill health has its roots in our experiences and opportunities in early life and throughout the life course. We know that some individuals, communities, and cohorts are at greater risk and are underserved by the support that exists.

Our key workstreams include:

- Tackling inequalities through the allocation of grant funding to the VCSE sector to focus on those individuals, communities, and cohorts who are at greater risk
- Delivering training and development to boost the understanding, confidence and skills of the wider health and social care workforce in relation to responding to poor mental wellbeing and building positive mental wellbeing
- Raise population level awareness to enable more people to identify and access timely self-help, support and services if required that will improve outcomes and reduce the need to access clinical support. A GM Mental Wellbeing e-module will be built and tested in 2023/24
- Continue to deliver workforce training, such as Connect 5, that is based on best practice and trauma informed evidence to inform and support our workforce to deliver better mental wellbeing outcomes for population

Measuring our delivery

- Improved wellbeing, satisfaction, worthwhile, happiness and anxiety as measured through the national ONS survey questions and the supplementary data provided by the quarterly GM Residents Survey
- 10% reduction in population reporting they do not know how to access timely self-help and further support by the end of 2023/24 and a 100% reduction by the end of the 5-year period meaning that every person in GM knows how to access self help and support if they require it

Accountability

- GM Population Health Board
- GM Mental Health Programme Board

6.2.5 Action: Food and Healthy Weight

Obesity and poor diet are linked with numerous health conditions. In GM, nearly two-thirds of adults (65.8%), and 40% of children in year six, are classified as overweight or obese (significantly higher than the England average)[7].

There is a strong relationship between obesity and deprivation, and rates are higher in some ethnic minority groups. Creating opportunities for people to be a healthy weight requires a whole system approach, and policies and programmes at neighbourhood, city-region, national and international levels. We will:

- Initially focus on supporting a whole system approach to food and healthy weight for pregnant women, children and young people and families
- Further develop primary care pathways into weight management services that align the local well-being offer with the national digital weight management programme.

Measuring our Delivery

- Increase in healthy weight prevalence for Y6 pupils across GM from 58.4% (latest GM data for 2021/22) to 60.8% (latest England average for 2021/22).
- Reduction in prevalence of overweight (including obesity) for Y6 pupils across GM from 40% (latest GM data for 2021/22) to 37.8% (latest England average for 2021/22).
- Reduce the prevalence of overweight and obesity in adults

Accountability

- GM Population Health Board

6.2.6 Action: Eliminating New Cases of HIV and Hepatitis C

GM has some of the highest diagnosed prevalence rates of HIV in the country, and over a third of diagnoses are made at a late stage. Preventing HIV and hepatitis C

[7] Obesity Profile - Data - OHID (phe.org.uk)

virus (HCV) infection, diagnosing it early, engaging people in care and starting treatment at an early stage are all critical to preventing the associated health consequences and premature death, and for preventing onward transmission.

Towards Zero – the HIV action plan for England outlines plans to reach zero new transmissions of HIV by 2030, with an interim target of an 80% reduction in HIV transmissions by 2025. For GM, this means a target of less than 35 new diagnoses a year by 2025. NHSE has also set out their ambition to eliminate HCV by 2025; five years earlier than WHO targets. In 2018, the Mayor of Greater Manchester and all 10 Council leaders signed the Paris Declaration and Greater Manchester joined the Fast-Track Cities Initiative, committing to achieve the UNAIDS targets for HIV (which GM has now reached and exceeded).

In the same year, a transformation programme ('ending all new cases of HIV in Greater Manchester within a generation' - HIVe) was launched. Over the next five years, we will:

- Continue to support the delivery and development of HIV and HCV opt-out testing at Manchester University Foundation Trust and scope out the feasibility of extending routine testing to other blood born viruses and areas
- Support mobilisation and development of HIV and HCV opt-out testing at Salford Royal Hospital.
- Continue investment and activity in the HIVe programme, and co-design of proposals for the next phase. This will be informed by community insights work, commissioned during to identify populations not reached by HIVe activities to date, and to identify the barriers and facilitators to accessing care and support

Measuring our Delivery

- The proportion of eligible people attending participating emergency departments who are tested for HIV and/or HCV on an opt-out basis
- The proportion of people newly diagnosed with HIV/HCV through opt-out testing, or who are identified as not currently engaged in care, who are contacted and offered an appointment with a specialist
- The proportion of people seen by a specialist who are offered community/peer support at their first appointment
- Reduction in the proportion of people diagnosed late with HIV (people first diagnosed in the UK).
- Increase in the proportion of people living with HIV who have a diagnosis.
- Maintain or increase the proportion of people diagnosed with HIV who are on treatment.

- Maintain or increase the proportion of people on treatment who are virally supressed.

Accountability

- GM Population Health Board
- GM BBV Opt Out Testing Steering Group

6.2.7 Action: Increasing the uptake of vaccination and immunisation, particularly amongst groups with the lowest uptake and the worst health outcomes.

High immunisation rates are key to preventing the spread of infectious disease, the associated complications, and premature death[8]. However, there are avoidable inequalities in immunisation rates between population groups, and the likelihood of complete and timely vaccination is influenced by variables such as where people live, their socio-economic status and their ethnic group[1].

Since the COVID-19 pandemic, vaccine uptake rates for routine childhood programmes have fallen globally. Coverage for the measles, mumps, and rubella (MMR) vaccination programme in the UK has also fallen to the lowest level in a decade. Uptake of the first dose of MMR by two years of age, and uptake of both doses of MMR by five years of age is below the 95% threshold across GM and has dropped in almost all locality areas compared with pre-pandemic.

Over the next five years, we will:

- Finalise and implement the GM winter vaccination strategy for COVIOD and flu once the upcoming national immunisation strategy is published
- Aligning with national plans, bring forward the second dose of the MMR vaccine from 3 years 4 months to 18 months of age (implementation by 2024/25) to improve coverage
- Review, refresh and then implement (Q2-4 2023/24) the GM measles and rubella elimination strategy action plan in collaboration with stakeholders across the system
- Commission behavioural insight work to understand the motivators, drivers, situational changes, nudge factors and steps that lead to positive attitudinal and change in members of communities where vaccine uptake is low and implement strategies to effect change.

[8] PHE Immunisation Inequalities Strategy (publishing.service.gov.uk)

- Improve population health management capability re immunisation data (systems, analysis and people), including enabling the flow of routine immunisation data from the GM Care Record into the GM Data Warehouse and development of data dashboard.

Measuring our Delivery

- Achieve and sustain ≥ 95% coverage with two doses of the MMR vaccine in the routine childhood programme (<5 years old)
- Increase the proportion of people over 65 receiving a seasonal flu vaccination to ≥ 85
- Demonstrate improvements in flu and COVID-19 uptake, and reduce inequalities in uptake in specified cohorts

Accountability

- GM Population Health Board
- Screening and Immunisation Oversight Committee

6.3 Area of Focus: Upscaling Secondary Prevention

Secondary prevention refers to a wide range of the activities included throughout this mission: from supporting people to take an active part to improve their own health by promoting healthier behaviours; to earlier detection and diagnosis of illness; to high impact interventions for the prevention and treatment of cardiovascular disease, diabetes, and respiratory disease

6.3.1 Action: Early cancer diagnosis through screening and early detection

Cancers are a significant driver of avoidable mortality. Effective cancer screening programmes and other activities that increase the proportion of cancers diagnosed at an early, more treatable stage have a central role to play in reducing premature mortality and morbidity.

The NHS Long Term Plan outlines the ambition for 75% of people with cancer to be diagnosed at an early stage (stage 1 or 2) by 2028. Research shows that eliminating

socioeconomic inequalities in stage at diagnosis across several different cancers could result in a 4% shift to early-stage cancer diagnosis[9] .

Over the next five years, we will implement improvements to cancer screening programmes to improve access and maximise uptake. These include:

- Continue staged roll-out of the NHS Bowel Cancer Screening Programme to younger age groups in line with the NHS Long Term Plan ambition to lower the starting age to 50. During 2023, we will continue the rollout to 54-year-olds, and then progress to 50- and 52-year-olds in 2024/25
- Remodel regional breast screening services for GM to deliver the infrastructure and integrated models of care to provide a high quality, efficient, sustainable service for all patients
- Implementing 5-year screening intervals for women aged 25 to 49 testing HPV negative on a routine screen
- Support increased uptake of cervical screening through the continued involvement of GM providers in the HPValidate study of self-sampling tests
- Commission a piece of city region-wide bowel, cervical and breast screening behavioural insights work to improve understanding of the barriers and motivators to accessing cancer screening for populations across GM. This will be completed in Q1 and 2 of 2023/24 and inform a GM wide communications campaign and future commissioning approaches

We will implement the GM Cancer Alliance 2023-24 programme of work on early diagnosis. This is overseen by the Early Diagnosis Programme Board. The work includes:

- Patient and public awareness to promote timely presentation – ongoing programme of communication with locality support and involvement. Funding to be allocated to support this in 2023-24, at a GM and locality level
- Primary Care Pathways – primary care engagement and education to support delivery of the Early Diagnosis Primary Care Network Direct Enhanced Service. Testing new referral pathways, including the national pharmacy referral pilot – GM is one of three national pilot sites
- GP Direct Access Diagnostics – ensuring GP have access to the appropriate range of pre-referral diagnostics and encouraging use of the established 'non-specific symptoms' (NSS) pathways.

[9] Socio-demographic variation in stage at diagnosis of breast, bladder, colon, endometrial, lung, melanoma, prostate, rectal, renal and ovarian cancer in England and its population impact - PubMed (nih.gov)

- Targeted Lung Health Checks (TLHC) – continued delivery and further expansion of this programme across Greater Manchester. This project is supported by additional targeted funding allocated to the Cancer Alliance
- Cancer Screening Programmes – joint work with the NHSE/I Screen and Immunisation Team and colleagues in primary care to improve uptake of the three cancer screening programmes and reduce inequalities in access, experience and outcomes.

Measuring our delivery

- Increasing and maintaining breast cancer screening coverage to ≥70%
- Increasing and maintaining cervical screening coverage (under and over 50) to ≥80%
- The proportion of eligible people invited to participate in the bowel cancer screening programme, in all age groups, achieves the national achievable standard (60%)
- The proportion of participants with an abnormal FoBT (Faecal Occult Blood Test) result who go on to have a diagnostic procedure achieves the national acceptable standard (82%)
- Increase the proportion of people with cancer diagnosed at an early stage (1 or 2) to ≥75% by 2028
- Meet the Faster Diagnosis Standard (FDS) Standard by March 2024 so that 75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days.

Accountability

- Population Health Board
- Cancer Board
- Locality Boards
- Primary Care System Board
- Screening and Immunisation Oversight Committee

6.3.2 Action: Early detection and prevention of Cardiovascular Disease

We will improve earlier detection of undiagnosed illness and earlier identification will enable earlier initiation of treatment. Given the inequity in health outcomes we currently see across GM, these key activities will focus on reducing inequalities in access and experience of healthcare and in reducing unwarranted variation in earlier diagnosis rates.

Earlier diagnosis of CVD

Whilst Cardiovascular disease (CVD) Prevention involves optimising and streamlining clinical pathways and areas, the underlying complexity and overlap with social and wider determinants of health means that a concerted system wide response is required. This needs to be combined with new ways of working with and for our communities: starting to change the dialogue from one about patients to *people*.

CVD has been identified as the single biggest area where our NHS can save lives over the next 10 years. The NHS Long Term Plan aims to prevent up to 150,000 heart attacks, strokes, and cases of dementia over 10 years. Key areas of focus include:

- Increase percentage of patients with hypertension treated to NICE guidance to 77% by March 2024
- Increase the percentage of patients aged between 25 and 84 years with a CVD risk score greater than 20% on lipid lowering therapies to 60%
- Continue to address health inequalities and deliver on the Core20PLUS5 approach

Modifiable risk factors explain 90% of CVD incidence and up to 80% of premature deaths from CVD are preventable[4]. Many people are living with common, treatable risk factors that significantly increase the risk of developing CVD:

- High blood pressure affects 1 in 4 adults, of whom half are undiagnosed or not receiving treatment. In GM, only 61% of adults with hypertension are treated to target.
- Nearly half of adults have cholesterol above recommended guidelines. In GM, 62% of people with no CVD, but a QRISK (Heart Attack and Stroke Risk Calculator) score of 20% or more are on lipid lowering therapy
- An estimated 1.4 million people have atrial fibrillation (AF), of whom almost 500,000 are undiagnosed and untreated10. In GM, around 89% of adults with AF and a CHA2DS2-VASc (Score for AF Stroke Risk) score of 2 or more are currently treated with anticoagulants

In general, GM figures are lower or worse than the England average, with variation between local authority areas in terms of both the prevalence and management of these risk factors.

NHS health checks are a crucial part of our prevention plans. We will continue to drive uptake of health checks across GM by:

[10] Prevalence | Background information | Atrial fibrillation | CKS | NICE

- Focusing NHS Health Check recovery on high-risk priority groups and explore mixed models of delivery to increase engagement
- Maximise impact of the programme by increasing prescribing of hypertensives and statins, referral into prevention programmes and links into wider welfare and support
- Increase take-up of the programme with a particular focus on populations with low uptake and higher CVD risk
- Explore a GM training approach which supports consistent and high-quality delivery and performance with a strong focus on effective behaviour change which is strength based and aligns to approaches to social prescribing and personalised care.

We will improve the identification and treatment of people with Hypertension by:

- Community pharmacy blood pressure case finding service. We have 456 community pharmacies providing a blood pressure (BP) case-finding service. These will be supported by the development of guidance for primary care around collaborating with community pharmacies.
- Supporting opportunistic blood pressure screening across all health and social care settings, making every contact count. Following the national rollout of the BP@home scheme, GM distributed over 10,000 BP machines across GP surgeries throughout so that patients can record their own blood pressure and send their readings to their GP practice to review

Measuring our delivery

- Reduction in prevalence gaps across our localities
- Reduction in inequalities in outcomes
- Improvement in the expected vs recorded prevalence of illnesses across differing socio-economic and ethnic groups
- Increased use of Community Pharmacy blood pressure case finding service
- Increased recorded prevalence of NDH (Non-Diabetic Hyperglycaemia) diabetes, hypertension, high cholesterol, obesity and behavioural risk factors

Accountability

- GM CV Prevention and Cardiac Board
- GM Clinical Effectiveness Group
- Locality Boards
- Primary Care System Board

Lipid management: Improve the identification and treatment of people with high cholesterol

Currently in GM we have approximately 11,000 patients who have had a CVD event, known to need basic statin medication to manage their cholesterol but who are not receiving this medication (cohort 1), plus a further 8,000 patients who are maximised for statin medication and yet their cholesterol levels remain unmanaged (cohort 4). These two cohorts are the two highest risk patient cohorts for our populations in terms of developing further cardiovascular events (such as a stroke or a heart attack). Our key actions in this area include:

- Development of a GM bespoke risk stratified case management tool Enabled on the Greater Manchester Shared Care Record, allowing system level data insight – shared with localities
- Development of lipids educational and training resources, including webinars, case management tool, medication pathway.
- An enhanced clinical pharmacist third-party review service for primary care supporting the optimisation of lipid lowering therapies for high-risk patients.

Measuring our delivery

- Improvements in the numbers of patients across the highest risk cohorts who are initiated on therapy against pathway criteria 1 and 4
- We conservatively estimate that optimising these patients will realise a 17% reduction on Major Adverse Cardiovascular Events (MACE) + events, 15% in MACE events and a total of 1,067 non-fatal events avoided
- Improvements in the proportion of patients who are optimised against the Accelerated Access Collaborative medication pathway

Accountability

- GM CV Prevention and Cardiac Board
- GM Clinical Effectiveness Group
- Locality Boards
- Primary Care System Board

6.3.3 Action: Earlier diagnosis of Respiratory Conditions through Quality Assured Spirometry

There are thousands of people in GM who have COPD but are undiagnosed. NHS RightCare estimate this to be around 19,000. Spirometry is essential for the diagnosis of respiratory conditions such as COPD and asthma. Limited spirometry has been

provided across Greater Manchester since COVID-19 due to infection prevention and control measures. Spirometry restart is necessary for the diagnosis of patients presenting with new symptoms but also to catch up on the 'backlog' of people who have been unable to access spirometry over the past three years. Spirometry provision will be embedded in the community so it can be aligned with Community Diagnostic Centres (CDCs).

Our focus is on achieving the following outcomes:

- To increase the number of people accurately diagnosed with COPD, asthma
- To increase the proportion of people diagnosed with COPD confirmed using post bronchodilator spirometry that is quality assured
- To increase the proportion of people with COPD who are diagnosed compared to predicted prevalence
- To reduce the risks related to inappropriate treatment of individuals misdiagnosed, and the associated medicines waste and environmental impact

Measuring our delivery

- Decrease Backlog in Spirometry
- Reduce respiratory referrals into secondary care
- Increase in diagnostic spirometry for children
- Increase the number of people who have been diagnosed with Asthma/COPD and have a quality assured spirometry on record

Accountability

- Primary Care System Board
- GM Clinical Effectiveness and Governance Group

6.3.4 Action: Early detection of unmet health needs for those living with Learning Disability and those with Severe Mental Illness

Learning from lives and deaths - people with a learning disability and autistic people (LeDeR) is an NHS England service improvement programme. Its purpose is to improve the quality of health and social care for people with a learning disability by requiring a review of the care received by a person after their death. The drivers for LeDeR were, and still are, the persistence of significant health inequalities and higher rates of morbidity and mortality between the general population and people with a learning disability. The role of health checks is key in supporting earlier access to healthcare and earlier detection of unmet health needs.

People with severe mental illness (SMI) face health inequalities and live on average 15 to 20 years less than the general population. They are less likely to have their physical health needs met, including identification of health concerns and appropriate, timely screening and treatment.

The CORE20PLUS5 Framework sets out the ambition for at least 75% of those living with a Learning Disability and at least 60% of those living with SMI to receive an annual health check.

Over the next five years we will:

Improve Learning Disability Annual health checks (AHC) uptake, quality and impact

- Work with General Practice to increase the numbers of people with Learning Disability on the General Practice Learning Disability register so as to reduce the numbers of those 'missing' from the register
- Increase both the uptake and quality of LD Annual Health Check (AHC), including provision of meaningful Health Action Plans (HAP) to meet (or exceed) national target of 75%
- Obtain strategic Intelligence through the development of GM LDA dashboard
- Develop and provide quality information for people with Learning Disability, families, health, and social care providers.
- Comprehensive training packages for stakeholders.
- Deliver health cafes, providing a structured platform to share accessible evidenced based information to people with Learning Disability

The above with be co-produced and co-delivered with experts by experience. We will obtain agreement for an annual audit cycle from all partner agencies and feedback from Experts by Experience

Increase Severe Mental Illness Annual Health Checks

- Continue to co-produce and embed innovative models to improve access for SMI patients and their physical health checks using principles of Making Every Contact Count
- Focus on patient engagement and completion of recommended physical health assessments with follow-up, involving delivery of or referral to appropriate NICE-recommended interventions
- Ensure patients are supported to make the lifestyle and behaviour changes needed to achieve and sustain improvements in their physical health through personalised care planning. This will also address the full needs of the person taking steps to

combat loneliness, isolation and promoting wider engagement in self-care, exercise, healthy eating and lifestyle
- Ensure that primary care teams continue to carry out annual physical health assessments and follow-up care for patients who are not in contact with secondary mental health services and patients with SMI who have been in contact with secondary care mental health teams for more than 12 months and /or whose condition has stabilised
- Ensure that secondary care teams continue to carry out annual physical health assessments and follow-up care for patients with SMI under the care of a mental health team for less than 12 months and/or whose condition has not yet stabilised

Measuring our delivery

- Achieving 75% uptake rate for annual health checks for those with Learning Disability across NHS GM
- Increase in those from ethnically diverse communities on register and having an LD AHC/HAP
- Increase in young people aged 14-25 on GP register and having an LD AHC/HAP
- Increase in LeDeR reviews identifying positive impact of AHC/HAP (and decrease in those not having one)
- Achieving 60% uptake rate for annual health checks for those with Severe Mental Illness across NHS GM

Accountability

- The GM LD&A delivery Group
- The GM Good Health Group
- The GM LDA Strategic Group
- GM Mental Health Board
- GM Clinical Effectiveness and Governance Group

6.4 Area of Focus: Living Well with long-term conditions

We have described the actions to prevent the worsening of disease, particularly of CVD, Diabetes and Respiratory disease. We now move focus to consider how we can support those with established long-term conditions to live well. The focus on prevention at every stage of the patient journey is to improve health and reduce severity of illness and to shift the balance away from care in hospitals towards care at home, with appropriate support (see section 5.1.4)

6.4.1 Action: Managing Multimorbidity and Complexity

Multimorbidity is a term used to describe the presence of two or more long-term health conditions, and includes both physical and mental health conditions, ongoing conditions such as learning disability, symptom complexes such as frailty or chronic pain, sensory impairment such as visual loss and alcohol/substance misuse[11].

Over the next five years, we will:

- Obtain the data to understand the prevalence of those living with multimorbidity in Greater Manchester, with a particular focus on identifying inequity and unwarranted variation
- Develop a strategic multi-morbidity approach to long term conditions, which will include person centred care and shared decision making
- Establish a systemwide approach to Chronic Musculoskeletal Conditions (including back pain), Chronic Pain and Chronic Fatigue

Measuring our delivery

- We will design/develop an approach to multimorbidity in years 1-2 of the Joint Forward Plan
- We will evidence delivery of this over years 3-5

Accountability

- GM Clinical Effectiveness and Governance Group
- GM Population Health Board

6.4.2 Action: Optimising treatment of long-term conditions

The focus here is the optimal treatment of the three main conditions driving preventable disability and mortality - cardiovascular disease, diabetes and respiratory disease

Cardiovascular Disease

Following a cardiac event, such as a heart attack, research shows that cardiac rehabilitation has a positive impact on wellbeing and quality of life and can also reduce the risk of being re-admitted into hospital with subsequent cardiac events.

[11] Recommendations | Multimorbidity: clinical assessment and management | Guidance | NICE

Measuring our delivery

Our aims are:

- 85% of eligible Acute Coronary Syndrome patients attending cardiac rehab
- 33% of eligible and newly diagnosed Heart Failure patients completing a personalised cardiac rehabilitation programme by 2028/29

Accountability

- Quality and Performance Committee

Improving access to diagnostics for people with Heart Failure

People with Heart Failure are often admitted to hospital due to limited access to diagnostics and treatments in the community. Improving access could prevent up to 230,000 hospital admissions and 30,000 deaths from heart and circulatory diseases over the next decade in England.

We will use digital services to support improvements. These include:

- GM heart failure digital care plan. We are working together to transform care planning in HF to a standardised digital heart failure care plan that can be utilised across care settings via the GM Care Record. It will support patients to be managed more effectively within the community while also empowering patients to take greater control and be more informed. It is currently being piloted in Rochdale and Tameside with a view to spread across the whole of GM.
- Remote Monitoring for Heart Failure. We are testing out a remote monitoring platform that allows people with heart failure to be monitored remotely

Measuring our delivery

- Roll out of standardised digital heart failure care plan

Accountability

- Quality and Performance Committee

Improving survival rates for Out of Hospital Cardiac Arrest

Cardiopulmonary resuscitation (CPR) is attempted in nearly 30,000 people who suffer out-of-hospital cardiac arrest (OHCA) in England each year, but survival rates are low and compare unfavourably to other countries.

Many lives can be saved if:

- CPR and early defibrillation are undertaken promptly and more often
- The whole pathway of care from successful resuscitation to subsequent rehabilitation were improved.

We will work with the British Heart Foundation to roll out training initiatives to support education on the use of defibrillators.

Measuring our delivery

- Our ambition in GM is to increase the survival rates for our patients to 25%.

Accountability

- Quality and Performance Committee

Diabetes

Over 170,000 people are living with Diabetes in GM and many others are at risk of developing the condition. We developed the GM Diabetes Strategy in 2018 and the GM Diabetes Board reviewed and refreshed the strategy in 2022.

Our main areas of delivery include:

- Structured Diabetes Education is being in adapted to offer it in more culturally appropriate formats for different communities (South Asian, Black and Afro-Caribbean, Deaf people, visually impaired people)
- The Manchester Amputation Reduction Strategy (MARS) is being developed and rolled out in more localities around GM to offer more integrated wound care in a more timely fashion to help prevent amputations
- The nationally commissioned BHS Type 2 Diabetes Pathway to Remission (formerly known as low-calorie diet) is being offered across GM, providing a 12 week total diet replacement course under clinical supervision
- Healthier You, the national diabetes prevention support offer, is being offered across GM with 14,000 places available each year
- A Diabetes Transition Strategy is being developed to set out the GM vision for improved transition for children living with diabetes into adult care services
- Diabetes My Way (www.diabetesmyway.nhs.uk) provides self-management support for people living with diabetes in GM by providing access to their own GP diabetes data dashboard, personalised advice, digital structured education, and support resources
- Healthcare professionals working with diabetes patients have been offered training and education in the areas of motivational interviewing and shared decision making to increase attendance rates at structured diabetes education

Measuring delivery

Using the GM Diabetes Intelligence Dashboard, we will measure key metrics at practice, PCN, locality and GM level, including:

- The prevalence of diabetes in GM
- Number of referrals and programme starts in the National Diabetes Prevention Programme
- Number of patients completing all 8 diabetes care processes (and individual care processes)
- Number of patients achieving all 3 diabetes treatment targets (and individual treatment targets)
- Number of patients attending structured diabetes education
- Number of referrals and programme starts into the NHS Type 2 Diabetes Pathway to remission programme
- Number of diabetes patients living with additional risk factors and/or other long-term conditions

Accountability

- GM Diabetes Board
- GM Clinical Effectiveness and Governance Group

Respiratory Disease

In GM in 2019, 26.78% of all respiratory hospital admissions were due to influenza or pneumonia. Influenza and pneumonia are one of the highest areas of spend due to non- elective admissions (source NHS RightCare).

The uptake of influenza, covid and pneumococcal vaccination varies across GM localities and across risk groups and all age groups. Increasing uptake rates of these vaccinations for people with respiratory disease, will lead to avoidance or reduction in severity of winter respiratory illness for the individual and reduce avoidable unplanned admissions to hospital.

We will work with vaccination and immunisations teams (as described in section 6.2.7) to deliver a comprehensive and targeted offer of vaccination for those with respiratory disease

Measuring our delivery

- Reduction in hospital admissions due to influenza and pneumonia

Accountability

- Quality and Performance Committee

COPD

Prevention of COPD by supporting people to stop smoking and earlier detection of COPD through quality assured Spirometry is considered in section 6.2.1 of this plan. Once COPD has been diagnosed, the priority turns to enabling a good quality of life by preventing progression and complications. Respiratory conditions are long-term conditions, with stable periods and exacerbations, and many patients experience deterioration over time. This means the access to services is an important aspect of care.

We plan to enhance and expand the Pulmonary Rehabilitation (PR) programme across GM. We have established a GM PR collaborative to reduce variation in offer, standards and access to PR across Greater Manchester. Over 2023/24, we will roll out the standardised PR educational booklet; work with community teams to provide early education sessions; continue to work towards national accreditation.

We will explore community based and led rehabilitation/ patient expert education group models and will work with other rehabilitation groups (e.g., cardiac rehabilitation) to provide a person-centred cross-cutting offer which encompasses other rehabilitation and chronic disease education.

Measuring our delivery

- Achieve nationally recognised accreditation standards for all pulmonary rehabilitation services
- Reduction in waiting times for PR
- Increase in choice of delivery of PR

Accountability

- Quality and Performance Committee

6.4.3 Action: Role out the Manchester Amputation Reduction Strategy (MARS) across NHS GM

The Manchester Amputation Reduction Strategy (MARS) is an example of a 'whole systems' approach to a single clinical problem: *How do we reduce lower limb amputations secondary to chronic disease across Greater Manchester?* A multi-disciplinary team with expertise across Public Health, community, hospital, finance,

digital, strategy and academia came together to co-design a solution with sustainability and scalability at its heart. Its' philosophy is that better outcomes result from the 'aggregation of marginal gains' which are only possible in a complex system if cultures across organisational boundaries are better aligned.

The work began by encapsulating the entire patient journey in one diagram and understanding amputation inequalities across regional, gender, ethnic and diabetes groups. An amputation is often the result of an ulcer that is inadequately treated which itself is often the result of chronic disease that is, itself, poorly managed made more difficult by variations in service provision and access which together are likely to be leading to the locality, gender and ethnic inequalities we see across the region.

MARS has 4 programmes of work being developed and becoming ready to scale up;

- ***'Move More':*** Improve physical activity in the general and ulcer population by linking Public Health services with clinical pathways both face to face and digitally
- ***'Reduce Inequality more':*** Level up access for all lower limb ulcers to the diabetes standard
- ***'Diagnose more':*** Raise capabilities and confidence of community nursing and podiatry teams to perform more non-invasive vascular assessments
- ***'Make every contact count more':*** Use Public Health Screening programmes e.g., aneurysm screening to case-find undiagnosed conditions of concern e.g., depression, hypertension and peripheral arterial disease

Measuring our Delivery

- Enable equity of access to community podiatry services by patients with foot ulcers regardless of diabetes status
- Raise uptake levels of screening from areas with high levels of deprivation and ethnic minorities
- Raise capability of community nursing and podiatry teams to perform and interpret non-invasive lower limb vascular assessments and reduce referrals into vascular surgery by 25%

Accountability

- Cardiac SCN
- Clinical Effectiveness and Governance Committee (CEG)
- Locality Boards
- Population Health Board

6.4.4 Action: The GM Dementia and Brain Health Delivery Plan

Dementia is a priority for Greater Manchester. Our vision and shared ambition is to improve the experience of being diagnosed and living with dementia and make GM the best place to live for all those affected by Dementia.

Our Strategic Aims are:

- Improving connections, quality of care and experience for everyone affected by dementia
- Promote brain health and help prevent avoidable cases of dementia, supporting wellbeing and independence
- Design, develop and facilitate education and training across all sectors
- Increase access to benefits of dementia research through awareness, involvement and participation

We are working hard to increase the dementia diagnosis rate (DDR) to pre-pandemic levels. The Greater Manchester DDR is currently above the national target (66.70%) with an average of 70% in 2022/ 2023. This is key to supporting people to live well at home for as long as possible and avoid care home or hospital admission.

Measuring our Delivery

- The longer-term ambition is for GM to recover pre-pandemic levels which reached 76% in 2018/2019. Immediate target to reduce variation across GM; to ensure that all boroughs have recovered the dementia diagnosis rate of 66.7%

Accountability

- Dementia United Board

6.4.5 Action: Taking an evidenced based approach to responding to frailty and preventing falls consistently across GM

Frailty is an increasingly problematic long-term health condition characterised by declining resilience and increased vulnerability to events associated with, but not specifically caused by, ageing.

We have launched the Greater Manchester Falls Collaborative to oversee and deliver the priorities for falls prevention, integration and reconditioning.

Over the next five years, we will:

- Develop GM strategy and standards focused on ageing well, identify and reduce of unwarranted variation, improve key clinical outcomes and improve patient experience for older people
- Review the Framework for Resilience and Independent Living to produce a GM Frailty Prevention and Care Strategy and an agreed set of frailty care standards for implementation to drive frailty care quality improvement.
- Develop a frailty care outcomes framework dashboard. This will be designed to support place-based teams allowing them to review, develop and quality improve services to achieve better care for local people as they age

Measuring our Delivery

- New care home admission
- Death in unplanned settings including in hospital
- ED attendance and admission resulting from a fall and/or fracture

Accountability

- GM Ageing Well Steering Group
- GM Clinical Effectiveness and Governance Group

6.4.6 Action: Anticipatory care and management for people living with, deteriorating and dying from life limiting illness

Individuals who are experiencing a life limiting illness should be supported to live as well as they can before they die. They should be empowered to make important decisions about their care and wishes. They should be treated with dignity, respect and conversations about their condition and care should be open and honest. Appropriate and culturally sensitive care should be available to all those who need it.

It is recognised that the majority of an individual's care in the last year of life will be. provided in their usual place of care. However, many people in Greater Manchester die in hospital. Dying in hospital is usually the least preferred place to be.

Our focus is on:

- Delivering a palliative and end of life care transformation programme
- Ensuring that care is available to all those needing it, prioritising quality of life and living and dying well within existing legal frameworks

We will develop and implement:

- A quality improvement plan against the GM Commitments and the National ambitions self-assessment
- The increased use and reporting of IPOS (Integrated Palliative Care Outcomes Scale) across Greater Manchester ensuring the transformational programme is in line with individuals' needs

Measuring our Delivery

- The availability of 24 hour/7 day a week specialist palliative care services in Greater Manchester
- Reduction in inappropriate admissions to secondary care in the last 90 days of life
- Increased use of the EPaCCS (Electronic Palliative Care Coordination System) Summary on the Greater Manchester Care Record
- Increased identification of people with palliative and end of life care needs

Accountability

- GM Palliative and End of Life Group
- GM Clinical Effectiveness and Governance Group

7 Helping people get into, and stay in, good work

One of the purposes of Integrated Care Systems is to support wider social and economic benefits from NHS investment. We will act on this by enhancing the Education, Work and Skills system, working with employers on employee wellbeing, through the Greater Manchester Good Employment Charter and developing social value through our network of anchor institutions.

Helping people get into, and stay in, good work Delivery Leadership: Locality Boards System Leadership: Population Health Board; GM Good Employment Charter Board, GM Employment and Skills Advisory Board	
Areas of Focus	**Actions**
Enhance Scale of Work and Health Programmes	Expansion of our Working Well System
Develop Good Work	Working with employers on employee wellbeing through the GM Good Employment Charter
Increase the contribution of the NHS to the economy	Developing the NHS as an anchor system
	Implementing the Greater Manchester Social Value Framework

NHS GM and the GM Combined Authority have been able to draw from shared evidence generated through publications such as Build Back Fairer in Greater Manchester: Health Equity and Dignified Lives (2021), the GM Independent Prosperity Reviews (2019 and 2022) and the Greater Manchester Local Industrial Strategy (2019) which all reinforce the connection between health and an inclusive economy.

7.1 Area of Focus: Enhance scale of work and health programmes

7.1.1 Action: Expansion of our Work and Health Models

Jointly developed by GMCA and NHS GM, the Working Well System Model has been in place since 2018. A co-investment approach aims to support the long term unemployed and people with health conditions or disabilities into sustainable 'good work' across the city-region.

Within the 2023 Devolution Trailblazer agreement, there is a commitment to a co-design approach for all future DWP contracted employment support programmes in the city-region, with an assumption of a GM footprint and a delegated delivery model. This will allow GM to further shape and define the Working Well system, and bring the additional resource and opportunity created by the introduction of the UK Shared

Prosperity Fund (replacing European Social Fund) for those not in employment or training, over 50s and those with complex needs.

NHS GM and the Combined Authority will work together in 2023/24 to redefine and advance our future model including for the Working Well model, as well as the Working Well: Specialist Employment Service (SES) comprising Supported Employment (SE) for people with a learning disability and/or autism, and Individual Placement and Support (IPS) for both people with severe mental illness and those referred through the Primary Care route.

7.1.2 Action: Expansion of our Working Well System

Working with GMCA, NHS GM will continue to evolve the Working Well System to ensure as many residents as possible are supported towards and into employment providing the right support at the right time to enable positive work outcomes. As funding and programme opportunities become available, a data and evidence led approach will be applied to ensure maximum impact. New services to be in place in 2023/24:

- Working Well: Individual Placement and Support in Primary Care service funded by the Department for Work & Pensions (DWP), to provide support for 1,500 GM residents running to March 2025. Delivery will take place in co-locations with a range of primary and community NHS health services and professionals. Participants will come from two distinct cohorts: out of work participants who require assistance and support to move into competitive employment; and in work participants who are off sick or struggling in the workplace due to their disability / health condition
- A Working Well: Early Help service building on leaning from our first pilot and further testing an early intervention primary care referral model for individuals with health conditions or disabilities at risk of falling out of work
- A programme of work delivered in partnership with The Health Foundation will improve health and reduce inequalities through scoping a system wide approach to addressing increasing economic inactivity resulting from poor health in those aged 50-64
- A response to the Joint Work and Health Unit's new Work Well Hub and Partnership programme. The Hubs are expected to link jobcentres, health services and other local organisations and provide wraparound support for jobseekers, those on benefits and those at risk of falling out of work due to their health conditions.
- Additional commissioning linked to the UK Shared Prosperity fund is likely to focus on economically inactive people with complex needs (all age groups) many of

which are likely to relate to health conditions. This programme will be delivered from late 2023 and aims to support over 8,000 people towards employment over coming years.

Measuring our Delivery

- Number of people supported into work
- Number of people supported to remain in work
- Number of people supported whose health conditions improve

Accountability

- Locality Boards
- Population Health Board
- GMCA Employment and Skills Advisory Partnership / new Integrated Education, Skills and Work Governance Board

7.2 Area of Focus: Develop good work

7.2.1 Action: Working with employers on employee wellbeing through the GM Good Employment Charter

The Greater Manchester Good Employment Charter aims to develop diverse, equal and truly inclusive working conditions across Greater Manchester. By promoting the benefits of equality, diversity and inclusion in the workplace, we aim to support employers to create workplaces that embrace the characteristics of good employment in ways that ensure fair pay, opportunity and progression to all. This will include adoption of the Real Living Wage (RLW)

This action applies to all Greater Manchester employers, in partnership with GMCA, but also includes health and care organisations. Our key actions in this area are set out in the Supporting our Workforce and Carers Mission.

Measuring our Delivery

- Number of Health and Care organisations achieving Charter Accreditation

Accountability

- People Board

7.3 Area of Focus: Increase the contribution of the NHS to the economy

7.3.1 Action: Developing the NHS as an anchor system

The Health Foundation describes anchor institutions as large organisations whose long-term sustainability is tied to the wellbeing of the populations they serve[12]. This agenda is also linked to the 'fourth purpose' of ICSs, unlocking the NHS's social and economic potential.

These anchor organisations are 'rooted in place' and have significant assets and resources which can be used to influence the health and wellbeing of their local community. By strategically and intentionally managing their resources and operations, anchor institutions can help address local social, economic and environmental priorities in order to reduce health inequalities.

In Greater Manchester, we will move from an institutional perspective to one more akin to a social movement. The next stage of our journey will be to develop a more strategic and aligned focus on what it is the ICS wants to change, developed in partnership with the range of other anchors in the system, all pulling and participating in the same strategic direction for the economy.

This work will be developed by a GM NHS Anchors Network with representation from each trust as well as each locality. Agreed short term priorities for the GM Anchors Network include:

- Develop and implement vision, strategy and targets
- Develop and implement local supply chain opportunities
- Develop and implement collaborative approaches to the development of effective local employment pathways

Measuring our Delivery

- To be confirmed through GM Anchors Network development

Accountability

- Population Health Board
- Provider Federation Board

[12] The NHS as an anchor institution (health.org.uk)

7.3.2 Action: Implementing the Greater Manchester Social Value Framework

The GM Social Value Framework sets out how our city region will deliver social value through commissioning and procurement activities. It sets out the outcomes that GM is collectively working on to make an impact through the policy, including supporting more people into work; a reduction in poverty and health inequalities; and avoiding acute problems by investing in prevention.

Our key actions as NHS GM:

- Embedding Procurement Policy Note 06/20 (taking account of social value in the award of central government contracts) into business-as-usual activity
- NHS GM Integrated Care and Provider Trusts formally adopt GMCA approach to lever more social value from public sector spending
- Agree and embed standard social value evaluation questions with model answers for procurements
- Implement standard approach to measurement and reporting on social value delivered:
- Evaluate the impact of a 20% (or higher) social value weighting for procurements
- Identify relevant categories and/or contracts for local supply chain development

Measuring our Delivery

- Improvements against Social Value Reporting Tool metrics – being developed at national level

Accountability

- Population Health Board

8 Recovering core NHS and care services

Improving access to high quality, core services and reducing long waits is the main issue raised by Greater Manchester residents participating in the Big Conversation and this will be delivered through our approach to the recovery of services. The impact of the COVID-19 pandemic was huge and exacerbated many of the challenges which were already influencing delivery of core health and care services.

Recovering Core NHS and Care Services Delivery Leadership: Locality Boards and PFB System Leadership: System Boards; Finance and Performance Recovery Board	
Areas of Focus	**Actions**
Improving urgent and emergency care and flow	Access to urgent care in the community
	Admission/Attendance Avoidance
	Improving discharge
	Increasing ambulance capacity
	Improving emergency department processes
Reducing elective long waits and cancer backlogs, and improving performance against the core diagnostic standard	Integrated Elective Care
	Improving productivity and efficiency
	Improving utilisation of the Independent Sector
	Improving how we manage our wait list
	Recovering children and young people's elective services
	Reducing waiting times in cancer
	Diagnostics
Improving service provision and access	Making it easier for people to access primary care services, particularly general practice
	Digital transformation of primary care
	Ensuring universal and equitable coverage of core mental health services
	Digital transformation of mental health care
Improving quality through reducing unwarranted variation in service provision	Improving quality
	NHS at Home – including Virtual Wards
Using digital and innovation to drive transformation	Implementation of Health and Social Care Digital Strategy
	Driving transformation through research and innovation

8.1 Area of Focus: Improving urgent and emergency care and flow

The GM Urgent and Emergency Care (UEC) Plan is based on a set of improvement priorities linked to the themes in the national UEC recovery plan.

8.1.1 Action: Access to urgent care in the community

Responsive urgent care services in our neighbourhoods and communities are a vital part of our system. Our priorities for these community-based services are:

- Fully implementing Urgent Treatment Centre (UTC) models consistently across GM. There are currently 10 accredited UTC sites open across GM that adhere to the guidance
- Improving 111 access and flow through reviews of community services and Directory of Services (DoS) accessibility
- Improving referral pathways for 999 access and response. Building on existing good work with North West Ambulance Service (NWAS) and system partners to increase "Hear and Treat" and "See and Treat" rates
- Continued GM Clinical Assessment Service (CAS) development, reviewing appropriate code sets and increasing options for 111 and 999 based on clinical appropriateness

Measuring our Delivery

- Reduce unnecessary GP appointments and improve patient experience by streamlining direct access and setting up local pathways for direct referrals
- Reduction in A&E attendances
- Reduction in Ambulance conveyances

Accountability

- UEC Board
- Locality Boards
- PFB

8.1.2 Action: Admission/Attendance Avoidance

Admission/Attendance Avoidance includes initiatives to ensure the expansion of out of hospital services to avoid an admission or attendance. These include:

- Same Day Emergency Care (SDEC) – working with system partners on improving direct access pathways for NWAS and primary care. Reviewing consistency of models across GM, supporting improvement, and overcoming barriers to make the most effective use of the services
- Urgent Community Response (UCR). All localities have plans to offer full geographic coverage for a minimum of 08:00 – 20:00 7 days a week for UCR.

Where demand necessitates, there is flexibility for longer operating hours and covering all 9 clinical conditions or needs, including level 2 falls. This is done by ensuring there are multi-disciplinary teams operational during the required times

- Our localities are aiming to increase referrals in from 111 and 999. The NW regional team are working with NWAS and the DoS team to produce a standardised code set for across the region to ensure consistency of approach

Measuring our Delivery

- Consistently meet or exceed the 70% 2-hour urgent community response (UCR) standard
- Reduction in non-elective admissions
- Reduction in A&E Attendances

Accountability

- UEC Board
- Locality Boards
- PFB

8.1.3 Action: Improving Discharge

Improving Discharge and Flow focuses on reducing Length of Stay (LoS) and supporting patients leaving hospital in a timely manner including:

- In-hospital flow – working with providers to support flow improvement initiatives, benchmarking and sharing best practice
- Evidenced-based audit work to support improvement
- Out of Area (OOA) placement discharge improvement

We have been working with partners to introduce new schemes and enhance existing models to improve Discharge and Flow. Specific areas of focus include:

- Setting up a directory in GM of contacts, and a national directory, and streamlining these through localities
- Ensuring points of escalation are in place through the relevant groups including acute and mental health discharges
- Review of systems and processes across GM, further embedding of escalation processes
- Review of other ICS Transfer of Care Hubs, working closely with social care

The GM Directors of Adult Social Services have led on the development of additional schemes to support winter and surge capacity engaging all GM partners in the decision making. This includes the GM Independent Provider Network.

Measuring our Delivery

- Reductions in Length of Stay
- Reductions in the number of patients in hospital beds with no criteria to reside
- Reduce adult general and acute (G&A) bed occupancy to 92% or below
- Increasing the number of patients being discharged to their usual place of residence

Accountability

- UEC Board
- Locality Boards
- PFB

8.1.4 Action: Increasing ambulance capacity

Several "alternative to transfer pathways" are in place across Greater Manchester. These pathways include direct referrals into two-hour UCR and other community services, as well as the falls lifting services, which are relieving some of the pressure on ambulance services. There is a dedicated mental health triage function developed between Greater Manchester Police (GMP), NWAS and mental health providers.

GM actions include:

- Ensure pathways to other services are clear on the DoS and Service Finder.
- Monitor ambulance referrals to other services - ensure consistency during busier and lighter periods
- System review of pathways across localities ensuring sufficient capacity is in place

Measuring our Delivery

- Improve category 2 ambulance response times to an average of 30 minutes across 2023/24 with further improvement towards pre-pandemic levels in 2024/25

Accountability

- UEC Board

8.1.5 Action: Improving emergency department processes

We are working with partners to standardise care at the ED front door, including for mental health patients. Our focus is on improving patient flow in and out of hospitals, including embedding fully functional bed management and the GM system control centres.

Work to improve and standardise Same Day Emergency Care (SDEC) is part of this improvement plan, ensuring patients can access SDEC services as an alternative to the Traditional ED process, through referral from their GP or from NWAS. Our key priorities include:

- Ensure consistency of approach across each ED to avoid inequity of service
- Ensure systems can cope with the operational and monitoring challenges on a day-to-day basis
- Further development of the SCC (System Control Centre) and embedding of a sustainable model across the whole system

Measuring our Delivery

- Improving A&E waiting times so that no less than 76% of patients are seen within 4 hours by March 2024 with further improvement in 2024/25
- Reducing 12hr waits in the Emergency Department

Accountability

- UEC Board
- PFB

8.2 Area of Focus: Reducing elective long waits and cancer backlogs, and improving performance against the core diagnostic standard

The GM elective recovery and reform strategy has six pillars (Figure 7) and addressing health inequalities is embedded as a priority through the programme supported through board level equalities champions. Each recovery pillar also has an equality impact assessment

Figure 7

8.2.1 Action: Integrated Elective Care

The Integrated Elective Care Pillar aims to support the early stages of a patient pathway. The Integrated Elective Care Pillar will support the Primary Care and Secondary Care interface principles through improving utilisation and implementation of referral optimisation initiatives. This pillar of work will also support the system in delivering outpatient recovery and transformation initiatives to improve efficiency and patient experience including increased use of advice and guidance and Patient Initiated Follow Up (PIFU).

Measuring our Delivery

- Utilisation of advice and guidance
- % patients moved to PIFU pathways
- New to follow up outpatient appointment ratio

Accountability

- GM Elective Recovery and Reform Board

8.2.2 Action: Improving productivity and efficiency

Driving productivity and efficiency to release the capacity required to increase elective activity, reduce long waits and improve patient safety, outcomes and experience.

Plans are underpinned by a systematic data-driven approach for identifying productivity opportunities with the highest impact on improving elective care and reducing inequalities. This is supported by the adoption of GIRFT (Getting it Right First

Time) and Right Care principles to reduce unwarranted variation and improve GM performance. The programme will focus on reducing DNAs; improving theatre utilisation; increasing day case rates; specialty specific focus on ophthalmology and orthopaedics

Measuring Delivery

- Increase in high volume low complexity procedures
- Theatre utilisation
- Day case activity as a percentage of overall activity
- Reduction in on the day cancellations
- Improvements in DNA rates

Accountability

- GM Elective Recovery and Reform Board

8.2.3 Action: Development of Surgical Hubs

Maximising the use of surgical hubs will ensure capacity for elective activity is protected and drive down the overall wait list in GM. GM has a number of hubs in place with plans for more to come on line in the next few years. We are also engaging with the national surgical hub accreditation process which focuses on performance, utilisation and patients experience in hub settings. One of our GM hubs is currently going through national accreditation process with more to follow. The use of surgical hubs through the pandemic has highlighted the importance of protecting elective activity and ensuring beds are available.

- We have developed a weekly GM surgical hub capacity report to review surgical hub utilisation and proactively manage surgical hub capacity using the 6-4-2 model, supporting the GM mutual aid approach, and the delivery of national targets.
- GM surgical hub sites will continue to work towards the achievement of 85% day case activity in 2023/24, and the development of Standard Operating Principles for all GM hubs will reduce variation and improve equity of access to hub capacity for patients across GM
- Plans to extend GM surgical hub sites in 2023/24 will increase the provision of elective capacity, particularly for children and young people, and surgical hub sites will work towards gaining national GIRFT (Getting it Right First Time) accreditation.
- A GM wide communication and engagement approach for both patients and staff will support these developments

To support digital activity, we have an identified digital lead on the GM Elective Board with links back to the GM Chief Digital Officers network. This will enable us to identify digital opportunities relating to the pillars of the Elective Recovery Strategy.

