Agenda

Locality Board – Meeting in Public

Date: 8th January 2024

Time: 4.00 pm – 6.00 pm

Venue: Bury Town Hall Chair: Cllr O'Brien/Dr Fines

Full agenda pack begins on next page.

Date and time of next meeting
Monday, 5th February 2024 at 4.00 pm to be held on 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 3rd January 2024 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.

This page is intentionally left blank

Agenda Item 1

BURY INTEGRATED CARE PARTNERSHIP

Agenda

Locality Board – Meeting in Public

Date: 8 January 2024

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 – 4.10pm	10 mins	Welcome and apologies	Verbal	Information	Chair
2.			Declarations of Interest	Paper	Information	Chair
3.			Minutes of previous meeting held on 4 December 2023 including action log	Paper	Approval	Chair
4.			Public Questions	Verbal	Discussion	Chair
Place Based Lead Update						
5.	4.10-4.20pm	10 mins	Key Issues in Bury	Paper	Discussion	Lynne Ridsdale
Planning priorities for 2024/25						
6.	4.20-4.30pm	10 mins	GM guidance on the contribution of locality working to the 2024/25 planning approach	Paper	Discussion	Will Blandamer
7.	4.30-4.45pm	15 mins	Bury Integrated Care Partnership Priorities 2024/25	Paper	Discussion	Kath Wynne - Jones
8.	4.45-5.00pm	15 mins	GM Strategic Financial Framework	Paper	Discussion	Warren Heppolette
Integrated Delivery Collaborative Update						
9.	5.15-5.30pm	15 mins	Palliative and End of Life Care Update –	Paper	Discussion	Helen Lockwood

‘Quadruple Aims’ Updates						
10.	5.35-5.45pm	10 mins	Strategic Finance Group Update	Verbal	Information	Simon O’Hare
11.	5.45-5.55pm	5 mins	Performance Framework	Presentation	Information	Will Blandamer
12.	----------	Take as read	Population Health & Wellbeing	Verbal	Information	Jon Hobday
13.	----------	Take as read	Live Well Update	Verbal	Information	Jon Hobday
14.	----------	Take as read	Clinical and Professional Senate Update	Paper	Information	Kiran Patel
15	----------	Take as read	PCCC Chair’s Highlight Report	Paper	Information	Adrian Crook
Closing Items						
16.	5.55 – 6.00pm	5 mins	Any Other Business	Verbal	Information	All

Date and time of next meeting in public

Monday, 5 February 2024, 4.00-6.00pm on 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 **3rd January 2024 at 5.00pm.** 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.

Meeting: Locality Board			
Meeting Date	8th January 2024	**Action**	Consider
Item No.	2	**Confidential**	No
Title	Declarations of Interest		
Presented By	Chair of the Locality Board		
Author	Emma Kennett, Head of Corporate Admin and Governance (Bury)		
Clinical Lead	N/A		

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 8th January 2024 and
- 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

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)
- Remaining present at the meeting but withdrawing from the discussion and voting capacity
- Remaining present at the meeting and participating in the discussion but not involved in any voting capacity
- Being asked to leave the meeting

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
					Financial Interests	Non-Financial Professional Interests	Non-Financial Personal Interests			From	To	
Voting Members (Pooled Budget & Aligned & Non-Pooled Budget)												
Cllr	Eamonn	O'Brien	Leader of Bury Council & Joint Chair of the Locality Board	Bury Council - Councillor Young Christian Workers - Training & Development Labour Party Prestwich Arts College Bury Corporate Parenting Board No Barriers Foundation CAFOD Salford Prestwich Methodist Youth Unite the Union	X X	 X X X X X X X		Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct	Councillor Development Team Member Governor Member Trustee Member Trustee Member			As per policy - see details above
Cllr	Tariq	Tamoor	Executive Member of the Council Adult Care and Health	Bury Council - Councillor Health Watch Oldham Pretty Little Thing Action Together CIC The Derby High School St Lukes Primary School Unite the Union Labour Party	X X X	 X X X	 X 	Direct Direct Indirect Direct Direct Direct Direct Direct	Councillor Manager Spouse Employed Governor Member Community Member Member	May 2010 August 2020 Present April 2018 May 2012 June 2007	Present	As per policy - see details above
Cllr	Smith	Lucy	Locality Board Member	Bury Council Business in the Community The Christie NHS Foundation Trust Labour Party Community in the Union Socialist Health Association Catholics for Labour GMB Union	X X	 X X X X X		Direct Direct Indirect Direct Direct Direct Direct Direct	Councillor Related to spouse Member Member Member Member Member	 July 2023 July 2023	 Sept 2023 Present	As per policy - see details above (Y,Y,Y,Y,Y)
Dr	Fines	Cathy	Associate Medical Director and Named GP	GP Federation Tower Family Health Care Horizon Clinical Network Greater Manchester Foundation Trust	X X X			Direct Direct Direct Indirect	Practice is a member Partner in a member practice in Bury Locality Practice is a member Husband is employed	2013 2017 2019	Present	Declaration of interest as per policy as detailed above (Y,Y,Y,Y,Y)
	Jackson	Catherine	Executive Nurse	NCA				Indirect	Partner is the Director of Patient Safety & Professional Standards at the NCA.	25/10/2021	Present	As per policy - see details above
	Ridsdale	Lynne	Chief Executive for Bury Council	Bury Council		X		Direct	Chief Executive	Mar-23	Present	As per policy - see details above (Y,Y,Y,Y,Y)
	O'Hare	Simon	Associate Director of Finance – Bury Interim Associate Director of Finance – HMR	Simlat Shore Holdings LTD	X			Direct	Director	Apr-19	Present	As per policy - see details above. (Y,Y,Y,Y,Y) ###### Y
	Heppolette	Warren	Chief Officer for Strategy & Innovation	Greater Sport FC United			X X	Direct Direct	Trustee Director	2018 2021	Present Present	As per policy - see details above (Y,Y,Y,Y,Y)
Voting Members (Aligned & Non-Pooled Budget)												
Dr	Howarth	Vicki	Member of the Locality Board	Unilabs Ltd - Private Histopathology Service Tameside and Glossop Integrated Care NHS Foundation Trust	X X			Direct Direct	Providing services as Consultant Histopathologist to the Alexandra Hospital, Cheadle. Bank Consultant Histopathologist performing Coronial Post-Mortems for Manchester South Coroner	2011 2015	 Present	As per policy - see details above (Y,Y,Y,Y,Y)
	Fawcus	Joanna	Director of Operations, NCA	None Declared					Nil Interest		Present	
	Caudle	Heather	Chief Nurse, NCA	Joint Royal College of Physicians Training Board National Mental Health Nurse Directors Forum The Shuri Network Kingston University, London University of Surrey					Member of the Specialist Advisory Committee in Palliative Medicine. – 4 days per year Alumni - Attendance at the annual conference Steering Group Member - Monthly 2 hour meeting Visiting Professor Visiting Professor		Present	As per policy - see details above
	Thorpe	David	Director of Nursing, Bury Care Organisation	Cavell Nurses Trust Advisory Panel		X			Member	April 2022	Present	As per policy - see details above (Y,Y,Y,Y,Y)
Dr	Patel	Kiran	Member of the Locality Board	Tower Family Health Care - Primary Care General Practice Bury GP Federation - Enhanced Primary Care Services Laserase Bolton - Provider of a range of cosmetic laser and injectable treatments Laserase Bolton - Provider of a range of cosmetic laser and injectable treatments Tower Family Health Care - Primary Care General Practice	X X X			Direct Direct Direct Indirect Indirect	GP Partner Medical Director Medical Director Spouse is a Shareholder Spouse is a Director	July 2018 April 2018 1994 2012 July 2018	Present Present Present Present Present	As per policy - see details above (Y,Y,Y,Y,Y)
	Preedy	Sarah	Chief Operating Officer	None Declared					Nil Interest		Present	
	Hargreaves	Sophie	Member of the Locality Board	Manchester & Trafford LCO				Indirect	Spouse works as Transformation Manager	Sep-18	Present	As per policy - see details above (Y,N,N,N,N)
	Tomlinson	Helen	Member of the Locality Board	H Tomlinson is Chief Officer in organisation which may seek to do business with health or social care organisations Bury One Commissioning Organisation	X			 Indirect	H Tomlinson is Chief Officer in organisation which may seek to do business with health or social care organisations Close family member is an employee at Bury One Commissioning Organisation	01/11/2021 Nov 2021	Present	As per policy - see details above (Y,Y,Y,Y,Y)
	Blandamer	Will	Deputy Place Based Lead & Executive Director Health and Adult Care	Ashton on Mersey Football Club Trafford Manchester Football Association Ashton on Mersey Rugby Club Trafford Manchester Foundation Trust (Trafford) & St Anne's Hospice (Cheadle) Liverpool University Leeds University			X X X	Direct Direct Direct Indirect Indirect Indirect	Chairman Board Champion for Safeguarding Director Spouse is a Community Nurse & Qualified Nurse Daughter is a medical student Daughter is a medical student	2018 2018 2023 2022 2017 2019	Present Present Present Present Present Present	As per policy - see details above (Y,Y,Y,Y,Y)
	Richards	Jeanette	Executive Director of Children and Young People, Bury Council	None Declared					Nil Interest		Present	
	Hobday	Jon	Director of Public Health	None Declared					Nil Interest		present	As per policy - see details above
	Crook	Adrian	Director of Adult Social Care and Community Services Member of the Locality Board	Bolton Hospice			X		Trustee	Jul-05	Present	As per policy - see details above (Y,Y,Y,Y,Y)
Non-Voting Members												
	Wynne-Jones	Wynne	Member of the Locality Board	KWJ Coaching and Consulting Roots and Branches CIC The University of Manchester - Elizabeth Garrett Anderson programme	X X X			Direct Direct Direct	Owner Director Tutor	July 2021 Nov 2023 Oct 2022	Present Present Present	As per policy - see details above (Y,Y,Y,Y,Y)
	Passman	Ruth	Chair of Bury Healthwatch	None Declared					Nil Interest			As per policy - see details above
	Wilkinson	Catherine	Member of the Locality Board	Bury Provider Age UK Lancs	X		 X	Direct	Director of Finance Trustee and Treasurer	November 2020 May 2018	Present	As per policy - see details above (Y,Y,Y,Y,Y)
Invited Members												
Cllr	Bernstein	Russell	Cllr Bury Council, Conservative Leader	Bury Council Philips High School Bury and Whitefield Jewish Primary Conservative Party	X	 X	 X X 	Direct Direct Direct Direct	Councillor Councillor	May 2021 September 2019 September 2019 July 2019	Present Present Present Present	As per policy - see details above (Y,Y,Y,Y,Y)
Cllr	Smith	Mike	Attendee of the Locality Board as Leader of Radcliffe First	Angles and Arches Anodising Colour Radcliffe First Radcliffe Litter Pickers Growing Older Together	X	 X X 	 	Direct Indirect Direct Direct Direct	Director Spouse is a lab technician Leader Member Member	16/1/2009 2017 2019 2019 2019	Present Present Present Present Present	As per policy - see details above (Y,Y,Y,Y,Y)

Meeting: **Locality Board**			
Meeting Date	08 January 2024	**Action**	Approve
Item No.	3	**Confidential**	No
Title	Minutes of the Previous Meeting held on 4th December 2023 and action log		
Presented By	Cllr Eamonn O'Brien/Dr Cathy Fines, Chair of the Locality Board		
Author	Emma Kennett, Head of Locality Admin and Governance (Bury)		
Clinical Lead			

Executive Summary

The minutes of the Locality Board meeting held on 4th December 2023 are presented as an accurate reflection of the previous meeting, reflecting the discussion, decision and actions agreed.

Recommendations

It is recommended that the Locality Board:-

- Approve the minutes of the previous meeting held as an accurate record;
- Provide an update on the action listed in the log.

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**

Minutes

Date: Locality Board, 4 December 2023

Time: 5.00 p.m.

Venue: Bury Training and Safety Centre

Title	**Minutes of the Locality Board**
Author	Emma Kennett
Version	0.1
Target Audience	Locality Board
Date Created	December 2023
Date of Issue	January 2024
To be Agreed	January 2024
Document Status (Draft/Final)	Draft
Description	Locality Board Minutes

Document History:			
Date	**Version**	**Author**	**Notes**
			Draft Minutes produced
			Submitted to Mr Blandamer for review.
Approved:			
Signature:			..... **Add name of Committee/Chair**

Locality Board

MINUTES OF MEETING
Locality Board Meeting in Public 4 December 2023 5.00 pm until 6.00 pm **Chair – Cllr E O'Brien**

ATTENDANCE

Voting Members
Cllr Eamonn O'Brien, Leader of Bury Council **(Chair)** Cllr Tamoor Tariq, Executive Member of the Council for Health and Wellbeing Cllr Lucy Smith, Executive Member of the Council for Children and Young People Dr Cathy Fines, Senior Clinical Leader in the Borough Ms Lynne Ridsdale, Place Based Lead Mr Simon O'Hare, Associate Director of Finance, GM ICP Bury Mr Warren Heppolette, Chief Officer for Strategy and Innovation (GMIC) Dr Vicki Howarth, Medical Director NCA (Bury) Dr Kiran Patel, Medical Director IDCB Mr David Thorpe, Director of Nursing, Bury Care Org (NCA) Ms Sarah Preedy, Chief Operating Officer, Pennine Care Foundation Trust 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 Ms Jeanette Richards, Executive Director of Children and Young People, Bury Council Mr Jon Hobday, Director of Public Health
Non-Voting Members
Ms Kath Wynne-Jones, Chief Officer, Bury IDC
Invited Members
Ms Zoe Alderson, NHS Bury ICP Cllr Russell Bernstein, Conservative Opposition Party Cllr Mike Smith, Leader, Radcliffe First Ms Andrea Tomlinson, Democratic Services (Bury) **(Minutes)** Ms Ruth Whittingham, Head of Legal Services Bury Cllr Gareth Staples- Jones

MEETING NARRATIVE & OUTCOMES

1.	Welcome, Apologies and Quoracy
1.1	The Chair welcomed all to the meeting.
1.2	Apologies were received from Ms Heather Caudle, Mr Adrian Crook, Ms Joanna Fawcus, Ms Sophie Hargreaves, Ms Catherine Jackson, Mr Paul McKevitt, Mr Simon O'Hare and Ms Catherine Wilkinson,
1.3	Director of Finance, NCA 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 6 November 2023** No declarations to note.
2.9	**Declarations of interest from today's meeting 4 December 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/12/01	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 6 November 2023 were considered as a true and accurate reflection of the meeting. The Board ratified the following items from the previously inquorate meeting: - Section 75 agreement - 6 monthly Assurance report for presented to NHS GM Integrated Care Board - Changes to Terms of Reference (it was noted further changes would be required in due course to reflect changes in finance staffing arrangements.)

ID	Type	The Locality Board	Owner
D/12/02	Decision	Accepted the minutes from the previous meeting as a true and accurate reflection of the meeting and ratified the Section 75 agreement, 6 monthly Assurance report for presented to NHS GM Integrated Care Board, and the changes to Terms of Reference.	

A/12/01	Action	Locality Board Terms of Reference to be submitted to future Locality Board meeting to reflect any changes in Finance staffing/membership.	Mrs Kennett/Ms Braithwaite

4.	Public Questions		
4.1	There were no public questions received or members of the public present at the meeting.		
ID	**Type**	**The Locality Board**	**Owner**
D/12/03	Decision	Noted that there had been no public questions received and no members of the public were present at the meeting.	

5.	Place Based Lead Update		
5.1	A report on key issues in the Bury Locality had been circulated. Lynne Ridsdale particularly commented on the update from the recent LGA (Local Government Association) Peer review which had taken place and thanked colleagues from the Locality Board who had met with the reviewing team. The paper gave an update on the informal feedback received which recognised the quality of the partnership working in the health and care system in Bury and a number of aspects of good performance in the system as a whole. The contribution of the wider health and care system to the achievement of Council corporate priorities – in terms of transformation of adult care, addressing health inequalities, and the childrens services improvement programme – was recognised and acknowledged. The paper also noted the Commissioning Priorities/2024/25 planning, the GM Medium Term Financial Plan, the Team Bury Event – Health Inequalities taking place on 5th December and the CQC/Ofsted SEND Annual review meeting on SEND which and the briefing taking place on 11 January in relation to the progress on the SEND improvement Plan.		
ID	**Type**	**The Locality Board**	**Owner**
D/12/04	Decision	Received the update.	

	Update on Locality Board priorities
6.1	• Update on Locality Board Priorities Will Blandamer updated the Board on progress made against the agreed 5 priorities, The Board had received a detailed update at its November meeting in relation to Priority 1 the first 1001 days of a child's life. An update on Right Sizing Intermediate Care and Wider Community Capacity would be presented to the Locality Board at its next meeting in January 2024. The report set out the ongoing work in relation to Locality Board Priority 4 - Ensuring Services are delivered as efficiently as possible and explained that a monthly update will be provided to the Locality Board through the IDC Chief Officer's update and the monthly finance report. It was reported that the Bury Locality Workforce Strategy had been signed off at the Strategic Workforce Group following its return to the October Board and the six priorities had been identified as workforce integration, good employment charter, workforce wellbeing, addressing inequalities, growing the workforce and developing the workforce. Progress of the workforce strategy priority areas will be reported monthly to IDC Board one the new governance arrangements are in place. The Board thanked Will for his update.
7.1	• Locality Board Priority 3 – fuller report on primary care Dr Kiran Patel gave a presentation updating the Board on Priority 3 Primary Care Strategy

Dr Patel thanked Zoe Alderson and Mark for their input into the work.

The presentation set out the work that was being carried out in relation to the General Practice Strategy for Bury

The purpose if the strategy was explained as 'to look specifically at general practice and describe a clear vision of the future to meet ever increasing demands'.

The vision and goals were set out and example measures proposed. Dr Patel explained that the aspiration was to develop a new model across Bury collaborating with GPs and partners, have a more diverse, resilient workforce to provide a service with more capacity, strengthened relationships between partners and improved outcomes for patients.

The strategy is coherent with both the national guidance and GM Blueprint for primary care.

There are 9 programmes of work in the Bury GP Strategy

- **At scale Solutions** – for example the proposed development of Women's Health Hubs were being developed, pump priming funding established and the phased implementation plan produced. . Winter support was providing 60+ extra appointments per week at acute respiratory hubs located in 4 sites and running for 16 weeks.
- **Estates, current and Future Need**. Need to ensure reliable, consistent estates to provide services across the borough. PCN toolkits completed, and outputs anticipated. Regeneration/improvement plans currently being developed for Whitefield and Prestwich. Work required on a strategy for Estates and future needs.
- **Effective Pathway navigation**. Work ongoing with GP colleagues to modernise front offices across all surgeries. Invested money for additional staff such as physiotherapists and pharmacists to allow for more options for patients other that GPs and nurses. Improving interface between primary and secondary care.
- **Communication and Engagement**. General Practice toolkit developed. Service Directory to be developed. Fortnightly communication and engagement webinars in place and quarterly membership events now reestablished. SharePoint providing regular updates.
- **Data and Digital Ambition**. Increased uptake of the NHS App allows for better patient experience enables repeat prescription ordering, appointment booking and cancellation, able to check test results all have increased.
- **Quality Assurance – GP** capacity back to pre-pandemic level with 2/3 now face to face. Capacity and Access Plans developed with a focus on improving patient experience. Transitional and transformation funding will support practices to move to the Modern General Practice Access Model. 3 out of 4 PCNs have provided assurance against the DES requirements. Bury LCS – under review for 24/25 (in alignment with BeCCoR). Practices working towards Military Vet RCGP Accreditation (was 12% now 32%)
- **Integration Wider PC, PSR Neighbourhood –** Have looked at JSNA with partner colleagues and now collaborating. Neighbourhood improvement indicators aimed at aligning priorities of providers, Bowel screening, Trauma informed practice /Adverse childhood experience, Dementia (HinM funding to digitise care plans), Mental Health, Frailty. Prestwich currently has joint PCN/Neighbourhood meeting which is looking to be mirrored in Whitefield. PCN and Neighbourhood Plans needed.
- **System Leadership** - GP Leadership Board in place. GP Strategy developed in collaboration with practices. Current gap - wider primary care forum needed (Dental, Optometrists and Pharmacy)
- Workforce recruitment, Development and Retention – Workforce Strategy in development, need to promote Bury as a place to live and work. Working collaboratively with partners to achieve. Expanded Burry HIVE and education programme. GM Workforce Leadership group looking at retention. Comparisons with GM/National workforce provided.

	Members discussed the presentation and particular reference was made in relation to the following: Working group to carry out deep dive re: Workforce and incentives to attract and retain, CPD or placement opportunities. Was confirmed that are strategic workforce groups across the organisation and a shred workforce programme across partners. Possible work with University of Bolton in relation to GP training. Health-check provision not mentioned, report to future Locality Board. Dr Patel confirmed that Health Checks were being carried out and backlog being worked through, some checks being undertaken in pharmacies such as hypertension checks and advice, but focus was urgent care, here and now. Review of estates required to ascertain what we have available right across the borough, not all healthcare has to be delivered through practice. The opportunity to carry out a review alongside the Council's current review. Making the most of social prescribers and the need to ensure that when social prescribers move to the PCNs the link with the VCFA is maintained. How to ensure that Bury receives its fair share of GM funding and also how to ensure the GM receives its fair share of national funding. The Board thanked Dr Kiran Patel for his presentation.

ID	Type	The Locality Board	Owner
D/12/05	Decision	Received the updates.	
A/12/02	Action	Update on Health Check backlog and provision requested at future meeting.	Dr Patel
A/12/03	Action	Provide Board with information relating to social prescribing contracts.	Dr Patel

	Integrated Delivery Collaborative Update
8.1	• Integrated Delivery Collaborative Update Kath Wynne-Jones presented a report outlining progress which has been made with the key programmes of work within the IDC. The report set out the key strategic developments for the past month, IDC Programme highlights from November, Performance and risks. The Board thanked Kath for the update.
9.1	• Fairer Health for All – Locality Engagement Jon Hobday presented a report outlining opportunities for partners to input and shape priorities for co-ordinated action on health inequalities across Greater Manchester, responding to the proposed principles, priorities, targets and metrics in the Greater Manchester Fairer Health for All Framework. The report also outlined plans to co-design intelligence and leadership tools and resources that will enable neighbourhood and locality partners to create Fairer Health for All and support delivery of Bury's Health Inequality plans. It was explained that the FHFA was a GM based framework for reducing health inequality and tackling inequalities across the wider, social, and commercial determinants of health, leading to a greener, fairer, more prosperous city-region.

	FHFA has been co-produced through extensive locality and community participation and engagement over the past fifteen months, which has taken place alongside the development of NHS Greater Manchester's Integrated Care Partnership strategy and our Five Year Joint Forward Plan. It prioritises coordinated action to deliver against the six strategy missions and a roadmap for how we will. • Work together to fulfil statutory NHS responsibilities such as unlocking social and economic potential and delivering against Core20Plus5 inequalities targets. • Enhance and embed prevention, equality, and sustainability into everything we do as a health and care system. • Tackle the discrimination, injustice and prejudice that lead to health and care inequalities. • Create more opportunities for people to lead healthy lives wherever they live, work and play in our city-region. The report set out the engagement that had been carried out across the VCFSE sector and Public Health service users, partner agencies, practitioners, staff and leaders from across all ten localities. Further information was provided in relation the range of work programmes already underway, tools that were being developed to enable co-ordinated action such as the Fairer Health for All Academy and the Health and Care intelligence Hub, work around Culture Change and leadership and population health management. Members discussed the presentation noting the request for feedback to be provided to Jon. It was noted that the Council Motion had been agreed at Council in November for Bury to adopt a Marmot Place approach and it was asked that the Board be updated on how to achieve this aspiration.

ID	Type	The Locality Board	Owner
D/12/06	Decision	Received the updates.	
A/12/04	Action	Report to Board on how to become Marmot Town/Place and how links in.	Jon Hobday

	"Quadruple Aims" Updates
10.	• Strategic Finance Group Update The Board received the report which updated members of the locality board on the financial position of the 3 statutory bodies who primarily serve the population of Bury, along with that of NHS Greater Manchester Integrated Care (NHS GM).
11.	• Performance Framework The Board received the report which presented members of the locality board with the performance data in relation Bury registered patients at all providers in relation o urgent care, elective care, mental health, adult care, learning disabilities, end of life, long term conditions, community services and primary care.
12.	• Population Health & Wellbeing The Board received the report of the Director of Public Health which updated members of the Locality Board in relation to Health and Wellbeing.
13.	• System Assurance Committee The Board received the report which provided the Locality Board with a summary from the Bury Integrated Care Partnership System Assurance Committee meeting that took place in November 2023.

ID	Type	The Locality Board	Owner
D/12/07	Decision	Received the updates.	

	Closing Items	
14.	• Any Other Business There were no items of other business. The Chair thanked everyone for their attendance and formally closed the meeting in public at 18.25	
ID	**Type**	**The Locality Board**	**Owner**
D/12/08	Decision	Noted that there was no other business to report and the meeting in public was closed at 18.25	

Locality Board

Action Log – December 2023

Status Rating: - **In Progress** - **Completed** - **Not Yet Due** - **Overdue**

Date	Reference	Action	Lead	Status	Due Date	Update
4th December 2023	A/12/01	Locality Board Terms of Reference to be reviewed and submitted to future Locality Board meeting to reflect changes in Finance staffing/membership.	Mrs Kennett/Ms Braithwaite		February 2024	
4th December 2023	A/12/02	Update on Health Check backlog and provision requested at future meeting.	Dr Patel		March 2024	Added to Forward Plan for March 2024
4th December 2023	A/12/03	Provide Board with information relating to social prescribing contracts.	Dr Patel		January 2024	Information to be provided
4th December 2023	A/12/04	Report to Board on how to become Marmot Town/Place and how links in.	Jon Hobday		February 2024	Added to Forward Plan for February 2024

BURY INTEGRATED CARE PARTNERSHIP

Meeting: Locality Board			
Meeting Date	08 January 2024	**Action**	Receive
Item No.	5	**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 issues 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		

BURY INTEGRATED CARE PARTNERSHIP

1. Urgent Care System

May I take this opportunity to thank all partners and staff for their contribution to the performance of the urgent care system over the Christmas and New Year period. I know parts of the system are under significant pressure currently because of a number of factors including levels of demand, acuity, challenges in adjacent boroughs (e.g Bolton), and the consequences of industrial action. I commend the ongoing work through the daily bronze calls and the work of our Urgent Care Board. However, I know that all parts of the system have worked well together and in accordance with the previously agreed winter plan. All parts of the system have contributed – surge hubs and respiratory hubs in primary care, the role of the infection control team, Bardoc, the Hospice, Intermediate Care provision, Social Care, Vaccination teams, mental health services, community health services, the voluntary sector, and of course colleagues at FGH in ED and on wards, and colleagues also at North Mcr Hospital.

2. **LGA Peer Review**

I reported last month that the Local Government Association (LGA) organise a peer review process as an important sector led improvement initiative, and that an inspection took place in early December. Thank you to a number of colleagues from the Locality board in meeting with the reviewing team to discuss the role of the Council in relation to the operation of the Bury Integrated Care Partnership.

We have received a draft report from the visit to check for factual accuracy and will circulate the final report to Locality Board colleagues when available. However, I can report that the report is very positive about the role of the Council in providing leadership in the place – with LETS DO IT recognised as a galvanising framework for a high level of ambition around economic growth and reducing inequality. The report highlighted the partnership work across the health and care system as a strength in the borough….

> *The council has continued to prioritise strong strategic positioning with health, at both a Bury and Greater Manchester level and the levels of performance observed in adult social care, health and public health are generally positive.*

The draft report also commends the steps taken on neighbourhood working.

> *The peer team heard of the strong examples of teams working together at a neighbourhood level, using a model which is seen as "innovative and brave". This has been developed over time in a collaborative way,*
>
> *As a place, Bury benefits from communities which cluster into local population sizes where interventions, and an approach like the neighbourhood model, can make a real impact - highlighting why the 'Local' aspect of LET'S is so appropriate for public service in a borough like Bury. Whilst there are similarities in this neighbourhood model to other Greater Manchester councils, Bury is seen to be one of the furthest ahead in advancing this model, showing bravery and ambition in making this progress, which aligns with examples of strong operational performance in adult social care and health.*

The presentation later on the agenda on priorities for 24/25 will highlight the opportunity of further developing our neighbourhood model and the active support of all partners in this would be welcome.

BURY INTEGRATED CARE PARTNERSHIP

3. Commissioning Priorities/2024/25 planning

Later on the agenda is a comprehensive update on the Locality Board contribution to the GM wide work on planning priorities. The presentation will reflect on the progress of the Bury Integrated care partnership in 23/24 and the outcome of a workshop of our integrated delivery board in identifying key priorities and opportunities for efficiency. It will propose a framework for presentation of our joint priorities for 24/25 ready for an initial draft submission to ICB by end of January.

This work will be informed by the GM Strategic financial framework and an update on this work is also on this agenda.

Overall, both presentations will point to the specific and real opportunity to address demand through scaled intervention on prevention and early intervention. This should be the focus of the work of the locality board in the coming months – recognising that individual providers and the work of the GM trust provider collaborative is substantially addressing the pressures of supply and efficiency of delivery.

4. SEND Briefing for Senior Leaders

In each of the last three locality boards there has been an update on SEND arrangements in Bury focusing on; NHS waiting times as they pertain to SEND, the implementation of the graduated approach, the improvement in mental health and well being pathways and services, and the implementation of new services.

We will continue to routinely update the locality board on the implementation of the SEND improvement plan. In addition we have, as indicated at the last meeting convened a senior Bury integrated Care partnership leadership briefing on SEND on 11th January at 230

Lynne Ridsdale
Place Based Lead
January 2023

BURY INTEGRATED CARE PARTNERSHIP

Meeting: Locality Board			
Meeting Date	08 January 2024	**Action**	Consider
Item No.	6	**Confidential**	No
Title	GM guidance on the contribution of locality working to the 2024/25 planning approach		
Presented By	Will Blandamer, Deputy Place Lead		
Author	Paul Lynch, Director of Strategy & Planning, NHS Greater Manchester		
Clinical Lead	N/A		

Executive Summary

Localities came together for a workshop on 8th December 2023 to shape the role of locality plans in contributing to GM's overall plans for 2024/25

The paper sets out the proposed process and timescales in relation to the contribution of Locality Plans to the 2024-25 GM System Delivery Plan.

Recommendations

The Locality Board are asked to consider the content of the attached 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	☒

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**
N/A		

NHS
Greater Manchester
Integrated Care

The Contribution of Locality Plans to the 2024-25 GM System Delivery Plan

Proposed Process

Introduction

1. Localities came together for a workshop on 8th December to shape the role of locality plans in contributing to GM's overall plans for 2024/25

2. 10 Locality plans for health and social care are in place (with some currently being refreshed) – each reflecting the distinctive features of the locality. They are part of a suite of local plans – including place plans; local authority corporate plans; and health and well-being board plans. The plans share many consistent features.

3. The ICS Operating Model confirms the core role of localities in driving population health improvement and delivering preventative, proactive integrated models of neighbourhood care. Although localities are delivering across all six of the missions in the ICP Strategy, their key areas of responsibility principally relate to the missions on stronger communities and helping people stay well and detecting illness earlier.

4. Our approach to planning for 2024/25 is different to that of previous annual operational plans: we will develop a broad, System Delivery Plan for GM rather than solely a response to the NHS guidance. There are three elements to our planning approach:

    - The role of localities in driving population health improvement and prevention at scale. Upgrading our approach to prevention will need to be a major part of GM's overarching plan for 2024/5
    - The role of providers in planning for activity, workforce, and finance to improve productivity through the NHS operational planning process
    - The role of GM commissioning to drive the changes needed

5. Upgrading our approach to prevention will need to be a major part of GM's overarching plan for 2024/5.

6. The Strategic Financial Framework draws on the care records of residents to quantify the financial impact of the projected continued decline of the health of our population. However, the analysis also shows that we can intervene to turn back this trend. This will require both grip and control of our current financial challenges, which all localities are deeply engaged in, and increasing the pace, scale and consistency of our models of preventative care as well as reducing unwarranted variation between localities.

7. Planning for next year will not require a full re-write of existing locality plans (although we recognise that in some localities these plans are in the process of being updated) but collectively agreeing our areas of priority focus as part of the 2024/25 GM System Delivery Plan and updated GM Joint Forward Plan.

8. Localities are already beginning to set out priorities for 2024/25 through a range of activities. This paper proposes that we build on these to describe a **Locality Delivery Portfolio** for 2024/5 comprising:

    - The outputs from the commissioning intentions process. These will be consolidated to a GM level but we will need to describe what delivery looks like in localities

- A set of priorities for 2024/5 identified **by each individual locality** – drawing on existing locality plans, the GM ICP Strategy and JFP, the Prevention Framework, SFF and other GM plans
- A small number of priorities **that all 10 localities** agree to focus on in 2024/25

9. The Locality Delivery Portfolio would then be built into the 2024/5 GM System Delivery Plan and updated Joint Forward Plan.

2024/25 Planning and Prevention

10. We have started the planning process earlier this year. We are working to an end of March deadline to complete the 2024/5 plan. The key dates are set out below and more detailed timetables will be shared with localities as well.

Figure 1

Meeting	Date
Leadership Forum 1	**12th Dec**
National Operational Planning Guidance	**w/c 18th Dec**
Leadership Forum 2 Review draft operational plan ahead of submission to NHSE, *and draft GM System Delivery Plan.*	**29th Jan**
NHSE Submission: DRAFT Plans	**w/c 12th Feb**
NHSE Draft Submission feedback	**w/c 26th Feb**
Confirm & Challenge Sessions	**w/c 4th March**
Leadership Forum 3 - reflect on NHSE draft submission feedback and agree key principles for final operational plan *and GM System Delivery Plan*	**12th March**
NHSE Submission: FINAL Plans	**w/c 25th March**
GM System Delivery Plan finalised	**w/c 1 April**

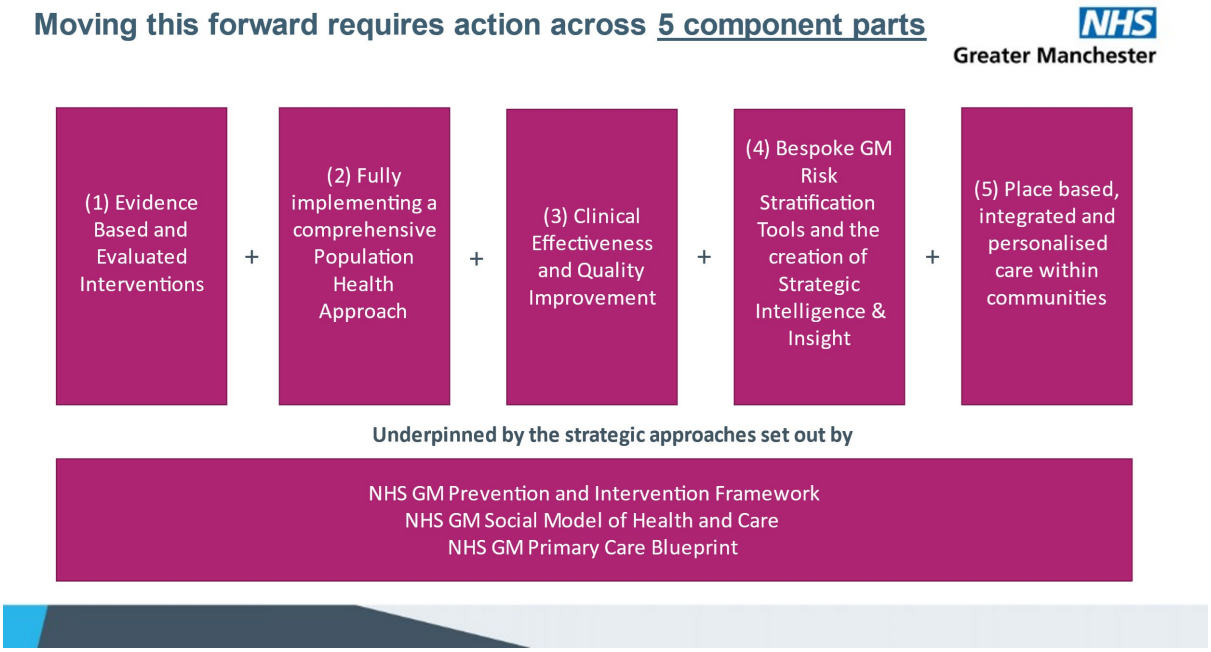
11. We have outlined the proposed roles for each part of the system during the planning round – including localities:

Figure 2

ICS Partner	Role in Planning Round	Outputs
Provider Trusts	• Develop trust-level activity, finance and workforce plans • Develop proposals for improved productivity and efficiency • Identify opportunities for shared services • Participate in prioritised service review process • Participate in check and challenge process for plans	• Completed NHSE finance, activity/performance and workforce templates • Collective trust plans (via TPC) set out in 2024/25 Narrative Plan
Localities	• Developing commissioning intentions for each place • Confirming priorities for 2024/5 identified by each individual locality – drawing on existing locality plans, the GM ICP Strategy and JFP, the Prevention Framework and the SFF • Agreeing a small number of priorities that all 10 localities agree to focus on in 2024/25	• Collective Locality Portfolio for 2024/25 – to be incorporated in 2024/25 GM Narrative Plan
GM ICB Team	• Design and operate the overall process • Ensure system engagement and governance approval • Develop GM Commissioning Intentions • Develop GM-level assumptions • Develop GM-level performance trajectories • Develop 24/25 implementation priorities for GM-level plans – population health, prevention, mental health, social care, primary care, system boards and others • Develop and implement modelling process • Undertake prioritised service review process • Lead on the check and challenge process • Lead on the triangulation of finance, activity and workforce plans • Lead on the narrative plan • Incorporate 24/25 plans into an updated Joint Forward Plan	• Completed NHSE finance, activity/performance and workforce templates • GM Narrative Plan • Updated Joint Forward Plan

12. Reflecting the broader perspective that we are adopting for our 2024/5 plan, and the work underway to develop a GM approach to prevention through the localities and the SFF, we have set out the five domains where we need to take concerted action to upscale prevention across GM. This is illustrated below:

Figure 3



13. Using the SFF and Joint Forward Plan, we have recommended some priority actions for the work on the GM Prevention Framework. This will need to be a multi-year framework to deliver across the prevention agenda – but we need to set out clear priorities for the first year – 2024/25.

Figure 4

Action domain	Proposed priorities	Type of prevention
Evidence-based and evaluated interventions	Behaviours leading to good health: • Healthy weight • Physically active • Making smoking history • Healthy alcohol intake	**Primary Prevention (2)** Preventing disease before it occurs by addressing modifiable risk behaviours
A Population Health Approach	• Best Start in Life • Poverty and Deprivation • Good Jobs • Good Homes	**Primary Prevention (1)** Creating the conditions for good health by tackling the societal causes of ill health
Applying a clinical effectiveness lens	• Frailty • Cardiovascular Disease (CV, Diabetes and Stroke) • Respiratory Disease • Dementia • Mental Illness • Cancer	**Secondary prevention** Catching ill-health as early as possible to prevent or reduce the chances of them leading to more serious conditions **Tertiary prevention** Taking action to stop, limit or more effectively manage disease progression including rehabilitation from a debilitating condition and providing palliative care
Place-based, integrated and person centred communities'	• Person and Community Centred Approaches (including Live Well and Social Prescribing) • Integrated Care in Neighbourhoods	All types

The Role of Localities in 2024/5 Planning

14. It is important that the process for the locality contribution to the 2024/5 System Delivery Plan is as clear as possible and has support across our 10 places.

15. As noted in the introduction to this paper, it is proposed that there are three parts to developing a Locality Delivery Portfolio for 2024/5

a) Commissioning Intentions

16. The process to develop commissioning intentions is underway with each locality sending these to the GM Commissioning Team. These will then be consolidated to give a single set of GM commissioning intentions, but we will need to describe what delivery looks like in localities.

b) 2024/25 Priorities for Each Individual Locality

17. Building on the commissioning intentions, each locality is invited to confirm a set of delivery priorities for inclusion in the 2024/25 GM System Delivery Plan.

18. It is anticipated that the majority of these priority areas will reflect work already underway in localities and will reflect the key role of localities in preventative, community orientated, early interventions connected to models of integrated neighbourhood-based delivery. The focus will be on what we will deliver in 2024/25, capturing the impact of this, and bringing this together in the overall GM plan for 2024/25.

19. These priorities should draw on:

- The existing respective Locality Plan – or updates of the Plan which are in train
- The GM ICP Strategy and Joint Forward Plan

- The action domains and proposed priorities (Figure 4) in the Prevention Framework
- The population health and prevention outputs from the Strategic Financial Framework
- Other GM-level strategies – for example, the Primary Care Blueprint and Mental Health and Well-Being Strategy

20. The identified priorities should, where possible, be costed and quantify the expected impact in terms of finance, activity, performance, quality and population health improvement. One function of this will be to enable the impact of locality delivery to be modelled as part of the process to develop the 2024/25 plan.

21. The GM Team will provide a template to capture this information. The template will be based on the six missions in the ICP Strategy and Joint Forward Plan so that our collective delivery maps to our strategic intent.

22. Localities are asked to complete a first draft set of 2024/25 priorities by 16th February 2024

c) A small number of priorities that all 10 localities agree to focus on in 2024/25

23. The establishment of the ICS and the confirmation of the operating model gives us greater scope to act collectively to address common challenges.

24. It is proposed that for 2024/25 localities agree a small number of priorities that all 10 places focus on – in addition to the priorities for each individual locality.

25. Deputy Place-Based leads will play the lead role in developing this process. It is suggested that it could include:

    - Reviewing the position in each locality against the five prevention domains (figure 3)
    - Using the Strategic Financial Framework to understand, and act on, unwarranted variation between localities
    - Sharing learning and best practice
    - How mechanisms such as the GM Advanced Data Science Platform and Risk Stratification can better enable us to target those residents most at risk
    - What support is needed from GM to deliver at place level

26. The Prevention Framework and Strategic Financial Framework point to some areas that we may want to focus on for 2024/25. There is a strong evidence-base for **collective action on CVD** for example.

27. We will work with the DPBL group to determine this small number of priorities and agree an action plan for 2024/25 shared by all 10 localities. It is recommended that this process is complete by 16th February 2024.

NHS Greater Manchester Integrated Care

Next Steps – Summary

28. With locality agreement, the key steps we will need to take are:

Action	Lead	Indicative Timeframe
Draft Commissioning Intentions for Each Locality – to be consolidated into GM Commissioning Intentions	DPBLs	In progress
First Draft of Individual Locality Priorities for 2024/25	DPBLs Templates provided by GM Team	16th February 2024
Draft Action Plan for Priorities Across all 10 Localities	DPBLs	16th February 2024
Final Version of Locality Delivery Portfolio – including all of the Above for inclusion in 2024/25 GM System Delivery Plan and Updated JFP	GM Team	20th March 2024

29. Whilst the focus in the next few months will need to be on the plan for 2024/5, we will need to consider how place-based delivery will contribute to scaling up prevention in the longer-term so that we can respond to the projected growth in demand that the SFF highlights. We will need to determine how we approach this in the first few months of 2024/25.

Paul Lynch
Director of Strategy & Planning
NHS Greater Manchester
21st December 2023

Bury Integrated Care Partnership Priorities 2024/25

Part of Greater Manchester Integrated Care Partnership

Presentation by:

Will Blandamer and
Kath Wynne-Jones

Context – this is complicated!

The Locality Board will wish to be very clear on the priorities of the work of the Bury ICP in 2024/25 and to clarify the metrics by which we will know we are improving. The priorities will be informed by;

1) GM wide priorities

- reflecting national planning guidance (awaited), the ICB Forward Plan (autumn 2023), the ICB Strategic financial framework), and GM System Boards priorities .

2) Bury System Priorities

- Lets Do It prioritaisaion of Population Health gain and health inequalities
- A refreshed Locality Plan, maintaining a focus on the core principles of working – preventative, neighbourhood based, timely and quality service delivery (all localities required to update January/February 2024)
- Building on the programmes of work already in place in Bury – reflective of , Locality Board priorities (e.g first 1001 days), Integrated Delivery Board Programme prioritisation (e.g specific pathways in elective care), Our locality partnership working e.g with primary care, NHS GM (Bury) review of contracts held by the locality.

3) Priorities derived from our supra local/sub GM level partnership with provider partners

- 4 localities working with Northern Care alliance, Partnership working with Pennine Care, Strengthening multi-borough partnership relationship with MFT particularly in relation to North Mcr

Roles within GM within the planning round

BURY INTEGRATED CARE PARTNERSHIP

ICS Partner	Role in Planning Round	Outputs
Provider Trusts	• Develop trust-level activity, finance and workforce plans • Develop proposals for improved productivity and efficiency • Identify opportunities for shared services • Participate in prioritised service review process • Participate in check and challenge process for plans	• Completed NHSE finance, activity/performance and workforce templates • Collective trust plans (via TPC) set out in 2024/25 Narrative Plan
Localities	• Developing commissioning intentions for each place • Confirming priorities for 2024/5 identified by each individual locality – drawing on existing locality plans, the GM ICP Strategy and JFP, the Prevention Framework and the SFF • Agreeing a small number of priorities that all 10 localities agree to focus on in 2024/25	• Collective Locality Portfolio for 2024/25 – to be incorporated in 2024/25 GM Narrative Plan
GM ICB Team	• Design and operate the overall process • Ensure system engagement and governance approval • Develop GM Commissioning Intentions • Develop GM-level assumptions • Develop GM-level performance trajectories • Develop 24/25 implementation priorities for GM-level plans – population health, prevention, mental health, social care, primary care, system boards and others • Develop and implement modelling process • Undertake prioritised service review process • Lead on the check and challenge process • Lead on the triangulation of finance, activity and workforce plans • Lead on the narrative plan • Incorporate 24/25 plans into an updated Joint Forward Plan	• Completed NHSE finance, activity/performance and workforce templates • GM Narrative Plan • Updated Joint Forward Plan

Purpose of this Locality Board Presentation

The purpose of this slide deck is therefore:

1. To serve as an initial high-level overview of the ingredients for locality priorities as a submission of the to the wider GM planning process in December/January ensuring Bury both contributes to and benefits from GM wide prioritisation

2. To discuss, develop and refine, based on further national, GM and local guidance, and then to be presented to Locality Board in February 2024 for collective endorsement by the Bury Integrated Care partnership members

Contents

This slide deck therefore has the following elements.

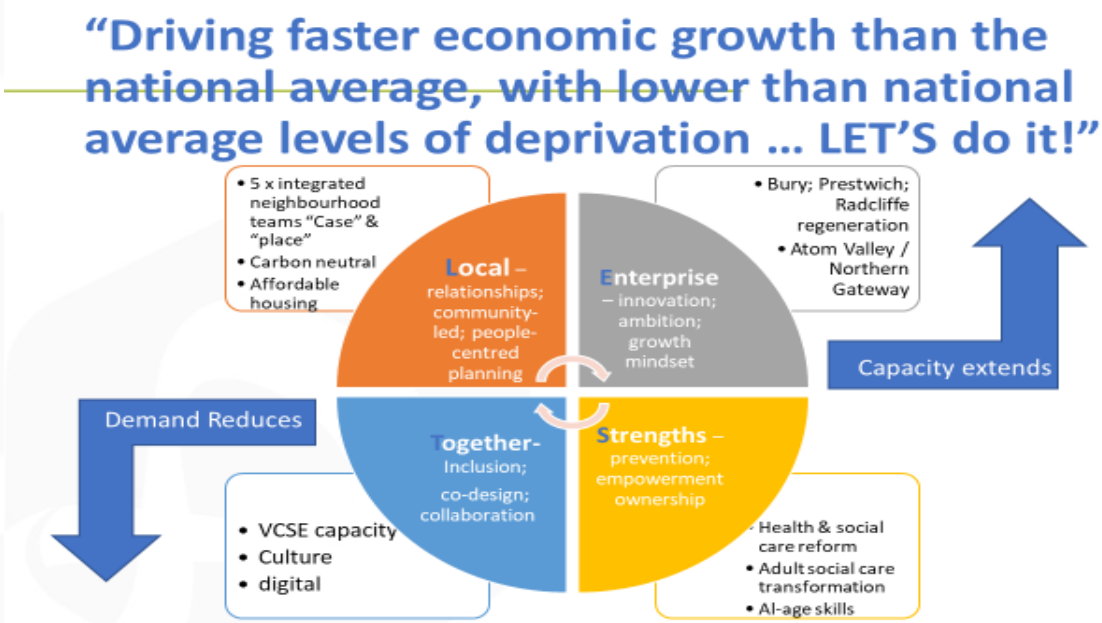
1. A Reminder of our Locality Board working and principles
2. Outcome of IDCB Workshop 13/12/23 - priorities
3. Outcome of IDCB workshop 13/12/23 - efficiency
4. The GM Strategic Financial Framework
5. NHS Trust Provider priorities
6. Summary – what does this tell us about our priorities
7. The Health and Well Being Board leadership of Population Health Strategy
8. Next Steps

1. Bury Locality Board - Plan, arrangements and priorities

Part of Greater Manchester Integrated Care Partnership

1a. Lets Do It - a plan for a better borough

Our locality plan for health and care sits in the context of the wider ambition for the borough – the Lets Do It strategy – with its ambition for faster economic growth and significant reduction in health inequalities.