Measuring our Delivery

- Meet the 85%-day case and 85% theatre utilisation national expectations, using GIRFT and moving procedures to the most appropriate settings
- Number of patients treated in surgical hubs
- Productivity of surgical hubs

Accountability

- Elective Care Recovery and Reform Board
- PFB

8.2.4 Action: Improved utilisation of the independent sector

Working with independent sector (IS) providers is critical to supporting our work to reduce the overall wait list and in particular those who have waited the longest. This programme of work will focus on a demand and capacity model for those patients that have waited over 65 weeks.

We will work in collaboration with IS providers to develop and implement a joint standard operating procedure and access policy for IS activity.

Measuring our delivery

- Utilisation of available independent sector capacity
- Number of long waits with IS providers
- System spend against plan on IS activity

Accountability

- Elective Care Recovery and Reform Board

8.2.5 Action: Improving how we manage our wait list

We will work collaboratively to eliminate long waits over 78 and 65 weeks by the end of June 2023 and March 2024 respectively. This will be undertaken in an equitable way through targeted support and a focus on choice. In addition, we will further

develop the While You Wait website to support people while they are on the wait list and through our work on the Myrecovery app.

We will agree and implement a consistent GM access policy and will pilot a GM approach to risk stratification and clinical prioritisation to support inclusion and reduce inequalities.

Through the Wait List Management Programme, we will also pilot alternative approaches to support patients through our Care Navigation Hubs.

Measuring our delivery

- Overall GM referral to treatment (RTT) wait list
- Number of patients waiting over 78 weeks
- Number of patients waiting over 65 weeks

Accountability

- Elective Care Recovery and Reform Board

8.2.6 Action: Recovering children and young people's elective services

Our focus on Children and Young People will consider five key areas of work: additional capacity opportunities; consistent clinical prioritisation; improved referral pathways; revised specialty pathways and shared productivity and efficiency opportunities.

Improvements have already been driven through our work on Walk In Walk Out approach to increasing day case activity and surgical hub funding has been allocated to children and young people. Recovery is however slower for children and young people, which is also being seen across the country. As a result, this is a particular focus as part of our cross-cutting work on health inequalities.

Measuring our delivery

- Overall number of children and young people on the RTT wait list
- Number of children and young people waiting over 65 weeks
- Activity relating to children and young people as a proportion of overall activity

Accountability

- Elective Care Recovery and Reform Board

8.2.7 Action: Reducing waiting times in cancer

Cancer Alliance planning requirements aim to improve performance against the Cancer Waiting Times standards with a specific focus on delivering the Faster Diagnosis Standard (FDS). This requires 75% of patients to have cancer confirmed or excluded within 28 days.

The target of 75% is for March 2024 with incremental milestones at the end of each quarter at system and provider levels. There is a requirement to reduce the volume of patients from a two week wait referral source who are on an active PTL (patient tracking list) beyond 62 days. The target set by NHSE is 1,051 by the end of March 2024. GM has set a stretch target of 761.

To achieve this, our key areas of focus are:

- GM system wide action plan
- Focused work on first attendance 'offer' and 'day 7'
- Best Practice Timed Pathway (BPTP) project delivery and compliance monitoring
- Roll out of tele-dermatology and Faecal Immunochemical Testing (FIT) and compliance monitoring
- Continued education and support to primary care
- Collaborative work with elective programme on referral options (urgent non-cancer capacity)
- Consolidation of oncology appointments (single queue)
- Ongoing work to improve waiting times for diagnostics and reporting for patients on suspected cancer pathways.
- Mutual aid offer for specialist surgery
- Embed faster diagnostic standard (FDS) principles in all site-specific pathways
- Roll out and compliance with personalised stratified follow-up (PSFU) to release clinical time to be re-invested pathway improvement

Measuring our Delivery

- Reduce the volume of patients on active PTLs over 62 days. NHSE target 1051 by end March 2024. GM target 761
- Meet the Faster Diagnosis Standard (FDS) Standard by March 2024 so that 75% of patients have cancer confirmed or excluded by day 28 of their pathway. Achieve the milestone targets of 67.5% end June 2023; 70.0% end September 2023; 72.5% end December 2023

Accountability

- Cancer Board
- Locality Boards
- Primary Care System Board

8.2.8 Action: Improving Diagnostics

GM trusts have each developed plans to achieve the ambition of 95% diagnostics tests within six weeks for all relevant modalities by March 2025. These have been brought together into a single plan for GM and approved by the regional team. The trajectories in these plans will achieve 87% within six weeks by the end of March 2024. This is being set as the target for the 2023/24 plan. Key risk areas within the plans have been highlighted and mitigating actions are being put in place.

The Endoscopy network have finalised a set of productivity KPIs as a starting point to extensive improvement and standardisation work in this area. The Theatre Rooms In Virtual Environments (THRIVE) tool is being rolled out at most GM sites to support this.

Endoscopy workforce scoping and review was undertaken in late 2022 with a workforce plan in development. This will which address workforce gaps and retention and drive up activity levels. It is planned to have at least one room at each site working a 6/7-day week giving the potential to increase activity significantly. Capital schemes are planned to build additional room capacity at specific sites.

At system level, the Community Diagnostic Centre (CDC) programme will create additional capacity across GM and short form business cases (SFBCs) have been submitted from all localities. GM will implement the CDC programme to create essential new diagnostic capacity within localities as soon as practical once capital and revenue funding is agreed.

We have plans to improve the productivity of pathology and imaging networks through digital diagnostic investments and optimal rates for test throughput and the expansion of diagnostic capacity including through the CDCs programme. Specifically, the introduction of PACS (Picture Archiving Communications System) based reporting by March 2024 across all organisations will facilitate delivery of a minimum 10% efficiency in reporting by 2024/5.

In addition, the introduction of MRI (Magnetic Resonance Imaging) accelerator technology will increase productivity of MR scanner throughput for image acquisition.

The implementation of digital pathology across all cellular pathologies in GM by end of 2023/4 will facilitate a minimum 10% efficiency gain in reporting by 2024/25.

Measuring our Delivery

- Deliver the ambition of 95% diagnostics tests within 6 weeks for all relevant modalities by March 2025
- Deliver diagnostic activity levels that support plans to address elective and cancer backlogs and the diagnostic waiting time ambition
- The implementation of digital pathology across all cellular pathologies in GM

Accountability

- Diagnostics Board
- PFB

8.3 Area of Focus: Improving service provision and access

8.3.1 Action: Improving Access to Primary Care

In organising primary care, we always seek to balance convenience and continuity of care between online or face to face appointments according to the patient's wishes and needs. Our Primary Care Blueprint (currently being finalised) will describe how we will approach this.

The pandemic brought change and in some cases transformation to demand, access and capacity. The Primary Care delivery model had to change overnight with a short term reduction in capacity and more access being delivered online. The opportunity to move to digital solutions where appropriate was accelerated and now needs to settle into a more measured way of understanding how digital can support Primary Care services and citizens alike.

It is important to reflect that demand, access and capacity is different in the four disciplines of Primary Care and in some cases demand and access are merged due to the open-door nature of services. It is also important to acknowledge the role of preventative, screening, and wellness services which fundamentally change the shape of demand into services, keeping citizens well, supporting early diagnosis and promoting self-care.

Primary Care, and particularly general practice has had the advantage of the Additional Roles Reimbursement Scheme (ARRS) initiative. This has brought many

more clinicians and support workers into Primary Care Networks, increasing workforce and the opportunity to offer flexible solutions to patients and more capacity into neighbourhoods. For this opportunity to work well we must integrate not only across Primary Care disciplines but also with the wider public sector, voluntary sector, and the business community to make the most of our workforce, local services, and buildings.

We will seek to secure additional capacity when periods of surge demand occur, which we assess through our framework for reporting pressures. Primary care providers will enable the spread of access to online advice on symptoms and self-care.

Our key aims on improving access across primary care are:

- Ensuring same day urgent access to Primary Care where clinically warranted and agreeing an appropriate response at first contact for all non-urgent requirements
- Removing the "8 am rush" in General Practice, via a support programme which will include investment in the telephony infrastructure, encouraging optimal use of the NHS App and a programme of development support for PCNs and practices
- Delivery of a Dental Quality scheme which will seek to improve access to NHS Dentistry across GM. NHS Greater Manchester and primary care providers are engaging on options to address the current issues surrounding access to NHS dental services and to develop a dental access plan
- Building on the core Community Pharmacy Contractual Framework to develop and deliver pharmacy services to improve access and reduce health inequalities – for example, in developing a harmonised GM Minor Ailments scheme

Measuring our Delivery

- Number of general practice appointments per 10,000 weighted patients
- Percentage of patients describing their overall experience of making a GP appointment as 'good'
- Continue on the national trajectory to deliver 50 million more appointments in general practice by the end of March 2024
- Make it easier for people to contact a GP practice, including by supporting general practice to ensure that everyone who needs an appointment with their GP practice gets one within two weeks and those who contact their practice urgently are assessed the same or next day according to clinical need

Accountability

- Primary Care System Board

8.3.2 Action: Digital transformation of Primary Care

Practices and Primary Care Networks have been on an accelerated journey of the deployment of digital tools from the start of the COVID-19 pandemic. Digitisation in General Practice broadly meets foundational requirements. However, there remain outstanding challenges to optimise the use of the digital technology. This involves a focus on workforce and connecting existing systems to truly integrate care across care settings.

Practices and PCNs are facing more aggregate demand and an increase in non-patient-facing workload. Change is required to manage demand and capacity efficiently with digital tools, delivering effective digital access for patients, alongside traditional routes – all to support the best possible experience and outcomes for patients.

Our Digital First Primary Care Programme is supporting the Primary Care Recovery Plan with digital access for capacity and demand management – measured by dashboards that provide evidence on benefits of using digital solutions. This will include supporting practices with Virtual Contacts, Digital Care Navigation and Triage to enable easier digital access to help tackle the 8am rush and assessment of need or signposting to appropriate services on first contact

Measuring our delivery

- Standardising practice websites across GM with consistent messages to meet national standards for accessibility and quality of information provided
- Promoting usage of NHS App across GM for particular use cases
- Every PCN to have a named person as a Digital Change Champion with support from Digital Facilitator or Digital Change Manager
- Deployment of GM Care Record to Community Pharmacy to improve medication safety, save time for pharmacists and practices and support decision making for enhanced services
- GM Care Record Realising Potential Programme to increase usage and utility including training and communications across care settings; clinical documents sharing; data feeds completion and data quality improvement
- Integrated Care Planning – adoption of the GM Care Record (GMCR) as the single platform for multi-agency integrated care planning - including EPaCCS (Electronic Palliative Care Communications System)
- Cloud-based telephony functionality for practices will help them offer a more reliable service and facilitating PCN hub delivery both in hours and out of hours

Accountability

- GM Health and Care Digital Transformation Board
- Primary Care System Board

8.3.3 Action: Ensuring universal and equitable coverage of core mental health services

We will support people with mental health needs through improvements in crisis services working with GMP and NWAS. We will also work in partnership to support people with a serious mental illness to access housing and employment. We must tackle long waiting-times in mental health as a priority.

We will adopt a proactive approach to supporting children and young people to reduce the impact of mental health problems and specifically to improve the pathway for eating disorders.

We intend to increase our longer-term baseline investment in mental health services, recognising that demand now is substantially above pre-pandemic levels, and that Greater Manchester has historically under-invested in mental health, learning disability and autism compared to other areas. This has resulted in significant variation in the availability of services across Greater Manchester, which must be properly resourced going forward through an agreed investment plan.

This is consistent with seeking parity of esteem for mental health services with physical health services and will be challenging for our system in terms of allocating limited resources. Recognising the starting position, our ambition would be to move Greater Manchester to the middle quartile of expenditure per capita with consequent improvements in access and outcomes across the life of this plan.

Measuring our Delivery

- Work towards eliminating inappropriate adult acute out of area placements
- Move Greater Manchester to the middle quartile of expenditure per capita on mental health

Accountability

- Mental Health Board

8.3.4 Action: Digital transformation of Mental Health Services

We have made progress in provision of digital tools to support mental health patients Fundamental risk factors for mental health patients are related to social challenges, and physical health.

In accordance with NHSE requirements, GM Provider Trusts are working towards implementing the Electronic Patient Record meeting the Minimum Digital Foundations by the end of 2025 across all their hospital sites.

Measuring our delivery

- Integrated Shared Care Record - increasing usage of the GM Care Record across all care settings; redefining and implementing a consistent data set for Mental Health feeding into the GMCR

Accountability

- GM Health and Care Digital Transformation Board
- Mental Health Board

8.4 Area of Focus: Improving quality through reducing unwarranted variation in service provision

8.4.1 Action: Improving Quality

Our quality strategy describes the collective ambition of GM Integrated Care to improve people's experience through the delivery of good quality, safe and effective care. The national principles for quality are fundamental to our approach:

1. A shared commitment to quality
2. Population-focused
3. Coproduction with people using services, the public and staff
4. Clear and transparent decision-making
5. Timely and transparent information-sharing
6. Subsidiarity

The actions needed to embed these principles into our system, with clear responsibilities, are completed or on track (as of June 2023) and detailed in the GM quality strategy.

In year 1 (2023/4) the focus will be on developing the quality priority workstreams and finalising the emerging quality governance assurance processes – putting the foundations in place. Our priority actions are:

a) Ensuring good governance of Quality Assurance for the ICB and a common understanding of quality data.
b) Establishing and embedding our integrated care system wide priorities for areas of quality improvement
c) Establishing and embedding locality quality arrangements for areas of quality improvement
d) Demonstrating where initial improvements have been made by measuring our progress as a system.
e) Confirming that the quality ambitions for years 2- 5 meet the triple aim of improving health and wellbeing, quality of care and are an efficient/sustainable use of resources

These actions are undertaken in the appropriate part of the system – the ICB, localities, system subject leads. Engagement on the strategy made clear that its implementation will be achieved through a series of improvement actions that contribute to the overall shared purpose. The delivery and coordination of the individual components of the quality strategy will be managed by the Quality Strategy Delivery Group.

Our shared purpose for 2023/24 is:

- Setting system-wide quality priorities
- Setting outcomes that are measured to inform improvement
- Setting the expectation of all those involved in providing care access across the system

For years 2-5 (2024/5 and onwards), our shared purpose will be:

- Improved standards
- Improved quality
- Improved population health and wellbeing through the reduction of inequalities

Safeguarding

The ICB has a statutory responsibility for safeguarding which is enacted via the NHS GM Chief Nurse and supported by the Deputy Chief Nurse and Associate Director of Safeguarding. Statutory safeguarding responsibilities are delegated to the Associate Director of Quality and Safety in each of the GM localities and delivery of the statutory functions are undertaken by the locality Designated Teams.

NHS GM can demonstrate that there are appropriate safeguarding governance systems in place for discharging statutory safeguarding duties and functions in line with the following key legislation:

- Care Act 2014
- Children Act 1989 and 2004
- Children and Social Work Act 2017
- Working together to Safeguard Children 2018

NHS GM will undertake their statutory duties across the GM Safeguarding Children Partnerships as one of the equal and joint statutory partners (Local Authority, ICBs and Chief Officer of police) and as a statutory partner for the GM Adult Safeguarding Boards. The ICB will ensure that the delivery of safeguarding aligns with the NHS Safeguarding Accountability and Assurance Framework (2022)[13].

It is the responsibility of the ICB and each of our Partner organisations to ensure that people in vulnerable circumstances are safe and receive the highest possible standard of care. We are committed to promoting the safety and wellbeing of children, young people and adults who may be at risk of abuse or neglect. NHS GM Safeguarding will encompass an all-age and a Think Family model supporting an integrated safeguarding partnership approach.

Measuring our Delivery

- Through metrics developed as part of the Quality strategy

Accountability

- Quality and Performance Committee

8.4.2 Action: NHS at Home – Including Virtual Wards

We recognise the potential and importance of developing new models of care enabled by technology to provide care to people in their own homes and place of residence as an alternative to a hospital bed.

The virtual wards programme has an aim to deliver between 40-50 virtual wards beds for per 100,000 adult population. This equates to between 1,110 to 1,250 for Greater Manchester. GM is now projecting to deliver approximately 1,095 beds by March 2024.

[13] B0818_Safeguarding-children-young-people-and-adults-at-risk-in-the-NHS-Safeguarding-accountability-and-assuran.pdf (england.nhs.uk)

The current virtual ward average length of stay is approximately 7 days, equating to a conservative estimate of 1,960 bed days saved each week. This will increase throughout 2023/24.

The GM virtual wards model comprises four networks working across the city-region to achieve adoption and spread at scale, equity of access for patients and reduce unwarranted variation. All sites have now mobilised standard clinical pathways for acute respiratory infection and frailty virtual wards (step-up and step-down) co-produced with senior clinical leaders, alongside a clear set of operating principles and standards.

The expansion of the programme through 2023/24 and beyond will focus on:

- New pathways – heart failure, end of life, post-op, general medicines
- Optimising admission avoidance and increasing referrals
- Enabling patient flow between virtual ward networks
- Optimising non-clinical activity at scale

Measuring our Delivery

- Deliver 1,095 virtual ward beds by March 2024, achieving 80% occupancy from September 2023 onwards
- Adoption and spread of all agreed pathways across all sites, supporting flow across the system

Accountability

- UEC Board
- NHS at Home Programme Board

8.5 Area of Focus: Using Digital and Innovation to Drive Transformation

8.5.1 Action: Implementation of Health and Social Care Digital Strategy

To deliver on our strategic vision and support the ambition for Greater Manchester to become a world-leading digital city region we need to embrace digital transformation opportunities across the health and care system. We want to be a truly digital health and care system, leveraging partnerships across academia and industry with one of the largest life sciences clusters in the country.

However, there are many areas of our health and care system which remain paper-based or operate on clunky, outdated systems that are not connected to each other.

This impacts on the quality and standard of care and the experience of people using our services. There is an urgent need to get the basics right alongside our ambition to develop leading-edge approaches.

Our five digital transformation ambitions are to:

- Deliver integrated, coordinated and safe care to citizens
- Enable staff and services to operate efficiently and productively
- Empower citizens to manage their health and care needs
- Understand population health needs and act upon insights
- Accelerate research and innovation into practice, as a globally leading centre

We have developed the GM Digital Maturity and Investment Framework in each care setting to understand our status and next priorities. This strategy presents three layers of activity required - to digitise, integrate and innovate.

Measuring our Delivery

- A joint delivery plan targeting the priority capabilities across all major delivery partners is being developed. Progress is measured through a) digital maturity scores per capability (assessed annually in each care setting), b) delivery of milestones and c) programme level benefits evaluation
- Social care - increasing uptake of Digital Social Care Records by independent social care providers (from ~50% to 80% by March 2025) and deployment of the GM Care Record to independent social care providers
- Secondary Care - In accordance with NHSE requirements, GM Provider Trusts are working towards implementing Electronic Patient Record meeting the Minimum Digital Foundations by the end of 2025, across all their hospital sites

Accountability

- GM Health and Care Digital Transformation Board

8.5.2 Action: Driving transformation through research and innovation

Greater Manchester is regarded as one of the most active, diverse and growing health innovation ecosystems due to our concentration of advanced health and care, academic, life sciences and digital sectors.

Health Innovation Manchester (HInM), now in its sixth year, continues to work on behalf of GM health, care and academic system partners to discover, develop and

deploy innovation aligned to the needs of GM citizens and supporting economic development across the city region.

Through the course of 2023/24, HInM will be working with GM system partners to develop a new three-year strategy, building on the research and innovation assets of the system and aligned to the new ICP strategy missions, as well as GM economic growth ambitions.

For the final year of the current three-year strategy, the innovation priority projects for 23/24 are:

- Enhanced diagnostics accelerator - this £15.1m programme will deliver novel diagnostics in cardiovascular, respiratory and liver disease, specifically addressing communities most at need. The programme will drive better access to care and improve clinical outcomes for local people, as well as increasing impact from GM academic activities and creating new market opportunities for local industry partners
- GM Care Record optimisation and development of the Secure Data Environment (SDE) - the GM Care Record is a direct care and innovation asset which is already funded by GM system partners. We will accelerate our activities to maximise the benefits from the platform
- Deployment of proven innovation - we are in the final stages of agreeing the initial set of deployment at scale projects with system partners, based on proven solutions that meet key system challenges, population health needs and contribute to tackling inequalities.
- Continued expansion of virtual wards and NHS at Home –this will include the rollout of further virtual ward pathways, supporting providers to optimise admission avoidance and further developing this model of care
- Strategic industry partnerships - we will continue to deliver our industry strategy and our pipeline of proven innovations, secure additional resource for local innovation deployment, and bring benefits to industry which will encourage further investment and collaboration
- Academic partnerships - we will continue to make develop our university and NHS research assets so that we can improve our innovation pipeline and achieve greater local impact from investment to the GM academic infrastructure.

GM Health Innovation Accelerator

GM is one of three UK city-regions to be awarded funding as part of the Government's levelling up white paper to launch 'innovation accelerators' to advance R&D in key areas.

The GM health innovation accelerator will focus on tackling some of the most challenging disease areas through early diagnosis using novel approaches and holistic treatment aligned to people's specific needs. It will focus on enhanced diagnostics and genomics, delivered through a partnership between Health Innovation Manchester, Manchester University NHS Foundation Trust, and the University of Manchester. Further significant investment has also been leveraged through partnerships with businesses in life sciences, digital and creative industries

Measuring our Delivery

Each innovation project is delivered through a structured innovation pipeline method and approach, including a PID, benefits realisation plan and logic model outlining the following deliverables:

a) Inputs – funding, costs and resources

b) Activities – the key tasks and milestones

c) Outputs – measurable/quantifiable results

d) Outcomes – what the innovation led to, short medium-term consequences

e) Impacts – longer term wider contextual changes

Accountability

- Health Innovation Manchester Board
- GM NIHR Infrastructure Oversight Board
- GM Health and Care Digital Transformation Board

9 Supporting our workforce and our carers

We will promote integration, better partnership working and good employment practices, as well as supporting our workforce to be well and addressing inequalities faced in the workplace. We want more people to choose health and care as a career and to feel supported to develop and stay in the sector.

Supporting our workforce and our carers Delivery Leadership: NHS GM People & Culture Function, NHS GM, NHS Trusts, Primary Care providers, Local Authorities, Social Care Providers, VCSE Organisations System Leadership: GM People Board	
Areas of Focus	**Actions**
Workforce Integration	Enable leaders and staff to work across traditional boundaries to support service integration
	Share best practice and develop tools to support a dynamic system culture
Good Employment	Increase in Good Employment Charter Membership and payment of Real Living Wage
	Improve access to staff benefits and flexible working
	Share best practice and resources to support managers
Workforce Wellbeing	Take action on the cause of staff sickness and improve wellbeing support
Addressing Inequalities	Building a leadership culture committed to addressing health inequalities
	Adapt the recruitment process to provide alternative entry routes for diverse talent
Growing and Developing	Develop our Greater Manchester careers approach to attract and support career development
	Develop and deliver the Greater Manchester retention plan
	Embrace digital innovation to improve the way we work – starting with HR digitisation
Supporting Carers	Provide more consistent and reliable identification and support for Greater Manchester's unwaged carers

We have set out a shared ambition for the health and care workforce in our People and Culture Strategy 2022-2025. The People and Culture Strategy is summarised in Figure 8:

Figure 8

9.1 Area of Focus: Workforce integration

We will increase the opportunities for sharing best practice and partnership working across our system and organisational boundaries and increase the number of people working in integrated roles.

9.1.1 Action: Enable leaders and staff to work across traditional boundaries to support service integration

- Co-create a culture of collaboration, including development of ways of working which are adopted at all levels such as our system boards and wider leadership development
- Promote the development of neighbourhood based integrated health and social care roles, including the expansion of the blended roles programme
- Make it easier for our workforce to move across different settings, including the expansion of the GM passport across health and care settings
- Work with our regulators to develop standards around integration

Measuring our Delivery

- Increase in number of integrated learning environments within nursing, AHP (Allied Health Professional) and medical education programmes
- Total number of senior leaders participating in system integration development programme
- Increase in number of integrated health and social care roles, including blended roles programme. Increase in number attending our workforce summits and post event evaluation
- Increase in number using the digital training passport

Accountability

- People Board
- Locality Boards

9.1.2 Action: Share best practice and develop tools to support a dynamic system culture

- Continue to share best practice and ways of working to support integration and collaboration, through toolkits and events such as the Workforce Collaborative Summit
- Establish a system induction toolkit that can be incorporated into place and organisation inductions to provide useful context around how our system works and supports the development of a system culture
- Establish a system staff survey to improve our understanding of our workforce experience across the sector
- Develop a plan for cross system mentoring and coaching

Measuring our Delivery

- Total number of organisations incorporating system induction piece into their induction programmes
- Survey measuring perceived integration/survey of leaders feeling able to work across boundaries

Accountability

- People Board
- Locality Boards

9.2 Area of Focus: Good Employment

9.2.1 Action: Increasing membership of the GM Good Employment Charter and payment of the Real Living wage for health and care organisations

- Increase in Good Employment Charter membership and payment of the Real Living Wage. Supporting organisations to achieve Charter membership will also improve employment standards across all areas covered by the Charter, including security, flexible working, employee engagement, recruitment, people management wellbeing provision and inclusion
- Establish a Good Employment Charter definition for good leadership – piloting in NHS Greater Manchester and sharing best practice with the system
- Work with partners to help embed good employment practices in our commissioning and contracting of services
- Share best practice and resources to support managers to be the best they can be and explore a core development programme for managers – including line management and clinical supervision
- Deliver the Greater Manchester Champion Awards to celebrate collaboration and good practices
- Continue to work in close partnership with trade unions, supporting ongoing engagement between unions and employers in the event of industrial dispute

Measuring our Delivery

- Increase in Good Employment Charter membership
- Good Employment Charter Steering Group engagement on perceived change in the system
- Increase in the number of health and care employers paying the Real Living Wage

Accountability

- People Board
- Locality Boards

9.2.2 Action: Improve access to staff benefits and flexible working

- Improve access to staff benefits, starting with the Blue Light Card
- Support our net zero ambitions by promoting active travel and improving access to electric cars and cycle schemes

Measuring our Delivery

- Improvement of the wider employment standards included in the Good Employment Charter, such as increase in access to flexible working

Accountability

- People Board
- Locality Boards

9.2.3 Action: Share best practice and resources to support managers

- Coordinate action to tackle violence and bullying experienced by our workforce in their place of work
- Improve workforce engagement and access to flexible working by sharing good practice

Measuring our Delivery

- Proportion of staff who say that they have personally experienced harassment, bullying or abuse at work from managers
- Proportion of staff who say that they have personally experienced harassment, bullying or abuse at work from patients/service users
- Staff survey engagement theme score (Out of 10)
- Aggregate score for NHS staff survey questions that measure perception of leadership culture

Accountability

- People Board
- Locality Boards

9.3 Area of Focus: Workforce Wellbeing

9.3.1 Take action on the cause of staff sickness and improve wellbeing support

- Supporting workplaces to keep people well to reduce workforce sickness levels
- Improve access to existing resources so that all our people can get the support they need for maintaining good wellbeing
- Improve infrastructure and systems for absence management to support effective workforce planning
- Take a more standardised approach to occupational health in secondary care
- Establish occupational health and Employee Assistance provision for NHS Greater Manchester and look to extend this where possible in primary care, social care and the VCSE sector
- Support organisations and networks to embed good wellbeing cultures and practices
- Establish a workforce wellbeing oversight group - with the power to act on system themes
- Identify Wellbeing needs/gaps and working with partners address them together at a Greater Manchester level

Measuring our Delivery

- Sickness absence rates
- Leaver rate

Accountability

- People Board

9.4 Area of Focus: Addressing Inequalities

We will improve diversity at senior manager and executive level and improve the opportunity and experience for all our workforce with protected characteristics.

9.4.1 Action: Building a leadership culture committed to addressing health inequalities

- Develop and implement a Greater Manchester Workforce Disability Equality Scheme

- Delivery of the national Stepping Up programme at scale
- Develop a culture of services across Greater Manchester addressing wellbeing inequalities experienced by specific groups
- Develop and implement an Equality, Diversity and Inclusion Framework for inclusive leadership

The work of the Fairer Health for All leadership academy (section 6.1.3) will also contribute to this action.

Measuring our Delivery

- Proportion of staff who agree that their organisation acts fairly with regard to career progression/promotion regardless of ethnic background, gender, religion, sexual orientation, disability or age
- Reduction in the disproportionality in disciplinary investigations by people with protected characteristics

Accountability

- People Board

9.4.2 Action: Adapt the recruitment process to provide alternative entry routes for diverse talent

- Implement the #InclusiveHR initiative to create more representative and inclusive People and Culture services
- Adapt the recruitment process to provide alternative entry routes for diverse talent

Measuring our Delivery

- Proportion of staff in senior leadership roles who are from a) a BME background or b) are women or c) are disabled
- Increase representation of people with protected characteristics at all levels, within the NHS that will be particularly at entry levels at Band 2, Band 5 and Junior Medical Grades
- Number of organisations that have adapted their recruitment processes to attract diverse talent and impact this has had on those recruited

Accountability

- People Board

9.5 Area of Focus: Growing and Developing

We will increase recruitment to the sector from within our own communities and beyond, including key areas such as nursing, midwifery, social care and mental health. We will support more people to develop and stay and improve our workforce planning system infrastructure.

9.5.1 Action: Develop our Greater Manchester careers approach to attract and support career development

- Develop our Greater Manchester careers approach to reach into our communities and engage with school leavers as well as those looking for a new career
- Develop our talent pool to ensure it is diverse and meets the needs of our system
- Develop the Social Care Careers Academy to support growth, retention and development of the social care workforce
- Building on the findings from research into the workforce development needs of the VCSE sector, support workforce development within the VCSE sector to create a more sustainable, resilient and integrated workforce
- Work closely with HEE (Health Education England) to create more development opportunities and enable people to have the protected time to participate
- Use the work within the People and Culture Strategy to build a strong narrative on why people should want to work in health and care in Greater Manchester
- Support Greater Manchester People Teams to develop by creating a development plan for our HR and OD colleagues

Measuring our Delivery

- Increase the number of people engaged through GM careers activity
- Increase in the size and diversity of the GM talent pool
- Increase in perceived access to development opportunities through staff surveys
- Increase in utilisation of CPD (Continuing Professional Development) funding to support development

Accountability

- People Board
- NHS Provider Trusts
- Locality Boards

9.5.2 Action: Develop and deliver the Greater Manchester retention plan

- Develop and deliver the Greater Manchester retention plan: focusing on the experience of our health and care people and integrated roles
- Provide a single point of contact for matching workforce and employers through a GM platform.
- Targeted action on nursing, midwifery and AHPs – including student recruitment, placement capacity and promotion of working in GM
- Recruit and retain key primary care roles including GPs, nurses, community pharmacists, NHS dentists and dental nurses working in partnership with HEE
- Support primary care employers to utilise Additional Roles Reimbursement Scheme (ARRS) funding and strengthen the multi-disciplinary approach in primary care
- Support providers with the delivery of the Sustainable Services programme – managing workforce shortages by developing new ways of working to support the system to continue to provide valuable services

Measuring our Delivery

- Increase in student numbers in nursing, midwifery and mental health
- Continue to recruit 26,000 Additional Roles Reimbursement Scheme (ARRS) roles by the end of March 2024
- FTE doctors in General Practice per 10,000 weighted patients
- Direct patient care staff in GP practices and PCNs per 10,000 weighted patients

Accountability

- People Board
- NHS Provider Trusts
- Locality Boards

9.5.3 Action: Embrace digital innovation to improve the way we work – starting with HR digitisation

- Improving workforce data within primary care to support better workforce planning
- Provide a single point of contact for matching workforce and employers through a GM platform
- Embrace digital innovation to improve the way work in a more efficient way, with a focus on digital literacy and exploring different ways of working

- A GM approach to supporting capacity and capability to deliver virtual wards – considering their impact on community services, the social care workforce and unwaged carers

Measuring our Delivery

- Increase number of programmes supporting workforce digitisation

Accountability

- People Board

9.6 Area of Focus: Supporting Carers

We recognise the enormous pressures faced by carers, making life harder for the people they are trying to support. As an Integrated Care Partnership, we need to take action to create the conditions to allow our people to provide the best possible care – including our paid and unwaged workforce.

9.6.1 Action: Provide more consistent and reliable identification and support for Greater Manchester's unwaged carers

- Implementation of GM Carers' Charter and the Greater Manchester Working Carers' Toolkit
- A GM approach to supporting capacity and capability to deliver virtual wards – considering their impact on unwaged carers
- Support for unpaid carers funded through the Better Care Fund (BCF) enabling people to stay well, safe and independent at home for longer
- Embed Carers Exemplar Model consistently across GM
- Further develop and promote tools and opportunities for supporting working carers
- Launch best practice for carers in ethnic minority communities
- Develop products to support primary care to identify and signpost carers

Measuring our Delivery

- 10,000 uses of SNOMED CT (an electronic health record) contingency code for carers in 22/23 (10% of 24/25 target below per region)
- 2,000 young carers identified by uses of SNOMED CT in 22/23 (10% of 24/25 target below per region)

Accountability

- GM Directors of Adult Social Care

10 Achieving financial sustainability

Financial sustainability - 'living within our means' - requires an initial focus on financial recovery to achieve a balanced position. We will identify the main reasons for financial challenges in Greater Manchester, and implement a system wide programme of cost improvement, productivity, demand reduction and service transformation.

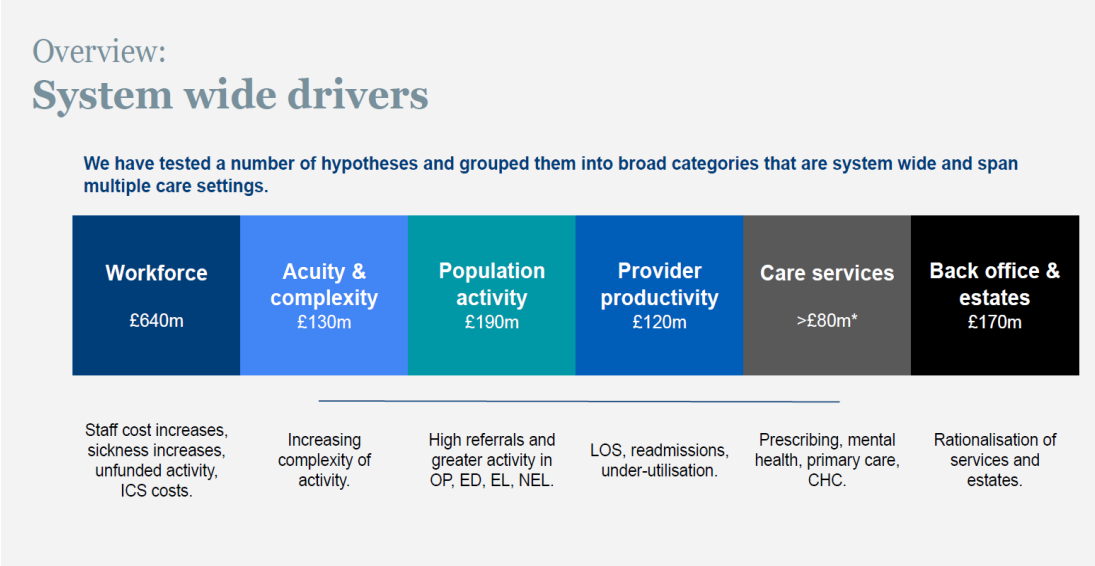
The Greater Manchester system has both an efficiency and a productivity challenge. NHS GM inherited a system structural budget deficit (commitments over revenue) of over £500 million (out of a total budget of £6.5 billion) on its establishment on 1st July 2022. This reflects the ongoing cost of additional resources (mainly workforce) put in place during the COVID-19 pandemic. One of the national requirements of an ICB is to bring the system into balance

Achieving financial sustainability Delivery Leadership: Locality Boards; PFB System Leadership: Finance and Performance Recovery Board	
Areas of focus	**Actions**
Finance and Performance Recovery Programme	System recovery programme based on drivers of operational and financial performance
Developing Medium Term Financial Sustainability Plan	Development of three-year financial plan

10.1 Area of Focus: Finance and Performance Recovery Programme

Our system is under significant financial and operational pressures with the position having worsened due to the impact of COVID-19. To build the foundations for long-term sustainability we will put in place a recovery programme covering both finance and performance. The first step we took in early 2023 was to deepen our understanding of what is driving our current challenges. Figure 9 shows one of the outputs of this exercise with the drivers set out in broad system categories.

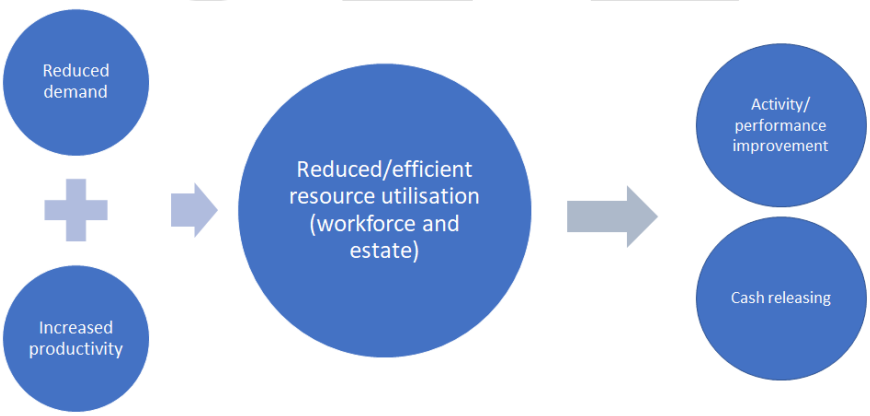
Figure 9



**Currently only includes medicines management, delayed discharges, CHC and small MH opportunities. It is likely that this number will grow when further analysis is undertaken.*

As part of our approach, we need to better understand and act on our performance on productivity (which has declined since 2019/20) Improved productivity will create activity or cash benefits (Figure 10).

Figure 10



Measuring our Delivery

- Return of System to Recurrent Financial Balance

Accountability

- Finance and Performance Committee

10.2 Area of Focus: Securing Long-Term Financial Sustainability

It is recognised that GM needs to move into a more sustainable position in terms of finance, performance and service sustainability. Specifically, that the system can plan and deliver financial and performance objectives without a sense of crisis or non-recurrent interventions. This is more than a single year task.

10.2.1 Development of three-year financial plan

Stakeholders from across the ICS have identified 13 improvement opportunities following the diagnostic into GM's drivers of operational and financial challenge. Reforming how the system operates in these areas will be key to our securing long-term transformation and financial sustainability.

Theme	Transformation Opportunities
Workforce	1. Identify opportunity to 'right size' the workforce across GM 2. Plan to identify shared services business model across corporate functions
Acuity and Complexity	3. GM System High Impact Care model 4. Digital Health Model
Population Activity	5. System review of volume of Outpatient referrals
Provider Productivity	6. Reduce DNAs through patient engagement 7. Reduce Non-Elective Length of Stay 8. Improve Outpatient Performance 9. Improve Theatre Throughput
Care Services	10. Mental Health Operational Processes and Demand and Capacity Review 11. Discharge to Adult Social Care Process Review
Corporate Functions and Estates	12. Optimised Estate 13. Maximise value of tech assets and licenses

This work will support the GM system moving to a multi-year planning cycle. Within this, we propose to start the planning process much earlier in the financial year – allowing us greater scope to align our approach across the system; confirm our priorities; and mitigate key risks. This will also support greater integration between NHS and local authority planning – including our approach to budget setting. Our approach would be to set out our plans and then make any adjustments to these based on the national NHS guidance.

Measuring our Delivery

- Return of System to Recurrent Financial Balance

Accountability

Finance and Performance Committee

11 How We Will Deliver

11.1 Performance Framework

The ICP strategy contains four high-level outcomes (what we are aiming to achieve) and six missions (what we will do – our actions) which will together lead to the outcomes. This relationship is shown in the table below:

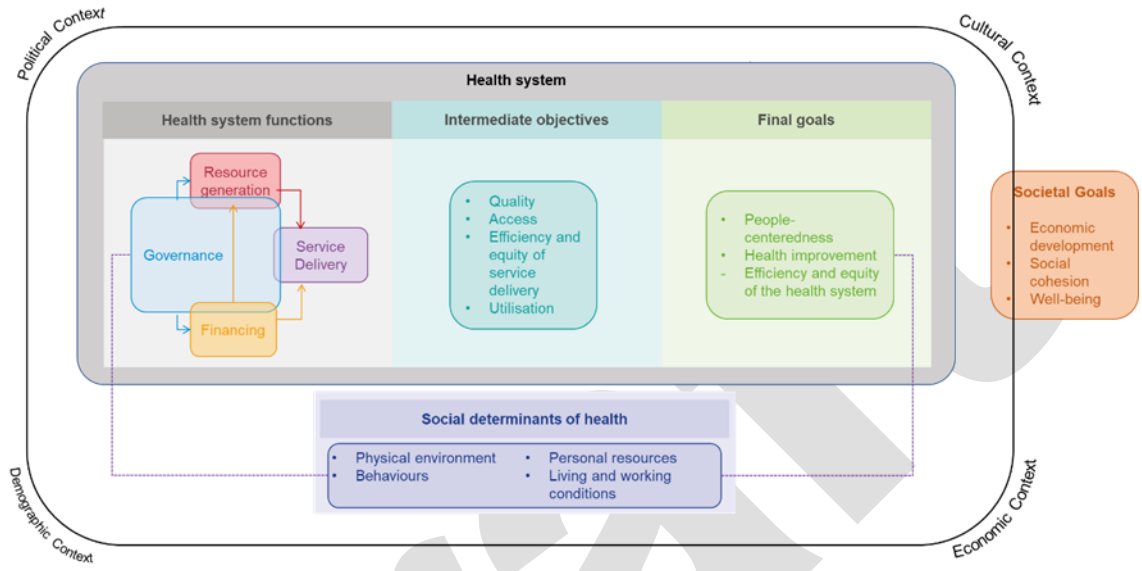
Health and care services are integrated and sustainable	Everyone experiences high quality care and support where and when they need it	Everyone has improved health and wellbeing	Everyone has an opportunity to live a good life
Achieving financial sustainability • Delivery of a balanced recurrent ICB and system financial position ***Supporting our workforce and our carers*** • Increase in Good Employment Charter membership from the health and care sector • Number of health and care organisations paying the RLW	***Recovering core NHS and care services*** • Year-on-year improvement in meeting national targets for core services • Equitable service provision across all areas in Greater Manchester	***Helping people stay well and detecting illness earlier*** • Life Expectancy and Healthy Life Expectancy • Avoidable mortality rates • Reductions in health inequality in the onset of multiple morbidities • Physical activity • Smoking prevalence • Obesity	***Helping people get into, and stay in, good work*** • Number of people starting work • Number of people staying in work ***Strengthening our communities*** • Reduced anxiety • Improved life satisfaction • Feelings of safety

Both the outcomes and the missions are interlinked and depend on each other. We have developed a framework for performance to be assured and assessed and accountability to be clear. This framework applies to both the activities under the direct influence and resourcing of NHS GM and the social determinants of health. Both are essential to improving the health of our population and delivering our strategy.

Our approach is based on a revised version of the framework selected by the University of Manchester research team for their analysis of the effects of health and social care devolution and the World Health Organisation (WHO) Health System Performance Assessment (HSPA) framework

This framework shows how the health system – its functions, intermediate objectives and final goals - and the social determinants of health act together to influence societal goals, within a political, socio-economic, demographic and cultural context. This is illustrated in Figure 11.

Figure 11



NHS England requires reporting against the objectives it sets for the NHS in England (NHS Oversight Framework metrics). For 2023/4 there are 56 measures across the domains defined by NHSE as:

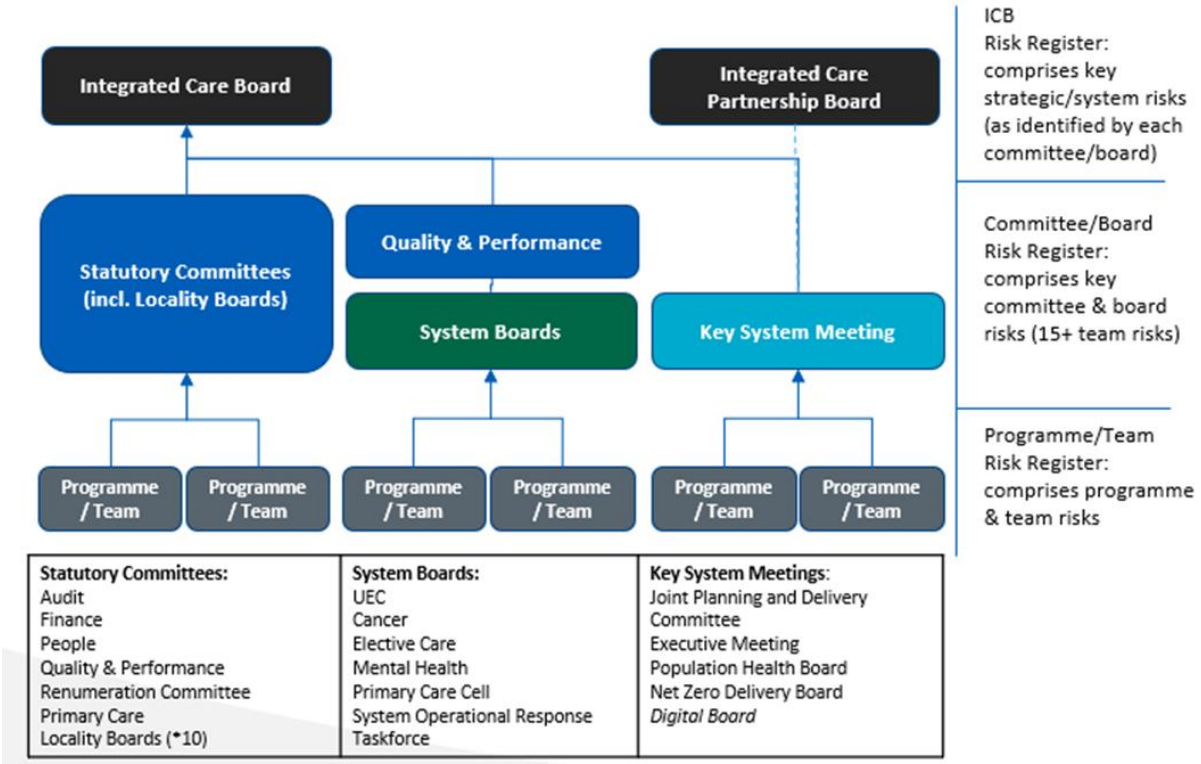
- Quality of care, access and outcomes (34 measures)
- Preventing ill health and reducing inequalities (8 measures)
- Leadership and capability (3 measures)
- Finance and Use of Resources (4 measures)
- People (7 measures)

We will use all these measures to assess progress against this plan but will also add others to enable a balanced view of performance across the whole health system and its wider context. These will be mapped to the sections of the performance framework.

11.2 Assurance and Governance Arrangements

We will manage delivery and risk through our governance and assurance arrangements – these are shown in Figure 12.

Figure 12



The delivery of our operational plans will be overseen by a Finance and Performance Recovery Board, which will be responsible for assuring delivery of the GM operational plan, providing overall system oversight and direction.

Through its membership reporting will flow into the various statutory organisations within the system.

It will be supported by

(a) A Finance and Workforce Group: responsible for

- Having oversight of the overall GM financial plan / position
- Tracking delivery of system/organisation Cost Improvement Plans (CIPs) and Quality, Innovation, Productivity and Prevention (QIPP) plans
- Alignment of workforce planning with financial recovery
- Overseeing implementation of specific projects relating to financial recovery

(b) A Performance and Delivery Group: responsible for

- Resolving planning risks
- Gaining greater assurance of delivery of high risk plans

- Tracking achievement of GM planning assumptions
- Overseeing implementation of specific projects to achieve either performance or financial objectives.

11.3 Commissioning

The 2022 Health and Care Act entailed significant structural change for NHS commissioning with NHS Greater Manchester Integrated Care becoming responsible for the commissioning responsibilities of CCGs, as well as taking on several commissioning functions from NHSE (with a plan for further delegation over time).

We are working with partners across GM to optimise the way we commission services and realise the efficiencies from bringing twelve organisations into one. We will confirm our plans in 2023/24.

11.4 Locality plans

Our ten localities in Greater Manchester - Bolton, Bury, Manchester, Oldham, Rochdale, Salford, Stockport, Tameside, Trafford and Wigan - all have local authority plans (or strategies), locality plans for health and care and Health and Wellbeing plans. The Joint Strategic Needs Assessments (JSNAs) in each locality have specifically informed the Health and Wellbeing plans, as well as the other plans.

These plans have informed our ICP Strategy and this Joint Forward Plan. As set out in this document, a significant proportion of this plan will be delivered by our 10 localities.

Links to each of these plans for each of the localities, where information is available at time of writing, are given in the table below, along with a link to the Health and Wellbeing Board in each locality. This information will be updated as plans in localities are updated. A summary of the plans can be found in Appendix 2.

A draft of this plan was sent to each Health and Well Being Board (HWB) in GM for comments. When the plan is updated, it will be shared with HWBs for comment and feedback will be incorporated.

Locality	Local Authority Plans/ Corporate Plans	Health & Care (Locality) Plans	Health & Wellbeing Plans Health and Wellbeing Board
Bolton	Bolton Vision 2030 (currently being updated)	Currently being updated	Same as LA plan **H&WB Board**: Active, Connected and Prosperous Board 2014 Onwards > The Active, Connected and Prosperous Board (bolton.gov.uk)
Bury	Let's Do It! Strategy (bury.gov.uk)	221222 locality plan refresh v3.1.docx	Same as LA plan **H&WB Board:** Browse meetings - Health and Wellbeing Board - Bury Council
Manchester	Our Manchester Strategy- Forward to 2025 | Manchester City Council	Refreshed 2021 - 5 yr. strategy Manchester Locality Plan Refresh v2.0 MPI Priorities for adults and children (2023-2026) MPB priorities - 2 slides.pptx	Making Manchester Fairer https://www.manchester.gov.uk/makingmanchesterfairer **H&WB Board** Browse meetings - Health and Wellbeing Board (manchester.gov.uk)
Oldham	Corporate Plan | Corporate Plan | Oldham Council - 2022-27	currently being updated	Currently being updated **H&WB Board:** Committee details - Health and Well Being Board (oldham.gov.uk)
Rochdale	https://www.rochdale.gov.uk/downloads/download/393/corporate-plan	Rochdale Borough Locality Plan 2020-2024	Same as locality plan **H&WB Board** https://democracy.rochdale.gov.uk/mgCommitteeDetails.aspx?ID=558
Salford	Our priorities, the Great Eight • Salford City Council	Salford Locality Plan 2020-25 (partnersinsalford.org)	Same as locality plan **H&WB Board** Browse meetings - Health and Wellbeing Board • Salford City Council
Stockport	borough-plan.pdf (onestockport.co.uk)	Enc 1 - One Health and Care Plan.pdf (stockport.gov.uk)	Same as locality plan **H&WB Board** https://www.stockport.gov.uk/health-and-wellbeing-board
Tameside	'Our People Our Place Our Plan'	Currently being updated - will be a joint locality and H&WB Plan	Currently being updated **H&WB Board** https://tameside.moderngov.co.uk/mgCommitteeDetails.aspx?ID=221
Trafford	Corporate-Plan-2021-2024.pdf (trafford.gov.uk)	2021 refresh Trafford Together Locality Plan (traffordpartnership.org)	2019-2029 Trafford Health and Wellbeing Strategy 2019.pdf **H&WB Board:** Health and Wellbeing Board (traffordpartlonership.org)
Wigan	The Deal 2030 (wigan.gov.uk)	Currently being updated - Due Sept 23	Currently being updated - Due Sept 23 **H&WB Board:** Committee details - Health and Wellbeing Board (wigan.gov.uk)

11.5 Implementing this Plan – Next Steps

This is the first delivery plan for the Integrated Care System in Greater Manchester. In developing this plan, we are clear that we must maintain our focus on making best use of our resources and achieving the best outcomes for our residents.

This means that we will continue to develop this plan after this first version is finalised at the end of June 2023.

The steps we will take following the publication of this plan will focus on confirming our approach to long-term financial sustainability. The steps we will take are:

- Setting out in detail the phasing of all the programmes set out in this plan – across years 1,2 and 3 of the plan and prioritising those initiatives that will have the greatest impact
- Ensure that all elements of the plan are costed in line with our medium-term financial plans and ensure we are maximising efficiency across the range of our activity
- Continue to strengthen the delivery metrics and accountability arrangements
- Quantify the population health potential of a fundamental shift in demand and a greater emphasis on early intervention and prevention. This will include modelling across all care settings. This needs to extend across all points of delivery
- Drawing on this, confirm the process to undertake the population level segmentation and analysis for the longer-term transformation
- Informed by this, position the key choices the GM system will need to make to deliver on long-term financial sustainability and continue to improve health outcomes

Appendix 1

How this plan addresses the statutory requirements for a JFP

The legislative requirements for the JFP[14] – which relate to the statutory responsibilities of the ICB – are summarised below, along with how they are covered in this plan.

Legislative requirement	GM response
Describing the health services for which the ICB proposes to make arrangements.	Covered particularly in our missions for: • Helping people stay well and detecting illness earlier • Recovering core NHS and care services • Supporting our workforce and carers
Duty to promote integration	As part of a mature partnership model in GM, working across sectors, this plan ensures that the ICB develops activities and works in ways which promote and enable integration. Going beyond the legislative requirements, the integrated approaches adopted in GM ensure that health services, social care and health-related services and designed and delivered in ways which align to support attainment of the whole systems shared outcomes and commitments.
Duty to have regard to wider effect of decisions	The outcomes we have defined through the strategy and that will be delivered through this plan, have been developed in ways which ensure we are clear on the impacts of our decisions, and responsive to the 'triple aims' of (a) health and wellbeing of the people of England (including by reducing inequalities with respect to health and wellbeing), (b) quality of healthcare services for the purposes of the NHS (including by reducing inequalities with respect to the benefits obtained by individuals from those services) and (c) sustainable and efficient use of resources by NHS bodies.
Financial duties	Described in our mission for: • Achieving financial sustainability

[14] https://www.england.nhs.uk/long-read/guidance-on-developing-the-joint-forward-plan/#appendix-1-legislative-framework-further-detail

Legislative requirement	GM response
Implementing any JLHWS	Our locality (health and care) and Health and Wellbeing Plans are all linked from this plan (section 11.4) and summarised in Appendix 2. They are aligned with this plan.
Duty to improve quality of services	Covered in our missions for: • Helping people stay well and detecting illness earlier • Recovering core NHS and care services. Our quality strategy is a specific action in this mission.
Duty to reduce inequalities	The activities we deliver through this plan seek to reduce unwarranted inequalities in outcomes, service experience and access for all people and parts of Greater Manchester, as described throughout. One of our ways of working (section 4.2) specifically emphasises this duty
Duty to promote involvement of each patient	In addition to this being one of our ways of working (section 4.2), it is also a fundamental element of our Model for Health and Wellbeing. It is also a focus of our missions for: • Strengthening our communities and • Helping people stay well and detecting illness earlier.
Duty to involve the public	The strategy was developed through extensive consultation and engagement with communities, partner agencies, practitioners and staff, across all ten localities (section 2.4). The process of development was iterative, developing and adapting to the feedback received and ensuring the strategy and this plan are reflective of the needs and expectations of our communities.
Duty to patient choice	This is implicit in our mission for recovering core NHS and care services
Duty to obtain appropriate advice	As part of the network of governance which oversees and supports the delivery of this plan the ICB has access to and routinely draws upon appropriate advice and guidance from partners, stakeholders and experts.
Duty to promote innovation	Innovation is a specific action in the mission for Recovering core NHS and care services (section 8.5.2), and draws on our assets in Health Innovation Manchester

Legislative requirement	GM response
Duty in respect of research	Utilising the research expertise in our city region, and building on working relationships we already have, we will ensure our responses to these challenges are data driven, drawing on the best possible evidence to support the design and delivery of our actions, as described in section 8.5.2.
Duty to promote education and training	Covered in our mission for: • Supporting our workforce and our carers
Duty as to climate change, etc.	As partners in Greater Manchester, we share the GMS vision of wanting Greater Manchester to be a place where everyone can live a good life, growing up, getting on and growing old in a greener, fairer more prosperous city region. The NHS contribution to this (section 5.3.1) is an area of focus in our mission for: • Strengthening our communities
Addressing the particular needs of children and young persons	This is a specific action in our mission for strengthening our communities (section 5.2.4) and is also covered in a number of other sections including sections 6.1.2 and 6.2.5.
Addressing the particular needs of victims of abuse	A specific action in our mission for strengthening our communities (section 5.2.6), and part of a GM approach to violence reduction.

Appendix 2

Our locality plans[15]

Bolton

The health and care (Locality) plan is currently being updated. The Health & Wellbeing Plan is the Local Authority Plan.

Bolton Vision 2030 is a local partnership that brings together senior leaders from the voluntary, community and faith sector, the private sector, the university, college and schools, health, emergency services and the council. Bolton 2030 is the long term vision for the borough. The vision partnership wants to see a Bolton which is ACTIVE, CONNECTED AND PROSPEROUS

Principles

The vision is supported by a set of principles:

- Generating inclusive growth and prosperity which reaches all corners of communities and benefits all citizens
- Protecting the most vulnerable whilst recognising that they are members of their communities and can have much to offer
- Reforming services in partnership in order to maximise the impact of activities and create sustainable change in communities.

Outcomes

Bolton 2030 is built around 6 outcomes for their people and places. These are:

- **Start Well:** Our children get the best possible start in life, so that they have every chance to succeed and be happy
- **Live Well:** The health and wellbeing of our residents is improved, so that they can live healthy, fulfilling lives for longer
- **Age Well:** Older people in Bolton stay healthier for longer, and feel more connected with their communities
- **Prosperous:** Businesses and investment are attracted to the borough, matching our workforce's skills with modern opportunities and employment
- **Clean and Green:** Our environment is protected and improved, so that more people enjoy it, care for it and are active in it
- **Strong and Distinctive:** Stronger, cohesive, more confident communities in which people feel safe, welcome and connected

[15] Correct as of 31 May 2023

Bury

The Health & Wellbeing Plan is the Local Authority Plan

Bury's refreshed Locality Plan (2023) is a refresh of their strategy for health and care and wellbeing in the borough. It sits in the context of the overall strategy for the borough – "Let's Do It". This plan – like its predecessors - has at its core the ambition to fundamentally improve population health and wellbeing, and to reduce health inequalities. This is important to ensure Bury residents can lead the lives they want, but also to create a financially sustainable health and care system that is characterised by prevention of poor health, and early intervention, rather than reactive and costly service provision.

Bury has four overarching outcomes for the Locality Plan:

1. A local population that is **living healthier for longer** and where healthy expectancy matches or exceeds the national average by 2025.
2. A **reduction in inequalities** (including health inequality) in Bury, that is greater than the national rate of reduction.
3. A local health and social care system that provides high quality services which are **financially sustainable and clinically safe.**
4. A greater proportion of local **people playing an active role in managing their own health** and supporting those around them.

The objectives of the refreshed locality plan are:

1) We will seek to **influence the factors that improve population health** and well-being and reduce health inequalities and foster inclusion
2) We will **support residents to be well, independent, and connected** to their communities and to be in control of the circumstances of their lives
3) We will support **residents to be in control of their health and well being**
4) We will **support children to 'start well'** and to arrive at school ready to learn and achieve
5) We will **support people to take charge of their health and care and the way it is organised around them, and to live well at home**, as independently as possible
6) We will ensure all residents **have access to integrated out of hospital services** that promote independence, prevention of poor health, and early intervention and where front-line staff are working together in 5 neighbourhood teams
7) We will work to ensure **high quality responsive services** where people describe a good experience of their treatment
8) We will work to **control the overall costs of the health and care system** by earlier intervention, prevention, and working with the strengths within people, families, communities

A range of Transformation Programmes are described including Urgent and Emergency Care; Learning Disabilities; Elective care; Cancer Services; End of Life Care Pathway; Primary Care; Mental Health; Community Services; Adult Social Care; Children's Health and Care and Public Health.

Manchester

The 2021 refresh of Manchester's Locality Plan, Our Healthier Manchester, seeks to reaffirm their ambition to create a population health approach that puts health at the heart of every policy, improving health and care outcomes for the people of Manchester, whilst recognising that plans for the future will need to continue to evolve and respond to those changing needs, within a new governance structure.

Manchester's Locality Plan has five strategic aims and key intended outcomes:

- Improve the health and wellbeing of people in Manchester
  - Narrow the life expectancy gap between the city's residents
  - Improved health & wellbeing, quality of life
  - Reduction in preventable deaths (all causes).
- Strengthen the social determinants of health and promote healthy lifestyles
  - Reduction in smoking prevalence to 15% or lower by 2021
  - Increase in the number of children who are school ready
  - Reduction in residents who are out of work due to an underlying health condition/disability.
- Ensure services are safe, equitable and of a high standard with less variation
  - All providers have a CQC rating of good or above
  - All national and local quality standards are met.
- Enable people and communities to be active partners in their health and wellbeing
  - Increase the level of knowledge and confidence that people have in managing their own health.
- Achieve a sustainable system
  - Achievement of financial balance across the system
  - Achievement of constitutional and statutory targets
  - Developing a sustainable workforce.

Manchester's Health and Wellbeing Plan is the 'Making Manchester Fairer' Plan 2022-2027 which has 8 themes focused on tackling health inequalities:

1) Focus on giving children the best start in life
2) Addressing poverty. This affects everything, especially set against the cost-of-living crisis
3) Good work is good for your health
4) Focus on preventing ill health and preventable deaths, so this will also include the four big killer diseases/conditions in Manchester
5) Homes and housing
6) Places, environment and climate change
7) Tackling systemic and structural racism and discrimination
8) Focus on communities and power, so that we concentrate on what really matters to our local communities and residents, and so that they are heard and influence what we do. This includes acting on the voices of those who are often less heard.

Oldham

Locality Plan currently being updated – due July 2023

The Oldham Health & Wellbeing Strategy (2022-30) does not represent the extent of their commitment to health and wellbeing or all the work on health and wellbeing taking place in the borough but focuses on some of the issues which make the greatest contribution, and where they can have the biggest impact in the shortest amount of time, working together. The overall aim for the Health and Wellbeing Strategy is to close the gap in life expectancy between Oldham and England as a whole.

Vision
Oldham residents are happier and healthier; they feel safe, supported and they thrive in this vibrant and diverse borough.

Ambition
People lead longer, healthier, and happier lives, and the gap in health outcomes between different groups and communities in Oldham, and between Oldham and England, is reduced. A demonstrable difference will be made to the average life expectancy and average healthy life expectancy of residents, and inequalities will be reduced.

Principles

Oldham are resident-focussed, this means they are:

- Having a two-way conversation with residents about their health and wellbeing, making sure residents feel heard and that needs are responded to in ways that can be understood by all
- Building trust and strengthening relationships with residents through kindness and compassion
- Engaging with communities to co-produce solutions and co-design services
- Providing support and care which is as close to, and as connected with, home and community as possible

We have a well-managed health and care system:

- Which provides good quality, safe services, and we use resident feedback to continually improve
- With services which are easy to access, and transition between different services is seamless; digital solutions are embraced where appropriate
- Which uses data, intelligence, and insight to plan services and improve the coordination of care
- Ensuring best value for the Oldham pound and maximising the wider social, economic, and environmental benefits of public spending

We are champions of equality; we are:

- Striving to reduce inequalities, offering more to those who face the greatest disadvantage or experience the worse outcomes
- Recognising diversity and delivering culturally competent services

- Developing a workforce which represents the community
- Focussing equally on mental health and emotional wellbeing, and physical health

We prioritise prevention by:

- Promoting wellbeing and prevention of ill-health for residents in all life-stages
- Providing residents with easy access to the information and support that need to stay well, healthy and be independent
- Taking a whole-system view for each of our residents, taking account of wider determinants and past experiences to provide the most appropriate and effective care
- Recognising the importance of voluntary, community and faith organisations in improving health and wellbeing, and making the most of existing community assets and insight

Oldham's Priorities

- Supporting our residents to gain the knowledge and skills to confidently make choices and participate in decisions about their own health
- Giving children the best start in life
- Improving mental wellbeing and mental health
- Reducing smoking
- Increasing physical activity

Rochdale

The Health & Wellbeing Plan is the Local Authority Plan

The Rochdale Locality Plan 2020-24 – 'Co-operating for better health and wellbeing' - sets out how they will do all they can so that residents in the borough live long and happy lives that are as healthy as possible, for as long as possible. If achieved, it will mean that they will have '**improved the health, care and wellbeing outcomes for the borough of Rochdale'.** They will work together in partnership so that '**everyone in the borough will make things better for themselves and others'.**

To do this, Rochdale have established six core principles, or ways of working across their partnership of stakeholders (including residents). These six principles run through every aspect of the plan and are core to how they operate. These principles are set out below.

- Co-operation
    - Public services, partners, citizens, businesses and the voluntary sector will share decision making and jointly design and deliver services.
- Prevention and intervention
    - Prevention will be part of everything they do, and they will support their residents and workforce to take care of themselves and others.

- Integrated and local
    - Public services, partners and the voluntary and community sector will share skills, expertise and resources to deliver person and community centred services at the right time and in the right places for residents.
- Strengthening community assets
    - Individuals and families will be supported to use their skills, experience and collective kindness to improve communities.
- Collective change
    - They will work together to change things so that Rochdale will have sustainable services and have reduced inequalities.
- Addressing the climate emergency
    - Rochdale will increase efforts to ensure that they consider and reduce the negative impacts that services and activities have on the environment

Strategic workstreams

- Further developing **Integrated Strategic Commissioning**
- Further establishing the **Local Care Organisation**
- Delivery of a programme of **transformation** in order to reduce demand, improve outcomes and reduce inequalities
- Strengthening a range of **enablers** to support this work; Workforce, Health and social care intelligence, Estates, Digital and Finance.

Salford

Locality plan is also the Health and Wellbeing Plan

The 2020-2025 refreshed Salford Locality Plan is the link between understanding of needs and opportunities in health and wellbeing, and the coordinated response to them. Right across Salford, all partners are committed to improving health and wellbeing and to reducing health inequalities and maximising the social value return to Salford. Pooling of the great majority of the health and social care budget, and greater transparency on the rest, is helping Salford to invest in prevention, to prioritise spend on areas most needed, and to mitigate the impact of reducing resources on the most vulnerable and on health inequalities.

Vision: Salford is a place where everyone can enjoy the best opportunities that Salford has to offer. People in Salford will get the best start in life, will go on to have a fulfilling and productive adulthood, will be able to manage their health well into their older age and die in a dignified manner in a setting of their choosing. People across Salford will experience health on a parallel with the current 'best' in Greater Manchester (GM), and the gaps between communities will be narrower than they have ever been before.

Core outcomes

1) People will live longer, and those years will be lived in good health
2) The gap in life expectancy between the most and least deprived communities in the city will be reduced

Starting well outcomes

- I am a child who is physically and emotionally healthy, feel safe and able to live life in a positive way
- I am a young person who will achieve their potential in life, with great learning, and employment opportunities
- I am as good a parent as I can be.

Living well outcomes

- I lead a happy, fulfilling and purposeful life, and I am able to manage the challenges that life gives me.
- I am able to take care of my own health and wellbeing and I am supported to care for others when needed.
- My lifestyle helps me to stop any long term condition or disability getting worse and keeps the impact of this condition or disability from affecting my life.

Ageing well outcomes

- I am an older person who is looking after my health and delaying the need for care.
- If I need it, I will be able to access high quality care and support.
- I know that when I die, this will happen in the best possible circumstances.

Strong and resilient communities

- I feel safe and connected, and able to influence the decisions that affect me.
- I feel supported to make healthy choices in the places where I live, work, volunteer or visit.
- I have opportunities to contribute, and benefit from, a strong economy with quality local jobs.

There are a number of cross-cutting enablers that will facilitate delivery of the plan through workforce, estate, supportive technology, and a focus on quality and social value.

Stockport

Locality plan is also the Health and Wellbeing Plan

ONE Stockport - the Borough Plan - is based on the priorities which have come from extensive engagement with the people who live and work in Stockport. Health and Wellbeing are at the forefront of Stockport's vision for 2030 and a key priority for local people. Stockport believe that the best way to deliver their vision is through collaboration across the wide range of partners who support health and wellbeing for local people.

The locality plan – ONE Stockport Health & Care Plan - sets how they will work together as a system to deliver ONE Stockport's vision for **a Healthy and Happy Stockport.** Stockport's vision for 2030 sees everyone working together to develop a borough which is inclusive, caring, enterprising and full of ambition. They want people to live the best lives they can and feel happy, healthy, included, and independent.

Their principles are:

- Person-centred
- Place-based
- Outcomes-focused
- Strengths and asset-based
- Fair
- Sustainable

Stockport intend to deliver each of the health and care commitments in the borough plan through eight delivery programmes:

- Quality & Leadership
- Early Help & Prevention
- Independence & Reablement
- Mental Health & Wellbeing
- Tackling Inequalities
- Stockport's Neighbourhoods
- Age-Friendly Borough
- Valued Workforce

The impact of these changes will be seen in the following outcomes:

- Stockport residents will be healthier and happier
- Health inequalities will be significantly reduced
- Safe, high quality services will work together for you
- Stockport residents will be independent and empowered to live their best lives

Tameside

Currently being updated (Joint Locality and Health and Wellbeing Plan) – Timescales TBC

Trafford

The Trafford Together Locality Plan 2019-24 was first agreed in November 2019, and the plan has been refreshed in 2021 in light of the changing context and the formation of the Integrated Care System. The refresh, like the 2019 Plan, is based on 4 main priorities; Our Population, The People We Serve, The Place Where We Live and Work, and The Partnerships We Create. There are three main aspirations for this plan: better lives for Trafford's most vulnerable people, better wellbeing for their population and better connections across their communities.

The principles in the 2019-24 Plan remain a key focus; Together as Partners – co-ordinating across the health and social care system, thinking bigger and doing better using combined resources to improve outcomes for residents.

- In a Place – being positive about places and spaces, bringing people who live and work in an area together to build stronger communities.
- With People – putting residents at the heart of what they do, listening and working with people.
- Focusing on Prevention – commitment to taking action early and making every contact count.
- Continually improving – making the most of technology and using data and information to make shared decisions. Continuing to learn and develop workforce and make the best use of combined assets

Trafford has 4 Strategic Design Groups:

- Living Well in My Community
- Living Well at Home
- Short Stay in Hospital
- Our Ambition for Children in Trafford

The Health and Wellbeing Board is focussed on its residents' journeys through life, taking a life course approach that reflects the public health needs of that age group. Through the Health & Wellbeing Strategy they aim to improve outcomes at each stage while ensuring that seven overarching priorities (below) are considered, and ensuring interventions are evidence based, measurable and add value.

1. To reduce the impact of poor mental health
2. To reduce physical inactivity
3. To reduce the number of people who smoke or use tobacco
4. To reduce harms from alcohol
5. To reduce poverty
6. Reduce the impact of climate change
7. Healthy Weight

Wigan

Locality and Health and Wellbeing Plan currently being updated – expected Sept 23

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NHS
Greater Manchester
Integrated Care

To the Chairs of: GM Integrated Care Board; GM Integrated Care Partnership Board; Joint Planning and Delivery Committee; Locality Boards; Provider Federation Board; Primary Care Board; Health and Well-Being Boards; VCSE Leadership Group; Health and Well Being Boards

Copied to: NHS GM Exec Team; Place-Based Leads; Deputy Place-Based Leads

Joint Forward Plan: Engagement Draft

Dear Colleague

Please find enclosed the engagement draft of Greater Manchester's Joint Forward Plan along with some summary slides. This is the delivery plan for our Integrated Care Partnership Strategy. The document is based on the six missions in the Strategy; the actions to deliver them; the measures for tracking delivery; and where accountability is held. This is supported via the performance framework and ways of working. NHS England guidance states that the plan needs to be published by 30th June.

A range of inputs have been used to develop the draft. These include:

- The ICP Strategy – and the system engagement to support its development, including the Big Conversation
- The 2023/24 Operational Plan – including the detailed narratives provided by the System Boards
- Current system plans – for example, the Mental Health and Well-being Strategy; People and Culture Strategy
- Feedback via discussion at system boards/groups
- Review and commentary from programme leads across the system

The draft incorporates a range of work already in train in the system as the foundation for our delivery plans. There are still some areas of the document that require further development – and we have highlighted these in the draft. This particularly relates to the financial sustainability mission – we are progressing a medium-term financial strategy, and associated actions, as a matter of urgency building on the recent PWC and Carnall Farrar reports.

The time to review the draft is much shorter than we would want it to be – and we recognise that it is challenging to review and discuss the detailed draft within the timescales. We are clear, however, that whilst the 30th June NHS England deadline is an important milestone, our work on delivery planning cannot stop there. Collectively, we will need to keep the momentum on our system conversations with a focus on making those choices that secure our long-term sustainability whilst continuing to improve outcomes for our population. NHS England's guidance describes that the plan should be continually reviewed and formally updated on at least an annual basis.

To develop the draft further we are seeking your views on some key questions. Please arrange for the draft and these questions to be discussed at the next meeting of your respective boards.

These are:

- What are your views on the proposed accountability arrangements for the missions – in particular, the distinction between delivery and system leadership
- What are your thoughts on the key actions? Are there any areas of work that are missing or that we need to place greater emphasis on?

4th Floor, Piccadilly Place, Manchester M1 3BN
Tel: 0161 6257791 **www.**gmintegratedcare.org.uk

- Are the metrics selected for the actions the right ones? Are there any that you would change or add?
- Any other views on the document?

Please send your feedback to gmhscp.gmjfpnhs@nhs.net by Monday, 26th June.

If there is no meeting scheduled for this period, you can, of course, circulate the draft for comment virtually if you wish. Similarly, if your meeting falls after the deadline, please do review and comment on the draft at the next meeting. Your feedback will inform the further development of the Joint Forward Plan.

My team and I are happy to support the discussion at meetings, and provide any materials, wherever we can. It may not be possible logistically, however, for us to be present at every meeting. We are confident that the draft document, summary slides and the questions in this letter will support a helpful and constructive discussion at your meeting.

Thank you for your support.

Warren Heppolette

Chief Officer – Strategy and Innovation

31st May 2023

Enc: GM Joint Forward Plan – Engagement Draft
Joint Forward Plan Summary Slides

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Agenda Item 6

BURY INTEGRATED CARE PARTNERSHIP

Meeting: **Locality Board**			
Meeting Date	05 June 2023	**Action**	Receive
Item No.	6	**Confidential**	No
Title	Integrated Delivery Collaborative Update		
Presented By	Kath Wynne-Jones, Chief Officer, IDC		
Author	Kath Wynne-Jones, Chief Officer, IDC		
Clinical Lead	Dr Kiran Patel		

Executive Summary

This paper is intended to provide an update to the Locality Board of progress with the next stage of the development programme for the IDC and progress with the delivery of programmes across the Borough

Recommendations

The Locality Board is asked to note the progress with the development plan of the IDC and progress of the programmes and consider the next steps outlined within the paper.

OUTCOME REQUIRED *(Please Indicate)*	**Approval** ☐	**Assurance** ☐	**Discussion** ☒	**Information** ☐
APPROVAL ONLY; (please indicate) whether this is required from the pooled (S75) budget or non-pooled budget	**Pooled Budget** ☐	**Non-Pooled Budget** ☐		

Links to Strategic Objectives	
SO1 - To support the Borough through a robust emergency response to the Covid-19 pandemic.	☒
SO2 - To deliver our role in the Bury 2030 local industrial strategy priorities and recovery.	☐
SO3 - To deliver improved outcomes through a programme of transformation to establish the capabilities required to deliver the 2030 vision.	☒
SO4 - To secure financial sustainability through the delivery of the agreed budget strategy.	☒
Does this report seek to address any of the risks included on the NHS GM Assurance Framework?	☐

Implications						
Are there any quality, safeguarding or patient experience implications?	Yes	☒	No	☐	N/A	☐
Has any engagement (clinical, stakeholder or public/patient) been undertaken in relation to this report?	Yes	☐	No	☐	N/A	☒
Have any departments/organisations who will be affected been consulted ?	Yes	☐	No	☐	N/A	☒
Are there any conflicts of interest arising from the proposal or decision being requested?	Yes	☐	No	☐	N/A	☒
Are there any financial Implications?	Yes	☒	No	☐	N/A	☐
Is an Equality, Privacy or Quality Impact Assessment required?	Yes	☐	No	☐	N/A	☒
If yes, has an Equality, Privacy or Quality Impact Assessment been completed?	Yes	☐	No	☐	N/A	☒
If yes, please give details below:						
Once achieved, the ambition of the IDC will have a positive impact on the quadruple aim domains of population health ,experience, workforce and economics						
If no, please detail below the reason for not completing an Equality, Privacy or Quality Impact Assessment:						
Are there any associated risks including Conflicts of Interest?	Yes	☐	No	☒	N/A	☐
Are the risks on the NHS GM risk register?	Yes	☐	No	☐	N/A	☐

Governance and Reporting		
Meeting	**Date**	**Outcome**
IDC Board	24/05/2023	Proposal supported, recognising there are risks with making further commitments to reduce demand

BURY INTEGRATED CARE PARTNERSHIP

Bury Integrated Delivery Collaborative Update

1. Context

This report is intended to outline to the Board progress which has been made with the key issues relating to the implementation of the IDC development plan, approved by the Board in March 2023.

2. Programme structures

As a reminder, programme leadership arrangements for locality programmes of care, enabler programmes and quadruple aim objectives are outlined below:-

System Committees / Subgroups	**SRO / Managerial Leadership**	**Clinical /Professional Leadership**
Clinical and Professional Senate	Kiran Patel / Cathy Fines	Kiran Patel / Cathy Fines
GP Collaborative	Mark Beesley	Kiran Patel / Cathy Fines
Strategic Estates Group: Health and Care subgroup	Paul Lakin / Catherine Wilkinson	No direct input – connection via senate
Digital Board	Andrew Carter/ Kate Waterhouse	Sanjay Kotegaonkar
Communications and Engagement Cell	Karen Johnston	No direct input – connection via senate
Strategic Finance Group	Sam Evans	No direct input – connection via senate
Population Health Delivery Board	Jon Hobday	Jon Hobday
Strategic Workforce Group	Kat Sowden	No direct input – connection via senate
System Assurance Committee	Catherine Jackson	Catherine Jackson
Primary Care Commissioning Committee	Will Blandamer	Cathy Fines
Programmes		
Urgent Care	Jo Fawcus	Kiran Patel
Elective Care and Cancer	Karen Richardson - interim	Wendy Craven / Simon Minkoff/ Leanne Harris
Adult Social Care	Adrian Crook	Adrian Crook
Mental Health	Donan Kelly	TBC
Learning Disabilities	Adrian Crook	Nigget Saleem
Complex Care	Catherine Jackson	Catherine Jackson
Neighbourhood Delivery	Ian Trafford – interim	Neighbourhood lead GP's and INT leads
Primary Care	Mark Beesley	Kiran Patel/ Cathy Fines

Community services transformation	Nina Parekh	Neighbourhood lead GP's and INT leads
Ageing Well (including frailty and dementia)	Frailty -Katy Alcock Dementia - TBC Ageing well at home – TBC	? NCA
End of Life and Palliative Care	Helen Lockwood/ David Thorpe	Richard Deakin
LTC (CHD, respiratory and diabetes)	TBC	Finn McCaul

As members may be aware, we reorganised programmes of change last year to try and reduce and streamline the number of programmes of change, directing those which connect more directly into neighbourhood working into the neighbourhood delivery group. However, this arrangement has proved unsuccessful, with other programme boards still remaining, therefore appendix 1 outlines the establishment of the following Boards reporting to the IDC Board.

- Urgent care
- Elective Care and Cancer
- Mental Health
- Learning Disabilities
- Complex Care
- Adult Social Care
- Palliative Care and End of Life
- Community Services Transformation
- Primary Care (via GP Collaborative)
- Ageing Well (including frailty , dementia and ageing well at home)
- Long Term Conditions

This approach sees the formal creation of an ageing well board to encompass aging well at home, frailty and dementia, and the creation of a long term conditions board to enable approaches to the management of LTC to be coordinated. This is also felt to be desirable to support clinical engagement across organisational boundaries

The new arrangement will negate the need for the Neighbourhood Delivery Board and NCAG as separate groups. We have tried to minimise the infrastructure required in the locality as much as possible , however it is felt that the above arrangements are required to deliver programmes of change that meet local, GM and national requirements in a coordinated yet manageable way.

Connectivity and communication between the SRO's will be key to ensure alignment and to reduce silo working. It is proposed that this is supported through regular workshops for SRO's. The first of these was held on the 16th May.

BURY INTEGRATED CARE PARTNERSHIP

3. Programme leadership

Work has continued to mobilise new arrangements for programme leadership with SRO's, and to identify capacity available to support the various programmes of change. An initial draft of current resource aligned to programmes for former CCG commissioning colleagues, former LCO colleagues and BMBC commissioning teams has been prepared. This will be finalised next week and shared with the Board and SRO's w/c 30th May, with a request to identify any provider-based change resource which could also be aligned to programmes to support delivery.

Clinical leadership discussions are continuing between the locality and GM to understand the arrangements which will need to be put in place to support the differing geographical footprints, to support the GM programmes of cancer, paediatrics, urgent and emergency care, primary care, mental health/LD/autism & long-term conditions.

A workshop was held for SRO's and Clinical Directors on the 16th May which had good attendance and good engagement in the discussions.

The session objectives were:

- To enable our system leaders to come together in a collaborative space for development work providing opportunities for relationship/trust building and the formation of a peer network of system leaders.
- To develop a shared understanding of the current strategic context/locality landscape (including governance structures) in which our system leaders operate.
- To determine the role requirements for the SRO/Clinical Leadership role covering both transformation and enabler programmes.
- To provide an approach/framework for system leaders to support the establishment of the programme infrastructure.
- To provide clarity on the current asks of SROs, including undertaking baseline assessments, development of priorities and associated metrics for each programme.
- To start to identify what support looks like for our system leaders.

The session served to:

Confirm that role outlines (SRO/Clinical Leader) are in line with understanding/expectations for role. However, key feedback from the group was requesting clarity regarding the levels of accountability/decision making in the role, and recognition of the capacity and complexity challenges, with a clear need identified for delivery support roles.

SROs agreed to undertake their baseline assessment using the maturity matrix, identify their 3 (ideally) key priorities and associated metrics for improvement, to then regroup on the 5th July to understand ambitions of programmes and determine our key priority areas.

To ensure coherence of delivery, and to enable a robust discussion regarding the prioritisation of where we direct our transformation resource, it is proposed that each of the programmes undertakes an initial baseline assessment against the domains of :

- System integration
- Key programme characteristics
- Programme maturity

System integration	Key programme characteristics	Programme maturity
Leadership	Description of purpose	Programme Board
Governance	Description of connectivity into neighbourhood delivery	Key priorities and milestones agreed
Culture	Adopt strength based /asset based approaches	Key provider engagement (including the VCFA)
Service user and carer engagement	Connectivity into GM programmes	Clinical and professional leadership
Financial and contractual mechanisms	Prevention and early intervention	Defined metrics against each of the quadruple aim objectives • population health and reducing inequalities • effectiveness • efficiency • workforce
Information and IT		Risk register in place
Workforce		Adequate programme support
Service and care model design		

There was a strong feeling in the room that whilst all programmes will need to report to the IDC Board to enable an holistic view of the system to be taken, we may wish to direct our dedicated transformation capacity to a small number of priorities which will have the biggest impact on outcomes.

As an IDC Board we still need to determine the weight of importance we will give the quadruple aims of:

- Population health
- Efficiency
- Outcomes and Effectiveness
- Workforce

This will be considered by quadruple aim leads over the coming weeks

4. May IDC Board update

Programme highlights:

Elective Care: Cardiology Advice and Guidance now live
End of Life and Palliative Care: Preparation for the summit on the 28th June and delivery of events to mark Dying Matters week

Urgent Care: Had the highest volume of patients receiving care on the virtual ward at one time. 19 patients were receiving care at any one time against our trajectory of 20
Mental Health: Sustained improvement in IAPT waiting times with progress being made on the design and delivery of the Living Well and CMHT models
Adult Social Care: 14-25 Programme Board established
Complex Care: April performance at 79% with no long waits or reviews waiting more than 3 months
Neighbourhood development: East have been leading and participating in events to mark national bowel screening month linked to their neighbourhood development priority
Community Services: Scoping work commenced to support the development of a rehabilitation hub and to rationalise single points of entry to the system across the Borough
Primary Care: Project Initiation Document developed for a women's health hub and to develop back office functions. Practice Nurse Forum relaunched on the 30th May

Board meeting summary: 24th May

1) Received an update from the Chief Officer on the work to support all of 11 programmes to identify key priorities and ambitions as outlined above. The Board will need to consider over the next month the weighting given to the domains of economics, population health, workforce and quality when prioritising where to target our limited transformation resources

2) Received an update on work to establish a system risk register as outlined below. The Board understands the obligation of each individual organisation to maintain its own risk register, but we meet as a partnership in recognition of the consequences of our actions on each and because of the opportunity to improve outcomes for our residents by working together more effectively. In this spirit, a shared understanding of common risks helps us to prioritise our work

3) Approved the paper which has been received by the Locality Board as a separate item by the Locality Board outlining trajectories submitted to the ICB for reducing growth and demand for some secondary care services in urgent and elective care.

4) The meeting then received a number of 'deep dive' presentations into 4 of the delivery programmes:
    a. Mental Health Programme – the established programme board is now producing and developing a implementation plan addressing national and locally derived priorities. There has been a focus on securing investment in mental health service provision, to increase mental health capacity to the neighbourhood teams. Discussion focused on the reality of mental health crisis resolution around the Emergency Department, and the need to focus on transitions. Further work will be undertaken regarding these 2 topics
    b. The graduated approach in SEND – health partners in the borough were briefed on this important development focusing on the shift from a medical to social model. Further opportunities for briefing all key partners, such as via the GP webinar are being progressed.
    c. Urgent Care – the Board received an update on the performance of the urgent care system which, while very challenged, has performed relatively well. The Board considered key next priorities for reform, which will be considered at a workshop on the 12th June. The meeting also received an update on the specific steps taken to

improve our “Days Kept Away from Home” numbers at FGH connecting to the NCA discharge frontrunner programme

d. Primary care programme– the Board was briefed on the implications for partners in the system of new responsibilities for GPs under ‘recovering access to GPs’ guidance issued on 9th May . Areas of focus are empowering patients, modernising GP services, building capacity and cutting bureaucracy.The priorities are
    1. To tackle the 8am rush and reduce the number of people struggling to contact their practice. Patients should no longer be asked to call back another day to book an appointment
    2. For patients to know on the day they contact their practice how their request will be managed within the next 2 weeks

5) The Board was briefed on the work of the communications leads from partners in the system to work together more effectively, and to note the establishment of the Bury Integrated Care Partnership website.

5. Risks

Following agreement of the proposed Bury system risk reporting process at April’s IDC Board, all programmes and relevant committees were asked to submit any risks of 12+ using the GM risk reporting template. It was recognised that due to the tight reporting deadline it may not be possible, in all cases, for programmes to obtain sign off from the relevant board of the risks to be escalated to IDCB.

From the first reports submitted, it is recognised that there is a need to issue some further guidance and provide further support with regard to risk scoring to ensure consistency of approach.

Over the next month we will follow up with all Chairs the need for the risk report which has been approved through their governance arrangements. As an IDC Board we are considering how we structure our discussions to enable robust risk management on behalf of the Locality Board.

6. Recommendations

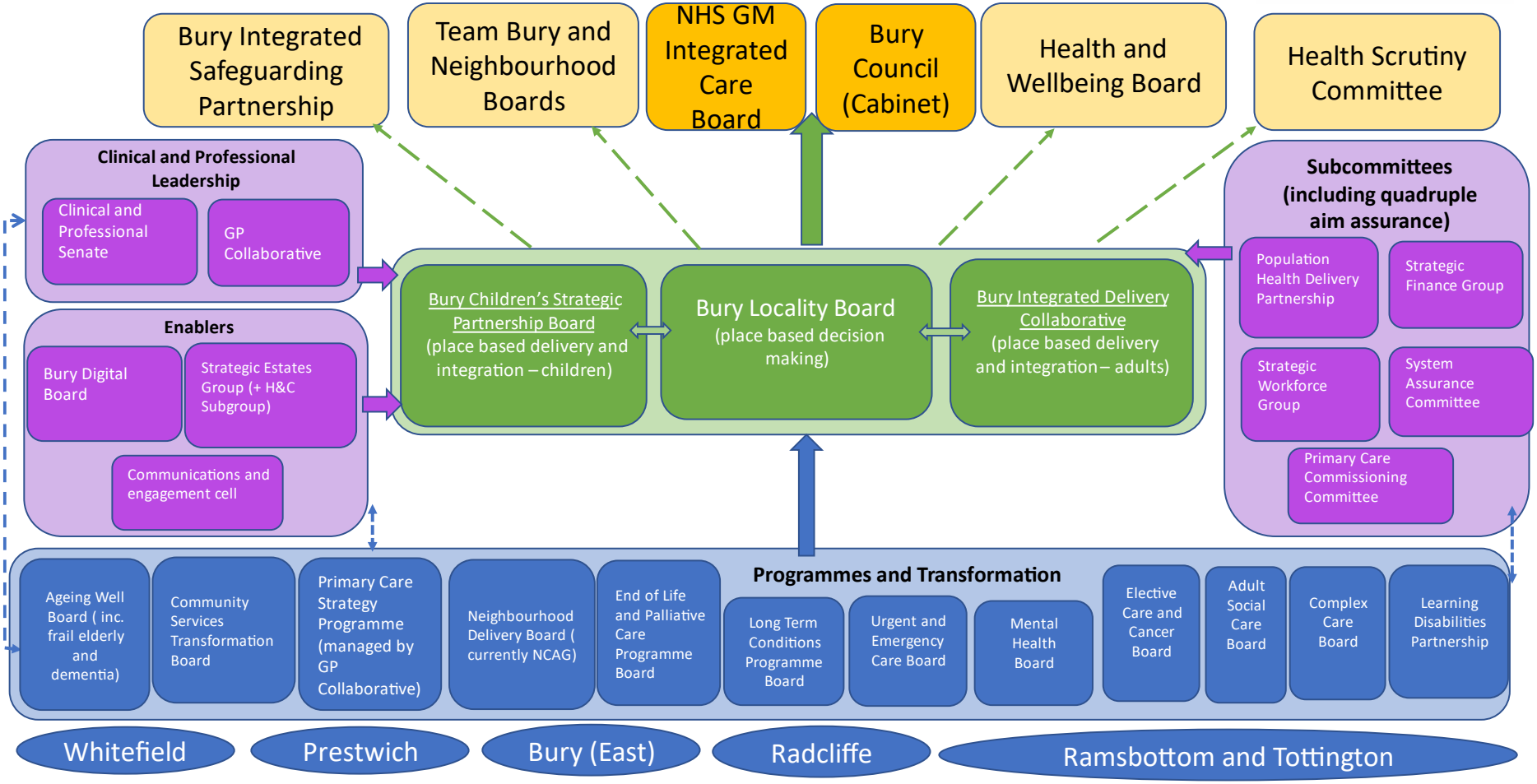
The Board are asked to note the progress with the development plan of the IDC, core programmes and consider the next steps outlined within the paper

Kath Wynne-Jones
Chief Officer – Bury Integrated Delivery Collaborative
kathryn.wynne-jones1@nhs.net
June 2023

Appendix 1

BURY INTEGRATED CARE PARTNERSHIP

Bury Integrated Care Partnership – Partnership Arrangements



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Agenda Item 7

BURY INTEGRATED CARE PARTNERSHIP

Meeting: Locality Board			
Meeting Date	05 June 2023	**Action**	Consider
Item No.	7	**Confidential**	No
Title	Bury Locality – Finance, Performance and Outcomes Standards 2023/24: Demand Management, Flow and QIPP		
Presented By	Kath Wynne-Jones, Chief Officer, IDC		
Author	Kath Wynne-Jones, Chief Officer, IDC		
Clinical Lead	Dr Kiran Patel		

Executive Summary

This paper includes the Bury Locality Finance, Performance and Outcomes Standards 2023/24 submission made to NHS Greater Manchester on the 19th May 2023.

The Locality Board is asked to consider the ambitions set out within this submission (subject to GM approval). These trajectories will need to be monitored on a monthly basis as part of the performance report received by the IDC Board.

The trajectories will receive in depth scrutiny through the following governance routes:

- Elective Care Programme Board: Outpatient Referrals
- Urgent Care Programme Board: A&E Attendances, Non-Elective Admissions and No Criteria To Reside patients
- Mental Health Programme Board: Mental Health Out of Area Placements and Clinically Ready for Discharge patients
- Bury Locality Savings Group: QIPP

Recommendations

The Locality Board is asked to consider the trajectories submitted and support the proposed approach to manage the delivery of trajectories.

OUTCOME REQUIRED *(Please Indicate)*	**Approval** ☐	**Assurance** ☒	**Discussion** ☒	**Information** ☐
APPROVAL ONLY; (please indicate) whether this is required from the pooled (S75) budget or non-pooled budget	**Pooled Budget** ☐	**Non-Pooled Budget** ☐		

Links to Strategic Objectives	
SO1 - To support the Borough through a robust emergency response to the Covid-19 pandemic.	☒
SO2 - To deliver our role in the Bury 2030 local industrial strategy priorities and recovery.	☐
SO3 - To deliver improved outcomes through a programme of transformation to establish the capabilities required to deliver the 2030 vision.	☒
SO4 - To secure financial sustainability through the delivery of the agreed budget strategy.	☒
Does this report seek to address any of the risks included on the NHS GM Assurance Framework?	☐

Implications						
Are there any quality, safeguarding or patient experience implications?	Yes	☒	No	☐	N/A	☐
Has any engagement (clinical, stakeholder or public/patient) been undertaken in relation to this report?	Yes	☐	No	☐	N/A	☒
Have any departments/organisations who will be affected been consulted ?	Yes	☐	No	☐	N/A	☒
Are there any conflicts of interest arising from the proposal or decision being requested?	Yes	☐	No	☐	N/A	☒
Are there any financial Implications?	Yes	☒	No	☐	N/A	☐
Is an Equality, Privacy or Quality Impact Assessment required?	Yes	☐	No	☐	N/A	☒
If yes, has an Equality, Privacy or Quality Impact Assessment been completed?	Yes	☐	No	☐	N/A	☒
If yes, please give details below:						
Once achieved, the ambition of these interventions will have a positive impact on the domains of experience and economics						
If no, please detail below the reason for not completing an Equality, Privacy or Quality Impact Assessment:						
Are there any associated risks including Conflicts of Interest?	Yes	☐	No	☒	N/A	☐
Are the risks on the NHS GM risk register?	Yes	☐	No	☐	N/A	☐

Governance and Reporting		
Meeting	**Date**	**Outcome**
IDC Board	24/05/2023	Proposal supported, recognising there are risks with making further commitments to reduce demand

Bury Locality – Finance, Performance and Outcomes Standards 2023/24: Demand Management, Flow and QIPP

1. Context

Following recent benchmarking undertaken across Greater Manchester ICS, a request was made to all localities to make further improvements relating to demand management, flow and QIPP. The attached presentation and trajectories outline the Bury Locality Finance, Performance and Outcomes Standards 2023/24 submission made to NHS Greater Manchester on the 19th May 2023.

The Locality Board is asked to consider the ambitions set out within this submission (subject to GM approval). These trajectories will need to be monitored on a monthly basis as part of the performance report received by the IDC Board.

The trajectories will receive in depth scrutiny through the following governance routes:

- Elective Care Programme Board: Outpatient Referrals
- Urgent Care Programme Board: A&E Attendances, Non-Elective Admissions and No Criteria To Reside patients
- Mental Health Programme Board: Mental Health Out of Area Placements and Clinically Ready for Discharge patients
- Bury Locality Savings Group: QIPP

2. Associated Risks

- Proposal is viewed as not ambitious enough by Greater Manchester ICS.
- Proposed reductions are not deliverable based on current demand patterns and available finances and workforce.

3. Recommendations

The Locality Board is asked to consider the trajectories submitted and support the proposed approach to manage the delivery of trajectories.

Kath Wynne-Jones
Chief Officer – Bury Integrated Delivery Collaborative
kathryn.wynne-jones1@nhs.net
June 2023

NHS
Greater Manchester
Integrated Care

Bury Locality – Finance, Performance and Outcomes Standards 2023/24: Demand Management, Flow and QIPP

Prepared by:
Last updated:

Bury Locality: Referrals

NHS Greater Manchester Integrated Care

Describe the areas identified as opportunities

The Bury locality has identified Cardiology, Gynaecology and Dermatology as its three target specialities to reduce GP referral activity as below:

- Cardiology – 1,857 referrals form the target cohort for GP referrals, excluding Rapid Access Chest Pain, between May-March 22/23. A 5% reduction by March 2024 has been profiled.
- Dermatology – 2,635 referrals form the target cohort for GP referrals, between May-March 22/23. A 5% reduction by March 2024 has been profiled.
- Gynaecology – 2,470 referral form the target cohort for GP referrals between May-March 22/23. A 5% reduction by March 2024 has been profiled.

The decision has been informed by several factors:

- review of local data to identify specialties where demand is high, there are large volumes of patients waiting, and the services are under considerable pressure.
- the specialities form part of an Outpatient Transformation Programme the locality is working with the NCA to deliver.
- there are schemes of work/plans in development that can be implemented at pace to support achievement of the trajectories in the required timescales.

Alongside these three priorities, the locality will continue to work with system partners to identify other opportunities to reduce referral activity where rates are high, through application of the learning acquired from these priority specialities.