BURY
LET'S Do It!

1. Improved quality of life
2. Improved development
3. Improved educational attainment for our children and young people
4. Increased adult skill levels and employability
5. Inclusive economic growth
6. Carbon neutrality by 2038
7. Iimproved digital connectivity

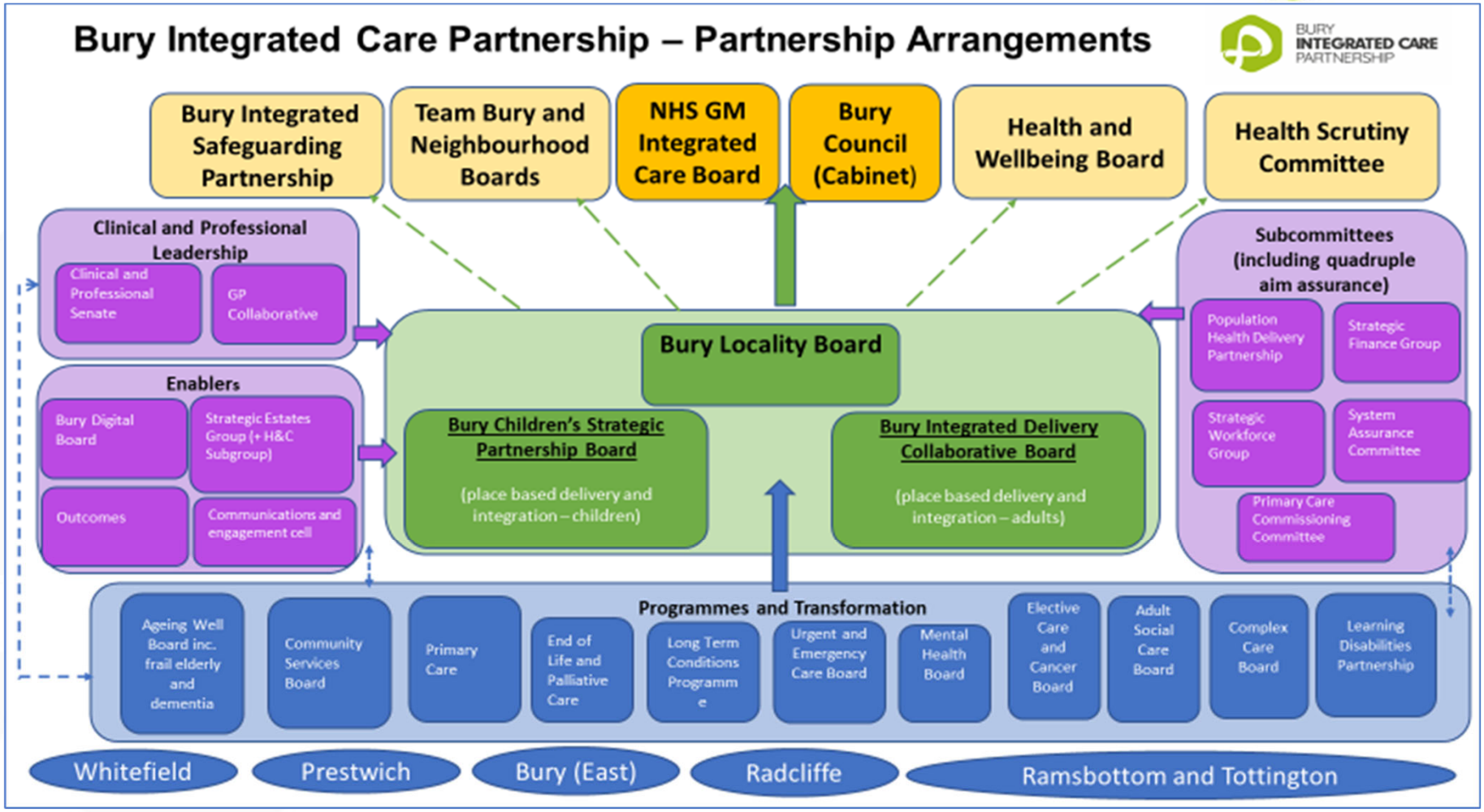
1b. Current Locality Plan – core principles

BURY INTEGRATED CARE PARTNERSHIP

- In the context of the Lets Do It Strategy we have together written a Locality plan – our strategy for the health and care system in Bury.
- Our ambition is close the financial gap whilst keeping a focus on the medium term financial plan, our focus on prevention, and operating plan requirements by:

Enabling health and care organisations and the voluntary sector in the borough to achieve more together than each individual organisation could do alone, to provide more effective integrated services, to achieve better outcomes and experience for people, to improve cost control in health and care services and to have a greater impact on improving population health, reducing health inequalities and increasing inclusivity.

1c. Our partnership arrangements



1d. Locality Board Priorities: 23/24

- **The integrated Delivery board** in supporting partners to work together on 13 programmes of work – urgent care, elective care, mental health, end of life care, learning disabilities etc.
  - Reported monthly via the IDCB Chief Officers report to locality board
  - Supplemented by:
    - Performance report, Quality report, Finance report
  - Occasional deep dives at Locality Board

The IDCB has allowed the **Locality board** elected to focus its work in 2023/24 on 5 key priorities

a. First 1001 days from conception to age 2 :new models of delivery connected to role out of family hubs in neighbourhoods, and recognising identified under resourcing in HV capacity
b. Sustainability and Transformation of Primary care, including recognising the relative under-doctoring of Bury
c. Future and sustainability model of intermediate care
d. Opportunities for improved workforce recruitment and retention and flexible working
e. Reducing duplication and inefficiency in pathway processes.

1e. In 2024 the Locality Board also focused on..

SEND

The locality board prioritised the work on improving the experience of families and children in the SEND Cohort.

1) SEND partnership arrangements
2) Graduated Approach
3) NHS waiting times

Neighbourhood working

- Application of a consistent operating model across the neighbourhoods but with flexibility to plan and deliver services in response to local need.
- Embedding the principles of personalisation, and assets / strengths-based working with people and communities.
- Focus on prevention and avoiding, reducing and delaying the need for higher and costlier types of intervention.
- Focus on providing care at home / in the community wherever possible.
- Further integration of health and care services at a Neighbourhood level
- Clear service pathways and ‘offers’ for people according to need [Thrive model].
- Improved use of data and information technology to understand need, deliver services and connect people and the workforce.
- Connection to wider Public Service Leadership Teams in neighbourhoods.

1f. As a result we have the following frameworks and systems in place and in delivery (examples)

BURY INTEGRATED CARE PARTNERSHIP

- GP Strategy
- Workforce Strategy
- 1001 days programme of work
- Intermediate Care medium term plan in development
- Palliative and End of Life Care Strategy
- Detailed understanding of SEND strengths and opportunities
- Maturing model of neighbourhood working
- Team Bury Health Inequalities Strategy and Implementation
- Assurance on the effective operation of the urgent care system
- Substantial progress on mental health programme board delivery
- Adult Social Care Transformation Programme

1g. Evidence of progress in 2023/24 (examples)

- A&E waiting times consistently one of best in GM
- £1.4m investment in CAMHS
- Establishment of Epilepsy Nurse role and consultant in palliative care,
- Nationally recognised wellness implementation (my happy mind)
- Best transforming care performance in GM
- Significant improvement in CHC performance
- Delivery of Substantial ASC savings programme based on reform
- GM vanguard delivery of e-Derma
- IAPT waiting times better than GM
- Additional activity in primary care and face to face recovery
- External validation of arrangements and progress for cancer network, LGA peer review, and Ofsted monitoring
- Consistent outperformance of GM average in vaccination
- National vanguard implementation securing fewer days kept away from home and lower complexity

BURY INTEGRATED CARE PARTNERSHIP

2. Integrated Delivery Board Workshop 13/12/23 - System Priorities

Part of Greater Manchester Integrated Care Partnership

2a. Key themes across all programmes in 2024/25

- Addressing the financial challenge faced by all partners in the Bury Health and Care System – NCA, Pennine, MFT Council, NHS GM (Bury), private providers, primary care, voluntary sector.
- Taking unnecessary or preventable demand out of the system (referrals, diagnostics, waiting list validation and urgent care, complex care for adults and children, secondary prevention)
- Reducing duplication across services (especially on urgent care services) through better connectivity
- Deepening integration across services horizontally and vertically
- Combining services across pathways to become more efficient e.g falls
- Communication plan with clinical and professional teams regarding the decision they make and recognition that we are likely only to be able to provide a bronze rather than gold standard service
- Communication plan with the public about our financial challenges
- Embracing fully the GM Medium Term financial strategy plans – for a financially sustainable system
- Further develop the capacity and capability of neighbourhood team working.

2b. Suggested High level priorities for 24/25

- Urgent and Emergency Care – demand management, service shaping and connectivity of out of hospital services
- Planned care, community services and cancer – demand management and prevention
- Primary Care and the neighbourhoods – sustainable model of primary care, embedding the neighbourhood model, primary and secondary prevention and reducing duplication across provider partners (including community pharmacy)
- Mental health and emotional wellbeing – demand management and reducing OOA placements
- Children and Young People – The first 1001 days
- Workforce (recruitment and retention across place)

3. Integrated Delivery Board Workshop 13/12/23 - Efficiencies

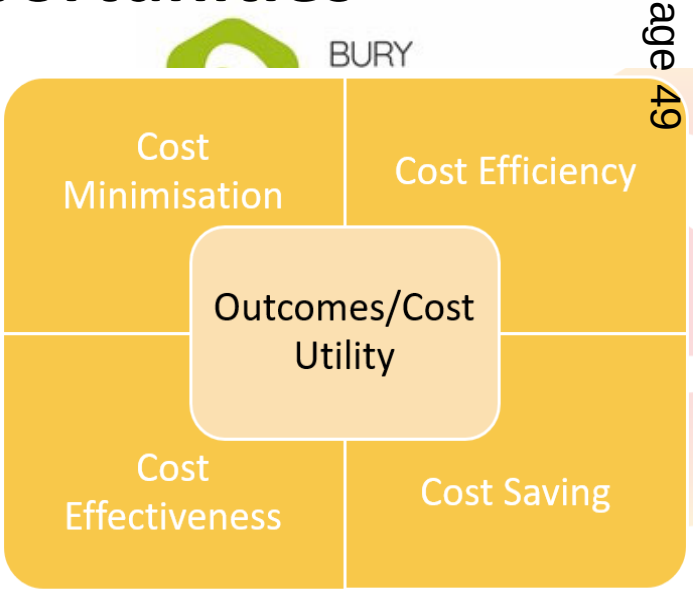
4 themes of work

Part of Greater Manchester Integrated Care Partnership

3a. - Theme 1 - Sense checking the current efficiencies

- Agreement with the list of efficiencies opportunities provided for the programme areas that we focussed on during the session with no additions provided.
- Some groups were able to start to define some of key pieces of work/activities to progress against each listed opportunity area.
- Others found the list needed further work with system colleagues to determine the opportunity and help shape this further especially when this impacts on moving demand from one part of the system to another.
- It was raised that there are programmes of current work that will release efficiencies for 24/25 which need to be considered then in terms of priorities too/continuation of work.

3b. Theme 2 - . Allocate the efficiency opportunities to the cost quadrant model



Model

- **Cost Minimisation - doing the same things for less** i.e. by using cheaper inputs. Examples might be **Skill mix changes** where a given task can be safely carried out by staff at a lower pay band who are trained and qualified.
- **Cost efficiency - doing more for the same** resources. This would be achieved by using inputs differently or making processes more efficient to achieve more outputs.
- **Cost effectiveness** is **about trying to doing things differently to achieve equivalent or better results with equal or greater productivity**. In contrast to cost efficiency, the focus is more on outcomes than outputs.
- **Cost Saving** may be simply about **reducing expenditure** and **stopping doing things** or ~~delivering interventions which **prevent, avoid or delay higher cost activities.**~~

Feedback

The model was socialised with system colleagues and conversations in the time available were mainly on clarifying the model quadrants.

- There were different views on which quadrants would be the priority.
- Some opportunities were able to be allocated to quadrants (expanding ACM, Out of Area mental health placements, supporting people with dual diagnosis, Virtual Ward, working with North Manchester, utilising VCFA and SPOA) but most groups didn't get to this position in the time available.
- There was an ask to be available to quantify costs of moving activity from one part of the system to another to ensure resources are identified to support this move.

3c - Theme 3 - Review the proposed approach to developing system efficiencies

Agreement with proposed approach but suggested the need to focus on a small number of appropriately resourced projects e.g. 2/3 priorities for each programme

- An ask to consider what to stop doing to focus efforts on the focussed priorities.
- Is there an opportunity to look across programmes and consider whether there is something we can achieve overarching first that will impact on several programme priorities.
- Need for Board commitment/senior leadership sign up to what we stop/prioritise with a clear mandate/permission to all work on these together with the teams also to enable this to happen.
- Priorities were identified by Group 1 as reducing admissions from care homes and relaunch of Pre-Ed streaming service.
- It was noted that some listed efficiencies are already being covered by ongoing work related to BCF/QUIP work with a need to sequence priorities
- Need to not loose sight of the primary and secondary prevention work that will ultimately create the greatest efficiencies in the medium to long term but recognise the need for short term savings
- Need to address the inefficiencies created by poor communication / lack of effective information sharing at different levels. This operates / requires intervention at different levels:
    - Relational / behavioural / cultural
    - System and process
    - Digital systems access

2d - Theme 4 - Identify opportunities to deepen connectivity with the neighbourhood model

Revisit the neighbourhood model with leadership teams to ensure understanding of this inc distinction between ACM as process and also comms/engagement piece with our key workforce teams.

- Opportunities to identify and manage Frequent flyers at FGH – data sharing issue to be addressed to enable info to be shared with neighbourhoods/PCNs/Primary Care/NMGH
- Build on and expand ACM process – consider from discharge process what can be picked up form VW/neighbourhoods building pathways.
- Explore and share benefits of current system model – consider what to keep
- Address the disconnect with North Manchester/Rochdale providing an understanding of bury services, ensuring agreements in place to effectively step/down patients and address capacity issues/other barriers that aren't enabling effective flow of patients across primary, community and secondary services.

BURY INTEGRATED CARE PARTNERSHIP

4. The GM Strategic Financial Framework and the unique role of the Locality Board

Part of Greater Manchester Integrated Care Partnership

4a. Context 1 – NHS GM Challenges

NHSE attempt to reset 23/24, which will impact where GM exits the financial year

- This was linked to the announcement of additional funding c£46m for GM, reduction in ERF targets c1% for GM ICB and flexibility offered for relating to some programme budgets

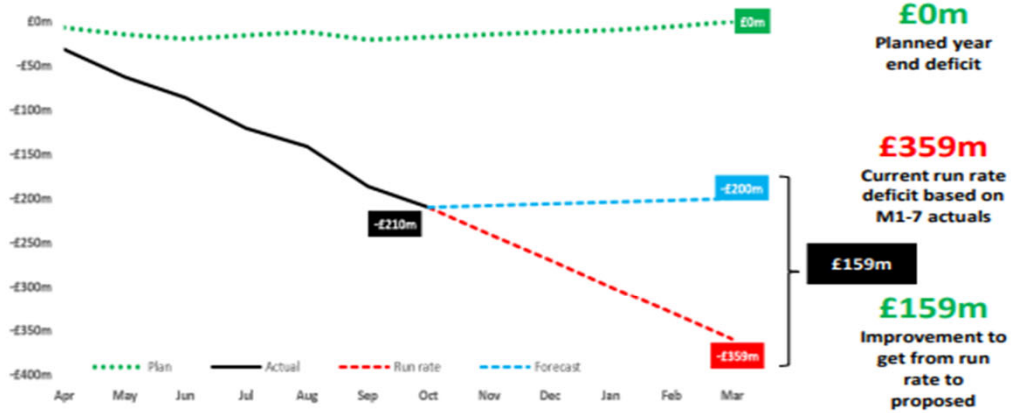
- Headline requirements:

  - **Deliver Financial Plans** - Systems must deliver revenue plan submitted in May which for GM was balance
  - **Elective Services –** Deliver performance submitted in May for incomplete Right To Treatment (RTT) timeframes and reduce 78 and 65 week waits to zero.
  - **Urgent Care –** 4-hour A&E performance as described in winter plans, this assumed all GM providers would be at 76% by March 24
  - **Cancer –** Deliver 62-day cancer reductions and the Faster Diagnostic Standards as per May plans

4b. Context 2 – NHS GM financial Challenge

BURY INTEGRATED CARE PARTNERSHIP

GM reset submission on finance



£0m
Planned year end deficit

£359m
Current run rate deficit based on M1-7 actuals

£159m

£159m
Improvement to get from run rate to proposed outturn

Organisation	22nd November 23 - £m		
	Plan	Submission	Variance
MFT	£0.0	-£11.6	-£11.6
CFT	-£8.0	-£4.0	£4.0
NCA	-£32.2	-£68.4	-£36.2
BFT	-£12.4	-£11.2	£1.2
TGICFT	-£31.5	-£30.8	£0.7
WWL	-£6.5	-£10.7	-£4.2
PCFT	£0.0	£2.1	£2.1
SFT	-£31.5	-£31.2	£0.3
GMMH	£0.0	£0.0	£0.0
Provider - Total	-£122.0	-£165.7	-£43.7
ICB - Total	-£8.0	-£34.7	-£26.7
System risk	£130.0	£0.0	-£130.0
ICB - Total	£122.0	-£34.7	-£156.7
System - Total	£0.0	-£200.4	-£200.4

Key messages

- **Variance to planned deficit £200m – This is broken down as follows:**
  - **£43m Providers –** Total deficit equates to **£165m** against a planned deficit of **£122m**. This assumed the release of flexibilities equating to just less than **£5m** that are still being discussed**.**
  - **£27m ICB –** Total deficit equates to **£35m** against planned deficit of **£8m**.
  - **£130m System risk –** To deliver a balanced plan, the system needed to manage a system risk of **£130m**. There is unlikely to be any offset of this risk in 23/24. This resides in the ICB accounts and results in the ICB reporting an overall deficit of **£156m.**

4c. The framework content, and risk

- The demand for health and care services for the population of Greater Manchester over the next five years, given current trends, and how much it will cost the providers to deliver on those requirements.
- The opportunities to improve the health and care for the population of Greater Manchester to keep people healthier and manage their health needs better
- How the change in population requirements will impact the demand on providers, and how this demand will be delivered efficiently
- What the opportunities are for the efficient delivery of this care (provider-side)
- The investments required to realise these opportunities, and how quickly these benefits can be realised to meet national and local priorities
- The impact of these opportunities on the Greater Manchester financial deficit, and whether there is any residual structural deficit and the drivers of it

GM faces a catastrophic financial outlook without making changes to mitigate the impacts

- Assumptions:
  - Flat real growth – 1.7%
  - Demographic growth – 0.4%
  - Cost inflation – 2.9%
  - Tariff inflation – 1.8%

- Applying the growth rates reveals a deterioration of the financial position across GM ICB from 2022/23 to 2027/28, with the deficit growing from **£570m to £1,922m**

4d. GM Strategic financial framework.

	Understand baseline and "do nothing" forecast	Consider opportunities to improve health, performance and finance	Phasing and Investment	Reflect in financial framework
Population	**Understand place** • Segment population by age, condition and deprivation • Level of consumption of healthcare • Allocation growth • Spend on providers	1. Reducing the growth in prevalence and progression of ill-health 2. Optimising models of care to optimize total spend (across all settings) for each segment 3. Improving care for the most disadvantaged communities	• Identification of interventions and ROI • Non-recurrent investment to ramp up/double run services • Investment in data and digital capabilities	• Calculate the total allocation change including ICS and NHSE in the do nothing baseline • Optimise spend while improving population health and shift pattern of spend
Provider	**Understand provider** • Understand current activity and expenditure • Apply growth assumptions • Understand the underlying recurrent financial position of each trusts	1. Improve model of care to increase quality and flow (theatres, OP, discharge) 2. Pure unit labour productivity (skill mix, rota, bank/agency) 3. Procurement (drugs, medical consumables, nonclinical) 4. Estates (facilities, capital, etc) 5. Back office (IT, admin)	• Non-recurrent costs to support transformation • Any restructuring of costs to address a deficit • Investment in data and digital capabilities	• Forecast current underlying position for each provider • Understand the productivity gains that are required to address the underlying position

4e. There are different types of prevention

BURY INTEGRATED CARE PARTNERSHIP

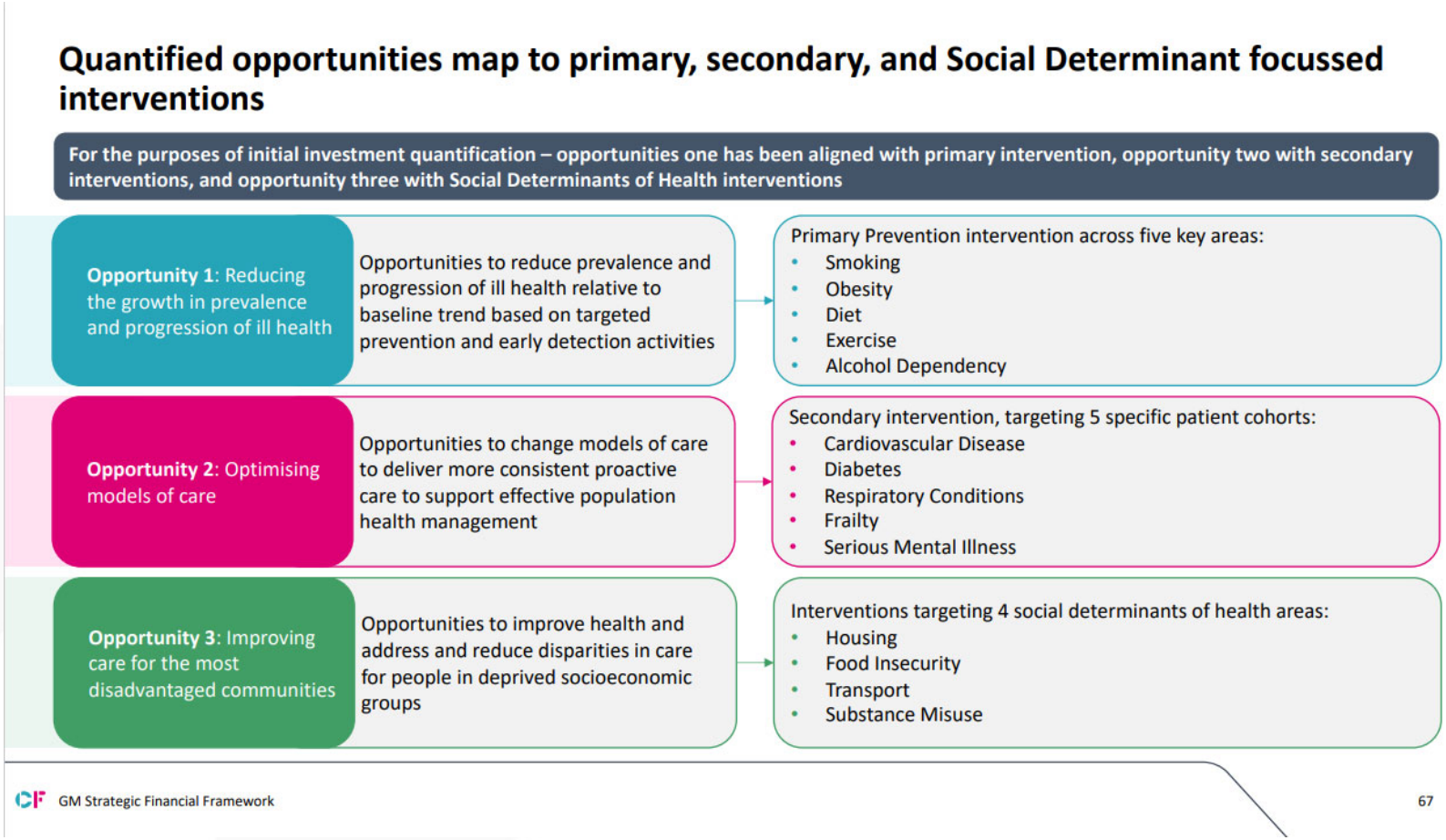
Primary Prevention (1)	Primary Prevention (2)	Secondary Prevention	Tertiary Prevention
Creating the conditions for good health by tackling the societal causes of ill health	**Preventing disease before it occurs by addressing modifiable risk behaviours**	**Catching ill-health as early as possible to prevent or reduce the chances of them leading to more serious conditions**	**Taking action to stop, limit or more effectively manage disease progression including rehabilitation from a debilitating condition and providing palliative care**
Tackling the **KEY DETERMINANTS** of ill health such as poverty, unemployment / poor quality work, poor housing and negative life experiences	Tackling the top modifiable behavioural **RISK FACTORS** for disease: Tobacco, diet / health weight, physical inactivity and alcohol	Early **DETECTION** and effective **TREATMENT** of key risk factors such as high blood pressure, high cholesterol and atrial fibrillation	Optimising **MEDICAL MANAGEMENT**, and providing **PLACE-BASED, INTEGRATED, AND PERSONALISED CARE**

A comprehensive & high impact approach requires action across, and between, all four domains.