A review of the PWC data packs identified opportunities in T&O for Bury, based on costs. The locality has been working for some time with the Orthopaedics Team at Bury Care Organisation on several schemes that will continue to support a reduction in GP referrals, e.g., introduction of FCP, Bury Integrated MSK Service. This work will continue alongside the three priority specialities, which it is believed will yield more short-term benefits.

Speciality	Bolton	Wigan	Oldham	Salford	Manchester	Stockport	Heywood, Middleton and Rochdale	Bury	Trafford	Tameside	Estimated cost pressure (£m)
Obstetrics	1.4	0.6	2.9	1.5	2.7	(1.8)	2.0	0.6	0.3	0.4	10.7
General surgery	7.6	3.4	(0.7)	0.9	0.2	(0.3)	(0.6)	(0.6)	(0.5)	(0.5)	8.7
Medical oncology	(0.2)	2.1	0.6	0.3	0.6	1.3	0.5	0.6	0.7	0.1	6.5
General internal medicine	(0.1)	(0.6)	0.1	(0.3)	(0.1)	6.7	0.1	0.1	(0.3)	(0.1)	5.6
Trauma & orthopaedics	1.2	1.9	3.8	1.8	(2.9)	(0.8)	0.2	0.9	(0.2)	(0.8)	5.2
Clinical psychology	0.1	(0.1)	(0.0)	1.6	1.8	0.0	(0.0)	0.0	0.1	(0.0)	3.4
Renal medicine	1.0	0.8	0.6	0.8	(0.5)	(0.4)	0.5	0.3	(0.1)	(0.7)	2.4
Anticoagulant service	(0.0)	1.0	0.0	(0.0)	1.0	0.3	0.0	(0.2)	0.2	0.1	2.3
Respiratory medicine	1.4	1.8	(0.2)	0.1	1.2	(1.4)	(0.4)	(0.0)	0.5	(0.8)	2.2
Clinical oncology	1.3	0.3	0.2	(0.1)	(0.2)	0.2	0.0	0.6	(0.1)	(0.3)	1.9
Estimated cost pressure (£m)	13.8	11.2	7.2	6.6	3.9	3.8	2.3	2.2	0.6	(2.7)	48.9

Delivery Programmes	Start Date
Cardiology - Revised Cardiology Pathway – straight to A&G, shared decision-making, diagnose to refer - Series of bi-monthly GP Education Sessions - Consultant Based Community Clinic Development - NCA Outpatient Transformation Programme - Cardiac Rehabilitation – Improving access and retention - Work with general practice to address unwarranted variation in referrals	Q2 23/24
Gynaecology - Front end pathway review with system partners - Work with general practice to address unwarranted variation in referrals - Review of low complexity pathways with primary care - NCA Outpatient Transformation Programme - Specialist Advice – NCA wide (pre referral A&G and post referral RAS)	Q2 23/24
Dermatology - E-Derma expansion - Work with general practice to address unwarranted variation in referrals - NCA Dermatology Improvement Programme - GM Dermatology Model of Care	Q2 23/24

Risk or Issue

- Counting of Specialist Advice and A&G to ensure all deflections are recorded.
- Resource/investment to continue e-Derma programme, subject to successful evaluation of pilot
- Estate availability to implement community-based clinics.
- Access to diagnostics to support diagnose to refer pathways.

Additional Support Required

- Support from GM for continuation of e-Derma, subject to successful evaluation of pilot and for DECIDE training.
- GM ICB RBMS review outcomes to be shared to inform Bury RBMS next steps.
- Investment required to increase community based diagnostic provision to support diagnose to refer pathways.

Bury Locality: A&E Attendances

NHS Greater Manchester Integrated Care

Describe the areas identified as opportunities

- **Localities should target 3 cohorts/specialties for A&E attendance.**

The Bury locality has chosen the following cohort of patients for target reductions for A&E attendances:

1. Mental Health, 1,216 attendances in the period May 22-Mar 23 have been identified relating to the target cohort of MH patients (based upon a proxy measure of any attendance in the period for self harm/poisoning). The staggered trajectory set is as a 5% reduction from December 2023

2. Respiratory (non paediatric) Under 75's (age 17-74), 1,712 attendances have been identified for the target cohort as A&E attendances for May 22-Mar 23 related to dyspnoea and difficulty in breathing. The staggered trajectory set is as a 5% reduction from December 2023

3. A&E over 75, 7,839 Bury attendances have been identified for the target cohort for May 22-Mar 23. The staggered trajectory set is as a 5% reduction from December 2023

The Bury locality is mindful of PWC locality analysis for A&E and Non Elective activity in particular the with regards to paediatrics admissions. This activity is however outside of NCA footprint and based primarily at the neighbouring MFT. The locality will review these findings though the Childrens Strategic Partnership Board and the Bury UEC Board.

Please note that NEL admissions and A&E attendances data for 2022/23 does not take account of growth assumptions.

Delivery Programmes	Start Date
1. Mental Health:	
a) Increase capacity in Bury Peer-led Crisis Service (Locality programme) (May 23)	May 2023
b) Implementation of 24/7 Home Treatment and Older Peoples Home Treatment	Sept 2023
c) Impl. of MDT approach to care planning as part of progressive impl. of living well model	Q4
d) Active case management and MDT approach within Neighbourhoods includes pts with MH	Ongoing (d/e)
e) Work to increase completion of SMI physical health checks	
2. Respiratory Under 75:	
a) Further development of the Virtual Ward Model across Bury in line with feedback from NHS Elective.	Ongoing
3. A&E Over 75:	
a) SDEC, continued development of the SDEC offer at FGH	Ongoing
b) INT's and RR are looking at frequent flyers that will then be put though active case management using an MDT approach across system partners	Ongoing
c) Inclusive of EOL within VW models and development of VW with Bury Hospice	Ongoing
d) AHP in A&E model	Ongoing

Risk or Issue

1	**Mental Health:** Ability to recruit suitably qualitied workforce and consultation requirements may delay mobilization. Multiple risks highlighted by providers around finance, information systems, contracts and workforce may delay implementation of Living Well model. Some challenges in ensuring reliable monitoring of A&E attendances by patients with an underlying MH problem
2	**Respiratory Under 75:** Ability to recruit suitable staff. All non elective assumptions are at risk of further COVID out breaks, the impact of Flu and potential extreme winter conditions.
3	**A&E over 75**: Flow through the hospital at pressures point impacting on SDEC. Ability to recruit suitable staff. All non elective assumptions are at risk of further COVID out breaks, the impact of Flu and potential extreme winter conditions.

Additional Support Required

- GM level leadership and support in addressing risks in relation to Living Well model implementation.
- Clarity on GM proposals for SDEC models following the GM review of all SEDC services

Bury Locality: Non-elective Admissions

Greater Manchester Integrated Care

Describe the areas identified as opportunities

- **Localities should target 3 cohorts/specialties for non-elective admissions.**

The Bury locality has chosen the following cohort of patients for target reductions for NEL Admission:

1. Respiratory HRG Under 75 (17 -74), 1,253 Bury NEL admissions have been identified in the target cohort for May 22-Mar 23. Staggered trajectory set is as a 5% reduction from December 2023

2. General Medicine Over 75, 2,831 Bury NEL admissions have been identified in the target cohort for May 22-Mar 23. This excludes, cardiac, neuro and stroke patients. The staggered trajectory set is as a 5% reduction from December 2023

3. Care home admissions, 963 NEL admissions have been identified in the cohort for May 22-Mar 23 from Bury Care Homes. The staggered trajectory set is as a 5% reduction from December 2023

The Bury locality is mindful of PWC locality analysis for A&E and Non Elective activity in particular the with regards to paediatrics admissions. This activity is however outside of NCA footprint and based primarily at the neighbouring MFT. The locality will review these findings though the Childrens Strategic Partnership Board and the Bury UEC Board.

Please note that NEL admissions and A&E attendances data for 2022/23 does not take account of growth assumptions.

Delivery Programmes	Start Date
1. Respiratory Under 75 a) Further development of the Virtual Ward Model across Bury in line with feedback from NHS Elective. Particular focus on Frailty pathways. b) Inclusive of EOL within VW models and development of VW with Bury Hospice	Ongoing Ongoing
2. General Medicine Over 75: a) SDEC, continued development of the SDEC offer at FGH b) INT's and RR are looking at frequent flyers that will then be put though active case management using an MDT approach across system partners c) Inclusive of EOL within VW models and development of VW with Bury Hospice	Ongoing Ongoing
3. Care Homes: a) The PCNs continue to deliver the requirements of the Enhancing health in care homes (part of the PCN DES) b) - Every CH in Bury attached to member of RR doing regular visits to discuss H@H/RR and hospital avoidance, also linking into NWAS and meeting with GPs to educate them on RR	Ongoing Ongoing

Risk or Issue

1. Respiratory Under 75: Flow through the hospital at pressures point impacting on SDEC. Ability to recruit suitable staff. All non elective assumptions are at risk of further COVID out breaks, the impact of Flu and potential extreme winter conditions

2. General Medicine Over 75: Ability to recruit suitable staff. All non elective assumptions are at risk of further COVID out breaks, the impact of Flu and potential extreme winter conditions.

3. Care Homes: A number of the IIF targets which include care home specific ones have been stood down in favour of improving capacity and access. Risk of private care home closures due to cost of living crisis and also closures due COVD/Flu and norovirus outbreaks. Care home data provided by FGH from internal data collection not national returns.

Additional Support Required

- Clarity on GM proposals for SDEC models following the GM review of all SEDC services

Bury Locality: No Criteria to Reside

NHS Greater Manchester Integrated Care

Describe the areas identified as opportunities

- Targets by provider have already been set as part of the planning process.
- These targets are based on hospital sites
- Localities will be responsible for discharge of their patients from all hospital sites. Locality figures will be provided or agreed with Trusts.
- In order to prepare for winter and as this is a pre-existing objectives target a trajectory reducing to target levels by September.

Locality	Acute Site	2022/2023 (COO Elective Restart)	2023/2024
Bolton	Bolton	60	58 (↓2)
Bury	Fairfield	40	39 (↓1)
Oldham	Oldham	35	34 (↓1)
Rochdale	Rochdale	2	2
Salford	Salford	127	122 (↓5)
Manchester & Trafford	MRI	80	77 (↓3)
	NMGH	50	48 (↓2)
	Wythenshawe	80	77 (↓3)
	Trafford	30	29 (↓1)
Stockport	Stockport	50	48 (↓2)
Tameside	T&G	60	58 (↓2)
Wigan	Wigan	60	58 (↓2)
Greater Manchester		**674**	**650 (↓24)**

- Absolute NC2R numbers don't take into account the length of delay and, therefore, bed days lost. It would be advantageous for localities to target longer delays. See info below.

PATIENT STATUS

Pathway	Threshold			
0	1 Day	2- 4 Days		5 Days
1	1 Day	2 - 3 Days	3 - 19 Days	20 Days
2	2 Days	3 - 5 Days	5 - 19 Days	20 Days
3	2 Days	3 - 5 Days	5 - 19 Days	20 Days
Unknown	1 Day	2 - 4 Days		5 Days

https://www.gmtableau.nhs.uk/#/site/GMHSCPPublic/views/PathwayPatientJourney-AwaitingDischarge_16590007042050/About?:iid=1

Delivery Programmes	Start Date
Discharge Frontrunner Programme	April 2023
Implementation of recommendations from ECIST review of Integrated Discharge Team	June 2023
Workstreams within Care Organisation patient flow and discharge collaborative group	May 2023
Review of meetings and escalation processes in and out of area patients.	August 2023
Across system work with, intermediate, community services and private care providers	July 2023
*NB – assumptions made for figures No criteria to reside - main provider – *Fairfield General Hospital Site – all localities* No criteria to reside – locality – *All Bury residents any hospital site – baseline is from FGH and North Manchester* Projected - No Criteria to reside - bed days lost – *Main provider site (FGH) - all localities*	

Risk or Issue

Care Organisation Risk related to NC2R (DKAFH) is:
If the number of patients on the Days Kept Away from Home (DKAFH) list do not reduce then patients will be kept in hospital unnecessarily leading to increased harm for those patients (e.g. increased risk of infection, deconditioning) and for other patients attending the emergency department and requiring admission to an acute bed (e.g. reduced ED capacity, trolley waits in ED).

Additional Support Required

Support with out of area patients
GM meeting took place 17th April 2023 – continue with work across GM re. out of area patients.

Bury: Mental Health OAPs and Clinically Ready for Discharge

NHS Greater Manchester Integrated Care

Describe the areas identified as opportunities

- The NHS Operational Planning objective is to reduce OAPs. The aim is to have no OAPs by the end of March 2024.
- Reduction in MH inpatients who are clinically ready for discharge will support mental health Trusts to manage overall capacity. There will be an indirect benefit to reducing out of area placement levels and urgent care access.
- GMMH will average 25% reduction in clinically ready for discharge numbers. PCFT to be confirmed. Locality specific figures will be provided as soon as possible. These will be reported on a consistent 'pathway basis' as NC2R
- The current Out of Area placement trajectories in the GM plan as submitted to NHSE are as follows. The planning target is for zero so GM should set more ambitious targets internally. These figures will be broken down by locality and will represent a minimum ambition for localities.

	Q1	Q2	Q3	Q4
PCFT	2425	2413	2172	1690
GMMH	2200	1700	1300	1113
ICB	4625	4113	3472	2803

Delivery Programmes	Start Date
Mental Health Urgent Triage service redesign – MHP/GMP/VCSE triage MH 999 calls based in NWAS EOC (GM-wide programme)	July 2023
Increase capacity in Bury Peer-led Crisis Service (Locality programme)	May 2023
Implement Older People's Crisis Resolution and Home Treatment Team (Locality programme)	Jun 2023
Commission additional MH supported accommodation options (Locality programme)	Apr 2023
Implementation of 24/7 Crisis Resolution and Home Treatment (Locality programme)	Jun 2023
Commissioning complex dementia step down resource (8 beds)	July 2023

Risk or Issue

- If there is insufficient acute bed capacity in GM then it is unlikely that the target for significantly reducing OAPs will be achieved even if admission avoidance and DTOC initiatives are optimised.
- Inability to recruit suitably qualified staff may delay full implementation of Older People's Crisis Resolution and Home Treatment Team and 24/7 CRHT provision.
- If there is insufficient appropriate community step down accommodation options this will be a limiting factor in reducing DTOC and improving flow.

Additional Support Required

- Locality level reporting of DTOC data.
- GM leadership of MH Urgent Triage redesign.
- GM and Trust-wide programme to support consistent application of good practice in relation to discharge planning and co-ordination.

Bury Locality: QIPP

NHS Greater Manchester Integrated Care

Describe the areas identified as opportunities

- **CHC** – review packages of care and ensure that the costs incurred are appropriate, including utilisation of Person Health Budgets. Work is ongoing with regard to data quality alongside the clinical work
- **CHC** – the current split of schemes is Green - £508k and Amber £508k
- **Prescribing** – a number of schemes have been identified but the removal of rebates to be a central scheme has created a pressure of £360k, as these were initially included as a CCG scheme. Furthermore the uncertainty around staffing allocations means that the full target is not currently deliverable.
- **Prescribing** – the current split of schemes is Green - £302k, Amber £134k, Red - £581k
- **Estates Subsidies** – reduction in subsidies for those practices that are an outlier, this needs support from NHS GM and an NHS GM wide push on this in all localities to give the Bury locality the best chance of delivery of this scheme
- **Estates Subsidies** – this is currently red rated and the value is £120k
- **Unidentified Stretch Target** – this was an additional target given to localities to support delivery of an NHS GM overall break even position, this is currently unidentified and red rated with a value of £109k

Delivery Programmes	£ Target
CHC – Green £508k, Amber £508k	£1,016k
Prescribing – Green £302k, Amber £134k, Red £581k	£1.017k
Estates Subsidies – Red £120k	£120k
Unidentified Stretch Target – Red £109k	£109k

Risk or Issue

Prescribing – Staffing & rebates
Estates subsidies – 2022/23 scheme that is rolled over as we could not progress due to NHS GM Position
Vacancy factor – the 14% vacancy factor centrally applied to staffing budgets means that the delivery of schemes will be compromised if any members of staff leave as they will not be able to be replaced in a timely manner.

Additional Support Required

Locality Finance, Performance and Outcome Standards

Locality:	Bury
Template completed by:	Kath Wynne-Jones

Opportunity	Baseline data	Baseline period	Target	Trajectory											Total Deflection	Notes
				May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24		
Referral Rates																
Cardiology Service (est excl 2WW)	1,857	May-Mar 22/23	2.7%	1	1	2	3	4	5	6	5	7	8	9	51	Trajectory reflects the numbers being deflected in each month
Dermatology Service	2,635	May-Mar 22/23	2.7%	1	3	3	5	6	7	7	7	8	11	12	70	
Gynaecology Service	2,470	May-Mar 22/23	2.8%	1	2	3	4	6	5	7	7	10	10	13	68	
A&E attendances																
Age 17-74 Estimated MH Attendances	1,216	May-Mar 22/23	2.5%	0	0	1	2	3	4	4	3	4	5	5	31	Trajectory reflects the numbers being deflected in each month
Age 75+ A&E Attendances	7,839	May-Mar 22/23	3.1%	0	0	6	12	18	24	30	38	37	35	43	243	
Age 17-74 Dyspnea/Difficulty Breathing	1,712	May-Mar 22/23	3.4%	0	0	1	2	3	6	8	14	10	7	8	59	
Admissions																
Age 17-74 Respiratory (DZ) subchapters	1,253	May-Mar 22/23	3.2%	0	0	1	1	2	4	6	8	7	6	5	40	Trajectory reflects the numbers being deflected in each month
Age 75+, Gen Med Spec, excl Cardio, Neuro, Stroke	2,831	May-Mar 22/23	3.1%	0	0	2	5	6	8	9	16	14	12	15	87	
Admissions from Care Homes	963	May-Mar 22/23	2.5%	0	0	1	2	2	3	3	4	3	3	3	24	
Discharges																
No criteria to reside - main provider	Mean 63 Range 34-101	01/04/22-31/03/23	39	80	70	65	60	55	50	50	45	45	40	39		
No criteria to reside - locality	Mean 70 Range 64-75	01/05/23-15/05/23	39	70	67	64	61	58	55	52	49	46	42	38		Only currently available for NMGH/FF
Projected - No Criteria to reside - bed days lost				1040	910	845	780	715	650	650	585	585	520	507		
Mental health - Out of Area placements	OAP bed days are managed on a PCFT footprint basis and monitored as a GM trajectory															
Mental Health - Clincally ready for discharge	This is not data that is routinely monitored at locality level and PCFT will need to provide															

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NHS Greater Manchester Integrated Care

Elective Care and Cancer Recovery and Reform Board - Update

Bury Locality Board, June 2023

Part of Greater Manchester Integrated Care Partnership

Karen Richardson, Deputy Director of Commissioning
Catherine Tickle, Commissioning Programme Manager

1

GM Elective Care Recovery and Reform Programme - Overview

NHS Greater Manchester Integrated Care

- **GM Elective Care Recovery and Reform (ECRR) Strategy -** established to help improve the elective care recovery position over the **next three years**.
- GM ECRR Programme - aims to **support GM recovery** through a number of objectives:
  - **Reduce** the overall size of the **elective waiting list**
  - **Reduce overall waiting times** for patients
  - Improve **patient experience**
  - Identify and address **health inequalities**
- **GM ECCR Programme -** reports into the **GM ECCR Programme Board,** chaired by John Patterson (Associate Medical Director NHS GM (Oldham) and Fiona Noden (Chief Executive, Bolton NHS Foundation Trust & Bolton Locality Placed Based Lead).
- **Alignment and collaboration** across the GM Strategic Recovery Programme areas (and wider) is crucial to enabling the delivery of GM Recovery.

2

3

Elective Care Recovery and Reform Programme Board – Update Headlines: 2 May 2023

NHS
Greater Manchester
Integrated Care

- **GM Elective Recovery Position**
  - Greater Manchester (GM) waiting list - gone up in the last month by approx. 5,000 to 541,000 people
  - Industrial action has impacted on the increase over the last month
  - GM Trusts to eliminate waits of 65 weeks or more by the end of March 2024
  - Northern Care Alliance NHS Foundation Trust and Manchester University NHS Foundation Trust – in national pilot looking at how to reduce waiting lists faster, learning will be shared.
  - Most people waiting across GM in General Surgery, T&O and Ophthalmology.
- **Endoscopy THRIVE Model**
  - THRIVE - make procedure recording and productivity reporting simple and efficient.
  - GM Endoscopy Network secured £58k to roll out THRIVE in GM -includes a 12-month license and tablets to support using the tool (1 per endoscopy room).
  - Most GM Trusts planning to implement THRIVE - all sites will have 'gone live' by 2 May 2023. Evaluation will inform business case for any future funding after 12 months.
  - Early indications positive - save time on manual data collection processes, improvement in data accuracy, the benefits of reports and highlighting job planning issues.
- **Sustainability Service Programme**
  - Under Provider Federation Board - links to the Elective Care Recovery and Reform Programme – looking at vulnerable services e.g. dermatology.
  - Sustainable Services Board set up May 23 - elective board to notify to Sustainable Services Programme of early warning signs in specialities.
- **GM Elective Recovery and Reform Programme updates**
  - Programme team - working on an outpatient transformation strategy.
  - Proposal being developed to support trusts to meet an agreed set of standards around patient engagement portals.
  - Funding proposals submitted by GM to increase capacity for Endoscopy at two GM Trusts – awaiting decision.
  - Children & Young Person's Pillar -focus on 5 specialties with most waiters- recruiting clinical leads to work on an improvement programme subject to funding agreement.
  - Funding for the Electronic Eye Referral System will run out this year and the programme team will need to do a cost/benefit exercise to assess whether to proceed to business case.

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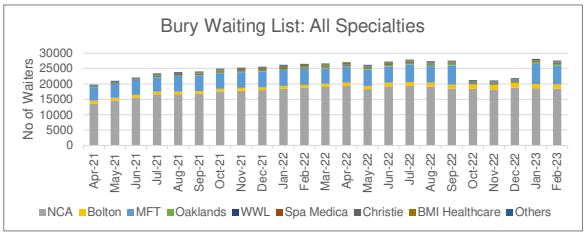
Elective Care (Bury patients at all providers)

NHS Greater Manchester Integrated Care



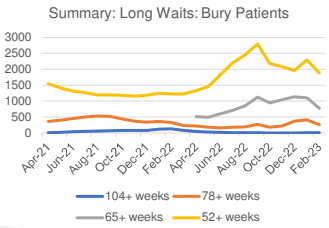
Source: Locality Elective Care report/Published data

Overall Waiting List:

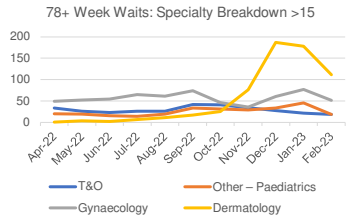
- MFT data is now included from January 23.
- Published Feb data shows an decrease on Jan 23 (-1.8%, -505 pathways). Since Jan 23 there have been small decreases across several specialties, plastic surgery and Respiratory medicine showing the 5.9% increases.
- Reductions in Feb in Paediatric (-9.2% since Jan) and Other – Surgical Services (-6.3% since Jan) .

Long Waits:

- 104+: Feb shows 2 which is a decrease of 2 on Jan 23 (4).
- 78+: Significant decrease in Feb. Has jumped down from 413 in Jan to 261 in Feb (-37%) . Primarily derm which has decreased from 178 in Jan to 111 in Feb. Further reduction in all specialties, in particular Paediatrics (46 in Jan to 18 in Feb) and Gynae (77 in Jan to 51 in Feb). GM expects circa 600 78+ waits by end of March.
- 65+: Decreased to 773 in Feb. To be zero by March 2024.
- 52+: Decrease in Feb on Jan (-17.6%). Mainly derm (-33% v Jan)



Source: Locality Elective Care report/Published data



Source: Locality Elective Care report/Published data

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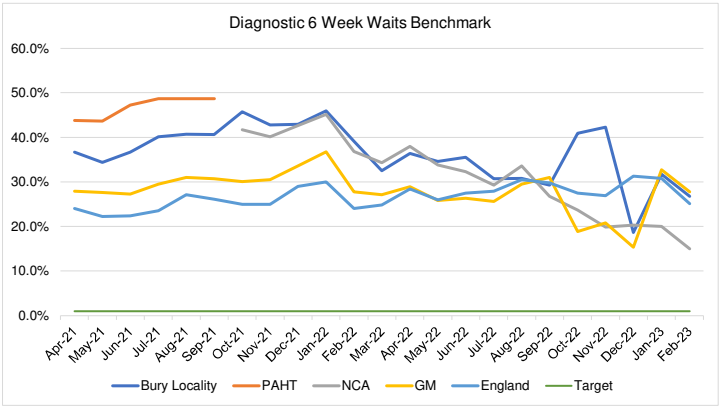
Diagnostics (Bury patients at all providers)

NHS Greater Manchester Integrated Care



Source: Locality Elective Care report/Published data

Diagnostic Performance notes:

- MFT Data is now included from Jan 23.
- Bury's Diagnostic performance has now settled since the Dexa issue was resolved and now that MFT data is included.
- February's performance of 26.8% is an improvement on the Jan figure of 31.7%.
- Across November to January NCA performance has remained steady.
- 23/24 requirement is to continue to work towards 95% of patients receiving diagnostic test <6 weeks by March 2025.

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GM Cancer Alliance Work Programme 22-23

Greater Manchester Integrated Care

Target			
Cancer Waiting Times inc FDS Backlog reduction	**Increase Stage 1 & 2 Diagnosis to 75% by 2028**	**Increase survival, 2750 more patients in GM living with cancer beyond 5 years (2018 > 2028)**	**Be fully integrated with the NHS GM (ICS)**
Operational Delivery and faster Diagnosis	**Early Diagnosis and Prevention**	**Personalised Care and Treatment**	**Structure**
Diagnostic Transformation (Single Queue, Shared Capacity and Reporting, Community Diagnostic Hub & Others)	Prevention (e.g. Smoking, Obesity)	Reduced Variation in treatment (Lung, GIRFT & Others)	Support ODNs in cancer (TYA, Children's Radiotherapy)
Best Practice Timed Pathway including Non-Site Specific	Symptom Awareness, presentation and referral	Personalised inpatient pathways & follow up (GM Living well with cancer, HNAs/PSCP/TSs/PSFU, supportive care & community services)	Models of Care (Breast, Lung, Colorectal & Others)
Treatment transformation to achieve CWT targets	Cancer Screening (Bowel, Breast, Cervical)	Genomics and targeted treatment	Collaboration with PCNs & localities
Innovation to drive recovery (Mastalgia pathway, tele-dermatology etc)	Effective Primary Care Pathways	Optimising for treatment (Prehab)	Integration with GM decision making
Effective secondary care pathways to reduce unwarranted variation in waiting time access	Targeted Case Finding (e.g. TLHC, Lynch, Liver)	Innovation to drive personalised care (Infoflex, Cancer Care Coordinator)	
Systemwide re-design of pathway delivery	Innovation to drive earlier diagnosis (e.g. NHS Galleri, FIT)		

Cross Cutting Programmes

- **Workforce and Education** e.g. Refreshed Cancer wf/ed strategy, Data, One Cancer workforce model, Cancer Academy, WF inequalities programme
- **Identifying and addressing inequalities**: e.g. Data, PCN Leads/DES, Locality engagement, Inequalities Working Group, Pathway Board Projects, Equality Impact Assessments
- **Communications & Engagement**: e.g. Patient Representative Programme, GM Cancer Conference, Annual Report, Podcasts & Others
- **Data Driven Improvement:** e.g. Tableau Developments, Clinical Outcomes, Dataset, Primary Care Dataset, Podcasts & Others
- **Research**: Research Framework, Activity and Inclusivity data, PWBs engagement, Charity-Industry Research Equity project, Annual report

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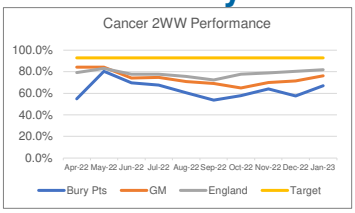
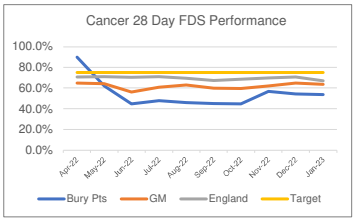
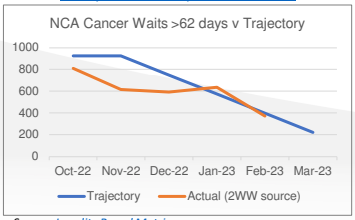
Cancer Bury Position - all providers

Greater Manchester Integrated Care





Source: Locality Elective Care report/Published data



Source: Locality Board Metrics

Cancer 2WW Target (93%)
(see specialist in 2 weeks of urgent referral):

- Increase in performance in Jan to 66.9% for Bury patients - highest performance has been since Aug 22, GM has also increased to 76.2%.
- Reduction to 322 breaches in Jan for Bury patients, 48% of which were in Skin (skin 2WW: 33% from 3% in Dec).
- Next highest were breast (70) and gynae (32).

Cancer 28 days Faster Diagnosis Standard (75%)
(patients diagnosed or have cancer ruled out within 28 days of being referred for suspected cancer):

- Slight dip in Jan to 53.5% for Bury.
- Lower GI deterioration noted in January (64.5% in Dec to 44.9% in Jan).
- 23/24 guidance requirement to meet the 75% target by March 2024.
- 23/24 guidance requirement to increase the % of cancers diagnosed at stages 1&2.
- Latest data (2020) shows Bury as 3rd best in GM at 53.6% compared to GM at 51.4%.

Cancer 62 day waits (85%):
(patients to begin treatment following an urgent GP cancer referral)

- 23/24 guidance requirement - reduce the number of patients waiting over 62 days.
- NCA target is 222 patients waiting >62 days by March 23.
- NCA now below the trajectory.
- NCA has a weekly cycle of improvement - dermatology, colorectal, urology and gynae to recover against the trajectory.

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Delivering Against the 23/24 NHS Plan: Showcasing the work by Bury System Partners

NHS Greater Manchester Integrated Care

GM Cancer Alliance Bury locality visit: 01 February 2023

- Purpose of the visits was to:
  - establish a 'peer to peer conversation', sharing best practice, progress, challenges / risks and determining ways in which the whole system can continue to work together to deliver the GM Cancer plan.
  - strengthen relationships between GM Cancer and the localities and further develop ways of joint working and mutual support.
  - focus on programmes of work which support delivery of the Long Term Plan Aims of improving early cancer diagnosis and survival.

- Bury Partners in Attendance:
  - Locality representatives – Placed Based Lead, Clinicians and Managers
  - Public Health
  - VCFA
  - PCN Cancer Leads
  - NCA representatives – Clinicians and Managers

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GM Cancer Alliance Bury Locality Visit – GM Feedback Highlights

NHS Greater Manchester Integrated Care

- Encouraged by the range of roles present at the Bury Locality meeting and the proactive nature of the discussions held.
- **Strong working relationship** between the locality and the PCNs on the cancer agenda was very clear in the meeting.
- **GM strong links with localities** is central to the success of the GM Cancer Alliance work as the knowledge and understanding of the needs of your population is the most relevant.
- Challenges with screening data – GM Cancer Alliance working with colleagues in the GM BI team to address. In the meantime **GM will ensure PCN and practice level data is available via Tableau.**
- Bury work on uptake of the **Breast Screening Programme -** GM Cancer keen to see the **outcomes of the project.**
- The Burden of Disease in Bury - Public Health– demonstrated a **clear understanding of the population need in Bury.**
- GM Cancer Alliance note the work that's being undertaken in Bury on the **E-Derma project** and will support locality staff in raising the profile of this in the **GM Dermatology Transformation Board meetings.**
- **Extensive work undertaken in the locality by the VCFA** was noted and it would be good to raise this for discussion in the GM commissioning leads meeting as a model of good practice and ensure this is also reported via the inequalities programme board.
- Considerable work undertaken in the locality to understand and address issues of **inequalities in cancer.** Locality encouraged to continue **to share this as a model of good practice** through the Cancer Alliance inequalities programme board and the locality sub-group. Noted that other localities could learn from and adopt the approach undertaken in Bury.
- Locality to **develop links into NCA through CCC** (Cancer Care Co-ordinators).
- All **PCN Cancer Leads** encouraged to attend the 7th of March PCN planning day.

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Locality Challenges – Elective Care and Cancer

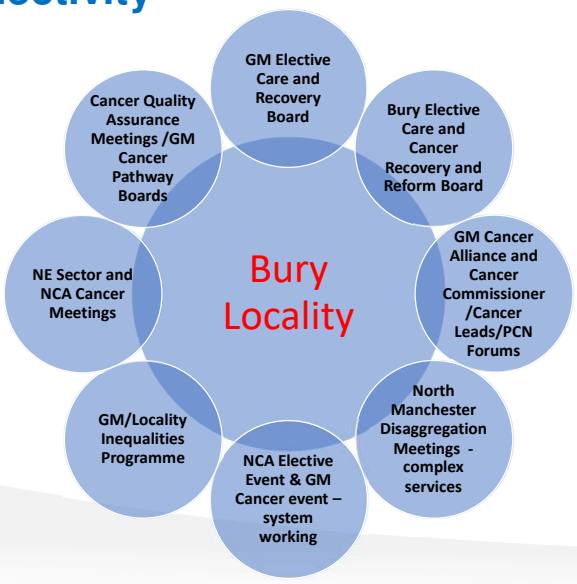
NHS Greater Manchester Integrated Care

- **NCA** classified in **Tier One of the most challenged providers.**
- **Impact of North Manchester disaggregation**.
- **Backlog of patients waiting over 62 days at NCA.**
- **Diminishing capacity within Independent Sector Providers** (ISP) to support pressured specialities.
- **Clinical workforce shortages** in several key areas including clinical nurse specialists, radiologists and primary care.
- **Sustainability of posts and programmes funded** through short term funding.
- **Diagnostic capacity** across radiology, pathology and endoscopy.
- **Expansion of cancer screening programmes and new testing programmes – capacity/demand** issues, e.g., BRCA gene mutation.
- **Impact of financial challenges** across parts of the **health and social care system - demand** on elective care.

11

Examples: Bury Locality, Pan locality and GM Connectivity

NHS Greater Manchester Integrated Care



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Agenda Item 9

BURY INTEGRATED CARE PARTNERSHIP

Meeting: **Locality Board**			
Meeting Date	05 June 2023	**Action**	Receive
Item No.	9	**Confidential**	No
Title	Joint Forward Plan		
Presented By	Warren Heppolette, Chief Officer for Strategy & Innovation, NHS Greater Manchester, Integrated Care		
Author	Warren Heppolette, Chief Officer for Strategy & Innovation, NHS Greater Manchester, Integrated Care		
Clinical Lead			

Executive Summary

National guidance states that each Integrated Care Board (ICB) must publish a five-year Joint Forward Plan (JFP) setting out how they propose to exercise their functions, which must be shared with NHSE by 30th June 2023.

Whilst legal responsibility for the JFP lies with the ICB, systems have also been encouraged to use the JFP to develop a shared delivery plan for the integrated care partnership strategy. This is the approach we are taking in Greater Manchester.

Guidance from NHSE describes that the plans should be;

- Fully aligned with the ambitions of the wider partnership
- Build on local strategies and plans and reflect universal NHS commitments
- Delivery-focused

Whilst the JFP will cover 5 years, it will necessarily be more detailed in terms of the first two years.

Attached are a series of slides which provide further detail surrounding the JFP.

Recommendations

That the Locality Board receive the JFP.

Links to Strategic Objectives	
SO1 - To support the Borough through a robust emergency response to the Covid-19 pandemic.	☒
SO2 - To deliver our role in the Bury 2030 local industrial strategy priorities and recovery.	☒
SO3 - To deliver improved outcomes through a programme of transformation to establish the capabilities required to deliver the 2030 vision.	☒

Links to Strategic Objectives	
SO4 - To secure financial sustainability through the delivery of the agreed budget strategy.	☒
Does this report seek to address any of the risks included on the NHS GM Assurance Framework?	☐

Implications						
Are there any quality, safeguarding or patient experience implications?	Yes	☐	No	☒	N/A	☐
Has any engagement (clinical, stakeholder or public/patient) been undertaken in relation to this report?	Yes	☒	No	☐	N/A	☐
Have any departments/organisations who will be affected been consulted ?	Yes	☒	No	☐	N/A	☐
Are there any conflicts of interest arising from the proposal or decision being requested?	Yes	☐	No	☐	N/A	☒
Are there any financial Implications?	Yes	☒	No	☐	N/A	☐
Is an Equality, Privacy or Quality Impact Assessment required?	Yes	☒	No	☐	N/A	☐
If yes, has an Equality, Privacy or Quality Impact Assessment been completed?	Yes	☐	No	☐	N/A	☒
If yes, please give details below:						
If no, please detail below the reason for not completing an Equality, Privacy or Quality Impact Assessment:						
Are there any associated risks including Conflicts of Interest?	Yes	☐	No	☐	N/A	☒
Are the risks on the NHS GM risk register?	Yes	☐	No	☐	N/A	☒

Governance and Reporting		
Meeting	**Date**	**Outcome**

Joint Forward Plan – Update

Greater Manchester Integrated Care Partnership

Joint Forward Plan

- National guidance states that each ICB must publish a five-year Joint Forward Plan setting out how they propose to exercise their functions, which must be shared with NHSE by 30th June 2023.

- Whilst legal responsibility for the JFP lies with the ICB, systems have also been encouraged to use the JFP to develop a shared delivery plan for the integrated care partnership strategy. This is the approach we are taking in Greater Manchester

- Guidance from NHSE describes that the plans should be:
  - Fully aligned with the ambitions of the wider partnership
  - Build on local strategies and plans and reflect universal NHS commitments
  - Delivery-focused

- Whilst the JFP will cover 5 years, it will necessarily be more detailed in terms of the first two years.

Update on Process

- The first draft is complete (see later slides) and is with key system leads for comments – and addressing gaps
- We have set out proposed delivery and system leadership for each of the missions
- We have developed a model for the Performance and Accountability Framework to track delivery of our strategy and plan
- We will be providing a summary of each Locality Plan – and have requested (via Deputy Place-Based Leads) each Locality to confirm that we have the latest version of the plans. We will share the summaries for comment
- We are tracking and wrapping in the work informing the recovery of finance and performance recognising the significant focus this will provide on reducing admissions, achieving flow, reducing the backlog and improving productivity in the first year
- It is also intended to develop a clear 3 year roadmap to system sustainability. That will relate strongly to the work on the recovery programme, but capture and quantify the contributions across the full plan

Developing the Content

Greater Manchester Integrated Care Partnership

Stage 1 (In Progress)

Populate the Document with content from existing strategies and plans. Focused on:

Actions

Metrics

Resources to deliver and

Accountability for delivery

Stage 2 (Early May)

Address gaps in content with relevant leads

Stage 3 (by early June)

Circulate draft document to stakeholders with key questions to respond to

JFP Structure

Greater Manchester Integrated Care Partnership

Chapter	Content	Information Sources/Drafting Process
Foreword	• Sir Richard Leese/Paul Dennett	• WH/PL to draft
Introduction and Context	• Short intro to GM system • Our strategic challenges • Our Opportunities and Assets	• ICP Strategy • 23/24 Operational Plan
Our Strategy	• Summary of the ICP Strategy – vision, outcomes, shared commitments, missions, ways of working	• ICP Strategy
Delivering the Strategy	• The Key System Objectives and Actions to Deliver the 6 Missions (See next slide for structure) • Roles and Responsibilities in Delivery • Metrics and Ambition • Role of ICB and other partners in enabling change	• ICP Strategy • 23/24 Operational Plan • PWC and Carnall Farrar reports • Range of current system plans – inc. Locality Plans • ICS Operating Model – *Refreshed to take Account of All of the Above* • Input from System Leads and Round Table Sessions – See Additional Slide
Tracking our Delivery	• Performance Framework	• Based on WHO Framework and populated with SOF metrics, GMS metrics and other key measures

Chapter: Delivering the Strategy – Example

Mission: Strengthening our communities

Description of Mission

- *Short description from ICP strategy*

Focus area: Scale up and accelerate delivery of neighbourhood model

- *Describe area of focus and set out 3 or 4 key actions e.g. Continue to develop social prescribing in Primary Care Networks, coordinate our response to poverty, Expand community-based mental health provision, Equip people with the skills, connectivity and technology to get online*
- *Metrics and Ambition*

Then repeat for other areas of focus

Leadership Arrangements

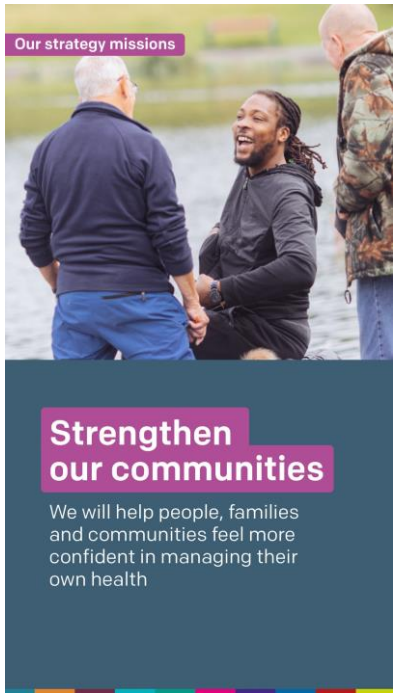
- *Describe ownership of mission and actions – both in terms of delivery and system leadership*

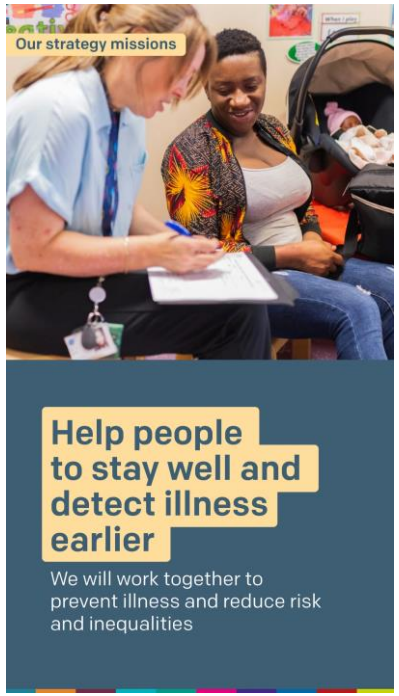
Delivery of the Missions
Key Actions and Proposed Accountability

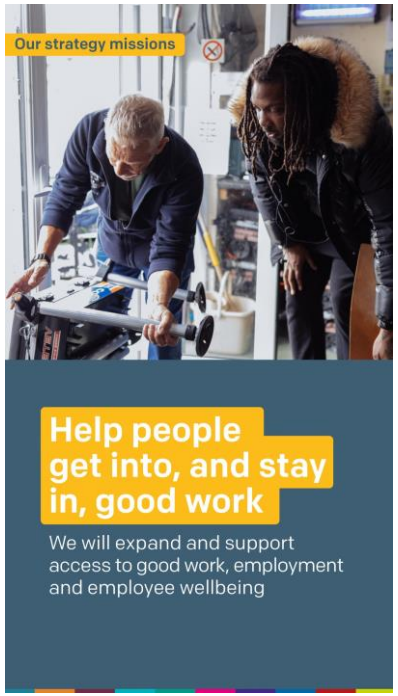
Greater Manchester Integrated Care Partnership

Our Missions – Overview

Greater Manchester Integrated Care Partnership







Proposed Accountability Arrangements

- Delivery Leadership – the board/organisation accountable for driving change and improvement in the relevant part of the system. This recognises that the key responsibility for bringing together and driving delivery will sit with Locality Boards, providers and provider collaboratives

- System Leadership – This recognises the board/group accountable for creating the system-wide conditions, frameworks, and standards to enable delivery

Our missions to meet the challenges

Strengthening our communities

Delivery Leadership: Locality Boards

System Leadership: Population Health Board

Areas of focus	Actions
Scale up and accelerate delivery of person-centred neighbourhood model	Continue to develop social prescribing in Primary Care Networks
	Coordinate our response to poverty
	Expand community-based mental health provision
	Living Well at Home
	Equip people with the skills, connectivity and technology to get online
Develop collaborative and integrated working	Embed the VCSE Accord
	Deliver a GM-wide consolidated programme for those experiencing multiple disadvantage
	Enable a system-wide shared vision and action for children and young people (CYP)
Develop a sustainable environment for all	Secure a greener Greater Manchester with places that support healthy, active lives
	Progress the NHS Net Zero climate change contribution

Our missions to meet the challenges

Helping people stay well and detecting illness earlier

Delivery Leadership: Locality Boards

System Leadership: Clinical Effectiveness and Governance Committee (CEG); Population Health Board

Areas of Focus	Actions
Tackling health inequalities	Reducing health inequalities through CORE20PLUS5 (adults and children)
	Monitoring and targeting of unwarranted variation in outcomes
Healthy behaviours	Tobacco
	Alcohol
	Food and Healthy Weight
	GM Moving
Reducing illness	Cancer screening
	Early detection e.g. hypertension
	Secondary prevention - CVD
	Expanding the use of tools for finding people at risk of poor health
Anticipatory care	Preventing falls and supporting frailty consistently across GM
	Helping people stay at home
	High intensity proactive care

Our missions to meet the challenges

Helping people get into, and stay in, good work

Delivery Leadership: Locality Boards

System Leadership: Population Health Board; Reform Board

Areas of Focus	Actions
Increase scale of work and health programmes	Expansion of our Work and Health Models
	Focus work and health support on excluded groups
Develop good work across all employers	Working with employers on employee wellbeing through the GM Good Employment Charter
Increase the contribution of the NHS to the economy	Implementing the Greater Manchester Social Value Framework
	Developing the NHS as an anchor system

Our missions to meet the challenges

Greater Manchester Integrated Care Partnership

Recovering Core NHS and Care Services

Delivery Leadership: Locality Boards and PFB

System Leadership: System Boards; Finance and Performance Recovery Board

Areas of Focus	Actions
Improving urgent and emergency care and flow	Access to urgent care in the community
	Admission/Attendance Avoidance
	Acuity and complexity
	Discharge
	Increasing ambulance capacity
	Improving emergency department processes
Reducing elective long waits and cancer backlogs, and improving performance against the core diagnostic standard	Overall coordination
	Restoring NHS services inclusively
	Surgical Hubs
	Theatre utilisation
	Cancer Care
	Reducing waiting times in cancer
	Diagnostics
	Digital opportunities for recovery
Improving service provision and access	Making it easier for people to access primary care services, particularly general practice
	Ensuring universal and equitable coverage of core mental health services
Improving quality through reducing unwarranted variation in service provision	Overall coordination
	Maximising capacity
	Using virtual wards
	Reducing inequalities in access to care
	Enabling effective outpatient activity

Our missions to meet the challenges

Supporting our workforce and our carers at home

Delivery Leadership: NHS Trusts, Primary Care providers, Local Authorities, Social Care Providers, VCSE Organisations

System Leadership: GM People Board

Areas of Focus	Actions
Developing good work in health and care	Increase in membership of the Greater Manchester Good Employment Charter and payment of the Real Living Wage in health and care
	Improving workforce wellbeing
Growing and developing the workforce	Grow and develop our workforce
	Develop productive capacity
	Workforce Integration
Addressing inequalities	Addressing workforce inequalities
	Strengthening leadership and accountability for addressing inequalities
Supporting carers	Provide more consistent and reliable identification and support for Greater Manchester's unwaged carers

Our missions to meet the challenges

Achieving financial sustainability

Delivery Leadership: Locality Boards; PFB

System Leadership: ICB; Finance and Performance Recovery Board

Mission/areas of focus	Actions
Finance and Performance Recovery Programme	System recovery programme based on drivers of operational and financial performance
Developing Medium Term Financial Sustainability Plan	Development of three-year financial plan
Taking system-wide action	Develop and implement a comprehensive system wide programme
	Identify factors from successful system working to implement the programme

Performance and Accountability Framework

- A key feature of the JFP will be the Performance and Accountability Framework to enable us to track delivery of our Strategy and Plan

- The Framework needs to incorporate the core NHS and care operational metrics but also a broader set of indicators to reflect our approach to improving population health

- We propose to use a modified version of the World Health Organisation Health System Performance Assessment (HSPA) Framework (as modified by the University of Manchester research team) as the basis to track delivery of our Strategy

- The Framework covers the two aspects of ICS performance:
  - The performance of the health system, which is primarily defined by NHSE, as the funders of the system, through their operating framework and other national requirements
  - The performance of the whole system (including wider partners) and in particular the contribution of the health system to societal goals

- We are working with BI colleagues to populate the Framework with current data for its incorporation into the JFP

Updated Timetable

Greater Manchester Integrated Care Partnership

DATE	KEY TASKS
4th May	Resubmission of Operational Plan
9th May	Agree JFP Process with JPDC
12th May	Complete First Draft and Share with NHS GM Exec
15th May	Share Draft with Key Leads for Review – Addressing any Gaps
26th May	Share Updated Draft with system partners for comment on set of questions – including the 10 HWBs
14th June	Complete update of Document following comments
21st June	Sign off JFP at Integrated Care Board
30th June	Publication of JFP

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Agenda Item 10

BURY INTEGRATED CARE PARTNERSHIP

Meeting:			
Meeting Date	05 June 2023	Action	Receive
Item No.	10	Confidential	No
Title	System Finance Group Update		
Presented By	Sam Evans – Executive Director of Finance Bury Council and NHS Greater Manchester Integrated Care (Bury)		
Author	Simon O'Hare – Locality Finance Lead NHS Greater Manchester Integrated Care (Bury)		
Clinical Lead			

Executive Summary

The financial position of public services in Bury and across Greater Manchester is very challenging in 2023/24. Even before the Covid-19 pandemic the NHS was facing a significant funding shortfall because of increasing demand for services and years of funding settlements that were both below the long-term average. In the decade following the global financial crisis in 2008, the health service faced the most prolonged spending squeeze in its history.