Source: Adapted from NHS England » About the prevention programme

4f. GM Strategic Financial Framework: Opportunities

BURY INTEGRATED CARE PARTNERSHIP

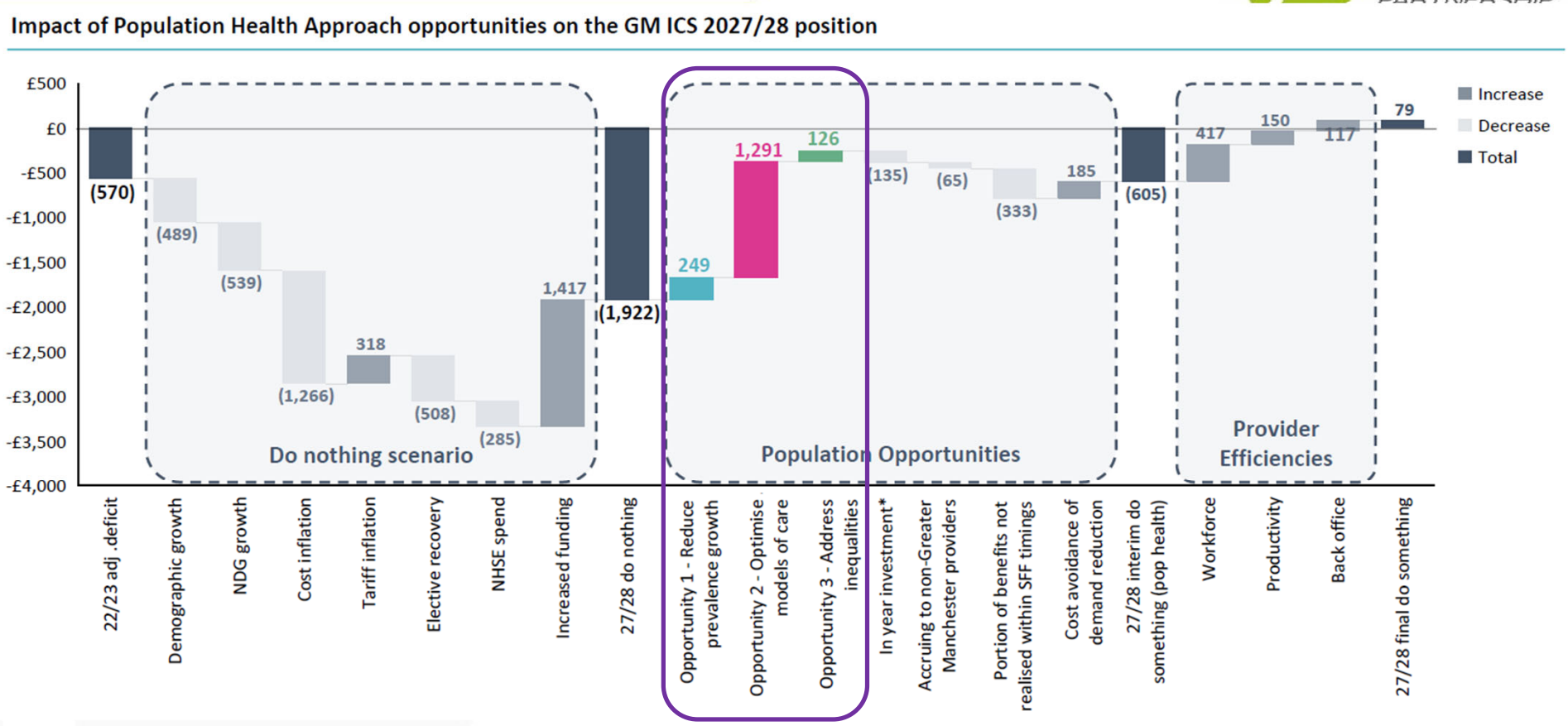


A comprehensive focus on secondary prevention, balancing a Population Health approach and a Clinical Effectiveness lens, and with clear priorities and objectives

This is a key opportunity for the Locality Board

Source: Carnell Farrar GM Strategic Financial Framework 2023

4g. GM Strategic Financial Framework: Findings



We can achieve sustainability through a radical scaling up of our approach to prevention.

Source: Carnell Farrar GM Strategic Financial Framework 2023

5. NHS Provider Trust Priorities – NCA and Pennine Care

Part of Greater Manchester Integrated Care Partnership

5a. NCA proposed planning priorities (1)

BURY INTEGRATED CARE PARTNERSHIP

Urgent and emergency care

- Formulate a position across localities on delivery of the national intermediate care framework for rehabilitation, reablement and recovery to improve admissions avoidance, discharge flow. This will include delivery of **Home First,** and critically, build on the tests of change developed by the FLP **DoH Discharge Integration Frontrunner** pilot site to improve dementia care and implement strengths-based approach to improve discharge flow.
- **GM Major Trauma -** complete the mobilisation of the GM Major Trauma model of care.

Elective care

- Work with partners to manage elective demand.
- Continue and further develop the **Outpatient Improvement Programme** delivering on key priority areas which include expansion of PIFU, virtual consultations, DNA reduction and working with partners to further develop specialist advice.
- Focus on key priority specialties with a particular focus on those currently with waits more than 52 weeks and with known capacity issues, including:
- **Dermatology** – Continue to work with partners to develop sustainable GM dermatology services, including:
  - Developing the delivery model aligned to the GM Model of Care.
  - Establishing consistent community service offers across GM.
  - Improving access to high-cost drugs.
  - Developing and embedding initiatives to improve demand management & triage and optimise use of capacity.
- **Neurology** – Continue to explore options with commissioners to develop more integrated Neurology services with a greater focus on long term condition management. This aligns with national GIRFT recommendations and should, through a team care approach, improve current inequities in access to specialist services in some parts of GM.

Diagnostics

- **Targeted Lung Health Checks (TLHC):** Working collaboratively with MFT and Christie, continue the roll-out the TLHC programme across GM to achieve 100% coverage within 3.5 years. The NCA and MFT will collaborate to deliver the diagnostic component of the pathway, utilising CDCs in Oldham, and Salford.
- Continue to collaborate through the **GM imaging and pathology networks** and GM chief pharmacist group, exploring opportunities for providers to better align capacity and demand across a larger population and to make digital systems more interoperable to facilitate this.
- Continue to develop the **Community Diagnostic Centre (CDC)** offer to our local populations, reducing inequalities in access.

5b. NCA proposed planning priorities (2)

BURY INTEGRATED CARE PARTNERSHIP

Maternity, children and young people

- **Maternity Improvement:** We will continue our Maternity Improvement journey and launch our Maternity Strategy in 24/25 to deliver safe equitable maternity care for our population. This will be delivered in line with the North West Regional Maternity Strategy and the Greater Manchester and East Cheshire Local Maternity and Neonatal System (LMNS) Maternity Equity and Action Plan 22-27. Continued collaboration with Maternity Voices Partnership, Public Health, and other locality partners. This work will support our targets around reduce stillbirth, neonatal mortality, maternal mortality, and serious intrapartum brain injury, and we will achieve fill rates against funded establishment for maternity staff.
- Identifying areas for collaboration to reduce unwarranted variation in service provision and alleviate financial pressures affecting **children and young people's services**, including Speech and Language Therapy, complex tongue tie pathways and others.
- **0-19 services** – continue to work with partners across the four localities to improve the sustainability of 0-19 services, including opportunities to collaborate on shared standards/specifications.

Mental health

- Following engagement with our people who deliver this care, people who have used our services, voluntary sector colleagues, localities, and other key stakeholders develop a draft Mental Health Strategy.
- Our **Mental Health Strategy 2024-27** (which will be reviewed at NCA Board in January 2024) is focused on providing person centred, high quality, compassionate care for our patients, carers, staff, and families living with mental ill health across all our settings. The strategy aligns with the GM Mental Health strategy.
- Working with our partners, develop alternatives to ED/UTC attendance and develop system wide responses to Right Care Right Place.
- Work with mental health provider colleagues to deliver mental health training for our people as well as appropriate physical health training for mental health provider colleagues in a reciprocal arrangement.

Community health services

- **Joint review of priority community service areas** identified through Four Locality Partnership – (provisionally identified as adult SLT, dietetics, district nursing, paediatric SLT, community diabetes but to be refined).
- **Review investment in community services across our places** and where action is required to secure sustainability. Participate in the review initiated by GM ICB on the funding levels for ICB commissioned community Services, including the potential for a standardised approach to funding provider overhead.

5c NCA planning priorities (3)

BURY INTEGRATED CARE PARTNERSHIP

Financial sustainability

- Deliver our **Financial Sustainability Plan** (due for Board approval Jan 24), including a CIP pipeline for the next 18-14 months which includes:
  - Improvements to patient flow and reduction of LOS
  - Improved OP and Theatre efficiency
  - Reduction in prescribing costs
  - Reduction in management costs
  - Digital and Estates strategies which maximise innovation and reduce the cost of our footprint (inc. community estates review with locality SEGs)
- Develop medium to long term financial sustainability plans including further standardisation and consolidation of clinical pathways.
- As a partner of the Four Locality Partnership, the GM Trust Provider Collaborative, and wider GM Integrated Care System (GMICS) we will work with partners to identify, develop, and implement system-wide changes which support efficiency and right-sizing the hospital sector.

Disaggregation of previous Pennine Acute footprint

- **ENT and Urology:** planned to fully disaggregate by April 2024
  - **Trauma and Orthopaedics**: planned to fully disaggregate by October 2024
  - **Colorectal (cancer and benign):** NCA and MFT to agree optimal approach and timescales for disaggregation of these pathways in 24/25.

5d. Pennine priority areas

BURY INTEGRATED CARE PARTNERSHIP

National performance targets	High risk areas – safe and effective core services (MH)	Sustainable funding for existing services (LD and autism)
• OAPs / Independent Sector Beds - In light of the system financial position a trajectory for the use of OAPs and the Independent Sector Beds should be developed and funding set aside to ensure these costs can be met. • Memory Assessment Services - PCFT is currently undertaking a deep dive to identify issues and recommendations. This is an area that will require levelling up once deep dive undertaken.	• In-patient services • Crisis services • Living Well – Transformation of Community Services • Female PICU • CMHTs • Core CAMHs	• Stabilise core services • ASD / ADHD – CYP

5e Pennine Care priority areas (2)

BURY INTEGRATED CARE PARTNERSHIP

Sustainable funding for existing services

- Discharge schemes
- Patient flow
- Learning disability and autism services

Lead Provider Collaborative

- Low secure unit
- CAHMS T4 in-patients
- Resilience hub

6. Summary and Discussion – what does this suggest to us about our priorities for 24/25

Part of Greater Manchester Integrated Care Partnership

6a. Suggestion - Building Blocks

- We have a track record of working well as a system and have confidence in the work on integrated delivery and we should build on that
- We have confidence that we can effect demand (and cost) reduction – see Adult Care, Childrens services, Discharge from FGH
- We have a set of key strategic frameworks and programme plans developed that can shape our work next year
- We recognise the enormous financial challenge to partners and the system and are focusing on a range of efficiencies.
- The GM Strategic Frameworks invites the focus on prevention and early intervention that is the unique contribution of the locality board – addressing demand reduction
- We recognise the role of providers and system boards in addressing supply side challenges, and have maturing collective footprint based partnerships with NCA, Pennine Care, and MFT.
- We have a population health system based health inequalities strategy and implementation plan – driving collective ambition towards the Lets Do It commitment.
- We have a model of neighbourhood working that provides a focal point, rooted to wider public service reform ambition

6b. Suggestion - Our 6 Obsessions

We Work Together to

1. **Optimise Demand Reduction -**
   Primary prevention, Secondary Prevention, Tertiary Prevention
2. **Reduce inefficiency and duplication** in the pathways of care as a major contribution to the financial recovery
3. **Reduce Health Inequality** of those in most disadvantaged areas, and in access, quality, and outcomes of care
4. **Fully realise the benefit of neighbourhood team working** with a focus on the assets of residents and communities
5. **Secure the right workforce in the right place with the shared ambition**
6. **Recognise Quality Delivery and Financial Sustainability** as inherent to the rest.

Our obsessions inform the way we deliver our priorities……

6c. Suggestion – Key Priorities (1)

Urgent Care	• Reduce demand on urgent care services (A&E attends and admissions
	  • Reducing admissions from care homes: support to care homes and responses in a crisis
	  • Increasing referrals through rapid response and virtual ward
	  • Increased Mental Health offer in the community
	  • Re-launch of the Pre-ED streaming service
	• Neighbourhood working
	  • Closer integration of pathways for long term conditions and identification / management of patients in primary care (diabetes, respiratory , CVD, cancer, stroke and neighbourhood working)
	  • Referral into neighbourhoods from acute services on discharge
	• Reduce Inefficiency and Duplication
	  • Closer integration of falls services and reduced duplication across services
	  • Via GP Connect, maximise referrals from A&E and NHS111 to GP Practices
	• Improving Quality
	  • Improving flow through sustainable model of intermediate care, frailty SDEC, the discharge frontrunner programme by reducing the number of days kept away from home patients, and reducing LOS for patients (a focus on stroke)

6c. Suggestion – Key Priorities (2)

Mental Health and Emotional Well Being	• Demand Reduction
	  • Further embed thrive model (all age) with VCSE provision of earlier support (all age)
	  • Implement CYP MH early help hub
	• Reduce Inefficiency
	  • Reduce OOA placements including a focus on reducing delayed discharges (working with NHS GM on pan GM solutions including ensuring supported accommodation capacity etc in place).
	• Quality
	  • Expand crisis response (all age) – linking with the pan GM work programme.
	• Neighbourhood working
	  • Implement Living Well model and mental health practitioners in primary care
	  • Mobilise expansion of community provision with agreed new investment [Home Treatment Teams, Early intervention in psychosis Team, Core CAMHS]
	• Health Inequality
	  • Adult ADHD/ASD – address current service gap and linking with the pan GM work programme to develop new pathways
	• PCFT Commissioning Intentions to be considered alongside new operating plan requirements

6d. Suggestion – Key Priorities (3)

Elective Care	• Reducing demand on elective services though
	  • Peer review
	  • Advice and guidance
	  • Onward referral or guidance
	  • Patient initiated follow up
	  • Direct access diagnostics and IS provision
	  • Role of RBMS, referral gateways, LCS contract and community services SPOA
	  • Alternatives models of provision in the community
	• Reducing Inefficiency
	  • Reducing waiting lists through alternative methods of group based clinical validation processes
	• Reducing Inequality
	  • Ensure prioritisation of inequalities in terms of treatment of people on the waiting list (all providers) – linking to the pan GM programmes.
	• Improving Quality
	  • Implementation of national and GM interface principles including C2C, complete care, call and recall and points of contact and clear communication for patients

6. Suggestion – Key Priorities (4)

BURY INTEGRATED CARE PARTNERSHIP

Children, Young People and Maternity	• Neighbourhood Working
	  • First 1001 days from conception to age 2 :new models of delivery connected to role out of family hubs in neighbourhoods, and recognising identified under resourcing in HV capacity
	  • Develop and fully implement Family Hubs aligned to neighbourhood model (inc education providers) – improve access to earlier support.
	• Quality
	  • Deliver outstanding commitments and priorities in relation to the childrens improvement plan, particularly around additional safeguarding nursing capacity in the MASH
	  • Development and full implementation of the neurodevelopmental pathways for Autism and ADHD (based on holistic need)
	  • Fully embed trauma informed approach - Early Years service integration with focus on first 1001 days (GM priority programme).
	  • Bury Corporate Parenting has established a bespoke task and finish group to look at Care Leavers mental health provision.
	  • Connect to the National Maternity Agenda being delivered through the GMEC-LMNS
	• Demand Reduction
	  • Improve emotional wellbeing access for CYP (work with VCSE on new delivery models in neighbourhoods) with fully commissioned VCSE provision.
	• Reduce Inequalities

6e. Suggestion – Key Priorities (5)

BURY INTEGRATED CARE PARTNERSHIP

Primary Care	• Quality
	  • Delivery of Bury GP Strategy including recognising the relative under-doctoring of Bury. Delivery of GM Primary Care Blueprint (with associated funding)
	  • Review locally commissioned service (linked to GM programme) HIU model implementation.
	• Neighbourhood
	  • Development of neighbourhood working , linking closer with PCN's addressing the medium term financial plan requirements: a focus on identification and prevention
	  • Closer integration of primary care and community pharmacy
	• Demand Reduction
	  • Implementation of 5 priorities guidance on population health management secondary prevention – particularly focus on frailty, diabetes, mental health , cardiovascular disease, respiratory

6. Suggestion – Key Priorities (6)

Planned Care, Cancer and Community	• Demand Reduction
	  • End to end pathway redesign of LTCS across primary, community and secondary care with a focus on primary and secondary prevention (and earlier detection) . Phase 1: respiratory and diabetes
	• Neighbourhood Working
	  • Priorities within NCA community services transformation programme : 0-19's, adult SLT, dietetics, community neuro-rehabilitation, paediatric SLT, community diabetes, district nursing
	• Demand Reduction in Cancer
	  • Improve earlier detection of cancer and survival rates (Cancer Alliance recommendations)
	  i. **Early Diagnosis** – achievement of LTP 75% ambition; incorporating work on primary care pathways / PCN DES, timely presentation, TLHC, FIT in lower GI pathways; improvements in screening uptake
	  ii. **Faster Diagnosis, Operational Performance & Treatment Variation** – delivery of CWT standards (28 Day FDS, 31 Day DTT to Treatment, 62 Day GP referral to FDD); Implementation of Best Practice Timed Pathways; Sustain NSS pathways; identify and address treatment variation
	  iii. **Personalised Care** – delivery of personalised care for cancer patients and Patient Stratified Follow Up

6f. Suggestion – Key Priorities (7)

End of life:	• Demand Reduction:
	  • Secure progress on palliative care register completion and track progress via numbers of admissions in last year of life.
	• Quality
	  • Key priorities identified as part of the revised palliative and end of life care strategy, the opportunity of social investment funding being discussed with Macmillan and GM service review

Learning Disabilities	• Quality
	  • Continue to improve the accuracy and increase size of GP Learning Disability registers,
	• Workforce
	  • develop integrated, workforce plans for the learning disability and autism workforce to support delivery of the objectives set out in this guidance, and test and implement improvement in autism diagnostic assessment pathways including actions to reduce waiting times

6. Suggestion – Key Priorities (8)

Adult Care	Delivery of the ASC Strategic plan including:
	• Quality
	  • Modernizing Learning Disabilities
	  • Making Safeguarding Everyone's business
	• Workforce
	  • Delivering Excellent in social work practice
	• Efficiency
	  • Local and enterprising market
	• Demand Reduction
	  • Delivering superb intermediate care

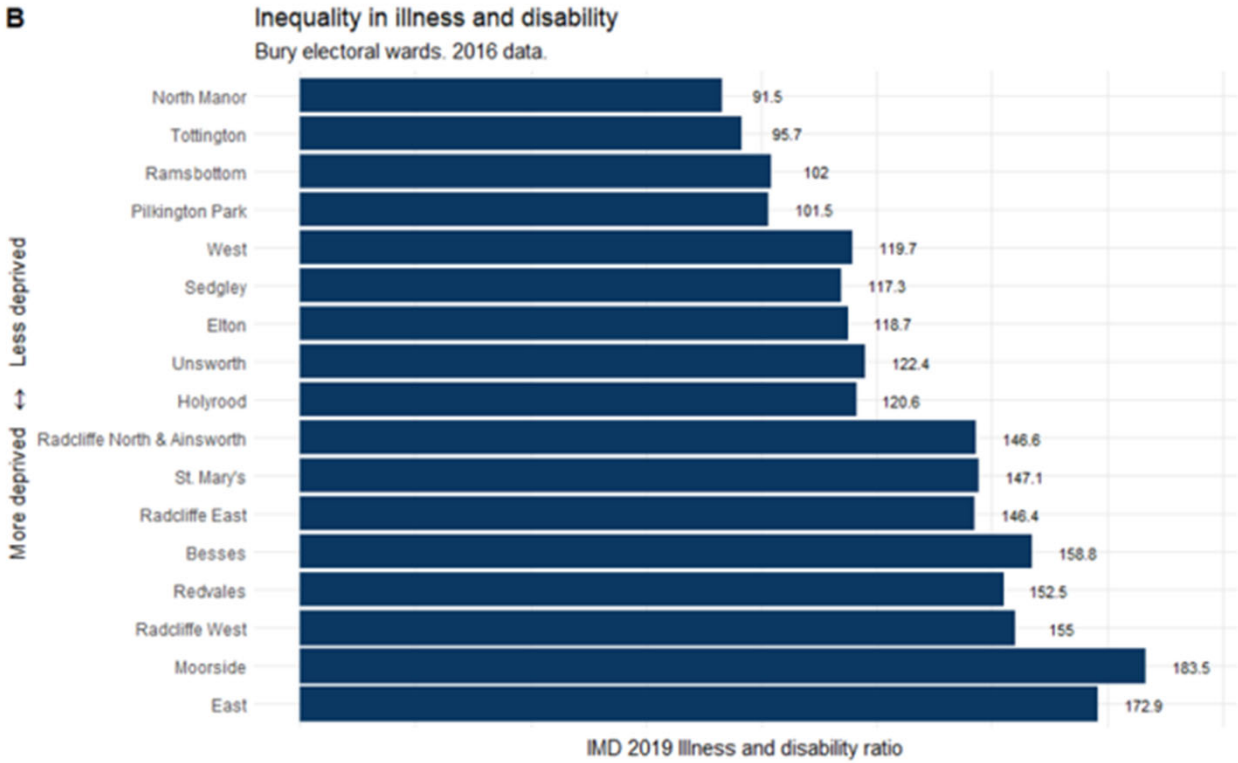
Complex Care	• Reduce inefficacy • Work with GM ICB colleagues to establish more robust market management and shaping arrangements.

BURY INTEGRATED CARE PARTNERSHIP

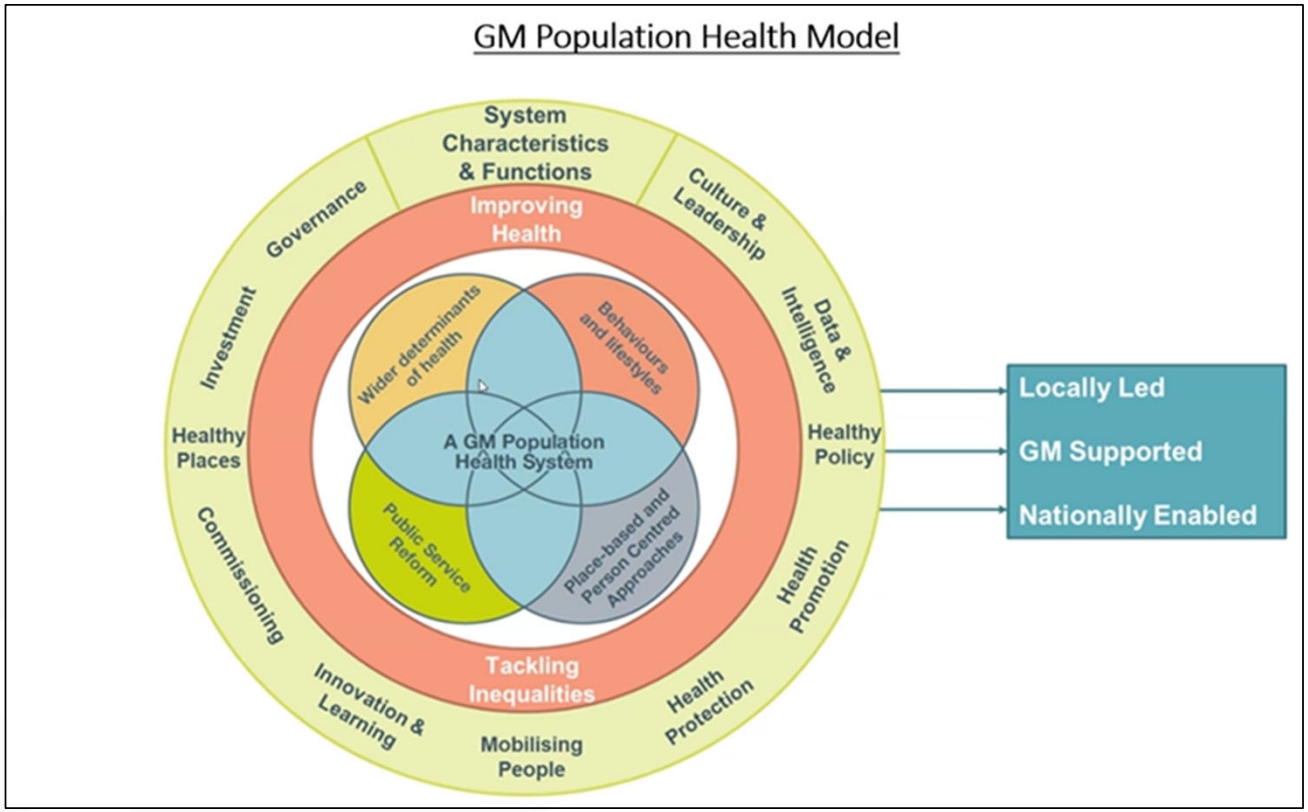
7. Health and Well Being Board Focus on a Population Health System

Part of Greater Manchester Integrated Care Partnership

7a. Our inequalities



7b. Population Health Model



The Health Inequalities Implementation plan, agreed at the December Team Bury event, is the foundation stone for our work on prioritising health inequalities.

This is managed and overseen by the Health and Well Being Board

An update will be presented to the Locality Board

BURY INTEGRATED CARE PARTNERSHIP

8. Summary and Next Steps

Part of Greater Manchester Integrated Care Partnership

8a. Summary

- This is a GM wide programme and we know what the specific contribution required is from each of the localities.
- We are in a good position based on delivery and on the frameworks we have developed in 2023 to guide our on- going transformation
- We recognise the very challenging financial situation and we have worked with partners to develop efficiencies and to frame our efficiency programme
- The GM Strategic Financial Framework requires a response from localities on demand reduction and population health gain as part of the planning priorities
- NHS provider trusts are identifying their key priorities and we need to reflect them (and that of other partners)
- We could guide our planning priorities, and the work of the locality board, according to 6 key obsessions – reducing demand, reducing inefficiency, building neighbourhood working, reducing inequality, securing workforce, and focusing on quality and financial sustainability.
- We can identify key priorities for each of our programmes that talks to our obsessions- this is the cornerstone of our priorities
- We know the health and well being board is overseeing the borough population health system health inequalities plan

8b. GM timelines

Action	Lead	Timeframe
Draft Commissioning Intentions for Each Locality	DPBLs	In progress
First Draft of Individual Locality Priorities for 2024/25	DPBLs Templates provided by GM Team	31st January 2024
Action Plan for Priorities Across all 10 Localities	DPBLs	26th February 2024
Final Version of Individual Locality Priorities	DPBLs	26th February 2024
Final Version of Locality Delivery Portfolio – including all of the Above for inclusion in 2024/25 GM Operational Plan and Updated JFP	GM Team	20th March 2024

8c. Next Steps in Bury

1. *Review of NHS GM (Bury) locally managed contracts undertaken December 2023*
2. *Actions from Bury workshop 13th December to review and develop operational and efficiency alignment*
3. *15th December – further iteration of this slide deck to GM*
4. December and January – further iteration based on national planning guidance, GM prioritisation, NHS provider footprint conversations, and consideration of ICB partners.
5. January 8th – presentation to locality board, alongside presentation by NHS GM of Medium Term financial strategy
6. Early January – Mid Feb - Development of a methodology to support consistent approach to prioritisation
7. End Jan – Mid Feb - Work with SROs/programme teams to apply prioritisation methodology to transformation programme areas (proposed approach shared/agreed at workshop).
8. Update to Locality Board February 2024 and IDCB
9. For Approval for Locality Board March 2024

Meeting: Locality Board			
Meeting Date	08 January 2024	**Action**	Consider
Item No.	8	**Confidential**	No
Title	GM Strategic Financial Framework Development		
Presented By	Warren Hepolette, Chief Officer – Strategy & Innovation, NHS Greater Manchester		
Author	Warren Hepolette, Chief Officer – Strategy & Innovation, NHS Greater Manchester		
Clinical Lead	N/A		

Executive Summary

The Greater Manchester Integrated Care Partnership (ICP) approved it's 5 year strategy in March. At the end of June the Partnership agreed and submitted the Joint Forwartd Plan (JFP) as the delivery plan for the ICP Strategy. It sets out the key actions to deliver our ambition against each of the six missions. It draws on a range of existing plans developed across the system and each GM locality. When submitting the JFP to NHS England, we recognised that further work was needed to strengthen our delivery plans provide much greater detail on the approach to delivering the mission on financial sustainability.

The JFP recognised, therefore, the need for a Strategic Financial Framework (medium term financial plan). A critical building block for that framework is a population health led analysis analysis to ensure itconnects to our abjectives as an Integrated Care Strategy and can respond to the missions of our 5 year strategy. This paper summarises the outputs of that analysis and sets out the next steps to support its use in developing the Strategic Financial Framework.

It takes a longer term perspective on our health and care economy – building on the more immediate work to identify savings in the system which is responding to the current imperative to support financial recovery in this financial year.

It has the fundamental purpose of identifying the population based approach opportunities to address our financial gap.

Recommendations

The Bury Localty Board is asked to discuss the paper in the context of the locality priorities and approach to delivery and commit to engage on the translation of this analysis into local and system wide activity.

Links to Strategic Objectives	
SO1 - To support the Borough through a robust emergency response to the Covid-19 pandemic.	☒

Links to Strategic Objectives	
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		

GM Strategic Financial Framework Development

Background to the Financial Framework

The Greater Manchester Integrated Care Partnership (ICP) approved it's 5 year strategy in March. At the end of June the Partnership agreed and submitted the Joint Forwartd Plan (JFP) as the delivery plan for the ICP Strategy. It sets out the key actions to deliver our ambition against each of the six missions. It draws on a range of existing plans developed across the system and each GM locality. When submitting the JFP to NHS England, we recognised that further work was needed to strengthen our delivery plans provide much greater detail on the approach to delivering the mission on financial sustainability.

The JFP recognised, therefore, the need for a Strategic Financial Framework (medium term financial plan). A critical building block for that framework is a population health led analysis analysis to ensure itconnects to our abjectives as an Integrated Care Strategy and can respond to the missions of our 5 year strategy. This paper summarises the outputs of that analysis and sets out the next steps to support its use in developing the Strategic Financial Framework.

It takes a longer term perspective on our health and care economy – building on the more immediate work to identify savings in the system which is responding to the current imperative to support financial recovery in this financial year.

It has the fundamental purpose of identifying the population based approach opportunities to address our financial gap.

Methodology

The Strategic Financial Framework is proposed to be developed via a four-stage approach

	Understand baseline and "do nothing" forecast	Consider opportunities to improve health, performance and finance	Phasing and Investment	Reflect in financial framework
Population	**Understand place** • Segment population by age, condition and deprivation • Level of consumption of healthcare • Allocation growth • Spend on providers	1. Reducing the growth in prevalence and progression of ill-health 2. Optimising models of care to optimize total spend (across all settings) for each segment 3. Improving care for the most disadvantaged communities	• Identification of interventions and ROI • Non-recurrent investment to ramp up/double run services • Investment in data and digital capabilities	• Calculate the total allocation change including ICS and NHSE in the do nothing baseline • Optimise spend while improving population health and shift pattern of spend
Provider	**Understand provider** • Understand current activity and expenditure • Apply growth assumptions • Understand the underlying recurrent financial position of each trusts	1. Improve model of care to increase quality and flow (theatres, OP, discharge) 2. Pure unit labour productivity (skill mix, rota, bank/agency) 3. Procurement (drugs, medical consumables, nonclinical) 4. Estates (facilities, capital, etc) 5. Back office (IT, admin)	• Non-recurrent costs to support transformation • Any restructuring of costs to address a deficit • Investment in data and digital capabilities	• Forecast current underlying position for each provider • Understand the productivity gains that are required to address the underlying position

The framework covers:

- The demand for health and care services for the population of Greater Manchester over the next five years, given current trends, and how much it will cost the providers to deliver on those requirements.
- The opportunities to improve the health and care for the population of Greater Manchester to keep

people healthier and manage their health needs better
- How the change in population requirements will impact the demand on providers, and how this demand will be delivered efficiently
- What the opportunities are for the efficient delivery of this care (provider-side)
- The investments required to realise these opportunities, and how quickly these benefits can be realised to meet national and local priorities
- The impact of these opportunities on the Greater Manchester financial deficit, and whether there is any residual structural deficit and the drivers of it

Headline Findings
The Strategic Financial Framework looks at keeping the population in good health, optimising the way healthcare services are used, and delivering care efficiently.

To support this, the Strategic Financial Framework has set out the baseline position, the ”do nothing” forecast, quantified the population health opportunities, set out the phasing and sequencing over time and considered the position of the 9 NHS providers. In short, this has outlined how a deficit of £570m today will grow to £1.9b in a “do nothing” scenario but can be addressed over time through a combination of population health measure and provider efficiencies.

GM ended 22/23 with a reported underlying financial deficit of £570m after removing nonrecurrent items. This will grow to £1.9b in 27/28 based on expected funding growth compared to activity growth and inflation.

This is driven by demographic growth of 0.4%, nondemographic growth of between 1.3 and 5% and tariff inflation of 1.8% p.a compared to activity growth and cost inflation of 2.9%. As a result, the financial position deteriorates.

To understand the health needs of the population we have used the Advanced Data Science Platform (ADSP) to access linked patient-level data on the GM population and developed a segmentation of the population. This shows that 29% of people in GM are not in good health and account for 79% of total costs. This can be reflected in the fact that a member of the adult population in good health cost £555 per capita whilst adults not in good health ranging from £1.7k per capita through to £84k per capita.

Responding to the Challenge
We have explored three opportunities to address the growing needs for healthcare:
1) reducing prevalence growth,
2) optimising models of care, and
3) addressing inequalities in access

Opportunity 1 addresses prevalence growth, we have examined the shift in population due to ageing and prevalence growth, whilst aligning this with the expected total growth in spending on providers. The analysis shows that the total spend on care will rise from £6,147bn to £8,488m based on a combination of population growth (£233m), age and prevalence changes (£1,381m), and tariff inflation (£724m). An opportunity of £249m or 16% of the impact of increasing prevalence and tariff inflation is proposed as the target to be delivered over five years starting in 24/25.

Opportunity 2 addresses variation in the model of care to support more cost-effective delivery. For this

opportunity spend per capita across 9 segments of the population and 3 age bands, separated into Core20[1] and non-core20 were analysed. By controlling this way, it is possible to calibrate like with like in GM. Adding the overall opportunity in each segment hights seven areas for focus: adults in good health, adults and older adults with multiple long-term conditions, children and adults with mental illness, adults suffering from homelessness or substance abuse and older frail adults. In total this added the opportunity stands at £1,294m, with over £1,025m concentrated in those seven segments.

Opportunity 3 focuses on addressing inequality. For this opportunity, the spend per capita difference between the Core20 and non-core20 in each segment, was analysed and showed that spend per capita is higher for the Core20 population in every POD except for outpatients and elective. The savings were calculated if that gap was closed. 80% of this gap was assumed realisable to reflect some underlying differences in need. This leads to a £126m opportunity, of which £100m is in non-elective admissions as interactions are happening too late for these communities.

The feasibility of these opportunities is tested in two ways: by validating the scale of the opportunity externally and by testing the achievability of the opportunities with analysis of quality indicators.

- The external validation of benchmarking focused on urgent and emergency care because of the need for elective recovery on the one hand and the difficulty in benchmarking community and mental health given national data quality limitations. This showed comparable scale of opportunity in urgent and emergency care when each place is benchmarked with its peers
- The validation of quality focused on selecting a basket of quality indicators for each segment and analysing a normalised position in GM relative to the rest of the country and comparing this the GM. This in general showed the low spending places within each segment we generally consistent with at least average or better quality. It is clear there is high variation in the model of care for mental illness, however, a particular issue to consider is whether the opportunity it is deliverable due to invisible waiting lists – both issues need to be better understood and addressed
- We also looked overall at how GM benchmarks in quality indicators which shows particular gaps in maternity and cancer and suggests that further action may be needed in these areas even though they do not deliver significant opportunity. This requires its own analysis and might represent an area where the system needs to spend more money.

To translate opportunities into potential spend/cost avoidance, each opportunity area has examined the evidence base for return on investment and timing.

- Opportunity 1 initiatives include smoking cessation, obesity management model and Semaglutide for advanced obesity care, which have a 5-year return on investment between 0.4 and 4.8
- Opportunity 2 initiatives include CVD prevention and monitoring, dementia interventions and Respiratory disease, which have a 5-year return on investment between 1.5 and 3.7
- Opportunity 3 initiatives include housing, food, transport and substance misuse, which have a 5-year return on investment between 1.5 and 11.6

Further analysis suggests that a more targeted selection of initiatives would be possible if GM wished to pursue only high ROI initiatives.

Total investment requirements for each of the opportunities has been determined by ROI and this investment

[1] The most deprived 20% of the national population as identified by the national Index of Multiple Deprivation (IMD).

has been distributed to different settings of care using expert clinical advice. These have been phased on a straight-line basis, with 20% in the first year, and starting April to enable some initial benefits to be realised in that year (24/25).

The overall impact considers the population side and then providers. The reduction in provider demand through these opportunities will have a larger impact on cost and will help towards reducing the forecast deficit.

Next Steps
The work to complete the SFF needs to be built on the foundation of both the current work across the ICS on grip and control of expenditure and on understanding and tackling the drivers of the deficit.

We need to maintain the grip and control measures to address the immediate challenge of the financial run rate in the system, the underlying drivers of the current deficit and the drivers of future demand signalled in the population health analysis to secure a sustainable health and are system in GM.

Work is underway to translate the findings from the framework into a set of actions as part of our approach to operational planning for 2024/25 and this will be a priority between now and March.

We have set out the additional steps required for completion of the framework:

- Testing the financial methodology underpinning the do nothing scenario and the opportunities
- Incorporating primary care data and provider plans into the analysis
- Alignment of year 1 financial plans with the financial recovery work in progress
- Continued engagement with places, to refresh locality plans and feed into an updated Joint Forward Plan
- Continued engagement with providers
- Consolidation of all outputs to contribute to the medium-term financial planAdditional work will need to be done to determine the level of provider efficiencies achievable and ensure alignment with the outputs of the current financial recovery work.

The implementation of the Operating Model should support us in these endeavours. It should remove some of the barriers to at-scale system change – including new approaches to decision-making, collective accountability, how money flows and system leadership development. Finally, it will support the discussion on the approach to implementation through proactive primary care, addressing unwarranted variation, tackling specific social determinants of health and through provider collaboration.

Recommendation
Bury Localty Board is asked to discuss the paper in the context of the locality priorities and approach to delivery and commit to engage on the translation of this analysis into local and system wide activity.

Warren Heppolette
21st December 2023

BURY INTEGRATED CARE PARTNERSHIP

Meeting: Locality Board			
Meeting Date	08 January 2024	**Action**	Receive
Item No.	9	**Confidential**	No
Title	Palliative and End of Life Care Programme Update		
Presented By	Helen Lockwood, SRO and CEO Bury Hospice		
Author	Helen Lockwood, SRO and CEO Bury Hospice		
Clinical Lead	N/A		

Executive Summary
To provide an update on the Palliative and End of Life Care Programme.
Recommendations
The Locality Board are asked to note/comment on the contents of the update provided.

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	☒

Implications						
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		

Palliative and End of Life Care Programme

BURY INTEGRATED CARE PARTNERSHIP

Bury Locality Board Update

Helen Lockwood, SRO and CEO
Bury Hospice

Part of Greater Manchester Integrated Care Partnership

Contents

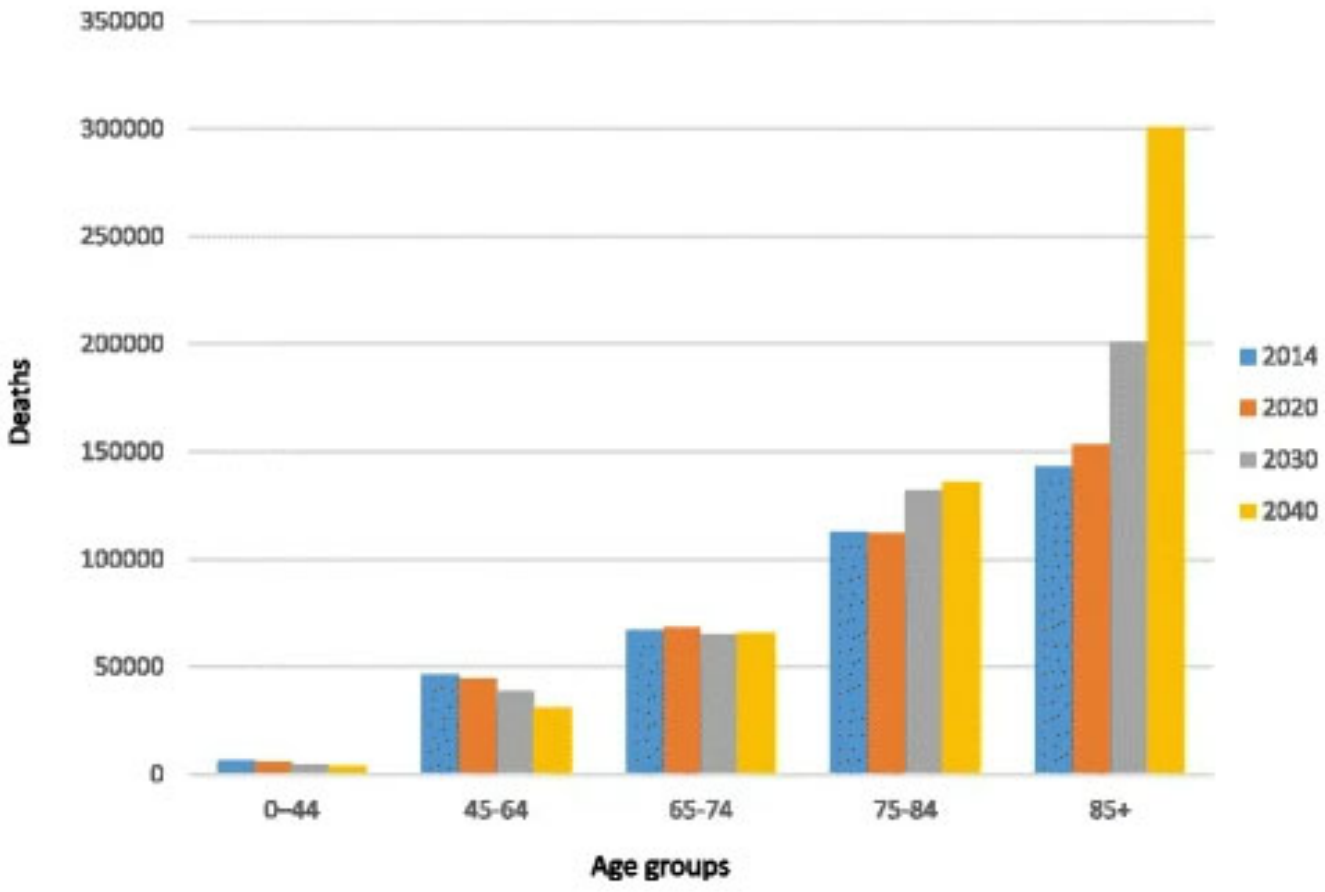
Demographic context

- Bury registered patient list size = **c208,000** patients
- Bury resident population = **c193,849**
- c**18.3%** of the population are aged over 65 with **4.6%** over 80
- This is a relatively older population than most other localities across Greater Manchester
- Bury's population is predicted to grow by **c1.7% by 2028** but with a **31% increase in the number of people over 80**
- The total number of deaths in Bury in 2022 was **2,075**
- Estimates suggest that c.**75%** of people would benefit from palliative care services at the end of life therefore for Bury this is roughly **1,500** people per annum

Projected palliative care needs

BURY INTEGRATED CARE PARTNERSHIP

- UK projections suggest that by 2040 annual deaths are expected to increase by **c25.4%**
- However, the number of people requiring palliative care could increase by over **40%**
- This could mean that by 2040 **c2,100** people a year could require palliative care in Bury.

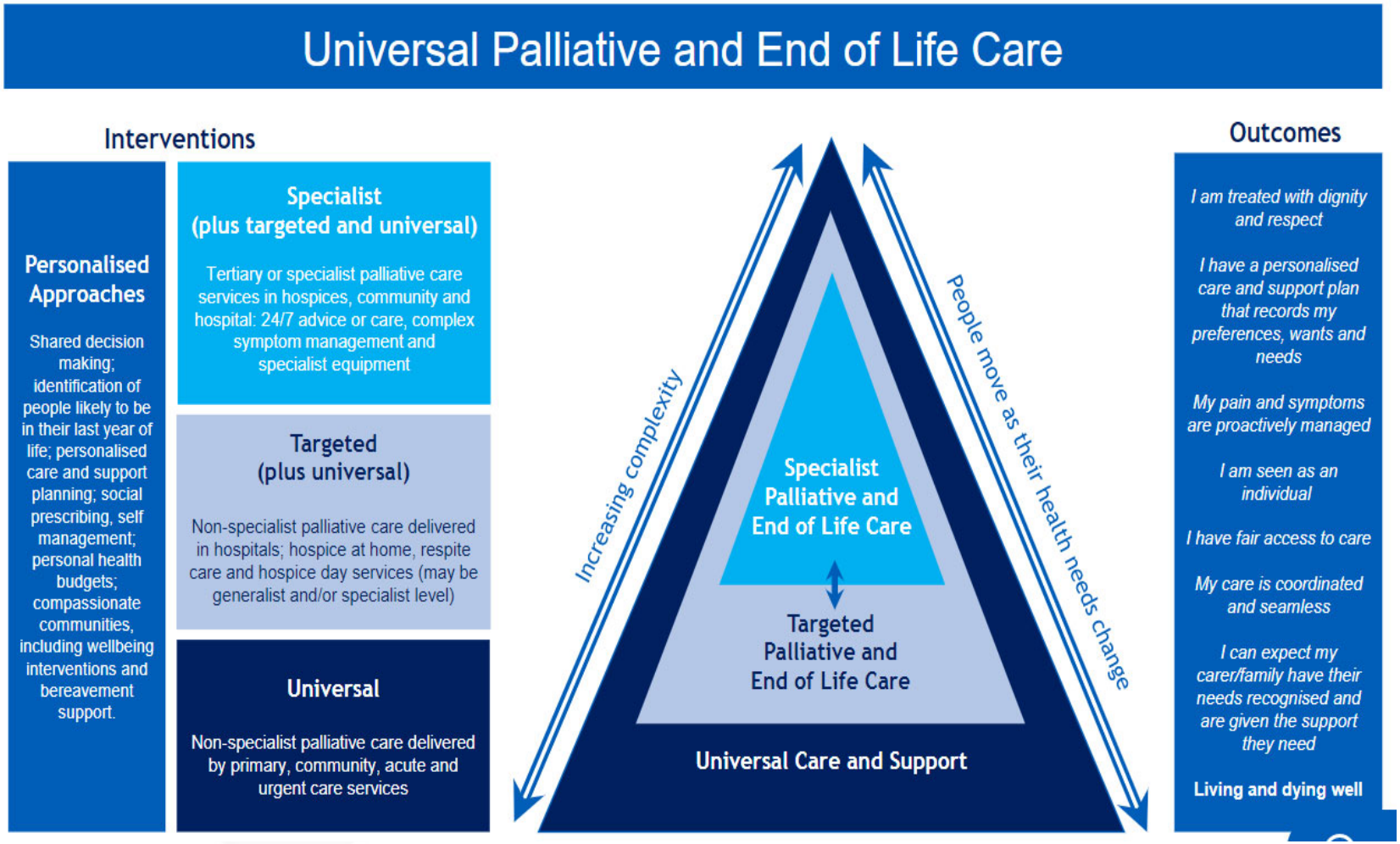


Number of people estimated to require palliative care by age, 2014–2040 [England]

Etkind, S.N., Bone, A.E., Gomes, B. et al. How many people will need palliative care in 2040? Past trends, future projections and implications for services. BMC Med 15, 102 (2017)

Background – Levels of palliative care support

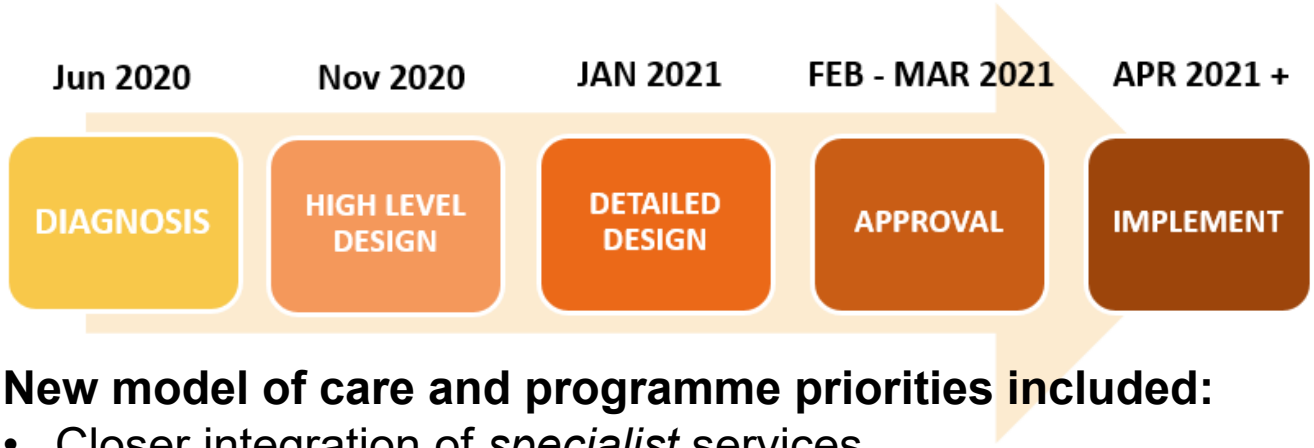
BURY INTEGRATED CARE PARTNERSHIP



But important to remember that for most people who are dying they are cared for in the main by:

- Families
- Informal carers
- Domiciliary care staff
- Care home staff

Background - AQUA whole system flow programme



New model of care and programme priorities included:

- Closer integration of *specialist* services
- Improved care coordination
- Streamlining & simplifying referral pathways and access to advice and info for patients, carers and professionals
- Improving early identification and care planning
- Better information sharing through the implementation of an Electronic Palliative Care Co-ordination system [EPaCCS]
- Workforce development

What would good look like for patient and carers?