Within Greater Manchester this was apparent in planning for 2020/21 with a number of CCGs likely to post deficit plans for the that year, until the funding formulary changed due to the Covid-19 pandemic. Therefore the 2023/24 financial position across the NHS and local government, both nationally and specifically for Greater Manchester is one that was merely delayed by the changes to funding mechanisms implemented during the Covid-19 pandemic.

In 2022/23 NHS GM was able to deliver it's financial duty of breaking even but this was achieved through significant use of non recurrent measures and therefore this has increased the savings requirement going in 2023/24.

The NHS Greater Manchester Integrated Care (NHS GM) submission to NHS England in March was a deficit plan of £240m, which was followed up with a deficit plan of £159m. Both of these were rejected by NHS England and a £45m deficit plan was submitted in late April 2023, with the aim of retaining non recurrent funding and additional NHS England support, together totalling £45m to deliver a break even plan. Within this position there is assumed savings delivery of £400m and also a System Risk of £130m, with no identified mitigations.

The delivery of this plan will be incredibly challenging and to this end the CFO of NHS England plans to visit NHS GM organisations in June to understand these plans in greater detail and receive greater assurance on delivery in some areas. In response to this position NHS GM is reviewing the outputs of the PWC diagnostic for savings opportunities, is implementing a Project Management Office to oversee delivery of the savings target and the mitigation of the System Risk.

Recommendations

The Locality Board is asked to:

- Consider the information within this paper, the level of savings required for NHS GM to deliver a break even position in 2023/24 and the risks to delivery
- Note that a Bury locality position will be brought to the next meeting, encompassing NHS partners and the council.

BURY INTEGRATED CARE PARTNERSHIP

OUTCOME REQUIRED *(Please Indicate)*	**Approval** ☐	**Assurance** ☐	**Discussion** ☒	**Information** ☒
APPROVAL ONLY; (please indicate) whether this is required from the pooled (S75) budget or non-pooled budget	**Pooled Budget** ☐	**Non-Pooled Budget** ☐		

Links to Strategic Objectives	
SO1 - To support the Borough through a robust emergency response to the Covid-19 pandemic.	☐
SO2 - To deliver our role in the Bury 2030 local industrial strategy priorities and recovery.	☐
SO3 - To deliver improved outcomes through a programme of transformation to establish the capabilities required to deliver the 2030 vision.	☐
SO4 - To secure financial sustainability through the delivery of the agreed budget strategy.	☒
Does this report seek to address any of the risks included on the NHS GM Assurance Framework?	☐

Implications						
Are there any quality, safeguarding or patient experience implications?	Yes	☐	No	☐	N/A	☒
Has any engagement (clinical, stakeholder or public/patient) been undertaken in relation to this report?	Yes	☐	No	☐	N/A	☒
Have any departments/organisations who will be affected been consulted ?	Yes	☐	No	☐	N/A	☒
Are there any conflicts of interest arising from the proposal or decision being requested?	Yes	☐	No	☐	N/A	☒
Are there any financial Implications?	Yes	☐	No	☐	N/A	☒
Is an Equality, Privacy or Quality Impact Assessment required?	Yes	☐	No	☐	N/A	☒
If yes, has an Equality, Privacy or Quality Impact Assessment been completed?	Yes	☐	No	☐	N/A	☒
If yes, please give details below:						
If no, please detail below the reason for not completing an Equality, Privacy or Quality Impact Assessment:						
Are there any associated risks including Conflicts of Interest?	Yes	☐	No	☐	N/A	☒
Are the risks on the NHS GM risk register?	Yes	☐	No	☐	N/A	☒

Governance and Reporting		
Meeting	**Date**	**Outcome**
N/A		

BURY INTEGRATED CARE PARTNERSHIP

System Finance Group Update

1. Introduction

1.1. The financial position of public services in Bury and across Greater Manchester is very challenging in 2023/24. This is due to the lasting impacts of the Covid-19 pandemic both directly and indirectly on the physical and mental health of the population, the increase in waiting lists and demand for services across health and social as a result of this, and the impact of the cost of living crisis both on statutory partners and the physical and mental health of the population.

1.2. Allocations and settlements from the Department of Health and central government had significantly lower growth in 2023/24 than in previous years, as there is a desire to return funding flows to align with pre-pandemic trajectories. This paper will focus upon the NHS position in Greater Manchester to set the scene for an in depth look at the Bury locality position in the July Locality Board meeting.

2. Background

2.1. Even before the Covid-19 pandemic the NHS was facing a significant funding shortfall because of increasing demand for services and years of funding settlements that were both below the long-term average and for the NHS excluded important areas of spending like long-term capital investment (including spending on buildings and equipment) and the education and training of clinical staff.

2.2. In the decade following the global financial crisis in 2008, the health service faced the most prolonged spending squeeze in its history: between 2009/10 and 2018/19 health spending increased by an average of just 1.5% per year in real terms, compared to a long-term average increase of 3.6 per cent per year. These pressures were not unique to the UK, whose public spending on health care as a share of GDP is above the EU average, though lower than several comparable nations, including Germany, France, Denmark and the Netherlands[1].

2.3. In response to rising financial pressures in the NHS, in 2018 the government announced a five-year settlement for some areas of health spending, covering the period from 2019/20 to 2023/24. Under this deal, NHS England's budget would rise by an average of 3.4 per cent each year in real terms. This however was not enough to resolve the building deficits in NHS organisations as a result of the decade of low growth in year on year funding

2.4. Within Greater Manchester this was apparent in planning for 2020/21 with a number of CCGs likely to post deficit plans for the that year, until the funding formulary changed due to the Covid-19 pandemic.

2.5. Council budgets have not been protected in the same way as NHS organisations and consequently have had to make significant cuts since 2010 and In an October 2020 report, the Health and Social Care Committee said an additional £7bn per year was required by 2023/24 to resolve the size of the social care funding gap, which it described as a "starting point". The Health Foundation has suggested that an additional £14.4 billion a year would be required by 2030/31 to meet future demand, improve access to care, and pay more for care[2].

2.6. Therefore the 2023/24 financial position across the NHS and local government, both nationally but specifically for Greater Manchester is one that was merely delayed by the changes to funding mechanisms implemented during the Covid-19 pandemic.

[1] Kings Fund - NHS funding: our position. May 2022
[2] House of Commons Library – Adult Social Care Funding (England). January 2023

BURY INTEGRATED CARE PARTNERSHIP

3. NHS Greater Manchester Integrated Care establishment

3.1 NHS Greater Manchester Integrated Care (NHS GM) came into being at 1st July 2022 as the successor organisation to CCGs, as part of the reorganisation of NHS bodies, governance and reporting. NHS GM is responsible for all NHS activities in Greater Manchester and is the largest Integrated Care System (ICS) in the country.

3.2 NHS GM is the reporting body for all NHS organisations in Greater Manchester, Acute Trusts, Mental Health Trusts, Community Services, General Practice and other primary care services, and it is NHS GM who are held to account by NHS England for performance be that financial, waiting lists, A&E, Mental Health Investment Standard and so on.

3.3 In 2022/23 NHS GM was able to deliver it's financial duty of breaking even but this was achieved through significant use of non recurrent measures and therefore this has increased the savings requirement going in 2023/24.

4 NHS Greater Manchester Integrated Care 2023/24 financial position

4.1 The initial NHS GM submission to NHS England in March was a deficit plan of £240m, which had been arrived at after a number of internal check and challenge sessions to drive down individual organisation deficits within the overall NHS GM position.

4.2 This position was not acceptable to NHS England and a revised position was submitted on 18th April with a deficit of £159m. Unfortunately this was again deemed to be unacceptable and therefore on 21st April a further submission was made with a deficit of £45m, which was to be supported to deliver a break even position through retention of surge funding £19m and NHS England support £26m.

4.3 This plan was deemed to be acceptable by NHS England but no guarantees were give on the retention of the £19m and £26m. Within this position there is assumed savings delivery of £400m and also a System Risk of £115m, with no identified mitigations.

4.4 This System Risk position has since increased to £130m due to a shortfall on inflation funding to be received and other risk mitigations.

4.5 The delivery of this plan will be incredibly challenging and to this end the CFO of NHS England plans to visit NHS GM organisations in June to understand these plans in greater detail and receive greater assurance on delivery in some areas. It should also be noted that alongside the concerns associated with financial delivery there are also concerns with regard to performance against other metrics.

4.6 With regard to delivery of the 2023/24 financial positions the NHS GM board has issued the following statement:

"Achievement of this plan is predicated on a number of assumptions and management of risk, and specifically requires the delivery of £123m system savings, which is in addition to the challenging efficiency targets already built into all organisational plans. For planning purposes, the £123m system target currently sits within the NHS GM plan, but all NHS organisations recognise that there is a collective responsibility of all organisations in the system to manage and mitigate this risk. To deliver savings at this level, all organisations and all parts of the system will be impacted".

5 NHS Greater Manchester Integrated Care actions to deliver 2023/24 savings

5.1 Delivery of this level of savings needs to focus on cost reduction, rather than an expectation of new income, though every opportunity to mitigate will be explored. Current examples include:

- Output from the PWC diagnostic and productivity opportunities identified both for the system and at an organisational level.
- Review of enduring costs resultant from COVID, examples include additional G&A and Critical Care beds as well as specific COVID services such as testing and Medicine Delivery Unit.
- Wider efficiencies and productivity measures, above CIP plans, which could include reviewing more sustainable commissioning of services including decommissioning.

5.2 As a result of the findings from the Carnall Farrah review, governance within NHS GM is expected to be revised. The current proposal to oversee not just the delivery of the System Risk savings, but also the wider underlying financial pressures and risks, is to develop a system wide Project Management Office (PMO) that will report into the NHS GM ICB Board via a Board Committee. The PMO will also ensure that GM has sufficient narrative to adequately articulate why the system has seen material increases in its workforce, but a corresponding reduction in activity when compared to pre-COVID levels. The PMO will facilitate the process and agree with system partners the impact on money, workforce, activity and performance metrics, and agree the changes on the impacted organisations.

6 Actions Required

6.1 The Locality Board is asked to:

- Consider the information within this paper, the level of savings required for NHS GM to deliver a break even position in 2023/24 and the risks to delivery
- Note that a Bury locality position will be brought to the next meeting, encompassing NHS partners and the council.

Simon O'Hare
Locality Finance Lead
s.ohare@nhs.net
May 2023

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Agenda Item 11

BURY INTEGRATED CARE PARTNERSHIP

Meeting: Locality Board			
Meeting Date	05 June 2023	**Action**	Receive
Item No.	11	**Confidential**	No
Title	Bury Integrated Care Partnership System Assurance Committee summary report		
Presented By	Catherine Jackson, Associate Director for Nursing, Quality and Safeguarding (Bury)		
Author	Carolyn Trembath, Head of Quality (Bury)		
Clinical Lead	Cathy Fines		

Executive Summary
This report provides the Locality Board with a summary from the Bury Integrated Care Partnership System Assurance Committee meeting that took place in May 2023 and the Greater Manchester Quality Strategy
Recommendations
The Locality Board is asked to receive the report and share any feedback to the System Assurance Committee for action

OUTCOME REQUIRED *(Please Indicate)*	**Approval** ☐	**Assurance** ☐	**Discussion** ☐	**Information** ☒
APPROVAL ONLY; (please indicate) whether this is required from the pooled (S75) budget or non-pooled budget	**Pooled Budget** ☐	**Non-Pooled Budget** ☐		

Links to Strategic Objectives	
SO1 - To support the Borough through a robust emergency response to the Covid-19 pandemic.	☒
SO2 - To deliver our role in the Bury 2030 local industrial strategy priorities and recovery.	☐
SO3 - To deliver improved outcomes through a programme of transformation to establish the capabilities required to deliver the 2030 vision.	☒
SO4 - To secure financial sustainability through the delivery of the agreed budget strategy.	☐
Does this report seek to address any of the risks included on the NHS GM Assurance Framework?	☐

Implications						
Are there any quality, safeguarding or patient experience implications?	Yes	☐	No	☐	N/A	☒
Has any engagement (clinical, stakeholder or public/patient) been undertaken in relation to this report?	Yes	☐	No	☐	N/A	☒
Have any departments/organisations who will be affected been consulted ?	Yes	☐	No	☐	N/A	☒
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If yes, please give details below:						
If no, please detail below the reason for not completing an Equality, Privacy or Quality Impact Assessment:						
Are there any associated risks including Conflicts of Interest?	Yes	☐	No	☐	N/A	☒
Are the risks on the NHS GM risk register?	Yes	☐	No	☐	N/A	☒

Governance and Reporting		
Meeting	**Date**	**Outcome**
System Assurance Committee	17/05/2023	Summary to be provided to Locality Board

BURY INTEGRATED CARE PARTNERSHIP

System Assurance Committee Highlight Report – May 2023

1. Introduction

1.1. This report provides the Locality Board with a summary from the Bury Integrated Care Partnership System Assurance Committee meeting that took place in May 2023.

2. Background

2.1. This report is a summary of the System Assurance Committee held on 17th May 2023.

3. Headlines from the System Assurance Committee

3.1 Greater Manchester Integrated Care Quality Strategy

- Locality feedback was for wider determinants of health to be included not limited to End of Life Care, social and health inequalities and outcomes and workforce.
- This is set out as part of the Bury LETS (Local, Enterprise, Together and Strength) strategy.
- This also needs to be consider within the context of the Care Quality Commission (CQC) framework both for all health and social care providers linked to funding.

3.2 Information Governance (IG)

- IG policies are being aligned following the establishment of NHS Greater Manchester Integrated Care (NHS GM), though the principle terms won't change just branding.
- Annual Data Protection Toolkit submission to NHS England (NHSE) will be completed for 31st July 2023. This will be a GM submission encompassing the 10 localities.
- GM Data Protection Officer lead role to support General Practice is still being finalised, but local responsibility is being maintained to ensure continuity.

3.3 Medicine Optimisation Team (MOT)

- Key pieces of work have been achieved to improve the health of the population by optimising the use of medicines during 2022/23.
- As well as looking at savings the areas of work where specifically to ensure that medication/prescribing was safe, effective and to improve patient care.
- This has supported health and social care providers to improve their Care Quality Commission (CQC) ratings.
- STOMP (Stop over medication of people with a learning disability (LD), autism or both) case studies will be shared for wider discussion at the LD Partnership Board.
- Work in relation to sustainability, over prescribing and medicines wastage to be taken forward in 2023/24.
- All information relating to Medicine Optimisation work is shared with GPs/primary care

via Sharepoint.

3.4 Pressures in Community Pharmacy

- Community pharmacies have been in financial deficit for a number of years, with no real increase in funding for a number of years, which has led to a net loss of 670 community pharmacies, nationally, since 2016.
- Nationally, Lloyds pharmacy offer which is likely to exit the market later this year. This is already having an impact on supplies and delivery services.
- Community pharmacy consultations saw an increase during the pandemic, and this has not diminished.
- Inflation, overheads and Real Living Wage is also having a major impact on finances across the service as costs can't be passed on due to NHS contractual requirements. This is causing impact on patient care and risks especially where short term closures occur due to staffing issues.
- Joint working to enable mitigation alongside wider pharmacy provision is being undertaken across GM taking into account locality Pharmaceutical Needs Assessment, the Primary Care Networks (PCN) and GP committees.

3.5 Attention Deficit Hyperactivity Disorder ADHD)/Autism Spectrum Disorder (ASD)

- The previous provider LANCuk ceased to provide a service at the end of December 2022 due to poor performance and an inability to improve their offer which was acceptable to the CQC.
- LANCuk provided a service which covered the boroughs of Bury, HMR and Oldham in GM and were responsible for approx. 4,000 patients, for adults with ADHD and ASD.
- A temporary provider Optimise has been identified to manage some patients, since the LANCuk service ceased, who require medication for ADHD.
- As yet GM ICB is still to commission a robust long-term provider for these services. Now with GM MH Transformation Board.

  There remains a current gap in the following provision:
  - No adults service for ADHD new referrals
  - No adults service for Autism new referrals
  - People on the waiting list and those who were part way through an assessment do not have a service and cannot be referred to another provider via Right to Choose.
  - Patients with ADHD who have moved to Bury from another area or who stopped taking their medication and need to restart cannot receive a prescription at present as there is no commissioned service however a contract variation with Optimise is being prioritised for these people.

- No communication has yet been sent so there are patient queries and complaints within the system (especially primary care).
- Bury has attendance on the GM task and finish group for a new GM ADHD service.

There is no timeframe for this at present and they are not looking at solutions for an alternative provider in Bury or the wider North East Sector in the short term.

- There is currently no GM plan for and no identified way forward to commission a service for autism assessments/diagnostics.

- Local mitigation –
  - limited as patient data is held by Heywood, Middleton and Rochdale (HMR - previous lead commissioner).
  - Weekly progress meeting held by HMR with Bury representation.
  - Access to ADHD/ASD services on the locality risk register and reported into the MH Programme Board.

3.6 Health Visiting (HV) and School Nursing (SN)

- Capacity challenges being faced across both services though actions are in place to mitigate risks. Pressures are compounded by increasing demand on universal services.
- Issues raised at the Children's Strategic Partnership Board in December 2022 in relation to deliverability of the early help (Healthy Child Programme) and safeguarding agendas.
- There are significant competing demands on safeguarding priorities impacting on early help and prevention and delivery of mandatory and statutory service requirements.
- Business case compiled by the Northern Care Alliance (NCA) detailing the level of investment required to deliver the core HV & SN activity, over the next 3 years, to be discussed further at Locality Board.

3.7 Pennine Care NHS Foundation Trust Quality Improvement (QI) Framework

- QI Framework outlines the approach to quality improvement in Pennine Care and sets out standards and processes for how the organisation will manage change, promoting patient/carer/service user engagement, ensuring that colleagues feel supported and have the skills to manage change effectively.
- The Framework sets out the governance and assurance principles for large-scale change through the Trust Programme Management Office (PMO).
- The framework will ensure that leadership and management behaviours support continuous improvement
- There is a golden thread throughout the standards to ensuring that all leaders/teams engage patients, service users and colleagues to increase participation using the Change Champions process.

3.8 NCA CQC Actions

- Trustwide Quality Standards Group now in place and a Communication and Engagement Plan is in development.

- Steady improvement in mandatory training across all staff groups.
- Sepsis steering group has been set up and policies in line with new guidance from the Association of Royal Medical Colleges will be launched in May 2023. Clinical Leads have responsibility to deliver this.
- Revised NCA governance structures have been instituted to ensure joint working and oversight of all service provision.
- Clear focus on staff engagement and morale.
- Deep dives into service development and improvement work planned for 2023/24 through the Clinical Quality Leads forum with localities.

3.9 Learning Disability Annual Health Checks

- Bury overall performance February 2023 – 65.8% (increase from 56.4% in January).
- Some lag in data identified which will further improve compliance against target when resolved with full year reporting.
- Options for future resilience utilising ARRS resources being pursued with Bury PCNs

3.10 Awards

- Persona – Most Improved Large Employer Award at the GM Good Employment Awards for improvements to their employment practices, including becoming real living wage accredited and implementing an innovative new approach to recruitment to become more inclusive.

- Gorsey Clough - Chief Nursing Officer Team Award from Deborah Sturdy for contribution to Adult Social Care Nursing, CQC Outstanding and the care and contribution to residents.

- Municipal Journal award nomination - A whole council approach to tackling health inequalities.

4 Associated Risks

4.1 Pressures in Community Pharmacy to be added to the locality risk register.
4.2 ADHD/ASD risks to be updated linked to ongoing lack of local provision and communication to patients potentially at risk due to LANCuk service cessation.

5 Recommendations

5.1 The Locality Board is asked to note that, with a new chair the System Assurance Committee and the GM Quality Strategy, the Terms of Reference are under review.

6 Actions Required

6.1 The Locality Board is asked to note the contents of the report and to raise any issues for the System Assurance Committee to address.

Carolyn Trembath
Head of Quality (Bury)
carolyntrembath@nhs.net
May 2023

NHS
Greater Manchester
Integrated Care

Quality Strategy V2.0

Anita Rolfe Deputy Chief Nurse

Part of Greater Manchester
Integrated Care Partnership

Co-production of this quality strategy has enabled an improved draft to be compiled. Approximately 150 respondents submitted comments and these have been incorporated.

There was general consensus from respondents was that the strategy is generally representative of the collective ambition in relation to quality.

This high-level Quality Strategy is designed to sit within the suite of other strategies that are guiding the business of the ICS localities and thematic workstreams

It remains the responsibility of each organisation to manage how they deliver good care, however this strategy creates the opportunity to coordinate the intentions of individual services and organisations of all sizes across the 10 localities to improve the experience of care for all across Greater Manchester.

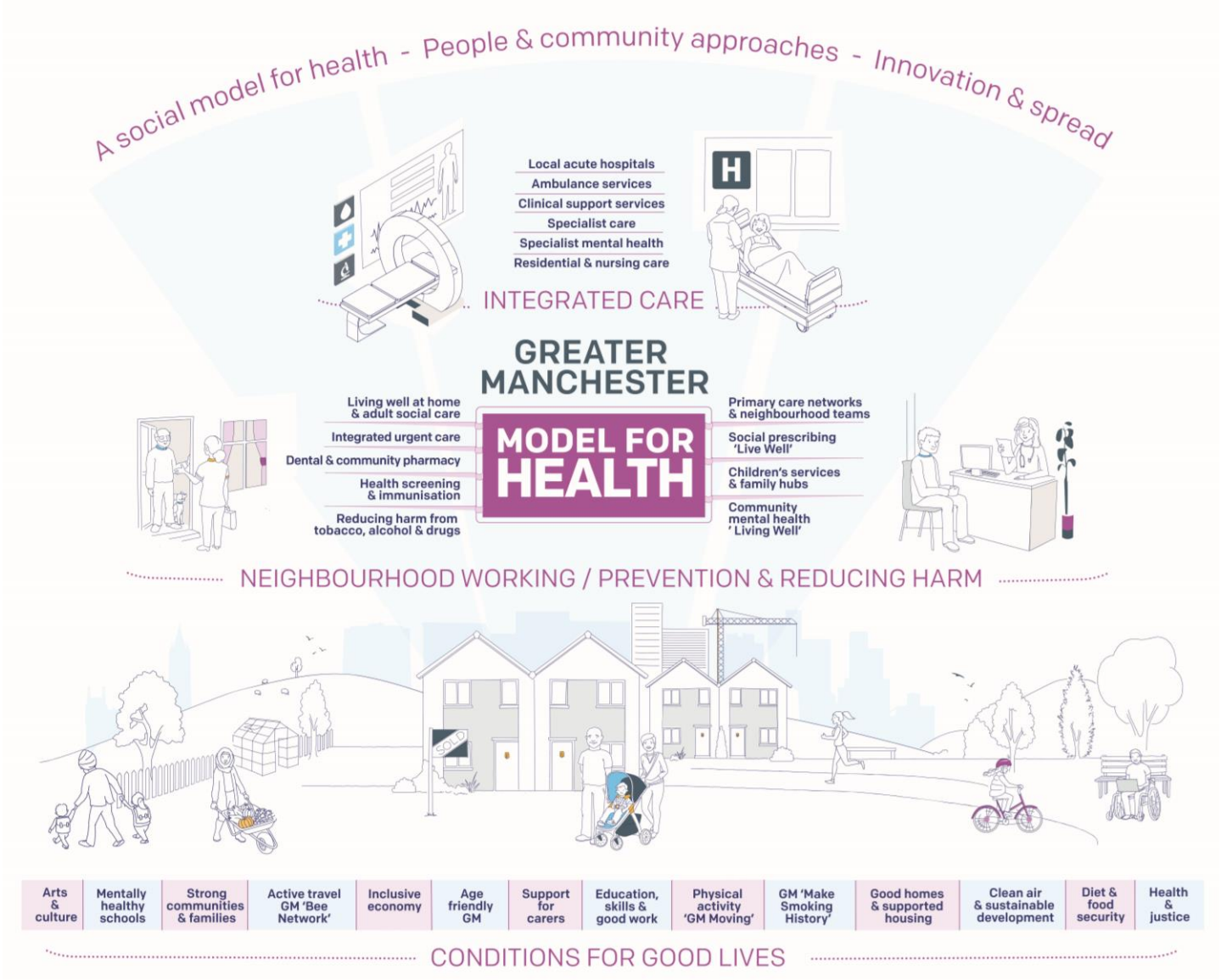
Please submit any final observations to anitarolfe@nhs.net
This final version will be submitted to the June Quality and Performance Committee

Greater Manchester Integrated Care Partnership

ICS Objectives

- Improve Outcomes in Population Health
- Tackle inequalities in health and health care
- Enhance productivity and Value for Money
- Help the NHS support broader social and economic development

ICS Objectives



Quality strategy Context

- Apply evidence based care standards
- Reduce inequities of care
- Improve Care Quality
- Improve Health and Well Being

Quality strategy

NHS Greater Manchester Integrated Care

All stakeholders and partners across **Greater Manchester Integrated Care** agree that we are committed to the shared purpose of people experiencing good quality care.

For the next 5 years, our collective ambition for ***quality*** is to improve people's experience through the delivery of good quality, safe and effective care.

We will do this by the:

- ✓ Good governance of Quality and a common understanding of quality data
- ✓ Delivery of our agreed system wide priorities
- ✓ Delivery of our agreed locality priorities
- ✓ Demonstrating where improvements have been made by measuring our progress.
- ✓ The triple aim of improving health & wellbeing, quality of care and ensuring efficient/sustainable use of resources

These NQB evidence-based principles are commonly featured in other system quality strategies as referenced in the following slide

Delivering Quality. The 6 Key Principles for 23/24 Priorities

NHS Greater Manchester Integrated Care

Based on learning from systems to date, there are six key principles that should underpin decisions around quality in health and care systems:

1. A shared commitment to quality
Partners have a single understanding of quality, which is shared across all services. Partners work together to deliver shared quality improvement priorities and have collective ownership and management of quality challenges.

We will further develop the Quality and Performance Committee to provide strategic leadership and oversight for quality across the ICS
Key principles 1, 3 & 4 (A)

2. Population-focused
Clear quality improvement priorities are based on a sound understanding of quality issues within the context of the local population's needs, variation and inequalities.

Locality Quality Meetings will bring together all partners to oversee quality and will provide Locality Board with a line of sight on people's care experience
Key principles 1, 2, 3 & 6 (C&E)

3. Co-production with people using services, the public and staff
Meaningful engagement ensures that people using services, the public and staff shape how services are designed, delivered and evaluated.

Healthwatch & VCSE will provide the QPC and the Locality Board with a line of sight on people's care experience
Key principles 1, 2, 3 & 6 (D)

4. Clear and transparent decision-making
Partners work together in an open way with clear accountabilities for quality decisions, including ownership and management of risks, particularly relating to serious quality issues.

We will implement the quality governance and assurance mechanisms across the system that reduces duplication and focuses on improvement and sustainability
Key Principles All (A)

5. Timely and transparent information-sharing
Partners share data and intelligence across the system in a transparent and timely way.

We will use existing as well as develop further metrics to understand the impact of quality improvements within our system
Key Principle 5 (A)

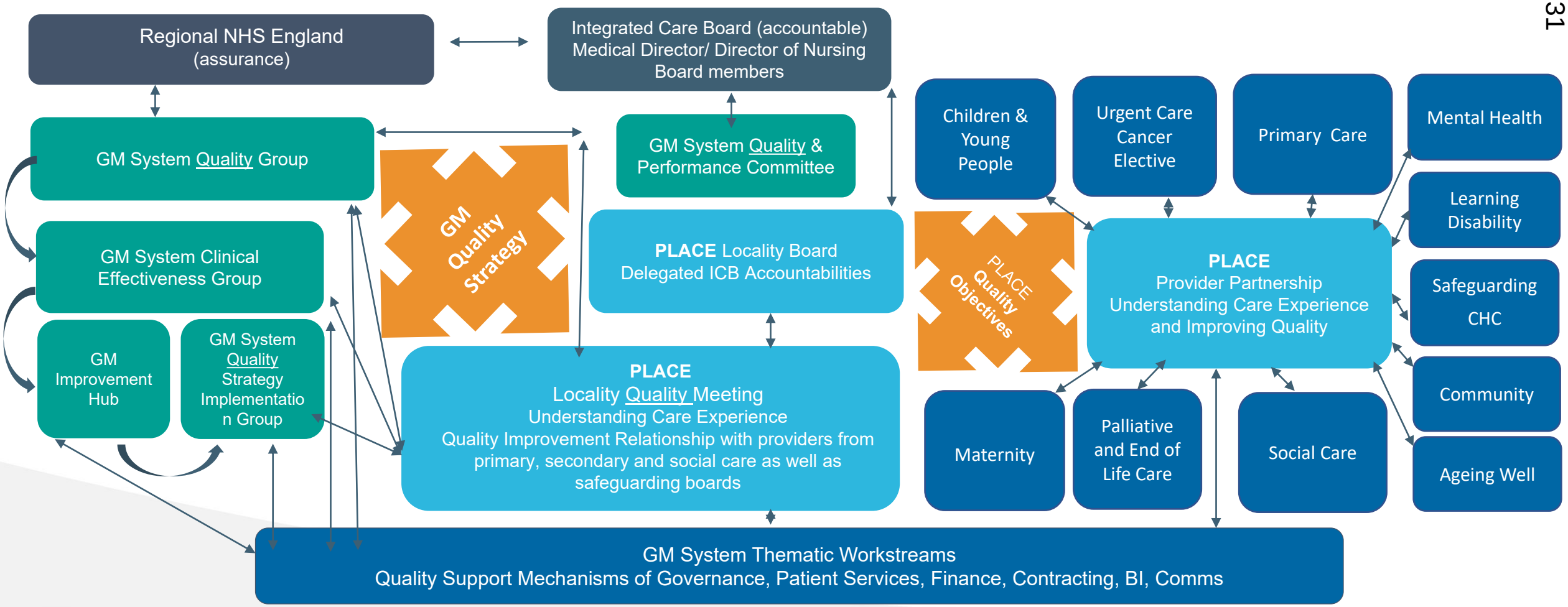
6. Subsidiarity
Management of quality largely take place locally; and is undertaken at scale where there is a need to improve the health and wellbeing for the local population.

We will continue to work to develop a shared definition, vision & understanding of quality to establish a single view of quality across health and social care, including the voluntary & 3rd sector
Key Principles 1, 2 & 6 (B)

Understanding Care Experience to identify years 2- 5 priorities for improvement
Key Principles All
Based on NQB Shared Commitment to Quality – Refreshed edition, April 2021

GM Quality Architecture – A joined up approach

NHS Greater Manchester Integrated Care



The architecture is complex due to the size of the GM system and the expectation of all partners to improve care and reduce inequalities in care experience

Quality strategy

NHS
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Integrated Care

All stakeholders and partners across **Greater Manchester Integrated Care** agree that we are committed to the shared purpose of people experiencing good quality care, and the NQB quality wheel has been adapted to reflect the comments received from those who responded during the engagement phase.

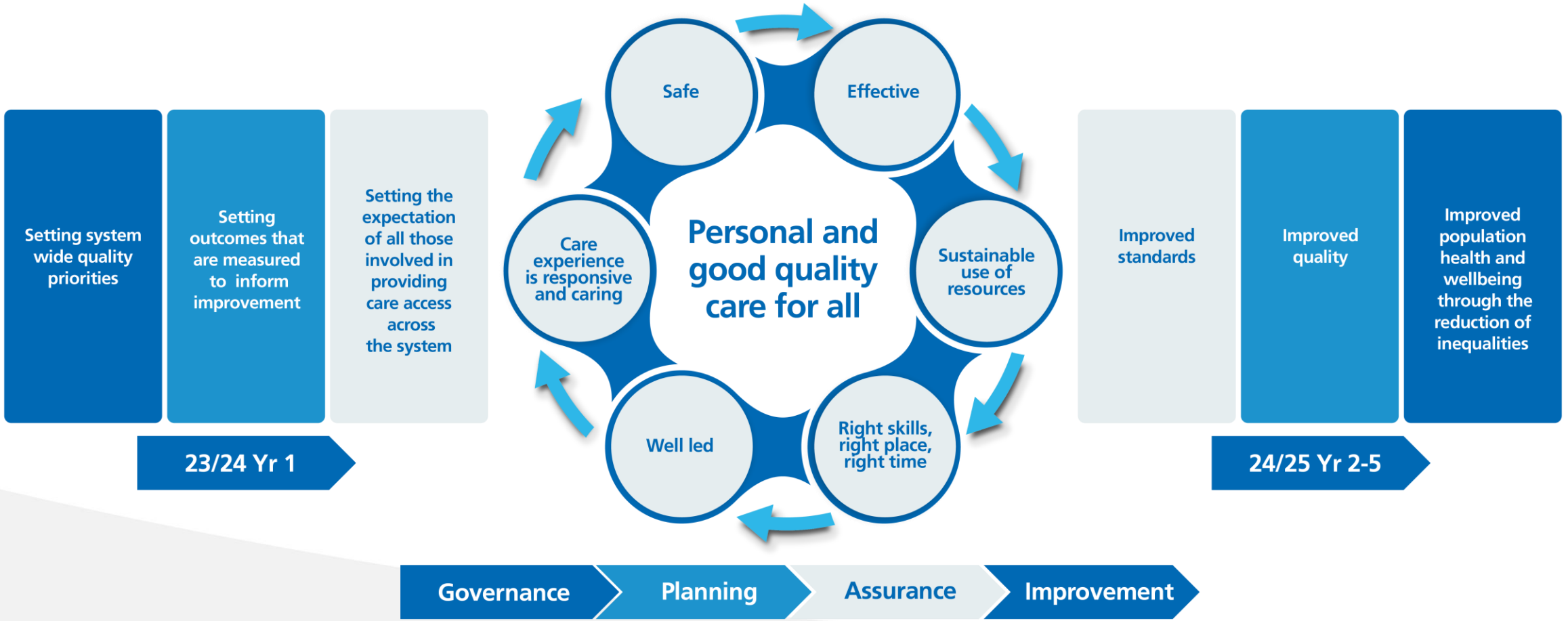
During the next 5 years, we will work to achieve our agreed priorities demonstrating that we are committed to providing a personalised care experience that is:

- ✓ Safe
- ✓ Caring
- ✓ Responsive
- ✓ Effective
- ✓ Well led
- ✓ Timely
- ✓ An efficient use of resources
- ✓ Meeting the required standard
- ✓ Provided by staff with the right skills
- ✓ Provided in the right place
- ✓ Well planned
- ✓ Well governed
- ✓ Continuously improving

Year 1 will focus on developing the quality priority workstreams and finalising the emerging quality governance assurance processes.

Our shared purpose for quality

NHS Greater Manchester Integrated Care



Establishing the ICS quality strategy in Year 1 2023-24 system priorities

NHS Greater Manchester Integrated Care

All stakeholders and partners across **Greater Manchester Integrated Care** agree that we are committed to the shared purpose of people experiencing good quality care.
For 23/24, our shared purpose is to put the foundations for the ICS quality strategy in place to enable us to renew our focus on good quality, safe and effective care for all.

Key Priorities for year 1 will be

- ✓ Ensuring good governance of Quality Assurance for the ICB and a common understanding of quality data.
- ✓ Establishing and embedding our integrated care system wide priorities for areas of quality improvement
- ✓ Establishing and embedding locality quality arrangements for areas of quality improvement
- ✓ Demonstrating where initial improvements have been made by measuring our progress as a system.
- ✓ Confirming that the quality ambitions for years 2-5 meet the triple aim of improving health & wellbeing, quality of care and are an efficient/sustainable use of resources

Establishing the ICS quality strategy in Year 1 2023-24 system priorities

NHS Greater Manchester Integrated Care

Priority 1. Ensuring good governance of Quality Assurance for the ICB and a common understanding of quality data.

ICB QPC

- Assures Quality through the further development of clear governance processes
- Provides strategic leadership to the system in relation to the quality escalation processes,
- Development of the ICS data pack for Quality
- Set clear standards to measure outcomes by
- Sets a just culture for the system
- Relationship development and maintenance with regulators to set clear standards for professionals and organisations

Locality Board

- Provides strategic leadership to the locality in relation to the quality escalation processes
- Has a Locality Quality Meeting in place that brings together all partners to discuss provider care quality and provider quality improvement
- Has a line of sight for quality from all providers, holding partners to account for continuous improvement of care experience
- Coproduction with local people and communities to shape the design and delivery of services
- Sets a just culture for the locality
- Collaboration to ensure seamless pathways between services and identify quality issues

Quality Strategy Implementation Group

- Membership representative of all parts of the system (from each locality and each subject)
- Collaboratively develops the year 2- 5 priorities
- Supports the delivery of year 1 priorities through identification of a delivery plan and implementation of agreed actions
- Reports on progress to the GM System Quality Group that leads on the joint approach to quality improvement
- Collaborate with universities and HEI to set a framework for research and innovation

Establishing the ICS quality strategy in Year 1 2023-24 system priorities

NHS Greater Manchester Integrated Care

Priority 2. Establishing and embedding our integrated care system wide priorities for areas of quality improvement
Priority 3. Establishing and embedding locality priorities for quality improvement

ICB QPC

- Assures Quality of Care across the system
- Will apply particular focus on reducing inequalities
- Provides strategic leadership to the system to ensure the quality objectives are being developed in line with the year 1 Quality Strategy Timeline
- GM System Quality Group (strategic quality improvement group) to triangulate data and evidence
- Share learning and best practice

Subject Leads for the system

- Agree evidence based Quality Priorities for each subject of Urgent Care, Cancer, Elective Care, Primary care, Palliative and End of Life Care, Social Care, Community Care, Mental Health, Maternity, Learning Disability, Safeguarding, CHC, Children and Young People, Ageing Well, Workforce development , patient services,
- Set year 2- 5 quality improvement plans
- Agree and Confirm the subject specific priorities to the Quality Strategy Implementation Group ,
- Inform commissioning intentions of improvements needed to care that reduce inequality
- Share learning and best practice

Locality Board

- Has established a Locality Quality Meeting to enable locality understanding of care quality, and agrees the care quality objectives for the locality
- Has a line of sight for quality from all providers
- Identifies the locality quality improvements specific to the locality
- Coproduction with people and communities and VCFSE groups to enable optimal well being
- Share learning and best practice

Quality Strategy Implementation Group

- Membership representative of all parts of the system
- Collaboratively develops the year 2- 5 priorities (with each locality and each subject lead)
- Supports the delivery of year 1 priorities
- Share learning and best practice

Establishing the ICS quality strategy in Year 1 2023-24 system priorities

NHS Greater Manchester Integrated Care

Priority 4. Demonstrating where improvements have been made by measuring our progress.
Priority 5. The triple aim of improving health & wellbeing, quality of care & ensuring efficient/sustainable use of resources

ICB QPC

- Assures Quality by referencing the ICS Quality Data Pack
- Will consider the GM Clinical and Care Audit Programme Summary
- Will receive thematic feedback of care from Healthwatch
- Will receive thematic Patient Safety Information
- Will be supported by ICS comms to share the improvements made

Subject Leads for the system

- Has a Locality Quality Meeting in place that considers local audits of care in line with the GM Clinical and Care Audit Programme
- Has a line of sight for quality from all providers
- Supports the locality delivery of year 1 priorities that will include accessing the live learning system, (once established), and a clinical and care audit programme (when esrablished) to test whether learning has been embedded (This will include learning from Incidents, Domestic Homicide Reviews, Serious Case Reviews (children and adults), Coroners Reports, PHSO recommendations, Thematic Learning from Complaints, Leder Reports, and CQC reports

Locality Board

- To agree the Clinical and Care Governance objectives
- To agree and undertake Clinical and Care Audits
- To agree and coordinate research

Quality Strategy Implementation Group

- Membership representative of all parts of the system
- Collaboratively develops the year 2- 5 priorities
- Supports the delivery of year 1 priorities that will include a live learning system and a clinical and care audit programme to test whether learning has been embedded (This will include learning from Incidents, Domestic Homicide Reviews, Serious Case Reviews (children and adults), Coroners Reports, PHSO recommendations, Thematic Learning from Complaints, Leder Reports, and CQC reports
- Supports the preparation and delivery of the GM Audit Programme
- Will lead the GM Quality Awards in March 24 that will recognise outstanding contributions to improving care

Next Steps - Quality Strategy Delivery Group
Action focussed, Understanding our progress

NHS Greater Manchester Integrated Care

All stakeholders and partners across Greater Manchester Integrated Care agree that we are committed to the shared purpose of people experiencing good quality care. It is important that the quality strategy is recognised and understood by all parts of the system, and is as relevant to a General Practice Nurse working in a single handed practice, as it is to a physiotherapist working in a large acute hospital. Those who responded during the engagement phase suggested plans for improvement for specific areas, and it was made clear that the implementation of the quality strategy will be achieved through a series of improvement actions that contribute to the overall shared purpose.

The delivery and coordination of the individual components of the quality strategy will therefore be managed by the Quality Strategy Delivery Group. The membership will include representation from the 10 locality quality groups, Healthwatch, and other system partners.
Through collaboration and coproduction, there will be agreement of key quality improvement priorities that the GM system will work towards for years 2- 5. Regular quarterly updates to be provided to QPC with a summary report at each year end.

There will be an inaugural meeting of the SQDG in early June that will agree and establish the initial work plan.

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Quality strategy delivery group

The engagement process identified these areas as priorities for the Quality Strategy Work Plan

- Care Home Standards
- Celebrating Good Practice and what we do well
- CQC Assessment of the System
- CCPL Workforce Development
- Independent provider quality assurance process
- Celebrating and rewarding good practice
- Primary Care Quality Oversight
- Restore 2 – A standardised approach to identifying deterioration in care homes
- Improving diabetes care
- Safeguarding
- Achieving the 6 standards of the Children and Young People Strategy
- Maternity Achieving Ockenden Standards
- Improving nutrition and hydration
- Establishment of a Clinical Audit Programme
- Reducing the use of antibiotics
- Locality Quality Improvement to inform Locality Boards
- Reducing inequalities by improving care for those with a Learning Disability
- Supporting providers who are in 'SOF' escalation process
- Establishment of a research programme
- Improving the timeliness of care / reducing waiting times
- Improving End of Life and Palliative Care
- A live learning system to embed learning
- Improving flow and discharge
- Medicines Management
- Building coproduction into everything we do

Note: These early priorities will need discussion and planning.
Other suggestions are still welcomed and will be included in the 5 year work plan

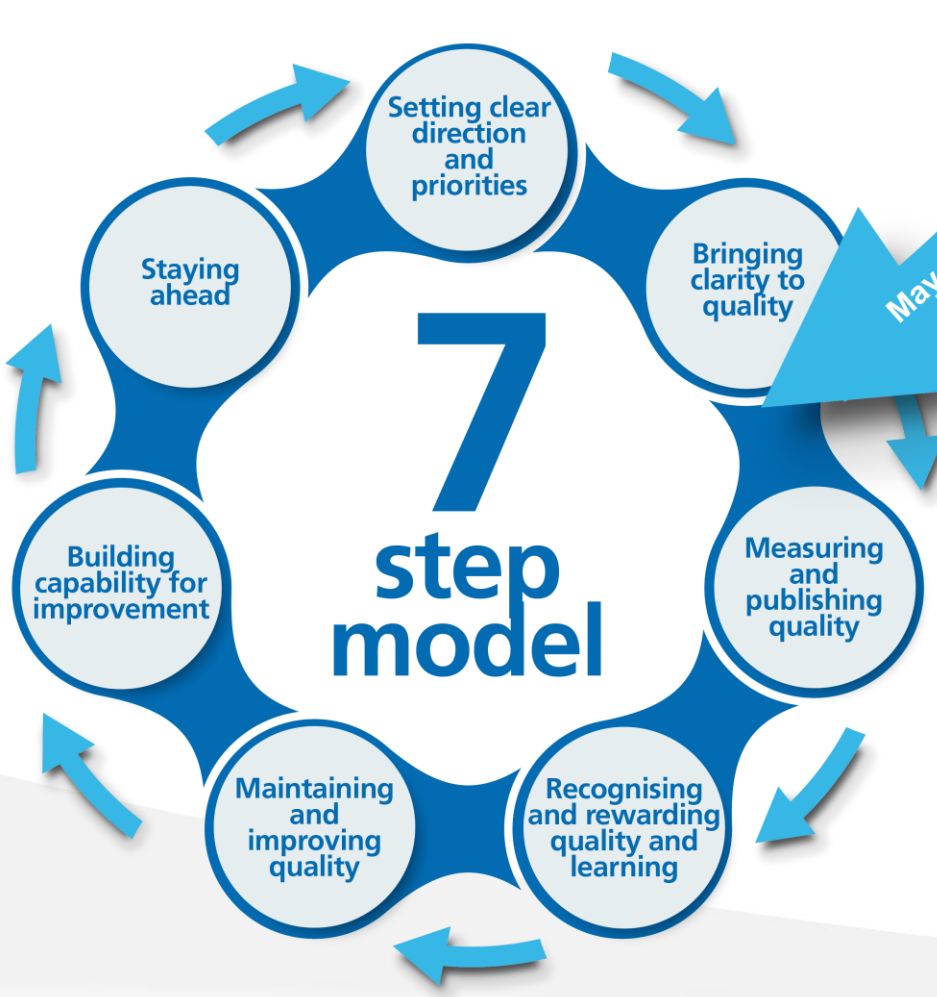
Meeting the National Quality Board (NQB) Requirements of the ICS

NHS Greater Manchester Integrated Care

Quality Principles- System Priorities & Responsibilities	Timeline	Update
1- A designated executive clinical lead for quality, including safety, in the ICS and clinical and care professional leaderships embedded at all levels of the system.	Completed	Mandy Philbin Chief Nursing Officer
2- Population focused vision: Clear vision and credible strategy to deliver quality improvement across the ICS, which draws together quality planning, quality control, quality improvement and assurance functions to deliver care that is high-quality, personalised and equitable	June 2023 ✓ On Track	Engagement with all partners during March to gauge opinion and enable contribution – completed Presentation of final document at June Quality and Performance Committee (QPC)
3- Co-production with people using services, public and staff- A defined governance and escalation process in place for quality oversight – covering all NHS and local authorities (included devolved direct commissioning functions)	Completed	The GM QA escalation process was approved at March 2023 QPC . The first process to be implemented is for NHS Trusts. This process is being adapted to support Primary Care, and the Independent sector
4- Clear and transparent decision making- An agreed way to measue quality, including safety, using key quality indicators triangulated with intelligence and professional insight, which is reported publicly and transparently at Board-level to inform decision-making and effective management of quality risks.	June 2023 ✓ On Track	Outcomes and metrics in development to be shared with QPC in June
5- Timely and transparent information sharing- A defined way to engage and share intelligence on quality, including **safety - at least quarterly and delivered through a system Quality Group**	Completed	SQG is well developed and is already meeting. Quality and Performance Committee is established
6. Subsidiary- A defined approach for the transfer and retention of legacy organisation information on quality in accordance with the Caldicott Principles.	Completed	Completed through CCG – ICS due diligence handover.

Delivering Quality – NQB Seven Steps ICS Ambitions

NHS Greater Manchester Integrated Care



5 Year Plan approved at ICS Quality Committee in June 2023

1 **Setting clear direction and priorities**
To deliver a new service model for the 21st century, which delivers better services in response to local needs, invests in keeping people healthy and out of hospital, and is based on clear priorities, including a commitment to reducing health inequalities.

2 **Bringing clarity to quality**
setting clear standards for what high quality care and outcomes look like, based on what matters to people and communities.

3 **Measuring and publishing quality**
Measuring what matters to people using services, monitoring quality and safety consistently, sharing information in a timely and transparent way, using data effectively to inform improvement and decision-making.

4 **Recognising and rewarding quality and learning**
Recognising, celebrating and sharing outstanding health and care, learning from others and helping others learn, recognising when things have not gone well.

5 **Maintaining and improving quality**
Working together to maintain quality, reduce risk and drive improvement.

6 **Building capability for improvement**
Providing multi-professional leadership for quality; building learning and improvement cultures; supporting staff and people using services to engage in coproduction; supporting staff development and wellbeing.

7 **Staying ahead**
By adopting innovation, embedding research and monitoring care and outcomes to provide progressive, high-quality heath and care policy.

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Agenda Item 12

BURY INTEGRATED CARE PARTNERSHIP

Meeting: Locality Board			
Meeting Date	5 June 2023	**Action**	Receive
Item No.	12	**Confidential**	No
Title	Workforce update		
Presented By	Kath Wynne – Jones, Chief Officer, IDC		
Author	Kat Sowden, SRO Workforce		
Clinical Lead	n/a		

Executive Summary
Update on ongoing programmes of work within Workforce workstream – OD and workforce strategy development.
Recommendations
For information

OUTCOME REQUIRED *(Please Indicate)*	**Approval** ☐	**Assurance** ☐	**Discussion** ☐	**Information** ☒
APPROVAL ONLY; (please indicate) whether this is required from the pooled (S75) budget or non-pooled budget	**Pooled Budget** ☐	**Non-Pooled Budget** ☐		

Links to Strategic Objectives	
SO1 - To support the Borough through a robust emergency response to the Covid-19 pandemic.	☐
SO2 - To deliver our role in the Bury 2030 local industrial strategy priorities and recovery.	☐
SO3 - To deliver improved outcomes through a programme of transformation to establish the capabilities required to deliver the 2030 vision.	☒
SO4 - To secure financial sustainability through the delivery of the agreed budget strategy.	☐
Does this report seek to address any of the risks included on the NHS GM Assurance Framework?	☐

Implications						
Are there any quality, safeguarding or patient experience implications?	Yes	☐	No	☐	N/A	☒
Has any engagement (clinical, stakeholder or public/patient) been undertaken in relation to this report?	Yes	☒	No	☐	N/A	☐
Have any departments/organisations who will be affected been consulted ?	Yes	☐	No	☐	N/A	☒
Are there any conflicts of interest arising from the proposal or decision being requested?	Yes	☐	No	☐	N/A	☒
Are there any financial Implications?	Yes	☐	No	☐	N/A	☒
Is an Equality, Privacy or Quality Impact Assessment required?	Yes	☐	No	☐	N/A	☒
If yes, has an Equality, Privacy or Quality Impact Assessment been completed?	Yes	☐	No	☐	N/A	☐
If yes, please give details below:						
If no, please detail below the reason for not completing an Equality, Privacy or Quality Impact Assessment:						
Not required. Report for information only. Due process will be followed when workforce strategy is completed						
Are there any associated risks including Conflicts of Interest?	Yes	☐	No	☐	N/A	☒
Are the risks on the NHS GM risk register?	Yes	☐	No	☐	N/A	☒

Governance and Reporting		
Meeting	**Date**	**Outcome**
Strategic Workforce Group	01/05/2023	Update only on developing workforce strategy

BURY INTEGRATED CARE PARTNERSHIP

Workforce Update

1. Introduction

1.1. This paper provides an update on ongoing workforce initiatives including system wide organisation development and producing the Bury workforce strategy.

2. Background

2.1 Following the launch of the Greater Manchester People and Culture Strategy on 9th March 2023, Bury is required to produce a system wide workforce strategy aligned with the GM document bespoke to Bury locality.

2.2 Workforce workstream continues to support the transformation programmes as an enabler. The workforce hub enables delivery of system wide OD programmes, system wide national training initiatives and locality based ethnography and strength based training.

3. Workforce update

3.1 Kat Sowden, Managing Director at Persona Care and Support is taking forward the SRO role for Workforce.

3.2 The Bury workforce team has met with key workforce representatives from partner organisation to understand individual organisation's workforce strategy and/or workforce ambitions, to align these with the GM People and Culture strategy priorities. Each organisation's HRD/CE/CO have signed off their organisation's workforce strategy and agreed the 5 principle priorities within GM as being representative of Bury locality. This includes VCFA, Primary Care and Independent providers. A workforce workshop is scheduled for 6th July to progress the workforce priorities, agreeing the key outcomes, metrics, actions and workstream representation to progress the priorities, prior to presentation at the Strategic Workforce Group and subsequently the IDC board. Once the strategy is completed, it will be submitted to Greater Manchester People Committee by Kat Sowden, SRO for Workforce on behalf of the locality. It is anticipated that this will occur by the end of August 2023.

3.3 The five priorities outlined in the GM strategy are:

1.3.1. Workforce Integration
1.3.2. Good Employment
1.3.3. Workforce Wellbeing
1.3.4. Addressing Inequalities
1.3.5. Growing and Developing our Workforce

3.4 Conversations across the system have demonstrated a strong commitment to shift more towards a distributed leadership approach; maximising the strengths of partners in leading specific areas of work with the Workforce Hub as facilitators and enablers. There has also been a shared intention to ensure that the strategy is clear and unambiguous in it's focus; identifying a small number of significant priorities where a demonstrable impact can be achieved and a shift towards measuring outcomes and impact as well as input and activity.

3.5 A development programme has commenced to support the SROs and Clinical Leaders for the transformation programmes and enabling functions in clarifying roles and responsibilities and understanding support/development requirements. This session was also designed to support the SROs to understand the requirements to undertake a baselines assessment of their programmes, identify their key priorities and metrics. The next event will occur on 5th July 2023.

3.6 The workforce hub continues to support the transformation programmes providing expert HR knowledge, advice and guidance including the diagnosis, design and delivery of a number of OD programmes system wide. A number of programmes are currently being supported with key session design and delivery to support the West Neighbourhood Plan Priorities in determining improvement areas for Trauma/ACES services. Also an Independent Provider event (approx. 30 attended) was delivered in partnership with UTS and Bury MBC on the 18th May to identify collective workforce challenges which impact on the provision of their service delivery in the system. The next step is to propose/implement collaborative support offers to assist the Providers in addressing their workforce challenges.

3.7 The hub also continues to deliver ethnographic and strength based training across the system and to date more than 1000 health and social care professionals have been trained. The nationally dictated mandatory Oliver McGowan Training is to be supported within the framework of the current system wide training infrastructure focussed on those organisations who are not in a position to deliver the programme of training within their own resources

3.8 A system wide recruitment event for entry level health and social care practitioners will take place in July 2023 in Bury Town Hall.

4 Associated Risks

4.1 Reduction in workforce hub resources by 1 WTE (FTC ending in August 2023) plus current 1WTE vacancy (progressing via recruitment) with remaining 1 WTE postholder supporting the workforce requirements with support from AD of Workforce.

4.1.1 Increased requirements for support from transformation programmes.
4.1.2 Specific requirement for dedicated resource to support system wide Oliver McGowan training.
4.1.3 Delivery against the commitment to take a more distributed leadership approach.
4.1.4 Availability of workforce data across the system to monitor impact and outcomes.

5 Recommendations

5.1 For information only at this stage.

6 Actions Required

6.1 To continue to encourage commitment to the workforce programme from partner organisations and active engagement with a more distributed leadership approach.

Kat Sowden - Kat.Sowden@personsupport.org
May 2023

Agenda Item 13

BURY INTEGRATED CARE PARTNERSHIP

Meeting: Locality Board			
Meeting Date	05 June 2023	**Action**	Receive
Item No.	13	**Confidential**	No
Title	Health and Wellbeing Board / Population Health update		
Presented By	Jon Hobday – Director of Public Health		
Author	Jon Hobday – Director of Public Health		
Clinical Lead	N/A		

Executive Summary

The report provides an update on the work of the Health & Wellbeing Board and Population Health Delivery Partnership.

Recommendations

To note the update provided.

OUTCOME REQUIRED *(Please Indicate)*	**Approval** ☐	**Assurance** ☐	**Discussion** ☐	**Information** ☒
APPROVAL ONLY; (please indicate) whether this is required from the pooled (S75) budget or non-pooled budget	**Pooled Budget** ☐	**Non-Pooled Budget** ☐		

Links to Strategic Objectives	
SO1 - To support the Borough through a robust emergency response to the Covid-19 pandemic.	☐
SO2 - To deliver our role in the Bury 2030 local industrial strategy priorities and recovery.	☒
SO3 - To deliver improved outcomes through a programme of transformation to establish the capabilities required to deliver the 2030 vision.	☒
SO4 - To secure financial sustainability through the delivery of the agreed budget strategy.	☒
Does this report seek to address any of the risks included on the NHS GM Assurance Framework?	☐

Implications						
Are there any quality, safeguarding or patient experience implications?	Yes	☐	No	☒	N/A	☒
Has any engagement (clinical, stakeholder or public/patient) been undertaken in relation to this report?	Yes	☒	No	☐	N/A	☒
Have any departments/organisations who will be affected been consulted ?	Yes	☐	No	☐	N/A	☒
Are there any conflicts of interest arising from the proposal or decision being requested?	Yes	☐	No	☐	N/A	☒
Are there any financial Implications?	Yes	☐	No	☐	N/A	☒
Is an Equality, Privacy or Quality Impact Assessment required?	Yes	☐	No	☐	N/A	☒
If yes, has an Equality, Privacy or Quality Impact Assessment been completed?	Yes	☐	No	☐	N/A	☒
If yes, please give details below:						
If no, please detail below the reason for not completing an Equality, Privacy or Quality Impact Assessment:						
Are there any associated risks including Conflicts of Interest?	Yes	☐	No	☐	N/A	☒
Are the risks on the NHS GM risk register?	Yes	☐	No	☐	N/A	☒

Governance and Reporting		
Meeting	**Date**	**Outcome**
N/A		

BURY INTEGRATED CARE PARTNERSHIP

Health & Wellbeing Board update

1. Introduction

1.1 The report provides an update on the work of the Health & Wellbeing Board and Population Health Delivery Partnership

2. Background

2.1 The Health and Wellbeing Board has been established to act as a 'Standing Committee' within the Bury locality system architecture to focus on driving and coordinating action across all stakeholders to improve population health and reduce health inequalities.

2.2 The Board has adopted the Greater Manchester adapted Kings Fund Model of a Population Health System as a framework of delivery and the agenda is structured around the 4 quadrants within the model:

- Wider Determinants of Population Health
- Behavioural and Lifestyle determinants of health
- The effect of place and community on health and well being
- The operation of the health and care system, and wider public service reform, in pursuit of population health gain

2.3 A Population Health Delivery Partnership chaired by the Director of Public Health has been established to support the work of the Health & Wellbeing Board, facilitate the development of Bury as a 'Population Health System' and to support system assurance around delivery against the 'Better Health' element of 'Triple Aim'.

3. Summary of progress

3.1 The last meeting of the Health & Wellbeing Board was held on the 28th March where the following items were discussed:

3.2 *Anti-Poverty Strategy Update.*

This is a standing item since the Health & Wellbeing Board took responsibility for the strategy on behalf of Team Bury. The Board noted the progress around the anti-poverty action plan which included an update around the most recent GM survey data on the impacts of the cost of living. There was challenge around the use of food and fuel vouchers and how we needed to move towards a cash first offer of support in line with best practice to ensure dignity and choice. We were also challenged to review our offer of support to new parents and whether we had baby bank offer. Since the HWB met we have made significant progress providing a cash support offer and coordinating our baby bank offer putting all the information online. In addition a third anti-poverty summit took place on 11th May where all key stakeholders agreed the use of the national household support fund of just over £3million from central government.

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3.3 Health related behaviours - Age Well Agenda

The Board received an overview from the integrated commissioning officer for older people and ageing well. The presentation highlighted that people are now living longer in poor health, there is increased amounts of socially isolated and lonely older people. In addition many older people are unpaid carers and we have more people with dementia and long term conditions than ever before. An overview of some of the positive work taking place was provided including the winter well campaigns, ageing well in place work, the frailty programme and the age friendly community work, including the older peoples network.

3.4 Health care services – Screening Programmes Update

The board received an update on the screening figures and work that is happening locally. The overview of local performance highlighted that breast screening and chlamydia screening levels were good, in contrast Bury has poor performance in new born hearing, abdominal aortic aneurysm, cervical and bowel screening. Example were provided on the good work that is happening to increase bowel screening through work with the Primary Care Networks (PCN's) and the voluntary community sector.

3.5 Wider determinants – Public Sector Reform, Improving Adult Lives

A summary of the improving adult lives work was provided including a pilot programme of work which is being run in Radcliffe to support a cohort of adults with complex health and social care needs. All the learning from the pilot has been collated and key issues affecting people's health and wellbeing included social concerns around issues such as neglect, domestic abuse, substance misuse and housing disrepair. From a support perspective the impact of cold referrals between teams and organisations was also highlighted as an area of improvement as was the importance of a strength based coordinated approach to supporting residents. Key opportunities for developments flagged included the importance of ownership of cases and not just lead professionals, and working more closely when individual are transitioning across from children to adults.

3.6 Wider determinants – Serious Violence Duty

The Community Safety Partnership Manager presented the new serious violence duty responsibilities. The responsibility of localities is to identify the kinds of serious violence that occur in Bury and take an evidence based analysis of the causes and develop local needs assessment and local strategy to address these. These duties were discussed and the role and responsibilities of key partners was agreed.

3.7 Population Health Board Update – Joint Strategic Needs Assessment (JSNA)

At the last population health board meeting an update of the JSNA was provided. The Bury JSNA has been developed in consultation with partners and is now an extensive online

resource (https://theburydirectory.co.uk/jsna). The JSNA provides a clear overview of the health and wellbeing of Bury residents including areas of inequalities. The resource is being promoted and shared with partners as it is integral tool to assist in planning, shaping and developing services and provision.

4 Associated Risks

4.1 There are no significant risks in relation to this report

5 Recommendations

5.1 To note the update provided

Jon Hobday
Director of Public Health
j.hobday@bury.gov.uk
June 2023

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Agenda Item 14

BURY INTEGRATED CARE PARTNERSHIP

Meeting: Bury Locality Board			
Meeting Date	5 June 2023	**Action**	Receive
Item No.	14	**Confidential**	No
Title	Bury Health and Care Outcomes and Performance Report		
Presented by	Will Blandamer, Deputy Place Based Lead		
Author	Helen Smith, Head of Strategic Intelligence and Performance		
Clinical Lead	-		

Executive Summary

This paper is a trial of new reporting for Locality Board during 2023 following feedback at the end of last year. A review of products that are provided across the refreshed Health and Care Governance in the locality which has identified where reporting can be either streamlined, aligned with GM reporting or where there are gaps for new products to be produced. This report will provide a high level activity and demand summary of the key work areas along with a placeholder and opportunity to escalate issues from both the IDC Board and the Children's Strategic Partnership Board.

Recommendations

It is recommended that the Locality Board:

- Acknowledge the current performance across the system
- Provide feedback on the new style of reporting
- Agree to this new style of reporting going forward

Links to Strategic Objectives

SO1 - To support the Borough through a robust emergency response to the Covid-19 pandemic.	☒
SO2 - To deliver our role in the Bury 2030 local industrial strategy priorities and recovery.	☐
SO3 - To deliver improved outcomes through a programme of transformation to establish the capabilities required to deliver the 2030 vision.	☒
SO4 - To secure financial sustainability through the delivery of the agreed budget strategy.	☐
Does this report seek to address any of the risks included on the NHS GM Assurance Framework?	☐

Implications

Are there any quality, safeguarding or patient experience implications?	Yes	☒	No	☐	N/A	☐
Has any engagement (clinical, stakeholder or public/patient) been undertaken in relation to this report?	Yes	☒	No	☐	N/A	☐
Have any departments/organisations who will be affected been consulted ?	Yes	☒	No	☐	N/A	☐

Implications						
Are there any conflicts of interest arising from the proposal or decision being requested?	Yes	☐	No	☒	N/A	☐
Are there any financial Implications?	Yes	☐	No	☒	N/A	☐
Is an Equality, Privacy or Quality Impact Assessment required?	Yes	☐	No	☒	N/A	☐
If yes, has an Equality, Privacy or Quality Impact Assessment been completed?	Yes	☐	No	☐	N/A	☒
If yes, please give details below:						
If no, please detail below the reason for not completing an Equality, Privacy or Quality Impact Assessment:						
Are there any associated risks including Conflicts of Interest?	Yes	☐	No	☒	N/A	☐
Are the risks on the NHS GM risk register?	Yes	☐	No	☐	N/A	☒

Governance and Reporting		
Meeting	**Date**	**Outcome**

Bury Health and Care Outcome and Performance Report

1. Introduction

This paper is a trial of new reporting for Locality Board during 2023 following feedback at the end of last year. It provides a summary of the activity around reviewing the performance products available through alignment of reporting with NHS GM ICS. It also provides a high level summary of current demand and activity across health and social care.

2. Product Review Update

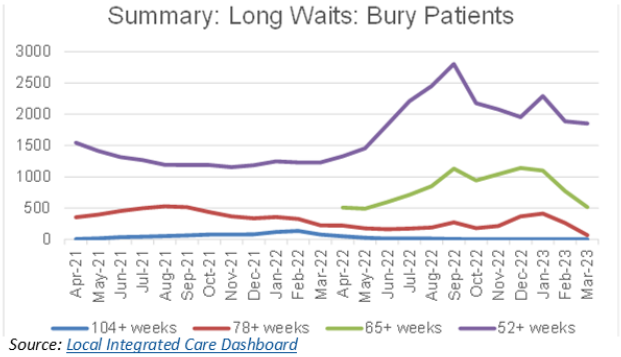
The following Boards have met with the Head of Strategic Performance and Intelligence and initial requests for meeting support and products have been discussed:

- System Assurance Committee
- IDC Board
- Children's Safeguarding Partnership

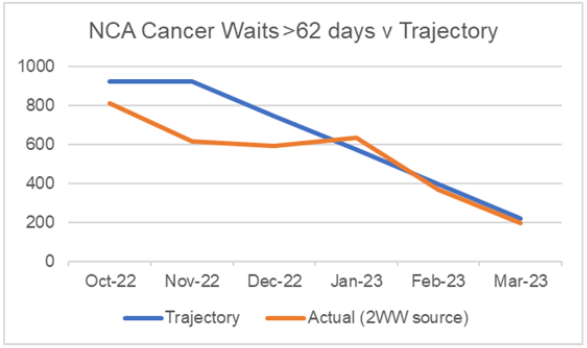
It has been requested that the attached dashboard is shared with the Locality Board and other meetings as a useful position on the constitutional metrics. Please note however it is expected that this dashboard will be replaced by a GM product in the future (see appendix 1).

3. Locality Board Performance Overview

Elective Care and Cancer



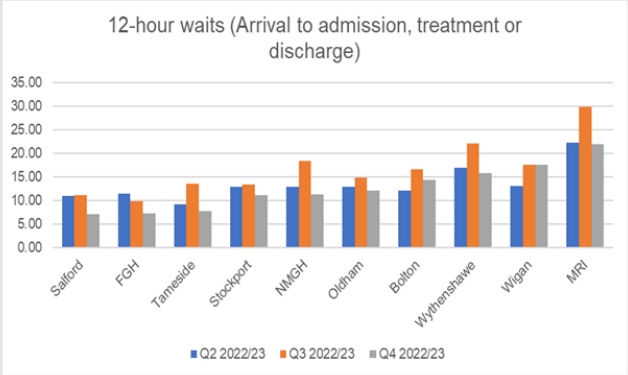
Source: Local Integrated Care Dashboard



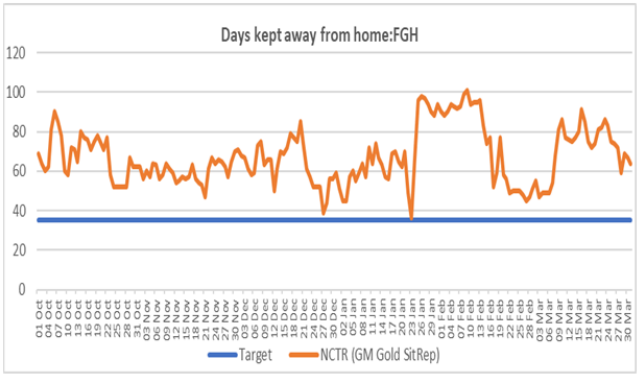
Source: Locality Board data source

- Oct, Nov & Dec elective waits impacted by lack of MFT data. Published Mar data now includes MFT and does though show a 0.1% decrease in wtg list compared to Sep 22.
- Immediate target is to eliminate 78+ week waits by Apr 23. These have decreased on Sep figure by 75% in Mar. Primarily the decrease is across all specialties, except Ophthalmology has an increase of 50% in Mar on Sep figures, although numbers still remain low with 3 waiters. GM expected there to be approx 675 78+ week waits at end of March, figures show there are 1054.

Urgent Care



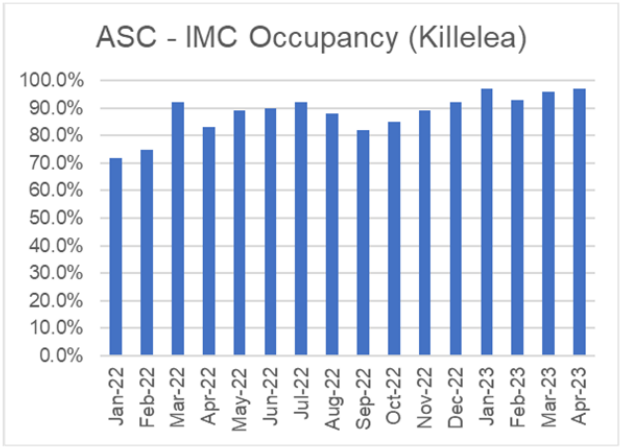
Source: Local Urgent Care reporting



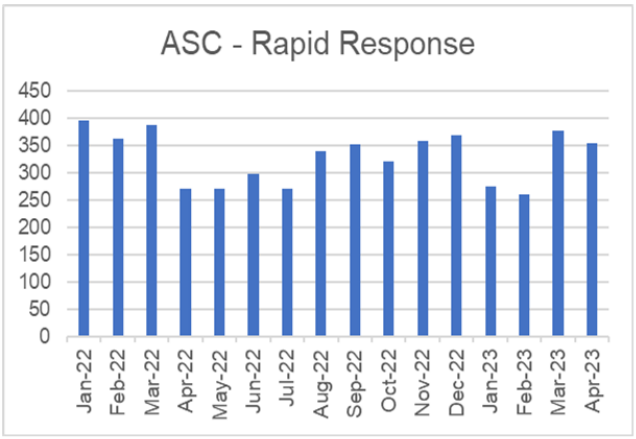
Source: Local Urgent Care reporting

- Req for <2% of A&E waits to exceed 12 hours. FGH best adult site in GM in Q3. In Q4, FGH is 2nd best behind Salford.
- DKAFH target of 35 for FGH achieved just once in 22/23. Average in Mar decreased slightly to 70 per day from 75 in Feb. Most DKAFH assigned to pathway 1 (care in own home) or 2 (residential care).

Adult Social Care



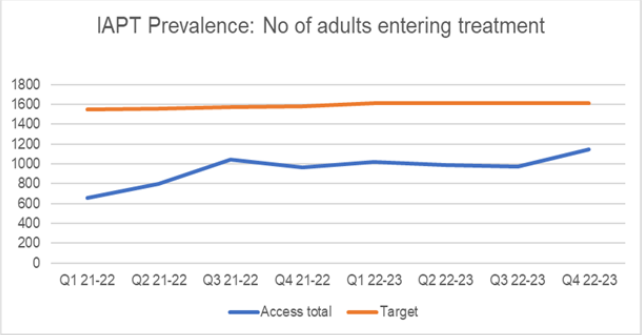
Source: Locality Board data source



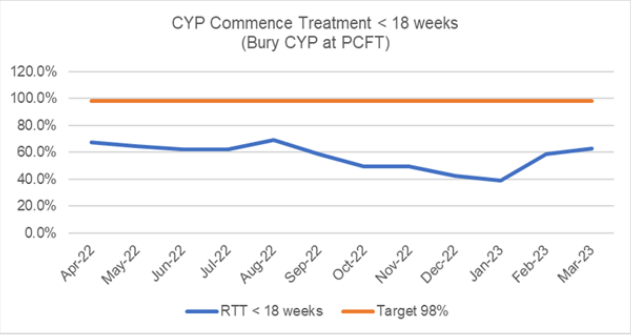
Source: Locality Board data source

- IMC bed occupancy has returned to normal levels following reduction linked to COVID-19 related closures, with a current length of stay of 32 days.
- Bury's Rapid Response team has seen a reduction in Mar (354) from Feb (378).

Mental Health (adults and children)



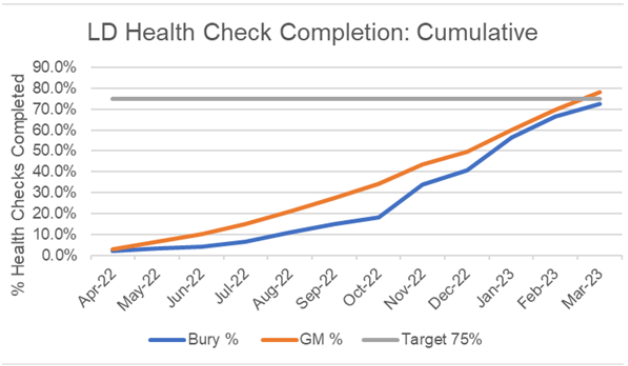
Source: Locality Board data source



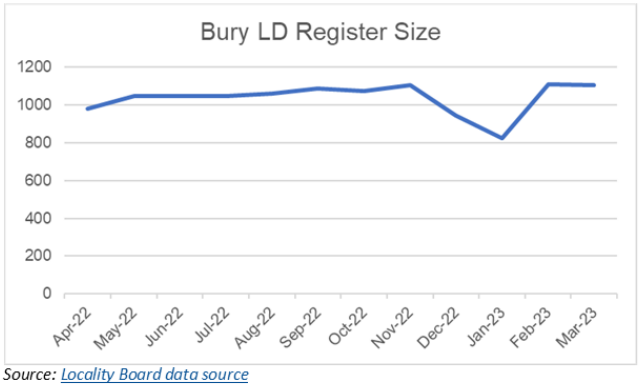
Source: Locality Board data source

- Indicative PCFT IAPT data used for Q2 due to national data issues following transition to ICS structure. Bury's IAPT access continues to be significantly below required level, although Q4 has seen an increase on Q3. System Maturity Tool has been completed and recommendations are currently under review.
- A decline in the proportion of CYP commencing treatment within 18 weeks has been seen at PCFT across 2022/23 and reflects the increasing demand seen since COVID-19. A joint proposed investment plan has been developed for the Bury system which, if approved, would seen increased clinical capacity within the core CAMHS service. February and March have both seen increases from Jan.

Learning Disabilities



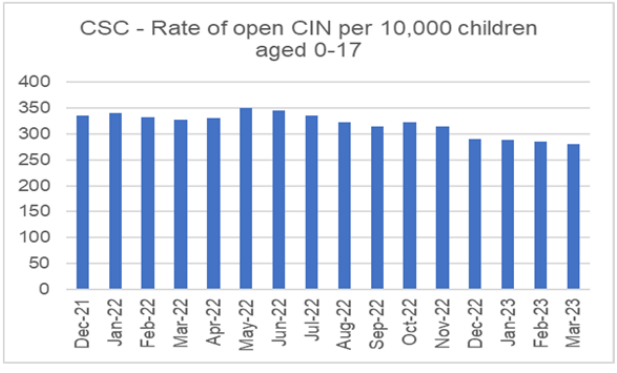
Source: Locality Board data source



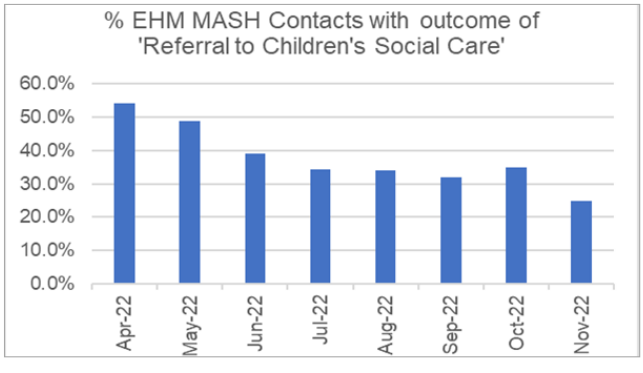
Source: Locality Board data source

- LD Health checks: The cumulative position in 22/23 to Mar shows 72.7% of Bury patients to have received an AHC (though this is based on an incomplete register size as noted in the point below). This compares to 78.3% for GM. Most AHC tend to take place in Q4.
- LD Register: Requirement also to increase the LD register size. Register has increased by 6.8% in the 12 mths to Nov 22 though as shown above a drop in register size is evident in December & January. This relates to data being included for only 23 of Bury's GP Practices. The missing data has been highlighted to the primary care team. Register size has increased from Feb.

Children's Social Care Services



Source: Locality Board data source



Source: Locality Board data source

- Rate of open CIN's has decreased since Nov each month up to Mar.
- % EHM MASH contacts decreased to 24.9% in Nov from 34.8% in Oct.

4. Escalations from IDC Board and CSPB – Placeholder

Board	Escalation	Mitigation	Actions

5. Recommendations

The Board are asked to note the contents of this report.

Helen Smith
Head of Strategic Performance and Intelligence, Bury Council
h.smith@bury.gov.uk
May 2023

Constitution and Must Do Dashboard

Measures									Period Actual Performance 2022-23																		
Indicator	IDC Programme	Description	Cons	Must Do	NHS SOF	F	Monitored Org	Period	Period Target	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Q1	Q2	Q3	Q4
	Adult Social Care Adrian Crook	Active Case Management: No of referrals received into ACM	✗	✗	✗	M	LA	Apr-22	N/A													-				
		ASC: No of referrals received by ASC	✗	✗	✗	M	LA	Mar-23	N/A	310	315	316	324	293	354	336	347	294	373	326	341	-				
		ASC: No of cases awaiting allocation	✗	✗	✗	M	LA	Mar-23	N/A	105	239	246	238	128	177	184	160	188	171	194	213	-				
		ASC: No of Rapid Response referrals	✗	✗	✗	M	LA	Mar-23	N/A	270	270	299	199	339	353	320	359	370	275	260	378	-				
		ASC: % Intermediate Care Bed Occupancy (Killelea)	✗	✗	✗	M	LA	Mar-23	N/A	83.0%	89.0%	90.0%	92.0%	88.0%	82.0%	85.0%	89.0%	92.0%	97.0%	93.0%	96.0%	-	-	-	-	-
		ASC: Intermediate Care: average length of stay (days)	✗	✗	✗	M	LA	Mar-23	N/A	35	26	27	38	29	34	33	34	38	30	31	31	-				
		ASC: % residential & nursing care bed occupancy	✗	✗	✗	M	LA	Mar-23	N/A	90.0%	91.0%	84.0%	83.0%	85.0%	83.0%	83.0%	82.0%	82.0%	82.0%	82.0%	82.0%	-	-	-	-	-
		ASC: No of Medically Optimised Patients	✗	✗	✗	M	LA	Mar-23	N/A	30	17	32	32	26	30	40	40	32	95	90	79	-				
E.B.6	Elective Care and Cancer Cath Tickle	Cancer 2 week waits: GP Referral for suspected cancer	✓	✓	✗	M/Q	ICS (Bury)	Mar-23	93.0%	54.8%	80.6%	69.7%	67.5%	60.5%	53.6%	57.9%	64.1%	57.4%	66.9%	79.5%	81.5%	-	73.9%	60.6%	60.2%	75.9%
E.B.7		Cancer 2 week waits: Urgent referral for breast symptoms where cancer was not initially suspected	✓	✓	✗	M/Q	ICS (Bury)	Mar-23	93.0%	22.9%	29.8%	22.6%	28.3%	38.6%	20.0%	18.8%	36.0%	22.1%	35.6%	38.7%	41.5%	-	25.3%	28.6%	26.7%	38.7%
E.B.27 / S012a		Cancer 28 day waits: Faster Diagnosis	✗	✓	✓	M/Q	ICS (Bury)	Mar-23	75.0%	90.0%	62.0%	44.7%	47.8%	46.0%	45.1%	44.7%	56.7%	54.4%	53.5%	68.7%	72.6%	-	53.9%	46.3%	52.3%	65.0%
E.B.8		Cancer 31 day waits: First definitive treatment within 1 month of diagnosis	✓	✓	✗	M/Q	ICS (Bury)	Mar-23	96.0%	93.3%	92.2%	95.3%	95.7%	94.7%	86.4%	91.1%	94.7%	96.4%	87.5%	94.6%	91.8%	-	93.9%	92.5%	94.1%	91.0%
E.B.9		Cancer 31 day waits: Subsequent cancer treatment - Surgery	✓	✓	✗	M/Q	ICS (Bury)	Mar-23	94.0%	100.0%	100.0%	92.3%	95.0%	90.0%	100.0%	100.0%	100.0%	88.9%	94.1%	92.3%	100.0%	-	96.7%	94.7%	95.2%	96.0%
E.B.10		Cancer 31 day waits: Subsequent cancer treatment - Anti cancer drug regimens	✓	✓	✗	M/Q	ICS (Bury)	Mar-23	98.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	-	100.0%	100.0%	100.0%	100.0%
E.B.11		Cancer 31 day waits: Subsequent cancer treatment - Radiotherapy	✓	✓	✗	M/Q	ICS (Bury)	Mar-23	94.0%	100.0%	96.7%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	97.0%	100.0%	100.0%	-	99.0%	100.0%	100.0%	98.5%
E.B.12 / S011a		Cancer 62 day waits: First definitive treatment within 2 months of urgent GP referral	✓	✓	✓	M/Q	ICS (Bury)	Mar-23	85.0%	46.2%	29.4%	48.0%	47.9%	57.4%	30.6%	46.8%	46.2%	48.8%	40.3%	45.5%	42.6%	-	41.2%	46.2%	47.1%	42.5%
E.B.13		Cancer 62 day waits: First definitive treatment within 2 months of NHS cancer screening referral	✓	✓	✗	M/Q	ICS (Bury)	Mar-23	90.0%	100.0%	50.0%	33.3%	81.8%	42.9%	80.0%	66.7%	90.0%	100.0%	57.1%	100.0%	69.2%	-	61.5%	69.6%	85.7%	68.2%
E.B.14		Cancer 62 day waits: First definitive treatment within 2 months of consultant decision to upgrade priority status	✓	✓	✗	M/Q	ICS (Bury)	Mar-23	85.0%	70.0%	80.0%	84.2%	65.0%	73.7%	60.0%	76.0%	78.6%	55.6%	60.0%	80.0%	71.4%	-	79.5%	66.1%	70.2%	70.5%
E.B.3		Referral To Treatment: Incomplete pathways within 18 weeks.	✓	✓	✗	M/Q	ICS (Bury)	Mar-23	92.0%	49.8%	52.6%	51.9%	52.2%	51.5%	51.1%	53.7%	53.7%	51.6%	49.0%	50.4%	50.8%	51.4%	51.4%	51.6%	53.0%	50.1%
E.B.3a / S008a		Referral To Treatment: Incomplete pathways (number of people waiting)	✗	✓	✓	M/A	ICS (Bury)	Mar-23	23993	27061	26223	27261	27843	27287	27571	21234	21089	21787	28059	27554	27542	-	-	-	-	-
E.B.18 / S009a		Referral To Treatment: Incomplete patients waiting 52 week waits or more	✓	✓	✓	M	ICS (Bury)	Mar-23		1328	1456	1835	2212	2450	2804	2178	2079	1955	2289	1866	1851	24303	-	-	-	-
S009a		Referral To Treatment: Incomplete patients waiting 78 week waits or more	✗	✓	✗	M	ICS (Bury)	Mar-23		220	178	162	173	191	272	180	215	367	413	261	67					
E.B.19 / S009a		Referral To Treatment: Incomplete patients waiting 104 week waits or more	✗	✓	✗	M	ICS (Bury)	Mar-23	0 (July)	49	28	12	11	11	7	1	1	1	4	2	1					
E.B.4		Diagnostic test waiting times (waiting 6 weeks or more)	✓	✓	✗	M	ICS (Bury)	Mar-23	1.0%	36.4%	34.6%	35.5%	30.7%	30.8%	29.3%	40.9%	42.3%	18.7%	31.7%	26.8%	26.8%	-	35.6%	30.3%	35.9%	28.4%
E.B.S.2.i		Cancelled Operations (28 day guarantee) - Quarterly	✓	✗	✗	Q	NCA	Q4 22/23	0	-	-	494	-	-	55	-	-	87	-	-	101		494	55	87	101
E.B.S.6		Urgent operations cancelled for a second time	✓	✗	✗	M	NCA	Not Avail	0	Paused	Paused	Paused	Paused	Paused	Paused	Paused	Paused	Paused	Paused	Paused	Paused		-	-	-	-
E.B.S.1		Single Sex Accommodation Breaches	✓	✗	✗	M	ICS (Bury)	Mar-23	0	4	18	13	10	6	4	7	7	7	5	6	8	95	-	-	-	-
E.P.1		E-Referrals - Increase in the proportion of GP referrals made by e-referrals	✗	✗	✗	M	ICS (Bury)	Feb-23	92.0%	71.9%	77.7%	57.4%	70.6%	78.9%	60.7%	66.7%	59.7%	53.5%	55.4%	54.0%		-	-	-	-	-
E.H.9 / S084a	Childrens Health & Maternity Jane Case Jeanette Richards	Access to CYP Mental Health Services (rolling 12 months)	✗	✓	✓	M	ICS (Bury)	Nov-22	2949 (Mar 23)	2490	2500	2490	2525	TBC	TBC	2595	2735					-	-	-	-	-
E.H.10		The proportion of CYP with ED (routine cases) that wait 4 weeks or less from referral to start of NICE-approved treatment (NHS Digital - rolling 4 quarters)	✗	✓	✓	Q	ICS (Bury)	Q4 22/23	95.0%	-	-	92.3%	-	-	92.5%	-	-	89.0%	-	-	91%	-	92.3%	92.5%	89%	91%
E.H.11		The proportion of CYP with ED (urgent cases) that wait 1 week or less from referral to start of NICE-approved treatment (NHS Digital - rolling 4 quarters)	✗	✓	✓	Q	ICS (Bury)	Q4 22/23	95.0%	-	-	100.0%	-	-	100.0%	-	-	80.0%	-	-	75%	-	100.0%	100.0%	80%	75%
E.0.1		Percentage of children waiting less than 18 weeks for a wheelchair	✗	✓	✗	Q	ICS (Bury)	Q3 22/23	92.0%	-	-	84.8%	-	-	90.0%	-	-	94.6%	-	-	87.0%	-	84.8%	90.0%	94.6%	87.0%
		% of Children Looked After (CLA) with an up to date health assessment	✗	✗	✗	M	LA	Mar-23	N/A	85.0%	80.0%	78.0%	78.0%	84.0%	85.0%	85.0%	83.0%	78.0%	83.0%	84.0%	91.0%	-	-	-	-	-
		% of Children Looked After (CLA) with a dental check in the last 12 months	✗	✗	✗	M	LA	Mar-23	N/A	53.0%	54.0%	55.0%	58.0%	65.0%	68.0%	65.0%	67.0%	64.0%	64.0%	66.0%	79.0%	-	-	-	-	-
E.A.3 / S081a	Dementia & Mental Health Kez Hayat	IAPT roll-out (prevalence of people entering IAPT services as a % of those estimated to have anxiety/depression) - (NHS Digital)	✗	✓	✓	Q	ICS (Bury)	Feb-23	M: 537 Q: 1610 A: 6440	-	-	1020	-	-		-	-	990	-	-		-	1020	320	990	
E.A.S.2		IAPT Recovery Rate (Moving to recovery) (NHS Digital)	✗	✓	✓	Q	ICS (Bury)	Feb-23	50.0%	-	-	50.4%	-	-		-	-	49.5%	-	-		-	50.4%	50.0%	49.5%	
E.H.1		IAPT waiting times: 6 weeks or less from referral. (NHS Digital)	✗	✓	✗	Q	ICS (Bury)	Feb-23	75.0%	-	-	41.9%	-	-		-	-	73.0%	-	-		-	41.9%	64.3%	73.0%	
E.H.2		IAPT waiting times: 18 weeks or less from referral. (NHS Digital)	✗	✓	✗	Q	ICS (Bury)	Feb-23	95.0%	-	-	88.4%	-	-		-	-	96.3%	-	-		-	88.4%	95.2%	96.3%	
E.A.S.1		Dementia diagnosis rate (65+)	✗	✓	✓	M	ICS (Bury)	Mar-23	66.7%	73.6%	74.3%	74.3%	75.0%	75.5%	76.4%	76.6%	76.1%	76.6%	76.1%	76.2%	77.0%	75.6%	-	-	-	-
E.H.4		Early Intervention in Psychosis Waiting Times	✗	✓	✗	Q	ICS (Bury)	Q3 22/23	60.0%	-	-	85.0%	-	-	78.0%	-	-	100.0%	-	-			85.0%	78.0%	100.0%	
E.H.30		Adult MH patients receiving a follow-up within 72 hours of discharge	✓	✓	✗	M	ICS (Bury)	Feb-23	80.0%	73.0%	75.0%	70.0%	TBC	73.0%	72.0%	68.0%	74.0%	63.0%	66.0%	59.0%		-	-	-	-	-
S032a	Continuing HC Catherine Jackson	Personal Health Budget Count (cumulative)	✗	✗	✓	Q	ICS (Bury)	Q4 22/23	n/a	-	-	185	-	-	321	-	-	452	-	-	601	-	185	321	452	601
E.B.5	Urgent Care	A&E waiting time (waiting less than 4hrs) (PAHT ALL)	✓	✓	✗	M	NCA	Mar-23	95.0%	60.3%		60.1%	60.6%	58.7%	59.3%	59.1%	58.8%	53.0%	64.9%	63.5%	62.2%	-	60.2%	59.6%	57.0%	63.5%
E.B.S.5		Trolley waits in A&E (12 hour waits)	✓	✗	✗	M	NCA	Mar-23	0	694		642	833	820	772	920	751	797	708	529	784	7417	-	-	-	-
E.B.23 S020a		Ambulance clinical quality: Cat 1 - 7 minute response time (average)	✓	✗	✓	M	NWAS	Mar-23	7 minutes	08:31	07:59	08:12	08:39	07:55	08:43	09:19	08:53	9:58	8:15	00.34	00.35	-	-	-	-	-
E.B.23 C1Bi		Ambulance clinical quality: Cat 1 - 90% of calls responded to within 15 minutes	✓	✗	✗	M	NWAS	Mar-23	15 minutes	14:27	13:39	13:59	14:38	13:51	14:51	15:54	15:18	16:56	14:11	######	######	-	-	-	-	-
E.B.23 S020b		Ambulance clinical quality: Cat 2 - 18 minute response time (average)	✓	✗	✓	M	NWAS	Mar-23	18 minutes	47:05	34;00	39:46	50:29	36:06	38:14	58:03	44:16	72:11	29:17	22:36	30:56	-	-	-	-	-
E.B.23 C2Bi		Ambulance clinical quality: Cat 2 - 90% of calls responded to within 40 minutes	✓	✗	✗	M	NWAS	Mar-23	40 minutes	107:46	73:31	87:31	112:36	79:43	84:21	125:56	95:33	165:19	61:08	44:21	66:54	-	-	-	-	-
E.B.25i		Ambulance handover time: proportion within 60 minutes	✓	✓	✗	M	NCA	Mar-23	100%	89.8%	92.7%	91.5%	88.9%	90.2%	90.3%	86.1%	92.3%	84.3%	94.1%	96.7%	90.5%	-	-	-	-	-
E.B.25ii / S019a		Ambulance handover time: proportion within 30 minutes	✓	✓	✓	M	NCA	Mar-23	95%	76.9%	80.6%	79.2%	76.3%	76.3%	77.7%	71.6%	77.6%	70.6%	83.4%	87.5%	78.5%	-	-	-	-	-
E.B.25iii		Ambulance handover time: proportion within 15 minutes	✗	✓	✗	M	NCA	Mar-23	65%	42.8%	45.9%	44.7%	43.0%	44.1%	43.3%	41.6%	44.5%	38.5%	46.6%	53.0%	45.8%	-	-	-	-	-

Elective_Cancer

Measures			Cons	Must Do	NHS SOF	F	Monitored Org	Period	Period Target	Period Actual Performance 2022-23																
Indicator	IDC Programme	Description								Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Q1	Q2	Q3	Q4
E.B.6	Cancer Care Cath Tickle	Cancer 2 week waits: GP Referral for suspected cancer	✓	✓	✗	M/Q	ICS (Bury)	Mar-23	93.0%	54.8%	80.6%	69.7%	67.5%	60.5%	53.6%	57.9%	64.1%	57.4%	66.9%	0.7947	0.8149	-	73.9%	60.6%	60.2%	75.9%
E.B.7		Cancer 2 week waits: Urgent referral for breast symptoms where cancer was not initially suspected	✓	✓	✗	M/Q	ICS (Bury)	Mar-23	93.0%	22.9%	29.8%	22.6%	28.3%	38.6%	20%	18.8%	36.0%	22.1%	35.6%	0.3871	0.4154	-	25.3%	28.6%	26.7%	38.7%
E.B.27 / S012a		Cancer 28 day waits: Faster Diagnosis	✗	✓	✓	M/Q	ICS (Bury)	Mar-23	75.0%	90.0%	62.0%	44.7%	47.8%	46.0%	45.1%	44.7%	56.7%	54.4%	53.5%	68.7%	72.6%	-	53.9%	46.3%	52.3%	65.0%
E.B.8		Cancer 31 day waits: First definitive treatment within 1 month of diagnosis	✓	✓	✗	M/Q	ICS (Bury)	Mar-23	96.0%	93.3%	92.2%	95.3%	95.7%	94.7%	86.4%	91.1%	94.7%	96.4%	87.5%	94.6%	91.8%	-	93.9%	92.5%	94.1%	91.0%
E.B.9		Cancer 31 day waits: Subsequent cancer treatment - Surgery	✓	✓	✗	M/Q	ICS (Bury)	Mar-23	94.0%	100.0%	100.0%	92.3%	95.0%	90.0%	100.0%	100.0%	100.0%	100.0%	88.9%	94.1%	92.3%	100.0%	-	96.7%	94.7%	95.2%	96.0%
E.B.10		Cancer 31 day waits: Subsequent cancer treatment - Anti cancer drug regimens	✓	✓	✗	M/Q	ICS (Bury)	Mar-23	98.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	-	100.0%	100.0%	100.0%	100.0%
E.B.11		Cancer 31 day waits: Subsequent cancer treatment - Radiotherapy	✓	✓	✗	M/Q	ICS (Bury)	Mar-23	94.0%	100.0%	96.7%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	97.0%	100.0%	100.0%	-	99.0%	100.0%	100.0%	98.5%
E.B.12 / S011a		Cancer 62 day waits: First definitive treatment within 2 months of urgent GP referral	✓	✓	✓	M/Q	ICS (Bury)	Mar-23	85.0%	46.2%	29.4%	48.0%	47.9%	57.4%	30.6%	46.8%	46.2%	48.8%	40.3%	45.5%	42.6%	-	41.2%	46.2%	47.1%	42.5%
E.B.13		Cancer 62 day waits: First definitive treatment within 2 months of NHS cancer screening referral	✓	✓	✗	M/Q	ICS (Bury)	Mar-23	90.0%	100.0%	50.0%	33.3%	81.8%	42.9%	80.0%	66.7%	90.0%	100.0%	57.1%	100.0%	69.2%	-	61.5%	69.6%	85.7%	68.2%
E.B.14		Cancer 62 day waits: First definitive treatment within 2 months of consultant decision to upgrade priority status	✓	✓	✗	M/Q	ICS (Bury)	Mar-23	85.0%	70.0%	80.0%	84.2%	65.0%	73.7%	60%	76.0%	78.6%	55.6%	60.0%	80.0%	71.4%	-	79.5%	66.1%	70.2%	70.5%
		1-year cancer survival for all-cancers	✗	✗	✗	A	ICS (Bury)	TBC																		
		Cancers diagnosed at an early stage	✗	✗	✗	A	ICS (Bury)	TBC																		
S010a		Cancer first treatments: the number of people receiving first cancer treatment compared to equivalent month (March 19 - Feb 20), adjusted for working days	✗	✗	✓	M	ICS (Bury)	TBC	Placeholder																	
S011a		Number of people waiting over 62 days for their first treatment	✗	✗	✓	M	NCA	TBC	Placeholder																	