Improvement in:

- Care Coordination
- Providing Information
- Communication skills
- Out of hours provision and information
- Reviewing Needs
- Transferring people between care settings
- Further engagement with specific communities
- Continued involvement of people with lived experience

Progress against the PEOLC Framework & AQUA model

BURY INTEGRATED CARE PARTNERSHIP

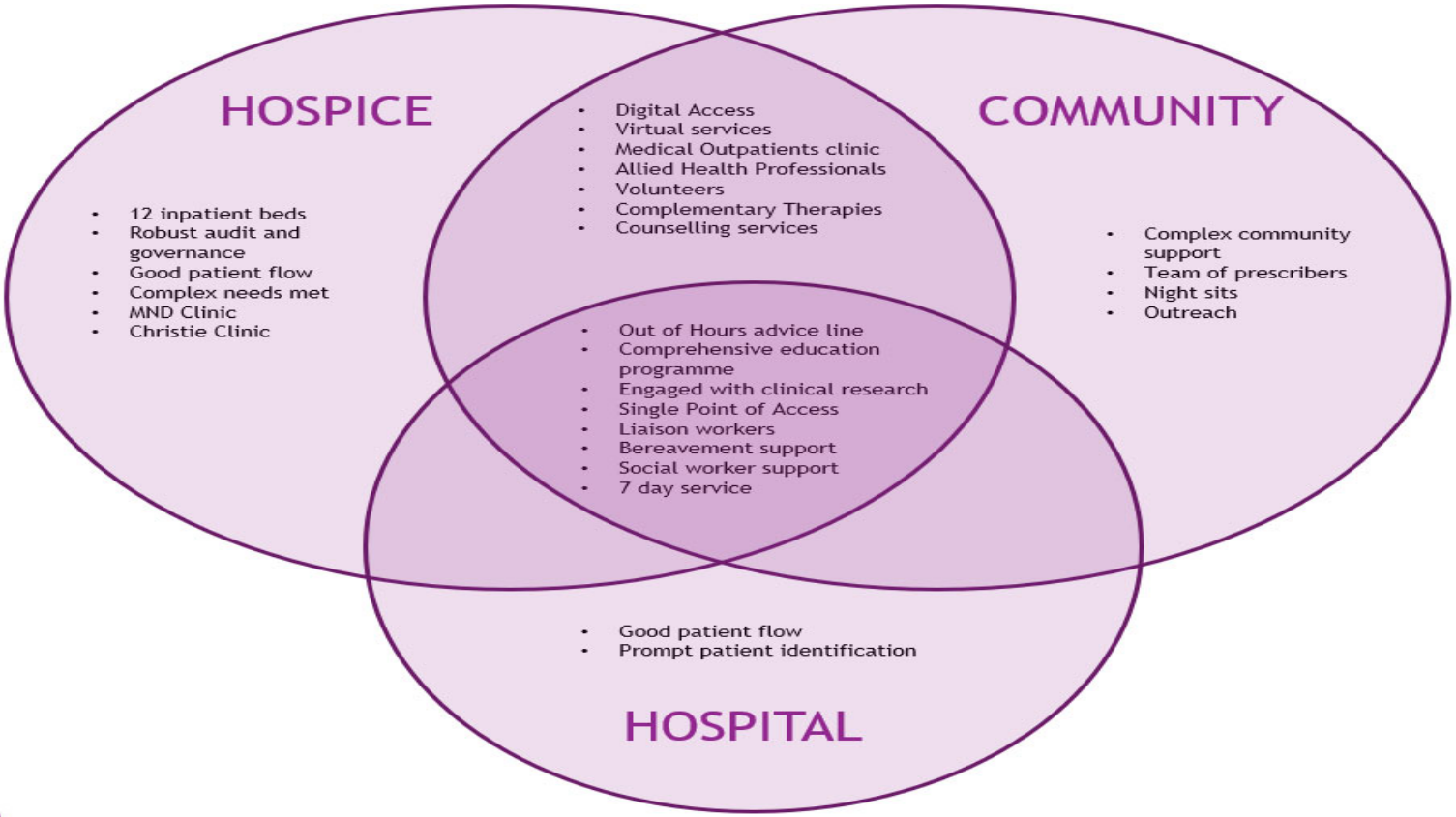
- Developed a system perspective with genuine collaboration through COVID and the Whole System Flow Programme.
- Establishment of the Bury Palliative and EoLC Integrated System Board along with a Clinical Reference Group and a multi-agency training and education group.
- Transformation funding was invested in the community Specialist Palliative Care Team to enable a limited move to 7-day working.
- Business case developed and approved for NCA to recruit a Palliative Care Consultant.
- Clinical leadership strengthened with the voice of clinicians driving the approach
- Non-recurrent funding secured for Bury Hospice to open additional beds; enable weekend admissions, expand the outreach provision across 7-days, pilot a night sitting service and a 5-day advice line.
- A daily ‘huddle’ involving staff across the Hospice, district nursing and acute and community specialist palliative care teams has been embedded.
- Hospice engagement and contribution to system Bronze and MDT strengthened

Development of refreshed strategy 2023

Bury patients, their families and carers receive high quality, timely, effective services that meets needs and preferences as far as possible, ensuring that respect and dignity is preserved both during and after the patient's life.

- Co-produced by NCA, Bury Hospice and a wide range of Bury locality stakeholders
- Builds on the previous Bury Palliative and EoLC Framework and the AQUA whole System Flow Programme
- Is informed by:
  - National Ambitions for Palliative and End of Life Care, 2021
  - GM Commitments to Individuals with Palliative Care needs approaching or within the Last Year of Life, 2019
  - The experience of patient and carers detailed in the AQUA lived experience diagnostic reports, 2018
  - NHSE Service specifications for specialist palliative and end of life care services, 2023
  - The Palliative and EoLC Service Specifications Assessment Tool, 2023
  - National Ambitions gap analysis, 2023
  - Output from the Bury Palliative Care Summit, 2023
  - Greater Manchester PEOLC programme and strategic priorities

Ideal Medical Model



Indicators

Key indicators are to be determined but are likely to include:

1. Early identification – increasing proportion of patients on GP palliative care registers
2. Reducing number of admissions in last year or 90 days of life
3. Enabling more patients to be discharged earlier back into an appropriate community setting
4. Reducing length of stay in FGH
5. Number of EPaCC records created
6. Proportion of deaths in usual place of residence

Risks & challenges

1. Financial resource to deliver the strategy will need to be considered alongside other system priorities
2. Marginalisation of the programme in the face of other system pressures and priorities.
3. Financial sustainability of Bury Hospice.
4. Lack of programme / project support capacity.
5. Sustaining buy-in and commitment from all partners esp. in relation to workforce development and EPaCCS.
6. Lack of digital systems access and interoperability – can be mitigated by EPaCCS.

Macmillian Social Investment Fund opportunity

- £36M fund established.
- Seeking to deliver transformational change with a focus on improving early identification, integration and achieving equitable access to high quality person-centred care.
- Social investment is the use of repayable finance to help an organisation achieve a social purpose. It is only repaid if mutually agreed outcomes are achieved e.g. reduction in non-elective admissions.
- Shifts focus to achieving outcomes and away from activity and inputs.
- We have submitted an expression of interest and are exploring this option.
- Progressing will require ICB and / or Trust willingness to engage with new financial model.

Key system messages

1. The Health and Care Act 2022 sets out a legal duty on ICBs to commission palliative care services for their populations. The Statutory Guidance indicates that this needs to include the following key considerations:
    1. A clear commissioning vision and strategy
    2. Sufficient financial investment
    3. Appropriate workforce capacity and capability
    4. A whole system and all age approach.
    5. A flexible approach to care across specialist, core and universal services

    What does this mean for Bury and how do we resolve?
2. We know Bury is currently under resourced in terms of palliative care services including specialist services.
3. Commissioners and providers need to plan strategically for a significant growth in the number of people requiring palliative and end of life care. This will require investment including in specialist services.
4. The Macmillan Social Investment Fund provides an opportunity worthy of exploring but it comes at cost, ie the bond needs repaying.

Key system messages

- The ambition to make palliative and end of life an areas that Bury can be proud off is tangible and real with many supporting this.
- Bury held its first Palliative and End of Life summit which brought senior leaders and practitioners together thus allowing us to refresh our strategy and plan for Bury.
- We have made progress in some areas such as having a Consultant in Palliative Care supporting and driving the clinical model and this will be a catalyst of change in its own right.
- Non-recurrent funding has supported and enabled pilot activity to progress.
- Recognition that not all change needs funding – collaboration and sharing essential but this alone will not take us far enough forward

BURY INTEGRATED CARE PARTNERSHIP

Locality Performance Report December 2023

Part of Greater Manchester Integrated Care Partnership

Presentation by:

Contents

BURY INTEGRATED CARE PARTNERSHIP

Headlines

Please note that unless stated, all intelligence relates to Bury registered patients at all providers.

In October 23, the total number of GP appointments increased by 11.3% on the previous month and 9.7% on October 22.

A&E attendances remain high and we have not seen the usual seasonal drop. The high attendances impacted on A&E 4 Hour performance, decreasing by -3.7% in November and an increased number of patients experiencing 12-hour waits.

Elective waits have slightly increased, with 31,421 patients currently waiting. Patients waiting over 78 weeks decreased by -16.1% in October compared to September, with 47 patients remaining.

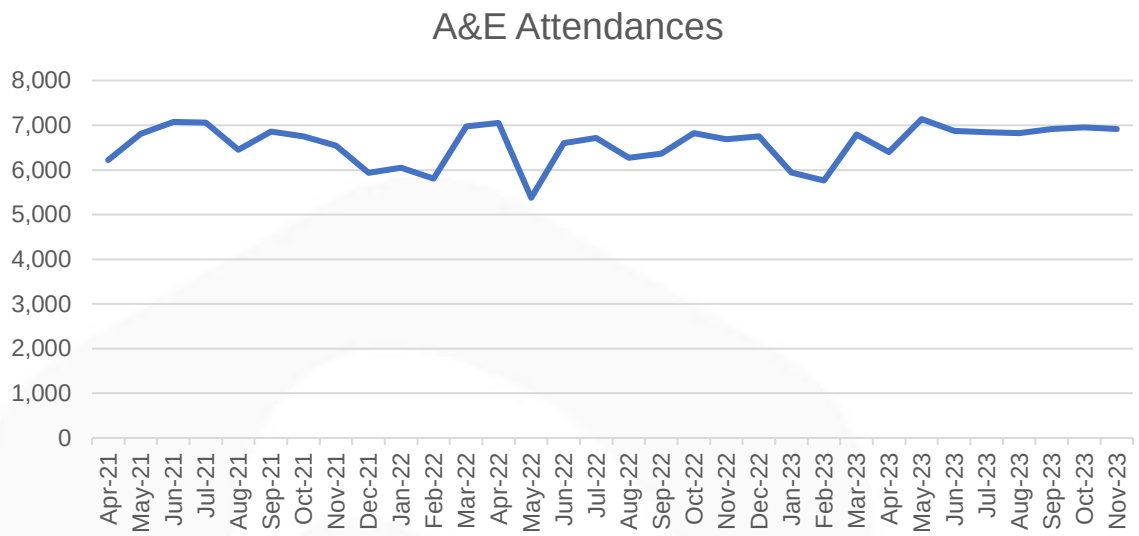
Cancer 2WW performance is no longer being reported from October 23.
Cancer 28 Days performance has increased by 1.6% on performance in September, this is despite receiving 14 more referrals in October to September.

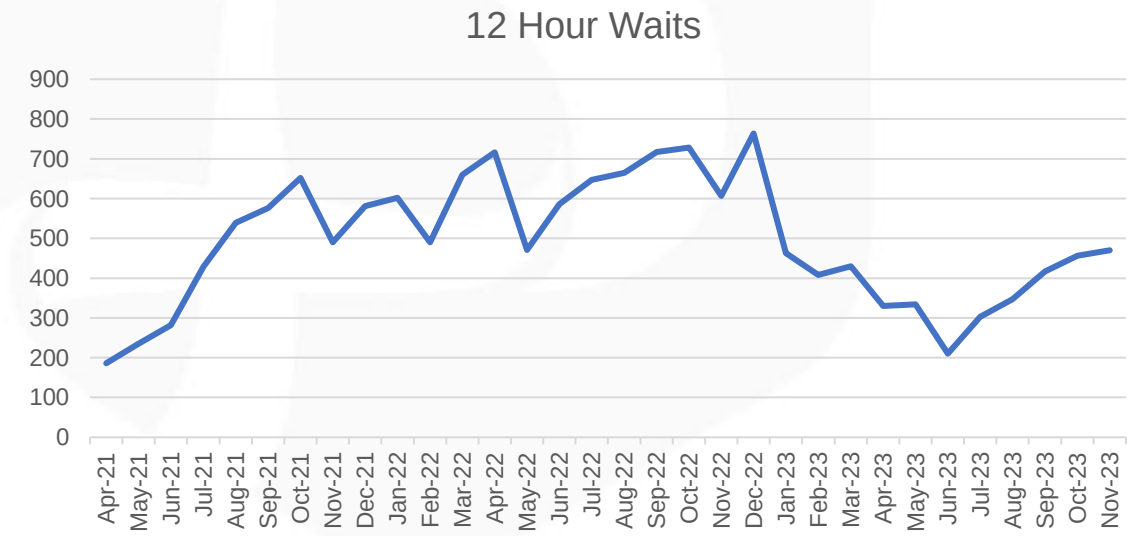
IAPT patients seen within 6-week timeframe has decreased in October, however still within target and Bury is currently performing better than GM.

The percentage of the Bury population on the palliative care register has remained the same in November from October.

UCR 2-hour response was below the target of 70% in November at 68.2%, this was previously 67% in October.

Urgent Care

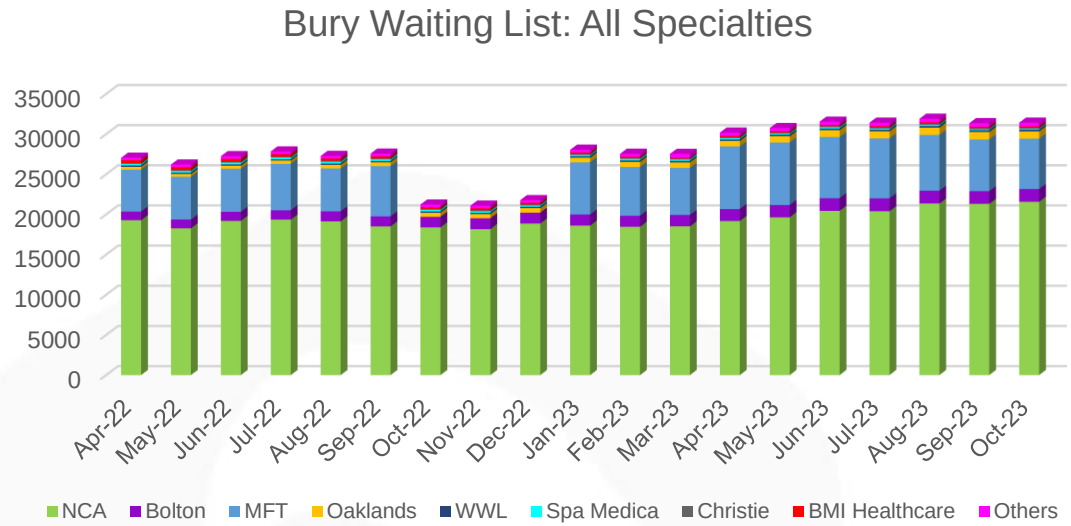


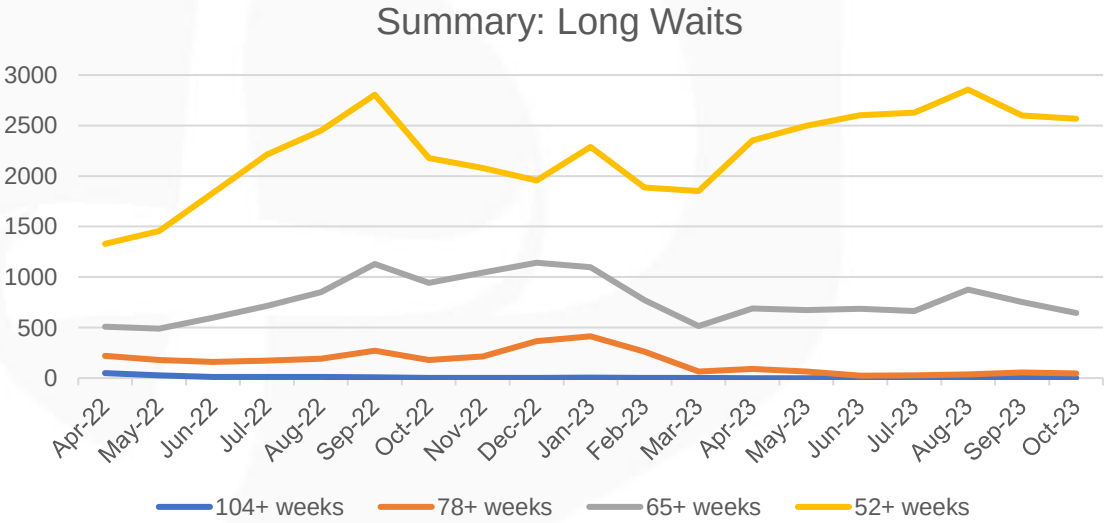


- There were 6,920 A&E attendances from Bury registered patients in November 23, slightly higher than November 22 (6,691). The proportion of Adult attendances increased slightly to 73% of attendances this year compared with 70% in November last year.
- 4-hour performance in November was 60.8%, a decrease on the previous month's performance of 64.5%. Slightly higher than November 22 which was 60.0%.
- The number of patients experiencing 12-hour waits (from arrival) increased in November to 470 from 456 in October. 12-hour waits are still significantly lower than November 22 (607).
- A&E attendances for mental health conditions have stayed static in the last few months, however these increased in November to 225 from 202 in October.

https://curator.gmtableau.nhs.uk/dashboard/uec-metrics

Elective Care

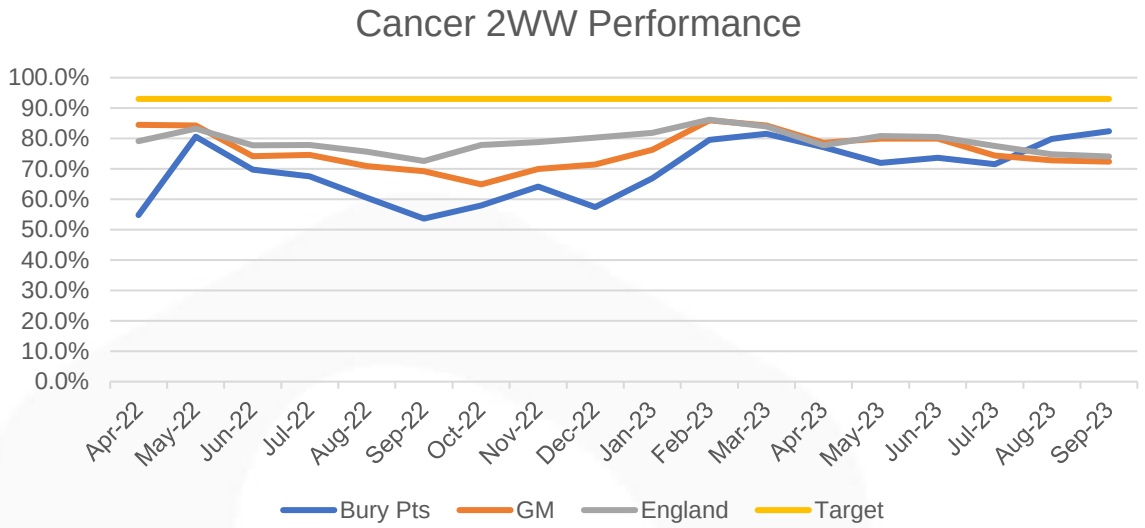


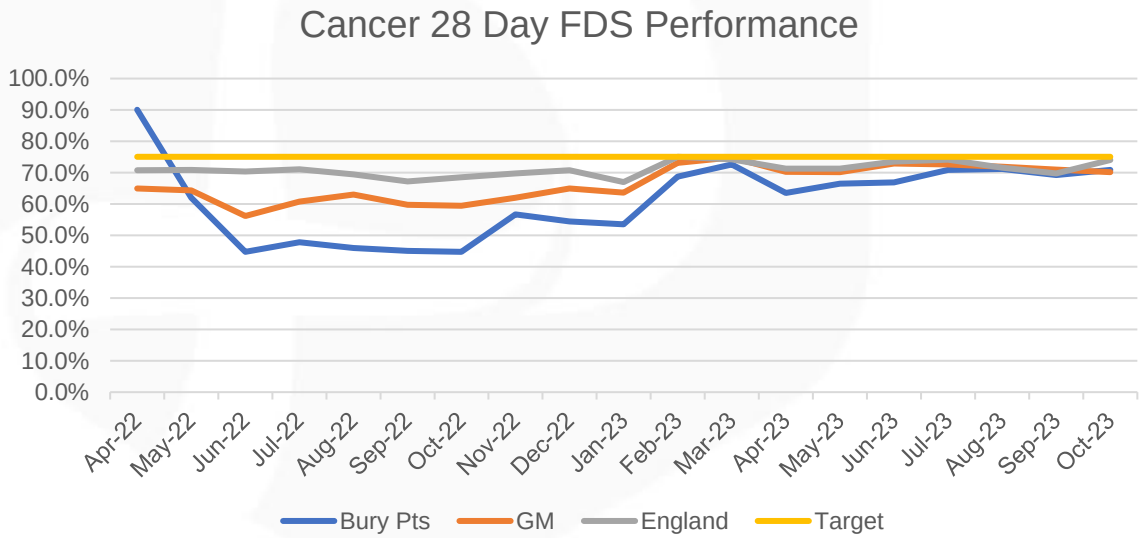


- Oct, Nov & Dec 22 elective waits impacted by lack of MFT data. Published data since January 23 now includes MFT.
- Published October data shows a slight decrease on September 23 (0.2%, +59 pathways). Since September 23 there have been minor increases across some specialties, with Respiratory Medicine showing an increase of 6.8%, Urology 3.7% and T&O showing increases of 3.1%.
- Small reductions seen across several specialties in October, Oral Surgery (-2.9% since September) and Other-Other (-18.9% since September).
- Immediate target was to eliminate 78+ week waits by Apr 23. These have decreased on September's figure by 16.1% (-9 pathways) in October. Primarily the decrease is in Oral Surgery (-6 Pathways) and Gynaecology (-5 Pathways) with an increase in Other-Paediatric (+5 Pathways).