Urgent Care Dashboard

Urgent Care Summary			Cons	Must Do	NHSOF	F	Monitored Org	Period	Period Target	Period Actual Performance 2022-23																
Indicator	IDC Programme	Description								Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Q1	Q2	Q3	Q4
E.B.5	Urgent Care David Latham	A&E waiting time (waiting less than 4hrs) (NCA ALL)	✓	✓	✓	M	NCA	Mar-23	95.0%	60.3%		60.1%	60.6%	58.7%	59.3%	59.1%	59.3%	53.0%	64.9%	63.5%	62.2%	-	60.2%	59.6%	57.0%	63.5%
E.B.S.5		Trolley waits in A&E (12 hour waits)	✓	✗	✗	M	NCA	Mar-23	0	694		642	833	820	772	920	751	797	708	529	784	7417	-	-	-	-
S103a		The proportion of patients spending more than 12 hours in an ED	✗	✗	✓	M	NCA	Placeholder	<2%													-				
E.B.23 / S020a		Ambulance clinical quality: Cat 1 - 7 minute response time (average)	✓	✓	✗	M	NWAS	Mar-23	7 mins	08:31	07:59	08:12	08:39	07:55	08:43	09:19	08:53	9:58	8:15	8:10	8:27	-	-	-	-	-
E.B.23.C1 Aii		Ambulance clinical quality: Cat 1 - 7 minute response time (average)	✓	✓	✗	M	ICS (Bury)	Mar-23	7 mins	8:15	7:12	07:19	08:07	06:33	07:56	08:19	08:03	8:57	8:04	7:55	6:59	-	-	-	-	-
E.B.23.C1 Bi		Ambulance clinical quality: Cat 1 - 90% of calls responded to within 15 mins	✓	✓	✗	M	NWAS	Mar-23	15 mins	14:27	13:39	13:59	14:38	13:51	14:51	15:54	15:18	16:56	14:11	13:47	14:20	-	-	-	-	-
E.B.23.C1 Bii		Ambulance clinical quality: Cat 1 - 90% of calls responded to within 15 mins	✓	✓	✗	M	ICS (Bury)	Mar-23	15 mins	13:07	11:49	11:31	12:57	11:18	12:49	14:14	13:24	14:06	13:33	13:06	11:34	-	-	-	-	-
E.B.23 / S020b		Ambulance clinical quality: Cat 2 - 18 minute response time (average)	✓	✓	✗	M	NWAS	Mar-23	18 mins	47:05	34;00	39:46	50:29	36:06	38:14	58:03	44:16	72:11	29:17	22:36	30:56	-	-	-	-	-
E.B.23.C2 Aii		Ambulance clinical quality: Cat 2 - 18 minute response time (average)	✓	✓	✗	M	ICS (Bury)	Mar-23	18 mins	41:10	32:50	36:34	42:23	31:23	32:42	54:33	38:21	56:00	22:59	18:48	25:00	-	-	-	-	-
E.B.23.C2 Bi		Ambulance clinical quality: Cat 2 - 90% of calls responded to within 40 mins	✓	✓	✗	M	NWAS	Mar-23	40 mins	107:46	73:31	87:31	112:36	79:43	84:21	125:56	95:33	165:19	61:08	44:21	66:54	-	-	-	-	-
E.B.23.C2 Bii		Ambulance clinical quality: Cat 2 - 90% of calls responded to within 40 mins	✓	✓	✗	M	ICS (Bury)	Mar-23	40 mins	95:09	70:18	80:17	93:53	66:59	66:46	120:33	78:38	123:59	45:32	33:37	48:12	-	-	-	-	-
E.B.25ii / S019a		Ambulance handover time: proportion within 30 mins: NCA	✓	✓	✗	M	NCA	Mar-23	95%	76.9%	80.6%	79.2%	76.3%	76.3%	77.7%	71.6%	77.6%	70.6%	83.4%	87.5%	78.5%	-	-	-	-	-
E.B.25ii		Ambulance handover time: proportion within 30 mins: Fairfield	✗	✗	✗	M	FGH	Mar-23	65%	67.6%	71.1%	71.7%	67.9%	74.1%	71.8%	70.3%	84.7%	69.2%	86.9%	92.6%	83.4%	-	-	-	-	-
E.B.25ii		Ambulance handover time: proportion within 30 mins: Royal Oldham	✗	✗	✗	M	RO	Mar-23	65%	62.8%	74.2%	69.7%	60.6%	63.8%	68.9%	44.4%	56.7%	51.6%	69.5%	74.3%	60.8%	-	-	-	-	-
E.B.25ii		Ambulance handover time: proportion within 30 mins: Salford Royal	✗	✗	✗	M	SR	Mar-23	65%	92.7%	91.0%	90.4%	91.1%	85.8%	87.4%	90.1%	89.1%	86.9%	92.7%	94.4%	89.3%	-	-	-	-	-
E.B.25ii		Ambulance handover time: proportion within 30 mins: Greater Manchester	✗	✗	✗	M	GM	Mar-23	65%	72.1%	76.4%	74.2%	68.0%	68.9%	65.2%	60.4%	65.5%	58.1%	71.9%	78.2%	74.5%	-	-	-	-	-
E.B.25i1		Ambulance handover time: proportion within 60 mins: NCA	✓	✓	✗	M	NCA	Mar-23	100%	89.8%	92.7%	91.5%	88.9%	90.2%	90.3%	86.1%	92.3%	84.3%	94.1%	96.7%	90.5%	-	-	-	-	-
E.B.25iii		Ambulance handover time: proportion within 15 mins: NCA	✗	✓	✗	M	NCA	Mar-23	65%	42.8%	45.9%	44.7%	43.0%	44.1%	43.3%	41.6%	44.5%	38.5%	46.6%	53.0%	45.8%					
		Avg Turnaround Time (all Attends) (h:mm:ss) Fairfield	✗	✗	✗	M	FGH	Mar-23	30 mins	56:49	47:48	51:02	51:58	49:13	50:19	52:21	32:56	51:24	34:17	28:37	37:58	-	-	-	-	-
		Avg Turnaround Time (all Attends) (h:mm:ss) Royal Oldham	✗	✗	✗	M	RO	Mar-23	30 mins	50:15	41:46	48:02	52:57	44:27	41:03	66:44	52:44	64:13	44:34	40:06	49:21	-	-	-	-	-
		Avg Turnaround Time (all Attends) (h:mm:ss) Salford Royal	✗	✗	✗	M	SR	Mar-23	30 mins	27:41	27:55	28:56	28:08	31:53	31:05	28:34	28:36	31:33	27:11	26:11	27:58					
		Avg Turnaround Time (all Attends) (h:mm:ss) NCA	✗	✗	✗	M	NCA	Mar-23	30 mins	43:32	38:07	41:37	43:06	40:52	39:48	47:50	38:12	48:39	35:19	31:30	38:03	-	-	-	-	-
		Avg Turnaround Time (all Attends) (h:mm:ss) Greater Manchester	✗	✗	✗	M	GM	Mar-23	30 mins	42:13	38:27	41:48	44:46	44:08	46:46	52:54	45:34	54:05	40:38	35:51	37:51	-	-	-	-	-
E.M.11		Total Non-elective Spells (Specific Acute)	✗	✓	✗	M	ICS (Bury)	Mar-23	N/A	2114	1903	1868	1879	1826	1618	1632	1633	1698	1700	1498	1765	0	5885	5323	4963	4963
E.M.12		Type 1-4 A&E Attendances	✗	✓	✗	M	ICS (Bury)	Mar-23	N/A	7052	5380	6601	6715	6271	6203	6617	6492	6643	5844	5734	6771	0	19033	19189	19752	18349
127b		Emergency admissions for urgent care sensitive conditions	✗	✗	✓	M	ICS (Bury)	Mar-23	N/A	260.0	198.1	221.8	219.4	229.3	203.9	218.7	177.7	176.2	213.3	169.3	206.5	-	683.5	315	0	284.75
106a		Inequality in unplanned hospitalisation for chronic ambulatory care sensitive and UC sensitive conditions	✗	✗	✓	Q	ICS (Bury)	Not Avail	N/A	-	-		-	-		-	-		-	-		-				

MENTAL HEALTH

Mental Health									Period Actual Performance 2022-23											
Indicator	IDC Programme	Description	Cons	Must Do	NHSOF	Freq	Monitored Org	Period	Period Target	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
E.A.3.i	Mental Health Kez Hayat	IAPT roll-out (Prevalence of people entering IAPT services as a % of those estimated to have anxiety/depression) - (PCFT Monthly Indicative)	✗	✓	✓	M	ICS (Bury)	Mar-23	M: 537 Q: 1610 A: 6440	239	342	423	319	346	322	334	385	257	401	355	388
E.A.3 / S081a		IAPT roll-out (prevalence of people entering IAPT services as a % of those estimated to have anxiety/depression) - (NHS Digital)	✗	✓	✓	Q	ICS (Bury)	Q1 22-23	M: 537 Q: 1610 A: 6440	-	-	1.6%	-	-	1.2%	-	-	1.0%	-	-	
E.A.3.ii		IAPT roll-out: proportion of over 65s accessing service (NHS Digital)	✗	✓	✗	Q	ICS (Bury)	Q1 22-23		-	-	5.7%	-	-	7.3%	-	-	7.9%	-	-	
E.A.S.2.i		IAPT Recovery Rate (Moving to recovery) (PCFT Monthly Indicative)	✗	✓	✓	M	ICS (Bury)	Mar-23	50.0%	55.7%	52.0%	44.1%	45.9%	51.9%	50.5%	51.1%	46.9%	53.2%	57.7%	50.0%	55.1%
E.A.S.2		IAPT Recovery Rate (Moving to recovery) (NHS Digital)	✗	✓	✓	Q	ICS (Bury)	Q1 22-23	50.0%	-	-	50.4%	-	-	50.0%	-	-	49.5%	-	-	
E.A.S.2.ii		IAPT Recovery Rate (BAME) - NHS Digital	✗	✓	✗	Q	ICS (Bury)	Q1 22-23		-	-	46.0%	-	-	44.0%	-	-	43.0%	-	-	
E.H.1.i		IAPT waiting times: 6 weeks or less from referral. (PCFT Monthly Indicative)	✗	✓	✗	M	ICS (Bury)	Mar-23	75.0%	39.5%	44.5%	38.6%	48.4%	54.6%	63.6%	67.9%	62.8%	70.47%	77.25%	77.70%	84.00%
E.H.1.		IAPT waiting times: 6 weeks or less from referral. (NHS Digital)	✗	✓	✗	Q	ICS (Bury)	Q1 22-23	75.0%	-	-	41.9%	-	-	64.3%	-	-	73.0%	-	-	
E.H.2.i		IAPT waiting times: 18 weeks or less from referral. (PCFT Monthly Indicative)	✗	✓	✗	M	ICS (Bury)	Mar-23	95.0%	91.9%	88.2%	85.7%	93.8%	96.9%	95.1%	94.7%	96.1%	96.0%	98.2%	99.3%	96.5%
E.H.2		IAPT waiting times: 18 weeks or less from referral. (NHS Digital)	✗	✓	✗	Q	ICS (Bury)	Q1 22-23	95.0%	-	-	88.4%	-	-	95.2%	-	-	96.3%	-	-	
E.H.21		IAPT in-treatment pathway waits	✗	✓	✗	M	ICS (Bury)	Jun-22	<10%	28.6%	45.3%	34.9%								23.8%	
E.H.4		Early Intervention in Psychosis Waiting Times	✗	✓	✓	Q	ICS (Bury)	Q1 22-23	60.0%	-	-	85.0%	-	-	78.0%	-	-	100.0%	-	-	
E.A.S.1		Dementia diagnosis rate (65+)	✗	✗	✓	M	ICS (Bury)	Mar-23	66.7%	73.6%	74.3%	74.3%	75.0%	75.5%	76.4%	76.6%	76.1%	76.6%	76.1%	76.22%	76.98%
E.H.30		Adult MH patients receiving a follow-up within 72 hours of discharge (NHS Dig)	✓	✓	✗	M	ICS (Bury)	Feb-23	80.0%	73.0%	75.0%	70.0%	TBC	73.0%	72.0%	68.0%	74.0%	63.0%	66.0%	59.0%	
E.H.30i		Adult MH patients receiving a follow-up within 72 hours of discharge (PCFT ind)	✓	✓	✗	M	ICS (Bury)	Mar-23	80.0%	80.0%	75.0%	79.3%	60.0%	85.7%	78.3%	75.0%	73.0%	84.6%	72.7%	75.0%	82.8%
E.H.12 / S086a		Inappropriate adult acute mental health Out of Area Placement (OAP) bed days	✗	✓	✗	M/Q	ICS (Bury)	Feb-23	0	150	60	50	105	155	95		175	80	100	130	
E.H.15		Access rate of women accessing specialist perinatal mental health services (12 months rolling)	✗	✓	✗	M/Q	ICS (Bury)	Jun-22	8.8% by Mar	6.4%	7.0%	7.0%									
E.H.17		No of people accessing Individual Placement and Support (cumulative)	✗	✓	✗	M	ICS (Bury)	Jan-23	TBC	5	10	15			15	15	15	20	20		
E.H.13 / S085a		SMI Annual Health Checks	✗	✓	✓	Q	ICS (Bury)	Q1 22-23	60.0%	-	-	29.2%	-	-	30.5%	-	-	31.1%	-	-	

Community Services

Measures			Cons	Must Do	NHS SOF	F	Monitored Org	Period	Period Target	Period Actual Performance 2022-23																
Indicator	IDC Programme	Description								Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Q1	Q2	Q3	Q4
S115a	Community Services Adrian Crook	Proportion of diabetes patients receiving all 8 diabetes care processes	✗	✗	✓	Q	ICS (Bury)	Q1 22/23	N/A	-	-		-	-		-	-		-	-		-				
(S052a)		Diabetes patients achieved 3 NICE recommended treatment targets	✗	✗	✗	A	ICS (Bury)	2021/22	N/A	-	-	-	-	-	-	-	-	-	-	-	-	35.3%	-	-	-	-
(103b)		Diabetes patients diagnosed <1 year attending structured education	✗	✗	✗	A	ICS (Bury)	2021/22	N/A	-	-	-	-	-	-	-	-	-	-	-	-	4.5%	-	-	-	-
S051a		Proportion of people achieving Milestone 1 of NHS Diabetes Prevention Programme	✗	✗	✓	Q	ICS (Bury)	Q1 22/23	N/A	-	-		-	-		-	-		-	-		-				
(108a)		Proportion of carers with LTC who feel supported to manage own condition	✗	✗	✗	A	ICS (Bury)	2021/22	N/A	-	-	-	-	-	-	-	-	-	-	-	-		-	-	-	-
S107a		Proportion of Urgent Community Response (rapid response) referrals reached within 2 hours	✗	✗	✓	M	ICS (Bury)	Placeholder	70%																	
S105a		Proportion of patients discharged from hospital to their usual place of residence	✗	✗	✓	M	ICS (Bury)	Placeholder	N/A																	
S117a		Proportion of patients who have a first consultation in a post-covid service within six weeks of referral	✗	✗	✓	M	ICS (Bury)	Placeholder	N/A																	
S106a		Available virtual ward capacity per 100,000 of population	✗	✗	✓	Q	NCA	Placeholder	40-50	-	-		-	-		-	-		-	-		-				
S031a		Number of personalised care interventions	✗	✗	✓	Q	ICS (Bury)	Placeholder	N/A	-	-		-	-		-	-		-	-		-				
S032a		Personal Health Budgets	✗	✗	✓	Q	ICS (Bury)	Q1 22/23	N/A	-	-		-	-	321	-	-	452	-	-	601	-	185	321	452	601

Children's Health and Maternity

Constitution Performance

Maternity & Childrens Summary			Cons	Must Do	NHSOF	F	Monitored Org	Period	Period Target	Period Actual Performance 2022-23													
Indicator	IDC Programme	Description								Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
Children and Young People Mental Health (CYP MH)																							
E.H.9 / S084a		Access to CYP mental health services (12 months rolling) (1 contact)	✗	✓	✓	M	ICS (Bury)	Jun-22	2949 (Mar 23)	2490	2500	2490	2525	TBC	Must Do	2595	2735					-
E.H.9.i		No of new CYP first contacts (in-month)	✗	✓	✓	M	ICS (Bury)	Jun-22	n/a	250	275	230										
		Access to 18-24 mental health services (12 months rolling) (1 contact)	✗	✗	✗	M	ICS (Bury)	Placeholder	n/a													
E.H.9a	Children and Young Peoples Mental Health (CYPMH) Jane Case	Improve access to rate to CYPMH (MHSDS monthly FINAL - rolling) (2 contacts)	✗	✓	✗	M/Q	ICS (Bury)	Jun-22	35.0%	40.6%	39.1%	38.0%										-
E.H.9i		Improve access to rate to CYPMH (MHSDS montlhly PROVISIONAL - in-month)	✗	✓	✗	M	ICS (Bury)	Jun-22	114	255	225	170										
E.H.9ii		Improve access to rate to CYPMH (MHSDS montlhly FINAL - in-month)	✗	✓	✗	M	ICS (Bury)	Jun-22	114	265	225	175										
E.H.10ii		% of CYP with ED (routine cases) that wait 4 weeks or less from referral to start of NICE-approved treatment (PCFT indicative)	✗	✓	✗	M	ICS (Bury)	Mar-23	95%	86%	75%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	83.3%	
E.H.10i		% of CYP with ED (routine cases) that wait 4 weeks or less from referral to start of NICE-approved treatment (NHS Digital) . Rolling 4 quarters	✗	✓	✗	Q	ICS (Bury)	Q4 22/23	95%	-	-	92.3%	-	-	92.5%	-	-	89.0%	-	-	91.4%	
E.H.11ii		% of CYP with ED (urgent cases) that wait 1 week or less from referral to start of NICE-approved treatment (PCFT indicative).	✗	✓	✗	M	ICS (Bury)	Mar-23	95%	No Cases	No Cases	No Cases	No Cases	No Cases	No Cases	100%	No Cases	No Cases	No cases	No cases	No cases	
E.H.11ii		% of CYP with ED (urgent cases) that wait 1 week or less from referral to start of NICE-approved treatment (NHS Digital). Rolling 4 quarters	✗	✓	✗	Q	ICS (Bury)	Q4 22/23	95%	-	-	100.0%	-	-	100%	-	-	80%	-	-	75%	
		ED % of those in treatment initiated goal based outcomes (GBO) within 10 working days at start of any intervention/treatment	✗	✗	✗	Q	PCFT	Not Avail		-	-		-	-		-	-		-	-		
		ED % of those that show positive distance travelled to their GBO	✗	✗	✗	Q	PCFT	Not Avail		-	-		-	-		-	-		-	-		
		ED % of those that show achievement of their GBO	✗	✗	✗	Q	PCFT	Not Avail		-	-		-	-		-	-		-	-		
		HYM (12 weeks first contact)	✗	✗	✗	M	ICS (Bury)	Mar-23	95%	64.9%	66.4%	66.7%	68.3%	68.9%	64.3%	62.9%	52.5%	67.8%	48.6%	68.2%	79.8%	63.8%
		HYM (18 weeks commence treatment)	✗	✗	✗	M	ICS (Bury)	Mar-23	98%	67.6%	64.6%	62.3%	62.1%	69.2%	58.5%	49.4%	48.9%	43.5%	40.4%	58.3%	64.7%	55.3%
		HYM % of those in treatment initiated goal based outcomes (GBO) within 10 working days at start of any intervention/treatment	✗	✗	✗	Q	PCFT	Not Avail		-	-		-	-		-	-		-	-		
		HYM % of those that show positive distance travelled to their GBO	✗	✗	✗	Q	PCFT	Not Avail		-	-		-	-		-	-		-	-		
Maternity																							
	Maternity David Latham	Booking 12+6 weeks (PAHT)	✗	✗	✗	M	NCA		-														
		3rd/4th Degreee tears (PAHT)	✗	✗	✗	M	NCA		-														
		Elective C-section (PAHT)	✗	✗	✗	M	NCA		-														
		Non-elective C-section (PAHT)	✗	✗	✗	M	NCA		-														
		Haemorrhage >2.5ltrs (PAHT)	✗	✗	✗	M	NCA		-														
		APGARS <7 at 5minutes in neonates (PAHT)	✗	✗	✗	M	NCA		-														
		Breastfeeding initiation (PAHT)	✗	✗	✗	M	NCA		-														
		SATOD (PAHT)	✗	✗	✗	M	NCA		-														
		Maternity - SATOD - Not Smoking at time of delivery	✗	✗	✓	Q	ICS (Bury)	Q4 22/23	-	-	-	7.5%	-	-	5.1%	-	-	4.3%	-	-	5.7%	-
S104a		Neonatal deaths per 1,000 total live births	✗	✗	✓	A	ICS (Bury)		-	-	-	-	-	-	-	-	-	-	-	-	-	-	
S022a		Stillbirths per 1,000 total births	✗	✗	✓	A	ICS (Bury)		-	-	-	-	-	-	-	-	-	-	-	-	-	-	
Paediatrics																							
	Paediatrics Jane Case	Emergency admission rate for children with asthma per 100,000 population aged 0-18 years	✗	✗	✗	M	ICS (Bury)	Mar-23	300 (rate) 138 (admissions)	6.3	16.8	16.8	14.7	4.2	12.6	8.4	2.1	4.2	29.3	10.5	18.8	144.5
		Unplanned hospitalisation for Asthma (under 19s)	✗	✗	✗	M	ICS (Bury)	Mar-23	0	3	8	8	7	3	6	4	2	2	8	4	9	64
		Unplanned hospitalisation for Diabetes (under 19s)	✗	✗	✗	M	ICS (Bury)	Mar-23	0	5	1	2	0	2	1	2	2	1	0	1	1	18
		Unplanned hospitalisation for Epilepsy (under 19s)	✗	✗	✗	M	ICS (Bury)	Mar-23	0	4	0	4	0	2	1	2	1	3	3	2	5	27
		Non-elective admissions at NMGH (under 19s)	✗	✗	✗	M	ICS (Bury)	Mar-23	0	263	238	-	225	184	230	167	178	200	211	167	197	2260

Author: Jonathan Kirkham

Primary Care

Primary Care Summary			Cons	Must Do	NHSOF	F	Monitored Org	Period	Period Target	Period Actual Performance 2021/22															
Indicator	IDC Programme	Description								Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Q1	Q2	Q3	Q4
S037a	Primary Care Zoe Alderson	Patient experience of GP services	✗	✗	✓	A	ICS (Bury)	92	N/A	-	-	-	-	-	-	-	-	-	-	-	-		-	-	-	-
E.D.17		Exended access appointment utilisation	✗	✓	✗	Q	ICS (Bury)	Placeholder	85%	-	-		-	-		-	-		-	-						
E.D.18		Proportion of population that 111 can directly book appoints into extended access services	✗	✓	✗	Q	ICS (Bury)	Placeholder	100%	-	-		-	-		-	-		-	-						
E.D.19 / S001a		Appointments in General Practice per 10,000 weighted patients	✗	✗	✓	M	ICS (Bury)	Mar-23	N/A	59570	67792	62183	64082	67908	72396	85358	82715	72980	78396	77007	90092	880478	189544	204386	241053	245495
S074a		FTE Doctors in General Practice per 10,000 weighted patients	✗	✗	✓	M	ICS (Bury)	Placeholder	N/A																	
S075a		Direct patient care staff in GP practices and PCNs per 10,000 weighted patient population	✗	✗	✓	M	ICS (Bury)	Placeholder	N/A																	
S108a		Number of completed referrals to Community Pharmacist Consultant Service (CPCS) from a general practice per 100,000 population	✗	✗	✓	M	ICS (Bury)	Placeholder	N/A																	
S108b		Number of completed referrals to Community Pharmacist Consultant Service (CPCS) from NHS 111 per 100,000 population	✗	✗	✓	M	ICS (Bury)	Placeholder	N/A																	
S109a		Units of dental activity delivered as a proportion of all units of dental activity contracted	✗	✗	✓	M	ICS (Bury)	Placeholder	N/A																	
S053a		Proportion of Atrial Fibrilation patients with a record of CHA2DS2-VASs score or more who are treated with anticoagulation drug therapy	✗	✗	✓	A	ICS (Bury)	2022/23	90.0%	-	-	-	-	-	-	-	-	-	-	-	-		-	-	-	-
S053b		Proportion of hypertension patients who are treated to target as per NICE guidance	✗	✗	✓	A	ICS (Bury)	2022/23	80.0%	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
S053c		Proportion of patients identified as having 20% or greater 10-year risk of developing CVD are treated with statins	✗	✗	✓	Bi-A	ICS (Bury)	2022/23	45.0%	-	-	-	-	-		-	-	-	-	-		-	-	-	-	-
S044a	Meds Optimisation Salina Callighan	Antimicrobial resistance: appropriate prescribing of antibiotics in primary care	✗	✗	✓	M	ICS (Bury)	Apr-22	1.161													-	-	-	-	-
S044b		Antimicrobial resistance: appropriate prescribing of broad spectrum antibiotics in primary care	✗	✗	✓	M	ICS (Bury)	Apr-22	10%													-	-	-	-	-

Quality Summary			Cons	Must Do	NHSOF	Freq	Monitored Org	Period	Period Target	Period Actual Performance 2022-23												
Indicator	IDC Programme	Description								Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
E.B.S.1		Single Sex Accommodation Breaches	✓	✗	✗	M	ICS (Bury)	Mar-23	0	4	18	13	10	6	4	7	7	7	5	6	8	95
S032a		Personal Health Budget Count (cumulative)	✗	✗	✓	Q	ICS (Bury)	Q4 22/23	n/a	-	-	185	-	-	321	-	-	452	-	-	601	
S037a		Percentage of patients describing their overall experience of making a GP appointment as good	✗	✗	✓	A	ICS (Bury)		N/A	-	-	-	-	-	-	-	-	-	-	-	-	
S035a		Overall CQC rating (provision of high-quality care): NCA	✗	✗	✓	M	NCA		N/A													
S035a		Overall CQC rating (provision of high-quality care): PCFT	✗	✗	✓	M	NCA		N/A													-
S059		CQC rating well-led	✗	✗	✓				N/A													-
S040a		HCAI MRSA	✗	✗	✗	M	ICS (Bury)	Mar-23	0	0	0	0	0	0	0	0	0	0	0	0	0	0
S041a	Quality Team Catherine Jackson	HCAI C.Diff	✗	✗	✗	M	ICS (Bury)	Mar-23	45 (3.75/mth	2	4	5	8	5	7	7	6	8	3	5	6	66
S042a		HCAI E.Coli	✗	✗	✗	M	ICS (Bury)	Mar-23	45	8	11	14	8	10	11	7	16	6	15	11	11	128

Learning Disability Summary		Workstream Lead	Cons	Must Do	NHSOF	Freq	Monitored Org	Period	Period Target	Period Actual Performance 2021/22																
Indicator	Description									Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Q1	Q2	Q3	Q4
E.K.3 / S030a	Proportion of people with LD on GP register receiving an annual health check	Kez Hayat	✗	✓	✓	M/Q	ICS (Bury)	Feb-23	70.0%	2.0%	0.0%	0.9%	2.5%	4.1%	3.7%	4.7%	12.5%	5.1%	8.5%	10.9%		55.8%	3.9%	10.1%	25.1%	
E.K.1a / S029a	Reliance on specialist inpatient care for people with an LD and/or autism: No of CCG commissioned inpatients	Kez Hayat	✗	✓	✓	Q	ICS (Bury)	Not Avail	2	-	-		-	-		-	-		-	-		-				
E.K.1b / S029b	Reliance on specialist inpatient care for people with an LD and/or autism: No of NHSE commissioned inpatients	Kez Hayat	✗	✓	✓	Q	ICS (Bury)	Not Avail	3	-	-		-	-		-	-		-	-		-				

Constitution and Must Do Dashboard

Population Health Measures			Cons	Must Do	NHS SOF	F	Monitored Org	Period	Period Target	Period Actual Performance 2022-23															
Indicator	IDC Programme	Description								Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Q1	Q2	Q3	Q4
S054a	Population Health Lesley Jones	Number of people receiving mechanical thrombectomy as a % of all stroke patients	✗	✗	✓	Q	NCA	Q1 23/24	10.0%	-	-		-	-		-	-		-	-		-				
S051a		Proportion of people achieving Milestone 1 of the NHS Diabetes Prevention Programme	✗	✗	✓	Q	ICS (Bury)	Q1 22/23	N/A																	
S055a		Number of referrals to NHS digital weight management services per 100,000 head of population	✗	✗	✓	M/Q	ICS (Bury)	Q1 22/23	N/A	-	-		-	-		-	-		-	-		-				
S116a		Proportion of adult acute inpatient settings offering Tobacco Dependence services	✗	✗	✓	M	ICS (Bury)	May-22	100.0%																	
S116b		Proportion of maternity settings offering Tobacco Dependence services	✗	✗	✓	M	NCA	May-22	100.0%																	
S048a		Bowel screening: % patients aged 60-74 screen in last 30 months	✗	✗	✓	A	LA	2022/23	60.0%	-	-	-	-	-	-	-	-	-	-	-	-		-	-	-	-
S049a		Breast screening: % females aged 53-70 screen in last 36 months	✗	✗	✓	A	LA	2022/23	80.0%	-	-	-	-	-	-	-	-	-	-	-	-		-	-	-	-
S050a		Cervical screening: % females aged 24-49 attending screening in last 42 months	✗	✗	✓	A	ICS (Bury)	2022/23	80.0%	-	-	-	-	-	-	-	-	-	-	-	-		-	-	-	-
S050a		Cervical screening: % females aged 50-64 attending screening in last 66 months	✗	✗	✓	A	ICS (Bury)	2022/23	80.0%	-	-	-	-	-	-	-	-	-	-	-	-		-	-	-	-
S047a		Proportion of people over 65 receiving a seasonal flu vaccination	✗	✗	✓	M/A	ICS (Bury)	TBC	85.0%														-	-	-	-
S046a		Proportion of 5 year olds that have received two doses of MMR	✗	✗	✓	Q/A	LA	2022/23	95.0%			-			-			-			-					

Agenda Item 15

BURY INTEGRATED CARE PARTNERSHIP

Meeting: **Locality Board**			
Meeting Date	05 June 2023	**Action**	Receive
Item No.	15	**Confidential**	No
Title	Bury Place Based Primary Care Commissioning Committee		
Presented By	Adrian Crook, Director of Adult Social Services and Community Commissioning		
Author	Lindsay Johnson, Committee Secretary, NHS GM (Bury)		
Clinical Lead	Dr Cathy Fines		

Executive Summary

The Chair's Highlight report from Bury's Place Based PCCC meeting is included for your information from the meeting held on 27th March 2023. This report has been issued to GM PCCC for submission at their meeting.

Recommendations

That the Locality Board receive for their information the Bury Place Based PCCC Chair's Highlight report.

Links to Strategic Objectives

SO1 - To support the Borough through a robust emergency response to the Covid-19 pandemic.	☒
SO2 - To deliver our role in the Bury 2030 local industrial strategy priorities and recovery.	☒
SO3 - To deliver improved outcomes through a programme of transformation to establish the capabilities required to deliver the 2030 vision.	☒
SO4 - To secure financial sustainability through the delivery of the agreed budget strategy.	☒
Does this report seek to address any of the risks included on the NHS GM Assurance Framework?	☐

Implications

Are there any quality, safeguarding or patient experience implications?	Yes	☐	No	☐	N/A	☒
Has any engagement (clinical, stakeholder or public/patient) been undertaken in relation to this report?	Yes	☐	No	☐	N/A	☒
Have any departments/organisations who will be affected been consulted ?	Yes	☐	No	☐	N/A	☒
Are there any conflicts of interest arising from the proposal or decision being requested?	Yes	☐	No	☒	N/A	☐

Implications						
Are there any financial Implications?	Yes	☐	No	☐	N/A	☒
Is an Equality, Privacy or Quality Impact Assessment required?	Yes	☐	No	☐	N/A	☒
If yes, has an Equality, Privacy or Quality Impact Assessment been completed?	Yes	☐	No	☐	N/A	☒
If yes, please give details below:						
If no, please detail below the reason for not completing an Equality, Privacy or Quality Impact Assessment:						
Are there any associated risks including Conflicts of Interest?	Yes	☐	No	☐	N/A	☒
Are the risks on the NHS GM risk register?	Yes	☐	No	☐	N/A	☒

Governance and Reporting		
Meeting	**Date**	**Outcome**
Place Based PCCC	27th March 2023	Chair's report produced from the PCCC meeting held on 27th March 2023

Bury Primary Care Commissioning Committee (PCCC) Highlight Report

Chair: Will Blandamer
Reporting period: March 2023
Attendance: Acceptable

This report updates / informs the NHS Greater Manchester PCCC on the Bury PCCC work to date. It also provides an opportunity to raise any issues and inform of any changes that may affect the progression of work.

Key updates:

Cost of Living Crisis - Bury PCCC received a GM report for information. A number of follow up actions were suggested. For example; linking in with the Local Authority and the GM Estates Team in order to identify any collective work that could be carried out in relation to decarbonisation grants to support Primary Care.

Bury LCS – PCCC approved the final LCS following confirmation of contract length permitted by GM. Thanks were given to the Primary Care Team for their continued work and engagement with practices.

Redbank/Mile Lane Partnership Change - PCCC received a paper informing them of impending changes to the contract holders for Redbank Group Practice and Mile Lane Surgery. Following a robust discussion, it was acknowledged that both options available to the providers ultimately resulted in the same outcome, but the preferred option was more open and transparent in terms of intended management arrangement for the contracts moving forward. PCCC were in no doubt that swift additional resilience was needed in order to maintain appropriate care of a significant number of patients, and therefore, noting the feedback from Greater Manchester Integrated Care Partnership that this model has been adopted in other GM localities PCCC were guided to support.

ARRS - PCCC where advised that **r**egular reporting would on ARRS Expenditure will be presented to future PCCC meetings to ensure that the allocations are utilised as much as possible.

23/24 budget setting - discussed in brief with Bury PCCC being informed of the budget allocation for the Place and QIPP targets. They were also notified that there would be a consistent approach for prescribing being implemented which would mean moving to a GM methodology and as such this would have an impact on the outturn position.

GM Quarterly Assurance Report and Risk Report - Bury PCCC also received for their information

Priority actions in coming period:

PCCC Membership - Consider additional attendees in order to mitigate future quoracy issues
Cost of Living Crisis – Progressing actions suggested by PCCC attendees
Bury LCS – Contract monitoring/management
General Practice Strategy – Continued development and delivery of key priorities identified as part of the general practice strategy
COVID Vaccination Programme - ongoing delivery support
Primary Care Assurance – both practice quality visits and contractual assurance taking place

Decisions made:

Endorsed the approval of the final LCS for Bury
Redbank/Mile Lane Partnership Change – PCCC noted the intention behind the proposals and supported following feedback from GM ICP.

Top 3 risks & mitigation:	RAG rating
Recruitment and retention of the workforce including ARRS recruitment/spend – work is in hand in understanding the risks associated with any underspend and of future planning in anticipation of the allocation for 24/25.	
Estates - The lack of suitable PC estate is impeding the way in which providers work and services are delivered. No mitigations in place, currently working beyond core hours to deliver services where necessary	
23/24 Budget Setting – allocation for Place and QIPP targets	

Any other information:

Key escalations for NHS Greater Manchester PCCC:

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Agenda Item 17

BURY INTEGRATED CARE PARTNERSHIP

Meeting: **Locality Board**			
Meeting Date	05 June 2023	**Action**	Receive
Item No.	17	**Confidential**	No
Title	GM Primary Care Blueprint – Final Engagement Draft		
Presented By	Mark Beesley, Chair of the GPLC		
Author			
Clinical Lead			

Executive Summary

The Primary Care Blueprint is attached for information. This is the final engagement draft for comment from colleagues.

The document has been co-created by leaders drawn from the Primary Care Provider Board and NHS GM Integrated Care's locality and central teams. It's starting point was the Primary Care Summit, held in September 2022 and it also provides a Primary Care response to the GM Integrated Care Partnership Strategy, as approved in March 2023 and the national Fuller Review of Primary Care from May 2022.

The purpose of this engagement draft is to provide as much opportunity as possible for the final version to be informed and shaped by Primary Care professionals, our health and care partners, our colleagues from the VCSE and our service users

Recommendations

That the Locality Board receive for their information the Primary Care Blueprint and comment as appropriate. All comments are to be received by 30th June 2023.

Links to Strategic Objectives	
SO1 - To support the Borough through a robust emergency response to the Covid-19 pandemic.	☒
SO2 - To deliver our role in the Bury 2030 local industrial strategy priorities and recovery.	☒
SO3 - To deliver improved outcomes through a programme of transformation to establish the capabilities required to deliver the 2030 vision.	☒
SO4 - To secure financial sustainability through the delivery of the agreed budget strategy.	☒
Does this report seek to address any of the risks included on the NHS GM Assurance Framework?	☐

Implications						
Are there any quality, safeguarding or patient experience implications?	Yes	☐	No	☐	N/A	☒
Has any engagement (clinical, stakeholder or public/patient) been undertaken in relation to this report?	Yes	☒	No	☐	N/A	☐
Have any departments/organisations who will be affected been consulted ?	Yes	☒	No	☐	N/A	☐
Are there any conflicts of interest arising from the proposal or decision being requested?	Yes	☐	No	☐	N/A	☒
Are there any financial Implications?	Yes	☒	No	☐	N/A	☐
Is an Equality, Privacy or Quality Impact Assessment required?	Yes	☒	No	☐	N/A	☐
If yes, has an Equality, Privacy or Quality Impact Assessment been completed?	Yes	☐	No	☐	N/A	☒
If yes, please give details below:						
If no, please detail below the reason for not completing an Equality, Privacy or Quality Impact Assessment:						
Are there any associated risks including Conflicts of Interest?	Yes	☐	No	☐	N/A	☒
Are the risks on the NHS GM risk register?	Yes	☐	No	☐	N/A	☒

Governance and Reporting		
Meeting	**Date**	**Outcome**

NHS

Primary Care Blueprint

Engagement draft - April 2023

Developed by:
NHS Greater Manchester Integrated Care
NHS Greater Manchester Primary Care Provider Board

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Primary Care Blueprint

Executive summary

Executive summary

This Engagement Draft of our Primary Care Blueprint sets out the initial outputs of our work and will be used to support a programme of detailed engagement across our system over the period to the end of June.

The document is deliberately framed to facilitate discussion and in particular, to allow debate to take place with regard to the specific outcomes and measures which will form the basis of the production version of the Blueprint. On this basis, we have resisted the temptation to be too prescriptive in this version, recognising the importance of a co-produced approach to this development.

Developing our vision for Primary Care in Greater Manchester

Currently split across nine areas or chapters, (we will take a view as part of this engagement process as to how best to structure the production version), the Blueprint sets out a vision for a Greater Manchester Primary Care system which will:

✓	Provide timely appropriate access to care delivered by a system which has sufficient capacity to meet the needs of service users, where processes are simple and straight forward
✓	Be part of a wider neighbourhood team, where individuals and communities are supported to take more control over their own health and where providers work together with the shared aim of improving the health of the population
✓	Ensure that we do not exacerbate health inequalities and takes practical steps to tackle these inequalities wherever we can
✓	Help people to stay well and focuses on disease prevention, early detection and effective management of long-term conditions
✓	Be viable for the long term, ensuring that services are available when and where needed
✓	Empower citizens and providers with gold-standard, digitally enabled Primary Care
✓	Be delivered from facilities which are appropriate for the provision of 21st century Primary Care
✓	Be standards based, with a focus on quality improvement
✓	Be recognised as a career destination for a happy, healthy and engaged workforce, trained to a consistent standard with knowledge and expertise to meet the needs of our population and provide timely, exemplar services.

Our Manifesto for Change

The document sets out a wide ranging suite of ambitions, designed to deliver the vision set out above, as well as describing the current issues facing our Primary Care system and some of the risks to delivery. The list below draws out some of the big ideas contained in the document to give a sense of the key objectives we plan to deliver over the next five years. We will further test and develop each of these points as part of the engagement process:

Critical Success Factors

The main document starts to describe the key issues and deliverables across our nine chapters. Engagement to date has identified a series of overarching issues which we believe will be essential to the delivery of the Blueprint. These are set out below and will be further augmented and reviewed as part of this engagement process:

- Primary Care must be viewed as an integral part of each of our 10 localities, including via formal representation on Locality Boards and other locality governance
- Completion of the implementation of the financial flows model previously agreed where money flows to Primary Care providers as directly and smoothly as possible
- Securing full implementation and visibility of our Primary/ Secondary Care and GP/ Community Pharmacy interface principles which will be important in managing pressures in our system but also in cementing the joint working which will be crucial to the delivery of the Blueprint
- The implementation process will need to be supported by:
    - An agreed programme delivery approach
    - Clinical leadership engagement and development
    - An organisational development process
- We will work to ensure some "early wins" to move forward on a series of issues which have been in train for some time, including but not limited to:
    - Occupational Health provision
    - Phlebotomy Services
    - Implementation of an updated "Sitrep" pressures management process

Next Steps

Over the period to the end of June, we will:

✓	Deliver a wide ranging engagement programme, informed by the content of this document
✓	Develop a business case for the investment necessary to deliver the ambition set out in the Blueprint
✓	Focus on maximising our use of information to inform our implementation plan and to further support the business case for investment made by this document
✓	Develop an implementation plan to cover the full five year period of the Blueprint, with a particular emphasis on making tangible early progress during year one

We will continue to test the emerging document with our Primary Care Assembly and use the content to progress discussions with wider industry partners, VCSE colleagues and others, with a view to building a delivery system that maximises all of their contributions.

How to contribute and influence the final content

As indicated above, we are keen that this engagement draft leaves scope for the production version to be shaped by this next phase of engagement. We therefore seek as much feedback as possible in the period to the end of June. We don't wish to limit this input by issuing a set list of questions to answer and welcome feedback on any aspect of the document.

To give a broad steer, these may be some of the issues that colleagues wish to feedback on:

Q.	Q.	Q.
Have we correctly identified the priorties for delivery and if not, what should be included?	If we implement the key issues set out in the document, will this make a positive difference to your experience either as a provider, service user or delivery partner? What could be added to the document to improve on this?	What should be the key delivery metrics and how will they be measured?

We welcome all comments

These should be addressed to: alison.wheatley6@nhs.net by 30th June.

Primary Care Blueprint

Introduction

Introduction

Since our Primary Care Summit in September 2022, we have been working on this initial version of the GM Primary Care Blueprint, designed to support a period of engagement through to the end of June. The results of this engagement will inform a production version of the Blueprint, which will then proceed through into implementation.

Each of the chapters in the document has been developed by a triumvirate of leads drawn from the following areas:

Primary Care Provider Board	Locality Teams	GM Primary Care Team

The following principles have informed all of our work:

- Each chapter must reflect all parts of our Primary Care system (Dental, General Practice, Pharmacy and Optometry)
- It must align with the NHS GM Integrated Care Partnership Strategy, (as approved at the March 2023 Integrated Care Partnership Board) and other related strategies/plans, i.e. Estates, People and Culture, Digital, etc
- The content should align with relevant national strategies, specifically the Fuller Report published in May 2022
- As well as our Primary Care teams, we have been informed and advised by our Primary Care Assembly, drawn from our wider GM Integrated Care partners

The main document starts to describe the key issues and deliverables across our nine chapters. Engagement to date has identified a series of overarching issues which we believe will be essential to the delivery of the Blueprint. **These are set out below and will be further augmented and reviewed as part of this engagement process:**

- Primary Care must be viewed as an integral part of each of our 10 localities, including via formal representation on Locality Boards and other locality governance
- Completion of the implementation of the financial flows model previously agreed where money flows to Primary Care providers as directly and smoothly as possible
- Securing full implementation and visibility of our Primary/ Secondary Care and GP/ Community Pharmacy interface principles which will be important in managing pressures in our system but also in cementing the joint working which will be crucial to the delivery of the Blueprint

- The implementation process will need to be supported by:
    - An agreed programme delivery approach
    - Clinical leadership engagement and development
    - An organisational development process

- We will work to ensure some “early wins” to move forward on a series of issues which have been in train for some time, including but not limited to:
    - Occupational Health provision
    - Phlebotomy Services
    - Implementation of an updated “Sitrep” pressures management process

Over the three month period to the end of June, we will:

✓	Deliver a wide ranging engagement programme, informed by the content of this document
✓	Develop a business case for the investment necessary to deliver the ambition set out in the Blueprint
✓	Focus on maximising our use of information to inform our implementation plan and to further support the business case for investment made by this document
✓	Develop an implementation plan to cover the full five year period of the Blueprint

We will continue to test the emerging document with our Primary Care Assembly and use the content to progress discussions with wider industry partners, VCSE colleagues and others, with a view to building a delivery system that maximises all of their contributions.

Primary Care Blueprint

Demand, access and capacity

Demand, access and capacity

Providing timely appropriate access to care delivered by a system which has sufficient capacity to meet the needs of service users, where processes are simple and straightforward and operate in a neighbourhood which promotes prevention, self-care and early diagnosis

2.1 What do we mean by Demand, access and capacity

DEFINITIONS

Demand:	People wishing to access the service or who would benefit from accessing the service
Access:	The mode of contact into the service
Capacity:	The health and support provision to make the contact and onward associated services work effectively and meet the needs of the person and their carers

When demand, access and capacity, as defined above, are in balance, the result is efficient flow through our system. They are however rarely in perfect harmony and our challenge is to balance all three in a continuous cycle of flexible review and change. When one of the elements comes under pressure, we find services become unbalanced and sometimes unsustainable, resulting in additional pressures for staff and service users reporting their expectations not being met.

In writing this chapter it is important to reflect that demand, access and capacity is different in the four disciplines of Primary Care and in some cases demand and access are merged due to the open-door nature of services. It is also important to acknowledge the role of preventative, screening, and wellness services which fundamentally change the shape of demand into services, keeping citizens well, supporting early diagnosis and promoting self-care.

The pandemic brought change and in some cases transformation to demand, access and capacity. The Primary Care delivery model had to change overnight, with a short-term reduction in capacity and more access being delivered online. The opportunity to move to digital solutions where appropriate was accelerated and now needs to settle into a more measured way of understanding how digital can support Primary Care services and citizens alike.

Primary Care, and particularly general practice has had the advantage of the Additional Roles Reimbursement Scheme (ARRS) initiative which has brought many more clinicians and support workers into Primary Care Networks, (PCNs), increasing workforce and the opportunity to offer flexible solutions to patients and more capacity into neighbourhoods. For this opportunity to work well we must integrate not only across Primary Care disciplines but also with the wider public sector, voluntary sector, and the business community to make the most of our workforce, local services, and buildings.

2.2 Greater Manchester Pledges

In making these pledges in Greater Manchester we are considering the recommendations coming from the Fuller Report, national GP Contract, GM ICS Strategy, Primary Care Recovery Plan (which we anticipate being published in May 2023).

Whilst the current process of engagement will firm up our detailed priorities, outcome measures and plans for delivery, there are some clear issues relating to access which we believe are of key importance to our service users and are therefore set out here as likely cornerstones of our work as we move forward:

- Ensuring same day urgent access to Primary Care where clinically warranted and agreeing an appropriate response at first contact for all non-urgent requirements
- Removing the so called “8 am rush” in General Practice, via a support programme which will include investment in the telephony infrastructure, encouraging optimal use of the NHS App and a programme of development support for PCNs and practices.
- Delivery of a Dental Quality scheme which will seek to improve access to NHS Dentistry across GM
- Building on the core Community Pharmacy Contractual Framework, to develop and deliver pharmacy services to improve access and reduce health inequalities e.g, in developing a harmonised GM Minor Ailments scheme

More generally, the following sets out how we will work together to realise our vision:

✓	We will create a culture where health, social care, the voluntary and third sector and local business will be committed to keeping neighbourhoods connected and wrap care around people, keeping people healthy and happy. This will support early presentation of illness and encourage uptake of prevention and social prescribing programmes, e.g., active initiatives, screening programmes and local groups such as gardening. Neighbourhoods will also be proactive in supporting people when they are living with long term and life limiting illness. This model of care will help us to manage the demand on our services, supporting people to make good decisions about their health and self-care. This point is emphasised in the ICP Strategy, which states that: *Our integrated neighbourhood teams work to connect all Primary Care services including GPs, dentists, pharmacists and optometrists with community, social and local acute care, local VCSE and wider public services (such as housing providers, schools, employment support and the local police and fire and rescue service). We will not miss the opportunity to maximise the enormous potential of community pharmacy* **(links to Neighbourhood, prevention and inequalities chapters)**
✓	Primary Care disciplines will work together, making every contact count and taking responsibility for those in their care by sign posting and undertaking checks such as blood pressure or giving simple advice. Contracts will be modernised so this can happen easily to the benefit of the person **(links to quality chapter)**
✓	Care records will be interlinked so that information is available to relevant practitioners when the person is happy for that to happen. People will also have access to their own information and be able to interact with it (**links to digital chapter)**
✓	Neighbourhood teams in health, social care and the voluntary sector will be

	co-located and available where people need them, working together for people and families. This approach will encourage shared caseloads and interactions between sectors **(links to estates and neighbourhood chapters)**
✓	We will work with our further education colleges and universities to create new roles which will emerge to support collaborative working. In doing this we will make the most of GM's One Workforce, One Model initiative **(links to workforce chapter)**
✓	We will establish good workforce planning so that we plan our future workforce to reflect our communities and their needs **(links to workforce chapter)**
✓	Primary Care will adopt digital technology to modernise access to care and case finding within neighbourhoods. Websites will be standardised and easy to navigate, telephony will be cloud based to enable calls to be picked up in different places, navigation tools will go hand in hand with good customer service and enable people to get to the right place and see the right professional in a seamless way. This will be helped by maximising the opportunities available in the NHS app **(links to digital chapter)**
✓	We will enable people to access our services in ways that suit them and how they understand, whether that be online, on the phone or at the door **(links to digital chapter)**
✓	We will create a data culture where we make the most of intelligence across the elements of demand, access and capacity, ensuring we understand our people and their preferences **(links to digital, prevention and inequalities chapters)**
✓	People will report a change in the way they experience our services and report a good experience. Where experiences are not so good, we will listen and respond with a culture of continuous improvement **(links to sustainability chapter)**

How will we know we are getting better?

Measuring the data we currently collect:
How many appointments are available/contacts made and in which modality (phone, face to face, virtual if applicable to discipline). We can then work out the profile against population and social economic status for each neighbourhood/locality.