https://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/

Elective Care





Cancer 2WW:

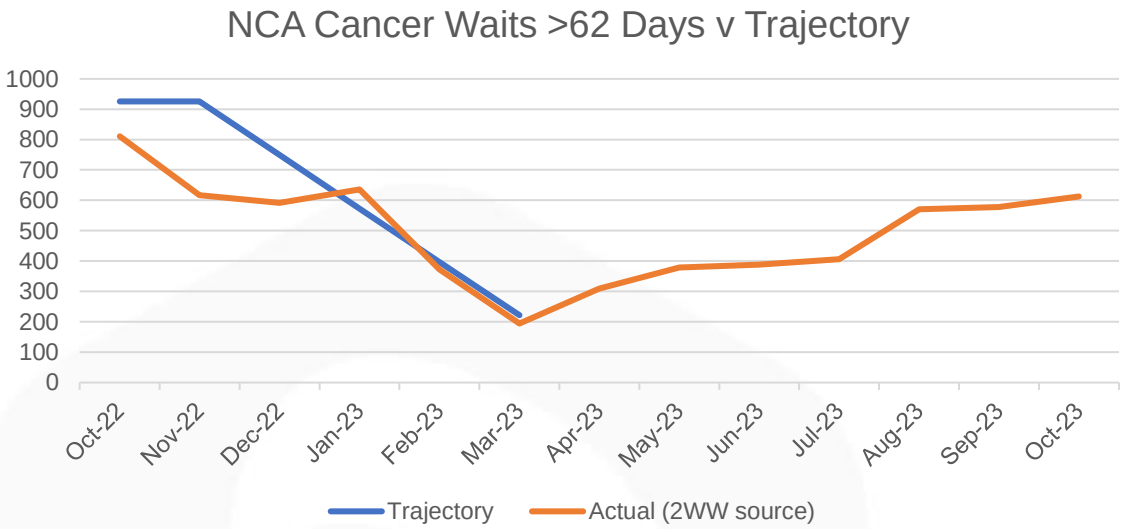
- Increase in performance in September to 82.4% from 79.8% in August for Bury patients, GM performance decreased from 72.8% to 72.3% in September.
- Decrease in number of breaches to 172 breaches in September for Bury patients, 65% of which were in Skin (111) , up from 40% in August.
- Next highest were Head and Neck (19) and Gynae (16).
- **As from October 2023 2WW is no longer reported.**

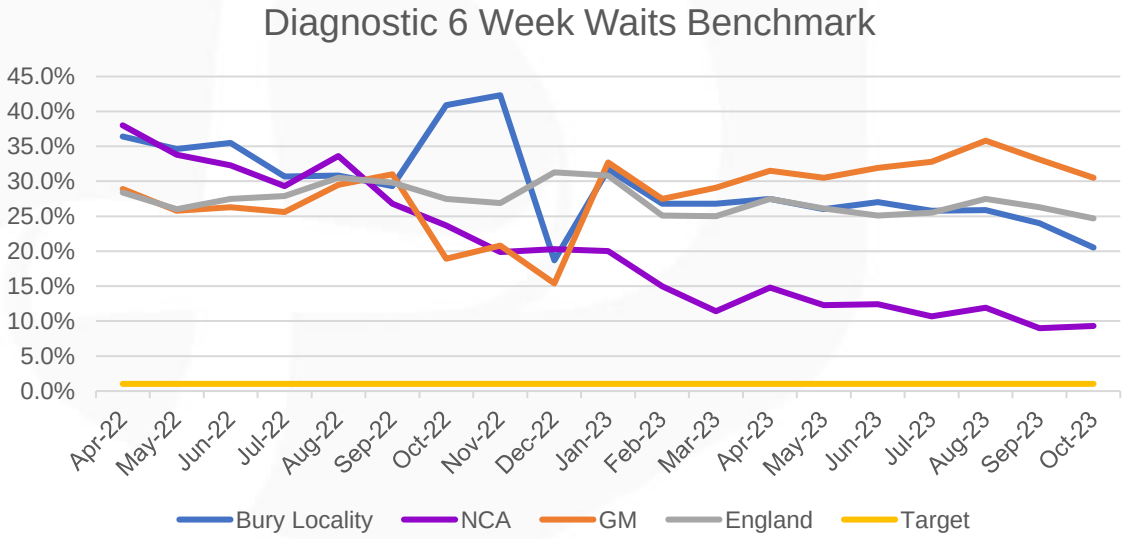
Cancer 28 days FDS:

- Increase in performance in October to 70.8% for Bury, this is slightly above GM where the performance decreased to 70.1%. This is the first time Bury performance has been better than GM since April 22.
- Children's cancer performance was at 40% in October, with 3 out of 5 not meeting standard.
- Gynaecology's performance is 61% for October which is an increase on 55% in September.
- Skin Cancers Performance for October has decreased to 51% from 56% in September and accounted for 13.8% or those not meeting standard.
- 23/24 guidance has restated the requirement to meet the 75% target by March 2024.
- Guidance also sets requirement to increase the % of cancers diagnosed at stages 1&2. Latest unadjusted data (2021) shows Bury as 6th best in GM at 53.6% compared to GM at 54.7%.

https://www.england.nhs.uk/statistics/statistical-work-areas/cancer-waiting-times/

Elective Care





Cancer 62 day waits:

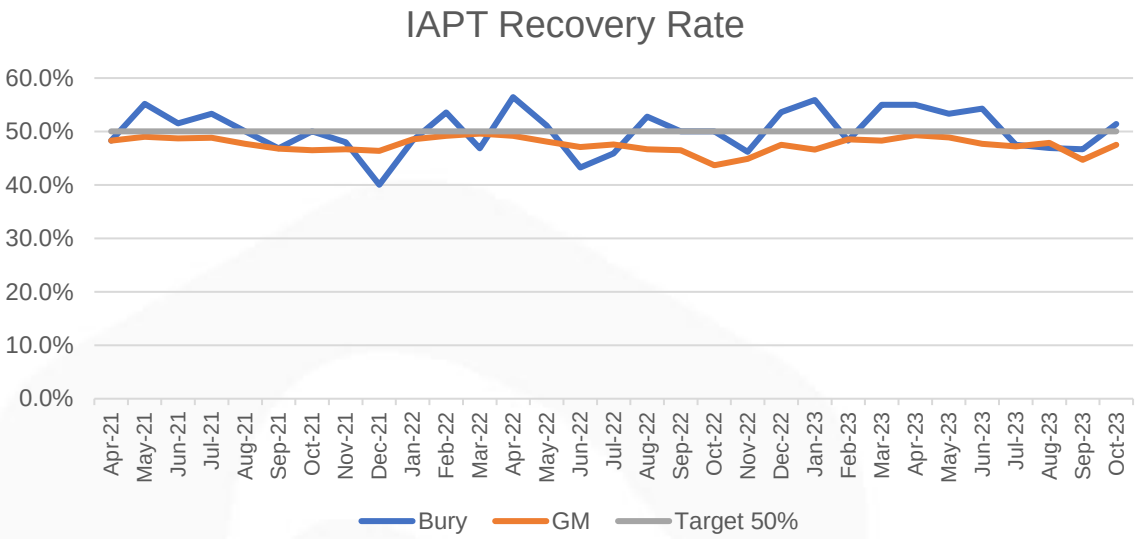
- 23/24 guidance sets the requirement to continue to reduce the number of patients waiting over 62 days.
- Current NCA target is 222 patients waiting >62 days by March 23. NCA was below the trajectory but has increased again through the start of 23/24. NCA has a weekly cycle of improvement in place in dermatology, colorectal, urology and gynae with a view to recovering against the trajectory.

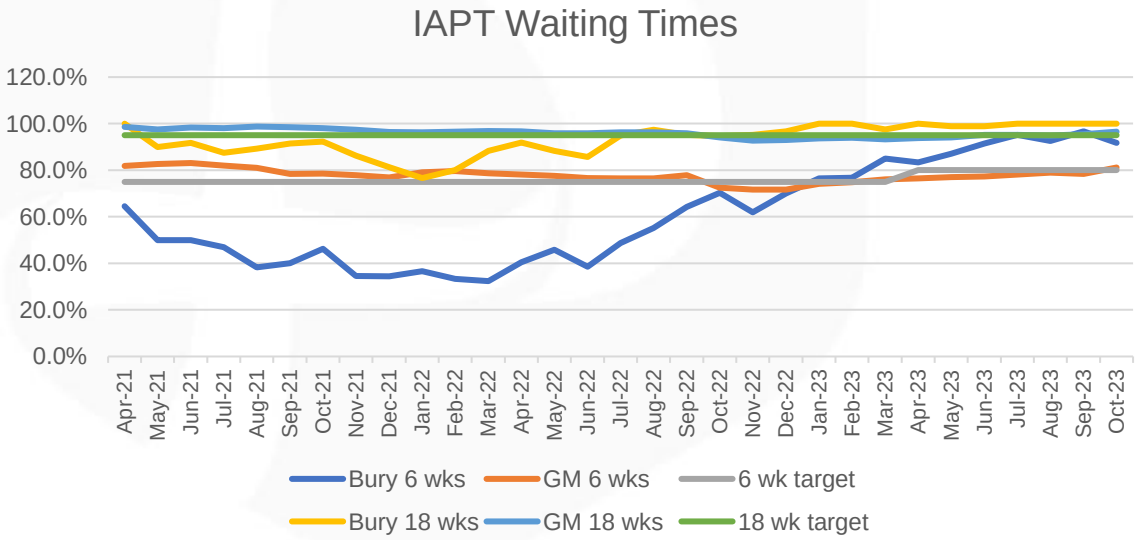
Diagnostic Performance:

- MFT Data is now included from Jan 23.
- October's performance of 20.5% of patients waiting more than six weeks is an increase on the September figure (24.0%).
- Across November to January 23 NCA performance has remained steady, but has seen increases and decreases since. Performance decreased from 9.0% in September to 9.3% in October.
- 23/24 requirement is to continue to work towards 95% of patients receiving diagnostic test <6 weeks by March 2025.

https://www.gmtableau.nhs.uk/#/site/GMHSCPPublic/views/PTL-TrustVersion/PTLWeeklySummaryReport?:iid=1
https://tabanalytics.data.england.nhs.uk/views/DiagnosticsWaitingTimesandActivityDashboard/PerformanceSummary?%3Aembed=y&%3Aiid=4&%3AisGuestRedirectFromVizportal=y#1

Mental Health





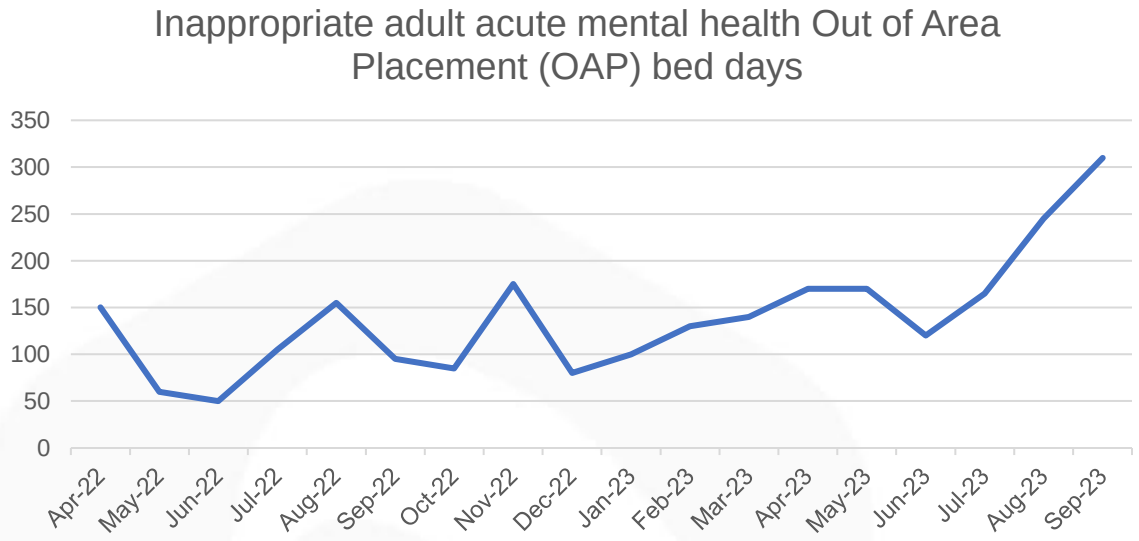
- IAPT: recovery rate – the rate for Bury has increased from September to October to 51.4% from 46.7%. The GM rate also increased by 2.8% in October and is currently at 47.5%.

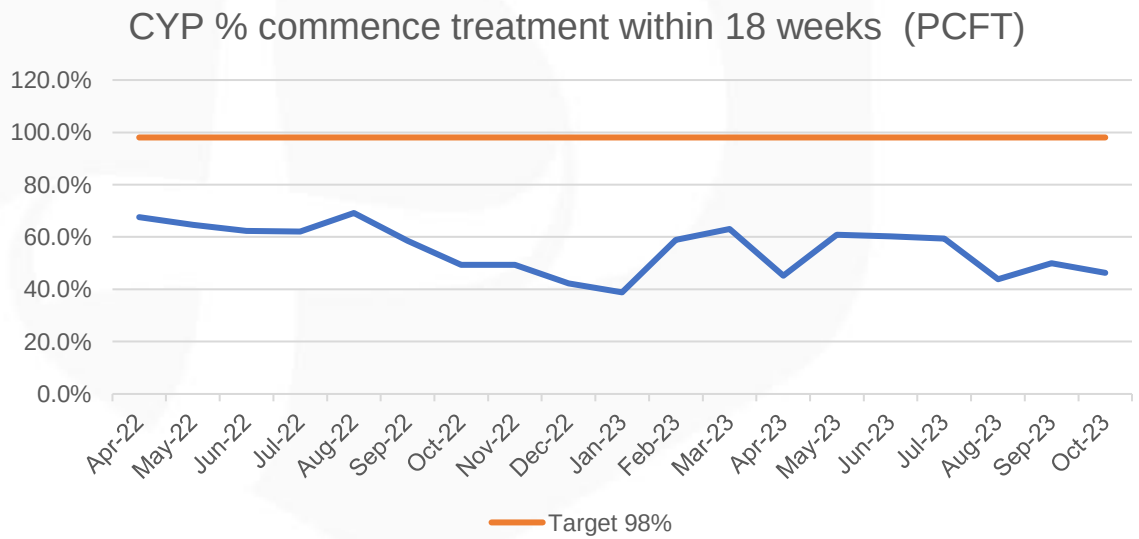
- IAPT: Seen within 6 weeks – the rate for patients seen within 6 weeks has decreased by 5.0% in October with the current rate being 91.7%. This is significantly higher than the GM rate of 81.2%.

- IAPT: Seen within 18 weeks - the rate for patients seen within 18 weeks has remained the same as September in October, with the current rate being 100%. This is higher than the GM rate of 96.5%.

https://curator.gmtableau.nhs.uk/dashboard/iapt-dashboard

Mental Health



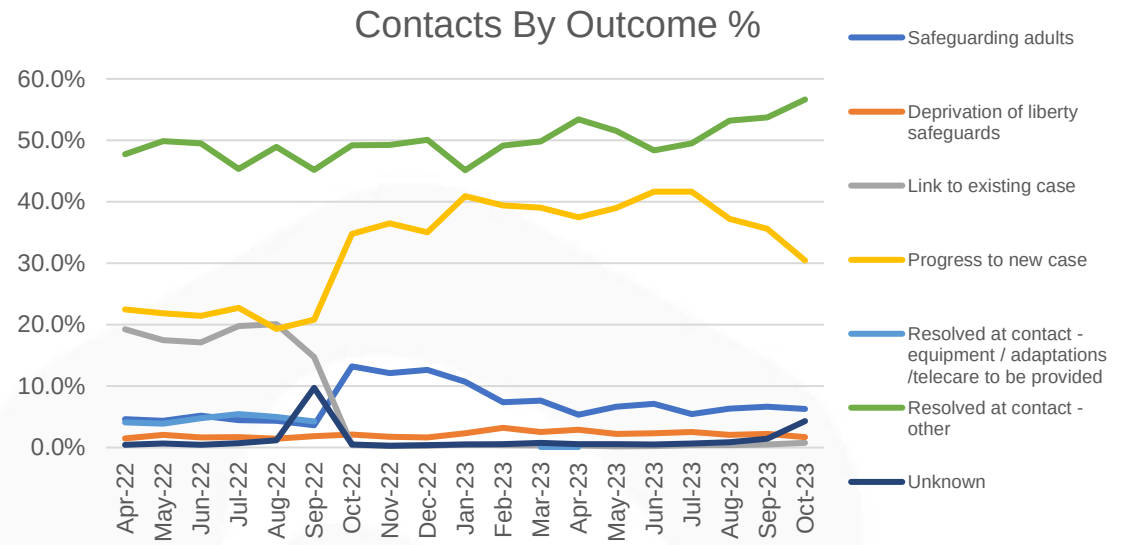


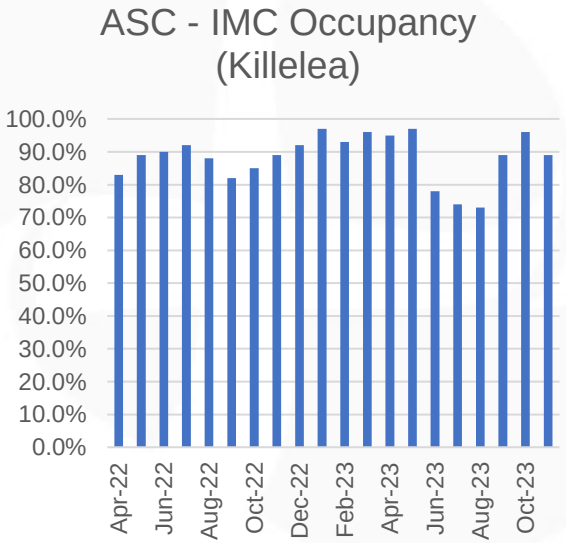
- MH out of area placements – the number of out of area placements in September has increased by 26.5% since August. Compared to September 22 this has increased by 226.3%, however these are subject to real time daily and weekly monitoring by mutli-agency teams and there is a slight lag in the formally reported data.

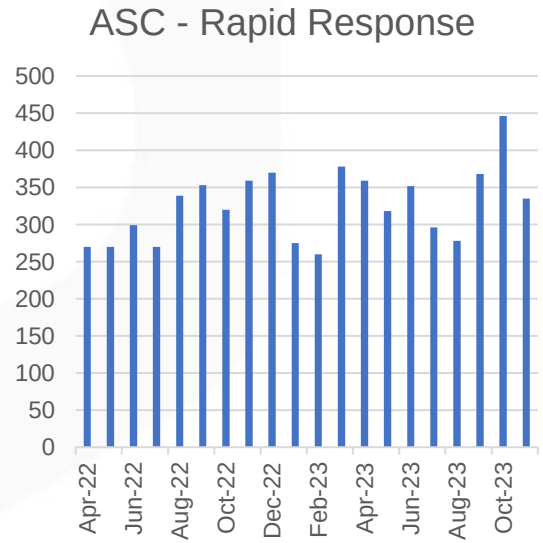
- Access rate to Children and Young People's Mental Health Services – A decline in the proportion of CYP commencing treatment within 18 weeks has been seen at PCFT across 2022/23 and reflects the increasing demand seen since COVID-19. A joint proposed investment plan has been developed for the Bury system which, if approved, would see increased clinical capacity within the core CAMHS service. October has seen a decrease by 3.7% on September's figure, with 46.3% commencing treatment within 18 weeks.

PCFT monthly CAMHS Outcomes Framework report

Adult care



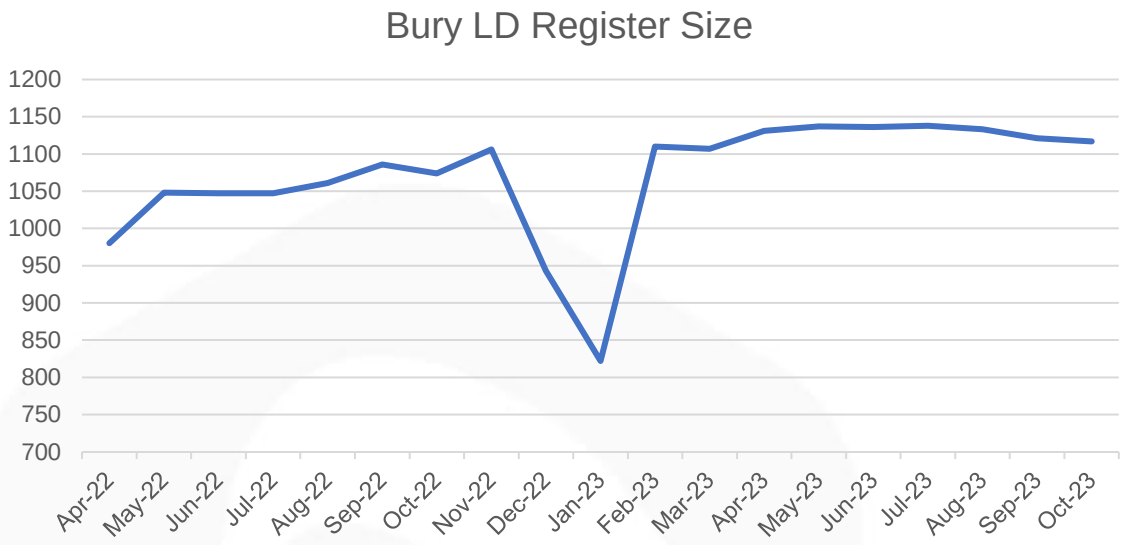


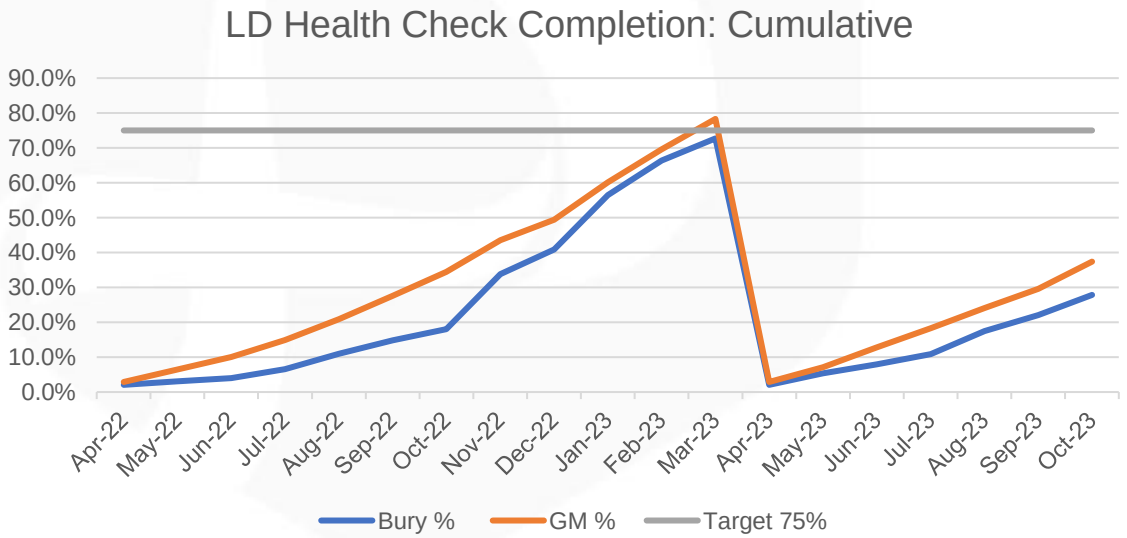


- The contact rate per 1000 population is not currently available from Aug 22.
- Contacts by outcome – 30.4% of contacts progressed to a new case in October, which is a decrease on 35.6% in September. 6.3% of contacts resulted in safeguarding in October, compared to 6.6% in September. The percentage of unknown outcomes increased to 4.3% in October from 1.4% in September.
- IMC Occupancy for Killelea – Bed occupancy was down to 89% in November.
- ASC rapid response – Total referrals decreased by 24.9% to 335 in November from October.

https://curator.gmtableau.nhs.uk/dashboard/gm-horizon-contacts-contacts

Learning Disabilities





- LD Register: Requirement to increase the LD register size. Register has increased by 15.4% in the 12 months to Apr 23 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.