By asking staff:
"Do you feel you have the right balance in your working day and are able to see the people you need to see and offer the service they need?"

By asking people who use our services:
"Did you receive the care you needed at a time convenient to you and with the most appropriate health/care professional?"

Primary Care Blueprint

Integrated working in neighbourhoods

Integrated working in neighbourhoods

Part of a wider neighbourhood team, where individuals and communities are supported to take more control over their own health and where providers work together with the shared aim of improving the health of the population

3.1 Where are we now

- ("*Our integrated neighbourhood teams work to connect all Primary Care services including GPs, dentists, pharmacists and optometrists with community, social and local acute care, local VCSE and wider public services (such as housing providers, schools, employment support and the local police and fire and rescue service). We will not miss the opportunity to maximise the enormous potential of community pharmacy…").*

The concept of integrated neighbourhood working is not a new one. Integrated Neighbourhood working is a key building block in our GM architecture. Indeed Greater Manchester is seen as a trailblazer, under GM Devolution harnessing the concept of integrated neighbourhood working, to remove fragmentation between services. The belief that Primary Care is integral to this model, built around populations of circa 30,000 – 50,000 to deliver population based models of care, was a fundamental aspect of the GM Primary Care Strategy, (2016 – 2021). Subsequent national strategy followed with the introduction of Primary Care Networks and the more recent Fuller Stocktake Report.

What we mean by integrated neighbourhood working is connecting communities, working alongside them and understanding their needs. By unlocking skills, expertise, and resources within communities, at neighbourhood level, we can address the inequalities that exist. This is not just about professional Integrated Neighbourhood Teams, (INTs), this is about working in a very different way, with the population rather than to them.

Integrated neighbourhood working has the ability to positively impact on rising demand through reducing avoidable hospital admissions and keeping people at home and more independent for longer. By providing proactive care in local neighbourhoods, seeking out those most at risk and through developing enhanced relationships at an intermediate tier level, working with system partners to enable people to be supported and managed at home and in their community.

Operating in a multi-disciplinary manner facilitates the provision of, and access to place based care with local services responding to local need. Integrated neighbourhood working with partners across VCSE, community and wider public services is one vehicle with which to tackle inequalities, drive the early intervention and prevention agenda and offer a more sustainable Primary Care with a much broader workforce, across multiple organisations, working with people and communities to deliver care and support at its heart.

These principles are very much paramount today and which we continue to base our delivery models, our ways of working and ethos upon them. A significant amount of work has taken place with numerous exemplar areas across Greater Manchester, yet we know that there is still variation across localities and across neighbourhoods. This is not necessarily due to a lack of aspiration but because of other factors.

For example, there are varying levels of maturity. There are pockets of innovation, but this is not universal across Greater Manchester. There are also barriers such as workforce, estates and digital. There is evidence of cross sector working to deliver care and strong VCSE partnerships in some areas but not all. Similarly, there are good working relationships with other clinical teams and providers, but this is not consistent. We engage with other providers as part of integrated neighbourhood working however this is not inclusive of all Primary Care providers.

3.2 Reiterating our reasons why – what would good like?

The benefits and rationale of integrated neighbourhood working have been well rehearsed and we believe these still resonate today, mainly that:

✓	People and communities within the neighbourhood are a fundamental part of the delivery model and are working with them, not to them
✓	Greater collaboration between providers can support better decision-making on resource allocation, reduced waste, increased efficiency and return on investment, higher quality, better outcomes and more sustainable services and a reduction of health inequalities
✓	Focus on the wider determinants of health, early intervention and prevention working with wider public sector, voluntary and business partners: • Schools • Employment • Housing • Fire and rescue Drugs and alcohol services • Local police • Criminal Justice system
✓	Utilising population health management tools and data to understand local populations, to proactively anticipate care needs and provide support and preventative care before crises occur. This approach to population health management will drive integrated care for people-especially with long term conditions and those most at risk
✓	Look for hidden communities, and offer tailored support and intervention to meet their specific needs. A neighbourhood model, typically serving 30-50,000 residents, centred around the GP list, connecting primary, community, social and local acute care with VCSE and wider public services, as can be seen on the next page.

Integration opportunities

This is very much aligned to the GM ICP Strategy which sets out the direction for the next 5 years for developing our model for health in Greater Manchester, with strong references to integrated working:

Providing proactive primary care and support and reducing demand on acute services through a comprehensive neighbourhood model spanning public services, local business and community led groups

Our thinking is also aligned to the national direction outlined in the Fuller Stocktake Report and the vision to build **integrated neighbourhood teams (INTs)** to achieve three essential deliverables:

✓	Improved access to Primary Care
✓	Improved **continuity** (and more proactive/personalised care) to people with complex needs
✓	Reduced **health inequalities** and a more ambitious approach to prevention

We also need to take our aspirations further, building on our original vision of more joined up services closer to people's homes. There is so much more that can be delivered through integrated teams, redirecting resources, upskilling our workforce and relieving pressures from other parts of the system, for example Practitioners with a Special Interest, service/pathway redesign and resource to primary/community care, delivered via integrated neighbourhood working.

1.3 How will we do this?

Our collective efforts to date clearly show that the establishment of integrated neighbourhood working does not happen overnight. A recent, GM study[1] has shown that for integrated teams to work effectively, there needs to be key elements for partnership working, such as consensus, equality, agreement, leadership, structured team building, flexibility, and a system of accountability across partners.

Furthermore, we know from our experience and learning that we need to create the right conditions, such as:

✓	Relationships
✓	Empowering frontline staff and giving permission to act
✓	Developing partnerships between PCNs and VCSE
✓	Enabling integrated working across health and social care teams and wider public sector
✓	Clinical and managerial leadership / capacity
✓	Interface across sectors
✓	Knowing your population – data and intelligence
✓	Time / Headspace
✓	Organisational Development (OD)
✓	Knowing what services are available within the neighbourhood
✓	Working / thinking differently to support people/communities and deliver improved patient care

Fundamentally, integrated neighbourhood teams are formed, developed and harnessed at a local level, through integrated locality partnerships, provider collaboratives and within neighbourhoods themselves. From a Primary Care system level, we need to consider what is within our gift, where can we add value and how we share the learning. We also need to ensure that we are striving for consistency of offer, that patients and communities have the same experience of the seamless care with fewer handoffs and providers working in an integrated way.

In doing that we want to reaffirm our GM model of care that has early intervention and prevention as an organising principle. We will describe our approach to seeking out those who are most at risk but unseen, and those who are seen and frequently use primary and secondary care services. We will use holistic, strength-based needs assessments through a personalised approach to coproduce care plans that include social, psychological and medical needs. This will be driven through a population health approach targeting those cohorts and conditions that drive demand through integrated working within local neighbourhoods. We will

[1] Primary Care Networks and Voluntary, Community, Faith and Social Enterprise Sector Partnerships Interim Report, March 2023

take learning from models such as proactive care, high intensity users, upstream models of care, focussed care to describe our single Greater Manchester model of care which we will look to mainstream over the next five years.

Our plan therefore is phased over the next five years, with an initial focus to understand the excellent work that has been delivered so far, sharing best practice and identifying barriers and challenges. To determine what can be done once at a GM level and where there can be central support to spread innovation and good practice. To identify where we can we influence and lever at a GM system level, regional level and nationally.

Priorities for 2023/24 – year one

- Understanding what works and sharing best practice via localities, PCNs, Providers (Primary, Secondary and Community Care, VCSE)
- Understanding what matters to the patient/public via ongoing patient/public engagement
- Prioritise wrapping care around the high users of health services, i.e. focussed care, care-co-ordination
- Supporting PCNs and Primary Care providers through a GM maturity matrix where PCNs can self-assess and identify areas of support
- Building on and enhancing the offer of support via PCN Development Programme
- Opportunities for different interface with people and communities, i.e. co-location, integrated 'primary/community hubs' with VCSE, particularly supporting prevention initiatives
- Survey in public spaces
- Influencing the enabling workstreams to support the continued development and delivery of integrated neighbourhood working, such as workforce, OD, Estates.
- Accelerate our digital programme such as:
    - Aiming toward a digitally connected neighbourhood – Community Providers, GPs, and social care frontline as the first priority
    - Enabling full use of NHS app by all practices for repeat prescriptions, booking and access to notes
    - Connect NHS app to all the triage platforms that sit behind it via booking mechanism
- Accelerate GP and Community Pharmacy Interface so that all areas have GP Community Pharmacy Consultation Services, (CPCS). Ensure there are connections with local Community Pharmacy. All PCNs meet with lead Community Pharmacy for neighbourhoods

- All PCNs identify high attenders / high users of urgent care and wrap care around them, such as Focussed Care, Care Co-ordination, pro-active care
- 'Getting the wiring right' – identifying and addressing infrastructure, i.e., contracts, regulatory frameworks, funding flows

From year two onwards, we will build on this foundation, continuing to take the learning and understanding which we have captured as part of the engagement, self-assessment and ongoing conversations with our people and communities.

We will build the digital model and look at automating processes.

We will evaluate the year 1 work.

We will focus on industry partnerships in NHDs.

To encapsulate the various programmes of work to ensure that consistency of offer to the population of GM.

To think differently and radically in terms of how we can support our population and our Primary Care workforce through a more resilient, sustainable model.

3.4 Benefits and outcomes

The benefits to individuals through integrated neighbourhood working will see a less fragmented service; fewer handoffs and a more seamless approach to care and support. The patient benefits are:

✓	To support individuals & communities to take **more control** and navigate their own health
✓	People remain **independent for longer** in their own home through early intervention & prevention
✓	Better experience of more **joined up, personalised care**
✓	People feel more **empowered to manage** their condition and feel more **socially connected** through asset based approaches
✓	**Less duplication and replication**, releases capacity and is more efficient by bringing in a wider range of partners
✓	Provides a focus on **tackling health inequalities** through the contribution of more partners and multi-disciplinary team working
✓	Focus on the **health & wellbeing of a defined population**
✓	**Reducing demand** on all parts of the system

From a Primary Care provider perspective, this will mean a more integrated way of working in the support and management of their patient's care. Being part of a broader integrated team in a joined up way therefore avoiding duplication, more timely intervention and a multi-disciplinary team approach to more complex cases.

Furthermore, working in broader partnerships with the VCSE and wider public service will also seek to address the wider social determinants which often have a significant impact on the healthcare needs of people, i.e. housing, deprivation, employment.

3.5 Risks and Barriers

Based on our learning and experience to date, risks and barriers to harnessing integrated neighbourhood teams however we anticipate capturing further risks and barriers as part of our engagement over the coming months.

- Time and dedicated capacity, recommending that each PCN will need a Transformation Manager
- Demonstrable outcome and impact
- Ability to remove ‘organisational walls’
- Resources – people, estates, funding
- Cost/ benefit and risk sharing
- Information Governance / Data Sharing
- Incompatible IT systems
- Infrastructure, i.e. regulatory frameworks, contracts
- Financial flows

Primary Care Blueprint

Health inequalities

Health inequalities

Ensuring that we do not exacerbate health inequalities and taking practical steps to tackle these inequalities wherever we can

4.1 What is driving inequalities?

Poverty and structural inequalities are key drivers of health inequalities and lead to unjust differences in opportunities to live a healthy life (a result of the interplay between individual, family, community and societal characteristics such as race, gender, disability).

The way we currently do things can make inequalities worse:

- Primary Care contractual and performance arrangements do not always ensure that resources (including capital, programmes and workforce) are targeted to communities and neighbourhoods with the greatest need
- Who does 'what', where and how we work as a system across organisations prevents progress on reducing inequalities e.g., there aren't mechanisms to scale up good practice or use a shared care record

4.2 What will good look like?

- Performance, contracting and quality systems are owned collaboratively at place and PCN level across all providers focusing on improving outcomes for all communities not simply focusing on outputs and population averages with shared accountability
- Primary Care workforce capacity and capability strengthened in areas of greatest need
- All resource is prioritised to reduce inequalities
- Primary Care pathways are co-designed with people who are digitally, financially or culturally disadvantaged and excluded and tools that promote access and engagement are adequately resourced e.g., through free GP phone lines or multilingual receptionists and through different delivery models/points of access such as hyper-local community settings that people trust and are familiar with for example schools, community centres, etc
- Mechanisms to scale up examples of good practice are used by default and to learn and share across VCSE and public sector
- Transparent mechanisms for accountability are natively digital and check and challenge is collective

4.3 How will we do this?

- Population Health Management tools - These tools will be hosted online (GM Health and Care Intelligence Hub) to plan, deliver, monitor and evaluate Primary Care. A range of tools are required to support:
  - Risk stratification
  - Reidentification
  - Performance improvement and recovery
  - Cost benefit analysis

  - Impact assessments
- Fundamentally revising accountability for reducing health inequalities – refocusing this so it sits equally across localities, ICB team and Primary Care providers
- Develop cross-sectoral system leadership – aligning leadership programmes that focus on inequalities, equalities and sustainability (NHS Net Zero) through a GM Population Health and Inequalities Academy
- Establish cross-sectoral Communities of Practice with other workstreams to co-design guidance and workforce development tools on integrated neighbourhood working and review key neighbourhood functions to address inequalities, including:
  - Community development
  - Neighbourhood planning and engagement with neighbourhood boards
  - Co-design and co-delivery
  - Targeted outreach (understanding and responding to appointment non-attendance and hidden harm)
- Push the boundaries of provision – make the most of every access point in every community. Develop multimodal approach for Primary Care and simplify points of access: Standardised and core offer clearly communicated, working with communities to co-design and co-deliver communication and engagement plans
- Develop an agreed workforce plan that aligns to the health needs of communities (interest, identity and geography) that is adequately resourced for inclusive recruitment, retention and workforce development
- Ensure the totality of the Primary Care workforce can access the GM Shared Care Record
- Establish a GM wide Business resource for wider Primary Care to enable
  - access to GM Care Record for all Primary Care
  - Single source of information (data lake)
  - Workforce planning and training provision
  - recruitment and retention including best practice and approved terms and conditions
- Locality boards to co-produce inequality reduction plan with locality GP/ Primary Care boards

The final version will incorporate a number of case studies to illustrate how we will increase access and engagement with Primary Care for different communities e.g.:

a. Targeted pop-up clinics
b. Partnerships with the 3rd sector, religious and community leaders
c. Making phone calls to GP practices on behalf of patients, albeit not sustainable
d. Multilingual and culturally aware staff

4.4 Benefits and outcomes

- Primary Care resource is distributed according to need (advocating nationally when national contracting/funding allocation is not proportionate and being clear what is in scope within GM to change)
- PCN/Localities/LCO/Provider Federation are supported to consider workforce constraints - Capacity/capability alongside wider Primary Care and neighbourhood workforce (including VCSE)

- Primary Care workforce paid the living wage – which will improve retention and improve health and well-being of the workforce
- Mechanisms to share and learn across clinical/organisational boundaries will lead to greater innovation, collaboration and less duplication of effort e.g. Bolton GP Federation already has these mechanisms in place through GM Training Hub. How can wider-GM utilise?

4.5 Risks and barriers

- How do we ensure equitable resource distribution (£ and people)? Is there commitment to differential investment to achieve desired outcomes? And at what geographical level is this decided at?
- How can we ensure Primary Care workforce are representative?
    a. Adequate re/training regarding race and gender?
    b. More transparency of workforce data e.g., to be published more frequently to understand patterns e.g., using Virtual Workforce Information System (VWIS)
    c. How can we encourage staff to move/work in more deprived areas?
    d. Would GM wide recruitment guidelines be useful?
- How can we support staff well-being? How can we support Primary Care organisations to become members of the Good Employment Charter?
- GM localities to explore and review best practices on how to spend budgets e.g., ARRS underspend/spillage
- How can the target operating model focus on outcomes and principles?

Primary Care Blueprint

Prevention

Prevention

A Primary Care system which helps people to stay well and focuses on the prevention and early detection of ill health, and the effective management of long-term conditions.

5.1 Where are we now?

In GM, people become ill earlier, spend more time in poor health, and die earlier than the national average. Life expectancy and healthy life expectancy for people born in GM is significantly lower than the England average. There are also significant health inequalities within the city-region. For example, a male born in Manchester can expect to live an average of almost 5 years less than a male born in Trafford. For healthy life expectancy there is almost 10 years difference between individual local authority areas. Much of the burden of poor health and early death (borne disproportionately by our most deprived and vulnerable communities) in GM can be attributed to conditions that are preventable (including many cardiovascular and respiratory diseases, type 2 diabetes, and some cancers). It is estimated that 42% of morbidity and premature mortality in England is attributable to modifiable risk factors.

There has been significant progress since devolution in helping people across GM to start well, live well, and age well (including scaled, multi-component approaches to some of our main modifiable risk factors). However, access to preventative services was impacted during the pandemic, and some have been slow to recover. As we continue to work towards pandemic recovery, we have the opportunity to build on previous work and create a Primary Care system that supports residents in GM to stay well for longer and works alongside patients and communities to build healthy lives and places.

5.2 What does good look like?

Our goals are to:

✓	Support individuals across the city region to protect, maintain and improve their mental and physical health, wellbeing, resilience, and social connections
✓	Create a culture where prevention is seen as ‘everyone’s business’ across the Primary Care workforce (including General Practice (GP), pharmacy, dentistry and optometry), and neighbourhood teams, and enable staff to take action
✓	Detect illness at an early stage and ensure it is proactively managed to reduce the risk of progression
✓	Ensure that long-term conditions are effectively managed to reduce their impact on individuals and the wider system
✓	Tackle health inequalities by working with system partners to address the wider determinants of health and wellbeing through integrated neighbourhood working
✓	Expand culturally appropriate, locally led preventative services that better reach into disadvantaged communities, and those not in contact with NHS services
✓	Shift the focus of activities and resources away from urgent and emergency care and towards prevention
✓	Achieve widespread implementation of upstream models of care, which means delivering care that is: person-centred, preventative, integrated with wider welfare

	and social support, trauma responsive, targeted and proportionate to need, and environmentally and socially sustainable

5.3 How will we do this?

Our areas of focus can be divided into four categories:

1. **Prevent** or reduce the risk of ill health
   - Utilise learning from the COVID-19 pandemic to maximise vaccination uptake, especially among target populations (focusing on COVID-19, influenza, pneumonia, and childhood vaccination)
   - Maximise the role of Primary Care in ensuring every child in GM has the best start in life (focusing on breastfeeding and perinatal and parent-infant mental health/relationships)
   - Work with the PCCA team and GM Primary Care Board to implement approaches to personalised care and support across PCNs through a common framework. Ensure all Primary Care staff are skilled and confident in practicing personalised care, including increasing uptake of health coaching and motivational interviewing training
   - Maximise the use of 'Making Every Contact Count' across all Primary Care disciplines to enable staff to support behaviour change, signpost to local services and provide very brief or brief advice during patient contacts
   - Improve interdisciplinary referral pathways for Primary Care and enable wider Primary Care teams to refer directly into social prescribing initiatives, behaviour change services, and wider welfare support
   - Optimise prevention programmes to improve oral health (particularly in children and young people and end of life care), including implementation of the Delivering Better Oral Health toolkit, and roll-out of the Mouthcare Matters training package
2. **Detect** conditions, or risk factors for disease, at an early stage
   - Increase the uptake, reach, quality, and impact of NHS health checks across GM, with an initial focus on high-risk and inclusion health groups
   - Work in partnership to improve hypertension/ atrial fibrillation (AF) case finding and diagnosis pathways in wider Primary Care (building on the current work in community pharmacies), and non-NHS settings, with a focus on CORE20+ groups
   - Optimise the Severe Mental Illness (SMI) and Learning Disabilities (LD) Health Check Programmes, with a focus on CORE20+5 groups
   - Optimise the early cancer diagnosis programme (PCN Directed Enhanced Service (DES), with a focus on improving access and reducing inequalities in uptake and experience
   - Increase the proportion of patients identified early for End of Life (EoL) care by rolling out tools and resources to support this
3. **Protect** people from worsening ill health by effectively managing conditions or risk factors for disease at an early stage
   - Work with the Strategic Clinical Networks (SCN) to develop and promote a range of tools and resources to optimise the management of hypertension, hyperlipidaemia, and AF across GM

- Ensure all Primary Care staff have access to trauma responsive training and develop pathways to improve identification of victims of Gender Based Violence and referral into support
- Carry out targeted work with PCNs to embed and reaffirm an approach to early intervention and prevention. Taking our learning from models such as proactive care, focussed care and high intensity users to describe a single model for GM which we will mainstream over time. This will be driven through a population health approach targeting those cohorts and conditions that drive demand through integrated neighbourhood working utilising ARRS roles and multi-disciplinary teams (MDTs) within local neighbourhoods.
- Through proactive care and the Aging Well Programme, work with the GM Combined Authority (the Aging Hub), and Falls Collaborative to prevent falls through early intervention

4. Manage long-term conditions effectively.
    - Create a GM standard for the management of chronic respiratory conditions (asthma/ Chronic Obstructive Pulmonary Disease (COPD)), cardiovascular disease, and diabetes
    - Promote environmentally sustainable approaches to prescribing across GM (such as green inhaler initiatives, awareness of air pollution impacts, and green social prescribing) in line with the 10-step plan, adhering to and exceeding national targets as defined annually
    - Support staff to have person centred holistic long term condition reviews, that integrate consideration for wider welfare and social support, and improve referral pathways into support services (social, financial, emotional, housing)
    - Increase use of digital solutions to support self-management e.g., Blood Pressure (BP) monitoring, blood sugar, pulse oximetry

This work will be enabled through:

✓	Strengthening relationships at place between Primary Care and Health and Wellbeing Boards and locality public health teams
✓	Partnering with our residents and communities and utilising innovative data architecture and capability to develop interventions and models of care that better target and engage those from higher risk populations
✓	Mapping current provision, and agreeing a standardised prevention offer across all ten localities, which can be flexed according to local need
✓	Ensuring all Primary Care staff have access to appropriate training on topics such as Making Every Contact Count (MECC), trauma-responsive care and personalised care

5.4 What are the benefits?

There are significant potential benefits of this work, which reach across the whole health and care system. In the short-term, we might expect to see improvements in wellbeing, stronger, more connected communities, and a reduction in health-harming behaviours (such as smoking, unhealthy diets, physical inactivity and alcohol excess). In the medium and longer

term, we would expect to see a reduction in the prevalence and exacerbation of long-term conditions and an associated drop in the demand for urgent and routine care. This will lead to cost savings for the NHS, increased productivity, and wider economic growth.

5.5 What are the risks?

The risks to this work include:

- Pressure on Primary Care capacity and workforce challenges
- Different Primary Care contracts and incentives, which can result in silo working and target/performance driven-care
- Limited access to integrated datasets for population health management
- Long term benefit realisation to see impact
- Limited funding

Primary Care Blueprint

Sustainability

Sustainability

Primary Care which is viable for the long term, ensuring that services are available when and where needed.

6.1 Introduction

High quality Primary Care is a critical and cost-effective part of the health care system. Patient satisfaction, while variable, is generally high. Although escalating demand and resource pressures can lead to growing dissatisfaction, especially around access to services.

We currently face significant challenges to the long term viability of elements of our Primary Care system in a number of areas, with recent examples including:

- The potential withdrawal from the market of a significant community pharmacy provider, including the recent closure of many branches situated within a major supermarket chain
- The withdrawal of a major dental provider from the market and a number of other providers moving away from NHS provision of dental care
- GP practices "handing back the keys" on their contracts

Unprecedented demand and workforce supply issues both contribute to the current pressures and are explored elsewhere in this document.

We recognise that, without tackling these issues head on, the delivery of the ambitions set out across the course of this document will be severely restricted and in many cases, will simply become unachievable.

6.2 What is the problem and the current position?

i. Viability

a. Business viability
    i. for each service provider model
    ii. Individual provider organisations
b. Resilient delivery and business models
c. Appropriate funding which enables longer term planning and delivery, with less reliance on short term, non-recurrent funding models

ii. System Development

a. *Culture*
    i. Citizen involvement and engagement
    ii. The creation of a culture where citizen involvement and engagement is the norm, where health and care is responsive to what is important to citizens and where there is a real feeling of working together
    iii. Strength of leadership
    iv. At provider, sector and system level
    v. Sharing of good practice
    vi. Spreading what we know works across neighbourhoods and localities?

b. *Information and Intelligence*
    i. Development of outcome based information as evidence for commissioning decisions
c. *Integrated model of care*
    i. The mobilisation of a large collection of individuals, groups, and organisations towards an integrated model of care

iii. Primary Care Delivery Model

a. Facing the challenge of a system response to the demands of the population
b. Meeting the needs of the GM population
c. Developing role and contribution of Primary Care

iv. Environmental Sustainability

a. Primary Care contribution to environmental sustainability and delivery of the NHS GM Green Plan to achieve net zero carbon footprint by 2038
b. Building on, and further development of existing Primary Care plans

6.3 Our ambition for the future

- **Viability** – Ensuring that our Primary Care providers are engaged in a way which supports the long term viability of the sector, with less reliance on short term, non-recurrent funding models and clear plans for future investment and sustainability
- **System Development** – To achieve a viable and flourishing Primary Care system for the future will require a programme of change management including support for:

✓	Development of outcome based information as evidence for commissioning decisions
✓	The mobilisation of a large collection of individuals, groups, and organisations towards an integrated model of care
✓	The creation of a culture where citizen involvement and engagement is the norm, where health and care is responsive to what is important to citizens and where there is a real feeling of working together
✓	Sharing good practice and spreading what we know works across neighbourhoods and localities

- Creation of a **Primary Care Delivery Model** for the needs of the population in 2025 and beyond, recognising the potential to broaden the role of Primary Care, as part of a wider redesign of our public service delivery model
- A focus on **environmental sustainability** recognising the wider NHS ambition to become the first net zero health service in the world

6.4 What we need to do to achieve this

To achieve a sustainable Primary Care system for the future requires a widespread change in our systems culture.

- Strategically we must use a system view and outcome information as evidence for commissioning decisions – remove barriers, pool resources
- Operationally we must mobilise a large collection of individuals, groups, and organisations towards an integrated model of care
- Collaboration through place-based care affords the best opportunity for systems to meet the needs of their populations
- Organisations should work together to govern the common resources available for improving health and care in their area
- The approach taken to develop pathways and services should be local and bespoke
- Commissioning needs to be outcome based and integrated
- Place-based integration (PBI) is a person-centred, 'bottom-up' approach used to meet the unique needs of people in one given location
- It is a way of working, owned by the whole system, not any one service or team

This is achieved by collaboration

✓	Public, community and health services working together to use the best available resources whilst collaborating to share local knowledge and insight
✓	Working in partnership with residents, it aims to build a picture of the system from a local perspective, taking an asset-based approach that highlights the strengths, capacity, and knowledge of all individuals and groups involved

Primary Care Blueprint
Digital

Digital

Empowers citizens and providers with gold-standard, digitally enabled Primary Care.

7.1 Context

In Greater Manchester, we aim to deliver a Primary Care System which empowers citizens and providers with gold-standard digitally enabled Primary Care.

Digital technologies have been ubiquitous in nearly all our daily lives for many years now and Primary Care is no exception to this. Effective utilisation of digital tools can improve efficiency and experience for the users and workforce of Primary Care, recognising that digital tools are not always the most appropriate interface for everyone in the population. As an enabler to Primary Care, digital has a role across all the themes in this blueprint however there are both foundational requirements and aspirational goals to be achieved.

This chapter is structured around four pillars that must be considered to leverage digital as an effective enabler for Primary Care. They are: inclusion, engagement and communication; workforce, training and skills; hardware and infrastructure.

7.2 What is the problem and the current position?

Digital tools are widely deployed but there is considerable variation in both what is in place and how the tools are deployed.

i. *Inclusion, engagement & communication*
    a. Inconsistencies in adoption of digital across people and places
    b. Digital inclusion has not been at the forefront of design of tools
ii. *Workforce/training/skills*
    a. Not currently getting the most out of digital tools
    b. Rapid adoption at start of the pandemic was not pre-empted with robust training
    c. Lack of investment in training workforce with digital skills across Primary Care
iii. *Hardware and infrastructure*
    a. Inequity in hardware available within and between Primary Care disciplines in GM
    b. Digital hardware funding is available for General Practice but not for other Primary Care disciplines
iv. *Software*
    a. Inconsistency in deployment and use of different software available for Primary Care
    b. Rapidly evolving ecosystem of products in use in Primary Care
    c. Lack of consistent interconnectivity and interoperability between Primary Care providers
    d. Limited funding for software is available for General Practice but not for other Primary Care disciplines

7.3 What would good look like if we solved the problem?

Digital tools when deployed effectively will make Primary Care work better for users and the workforce, enabling more efficient and effective care that is experienced positively by all.

i. *Inclusion, engagement & communication*
    a. Accessible and usable tools
    b. Digitally inclusive services, recognising that digital exclusion does not always follow standard patterns of exclusion and health inequality
    c. A population that is knowledgeable about how and when to access care digitally.
ii. *Workforce/training/skills*
    a. Robust training plan for the whole GM Primary Care workforce to enable digital tools to be deployed to maximal effect
iii. *Hardware and infrastructure*
    a. Appropriate hardware in place to make Primary Care fit for purpose now and to be flexible to ensure this is kept fit for purpose in the future
iv. *Software*
    a. Appropriate software in place to make Primary Care fit for purpose now and to be flexible to ensure this is kept fit for purpose in the future

7.4 What will we do to achieve this and what is within our gift?

The digital tools currently available to Primary Care are plentiful, with new tools constantly in development. We will need to take a collaborative approach as a Greater Manchester Primary Care system, ensuring a minimum level of digital capability and functionality across the region, whilst allowing flexibility to account for nuances in local variations in need.

i. *Inclusion, engagement & communication*
    a. Effective use of data e.g. Digital Environment Research Institute (DERI)
    b. Digital inclusion must be a fundamental consideration in all developments.
ii. *Workforce/training/skills*
    a. Create training standards and provide support to Primary Care to achieve them
iii. *Hardware and infrastructure*
    a. Agree a minimum standard of digital hardware for all Primary Care within an appropriate financial envelope to enable Primary Care to achieve its desired outcomes
iv. *Software*
    a. Agree a minimum standard of software functionality for all Primary Care within an appropriate financial envelope to enable Primary Care to achieve its desired outcomes

7.5 What are the benefits for the ICS, organisations, individual and patient?

There are significant benefits of enhancing our digital capabilities and functionality in Primary Care. When our human resources are stretched as they are now and have been for some time, digital tools can enable Primary Care to work more effectively and efficiently. Patients will benefit from Primary Care delivering a more effective service, enabling them to have better access to their health information and promote prevention and self-care.

i. *Inclusion, engagement & communication*
    a. Support Primary Care to meet the needs of the population
ii. *Workforce/training/skills*
    a. A digitally enabled workforce can be deployed in a more agile way
    b. Opportunities for new career pathways will support a more sustainable workforce
iii. *Hardware and infrastructure*
    a. Appropriate hardware to meet the needs of Primary Care to achieve their desired outcomes.
iv. *Software*
    a. Appropriate software to meet the needs of Primary Care to achieve their desired outcomes
    b. We can optimise user experience through deployment of fit-for purpose software

7.6 What are the risks and potential barriers?

We must ensure that the deployment of digital tools does not worsen any inequalities that exist in Greater Manchester and must not create new ones. It is important to acknowledge that digital tools come at a cost and demonstrating return on investment is essential, however we acknowledge that this is not always easy to quantify due to the complexity of Primary Care.

i. *Inclusion, engagement & communication*
    a. Huge task to effectively engage the population, specifically those at risk of digital exclusion and health inequalities
    b. Digital inclusion must be considered from the outset of any development and deployment plans for digital tools
ii. *Workforce/training/skills*
    a. Cost of ongoing training and development of the workforce
    b. Workforce turnover and continuity of knowledge and skills must be continuously considered
    c. Ongoing digital transformation requires organisational cultural change
    d. Effective deployment of digital tools at scale requires some standardisation of processes, which is challenging when needed across the numerous providers of Primary Care in Greater Manchester
iii. *Hardware and infrastructure*
    a. Investment across Primary Care in digital hardware will be required and funding across the breadth of Primary Care is currently lacking
iv. *Software*
    a. Understand levels of standardisation and potential controversy of standardisation
    b. Ongoing costs of licensing should be continuously monitored
    c. As software available to enhance Primary Care continues to grow, funding may not be available to purchase new products across all Primary Care disciplines

Primary Care Blueprint

Estates

Estates

Delivered from facilities which are appropriate for the provision of 21st century Primary Care

8.1 What is the problem and the current position?

- There are access challenges, particularly in areas with significant health inequalities and deprivation
- There are challenges and variation across GM in the condition, compliance, and fitness for purpose of Primary Care estate
- Some premises do not meet contractual standards for Primary Care service delivery and some significantly fall short
- It is difficult to assess and quantify the baseline utilisation of existing estate as very little data on actual use is available for demise and bookable
- Sensors and data are in place for some NHS Property Services (NHS PS) buildings on the Open Space system for bookable rooms which shows massive disparity between rooms block booked in advance and those actually used
- The cost burden for voids and unused accommodation lies with NHS GM which indicates significant wasted underutilised estates resource which could otherwise be invested in estates improvements
- There are lease issues in many NHS PS and Community Health Partnerships (CHP) buildings with unclear documentation on responsibilities, requirements and occupational costs
- There are undocumented Primary Care estate occupiers which put the provider at risk of that occupation being terminated
- Implications and restrictions of the Local Improvement Finance Trust (LIFTCo) funding models that prevent cost effective premises variations
- There are some material debt issues identified by the property companies that act as a barrier to tenants increasing the level of or making changes to accommodation
- There has been variation in the level of estates investment over time across the different localities
- There is inequitable contribution by practices to premises costs with differing levels of historic subsidies
- There is a national requirement to meet sustainability & BREEAM targets by 2038/2040 and there has been limited national funding routes for Primary Care

8.3 What would good look like if we solved the problem?

✓	There would be a clear understanding of the challenges of Primary Care estate and how these can be dealt with
✓	All Primary Care premises should as a minimum meet statutory compliance requirements and ideally be configured to support optimal flow

✓	There would be efficient and effective collaborative ways of working across Integrated Neighbourhood Teams, and PCNs supporting new models of care and more efficient use of estate, particularly patient facing estate
✓	Clear prioritisation criteria developed preferably aligned to national guidelines. Thus providing a clear understanding of the prioritised premises schemes for improvement and investment
✓	Clear agreements to enable property companies to charge effectively and reduce occupancy, lease and debt issues
✓	Effective collaboration between Local Authorities, Place and Community to develop robust integrated system plans and facilitate actions to deliver GMICP strategic priorities
✓	Improving utilisation of paid for estate in owned, demised and bookable accommodation, in and outside of core hours
✓	Reducing voids to an absolute minimum
✓	Achieving a high level of utilisation mid-week, and increased utilisation at weekends and evenings also to sweat current estate
✓	Increased utilisation of community buildings to support social value for VCSE and community groups
✓	A better understanding of the estates opportunities under the various contracts ensuring that responsibility for estates is known whilst making sure patients have access to services
✓	All Primary Care providers in CHP, NHS PS and third party owned premises are within a lease agreement; and all GP partner owned premises have a lease agreement with the GP practice
✓	Have a clear Primary Care premises subsidy policy and processes to access support on a fairer and more reasonable basis
✓	Clear and transparent contribution by all GP practices to a fair proportion of premises costs
✓	Be in a position to address estates sustainability, develop a forward plan and be ready and in a position to apply for potential national funding that may be available with partners

8.4 What will we do to achieve this and what is within our gift?

- Completion of the GM Estates Infrastructure Strategy in 2023/24
- Completion of the Locality Asset Review refresh to enable local system Strategic Estates Groups (SEG) to identify use of surplus estate or estate for disinvestment
- Prioritisation criteria developed to enable fair and transparent prioritisation of estate to access the limited funding based on most effective use of resource
- Completion of PCN clinical and estates plans by summer 2023 and the development of ten prioritised Locality plans and an overarching ICB prioritisation plan by Sept 2023
- Relaunch the SEGs ensuring consistent and effective strategic estates arrangements in place including Primary Care representation
- Provide assessment of current premises compliance and actions that are needed for example, through the 3 & 6 facet surveys collation and PCN estates toolkit implementation

- Progress development of an overarching GM utilisation framework to include utilisation principles to be adopted across GM e.g., in relation to protocols for block bookings
- Improve the utilisation of existing estate including internal reconfiguration of premises with longer term occupational commitment
- Removal, or where not possible, mitigation against barriers to improved use e.g., understanding LIFTCo covenants vs model flexibilities including lifecycle costing
- Collecting data on use and sharing this with localities and Strategic Estates Groups to enable actions to deliver improvements
- Identify specific buildings to target utilisation studies / manual data collection
- Plan for the conversion of former patient records storage footprint to clinical rooms and secure use of NHS PS and CHP capital for reconfigurations
- Continue to bid for external funds to support investment and for other use such as towards achieving improved utilisation and increasing clinical capacity e.g. One Public Estate (OPE) funding and Section 106 monies
- Review current position and consider options for GM policy approach for tenant subsidies
- Under the terms of the Premises Cost Directions (PCD) reimbursement costs only have to be paid to a GP practice if a lease is in place or if partners in the practice own the premises. Practices should have lease agreements to receive reimbursement costs

8.5 What are the benefits for the ICS, organisations, individual and patient?

- Enabling plans that will deliver most effective use of resource to provide maximum outcomes for patients and improved health inequalities
- Effective system working to facilitate best use of public estate resource – improving utilisation and access to clinical services, and disinvesting in surplus premises
- Enable additional clinical activity to be undertaken in the funded estate including bringing service delivery out of hospital
- Enabling / assuring patient safety and accessibility to services, as paramount
- Provide physical configuration to maximise service flow and efficiency for Primary Care providers ultimately enabling greater productivity
- Commissioner has a consistent policy to enable consideration of applications for non-mandatory financial assistance and provides resilience and clarity to providers
- GP practices are in appropriate leases thereby providing security of tenure and clear reimbursement in line with the terms and conditions of the Premises Cost Directions

8.6 What are the risks and potential barriers?

- Without an improvement grant prioritisation process and matrix we will not address the estates issues in the areas where they are needed most
- Lack of leadership representation from stakeholders at the SEGs such that key strategic priorities are not delivered e.g. agreement on investment and disinvestment
- May not be sufficient challenge to the future models of care and potential estates solutions in the PCN toolkit to ensure all possibilities explored to demonstrate best use of public money; including use of property outside core hours to sweat assets

- Insufficient access to external funding e.g. national improvement grant slippage and section 106 monies
- Unaffordable to continue to fund high levels of underutilised fit for purpose Primary Care premises
- Unable to remove occupational Property Company barriers
- Do not deliver improvements in IT and the digitisation of patient records to free up and convert records storage accommodation
- Patient safety risk under NHSE contracts where minimum practice standards aren't adhered to, to ensure safe, compliant and accessible premises
- If access to services outside of the core GP contracted hours is limited or patients have to travel there may be an increase in DNAs and health outcomes will be poorly affected
- If no changes are progressed LIFTCo constraints will remain which will impact on changes to occupancy restricting use of accommodation
- Without leases in place a practice has less security of occupation, however where practices enter leases there will be associated legal costs and Stamp Duty Land Tax (SDLT) to pay
- Some Locality areas will have more estates expertise than others, lack of capacity and capability to progress improvements

Primary Care Blueprint

Quality, improvement and innovation

Quality, improvement and innovation

Is standards based, with a focus on quality improvement

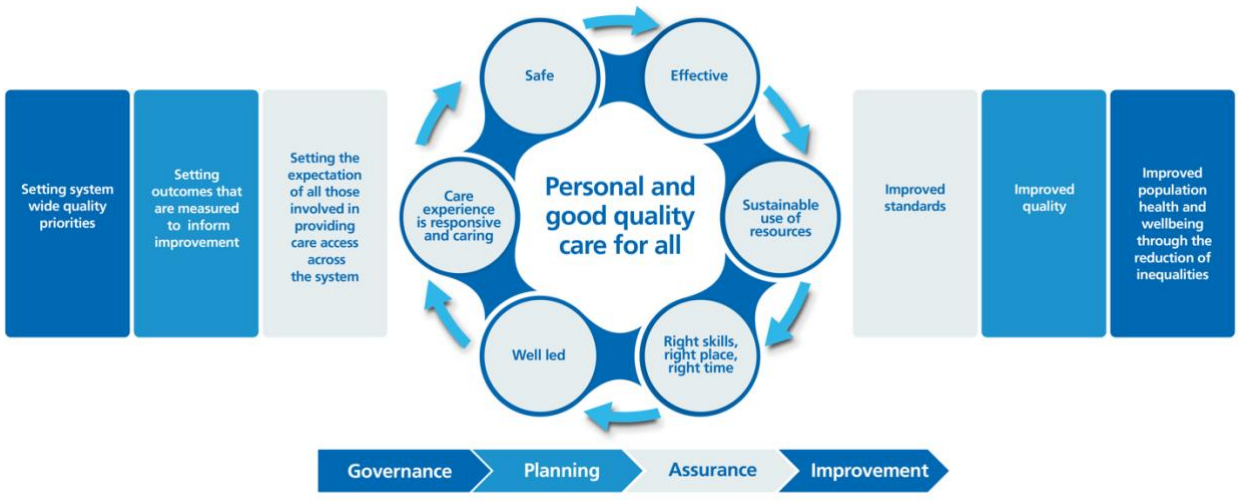
In Greater Manchester we aspire to embed and espouse good quality as the basis for everything that we do. The opportunities presented through the Greater Manchester Integrated Care Partnership will build on systems and processes to improve patient experience and outcomes, with consistency and equity at the heart.

In Greater Manchester**,** Primary Care provision is delivered across 4 disciplines and c1700 practices and it is therefore not unexpected that there is variation in the way that services are delivered to patients. This variation may be warranted, particularly where the outcomes and experience for patients is consistent and of an expected level. However, where there is variation there is also potential for this to be unwarranted, evidenced in the relative health outcomes within communities, individuals' experiences in accessing services

In developing this chapter, it is acknowledged that we are also working from a position of different interpretations of quality and what it means to individuals. Across the four Primary Care disciplines there are different ways of operating and regulatory frameworks, however we are working in the context of a clear willingness to work together to improve quality, reduce unwarranted variation and reduce health inequalities.

This chapter sets out how an embedded culture of delivering for quality across Primary Care, will support the drive for levelling up aspirations through continuous improvement, reduction of health inequalities and an ethos for shared learning. It is important to note that whilst this chapter focuses on Primary Care, the ambition is clearly aligned to the GM system quality strategy which reinforces the development of a single, cohesive quality approach across Primary Care in Greater Manchester.

The diagram below illustrates the shared purpose for quality.



This chapter will also describe how innovation plays a role in how our quality improvement ambitions are achieved.

How will we deliver quality, improvement and innovation for Primary Care in Greater Manchester?

Building on the opportunities presented through the Greater Manchester Integrated Care Partnership, the overarching principles that underpin delivery of this plan are:

✓	Embed a culture of supportive improvement through shared learning and peer-based improvement
✓	Central data dashboards will be available to a range of stakeholders
✓	Assigning resources will be managed with evidence-based decision making through clear governance
✓	The use of data to provide the evidence-base for flexible and innovative commissioning as a key enabler to improvement, with continuous improvement at the heart

The Primary Care Blueprint sets out the ambition over the next five years for Greater Manchester. A number of tangible deliverables are set out below; the delivery plan will be inclusive but not limited to these activities and workstreams:

- Implementation of the Patient Safety Incident Reporting Framework (PSIRF) across Primary Care
- Development of a consistent set of GM Primary Care Quality Standards, applied to all four disciplines as appropriate to the relative commissioning opportunities and regulatory frameworks that exist
- In conjunction with the GM Quality Directorate, establish a clear process for reporting, escalation and assurance to support patients, providers, localities and GM teams
- Establish a 'go-to' data repository within tableau, to enable reporting and analysis across the many data and information sources that are available
- Establish and embed shared learning forums through in-person and online forums, where needed to facilitate good communication, relationship building and sharing of good practice
- Develop a robust process for risk management at GM and locality level
- Continuous improvement through shared learning with a supportive, assurance-based approach

In order to deliver on these areas of work (expected to be delivered in years 1 and 2), there will need to be an understanding of the relative roles and responsibilities across our Primary Care system. Quality has been identified as an enabler within the blueprint, as improving quality of health and care for our population runs through everything that we do.

A culture of continuous improvement is required as we strive to deliver quality provision, for the benefit of our population. This will come from understanding unwarranted and warranted variation between providers and our population. Working with system partners, regulatory bodies and a range of wider stakeholders, we will build a shared understanding in order to engage, supporting innovation through application of quality improvement and quality assurance. All of which will be supported by systematic reporting through robust governance and decision-making processes.

Success factors: quantitative and qualitative indicators to that will impact. This section is subject to further work to fully understand how we can measure impact and success across Primary Care.

- Staff being aware of how to raise concerns, with confidence, about quality and safety of care
- Improved patient satisfaction across all of Primary Care (for example, friends and family test, GP Patient Survey etc)
- Reporting and data capture seen through established reporting routes and governance
- Improved dental access and numbers of related complaints over time
- Reduced referrals for child dental general anaesthesia (GA)

Primary Care Blueprint

Workforce

WORKFORCE

Greater Manchester Primary Care is recognised as a career destination for a happy, healthy and engaged workforce, trained to a consistent standard with knowledge and expertise to meet the needs of our population and provide timely, exemplar services.

10.1 What is the problem and the current position?

'Growing workforce crisis linked to individuals not choosing Primary Care as a career destination, workforce not growing fast enough to support demands, attrition of existing staff leaving a workforce shortage across general practice, community pharmacy, dentistry and optometry.'

- **Recruitment** - Working in Primary Care is incredibly challenging linked to (but not exhaustive) public expectations, central demands, variation in standards of employment and wider employment options which impact on our ability to recruit and retain: Primary Care and the NHS are not perceived as an attractive career option

- **Retention -** For the same reasons it is difficult to recruit, retaining staff is further exacerbated by the impact of COVID, recovery and external pressures such as competition from other employment sectors particularly around pay and conditions (for example dental nurses). This impact is apparent across the whole of Primary Care, but data also highlights certain roles (for example general practice nurses) being disproportionally affected due to aging workforce

- **Education and development** - Priority is placed on clinical skills, but importance is placed on areas such as leadership, wellbeing resilience and personal development. There is little evidence of consistency of emphasis on and approach to succession planning. There is also significant disparity across GM in the investment of funding to support the education and development across all four Primary Care disciplines (for example business / practice managers)

10.2 What would good look like if we solved the problem?

'GM Primary Care recognised as a career destination, a happy and healthy PRIMARY CARE workforce, trained to a consistent standard with enough knowledge and expertise to meet the needs of our population and provide timely, world-class services.'

- **Recruitment** - Flexible, inclusive recruitment models at all levels which attract and respond to both individual career aspirations and the needs of the population, ensuring the workforce is reflective of the population it serves. Clear understanding of the breath of roles, both clinical and non-clinical to ensure Primary Care is valued as a career destination for all. Understanding priorities, and the need to align both short and longer-term workforce planning, service development and cross sector working, including VCSE organisations

- **Retention** - All providers demonstrate the value they place on workforce by committing to good management practice including, talent management, inclusion and engagement, support for health and wellbeing, consistent terms and conditions (e.g., becoming members of GM's Good Employment Charter) and succession planning

- **Education and development** - Equitable access to training and development which is appropriately funded which include ambitions to meet role specific objectives and personal aspirations

10.3 What are the risks and potential barriers?

A summary of high-level risks has been identified in the table below; these will be reflective across several chapters, varying in impact, influence and GM control.

	Risk (High level)
✓	Political environment and public expectations of NHS services
✓	Limitations of National contracts
✓	NHS reputation and perception of NHS as an employer
✓	Uncertainty of future supply
✓	Time required to grow workforce
✓	Competition for roles across health economy
✓	Lack of parity of employment contracts

**The risks below have been identified as high level and affect all three themes Recruitment, Retention and Training & Development*

10.4 How will we achieve our overall aim?

'Recruitment, Retention and Development of the Primary Care workforce, enabling the workforce to deliver health in a changing, innovative, and digital environment to provide better population health outcomes.'

- **Recruitment** - Engagement and influencing across all areas of workforce supply (e.g., schools, colleges, educational institutes, Department for Work and Pensions (DWP), local population aligned to GM Creative Health Strategy. Ensuring there are career pathways promoting GM Primary Care roles which are available to all. Influencing GM apprenticeship levy

- **Retention** - Encourage all organisation to adopt the GM Good Employment Charter and support Primary Care organisations to achieve the standards (The Charter | GM Good Employment Charter). Identifying and sharing best practice on workforce health and wellbeing terms and conditions and good leadership

- **Education and development -** Development of the Primary Care workforce across general practice, community pharmacy, dentistry and optometry, enabling the workforce to deliver health in a changing, innovative, and digital environment to provide better population health outcomes. Optimizing the benefits and use of the GM Training Hub and focus on supervision, mentorship and prioritizing access to learning and development

NHS

Developed by:
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NHS Greater Manchester Primary Care Provider Board

Part of Greater Manchester Integrated Care Partnership

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