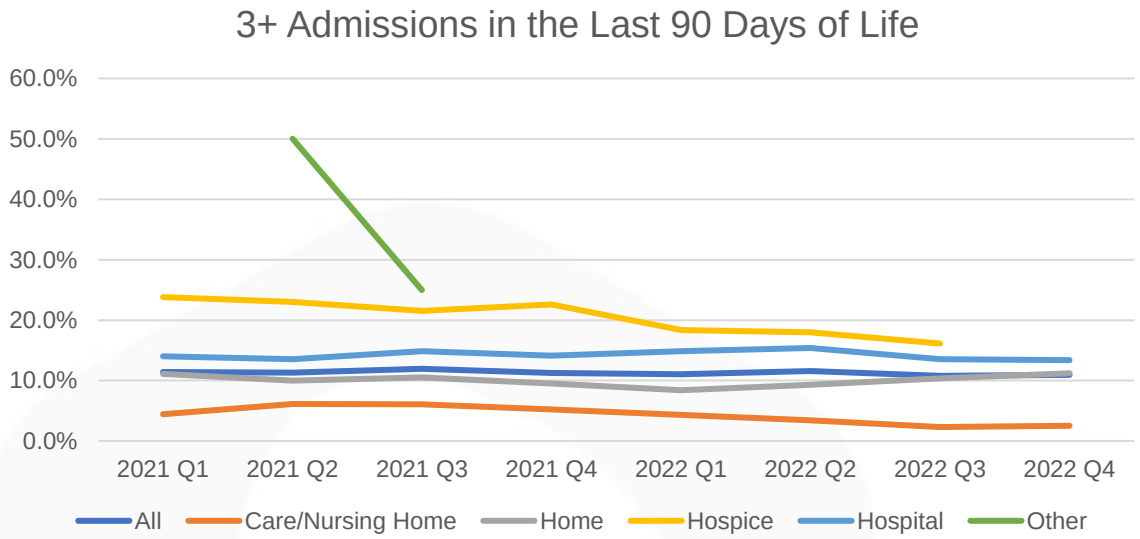
- Register size has decreased by 4 in October 23.

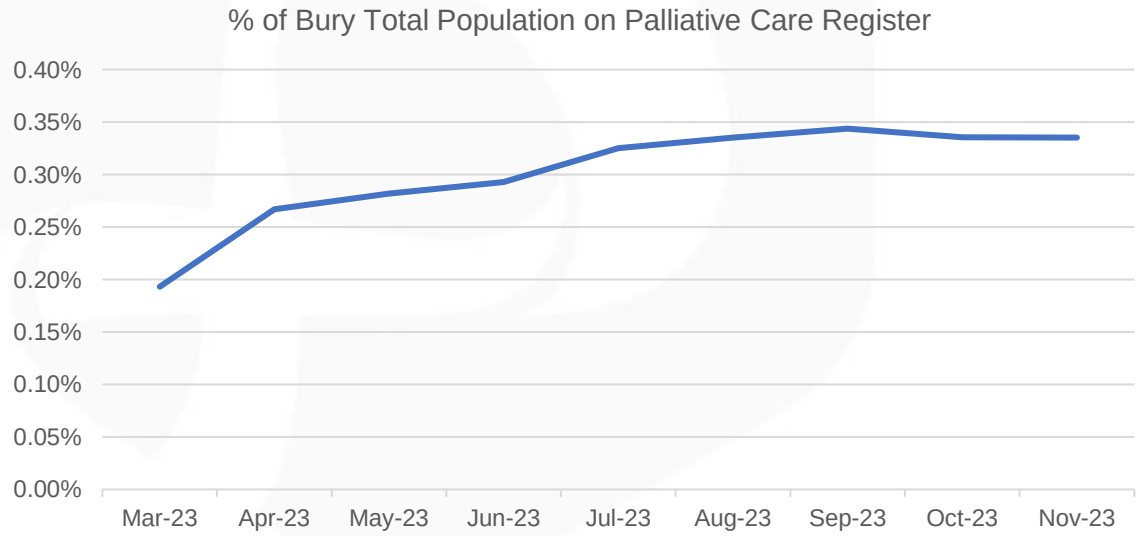
- LD Health checks: The cumulative position in 23/24 to October shows 27.8% of Bury patients have received an AHC. This compares to 37.4% for GM. Most AHC tend to take place in Q4. In October 22 the cumulative position was 18.0% for Bury patients.

- Inpatients – Transforming Care Numbers: Current position (26/11) shows that Bury are below the Q3 target of 2 for Secure patients with 0 and upto the target of two for non-secure. GM currently above target.

https://future.nhs.uk/MHRH/view?objectID=44149552

End of Life





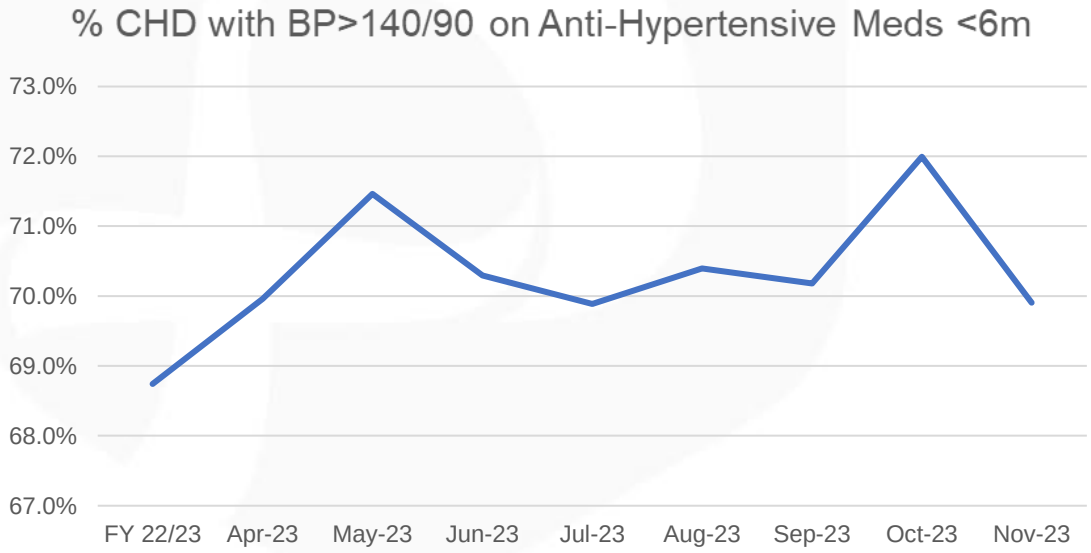
- Percentage of patients with 3+ admissions in the last 90 days of life – 11.0% of all deaths in Q4 of 2022 had three or more admissions in the last ninety days of life. Of those patients that died at home, 11.2% had three or more admissions, which was an increase from 10.4% on Q3.

- The percentage of the Bury population on the palliative care register has remained the same from October to November at 0.34%.

https://curator.gmtableau.nhs.uk/dashboard/place-of-death-dashboard

Long Term Conditions

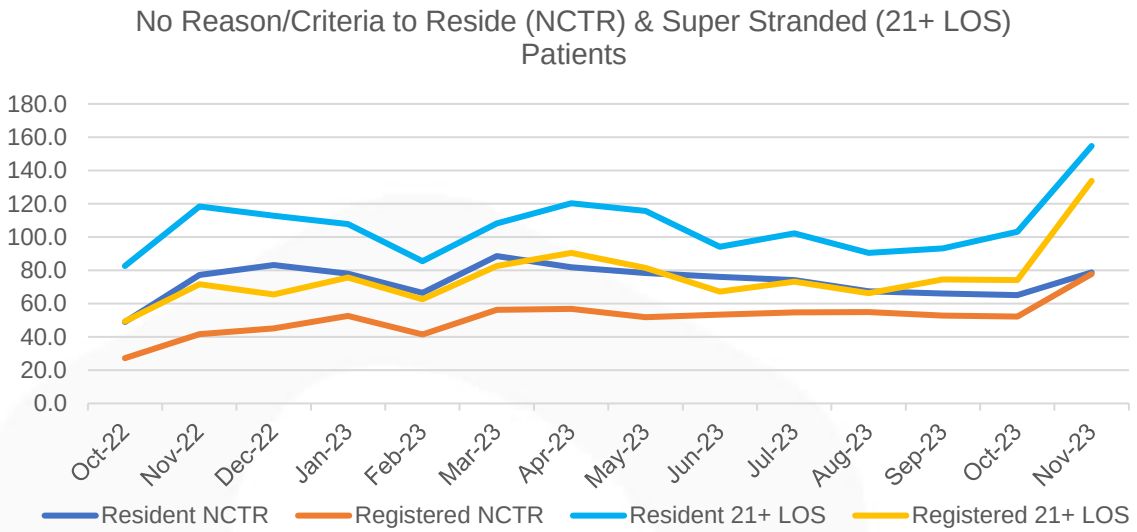
Diabetes Type 1	All Eight Care Processes		
Bury	355	895	39.70%
England	107,795	265,910	40.50%
DiabetesType 2 and other	All Eight Care Processes		
Bury	6,205	12,045	51.50%
England	1,985,545	3,436,315	57.80%

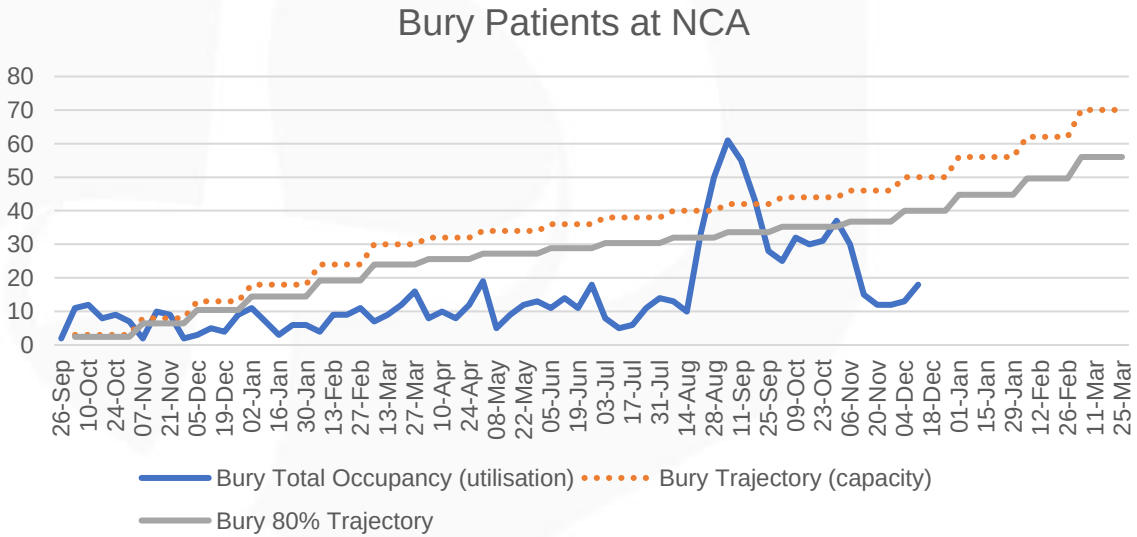


- Diabetes – For the period January 22 to March 23 39.7% of Bury patients with Type 1 diabetes had all eight care processes compared to 40.5% for England. 51.5% of those with Type 2 diabetes had all eight care processes compared to 57.8% for England.

- % of hypertension patients who are treated to target as per NICE guidance – 69.9% of patients were treated within target for November, which is a decrease on October which was 72.0%, however the YTD figure of 70.5% for 23/24 is still above to 22/23 figure of 68.7%

Community Services





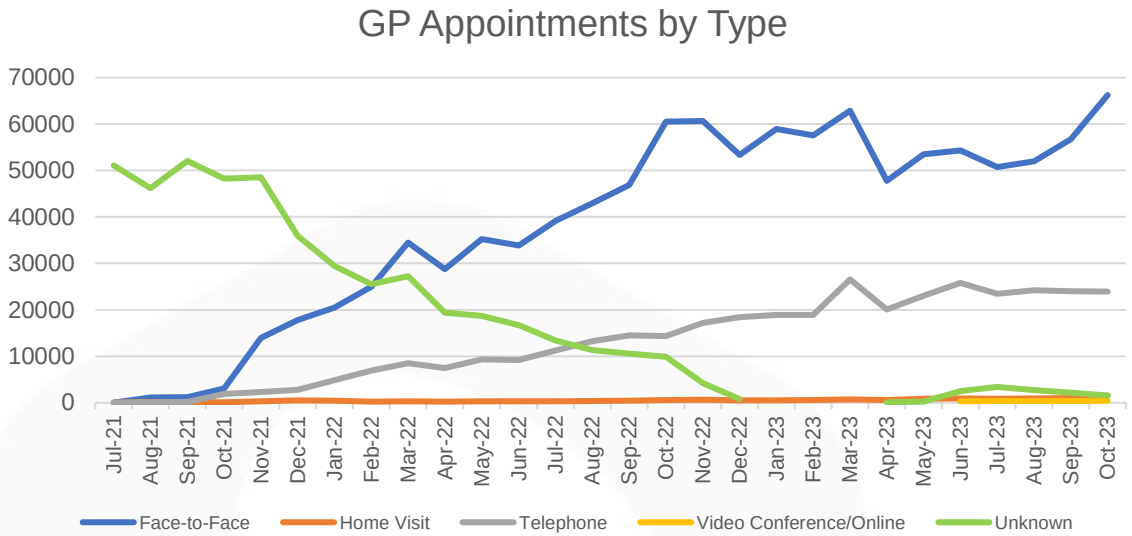
- NCTR monthly average for October was up by 21.1% for Bury residents to 78.8 from 65.1 in October. The monthly average for registered patients increased by 49.1% to 77.8 from 52.2 in October.
- The average monthly length of stay since NCTR for residents has increased from October to November, and the average for registered has also increased. The average LOS for November for resident was 25.4 days and registered 24.1 days.
- The Super Stranded monthly average increased in November from October for resident from 103.1 to 154.8. Registered increased by 80.4% from 74.1 in October to 133.7 in November.
- However these are subject to real time daily and weekly monitoring by mutli-agency teams and there is a slight lag in the formally reported data.

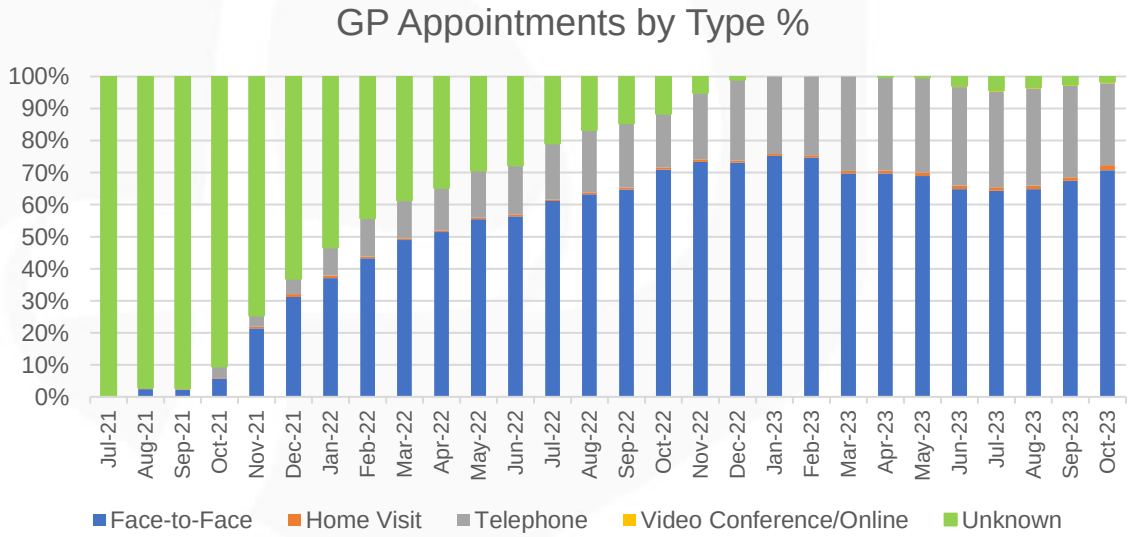
- The total patients in Virtual Wards at NCA at the beginning of December decreased by -12 on the beginning of November to 18 patients from 30. The occupancy is higher than the beginning of December 22 when the total occupancy was 3.

- UCR 2 hour response was below the target of 70% in November at 68.2%, this was previously 67% in October.

https://curator.gmtableau.nhs.uk/UrgentFlow

Primary Care





- In October 23 the total number of GP appointments has increased by 11.3% on September 23.
- 70.7% of GP appointments were Face-to-Face in October 23 compared to 67.4% in September.
- Home visits have increased by 59.3% in October but the percentage split by type is 1.6% of all appointments which was similar in September 23, 1.1%.
- The number of Unknown appointments types has decreased by -27.6% in October to 1548 appointments from 2138 in September.

https://https://curator.gmtableau.nhs.uk/dashboard/gp-appointments

BURY INTEGRATED CARE PARTNERSHIP

Meeting: Locality Board			
Meeting Date	08 January 2024	**Action**	Receive
Item No.	14	**Confidential**	No
Title	Clinical and Professional Senate Update		
Presented By	Dr Kiran Patel, Medical Director IDCB		
Author	Dr Kiran Patel, Medical Director IDCB		
Clinical Lead	N/A		

Executive Summary
To provide an update on discussions held at the Clinical and Professional Senate meeting on the 6th December 2023.
Recommendations
The Locality Board are 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	Yes	☐	No	☐	N/A	☒

Implications						
Assessment required?						
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**
Clinical and Professional Senate	06/12/2023	Meeting held.

BURY INTEGRATED CARE PARTNERSHIP

Clinical & Professional Senate 6th December 2023

1. **Reasonable Adjustment Digital Flag (RADF)**
    a. Awareness raising of the ability to flag on a patients Electronic Patient Record (EPS) – The RADF has been built by NHS England in the NHS Spine and aims to ensure that health and care professionals can record, share, and view and review details of the reasonable adjustments that an individual needs. The flag may also include details of a person's significant impairments and underlying conditions, on an optional basis
    b. Need for training and awareness raising – will hopefully be available from February

2. **All age GM Autism Strategy**
Helen Dawson presented a one year strategy produced along with the voices of adults, young people and children and captured by the SEND Partnership Board.
    - Increase skills of workforce using the Oliver McGowan Training
    - Improvements to assessment forms in adult social care
    - Work to increase opportunities to get involved and help describe what good services look like
    - Adult social care - reviewing and establishing pathways for adults and young people to ensure they have the correct support they need.

3. **Greater Manchester Review of Assisted Conception and Fertility Provision**
    a. Will gave some background information around anxieties regarding estate issues on the Central Manchester site. There is recognition that pathways are unclear and differ across providers; and feedback/frustrations from patient experience of the service
    b. going forwards there needs to be some standardisation; it is untenable to have different levels of service across the ICB
    c. discussion around how we feed into the clinical discussions and subsequent implementation – we agreed this can be done on behalf of the Senate via Cathy Fine who sits on the Clinical Effective & Governance Committee (CEG)
    d. However, both IDC Board and Locality would have ultimate say as may have impact on finance and services

4. **Elective Care Pathway Checklist**
    a. Checklist developed by Cath Tickle to systematically work through any proposed changes was presented for comment
    b. There was recognition that the checklist was a good way to ensure any changes are properly implemented and adopted
    c. However, work need to be done to socialise the checklist and broader acceptance of the way of working that it recommends
    d. Some tensions remain at the footprint that these changes and processes that is adopted – locality vs NCA

5. **Efficiency Plan - Roll out plans**
    a. Highlight the workshop and the aims for it
    b. Discussion around more broader buy in – from professionals on the front line

6. **Clinical & Professional Leadership Update (from GM)**
    a. CEG & GMMMG – discuss, review and seek opinions on a range of issues
    b. It was agreed that we would ask members of the senate to provide any locality views to feed into the GM discussions

c. The senate cannot make any decisions but can provide a professional view which would need to ratified or not by the Locality or IDC boards
d. I would use the allotted time on the agenda to highlight any issues

7 Recommendations

7.1 The Locality Board are asked to note the update.

Dr Kiran Patel
Medical Director IDCB
kiran.patel5@nhs.net
December 2023

Meeting: Locality Board			
Meeting Date	08 January 2024	**Action**	Receive
Item No.	15	**Confidential**	No
Title	PCCC Chair's Highlight Report		
Presented By	Adrian Crook, Director of Adult Social Services and Community Commissioning		
Author	Zoe Alderson, Head of Primary Care		
Clinical Lead	N/A		

Executive Summary
To provide an update on discussions held at the PCCC Meeting on the 29th November 2023.
Recommendations
The Locality Board are 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	☒

Implications						
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**
Primary Care Commissioning Committee	29/11/2023	Meeting held

Bury Primary Care Commissioning Committee (PCCC) Highlight Report

Chair: Adrian Crook **Reporting period: November 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:

GP Leadership Collaborative – the Chair of the GPLC attended to provide the Committee with a verbal update against the key items of the last meeting

Bury LCS – BeCCor update provided around the inclusion of the 3 key areas for all localities as determined by GM. Funding to be determined for those key areas alongside early thoughts on what the Bury LCS will look like for 24/25

General Practice Q2 Contract Update – update provided around general practice held contracts including key risks and mitigations

Commissioning Intentions 24/25 – Report presented to outline the commissioning intentions against key contracts for 24/25 inc QAS, paediatric phlebotomy, Bury LCS, Minor Surgery, SAS including recommendations, key risks and mitigations for agreement and decision by PCCC

Primary Care Quality Visit Programme – update report provided around the PCQV programme in the locality inc key updates and performance

OPEL Score Cards and Sit Rep Reporting – Update report provided to seek approval for implementation of updated OPEL Score Card for General Practice in anticipation of winter.

QoF Review Outputs – Report presented highlighting findings following analysis of Bury Locality QoF results for 2022/23. Plan presented on how to improve QoF overall performance in 2024/25

Updates provided to the Committee on the following areas:

Primary Care Blueprint, NHS GM PC Access Improvement Plan and the alignment to our local General Practice Strategy
PC Highlight Report
GP Out of Hours
LMC budget reporting requirements

Finance Report inc ARRS Expenditure Update

GM Quarterly Assurance Report and Risk Report - Received for information

Priority actions in coming period:

Locally Commissioned Services / Discretionary Funding

Bury LCS – Contract monitoring/management and continued work with GM to align the local quality contract for 2024/25 with the key areas for harmonisation across GM. Attention needs to be focused on discretionary budget available for this contract as we move through the last part of 2023/24.

Quality Assured Spirometry – future commissioning intentions to be determined in light of GM requirement to continue with the service using local discretionary funding

Minor Surgery ES - requirement to review the contact against other locality tariffs to ensure equity across Bury to ensure continued provision of the service by general practice to avoid increased secondary care costs

ARRS – ensure all claims and outstanding supporting evidence for those claims are submitted by all PCNs for 2022/23 and 2023/24

General Practice Strategy – Continued development and delivery of key priorities identified as part of the general practice strategy

COVID Vaccination Programme - ongoing delivery support with 2 pop up clinics signed off in Radcliffe targeting hard to reach communities

Primary Care Assurance – both practice quality visits and contractual assurance taking place

Decisions made:

The Committee supported the financial position including the need to progress receipt of the evidence to supporting the outstanding ARRS payments to PCNs
The Committee accepted the update re the GM Quality Scheme and planned harmonisation across localities pending further information as available

Top 3 risks & mitigation:	RAG rating
Recruitment and retention (including ARRS) – 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 hrs to deliver services	
23/24 Budget Setting – allocation for locality and QIPP targets	

Any other information:

Progress is being made across the locality with regards to the availability of 111 appointments via GP Connect in the Enhanced Access Service
Work is being undertaken with practices to improve coding of appointments and to ensure the contractual 111 appointment offer is achieved and coded correctly to inform accurate system reporting

Key escalations for NHS Greater Manchester PCCC: